July 2021

Practice Manager Meeting

Welcome

Melissa Anderson

Director, Provider Operations

Prior Authorization

Sarah Dencker

Vice President, of Care Services

iExchange

iExchange – Provider Authorization Portal

- Most efficient way to communicate with Network Health and allows us to process your request faster
- Confirmation of requests with tracking numbers
- Ability to provide clinical notes to Network Health
  - Attach documents or provide additional information in the comments section. Utilization management can ask your organization for additional information required to obtain and approve status.
- Ability to print an authorization request confirmation for your patient and your files
- Ability to check the status of requests and avoid duplicate requests
- Single sign-on access to iExchange is available on our provider portal

iExchange

Visit the Medecision website for more information on iExchange

medecision.com/iExchangeProviders/

For additional information or if you have questions, contact Network Health's Utilization Management Department or your provider operations manager.

Master Prior Auth List

In 2020 we launched a master prior auth list by code

Self-help access

- Excel format
- Searchable by CPT/HCPCs code
- Separated by line of business

It’s located in the provider resources section of networkhealth.com titled Authorization Lists by Code

2021 Prior Authorization Changes

- Effective June 1, 2021 Network Health expanded services with eviCore Healthcare to include the following
  - Outpatient Physical and Occupational Therapy for all lines of business
- Effective July 1, 2021 Network Health expanded services with eviCore to include the following
  - Gastroenterology (EGDs, capsule endoscopy and non-preventive colonoscopy)
- Program resources are located at

  evicore.com/resources/healthplan/network-health-wisconsin

  Resources include code lists, FAQ and Q&A documents, as well as access to the clinical criteria used by eviCore

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Pharmacy

Ted Regalia

Vice President, Pharmacy Benefit

Content

- Appeals
- Provider Disputes
- Care Continuum (Medical Drug) Step Therapies
- Oncology (Medical Drug) Step Therapies
- Real Time Benefit Analysis Tools
- Network Health Pharmacist Access
- Q & A

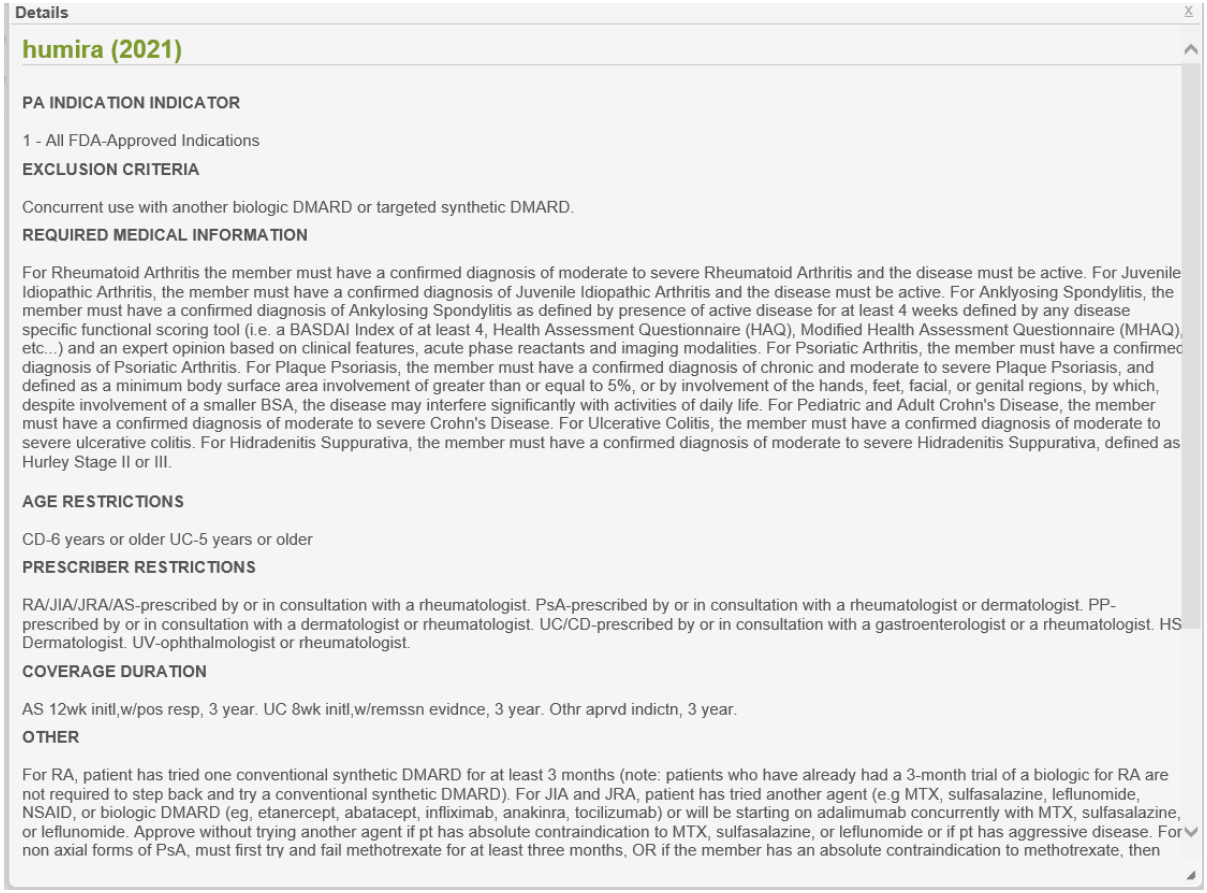
Appeals

- Approximately 75 percent of appeals are preventable
  - Missing information
  - Erroneous answers to electronic Prior Authorization (ePA) such as CoverMyMeds
  - Untimely provision of information if contacted

- Prior authorization criteria online for Part D and commercial (see next slide).

Example of Prior Auth Criteria Online

networkhealth.com/look-up-medications



Details

humira (2021)

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

EXCLUSION CRITERIA

Concurrent use with another biologic DMARD or targeted synthetic DMARD.

REQUIRED MEDICAL INFORMATION

For Rheumatoid Arthritis the member must have a confirmed diagnosis of moderate to severe Rheumatoid Arthritis and the disease must be active. For Juvenile Idiopathic Arthritis, the member must have a confirmed diagnosis of Juvenile Idiopathic Arthritis and the disease must be active. For Anklyosing Spondylitis, the member must have a confirmed diagnosis of Ankylosing Spondylitis as defined by presence of active disease for at least 4 weeks defined by any disease specific functional scoring tool (i.e. a BASDAI Index of at least 4, Health Assessment Questionnaire (HAQ), Modified Health Assessment Questionnaire (MHAQ), etc...) and an expert opinion based on clinical features, acute phase reactants and imaging modalities. For Psoriatic Arthritis, the member must have a confirmed diagnosis of Psoriatic Arthritis. For Plaque Psoriasis, the member must have a confirmed diagnosis of chronic and moderate to severe Plaque Psoriasis, and defined as a minimum body surface area involvement of greater than or equal to 5%, or by involvement of the hands, feet, facial, or genital regions, by which, despite involvement of a smaller BSA, the disease may interfere significantly with activities of daily life. For Pediatric and Adult Crohn's Disease, the member must have a confirmed diagnosis of moderate to severe Crohn's Disease. For Ulcerative Colitis, the member must have a confirmed diagnosis of moderate to severe ulcerative colitis. For Hidradenitis Suppurativa, the member must have a confirmed diagnosis of moderate to severe Hidradenitis Suppurativa, defined as Hurley Stage II or III.

AGE RESTRICTIONS

CD-6 years or older UC-5 years or older

PRESCRIBER RESTRICTIONS

RA/JIA/JRA/AS-prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist. PP-prescribed by or in consultation with a dermatologist or rheumatologist. UC/CD-prescribed by or in consultation with a gastroenterologist or a rheumatologist. HS Dermatologist. UV-ophthalmologist or rheumatologist.

COVERAGE DURATION

AS 12wk initl,w/pos resp, 3 year. UC 8wk initl,w/remssn evidnce, 3 year. Othr aprvd indictn, 3 year.

OTHER

For RA, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). For JIA and JRA, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. For non axial forms of PsA, must first try and fail methotrexate for at least three months, OR if the member has an absolute contraindication to methotrexate, then

Provider Disputes on Medical Drug Claims

- Top reasons for disputes
  - Failure to get pre-determination or prior authorization
    - Retrospective medical necessity review performed on all items that require pre-determination or prior authorization
  - Dose Change in middle of authorization period
    - We provide 10 percent variance for weight changes
  - Failure to use “JW” modifier code to denote waste

- Contact me by secure email if assistance is needed
  - tregalia@networkhealth.com

Care Continuum Step Therapies

CARECONTINUUM

DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	STEP THERAPY REQUIREMENTS	LINE OF BUSINESS
Colony Stimulating Factors – filgrastims*	Nivestym Zarxio	Neupogen Granix	Use of 1 of the preferred drugs before non-preferred drug	C, E, MA
Erythroid Stimulating Agents*	Procrit Retacrit	Aranesp Epogen Mircera	Use of 1 of the preferred drugs before non-preferred drug	C, E, MA
Hyaluronic Acid Derivatives	Euflexxa Monovisc Orthovisc	Durolane Gel-One Gelsyn-3 GenVisc 850 Hyalgan Hymovis Synvisc Synvisc One Synojoynt Supartz FX Triluron TriVisc Visco-3	Use of 1 of the preferred drugs before non-preferred drug	C, E
Immunologicals	Fasenra Nucala	Cinqair	Use of 1 of the preferred drugs before non-preferred drug	C, E, MA

eviCore Step Therapies

Preferred Agents	Non-Preferred Agents	Step Therapy Requirements
Ruxience or Truxima	Rituxan or Rituxan Hyclea	Continuation of therapy (within past 180 days) or trial and failure or contraindication to preferred agents.
Mvasi or Zirabev	Avastin	Continuation of therapy (past 180 days) or trial and failure or contraindication to preferred agents.
Ogivri or Trazimera	Herceptin, Herceptin Hylecta, Herzuma, Kanjinti	Continuation of therapy (past 180 days) or trial and failure or contraindication to preferred agents.
Zarxio or Nivestym	Neupogen or Granix	Continuation of therapy (within past 180 days) or trial and failure or contraindication to preferred agents.

Real Time Benefits Tools Benefits for All

RTPB Improves the ePrescribing Experience

Patient

Reduces sticker shock, increases savings and speed to treatment

Provider

Increases access to information and provider productivity

Plan

Lower costs, higher-performing benefit designs, higher net promoter scores

Pharmacy

Increases savings for plan and member due to pharmacy alternatives

"Allows me to give my patient an expectation of what they will pay which helps to impact them immediately. Saves me time and them money."

Clinical Pharmacist Access

- Monday–Friday, 8 a.m. to 5 p.m.
- 920-720-1287 or 888-665-1246
- pharmacist@networkhealth.com
- Case management
- Medication costs and manufacturer assistance
- Formulary
- Prior authorization
- Clinical inquiry

Family Savings Plan™

Anne Roeder

Client Implementation Executive

What is Network Health's Family Savings Plan (FSP)?

- The Network Health FSP is a medical and prescription drug reimbursement plan providing members 100 percent reimbursement for eligible out-of-pocket health care expenses (copayments, coinsurance and deductibles).
- FSP is funded by the employer for participants who are eligible under their spouse's employer insurance plan

Network Health's FSP Partner

Network Health has partnered with Catilize Health to administer this plan.

Please note, the medical and drug reimbursement is funded by the member's employer.

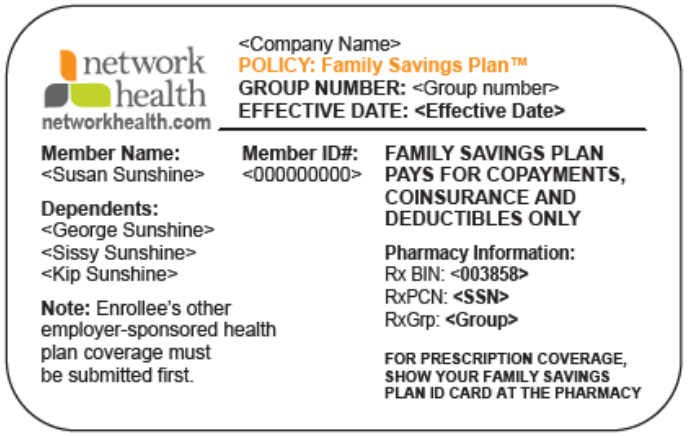
This plan benefits providers by reducing collections of out-of-pocket costs from patients, as the payment will be issued directly to providers by Catilize Health.

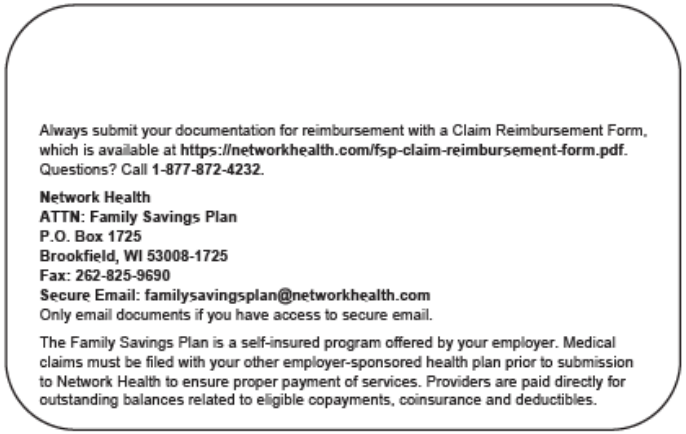
What Participants Need to Show at Time of Medical Visit

Participants will present two different insurance cards at the time of their medical visit.

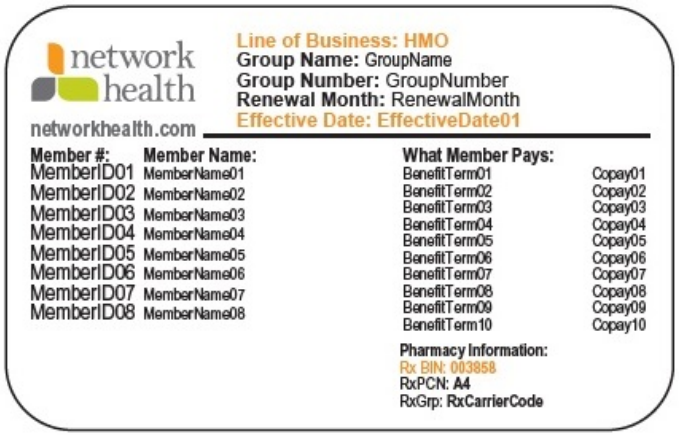
- Primary insurance ID card (spouse's insurance carrier)
- Family Savings Plan™ ID card

Difference Between ID Cards





Network Health
FSP ID Card



Network Health
Commercial ID Card

How Providers Bill for Services

1. Providers send the claim to the primary insurance.

2. Providers bill Network Health for remaining out-of-pocket costs.

Ways to Submit a Claim

There are three ways our providers can submit a claim for FSP reimbursement.

- **Mail** – Network Health
  Attn: Family Savings Plan
  PO Box 1725
  Brookfield, WI 53008-1725
- **Fax** – 262-825-9690
- **Secure Email** – familysavingsplan@networkhealth.com

We are working on enhancements to the FSP program to allow for electronic submissions in the future.

What Is Needed for Medical Claims Reimbursement

- All claims should be submitted on an HCFA-1500 or UB-04 form.
  - When the HCFA-1500 claim or UB-04 form is submitted to FSP as a secondary;
    - It is imperative to include the EOB from the primary payer.
    - If we do not have the EOB from the primary payer, the claim will be denied until it is submitted to Network Health.
  - If you do not submit the EOB along with the claim and receive a denial informing you the EOB is needed, please **re-submit both the claim and the EOB** together for Network Health to process.

What Is Needed for Medical Claims Reimbursement

- In order to reimburse the provider directly for members on our FSP plans, our partner Catilize Health requires we have a current W9 on file.
  - If we do not have a current W9, Catilize Health or Network Health will reach out to the provider to obtain a current W9.
- Catilize Health processes and pays providers directly for copayments, coinsurance and deductibles.

Lines of Business/Products Included In FSP

- The following Network Health insurance plans are included in FSP
  - Fully insured plans
  - Self-insured plans
- The following Network Health insurance plans ARE NOT included in FSP
  - Medicare plans
  - ACA/Marketplace plans
  - State of Wisconsin Group Health Insurance Program plans

Questions Regarding Claims

For claims questions, please contact Network Health's FSP team.

- Call-262-825-9665
- Email–familysavingsplan@networkhealth.com

Provider Directory Update

Jennifer Delebreau

Director of Provider Integration

Provider Directory API Requirement Using NPPES NPI Provider Data

New CMS Interoperability Rules

Begin updating NPPES provider data

- Help maintain accuracy of provider directories
- Ensures compliance with the Provider Directory API rule
- NPPES allows providers to attest to accuracy of their NPI data
    - When the provider requests any change to the NPI record, the provider will be able to attest to changed NPI data, resulting in updated certification date within the NPPES database

Provider Directory API Requirement Using NPPES NPI Provider Data

New CMS Interoperability Rules

Access the NPPES webpage data nppes.cms.hhs.gov

- Update and/or attest to your provider data quarterly
- Imperative to ensuring provider directory accuracy
- Meet the new CMS Provider Directory API requirements

No Surprise Act Requirements

- Plans must establish a provider directory verification process and establish a procedure for removing providers or facilities with unverifiable information
  - **JANUARY 1, 2022**
- Not less than once every 90 days, plans must verify and update their provider directory database
  - **90 DAYS**
- Plans will be required to update their directory database within two business days of receiving a provider update

Other Housekeeping Items

- Reminder for quarterly roster submission
  - Provider informatics department representative reaching out quarterly with your organization's roster
  - Review the roster information and return within 10 business days
  - Complete at least quarterly
  - Email provinfo@networkhealth.com with changes
  - Ensures regulatory compliance with NCQA and CMS
  - Contractual requirement of agreement with Network Health
- Telemedicine
  - Will begin to track and monitor providers performing telemedicine
  - Information should be reflected and updated during quarter roster review

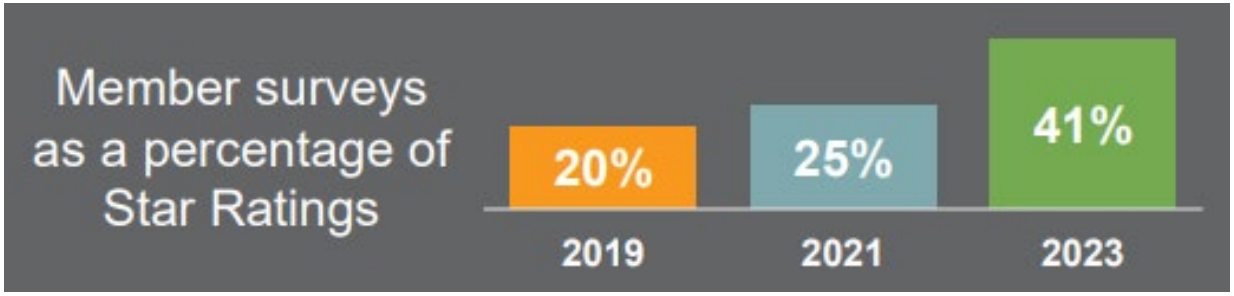
Quality Health Integration and Member Experience

Nancy Weber

Clinical Integration Program Manager

Member Perception
Why is it Important?

- For the 2021 CMS Star Rating, member experience measures were weighted a two
- For the 2023 CMS Star Rating, some measure **weights increase to four**, increases the impact of "member experience" with health plan and provider services on Star Ratings significantly



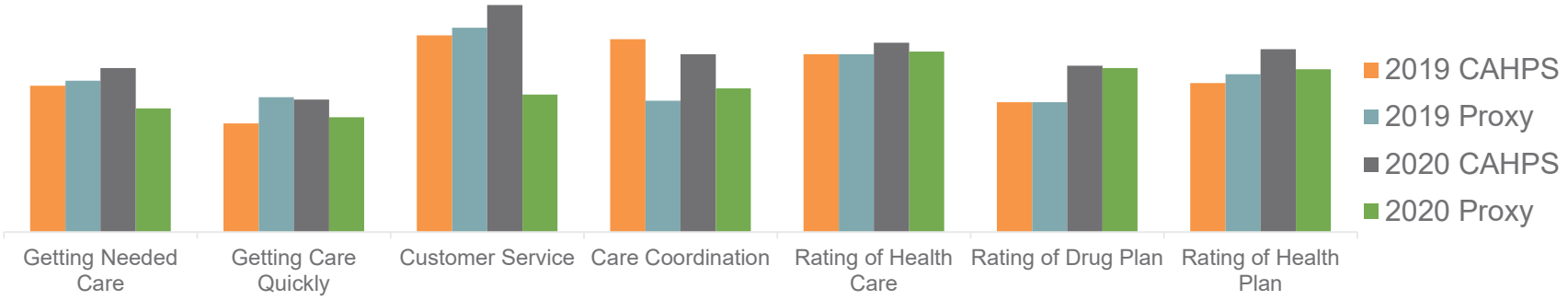
- Commercial member satisfaction is a component of the ETF (State of Wisconsin) quality rating as well
- **How providers and health plans engage and interact with their patients and members can greatly impact member satisfaction, retention, and overall health**

Medicare CAHPS® Scores

Consumer Assessment of Healthcare Provider and Systems (CAHPS)

*Medicare rates are based on the scaled mean score. Scaled Mean Score is the average score converted to a 100-pt scale.

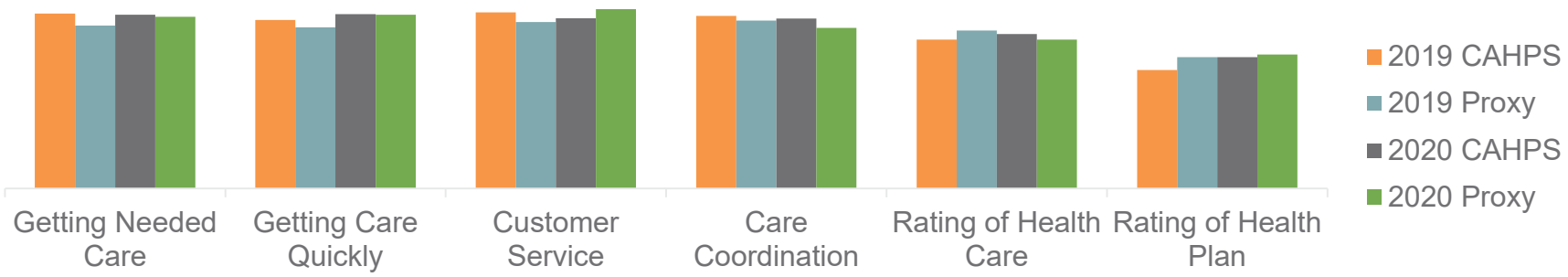
Survey Measures	2019 CAHPS	2019 Proxy	2020 CAHPS	2020 Proxy	Trend 2020 CAHPS vs 2020 Proxy
Getting Needed Care	86.6	88.2	88.0	84.8	↓
Getting Care Quickly	83.6	86.5	85.5	84.1	↓
Customer Service	90.6	91.4	93.0	85.9	↓
Care Coordination	90.1	86.9	89.1	86.4	↓
Rating of Health Care	89.1	90.0	90.0	89.3	→
Rating of Drug Plan	85.3	86.6	88.2	88.0	→
Rating of Health Plan	86.8	86.2	89.5	87.9	↓



Commercial CAHPS Scores

*Commercial Rates are based on summary rate scores. NCQA defines them as generally the most favorable response percentages.

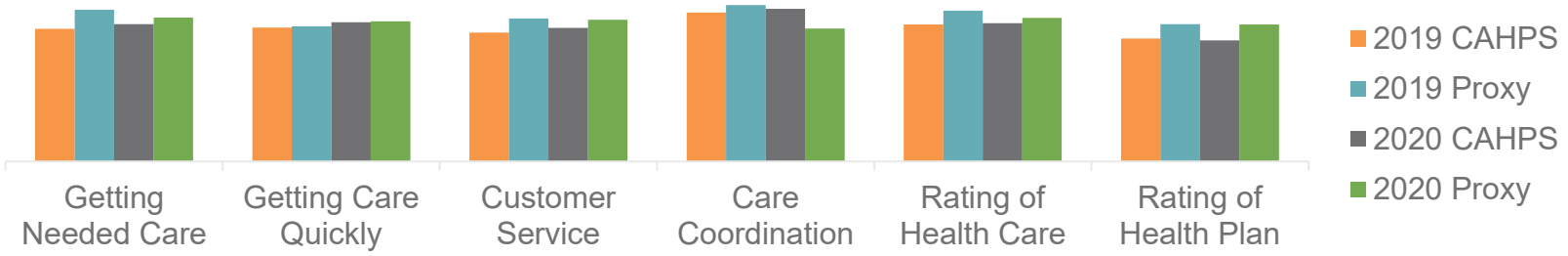
Survey Measures	2019 CAHPS	2019 Proxy	2020 CAHPS	2020 Proxy	Trend 2020 CAHPS vs 2020 Proxy
Getting Needed Care	89.5	89.2	88.9	87.8	↓
Getting Care Quickly	86.2	88.2	89.1	88.9	→
Customer Service	90.0	85.4	87.1	91.7	↑
Care Coordination	88.3	85.9	86.9	82.1	↓
Rating of Health Care	76.7	80.8	79.0	76.1	↓
Rating of Health Plan	60.5	67.1	67.1	68.5	↑



Marketplace Enrollee Experience Scores

*Marketplace rates are based on the scaled mean score. Scaled Mean Score is the average score converted to a 100-pt scale.

Survey Measures	2019 CAHPS	2019 Proxy	2020 CAHPS	2020 Proxy	Trend 2020 CAHPS vs 2020 Proxy
Getting Needed Care	77.0	88.1	79.7	83.6	↑
Getting Care Quickly	77.8	78.4	80.9	81.3	→
Customer Service	74.9	79.5	77.6	82.2	↑
Care Coordination	88.9	90.8	88.6	81.5	↓
Rating of Health Care	79.6	87.5	80.2	83.4	↑
Rating of Health Plan	71.3	79.7	70.3	79.5	↑



Influencing Member Perception

Encourage your staff to use phrases such as *we are running on time* and *thank you for being early* to reduce the potential for patients to get frustrated waiting for their appointment.

KEY TERMS AND PHRASES

Use the key terms and phrases below whenever possible, where it makes sense.

- Annual flu shot
- Appreciate
- Assistance to manage care
- Cares about you
- Coordination of care
- Customer service
- Ease of getting care
- Ease of filling out forms
- Easy to do business with
- Encourages relationship with your personal doctor
- Follow-up care done
- Get needed care right away
- Getting needed prescription drugs
- Help
- Help navigating health care
- Important
- Improve
- Improve/maintain mental health
- Improve/maintain physical health
- Improving bladder control
- Informed
- Listened
- Listen and learn from our surveys and member feedback
- Maintain
- Manage care
- Necessary appointments
- Pain
- Personal doctor
- Physical activity
- Prescription drug cost savings
- Provides connection between your personal doctor and specialists
- Responsive
- Risk of falling
- Talked about prescription meds
- Treat with courtesy and respect
- Understand
- Wait time

Network Health's brand proposition is to bring value to our member relationships and make health insurance easy to understand. Our no-jargon approach contributes to our NCQA annual ratings and overall success as an organization. 2862-02b-0120

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Influencing Member Perception

- We have materials to hand out to your staff or post in your clinics.
- We can co-brand
- This type of messaging during patient care visits is important.

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Net Promoter Score-
Good Range

NPS Ranges	
World Class	76 to 100
Excellent	51 to 75
Good	1 to 50
Bad	-49 to 0
Very Bad	-100 to -50

Network Health Medicare Advantage Plans

62*

Good

Apple
47

Excellent

Intel
52

World Class

Starbucks
77

Costco
79

2021 NPS Fortune 1000: https://customer.guru/net-promoter-score/fortune-500

*NPS weighted based on membership by provider system

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Highly Recommended
(Net Promoter Score)

- Asks members — would you recommend Network Health to your family and friends?
- Answer measures customer satisfaction and loyalty and predicts growth
- Organizations with a NPS higher than their competitors tend to grow faster and experience greater success

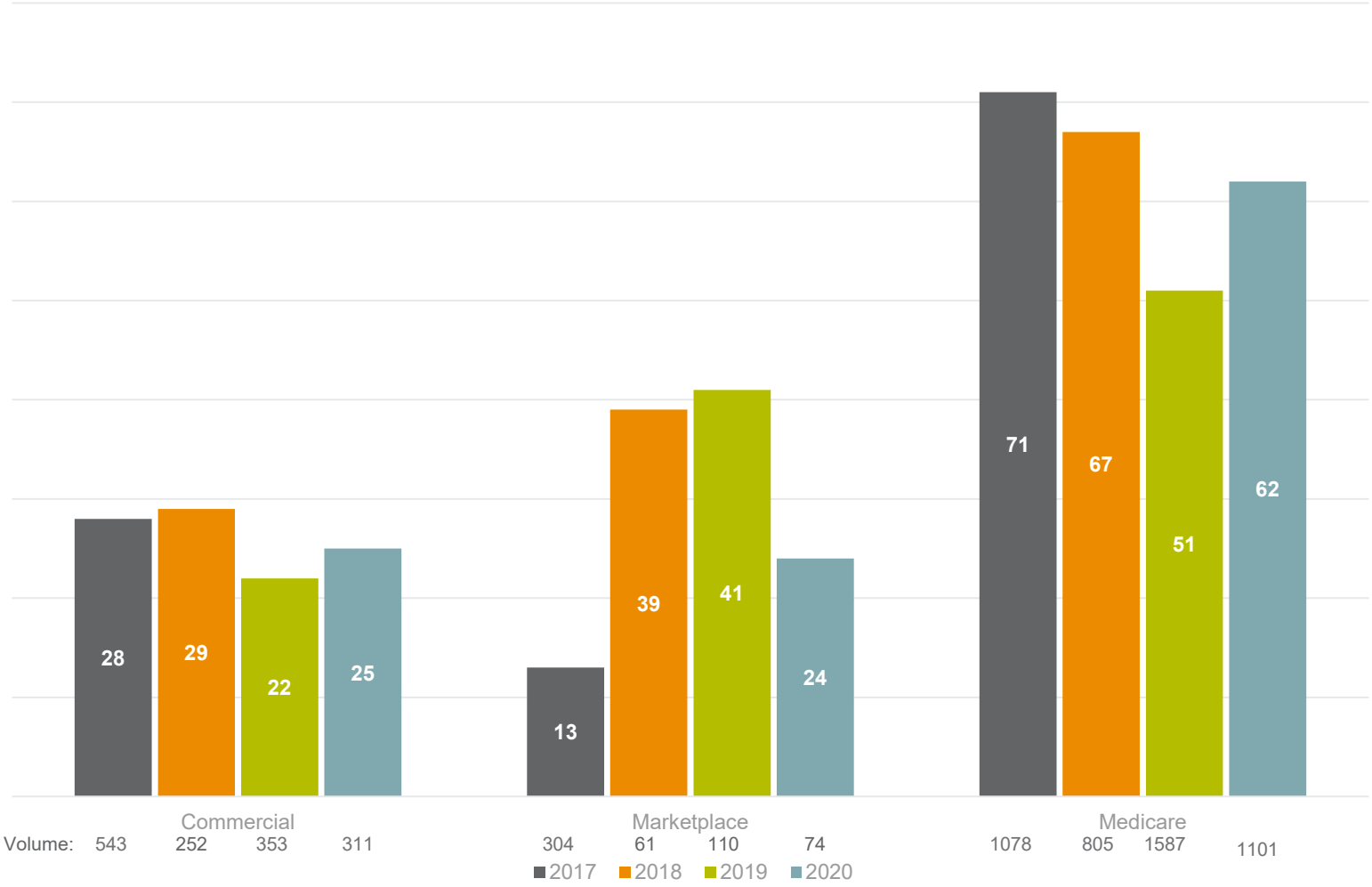
Health Plan Net Promoter Score Comparison for Commercial and Medicare Combined	
Plan	**NPS**
Network Health	**49***
Humana	32
Anthem	16
Aetna	16
United Health Group	1
Cigna	-5

*NPS weighted based on membership by provider system

- 2020 Health Plan Industry Avg. NPS: **17**
- 2020 Health Plan Industry Promoters: **39**

2020 ClearlyRated benchmark; https://www.clearlyrated.com/solutions/2020-insurance-nps-benchmarks/
Competitor 2021 NPS: https://customer.guru/net-promoter-score/industry/health-care-insurance-and-managed-care
https://customer.guru/net-promoter-score/humana

NPS by Year



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Complete and Accurate Clinical Documentation

- Un-coded chronic conditions lead to artificially low risk scores
  - Result in insufficient reimbursement to cover costs of care for members
- Clinical documentation represents a member's health status as a complete picture
  - Exposing gaps in preventive services and chronic health needs that may require evaluation and treatment
- Updated and accurate EMR **Problem List**, as well as documentation to address coding and quality best practice alerts
  - Document the **presence of the condition** and **indicate an assessment and/or plan** for management of the condition

Complete and Accurate Clinical Documentation

- We support physicians focusing on what you do best- providing excellent patient care
- When the overall health status of patients are identified, we all can positively impact the quality and affordability of health care