



## **Pediatric Palliative Care (PPC) Waiver Transition Frequently Asked Questions for Call Centers**

Updated December 2018

### **Background**

The PPC Waiver is authorized under Section §1915(c) of the U.S. Social Security Act and §14132.74 of the State's Welfare and Institutions Code (WIC). Waivers are programs that allow the State to offer services above and beyond the currently approved Medicaid State Plan. The PPC Waiver was first approved by the Centers for Medicare & Medicaid Services (CMS) in December 2008, and started as a three (3) year pilot program on April 1, 2009. On December 27, 2012, the PPC Waiver was renewed for an additional five (5) year term through December 26, 2017. Following that renewal and subsequent discussions with CMS, it was determined that the PPC Waiver could not continue as structured and needed to end. Currently, the State has approval to operate the PPC Waiver through the end of December 2018.

### **Current Status**

Effective December 31, 2018, the way participants get PPC will change. PPC services will be provided through the Managed Care and Regular Medi-Cal delivery systems under Medi-Cal for members under age 21 who qualify. Nothing about how Medi-Cal benefits are provided will change, only the way PPC services are provided.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are a part of the Medi-Cal program. EPSDT provides preventive, diagnostic, and treatment services to eligible beneficiaries under the age of 21. The goal of this benefit is to have beneficiaries under the age of 21 receive necessary health screenings for their age, get preventive services to keep them healthy, and to identify health problems and medically necessary treatments. PPC waiver services, such as pain and symptom management, counseling, and end of life discussions, are available through all Managed Care Plans. Other services, including expressive therapy and respite, may be available through Managed Care Plans.

Because the PPC Waiver is ending, the Department of Health Care Services (DHCS) has created a transition plan that identifies activities to move PPC Waiver beneficiaries to either the Managed Care or Regular Medi-Cal delivery systems by January 1, 2019, as applicable. The transition plan includes a 60- and 30-day notice mailing and call campaigns to educate waiver participants about the transition. It also provides an opportunity for the enrollment of non-mandatory participants into a Managed Care Plan.

## **A. General Questions**

### **1. Why is the PPC Waiver ending?**

Answer:

The PPC Waiver was only approved to last for a certain number of years. That time ends on December 31, 2018.

### **2. How will I receive my PPC services on or after Jan 1, 2019?**

Answer: Medi-Cal covers most medically necessary PPC services for all Medi-Cal members under age 21.

- Members now in a Medi-Cal Managed Care Plan will get PPC services through their plan starting **January 1, 2019**.
- Members receiving Medi-Cal services in Regular Medi-Cal will get their PPC services through Regular Medi-Cal starting **January 1, 2019**.

### **3. What are EPSDT services?**

Answer: EPSDT services are State Plan benefits that provide comprehensive, preventative, diagnostic, and treatment services to Medi-Cal-eligible beneficiaries under the age of 21. The EPSDT program includes all services that are medically necessary, even if the service is not covered under Medi-Cal, as long as it is a Medicaid benefit. Most of the services provided by the PPC Waiver are also covered under EPSDT.

### **4. Who can get EPSDT services?**

Answer: Medicaid-eligible beneficiaries who are under the age of 21.

**5. Will beneficiaries transitioning from receiving services under PPC to the Managed Care or Regular Medi-Cal delivery systems keep the same services?**

Answer: Medi-Cal PPC services are not exactly the same as PPC Waiver services.

PPC Waiver Services Covered by Medi-Cal		
	Yes	No
Pain and symptom management	X	
Personal care services	X	
Family counseling (see below)	X	
Care coordination (see below)	X	
Family training (see below)	X	
Respite care in and out of home		X
Expressive therapies (art, music, and massage)		X
24/7 palliative care phone consultation access (See below)		X

\* Please see Appendix A for a service code crosswalk

*Family counseling:*

Services are available through the Managed Care Plan, the county mental health plan, and/or social services benefits as psychotherapy, bereavement counseling, and medical social services.

*Care coordination:*

Coordination of care is available in Managed Care Plans and by your PPC provider. Care coordination is available in Regular Medi-Cal to the extent that the PPC service provider will work to coordinate the specific service(s) they are providing but is not a separate billable service. Care coordination may be less intensive in Regular Medi-Cal because there are no managed care supports. Beneficiaries enrolled in managed care receive the care coordination by the Managed Care Plan.

*Family training:*

Although family training is not a Medi-Cal covered service, a similar service is covered through the Palliative Care Assessment and Consultation by the beneficiary's care team. The consultation aims to collect both routine medical data and additional personal information such as patient goals. Topics may include, but are not limited to:

- Treatment plans, including palliative care and curative care
- Pain and medicine side effects
- Emotional and social challenges
- Spiritual concerns
- Patient goals
- Advance directive, including Physician Orders for Life-Sustaining Treatment forms
- Legally recognized decision maker

The assessment includes the beneficiary and/or his or her representative in the development of the plan of care. The plan of care is designed to meet the physical, medical, psychosocial, emotional, and spiritual needs of the beneficiary. The plan of care will also address other issues such as medication services and allied health.

*24/7 palliative care phone consultation access:*

Although 24/7 palliative care phone consultation access is not a Medi-Cal covered service, many Managed Care Plans have nurse advice lines to use.

Managed Care Plans may authorize additional palliative care services not described above, at the Managed Care Plan's discretion and cost. Therefore, work with your Managed Care Plan to see if they will authorize additional palliative care services.

**6. Will beneficiaries get a notice about the PPC Waiver transition?**

Answer: Yes. Beneficiaries received a notice from DHCS 60 days prior to January 1, 2019, letting them know that the PPC Waiver is ending.

- Beneficiaries in a Medi-Cal Managed Care Plan will also receive a notice from their plan.
- Beneficiaries in Regular Medi-Cal will also receive a 30-day notice from DHCS.
  - Beneficiaries in Regular Medi-Cal who are eligible for enrollment into Managed Care will also receive an Enrollment Packet to choose a Health Plan.

- Beneficiaries will also receive follow up phone calls after they receive their Enrollment Packet to help answer any questions or to help them make a health plan choice.

**7. How will beneficiaries be receive referrals for PPC services moving forward?**

Answer: Currently, PPC referrals come from the county only. Beginning January 1, 2019, referrals for PPC services may either go to a beneficiaries Managed Care Plan or seek services through Regular Medi-Cal, as applicable. Referrals may come from hospitals, home health agencies, specialty providers, and other community-based providers that include licensed clinical staff with experience and/or training in palliative care.

**B. Managed Care Questions**

**1. What are the benefits of being in managed care?**

Answer: There are many benefits of being in managed care. Here are a few examples:

- Primary Care Physician (PCP) assignment. Managed Care Plans are responsible for ensuring that beneficiaries always have a primary doctor, also called a PCP. Beneficiaries and their families may either choose a PCP or have one chosen for them by the plan. Beneficiaries and their families can change their doctor to another in-network doctor at any time.
- Timely access to appointments. PCPs and specialists must offer appointments within certain time requirements.
- Out of network access. Managed Care Plans must make sure beneficiaries can get all medically necessary services. This means that beneficiaries can get services outside of the health plan or out of network if the plan cannot provide the services in network.

Managed Care Plans must give beneficiaries and their families' resources for their care. This includes:

- Provider Directory. Managed Care Plans must have a list of providers in print and electronic forms. The Provider Directory will help beneficiaries and their families find the types of providers that are in the Managed Care Plan's network and where offices and clinics are located.
- Member services. Managed Care Plans must have a Member Services Center. Members can call the Member Service Center with any questions or concerns. This will help beneficiaries and their families when they have questions such as how to find a doctor and get care.
- Interpreter services. If a member speaks another language other than English, translators are available 24 hours a day, seven days a week.

- Member informing materials. Members can request alternative formats such as Braille, large size print, or audio.
- Care coordination. Managed Care Plans must have a care coordination team available to help beneficiaries get services, and manage referrals and authorizations.

## **2. How will DHCS make sure Managed Care Plans are following the requirements of EPSDT to include PPC?**

Answer: DHCS will use many different ways to make sure Managed Care Plans are following the requirements of EPSDT. DHCS will monitor the transitions for up to two years after the transition. DHCS will collect and analyze data for the PPC Waiver beneficiaries to ensure services are provided in a timely manner. DHCS will also use the tools below (in addition to others) to monitor Managed Care Plans:

- Encounter data
- Provider networks oversight to monitor:
  - Network certification
  - Require Managed Care Plans contracts with as many California Children's Services paneled providers needed in-county, regionally and statewide
  - Timely access to services
- Grievances and appeals and State Hearings
- Annual audits
- Continuity of care
- Utilization data
- Managed Care Plan call center data
- DHCS Ombudsman call center data

DHCS has a formal process for monitoring and providing Managed Care Plans with technical assistance, ensuring the implementation of corrective action plans, and applying penalties, as appropriate.

## **C. Beneficiary Protections**

### **1. What happens if a beneficiary is not happy with a provider or does not like the services they get from the Managed Care Plan?**

Answer: Managed Care Plans must have a Member Grievance System, which includes an appeal process. If a beneficiary is not happy with their services, they have the option to contact the Managed Care Plan and share their questions or concerns. Beneficiaries and their families can also file a complaint directly with the Managed Care Plan, contact the plan's member services department, file a complaint with the Department of Managed Care (DMHC), or request a State Hearing from the State of California and an Administrative Law Judge will review the complaint.

## 2. What is continuity of care (CoC)?

Answer: CoC rights apply to transitioning Regular Medi-Cal beneficiaries going into a Medi-Cal Managed Care Plan in accordance with state law. Beneficiaries who make a request to a Managed Care Plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. Eligible members may require CoC for services they have been receiving through Regular Medi-Cal or through another Managed Care Plan.

## 3. What are the CoC protections with the PPC transition?

Answer: If a beneficiary's palliative care provider and Managed Care Plan enter the agreement, the beneficiary's palliative care services or palliative care provider will **not** change for up to 12 months. If a beneficiary believes they should have CoC for their medically necessary services, they can contact their Managed Care Plan or provider for help.

If beneficiaries receive health care services through Regular Medi-Cal, they can get PPC services from any enrolled Medi-Cal provider. Beneficiaries can ask their provider if they are enrolled as a Medi-Cal provider. If they are not, then beneficiaries will need to choose another provider who is enrolled in Medi-Cal to keep getting the PPC services.

## D. Where to Find More Information

### 1. Where can PPC Waiver beneficiaries and their families go if they have questions?

Answer: For questions about this change:

- If you are in a Managed Care Plan, call your plan's member services. Tell them you have a question about your PPC services.
- If you are in Regular Medi-Cal, call **1-800-541-5555**.

If you need more help, call the Department of Health Care Services Ombudsman toll free Monday through Friday from 8:00 a.m. to 5:00 p.m. at **1-888-452-8609**.

For questions or comments, please send an email to [CCSPPC@dhcs.ca.gov](mailto:CCSPPC@dhcs.ca.gov).

**E. What if I do not want to be in a Managed Care Plan?**

Answer: You will receive these services under Regular Medi-Cal delivery system:

- 1) Advance Care Planning
- 2) Palliative Care Assessment and Consultation
- 3) Plan of Care
- 4) Palliative Care Team
- 5) Pain and Symptom Management
- 6) Mental Health and Medical Social Services

Care Coordination provided by the plans will not be available.

Appendix A – Service Code Crosswalk

<b>PPC Services</b>	<b>PPC Waiver Codes</b>	<b>Regular Medi-Cal Codes</b>	<b>National Code (effective 1/1/2019)</b>
Pain and symptom management	S9123	Prescription drugs, physical therapy (TAR) (I/O), Home health physical therapy (Multiple Codes – Please See Provider Manual)	Prescription drugs, physical therapy (TAR) (I/O), Home health physical therapy (Multiple Codes) – Please See Provider Manual)
Personal care services	S9123	Z5804, Z5805, Z5806, Z5807, Z5832, Z5834, Z5836, Z5838	S9123, T1030, S9124, T1031, G0299, G0300, G0162, G0156
Family counseling	90837	Z5814, Z5816	N/A
Care coordination	G9001, G9012, T2022, T2025	Z5820	T1016
Family training	S5110	<ul style="list-style-type: none"> <li>• Not an available benefit under the State Plan or through EPSDT.</li> <li>• Although family training is not a Medi-Cal covered service, a similar service is covered through the Palliative Care Assessment and Consultation. This includes the beneficiary and/or his or her representative in the development of the plan of care.</li> </ul>	N/A
Respite care in and out of home	H0045, T1005	<ul style="list-style-type: none"> <li>• Not an available benefit under the State Plan or through EPSDT.</li> <li>• DHCS' Managed Care Plans will have the option to provide this service at their own discretion.</li> </ul>	N/A

Expressive therapies (art, music, and massage)	G0176	<ul style="list-style-type: none"><li>• Not an available benefit under the State Plan or through EPSDT.</li><li>• DHCS' Managed Care Plans will have the option to provide this service at their own discretion.</li></ul>	N/A
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