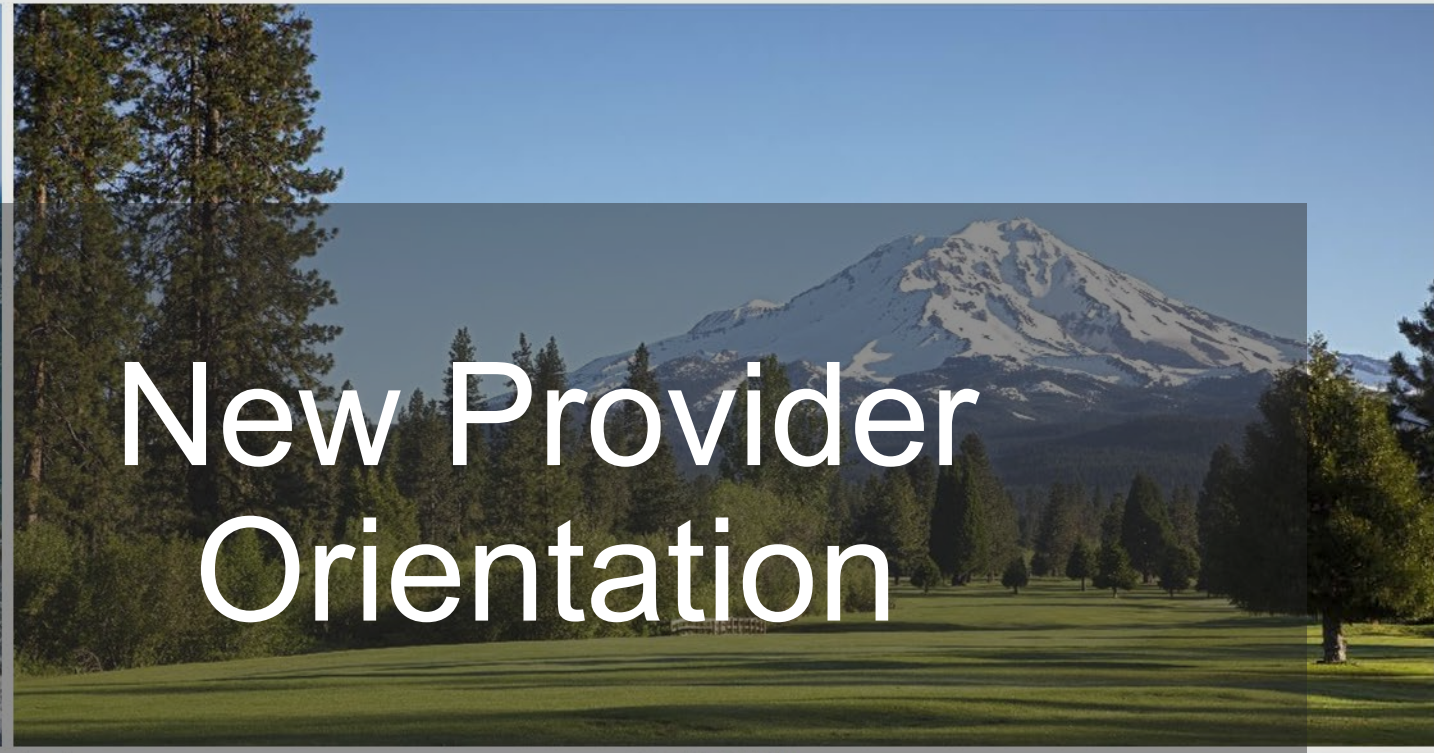
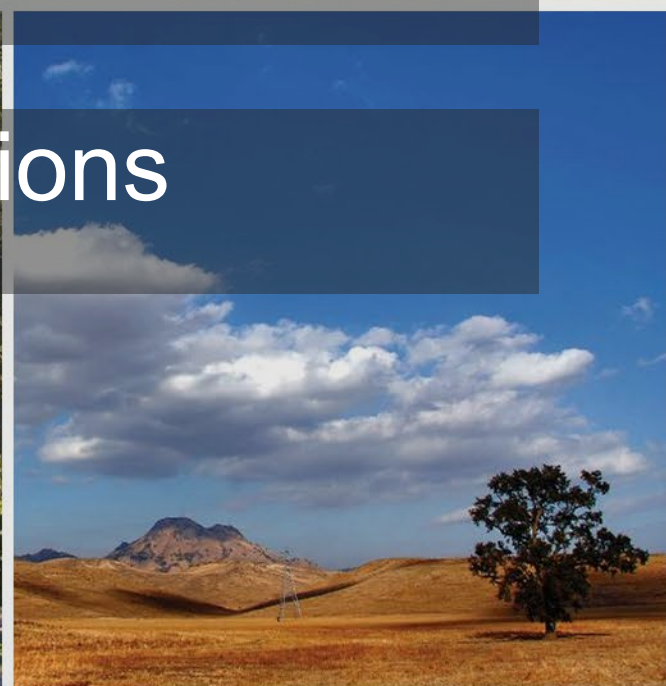
PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN



New Provider Orientation

Provider Relations



Agenda

- Background
- Organizational Goals
- Departments and Responsibilities
  - Member Services
  - Health Services
  - Claims
  - Provider Relations
- Additional Benefits and Information

About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Organizational Goals

- Improve patient access to care
- Focus on primary and preventative care
- Increase availability of specialty services
- Decrease avoidable emergency room services
- Provide timely reimbursement
- Be a locally responsive organization


PARTNERSHIP
HEALTHPLAN
of CALIFORNIA
A Public Agency
ACCREDITED
NCQA
HEALTH PLAN
Member Services

Member Services

Member Services assist with:

- Information about on health benefits
- Select/change primary care provider (PCP)
- Order a new Partnership ID Card
- Request a Member Handbook, Provider Directory, or other Partnership materials
- Assist with problems getting appointments
- Vision services
- Interpreting services
- Auxiliary aids and alternative formats
- Billing problems
- Complaints and appeals
- Member Portal
- Capture and report member demographic changes (Name, phone, and address) to the county offices

Available Monday – Friday
8 a.m. – 5 p.m.
(800) 863-4155

Membership

Partnership Members are
Medi-Cal Recipients

Direct Members are

- Members who are not assigned to a PCP
- Member with a share of cost
- First month eligibility, if they haven't selected a PCP
- Long term care (LTC) residents
- Foster care children, if known to Partnership.

Primary Care Provider (PCP) Assignment

- Members who are assigned to a unique PCP site are called “Case Managed” members.
- Members select their PCP from a list of practices that are open.
- Members who do not select a PCP will be assigned based on home zip code to a practice open to new members.
- The PCP is responsible for the management of patient’s care. The PCP office issues Referral Authorization Form (RAF) for specialty care.

Accessibility

- **Preventive Care** – within 10 business days of request
- **Routine Care** – within 10 business days of request
- **Prenatal Care** – within 10 business days of request
- **Newborn Care** – newborns discharged from hospital should be seen within 48 hours of discharge
- **Emergent Visit** – immediate treatment or referral to an appropriate emergency services provider
- **Same-Day Appointments** – open access appointments available same day or advanced access appointment scheduling if patient prefers
- **Specialty Care** – within 15 business days
- **Urgent Care** – within 48 hours

Community Resources

Members can access health education materials and community resources online at: https://www.partnershiphp.org/Community/Pages/Community-Resources.aspx

- Support Groups
- Emergency Response
- Vision Services
- Support Groups
- Veteran Services
- Children and Families
- Dental
- Disabilities
- Clothing and Personal Care
- COVID-19
- Transportation
- Utilities

Interpretive Services
AMN Healthcare

Telephone Language Services: (844) 333-3095

Providers will be asked to provide the following at the start of the call:

- Partnership number, provider site name and city, member ID (if applicable)
- If you do not have the member's ID, bypass the prompt by stating you do not have that information but will still require interpreting services.

Video Language Services:

- Determine if the device meets the technical requirements for the app (linked below).
- Request a license from AMN by completing the VRI Setup Form link and submitting.
- AMN will contact provider within three business days to confirm approval status.
- Please note that each individual device will require a separate license and login.

There is no cost for each provider license. Partnership will pay the cost of interpreting services.

Resources:

AMN Healthcare Training Video: https://bit.ly/3A7x8uM

Where to find your Partnership number: https://bit.ly/2YpnruI

VRI Guidelines: https://bit.ly/3DjCF3z

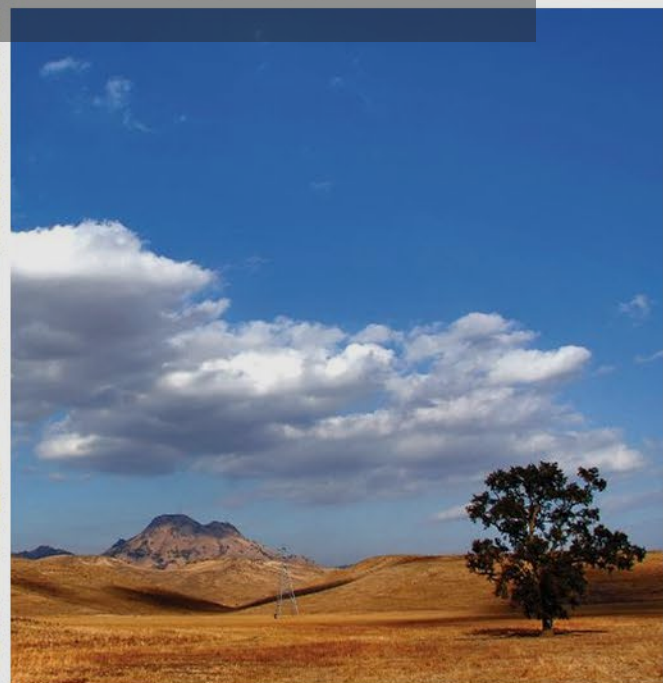
VRI Setup Form: https://bit.ly/3lchVEv

Health Services

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

ACCREDITED NCQA HEALTH PLAN



Health Services

Utilization Management

- Referrals (RAF – Referral Authorization Form)
- Authorizations (TAR – Treatment Authorization Request)
- (707) 863-4133

Care Coordination

- Complex Case Management
- Transitional Care Services
- Access to Care
- (800) 809-1350

Quality Improvement

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Quality Improvement Program (QIP)
- (707) 863-4213

Population Health

- Health Education
- Community Outreach
- (855) 798-8764

California Advancing and Innovating Medi-Cal (CalAIM)

- Enhanced Care Management
- Community Supports
- CalAIM@partnershiphp.org

Referral Authorization Form (RAF)

What is a RAF?	• A RAF is a permission slip from the PCP to a specialist
What does a RAF cover?	• RAFs only cover office visits, consultations, evaluations, and follow-ups
When do I need a RAF?	• A RAF is required anytime a member has an assigned PCP. If a member switches PCPs during eligibility, a new RAF is needed from the new PCP
How long does it take Partnership to review a RAF?	• RAF request can take up to five business days, 80% will auto adjudicate. “Urgent” RAFs will be reviewed within 72 hours
Who submits the RAF?	• PCP submits a RAF on the provider portal: https://provider.partnershiphp.org/UI/Login.aspx

eRAF Pop-Ups

A specialty pop-up will display when a PCP provider office selects one of the following Specialties:

Cardiology	Ophthalmology	Orthopedic
Pain Medicine	Podiatry	Vascular Surgery

- eRAFs are submitted by the Primary Care Physician (PCP) to the specialist on the Provider Portal at https://provider.partnershiphp.org/UI/Login.aspx
- Partnership requires one RAF per member, per specialist.
- Each referral pop-up will include a color key for reference:

Black – For Referral Staff
Purple – For Referral Staff/Clinicians
Blue – For Clinicians

Cardiology

Black – For Referral Staff
Purple – For Referral Staff/Clinicians
Blue – For Clinicians

All referral requests should include:
Brief Summary of Relevant history (including detailed medication history), pertinent findings on physical exam, and pertinent laboratory data

Cardiology- Chest Pain
Do the following before referral, as appropriate:
- CBC,CMP, and lipid panel
- EKG (1 if normal; additional older EKG (if available) if EKG is not normal)
- Echocardiogram
- Appropriate stress test (should can be ordered before consultation): (E.g. Exercise stress test, stress echo, nuclear imaging with adenosine and/or Cardiolyte, depending on clinical scenario)

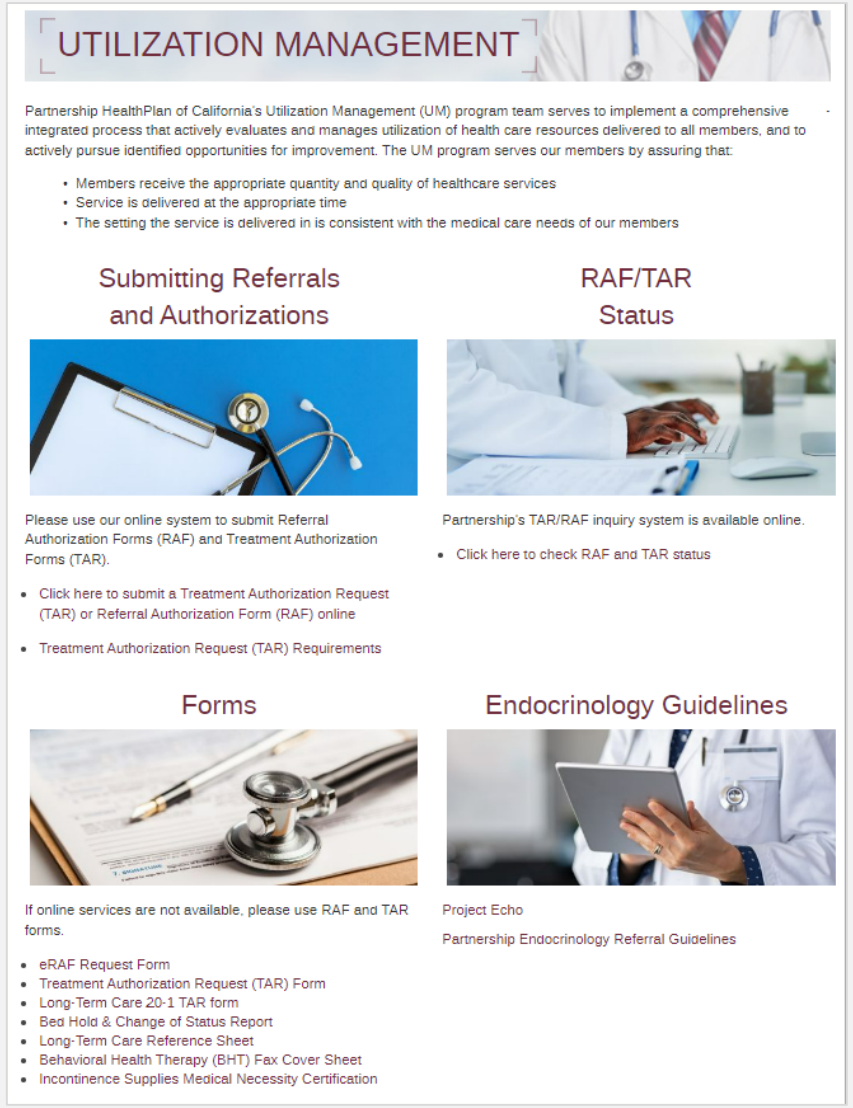
Cardiology- Dilated Cardiomyopathy
Do the following before referral, as appropriate:
- CXR
- EKG
- Echocardiogram
- CMP,CBC,TSH,HIV,BNP and lipid panel
- Urine toxicology screen

Cardiology- Murmur of Possible Valvular Heart Disease
Do the following before referral, as appropriate:
- EKG
- CXR
- Echocardiogram
- CBC, CMP and lipid panel

Cardiology- Palpitation or syncope
Do the following before referral, as appropriate:
- EKG
- Echocardiogram
- Results of 24 hour Holter monitor or event monitor or Zio Patch
- CBC,CMP, Lipid Panel and TSH

Cardiology- Coronary Artery Disease- S/P Coronary Artery Bypass Graft (CABG) and/or Angioplasty (PCI)
Do the following before referral, as appropriate:
- CBC,CMP, and lipid panel done in the past year
- EKG (1 if normal; additional older EKG (if available) if EKG is not normal)
- Echocardiogram

Treatment Authorization Requests (TAR) Requirements



UTILIZATION MANAGEMENT

Partnership HealthPlan of California's Utilization Management (UM) program team serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement. The UM program serves our members by assuring that:

- Members receive the appropriate quantity and quality of healthcare services
- Service is delivered at the appropriate time
- The setting the service is delivered in is consistent with the medical care needs of our members

Submitting Referrals and Authorizations

Please use our online system to submit Referral Authorization Forms (RAF) and Treatment Authorization Forms (TAR).

- Click here to submit a Treatment Authorization Request (TAR) or Referral Authorization Form (RAF) online
- Treatment Authorization Request (TAR) Requirements

RAF/TAR Status

Partnership's TAR/RAF inquiry system is available online.

- Click here to check RAF and TAR status

Forms

If online services are not available, please use RAF and TAR forms.

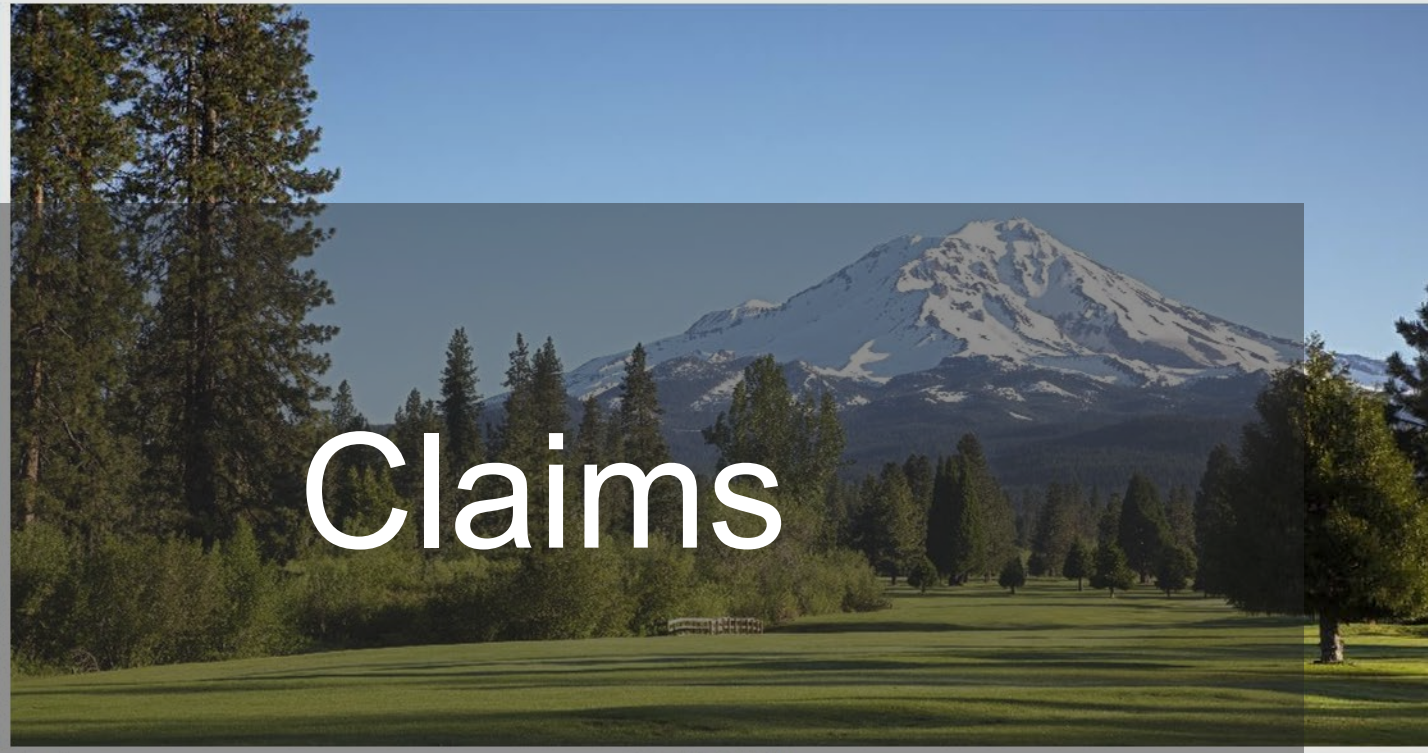
- eRAF Request Form
- Treatment Authorization Request (TAR) Form
- Long-Term Care 20-1 TAR form
- Bed Hold & Change of Status Report
- Long-Term Care Reference Sheet
- Behavioral Health Therapy (BHT) Fax Cover Sheet
- Incontinence Supplies Medical Necessity Certification

Endocrinology Guidelines

Project Echo

Partnership Endocrinology Referral Guidelines

- Treatment Authorization Requests (TARs) are submitted by the rendering provider of the service prior to a provision of services unless emergent.
- TARs can be submitted through the Provider Portal: https://provider.partnershiphp.org/UI/Login.aspx
- TAR requirements can be found on our website: http://www.partnershiphp.org/Providers/HealthServices/Pages/Utilization-Management.aspx

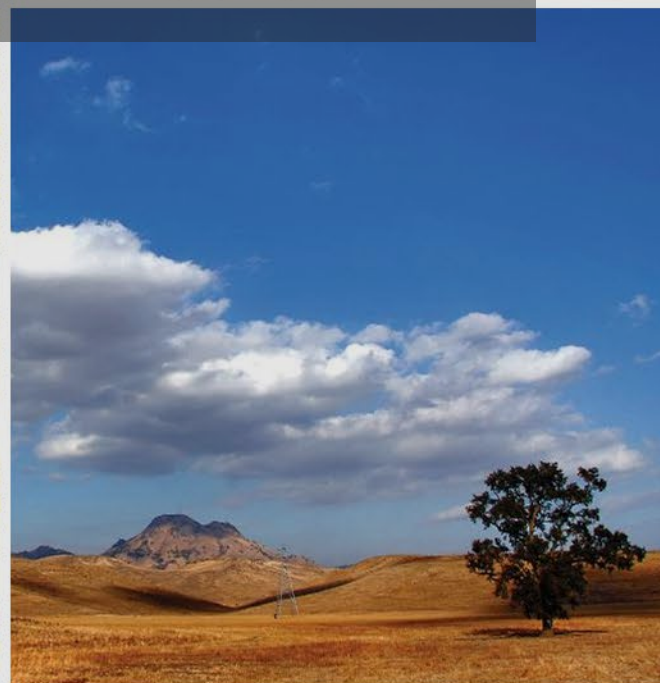


Claims

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

ACCREDITED NCQA HEALTH PLAN



How to Submit Claims

Electronic Claims

✓ Electronic Data Interchange (EDI)
✓ Submission of HIPAA-compliant 5010 version 837P File
✓ Preferred submission method for faster reimbursement

Contact EDI Enrollment and Testing at:
Phone: (707) 863-4527 or
EDI-Enrollment-Testing@partnershiphp.org

Paper Claims

✓ Submission of CMS-1500 format only
✓ Send to: Partnership HealthPlan (Medi-Cal)

P.O. Box 1368
Suisun City, CA
94585-1368

Provider Support

- General Claims information
- Denied Claims
- Claims Submission Process
- Remittance Advice (RAs)
- Provider Dispute Resolutions (PDRs)

Services provided by EDI

- Assists providers with the set-up of electronic billing
- Supports each provider that is currently billing electronically
- Works with provider's clearing house
- 835 files
- 837 submission files

Claims Customer Service Phone Number:
(707) 863-4130

Claims Mailing Addresses and Limits

Partnership HealthPlan of California (Medi-Cal)
P.O. Box 1368, Suisun City CA 94585-1368

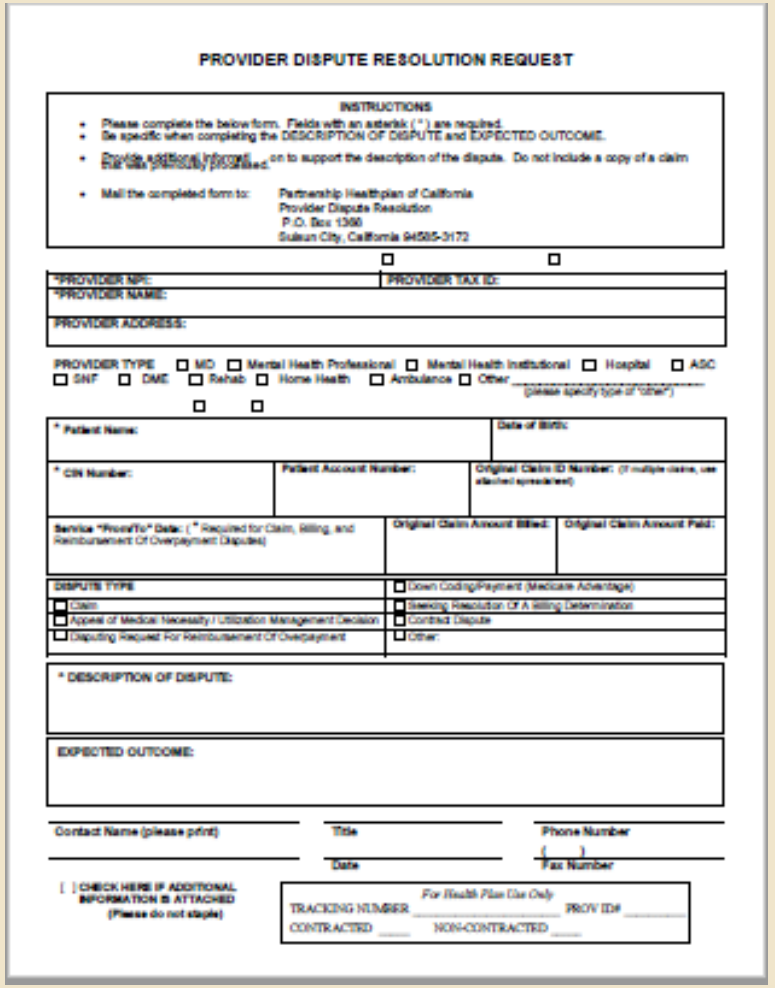
- Billing limit = 365 days.
- This will apply to claims for date of service on or after 07/01/2014.
- PCP-QIP – note to receive PCP-QIP credit, billing limit is 90 days.
- Paper Claims, PDRs and Appeals can be sent to address above.

“Clean” claims are processed within 45 days of receipt. Current Version CMS 1500

Claim Corrections:
Provider Dispute Resolution

Providers have the right to submit a payment dispute if they disagree with a claim decision regarding the denial or compensation of a claim. Providers may submit disputes via Provider Online Services or by mail.

The Provider Claims Dispute Resolution Mechanism is a fair and cost-effective process used by contracted and non-contracted providers for disputes regarding invoices, billing determinations or other contractual or non-contractual issues.



PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information on to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: Partnership Healthplan of California, Provider Dispute Resolution, P.O. Box 1390, Suisun City, California 94585-3172

*PROVIDER NPI: | PROVIDER TAX ID:
*PROVIDER NAME:
PROVIDER ADDRESS:

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "Other")

* Patient Name: | Date of Birth:
* CIN Number: | Patient Account Number: | Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes) | Original Claim Amount Billed: | Original Claim Amount Paid:

DISPUTE TYPE
☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Down Coding/Payment (Medicare Advantage)
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

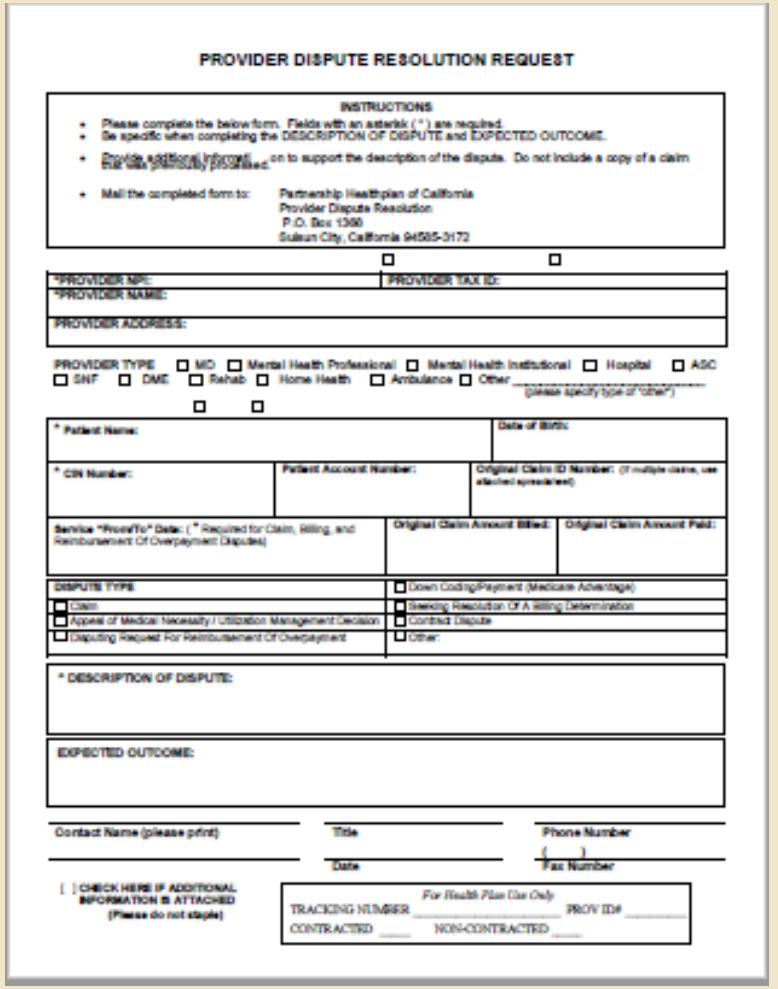
Contact Name (please print) | Title | Phone Number
Date | Fax Number

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

For Health Plan Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED ____ NON-CONTRACTED ____

Claim Corrections:
Provider Dispute Resolution

- Disputes can be submitted within 365 days from the original paid/denied date on the Partnership RA. Disputes received after one year are subject to automatic denial.
- Partnership will acknowledge receipt of the dispute immediately and will respond electronically indicating the outcome of the dispute review within 45 working days.
- Provider Dispute form can be downloaded from the Partnership website.
- Provider Claims Dispute Resolution Request Form



PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information on to support the description of the dispute. Do not include a copy of a claim that was previously submitted.
- Mail the completed form to: Partnership Healthplan of California, Provider Dispute Resolution, P.O. Box 1390, Suisun City, California 94585-3172

*PROVIDER NPI: | PROVIDER TAX ID:
*PROVIDER NAME:
PROVIDER ADDRESS:

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")

* Patient Name: | Date of Birth:
* CIN Number: | Patient Account Number: | Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes) | Original Claim Amount Billed: | Original Claim Amount Paid:

DISPUTE TYPE
☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Down Coding/Payment (Medicare Advantage)
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print) | Title | Phone Number
Date | Fax Number

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

For Health Plan Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

Balance Billing

The Department of Health Care Services (DHCS) reminds all providers that balance billing Medi-Cal beneficiaries is prohibited by federal and state law.

Medi-Cal beneficiaries should not pay for physician visits and other medical care when they receive covered services from a provider in their provider network.

This means beneficiaries cannot be charged for co-pays, co-insurance, or deductibles.

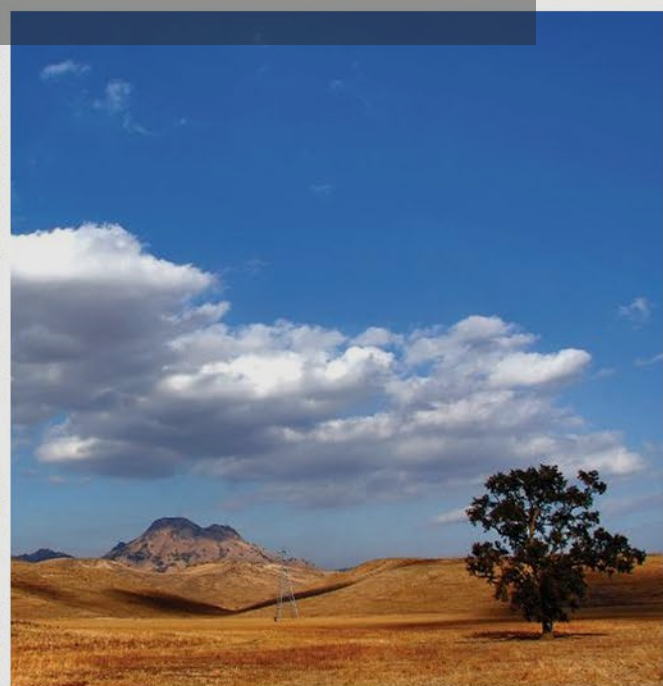
Billing Medi-Cal beneficiaries violates Federal law as outlined in section 1902(n)(3)(B) of the Social Security Act (SSA), as modified by section 4714 of the Balanced Budget Act of 1997. This Section is available at

http://www.ssa.gov/OP_Home/ssact/title19/1902.htm

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Relations

ACCREDITED NCQA HEALTH PLAN



Provider Relations

- Contracting/ network development
- Credentialing activities
- Provider education
- On-site visits, trainings and meetings
- Provider database directory maintenance
- eSystems applications (Provider Portal)
- Provider Newsletter and Bulletins
- Cultural and Linguistic Services
- Provider Dispute Resolution
- Provider Manual
- Electronic Funds Transfer (EFT) via FIS (877) 330-4950
- Provider Support

Provider Communication

Provider Newsletter

http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Provider-Newsletter.aspx

Provider Bulletins

http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Provider-Bulletins.aspx

Provider Resources

https://www.partnershiphp.org/Providers/Medi-Cal/Pages/default.aspx

Policies

http://www.partnershiphp.org/Providers/Policies/Pages/default.aspx

PROVIDER RELATIONS

Supporting our Providers

The Provider Relations Department is responsible for supporting PHC providers in helping keep the communities we serve, be healthy. The department is responsible for contracting, credentialing, provider education and the Provider Directory. If you have any questions, please reach out to your Provider Relations Representative or call the Provider Relations Department at 707-863-4100.

Provider Resources

Provider Manuals
Provider Bulletin
PHC Provider Learning Portal
Provider Representative Territory
Provider Changes Requirements
Cultural Competency for Providers
Telehealth Toolkit
New Provider Education Packet
Interpretive Services | Adding Video App to Device
Video App Request Form | VRI Training Video

Provider Directory

Medi-Cal Provider Directory

Additional Resources

Provider Grievance Process
BHT Provider Best Practices
HIPAA/Fraud, Waste and Abuse
Quality Measure Highlights
Anti Bias Strategies for Providers

Policy Updates

2022 Policy Updates
2021 Policy Updates
2020 Policy Updates

Forms

Common Forms
NEMT Required Justification Form (PCS)
Provider Request to Discharge Member
Medicare/Medi-Cal Crossover Claim Form
Medical Equipment Distribution Services
Guidelines | Request Form | Instructions
Growing Together Referral Form
Referral Authorization Form (RAF)
Treatment Authorization Request (TAR) Form
Missed Appointment Form
Provider Change Form
Interested in Contracting with PHC? Click here
PHC Contracted Providers Adding New Sites, click here
PCP-Beacon Referral Form

Provider Newsletter

Winter 2021 Provider Newsletter
Fall 2021 Provider Newsletter
Summer 2021 Provider Newsletter
Spring 2021 Provider Newsletter

Provider Emergency Notification

The Provider Emergency Notification (PEN) is designed for the PCP network to notify Partnership the status of the site during a State of Emergency, Public Safety Power Shutoff (PSPS), office closure due to COVID-19 or devastation such as fire, earthquake, or flood.

It is important to send your notification e-mail the night before possible closure or before 9 a.m. the following morning.

In an Emergency we encourage you to notify Partnership of your clinic's status with the following information:

- Daily clinic status (open or closed)
- Alternative phone numbers (if applicable)

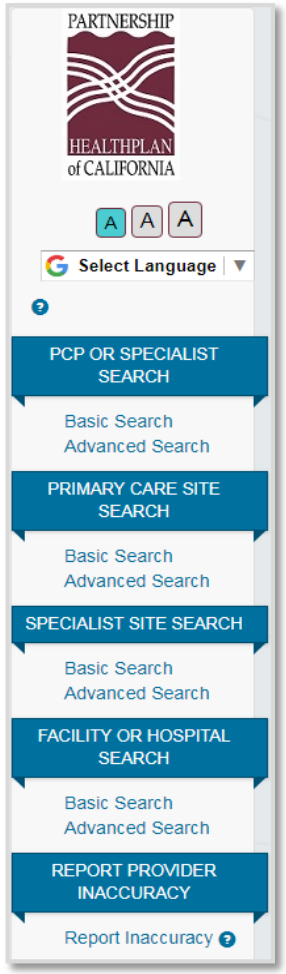
PEN-NR@partnershiphp.org - **Northern Region** counties (Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen)

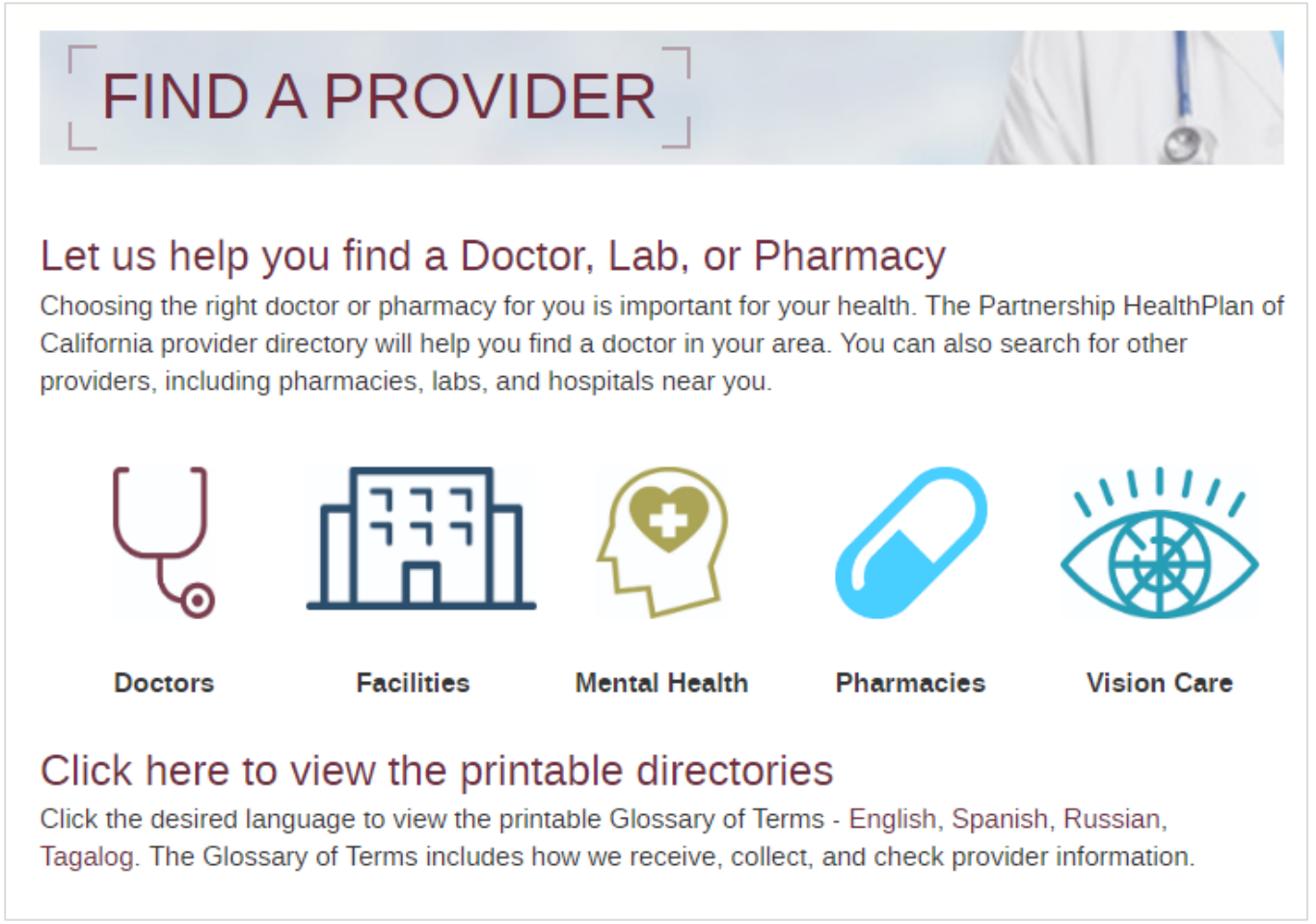
PEN-SR@partnershiphp.org - **Southern Region** counties (Mendocino, Lake, Sonoma, Napa, Yolo, Solano, Marin)

PEN-ER@partnershiphp.org – **Eastern Region** counties (Tehama, Glenn, Colusa, Sutter, Butte, Plumas, Sierra, Yuba, Nevada, Placer)

Provider Relations Directory

Partnership launched our new searchable Online Provider Directory with interactive tools. If you believe that you have found an error email PHCDirectory@partnershiphp.org.



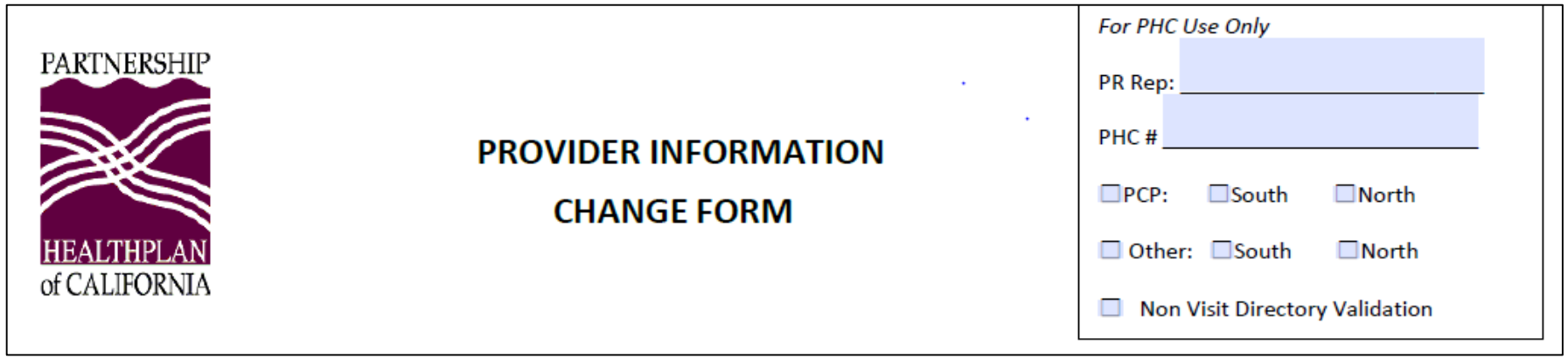


Partnership updates the Provider Directory with new information as received.

Provider Relations Directory

Directory changes can be submitted by completing an electronic change form to the changes provider email box (changesproviders@partnershiphp.org) or by faxing the form to (707) 863-4599. Please ensure you are keeping us up to date with provider and clinic changes, moves, additions, and closures as per DHCS regulatory requirements.

Partnership must be notified 90 days prior to closing the site.



PARTNERSHIP HEALTHPLAN of CALIFORNIA

PROVIDER INFORMATION CHANGE FORM

For PHC Use Only

PR Rep: _____

PHC # _____

☐ PCP: ☐ South ☐ North

☐ Other: ☐ South ☐ North

☐ Non Visit Directory Validation

The Change Form can be found at:
http://www.partnershiphp.org/Providers/MediCal/Documents/OnDemandTrainingWebinars/Common%20Forms/Provider%20Information%20Change%20Form.pdf

Initial Health Appointment

On January 1, 2023, the Initial Health Assessment was changed to **Initial Health Appointment (IHA)** pursuant to APL 22-030. In addition, the Individual Health Education Behavioral Assessment (IHEBA) or a Staying Healthy Assessment (SHA) will no longer be required components of the IHA.

An IHA must include:

- A history of the members physical and mental health.
- An identification of risks.
- Assessment for preventative screening/services.
- Health education
- Diagnosis and plan for treatment of any diseases.

An IHA must be completed within 120 days for newly enrolled members and periodically administered according to requirements in the Population Health Management (PHM) Policy Guide and Partnership contract.

For more information visit:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf

California Children's Services Moves to Whole Child Model

Partnership's Whole Child Model (WCM) program provides diagnostic, treatment and case management services for children under age 21 who have been diagnosed with a condition eligible for California Children's Services (CCS).

The WCM program was established by the Department of Health Care Services (DHCS) as authorized by Senate Bill (SB) 586. The program incorporates CCS program covered services for Medi-Cal eligible CCS children and youth into a Medi-Cal Managed Care Plan (MCP) contract. This is to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

Interested in becoming a CCS provider? Click **HERE**

A list of CC-eligible conditions can be found as the link below:
https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx

***Partnership does not manage Whole Child Model in our new 10 counties – Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama or Yuba.**

Blood Lead Screening

Federal and State law *requires* clinicians caring for Medi-Cal patients to conduct blood lead screening on ***all*** children at 12 and 24 months of age, and to talk about potential lead exposures at ***every*** well child visit from six months to six years of age.

Beginning January 1, 2021 Partnership will reach out to all members aged six months to six years of age who have no recorded blood lead screening to recommend lead screening. Partnership will pass this list to Primary Care Providers (PCP) who are expected to reach out to these members to remind them to get tested.

If providers elect not to order the screening, they must:

- document in detail the reason for not conducting the screening
- include the signature of the parent/guardian who refused the screening
- or state the reason the signature could not be collected

Partnership offers several Improvement Programs, including the Primary Care Provider Quality Improvement Program (PCP QIP) offering financial incentives, data resources, and technical assistance to providers who serve our members so that significant improvements can be made in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience

For more information visit: PCP Quality Improvement Program
Additional resources: Provider Learning Portal

Behavioral Health Treatment (BHT) for Members under the Age of 21

Partnership is responsible for providing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under the age of 21.

Services include BHT services that are determined to be medically necessary to correct or ameliorate any physical behavioral conditions.

Providers can check member eligibility online through the provider portal: https://provider.partnershiphp.org/UI/Login.aspx

Refer to the provider directory for a list of contracted BHT providers: Find a Primary Care Provider

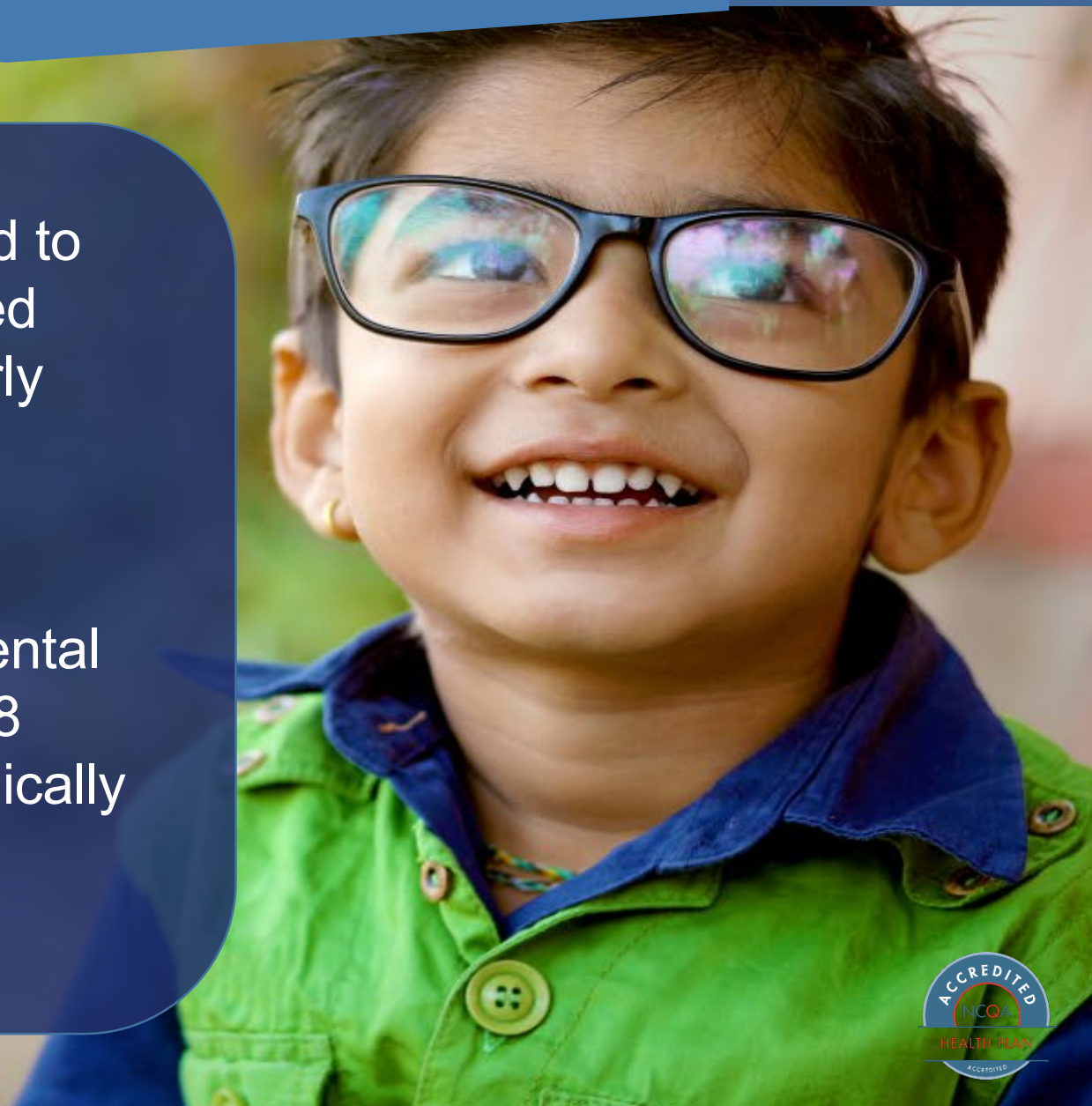
Policy MPUP3126:

https://public.powerdms.com/PHC/documents/1850144

Developmental Screening

All children enrolled in Medi-Cal are entitled to receive developmental screening, a required service for children under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

National guidelines recommend developmental screening for all children at nine months, 18 months, and 30 months of age and as medically necessary when risk is identified on developmental surveillance.



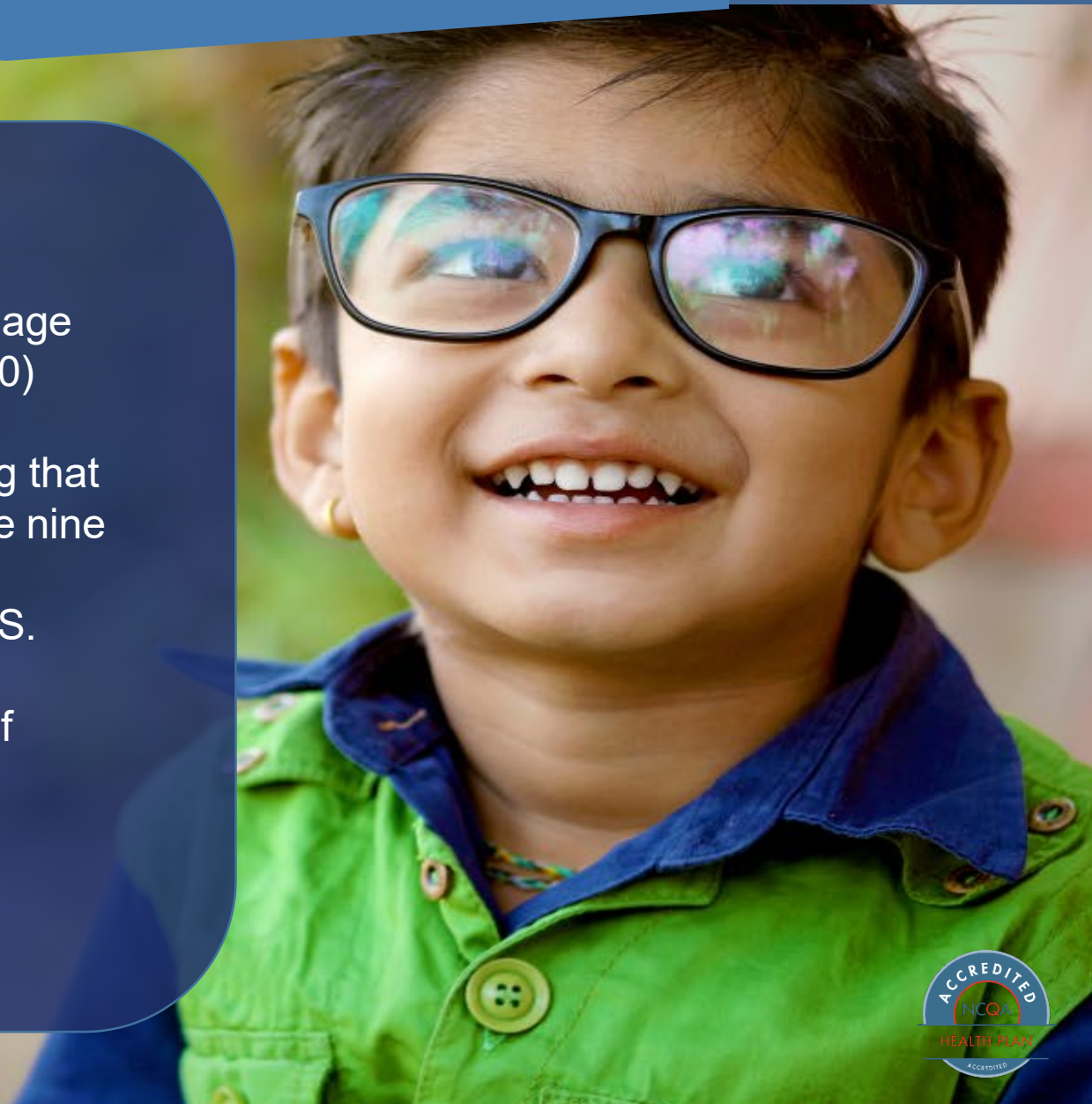
Developmental Screening

CPT Code 96110.KX

- Payable per year, age (two months to <20) without a TAR.
- Used for screening that does not include one of the nine screening tools approved by DHCS.
- Autism only screening, socio-emotional screens and other must use 96110.KX
- Paid fee for service (not part of PCP capitation).

CPT Code 96110

- Payable per year, age (two months to <20) without TAR.
- Used for screening that includes one of the nine screening tools approved by DHCS.
- Paid fee for service (not part of PCP capitation).



Vaccines for Children Program

The Vaccines for Children (VFC) Program was established in 1993 by the United States Federal Government, the VFC program is administered nationally by the Centers for Disease Control and Prevention (CDC) and the National Center for Immunization and Respiratory Diseases.

Vaccines available through the VFC Program	
Diphtheria	Meningococcal
Haemophilus influenza type b	Mumps
Hepatitis A	Pertussis (whooping cough)
Hepatitis B	Pneumococcal
Human Papillomavirus	Poliomyelitis
Influenza	Rotavirus
Measles	Tetanus

Providers who administer vaccines to persons 19 years of age must enroll separately in the VFC Program. To learn more about how to become a VFC-enrolled provider, please contact the MyVFCvaccines@cdph.ca.gov or (877) 243-8832.

Adverse Childhood Experience Screening Services (ACEs)

Partnership would like to inform providers of a DHCS provided training; ACE-oriented trauma-informed care training for Providers and their ancillary office staff.

Join the “Becoming ACEs Aware in California” core training for a **free**, two-hour training for clinicians and clinical team members to receive 2.0 Continuing Medical Education and/or 2.0 Maintenance of Certification credits upon completion.

The training provides information about:

- ACEs Aware
- Toxic stress
- Screening
- Risk assessment
- Evidence-based care to effectively intervene

More information about training and registration links are available at https://www.acesaware.org/learn-about-screening/training/

Annual Cognitive Health Assessment

Partnership Providers must cover an annual cognitive health assessment for members who are 65 years of age or older and who do not have Medicare coverage.

In order to appropriately bill and receive reimbursement, providers must do the following:

- Complete the DHCS Dementia Care Aware cognitive health assessment training
- Administer the annual cognitive health assessment
- Document the following in Member's medical record
  - Screening tools used in assessment (at least one cognitive assessment tool)
  - Verification that screening results were reviewed by the Provider
  - Results of screening
  - The interpretation of results
  - Details discussed with the member and any appropriate actions taken in regards to screening results.
  - Use allowable CPT codes

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf

Mental Health

Carelon Behavioral Health provides mental health care services to Partnership members.

- Screens, then directs members to local Carelon Behavioral Health provider if **mild to moderate impairment** is determined.
- Supports member's transition between levels of care from Carelon Behavioral Health to County Mental Health or vice versa.
- Offers PCPs psychiatric decision support via telephone consultation with a Carelon Behavioral Health psychiatrist.
- Medication management and diagnostic clarification.
- Calls related to outpatient mental health services can be connected to Carelon Behavioral Health at **(855)-765-9703.**

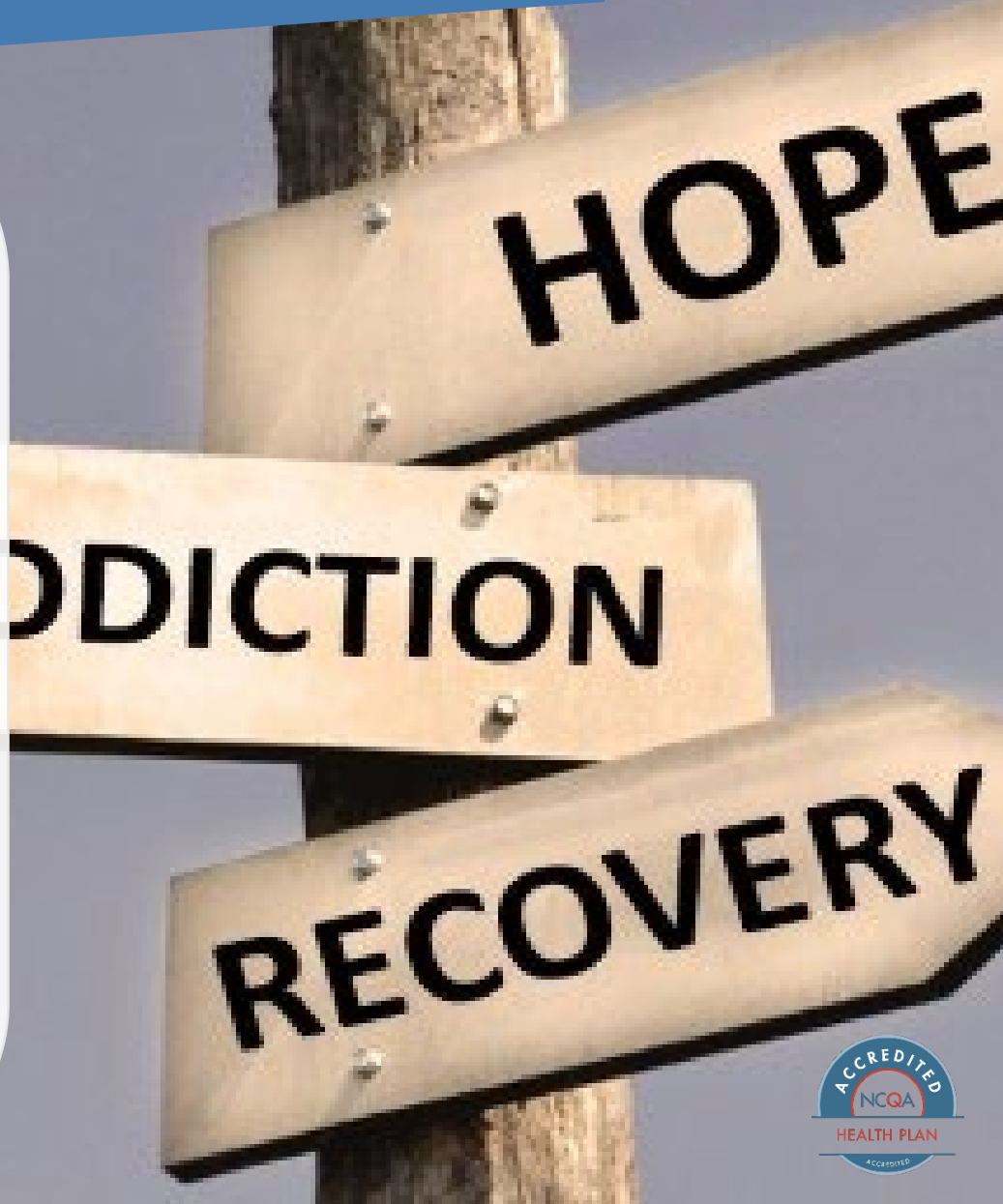
Visit our Mental Health Services page for more resources:
http://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx

Wellness and Recovery

On July 1, 2020, Partnership HealthPlan of California, along with seven of its 24 member counties – **Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano** – administers the substance use disorder (SUD) services program.

Wellness & Recovery Program includes:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, nine - 19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (DHCS licensed facility, certified staff)
- Medically assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)



California Advancing and Innovating Medi-Cal

California Advancing and Innovating Medi-Cal (CalAIM)

Enhanced Care Management (ECM)

- ECM is a Medi-Cal benefit that provides a standardized set of case management services and interventions to improve quality of life.
- ECM referrals can come to Partnership from anyone, anywhere. There is no wrong door.
  - Fill out the ECM Referral Form or contact Partnership directly.

For more information go to: http://www.partnershiphp.org/Community/Pages/CalAIM.aspx
For ECM/CS general questions, email CalAIM@partnershiphp.org

California Advancing and Innovating Medi-Cal

California Advancing and Innovating Medi-Cal (CalAIM)

Community Supports (CS)

- CS services are provided as cost-effective alternatives or in-lieu of, traditional medical services or settings.
- CS referrals can come to Partnership from anyone, anywhere. There is no wrong door.
  - Fill out the CS Referral Form or contact Partnership directly.

For more information go to: http://www.partnershiphp.org/Community/Pages/CalAIM.aspx
For ECM/CS general questions, email CalAIM@partnershiphp.org

Enhanced Care Management

To qualify, members must meet DHCS criteria outlined – “Population of Focus”.

Goal is to provide a lead, community-based case manager to coordinate: medical, oral, behavioral health, long-term supports and community referral needs.

Authorizing ECM

- ECM requires a Treatment Authorization Request (TAR)
- ECM provider will submit the TAR to Partnership via provider portal or fax TAR form

For more information: Enhanced Care Management
More details on timeline and criteria: Enhanced Care Management (ECM) Timeframes

Enhanced Care Management

ECM Populations of Focus

- Individuals experiencing homelessness
- Individuals at risk for avoidable hospital or ED Utilization
- Individuals with serious mental health and /or SUD needs
- Adults living in the community and at risk for long-term care (LTC) institutionalization
- Adult nursing facility residents transitioning to the community
- Children & Youth
- Justice
- Birth equity

For more information: Enhanced Care Management
More details on timeline and criteria: Enhanced Care Management (ECM) Timeframes

Community Supports

Community Supports Services:

Housing Transition and Navigation	Housing Deposits	Housing Tenancy and Sustaining	Short-Term Post-Hospitalization
Recuperative care (Medical Respite)	Personal Care and Homemaker Services	Medically Supportive Foods	Respite Care

CS referrals can come from anyone. **There is no wrong door.**

https://www.partnershiphp.org/Community/Pages/Community-Supports.aspx

Community Supports

Examples of referral sources:

- ✓ PCPs/Specialists
- ✓ ECM providers
- ✓ Hospitals
- ✓ SNFs
- ✓ Palliative care providers
- ✓ SUD providers
- ✓ Self-referrals – via Member Services Team, or Care Coordination
- ✓ Family referred

CS Providers	✓ Attach the completed CS referral form when submitting a TAR
Non-CS Provider	❑ Fill out the CS Referral form and send back to the CS helpdesk: CommunitySupports@partnershiphp.org ❑ Members can connect with Member Services/Care Coordination (if applicable)

Laboratory and Vision Services

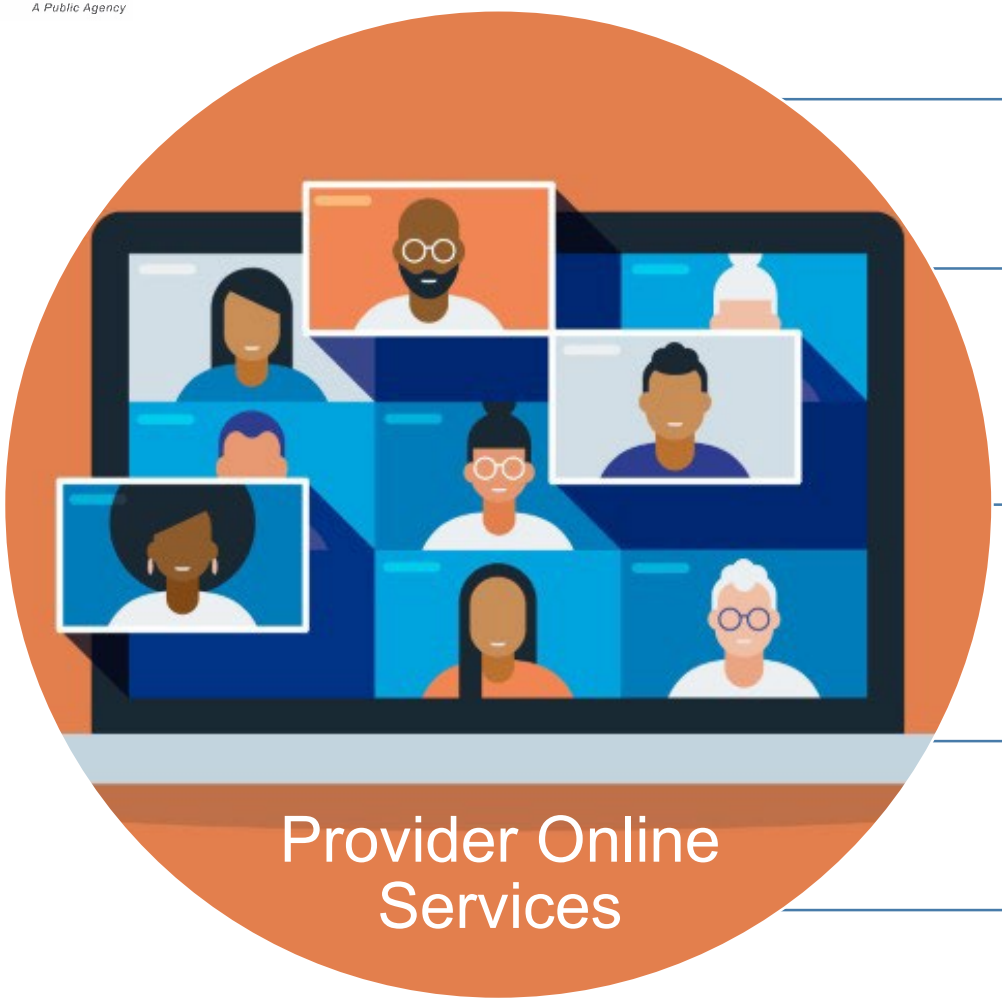
Laboratory Services

- Partnership members in Marin, Napa, Sonoma, Solano, and Yolo counties are capitated to Quest Diagnostics for routine lab services
- Members in Del Norte, Humboldt, Lake, Siskiyou, and Trinity counties can visit contracted providers, Quest and Lab Corp for routine lab services
- Check member's eligibility to determine if member is capitated for lab.

Vision Services

- Partnership members are covered through Vision Services Plan (VSP)
- Members can refer to the provider directory for a list of contracted vision providers
- No referral is necessary

Provider Online Services (OLS)



- Check eligibility
- Submit referrals
- View status of authorizations
- View status of claims
- Submit Provider Dispute Resolution Form (PDR)

https://provider.partnershiphp.org/ui/login.aspx

For portal inquiries and trainings, please contact eSystemsSupport@partnershiphp.org.

eEligibility

Identify member's PCP and other capitated entities:			
Lab Services **Quest Laboratories**	Vision Care **Vision Service Plan**	Hospital (if applicable)	Mental Health – outpatient mild-to-moderate Carelon Behavioral Health

Verify Eligibility		
Partnership website https://provider.partnershiphp.org/UI/Login.aspx	Monday - Friday 8 a.m. – 5 p.m. (707) 863-4120	If not a Partnership member contact the State of California www.medi-cal.ca.gov

Medi-Cal Rx

Medi-Cal Pharmacy Benefits (Medi-Cal Rx) is administered through the Fee-For-Service (FFS) delivery system. For more information, go to http://www.partnershiphp.org/Providers/Pharmacy/Pages/default.aspx. Magellan is the Pharmacy Benefit Manager (PBM) for Medi-Cal Rx.

What changed?	What stayed the same?
▪ Medi-Cal RX includes all Pharmacy services billed as a pharmacy claim, including but not limited to: ✓ Outpatient drugs (prescription and over-the counter), including Physician if ordered from Pharmacy ✓ Administered Drugs (PADs) ✓ Enteral nutrition products ✓ Medical supplies	▪ The scope of existing Medi-Cal pharmacy coverage. ▪ Provision of pharmacy services billed on medical or institutional claims and/or as part of a bundled/all-inclusive billing structure in an inpatient or long-term care (LTC) setting, including Skilled Nursing Facilities (SNF) and other Intermediate Care Facilities (ICF), regardless of delivery system. ▪ Existing Medi-Cal managed care pharmacy carve-outs ▪ Any pharmacy services billed as a medical and/or institutional claim instead of a pharmacy claim.

Data Sharing

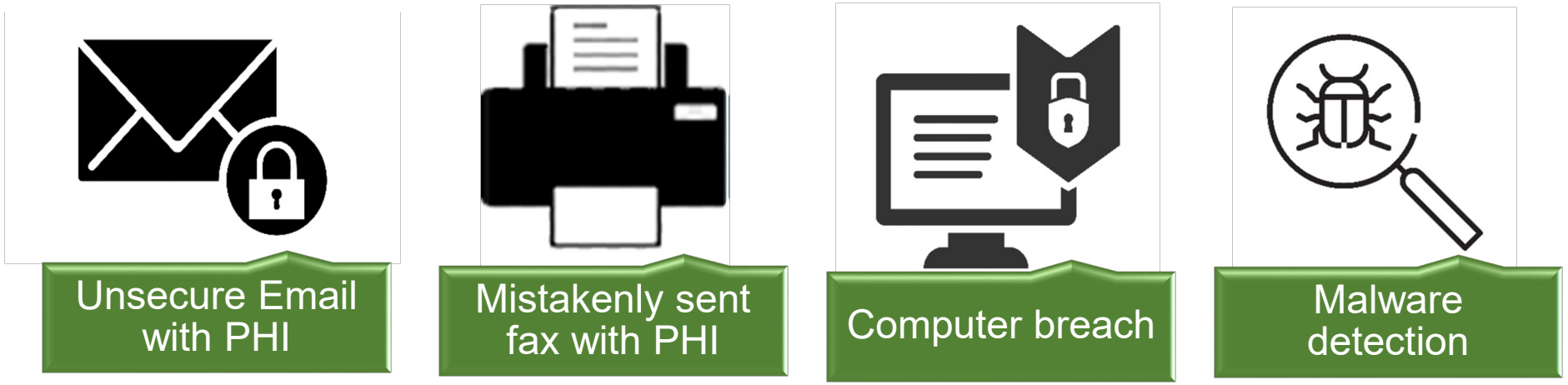
Partnership shares information with **Members** through the Member Portal and the Partnership website.

Partnership shares data with its **Providers** through the Provider Portal and the Partnership website.

Compliance and Regulatory Affairs

PRIVACY INCIDENTS

It is the acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under the HIPAA Privacy Rule, which compromises the security or privacy of PHI. Privacy incidents must be reported immediately even if you don't have all the details. When in doubt, report it to Partnership:



Report discovery of incident within 24 hours by:
Email: RAC_Reporting@partnershiphp.org
Fax: (707) 863-4363
Phone: (800) 601-2146

Fraud, Waste, and Abuse

FRAUD

- An intentional act of deception, misrepresentation, or concealment in order to gain something of value.

WASTE

- Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

ABUSE

- Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices. This refers to incidents that, although not fraudulent, they may directly or indirectly cause financial loss.

Partners in Fighting Fraud

We ask our providers help us combat fraud by reporting suspicious and fraudulent activity. DHCS and CMS require us to maintain a robust anti-fraud plan and share it with our providers, members, and employees.

- Partnership Anonymous Fraud Hotline (800) 601-2146
- Medi-Cal Fraud Issues (800) 822-6222
- Medicare Fraud Issues (800) 633-4221

Examples

- Charging excessive costs for services or supplies
- Billing for services at a higher rate than justified
- Providing medically unnecessary services

Required Trainings

Required Trainings:

- Cultural Competency Training
- Seniors and Persons with Disabilities (SPD) Training
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Provider Training

Provider Learning Portal:
https://www.partnershiphp.org/Providers/MediCal/Pages/ProviderEducationTrainingMaterials.aspx

Contact Us

Business hours
- Monday – Friday
- 8 a.m. – 5 p.m.

Address
- 4665 Business Center Drive Fairfield CA

Member Services
- (707) 863-4120

Partnership website
- www.PartnershipHP.org

Provider Relations
- (707) 863-4100

FIS Integrated Payables (EFT)
- (877) 330-4950

Just a reminder if you are sending PHI please utilize your internal secure email system to meet HIPAA standards. If unable to send a secure email then please send via fax.