Health matters MD
HealthPlan OF SAN MATEO
Fall 2016

A "Landmark" in Healthcare Partnership

New in-home care program helps chronically ill CareAdvantage patients

HPSM is proud to announce our new partnership with Landmark Health, which brings multidisciplinary care teams directly to the homes of members with multiple chronic conditions. Many eligible members are frail, home-bound and have complex health needs. Through this program, comprehensive care teams comprised of doctors, nurse practitioners, nurse care managers, behavioral health practitioners, social workers, pharmacists and dietitians support your treatment plans for these high-needs patients. Patients will continue to visit your office as often as needed, while Landmark Health's care teams coordinate their home-based care with you—extending your practice into their everyday lives and promoting optimal outcomes.

"HPSM's partnership with Landmark Health allows us to provide our most complex members with convenient, coordinated care available 24/7 wherever they reside and keep members as healthy as possible."

Margaret Beed, M.D., MPH
HPSM Chief Medical Officer

Patient benefits include:

- Routine home visits from Landmark Health care team members and urgent on-call visits to reduce unnecessary hospitalizations
- Phone access to Landmark Health providers 24 hours per day, 365 days per year
- No cost for eligible members and no impact on their CareAdvantage coverage

Landmark Health services are available to a subset of CareAdvantage members with five or more chronic conditions. Over the next six months we will reach out to eligible members and invite them to engage with Landmark Health.

If you have any questions about this program, which members are eligible and how you can coordinate your treatment plans with Landmark Health's care team, please call HPSM's Provider Services department at **650-616-2106**.

IN THIS ISSUE

There *Is* a Doctor in the House

HPSM now provides Comprehensive Home-Based Assessments

In October 2016, HPSM started providing our CareAdvantage members (i.e., those covered by both Medicare and Medi-Cal) with Comprehensive Home-Based Assessments. Many of HPSM's nearly 10,000 CareAdvantage members are advanced in age, have ongoing care management needs or suffer from multiple chronic conditions. Evaluating these high-needs patients at home is much more convenient for people with mobility issues. A summary of assessment findings is shared with HPSM and the patient's Primary Care Physician (PCP), allowing us to stay up-to-date on their health status.

These evaluations are conducted by advanced practice clinicians from ComplexCare Solutions, an organization that specializes in home-based clinical assessment. Each hour-long house-call includes a review of the member's physical and mental status, medications and living environment, and provides an opportunity for patients to discuss health concerns in the comfort of their home. If a clinician identifies an urgent medical condition or unmet need during the assessment, the clinician may call the patient's PCP and send a report to HPSM for follow-up by a Case Manager.

A key advantage of the program, says HPSM Chief Medical Officer Dr. Margaret Beed, is that "The assessment is performed in addition to the care that PCPs provide. This allows the assessors to be the PCP's 'eyes and ears' in the member's home."

HPSM is offering Comprehensive Home-Based Assessments to our CareAdvantage members through December 31, 2016. If you have any questions about this initiative, please contact HPSM Provider Services, Monday through Friday, 8 a.m. to 5 p.m., at **650-616-2106**.

HPSM Gives Providers a Raise

175% increase over Medi-Cal payments for specialty care

Starting on July 1, 2016, HPSM boosted our Medi-Cal reimbursements for certain specialties to 175% of the rates set by the State. The rate increase is part of a new incentive program aimed at attracting the highest-quality specialty providers to HPSM's network to ensure members get the specific treatment they need to be healthy. It is also designed to improve data collection and align reimbursement with current market trends.

HPSM CEO Maya Altman emphasized that strengthening the partnership with our current specialty providers works hand-in-hand with expanding our provider network's reach to ensure optimal care for HPSM's members. "Accessing specialty care, in particular, can be challenging for some members in our Plan," she said. "We believe these increases will help us retain critical specialty providers and also spur more specialists to work with us, giving our patients the ability to get the high quality care they deserve from specialty practices."

HPSM's 145,000 members currently have access to over 2,300 specialty physicians. The new rates apply to providers treating patients under HPSM's Medi-Cal, California Children's Services, Healthy Kids and HealthWorx programs. They will be in effect through at least June 30, 2018.

For information about accessing the incentive program, visit the HPSM website at: hpsm.org/providers/specialists-incentive.aspx.

Build Your Practice

with HPSM's new Quality Improvement Toolkit

HPSM is pleased to introduce our new online **Provider Quality Improvement (QI) Toolkit** as an informational and educational resource that will help you continue to deliver the highest quality of care to our members. This comprehensive but easy-to-follow training highlights seven critical training topics:

1. Healthcare Effectiveness Data and Information Set (HEDIS)
2. Initial Health Assessment (IHA)
3. Language Services
4. Nurse Advice Line (NAL)
5. Potential Quality Issue (PQI)
6. Seniors & Persons with Disabilities (SPDs)
7. Tobacco Cessation Services

To orient our providers to this new training, we will spotlight specific Toolkit items here in issues of HealthMatters MD—starting with the **ICE Employee Language Skills Self-Assessment Form** in the Language Services module. This questionnaire helps our bilingual providers and their non-clinical employees determine whether they have the level of fluency needed to communicate with non-English-language patients in a clinical setting. Please note that the ICE Employee Language Skills Self-Assessment Form is only a screening assessment. If you pass this assessment, you will also need to use a professional language testing vendor to evaluate your level of proficiency. If you are proficient in languages other than English, we will list that skill as part of your profile in our provider directory; if not, you can always use our free telephonic and in-person interpreter services.

The Provider QI Toolkit is posted on the Provider portal of hpsm.org under the Provider Resources section. For questions about the Provider Toolkit, please call **650-616-8235**.

Needle in a Health Plan

HPSM to cover acupuncture in 2017

Starting on January 1, 2017, HPSM will cover outpatient acupuncture services for all Medi-Cal and CareAdvantage plan members who would benefit from this holistic treatment. Starting next year, we will reimburse network acupuncturists for up to two outpatient sessions per calendar month provided to our Medi-Cal and CareAdvantage CMC members. Additional or more frequent sessions may be authorized if medically necessary.

What is acupuncture?

Acupuncture is a 3,000-year-old Traditional Chinese Medicine healing technique that involves inserting thin needles into the skin at specific anatomic sites called acupoints. Complementary acupuncture techniques include massage, heat therapy and herbal medicines. The U.S. National Institutes of Health (NIH) confirmed acupuncture's medical safety and efficacy in 1997.

What can acupuncture help with?

Clinical studies show acupuncture to be an effective treatment for pain, nausea, headaches, anxiety, depression, insomnia, infertility, allergies, arthritis and many other disorders.

How do I provide acupuncture services for HPSM members?

If you are an acupuncturist or have a colleague who practices acupuncture, call **650-616-2106** to learn more or join HPSM's network.

Source:
UC San Diego Center for Intergrative Medicine (2016)

Has Your Availability Changed?

Notify HPSM within five days for our provider directory

A recently enacted state law now requires HPSM and other health plans to update our online provider directories regularly. This will ensure that current and prospective members can easily identity which providers are currently in our network and whether they are accepting new patients. As a contracted HSMP provider, you must now inform us within five business days when your status changes regarding whether or not you are currently accepting new patients. For more information about these new requirements, please visit leginfo.legislature.ca.gov and enter "SB 137" in the Quick Search box at the top right corner.

No More Retrospective Authorization Requests

As of September 1, 2016, HPSM no longer retroactively reviews or pays claims submitted for unauthorized services. Exceptions to this rule will be made for certain rare cases, such as emergency and urgent out-of-area services, but providers must get preauthorization for all service in order to receive payment. For a list of these services, printable Authorization Request Forms and more information, visit hpsm.org/providers.

Watch Your PQIs (Potential Quality Issues)

A PQI is a suspected provider performance, clinical care or outcome of care issue that requires further investigation to determine if an actual quality of care concern exists. Referrals for PQI investigations can come from HPSM staff or members, contracted or non-contracted providers and their staff, or any member of the community (such as a member's family or friend). HPSM also identifies PQIs by reviewing:

- Complaints, Grievances and Appeals
- Concurrent, prospective and retrospective utilizations
- Claims and encounter data
- Care coordination reports
- Medical record audits

Some examples of PQIs include:

- Delays in obtaining referrals
- Rude behavior by clinical providers or staff members
- Inadequate assessment of patients
- Complication in the delivery of a child
- Unexpected death of a patient

When a PQI is identified, an HPSM nurse conducts an initial and clinical review, and then refers PQI cases to a Medical Director for investigation. We ask the provider for the member's medical records and their response to the PQI to get their side of the story.

To report a PQI, please use the PQI referral form available on the HPSM website, or contact us at:

- Phone: **650-616-2170**
- Fax: **650-616-8235**
- Email: PQIReferralRequest@hpsm.org

Look Out for Fraud, Waste & Abuse (FWA)

Studies estimate that healthcare fraud, waste and abuse (such as fraudulent claims, kickbacks and self-referrals) cost the national healthcare system between $505 billion and $1.2 trillion per year. FWA also endangers people's health and lives, such as when doctors overprescribe medications or bill for services they did not provide and patients need.

HPSM strictly follows all federal and California State laws against FWA and requires our providers to do the same—both as an ethical obligation and to avoid legal penalties that result from violations. But patients can also commit FWA offenses. As healthcare professionals, we must work together to ensure that no one abuses the healthcare system so that our resources are used efficiently to benefit the community.

How To Prevent FWA in Your Practice

- **Verify patients' identities**—At your intake meeting with a new patient, check the member's healthcare ID card against a picture ID such as a driver's license to confirm their identity.
- **Know the coding requirements**—Using the wrong code on a claim form could qualify as fraud and waste—even if it's an innocent mistake. Call our Claims department at **650-616-2056** if you have claim coding questions.
- **Keep prescription pads secure—**Some members have committed abuse by stealing prescription pads from doctors' offices and submitting scrips to pharmacies for controlled substances. Always keep your prescription pad safely out of reach.

To report potential FWA violations, or if you have questions or concerns, call HPSM's toll-free Compliance Hotline. Operators are available 24/7, and you can remain anonymous if you prefer.

Sources:
Thompson Reuters (2009)
PriceWaterhouseCoopers Health Research Institute (2008)

New Medi-Cal Benefits Identification Card (BIC)

In September, the Department of Health Care Services (DHCS) issued redesigned Medi-Cal Benefits Identification Cards (BICs). The old cards are still valid as well, since DHCS is only giving the new ones to new Medi-Cal recipients and those requesting replacement cards. Whichever Medi-Care card a patient presents, always remember to verify their eligibility for benefits.

Grievances: What You Need to Know

HPSM has a Grievance and Appeals process in place both because it's a legal requirement and to give our members a voice in their healthcare. A grievance is basically when a member reports dissatisfaction with a service provider or HPSM staff. Complaints can range from difficulty getting an appointment or reports of a problematic interaction with a doctor to a claim of misdiagnosis.

However, just because you receive a grievance notice does not mean there's a problem. First, it is not an accusation of wrongdoing: we merely want your side of the story so we can resolve the matter swiftly and get your treatment plan back on track. Second, the vast majority of grievances are merely miscommunications or misunderstandings between providers and members that are resolved internally without any negative consequences whatsoever.

To reassure our providers that receiving a grievance notice is usually not a big deal, here is a quick overview of the process.

1 **HPSM members have the right to file an unlimited number of grievances**—and we are legally obligated to investigate every one.

2 **We send you a grievance notice to get your side of the story—not to accuse you of anything.** The member's account may well be inaccurate or incomplete, so we need to get your perspective to fully understand what happened. We'll send you some questions about the incident and give you five days to respond. Answering in a timely manner allows us to resolve the matter quickly and efficiently. Then we send you and the member a resolution letter confirming that the case is closed.

3 **Escalation.** Grievances concerning quality of care (e.g., medications or diagnoses), are reviewed by a nurse and medical director in our Quality department. If a potential quality of care problem is found, the case may be referred to our Physician Peer Review Committee.

We greatly appreciate your timely response to our grievance inquiries, and are available to support you through every step of the process. Please call our Grievances and Appeals department at **650-616-2850** with any questions or concerns.

Speaking Your Language

Get free interpreter services for all HPSM members

All Limited English Proficient (LEP) patients are legally entitled to free language interpretation services so they can communicate effectively with their providers. HPSM offers our LEP members three types of interpreter services: in-person, telephonic and American Sign Language.

For Telephonic Interpreters

No matter what language the member speaks, a telephonic interpreter who speaks that language is available 24 hours a day, seven days a week. To get an interpreter on the line, simply call 800-CALL-CLI (**800-225-5254**) and provide the:

- Provider access code (64095)
- Language needed
- Provider's office name
- HPSM member's ID#
- HPSM member's date of birth

Get a $90 Bonus for every Initial Health Assessment (IHA)

HPSM complies fully with a California state mandate requiring that all new members receive an Initial Health Assessment (IHA) within 120 days of enrollment. The IHA consists of a comprehensive assessment including health history and physical and mental health status. In addition, where age appropriate, it may require a developmental exam, diagnosis, treatment plan, retentive services and the Staying Healthy Assessment (SHA).

HPSM rewards providers for conducting high-quality IHAs with a $90 per-member payment on top of your regular Medi-Cal remittance. To find the correct IHA CPT codes and learn more, email ramla.jirde@hpsm.org, call **650-616-2895** or consult the IHA incentive guidelines on HPSM's website.

The Staying Healthy Assessment (SHA)

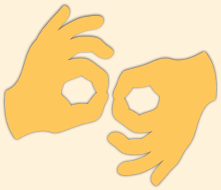
The SHA is a standardized form used by all Medi-Care managed care plans to streamline the IHA that helps providers:

- Identify and track individual health risks and behaviors
- Target health education counseling interventions
- Provide referrals and follow-up

PCPs are legally required to make the SHA a permanent part of their patient's medical record and review it annually. When potentially high-risk health behaviors are identified, providers must ask follow-up assessment questions, identify the patient's health education needs and facilitate focused counseling that addresses health-behavior changes.

All SHA forms are available for download and printing on HPSM's website under Provider Resources.

For In-Person or Sign Language Interpreters



1. Make your request at least five days prior to the appointment
2. Complete the In-Person Request Form from the Language Services web page on hpsm.org or call HPSM's Members Services Department at **1-800-750-4776**
3. Fax the completed request form to the HPSM Quality Department at **650-616-8335**

Qualifying Criteria for In-person Interpreter Services

Member must have at least one of the following:

- Hearing disorder
- End of life issues
- Sexual assault/abuse or other sensitive issues
- Complex course of therapy or procedures such life-threatening diagnosis (e.g., cancer, chemotherapy, transplants, etc.)
- Other conditions by exception as determined by an HPSM Medical Director

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