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

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DATE:

N.L.: XX-XXXX
Index:

TO: WHOLE CHILD MODEL CALIFORNIA CHILDREN'S SERVICES PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES PROGRAM WHOLE CHILD MODEL

I. PURPOSE

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

II. BACKGROUND

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

[1] CCS WCM Transition APL XX-XX (link)
[2] SB 586 is available at:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS paneled providers, approved special care centers, and pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible Medi-Cal beneficiary and ensure that beneficiaries receive protections such as COC, oversight of network adequacy standards, and quality performance of providers.

The WCM program will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. MCPs must transition CCS-eligible member population into their MCP network of providers by their scheduled implementation date.

WCM MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

III. POLICY

Under the WCM, MCPs will assume full financial responsibility for authorization and payment of CCS Program eligible medical services, including but not limited to service authorization activities, claims processing and payment, case management, and quality oversight. MCPs will be required to apply CCS Program standards, as outlined in existing and future CCS numbered letters, to avoid any reduction in benefits for CCS-eligible children and maintain access to high-quality specialty care for CCS-eligible conditions.

County CCS programs are responsible for performing all functions reserved to them under the WCM legislation (SB 586)[3]. Independent county CCS programs will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. DHCS will continue to maintain the responsibility of eligibility determinations and redeterminations for dependent counties. MCPs are required to refer potentially eligible Medi-Cal beneficiaries to the counties and provide

[3] SB 586 is available at:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586

county CCS programs with all medical utilization data related to the annual medical redeterminations.

County CCS programs are responsible for coordinating with MCPs regarding the development of a comprehensive transition plan for the transition of existing CCS Program beneficiaries into managed care. County CCS programs will moreover be required to coordinate with MCPs on an ongoing basis to ensure the effective delivery of services by the MCP in accordance with applicable CCS regulations, program guidelines, CCS Program N.L.s, and program information notices. This includes ongoing responsibility on the part of county CCS programs to assist MCPs regarding CCS Program standards and cooperate with MCPs in the exchange of beneficiary medical records as necessary, including after a beneficiary has transitioned to managed care.

CCS Program will continue to refer providers to the State for CCS paneling and will continue to provide all existing CCS program services, including care coordination, for CCS Program children not included in the WCM. This includes children who do not have full scope Medi-Cal, children with other health coverage, children who are recipients of the Pediatric Palliative Care (PPC) Waiver Program, and children who receive Medical Therapy Program (MTP) services. Counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs.

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

A. CCS Program Coordination and MCPs

1. Memorandum of Understanding (MOU)

County CCS programs' and MCPs' must execute a MOU outlining their respective responsibilities and obligations under the WCM program. The purpose of the MOU is to explain how the county CCS programs and MCPs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to CCS Program WCM beneficiaries. A template MOU[4] has been provided that addresses minimum requirements under SB 586. Using the template as a framework, county CCS programs and MCPs are encouraged to work together in developing additional details regarding the coordination of CCS Program services at the local level, consistent with SB 586 and the minimum

[4] MOU Template

requirements of the MOU template. County CCS programs must submit an executed MOU or prove intent and/or progress made toward an executed MOU by March 30, 2018, for Phase 1 counties, and September 28, 2018, for Phase 2 counties. All WCM MOUs are subject to DHCS approval.

2. Transition Plan

MCPs are required to develop a comprehensive transition plan to govern the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. County CCS programs are required to provide input and collaborate with MCPs on MCP transition plans. MCP transition plans must be submitted to DHCS for approval.

The transition plan should describe collaboration between the two entities on the transfer of case management, care coordination, provider referral and service authorization administrative functions to the MCPs. The transition plan should also include post-implementation communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS.

3. Eligibility Determinations

New CCS Referrals for Eligibilty Review CCS Program will maintain responsibility for medical eligibility determinations for potential CCS beneficiaries. CCS Program will inform providers to send their authorizations for services to the MCPs.

a. Annual Redeterminations

County CCS programs will continue to review for annual CCS Program medical eligibility. CCS Program will be responsible for obtaining any information required to determine program eligibility from the MCP.

4. Inter-County Transfer (ICT)

County CCS programs will continue to be responsible for Inter-County Transfers (ICTs) from one county CCS program to another under the WCM program. County CCS programs use CMSNet to house and share data needed for ICT, while MCPs utilize different data systems. Through their respective MOU, the WCM county CCS programs and MCPs will develop protocols for the exchange of ICT data as necessary to ensure an efficient transition of the CCS beneficiaries and allow for continuity of care of existing authorized service authorization requests (SARs), as requested. Applicable

guidance from CCS Program N.L. 09-1215, ***ICT Transfer Policy***[5], will remain in effect.

The MCP is responsible for providing transfer data for beneficiaries who move out of the WCM county to the local CCS program office who will coordinate the sharing of beneficiary data to the new county CCS program.

5. Dispute Resolution

a. County CCS Program and MCPs Disputes

1) CCS Program Eligibility Determinations

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

2) Other Disputes between CCS Program and MCP

Disputes between the county CCS program and the MCP that are unable to be resolved will be referred to DHCS for review and final determination.

6. Beneficiary Grievance, Appeal and Fair Hearing Process

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

a. CCS Program Eligibility:

MCPs must continue to identify and refer potentially eligible children to be assessed for CCS Program eligibility. If the beneficiary is not satisfied with the CCS Program eligibility decision, the beneficiary shall use the CCS Program Appeal Guideline to file an appeal and/or request a Fair Hearing as specified in the CCS N.L. 18-0594[7].

[5] CCS Program N.L. 09-1215 ICT Transfer Policy is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl091215.pdf
[6] Welfare and Institution Code 14093.06(b) is available at:
http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14093-06.html
[7] Appeal Guidelines CCS N.L. 18-0594 is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl180594.pdf

b. Health Plan Grievance:

The CCS beneficiary can file a grievance and appeal with their MCP and go through the MCP Grievance and Appeals process for other matters not associated with CCS eligibility determination.

7. Provider Grievances, Appeals, and Disputes

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

8. Transportation

MCPs shall ensure that beneficiaries and their families have appropriate access to transportation services necessary to receive treatment[8] and shall authorize and coordinate non-emergency medical transportation (NEMT) for CCS Program services, as specified in CCS N.L. 03-0810[9]. If a beneficiary requests transportation through the MCP, the MCP must comply with all requirements listed in APL 17-010[10] and authorize transportation.

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible beneficiaries or the beneficiary's family when the cost of M&T presents a barrier to accessing authorized CCS services. Services provided by M&T include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.) in addition to transportation expenses and must comply with all requirements listed in N.L. 03-0810.

The CCS Program is responsible for M&T for non-WCM CCS Program beneficiaries that remain the full responsibility of the county. County CCS programs shall refer beneficiaries to the MCP for transportation services the counties do not provide.

[8] Welfare and Institution Code 14094.11(b)(6) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC
[9] Maintenance and Transportation of CCS Clients to Support Access to CCS Authorized Medical Services CCS N.L. 03-0810 is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[10] APL 17-010 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

9. Continuity of Care (COC)

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

a. Case Management and Care Coordination:

MCPs must case management, care coordination, service authorization, and provider referral services.

At the request of CCS beneficiary or their parent or his or her designated caregiver, the MCP must allow the MCP member to continue receiving care from their existing public health nurse (PHN).[12] The MCP member must elect to continue receiving case management from the PHN within 90 days of transitioning into the MCP. County CCS programs must work with the MCPs to develop protocols for necessary information sharing when a member elects to continue to receive case management services from the PHN. If the beneficiary's PHN is no longer available, the county CCS program must notify the MCP immediately so the MCP can comply with its statutory responsibilities to provide alternative care coordination services.

b. High Risk Infant Follow-Up

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

10. Advisory Committees

a. Clinical Advisory Committee

The county CCS program shall provide a medical director or designee to actively participate in the MCP's quarterly CCS Program Clinical Advisory

[11] Welfare and Institution Code 14094.13 is available at:
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[12] WIC 14094.13(e), (f) and (g) is available at:
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

Committee. The medical director or designee shall attend meetings and engage in discussions to offer feedback and recommendations on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisors on other clinical issues relating to CCS conditions.

B. Quality Assurance and Monitoring

The county CCS program shall participate, at a minimum, in quarterly meetings with the MCP to update P&Ps and protocols as appropriate, and to discuss activities related to the MOU and other related matters. The County and MCP may establish the frequency of meetings and meeting facilitation protocols in the MOU.

C. Neonatal Intensive Care Unit (NICU) Acuity Assessment and Authorization

NICU acuity assessment and authorization will be the responsibility of the MCP in all WCM counties. The payor for NICU services remain the same. The MCPs will continue to pay for NICU services in NICU carved-in counties and the State will continue to pay for NICU services in NICU carved-out counties.

Marin, Napa, San Mateo, Santa Barbara, Solano, and Yolo are NICU carved-in counties. The MCPs will be responsible for NICU reimbursements in the specified counties.

The chart below identifies the entity (state, county, or health plan) responsible for NICU acuity assessment, authorization, and payment function activities in the WCM.

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/Physician)
Carved-In	MCP	MCP	MCP
Carved-Out	MCP	MCP	State

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

Sincerely,

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