

CONTRA COSTA HEALTH PLAN
 Central County
 Quarterly Community Provider Network (CPN)
Meeting Minutes – April 25, 2017


Attending:

CCHP Staff:

Jose Yasul, MD, Christine Gordon, RN, BSN, Jonel Sangalang, Clerk

CPN Providers:

M. Chang, MD, G. Graves, MD, A. Lopresti, MD, T. Mostaghasi, MD, E. Risgalla, MD, S. Sachdeva, MD, W. Taft, MD, R. Tracy, MD, K. Warren, MD, L. Yang, MD, V. Hoffmann

Discussion	Action	Accountable
Meeting called to order @ 7:41 A.M.		C. Gordon, RN
I. Agenda was approved with no revisions.		J. Yasul, MD
II. Review and Approval of Minutes from January, 24, 2017 : Minutes were approved as presented.		J. Yasul, MD
III. Regular Reports: Review Care Matters Bulletin: <ul style="list-style-type: none"> • Providers like receiving the bulletin • Providers have been utilizing the dental varnish • HEAL Program Guidelines for Child Obesity ages 2 – 18 with BMI ≥95% tile <ul style="list-style-type: none"> ➤ 4 Touches within a year to refer to UCSF/CHO <ol style="list-style-type: none"> 1. Primary care Provider (Minimum of 2 visits) 2. Dietician 3. Patient Educator 4. Group Visit and/or Go! Club Nurse • Blood Pressure monitors are now available to Medi-Cal members only at no charge. <ul style="list-style-type: none"> ➤ Limited to 1 monitor per member every 5 years ➤ Omron 3 can only monitor for 1 family member ➤ Omron 5 can monitor for 2 family members • Tuberculosis (TB) Screenings (forms are on the www.cta.org website) <ul style="list-style-type: none"> ➤ Adult - 3 factors are on the risk assessment ➤ Pediatric - 4 factors are on the risk assessment ➤ Forms can be download from the following website https://archive.cdph.ca.gov/programs/tb/Pages/RiskAssessment.aspx • Pharmacy & Therapeutic <ul style="list-style-type: none"> ➤ Factor Xa inhibitors (90% conversion experience by some health plans) ➤  ePOCRATES is updated monthly 		J. Yasul, MD

IV.	<p>New Business:</p> <ol style="list-style-type: none"> 1. Drug Medi-Cal Organized Delivery System Waiver <ul style="list-style-type: none"> ➤ “Bridge to Reform” Demonstration Waiver (“DMC Waiver”) is a pilot program that would explain benefits to treat substance use disorders (SUDs). The DMC Waiver will test new models of delivering services to Medi-Cal eligible county residents with SUD. ➤ Five points that DMC Waiver will improve SUD treatments. <ol style="list-style-type: none"> 1) Increase and improve the quality and availability of SUD services. 2) Expand the types of services available 3) Support coordination and integration of physical and behavioral healthcare systems. 4) Reduce emergency room and hospital inpatient visits. 5) Ensure faster access to SUD services while also increasing program oversight and integrity at the county and state level. 2. Transgender CCHP Benefits <ul style="list-style-type: none"> ➤ Needs parent consent to take hormones if under 18 years of age ➤ Surgery Consultation <ul style="list-style-type: none"> • Not on hormones for 12 months • Living as desired gender (chest/hyst 3 months genitals 12 months) • Need 2 or 3 letters (PCP and Mental Health or PCP with experience in gender dysphoria and PhD or MD) 3. CCHP achieved NCQA accreditation for 3 more years. 4. Childhood Obesity Prevention & Treatment (CHOPT) <ul style="list-style-type: none"> ➤ GO! Club: Pediatric Obesity Disease Management 5. P&T Formulary Update <ul style="list-style-type: none"> ➤ Quarterly updates are now posted online 6. CCHP Enrollment & Dashboard <ul style="list-style-type: none"> ➤ Advice Nurse – Service is better since the calls are answered faster and less people hanging up. ➤ State requires we define any request for help as a complaint <p>Follow-up:</p> <ol style="list-style-type: none"> 1. Remove the form numbers on the authorization forms 2. Use Provider web portal to enter referrals (restricted access) 3. Obesity billing code does not get paid 4. Obesity resources English information webpage 5. La Clinica – Provide ICE documents 6. Telephone refills is only for 30 days at a time. 		J. Yasul, MD
	<p>Adjournment: Meeting adjourned @ 8:50 A.M.</p>		

Next meeting July 25, 2017



California Tuberculosis Risk Assessment Adults



- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.
- For TB symptoms or abnormal chest x-ray consistent with active TB disease → Evaluate for active TB disease
Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

Check appropriate risk factor boxes below.

LTBI testing is recommended if any of the 3 boxes below are checked.

If LTBI test result is positive and active TB disease is ruled out, LTBI treatment is recommended.

Foreign-born person from a country with an elevated TB rate

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, **prioritize** patients with at least one medical risk for progression (see User Guide for list)
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-born persons

Immunosuppression, current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication

Close contact to someone with infectious TB disease at any time

See the [California Adult Tuberculosis Risk Assessment User Guide](#) for more information about using this tool.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____
(Place sticker here if applicable)



To ensure you have the most current version, go to the PROVIDERS page at www.ctca.org

Avoid testing persons at low risk

Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

If health system resources do not allow for testing of all foreign-born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤ 20
- history of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

United States Preventive Services Task Force

The USPSTF has recommended testing persons born-in or former residents of a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. USPSTF did not review data supporting testing among close contacts to infectious TB nor among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Local recommendations

Local recommendations and mandates should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.**

Directory of TB Control Programs:

http://www.ctca.org/index.cfm?fuseaction=page&page_id=5071

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the 3 components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger foreign-born persons when all foreign-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Children

This risk assessment tool is intended for adults. A risk assessment tool created for use in California for children is available here: <http://www.cdph.ca.gov/programs/tb/Documents/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf>

Foreign travel

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with infectious TB cases, high TB prevalence of TB in travel location, non-tourist travel).



California Adult TB Risk Assessment User Guide — *continued*

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB. In fact, a negative TST or IGRA in a patient with active TB can be a sign of extensive disease and poor outcome.

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

Decision to test is a decision to treat

Because testing of persons at low risk of LTBI should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are frequent reasons these regimens cannot be used.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine*	Weekly	12 weeks

*The CDC currently recommends DOT for this regimen, however, preliminary data suggests that SAT is noninferior to DOT in the United States. Many clinicians are using SAT or modified DOT.

CDPH 12-dose isoniazid + rifapentine regimen Fact Sheet:

<http://cdph.ca.gov/programs/tb/Documents/TBCB-INH-RIF-LTBI-fact-sheet.pdf>

DOT = Directly observed therapy; SAT = Self-administered therapy; IGRA = Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB); BCG = Bacillus Calmette-Guérin; TST = tuberculin skin test; LTBI = latent TB infection

- Use this tool to identify asymptomatic **children** for latent TB infection (LTBI) testing.
- Re-testing should only be done in persons who previously tested negative, and have **new** risk factors since the last assessment.
If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older
- For children with TB symptoms or abnormal chest x-ray consistent with active TB disease → Evaluate for active TB disease
Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.
- Do not treat for LTBI until active TB has been excluded.

Check appropriate risk factor boxes below.

LTBI testing is recommended if any of the 4 boxes below are checked.

If LTBI test result is positive and active TB disease is ruled out, LTBI treatment is recommended.

Foreign-born person from a country with an elevated TB rate

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-born persons ≥ 2 years old

Immunosuppression, current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 2 mg/kg/day, or ≥ 15 mg/day for ≥ 2 weeks) or other immunosuppressive medication

Close contact to someone with infectious TB disease at any time

Foreign travel or residence of ≥ 1 month consecutively in a country with an elevated TB rate

- Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe

See the [Pediatric TB Risk Assessment User Guide](#) for more information about using this tool.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)



Avoid testing persons at low risk

Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select children for TB screening historically or in mandated programs are not included among the 4 components of this risk assessment. This is purposeful in order to focus testing on children at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Testing can also be considered in children with frequent exposure to adults at high risk of TB infection, such as those with extensive foreign travel in areas with high TB rates. Local recommendations should also be considered in testing decisions. Local TB control programs and clinics can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.**

Decision to test is a decision to treat

Because testing of persons at low risk of TB infection should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification (NAAT). However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

When to repeat a risk assessment and testing

Risk assessments should be completed on new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the child. High-risk children who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used here are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with infectious TB cases, high TB prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a child's return.

IGRA preference in foreign-born children ≥2 years old

Because IGRA has increased specificity for TB infection in children vaccinated with BCG, IGRA is preferred over the tuberculin skin test for foreign-born children ≥2 years of age. IGRAs can be used in children <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent children with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB. A negative TST or IGRA in a patient with active TB can be a sign of extensive disease. Any suspicion for active TB or extensive exposure to TB should prompt an evaluation for active disease.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age, children on antiretroviral medications, or pregnant adolescents. Drug-drug interactions and contact to drug resistant TB are other contraindications for shorter regimens.

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine*	Weekly	12 weeks**

*The CDC currently recommends DOT for this regimen; however, preliminary data suggests that SAT is noninferior to DOT in the United States. Many clinicians are using SAT or modified DOT.

**11-12 doses in 16 weeks required for completion

CDPH 3HP Fact Sheet: available on the CDPH TBCB website: <http://www.cdph.ca.gov/programs/tb>

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 3 months from the initial evaluation.

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

ACIP= Advisory Committee on Immunization Practices; LTBI=latent TB infection; IGRA= Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB); BCG=Bacillus Calmette-Guérin; TST= tuberculin skin test; DOT=Directly observed therapy; CXR=chest x-ray



TUBERCULOSIS in Contra Costa County 2016

A Story of Tuberculosis in Contra Costa County

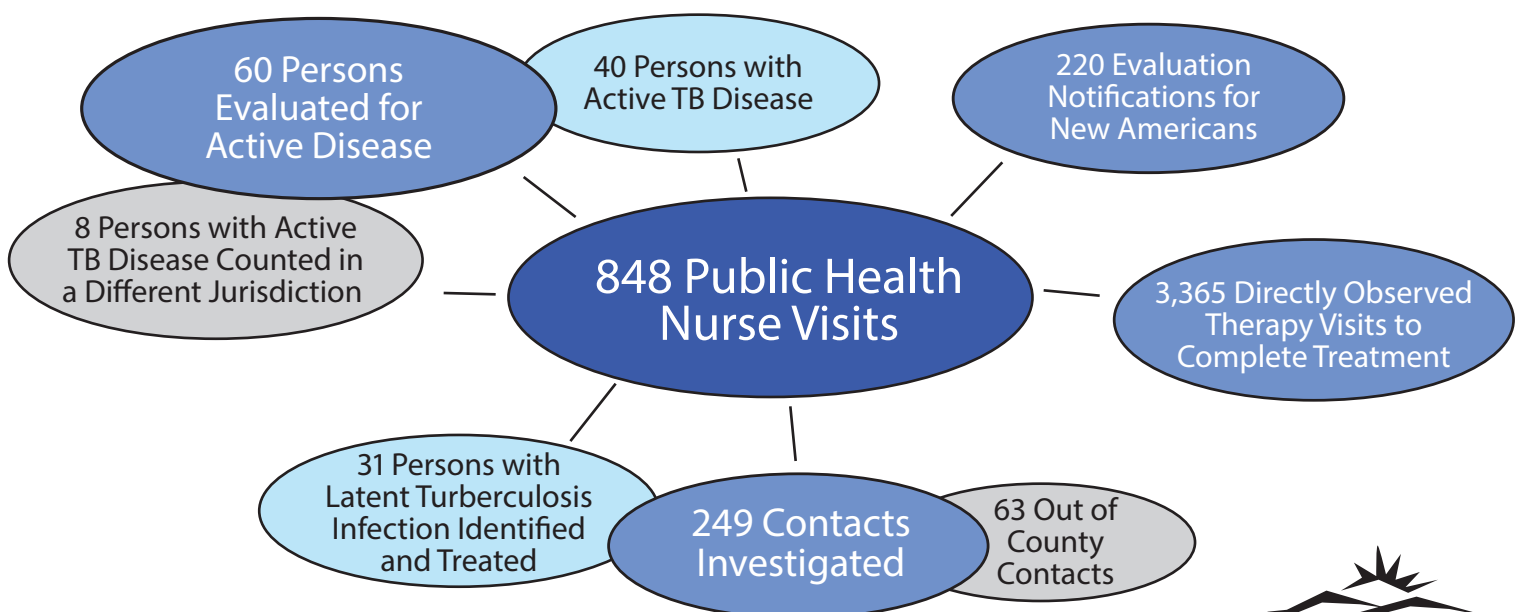
Mario was 18 years old in 1938 when he was diagnosed with tuberculosis (TB). His illness was discovered during a school health screening at his high school in Martinez. At that time, one in nine adults died of TB and there were no medications to treat it. Mario was sent to Alum Rock sanatorium in San Jose. He was put on bed rest (he was only allowed to get up to go to the bathroom), required to eat a large amount of healthy food daily, and had air pumped into his chest cavity to collapse the part of his lung that was most affected by the TB infection. When he was sent home two months later, he continued on a strict regimen of diet and rest. He went to his doctor regularly to make sure his lung remained collapsed for the next 4 years, though he was able to return to school in the fall of 1939.

Mario continued to report to the Contra Costa County Health Department for yearly chest x-rays until 1977 when he was 57 years old. If Mario contracted TB today, he would be one of only 40 cases in the county. The rate of people who get TB in California has decreased 24 fold since 1938. Mario would take 6-9 months of medications for his TB in his community instead of having to leave his family and suffer a painful procedure far from home. He would have to stay home from school for 2-3 weeks instead of 1½ years. Due to the hard work of

scientists, healthcare professionals, and the public health workforce, in the past 100 years, TB has gone from a terrifying disease that was the number one cause of death and disability in the US, to an illness that is treatable and curable. We are lucky here in Contra Costa County to have access to the benefits of TB care and prevention that are still not available in many parts of the world today.

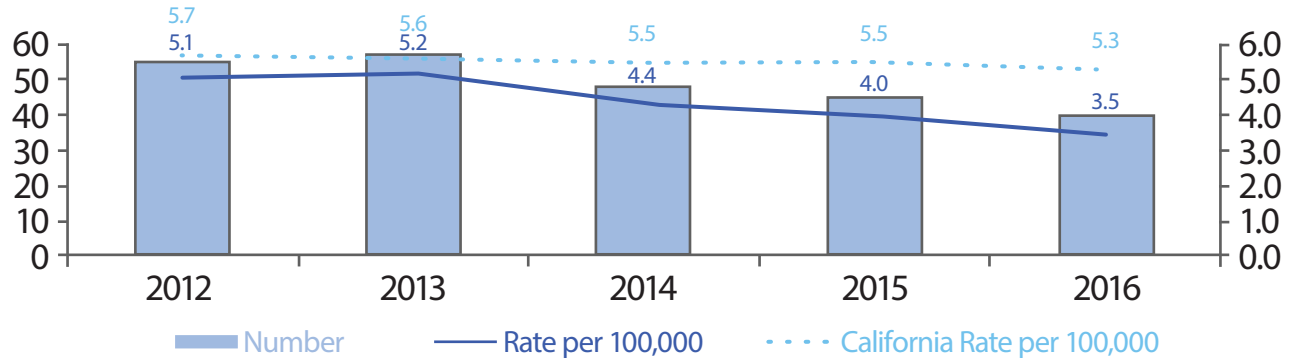
Public Health Department Role in Managing Tuberculosis

The Contra Costa Public Health Department TB Control Program is responsible for protecting the health of both individuals and our community. We are charged with investigating persons with known or suspected TB disease as well as persons exposed to TB to ensure successful TB treatment and to prevent the spread of TB in our community. The team of Public Health Nurses (PHN) and Disease Intervention Technicians monitor each person closely to ensure those with TB disease receive effective treatment, and those exposed to TB disease or are new Americans from TB-endemic countries (B-Immigrants) are located and receive prompt evaluation and treatment services. This is accomplished by intensive case management, thorough contact investigations and daily home visits to provide Directly Observed Therapy (DOT).

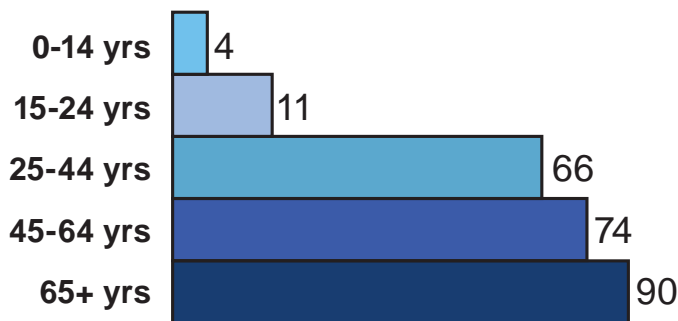


TUBERCULOSIS in Contra Costa County 2016

Contra Costa County Tuberculosis Cases & Case Rates Over 5 Years, 2012-2016

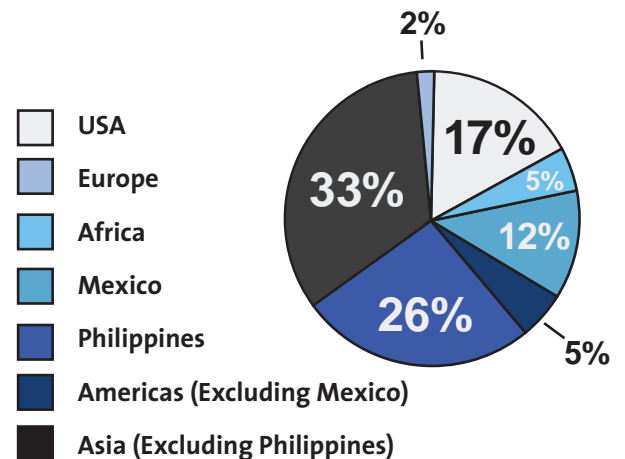


Age Distribution of People with TB Disease, Over 5 years, 2012-2016



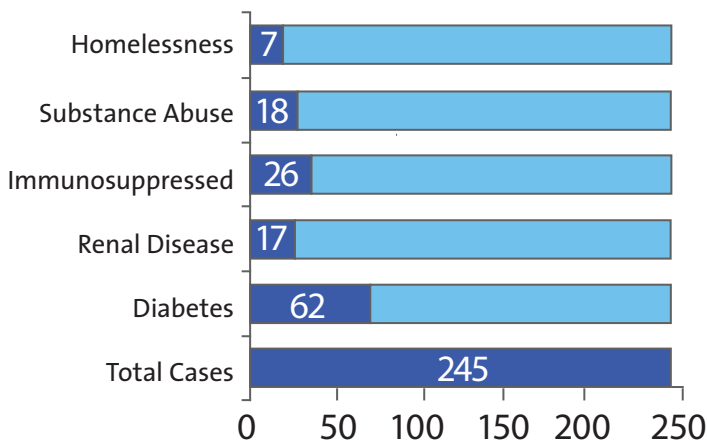
Older people are more likely to get sick with TB disease. They can have latent TB for many years and then get sick as their immune system weakens.

Origin of People with TB Disease Over 5 years, 2012-2016



Many people with TB come from parts of the world where they do not have access to the level of TB care and prevention that we provide in the United States.

Risk Factors for People with TB Disease Over 5 years, 2012-2016



Prepared by Contra Costa Health Services, Public Health Communicable Disease Programs. Data obtained from the Contra Costa Public Health Tuberculosis Program and the California Department of Public Health Tuberculosis Control Branch. For more information, call the Contra Costa Public Health Tuberculosis Program at 925-313-6740 or visit cchealth.org

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER CONTRA COSTA COUNTY

FAQ

What is the Waiver?

The Drug Medi-Cal Organized Delivery System “Bridge to Reform” Demonstration Waiver (“DMC Waiver”) is a pilot program that would expand benefits to treat substance use disorders (SUDs). The DMC Waiver will test new models of delivering services to Medi-Cal eligible county residents with SUD.

California counties opting into the DMC Waiver will be allowed Medi-Cal reimbursement for additional SUD treatment modalities and new benefits for Medi-Cal beneficiaries.

How will the DMC Waiver improve SUD treatment?

- Increase and improve the quality and availability of SUD services
- Expand the types of services available
- Support coordination and integration of physical and behavioral healthcare systems
- Reduce emergency room and hospital inpatient visits
- Ensure faster access to SUD services while also increasing program oversight and integrity at the county and state level

How will the DMC Waiver change current SUD treatment services?

It would expand reimbursable services under Drug Medi-Cal (DMC). DMC will fund outpatient, intensive outpatient, residential and opioid (methadone) treatment programs. The Waiver would allow DMC to fund a more comprehensive system of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD services.

Who is eligible for the SUD benefits?

All Medi-Cal beneficiaries who live in Contra Costa County or another participating county will have access to the new services. This includes previously eligible Medi-Cal beneficiaries (such as children in households with income up to 250% of the federal poverty level) and the Medi-Cal expansion population (single adults without children with incomes up to 138% of the federal poverty level). A qualified physician or Licensed Professional of the Healing Arts (LPHA) MUST determine the services to be medically necessary.

When will the DMC Waiver take effect in Contra Costa County?

We expect the new services to become available by 2017. A condition of the DMC Waiver is to have a contract approved by the federal Centers for Medicare & Medicaid Services and by the county Board of Supervisors. Contra Costa Health Services is currently developing the basis in preparation for the contract.

What does medical necessity mean?

“Medically necessary” means the patient is diagnosed with at least one disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except tobacco-related disorders and non-substance-related disorders, or is younger than 21 and assessed to be at risk for developing a SUD. Patients must meet ASAM criteria for medical necessity or, if applicable, the ASAM adolescent treatment criteria.

How will residents access services under the DMC Waiver?

Contra Costa residents may access services by calling the toll-free Behavioral Health Access Line at 1-800-846-1652. to obtain ASAM placement and be referred to a Drug Medi-Cal certified provider.

What is Medication Assisted Treatment (MAT)?

Medications can be used in combination with behavioral therapies to treat alcohol or opiate abuse. Methadone treatment is already available through DMC. Several more pharmacotherapies are available through the DMC Waiver.

For example, **Acamprosate** reduces alcohol withdrawal symptoms and can help patients to achieve abstinence or maintain longer sobriety periods.

Naltrexone, a medication used to block the effects of opioids, can also reduce craving in those with alcohol use disorders.

Disulfiram changes the way the body metabolizes alcohol, resulting in unpleasant reactions such as flushing and nausea if a patient consumes alcohol after taking it.

Buprenorphine is a safe and effective medication to help people reduce or quit their use of heroin or other opiates.

Summary of Benefits and Coverage				
Services you May Need	ASAM Level	Youth (13-18)	Adult	Limitations and Exceptions
Preventive Care: Screening and Brief Intervention (SBIRT)	.5	✓	✓	Once per year with your medical provider or managed care plan benefits
Outpatient care from DMC-certified providers	1	✓	✓	Up to nine hours of weekly treatment for adults and six for youth
Intensive Outpatient care from DMC-certified providers	2.1	✓	✓	Nine to 19 hours of weekly treatment for adults and six to 19 hours for youth
Short-term & long-term residential treatment (Social Model DMC-certified providers)	3.1	✓	✓	Two non-continuous, 90-day stays for adults per year. Requires prior authorization. One 30-day extension may be authorized, subject to utilization review.
				Two non-continuous stays of up to 35 days for youth per year. Requires prior Authorization. One 30-day extension may be authorized, subject to utilization review.
Non-medical withdrawal management 24-hour detoxification and moderate withdrawal support in a Social Model setting	3.2	N/A	✓	Immediate admission with authorization required.
MEDICATION ASSISTED TREATMENT (MAT) PHARMACOTHERAPY				
Opioid Treatment				
Methadone - NTP licensed facilities Behavioral counseling of up to 200 minutes per month, in 10- to 20-minute sessions.		N/A	✓	Additional counseling with medical justification for individual and group behavioral therapy
Suboxone Services available through specialty "Choosing Change" clinics within Contra Costa Health Services and waived doctors		N/A	✓	Behavioral Health individual and group counseling through behaviorists in the clinics
Case Management		✓	✓	Supports transition across levels of care.
Recovery Support		✓	✓	Prevents relapses, sustains sobriety and builds self-management skills. Benefit may be available after completion of treatment.



JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

DATE: October 6, 2016

ALL PLAN LETTER 16-013
SUPERSEDES ALL PLAN LETTER 13-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ENSURING ACCESS TO MEDI-CAL SERVICES FOR TRANSGENDER BENEFICIARIES

PURPOSE:

The purpose of this All Plan Letter (APL) is to remind Medi-Cal managed care health plans (MCPs) that they must provide covered services to all Medi-Cal beneficiaries, including transgender beneficiaries.

BACKGROUND:

The Insurance Gender Nondiscrimination Act (IGNA) prohibits MCPs from discriminating against individuals based on gender, including gender identity or gender expression (Health and Safety Code Section (§)1365.5). The IGNA requires that MCPs provide transgender beneficiaries with the same level of health care benefits that are available to non-transgender beneficiaries.

In addition, the Affordable Care Act (ACA) and the implementing regulations prohibit discrimination against transgender beneficiaries and require MCPs to treat beneficiaries consistent with their gender identity (Title 42 United States Code § 18116; 45 Code of Federal Regulations (CFR) §§ 92.206, 92.207; see also 45 CFR § 156.125 (b)).¹ Specifically, federal regulations prohibit MCPs from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a transgender beneficiary based on the fact that a beneficiary's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available (45 CFR §§ 92.206, 92.207(b)(3)). Federal regulations further prohibit MCPs from categorically excluding or limiting coverage for health care services related to gender transition (45 CFR § 92.207(b)(4)).

¹ The ACA requires that MCPs provide all beneficiaries with a common core set of benefits, known as Essential Health Benefits (EHB). Health insurers covering EHBs are prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. (45 CFR § 156.125 (b).)

MCPs must provide medically necessary covered services to all Medi-Cal beneficiaries, including transgender beneficiaries. Medically necessary covered services are those services “which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury” (Title 22 California Code of Regulations § 51303).

MCPs must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender beneficiaries. Reconstructive surgery is “surgery performed to correct or repair abnormal structures of the body . . . to create a normal appearance to the extent possible” (Health and Safety Code § 1367.63(c)(1)(B)). In the case of transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.

MCPs are not required to cover cosmetic surgery. Cosmetic surgery is “surgery that is performed to alter or reshape normal structures of the body in order to improve appearance” (Health and Safety Code § 1367.63(d)).

POLICY:

MCPs shall use nationally recognized medical/clinical guidelines in reviewing requested services from transgender beneficiaries and shall apply those standards consistently across the population. One source of clinical guidance for the treatment of gender dysphoria² is found in the most current “Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People,” published by the World Professional Association for Transgender Health (WPATH).³ The WPATH SOC includes a comprehensive discussion of the clinical management and treatment of transgender individuals by physicians and health care professionals.

Nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria: behavioral health services; psychotherapy; hormone therapy; and a variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual’s identified gender.⁴

Medically Necessary and/or Reconstructive Surgery

MCPs are required to provide beneficiaries who have been diagnosed with gender dysphoria with all Medi-Cal covered services that are provided to non-transgender beneficiaries, so long as the services are medically necessary, or meet the definition of reconstructive surgery. The determination of whether a service requested by a transgender beneficiary is medically necessary and/or constitutes reconstructive surgery must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary’s primary care provider.

² See “Gender Dysphoria” in the *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)* (DSM-5).

³ See http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926

⁴ See Kellen Baker & Andrew Cray, *Ensuring Benefits Parity and Gender Identify Nondiscrimination in Essential Health Benefits*, Center for American Progression (Nov. 15, 2012).



National Committee for Quality Assurance

has awarded

Contra Costa Health Plan

Medicaid HMO

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed
NCCQA's rigorous requirements for consumer
protection and quality improvement.



Doris Choi, MD

CHAIR, BOARD OF DIRECTORS

Margaret S. J. J.

PRESIDENT

Valerie...

CHAIR, REVIEW OVERSIGHT COMMITTEE

February 24, 2017

DATE GRANTED

February 24, 2020

EXPIRATION DATE

Contra Costa Health Plan

INSURANCE TYPE Medicaid

PRODUCT TYPE HMO

WEBSITE <http://www.cchealth.org> <<http://www.cchealth.org>>

STATE(S) SERVED California

MEMBERS ENROLLED 184650

OTHER NAMES Medi-Cal

Accreditation Status for this Health Plan

Accreditation Status last updated on 04/17/17

Why This Matters

Health care quality means patients are getting the right care, in the right amount, at the right time. This means having timely access to care, getting the right treatment and the right preventive care. Choosing high-quality health plans and doctors plays a key role in knowing whether you'll get high-quality care.



*Building a Culture of Health in
Childhood Obesity:*

Overview & Action Plan for Medicaid Health Plans



acknowledgments

The **CH**ildhood **O**besity **P**revention and **T**reatment (CHOPT) for Medicaid project is a collaborative project between the **Institute for Medicaid Innovation (IMI)**, **Medicaid Health Plans of America (MHPA)**, and the **Association for Community-Affiliated Plans (ACAP)**. The purpose of this toolkit is to describe initiatives developed by Medicaid managed care organizations (MMCOs) to prevent and treat childhood obesity and to offer resources and tools to support future efforts.

The CHOPT for Medicaid project is appreciative of the participation of the National Advisory Committee, MMCOs, federal agencies, and community stakeholders. Their dedication to preventing and treating obesity in the pediatric Medicaid population has resulted in the development of innovative programs and critical lessons learned that have the potential to assist other MMCOs to launch their own initiatives. This project would not be possible without the participation of Medicaid enrollees and their families as well as health clinics, schools, churches, and other community resources. We are grateful for their enthusiastic engagement in this project and imparting their expertise and wisdom with us.

The important work of CHOPT for Medicaid was realized through the generous support of the **Robert Wood Johnson Foundation**. Their commitment to building a Culture of Health to reduce health disparities and improve social determinants of health serves as the foundation for the nation's work in addressing salient issues for the Medicaid population.



Robert Wood Johnson Foundation

snapshots of additional childhood obesity prevention and treatment initiatives

The following initiatives provide examples of other approaches in implementing childhood obesity prevention and treatment initiatives amongst the Medicaid population. Each of these programs had varying levels of engagement with stakeholders and local community resources, depending on the goals of the program.



THE HEALTHY HEARTBEATS PRENATAL CARE PROGRAM

Organization: Virginia Premier

The Healthy Heartbeats Prenatal Care Program was created in 2010 by Virginia Premier to curb childhood obesity by promoting breastfeeding amongst new mothers. The health plan enhanced breastfeeding awareness through group interaction at baby showers, offering double electric breast pumps to all pregnant and postpartum women enrolled in the health plan, and educating members on short and long term benefits of breastfeeding. Once Virginia Premier identified that a low percentage of their enrollees breastfed or had access to breast pumps, the health plan began to offer pumps to every pregnant or postpartum woman enrolled in the plan. Since 2014, participation in the program has increased roughly 2.5 percentage points per year, reaching a total of 1,559 participants.

Virginia Premier delivered patient education through a number of sources, including Facebook, email, phone, text messages, and at baby showers and home visits. In particular, the main educational components of baby showers were breastfeeding, nutrition, healthy eating, parenting, and child wellness. Virginia Premier offered healthy cooking demonstrations and enrollees were allowed to bring their children and partners. Additionally, the health plan provided referrals to health educators for individualized diet and exercise plans. Key partnerships for the Healthy Heartbeats program included Women, Infants, and Children (WIC), local health departments, Virginia Cooperative Extension Nutrition Education, Virginia Commonwealth University Hospital Breastfeeding Education, Baby Basics Mom's Club, and Smiles for Children.



GO! CLUB: PEDIATRIC OBESITY DISEASE MANAGEMENT PROGRAM

Organization: Contra Costa Health Plan

In 2013, Contra Costa Health Plan launched the Go! Club: Pediatric Obesity Disease Management Program to promote healthy lifestyle changes after recognizing high rates of obesity in their pediatric population. The health plan promoted these changes by increasing knowledge, connecting families to community resources, and engaging clinicians to utilize tools that support healthy lifestyle changes among families. Prior to the initiative, families with obese children were not receiving consistent, intensive care for obesity in the delivery system. The program has reached over 1260 children with body mass index (BMI) scores greater than or equal to the 95th percentile. Since its launch in 2013, the program has primarily impacted children between the ages of 2-11 years, 52 percent from Spanish speaking families, and 98 percent from low-income households.

Working with Women, Infants, and Children (WIC) and the Healthy and Active before 5 Community Collaborative, Go! Club provided enrollees with consistent, intensive care to treat pediatric obesity. Participants were identified quarterly through referrals from clinicians, screening of electronic health record and claims data, patient educators, case managers, and self-referrals. The health plan sent welcome packets about the program with educational materials and recipes, encouraging families to contact the Pediatric Obesity Program nurse for counseling, education, and goal setting. After enrolling in the program, the families began to receive ongoing quarterly health education, including low literacy materials covering topics like sugar-sweetened beverages, active play, screen time and sleep. Patients were also offered support in making appointments to see patient educators, nutritionists and local obesity programs.



Contra Costa Health Plan
P&T Formulary Update
March 31, 2017

Volume 1, Issue 1

Effective: 5/1/2017

Contra Costa Health Plan Pharmacy & Therapeutics (P&T) Committee Decisions

On March 31, 2017, the CCHP P&T Committee has reviewed the following Therapeutic Classes, Drug Monographs and PA criteria for efficacy, utilization, cost and safety:

Therapeutic Class Reviews

- Oxytocic Agents
- Androgens
- Antiviral Topical Agents
- Long-acting Insulins
- Chelating Agents
- Oral 5HT3 antagonists
- Proton Pump Inhibitors
- Intra-nasal Corticosteroids
- Novel oral anticoagulants (NOACs)
- DPP-4 class (*April 2016 P&T*)
- Pulmonary Arterial Hypertension (*Jan 2017 P&T*)
- Benign Prostatic Hyperplasia (*Jan 2017 P&T*)

Drug Monographs

- Cyclosporine 0.05% , ophthalmic solution (Restasis)
- Prenatal vitamins with DHA

Prior Authorization Criteria

- Olopatadine ophthalmic solution (Pataday, Patanol)
- Testosterone (Androderm)
- Flunisolide (Nasarel)
- Rivaroxaban (Xarelto), Apixaban (Eliquis), Dabigatran (Pradaxa)

Special Guest Speaker

Dr Lisa Keller

Presenting on behalf of the Ob-gyn team

Discussion on post-menopausal hormonal therapies such as micronized progesterone and transdermal estrogens

CCHP P&T Committee has approved the following modifications to the formulary on March 31, 2017:

Medication Name & Dosage Strength	Approved Formulary Changes
Methylergonovine (Methergine) 0.2mg Tablet	Add Quantity Limit: 7 day maximum
Olopatadine (Patadol, Pataday) 0.2% Ophthalmic	Add PA criteria: must try and fail Ketotifen and Cromolyn. Applies to all members.
Testosterone (Androderm)	PA criteria added
Acyclovir (Zovirax) 5% Cream, Ointment	PA criteria modified
Docosanol (Abreva) 10% Topical Cream	Add to formulary
Penicillamine (Cuprimine) 250mg Capsules	Remove from formulary
Dolasetron (Anzemet) 50mg, 100mg Tablets	Remove from formulary
Protonix Oral Suspension & Prilosec OTC	Remove from formulary
Flunisolide Nasal Spray (Nasarel)	Add step therapy
Rivaroxaban (Xarelto) Tablets	Add to formulary
Apixaban (Eliquis) Tablets	Add to formulary
Dabigatran (Pradaxa)	PA criteria modified
Cyclosporine 0.05% Ophthalmic (Restasis)	PA criteria added
Prenatal Vitamins with DHA	Add to formulary