

# PROVIDER Update



NEWS & ANNOUNCEMENTS

SEPTEMBER 1, 2021

UPDATE 21-478m

15 PAGES

## Help Your Patients Achieve Better Health Outcomes

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

This update provides the components of the Health Net\* multifaceted Cal MediConnect Plan (Medicare-Medicaid Plan) quality management program. It includes quality improvement (QI) processes and instructions on how to get more information from the Health Net 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

provider\_services@healthnet.com  
Los Angeles County – 800-675-6110  
San Diego County – 855-464-3572  
provider.healthnet.com

#### 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 Dual Plan Letters (DPLs) and Policy Letters from the Department of Health Care Services (DHCS).

COVID-19 impacts	Description
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 Medicare Advantage plans to submit their data for accreditation purposes.</p> <p>The Centers for Medicare &amp; Medicaid Services (CMS) will allow plans to use the “higher of” Star Rating between 2021 Stars and 2022 Stars (which includes performance as far back as 2018) for HEDIS.</p>
Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey	<p>NCQA will be requiring Medicare Advantage plans to submit their data for accreditation purposes.</p> <p>CMS will allow plans to use the “higher of” Star Rating between 2021 Stars and 2022 Stars for CAHPS.</p>
Health outcomes survey (HOS)	The HOS will be administered between late July and November 2021, per guidance from CMS.
Initial health assessment (IHA) and Staying Healthy Assessment (SHA)	<p>Per DHCS All Plan Letter 20-004 (revised)<sup>1</sup>, contractual requirements of completing the initial health assessment for all new members have been suspended until the end of the public health emergency. Providers are to complete the IHA when the public health emergency is over.</p> <p>The use of email, telephone, or telehealth to administer the SHA is acceptable.</p>
Health risk assessments (HRAs)	Per DHCS APL 20-011 (revised) <sup>2</sup> released on July 8, 2021, the extension of HRA completion time frames for newly enrolled Seniors and Persons with Disabilities (SPDs), as a result of COVID-19 public health emergency, ended June 30, 2021. Effective July 1, 2021, plans must complete HRAs following the standard time frames set prior to the extension. Completion of HRAs for members newly enrolled on or prior to June 30, 2021 will remain subject to the extended time frames.
HEDIS measures with telehealth options	<p>The July 1, 2020 release of the NCQA Measurement Year (MY) 2020 and 2021 Volume 2 Technical Specifications provided guidance for telehealth options on 40 HEDIS measures. 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 &amp; MY 2021 Volume 2 Technical Specifications for MY 2021 reporting.</p>

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## Impact of COVID-19 on regulations and requirements, continued

COVID-19 impacts	Description
Performance improvement activities	DHCS decided to end current performance improvement projects (PIPs) as of June 30, 2020.
Facility site reviews (FSRs, medical record reviews (MRRs) and physical access review surveys (PARS)	Per DHCS APL 20-011 (revised) <sup>2</sup> released on July 8, 2021, the suspension of FSRs, MRRs and PARS, as a result of the COVID-19 public health emergency, ended on Jul 1, 2021. Plans must resume operations completely within six months from July 1, 2021.

### Stay informed about COVID-19

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

- [www.ncqa.org/covid](http://www.ncqa.org/covid)
- [www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page](http://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page)
- [www.dhcs.ca.gov/Pages/DHCS-COVID-19-Response.aspx](http://www.dhcs.ca.gov/Pages/DHCS-COVID-19-Response.aspx)
- [www.cdc.gov/coronavirus/2019-ncov/index.html](http://www.cdc.gov/coronavirus/2019-ncov/index.html)
- [www.healthnet.com/content/healthnet/en\\_us/providers.html](http://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](http://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 Health Net's commitment to a whole-person strategy. Members who qualify have access to wellness programs, such as obesity prevention and smoking cessation, and chronic conditions management.

#### 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 member's plan of care.

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- Manage medications and enhance symptom control.
  - Educate members about recommended preventive screenings and tests according to national clinical guidelines.
  - Encourage the correct use of medications to prevent medication errors.

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 found 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.<sup>3</sup> 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.

### **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. Translation services are available for other languages.

### **Decision Power wellness programs**

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

- Health Risk Questionnaire (HRQ) – An online interactive tool that helps members identify health risks based on current lifestyle behaviors and family history. Members are provided a summary of their HRQ results that can be printed and shared with their physicians.
- Health record – An online secure database where members can track important medical history, which includes health conditions, immunizations, medications, tests, and procedures. Information from the HRQ automatically becomes part of their personal health records (PHRs). PHRs are auto-populated with member claims and pharmacy data.
- Health promotion programs – These online health improvement programs are comprehensive behavior change programs. They provide information and tools to improve health and reduce disease risk. The programs include achievable goals personalized to individual preferences and interests. Each program focuses on one health topic and includes a to-do list of action items to help individuals reach their goals. Health promotion program topics include stress management, weight loss, nutrition, exercise, and tobacco cessation.
- Quit For Life<sup>®</sup> Tobacco Cessation program – Telephonic and online support with a quit coach. Individuals receive one-to-one help during their quit process, a comprehensive quit guide and a guide for family members, unlimited access to online education, and coaching support. Text2Quit messages keep members motivated and on track. Health Net members can register for the Quit For Life telephonic tobacco cessation program by calling 800-893-5597 to speak to an enrollment specialist, or dial directly at 866-QUIT-4-LIFE (866-784-8454). Additional program and enrollment information is available online at [www.healthnet.com](http://www.healthnet.com) > *Wellness Center*.

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- Decision Power<sup>®4</sup> 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<sup>®</sup> and Weight Watchers<sup>®</sup>.
  - Health challenges – Online quarterly challenges to help individuals achieve small changes through healthy eating, exercise, stress management, and weight loss. The duration of each challenge is about one month and offers focused behavior change and record-keeping strategies to help participants stay on track for success.
  - Tools to monitor prescription history and check medication interactions; estimated cost of care for more than 100 conditions, 50 procedures or surgeries, and 200 medical tests or visits; compare hospital performance on more than 160 common diagnoses and procedures; and help members understand their health plan options, so they can choose the plans that best fit their families.

## **Initial health assessments**

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

Newly enrolled adult plan members receive preventive services in accordance with the latest edition of the Clinical Preventive Services published by the United States Preventive Services Task Force (USPSTF).

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

- Identifying and tracking high-risk behaviors including smoking and alcohol consumption of individual Cal MediConnect members.
- Assigning priority to individual health education needs related to lifestyle, behavior, disability, environment, culture, and language.
- Initiating discussion, counseling and documenting health education interventions, referrals and follow-up care regarding high-risk behaviors.
- Identifying members whose health needs require coordination with appropriate community resources and other agencies for services not covered under the current contract.

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 and download or print electronic versions of the SHA directly from the DHCS website at [www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx](http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx). It is available in nine threshold languages. The SHA is also available in Arabic, English, Farsi, Khmer and Spanish in the Provider Library at [providerlibrary.healthnetcalifornia.com](http://providerlibrary.healthnetcalifornia.com) under *Forms and References*. Providers should contact the Health Net Health Education Department at 800-804-6074 for more information about SHA.

## **Health risk assessment**

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

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medical care which is essential to the success of the care management program for both PPGs and Health Net. Health Net contracts with Optum® to conduct HRAs on its behalf.

Optum tries to complete all HRAs for members identified as high-risk within 45 calendar days of enrollment and for low-risk members within 90 days and annually thereafter. This can be done by telephone, mail or face-to-face. A clinical HRA summary report is developed for each completed HRA and made available to the case manager and PCP via the Health Net provider portal post login at [provider.healthnet.com](http://provider.healthnet.com). The report supports them in developing a comprehensive care plan using evidence-based alerts. The alerts/flags on the summary report identify areas that warrant prompt attention or monitoring.

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

## **Health education programs and services**

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

### **Health education programs**

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

- Weight management program – Members have access to Healthy Habits for Healthy People weight management educational resources. This includes an educational guide, cookbook and exercise band to help older adults and people living with disabilities eat healthy and stay active.
- Healthy Hearts, Healthy Lives program – Members have access to a heart health prevention toolkit (educational booklet and tracking journal) to maintain a healthy heart.

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

## **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](http://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 heart failure (HF), coronary artery disease (CAD) and diabetes. Sources are found within the guidelines.
- Behavioral health – Clinical guidelines are available for such disorders as attention deficit hyperactivity disorder (ADHD) and substance use disorder.

## **Preventive health guidelines**

Health Net's preventive health guidelines are standards of care developed to encourage the 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

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Practices (ACIP), Centers for Disease Control and Prevention (CDC), American Congress of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and American Academy of Family Physicians (AAFP). These guidelines do not address the specific diagnostic testing or medical care that may be necessary as indicated by the member's medical history and physical examination. As always, the judgment of the treating provider is the final determining factor regarding a member's care.

Centene's Clinical Policy Committee and Health Net's MAC review the 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](http://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.

### **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 Cal MediConnect Provider Manual, which can be accessed in the Provider Library at [providerlibrary.healthnetcalifornia.com](http://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.

### **Medical record documentation standards**

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

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

Practitioners and providers are responsible for protecting the confidentiality interests of Health Net members when responding to requests for information. All practitioners and providers must have policies and procedures that address confidentiality and the consequences of improper disclosure of member protected health information (PHI). Refer to the Cal MediConnect Provider Manual in the Provider Library at [providerlibrary.healthnetcalifornia.com](http://providerlibrary.healthnetcalifornia.com). Then select *Medical Records > Confidentiality of Medical Records > Procedure* to review specific levels of medical record security. Medical record security must be addressed by practitioner's and provider's 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 in the Cal MediConnect Provider Manual in the Provider Library at [providerlibrary.healthnetcalifornia.com](http://providerlibrary.healthnetcalifornia.com). Then select *Medical Records*. You can also request the information by contacting the Health Net Provider Services Center.

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## Medical record and facility site review

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

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

DHCS reviews the results of Health Net's site reviews and may also audit a random sample of provider offices to ensure they meet DHCS standards. Detailed information about audit criteria, compliance standards, scoring, and CAPs is available in the Cal MediConnect Provider Manual in the Provider Library at [providerlibrary.healthnetcalifornia.com](http://providerlibrary.healthnetcalifornia.com). Then select *Quality Improvement > Facility Site Review*.

## 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) and hospitals. All PCP sites must undergo PARS. Based on the outcome of PARS, each PCP site is designated as having basic or limited access along with the specific accessibility indicator designations for parking, exterior building, interior building, restrooms, examination rooms, and medical equipment (accessible weight scales and adjustable examination tables).

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

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

## Utilization management

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

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

In the event one plan benefit is broader than the other, Health Net applies the broader benefit when making medical management decisions. When there is no documented medical necessity coverage guidelines from Medi-Cal or Medicare, the hierarchy of medical resources notes that Health Net's licensed professionals may refer to Centene and Health Net's clinical policies as well as other evidence-based guidelines. These guidelines are based on a critical review

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of published scientific literature and include review of the efficacy and safety of existing and emerging technologies or new uses of existing technologies.

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

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

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

### **Quality improvement initiatives**

The Quality Improvement (QI) Department utilizes several specific quality initiatives to help improve member health outcomes. Members may receive general or targeted outreach through mailings, emails, 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 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](http://www.calquality.org).

### **Quality measures and surveys**

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

### **Quality and safety reporting**

Health Net's Hospital Advisor Tool from WebMD enables users to easily access a wide range of quality details about hospitals, including rates of complications, the quantity of specific types of procedures performed at the facility, typical length of stay, and a variety of patient safety indicators. The data are based on sources such as state reporting, The Leapfrog Group findings, CMS hospital quality indicators, and hospital 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](http://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 the Leapfrog Group and its partners to improve the safety and quality of health care. Health Net currently serves as co-chair of the Leapfrog Group's Partners Advisory Committee. Health Net's work as a Leapfrog Partner includes promoting participation in the Leapfrog Hospital Survey, a national rating system that offers consumers key information about 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.
- Intensive care unit physician staffing.

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- Evidence-based hospital referral.
  - Safe practices score based on National Quality Forum standards.

Participation in Leapfrog's survey facilitates hospitals' ability to assess their strengths and vulnerabilities with respect to meeting quality standards, such as hospital-acquired infection scores and evidence-based care to address common acute conditions. Leapfrog also publishes a Hospital Safety Grade, which assigns individual hospitals a letter grade to indicate how safely the hospital cares for patients based on an analysis of up to 27 quality measures. For more information about The Leapfrog Group, visit [www.leapfroggroup.org](http://www.leapfroggroup.org).

### **Office of the Patient Advocate**

Office of the Patient Advocate (OPA) publishes reports on quality performance by medical group and health plans, as well as detailed findings about health care complaints filed within the state. OPA's goal is to better enable health care consumers to access the health care services for which they are eligible. Health Net links to the OPA website via the provider portal at [www.healthnet.com/content/healthnet/en\\_us/providers/working-with-hn/quality\\_imp\\_tools.html](http://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/quality_imp_tools.html). Then select *Medical Group Report Card* under Provider Resources.

### **Pharmaceutical management**

Health Net pharmaceutical management includes the development and maintenance of the Health Net Cal MediConnect formulary and prior authorization criteria. This information is available to members and participating providers. The Health Net Cal MediConnect formulary serves as a reference for physicians to use when prescribing pharmaceutical products for Health Net Cal MediConnect members. Providers can access the formulary online at [mmp.healthnetcalifornia.com](http://mmp.healthnetcalifornia.com) > *Drug and Pharmacy Information* > *List of Drugs (Formulary)*.

The Health Net Pharmacy and Therapeutics (P&T) Committee consists of practicing physicians and pharmacists from various specialties. The formulary contains those medications that the P&T Committee has chosen based on safety and effectiveness as part of the Health Net quality treatment program. The P&T Committee reviews and updates the formulary at least quarterly. CMS also must approve of the drugs in the formulary.

### **Behavioral health services**

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

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

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

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

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

## Depression program

Health Net offers its depression program for most Health Net members. Members newly prescribed with antidepressant medication receive automated IVR calls to educate them about how antidepressants work and the importance of taking medications as prescribed and refilling them, as needed. The calls 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 the provider portal at [www.healthnet.com/content/healthnet/en\\_us/providers/working-with-hn/quality\\_imp\\_tools.html](http://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/quality_imp_tools.html), and select *Provider Tip Sheets*. Then select:

- Alcohol and Other Drug Treatment – IET Tip Sheet
- Anxiety and Treatment Options to Improve Health Outcomes – Learn More About Anxiety
- Depression Screening and Follow-up – CDF, DSF Tip Sheet
- Severe and Persistent Mental Illness – Address Medical Needs for Patients with SPMI

Additionally, in an effort to increase awareness of the importance of depression identification and management among both providers and members, Health Net has been developing and posting member online news articles to educate members on what depression is, how to recognize it, the availability and types of treatments, and the importance of treatment and antidepressant medication adherence.

## 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 the Medicare Advantage portion of Cal MediConnect 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 that have children who are prescribed ADHD medication.
- Physicians who are prescribing ADHD medication.
- Members about antidepressant medication management and the importance of coordination of care.

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- Members that had an inpatient hospitalization for mental illness or intentional self-harm.

MHN written outreach to –

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

## **Rights and responsibilities**

### **Member rights and responsibilities**

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

Members have the responsibility for:

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

Members have the right to:

- 1 Receive information about the organization (including all enrollment notices, and informational and instructional materials), its services, its practitioners and providers, and member rights and responsibilities in a manner and format that may be easily understood.
- 2 Be treated with respect and recognition of their dignity and right to privacy.
- 3 Participate in decisions regarding their health care, including the right to refuse treatment.
- 4 A candid discussion of appropriate medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- 5 Voice complaints or appeals about the organization or the care it provides.
- 6 Make recommendations regarding the organization's member rights and responsibilities policy.
- 7 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 8 Have access to personal medical records, and where legally appropriate, receive copies of, amend or correct their medical record.
- 9 Reasonable accommodations.
- 10 Be treated with dignity and respect.
- 11 Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
- 12 Be provided a copy of their medical records, upon request, and to request corrections or amendments to these records.

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- 13 Not be discriminated against based on race, ethnicity, national origin, religion, gender, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
  - 14 Have all plan options, rules and benefits fully explained, including through use of a qualified interpreter if needed.
  - 15 Access an adequate network of primary and specialty providers who are capable of meeting their needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality, including required reporting.
  - 16 Choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
  - 17 Participate in all aspects of care and to exercise all rights of appeal. Members have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired and must be appropriately informed and supported to this end. Specifically, members must:
    - Receive a comprehensive health risk assessment within 45–90 days of coverage in a plan and participate in the development and implementation of an individualized care plan (ICP). The assessment must include considerations of social, functional, medical, behavioral, wellness, and prevention domains. The ICP is an evaluation of their strengths and weaknesses, and a plan for managing and coordinating their care. Members, or their designated representative, also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.
    - Receive complete and accurate information about their health and functional status by the interdisciplinary team.
    - Be provided information about all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration their condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
      - Before enrollment.
      - At enrollment.
      - At the time needs necessitate the disclosure and delivery of such information in order to allow members to make an informed choice.
    - Be encouraged to involve caregivers or family members in treatment discussions and decisions.
    - Receive reasonable advance notice, in writing, of any transfer to another treatment setting and justification for the transfer.
    - Be afforded the opportunity to file an appeal if services are denied that they think are medically indicated, and to be able to ultimately take that appeal to an independent external system of review.
  - 18 Receive medical and non-medical care from a team that meets their needs in a manner that is sensitive to their language and culture, and in an appropriate care setting, including the home and community.
  - 19 Freely exercise these rights and that the exercise of those rights does not adversely affect the way Health Net and its providers or DHCS treat them.
  - 20 Receive timely information about the plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once per year, and the right to receive notice of any

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significant change in the information provided in the orientation materials at least 30 days prior to the intended effective date of the change.

- 21 Be protected for liability for payment of any fees that are the obligation of Health Net.
- 22 Not to be charged any cost-sharing for Medicare Parts A and B services.
- 23 The unconditional and exclusive right to hire, fire and supervise their in-home supportive services (IHSS) provider.
- 24 Receive their Medicare and Medi-Cal appeals rights in a format and language understandable and accessible to them.
- 25 Opt out of Cal MediConnect at any time, beginning the first of the following month.

In addition:

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

## **Member appeals**

A member or a member representative who believes that a determination or application of coverage is incorrect has the right to file an appeal. Health Net has a process in place to record and respond to all member appeal requests. Health Net responds to standard appeals within 30 calendar days after receiving the reconsideration requests (or an additional 14 calendar days if an extension is justified).

If Health Net makes a reconsideration determination on a request for payment that is fully favorable to the member, it must issue a written notice of its reconsideration determination to the member and pay the claim no later than 60 calendar days for Medicare and 30 calendar days for Medi-Cal claims after receiving the reconsideration request. Requests that meet expedited review criteria must be reviewed and resolved within 72 hours of receipt. The 72-hour time frame includes weekends and holidays and begins upon receipt.

## **Privacy and confidentiality**

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

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

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

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

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

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## Interpreter services

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

### Provider guidelines

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

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

### Additional information

Practitioners and providers who do not have access to the internet may request printed copies of practitioner and provider materials by contacting the Health Net Provider Services Center. A complete copy of Health Net’s QI program description is available on request by sending an email to the QI Department at [cqi\\_dsm@healthnet.com](mailto:cqi_dsm@healthnet.com).

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

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

<sup>1</sup> DHCS APL 20-004 (revised) [www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2020/APL20-004-Revised.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2020/APL20-004-Revised.pdf)

<sup>2</sup> DHCS APL 20-011 (revised) [www.dhcs.ca.gov/Documents/COVID-19/APL-20-011-EO-Revision.pdf](http://www.dhcs.ca.gov/Documents/COVID-19/APL-20-011-EO-Revision.pdf)

<sup>3</sup> Care gaps are refreshed twice monthly and pushed to participating primary care physicians (PCPs) via the Cozeva® provider portal

<sup>4</sup> Health Net Community Solutions, Inc. (Health Net) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees in Health Net’s Cal MediConnect Plan. Decision Power® services, including its clinicians, are additional resources that Health Net makes available to its Cal MediConnect Plan enrollees. It is not affiliated with Health Net’s provider network. Decision Power is neither offered nor guaranteed under Health Net’s Cal MediConnect Plan (Medicare-Medicaid Plan) contract with Medicare or Medi-Cal, and it may be revised or withdrawn without notice. Decision Power services are not subject to the Medicare appeals process. Disputes regarding products and services may be subject to Health Net’s grievance process.