PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2024</td><td colspan="3">Lead Department: Health Services</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: 02/14/2025
Last Review Date: 02/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</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: 02/14/2024</td></tr>
</table>

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. MCCP2014 – Continuity of Care
G. MCCP2030 – Ancillary Transportation Services: Lodging, Meals, Attendants, Parking and Tolls
H. MCRP4064 – Continuation of Prescription Drugs[1]
I. MCUP3039 – 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. MCUP3143 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
N. MPCP2002 – California Children’s Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
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.

[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, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/Magellan instead of PHC. Refer to the PHC website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx
The State Medi-Cal Contract Drug List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx?t=4

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. 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.
D. Memorandum of Understanding (MOU): Where no reimbursement is to be made, PHC shall negotiate in good faith an 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.
E. 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).
F. 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.
G. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by PHC.

IV. ATTACHMENTS:

A. Pediatric Risk Stratification Process

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 (PHC) will be integrated into the operations of PHC as part of the Whole Child Model (WCM); and to outline the collaboration between PHC, providers, county CCS agencies, community resources, and the CCS member and his/her caregiver. The counties included are Lake, Marin, Mendocino, Napa, Solano, Sonoma, Yolo, Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity[2]. The goals of the WCM are as follows:

A. Ensure ongoing, timely eligibility determination for CCS conditions.
B. Coordinate appropriate care and services for PHC'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 PHC 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.

[2] Collaboration between the California Children's Services (CCS) program and PHC as an adjunct to the county specific Memorandum of Understanding (MOUs). The counties included are Tehama, Plumas, Glenn, Butte, Colusa, Sutter, Yuba, Sierra, Nevada, and Placer and would not apply to this policy. Refer to policy MPCP2002 - California Children's Services for more details.

Policy/Procedure Number: MCCP2024		Lead Department: Health Services
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)		☒**External Policy** ☐**Internal Policy**
Original Date: 11/14/2018 **Effective Date:** 01/01/2019 per DHCS	**Next Review Date: 02/14/2025** **Last Review Date: 02/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE

A. CCS Program Eligibility

1. PHC actively screens for members who may meet the CCS program eligibility. PHC 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, PHC will instruct providers to submit supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program and/or DHCS.
2. PHC 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, the weekly Hospital Discharge Report, 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. PHC will instruct providers to provide medical records to the CCS county/California Department of Health Care Services (DHCS) staff to review for the initial medical determination for the CCS program. In the event of a provider's failure to refer in a reasonable timeframe, PHC will intervene to provide referral information and educate the provider on the importance of referrals to the CCS program. For annual medical redeterminations, PHC will provide the medical records to the CCS program.
    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 medical report identifying the suspected CCS-eligible medical condition
    b. The referral shall be transmitted by a method mutually agreed upon by both PHC 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.
    c. The County CCS Program and/or the State will review and complete annual eligibility no later than thirty (30) calendar days prior to the CCS client's program eligibility end date.
    d. The county CCS program/DHCS will notify the member and/or primary caregiver of the CCS program eligibility determination.
    e. The County CCS Program/State will complete CCS program eligibility on new Medi-Cal covered referrals within ten (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 PHC at the time the decision is made.
    f. PHC will inform the member/caregiver and primary care provider of the referral within 90 days of making the referral.
    g. When PHC becomes aware that a member has lost PHC eligibility, or has moved out of PHC's service area, PHC will notify the County CCS program.
    h. The County CCS Program will alert PHC of any CCS case closure or loss of eligibility and will

send a CCS Notice of Action (NOA) will be sent to family upon case closure.

4. PHC 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.
5. If a member or caregiver(s) disputes the county CCS program eligibility determination, the member/caregiver(s) must appeal to the county and/or DHCS directly. The CCS county program shall communicate all resolved disputes in writing to PHC within a timely manner.

B. Utilization Management

1. Under WCM, CCS members are able to receive the same CCS benefits and services through PHC as they did through County CCS programs. These services are based on medical necessity and are reviewed by PHC 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 PHC policy MPCP2006 "Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities."
2. PHC 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, PHC 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 MCUP3039 Direct Members. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist, however, PHC assigns the member a medical home to ensure completion of preventative care.
4. PHC 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 MCCP2030 – 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 policy MCUP3013 Durable Medical Equipment (DME) Authorization).
    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 PHC.
    c. The County MTU/MTP liaison will assist PHC with interpretation of applicable CCS DME numbered letters.
    d. The county MTU/MTP liaison will provide technical assistance to the vendor, family and PHC in the approval process.

C. Care Coordination

1. PHC members participating in the WCM and their families/caregivers are eligible to receive

comprehensive Care Coordination and Case Management services.

2. Pediatric members who are new to PHC 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 PHC Welcome Packet.
3. PHC will use a Pediatric Risk Stratification Process (PRSP) to assess the risk of new pediatric members, newly CCS-eligible members, or WCM transition members within 45 days of enrollment or transition from a county CCS program. 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 claims data
            c) Members in the NICU
            d) Members with a new CCS diagnosis
        2) Low Risk:
            a) Members who do not meet the criteria for High Risk
4. PHC 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 licensed staff within 90 days of a completed HRA or when identified by PSRP to be High Risk.
    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.
5. PHC 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), PHC'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 PHC'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 PHC'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. 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.
    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 PHC'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 PHC.
    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. PHC's Care Coordination department facilitates referrals to specialty care when appropriate. If needed, PHC 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). PHC provides guidance and facilitates sharing of information between clinical settings as needed and per DHCS guidelines.

e. For pediatric members stratified as high risk, PHC 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 PHC. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 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, PHC 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 PHC member is receiving services through an MTP/MTU, PHC 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 PHC's Utilization Management Department, Care Coordination staff will coordinate and authorize HRIF services for members needing case management services.
   a. PHC 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. PHC will provide continuity of care information to the member.
10. For members aging out of WCM, PHC will provide comprehensive, individualized case management support to assist the member, family, designated caregiver(s), and providers in transition care to the appropriate setting. Per state guidelines, PHC will monitor the WCM member for three years following age out, while the WCM member remains a PHC member.

D. Continuity of Care
   1. PHC 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 MCCP2014 Continuity of Care.
   2. In addition to the specifications outlined in PHC Policy MCCP2014, 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, PHC will provide access to that provider for up to 12 months. PHC may extend the continuity of care (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. Case Management: Where available, WCM members may continue to receive case management and care coordination services from their existing Public Health Nurse (PHN) at their CCS county office of record. Members who wish to continue to receive case management services under COC must request to do so within 90 days of transitioning to PHC under the WCM. In the event that the county PHN is unavailable, PHC will provide the member with comparable case management services.
      c. Prescription Drugs [3]: CCS-eligible members transitioning into the PHC Whole Child Model

[3] 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, and all medications (Rx and OTC) which are

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 PHC for an extension of the COC period, criteria used to evaluate the petition and the appeals process if PHC denies the petition.
   a. WCM members must direct their first appeal of a COC decision to PHC.
   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 PHC'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 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.

E. PHC and CCS County Coordination
   1. PHC and County CCS programs will coordinate the delivery of CCS services to CCS-eligible members.
   2. PHC and each WCM CCS county shall execute a Memorandum of Understanding (MOU) outlining respective responsibilities and obligations under the WCM.
   3. PHC 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. PHC 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 PHC 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.

VIII. REFERENCES:

A. DHCS All Plan Letter (APL) 21-005 *Revised* – California Children's Services Whole Child Model Program (12/10/2021)
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. Department of Health Care Services All Plan Letter (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 (10/11/2023)

IX. DISTRIBUTION:

provided by a pharmacy must be billed to State Medi-Cal/Magellan instead of PHC. Refer to the PHC website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx The State Medi-Cal Contract Drug List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx?t=4

A. PHC Department Directors
B. PHC Provider Manual

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

XI. REVISION DATES: 11/13/19; 02/12/20; 04/14/21; 01/12/22; 01/11/23; 02/14/24

PREVIOUSLY APPLIED TO:
MPCP2002 – California Children's Services was previously in effect 04/25/1995 – 12/31/2018

****

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 PHC 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 PHC.

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