HEALTH*matters*MD

HPSM's quarterly newsletter to update network providers on policy changes, regulatory requirements and best practices

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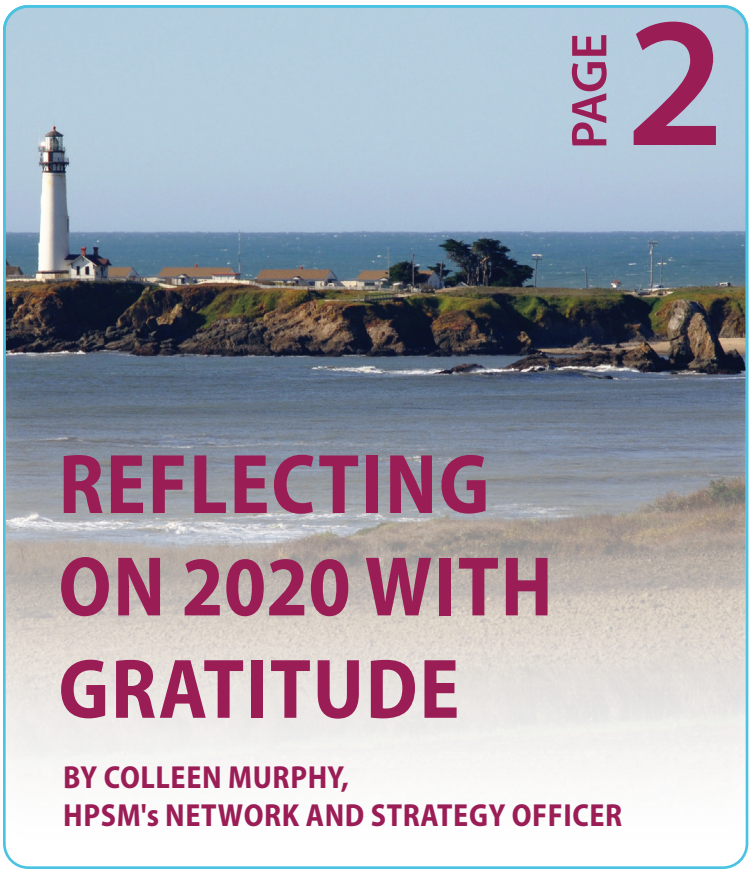
HealthPlan OF SAN MATEO
Healthy is for everyone

Q4 | 2020



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REFLECTING ON 2020 WITH GRATITUDE

Dear Providers,

As 2020 comes to a close, we have much to reflect on. It is hard to keep track of how often the term "unprecedented" has been used to describe this year. Phrases like "social distancing" and "positivity rates" and words like "PPE" and "quarantine" have become all too familiar in our vocabulary. The year has shone a harsh spotlight on areas where our work and time is urgently needed: on dismantling racial injustice and the impact it has on health outcomes. On strengthening and investing in our healthcare community, who have shouldered the lion's share of the COVID-19 burden and shown the world new forms of resilience.

This has been a year of loss for too many – whether of loved ones, jobs or normalcy. However, it has also been a year of gratitude and creativity in the face of adversity. Here at HPSM, we have been awed at the speed with which you, our provider community, adopted telehealth and virtual care tools. We've been humbled by your commitment to your patients through this crisis. We've been stretched to do more to support you with online tools and virtual learning forums. We've strengthened connections with our Public Health peers and providers as we've partnered to expand testing capacity, prevent COVID-19 outbreaks in congregate care settings, and accelerate efforts to reduce population health disparities. We've been energized by the tenacity and commitment of HPSM's staff, the majority of whom rapidly transitioned to remote work – juggling family commitments, new technology, and the personal impacts of COVID-19 with grace and good humor. And we've been inspired by the ways in which the Bay Area community continues to come together.

Many people have compared 2020 to a storm that individuals are navigating in very different boats. Income, race, ethnicity, profession, access to housing and many other social determinants of health play a significant role in how one has experienced this year. But in a year of uncertainty and stormy weather, there is one thing I am certain of: that HPSM and our provider community are working to build a bigger boat and live up to our mission that *Healthy is for Everyone*. Thank you for everything you do to advance that mission and care for our members. We look forward to seeing you in the New Year.

With gratitude,

Colleen Murphey
HPSM Network and Strategy Officer

WELCOME BEHAVIORAL HEALTH PROVIDERS

HPSM is delighted to welcome many new behavioral health providers to our network in 2020. This October, HPSM took on several administrative functions (including provider contracting, credentialing and claims payment) for much of the behavioral health network that serves HPSM members today. These functions were previously managed by our close partner, Behavioral Health and Recovery Services (BHRS), San Mateo County's mental health plan. This change was made as part of BHRS's and HPSM's ongoing effort to invest in stronger, more efficient integration of behavioral health services and administration in San Mateo County.

Going forward, providers and agencies delivering primary mental health care (which DHCS calls "Mild to Moderate Services") to HPSM members will now be directly contracted with and credentialed by HPSM.

Over the past several months HPSM has onboarded nearly 120 individual mental health providers and several large agencies, who transitioned from holding a contract with BHRS to being part of HPSM's direct network. We are also working hard to expand our primary mental health network. For example, we recently brought on several new behavioral health providers, such as 3Prong Health (3pronghealth.com), to serve HPSM members.

This is an exciting time for San Mateo County, as we leverage our great relationship with San Mateo County Health's BHRS team and continue working together to improve behavioral health services and integration for our members.

▶ Know any great behavioral health providers who offer primary mental health care (or "Mild to Moderate Services")? If so, refer them to join HPSM's network by emailing PSinquires@hpsm.org.

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LOOK FOR US ON SOCIAL MEDIA

Starting January 1, 2021

Like us on Facebook

Follow us on Instagram

MEDI-CAL RX: WHAT YOU NEED TO KNOW

In 2019, Governor Gavin Newsom issued Executive Order N-01-19[1], a statewide mandate requiring the Department of Health Care Services (DHCS) to transition all Medi-Cal pharmacy services from HPSM to fee-for-service (FFS) Medi-Cal by January 1, 2021. This deadline has since been moved to April 1, 2021, but planning efforts for the transition continue.

Starting in April of next year, outpatient pharmacy benefits and services for Medi-Cal members will be administered by DHCS and *not* HPSM. The major implication for you and our members is that outpatient pharmacy benefits for HPSM Medi-Cal members will no longer be managed by HPSM, but by DHCS in partnership with its contracted pharmacy benefits manager (PBM), Magellan.[2]

[1] gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf
[2] dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx

WHAT'S CHANGING

FORMULARY Instead of a formulary, Medi-Cal Rx will have a preferred drug list called the "Medi-Cal Contract Drug List"

Starting in April, for pharmacy-benefit drugs, you'll need to refer to this list instead of HPSM's formulary. Please familiarize yourself with the Medi-Cal Contract Drug list at **dhcs.ca.gov/services/pages/ff.html**. Keep in mind that, like most formularies you are used to, the preferred drug list may change.

AUTHORIZATIONS Where and how you submit pharmacy-benefit prior authorization requests will change

There are two instances when you will need to submit a prior authorization request to allow for payment of a drug you are prescribing:

1. The drug is not on the Medi-Cal Contract Drug List
2. The drug is on the Medi-Cal Contract Drug List, but is flagged as requiring a prior authorization

Prior authorization requests will go to Magellan, the contracted PBM for DHCS. Magellan's prior authorization requirements, review criteria and process for handling authorization denials will differ from what HPSM has historically required.

To ease with this transition, DHCS will allow for a 180-day transition supply. That means DHCS will not require prior authorization for any drug that normally requires one, as long as the patient is currently being prescribed the drug through HPSM.There will be two ways to submit prior authorization requests:

1. Online through **medi-calrx.dhcs.ca.gov** or **covermymeds.com**
2. By fax or mail (for instructions, visit **med-calrx.dhcs.ca.gov**)

BILLING How pharmacies bill for prescriptions will change

Starting on April 1, 2021, pharmacies are to bill Magellan instead of HPSM (or HPSM's PBM, SS&C). To bill Magellan, pharmacies should use the following information:

- BIN 022659
- PCN 6334225
- The 14-character beneficiary identification number located on the patient's BIC card.

WHAT'S STAYING THE SAME

Medi-Cal Rx will not affect:

1. All other Medi-Cal health care benefits currently managed by HPSM.
2. Pharmacy services billed as a medical and/or institutional claim instead of a pharmacy claim. These will continue to be billed through HPSM.
3. Pharmacy benefits for HPSM CareAdvantage or HealthWorx patients, which will still be managed by HPSM.

WHAT'S NEXT

Take these three steps to learn more about Medi-Cal Rx and stay informed as we head into this new chapter:

1. Sign up to receive training on Medi-Cal Rx and the new required provider portal at **medi-calrx.dhcs.ca.gov/home/education**
2. Register for the new required provider portal via the Learning Management System, Saba, at **medi-calrx.dchs.ca.gov**
3. Subscribe to receive emails for the latest Medi-Cal Rx updates at **mcrxsspages.dhcs.ca.gov/Medi-CalRxDHCScagov-Subscription-Sign-Up**

PCP SPOTLIGHT

CONGRATULATIONS TO THREE HPSM PROVIDERS FOR AN EXCEPTIONAL YEAR

2020 marks two years since the start of HPSM's Medi-Cal Primary Care Benchmark Pay-for-Performance (P4P) Program. This year, we have good cause to celebrate: three providers have achieved full credit on all P4P quality benchmarks.

North East Medical Services (NEMS), San Bruno Pediatrics and LiveWell Medical Clinic in South San Francisco all excelled at every quality measure. As a result, these providers will receive more than double their base capitation payments in quality and access bonuses from HPSM.

So how did they do it? Dr. Helen Wong and Dr. Kimberly Wong of NEMS and Dr. Maria Abunto of San Bruno Pediatrics explain below in their answers to HPSM's questions. (LiveWell Medical Clinic was the only primary care provider to successfully make this prestigious list last year, and was profiled in our Q4-2019 newsletter. You can read what LiveWell's Dr. Osmena had to say about her learnings at **tinyurl.com/y7rpetvj**.)

Q: What key strategies do you think led to your clinic's success in the Benchmark P4P program? Can you talk about specific steps taken to drive the outcomes of your quality scores?

NEMS The key to our success was in reviewing and analyzing the data provided to us by HPSM and comparing the reports from our own internal data. In doing this we were able to identify care gaps and discrepancies in the reports. This would not have been possible without a team-based effort involving operations, physician leadership, IT/EHR support, nursing and billing to address those gaps.

HPSM's responsiveness and support in addressing our questions and concerns related to certain aspects of the reporting was invaluable.

SAN BRUNO PEDIATRICS Our office's key strategy is first understanding the purpose of the HPSM Benchmark Program, which is really about ensuring the health and wellness of a patient population – in this case our assigned patient panel.

eReports is one key tool in our success, since it provides us with the patient lists that became an integral part of our day-to-day activities. Office staff download, filter and distribute the lists amongst themselves on a monthly basis to prioritize patients who need services and to reach out to them accordingly to schedule/reschedule appointments.

Another strategy we live by is to adopt the mindset of offering patients all the services they need (and are due for) if possible at each encounter, keeping in mind that a person's circumstances may change at any time and they may not be able to access care in a timely manner in the future.

Finally I want to congratulate and acknowledge my office staff, as this endeavor would be impossible without their understanding and hard work.

▶ To learn more about our primary care value-based payment program, please visit **hpsm.org/provider/value-based-payment**

Q: What internal changes or workflows were required to operationalize this approach?

NEMS Our electronic medical record (EMR) team assisted with inputting into our EMR new CPT2 codes required to report data relating to several of the measures, as well as automating some of the submissions.

We implemented Digital Retinal Scanning in our clinic to improve access for patients needing diabetic eye screening.

We continuously tracked our progress and created work plans every month to improve on each measure, reviewing them as a group at monthly team meetings.

We had educational sessions with our providers and nursing team members on topics such as appropriate asthma medication prescribing, usage and monitoring. And we assigned staff to do outreach to engage and shadow new patients, as well as those with care gaps, in a coordinated effort.

SAN BRUNO PEDIATRICS Keeping our answer to the first question in mind, staff are allotted time to pore over the lists each day and schedule or reschedule patients accordingly. A significant amount of time is devoted to ensuring that patients are up to date with their preventive care needs.

With our upcoming transition to Epic's EMR system slated for January 2021, this time-intensive process might hopefully become further integrated into our EMR.

Q: Do you believe these approaches could be adopted by other providers and practices, or is there something about your method that is specific to your practice?

NEMS Our approach certainly could be adopted by other providers and practices. However, a robust EMR support team was instrumental to our success. When reviewing our internal reports, we realized we were much closer to meeting targets for several of the measures when compared to the reports provided by HPSM. Most of our effort was then focused on eliminating those data gaps by improving our reporting, resulting in cleaner data for us to work with.

Q: Did you find that efforts to improve quality in one measure led to quality improvements in other measures as well?

SAN BRUNO PEDIATRICS Absolutely. The measures are linked and each one has a bearing on the other, as the P4P program is for health and wellness in general.

LiveWell MEDICAL CLINIC

NEMS NORTH EAST MEDICAL SERVICES

SAN BRUNO PEDIATRICS

POLICIES & PROCEDURES

SUBMIT YOUR CLAIMS ELECTRONICALLY

HPSM is committed to making sure you receive payment as quickly and easily as possible. One of the most effective ways to streamline payment is to submit your claims electronically. Electronic claims reduce data entry errors, speed up claims turnaround time and give you immediate confirmation that your claim has been received.

As an HPSM provider, you can choose from two ways to submit claims electronically:

1) Via clearinghouses

Clearinghouses provide the service of gathering all necessary information to submit a claim. They can do this either through proprietary software or through integration with your current software using the 837 file. HPSM currently partners with two different clearinghouses: **Office Ally**[1] (Payer ID: HPSM1) and **Change Healthcare**[2] (Payer ID: SX174 for 837 professional and 12X74 for 837 Institutional).

2) Using our eHEALTHsuite portal

Providers can manually enter claims directly into HPSM's claim system using eHEALTHsuite. To use this option, providers must submit the CMS 1500 claim form. New users can register for an account online at **tinyurl.com/y3aku4f6**.

WHAT ABOUT PAPER CLAIMS?

In limited cases, a paper claim is still required. Here are examples of paper claims we accept:

- Claims requiring attachments (including "By Report" and unlisted codes)
- LTC (25-1 Form)
- Medicare crossover claims or claims that require primary insurance information for coordination of benefits
  - ▷ Reminder: Most claims processed by Medicare FFS will automatically cross over to HPSM electronically through the Coordination of Benefit Agreement (COBA). Please allow three weeks from the Medicare Explanation of Benefits (EOB) date before submitting a claim directly to HPSM for secondary payment.
- Durable medical equipment (DME) or medical supplies requiring Medicare Secondary Payer Recovery (MSRP) and/or invoice for pricing
- Claims requiring consent forms for sterilization and hysterectomy

▶ For more information, please visit **hpsm.org/provider/claims/submit-claims**. If you have questions, contact our Claims Department at **650-616-2056** or **claimsinquiries@hpsm.org**.

[1] Visit **officeally.com**

[2] Visit **changehealthcare.com/solutions/medical-network/claiming-remittance**

UNDERSTAND YOUR PATIENTS' RIGHTS AND RESPONSIBILITIES

All HPSM members have certain rights and responsibilities. These range from the right to health care access and privacy to the responsibility of following agreed-upon treatment plans. As an HPSM network provider, it is your responsibility to familiarize yourself with these rights and responsibilities. They are listed in the member handbooks for each of our four of health care plans – Medi-Cal, CareAdvantage, HealthWorx and ACE. These handbooks are available online at **hpsm.org/member-handbooks**.

REQUEST PRIOR AUTHORIZATION IN 4 STEPS

Before delivering a non-emergency service, HPSM providers are expected to check the Medi-Cal Provider Manual[1] and HPSM's Prior Authorization Required list[2]. These provider resources indicate which codes are covered benefits and whether they require prior authorization or not.

To help us ensure prior authorization requests get answered as quickly as possible, providers must complete request forms correctly and accurately. Here are four simple steps to make that happen:

1 **Download the latest form at hpsm.org/provider/authorizations**. Make sure the form you are using is the most current. As of this publication, the form dated February 2020 is the most current form for general authorizations. Older request forms will not be accepted and may result in delay of payment.

- Certain types of specialty authorizations, including Non-Emergency Medical Transport (NEMT) and nutritional supplements, require a unique form or have unique documentation requirements. Read more and download the latest forms at **hpsm.org/provider/authorizations/specialty-provider**.

2 **Complete the fillable PDF on your computer**, typing information into the required boxes. Here are some important tips to make sure your request is not rejected and is processed as quickly as possible:

- **Hand-written forms will be rejected.** The only field that should be completed by hand is the signature field at the bottom of the form.
- **Only enter information and check off items that are necessary.** You will select "Routine" for nearly all requests. Two common errors that result in reprocessing requests (and slow down response time) are:
  - ▷ Marking "Urgent" for non-urgent services
  - ▷ Checking off items within the "Long Term Care (LTC) authorization requests" box when the request is not for a long-term care stay
- **Double check your form to make sure you've entered correct information for your patient.** Common errors, such as incorrect member data, benefit not active, invalid National Provider Identifier (NPI) number or invalid diagnosis codes can result in your request being denied.

3 **Fax in the authorization form to 650-829-2045.** You may also include medical necessity documents with your fax. Don't use a coversheet with your fax. To prevent delays, please use only one form per patient, and one form per fax.

4 **Wait for prior authorization to be granted.** Urgent requests for all lines of business will be answered within 72 hours of receipt. Standard requests for Medi-Cal, HealthWorx and ACE patients will be answered within five business days from receipt. CareAdvantage requests will be reviewed within 14 calendar days from receipt.

Did you know? You can check the status of your authorization requests online! Please allow up to 48 hours for authorization status to update. Visit **hpsm.org/provider/portal** to sign up.

Still have questions? You can watch a new video explaining how to properly submit a prior authorization form on our website at **hpsm.org/provider/authorizations**.

[1] **medi-cal.ca.gov**

[2] **hpsm.org/docs/default-source/provider-services/authorizations/20200901-q3---finalf26b4f475c5747f88fa5462ac13c16a1.pdf**

CLINICAL CORNER

REFER QUALIFIED PATIENTS TO THE DIABETES PREVENTION PROGRAM (DPP)

Did you know that HPSM members with prediabetes may qualify for an evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes? The 12-month **Diabetes Prevention Program (DPP)** coaches patients on how to make healthy lifestyle changes like eating better and being more physically active. DPP is provided at no cost to eligible HPSM members. Program components include (but are not limited to):

A trained lifestyle coach | Educational materials | Regular weigh-ins | Group support

WHO IS ELIGIBLE FOR THE PROGRAM?

To qualify, HPSM Medi-Cal and CareAdvantage members must:

- Be 18 years or older
- Have no previous diagnosis of type 1 or type 2 diabetes
- Not be pregnant
- Not have end-stage renal disease
- Have a body mass index (BMI) of at least 25, or at least 23 if self-identified as Asian

Meet one of the following:

- ▷ Hemoglobin A1c test: 5.7%-6.4%
- ▷ Fasting plasma glucose: 100-125 mg/dL
- ▷ Two-hour plasma glucose: 140-199 mg/dL (oral glucose tolerance test)

OR have a gestational diabetes diagnosis in a previous pregnancy (Medi-Cal members only)

HOW CAN I REFER MEMBERS?

If a member meets the above requirements and is interested in enrolling in DPP, please complete the DPP Provider Referral form located on HPSM's website at **hpsm.org/diabetes-prevention-program**. To learn more about the program and eligibility, members can visit that web page or call HPSM's Health Education line at **650-616-2165**.

HEDIS® RECORD REQUESTS COMING IN FEBRUARY 2021

HPSM's annual Healthcare Effectiveness Data and Information Set (HEDIS) review starts in early February. At that time, someone from HPSM or Change Healthcare (our certified vendor) will contact your office to arrange a visit from a Medical Records Technician (MRT) to get requested charts.

COVID-19 PRECAUTIONS

Change Healthcare MRTs are trained in COVID-19 precautions and follow strict COVID-19 safety guidelines. Change Healthcare can offer alternative methods for records collection. They can provide you with:

- A secure fax number
- Information on encrypted emails
- Secure drop box access

Change Healthcare also has a record collection team that specializes in secure, remote access to electronic medical record (EMR) systems. They are familiar with most EMR systems, and once you provide the necessary access, they will collect all the required records.

If you wish to take advantage of one of these services, let the Change Healthcare representative know when they call to schedule chart retrieval.

▶ Please schedule an appointment as early as possible to avoid the rush and ensure your staff has time to prepare the records. HPSM will send pull lists between late February and early March. Please submit all HEDIS records by April 9, 2021.

HEDIS data collection is time-sensitive with a firm deadline. HPSM providers are contractually required to participate and submit medical records. Your compliance with this deadline ensures that HPSM can report complete and accurate data to state and federal regulatory bodies, as well as the National Committee for Quality Assurance (NCQA), which administers HEDIS.

▶ If you have questions or concerns about HPSM's HEDIS review, contact Tim Shoemaker, RN, HEDIS Quality Improvement Nurse Supervisor, at **timothy.shoemaker@hpsm.org** or **650-616-5016**.

IMPROVING MEMBERS' HEALTH WITH POPULATION NEEDS ASSESSMENT

In June 2020, HPSM conducted an annual Population Needs Assessment (PNA) of our Medi-Cal membership. The goal of the PNA is to improve the health of our members. We do this by assessing member needs, identifying health disparities and then using our findings to develop strategies that address these needs and disparities.

The PNA was informed by a variety of data sources, including (but not limited to):

- Healthcare Effectiveness Data and Information Set (HEDIS) results
- Claims data
- Language Assistance Services Utilization data
- Member survey data, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

To conduct the PNA, we segmented HPSM's Medi-Cal member population by several factors (including age, gender, language preference, race/ethnicity, geographic distribution and vulnerable group status). Segmenting the population

helped us better understand our members' health status and behaviors, cultural/linguistic needs, health education needs and any gaps in services related to these areas.

Based on the PNA findings, we developed an action plan with targeted Health Education, Quality Improvement and Culturally & Linguistic Appropriate Services (CLAS) program strategies. We will report some of the specific PNA findings and the work we are doing to address them in future newsletter articles. Some of the focus areas identified through the findings include:

Perinatal population

- Gestational diabetes
- C-sections
- Hypertension

Pediatric population

- Teen pregnancy
- Well child visits
- Asthma management

Chronic disease prevalence and self-management

- Asthma
- Diabetes
- Hypertension

Performance metric disparities

Member experience and access to care

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REMIND YOUR PATIENTS TO GET A FLU SHOT

This flu season, health authorities say getting the vaccine is even more important than usual to help avoid a flu/COVID-19 "twindemic". Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), warned that "There's considerable concern as we enter the fall and the winter months and into the flu season that we'll have that dreaded overlap" of the flu and COVID-19.

When you see your patients, ask if they've gotten their flu shot this year. If they haven't, encourage them to get one. The best way to be sure your patients get vaccinated is to give them a shot during their appointment. If your patients don't have time to get the flu shot during an appointment, they can still get the flu shot by visiting their local pharmacy. Just remind them to bring their HPSM member ID with them. If they are due for other shots (such as the pneumonia vaccine), also offer to administer them as well. For more detailed tips on how to support immunization discussions with patients during the public health emergency, see page 8 of our Fall 2020 newsletter: **tinyurl.com/yc96ou8v**.

- **HPSM held our first-ever Drive-Thru Flu Clinic** in the parking lot outside of our offices on Saturday, November 7th from 10am to 2pm. In partnership with Safeway Pharmacy, we gave over 50 HPSM members their flu shots at this event. We observed COVID-19 safety and social distancing guidelines, such as requiring face coverings and administering the vaccinations while members stayed in their vehicles.