Policy:	GG.1330
Title:	**Case Management - California Children's Services Program/Whole-Child Model**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 02/27/2025*
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Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for the provision of Case Management by CalOptima Health or a Health Network to CalOptima Health Members eligible with the California Children's Services (CCS) program, newly CCS-eligible Members, or established or new CCS Members enrolling in the CalOptima Health Whole-Child Model (WCM) program.

II. POLICY

A. CalOptima Health or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, case management, and quality oversight.

1. CalOptima Health and its Health Networks shall ensure the provision of case management and Care Coordination by staff with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

B. CalOptima Health or a Health Network shall identify and refer all Members with potential CCS-Eligible Conditions including but not limited to Members in the Neonatal Intensive Care Unit (NICU), Members identified as High Risk Infant Follow-up (HRIF), Members who present to the emergency department, or have a Medical Therapy Program (MTP) eligible condition to County CCS Program for CCS medical eligibility determination in accordance with CalOptima Health Policy GG.1101: California Children's Services(CCS)/Whole-Child Model-Coordination with County CCS Program.

1. CalOptima Health or a Health Network will provide services to WCM Members with Other Health Coverage, with full scope Medi-Cal as the payor of last resort.

2. CalOptima Health or Health Network must refer a WCM Member who develops a new potential CCS-Eligible Condition as soon as possible to the County CCS Program for an eligibility determination and not wait until the annual CCS Medi-Cal eligibility redetermination period.

C. CalOptima Health shall identify the health risk of each CCS-eligible Member using a Department of Health Care Services (DHCS)-approved proprietary pediatric Risk Stratification algorithm within forty-five (45) calendar days of the eligibility with the CCS program.

D. Based on the results of the Risk Stratification, CalOptima Health shall collect a DHCS-approved Health Needs Assessment (HNA), also known as a risk assessment, as follows:

1. High-risk: Within ninety (90) calendar days; and

2. Low-risk: Within one hundred twenty (120) calendar days.

3. CalOptima Health shall reassess Members as follows:

    a. Annually, at a Member's CCS eligibility redetermination; or

    b. Upon significant change to a Member's health condition.

4. The HNA shall address, at a minimum, the following:

    a. General health status and recent health care utilization;

    b. Health history;

    c. Specialty provider referral needs;

    d. Prescription medication utilization;

    e. Specialized or customized Durable Medical Equipment (DME) needs;

    f. Need for specialized therapies;

    g. Limitations of activities of daily living (ADLs) or daily functioning;

    h. Demographics and social history; and

    i. Age-specific questions.

E. CalOptima Health or a Health Network shall use the HNA to develop an Individual Care Plan (ICP) individualized to meet Member's medical (including specialty care and behavioral health needs), functional, psychosocial, social support and access to care needs, for all Members assigned a care management level of Care Coordination or Complex Case Management.

F. CalOptima Health or a Health Network is responsible for providing all available necessary documentation that confirms each of the Member's CCS-Eligible Conditions for the Annual Medical Redetermination, including but not limited to Medical Records, case notes, discharge summaries if applicable and reports pertaining to the CCS-Eligible Condition.

G. CalOptima Health shall engage in a collaborative process with the County CCS Program to remedy any issues or challenges related to the timeliness and/or completeness of records that are needed for the Annual Medical Redetermination through monthly collaborative meetings.

H. CalOptima Health or a Health Network shall proactively coordinate services for a CCS-eligible Member reaching twenty-one (21) years of age, including:

1. Identification of primary care and specialty care providers appropriate to the Member's CCS-Eligible Condition; and

2. Assistance with transition planning to allow for purposeful, planned preparation of Members, families, and caregivers for transfer of a Member from pediatric to adult medical or health care services prior to age twenty-one (21).

I. Care Coordination by CalOptima Health or a Health Network to CCS-eligible Members who require a pediatric provider phase-out plan. This plan is for Members in need of an adult provider when a treating CCS-paneled provider determines his or her services are no longer beneficial or appropriate to the treatment of the CCS-eligible Member, or the CCS-eligible Member no longer requires the services of a pediatric provider. The timing of the transition will be individualized to take into consideration the Member's medical condition and the established need for care with adult providers.

J. Members eligible with CCS program and transitioned into the WCM program may submit a request to continue receiving Case Management and Care Coordination service from his or her existing public health nurse. A Member shall submit the request to CalOptima Health within ninety (90) calendar days of his or her transition date.

K. CalOptima Health will review the Memorandum of Understanding (MOU)annually to determine if any modifications, amendments, updates, or renewals of responsibilities and obligations are needed, including incorporating any applicable contractual requirements and policy guidance into their MOU in accordance with CalOptima Health Policy EE.1144 Memorandum of Understanding (MOU) Requirements for CalOptima Health and Third-Party Entities.

L. CalOptima Health will designate a CCS Liaison who is the primary point of contact responsible for CCS Members' Care Coordination and will receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, and care management and authorization processes for CCS children. The liaison may also be a point of contact for Enhanced Care Management (ECM) and Community Supports Providers that serve CCS-eligible Members under the ECM populations of focus.

M. When WCM Members are eligible for and choose to receive both CCS Case Management and ECM services, CalOptima Health may assign some or all CCS Case Manager functions to be delivered by qualified ECM Providers, as outlined in ECM Policy Guide.

1. 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, including previous experience directly providing CCS Case Management and/or CCS clinical services.

N. CalOptima Health shall ensure that the HNA is provided in a linguistically and culturally appropriate manner and will offer an in-person assessment.

O. For Members eligible with CCS program and transitioned into the WCM program, CalOptima Health and a Health Network shall identify and track CCS-eligible Members for the duration of their participation in the WCM program, and for those who continue to be enrolled in CalOptima Health, for at least three (3) years after they age-out of the WCM program, to the extent feasible.

P. CalOptima Health, a Health Network, or a practitioner shall identify Members, such as but not limited to Children with Special Health Care Needs (CSHCN), who may have a CCS-Eligible Condition in accordance with CalOptima Health Policies GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program, and GG.1116: Pediatric Preventive Services; and to Regional Center of Orange County who is overseen by the California Department of Developmental Services, in accordance with CalOptima Health Policy GG.1302a: Coordination of Care for RCOC Members.

Q. CalOptima Health and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical services under the scope of the CalOptima Health program to eligible children under age twenty-one (21) years in accordance with CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

R. CalOptima Health or a Health Network shall ensure the provision of the Maintenance and Transportation benefit for eligible Members and a Member's family seeking transportation to a medical service related to the Member's CCS-Eligible Condition in accordance with CalOptima Health Policy GG.1547: Maintenance and Transportation. In the event that a Member requires transportation services outside of the Maintenance and Transportation benefit, such as transportation unrelated to their CCS-Eligible Condition(s), Non-Emergency Medical Transportation or Non-Medical Transportation may be provided when it meets the requirements under CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

S. CalOptima Health or a Health Network shall provide continuity of care for Members with CCS-Eligible Conditions, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services; and GG.1301 Comprehensive Case Management Process which includes Members who move to a different county but maintain their eligibility with CalOptima Health.

T. CalOptima Health or a Health Network shall provide transfer data including clinical and relevant data with County CCS Program on Inter-County Transfers as outlined in section III.J. of this Policy, including Members who move from CalOptima Health to a different WCM county. CalOptima Health shall transfer data for these Members to the receiving WCM Managed Care Plan (MCP) as well as the local CCS program.

U. CalOptima Health or a Health Network shall provide case management services for eligible Members with approved Private Duty Nursing services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit or under the CCS/WCM program in accordance with CalOptima Health Policy GG.1352: Private Duty Nursing Care Management.

V. CalOptima Health or a Health Network shall cover all blood, tissue, and solid organ transplants for CCS eligible Members in accordance with CalOptima Health Policies GG.1105: Coverage of Organ and Tissue Transplants and GG.1313: Coordination of Care for Transplant Members

W. CalOptima Health or a Health Network shall ensure non-duplication of services for Members provided with ECM in addition to the WCM program.

    1. The ECM Lead Care Manager (LCM) will be responsible for coordinating with CalOptima Health or a Health Network to ensure there is no duplication of services for WCM Members, in accordance with CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery.

X. For WCM Members receiving CCS Case Management and either Complex Care Management (CCM) or ECM, CalOptima Health or a Health Network must ensure the appropriate coordination of care across all settings, including, but not limited to, between the Members' PCP, CCS specialty services, and, if applicable, Non-Specialty Mental Health Services and Regional Center services.

Y. CalOptima Health or a Health Network shall ensure comprehensive diagnostic and treatment services of the whole child and Care Coordination in the areas of primary, specialty, and behavioral health for CCS-Eligible and non-CCS-Eligible Conditions.

Z. CalOptima Health shall conduct, at least quarterly, a review of the inpatient utilization data to assess whether all CCS eligible Members have been appropriately referred to the CCS Program.

AA. CalOptima Health shall notify County CCS Program if a Member is no longer eligible with CalOptima Health no later than fifteen (15) calendar days of being made aware.

BB. CalOptima Health or a Health Network shall ensure training and notification requirements for Child Welfare Liaison are in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

III. PROCEDURE

A. Pediatric Risk Stratification

1. The pediatric Risk Stratification algorithm shall incorporate Member-specific data that signifies each CCS-eligible Member's clinical history and specific utilization data to assess the health risk, high or low, of a Member to include review of:

    a. Medical utilization data;

    b. Medical claims and encounter data;

    c. Existing assessment or survey data;

    d. Pharmacy data;

    e. Data provided by the local CCS program and DHCS; and

    f. Telephonic or in-person communications, if available at the time of the Risk Stratification.

2. For Members for which medical utilization data, claims processing data, or other assessments or survey information is not available, CalOptima Health shall automatically categorize such Member as high-risk until CalOptima Health is able to gather further assessment data to make an additional risk determination.

B. Health Needs Assessment (HNA)

1. Upon enrollment in CCS, CalOptima Health shall perform outreach to a CCS-eligible Member to complete the HNA telephonically or in-person as follows:

    a. High Risk Members

i. Make three (3) attempts to reach the Member/Member's family by telephone within ninety (90) calendar days. CalOptima Health shall offer to assist the Member with completion of the HNA by telephone or in-person.

ii. If CalOptima Health is not able to reach the Member after three (3) attempts, CalOptima Health shall mail a letter to the Member's address, requesting the Member telephone CalOptima Health to complete the HNA.

iii. CalOptima Health shall establish an Individual Care Plan (ICP) for high risk Members based on the results of the Risk Stratification and HNA, within thirty (30) calendar days of the completion of the HNA by telephone or in-person communication or if the Member is identified as needing Care Coordination or Complex Case Management as described in Section III.D. of this Policy.

b. Low Risk Members

i. CalOptima Health shall make three (3) attempts to reach the Member/Member's family by telephone within one hundred twenty (120) calendar days. CalOptima Health shall offer to assist the Member with completion of the HNA by telephone or in-person.

ii. If CalOptima Health is not able to reach the Member after three (3) attempts, CalOptima Health shall mail a letter to the Member's address, requesting the Member telephone CalOptima Health to complete the HNA.

2. CalOptima Health shall offer an in-person HNA to a CCS-eligible Member administered by a CalOptima Health Registered Nurse or Personal Care Coordinator (PCC) when a Member's health condition precludes the administration of an HNA via telephone during the HNA collection time period (based on risk level), including but not limited to, inpatient hospitalization.

3. If a Member fails to complete the HNA after the third outreach attempt, CalOptima Health shall close the Member's HNA file in the electronic database.

4. CalOptima Health shall offer reassessment annually, either telephonically or in-person, to all CCS-eligible Members no later than the anniversary date of their most recent HNA or the month of their eligibility date, if no HNA has been collected.

C. Care Management and Care Coordination

1. A CalOptima Health Registered Nurse shall review and evaluate the responses to the HNA to assign one (1) of the following care management levels to a CCS-eligible Member:

a. Complex Case Management (high risk);

b. Care coordination care management (high risk); or

c. Basic care management.

2. Care Management

a. CalOptima Health or a Health Network will assign a Personal Care Coordinator (PCC) to each CCS-eligible Member. The PCC shall serve as the Member's assigned primary point of contact with CalOptima Health or a Health Network. The PCC shall:

   i. Perform initial and periodic outreach to assist the Member with Care Coordination;

   ii. Provide information, education and support continuously, as appropriate; and

   iii. Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.

   iv. Assist as point of contact for other care managers and service Providers that serve WCM members, including ECM and Community Supports providers.

b. PCCs shall be supported by a CalOptima Health or Health Network Registered Nurse for clinical considerations.

c. CalOptima Health or a Health Network may transition a Member to a higher or lower level of care management as needed, due to a change in the Member's condition or as requested by the Member.

3. For those Members assigned a care management level of Care Coordination care management or Complex Case Management, CalOptima Health or a Health Network shall assign a licensed care manager, in addition to the PCC. An ICP shall be developed within thirty (30) calendar days of a completed HNA or identified as needing Care Coordination or Complex Case Management in accordance with Section III.D. of this Policy. The ICP shall be shared with the Member and/or Member's family, Primary Care Provider (PCP), and Interdisciplinary Care Team (ICT).

4. The Care Management process shall also address:

   a. Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are;

   b. Support for family navigation including but not limited to the following:

      i. Educate about Special Care Centers and community resources such as peer and family support organizations;

      ii. Families who are having difficulty maintaining their Medi-Cal enrollment;

      iii. Support the educational team when request by the member and or their family; and

      iv. Educate families on available transportation resources.

   c. A primary or specialty care physician who is the primary clinician for the CCS-eligible Member and who provides core clinical management functions;

d. Care management and Care Coordination for the CCS-eligible Member across the health care system, including transitions among levels of care and ICTs

e. Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of CalOptima Health; including but not limited to:

i. Community-based activities such as exercise and socialization for children with physical disabilities.

ii. Resources for county mental health, Regional Centers, public health nursing and/or schools, ECM and Community supports, CalFresh and Women, Infants & Children (WIC) Program.

f. Coordination of referrals and monitoring to confirm member receives referred treatments with documentation of when, where, and any next steps following treatment;

g. Conduct Interdisciplinary Care Team (ICT) meetings as needed;

h. Facilitate referrals for behavioral health services and pediatric palliative care when indicated; and

i. Assistance with any barriers related to required medical appointments or treatments including but not limited to the following:

i. If a Member does not receive referred treatments, follow-up must be made with Member to assist in:

a) Care coordination next steps:

b) Understanding of barriers, and if applicable;

c) Adjustment to referrals; and

ii. Attempts must be made to connect with the referred provider and facilitate a warm hand off to necessary treatment as needed.

2. CalOptima Health or a Health Network shall ensure ongoing Care Coordination in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

D. Individual Care Plan (ICP)

1. CalOptima Health or a Health Network shall develop an ICP for a high-risk Member within thirty (30) calendar days of the completion of the HNA by telephone or in-person communication or identified as needing Care Coordination or Complex Case Management. CalOptima Health shall develop the ICP in collaboration with the Member, as appropriate, the Member's family, or caregiver and ICT. If a Member's family declines having an ICP developed, CalOptima Health or a Health Network shall document the denial in the Member's case record

2. The ICP shall incorporate the CCS-eligible Member's goals and preferences and provide measurable objectives and time frames for completion to meet the needs for:

a. Medical services (primary and specialty services);

b. Mild to moderate or county specialty mental health services;

c. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);

d. County substance use disorder (SUD) or Drug Medi-Cal services;

e. Home health services;

f. Regional center services;

g. Other Medically Necessary services provided by CalOptima Health or a Health Network, including, when necessary, out-of-network providers; and

h. Home and community-based services.

3. CalOptima Health or a Health Network shall reevaluate and update each CCS-eligible Member's ICP upon a significant change to the Member's condition; and outreach, at least annually either telephonically or in-person, to all CCS-eligible Members no later than the anniversary date of their most recent HNA or the month of their eligibility date, if no HNA has been collected.

E. Annual Medical Redetermination

1. CalOptima Health or a Health Network is responsible for providing all available necessary documentation that confirms each of the Member's CCS-Eligible Conditions which includes:

a. Member's most current Medical Records that document the Member's medical history, results of a physical examination by a physician or an advanced practiced provider acting within the scope of their licensing authority, laboratory test results, radiologic findings, or other tests or examinations that support the diagnosis of the eligible condition(s), including any MTP diagnosis. If applicable, discharge summaries, and High Risk Infant Follow-Up (HRIF) reports that confirm the CCS-Eligible Condition(s) must also be included.

b. All documentation must be, to the extent possible, produced within the last six (6) months but no later than twelve (12) months.

i. The documentation must include efforts made to receive required documentation when it is not available no later than sixty (60) calendar days before the Member's program eligibility end date, unless the County CCS Program verifies that all needed medical information is already available.

2. CalOptima Health or a Health Network must outreach to the provider to obtain the Medical Records, including outreach to the Member for coordination support as appropriate if Medical Record recovery is unsuccessful.

F. CCS NICU Eligibility Criteria Assessment

1. CalOptima Health or a Health Network shall conduct assessments of medical eligibility for care in a CCS-approved NICU in accordance with CCS Program guidelines found in DHCS

California CCS Numbered Letter (NL) 05-0502 Medical Eligibility for Care in a CCS-approved Neonatal Intensive Care Unit (NICU), or any superseding NL.

2. CalOptima Health or a Health Network shall report and refer to the County CCS Program all members as meeting the criteria for the NICU eligibility criteria assessment in order to capture the CCS referral including if applicable NICU discharge summaries.

    a. CCS NICU eligibility involves identification of a CCS-eligible medical condition, which will confer CCS Program eligibility beyond the NICU stay.

    b. A Member shall also be medically eligible for care in a CCS approved NICU and only during the time period the service(s) described below is (are) delivered:

        i. At least one (1) service as follows:

            a) Positive pressure ventilatory assistance that is invasive or non-invasive;

            b) Supplemental oxygen concentration by hood of greater than or equal to forty (40) percent;

            c) Maintenance of an umbilical arterial catheter or peripheral arterial catheter for Medically Necessary indications;

            d) Maintenance of an umbilical venous catheter or other central venous catheter for Medically Necessary indications;

            e) Maintenance of a peripheral line for intravenous pharmacologic support of the cardiovascular system;

            f) Central or peripheral hyperalimentation; or

            g) Chest tube; or service for care in a CCS approved NICU.

        ii. Or at least two services as follows:

            a) Supplemental inspired oxygen;

            b) Maintenance of a peripheral intravenous line for administration of intravenous fluids, blood, blood products, or medications other than those agents used in support of the cardiovascular system;

            c) Pharmacologic treatment for apnea and/or bradycardia episodes; and/or

            d) Tube feedings.

    c. Termination of medical eligibility for care in a CCS approved NICU will occur when the Member no longer meets the criteria in Section III.F.2.b. of this Policy.

    d. Must inform the County CCS Program if a Member is at any point subsequently identified as having a CCS-Eligible Condition so that the County CCS Program can conduct the CCS eligibility determination process for the Member.

e. Must review authorizations and determine if services meet CCS NICU requirements in accordance with CCS Program guidelines found in DHCS CCS NL 02-0413: Neonatal Intensive Care Unit (NICU) Authorizations, or any superseding N.L.

G. High Risk Infant Follow-Up (HRIF)

1. The HRIF Program provides for three standard visits which include a limited number of outpatient diagnostic services for infants up to three years of age and children who have high risk for neurodevelopmental delay or disability whose care was provided in a CCS Program-approved NICU.

2. The HRIF programs are outpatient CCS Program Special Care Centers (SCC) and provide a limited range of core diagnostic services for infants and children.

3. CalOptima Health or a Health Network shall conduct a HRIF program acuity assessment and authorize any HRIF services for the Member in accordance with the HRIF Eligibility Criteria.

4. CalOptima Health or a Health Network shall ensure access or arrange for the provision of HRIF case management services.

5. CalOptima Health or a Health Network shall notify the County CCS Program 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, in accordance with DHCS CCS NL 05-1016: High Risk Infant Follow-Up (HRIF) Program Services.

6. CalOptima Health or a Health Network shall include the potential CCS-eligible Members' HRIF records, including final evaluation reports, if available, to the County CCS Program.

H. Medical Therapy Program (MTP)

1. CalOptima Health or a Health Network shall refer Members to the County CCS Program if these Members are suspected of having a MTP eligible condition and must include all supporting documentation with the referral.

   a. As a part of the CCS eligibility review, the County CCS Program will review and determine MTP eligibility, if applicable.

I. Age-Out Transition and Planning

1. CalOptima Health or a Health Network shall proactively coordinate services for a CCS-eligible Member reaching twenty-one (21) years of age as follows:

   a. Age fourteen (14):

      i. Identify CCS-eligible Members who will require long-term health care transition planning; and

      ii. Notify, via mail, the Member, the Member's family, and PCP, of the transition process.

   b. Age sixteen (16):

i. Identify CCS-eligible Members who will require long-term health care transition planning who were not identified or known at age fourteen (14);

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify, via mail, the Member and the Member's family of the need to formally institute transition planning;

iv. Notify the PCP of the need to schedule an adolescent transition health care conference; and

v. Request information from Special Care Centers (SCCs), as appropriate, regarding steps the center(s) has taken to institute the transition planning process, including identification or primary and specialty care providers appropriate to the Member's CCS-Eligible Condition who will provide care after the Member's 21st birthday, the need for DME, and the Member's PCP.

c. Age seventeen (17):

i. Send Adult Services Declaration and Notice of Privacy Practices with acknowledgement receipt to those CCS-eligible Members identified as needing transition services.

d. Age eighteen (18):

i. Identify CCS-eligible Members who will require long term health care transition planning who were not identified or known at age sixteen (16);

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify, via mail, the Member and the Member's family of the need to prepare or update transition planning;

iv. If not received, resend Notice of Privacy Practices with acknowledgement of receipt via mail;

v. Request updated information from special care centers regarding steps the center (s) has taken to institute the transition planning process, including identification or primary and specialty care providers appropriate to the Member's CCS-Eligible Condition who will provide care after the Member's twenty-first (21st) birthday, the need for DME, and the Member's PCP.

e. Age twenty (20):

i. Identify CCS-eligible Members who will require long term health care transition planning who were not identified or known to the program at age eighteen (18);

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify the Member and the Member's family of the need to prepare or update transition planning, or update Adolescent Transition Health Care Plan to identify any unmet needs and modify, as necessary;

iv. Send a letter to the Member's CCS PCP to determine if he or she will continue to provide care after the Member's twenty-first (21st) birthday and name of the identified adult provider if the pediatric provider will not continue care. If necessary, request a referral to adult provider if one is required and has not been identified;

v. Send a letter to the Member and the Member's family requesting transition planning meeting or teleconference;

vi. Evaluate the Member for additional Care Coordination needs; and

vii. Send an exit interview survey to the Member and the Member's family.

f. Age twenty (20) and eight (8) months:

i. A CCS-eligible Member who is enrolled in CHOC Health Alliance shall select another Health Network prior to his or her twenty-first (21st) birthday in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network (CCN) Selection Process; and

ii. CalOptima Health will assist Members who need to change his or her Health Network with selecting a new Health Network and with coordinating care through the transition.

J. CalOptima Health must review and complete Inter County Transfers (ICT) as follows:

1. CalOptima Health will submit ICT requests to the County CCS Program using Attachment B of this Policy, Whole Child Model Inter-County Transfer Form, of the DHCS CCS NL 10-1123: Inter-County Transfer Policy.

2. CalOptima Health must provide copies of all medical reports, case management notes, and utilization information which includes a copy of the PCP version of the most recent ICP and most recent HNA for the previous twelve (12) months in a transfer packet to the County CCS Program for transfer to the receiving county within ten (10) business days; and to the sending county within five (5) business days, using Attachment B of this Policy.

a. If there are no physical copies of the medical reports within the last twelve (12) months, the transfer case notes shall include a written statement indicating that there are no physical copies of medical reports for the last twelve (12) month period.

3. CalOptima Health must collaborate with the receiving and previous county on a transfer date.

4. For a Member who moves to another county and is still enrolled with CalOptima Health, CalOptima Health or a Health Network shall remain responsible for case management, and must provide continued access to Medically Necessary services, emergency services or any other coverage that may be authorized until the Member is disenrolled and the ICT is complete.

K. Case Management Oversight of Health Network ICPs

1. CalOptima Health Registered Nurses shall review the data collected from each HNA and shall:

a. Evaluate completion and accuracy of information provided;

b. Evaluate clinical data; and

c. Assign a provisional care management level.

2. A CalOptima Health Registered Nurse shall upload HNA via secure FTP site to the CCS-eligible Member's assigned Health Network for completion of the ICP, as appropriate.

3. The Health Network shall retrieve the HNA.

4. The licensed care manager at the Health Network shall be responsible for the care management of the Member as described in Section III.C. of this Policy.

5. CalOptima Health shall conduct quarterly oversight audits to ensure compliance with CalOptima Health Policies and Procedures. Audit feedback shall be provided quarterly upon completion to the Health Networks.

L. CalOptima Health shall convene a quarterly meeting between CalOptima Health and the local CCS program to assist with overall coordination by updating policies, procedures, and protocols, as appropriate and to discuss activities related to the Memorandum of Understanding and other WCM related matters

IV. ATTACHMENT(S)

A. CalOptima Health Children with Special Health Care Needs Assessment
B. Whole Child Model Inter-County Transfer Form

V. REFERENCE(S)

A. CalAIM Enhanced Care Management Policy Guide, August 2024
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Network Service Agreement
D. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
E. CalOptima Health Policy EE.1144 Memorandum of Understanding (MOU) Requirements for CalOptima Health and Third-Party Entities
F. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program
G. CalOptima Health Policy GG.1116: Pediatric Preventive Services
H. CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
I. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
J. CalOptima Health Policy GG.1302a: Coordination of Care for Regional Center of Orange County (RCOC) Members
K. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
L. CalOptima Health Policy GG.1313 Coordination of Care for Transplant Members.
M. CalOptima Health Policy GG.1352: Private Duty Nursing Care Management
N. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
O. CalOptima Health Policy GG.1547: Maintenance and Transportation

P. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
Q. Welfare and Institutions Code §§ 14094.7(d)(4)(C), 14094.11(b)(1)-(6), 14094.11(c), 14094.12(j), 14094.13(e)-(g)
R. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 02-0413: Neonatal Intensive Care Unit (NICU) Authorizations
S. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 05-0502: Medical Eligibility for Care in a CCS-Approved Neonatal Intensive Care Unit (NICU)
T. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 05-1016: High Risk Infant Follow-Up (HRIF) Program Services
U. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 10-1123: CCS Intercounty Transfer Policy
V. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 10-1224
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004 (Revised 05/24/23): Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Supersedes APL 17-011 and PL 99-003 and 99-004)
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL)24-015: California Children's Services Whole Child Model Program (Supersedes APL23-004)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/29/2018	Department of Health Care Services (DHCS)	Approved as Submitted
12/18/2018	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted
03/07/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
02/21/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
10/04/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2019	GG.1330	Case Management - California Children's Services Program/Whole-Child Model	Medi-Cal
Revised	07/01/2021	GG.1330	Case Management - California Children's Services Program/Whole-Child Model	Medi-Cal
Revised	04/01/2023	GG.1330	Case Management - California Children's Services Program/Whole-Child Model	Medi-Cal
Revised	10/01/2023	GG.1330	Case Management - California Children's Services Program/Whole-Child Model	Medi-Cal
Revised	04/01/2024	GG.1330	Case Management - California Children's Services Program/Whole-Child Model	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2025	GG.1330	Case Management - California Children's Services Program/Whole-Child Model	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)-Eligible Conditions	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children with Special Health Care Needs	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Complex Care/Case Management (CCM)	An approach to care management that meets differing needs of high-and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Enhanced Care Management (ECM) Lead Care Manager (LCM)	The Lead Care Manager (LCM) is a Member's designated care manager for ECM, who works for the ECM Provider organization and in the case of CalOptima Health Direct (COD) serving as the ECM Provider, the LCM could be on staff with CalOptima Health. The LCM operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers or participates in other care management programs, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

Term	Definition
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended commencing with Section 1340 of the California Health and Safety Code.
Health Needs Assessment (HNA)	The HNA is CalOptima Health's standardized, DHCS approved risk assessment tool that collects comprehensive information about the Member's health, behavioral health, social, family, treatment, and cultural and linguistic needs.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members
High-Risk Infant Program	Program to identify infants who might develop CCS Program-Eligible Conditions after discharge from a CCS Program-approved Neonatal Intensive Care Unit (NICU).
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Inter-County Transfer (ICT)	Inter-County Transfer is the process of formally transferring the administration of a CCS beneficiary's benefits between counties within the State of California.
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Medical Therapy Program (MTP)	Medically Necessary outpatient physical therapy and/or occupational therapy and may include physician consultation with the Medical Therapy Conference (MTC) for children with specific eligible medical conditions

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Memorandum of Understanding (MOU)	A formal written agreement between CalOptima Health and local government agencies, county programs, and third-party entities.
Non-Specialty Mental Health Services (NSMHS)	All of the following services that CalOptima Health must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice: 1. Mental health evaluation and treatment, including individual, group and family psychotherapy; 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; 3. Outpatient services for the purposes of monitoring drug therapy; 4. Psychiatric consultation; and 5. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.
Other Health Coverage (OHC)	Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.