July/August 2026

The pulse

network health

Keeping you in **rhythm** with **provider news** and **updates**

Epic Tapestry Link Implementation LIVE Monday August 10th

Effective Monday August 10, Network Health is implementing Epic Tapestry Link for online authorizations (non-EviCore and non-CCUM), which will be replacing iExchage. If you are requesting an authorization via EviCore or CCUM, you can continue with your current process.

- iExchange will no longer be available as of **Friday, August 7, 2026.**
- Epic Tapestry Link will be available Monday, August 10, 2026, and you may also SSO to EviCore and CCUM via Epic Tapestry Link.
- You must be a registered user of Network Health's provider portal to access Epic Tapestry Link. Please click here and navigate to the **I'm a provider**" tab to register for our provider portal if you are not already a registered user. If you need assistance in registration, please reach out to your provider operations manager.
- As part of the transition to Epic Tapestry Link, we will provide a **14-calendar day** grace period during which providers may continue to submit prior authorization requests. The grace period does not waive prior authorization requirements. Prior authorization is still **required** for all services during this grace period, and standard prior authorization timeframes resume **Friday, August 21, 2026.**
- Prior authorizations that were previously entered in iExchange will be carried over into Epic Tapestry Link.

- **Click here** to access the document **Entering a Referral in Tapestry Link** for step-by-step instructions.

Coming January 1, 2027 - CredentialStream Credentialing Platform

We are excited to announce that Network Health will transition from the ECHO Credentialing System to CredentialStream effective January 1, 2027.

CredentialStream will provide providers and delegated entities with a more streamlined, user-friendly credentialing experience, including enhanced self-service capabilities for online submissions connected to CAQH, simplified document management, improved status visibility, automated notifications, and faster processing of credentialing and recredentialing activities.

Additional information, training resources, and system access details will be shared in the coming months to help ensure a smooth transition. We look forward to delivering a more efficient and transparent credentialing experience for our provider network.

Stay tuned for future communications and implementation updates.

CPT and HCPCS Code Updates

Quarterly, the American Medical Association updates Current Procedural Terminology (CPT) codes and the Centers for Medicare and Medicaid Services updates Healthcare Common Procedure Coding System (HCPCS) codes.
There are new codes that will require prior authorization and these services fall within our current authorization, experimental and/or genetic review processes. You can find a list of all services requiring prior authorization online at www.networkhealth.com.

If you have specific questions regarding a service, please contact our customer service or health management teams for assistance. For more information about authorization requirements, forms or services that require review under the experimental and/or genetic process visit the **Provider Authorization Information** section of our website at www.networkhealth.com

Please forward this information to those within your facility who will need to follow these

processes. For prior authorization requests or questions, contact our population health department Monday through Friday; 8 a.m. to 5 p.m.

They can be reached at 920-720-1602 or 866-709-0019.

Language assistance is available for members or practitioners to discuss utilization management issues. Network Health also offers TDD/TTY services for deaf, hard of hearing or speech-impaired individuals. Anyone needing these services should call 800-947-3529. All callers may leave a message 24 hours a day, seven days a week.

Network Health Behavioral Health Care Managers Support Patients in Need

If your patient has recently been discharged from an inpatient behavioral health unit, he or she should have a follow up appointment with a behavioral health provider within 7 days of discharge for optimum stability of symptoms.

Finding the right behavioral health provider for your patient can make all the difference in the counseling experience, and sometimes it can be challenging to find the right fit.

Does your patient need a psychiatrist for medication management, a psychologist for neuropsychological testing or a therapist for talk therapy? Would he or she prefer a male or female therapist? Does the therapist have special interest and training in the issue your patient wants to address?

Referring your patients to a Network Health care manager is like giving them a personal GPS to navigate the health care system, find providers, explore patients' benefits and offer supportive phone calls between appointments. If patients agree, care managers will collaborate with their primary care doctors and specialists for optimum coordination of their care.

It is key for members to connect with the right providers for treatment plans that best serve members' needs. The care managers stress to members the importance of follow-up appointments with their providers, encourage members to follow through with treatment plans, and help members find additional resources within the community. Network Health care managers may be reached at: 920-720-1340 or 1-800-555-3616.

Supporting Successful Transitions of Care

Care Management provides additional support for members after a hospital or emergency department visit, helping them understand discharge instructions, manage medications, coordinate follow-up care, and connect with community resources.

Referring eligible members before discharge can improve engagement, especially when discharge planners let members know a care manager will be reaching out. Early follow-up with a primary care provider, specialist, or qualified behavioral health provider is a best practice to support recovery and reduce the risk of readmission.

To learn more or refer a member, call 866-709-0019 (TTY 800-947-3529) or visit Network Health Care Management Support.

New Provider / Pharmacy Data Publications Coming Soon!

Network Health Provider / Pharmacy Directories Publication Dashboard and Search Improvements

At Network Health, we are committed to making it easier than ever for our members, providers and pharmacy partners to access accurate, up-to-date information when and where they need it. As part of that commitment, we are excited to introduce significant enhancements to our Provider and Pharmacy Directory experience.

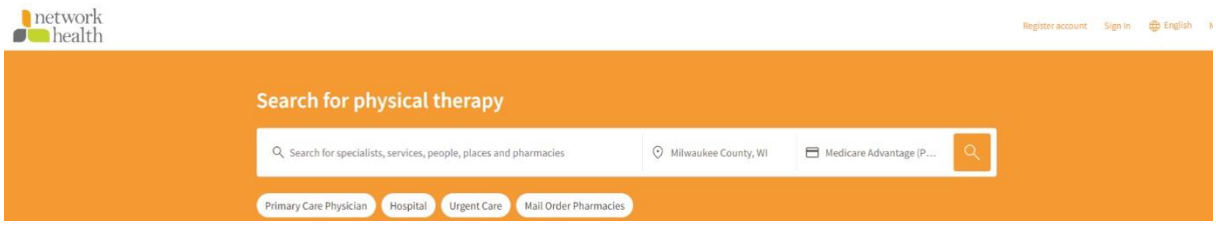
These improvements leverage advanced search technology, conversational AI capabilities, richer provider information and automated nightly updates to deliver a more intuitive, reliable and user-friendly experience. Beginning in 2026, users will benefit from faster, smarter searches, enhanced provider matching, expanded directory data and improved transparency, helping members make more informed healthcare decisions with confidence.

Network Health's provider/pharmacy directories can be found by visiting networkhealth.com and clicking “Find a Doctor” or “Find a Pharmacy” at the top of the webpage.

Improvement / Change

Easier navigation and significant search enhancements (to include a dashboard restructure) (example of new dashboard image is below) including the following.

- Search by provider/pharmacy name
- Specialty search
- Provider/pharmacy type search
- Address/location search
- Mail Order Pharmacy Shortcut
- Advanced filtering capabilities based on provider attributes
- Natural language searching
- Intent-based search results
- Enhanced provider/pharmacy matching
- Improved user interface
- More intuitive member experience



Enhanced Provider Profiles

- Practice information
- Languages spoken
- Appointment location details
- Quality information – NCQA and TJC Indicators
- Network participation
- Clinically Integrated (CI) identifiers

- Visibility into participating provider relationships
- Two Years of Provider Data and Pharmacy Data will now show in the directory for Open Enrollment beginning in September 2026
- Online Scheduling expansion tied to some Network Health's Clinically Integrated Groups
- Automated Provider/Pharmacy Directory Publication
    - Directory updates are published nightly
- Additionally, Network Health is required to participate in the CMS Medicare Plan Finder requirement beginning in mid - 2026.

CMS Medicare Plan Finder (MPF) Provider Directory Requirements

The **CMS Medicare Plan Finder (MPF) Provider Directory requirement** is intended to ensure that Network Health Medicare beneficiaries have access to accurate, current and easily accessible provider directory information when researching and selecting Medicare Advantage plans.

Under CMS requirements, Network Health must maintain and provide access to provider directory information for their contracted provider networks. More recently, CMS expanded these requirements to include both:

- A publicly accessible **Provider Directory URL** and
- A **FHIR-based Provider Directory API Endpoint**, which allows provider directory information to be shared in a standardized digital format.

As part of ongoing provider directory compliance efforts, Network Health is expected to have processes in place to ensure provider directory data is reviewed, updated and published accurately and timely. Today, Network Health's provider directory updates are processed nightly to help maintain current online directory information. We also gather roster updates quarterly to ensure accurate information. CMS places significant emphasis on provider directory accuracy because outdated or incorrect information can:

- Create barriers to care for members.
- Cause confusion about provider participation status.

- Affect member satisfaction and confidence in plan information.
- Lead to compliance findings or corrective actions.

What Is It Used For?

The CMS MPF Provider Directory serves several important purposes:

- For Medicare Beneficiaries
    - Helps members and prospective members identify participating providers within Network Health's network.
    - Allows beneficiaries to evaluate provider access when comparing Medicare Advantage plans.
    - Supports informed healthcare and enrollment decisions.
- For CMS
    - Enables CMS to validate that Network Health maintain accurate and accessible provider network information.
    - Supports transparency and compliance with federal provider directory regulations.
    - Promotes consistency in how provider directory information is shared across health plans.
- For Health Plans
    - Demonstrates compliance with CMS provider directory and interoperability requirements.
    - Improves provider data transparency and accessibility.
    - Supports efforts to maintain accurate provider records and network information.

CMS Medicare Plan Finder (MPF) data when shopping for plans, key dates

October 1, 2026	CMS makes upcoming plan-year information available for preview and comparison on Medicare.gov. Members can begin reviewing

	plans, provider networks and benefits for the following year.
October 15, 2026 – December 7, 2026	Annual Medicare Open Enrollment Period. Beneficiaries actively use the Medicare Plan Finder to compare Medicare Advantage and Part D plans and make enrollment decisions for the next plan year.
January 1, 2027	Coverage selected during Open Enrollment becomes effective and any changes to provider networks, benefits, or costs take effect for members.

Appointment Access Requirements

As a reminder, as part of our NCQA accreditation, our providers must meet the following appointment access times in order for us to maintain our accreditation. Here are the appointment access standards that must be met.

For Primary Care Services

1. Regular or routine care within 60 days of request
2. Urgent care appointment within 48 hours of request

For Specialist Services

1. Care within 30 days of the request
2. Non-life threating, urgent appointment within 48 hours of request

For Behavioral Health Services

1. Non-life-threatening emergency within 6 hours of request
2. Urgent care appointment within 48 hours of request
3. Initial visit for routine care within 10 business days of request
4. Follow up appointment for a routine care visit within 30 days of request

Additionally, you must have an answering service, on-call provider, or message to direct patients to the emergency room for after-hours calls.

Provider Resources for New and Existing Providers

- Member's Rights and Responsibilities
- Prior Authorization Requirements
- Payment Policies and Procedures
- Appointment Access Standards (Network Management policy)
- Population Health Standards and Initiatives
- Pharmacy Formulary and Authorization Requirements
- Credentialing Policies and Procedures You can find all the information here.

MDPP Elevator Speech

Nearly half of American adults aged 65 or older have prediabetes. Without weight loss or routine moderate physical activity, many of them will develop type 2 diabetes within a few years. People with prediabetes are also at higher risk of having a heart attack and stroke. The Medicare Diabetes Prevention Program (MDPP) , offered by Network Health, can help make lasting changes to prevent type 2 diabetes and improve overall health. The program is free for participants who are enrolled in Medicare or Medicare Advantage plans and it is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC). It is backed by years of research showing that program participants aged 60 and older can cut their risk of type 2 diabetes by 71 percent—by losing weight, eating better, and being more active.

Participants will receive a full year of support from a lifestyle coach and peers with similar goals, along with tips and resources for making lasting healthy changes. The program provides weekly 1-hour core sessions for up to 6 months and then monthly sessions for the rest of the year. Participants will also learn how to manage stress, set and achieve realistic goals, stay motivated, and solve problems. Participants may even

be able to manage other conditions like high cholesterol or high blood pressure with fewer medications.

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