Whole Child Model: FAQs for Providers

(Questions following January 1, 2019 implementation)

January 23, 2019

ELIGIBILITY/CARE COORDINATION

I have a child who has CCS and is a part of the WCM and Partnership is saying that no RAF's are required. However, this patient does not have a CCS SAR – do I still see the member?

Yes. If you check eligibility on PHC's Provider Portal and they are CCS Eligible/Whole Child Model Healthplan (WCM) then they do not need a RAF. It is always a good idea to take a screen shot of eligibility page.

If a CCS member shows up at the PCP and it is not their Medical Home, should the PCP still see the member?

Yes, the Provider should still see the member. CCS members are not capitated and can go to providers of their choosing. Do reach out to care coordination to work with the member on either changing their medical home or to help them understand their PCP/Medical Home location.

Is it correct that there will be some CCS members that will still go through the county for services instead of PHC?

Yes if they are not a PHC member (do not have a PHC ID card), their CCS conditions will be managed by the County.

Can CCS members cross county for their Medical Home?

PHC feels it is best to have a Medical Home that is within the member's county of residence to meet their needs. Please contact the PHC Case manager for further information

Where does it tell the provider the WCM Diagnosis for eligibility?

The link to the DHCS website lists conditions that may be eligible for CCS. The CCS County Offices still determine eligibility.
https://www.dhcs.ca.gov/services/ccs/pages/medicaleligibility.aspx

Does the initial referral for CCS continue to be faxed to county of residency for the patient and do we still send the clinical information with a SAR?

Yes, the initial referral for CCS needs to be sent to the county of residency for the patient. The county CCS will continue to determine CCS eligibility. You can continue to send the clinical information for determination with or without a SAR form to the county. Once the county determines eligibility, they will notify PHC and going forward you will use our TARs to get authorization for treatments that are listed on our TAR requirements. Note that CCS members do not need referral authorizations. Please contact your local CCS office if you have further questions about their process.

Is the CCS office determining initial CCS eligibility and continued eligibility?

Yes

Since your office will request clinical updates when needed, do we still send weekly updates to CCS office as well?

Once the County has determined CCS eligibility, you will not need to send them updates. The PHC Care Coordination team will request clinical updates and work with the member and their providers to get their CCS eligibility re-determined by the County each year.

CLAIMS

If a CCS member who has PHC sees a provider that is not a PHC provider, will we continue to pay their claim?

Yes, as long as they are Medi-Cal enrolled, will bill PHC, and will accept our rates. We will continue to pay their claim fee-for-service

Are there CCS kids who might not be PHC and for whom we would pay that claim?

No, we would not pay the claim if they were not PHC.

If we are an Indian Health Services clinic, will we still receive OMB rate?

Yes.

If the CCS diagnosis is not listed on a claim for a WCM client, is it denied or just paid at the regular Partnership Health Plan rate?

If the CCS diagnosis is not listed on a claim, it will be reviewed and processed per Medi-Cal and/or PHC guidelines.

UTILIZATION MANAGEMENT

My team is trying to understand if your team utilizes a list of ICD-10 to guide your utilization review process in determining if a baby has a CCS eligible medical condition.

The county CCS offices still determine eligibility for CCS. The following is a link to the DHCS page listing eligible CCS conditions.
https://www.dhcs.ca.gov/services/ccs/pages/medicaleligibility.aspx

Can a specialist just submit a TAR, or do they have to use up the SAR?

They can submit a TAR for treatment if a TAR is required. Please refer to the link below for a list of services that require a PHC TAR.
http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf

Do we need to notate that a patient is open to CCS on the TAR request or just the claim?

It is helpful to notate that the patient is open to CCS on the TAR but is not a TAR requirement. The same is also true for a claim; not required, but helpful information.

If someone needs infusion, who should provide the TAR for infusion?

The infusion center should be providing the TAR for the service they are providing. If the PCP has problems with the infusion center not wanting to do the TAR, please reach out to your PR Rep for assistance.

Do inpatient TARs need to have a separate accompanying professional TAR or are all inpatients services (facility and professional) covered under one authorization?

No, a separate TAR is not needed. All inpatient services are covered under one authorization.

Will the WCM continue to cover batteries and other hearing aid supplies like CCS would?

Yes, CCS benefits do not change.

We previously needed to mail in a copy of the HCFA1500 form along with an invoice of the supplies to Medi-Cal. Do we continue to mail these invoices to Medi-Cal's address or do we mail it to PHC's address?

Please send to PHC and include the invoice. If you would like to do electronic billing, please contact us.

It sounds like we will need to obtain TARs for any services that are completed, is this correct?

No, the TAR requirement list can be accessed here: http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf. TARs only need to be completed for those services on the TAR Requirement list.

What happens if we miss the 15-day window to get a TAR sent? Do our claims get denied?

PHC does have a window of 15-days from the date of service for outpatient services. In-network hospitals must notify PHC of an inpatient admission the next day. If there are extenuating circumstances, the provider should describe those circumstances on the TAR form.

On the PHC TAR form, it gives the option for retro TAR. How far back does PHC retro TARs?

15 days. Again, if there are extenuating circumstances the provider can call Utilization Management at (707) 863-4133.

For retroactive TAR requests, is the 15 days post-date of service (calendar or business days)?

Business days

For Admit Notification, is there a separate fax number for WCM patients?

No, the fax number is (707) 863-4118

If PHP is secondary to commercial, do we still need to provide Admit Notification? If so, what is required?

Not in normal circumstance. PHC does not require Admission notification if another insurance has primary responsibility. However, if the member exhausts his/her primary insurance benefits you must notify PHC as soon as you become aware of it, as PHC will then become the primary payer. To submit a claim you will need to send the EOB or denial letter with each claim.

Can Urgent Direct Admits from same-day or next-day admissions from clinic appointments be handled as Admit Notification the next day?

Yes, within 24 hours of admittance.

Typically billing is on the backend of the process, how do other health centers proactively manage and track TARs on the front end? Is this part of the preregistration process?

TARs are submitted by the provider performing the service. For example, if it is an MRI being done then the MRI group does the TAR. Every Health Center has their own process, but the TAR is generally approved before having the service done so it could be included as part of the registration process.

Does the provider need to be contracted with PHC in order to submit a TAR?

No, they do not need to be contracted for TAR approval, but they do need to be Medi-Cal enrolled. If they have a SAR we will honor the SAR until its expiration date. For Continuity of Care they should then complete a TAR 15 business days prior to the SAR expiration. Non-contracted providers need to submit paper TARs. Please refer to the link below. http://www.partnershiphp.org/Providers/HealthServices/Pages/Utilization-Management.aspx

Are labs and vision capitated?

Yes, VSP is capitated for all counties. Labs are capitated to QUEST in Solano, Napa, Yolo, Marin, Sonoma. All other counties are fee-for-service lab.

Based on the webinar, we understand that a TAR is not required if PHC is secondary to commercial, is that correct?

Yes that is true.

Does PHC maintain a separate list from Medi-Cal for reference that identifies whether a CPT code requires an authorization?

Our TAR requirements list is located on our website at http://www.partnershiphp.org/Providers/HealthServices/Pages/Utilization-Management.aspx under Submitting Referrals and Authorizations and some items are different from Medi-Cal.

Whole Child Model: FAQs for Providers

(November 14, 2018)

What is the Whole Child Model (WCM) program?

A program developed out of Senate Bill (SB) 586 to improve care coordination for primary, specialty, and behavioral health services for California Children Services (CCS) and non-CCS conditions. The benefits are consistent with CCS program standards and provided by CCS paneled providers, specialty care centers, and pediatric acute care hospitals.

What children qualify for WCM?

A child would qualify if he/she is:

- Under the age of 21
- A PHC member
- Eligible for CCS

How will we find out if the patient is a CCS-eligible member prior to rendering services?

PHC contracted providers can use the PHC Provider Portal (https://provider.partnershiphp.org/UI/Login.aspx) to verify eligibility and note whether the member is flagged as a CCS member. Providers may also call our Member Services (800-863-4155) to see if a member is CCS-eligible.

After January 1, 2019, who determines CCS eligibility?

Eligibility will remain the responsibility of each county's CCS program or DHCS depending upon county of the child's residence.

How will the hospital's relationship with county CCS staff change?

After January 1, 2019:

- County CCS staff remain responsible for determining CCS eligibility
- Treatment for CCS-eligible conditions should be submitted and billed to PHC
- Please see the PHC TAR requirements at http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf

How will the outpatient provider's relationship with county CCS staff change?

After January 1, 2019:

- County CCS staff remain responsible for determining CCS eligibility
- Treatment for CCS-eligible conditions should be submitted and billed to PHC
- Please see the PHC TAR requirements at http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf

Will SAR's approved prior to January 1, 2019, be honored for continuing care that started prior to January 1, 2019?

Yes. PHC will honor and pay for all services approved on a SAR until the SAR expires, as long as the member remains eligible for coverage. When the SAR expires and care needs are ongoing, the provider will be required to submit at Treatment Authorization Request (TAR) at least 15 business days prior to the expiration date. To access a list of TAR Requirements go to http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf.

Does a PCP need to complete a Referral Authorization (RAF) for a CCS member to be seen by a specialist?

No.

After January 1, 2019, what will the authorization process entail?

PHC will use our standard review processes for all requested services.

- New TAR(s) will be reviewed for medical necessity based upon:
  - PHC's policies
  - CCS Numbered Letters
  - Evidence Based Guidelines
- Pediatric Medical Directors provide program oversight
  - Any potential TAR denial will require medical director review
- Expiring SAR(s) / TAR(s) require a new TAR 15 business days prior to expiration
- Please see the PHC TAR requirements at http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf

Do PCP services for a Whole Child Member require a TAR?

Most PCP services do not require a TAR. Please refer to the PHC TAR requirements at http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf.

Do all Medical Supply / Durable Medical Equipment items need an authorization?

Certain medical supplies / durable medical equipment do not require a TAR. Please see the PHC TAR requirements at http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequirements.pdf.

After January 1, 2019, what will the authorization and payment process for neonatology services entail?

Neonatology services:

- That started prior to January 1, 2019, may be covered under existing SARs. Providers should submit their claims directly to the PHC, noting the SAR number on that claim
- NICU concurrent review process will cover Inpatient Neonatal Services that begin on or after January 1, 2019
- Outpatient follow-up visits do not require a TAR

After January 1, 2019, who authorizes CCS hospital services?

TARs for scheduled hospital admissions require a TAR. For unplanned hospital admissions, PHC will perform concurrent review for all hospital services.

How will Partnership work with the Counties' Medical Therapy Program/Unit (MTP/MTU)?

The MTP/MTU will continue to provide therapy to members and make recommendations for DME needs. PHC will review the TARs received from the DME provider(s).

Will the appeal and fair hearing process be available to CCS children under PHC managed care?

Yes. All CCS children will retain their rights to CCS program appeals and fair hearings.

Will WCM members have access to the CCS provider network?

PHC is committed to ensure that our members receive continuity of care whenever possible for a minimum of 12 months. When a CCS-eligible child or youth is already receiving care from a

non-contracted provider, the child or youth may remain with that non-contracted CCS provider for up to 12 months, if the provider:

1. Agrees to continue care for the child
2. Accepts the contract rate
3. Has no outstanding quality of care issues
4. Willing to bill PHC. PHC will work closely with these children and their families to ensure access to care

Will WCM members be linked to a PCP?

Many of our PHC CCS members already have a Medical Home/PCP and this will continue. Transitioning CCS members will be able to choose a Medical Home/PCP and will not be capitated to the provider, but will be paid Fee-for-Service (FFS). We do not expect any disruption for your existing patients

Will WCM members be capitated to a PCP office?

No. The provider will be paid Fee-for-Service (FFS).

If providers are currently credentialed with PHC, but not CCS-paneled, do they need to become CCS-paneled by CCS?

If a physician would like to see a CCS member for a CCS condition, then he/she must be paneled for CCS. To access the CCS provider paneling application, please visit: https://cmsprovider.cahwnet.gov/PANEL/index.jsp.

After January 1, 2019, will PHC contract providers that are interested in participating in the CCS program?

Providers wanting to contract with PHC to provide care must be Medi-Cal certified. Providers can contact our Provider Relations (707-863-4100 or eSystemsSupport@partnershiphp.org) for more information on this process.

For physical / occupational therapy offices, how can we find out if the patient is a CCS-eligible member prior to rendering services?

PHC contracted providers can use the PHC Provider Portal (https://provider.partnershiphp.org/UI/Login.aspx) to verify eligibility and note whether the member is flagged as a CCS member. Providers may also call our Member Services (800-863-4155) to see if a member is CCS-eligible.

Will the WCM affect my PCP QIP? If yes, how?

The impact will be small for family medicine sites and slightly larger for pediatric sites. The changes to note will be as follows:

- Because additional patients may be assigned to you, there will be an increase in member months, which will affect your total potential payout. More member months = more payout because for any given measure, the formula for payout is (rate x QIP points x MM). Actual total payout will depend on the actual performance of the total population.
- The number of patients in your denominator may go up depending on the measure. This is determined by how many patients have been assigned to you continuously for 9 months during the measurement year, and the specific measure in question. This will primarily impact the pediatric practices and the measures for which you are held accountable.
- The same exclusions for QIP denominators will still apply – meaning no one who is enrolled

in another type of insurance (e.g. Medicare, Medi-Medis) will be included in the denominator. For more information regarding the QIP program, please e-mail: QIP@partnershiphp.org.

Is PHC's drug criteria different from CCS' medication criteria?

PHC and CCS may have differences in their formulary and drug criteria, however, PHC will comply with all WCM State requirements.

How can a provider verify if a medication is on the PHC formulary?

The provider can access the formulary on the PHC website www.partnershiphp.org or at https://client.formularynavigator.com/Search.aspx?siteCode=9588242881.

Can providers submit for early authorization(s) to PHC prior to January 1, 2019, to prevent interruption in care for their patients?

Please do not submit any TAR(s) for CCS members residing in current carve-out counties prior to January 1, 2019. These carve-out counties are prepared to continue to process SARs until EOB December 31, 2018. Based on current state instructions, all SARs in pending status with CCS after December 31, 2018, will continue to be the responsibility of the county. You may want to ensure refills are available through this transition to avoid potential issues.

Will providers need to submit SARs to CCS after January 1, 2019?

After January 1, 2019, medications that are non-formulary to PHC will require a TAR submitted to PHC for review and consideration. Though certain PHC drug criteria may be different from CCS. PHC will ensure our pharmacy processes are compliant with all WCM requirements set forth by the State.

If a medication is non-formulary, how does a provider submit a TAR to PHC?

The provider has two options:

1. They can provide the TAR information: diagnosis, medical justification, and any other relevant information to the patient's dispensing pharmacy so that they can submit the TAR on their behalf
2. The provider can submit the TAR themselves using our paper TAR form and faxing it to the PHC Pharmacy Department (*707-419-7900*). The PHC Pharmacy TAR form can be found with this link: http://www.partnershiphp.org/Providers/Pharmacy/Documents/TAR/MCTAR.pdf

Are CCS-paneled clinicians required to go through the specialty pharmacy referenced for specialty or limited distribution drugs (LDDs)?

Yes.

- Walgreens is our direct contract specialty pharmacy for limited set of specialty medications
- If Walgreens does not carry a certain specialty medication, the CCS-paneled clinician can have the prescription filled through another specialty pharmacy that have access to the medication
- Walgreens can deliver prescriptions to the member's home or to a local Walgreens Pharmacy

After January 1, 2019 which CCS services will be paid by PHC?

PHC will receive and process claims for all CCS and non-CCS covered services for PHC Medi-Cal members. Claims can be submitted to PHC electronically using the PHC's secure EDI site or

via hard copy claim mailed to the following address: PHC, PO Box 1368, Suisun City, CA 94585-1368.

NOTE: for all services authorized on a SAR by the County CCS programs prior to January 1, 2019, the SAR Number will need to be noted on the claim form in order for those services to be paid.

When submitting a claim to PHC do providers need to include "CCS" on the claim?

No. When submitting a CCS claim, providers need to ensure the CCS diagnosis is included on the claim as well as the SAR number if the service was authorized under a SAR prior to January 1, 2019.

Do any of these changes affect patients with PHC as secondary insurance?

Yes. There are some children included in WCM where PHC is the secondary insurance. A provider should ensure benefits are billed to primary insurance before billing PHC.

After January 1, 2019 what will the payment process for neonatology services entail?

PHC will also pay for CCS inpatient neonatology services effective January 1, 2019. Providers should submit their claims directly to PHC. The State originally planned to assume responsibility of payment for these services; however, in early June of 2018, the State decided PHC would assume this responsibility instead.

Note: All members that are not assigned to PHC, those services will continue to be processed by the County CCS offices.

There are numerous services and benefits provided to CCS families that are not included in regular Medi-Cal. Will PHC continue to provide those enhanced services to CCS children and their families under WCM?

Yes.

Can providers refer members for behavioral health services? If so, are these only for certain CCS diagnoses?

PHC works with a partner, Beacon Health Options (Beacon), to provide these services. Members can be referred by their provider or they can call Beacon directly at 1 (855) 765-9700.

Will PHC provide transportation benefits to CCS children and their families?

Yes. PHC will follow the same transportation benefits that they received from their county programs.

Will a WCM member have a case manager or care coordinator?

Yes, PHC has Care Coordination staff dedicated to the WCM program.