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May 2017

Please see these important updates from San Francisco Health Plan

Our May Update includes information on:

1. Invitation: Provider Seminar, May 18
2. Our New and Improved Provider Portal
3. NOTICE: Acupuncture Authorizations
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5. CME Training for Acute Pain Management
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8. Behavioral Health Therapy for Children with ADHD
9. Addiction Symposium - June 9th, 2017
10. SFHP vs. Tougher Immigration Enforcement
11. Pharmacy Update

1. Invitation: Provider Seminar, May 18

Come hear about the new Provider Portal and Teladoc!

PROVIDER RESOURCES

- Understanding the Network Operations Manual
- Navigating the new website and provider portal, SFHP ProviderLink
- Learn about Teladoc benefits

UTILIZATION MANAGEMENT

- Align your process for ease of authorization requests
- Learn about what requires an authorization and what does not
- Be able to ask questions and receive feedback in real time

CLAIMS

- Claims department and billing process overview
- Understanding the Claims Operations Manual
- Claims inquiries and disputes

RSVPs have been closed, but we strongly encourage you to join us via our Webinar
https://global.gotomeeting.com/join/955083301

Learn how SFHP authorizations and claims processes work to align with your business practices.

Please email us for more information or questions about the seminar or call us at: 1(415) 547-7818 Ext. 7084.

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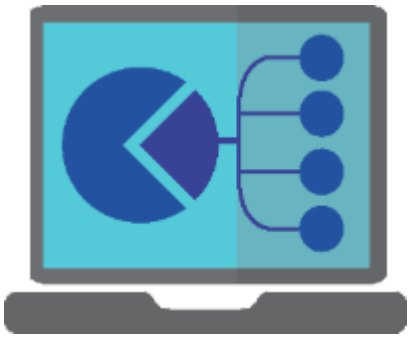
2. Our New and Improved Provider Portal

We are excited to announce our new provider portal, SFHP ProviderLink. Built with new features and functions, you will have greater access to your patients' health information.

SFHP ProviderLink will make it easier to:

- Check member eligibility
- Submit Prior-Authorization requests
- Check members' pharmacy information
- Upload claims online
- And more

It's a better way to work with us.



Through our secure and trusted platform you will be able to see your patients' entire service history, including eligibility history, view provider dispute resolutions, and see billing status.
Our new provider portal offers a new design that you will find easy to navigate. It is built for providers, administrators, and staff.

To register for our new portal go to sfhp.org and click on the Provider Portal Login link.

Important: To use the new portal, you will need to set up a new password and user name. Each person authorized under HIPAA can be provided a login, so do not share user names.

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3. NOTICE: Acupuncture Authorizations

San Francisco Health Plan's Utilization Management Department has removed its authorization requirements for acupuncture services for contracted acupuncture providers.

Effective immediately, you do not need to submit a request for authorization as long as the number of treatments does not exceed 24 visits per year. Extended treatment beyond 24 visits per (calendar) year requires prior authorization.

If you have any questions or concerns, please contact the Provider Network Operations Department at 415-547-7818 ext. 7084 or by email at provider.relations@sfhp.org.

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4. Important Notice: Retroactive PCP Changes

As a reminder, **all members may change PCPs upon request** by contacting SFHP's Customer Service department. In most cases, PCP changes will be effective on the first day of the month after the request was made or if hospitalized, the first day of the month after discharge .

Retroactive PCP changes can only be made effective on the 1st of the current month if the change is requested before the 16th of the current month, and if the member has not received services during the

current month.

If you or your patients have any questions about changing PCPs, please contact SFHP Customer Service at: 1(800) 288-5555 or 1(415) 547-7800.

Please distribute this important information to all patient-facing staff.

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5. Acute Pain Management: Putting Use of Opioids in Proper Perspective

SFHP offers a free, on-line one hour CME program **focusing on acute pain management. The intent is to give providers skills to better identify opiate alternatives.**

FREE Online Training Module

SFHP is releasing an online learning module to all providers.

Developed by SF Safety Net Pain Management Workgroup and Quality Healthcare Concepts, this 1 hour 1 CME experience teaches an evidence-based approach to using opioids to treat acute pain. Content includes:

- Risk assessment
- Alternative treatments
- Dose and duration guidelines
- Video case vignettes to practice new strategies for conversations with acute pain patients

Click here to access the training module.

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6. CHCF Webinar on Technical Assistance for Palliative Care (SB1004)

SB 1004, the California law that requires Medi-Cal managed care plans to provide access to palliative care, is slated for implementation starting in July 2018.

As part of the California Health Care Foundation's (CHCF) ongoing efforts to help plans and providers prepare for implementation, we are excited to announce the launch of a series of technical assistance activities to take place over the next year, which will be described in a kick-off webinar:

Date: Thursday, June 1
Time: 12:00 p.m. - 1:00 p.m.
Register in advance at: Go Webinar

After you register, you will receive a unique log-on URL and access code; at the time of the webinar, please log in using that URL and follow the cues on the GoToWebinar platform for audio access.

During the webinar, Kathleen Kerr (Kerr Healthcare Analytics) and Anne Kinderman, MD (Zuckerberg San Francisco General Hospital) will provide an overview of the technical assistance products and workshops planned for the next year, as well as guidance on the appropriate audience for each activity.

The year's activities, and the kickoff webinar, will focus on five topics that are central to planning and implementing palliative care services:

1. Estimating the number of members or patients eligible for SB 1004 palliative care and understanding their baseline end-of-life care utilization patterns and costs
2. Estimating the cost of providing home and clinic-based palliative care
3. Evaluating current network/group capacity to provide palliative care
4. Developing and implementing a strategy to enhance access to palliative care
5. Gauging and promoting success

Target audiences include Medi-Cal managed care plans, health systems with delegated fiscal and operational responsibility for implementing SB 1004, and provider groups that might offer palliative care clinical services.

Please share this message with colleagues inside and outside your organization that may have responsibility for improving access to palliative care services.

We look forward to your participation! Please register in advance at the link above.
For questions about the June 1st webinar, please contact Glenda Pacha.

For questions about the overall technical assistance effort, please contact Kate Meyers.

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7. NYTimes: A Transgender Learning Gap in the Emergency Room

We'd like to share the follwoing article featured in the New York Times:

By HELEN OUYANG, M.D.
APRIL 13, 2017

As an emergency physician, I'm always engaging in a fast-tempo, often awkward, all too stressful dance with strangers. Lately, though, I've noticed a particular gap in my own medical education and training, as well as in that of my colleagues, that's further tripping up our steps: how to provide optimal health care for transgender patients.

The gap is amplified in the emergency room, where even under the best of circumstances the interaction we have with patients is typically rushed and never entirely comfortable — and where I'm usually meeting a patient for the first time and don't have the patient's medical history at my fingertips. Because transgender people are less likely to have health insurance and are four times more likely to live in poverty compared to the general population, the emergency room serves as a particularly important safety net for these patients.

Sometimes the patient is registered as the wrong gender immediately from triage, resulting in a strained communication from the get-go. Other times, a staff member lets out a surprised gasp as a patient undresses for a physical exam. Then there are the moments when providers call a patient a “he/she” or “they” on rounds. Private rooms are also hard to come by in busy, overcrowded emergency rooms, and patients may be inappropriately clustered by gender.

None of this, for the most part, is out of malice. Instead it’s because of our own ignorance — and stems from our lack of education and training on providing sensitive and evidence-based care for transgender patients.

Currently, American medical schools’ curriculums are not sufficiently addressing the health needs and concerns of the lesbian, gay, bisexual and transgender community. A comprehensive survey of schools in the United States and Canada revealed that less than five hours in medical schools are devoted to L.G.B.T. health over all; some medical schools reported zero hours of training. While I did learn about providing health care for lesbian, gay and bisexual patients when I went to medical school over a decade ago, I didn’t receive any special education on the particular health needs and concerns of the estimated 1.4 million adults living in the United States who identify as transgender.

In one study, half of these patients had to teach their doctors about transgender health issues at some point. A Twitter hashtag #transhealthfail started trending in August of 2015, when transgender patients shared stories about their negative experiences with the health care system. Patients continue to use the hashtag today.

These holes in medical education and training can cost lives. Over 70 percent of transgender people nationwide say they have experienced serious discrimination in a health care setting. A third of transgender people postpone — or completely avoid — seeking health care because of the fear of discrimination. One in five have yet to disclose their transgender status to any medical provider.

Though still in the nascent stages, our medical education system may be on the cusp of changing. The Association of American Medical Colleges released its first medical education guidelines for L.G.B.T. health in November 2014. The University of Louisville School of Medicine became the national pilot site to

implement a new model of physician training. The initiative, called the eQuality Project, was fully integrated into the curriculum this academic year.

Dr. Amy Holthouser, the associate dean for medical education at Louisville, explained that one way the program is unique is that instead of having an isolated module designated for learning about L.G.B.T. health, the issues pertinent to L.G.B.T. patients are integrated into the entire curriculum. In the pharmacology block, for instance, students may learn about hormone therapies used for transitioning, in the same way that they might learn about medications to treat high blood pressure. When students are educated about routine pap smears, the importance of screening transgender men is also taught; the same goes for prostate exams and transgender women.

Some schools make the commendable effort of allocating hours to L.G.B.T. health, but often they focus too narrowly on subjects like sexually transmitted infections and H.I.V., Dr. Holthouser explained, which can further stigmatize patients. “Instead, we want to teach students how to provide all aspects of patient care,” she said.

All in all, the school now has revised about 50 hours of its curriculum to include L.G.B.T. health — which puts it far ahead of the curve. The medical colleges’ association’s standards are not mandatory. But Dr. Holthouser predicts that “once they start putting questions specific to L.G.B.T. health on board exams and require them in reports for accrediting bodies, schools will quickly catch up.”

At New York University School of Medicine, Richard Greene, the director of gender health education, is working on incorporating L.G.B.T. education into both undergraduate medical education and residency training. For all medical students and those residents training to become primary-care physicians, he has already implemented standardized patient exams — simulated clinical scenarios in which actors play patients — that test candidates’ competency with transgender health issues. He is working on expanding this across all residency training programs, regardless of the specialty.

Dr. Greene’s efforts have been met with enthusiasm. “I find young learners, like new medical students and new residents, are really excited to learn about transgender health. I’m really optimistic about the next generation,” he told me. “Senior providers don’t know what they know.”

For doctors like me who didn’t get the training in our earlier years, there are easily accessible learning

resources. The National LGBT Health Education Center, a part of the Fenway Institute, provides free web-based interactive modules, which I recently took. The University of California-San Francisco and the World Professional Association for Transgender Health also have extensive online resources and learning modules. Conferences and webinars are routinely available for physicians to attend and learn more about providing health care to the L.G.B.T. community.

But the first step is simply recognizing our own deficiencies — and realizing that learning about transgender health is as pressing as mastering dosages of the newest cholesterol-lowering drug or memorizing the latest protocol for resuscitating a patient from cardiac arrest. “This is something that’s not going away,” Dr. Greene said. “In fact, it’s becoming more urgent.”

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8. Behavioral Health Therapy for Children with ADHD

Attention deficit hyperactivity disorder (ADHD) is one of the most common disorders among school-age children, with boys more commonly diagnosed than girls. People with ADHD have trouble paying attention and staying focused. Many of them are also hyperactive and compulsive.

A child who displays symptoms of ADHD does not necessarily have the disorder. Most children act hyper, impulsive, and distracted at certain times. A child with ADHD will behave this way more frequently and to a greater degree than other children.
To be diagnosed with ADHD, the child must display symptoms for at least 6 months. These symptoms should also be more severe than those of children the same age. Symptoms include trouble sitting still, constant talking, interrupting, short attention span, easily bored and distracted, and trouble finishing tasks.

Co-existing disorders include Oppositional Defiant Disorder, Conduct Disorder, Bipolar Disorder, Learning Disorders, Depression, Anxiety, and Tourette’s syndrome. The combination of ADHD with other disorders often presents extra challenges for children, parents, educators, and healthcare providers. Indicators of co-existing disorders may include: a child acting out persistently or showing a behavioral pattern of aggression towards others and serious violations of rules and social norms causing serious problems at home, in school or with peers; a child having a clear difficulty in one or more areas of learning, even when their intelligence is not affected; and a child experiencing persistent fears and worries as well as sadness and hopelessness. Therefore, it is important for doctors to screen every child with ADHD for other

disorders and problems.

There is no cure for ADHD, but symptoms can be effectively controlled. Treatment for ADHD has two important components — psychotherapy interventions (for both the child and the parents) and medications. There is a significant amount of research demonstrating that medication alone won't help address all of a patient's attention and hyperactivity issues. Medication may help with some immediate relief from some symptoms, but the person with attention deficit disorder still often needs to learn the skills necessary to be successful while living with the disorder.

- **Behavior therapy with children**: the therapist works with the child to learn to be aware of and keep track of their behavior and to learn or strengthen positive behaviors to replace problem behaviors. Behavioral therapy can also help the child develop practical ways to get organized and learn to control emotions.

- **Parenting skills training**: parents learn new skills or strengthen their existing skills to teach and guide their children and to manage their behavior. Parent training in behavior therapy has been shown to strengthen the relationship between the parent and child, and to decrease children's negative or problem behaviors. The therapist may also help parents learn stress-management techniques.

- **Social skills training**: Some children do well in social skills groups in which they learn appropriate skills with other children. Other children may benefit from a social thinking program which focuses on teaching children to recognize how they think about and react to other people. It also teaches them how their behavior affects how other people react to them.

- **Educational strategies**: There are a number of classroom accommodations that can help children with ADHD—such as seating a child away from windows, doors, and other distractions. A 504 plan or an Individualized Education Program (IEP) can provide formalized accommodations. A behavior intervention plan (BIP) which outlines how teachers and the school will deal with a child's

inappropriate behavior could be helpful too. A BIP also explains how teachers and the school will encourage appropriate behavior. The child may, for example, have a reward system in place to encourage more positive behaviors.

Children with ADHD often receive medication from their pediatrician. If you are treating a child and have questions or the child is in need of further support, you may want to refer them to a mental health professional for assessment. One key way to assess whether a child may benefit from additional help is if the interventions tried are ineffective or the behaviors are hampering a child's social or academic performance and life.

SFHP is contracted with Beacon Health Options (Beacon) for the delivery of mental health services. A member can contact Beacon directly at 855-371-8117, or you can refer a member to Beacon using the PCP referral form available on the Provider Resources section of SFHP's website. This form can also be used to access Beacon's PCP Decision Support service, which allows you to consult with a Beacon psychiatrist about prescribing psychotropic medications to your patients.

Resources:

- Achieve Solutions
- Centers for Disease Control and Prevention— Attention-Deficit/Hyperactivity Disorder
- Children and Adults With Attention-Deficit/Hyperactivity Disorder
- National Resource Center on ADHD: A Program of CHADD
- Attention Deficit Disorder Association
- Healthy Children (the official American Academy of Pediatrics Web site for parents)

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9. Addiction Symposium

Join David E. Smith, MD and other addiction professionals for a one-day symposium on the opioid epidemic, Surgeon General's report and addiction medicine. On Friday, June 9th at the UCSF Mission Bay Conference Center, speakers will discuss the Surgeon General's Report and Healthcare Reform; Pain, Opioids and CURES; and Substance Abuse - The San Francisco Response.

Attendees can earn up to 7 Continuing Education Credits! CE Credits will be available through CE Learning Systems, LLC (APA, ASWB, NAADAC).

CME's will be provided by AAFP. An application for 7 prescribed credits has been submitted to the American Academy of Family Physicians and is under review. AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 credit TM toward the AMA Physician's Recognition Award. It is also accepted by the State of California for continued licensure.

10. SFHP vs. Tougher Immigration Enforcement

SFHP has recently released this letter to our patients in reference to the immigration enforcement regulations that have caused much worry and frustration for our community.

Below is an article from ModernHealth, which illustrates the struggle that our health system is currently facing.

Tougher immigration enforcement is taking a toll on healthcare

The Trump administration's more aggressive policy of detaining and deporting undocumented immigrants is posing new challenges for healthcare providers who serve immigrant communities.

While there is no definitive proof yet, leaders of community health centers and hospital emergency physicians say they see anecdotal evidence that immigrant patients are making fewer appointments and not coming in for follow-up care. They worry chronic conditions will worsen and infectious diseases will go untreated.

They attribute this to heightened patient fears of leaving home and thus risking apprehension and deportation by federal authorities.

"The providers say they've heard there are some families and patients who are concerned about coming to the center," said Dr. A. Scott McNeal, chief medical officer of Delaware Valley Community Health in Philadelphia. "There also was a rumor circulating that our organization had given out information to (Immigration and Customs Enforcement) agents, which we are very upset about. We tried to dispel that rumor quickly."

Providers and others who work in immigrant communities say anxieties have spiked in the wake of President Donald Trump's election. Trump's campaign platform included calls to deport all undocumented residents. His executive orders have broadened the focus of deportation efforts from convicted criminals to individuals with minor offenses.

Some clinic leaders say they frequently discuss whether elevated patient fears about immigration enforcement are hurting care and how to address these fears with colleagues. But they have no good solutions other than emphasizing to patients that no information will be shared with immigration authorities.

"In talking to our member centers, they're seeing more appointments being canceled, and they're asking the same questions you are asking," said Jose Camacho, executive director of the Texas Association of Community Health Centers.

Some clinics and hospital EDs are considering posting signs or other gestures to reassure immigrant patients that they are protected from immigration enforcement while they are in these healthcare settings. But some experts aren't sure that's helpful.

"I think bringing attention to the issue actually incites fears, because some patients may not have thought of it before," McNeal said.

At a community health center in Woodburn, Ore., the issue became acute in late February after ICE stopped two vans carrying 19 flower nursery workers and detained 11 of them.

"Our no-show ratios increased, and we experienced a tremendous amount of phone calls and expressions of concern from patients," said Carlos Olivares, CEO of the Yakima Valley Farm Workers Clinic, which operates the Woodburn facility in a heavily Latino community located south of Portland.

Olivares said his organization is most concerned about women with high-risk pregnancies who stop coming in for prenatal care, patients with chronic conditions such as diabetes who don't come in for monitoring and medication refills, and patients with major dental problems who discontinue treatment.

"When you look at parents who want a healthy baby and have been coming in during the first and second trimesters of pregnancy and all of a sudden stop coming, it makes sense to assume they are fearful of driving and finding themselves in the position of getting picked up and deported," he said.

Previous studies have found that anxiety about deportation has negative effects on immigrants' health and healthcare utilization. A study published in 2012 found that more than 40% of providers surveyed reported that ICE activities produced negative health effects among their immigrant patients, including severe stress

and avoidance of the healthcare system.

"Immigrants, particularly the undocumented, don't tend to use the medical system that much to begin with," said Dr. Karen Hacker, director of the Allegheny County (Pittsburgh) Health Department, the lead author of that study. When there is a greater threat of deportation, "you just get more avoidance. They don't show up until they are doing really poorly."

During such times, immigrant patients become more fearful that healthcare organizations and staffers will provide information about them to federal immigration authorities, said Dr. Robert Rodriguez, a professor of emergency medicine at the University of California, San Francisco. A 2013 study he co-authored found that 12% of undocumented Latino immigrant patients at two California hospitals expressed fear they would be discovered and deported by coming to the hospital.

"They don't really understand that we don't report patients and that they are safe in coming to the emergency room," Rodriguez said.

In January, Puentes de Salud, a free clinic in Philadelphia, posted signs to reassure its predominantly Latino patients that federal immigration agents were not allowed on or near the premises. "Private property, access without permission is prohibited," the sign reads.

Carlos Pascual, the clinic's administrator, said the purpose of the sign is to tell patients that ICE agents aren't allowed there and that they can "feel faith in the space." Since the beginning of the year, more patients have raised questions about immigration issues and how they can be prepared for raids. The clinic now has a lawyer available to advise patients on these issues.

Current ICE policy "directs agency personnel to avoid conducting enforcement activities at sensitive locations unless they have prior approval from an appropriate supervisory official or in the event of exigent circumstances," said Dani Bennett, an ICE spokeswoman.

But that policy appears to offer the agency some flexibility in where it can conduct raids. And official policy pronouncements likely will do little to quell word-of-mouth alarms spread in frightened immigrant communities, especially after raids like the one in Oregon that took place not far from a clinic serving Latino immigrants.

Olivares said he's now trying to reach out to ICE to discuss how the agency's activities may be affecting healthcare. "Our objective is to connect with ICE and say, 'You do understand this is causing a significant problem in our community,'" he said. "But who do we call? That's our dilemma."

Rodriguez said one girl recently arrived at the ED of his hospital, San Francisco General, complaining of abdominal pain. After examination by the staff, it became clear her symptoms were related to her intense worries about her parents being deported.

"This president's rhetoric is having a negative impact on patient care," he said.

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11. Pharmacy Update

12 Month Supply of Contraceptive Medications

Effective 1/1/17, SFHP covers up to one year supply of self-administered hormonal contraceptives including oral pills, vaginal rings and transdermal patches. One year supply can be filled if a patient requests it and has a valid prescription for the correct quantity (i.e. up to 364 pills, 12 vaginal rings, and 36 patches) or if the pharmacy is under a protocol with a prescriber through SB493. Patients can obtain a refill when one month supply of the medication is left. This policy does not cover emergency contraceptives such as Ella or Plan B. Patients can continue to get their usual 30 or 90 day supply of contraceptives and are not required to fill one year supply.

90 Day Supply Policy for Maintenance Brand Medications Used for Chronic Conditions

- SFHP's standard days supply policy is 30 days for brand medications and 90 days for generic medications with some exceptions.
- In order to increase access and improve adherence to medications used for treatment of chronic conditions, effective 11/1/15 select brand medications are allowed to be filled for a 90-day supply.
- Examples of medication classes covered under this policy include but are not limited to: antidiabetic agents, anticonvulsants, anticoagulants, antidepressants, antihyperlipidemics, antihypertensives, inhaled glucocorticoids and contraceptives. Specialty medications are limited to a 30 days supply.

Medi-Cal Formulary Tier Structure Changes

Effective 4/26/17, SFHP has updated the formulary tier structure for Medi-Cal, Healthy Kids, and Healthy Workers lines of businesses pursuant to California Assembly Bill No. 399, Chapter 619 on Health care coverage: outpatient prescription drugs.

The following tier structure now applies to SFHP Medi-Cal, Healthy Kids, and Healthy Workers formularies:

Tier	Definition	Description
T1	Formulary Drug, Generic (can have quantity limits, age, gender and other code 1 restrictions)	Drug is a **generic** and is covered at point of sale if quantity limits, age, gender, and other code 1 restrictions are met (NOTE: If quantity limits, age, gender, and other code 1 restrictions are not met, drug may still be covered through Prior Authorization process).
T2	Formulary Drug, Brand (can have quantity limits, age, gender and other code 1 restrictions)	Drug is a **brand** and is covered at point of sale if quantity limits, age, gender, and other code 1 restrictions are met (NOTE: If quantity limits, age, gender, and other code 1 restrictions are not met, drug may still be covered through Prior Authorization process).
T3	Formulary Drug, Step Therapy or Prior Authorization required	Drug is a brand or generic and is covered through **Prior Authorization** process or at point of sale if **step therapy** criteria are met
T4	Formulary Specialty Drug, Prior Authorization required	Drug requires distribution through a **specialty pharmacy or is a limited distribution drug (LDD).** Prior authorization process is required.
T5	Non-Formulary Drug	Drug is **non-formulary, provided through a medical benefit or excluded**. Non-formulary drugs may be covered through Prior Authorization process. Excluded drugs (e.g. carve-outs) are not covered.

Tier updates to the remaining lines of business (i.e. Healthy San Francisco and Medicare/Medi-Cal) are currently under way and will be live over the next several months. **This update does not impact how medications are currently processing at point of sale and SFHP members are not affected by this**

change. Above tier definitions are listed in the searchable and printable formularies available on SFHP website at http://www.sfhp.org/providers/formulary/sfhp-formulary/.

Please do not hesitate to contact Provider Relations at **1(415) 547-7818 ext. 7084**, Provider.Relations@sfhp.org or Chief Medical Officer **Jim Glauber, MD, MPH**, at jglauber@sfhp.org.