



Children and Adults Health Programs Group

JAN 16 2013

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 99589-7413

Dear Mr. Douglas:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) reviewed and approved, effective the date of this letter, the California Department of Health Care Services' (DHCS) protocol for the "California Children's Services – Demonstration Project" under the state's section 1115 demonstration, entitled "Bridge to Reform Demonstration (No. 11-W-00193/9)."

If you have any questions regarding the terms of this approval, please contact your project officer, Mr. Robert Nelb. He can be reached by phone at (410) 786-1055, or by email at Robert.Nelb@cms.hhs.gov

Sincerely,

A handwritten signature in black ink, which appears to read "Angela D. Garner". The signature is written in a cursive style with a long horizontal stroke at the end.

Angela D. Garner, Acting Director
Division of State Demonstrations and Waivers

Attachment

cc: Gloria Nagel, ARA, CMS San Francisco Regional Office
Rob Nelb, CAHPG

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CCS Demonstration Projects

The California Department of Health Care Services (DHCS), as part of the 1115 Bridge to Reform Waiver, intends to develop and implement the California Children's Services (CCS) Demonstration Project (DP) which will utilize alternative health care delivery models for children with special health care needs. The identified models of health care delivery for the CCS population under the CCS DP will be described in greater detail in the pages that follow; however, the intended goal of the demonstration, in part, is to improve timely access to care, improve coordination of care, promote the use of community-based services, improve patient and provider satisfaction with care, and overall improve health outcomes and greater cost-effectiveness.

Background

The information below provides a description of the CCS Program, which is currently structured under a Fee-For-Service (FFS) health care delivery model.

The CCS Program, California's designated federal Title V Children with Special Health Care Needs program, provides or makes available health care services to children and youth who meet CCS eligibility requirements and who are under twenty-one (21) years of age. Children and youth who are enrolled in the CCS Program receive medical services for treatment of their CCS eligible medical condition. Seventy-five (75) percent of all eligible CCS children (currently 180,000 are enrolled) are also Medi-Cal eligible beneficiaries. The expenditures for this population's medical services totaled \$1.8 billion during fiscal year (FY) 2009-10.

The CCS population is comprised of children with complex, chronic and often disabling medical conditions. Over the course of the last eighty-five (85) years, the program has created and maintained quality standards for pediatric specialty care and standards for approval of individual providers and facilities for participation in the program. Since the 1960s the CCS Program provider network has evolved to create a regionalized provider network of Specialty Care Centers (SCC), multi-specialty, multi-disciplinary teams providing care to children with a defined set of medical conditions. These centers, located at tertiary medical centers, provide staffing and services according to program standards.

Eligibility

A child may qualify for the CCS Program if he/she is less than twenty-one (21) years of age, has a health condition that is covered by CCS, is a resident of the county in which application is made, and meets one of the following criteria:

- Family income of \$40,000 or less;
- Out-of-pocket medical expenses expected to be more than twenty (20) percent of family's adjusted gross income;
- A need for an evaluation to find out if there is a health problem covered by CCS;
- Was adopted with a known health problem that is covered by CCS;
- A need for the Medical Therapy Program (MTP);
- Medi-Cal eligible (full scope); or
- Healthy Families (HF) subscriber.

Currently, sixty (60) percent of the CCS-enrolled children and youth who are Medi-Cal beneficiaries are enrolled in a Medi-Cal managed care plan. For the majority of these individuals, the treatment of CCS eligible medical conditions is carved-out of the health plan's contractual obligation. Exceptions to the managed care carve-out are the three (3) County Organized Health Systems (COHS) operating in eight (8) counties, five (5) of which are at risk for the cost of treatment for CCS eligible conditions. In these latter five (5) counties, the county CCS Program continues to perform

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eligibility determination and service authorization. The remaining forty (40) percent of Medi-Cal children and youth enrolled in the CCS Program receive all of their care through the FFS system.

The CCS Program provides diagnostic and treatment services, medical case management, and physical and occupational therapy (OT and PT) services to children under age twenty-one (21) with CCS eligible medical conditions. CCS also provides medical therapy services that are delivered at public schools.

CCS eligibility includes most health conditions that are physically disabling such as congenital heart disease; malignancies; hemophilia, sickle cell anemia; thyroid problems, diabetes; chronic kidney problems; liver or intestine diseases; cleft lip/palate, spina bifida; hearing loss, cataracts; cerebral palsy, uncontrolled seizures; rheumatoid arthritis, muscular dystrophy; acquired immunodeficiency syndrome (AIDS); severe head, brain, or spinal cord injuries, severe burns; problems caused by premature birth; and severely crooked teeth.

Demonstration Program Requirements

The State of California is piloting four (4) models of care for children enrolled in the CCS Program. By testing multiple models of care, California believes it will be able to create health care delivery systems that respond to the unique needs of regions and populations throughout the State. The pilots will also help inform best practices, through a comprehensive evaluation component, so that at the end of the demonstration period decisions can be made on permanent restructuring of the CCS Program design and delivery systems.

Encounter data, hearings, and appeals requirements will be in compliance with Title 42 Code of Federal Regulations (CFR) Section 438.

The four health care delivery models include:

- Enhanced Primary Care Case Management (EPCCM) Program
- Provider-based Accountable Care Organization (ACO)
- Specialty Health Care Plan (SHCP)
- Medi-Cal Managed Care Plan (existing)

The models in this demonstration are designed to preserve the strengths of the current CCS Program such as the standards for participating providers and access to the regionalized system of qualified sub-specialists and tertiary care providers who treat children and youth with conditions that require specialized care. These approaches incorporate the core concepts of organized delivery systems into the care received by children and youth under twenty-one (21) years of age with special health care needs (i.e., CCS eligible children and youth). Responsibilities and incentives for specialty and non-specialty care will be better integrated and aligned to promote clearer accountability, better care coordination, more effective and efficient use of public dollars, and improved health care outcomes. Family-centered care coordination will be provided in a way that streamlines the care delivery process and provides more flexibility to ensure that the most appropriate care is provided at the right time, in the right place and by the right provider.

General Principles (identified and incorporated in specific detail in each contract):

Whole Child

Each contractor, regardless of financial responsibility for specific services, will be responsible for managing and coordinating the health care of the "whole" child or youth. The contractor will be required to provide the full range of preventive health care services, including periodic health assessments and immunizations, as well as primary health care services that are not related to the care of the CCS eligible medical condition.

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Family-Centered Care

Each contractor will ensure the delivery of family-centered care that is based on recognition of the family as the foundation for the provision of comprehensive services to the child. Family-centered care is an approach which integrates the child's family into all aspects of health care planning to ensure that the organization and delivery of health care services meet the child's physical, mental, emotional, social and developmental needs including:

- Respect and dignity: Health Care Practitioners listen to and honor patient and family perspectives and choices.
- Information Sharing: Health Care Practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information to effectively participate in care and decision-making.
- Participation: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
- Collaboration: Health Care Professionals collaborate with patients and families at all levels of health care, including: care of an individual child; program development, implementation and evaluation; and policy formation.

Medical Home

In each contract, the medical home will incorporate the following principles:

- Each child or youth will have a personal physician;
- The medical home is a physician directed medical practice;
- The medical home utilizes a whole child orientation;
- Care is coordinated and/or integrated across all elements of the health care system, the family and child or youth's community;
- Quality and Safety Practices and Measures emphasize:
 - The medical home actively advocates for children and youth and their families;
 - Use of evidence-based medicine and clinical decision-support tools to guide decision making;
 - Physicians in the practice accept accountability for continuous quality improvement;
 - Families and children and youth actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;
 - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;
 - Patients and families participate in quality improvement activities at the practice level;
- The medical home provides enhanced access to care including access to after-hours care; and
- Payment is structured appropriately to recognize the added value provided to children and youth and their families.

Culturally and Linguistically Appropriate Care

Each contractor and its network of providers will acknowledge and respect the diverse cultural traditions and languages that families bring to health care settings. There will be linguistically and culturally appropriate information and resources available to families.

Access to Appropriate Care

Each contractor will ensure that there is timely access to the most appropriate care by the most appropriate health care provider. In order to support the multiple and complex needs of children and youth with CCS eligible medical conditions and their families, health care services will be delivered in a coordinated manner to assure that care

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provided by different sources, regardless of responsibility for reimbursement, is integrated and understood by all involved and that there is no duplication of services.

Access Requirements

Each contractor will ensure that enrollees have access to:

- *Appointments* – Ensure Enrollees obtain appointments for various types of care, health assessments, and follow-up on missed appointments.
- *First Prenatal Visit* – Ensure the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
- *Waiting Times* – Monitor waiting times, telephone calls, and time to obtain various types of appointments.
- *Telephone Procedures* – Triage Enrollees' telephone calls, providing telephone medical advice and accessing telephone interpreters.
- *After Hours Calls* – Ensure that a physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.
- *Specialty Services* – Provision of specialty services from specialists outside the network if unavailable within the Contractor's network.
- *Access Standards* – Submit policies and procedures (P&Ps) describing the provision of accessibility standards, as follows:
 - Appropriate Clinical Timeframes, as per the requirements stated in Title 28 California Code of Regulations (CCR) Section 1300.67.2.2.
 - Standards for Timely Appointments, as per the requirements stated in 28 CCR 1300.67.2.
- *Telephone Access and Response Time* – Submit P&Ps that ensures toll-free telephone access and timely response to requests for medical advice, services information and Enrollees concerns.
- *Geographic/Physical Access* – Submit P&Ps that ensures the network of providers meet the requirements for travel time and physical accessibility.
- *Geo Access Report* - Submit (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in the contract.
- *Site Review* – Submit P&Ps for performance of Personal Physician Provider site reviews, as per the requirements stated in 22 CCR 53913, Welfare and Institutions (W&I) Code, Section 14182(b)(9).
- *Linguistic and Cultural Access* – Submit P&Ps that ensure communication and/or cultural barriers will ensure access of enrolled children and youth and their families when obtaining services from the health care system.

Eligibility

Each of the DPs model has different eligibility requirements.

- **Enhanced Primary Care Case Management (EPCCM) (Alameda County)**
CCS clients eligible for the EPCCM are those whose CCS eligible medical conditions are anticipated to last at least twelve (12) months. These clients will be required to participate and enroll in the DP if they reside in the designated EPCCM pilot service area.
- **Accountable Care Organization (ACO) (Orange County and San Diego County)**
The target population for the ACO model will include a subset of the CCS population with a chronic eligible medical condition, anticipated to last twelve (12) months or more, and whose needs are best met by hospital-based outpatient SCCs. For example, this population could include children or youth who have been identified as having one of the following specified conditions:
 1. Malignancies (such as leukemia, brain tumors, lymphomas);
 2. Sickle cell disease;

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3. Cystic fibrosis;
4. Cardiac conditions, including disorders of the myocardium and heart valves and congenital heart disease; or
5. Spina bifida.

Children and youth residing in the designated geographic service area, who have been receiving care through the health care organization that will be contracting with the State, who have a CCS medical condition eligible for the ACO and who meet all of the CCS Program eligibility requirements will be required to enroll into the ACO.

Children and youth who develop a CCS medical condition eligible for the ACO and who meet all of the CCS Program eligibility requirements and are referred to the health care organization for care will also be enrolled into the ACO.

The medical conditions for Orange County, as of August 28, 2012 follow:

1. Cardiac (Circulatory and Congenital Heart)
2. Craniofacial (Cleft Lip and Palate)
3. Gastroenterology
4. Hematology/Oncology (Malignancies)
5. Hemophilia
6. Metabolic
7. Rheumatology
8. Spina Bifida

The medical conditions for San Diego County, as of August 28, 2012 follow:

1. Cystic Fibrosis
2. Hemophilia
3. Sickle Cell

- **Specialty Health Care Plan (SHCP) (Los Angeles County)**

CCS clients eligible for the SHCP will be those children and youth whose CCS eligible medical conditions are anticipated to last at least twelve (12) months. Infants who are born with or develop, while in a CCS-approved NICU, a CCS eligible medical condition that is anticipated to last more than twelve (12) months and meet CCS financial eligibility requirements will be enrolled in SHCP at the time eligibility is determined. CCS children and youth residing in the designated geographic service and meeting the medical eligibility criteria will be required to participate in the DP.

- **Medi-Cal Managed Care Plan (San Mateo County)**

All infants, children and youth with CCS eligible medical conditions residing in the designated geographic service area, regardless of source of funding for their services and how long the conditions are expected to last, will be enrolled into the Medi-Cal Managed Care Plan. This population will include all infants eligible for NICU care through the CCS Program. Children and youth with a CCS eligible medical condition that is anticipated to last less than twelve (12) months and who are either HF subscribers or are designated CCS-only will remain enrolled in the DP for a period of one year.

Enrollment

Enrollment in the CCS demonstration models is mandatory for CCS clients meeting medical eligibility criteria for the model, who reside in the defined service area and who:

- Do not have other health care coverage as defined in 22 CCR 53845(e); or

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- Are not in foster care placement; or
- Are not enrolled in Medicare.

CCS clients in foster care placement may voluntarily enroll in a DP if they otherwise meet the eligibility requirements of the specific model.

Providers

The Contractor shall ensure that the treatment of the child or youth's medical care is performed by CCS-approved providers. The network of providers shall include:

- *Primary Care Physicians*
Primary care physicians (PCP) including CCS-approved pediatricians and family physicians and, for enrollees age fourteen (14) and older, CCS-approved internists.
- *Pediatric Medical Specialties and Subspecialties*
CCS-approved physicians in the following pediatric medical specialties and subspecialties: adolescent medicine, behavioral/developmental pediatrics, cardiology, critical care medicine, endocrinology, gastroenterology, hematology/oncology, infectious disease, neonatology, nephrology, neurology, neurodevelopmental pediatrics, physical medicine and rehabilitation, psychiatry, pulmonology and rheumatology.
- *Pediatric Surgical Specialties and Subspecialties*
CCS-approved physicians in the following pediatric surgical specialties and subspecialties; cardiac surgery, otolaryngology, pediatric surgery, and urology.
- *Other Physician Providers*
CCS-approved physicians specializing in allergy and immunology, dermatology, neurosurgery, obstetrics and gynecology, ophthalmology, oral and maxillofacial surgery, orthopedics, otolaryngology, plastic surgery, thoracic surgery, and urology.
- *Other Health Care Professionals*
Other health care professionals with experience in treating children with CCS eligible medical conditions and their families, including CCS-approved genetic counselors, marriage and family therapists, OTs, PTs, speech and language pathologists, audiologists, dietitians, registered nurses (RN), psychologists and medical social workers (MSW)/licensed clinical social workers (LCSW).
- *Hospital Facilities*
CCS-approved inpatient hospital facilities that are capable of providing a full range of medically necessary hospital care appropriate to an enrolled child's CCS eligible medical conditions. The facilities must include CCS-approved tertiary hospitals in the DP's geographic service area.
- *Inpatient Special Care Centers*
CCS-approved inpatient SCCs including NICUs, pediatric intensive care units and pediatric rehabilitation centers. The NICUs must include, at a minimum, CCS-approved Regional NICUs in the DP's geographic service area.
- *Outpatient Special Care Centers*
CCS-approved outpatient SCCs including:

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1. Amputee Centers,
 2. Bone Marrow Transplant Centers,
 3. Burn Centers,
 4. Cardiac Centers,
 5. Communication Disorder Centers (CDC), Type C,
 6. Craniofacial Centers,
 7. Cystic Fibrosis and Pulmonary Disease Centers,
 8. Gastrointestinal Centers,
 9. Heart and Lung Transplant Centers,
 10. Heart Transplant Centers,
 11. Hematology/Oncology Centers,
 12. Hemophilia Centers,
 13. HRIF Centers,
 14. Immunology/Infectious Disease Centers,
 15. Liver Transplant Centers,
 16. Metabolic (including Phenylketonuria (PKU)) and Endocrine Centers,
 17. Prosthetic/Orthotic Centers,
 18. Renal Dialysis and Transplant Centers,
 19. Rheumatology Disease Centers,
 20. Selective Posterior Rhizotomy Centers,
 21. Sickle Cell Disease Centers,
 22. Specified Inherited Neurological Diseases Centers, and
 23. Spina Bifida Centers.
- *Other Healthcare Providers*
 - Licensed by the State of California
Pharmacies, hearing aid dispensers, home health agencies (HHA), durable medical equipment (DME) vendors, clinical diagnostic laboratories, medical supply vendors, and medical imaging (radiology, ultrasound, magnetic resonance imaging) centers.
 - Prosthetists and Orthotists, certified by either the Board of Certification/Accreditation (in Orthotics and Prosthetics) or the American Board for Certification (in Orthotics, Prosthetics and Pedorthics).

Specialty Care

- The Contractor shall be in compliance with 22 CCR and Health and Safety (H&S) Code, Section 1374.16 for CCS-approved providers to ensure that all medically necessary specialty services are made available to enrolled children and youth in a timely manner.
- The Contractor shall ensure that enrolled children and youth are referred to the appropriate CCS-approved special care center for medical management and coordination of multispecialty, multidisciplinary coordinated care when the child or youth has a CCS eligible medical condition.
- A CCS eligible enrollee can only see a CCS paneled physician who has been certified by the American Board of Medical Specialties and the enrollee must have a CCS eligible medical condition. For more information on the CCS eligible medical conditions please go to: <http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx> or review DHCS CMS Information Notice 09-02 located at: <http://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/cmsin/cmsin0902.pdf> .

Access to Culturally Appropriate Care

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The Contractor shall provide a mechanism to ensure that health care services provided through the DP are designed and delivered in a manner which is sensitive and responsive to the varying cultural needs of the enrolled children and youth and their families. State will review P&Ps to ensure the plans are striving to deliver care in culturally competent manner.

This mechanism shall, at a minimum, address:

- Staffing that reflects the racial and ethnic makeup of the population served, and is familiar with the cultural backgrounds of enrolled children and youth.
- Written policies stating the importance of culturally competent care and acknowledging differing cultural definitions of "family" and respecting differing views of medical care.
- Provision for asking each family who should attend conferences, what kind of translation services are needed, what are the families' concerns and what added assistance is needed to gain access to care.
- Provision for working with families and providers when the child or youth's and/or family's view of the illness and treatment differs substantially from the physician's.
- Protocols for defining and removing practices which are found to be barriers to care for enrolled children and youth.

Provider Reimbursement

- The contractor shall compensate all network providers as the contractor. Contractor and provider negotiate and agree on compensation for services rendered.
- The contractor shall maintain procedures for prepayment and post payment claims review, including review of data specific to the provider, enrollee and covered services for which payment is claimed.
- The contractor shall maintain sufficient claims processing/tracking/payment systems capability to comply with applicable State and Federal laws, regulations and contractual requirements, determine the status of received claims and calculate the estimate for incurred and unreported claims.
- The contractor shall reimburse for emergency services received by an enrollee from non-contracting providers for treatment of an emergency medical condition until the enrollee's condition has stabilized sufficiently to permit discharge and/or referral and transfer in accordance with instructions from the contractor.
- Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of W&I Code, Section 14454 (b) and 22 CCR 53875. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within thirty (30) days of the effective date of a decision that contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with W&I Code, Section 14454(c) and 22 CCR 53702.

Benefits

Services covered under all CCS demonstration models are based on the current range of Medi-Cal benefits available to individuals under twenty-one (21) years of age and each of the demonstration models will provide or arrange for all medically necessary covered services for children and youth enrolled in the DP. Covered services are those services set forth in 22 CCR, Chapter 3, Article 4, beginning with 51301 and 17 CCR Division 1, Chapter 4, Subchapter 13, beginning with 6840, (all of which fulfill the requirements of Section 1905(r) Title XIX of the Social Security Act) unless otherwise specifically excluded under the terms of the specific contract.

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These services will include all medically necessary primary and preventive health care services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to the care coordination and case management that are necessary for the appropriate treatment of the CCS eligible condition. These services include:

- Physician services
 - Preventive services, including periodic health assessments, immunizations and blood lead screens;
 - Primary care and specialist services; and
 - Laboratory and radiology services
- Inpatient/outpatient hospital services
- SCC services
- Emergency services
- Home and Community Based Services (HCBS), including HHA services, shift nursing services, hospice, DME, medical supplies, incontinence supplies, prosthetics and orthotics
- Medical transportation
- Maintenance and transportation to access authorized care
- HRIF services
- Pharmacy services
- Minor consent and sensitive services
- Family planning services
- Early and Periodic Screening, Diagnosis and Treatment Services and Supplemental Services
- Organ transplant services, evaluation and coordination of care for major organ transplants; payment of care for renal and corneal transplants
- Dialysis
- Therapies, such as speech and language and PT and OT
- Augmentative and alternative communication devices
- Audiology, including hearing aids and cochlear implants
- Medical nutrition therapy
- Vision care, including lenses
- Mental Health
- Comprehensive perinatal services
- Investigational services
- Out-of-state services

Access to Care

Appointment Availability/Waiting Time

Each contractor must adhere to the following time frames in implementing the system of care.

- All non-symptomatic office visits, e.g., routine wellness/preventive care appointments, periodic visits for medication or management review, shall be available to the child/family within ten (10) days of the request.
- Symptomatic office visits which are non-emergent in nature shall be available within twenty-four (24) hours of request. Such visits might include care for symptoms or diagnoses which may or may not be related to the treatment of the CCS eligible medical condition, such as an upper respiratory infection in a child with moderately severe asthma, ear pain in a child with cleft lip and palate.
- Urgent Care appointments for conditions such as recurring high fever, moderate to severe nonspecific pain, hematuria or dyspnea, shall be available on a same day basis.

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- Emergency services shall be available seven days a week, twenty-four (24) hours per day within thirty (30) minutes travel time from the child's home. Emergency services shall not be subject to prior authorization by the DP.

Emergency and After Hours Care

Each Contractor will maintain a system able to provide:

- Twenty-four (24) hour, seven (7) day per week, telephone access for families of children in the DP to personnel qualified to provide advice and triage access to emergency services; recorded messages are unacceptable for these purposes.
- Twenty-four (24) hour, seven (7) day per week, telephone access by providers to obtain service authorization for medically necessary, non-emergency care; recorded messages are unacceptable for these purposes.
- The contractor will maintain (directly or through sub-contract and/or referral) access to inpatient hospital services, service sites and qualified personnel to ensure provision of all medical care necessary under emergency circumstances.
- An appropriately qualified health care professional working under the supervision of the DP's Medical Director shall be available twenty-four (24) hours a day and responsible for the timely authorization of medically necessary emergency care. The health care professional, working with the Medical Director, shall coordinate the transfer of stabilized children from emergency departments (including those in the provider network and non-contractor emergency departments) and admission to the appropriate facility for in-patient care, as necessary.

Medical Home

- Each contractor will implement a medical home model and will ensure care coordination at two levels – one by the child or youth's designated personal physician and the second by the contractor's CCs.
- Each child or youth in the DP will be assigned to a personal physician, who with the supports provided by the contractor, will function as the child's medical home. Physicians that may serve as a child or youth's personal physician, include CCS-approved general pediatricians, family physicians, internists for enrollees over fourteen (14) years of age, specialty physicians, or qualified sub-specialty physicians appropriate to the child's condition.
- The medical home will be responsible, working with the contractor's CCs and the family, for the development of an individual plan of care that will serve as the basis for ensuring enhanced access to timely and appropriate services across the entire continuum of care and providing family-centered care coordination services. Utilization management and care coordination will be performed by the medical home, utilizing the services and guidelines established by the contractor.
- It will be the responsibility of the medical home to stay apprised of all condition-related services and assure appropriate coordination of those services. The medical home will be responsible for assuring that the child or youth receives needed services timely and in an appropriate setting.
- If a child or youth or parent/legal guardian does not select a personal physician, the contractor will assign a personal physician based on past history, the provider's experience with the child or youth's specific disease, disability and/or special needs, and the location of the child or youth's home and the provider's office.
- Each contractor will provide support to the medical home by providing care coordination services; chronic care management and disease management services that support the personal physician and the child or youth and family (See activities below).

Care Coordination

Director of Care Coordination

The Contractor shall have a full time Director of Care Coordination, who meets the following qualifications:

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- Current licensure as an RN in California,
- Bachelor of Science in Nursing and a Master's Degree in Nursing or health related field,
- Minimum of three (3) years of management experience, and
- Relevant experience with children and youth with special health care needs, as well as experience with care coordination, utilization review, insurance authorization, regulatory compliance, and quality monitoring.

The responsibilities of the Director of Care Coordination shall include:

- Supervision of the CCs,
- Development and implementation of the policies and procedures for the CCs,
- Participation in utilization review activities, and
- Serving as a quality improvement team member.

Social Worker

The Contractor will employ or contract with a social worker to provide consultation to the DP's provider network and the CCs. The social worker shall:

- Possess a Master's Degree in Social Work,
- Be a LCSW, and
- Have at least two (2) years of experience providing social work services to children and youth with special health care needs.

Nutritionist

The DP will employ or contract with a nutritionist to provide consultation to the DP's provider network and to the CCs. The Nutritionist shall:

- Possess a Master's Degree in Nutrition, Dietetics, Institutional Management, Public Health Nutrition or other nutrition field,
- Possess a valid Certificate of Registration with the Commission of Dietetic Registration of the American Dietetic Association, and
- Have at least two (2) years of full-time or equivalent clinical nutrition experience providing nutrition assessment and counseling for children and youth with special health care needs.

Care Coordinators

The contractor shall employ or contract with either licensed RNs or MSWs to perform the functions of care coordination.

Each contractor will be required to provide specialized care coordination for each member.

- The contractor will employ and/or subcontract with CCs to work in partnership with the personal physician and other agencies to ensure the member's care is coordinated and well managed.
- The CCs shall have experience working with children and youth with special health care needs.
- Care coordination for children or youth with special health care needs shall include both face-to-face and telephone contacts.
- The contractor will utilize the initial needs assessment of the enrolled child or youth and their family's needs to determine the level and frequency of the care coordination required.

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- An initial needs assessment by the care coordinator will be initiated within thirty (30) days of enrollment in the DP and will help inform the choice of an appropriate medical home for the child and ensure continuity of care and services and a smooth transition from FFS to the DP.
- Initial and subsequent assessments shall be performed using a standardized tool provided by the DHCS. This tool shall be developed with input from participating plans and stakeholders.
- Subsequent assessments shall be performed at a frequency determined by the ranking on the initial assessment, and, at a minimum, every six (6) months.
- The CC will be responsible for the following key functions:
 - Assessment of a child or youth's medical, behavioral, psychosocial and functional needs.
 - Assessment of the family's functional needs;
 - Development and implementation of an individualized family-centered care plan in collaboration with the family and medical home provider;
 - Development of an individualized family support plan;
 - Facilitation of meetings and/or team conferences with family, child or youth and relevant and appropriate providers of services;
 - On-going monitoring and evaluation of the care plan, including re-assessments upon a change in condition or status;
 - Coordination of care among systems and providers;
 - Member education and advocacy, including research of and linkage to resources, services and support for the family;
 - Referral into disease and chronic care management programs, ongoing monitoring of the child or youth's status in these programs and coordination and linkage with or to other appropriate providers or resources
 - Making referrals and ensuring authorization of services;
 - Transition planning;
 - Coordination with the evaluation contractor to obtain youth and family feedback regarding their experiences of health care; and
 - The contractor shall inform members that EPSDT services are available for members under twenty-one (21) years of age.
- The contractor shall ensure, on an ongoing basis and that after initial implementation, children and youth newly enrolled in the DP shall receive an initial health assessment (IHA) by the designated personal physician within sixty (60) days of enrollment, if the enrollee was not previously receiving primary and preventive care services from the personal physician. The IHA shall include performance of the Child Health and Disability Prevention (CHDP) program's age appropriate assessment, including the provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate health education behavioral assessment.
- In the ACO model, the CC(s) shall be integral members of the SCC team.
- While the contractor may not be financially responsible for a range of special services, such as those provided through Regional Centers, HCBS waiver services, behavioral health, medical therapy through the MTP, residential and institutional care services and dental services, the contractor will be responsible for ensuring coordination of all the care the enrolled child or youth receives.
- Out of Plan Case Management and Coordination of Care
 - The contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective join case management for services.
 - P&Ps for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.
 - The contractor shall implement and maintain P&Ps to ensure the member's right to confidentiality of medical information.

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Special Education and County Mental Health

Special Education and County Mental Health to adequately address the complexity of needs of the child or youth and may involve advocacy on behalf of the child or youth and family to obtain the full range of services and support necessary to maximize the child or youth's long range health outcomes. DHCS will ensure that each of the DPs will execute Memorandum of Understanding (MOUs) with each plan for Special Education and County Mental Health services.

Budget/Allotment Neutrality Projections

The DPs will meet the budget neutrality requirements of the Special Terms and Conditions (STCs) for California's Bridge to Reform Demonstration, 11-W-00193/9 and be in conformance with 2011 California Governor's Budget and provisions of AB 97, (Chapter 3, Statutes 2011) the 2011 Omnibus Health Budget Act Trailer Bill.

Fiscal accounting processes and budgetary controls will be employed to ensure the responsible use and management of contract funds, and will include, at a minimum, a brief description of the organization's fiscal reporting and monitoring capabilities to ensure that contract funds are managed responsibly for the following:

- Budget Neutrality Effective Date - All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning November 1, 2010. (STC Page 46, Paragraph 106)
- Limit on Title XIX Funding – California is subject to a limit on the amount of Federal title XIX funding that California may receive on “selected” Medicaid expenditures during the period of approval of the CCS DP. Selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month (PMPM) limits under this CCS DP. Spending under the budget neutrality limit is authorized for managed care population expenditures for CCS expenditures. (STC Page 46, Paragraph 107)
- Risk – California will be at risk for the per capita cost for CCS DP enrollees under this budget neutrality agreement, but not for the number of CCS DP enrollees in each CCS model. (STC Page 47, Paragraph 108)
- Budget Neutrality Annual Expenditure Limit – For each Demonstration Year (DY) two annual limits will be calculated. (STC Page 47, Paragraph 109)
- Composite Federal Share Ratio – The CCS DPs will follow the rules for composite federal share ratio. (STC Page 48, Paragraph 110)
- Enforcement of Budget Neutrality – Budget neutrality will be enforced by CMS in this agreement over the life of the CCS DP models as adjusted November 1, 2010, rather than on an annual basis. (STC Page 49, Paragraph 112)
- Exceeding Budget Neutrality – If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds will be returned to CMS using the methodology outlined in paragraph 110 “Composite Federal Share Ratio”. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date. (STC Page 45, Paragraph 114)

Quality Improvement

Each of the DPs will be required to participate in State-led collaborative Quality Improvement Projects (QIPs) during the course of the contract. It is the intent of the DHCS to meet with representatives from each of the DPs, including administrators, network physicians and families to jointly develop QIPs specific to the projects.

Quality Monitoring and Quality Improvement Measures

Quality monitoring and improvement activities undertaken by each of the contractors will focus on the primary goals of the program:

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- Improvement in care coordination.
- Improvement in access to services and community-based care.
- Timely provision of primary, preventive, and specialty care.
- Increased child/family satisfaction with care.
- Increased provider satisfaction with the system of care.
- Cost-effectiveness of the model.

Quality monitoring, evaluation and improvement across all of the demonstration models will include the following elements:

- Measures that will quantify improvements in the quality of care received by CCS children and youth that can be utilized to structure incentive payments tied to achievement of these desired outcomes.
- Measures that will evaluate the child or youth and family and/or legal guardian and provider satisfaction and experience with the model.
- Measures for select disease-specific measures.
- Claims and encounter data and independently generated data (such as data derived from surveys and record review) to comprehensively assess provider performance and to evaluate the effectiveness of the model.
- Measures related to access to comprehensive and timely care coordination and access to community-based care will be developed with provider and consumer input.
- Measures related to meaningful outcomes in daily life could be included such as
 - Self-reported (or family reported) health and/or functional status of child at beginning and end of pilot.
 - Self-reported (or family reported) school days missed at beginning and end of pilot.
- Quality benchmarks for primary and preventive care will focus on standard measures of timeliness of well child checks/adolescent well-care and immunization periodicity.
- Claims data analysis will be employed to generate the average PMPM cost for children enrolled in the model compared to those not enrolled, controlling for factors such as age and diagnosis. Cost analysis may be stratified by age groupings, diagnoses and other relevant criteria.
- Any additional measures that DHCS deems as necessary.

Encounter Data Requirements

- The Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of encounter level data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements. Encounter data shall include data elements specified in the contract.
- The Contractor shall require subcontractors and non-contracting providers to provide service level data to the Contractor, which allows the Contractor to meet its administrative functions and the requirements. The Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure service level data is complete and accurate prior to submission to DHCS.
- The Contractor shall submit encounter data to DHCS on a monthly basis in the form and manner as specified by DHCS.
- Upon written notice by DHCS that the encounter data is insufficient or inaccurate, the Contractor shall ensure that corrected data is resubmitted within fifteen (15) days of receipt of DHCS' notice. Upon the Contractor's written request, DHCS may provide a written extension for submission of corrected encounter data.
- The Contractor shall submit encounter data on periodic health assessments as specified by the most recent American Academy of Pediatrics (AAP) periodicity schedule and immunizations rendered as specified by the Advisory Committee on Immunization Practices (ACIP) to demonstration project enrollees. Data will be gathered

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using the CHDP Information-Only Confidential Screening/Billing Report (PM-160) or other reporting forms or formats as specified by DHCS.

Grievance and Appeal Requirements

DHCS will review Grievance and Appeal P&Ps to ensure compliance with the requirements of 42 CFR 438.

- Grievances: Submit P&Ps describing the member grievance and complaints system which includes written procedures for the submission, timely processing and resolution of all child or youth/family grievances and complaints.
- Grievance System Oversight: Submit P&Ps to monitor the member's grievance system and the expedited review of grievances.
- Grievance Log and Quarterly Grievance Report: Submit a template of the grievance log and the grievance report that will be submitted to DHCS on a quarterly basis.
- The Contractor shall submit the quarterly grievance reports for the following quarters: April – June, July – September, October – December, January – March. The reports are due thirty (30) calendar days from the date of the end of the reporting quarter.

Hearings Requirements

Fair Hearing

- The Contractor is responsible for ensuring written procedures are in place to inform the enrolled child's family of its right to a fair hearing conducted by the State in the event that a complaint/grievance is not resolved to their satisfaction. The Contractor shall inform each enrolled child's family in writing of their right within seven (7) days of the date of the enrollment in the DP and annually thereafter.
- Written notification shall be sent to the enrolled child's family within seven (7) calendar days of the decision by the Contractor if there is a denial, deferral or modification of a request for a health care service requiring prior authorization.

Expedited Hearing

- Within two (2) working days of being notified by DHCS that a Member has filed a request for fair hearing which meets the criteria for expedited resolution.
- The Contractor shall deliver directly to the designated/appropriate DHCS, Office of Administrative Hearings administrative law judge all information and documents which either support, or which the Contractor considered in connection with, the action which is the subject of the expedited CCS fair hearing.
- This includes, but is not limited to, copies of the relevant treatment authorization request and Notice of Action (NOA), plus any pertinent grievance resolution notice.
- If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DHCS along with copies of the original NOA and grievance resolution notice.
- One or more plan representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited fair hearing, shall be available by phone during the scheduled CCS fair hearing. During the fair hearing process, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the hearing is pending and the Contractor reverses a decision to deny, limit, or delay services.
- The member has the responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the member, the Managed Care Organization or Prepaid Inpatient Health Plan may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished based on 42 CFR 431.230(b).
- If the Contractor's action is sustained by the hearing decision, the Contractor may institute recovery procedures against the member to recoup the cost of any services furnished the member based on 42 CFR 431.230(b).

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Appeals and State Processes Requirements

- Member Appeal Process: Submit P&Ps describing the Member Appeals process. Include the Contractor's responsibilities in expedited Appeals and State Fair Hearings.
- Responsibilities in Expedited Appeals: Submit P&Ps to resolve expedited appeals.
- Denial, Deferral, or Modification of Prior Authorization Requests: Submit P&Ps describing the process for denial, deferral or modification of services for providers and Enrollees.
- Timeframes for NOA: Submit P&Ps describing the process of notifying beneficiaries and their authorized representatives in accordance with the timeframes set.
- Appeal and State Fair Hearing Process: Submit P&Ps describing the process of appeals and State Fair Hearings in regards to continued or reinstated benefits.

Quarterly Grievance and Appeals Data

Provide the following information, separately, for both the grievances and appeals:

- Total number received
 - By month
 - By provider number (National Provider Identification (NPI))
- Type of service(s)
 - By service code or national drug code (NDC) and
 - Description
- Total number filed
 - In writing
 - Verbally
- Total number
 - Approved
 - Denied
- Number of fair hearings filed based on final decision
- Average time it took for each quarter to resolve, separately, the grievances and appeals, which include providing written notification to the Member.
- Provide, at least, a breakdown of the following:
 - Zip codes
 - Ethnicity
 - Gender
 - Primary language
- Other data as requested by DHCS

Goals and Objectives

As previously indicated the goal of the DPs is to identify the model or models of health care delivery for children and youth enrolled in the CCS Program that result in improving timely access to care, improved coordination of care, promotion of increased use of community-based services, improved satisfaction with care and improved health outcomes. Each contractor will design and implement an enrollee satisfaction survey with input and review from DHCS; during the first year of operation which will serve as the "baseline," the survey will be administered again during the second and third year of operations.

Measurement of the following objectives will be accomplished in concert with the DPs, an Evaluation Contractor (University of California Los Angeles, Center for Health Policy Research) and DHCS staff. An Evaluation Advisory Committee has been convened to develop and recommend the metrics to be used by all of the DPs in the evaluation.

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- **Objective 1**
By September 2015, (at the end of the Demonstration Waiver) there will be a reduction in the annual rate of growth of expenditures for children and youth enrolled in a DP.

- **Objective 2**
By September 2015, there will be an increase in satisfaction with the delivery of health care services among children and youth enrolled in the CCS Program and their families. Measurement of the changes in satisfaction will be accomplished through surveys of the enrollees and their families

- **Objective 3**
By September 2015, there will be an increase in satisfaction with the delivery of health care services among providers serving children and youth enrolled in the CCS Program. Measurement of the changes in satisfaction will be accomplished through surveys of providers participating in the DPs' networks.

- **Objective 4**
By September 2015, there will be improved health outcomes among the children and youth enrolled in a DP.

Measures

A final determination has not yet been decided as of September 28, 2012. DHCS will use measures that include, but are not limited to:

- Grievances filed by CCS members
- Appeals filed by CCS members or providers
- Utilization reviews
- Service approvals, modifications, deferrals, denials
- Referral approvals, modifications, deferrals, denials
- Drug utilization review
- Prior authorizations for key services: home health assistance, durable medical equipment, surgery, or skilled nursing facility stays
- Disputed emergency services claims
- Sentinel events
- Completion of initial and subsequent needs assessments
- Completion of initial and subsequent health assessments
- Completion of care plans
- Completed transition plans
- Referrals and follow-ups