DATE: ALL PLAN LETTER 18-XXX

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 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 Numbered Letter (N.L.) XX-XXXX¹, which provides direction and guidance to counties on requirements pertaining to the implementation of the WCM program.

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. The purpose of the WCM program is to incorporate services covered by the CCS Program into Medi-Cal managed care for Medi-Cal-eligible CCS Program members.² MCPs operating in WCM counties will integrate Medi-Cal managed care and 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.

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 members and ensure that members receive protections such as continuity of care (CoC), oversight of network adequacy standards, and quality performance.

¹ N.L. XX-XXXX is available at: SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018.

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

**POLICY:**
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility for authorization and payment of CCS-eligible medical services, including service authorization activities, claims, case management, and quality oversight.

The MCP, the county and DHCS each bear responsibility for various administrative functions to support the CCS Program. The division of responsibility is determined by whether CCS is carved-in or carved-out of the MCP and whether or not the county operates as an independent or dependent county.  

3 Independent counties 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 maintains responsibility for eligibility determinations and redeterminations for dependent counties. The MCP is responsible for providing all medical utilization data for purposes of completing the annual medical redetermination for the CCS-eligible member.

There are activities and functions that are not impacted by the implementation of WCM, including the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). Counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. For any services that remain carved-out, the MCP is responsible for care coordination.

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3 Division of responsibility charts are available at: [http://www.dhcs.ca.gov/services/ccs/Documents/DOR.pdf](http://www.dhcs.ca.gov/services/ccs/Documents/DOR.pdf)
MCPs continue to be responsible for identifying and referring potential CCS-eligible members to the county for an eligibility determination.

MCPs must comply with all current and applicable CCS program guidelines, including CCS program regulations, CCS numbered letters (N.L.), and CCS program information notices, in the development of criteria for use by the plan’s chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, contractual requirements, and Neonatal Intensive Care Unit (NICU) guidelines.  

I. MCP AND COUNTY COORDINATION

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

A. Memorandum of Understanding

MCPs and the counties must execute a WCM MOU using the attached template (Attachment 1). MCPs are responsible for providing medically necessary CCS covered services for Medi-Cal-eligible CCS members. The MOU between the individual county and the MCP should serve as the primary vehicle for ensuring collaboration between the MCP and counties. The MOU can be customized, based on the needs of the individual county and the MCP, but cannot be changed significantly without approval from DHCS. Phase 1 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by March 30, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

MCPs must develop a comprehensive transition plan detailing how the MCP will take over responsibility for case management, care coordination, provider referrals, and service authorizations for members enrolled in the CCS Program at the time of transition. The MCP and the county must agree to each transition plan. MCPs must submit transition plans to DHCS for approval.

4 CCS N.L. 05-0502 is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl050502.pdf
C. Inter-County Transfer
Inter-county transfers occur when a CCS-eligible member moves from a WCM county to a non-WCM county. The MCP is responsible for providing transfer data for members who move out of the WCM county to the local county’s CCS program office. The county will then coordinate the sharing of member data to the new county of residence. Through their respective MOUs, the counties and MCPs will exchange Inter-County Transfer (ICT) data, including authorization data, member data, and case management information, to ensure an efficient transition of the member and allow for Continuity of Care (COC) of existing authorized service authorization requests (SARs), as required by this APL and applicable state and federal laws.

D. Dispute Resolution and Provider Grievances
Disagreements between the MCP and the county regarding eligibility determinations must be resolved by the county, in consultation with DHCS.\(^5\) All disputes resolved will be communicated in writing from the county to the MCP within a timely manner. Disputes between the MCP and the county that are unable to be resolved will be referred to DHCS by either entity for review and final determination.

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.\(^6\) A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBER

A. Assessment Process
MCPs are required to assess each CCS-eligible member’s health through a Pediatric Health Risk Assessment (PHRA) process and to develop a comprehensive Individual Care Plan (ICP) specific to the member’s overall health needs.

1. Pediatric Risk Stratification Process
MCPs must develop a risk stratification mechanism, or algorithm, to assess the CCS member’s risk level. The risk stratification is used to classify CCS members into higher and lower risk groupings, allowing the MCP to identify

\(^5\) WIC 14093.06(b) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14093.06&lawCode=WIC

\(^6\) WIC 14094.15(d) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.15&lawCode=WIC
those members who have more complex health care needs. Members identified as higher risk through the risk stratification process must receive a PHRA within 45 calendar days of their risk determination, while members identified as lower risk must receive a PHRA within 105 calendar days. MCPs will complete a risk stratification by review of medical utilization data and claims processing data received from the county and DHCS. The risk stratification tool must be submitted to DHCS for approval.

2. Pediatric Health Risk Assessment Process
MCPs must develop a PHRA to assess a member’s current health including the CCS condition. The PHRA will ensure that each CCS member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider who has clinical experience with the CCS population or clinical experience with pediatric patients with complex CCS conditions. The PHRA will establish a starting point for the ICP, which will be developed for each member that demonstrates a need for an ICP. The PHRA must be tailored to the member’s age group and CCS condition. The PHRA must be submitted to DHCS for approval.

The PHRA must at a minimum assess the following:

a) Current Health
   - General Health
   - Diagnosis: CCS related conditions and other health conditions
   - Level of care
   - Specialists being utilized
   - Prescribed medications
   - Specialized or customized durable medical equipment (DME)
   - Daily limitations
   - Assistance Required

b) Medical History
   - Hospitalizations
   - ER visits

c) Social and Linguistic History

d) Age Appropriate Questions (Mental Health, Substance Use, Family Planning, etc.)
For lower risk members, the MCP must attempt to contact the member, the member’s family, or his or her designated caregiver, by phone or in a manner consistent with the member’s physical or cognitive needs. For higher risk members, an in-person PHRA conducted by a trained or licensed provider (e.g., a registered nurse or a licensed social worker) is preferable. All communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the PHRA be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.7

3. Individual Care Plan
MCPs are required to establish an individual care plan (ICP) based on the results of the PHRA, with particular focus on specialty care, within 90 days of completing the PHRA.8 This does not relieve the MCP of the ongoing obligation to follow the same procedure when a new CCS member enrolls in a MCP. The ICP will, at a minimum, include questions to address member’s goals and preferences, measurable objectives and timetables to meet medical, behavioral health, mild to moderate mental health services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), substance use disorder (SUD) needs, other medically necessary services within the MCP network and, when necessary, treatment by an out-of-network provider. The ICP must be completed in collaboration with the member, member’s family, and/or their designated caregiver based on the results of the PHRA. The ICP must include the following information:9

- Access and direction for families and designated caregivers on where to go for ongoing education, information, and support in order to understand the goals, treatment plan, and course of care management for their child or youth.

- The member’s primary or specialty care physician who is the primary clinician for the member.

- Case management and care coordination for the member.

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8 WIC 14094.11(b)(4) is available at: [https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC)
9 WIC 14094.11 is available at: [https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC)
• Clinical data used to identify CCS-eligible members with chronic illness or other significant health issues.

• The CCS-eligible member, member's family, or designated caregiver's determination about the appropriate involvement of his or her medical providers and caregivers.

• Arrangements for timely preventive, acute, and chronic illness treatment of CCS-eligible members in the appropriate setting.

• Other health conditions that are not related to the member's CCS condition.

MCPs must re-evaluate and update the ICP at least annually or upon a significant change to the member’s condition.

B. Case Management and Care Coordination

MCPs must provide case management and care coordination for CCS members and their families. MCPs must ensure that information, education and support is continuously provided to the member and family to assist in their understanding of the CCS member’s health, other services that might be available, and overall collaboration on the member’s ICP. MCPs must also coordinate services that have been identified in the ICP including:10

• Primary and preventive care services with specialty care services
• Medical therapy units (MTU)
• Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
• Regional center services
• Home and community-based services

1. High Risk Infant Follow-up Program

High Risk Infant Follow-Up (HRIF) is a program to assist with identifying infants who might develop CCS-eligible conditions after they are discharged from a NICU. The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties, 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.

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10 WIC14094.11(b)(1)-(6) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC
2. **Age Out Planning Responsibility**

MCPs must establish and maintain a process for preparing members approaching WCM age limitations. MCPs must communicate the age out process to the counties to ensure that members do not experience an interruption in their treatment plan as they prepare for and transition to the adult Medi-Cal program. The age out planning process must be communicated in the transition plan.

MCPs must identify and track children and youth with CCS-eligible conditions for the duration of his or her participation in the WCM program and who continue to be enrolled in the same MCP for at least three years after they age out of the CCS program.

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

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

C. **Continuity of Care**

MCPs must establish and maintain a process to allow for members to receive CoC with existing provider(s) for up to 12 months. This APL does not alter the MCP’s obligation to fully comply with the requirements of Health and Safety Code (HSC) §1373.96 and all other applicable APLs regarding CoC. The sections below include additional CoC requirements.

1. **Specialized or Customized Durable Medical Equipment**

If the MCP member has an established relationship with specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months. The MCP must extend the CoC period beyond 12 months for the DME if it is still under warranty and is deemed medically necessary by the treating provider. The DME provider must accept

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11 WIC 14094.13 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
12 WIC 14094.12(f) and 14094.13(b) are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
13 WIC 14094.13(b)(3) is available at:
the MCP’s rate for the service offered or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the DME provider agrees to an alternative method of payment.

Specialized or Customized DME must meet all of the following criteria:
- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is 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. CoC Case Management
MCPs must provide CoC for members through case management, care coordination, service authorization, and provider referral services.

At the request of the member, their parent, or designated caregiver, the MCP must allow the member to continue receiving care from their 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 a MCP case manager who has received adequate training on the CCS Program and who has clinical experience with the CCS population or 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 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.

3. CoC for Pharmacy
CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The member must be allowed to use their prescribed drug until the MCP and the prescribing physician have completed the member’s PHRA, created an ICP, and agree that the particular

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC  

14 WIC 14094.13(e), (f) and (g) is available at:  
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC  

15 WIC 14094.13(e) is available at:  
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
drug is no longer medically necessary or is no longer prescribed by the county provider.

4. **Appealing a CoC Decision**

MCPs must provide CCS members with information regarding the WCM appeal process for CoC limitations, in writing, 60 days prior to the end of their authorized CoC period. The notice must explain the member’s right to petition the MCP for an extension of the CoC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

- The CCS member must first appeal a CoC decision with the MCP.
- A family member or caregiver of the CCS member may appeal the CoC limitation to the DHCS director or his or her designee after exhausting the MCP appeal process.
- The DHCS director or designee will have five days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member’s health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.\(^{16}\)

In addition to the protections set forth above, MCP members also have rights to protections in current state law pertaining to COC.\(^ {17}\)

D. **Grievance, Appeal, and State Fair Hearing Process**

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in a MCP are provided the same grievance, appeal and state fair hearing rights as provided in state and federal law.\(^ {18}\) Members appealing a CCS eligibility determination must appeal to the county.

E. **Transportation**

MCPs must ensure that members and their families have appropriate access to transportation services necessary to receive treatment and must provide non-emergency medical transportation (NEMT) and non-medical transportation (NMT)

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\(^{16}\) WIC 14094.13(i) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

\(^{17}\) WIC 14185(b) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14185.&lawCode=WIC

for all CCS services. If a CCS-eligible member requests transportation through the MCP, the MCP must comply with all requirements listed in APL 17-010.

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services 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.

F. Advisory Committees
MCPs must establish a quarterly Family Advisory Committee for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The Family Advisory Committee will also consist of local providers, including, but not limited to, the parent centers, such as family resource centers, family empowerment centers, and parent training and information centers. Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee. A representative of this local committee will be invited to serve as a member of the DHCS CCS Advisory Group.

MCPs must establish a quarterly Clinical Advisory Committee composed of the chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.

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19 WIC 14094.11(b)(6) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC
21 N.L. 03-0810 is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
22 WIC 14094.7(d)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
23 WIC 15094.17(b)(2) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
24 WIC 14094.17(a) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
III. WCM Payment Structure

A. Payment and Fee Rate
CCS physicians and surgeons must accept the MCP’s rate for the service offered or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS provider enters into an agreement on an alternative payment methodology mutually agreed to by the CCS physician/surgeon and the MCP.  

The payor for Neonatal Intensive Care Unit (NICU) services remains the same as it exists today, with the MCP paying in NICU carved-in counties and the state paying in NICU carved-out counties.

The chart below identifies the entity responsible for NICU acuity assessment, authorization and payment function activities for WCM:

<table>
<thead>
<tr>
<th>CCS NICU</th>
<th>NICU Acuity Assessment</th>
<th>Authorization</th>
<th>Payor (Facility/Physician)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carved-In Counties:</td>
<td>Marin, Napa, San Mateo, Santa Barbara, Solano, and Yolo</td>
<td>MCP</td>
<td>MCP</td>
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<tr>
<td></td>
<td></td>
<td>MCP</td>
<td>MCP</td>
</tr>
<tr>
<td>Carved-Out</td>
<td>MCP</td>
<td>MCP</td>
<td>State</td>
</tr>
</tbody>
</table>

IV. MCP Responsibilities to DHCS

A. Network Certification
MCPs are required to have an adequate network of providers to serve the CCS-eligible population. Each network of providers will be reviewed by DHCS and certified annually. The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP’s network of providers meets network adequacy requirements as described in the WCM Network Certification Template (Attachment 2).

25 WIC 14094.16(b) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.16(b).&lawCode=WIC
26 Division of responsibility is available at: http://www.dhcs.ca.gov/services/ccs/Documents/DOR.pdf
MCPs must show that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005.\textsuperscript{27} Members cannot be limited to a single delegated entity’s provider network. The MCP must ensure members have access to all medically necessary CCS paneled providers within the entire MCP provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. Credentialing
Physicians must be CCS-paneled with full or provisional approval status. MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the Children’s Medical Services CCS Provider Paneling website.\textsuperscript{28}

Written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.\textsuperscript{29} MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network. MCPs are required to verify the credentials of their contracted providers.

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:\textsuperscript{30}

- 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.
- Procedures to detect both under- and over-utilization of health care services.

\textsuperscript{27} APL 18-005 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-005.pdf
\textsuperscript{28} Children’s Medical Services CCS Provider Paneling is available at: https://cmsprovider.caahw.net/PANEL/index.jsp
\textsuperscript{30} COHS Boilerplate Contract is available at: COHS Boilerplate, Exhibit A, Attachment 5
In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties. 31

D. MCP Reporting Requirements

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 form and manner specified by DHCS.

2. Reporting and Monitoring
   DHCS will develop specific MCP CCS Program monitoring and oversight standards for MCPs. MCPs must submit the required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority
   In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004. 32

If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Attachments:
   1) MOU Template
   2) WCM Network Certification Template

31 WIC 14094.65 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC