TABLE OF CONTENTS

Section 2: Benefit Programs 2-1

Health Plan Medi-Cal Managed Care (HMO) 2-1
Obtaining Coverage and Exclusions Information 2-1
Services Covered by Health Plan 2-1
Services Not Covered by Health Plan 2-1
Enhanced Care Management (ECM) 2-2
Community Supports 2-8
Major Organ Transplant 2-13
Medi-Cal Rx: Transition 2-13

Health Plan of San Joaquin
Mountain Valley Health Plan

SECTION 2: BENEFIT PROGRAMS

HEALTH PLAN MEDI-CAL MANAGED CARE (HMO)

Medi-Cal is California's Medicaid health care program serving children and adults with limited or no income. People eligible for coverage include families, seniors, people with disabilities, children in foster care, pregnant women and childless adults who meet certain income and eligibility requirements. Health Plan provides high quality, accessible and cost-effective health care to Medi-Cal Members through our managed care delivery system which is structured as a health maintenance organization (HMO). Our Medi-Cal product in San Joaquin, Stanislaus, Alpine and El Dorado counties provides a full range of medical benefits and Covered Services.

A primary advantage for Medi-Cal individuals enrolling in Health Plan is the opportunity to develop ongoing relationships with Primary Care Physicians (PCP) and other Participating Providers (Providers) in a Group or clinic that can support preventative as well as acute care. The primary benefit to Providers is the ability to better coordinate and more efficiently manage Member care by working with a local managed care plan.

OBTAINING COVERAGE AND EXCLUSIONS INFORMATION

Health Plan covers, at a minimum, those medically necessary core benefits and services specified in the agreement with the California Department of Health Care Services (DHCS). Excluded services will not be reimbursed by Health Plan. To ensure that the services provided to Members are covered, please review the *Medi-Cal Combined Evidence of Coverage and Disclosure Form* for the appropriate year. This document can be found on the Health Plan's website www.hpsj-mvhp.org.

If you are not currently part of the Health Plan's Provider network, you can still access the *Health Plan's Medi- Cal Combined Evidence of Coverage and Disclosure Form* on our website. You can also obtain information from the DHCS Medi-Cal Benefits Division at www.dhcs.ca.gov or visit the Medi- Cal website at www.medi-cal.ca.gov.

SERVICES COVERED BY HEALTH PLAN

Covered Services refers to the health care services and items Health Plan provides to its Members through its health care programs. Health Plan's health care programs currently include Medi-Cal HMO but may also include other health care programs and/or products that Health Plan may offer to individuals or other entities.

SERVICES NOT COVERED BY HEALTH PLAN

Non-Covered Services typically refer to the following health care services and items:

- Health care services and items which are not the financial responsibility of Health Plan but are covered on a fee-for-service basis by the Medi-Cal Program

- Health care services and items which are not covered by the Medi-Cal program
- Health care services and items which are not covered under any other Health Plan health care program (excluded services)

For a complete list of excluded services for Health Plan's Medi-Cal HMO program, please review the *Medi-Cal Combined Evidence of Coverage and Disclosure Form*, which is available on the website at www.hpsj-mvhp.org.

ENHANCED CARE MANAGEMENT (ECM)

CalAIM is a multi-year initiative led by DHCS that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries. Enhanced Care Management (ECM) and Community Supports are part of CalAIM.

Enhanced Care Management (ECM) is a Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

ECM Populations of Focus include:

- ECM eligible members transitioning from WPC Program
- Individuals Experiencing Homelessness
- Adult High Utilizers
- Adult with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)
- Adults and Youth Transitioning from Incarceration
- Adults at Risk for Institutionalization and Eligible for Long-Term Care
- Nursing Facility Residents Who Want to Transition to the Community
- Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
- Children and Youth
    - Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
    - Children and Youth at Risk for Avoidable Hospital or ED Utilization
    - Children and Youth with Serious Mental Health and/or SUD Needs
    - Children and Youth Enrolled in CCS or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition
    - Children and Youth Involved in Child Welfare
    - Children and Youth with I/DD
    - Pregnant and Postpartum Youth
    - Birth Equity/Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes who are subject to Racial and Ethnic Disparities

ECM Providers who are contracted with Health Plan to provide ECM services must adhere to the following provider terms and conditions in accordance with their contract and requirements as set

forth in this provider manual.

Providers of Enhanced Care Management (ECM) are required to:

- Be community-based entities, with experience and expertise providing intensive, in-person care management services to individuals in one or more of the populations of focus for ECM.
- Comply with all applicable state and federal laws and regulations and all ECM program requirements.
- Have capacity to provide culturally appropriate and timely in-person care management activities, including accompanying Members to critical appointments when necessary.
- Deliver care in culturally and linguistically appropriate and accessible ways.
- Have formal agreements and processes in place to collaborate and coordinate care with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including community support providers.
- Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the Member care plan.
- Enroll as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters, including Provider C redentialing/Recredentialing and Screening/Enrollment (APL 19-004), if a state-level enrollment pathway exists.
- Comply with the Health Plan's process for vetting the provider, which may extend to individuals employed by or delivering services on behalf of the provider, to ensure it can meet the capabilities and standards required to be a provider of ECM if APL 19-004 does not apply to a provider.
- Return an authorization request and proposed individualized plan of care consistent with Health Plan's process for such request.
- Identify Members who would benefit from ECM and send an authorization request and proposed individualized plan of care, consistent with Health Plan's process for such request.
- Upon communication of new Member assignments to provider within 10 days of ECM authorization, immediately accept all Members assigned by Health Plan for ECM, with the exception that a provider should be permitted to decline a Member assignment if provider is at its pre-determined capacity. Provider should immediately alert Health Plan if it does not have the capacity to accept a Member assignment.
- Provider should ensure assignments are conducted in an equitable and non-discriminatory manner.
- Upon initiation of ECM, ensure each Member assigned has a lead care manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical,

behavioral, developmental, oral health, long-term services and supports (LTSS), specialty mental health services, drug Medi-Cal organized delivery system services, and any community supports and other services that address social determinants of health (SDOH) needs, regardless of setting.

- Advise the Member on the process for switching providers, which is permitted at any time. Provider should conduct due diligence to notify Health Plan if the Member wishes to change Providers.
- Maintain adequate staff to ensure its ability to carry out responsibilities for each assigned M ember, consistent with contractual obligations and any other related DHCS guidance.
- Be responsible for conducting outreach and engagement to each assigned Member into ECM, in accordance with Health Plan's policies and procedures. Provider should prioritize those with highest level of risk and need for ECM.
- Outreach should be conducted primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.
- Provider should use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: Mail, Email, Texts, Telephone Calls, and Telehealth.
- Comply with non-discrimination requirements set forth in State and Federal law and the agreement with Health Plan.
- Obtain, document, and manage Member authorization for the sharing of personally identifiable information between Health Plan and ECM, Community Supports, and other providers involved in the provision of Member care to the extent required by federal law.
    - Member authorization for ECM-related data sharing is not required for the provider to initiate delivery of ECM unless such authorization is required by federal law.
    - When federal law requires authorization for data sharing, provider should demonstrate that it has obtained Member authorization for such data sharing back to Health Plan.
- Provider shall notify Health Plan to discontinue ECM in a timely manner (no greater than 10 business days) under the following circumstances:
    - The Member has met their care plan goals for ECM;
    - The Member is ready and consents to transition to a lower level of care.
    - The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
    - Contact with the Member has been unsuccessful despite multiple documented attempts.
- When ECM is discontinued, or will be discontinued for the Member, the provider is responsible to send a closure of case management notice to the Member with a copy to

Health Plan within 5 business days.

- Providers should document and submit a report of the Members who have declined/opted out of ECM services, or remain unable to reach for each month, no later than the 15th of the following month.
- Provider should communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).
- When ECM is discontinued, or will be discontinued for the Member, Health Plan is responsible to send a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA.
- Providers of ECM should ensure:
    - The ECM approach is delivered in a person-centered, goal oriented, and culturally appropriate manner.
    - Each Member receiving ECM has a lead care manager.
    - Each Member has a written, prioritized, culturally relevant individualized care management plan.
    - Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources.
    - Alert the Health Plan and follow Health Plan instructions to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources.
    - To collaborate with area hospitals, primary care providers, behavioral health providers, specialists, dental providers, providers of services for LTSS and community support providers to coordinate member care.

- Provider shall provide all core service components of ECM as noted below to each assigned M ember, in compliance with Health Plan's policies and procedures:
    a. Outreach and engagement of HPSJ members into ECM.
        a. Provider shall make five (5) attempts over the course of 30 days.
    b. Comprehensive assessment and care management plan, which shall include, but is not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in- person contact
        b. When in-person communication is unavailable or does not meet the needs of the Member, the provider shall use alternative methods (including telehealth) to provide care.
    c. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and as may be needed

to inform the development of an individualized care management plan.

d. Develop a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
e. Incorporate into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community based and social services, and housing;
f. The care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the care management plan; and
g. The care management plan is reviewed, maintained, and updated under appropriate clinical oversight.

- Enhanced Coordination of Care, which shall include, but is not limited to:
    a. Organizing patient care activities, as laid out in the care management plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the member's care management plan.
    b. Maintaining regular contact with all providers, that are identified as being a part of the M ember's multi-disciplinary care team, whose input is necessary for successful implementation of member goals and needs.
    c. Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
    d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
    e. Communicating the Member's needs and preferences timely to the Member's multi- disciplinary care team in a manner that ensures safe, appropriate, and effective person- centered care; and
    f. Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

- Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:

a. Working with Members to identify and build on successes and potential family and/or support networks;
b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and, supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

- Comprehensive Transitional Care, which shall include, but is not limited to:
  a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
  b. For Members who are experiencing, or who are likely to experience, a care transition:
     i. Developing and regularly updating a transition of care plan for the Member;
     ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
     iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
     iv. Coordinating medication review/reconciliation; and
     v. Providing adherence support and referral to appropriate services.

- Member and family Supports, which shall include, but are not limited to:
  a. Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and the Health Plan.
  b. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws.
  c. Ensuring the Member's provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s).
  d. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services.
  e. Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care

instructions for the member; and,

f. Ensuring that the Member and the primary care provider has a copy of their care plan and information about how to request updates.

- Coordination of and Referral to Community and Social Support Services which shall include, but are not limited to:
    a. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by the Health Plan as community supports; and,
    b. Coordinating and referring Members to available community resources and following up with members to ensure services were rendered (i.e., "closed loop referrals").

COMMUNITY SUPPORTS

Community supports are flexible wraparound medical or social services that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. They are provided as substitute for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. Examples include housing navigation, recuperative care, and meals/medically tailored meals. These services are optional for the plan to offer and beneficiary to accept.

DHCS has preapproved a 14 community supports as part of CalAIM. Plans, such as Health Plan, may elect the community supports they will provide and may elect to add or remove after the implementation. Health Plan offers the following community supports for San Joaquin, Stanislaus, Alpine and El Dorado counties.

- Housing Navigation and Transition Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post Hospitalization Housing
- Recuperative Care
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation
- Environmental Accessibility Adaptations (Home Modifications)
- Day Habilitation Programs
- Personal Care and Homemaker Services
- Respite Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home

Providers of community supports are required to:

- Be community-based medical and social service providers with experience and/or training in providing one or more of the community supports approved by DHCS.
- Enroll in Medi-Cal, pursuant to DHCS APLs, including APL 19-004, Credentialing/ Recredentialing and Screening/Enrollment, if a State-level enrollment pathway exists. If APL 19-004 does not apply to a community support provider, the community support provider will comply with Health Plan's process for vetting the community support provider, which may extend to individuals employed by or delivering services on behalf of the community support provider.
- The community support provider shall have the capacity to provide the community support in a culturally and linguistically competent manner.
- If the community support provider subcontracts with other entities to administer its functions of community supports, the community support provider shall ensure agreements with each entity bind each entity to applicable terms and conditions.
- Deliver contracted community support services in accordance with DHCS service definitions and requirements.
- Maintain staffing that allows for timely, high-quality service delivery of the community supports that it is contracted to provide.
- Accept and act upon Member referrals from Health Plan for authorized community support unless the community support provider is at pre-determined capacity.
- Follow Health Plan community support authorization guidelines.
- Conduct outreach to the referred member for authorized community support as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment.
- Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week.
- Coordinate with other providers in the Member's care team, including ECM Providers, other community support providers and Health Plan.
- Comply with cultural competency and linguistic requirements required by Federal, State and local laws, and in contract(s) with Health Plan; and
- Comply with non-discrimination requirements set forth in State and Federal law and the contract with Health Plan.
- When federal law requires authorization for data sharing, community support provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to Health Plan.
- Member authorization for community supports-related data sharing is not required for the community support provider to initiate delivery of community supports unless such authorization is required by federal law. Community support providers will be reimbursed only for services that are authorized by Health Plan. In the event of a Member requesting services not yet authorized by Health Plan, community support provider shall send prior authorization request(s) to Health Plan, unless a different agreement is in place (e.g., if Health Plan has given the community support provider authority to authorize community supports directly).
- If a community support is discontinued for any reason, community support provider shall support transition planning for the Member into other programs or services that meet their needs.

- Community support provider is encouraged to identify additional community supports the M ember may benefit from and send any additional request(s) for community supports to Health Plan for authorization.
- In addition to all ECM and community support requirements noted above, providers should
    - Participate in all mandatory, provider-focused ECM training and technical assistance provided by Health Plan including in-person sessions, webinars, and/or calls, as necessary.
- Accept and consume data associated with ECM. HPSJ will follow DHCS guidance for data sharing where applicable.
- Health Plan will provide to provider the following data for ECM:
    - Member assignment files, defined as a list of Medi-Cal members authorized for ECM and assigned to the provider.
    - Encounter and/or claims data.
    - Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned members; and
    - Reports of performance on quality measures and/or metrics, as requested.
- As part of the referral process, Health Plan will ensure community support provider has access to:
    - Demographic and administrative information confirming the referred Member's eligibility for the requested service.
    - Appropriate administrative, clinical, and social service information the community support provider might need in order to effectively provide the requested service; and
    - Billing information necessary to support the community supports provider's ability to submit invoices to MCP.
- ECM and Community Supports Claims/Billing:
    - ECM and community support providers that have capabilities to submit claims should submit to HPSJ via CMS 1500, UBO4 form or submitted Electronic Data Interchange (EDI) in accordance with ECM and Community Supports coding guidance.
    - The Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Health Plans (MCP) to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. For ECM and Community Supports, plans will be required to submit encounter data for these services through the existing encounter data reporting mechanisms for all covered services.
    - Providers are required to submit claims/encounters for adequate data collection and in accordance with the reporting requirements of their contract. ECM and Community Supports providers must use the Healthcare Common Procedure Coding System (HCPCS) codes for ECM services. The HCPCS code and modifier combined define the service as ECM.
    - **DHCS Coding Guidance for ECM and Community Supports**

https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf

- ECM Claims/Billing Guidelines
  - Each unit shall represent a 15-minute interval.
  - One claim per Member per month should be submitted. From and through dates should equal the month of service provided.
  - The Per Enrollee Per Month (PEPM) payment shall be paid for ECM Members who receive 2 or more hours of ECM services in a given month as identified by 8 or more units billed.
  - ECM outreach should be billed with respective HCPCS codes and will be reimbursed at specified rate.
  - For the PEPM case rate, all providers will need to include a secondary modifier on the first line of the claim to help differentiate this as case rate.
  - Per coding guidance, if an ECM service is provided through telehealth, an additional modifier GQ must be used.
- Community Supports Claim/Billing
  - Providers should bill with applicable HCPCS codes for the Community Support they will be providing as per the designated HCPCS codes.
  - If Community Supports is provided through telehealth, an additional modifier of GQ shall be used.
  - Housing services such as housing tenancy and sustaining services and housing transition navigation services are paid on a PMPM basis and should include a secondary modifier on the first line of the claim.
- Please Note: These guidelines are intended for educational purposes only and are subject to change.

Community Health Workers (CHWs)

Health Plan covers community health worker (CHW) benefits for individuals when recommended by a physician or other licensed practitioner to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. CHW services are considered preventative care services and are Medi-Cal covered benefits.

Services may include:

- Health education and training, including control and prevention of chronic or infectious diseases; behavioral, perinatal and oral health conditions; and injury prevention
- Health promotion and coaching, including goal setting and creating action plans to address disease prevention and management
- Screening and assessment that does not require a license to assist Members to obtain services to improve their health
- Individual support and advocacy

CHWs are required to meet minimum provider requirements and qualifications through training and experience as specified by DHCS,ncluding having life experience with the population they are serving and can connect members with health and social services.

CHWs are required to have a supervising provider who should be a licensed provider, a hospital, an outpatient clinic or a local health jurisdiction (LHJ) or a community-based organization (CBO).

Licensed provider should ensure that the Member meets eligibility criteria before recommending CHW services, as defined by DHCS. No prior authorization is required. For Members who may need ongoing CHW services or continued CHW services, a written plan of care may be required.

Street medicine Providers can also be reimbursed for providing State Plan benefits, including the use of CHW services as defined in 42 CFR 440.130(c) and APL 22-016. Health Plan is responsible for ensuring non-duplication of services provided by a CHW and any other covered benefit, program, and/or delivery system.

For any questions regarding the referral process for CHW services please contact your Provider Services Representative or Health Plan's Utilization Management Department at 209-942-6320.

Electronic Visit Verification (EVV) for In-Home Visits

EVV is required for personal care services (PCS) and home health care services (HHCS) for in-home visits by a Provider. This includes PCS and HHCS delivered in the Members' homes as part of a Community Based Adult Services (CBAS), Community Supports or any other Medi-Cal benefit.

Providers rendering Medi-Cal services subject to Electronic Visit Verification (EVV) must comply with the requirements established by DHCS.

Health Plan monitors compliance with these requirements. Non-compliance with these requirements can result in corrective action, denial of payment and/or reassignment of members.

Registering for Electronic Visit Verification (EVV)

Health Plan providers and subcontractors must sign up with DHCS's EVV system.

Provider agencies and individual nurse providers (INPs) who provide PCS and HHCS are required to register in the Provider Self Registration portal.

More information can be found on the DHCS website:
https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx

All Plan Letter 22-014 provides additional guidance regarding the implementation of federally mandated Electronic Visit Verification (EVV) requirements.
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22014.pdf

For submitting claims for Personal Care Services (PCS) and Home Health Care Services (HHCS) for In-Home Visits, see Section 10 – Claims Submission.

MAJOR ORGAN TRANSPLANT

Transplants for Children Under Age 21

State law requires children who need transplants to be referred to the California Children's Services (CCS) program to see if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for the transplant and related services. If the child is not eligible for CCS, prior authorization should be requested. If appropriate, Health Plan will refer the child to a qualified transplant Center of Excellence (COE) for evaluation. If the transplant center confirms the transplant would be needed and safe, Health Plan will cover the transplant and related services.

Transplants for Adults Age 21 and Older

If you identify a Health Plan member who needs a major organ transplant, you should request prior authorization from Health Plan. As appropriate, Health Plan will refer the member to a qualified transplant COE facility for an evaluation. If the COE confirms a transplant is needed and safe for their medical condition, Health Plan will cover the transplant and other related services.

Transplants are covered under Health Plan if:

1. The transplant is performed at COE facility
2. The Member meets patient selection criteria for the transplants below.

Transplant and services covered by Health Plan are:

- Bone marrow
- Heart
- Heart/Lung
- Kidney
- Kidney/Pancreas
- Liver/Small bowel
- Lung
- Pancreas
- Small bowel

Other Transplants covered by Health Plan:

- Cornea

Please contact Health Plan's Case Management team at (209) 942-6352 if you need further assistance.

MEDI-CAL RX: TRANSITION

Under guidance of California Governor Gavin Newsom's Executive Order N-01-19, DHCS has transitioned all outpatient pharmacy dispensing services from the managed care (MC) plans to Medi-

Cal Rx. This was to provide standardization of the Medi-Cal pharmacy benefit statewide, under one pharmacy benefit manager. Doing so allowed improvement of Medi-Cal beneficiary access to pharmacy services with a pharmacy network that includes approximately 94% of the state's pharmacies.

Additional resources and information ca be found at https://medi-calrx.dhcs.ca.gov/provider/