QUESTIONS TO DETERMINE CLIENT'S HEALTHCARE COVERAGE

The federal Affordable Care Act (ACA, aka "Obamacare") requires everyone to have health insurance coverage. Health insurance plans now cover Mental Health and Substance Abuse treatment services as part of the ACA's "essential benefits". If the Client states he/she does not have healthcare coverage, please refer the Client to an Eligibility Worker (RAMS or in BHAC) or, to the SF Health Plan so they can apply for Medi-Cal or obtain health insurance coverage. Use the following questions to obtain information for your Episode Guarantor Information

Please verify the Client's identity. Ask the following questions about their health Insurance coverage, Medicare and/or Medi-Cal benefits. If possible, please make a copy of their Insurance, Medicare or Medi-Cal ID Card.

1. **Does the Client have Medi-Cal benefits?** _____ Yes _____ No
2. **What is their Medi-Cal Number?** _____ If the Client does not know their MC number, what is his/ her Social Security Number? _____
3. **Does the Client have Medicare benefits?** _____ Yes _____ No
4. **What is their Medicare HIC Number**: _____ If the Client does not know their number, what is his/ her Social Security Number? _____
5. **Is the Client enrolled in a Medicare Managed Care Plan?** _____ Yes _____ No
   (Also known as: Part C, Medicare HMO, or Senior Advantage Plan)
6. **What is the name of their Medicare HMO Plan?** _____
   See DHCS List of Medicare HMO Plans. If the Client is enrolled in one of these plans, services can be billed directly to SDMC. The Client may receive services from CBHS Providers.
7. **Does the Client have a Health Insurance plan?** _____ Yes _____ No
8. **What is the name of their Insurance Health Plan or HMO?** _____
   (e.g.: SF Health Plan, Aetna, Kaiser, Blue Cross, etc.)
9. **What is their Insurance Policy ID and Group Number?** _____
10. **Is this Insurance under the Client's Name?** _____ Yes _____ No
    If no, who is the Primary Person on this Insurance? _____
    Relationship to the CBHS Client: ____Self ____Spouse ____ Child ____Other: _____
    Insured or Subscriber's Social Security Number: _____
    Subscriber's Date of Birth: _____

9. **Is an Authorization or Primary Care referral required before CBHS services can be provided?** _____
   Insurance contacted on _____ Contact Name: _____

   Authorization Number: _____ (Send a copy to CBHS Billing Office)

12. **Is there a Health Savings Account * or a Flexible Healthcare Spending Account?** ____Yes ____No

*A Health Savings Account (HSA) or FHSA is Money available from an Employer or from a pre-tax account set-aside to pay for the Client's health insurance deductible, co-pays, and for their other out-of-pocket medical expenses.

Employer Name: _____
Employer's Phone Number or Address: _____

Summary of the CBHS Policy for Medi-Cal, Medicare, Insurance, HMO and Dually-eligible Clients

Medi-Cal

Specialty Mental Health (MH) and Substance Use Disorder (SUD) services are provided by CBHS Providers or by the San Francisco Mental Health Plan to Medi-Cal beneficiaries who do **not** have Other Healthcare Coverages (Insurance or Medicare).

A Medi-Cal Client who has SFHP or Anthem Blue Cross as their Medi-Cal Managed Care Plan (HCP) may receive Specialty MH and/or SUD services from CBHS.

Original Medicare or Fee-for-Service Medicare Part B

Specialty Mental Health services can be provided by CBHS Providers who are authorized to provide services under the Medicare program. Specialty Substance Use Disorder treatment (SUD) services can be provided by CBHS Providers. SUD services are not covered by Medicare. The Client is responsible for services that are not covered by Medicare, in addition to their annual Medicare deductible and co-insurance amounts.

Part C - Medicare Advantage Plan or Medicare HMO Plan

Unless the Medicare Managed Care Plan is on the DHCS exemption list, please refer to the HMO for MH and SUD services. Per Title 9 CCR, CBHS may provide services if there is written documentation the Medicare HMO or Managed Care Plan does not cover the mental health or substance use disorder treatment services the Client needs. Refer to the CA Department of Health Care Services (DHCS) Information Notice 13-24 and MHSUDS Info Notice 15-001 for information.

Insurance, PPO or HMO Plans

Refer Clients who have Insurance, PPO, or HMO coverages to their HMO plan or Insurance plan for services. Per Title 9 CCR, CBHS may only provide services if there is written proof or documentation the Insurance, PPO or HMO Plan does not cover the MH or SUD services the Client needs. In addition, the CBHS Age Director approves all privately insured Clients' admissions into CBHS Clinics. There are exemptions to this rule for authorized CYF Program Clients including: ERMHS (Education Related Mental Health Services), ISCS (Intensive Services and Clinical Services), Therapeutic Behavioral Services (TBS), Katie A., Foster Care, and other special programs.

Dually-eligible Medi-Cal and Original Medicare

Specialty MH services can be provided by CBHS Providers and Clinicians authorized to provide services under the Medicare program. Specialty SUD services can be provided by CBHS SUD Providers. Medicare is billed first for services covered by Medicare and remaining balances are billed to Medi-Cal.

Dually-eligible Medi-Cal and Medicare HMO (Part C – Medicare Advantage Plan)

Refer Clients who are enrolled in a non-exempt Medicare Advantage Plan to their Medicare HMO Plan for services. Per Title 9 CCR, CBHS may only provide services if there is written proof or documentation the Medicare HMO Plan does not provide additional coverage than the Original Medicare Program. Refer to DHCS Information Notice #13-24 and MHSUDS Information Notice 15-001

Several Medicare Advantage Plans have provided certifications to DHCS indicating they do not provide coverage for specialty services to dually-eligible Medicare and Medi-Cal beneficiaries (aka Medi-Medi). CBHS provides the Specialty Mental Health and SUD treatment services they need and

SDMC is billed directly for these services. See the list of Medicare Advantage Plans, including those on the DHCS Exempt List, on Page 5.

Dually-eligible Medi-Cal and Insurance HMO Clients

Refer Clients who have these coverages to their HMO or insurance plan for services. California DHCS requires the Insurance, HMO, or PPO plan to be billed first because Medi-Cal is the payer of last resort. Insurance, particularly HMO plans will deny services if they are not prior authorized or, if services are provided outside of their Provider network. Medi-Cal automatically denies payment if the Client's primary Insurance or HMO plan did not prior authorize services or, because the service provider is not part of their provider network.

For existing Clients who become enrolled in an HMO Plan, please contact the HMO to coordinate a transition plan for the Client to receive mental health or substance abuse treatment services from one of their Providers. The HMO Plan may issue a short term authorization to cover this transition period. Please send copies of the authorizations to the CBHS Billing Office, 1380 Howard St. 3rd Floor, SF 94103

Billing Questions or Assistance Needed

The CBHS Billing Office provides assistance with eligibility verifications and answers Provider questions about Medi-Cal, Medicare, Insurance, and Patient Accounts billing. Call the 24-hour Billing Inquiry Line at (415)255-3557 and leave a message which will be returned by the next business day. Or, send your billing questions by e-mail to: Maria.J.Barteaux@sfdph.org or Nanalisa.Rasaily@sfdph.org

Frequently Asked Questions about Medicare, HMO and Insurance Plans

What are the different types of Healthcare Insurance Coverages?

- **Health Maintenance Organization (HMO) plans** – HMO plans require their Enrollees to receive healthcare from their Provider Network and Hospitals, except in Urgent or Emergency situations. The Client must obtain a Referral from their Primary Care Physician before they can see other doctors or Specialists (i.e., for Psychiatric MH or Substance Abuse treatment) or for Lab tests.
- **Point-of-Service (POS) Insurance Plans** - These are HMO or Insurance plans that generally allow their Enrollees to get healthcare services outside of their Provider network; however, Enrollees pay a higher Copayment, Co-insurance or out-of-pocket expenses.
- **Preferred Provider Organization (PPO) plans** - In a PPO, the Enrollee will pay less if they use doctors, hospitals, and other providers in the Plan's network. If the Enrollee chooses to go to a Provider who is not in the Plan's network, they will have a higher Copayment, Co-insurance or out-of-pocket expense.
- **Private Fee-for-Service (PFFS) plans** - PFFS plans allow their Enrollees to receive healthcare services from any Doctor, healthcare Provider or Hospital. The plan determines how much it will pay these providers, and how much their Enrollee must pay for the healthcare they receive.
- **Special Needs Plans (SNPs)** - SNPs provide focused and specialized health coverage for specific groups; for example, those living in a nursing home, or with certain chronic medical conditions.
- **Medical Savings Account (MSA) plans** - These Plans combine a high-deductible health insurance plan with a medical savings account. Plans have specific rules and requirements for Enrollees to access healthcare services and to use the funds or money set aside in a designated account that can be used for their healthcare expenses.

What is Covered California?

Covered California is California's health insurance exchange, where individuals, families and small businesses can find affordable, quality health insurance. For additional information or to sign-up for healthcare coverage, go to: ***www.healthforcalifornia.com*** or ***www.coveredca.com***

What are the current Insurance or HMO plans in Covered California?

1. San Francisco Health Plan
2. Anthem Blue Cross
3. Blue Shield of CA
4. Chinese Community Health Plan (CCHP)
5. Kaiser Permanente
6. Health Net
7. Sharp
8. Western Health Advantage
9. Molina Healthcare
10. Valley Health Plan
11. LA Care Health Plan

Medicare

How does Fee-for-Service or Original Medicare work?

Fee-for-Service (FFS) or Original Medicare is one of the health coverage choices available to Medicare beneficiaries. Medicare Beneficiaries choose to sign up with the Original Medicare plan or with a Medicare Advantage Plan.

Original Medicare is coverage managed by the federal government. Under this plan, Medicare uses a Fee Schedule to pay Providers and, the Beneficiary pays an annual deductible and a Co-insurance which is a portion of the service cost, for each Service they received.

In order for medically necessary health Services to be covered by Medicare, the Clinic Facility must be certified under Medicare and, the Rendering Clinician must be certified to provide services under the Clinic's Medicare Group Practice number. There are additional requirements before services will be paid by Medicare.

What are Medicare Advantage Plans?

Medicare Advantage Plans are private Insurance carriers who have a contract with the federal government to provide Part A – Hospital, Part B – Outpatient, and Part D – Prescription Drug benefits. Medicare Advantage Plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service Plans (PFFS), Special Needs Plans (SNP), and Medicare Medical Savings Account Plans (MSA). If enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Once enrolled in a Medicare Advantage Plan, healthcare services are provided by the plan. This includes the Medicare Part A - Hospital benefits and Part B - medical coverages, and **not** from Original Medicare.

What Services are covered by Medicare Advantage Plans?

Medicare Advantage Plans must cover all of the services that Original Medicare covers except for hospice care and care in clinical research studies. In addition, Medicare Advantage Plans may offer extra coverage, such as: vision, hearing, dental, health and wellness programs, prescription drug coverage (Part D), emergency and Urgent Care services.

Do Medicare Advantage Plans have the same rules as Original Medicare?

Medicare beneficiaries and the Federal government pay fixed amounts for Enrollees who receive their Medicare health coverage thru a Medicare Advantage Plan. These Insurance companies must follow

rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for services; for example, they may require prior authorization or a referral for specialty services, Lab Tests, medical equipment and supplies. These rules can change each year. The plan must notify the Federal government and Medicare beneficiaries about any changes before the start of the next enrollment year.

When can the Client enroll in, change, or drop their Medicare Advantage Plan?

When the Client first becomes eligible for Medicare, *he or she can join during the 7-month period that begins 3 months before the month they turn 65, during the entire month when they turn 65, and up to 3 months after the month they turn 65.*

If the Client gets Medicare due to a disability, *he or she can join during the 7-month period that begins 3 months before their 25th month of disability, their 25th month of disability, and up to 3 months after their 25th month of disability.*

Every Year between October 15 to December 7, anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. *Coverage will begin on January 1, as long as the plan gets their request by December 7.*

> ***Can the Client make changes to their coverage after December 7?***
> *Between January 1 and February 14, if enrolled in a Medicare Advantage Plan, the Client can leave that plan and switch to Fee-for-Service Medicare. In addition, during this period, the Client will have until February 14 to join a Medicare Part D - Prescription Drug Plan to add drug coverage.*

What are the current Medicare Advantage Plans or Medicare Part C – Risk HMO (Health Maintenance Organizations) plans operating in California?

1. Anthem Medicare HMO/PPO
2. Aetna Health Plan of California – *on the DHCS Exempt List*
3. Alameda Alliance for Health – *on the DHCS Exempt List*
4. Blue Cross Senior Secure Plan
5. Blue Shield of California - *on the DHCS Exempt List*
6. CCHP Senior Program
7. Care 1st Health Plan / Advantage Optimum - *on the DHCS Exempt List*
8. Central Health Medicare Plan of CA - *on the DHCS Exempt List*
9. Citizens Choice Health Plan - *on the DHCS Exempt List*
10. Community Health Group - *on the DHCS Exempt List*
11. Easy Choice Health Plan - *on the DHCS Exempt List*
12. Health Net Healthy Heart
13. Health Net Seniority Plus
14. Health Plan of San Mateo - *on the DHCS Exempt List*
15. Humana Gold Plus
16. Inland Empire Health Plan - *on the DHCS Exempt List*
17. Inter Valley Health Plan - *on the DHCS Exempt List*
18. Molina Healthcare Inc. - *on the DHCS Exempt List*
19. Kaiser Permanente Senior Advantage Plan
20. Partnership Health Plan of CA - *on the DHCS Exempt List*
21. SCAN (Senior Care Action Network) Health Plan - *on the DHCS Exempt List*
22. United Healthcare of CA/Secure Horizon - *on the DHCS Exempt List*