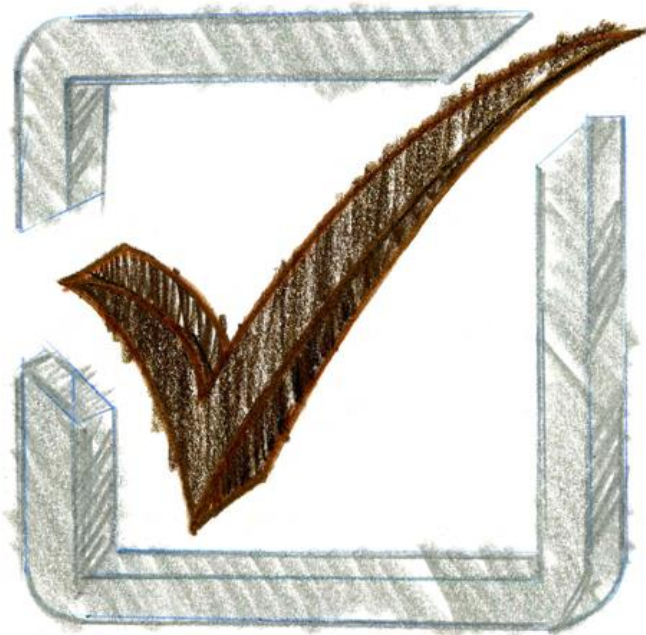


Cal MediConnect Provider Training



Cal MediConnect Program Overview

April 2014

Training Goals

- Cal MediConnect Program Overview
- Health Net's Model of Care
 - Health Risk Assessment
 - Interdisciplinary Care Team
 - Individualized Care Plan
 - Quality Improvement Program
 - Long Term Services and Supports Overview
- Pharmacy Benefit Overview
- Cal MediConnect Ombudsman Program
- Fraud, Waste and Abuse

Cal MediConnect Program Overview

Dual Eligible Beneficiaries

- Dual eligible beneficiaries are eligible for both Medicare and Medicaid.
- Most dual eligible beneficiaries are likely to have mental illness, have limitations in activities of daily living, and multiple chronic conditions.
- Few dual eligible beneficiaries are served by coordinated care models and even fewer are in integrated models that align Medicare and Medicaid.

Federal Coordinated Health Care Office

- CMS's goal is to identify and validate a delivery system and payment coordination model that can be tested and replicated in other states.
- To accomplish this, the Federal Coordinated Health Care Office (FCHCO) was created as a part of CMS by the Affordable Care Act.

Federal Coordinated Health Care Office

The FCHCO works to improve coordination between the federal government and state governments for Medicare-Medicaid beneficiaries in order to ensure full access to covered services in both programs, and high quality of care.

- The FCHCO will use models and demonstrations as one method to improve healthcare access, coordination and cost for members.
- California was one of the states selected to develop a Duals Demonstration that can potentially be replicated in states across the nation.

California's Duals Demonstration

Cal MediConnect is the name that California has assigned to its Duals Demonstration.

It will be available in eight counties:

- Northern California
 - Alameda
 - San Mateo
 - Santa Clara

- Southern California
 - Los Angeles
 - Orange
 - Riverside
 - San Bernardino
 - San Diego

Health Plan Readiness

- Health Plans have undergone thorough readiness reviews prior to beneficiaries enrollment including on-site visits and desk reviews.
- California and CMS are routinely auditing the Health Plans throughout the demonstration.

Cal MediConnect Goals

- Improve the continuity of care and services by coordinating benefits and access to care.
- Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and support in lieu of institutional care.
- Increase the availability and access to home and community-based alternatives.
- Improve health processes and satisfaction with care.
- Optimize the use of Medicare, Medi-Cal and other State and County resources.



What will the Program Look Like?

Benefit Plan Configuration

Medicare:

- Parts A, B, and D benefits covered

Medi-Cal:

- All Medi-Cal services currently required in managed care services
- Long-Term Supports and Services
 - Skilled Nursing
 - Home and Community-Based programs

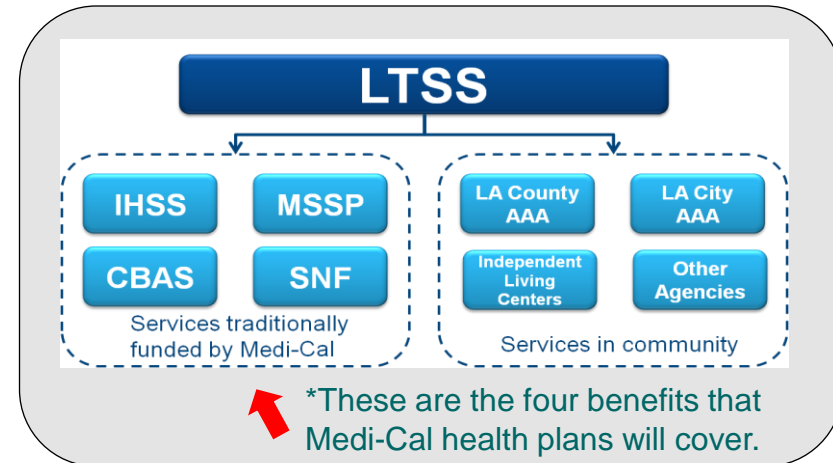
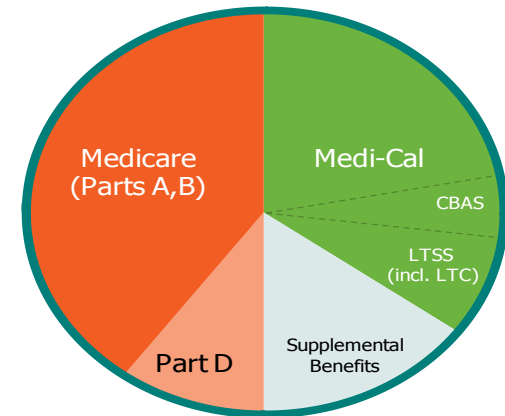
Supplemental benefits:

- Vision
- Transportation

Coordination:

- With mental health and substance abuse programs
- Other “non-benefit” community based programs

Duals Demonstration Benefits



*These are the four benefits that Medi-Cal health plans will cover.

Health Net – Cal MediConnect

Health Net has been selected in California to participate in two of the eight eligible counties:

- Los Angeles
- San Diego

Los Angeles has an enrollment cap of 200,000.

- Health Net will receive approximately 90,000 Cal MediConnect members.
- Health Net expects about 10,000 members to be passively enrolled each month starting July 1st, 2014.

Los Angeles Enrollment Timeline

Implementation to begin April 1, 2014 through December 31st, 2017

**Cal Medi-Connect
Voluntary Only
Enrollment**

- April 1st, 2014
- May 1st, 2014
- June 1st, 2014



**Cal Medi-Connect
Passive
Enrollment Begins**

- July 1st, 2014

Passive enrollment means dual eligible beneficiaries will be assigned to a health plan if they do not affirmatively opt out or choose a specific health plan.

Health Net's Model of Care

Health Net's Goal

- Health Net's goal is for every Cal MediConnect member to experience seamless, patient centered care that integrates physical and behavioral health with long-term services and supports.
- Integrated delivery systems will actively support member health and member's decisions about their health care.
- Health Net has created a Model of Care for Cal MediConnect that creates one point of accountability for delivery, coordination, and management of benefits and services to members.

Member-Centered

- Health Net's Cal MediConnect Program will reflect a member-centered, outcomes-based approach to care planning, consistent with the Medicare Model of Care approach.
- Member-centered means the member has the primary decision making role in identifying his or her needs, preferences and strengths, and a shared decision-making role in determining the services and support that are most effective and helpful.

Cal MediConnect Model of Care Goals

The goals for Cal MediConnect's Model of Care are to improve health outcomes by improving:

- Access to essential services such as medical, mental health, long-term services and supports, and social services.
- Access to affordable care by optimizing utilization of Home- and Community-Based Services (HCBS).
- Coordination of care through an identified point of contact and medical home.
- Seamless transitions of care across health care settings, providers and HCBS.
- Access to preventive health services.
- Appropriate utilization of services.
- Member health outcomes and satisfactions.

Health Net's Model of Care

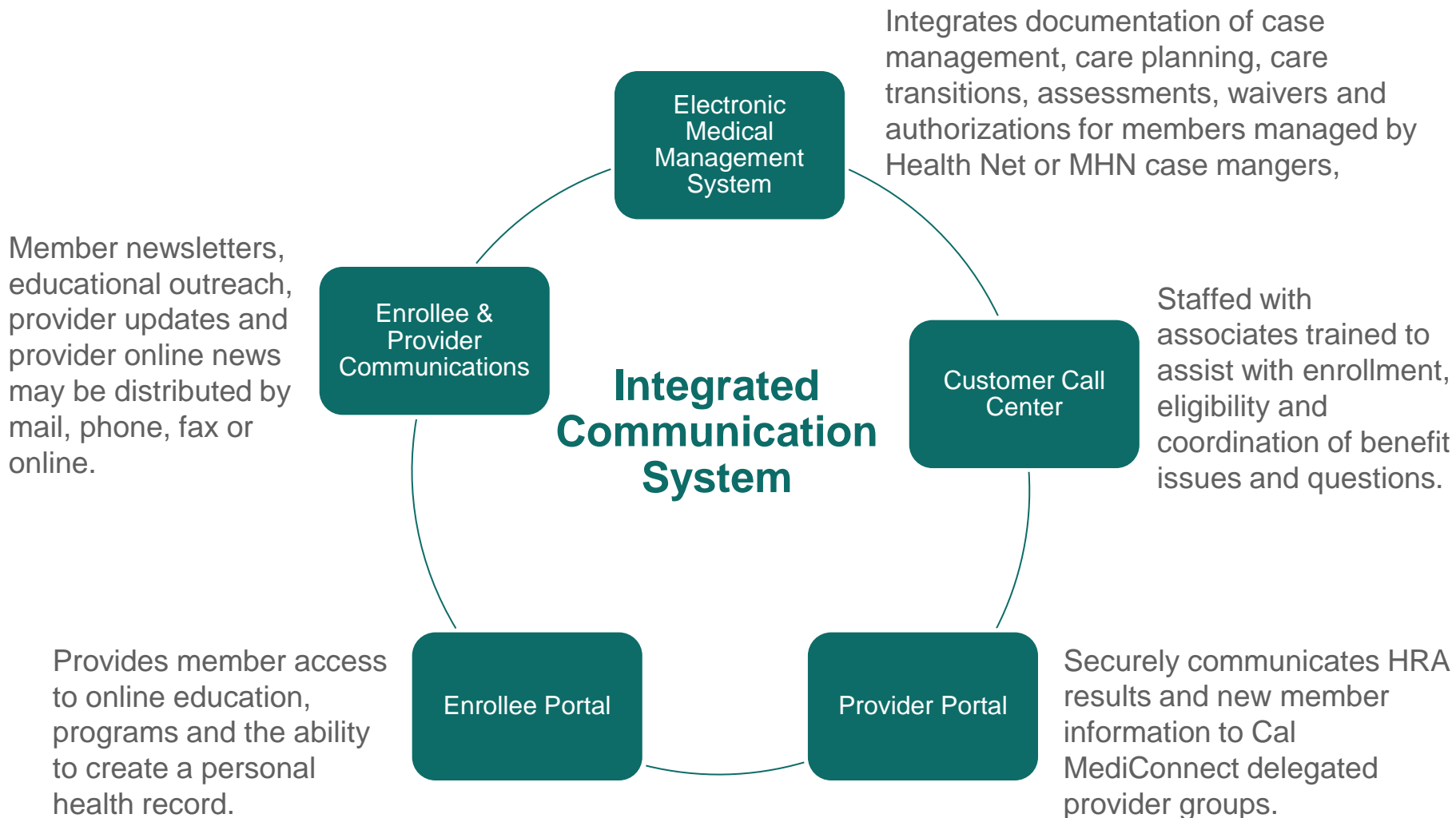
Health Net's Model of Care will provide a person-centered approach that emphasizes the coordination of benefits and services to improve the quality of care and healthcare outcomes.

Model of Care Components:

- Integrated Communication Systems
- Annual Health Risk Assessments
- Case management for all members
- Specialized Provider Network
- Individualized care plan for each member
- Management of care transitions
- Quality Improvement Program
- Long Term Services and Supports

Integrated Communication System

Health Net has integrated an extensive communication system necessary to implement Cal MediConnect’s care coordination requirements.



Specialized Provider Network

- Health Net maintains a comprehensive network of primary care providers, facilities, specialists, behavioral health care providers, social service providers, community agencies and ancillary services to meet the needs of Cal MediConnect members with complex social and medical needs.
- Health Net will coordinate with Home- and Community-Based Services as necessary to meet the needs of Cal MediConnect members and to assist them with their goal to remain independent in their homes.

Health Risk Assessment

A Health Risk Assessment (HRA) is conducted on each member to identify medical, psychosocial, cognitive and functional risks as well as long term services and support needs. Here is how the HRA will work:

Utilization data is received from the State, which Health Net analyzes to identify members as high, moderate or low risk. Risk level determines whether the HRA needs to be completed in 45 or 90 days.

HRA calls are made by staff who are bilingual or have access to interpreter services.

Multiple attempts are made to contact the member. The HRA survey is mailed the member can not be reach.

Member's responses to the HRA survey are incorporated into the member's care plan and communicate to the case manager via Health Net's provider portal or by mail.

Case Management

The goal of case management is to support the member's desire to self direct care, help the member regain optimum health, and improve functional capability in the right setting and most cost effective manner.

- All Cal MediConnect members are eligible for case management, have an Interdisciplinary Care Team and have an individualized care plan developed.
- Members may opt out of active case management but will remain assigned to a case manager who will contact the member if there is a change in status.
- Members are stratified according to their risk profile to focus resources on the most vulnerable.

Interdisciplinary Care Team

The Interdisciplinary Care Team (ICT) is a team of caregivers from different professional disciplines and/or services who work together to deliver care services focused on care planning, optimizing quality of life, and support for the individual and/or family.

- The ICT will coordinate care for the Cal MediConnect member to address medical, cognitive, psychosocial, and functional needs.
- The ICT is responsible for overseeing, coordinating, and evaluating the care delivered to the member.
- The ICT meets to review the needs of the member.

Interdisciplinary Care Team Members

All Cal MediConnect members are assigned to a case manager, have an ICT and have an individualized care plan.

Required Team Members

- Delegated provider group case manager assigned to member
- Medical Expert (e.g., PCP, Specialist, or Nurse Case Manager)
- Social Services Expert (e.g., Social Worker, or Community Resource Specialist)
- Mental/Behavioral Health Expert – when indicated

Optional Team Members

- Pharmacist
- Nutrition Specialist
- Health Educator
- Disease Management Specialist
- Pastoral Specialist
- Restorative Health Specialist
- Public Program Coordinator
- Caregiver/Family

The ICT is determined based on member needs and with member approval.

Individualized Care Plan

The Individualized Care Plan (ICP) is created for each member by the case manager with input from the ICT, the member and/or caregiver.

The ICP is based on both:

- Member's preferences and desire level of involvement in the case management process.
- Member's assessment and identified problems.

The ICP outlines all the different types of care and services the member needs, including services not traditionally covered by Medical or Medicare.

Case Manager's Role & Responsibilities

- Performs an assessment of medical, psychosocial, cognitive and functional status.
- Develops a comprehensive individualized care plan and makes updates when there is a change in the member's medical status or at a minimum annually.
- Identifies barriers to goals and strategies to address.
- Provides personalized education for optimal wellness.
- Encourages preventive care such as flu vaccines and mammograms.
- Reviews and educates on medication regimen.
- Promotes appropriate utilization of benefits.
- Assists member to access community resources.
- Assists caregiver when member is unable to participate.
- Provides a single point of contact during care transitions.
- Shares information with all the interdisciplinary care team members.

Member's Participation

Member ...

- Is informed of and consents to case management.
- Participates in development of the ICP.
- Agrees to the goals and interventions of the ICP.
- Is informed of ICT members and meetings.
- Either participates in the ICT meeting or provides input through the case manager and is informed of the outcomes.

Provider Participation

As a condition of participation in Cal MediConnect, providers are required to participate in ICT meetings as needed via phone.

- The frequency of ICT meetings will be determined based on complexity and acuity of the member's needs.
- ICT meeting frequency can range from once annually for stable, self-directed individuals, to daily interaction during an acute episode or transitional care process.
- ICP is reviewed annually, at a minimum, and when the member's status changes or there is a care transition.
- The case manager will coordinate the ICT activities to review the ICP and progress towards meeting documented goals.

Provider Participation

- Providers will be notified of a change in a member's health status, care plans, discharge plans, hospital admission, and nursing facility placements.
- ICTs will help providers get the information they need to care for their patients.
- Health Net asks you to participate on the ICT for your patients. Your participation is valuable – you know your patients and what they need best.

Quality Improvement Program

- Health Net has implemented a Quality Improvement Program to monitor health outcomes and the implementation of the Model of Care.
- The Quality Improvement Program is responsible for collecting data to evaluate if the program's goals are met.

Quality Improvement Program

Each domain of care is evaluated to identify areas for improvement and to ascertain if program goals have been met:

- Health Outcomes
- Access to Care
- Improved Health Status
- Implementation of MOC
- Health Risk Assessment
- Implementation of Care Plan
- Provider Network
- Continuum of Care
- Delivery of Extra Services
- Integrated Communications

Quality Improvement Program

Health Net's Quality Improvement Program will monitor health outcomes and implementation of the Model of Care by:

- Collecting dual eligible specific HEDIS® measures.
- Meeting National Committee for Quality Assurance (NCQA) Structure and Process standards.
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the dual eligible population.
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness.
- Collecting data to evaluate if Cal MediConnect program goals are met.

Long Term Services and Supports Overview

Long Term Services and Supports (LTSS) refers to services that support people living independently in the community.

- A member can be enrolled in several LTSS programs simultaneously.
- A core set of LTSS include:
 - In Home Supports and Services (IHSS)
 - Multi-Purpose Senior Services Program (MSSP)
 - Community Based Adult Services (CBAS)
 - Home- and Community-Based Services (HCBS)
- LTSS will be incorporated into the ICP to support the independence of the member in their home and community.

In Home Supports and Services

In Home Supports and Services (IHSS) is a State program that provides in-home care to seniors and persons with disabilities allowing them to remain safely in their homes.

IHSS services include:

- Domestic and Related Services
 - House cleaning and chores, meal preparation and clean-up, laundry, grocery shopping, heavy cleaning
- Personal Care
 - Bathing and personal grooming, dressing, feeding
- Paramedical Services
 - Administration of medications, puncturing skin, range of motion exercises
- Other Services
 - Accompaniment to medical appointments, yard hazard abatement, protective supervision

The IHSS program serves approximately 182,000 beneficiaries in LA County.

Multi-Purpose Senior Services Program

Multi-Purpose Senior Services Program (MSSP) is an intensive case management program that provides both social and health care management services for frail elderly Medi-Cal enrollees who are certified or certifiable for placement in a nursing facility but who wish to remain at home.

Six MSSP sites serve approximately 3,400 beneficiaries in LA County

MSSP services include:

- Adult Day Care
- Housing Assistance
- Chore and Personal Care Assistance
- Protective Supervision
- Care Management
- Respite Care
- Transportation
- Meal Services
- Social Services
- Communication Services

MSSPs work closely with local organizations and agencies that provide LTSS and home- and community-based services.

Community Based Adult Services

Community Based Adult Services (CBAS) is a facility-based program that provides skilled nursing, social services, physical and occupational therapies, personal care, family/caregiver training and support, meals, and transportation.

The primary objectives of the CBAS program are to:

- Restore or maintain optimal capacity for self-care to frail elderly persons and other adults with physical or mental disabilities.
- Delay or prevent inappropriate or personally undesirable institutionalization in long-term care facilities.

CBAS serves approximately 20,000 beneficiaries in LA County.

Home- and Community-Based Services

Home- and Community-Based Services (HCBS) provides opportunities for Medi-Cal beneficiaries to receive services in their own home or community that are not managed care benefits

Examples of services that are not managed care benefits:

- AAA
- Meals on Wheels
- Housing Authority of the County of Los Angeles
- Access Services

Pharmacy Benefit

Pharmacy Benefit Overview

- The Cal MediConnect pharmacy benefit is a combination of the regular Medicare Part D benefit subject to all rules and regulations associated with Medicare Part D, plus coverage of Medi-Cal required drugs.
- Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States.

Health Net – Pharmacy Benefits

- Health Net Pharmaceutical Services (HNPS) will administer the pharmacy benefit for the Cal MediConnect Program.
- All Cal MediConnect members will be set up on the Cal MediConnect formulary.

Cal MediConnect Formulary:

Tier 1 – Medicare Generic Drugs

Tier 2 – Medicare Brand Drugs

Tier 3 – Medi-Cal Required Drugs (available to members at \$0)

Additional Information

Cal MediConnect Ombudsman Program

Starting April 1, 2014, the Cal MediConnect Ombudsman Program will assist Cal MediConnect enrollees in navigating issues and filing appeals and complaints where needed.

The Cal MediConnect Ombudsman will also:

- Investigate, negotiate and resolve enrollee problems/complaints with Cal MediConnect plans;
- Refer enrollees to relevant entities and programs as needed.

Hours of Operation: Monday - Friday, 8am to 5pm PST

By Phone: 1-855-4501-3077

By email: MMCDOmbudsmanOffice@dhcs.ca.gov

Fraud, Waste & Abuse

Health care fraud contributes to the rising cost of health insurance, reduces the amount of funds available to pay honest providers, and increases premiums to employers and members. Health Net investigates allegations of fraud, waste and abuse (FWA) and reports of noncompliance at every level.

Fraud: An intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person.

Waste: The inappropriate utilization and/or inefficient use of resources.

Abuse: Occurs when an individual or entity intentionally provides information which results in higher payments than the individual or entity is entitled to receive.

Reporting Fraud, Waste & Abuse

To report suspected fraud, waste or abuse, contact Health Net as listed below:

Health Net, Inc. Special Investigations Unit
PO Box 2048
Rancho Cordova, CA 95741-2048

Health Net's Fraud Hotline: (800) 977-3565

To report potential or actual noncompliance or ethical concerns, contact Health Net as listed below:

Health Net Medicare Compliance Officer
Gay Ann Williams
21650 Oxnard Street
Woodland Hills, CA 91367

Health Net's Integrity Line: (888) 866-1366

Health Net maintains confidentiality to the extent possible, allows callers to remain anonymous if desired and ensures non-retaliation against those who report suspected misconduct.

Questions

For more information, please contact us at:

Professional Relationships Customer Service

(800) 541-3353

9 AM to 1 PM Central

Provider Portal

<https://www.mhn.com/provider/start.do>