

PROVIDER Update



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Help Your Patients Achieve Better Health Outcomes

Use quality management programs and resources to support the care you give

This update provides an overview of the components of the Health Net* multifaceted quality management program. It includes quality improvement (QI) processes and how to access more information about the program. Health Net recommends that providers regularly access Health Net's provider website as described in this update.

Quality management program scope

Health Net's quality management program continuously monitors and evaluates the quality, appropriateness and outcome of care and services delivered to our members. It includes the development and implementation of standards for clinical care and service, measurement of compliance to standards, and the implementation of actions to improve performance.

The scope of the program includes:

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THIS UPDATE APPLIES TO CALIFORNIA PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

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

PROVIDER SERVICES

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EnhancedCare PPO (IFP) – 844-463-8188
provider.healthnetcalifornia.com
EnhancedCare PPO (SBG) – 844-463-8188
provider.healthnet.com
Health Net Employer Group HMO, POS, HSP, PPO, & EPO – 800-641-7761
provider.healthnet.com
IFP – CommunityCare HMO, PPO, PureCare HSP, & PureCare One EPO – 888-926-2164
provider.healthnetcalifornia.com
Medicare (individual) – 800-929-9224
provider.healthnetcalifornia.com
Medicare (employer group) – 800-929-9224
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PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

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Impact of COVID-19 on regulations and requirements

The following table lists impacts to the QI program due to COVID-19. Providers must comply with all applicable contract requirements, state and federal regulations and guidance, including All Plan Letters (APLs) and Policy Letters.

COVID-19 impacts	Medicare Advantage (MA)	Exchange	Commercial
Healthcare Effectiveness Data and Information Set (HEDIS®) measurement year (MY) 2020/reporting year (RY) 2021	<p>The National Committee for Quality Assurance (NCQA) will require MA plans to submit their data for accreditation purposes.</p> <p>The Centers for Medicare & Medicaid Services (CMS) will allow plans to use the “higher of” Star Ratings between 2021 and 2022 Stars (which actually includes performance as far back as 2018) for HEDIS.</p>	<p>HEDIS MY 2020 data submission closed as planned on June 15, and will continue to monitor the effects the pandemic may have on results.</p>	<p>HEDIS MY 2020 data submission closed as planned on June 15, and will continue to monitor the effects the pandemic may have on results.</p>
Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey	<p>NCQA will require MA plans to submit their data for accreditation purposes.</p> <p>Quality Compass 2021 Medicare products will be reported or released.</p> <p>The CMS will allow plans to use the “higher of” Star Rating between 2021 Stars and 2022 Stars for CAHPS.</p>	<p>Qualified Health Plan (QHP) Enrollee Survey not collected by NCQA</p>	<p>NCQA will require Commercial plans to submit their data for accreditation purposes.</p>
NCQA Health Plan Ratings (HPRs)	<p>For HPRs in 2021, NCQA will implement a special Overall Rating Policy for NCQA-Accredited plans: Ratings will display the higher of the Overall Rating score between HPR 2021 and HPR 2019.</p>	<p>For HPRs in 2021, NCQA will implement a special Overall Rating Policy for NCQA-Accredited plans: Ratings will display the higher of the Overall Rating score between HPR 2021 and HPR 2019.</p>	<p>For HPRs in 2021, NCQA will implement a special Overall Rating Policy for NCQA-Accredited plans: Ratings will display the higher of the Overall Rating score between HPR 2021 and HPR 2019.</p>

Impact of COVID-19 on regulations and requirements, continued

COVID-19 impacts	Medicare Advantage (MA)	Exchange	Commercial
Health Outcomes Survey (HOS)	The HOS will be administered between late July and November 2021, per guidance from CMS.	Not applicable.	Not applicable.
HEDIS measures with telehealth options – access and availability	<p>NCQA provided guidance of telehealth options on 40 HEDIS measures in the July 1, 2020 release of the NCQA HEDIS MY 2020 and 2021 Volume 2 Technical Specifications. The updates follow CMS guidance on telehealth services and support the increased need for a telehealth option during the pandemic.</p> <p>On March 31, 2021, NCQA released the HEDIS MY 2021 Volume 2: Technical Update. This includes corrections to HEDIS MY 2020 & MY 2021 Volume 2 Technical Specifications for MY 2021 reporting.</p>		
Covered California Quality Rating System (QRS)	Not applicable.	<p>For the Plan Year 2022 QRS Star Ratings, CMS will rank-order the QHPs' QRS MY 2020 scores and use a "policy-based distribution" that allocates a proportion of QHPs to each of the five rating categories.</p> <p>A second scoring rule precludes decreasing a QHP's overall global rating or any of the three summary indicator ratings by more than one star - this will be in place for MY 2020 only due to the pandemic impact. Covered CA requested NCQA audited HEDIS results, and unadjusted CAHPS results.</p>	Not applicable.
Office of the Patient Advocate (OPA)	Not applicable.	Not applicable.	To be determined.

Stay informed about COVID-19

For ongoing changes and requirements for COVID-19, visit the following web sites:

- www.ncqa.org/covid
- www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- www.cdc.gov/coronavirus/2019-ncov/index.html
- www.healthnet.com/content/healthnet/en_us/providers.html > select *Health Net Alerts* under Covid-19 Updates
- www.healthnet.com/content/healthnet/en_us/covid-19-updates.html

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

Health Net unifies programs, from wellness to complex care, reflecting our commitment to a whole-person strategy. Members who qualify have access to wellness programs for obesity prevention, smoking cessation, pregnancy support, and chronic conditions management.

Decision Power program

The Decision Power program offers a health management solution to improve members' health and quality of life. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced staff can help members at risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. Decision Power includes a suite of programs and support encompassing health and wellness, integrated care management, case management, and women's and children's health.

Decision Power wellness programs

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

- Health risk assessment— 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 health assessment results that can be printed and shared with their physicians.
- Health record – An online secure database where members can track important medical history, including health conditions, immunizations, medications, tests, and procedures. Information from the health assessment automatically becomes part of their personal health records (PHRs). PHRs are auto-populated with member claims and pharmacy data.
- Online wellness resources – Offers a flexible way to improve health and wellness – on the member's own terms. Our content library has a variety of physical, emotional, social, financial health, and clinical materials. This consists of numerous articles and videos that relate to healthy weight, improving your diet, stress management, tobacco cessation, and more. Examples of some of our online wellness resources include health articles, trackers, health videos, and health challenges. Health coaching – One-to-one telephonic health coaching provides extra help individuals need; online health coaching and resources provide additional support to members. A personal health coach helps with short- and long-term goal setting and achievement for lasting results. The program includes trackers and easy tools to use in the behavior change process. Personalized health coaching is available for weight loss, healthy eating, stress management, exercise, and tobacco cessation. Additional program and enrollment information is available online at www.healthnet.com > *Wellness Center*.
- Smoking 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. Additional program and enrollment information is available online at www.healthnet.com > *Wellness Center*.

For Medicare members – Coaching support is available 24/7 for up to a year during their flexible quit approach. A member initiates through the Teladoc smartphone app, or visiting www.teladoc.com/hn, or referred into the program by a provider during a general medical visit. Ways to request a consult include the smartphone app, website, or dialing 800-TELADOC (800-835-2362 TTY: 711).

- Decision Power^{®1} 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[®].

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- Health challenges – Online challenges to help individuals achieve small changes related to healthy eating, exercise, stress management, and weight loss. The health challenges offer focused behavior change strategies and record keeping 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, procedures or surgeries, and medical tests or visits; compare hospital performance on common diagnoses and procedures; and help members understand their health plan options, so that they can choose the plans that best fit their families.

Chronic conditions management

The Integrated Care Management program addresses the physical, behavioral and psychosocial needs of the member as part of Health Net’s Population Health Management. The program supports members, families and caregivers by assisting members in achieving optimum health, functional capability and quality of life through improved management of their disease or condition.

Management of chronic conditions (diabetes, asthma and chronic obstructive pulmonary disease (COPD)) and cardiac conditions (heart failure, coronary artery disease and hypertension) is incorporated into the Integrated Care Management program.

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 the member’s plan of care.
- Manage medications and enhance symptom control.
- Educate members regarding recommended preventive screenings and tests according to national clinical guidelines.
- Encourage the correct use of medications to prevent medication errors.

Providers and members may contact their designated care manager for additional assistance with chronic disease management.

Care reminder messages for members and providers

Care reminder messages are sent when potential gaps in care are identified through claims, laboratory data and other sources. These reminders aim to help specific individuals take action and to align with industry-recognized HEDIS measures to improve preventive health, chronic condition management and more.

Health Net care gap reports are available monthly to providers and accompanied by a HEDIS report card so that medical groups can track their performance compared to national benchmarks.² On the member side, Health Net uses the care gap information to send out messaging in modes members prefer, including text messaging, emails, live calls with a clinical pharmacist, and mailings.

Pregnancy Program

The Pregnancy Program incorporates the concepts of case management, care coordination, disease management, and health promotion. The program helps teach pregnant members how to have a healthy pregnancy and first year of life for babies. It also aims to reinforce the appropriate use of medical resources to extend the gestational period, reduce the risks of pregnancy complications, premature delivery, and infant disease. Members can participate by calling Member Services at the phone number on the back of their card.

Health Net Community Connect

Powered by Aunt Bertha, Health Net Community Connect offers the largest online search and referral platform. There are 10 topics to choose from, such as food, housing and transportation. Then select a subtopic which will contain a list of services based on the zip code entered. The results can be viewed in over 100 languages. To use the tool, go to www.healthnet.com, search for the tile *Find Social Services in Your Community* (use the scroll arrows, if needed). Then enter a zip code and click on *Search*.

Integrated Care Management program

Health Net's Integrated Care Management programs target the most complex cases, often with life-limiting diagnoses, and assist members who have critical barriers to their care. Trained Registered Nurses and Licensed Clinical Social Workers provide case management services to Health Net members, their families and caregivers as needed. These members may have multiple comorbid conditions and need assistance in planning, managing and executing their care.

Referral guidelines

Health Net conducts utilization surveillance and uses predictive modeling tools to identify appropriate members for this program; however, providers may also become aware of a severely ill Health Net member not currently enrolled in this program who may benefit from integrated case management services. Providers should use the criteria below when considering whether to refer a member to the Health Net integrated case management program.

It is appropriate to refer Health Net members with the following complex concerns to this program for evaluation:

- Moderate to late stage cancer, neurological, circulatory, endocrine, respiratory conditions, and uncontrolled pain/uncontrolled symptomology.
- Multiple care providers who may not be communicating with each other, which increases the risk of an acute event, such as hospital readmission.
- Advanced chronic diseases with multiple hospitalizations (greater than two in the last six months).
- Experiencing significant symptoms and side effects that could lead to an emergency room visit or hospitalization.
- Problematic or unstable comorbidities.
- Rare conditions requiring more extensive education, care coordination and support.
- Member seeking alternative therapeutic options, using out-of-network facilities and providers.
- Clinical trials.
- Active terminal care issues.
- High utilization of expensive resources, including multiple admissions or frequent emergency room visits.
- Complex support and caregiver needs.
- Acute uncontrolled symptoms of disease process or treatment.
- High degree of coordination, integration, referrals, and planning needed.
- Social determinant issues which may include:
 - No support system or inadequate support system that is unable to cope without intervention.
 - Caregiver burnout.
 - Unsafe environment.
 - Significant financial difficulties.

In addition, providers should consider the questions below to determine whether the member has one or more of the following issues that cannot be managed by the provider's office or treating specialists:

- Does the member have a terminal diagnosis or prognosis and struggle with whether to proceed with aggressive or palliative treatment?
- Is the member experiencing significant problems due to disease-related pain and symptom control, such as fatigue, anxiety, nausea, constipation, dyspnea, or depression?
- Does the member live in an unsafe environment?
- Does the member have significant financial issues?
- Does the member have multiple providers of care who may not be communicating, which creates an ongoing risk for an acute event, such as readmission?
- Has the member developed severe, complicated comorbidities?
- Does the member have an inadequate support system or is the primary caregiver suffering from burnout?
- Is the member frequently using the emergency room to obtain their care?

If a Health Net member meets any of these criteria, providers may contact the Health Net Case Management Department at 800-977-7915 for non-commercial Medicare members or 888-732-2730 for commercial Medicare (employer group coverage) and commercial members. Members who want to self-refer to this program may call the toll-free Customer Contact Center number on the back of their Health Net identification (ID) cards. The Customer Contact Center representative contacts the Case Management Department with the member's information for appropriate outreach. Contacting the Case Management Department does not automatically qualify the member for the Health Net integrated case management program.

Nurse advice line

The nurse advice line provides appropriate and timely triage for health-related problems through experienced registered nurses (RNs) utilizing industry-approved guidelines and protocols. Using nationally recognized algorithms and world-class clinical triage guidelines, nurse advice line RNs identify member needs and ensure they are directed to the appropriate level of care for the situation – whether it is providing self-care guidance, or recommending a visit to urgent care or the ER. The service is offered 24 hours a day, seven days a week, 365 days a year in English and Spanish with translation services available for other languages.

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 on the provider portal at www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html. 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:

- Chronic conditions management – Decision Power clinical guidelines are available for providers to quickly reference information about a number of chronic conditions, which include asthma, COPD, CAD, 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's preventive health guidelines are standards of care developed to encourage the appropriate 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 College 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 determinant of member care.

Centene's Clinical Policy Committee and Health Net's MAC review preventive health guidelines periodically. The guidelines are available on the provider portal at www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html. Providers who do not have access to the Internet may contact the Health Net Provider Services Center to request printed copies of these guidelines.

Utilization management

Health Net uses utilization management (UM) decision-making criteria that are objective and based on medical evidence to determine medical necessity, including InterQual®, Hayes Medical Technology Directory, Medicare coverage determinations, and Centene clinical policies and Health Net medical policies.

For commercial lines of business –

MHN, Health Net's behavioral health administrator, conducts utilization review of covered health care services and benefits for the diagnosis, prevention and treatment of mental health and substance use disorders. This includes children, adolescents and adults. MHN applies the criteria and guidelines from the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty including:

- American Society of Addiction Medicine.
- Child and Adolescent Level of Care Utilization System.
- Early Childhood Service Intensity Instrument.
- Level of Care Utilization System.

Centene and Health Net medical policies are available to providers on the provider portal at www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html. Providers may obtain copies of specific Health Net criteria upon request by contacting the appropriate Health Net Provider Services Center as listed in the right-hand column on page 1.

When a medical necessity decision results in a denial, the denial letter contains an explanation of the denial, the criteria used to make the decision and appeal rights. The letter also includes the contact name and telephone number of the Health Net medical director if the requesting provider needs to discuss the denial.

Practitioners and providers participating with a Health Net delegated partner may also contact the delegated partner's UM department for the UM criteria. Health Net UM staff are available by contacting the Health Net Provider Services Center. The delegated partner UM staff can be contacted through the delegated partner.

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

Quality improvement initiatives

The Quality Improvement Department utilizes several specific quality initiatives to help improve member health outcomes. Members may receive general or targeted outreach through mailings, emails, text messages, live or automated 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. Outreach may be 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.

Medicare Star Ratings

Improving quality of care is of primary importance for the Centers for Medicare & Medicaid Services (CMS) and one method it uses to monitor plans to ensure they meet Medicare's quality standards is the Medicare Star Ratings. This system is also used by CMS to tie improved quality of care for MA beneficiaries to quality bonuses. The ratings provide a tool for Medicare members to compare the quality of care and customer service offered by MA health and pharmacy plans. It is important that providers participate in and promote QI initiatives to improve the quality of care provided to MA members. Provider activities to help meet the goals of these QI initiatives include:

- Ensuring patients are up to date with all preventive health screenings.
- Developing or using registries to improve chronic disease management.
- Identifying patients with gaps in care and providing follow-up calls or letters.
- Conducting comprehensive annual exams to monitor medications, document care needs, review care plans, determine functional status, and identify social and physical needs (including pain status), and barriers they may have to routinely taking their medications.
- Coding claims and encounters accurately for the best data capture.
- Distributing educational materials to patients to help them understand and recall discussions, and improve compliance with their treatment plans.

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, CAHPS® for annual assessments of member satisfaction and the Health Outcomes Survey (HOS®) for Medicare members.

PPGs participating in Health Net's Pay for Performance (P4P) program for commercial plans receive annual reports, known as P4P Report Cards, which reflect effectiveness of care and member satisfaction.

The information gathered from members, practitioners and providers enables Health Net to address opportunities for improvement and are the basis for the implementation of various QI initiatives. Health Net performance results for many of these efforts are available online through the provider portal or by mail on request. Refer to the Additional information section at the end of this update. It lists which provider portal to access based on the line of business.

Quality and safety reporting

Health Net offers WebMD's Hospital Advisor tool, which provides hospital-specific performance information by diagnosis or procedure, and features metrics including volume, cost, mortality, and complication rates. Data are based on a variety of sources, such as state reporting, survey results from The Leapfrog Group, CMS hospital quality indicators, and patient satisfaction information. This online tool is available to members and providers to support informed

decision-making when choosing a site for care. Go to the provider portal at www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/quality_imp_tools.html. Then select *Compare Hospital tool* under Provider Resources.

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 actively works with Leapfrog and its partners to improve the safety and quality of care. Health Net is serving as co-chair of Leapfrog's Partners Advisory Committee for the third year and participates in its Data Users Group. Health Net promotes participation in the Leapfrog Hospital Survey, a national rating system of a hospital's quality and safety performance with respect to endorsed patient safety practices and progress toward national quality standards. Measures include:

- 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.

Participation in Leapfrog's survey facilitates hospitals' ability to assess their strengths and vulnerabilities on standards, such as hospital-acquired condition scores and evidence-based care to address common acute conditions. Health Net also promotes Leapfrog's most recent initiative, the Ambulatory Surgery Center (ASC) Survey to network ASCs. Health Net uses and promotes Leapfrog's Hospital Safety Grade in a variety of capacities. The Safety Grade program assigns hospitals a letter grade to indicate how safely the facility cares for patients based on an analysis of up to 27 quality measures. For more information about The Leapfrog Group, providers can visit www.leapfroggroup.org.

Office of the Patient Advocate

The California Office of the Patient Advocate (OPA) rates health plans and medical groups in their Health Care Quality Report Cards. The Report Cards allow consumers to compare the quality of care. The quality information includes clinical as well as patient experience data and is available on the provider portal at www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/quality_imp_tools.html. Then select *Medical Group Report Card* under Provider Resources.

Transplant and bariatric performance centers

Health Net providers must utilize contracted transplant and bariatric performance centers for all members qualifying for these procedures to promote the best clinical outcomes and coordination of care. These performance centers and their participating surgeons have been selected based on adherence to national guidelines and accredited requirements, and have demonstrated an ongoing commitment to improving surgical performance and patient outcomes. The performance centers are also expected to coordinate a seamless transition of care by sharing information and keeping PCPs informed of their patients' status. Lists of transplant and bariatric performance centers are available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Benefits > Bariatric Surgery or Transplants*.

Behavioral health services

As appropriate, PCPs provide care for Health Net members who have behavioral health diagnoses. Health Net also offers behavioral services from MHN providers. 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 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 an MHN CM. For physicians who need help finding appropriate behavioral health care for their members, MHN customer service representatives can answer questions about 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 the U.S. Preventive Services Task Force at www.phqscreeners.com. There is no cost to users and it is available in English and over 30 other languages. Newly enrolled Medicare members are screened for depression through a health risk assessment (HRA).

Depression program

Health Net offers medication reminders and educational messages for adult commercial and MA members identified with depression. Members newly prescribed with an antidepressant medication receive automated IVR calls. The calls also offer a phone number to call a pharmacist if there are any medication-related questions. The call also offers a live transfer to MHN, if members would like to talk to a psychiatrist, therapist, or other behavioral health provider about their medicine.

Most Health Net members appropriately seek depression treatment from their PCPs, which is why Health Net provides physicians and PPGs with the following tip sheets to manage and coordinate care for their patients with depression. Go to www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/quality_imp_tools.html and select *Provider Tip Sheets*, then select:

- Antidepressant Medication Management – AMM Tip Sheet.
- Behavioral Health (BH) Information Exchange to Help Improve Outcomes – BH Information Exchange.
- Depression Screening and Follow-Up – CDF, DSF Tip Sheet.

MHN Outreach program

The QI Department utilizes several specific quality initiatives to help improve members' physical and mental health outcomes. The health plan has collaborated with MHN on new quality improvement activities that may reach your office or practices. Note for Medicare Advantage members: Any reference to prescribing ADHD medication to children does not apply.

Overall, members and providers may receive live calls from MHN's quality team, providing members and providers with important educational information or reminders to take action when necessary. The focus of these initiatives may include antidepressant medication management, follow-up for children prescribed ADHD medication, and coordinating referrals and care. Below is a summary of the collaborative quality improvement projects:

MHN telephonic outreach to –

- Families with children who are prescribed ADHD medication.
- Physicians who are prescribing ADHD medication.

-
- Members about antidepressant medication management and the importance of coordination of care.

MHN written outreach to –

- Physicians about antidepressant medication management and the importance of coordination of care.

Alcohol and substance use

In collaboration with MHN to help improve the diagnosis, treatment and follow-up care of alcohol and other drug (AOD) use, Health Net has included information about signs, symptoms and PCP management in the following tip sheets. Go to providerlibrary.healthnetcalifornia.com. Select *Education, Training and Other Materials*, then select:

- Alcohol and Other Drug Treatment – IET Tip Sheet.
- Behavioral Health (BH) Information Exchange to Help Improve Outcomes – BH Information Exchange.
- Follow-up after an Emergency Department Visit for Mental Illness (FUM) / Follow-up after an Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – FUM/FUA Tip Sheet.

Providers have access to MHN's customer service line by dialing the MHN number on the back of the member's ID card or by dialing 888-935-5966 for help finding appropriate care for members, information about the referral process, member eligibility, and benefits.

Pharmaceutical management

Health Net and Centene Corporate Pharmacy and Therapeutics (P&T) Committees and the Envolve Pharmacy Solutions Strategy Development Committee manage the Health Net formularies, *Medicare Part D Formulary* and Health Net *Drug Usage Guidelines*. These documents are available to participating providers and members with pharmacy coverage through Health Net. The Health Net formularies and *Medicare Part D Formulary* serve as references for providers to use when prescribing pharmaceutical products for Health Net members with pharmacy coverage. The Health Net formularies and *Medicare Part D Formulary* are available on the provider portal at www.healthnet.com/content/healthnet/en_us/providers/pharmacy.html. Then select *Drug Information for Commercial Plans* or for *Medicare Plans* under Drug Lists. The Health Net P&T Committee consists 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.

Prescribing practitioners receive information annually and when updates occur that include:

- A list of pharmaceuticals with restrictions and preferences.
- How to use the pharmaceutical management procedures.
- An explanation of limits or quotas.
- How prescribing practitioners must provide information to support an exception request.
- The process for generic substitution, therapeutic interchange and step-therapy protocols.

The Envolve Pharmacy Solutions Strategy Development Committee may recommend cost-based tier placement in the formularies for medications determined to be clinically equivalent by the P&T Committee.

Pharmacy clinical and safety initiatives

Health Net's pharmacy clinical and safety initiatives focus on the following topics: use of potentially high-risk medications in the elderly; appropriate narcotic/acetaminophen utilization; antibiotics; osteoporosis; medication therapy management (MTM) program; and medication adherence.

Use of Potentially High-Risk Medications in the Elderly Initiative

The primary objective of the Use of Potentially High-Risk Medications in the Elderly Initiative is to improve the quality of care in the elderly population through the promotion of appropriate prescribing. Medication safety is also a HEDIS and NCQA accreditation measure for Medicare members.

Health Net has developed specific prior authorization criteria delineating potentially harmful use of medications in the elderly. The criteria have been derived from recent medical studies and publications, including the *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* list on adverse medication events in elderly members. The information indicates specific medications that should be avoided and suggests alternatives. Community pharmacists may also contact providers to recommend safer alternatives.

Appropriate Opioid Utilization Initiative

The Appropriate Opioid Utilization Initiative's objectives are to reduce opioid overutilization, promote appropriate opioid use by members, enhance coordination of care between prescribers, and decrease the use of opioids after filling a prescription for opioid dependence. In addition, the program offers strategies and tools to providers for proper pain assessment and treatment of Health Net members.

Health Net sends targeted providers a biannual mailing, including a letter, medication reviews of members identified as having a high use of narcotic medications (greater or equal to 90 MME per day) and notifies all prescribers.

Health Net's pharmacy benefit manager (PBM) has implemented an opioid overutilization program to manage narcotic utilization for MA Part D prescription drug (MA-PD) members. The program includes a pharmacist review of opiate prescriptions, notifications to members and providers, clinical discussions with members and providers, documented interventions in a central system, and point of service edits to restrict use if needed. Information about appropriate narcotic prescribing is on the provider portal at https://www.healthnet.com/content/healthnet/en_us/providers/pharmacy/policies.html.

Osteoporosis Initiative

The primary objective of the Osteoporosis Initiative is to improve the quality of care for post-menopausal women with osteoporotic fractures. Members who have not had a bone mineral density (BMD) test or an appropriate medication for osteoporosis treatment after an osteoporotic fracture are identified for intervention.

Targeted Medicare members receive educational materials in the mail. Members may also receive calls from a vendor who offers in-home bone mineral density tests. Targeted providers are faxed an Osteoporosis Fracture Patient Alert with a claims history of their patients. The program is a bimonthly intervention to reach high-risk members in a timely manner.

Medication therapy management program

MA members with a prescription medication benefit are eligible for the MTM program if they have eight or more chronic medications; three or more of the following conditions: COPD, depression, osteoporosis, diabetes, or hyperlipidemia; and are likely to incur an annual medication cost of \$4,376, as specified by CMS. All Special Needs Plan (SNP) members are also enrolled in the MTM program, regardless of the criteria listed above. In this program, Health Net pharmacists review medication claims to reduce therapeutic duplications, find opportunities to reduce costs, fill therapeutic care gaps, improve medication adherence, inform members of medication interactions, and provide education on medication-age contraindications.

Health Net sends targeted members a letter with recommendations and a telephone number to connect them to a Health Net pharmacist and receive a comprehensive medication review, including a review of over-the-counter or herbal products. Health Net also sends physicians a fax notifying them of the same issues so they can coordinate the member's care. For SNP members, Health Net sends copies of the interventions to PCPs and case managers.

Adherence program

Health Net's PBM calls MA-PD members taking oral diabetes medications, statins and renin-angiotensin system inhibitors to evaluate and help them overcome barriers to medication adherence. Members identified as non-adherent receive an IVR call with an option to speak with a pharmacist to address barriers and an offer for pillboxes, if useful. The PBM sends follow-up letters to members who could not be reached on the telephone. All members receive a flyer with written information for future reference.

Personal wellness assessment and health risk assessment for Medicare Advantage members

Health Net makes every effort to encourage completion of a personal wellness assessment or HRA for new MA members within 90 days of enrollment and annually. The assessment can be completed in three easy ways – mail, phone and online. Member responses are shared with appropriate PPGs and PCPs to facilitate more efficient access to health care for each MA member's medical or behavioral health concerns.

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 in the Provider Library at providerlibrary.healthnetcalifornia.com. Then select *Provider Oversight > Service and Quality Requirements > Access to Care and Availability Standards*. 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.

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. 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. Member rights and responsibilities statements are distributed to new practitioners when they join the network and to existing practitioners, if requested.

The member rights and responsibilities are also available in the operations manual under *Member Rights and Responsibilities* or upon request by contacting the Health Net Provider Services Center.

Potential quality of care issue referrals

In compliance with regulatory requirements and to ensure members receive the highest quality of care, Health Net monitors and evaluates potential quality of care issues involving Health Net members through the Health Net quality management program. The Potential Quality Issue Referral Form is available for providers to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation. Providers

may continue to refer issues identified as member appeals or grievances, including member complaints, to Health Net's Customer Contact Center or Member Appeals and Grievances departments for appropriate resolution.

Potential Quality Issue Referral Form

Providers may access the Potential Quality Issue Referral Form in the Provider Library on the provider portal under *Forms*, and searching for the Potential Quality Issue Referral Form.

Providers can complete the Potential Quality Issue Referral Form and submit it to the quality management program via confidential fax at 877-808-7024, preferably within one business day of the incident. The indicators on the form refer to an event or trigger. Use the broad general category lists to identify the potential quality of care issue, or use the *Other* category to describe the incident. Additional completion instructions are provided on the form.

Member appeals and grievances

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 responds to commercial standard appeals within 30 calendar days. A 72-hour appeal resolution is available if waiting could seriously harm the member's health.

In addition to this appeal process, HMO, POS and HSP members may also contact the California Department of Managed Health Care (DMHC). DMHC is responsible for regulating managed health care service plans. DMHC receives complaints and inquiries about health plans via a toll-free number at 888-466-2219. The hearing and speech impaired may contact DMHC at 877-688-9891 (TDD). DMHC's complaint forms and instructions are available online via the DMHC website at www.dmhc.ca.gov. EPO and PPO members may contact the California Department of Insurance (CDI) by telephone at 800-927-4357 or online at www.insurance.ca.gov.

Health Net does not delegate member grievances or appeals. All grievances and appeals must be forwarded within one business day to the Health Net Appeals and Grievances Department.

Appeals and grievances PPG reports

Health Net has added a written record of commercial HMO and POS appeals and grievances to the quarterly PPG-specific performance reports. Metrics contained in these reports are benchmarked against overall health plan experience, and detail is provided for both clinical and administrative appeals. This may reveal opportunities at the PPG level to improve management of appeals and grievances with the ultimate goal of enhancing the customer experience, decreasing the overturn volume and improving the denial process.

Medicare Advantage members

Federal regulations stipulate that special appeals procedures must be followed for MA members. MA members may first appeal to the health plan. If the denial decision is upheld, or partially upheld, the case is forwarded to the independent review entity. The MA appeals procedure does not include binding arbitration. MA members have a right to appeal any decision about payment for, or failure to arrange or continue to arrange for, what the member believes are covered services (including non-Medicare-covered benefits) under the Health Net MA plan. More information about the MA member appeals process is available in the Provider Library at providerlibrary.healthnetcalifornia.com. Then select *Member Appeals* under Dispute Resolution, Organization Determinations and Appeals.

Privacy and confidentiality

Health Net members' protected health information (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.

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- 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 disorder (SUD). 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 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 Health Net Member Services at the telephone number located on the member's ID card.

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 to 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 disclosures of member 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 that 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 through the original website at provider.healthnet.com or upon request by contacting the Health Net Provider Services Center.

Additional information

A complete copy of Health Net’s QI program description and overall progress toward meeting QI goals is available upon request from the Health Net QI Department via email at cqi_dsm@healthnet.com.

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

Line of Business	Phone Number	Provider Portal	Email Address
EnhancedCare PPO (IFP)	844-463-8188	provider.healthnetcalifornia.com	provider_services@healthnet.com
EnhancedCare PPO (SBG)	844-463-8188	provider.healthnet.com	
Health Net Employer Group HMO, POS, HSP, PPO, & EPO	800-641-7761	provider.healthnet.com	
IFP (CommunityCare HMO, PPO, PureCare HSP, PureCare One EPO)	888-926-2164	provider.healthnetcalifornia.com	
Medicare (individual)	800-929-9224	provider.healthnetcalifornia.com	
Medicare (employer group)	800-929-9224	provider.healthnet.com	

¹ Health Net members have access to Decision Power through their current enrollment with Health Net of California, Inc. and Health Net Life Insurance Company. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies. Decision Power is not affiliated with Health Net's provider network. Decision Power is not part of Health Net's commercial medical benefit plans and it may be revised or withdrawn without notice. However, Decision Power is part of Health Net's Medicare Advantage benefit plans for the plan year. Health Net and Decision Power are registered service marks of Health Net, LLC. All rights reserved.

² Care gaps are refreshed twice monthly and pushed to participating primary care physicians (PCPs) via the Cozeva[®] provider portal.