DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) TRANSITION PLAN

CHDP Program Transition Plan Summary

Senate Bill (SB) 184 (Committee on Budget and Fiscal Review, Chapter 47, Statute of 2022) authorized DHCS to phase out the CHDP program and transition services to other Medi-Cal delivery systems by July 1, 2024. This transition simplifies and streamlines the delivery of services to children and youth under the age of 21, in alignment with the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative. CalAIM increases standardization of care across Medi-Cal by consolidating care responsibilities for children and youth under Medi-Cal managed care health plans (MCP). DHCS plans to reallocate CHDP county allocations starting in fiscal year (FY) 2024-2025. Currently, the CHDP program includes:

- Preventive health, vision, and dental screening, and care coordination for Fee-For-Service (FFS) members eligible for Medi-Cal for Kids & Teens, federally known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit;
- CHDP Gateway which serves as a presumptive eligibility (PE) entry point for children to receive temporary preventive, primary and specialty health care coverage through the Medi-Cal Fee-For-Service (FFS) delivery system;
- Responsibility for local administration of the Health Care Program for Children in Foster Care (HCPCFC); and
- CHDP-Childhood Lead Poisoning Prevention (CLPP) program activities.

DHCS' transition of CHDP programs and services does not result in a loss of EPSDT services, as these services are covered in both the Medi-Cal FFS and managed care delivery systems. PE services will continue and expand under the new Children's Presumptive Eligibility (CPE) program, and PE services for individuals over the age of 19 will continue under Hospital Presumptive Eligibility (HPE).[1] HCPCFC will be preserved as a standalone, locally self-administered program. CHDP-CLPP activities will transition to MCPs and the California Department of Public Health (CDPH) Lead Poisoning Prevention Program Branch. DHCS will continue to share childhood lead poisoning data with CDPH and work in close partnership with CDPH on this front.

1 Note that any HPE-qualified and enrolled provider, including those in a Federally Qualified Health Center, can enroll eligible individuals over the age of 19.

CHDP Background

The CHDP program was established in 1973 by Assembly Bill (AB) 2068 (Brown, Chapter 1069, Statutes of 1973), to provide preventive health, vision, and dental screenings to children and youth. CHDP providers and locally based CHDP programs worked together to provide EPSDT services, as well as care coordination, for children and youth under the age of 21, who were enrolled in Medi-Cal FFS. The CHDP program is locally administered by 58 counties and three cities (Berkeley, Long Beach and Pasadena) that receive an annual budget allocation from DHCS. The purpose of the CHDP program funding was for activities including but not limited to care coordination and conducting CHDP provider oversight, site visits, provider certification, enrollment, education and training.

Under the EPSDT benefit, states are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the Social Security Act, Section 1905(a), necessary to correct or ameliorate a condition which could include care coordination as outlined in DHCS's EPSDT Policy.[2] Most children in Medi-Cal receive these care coordination services through their MCP. CHDP provided care coordination to children and youth who were uninsured or enrolled in Medi-Cal FFS. Once the CHDP program transitions, eligible children may receive care coordination services through county California Children's Services (CCS) programs, local HCPCFC programs, home and community-based service waiver providers, Targeted Case Management (TCM), county behavioral health programs, and other programs as identified.

In July 2003, the CHDP program began using the "CHDP Gateway" as an automated pre-enrollment process for non-Medi-Cal, uninsured children. Children and youth enrolled through CHDP Gateway receive Medi-Cal FFS coverage for up to 60 days while enrollment in Medi-Cal is being established.

Legislative Authority

SB 184 (Chapter 47, Statutes of 2022) approved trailer bill language to amend California Health & Safety (H&S) Code to repeal the CHDP program authority by July 1, 2024, and to transition CHDP services to other existing Medi-Cal delivery systems or services. Per requirements of SB 184, DHCS provided an update in the 2023-2024 legislative budget hearings pertaining to the CHDP program transition. SB 184 required DHCS to develop a transition plan includes the following:

- A post transition oversight and monitoring plan for Medi-Cal children currently served through CHDP, including those in fee-for-service and foster youth.
- A plan for how managed care plans will monitor providers serving children for adherence to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and Anticipatory Guidance as well as the EPSDT requirements, including but not limited to, requirements for site reviews, provider

2 EPSDT Policy Webpage

training audits, and coordination of care to needed services, including to dental and behavioral health providers.
- A plan to fund the administrative and services costs of the HCPCFC to meet statutory requirements.
- An analysis and plan for retaining existing local CHDP positions through the exploration of new partnerships or roles, or through bolstering existing programs that can leverage CHDP expertise, or both.

SB 184 requires DHCS to issue a declaration certifying the date that all activities pursuant to subdivision (a) (H&S Code 124024(a)), summarized above, have been completed. The declaration will be posted online and provided to the Secretary of State, Secretary of the Senate, Chief Clerk of the Assembly, and Legislative Counsel. This certification will be completed and posted following the issuance of this transition plan and ahead of the CHDP program phasing out date, July 1, 2024.

Enabling legislation of the CHDP program included:

- H&S Code, sections 104395, 105300, 105305, 120475, and 124024 through 124110.5. CHDP program statute that implemented, interpreted, or make specific the enabling legislation.
- California Code of Regulations (CCR), Title 17, sections 6800 through 6874. Medi-Cal regulations that authorize the availability and reimbursement of EPSDT services through the CHDP program.
- CCR, Title 22, sections 51340, 51340.1 and 51532-51532.3. Medi-Cal regulations pertaining to the requirement to cover EPSDT screening services.

Rationale for the CHDP Program Transition

Transitioning the CHDP program by July 1, 2024, aligns with DHCS' goals under CalAIM to make Medi-Cal a more consistent and seamless system for enrollees to navigate, by reducing complexity and increasing flexibility by streamlining and reducing duplication across multiple programs.

As of January 1, 2024, DHCS expects approximately 99% of all Medi-Cal members are enrolled in managed care and most members under the age of 21 are enrolled in an MCP. Consequently, it is duplicative to retain the CHDP program, since both Medi-Cal FFS providers and MCPs are required to meet all EPSDT requirements under federal law. In addition, foster children and youth will continue to receive services through HCPCFC, which will be maintained as a standalone program following the CHDP program transition.

Stakeholder Process

In preparation for the CHDP program transition, DHCS sought stakeholder input on a plan to ensure the successful transition of the CHDP program. A CHDP program transition workgroup was formed in September 2022 to inform DHCS in the

development and implementation of a transition plan and defined milestones to guide the transition of CHDP to other existing Medi-Cal delivery systems or services. The CHDP program workgroup included representatives of the California Department of Social Services (CDSS), CDPH, the County Health Executives Association of California, the County Welfare Directors Association of California, the California Dental Association, the AAP California, the Service Employees International Union, MCPs, children's advocates, as well as other subject-matter experts from across the state. Additional information about the stakeholder engagement process and workgroup meetings can be found on the CHDP program transition webpage.[3]

CHDP Stakeholder Engagement

Stakeholders were informed of the CHDP program transition through CHDP program letters, CHDP provider notices, Medi-Cal provider bulletins, and postings to the CHDP program transition webpage. Stakeholder engagement efforts included:

- A dedicated CHDP program transition stakeholder meeting series which included the members of the CHDP workgroup, listed above, and were open to the public. Each meeting provided opportunities for workgroup members and members of the public to raise questions, address any potential gaps, and provide feedback on the CHDP program transition activities. CHDP transition meeting topics include:
  - CPE;
  - Monitoring and Oversight Activities;
  - Transition of CHDP Resources;
  - CHDP-CLPP Activities;
  - HCPCFC as a Standalone Program; and
  - CHDP Program Transition Capstone Meeting
- Posting of the CHDP program transition workgroup meeting materials to the CHDP program transition webpage for stakeholder reference and accessibility. Targeted requests for review, comment, concerns, and suggestions from CHDP program transition workgroup members.
- A two-week public comment period to solicit input on the draft CHDP program transition plan.

Throughout the stakeholder engagement process, DHCS has solicited, gathered, and synthesized feedback and input from a variety of sources. DHCS has taken stakeholder input into consideration when developing this CHDP program transition plan and necessary policy guidance to ensure all stakeholders are informed of the CHDP program transition. After each workgroup meeting, DHCS provided the opportunity for stakeholders to provide additional comments and seek clarification on relevant topics. DHCS compiled this feedback, provided responses at the subsequent CHDP program workgroup meeting, and incorporated these responses into the transition plan, as appropriate. Following the capstone workgroup meeting, the two-week public comment

3 CHDP Transition

period yielded over 250 individual comments, all of which DHCS took into consideration and incorporated into this document as needed. Following the conclusion of the CHDP program workgroup, DHCS continued to engage stakeholders. DHCS facilitated regular meetings with CDSS and CDPH, in addition to targeted meetings such as the CHDP Executive Committee Quarterly Meetings and the Statewide Foster Care Subcommittee Quarterly HCPCFC Meetings. Additionally, DHCS has and continues to host ad hoc meetings with select stakeholders and counties to discuss relevant aspects of the CHDP program transition.

Stakeholder Communication

Revisions are being made to the Medi-Cal Provider Manual, Medi-Cal Dental provider handbook, MCP contract, the HCPCFC Program Manual, and other relevant policy guidance documents to reflect the transition of CHDP to other existing Medi-Cal delivery systems. DHCS has issued county guidance for the last fiscal year of the CHDP program, *CHDP Program Activities in Fiscal Year 2023-2024*.[4] DHCS will continue to communicate all transition plan guidance by the following methods: program letters, provider notices, Medi-Cal bulletins, weekly stakeholder update and stakeholder meetings. All current materials pertaining to the transition plan have been posted on the CHDP program transition website. All Plan Letters (APLs) and program letters will be distributed and posted on the CHDP program transition website, as applicable. Regarding CPE, DHCS will notify all current CHDP Gateway providers of the change and any new requirements pertaining to CPE through a provider newsflash bulletin prior to their automatic enrollment in the CPE program on July 1, 2024. Additional detail about the transition to CPE for current CHDP providers and prospective CPE providers is included in the CPE section below.

For ongoing stakeholder communication leading up to and following the CHDP program transition, DHCS maintains the following email inboxes:

- CHDPprogram@dhcs.ca.gov for general questions or comments related to the CHDP program and its transition;
- ChildrenPE@dhcs.ca.gov for questions about PE and the transition to CPE or manual determination requests for CPE; and
- HCPCFC@dhcs.ca.gov for questions regarding the establishment of HCPCFC as a standalone program.

Local CHDP Program Communication

In addition to CHDP program transition workgroup meetings, DHCS conducted a series of informational interviews with representatives from counties ranging in size and geography to inform this transition plan and related policy decisions. Informational

4 CHDP Program Activities in Fiscal Year 23-24

interview topics included overviews of medical record reviews (MRR), site reviews, referrals, and triage management activities. A key theme of these informational interviews centered on care coordination for the FFS population. Through conversations with county representatives and the results of a survey administered to all local CHDP programs, DHCS learned some local CHDP programs have historically relied on other county programs to provide care coordination. Additionally, aggregate survey results indicate most counties have seen a consistent decrease in the number of children served through CHDP due to increased enrollment into MCPs. Concurrently, DHCS analyzed internal enrollment data to verify this understanding. Thus, taken together, DHCS anticipates the number of FFS beneficiaries impacted due to the CHDP program transition is limited and will continue to decrease.

Table 1 below displays both outstanding and completed stakeholder activities.

Table 1 – Stakeholder Communication

<table>
<tr><th>Completed</th><th>In Process</th></tr>
<tr><td>CHDP program transition proposal included the following:

Disseminated a CHDP program letter and provider notice (22-02 and 22-06)
Issued a Medi-Cal provider bulletin
Posted updates to the CHDP program transition webpage CHDP program guidance for activities in FY 23/24

This document includes guidance on communicating staffing shortages or other factors which hinder the continuation of all or some local CHDP program activities to DHCS, MCPs, and members; CPE and contacts for questions; HCPCFC and expectations of the HCPCFC Program Administrator; communication with providers and Medi-Cal MCPs, including the sharing of training materials; records retention; responsibilities for CLPP; needed updates to local CHDP program websites; and available CHDP program county resources.
Timeline: Was published by the end of calendar year (CY) 2023.

</td><td>The stakeholder communication has concluded.</td></tr>
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Completed	In Process
Hosted CHDP Program Transition Stakeholder Workgroup meetings • Posted CHDP program transition materials to the webpage for stakeholder reference and accessibility.	CHDP provider notices *Timeline: To be published on an ad hoc basis through July 1, 2024.* • *CHDP Program Gateway providers transition to CPE*
Held individual meetings with various counties and advocacy groups about current CHDP program activities and transition efforts.	Medi-Cal provider bulletins *Timeline: To be published on an ad hoc basis through July 1, 2024.* • CHDP Provider Enrollment Deadline posted on January 26, 2024. • Revised CHDP Provider Enrollment Deadline
To communicate with MCP stakeholders, DHCS: • Hosted a two-day training conference with MCPs’ Master Trainers to review training requirements. • Included topics related to the CHDP program transition and existing training requirements during regular meetings with MCPs and Associations, as well as the Managed Care Advisory Group.	Template memorandum of understanding (MOU) to guide MCPs’ interactions with educational entities.

Transition Plan

SB 184 requires DHCS to consult with stakeholders in the development of a transition plan. The CHDP program is on track to sunset and fully transition all functions to other existing Medi-Cal delivery systems or services as described in this transition plan on July 1, 2024. DHCS will reallocate the CHDP program budget county allocation starting in FY 2024-2025 to HCPCFC and CCS Monitoring, and Oversight.

DHCS conducted an analysis and plan for retaining CHDP program positions, to stand up the HCPCFC administrative activities and CCS Monitoring and Oversight. DHCS only considered non-clinical administrative classifications in the CHDP program budget reallocation. Additionally, DHCS considered any additional operating costs such as employee benefits and indirect rates. DHCS will preserve the HCPCFC as a standalone program and transition the CHDP-CLPP program responsibilities to MCPs and CDPH. PE services will continue under the CPE program and all qualified Medi-Cal providers will be eligible to participate. Below is a summary of key provisions in this plan.

CPE

CHDP provides PE for children through the CHDP Gateway. The CHDP Gateway is utilized by CHDP providers to provide temporary, full scope Medi-Cal services to CHDP-eligible children and youth. Non-Medi-Cal children and youth who meet the following criteria are eligible for pre-enrollment through the CHDP Gateway:

- Residents of California;
- Younger than 19 years of age;
- Members of a family whose income is at or below 266 percent of the federal poverty guidelines;
- Do not have Medi-Cal eligibility;
- The applicant has not exceeded two Presumptive Eligibility enrollment periods in the last 12 months; and
- Additionally, if a child's mother was enrolled in Medi-Cal when going through the CPE process, the child will also be deemed eligible.

The function of the CHDP Gateway has been preserved, expanded, and renamed CPE. Under PE, a family can quickly and easily enroll their child in temporary full scope Medi-Cal based on a simple attestation of their circumstances. They must then file a full Medi-Cal application to ensure that they are in fact eligible to maintain coverage, but, in the interim, the child can secure prompt access to care for up to a 60-day time period. Enrollment in Medi-Cal through the CHDP Gateway for children and youth younger than 20 years of age is limited to two PE program enrollment periods in a 12-month period.

CPE Enrollment Process

The CPE provider will guide families through the application process, share the eligibility determination, and offer a Medi-Cal application. CPE providers and provider site staff provide prospective members a paper copy of eligibility questions during office visits and are available to assist with any questions. The responses are then used to perform CPE determination. If a child is determined eligible, they will receive a temporary card. If a child is determined ineligible, the determination is reflected on the electronic medical record and the family is offered a Medi-Cal application in the event that they qualify for full-scope Medi-Cal. The transition to CPE will not impact the general process for enrollment into Medi-Cal from either the provider's or the MCP's perspective.

Upon enrollment into CPE, families will receive a CPE welcome letter, which emphasizes that the child is only temporarily enrolled in CPE. To encourage families to maintain Medi-Cal coverage, the letter includes an application used to determine eligibility for Medi-Cal or premium assistance programs through Covered California. The letter will include a toll-free number for assistance with the application in addition to a link to the Medi-Cal Health Enrollment Navigator home page. Medi-Cal Health Enrollment Navigators, funded by DHCS via SB154, will be available to assist families in submitting Medi-Cal applications. Health Enrollment Navigators include counties and community-based organizations and conduct varied outreach to hard-to-reach potentially eligible Medi-Cal populations. The Medi-Cal Health Enrollment Navigators Project will be available leading up to and following the CHDP program transition, as the

Project is funded through at least June 30, 2025.

As an additional reminder to submit a full Medi-Cal application, DHCS will continue to automatically send the existing CHDP 15-day reminder letter as part of CPE. The notice specifies the date on which a child's CPE coverage will end, lists the toll free number and link to the Health Navigator webpage, as included in the welcome letter, and includes information about the Medi-Cal application. Both the welcome letter and the 15-day reminder letter are available in all threshold languages; additionally, large-print versions in all threshold languages are forthcoming. The welcome letter and 15-day reminder letter, in addition to any related updates, will be posted to the Medi-Cal provider webpage.

Expansion of CPE Providers

California has long authorized certain providers – namely CHDP Gateway providers (i.e., pediatricians, family practitioners, internists, independent certified family or pediatric nurse practitioners) – to conduct PE determinations. As of December 2023, there were 2,755 active medical providers approved to provide services and access the CHDP Gateway. In FY 2022/2023, on average, approximately 2,500 monthly pre-enrollments were processed via the CHDP Gateway.

Following the transition, CPE will be available for use to an expanded list of qualified Medi-Cal providers including, but not limited to, FQHCs, local education agencies, family centers, community clinics (which have historically been eligible to conduct PE for pregnant women), pediatricians, family practitioners, internists, dental providers, and independent certified family or pediatric nurse practitioners. DHCS anticipates this will significantly increase overall access to services for this population.

On or by July 1, 2024, DHCS will publish a list of CPE providers searchable by county on DHCS's CPE landing page, which CPE beneficiaries and their families can access directly. This list will be updated regularly and will include providers who serve the FFS population. Additionally, DHCS is planning to implement an updated directory of Medi-Cal providers, including but not limited to CPE providers, that Medi-Cal members can easily access and search.

To ensure provider site staff know how to assist families with CPE, all qualified CPE providers are required to successfully complete required training, which covers how to access the CPE Portal and enroll eligible children into CPE. Providers are unable to access the CPE portal or submit a CPE transaction until they successfully complete the training. CPE providers are only permitted to bill for services within their scope of practice; while all qualified CPE providers will be able to determine presumptive eligibility, they will not be providing services outside of their scope of practice. Additionally, only Medi-Cal providers with active licenses are eligible to be a CPE provider. If a provider were to lose their status as a medical provider, they would automatically lose their ability to access the CPE portal or otherwise participate in CPE. Table 2 outlines the transition plan for CPE, including CHDP program activities, outcomes, as well as completed or planned steps.

Table 2 - Transition Plan for CPE

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps taken
CHDP providers used the CHDP Gateway process to temporarily pre-enroll CHDP-eligible children and youth in FFS, full-scope Medi-Cal.	Outcome(s): DHCS will 1.) Transition the CHDP Gateway to the CPE program; and 2.) Expand access to the CPE program to include all qualified Medi-Cal providers. Transition Plan/ Steps Taken: 1. DHCS developed a CPE program training module (similar to hospital PE) as part of applicable State requirements to expand access to PE to all qualified Medi-Cal providers. All new CPE providers must undergo a computer-based training. • CPE providers are only required to complete this training once but will be responsible for staying apprised of updates through provider bulletins. • DHCS will publish a provider bulletin notice with information on accessing the training. • The CPE training is available to all qualified Medi-Cal providers, including current CHDP Gateway providers, but is not a general Medi-Cal requirement; i.e., only those Medi-Cal providers enrolling in CPE will be required to complete the training. 2. The Telephone Service Center (TSC) is available for assistance during business hours. Providers can also e-mail the CPE inbox at childrenPE@dhcs.ca.gov with questions about presumptive eligibility, questions related to the transition to CPE, and for assistance with processing manual determination requests. 3. Existing CHDP providers' will be automatically transitioned into the CPE program on July 1, 2024. Local CHDP programs should continue processing new CPE enrollments until the date specified in the CHDP Program Activities in FY 2023-2024 guidance and work through any backlog up until the transition date. Implementing a cutoff will ensure prospective CPE providers do not have to go through the

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps taken
Eligibility was based on age, household composition, and family income. Services were available beginning on the date eligibility was determined. CHDP Manual - Gateway	enrollment process twice. 4. Link to Medi-Cal Health Enrollment Navigators home page will be included on the CPE eligibility notice. 5. DHCS will update all CHDP system messages to read “Children’s Presumptive Eligibility” instead of “CHDP Gateway.” DHCS will conduct outreach to all Medi-Cal providers using processes such as provider bulletin notices in advance of the July 1, 2024 transition date.

EPSDT Screening and Follow-Up Services

Historically, local CHDP programs provided EPSDT screenings, including preventive health, vision, and dental screenings, follow-up services, and care coordination, for children and youth under the age of 21 who were enrolled in the Medi-Cal FFS. The services provided under the CHDP program were Medi-Cal EPSDT services and are available in both FFS and managed care delivery systems.[5] Access to preventive health screenings and follow-up services will not be diminished due to this transition. In fact, with the addition of all eligible Medi-Cal providers in the CPE program, DHCS anticipates that more children and youth will have access to care than prior to the CHDP program transition.

Care Management and Case Management Services

FFS providers are also responsible for providing all EPSDT screening and treatment services to their enrollees. Referrals and care management or case management services for the FFS population will continue to be processed or provided by any FFS provider, FQHCs, CCS programs, HCPCFC, or MCAH or receive services from county social workers, TCM, HCBS waiver providers, or through the community health worker (CHW) benefit or other programs as identified. The Medi-Cal Evaluation and Management provider manual provides a comprehensive overview of the care management and case management services and reimbursement codes specific to them.

By July 2024, most children and youth under the age of 21 will be enrolled into an

5 CHDP providers submit claims to the Medi-Cal Fiscal Intermediary for EPSDT services rendered to Medi-Cal FFS enrolled recipients younger than 21 years of age.

MCP.[6] MCPs are required to meet all EPSDT requirements under federal law, and, as such, cover all medically necessary preventive services for children and youth in accordance with the AAP Bright Futures Periodicity Schedule and Anticipatory Guidance.[7] MCPs must also provide care coordination to all members including children and youth under the age of 21 to ensure appropriate and timely access to all needed medical, mental health, substance use disorder, developmental, dental, social, and health education services, including coordinating transportation as needed. MCPs assess the needs of children and youth for screenings, such as for adverse childhood experiences, and deploy strategies to mitigate negative impacts of social drivers of health, such as coordinating community-based services and other appropriate resources.[8] Additionally, under the comprehensive EPSDT benefit, MCPs are required to coordinate referrals to other medically necessary services to correct or ameliorate a condition even if not specifically enumerated in the Medicaid State Plan for coverage in the Medi-Cal program, as well as all required specialty and/or other follow-up services for problems identified at well-child visits.[9] Provider referrals serve as the primary mechanism for communicating needed follow-up services to MCPs. To effectively process those referrals, MCPs are required to have referrals systems in place, which DHCS monitors through utilization reviews and quality measures.

MCPs must adhere to timely access requirements by ensuring network providers offer appointments and making referrals in accordance with state guidelines.[10] There are existing appointment time standards for MCPs. If a member specifically does not pass a hearing screening, MCPs are required to have policies and procedures in place to refer potential CCS program eligible members to the county CCS program for a CCS program eligibility determination. If the child resides in a Whole Child Model (WCM) county, the MCP would be responsible for ensuring the member receives the necessary follow-up services including occupational and physical therapy provided by the county CCS Medical Therapy Program.

All members in managed care are eligible for care management. There are three types of care management including basic population health management, complex care management and enhanced care management (ECM). Children will receive care management based on identified social and medical needs. Children with extensive care coordination needs will be assigned a care manager for EPSDT services and will potentially be eligible for the highest level of care management, ECM.[11] In July 2023, ECM was made available to eligible children or youth enrolled in an MCP with complex physical, behavioral, or developmental health needs (e.g., enrolled in the CCS program;

6 Today about half of foster care children and youth receive services through the FFS Medi-Cal program and half receive services through Medi-Cal MCPs. For foster care children/youth not enrolled in an MCP, systematic coordination of services and comprehensive care management will continue to be provided through the HCPCFC.
7 See Exhibit A, Attachment 10 (Scope of Services), Provision 5 (Services for Members under Twenty-One (21) Years of Age), of the MCP Contract.
8 Additional information about the components of a health assessment, Current Procedural Terminology billing codes, frequency limitations, immunizations and interperiodic health assessments is available in the Preventive Services section of the appropriate Part 2 Medi-Cal manual.
9 See MCP Contract, Exhibit A, Attachment 10 – Scope of Services, Para 5.B.4.
10 Network Adequacy
11 CalAIM ECM Policy Guide

involved in or with a history of involvement in children welfare, including foster care up to age 26; with Clinical High-Risk Syndrome, or experiencing first episode of psychosis). ECM providers address the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services and comprehensive care management.

Ensuring the Provision of Covered Dental Services

Dental administrative service organizations (ASOs) are responsible for ensuring the provision of dental services for the FFS population, while dental managed care (DMC) plans are responsible for ensuring the provision of dental services for their members. The Medi-Cal Dental FFS and DMC plans are required to provide care coordination and case management services in order to ensure the member receives appropriate dental care.

Additionally, MCPs have contractual responsibility to ensure the provision of dental services for managed care members. For dental periodicity, MCPs must cover and ensure that dental screenings and oral health assessments are included as a part of the Initial Health Appointment (IHA) for all members, regardless of comorbidities.[12] For members under 21 years of age, MCPs are responsible for ensuring that a dental screening/oral health assessment is performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Further, MCPs must ensure that members are referred to appropriate Medi-Cal dental providers.

To ensure delivery of required dental-related services, DHCS reviews and approves MCP policies and procedures. These must include the roles and responsibilities of the MCP's dental liaison in coordinating referrals to Medi-Cal dental providers as well as to other covered Medi-Cal services including, but not limited to, laboratory services and pre-admission physical examinations required for admission to an outpatient surgical service center or an in-patient hospitalization required for a dental procedure.

MCP Dental referral navigators are available to the DMC and dental FFS population, including foster youth. For dental referrals, MCP providers should be making referrals directly to a dentist. If the provider needs help finding a dentist, they can contact the Medi-Cal Dental member number (1-800-322-6384) or utilize the Medi-Cal Dental Provider Directory to find a provider. For dental referrals for members who reside in Sacramento or Los Angeles County and have a DMC plan, the MCP should contact the DMC plan's member number or utilize the Medi-Cal DMC plan's online directory.

Monitoring and Oversight

MCPs ensure that network providers are able and ready to conduct preventive healthcare services, including EPSDT services such as vision, hearing, fluoride varnish application, and anthropometric screenings and provide network providers information on programs such as Vaccines for Children (VFC).[13] DHCS confirms MCPs' provision of

12 Refer to MCP Contract, Exhibit A, Attachment 11 – Case Management and Coordination of Care.
13 APL 23-005

these services through the ongoing monitoring of encounter data and metrics.

Further, MCPs conduct initial site reviews of network provider sites, termed Facility Site Reviews (FSR), and are required to re-survey the site no less than every 3 years.[14] To ensure providers follow all preventative guidelines, MCPs must have the capacity to conduct the required site reviews, which is accomplished through a DHCS certified train-the-trainer program through which DHCS observes and certifies all Master Trainers.[15]

MCPs review medical records during FSR to ensure appropriate screenings were conducted and appropriate referrals are made by network providers. To increase standardization across MCPs, DHCS requires the use of its MRR tool, which follows Bright Future guidelines. To oversee compliance and create an additional level of accountability, DHCS' nurse consultants conduct site reviews and monitor noncompliance trends which provides an extra level of accountability. An MCP's continued noncompliance with minimum performance levels (MPLs) or FSR/MRR requirements can result in administrative actions including technical assistance, corrective action plans (CAPs) and/or monetary sanctions.

DHCS requires MCPs to submit data on all provider site reviews as well as documentation of any completed deficiencies identified by the MCP during an on-site audit. State law requires MCPs to have adequate facilities and service site locations available to meet contractual requirements for the delivery of primary care within their service areas. All primary care physician (PCP) sites must have the capacity to support the safe and effective provision of primary care services. Beginning in Q3 2024, DHCS will require MCPs to transmit all fields in the MRR tool to DHCS. The intent of capturing these data elements is for DHCS to track instances of MCPs' identification of provider non-compliance and hold MCPs to provider oversight and correction when required screenings and services are not conducted. DHCS has updated its MRR tool to incorporate a review of the provider site staff's ability to proficiently conduct required screenings. Table 3 outlines the transition plan for EPSDT, including CHDP program activities, outcomes, as well as completed or planned steps.

14 APL 22-017 For more information on facilities and service sites, see CCR, Title 22, sections 53230 and 53856.

15 DHCS is aware that some MCPs have historically relied on local CHDP programs for the provision of required trainings. In these cases, DHCS has encouraged both MCPs and local CHDP programs to share training materials and best practices ahead of the CHDP program transition. DHCS has offered to both MCPs and local CHDP programs to facilitate this collaboration if needed. Following CHDP sunset, MCPs may consider opportunities to contract with local health jurisdictions as appropriate to provide these services.

Table 3 - Transition Plan for CHDP Activities Related to EPSDT Prevention and Treatment Services

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
Children and youth are eligible to receive the complete range of Medi-Cal FFS benefits via PE.	Outcome(s)/Transition Plan: None necessary/no change. FFS benefits include Medi-Cal EPSDT services. In addition, TCM will remain available in counties that choose to participate and provide those services covered under the State Plan.
Periodicity and Medically Necessary Interperiodic Health Assessments: • Periodic and interperiodic screenings and assessments are reimbursable for infants and children under 21 years of age, as specified in Bright Futures/ AAP Recommendations for Preventive Pediatric Health Care. Comprehensive no-cost preventive visits for children include age and gender appropriate history, examination, counseling/ anticipatory guidance, development surveillance, risk factor reduction interventions and the ordering of laboratory/diagnostic procedures.	Outcome(s)/Transition Plan: None necessary/no change. EPSDT services are available in both FFS and Managed Care delivery systems. These services can be accessed through the PCP at any appointment and specifically child wellness visits. MCPs are responsible for the oversight of compliance AAP's Bright Futures Periodicity Schedule and Anticipatory Guidance.
Dental Periodicity: • A dental screening/oral assessment is required at every Medi-Cal for Kids & Teens/CHDP health assessment, regardless of age. Children and youth should be referred to a dentist as follows:	Outcome(s)/Transition Plan: None necessary/no change. Services are Medi-Cal EPSDT services and are available in both FFS and Managed Care delivery systems through ASOs as well as DMC plans and MCPs, respectively. The Department of Managed Health Care monitors the provision of services under dental MCPs for compliance, in addition to regular DHCS audits. In addition, DHCS conducts continuous and targeted outreach for all Medi-

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
○ Beginning at age 1 as required by H&S Code, section 12040(6)(D). ○ At any age if a problem is suspected or detected. ○ Every six months for maintenance or oral health. ○ Every three months for children with documented special health care needs when medical or oral condition can be affected, and for other children at high risk for dental caries.	Cal members to use their dental benefits. This includes annual dental exams and preventive services for children.
CHDP providers to adhere to CHDP Health Assessment Guidelines, which support the AAP Bright Futures Periodicity Schedule and (CHDP Provider Information Notice 17-03).	Outcome(s)/Transition Plan: None necessary/no change. Bright Futures/AAP is the nationwide standard of practice for all medical providers, including all Medi-Cal providers in all Medi-Cal delivery systems. The current MCP contract boilerplate currently requires all MCPs, and the network providers which they oversee, to comply with these requirements.
CHDP providers must participate in the VFC program (CHDP Provider Manual).	Outcome(s)/Transition Plan: None necessary. Medi-Cal providers are required to provide necessary immunizations. In addition, all Medi-Cal providers that meet the VFC program criteria, as defined in federal law, not just CHDP providers, may participate in the VFC program. MCPs are contractually required to ensure children receive necessary immunizations timely and in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices.
The local county CHDP programs were responsible for day-to-day program operations, including the following:	Outcome(s): Maintain existing requirements for MCPs to provide care coordination assistance under EPSDT/Medi-Cal for Kids & Teens.

<table>
<tr><th>Previous CHDP Program Activities</th><th>Outcomes / Transition Plan / Steps Taken</th></tr>
<tr><td>
Education and outreach to eligible families (CHDP Provider Manual).
Providers were responsible for informing patients about the availability of EPSDT/CHDP services and assisting recipients, in coordination with the local CHDP program, to obtain preventive health services for which they are eligible.
</td><td>
<u>Transition Plan/Action Steps</u>:

Amended MCP contract, as appropriate, to eliminate references to CHDP.
Communicate with MCPs to encourage them to have a robust engagement process with their local partners, including local CHDP staff, prior to the CHDP program transition to share training resources and best practices. While DHCS encourages MCPs to learn from local CHDP programs and adapt existing trainings and educational materials as appropriate, DHCS does not mandate MCPs to use specific training or educational material. However, DHCS does mandate the appropriate provision of required screening, which MCPs ensure through effective training and education.
At the local level, providers will continue to utilize their established community relationships to share information related to CPE for FFS beneficiaries. Similarly, where they are present, Health Navigators can assist with CPE and Medi-Cal enrollment.

</td></tr>
<tr><td>
The local county CHDP programs were responsible for day-to-day program operations, including the following:
Assistance to families in obtaining services, including transportation for medical appointments and services.
</td><td>
<u>Outcome(s)</u>:
1) Maintain existing requirements for MCPs to provide care coordination assistance under Medi-Cal for Kids & Teens. Per the MCP Contact’s Scope of Services, MCPs are required to provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary Covered Services that contractor is responsible for providing pursuant to this contract.
Transportation

MCP members reach out directly to your MCP for NMT assistance. Health Plan Directory (ca.gov)
FFS members can find more information at Transportation (ca.gov) and email DHCSNMT@dhcs.ca.gov to arrange assistance.

</td></tr>
</table>

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
	2) Maintain requirements for county TCM consistent with DHCS policy. 3) General questions: DHCS Ombudsmen for general questions Ombudsman (ca.gov) ○ By Phone: 1-888-452-8609 ○ By email: MMCDOmbudsmanOffice@dhcs.ca.gov
• Assistance to providers in contacting patients and scheduling appointments with other providers. (CHDP Provider Manual)	Transition Plan/Action Steps: • 1. Amend CHDP website to provide transition updates and redirect members to available resources notifying them of their participants rights.

FFS Care Coordination

DHCS is monitoring the FFS population closely. As the population transition to managed care continues, DHCS anticipates a continuing decline in FFS population numbers.

Survey results and interviews with local CHDP programs conducted during the transition process have indicated that a gap in care coordination services for the FFS population has existed under the CHDP program. DHCS is aware that a portion of the FFS population was not receiving care coordination prior to the CHDP program transition. DHCS is unable to specifically identify with local CHDP programs the volume of FFS population that may be receiving care coordination today or the duration of any enrolled members in care coordination services. DHCS acknowledges that there will continue to be a portion of the FFS population who may not receive care coordination services following the CHDP program transition. However, individuals in FFS will continue to receive care coordination if they qualify for specialty programs such as FQHCs, CCS programs, HCPCFC, or MCAH or receive services from county social workers, TCM, HCBS waiver providers, or through the CWH benefit or other programs as identified. FFS providers are also able to provide care management or case management services for the FFS population as identified and needed. In addition, as January 8, 2024, providers will be able to use PAVE to submit enrollment applications for Community-Based Organizations (CBOs) and Local Health Jurisdictions (LHJ) for Provider Enrollment Division (PED) review and enrollment.[16] CBOs/LHJs may enroll in order to be reimbursed for services provided by CHW and Asthma Prevention Specialist (APS) workers.

16 Community-Based Organizations and Local Health Jurisdictions Enrollment

Managed care enrollment remains an option for individuals currently in FFS who wish to receive care coordination. A FFS member can apply to enroll in an MCP at any time, with the effective date being the first day of the subsequent calendar month, and will receive care coordination via their health plan of choice. To join an MCP, prospective members should visit their local county office. Additionally, upon enrollment into Medi-Cal, members receive a Medi-Cal Managed Care Health Care Options information packet, which provides useful resources to ensure members understand the managed care option. With few exceptions, most Medi-Cal members, including those in FFS, receive this packet.

Lastly, counties are encouraged to visit the CHDP program website, which will have links to additional resources, for six months after the transition. DHCS asks for the counties' assistance to connect or refer FFS beneficiaries to other available community resources such as First 5, Women, Infants, and Children (WIC), CCS, and HCPCFC as appropriate.

Current CHDP Program Staff and Redirection of Staff Post-Transition

In compliance with SB 184, DHCS conducted an analysis of the current county CHDP program budgets submitted over the last five years to determine which existing CHDP program staff classifications should be redirected to bolster existing county programs. Below is a list of classifications currently funded under the CHDP program and potential ways to redirect those positions while leveraging other county programs:

Currently funded under the CHDP Program	Possible Redirection of Staff
Administrator (Non-Public Health Nurse (PHN)/Physician)	CCS CMO, CCS, First 5, WIC
Supervising PHN	HCPCFC, CCS, Immunization Program, WIC
Public Health Assistant	HCPCFC, MCFHS, First 5, WIC
Administrative Support Staff	Any county program staff
Fiscal Support Staff	County fiscal team
Dental Hygienist	County Oral Health Program, First 5
Nutritionist/Registered Dietician	County public health departments, First 5, WIC
Registered Nurse	CCS, CCS CMO, county public health departments, Immunization Program, MCFHS, First 5, WIC

Health Care Program for Children in Foster Care

HCPCFC provides consultation and resource guidance to the multidisciplinary care team to address and oversee the medical, dental, developmental, and behavioral health needs of foster children and youth. The program navigates the health care system to facilitate appropriate referrals and continuity of care for children and youth who are in out-of-home placements. HCPCFC is a PHN-led program serving Foster Youth as defined by Welfare & Institutions Code (WIC) 11400(f)(G), Non-Minor Dependents (NMD), as defined by W&I Code section11400 (v)(1-3), and Wards of the Juvenile Court, as defined by WIC 450, who have been either:

- Removed from their home pursuant to W&I Code section 309 (temporary custody);
- Subject of a petition filed under W&I Code section 300 (dependent-victim of abuse or neglect) or W&I Code section 602 (juvenile who has violated the law); or
- Removed from their home and are the subject of a petition under W&I Code section 300 or 602.

Health services and care coordination are often provided to the HCPCFC population by a number of different entities. A case manager from other participating agencies, such as the CCS program, the regional center, or a home health agency may simultaneously enact specific case management responsibilities. When other entities are providing health services, it is HCPCFC's role to: monitor and collaborate toward optimal outcomes, maintain the record of care provided and those providing services in Child Welfare System/Case Management System, share available information with the Child Welfare/Probation team, identify and address gaps in care provided, continue ongoing administrative monitoring and oversight, communicate and consult with the case worker as appropriate, and address unmet needs through facilitation or direct intervention, within the scope of program responsibility.

Although statutorily CHDP and HCPCFC are separate programs, local county and city CHDP programs are responsible for the administration and oversight of HCPCFC. HCPCFC is a CDSS program, in which DHCS and CDSS partner to administer, via an interagency agreement (IA). Program guidelines are established by CDSS, DHCS, and statutory authority. DHCS leveraged CHDP programs to provide administrative support and oversight of the provision of public health nursing in Child Welfare and Probation departments statewide.

Per the establishing statute, W&I Code section 16501.3, CDSS is responsible for administering the HCPCFC and has entered into an IA with DHCS to obtain federal approvals to claim Federal Financial Participation (FFP). The Social Security Act provides for a FFP rate of 50 percent (nonenhanced) for the majority of expenses necessary to the proper and efficient operation of the program and an FFP rate of 75 percent (enhanced) for expenses of skilled professional medical personnel (SPMP) and their direct clerical support staff necessary for development and administration of a medically sound program. Direct support staff means clerical staff who: are secretarial,

stenographic, copy, file, or record clerks providing direct support to the SPMP, and provide clerical services directly necessary for carrying out the professional medical responsibilities and functions of the SPMP.

HCPCFC is embedded in local Child Welfare Departments providing PHN oversight, and management of the medical, dental, behavioral, and developmental needs. In addition, the foster care PHNs provide oversight to foster youth prescribed psychotropic medications. The program functions as a part of local Child Welfare Departments, bridging the unique social determinants of health experienced by this population, health outcomes, and providers of health services.

DHCS will establish the HCPCFC as a standalone program with the funding and staff necessary to conduct its own program administration. The transition of the CHDP program is not a cost savings effort; all funds currently allocated to the CHDP program will be reallocated to the HCPCFC and CCS Monitoring and Oversight. Currently, the HCPCFC funded staff include registered nurses with an active California PHN certificate and their direct support staff (non-administrative). Since the CHDP program provided administrative support to the HCPCFC, DHCS needed to allocate funding to the HCPCFC program to cover administrative support once the CHDP program phases out.

Budget and Allocation Methodology

To determine the HCPCFC administrative allocation, DHCS conducted an analysis of the CHDP program administrative costs and took into account how the HCPCFC and CCS Monitoring and Oversight could retain existing CHDP program staff and their expertise. DHCS only considered CHDP program staffing budgets associated with administrative employee classifications. Additionally, DHCS considered any additional operating costs such as employee benefits and indirect rates. The administrative classifications considered in the analysis included: Supervising PHNs, Public Health Assistants, administrative support staff, and fiscal support staff. The new HCPCFC administrative allocation will cover the following positions: Supervising PHNs, and administrative classifications. Budget allocations will be up for review and reassessed on an annual basis.

As a result of the continued stakeholder engagement, DHCS assessed the HCPCFC new program requirements and determined that additional allocation was needed. DHCS determined that in order for the HCPCFC program to be a standalone program there were minimum staffing requirements needed for each county to ensure program efficacy.

PHNs serve in a variety of program leadership positions ranging from direct supervision of staff to managing, charge, and administrative positions. Each local HCPCFC program is overseen by a Supervising PHN serving as the HCPCFC Program Administrator for that jurisdiction. All HCPCFC staff must be supervised by a PHN. The HCPCFC PHN Program Administrator is responsible for all aspects of the program within the jurisdiction and compliance with local, state, and federal requirements for the program. Some counties may appoint more than one Supervising PHN.

Program Administrators/Supervising PHNs are responsible for: managing staff, maintaining up-to-date and readily accessible local policies and procedures, providing assistance and direction to HCPCFC staff upon request, being the primary point of contact for Child Welfare and Probation staff at the level of their classification or above, and for discussions regarding collaboration procedures with non-HCPCFC entities, providing adequate supervision to program staff ensuring adherence to program requirements and goals, obtaining and providing training to program staff, providing and maintaining program staff access to systems and resources, appropriate record keeping including Protected Health Information (PHI) and information required in the case of an audit by any applicable entity, maintaining adequate staffing to meet program caseload and staffing requirements, monitor staff documentation and procedures in order to identify and correct errors.

Supervision of program staff may not exceed 15 HCPCFC staff persons to every PHN directly supervising that individuals work, with the exception of the PHN overseeing the program as a whole within that jurisdiction. Caseload methodology is developed by CDSS in partnership with the California Child Welfare Indicators Project (CCWIP). More information regarding caseload methodology can be found on the CCWIP website.[17]

DHCS, in consultation with CDSS, will monitor and oversee local implementation of the HCPCFC program at the county level through the execution of performance measures. Performance measures were developed in collaboration with CDSS. DHCS will begin collecting performance measures from counties beginning in FY 2025-26, allowing counties approximately one (1) year to implement said performance measures and stand up the HCPCFC program.

DHCS will work collaboratively with CDSS to create a new IA to be in place on or before June 30, 2024.

HCPCFC will continue to provide monitoring and oversight for the foster youth through their existing PHNs, additional supervising PHN's, and additional administrative staff. Also, performance measures will be in place to hold counties accountable and DHCS will be available to help guide the counties. Table 4 outlines the transition plan for HCPCFC, including CHDP program activities, outcomes, as well as completed or planned steps.

Table 4 - Transition Plan for the HCPCFC

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
Local HCPCFC administration, monitoring, and oversight was conducted by local CHDP administrators.	Outcome(s): DHCS will reallocate a portion of the current CHDP budget allocation annually to the HCPCFC to cover administrative costs. The remaining CHDP funds will be reallocated to the counties for the CCS CMO

17 California Child Welfare Indicators Project homepage

<table>
<tr><th>Previous CHDP Program Activities</th><th>Outcomes / Transition Plan / Steps Taken</th></tr>
<tr><td></td><td>Program efforts. CDSS will continue to cover allocations associated with PHNs and their direct support staff, as is currently the case for HCPCFC dependent on county/city caseload. As part of the reallocation of the CHDP program funds, DHCS will allocate funds specific to HCPCFC administrative support staff.

<u>Transition Plan/Action Steps:</u>

1. Engaged key stakeholders (e.g., CDSS, counties, county associations, advocates).
2. Establish county allocation for local county administration of HCPCFC.
3. Expanded allowable expense categories to support HCPCFC self administration. Previous restrictions were lifted; local HCPCFC budgets are now composed of the following five major line items:
• Personnel Expenses
• Operating Expenses
• Capital Expenses
• Indirect Expenses
• Other Expenses
4. Enter into new IA with CDSS.
5. Revise the HCPCFC Program Manual and implement performance measures to reflect administration and define program requirements.
6. Develop training modules for program staff that are grouped by role: financial, administrative, and frontline activities. The modules will be posted to the DHCS HCPCFC webpage and summarize program requirements found in the HCPCFC Program Manual and the HCPCFC Financial Policy & Procedure. DHCS plans to post these training modules in advance of the transition date.
7. DHCS has started hosting bi-monthly meetings, starting in February 2024 with HCPCFC PHN’s and county officials to discuss updates and changes to the HCPCFC.</td></tr>
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CHDP Childhood Lead Poisoning Prevention Program

The CHDP-CLPP program was administratively tied to CHDP through an IA with CDPH which will expire on June 30, 2024. The IA between the CDPH and DHCS outlines several responsibilities of the CHDP-CLPP program, including but not limited to:

- Identify and review Medi-Cal lead records.
- Provide CLPP educational materials and trainings to Medi-Cal providers.
- Share Medi-Cal data and information with CDPH.
- Work collaboratively to update policy guidance pertaining to lead assessments, blood lead screening, follow-up for lead testing, and appropriate interventions.
- Provide resources to counties without contracts with CDPH's Childhood Lead Poisoning Prevention Branch (CLPPB) to manage lead poisoned children to the greatest extent possible.

Previously, DHCS issued annual budget allocations to local CHDP counties to perform these various activities. However, in accordance with the MCP contract and APLs 20-006 and 20-016, MCPs were already required to comply with CLPP program requirements and are responsible for conducting blood lead screening for MCP enrollees.[18] All MCPs are assessed for compliance through DHCS Audits and Investigation Division' routine medical audit Additionally, MCPs conduct chart reviews as a part of regular FSR and MRRs, which currently includes lead screening reviews and provider training. DHCS has aligned the MCP MRR requirements with the specific CLPP chart review requirements to ensure there are no gaps in requirements following the transition. In addition, DHCS added the lead screening measure to its annual performance reporting, so all MCPs will be reporting this measure for their population annually. CDPH's CLPPB will continue existing lead screening-related activities following the CHDP program transition. Table 5 outlines the transition plan for CHDP-CLPP, including CHDP program activities, outcomes, as well as completed or planned steps.

18 See MCP Contract, Exhibit. A, Attachment 10.

Table 5 – Transition Plan for CHDP-CLPP

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
Local CHDP programs conduct MRRs and targeted provider outreach and education activities for the CLPP program. Inclusion (Consultation) of CDPH Lead Branch in DHCS Lead related activities. DHCS shares lead related data with CDPH.	Outcome(s): DHCS will (1) Transition MRR and targeted provider outreach and education to the Medi-Cal MCPs, as appropriate, per requirements of AB 2276 (Chapter 216, Statutes of 2020) as outlined in APL 20-016; (2) Continue to share lead data with CDPH through the Business Use Case Proposal; (3) Transition lead guidelines to the Medi-Cal Provider Manual; (4) CDPH is responsible for continuing activities related to lead screening for fee-for-service members after the CHDP program phases out on July 1, 2024 Transition Plan/Steps Taken: 1. DHCS will work collaboratively with CDPH to ensure all existing responsibilities and resources are appropriately transitioned to MCPs, the local public health department, or to CDPH, as applicable. • Data Sharing • Joint Lead Guidelines 2. DHCS confirmed future MCP policies are explicit and ensured the continuation of all provider-related CLPP program activities. For example, DHCS' Audits and Investigation Division assesses all MCPs for compliance with their contractual requirements for Lead screening on a routine basis. 3. CDPH's CLPPB will continue to offer resources to parents/families via distribution Lead Education Materials to local health jurisdictions. 4. DHCS and CDPH will match up Medi-Cal kids meeting criteria for applicable lead screening requirements during a certain time period (e.g., calendar year) with lab data to identify which children did not receive a lead screening who should have. 5. DHCS will send outreach notices to families that did not receive a screening who should

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
CDPH & CHDP published joint lead guidelines (CHDP Health Assessment Guidelines, Section 6).	have and still meet the requirements. 6. CDPH will conduct analysis of data of children not screened and provide education and training to providers in areas where groups of children not screened reside; if identified.

Newborn Hearing Screening Program (NHSP)

The NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills. NHSP does not require insurance coverage and is offered to every baby born in a CCS program-approved hospital whose family chooses to participate. The CHDP program currently assists DHCS NHSP's contracted Hearing Coordination Centers (HCCs) by following up with the families of babies who have failed hearing screenings and have not kept their appointments for rescreening or diagnostic evaluation or have become unreachable by the provider and HCC. After attempting to reach the family a minimum of three times, the HCC refers them to CHDP for county staff to use their resources to attempt to contact the referred family to determine if they need assistance with scheduling an appointment or transportation to and from an appointment for hearing screening or diagnostic evaluation.

DHCS and the HCCs work together to contact the families who need assistance in scheduling appointments or transportation to and from an appointment for hearing screening or diagnostic evaluation. The HCCs will attempt to reach the family a minimum of five times on separate days and times through multiple contact methods, and if unsuccessful, will request DHCS assistance in locating updated contact information for the family. To aid their collaborative efforts, DHCS will create a dedicated inbox for the HCC staff to submit requests for updated beneficiary information. DHCS staff will use the Medi-Cal Eligibility Data System (MEDS) to retrieve current contact information and report back to the HCCs weekly for additional contact attempts to be made.

DHCS is revising the procedures and flow of processes in the HCC Tracking and Monitoring Procedure Manual to have the HCCs notify the baby's PCP when an initial hearing screen is not passed rather than waiting to notify the PCP by letter when an evaluation appointment is not kept. Looping the PCP in earlier in the process may help decrease the number of babies lost to follow up by ensuring the PCP is aware of the initial hearing screening result and enabling the PCP to also follow up with the family at well-baby checks. The revised procedures will also increase the number of contact attempts made and expand the contact method to telephone and mail. The requirements and procedures for NHSP family follow-ups will exceed the current standards to ensure families receive at minimum the same level of outreach and engagement as families who were referred to CHDP.

The HCCs will continue to track each baby screened and run data reports identifying the number and percentage of babies lost to follow-up which can be compared to past data on those referred to CHDP. As needed, DHCS will make changes to the procedures for NHSP family follow-ups to ensure there are no gaps between how these functions are carried out today, as these responsibilities will transition to DHCS and the HCCs.

DHCS and the HCCs will utilize every resource available to find and reach out to families of babies who did not pass their initial hearing screening, offering assistance with scheduling appointments or transportation to/from appointments for hearing rescreening or diagnostic evaluation. For instance, babies enrolled in Medi-Cal are referred to the CCS program when they have a medically-eligible condition such as hearing loss. DHCS can reach out to an infants' local county CCS program office or ECM community worker to request assistance with locating the family to facilitate follow up.

Additionally, MCPs are responsible for case management services related to EPSDT and have policies and procedures in place to ensure follow-up for missed EPSDT related appointments, which includes follow-up with the families of babies that miss their rescreening or diagnostic appointments. If a family contacts their county for assistance with follow-up services, the county would continue to either refer the family to the CCS program if the baby is CCS program-eligible or to the HCCs who can direct the family to available providers within their insurance plan. DHCS does not maintain a directory of all Ear, Nose and Throat (ENT) providers or audiology providers, however, families of babies covered by Medi-Cal or the CCS program can find a directory of Type C Communication Disorder Centers (CDCs) on DHCS's website. The Type C CDCs are certified to serve children of all ages with hearing loss. Additionally, each health plan should have their own directory of providers that would include providers specializing in ENT and audiology and should also include subspecialities such as pediatric ENT or pediatric audiology. Table 6 outlines the transition plan for NHSP, including CHDP program activities, outcomes, as well as completed or planned steps.

Table 6 - Transition Plan for NHSP

Previous CHDP Program Activities	Outcomes / Transition Plan / Steps Taken
HCC refers unreachable families to the local CHDP program to use their resources to attempt to contact the family.	Outcome(s): DHCS assumed previous CHDP responsibilities with the assistance of the HCCs to locate families and ensure they are not lost to follow up. DHCS created a dedicated inbox for the HCCs to email inquiries to. DHCS staff looks up the family information in MEDS and shares any updated contact information back to the HCCs for them to make a second round of attempts, to offer assistance in scheduling further appointments. As needed, DHCS made changes to the procedures for NHSP family follow-ups to ensure there were no gaps between how these functions were carried out under CHDP and post-transition. The HCCs continued to track each baby screened and ran data reports identifying the number and percentage of babies lost to follow-up (unreachable) which can be compared to past data on those referred to CHDP.

Post-Transition Monitoring and Oversight Plan

In the following tables, DHCS has outlined planned monitoring and oversight activities and associated frequencies specific to each CHDP program component across delivery systems (e.g., MCP, FFS, and HCPCFC).

Table 7 - Managed Care: EPSDT

Monitoring and Oversight Activity	Quarterly	Annually	Ongoing
DHCS confirms MCPs' provision of services through the ongoing monitoring of encounter data and metrics.			x
MCPs are required to conduct initial FSRs			x
MCPs are required to re-survey provider sites		x[19]	
To oversee compliance, DHCS' nurse consultants conduct site reviews and monitor noncompliance trends which provides an extra level of accountability.			x
To conduct additional oversight of MCP's requirement for ensuring provider proficiency in conducting required services and screenings, DHCS has updated the FSR tool. Additional updates will be made as needed.			x
During FSRs, MCPs are required to conduct MRRs. DHCS requires the use of its standardized MRR tool, which outlines the Bright Future guidelines, ensuring pediatric specific guidelines are met when reviewing pediatric medical records.			x
DHCS will require all fields in the MRR tool to be transmitted to DHCS. This enables DHCS to review specific records for providers by age-specific required services and screenings. DHCS will be better able to track instances of provider non-compliance discovered by MCPs and hold MCPs to provider oversight and correction when required screenings and services are not conducted.			x[20]

19 Occurs every three years.
20 Beginning in 2024.

Monitoring and Oversight Activity	Quarterly	Annually	Ongoing
To ensure providers follow all preventative guidelines, MCPs must have the capacity to conduct the required site reviews, which is accomplished through a DHCS certified train-the-trainer program through which DHCS observes and certifies all Master Trainers. Master Trainers are responsible for the oversight of the site review program at each plan.			x
Providers identified as not providing the required screenings will be scored as deficient and are subject to technical assistance and could be placed under a CAP. The provider's CAP is closed once the provider is found compliant with requirements.			x
DHCS requires MCPs to submit data on all provider site reviews as well as documentation of any completed deficiencies identified by the MCP during an on-site audit.			x
An MCP's continued noncompliance with minimum performance levels (MPLs) or site reviews requirements can result in administrative actions including technical assistance, CAPs and/or monetary sanctions. DHCS may use these measures to oversee and monitor compliance with services and requirements covered in MCPs' contracts.			x
Medi-Cal Managed Care Plans must adhere to timely access requirements by offering appointments and making referrals in accordance with state guidelines.			x
To ensure delivery of required dental-related services, DHCS reviews and approves MCP policies and procedures that must also include the roles and responsibilities of the MCP's dental liaison in coordinating referrals to Medi-Cal dental providers as well as coordinating referrals for Medi-Cal dental providers to other Medi-Cal covered services			x
DHCS Audits and Investigations conducts routine audits of all MCPs with compliance and contractual requirements for coverage of Medi-Cal covered services.		x	

Table 8 – Managed Care: CHDP-CLPP and NHSP

CHDP Program Component	Monitoring and Oversight Activity	Quarterly	Annually	Ongoing
CHDP-CLPP	MCPs are currently required to comply with CLPP program requirements and are responsible for conducting blood lead screening for MCP enrollees.			x
CHDP-CLPP	MCPs conduct chart reviews as a part of initial and recurring FSR and MRRs, which currently includes lead screening reviews and provider training.			x
CHDP-CLPP	DHCS has aligned the MCP MRR requirements with the specific CLPP chart review requirements to ensure there are no gap in requirements now that CHDP has transitioned. MCPs are required to use DHCS's MRR tool.			x
CHDP-CLPP	DHCS added the lead screening measure to its annual performance reporting, so all MCPs will be reporting this measure for their population annually.		x	
CHDP-CLPP	DHCS and CDPH will continue to share lead data through a business use case proposal for the managed care population for monitoring purposes.	x		
CHDP-CLPP	DHCS Audits and Investigations conducts routine audits of all MCPs with compliance and contractual requirements for coverage of Medi-Cal covered services		x	
NHSP	MCPs are responsible for case management services related to EPSDT and have policies and procedures in place to ensure follow-up for missed EPSDT related appointments, which includes follow-up with the families of babies that miss their hearing rescreen or diagnostic appointments.			x

Table 9 – Fee for Service

CHDP Program Component	Monitoring and Oversight Activity	Quarterly	Annually	Ongoing
CPE	DHCS will periodically monitor the number of providers approved to access the CPE portal to validate the number of CPE providers is maintained or increases following the transition, as intended.	x		
CPE	DHCS will require all prospective CPE providers to complete necessary trainings before becoming an active CPE provider. Prospective CPE providers are unable to access the CPE portal until they have taken and passed required training(s).			x[21]
CPE	DHCS will maintain and monitor a CPE inbox (childrenPE@dhcs.ca.gov) and a TSC to monitor and address issues or concerns related to CPE			x
EPSDT	DHCS will maintain compliance with federal and national clinical and care coordination guidelines and shall update its guidance accordingly. This shall be accomplished through monitoring of national guidelines and best practices.			x
EPSDT	DHCS shall maintain an inbox, which collects beneficiary experiences in relationship to receiving EPSDT services and respond to them accordingly.			x
CHDP-CLPP	DHCS and CDPH will continue to share lead data through a business use case proposal for the fee for service population for monitoring purposes.	x		

21 Beginning July 1, 2024.

CHDP Program Component	Monitoring and Oversight Activity	Quarterly	Annually	Ongoing
NHSP[22]	To aid their collaborative efforts, DHCS will create a dedicated inbox for the HCC staff to submit requests for updated beneficiary information.			x
NHSP	DHCS staff will use MEDS to retrieve current contact information and report back to the HCCs weekly for additional contact attempts to be made.			x
NHSP	DHCS will require the HCCs to notify the baby's PCP when an initial hearing screen is not passed rather than waiting to notify the PCP by letter when an evaluation appointment is not kept. The HCC's report this number of PCP notifications to DHCS on a quarterly basis in their quarterly reports.	x		x
NHSP	The requirements and procedures for NHSP family follow-ups will increase to five times of outreach and engagement as families who were previously referred to CHDP. The HCC's go above and beyond what is required to try and reach a family who is lost to follow up, trying to get them access to care.			x
NHSP	The HCCs will continue to track each baby screened and run data reports identifying the number and percentage of babies lost to follow-up which can be compared to past data on those referred to CHDP.			x

22 NHSP is not insurance-based and all babies born in California, regardless of insurance, are tracked and monitored if they fail a hearing screening and need further audiologic diagnostic testing or diagnosis.

Table 10 – Foster Care

Monitoring and Oversight Activity	Quarterly	Annually	Ongoing
Each local HCPCFC program is overseen by a PHN serving as the HCPCFC Program Administrator for that jurisdiction.			x
Supervision of program staff may not exceed 15 HCPCFC staff persons to every PHN directly supervising that individuals work, with the exception of the PHN overseeing the program as a whole within that jurisdiction.			x
DHCS will develop training modules for program staff that are grouped by role: financial, administrative, and frontline activities. The modules will be posted to the DHCS HCPCFC webpage and summarize program requirements found in the HCPCFC Program Manual and the HCPCFC Financial Policy & Procedure. DHCS plans to post these training modules in advance of the Transition date. • County/City HCPCFC staff must complete training modules within the first 6 months of program or within 6 months of the website going live, whichever is first. • County/City staff and supervisor sign a certificate of completion and submit to general inbox. • New staff must complete within 90 days.			x
Verification that county allocation letters for HCPCFC are completed and delivered timely to all counties.	x		