State of California—Health and Human Services Agency
Department of Health Care Services

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TO: All California Children's Services Programs Participating in the Whole Child Model Program

SUBJECT: California Children's Services Program Whole Child Model (Revised)

I. PURPOSE

The purpose of this Numbered Letter (N.L.) is to provide guidance to local county California Children's Services (CCS) programs about requirements pertaining to the CCS Whole Child Model (WCM) program. This N.L. is written in conformance with All Plan Letter (APL) 18-011[1], which provides guidance to participating Medi-Cal managed care health plans (MCPs) on requirements pertaining to the implementation of the WCM.

II. BACKGROUND

Senate Bill (SB) 586[2] (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties to incorporate CCS Program covered services for Medi-Cal eligible CCS Program members into Medi-Cal managed care. MCPs operating in WCM counties will integrate Medi-Cal managed care and CCS Program administrative functions to provide comprehensive care coordination and integrated services to meet the needs of the whole child, including both CCS-eligible and non-CCS conditions. Integration of CCS Program administrative functions will help retain or exceed CCS Program standards, safeguard beneficiary protections such as continuity of care (COC), improve transition of CCS youth to adult Medi-Cal managed care, and help make future CCS Program improvements.

The WCM program will be implemented in 21 specified counties, starting July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible beneficiaries, MCPs must transition CCS-eligible beneficiaries into their MCP network of providers by their scheduled implementation date.

[1] CCS WCM APL 18-011 is available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586

WCM MCP	COHS 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 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

Implementation of the WCM will impact current CCS Program policies in the 21 participating counties. This N.L. provides policy direction to the participating counties to work in partnership with the MCPs operating in their county to implement the WCM effectively.

III. POLICY

Under the WCM, MCPs will assume full financial responsibility for authorization and payment of CCS-eligible medical services, including but not limited to, service authorization activities, claims processing and payment, case management, and quality oversight. MCPs will be required to apply CCS Program standards, as outlined in existing and future CCS N.L.s, and forthcoming regulations, to avoid any reduction in benefits for CCS-eligible children and maintain access to high-quality specialty care for CCS-eligible conditions. MCPs will authorize care that is consistent with CCS Program standards provided by CCS paneled providers, approved special care centers, and approved pediatric acute care hospitals. Further, the WCM program will support active parent/family participation of CCS-eligible Medi-Cal beneficiaries and ensure that beneficiaries receive protections such as continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

A. CCS Program Responsibilities

Local county CCS programs are responsible for performing all functions reserved to them under the WCM legislation (SB 586). Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county operates as an Independent or Dependent county.[3] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. DHCS will continue to maintain the

[3] Division of responsibility charts are available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

responsibility of eligibility determinations and redeterminations for Dependent counties.

MCPs are required to refer potential CCS-eligible Medi-Cal beneficiaries to the counties for CCS Program eligibility determination. Further, MCPs are responsible for providing all medical utilization and other clinical data for purposes of completing the annual CCS medical redetermination and other medical determinations as needed for CCS-eligible beneficiaries.

MCPs are required to oversee the authorizations (including PICU/NICU), benefits, case management, pharmaceutical, and/or program administration responsibilities, otherwise provided for by the counties/state in non-WCM counties, and will be responsible for ensuring compliance. To assist with this requirement, DHCS distributed a N.L. Index to all MCPs and Local county CCS programs participating in the WCM program. The CCS N.L. Index provides a sortable view for CCS N.L. and Information Notice letters up to June 2018. All CCS Paneled Providers and MCPs should refer to the Letters for the CCS Program website for future letters posted after June 2018.

The WCM will include CCS-eligible beneficiaries in a MCP with other health coverage (OHC) with full scope Medi-Cal as payor of last resort. Local county CCS programs will continue to provide all existing CCS Program services, such as care coordination, for non-WCM beneficiaries. The Medical Therapy Program (MTP) is not impacted by the implementation of WCM. WCM counties participating with the MTP will continue to receive a separate allocation for the program.

MCPs must ensure members have access to all medically necessary CCS paneled providers within the entire MCP provider network. MCPs are required to allow out of network access for beneficiaries to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the provider network or if in-network providers are unable to meet timely access standards. MCPs shall work collaboratively with local county CCS programs to refer providers who need to be paneled to DHCS.

B. County CCS Program and MCP Coordination

1. Memorandum of Understanding (MOU)

Local county CCS programs and MCPs must execute a MOU, based on DHCS' WCM MOU template,[4] outlining their respective responsibilities and obligations under the WCM program. The purpose of the MOU is to explain how the local county CCS programs and MCPs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM beneficiaries. The MOU between the

[4] MOU template for WCM Program: http://www.dhcs.ca.gov/services/ccs/Documents/WCM_MOU_Template_REVISED%20March%202018.pdf

individual county and the MCP should serve as the primary vehicle for ensuring collaboration between the counties and MCP. The MOU can be customized, based on the needs of the individual county and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. However, the MOU must include, at a minimum, all of the provisions specified in the MOU template. MCPs are responsible for submitting the MOU to DHCS. Phase 1 MCPs were required to submit an executed MOU by March 31, 2018. Phase 2 and 3 MCPs were required to submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

2. Transition Plan

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

3. Eligibility Determinations

a. New CCS Referrals for Eligibility Review

Independent CCS counties will maintain responsibility for medical, financial, and residential eligibility determinations for potential CCS beneficiaries. MCPs will notify the CCS county of any newly identified potential CCS condition, including infants with a potential CCS condition at time of discharge from the neonatal intensive care unit (NICU). Local county CCS programs will inform providers to send their authorizations for services to the MCPs. Dependent counties will continue to determine financial and residential eligibility, while DHCS will maintain responsibility for determining medical eligibility for potential CCS beneficiaries in Dependent counties.

b. Annual Redeterminations

Independent CCS counties will continue to review for annual CCS Program medical, financial, and residential eligibility. MCPs are responsible for providing necessary documentation, including medical records, to the CCS

counties to assist with CCS Program eligibility determination. Local county CCS programs will be responsible for obtaining any additional information required (e.g., medical reports) to make a program eligibility determination. Dependent counties will maintain responsibility for financial and residential eligibility annual redeterminations for CCS beneficiaries and DHCS will maintain responsibility for medical eligibility annual redeterminations.

4. Inter-County Transfer (ICT)

Local county CCS programs use CMSNet to house and share data needed for ICT, while MCPs utilize different data systems. Through their respective MOU, the local county CCS programs and MCPs will develop protocols for the exchange of ICT data as necessary to ensure an efficient transition of CCS beneficiaries and allow for continuity of care of existing authorized service authorization requests (SARs). Applicable guidance from CCS Program N.L. 09-1215, ICT Transfer Policy[5] will remain in effect.

Local county CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a beneficiary moves out of a WCM county, the local county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data, for beneficiaries who move out of the WCM county to the local county's CCS program office. The county will then coordinate the sharing of beneficiary data to the new county of residence. Similarly, when the beneficiary moves into a WCM county, the local CCS county will provide transfer data to the MCP as applicable.

5. Dispute Resolution

a. County CCS Program and MCPs Disputes

Interpretations of CCS Program medical eligibility disagreements between the local county CCS program and MCP contractor shall be resolved by the local county CCS program, in consultation with DHCS, as determined by Welfare and Institutions Code (WIC) 14093.06(b)[6]. The local county CCS program shall communicate the resolution of any such dispute in writing to the MCP contractor in a timely manner.

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[5] CCS Program N.L. 09-1215 ICT Transfer Policy is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl091215.pdf
[6] Welfare and Institution Code 14093.06(b) is available at:
http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14093-06.html

Disputes between the local county CCS program and the MCP that are unable to be resolved will be referred to DHCS via email at ISCDHAU@dhcs.ca.gov by either entity for review and final determination.

6. Beneficiary Grievance, Appeal and Fair Hearing Process

The grievance, appeal and Fair Hearing process is for the beneficiary or designated parent, legal guardian, or authorized representative of a CCS eligible beneficiary as specified below:

a. CCS Program Eligibility:

Independent CCS counties will continue to be responsible for determining program eligibility, while the DHCS remains responsible for determining program eligibility for Dependent counties. If the beneficiary is not satisfied with the CCS Program eligibility decision, the beneficiary shall use the CCS Program Appeal Guideline to file an appeal and/or request a Fair Hearing as specified in the CCS N.L. 18-0594[7].

b. Health Plan Grievance:

For matters not associated with CCS Program eligibility, the CCS beneficiary can file a grievance and appeal with their MCP and go through the MCP grievance and appeals process. CCS-eligible beneficiaries enrolled in a MCP are provided the same grievance, appeal and fair hearing rights as provided in State and federal law.8

7. Provider Grievances, Appeals, and Disputes

MCPs shall implement formal processes to accept, acknowledge, and resolve provider disputes and grievances. A CCS provider may submit to the MCP a dispute or grievance concerning the authorization or denial of a service, denial, deferral or modification of a prior authorization request on behalf of a MCP member, or the processing of a payment or non-payment of a claim by the MCP directly to the MCP. Local county CCS programs should refer any provider grievances to the MCP for resolution. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

8. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible beneficiaries or the beneficiary's family seeking transportation to a

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[7] Appeal Guidelines CCS N.L. 18-0594 is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl180594.pdf
[8] APL 17-006 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf

medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. Services provided by M&T include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.) in addition to transportation expenses. In providing M&T, MCPs must comply with all requirements listed in N.L. 03-0810.[9] These services include, but are not limited to, M&T for out of county and out of state services.

The local county CCS programs are is responsible for M&T for non-WCM CCS Program beneficiaries that remain the full responsibility of the county. Local county CCS programs shall refer beneficiaries to the MCP for transportation services the counties do not provide. MCPs must also comply with all requirements listed in APL 17-010.[10]

9. Continuity of Care (COC)

Medi-Cal beneficiaries who are transitioning into a MCP have the right to request and receive COC in accordance with State law and MCP contracts. MCPs are required to establish and maintain a process to allow beneficiaries to continue to access their existing provider(s) for up to 12 months[11.] MCPs, at their discretion, may extend the COC period beyond the 12-month period. Please refer to all applicable APLs related to COC requirements.

a. Case Management and Care Coordination:

MCPs must provide continuity of care for members through case management, care coordination, service authorization, and provider referral services.

At the request of a CCS beneficiary or their legal guardian, the MCP must allow the MCP member to continue receiving care from their existing public health nurse (PHN).[12] The MCP member must elect to continue receiving case management from the PHN within 90 days of transitioning into the MCP. Local county CCS programs must work with the MCPs to develop protocols for necessary information sharing when a member elects to continue to receive case management services from the PHN. If the beneficiary's PHN is no longer available, the local CCS program must notify the MCP immediately so the MCP can provide the member with a MCP case manager who has received adequate training on the CCS Program and who

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[9] Maintenance and Transportation of CCS Clients to Support Access to CCS Authorized Medical Services CCS N.L. 03-0810 is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[10] APL 17-010 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf
[11] Welfare and Institution Code 14094.13 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?.Num=14094.13.&lawCode=WIC
[12] WIC 14094.13(e), (f) and (g) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

has clinical experience with the CCS population or pediatric patients with complex medical conditions.[13]

b. High Risk Infant Follow-Up

MCPs are responsible for determining High Risk Infant Follow-Up (HRIF) Program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services. MCPs must notify the county CCS Program, in writing within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

10. Clinical Advisory Committee

The local county CCS programs shall provide a medical director or designee to actively participate in the MCP's quarterly CCS Program Clinical Advisory Committee. The CCS medical director or designee shall attend meetings and engage in discussions to offer feedback and recommendations on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisors on other clinical issues relating to CCS conditions.

C. NICU Acuity Assessment, Authorization and Payment

NICU acuity assessment, authorization and payment will be the responsibility of the MCP in all WCM 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 WCM:

[13] WIC 14094.13(e) is available at:
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

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	MCP	MCP	MCP

D. Quality Assurance and Monitoring

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

For questions regarding this N.L., contact CCSRedesign@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

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