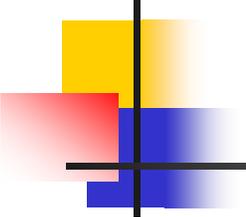


MEDI-CAL PROGRAM HIGHLIGHTS AND THEREAPEUTIC FORMULA POLICIES

Vivian Auble, Chief, Plan Management Branch
California Department of Health Services
Medi-Cal Managed Care Division

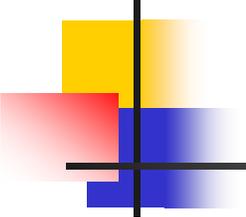




Medi-Cal (MC) Eligibility

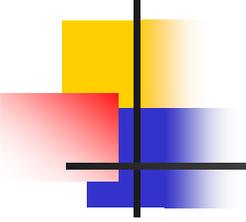
Apply to County Welfare Department for eligibility:

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



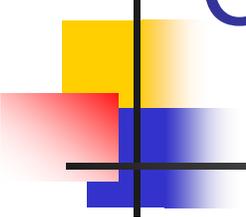
Fee-For-Service Delivery

- 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



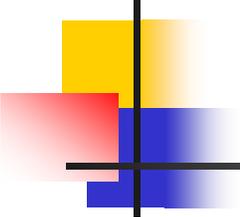
Medi-Cal Managed Care Models

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



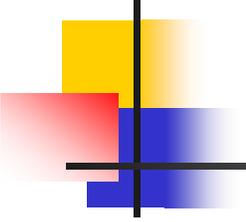
County Organized Health Systems (COHS)

- 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



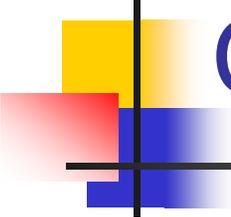
COHS (con't)

- CalOptima
 - Orange County
- Central Coast Alliance for Health
 - Santa Cruz County and Monterey County



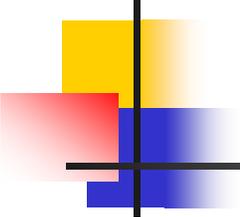
COHS Qualities

- 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



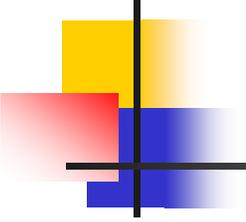
Geographic Managed Care (GMC)

- Sacramento County
 - Molina Health Plan
 - HealthNet
 - Blue Cross
 - Kaiser
 - Western Health Advantage
 - Care 1st



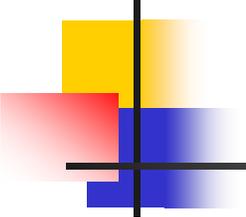
GMC (con't)

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



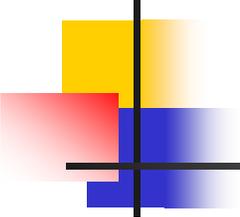
GMC Model

- 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



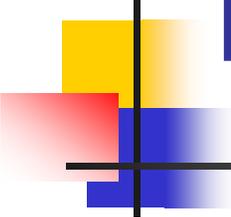
Two-Plan Model

- 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

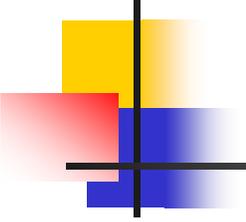
- Alameda
- Contra Costa
- Fresno
- Kern
- Los Angeles
- Riverside
- San Bernardino
- San Francisco
- San Joaquin
- Santa Clara
- Stanislaus
- Tulare



Medi-Cal Managed Care Enrollment

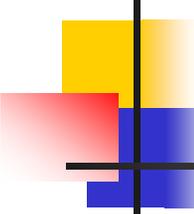
County Organized Health Systems (COHS) enrollment is automatic at time of eligibility determination:

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



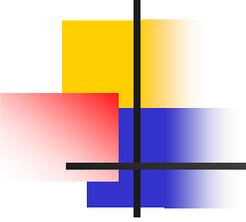
Two-Plan and GMC Enrollment

- 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



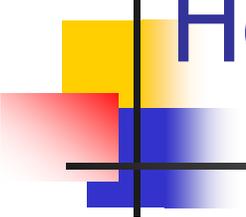
Medical Exemption Requests (MERs)

- 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



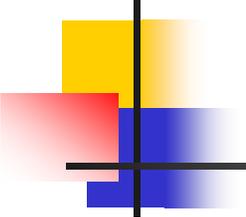
MERs (con't)

- Forms are completed by the beneficiaries' physician and certified under penalty of perjury
- MERs are evaluated by MMCD nurses in the Medical Monitoring Unit



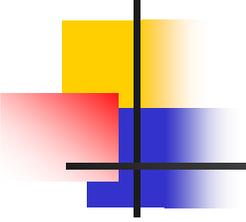
Health Care Options (HCO) Program

- 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)

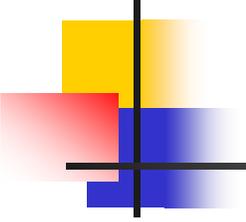
- HCO process choice forms and initiate automatic assignment (default) of mandatory beneficiaries who do not choose a plan
- HCO maintains a toll free beneficiary assistance line (800-430-4263) for:
 - Questions about managed care plan choices
 - Enrollment
 - Help in finding a plan with a desired physician



Provider Networks

Health Plans have sub-contracts with:

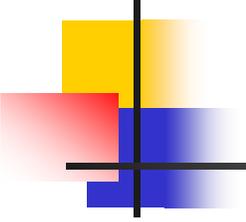
- Individual physicians
- Medical clinics
- Physician groups
- Hospitals
- Pharmacies
- Labs
- Ancillary providers
- FQHCs
- Indian Health Clinics
- Rural Health Clinics
- Etc.



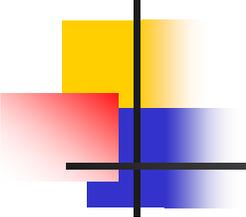
Provider Network Requirements

- 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)

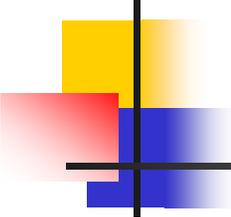


- Demonstrate contracts or arrangements with over 28 specialty physicians
- Members must have access to 24 hour oral interpreter services



Carved Out Services

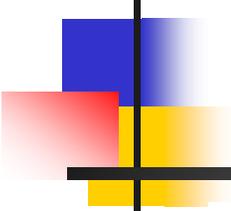
- Major organ transplants (not kidney)
- Long term care
- CA Children Services (CCS)
- Specialty mental health
- Alcohol and substance abuse treatment
- Dental services
- Acupuncture
- Adult day health care
- Some psychotherapeutic drugs
- Some HIV and AIDS drugs



MCMC Ombudsman

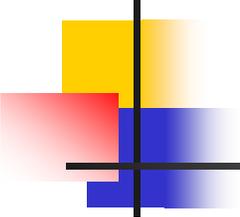
A toll free number 888 - 452 – 8609 to:

- 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



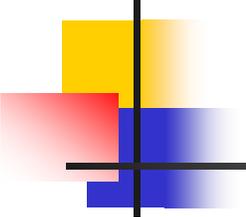
MEDI-CAL APPLICATION AND ELIGIBILITY





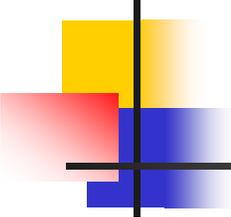
Applying to Medi-Cal





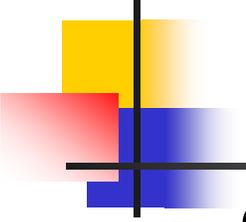
Applying to Medi-Cal

- 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.



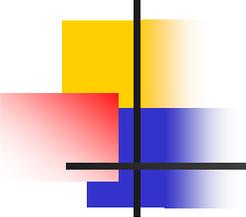
Applying to Medi-Cal (con't)

- 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



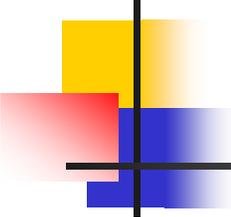
Presumptive Eligibility

- 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 2nd 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.



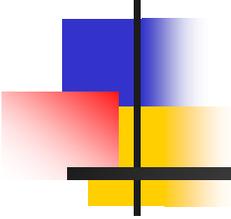
Accelerated Enrollment CHDP Gateway

- 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.



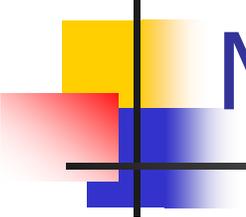
WIC Roles and Responsibilities

- 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.



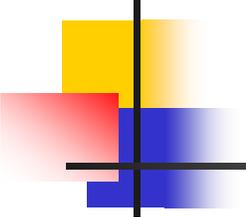
General Medi-Cal Issues:

Health Plan Changes and Procedures



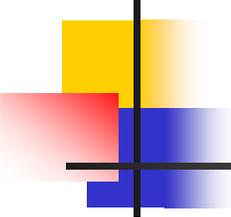
CA Children's Services (CCS) & Medi-Cal Managed Care (MCMC)

- 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)

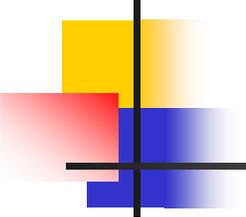
- Not all LBW preemies are eligible for CCS; they must have an eligible CCS covered condition for CCS to pay for therapeutic formula.
- Coordination of care occurs with MCMC and Regional Centers. Workgroups of both county and managed care plan staff meet regularly with Regional Centers.
- Regional Centers do NOT pay for therapeutic formula if beneficiaries are eligible for MC.



Inappropriate Referrals to WIC

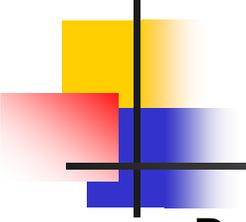
MCMC has been informed about:

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



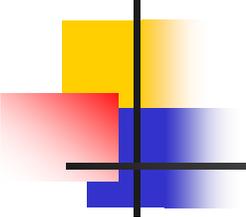
Inappropriate Referrals to WIC

- 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.



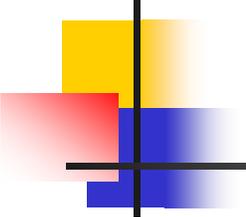
Denial of Medi-Cal (MC)

- 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.



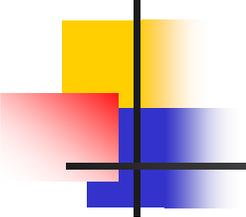
Private or Military Insurance

- 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

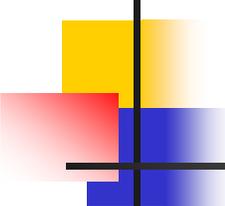
- Failure to thrive

- Malabsorption syndrome

- Prematurity

- Soy or milk allergies

- Other metabolic syndromes.

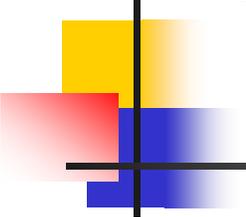


Formulas Covered by Medi-Cal Approval Criteria

- 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.

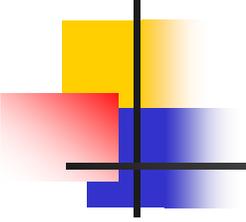
- Although therapeutic enteral formulas are not considered “pharmaceuticals,” they are provided by means of a prescription that the beneficiary takes to a pharmacy.



All Plan Letter & Formula Covered and Approved by MCMC

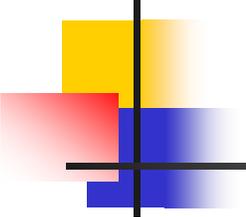
The draft APL ,“Therapeutic Enteral Formulas for Medical Conditions in Infants and Children,” will require MCMC plans to inform their providers about their:

- 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



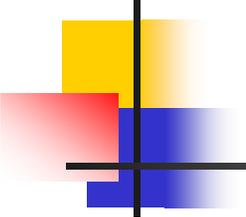
Formulas Covered by MCMC Approval Criteria

- 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.



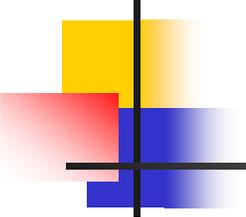
Types of Formulas Paid by MCMC Plans

- 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.



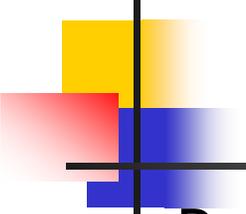
Medi-Cal Approval of Formulas for Allergies and FTT

- 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.



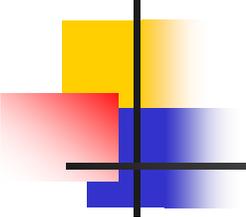
What Is a Treatment Authorization Request (TAR)?

- 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.