Health*matters* MD

HealthPlan OF SAN MATEO
Healthy is for everyone

SUMMER 2018

Help HPSM Test Our New Provider Portal

In June, HPSM launched our new-and-improved website: check it out at **hpsm.org**. The next phase of our website revamp is expanding the Provider Portal to be a one-stop shop for more self-service tools. Right now, you can check claim status, submit claims, view your remittance advice, search our provider directory and verify member eligibility online. HPSM is currently working to rebuild these tools in a central, easier-to-use interface. We're also adding the ability to view the status of prior authorization and referral requests, as well as submit referrals and authorizations online.

Before we launch our new portal, we would love to have your feedback on what features and functionality would be most helpful to you. You can provide feedback by signing up to be an early tester of the portal. We're eager to hear your ideas about how we can better support you with our website and online tools.

To sign up to be an early tester of HPSM's new Provider Portal, contact Provider Services at **psinquiries@hpsm.org**. Provider testing will start in September.

Have Questions About Your Prop 56 "Tobacco Tax" Incentive Payments?

In the May 2018 issue of *HealthMatters MD*, we explained that the passage of Proposition 56 (the California Healthcare, Research and Prevention Tobacco Tax Act of 2016) set aside funds for statewide nicotine cessation programs. This included supplemental payments for eligible physicians who serve Medi-Cal beneficiaries and provided qualified services between July 1, 2017 and June 30, 2018.* Payments are based on submission of the following CPT-4 codes to HPSM, so we encourage you to submit your claims or encounters in a timely manner:

CPT-4 code	Supplemental payment
90863	$5
99201, 99211	$10
99202, 99212, 99213	$15
99203, 99204, 99214, 99215	$25
90791, 90792	$35
99205	$50

If your group or practice receives these supplemental payments, please carefully review the report included with your payment. It will list the rendering providers who delivered the qualifying services so that you may distribute payment accordingly.

For more information about Prop 56 incentive payments:

- Read the DHCS notice about Proposition 56 Supplemental Payment for Physician Services at **files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_26581.asp**
- For other questions, call HPSM's Claims Department at **650-616-2056**

** Services rendered in a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Cost-Based Reimbursement Clinic (CBRC) or Indian Heath Setting (IHS) are not eligible.*

Tell Your 65+ Patients about CareAdvantage

HPSM's CalMediConnect plan benefits patients and providers

As a doctor, your patients respect your expertise and trust your advice about what's best for their health. If you treat people who have both Medicare and Medi-Cal, HPSM's CareAdvantage Cal MediConnect (CMC) program may be their best health care option. It features valuable benefits for members *and* providers:

You get

- Reimbursement rates starting at 80% of the Medicare fee schedule plus 10% of the Medi-Cal fee schedule
- No annual deductible from your claim payments
- No referrals required for outpatient services
- One local phone number and one place to submit claims

Members get

- CareAdvantage Navigators who guide them through the health care system
- Unlimited taxi rides to medical appointments
- No co-pays for medical, preventative, mental health and hospital services
- No to low co-pays for prescription drugs

See more benefits at **hpsm.org/enroll**

Call **1-888-252-3153** or **650-616-1500** to:

- Refer a patient to CareAdvantage
- Have CareAdvantage brochures delivered to your office

The Importance of New Enrollee Initial Health Assessments (IHAs)

HPSM complies fully with the California state mandate requiring that all new members receive an Initial Health Assessment (IHA) within 120 days of enrolling with HPSM. The IHA is a comprehensive assessment that captures each patient's health history and current physical/mental health status. Where age appropriate, it may include a developmental exam, treatment plan, preventative services and the Staying Healthy Assessment (SHA), which helps identify high-risk behaviors and health education needs.

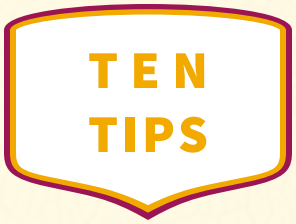
It is important to perform IHAs in a timely manner with new patients to get baseline information about their health. This enables you to prescribe effective interventions and track patient progress over time. That is why HPSM rewards providers for conducting high-quality IHAs through our pay-for-performance (P4P) programs.

- Providers participating in the fee-for-service P4P program (the Track 1 or Track 2 Medi-Cal primary care payment model) qualify for a $90 bonus payment each time they complete a new enrollee IHA and submit the claim to HPSM
- Providers participating in the benchmark P4P program (the Track 3 Medi-Cal primary care payment model) receive credit towards their total quality score and an annual bonus payment each time they complete a new enrollee IHA and submit the claim to HPSM

For full details on the billing guidelines for both P4P programs, visit **hpsm.org/p4p**.

Ten Tips for Communicating with Patients with Disabilities

People with disabilities want to be treated with the same respect as anyone else. Understanding how patients with disabilities want to be treated will help you and your office staff provide them with quality care in both the waiting room and the exam room. Here are ten tips that cover the basics of communicating with people with disabilities.



1 **Speak directly to the person** rather than through a family member, friend, language or sign language interpreter who may be present.

2 **Offer to shake hands when introduced.** People with limited hand use or an artificial limb can usually shake hands. Offering your left hand is an acceptable greeting.

3 **When meeting someone with a visual disability, always identify yourself** and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.

4 **If you offer assistance, wait until your offer is accepted.** Then listen or ask for instructions.

5 **Treat adults as adults.** Address people with disabilities by their first names only when extending the same familiarity to all others. Never patronize people in wheelchairs by patting them on the head or shoulder.

6 **Do not lean against or hang on someone's wheelchair.** Bear in mind that people with disabilities treat their chairs as extensions of their bodies.

7 **Listen attentively when talking with people who have difficulty speaking** and wait for them to finish. If necessary, ask short questions that require short answers or a nod of the head. Never pretend to understand; instead, repeat what you have understood and allow the person to respond.

8 **When speaking with someone in a wheelchair or on crutches**, place yourself at eye level by sitting or crouching.

9 **Get the attention of a person who has a hearing disability** by tapping them on the shoulder or waving your hand. Look directly at the person and speak clearly, slowly and expressively to establish if the person can read your lips. If you can, try to face the light source and keep hands, food and other distractions away from your mouth when speaking.

- If the person is wearing a hearing aid, don't assume they have the ability to discriminate your speaking voice from background noise.
- Never shout at a person. Just speak in a normal tone of voice.

10 **Relax.** Don't be embarrassed if you happen to use common expressions such as "see you later" or "did you hear about this?" that seem to relate to a person's disability.

These tips were adapted from many sources as a public service by the United Cerebral Palsy Association, Inc. (UCPA). UCPA's version was updated by Irene M. Ward & Associates (Columbus, OH) as a public service and to provide the most current language possible for its video entitled *The Ten Commandments of Communicating with People with Disabilities*.

New Pilot Supports Post-Acute Health Outcomes

Numerous studies have demonstrated the importance of post-acute care following hospitalization. That's because post-acute care providers play a critical role in promoting recovery and preventing relapse, whether in a skilled nursing facility, long-term care facility or a member's home. To support health outcomes for members in these care settings, HPSM launched the **Post-Acute Care Pilot (PACP)** in June. The pilot has three main goals:

1. Increase coordination between care settings, especially for our most complex members who are eligible for home-based care
2. Reduce readmissions to the hospital
3. Invest in additional post-acute care capacity

To launch the Post-Acute Care Pilot, HPSM is partnering with Landmark Health providers to care for our members at six facilities (see "Availability" below). These providers will also deliver home-based care for these patients for 45 days after they leave the nursing facility. Landmark currently provides home-based services for many of our most complex members, which positions them well to increase care continuity between post-acute settings and the community.

How the Post-Acute Care Pilot works

Eligibility All HPSM members who have CareAdvantage or Medi-Cal only (with no other health coverage) are eligible for the PACP.

Availability The PACP is currently offered at six facilities: Burlingame Long-Term Care, Millbrae Skilled Care, Peninsula Post-Acute, Providence San Bruno, St. Francis Heights and St. Francis Pavilion.

Credentials Landmark's provider team currently consists of Dr. David Portier and Laurensia Widyastami, a nurse practitioner. Both have extensive training and experience caring for the elderly. Dr. Portier is a member of the Society for Post-Acute and Long-Term Medicine (PALTC), and is a certified medical director through that organization.

Participation All new admissions to the six participating facilities will be assigned to Dr. Portier, as will any long-term care residents whose care complexity qualifies them for the HomeAdvantage program. Members may choose to opt out of the PACP if they wish to be seen by a different provider.

Landmark providers Dr. David Portier and Laurensia Widyastami, nurse practitioner, provide post-acute care

Duration Post-acute care begins with the member's arrival at a nursing facility. Post-discharge, Landmark providers visit the member at their home for 45 days to check in on their health and provide home-based care as needed.

Care Coordination Hospital discharge staff, care coaches and post-acute facility administrators continue coordinating with the member's assigned PCP.

Quality Assurance HPSM medical directors maintain clinical quality oversight of the PACP, including monitoring quality measures and reviewing clinical concerns.

If you have questions about how the Post-Acute Care Program can help your patients, please call Provider Services at **650-616-2106**.

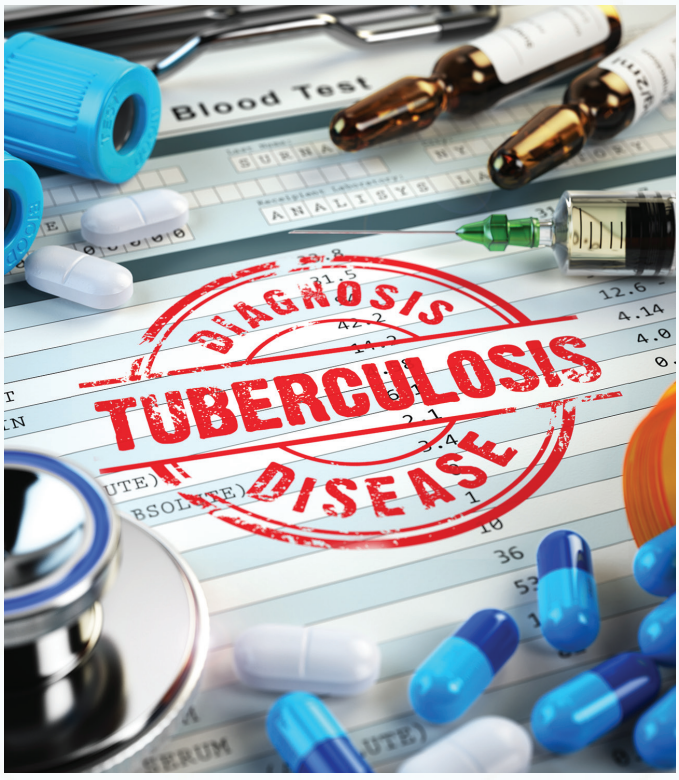
Remember to Screen for TB

The results of HPSM's medical record reviews show that providers are not screening frequently enough for tuberculosis (TB). So here is a reminder about the importance of screening all patients for TB, and doing skin and blood tests on those with identified risk factors.

Screening

- You can perform a **TB risk assessment for adults** by answering just three questions
- Perform a **Pediatric TB Risk Assessment** on every pediatric patient during routine well-child visits — especially all new patients, those that may have been exposed after a trip, those with a new risk factor and immunosuppressed children

Download the California Department of Public Health's adult and pediatric risk assessment tools by clicking the hyperlinks above.



Testing

- The United States Preventive Services Task Force recommends testing patients for TB who:
  - Were born or lived in any country with an elevated tuberculosis rate
  - Live or have lived in homeless shelters and correctional facilities
- Prioritize TB testing for patients with:
  - Diabetes, ESRD, leukemia, lymphoma, silicosis, head or neck cancer, gastrectomy or chronic malabsorption
  - A body mass index lower than 20
  - A history of a chest x-rays suggesting previous or inactive TB
- Evaluate patients with the following TB symptoms (if unexplained): cough for more than 2-3 weeks, fever, night sweats, weight loss and/or hemoptysis
- People who volunteer or work in a health care setting may require annual testing

If a patient tests positive for TB and refuses treatment, you must document this in the patient's medical record.

Repeat screening eight weeks after a patient:

- Returns from a country with an elevated TB rate
- Moves to a homeless shelter or
- Is diagnosed with head cancer

Whooping Cough is Rising — Vaccinate Your Patients

In 2017, 2,925 Californians contracted pertussis (whooping cough) — a 51 percent increase compared to 2016. This highly contagious bacterial infection is especially dangerous for babies under six months old: sometimes even fatal.

With pertussis cases on the rise nationwide, it's more important than ever to vaccinate your patients at the appropriate times. Here are the basic pertussis vaccination guidelines.

Children

- You can administer the DTaP vaccine series to infants starting at six weeks old
- Children should receive a total of five DTaP doses administered at the following times:
  1. Two months old
  2. Four months old
  3. Six months old
  4. Between 15 and 18 months old
  5. Between four and six years old
- The state of California also mandates that students receive a pertussis booster vaccine on or after their seventh birthday before entering or advancing to grades seven through twelve

Adolescents

- Adolescents should receive one dose of Tdap between the ages of 11 and 12

Pregnant women

- Pregnant women can receive a Tdap vaccine during their third trimester of every pregnancy to protect newborns

Patients of all ages

- Tdap can be administered to patients with the following medical conditions if the benefits outweigh the risks:
  - A moderate/severe acute illness with or without fever
  - Had Guillain-Barré syndrome (GBS) within six weeks after a previous dose of tetanus toxoid-containing vaccine
  - A history of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine

Encourage Your Colleagues to Join HPSM's Provider Network

HPSM's provider network is more than 5,000 PCPs and Specialty Care Providers strong. But we're always looking to expand it to better serve our members' diverse medical and geographical needs. If you know qualified clinicians in San Mateo County who are certified for Medi-Cal and/or Medicare, please encourage them to apply to HPSM's provider network. We especially want to recruit clinicians and office staff who speak Spanish, Tagalog, Mandarin and Cantonese.

As a contracted HPSM provider, you know the benefits of being in our network. Contracted providers receive better rates and the opportunity for bonus payments through our Specialists Incentive and pay-for-performance programs. Please recommend HPSM to your colleagues so they can enjoy these advantages while providing health care to our community's most underserved residents.

Apply to HPSM's network by contacting Provider Services

- **833-694-7761**
- **psinquiries@hpsm.org**

Reminder: Annual Advance Care Planning Requirement

Advance care planning (ACP) defines how someone wants to be treated in a life-threatening medical situation and who should make decisions about their care if they cannot. HPSM requires PCPs to discuss ACP with members 18 years and older annually until a plan is completed. We require this because having a legally binding end-of-life plan in place helps people and their families cope better during one of life's most stressful challenges.

HPSM's ACP requirement

You may need to have multiple conversations with a patient before they complete an ACP. But PCPs must document one of the following in each adult patient's medical record:

1. An ACP discussion between provider and patient with the date it occurred (repeat every year until the member has a plan in place)
2. The member completed an advance care plan before they started treatment with you
3. The member completed an advance care plan after they started treatment with you

What does not meet HPSM's requirement

- Merely asking a patient if an advance care plan is in place and the member saying no
- Only providing the patient with ACP materials

Types of advance care plans

- **Advance directive:** Documents the patient's treatment preferences and the designation of a surrogate who can make medical decisions for a patient who is unable to make them
- **Actionable medical orders:** Specifies the patient's instructions regarding initiating, continuing, withholding or withdrawing specific forms of life-sustaining treatment; examples include Physician Orders for Life Sustaining Treatment (POLST) and the Five Wishes protocol
- **Living will:** Legal document stipulating the patient's preferences for life-sustaining treatment and end-of-life care
- **Surrogate decision maker:** A contract that assigns someone (e.g., a trusted family member) to make medical treatment choices on the patient's behalf in the event that they become incapacitated

You can discuss ACP with a patient during any one of these:

- Annual Wellness Visit (AWV)
- Evaluation and Management visit
- Transition Care Management (TCM)
- Chronic Care Management (CCM) visit

Use the following claims codes to bill for ACP:

- CPT: 99497 and CPT99498
- CPT Category II Codes: 1157F, 1158F
- HCPCS: S0257

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SUMMER 2018—IN THIS ISSUE

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