



# Section 2

## Member Services

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# Introduction

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The Health Plan of San Mateo provides customer service to its members through the following departments:

- The HPSM Member Services Department assists members who have Medi-Cal, Healthy Families, Healthy Kids, HealthWorx and San Mateo County ACE. Member Services Representatives can help members with questions about their HPSM coverage and provide assistance in resolving problems related to healthcare services. The Member Services Department can be reached at 1-800-750-4776 or (650) 616-2133. Call Center hours are Monday through Thursday from 8 a.m. to 6 p.m. and Friday from 9:30 a.m. to 6 p.m. Hearing impaired members can use the California Relay Service (CRS) at (800) 735-2929 (TTY) or dial 711. Office hours are Monday through Friday, 8 a.m. to 5 p.m. Member Services Representatives speak Spanish and Tagalog and can access telephone interpreters to assist members with other language needs.
- The HPSM CareAdvantage Unit assists members who have CareAdvantage coverage. CareAdvantage is HPSM's Medicare Advantage/Prescription Drug Plan. CareAdvantage Navigators can help members with questions about their CareAdvantage coverage and provide assistance in resolving problems related to healthcare services. The CareAdvantage Navigators can be reached at (866) 880-0606 Monday through Sunday from 8 a.m. to 8 p.m. Hearing impaired members can use the California Relay Service (CRS) at (800) 735-2929 (TTY) or dial 711. Office hours are Monday through Friday, 8 a.m. to 5 p.m. CareAdvantage Navigators speak Spanish, Tagalog, Mandarin, Cantonese and Russian and can access telephone interpreters to assist members with other language needs.

HPSM mails each new member a welcome packet which includes their *Member Handbook and Evidence of Coverage (EOC)*. These publications tell members:

- How to choose a PCP or change his/her PCP
- How to receive care
- What the member's benefits are
- What to do if a member has a question or a problem

The most recent EOC for each of the programs can be downloaded from the HPSM website at [www.hpsm.org](http://www.hpsm.org). There are links to the EOCs under the "Members" section of HPSM's website. The EOCs are also available in hard copy format from the Provider Services staff.

## **Member Rights and Responsibilities**

Each program's EOC includes a section on Members Rights and Responsibilities. These Member Rights and Responsibilities are established and enforced by California State Law, HPSM Policies and Procedures, and in provider contracts between you and HPSM. Some of the key Member Rights and Responsibilities are:

*HPSM members have the right to:*

- Get dignified, courteous, and considerate treatment regardless of race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, medical condition, or stage of illness.
- Get up-to-date information about HPSM, HPSM's services and how to use them.
- Get care from the Primary Care Provider (PCP) the member chooses from HPSM's network or change the member's PCP to another HPSM network doctor.
- Access family planning services, Federally Qualified Health Centers, certified nurse practitioner services, Indian Health Service Facilities, sexually transmitted disease services and Emergency services outside HPSM's network. Minors also have the right to access minor consent services.
- Know and understand their medical problem. Receive information on available treatment. Obtain a second opinion from a different doctor at no cost to the member.
- Participate in decisions about their medical care. The member has the right to refuse or discontinue treatment and prepare advance directives.
- Have their confidential health information protected. Members also have the right to access their health information for reasons allowed by law and receive copies of, or add a statement to their records.
- Get information and services in a way which respects their language and culture. Receive information in the member's language or alternative formats and large size print upon request.
- Not use family or friends as interpreters, including as sign language interpreters.
- Use HPSM's free interpreter service, including during discussion of complex medical conditions and treatment options and after hours services, and file a Grievance if the member's language needs are not met.
- File a Grievance about HPSM or the care the member receives, either orally or in writing.

- Freely exercise these rights without adversely affecting how the member is treated by HPSM and/or providers.

*HPSM members have the responsibility to:*

- Carefully read all HPSM member materials to understand how to use HPSM benefits and what procedures to follow when they need care.
- Do their best to keep appointments and call the provider or clinic as soon as possible if there is a need to cancel or reschedule an appointment.
- Show their HPSM ID card or remember to tell the provider that they are an HPSM member before receiving care.
- Follow the treatment plan they and their provider have agreed upon.
- Provide accurate and complete information about their health care needs when they see a provider. Let their provider know if they have a medical condition.
- Ask their doctor questions if they do not understand something or are unsure about the advice they are given.
- See the specialists to whom their Primary Care Provider (PCP) refers them.
- Actively participate in health care programs that will keep them well.
- Work with their provider to build and maintain a good working relationship.
- Use the emergency room only in cases of an emergency or as directed by their provider.
- Follow up with their PCP after getting care at an emergency facility.
- Report lost or stolen ID cards to HPSM and do not let anyone else use their ID card.
- Contact HPSM if they do not understand how to use their benefits or have any problems with the services provided.
- Help HPSM maintain accurate and current records by providing timely information regarding changes in address, family status and other health care coverage.
- Promptly follow the HPSM Grievance procedure if the member believes he/she needs to submit a Grievance.

- Treat all HPSM personnel and health care providers respectfully and courteously.

## **Missed Appointments by Members**

The *Member Handbook and Evidence of Coverage (EOC)* reminds members that if they cannot keep their appointment or want to cancel an appointment, they need to call their provider to cancel or reschedule as soon as possible. A provider's office can send HPSM a Missed Appointment Report. The HPSM Member Services Department or CareAdvantage Unit will send a letter to the member documenting the missed appointment and reminding him/her to follow his/her doctor's advice and the importance of calling to cancel appointments in advance. HPSM will also remind members that missed appointments may be a basis for a provider requesting reassignment of a member to a different provider for care. You will receive a copy of this letter for the member's medical record.

## **Advance Directives**

HPSM provides written information in the HPSM Member Handbook about members' rights under California State Law to make healthcare decisions, including the right to accept or refuse treatment and the right to execute Advance Directives. San Mateo County residents may arrange to have "Do Not Resuscitate" (DNR) orders.

Providers are required to document in the patient's medical record whether he/she has executed an Advance Directive. Information on Advance Directives is available at the California Medical Association website at <http://www.cmanet.org/publicdoc.cfm/7>. A simplified Advance Directive form is available and can be downloaded from our website. The document is available in English and Spanish and the link can be found through the "Provider" section of our website under "Provider Resources."

## **Member's Right to Select a Provider**

### *Primary Care Physician (PCP)*

HPSM Members' care is managed by the PCP that they have selected. A PCP may be a pediatrician, a general practitioner, a family practitioner, an internist, a Federally Qualified Health Care Clinic (FQHC), a Native American health service provider, a nurse practitioner, or in some cases, an OB/GYN provider.

The name and telephone number of each member's PCP is printed on their individual HPSM Member Identification (ID) Card.

### *Women's Services – OB/GYN Services*

Female HPSM members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by their PCP or members may self-refer to any contracted OB/GYN or PCP within the HPSM network for OB/GYN services.

### *Pregnancy Care*

The Health Plan of San Mateo encourages pregnant women to get early prenatal care. Members may select an Obstetrician or Certified Nurse Midwife for care during

pregnancy. Members have the right to select Certified Nurse Midwife services from an out-of-plan Medi-Cal Provider if they are not available through HPSM.

*Indian Health Services*

American Indians or Alaskan Natives who are HPSM members may choose any available Indian Health Service Provider available, as provided under Federal Law. The provider does not have to be an HPSM network provider and HPSM will make arrangements to coordinate appropriate services for these members.

# Programs and Enrollment Information

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The following programs are offered by the Health Plan of San Mateo. You may receive inquiries from existing or new patients asking how they can join the various programs offered by the Health Plan of San Mateo.

## **Medi-Cal**

Medi-Cal is a government program administered through the State of California Department of Health Services. Eligibility is determined by the San Mateo County Human Services Agency; or through Supplemental Security Income (SSI). Eligibility guidelines and enrollment information is available at the Human Services Agency website at <http://www.smchsa.org> or prospective members can call the San Mateo Health Insurance TeleCenter at (800) 223-8383 to find out if they are eligible to receive Medi-Cal health benefits.

## **Healthy Kids**

Uninsured children from birth through age 18 who are not eligible for coverage through Medi-Cal or Healthy Families and fall within certain income guidelines may be eligible to enroll in the Healthy Kids program. Enrollment information can be found on the Children's Health Initiative website at <http://www.smcchi.org> or prospective members may call the San Mateo County Coverage Unit at (650) 616-2002 for more information.

## **Healthy Families**

Uninsured children from birth through age 18 who are residents of California and fall within certain income guidelines may be eligible to enroll in the Healthy Families program. More information about the Healthy Families program is available at [www.healthyfamilies.ca.gov](http://www.healthyfamilies.ca.gov). Enrollment information can also be found on the Children's Health Initiative website at <http://www.smcchi.org> or prospective members can call (650) 616-2002 for more information.

## **CareAdvantage**

CareAdvantage is HPSM's Medicare Advantage/Prescription Drug Plan and was designed for people who have both Medicare and Medi-Cal. Members must have Medicare Part A (hospital insurance) and Part B (medical insurance) and full-scope Medi-Cal through HPSM. CareAdvantage members must live in San Mateo County. Prospective members may call a CareAdvantage Representative at 1-888-252-3153 or (650) 616-1500 for more information about enrollment. A link to the Medicare Online Enrollment Center (OEC) is also available on the HPSM website at [www.hpsm.org](http://www.hpsm.org). People with questions about Medicare can also call the local Health Insurance Counseling and Advocacy Program (HICAP) at (800) 434-0222.

## **HealthWorx/ICP**

San Mateo County Public Authority In-Home Support Services (IHSS) workers and certain San Mateo County Extra Help Employees and City of San Mateo Per Diem employees are eligible for HealthWorx.

- IHSS Workers need to call the SEIU Local 715 at 1-877-734-8521 or (650) 779-9910
- San Mateo County Extra Help Employees must contact the San Mateo County Employee Benefits Division at (650) 363-1919

Please note, City of San Mateo part-time employees should call SEIU at 1-877-734-8521 or (650) 779-9910.

HealthWorx members are also eligible for COBRA, CalCOBRA, and an Individual Conversion Plan (ICP). These programs are available to former HealthWorx members whose employment has been discontinued. Members should call Member Services at (650) 616-2133 for more information.

### **San Mateo County ACE**

The San Mateo ACE Program is a county-sponsored program that provides health care coverage to low-income adult residents of San Mateo County who meet eligibility requirements. HPSM administers the San Mateo ACE Program under a contract with San Mateo County. **San Mateo ACE is not insurance.** The San Mateo ACE Program covers a wide range of health care and pharmacy benefits under a coordinated system of care, but it is not an insurance product subject to state insurance requirements. It is a payer of last resort, which means it pays only for certain services that are not covered by other existing coverage programs. Services are primarily provided through the San Mateo Medical Center and the Ravenswood Family Health Center. ACE participants may be referred for specialty services to non-County providers but prior authorization is required. Prospective enrollees can call (650) 616-2002 for more information.

## **Identifying HPSM Members**

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Health Plan of San Mateo (HPSM) members may be enrolled in one of HPSM programs. These programs are Medi-Cal, Healthy Families, Healthy Kids, HealthWorx, San Mateo County ACE and CareAdvantage. The majority of HPSM members are in the Medi-Cal program. All HPSM members are issued HPSM Identification (ID) cards showing the program they are enrolled in, and the PCP on record for them. Examples of ID cards can be found later in this chapter.

### **PCP Case Management List**

Case Management lists are distributed monthly to Primary Care Physicians. The list includes all members assigned to the PCP and information such as assigned member name, member ID number, date assigned to the PCP, and prior PCP if applicable. Please see the last section of the Provider Manual for a sample of the monthly Primary Care Physician Case Management List.

### **Medi-Cal Members**

HPSM Medi-Cal Members are Medi-Cal beneficiaries who are determined to be eligible for Medi-Cal by the San Mateo County Human Services Agency, or are eligible for Supplemental Security Income (SSI), which provides Medi-Cal as an automatic benefit.

Medi-Cal eligible beneficiaries with qualifying aid codes are automatically enrolled in HPSM.

Each member is issued an HPSM identification card in addition to the Benefits Identification Card (BIC) issued by the State. Sample cards are included later in this section.

### *Types of Medi-Cal Members*

#### Full Scope Capitated Members

These are members who are entitled to the full scope of HPSM Covered Benefits and Services and are assigned to a Primary Care Provider for case management.

#### Full Scope Special Members

Full scope special members are those whose health care services are delivered in a fee-for-service manner for a limited period of time. Special members are not assigned a PCP and do not require referrals to see contracted, in-network specialists.

Members with chronic or complex medical conditions may be granted special member status to allow for direct access to specialists. Special members may self-refer to any HPSM specialist provider and have "HPSM" assigned as their Primary Care Provider. Members of this group may include the following:

- Specific eligibility status (e.g. retroactively eligibles, share-of-cost, other specific aid code designations).
- Out-of-County institutional and residential placement.
- Court jurisdiction for foster care and adoption.
- Individuals currently diagnosed with AIDS or End-Stage Renal Disease (ESRD) who require dialysis.
- Individuals given a temporary "one month only" special member status in order to choose another Primary Care Provider (PCP).
- Individuals assigned to the Special Member status by the HPSM Medical Director.

The HPSM Medical Director or designee is responsible for evaluating members and provider requests for Special Member Status. The Medical Director will review the requests of those members who have been designated Special Members. The purpose of the review is to:

- Reaffirm the decision, or
- Return the member to a case management status due to an improvement in the member's situation or medical need.

Special Members may be placed into a capitated case-management group and be required to select a Primary Care Provider (PCP) at the earliest possible date when their aid code changes, or if their health condition and/or other factors change.

### Share-of-Cost Members

Some Medi-Cal subscribers (recipients) must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share-of-Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible.

Until a member has met his/her SOC amount for the month, they are not eligible for Medi-Cal coverage. After a member meets the SOC for the month, HPSM will pay for the member's covered medical expenses for the rest of the month. More information about the Medi-Cal SOC can be found at the Medi-Cal website at

[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc)

### **Healthy Families Members**

Healthy Families is a low cost insurance for children up to their 19<sup>th</sup> birthday. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal. Healthy Families is California's Children Health Initiative Program, and the program is administered by the Managed Risk Medical Insurance Board (MRMIB). MRMIB determines eligibility for the program and program cost sharing requirements.

### **Healthy Kids Members**

Healthy Kids is a San Mateo County based low cost insurance for children up to their 19<sup>th</sup> birthday. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for Medi-Cal or Healthy Families. The San Mateo County Coverage Unit processes applications and determines final eligibility.

### **CareAdvantage Members**

Health Plan of San Mateo (HPSM) CareAdvantage Members are dual eligible members (Medicare **and** full-scope Medi-Cal) who have enrolled in HPSM's Medicare Advantage/ Prescription Drug Plan, CareAdvantage. CareAdvantage members must live in San Mateo County. Members must have both Medicare Part A (hospital insurance) **and** Part B (medical insurance) and full-scope Medi-Cal through HPSM.

Enrollment in CareAdvantage is optional. Some dual eligible members may elect to remain in original fee for service Medicare and enroll in a Prescription Drug Plan (PDP) or join another Medicare Advantage Plan. In both of these cases, the member will retain his/her Medi-Cal eligibility but **will not** be a member of CareAdvantage.

### **HealthWorx Members**

Health Plan of San Mateo (HPSM) HealthWorx Members are In-Home Support Services (IHSS) workers in San Mateo County who have met eligibility requirements by working a specified number of hours in a calendar quarter. Eligibility is determined by the local union, SEIU Local 715.

HealthWorx members may also be San Mateo County Extra Help Employees who have met eligibility requirements by working a specified number of hours in the prior fiscal year. Eligibility is determined by the San Mateo County Employee Benefits Division.

HealthWorx members may also be City of San Mateo Per Diem employees who have met eligibility requirements established by the City of San Mateo.

### **San Mateo County ACE**

San Mateo ACE is offered to San Mateo County residents who are not eligible for coverage through Medicare, full-scope or share-of-cost Medi-Cal, private insurance or other third-party payers. Enrollees in the ACE program must meet established income levels. Asset levels are also considered in determining eligibility for the ACE program. The San Mateo County Coverage Unit processes applications and determines final eligibility for the ACE Program. Services for ACE participants are primarily offered at the San Mateo Medical Center and Ravenswood Family Health Center. Services to other providers is by authorized referral only.

## **Member Eligibility**

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It is important that the member eligibility is checked at the time of each visit. A member's eligibility can change at any time for any number of reasons, including change in aid code, non-payment of premiums, and home address change.

### **Ways to Check Eligibility**

#### *Check Monthly Primary Care Physician (PCP) Case Management List*

PCPs should check for the member's name on the list sent at the beginning of each month. It is available via HPSM's web portal "eReports." This listing will also let you know if any patients have been added or deleted from your practice, along with an effective date or termination date.

Please see the end of this manual for a sample of the PCP Case Management List.

#### *Check HPSM's Website, [www.hpsm.org](http://www.hpsm.org)*

The website allows for both electronic billing and member eligibility information (including PCP Assignment) for dates of service within the prior six (6) months. To obtain a provider login and password, please contact the HPSM Provider Services Department at (650) 616-2106.

#### *Check HPSM's ATEV/IVR*

Eligibility information is also available by telephone, using the HPSM's 24-hour Automated Telephone Eligibility Verification/Interactive Voice Recognition (ATEV/IVR) system. To verify eligibility and PCP assignment for dates of service within the prior six (6) months, please call (800) 696-4776. Please have the member's ID number available. When a member is not assigned a PCP, the eligibility recording will state "Special Member." Since member status can change from month to month, it is important to verify a member's status for the month that the service was rendered.

*Check Medi-Cal's 24-Hour State Automated Eligibility Verification System (for Medi-Cal members only)*

Please call (800) 456-2387.

*Check Medi-Cal's Website (for Medi-Cal and Medicare/Medi-Cal members only)*

Eligibility information is available on the State of California's Medi-Cal website, [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). For assistance in obtaining a login and password for the State of California Medi-Cal website, please call the POS Help Desk at (800) 427-1295 for more information.

*Check the Point of Service (POS) device (for Medi-Cal members only)*

Swiping the patient's Beneficiary Identification Card (BIC) in a POS device will also enable you to determine eligibility. The POS device provides eligibility as well as Share-of-Cost liability information for dates of service within the prior twelve (12) months. To learn more about using POS devices, please call the State POS Help Desk at (800) 427-1295.

Please remember that verification of active enrollment is subject to retroactive adjustment in accordance with the terms and conditions of coverage described in the member's benefit plan.

Specialist providers, hospitals, and other service providers should verify eligibility on the date that the service is rendered. A referral or authorization is not sufficient to guarantee that the member is eligible on the date of service.

## **Identification Cards and Co-Payments**

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Each HPSM member is issued an identification card which gives specific information about the member. This information includes:

Program name

Member's name

Member's date of birth

Member's ID number (Effective date of the most current member information)

Member's Primary Care Physician (PCP)

PCP's office phone number

Pharmacy Benefit Manager

# ID CARDS BY LINE OF BUSINESS

## Medi-Cal ID Card:



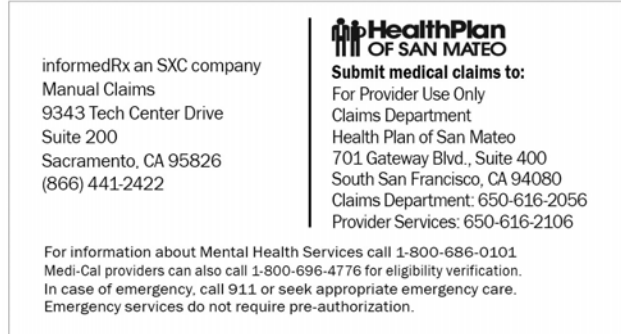
**HealthPlan OF SAN MATEO**

**Medi-Cal**

ID: \_\_\_\_\_ EFF DATE: \_\_\_\_\_  
 \_\_\_\_\_ DOB: \_\_\_\_\_

PCP: \_\_\_\_\_

**HPSM MEMBER SERVICES: 1-800-750-4776**      **MEDICARE:**  
 PBM: informedRx - 1-866-441-2422  
 PCN# IRX GROUP# 090002 BIN#610011



**HealthPlan OF SAN MATEO**

informedRx an SXC company  
 Manual Claims  
 9343 Tech Center Drive  
 Suite 200  
 Sacramento, CA 95826  
 (866) 441-2422

**Submit medical claims to:**  
 For Provider Use Only  
 Claims Department  
 Health Plan of San Mateo  
 701 Gateway Blvd., Suite 400  
 South San Francisco, CA 94080  
 Claims Department: 650-616-2056  
 Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101  
 Medi-Cal providers can also call 1-800-696-4776 for eligibility verification.  
 In case of emergency, call 911 or seek appropriate emergency care.  
 Emergency services do not require pre-authorization.

## HealthWorx ID Card:



**HealthPlan OF SAN MATEO**

**HealthWorx**

ID HWK- \_\_\_\_\_ EFF DATE: \_\_\_\_\_  
 \_\_\_\_\_ DOB: \_\_\_\_\_

PCP: \_\_\_\_\_

**HPSM MEMBER SERVICES: 1-800-750-4776**  
 PBM: informedRx - 1-866-441-2422  
 PCN# IRX GROUP# 090002 BIN#610011



**HealthPlan OF SAN MATEO**

informedRx an SXC company  
 Manual Claims  
 9343 Tech Center Drive  
 Suite 200  
 Sacramento, CA 95826  
 (866) 441-2422

**Submit medical claims to:**  
 For Provider Use Only  
 Claims Department  
 Health Plan of San Mateo  
 701 Gateway Blvd., Suite 400  
 South San Francisco, CA 94080  
 Claims Department: 650-616-2056  
 Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101  
 Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM  
 PIN 24 hours a day.  
 In case of emergency, call 911 or seek appropriate emergency care.

## Healthy Families ID Card:



**HealthPlan OF SAN MATEO**

**Healthy Families**

ID HF- \_\_\_\_\_ EFF DATE: \_\_\_\_\_  
 \_\_\_\_\_ DOB: \_\_\_\_\_

PCP: \_\_\_\_\_

**HPSM MEMBER SERVICES: 1-800-750-4776**  
 PBM: informedRx - 1-866-441-2422  
 PCN# IRX GROUP# 090002 BIN#610011



**HealthPlan OF SAN MATEO**

informedRx an SXC company  
 Manual Claims  
 9343 Tech Center Drive  
 Suite 200  
 Sacramento, CA 95826  
 (866) 441-2422

**Submit medical claims to:**  
 For Provider Use Only  
 Claims Department  
 Health Plan of San Mateo  
 701 Gateway Blvd., Suite 400  
 South San Francisco, CA 94080  
 Claims Department: 650-616-2056  
 Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101  
 Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM  
 PIN 24 hours a day.  
 In case of emergency, call 911 or seek appropriate emergency care.

## Healthy Kids ID Card:

		<h3>Healthy Kids</h3>	
ID HK- DELTA DENTAL ID		EFF DATE:	
PCP:		DOB:	
<p><b>HPSM MEMBER SERVICES: 1-800-750-4776</b>                  PBM: informedRx - 1-866-441-2422                  PCN# IRX GROUP# 090002 BIN#610011                  DELTA DENTAL: 1-866-527-9564 GROUP NO. SM60</p>			

informedRx an SXC company Manual Claims 9343 Tech Center Drive Suite 200 Sacramento, CA 95826 (866) 441-2422	 <p><b>Submit medical claims to:</b>                  For Provider Use Only                  Claims Department                  Health Plan of San Mateo                  701 Gateway Blvd., Suite 400                  South San Francisco, CA 94080                  Claims Department: 650-616-2056                  Provider Services: 650-616-2106</p>
<p>For information about Mental Health Services call 1-800-686-0101                  Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM PIN 24 hours a day.                  In case of emergency, call 911 or seek appropriate emergency care.</p>	

## CareAdvantage ID Card:

		<h3>CareAdvantage (HMO)</h3> <p>An HPSM Medicare Plan</p>	
EFF. DATE: ID:		HPSM CareAdvantage Unit: 1-866-880-0606	
DOB:		RxBin: 610011	
PCP:		RxPCN: IRX	
		RxGrp: 090002	
		Issuer: 80840	
<p style="text-align: center;"><b>MedicareRx</b>                  Prescription Drug Coverage                   CMS-H5428 001-0</p>			

informedRx an SXC company Manual Claims 9343 Tech Center Drive Suite 200 Sacramento, CA 95826 (866) 441-2422	 <p><b>Submit medical claims to:</b>                  For Provider Use Only                  Claims Department                  Health Plan of San Mateo                  701 Gateway Blvd., Suite 400                  South San Francisco, CA 94080                  Claims Department: 650-616-2056                  Provider Services: 650-616-2106</p>
<p>HPSM CareAdvantage Unit: 1-866-880-0606; 1-800-735-2929 (TTY)                  In case of emergency, call 911 or seek appropriate emergency care</p>	

## Individual Conversion Plan ID Card:

		<h3>Individual Conversion Plan</h3>	
ID-		EFF DATE:	
PCP:		DOB:	
<p><b>HPSM MEMBER SERVICES: 1-800-750-4776</b>                  PBM: informedRx - 1-866-441-2422                  PCN# IRX GROUP# 090002 BIN#610011</p>			

informedRx an SXC company Manual Claims 9343 Tech Center Drive Suite 200 Sacramento, CA 95826 (866) 441-2422	 <p><b>Submit medical claims to:</b>                  For Provider Use Only                  Claims Department                  Health Plan of San Mateo                  701 Gateway Blvd., Suite 400                  South San Francisco, CA 94080                  Claims Department: 650-616-2056                  Provider Services: 650-616-2106</p>
<p>For information about Mental Health Services call 1-800-686-0101                  Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM PIN 24 hours a day.                  In case of emergency, call 911 or seek appropriate emergency care.</p>	

## Co-Payment Requirements and Co-payment Table by Program

Service	Healthy Kids-HK*	Healthy Kids-K1*	Healthy Families-9H**	Healthy Families-H1**	HealthWorx	ICP
Physician Visit (PCP)	\$5	\$10	\$5	\$10	\$5	\$25
Physician Visit (Specialist)	\$5	\$10	\$5	\$10	\$5	\$25
Prescription	\$5	\$10	\$5	\$10	\$5	\$10/\$35 or 50% of charges
ER	\$5 - (waived if admitted)	\$15 (waived if admitted)	\$5 (waived if admitted)	\$15 (waived if admitted)	\$25	\$100
Hospital	\$0	\$0	\$0	\$0	\$0	\$200 per day
Vision	\$5	\$10	Not covered by HPSM***	Not covered by HPSM	Not covered by HPSM***	\$25
Dental	Covered through Delta Dental	Covered through Delta Dental	Not covered by HPSM	Not covered by HPSM	Not covered by HPSM	Not covered by HPSM

There are ***no co-pays for preventive health care services*** except for the Individual Conversion Plan (ICP).

\* Healthy Kids co-payments are based on the current Federal Poverty Income Guidelines. Category A members have \$5.00 co-payments. Category B and C members have \$10.00 and \$15.00 co-payments. \$250 annual co-pay maximum per family for Healthy Kids. Members will be notified when the maximum has been reached. Please note that Healthy Kids co-payments are tied to the Healthy Families co-payments and are subject to change. Refer to the aid code column of the monthly Case Management report to determine the members aid code (HK or K1).

\*\* Healthy Families co-payments are based on the current Federal Poverty Income Guidelines. Category A members have \$5.00 co-payments. Category B and C members have \$10.00 and \$15.00 co-payments. \$250 annual co-pay maximum per family. Members will be notified when the maximum has been reached. Please note that Healthy Families co-payments are determined by the State and are subject to change. Refer to the aid code column of the monthly Case Management report to determine the members aid code (9H or H1).

\*\*\* Except for cataract spectacles and lenses that replace the natural lens of the eye after surgery – no co-pay.

CareAdvantage members pay a co-payment when they fill each covered prescription. The amount the member pays will depend on his/her income and is determined by Medicare. Medicare changes the co-payment amount annually. Members who live in a long-term care facility do not have any co-payments.

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. This catastrophic coverage begins when the total cost of the drugs that the member receives under the Medicare Part D benefit reaches the specified amount (in 2010 the amount was \$6,440). This includes costs that are paid by the member, as well as costs that CareAdvantage and certain others pay. Once the total drug costs reaches the catastrophic amount in a calendar year, the member will no longer have to pay any prescription co-payments for the rest of the calendar year.

## **PCP Selection Process**

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HPSM members are encouraged to select his or her own PCP as soon as they become eligible for or are enrolled in an HPSM program. Member Services Representatives/CareAdvantage Navigators are available to assist members with the PCP selection process.

When Medi-Cal members become eligible, “New Member Packets” are mailed to the member, requesting that they select a PCP. New HPSM Medi-Cal members are placed in the special member category for one month to allow them time to select a PCP. Members who do not select a PCP are automatically assigned to a PCP (see below for more information) according to the guidelines prescribed by the California Department of Health Care Services.

New HPSM members in other programs (Healthy Kids, Healthy Families, HealthWorx, ACE and CareAdvantage) are required to select a PCP as part of their initial enrollment process.

Members may elect to continue an established relationship with an HPSM participating provider, or choose a new Primary Care Provider from the HPSM Provider List.

### **Established Patients Only (EPO) PCPs**

If a member selects a PCP who is in an “Established Patients Only (EPO)” status, the selection will be denied unless the provider confirms the member is an established patient.

There are two ways an EPO PCP can approve selection by a member. If a member contacts HPSM about a selection request, Member Services staff will fax a “Provider Selection Form for HPSM Physicians Accepting Established Patients Only” form to the provider’s office. If the provider or an authorized employee of the office signs and returns the form, then the member will be assigned to the EPO PCP. Alternatively, the standard “Primary Care Physician Selection/Change of Address Form (PCP/COA)” can be completed by the member, and the provider or an authorized employee of the office

can indicate on the form the approval to accept the member. The standard PCP/COA form is available in many PCP offices, can be requested from HPSM, or can be downloaded from HPSM's website, [www.hpsm.org](http://www.hpsm.org)

### **Automatic Assignment of a PCP (for Medi-Cal members only)**

The PCP auto-assignment program is designed to match members and PCPs by geographic location, member age, PCP capacity and specialty.

If a member is auto-assigned to a PCP, the member is notified by mail of the automatic selection and information is included in the packet informing the member of the option to change if he or she wants to do so.

### **Changing Primary Care Providers**

Members may request a change in PCP selection at any time. Member Services Representatives or CareAdvantage Navigators will discuss the reason for the change with the member so that HPSM can provide help as necessary and monitor for quality of care.

Changes in the PCP selection can be effective only at the beginning of a specific month, so requests for PCP changes must be received by the 22nd of the month to be effective the 1st of the following month. After HPSM staff complete the change, the member will receive a confirmation letter, and a new HPSM ID card with the new PCP selection.

When a PCP change request is approved due to the deterioration of the doctor/patient relationship, the HPSM Medical Director, at his/her discretion, may arrange for care of the member by another physician until the change becomes effective.

### **Member Reassignment**

Providers may request that a member be reassigned to another provider based on the following criteria:

- Lack of member cooperation
- Consistent failure to keep appointments
- Non-compliance with the provider's instructions
- Poor understanding and/or communication between doctor and patient
- Inability to establish a relationship, continue a relationship or the deterioration of an existing relationship
- Abusive behavior toward the provider and/or the provider's staff
- Member exhibits drug seeking behavior
- Member has a past history of bad debt and no payment arrangements with PCP prior to coverage under a HPSM program
- A determination that care can be more appropriately provided by another provider due to geographic, cultural, and other social situations or considerations.

Physician requests for member reassignment must be in writing, documenting the reasons for the request, and sent to the HPSM Provider Services Department to initiate the process. Requests for member reassignment can be mailed to the Provider Services Department, or submitted by fax to (650) 616-8046.

A request for change of a PCP during “active treatment” will require a special review by the Medical Director and the Grievance Coordinator. Active treatment is defined as care for a medical condition which is ordinarily not short term in nature (i.e. sore throat, cold, etc.) and which is most appropriately continued by the current treating PCP. Examples of active treatment conditions include: late stage perinatal care, pre-operative preparation for a scheduled surgery, post operative follow-up, or any medical condition/treatment which, in the opinion of the Medical Director, should be completed by the current treating PCP. This process allows HPSM to assist the member as necessary and monitor for quality of care during the transition to a new PCP provider.

Action on such requests is at the discretion of the Medical Director or designee who will determine if the change would have a detrimental effect on the health of the member during the course of active treatment.

The Medical Director may, upon consultation with the current treating PCP and the new proposed PCP, determine that the change is acceptable during the course of the active treatment period.

All such requests for member reassignment during active treatment, whether they are initiated by the provider or the member, will require documentation from the current treating PCP. This documentation must include the member’s diagnosis(es), member’s current physical condition, treatment plan as well as the reasons for the request for member reassignment.

A written notice of the decision will be sent to the requesting member or provider, with information about the rights of the individual to file a grievance and the necessary procedures to take such an action. Please see Section 4 of this Manual for information about the HPSM Complaint and Grievance procedures.

### **Continuity of Care for New Members**

As required by California law, under some circumstances, HPSM will provide continuity of care for new Members who are receiving medical services from a non-participating provider, such as a doctor or hospital, when HPSM determines that continuing treatment with a non-participating provider is medically appropriate. In such cases the HPSM contracted provider may be required to coordinate a member’s care with a non-contracted provider.

A new member may request permission to continue receiving medical services from a non-participating provider if he/she was receiving this care before enrolling in HPSM and if the member has one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with HPSM.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the member enrolls with HPSM.
- Performance of a surgery or other procedure that the member's previous plan authorized 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 time the member enrolled with HPSM.

Members should contact either the Member Services Department or CareAdvantage Unit to request continuing care or to obtain a copy of HPSM's Continuity of Care policy. Normally, eligibility to receive continuity of care is based on the member's medical condition. However, eligibility is not based strictly upon the condition and will be determined by the HPSM Medical Director. If the request is approved, the member will be financially responsible only for applicable co-payments.

HPSM will request that the non-participating provider agree to the same contractual terms and conditions that are imposed upon participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, HPSM is not required to continue that provider's services. HPSM is not required to provide continuity of care as described in this section to a newly covered member who was covered under an individual subscriber agreement. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement.

HPSM staff will notify a member of HPSM's decision. If HPSM determines that the member does not meet the criteria for continuity of care, the member can file a grievance with HPSM. Members can also contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-

888-466-2219; or at the TDD number for the hearing impaired, (877) 688-9891; or online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)

### **Continuity of Care for Termination of Provider**

HPSM will provide continuity of care for covered services rendered to a member by a provider whose participation has terminated, if the member was receiving this care from this provider prior to termination and if the member has one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time the provider stops contracting with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- Performance of a surgery or other procedure that HPSM had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to a member in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with HPSM prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, HPSM is not required to continue the provider's services beyond the contract termination date.

Members should contact either the Member Services Department or CareAdvantage Unit to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on the member's medical

condition and will be determined by the HPSM Medical Director. However, eligibility is not based strictly upon the condition. If the request is approved, the member will be financially responsible only for applicable co-payments.

HPSM staff will notify a member of HPSM's decision. If HPSM determines that the member does not meet the criteria for continuity of care, the member can file a grievance with HPSM. Members can also contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, (888) 466-2219; or at the TDD number for the hearing impaired, (877) 688-9891; or online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)