PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MCUP3027 (previously UP100327)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Members with Limited Benefits</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Archived Date: 05/11/2022</td></tr>
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I. RELATED POLICIES:

A. MCUP3014 – Emergency Services
B. MCUG3118 – Prenatal and Perinatal Care
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MC313A – Wellness and Recovery Program Enrollment

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims

III. DEFINITIONS:

A. Aid Codes developed by the State of California to facilitate the Administration of Medi-Cal: This list allows the provider to determine which services a recipient qualifies for and what services the provider may claim under Medi-Cal regulations. County Eligibility departments assign the Aid Codes, subject to State and federal guidance, when the person is determined to be eligible for Medi-Cal. PHC is financially responsible for certain Aid Codes as identified in the Department of Health Care Services (DHCS) Aid Codes Master Chart.
B. Emergency Medical Condition: A condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
   1. Placing the health of the member (or, in the case of a pregnant member, the health of the member and/or member's unborn child) in serious jeopardy
   2. Serious impairment to bodily functions; or
   3. Serious dysfunction of any bodily organ or part
C. IRCA: Immigration Reform and Control Act of 1986
D. Medi-Cal Fee-for-Service (FFS): The component of the Medi-Cal Program in which Medi-Cal Providers are paid directly by the State for services not covered under the PHC/ Department of Health Care Services (DHCS) Medi-Cal Contract.
E. Medi-Cal Managed Care: The component of the Medi-Cal Program in which Medi-Cal Providers are contracted directly with and paid directly by PHC as the managed care health plan that is contracted with DHCS for provision of Medi-Cal benefits and services.
F. OBRA: Omnibus Budget Reconciliations Act
G. Wellness and Recovery Program (W&R): PHC's regional Drug Medi-Cal Organized Delivery System waivered program for members in designated counties within PHC's service area.

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IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To define the benefits available to members with limited services coverage.

VI. POLICY / PROCEDURE:
A. Limited Scope Members:
1. Some members of Partnership HealthPlan of California (PHC) have a limited scope of benefits. These members have the following Aid Codes:

Restricted/Limited Aid Code Category	Aid Code(s)	Limited Services
LTC	53 -	LTC services only (PHC responsible for facility fee only)
IRCA/OBRA[1]	D2, D3, D4, D5, D6, D7, 55	Limited LTC, emergency services, and pregnancy (Applies to Solano, Napa, and Yolo counties only)
IRCA/OBRA[1]	C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D8, D9, 58, 5F	Limited pregnancy and emergency services (non-emergency dental benefits available during pregnancy) (Applies to Solano, Napa, and Yolo counties only)
Limited to ER only	5G -	Emergency services only (Applies to Solano, Napa, and Yolo counties only)
Limited to Pregnancy only[2]	5N -	Pregnancy services only - (Applies to Solano, Napa, and Yolo counties only)
Breast and Cervical Cancer (BCC)[3]	ØU -	Breast / Cervical Cancer treatment AND emergency, pregnancy, LTC services only under age 65
BCC Treatment[3]	ØT -	Breast / Cervical Cancer treatment only
BCC Treatment[3]	ØR -	Breast / Cervical Cancer treatment only (these members have other insurance w/ deductible greater than $750)

B. All members, including those with a limited scope of benefits, are eligible for inpatient and outpatient services that are necessary for the treatment of an emergency medical condition as defined in III. B. above. Emergency services are defined as those required for the alleviation of severe pain, or immediate

As per the California Advancing and Innovating Medi-Cal (CalAIM) draft All Plan Letter (APL) Attachment 3 "Mandatory Managed Care Enrollment (MMCE) Requirements," the following changes are effective January 1, 2022:

[1] OBRA beneficiaries will transition from the Medi-Cal managed care delivery system to Medi-Cal Fee for Service (FFS).
[2] Beneficiaries receiving pregnancy-related Medi-Cal services prior to January 1, 2022, will remain in their current delivery system through the end of the individual's postpartum period. New enrollments on January 1, 2022, and forward, will enroll into mandatory managed care.
[3] Beneficiaries in the Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual) will transition from Fee-For-Service (FFS) to Medi-Cal managed care on January 1, 2022.

diagnosis of unforeseen medical conditions which, if not immediately diagnosed and treated, would lead to disability or death. Services that fall into this category do not require prior authorization, but inpatient days do require authorization upon admission.

1. The Medi-Cal coverage for individuals whose eligibility is limited to emergency services begins at the point when the emergency condition is diagnosed by the attending provider and ends when the emergency condition is stabilized.
2. Continuation of medically necessary inpatient hospital services and follow-up care after the emergency is stabilized, is not covered. This means that treatment aimed at a cure or long-term solution to the problem, related to the underlying chronic medical condition, is not authorized or reimbursed by PHC.
3. While both inpatient and outpatient services that are necessary to stabilize the emergency medical condition are covered, follow-up care that may be necessary to restore the member to health is not covered.
4. Emergency services rendered in an emergency room, urgent care facility, or provider's office are paid on a Fee for Service (FFS) basis for conditions on the PHC Emergency Medical Conditions list. (See policy MCUP3014 Emergency Services Addendum C) All other care is considered either urgent or routine and payment is denied.
5. Claims for emergency services for limited scope members are reviewed for medical necessity by the Health Services staff. Services for conditions that do not meet the emergency condition definition are denied payment by the Chief Medical Officer or physician designee.
6. Dialysis and related services are considered emergency services, however, for tracking purposes a Treatment Authorization Request (TAR) is required.
7. Routine prenatal care, labor and delivery, routine post-partum care, and family planning are considered pregnancy-related services. Medical conditions which might complicate the pregnancy are covered. Routine post-partum care including family planning is available for the month of, and the month following, the delivery.
    a. Newborns are covered for full scope under the mother's limited eligibility for treatment of emergency medical conditions for the month of birth and the following month.

C. Wellness and Recovery Program Beneficiaries:

1. Medi-Cal enrollees in specific PHC Wellness and Recovery (W&R) counties who are not members of Partnership HealthPlan, are eligible for the services provided under the W&R program. As shown in the chart below, these members are assigned certain Aid Codes by their County Eligibility departments, subject to State and federal guidance, when they are determined to be eligible for Medi-Cal.

PHC Aid Codes Eligible for W&R (W&R counties only- Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano)	1E, 1H, 10, 14, 16, 17, 36 2E, 2H, 20, 24, 26, 27, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, 60, 64, 66, 67, L6, 01, 02, 03, 04, 07, 08, 2P, 2R, 2S, 2T, 2U 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 30, 32, 33, 34, 35, 37, 38, 39, 4A, 4F, 4G, 4H, 4L, 4M, 4N, 4S, 4T, 4W, 40, 42, 43, 45, 47, 49, 5C, 5D, 5K, 54, 59, 7A, 7J, 7S, 7W, 7X, 72, 82, 83, 8U, 0A, 0E, 0M, 0N, 0P, 0W, H1, H2, H3, H4, H5, K1, 3F, E2, E5, M3, M5, M7, P5, P7, P9, R1, T1, T2, T3, T4, T5, 86, 87, 13,23, 63, L1, M1, 7U, 8P, 8R 58, 5F, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9
State Aid Codes Eligible for W&R (W&R counties only- Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano)	E1, E4, H7, H0, H6, H9, H8, K6, K7, K8, K9, L7, J1, J2, J3, J4, M0, M2, M4, M6, M8, M9 P1, P2, P3, P4, P6, T6, T7, 1U,1X, 1Y, 4E, 2C, 44, 3D, 3T, 3V, 48, 5E, 5T, 5W, 6U, 7C, 7M, 7N, 7P, 76, 8E, 8G, 8L, 8T, 8V, 8W, 8X

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VII. REFERENCES:

A. The Aid Codes Master Chart developed for use in conjunction with the Medi-Cal Eligibility Verification System
B. Wellness and Recovery (W&R) Designated Aid Code List (PHC document MS02-04)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 06/16/95; 10/10/97 (name change only); 06/02/00; 06/20/01; 09/18/02; 10/20/04; 10/19/05; 10/18/06; 10/17/07; 10/15/08; 11/17/10; 11/28/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 10/14/20; 11/10/21; ARCHIVED 05/11/2022

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.