PROVIDER*Update*

Health Net®

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Help Your Patients Achieve Better Health Outcomes

Quality management programs and resources to support the care you give

This update provides an overview of the components of the Health Net multifaceted Medi-Cal quality management program. It includes quality improvement (QI) processes and instructions on how to get more information from the Health Net provider website at provider.healthnet.com.

Quality improvement program scope

Health Net's QI program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The QI program covers the development and implementation of standards for clinical care and service, measurement of conformance to the standards, and implementation of actions to improve performance.

The scope of the program contains:

- Quality improvement projects.
- Quality measures and surveys.
- Wellness and disease management.
- Case management.
- Clinical practice and preventive health guidelines.
- Initial health assessments.
- Access to care.
- Medical record documentation standards.
- Medical record, facility site and physical accessibility reviews.
- Utilization management processes.
- Pharmaceutical management.
- Rights and responsibilities.
- Member appeals.
- Privacy and confidentiality.
- Interpreter services.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ● Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ● Molina
  - ○ Riverside
  - ● Sacramento
  - ○ San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

Open clinical dialogue

Health Net's Medi-Cal *Provider Participation Agreement (PPA)* states that participating providers can talk freely with members about their medical conditions, treatment options and medications, regardless of limits to coverage.

Quality performance improvement projects

Health Net conducts quality performance improvement projects (PIPs) targeting specific health care issues that impact a significant number of members. PIPs may also address the use of health services to enhance health outcomes. It includes testing small-scale changes at the provider-, member- and health plan-level to improve the quality of members' health care and outcomes.

From 2017 through 2019, Health Net is conducting two PIPs. They address childhood immunizations and disparities in cervical cancer screening outcomes. Both PIPs require frequent reporting to the Department of Health Care Services (DHCS) and specific expectations for working with a clinic or federally qualified health center (FQHC), completing a process map, failure modes effect analysis, intervention analysis, and monthly progress monitoring. Select provider groups are engaging in these focused studies. The results and lessons learned will be provided at the end of the project. Depending on the progress of the initiatives, Health Net will expand the interventions to other clinics and potentially across all counties.

Quality measures and surveys

Health Net measures quality of care and services provided to members through Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures for care and service, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for member satisfaction, member appeals and grievances, and access and availability surveys. In addition, Health Net conducts an annual provider satisfaction survey to find ways to better serve its participating providers.

Starting in 2019, DHCS began leveraging the CMS Adult and Child Core sets to measure health plan performance. The new measure set, called the Managed Care Accountability Set (MCAS), holds plans to significantly more measures and addresses care needs across preventative, chronic and behavioral health. DHCS holds the plan accountable to meet minimum performance levels at the 50th percentile on the following 19 measures:

- Adolescent Well-Care Visits (AWC)
- Adult Body Mass Index Assessment (ABA)
- Antidepressant Medication Management – Acute Phase Treatment (AMM-Acute)
- Antidepressant Medication Management – Continuation Phase Treatment (AMM-Cont)
- Asthma Medication Ratio (AMR)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Childhood Immunization Status – Combo 10 (CIS-10)
- Chlamydia Screening in Women Ages 16 – 24 (CHL)
- Comprehensive Diabetes Care (CDC) – CDC-HT(DE): HbA1c Testing
- Comprehensive Diabetes Care (CDC) – CDC-H9: HbA1c Poor Control (> 9.0%)
- Controlling High Blood Pressure < 140/90 mm Hg
- Immunizations for Adolescents – Combo 2 (IMA-2)
- Plan All-Cause Readmissions (PCR)
- Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)
- Prenatal & Postpartum Care: Postpartum Care – (PPC-Pst)
- Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index (WCC-BMI)
- Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits (W15)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)

DHCS uses a performance-based auto-assignment algorithm for managed care plans in Two-Plan and Geographic Managed Care counties. Distribution of Medi-Cal default enrollment is determined based in part on comparative plan performance on six HEDIS measures. The following six key preventive measures support Health Net's interest in providing quality care and service for Medi-Cal members and meet DHCS requirements:

- Well-child visits for members ages three to six (annually) per American Academy of Pediatrics (AAP) guidelines.
- Childhood immunizations, including four diphtheria and tetanus toxoids and acellular pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps and rubella (MMR); three *haemophilus influenzae* type b (HIB); three hepatitis B (Hep B); one varicella zoster virus (VZV); and four pneumococcal vaccines by the child's second birthday.
- Prenatal care visits (first visit is within the first trimester).
- Cervical cancer screening for females ages 21 to 64 (Pap test performed at least every one to three years).
- Comprehensive diabetes care for hemoglobin A1c testing.
- Controlling blood pressure (BP) less than 140/90 for ages 18–85 who had a diagnosis of hypertension.

Appropriate timeliness of services, outreach to members, clinical documentation, correct coding, as well as timely and complete encounter submissions are important elements of meeting preventive care guidelines. Health Net offers provider offices training materials, member outreach calls, member newsletters, and an online provider newsletter. All the information is designed to help providers and members accomplish these preventive measures.

Be in Charge![SM] Disease Management program

The *Be in Charge!* Disease Management program provides disease-specific management for members with asthma, diabetes and heart failure (HF). The goal of the program is to improve member knowledge and self-management of these diseases. This can lead to improved quality of life and better functional status. Additionally, the program aims to help members manage their conditions in accordance with national, peer-reviewed published guidelines and to ensure that members receive necessary screenings and monitoring services.

Health Net mails educational materials and information about the program to enrolled members. Health Net conducts outbound telephonic interventions and makes referrals to case management for members identified as being at high risk for hospitalizations or poor outcomes, or in need of assistance with behavioral issues. Members may also be referred to the program by a health plan physician or case manager, or they can self-refer. Providers receive notification about members targeted for the program.

To refer a member to the program, use the Case Management Referral Form available on provider.healthnet.com in the Provider Library under *Forms*. Members may self-refer to the program by calling 1-844-799-9048.

Fit Families for Life – *Be in Charge!* weight control programs

Providers should complete and fax a copy of the Fit Families for Life – *Be in Charge!* Program Referral form to the Health Net Health Education Department at 1-800-628-2704 to refer members to the weight control program, or to request program materials and resources. To request a copy of the Fit Families for Life Program Referral Form, contact the Health Net Health Education Department at 1-800-804-6074. Members interested in the program and nutrition related materials may also contact the Health Net Health Education Department.

Fit Families for Life – Home Edition

The Home Edition program is one of a number of member-based offerings under the Fit Families for Life – *Be in Charge!* program. It is a five-week, home-based family intervention program that promotes healthier lifestyles. Through goal-setting strategies, participants receive guidance on making better food choices and increasing physical activity. A program workbook covers topics about how to read a nutritional facts label, tips for adding fruits and vegetables to everyday meals, family involvement in the kitchen, tips for eating out, and aerobic exercise options. A healthy recipes cookbook, exercise stretch band and DVD accompany the workbook. The DVD is available in English, Spanish, sign language, and closed captioning. It provides multiple easy-to-follow exercise segments designed to accommodate various levels of physical ability, including a strength training demonstration. Program materials are available in English and Spanish, which providers can request for Health Net members (regardless of weight status). The program is also available to members and the community through a classroom format. Trained classroom facilitators educate participants about how to incorporate healthy eating and active living strategies into their family lifestyle.

Pediatric and adolescent overweight assessment and management guidelines

In an effort to support busy providers with resources to care for children and adolescents at risk for being overweight and obese, Health Net offers the Pediatric and Adolescent Overweight Assessment and Management Guidelines flip chart. This flip chart gives providers practical, point-of-care guidance on the prevention and treatment of overweight and obese patients. Adapted from the Child and Adolescent Obesity Provider Toolkit produced by the California Medical Association (CMA) Foundation and an expert panel of health care professionals, Health Net created this flip chart to offer the latest tools and practice recommendations when addressing excess weight and obesity in patients, including:

- Identification and management of body weight with a routine calculation of BMI.
- Assessment, monitoring and management of at-risk children and adolescents, including brief education and counseling tools, targeted laboratory screenings, and appropriate specialty referrals.
- Cultural sensitivity considerations during the patient-provider experience.
- Resource information for nutrition, physical fitness and life-skill support education, national guidelines, and weight management programs.

The complete Child and Adolescent Obesity Provider Toolkit is on the CMA Foundation website at www.thecmafoundation.org/programs/obesity.

Fit Providers for Life

Fit Providers for Life is a worksite wellness program for providers and their staff. Healthy providers and staff are more motivated, energetic and happy, which contributes to a favorable and productive workday. Provider offices interested in this program receive a program toolkit to develop their own worksite wellness activities. Additionally, all staff receive a nutrition and physical activity tip sheet and Fit Families for Life DVD.

Rethink Your Drink and My Plate provider tool

The escalating trend to consume sugar-sweetened beverages and unhealthy foods continues in many households. To help medical providers fight this trend, the two-sided poster/table-top piece, *Rethink Your Drink* and *My Plate*, was developed in partnership with the Los Angeles Collaborative for Healthy Active Children. It is a clinic-based tool for office visits with adolescents and parents and is available in English and Spanish. To request a copy, contact the Health Net Health Education Department at 1-800-804-6074.

Diabetes prevention program

Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist members in preventing or delaying the onset of type 2 diabetes. Members can participate by calling Health Net's Health Education Department at 1-800-804-6074.

Pregnancy Matters®

Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy, caring for your baby and teen parenting. High-risk pregnancies receive additional case management services. Members can participate in this program by calling 1-800-675-6110.

Tobacco cessation program

The California Smokers' Helpline tobacco cessation program is available to Health Net Medi-Cal members. The program offers free telephone counseling, self-help materials and online help in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese) to help members quit smoking and stay tobacco-free. Health Net Medi-Cal members can enroll in the telephonic tobacco cessation program by calling the California Smokers' Helpline at 1-800-662-8887 or 1-800-NO-BUTTS, or online at www.nobutts.org. Members may request a referral to group counseling by calling Health Net's Health Education Department at 1-800-804-6074.

The program provides additional support through texting. Members receive customized daily texts during the first important weeks of quitting and staying tobacco-free. Members may enroll at www.nobutts.org and select *Texting Program*.

Electronic health education programs

T2X is a Web and mobile technology platform that educates and motivates individuals to adopt healthier lifestyles by addressing topics about nutrition, fitness, asthma, diabetes, smoking cessation, depression, vaccination, anti-bullying, teen pregnancy, and sexual health. The goal of T2X is to increase participants' capacity to access and the appropriate use of their health coverage, become more engaged in their health care and health behavior decisions, and develop pro-health attitudes. Individuals ages 13 and older, regardless of health coverage status, can join for free online at www.t2x.me.

Case management program

Clinical licensed nurses and social workers lead our case management (CM) teams and are familiar with evidence-based resources and best practice standards. They also have experience with the population, the barriers and obstacles they face, and how socioeconomic factors impact their ability to access services. The Health Net CM team coordinates care for members whose needs are functional and social in nature, as well as those with complex physical and or behavioral health conditions, including high-risk pregnancy. Health Net uses a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices. Case managers partner with primary care physicians (PCPs) to support members with achieving their self-management health care goals.

Program components

This program supports Health Net members, families and caregivers by coordinating care and facilitating communication between health care providers. Once a member is selected to participate in the program, a care manager contacts the member's PCP to coordinate care. This helps facilitate an appropriate personalized level of care for members, which may include:

- Telephonic and face-to-face (as needed) interactions.
- Comprehensive assessment of medical, psychosocial, cognitive, medication adherence, and durable medical equipment (DME) needs.
- Development of an individual care treatment plan in collaboration with the member and the health care team that reflects the member's ongoing health care needs, abilities and preferences.
- Consolidation of treatment plans from multiple providers into a single plan of care to avoid fragmented or duplicate care.
- Coordination of treatment plans for acute or chronic illness, including emotional and social support issues.
- Coordination of resources to promote the member's optimal health or improved functionality with referrals to other team members or programs, as appropriate.
- Education and information about medical conditions and self-management skills, compliance with the medical plan of care, and other available services to reduce readmissions and inappropriate utilization of services.
- Communication to the provider and medical home.

On an ongoing basis, Health Net evaluates the efficacy of this program by reviewing and comparing specific member outcomes and utilization before and after case management intervention.

Referrals

Providers may refer a member by email to cashp.acm.cma@healthnet.com or via fax to 1-866-581-0540. The Case Management Referral Form is available on provider.healthnet.com in the Provider Library under *Forms*. Members may self-refer to the program by calling 1-800-675-6110, option 2 and request case management.

Clinical practice guidelines

Health Net's evidence-based clinical practice guidelines are from nationally recognized sources and form the foundation for its disease management programs. All guidelines are reviewed and updated at least biannually and when new scientific evidence or national standards are published. Centene's Corporate Clinical Policy Committee and 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*.

Guideline sources include, but are not limited to:

- Disease management – Clinical guidelines and overview summaries are available to providers. They can quickly reference information about chronic conditions, which include asthma, diabetes and HF. 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 recommends that participating providers follow the preventive guidelines adopted from the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), the American Congress of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), and the American Academy of Family Physicians (AAFP) in the treatment of adult, senior, prenatal, and postpartum Health Net members. The guidelines from AAP and the Advisory Committee for Immunization Practices (ACIP) are recommended for the preventive care and treatment of infants, children and adolescents. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. As always, the judgment of the treating physician is the final determinant of member care.

Current recommended guidelines of the specialty boards, academies and organizations used in the development of Health Net preventive health guidelines are available online at:

- USPSTF – www.uspreventiveservicestaskforce.org
- CDC – www.cdc.gov
- ACOG – www.acog.org
- ACS – www.cancer.org
- AAP – www.aap.org
- AAFP – www.aafp.org

Health Net preventive health guidelines are available through provider.healthnet.com. All information offered on the Health Net provider website is available to participating providers in print copy upon request.

Initial health assessments

New Medi-Cal 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 should be used to determine health practices, values, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, and health education needs.

Members under age 18 months require a health assessment within periodicity timelines established by the AAP for ages two and younger, whichever is less.

For members ages 21 and older, the IHA must follow DHCS guidelines and Health Net preventive care services guidelines. The preventive care guidelines in the USPSTF Guide to Clinical Preventive Services A and B Recommendations are considered the minimum acceptable standards for adult preventive care services (see www.uspreventiveservices taskforce.org/Page/Name/uspstf-a-and-b-recommendations/). Guidelines for members under age 21 follow the AAP Recommendations for Preventive Pediatric Health Care's periodicity schedule for wellness examinations.

DHCS's approved IHEBA is the Staying Healthy Assessment (SHA). The SHA is the established assessment tool that enables PCPs to assess Medi-Cal 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 Medi-Cal 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, where 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 are encouraged to contact the Health Net Health Education Department at 1-800-804-6074 for more information about SHA.

Notice of access standards

Health Net has established access and availability standards, which are reviewed and revised annually as needed. The standards strive to ensure compliance with all applicable state, federal, regulatory, and accreditation requirements. They also help ensure members have a comprehensive provider network and timely access to care.

Health Net monitors the network and evaluates whether members have sufficient access to practitioners and providers who meet members' care needs. These include waiting time standards for regular and routine appointments, urgent care appointments and after-hours care, and provisions for appropriate back-up for absences. The access standards are reviewed annually against applicable state and federal regulations and mandates, and are revised as needed. Health Net recommends providers review these periodically. After-hours scripts are also available that include examples on how to implement the script for live voice, auto attendant or answering machine messaging.

The complete set of access standards and revised after-hours scripts are available on provider.healthnet.com in the Quality Improvement Corner under *Working with Health Net* > *Quality* > *Patient Experience Provider Toolkit* > *Improving Access to Care References*. 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 scripts.

Medical record documentation standards

Health Net has established standards for the administration of medical records to ensure medical records conform to good professional medical practice, support health management and permit effective member care. A good medical records management system not only provides support to clinical participating providers in the form of efficient data retrieval but 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 to support information in a lawsuit. It is the participating provider's responsibility to ensure not only completeness and accuracy of content but also the confidentiality of the health record. Health Net requires that the provider adhere to the standards for maintaining member medical records and to safeguard the confidentiality of medical information.

Participating providers are responsible for responding to demands for information while protecting the confidentiality interests of Health Net members. All participating providers must have policies and procedures that address confidentiality and the consequences of improper disclosure of protected health information (PHI). Providers should refer to provider.healthnet.com under *Provider Library* > *Operations Manuals* > *Medical Records* > *Confidentiality of Medical Records* > *Procedure* to review specific levels of security of medical records that must be addressed by the participating provider's policies and procedures governing the confidentiality of medical records and the release of members' PHI.

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

Medical record and facility site reviews

Health Net's Facility Site Review Compliance Department conducts periodic medical record reviews (MRRs) and facility site reviews (FSRs) to measure PCP 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 Medi-Cal 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 plan (CAP) issues. In an effort to decrease duplicative MRRs and FSRs and minimize the disruption of patient care at participating provider offices, Health Net and all other 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.

DHCS reviews the results of Health Net's site reviews and may also audit a random sample of provider offices to ensure that they meet DHCS standards. Detailed information about audit criteria, compliance standards, scoring, and CAPs is available on 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, community-based adult services (CBAS) providers, and hospitals. All PCP sites must undergo PARS. Based on the outcome of PARS, each PCP, high-volume specialist, ancillary, CBAS, or hospital provider site is designated as having basic or limited access along with the six 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, 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 PARS are made available in the provider directory, health plan website and to Health Net's Medi-Cal Member Services Department to assist members with selecting a PCP who can best serve their health care needs.

Utilization management

To determine medical appropriateness, Health Net uses recognized guidelines and criteria sets that are clearly documented, based on sound clinical evidence and include procedures for applying criteria based on the needs of individual Health Net members and characteristics of the local delivery systems. For the Medi-Cal program, Health Net uses the following criteria:

- Title 22 of the California Code of Regulations (CCR).
- Medi-Cal Managed Care Division (MMCD) policy letters.
- DHCS Manual of Criteria for Medi-Cal Authorization.
- DHCS Medi-Cal Provider Manuals.
- Health Net's Medi-Cal contract with DHCS.
- Centene clinical policies and Health Net medical policies. If no plan-specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used.

  Additional information that the applicable Health Plan Medical Director will consider, when available, includes:

  - Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations.
  - Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment.
  - Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines.
  - Medical association publications.
  - Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and the National Institute for Health and Care Excellence (NICE).
  - Published expert opinions.
  - Opinion of health professionals in the area of specialty involved.

When a decision results in a denial, the criteria used to arrive at the determination are identified in the denial letter. Each denial letter explains Health Net's appeal process. A Health Net physician reviewer is available to discuss denial decisions. Copies of specific Health Net criteria are available on request by contacting the Health Net Medi-Cal Provider Services Center at 1-800-675-6110. Participating providers contracting with a Health Net-delegated PPG may also contact the PPG's utilization management (UM) department for the UM criteria.

Under California Health & Safety Code Section 1367(g), medical decisions regarding the nature and level of care to be provided to members, including the decision of who renders the service (for example, PCP instead of specialist, or in-network provider instead of out-of-network provider), must be made by qualified medical providers, unhindered by fiscal or administrative concerns.

Providers may contact Health Net's UM staff through the Health Net Medi-Cal Provider Services Center at 1-800-675-6110. Providers must contact PPG UM staff through the PPG.

UM decisions are based only on appropriateness of care, service and existence of coverage. Health Net does not specifically reward participating providers or other individuals for issuing denials of coverage for care or service. There are no financial incentives for UM decision-makers to encourage decisions that result in underutilization.

Pharmacy management

Health Net pharmaceutical management includes the Health Net *Medi-Cal Recommended Drug List (RDL)* and prior authorization criteria. This information is available to members and participating providers. The Health Net *Medi-Cal RDL* serves as a reference for physicians to use when prescribing pharmaceutical products for Health Net Medi-Cal members. It provides a comprehensive selection across therapeutic classes. Unlike the state Medi-Cal list of contract medications, the Health Net *Medi-Cal RDL* does not limit prescriptions to six per month. In addition, select over-the-counter (OTC) medications comparable to those approved by DHCS are covered on the Health Net *Medi-Cal RDL*, and generic medications are not limited to selected manufacturers. Providers can access the Health Net *Medi-Cal RDL* at provider.healthnet.com under *Provider Library* > *Operations Manuals* > *Prescription Drug Program* > *Medi-Cal Recommended Drug List*.

The Health Net Pharmacy & Therapeutics (P&T) Committee maintains the Health Net *Medi-Cal RDL*. The P&T Committee, which consists of actively practicing pharmacists and practitioners, evaluates the safety profile, effectiveness and affordability of the medications. The medications listed are approved by the U.S. Food and Drug Administration (FDA) and are reviewed by the P&T Committee. The Health Net *Medi-Cal RDL* is continually reviewed and revised in response to recommendations from participating providers and as new clinical data and medication products become available.

In Los Angeles County, providers affiliated with Molina Healthcare, a subcontracting health plan, must use Molina Healthcare's medication formulary when prescribing medications to Health Net members linked to Molina Healthcare PCPs.

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 member rights and responsibilities, which 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.

Member appeals

A member or member representative who believes that a determination or application of coverage is incorrect has the right to file an appeal. Health Net responds to standard appeals within 30 calendar days. A 72-hour appeal resolution is available if waiting could seriously harm the member's health.

Additionally, a Medi-Cal member must go through the plan's internal appeals process before requesting an external state fair hearing and an independent medical review (IMR). Once the internal appeals process has been exhausted, the member may request a state hearing from the California Department of Social Services (DSS) by calling the Public Inquiry and Response Unit at 1-800-952-5253 (TTY: 1-800-952-8349), or in writing via mail or secure fax to:

California Department of Social Services
State Hearings Division
Mail Station 19-17-37
PO Box 944243
Sacramento, CA 94244-2430
Fax: (916) 229-4110

In addition to the appeal process described above, members may contact the California Department of Managed Health Care (DMHC). DMHC is responsible for regulating health care service plans. DMHC receives complaints and inquiries about health plans via a toll-free number at 1-888-466-2219 (TTY: 1-877-688-9891). DMHC's website has complaint forms and instructions online at www.hmohelp.ca.gov.

Health Net does not delegate member grievances or appeals. All grievances and appeals should be forwarded immediately to the Health Net Medi-Cal Member Services Department.

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.

Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Participating providers must maintain the confidentiality of member information pertaining to the member's access to these services. Health Net requires PPGs to obtain Health Insurance Portability and Accountability Act (HIPAA) Business Associate agreements from people or organizations with which the PPG contracts 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 participating providers must obtain prior, written authorization from the member (or authorized representative) that states information specific to the sensitive condition 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 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 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 the Customer Contact Center 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 on the Health Net provider website at provider.healthnet.com.

A complete copy of Health Net's QI program description is available on request by email at cqi_dsm@healthnet.com. Providers who do not have access to the Internet may request print copies of provider materials by contacting the Health Net Medi-Cal Provider Services Center at 1-800-675-6110, or the Health Net Provider Communications Department via email at provider.communications@healthnet.com. If you have questions regarding the information contained in this update, or the information or instructions on how to use the services described in this update, contact the Health Net Medi-Cal Provider Services Center at 1-800-675-6110.