SAN FRANCISCO HEALTH PLAN
Here for you

September 1st, 2022

UPDATES INCLUDE:

COVID-19 Therapeutics

DMHC and DHCS require **timely access** to Covid-19 therapeutics. All SFHP members with confirmed diagnosis of Covid-19 should have access to therapeutics at no-cost within 5-7 days from symptoms onset. If providers have any problems accessing these medically necessary Covid-19 treatments, please call SFHP Provider Relations **at 1(415) 547-7818 ext. 7084.**

For more information, please refer to references below:
DHCS APL 22-009 COVID-19 Guidance for MEDI-CAL Managed Care Health Plan issued on 6/13/2022
DHMC APL 22-017 Coverage of Covid-19 therapeutics issued on 6/14/22

The National Institutes of Health (NIH) provides COVID-19 Treatment Guidelines for healthcare providers to determine the best treatment options. Several options are now available for treating COVID-19 at home or in an outpatient setting. They include: Nirmatrelvir with Ritonavir (Paxlovid), Molnupiravir (Lagevrio), Remdesivir (Veklury) and Bebtelovimab. Additionally, Pre-exposure prophylaxis, Evusheld, is authorized to help eligible people from getting sick before they have been exposed to COVID-19.

For additional information and resources for COVID-19 therapeutics, please visit:
CDPH
CDC (Centers for Disease Control)

On August 1, 2022, the California Department of Public Health (CDPH) launched a new bi-weekly Webinar series for healthcare providers about therapeutics used to treat COVID-19. You can register here or visit this website for more information.

Test to Treat (T2T) program connects eligible people who are at high risk of severe COVID-19, to treatments. These locations provide access for people to get tested, receive a prescription from a healthcare provider, and fill that prescription -- all at one place at a T2T site. The Test to Treat (T2T) Locator (website link at https://covid-19-test-to-treat-locator-dhhs.hub.arcgis.com/) will help you find places that provide these services to our SFHP members.

For your convenience, here are our in-network infusion centers for eligible members who need monoclonal antibodies infusion.

Should you have any questions on COVID-19 Oral Antivirals prescriptions and/or billings, please visit **Medi-Cal-Rx** at https://medi-calrx.dhcs.ca.gov/home/ to review topics under Medi-Cal-Rx such as Billing Guidance for Pharmacy Providers on COVID-19 Oral Antivirals.

FSR Provider Pearl: Medical Record Review Preventive Services Pediatric and Adult Alcohol Use Disorder Screening and Behavioral Counseling

Each September, National Recovery Month is held to educate people about how substance use and mental health services can enable individuals and their families to live healthy and rewarding lives. Primary care providers (PCP) play a vital role in the screening and management of alcohol use disorders. Per the California Department of Health Care Services (DHCS), APL 20-006, Facility Site Review and Medical Record Review, there are alcohol use disorder screening and behavioral counseling recommendations in both the pediatric and adult preventive services sections.

All providers and support staff in the practice setting should be trained to facilitate alcohol use disorder screening and assessment of all appropriate members. In busy primary care settings, best practice approaches to incorporating new behaviors in the clinic or

functions, e.g. telephone follow-up and coordination and assessment, from individual providers to multidisciplinary teams[1].

Below is a chart summarizing the requirements that are evaluated in the medical records of your members during your periodic site and medical record inspections by the Facility Site Review nurse evaluator. Consider using this chart to ensure your office practice or clinic is set-up for successfully complying with Medi-Cal Managed Care DHCS requirements. See APL 21-014 for additional details regarding alcohol and drug screening.

<table>
<tr><th colspan="2">Alcohol Use Disorder Screening and Behavioral Counseling</th></tr>
<tr><td>18 years old and older</td><td>11 years old and older</td></tr>
<tr><td colspan="2">There should be evidence of documentation of at least one expanded screening, using a validated screening tool and brief intervention, every year.</td></tr>
<tr><td colspan="2">If patient answered “yes” to the alcohol question in an Individual Health Education Behavior Assessment (IHEBA) or at any time the PCP identifies a potential alcohol misuse problem through patient/parent questionnaires or examination, then assess documentation for additional screenings), evaluate documentation for the following:</td></tr>
<tr><td>Suggested validated assessment tools include, but are not limited to:
- Alcohol Use Disorder Identification Test (AUDIT)
- Alcohol Use Disorder Identification Test-Consumption (AUDIT-C)</td><td>Suggested validated assessment tools include, but are not limited to:
- *CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) for adolescents aged 14 and older. The CRAFFT, the featured screening tool in this guide, is a series of 6 questions developed to screen adolescents for high-risk alcohol and other drug use disorders simultaneously. (*AAP recommended assessment tool)
- NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)</td></tr>
<tr><td colspan="2">Additional screenings can be provided in a calendar year if medical necessity is documented.</td></tr>
<tr><td colspan="2">Evidence/documentation referral for member identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for evaluation and treatment.</td></tr>
<tr><td colspan="2">Evidence/documentation of behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member response is affirmative to the alcohol question in the IHEBA or when otherwise identified.
- Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities.
- Counseling a member might include discussing additional treatment options, referrals, or services.
- Brief interventions include evidence in documentation of the following:
• Providing feedback to the patient regarding screening and assessment results.
• Discussing negative consequences that have occurred and the overall severity of the problem.
• Supporting the patient in making behavioral changes.
• Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.</td></tr>
<tr><td colspan="2">Additional documentation evidence to include the following:
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record)
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
- If and where a referral to an alcohol or substance use disorder program was made
Note: When recording screening results, the clinician should specifically indicate that a positive screen is not a diagnosis, which should not be given until and unless the positive screen is confirmed by further assessment and discussed with the patient. An unconfirmed substance use disorder diagnosis entered on a patient’s record may cause health insurance problems.</td></tr>
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References:

[1]DHHS Publication No. (SMA) 08-4075 Substance Abuse and Mental Health Services Administration, Reprinted 2008

“Provider Pearls” are monthly articles written to help you prepare for the California Department of Health Care Services (DHCS) FSR review processes.

For any questions about the Facility Site Review or Medical Record Review processes or tools, please use our fsr@sfhp.org email. A facility site review team member will respond and/or reach out to you to help you with your inquiry.

Timely Eye Exams for Your Patients with Diabetes

Diabetic retinopathy is the leading cause of preventable vision loss and blindness in people ages 18 to 64 years old. Around 50 percent of people with diabetes do not get their eyes examined or are diagnosed too late for effective treatment. Annual eye exams play a crucial role in the early detection, intervention, and prevention of eye disease and vision loss caused by diabetes. Early detection, timely treatment, and appropriate follow-up care can reduce a person’s risk for severe vision loss by 95 percent.

For your patients living with, or at-risk for diabetes, an annual retinal screening is a must. Remind your patients to get a comprehensive vision exam, including a dilated retinal exam. At each health care visit, tell your patients with diabetes about the signs of eye problems. Often eye problems do not have obvious symptoms. Let your patients know to look out for any changes, such as:

- Blurred vision
- Sudden black “floaters” (black or grey specks or strings) in their vision
- Fluctuating vision
- Dark or empty areas of vision

Identifying retinopathy early is key to supporting your patients’ eye health. Refer your patients to a Vision Service Plan (VSP) provider for retinal screening and treatment if necessary. Treatments include injections, laser treatment, or surgery. To find a VSP provider, have your patients visit www.vsp.com or call **1(800) 877-7195**. Also, refer patients to diabetes self-management education. Classes can be found at www.sfhp.org/health-wellness/classes.

People with Diabetes Can Prevent Vision Loss (nih.gov)
FocusOnDiabetes-PocketGuide-logo-update.pdf
Coexisting Conditions and Complications | Diabetes | CDC
Professional Resources | ADA (diabetes.org)
What is Retinopathy? | ADA (diabetes.org)
Diabetic Retinopathy | National Eye Institute (nih.gov)
Diabetic Retinopathy (cdc.gov)
How to Promote Eye Health for People With Diabetes | Diabetes | CDC

Postpartum Medical Visits

Postpartum care is an important determinant of quality health care outcomes for members giving birth. Since medical complications can

indicator of a retained placenta, uterine atony, lacerations, hematoma, or coagulation disorders.

Studies have shown that socioeconomic factors that present barriers to consistent care are common in the Medicaid populations. According to a National Committee for Quality Assurance (NCQA) article, “each year, about four million women in the U.S. give birth, with one million women having one or more complications during pregnancy, labor and delivery or the postpartum period.” This article further states that studies indicate that “as many as 60% of all pregnancy-related deaths could be prevented if women had better access to health care, received better quality of care and made changes in their health and lifestyle habits.” NCQA suggests that timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. Joint guidelines published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG) recommend “a prenatal visit in the first trimester for all [pregnant people]”. ACOG also recommends that “all [birthers] have contact with their obstetrician-gynecologists or other obstetric providers within 3 weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.”

According to the California Department of Health Care Services (DHCS), there are physical issues associated with pregnancy that should be closely monitored during the postpartum period. For example, “1 to 3 percent of vaginal deliveries result in postpartum endometritis. Urinary incontinence is prevalent in 3 to 23 percent of pregnancies after the first year of delivery. Approximately 4 to 7 percent of pregnancies result in a thyroid disorder during the first year of pregnancy.” Birthers at risk for any of these issues should be tested and treated during the postpartum period. Postpartum visits also provide an opportunity for members to be instructed on certain health care guidelines, such as contraceptive use.

Moreover, according to DHCS, postpartum depression is one of the most prevalent complications that can occur after delivery. Approximately 30 to 70 percent of pregnant people experience postpartum sadness immediately after delivery (i.e., within the first week). If left untreated, postpartum depression may last around seven months. DHCS suggests that appropriate postpartum care can address these emotional issues.

Source:
https://www.dhcs.ca.gov/dataandstats/Pages/Prena.aspx
https://www.ncqa.org/about-ncqa/

Provider Appointment Availability Survey Has Begun

Under the Department of Managed Health Care (DMHC) Timely Access Regulations, health plans are required to demonstrate that urgent and routine appointments are offered within specified time frames. To meet these requirements, SFHP administers the 2022 Appointment Availability Survey from August 22nd until December 31st 2022.

The survey, delivered by fax (from 973-996-4562) or email (from SutherlandPaasTeam@sutherlandglobal.com), will ask provider offices to identify individual provider’s next available appointment (date/time) for various types of nonemergency care. Fax (example) and emailed (example) surveys that are not responded to in five business days will be followed by a phone survey.

Please inform your front-line staff who answer the phone that they may be receiving this call (if an email or fax survey is not responded to) and that non-participation must be deemed non-compliant with the Timely Access Regulations, per state requirements. Please refer to the informative flyer that can be shared with your team, as well as this guide that clarifies the timely access regulations. Providers can also find more information about survey process and requirements on the DMHC website located here. For any questions about the Timely Access Regulations or the Appointment Availability Survey, please reach out to SFHP’s Provider Relations Department at 1(415) 547-7818 ext. 7084 or through email at provider.relations@sfhp.org.

Medi-Cal Rx Benefit: Reinstatement of Prior Authorization for Select Drug Classes

Effective September 16, 2022, the Department of Healthcare Services (DHCS) is reinstating prior authorization (PA) requirements for select drug classes for Medi-Cal Rx claims, for new starts only. Specifically, DHCS is reinstating PA requirements for the following classes:

- Diuretics
- Antilipemic agents (including statins and omega-3 fatty acids)
- Hypoglycemics and glucagon
- Antihypertensives
- Coronary vasodilators (nitrates and pulmonary arterial hypertension agents)
- Cardiovascular agents (including antiarrhythmics and inotropes)
- Anticoagulants and antiplatelets
- Niacin, Vitamin B, and Vitamin C products

Impacted drugs are now flagged (“PW13”) on the Medi-Cal Rx Approved NDC list on the Forms & Information page under Covered Products Lists.

This reinstatement applies only to new starts; members who are currently (within the 15-month look-back) taking medications in the above classes can continue without a PA. Members 21 years and younger are also exempt from PA requirement for these classes. Preemptive PA requests for new starts on these classes will not be accepted prior to 9/16.

For additional details, see the 30-day notice for this reinstatement and other bulletins on the Medi-Cal Rx Bulletins & News page. For further information on the Reinstatement Plan, please visit the DHCS Medi-Cal Rx Transition page.

Medication-Related Quality Improvement

SFHP has an interdisciplinary Quality Improvement (QI) workgroup that focuses on appropriate testing, medication regimen, and adherence for patients with diabetes, asthma, schizophrenia or schizoaffective disorder on antipsychotics, and major depression on antidepressants. A few preliminary findings are outlined below. Further information will be shared in the October newsletter.

Diabetes A1C Testing

under 8% in the past year. Members who speak Spanish have also communicated through a recent SFHP survey that they did not always feel that translation was appropriately sought by their provider. Together, these trends suggest that appropriately translated in person consultations and written reviews would help with A1C control in SFHP's Spanish-speaking population. Spanish language materials are available on the CDC website.

Asthma Medication Adherence

Adherence is measured through the Asthma Medication Ratio (AMR), which is the ratio of controller medications to total asthma medications during the measurement year. To be compliant, a member should reach a ratio of 0.5 or greater. Most recent Global Strategy for Asthma Management and Prevention (GINA) international guidelines (2022) recommend against SABA-only treatment of asthma in adults or adolescents; compared to ICS, patients on SABA alone are at risk of asthma-related death and urgent asthma-related healthcare.
Based on a review of HEDIS data, only 47% of members aged 22 to 44 have an AMR ratio of less than 0.5. This is the lowest percentage of adherent members across age groups. This could potentially be a result of incomplete transition of care when entering young adulthood. It may indicate a need for a review of the role of adherence medications in young adults.

Please do not hesitate to contact Provider Relations at
1(415) 547-7818 ext. **7084** or Provider.Relations@sfhp.org
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to SFHP's Monthly Provider Update, please visit our Provider Update archive page.
Register for SFHP ProviderLink here.