HPSM New Provider Onboarding

9/25/2020

Agenda:

1. Welcome/Introductions
2. Medi-Cal Managed Care Overview
3. Process Overview
4. Prior Authorizations
5. Claims
6. eReports
7. HPSM Communication Tools
8. Next Steps
9. Questions/Discussion

Medi-Cal Managed Care Program Overview

HealthPlan OF SAN MATEO
Healthy is for everyone

About HPSM

- Health Plan of San Mateo (HPSM) is a managed care health plan that provides health care benefits to San Mateo County's underserved residents.

- We are what is known as a County Organized Health System (COHS) per state designation.

- HPSM is governed by the San Mateo Health Commission.

  - Members of the Commission represent community advocates, physicians, pharmacists, and elected officials who serve on the San Mateo County Board of Supervisors.

- HPSM Lines of Business:

  - Medi-Cal (MC)

  - HealthWorx (HW)

  - CareAdvantage Cal MediConnect (CA-CMC)

 - Access and Care for Everyone (ACE)

About Medi-Cal Managed Care

- Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems.

- Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

- Members select a PCP (primary care provider) who is responsible for members' primary and preventive care and arranging and coordinating all other aspects of their health care.

About HPSM

Health Plan of San Mateo manages programs that provide health care to more than 147,000 San Mateo County residents. We serve 1 out of every 5 San Mateo County residents.

There are more than 20 languages spoken in San Mateo County – the most common among our members are: English, Spanish, Mandarin, Cantonese, Tagalog, and Russian.

HPSM Members by Program

6%
15%
1%
78%

■ CareAdvantage   ■ ACE   ■ HealthWorx   ■ Medi-Cal
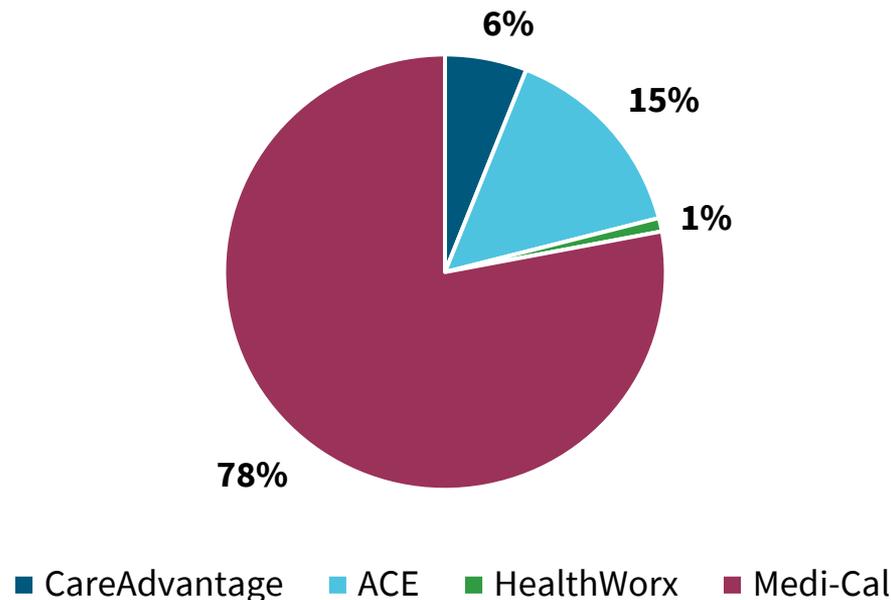
HPSM Lines of Business

- ## Medi-Cal

  - Eligibility is determined by the state of California. Medi-Cal eligible members must live in San Mateo County to be eligible for HPSM Medi-Cal coverage.

- ## CareAdvantage Cal MediConnect

  - Members are eligible for Medicare Parts A, B, D and Medi-Cal.

- ## HealthWorx

  - The only commercial product HPSM currently offers. Public Authority (SEIU #715) determines eligibility. This program largely covers In Home Support Services (IHSS) Workers and some county employees.

- ## Access and Care for Everyone (ACE)

  - San Mateo County Access and Care for Everyone (ACE) is a locally funded health care program for low-income adults who do not qualify for health insurance. HPSM serves as the third-party administrator. San Mateo County is the service area for the program.

Process Steps for Providers to see HPSM Members:

You are enrolled in Medi-Cal, have signed your contract with HPSM, and your credentialing application has been approved. You have a new member who has been referred to you - **what is next?**

1. You got a new member **referral**!
   1. This will be through a phone call from HPSM. If we don't reach you we will leave a voicemail with member name, DOB and phone number of the member from whom you should expect a call. **(Please ensure your voicemail identifies your name and/or practice name.)** Members will then call you to schedule an appointment. You no longer need an auth # to schedule the initial assessment appointment.
2. Now use the HPSM **provider portal** to check to see that the member's HPSM benefit is active; and
3. Confirm that you are **contracted** to provide care for the member's line of business with HPSM.
4. Identify what **treatment** you plan to provide on your first visit and possible future visits.
   Examples:
   i. Initial assessment
   ii. Individual therapy
   iii. Family therapy
   iv. Group therapy

What if this member needs services other than mild to moderate mental health care?

Following the initial assessment, or if at any point you determine that the client requires behavioral health services other than mild to moderate call the BHRS ACCESS Call Center (1-800-686-0101) for any of the following:

1. Higher level of care needs

2. Specialty Mental Health services

3. Substance use treatment services

4. Behavioral Health Treatment (BHT) for Autism Spectrum Disorder

Checking Covered Benefits/Procedure Codes

1. Check the Medicare website to determine if the code(s) you plan to use are covered by Medicare:
   https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

   – If **yes**, the code will be covered for CA, MC and HW.

   – If **no**, check the Medi-Cal procedure code list to determine if the code is covered   by Medi-Cal:
   https://files.medi-cal.ca.gov/rates/rateshome.aspx

     • If **yes**, the code will be covered for CA, MC and HW.

     • If still not listed under Medi-Cal, the code is **not covered** for CA, MC or HW

Checking Covered Benefits/Procedure Codes

2. Once you've identified that the code is covered, next check code descriptions/limitations by member line of business:

   – For CA check Noridian:
   https://med.noridianmedicare.com/web/jeb/specialties/mental-health

   – For MC and HW check: **(Including for codes covered by Medicare)**
   https://files.medical.ca.gov/pubsdoco/Publications.aspx

*Once you become familiar with the codes, you should not need to check them as frequently. But be aware that covered benefits and codes are subject to change.

Checking Covered Benefits/Procedure Codes

3. Check the prior **HPSM Prior Authorization Required list** to see if the CPT code for the treatment you plan to provide requires prior authorization or not: https://www.hpsm.org/provider/authorizations
   a. If the CPT code does not require prior authorization you can provide the treatment and submit the claim to HPSM.
   b. If the CPT code requires prior authorizations, you will need to submit a **PA form** with clinical attachments that demonstrate medical necessity for the treatment.
      i. You will get a fax confirmation or rejection, with explanation, within 24 hours.
         1. Once you receive a confirmation a decision will be made within 5 business days and you and the member will receive a letter with the outcome
         2. IF Approved: provide the treatment.
         3. IF Denied: Review the denial letter and next steps or options will be explained there.
   c. You can also check authorization status on the HPSM provider portal.

   *HPSM updates prior authorization requirements on a quarterly basis and notifications are sent out via fax and posted to the HPSM website about these changes.

Authorization Process Change:

Current:
With BHRS this was called "Initial authorization" and the "Continuing authorization" process. BHRS required prior authorizations (continuing authorization) for all treatment to be provided and for those claims to be paid.

Future (Post 10/1/2020):
HPSM will only require authorization for some treatment codes. Some codes will not require an authorization for the claim to be paid. Refer to the HPSM Prior Authorization requirements on the HPSM website.

For individual and family therapy, you can submit a claim and do not need to send in clinical information requesting authorization (initial/continuing authorization) before you provide and claim the service. This change in process will save you a lot of paperwork submission!

Member Process Recap

4. Provide the service

5. Submit the claim

   – You can check the status of your claim on the HPSM provider portal

6. You can view your Remittance Advices (payment) with claims detail on the HPSM eReports portal

*This process is the same for existing or new clients.
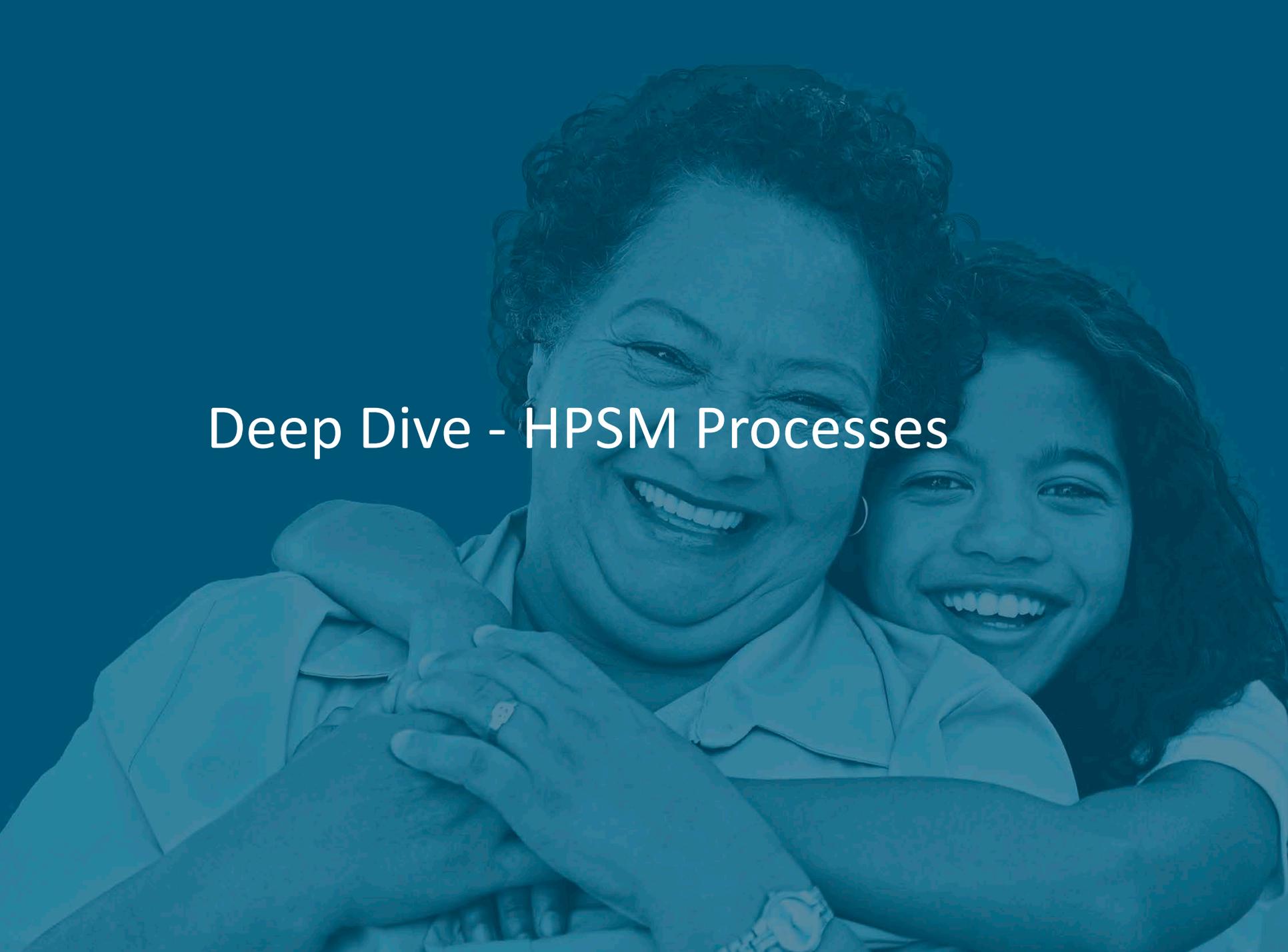
Deep Dive - HPSM Processes

Prior Authorizations

What is Prior Authorization?

- Some services that you would provide to members require **prior authorization** before providing the service.

- This is a process through which HPSM **verifies that a service is medically necessary** before you are authorized to provide the service.

Prior Authorization Request (PA)

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When should I use the PA?

- **Prior to delivering a non-emergency service, providers are expected to check the Medi-Cal Provider Manual (www.medi-cal.ca.gov), and also review HPSM's Prior Authorization Required list: https://www.hpsm.org/provider/authorizations**

- **The Prior Authorization Required list indicates which codes require or do not require prior authorization**

- Authorization is based on medical necessity, and is not a guarantee of coverage or eligibility

- If a service is not included on this list, the service does not require prior authorization. However, this does not mean it is a covered benefit

- Please note, outpatient authorization requirement guidelines are applicable to HPSM CareAdvantage, Medi-Cal, and HealthWorx programs

How often do I need to check the Prior Authorization Required list?

- It's best to check regularly; our PAR list is typically updated quarterly but additional updates may occur

- Make sure you're on our email and fax distribution list to be notified of changes

Differences between HPSM and BHRS PA Processes:

- **As of today HPSM does not require a PA for Individual Therapy.**

- HPSM providers are required to submit PA forms themselves for services they plan to render.

- **HPSM does not accept hand-written prior authorization requests (PA).**

- Providers must utilize HPSM's Prior Authorization Form and it must be typed.

Anatomy of the PA Form

We've automated the intake process of the PA forms to speed up our response time to you. This means that you must make sure:

- You do not use a cover sheet
- You're using the current version of the form (posted to our website at https://www.hpsm.org/provider/authorizations/treatment)
- You complete all fields using the fillable PDF (typed, not handwritten)
- You include medical necessity documents (treatment plan, clinicals)
- Information is accurate- correct diagnosis and CPT codes, correct dates of service (start to end date)
- Use one form for one patient – we cannot process multiple patients' information per form and only one form per fax

Select "Routine" for nearly all requests

The provider rendering the service / providing the items is the one responsible for submitting the PAR Form.

Pro tip: Set your fax machine settings to the highest quality possible and double-check the member ID number before sending. If PA is rejected, notification will be sent out.

Authorization Time frames & Common Errors

Authorization Review Time Frames

- **Urgent** Requests for all lines of business - **72 hours** from receipt
- **Standard** Requests: **Five (5) business days** from receipt

Common Authorization Submission Errors (may result in delays for the timeframes outlined above)

- Incorrect member information
- Benefit not active
- Invalid NPI number
- Invalid diagnosis codes etc.
- Handwritten PA forms

Claims

Submitting Claims

There are two different methods HPSM providers can use to submit claims:

1. Paper claims submission *(Mailed to HPSM)*

2. Online using eHealthSuite *(CMS-1500 format only)*

   *For eHealthSuite access please register for the HPSM Provider Portal

Claims may be suspended or denied when necessary data fields on claim forms are incomplete or incorrect. The following link provides item numbers and descriptions that correspond to the standard CMS 1500 Claim Form. https://www.hpsm.org/docs/default-source/provider-services/claims_submission_cms1500.pdf?sfvrsn=832ae811_8

Differences between HPSM and BHRS Claims Processes:

- HPSM does not accept hand-written claim submissions.

- Providers must utilize the CMS-1500 form.

- Paper claims must be typewritten.

Common Billing Errors
(May result in delays)

- Not entering members correct member ID number

- Not using appropriate coding depending upon line of business

- Not verifying other insurance

- No Prior Authorization on file (if needed)

- No Rendering NPI in box 24J of CMS-1500

- Not utilizing the "Billing" or Incorporated NPI in Box 33A of CMS-1500

- No NPI in: Box 33a of CMS-1500

Online Portals

- HPSM has two online portals for you to use:

- Provider Portal
  - Eligibility
  - Prior Authorization Status
  - eHealthSuite (Submitting claims)
  - Referral Status
  - Claims Status

- eReports
  - Remittance Advice (Claims payment detail)

Registration/Access to Provider Portal

Initial setup:

- Contact HPSM Claims Department –

  - Email: ClaimsInquiries@hpsm.org

  - Phone: 1-833-694-7761 or 650-616-2106

- Register/login link available on the HPSM website: www.hpsm.org

- Preferred browser for usability: Internet Explorer

eReports

- HPSM's eReports portal allows you to access to valuable information including claims payment detail (aka Remittance Advice)

- The website for eReports login is: https://reports.hpsm.org

- Register for eReports on HPSM's website: https://www.hpsm.org/ereports-registration

HPSM Communication Tools

HPSM Modes of Communication

- Fax notifications
- Quarterly newsletters
- Mailings
- Webinars
- Website
- Email

HPSM Website

- Provider notices/news/announcements
- Provider manual: https://www.hpsm.org/provider/resources/provider-manual
    - Refer to the provider manual for department contact information
- Portal access
- Forms
- Authorizations: forms, prior-auth requirements, etc.
- Claims: how to submit, etc.
- Rx formulary
- Send updated information – link to modes of communication
- Directory
- Clinical guidelines
- Grievances and appeals

https://www.hpsm.org/

Next Steps

- Please ensure you have submitted all your credentialing items to HPSM's credentialing team

- Check your contract effective date

- Follow HPSM processes and procedures for *any dates of service on or after your contract effective date*

- Register for the Provider Portal and eReports online.
  - Provider Portal: https://www.hpsm.org/provider/portal
  - eReports: https://www.hpsm.org/ereports-registration

- Familiarize yourself with HPSM's website: https://www.hpsm.org/provider

Questions?
Contact HPSM Provider Services:
Email: psinquiries@hpsm.org

Questions/Discussion

Thank You

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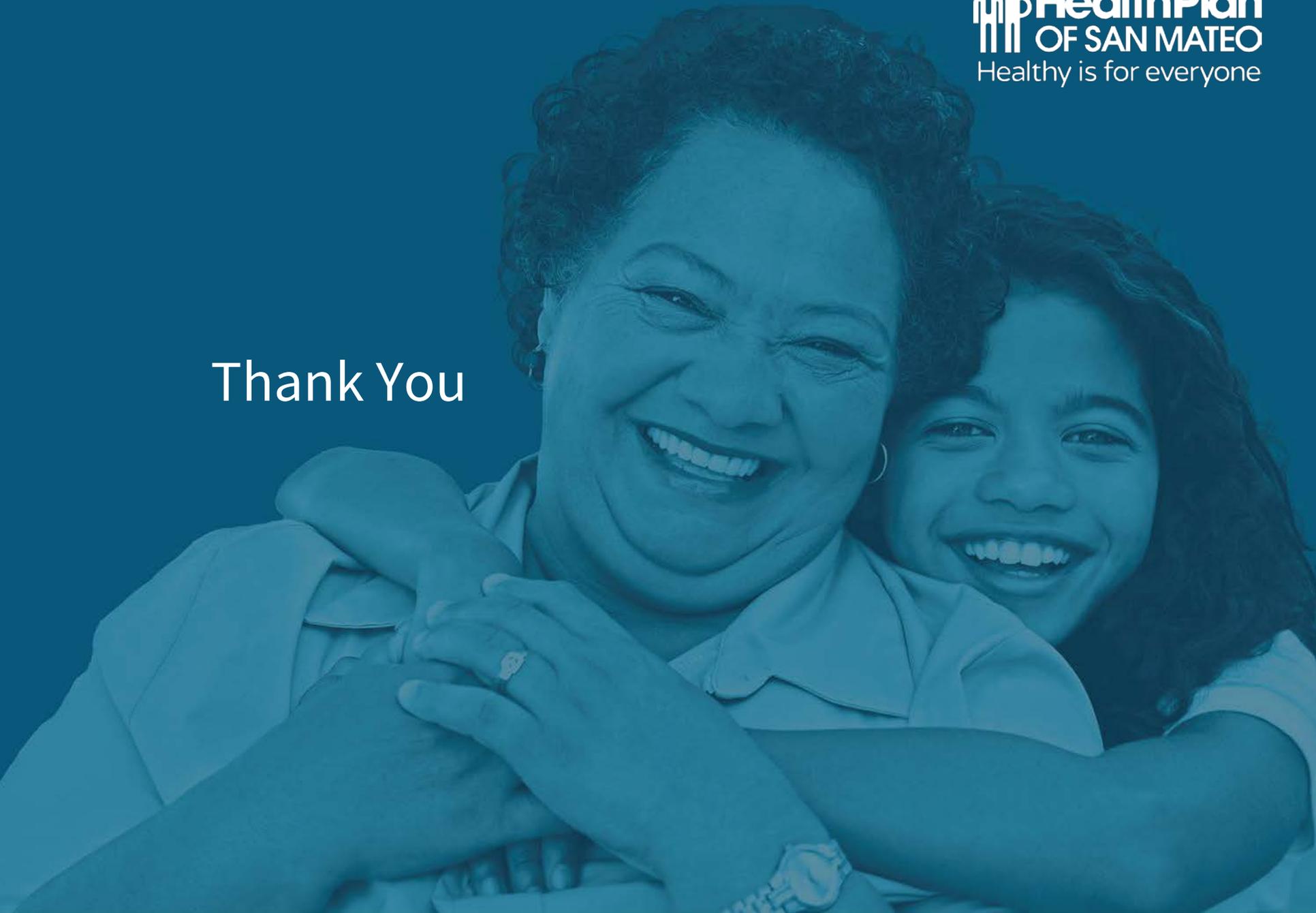
Medi-Cal Managed Care Policies and Procedures

Balance Billing is Prohibited

Providers who offer services or supplies to Medi-Cal and Cal MediConnect members are prohibited from balance billing the member for any cost-sharing <u>not related to the member's share of cost</u>. This includes deductibles, co-insurance, co-payments and non-covered charges.

Medi-Cal Managed Care Policies and Procedures (continued)

Medi-Cal State Fair Hearing Process

Medi-Cal members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with a Medi-Cal Managed Care Plan's decision regarding denial of a requested service. A State Hearing is an appeal with an Administrative Law Judge from the Department of Social Services. Expedited State Hearings may also be requested.

Requests for State Hearings can be submitted by telephone at **800-952-5253** or in writing to:

California Department of Social Services
State Hearing Division
Post Office Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430
Fax: (916) 651-5210 or (916) 651-2789
Online: http://www.dss.cahwnet.gov/shd/PG1110.htm

A Medi-Cal member must first exhaust a Medi-Cal Managed Care plan's appeals process prior to proceeding with a State Hearing. Requests for State Hearings must be submitted within *120 calendar days* of an action with which the member is dissatisfied. For standard State Hearings, the State will make a decision within 90 days of the request. For expedited State Hearings, the State will make a decision *within 72 hours*.

Member Rights

Members have the following rights per DHCS:

- To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.

- To be provided with information about the plan and its services, including Covered Services.

- To be able to choose a Primary Care Provider within the plan's network.

- To participate in decision making regarding their own health care, including the right to refuse treatment.

- To voice grievances, either verbally or in writing, about the organization or the care received.

- To receive oral interpretation services for their language. This includes communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language methods that ensure communication, including assistive listening systems, sign language interpreters captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English proficient, or non-English speaking.

- To formulate advance directives.

Member Rights (continued)

- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the plan's network pursuant to the Federal law.

- To request a State Medi-Cal state hearing, including information on the circumstances under which an expedited-state hearing is possible.

- To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.

- To access Minor Consent Services.

- To receive written Member informing materials in an alternative format (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

- Freedom to exercise these rights without adversely affecting how they are treated by the plan, providers, or the State.

- To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

Clinical Protocol and Evidence-Based Practice Guidelines

Clinical Practice Guidelines are evidence-based recommendations for optimizing patient care. They are intended to assist providers and patients in making decisions about appropriate health care in specific clinical circumstances, including preventive care.

HPSM provides clinical practice guidelines to guide our providers on HPSM's website at https://www.hpsm.org/provider/resources/guidelines.

These guidelines are developed by nationally recognized medical organizations, health professional societies, and expert task forces. Some links connect to expert organization websites, and others are direct links to practice guideline documents. HPSM's Quality Improvement Committee reviews the guideline topics and posted guidelines annually, to ensure they remain current and relevant to our member population.

Serving Seniors and Persons with Disabilities

What is defined as a disability and/or functional limitation?

- Disability may be **physical, cognitive, mental, sensory, emotional, developmental or some combination of these**. A disability may be present from birth or occur during a person's lifetime.

- Functional limitations are difficulties completing a variety of basic or complex activities that are associated with a health problem. For example, vision loss, hearing loss, and inability to move one's legs are functional limitations.

When checking eligibility of your patients, aged / blind / disabled aid codes for SPD are:

- 10, 13, 14, 16, 17, 20, 23, 24, 26, 27, 36, 53, 60, 63, 64, 65, 66, 67, 1E, 1H, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y

Serving Seniors and Persons with Disabilities (continued)

How SPD members may have barriers to access and care:

Physical Access – the ability to get into a building or the area where healthcare services are offered

> *Areas of the office to consider*: building entrances , restrooms , parking lots, doors, doorways and hallways, waiting areas and reception desk , drinking fountains and water coolers , elevators, posted signs , telephones, forms and documents

Communication Access – the ability of the provider and member to communicate and understand the information asked and directions given

> *Methods of communication*: Qualified ASL Interpreters, Relay service, Assistive listening device, Text message, Email, Captioning, Qualified readers, Audio recordings, Braille, Large print

An accommodation checklist was developed to help providers and office staff identify accommodation needs for SPD members. Please place checklist in medical record of patient for easy access and future use.

Serving Seniors and Persons with Disabilities (continued)

Here are some ways you may modify your office policies:

- Flexible appointment time

- Longer appointment time

- Providing assistance filling out forms

- Providing lifting assistance

- Providing print materials in alternative, accessible formats

- Allowing service animals

How the Health Plan of San Mateo can help you :

- Assistance with arranging for Sign Language interpreters

- Methods for providing print materials in alternative formats

- Sources for equipment such as assistive listening devices, accessible weight scales, conversion of print material to Braille

Serving Seniors and Persons with Disabilities (continued)

Health education materials in alternate formats:

Call Health Plan of San Mateo's Health Education Line at **650-616-2165** or visit www.hpsm.org for more information and resources:

- Accommodation Checklist
- Access to Medical Care for Individuals with Mobility Disabilities
- Communication with People who are Deaf or Hard of Hearing
- Information on Health Plan of San Mateo's Interpreter Services

Cultural Competency

What is culture?

Culture is comprised of a group's learned patterns of **behavior, values, norms, and practices.**

What is Cultural Competency?

Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided.

Why is cultural competency important?

Being culturally competent means improved communication between providers and health plan members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to **improved access and health outcomes.**

Elements of Culture Include:

- Collective values, experiences, beliefs- beliefs about health and health care, as well as behavioral styles

- Non-verbal communication

- Perspectives, world views, frames of reference

- Community motivation and social identification

- Cultural awareness

- Languages and dialect

Cultural Competency Resources

- **Language Access Services**

    – Accurate communication between patients and healthcare providers helps reduce health disparities and improves quality of care.

    – HPSM provides 24/7 telephonic video interpreter services at no cost to the member.

        • More than 200 languages are available including American Sign Language.

        • HPSM can provide an office-based training session to discuss how to identify and address the linguistic needs of patients whose English proficiency is limited.

    – When using interpreter services be sure to:

        • Ensure inclusion of statement on informing assigned members with Limited English Proficiency, on right to qualified interpreter (phone or video) free of charge.

        • Document member's language preference in medical record

        • Document member's request or refusal of interpreter service (phone or video) at each visit

        • When member declines offer to use free interpreter service (phone or video), document how language barrier was addressed (i.e. certified bilingual staff person, member brought friend or relative to serve as interpreter)

Cultural Competency Resources

- **Culturally Competent Care**

  - Visit hpsm.org/provider/resources/language-services for links to cultural competency training and resources including:

    - Tips for working with diverse patients

    - Guidelines for communicating with hard of hearing patients

    - Tips for identifying health literacy issues

- **Translated Materials**

  - HPSM materials are available translated into **HPSM's threshold languages: English, Spanish, Russian, Chinese and Tagalog.**

  - You can also request HPSM materials in alternative formats, such as Braille.

  - For additional resources and questions, call HPSM's Health Education line at **(650) 616-2165.**

Member Complaint Requirements

Providers must have a process for documenting and submitting to the managed care plan any complaint submitted by members in their office(s).

Timeframes for filing & resolving complaints	
Timeframe for filing (from date of denial, service, incident or bill)	
Type of complaint	**Timeframe**
Appeal	60 calendar days
Grievance	No time limit
Timeframe for processing	
Type	**Grievance and appeals processing**
Standard	30 calendar days
Expedited	72 hours