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Memorandum of Understanding combined training

Provider training, 2026

ProvEd_0626_05

Instructions for completing this training

Click the links below to review specific sections. Please review all the slides.

Memorandums of Understanding (MOUs) included in this training

- Child Welfare/ Child and Family Well Being
- In Home Supportive Services (IHSS)
- Medi-Cal Behavioral Health
  - Substance Use Disorder treatment services
  - Specialty Mental Health services
- Local Health Department Services
  - Blood Lead Screening & Case Management
- Non-Contracted Local Health Department Services
  - Immunization services
  - Sexually Transmitted Infections services
- Tuberculosis Screening, Diagnosis, Treatment & Care Coordination
- Maternal Child & Adolescent Health Services
  - Doula services
- California Children's Services
- Targeted Case Management (TCM)

Objectives

1. Identify the main components of Local Health Department Programs
2. Describe the features and benefits of each program
3. Describe the age, residential, medical, and financial eligibility criteria for each program
4. Be able to preview services, eligibility, and intake procedures with patient families

Memorandum of Understanding

What is an MOU?

Memorandums of Understandings (MOUs) are legally binding and enforceable agreements between Medi-Cal Managed Care Plans (MCPs) and Third-Party entities such as Mental Health Plans (MHPs), Drug-Medi-Cal (DMC) State Plan counties, or Drug- Medi-Cal Organized Delivery System (DMCODS) counties. These agreements outline each party's respective responsibilities and obligations in coordinating medically necessary Covered Services and carved out services for members served by multiple parties.

What are the goals of an MOU?

The MOUs are intended to:

- Clarify roles and responsibilities of each party
- Enhance local engagement
- Improve care coordination among parties
- Develop and document processes and procedures to provide whole-person care to Members

MOU Section Overview: Sections 1-6

Section	Purpose
1. Definitions	Clarifies key terms, including MCP Responsible Person, Liaison, and other agency/county roles.
2. Term	Specifies the effective term of the MOU (agreed upon by the MCP and third parties).
3. Services Covered	Describes the services that the MCP and other party must coordinate for members.
4. Party Obligations	Outlines each party's provision of services and oversight responsibilities.
6. Training & Education	MCP requirements to provide education to members and Network Providers about covered services and other party's services. Also requires MCP to train employees who carry out responsibilities under the MOU.

MOU Section Overview: Sections 7-10

Section	Purpose
7. Referrals	Requires the parties to refer to each other as appropriate and describes each party's referral pathways.
8. Care Coordination & Collaboration	Describes the policies and procedures for coordinating care between the parties, addressing barriers to care coordination, and ensuring ongoing monitoring and improvement of care coordination.
9. Quarterly Meetings	Requires the parties to meet at least quarterly to address care coordination, Quality Improvement (QI) activities, QI outcomes, and systemic and case-specific concerns, and to communicate with others within their organization about such activities.
10. Quality Improvement	Describes County/Agency responsibilities, authorization, oversight, compliance, and other provisions.

MOU Section Overview: Sections 11-12

Section	Purpose
1. Data Sharing 	Requires the MCP to have policies and procedures for sharing the minimum data and information necessary to ensure the MOU requirements are met and describes the data and information the other party may share with MCP to improve care coordination and referral processes.
2. Dispute Resolution 	Describes the policies and procedures for resolving disputes between the parties and the process for bringing the disputes to DHCS when the parties are unable to resolve disputes.

Child Welfare/ Child Family Well Being (CFWB)

Ensuring Blue Shield Promise Medi-Cal enrolled (or eligible) members involved with CFWB services and/or receive foster care services receive coordinated, integrated services across the MCP and county systems.

Child Welfare (CW)/ Child and Family Well-Being (CFWB) MOU definitions

- County CFWB Services are services provided by the state's program for child protection services and interventions, including foster care, that are administered by the county and monitored by the California Department of Social Services ("CDSS"), Children and Family Services Division.
- County Responsible Person:
  - Designated by the county to oversee coordination and communication with MCP
  - Designated to monitor county's compliance with the MOU and P&Ps
- County Liaison:
  - Acts as the liaison between county and MCP
  - Facilitates communication and care coordination between the Parties
  - Facilitates quarterly meetings and provides updates to the County Responsible Person as appropriate
- MCP Responsible Person:
  - Designated by MCP to oversee MCP coordination and communication with county and ensure MCP's compliance with MOU
  - Ensures sufficient staffing to support compliance with and management of MOU
  - Ensures training and education regarding MOU is conducted annually

Child Welfare (CW)/ Child and Family Well-Being (CFWB) MOU definitions

- MCP-County Liaison:
  - Is MCP's point of contact responsible for acting as the liaison between MCP and county.
  - Ensures appropriate communication and care coordination are ongoing between the Parties.
  - Facilitates quarterly meetings.
  - Provides updates to the MCP Responsible Person and/or MCP's compliance officer as appropriate.

- Health Care Program for Children in Foster Care (HCPCFC):
  - Public health nursing program administered by the county
  - Provides public health nurse ("PHN") expertise to assist in meeting health care needs of children and youth in foster care
  - Consults with and educates the foster care team to enhance the physical, mental, dental, and developmental well-being of children and youth in foster care
  - Questions and requests for information may be directed to HCPCFC@dhcs.ca.gov
  - HCPCFC San Diego: (619) 692-8808 HCPCFC@sdcounty.ca.gov
  - HCPCFC Los Angeles: (626) 569-6020 hcpcfc@ph.lacounty.gov

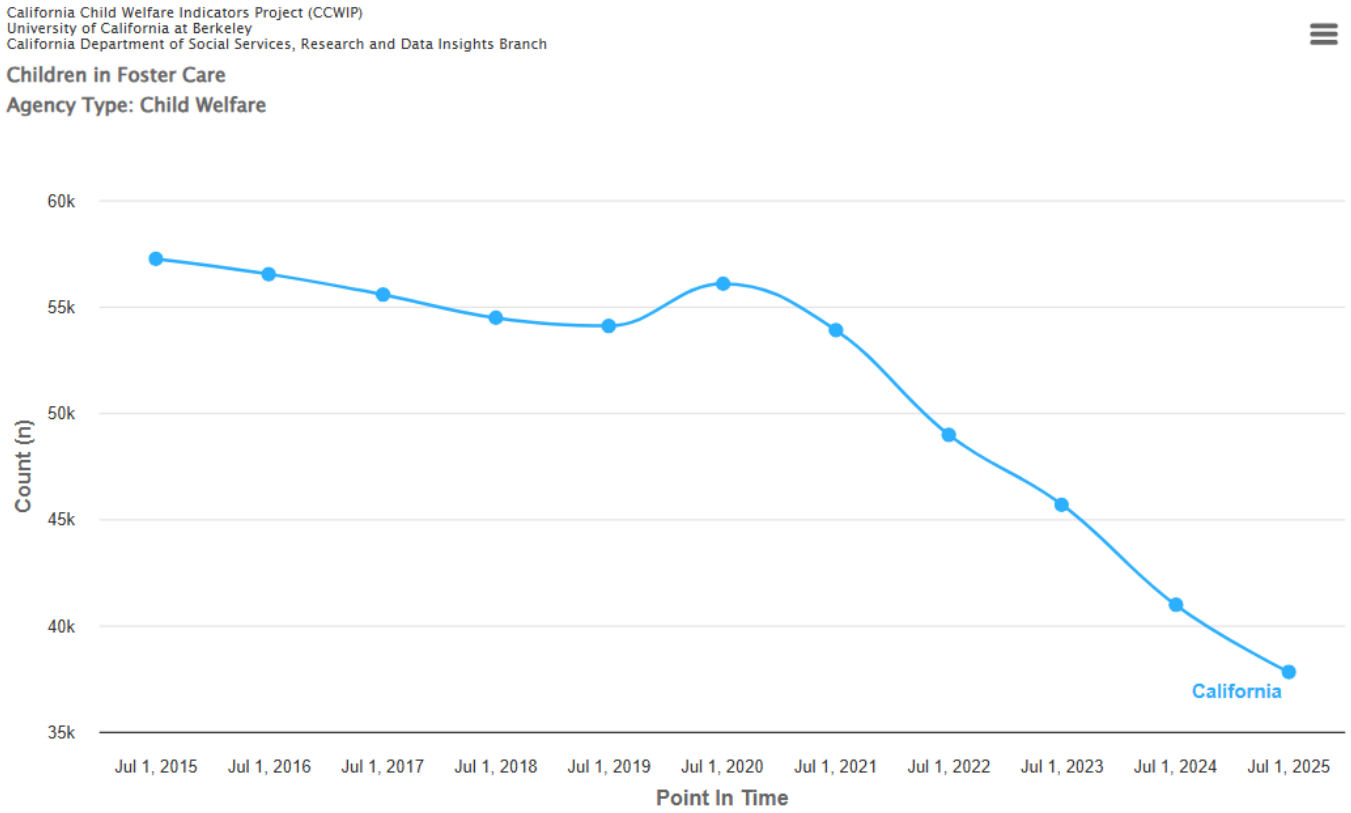
Child and Family Well-Being (CFWB) MOU definitions, continued

- MCP-LTSS (Long Term Services and Supports) Liaison:
  - Helps support care coordination and transitions from institutional settings
- MCP-Tribal Liaison:
  - Works with contracted and non-contracted Indian Health Care Provider ("IHCP") in service area
  - Coordinates referrals and payment for services provided to American Indian MCP members who are qualified to receive services from an IHCP
- MCP Regional Center Liaison:
  - Designated by the MCP to be the liaison between the MCP and the respective Regional Centers of each county
- MCP Child Welfare Liaison (CWL): See next page for more information

Child Welfare Cases declining over past 10 years

Point in Time/In Care

- These reports include all children who have an open child welfare episode in the CWS/CMS system.
- California and multiple counties, including San Diego and Los Angeles show significantly fewer children with open child welfare cases over the past 10 years.



County	Point In Time: Child Welfare involved children/ youth										
	1/1/15	7/1/16	7/1/17	7/1/18	7/1/19	7/1/20	7/1/21	7/1/22	7/1/23	7/1/24	7/1/25
Los Angeles	20,007	19,981	20,108	20,117	20,247	21,637	20,687	18,049	16,308	13,728	11,745
San Diego	3,079	2,830	2,468	2,138	2,055	2,279	2,138	2,045	1,748	1,509	1,396

MCP Child Welfare Liaison (CWL)

The CWL:

- Serves as point of escalation for issue resolution (e.g., difficulty accessing services, obtaining referrals, difficulty reaching a social worker, changing providers, or facing operational obstacles to receiving health care services)
- Is not case carrying and should not be first point of contact for social workers
- Supports Trauma Informed Care
- Facilitates quarterly meetings with county child welfare agencies
- Participates in quality improvement activities
- Provides technical assistance to MCP, Providers and county staff
- Facilitates addressing the needs of children and youth involved with child welfare
- Assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure members' health care needs are met

Who may request assistance from Blue Shield Promise Child Welfare Liaison (CWL):

- ECM Lead Care Managers, Community Supports, county liaisons, MCP county liaison, tribal liaison, Blue Shield Promise internal staff (including Population Health Management care managers), county child welfare staff, Health Care Program for Children in Foster Care public health nurses, County staff (probation officers, child welfare social workers and staff, health education specialists and other staff), California Wraparound care coordinators, Child & Family Teams facilitators, and Secondary case managers, and/or service providers, as applicable

MCP Child Welfare Liaison (CWL)

The CWL ensures members are assisted with benefits navigation and coordination for the following:

- Medi-Cal for Kids and Teens (Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT)
- Enhanced Care Management (ECM) - Collaborate with ECM to enroll eligible children/youth
- Community Supports (CS)
- Behavioral Health
- Transitional Care Services
- Health Education
- Home and Community Based Services
- California Children's Services (CCS)
- Tribal health care
- Other local service area resources
- Specialty Mental Health Services and Substance Use Disorder Services
- County Child Welfare Services overseen by the California Department of Social Services.
- Care Coordination for Children's Temporary Shelter Facility (e.g. Polinsky Children's Center)
- Coordination for member transitions between counties

Child Welfare Services (CWS)

Child Welfare Services is a system of services and interventions of child abuse and neglect in California, overseen by the California Department of Social Services, Children and Family Services Division, and administered by individual counties. The goal of CWS is to keep the child in their own home when it is safe, and to develop an alternate plan when the child is at risk.

- How CWS are engaged:
  - Voluntary: for families not in crisis but seeking additional support to address issues that could put children at risk.
  - Court-Ordered: interventions are ordered by a judge and require parents to follow specific actions to ensure child safety
- Placement options:
  - Relative/kinship home
  - Non-kinship family-based setting foster care
  - Resource family
  - Tribally approved home

California's Family Maintenance program

About California's Family Maintenance program

- For children up to age 18
- Services provided or arranged for by county welfare department staff to assist children in remaining in their home
- Strength-based, family-focused services to help a child or youth remain in a safe, secure, stable home.
- Links to programs:
  - San Diego County Department of Child Support Services
  - Superior Court of California County of San Diego- Family & Children
  - San Diego County Identification of Court-Ordered Family Maintenance (FM) Services
  - Los Angeles County Department Child Support Services
  - Superior Court of California County of Los Angles- Family Court Services
  - Los Angeles County Family Maintenance

Foster care

Foster care is 24-hour out-of-home care for children in need of a temporary or long-term placement due to their family being unable or unwilling to care for them.

The Foster Youth Bill of Rights protects the personal rights to all children and non-minor dependents placed in foster care. It includes:

- Personal rights
- Sexual orientation
- Gender identity and expression (SOGIE)
- Indian Child Welfare Act (ICWA)
- Education
- Health
- Mental health
- Sexual and reproductive health
- Case plan
- Child and Family Team (CFT)
- Family and Social Connections
- Preparing for Adulthood and Money Management
- Communications
- Records

California's Adoption Assistance program

- For children under age 18, or under age 21 with a mental or physical disability that warrants the continuation of assistance.
- Provides financial and medical coverage to facilitate the adoption of children who otherwise may have remained in long-term foster care.
- Provided for up to 5 years.
- Links to programs:
  - California Adoption Assistance Program (California Department of Social Services – CDSS)
  - San Diego County Adoptions (Health & Human Services)
  - Los Angeles Adoption Assistance Program

Child Family Well Being (CFWB) and Child Welfare Resources

To obtain the list of child welfare agency points of contact for Medi-Cal MCPs to support care coordination and collaboration, email cwshealth@dss.ca.gov.

Additional helpful links

- Foster Youth Wellness Resources (CDSS Social Services Website)
- San Diego County Child and Family Well Being
- San Diego County Child and Family Well Being Homepage
- CFWB Resources for Families (San Diego)
    - For more information related to San Diego County Child and Family Well Being, call the KidsLine at 877-792-KIDS (5437)
- Los Angeles Department of Child and Family Services
- Los Angeles County Department of Mental Health CW Division
- Apply for Medi-Cal
- Member Help Line Phone: (800) 541-5555; TDD (800) 430-7077
  Website: www.dhcs.ca.gov/myMedi-Cal
- Medi-Cal Provider Resources
- Crisis Support: National Suicide Prevention Line. Dial 988

Resources and information for CW/ CFWB population

Issue	Resource
What consent is required to share information between HHSA/ DCFS and MCP?	The Order Authorizing Release of Health Information of Children in the Custody of HHSA/ DCFS, will be faxed to Blue Shield Promise (323) 889-2101
How do social workers, Public Health Nurses (PHNs), or caregivers check pediatrician assignments and availability?	Check the member ID card for Primary Care Provider (PCP) assignment or call Blue Shield Promise Customer Care at (855) 699-5557 (San Diego) or (800) 605-2556 (Los Angeles).
Can caregivers schedule PCP appointments?	Caregivers can schedule PCP appointments by calling the PCP or Blue Shield Promise if support is needed.
How can a parent or caregiver can find a dentist?	Visit DHCS Medi-Cal Dental or Smile California or call Find a Dentist (Medi-Cal Dental Program) at (800) 322-6384; TTY (800) 735-2922 or 711.
How can a parent or caregiver find in-network urgent care?	Visit Find a Doctor or call Blue Shield Promise Customer Care at (855) 699-5557 (San Diego) or (800) 605-2556 (Los Angeles).
How does a child/youth obtain mental health services for Specialty Mental Health?	Members can go directly to a county contracted provider. Members who need assistance navigating the county network can call the San Diego Access and Crisis Line at (888) 724-7240 or Los Angeles County Department of Mental Health (800)854-7771.
How does a child/youth obtain substance use treatment/screening?	Caregiver or youth can call the Access and Crisis Line at (888) 724-7240 (San Diego), Los Angeles County Department of Mental Health (800) 854-7771 or Blue Shield Promise can assist.

In-Home Supportive Services (IHSS)

In-Home Supportive Services (IHSS)

IHSS provides in-home personal care assistance as an alternative to out-of-home care to allow recipients to stay safely in their own homes.

Examples of IHSS

- Providing personal care services such as bathing, grooming, help with walking, bowel and bladder care
- Paramedical Services
- Accompanying member to appointments
- Help with
    - Dressing
    - Housework
    - Laundry
    - Shopping and errands
    - Meal prep and clean-up

IHSS eligibility

To qualify for IHSS, members must be:

- California resident
- Over 65, blind and/or disabled
- Medi-Cal-eligible, including those who are aged, blind, and/or disabled
- Living at home (not in an acute care hospital, long-term care facility, or licensed community care facility)
- Member's health care provider must agree that the member needs in-home personal care assistance and that they would be at risk of placement in out-of-home care if they did not receive IHSS services

The IHSS program will also conduct a needs assessment

IHSS process: Assessment to notification

- IHSS Assessment is completed at the initial visit and yearly, or as needed.
  - County social worker interviews member at their home to determine IHSS eligibility and need.
  - Information considered in the assessment may be provided by member and if appropriate, member's family, friends, physician, or other licensed healthcare professional.
  - Types of services and number of hours the county will authorize for each service will be based upon the member's ability to safely perform certain tasks.
- Service Authorization: a completed Health Care Certification (SOC 873) must be received by the county prior to authorization of services.
- Member is notified: if approved or denied (and reason for denial).
  - If approved, the members will be notified of which services they will receive and how many hours per month are authorized.
  - Members can either utilize IHSS county-contracted providers or hire their own individual provider.

IHSS MOU

- Members that have Medi-Cal (or eligibility) and who are receiving (or eligible to receive) In-Home Supportive Services (IHSS) may access and/or receive services in a coordinated manner from the MCP and the county.
- Members receive IHSS in a timely manner.
- IHSS is coordinated with medical services and long-term services and supports (LTSS) to promote the health and safety of members.

Definitions of roles and responsibilities related to MOU

County IHSS Responsible Person	County IHSS Liaison	MCP Responsible Person	MCP-IHSS Liaison
County-designated person who oversees communication and coordination with the MCP and ensure the county's compliance with IHSS MOU.	County's designated point of contact responsible for acting as the liaison between the county and MCP to ensure appropriate care coordination and communication. Collaborates and participates in quarterly meetings and provides updates to the IHSS Responsible Person as appropriate.	MCP-designated person who oversees MCP coordination and communication with county and ensure MCP's compliance with IHSS MOU. MCP-LTSS Liaison: designated by the MCP to assist in support care coordination and transitions from institutional settings.	MCP's designated point of contact responsible for acting as the liaison between the MCP and county to ensure the appropriate communication and care coordination are ongoing. Participates in quarterly meetings and provides updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

IHSS MCP obligations

- Provision of Covered Services
- The MCP is responsible for:
  - Authorizing medically necessary covered services
  - Coordinating care for members provided by MCP's participating network providers
  - Providing information necessary to assist with referring to county for IHSS
  - Coordinating services and other related Medi-Cal LTSS provided by MCP and other providers of carve-out programs, services, and benefits

IHSS MCP obligations, continued

- Oversight and responsibility:
  - Meet at least quarterly with county
  - Oversee MCP's compliance with MOU (including compliance oversight reports & address any deficiencies)
  - Report on MCP's compliance with the MOU to MCP's compliance officer (minimum quarterly)
  - Ensure sufficient staffing at MCP to support compliance and management of MOU
  - Ensure appropriate levels of MCP leadership involved in implementation, and ensure appropriate levels of leadership from county are invited to participate in the MOU engagements
  - Training and education regarding MOU provisions (conducted annually)
  - Designate MCP-IHSS Liaison and MCP-LTSS Liaison
  - Notify county of MCP-IHSS Liaison changes in writing as soon as reasonably practical but no later than date of change and notify DHCS within 5 Working Days of change.
  - Require and ensure Subcontractors, Downstream Subcontractors, & Network Providers, comply with all applicable provisions of this MOU

County IHSS obligations

- Provision of Services
  - Responsible for assessing, approving, and authorizing members' initial and continuing need for IHSS
- Oversight Responsibility
  - Oversee county's compliance with MOU
  - Designate IHSS Liaison to serve as the point of contact and liaison with MCP
  - Notify MCP of changes to IHSS Liaison as soon as reasonably practical but no later than the date of change
- Refer members to MCP for services or supports for which members qualify
  - For example: Community Supports (CS), care management programs such as Enhanced Care Management (ECM) or Complex Case Management (CCM)

IHSS Referral Information by county – San Diego

IHSS San Diego website

Online: Professionals, such as hospital discharge planners, may make a referral online. New users must first register at the HHSA Web Portal then submit referral at the IHSS/Case Management Portal.

Phone: Call **(800) 339-4661** to apply with Call Center staff.

Email: Email completed IHSSapplication to: AIS.295only.HHSA@sdcounty.ca.gov.

Fax: Fax a completed IHSS application to (619) 344-8077.

Mail or in Person: Visit or send the IHSS application to one of these IHSS Offices:

- El Cajon: 389 N. Magnolia Ave. El Cajon, CA 92020
- Escondido: 649 W. Mission Ave Ste. 5. Escondido, CA 92025
- National City: 401 Mile of Cars Way Ste. 210. National City, CA 91950
- Oceanside: 3708 Ocean Ranch Boulevard Ste.320. Oceanside, CA 92056
- Overland: 5560 Overland Ave. Ste. 310. San Diego, CA 92123
- Southeastern Live Well Center: 5101 Market Street Ste. 2100. San Diego, CA 92114

IHSS Referral Information by county – Los Angeles

IHSS Los Angeles website

Phone:

- Toll Free Number (888) 944-IHSS (4477) OR
- Local Number (213) 744–IHSS (4477) OR
- IHSS Helpline (888) 822-9622 (option 4 from main menu) Mon-Fri from 8AM - 5PM

Secure Fax (eFax):

- Print the IHSS application SOC 295 (9/18) - Application for In-Home Supportive Services
- Fax the IHSS application to 562-222-2827

Mail:

- Print the IHSS application SOC 295 (9/18) - Application for In-Home Supportive Services
- Mail IHSS application to:

  DPSS In-Home Supportive Services

  PO Box 769

  Rosemead, CA 91770

Medi-Cal Behavioral Health

Medi-Cal Behavioral Health

Mild-to-Moderate Mental Health Services (Carved-In: Managed by Blue Shield Promise)

- Available for all ages
- Covers outpatient therapy (individual, family, and group), outpatient psychiatry, psychological testing, and psychiatric medication evaluations/management
- no copays for covered services
- Access support through:
  - Find a Doctor
  - Customer/member services
  - PHM Social Services
  - County Mental Health Department referral

Specialty Mental Health Services (Carved-Out: Managed by county Mental Health)

- Available for all ages
- Covers higher levels of care for serious mental illness:
  - Inpatient psychiatric hospitalization
  - Residential treatment
  - Partial hospitalization and intensive outpatient programs (IOP)
  - Crisis intervention services
- Includes substance use disorder (SUD) treatment.
- No wrong door policy: Members can seek help through any point of entry, including their health plan or directly through the county Mental Health Department.

Behavioral Health Treatment (BHT) (Carved-In: Managed by Blue Shield Promise)

- For members under 21
- Covers diagnostic evaluation, psychological assessment, and services for Autism Spectrum Disorder which typically includes Applied Behavior Analysis (ABA)

Medi-Cal Behavioral Health services at-a-glance

Service type	Who manages?	Service examples	Authorization needed?	How members access care
Mild-to-Moderate Mental Health	Blue Shield Promise (Carved In)	Outpatient therapy, outpatient psychiatry, psych testing. No limits on outpatient visits.	No	Members can self-refer through Blue Shield Promise Find a Doc, Customer Care, Population Health Management Social Services, or by county Referral
Specialty Mental Health/Substance Use Disorder (SUD)	County Mental Health (Carved Out)	Inpatient psych, residential, Intensive Outpatient, Partial Hospitalization, Crisis Services, SUD Programs	County handles if needed	County Mental Health department, Blue Shield Promise Customer Care assistance
Behavioral Health Treatment (BHT)	Blue Shield Promise (Carved In)	Autism/ABA therapy, diagnostic evals (under age 21)	Yes	Referral and authorization via Blue Shield Promise Customer Care

Note that Medicare beneficiaries need to exhaust Medicare benefits before accessing Medi-Cal benefits

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To learn more about the Medi-Cal Behavioral Health Services Program, visit the Blue Shield Promise Behavioral Health website:

Behavioral Health Services Program

How Blue Shield Promise supports behavioral health access

Blue Shield Promise's Medi-Cal Behavioral Health Care Management team is available to:

- Support care coordination with members, providers, and county stakeholders.
- Maintain liaison relationships with county behavioral health teams to streamline care coordination when a higher level of care is needed.
- Maintain a robust behavioral health network with diverse provider types to meet member's unique needs.
- Assist with authorizations (e.g., for BHT/ABA).

Local Health Department

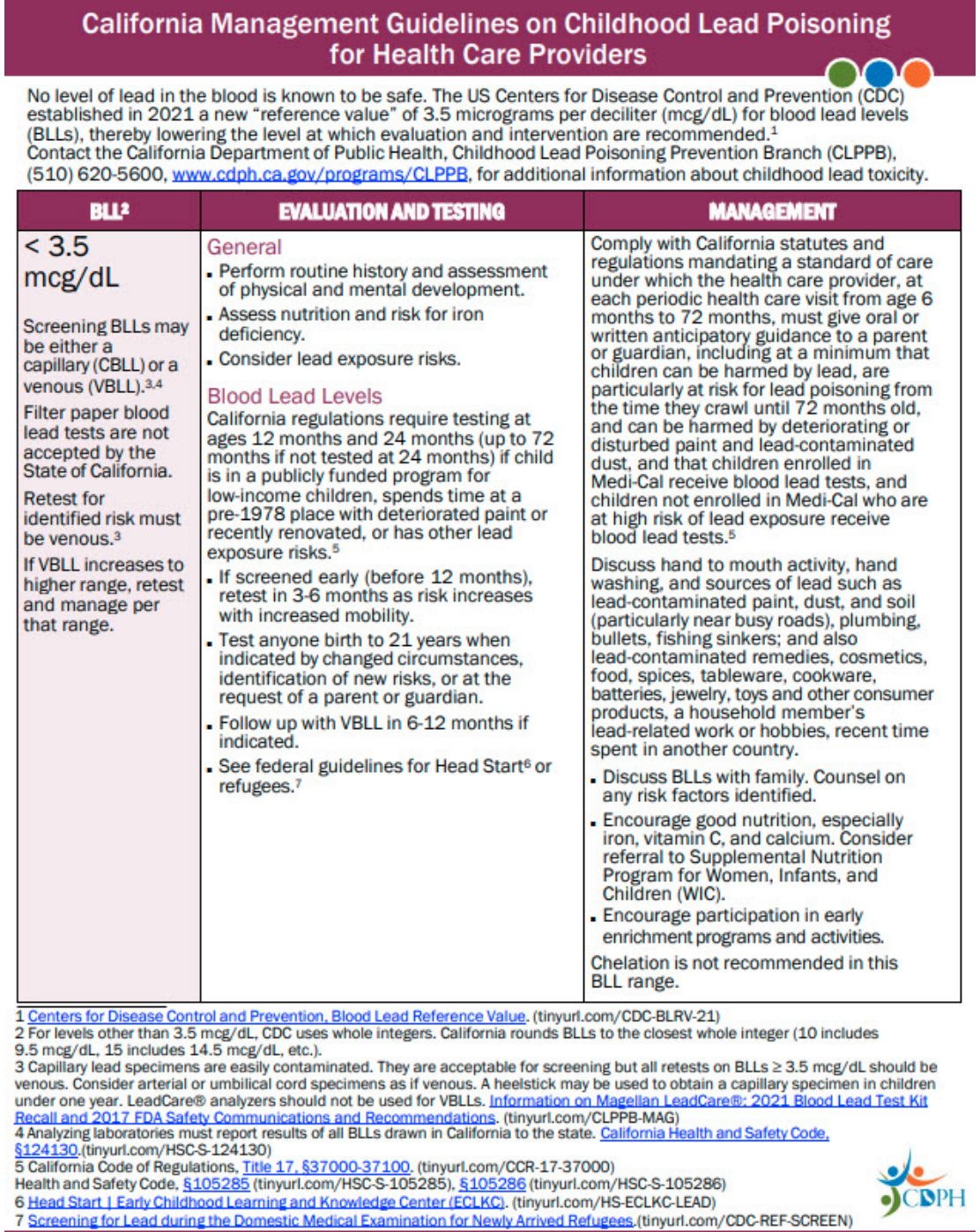
Overview

Federal law requires states to screen children enrolled in Medicaid for elevated blood lead levels as part of required prevention services offered through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

Policy

Blue Shield Promise must ensure that their network providers (e.g., physicians, nurse practitioners, and physician's assistants) who perform periodic health assessments on members between the ages of six months to six years (72 months) comply with current federal and state laws, and industry guidelines for health care providers issued by the Childhood Lead Poisoning Prevention Branch ("CLPPB").

[California Management Guidelines on Childhood Lead Poisoning for Health Care Providers]



California Management Guidelines on Childhood Lead Poisoning for Health Care Providers

No level of lead in the blood is known to be safe. The US Centers for Disease Control and Prevention (CDC) established in 2021 a new "reference value" of 3.5 micrograms per deciliter (mcg/dL) for blood lead levels (BLLs), thereby lowering the level at which evaluation and intervention are recommended.[1] Contact the California Department of Public Health, Childhood Lead Poisoning Prevention Branch (CLPPB), (510) 620-5600, www.cdph.ca.gov/programs/CLPPB, for additional information about childhood lead toxicity.

BLL[2]	EVALUATION AND TESTING	MANAGEMENT
< 3.5 mcg/dL Screening BLLs may be either a capillary (CBLL) or a venous (VBLL).[3,4] Filter paper blood lead tests are not accepted by the State of California. Retest for identified risk must be venous.[3] If VBLL increases to higher range, retest and manage per that range.	**General** ▪ Perform routine history and assessment of physical and mental development. ▪ Assess nutrition and risk for iron deficiency. ▪ Consider lead exposure risks. **Blood Lead Levels** California regulations require testing at ages 12 months and 24 months (up to 72 months if not tested at 24 months) if child is in a publicly funded program for low-income children, spends time at a pre-1978 place with deteriorated paint or recently renovated, or has other lead exposure risks.[5] ▪ If screened early (before 12 months), retest in 3-6 months as risk increases with increased mobility. ▪ Test anyone birth to 21 years when indicated by changed circumstances, identification of new risks, or at the request of a parent or guardian. ▪ Follow up with VBLL in 6-12 months if indicated. ▪ See federal guidelines for Head Start[6] or refugees.[7]	Comply with California statutes and regulations mandating a standard of care under which the health care provider, at each periodic health care visit from age 6 months to 72 months, must give oral or written anticipatory guidance to a parent or guardian, including at a minimum that children can be harmed by lead, are particularly at risk for lead poisoning from the time they crawl until 72 months old, and can be harmed by deteriorating or disturbed paint and lead-contaminated dust, and that children enrolled in Medi-Cal receive blood lead tests, and children not enrolled in Medi-Cal who are at high risk of lead exposure receive blood lead tests.[5] Discuss hand to mouth activity, hand washing, and sources of lead such as lead-contaminated paint, dust, and soil (particularly near busy roads), plumbing, bullets, fishing sinkers; and also lead-contaminated remedies, cosmetics, food, spices, tableware, cookware, batteries, jewelry, toys and other consumer products, a household member's lead-related work or hobbies, recent time spent in another country. ▪ Discuss BLLs with family. Counsel on any risk factors identified. ▪ Encourage good nutrition, especially iron, vitamin C, and calcium. Consider referral to Supplemental Nutrition Program for Women, Infants, and Children (WIC). ▪ Encourage participation in early enrichment programs and activities. Chelation is not recommended in this BLL range.

1 Centers for Disease Control and Prevention, Blood Lead Reference Value. (tinyurl.com/CDC-BLRV-21)
2 For levels other than 3.5 mcg/dL, CDC uses whole integers. California rounds BLLs to the closest whole integer (10 includes 9.5 mcg/dL, 15 includes 14.5 mcg/dL, etc.).
3 Capillary lead specimens are easily contaminated. They are acceptable for screening but all retests on BLLs ≥ 3.5 mcg/dL should be venous. Consider arterial or umbilical cord specimens as if venous. A heelstick may be used to obtain a capillary specimen in children under one year. LeadCare® analyzers should not be used for VBLLs. Information on Magellan LeadCare®: 2021 Blood Lead Test Kit Recall and 2017 FDA Safety Communications and Recommendations. (tinyurl.com/CLPPB-MAG)
4 Analyzing laboratories must report results of all BLLs drawn in California to the state. California Health and Safety Code, §124130.(tinyurl.com/HSC-S-124130)
5 California Code of Regulations, Title 17, §37000-37100. (tinyurl.com/CCR-17-37000)
Health and Safety Code, §105285 (tinyurl.com/HSC-S-105285), §105286 (tinyurl.com/HSC-S-105286)
6 Head Start | Early Childhood Learning and Knowledge Center (ECLKC). (tinyurl.com/HS-ECLKC-LEAD)
7 Screening for Lead during the Domestic Medical Examination for Newly Arrived Refugees.(tinyurl.com/CDC-REF-SCREEN)

CDPH

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Blood lead screening requirements for providers

- Blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods. Lead filter paper tests should not be used.
    - All confirmatory and follow-up blood lead level testing must be performed using blood samples taken through the venous blood sampling method.
- Network providers are required to provide oral or written anticipatory guidance to the parent/guardian(s) of a child member that, at minimum, includes information that children can be harmed by exposure to lead.
    - The anticipatory guidance must be provided to the parent/guardian(s) of a child member at each PHA, starting at 6 months of age and continuing until 72 months of age.
- Blue Shield Promise will ensure network providers order and/or perform blood lead screening tests on all child members in accordance with the following:
    - At 12 months and at 24 months of age.
    - When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
    - When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
    - At any time, a change in circumstances has, in the professional judgment of the network provider, put the child member at risk.
    - If requested by the parent or guardian.

Anticipatory guidance

- Anticipatory guidance must be provided to the parent/guardian(s) of a child member at each periodic assessment from 6 months to 6 years of age.
- Under California state laws and regulations, all health care providers are required to inform all parents and guardians about:
  - The risks and effects of childhood lead exposure
  - The requirement that children enrolled in Medi-Cal receive blood lead tests
  - The requirement that children not enrolled in Medi-Cal who are at high risk of lead exposure receive blood lead tests
- Anticipatory guidelines are available for download, along with tools and education for providers: Health Care Providers

Blood lead levels: recommended actions

- Healthcare providers may use a capillary or venous sample for in screening.
  - If the capillary results are equal to or greater than CDC's Blood Lead Reference Value (BLRV), (>3.5 ug/dL) providers should collect a venous sample
- Initial screening blood lead level - Recommended actions if the If the patient's BLL is ≥3.5 micrograms per deciliter (µg/dL):
  - Provide education about common sources of lead exposure and information on how to prevent further lead exposure.
  - For children living in or visiting homes or structures built before 1978, adults can reduce lead exposure from lead-based paint by doing the following:
    - Regularly wet-wiping windows and windowsills and wet-mopping floors.
    - Avoiding repairs and construction projects that may create lead-based paint dust.
    - Covering chipping or peeling paint to keep lead from spreading to surrounding areas.
    - Using approved methods for removing lead hazards from the home and using contractors certified by the Environmental Protection Agency (EPA) when repairs or renovations are needed. Visit the EPA's web page to locate a certified contractor.
  - Obtain a confirmatory venous sample for blood lead testing.

Refusal requirements

- Providers are not required to perform a blood lead screening test if either of the following applies:
  - In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
  - If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

What to do if a parent, guardian, or other person with legal authority refuses the blood lead screening test

- Provider must document refusal or reasons for not performing the blood lead screening test into child's medical records.
- Providers must obtain signed statement of voluntary refusal to document refusal or reason for not performing blood lead screening test into the child's medical records.
  - Lead Declination Form, English
  - Lead Declination Form, Spanish
- If providers *cannot* obtain signed statement of voluntary refusal because the party (1) refuses or declines to sign it or (2) is unable to sign it (e.g., services provided via telehealth), providers are required to document the reason for not obtaining signed statement into the child's medical record.
- DHCS will consider the above-mentioned documented efforts that are noted in the child's medical record as evidence of compliance with blood lead screening test requirements.

Elevated blood lead levels: San Diego County resources

If a child presents with blood lead levels above 3.5 µg/dL, report the test result to your state or local health department and refer child to the county programs below for case management, environmental assessment, and other services.

Program Description

The San Diego Childhood Lead Poisoning Prevention Program is a Public Health Services program that seeks to eliminate childhood lead poisoning by caring for lead-poisoned children and identifying and eliminating sources of lead exposure. Available Services include:

- Case Management
- Environmental Investigations
- Education to health care providers, community groups and families
- Surveillance data
- Lead Safety and Healthy Homes Program- Lead Safety and Healthy Homes Program | Environmental Services | City of San Diego Official Website
- San Diego Housing Commission
  (financial assistance removing lead hazards)
- Environmental Health Coalition
  (City of San Diego and National City)

For more information, contact the Childhood Lead Poisoning Prevention Program

- Childhood Lead Poisoning Prevention Program -CLPPP (sandiegocounty.gov)
- Phone: (619) 692-8487

Elevated blood lead levels: Los Angeles County Resources

If a child present with blood lead levels above 3.5 µg/dL, report the test result to your state or local health department and refer child to the county programs below for case management, environmental assessment, and other services.

Program Description: Childhood Lead Poisoning Prevention Program (CLPPP) Home

CLPPP works to improve the health of children who live, learn, and play in Los Angeles County by preventing lead poisoning and providing complete support to lead burdened children and their families. LA Public Health Department.

Available Services include:

http://publichealth.lacounty.gov/lead/2023families.htm

http://publichealth.lacounty.gov/lead/2023providers.htm

http://publichealth.lacounty.gov/lead/2023partners.htm

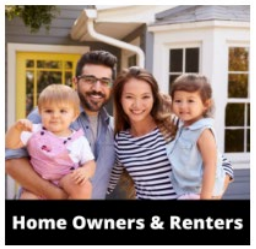
http://publichealth.lacounty.gov/lead/2023painters.htm

http://publichealth.lacounty.gov/lead/2023home.htm

http://publichealth.lacounty.gov/lead/2023materials.htm

COACH for Kids: Pediatric Mobile Clinic. Lead Testing done ONLY with Well Child Visit. Request an appointment: (888) 9-COACH-9

California Department of Public Health Guidelines: Lead Service Line Replacement



Lead Screening Information

- Quarterly gaps in care for members aged 0-6 and monthly reports for HEDIS measure Lead Screening in Children (LSC) is provided by Blue Shield Promise Program Managers.
- Anticipatory Guidance - Lead Poisoning Prevention – California Department of Public Health (CDPH)
- Childhood Lead Poising Prevention Branch home page - CDPH
- Childhood Lead Poisoning Prevention Branch testing guidance for providers – CDPH
- APL 20-016 – Department of Health Care Services (DHCS)
- Blue Shield of California home page
- Blue Shield Promise Provider Manuals
- Testing for Blood Lead Levels in Children – Centers for Disease Control (CDC)
- About the Data: Blood Lead Surveillance – CDC
- Fact Sheet: Blood Lead Levels in Children – CDC
- CDC's Recommended Terminology When Discussing Children's Blood Lead Levels – CDC guidance for interpreting and discussing children's blood lead levels

Lead Screening Information, continued

- AAP Information on lead exposure – American Academy of Pediatrics (AAP) information and resources for physicians on prevention and medical management.
- Find a Pediatric Environmental Health Specialty Unit (PEHSU) in Your Region – information about protecting children from environmental hazards.
    - Videos about the causes, symptoms, and prevention of childhood lead exposure:
        - English
        - Spanish
- Protect Your Child from Lead – CDPH brochure in English and Spanish
- Getting Your Child Tested For Lead – CDPH brochure in English and Spanish
- Keeping Your Child Safe from Lead and Other Heavy Metals in Baby Foods – CDPH brochure in English and Spanish

Non-Contracted Local Health Department

Non-Contracted Local Health Department (LHD) services

Immunizations

The Medi-Cal Managed Care Plan (MCP) is responsible for providing all immunizations to members recommended by the California Department of Public Health guidance for the immunization schedule and American Academy of Pediatrics (AAP) pursuant to the Medi-Cal Managed Care contract and must allow members to access immunizations through the Local Health Department (LHD) regardless of whether the LHD is in the MCP's provider network. The MCP must not require prior authorization for immunizations from LHD.

i. MCP must reimburse LHD for immunization services provided under this MOU at no less than the Medi-Cal fee for service (FFS) rate.

ii. MCP must reimburse LHD for the administration fee for immunizations given to members who are not already immunized as of the date of immunization, in accordance with the terms set forth in APL 26-015.

To follow recommendations for Preventative Pediatric Health care please refer to the California Department of Public Health; Information for Health Care Providers - American Academy of Pediatrics Periodicity Schedule: AAP Immunization Schedule | Red Book Online | American Academy of Pediatrics.

Responsibilities of Medi-Cal Managed Care Plans

Provide All Recommended Immunizations

MCPs must cover and administer all vaccines recommended by:

- The California Department of Public Health (CDPH) immunization schedule
- The American Academy of Pediatrics (AAP) guidelines

Contractual Obligation

This requirement is explicitly written into the Medi-Cal Managed Care contract. MCPs cannot limit or restrict access to these vaccines.

Access Through Local Health Departments (LHDs)

Members must be allowed to receive immunizations at Local Health Departments, even if the LHD is not part of the MCP's provider network. This ensures members can always get vaccines without being blocked by network restriction

Why This Rule Exists

- **Public Health Protection**: Ensures widespread vaccination coverage to prevent outbreaks.
- **Equity in Care**: Guarantees that all Medi-Cal members, regardless of their plan or location, can access vaccines.
- **Flexibility for Families**: Parents can take children to county health departments for shots without worrying about insurance network rules.

Non-Contracted LHD services, continued

****Vaccines for Children (VFC) program**

The Vaccines for Children (VFC) program provides free vaccines to children less than 19 years old who qualify for Medi-Cal, are uninsured, or are American Indian or Alaska Native. The VFC program provides vaccines at no cost to enrolled providers to administer to eligible children between the ages of 0-18 years.

Blue Shield Promise provides information to all network providers regarding the VFC program, strongly encourages all providers who provide immunizations to children 0-18 years to participate in the program, and promotes and supports enrollment in the VFC program by including information about the California Vaccines for Children program in our Medi-Cal Provider Orientation materials and in our Provider Manual.

Links

- California Vaccine Programs – California Vaccines for Children (VFC)
- IMM-395 Routine Immunization Timing 2025
- CDPH letter to California Vaccines for Children (VFC) Providers
- AAP Immunization Schedule | Red Book Online | American Academy of Pediatrics

**Vaccination schedule and requirements are subject to change per CDC guidelines

Non-Contracted LHD services, continued

Sexually Transmitted Infections ("STI") services, family planning, and HIV testing and counseling

MCP must ensure members have access to STI testing and treatment, family planning, and HIV testing and counseling services, including access through LHD pursuant to 42 United States Code Sections 1396a(a)(23) and 1396n(b) and 42 Code of Federal Regulations Section 431.51.

No prior authorization or referral for members is needed to access STI, family planning or HIV testing services.

Tuberculosis screening, diagnosis, treatment and care coordination

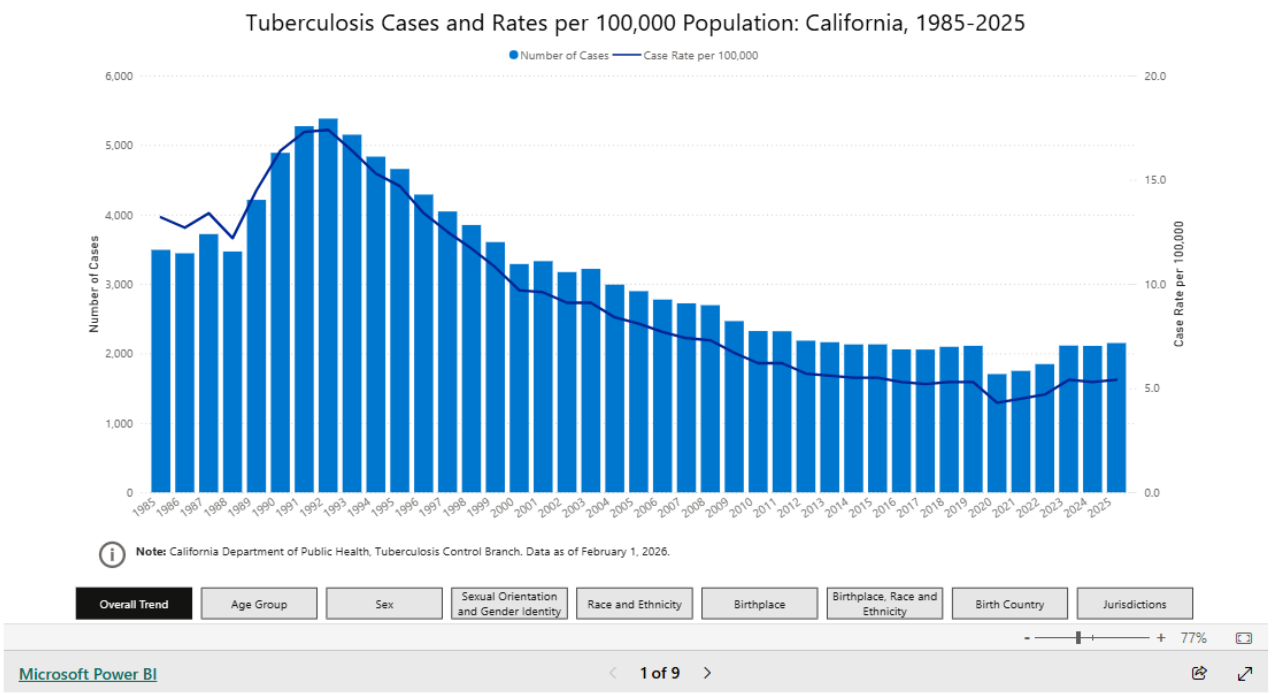
Tuberculosis (TB) overview and statistics

Tuberculosis Disease

Once the leading cause of death in the United States, today people with active Tuberculosis (TB) disease can be treated and cured if they seek medical help. Even better, people with latent TB infection can take medicine so they will not develop active TB disease.

To protect and improve the health of all, the California Department of Public Health Tuberculosis Control Branch (TBCB) provides leadership and resources to prevent and control TB. Their vision is to speed the decline of TB morbidity and mortality. For more information, visit the Tuberculosis Control Branch website.

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TBCB-California-TB-Dashboard.aspx



San Diego Fact Sheets

- San Diego County TB Elimination Fact Sheet, 2025 edition
- Tuberculosis in San Diego County: By the Numbers, 2025 edition
- TB Elimination Initiative

About the San Diego Tuberculosis Elimination Initiative (TBEI)

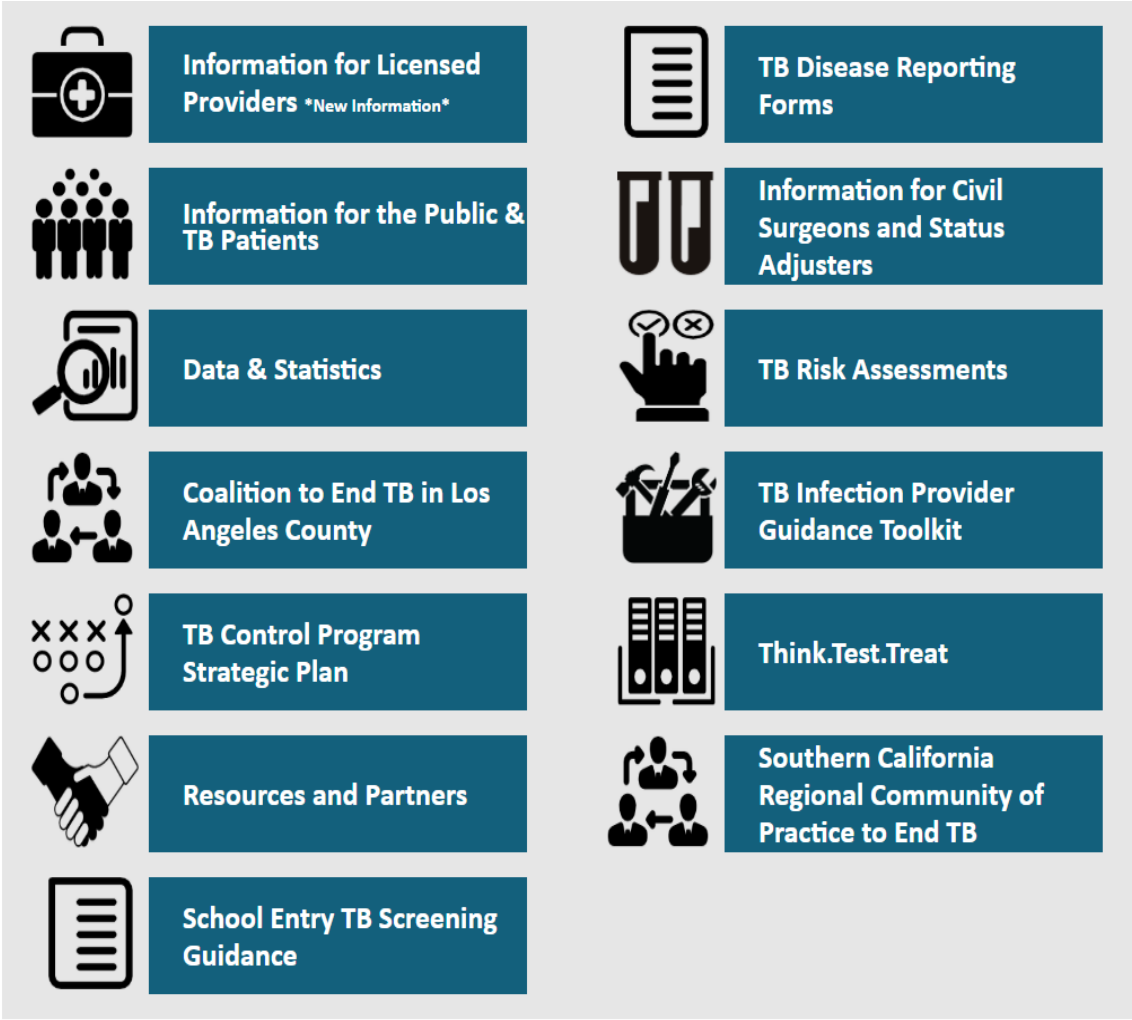
TBEI is a public-private partnership launched in January 2020 to build a coordinated Tuberculosis elimination framework for the county. The initiative focuses on effective TB prevention, including risk assessment, testing, and treatment of latent TB infection (LTBI) cases to prevent progression to active TB. Over 25 unique entities are currently engaged in this initiative.

TBEI FOCUS: An estimated **85%** of active tuberculosis (TB) cases are due to progression of Latent TB Infection (LTBI) to active TB. Approximately **175,000** San Diego County residents have LTBI, which can progress to active TB disease without treatment. Only **25%** of residents with LTBI are aware of their infection and only **15%** have been treated.

Los Angeles Fact Sheets

LA County Of Public Health for Tuberculosis

To Learn More:
http://publichealth.lacounty.gov/tb/



Tuberculosis (TB) resources

- Think. Test. Treat TB website – Centers for Disease Control (CDC)
- CDPH Tuberculosis Control Branch – California Department of Public Health (CDPH)
- California Tuberculosis Dashboard
- California Tuberculosis Controllers Association – (CTCA)
- Preventing Tuberculosis in Your Clinical Setting: A Practical Guidebook – CTCA

Blue Shield Promise

Purpose

To implement and manage members who will be screened for TB, notification to the LHD, and referral for provision of Direct Observed Therapy (DOT).

Management strategy

DOT is the preferred core management strategy the Centers for Disease Control (CDC) recommends for treatment of TB disease, and if resources allow for Latent Tuberculosis Infection (LTBI) treatment. DOT can reduce the development of drug resistance, treatment failure, or lapse after the end of treatment.

Policy

i. Ensures TB screening, diagnosis, treatment, and follow-up care is provided in compliance with the guidelines recommended by the American Thoracic Society and the Centers for Disease Control and Prevention.

ii. Primary care physicians (PCPs) are responsible for TB screening, identifying active cases, notifying the LHD, assessing the need for DOT, and referring cases for DOT to the LHD TB Control Officer. Blue Shield Promise shall aid the PCP as requested in completing these requirements. Members identified as having active TB or requiring DOT will be referred to Blue Shield Promise Case Management for coordination of care.

Blue Shield Promise, continued

Procedure

I. Primary care physicians (PCPs) are required to screen adults and children for tuberculosis as part of the Initial Health Assessment and periodically thereafter for high-risk individuals.

II. PCPs are required to notify the LHD of any active cases of TB or when the member ceases treatment using a Confidential Medical Report (CMR). The report should also include an individualized treatment plan. Periodic reports are to be made thereafter as required by the LHD.

III. PCPs are required to refer members with active TB who may be non-compliant to the DOT program. Blue Shield Promise may assist in referring members who are at risk for treatment resistance or noncompliance with treatment to the LHD for DOT.

IV. DOT is defined as delivery of every dose of medication by a health care worker who observes and documents that the patient ingests or is injected with the medication.

V. Blue Shield Promise Case Management and Pharmacy Departments will query pharmacy claims monthly to identify potential active TB cases. A case manager will outreach to members at risk/or identified as non-compliant with treatment. They will contact the PCP to verify care management needs, verify that patient has active TB and to determine if the LHD has been notified. These cases will be referred to the Chief Medical Officer (CMO) for review if there is a risk for non-compliance.

VI. If the member has been referred for DOT, Blue Shield Promise Case Management will coordinate care between the PCP & the LHD to ensure the member receives all medically necessary covered services not related to the TB diagnosis.

VII. Blue Shield Promise shall provide all medically necessary covered services to the member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

Maternal, Child, and Adolescent Health (MCAH)

Maternal, Child, and Adolescent Health (MCAH)

The state of California Maternal, Child, and Adolescent Health (MCAH) Division supports and implements strategies to improve health, support the development of children and adolescents, and foster well-being and equity across the reproductive life course.

Maternal Health strives to ensure every woman in California can experience a healthy pregnancy and delivery. MCAH programs encourage ongoing education, self-sufficiency, healthy life choices, and mental and physical wellness during pregnancy.

Maternal, Child, and Adolescent Health (MCAH) Services and Programs: Links

Black Infant Health (BIH) Program

Home Visiting Programs

Chronic Disease and Health Equity (CDHE)

Health Care Program for Children in Foster Care (HCPCFC)

Office of Violence Prevention (OVP)

Oral Health Program

Perinatal Care Network (PCN)

Perinatal Equity Initiative (PEI)

Sudden Infant Death Syndrome (SIDS)

Tobacco Control Resource Program (TCRP)

First 5 San Diego

First 5 Los Angeles

Health Start Global Communities

California Department of Public Health (CDPH) Women, Infants & Children (WIC) program

San Diego County Maternal, Child, and Family Health Services (MCFHS)

Purpose

San Diego Maternal, Child, and Family Health Services is a multidisciplinary, multicultural branch dedicated to working with community and Health and Human Services Agency partners to promote health and to protect and support pregnant women, children, families and communities.

Doula Services All Plan Letter 23-024 (APL)

The Department of Health Care Services (DHCS) added doula services as a covered Medi-Cal benefit on January 1, 2023.

Blue Shield Promise aims to eliminate inequities in maternal and infant health outcomes by providing doula services to Medi-Cal beneficiaries to aid in preventing perinatal complications and improving health outcomes for birthing parents and infants in Los Angeles and San Diego counties.

What is a Doula?

A traditional doula is a trained non-clinical professional who provides continuous educational, physical, and emotional support to women and their birth partners before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.

Doulas are:

- Trained professional childbirth champions
- Birth workers
- Birth companions
- Advocates and caregivers

How doulas aid in preventing adverse birth outcomes

- Doulas serving Blue Shield Promise Health Plan Medi-Cal beneficiaries provide person-centered, culturally competent care encompassing health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage and stillbirth, and after abortion.
- Doula services include health navigation, lactation support, development of a birth plan, postpartum support and linkages to community-based resources to mitigate social determinants of health (SDH) throughout the pregnancy support life cycle.

Doula supportive services

- Doulas provide care that supports members across race, ethnicity, language, and culturally diverse communities.
- Doulas educate and advocate for members. They provide physical and emotional support to pregnant and postpartum people before, during, and after childbirth or pregnancy.
- Doulas can help ensure members are being heard, supported, and informed to help close racially biased maternal care gaps.
- Doula services may help prevent perinatal complications and improve health outcomes for birthing people and infants.

Blue Shield Promise doula benefit authorized visits

- The Doula benefit is a preventive service requiring a written recommendation from a physician or other licensed practitioner of the healing arts (clinical social worker, acupuncturist, midwife or any other healing arts professional). To increase access to services, DHCS Medical Director, Karen Mark, MD, issued a standing recommendation for the initial set of doula services for any Medi-Cal member who is pregnant or was pregnant within the past year.
- The standing recommendation authorizes the following doula services:
  - One initial 90-minute visit
  - Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits, as determined by the birthing person and doula
  - Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
  - Up to two extended three-hour postpartum visits after the end of a pregnancy
  - The extended three-hour postpartum visits provided after the end of pregnancy do not require the beneficiary to meet additional criteria or receive a separate recommendation
    - Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.
    - Doulas may provide services in the community, at a member's home, and in hospitals, among other locations.
  - If a member has used all the visits for the standing recommendation, the member would need an additional recommendation from a physician or other licensed practitioner of the healing arts acting to receive up to nine additional postpartum visits. The standing recommendation from DHCS cannot be used for additional postpartum visits.
- Doula services can be provided virtually or in-person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.

Blue Shield Promise doula benefit authorized services

- Doulas may provide various types of support during the perinatal period, including during pregnancy, labor and delivery, miscarriage, and abortion, and up to one year postpartum. Services include guidance, health navigation, evidence-based education for prenatal, postpartum, childbirth, and newborn/infant care, lactation support, development of a birth plan, and linkages to community-based resources.

- More than one doula may provide services during a member's pregnancy and postpartum period. However, the total number of visits that a member may receive are per pregnancy and not per doula. In addition, only one doula may bill for services provided during labor, miscarriage, or abortion.

- Doula services are available up to one year after pregnancy. If the member did not have a doula while pregnant, they may use the initial visit and all eight visits during the postpartum period and up to nine additional postpartum visits with a second written recommendation.

- Doula may provide all services via telehealth, including by telephone. Services rendered via telehealth must be billed consistent with DHCS' telehealth policy as outlined in the Medicine: Telehealth section of the Medi-Cal Provider Manual. Additionally, all doula services provided via telehealth must meet federal requirements for privacy, including the Health Insurance Portability and Accountability Act.

California Children's Services (CCS)

California Children's Services (CCS) 101

CCS history

- Established in 1927 as "Crippled Children's Services" in California in response to the Polio epidemic.
- Focused on providing therapy for children with physical disabilities.

CCS today

- CCS is a partnership between the state and counties that provides medical case management for children in California diagnosed with serious chronic diseases.
- Today, CCS Provides services to more than 165,000 California Children

CCS organization

- County of San Diego and Los Angeles CCS Program

CCS services

- Medical Case Management and Medical Therapy Program

CCS eligibility

- Medical, financial, and age criteria

eSAR

- State Electronic Referral System

Medi-Cal Eligibility

CCS is a statewide program that provides funding for treatment of children with certain physical limitations and chronic health conditions or diseases. CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists.

CCS Program website

- Welfare and Institutions Code and the California Code of Regulations (Title 22, Section 51013) mandates CCS to act as an agent of Medi-Cal. Assembly Bill (AB) 118, Chapter 42, Section 14094.7 mandates the Department of Health Care Services (DHCS) to annually provide an analysis on its website regarding trends in California Children's Services (CCS) enrollment among CCS Whole Child Model (WCM) and Classic counties beginning January 1, 2025.

- The dashboard's data sources are derived from a combination of systems within the department. The dashboard includes CCS-eligible and Medical Therapy Program (MTP) beneficiaries and excludes CCS-State only beneficiaries.

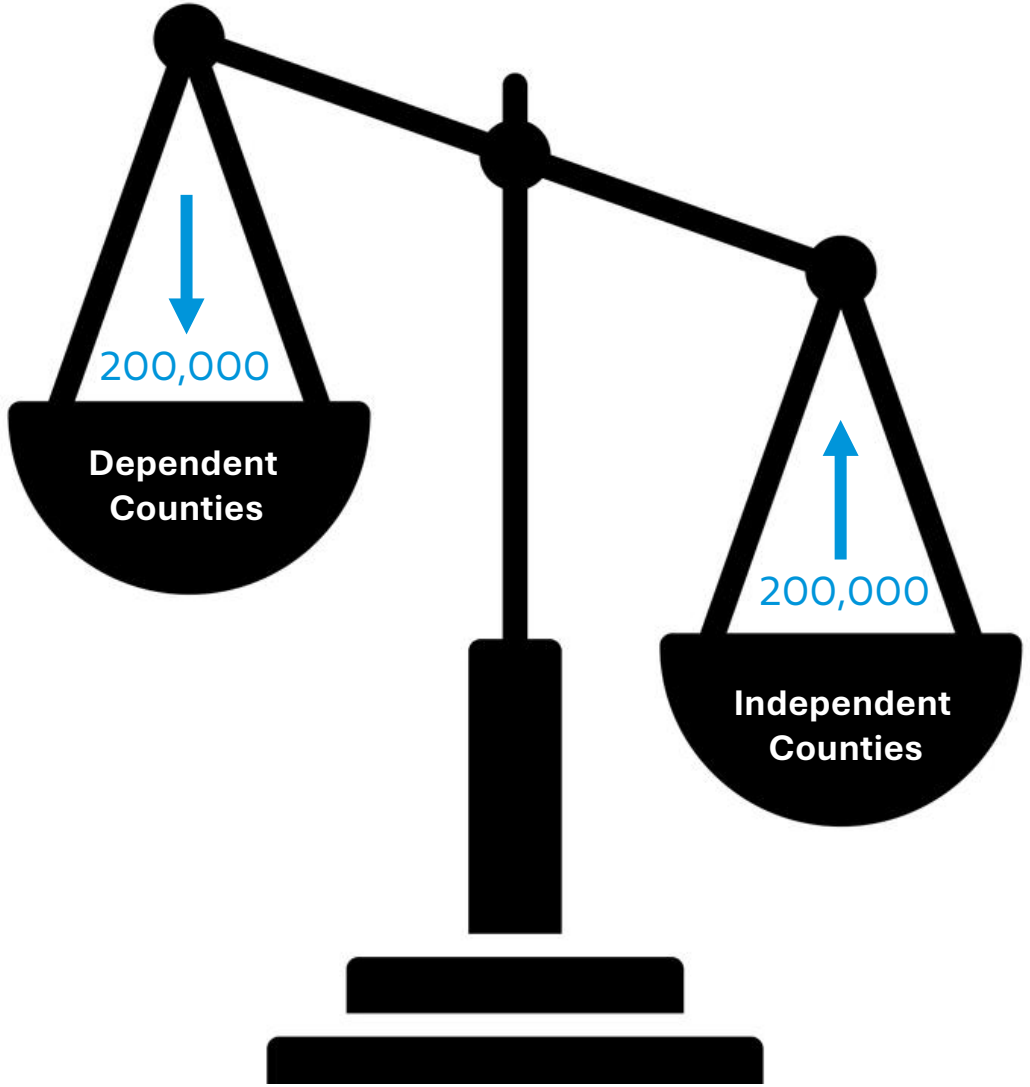
- The initial iteration of this dashboard includes CCS data related to demographics and enrollment.

- CCS Demographics and Enrollment Dashboard | DHCS (For a better viewing experience, please open in full-screen mode)

CCS Program structure

Program administration depends on the size of the county.

The Children's Medical Services Branch assists with determinations and authorizations through its regional offices.



County staff are responsible for evaluation, financial and medical eligibility determinations and authorization of services.

Treatment vs. therapy

Treatment

Reviewed by Supervising Public Health Nurse:

- Medical conditions that are physically disabling or require medical, surgical, or rehabilitative services
- Medical eligibility is disease–specific and covers only what is related to or impacts the CCS eligible condition

Therapy

Reviewed by Medical Therapy Program Consultant:

- Children with neuromuscular, musculoskeletal, or muscular disease
- Children under 3 years old without a clear medical diagnosis but with symptoms that indicate a high chance that they may have an MTP eligible diagnosis in the future

Treatment vs. therapy: Eligible conditions

Treatment

- Birth Defects
- Cerebral Palsy
- Diabetes
- Heart Disease
- Cancer
- Cystic Fibrosis
- Hearing Loss
- Hemophilia
- HIV/AIDS
- Major Trauma
- NOT eligible: syndromes, developmental delay, mental conditions, behavioral issues

Therapy

- Cerebral Palsy
- Spina Bifida
- Muscular Dystrophy
- Rheumatoid Arthritis
- Spinal Cord Injuries
- Spinal Muscular Atrophy
- Arthrogryposis
- Osteogenesis Imperfecta

Treatment vs. therapy: Financial, residential and age criteria

Treatment

Financial eligibility

- Enrolled in Medi-Cal
- Uninsured and annual family income less than $40,000; or
- Costs to not to exceed 20% of the family's annual adjusted gross income

Residential criteria

- Residents of San Diego County

Age criteria

- Birth until the day before 21st birthday

Therapy

Financial eligibility

- No financial eligibility requirements.
- However, needs financial if also open to treatment or has DME needs.

Residential criteria

- Enrolled or eligible to be enrolled in a San Diego County public school

Age criteria

- Birth until the day before 21st birthday

Medical diagnostic services vs. treatment services

Treatment

- CCS eligible condition already established
- Authorized for 1 year
- Financial eligibility needed

Medical diagnostic services

- For evaluation to confirm CCS eligible condition
- Authorized for 6 months
- Financial eligibility not needed

CCS Providers

Paneled Physicians

- MD paneling is required for CCS to authorize services.
- MDs go through a paneling application for state approval.
- Provider must have an active Medi-Cal National Provider Identifier (NPI) number, be board certified and have an active California license.

Approved Facilities

- Facilities require state approval to provide services for CCS clients.
- In an emergency, CCS can authorize for a non-approved facility if the MD is paneled.
- Care is coordinated with a CCS-approved facility who will accept the patient.
- Patient must be stable for transfer.

For more information about CCS Provider Paneling, visit:
Becoming a California Children's Services Provider | DHCS

Authorized services

Medical eligibility

- Is the patient less than 21 years old?
- Is the patient medically eligible for CCS?

Financial eligibility

- Is the patient a resident of San Diego or Los Angeles County?
- Is the patient financially eligible for CCS?

Facility approved/MD paneled

- Is the facility approved?
- Is the facility MD paneled?

Services authorized!

- Service authorization or SAR is provided for requested services.

How to refer Blue Shield Promise members to CCS

Assist the family in filling out the CCS Application

- Apply on the website for San Diego County: http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/california_children_services.html
  - Click “How to Apply”
  - Fax the completed application to (858) 514-6514

- Apply on the website for Los Angeles County: LA County Public Health - Children's Medical Services

Or

- Email: CCS@ph.lacounty.gov
- Fax the completed application to (855) 481-6821

For additional assistance families may call Blue Shield Promise at (619) 528-4000

Targeted Case Management (TCM)

TCM is specialized case management services provided by the County/Local Governmental Agencies (LGA's) to Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services.

Targeted Case Management (TCM)

Overview

- The purpose of TCM is to ensure the medical, social and other needs of Medi-Cal enrollees are addressed on an ongoing basis and appropriate choices are provided among the widest array of options to meets those needs.
- Participating Local Governmental Agencies (LGAs) use their certified public expenditures (CPEs) to draw down federal funds.
- Providers of TCM services are LGAs under contract with the Department of Health Care Services (DHCS).
- TCM is funded by local and Federal Title XIX (Medicaid) funds.

Target Population

- Children under the age of 21
- Medically fragile individuals
- Individuals at risk of institutionalization
- Individuals in jeopardy of negative health or psycho-social outcomes
- Individuals with a communicable disease

Definitions of MOU roles and responsibilities

- **Managed Care Plan (MCP) Responsible Person:** Designated by the MCP to oversee MCP coordination and communication with LGA TCM Program. Facilitates quarterly meetings and ensures MCP's compliance with the MOU.
- **MCP - TCM Liaison**: Liaison between MCP and LGA TCM Program. Ensures the appropriate communication and care coordination are ongoing between the parties, facilitates quarterly meetings, and provides updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.
- **LGA TCM Program Responsible Person:** Designated to oversee coordination and communication with the MCP. Facilitates quarterly meetings and ensures LGA TCM Program's compliance with MOU.
- **LGA TCM Program Liaison:** Liaison between MCP and LGA TCM. Ensures the appropriate communication and care coordination are ongoing between the parties, facilitates quarterly meetings, and provides updates to the LGA TCM Program Responsible Person.

Programs

TCM is duplicative to Enhanced Care Management (ECM)

- Members who meet ECM Population of Focus (“POF”) should be enrolled in ECM and may not be enrolled in ECM and the TCM Program at the same time.
- TCM is provided by the county/LGA to assist eligible members in accessing medical, social, educational, and other services. TCM services include assessment, care planning, service coordination, and monitoring.

Eligibility screening and identification

County TCM Program or MCP Enhanced Care Management (ECM) Program

- Initial Screening
    - Upon identification of a member who may be eligible for TCM or ECM services, an initial screening will be done.
    - This will also assess member's needs and current service enrollment. The initial screening will help determine if member is already enrolled in ECM or TCM services and assist in avoiding duplication of services.
    - If a member is not eligible for ECM and would benefit from TCM, a referral can be made to county TCM. If a member is eligible for ECM, the county can refer the member to the MCP for ECM.
- MCP and TCM Program Coordination: MCP and county TCM will cross-check member eligibility and current program enrollment to prevent dual enrollment.
- Coordination of care
    - The MCP will provide the TCM program with a monthly file of members who are enrolled in both TCM and ECM.

TCM Program service components

The TCM Program includes:

- Comprehensive assessment and periodic reassessment of individual client needs, to determine the need for any social, education, medical, social, or other services.
    - Review of client history (may include gathering information from client, family, social workers, medical providers, client supports, or educators).
    - Identification of client needs.
- Development of an Individualized Care Plan (ICP) to address the social, educational or medical needs identified with the client. Progress towards plan goals will continue to be reviewed and goals will be updated as needed.
- TCM Case Management involves activities to help link the client with social, medical, and educational providers or other programs/services that can address identified needs and achieve goals in the care plan.
- Referral and related activities (such as scheduling clients' appointments) to help them obtain needed services.
- Monitoring and follow-up activities.
    - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible client's needs. This may involve the client, individual, family members, service providers, or other entities or individuals, and should be conducted as frequently as needed and/or at 6 months.

TCM additional information

Email TCM general inquiries and questions to: BSCPHMMOUReferrals@blueshieldca.com

Department of Health Care Services (DHCS) TCM web links

- TCM Provider Manual
- TCM Program Requirements Checklist
- TCM On-Line System
- TCM Forms

Blue Shield Promise web links

- Blue Shield Promise home page
- Provider Manual
- Member Handbook
- Community Resources

Additional resources and links

Blue Shield Promise links

Blue Shield Promise

- Blue Shield Promise contact information
- Provider Manual
- Member Handbook
- Community Resources
- For MOU general inquiries, questions and escalations, email BSCPHMMOUReferrals@blueshieldca.com
- For Children's Services Programs inquiries, email MCSPHMChildrensLeaders@blueshieldca.com

Thank you for completing this mandatory training!