SAN FRANCISCO HEALTH PLAN
Here for you

September 1st, 2023

UPDATES INCLUDE:

Introducing the Sparkler App

sparkler

SFHP is partnering with the Department of Early Childhood (DEC) to make the Ages & Stages Questionnaires® (ASQ) more accessible and easier to complete using the Sparkler app. Sparkler is a FREE, evidence-based, mobile family engagement platform, available in Chinese, English, and Spanish to San Francisco providers and families of children aged 0 to 5.

We can ensure all children receive comprehensive developmental screenings early on in their lives by collaborating with families. With proper screening, care providers can better understand a child's development and detect any potential risks and intervene early on.

Sparkler offers:

1. **Tools to cultivate** children's social-emotional, cognitive, communication, and physical development, including the ASQ and ASQ:SE®
2. **Play activities and tips** for parents, designed by early childhood educators, which help parents and caregivers support children's early learning by developing their skills and sparking their passions.
3. **Provider Dashboard** to monitor families' ASQ completion and download screening reports.

For Providers:
Use Sparkler in your program to screen, monitor, engage, and promote healthy early development:
• Get a unique Sparkler access code for your program so YOUR families can link with YOU.
• Use Sparkler's web-based dashboard to monitor engagement and progress: download reports and data; and engage with and support families.

Huynh at ahuynh@sfhp.org.
To learn more visit San Francisco's Sparkler webpage.

CCHCA Name Change to AAMG

CCHCA has become All American Medical Group (AAMG) effective March 1, 2023. There will be nearly no changes to Members or Providers. Each member will keep their same PCP in the new AAMG Network. However, Authorization and Claims requests for patients in this group now need to be sent to AAMG's MSO, Network Medical Management (NMM) for processing.
Complete claims and authorization contact information for all of SFHP's members can be found here:

Link to Claims Matrix: Claims Submission - San Francisco Health Plan (sfhp.org)
Link to Authorization Information: Pre-Authorizations - San Francisco Health Plan (sfhp.org)

Restarting Medi-Cal Eligibility Renewals

CMS had temporarily waived certain Medicaid requirements and conditions for enrollment during the COVID-19 Public Health Emergency (PHE). The continuous health coverage for Medi-Cal members came to an end on March 31, 2023. States are now required to restart eligibility renewals per APL 22-004 (ca.gov).

DHCS has instructed Medi-Cal managed care health plans, in collaboration with their respective counties, to perform outreach to ensure that eligible beneficiaries retain their Medi-Cal coverage.

A subset of beneficiaries are able to auto renew their coverage through the Federal Hub process, while most beneficiaries will still need to go through the redetermination process via an online renewal or by completing the printed renewal package.

Please advise Medi-Cal patients to provide the requested information if they receive a letter from San Francisco County asking for information about their Medi-Cal coverage. They may also contact the San Francisco Medi-Cal Office at 1(415) 558-4700 or 1(855) 355-5757 for further assistance.
For more information, check out the Medi-Cal renewal toolkit on our website: https://www.sfhp.org/providers/medi-cal-renewal-toolkit/

Maternal Mental Health Training Opportunities

Provider Training: Dignity in Pregnancy and Childbirth Training: Preventing Racial Bias in Perinatal Care
(Fee: Free without CEUs - CEUS have a small fee under $50)
- Presented by CA Health Care Foundation
- SB 464 "California Dignity in Pregnancy and Childbirth Act" was signed into law by Governor Newsom in October of 2019 and aims to decrease Black maternal deaths. This law requires that physicians complete evidence-based implicit bias training at least every 2 years. It also requires hospitals to let patients know their rights to be treated fairly and without discrimination and where to file a complaint if they feel this right has been violated.
-The course is accredited for 1 hour of CME or CEU credits for a small fee.
- https://www.diversityscience.org/perinatal-care-equity/

Provider Training: Perinatal Mental Health 101 Training
(Fee: Free - 90 minute complimentary webinar)
- Presented by Postpartum Support International and 2020 Mom
- Faculty: Birdie Gunyon Meyer, RN, MA, PMH-C
-https://www.postpartum.net/professionals/mmh-online-webinar/

(Fee: Free)
-Presented by the UCLA Division of Population Behavioral Health
The Learning Center (wellbeing4la.org)

Community Health Worker Benefit (CHW) for Medi-Cal

Community Health Workers are an excellent resource available to Providers who are ideally positioned to offer culturally specific care that can support your practice in many ways—with Medi-Cal reimbursement! CHWs can help Members receive appropriate services related to primary care, perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

CHW services billed to Medi-Cal require a written recommendation submitted to SFHP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

Many FQHCs and other large clinics have staff that fill the role of CHW under the title of care coordinator, health navigator, etc. If your clinic does not have CHW on staff or needs additional capacity, providers can still recommend CHW services for a member by using this SFHP form. When complete, then SFHP will link the member with a CHW in our network.

The supervising provider is an enrolled Medi-Cal provider who submits claims for services provided by CHWs. The supervising provider ensures a CHW meets the qualifications required by DHCS, and directly or indirectly oversees a CHW and their services delivered to Medi-Cal beneficiaries. The supervising provider can be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO). CHWs may be supervised by a CBO or LHJ that does not have a licensed provider on staff.

For more information about adding Community Health Services to your clinic contact Provider Relations at 1(415) 547-7818 ext. 7084. For more information about the CHW benefit and billing see the DHCS page: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/31781_01

All pregnant Medi-Cal members have a Doula Benefit

Effective January 1, 2023, Managed Care Plans (SFHP) are required to cover doula services for prenatal, perinatal and postpartum Medi-Cal members. Doulas are not licensed, and they do not require supervision.

Doula **services can be provided virtually (telehealth) or in-person** with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.

1. To get a doula with SFHP the member must first have a written recommendation in their chart. The recommendation can be made by a doctor, midwife, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse (RN), Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), or Licensed Marriage and Family Therapist (LMFT). *The recommending provider does not need to be enrolled in Medi Cal or be a Network Provider within SFHP.* Medical groups may choose to use a Standing order. SFHP's standing order will be posted soon on our Member Centered Programs page: https://www.sfhp.org/providers/member-centered-programs/
2. The provider shares the directory of doulas with the member. [Note, SFHP members must work with a doula who is enrolled in San Francisco Health Plan's provider network.]
    a. Find a doula in our online Provider Directory at sfhp.org.
3. The member can reach out to any of our doulas to receive services.

A second recommendation is required for additional visits during the postpartum period. A copy of SFHP's second recommendation form will be posted to the SFHP website (TBD).

Medi-Cal Eligibility Checks: DHCS requires that Doulas verify the Member's Medi-Cal eligibility for the month of service. Doulas must contact the Medi-Cal member's assigned MCP to verify eligibility. It is important to check the member's eligibility each time a visit occurs.

Resources:
Doula (ca.gov),
Doula-FAQ-Sheet.pdf (ca.gov)
APL 22-031 (ca.gov)

New Asthma Preventive Services for Medi-Cal

Medi-Cal has added Medi-Cal Asthma Preventive Services (APS). This will comprise of clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments for eligible patients of any age, as medically necessary. This is not to be confused with the Community Supports Asthma Remediation Services which will go live in 2025.

Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school. In San Francisco, we know that 46% of ED visits are paid for by Medi-Cal and that 0–4-year-olds and members self-describing as Blacks and Pacific Islander has excessive rates of ED utilization for Asthma as compared to CA overall.[i]

We are very fortunate to be working with two agencies who will take provider referrals to provide patients with additional education, assess triggers in the home and other key activities. For delegated medical groups, if you do not have a qualified Asthma Health Educator on staff, you may refer to these agencies to serve your patients. Details available in the Provider Manual: sfhp.org/wp-content/files/providers/ProviderManual.pdf

[i] Source: 2005 California Health Interview Survey, 2019-2020

Pharmacy Updates

Medi-Cal Rx Prior Authorization Requirements for Enteral Nutrition for Members 22 Years of Age and Older
On September 22, 2023, all new start enteral nutrition orders will require a prior authorization (PA) for members 22 years of age and older. On November 9, 2023, all enteral nutrition claims that previously paid under the Transition Policy will need a PA submitted for members 22 years of age and older.

- Providers can begin PA submissions for all enteral nutrition products on September 22, 2023.
- The *Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form* will be the preferred form to submit enteral nutrition PA requests and will be available before September 22, 2023.
- Providers can refer to the *List of Contracted Enteral Nutrition Products* to see the products that are covered. This list is on the Medi-Cal Rx Provider Portal, under “Covered Products Lists”.
- The established criteria for enteral nutrition can be found in the *Enteral Nutrition Product* section (page 120) of the Provider Manual.

Alternatively, providers can send the prescription for the enteral nutrition product to an SFHP contracted DME vendor to be covered under the medical benefit.
For more information, see the Enteral Nutrition New Start PA Reminders, 90-day notice for Enteral Nutrition PA Retirement, How to Prepare for Retirement of Transition Policy for providers, 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 Reinstatement tab on the Education & Outreach page.

Facility Site Review Provider Pearls

This month's Provider Pearl is about pediatric and adult obesity screening requirements and appropriate follow-up interventions for patients whose screening identifies overweight, obesity, severe obesity, or related comorbidities.

The World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC) and other organizations identify obesity as a chronic disease that is increasing in prevalence in adults, adolescents, and children and is now considered to be a global epidemic (Source). Four in ten American adults have obesity, and obesity rates continue to climb nationwide and within population groups (Source) and one in five children and adolescents between the ages of 2 and 19 is obese (Source).

There is a vast amount of information on this topic; however, the focus of this article is on the California Department of Health Care Services (DHCS) requirements that the Facility Site Review (FSR) Team must follow to appropriately score providers/clinics using the current Medical Record Review (MRR) Standards for obesity screening criteria for adult and pediatric members. With obesity screening, the requirement is to evaluate not just that the screening for obesity is completed but that there has been counselling and when appropriate, interventions to address this health condition appropriately. The first item that the site reviewer will evaluate is that there is documentation in a member's medical record that there has been screening for obesity and/or any risk factors related to the unhealthy weight are identified. If a member does have an abnormal BMI or related risk factor, there is a second component to the reviewer's medical record evaluation, which includes identifying interventions such as counseling for addressing the unhealthy weight or any number of interventions that demonstrate clearly that the problem has an applied treatment plan.

Please refer to the chart provided in this article for a more comprehensive overview of addressing obesity practice recommendations that align with MRR DHCS obesity screening requirements. As a reminder, your practice will have a FSR site review and medical record review every 3-years per DHCS APL 22-017. For members 2-21 years of age, the American Academy of Pediatrics (AAP) has an excellent and printable tool: Evaluation and Treatment of Children and Adolescents with Overweight & Obesity: Coding Quick Referenc
Please review this chart that provides an overview of the requirements to comply with the DHCS MRR audit:

DHCS FACILITY SITE REVIEW OBESITY SCREENING STANDARD (USPSTF Grade B)			
FACTORS	**DESCRIPTION**	**CRITERION SPECIFIC INFORMATION**	
Gender	Gender parameters.	M, F, MTF, FTM	
Age	Age parameters of the criterion.	• 6* years old and older (USPSTF obesity screening is currently being updated. As of 2023, AAPrecommends pediatricians and other clinical providers start obesity evaluation and treatment for children at age 2, instead of 6 years old.)	
Periodicity	Periodicity.	• Adult: DHCS requirement is to assess and document BMI at each well visit. • Pediatric: DHCS anthropometric requirement is to assess and document height, weight, and BMI on a CDC growth chart at ages 2-21 years old at each well visit. • ***At least annually for all children 2 to 18 years of age*** *m*easure height and weight, calculate BMI, and assess BMI percentile using age- and sex-specific CDC growth charts or growth charts for children with severe obesity to screen for overweight (BMI ≥ 85th percentile to <95th percentile), obesity (BMI ≥ 95th percentile), and severe obesity (BMI ≥ 120% of the 95th percentile for age and sex) (Source).	
Risk Factors		• Genetics. • Epigenetics. • Obesogenetic environment, e.g., 24/7 food availability.	• Unhealthy eating habits. • Lifestyle factors. • Economic factors.
Consequences	Identify eligible conditions related to the criterion or susceptible factors. (Examples, but are not limited to).	**ADULT**	**PEDIATRIC**
		• All-causes of death (mortality). • High blood pressure (hypertension). • High LDL cholesterol, low HDL cholesterol, or high levels of triglycerides (dyslipidemia). • Type 2 diabetes. • Coronary heart disease.	• Cardiovascular co-morbidities such as high blood pressure (hypertension)/Cardiovascular co-morbidities and high LDL cholesterol, low HDL cholesterol, or high levels of triglycerides (dyslipidemia).

		• Osteoarthritis (a breakdown of cartilage and bone within a joint). • Sleep apnea and breathing problems. • Chronic inflammation and increased oxidative stress. • Some cancers (endometrial, breast, colon, kidney, gallbladder, and liver). • Low quality of life. • Mental illness such as clinical depression, anxiety, and other mental disorders. • Body pain and difficulty with physical functioning.	• Sleep apnea and breathing problems. • Neurological alterations. • Impaired oral health. • Psychosocial stigmatization. • Endocrine and metabolic disturbances. • Pulmonary complications. • Cancer. • Renal disturbances. • Gastrointestinal and nutrition complications. • Musculoskeletal disturbances. • Dermatologic complications.
Screening Tools	Process for evaluating the possible presence of a particular problem.	• Most common and cheapest screening tool for obesity is body mass index (BMI). • Methods to measure body composition vary regarding accuracy, reproducibility, expense, and accessibility.	
Assessment Tools	Assessment is a process for defining the nature of that problem, determining dx, and developing specific treatment recommendation	• Compile the patient's history and physical exam with laboratory and diagnostic testing. • Methods to measure body composition vary regarding accuracy, reproducibility, expense, and accessibility. • Routine lab assessment may include fasting glucose levels, hemoglobin A1c, fasting lipid levels, liver enzymes, electrolytes, creatinine & blood urea nitrogen, thyroid stimulating hormone, complete blood count, urine for albumin, & vitamin D.	
Criteria Action Item	Documentation that the age-appropriate patient with any relevant risk factors has received screening and counselling per USPSTF recommendations.		
Interventions	Credit for complying with this criterion is based upon evidence of documentation that could include any variety of messages or components to demonstrate that counselling was provided. (Examples, but are not limited to).	• Physical activity treatment. • Nutritional professional dietary counseling and advice. • Intensive health behavior and lifestyle treatment (IHBLT). • Motivational interviewing (MI) methods, defined as a patient-centered method of guiding to elicit and strengthen personal motivation for change, to identify and target any barriers to determine providing additional support, such as appropriate follow-ups, counseling services, and social work for financial assistance. -5 A's (Ask, Assess, Advise, Agree, Assist). -FRAMES (Feedback about personal risk, Responsibility of the patient, Advice to change, Menu of strategies, Empathy, and Self-efficacy. -OARS (Open-ended questions, Affirmations, Reflections, and Summaries). • Pharmacotherapy. • Metabolic and bariatric surgery. • Comprehensive obesity treatment.	
Documentation Recommendations		• Any changes in patient's weight and what caused the changes. • Review patient's activity level. • Review patient's diet/nutrition.	• Provider documentation might include a diagnosis where a provider is documenting a condition will:

		pertinent.
		• Document any associated comorbidities.
		• Add to the problem list so that you do not forget to include it in the future.
		  ◦ Update problem list when BMI/obesity diagnosis Changes.
			BMI.
			  ◦ Worsen if the patient gains weight or increases his/her BMI.
			• Patients who have had bariatric surgery need to have BMI and Problem List updated to reflect this.
			  ◦ Include dx for post-surgical status (i.e.: Z98.84 status post gastric bypass for obesity).
			• Standard from American Heart Association asks providers to document a weight related diagnosis for any patient with an abnormal BMI.

Additional References:

All Plan Letter 22-017: Primary Care Provider Site Reviews: Facility Site Review And Medical Record Review

Evidence-based recommendations on medical care for those age 2 and older are included within a new "Clinical Practice Guideline for the Evaluation and Treatment of Pediatric Obesity," published in the February 2023 *Pediatrics**[1]***. The guideline is accompanied by an executive summary and two technical reports, "Appraisal of Clinical Care Practices for Child Obesity Treatment. Part I: Interventions," and "Appraisal of Clinical Care Practices for Child Obesity Treatment. Part II: Comorbidities."

An excellent reference for the evaluation and treatment of children and adolescents with overweight and obesity can be found in a coding resource developed by the American Academy of Pediatrics Institute for Healthy Childhood Weight:Evaluation and Treatment of Children and Adolescents with Overweight & Obesity: Coding Quick Reference Card

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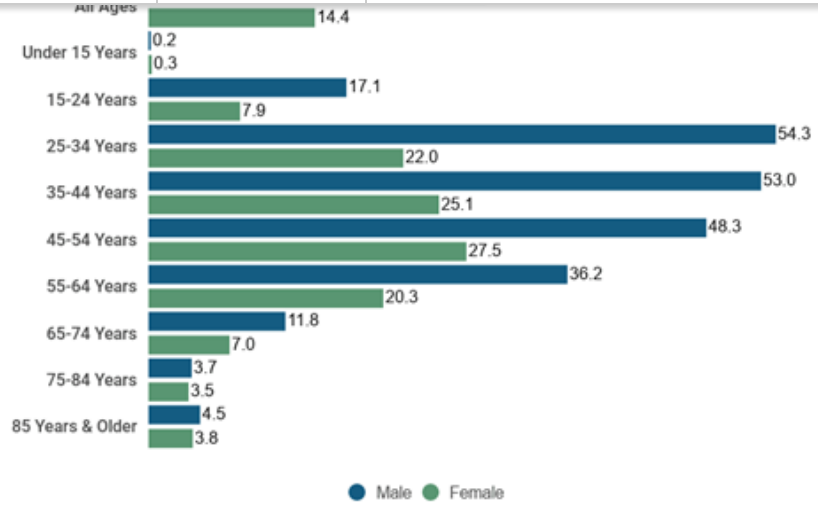
Facility Site Review: Bonus Pearl

Drug Disorder Screening and Assessment Including Overdose Awareness

This Bonus Provider Pearl is about pediatric and adult drug disorder screening and appropriate follow-up interventions for patients whose screening reveals unhealthy drug use. Also included in this article is information to raise overdose awareness. Based on data from the National Center for Drug Abuse Statistics, drug use went up by 61% among 8th graders between 2016 and 2020 with the finding that 50% of teenagers have misused a drug at least once. In addition, 3.63% of teenagers aged 12-17-years-old met the criterial for Illicit Drug Use Disorder (IDUD) in the last year (Source). In the general population, 96,700 people die from drug overdoses in a year with California having the highest number of overdose deaths (Source). One in seven of the general population's deaths or 72% were related to Opioids.



Your practice as a Medi-Cal provider is audited every three years for compliance with The California Department of Health Care Services (DHCS) Facility Site Review (FSR) and Medical Record Review (MRR) Standards. At that time, depending on your population, the medical record review includes Pediatric and Adult Preventive Services sections with criteria on drug disorder screening. This screening evaluates compliance with screening, assessing, and the follow-up for any positive findings for “unhealthy drug use”, which is defined as “the use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual”. Screening refers to asking 1 or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format (Source).

Importantly, stay aware of state requirements and best practices on informed consent for screening, mandatory screening, documenting screening results in medical records, reporting of screening results to medicolegal authorities, and confidentiality protections to minimize the potential adverse effects such as stigma, labeling, or medicolegal consequences of asking questions about drug use and documenting and reporting answers (Source).

Please review this chart that provides an overview of the requirements to comply with the DHCS MRR audit:

FACTORS	DESCRIPTION	CRITERION SPECIFIC INFORMATION
Gender	Gender parameters of the criterion.	M, F, MTF, FTM
Age	Age parameters of the criterion.	• Begin at 11 years of age • 18 years old and older
Periodicity	Periodicity.	• Assess at each well visit • Complete at least one expanded screening, using a validated screening tool, every year • Additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider
Risk Factors	Identify eligible conditions related to the criterion or susceptible factors. (Examples, but are not limited to)	• Tobacco use puts children at greater risk of early substance use • Genetics • Behavior Patterns, i.e., impulsiveness, aggressiveness, antisocial, etc. • ADHD & Anxiety Disorders • Trauma • Positive Perception of Alcohol Environment
Screening Tools	Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no. (Examples, but are not limited to)	• CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) [Pediatric] • NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST) • Drug Abuse Screening Test (DAST-20)
Assessment Tools	Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.	Rather than using one method for evaluation, assessments should include multiple sources of information to obtain a broad perspective of the client's history, level of functioning and impairment, and degree of distress.
Criteria Action Item	Must have documentation that the age-appropriate patient with any relevant risk factors has received counselling per USPSTF recommendations.	• 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
Interventions	Credit for complying with this criterion is based upon evidence of documentation that could include any variety of messages or components to demonstrate that counselling was provided. (Examples, but are not limited to)	• Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT); referral for any member identified with possible drug use disorders is made to the treatment program in the county where the member resides or documents how member was assisted to locate available treatment service sites • Primary care provider 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
Documentation Requirements	Summary	Credit can be given for simple screening tools that were verbally administered or shown to a patient to solicit their verbal response and will meet the requirement if the following is documented in the medical record: •Date of the encounter •The service provided (e.g., screen and/or brief intervention) •Presence or absence of risk •Name of the screening form(s)/instrument(s) 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) •Interventions for those at risk including if and where a referral to an appropriate program was made. •Provider's signature

Please do not hesitate to contact Provider Relations at
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