Health Net®

Partners in Performance Webinar

Focusing on:

Continuity of Care (COC)

&

Long Term Services and Supports (LTSS)

November 20, 2019

Coverage for every stage of life™

Agenda

- Introduction
- Continuity of Care
- Long-Term Services and Supports
- Conclusion and Final Remarks

Overview of Continuity of Care (COC)

Participating Physician Group (PPG) Responsibilities for COC

- Members are eligible for COC when:
  - They have a **qualifying condition and their treating provider is no longer in-network** due to a change in the network for which the **member had no control**, or
  - They **transition** into Health Net
- These changes can result in a disruption of needed care, placing members at risk.
- **Members with pre-existing provider relationships have the right to request continuity of care** in accordance with state law and the Managed Care Plan (MCP) contract, with some exceptions.

PPG Responsibilities for COC

- To ensure members' continued health and safety, **PPGs and managed care organizations (MCO) must inform members of their right to request COC** and must process their request for COC in a timely manner.

- **Members** who make a COC request to Health Net **are given the option to continue treatment.**

  – **Medi-Cal and Cal MediConnect members may continue treatment for up to 12 months with an out-of-network Medi-Cal provider**.

- These eligible members may require COC for services they have been receiving through another MCP or Medi-Cal Fee-For-Service.

Members' Right to Request COC

- **Members must be notified of their right to request COC** and should be directed to contact the PPG to arrange for services.
- **If the application is received by Health Net,** we will determine whether the member likely qualifies for COC under Health and Safety Code §1373.96, All Plan Letter 18-008, or Dual Plan Letter 16-002, and we **will refer members who have requested COC to their PPG**.
- The current or receiving **PPG shall render a decision to approve or deny the COC** request as appropriate.
- **The receiving PPG shall be responsible for negotiating payment terms** with the current treating providers for services qualifying for COC (if not part of the receiving PPG's network) and authorizing services as appropriate.

COC Eligible Conditions

Under Health and Safety Code §1373.96

- ***PREGNANCY***
  - For the duration of the pregnancy and the immediate postpartum period
- ***SURGERY OR PROCEDURE SCHEDULED BY A PROVIDER THAT IS AUTHORIZED BY HEALTH NET OR ONE OF ITS DELEGATED PPGS***
  - As part of a documented course of treatment recommended to occur within 180 days of the provider termination date for current Health Net members or the effective date of coverage for newly enrolled Health Net members
- ***CARE OF NEWBORN***
  - Birth to 36 months, for up to 12 months
- ***A MEDICAL CONDITION THAT INVOLVES A SUDDEN ONSET OF SYMPTOMS DUE TO AN ILLNESS, INJURY, OR OTHER MEDICAL PROBLEM REQUIRING PROMPT MEDICAL ATTENTION AND WITH A LIMITED DURATION***
  - Completion of covered services is provided for the duration of the acute condition

COC Eligible Conditions (continued)

- ***SERIOUS CHRONIC CONDITION***
  - A medical condition due to a disease, illness, or other medical problem or medical disorder serious in nature and that does either of the following:
    - Persists without full cure or worsens over an extended period of time
    - Requires ongoing treatment to maintain remission or prevent deterioration

- ***TERMINAL ILLNESS***
  - An incurable or irreversible condition that has a high probability of causing death within one year or less
    - Completion of covered services are provided for the duration of a terminal illness for current Health Net members, which may exceed 12 months from the provider termination date or 12 months from the effective date of coverage for newly enrolled Health Net members

- ***MEDICALLY NECESSARY BEHAVIORAL HEALTH TREATMENT FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER (ASD)***
  - These services include applied behavioral analysis (ABA)
    - For up to 12 months

COC Eligibility Under All Plan and Dual Plan Letters

A COC REQUEST MUST BE GRANTED IF:

- **Health Net or its delegate is able to determine that a pre-existing relationship exists with the requested provider** (self-attestation is not sufficient to provide proof of a relationship with a provider)
  - An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment in Health Net for a non-emergency visit

COC Criteria

- The requested provider is willing to accept the contracted rates
- The requested provider has no quality of care concerns
- The requested provider is a California approved provider
- The requested provider supplies all relevant treatment information to determine medical necessity, as well as current treatment plan

COC Exceptions

SECONDARY REFERRALS:

An approved Continuity of Care out-of-network provider must work with Health Net or its delegated Preferred Provider Group (PPG) and cannot refer the member to another out-of-network provider without prior authorization.

- In such cases, Health Net or the PPG will review the referral request, assess for medical necessity, and, if Health Net or the Provider Group does not have an appropriate provider within the network, make an initial determination on the referral request.
- Neither Health Net nor the provider is required to continue services if the provider does not accept these terms and conditions.

TERMINATED FOR REASONS RELATED TO MEDICAL DISCIPLINARY FINDINGS:

This policy does not require Health Net to provide completion of covered services by a provider whose contract with Health Net or the PPG was terminated or not renewed for reasons relating to a medical disciplinary cause or action, as noted in the California Business and Professions Code, Section 805, or for fraud and/or other criminal activity.

COC Turn-Around-Times (TAT) Requirements

DECISION TIMELINES:

- COC requests must be completed within **3 calendar days** if there is **RISK OF HARM** to the member

- All other continuity of care request reviews must be started within **5 working days** following the receipt of the request

- COC requests must be completed within **15 calendar** days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs

- All other requests: **30 calendar days** from the date the PPG or MCO received the request, whichever comes first

PPG Responsibility for COC During PPG Transitions Facilitated by Health Net

- **PPGs must provide a single point of contact** to interface with the Health Net, Cal Viva, and California Health & Wellness team as part of the transition and must report progress and outcomes on all cases meeting COC needs and/or requiring care coordination

- **PPGs must provide responses to Health Net within three business days** or sooner if the situation dictates for COC

- **Health Net will track requests as they are received** and will forward the information related to members shortly after eligibility assignments are complete

PPG Responsibility for COC When the PPG Makes Changes to the Network

- **PPGs should have a designated team or point of contact** to interface with members requesting COC

- **PPGs should have COC policies, procedures, and training on these policies and procedures for your staff**

- **PPGs should track requests as they are received** and document the information related to the disposition of the requests, noting the degree of urgency, the timeliness of the decision, and the outcome (e.g., denial letter issued, authorization entered, out-of-network agreement signed)

COC Contact Information

FOR COC, PROVIDERS CAN:

- Refer members to their respective member contact center
- Provide members with the COC form

THE COC FORM CAN BE ACCESSED ON THE PROVIDER PORTAL:

- **For individual MA and IFP members**, refer to provider.healthnetcalifornia.com
  - Select product type on the Home Screen under Welcome, select Reports, and then select Resources > Contractual > Go to the Provider Library > Forms > Health Net Continuation of Care Request form

- **For employer group MA HMO, HMO, PPO (including EnhancedCare PPO for small business groups), HSP, EPO, and POS members**, refer to provider.healthnet.com
  - Under Working with Health Net > Contractual > Go to the Provider Library > Forms > Health Net Continuation of Care Request form

Long-Term Services and Supports (LTSS)

What Are Long-Term Services and Supports (LTSS)?

Long Term Services and Supports are an array of federally funded “waiver” programs (available in all states) that provide services designed to support people living in a home environment, either in lieu of, or in order to **prevent**, institutionalized care (i.e. nursing home)

THE CORE SET OF LTSS PROGRAMS INCLUDE:

- **In-Home Supportive Services (IHSS)**
- **Community Based Adult Services (CBAS)**
- **Multi-Purpose Senior Services Program (MSSP**)

THE CORE SET OF LTSS PROGRAMS INCLUDE:

- **Connect the Needs Program (CTN)*** – is similar to MSSP and was created to be a short-term solution to MSSP’s wait list
- **Respite Care*** – gives temporary relief to a member’s caregiver for up to 24 hours, every 6 months

*These are Cal MediConnect benefits

IHSS (In-Home Supportive Services)

Description

A state funded program that pays for in-home services for Medi-Cal beneficiaries who need assistance with Activities of Daily Living (ADL) / Instrumental Activities of Daily Living (IADL)* as based on assessed level of need. Examples of services include:

- House cleaning
- Meal preparation
- Laundry
- Grocery shopping
- Personal care services (toileting, bathing, grooming)
- Accompaniment to medical appointments
- Protective supervision

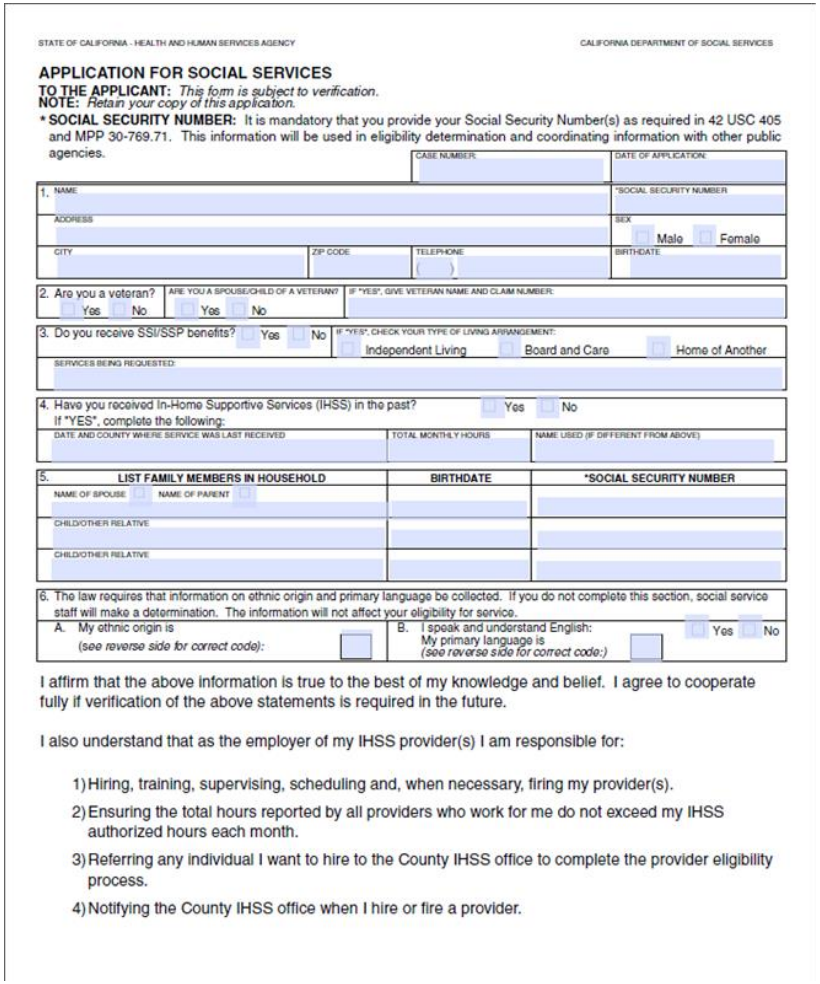
Eligibility

- Active Enrollment in a Health Net Medi-Cal or CMC plan
- No age requirement – eligibility and number of hours per week are based on functional need, as determined upon assessment by a social worker from the Department of Public Social Services (DPSS)
- Member must live in a permanent "home" setting such as a house, apartment, assisted living/board and care, etc.
  - Members who reside in long-term care facilities are not eligible

** See Appendix for ADL/IADL information*

IHSS – Los Angeles County

REFERRAL PROCESS: SOC 295



STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: *This form is subject to verification.*
NOTE: *Retain your copy of this application.*

* **SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

CASE NUMBER | DATE OF APPLICATION

1. NAME | *SOCIAL SECURITY NUMBER
ADDRESS | SEX: Male Female
CITY | ZIP CODE | TELEPHONE ( ) | BIRTHDATE

2. Are you a veteran? Yes No | ARE YOU A SPOUSE/CHILD OF A VETERAN? Yes No | IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:

3. Do you receive SSI/SSP benefits? Yes No | IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: Independent Living Board and Care Home of Another
SERVICES BEING REQUESTED:

4. Have you received In-Home Supportive Services (IHSS) in the past? Yes No
If "YES", complete the following:
DATE AND COUNTY WHERE SERVICE WAS LAST RECEIVED | TOTAL MONTHLY HOURS | NAME USED (IF DIFFERENT FROM ABOVE)

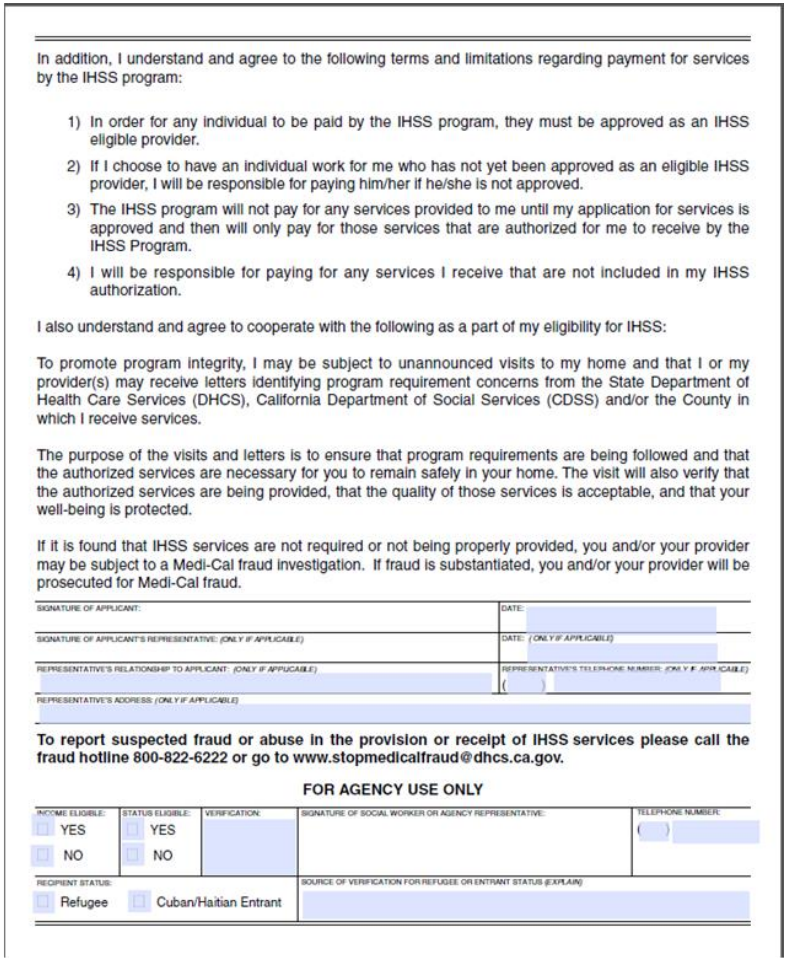
5. LIST FAMILY MEMBERS IN HOUSEHOLD	BIRTHDATE	*SOCIAL SECURITY NUMBER
NAME OF SPOUSE NAME OF PARENT		
CHILD/OTHER RELATIVE		
CHILD/OTHER RELATIVE		

6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.
A. My ethnic origin is *(see reverse side for correct code):*
B. I speak and understand English: Yes No
My primary language is *(see reverse side for correct code:)*

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4) Notifying the County IHSS office when I hire or fire a provider.



In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

SIGNATURE OF APPLICANT: | DATE:
SIGNATURE OF APPLICANT'S REPRESENTATIVE: *(ONLY IF APPLICABLE)* | DATE: *(ONLY IF APPLICABLE)*
REPRESENTATIVE'S RELATIONSHIP TO APPLICANT: *(ONLY IF APPLICABLE)* | REPRESENTATIVE'S TELEPHONE NUMBER: *(ONLY IF APPLICABLE)* ( )
REPRESENTATIVE'S ADDRESS: *(ONLY IF APPLICABLE)*

To report suspected fraud or abuse in the provision or receipt of IHSS services please call the fraud hotline 800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

FOR AGENCY USE ONLY

INCOME ELIGIBLE:	STATUS ELIGIBLE:	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER:
YES NO	YES NO			( )

RECIPIENT STATUS: Refugee Cuban/Haitian Entrant | SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS *(EXPLAIN)*

IHSS – Los Angeles County

LOS ANGELES COUNTY IHSS REFERALS REQUIRE TWO FORMS:

1. Licensed Health Care Professional (LHCP) Must Complete: **SOC 873**

SOC 873 is a Health Care Certification Form

- Applicant's name, DOB, address, and county of residence must be completed in section A on page 1
- Section B on page 1 is left blank for member to sign
- Fill in applicant name on top of page 2
- **Sections C & D on page 2 must be filled out by Licensed Health Care Professional (LHCP)**

2. PPS Must Complete: **SOC 295**

SOC 295 is the application for In-Home Supportive Services (IHSS)

- Complete page 1 with as much information available
- Form **MUST** include member's social security number
- It is okay to send page 2 without member's signature
- Use page 3 to complete sections 6a and 6b on bottom of page 1 (Ethnicity & Language Codes)

IHSS – Los Angeles County (continued)

Locating a Care Provider

- Many members elect for someone they know to be their caregiver
  - i.e., family member, friend, neighbor

- Members who need assistance in locating a care provider may contact:

  - Personal Assistance Services Council (PASC), which operates a referral registry for IHSS consumers and providers
    - 1-877-565-4477

  - Service Employees International Union - United Long Term Care Worker (ULTCW) Homecare Exchange Registry, which operates a registry for IHSS consumers and providers
    - 1-866-544-5742

Community-Based Adult Services (CBAS)

Formally known as Adult Day Health Care (ADHC), CBAS centers are "one-stop shops" that provide a variety of medical and social services with the overarching goal of improving functioning and delaying or avoiding placement in a nursing home or other long-term care facility

CORE SERVICES:

- Professional nursing and medication management
- Therapeutic activities
  - (ex: memory group, yoga, card games, arts and crafts, bingo, etc.)
- Social services and/or personal care services
- One meal offered per day

ADDITIONAL SERVICES:

- Physical, occupational, or speech therapy
- Mental health/psychiatric services
- Registered dietician services
- Transportation
  - (to/from center to member residence)

CBAS (continued)

MEMBER MUST BE ACTIVELY ENROLLED IN A HEALTH NET MEDI-CAL OR CMC PLAN AND MUST MEET THE FOLLOWING CRITERIA:

- Be 18 years of age or older
- Have impairments in two or more ADLs and/or require assistance or supervision performing ADLs*
- Require ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by **skilled health or mental health professional**

SOME EXAMPLES OF POTENTIALLY ELIGIBLE MEMBERS INCLUDE THOSE SUFFERING FROM:

- Moderate to severe cognitive disorder such as dementia, including Alzheimer's
- Developmental disability (i.e., have a diagnosed developmental disability that originated before age 18)
- Chronic mental illness or acquired, organic, or traumatic brain injury

* See Appendix for ADL/IADL information

CBAS (continued)

A Registered Nurse (RN) from PICF uses the CBAS Determination of Eligibility Tool (CDET) during a face-to face assessment to determine eligibility

- (i.e., the member meets medical necessity for CBAS)

- If a member is determined eligible, the identified CBAS is informed and engages their Multidisciplinary Team (MDT) to conduct an assessment and create a care plan called the Interdisciplinary Plan of Care (IPC), which outlines services, including type, frequency, goals, etc.
  - An MDT is comprised of the following:
    - nurse
    - social worker
    - physical therapist
    - occupational therapist
    - speech therapist
    - nutritionist

CBAS (continued)

- An MDT assesses needs based on:
  - Medical and/or mental health diagnosis
  - Active prescriptions
  - Need for assistance with ADLs/IADLs
  - Use of assistive devices
  - Need for feeding assistance
  - Need for continence assistance
  - Use of other approved services (i.e., IHSS, MSSP, hospice)
  - Risk factors (i.e., poor judgment, prone to falls, self neglect)
- The average number of service days is less than 3 days a week
- IPCs are reviewed every 6 months

Multipurpose Senior Services Program (MSSP)

Provides case and healthcare management for frail, elderly members who are certifiable for placement in a nursing facility but who wish to remain in the community.

The goal is to arrange for and monitor community services to prevent or delay institutional placement. Some services include:

- Care management
- Personal care assistance (via IHSS)
- Environnemental adaptations (ex: ramps, grab bars, Personal Emergency Response System (PERS), etc.)
- Housing assistance and/or minor home repairs
- Money management
- Protective supervision

Member must be an actively enrolled Health Net Medi-Cal or CMC member and:

- Be 65 or older
- Be certified or certifiable for a nursing home (Members who reside in long-term care facilities, such as skilled nursing facility (SNF), are NOT eligible)
- Reside within an MSSP service area
- Be appropriate for care management services (MSSP site staff makes this determination)

Please Note: *MSSP Site Manual Chapter 3 – (Page 41)* Members often receive MSSP in conjunction with other LTSS services such as IHSS and CBAS. There are a limited number of spaces available for MSSP services – the current waiting list for services is ~ 6 months

MSSP – San Diego County

REFERRAL PROCESS

- MSSP (and IHSS) referrals for SD County are done online through Aging and Independent Services (AIS) website

- It is suggested to have member on the phone when completing the referral in order to answer referral questions

CONNECT THE NEEDS (CTN) - (Los Angeles County)

A Health Net Specific Program

For members with immediate, complex, unmet LTSS needs that may include but are not limited to:

- Emergency utility assistance
- Non Medi-Cal covered home equipment and installation, and assistive devices
- Referrals to home delivered meal programs
- Medication management
- Referrals for transportation services
- Emergency Response System
- Length of service is ~3 months

Eligibility

- Must be actively enrolled in Cal MediConnect
- Must have unmet needs in a minimum of 3 ADL/IADL
- Must be willing to have an in-person assessment completed

Please Note: CTN is only available in Los Angeles County

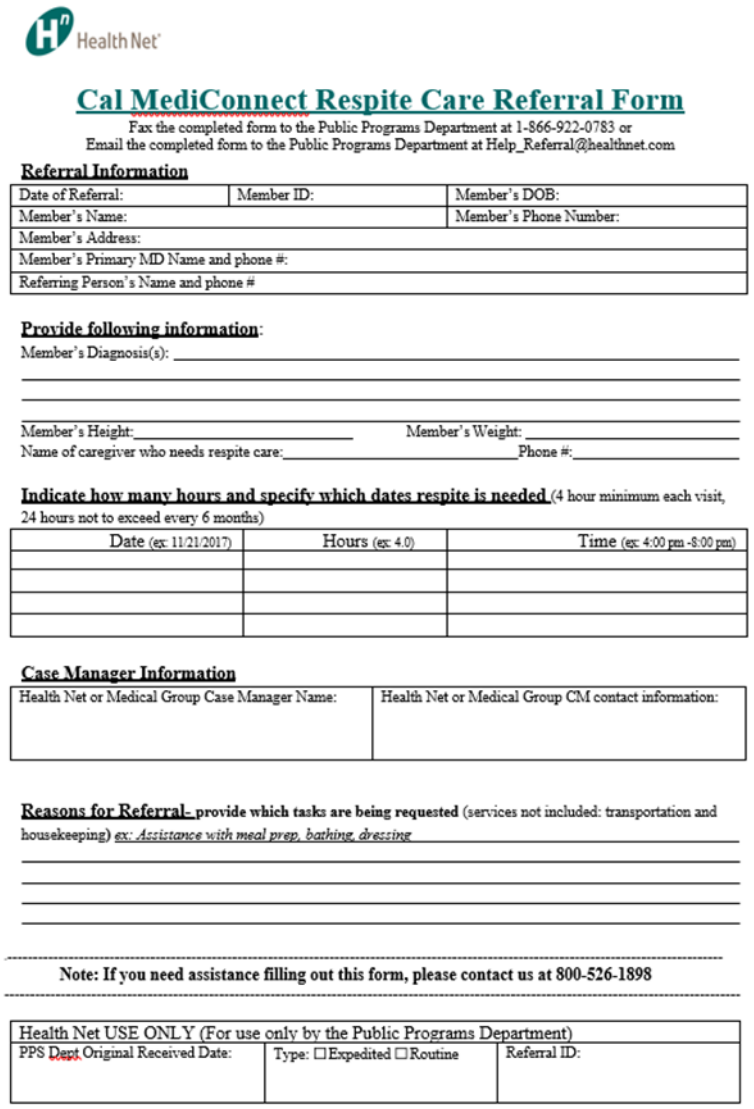
Respite Care (Los Angeles and San Diego County)

Eligibility

- Member must be enrolled in Cal MediConnect in Los Angeles or San Diego County
- Member must have an active caregiver (formal or informal)
- Member must be willing to allow a temporary caregiver in their home

Member: Caregiver matching

- Caregiver available must be able to meet member needs
- Caregiver must be available at the time requested for respite
- Services provided are meal preparation, bathing, dress
- Services excluded are transportation, housekeeping, etc.



Health Net

Cal MediConnect Respite Care Referral Form

Fax the completed form to the Public Programs Department at 1-866-922-0783 or
Email the completed form to the Public Programs Department at Help_Referral@healthnet.com

Referral Information

Date of Referral:	Member ID:	Member's DOB:
Member's Name:		Member's Phone Number:
Member's Address:		
Member's Primary MD Name and phone #:		
Referring Person's Name and phone #		

Provide following information:

Member's Diagnosis(s): _____

Member's Height: _____ Member's Weight: _____

Name of caregiver who needs respite care: _____ Phone #: _____

Indicate how many hours and specify which dates respite is needed (4 hour minimum each visit, 24 hours not to exceed every 6 months)

Date (ex: 11/21/2017)	Hours (ex: 4.0)	Time (ex: 4:00 pm -8:00 pm)

Case Manager Information

Health Net or Medical Group Case Manager Name:	Health Net or Medical Group CM contact information:

Reasons for Referral- provide which tasks are being requested (services not included: transportation and housekeeping) *ex: Assistance with meal prep, bathing, dressing* _____

Note: If you need assistance filling out this form, please contact us at 800-526-1898

Health Net USE ONLY (For use only by the Public Programs Department)		
PPS Dept Original Received Date:	Type: ☐Expedited ☐Routine	Referral ID:

Contact

HOW TO CONTACT THE PUBLIC PROGAMS DEPARTMENT

- Telephone
  - 1-800-526-1898
- Fax
  - 1-866-922-0783
- COC Inquiries Email
  - SHP_TOC-COC_SPD@healthnet.com
- LTSS Referrals Email
  - HELP_referral@healthnet.com

Appendix

Appendix

Activities of Daily Living (ADL)

- Basic self-care tasks, similar to those we learn in early childhood - activities needed to get going in the morning, get from place to place using one's body, and then finish the day in the evening.
- Some people can still live independently even though they need assistance with ADLs, such as:
  - Ambulation/Walking
  - Bathing
  - Dressing
  - Self-feeding
  - Toileting
  - Transferring (in/out of bed, chair, etc.)

Instrumental Activities of Daily Living (IADL)

- Activities people do once they're up, dressed, and ready for the day. These tasks support an independent life style.
- Many people can still live independently even if they need help with IADLs, such as:
  - Accessing Resources
  - Meal Preparation
  - Medication Management
  - Money Management
  - Transportation