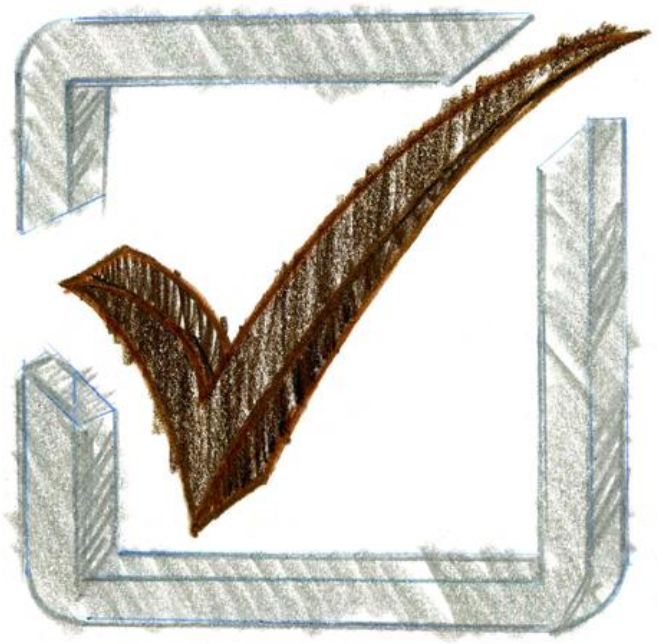
Cal MediConnect Provider Training



Health Net and MHN Orientation

April 2014

Health Net®

Training Goals

- ❑ Cal MediConnect Program Overview
- ❑ Case Management
- ❑ Referrals
- ❑ Authorization Process
- ❑ Provider Dispute Resolution
- ❑ Provider Contracting & Credentialing
- ❑ Claims Process

Cal MediConnect Program Overview

Health Net Background

- Health Net, Inc. is a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans.
- Our mission is to help people be healthy, secure and comfortable.
- Health Net provides and administers health benefits to approximately 5.3 million individuals across the country through group, individual, Medicare, Medicaid, U.S. Department of Defense, including TRICARE, and Veterans Affairs programs.
- Health Net has been selected to participate in Cal MediConnect in Los Angeles and San Diego counties.

MHN Background

- MHN is a Health Net company and is headquartered in San Rafael, California.
- MHN has offices and call centers throughout the United States.
- MHN delivers clinically based services to enhance the lives of its members.
- With almost 40 years of behavioral health care experience, MHN serves over 1,200 client accounts, including Fortune 500 companies, government agencies, multi-employer funds and affiliate accounts through Health Net.
- MHN is URAC accredited in Health Utilization Management and Health Network and is licensed under the Knox-Keene Health Care Service Plan Act as a specialized health care service plan in mental health and chemical dependency.

Cal MediConnect

- The scope of Cal MediConnect is to design and operationalize a fully-integrated care delivery system that coordinates care for the total needs of dual eligible beneficiaries including medical, behavioral, social and long-term care needs.
- Health Net has created a Model of Care for the Cal MediConnect Program that creates one point of accountability for the delivery, coordination, and management of benefits and services to members.

Cal MediConnect: Behavioral Health

- The delivery of behavioral health services to members will be provided through an integrated network of private, contracted behavioral health specialists and county mental health and substance abuse programs.
- Through the combined efforts of these delivery systems, Health Net will provide comprehensive behavioral health services for Cal MediConnect members to ensure the development of a comprehensive, person-centered care plan.

Cal MediConnect: Behavioral Health Population

- The State of California has published data showing 40% of the Cal MediConnect population has mental health needs.
- Health Net estimates that 9-13% of the Cal MediConnect population will access services that will be managed and provided by behavioral health professionals.

Coordinating Behavioral Health

- Health Net, MHN, Delegated Provider Groups, Behavioral Health Providers, the Department of Public Health (DPH) and the Department of Mental Health (DMH) each have a role to play in the care coordination of the Cal MediConnect population.
- Health Net and MHN will support the coordination process whenever identified issues need to be addressed.

Benefit Structure: County vs. Cal MediConnect Benefits

Health Net

County-Administered Carve Out Benefits

Specialty Mental Health Services

A. Rehabilitative Mental Health Services
   - Crisis Intervention
   - Crisis Stabilization
   - Crisis Residential
   - Institute for Mental Disease (age 22-65)
   - Club Houses

B. Targeted Case Management

Drug Medi-Cal Services

- Day Care Rehab
- Outpatient Individual and Group Counseling
- Methadone Maintenance Therapy

Cal MediConnect Benefits

MHN Higher Level Services

- Mental Health Hospital Inpatient Services
- Institute for Mental Disease (over age 65)
- Skilled Nursing Facility
- Mental Health Outpatient Services
- Psychotropic Drugs
- Mental Health Services within the Scope of Primary Case Practitioner

MHN Alcohol & Drug Servcies

- Inpatient Detox
- Alcohol Misuse Screening
- Individual/Outpatient
- Naltrexone (vivitrol) Treatment

Cal MediConnect requires collaboration to provide coordinated case management

Case Management

Assignment of Primary Case Manager

Assignment of a primary case manager for a member with potential behavioral health needs requires strong communication between MHN and Delegated Provider Group case managers.

- A Health Risk Assessment is conducted on each member to identify medical, psychosocial, cognitive and functional risks as well as long term services and supports needs.
- MHN will be the primary case manager if the member is rated as high risk for behavioral needs, regardless of the medical and social needs.
- In all other situations, the PPG will be the primary case manager.

Behavioral High Risk Criteria

Any of the following:

- 1+ BH hospitalization in past 90 days
- 3+ BH hospitalizations in past yr.
- 2+ BH-related ER visits in past yr.
- Risk of future BH cost > very high threshold TBD
- SMI - **Either** of the following: **(A)** Schizo; **(B)** Bipolar **and** 1+ physical chronic condition
- SMI - **Either** of the following: **(A)** Schizo; **(B)** Bipolar **and** no office visit in last 12 mos
- EBM – **Both** of the following: **(**A) Evidence of severe depression; **(B)** No mental health eval in last 3 months.
- EBM – **Both** of the following: **(A)** Hospitalized for depression; **(B)** No psych consult within 30 days after discharge

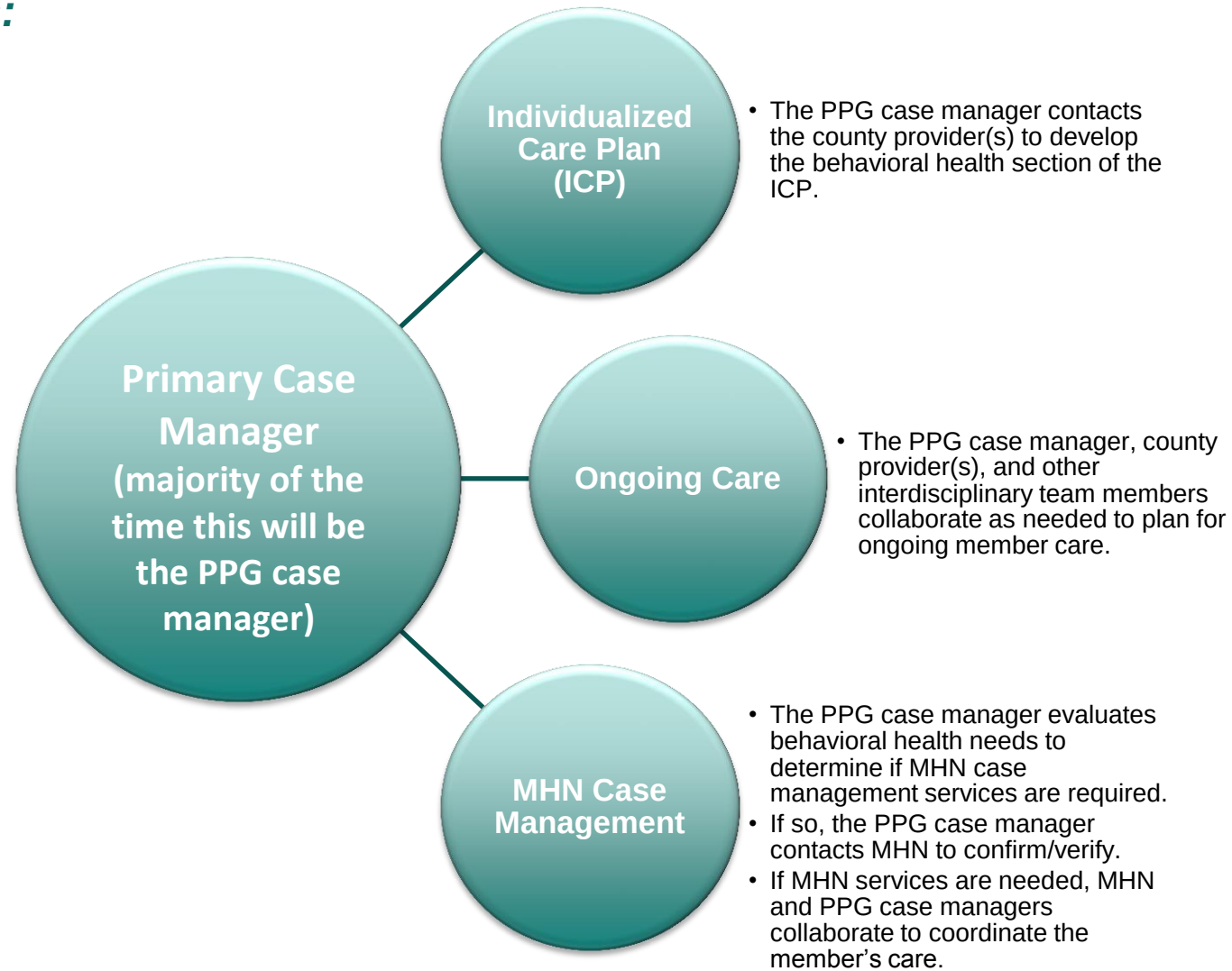
Delegated Provider Group: Managing Behavioral Health

The majority of Health Net's Cal MediConnect members assigned to a Delegated Provider Group (PPG) case manager who require behavioral health services will likely already be receiving or have received in the past County Specialty Mental Health Services (SMHS) or Substance Use Disorder (SUD) services .

- If a PPG case manager determines a member requires County SMHS and/or SUD services, coordination of care will occur between the PPG case manager and county provider(s).
- MHN will assist in support of the service coordination.
  - For example, if a county provider calls a PPG case manager to initiate care coordination and does not receive a response, the county provider can contact MHN for assistance.

Delegated Provider Group: Managing Behavioral Health

Care Coordination for members receiving County SMHS and/or SUBD services:



- The PPG case manager contacts the county provider(s) to develop the behavioral health section of the ICP.
- The PPG case manager, county provider(s), and other interdisciplinary team members collaborate as needed to plan for ongoing member care.
- The PPG case manager evaluates behavioral health needs to determine if MHN case management services are required.
- If so, the PPG case manager contacts MHN to confirm/verify.
- If MHN services are needed, MHN and PPG case managers collaborate to coordinate the member's care.

Interdisciplinary Care Team

If the member's Health Risk Assessment identifies behavioral health needs for any member, the interdisciplinary care team (ICT) will include behavioral health specialist(s) who work in partnership with the member and the team.

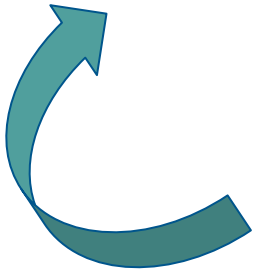
- The ICT will provide member support by removing access to care barriers.
- ICT coordination will include the following directives:
  - Improve continuity of care and services by coordinating with county behavioral health resources.
  - Develop a comprehensive behavioral health assessment for any identified member. Assessment is conducted by the behavioral health specialist who is a member of the ICT.

Individualized Care Plan Development

An individualized, integrated care plan is created for each Cal MediConnect member.

Individualized Care Plan (ICP)

- Based on a member's goals and includes all care planning needs, including medical, social, LTSS and Behavioral Health services.
- Developed by primary case manager in consultation with the member and interdisciplinary care team.
- At a minimum, the ICP must have the names of the county provider(s) & show coordination between primary case manager and county provider(s).



Medi-Cal Specialty Mental Health Services AIA & CCCP or Drug Medi-Cal Treatment Plan

- Created by Medi-Cal SMHS/SUD provider.
- SMHS/SUD provider submits to Health Net to be incorporated into ICP.

Evidence of coordination between Cal MediConnect case manager and County SMHS and/or SUD provider(s) for members who receive any Medi-Cal funded behavioral health services is required.

Referrals

Referrals to County Mental Health Provider

Cal MediConnect members who have been assessed and identified as needing County SMHS and/or SUD services will be referred to County Mental Health and/or Substance Abuse providers.

Health Net and MHN network providers are expected to coordinate referrals to County SMHS and SUD providers as necessary and as determined by the interdisciplinary care team.

There referrals may include:

- Member self-referral
- PPG Case Manager
- MHN Case Manager
- Primary Care Physician and/or
- Other interdisciplinary care team members, based on evaluation of the member's medical and psychosocial history, current state of health, and request for services by member or member's family.

Referrals to County SMHS & SUD Providers

Delegated Provider Group (PPG) Case Manager will refer directly to County SMHS and SUD providers when:

- The case manager identifies member as needing Medi-Cal County SMHS and/or SUD services based on their assessment of the case.
- The member is currently receiving county SMHS and/or SUD services.
- The member was previously receiving county SMHS and/or SUD services.

Referrals to MHN

Refer directly to MHN if the member is identified as possibly needing MHN case management or additional behavioral health services.

- MHN will assess the case to determine behavioral health needs.
- MHN case manager will collaborate with PPG case manager to identify appropriate primary case manager and coordinate member care.

Intake, Care Management Access Line

(855) 464 - 3571

MHN Referral Process

Customer Service Representatives (CSRs)
Non-Clinical/Administrative

Responsible for:
- Receiving initial phone contact.
- Determining member's benefit coverage.

CSR transfers treatment authorization requests to Clinical Service Team Care Manager.

Clinical Service Team Care Managers
Licensed BH Clinician

Responsible for:
- Completing an assessment to determine medical necessity for requested level of care.
- Completing authorization for appropriate level of care.
- Completing utilization reviews for ongoing course of treatment.
- Discharge planning.

Higher Levels of Care
(Services that require authorization)
- Inpatient Treatment/Detox
- Partial Hospitalization Program (PHP)
- Intensive Outpatient (IOP)
- Psych and Neuro-psych Testing
- ECT

Case Manager and Care Manager work together to coordinate referral process.

Cal MediConnect Case Managers
Licensed BH Clinician

Responsible for:
- Providing case management support and linkages to services.
- Developing individual care plan.
- Coordinating interdisciplinary care team.

Referrals for Non-Behavioral Health Services

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- ??????

Authorization Process

MHN Prior Authorization for Medicare Services

"Higher level of care services" are Medicare services that require prior authorization.

Authorization is NEVER required for emergency services or traditional outpatient services.

- Inpatient Treatment/Detox
- Partial Hospitalization Program (PHP)
- Intensive Outpatient (IOP)
- Psych and Neuro-psych Testing
- ECT

MHN Authorization Process

- MHN will have a licensed clinician available twenty-four hours a day, seven days a week, to address all urgent requests for authorization for admission to a facility if the member poses a danger to himself/herself or others or is gravely disabled.
- In an emergency, members should be encouraged to call "911" or be referred to the nearest emergency room.
- It is the policy of MHN to authorize payment for emergency services if a practitioner or other authorized representative acting through MHN (i.e. a delegated entity) has authorized the provision of emergency services.
- In cases of emergency services, MHN uses the "Prudent Layperson Standard" to make authorization decisions.

MHN Authorization Process

- The care manager renders pre-service authorization decisions during the initial phone call unless receipt of adequate clinical information is delayed.
  - A decision is rendered the same day (preferably within 2 hours, but no later than 24 hours) after the request and clinical information are received.
- The care manager evaluates the referral presented using InterQual, MHN's Level of Care and Treatment Guidelines, and Cal MediConnect benefits.
- The care manager authorizes payment to the provider only for the number and type of medically necessary service units that will occur.
  - For inpatient services, the care manager authorizes through the next scheduled review date.

Provider Dispute Resolution

Provider Dispute Resolution

MHN has established a provider dispute resolution process that provides consistent, timely, and effective de novo review of an issue that has not been satisfactorily resolved through our regular provider customer service channels. This process is available to both contracted and non-contracted providers.

- A contracted provider dispute is a provider's written notice to MHN that:
  - Challenges, appeals or requests reconsideration of a claim that has been denied, adjusted or contested.
  - Seeks resolution of a billing determination or other contract dispute.
  - Disputes a request for reimbursement of an overpayment of a claim.

Provider Dispute Resolution

The first steps towards resolving a dispute are outlined below:

- For claims payment issues, call MHN's Claims Customer Service Department at (800) 444-4281.
- For concerns regarding authorizations and/or wish to access care for a member, please call the MHN Service Team at _____.
- For provider contracting status, call MHN's Professional Relations representatives at (800) 541-3353.
- If you suspect fraud or abuse in the provision of services or submission of claims, contact our Fraud & Abuse Hotline at (800) 327-0566.

If the steps outlined to the left do not fully resolve the issue or concern, complete and submit the Provider Dispute Resolution Request form to:

MHN
Provider Disputes
P.O. Box 10697
San Rafael, CA 94912

Provider Dispute Resolution

- Contracted provider disputes must be received by MHN within 365 calendar days from either MHN's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute.
- In the case of inaction, contracted provider disputes must be received by MHN within 365 calendar days after MHN's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
- Contracted provider disputes that do not include all required information may be returned to the submitter for completion.
  - An amended contracted provider dispute, which includes the missing information, may be submitted to MHN within thirty (30) business days of your receipt of a returned contracted provider dispute.

Provider Dispute Resolution

- MHN will acknowledge receipt of all contracted provider disputes within fifteen (15) business days of the Date of Receipt by MHN.
- MHN will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) business days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

Provider Contracting & Credentialing

Initial Credentialing

- Providers in MHN's Cal MediConnect network are selected and credentialed based on established criteria reflecting professional standards for education, training and licensure.
- Credentials are verified upon initial application to the network and every three years thereafter, as required by regulatory and accrediting agencies.

Recredentialing

- MHN recredentials providers in its network every 36 months.
- MHN conducts primary and secondary source verification on all credentials in the recredentialing process.
- Recredentialing also includes a review of any prior quality issues and member compliant history.

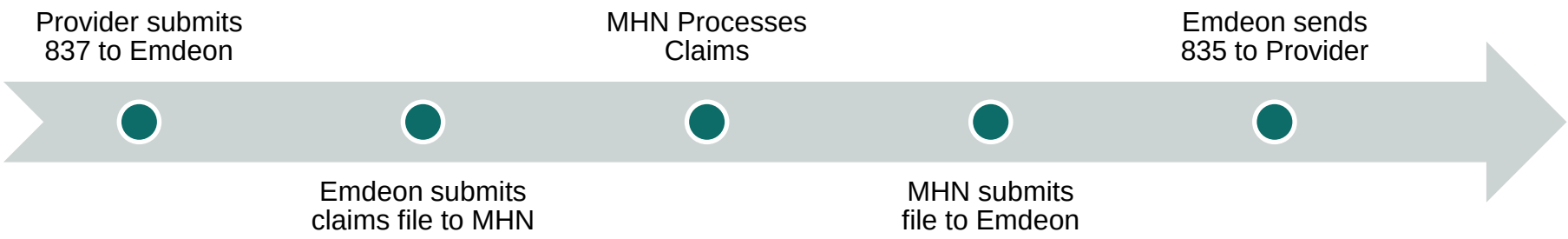
Ongoing Monitoring of Sanctions

- MHN performs ongoing monitoring of Medicare/Medicaid sanctions and exclusions, board sanctions or licensure actions, and member complaint history.
- When MHN participating providers are identified as being subject to these actions, they are presented to MHN's Credentialing Committee for review and appropriate action.

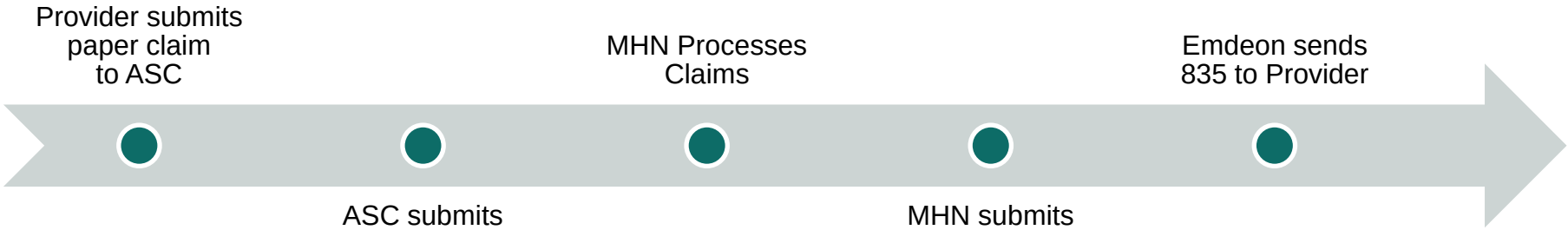
Claims Process

Health Net Claims Process

Processing Electronic Claims



Processing Paper Claims



Electronic Claims Submission

Using MD On-Line

- Providers can submit electronic claims directly to MHN for free via MD On-Line.
- To set up an account, visit the MD On-Line website.
- For help regarding the MD On-Line website, call their Help Desk at (888) 397-3434.

Electronic Claims Submission

Using Emdeon (formerly WebMD)

- MHN accepts electronic submission of both Professional and Institutional claims through Emdeon.
- Submit claims using MHN's payer ID: 22771
- For more information about Emdeon services, call (877) GO-WebMD (469-3263) or visit: www.emdeon.com.

Paper Claims Submissions

Paper claims must be submitted using a CMS (HCFA)-1500. Claims which do not include all of the required information will be returned to the provider for completion and resubmission. Claim MUST include:

- Correct Subscriber/Insured ID number
- Subscriber/Insured name
- Subscriber/Insured address
- Patient Name
- Patient address
- Patient Date of Birth
- Provider Name
- Provider Tax Identification Number
- Provider's servicing address, zip code and phone number
- Billing Provider address, zip code and phone number
- Date(s) of Service
- Diagnoses Codes
- Current year CPT Procedure Code(s)
- CMS Place of Service Code
- Number of days or units
- Billed Charges

Where to Submit Claims

To submit paper claims, please mail completed form to:

MHN Claims

P.O. Box 14621

Lexington, KY 40512-4621

Questions

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