SAN FRANCISCO HEALTH PLAN
Here for you

November 2, 2020

UPDATES INCLUDE:

- Access Surveys: Provider Appointment Availability Survey, Daytime Survey, and After-Hours Survey
- Facility Site Review and Pediatric Blood Lead Screening Testing
- Pharmacy Updates: Diabetes Care, PA/Formulary Changes, Rx Transition to Medi-Cal Rx (FFS)
- 2020 Immunization Updates: Vaccination during COVID-19, Flu, HepA, and Tdap

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Access Surveys: Provider Appointment Availability Survey, Daytime Survey, and After-Hours Survey

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 2020 Appointment Availability Survey from August 17th until December 31st 2020. 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 non-emergency care. Fax and emailed 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 will be deemed non-compliant with the Timely Access Regulations, per state requirements.

The DMHC and the Department of Health Care Services (DHCS) also require health plans to monitor providers for access elements aside from appointment availability. To meet these requirements, SFHP administers the 2020 Daytime & After-Hours Surveys to primary care sites from November 9th to December 11th. The Daytime survey, delivered by fax (from 415-615-5894) or email (from access@sfhp.org), is expected to take approximately five minutes and will ask provider offices questions about access to language interpretation, access to triage by a provider, average wait times in provider office waiting rooms, and appointment availability. Fax and emailed surveys that are not responded to will continue to receive faxes and emails weekly until the survey is responded to. Please inform your front-line staff who answer the phone that they may be receiving this fax or email from SFHP and that non- participation may be deemed non - compliant with the Timely Access Regulations, per state requirements. It is also a state requirement to provide 24-hour telephone coverage and language interpretation to your patients. Your patients and SFHP's members require the ability to call a provider's offices and speak to a clinician within 30 minutes. SFHP will contact primary care offices throughout November and December after business hours to assess members' access to care.

Please refer to the informative flyer that can be shared with your team as well as an access one-pager 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.

Facility Site Review and Pediatric Blood Lead Screening Testing

The 2020 California Department of Health Care Services (DHCS) Medical Record Review (MRR) Standards recommends that children receiving health services through publicly funded programs for low-income children must receive anticipatory guidance performed at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age. Based on universal screening requirements for patients with Medicaid or in high prevalence areas, anticipatory guidance periodic health

standards from APL 20-006 for BLL monitoring are as follows: venous blood for testing at 12 month and 24 months of age, between 12 months and 24 months of age, if there is no documented evidence of BLL testing at 12 months or thereafter, and, between 24 months and 72 months of age, if there is no documented evidence of BLL testing at 24 months or thereafter. Additional considerations for the nurse reviewer to score BLL come from APL 20-016, *Blood Lead Screening of Young Children.*

The new, APL 20-016, *Blood Lead Screening of Young Children* (Supersedes APL 18-017), recommends that network providers are **not** required to perform a blood lead screening test if either of the following applies:

a. In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
b. If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Please note that the preceding (now retired) APL 18-017, *Blood Lead Screening of Young Children,* provided different verbiage. It stated that the health care provider is not required to perform Blood Lead Level (BLL) testing if:

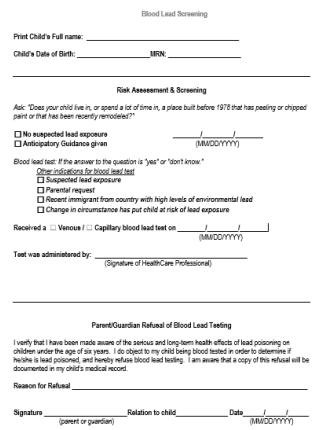
a. A parent or guardian of the child, or other person with legal authority to withhold consent, refuses to consent to the screening.
b. If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.
c. Providers must document the reasons for not screening in the child's medical record.

It is important to note that when a Facility Site Review (FSR) nurse is auditing medical records to comply with both APL 20-006, *Site Reviews: Facility Site Review and Medical Record Review,* and APL 20-016, *Blood Lead Screening of Young Children,* scoring is in accordance with the specific DHCS 2020 MRR Standard requirements. These requirements may vary from U.S. Preventive Services Task Force (USPSTF) or Preventive Pediatric Health Care Bright Futures/American Academy of Pediatrics recommendations. To receive full credit in your scoring for this element, the nurse reviewer will need to see clear evidence of lead risk assessment screening and testing, if indicated, or documented evidence that the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning, or the screening has been declined by the legally appropriate caretaker.

To support your compliance with DHCS All Plan Letters 20-006 and 20-016, you can use this link to access or it is on the sfhp.org FSR website a Blood Lead Screening questionnaire that you may consider customizing or referencing for incorporating the requirements into your workflow. The sample questionnaire includes the following:

- Risk assessment screening (documentation of no suspected lead exposure/low risk)
- Anticipatory Guidance verification
- Documentation of initial test (venous vs capillary; date; provider sign off)
- Written refusal signed by parent/guardian

References:



Blood Lead Screening

Print Child's Full name: _____

Child's Date of Birth: _____ MRN: _____

Risk Assessment & Screening

Ask: "Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently remodeled?"

☐ No suspected lead exposure
☐ Anticipatory Guidance given
_____/_____/_____ (MM/DD/YYYY)

Blood lead test: If the answer to the question is "yes" or "don't know."
Other indications for blood lead test
☐ Suspected lead exposure
☐ Parental request
☐ Recent immigrant from country with high levels of environmental lead
☐ Change in circumstance has put child at risk of lead exposure

Received a ☐ Venous / ☐ Capillary blood lead test on _____/_____/_____ (MM/DD/YYYY)

Test was administered by: _____ (Signature of HealthCare Professional)

Parent/Guardian Refusal of Blood Lead Testing

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned, and hereby refuse blood lead testing. I am aware that a copy of this refusal will be documented in my child's medical record.

Reason for Refusal _____

Signature _____ (parent or guardian) Relation to child _____ Date _____/_____/_____ (MM/DD/YYYY)

California Department of Health Care Services Medical Record Review Standards (2020)

Children receiving health services through publicly funded programs for low-income children must receive anticipatory guidance performed at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age.

Scoring Criteria:
Blood Lead Level (BLL) testing preferably using venous blood as follows:
1) At 12 month and 24 months of age,
Between 12 months and 24 months of age, if there is no documented evidence of BLL testing at 12 months or thereafter, and
Between 24 months and 72 months of age, if there is no documented evidence of BLL testing at 24 months or thereafter.
Note: The nurse reviewer will need to see clear evidence of lead risk assessment screening and testing, if indicated, provider's judgement documented that the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning, or the screening has been declined by the legally appropriate caretaker.
California law requires laboratories and health care providers performing blood lead analysis on all blood, blood specimens drawn in California to electronically report all results to the Childhood Lead Poisoning Prevention Branch (CLPPB), along with specified patient demographic, ordering physician, and analysis data on each test performed.

Refer to California Department of Public Health (CDPH) California Lead Prevention Program Branch (CLPPB) and CDC for recommended actions based on BLL levels:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx
https://www.cdc.gov/nceh/lead

For children at risk of led exposure, see "Prevention of Childhood Lead Toxicity" https://pediatrics.aappublications.org/content/138/1/e20161493
and
"Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention
https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf

APL 20-006, Site Reviews: Facility Site Review and Medical Record Review,
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-006.pdf

APL 20-016, Blood Lead Screening of Young Children (Supersedes APL 18-017),
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

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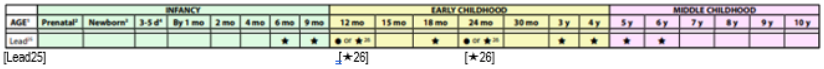
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf



[Lead25] [★26] [★26]

Footnotes:
25. For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity”; http://pediatrics.aappublications.org/content/138/1/e20161493 and “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf

26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence area. (Bright Futures recommends screening in accordance with state law and universal screening at ages 12 and 24 months in states with no screening program in place.)

U.S. Preventive Services Task Force (USPSTF)

Grade I for screening children at elevated risk
Grade D for screening children at average risk

In 2006, the USPSTF concluded that the evidence was insufficient to recommend for or against routine screening for elevated blood lead levels in asymptomatic children aged 1 to 5 years at increased risk (I recommendation).[1] The USPSTF recommended against routine screening for elevated blood lead levels in asymptomatic children aged 1 to 5 years at average risk (D recommendation). The USPSTF also recommended against routine screening for elevated blood lead levels in asymptomatic pregnant women (D recommendation).[2]

The understanding of lead exposure has changed considerably since 2006. No safe level of lead exposure has been established, and since the previous USPSTF recommendation, the reference level to identify children with elevated blood lead levels has been lowered from 10 to 5 µg/dL. Other sources of lead that could affect blood lead levels may now be more prevalent than in 2006, and these sources were not studied in the currently available evidence. There is a lack of evidence on interventions that can be done in a clinical setting that would improve health outcomes. A change in the context and applicability of older evidence resulted in the USPSTF assessing the evidence on harms of treatment as inadequate. As a result, the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for elevated blood lead levels, leading the USPSTF to issue an I statement for both populations.[2]

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for elevated blood lead levels in asymptomatic children.

[1]U.S. Preventive Services Task Force. Screening for Elevated Blood Lead Levels in Children and Pregnant Women: U.S. Preventive Services Task Force Recommendation Statement. Rockville, MD: U.S. Preventive Services Task Force; 2006.

[2] US Preventive Services Task Force. Screening for Elevated Blood Lead Levels in Children and Pregnant Women: US Preventive Services Task Force Recommendation Statement. JAMA. 2019;321(15):1502–1509. doi:10.1001/jama.2019.3326
https://jamanetwork.com/journals/jama/fullarticle/2730621

Grade	Definition	Suggestions for Practice
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

“Provider Pearls” are monthly articles written to help you prepare for the California Department of Health Care Services (DHCS) FSR review processes. If a clinic manager, office manager, nurse manager, or operations person, can take the time to independently self-monitor clinic practices with the aid of SFHP checklists and DHCS standards at least annually, we can all work together to strive toward improved quality standards in office practice operations.

For any questions about the Facility Site Review or Medical Record Review processes or tools, please contact Jackie at jhagg@sfhp.org or by her direct line at 1(415) 615-5637.

Pharmacy Updates: Diabetes Care, PA/Formulary Changes, Rx Transition to Medi-Cal Rx (FFS)

Diabetes Standards of Care

SFHP has published a one-page update on the recommended oral medication options for initial management of patients with type 2 diabetes, based on 2020 diabetes guidelines. It is available on the SFHP Pharmacy DUR webpage under the title 2020 Standards of Care for Diabetes.

Metformin is always considered first-line for initial management of diabetes. Newer medication classes including glucagon-like peptide 1 (GLP-1) receptor agonists and

such as dipeptidyl peptidase-4 (DPP4) inhibitors have been de-emphasized in current guidelines due to lack of demonstrated cardiovascular benefit.

Monthly trends of select classes of oral diabetes medications are presented in the table below, comparing September 2020 to January 2019. Among SFHP members utilizing any oral medication for diabetes, three-fourths are using metformin. Use of GLP-1 receptor agonists and SGLT2 inhibitors has increased over time. By comparison, the proportion of members utilizing DPP4 inhibitors has decreased slightly but remains similar to that of preferred second-line classes.

Medication class	January 2019		September 2020	
	Unique Utilizing Members	% of Members on Oral DM meds	Unique Utilizing Members	% of Members On Oral DM meds
Biguanides (metformin)	1,668	78%	1,619	75%
GLP-1 receptor agonists	160	7%	257	12%
SGLT2 inhibitors	93	4%	185	9%
DPP4 inhibitors	305	14%	261	12%
Any oral DM medication	2,142	-	2,167	-

Pharmacy Update Quarterly Formulary and Prior Authorization (PA) Criteria Changes

Changes to the SFHP formulary and prior authorization criteria have been approved by the SFHP Pharmacy and Therapeutics (P&T) Committee at the P&T Committee meeting on October 21, 2020. The summary of formulary and prior authorization criteria changes is available on the SFHP website. A complete list of approved formulary and prior authorization criteria is also available on the SFHP website here. All changes are effective November 20, 2020. For formulary or criteria information please visit our website or call SFHP pharmacy department at 415-547-7818 ext. 7085, option 3.

Reminder: Rx Transition to Medi-Cal Rx (Fee-For-Service)

Effective **January 1, 2021**, the pharmacy benefit for Medi-Cal members across the state including SFHP members is transitioning to fee-for-service from managed care. The new state-wide system used to administer pharmacy benefits is known as Medi-Cal Rx. SFHP will continue to manage medical and institutional care for Medi-Cal members, including medications administered in these settings.

Information on this transition is available from the California Department of Health Care Services website.

Providers can now register to access the Medi-Cal Rx provider portal at the main Medi-Cal Rx website. Click on the Provider Portal button to learn more and register.

Prior Authorization Submission Options for Medi-Cal Rx (Fee-For-Service)

As of **January 1, 2021**, Prior Authorization (PA) requests for prescription drugs and some medical supplies for Medi-Cal beneficiaries will be adjudicated by Medi-Cal Rx. To submit a request providers can:

- Fax requests for prior authorizations and attachments to 1-800-869-4325
- Enter PA information on Medi-Cal Rx provider portal (registration required, please go to www.Medi-CalRx.dhcs.ca.gov for more information)
- Submit PA electronically through CoverMyMeds® (registration required, please go to www.covermymeds.com for more information)
- Mail PA requests to Medi-Cal Rx Customer Service Center, Attn: PA Request, PO Box 730, Sacramento CA 95741-0730.

After January 1, 2021, providers can call 1(800) 977-2273 for assistance.

2020 Immunization Updates: Vaccination during COVID-19, Flu, HepA, and Tdap

DHCS has released the 2020 immunization update, summarized below.

- The rate of pediatric vaccination has declined significantly during the COVID-19 pandemic.
- The American Academy of Pediatrics (AAP) and CDC recommend that immunizations be brought up tot date as quickly as possible and that, when possible, the clinic physically and temporally separate sick visits from well visits.
- Providers and clinic staff should strengthen parents' understanding and confidence around vaccination using the CDC's Strategic Framework.
- Flu vaccination this year is critically important to reduce the impact of respiratory illness in the population and the burden on the healthcare system during COVID-19.
- ACIP recommends routine vaccination of children for Hepatitis A and that adults at risk of infection or severe disease be vaccinated as well.
- ACIP also recommends the use of either Tdap or Td vaccination where previously only Td was recommended.
