Health Net Cal MediConnect

2021 Annual Product Training

Date: 10/15/2020

Coverage for every stage of life™

Agenda

- General Program Updates
- Cal MediConnect Overview
- Market Landscape
- Product
- Accessing Benefits
- Provider Network
- Accessing Services
- Beneficiary Protections
- Enrollment

General Program Updates

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General Program Updates

Care Plan Optional (CPO) services may be available under the member's Individualized Care Plan. These services give more help at home, like meals, help for members or caregivers, or shower grab bars and ramps. These services can help our members live more independently but do **not** replace long-term services and supports (LTSS) that they are authorized to get under Medi-Cal.

Examples of CPO services that Health Net Cal MediConnect has offered in the past include meal delivery services for up to 2 weeks post hospital discharge with our contracted vendor, Mom's Meals; respite care for family caregivers up to 24 hours every 6 months; and Special Services for Groups (SSG) where home visits are scheduled and conducted with the goal of connecting our members to community resources. Members who need help or would like to find out how CPO services may help them should contact their care coordinator.

Cal MediConnect Overview

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Cal MediConnect Overview

What	• Mandatory enrollment into a Medi-Cal health plan • Mandatory transition of Medi-Cal Long-Term Services and Supports (LTSS) to Medi-Cal health plans • Cal MediConnect (MMP)– a voluntary demonstration for individuals covered by both Medicare and Medi-Cal (Dual Eligible)
Who	• Dual eligibles (including 21+, excluding partial duals, developmentally disabled, certain 1915 (c) waiver participants, etc.) • Medi-Cal only (Seniors & Persons with Disabilities and other applicable aid codes)
Where	• 7 counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara
Why	• Improve the coordination of care across the spectrum (physical, behavioral and social services) • Improve quality of care and service • Reduce unnecessary cost

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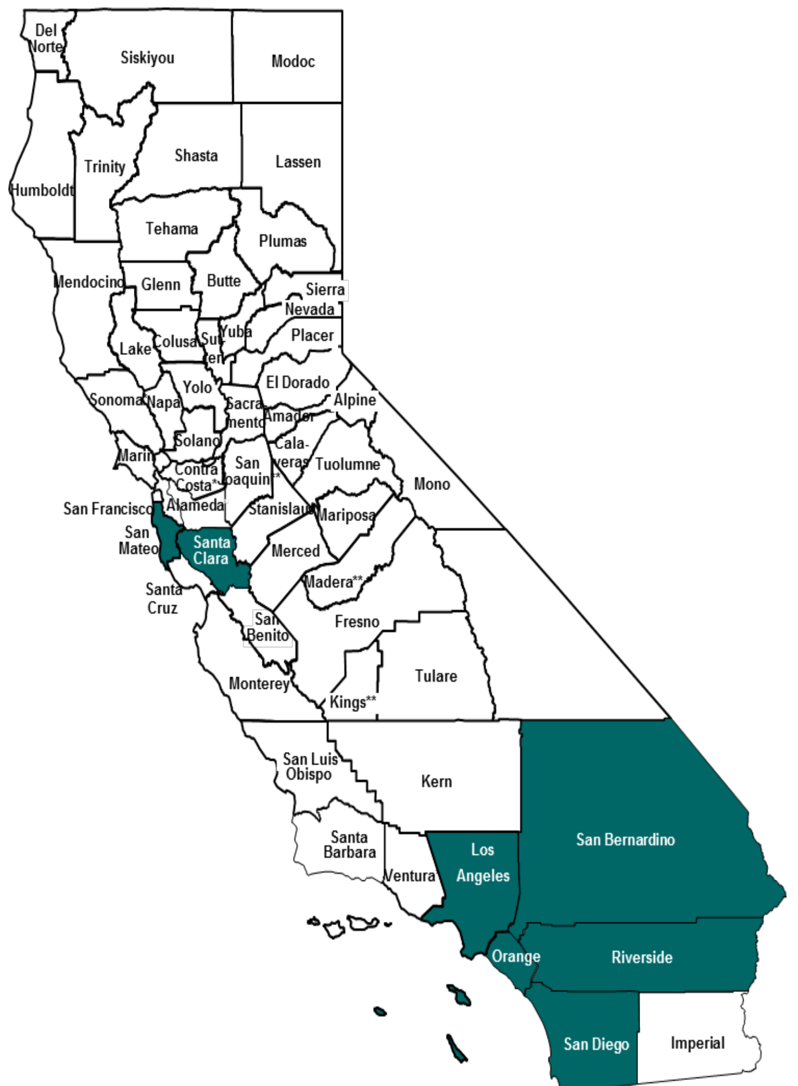
Cal MediConnect Demonstration

Participating plans

1. Los Angeles
   - **Health Net**
   - LA Care
   - Care1st
   - CareMore
   - Molina
2. Orange
   - CalOptima
3. Riverside
   - Inland Empire Health Plan
   - Molina Healthcare
4. San Bernardino
   - Inland Empire Health Plan
   - Molina Healthcare
5. San Diego
   - **Health Net**
   - Care1st
   - Community Health Group
   - Molina
6. San Mateo
   - Health Plan of San Mateo
7. Santa Clara
   - Anthem Blue Cross
   - Santa Clara Family Health Plan



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Eligibility and Exclusions

- Eligible beneficiaries:
  - Age 21 and older at the time of enrollment
  - Entitled to or enrolled in Medicare Part A, enrolled in Part B, and eligible to enroll in a Part D plan as of the effective date of coverage under the MMP
  - Eligible for full Medicaid (Medi-Cal)
  - Permanently reside in the service area of the MMP

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Eligibility and Exclusions

- Excluded from enrollment:
  - Individuals under age 21
  - Individuals with partial benefits or other private or public health insurance, including an employee benefit plan
  - Individuals receiving services through California's regional centers or state developmental centers or intermediate care facilities for the developmentally disabled
  - Individuals residing in one of the Veteran's Homes of California
  - Individual living in rural zip codes [LA: 90704 (Catalina Island)]
  - Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment unless they are already enrolled in a separate line of business operated by the Contractor. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all Enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

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Benefits of Managed Care

Simplified, streamlined services

- One point of contact for all covered benefits
- One health plan membership card
- One phone number to call for help

Patient-centered care

- Access to nurses, social workers, and a care coordination team
- Beneficiaries and their families may participate in the care team
- Continuity of care and care coordination between settings

Improved access to home-and community-based services and reduced reliance on institutional settings

Access to interpreters for non-English speakers and documents in their language

Care and Setting Transition Teams

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Value Proposition to Beneficiaries

Cal MediConnect is a voluntary program, and beneficiaries should choose the delivery model that they believe will work best for their needs. However, Cal MediConnect is designed to improve the delivery of care for people receiving both Medicare and Medi-Cal services. Under Cal MediConnect:

1. Medicare and Medi-Cal benefits will work together and work better without any extra costs
2. Beneficiaries will get one membership card and one phone number to call when they need help.
3. Beneficiaries keep all of the services or benefits they receive now.
4. Providers will work together in what is called “care coordination” to get beneficiaries the care and services they need. The care coordinator will answer members’ questions, help them find community services, assist them in making medical appointments, and help them talk with their doctors.
5. Health Net will seek to understand members’ health care needs and work with members and their doctors to create a personal care plan.
6. Members can call a 24-hour nurse advice line for help.
7. Beneficiaries will receive additional vision benefits.
8. With Health Net in LOS ANGELES ONLY, beneficiaries also receive additional over-the-counter (OTC) items, meals following discharge from an inpatient hospital or skilled nursing facility, routine podiatry and worldwide emergency/urgent care benefits.

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Market Landscape

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CMC Statewide Enrollment – Sept. 2020

DHCS California Department of Health Care Services — **Cal MediConnect Performance Dashboard - Released September 2020** — CalMediConnect

Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 03/01/2020)
See metric summary for additional information

Fig. 2: Count and Percentage of Total Active Enrollments, by County and Plan as of March 2020

County total(s) and percentage(s) of active enrollments	County	Plan	Enrollment
10,304; 10%	Santa Clara	SCFHP	8,283
		Anthem	2,021
8,469; 8%	San Mateo	HPSM	8,469
13,641; 13%	San Diego	Molina	3,933
		Health Net	1,309
		CHG	6,242
		Blue Shield	2,157
15,111; 14%	San Bernardino	Molina	1,488
		IEHP	13,623
15,652; 15%	Riverside	Molina	1,606
		IEHP	14,046
13,838; 13%	Orange	CalOptima	13,838
29,734; 28%	Los Angeles	Molina	1,715
		L.A. Care	15,700
		Health Net	7,409
		Blue Shield	2,677
		Anthem	2,233

Axis: - 10,000 20,000

Source: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx

Product

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Medicare vs. Medi-Cal

Traditionally, who pays for what service?

MEDICARE • People 65 or older • People under 65 with certain disabilities • ESRD & ALS	MEDICAID (Medi-Cal) • Low-income Californians
• Hospital care • Physician & ancillary services • Short-term skilled nursing facility (SNF) care • Hospice • Home health care • Prescription drugs • Durable medical equipment	• Medicare cost sharing • Long-term nursing home (after Medicare benefits are exhausted) • Long Term Services and Supports (CBAS, MSSP, IHSS, HCBS)* • Prescriptions, durable medical equipment, and supplies not covered by Medicare

*LTSS - Long Term Services and Supports:

CBAS: Community-Based Adult Services
MSSP: Multipurpose Senior Services Programs
IHSS: In-Home Supportive Services
HCBS: Home and Community-Based Services

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Health Net Cal MediConnect Benefit Plan Configuration

Medicare:

- Parts A, B, and D benefits are covered

Medi-Cal:

- All Medi-Cal services currently required in managed care services
- Dental through Denti-Cal
- Long-Term Supports and Services
  - Nursing home placement (LTC)
  - Home and community-based programs (CBAS, MSSP)
    - IHSS carved out of CMC plans effective 1/1/18; beneficiaries access IHSS through Medi-Cal FFS

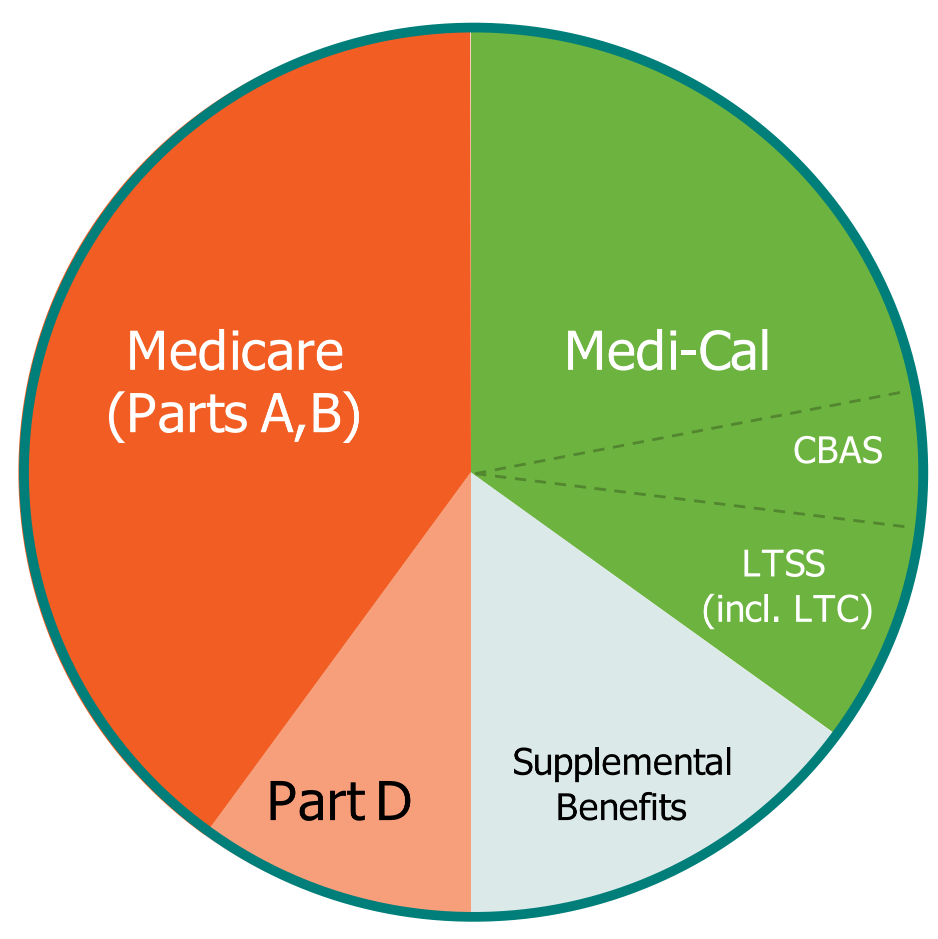
Supplemental benefits

(details next slides)

Coordination:

- With mental health and substance use programs (incl. County DMH)
- Other "non-benefit" community based programs

Duals Demonstration Benefits



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Changes in Supplemental Benefits

2020	2021
Los Angeles & San Diego Counties Additional Telehealth services are **not** covered.	**Los Angeles & San Diego Counties** Members pay a **$0** copay for additional telehealth for the following services: Prior authorization and referral may be required. • Primary Care Physician Services • Physician Specialist Services • Individual sessions for Mental Health Specialty Services • Group Sessions for Mental Health Services • Other Health Care Professional • Individual sessions for Psychiatric Services • Group sessions for Psychiatric Services

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Changes in Supplemental Benefits

2020	2021
Los Angeles & San Diego Counties **Diabetes supplies and services:** Members pay a **$0** copay Diabetic glucometer and supplies are available through PCP.	**Los Angeles & San Diego Counties** **Diabetes supplies and services:** Members pay a **$0** copay Diabetic glucometer and supplies are limited to Accu-Chek and OneTouch and can now be obtained at a Pharmacy. Other brands are not covered unless pre-authorized

Changes in Supplemental Benefits

2020	2021
Los Angeles & San Diego Counties **Multi-Purpose Senior Services Program (MSSP):** This benefit is covered up to **$4,285** per year. **Los Angeles** **Over-the-counter (OTC) items:** You can order up to **15** of the same item per quarter unless otherwise noted in the catalog. There is no limit on the number of total items in your order.	**Los Angeles & San Diego Counties** **Multi-Purpose Senior Services Program (MSSP):** This benefit is covered up to **$5,356.25** per year. **Los Angeles** **Over-the-counter (OTC) items:** You can order up to **9** of the same item per quarter unless otherwise noted in the catalog. There is no limit on the number of total items in your order.

Changes in Supplemental Benefits

2020	2021
Los Angeles The following **required** prior authorization: • Dialysis Services • Kidney Disease Education Services • Other Medicare-Covered Preventive Services o Glaucoma Screening o Diabetes Self-Management Training o Barium Enemas o Digital Rectal Exams o Medicare-Covered EKG following Welcome Visit o Other Medicare-Covered Preventive Services • Hearing Exams	**Los Angeles** The following **no longer require** prior authorization: • Dialysis Services • Kidney Disease Education Services • Other Medicare-Covered Preventive Services o Glaucoma Screening o Diabetes Self-Management Training o Barium Enemas o Digital Rectal Exams o Medicare-Covered EKG following Welcome Visit o Other Medicare-Covered Preventive Services • Hearing Exams

Changes in Supplemental Benefits

2020	2021
Los Angeles The following **required** a referral for services: • Skilled Nursing Facility (SNF) • Outpatient Diagnostic Procedures, Tests and Lab Services • Outpatient Hospital Services • Other Medicare-covered Preventive Services	**Los Angeles** The following **no longer require** a referral for services: • Skilled Nursing Facility (SNF) • Outpatient Diagnostic Procedures, Tests and Lab Services • Outpatient Hospital Services • Other Medicare-covered Preventive Services

Changes in Supplemental Benefits

2020	2021
Los Angeles & San Diego Counties The following **did not require** a referral for services: • Home Health Services	**Los Angeles & San Diego Counties** Preventive Services: The following **requires** a referral for services: • Home Health Services

LTSS Benefits

Medi-Cal FFS Benefit	Cal MediConnect	Cal MediConnect	Cal MediConnect
In-Home Supportive Services (IHSS)	**Multipurpose Senior Services Program (MSSP)**	**Community-Based Adult Services (CBAS)**	**Long Term Care (LTC)**
• Domestic Services (house cleaning & chores) • Meal Preparation / Clean Up • Grocery Shopping and Errands • Routine Laundry • Personal Care Services (e.g., bathing, personal grooming, dressing, feeding) • Accompaniment to-and-from Medical Appointments	• Adult Day Care / Support Center • Housing Assistance • Chore and Personal Care Assistance • Protective Supervision • Care Management • Respite • Transportation • Meal Services • Social Services • Communications Services	• Nutrition service • Professional nursing care • Therapeutic activities • Facilitated participation in group or individual activities • Social services • Personal care services - Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). • Physical therapy • Occupational therapy • Speech therapy • Behavioral health services • Registered dietician services • Transportation	• Long-term (Medi-Cal) nursing facility care after the Short-term (Medicare) benefit is exhausted or member no longer qualifies

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2021 Benefit Highlights

2021 Benefit Highlights	Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)	Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)
County Plan Offered	**Los Angeles**	**San Diego**
Contract/PBP	**H3237-001**	**H3237-002**
Monthly Plan Premium	$0	$0
Annual Maximum Out-of-Pocket (MOOP)	N/A	N/A
Primary Care Visit (PCP)	$0 copay	$0 copay
Specialist Care Visit	$0 copay	$0 copay
Inpatient Hospital Care	$0 copay	$0 copay
Inpatient Mental Health	$0 copay	$0 copay
Skilled Nursing Facility (SNF)	$0 copay	$0 copay
Worldwide Emergency/Urgent Coverage (urgent, emergent and post-stabilization care received outside of the U.S.)	**$0 copay $50,000 annual limit**	**Not Covered**

This information is not a complete description of benefits. The actual complete terms and conditions of the health plan are set forth in the Member Handbook

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2021 Benefit Highlights

2021 Benefit Highlights	Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)	Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)
County Plan Offered	**Los Angeles**	**San Diego**
Contract/PBP	**H3237-001**	**H3237-002**
Hearing Aids	$0 copay for Medi-Cal covered hearing aids $1,510 maximum benefit amount per year	$0 copay for Medi-Cal covered hearing aids $1,510 maximum benefit amount per year
Incontinence Cream and Diapers	$0 copay	$0 copay
Meals	**$0 copay** Up to two home delivered meals per day up to 14 days following discharge from an inpatient hospital or skilled nursing facility	**Not Covered**
Non-medical Transportation (NMT): car, taxi, public/private transportation	$0 copay per trip; unlimited round trips	$0 copay per trip; unlimited round trips
Non-Emergency Medical Transportation (NEMT): ambulance, litter van, wheelchair van	$0 copay	$0 copay
Over-the-Counter (OTC) Items	**$55 allowance per quarter**	**Not Covered**
Routine Podiatry	**$0 copay; 12 visits every year**	**Not Covered**
Routine Vision Exam	$0 copay; 1 every year	$0 copay; 1 every year
Routine Vision Eyewear	$0 copay Eye glasses (frames and lenses) OR contact lenses 1 every 2 years; **$250 allowance every 2 years**	$0 copay Eye glasses (frames and lenses) OR contact lenses 1 every 2 years; **$100 allowance every 2 years**

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2021 Benefit Highlights

2021 Benefit Highlights	Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)	Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)
County Plan Offered	**Los Angeles**	**San Diego**
Contract/PBP	**H3237-001**	**H3237-002**
Routine Preventive & Comprehensive Dental	Not Covered Dental services are available through the Medi-Cal Denti-Cal Program.	Not Covered Dental services are available through the Medi-Cal Denti-Cal Program.
Acupuncture	$0 copay	$0 copay
Routine Chiropractic	Not Covered	Not Covered
Fitness Program	$0 copay Basic membership at a participating fitness facility or an in-home fitness program	$0 copay Basic membership at a participating fitness facility or an in-home fitness program
Community-Based Adult Services (CBAS)	$0 copay	$0 Copay
Family Planning Services	$0 copay	$0 Copay
In-Home Supportive Services (IHHS)	Not Covered IHSS services are available through Medi-Cal FFS	Not Covered IHSS services are available through Medi-Cal FFS
Long Term Care (LTC)	$0 copay	$0 Copay
Multipurpose Senior Services Program (MSSP)	$0 copay Up to **$5,356.25** per year	$0 copay Up to $5,356.25 per year

This information is not a complete description of benefits. The actual complete terms and conditions of the health plan are set forth in the Member Handbook

Pharmacy Updates

If a member has been in the plan for more than 90 days and lives in a long-term care facility, we will cover a one-time 31-day supply of medication, or less if their prescription is written for fewer days. This is in addition to the long-term care transition supply.

- If they are moving from a long-term care facility or a hospital stay to home, we will cover one 30-day supply, or less if their prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 30-day supply of medication).
- If the member is moving from home or a hospital stay to a long-term care facility, we will cover one 31-day supply, or less if their prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 31-day supply of medication). The member must fill the prescription at a network pharmacy.

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Pharmacy Updates

	2020	2021
Drugs in Tier 1 (Tier 1 drugs have a lower copay. They are generic drugs.) Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy	Copay for a one- month (30-day) supply $0 - $3.60 per prescription.	Copay for a one- month (30-day) supply $0 - **$3.70** per prescription.
Drugs in Tier 2 (Tier 2 drugs have a higher copay. They are brand-name drugs.) Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy	Copay for a one- month (30-day) supply $0 - $8.95 per prescription.	Copay for a one- month (30-day) supply $0 - **$9.20** per prescription.
Drugs in Tier 3 (Tier 3 drugs are prescription and over-the-counter drugs that Medi- Cal covers.) Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy	Copay for a one- month (30-day) supply $0 per prescription.	Copay for a one- month (30-day) supply $0 per prescription.

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Pharmacy Updates

See CMC Drug List:

- Some Drug List exceptions will still be covered next year.
- Some of the drugs on the Drug List have been moved to a lower or higher drug tier.

The Initial Coverage Stage ends when total out-of-pocket costs reach **$6,550*.*** At that point the Catastrophic Coverage Stage begins. During this stage, the plan will pay all of the costs for the member's Medicare drugs.

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Accessing Benefits

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Meal Benefit

- Members in Los Angeles County can receive up to two home delivered meals per day for up to 14 days following discharge from an inpatient hospital or skilled nursing facility.

- Menu options meet the nutritional requirements of most major health conditions, such as diabetes, vegetarian, gluten free, pureed, low sodium, etc.

- Meals are administered by Mom’s Meals. Meals must be medically necessary and are coordinated through the care management process during discharge.

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Over-the-Counter (OTC) Items

Members in Los Angeles County receive a $55 allowance every three months to spend on commonly used OTC items. These are health related items that can be purchased without prescriptions such as: pain relief items, antacids, laxatives, cough or cold items, first aid supplies, dental care, ear and eye care and vitamins

- Orders can be placed online or by phone, mail, or fax
- Items are shipped directly to the member's home in 7-10 working days
- One order is allowed every three months
- Up to 15 of the same item per quarter can be ordered. There is no limit on the number of total items in an order
- Unused balances at the end of the each quarter will be forfeited

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Transportation Coverage

Cal MediConnect provides both Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)

Non-Emergency Medical Transportation (Door-Through-Door Service)

- NEMT includes ambulance, wheelchair and gurney vans, and is provided when medically necessary and members are not ambulatory.
- NEMT provides door-through-door service. This is a higher level of service than door-to-door where the driver actually provides assistance within the origin or destination.
- NEMT under Medi-Cal is covered when a member's medical and physical conditions do not allow members to travel by bus, passenger car, taxicab, or another form of public or private conveyance.
- NEMT is provided to obtain covered medical services and requires a valid Physician Certification Statement (PCS) form authorized by a licensed practitioner.

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Transportation Coverage

Non-Medical Transportation (Curb-to-Curb or Door-to-Door Services)

- NMT includes taxi, standard passenger vehicle, mini-van, wheelchair (uses wheelchair but is able to transfer without assistance para-transit such as Access, or fix route transportation such as buses/mass-transit.
- NMT is provided to obtain covered medical services and DOES NOT require a valid Physician Certification Statement (PSC) form authorized by a licensed practitioner.
- NMT provides the following types of services:
- Curb-to-Curb: the transportation provide picks up and discharges the member at the curb or driveway in front of their home or destination. In curb-to-curb service the drive does not assist the member along walkways or steps to the door of the home or other destination.

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Transportation Coverage

<u>Non-Medical Transportation (Curb-to-Curb or Door-to-Door Services)</u>

- Door-to-Door: this is a form of paratransit service which includes member assistance between the vehicle and the door of his or her home or other destination. The drive will provide limited assistance from the front door of the building where the destination is as well as securing the member in the vehicle. It is not the expectation that a driver function as an escort in helping or staying with a member in need of supportive care or assistance. It is also not the expectation that the driver assist a member within a facility once they have arrived to drop the member off at a facility.
- NMT does not include any form of door-through-door services for the member.

Scheduling Transportation

<u>Routine Reservation hours:</u>

Health Net Cal Medi-Connect: Monday – Friday: 8:00 AM – 5:00 PM (PST)

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Transportation Coverage

Scheduling Transportation

Routine Reservation hours:

To request routine transportation: 866-799-4465 (Mass-transit/Para-transit/Ambulatory/Wheelchair)

Advance Notice Requirements for Routine:

- 7 Calendar Days
- PLEASE NOTE: For scheduled medical appointments that are urgent in nature, such as Dialysis, Chemo Therapy, Radiation Therapy, Infusion Therapy, Discharges and wound care does not require the 7 calendar days advance and will be scheduled same day. For all other possible urgent transports (i.e. same day appointments made by the physicians office) will be subject to appointment verification and we will make every effort to arrange transportation but it's not an guarantee as it's based on network availability.

To check the status or confirm the estimated time of a ride:

- Where' s My Ride: Option#1
- Bilingual Services are available

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Transportation Coverage

Gurney and Above Reservations:

To request transportation: 866-799-4465 Option #2 (Gurney / Ambulance)

- Available 24 hours a day, seven days a week.

To check the status or confirm the estimated time of a ride:

- Where' s My Ride: Option#1
- Bilingual Services are available

Trip Limits:

- Medicare (NMT): **Unlimited Trips**
- Medi-Cal (NEMT): **Unlimited Trips**

Services:

- Service to and from medical appointments, pharmacy, radiology provider or laboratory facility
- No limitation on mileage within the service area
- 1 escort (i.e. family member or caretaker 18 years of age or older) allowed on the transport at no additional cost

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Provider Network

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Care Delivery Spectrum

Under the Demonstration, Health Plans are responsible for the full spectrum of care delivery

Care Delivery	Traditional Medical	SNF's	LTC	HCBS	Community Well
Benefit	• Professional services • Acute Hospital • Etc.	• Skilled Nursing • Skilled therapy	• Custodial Care	• CBAS • MSSP • IHSS (Medi-Cal FFS Benefit Eff. • Other HCBS	
Traditional Payer	• Medicare	• Medicare for 1st 100 days	• Medi-Cal	• Medi-Cal	

Inter-disciplinary Care Teams (ICT) provide one point of accountability for the delivery, coordination, and management of benefits and services. Comprised of Member and Caregivers, Primary Care Physician, Nurse, Behavioral Health Clinician, Pharmacist, Case manager, and Social worker

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Enabling the Interdisciplinary Care Team

LTSS Providers
Participating with member consent

Participating Physician Groups
Focused on coordination and member needs at a very local level.

Primary Care Physician & Case Manager
Primary Points of Contact for the member and ICT

Health Net Connect The Needs Program & LTSS Support Team
Home assessment and face to face supporting care plan options & linkages

Health Net IT
Facilitate care delivery by connecting providers and members with information they need about member care

Health Net Oversight & Quality
Monitor to ensure high quality care

Partnering Together to Meet the Needs of the Member

This Model:

- Allows us to mobilize in a way that the State has not been able to in the past.
- Allows the case manager to serve as the "quarterback" for the member's care through the ICT, to pull resources together to meet the member's need at the right time, the right place, and in the right way

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Cal MediConnect is Member Centric

Health Net's goal is for every Cal MediConnect member to experience seamless, patient centered care that integrates physical, behavioral health and long-term services and supports.

Social Services
Long Term Services & Supports
Caregiver
Member
Case Manager
Service Providers
Specialists
Behavioral Health

At the center of the ICT model are the persons who serve at the core and most closely interact with one another: the Member and caregiver, the Case Manager and the service providers.

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Interdisciplinary Care Team (ICT)

The Cal MediConnect model of care is predicated on person centered care coordination supported by interdisciplinary care teams (ICT)

ICTs are customized and periodically updated to meet the needs of the member, meaning that participants may change, depending on current needs

The Cal MediConnect model of care encourages the involvement of caregivers in the ICT ***so long as the member allows them to participate***

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Contracted Providers

Los Angeles County

- Allied Pacific of California IPA
- AltaMed Health Services
- Angeles IPA
- AppleCare Medical Group
- Axminster/Providence Medical Associates
- Facey Medical Foundation
- Health Care LA
- Healthcare Partners
- Heritage Provider Network
- Lakewood IPA
- Los Angeles Jewish Home Medical Associates
- Martin Luther King Jr. Community

Los Angeles County

- Medical Group - Compton
- Physicians Associates
- Preferred IPA of California
- Prospect Medical Group
- Seoul Medical Group, IPA
- St. Vincent IPA Medical Group
- Torrance Hospital IPA

San Diego County

- Direct Network: San Diego
- Health Essentials Physician Network (GeriNet)
- Scripps Coastal Medical Center
- Scripps Physicians Medical Group

Provider Network is subject to change. For the most recent network information, please refer to the provider search function on www.healthnet.com

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Health Essentials Physician Network (GeriNet)

GeriNet is a provider organization that cares for members in nursing facilities that Health Net has contracted with to provide **Professional services only** to Cal MediConnect institutionalized members living in San Diego County.

GeriNet's full contractual name is "GeriNet Medical Associates DBA Health Essentials Physician Network, a California Professional Medical Corporation", meaning GeriNet is managed by an organization named Health Essentials. They show up in the Health Net system as "Health Essentials Physician Network PPG# 5392."

If a San Diego county member is a permanent resident of a nursing home upon enrollment into the CMC program, they will be automatically assigned to a Health Essentials Physician Network provider as their primary care provider in our enrollment system.

Health Essentials Physician Network will be those members' assigned PPG; however, they do not provide specialty care services and are not delegated for utilization management or case management.

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Health Essentials Physician Network (GeriNet)

Health Essentials Physician Network supports our members needs by supporting care coordination efforts in partnership is Health Net's case management team. Essentially, they provide primary care services to members residing in a nursing home facility.

If you see a member is assigned to Health Essentials Physician Network in Health Net’s system, that means that Health Net is providing the Case Mgmt/ Care Coordination services for that member, and that Health Essentials Physician Network is providing their physician-level care.

If a member is assigned to Health Essentials Physician Network, there is no dual risk PPG partner or hospital in these situations. If the member has an inpatient admission while in the nursing facility, authorizations and billing would need to be routed to Health Net directly.

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Delivery System Strategy and Goals

Integrate behavioral, medical and social services

- Participating Provider Groups with the ability to deliver on our model of care
- Align PPGs and Hospitals in local communities

Identify Unmet Need

- IHSS, CBAS, MSSP (limited slots)
- Home & Community Based Services
- Nursing Facility Placement

Minimize Fragmentation and Improve Coordination

- Leverage IT to facilitate Care Plan Sharing
- Train: Medical, Behavioral Health, LTSS Providers and Other “Trusted Sources”
- Oversee Performance and Communicate Often

Reduce Rate of Institutionalization

- Alternative Placements
  - Repatriation; use of board and care, residential care facilities

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Overview of HELP and Connect to Needs

Health Net Empowered Living Program (H.E.L.P):

What: H.E.L.P. is a Health Net support center available to assist PPG Case Managers with referrals and connecting members to the appropriate LTSS program, such as CBAS, IHSS, MSSP, HCBS.

Why: Because coordinating LTSS for members may be a new concept for Participating Provider Groups (PPG). Providing assistance to PPG Case Managers through the H.E.L.P. creates a stronger partnership with our Groups, and ensures the members access LTSS programs.

Connect the Needs (CTN):

What: A Health Net-specific service for members with complex, unmet LTSS need. If a member is eligible for CTN, MSSP providers will be available to conduct an in-home assessment, develop and execute on a social service plan of care that focuses on linking members to supports and services in the community. The social service care plan is then incorporated into the member's overall care plan that is managed by the interdisciplinary care team.

Why: To prevent unnecessary hospitalization and institutionalization to at-risk members by providing access to home and community based alternatives through leveraging the experience of providers in the community.

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Accessing Services

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Public Programs Department

The Health Net Public Programs Department ensures that Medi-Cal and Cal MediConnect members have access to services and public health programs and advocates on behalf of members.

Members and providers are encouraged to call the Member Services and Provider Services Departments directly as most issues can be easily resolved by those units.

Issues that are complicated in nature and may require special attention are escalated to Public Programs Coordinators (PPCs) by the member services unit.

Health Net PPCs assist members needing support with access to care and continuity of care (COC) requests, as well as link members to Long Term Services and Supports (LTSS).

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Continuity of Care

Continuity of care requirements for Cal MediConnect are defined at Welfare and Institutions (W&I) Code §14182.17

All Cal MediConnect beneficiaries with an existing relationship with a primary or specialty care provider can request continuity of care. An existing relationship means the beneficiary has seen an out-of-network primary care or specialty care provider at least once during the twelve months prior to the date of his or her initial enrollment in the plan for a non-emergency visit.

A beneficiary with pre-existing provider relationships who make a continuity of care request to the plan must be given the option to continue treatment with their current out-of-network providers and service authorization at the time of enrollment for a period up to 12 months for Medicare or Medi-Cal services, if all of the required criteria are met.

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Continuity of Care

The plan is not required to provide continuity of care for services not covered by Medi-Cal or Medicare.

The following providers are <u>not</u> eligible for continuity of care:

- Providers of durable medical equipment (DME)
- Transportation
- Other ancillary services
- Carved-out services

The plan may choose to not provide continuity of care with an out-of-network provider when:

1. The ability to demonstrate an existing relationship between the beneficiary and provider does not occur
2. The provider is not willing to accept payment from the plan based on the current Medicare or Medi-Cal fee schedule, as applicable, and
3. The plan would otherwise exclude the provider from its provider network due to documented quality of care concerns.

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Continuation of Care

A quality of care issue means that a health plan can document concerns with the provider’s quality of care to the extent that the provider would not be eligible to provide services to any other health plan members.

Where can I check for quality of care?

- Medical Board: http://www.medbd.ca.gov/lookup.html
- OIG exclusion list: http://oig.hhs.gov/exclusions/index.asp
- Medi-Cal excluded provider list: You can get to this link by going to the Medi-Cal Provider Manual site: (http://files.medical.ca.gov/pubsdoco/Manuals_menu.asp). It is under menu item "Other Sections" at the very bottom. (Need the exact spelling of the provider’s name and her/his license number)

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Continuation of Care

If the member does not qualify for continued access to a non-participating provider or the non-participating provider does not agree to Medicare or the Med-Cal FFS rate, the PPG must:

- Arrange for another provider to render the member's care
- Inform the member of the determination in a timely manner appropriate for the member's clinical condition, not to exceed thirty days from the date of the request.

PPG should determine whether existing transition of care requirements under H&S Code Section 1373.96 apply:

- Transition of care applies in cases of pregnancy/care of a newborn, serious chronic illness, acute condition, terminal illness or scheduled surgery or procedure
- **The COC rate requirements do not apply in transition of care cases**

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Continuity of Care (COC)

Continuity of Care (COC) Requests

- New members, their authorized representatives on file with Medi-Cal, or their providers may initiate a request for continuity of care directly from Health Net.
- Public Programs Coordinators receive continuity of care requests from the Member Services Department through:
  - inbound calls;
  - faxes; or
  - encrypted emails.
- PPCs initiate the process of reviewing the request within five business days after receipt of the request.
- Using DHCS guidelines, PPCs complete continuity of care requests within the following timeline:

  - 30 calendar days from the date of receipt;
  - 15 calendar days if the member's medical condition requires more immediate attention; or
  - three calendar days if there is risk of harm to the member.

***Risk of harm is defined as an imminent and serious threat to the member's health.**

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Public Programs Department

Common Continuity of Care (COC) Examples

Example # 1

- Mike enrolled into HN's Cal MediConnect plan on June 1st, but he has a pending doctor's appointment with Dr. Smith, an out-of-network (OON) provider, for the following week.
- Mike has been waiting a long time for this appointment date, so he submits a COC request.
- PPC first verifies that Dr. Smith is an OON provider then contacts the provider to confirm that Mike has been seen by Dr. Smith at least twice within the past 12 months.
- PPC determines that Dr. Smith is willing to see Mike for his upcoming appointment and accepts fee schedule rates.
- PPC obtains necessary information and relays information to PPG for approval.
- PPC communicates approval to Mike.

Example # 2

- Sarah is a newly enrolled member and would like to continue seeing her OBGYN provider who has been seeing her throughout her pregnancy.
- HN PPC first verifies that Sarah's OBGYN is indeed an OON provider.
- PPC contacts the OON provider to confirm that Sarah has been seen by the OBGYN at least twice within the 12 month period from date of COC request.
- PPC determines that the OBGYN is willing to continuing seeing Sarah and accepts Medicare fee schedule rates.
- PPC obtains appointment and provider's information and forwards information to the PPG for review.
- PPG authorizes services.
- PPC advises member of the outcome.

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Public Programs Department

Access to Care Requests

Public Programs Coordinators (PPCs) receive requests of members in need of assistance from any source including, but not limited to the following:

- HN Member Services Department
- Inbound calls from members directly to the PPCs toll free # 800-526-1898
- Public Programs Administrators
- County Public Health Programs Case Managers
- Community Organizations, Advocates and Advocate Attorneys
- Ombudsman's office, Legislator or Senator's office
- Internal departments (Provider Services, Pharmacy, Claims, Compliance at the request of DHCS or DMHC, Appeals & Grievance and Medical Directors)

PPCs acknowledge, review and triage member referrals within two hours and initiate resolution.

Once the issue is resolved, the PPC notifies the member, the referral source, and all the appropriate parties involved.

The PPC follows up with the member a week later to ensure there are no additional issues and encourages the member to call for assistance as needed.

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Public Programs Department

Common Access to Care Examples

Example # 1

- Bob has been newly enrolled into HN and is unable to access his incontinence supplies.
- He had been using a vendor of choice but delivery has stopped.
- HN PPC reaches out to Bob's Primary Care Physician (PCP) and requests a prescription with codes for supplies.
- PPC faxes the prescription to a preferred vendor and confirms the delivery date and time.
- PPC communicates the delivery information with Bob.
- PPC follows up to ensure Bob received all of his incontinent supplies.

Example # 2

- Maria is a newly enrolled HN member and is unable to access her diabetic supplies.
- All diabetic supplies are supplied with an authorization from the member's Participating Physician Group (PPG).
- HN PPC reaches out to Maria's PCP and requests that PCP submit the referral and prescription to the PPG.
- PPC ensures that Maria's PPG submits the diabetic supplies authorization to E-Medical.
- PPC ensures vendor has received the order and confirms delivery day and time.
- PPC communicates delivery information with Maria and follows up to ensure she received all of her supplies.

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Beneficiary Protections

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Enrollee Rights

Health Net must protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers most frequently utilized by the Medicare-Medicaid population, and fully meet the diverse needs of the Medicare-Medicaid population.

Health Net honors enrollee rights and protections, and assures that enrollees are free to exercise those rights without negative consequences.

Consistent with CMS and California regulations, enrollees' rights states that enrollees are free to exercise these rights without consequences for doing so, and includes disciplinary procedures for staff members who violate this policy.

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Enrollee Rights

Health Net provides enrollees with the following rights to:

1. Be treated with respect and with due consideration for his or her dignity and privacy
2. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition(s) and ability to understand
3. Participate in decisions regarding his or her health care, including the right to refuse Treatment
4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
5. Request and receive a copy of his or her medical records, and to request that the medical records be amended or corrected
6. Receive information, including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood
7. Reasonable accommodations

Health Net will ensure enrollees are free to exercise these rights without negative consequences.

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Enrollee Rights

Health Net does not discriminate against enrollees due to:

1. Medical condition (including physical and mental illness)
2. Claims experience
3. Receipt of health care
4. Medical history
5. Genetic information
6. Evidence of insurability
7. Disability

Health Net will ensure that enrollees will not be balance billed by a provider for any service.

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Enrollment

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Personalizing Cal MediConnect - Case Study 1

Mrs. Ortega

Mrs. Ortega is a nearly blind, 68-year-old woman who currently lives on her own in a tiny studio in East Los Angeles. She used to like to go for walks to visit her husband's grave, attend mass at her local church and even used to visit the library to check out audio books. However, now due to her limited eye-sight, she's scared to take walks on her own. Mrs. Ortega is prescribed a few medications to manage her high blood pressure and diabetes. She understands English, but needs assistance speaking English and prefers speaking Spanish when it comes to understanding technical or complex details.

Her daughter, Lucia, and 17-year-old grand-daughter visit her a few times a week, assisting her with meals, arranging doctor appointments and transportation to and from the hospital, as well as ensuring she visits the cemetery and library, and attends mass on Sundays. Her son-in-law recently got a promotion outside of California and Mrs. Ortega's grand-daughter, who helps with Mrs. Ortega, is off to college in Santa Barbara. Lucia is concerned how her mother can continue to live on her own, while ensuring she gets the support she needs for her day-to-day living.

How we can help:

- *The Spanish speaking Health Net Case Manager recommends Mrs. Ortega take advantage of the services of Cal MediConnect to hire a Spanish speaking in-home support services worker to assist her at home twice a week for four hours a visit.*
- *This person would help Mrs. Ortega organize and prepare easy meals, help with light housekeeping, sort out her medications, and assist with paper work for special appointments using public transportation.*
- *Mrs. Ortega qualifies for Access Para-Transit Program, a door-to-door transportation system in Los Angeles County, which will take her to the library and doctor appointments, a few times a week. Her support services worker can also assist Mrs. Ortega in filling out the paperwork to take advantage of these services.*

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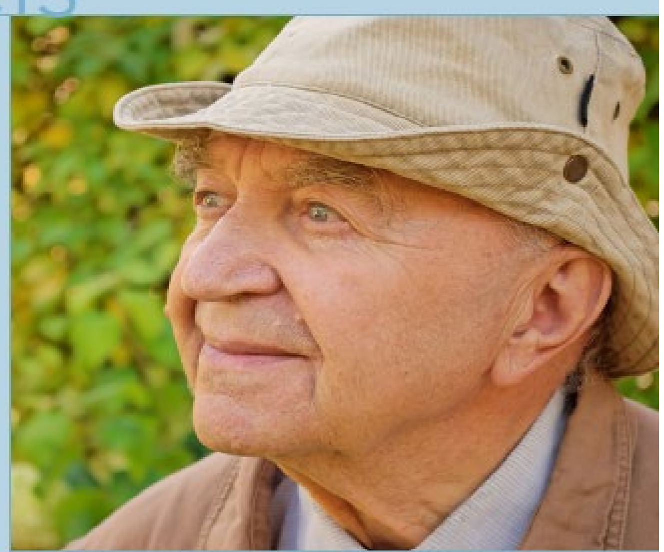
Personalizing Cal MediConnect – Case Study 2

Mr. MacDaniels

Mr. MacDaniels is 87 years old, formerly self-employed and now bankrupt. He recently moved from Tucson, Arizona to Los Angeles County to live with his daughter, Rebecca, and her family. He has high blood pressure and has been having episodes of forgetfulness. His family believes these episodes may be tied to Alzheimer's disease. His memory has not improved since he first arrived at his daughter's home, and now, the situation has worsened because he is starting to wander from home. Rebecca works full time and thinks he might need 24 hour care so he can receive constant supervision. She could use help assessing what support services would be best for her dad.



How we can help:

- *The Health Net Case Manager suggests that Rebecca consider an alternative to residential care called Community-Based Adult Services (CBAS), which will allow him to live with her but provide day time support services at a local center, 5 days a week.*
- *Care at CBAS centers is provided through the county and is available in his community. Transportation to and from Rebecca's home and the CBAS center is included.*
- *This will allow his daughter, Rebecca, to continue working full-time and have peace of mind knowing her dad is getting the therapy he needs, but also meeting his goals of remaining in the home with his family.*
- *Other Health Net support, if needed, includes: coordinating medical and behavioral health needs collaboratively with his providers and family to avoid duplicative medications and tests.*

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AND AGAIN: Value Proposition to Beneficiaries

Cal MediConnect is a voluntary program, and beneficiaries should choose the delivery model that they believe will work best for their needs. However, Cal MediConnect is designed to improve the delivery of care for people receiving both Medicare and Medi-Cal services. Under Cal MediConnect:

1. Medicare and Medi-Cal benefits will work together and work better without any extra costs.
2. Beneficiaries will get one membership card and one phone number to call when they need help.
3. Beneficiaries keep all of the services or benefits they receive now.
4. Providers will work together in what is called "care coordination" to get beneficiaries the care and services they need. The care coordinator will answer members' questions, help them find community services, assist them in making medical appointments, and help them talk with their doctors.
5. Health Net will seek to understand members' health care needs and work with members and their doctors to create a personal care plan.
6. Members can call a 24-hour nurse advice line for help.
7. Beneficiaries will receive additional vision benefits.
8. With Health Net in LOS ANGELES ONLY, beneficiaries can also get additional over-the-counter (OTC) items, meals following discharge from an inpatient hospital or skilled nursing facility, routine podiatry and worldwide emergency/urgent care benefits.

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Enrollment Mechanics: How people join CMC

CALL HEALTH NET CAL MEDICONNECT

Call Health Net Cal MediConnect at 1-888-788-5395 (Los Angeles) or 1-888-788-5805 (San Diego) (TTY 711), Monday to Friday, 8:00 am – 8:00 pm.

CALL HEALTH CARE OPTIONS (HCO)

Call Health Care Options at 1-844-580-7272 (TTY 1-800-430-7077), Monday to Friday, 8:00 am – 5:00 pm, or visit www.healthcareoptions.dhcs.ca.gov

Current Health Net Medi-Cal Members

Call 1-800-977-6738 (TTY 711), Monday to Friday, 8:00 am – 5:00 pm, or visit www.healthnet.com

MAIL

Complete the Choice Form found in the choice booklet and mail it in the postage paid envelope provided. Enrollment will be effective the first of the following month after the date it is received by Health Care Options (HCO).

STREAMLINE ENROLLMENT

Allows Cal MediConnect health plans to submit enrollment changes to DHCS on behalf of their MLTSS members

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Questions?

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