

Cal MediConnect 2020 Operations Guide



PROVIDER COMMUNICATIONS

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every stage of life™*

Introduction

The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) have partnered to enroll beneficiaries who are covered by both Medicare and Medi-Cal (dual eligible) into managed care health plans. This integrated care delivery program is known as the Cal MediConnect Plan (Medicare-Medicaid Plan).

Health Net* participates in Cal MediConnect in Los Angeles and San Diego counties. The goals of Health Net's Cal MediConnect plan are to improve the quality of care dually eligible managed care members receive by providing access to seamless, integrated care, and to increase the availability and access to home- and community-based services, so members have better health outcomes and remain in their homes and communities as long as possible. The primary objective of Health Net Cal MediConnect is to promote better care and improve alignment and coordination of Medicare and Medi-Cal benefits.

How to Use the Guide

The Health Net *Cal MediConnect Operations Guide* provides an overview of Health Net's Cal MediConnect plan's essential components, containing basic information about how to work with Health Net, how to arrange for the provision of health care services for Cal MediConnect members, and provider responsibilities in coordinating patient care. The guide serves as a supplement to the comprehensive provider operations manuals for participating physician groups (PPGs), hospitals and ancillary providers. The operations manuals are available in the Provider Library on the Health Net provider website. Physicians participating in Cal MediConnect through an affiliated PPG must adhere to the PPG's established policies and processes.

The contents of this guide are supplemental to the *Provider Participation Agreement (PPA)*. When the contents of this guide conflict with the *PPA*, the *PPA* takes precedence. Updates to the information in this guide are made through provider updates or signed letters distributed by fax, the United States Postal Service or other carrier. Provider updates and signed letters are considered amendments to this guide.

Providers are encouraged to use the electronic version of the Cal MediConnect operations manuals available in the Provider Library for the most current information. Updated information in the electronic version of the manual supersedes information contained in this print guide.

Disclaimer

This guide is not intended to provide legal advice on any matter and may not be relied on as a substitute for obtaining advice from a legal professional.

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Who to Contact

Resources for providers and members are described below, followed by a list of phone numbers and addresses for contacting Health Net departments or public health programs providing services to Cal MediConnect members.

Provider Resources

ACCESS TO INTERPRETER SERVICES

Health Net offers language assistance services to its participating providers. Participating providers may request interpreter support for Health Net members at no cost to the provider or member.

CULTURAL AND LINGUISTIC SERVICES DEPARTMENT

The Health Net Cultural and Linguistic (C&L) Services Department promotes access to care for all members and providers through the provision of culturally and linguistically responsive services, including ensuring clear and understandable member communication and cultural awareness education and consultation. The department also provides language services support to members who speak a primary language other than English or have limited hearing and vision abilities. The department is responsible for developing, implementing and monitoring processes to meet regulatory requirements. The department assesses the cultural and language needs of members and encourages provider, community advocate and member input through ongoing communication and by participation in the health plan's Community Advisory Committee (CAC) meetings. This helps ensure that materials and interpreter services are available in the member's language, while taking into consideration the member's cultural background in the development of member materials.

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Facility Site Review (FSR) Compliance Department develops materials that educate providers on regulatory requirements, medical record criteria, documentation of preventive care services, health education, continuity of care (COC), clinical interventions, public health programs and disease management.

HEALTH NET EMPOWERED LIVING PROGRAM (H.E.L.P.) CALL CENTER

Health Net's H.E.L.P. team is available to assist providers and case managers with Long-Term Services and Supports (LTSS) referrals and connecting members to appropriate social services programs available in the community. Social services and community support systems are a key component of the Cal MediConnect program, and utilization of these services can help members continue to live safely and independently in the community.

HEALTH NET WEBSITE

The Provider Library on Health Net's provider website is the one-stop resource for provider operational policies and communications designed to assist providers in their everyday interaction with Health Net and in providing care to Health Net members. The Provider Library provides convenient access to pertinent materials, including provider operations manuals, mass-distributed provider communication archives (updates and letters), forms, contacts and more. Health Net provider materials and communications contained in the Provider Library are developed to notify providers and staff of new programs, changes, policies and procedures, and to support members' care.

Providers may also quickly locate Health Net's evidence-based medical policies on Health Net's website. Medical policies are developed to support providers in making appropriate utilization and care management decisions related to requests for services and supplies for Health Net members.

MHN CUSTOMER SERVICE

If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or the PCP's staff may contact the MHN Customer Service Department for a referral to an MHN provider. Customer service specialists may also assist with member eligibility, benefits and general questions about MHN.

PROVIDER NETWORK MANAGEMENT

Regional provider network managers and network administrators are key contacts for participating physician groups (PPGs), hospitals and other providers. They resolve contractual and operational matters and conduct training sessions to keep participating providers abreast of policy, operational and product changes.

PROVIDER SERVICES CENTER

The Health Net Cal MediConnect Provider Services Center is available Monday through Friday, 8 a.m. to 8 p.m., to assist providers with member eligibility, benefit information, claims, billing, complaints and grievances, and other provider inquiries.

PUBLIC PROGRAMS DEPARTMENT

The Health Net Public Programs Department ensures that Cal MediConnect members have access to public health programs. The department's primary responsibility is to coordinate care with various public health entities and programs. The Health Net Public Programs Department is staffed by Public Programs Managers who work to find strategies for improving health care delivery.

Member Resources

MEMBER SERVICES DEPARTMENT

The Health Net Cal MediConnect Member Services Department is available to members Monday through Friday, 8 a.m. to 8 p.m., to handle phone calls and correspondence from members regarding problems and inquiries; Cal MediConnect benefit questions and information; professional and hospital services, bills and claims; address changes; PCP selections and changes; identification (ID) card requests; and member grievances. Members can leave a voicemail Saturday, Sunday and federal holidays, 8 a.m. to 8 p.m., and their call will be returned the following business day. The Cal MediConnect Member Services Department also arranges for interpreter or sign language assistance for Health Net Cal MediConnect members. Problems that need further attention are forwarded to Health Net management.

CAL MEDICONNECT OMBUDSMAN PROGRAM

The Cal MediConnect Ombudsman program is responsible for assisting and resolving issues members may encounter with Cal MediConnect health plans.

Phone Numbers and Addresses

ACCESS TO INTERPRETER SERVICES

Health Net offers language assistance services to its participating providers. Participating providers may request interpreter support for Health Net members at no cost to the provider or member. Providers contact the Health Net Cal MediConnect Provider Services Center to request interpreter services as follows:

1-855-464-3571 – Los Angeles County

1-855-464-3572 – San Diego County

CAL MEDICONNECT OMBUDSMAN PROGRAM

The Cal MediConnect Ombudsman program is responsible for assisting and resolving issues members may encounter with Cal MediConnect health plans.

1-855-501-3077

TTY: 1-877-735-2929

Monday through Friday, 9 a.m. to 5 p.m.

The Ombudsman Program website is found at healthconsumer.org.

CAPITATED ENCOUNTERS

Contact the Health Net Capitated Encounter Department via email with encounter data questions.

Enc_group@healthnet.com

COMMUNICATIONS

The Health Net Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, and changes in contractual, legislative and regulatory requirements through provider operations manuals, updates and letters.

provider.communications@healthnet.com

COMMUNITY-BASED ADULT SERVICES FACE-TO-FACE REQUEST LINE

To initiate a face-to-face assessment for Community-Based Adult Services (CBAS), fax a completed CBAS Treatment Request form to 1-833-581-5908. The form is available on the Health Net provider website under *Provider Library > Forms*.

Note: To facilitate the face-to-face assessment, providers should submit a recent history and physical with the request. Include a fax cover sheet with faxes that have protected health information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Fax: 1-833-581-5908

COMPLIANCE AND ETHICS HELPLINE

Suspected cases of health care fraud and abuse by providers or members should be reported to the Centene Compliance and Ethics Helpline.

1-866-685-8664

CREDENTIALING

The Health Net Credentialing Department is responsible for credentialing and recredentialing directly contracting providers and all providers affiliated with PPGs to which credentialing responsibilities have not been delegated. The Health Net Credentialing Department also oversees delegated and subcontracting credentialing activity.

Fax: (818) 676-5323

CULTURAL AND LINGUISTIC SERVICES

The Health Net Cultural and Linguistics (C&L) Services Department promotes access to care for all members and providers through the provision of culturally and linguistically responsive services, including ensuring clear and understandable member communication and cultural awareness education and consultation.

Health Net offers a Language Assistance Program that provides no-cost access to sign language interpreters and interpreters for limited-English proficient members. To access interpreter services, please contact Health Net Provider Services or call the number on the back of the member's ID card. To request cultural competency or plain language training, please contact the C&L Services Department as shown below.

101 North Brand Blvd., Glendale, CA 91203

1-800-977-6750

Fax: (818) 543-9188

DELEGATION OVERSIGHT

The Health Net Delegation Oversight Department oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net state, federal, regulatory and accreditation agency requirements.

Fax: 1-866-476-0311

Email: provider.oversight@healthnet.com

DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

The Department of Managed Health Care (DMHC) licenses and regulates managed care plans in California. DMHC may assist members with complaints involving emergency grievances or grievances that have not been satisfactorily resolved by the health plan.

1-888-466-2219

DEPARTMENT OF SOCIAL SERVICES (DSS)

The DSS Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding fair hearings and grievances.

PO Box 944243, M.S. 9-17-37, Sacramento, CA 94244-2430

1-800-952-5253

Fax: (916) 651-5210 or (916) 651-2789

DHCS MANAGED CARE OMBUDSMAN

The Department of Health Care Services (DHCS) Medi-Cal managed care ombudsman investigates and attempts to resolve complaints about managed care plans that members have been unable to resolve through their health plans.

1-888-452-8609

ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse (Change Healthcare™ or ABILITY®). All other questions regarding electronic claims submission should be directed to Health Net's EDI Department.

1-800-977-3568

ENVOLVE PHARMACY SOLUTIONS™, PHARMACY BENEFIT MANAGER (PBM)

Envolve Pharmacy Solutions administers Health Net's Cal MediConnect formulary and medication prior authorization requests.

PO Box 419069, Rancho Cordova, CA 95741

1-800-867-6564

Fax: 1-800-977-8226

FACILITY SITE REVIEW COMPLIANCE DEPARTMENT

The Health Net Facility Site Review Compliance Department provides one-to-one education and provider support.

21281 Burbank Blvd., Woodland Hills, CA 91367

(209) 943-4803

Fax: 1-877-779-0753

HEALTH CARE OPTIONS

Health Care Options (HCO) is the DHCS enrollment broker.

1-844-580-7272

HEALTH NET CAL MEDICONNECT CLAIMS

Submit paper **pharmacy claims** for Cal MediConnect members to:

PO Box 419069, Rancho Cordova, CA 95741-9069

Submit **non-pharmacy** paper claims for Cal MediConnect members to:

PO Box 9030, Farmington, MO 63040-9030

HEALTH NET CAL MEDICONNECT MEMBER SERVICES

The Health Net Cal MediConnect Member Services Department handles phone and written inquiries from members regarding eligibility and benefits, identification card requests, selecting or changing PCPs, grievances, and disputes and appeals.

1-855-464-3571 – Los Angeles County

1-855-464-3572 – San Diego County

HEALTH NET CAL MEDICONNECT PROVIDER SERVICES

The Health Net Cal MediConnect Provider Services Center handles phone and written inquiries from providers regarding member eligibility and benefits, claims status, and provider grievances and appeals.

1-855-464-3571 – Los Angeles County

1-855-464-3572 – San Diego County

HEALTH NET EMPOWERED LIVING PROGRAM (H.E.L.P.) CALL CENTER

The H.E.L.P. call center provides referral and coordination support for Long-Term Services and Supports (LTSS) program referrals.

1-800-526-1898

Fax: 1-866-922-0783

HEALTH NET HEALTH EDUCATION DEPARTMENT

The Health Education Department improves the health of Health Net members through education, information and support.

1-800-804-6074 (TTY: 711)

Fax: 1-800-628-2704

HEALTH NET LONG-TERM CARE INTAKE LINE

Providers must notify the Health Net Long-Term Care Intake Line when a Cal MediConnect member is admitted to a long-term nursing facility.

Fax: 1-855-851-4563

HEALTH NET PUBLIC PROGRAMS DEPARTMENT

The Health Net Public Programs Department ensures that Cal MediConnect members have access to public health programs.

1-800-526-1898

Fax: 1-866-922-0783

HEALTH NET WEBSITE

Health Net's website offers information about member eligibility, claim status and Health Net reference materials, such as the *Cal MediConnect Formulary*, *Member Handbook*, Cal MediConnect operations manuals, forms and information about how to contact Health Net with questions.

HOSPITAL NOTIFICATION UNIT

Hospitals are required to report any Health Net member's inpatient admissions within 24 hours or one business day when an admission occurs on a weekend, seven days a week to the Hospital Notification Unit.

1-800-995-7890

Fax: 1-800-676-7969

LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

Providers may call the Los Angeles Department of Public Social Services (DPSS) for assistance with In-Home Supportive Services (IHSS).

1-888-944-4477

(213) 744-4477

SAN DIEGO COUNTY AGING AND INDEPENDENCE SERVICES

Providers may call the San Diego County Aging and Independence Services (AIS) for assistance with In-Home Supportive Services (IHSS).

1-800-339-4661

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Chapter 2 – Enrollment and Disenrollment

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Enrollment and Disenrollment

This chapter describes the processes for enrollment and disenrollment, auto-assignment of a member to a primary care physician (PCP) and how to verify member eligibility.

Enrollment Criteria for Cal MediConnect

Cal MediConnect is available to individuals who meet all of the following criteria:

- Ages 21 and older at the time of enrollment.
- Entitled to benefits under Medicare Part A, enrolled under Medicare Part B and eligible for Part D.
- Eligible for full Medi-Cal benefits, including:
 - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
 - Individuals who meet the share-of-cost provisions below:
 - » Nursing facility residents with share-of-cost.
 - » MSSP members with share-of-cost.
 - » In-Home Supportive Services (IHSS) recipients who met share-of-cost on the first day of the month, in the fifth and fourth months prior to effective date with Cal MediConnect.
 - Individuals eligible for full Medi-Cal per the spousal impoverishment rule.
- Reside in a Cal MediConnect county.
- Reside in San Mateo or Orange counties with a diagnosis of end-stage renal disease (ESRD) at the time of enrollment.

NOT PERMITTED TO ENROLL

Individuals who meet the following criteria are not permitted to enroll in a Cal MediConnect health plan:

- Those under age 21.
- Those covered under an employer benefit plan.
- Those with other private or public health insurance.
- Those receiving services through California's regional centers or state developmental centers, or intermediate care facilities for the developmentally disabled.
- Those with share-of-cost who do not meet the enrollment requirements outlined above.
- Those residing in a Veterans' Home of California.
- Those in certain rural ZIP codes in Los Angeles, Riverside and San Bernardino counties.

Those with a diagnosis of ESRD at the time of enrollment and residing in Alameda, Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara counties, unless they are already enrolled in a separate line of business operated by the health plan offering the Cal MediConnect plan on the first day of eligibility. Individuals enrolled in Cal MediConnect who are subsequently diagnosed with ESRD, as with all enrollees, may choose to disenroll from Cal MediConnect or stay enrolled.

OPTIONAL DEEMED ELIGIBILITY

Health Net provides a two-month period of deemed continued eligibility to Health Net Cal MediConnect plan members. The deeming period starts on the first day of the month following the month the Department of Health Care Services (DHCS) notifies Health Net that the member has lost his or her Medi-Cal eligibility or state-specific eligibility for Cal MediConnect.

Member Enrollment Process

Eligible individuals must complete and submit an enrollment request to enroll in a managed care health plan participating in Cal MediConnect. If necessary, an individual's legal representative, the Department of Health Care Services (DHCS) or Centers for Medicare & Medicaid Services (CMS) may complete an enrollment request on behalf of an eligible individual.

DHCS is responsible for accepting enrollment requests related to Cal MediConnect. DHCS accepts enrollment requests several ways, including during a face-to-face interview in which a paper form is completed, by mail and by contacting DHCS' enrollment broker, Health Care Options (HCO).

On a month-to-month basis, individuals who meet enrollment criteria may switch:

- From Original Medicare to a Cal MediConnect health plan.
- From a Medicare Advantage (MA) or a standalone Medicare Part D Prescription Drug Plan to a Cal MediConnect health plan.
- From a Cal MediConnect health plan to a non-Dual Special Needs Plan (D-SNP) Medicare Advantage or a standalone Medicare Part D Prescription Drug Plan (PDP). Members are required to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits.
- From one Cal MediConnect health plan to another Cal MediConnect health plan.
- From a Cal MediConnect health plan to Original Medicare. Members are required to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits.
- From a Cal MediConnect health plan to a PACE organization.
- From a PACE organization to a Cal MediConnect health plan.
- From a Cal MediConnect health plan to a Medi-Cal managed care plan.
- From a Medi-Cal managed care plan to a Cal MediConnect health plan.
- From Medi-Cal fee-for-service (FFS) to a Cal MediConnect health plan.

Voluntary enrollment requests are generally effective on the first day of the month following DHCS' receipt of the enrollment request.

PCP SELECTION CRITERIA

The Cal MediConnect Member Services Department is available to assist members in selecting a PCP. Provider directories listing PCP office locations, language capabilities and phone numbers are also available for member use.

If a member does not select a PCP at the time of enrollment, Health Net assigns a PCP to allow member access to medical care immediately upon enrollment.

The following assignment process is used:

- In auto-assigning a PCP, the system searches for a PCP within 10 miles or 30 minutes of the member's residence.
- Health Net considers the language preference of the member. The system searches for a PCP who is fluent in the member's preferred language or who has staff fluent in that language.

If the member has an existing relationship with a participating provider, as identified in the historical claims information received from CMS and DHCS, every attempt is made to preserve the relationship in the PCP assignment.

Member Disenrollment Process

VOLUNTARY DISENROLLMENT

A member may request disenrollment from Cal MediConnect in any month and for any reason, or he or she may enroll in another Medicare Advantage (MA) plan, or a standalone prescription drug (Part D) plan, which automatically disenrolls him or her from Cal MediConnect. A member may disenroll by:

- Contacting the DHCS enrollment broker, HCO.
- Calling 1-800-633-4227 (1-800-MEDICARE).
- Sending or faxing a signed written disenrollment notice to HCO.
- Enrolling in an MA plan or Medicare prescription drug plan by calling 1-800-633-4227 or using the CMS online enrollment center.
- Enrolling in another health plan participating in Cal MediConnect.

Health Net forwards all requests to disenroll to HCO. Members who verbally request disenrollment from Health Net are instructed to make the request in one of the ways outlined above.

After the member submits a request to disenroll, DHCS provides the member with a disenrollment notice within 10 calendar days of receipt of the request to disenroll. Members have until the last calendar day of the month to request disenrollment. The effective date for all voluntary disenrollments is the first day of the month following DHCS' receipt of the disenrollment request.

When a member voluntarily disenrolls from Cal MediConnect, he or she returns to Original Medicare and is mandatorily enrolled in the Medicare-Medicaid Plan's (MMP's) Medi-Cal-only managed care plan (unless the individual elects a different Medi-Cal managed care plan), effective on the first day of the following month, and will remain in the Cal MediConnect plan until the last day of the month the disenrollment request was received.

If the member disenrolls from the Cal MediConnect plan by enrolling in an MA plan or Medicare prescription drug plan, he or she is mandatorily enrolled in the MMP's Medi-Cal-only managed care plan (unless the individual elects a different Medi-Cal managed care plan), effective on the first day of the following month.

If eligible for the Medicare Part D Low-Income Subsidy (LIS) that helps pay Medicare Part D plan costs, CMS auto-enrolls the member into a Medicare Prescription Drug Plan. The member has access to the Limited Income Newly Eligible Transition (LI NET) prescription drug plan during any coverage gap. If a member elects a Medicare health or drug plan while still a member of a Cal MediConnect plan, they are automatically disenrolled from the Cal MediConnect plan upon enrollment in the new Medicare plan.

INVOLUNTARY DISENROLLMENT

DHCS or CMS can initiate involuntary disenrollment requests. DHCS disenrolls members for the following reasons:

- Members permanently move outside the service area (includes incarceration) or reside temporarily outside the service area for more than six consecutive months.
- Members lose entitlement to either Medicare Part A or B.
- Members lose Medi-Cal eligibility.
- Death.
- Information is materially misrepresented regarding reimbursement for third-party coverage.
- The health plan's contract with CMS is terminated, or the member is within an area excluded by the health plan due to the health plan reducing its service area.
- Members are not lawfully present or lose lawful presence status.

DHCS may request Contract Management Team (CMT) approval to disenroll a member from a Cal MediConnect plan if:

- The member engages in disruptive behavior, which is so disruptive, uncooperative or abusive that continuing membership seriously impairs Health Net's or its participating providers' ability to provide services to the member or other members. Disruptive behavior includes threats of violence by the member to employees of Health Net or its participating providers. Members are disenrolled only after serious efforts to resolve the problem have been made.
- The member provides fraudulent information on an enrollment request or permits abuse of the Health Net identification (ID) card.

Disenrollment is generally effective the first day of the calendar month after the month in which DHCS sends the final notice to the member indicating the intended action.

PROVIDER REQUESTS TO DISENROLL A MEMBER

To request disenrollment of a member, providers must contact the Health Net Cal MediConnect Member Services Department and be prepared to describe the circumstances and submit documentation to support the request.

Eligibility Reports

Eligibility reports are generated by the health plan on a monthly basis to provide information about member assignments to participating physician groups (PPGs) and hospitals. Providers who have questions or would like to order reports should contact the Health Net Cal MediConnect Provider Services Center.

Verifying Eligibility

Before providing care to an individual seeking medical attention, providers must attempt to determine the individual's eligibility as a Health Net member. Although member eligibility is verified at the time the ID card is issued, possession of the card at the time of service does not guarantee eligibility. If eligibility is not verified by the health care provider and services are provided to an ineligible individual, Health Net does not accept financial responsibility for any services performed.

ELIGIBILITY VERIFICATION SYSTEM

Eligibility can be verified using one of the following options:

- Health Net provider website.
- Health Net Cal MediConnect Provider Services Center, which offers an interactive voice response (IVR) system allowing providers to verify member eligibility without waiting to speak with a Provider Services Center representative. If the provider prefers, he or she may also choose to speak with a representative.

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Chapter 3 – Access to Care

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Access to Care

This chapter summarizes member rights and responsibilities and standards and processes for member access to care, including primary care, specialty care, emergency and urgent care, and prescription medication. Referrals and authorization for coverage of care are also covered.

Covered Services

Benefits covered under Cal MediConnect are as follows:

- Medicare Part A, Part B and Part D services as the members' primary benefits. These benefits include medically necessary services, such as acute care services, physician services, hospital services, rehabilitative skilled nursing facility (SNF) services, dialysis, durable medical equipment and home health care services.
- Medi-Cal services as secondary benefits, which generally cover services not covered under Medicare after the Medicare benefit is exhausted or Medicare-specific criteria have not been met. This may include some mental health services, long-term care, custodial nursing facility care, home and community-based services, and personal care services.
- Supplemental benefits, such as transportation services and vision care. Members can consult the *Member Handbook* for additional information, as supplemental benefits can vary by county.

Member Rights and Responsibilities

Cal MediConnect members have the right to expect a certain level of service from their health care providers. Members are responsible for cooperating with providers in obtaining health care services. These member rights and responsibilities apply to members' relationships with Health Net and all participating providers responsible for member care.

Members have the responsibility for:

- Being aware of their benefits and services and how to obtain them.
- Supplying information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Following plans and instructions for care that they have agreed to with their practitioners.
- Understanding their health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible.

Members have the right to:

- Receive information about the organization (including all enrollment notices, informational and instructional materials), its services, its practitioners and providers, and member rights and responsibilities in a manner and format that may be easily understood.
- Be treated with respect and recognition of their dignity and right to privacy.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- A candid discussion of appropriate medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Have access to personal medical records, and where legally appropriate, receive copies of, amend or correct their medical record.
- Reasonable accommodations.
- Be treated with dignity and respect.
- Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
- Be provided a copy of their medical records, upon request, and to request corrections or amendments to these records.
- Not be discriminated against based on race, ethnicity, national origin, religion, gender, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
- Have all plan options, rules and benefits fully explained, including through use of a qualified interpreter if needed.
- Access an adequate network of primary and specialty providers who are capable of meeting their needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality, including required reporting.
- Choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
- Participate in all aspects of care and to exercise all rights of appeal. Members have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired and must be appropriately informed and supported to this end. Specifically, members must:
 - Receive a comprehensive health risk assessment upon date of coverage in a plan and participate in the development and implementation of an individualized care plan (ICP). The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of their strengths and weaknesses, and a plan for managing and coordinating their care. Members, or their designated representative, also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.
 - » Health Net or the participating provider group, when delegated to do so, must provide enrollees with copies of the ICP and any of its amendments. The ICP must be made available in alternative formats and in an enrollee's preferred written or spoken language.
 - » Enrollees or their authorized representative must have the opportunity to review and sign the ICP and any of its amendments.
 - Receive complete and accurate information about their health and functional status by the interdisciplinary team.
 - Be provided information about all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration their condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
 - » Before enrollment.
 - » At enrollment.
 - » At the time needs necessitate the disclosure and delivery of such information in order to allow members to make an informed choice.
 - Be encouraged to involve caregivers or family members in treatment discussions and decisions.

- Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
- Be afforded the opportunity to file an appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that appeal to an independent external system of review.
- Receive medical and non-medical care from a team that meets their needs in a manner that is sensitive to their language and culture, and in an appropriate care setting, including the home and community.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Freely exercise these rights and that the exercise of those rights does not adversely affect the way Health Net and its providers or the Department of Health Care Services (DHCS) treats them.
- Receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once per year, and the right to receive notice of any significant change in the information provided in the orientation materials at least 30 days prior to the intended effective date of the change.
- Be protected from liability for payment of any fees that are the obligation of Health Net.

Not to be charged any cost-sharing for Medicare Part A and B services.

- The unconditional and exclusive right to hire, fire and supervise their in-home supportive services (IHSS) provider.
- Receive their Medicare and Medi-Cal appeals rights in a format and language understandable and accessible to them.
- Opt out of Cal MediConnect at any time, beginning the first of the following month.

In addition:

- Members shall not be balance billed by a provider for any covered service.
- Members are free to exercise their rights without negative consequences.

Access Standards

APPOINTMENTS AND REFERRALS

Members are instructed to call their primary care physician (PCP) directly to schedule appointments for routine care, except in the case of a life-threatening emergency. The PCP is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice.

The PCP is also responsible for:

- Providing an initial health assessment (IHA), which includes an age-appropriate history, physical examination and individual health education behavioral assessment (IHEBA), within 120 calendar days after enrollee's date of enrollment.
- Completing an IHEBA using the Staying Healthy Assessment (SHA) as indicated by the periodicity table.

ACCESS AND AVAILABILITY STANDARDS

The following access and availability standards have been developed to monitor the availability of timely health services to members. All standards are from the date of the member's request unless otherwise noted.

Health Net monitors these access standards to confirm compliance.

Type of Care	Standard
Emergency care	Immediately
First prenatal visit	Within 2 weeks of request
Non-urgent/routine care with a PCP	Within 10 business days of request
Non-urgent/routine care with a specialist	Within 15 business days of request
Preventive health, physician exams and wellness checks	Within 30 calendar days of request
Urgent care visit with a PCP or specialist that does not require prior authorization	Within 48 hours of request
Urgent care visit with a PCP or specialist that requires prior authorization	Within 96 hours of request
Initial health assessment	Within 120 days of enrollment
Non-urgent ancillary services for MRI/mammogram/physical therapy	Within 15 business days of request
Non-urgent appointment in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Rural and small counties: Within 14 calendar days of request. Medium counties: Within 7 business days of request. Large counties: Within 5 business days of request.

The following standards also apply:

- In-office wait time for scheduled appointments must not exceed 30 minutes.
- The PCP or designee must be available 24 hours a day, seven days a week.
- Phone service must be available 24 hours a day, seven days a week.
- Provider offices or an IVR should answer the phone within 60 seconds during normal business hours.
- After office hours, physicians must return phone calls and pages within 30 minutes.
- Providers should call a patient back within 24 hours if a patient leaves a message for non-urgent issues.

Access for Members with Disabilities

Health Net requires participating providers to maintain reasonable accommodations for members with disabilities, including seniors and persons with disabilities (SPD), in accordance with the Americans with Disabilities Act (ADA) of 1990. Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

During Health Net's facility review process, a finding of any obvious physical barrier to accessibility for SPD members is noted. If any obvious physical barrier is found, Health Net discusses potential resolution with the provider or participating physician group (PPG) administrator.

Emergency and Urgent Care

Emergency care by any licensed provider is covered regardless of where services are performed. Emergency services may be provided inside and outside the Health Net Cal MediConnect service area.

An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that, if it does not get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
2. Serious impairment to bodily function.
3. Serious dysfunction of any body, organ or other part.

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services.
- Needed to evaluate or stabilize an emergency medical condition.

AFTER-HOURS ACCESS

Health Net requires physicians, or a registered nurse under physician supervision, to maintain 24-hour phone coverage, seven days a week through their answering service, or 24-hour onsite medical care for members. PPGs and PCPs who do not have services available 24 hours a day may use an answering service (live answering or automated) to provide members with clear and simple instruction about after-hours access to medical care. This information is vital in case of an urgent or emergency situation or if there is a need to contact a physician after normal business hours. Health Net has sample scripts available in the Health Net Provider Library. Physicians must return after-hour phone calls and pages within 30 minutes.

URGENT CARE

Urgent care is defined as services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury, such as sore throat, fever, minor lacerations and some broken bones. This includes medical services that require attention promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required. When possible, urgent care must be provided by the PCP, on-call designee or participating urgent care center. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

Nurse Advice Line

Access-to-care standards require all PCPs to provide 24-hour phone service for instructions, medical condition assessment and advice. The Nurse Advice Line is a telephonic support program that is staffed by registered nurses and licensed health care professionals. Clinicians can assess a member's medical condition, provide referral services and patient education services, and offer instructions on home care techniques and general health information 24 hours a day, seven days a week. The toll-free number is printed on the back of the member's identification (ID) card.

Long-Term Services and Supports

Long-Term Services and Supports (LTSS) refer to a variety of services and supports that help eligible members live independently in the community. Covered LTSS include the following:

- Community-Based Adult Services (CBAS)
- In-Home Supportive Services (IHSS)
- Multipurpose Senior Services Program (MSSP)
- Long-term care (LTC) services in a skilled nursing facility (SNF) and subacute care services

LTSS are usually provided in homes and communities, over an extended period, but are also provided in facility-based settings, such as SNFs.

As required by DHCS, timely access standards will be established for services when the provider travels to the member and/or community locations to deliver services. Timely access references the number of business days or calendar days from the date of request that an appointment must be available within the type of service. Standards for skilled nursing facilities (SNF) and intermediate care facilities (ICF) are based on county population density as follows:

- Rural counties: Within 14 calendar days of request
- Small counties: Within 14 calendar days of request
- Medium counties: Within seven business days of request
- Large counties: Within five business days of request

COMMUNITY-BASED ADULT SERVICES

CBAS provides an alternative to institutionalization for eligible Cal MediConnect members. CBAS offers a bundle of services during a service day, including, but not limited to:

- Skilled nursing care and social services.
- Personal care.
- Physical, occupational and speech therapy.
- Family and caregiver training.
- Meals.
- Mental health services.
- Transportation to and from the CBAS center.

Referral Process

Members who may benefit from CBAS are those with multiple complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring, skilled nursing and therapeutic intervention, and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short- or long-term nursing facility admission.

Participating providers who believe a Health Net member may benefit from the CBAS program must request a face-to-face assessment by submitting the CBAS request form via fax to the CBAS Request Line to initiate an assessment. CBAS centers use an interdisciplinary clinical team to evaluate service needs and then submit an evaluation to Health Net. Health Net validates eligibility for services and reviews and approves authorization requests for more than five days/week of CBAS service. Requests for one to five days per week are reviewed for eligibility but do not require prior authorization.

CBAS services are a managed care benefit, and Health Net is financially responsible for covered services provided by CBAS centers.

IN-HOME SUPPORTIVE SERVICES

The IHSS program provides in-home care for seniors and persons with disabilities who cannot safely remain in their own homes without assistance, providing as much independence as possible. Members who qualify may receive up to 283 hours of IHSS every month. Services include, but are not limited to:

- Domestic and related services (housecleaning, meal preparation and clean-up, laundry and grocery shopping).
- Personal care services (bathing, dressing, grooming).
- Paramedical services (wound care, catheter care, injections).
- Family and caregiver training.
- Accompaniment to medical appointments.
- Protective supervision for the mentally impaired.

Members who may benefit from IHSS are those with complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short- or long-term nursing facility admission.

Referral Process

Participating providers, case managers, community-based organizations and family members who believe a member may benefit from IHSS can contact Health Net's H.E.L.P. team to receive assistance in initiating a new IHSS referral, receive an update on a pending referral or for any questions regarding the IHSS process. Providers or members may also make a referral directly to the Los Angeles County Department of Public Social Services (DPSS) or the County of San Diego Aging and Independence Services (AIS) to apply for the IHSS program. Members potentially eligible for IHSS may also be identified through emergency room/urgent care usage, inpatient admissions, authorization, claims and encounter data.

Providers must supply the completed health care certification form (SOC 873) required by the IHSS program in order for a referral to be processed. If the referral comes from a source other than the member's provider, the IHSS social worker mails the SOC 873 to the member to have his or her licensed health care professional complete and return the form in order to complete the referral.

IHSS is a managed care benefit, and covered services are Health Net's financial responsibility.

MULTIPURPOSE SENIOR SERVICES PROGRAM

MSSP provides social and health care case management services for members ages 65 and older who wish to remain in their homes and communities, and provides a cost-effective alternative to institutionalization. The goal of the program is to use available community services to prevent or delay institutionalization. The services must be provided at a cost lower than that of a SNF. MSSP services include, but are not limited to:

- Environmental accessibility adaptations.
- Personal emergency response systems (PERS) and communication devices.
- Care management.
- Personal care services (bathing, dressing, grooming).
- Respite care (in- and out-of-home).
- Adult day care, support center and health care.
- Housing assistance.
- Chore services.
- Income maintenance counseling.
- Mental health services.
- Transportation services.
- Protective supervision.
- Meal services.
- Communication services (translation or interpreter).

Referral Process

Members who are potentially eligible for MSSP may be identified through a variety of sources, including the member's PCP or specialist, community-based organizations, inpatient admissions (concurrent review), or claims and encounter data. Participating providers who believe a member may benefit from MSSP may contact Health Net's H.E.L.P. team for referral information. Members in either San Diego County or Los Angeles County may apply for MSSP directly by calling the Health Net Member Services Department.

With the member's consent, Health Net provides case management information required by MSSP. A team of health and social service professionals determine the member's eligibility for MSSP participation. The team's assessment determines the member's medical diagnosis, physical disabilities, functional abilities, psychological status, and social and physical environment. Health Net case managers continue to provide needed care coordination with the member's PCP and other community agencies pending MSSP waitlist activity.

MSSP is a managed care benefit, and covered services are Health Net's financial responsibility.

LONG-TERM CARE

Health Net must authorize LTC services when a member has a medical condition that requires LTC. This applies for all PPGs except for Heritage Provider Network (in which case Heritage Provider Network will issue the authorization). LTC includes both skilled nursing care and non-skilled custodial care, specific to out-of-home protective living arrangements with 24-hour supervised or observation care on an ongoing intermittent basis to abate deterioration.

LTC is care provided in a SNF, intermediate care facility or subacute care facility. Additionally, it is an inpatient care level for members who meet medical necessity at the following care levels as defined in the Manual of Criteria for Medi-Cal Authorization:

- A SNF admission for members accessing Medi-Cal nursing facility level A or B benefit level.
- An intermediate care facility admission for members accessing Medi-Cal nursing facility level A benefits.
- A subacute care facility admission for members accessing Medi-Cal covered subacute care services.

Members in need of LTC services are placed in facilities providing the level of care commensurate with their medical needs.

Referral Process

Providers must supply both the completed Health Net Long-Term Care Authorization Notification Form as well as any supporting clinical information, such as the Pre-Admission Screening and Resident Review (PASRR), Minimum Data Set (MDS) or approved Treatment Authorization Request (TAR), as applicable, to the Health Net Long-Term Care Intake Line by fax. Health Net continues to honor any currently active TAR-approved authorizations.

For new admission authorization/notification requests, once a decision is made, Health Net notifies the provider by phone or fax. Other ancillary services may require prior authorization and are not included in the nursing facility room rate. Providers must obtain prior authorization prior to providing such services.

Providers may contact the Health Net Long-Term Care Intake Line with all questions regarding LTC referrals and authorizations, or to check the status of a request.

Access to Services in Primary Language

Participating providers must communicate with members in a manner that accommodates their needs, including providing interpreters for those who are deaf or hard of hearing and for those who do not speak English. Members whose primary language has been identified as a threshold language receive written information in that language from Health Net. Health Net monitors member access to information and services in threshold languages in many ways, including primary care site certification.

THRESHOLD LANGUAGES

In Los Angeles County, the identified threshold languages are:

- Arabic
- Armenian
- Cambodian
- Chinese (traditional)
- Farsi
- Korean
- Russian
- Spanish
- Tagalog
- Vietnamese

In San Diego County, the identified threshold languages are:

- Arabic
- Spanish
- Tagalog
- Vietnamese

Provider Demographic Data Verification

To ensure Health Net Cal MediConnect members have access to accurate information when selecting providers, providers are required to provide advance notification to Health Net or their participating physician group (PPG) when they have changes to their demographic information. On a monthly basis, providers should validate that their demographic information is reflected correctly on the Health Net website.

If a provider sees patients at multiple locations, the provider should review the address, phone number, fax number and office hours for all locations to ensure data accuracy.

DEMOGRAPHIC INFORMATION

Providers' demographic data include the following:

- Name
- Alternate name
- Address
- Phone number
- Fax number
- License number
- National Provider Identifier
- Office hours
- Patient age ranges (lowest to highest) seen by provider
- Specialty
- Email address – used for members and is Health Insurance Portability and Accountability Act (HIPAA) compliant
- Practice website
- Hospital affiliation
- Languages other than English spoken by the physician
- Languages other than English spoken by the office staff
- Panel status – Accepting new patients, accepting existing patients, available by referral only, available only through a hospital or facility, not accepting new patients
- Handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/ scale (T) – if accessibility is not yes to all, then indicate no

NOTIFICATION AND MAINTENANCE REQUIREMENTS

Providers directly contracting with Health Net must notify Health Net of changes by completing the online form or by reaching out to their provider network administrator (PNA). The online form is available on the Health Net provider website. Providers must have privileges to update provider information and submit changes online.

As stated in the *Provider Participation Agreement (PPA)*, providers are required to provide a minimum of 30 days advance notice of any changes to their demographic information. If the change pertains to the status of accepting new patients, the provider must notify Health Net or the applicable PPG within five business days.

Providers contracting through a PPG must notify the PPG directly of changes, and the PPG notifies Health Net. PPGs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net on a real-time basis. Real time is within 30 days, as defined by the Centers for Medicare & Medicaid

Services (CMS). Health Net conducts random audits of PPGs to validate processes and policies to ensure they are maintaining provider demographic information on a regular basis.

Referrals for Specialty Care

PPGs are responsible for providing or coordinating all professional services for Cal MediConnect members, including care among participating and nonparticipating providers. A referral is required for care that is beyond the PCP's or PPG's scope of practice.

The following are examples of services that are referred for specialty consultation. This list provides guidelines and is not intended to be all-inclusive.

- **Cardiology.** Complicated hypertension (failure to respond or adverse response to conventional therapy).
- **Endocrinology.** Diabetic complications, including retinopathy and nephropathy.
- **Gastroenterology.** Polyps or other abnormalities.
- **Behavioral health services.** Diagnosis, treatment and consultation regarding management of clearly emotional issues for which the member or PCP feels the need for consultation. PCPs may refer members to MHN for assessment and referral to a behavioral health provider (behavioral health services should be coordinated with medical services).
- **Neurology.** Seizures that are recurrent or refractory to treatment.
- **Rheumatology.** Collagen vascular diseases depending on the extent and severity of manifestations or complications.
- **Pulmonology.** Percutaneous lung biopsies.
- **Urology/nephrology.** Prostate suspicious for malignancy or obstructive symptoms that may lead to surgical treatment.

SELF-REFERRAL SERVICES

Cal MediConnect members may self-refer for the following services without prior authorization:

- Basic prenatal care from a provider who works with Health Net, unless the member has been receiving prenatal care from another provider
- Emergency services
- Urgently needed services from network providers
- Urgently needed care from out-of-network providers when the member cannot get to network providers (for example, when the member is outside of the plan's service area)
- Urgently needed services when outside of the country
- Family planning services
- HIV testing
- PCP visits
- Pregnancy termination
- Preventive services
- Services provided by participating certified nurse midwives or obstetricians/gynecologists (OB/GYNs)
- Sexually transmitted infection (STI) services

Prior Authorization

Delegated PPGs perform the initial utilization review and authorization, while Health Net Medical Management staff conducts utilization review and authorization for select services.

Physicians participating through a delegated PPG should contact their PPG for information.

PPG RESPONSIBILITIES

Each PPG is responsible for:

- Contracting or arranging with licensed and certified providers for a full range of primary and specialty care services, as well as with key ancillary and subspecialty providers, such as psychologists, family counselors, social workers, chiropractors, podiatrists, audiologists and physical therapists.
- Submitting copies of all referrals to Health Net for review and approval for those services for which Health Net retains responsibility.
- Monitoring the quality of care and costs associated with services based on referrals to nonparticipating providers.
- Obtaining encounter data from each referred physician.
- Assuring timely payment to referred providers for covered services.

Cal MediConnect-delegated PPGs have five business days from receipt of the reasonably necessary information to render a prior authorization decision. The decision may be deferred and the time limit extended an additional 14 calendar days only where the enrollee or the enrollee's provider requests an extension. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. For expedited service authorizations, where the provider indicates or Health Net determines that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, delegated PPGs must make a decision and provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after the receipt of the request for service.

PRIOR AUTHORIZATION REQUIREMENTS

For a Health Net member assigned to a Direct Network PCP, providers are encouraged to access the provider operations manuals to obtain the most current prior authorization requirements. Provider operations manuals are available in the Provider Library. Providers requesting services for a member assigned to a delegated PPG must consult the PPG for the PPG's prior authorization requirements. When faxing a request, please attach pertinent medical records, treatment plans, test results and evidence of conservative treatment to support the medical appropriateness of the request.

Accessing Prescription Medication

Members enrolled in Health Net's Cal MediConnect plan can access prescription medication benefits through a Health Net participating pharmacy. To obtain the highest level of benefits, the prescription medication must be listed on the Health Net Cal MediConnect formulary.

Prior authorization is needed for prescription medication when:

- A medication is listed on the Health Net Cal MediConnect formulary as needing prior authorization or a formulary restriction or limitation is exceeded.
- A medication is not listed on the Cal MediConnect formulary.

CoverMyMeds® is Health Net's preferred way to receive prior authorization requests.

There are three options for submitting a prior authorization form:

- Submit the prior authorization request electronically through the CoverMyMeds website at go.covermymeds.com/envolve.
- Complete and submit the Envolve Pharmacy Solutions online form through the Envolve Pharmacy Solutions website at <https://paform.envolverx.com>.
- Print the appropriate form found on the Health Net provider portal or in the portal's Provider Library under *Forms*. Once you have printed the form and completed all appropriate fields, fax the completed form to the number listed on the form.

Medication Prior Authorization Request forms are available through the Envolve Pharmacy Solutions fax-back system at 1-800-867-6564, option 1. Prior authorization requests for urgent Part D medication requests are processed within 24 hours. Non-urgent Part D medication requests are processed within 72 hours.

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Chapter 4 – Health Care Management

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Health Care Management

This chapter outlines care management, utilization management, quality improvement programs and credentialing.

Care Management

The Health Net care management program provides individualized assistance to members experiencing complex, acute or catastrophic illnesses. Health Net's care management program uses qualified nurses and medical directors to provide a fully integrated network of programs and services for these members. The focus is on early identification of and engagement with high-risk members. The care management program integrates the care management process, eliminates duplication of services between Health Net and its participating physician groups (PPGs), and facilitates communication and cooperation between Health Net, PPGs and members.

REFERRAL TO CARE MANAGEMENT

Care management is required for all Cal MediConnect members. Most cases are received through a monthly eligibility enrollment file, and a care manager is assigned at that time as the primary contact. In addition, referrals can also be identified through the inpatient concurrent review process, but referrals are accepted from any source. Most case management is delegated to PPGs. Such PPGs are required to case manage all Cal MediConnect members.

PRIMARY CARE PHYSICIAN RESPONSIBILITIES

The primary care physician (PCP) continues to be responsible for directing the member's care. The Health Net care manager provides the PCP with reports regarding the member's progression through the care management plan. The PCP is responsible for:

- Providing ongoing medical treatment.
- Providing health care information, such as medical records and the treatment plan, to expedite health services for the member.
- Participating on the health care team to develop and implement the member's care management plan.
- Attending care conferences to evaluate the member's progress and modify the care plan, if necessary, and/or reviewing the care management plan of care and providing feedback to the care manager.
- Maintaining complete documentation in the member's medical record.

Health Risk Assessment

Health plans must complete a health risk assessment (HRA) for members within 45 or 90 calendar days of the member's effective date of enrollment, depending on the member's risk level, and on an annual basis thereafter, or more frequently in the instances of a health status change or by member request. Health Net is contracted with Optum™ to conduct HRAs on its behalf.

HRA completion assists Health Net and PPGs with early and ongoing identification of member needs, enabling Health Net and PPG care management teams to develop more comprehensive member-centric care plans. HRAs also predict future consumption of medical care and are imperative to the success of the care management program for both PPGs and Health Net. The HRA 43-question assessment includes the QualityMetric SF-12v2[®] Health Survey, which is a shorter version of the SF-36v2[®] Health Survey, and uses 12 questions to measure functional health and well-being from the patient's point of view and addresses the following areas:

- Member demographics
- Health history and medical conditions
- Current health and well-being
- Activities of daily living
- Lifestyle and health behaviors
- Preventive care

Optum utilizes criteria provided by the Department of Health Care Services (DHCS) to establish an initial high or low-risk level for members based on 12 months of historical data from CMS and DHCS. Optum complies with the outreach guidelines from DHCS to contact newly enrolled members by phone, mail or in person to complete the HRA.

Optum attempts to complete all HRAs with the member within 45 calendar days of enrollment for members identified as high-risk, within 90 days for low-risk members, and annually thereafter for both low- and high-risk members. High-risk for risk-assessment purposes means members who are at increased risk of having an adverse health outcome or worsening health and functional status if they do not receive their initial contact within 45 calendar days of enrollment. Case managers and the member's PCP have the option to complete the HRA for a member through Optum's Web-based HRA tool if the member prefers.

For members in nursing facilities, HRAs are completed face-to-face by a Health Net vendor, PPG care managers or the member's PCP within 90 calendar days of enrollment.

If a member cannot be reached after the required attempts to complete an HRA, Health Net will send a letter to the member's assigned PCP advising that the HRA was not completed.

Using predictive models, Optum further uses HRA and claims data to stratify members and provide a recommended care level of high or low risk for medical, behavioral and social needs.

The Health Risk Assessment is accompanied by a state-mandated Long Term Services and Supports assessment.

HEALTH RISK ASSESSMENT SUMMARY AND QUESTION AND ANSWER REPORTS

An HRA summary report is developed for each member and made available to the case manager and PCP to support them in developing a comprehensive care plan using evidence-based alerts that identify areas warranting prompt attention or monitoring. The HRA summary report is easy to read and structured to quickly identify areas that may require intervention. It is derived based on the member's answers to the questions on the HRA. The HRA Question and Answer (Q&A) report reflects the member's response to each individual question on the HRA. Once the HRA has been completed, both the summary and the Q&A reports are posted on the Health Net provider website.

HRAs must be completed annually, but if there is a change in the member's clinical status, a PCP or care manager can request an updated HRA prior to the anniversary of the previous HRA. The PCP or case manager can complete a reassessment by contacting Optum, or by completing the HRA using Optum's HRA tool available on the Health Net provider portal.

Individual Care Plan

The HRA and other available information (pharmacy history, medical records, etc.) are used by the care manager to establish/update the plan of care in collaboration with the member. The care plan includes specific, measurable goals and the interventions/actions to be implemented to reach the goals. The goals are prioritized based on the member preferences and care needs.

Interdisciplinary Care Team

An Interdisciplinary Care Team is available for each member. The team consists of the member and the care team responsible for implementing the Individual Care Plan.

Care Transitions

The Interdisciplinary Care Team is responsible for effectively managing member transitions such as discharge from hospital to home. The care manager completes outreach and actions necessary to assure the member's discharge plan is in place and followed post-discharge.

Utilization Management

Health Net's utilization management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management and retrospective review are the elements of the UM process.

CLINICAL CRITERIA FOR MEDICAL MANAGEMENT DECISIONS

As part of Health Net's quality improvement (QI) and UM programs, Health Net applies a hierarchy of medical resources for making medical management decisions for Cal MediConnect members. For Medi-Cal-specific benefits, the Health Net medical management team uses medical necessity guidelines from Medi-Cal's online Provider Manual, Part 2. For Medicare-specific benefits, the medical management team uses Medicare's guidelines in the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, National Coverage Determinations Manual and Local Coverage Determinations documents.

In the event one entity provides broader benefits than the other, Health Net applies the broadest benefit when making medical management decisions. When this hierarchy of information does not provide documented coverage guidelines, Health Net's licensed professionals refer to Health Net's National Medical Policies for evidence-based guidelines. Health Net's National Medical Policy Department critically reviews published scientific literature pertaining to the efficacy and safety of existing and emerging technologies or new uses of existing technologies.

Health Net's national medical policies are used as guidelines for clinical decision-making as they relate to requests for services and/or supplies for members. The policies support Health Net's licensed professionals in making appropriate utilization management or care management decisions. Health Net's national medical policies provide guidance as to whether certain services or supplies are cosmetic, medically necessary or appropriate, or experimental and investigational.

The foundation for Health Net policies include nationally recognized sources, such as:

- McKesson's InterQual® medical necessity criteria.
- Hayes Medical Technology Directory and Hayes Alert technology-based evaluations.

CONTINUITY OF CARE FOR NEW MEMBERS

Health Net offers continued access to care assistance that allows new Cal MediConnect members to continue treatment with nonparticipating providers for medically necessary covered Medicare services and medically necessary covered Medi-Cal services for up to 12 months. There must be no quality-of-care issues involving the nonparticipating provider, and the provider must be willing to accept payment from Health Net or the delegated entity based on the current Medicare fee schedule, the higher of the plan's contracting rates or Medi-Cal fee-for-service (FFS) rates.

Note, if a member opts out of or disenrolls from Cal MediConnect and later re-enrolls in Cal MediConnect, the member has the right to a 12-month continuity of care (COC) period, regardless of whether the member received COC in the past.

Members must contact the Health Net Cal MediConnect Member Services Department to request continued treatment. Health Net Cal MediConnect Member Services representatives assist members by submitting the continuation of care request to Health Net's Utilization Management for clinical review and triaging. If the request meets clinical criteria, then it is further processed by the Utilization Management Department. However, if the request meets non-clinical criteria, then it is submitted to the Public Programs Department for processing. The appropriate team will verify, to the extent possible, that the member has an ongoing relationship with the requested nonparticipating provider.

For delegated PPGs, the appropriate team will forward the completed, reviewed and qualifying continuity of care request to the PPG's UM department. The UM designee issues Health Net's qualifying continuity of care authorization and notifies the member and the nonparticipating provider's office of the authorization number. The PPG utilization management designee is responsible for issuing the authorizations, explaining the process for requesting continued services beyond the initial authorization and, if warranted, continuing out-of-network services up to the allowable continuation time frame of 12 months.

Quality Improvement

The Health Net Quality Improvement (QI) program manages improvement of the quality of care and services provided to Health Net members. The program encompasses all PPGs and ancillary service providers, including all medical and behavioral health providers, contracting with Health Net. The QI program includes the development and implementation of standards for clinical care and service, the measurement of adherence to the standards and the implementation of actions to improve performance. The scope of the program includes:

- Wellness and disease management programs.
- Practice guidelines for prevention and chronic care.
- Monitoring and evaluating care and services provided in all health care delivery settings, including behavioral health services and Long-Term Services and Supports (LTSS) in coordination with other medical conditions.
- Clinical quality and safety of care.
- Member, practitioner and provider satisfaction.
- Hospital and PPG quality comparison reports.
- Practitioner and provider site and facility inspections.
- Practitioner and provider access and availability for members.
- Medical record and documentation standards.
- Practitioner and provider qualifications and selection.
- Organizational performance.
- Support for cultural and linguistic services.
- Monitoring continuity and coordination of care.
- Evaluating the effectiveness of the model of care.
- Maintaining compliance with the QI requirements of regulatory agencies, such as CMS, DHCS and the Department of Managed Health Care (DMHC).

QI AUDITS OF CAL MEDICONNECT PROVIDERS

Facility Site Review

All PCPs participating in Cal MediConnect are required to complete an initial facility site inspection and subsequent periodic facility site inspections. The full-scope site review includes the facility site review (FSR) and the medical record review (MRR). DHCS reviews the results of Health Net's FSRs and may also audit a random sample of provider offices to ensure they meet DHCS standards. Re-audits are conducted at least every three years as part of the recredentialing process.

An FSR is conducted as part of the initial credentialing and contracting process for PCPs, who must achieve a passing score of at least 80% prior to being admitted into the Health Net provider network. This initial site visit is the first inspection of a site that has not had a previous visit.

An MRR will follow the initial FSR within 90 calendar days from the date members are first assigned to the PCP, with subsequent combined FSRs and MRRs occurring within three years. Details of FSRs, MRRs and related requirements may be provided in advance to each PCP's office providing ample time to prepare. However, please note that access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

FSRs contain nine critical elements. Critical element deficiencies identified during any site review must be corrected within 10 business days of the survey date and verified by the plan as completed within 30 days of the survey date.

The provider whose site is to be audited may be advised in advance, by phone and in writing, of the selected date for the audit of the office or facility. However, as advised above, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced. Using the DHCS Facility Site Review tool, a Health Net QI Department nurse, who is a DHCS-certified site reviewer, visits the provider's site.

Results of each audit are reviewed by the QI Department for compliance with and maintenance of standards. Results of the completed site audit are conveyed to the provider and PPG. QI actions are taken as deemed necessary following the audit.

Physical Accessibility Review Survey

A component of the FSR is the Physical Accessibility Review Survey (PARS). PARS is conducted for participating PCPs, high-volume specialists, ancillary providers, CBAS and hospitals. All PCP sites must undergo the PARS. Based on the outcome of the PARS, each PCP site is designated as having basic or limited access along with the six specific accessibility indicator designations for parking, external building, interior building, restrooms, examination rooms and medical equipment (accessible weight scales and adjustable examination tables).

Basic access demonstrates facility site access for members with disabilities to parking, building access, elevator, physician's office, examination rooms and restrooms.

Limited access demonstrates facility site access for members with disabilities as missing or incomplete in one or more features for parking, building access, elevator, physician's office, examination rooms and restrooms.

Results of the PARS are made available to Health Net's Cal MediConnect Member Services Department and listed in the provider directory to assist members in selecting a PCP that can best serve their health care needs.

Medical Record Reviews

Participating physician groups (PPGs), physicians, hospitals and ancillary providers are required to provide Health Net with copies of medical records, and accounting and administrative books and records, as they pertain to the *Provider Participation Agreement (PPA)*.

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records, including electronic medical records (EMR), when Health Net or its designated representative requests access to them in order to audit, inspect, review, perform chart reviews and duplicate such records.

Health Net is required to monitor the maintenance of medical records by the PCP that document care provided to members. CMS requires Medicare Advantage and Part D plans to maintain records a minimum of 10 years. This includes copies of provider contracts, medical records and patient care documentation.

The provider whose medical records are to be audited may be advised in advance, either by phone or in writing, of the selected dates. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

Using the DHCS MRR tool and criteria, the Health Net QI Department nurse, who is a DHCS-certified nurse reviewer, reviews the selected charts for appropriate medical records management and documentation. When possible, the facility and medical record audits are conducted concurrently. QI program actions are taken as deemed necessary following the audit. DHCS reviews the results of MRRs and may also audit a random sample of provider offices to ensure they meet DHCS standards.

Review Results

A minimum passing score for the FSR and MRR is 80%. Practitioners receiving scores between 80 and 89%, or 90% or above with deficiencies in critical elements, pharmaceutical services or infection control, are given a conditional pass and are required to complete a corrective action plan (CAP) to address all identified deficiencies.

Practitioners who do not comply with a CAP or fail to meet threshold scores on an FSR or MRR are forwarded to Health Net's Credentialing Committee for administrative termination. The termination will be applicable to the Medi-Cal and Cal MediConnect contracting lines of business and practice locations and remain in effect for three years from the date of the committee's final decision. The affected practitioner is afforded rights to an informal appeal (reconsideration) of the committee's decision to administratively terminate.

FSR and MRR tools, and related regulatory requirements, are available on the DHCS website at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/PL2014/PL14-004.pdf. Providers are required to understand and maintain compliance with these requirements at all times.

DECISION POWER®

Decision Power is Health Net's suite of care management, wellness, education and support tools for members.¹

Disease Management

Health Net's Disease Management program includes care management for heart failure, coronary artery disease (CAD) and diabetes with comorbidity. The program focuses on:

- Slowing the progression of the disease and the development of complications through proven program interventions.
- Changing behaviors and improving lifestyle choices.
- Improving compliance with guidelines and member care plans.
- Managing medications and enhancing symptom control.
- Education regarding recommended preventive screenings and tests.
- Reducing emergency room visits and hospitalization, drug errors and preventing future occurrences.

¹ Health Net Community Solutions, Inc. (Health Net) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees in Health Net's Cal MediConnect plan.

Decision Power® services, including its clinicians, are additional resources that Health Net makes available to its Cal MediConnect plan enrollees. It is not affiliated with Health Net's provider network. Decision Power is neither offered nor guaranteed under Health Net's Cal MediConnect Plan (Medicare-Medicaid Plan) contract with Medicare or Medi-Cal, and it may be revised or withdrawn without notice. Decision Power services are not subject to the Medicare appeals process. Disputes regarding products and services may be subject to Health Net's grievance process.

In-home biometric monitoring units are offered to qualified beneficiaries. Data is reviewed by clinically trained nurses, giving beneficiaries and their families valuable peace of mind. The program objectives are to reduce preventable health care utilizations, promote member adherence to treatment guidelines and improve self-management skills.

Care Reminder Messaging for Members and Providers

Health care reminders are sent to members and/or providers when potential gaps in care are identified through claims, laboratory data and other sources. On the member side, the care gap data are used to send out messaging in modes members prefer, including emails, live calls with a clinical pharmacist, a live call to close multiple gaps at once, and mailings with information about the condition and links to helpful resources from leading national organizations. These reminders aim to create actionable opportunities for specific individuals and align with industry-recognized Healthcare Effectiveness Data and Information Set (HEDIS®) measures to improve preventive health, chronic condition management and more.

Wellness Programs

Health Net offers many tools and programs to help members adopt and maintain healthy lifestyles, such as:

- **Health Risk Questionnaire (HRQ).** An online interactive tool that helps members identify health risks based on current lifestyle behaviors and family history. Members are provided a summary of their HRQ results that can be printed and shared with their physicians.
- **Health record.** An online secure database where members can track important medical history, including health conditions, immunizations, medications, tests and procedures. Information from the HRQ automatically becomes part of their personal health records (PHRs). PHRs are auto-populated with member claims and pharmacy data.
- **Health promotion programs.** These online health improvement programs are comprehensive behavior change programs that provide information and tools to improve health and reduce disease risk. The programs include achievable goals personalized to individual preferences and interests. Each program focuses on one health topic and includes a to-do list of action items to help individuals reach their goals. Health promotion program topics include stress management, weight loss, nutrition, exercise and tobacco cessation.
- **Quit For Life® Tobacco Cessation program.** Telephonic and online support with a quit coach. Individuals receive one-to-one help during their quit process, a comprehensive quit guide and a guide for family members, unlimited access to online education, and coaching support to keep members motivated and on track.

Also, to support members' willingness to quit smoking, Health Net offers all FDA-approved smoking cessation products on the formulary without prior authorization with a valid prescription.

Cal MediConnect enrollees can register for the Quit For Life telephonic tobacco cessation program by calling 1-800-893-5597 to speak to an enrollment specialist, or dial directly at 1-866-QUIT-4-LIFE (1-866-784-8454). Additional program and enrollment information is accessible online on the provider portal by selecting *Wellness Center*.

- **myStrength™.** The myStrength program addresses depression, anxiety, stress, substance abuse, pain management and mindfulness. myStrength has a new guided program for living with chronic pain. Peer-led exercises help users find the pain management techniques that work best for them while educating them about the careful use of medications.

Cal MediConnect enrollees can register for this program online on the myStrength website at www.mystrength.com/HNWell. They can also access on-demand stress-relief apps at their fingertips via the myStrength mobile application.

- **Decision Power healthy discounts.** Health Net members have access to exclusive discounts on eye examinations and eyewear and other health-related products and services, including discounts with Jenny Craig® and Weight Watchers®.

- **Health challenges.** Online quarterly challenges to help individuals achieve small changes through healthy eating, exercise, stress management and weight loss. The duration of each challenge is approximately one month and offers focused behavior change and record-keeping strategies to help participants stay on track for success.
- **Tools.** Tools to monitor prescription history and check medication interactions; estimate cost of care for more than 100 conditions, 50 procedures or surgeries, and 200 medical tests or visits; compare hospital performance for more than 160 common diagnoses and procedures; and help members understand their health plan options, so they can choose the plans that best fit their families.

HEALTH EDUCATION

Health Net's Health Education Department educates members on how to improve their health and emphasizes the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems. The department ensures that education brochures, newsletters, classes and other information are offered in threshold languages and alternative formats. Health education programs and services include:

- **Staying Healthy Assessment (SHA).** Providers need to complete a SHA to prioritize individual health education needs of their assigned members related to lifestyle, behavior, disability, environment and cultural and linguistic background.
- **Weight Management Program.** Members have access to Healthy Habits for Healthy People weight management educational resources which include an educational guide, cookbook and exercise band to help older adults and people living with disabilities eat healthy and stay active.
- **Healthy Hearts, Healthy Lives program.** Members have access to a heart health prevention toolkit (educational booklet and tracking journal) and access to community classes to learn how to maintain a healthy heart.
- **Health education classes.** Members may access health education classes on a variety of health topics, such as diabetes, Alzheimer's disease, healthy eating, heart health, blood pressure, fitness and more.
- **Member newsletter.** Newsletter mailed to members on a regular basis with health information.
- **Toll-free Health Education Information Line.** Members can call the Health Education Department to order health education materials and access local classes. Materials are available on a wide range of topics, such as oral health, diabetes, advance directive, osteoporosis, fall prevention, nutrition, exercise and more.

To order health education materials, providers may call the Health Education Department or fax the Cal MediConnect Health Education Provider Order Form to the Health Education Department. The Cal MediConnect Health Education Provider Order Form is available in the Health Net provider operations manual.

Credentialing and Recredentialing

Health Net's credentialing program establishes criteria and reviews professional qualifications for approving new and continuing Health Net participating providers.

Providers and practitioners are evaluated for compliance with federal and state regulatory requirements and Health Net criteria. Providers and practitioners must be credentialed prior to providing health care services to Health Net members. Only licensed, qualified applicants meeting these standards and participation requirements are accepted or retained in Health Net's provider network. The credentialing process is administered by Health Net, agencies or PPGs to which credentialing responsibilities have been delegated in accordance with Health Net criteria. Health Net does not authorize these entities to grant temporary privileges. Health Net retains the right to deny, approve, suspend, limit or terminate a practitioner agreement through the credentialing process.

On an ongoing basis, the recredentialing cycle is consistent with regulatory requirements. Currently, practitioners are subject to recredentialing at least every three years.

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Chapter 5 – Appeals and Grievance Procedures

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Appeals and Grievance Procedures

Health Net's appeals and grievance procedures offer recourse to members and providers who are dissatisfied with any aspect of service from Health Net or its participating providers.

Provider Appeals Processing

Participating provider appeals must be submitted to Health Net or the participating physician group (PPG), depending on contractual relationship, within the timeliness guidelines stated in the *Provider Participation Agreement (PPA)*. If the *PPA* does not stipulate a specific time frame, the timely filing period is 365 days from the date of the denial.

Provider appeals submitted directly by the participating provider or by parties acting on behalf of the participating provider, such as attorneys and collection agencies, are considered appeals.

A written letter of appeal and supporting documentation must be included with the appeal request. Incomplete records delay the review process.

Health Net notifies the appealing participating provider in writing that Health Net has received the provider appeal and provides Health Net's Provider Services Center contact information. Providers can contact Health Net's Provider Services Center to check the status of an appeal or dispute. Health Net sends a second letter with a Health Net medical director's determination within 30 calendar days of receipt of complete information.

Member Appeals Processing

Health Net has a process in place to record and respond to all member appeal requests. When an appeal is received, Health Net:

- Documents the member information, provider information, appeal issue and the date and time the request was received.
- Fully investigates the substance of the appeal, including any aspects of clinical care, and obtains all pertinent information, including medical records.
- Ensures that the review of the denied service or claim is conducted by an individual who was not involved in making the initial organization determination. If the original denial was based on a lack of medical necessity, the review must be performed by a physician with expertise in the field of medicine related to the denied services.

Health Net is required to perform the following:

- Ensure the reconsideration decision is not made by the same person who was involved in making the initial determination.
- Ensure that denials due to lack of medical necessity are reconsidered by a physician with expertise in the medical field of the services under appeal.

- Send a notice of the decision to the requesting party stating whether a decision has been made to make full payment or provide the requested service:
 - For Medicare services not covered by Medicare Part D, if the decision has been made to uphold the initial determination, the requesting party is informed that the case has been forwarded to the Centers for Medicare & Medicaid Services (CMS) independent review entity, MAXIMUS Federal Service. This is considered a level two appeal.
 - For Medi-Cal services, if a decision has been made to uphold the initial determination, the requesting party receives a letter notifying him or her of the decision. Members may request a state fair hearing or an independent medical review (IMR). This is considered a level two appeal. An IMR cannot be requested if a state fair hearing has already been requested. A member may be able to get an IMR immediately and without filing an appeal first. This is in cases where the member is in immediate danger or the request was denied because treatment was considered experimental or investigational.

If Health Net makes a fully favorable decision on a standard pre-service reconsideration, it must issue a notice of the decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but not later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

If Health Net makes a reconsideration determination on a request for payment that is fully favorable to the member, it must issue a written notice of its reconsideration determination to the member and pay the claim no later than 60 calendar days for Medicare and 30 calendar days for Medi-Cal claims after receiving the reconsideration request.

Pre-service requests that meet expedited review criteria must be reviewed and resolved within 72 hours of receipt. The 72-hour time frame includes weekends and holidays and begins upon receipt.

Chapter 6 – Claims and Encounter Information

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Claims and Encounter Information

This chapter covers claims, billing and encounter reporting procedures. It describes processes for tracing the status of a claim or requesting a claim payment adjustment. It also explains provider responsibilities for coordination of benefits and third-party tort liability.

Balance Billing

Balance billing is strictly prohibited by state and federal law and Health Net's *Provider Participation Agreement (PPA)*. Balance billing occurs when a participating provider bills a member for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for services denied by Health Net or a participating physician group (PPG). Health Net Cal MediConnect members are not subject to copayments; participating providers must not collect copayments from these members.

Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for nonpayment of a claim for covered services. Participating providers agree to accept Health Net's fee for services as payment in full.

Claims Submission Information

TIMELY CLAIMS SUBMISSION

Providers must submit claims for covered services that are Health Net's responsibility within 180 days from the end of the month in which services are rendered. Health Net is not obligated to pay for claims when providers fail to comply with timely claims submission requirements, and providers are prohibited from billing the Cal MediConnect member.

ELECTRONIC CLAIMS SUBMISSION

Health Net encourages participating providers to submit claims electronically. Electronic claims from fee-for-service (FFS) providers are submitted to the Health Net Electronic Data Interchange (EDI) Claims Department. An authorized vendor may be used for electronic claim submission. Health Net has contracts with Change Healthcare™ and ABILITY® to provide claims clearinghouse services for Health Net claims submission. Contact the Health Net EDI Claims Department to establish electronic claims submission or for more information.

Coordination of Benefits

Health Net's Cal MediConnect program's goal is to improve the quality of care for its members eligible for both Medicare and Medi-Cal by providing access to a seamless, integrated program. Cal MediConnect members are enrolled in both Medicare Advantage (MA) and Medi-Cal managed care, so determining and coordinating the primary insurer is not applicable. Care is provided based on integrating the benefits, utilizing MA as the primary benefit and Medi-Cal managed care as the secondary benefit.

Encounter Reporting

PPGs must provide encounter data about professional services rendered to Health Net members no later than 60 days from the date of service. Participating hospitals must provide encounter data monthly about institutionally-based services rendered to Health Net members no later than 60 days from the date of service.

The following requirements apply to encounter reporting:

- Reporting services on a per-member, per-visit basis, rather than a monthly summary. Providers must submit an accounting of all services rendered by date and member. The encounter data should be submitted via electronic transmission in the ANSI 837 5010 X12 format. Encounter records must include the same data elements as required on a FFS claim form and meet Health Net companion guide standards. An authorized EDI vendor or clearinghouse may also be used for encounter reporting purposes.

Claims and Encounter Information

- Health Net does not accept encounter and encounter summary reports on paper. Only electronic encounters are accepted.
- PPGs and providers must report services according to the terms of the *PPA*. A PPG is required to submit an electronic encounter file once a month (at a minimum).
- All encounter reporting must identify members by their Health Net member identification (ID) number. This number is printed on each member's ID card. Submission of encounter data without the member ID number is not acceptable and will be returned for correction.
- Health Net will accept encounter data after the 60th day of service, but data will not be counted toward provider agreement incentive program scores.

PROVIDER NPI VALIDATION

Per the requirement of the Centers for Medicare & Medicaid Services (CMS), Health Net validates submitted billing provider National Provider Identifiers (NPIs) against the National Plan and Provider Enumeration System (NPPES) database for all dates of service. If the billing NPI is not found or is inactive, capitated encounter claims will be rejected.

Rejected capitated encounter claims will receive an edit with the reason for rejection. The edit reads, "NPPES BILLING PRV NPI IS MISSING OR INACTIVE."

This process applies to professional and institutional capitated encounter claims for all dates of service.

The following three default NPIs are excluded from the validation process:

- Professional: 1999999984
- Institutional: 1999999976
- Durable medical equipment (DME): 1999999992

Contact the Capitated Claims/Encounters Department for assistance in developing or modifying procedures to accomplish complete encounter data submission.

Capitated providers are asked to produce a corrective action plan if the format, quality, timeliness or expected volume of encounters is not in compliance with Health Net standards. Capitated providers may be sanctioned if they continue to demonstrate noncompliance. Sanctions may include requiring the capitated provider to use an encounter vendor at their own expense, freezing new enrollment and can ultimately result in termination of the capitation contract.

Third-Party Tort Liability

Under Health Net's Cal MediConnect contract, Health Net and its subcontracting providers may claim for recovery of the value of covered services rendered to a member subject to Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) lien and third-party recovery rights, if such recovery does not result from an action involving the tort liability of a third party or recovery from the estates of deceased members or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage.

Health Net and its subcontracting providers are required to assist the DHCS in pursuing the state's right to reimbursement from such recoveries. Health Net and its PPGs are required to notify DHCS within 10 days of the discovery of such cases. On request from DHCS for information, Health Net and PPGs must provide additional information within 30 days of the request. Individual providers are obligated to help Health Net and affiliated PPGs provide the additional information on request.

PROVIDER RESPONSIBILITIES

- Notifying Health Net or the PPG in writing of all potential and confirmed third-party tort liability cases involving a Health Net Cal MediConnect member.
- Notifying Health Net if the provider receives any requests by subpoena from attorneys, insurers or beneficiaries for copies of bills.
- Supplying Health Net with copies of the request, copies of documents released as a result of the request, and providing the name, address and phone number of the requesting party.

Glossary

Authorization. Approval requested and obtained by providers for a designated service before the service is rendered; used interchangeably with prior authorization.

Cal MediConnect Ombudsman Program. The independent contractor established to safeguard the rights of Cal MediConnect beneficiaries.

Centers for Medicare & Medicaid Services (CMS). The federal agency under the United States Department of Health and Human Services responsible for administering Medicare and Medicaid programs.

Community-Based Adult Services (CBAS). Outpatient, facility-based program that offers skilled nursing care, social services, personal care and family and caregiver training to eligible Cal MediConnect members.

Department of Health Care Services (DHCS). The state department in California responsible for the administration of the Medi-Cal program and other affordable health care services, including Long-Term Services and Supports.

Department of Managed Health Care (DMHC). The state department charged with overseeing health care service plans licensed under the Knox-Keene Act.

Eligible Beneficiary. Individual age 21 or older at the time of enrollment and entitled to benefits under Medicare Part A and enrolled under Medicare Part B and eligible for Part D and eligible for full Medi-Cal benefits.

Emergency Care. The provision of medically necessary services required for the immediate alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Lack of such care could lead to disability or permanent damage to the patient's health if not diagnosed and treated without delay.

Grievance. An expression of dissatisfaction regarding access to care or quality of care problems by a member or provider.

In-Home Supportive Services (IHSS). Program that provides in-home care for beneficiaries who cannot safely remain in their own homes without assistance.

Long-Term Care. Includes skilled nursing care and non-skilled custodial care, specific to out-of-home protective living arrangements with 24-hour supervised or observation care on an ongoing intermittent basis to abate deterioration.

Managed Long-Term Services and Supports (MLTSS). Variety of services and supports that help eligible beneficiaries meet daily needs for assistance and improve the quality of their lives. MLTSS includes CBAS, IHSS, MSSP and LTC services.

Medical Records. A confidential document containing written documentation related to the provision of physical, social and mental health services to a patient.

Member. An eligible beneficiary who has enrolled in a Health Net plan.

Member Appeal. A request for reconsideration of an adverse determination regarding health care services, including a delay in providing, arranging or authorizing health care services.

Multipurpose Senior Services Program (MSSP). A program that provides social and health care case management services for eligible beneficiaries who wish to remain in their homes and provides a cost-effective alternative to institutionalization.

Participating Physician Group (PPG). Health Net's practice of contracting with individual physicians through a global contract with the physicians' contracting medical groups or independent practice associations (IPAs); also known as a subcontractor.

Participating Provider. A facility, physician, physician organization, other health care provider, supplier or other organization, which has met applicable credentialing and/or recredentialing requirements, if any, and has, or is governed by, an effective agreement directly with Health Net, or indirectly through another entity, such as another participating provider, to provide covered services.

Primary Care Physician (PCP). A physician responsible for supervising, coordinating and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP has focused the delivery of medicine to general practice or is a board-certified or board-eligible internist, pediatrician, obstetrician/gynecologist (OB/GYN) or family practitioner.

Referral. The practice of sending a patient to another participating provider for services or consultation that the referring provider is not prepared or qualified to render.

Skilled Nursing Facility (SNF). An institution or distinct part of an institution that provides rehabilitation services, skilled nursing care and related services.

Urgent Care. Medically necessary services provided for an unforeseen illness or injury required to prevent the serious deterioration of health. Treatment of the illness or injury requires professional attention that cannot be delayed for longer than 48 hours, or disability or permanent damage to the patient's health could result.

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