westernhealth ADVANTAGE

CLINICAL PROVIDER HANDBOOK

WHA CLINICAL PROVIDER HANDBOOK

PUBLISHED APRIL 2023

IMPORTANT CONTACTS AND RESOURCES

PROVIDER RELATIONS

Monday through Friday, 8 a.m. to 4 p.m. (excluding holidays)

Call: 916.614.6096 or 844.870.2178 toll-free
Email: general – providerrelations@westernhealth.com • provider directory – directory@westernhealth.com
Fax: 916.568.0126

CLINICAL RESOURCES

Monday through Friday, 8 a.m. to 4 p.m. (excluding holidays)
Call: Clinical Resources — 916.437.3203
Assistant Medical Directors — 916.563.2250 or 888.563.2250 toll-free, option #4 (UM Decisions)
Fax: 916.568.0278

PHARMACY DEPARTMENT

Monday through Friday, 8 a.m. to 5 p.m. (excluding holidays)
Call: 916.563.2250 or 888.563.2250 toll-free
Fax: 916.568.5280
Email: pharmacy@westernhealth.com

ELIGIBILITY

Monday through Friday, 8 a.m. to 4 p.m. (excluding holidays)
Call: 916.563.2206 or 888.442.2206 toll-free
Email: eligibility@westernhealth.com
Fax: 916.568.1338

MEMBER SERVICES

For Commercial Members

Monday through Friday, 8 a.m. to 5 p.m. (excluding holidays)
Call: 916.563.2250 or 888.563.2250 toll-free; 888.877.5378 TDD/TTY
Email: memberservices@westernhealth.com
Fax: 916.568.0126

For Medicare Advantage Members

October through March: Seven days a week, 8 a.m. to 8 p.m. (except holidays)
April through September: Monday through Friday, 8 a.m. to 8 p.m. (except holidays)
Call: 888.942.4777 toll free; 711 TTY

For CalPERS Members

Seven days a week, 7 a.m. to 8 p.m. (except holidays)
Call: 888.942.7377 toll-free; 888.877.5378 TDD/TTY
Email: whapers@westernhealth.com

Language Assistance: 888.563.2250 • 888.877.5378 TDD/TTY

Optum Behavioral Health: Group/Individual Plan Members: 800.765.6820
Medicare Advantage Plan Members: 855.857.9748

NurseLine: 877.793.3655

TABLE OF CONTENTS

HOW TO USE THIS HANDBOOK

Western Health Advantage developed this *Clinical Provider Handbook* as a comprehensive resource for our clinical providers and their staff to have access to our policies, procedures, and standards in patient (member) care, as well as important contacts, tools, and processes for communications with WHA, and the ongoing delivery of health care services to our members.

You may download this handbook from the WHA website at **mywha.org/providerhandbook**. Request additional copies by contacting WHA's Provider Relations: call 844.870.2178 or email providerrelations@westernhealth.com.

INTRODUCTION: WHA INFORMATION SOURCES

WHA Provider Portal

Clinical providers are encouraged to reference the resources available on WHA's website by visiting **westernhealth.com/provider**. From the Provider home page, you have access to valuable tools and information. You will find proprietary information under password-protected web pages, including the verify eligibility tool. To gain access to password-protected pages, visit **mywha.org/signup** to get started.

Online Provider Portal

Clinical providers can verify their patients' past, current and future eligibility and benefits online 24/7 by signing up for a secure provider account on our portal; to do so visit **westernhealth.com/provider.**

Here are the steps for setting up a secure provider account:

1. Go to westernhealth.com
2. Click on "Login" or "Register"
3. Choose the "Provider, Broker, or Employer" tab
4. Log in if an account has already been created, or click on "Sign-up for Secure Access"
5. Choose the appropriate account type from "Provider/Administrator, Medical Group, Hospital, Ancillary Facility, DME Supplier, or All Other Organizational Providers/Suppliers"
6. Complete the form — this will include Provider Information or Organization Information based on the type of provider, whom the provider or organization is contracted with and the requests for information
7. Enter a Username for the account and select a Security Question
8. Review the Terms & Conditions of Use
9. Complete sign-up (provider will receive an email)

WHA places no limit on the number of website accounts for providers. We encourage each provider in the office to create an account so they have their login to the portal and can use this as a resource. Additionally, we're including a sign-up form under Provider Communication for our quarterly **Clinical Connections e-newsletter**, where you'll learn of new programs and important updates we'll share with our provider partners.

Providers can also contact Change Healthcare at 877.363.3666 for real-time eligibility, benefits information, claims and EFT Status.

Real-Time Eligibility and Benefits

There are four ways to get real-time eligibility and benefit information for WHA members:

1. Through your medical group/IPA portal
2. 270-271 transactions: WHA has partnered with Change Healthcare to electronically exchange real-time eligibility and benefit information. To get started, contact your practice management system vendor to initiate the process. For more information, call Change Healthcare at 877.363.3666 or visit changehealthcare.com.

- **Commercial Members**
  - Use Payer ID: WSTHA
  - For more information, contact WHA at 916.563.2250 or 888.563.2250
- **Medicare Members**
  - Use Payer ID: PVDNC
  - For more information, contact WHA at 916.563.2250 or 888.563.2250, and select the option for Medicare members

3. Use WHA's online eligibility tool available at **westernhealth.com/provider**.
4. Call WHA at 916.563.2250 or 888.563.2250.

Claim Submissions

To expedite and improve the efficiency of claim processing, WHA has created an online resource at **mywha.org/claims** to provide you with the applicable claim address per medical provider.

WHA complies with federal and state regulatory requirements and NCQA standards for the receipt,

acknowledgment, payment and denial of claims. Generally, WHA has retained primary responsibility for medical claims handling for out-of-area emergencies and, pharmacy services (PBM).

All other provider claims are the contractual responsibility of WHA's contracted medical groups, IPAs hospitals and partners, and the in-area or authorized services and claims should be directed to the responsible party.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1.888.563.2250**, TTY/TDD **1.888.877.5378**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1.888.466.2219**) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

WHA's Provider Manual

A current copy of WHA's Provider Manual has been provided to your medical group and is available online at **westernhealth.com/provider** under Provider Communications. The Provider Manual contains information about the health plan, WHA's administrative and clinical policies and procedures, references to documents available on the WHA website, and other helpful information to support you and your staff.

WHA Member Services Department

If you need information on a subject or are seeking clarification regarding member eligibility or benefit information, contact WHA's Member Services Department at 916.563.2250 or toll-free at 888.563.2250, Monday through Friday, 8 a.m. to 6 p.m. (except holidays). Note: Member Services for Medicare Advantage is open seven days a week, 8 a.m. to 8 p.m. (except holidays). A representative will assist you in obtaining information or will direct you to the appropriate party.

WHA Provider Directory

WHA's provider directory can be accessed on WHA's website and is available in print format upon request. All members should use the online search at **mywha.org/directory** while the Medicare Advantage search is available at **mywha.org/MyCareDoctors**.

The provider directory contains information regarding WHA network providers, including participating pharmacies and radiology centers, along with WHA contracted hospitals. The directory is searchable by name, gender, specialty, hospital and medical group affiliations, languages spoken by the physician, office locations, if the practitioner is accepting new patients and other information. The hospital directory is searchable by facility name and location.

Provider Directory Updates: Providers must notify WHA of changes in the language capabilities of their office staff to ensure information on the WHA website and in the printed Provider Directory is current. Questions regarding language assistance services should be directed to WHA's Member Services Department at 915.563.2250 or toll-free at 888.563.2250.

Collection of Race and Ethnicity Data: WHA was awarded the Multicultural Health Care (MHC) distinction from NCQA (June 2022). This MHC distinction is required by Covered California and CalPERS. The MHC distinction includes standards that address the cultural responsiveness of the practitioner network. Patient and practitioner communications are enhanced when there is

a common language and culture. To provide our members with the tools to choose health care providers who can better meet their needs, WHA is enhancing the provider directory to show provider race and ethnicity, when available. Providing race and ethnicity information is voluntary, but highly encouraged.

Provider Directory Data Validation: Following the passage of SB 137 in 2015, California's Health and Safety Code section 1367.27 requires that health plans update their online provider directories weekly. WHA has therefore updated its policies and procedures for providers to keep WHA up to date on their information.

Providers are required to confirm no changes or inform WHA within five business days of any updates to their panel status, the name of the affiliated provider group they are currently contracted with, and if they are still or are no longer contracted with WHA.

The Provider's panel status must be reported as one of the following:

- Accepting new patients
- Accepting existing patients
- Available by referral only
- Available only through a hospital or facility
- Not accepting new patients

Also, the following information must be given to WHA for inclusion in the provider directory:

- Provider name, practice location(s), contact details
- Type of practitioner
- National Provider Identification number
- California license number and type of license
- Area of specialty, including any board certifications
- Provider admitting privileges, if any, at hospitals contracted with the plan
- Provider languages

WHA has established policies and procedures for updating information. The public can report any inaccuracies in WHA's provider directory by emailing directory@westernhealth.com.

Providers who are not accepting new patients but are contacted by someone about being their provider, must direct that person to WHA for help in finding a provider who is accepting new patients as well as report the provider directory inaccuracy to the DMHC.

For more information on SB 137 and provider directory standards visit **ca.gov**.

BetterDoctor: WHA has partnered with BetterDoctor to keep our provider directories up-to-date and compliant with state and federal regulations. Every quarter, your practice will receive a fax, post letter, email or phone call from BetterDoctor asking you to update your information online. Please respond to quarterly verification requests from BetterDoctor. This is an easy way to update your information with WHA without any administrative burden.

California law requires providers to verify their practice information with any health plan they contract with. Compliance with the law ensures that patients won't be misdirected to inactive practices or providers.

In California, Senate Bill 137 mandates health plans reach out twice a year to networked providers to gather updated information. Failure to update information in accordance with California law can result in plans delisting or delaying reimbursements to providers.

Email validation@betterdoctor.com to reach BetterDoctor or you can contact WHA's Provider Relations Department. You may also email directory@westernhealth.com to report any inaccuracies in WHA's provider directory.

WHA has also begun a partnership with Integrated Healthcare Association (IHA), which offers a centralized platform for provider data management. IHA Symphony, is a "cloud-based technology platform that serves as a single source for provider directory data, including demographics, services, products, and networks." Since SB 137, California has been working towards a state-wide directory/source for participating provider data to improve the quality of provider data. IHA Symphony ensures that consumers have the right information when choosing a physician or health plan online. WHA was estimated to be live with Symphony by the end of the calendar year 2022. This timeline has been extended to Q4 2023 due to IHA's transition from Gaine Solutions, Inc to a new vendor and data platform with Availity, LLC. Since this is an estimate; the date is subject to change.

WHA Service Area and Network

WHA's service area by line of business are:

- Large employer group (100+ eligible employees) plans (large and small) are available in Humboldt, Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties and parts of Colusa, El Dorado and Placer.
- Small employer groups (1 to 100 eligible employees) plans are available in Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties and parts of Colusa, El Dorado, Humboldt and Placer.
- Individual plans are available in Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties and parts of El Dorado and Placer.

- Medicare Advantage plans for individuals are available in Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties.
- Medicare-eligible group retiree plans are available in Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties and parts of Colusa, El Dorado and Placer.

WHA's clinical provider network includes participating primary care physicians (PCPs) and hospitals affiliated with these medical groups:

- Hill Physicians Medical Group
- Mercy Medical Group
- Meritage Medical Group
- NorthBay Health
- Providence Medical Network
- Woodland Clinic

ACCESS & AVAILABILITY

Accessibility standards are related to the number, type, and location of providers in our network. Availability standards reflect the timeliness by which a member can obtain covered health care services for routine/regular care, routine specialty care for non-urgent conditions, emergency care, urgent care/after-hours care, behavioral health care, and ancillary services. The standards also include guidelines for Extending Appointment Waiting Time and Rescheduling Appointments.

All health plans and providers, including WHA and its contracted medical groups/IPAs, are subject to the Department of Managed Health Care's (DMHC) Timely Access to Health Care Services standards. WHA annually assesses organization-wide and practice-specific performance against the standards and reports findings as required to the DMHC. As a contracted provider, your participation in these assessments is vitally important to ensure an accurate representation of the WHA provider network.

The Timely Access to Care standards available online at **mywha.org/timelyaccess** should be reviewed by all practitioners and scheduling staff to ensure they understand their role in meeting the requirements.

Nurse Advice Line

WHA provides our members with access to a Nurse Advice Line 24/7 through Optum's NurseLine services. Optum employs California-licensed nurses experienced in screening, triage and health education.

Members can access an advice nurse by calling 877.793.3655 or by visiting **mywha.org/nurseadvice** for Optum's NurseLine secure chat/email. It's another way to access care for answers to health questions, and when needed, direct referrals to disease management and other programs.

Teladoc – Virtual Urgent Care

WHA members also have access to 24-hour virtual urgent care visits with a health care professional through Teladoc. A Teladoc clinical provider can support members appropriately for their medical needs. Members can download the smartphone app and access the Teladoc phone number and portal at **mywha.org/Teladoc**.

CONTINUITY & COORDINATION OF CARE

WHA has the responsibility for ensuring there is continuity in the delivery of care and that care is coordinated between providers across the health care network. To learn about WHA's continuity and coordination of care policies and procedures, visit **mywha.org/umpolicies.**

WHA's transition and continuity of care activities focus on:

- Transition of care between providers of care
- Transitions between settings of care
- Transitions to other care when a member's benefits end or transition from pediatric to adult care
- Coordination and access to a practitioner when the member's PCP terminates
- Coordination and access to a practitioner when a practitioner's contract is discontinued
- Continuity and coordination between behavioral health care providers and general medicine

For Medicare Advantage, CMS outlines continuity as follows:

- Linkages between primary and specialty care
- Coordination among specialists
- Appropriate combinations of prescribed medications
- Coordinated use of ancillary services
- Appropriate discharge planning
- Timely placement of different levels of care including hospital, skilled nursing and home health care.

Transition of Care Between Providers of Care

In most circumstances WHA's practice is to encourage members to submit Transition of Care/Continuity of Care requests within 30 days of a new member's effective date of enrollment with WHA. WHA members can download request forms at **mywha.org/cocform** and **mywha.org/MyCareCOC** (Medicare members).

If a contracted medical group/IPA receives a retrospective request for continuity of care from a new member after services were rendered by a non-participating provider, or receives a bill for those services, the group may be responsible for determining financial responsibility. WHA ensures that new members that fall into the categories listed below are allowed, upon request and when appropriate, to continue receiving limited uninterrupted care from their non-participating provider for a specified length of time, or until a safe transition to a WHA network provider, as determined by legal requirements and the condition of the patient, can be accomplished. Applicable situations are as follows:

- A member with an acute condition – for the duration of the acute condition;
- A member with a serious chronic condition – for a period of time necessary to complete a course of treatment and to arrange for safe transfer to another provider, not to exceed 12 months from the member's effective date of coverage;
- A pregnancy – for the duration of the pregnancy and the immediate postpartum period;
- A terminal illness – for the duration of the terminal illness that may exceed 12 months from the date of the member's effective date of coverage;
- Care of a newborn child, whose age is between birth and 36 months – for a period to not exceed 12 months from the date of the member's effective date of coverage;
- Performance of a surgery or other procedure that has been authorized by WHA as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the member's effective date of coverage.

Transition of Care Between Settings of Care

Hospital discharge planning staff and medical group case managers coordinate member care between practitioners, practice sites and transitions of care between different levels and settings. WHA Clinical Resource nurses assist in the coordination of care for members hospitalized outside the area due to an emergency situation.

Transitioning Care When Benefits End

If a member's benefits are exhausted while the member still needs care and they are in a case management (CM) or disease management (DM) program, the CM or DM staff can discuss alternatives for continuing care and how to obtain care. If the member is not receiving these health care services, ask to speak to a WHA Clinical Resources representative who will be happy to assist the member. Other alternatives such as COBRA coverage, Individual plan, Medi-Cal, ACA Exchange coverage or community resources can be explored to meet the member's individual needs.

Transitioning from Pediatric to Adult Care

Generally, patients begin the transition of care from a Pediatrician to a Family Practice, Internal Medicine, OB-GYN or Physician between the ages of 19 to 26 years. However, there are chronic conditions that may warrant a patient to continue their relationship and health care services within the pediatric setting.

WHA encourages members and their families to discuss this important transition with their individual physicians, as this decision should be based on each individual's health care needs.

A WHA Clinical Resources representative is available to help should the member need assistance in transitioning health care services or have any questions. For more information, the member can call WHA's Member Services and ask to speak with a Clinical Resource Nurse.

Termination of Network Provider

WHA must provide written notification to the member at least 30 calendar days prior to the effective date of a termination or upon receipt of a termination notice.

WHA also ensures that members who fall within the categories listed under "Transitions of Care Between Providers" whose current providers are terminated from WHA's network and who are receiving active treatment from the provider at the time the contract is terminated, are allowed, upon request and when appropriate, to continue receiving ongoing care and treatment from that provider for a specified amount of time, or until it is considered reasonably safe to transition their care to another appropriate participating provider, depending on relevant legal requirements, and the patient's diagnosis and treatment plan.

Termination of Coverage

When a member's coverage ends and they still need care, WHA offers information regarding alternatives for continuing care. Members are encouraged to contact WHA's Member Services.

Continuity and Coordination of Care Between Medical and Behavioral Health (BH) Practitioners

Effective Jan. 1, 2023, Optum Behavioral Health is our contracted provider of behavioral health services, support continuity and coordination of care between general medicine and behavioral health practitioners through the following performance measures:

- Anti-depressant medication management
- Initiation and engagement in alcohol and other drug dependence treatment
- Prenatal and Postpartum Depression Screenings and Follow-up
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Optum Behavioral Health conducts an annual Treatment Record Audit on WHA members receiving outpatient services for evidence of coordination of care. Records are reviewed for consistent and complete documentation of continuity of care through evaluation of:

- Timely, confidential communication with PCP/Specialist when consent has been granted by the patient
- Timely exchange of information with relevant organizational providers especially for those with an identified medical condition, and/or with the initiation of a new medication
- The attempt to obtain member consent for sharing of clinical information with the PCP

Transition of Care for New Enrollees

The BH provider facilitates continuity of care for all new members who are receiving services from a non-network provider during a current episode of care for an acute condition.

Other BH Continuity of Care Measures

- Psychotropic medications ordered for a member by a BH specialist are reported to the PCP if the member has given consent.
- Adult Members are monitored for continued adherence for at least 80% of their treatment period when prescribed antipsychotics for schizophrenia.
- Ensuring that children and adolescent members who are prescribed antipsychotics have glucose and cholesterol testing performed every year, and those without a clinical indication have had psychosocial care as first-line treatment.
- InterQual® discharge planning criteria are used to identify members hospitalized in the acute care setting who have co-existing BH disorders. BH consultations are available within 24 hours.
- BH practitioners facilitate outpatient appointments for members discharged from inpatient care within seven (preferable) or 30 calendar days of the discharge, prioritizing by urgency of the case.
- Members requesting BH services that are not a covered benefit are offered fee-for-service alternatives or referral to community services on an ability to pay basis.
- When BH is managing a member with co-existing medical and BH disorders, the BH case manager notifies WHA's Medical Management staff to coordinate case management of the medical disorders. WHA staff sends a CM referral to the contracted medical group which initiates the case management screening process upon receiving member consent.

For more details regarding Continuity and Coordination of Care issues please see WHA's policies titled: "Continuity of Care (Transition of Care or Care Management)," "Continuity and Coordination of Medical Care" and "Continuity and Coordination of Behavioral Health Care" at **mywha.org/policies**. A copy of the Continuity of Care Request Form is available at **mywha.org/COCform**.

CREDENTIALING/RECREDENTIALING

WHA has delegated credentialing/recredentialing functions to its contracted medical groups/IPAs.

Practitioner Rights

The following rights are afforded to all practitioners being credentialed/recredentialed:

- The right to review the information submitted to support their credentialing/recredentialing application;
- The right to correct erroneous information in their credentialing file; and
- The right to request and be informed of the status of their credentialing/recredentialing application

Credentialing/recredentialing decisions cannot be based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Commercial) in which the practitioner specializes. If a practitioner feels they have been discriminated against during the credentialing/recredentialing process conducted by their medical group, they may contact WHA's Medical Management Department. If a practitioner wishes to

review their credentialing information, correct erroneous information or check the status of their credentialing/recredentialing application they should contact their medical group.

Right to a Fair Hearing

A practitioner who has received notice of an adverse action being taken against them may request a hearing within 30 days receipt of such notice. If you have any questions regarding the credentialing/recredentialing process, contact your medical group.

CULTURAL AND LANGUAGE ASSISTANCE SERVICES

WHA is committed to delivering culturally and linguistically appropriate services to all members. Many factors can affect how an individual accesses care, and/or receives or understands information. Members who have limited English proficiency, are deaf or hard of hearing, or are blind or have low vision may need interpreters or other assistive devices. Members can call 888.877.5378 for TDD/TTY services.

Patients of different ages, language preference, sexual orientation, gender identification, religions, cultures, along with other socioeconomic factors, all have different needs and may interpret interactions with health care professional differently.

WHA and its clinical providers must be sensitive to both the cultural and language differences of their members, including the cultural variation in the management of disease. Such differences may create mistrust, misunderstanding, a lack of compliance, or other factors that negatively influence clinical situations and impact patient health outcomes.

Providers should first utilize the cultural and linguistic services offered by their medical group/IPA. If those resources are not available, provider should utilize WHA's resources.

Language Assistance and Translation Services

WHA's Language Assistance Program (LAP) offers a variety of interpretation services in over 100 languages as well as written translations or alternative formats, at no cost to the member. Additional communication resources such as audio translation, ASL interpreters, and braille are available for members with hearing, speech or vision loss or impairment.

For detailed information about WHA's Language Assistance Program, how to access interpreter services, WHA's Cultural and Linguistic Resources Guide, and all the DHHS and HICE resources described in this section, direct your providers and office staff to **mywha.org/lap**.

Verbal Interpretation Services: Oral interpretation services must be available at all points within the health plan and contracted medical groups/IPAs in any language the member needs. This includes administrative and clinical services, telehealth, telephonic, and in-person contacts. WHA contracts with multiple language services vendors to provide interpretation services for members who contact WHA or the practitioner's office, or are in the practitioner's office. WHA's language services vendors are available 24/7 to provide interpretation assistance by phone.

It is WHA's policy to use phone interpretation services whenever possible. Requests for in-person interpretation should be forwarded to WHA's Member Services Department where they will be considered on a case-by-case basis. American Sign Language interpreters can also be provided.

Written Translation Services: All standard written materials that are considered critical for obtaining care must be translated and made available in the Plan's threshold language(s): Spanish.

Standardized notices, as well as non-standard, member-specific material, such as authorization notices, explanations of benefits, and claims denials, must include a Notice of Language Assistance (NOLA). The notice is included in this packet.

If a member desires translation of a document, they can call WHA Member Services. Member Services may offer to interpret the document over the phone using the language services vendor, if applicable. If a member prefers to receive a written translation of the document, Member Services will initiate the translation process.

Alternatively, a member may request translation from his or her medical group/IPA. Requests for translation of a non-urgent "vital document" sent from a medical group must be sent to WHA within two (2) business days of member request. Urgent documents must be provided to WHA within one (1) business day of the request.

The medical group/IPA must keep a log of the date the member translation request was received and when the document was provided to WHA. WHA will provide members with a written translation within twenty-one (21) days for non-urgent and 72 hours for urgent requests.

Provider Responsibilities Related to Language Assistance Services

In addition, WHA's contracted medical groups/IPAs and the practitioners associated with those entities are responsible for the following:

Member Notification: Providers must inform members of the availability of language assistance services at no cost to the member. This may be accomplished in two ways:

- By posting a multilingual sign in areas likely to be seen by members or
- By informing members that they may receive important written materials in materials in other languages or alternate formats, such as audio, large print or braille. Providers who send claim/UM denial notices must add the attached NOLA to their written communications to inform members of the availability of translated documents.

Use of Family Members as Interpreters: Providers must not require or suggest that Limited English Proficient (LEP) members provide their own interpreters or use family members or friends as interpreters. In addition, providers cannot use minor children as interpreters and must not rely on minor children to facilitate communication with LEP patients. The only exception to this rule is an emergency involving an imminent threat to the safety or welfare of an individual or the public where no qualified interpreter is immediately available. If a member insists upon using a family member or friend as an interpreter after being informed of the availability of language assistance services, the provider should document this choice in a prominent place in the member's medical record.

Adequate Accommodation: Provider offices should be equipped to facilitate the use of interpretive services. Examples include additional phones for three-way calling, dual handset phones or speakerphones.

Confidentiality: Providers must take steps to maintain patient confidentiality when using an interpreter. This includes private areas for three-way calling or for conference calls using a speakerphone.

Updating Member Records: Providers should ascertain a member's need for language assistance at the time an appointment is made or when the member appears for services, and document this information in the member record. On the Provider portion of the WHA website and in the WHA's Provider Manual, there is a Language Identification Guide that may be of assistance in determining the language the member speaks.

After-hours Linguistic Access: Providers are encouraged to accommodate LEP members by having multilingual messages on answering machines and training their answering services and on-call personnel on how to access interpreter services after hours. (WHA's NurseLine service meets the requirements for this standard.)

Full and Equal Access: WHA members are entitled to full and equal access to covered services. This includes access for members with disabilities, as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

Cultural Competency and Linguistic Education and Training Resources

WHA's providers have access to cultural and linguistic education and training that was developed by the US Department of Health and Human Services (DHHS) and the Health Industry Collaboration Effort, Inc. (HICE). These organizations have online resources to help support effective, compassionate care to our diverse population of members, as well as training tools for providers and staff. We encourage our providers and medical groups to use the tools available for regular staff training and to ensure our members have the best experience possible.

The DHHS's Office of Minority Health (OMH) funded development of training modules to equip physicians and nurses with cultural and linguistic competencies. The Cultural Competency Curriculum Modules, which are grounded on the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, are accredited for 9 continuing medical education (CME) for physicians and 9 contact hours (CE) for nurse practitioners. Visit **thinkculturalhealth.hhs.gov/education** to access the training modules.

The HICE Cultural & Linguistics Services Team offers training modules that have incorporated DHHS content and other resources. Additionally, a tool kit is available for download that includes components to improve and enhance communication for diverse populations, guidelines for gender-inclusive language, and interpretation quality standards and proficiency assessment resources. To access HICE content visit **iceforhealth.org/library**.

FRAUD, WASTE AND ABUSE

WHA is committed to deterring, detecting and investigating health care fraud, waste and abuse. Clinical providers are encouraged to undertake activities related

to fraud prevention and detection. WHA requires providers to give FWA training to all employees and subcontractors to the extent required by law. WHA maintains a confidential Hotline for members and providers to report concerns and submit complaints concerning fraud, waste, and abuse, WHA policies, procedures, or the organization's compliance with its policies and procedures.

The confidential Hotline is accessible 24 hours per day/7 days a week via a toll-free telephone number (English speaking: 833.310.0007; Spanish speaking: 800.216.1288) or by submitting a report online at **lighthouse-services.com/westernhealth**.

HEALTH EQUITY

Advancing health equity is the core of WHA's mission statement; "We expand access to health care and respond to the changing needs of our members, providers, and community to improve the health and well-being of all."

The ability to achieve optimal health and wellness is determined by the availability of fair and just opportunities within the health care system. WHA understands that cultural and language issues impact the delivery of those opportunities, the quality of care and ultimately health outcomes. A new Culturally and Linguistically Appropriate Services (CLAS) program was created in 2021 to help identify gaps in services and areas in which interventions to reduce health care disparities could have the most impact. By achieving NCQA's Multicultural Health Care (MHC) in June 2022, WHA demonstrates its commitment to provide high-quality culturally sensitive care and closing the gaps in disparities.

At this time, WHA is focusing on reducing health care disparities by improving the following clinical performance measures for all lines of business in the Spanish-speaking and Hispanic populations:

- Members diagnosed with diabetes with no HbA1c
- Members diagnosed with diabetes whose HbA1c <8%

Request to Collect Race, Ethnicity and Other Demographic Data

To appropriately determine the presence of health care disparities and discover effective interventions, an organization must first be able to identify the population for which it serves. The same is necessary for providers when the goal is to also provide concordant care. WHA had identified a large gap in the collection of race and ethnicity data of both members and providers.

Please use ProviderDemographics@westernhealth.com to update WHA of any important demographic for our member touch points, as you play a critical role in the advancement of health equity.

HEDIS AND PERFORMANCE MEASUREMENT

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of health care's most widely used performance improvement tools. 191 million people are enrolled in plans that report HEDIS results. HEDIS measures performance in health care where improvements can make a meaningful difference in people's lives. The "Effectiveness of Care" measures are categorized as follows:

Effectiveness of Care

Prevention and Screening

- Childhood Immunization Status
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Chlamydia Screening in Women
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children
- Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Respiratory Conditions

- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management COPD
- Asthma Medication Ratio
- Appropriate Testing for Pharyngitis

Cardiovascular Conditions

- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Cardiac Rehabilitation
- Statin Therapy for Patients with Cardiovascular Disease

Musculoskeletal Conditions

- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture

- Osteoporosis Screening in Older Women

Diabetes

- Comprehensive Diabetes Care
  - HbA1c Control (<8.0%)
  - Diabetic Retinal Eye Exam
  - BP Control <140/90
- Kidney Health Evaluation for Patients with Diabetes
- Statin Therapy for Patients with Diabetes

Behavioral Health

- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up Care for Children Prescribed ADHD Medication
- Pharmacotherapy for Opioid Use Disorder

Medication Management and Care Coordination

- Transitions of Care
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
- Overuse/Appropriateness: Use of Opioids
  - High Dosages
  - Risk of Continued Opioid Use ≥ 15 Days
- Appropriate Treatment of Children with URI
- Avoidance Antibiotics–Adults with Bronchitis
- Use of Imaging for Low Back Pain
- Non-Recommended PSA-Based Screening in Older Men
- Use of High-Risk Medications in Older Adults
- Potentially Harmful Drug-Disease Interactions in Older Adults
- Use of High-Risk Medications in Older Adults

Access/Availability of Care

- Timeliness of Prenatal Care
- Timeliness of Postpartum Care
- Initiation and Engagement of Alcohol & Other Drug Dep Tx
- Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics

HEDIS Record Request

HEDIS season is a small window of time annually during the spring (February to May). Charts requested are used for assessment of management of chronic health conditions and wellness screenings. Data abstracted from clinical records are reported to NCQA, CMS and link to AMP/P4P. We ask providers' offices to submit records in a timely fashion to assure a successful HEDIS season.

MEDICAL RECORD DOCUMENTATION & MANAGEMENT

WHA delegates medical record management functions to its contracted delegated entities. WHA retains responsibility for ensuring the medical record documentation standards are met. Annually WHA audits both electronic and hard copy medical records to assess the medical group's medical record management and practitioners' compliance with the medical record documentation standards.

The standards for medical record documentation and medical record management can be found once logged into the WHA Provider Portal under Patient Safety and in the Provider Manual. A passing score for these standards is 90% and above. Both your medical group/IPA and WHA conduct medical record audits to assess the level of compliance with these standards.

To learn more about Medical Record Management policies, visit **mywha.org/policies.**

PHARMACEUTICAL MANAGEMENT PROCEDURES

WHA contracts with OptumRx, a pharmacy benefit manager (PBM), to manage the following pharmacy functions for commercial plans: claims adjudication; initial coverage determinations; and development and maintenance of the pharmacy network.

WHA maintains a three-tier, incentive-based Preferred Drug List (PDL) for its commercial members whose employer purchased a pharmacy benefit. WHA's ACA-compliant plans, including those purchased through Covered California, have a four-tier PDL.

Most commonly, the PDL lists generic drugs with a first-tier copayment and preferred brand-name drugs with a second-tier copayment. Non-preferred brand name drugs have a third-tier copayment. Office-based injections, except for some self-injectables, are covered under the medical benefit. Specialty medications are most often oral, nasal, inhaled, topical, or injectable drugs used to treat complex, chronic conditions such as cancer, rheumatoid arthritis, and multiple sclerosis and in general cost more than $600 for a 30-day supply. Specialty drugs sometimes require special handling and patients using them may need careful oversight or education from a health care provider. Most commonly, oral, nasal, inhaled, self-injectable, and topical specialty

drugs are Tier 3 for commercial members and Tier 4 for Covered California/Individual members. The PDL is available to members and clinical providers on the WHA website. The PDL identifies drugs with age limits (AL), quantity limits (QL), prior authorization (PA), and step therapy (ST) requirements. WHA identifies medications that are available through the Preventive Health Benefit (PV) on the PDL as well as office-administered medications (OA), which are covered through the medical benefit. Routine medications for both medical and mental health conditions do not require PA. Most non-preferred brand name drugs also do not require PA but do have higher copayments. Most specialty drugs require PA and are limited to a 30-day supply at a specialty network pharmacy.

Specialty network pharmacies include Optum Specialty Pharmacy for mail orders, the onsite pharmacies of NorthBay Health and UC Davis, or St. Joseph's McAuley Pharmacy of Dignity Health. When a medication request fails the online adjudication process at the pharmacy and is not changed by the prescribing clinical provider to meet criteria, the submission of a PA request is required, using Prescription Drug Prior Authorization Request Form #61-211, per state regulations. The use of pharmaceutical company forms or outside company forms cannot be accepted. Any request not submitted on the required form will be denied and the clinical provider will be required to resubmit the request on the required form.

The PDL is reviewed and updated as needed at WHA Pharmacy and Therapeutics (P&T) Committee meetings, which take place quarterly. The P&T Committee reviews newly released drugs and performs drug class reviews during our P&T meeting. WHA network clinical providers may request in writing or in person that a drug or drug class be reviewed by the P&T Committee for addition to the PDL. The online PDL, available at **mywha.org/pharmacy**, is updated monthly and after each P&T Committee meeting. You may also request a hard copy by contacting WHA Member Services.

Note: Medicare Advantage Prescription Drug (MAPD) plan formularies are managed by Providence Plan Partners (PPP) using a 6-tier drug list; details are outlined in MyCare Evidence of Coverage documents available at **mywha.org/MyCareEOC**. PPP is also responsible for investigation of prescription drug appeals, specific to Part D.

Self-Injectable Medications

Self-injectables are included in the pharmacy program. **Exception:** Insulin, which is covered under the pharmacy benefit. Most self-injectables require PA. As stated above, the approved Prescription Drug Prior Authorization Request Form #61-211 should be submitted directly to WHA per state regulations. Injectable medication approvals are limited to a 30-day supply per fill. In addition, if the injectable medication is approved, all related supplies will also be approved. Office-administered injectables are covered under the medical benefit, require PA by the WHA member's medical group.

Drugs and medications, including "unlabeled" or "off-label use," may be obtained by prescription by requesting PA approval. A PA request will be approved when all of the following conditions are met:

- Drug is medically necessary for the treatment of condition for which it is administered, according to accepted standards of medical practice
- Drugs listed on the PDL have failed to achieve therapeutic goals, or are contraindicated, or the patient experienced unacceptable side effects
- A participating clinical provider prescribes the drug
- The drug is FDA-approved for at least one indication
- There are a least two peer-reviewed articles detailing the safety and efficacy of the medication for indicated use

Note: WHA does not cover compound medications made from bulk powders, as these products are not FDA-approved ingredients. Compound medications for which there is an FDA-approved alternative, that do not contain at least one prescription ingredient, and/or exceed a cost of $200 may require prior authorization for coverage. PA documentation for compound medication coverage must include at least two peer-reviewed articles detailing the safety and efficacy of its use.

Quantity Limitations

Prescriptions filled at retail pharmacies are limited to up to a 30-day supply. Mail service prescriptions allow for up to a 90-day supply. **Exception:** California prescription requirements for Schedule II medications do not allow for refills. Specialty medications can be obtained through WHA's exclusive specialty pharmacy network, as noted above, and are limited to a 30-day supply.

Generic Substitution

The generic product will be dispensed in compliance with applicable California Board of Pharmacy regulations for all multi-source brand name drugs unless the physician specifies "dispense as written."

Prior Authorization (Exception Requests)

When the drugs listed in the PDL do not adequately meet a member's clinical needs, WHA considers the drug an "exception" based on medical necessity. PA requests for oral, self-injectable, and specialty medications should be submitted directly to WHA for review as stated above. Initial approval or denial is the responsibility of WHA's Clinical Pharmacists.

Infertility Medications

Infertility medications are only covered when the member's employer has purchased the WHA Infertility Rider. All infertility services require medical group PA for the services and WHA PA for the infertility drugs.

Investigational Drugs

Any drug that is undergoing investigational testing in humans requires a case-by-case review. *Investigational drugs are not eligible for routine WHA coverage.*

Appeal Process

Appeals for PA denials will be reviewed by WHA's Appeals and Grievance division. Medical group denials can be appealed through WHA's Appeals and Grievance division. When WHA upholds a denial, the next level of appeal is to the Department of Managed Health Care (DMHC) at **www.dmhc.ca.gov.**

POPULATION HEALTH MANAGEMENT

Chronic Care/Condition Management – Disease Management (DM)

WHA's Disease Management Programs are provided as a benefit at no additional cost to WHA members living with a chronic condition. The programs are managed by Optum Health, an NCQA-accredited disease management organization, and overseen by WHA. The programs use evidence-based interventions that follow the recommendations of nationally recognized sources.

WHA's DM programs are available for the following conditions and age groups:

- Coronary Artery Disease: Ages 18+ years
- Diabetes (type 1 and type 2): Ages 18+ years (including our Medicare population)
- Asthma: Ages 5 to 64 years

Program Goals: To assist members in managing their chronic conditions while reinforcing the PCP's care plan.

Members can be enrolled through 1) PCP referral to WHA or Optum; 2) member self-referral; 3) claims, pharmacy, and lab data; or 4) health assessment results. Refer your WHA patients to **mywha.org/dm** for details.

Once enrolled, participants can choose to "opt-out" of a program at any time. Interventions are based on the severity of the participant's condition and may include telephonic outreach from a DM care manager and/or health education materials related to the condition.

The program works with you, the practitioner, to support your patient's treatment plan through reinforcement and education of the member. When necessary, evidence-based treatment recommendations are faxed that support your efforts in managing your patient's care. For more information about WHA's DM programs, contact Member Services or contact Optum directly at 877.793.3655 Monday through Friday, 8 a.m. to 6 p.m. (PST).

An online DM referral form is available at **mywha.org/dmrf**. The completed form can be sent by mail, secure email or faxed to Medical Management's confidential fax line at 916.568.0278.

Kaia for Digital Physical Therapy

Kaia Health digital physical therapy is for acute and chronic musculoskeletal (MSK) pain for commercial and individual plan members over age 18. This web-based program and mobile app provide members with artificial intelligence/AI-driven physical therapy instruction and monitoring to help those with neck, shoulder, back, hip, wrist and knee pain benefit from physical therapy care anywhere, anytime. Refer your WHA patients to **mywha.org/Kaia**.

Livongo for Hypertension

For commercial and individual plan members over age 18 living with hypertension, WHA offers this comprehensive hypertension management program including a connected blood pressure monitor, real-time insights readings, health education, and one-on-one support from expert coaches. Members also have access to Livongo's wireless, mobile, and web-based hypertension management systems and technologies through a personalized web portal. For more information, your WHA patients may go to **mywha.org/Livongo**.

Nutritional Counseling

WHA's network medical group partners support our commercial and individual plan members in weight management, whether for addressing obesity, eating disorders, or needed weight gain. WHA patients must meet specified medical criteria and demonstrate a

documented readiness to make nutrition and lifestyle changes. Eligible members get three initial visits with a nutritionist; with additional visits based on documented improvement and criteria. For information, go to **mywha.org/nutrition.**

Virta Health for Type 2 Diabetes Nutrition Support

Virta Health for Diabetes Nutrition Support is available for the commercial, individual, and Covered California members aged 18 to 79 with a diagnosis of type 2 diabetes (WHA MyCare Medicare Advantage members are not eligible for this program at this time). WHA teamed up with Virta Health to offer an innovative, nutritional treatment program that reverses type 2 diabetes, without the risks, costs, or side effects of medications or surgery. Virta's telehealth program helps people lower their blood sugar and hemoglobin A1c, making it possible to reduce diabetes medications and lose weight. This program is offered at no additional cost to qualifying members. Refer patients to **mywha.org/Virta** to find patient application and details. This program is also offered in Spanish.

Tools and resources for members include:

- A clinical provider care team: access to Virta's board-certified clinical providers and healthcare professionals who coordinate care as needed with the member's primary care provider
- health coaching: message a Virta Health Coach, available to help answer questions on nutrition and offer encouragement. Spanish-speaking coaches are available.
- Diabetes testing supplies: Virta provides members with a bodyweight scale, a meter with glucose and ketone strips, lancets, and swabs and if needed, a blood pressure cuff
- Digital educational tools: Members can access videos and recipes, and engage with a private online support community through Virta's website and mobile app

Chronic Care/Condition Management – Case Management Programs

Both routine Case Management and Complex Case Management services are available at no cost to WHA members when deemed appropriate. These functions have been delegated to WHA's contracted medical groups/IPAs. Contact your group's Case Management/Care Coordination Department for information or to make a referral requesting case management program services for your patients.

For WHA's Medicare Advantage members, a Chronic Care Improvement Program (CCIP) is a required multi-year clinically focused initiative designed to improve the health of a specific group of members. The selection of members for the CCIP program takes into consideration issues that affect the largest number of members, issues that are of high significance to members, and issues that have the potential for making significant improvement.

PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINES

WHA's Preventive Health Guidelines are available online at **mywha.org/phgs** and include:

- Infant to Adolescent
- Adults
- Perinatal Care

Clinical Practice Guidelines

WHA's Clinical Practice Guidelines are available online at **mywha.org/cpgs** and include:

Asthma - Updated

- 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group. National Heart, Lung and Blood Institute, 2020
- Global Strategy for Asthma Management and Prevention. Global Initiative for Asthma 2021
- 2022 Global Strategy for Asthma Management and Prevention

Blood Pressure/Hypertension – Updated

- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Chronic Obstructive Pulmonary Disease – Updated

- GOLD Global Strategy for Diagnosis, Management, and Prevention of COPD 2022

Congestive Heart Failure – Updated

- 2022 ACC/AHA/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Coronary Artery Disease

- AHA/ACC Guideline on the Primary Prevention of Cardiovascular Disease, 2019

Diabetes

- ADA Standards of Medical Care in Diabetes, 2021
- ADA National Standards for Diabetes Self-Management Education and Support, 2017

Feedback on the guidelines is always welcome and may be directed to WHA's Chief Medical Officer at k.arif@westernhealth.com.

Wellness and Interactive Health Tools

WHA provides an internet-based wellness program to WHA members at **mywha.org/wellness**. WHA members can complete a personal health assessment and track their numbers such as blood pressure, lab value or BMI. They have access to online audio and video health education classes, a robust health library and more. For more information about WHA's wellness programs, contact the Member Services Department.

Member Health Education and Reminders: WHA members receive health education and health screening reminders for the following preventive health services:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Childhood/Adolescent Immunizations
- Heart Health
- Cervical Cancer Screening
- Diabetes
- Chlamydia
- Postpartum Care

WHA currently offers incentives for members who complete health care activities associated with the services. Please have members visit mywha.org/preventive to check for incentive forms and details.

Members also receive a quarterly *Advantage Magazine* with health-related information and how to take advantage of plan benefits. In addition, you may read and subscribe to the WHA blog at **mywha.org/blog** and providers are welcome to "follow" us on Facebook, Instagram, Twitter social media sites, and find MyWHA Wellness videos and more on our YouTube channel.

PRIVACY AND SECURITY OF INFORMATION

WHA and its contracted medical groups/IPAs must comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), California's Confidentiality of Medical Information Act and other federal and state laws with respect to the security, privacy and confidentiality of medical records and all other protected health information (PHI). Information regarding WHA's privacy program, including its Notice of Privacy Practices, are available at **mywha.org/privacy**. Below are some key components of the regulations. For additional information about HIPAA, visit the website of the US Department of Health and Human Services (DHHS) at **hhs.gov/hipaa**.

Use and Disclosure of PHI

Privacy Safeguards: PHI may only be used or disclosed as permitted or required by the HIPAA Privacy Rule or as permitted or required by the Business Associate Agreement (BAA) with WHA. If PHI is to be used or disclosed for purposes other than those required or permitted, the member's, or as appropriate, WHA's written authorization is required.

WHA and its contracted medical groups/IPAs must also take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose.

Covered Entities and Business Associates under HIPAA, must:

- Develop and implement written privacy policies and procedures consistent with the HIPAA Privacy Rule.
- Train workforce members on its privacy and security policies and apply appropriate disciplinary action on those who violate policies and procedures.
- Mitigate any harmful effect caused by the inappropriate use or disclosure of PHI by its workforce members.
- Obtain satisfactory assurances that subcontractors to whom it provides PHI received from, or created on behalf of, WHA, agree to the same restrictions and conditions per the Business Associate Agreement HIPAA regulations.

Security Safeguards: The HIPAA Security Rule requires Covered Entities and their Business Associates to put in place administrative, physical, and technical safeguards to secure electronic PHI. Providers are obligated to:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information (PHI) it creates, receives, maintains, or transmits on WHA's behalf,
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information,
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA rules, and
- Ensure compliance by its workforce.

Incident Reporting: Pursuant to the HIPAA Breach Notification Rule, the California Information Practices Act of 1977 and the BAA with WHA, Business Associates are required to notify WHA of the occurrence of a security incident and/or a breach of unsecured PHI. A "breach" is defined as the unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom the information is disclosed would not reasonably have been able to retain the information, and as defined under HIPAA regulations. "Unsecured" means the information is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of an encryption or destruction technology or methodology specified by the HHS Secretary. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

The notification to WHA must be made without unreasonable delay after discovery of the security incident or breach but in no case later than 15 days after such discovery.

The notification must include to the extent possible the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used or disclosed during the breach.

The notification must also include all other information that WHA may require to make timely and appropriate notifications as required by regulations.

The obligation of a contracted medical group/IPA to report a breach to WHA is limited to a breach involving PHI created, received, used or disclosed by the contracted medical group/IPA on WHA's behalf.

To report breaches, submit an email to privacy@westernhealth.com. To make any other notifications of security incidents required by the BAA between you and WHA, submit an email to informationsecurity@westernhealth.com. If your notification includes PHI, please email the information as an encrypted attachment. Be sure to provide the password in a separate communication other than email (phone call or private fax, for example).

PROVIDER DISPUTE RESOLUTION

Most provider appeals are handled initially at the contracted medical group/IPA level then forwarded to WHA for second-level review and decision-making. If the issue involves a medical necessity or UM decision, the provider appeal can be made directly to WHA, bypassing the contracted medical group's/IPA's internal appeal process.

Provider appeals must be submitted in writing to WHA's Claims Department within 365 days of receiving the written determination. Provider appeals submitted after 365 days will be rejected by WHA. The appeal is to be submitted on the Provider Dispute Resolution Request form and must include the provider's name, identification number and contact information. Additional information regarding the Provider Dispute Resolution process and the Provider Dispute Resolution Request form is available on the password-protected section of the WHA website and the online Provider Manual. A copy of the Provider Dispute form is also included in this packet.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1.888.563.2250**, TTY/TDD **1.888.877.5378**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free

telephone number (**1.888.466.2219**) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

QUALITY MANAGEMENT

WHA's Quality Improvement (QI) Program

WHA's Quality Improvement Committee (QIC) oversees WHA's QI Program. QIC membership includes primary and specialty care practitioners from WHA's contracted medical groups/IPAs, Optum's Behavioral Health Medical Director, WHA's Chief Medical Officer, Medical Director, Assistant Medical Director, WHA's Clinical Pharmacist and key WHA management staff. Contracted medical group physicians participate in the QI program and its activities through:

- QIC, P&T Committee, Utilization Management and Credentialing Committee membership
- Review and development of WHA's Preventive Health Guidelines and Clinical Practice Guidelines
- Peer review activities associated with grievances, appeals and potential quality of care issues
- Participation in health promotion/prevention and disease management program activities, and
- Sharing best practices with other network practitioners

WHA is a National Committee for Quality Assurance (NCQA) accredited health plan. A report card on WHA's performance on health care and service measures is available on the State of California's Office of the Patient Advocate (OPA) website located at **opa.ca.gov**.

Additionally, the QI program strives to ensure that services provided to WHA Medicare members conform to the standards and requirements that CMS requires of Medicare Advantage Organizations (MAOs). The requirements for the QI program are based on regulation at 42 CFR§ 4.22.152. Therefore, WHA must:

- Develop and implement a chronic care improvement program (CCIP)
- Develop and maintain a health information system
- Encourage providers to participate in CMS and HHS QI initiatives
- Implement a program review process for formal evaluation of the impact and effectiveness of the QI program at least annually
- Correct all problems that come to its attention through internal surveillance, complaints or other mechanisms
- Contract with an approved Medicare Consumer Assessment of Health Providers and System (CAHPS) vendor to conduct the Medicare CAHPS® satisfaction survey of Medicare enrollees, and
- Measure performance under the plan using standard measures required by CMS and report its performance to CMS

Information about WHA's QI Program and current goals can be found online at **mywha.org/qiprogram**.

QI Program Scope

The QI Program applies to all network providers who offer services to WHA members and have the potential to impact the member's clinical care and services. Included are:

- Inpatient settings: hospitals, skilled nursing facilities, residential and sub-acute facilities and behavioral health/chemical dependency facilities
- Outpatient settings: home health, diagnostic services, ambulatory surgery centers, pharmacies, and behavioral health/chemical dependency-related services
- Primary care, high-volume specialty care, behavioral health, and telehealth services
- UM services including prior authorization, concurrent review, retrospective review, continuity of care and long-term care
- Case management including routine and complex case management
- Disease management, wellness programs, health care services provided through web-based programs, and the nurse advice line that's available 24/7

Grievances, Appeals and Potential Quality Issues (PQIs)

All grievances and appeals received by WHA are documented, investigated and resolved within the time frames required by regulatory and accreditation agencies. Those grievances related to the quality of care and practitioner office site quality are treated as potential quality issues (PQIs). WHA's providers are required to maintain a supply of and provide members with a copy of their plan's grievance form upon request. WHA's grievance form is available online as well as a downloadable PDF at **mywha.org/grievance**.

Ayin Health Solutions (Ayin) receives telephonic complaints, grievances and appeals and screens them for PQIs on behalf of our Medicare Advantage members. WHA is responsible for the identification, reporting, investigation, and documentation of PQIs.

WHA may also identify PQIs through medical record audits, concurrent and retrospective review, medical group reporting, practitioner/provider reporting, and other sources. PQIs may include access, quality of service, quality of care, and practitioner office site quality. WHA's contracted providers are required to comply with the PQI investigation process; which is Peer Review protected. When a PQI is identified and reported to a contracted medical group, the group must provide WHA's Medical Management Department, with member medical records and a timely response to the inquiry. Most often that response will come from the Medical Group's Quality Improvement Department.

For WHA's PQIs, and following receipt of all corresponding supporting documents including the practitioner's response, WHA's PQI Review Committee will review the case and assign a Severity Level. A Severity Level of 2 or higher requires review by WHA's QIC and may require a Corrective Action Plan (CAP). Levels 2 through 4 peer review findings are forwarded to the Medical Director of the practitioner's medical group and/or Quality staff for further review and action. Findings are also included in the practitioner's credentialing file as part of the ongoing quality monitoring activities that are conducted between recredentialing cycles. WHA defines its Severity Levels as follows:

- Level 0 – NO QUALITY OF CARE ISSUE: Unfounded complaint, unavoidable complication, unavoidable disease progression
- Level 1 – NO POTENTIAL HARM TO PATIENT: Includes issues of poor documentation, poor communication, and non-compliance, may reflect a health care problem such as office wait time, etc.
- Level 2 – MINIMUM ADVERSE EFFECT: Includes systems issues and possibly less severe clinical judgment issues and/or process issues
- Level 3 – MODERATE ADVERSE EFFECT: Includes preventable complication and/or readmission or delay in diagnosis and/or treatment
- Level 4 – SIGNIFICANT ADVERSE EFFECT: All serious issues of medical mismanagement

At least semi-annually, WHA sends specific provider/practitioner reports to each contracted medical group/IPA noting the grievances and appeals WHA has received. Quality staff also monitors trends in provider/practitioner grievances, appeal and PQIs, which are reported to the QIC.

Practitioner Site Quality Criteria

WHA maintains practitioner office site guidelines for physical accessibility, physical appearance, and the adequacy of a practitioner's waiting and examining room space. Member complaints and grievances related to these issues are continually monitored by WHA and are reported to the appropriate contracted medical group/IPA within 5 days of being received by WHA. If a physician has reached WHA's established threshold of more than three (3) member complaints regarding office site quality in a rolling 12-month period, the contracted medical group/IPA must conduct an office site visit using the office site guidelines within 60 days of reaching the threshold. Depending on the outcome of that visit the practitioner may be required to complete a CAP. WHA's office site quality guidelines can be found on the WHA website and in the Provider Manual.

Provider Satisfaction

WHA measures provider satisfaction through its Annual Provider Satisfaction Survey conducted by an outside vendor, SPH Analytics. Survey results generated from this survey and analysis of practitioner complaints and appeals assist WHA with the identification of improvement opportunities. Historically, provider response rates are low so we encourage you to participate by responding to this survey. This is a mail/internet survey with telephonic follow-up and generally begins in September and ends in November.

SAFETY

Hospital Safety

WHA uses information from reputable quality reporting organizations, such as the Leapfrog Group and Cal Hospital Compare, to evaluate the quality of care, service and safety of the Health Plan's contracted hospitals. WHA's contracted hospitals are asked to attest to meeting the ACA requirements for patient safety standards and programs and are encouraged to participate in the Leapfrog Hospital Survey.

Leapfrog Group: The annual voluntary Leapfrog Hospital Survey assesses hospital performance based on national performance measures, which cover a broad spectrum of hospital services, processes and structures. These measures provide hospitals the opportunity to benchmark the progress they are making in improving the safety, quality and efficiency of the care they deliver.

Their website, **leapfroghospitalsurvey.org/cp** includes information on hospitals' Hospital Safety Scores. This survey is open from April 1 to December 31 of each year, and is free to all hospitals. The survey results are publicly reported, by the hospital, at leapfroggroup.org/cp each month. Leapfrog issues a hospital safety score from A-F for each participating hospital.

Metrics include, but are not limited to:

- Preventing medication errors
- Appropriate ICU staffing
- Steps to avoid harm
- Managing serious error
- Safety-focused scheduling
- Hospital-acquired infections

Cal Hospital Compare (formerly CalQualityCare.org): Cal Hospital Compare is a performance reporting initiative managed by a multi-stakeholder Board of Directors, with representatives from hospitals, purchasers, health plans, and consumer groups. Prior to 2016, Cal Hospital Compare was known as the California Hospital Assessment Task Force (CHART). CHART was first established in 2004 to develop a statewide hospital performance reporting system using a multi-stakeholder collaborative process. CHART aggregated data from participating hospitals until 2011, when its Board of Directors moved to use only publicly available data sources for all hospitals to ensure all California hospitals are represented. CHART, and now Cal Hospital Compare, are supported by a generous grant from the California Health Care Foundation (CHCF).

Comparison is over a broad array of quality of care areas, including:

- Patient Experience
- Mother & Baby
- Hip & Knee
- Patient Safety
- Healthcare Acquired Infections (HAIs)
- Cancer Surgery
- Emergency Department (ED) Care
- Heart & Lung Conditions
- Stroke
- Surgeries/Other Conditions

WHA uses the Mother & Baby and Healthcare Acquired Infections (HAIs) performance rates provided by Cal Hospital Compare to monitor our network hospitals to ensure compliance with applicable measurement goals. WHA also meets with these hospitals at least annually to discuss their best practices and/or improvement opportunities.

Patient Safety HEDIS Monitoring

HEDIS Measures related to patient safety, which WHA monitors includes:1) Medicare HEDIS: Appropriate Treatment for Upper Respiratory Infection; Avoidance of Antibiotic Tx in Adults with Acute Bronchitis; High Dosages (HDO); Risk of Continued Opioid Use and Plan All Cause Readmissions. 2) Commercial HEDIS: Appropriate Treatment for Children with Upper Respiratory Infection; Avoidance of Antibiotic Treatment for Adults with Bronchitis; Use of Imaging for Low Back Pain; Use of Opioids, High Dosages and Risk of Continued Opioid Use; and Plan All-Cause Readmission. 3) Exchange HEDIS: Appropriate Treatment for Children with Upper Respiratory Infection; Avoidance of Antibiotic Treatment for Adults with Bronchitis; Annual Monitor for Long-term Opioid Therapy; Use of Imaging for Low Back Pain; and Plan All-Cause Readmission.

Pharmaceutical Safety: Retrospective Drug Utilization Review Program

WHA's retrospective drug utilization review program works in collaboration with the Pharmacy Benefit Manager (PBM), OptumRx. OptumRx's Retrospective Drug Utilization Review (RDUR) Medication Safety Management and Care Gap Management program focuses on addressing safety, quality of care and cost issues. Both components of this program offer a unique set of options to help guide drug therapy changes, promote evidence-based prescribing, and control healthcare costs. The program includes safety management that targets potentially inappropriate medication patterns across a broad range of drug classes. Claims data is analyzed for concerns including drug-drug, drug-age and drug-disease interactions, therapeutic duplication, dose per day and overutilization of non-controlled medications.

The gaps in care program help close medication gaps for people with chronic diseases. Drawing from evidence-based medicine, claims data is used to identify members with select disease states such as asthma, diabetes and cardiovascular disease. Clinically appropriate medication choices are then recommended to providers to help support members' care.

The actionable data provided by OptumRX's program increases the effectiveness of clinical care by making it easier for pharmacists and physicians to make decisions that improve patient health and safety.

UTILIZATION MANAGEMENT

WHA delegates utilization management (UM) functions to WHA's contracted medical groups/IPAs. Excluded from the UM delegation agreements are the management of member and provider appeals, which are managed by WHA.

UM Criteria and UM Decisions

A description or copy of WHA's current UM criteria for a specific condition can be obtained through your medical group's UM Department or WHA's Clinical Resources Department at 916.563.2274. WHA, at the health plan level, primarily uses current MCG® medical necessity criteria, UpToDate online resources, InformedDNA, and Hayes, Inc. guidelines for experimental/new technology decisions. Criteria, plan benefits, the member's individual circumstances, local delivery system, and the appropriateness of the care or services requested are taken into consideration when making UM decisions. If certain specialty expertise is needed to make a medical necessity decision, some cases are referred for Independent Medical Review from a non-network appropriately qualified board-certified professional. Denials made by WHA or its contracted medical groups/IPAs, are never linked to financial incentives or compensation to the person(s) conducting the review to avoid decisions that might result in over- or underutilization. To ensure consistency, review decisions are evaluated annually. If you have questions about WHA's UM criteria you may email WHA's Chief Medical Officer at k.arif@westernhealth.com.

UM Physician-to-Physician Communication

WHA and its contracted medical groups/IPAs must provide 24-hour/7-day-a-week access to physicians to address UM decisions. During regular business hours, Monday through Friday, 8 a.m. to 5 p.m. (except holidays), physician reviewers are available to discuss denial or appeal decisions with providers. To discuss a decision that was made by WHA, contact WHA's Medical Director or Assistant Medical Director. WHA responds to after-hours messages on the next business day. WHA's Member Services Department may also be contacted regarding UM issues.

ADVANTAGE REFERRAL

With Advantage Referral, eligible enrollees have access to specialists who are outside their own assigned medical group. If a PCP determines that a specialist referral is needed, a member can go to a specialist from among any of WHA's six medical groups. The PCP sends a written referral to her own medical group's Utilization Management department. A referral takes five days to complete for routine requests and 72 hours for an expedited request. Once the referral is processed, the home medical group sends a notification with details of the referral.

Medical Treatment Decisions/Member Participation

Practitioners may freely communicate with their patients about treatment options available to them, including medication treatment options, regardless of the member's benefit coverage and limitations. Members have the right to participate fully in all decisions regarding appropriate and medically necessary treatment regardless of cost or benefit coverage limitations. This includes a discussion of all risks, benefits, and consequences of treatment or non-treatment, and the opportunity to refuse treatment and express preferences about future treatment decisions.

To facilitate greater communication between patients and providers, WHA will:

- Disclose information to the member, upon their request, such as methods of compensation or ownership of or interest in health care facilities that could influence advice or treatment decisions; and
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual language that restricts the ability of health care providers from communicating with or advising their patients about Medically Necessary treatment options.

Experimental and New Technology Assessments

Experimental requests are defined as services, devices, drugs, treatments or procedures that:

- Are outside the usual and customary standard of practice,
- Have not been FDA-approved, or
- Have not yet been proven to be efficacious or safe per valid clinical trials.

Contracted medical groups/IPAs are to refer all requests that might be experimental in nature to WHA's Clinical Resources Department for review and determination. Relevant clinical information and/or records should be included with the request.

WHA uses UpToDate® decision support resources, InformedDNA® Genetic Testing UM Guidelines, and Hayes, Inc., New Technology Assessment criteria to support decisions regarding experimental services. When an individual case requires independent medical

review, Independent Medical Expert Consulting Services, Inc. (IMEDECS), the parent company of Hayes, Inc., conducts the review using board-certified clinical experts who provide an opinion/recommendation based on the treating physician's request, the member's medical condition/circumstances, specialists' expertise, clinical trials and other current scientific evidence/opinions obtained from reliable medical sources. WHA may also use InformedDNA for evaluation of genetic testing requests.

When an experimental request is reviewed at the health plan level, WHA provides the medical group/IPA a determination as to whether the requested service is considered by current criteria/standards to be experimental. If WHA decides a request is experimental, WHA issues the denial letter(s) and states the reason as: "not a covered benefit" and refers the member to the EOC exclusions. Services, devices, treatment and procedures determined by WHA to be experimental are not covered benefits for WHA members.

There are a few rare exceptions where a member may be allowed an experimental service. The following are examples of situations when coverage of an experimental service may be approved:

- A regulatory body requires WHA to provide/cover the service
- The member has undergone every known conventional treatment, or
- The member's condition is life-threatening and there is no other alternative.

If WHA determines the request is not experimental, the medical group/IPA must review the request for medical necessity and will be financially responsible for the services provided. WHA does not make medical necessity determinations on these cases.

For more detailed information about WHA's experimental/new technology assessment processes and requirements and Hayes' ratings, see WHA's UM policies titled: "New Technology Evaluation and New Technology Benefit Assessment" on WHA's website. For general information about Hayes, Inc., visit their website at **hayesinc.com**.

Second Opinions

Second opinions must be provided to members regarding any diagnosis and/or prescribed medical procedures. The contracted medical group/IPA is financially responsible for in-network second opinions while WHA assumes responsibility for approved out-of-network second opinions. If possible, the second opinion is to be arranged with an appropriately qualified health care professional of a like-specialty within WHA's provider network, which includes providers who accept Advantage Referrals in any of WHA's contracted medical groups. If such an individual is not available, providers should submit an out-of-network second opinion request and pertinent clinical records to your medical group's UM Department for physician review. WHA's confidential Medical Management fax number is 916.568.0278. Routine second opinion decisions must be made within five business days of receipt of the request and all required clinical records. Expedited cases must be completed within 72 hours. For more detailed information about the second opinion process and requirements, see WHA's UM policy "Second Opinions" available at **mywha.org/umpolicies**.

Standing Referrals

A Standing Referral allows a member access to a specialist and/or specialty care services from a provider with expertise in treating a medical condition or disease that requires ongoing monitoring. A standing referral will be issued if a PCP determines, in consultation with a specialist or specialty care center and the medical group's Medical Director, that the member needs continuing specialist care. After the standing referral is made, the specialist will be authorized to provide health care services to the member that are within that person's area of expertise and training in the same manner as the member's PCP, subject to the terms of the treatment plan.

The contracted medical group may limit the number of specialist visits or the period of time that the visits are authorized and may require the specialist to provide the PCP regular reports on the health care services provided to the member. The treatment plan should be agreed upon by the PCP, specialist and medical group Medical Director or designee, with the member's approval. To learn more about standing referrals, visit **mywha.org/umpolicies.**

HIV/AIDS Standing Referrals

Specialists in WHA's provider network with specific expertise to treat HIV or AIDS are noted in the provider directory. Determinations regarding the need for a member to receive ongoing care from an HIV/AIDS Specialist will be made within three (3) business days of the date the request is received, or within four (4) business days of receiving the proposed treatment plan (if needed). The member, the PCP, and the HIV/AIDS Specialist will be notified in writing of approval for the standing referral within established decision/notification

time frames and per plan/group UM protocols. To learn more about HIV/AIDS standing referrals, visit **mywha.org/umpolicies.**

VALUE-BASED PERFORMANCE PROGRAM

Value-based Pay for Performance (P4P) Program Summary for Measurement Year 2022 (Medical Group / IPA Payment in 2023)

Program Purpose MY2022: To support and improve WHA's NCQA Commercial Accreditation Stars and WHA's CMS Medicare Advantage Stars Performance through medical group financial incentives linked to performance on select HEDIS measures.

Program Goals

- Improve WHA's NCQA Commercial Accreditation Stars Rating to 4.5 Stars (current rating is 4 Stars)
- Improve WHA's Medicare Advantage Stars Performance to 4 Stars (current rating is 3 Stars)
- Minimize Covered California and CalPERS Quality penalties (for performance <+65th percentile NCQA HEDIS)

Program Overview:

WHA's NCQA Accreditation is determined by NCQA Clinical Quality HEDIS and NCQA CAHPS scores. WHA's MA Stars Rating is determined by CMS HEDIS and MA CAHPS scores. These P4P program measures comprise select HEDIS and CAHPS measures based on WHA's strategic focus for Stars improvement.

To obtain standardized clinical quality measure performance, WHA participates in the Integrated Healthcare Association (IHA) sponsored Aligned Measures Program (AMP) collaborative for the majority of its P4P HEDIS measures. P4P measure scores not included in the AMP program are obtained from WHA's annual NCQA Commercial HEDIS report and MA HEDIS report. Patient Experience measures are obtained through WHA's annual NCQA CAHPS survey and MA CAHPS. Individual measure payout percentage is determined by performance against applicable benchmarks.

- Commercial Program Components
  - 65% weight – Clinical Quality
  - 30% weight – Patient Experience
  - 5% weight – SDOH & Health Equity
  - 10% weight – Stretch Bonus
- Medicare Advantage Program Incentive Goals
  - 100% weight – Clinical Quality

Incentive Calculation Details

Total available incentive amount:

- Commercial = $1.00 pmpm
- Medicare Advantage = $0.25 pmpm

WHA is a regional, not-for-profit, provider-owned health plan therefore a payment contingency will be placed on the total P4P incentive payout as follows:

- 60% guaranteed payment
- 40% contingent on WHA profitability

Individual Measure Payment Method:

- >= 75th percentile = 100% measure incentive
- >= 50th percentile = 50% measure incentive
- <= 49th percentile = 0% measure incentive

Stretch Bonus:

- PCMH/Advanced Primary Care measure may require email confirmation from medical groups to determine related incentive payout amount.

For more detailed information regarding your medical group's priorities and goals related to their participation in the WHA Value-Based P4P program, please contact your Provider Relations/Medical Staff office.

westernhealth
ADVANTAGE

2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833
916.563.2250 | 888.563.2250 toll-free

westernhealth.com/providers