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

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ALL PLAN LETTER 21-005 (REVISED)
SUPERSEDES ALL PLAN LETTER 18-023

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction and guidance to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 03-0421, which provides direction and guidance to county CCS programs on requirements pertaining to the WCM program.[1] This APL supersedes APL 18-023.[2] Revised text is found in *italics.*

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[3] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[4, 5]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[3] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[4] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[5] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs authorize care that is consistent with CCS program standards and that is provided by CCS-paneled providers, *CCS*-approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program supports active participation by parents and families of CCS-eligible members and ensures that members receive protections such as continuity of care, oversight of network adequacy standards, quality performance of providers, and routine grievance and appeal processes.

WCM has been implemented in 21 COHS counties (see the following chart for more details).

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

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

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS program. Responsibility for the CCS program's eligibility functions under the WCM is determined by whether the county CCS program operates as an independent or dependent county.[6] Independent CCS counties maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical

[6] A link to the Division of Responsibility chart can be found on the CCS WCM page of the DHCS website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS maintains responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs maintain responsibility for financial and residential eligibility determinations and re-determinations. MCPs are responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for CCS-eligible members.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as the payor of last resort.

The implementation of WCM does not affect the activities and functions of the MTP. However, MCPs must refer members to local county CCS programs if members are suspected of having an MTP eligible condition. As a part of the CCS eligibility review, local county CCS programs will review and determine MTP eligibility, if applicable. WCM counties participating with the MTP receive a separate allocation for this program and are responsible for care coordination of MTP services. MTPs must submit referrals to MCPs for medically necessary specialty services and follow-up treatment, as prescribed by the MTU Conference Team Physician.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program *statutes,* regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices.[7, 8] Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[9]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/PICU/NICU

[7] CCS program statutes and regulations can be found at: https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx
[8] CCS program guides can be found at: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx
[9] The WCM CCS N.L. Category List is available under the Resources and Information heading on the CCS WCM page of the DHCS website

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all *other* applicable *APLs,* state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members according to the parameters outlined in the Memorandum of Understanding (MOU). They must also continually update policies, procedures, and protocols, as appropriate, and discuss activities related to the MOU and other WCM related matters as prescribed in the MOU.

A. Memorandum of Understanding

Participating MCPs and county CCS programs must execute an MOU that outlines their respective responsibilities and obligations under the WCM program. All MOUs must follow the MOU template.[10] The purpose of the MOU is to explain how the MCP and county CCS program coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP *must* ensur*e* collaboration between the MCP and county CCS program. The MOU is customizable based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template posted on the CCS WCM page of the DHCS website and must be consistent with the requirements of SB 586. MCPs must submit MOUs to DHCS for approval.

B. Transition Plan

To be approved to participate in the WCM program, MCPs must develop a comprehensive transition plan detailing their collaboration with the county CCS program on the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe the transfer of case management; care coordination; provider referrals; and service authorization, including administrative functions, from the county CCS program to the MCP.[11] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensur*ing* continuity of care and services for members who are in the process

[10] The MOU template can be found at: https://www.dhcs.ca.gov/services/ccs/Documents/WCM-MOU-Template-REVISED-March2018.pdf
[11] WIC Section 14094.7(d)(4)(C)

of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Data and Information Sharing

1. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. In their respective MOUs, the MCPs and county CCS programs must set out protocols for the exchange of ICT data as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of CCS members and allow for continuity of care of already approved service authorization requests, as required by this APL and applicable state and federal laws and regulations.

When a CCS-eligible member moves from one county to another, the county CCS program and MCP, pursuant to their respective MOUs, must exchange ICT data. County CCS programs continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS-eligible member moves out of a WCM county, the county CCS program must notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The *originating* county CCS program must then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the *originating* county CCS program must provide transfer data to the MCP as applicable.

2. MCP Reporting to County CCS Program

MCPs must timely refer and report the following to the county CCS program:

<u>Determinations and Redeterminations</u>
MCPs must provide to the county CCS program all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed for each CCS-eligible member.

<u>NICU Acuity Assessment</u>[12]

[12] See WCM FAQ, which can be found on the CCS WCM page of the DHCS website

MCPs must report to the county CCS program all members identified as meeting the criteria for the NICU acuity assessment in order to capture the CCS referral. MCPs must review authorizations and determine if services meet CCS NICU requirements.

High-Risk Infant Follow-Up Program
MCPs must report to the county CCS program all members identified as High-Risk Infant Follow-Up (HRIF) in order to capture the CCS referral. MCPs must also notify the county CCS program in writing of all CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services. *Notification must occur as soon as the MCP is made aware, but no later than* 15 calendar days of *being made aware,* of *a member no longer having Medi-Cal eligibility*.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[13] The county CCS program must communicate all resolved disputes in writing to the MCP. If disputes between the MCP and the county CCS program cannot be resolved, the dispute must be referred to DHCS by either entity, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[14] A CCS provider may submit directly to the MCP a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Screening and Referrals

MCPs must provide screening, diagnostic, and treatment services in accordance with APL 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL, to identify potential CCS-eligible members.
MCPs must also refer potential CCS-eligible members to the county CCS program for a CCS eligibility determination if the members:

[13] WIC Section 14093.06(b)
[14] WIC Section 14094.15(d)

- Demonstrate potential CCS condition(s) as outlined in the CCS Eligibility Manual, including members who are suspected of having CCS condition(s) resulting from diagnostic services or who are undergoing diagnostics for CCS;[15]
- Present at the Emergency Department, provider, or facility for other primary conditions, and demonstrate potential CCS condition(s); or
- Are potentially MTP eligible.

B. Risk Level and Needs Assessment Process

MCPs must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include a pediatric risk stratification process (PRSP) and, for high risk members, an Individual Care Plan (ICP).

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

1. Pediatric Risk Stratification Process

MCPs must have a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing MCPs to identify members who have more complex health care needs.

MCPs are required to complete a risk stratification within 45 days of enrollment for all members, including new CCS members enrolling in the MCP and newly CCS-eligible members. The risk stratification will assess the member's risk level through:

- Review of medical utilization and claims processing data, including data received from the county and DHCS;
- Utilization of existing member assessment or survey data; and
- Telephonic or in-person communications, if available at the time of PRSP.

[15] See the CCS Medical Eligibility Guide at: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx

Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available must be automatically categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
MCPs must have a process to assess a member's current health, including CCS condition(s), to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

New Members and Newly CCS-Eligible Members Determined High Risk
Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by MCPs for the purposes of WCM is subject to review and approval by DHCS.

Risk Assessment
The risk assessment process must address:

- General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;
- Health history. This may include, but is not limited to, both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs must establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on *coordinated* specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[16] The ICP must, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver, as applicable. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[17]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may

[16] WIC Section 14094.11(b)(4)
[17] WIC Section 14094.11(c)

understand the goals, treatment plan, and course of care for the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;

- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams*, as well as coordination of care plans across specialties* including mechanisms to track completion of follow up visits*, if applicable. For example, MCPs must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the MCP must follow up with the member to assist in planning next steps in care coordination understand barriers and make adjustments to the referrals if warranted. MCPs should also attempt to connect with the provider to whom the member was referred to and facilitate a warm hand off to necessary treatment. and*

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

  Further, the MCP must reassess a member's risk level and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

  <u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
  For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

  The MCP must reassess a member's risk level and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

WCM Transitioning Members

For members transitioning into the WCM program, the MCP must complete the PRSP within 45 days of transition to determine each member's risk level. The MCP must also complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members, within one year of the transition. Additionally, the MCP must reassess a member's risk level and needs annually at the CCS eligibility redetermination, or upon a significant change to a member's condition.

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

Regardless of a member's risk level, all communications, whether by phone, mail, or other forms of communication, must inform the member and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and must identify the method by which providers will arrange for in-person assessments.[18]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

C. Case Management and Care Coordination[19]

MCPs must provide case management and care coordination*, including referrals to subspecialists, if not previously referred by the Primary Care Physician (PCP), and service authorizations* for CCS-eligible members and their families. *MCPs must ensure that case management is administered by their employees (e.g., nurse case managers) who have knowledge of, and receive adequate training on, the CCS program, and have clinical experience with CCS-eligible members or pediatric patients with complex medical conditions.*[20] MCPs that delegate the provision of CCS services to subcontractors *and network providers,* must ensure that all subcontractors *and network providers provide* case management and care coordination for members.

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[18] See APL 99-005: Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population, or any superseding APL

[19] WIC Section 14094.11(b)(1)-(6)

[20] *WIC Section 14094.11(a)*

MCPs must allow members to access CCS-paneled providers within all of the MCP's subcontracted provider network for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- MTUs;
- EPSDT services, including palliative care;[21]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-up Program**
   The HRIF program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[22]

2. **Age-Out Planning Responsibility**
   MCPs must maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program, to the extent feasible.[23]

3. **Pediatric Provider Phase-Out Plan**

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[21] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 19-010*,* or any superseding APL.
[22] HRIF Eligibility Criteria is available at: https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[23] WIC Section 14094.12(j)

A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment of the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the services of a pediatric provider. The timing of the transition must be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

D. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive continuity of care with existing CCS provider(s) for up to 12 months.[24] This APL does not in any way limit the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding continuity of care. The continuity of care requirements extend to the MCP's network providers and subcontractors. Sections 1 through 4 below include additional continuity of care requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If a member has an established relationship with a specialized or customized DME provider, the MCP must provide access to that provider for up to 12 months.[25] The MCP is required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the continuity of care period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[26]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[27]

[24] WIC Section 14094.13
[25] WIC Section 14094.13(b)(2)(A)
[26] WIC Section 14094.13(b)(3)
[27] WIC Section 14094.13(e), (f), and (g)

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs must meet this requirement by, at the request of CCS-eligible members, their families, or designated caregivers, allowing continuity of care case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs must be allowed continued use of any currently prescribed drug that is part of their prescribed therapy for the CCS-eligible condition(s) immediately prior to the date of enrollment, whether or not the prescription drug is covered by the MCP. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician have completed an assessment, created a treatment plan, and agree that the particular drug is no longer medically necessary, or the prescription drug is no longer prescribed by the county CCS program provider.[28] *In such cases, the MCP must send a Notice of Action to the CCS-eligible member informing them of the service change, as well as their appeal rights.*[29]

4. **Extension of Continuity of Care Period**[30, 31]
   MCPs, at their discretion, may extend the continuity of care period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the continuity of care period

[28] WIC Section 14094.13(d)(2)
[29] *See APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL.*
[30] HSC Section 1373.96
[31] WIC Section 14094.13(k)

informing members of their right to request a continuity of care extension and the WCM appeal process for continuity of care limitations.

The notification must be submitted to DHCS for approval and must include:

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

In addition to the WCM continuity of care protections set forth above, MCP members also have continuity of care rights under current state law as described in APL 18-008*,* Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care, or any superseding APL.

E. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure that all members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. All CCS-eligible members enrolled in managed care must be provided the same grievance, appeal, and SFH rights as other MCP members. This does not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a continuity of care period.[32]

MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to APL *21-004:* Standards for Determining Threshold Languages, *Nondiscrimination* Requirements *and Language Assistance Services*, or any superseding APL.

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended continuity of care with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, or any superseding APL.

[32] WIC Section 14094.13(j)

If MCPs deny requests for extended continuity of care, they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, or any superseding APL, when denying extended continuity of care requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

F. Major Organ Transplants

MCPs are required to cover all medically necessary major organ transplants (MOT) for CCS-eligible members as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the manual.[33] *The MCP must refer CCS-eligible members to a CCS-approved SCC for an evaluation within 72 hours of the member's PCP or specialist identifying the CCS-eligible member as a potential candidate for a MOT. MCPs must authorize the request for the MOT after the SCC confirms that the member is a suitable candidate for the MOT.*[34]

G. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[35]

Reimbursements for M&T expenses are available to the CCS-eligible member/family in accordance with CCS N.L. 03-0810. MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition(s) when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810*, or any superseding version of that N.L*. These services include, but are not limited to, M&T for out-of-county and out-of-state services*, and reimbursement for private car conveyance at the Internal Revenue Service (IRS) standard mileage rate for medical transportation in effect on the date the travel occurred.*

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[33] *See the Medi-Cal Provider Manual - Transplants at:* https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant.pdf

[34] *HSC Section 1367.01*

[35] See APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services, or any superseding APL

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

MCPs must also comply with all requirements listed in *the DHCS Contract and* APL 17-010, or any superseding version of that APL, for CCS-eligible members to obtain NEMT and NMT *exceeding the CCS M&T benefit as set forth in CCS N.L. 03-0810, or* for services not related to *a member's* CCS-eligible condition(s).

H. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition(s) within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontracted provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition(s). If CCS-eligible members require services or treatments for their CCS condition(s) that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

I. Advisory Committees

MCPs must meet quarterly with a Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

centers.[36] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[37] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also meet quarterly with a Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director or *designee*, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions.[38]

III. WCM PAYMENT STRUCTURE

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[39] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

MCPs are responsible for NICU acuity assessment, authorization, and payment function activities in all WCM counties. The MCP will review authorizations and determine whether or not services meet CCS NICU requirements. MCPs are also required to assume responsibility of coverage for PICU/NICU eligible newborns through their second month of life when the newborn's mother is Medi-Cal eligible and enrolled in the MCP.

IV. MCP RESPONSIBILITIES TO DHCS

A. Network Certification[40]

MCPs and their subcontracted provider networks are required to meet specific network certification requirements while participating in the WCM program, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals,

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[36] WIC Section 14094.7(d)(3)
[37] WIC Section 14094.17(b)(2)
[38] WIC Section 14094.17(a)
[39] WIC Section 14094.16(b)
[40] These requirements are further outlined in the APL *21-006*: Network Certification Requirements, or any superseding APL

SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[41]

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

In accordance with APL *21-006*, or any superseding APL, WCM MCPs must request to add subcontracted provider networks to their WCM network no later than *the Annual Network Certification submission date provided in the APL.*

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[42] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs must direct providers who need to be paneled to the CCS Provider Paneling website.[43] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[44]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and re-credentialing guidelines contained in APL 19-004: Provider Credentialing/Re-credentialing and Screening Enrollment, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, re-credentialing, recertification, and reappointment of providers within their network.

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[41] The WCM Provider Network Reporting Template will be provided to MCPs upon request
[42] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx
[43] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[44] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[45]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and,
- Procedures to detect both under- and over-utilization of health care services.

D. MCP Reporting to DHCS

1. **Quality Performance Measures**
   DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.
2. **Reporting and Monitoring**
   MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been

[45] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[46] These requirements must be communicated by each MCP to all subcontractors and network providers.

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

Sincerely,

Original signed by Dana Durham

Dana Durham Chief
Managed Care Quality and Monitoring Division

[46] For more information on subcontractors and network providers, including the definition and requirements applicable, see APL 19-001, or any superseding APL