PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2024</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Whole Child Model For California Children’s Services (CCS)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/14/2018
Effective Date: 01/01/2019 per DHCS</td><td colspan="4">Next Review Date: 08/13/2026
Last Review Date: 08/13/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/13/2025</td></tr>
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I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2007 – Complex Case Management
C. MCCP2023 – New Member Needs Assessment
D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children’s Services
E. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
F. MPCP2014 – Continuity of Care
G. MPTP2503 – Ancillary Transportation Services: Lodging, Meals, Attendants, Parking and Tolls
H. MCRP4064 – Continuation of Prescription Drugs[1]
I. MPUP3039 – Direct Members
J. MCUP3013 – Durable Medical Equipment (DME) Authorization
K. MCUP3041 – Treatment Authorization Request (TAR) Review Process
L. MCCP2032 - CalAIM Enhanced Care Management (ECM)
M. MCAP7001 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
N. MCCP2035 - Local Health Department (LHD) Coordination
O. MCUP3104 - Transplant Authorization Process
P. MCCP2025 - Pediatric Quality Committee Policy
Q. MCUP3037 - Appeals of Utilization Management/ Pharmacy Decisions
R. CGA024 - Medi-Cal Member Grievance System
S. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

[1]Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012 *Revised*, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria and a link to the State Medi-Cal Contract Drug List (CDL): http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

D. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the Member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.
C. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
D. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
E. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
F. Individualized Care Plan (ICP): A care plan developed through Care Coordination tailored to the needs of the Member and supporting him/her to attain the health/wellness goals that he/she has identified. This care plan may be developed through discussion with the Member and/or with the Member's caregiver, and will reflect collaboration with the Member's providers.
G. Memorandum of Understanding (MOU): Where no reimbursement is to be made, Partnership shall negotiate in good faith a MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.
H. Newly Eligible WCM Members: Members recently determined to be eligible for the WCM Program with no history of participation in the WCM or CCS Programs.
I. Newly Transferred WCM Members: Any Member who is new to the MCP but already a part of the CCS/WCM Program, as in the case of Intercounty Transfer (ICT).
J. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric Members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
K. Pediatric Risk Stratification Process (PRSP): A process in which a child's medical needs are triaged into high-risk and low-risk. This process will help identify those children that are at a higher risk for needing medical case management.
L. Receiving County: i.e. County to which a Member is moving to and in which they will claim residence.
M. Sending County: i.e. CCS counties from which Members are moving.
N. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.

IV. ATTACHMENTS:

A. Pediatric Risk Stratification Process
B. FAC Charter

V. PURPOSE:

To describe how California Children's Services (CCS) and the coordination of care for the CCS-eligible population assigned to Partnership HealthPlan of California (Partnership) will be integrated into the operations of Partnership as part of the Whole Child Model (WCM); and to outline the collaboration between Partnership, providers, county CCS agencies, community resources, and the CCS Member and their caregiver. The goals of the WCM are as follows:

A. Ensure ongoing, timely eligibility determination for CCS conditions.

B. Coordinate appropriate care and services for Partnership's pediatric population through integration of care for both CCS-eligible and non-CCS-eligible conditions.
C. Work collaboratively with the Member/caregiver to establish a medical home while ensuring access to necessary specialty services.
D. Ensure collaboration between Partnership and county CCS agencies to promote consistent care delivery standards.
E. Authorize medically necessary and appropriate services for care related to both CCS and non-CCS conditions.
F. Develop and implement an Individualized Care Plan (ICP) or care coordination strategy to support Member/caregiver in accessing services and managing his/her health and wellbeing.

VI. POLICY / PROCEDURE

A. CCS Program Eligibility
   1. Partnership actively screens for Members who may meet the CCS program eligibility.
      a. Partnership will instruct providers to refer Members with suspected CCS eligible conditions to the CCS program in the county of residence or to DHCS where applicable for CCS program eligibility determination. As part of the referral process, Partnership will instruct providers to submit supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program and/or DHCS.
      b. Partnership provides services to WCM Members with other health coverage, with full scope Medi-Cal as the payor of last resort.
   2. Partnership proactively identifies eligible Members for the CCS program and services through use of risk stratification, monthly reports, as well as through multiple referral sources. Data sources include, but are not limited to:
      a. New Member Assessments such as the Health Information Form (HIF) or the Pediatric Health Risk Assessment (PHRA)
      b. Internal reports such as the monthly Pediatric Case Finding Report, the monthly Utilization Report, Admission, Discharge, and Transfer Reports, etc.
      c. Provider or Specialist referral
      d. Member / Caregiver self-referral
      e. External reports such as county CCS enrollment report(s), Regional Center report(s), Medical Therapy Unit/Medical Therapy Program (MTU/MTP) report(s), etc.
   3. Partnership will refer all Members via fax or secure File Transfer Protocol (sFTP) who demonstrate a potential CCS-Eligible Condition(s) or if a WCM Member develops a new potential CCS-Eligible Condition as soon as possible to the County CCS Program for an eligibility determination and supply the necessary clinical documentation to the County CCS Program for a CCS eligibility determination if the Member:
      a. Demonstrates a potential CCS-Eligible Condition(s) as outlined in the CCS Eligibility Manual, including results from diagnostic services or who is undergoing diagnostics for CCS;
      b. Presents at the Emergency Department, Provider, or facility for other primary conditions, and demonstrates a potential CCS-Eligible Condition(s); or
      c. Demonstrates a potential MTP eligible condition.
   4. Partnership will refer NICU, HRIF, and MTP Members with potential CCS eligible conditions to the County CCS Program for review and determination of eligibility for services.
      a. CCS NICU eligibility may involve identification of a potential CCS-Eligible Condition which may confer CCS Program eligibility beyond the NICU stay. Partnership will inform the County CCS Program if a Member is at any point subsequently identified as having a potential CCS-Eligible Condition so that the County CCS Program can conduct the CCS eligibility determination process for the Member. MCPs will review authorizations and determine if

services meet CCS NICU referral requirements in accordance with CCS Program guidelines found in CCS NICU Standards and CCS N.L. 02-0413.

b. Partnership will conduct NICU eligibility assessments in accordance with CCS Program guidelines for medical eligibility for care in a CCS-approved NICU, as found in CCS NL 05-0502. All Members identified as meeting the criteria for the NICU eligibility assessment will be referred to the County CCS program as described above.

c. Partnership will refer all Members with a potential MTP eligible condition to the County CCS Program and will include all supporting documentation with the referral. As a part of the CCS eligibility review, the County CCS Program will review and determine MTP eligibility. County MTPs will submit referrals to Partnership for Medically Necessary specialty services and follow-up treatment, as prescribed by the MTC physician or CCS-paneled physician who is providing the MTP medical direction for occupational and physical therapy services. Partnership will collaborate with county MTU/MTP programs to facilitate referrals to the program, when MTU/MTP service needs are identified, including the Members under age three who are at risk for needing MTU/MTP services.

d. Partnership will conduct a HRIF program acuity assessment and authorize any HRIF services for the Member in accordance with the HRIF Eligibility Criteria. Partnership will ensure access or arrange for the provision of HRIF case management services. Partnership will notify the county of any CCS-eligible neonates, infants, and children up to three years of age who have been identified as having a potential CCS-eligible condition through the HRIF program.

e. Partnership will include supporting documentation of the Member's potential CCS-Eligible condition when submitting referrals to the CCS Program for eligibility determinations for HRIF, MTP, and NICU. Documentation may include NICU discharge summaries, HRIF reports and final reports, or necessary documentation as listed below.

5. Partnership will provide available necessary documentation received or retrieved by Partnership's case management or utilization management staff, or assist Network Providers in referring with necessary documentation, including but not limited to current medical records, case notes, discharge summaries (if applicable), physical examination results, laboratory test results, radiologic findings, and other tests/examinations or reports that pertain or support to the CCS-Eligible Condition, including any MTP diagnosis to the CCS county. Independent counties will review for the initial medical determination for the CCS program and dependent counties will send it to DHCS, who is responsible for dependent county medical determinations. All documentation will be, to the extent possible, produced within the last 6 months but no later than 12 months. Partnership will make outreach attempts to the Network Provider and the CCS Member to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful. County CCS will notify Partnership within 5 days of receipt if referral is incomplete where Partnership will then notify Network Provider for record request. The case manager will send the received or retrieved medical record documentation to the County CCS.
   a. A complete referral shall include:
      1) First and last name of the referred Member
      2) First and last name of parent or legal guardian (except for Members aged 18 years or older)
      3) Date of birth
      4) Address and telephone number
      5) Statement of services requested
      6) A comprehensive medical documentation identifying the suspected CCS-eligible medical condition
   b. The referral shall be transmitted by a method mutually agreed upon by both Partnership and the county CCS program/DHCS. Referrals will be made upon identification and will not be postponed until the annual CCS medical eligibility redetermination period.

6. For the Annual Medical Redetermination, Partnership will receive a list from the counties a minimum of 120 days in advance of the eligibility end date. Partnership sorts by soonest eligibility end date and will make outreach attempts to the Network Provider and the CCS Member to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful.
    a. Partnership will provide the documentation received or retrieved by Partnership's case management staff (VI.A.5.a), including efforts made to receive required documentation when it is not available, to the County CCS program no later than 60 calendar days before the Member's program eligibility end date, unless the County CCS Program verified that all needed medical information is already available to them. DHCS is responsible for dependent county medical determinations and independent counties conduct medical determinations for their counties.
    b. The county CCS program/DHCS will notify the Member and/or primary caregiver of the CCS program eligibility determination.
    c. The County CCS Program/State will complete CCS program eligibility on new Medi-Cal covered referrals within 10 working days of receipt of a referral or receipt of adequate medical reports to a medical eligibility determination. The disposition of eligibility determination will be documented in the state eligibility tracking system and will be made available to Partnership at the time the decision is made.
7. When Partnership becomes aware that a Member has lost Partnership eligibility or has moved out of Partnership's service area, Partnership will notify the County CCS program.
8. The County CCS Program will alert Partnership of any CCS case closure or loss of eligibility and a CCS Notice of Action (NOA) will be sent to family upon case closure.
9. Partnership will inform the Member/caregiver and primary care provider of the referral.

B. Utilization Management
1. Under WCM, CCS Members are able to receive the same CCS benefits and services through Partnership as they did through County CCS programs. These services are based on medical necessity and are reviewed by Partnership Health Services staff. In addition, care for pediatric Members will also consider the benefits outlined in APL 23-005 "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the age of 21" and Partnership policy MPCP2006 "Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities."
2. Partnership ensures coverage for medically necessary Medi-Cal covered services for the Member's potential CCS eligible condition while CCS eligibility is determined.
3. Once CCS program eligibility is established, Partnership is responsible for the provision of all medically necessary covered services under the WCM and assigns the Member to "Direct Member" status as described in policy MPUP3039 Direct Members. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist, however, Partnership assigns the Member a medical home to ensure completion of preventative care.
4. Partnership shall provide the CCS Maintenance and Transportation (M&T) benefits for CCS eligible Members or the Member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services and per criteria set forth in DHCS Numbered Letter (NL) 03-0810. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.). (See policy MPTP2503 – Meals, Lodging, Parking and Tolls for Members under 21 years of Age).
5. County MTU/MTP programs will perform the initial review of therapy services, durable medical equipment (DME), orthotics and prosthetics per state guidelines. (See Attachment E of Partnership policy MCUP3013 Durable Medical Equipment (DME) Authorization for recommended review process).
    a. Once the MTU/MTP review is completed by MTU/MTP staff, a referral packet will be sent to vendor for their use in submitting a Treatment Authorization Request (TAR). [See policy

MCUP3041 Treatment Authorization Request (TAR) Review Process.] A TAR packet will include the following:

1) First and last name of the Member
2) Date of birth
3) Client Identification Number (CIN)
4) Statement of services requested/ prescription form
5) Medical justification for the requested services, such as therapy notes, physician visit notes, etc.

b. If the request is deemed unnecessary or inappropriate, the MTU/MTP program will forward a copy of their recommendation with supporting documentation to Partnership.
c. The county MTU/MTP will provide technical assistance to the vendor, family and Partnership in the approval process.

6. Partnership is required to cover all medically necessary blood, tissue, and solid organ transplants for WCM Members, please refer to Partnership policy MCUP3104 Transplant Authorization Process for more details.
7. Partnership will conduct, at least quarterly, a review of their inpatient utilization data to assess whether all potential WCM Members have been appropriately referred to the County CCS program. If Partnership identifies any Members that have a potential CCS Eligible-Condition and a referral has not been made to the County CCS Program, Partnership will promptly refer the Member, providing their most recent medical records as outlined above.

C. Case Management and Care Coordination

1. Partnership Members participating in the WCM and their families/caregivers are eligible to receive comprehensive Care Coordination and Case Management services. Partnership WCM case management and care coordination is a Member and family centered care approach which ensures needed clinical and non-clinical services for the CCS eligible condition are made available to each WCM Member through comprehensive, interdisciplinary, and person-centered case management and care coordination to ensure that WCM Members have access to diagnostic and treatment services of the whole child in the areas of primary, specialty, and behavioral health for CCS eligible and non-CCS eligible conditions. Partnership collaborates with the WCM Member, Member's family, or authorized representative of the WCM Member to identify needs, goals, and preferences in accessing such diagnostic and treatment services. Partnership interventions to identified barriers to access to care include coordination of services for appointments, referrals, DME, transportation, and subsequent confirmation that ICP access goals are met. Members may decline Case Management services without impact to their enrollment and/or participation in the WCM Program.
2. Pediatric Members who are new to Partnership will be mailed a survey to stratify their risk in accordance with policies MCCP2023 New Member Needs Assessment, and MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services.
    a. Pediatric Members assigned a Seniors and Persons with Disabilities (SPD) aid code and/or those with a CCS identifier will be sent a PHRA survey within 10 calendar days of enrollment into the plan.
        1) The Health Risk Assessment (HRA) will address:
            a) General health status as reported by the Member and/or primary caregiver(s)
            b) Recent health care utilization (ex. outpatient, emergency room, inpatient visits, school days missed due to illness, etc.)
            c) Review of health history; both CCS and non-CCS diagnoses and past surgeries.
            d) Referral needs
            e) Prescription medication utilization
            f) Durable Medical Equipment (DME) needs

g) Need for specialized therapies if applicable (ex. physical, occupational, speech, mental or behavioral health services, and educational or developmental services).
h) Limitations of Activities of Daily Living (ADLs) or daily functioning if applicable.
i) Demographics and Social History, including but not limited to Member demographics, home/school environment(s), and cultural and linguistic needs and preferences.

b. New pediatric Members who are not assigned an SPD aid code, or who are not identified as a CCS beneficiary, will be sent a Health Information Form (HIF) survey with their Partnership Welcome Packet.

3. Partnership will use a Pediatric Risk Stratification Process (PRSP) to assess the risk new pediatric Members, newly CCS-eligible Members, or WCM transition Members within 45 days of the County CCS program eligibility determination for newly eligible WCM Members and newly transferred WCM Members. Members will be assigned a risk score (High or Low) based on PRSP results. The methodology of the PRSP is as follows:
   a. Members with available claims data:
      1) Application of a Pediatric Risk Stratification Algorithm (see Attachment A)
      2) Analysis of utilization and costs
   b. Members previously managed by a County CCS Program:
      1) Case Review with County CCS staff, when possible
   c. Risk Assignment:
      1) High Risk:
         a) Members who qualify as High Risk through any of the screening methods
         b) Members without available medical utilization data, claims data, or other assessments and/or survey information available
         c) Members in the NICU
         d) Members with a new CCS diagnosis
         e) Newly CCS-eligible Members
         f) New CCS Members enrolled in Partnership
      2) Low Risk:
         a) Members who do not meet the criteria for High Risk
4. Partnership will use the results of the PRSP and the HRA or HIF responses to triage Care Coordination interventions.
   a. High Risk Members will be assessed telephonically, by video or in-person by Care Coordination staff within 90 calendar days of a completed HRA or when identified by PSRP to be High Risk to assist in the development of the Member's ICP.
   b. Low Risk Members will be assessed telephonically, by video or in-person by a Health Care Guide within 120 days of completed HRA or when identified by PRSP to be Low Risk to identify the Member's health care needs.
5. Partnership will offer care coordination to all CCS Members. Building upon the information gathered through the risk assessment process, and in collaboration with the Member, his/her family, and/or his/her designated primary caregiver(s), Partnership's Care Coordination department will review the Member's needs and document the results in the case management system.
   a. All CCS Members will be assigned an Acuity Level ranging from One to Five, and the acuity level may be adjusted throughout the course of the case as the Member's needs change. See MPCD2013 Care Coordination Program Description for further information on Acuity Levels and associated activities.
   b. Low Risk CCS Members (Acuity Levels One to Two) will be assessed through targeted questions that ensure WCM Members have access to care and coordination of benefits to support their health and wellbeing. Low Risk Members will be reassessed annually to ensure that the Member's needs are addressed and that there have been no significant changes in the

Member's condition. Specific areas for review will include:

1) Information and education regarding Partnership's Care Coordination services and where to go for ongoing information, care, and support
2) Medical (primary care and CCS specialty) services
3) Other medically necessary services provided within Partnership's network, or when necessary, services provided by an out-of-network provider
4) Resources available in the community
5) Age-specific questionnaires

c. High Risk CCS Members (Acuity Levels Three, Four, and Five) will be assessed through comprehensive, age-specific questions to support transitions of care across settings or from pediatric to adult care, complex care coordination, facilitate interactions between providers and community agencies, and bolster fragile support systems. The results will be documented in an Individualized Care Plan (ICP) tailored to the needs of the Member, incorporating the Member/caregiver's goals and preferences, and providing measurable objectives and timetables. ICP for Members determined to be high risk based on the results of the risk assessment process will be established within 90 calendar days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication. However, if a Member's family declines having an ICP developed, Partnership will notate the denial in the Member's medical record as evidence of compliance. The ICP will gather information, as appropriate, such as:

1) Information and education on the roles of the interdisciplinary care team, where to go for ongoing information, care, and support.
2) Medical (primary care and CCS specialty) services, including care needs that may be met under Early and Periodic Screening Diagnostic, and Treatment (EPSDT) services including but not limited to palliative care.
3) Developmental, behavioral, and mental health concerns. This includes mild-to moderate or county specialty mental health services, as well as county substance use disorder (SUD) or Drug Medi-Cal service needs.
4) Family/community supports.
5) Home health services.
6) Services provided in school and community.
7) Other medically necessary services provided within Partnership's network, or when necessary services provided by an out-of-network provider.
8) Resources available in the community, including those outside the scope of responsibility of Partnership.
9) Identification of other programs with which the Member is affiliated, such as: Regional Centers, MTP/MTUs; High Risk Infant Follow-Up (HRIF): Genetically Handicapped Persons Program (GHPP), etc., in order to promote collaboration and reduce duplication of effort.
10) Planning for when the CCS Member will age-out of the CCS program.
11) Pediatric provider phase-out planning, supporting the transition from pediatric to adult providers while taking into consideration the Member's medical condition and the established need for care with adult providers.

d. For Members transitioning into the WCM Program from Classic CCS Programs, Partnership will complete the PRSP within 45 calendar days of transition to determine each Member's risk level. Partnership will 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, Partnership will reassess a Member's risk level and needs at the annual medical eligibility redetermination, or upon a significant change to a Member's condition. Regardless of a Member's risk level, all

communications, whether by phone, mail, or other forms of communication, will inform the Member and/or the Member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and will identify the method by which providers will arrange for in-person assessments.

e. Partnership's Care Coordination department facilitates referrals to specialty care when appropriate. If needed, Partnership Care Coordination will make direct referrals as well.
   1) WCM Members are assigned to Direct Member status which allows for direct referral to specialty clinics by providers and Member self-referral without a Referral Authorization Form (RAF). Partnership provides guidance and facilitates sharing of information between clinical settings as needed and per DHCS guidelines.
   2) Partnership identifies needs, goals, barriers, and interventions to access diagnostic and treatment services including access to primary and specialty care by a CCS-Paneled Provider and preventive care services with specialty care services through the collaborative case management and care coordination process with WCM Members. Partnership evaluates Risk Assessments, ICP's, AMR's, ongoing case management with the WCM Member, family, or authorized representative, and available data to identify referred services in plan of care and confirm Member received referred treatments.

f. Partnership will provide information on what community resources exist for Members to utilize via Member's preferred method of communication or by telephone. The Partnership External Website which includes the Partnership's Community Resources pages has information readily available for the Members.

g. For pediatric Members stratified as high risk, Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible Members. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership. ECM can be provided in addition to the WCM Program and Partnership will ensure non-duplication of services. When WCM Members are eligible for and choose to receive both CCS Case Management and ECM services, Partnership may assign some or all CCS Case Manager functions to be delivered by qualified ECM Providers. To be qualified for assignment of CCS Case Management functions, ECM Providers must meet all existing CCS and WCM requirements to provide Case Management services. In addition, these qualified ECM Providers must have previous experience directly providing CCS Case Management and/or CCS clinical services. This only applies when Partnership assigns some or all CCS Case Manager functions to an ECM Provider. If these functions are not being assigned, an ECM provider does not need to meet these additional requirements. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

6. No less than annually, or upon significant change in the WCM Member's condition, Partnership will reassess the WCM Member and his/her:
   a. Risk level via the PRSP,
   b. Age-specific needs and milestones,
   c. Age-Out transition plan and Pediatric Provider Phase Out plan, where appropriate
   d. Documentation needed to support eligibility re-determination
7. When a Partnership Member is receiving services through an MTP/MTU, Partnership staff will act as a liaison with the county MTP/MTU, and collaborate in providing coordinated delivery of care.
8. All information and communications with Members and/or designated caregiver(s) will be provided in a linguistically and culturally appropriate manner.
9. In collaboration with Partnership's Utilization Management Department, Care Coordination staff will coordinate and authorize HRIF services for Members needing case management services.

a. Partnership will notify the CCS county of record of CCS-eligible neonates, infants and children up to 3 years of age that lose Medi-Cal coverage for HRIF services. Partnership will provide continuity of care information to the Member.

10. For Members aging out of WCM, Partnership will provide comprehensive, individualized case management support to assist the Member, family, designated caregiver(s), and providers in transition care to the appropriate setting. The care coordination plan will be developed at least 12 calendar months before the Member ages out. Per state guidelines, Partnership will monitor the WCM Member for at least 36 calendar months following age out of the WCM Program, to the extent feasible.
11. 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 WCM Member. Partnership will provide Care Coordination to WCM Members in need of an adult Provider when the WCM Member no longer requires the services of a pediatric Provider. The timing of the transition will be individualized to take into consideration the WCM Member's medical condition and the established need for care with adult Providers.

D. Inter-County Transfer (ICT)
1. Partnership and the County CCS program will collaborate to facilitate the exchange of ICT data to ensure that CCS WCM Members who relocate to another county can effectively transfer their CCS benefits without interruption, including the provision of continuation of services and the transfer of current service authorization request.
2. CCS-eligible Members that move out of a WCM county:
   a. County CCS Programs will initiate the data transfer request to Partnership using Attachment 4 "Whole Child Model Inter-County Transfer Form" of CCS NL 10-1123, "CCS Intercounty Transfer Policy."
   b. Partnership will provide the County CCS Program office with relevant Member transfer data including case management notes and utilization data for the previous 12 months within 10 business days using Attachment 4 or an agreed upon process between the sending county and Partnership.
   c. The sending county CCS program will coordinate the sharing of CCS-eligible Member data to the receiving county.
3. CCS-eligible Members that move into a WCM county, the sending county CCS Program will provider transfer data to Partnership.
4. CCS-eligible Members that move from one WCM county to a different WCM county, Partnership will provide transfer data to the receiving MCP and the County CCS Program.
5. When the previous county, receiving county, or Partnership cannot agree on the transfer process, the county or Partnership will contact CCSProgram@dhcs.ca.gov.
6. The sending county is responsible for obtaining the Member's medical information even if the transfer is to the same MCP in the receiving county.
   a. If there are no physical copies of the medical reports within the last 12 months, the transfer case notes should include a written statement indicating that there are no physical copies of medical reports for the last 12 month period.
7. When a Member moves out of Partnership service area:
   a. Member is assigned to a direct Member status called HP 8 (Out of Area), refer to Partnership Policy MPUP3039 Direct Members for more details.

E. Continuity of Care
1. Partnership maintains a process to allow for Members to continue receiving care with an existing in-network or out-of-network provider for up to 12 months in accordance with Health and Safety Code 1373.96. For further information, please see policy MPCP2014 Continuity of Care.
2. In addition to the specifications outlined in Partnership Policy MPCP2014, Members participating in

WCM have the additional continuity of care provisions, when applicable, outlined below:

a. Specialized or Customized DME: If the WCM Member has an established relationship with a specialized or customized DME provider, Partnership will provide access to that provider for up to 12 months. Partnership may extend the COC with a DME provider beyond the 12 months for specialized or customized DME still under warranty and deemed medical necessary by the treating provider.

b. Prescription Drugs [2]: CCS-eligible Members transitioning into the Partnership Whole Child Model program are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. For further details, please see policy MCRP4064 Continuation of Prescription Drugs.

3. 60 days prior to the end of their authorized COC period, WCM Members are notified in writing of information regarding the WCM appeal process for COC limitations. This notice explains the Member's right to petition Partnership for an extension of the COC period, criteria used to evaluate the petition and the appeals process if Partnership denies the petition.
   a. WCM Members will direct their first appeal of a COC decision to Partnership.
   b. WCM Member, Member's family or designated caregiver of the WCM Member may appeal the COC limitation to the DHCS Director (or designee) after exhausting Partnership's appeal process.
   c. The DHCS Director (or designee) will have 5 business days from the date of appeal to inform the family or caregiver of receipt and will 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.

F. Continuity of Care for WCM Implementation
   1. Partnership will be able to initiate, accept, and process COC requests from transitioning Members, providers, and authorized representatives beginning 60 calendar days prior to the transition date.
      a. Continuity of Care for Providers: Upon receipt of detailed transition data from DHCS for each transitioning Member, or at least 30 calendar days prior to the transition date, whichever occurs sooner, Partnership will conduct outreach to OON COC eligible providers with whom Members have pre-existing relationships to initiate a Network Provider Agreement or a COC for Providers agreement.
         1) Partnership will review all available data to identify eligible providers that provided services to CCS beneficiaries during the 12 months preceding the transition.
      b. Continuity of Care for Covered Services – Prior Authorization and Active Course of Treatment: Partnership will honor active Prior Authorizations identified in any data available to Partnership and/or when requested by a transitioning Member, provider, or authorized representative, and the MCP obtains documentation of the Prior Authorization before or within the six-month period following the transition date.
      c. Durable Medical Equipment Providers and Medical Supplies: Partnership will allow Members to keep their existing DME rentals and medical supplies from their existing DME Providers without further authorization for the full 12-month period following the transition date and until a reassessment has been completed and the new equipment or supplies are in the possession of the Member and ready for use.

[2] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012 *Revised*, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria and links to the State Medi-Cal Contract Drug List (CDL): http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

d. Continuing Services with County CCS Program Public Health Nurse (PHN): WCM Members or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives may request continuing case management and Care Coordination from their CCS County PHN within 90 calendar days of transitioning to the WCM program. If the requested County CCS Program PHN is no longer available to provide case management and Care Coordination, Partnership will transition those services to one of its CCS Case Managers who has received adequate training on the CCS Program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

e. Member and Provider Outreach and Education: Partnership will follow the Member notification guidelines for COC requests in APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 and Partnership will inform Members of their continuity of care protections and include information about these protections in Member information packets, handbooks, and on the Partnership website.

2. For further details regarding COC, please see policy MPCP2014 Continuity of Care.

G. Partnership and CCS County Coordination

1. Partnership and County CCS programs will coordinate the delivery of CCS services to CCS-eligible Members to prevent duplication of services.
2. Partnership and each WCM CCS county shall execute a Memorandum of Understanding (MOU) outlining respective responsibilities and obligations under the WCM, refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Children's Services (CCS) Whole Child Model Program for more details.
3. Partnership shall hold collaborative meetings with WCM CCS counties no less than quarterly to assist in overall coordination of services, to update policies, procedures and protocols as appropriate, and to discuss activities related to the MOUS and WCM matters.
4. Partnership shall work collaboratively with the CCS county office of record to assist in the inter-county transfer for CCS-eligible Members who move from a WCM county to a non-WCM county. Similarly, the county CCS office will provide transfer data to Partnership if a CCS-eligible Member moves into a WCM county. The county CCS program retains the responsibility for providing transfer data, including clinical and other relevant data, from one county to another.
5. Partnership coordinates with Regional Centers and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) to ensure Members who are individuals with developmental disabilities receive all medically necessary covered services in accordance with APL 23-023 *Revised* Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, please refer to MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities for more details.
6. Partnership ensures that Members living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports as appropriate in coordination with the Regional Center. Please refer to MPCD2013 Care Coordination Program Description for more details.

H. Advisory Committees

1. Partnership meets quarterly with a Clinical Advisory Committee. For more details on Partnership Clinical Advisory committees, refer to Partnership policy MCCP2025 Pediatric Quality Committee.
2. Partnership meets 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 includes, but not be limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers. For more details, please refer to Partnership Policy MCCP2024- B FAC Charter. Family Members serving on this advisory committee may receive a reasonable per diem payment to enable participation in the advisory committee. For more details on per diem payments, refer to Partnership policy ADM21 Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, QIHEC and Q/UAC Committees. A representative of this committee will be invited to serve as a Member of the statewide DHCS CCS stakeholder advisory group.

a. Partnership meeting facilitation and representation ensures proper coordination of roles and responsibilities and support to participating Members.
b. FAC meetings are conducted with options for attendance in-person and via teleconference.
c. Partnership recruits FAC families through opportunities for discussion during ongoing case management interaction, offering per diem payment, engagement and discussion with community based organizations, regional centers, and county CCS programs to collaborate on shared communication, opportunity for families to represent on FAC (including outreach to counties where Membership representation is needed), and through other Partnership departments where customer service and engagement indicates an opportunity for Members to participate. These Members will be referred to Care Coordination for Member or family outreach to discuss the FAC.
d. Partnership recruits FAC Members through engagement and discussion during meetings, and outreach to the following representatives from Partnership counties: local providers, CCS County staff, Parent Advocacy groups, or CCS paneled providers. This may include, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.
e. Partnership retains FAC families and Members through offering per diem payment, facilitating quarterly meeting series that includes diverse range of representation and meeting topics, including resource speakers, for engagement, offering flexibility and encouragement of family participation in advisory capacity, as well as contributions from representative Members.

3. Partnership representatives meet quarterly with the WCM Program stakeholder advisory group composed of representatives of CCS providers, County CCS Program administrators, health plans, family resource centers, regional centers, recognized exclusive representatives of County CCS providers, CCS case managers, CCS MTUs, and representatives from Family Advisory Committees.

I. CCS Liaison
1. Partnership designates one individual as the point of contact for the MOU and the coordination of services between Partnership and Couty CCS Programs who has the knowledge and adequate training on the CCS Program and clinical experience with either the CCS Population or pediatric patients with complex medical conditions. Partnership designates a liaison with training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical eligibility redetermination processes with County CCS Programs, and care management and authorization processes for CCS children. The liaison will ensure the case management assignment is communicated to the county, as needed.

J. Dispute Resolution and Provider Grievances
1. Medical eligibility determination disputes between Partnership and the County CCS Program will be resolved by the County CCS Program. The County CCS Program, in consultation with DHCS in dependent counties, will make a medical eligibility determination. The CCS County program shall communicate all resolved disputes in writing to Partnership within a timely manner.

2. If other disputes arise between Partnership and the County CCS Program, all parties will fulfill their responsibilities in alignment with DHCS policies, including APL, NL, MCP Contract and WCM MOU, without delay. This includes ensuring that Members have timely access to services as specified under the WCM MOU. Partnership and County CCS Programs will attempt to resolve all disputes at the local level before submitting the dispute to DHCS for resolution.
3. If disputes between Partnership and the County CCS Program cannot be resolved, the dispute will be submitted to DHCS by either entity, via email with subject "Request for Resolution" to CCSProgram@dhcs.ca.gov, for review and final determination and will include the following:
   a. A summary of the disputed issue(s) and a statement of the desired remedies
   b. A history of the attempts to resolve the issue(s)
   c. Justification for the desired remedy
   d. Any additional documentation that are relevant to resolve the dispute, if applicable
4. For more details, please refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and APL 24-015– California Children's Services Whole Child Model Program.
5. Partnership will have a formal process to accept, acknowledge, and resolve Provider disputes and grievances. A CCS Provider may submit directly to Partnership a dispute or grievance concerning the processing of a payment or non-payment of a claim by Partnership. The dispute resolution process will be communicated by Partnership to all of its CCS Providers.

K. Grievance, Appeal, and State Hearing
1. Partnership will ensure that all Members are provided information on Grievances, Appeals, and State Hearing rights and processes. All WCM Members will be provided the same Grievance, Appeal, and State Hearing rights as other Partnership Members. Please refer to Partnership policies MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions and CGA024 Medi-Cal Member Grievance System for more details.

IX. REFERENCES:

A. DHCS All Plan Letter (APL) 24-015 California Children's Services Whole Child Model Program (12/02/2024 supersedes 23-034)
B. California Code, Health and Safety Code §1373.96
C. CCS Numbered Letter (NL) 03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services (08/19/2010)
D. DHCS APL 23-005 - Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
E. DHCS APL 22-012 – Governor's Executive Order N-01-19 Regarding Transitional Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (*Revised* 12/30/2022)
F. DHCS APL 23-029 - Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 01/08/2025)
G. Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Childrens Services (CCS) Whole Child Model Program (07/2024)
H. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)
I. DHCS APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services (02/12/2025)
J. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Template (08/31/2022)
K. DHCS All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in

Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (08/15/2023)

L. CCS NL 05-0502 Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit (NICU) (09/06/2024)

M. CCS NL 10-1123 CCS Intercounty Transfer Policy (11/1/2023)
Attachment 1: Intercounty Transfer Process Flowchart
Attachment 2: Intercounty Transfer Frequently Asked Questions
Attachment 3: CCS Intercounty Transfer Check List
Attachment 4: CCS Whole Child Model Intercounty Transfer Check List

N. CCS Medical Eligibility Guide (03/15/2017)

O. CCS NL 10-1224 California Children's Services Whole Child Model Program (*Revised* 12/02/2024)
Attachment A: CCS Case Management Core Activities

X. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

XI. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

XII. REVISION DATES: 11/13/19; 02/12/20; 04/14/21; 01/12/22; 01/11/23; 02/14/24; 04/09/25; 08/13/25

PREVIOUSLY APPLIED TO:
MPCP2002 – California Children's Services was previously in effect 04/25/1995 – 12/31/2018 and reinstated 01/01/2024-12/21/2024

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.