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Memorandums of Understanding for

- Women, Infants & Children (WIC)
- Regional Centers

Provider training, 2026

ProvEd_0626_04

Instructions for completing this training

Complete this training to fulfill the requirements outlined in California Department of Health Care Services (DHCS) All Plan Letter (APL) 23-029.

This training covers two Memorandums of Understanding (MOUs): Women, Infants & Children Program (WIC) and Regional Centers - Intermediate Care Facility/Developmentally Disabled Services (ICF/DD)

The full MOUs will be posted on the Memorandums of understanding and agreement page of the Blue Shield Promise website.

Click the links below to review specific sections.

- MOU overview
- Women, Infants and Children (WIC) program MOU with Blue Shield Promise
  - WIC Program referral process
  - Care coordination for WIC participants and relevant covered services
  - WIC resources
- Regional Centers – ICF/DD MOU with Blue Shield Promise
  - Regional Center Early Start program
  - Blue Shield Promise Care Management
  - Regional Centers – ICF/DD resources

Training objectives

1. Define a Memorandum of Understanding (MOU) and its goals
2. Identify key components and requirements of the Women, Infants & Children (WIC) Program MOU with Blue Shield Promise
3. Identify key components and requirements of the Regional Centers MOU with Blue Shield Promise
4. List resources for the WIC Program
5. List resources for Regional Centers

MOU overview

Memorandum of Understanding

Memorandums of Understandings (MOUs) are legally binding and enforceable agreements between Managed Care Plans (MCPs) including Blue Shield Promise, and Third-Party entities. 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.

Goals of an MOU

- 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.

These provisions are intended to ensure that Medi-Cal members receive coordinated, non-duplicative, and timely services and as mandated under APL 23-029, must be reviewed annually by all parties to the MOU.

MCP obligations

- Provide covered services and coordinate member care.
- Meet quarterly with Agency to address care coordination, Quality Improvement (“QI”) activities, QI outcomes, systemic and case- specific concerns.
- Report on MCP’s compliance with the MOU to MCP’s compliance officer at least quarterly.
- Ensure there is sufficient staff to support compliance with and management of the MOU.
- Ensure the appropriate levels of MCP leadership are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from Agency are invited to participate in the MOU engagements, as appropriate.
- Ensure training and education regarding MOU provisions are conducted annually for MCP’s employees responsible for carrying out activities under the MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers.
- Designate an MCP- Agency Liaison. Notify WIC of any changes to the MCP- Agency Liaison in writing as soon as reasonably practical but no later than the date of change and notify DHCS within five (5) working days of the change.
- Require subcontractors, downstream subcontractors and network providers comply the MOU.

WIC Program MOU with Blue Shield Promise

Definitions of roles and responsibilities related to WIC MOU

MCP Responsible Person	MCP-Agency Liaison	Agency Responsible Person	Agency Liaison
MCP-designated person designated who oversees MCP coordination and communication with the Agency Responsible Person, facilitates quarterly meetings, and ensures MCP's compliance with this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices.	MCP-designated person who acts as the liaison between the MCP and Agency. Ensures appropriate communication and care coordination between the Parties, facilitates quarterly meetings, and provides updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.	Agency-designated person who oversees coordination and communication with MCP and ensure Agency's compliance with this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in Agency practices.	Agency-designated person who acts as the liaison between MCP and Agency. Ensures appropriate communication and care coordination, facilitates quarterly meetings, and provides updates to the Agency Responsible Person as appropriate. It is recommended that this person have WIC Program subject matter expertise.

What is the WIC program?

WIC is a free, supplemental nutrition program designed to help pregnant or nursing women, infants and children in families with limited incomes get the best start in life. Funded by the United States Department of Agriculture, WIC provides access to healthy food, health and nutrition education, referrals to other resources and breastfeeding support.

The WIC program serves:

- Pregnant women
- Breastfeeding women
- Non-breastfeeding women
- Women who experienced a pregnancy loss
- Infants and children under 5 years old

Benefits and services

WIC program services include:

- EBT card for access to healthy food including milk, eggs, fruits, vegetables, proteins and whole grains
- Nutrition education and personalized nutrition counseling
- Breastfeeding education, peer counseling and breast pump support
- Prenatal and pediatric health services including health screenings and nutrition assessments
- Community resource referrals for healthcare, housing, and social support programs for holistic well-being

WIC Program eligibility criteria

California residents who meet the following criteria may be eligible for WIC

- Women who are pregnant, breastfeeding or have or are caring for a child under five years old, including:
  - Breastfeeding up to one year after the birth of the baby (postpartum).
  - Non-breastfeeding up to six months after the birth of the baby.
- Postpartum women up to six months after termination or loss of pregnancy.
- Women whose diets can be improved through WIC services.
- Women whose family's household income falls within established limits.
  - Income limits are dependent upon family size (a pregnant woman counts as two people) and are subject to change.
  - Many working families and military families are eligible.
- Infants and children under five years old, including foster children.

WIC Program referral process

How to refer Blue Shield Promise members to WIC

Eligibility assessment

Providers assess patients for WIC eligibility during prenatal, postpartum, and pediatric visits considering age and social risk factors.

Referral process

Providers may initiate referrals through California Department of Public Health (CDHP) WIC, which includes additional information and resources.

Providers may also direct patients to apply in the following ways:

- Apply on the California WIC or text "91997" to schedule an appointment
- San Diego providers may visit the San Diego WIC Program page to learn more. Email wicprogram@scrippshealth.org to see if members qualify, or to make an appointment.
- LA providers may visit https://www.phfewic.org/en/home/
- Visit the CDPH WIC page for more information and referral forms, and for a list of WIC local agencies.

A WIC representative will follow up with the member. Required documents are proof of California residency, proof of family income, identification for enrolling individuals, and proof of pregnancy (if applicable).

Referrals provisions in the WIC MOU

These provisions are intended to ensure that WIC-eligible members are referred to the appropriate WIC services, and to ensure timely, complete referrals and information sharing to support WIC enrollment and coordinated care.

Provider responsibilities include:

- Documentation and compliance. Proper documentation of referrals in medical records ensures compliance with MOU guidelines.
- Identify and refer eligible patients to WIC with focus on patient understanding and support, emphasizing WIC benefits throughout the process.
- Ensure referrals to the WIC Program are properly documented per requirements.
- Share clinical information with the WIC Program including:
    - Height and weight measurements
    - Hemoglobin/hematocrit lab values
    - Blood lead levels
    - Immunization records (for infants/children)
    - Relevant health conditions
- Share all required WIC Program forms and documentation when making referrals or upon request.
- Assist members with obtaining lab tests (if needed).
- Coordinate with Blue Shield Promise and the member to ensure required labs are ordered and completed when missing.

Referrals provisions in the WIC MOU

These provisions are intended to ensure that WIC-eligible members are referred to the appropriate WIC services, and to ensure timely, complete referrals and information sharing to support WIC enrollment and coordinated care.

Provider responsibilities include (continued):

- Follow requirements for coordinating medical formula and nutritional referrals where applicable, including required documentation. Refer to the WIC Formulas and Nutritionals List to view product coverage.
    - After submitting a prior authorization (PA) to Medi-Cal Rx for provision of medical formula and nutritionals, include with the WIC referral, along with the following information:
        - (1) a copy of the Medi-Cal Rx PA denial notification upon receipt from Medi-Cal Rx or an attestation from the provider that the request has been submitted to and denied by Medi-Cal Rx.

        AND

        - (2) a completed WIC Medical Formula and Nutritionals Request Form or a prescription or hospital discharge papers that contain: the WIC Participant's first and last name, a qualifying medical diagnosis, the name of the medical formula and nutritionals, amount required per day, length of time prescribed in months, WIC authorized food restrictions (if applicable), the Network Provider's signature or signature stamp, contact information of the Network Provider who wrote the medical documentation, and the date the Network Provider signed the medical documentation.

Care coordination for WIC participants and relevant covered services

Relevant covered services offered by Blue Shield Promise

The WIC MOU outlines requirements care coordination of WIC participants to ensure they receive coordinated, non-duplicative, and timely services.

Here are some related programs offered by Blue Shield Promise that offer services and benefits to women, infants and children.

- Maternity Program
- Maternal Mental Health
- Promising Start
- Doula services
- Community Health Worker Program (CHW)

Blue Shield Promise member programs

- **The Maternity Program** is a comprehensive care management program designed to support Blue Shield Promise Health Plan members and their partners before, during, and after pregnancy with a goal of improved health outcomes for parents and their infants. Visit the Maternity Program web page for more information.
- To refer Blue Shield members, either complete the referral form and fax it to (844) 893-1211, or call (888) 802-4410.

- **Maternal Mental Health** offers specialized social workers to provide support and referrals to other behavioral health specialists. Click for more information.
- To refer Blue Shield members, complete a maternal mental health screening follow up with a phone call. View instructions are on the Maternal Mental Health web page.

- **The Promising Start Program** offers essential newborn and maternal care products for babies and new parents to incentivize Medi-Cal members to go to a postpartum visit and bring their babies to well-child visits during their first 12 months.
- To refer, ask members to call Blue Shield Promise Customer Service to request enrollment into the program.

Blue Shield Promise member programs, continued

- **Doula services** are available to pregnant and post-partum persons before, during, and after childbirth, including support during miscarriage and stillbirth. They include health navigation, lactation support, development of a birth plan, and linkages to community-based resources to mitigate social determinates of health throughout the pregnancy support life cycle. Visit the Maternity Program web page for more information.
- To refer Blue Shield members, providers must write a recommendation and complete the Maternity Program referral form and fax it to (844) 893-1211. For more information, call (888) 802-4410 (TTY: 711).

Blue Shield Promise member programs, continued

- **Community Health Worker services (CHW)** Community Health Workers (CHWs) are non-licensed public health workers who have personal experience that helps them connect with members. They provide a variety of services including support with chronic health issues, mental health challenges, substance use recovery, and domestic abuse recovery and prevention. Visit the Community Health Worker Services web page for more information.
- To refer Blue Shield members:
  - A written recommendation by a licensed care practitioner is required for members to receive CHW services and prior authorization is NOT required.
  - Complete the CHW Recommendation form and fax it to (844) 742-1152.
  - For members requiring CHW services beyond 12 units in a single year, complete the CHW Benefits Extension Request Form and fax it to (844) 742-1152.

WIC resources

Helpful links to support providers and members

Agency links

- DHCS APL 23-029
- California WIC website
- California Department of Public Health (CDHP) WIC website for health care providers
- Scripps WIC website
- San Diego WIC website
- PHFE WIC website for LA county
- Medi-Cal Rx Prior Authorization Request (DHCS)
- WIC Formulas and Nutritionals List
- WIC Medical Formula and Nutritionals Request Form

Blue Shield Promise links

- Memorandums of understanding and agreement
- Medi-Cal Provider Manual
- Maternity Program (includes information about Promising Start and Doula services)
- Maternal Mental Health Program
- Maternity Program referral form
- Community Health Worker Services
- CHW Recommendation form
- CHW Benefits Extension Request Form
- Contact Blue Shield Promise
- Member Handbook
- Community Resources

Regional Centers – ICF/DD MOU with Blue Shield Promise

Regional Centers

Blue Shield Promise:

- Assists in Identifying and referring members to local Regional Center
- Authorizes and pays for medically necessary needs and prescriptions not provided by Regional Center
- Ensures members are referred for evaluation
- Provides care coordination and case management of medically covered services identified in the Individual Family Service Plan or Individual Program Plan
- Has MOUs with Regional Centers to support care coordination for shared members enrolled in the Developmental Disability Services (DDS) program. These MOUs allow **collaborative care coordination.**

Regional Center services ages 3 and older

Ages 3 - 10 years

- Behavior intervention
- Crisis support
- Day care support
- Incontinence supplies
- IEP support
- In-home respite care
- Overnight/out of home respite
- Parent education classes
- Referrals
- Service coordination
- Social skills training
- Support groups
- Translation
- Transportation

Ages 11 - 17

- Behavior intervention
- Crisis support
- Day care support
- Incontinence supplies
- IEP support
- In-home respite care
- Overnight/out of home respite
- Parent education classes
- Referrals
- Residential homes
- Self-advocacy groups
- Service coordination
- Social skills training
- Some medical equipment
- Support groups
- Translation

Ages 18 and older

- Adult day services
- Behavior intervention
- Crisis support
- Driver training
- Independent living training
- In-home respite care
- Overnight/out of home respite
- Referrals
- Residential homes
- Self-advocacy groups
- Service coordination
- Social skills training
- Some medical equipment
- Supported employment
- Supported living

Regional Center eligibility

Age

Substantial disability

Diagnosis

A person may receive services at any age, but the developmental disability diagnosis must occur during the "developmental period" from birth to 18 years.

Regional Center eligibility

Age

Substantial disability

Diagnosis

"Substantial disability" means:

1. A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of services to assist the individual in achieving maximum potential; and,

2. The existence of significant functional limitations in three or more of the following areas of major life activity, as appropriate to the person's age:
   - Receptive and expressive language
   - Learning
   - Self-care
   - Mobility
   - Self-direction
   - Capacity for independent living
   - Economic self-sufficiency

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Regional Center eligibility

Age

Substantial disability

Diagnosis

The primary Department of Health Care Services (DHCS) diagnosis must be a developmental disability.

- Developmental disabilities include:
  - Autism spectrum disorder
  - Cerebral palsy
  - Epilepsy or seizure disorder
  - Intellectual disability
  - Other conditions closely related to intellectual disability that require similar treatment such as neurofibromatosis, tuberous sclerosis, or Prader-Willi syndrome

- Regional Centers don't provide services to persons solely diagnosed with:
  - Deafness or blindness
  - A learning disability (dyslexia, etc.)
  - A mental illness (schizophrenia, bipolar disorder, etc.)
  - A speech disorder

Regional Center intake process

1. Local Regional Center “Intake” department contacted, and phone screening completed
2. Potential client and family interviewed by Intake Service Coordinator (at office and/or home)
3. Available medical, psychological, and school records reviewed
4. School or community observation may be conducted
5. Other clinicians may also assess the potential client (physician, psychologist, OT/PT, etc.)
6. Psycho-social intake assessment completed (see below for details)
7. Clinician team makes eligibility determination (if ineligible, referred to other resources)
8. Eligible clients assigned a Service Coordinator
9. An Individual Program Plan is developed with the client, family, and Service Coordinator

The psycho-social assessment covers birth and developmental history, family constellation and functioning and the applicant’s abilities in the following areas: cognitive, motor, communication, social, emotional, educational/vocational, and self-care/independent living skills.

Regional Center Early Start program

Regional Center Early Start services

- Behavior intervention
- Early identification assessment
- Early intervention programs
- Family training
- Feeding therapy
- Incontinence supplies
- Individual Family Service Plan
- Nursing supports
- Nutrition services
- Occupational therapy
- Physical therapy
- Referrals
- Service coordination
- Special instruction
- Speech therapy
- Support groups
- Translation
- Transportation

Regional Center Early Start eligibility

Age

Substantial delay

High risk

Infants and toddlers from birth to 3 years of age (0-36 months)

Regional Center Early Start eligibility

Age

Substantial delay

High risk

Experiences a 25% delay in at least one developmental domain:

Adaptive – daily activities, self-help skills
Cognitive – learning, problem solving
Communication – speech, language
Physical – gross motor, fine motor
Social and emotional – interactions with others, managing emotions

Regional Center Early Start eligibility

Age

Substantial delay

High risk

Has a risk factor for developmental delays or disabilities such as:
Prematurity of <32 weeks' gestation and/or low birth weight.
Prenatal substance exposure.
A parent with a developmental disability.

Are born with a condition with a known probability of causing a developmental delay or disability such as:
Genetic conditions (e.g., Down syndrome).
Cerebral palsy.

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Blue Shield Promise Care Management

Blue Shield Promise Care Management

Because both Regional Centers and Blue Shield Promise Care Management (CM) offer care coordination, **services may be duplicative**.

To avoid duplication:

1. DHCS sends a monthly file of members who are enrolled in the Regional Center.
2. Blue Shield Promise CM compares the list to its internal CM enrollment to identify overlap.
3. Blue Shield Promise conducts outreach to assess the member's needs and provides the appropriate CM services in partnership with the Regional Center to ensure services are aligned and not duplicated.

Care Management program overview

- Program designed to help members understand their current health status, health care needs, and treatment plan.
- Care Managers consist of **nurses, social workers, community health workers, and care coordinators** who work with members "where they are at" to provide support, guidance, education and resources to help members meet their health goals.
- Referrals for Care Management come from a variety of sources: members, doctors, medical groups, family members and community advocates.
- Care Management is a limited term program. Our goal is to graduate members to be independent to navigate the health care system.
- Learn about Blue Shield Promise programs on Provider Connection.

Care Management conditions and needs

Care Management often includes supporting members with the following conditions or needs:

- Readmission in last 30 days
- Hospital discharge
- Skilled nursing facility discharge
- Cancer
- Diabetes
- Hypertension
- Multiple co-morbidities
- History of nonadherence to treatment
- Pregnancy
- Lack of education of disease course or process
- Social Determinants of Health (SDOH) needs
- Behavioral health needs such as depression and anxiety

Care Management Services

- Understand your care if you have multiple health conditions
- Avoid frequent emergency room visits
- Get transportation to see your doctors
- Make sense of your medications
- Navigate the health care system
- Address social drivers of health
- Connect with your plan benefits and resources in your community
- Transitional care services following a hospital or nursing facility stay

Levels of Care Management

Enhanced Care Management
Intended for highest risk members who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems.

Complex Care Management
Intended for high-risk members who need coordination of services for complex conditions or episodic need.

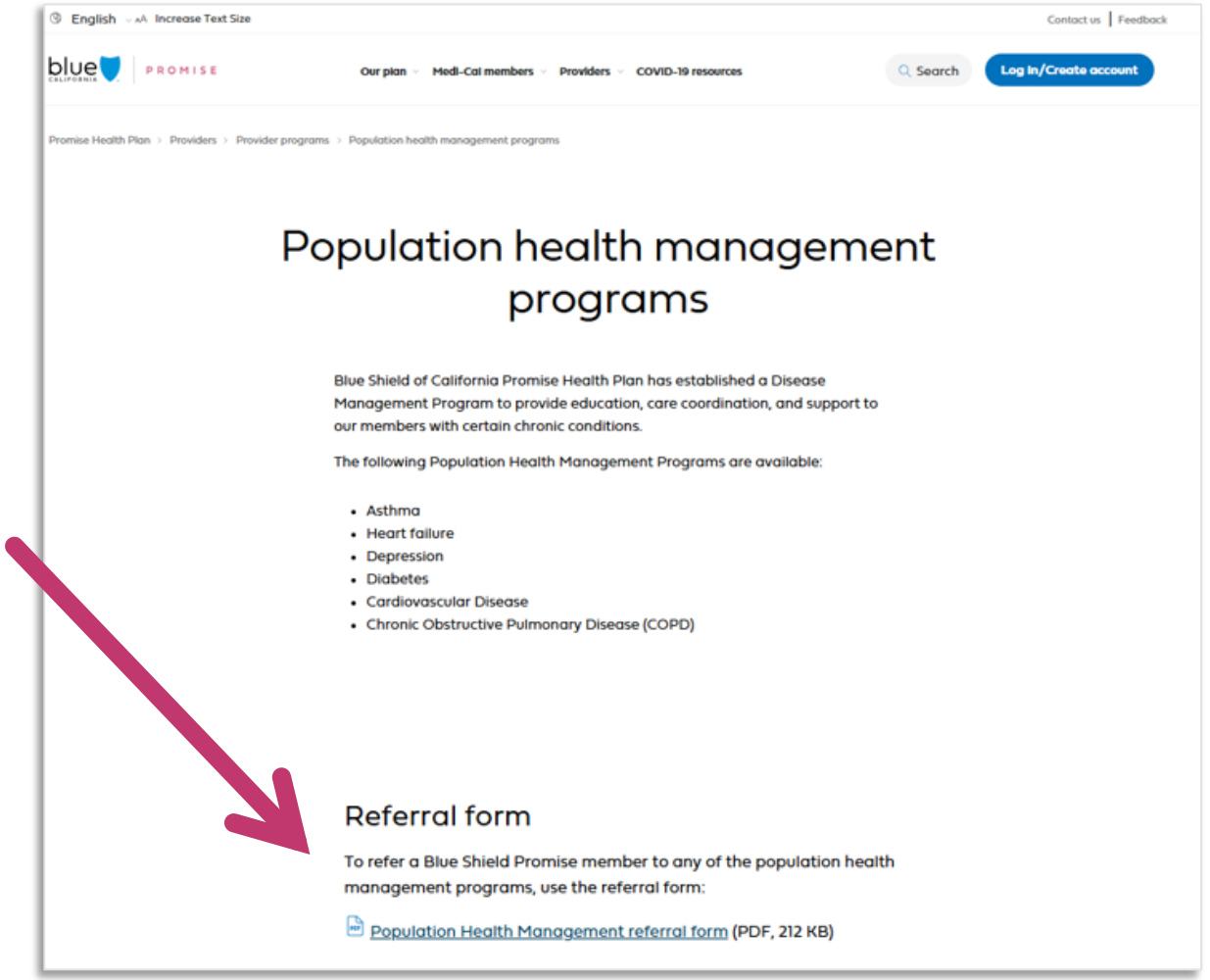
High Risk Care Management
Intended for members who require support with planning and coordination that is not at the highest level of complexity, intensity, or duration.

Population Health Management Referral Form

To refer a member, complete the Referral form located in our Population health management programs page.

[Population health management programs | Blue Shield of CA Promise Health Plan]

Questions? Contact Blue Shield Promise Children's Services Team at MCSPHMChildrensLeaders@blueshieldca.com



Transportation

Members can utilize transportation services to see their Provider and to obtain medically necessary covered services at no cost.

Non-Emergency Medical Transportation (NEMT)

- ✓ Requires physician certification
- ✓ For the purpose of obtaining needed medical care
- ✓ Includes transportation by ambulance, litter van, wheelchair van medical transportation services, etc.
- ✓ Authorized when a member's medical or physical condition does not allow them to travel by general public and private transportation

Non-Medical Transportation (NMT)

- ✓ Does not require physician certification
- ✓ For medically necessary covered services
- ✓ Unlimited round trips to approved medical services by car, taxi or public/private transportation

Program services summary

Regional Center services ages 3-22	Early Start services to age 3
Adult day services	Behavior intervention
Behavior intervention	Early identification assessment
Crisis support	Early intervention programs
Day care support	Family training
Driver training	Feeding therapy
Incontinence supplies	Incontinence supplies
Independent living training	Individual Family Service Plan
IEP support	Nursing supports
In-home respite care	Nutrition services
Overnight/out of home respite	Occupational therapy
Parent education classes	Physical therapy
Referrals	Referrals
Residential homes	Service coordination
Self-advocacy groups	Special instruction
Service coordination	Speech therapy
Social skills training	Support groups
Some medical equipment	Translation
Support groups	Transportation
Supported employment	
Supported living	
Translation	
Transportation	

Regional Centers – ICF/DD resources

Regional Centers Resources

Regional Centers	Regional Centers Early Start
Department of Developmental Services Regional Centers Website	Department of Developmental Services Early Start Website
Los Angeles County Regional Centers directory	Contact and intake numbers
San Diego Regional Center	Healthcare providers brochure
Patient zip-code RC look-up	FAQ
Medical information	**Free family resources:**
Early signs of autism video	Reasons for concern pamphlet
Developmental disability facts	Family guide to intervention
CDC resources	Family introduction to Early Start
Parent information	

Authorizations, concurrent review, claims, and credentialing

Authorizations

- ✓ New authorization requests must include accurate Treatment Authorization Request (TAR) form.
  - ✓ Only fill out section 1 and facility request type in section 2.
  - ✓ Certification for Special Treatment Program Services form HS231 from the Regional Center.

Concurrent review process

- ✓ Provide updated Regional Center authorization to the Blue Shield Promise utilization manager on or before last day covered or when requested. Fax requests to (844) 200-0121.
- ✓ Blue Shield Promise will:
  - ✓ Fax the authorization letter to the number provided on the TAR.
  - ✓ Provide authorizations for 12 months and may approve up to two (2) years at a time.

Claims

- ✓ Submit claims on Provider Connection at https://www.blueshieldca.com/en/provider/claims.

Credentialing process

- ✓ As a Managed Care Plan, Blue Shield Promise adheres to Department of Health Care Services (DHCS) guidelines.

Blue Shield Promise contacts

Provider help

- ✓ For questions about claims, authorizations, how to use Provider Connection, and more, call Provider Customer Service at (800) 468-9935 6 a.m. to 6:30 p.m., Monday through Friday. Available 24/7 for hospital admissions.
- ✓ For additional resources, download the Resources Quick Reference guide

Long Term Services and Support (LTSS)

- ✓ For LTSS inquiries, email PHPSNFProvInquiries@blueshieldca.com.

WIC and Regional Centers referrals

- ✓ For WIC and Regional Centers referrals, inquiries, or escalations, email: BSCPHMMOUReferrals@blueshieldca.com