MEDICAL PROGRAM HIGHLIGHTS AND THERAPEUTIC FORMULA POLICIES

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Medi-Cal (MC) Eligibility

Apply to County Welfare Department for eligibility:

- Determination of aid code
- Can be:
  - full scope
  - restricted services, or
  - share of cost
- Annually, family must undergo re-determination of eligibility
Fee-For-Service Delivery

- Family seeks services from any willing certified MC provider
- Provider must submit a Treatment Authorization Request (TAR) to MC Operations Field Office
- Provider submits claim to Electronic Data Systems (EDS) the fiscal intermediary for regular MC
- With an approved TAR, the product can be dispensed and the claim submitted for payment
- EDS adjudicates and pays claim
Medi-Cal Managed Care Models

- County Organized Health Systems (COHS)
- Geographic Managed Care (GMC)
- Two-Plan
## County Organized Health Systems (COHS)

- Santa Barbara Regional Health Authority
  - Santa Barbara County
- Health Plan of San Mateo
  - San Mateo County
- Partnership Health Plan of California
  - Solano, Napa, & Yolo Counties
COHS (con’t)

- CalOptima
  - Orange County

- Central Coast Alliance for Health
  - Santa Cruz County and Monterey County
COHS Qualities

- Locally developed & operated managed care organization (MCO)
  - Governing Board approved by County Board of Supervisors
- Capitated arrangements and full risk contracts
- Providers must be MC certified
- Enrollment is mandatory
- No fee-for-service option in county
Geographic Managed Care (GMC)

- Sacramento County
  - Molina Health Plan
  - HealthNet
  - Blue Cross
  - Kaiser
  - Western Health Advantage
  - Care 1st
GMC (con’t)

- San Diego County
  - Community Health Group
  - Blue Cross
  - Health Net
  - Molina
  - Care 1st
  - Kaiser
GMC Model

- Noncompetitive application process
- No local/community health plan
- Capitated arrangements & full risk contracts
- Mandatory enrollment for specific aid codes
- Members choose from several commercial plans
- No fee for service option for mandatory beneficiaries
Two-Plan Model

- Members choose between Commercial Plan or Local Initiative (LI)
- LI is a community developed HMO (quasi-governmental)
- Commercial plan is selected via competitive procurement
- Capitated arrangements & full risk contracts
- Enrollment mandatory for specific aid codes
- No fee-for-service option for mandatory beneficiaries
Two-Plan Counties

- Alameda
- Contra Costa
- Fresno
- Kern
- Los Angeles
- Riverside
- San Bernardino
- San Francisco
- San Joaquin
- Santa Clara
- Stanislaus
- Tulare
County Organized Health Systems (COHS) enrollment is automatic at time of eligibility determination:

- All beneficiaries, all aid codes
- County submits electronic data tape to State (MIS/DSS)
- State forwards data to Plans
Two-Plan and GMC Enrollment

- Mandatory aid codes
  - Public assistance aid codes
  - Percent of poverty aid codes
- Voluntary aid codes
  - Aged, blind and disabled
- Ineligible
  - Some restricted aid codes and share of cost
Medical Exemption Requests (MERs)

- MERs are requests to be exempted from managed care enrollment because the beneficiary is in treatment with a non-managed care doctor.
- MERs are reviewed for mandatory aid code beneficiaries
- Exemption criteria include:
  - Pregnancy
  - AIDS/HIV
  - Critical medical condition
  - Transplants
  - Dialysis
  - Cancer
MERs (con’t)

- Forms are completed by the beneficiaries’ physician and certified under penalty of perjury
- MERs are evaluated by MMCD nurses in the Medical Monitoring Unit
Health Care Options (HCO) Program

- Maximus is the enrollment contractor for the Dept Health Services (DHS) and operates the HCO program

- HCO makes presentations at County Welfare Depts about managed care plan choices

- HCO sends enrollment packages to new MC beneficiaries in managed care counties
Health Care Options (HCO) Program (con’t)

- HCO process choice forms and initiate automatic assignment (default) of mandatory beneficiaries who do not choose a plan.

- HCO maintains a toll free beneficiary assistance line (800-430-4263) for:
  - Questions about managed care plan choices
  - Enrollment
  - Help in finding a plan with a desired physician
Provider Networks

Health Plans have sub-contracts with:

- Individual physicians
- Medical clinics
- Physician groups
- Hospitals
- Pharmacies
- Labs
- Ancillary providers
- FQHCs
- Indian Health Clinics
- Rural Health Clinics
- Etc.
Provider Network Requirements

- Ratio: 1 primary care physician to 2,000 members
- PCP must be located within 30 minutes or 10 miles of members’ residence, unless health plan has an approved alternative time and distance standard.
- Health plan must have physician available 24 hrs per day 7 days a week for coordination with ER.
Provider Network Requirements (con’t)

- Demonstrate contracts or arrangements with over 28 specialty physicians
- Members must have access to 24 hour oral interpreter services
Carved Out Services

- Major organ transplants (not kidney)
- Long term care
- CA Children Services (CCS)
- Specialty mental health
- Alcohol and substance abuse treatment
- Dental services

- Acupuncture
- Adult day health care
- Some psychotherapeutic drugs
- Some HIV and AIDS drugs
MCMC Ombudsman

A toll free number 888 - 452 – 8609 to:

- Help beneficiaries having problems contacting their plan, accessing services, or navigating the managed care system
- Coordinate and process all State fair hearing requests submitted by beneficiaries enrolled in a managed care plan
MEDI-CAL APPLICATION AND ELIGIBILITY
Applying to Medi-Cal
Applying to Medi-Cal

- Apply at a local county welfare office. Some hospital & county clinics take applications.
- The MC application is the same whether applying for regular MC or MC managed care.
- Non-citizens may be eligible for limited scope MC, i.e., pregnancy and emergency services.
- Applications can be mailed; face-to-face interviews with eligibility workers are not necessary.
Applying to Medi-Cal (con’t)

- It typically takes 45-90 days to determine eligibility.

- WIC families **must choose** a managed care plan if residing in a managed care county.

- If they do NOT choose, one will be chosen for them.

- WIC families can always change plans by contacting the enrollment contractor, MAXIMUS at the 800 number
Presumptive Eligibility

- Can be established for a limited number of beneficiaries who provide information that appears to meet the eligibility criteria.

- Can be established by some physicians and hospitals who have been certified and have the computer software.

- Only covers 2 months: the month when applying & the month after applying.

- Ends after the 2\textsuperscript{nd} month if the beneficiary does NOT complete and submit a full MC application to a county welfare office.

- Only available to pregnant women and children < 1 yr.
Accelerated Enrollment
CHDP Gateway

- Offered through the Child Health and Disability Prevention (CHDP) Program

- CHDP Gateway is a process where information from a CHDP application is used to determine MC eligibility. This eliminates the need for a separate application.

- It is also referred to as CHDP Gateway and means an accelerated process to establish MC eligibility.
WIC Roles and Responsibilities

- Refer WIC families to a county welfare office to apply for MC or to download an application from the Internet.

- Go to GOOGLE and type in *Medi-Cal application*.

- The application is self explanatory; encourage WIC families to return it to the county for processing.

- Refer families to the MC managed care plan membership services office for questions about why formula is NOT authorized. See All Plan Letter and MCMC Membership Services list contact #s.
General Medi-Cal Issues:

Health Plan Changes and Procedures
CA Children’s Services (CCS) & Medi-Cal Managed Care (MCMC)

- Generally, CCS services are carved out of most MCMC plans.

- MCMC plans must:
  - Coordinate provision of care when a member is eligible for both CCS and MCMC programs.
  - Provide all non-CCS covered services
CCS and MCMC (con’t)

- Not all LBW preemies are eligible for CCS; they must have an eligible CCS covered condition for CCS to pay for therapeutic formula.

- Coordination of care occurs with MCMC and Regional Centers. Workgroups of both county and managed care plan staff meet regularly with Regional Centers.

- Regional Centers do NOT pay for therapeutic formula if beneficiaries are eligible for MC.
Inappropriate Referrals to WIC

MCMC has been informed about:

- Inappropriate referrals to WIC from MCMC physicians
- Physicians writing prescriptions for formula not covered by the MCMC plan
Inappropriate Referrals to WIC

MCMC has:

- Provided contract manager training to initiate discussions with MCMC plans
- Addressed the issue in the MCMC plan Medical Directors meetings
- Drafted an All Plan Letter (APL) to provide policy direction to MCMC plans on the coverage of therapeutic infant formula.

The APL is included in this package; WIC may use it for a reference.
Denial of Medi-Cal (MC)

- Refer a WIC participant without MC coverage to the county welfare office to apply for MC.

- Income never disqualifies for MC; it only impacts share of cost, i.e., may have a share of cost for income $\geq 200\%$ federal poverty.

- Having other health coverage does NOT disqualify someone for MC

- All applicants receive a Notice of Action (NOA) from the county welfare office within 45-90 days advising about eligibility effective date or denial of eligibility.

- MC eligibles must first use their private insurance before MC will pay for services.
Private or Military Insurance

- Military insurance never disqualifies a person from MC. It is similar to other health coverage (OHC).
- Often MC scope of coverage is more generous than OHC and covers services not paid for by OHC.
- The MC application (MC-210) clearly states on page 5 that OHC does not disqualify a person for MC.
- It is appropriate for participants with OHC to apply for MC if their OHC:
  - Does not cover some services
  - Has a large co-pay
  - Is not accessible to them where they live
Formulas Paid by Medi-Cal

Referrals to MC are based on eligibility; not diagnosis.

There are no “typical diagnoses” for referral for treatment for therapeutic formulas.

The primary care provider (PCP) determines appropriate medically necessary “treatment with therapeutic formulas” for medical conditions.

WIC should refer the infant/child to their PCP whenever there are concerns about:
- Growth and development
- Inappropriate weight gain/loss
- Anorexic/malnutrition issues
- Other conditions that may need medical evaluation
Formulas Paid by Medi-Cal

The most common diagnoses referred to MC Field Offices for approval of Treatment Authorization Requests (TAR) include:

- Colic
- Failure to thrive
- Malabsorption syndrome
- Prematurity
- Soy or milk allergies
- Other metabolic syndromes.
Formulas Covered by Medi-Cal Approval Criteria

- All MCMC plans cover medically necessary infant formulas.
- Each plan has its own formulary and determines medical necessity.
- For regular Fee-for-Service MC, the MC Provider Manual states:

  *Enteral formulas are covered, subject to prior authorization, if used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food.*

- Although therapeutic enteral formulas are not considered “pharmaceuticals,” they are provided by means of a prescription that the beneficiary takes to a pharmacy.
All Plan Letter & Formula Covered and Approved by MCMC

The draft APL, "Therapeutic Enteral Formulas for Medical Conditions in Infants and Children," will require MCMC plans to inform their providers about their:

- Formulary list of approved therapeutic formulas
- Processes to approve medically necessary therapeutic formulas
- Authorization procedures for provision of therapeutic formulas
- Timeliness standards
- Requirements for periodic physical assessment and follow-up
MCMC Plans are required to execute a Memorandum of Understanding (MOU) with the WIC program for MCMC services provided to its members through the WIC program.

County WIC directors may raise these questions with health plans via the local county (MOU) process.
Types of Formulas Paid by MCMC Plans

- All contracted MCMC plans cover enteral formulas when medically necessary.
- Plans make their own decisions about types of enteral formulas covered and can add/delete enteral formula products.
- County WIC directors can request plan-specific information about covered products via the local county health department MOU process.
- Request this information directly by contacting the MCMC plan membership services office or health and benefit manager.
Medi-Cal Approval of Formulas for Allergies and FTT

- MC managed care plans must have written criteria or guidelines for Utilization Review.
- Plans determine criteria used to review and approve services (e.g., AAP, Milliman & Robertson, Interqual, others).
- When evidence of medical necessity is provided, approval is based on the medical need as assessed by the PCP and reasons for decision must be clearly documented.
- Qualified health care professionals supervise review decisions and a qualified physician will review all denials.
What Is a Treatment Authorization Request (TAR)?

- A TAR is a request by a physician for approval of medical services in regular Medi-Cal (MC).

- A retail pharmacist submits TAR to a MC Field Office for medical products.

- The TAR is adjudicated by a state employed, licensed pharmacist based on medical necessity.

- The pharmacist reviews the diagnosis, medical justification, patient’s profile, drug and medical history and other pertinent information prior to making a decision.
How a TAR Is Processed

- Providers can send pharmacy TARs for enteral products directly to regular Medi-Cal Northern and Southern Field Offices (FO) via fax or online.
- The FO consultant reviews and takes appropriate action. The on-line automated system typically results in a decision within 24 hrs.
- A TAR is denied when medical necessity criteria is not met for services requested.
- Beneficiaries can request an appeal of denial of a TAR.
- Providers may appeal denied TARs by submitting to the FO documentation within 60 calendar days from the date of the original decision.
How to Submit Prescriptions and Request Therapeutic Formulas

- Regular Fee-For-Service MC: follow the TAR process outlined previously
- MCMC: PCP must evaluate the infant/child and a treatment request or prescription made according to plan procedures. Medical necessity criteria for the requested service must be met.
- MCMC members are prescribed enteral formulas available on the plan formulary.
- The beneficiary can appeal any denied service.