

The Benefits of Care Coordination

The Health Plan of San Mateo acts as the communications and case management center for our members and providers. We are in the unique position of interacting with all of the interdisciplinary providers that are involved with the care of your patients.

Our providers have been receiving newly mandated care plans since the beginning of the year. It is vitally important that you understand the process by which these plans are formulated, as well as the state and contractual requirements that accompany them.

Care Plan Process

The new care plans are initiated when a member completes an HPSM Health Risk Assessment (HRA). These surveys are normally completed via telephone. A member's responses to the HRA trigger the inclusion and referral of appropriate physicians and community resources based on their medical, behavioral, and psycho-social needs.

HPSM notifies the member's primary care

physician and other care providers that a plan development meeting is being scheduled. Doctors are invited to attend the planning session in person, via telephone, or are asked to submit input via mail. These sessions are a valuable opportunity for a member's care team to collectively discuss their treatments and needs.

Information collected from the planning session is added to utilization and claims and input to our case management software, MedHok. The care plan report is then generated and submitted via fax or mail to the PCP and other relevant parties, including the member.



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Mandated Care Plans Requirements

HPSM complies fully with state mandates to include members, in-home services, primary care physicians, behavioral health providers, and other interdisciplinary care team members in this process.

HPSM providers should maintain a copy of these mandated care plans in our member's medical files.

Provider Benefits

- **Case Management.** It can be difficult to track the many specialists, hospitalizations, prescriptions, and social services that a patient receives outside of your office. As an HPSM provider, you receive the support of our care coordinators and nurse case managers for those patients who are in need of the most help.
- **Access to Health Risk Assessments.** It is not always possible to ask your patients in-depth health questions. Often, patients are hesitant to discuss some health issues with their doctor. The HRA is a resource that can provide a well-rounded view of your patient's health and home environment.
- **Communication.** Your participation in the care plan process allows you to share care goals with, and receive information from, other providers and collateral partners.

- **In-Home Social Services,** behavioral specialists, residential care providers, and the members themselves contribute to the care plan, making it a valuable resource to all involved. The plans also include case notes and minutes from any interdisciplinary team meetings.

Member Benefits

- **Comprehensive Care.** HPSM Nurse Case Managers are able to get an overview of a member's home environment, behavioral and physical health needs, and provide recommendations and benefit information tailored to the patient.
- **Utilization Review.** Case management can help contain out-of-pocket costs for our members, as well as ensure that they are taking full advantage of the benefits available to them.

Questions about this process should be directed to your HPSM provider services representative. ■

The HPSM Care Coordination Program proactively coordinates complex care to help facilitate the best clinical and functional outcomes for our members. Program staff is knowledgeable of each member's benefits and work to facilitate optimal use of those benefits. For questions, call the Care Coordination Program at **650-616-2060**.

Introducing Margaret Beed, M.D.

The Health Plan of San Mateo is pleased to announce Dr. Margaret Beed as our new Chief Medical Officer (CMO).

Dr. Beed is a board-certified pediatrician with extensive experience as an executive with Blue Shield, the counties of San Bernardino and Orange, and CalOptima, the largest County Organized Health System (COHS) in California.

She received her medical training and M.D. from the University of Illinois, and her master's in public health from the University of North Carolina, Chapel Hill. She completed her pediatric residency at Valley Medical Center in Fresno, California. ■



One of the most popular services that HPSM offers to our members and providers alike is access to our Nurse Advice Line.

The nurses who staff the 24-hour advice line use their years of experience and knowledge to direct patients to the appropriate level of care. They can provide self-care instructions for minor illnesses or injuries. They also encourage prevention, wellness, and early detection.

Primary care physicians receive immediate post-call reports that present a great opportunity to engage their patients for follow-up appointments.

HPSM includes the Nurse Advice Line phone number in a majority of our marketing materials, including the member newsletter and new member packets.

Under our contract with the vendor, Nurse Response, we are able to offer private physician's offices a discounted rate for telephone triage services for their entire practice.

For more information on signing up for this service, please contact Nurse Response Client Services at **317-725-4477**. ■

Nurse Advice Line

P4P Incentive Opportunities

Health Plan of San Mateo's Pay for Performance (P4P) program offers monetary rewards for practices that provide high quality care for our Medi-Cal members.

The incentives highlighted here tend to be underutilized in our network. These preventative measures can improve your accounts receivable, not to mention your patient's health.

Initial Health Assessment

1. Perform an initial health assessment (IHA) of new members (all ages) within 120 days of HPSM enrollment that includes:
 - Full history with evaluation of physical, behavioral, and emotional growth and development
 - Complete physical exam
 - Diagnosis(es) and care plan
 - Age specific anticipatory guidance
2. Complete the Staying Healthy Assessment (SHA) Tool
3. Bill the visit with the appropriate CPT code for a new visit.
 - Payment of \$90 will be paid with your regular Medi-Cal remittance advice.

Referrals by PCP to OB Physicians

1. Identify pregnant women as early in pregnancy as possible.
2. Refer the pregnant woman to an OB provider immediately.
3. Help the pregnant woman make an appointment with an OB provider in the woman's first trimester.
4. Complete the HPSM OB referral verification form.
5. Fax the verification form to HPSM: **650-829-2009**.
 - Available per pregnancy.
 - Payment of \$50 will be paid on your quarterly P4P remittance advice.
 - Provider Services can provide you with a pad of verification forms. Forms are also available online: www.hpsm.org/providers/medi-cal-p4p.aspx

Depression Screening

1. For adults (18+ years old), conduct a screening for depression using HPSM's behavioral health consolidated screener or any standard depression screening tool.
2. Bill HPSM with procedure (HCPCS) codes:
 - G8510 for negative screen, or
 - G8431 for positive screen and follow-up plan documented.
 - If HPSM's consolidated screening tool is used, you can also bill alcohol screening with H0049, a \$24 Screening, Brief Interventions, and Referral to Treatment (SBIRT) Medi-Cal benefit.
 - Not available with or after billing G0444 within the calendar year.
 - Available once per eligible member per calendar year.
 - Payment of \$30 will be paid on your quarterly P4P remittance advice.

The P4P program is dynamic and continues to improve with suggestions from our provider network. If you have any ideas about ways to make our program even better, please contact Nicole Ford at nicole.ford@hpsm.org or 650-616-2169. ■

Changes in Your Access to the Provider Portal

The HPSM Provider Portal is undergoing a security overhaul to better comply with HIPAA regulations and control access to sensitive member and claims information.

Effective July 20, 2015, each provider must have an individual login and password to access the Health Plan of San Mateo Provider Portal. Shared office logins will no longer be granted access.

You will be prompted to create a new user name and password on a future login.

Additionally, each office may designate one "administrator" who will be responsible for creating and managing access for individuals within their organization.

HPSM's Provider Portal allows you to:

- Check Member Eligibility
- Submit New Claims
- View Claim Status/History

If you have any questions about designating an administrator or need access to the HPSM Provider Portal, please contact Provider Services at psinquiries@hpsm.org or via phone: 650-616-2106 ■

CCS Demonstration Project/Pilot Anniversary

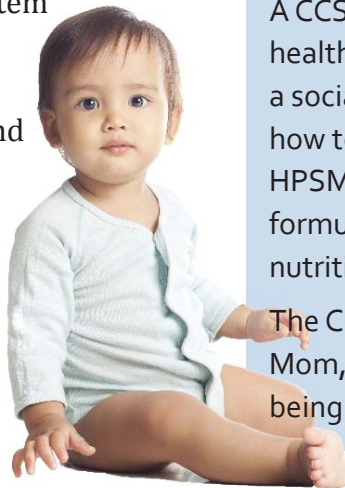
The Health Plan of San Mateo (HPSM) is celebrating the two-year anniversary of the San Mateo County California Children Services (CCS) Demonstration Project/Pilot program.

The CCS DP/Pilot program was implemented in conjunction with the San Mateo County Health System with a goal of providing an integrated, family-centered, care delivery and coordination system.

This program is part of a state-wide effort to provide diagnostic and treatment services, medical case management, and physical or occupational therapy to patients under age 21 with certain chronic diseases and limited financial resources.

Some of the significant milestones reached:

- Assignment of a single case manager to provide care coordination for patients with both CCS-eligible and non-eligible conditions
- Reduction in the number of denials of service from CCS and HPSM
- Expansion of the CCS formulary, including greater access to incontinence supplies



A CCS Success Story

Charlie was at risk of losing access to formula, his major source of nutrition, due to no longer meeting the medical criteria. His family does not speak English and needed help understanding how to meet his nutritional needs with familiar and traditional foods.

A CCS Clinical Case Management team consisting of public health nurses, a dietitian, a therapy case manager, and a social worker partnered with the family to teach them how to meet Charlie's nutritional needs. They worked with HPSM's Medical Director to extend the authorization for formula and developed a feeding schedule to ensure proper nutrition during the learning period.

The CCS Team happily reports, "The last time we talked to Mom, she was very comfortable with Charlie's progress, and being discharged from the formula and feeding therapy."

- Implementation of annual comprehensive family and member needs assessments
- Simplified the grievance and appeals process for CCS members
- Formation of the Demonstration Project Advisory Committee and Family Subcommittee to provide community, provider, and family input into the DP/Pilot process

The DP/Pilot program is scheduled to continue through April of 2016 with two possible one-year extensions. ■

ICD-10 Reminder

- The ICD-10 federal compliance date is October 1, 2015.
- HPSM will not offer a grace period for converting to ICD-10. Claims with ICD-9 codes with dates of service on or after October 1, 2015 will be rejected.
- For questions about the conversion, or to be included in ongoing provider testing, please contact: **ICD10@hpsm.org** .
- See the provider resources page on our website (www.hpsm.org/providers/) for an FAQ document with more information on:
 - Pre-authorizations and claims spanning the conversion date
 - HPSM readiness
 - Testing schedule
 - Training resources



HPSM Office Relocation

The explosive growth in our membership and staff has caused us to outgrow our current space.

We are pleased to announce our relocation to 801 Gateway Boulevard in South San Francisco.

This building, literally next door to our current location, is being renovated to include an employee cafeteria, collaborative work spaces, and improved member intake and interview areas.

The physical move is scheduled for mid-December 2015. ■



Redwood Pulmonary Medical Associates

Located on the lobby level of Sequoia Hospital in Redwood City, Redwood Pulmonary Medical Associates (RPMA) is working to provide sleep apnea diagnosis and treatments for Health Plan of San Mateo (HPSM) members.

Dr. Melissa Lim, Medical Director and founder, is board certified in internal medicine, pulmonary diseases, and sleep medicine. She is also an intensive care unit specialist who earned her medical degree at Ohio State University College of Medicine. She was the Eudowood Fellow in Pulmonary and Critical Care Medicine at Johns Hopkins.

“I’ve been in practice at Sequoia Hospital for fifteen years and in our office we see patients that have sleep disorders as well as breathing disorders, such as asthma, smoking-related lung disease, and scarring diseases of the lung.”

Dr. Lim founded the Health Plan of San Mateo Adult Sleep Apnea Program in 2014, shortly after Sequoia Hospital’s decision to stop evaluating Medi-Cal patients for sleep disorders.

“We are emphasizing the home sleep study, testing just the cardiopulmonary channels,” she explained. “If we can extract those channels out of a formal sleep study: heart rate, airflow, chest and abdominal movement, oxygen saturation, and pulse, a person can be tested at home.”

RPMA is currently performing between thirty and forty sleep studies per month.

“We need to get more people diagnosed. If you consider there are about 120,000 HPSM members, and roughly 10,000 of them have sleep apnea, we are still only seeing a sliver of those patients.”



-- Melissa Lim, M.D.

Referrals

HPSM members do need to be referred by their primary care provider. “We can get a better sense of what patient’s complaints are. It’s helpful to get a progress note to get some background and medical history. Do they have diabetes, heart diseases, high blood pressure, seizure disorders?”

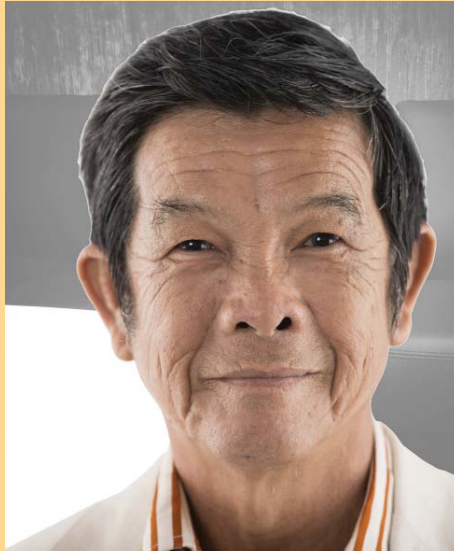
Better Compliance and Healthy Improvements

“Sleep apnea is a hub disease; hopefully our focused attention can improve the compliance with therapy and treatment, which can decrease patient difficulties with some of their other medical problems. We look at ourselves as an adjunctive service to the primary care provider, where we can really help them with their patients.” ■

Reynaldo had to move out of the Section 8 apartment where he had lived for more than twenty years when he was admitted to a skilled nursing facility for rehabilitation following surgery. A year later, his advanced age and poor health made securing new housing a barrier for discharge.

His dedicated case manager was able to work with a local housing assistance organization to not only find an apartment, but also obtain furniture and housewares free of charge.

Today, Reynaldo has reclaimed his independence, reporting, "I often cry when I look around my apartment and realize that I am finally home."



The Community Care Settings Pilot program (CCSP), implemented last year, assists Health Plan of San Mateo members to transition out of nursing facilities and back to living independently in the community. CCSP also provides services to individuals living in the community, or those who are in acute care settings, that are at imminent risk of institutionalization. CCSP staff work to ensure that individuals are taking advantage of all

available community resources, stable housing, and appropriate healthcare services to support their ability to live at home safely.

Please call **650-285-6432** for questions regarding eligibility criteria or to make a referral.

Community Care Settings Pilot Program

Lee was living in his car. He was 49 years old and had been battling a significant history of substance abuse and mental health crises. After suffering a major depressive episode and a suicide attempt he was admitted to a locked psychiatric unit. He was eventually placed in a long-term care facility following surgical complications with no clear path to discharge.

Under the Community Care Settings Pilot, HPSM was able to work with community partners to secure an apartment unit and coordinate his continued care with Behavioral Health Services and his PCP.

Lee has successfully transitioned back into the community and has been doing well.



In-home Health Services



Health professionals recognize that there are many working parts in treating chronically ill and disabled patients. Daily activities, such as dressing, meal preparation, housecleaning, driving, etc. are often overlooked when assessing the treatment needs of patients. Assisting with these activities can put an excessive burden on family members and loved ones.

The In-home Support Services (IHSS) program is a state entitlement that provides resources for Medi-Cal eligible patients who need assistance with daily activities in order to prevent hospitalizations or institutionalization.

The program is managed by Health Plan of San Mateo and our team of social workers, nurse case managers, and care coordinators.

Eligibility

- California Resident
- Medi-Cal or Supplemental Security Income (SSI) eligible
- Live at home (outside of a hospital or long-term care facility)
- Must complete the Health Care Certification process

Health Care Certification

State law requires that a licensed health professional, normally the primary care physician, document that the patient is at risk of placement in out-of-home care due to an inability to perform some or all of the normal activities of daily living.

The certification form is fairly simple to fill out and asks three main questions:

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care?

3. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months?

It is the physician's responsibility to fill out this form at the request of a member. Regardless of your responses to the above questions, an evaluation will be conducted by an HPSM social worker to determine the number of hours and level of care, if any, that a member requires.

Under state law, members are allowed to appeal a denial.

Information collected by the social worker will be included in the Care Plan (see cover page) and disseminated to the member's interdisciplinary care team.

Program Benefits

Once the need for IHSS has been established and approval is granted by the state, members are able to employ one or more caregivers.

Approximately 70% of caregivers are family members, many of whom have had to quit their jobs or reduce their full-time work in order to assist the patient. This program pays an hourly rate slightly more than minimum wage.

The number of hours of care allowed is determined on a case-by-case basis, up to a maximum benefit of 283 hours per month.

San Mateo County maintains a registry of independent workers available in lieu of, or to supplement, family care givers. "Homebridge" is a private company that also provides care givers.

The entire IHSS team, including any family members or workers compensated under the program is invited to participate in periodic care plan meetings. The information collected from daily interactions with the patient can be crucial in reaching long term care goals.

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In-Home Support Services Provider Responsibilities

We have found that some providers are hesitant to make recommendations for IHSS, for reasons ranging from “creating dependence on others” to “potential for fraud/abuse.” It is important to remember that a recommendation merely starts the evaluation process. A social worker and nurse case manager will do an in-depth evaluation of the member’s needs, taking into consideration the home environment and effect on other members of the household.

It is a disservice to our members to not make all benefits due to them accessible.

We share the common goal of improving the health and welfare of our members. Our mutual cooperation and teamwork will ensure that the systems in place will responsibly serve the needs of your patients. ■



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