California

PROVIDER *Update*

Health Net® COMMUNITY SOLUTIONS

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Help Your Patients Achieve Better Health Outcomes

Quality management programs and resources to support the care you give

Health Net's* multifaceted quality management program has many components. This update describes the components and the quality improvement (QI) processes. It also includes instructions on how to get more information about the program for providers participating in the Cal MediConnect Plan (Medicare-Medicaid Plan).

Providers should review the complete description of the QI program every year. By regularly accessing the provider website at provider.healthnet.com, you can stay current on available programs and resources to help improve members' health.

Quality improvement program scope

The Health Net QI program monitors and evaluates the appropriateness of health and administrative services on a regular basis. It 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.
- Clinical practice and preventive health guidelines.
- Health risk assessment.
- Community health education.
- Practitioner and provider site and facility inspection.
- Practitioner and provider access and availability.
- Medical record and documentation standards.
- Utilization management process.
- Pharmaceutical management.
- Behavioral health services.
- Member and provider rights and responsibilities.
- Member appeals.
- Privacy and confidentiality.
- Interpreter services.

THIS UPDATE APPLIES TO **CAL MEDICONNECT** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

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Open clinical dialogue

Health Net practitioners and providers are encouraged to talk freely with members about their medical conditions, treatment options and medications, regardless of limits to coverage.

Whole-person strategy

Through Decision Power,®[1] Health Net unifies programs, from wellness to complex care, reflecting Health Net's commitment to a whole-person strategy. Members who qualify have access to wellness programs, such as obesity prevention and smoking cessation, and disease management (including in-home biometric devices for qualified members).

Disease management

The Decision Power disease management program supports members with chronic conditions, such as heart failure (HF), coronary artery disease (CAD) and diabetes with comorbidity. It helps increase efficient and effective care. This leads to more personalized and actionable solutions that can improve health outcomes. Health Net offers participants and their providers the programs, tools, connectivity, and information to make better health care decisions to:

- Slow the progression of the disease and the development of complications through proven program interventions.
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines and member's plan of care.
- Manage medications and enhance symptom control.
- Educate members about recommended preventive screenings and tests according to national clinical guidelines.
- Encourage the correct use of medications to prevent medication errors.

Care reminder messages for members and providers

Care reminder messages are sent to members and/or providers when potential gaps in care are found through claims, laboratory data and other sources. These reminders aim to help specific individuals take action and to align with industry-recognized Healthcare Effectiveness Data and Information Set (HEDIS®) measures to improve preventive health, chronic condition management and more.

Nurse advice line

The nurse advice line is a telephonic support program that enables members to make informed health care decisions. The program offers support for members coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained clinicians are available 24 hours a day, seven days a week to monitor and process health care inquiries.

The nurse advice line staff is trained in telephone triage and may help members with questions and concerns about symptoms, appropriate treatment choices and more.

Decision Power 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, which includes 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. They 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. Text2Quit messages keep members motivated and on track. Health Net members 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 available online at www.healthnet.com > *Wellness Center*.

- Decision Power healthy discounts – Health Net members have access to exclusive discounts on eye examinations and eyewear, a weight loss program, vitamins, herbs and supplements, health clubs, 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 about one month and offers focused behavior change and record-keeping strategies to help participants stay on track for success.
- 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 on 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.

Community health education programs and services

Health Net's Health Education Department offers a variety of community health education programs and services to its Cal MediConnect members.

Health education programs

The following health education programs and resources are available for Cal MediConnect members:

- Healthy Habits for Healthy People program – Health Net mails nutrition tips, an exercise stretch band and the Fit Families for Life – *Be In Charge!*℠ DVD to help members eat healthy and stay active.
- Healthy Hearts, Healthy Lives program – Health Net mails a cardiovascular educational toolkit to help members stay heart-healthy. The toolkit includes a comprehensive heart health prevention booklet, a health tracking journal and the Fit Families for Life – *Be In Charge!* DVD.

Health education materials on additional topics are available to members in approved threshold languages upon request. Topics include weight management, diabetes, osteoporosis, advance directive, fall prevention, and more. Providers should contact the Health Net Health Education Information Line at 1-800-804-6074 to request education materials for their sites. Members can also call the Health Net Health Education Information Line at 1-800-804-6074 (TTY: 711) to request materials.

Community classes

Health Net offers health education classes on a variety of topics, such as fall prevention, medicine adherence, nutrition, heart health, blood pressure, fitness, and more. Providers are encouraged to call the Health Education Information Line at 1-800-804-6074 to coordinate health education classes for their sites. Members can also call the Health Net Health Education Information Line at 1-800-804-6074 (TTY: 711) to find classes that may be near their area.

Clinical practice guidelines

Health Net's evidence-based clinical practice guidelines are updated at least every other year and when new scientific evidence or national standards are published. Centene's Corporate Clinical Policy Committee and/or Health Net's Medical Advisory Council (MAC) adopt the clinical practice guidelines and tools, which are available at provider.healthnet.com under *Working with Health Net* > *Clinical* > *Medical Policies* > *Clinical Guidelines*. Providers who do not have access to the Internet may contact the Health Net Provider Services Center to request printed copies of these guidelines.

Guideline sources include, but are not limited to, the following:

- Disease management – Decision Power clinical guidelines are available for providers to quickly reference information about a number of chronic conditions, which include HF, CAD and diabetes. Sources are found within the guidelines.
- Behavioral health – Clinical guidelines are available for such disorders as attention deficit hyperactivity disorder (ADHD) and substance use disorder.

Preventive health guidelines

Health Net's preventive health guidelines are standards of care developed to encourage the correct preventive services to members, according to their age, gender and risk status. These services include screening tests, immunizations and physical

examinations. Health Net bases these guidelines on recommendations from evidence-based sources, such as the United States Preventive Services Task Force (USPSTF), Advisory Committee for Immunization Practices (ACIP), Centers for Disease Control and Prevention (CDC), American Congress of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and American Academy of Family Physicians (AAFP). These guidelines do not address the specific diagnostic testing or medical care that may be necessary as indicated by the member's medical history and physical examination. As always, the judgment of the treating provider is the final determining factor regarding a member's care.

Centene's Clinical Policy Committee and Health Net's MAC review and approve the preventive health guidelines at least every two years or when new recommendations are published. The guidelines are available at provider.healthnet.com under *Working with Health Net > Clinical > Preventive Health Guidelines*. Providers who do not have access to the Internet may contact the Health Net Provider Services Center to request printed copies of these guidelines.

Initial health assessments

New Cal MediConnect members must receive an initial health assessment (IHA), which includes an age-appropriate history, physical examination and Individual Health Education Behavioral Assessment (IHEBA) within 120 days after the date of enrollment. In addition to assessing the member's health, this examination should be used to determine health practices, values, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, and health education needs.

Newly enrolled adult plan members receive preventive services in accordance with the latest edition of the Clinical Preventive Services published by USPSTF.

The Department of Health Care Services (DHCS) approved IHEBA is the Staying Healthy Assessment (SHA). The SHA is the established assessment tool that enables primary care physicians (PCPs) to assess members' current acute, chronic and preventive health needs. The SHA includes standardized questions to assist PCPs in:

- Identifying and tracking high-risk behaviors of individual Cal MediConnect members.
- Assigning priority to individual health education needs related to lifestyle, behavior, environment, culture, and language.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referrals, and follow-up care.

All SHA questionnaires must include the PCP's name, signature and date. The SHA should be completed at age-related intervals, as appropriate. If a member refuses to complete the SHA, the PCP must make note of the refusal in the member's medical record.

Providers can access SHA training and download or print electronic versions of the SHA directly from the DHCS website at www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx. It is available in nine threshold languages. The SHA is also available in English, Spanish, Arabic, Farsi, and Khmer on provider.healthnet.com in the Provider Library under *Forms*. Providers should contact the Health Net Health Education Department at 1-800-804-6074 for more information about SHA.

Health risk assessment

Health Net makes every effort to complete a health risk assessment (HRA) for new Cal MediConnect members within 45 to 90 days of enrollment, depending on risk level, and on an annual basis thereafter. HRAs can be completed more frequently than annually, such as a health status change or by member request. HRA completion helps with early identification of member needs, enabling Health Net and participating physician group (PPG) care management teams to develop more comprehensive member-centric care plans. HRAs also help predict future consumption of medical care which is essential to the success of the care management program for both PPGs and Health Net. Health Net contracts with Optum® to conduct HRAs on its behalf.

Optum tries to complete all HRAs face-to-face for members identified as high-risk within 45 calendar days of enrollment. For the purpose of developing individual care management plans for members identified as lower risk, HRAs may be conducted by Optum, PPG care managers or the member's PCP. This can be done by telephone, mail or face-to-face within 90 calendar days of enrollment. An HRA summary report is developed for each member and made available to the case manager and PCP. The report supports them in developing a comprehensive care plan using evidence-based alerts. The alerts identify areas that warrant prompt attention or monitoring. The completed HRA reports are available at provider.healthnet.com.

Notification of access standards

Health Net strives to ensure compliance with all applicable state, federal, regulatory, and accreditation requirements to provide members with timely access to care. Health Net regularly monitors the network and evaluates whether members have enough access to practitioners and providers who meet their care needs. Health Net notifies all applicable providers about Health Net's established appointment access standards, network adequacy requirements, and access and availability monitoring processes. The standards include, but are not limited to, appointment waiting times for routine, urgent and

preventive care; requirements for after-hours access to care; and other requirements and guidelines for access to medical care as mandated by the applicable regulatory body for the line of business.

The complete set of access standards and revised after-hours script templates are available in the Provider Library at provider.healthnet.com. Providers who do not have access to the Internet may contact the Health Net Provider Services Center to request printed copies of these standards and after-hours script templates.

Medical record documentation standards

Health Net has established standards for the administration of medical records that ensure medical records conform to good professional medical practice, support health management and permit effective member care. A good medical record management system provides support to clinical practitioners and providers in the form of efficient data retrieval. It also makes data available for statistical and quality-of-care analyses.

The medical record serves as a detailed analysis of the member's history, a means of communication to assist the multidisciplinary health care team in providing quality medical care, a resource for statistical analysis, and a potential source of defense support information in a lawsuit. It is the practitioner's and provider's responsibility to ensure completeness and accuracy of content, as well as the confidentiality of the health record. Health Net requires that the practitioner and provider adhere to the standards for maintaining member medical records and safeguard the confidentiality of medical information.

Practitioners and providers are responsible for protecting the confidentiality interests of Health Net members when responding to requests for information. All practitioners and providers must have policies and procedures that address confidentiality and the consequences of improper disclosure of member protected health information (PHI). Refer to the Medical Records Guidelines topic in the Health Net provider operations manuals (available at provider.healthnet.com) to review specific levels of medical record security. Medical record security must be addressed by practitioner and provider policies and procedures governing the confidentiality of medical records and the release of member PHI.

Health Net monitors medical record documentation compliance and implements appropriate interventions to improve medical record-keeping. Medical record guidelines are available at provider.healthnet.com or upon request by contacting the Health Net Provider Services Center.

Medical record and facility site review

Health Net's Facility Site Review Compliance Department conducts medical record reviews (MRRs) and facility site reviews (FSRs). These reviews are to measure PCPs' compliance with current DHCS medical record documentation and facility standards. As part of the credentialing and recredentialing process, these audits are performed prior to admittance to the Cal MediConnect network and at least every three years thereafter in accordance with DHCS requirements, or on an as-needed basis for monitoring, evaluation or corrective action plans (CAPs). In an effort to decrease duplicative MRRs and FSRs and minimize the disruption of patient care at participating provider offices,
Cal MediConnect and Medi-Cal managed care plans are required to collaborate in conducting FSRs and MRRs. On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a PCP and administering a CAP when necessary. The responsible plan shares the audit results and CAP with the other participating health plans to avoid redundancy.

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.

DHCS reviews the results of Health Net's site reviews and may also audit a random sample of provider offices to ensure they meet DHCS standards. Detailed information about audit criteria, compliance standards, scoring, and CAPs is available at provider.healthnet.com.

Physical accessibility review surveys

A component of the FSR is the Physical Accessibility Review Survey (PARS). PARS is conducted for participating PCPs, high-volume specialists, ancillary providers, and hospitals. All PCP sites must undergo PARS. Based on the outcome of PARS, each PCP site is designated as having basic or limited access along with the specific accessibility indicator designations for parking, exterior 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, elevators, 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, elevators, physician's office, examination rooms, and restrooms.

Results of PARS are made available to Health Net's Cal MediConnect Member Services Department to assist members in selecting a PCP who can best meet their health care needs.

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 appropriate level of care. The scope of the program includes all members and network providers. Elements of the UM process include prior authorization, concurrent review, discharge planning, care management, and retrospective review.

As part of Health Net's 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 guidelines in the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, National Coverage Determination Manual and Local Coverage Determinations documents.

In the event one plan benefit is broader than the other, Health Net applies the broader benefit when making medical management decisions. When this hierarchy of information does not provide documented coverage guidelines, Health Net's licensed professionals refer to Centene and Health Net's clinical policies for evidence-based guidelines, which are based on a critical review of published scientific literature pertaining to the efficacy and safety of existing and emerging technologies or new uses of existing technologies.

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

The foundation for clinical policies includes evidence based clinical literature and nationally recognized sources, such as:

- Change Health Care InterQual® medical necessity criteria.
- Hayes Medical Technology Directory.

Quality improvement initiatives

The Quality Improvement (QI) Department utilizes several specific quality initiatives to help improve member health outcomes. Members may receive mailings, emails, live calls, or interactive voice response (IVR) calls providing them with important educational information or reminders to take action when necessary. The focus of these initiatives may include preventive health screenings, influenza and vaccines, chronic disease management, and medication management. IVR calls are conducted by qualified vendors contracting with Health Net.

Health Net also collaborates with the California Quality Collaborative (CQC) to facilitate the sharing of ideas, best practices and resources. Various programs are available to providers to improve chronic disease care, patient satisfaction and efficiency. For a listing of educational programs and patient satisfaction and condition management resources, providers can visit www.calquality.org.

Quality measures and surveys

Health Net measures quality of care and services provided to members in a number of ways, including HEDIS for performance measures for care and service, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for annual assessment of member satisfaction, and the Health Outcomes Survey (HOS) for older members. These results enable Health Net to address opportunities for improvement and are the bases for the implementation of various QI initiatives.

Quality and safety reporting

Health Net maintains the Hospital Advisor Tool, which includes performance metrics by diagnosis or procedure, such as volume, cost, mortality, and complications. The report also includes safety information from the Leapfrog Group and CMS' Hospital Quality Initiative. This web-based tool is available to members, practitioners and providers to support informed decisions when seeking care. Providers can access this information at provider.healthnet.com under *Providers and Facilities* > *Compare Hospitals* > *Continue* > *Hospital Advisor.*

The Leapfrog Group

The Leapfrog Group is a nationwide collaborative effort to promote patient safety and improve quality of care. Since 2014, Health Net has been a Leapfrog Partner and is actively working with the Leapfrog Group, its board of directors, and other partners to improve the safety, quality and affordability of health care. This effort includes the Leapfrog Hospital Survey, a national rating system that gives consumers reliable information about a hospital's quality and safety. The Leapfrog Group identifies hospital progress toward implementing endorsed patient safety practices and meeting national quality standards. Leapfrog promotes patient safety and quality of care through:

- Computerized physician order entry (CPOE).
- Intensive care unit (ICU) physician staffing.
- Evidence-based hospital referral.
- Safe practices score based on National Quality Forum (NQF) standards.

Leapfrog helps hospitals measure their progress in preventing certain hospital-acquired conditions and in properly caring for patients with certain common acute conditions. Leapfrog also publishes a Hospital Safety Score, which assigns each hospital a letter grade to indicate how safe the hospital is for patients. For more information about The Leapfrog Group, providers can visit www.leapfroggroup.org.

Office of the Patient Advocate

Office of the Patient Advocate (OPA) coordinates, provides assistance to, and collects data from state health care consumer assistance call centers. The goal of these efforts is to better enable health care consumers to access the health care services for which they are eligible. Health Net links to the OPA website via the online provider portal at provider.healthnet.com in the Quality Improvement Corner under *Working with Health Net > Quality > Patient Experience Provider Toolkit > Additional Resources and Links.*

Pharmaceutical management

Health Net pharmaceutical management includes the development and maintenance of the Health Net Cal MediConnect formulary and prior authorization criteria. This information is available to members and participating providers. The Health Net Cal MediConnect formulary serves as a reference for physicians to use when prescribing pharmaceutical products for Health Net Cal MediConnect members.

The Health Net Pharmacy and Therapeutics (P&T) committee is comprised of actively practicing physicians and pharmacists. The committee reviews medications based on clinical efficacy, safety, side effects, cost-effectiveness, quality outcomes, and comparisons to existing products.

The committee also develops protocols for medications requiring prior authorization. Considerations include benefit plans and exclusions, step-care protocols, quantity or duration limits, and potential for misuse. Other considerations are potential usage indications that do not meet U.S. Food and Drug Administration (FDA) criteria, experimental or off-label use, and required level of laboratory or safety monitoring.

The medication list and usage guidelines are reviewed and updated quarterly by the P&T committee. The Health Net Cal MediConnect formulary is continually reviewed and revised in response to recommendations by participating providers and as new clinical data and medication products become available.

Behavioral health services

As appropriate, PCPs provide care for Health Net members who have behavioral health diagnoses. Health Net offers behavioral services from MHN providers. MHN is Health Net's behavioral health division. Practitioners and providers may refer members for behavioral health services or members can self-refer by calling MHN at the telephone number on their Health Net ID cards.

For routine behavioral health service requests, MHN notes the member's needs, geographic area, benefit plan, and scheduling requirements to identify a practitioner or program that meets the clinical needs of the member. Member preferences, such as gender and cultural experience, are considered whenever possible. MHN's standards make services available within six hours for non-life-threatening emergencies, within 48 hours for urgent situations, within 10 business days for routine services with a non-physician mental health provider, and within 15 business days with a psychiatrist.

PCPs and their office staff may contact MHN customer service and speak with a licensed care manager (CM). Patients must sign an Authorization for Disclosure form before the PCP or office staff speaks to the MHN CM. For physicians who need help finding appropriate behavioral health care for their members, MHN customer service representatives can answer questions regarding MHN, its network of practitioners and programs, the referral process, member eligibility and benefits.

Coordination of care is fundamental to the member's well-being. PCP offices that receive information from other medical or behavioral health specialists are encouraged to document the information in the member's medical record and review relevant information with the member at his or her next primary care visit.

Screening for depression

Practitioners and providers are encouraged to screen members for depression and other behavioral health conditions. Various brief screening instruments are available, such as the Patient Health Questionnaire (PHQ-9) from USPSTF at

www.uspreventiveservicestaskforce.org/Page/Name/browse-tools-and-resources. Newly enrolled Cal MediConnect members are screened for depression through an HRA. Through Health Net's Decision Power program, clinicians also perform depression screenings for members with chronic medical conditions. Members who screen positive for depression by a clinician may be referred to a participating behavioral health provider for evaluation and follow-up care if indicated, and if the member agrees to the referral. In addition, educational materials about the treatment of depression are available to members through Decision Power and on the Health Net website. Members may call 1-800-893-5597 to speak to a clinician, 24 hours a day, seven days a week.

Depression program

Health Net offers its depression program for most Health Net members. Members newly prescribed with antidepressant medication receive automated IVR calls to educate them about how antidepressants work and the importance of taking medications as prescribed and refilling them, as needed. The calls also offer a live follow-up call from a pharmacist.

Most Health Net members appropriately seek depression treatment from their PCPs, which is why Health Net provides physicians and PPGs with the following tool to manage and coordinate care for their patients with depression:

- The MHN/Envolve People Care (EPC) Provider Toolkit – Treating and Managing Behavioral Health Conditions contains information about depression, alcoholism and ADHD along with medication management information and guidelines for sharing information and making referrals. The brochure also includes the Behavioral Health Care Coordination Form, which encourages communication between the behavioral health provider and medical provider. PCPs and specialists can download the form from the Health Net provider website at provider.heathnet.com under *Working with Health Net > Quality > Behavioral Health Resources for Health Net Providers*.

Additionally, in an effort to increase awareness of the importance of depression identification and management among both providers and members, Health Net has been developing and posting:

- Member online news articles to educate members on what depression is, how to recognize it, the availability and types of treatments, and the importance of treatment and antidepressant medication adherence.
- Provider online news articles on the importance of antidepressant medication management, coordination of care and exchange of information between medical and behavioral health providers, and available resources for easy reference and assistance.

Rights and responsibilities

Member rights and responsibilities

Health Net is committed to treating members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net has adopted the following member rights and responsibilities. These rights and responsibilities apply to members' relationships with Health Net, its practitioners and providers, and all other health care professionals providing care to its members. The member rights and responsibilities are available at provider.healthnet.com under *Provider Library > Operations Manuals > Member Rights and Responsibilities* or upon request by contacting the Health Net Provider Services Center.

Members have the responsibility for:

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

Members have the right to:

1. Receive information about the organization (including all enrollment notices, and 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.
2. Be treated with respect and recognition of their dignity and right to privacy.
3. Participate in decisions regarding their health care, including the right to refuse treatment.
4. A candid discussion of appropriate medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

5 Voice complaints or appeals about the organization or the care it provides.

6 Make recommendations regarding the organization's member rights and responsibilities policy.

7 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

8 Have access to personal medical records, and where legally appropriate, receive copies of, amend or correct their medical record.

9 Reasonable accommodations.

10 Be treated with dignity and respect.

11 Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

12 Be provided a copy of their medical records, upon request, and to request corrections or amendments to these records.

13 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.

14 Have all plan options, rules and benefits fully explained, including through use of a qualified interpreter if needed.

15 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.

16 Choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.

17 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 to 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.
- 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 justification for the transfer.
- Be afforded the opportunity to file an appeal if services are denied that they think are medically indicated, and to be able to ultimately take that appeal to an independent external system of review.

18 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.

19 Freely exercise these rights and that the exercise of those rights does not adversely affect the way Health Net and its providers or DHCS treat them.

20 Receive timely information about the 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.

21 Be protected for liability for payment of any fees that are the obligation of Health Net.

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

23 The unconditional and exclusive right to hire, fire and supervise their in-home supportive services (IHSS) provider.

24 Receive their Medicare and Medi-Cal appeals rights in a format and language understandable and accessible to them.

25 Opt out of Cal MediConnect at any time, beginning the first of the following month.

In addition:

26 Members shall not be balance billed by a provider for any covered service.

27 Members are free to exercise their rights without negative consequences.

Member appeals

A member or a member representative who believes that a determination or application of coverage is incorrect has the right to file an appeal. Health Net has a process in place to record and respond to all member appeal requests. Health Net responds to standard appeals within 30 calendar days after receiving the reconsideration requests (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. 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.

Privacy and confidentiality

Health Net members' PHI, whether it is written, oral or electronic, is protected at all times and in all settings. Health Net practitioners and providers can only release PHI without authorization when:

- Needed for payment.
- Necessary for treatment or coordination of care.
- Used for health care operations (including, but not limited to, HEDIS reporting, appeals and grievances, UM, QI, and disease or care management programs).
- Where permitted or required by law.

Any other disclosure of a Health Net member's PHI must have a prior, written member authorization.

Health Net practitioners and providers must ensure that only authorized people with a need to know have access to a member's PHI. Health Net requires PPGs to obtain Health Insurance Portability and Accountability Act (HIPAA) Business Associate agreements from people or organizations with which the PPG participates to provide clinical and administrative services to members.

Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release a member's PHI regarding sensitive conditions, Health Net practitioners and providers must obtain prior written authorization from the member (or authorized representative), which states the information specific to the sensitive condition that may be disclosed.

Interpreter services

Interpreter services are available at no cost to Health Net members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if linguistic needs are not met.

Provider guidelines

- Providers may not request or require an individual with limited English proficiency (LEP) to provide his or her own interpreter.

- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not request or rely on an adult or minor child accompanying an individual with LEP to interpret or facilitate communication.
  - A minor child or an adult accompanying the patient may only be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
  - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.
  - Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

To obtain interpreter services, members and providers can contact Health Net Member Services at the telephone number located on the member's ID card.

Additional information

More extensive information about all the programs described in this update is available at provider.healthnet.com. A user name and password are required to use the provider website. At the home page under *Sign Up*, select *Register* to set up a name and password. Each practitioner or provider office can designate a delegated administrator (usually an information technology, office or security manager) who is responsible for opening accounts and monitoring employee-level access to the practitioner and provider information on the site.

Practitioners and providers who do not have access to the Internet may request printed copies of practitioner and provider materials by contacting the Health Net Provider Services Center. A complete copy of Health Net's QI program description is available on request by sending an email to the QI Department at cqi_dsm@healthnet.com.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by county within 60 days at:

Line of Business	Telephone Number	Email Address
Cal MediConnect – Los Angeles County	1-855-464-3571	provider_services@healthnet.com
Cal MediConnect – San Diego County	1-855-464-3572	

[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.

California

PROVIDER *Update*

Health Net® COMMUNITY SOLUTIONS

NEWS & ANNOUNCEMENTS | JULY 19, 2019 | UPDATE 19-522sum | 2 PAGES

Summary Update: Help Your Patients Achieve Better Health Outcomes

Quality management programs and resources to support the care you give

Health Net's quality management program is designed to monitor and assess the appropriateness of health and administrative services on a regular basis. A complete overview of the quality management program components is described in provider update 19-522, *Help Your Patients Achieve Better Health Outcomes*. You can access this update in the Provider Library at provider.healthnet.com under *Updates and Letters > 2019.*

Quality improvement program scope

The program includes the standards for clinical care and services, the measurements of adhering to the standards, and the implementation of actions to improve performance.

The scope of the program includes:

- Wellness and disease management.
- Community health education programs and services.
- Clinical practice and preventive health guidelines.
- Health risk assessment.
- Practitioner and provider site and facility inspection.
- Practitioner and provider access and availability.
- Medical record and documentation standards.
- Quality improvement initiatives, measures and surveys.
- Quality and safety reporting.
- Pharmaceutical management.
- Behavioral health services.
- Member and provider rights and responsibilities.
- Privacy and confidentiality.
- Interpreter services.

Go online for more information to help you deliver care

More information on all the programs listed above is available on the Health Net provider website at provider.healthnet.com.

THIS UPDATE APPLIES TO **CAL MEDICONNECT** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

provider_services@healthnet.com
Los Angeles County – 1-855-464-3571
San Diego County – 1-855-464-3572
www.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

Also online is the Quality Improvement Corner. Here you can view Health Net's quality outcomes and progress toward goals. You can also access tools and materials to help you give the care that members expect. Go to provider.healthnet.com > *Working with Health Net* > *Quality*.

Additional information

If you do not have access to the Internet, you may request a print copy of update 19-522. Contact the Health Net Provider Communications Department by email at provider.communications@healthnet.com.

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by county within 60 days at:

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