California Children's Services (CCS) Program
Medi-Cal Managed Care – CCS – Whole-Child Model Comparison Chart
January 6, 2016

Topic	Medi-Cal Managed Care	CCS	Whole-Child Model
Authorization for Services	• Plan to adjudicate authorization request. • Authorization timeframes: o Expedited authorizations – 3 days o Concurrent review of authorization for treatment regimen already in place – 5 working days or less, consistent with urgency of the Member's medical condition o Routine authorizations – 5 working days from receipt of the information reasonably necessary to render a decision, but no longer than 14 calendar days from the receipt of the request. • Plan notifies the member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. o Deferral may occur only when the member or the member provider requests an extension, or the Plan can provide justification for the need for additional information and how it is in the Member's interest.	• State or County to adjudicate authorization request. • Member is notified within 7 days if denied, deferred, or modified.	• Plan to adjudicate authorization request. • Authorization time frames: o Expedited authorizations – 3 days o Concurrent review of authorization for treatment regimen already in place – 5 working days or less, consistent with urgency of the Member's medical condition o Routine authorizations – 5 working days from receipt of the information reasonably necessary to render a decision, but no longer than 14 calendar days from the receipt of the request. • Plan notifies the member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. o Deferral may occur only when the member or the member provider requests an extension, or the Plan can provide justification for the need for additional information and how it is in the Member's interest.

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	• If the final decision is to deny or modify the request, Plan shall provide written notification of the decision to members no later than 28 calendar days from the receipt of the original request.		• If the final decision is to deny or modify the request, Plan shall provide written notification of the decision to members no later than 28 calendar days from the receipt of the original request.
Case Management or Care Coordination Services *(includes services both in and out of the capitated rate)*	• Plan provides comprehensive medical case management to each member. • Plan maintains procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member. • Plan provides or arranges for payment of EPSDT, including case management and nursing services.	• CCS eligible medical conditions are referred to a CCS approved Special Care Center (SCC) • SCC coordinates services: o Emotional and social support issues o Physical and occupational therapy • SCC uses a multidisciplinary case management team • Team members required to include in the child's medical file an annual team report and contains: o Evaluation by individual team members o Recommendations o Documents evidence of case management and coordination o Proof of authorization of SCC services and receipt of services	• Plan provides comprehensive medical case management to each member. • Plan maintains procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member. • Plan provides or arranges for payment of EPSDT, including case management and nursing services.

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Continuity of Care	• Plan provides continuity of care for providers for up to 12 months if: o Pre-existing relationship; o Plan and provider agree to a rate; o No provider quality issues; o Provider shares treatment plan information with Plan; and o Provider is a State Plan approved provider. • Notice to beneficiaries occurs prior to continuity of care period ending and warm handoff to in network provider occurs. • Continuity of care for all medically necessary services continues until new medical assessment shows new/changed treatment plan is needed.	Continuity of care / services provided when: • Client moves from county to county in the State • Client needs health care outside the county or in another state	• Plan provides continuity of care for providers for up to 12 months if: o Pre-existing relationship; o Plan and provider agree to a rate; o No provider quality issues; o Provider shares treatment plan information with Plan; and o Provider is a State Plan approved provider. • Notice to beneficiaries occurs prior to continuity of care period ending and warm handoff to in network provider occurs. • Continuity of care for all medically necessary services continues until new medical assessment shows new/changed treatment plan is needed.

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Covered Services	• Adult Preventative Services Alcohol and Substance Abuse Services • Audiology • Behavioral Health Treatment (BHT) • Blood Lead Screens • Chiropractic • Chronic Hemodialysis • Cochlear Implants (Post implant related services) • Comprehensive Perinatal • Community Based Adult Services (CBAS) • Dialysis • Durable Medical Equipment • Emergency Services • Early Periodic Screening Diagnostic Treatment (EPSDT Program) • Family Planning • Health Education • Hearing Aids • Home and Community Based Services • Home Health Agency Services • Hospice • Immunizations • Individual Health Education Behavioral Assessment (IHEBA) • Initial Health Assessment • Inpatient/Outpatient Hospital • Investigational Services • Laboratory, Radiological & Radioisotope • Long Term Care (COHS and CCI Counties only) • Medical Home	• Audiology • Augmentative and Alternative Communication Devices • Cochlear Implants • Comprehensive Perinatal • Dialysis • Durable Medical Equipment • Emergency Services • Family Planning • Health Education • High Risk Infant Follow-Up (HRIF) Program • Hospice • Immunizations • Initial Health Assessment • Inpatient/Outpatient Hospital • Investigational Services • Long Term Care • Medical Home • Medical Nutrition Therapy • Medical Supplies • Mental Health • Minor Consent and Sensitive Services • Organ Transplants • Pharmacy • Physician • Post-Stabilization • Prosthetics and Orthotics • Provider Referrals • Renal and Corneal Transplants • Rehabilitative	• Adult Preventative Services Alcohol and Substance Abuse Services • Audiology • Augmentative and Alternative Communication Devices • Behavioral Health Treatment (BHT) • Blood Lead Screens • Chiropractic • Chronic Hemodialysis • Cochlear Implants (Post implant related services) • Comprehensive Perinatal • Community Based Adult Services (CBAS) • Dialysis • Durable Medical Equipment • Emergency Services • Early Periodic Screening Diagnostic Treatment (EPSDT Program) • Family Planning • Health Education • Hearing Aids • High Risk Infant Follow-Up (HRIF) • Home and Community Based Services • Home Health Agency Services • Hospice • Immunizations • Individual Health Education Behavioral Assessment (IHEBA) • Initial Health Assessment • Inpatient/Outpatient Hospital • Investigational Services • Laboratory, Radiological & Radioisotope

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	• Medical Nutrition Therapy • Medical Supplies • Medical Transportation • Mental Health • Minor Consent and Sensitive Services • Major Organ Transplants (COHS and CCI Counties only) • Nurse Anesthetist Services • Nursing Facility and Transitional Inpatient Care Services • Nurse Midwife Services • Optometrists Services • Organized Outpatient Clinic Services • Pharmacy • Physician • Post-Stabilization • Prenatal Care • Preventative Services • Prayer and Spiritual Healing (COHS Counties only) • Private Duty Nurse • Prosthetics Orthotic Appliances • Provider Referrals • Rehabilitative • Renal and Corneal Transplants • Respiratory Care Services • Rural Health Clinic Services • Sign Language Interpreter Services • Skilled Nursing • Special Care Center • Tuberculosis (TB) • Vision Care	• Services Provided in Home and Community • Skilled Nursing • Special Care Center	• Long Term Care • (COHS and CCI Counties only) • Medical Home • Medical Nutrition Therapy • Medical Supplies • Medical Transportation • Mental Health • Minor Consent and Sensitive Services • Major Organ Transplants (COHS and CCI Counties only) • Organ Transplants • Nurse Anesthetist Services • Nursing Facility and Transitional Inpatient Care Services • Nurse Midwife Services • Optometrists Services • Organized Outpatient Clinic Services • Pharmacy • Physician • Post-Stabilization • Prenatal Care • Preventative Services • Prayer and Spiritual Healing (COHS Counties only) • Private Duty Nurse • Prosthetics Orthotic Appliances • Provider Referrals • Rehabilitative • Renal and Corneal Transplants • Respiratory Care Services • Rural Health Clinic Services • Services Provided in Home and Community

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			• Sign Language Interpreter Services • Skilled Nursing • Special Care Center • Tuberculosis (TB) • Vision Care
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	• Plan ensures the provision of all medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members less than 21 years of age, including those who have special health care needs. • Plan covers all medically necessary services for members less than 21 years of age including health education, vision, dental and hearing, and various therapies and other long-term services and supports. • Plan ensures an adequate level of benefits and services. Plan shall also ensure that appropriate EPSDT services are initiated in a timely fashion, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.	• State and County CCS Programs and CMS Regional Offices may authorize EPSDT supplemental services not within the scope of regular benefits of the Medi-Cal program and may include: o Registered dietitians o Registered nurses o Marriage and family therapists o Licensed clinical social workers	• Plan ensures the provision of all medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members less than 21 years of age, including those who have special health care needs. • Plan covers all medically necessary services for members less than 21 years of age including health education services, vision, dental and hearing services, and various therapies and other long-term services and supports. • Plan ensures an adequate level of benefits and services. Plan shall also ensure that appropriate EPSDT services are initiated in a timely fashion, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.
Grievances and Appeals	• A formal grievance and appeal process exists.	• No formal CCS grievance process • Member has 30 days to appeal	• A formal grievance and appeal process exists.

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	• Member has 90 days to appeal a received Notice of Action • Health plan has 30 days or as quickly as the member's health condition requires to resolve a grievance. • Health plan must inform the member of the result in writing.	Notice of Action • State or County has 21 days to review appeal for reconsideration or 3 days if expedited appeal	• Member has 90 days to appeal a received Notice of Action. • Health plan has 30 days or as quickly as the member's health condition requires to resolve a grievance. • Health plan must inform the member of the result in writing.

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Individual Care Plan	• Health Plan responsible for Individual Care Plan for all medically necessary services. • The ICT may be shared with, but not limited to, the following: o Beneficiary; o Beneficiary's representative; o Family member and/or caregiver, as approved by the beneficiary; o Specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists; o Primary Care Provider o Other professionals as appropriate	• Individual care plans shared with the county care manager: o SCC Team assessments o Plans of care o Medical evaluations	• Health Plan responsible for Individual Care Plan for all medically necessary services. • The ICT may be shared with, but not limited to, the following: o Beneficiary; o Beneficiary's representative; o Family member and/or caregiver, as approved by the beneficiary; o Specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists; o Primary Care Provider o Other professionals as appropriate
Informing Materials	• Health Plans are required to provide informing materials which ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions. • Members may also request informing materials translated into the identified threshold and concentration languages, and alternative formats such as Braille and large size print. • DHCS and Plan have informative materials posted online for members and other stakeholders.	• State and County CCS have informative materials posted online for members and other stakeholders.	• Health Plans are required to provide informing materials which ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions. • Members may also request informing materials translated into the identified threshold and concentration languages, and alternative formats such as Braille and large size print. • DHCS and Plan have informative materials posted online for members and other stakeholders.

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Medically Necessary Service Definition	• Medical necessity includes any reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.	• Medically necessary benefits are those services, equipment, tests, and drugs which are required to meet the medical needs of the client's CCS-eligible medical condition as prescribed, ordered, or requested by a CCS physician and which are approved within the scope of benefits provided by the CCS program.	• Medical necessity includes any reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Network Adequacy	• Primary Care Time and Distance o 10 miles / 30 minutes • Timely Access o 10 days non-urgent primary care o 15 days non-urgent specialty care o 10 days mental health o 48 hours urgent appointment o Primary Care Ratio - 1:2,000 o Physician Ratio - 1:1,200 o Network must be certified prior to expansion occurring	• None	• Primary Care Time and Distance o 10 miles / 30 minutes • Timely Access o 10 days non-urgent primary care o 15 days non-urgent specialty care o 10 days mental health o 48 hours urgent appointment o Primary Care Ratio - 1:2,000 o Physician Ratio - 1:1,200 o Network must be certified prior to expansion occurring
Out-of-Plan Services From Out-of-plan Providers and/or Programs	• Plans are required to provide policies and procedures outlining access to out-of-plan program and services from out-of-plan providers when medically necessary and not available within the Plan network.	• Out-of-Plan services are allowed when medically necessary and the services are not available in California.	• Plans are required to provide policies and procedures outlining access to out-of-plan program and services from out-of-plan providers when medically necessary and not available within the Plan network.

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Parental Involvement/Family Participation	• Health Plans shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between providers and family members. • Member satisfaction is conducted annually through a CAHPS survey for children with chronic conditions and triennially for all members.	• Family members provide feedback of satisfaction with services through: o surveys o group discussions o individual consultation	• Health Plans shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between providers and family members. • Member satisfaction is conducted annually through a CAHPS survey for children with chronic conditions and triennially for all members. • Family member feedback provided through Title V needs assessment process.
Personal Physician or Primary Care Provider/ Medical Home Assignment	• Plan ensures that a member has a Primary Care Provider. If the member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Plan shall assign that member to a Primary Care Provider and notify the member and the assigned Primary Care Provider. • Primary Care Provider operates as member medical home and coordinates with Plan case manager and other providers, when applicable.	• State or County ensures member has the following: o Designated primary care physician o Physician who provides a medical home	• Plan ensures that a member has a Primary Care Provider. If the member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Plan shall assign that member to a Primary Care Provider and notify the member and the assigned Primary Care Provider. • Primary Care Provider operates as member medical home and coordinates with Plan case manager and other providers, when applicable.
Provider Credentialing (or CCS Paneling)/ Re-credentialing	• All providers are required to be credentialed prior to rendering services. • Credentialing includes: o Background check o Facility site review o Medical record audit o Physical accessibility review	• The CCS Program: o Panels providers o Approves facilities o Ensures hospitals meet CCS provider requirements / standards • Provider paneling process	• All providers are required to be credentialed prior to rendering services. • Credentialing includes: o Background check o Facility site review o Medical record audit o Physical accessibility

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	• All providers must be re-credentialed at least every three years.	determines if the provider meets the following for the provider type: o Advanced education o Training and/or o Experience requirements • Plans are required to use CCS paneled providers, CCS approved SCCs, and follow treatment plans as approved by the program. If a paneled provider cannot be found, the Plan will seek program approval to use a specific non-paneled provider with appropriate qualifications.	• All providers must be re-credentialed at least every three years. • Plans are required to use CCS paneled providers, CCS approved SCCs, and follow treatment plans as approved by the program. If a paneled provider cannot be found within the plan network, the Plan will make an effort to enter into an agreement with an out of network CCS paneled provider to provider treatment. If that cannot be accomplished the plan may seek program approval to use a specific non-paneled provider with appropriate qualifications.

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State Fair Hearings	• Member has 90 days to request a fair hearing through the Department of Social Services. • Member can continue treatment by asking for a fair hearing in 10 days and requesting "aid paid pending." • Office of Administrative Hearings reviews case after receiving a request to appeal.	• Member has 14 days to request a CCS fair hearing through DHCS. • State Fair Hearings for CCS are adjudicated by the DHCS Office of Administrative Hearings and Appeals (OAHA).	• Member has 90 days to request a fair hearing through the Department of Social Services. • Member can continue treatment by asking for a fair hearing in 10 days and requesting "aid paid pending." • Office of Administrative Hearings reviews case after receiving a request to appeal.
Transition Planning	• Plans must continue to provide all medically necessary covered services following transition from CCS age group to adult age group. Plan must ensure that members will have a care plan completed on an annual basis prepared in conjunction with the enrollee and family.	• A child 14 years and older and expected to have chronic health conditions that will extend past the twenty-first (21) birthday will have the following occur: o Be evaluated for long-term health care transition planning o Documentation of a biannual review for long term transition planning to adulthood o Receive recommendations and tools for health care transition planning	• Plans must continue to provide all medically necessary covered services following transition from CCS age group to adult age group. Plan must ensure that members will have a care plan completed on an annual basis prepared in conjunction with the enrollee and family.
Transportation, Lodging and Meals	• Emergency Medical Transportation services necessary to provide access to all Medi-Cal covered services. • Non-Emergency Medical Transportation (NEMT) when members cannot get to medical appointments by car, bus, train,	• CCS may help with travel expenses if clients cannot afford them and other resources are not available: o Mileage o Bus transportation o Eating out	• Emergency Medical Transportation services necessary to provide access to all Medi-Cal covered services. • Non-Emergency Medical Transportation(NEMT) when members cannot get to medical appointments by car,

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	or taxi under the following conditions: o Medically needed; o member can't use a bus, taxi, car or van to get to medical appointment; o Requested by a health plan provider; and o Approved in advance by the plan. • Non-Medical Transportation which allows a member to use a car, taxi, bus, or other public/private way of getting to medical appointments for covered medical services from those providers who are not Medi-Cal providers. • There are no limits to accessing Non-Medical Transportation under the EPSDT program. • NMT does not apply if: o An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service. o The service is not listed as a covered by the Plan outside of EPSDT. A list of covered services is in this member handbook (or also called EOC).	o Hotel • This option is available for the following: o Distance from client's home to the CCS-approved provider is more than a day trip o Remain at the hospital to learn how to care for their child	bus, train, or taxi under the following conditions: o Medically needed; o member can't use a bus, taxi, car or van to get to medical appointment; o Requested by a health plan provider; and o Approved in advance by the plan. • Non-Medical Transportation which allows a member to use a car, taxi, bus, or other public/private way of getting to medical appointments for covered medical services from those providers who are not Medi-Cal providers. • There are no limits to accessing Non-Medical Transportation under the EPSDT program. • NMT does not apply if: o An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service. o The service is not listed as a covered by the Plan outside of EPSDT. A list of covered services is in this member handbook (or also called EOC).