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Section 1: Introduction and Contact Information

1. Purpose of the Manual
The Network Operations Manual is a reference tool designed to guide both San Francisco Health Plan (SFHP) providers and medical groups in implementing the benefit programs offered by SFHP. If the terms of your Medical Group, Hospital, or Ancillary Service Agreement differ from the information contained in this Operations Manual, your Service Agreement supersedes this Operations Manual.

This is a combined manual for the Medi-Cal (MC), Healthy Kids (HK), and Healthy Workers (HW) programs. Although most sections of the manual apply to all programs, sections that apply only to particular programs are marked with a notation such as (*HK only).

The Network Operations Manual is proprietary to San Francisco Health Plan and should not be disclosed to parties outside of your medical group without San Francisco Health Plan’s written approval. SFHP will update this manual on a regular basis to incorporate program, administrative, and regulatory changes as they occur.

2. History and Who We Are
San Francisco Health Plan was created in 1994 by the City and County of San Francisco to provide services in a managed care system for people who qualified for Medi-Cal. We enrolled our first member in 1997, and today have over 80,000 members.

Since 1997, we have added four programs in addition to Medi-Cal; three of those are health coverage expansion programs that were started by SFHP.

Our first expansion occurred in 1998 when we were chosen as the Healthy Families Program community provider plan for San Francisco. In 2012 our Healthy Families Program provided comprehensive health coverage for over 7,300 children. In 2013, the State of California approved the transition of all Healthy Families Program members into the Medi-Cal program. By the end of 2013, all of SFHP’s Healthy Families members should be transitioned into the SFHP Medi-Cal program.

In 1999, we created California’s first health plan program for In-Home Supportive Service (IHSS) workers. IHSS workers provide in-home care to disabled and elderly people who are at risk for transfer to skilled nursing facilities, but wish to remain in their homes. Until 1999, IHSS workers themselves had no health insurance. Today, more than 11,300 have comprehensive health coverage through our Healthy Workers program. Numerous other counties have followed our lead by creating similar programs.

In 2002, we launched the Healthy Kids program, providing essentially universal health coverage for children, aged 0-18, in San Francisco.

In 2007, SFHP became the Third Party Administrator for the Healthy San Francisco Health Access Program, now known as Healthy San Francisco.

In 2011, SFHP became the Third Party Administrator for the SF PATH (San Francisco Provides Access to HealthCare) health access program, a state and federally-funded program that provides coverage for low-income people who do not qualify for other public programs.
3. Mission Statement
By providing superior, affordable health care that emphasizes prevention and promotes healthy living, we strive to improve the quality of life for the people of San Francisco and to support the providers who serve them.

San Francisco Health Plan’s Guiding Principles
- Educate, inspire and assist our Members to lead healthy lifestyles.
- Maintain strong, collaborative relationships between our members, community-based organizations and health care providers throughout the City.
- Recognize the cultural and linguistic diversity of San Franciscans
- Lead with innovation, continually creating new ways to make health care more accessible and affordable.
- Create a team-oriented environment based on respect that supports personal and professional integrity and encourages employee growth.

San Francisco Health Plan’s Four Organizational Goals
- Universal Coverage: Achieve universal access to health care for all San Francisco residents by partnering with the City/County, Public Health System and community providers.
- Quality Care and Access: Improve the quality of health care received by our members and participants.
- Exemplary Service: Offer exemplary service and support to our members, participants, purchasers, physicians and other health care providers.
- Financial Viability: Sustain and strengthen the financial viability of the health plan and safety-net providers.

4. Organization Chart
Please refer to the appendix for the SFHP Organization Chart.

5. Financial Arrangements and Financial Oversight of Providers

Financial Agreements
SFHP pays medical groups and hospitals a monthly per-member/per-month (PMPM) capitation payment for covered services in accordance with the benefit programs. The medical group and its affiliated hospital(s) determine how this payment is shared between the two entities.

For Healthy Kids, the capitation rates do not include the cost of well-child vaccines. SFHP separately remunerates medical groups for the cost of covered vaccines in these programs.

A Remittance Summary/Capitation Report and a compact disc with membership data accompany each PMPM capitation check, including details of beneficiaries who are eligible for covered services and the amount payable for services. Current-month membership and capitation payment amounts are calculated based on eligibility information received by SFHP. Eligibility for SFHP members can be checked via the Internet at the SFHP secure website www.sfhp.org/providers.

Financial Oversight of Providers
SFHP is responsible for the financial oversight of providers who are at financial risk for providing covered services to SFHP members under the terms of their contract with SFHP.

SFHP ensures that all at-risk providers are financially stable through regular reviews of audited financial statements. These reviews, performed on an annual basis at a minimum, are designed
to insure compliance with fiduciary obligations, statutory requirements, and to protect SFHP and its members from the consequences of a sub-contractor’s financial failure.

6. Contact Information

SFHP Administrative Contact Information
San Francisco Health Plan
P.O. Box 194247
San Francisco, CA 94119
Administration Telephone 1(415) 547-7818

Customer Service Department
Hours of Operation: Monday through Friday, 8:30am to 5:30pm.
The Customer Service Department is available to assist with any general questions about member benefits, eligibility, covered services, etc.

Customer Service Telephone 1(415) 547-7800 or 1(800) 288-5555
1(415) 547-7830 TTY/TDD

Linguistic Abilities and Services:
SFHP is committed to meeting the cultural and linguistic needs of our members. SFHP accommodates members who require languages not spoken by our Customer Service Representatives through the Language Line interpreting services. San Francisco Health Plan also uses the California Relay Services for those who are speech or hearing impaired.

Nurse Advice Line
San Francisco Health Plan’s Nurse Advice line is available 24/7 to SFHP members. Members can call 1(877) 977-3397 to speak to a registered nurse and receive advice, next steps and potential triage. Kaiser members are to call Kaiser’s 24/7 Call Center at 1(415) 833-2200 to speak to an advice nurse who can give advice and instruct members to go to the urgent care center if needed.

Provider Relations Department
Hours of Operation: Monday through Friday, 8:30am to 5:00pm for any questions or concerns about provider issues, network and contracting, credentialing, and payment disputes, etc.

Provider Relations Telephone: 1(415) 547-7818 ext. 7084
Provider Relations Email: provider.relations@sfhp.org

Utilization Management Department
Hours of Operation: Monday through Friday, 8:30am to 5:00pm for any questions or concerns about prior authorizations and inpatient concurrent review.

Utilization Management Telephone: 1(415) 547-7818 ext. 7080
Utilization Management Email: authorizations@sfhp.org
7. Provider Network Overview

**Contracted Medical Groups**
San Francisco Health Plan (SFHP) contracts with seven medical groups and their affiliated hospitals for clinical services. Individual physicians, allied health care providers, and clinics participate in the SFHP network through one of these groups. Currently, SFHP contracts with the following medical groups:

- Brown & Toland Physicians Medical Group (BTP)
- Chinese Community Health Care Association (CCHCA)
- Community Health Network (CHN), consisting of
  - Department of Public Health
  - Clinics in the San Francisco Community Clinic Consortium
  - Independent contracted providers
- Hill Physicians Medical Group (HILL)
- Kaiser Permanente (KAISER)
- North East Medical Services (NEMS)
- University of California, San Francisco (UCSF)
## Medical Group Prior Authorization and Claims Matrix

<table>
<thead>
<tr>
<th>Patient's Medical Network</th>
<th>Who processes claims?</th>
<th>Who makes UM decisions?</th>
<th>Member Grievance Line</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BTP</strong></td>
<td>Professional: BTP</td>
<td>All UM decisions: BTP</td>
<td>1(415) 547-7800</td>
</tr>
<tr>
<td></td>
<td>Phone 1(415) 972-6000</td>
<td>Phone 1(415) 972-6002</td>
<td></td>
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<tr>
<td></td>
<td>Mail claims to:</td>
<td>Fax 1(415) 972-6011</td>
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<tr>
<td></td>
<td>PO Box 72710, Oakland, CA 94612-8910</td>
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<td></td>
<td><strong>Facility &amp; DME: SFHP</strong></td>
<td></td>
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<tr>
<td></td>
<td>Phone 1(415) 547-7818 x7115</td>
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<td>Mail claims to:</td>
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<td></td>
<td>P.O. Box 194247, SF, CA 94119</td>
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<tr>
<td><strong>CCHCA</strong></td>
<td>Professional &amp; Technical: CCHCA</td>
<td></td>
<td>1(415) 547-7800</td>
</tr>
<tr>
<td></td>
<td>Phone 1(888) 467-4390, option 4</td>
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<td>Mail claims to: Excel MSO Claims Department</td>
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<td>P.O. Box 1120, San Jose, CA 95108</td>
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<td><strong>Facility &amp; DME: CCHP</strong></td>
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<td></td>
<td>Phone 1(415) 955-8800</td>
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<td></td>
<td>Fax 1(415) 955-8812</td>
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<tr>
<td></td>
<td>Mail claims to: 445 Grant Ave, Suite 700, SF, CA 94133</td>
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<tr>
<td><strong>CHN</strong></td>
<td>All claims: SFHP</td>
<td>All UM decisions: SFHP</td>
<td>1(415) 547-7800</td>
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<tr>
<td></td>
<td>Phone 1(415) 547-7818 x7115</td>
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<td></td>
<td>Mail claims to: P.O. Box 194247, SF, CA 94119</td>
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<tr>
<td><strong>HILL</strong></td>
<td>Professional: HILL</td>
<td>All UM decisions: HILL</td>
<td>1(415) 547-7800</td>
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<tr>
<td></td>
<td>Phone 1(800) 445-5747</td>
<td>Phone 1(800) 445-5747</td>
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<tr>
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<td>Mail claims to: PO Box 8001, Park Ridge, IL 60068</td>
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<td><strong>Facility &amp; DME: SFHP</strong></td>
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<td>Phone 1(415) 547-7818 x7115</td>
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<td>Mail claims to: P.O. Box 194247, SF, CA 94119</td>
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<tr>
<td><strong>KAISER</strong></td>
<td>All claims: Kaiser</td>
<td>All UM decisions: Kaiser</td>
<td>1(800) 464-4000</td>
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<td>Member Services 1(800) 390-3510</td>
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<tr>
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<td>Mail claims to: 2425 Geary Blvd, SF, CA 94115</td>
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<tr>
<td><strong>NEMS</strong></td>
<td>All claims: NEMS</td>
<td>All UM decisions: NEMS</td>
<td>1(415) 547-7800</td>
</tr>
<tr>
<td></td>
<td>Phone 1(415) 391-9686 x5241</td>
<td></td>
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<tr>
<td></td>
<td>Fax 1(866) 930-2290</td>
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<td>Mail claims to: 369 Broadway Street, SF, CA 94133</td>
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<td><strong>NEMS with SFHN</strong></td>
<td>All claims: NEMS</td>
<td>All UM decisions: NEMS</td>
<td>1(415) 547-7800</td>
</tr>
<tr>
<td></td>
<td>Phone 1(415) 391-9686 x5241</td>
<td></td>
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<tr>
<td></td>
<td>Fax 1(866) 930-2290</td>
<td></td>
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<tr>
<td></td>
<td>Mail claims to: 369 Broadway Street, SF, CA 94133</td>
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<tr>
<td><strong>UCSF</strong></td>
<td>All claims: SFHP</td>
<td>All UM decisions: SFHP</td>
<td>1(415) 547-7800</td>
</tr>
<tr>
<td></td>
<td>Phone 1(415) 547-7818 x7115</td>
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<tr>
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<td>Mail claims to: P.O. Box 194247, SF, CA 94119</td>
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</table>

### Non-Specialty Mental Health Benefit Managed by Beacon Health Strategies

<table>
<thead>
<tr>
<th>All Networks except Kaiser</th>
<th>All claims: Beacon</th>
<th>All screening/UM: Beacon</th>
<th>1(855) 371-8117</th>
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<tbody>
<tr>
<td></td>
<td>Phone 1(855) 371-8117</td>
<td>Phone 1(855) 371-8117</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mail claims to: 5665 Plaza Drive, Suite 400, Cypress, CA 90630</td>
<td>Fax: (866) 422-3413</td>
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</table>
# Contracted Hospitals

<table>
<thead>
<tr>
<th>Medical Group Affiliation</th>
<th>Hospital</th>
<th>Address</th>
<th>General Administration Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCHCA</td>
<td>Chinese Hospital</td>
<td>845 Jackson Street</td>
<td>1(415) 982-2400</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Francisco, CA 94133</td>
<td></td>
</tr>
<tr>
<td>CHN</td>
<td>San Francisco General Hospital</td>
<td>1001 Potrero Avenue</td>
<td>1(415) 206-8000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Francisco, CA 94110</td>
<td></td>
</tr>
<tr>
<td>BTP HILL</td>
<td>California Pacific Medical Center</td>
<td>3555 Cesar Chavez Street</td>
<td>1(415) 647-8600</td>
</tr>
<tr>
<td>NEMS</td>
<td>St. Luke’s Campus</td>
<td>San Francisco, CA 94110</td>
<td></td>
</tr>
<tr>
<td>KSR</td>
<td>Kaiser Permanente Medical Center</td>
<td>2425 Geary Blvd</td>
<td>1(415) 833-2000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Francisco, CA 94115</td>
<td></td>
</tr>
<tr>
<td>NEMS</td>
<td>CPMC - California Campus</td>
<td>3700 California Street</td>
<td>1(415) 600-6000</td>
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<tr>
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<td>San Francisco, CA 94118</td>
<td></td>
</tr>
<tr>
<td>NEMS</td>
<td>CPMC - Pacific Campus</td>
<td>2333 Buchanan Street</td>
<td>1(415) 600-6000</td>
</tr>
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<td></td>
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<td>San Francisco, CA 94115</td>
<td></td>
</tr>
<tr>
<td>NEMS</td>
<td>CPMC - Davies Campus</td>
<td>44 Castro Street</td>
<td>1(415) 600-6000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Francisco, CA 94115</td>
<td></td>
</tr>
<tr>
<td>UCSF</td>
<td>UCSF Medical Center, Parnassus</td>
<td>505 Parnassus Avenue</td>
<td>1(415) 476-1000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Francisco, CA 94143</td>
<td></td>
</tr>
<tr>
<td>UCSF</td>
<td>UCSF Medical Center, Mt. Zion</td>
<td>1600 Divisadero Street</td>
<td>1(415) 567-6600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>San Francisco, CA 94115</td>
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</tbody>
</table>

## Ancillary Vendors

The list of ancillary vendors can be found on the SFHP website at:

[http://www.sfhp.org/providers/our_network/](http://www.sfhp.org/providers/our_network/)
8. Provider Directories
San Francisco Health Plan publishes provider directories for each line of business (Medi-Cal, Healthy Kids, and Healthy Workers). These directories are mailed to new members and are available to existing members and providers at any time. If you would like a copy of a provider directory, please email provider.relations@sfhp.org or call 1(415) 547-7818 x7084. The provider directories are also available and searchable on the SFHP website at http://www.sfhp.org/providers/our_network/find_a_provider.aspx.

9. Oversight of Delegated Functions
SFHP delegates certain functions and activities to medical groups and gives the medical group the authority to act on its behalf. The Plan is accountable to the Department of Health Care Services (DHCS) to ensure that the medical group performs the function or activity according to the Plan’s standards and state contract obligations. SFHP oversees the activities delegated to medical groups through regular audits and reports. When the Plan identifies problems, a Corrective Action Plan (CAP) is requested from the group. The Plan may reclaim its authority to carry out any function or activity at any time.

“Delegation” occurs when SFHP gives another entity the authority to carry out a function that it would otherwise perform. This authority includes the right to decide what functions or activities to delegate and how to implement them within defined parameters. A mutual agreement (Responsibilities, Reporting and Requirements Agreement) delineates the specific functions that are delegated. The Plan is obligated to oversee delegated functions, i.e., to ensure that the functions are properly performed.

“Sub-delegation” occurs when a delegate of the Plan gives a third entity the authority to carry out a function. Either the Plan or the delegated entity conducts oversight of the sub-delegated function to ensure that the sub-delegate meets required standards. The Plan is accountable for all activities performed on its behalf by the delegate and sub-delegate organizations.

SFHP may delegate utilization management and case management, credentialing and re-credentialing, member rights and responsibilities, cultural and linguistic services, claims adjudication, preventive health and facility site and medical record reviews. It may also delegate specific activities to the medical group without delegating the entire function.

Separate policies insure SFHP routinely monitors its providers’ performance. Providing medical services is not a delegated function, as it would not otherwise be performed by the Plan. However, SFHP is responsible for ensuring that medical services are provided in compliance with the Plan’s contract with the Department of Health Care Services (DHCS) and with evidence-based standards of clinical practice. SFHP meets this responsibility through a comprehensive Quality Improvement Program and by conducting annual audits, facility site and medical record reviews at provider sites.

As a prerequisite for the delegation of any Plan function, SFHP requires that the medical group engage in a quality improvement (QI) process that includes:

- A written document outlining the QI, utilization management (UM) and credentialing program structure and content
- An annual QI and UM work plan
- Accountability to the medical group’s governing body
- A designated physician with substantial involvement in implementing the QI program
- A QI committee that meets at least quarterly to track the quality of care and service provided by the medical group, act to improve it, and maintain concurrent minutes of its activities and outcomes.
- A process to evaluate and revise the QI, UM and Credentialing Programs on an annual basis.
SFHP and the medical group sign a written agreement outlining delegated functions and activities. The agreement describes the responsibilities of the medical group for each delegated function or activity and the lists reporting requirements. The agreement describes the standards that the Plan will use to evaluate the medical group’s performance.

In all delegation agreements, the Plan retains the authority to:

- Accept or reject the qualifications of all network providers, approve new providers and practice sites, terminate or sanction providers, and report serious quality deficiencies to the appropriate authorities
- Accept or reject all decisions to deny or modify care
- Review new technologies and alter the member’s benefit under the Plan
- Conduct the final review of a member’s appeal and to respond to any complaint or appeal the member directly addresses to the Plan

Before delegating a function, SFHP audits the medical group against all relevant standards for the function. Subsequently, the plan conducts an annual review that includes an audit of credentialing; UM denial, deferred and expedited files; case management coordination with community resources; grievance files; areas previously found to have deficiencies, and a review for implementation of new California legislated regulations and SFHP policies.

Appropriate methods of evaluation include but are not limited to, asking the medical group to submit a revised policy, conducting a focused audit, requesting periodic progress reports or evaluating the effectiveness of an improvement effort at the next audit.

If the medical group fails to agree to an effective Corrective Action Plan or to take steps to resolve deficiencies, the SFHP Provider Network Development (PND) Director will discuss the case with the SFHP Chief Medical Officer (CMO). The PND Director and CMO will decide whether it is pertinent to present the issues to the SFHP Quality Improvement Committee. The Quality Improvement Committee may propose alternative corrective action strategies and/or progressive sanctions, including recommendations that the Plan suspend the medical group from performing the delegated function.

10. Medical Group Meetings and Provider Site Visits
SFHP conducts regular Medical Group meetings, usually held at Medical Group offices. Each medical group is expected to send administrators and practice managers as representatives to these Joint Administrative Meetings (JAMs). In addition, SFHP visits clinic and provider sites annually or more frequently as needed.

For additional information on these meetings, please contact the SFHP Provider Relations Department at 1(415) 547-7818 ext. 7084 or provider.relations@sfhp.org.
Section 2: Member Enrollment, Eligibility and Services

1. Program Eligibility and Enrollment

Health Coverage Program Eligibility
SFHP provides health care to its members through public health coverage programs funded by local, State, and Federal funds. Persons must be deemed eligible by these programs in order to join SFHP as a member. These programs are Medi-Cal (MC), Healthy Kids (HK), and Healthy Workers (HW). Each program is administered by an agency separate from SFHP, with the exception of Healthy Kids (HK), which is administered by SFHP.

For SFHP members to remain enrolled with the plan, eligibility must be maintained for their respective programs. Each program has its own eligibility guidelines and application process. With the exception of HK, SFHP does not determine eligibility for these health programs. Patients must contact the administering agencies with questions relating to program eligibility.

Medi-Cal (MC)
Medi-Cal provides free and low-cost health care coverage services that are funded by State and Federal dollars. These services are available to San Franciscans of low-income or limited resources. MC provides health services ranging from limited scope coverage to full scope coverage (inclusive of vision and dental for children). All SFHP members are MC full-coverage, no cost beneficiaries and are required to choose a health plan (Anthem Blue Cross or SFHP). Most Seniors and Persons with Disabilities, with only MC, are also required to choose a health plan. There are no premiums or co-pays for MC with SFHP. Eligibility is determined by the eligibility workers at the local Human Services Agency (HSA) or linked by other social services programs, such as CalWORKS, TANF, and SSI.

To apply:


Healthy Kids (HK)
HK is a health coverage program for low to moderate income children aged 0 to 18 (inclusive) in San Francisco who are not eligible for MC, regardless of immigration status, up to 300% of the Federal Poverty Level. The program provides comprehensive health, vision and dental care. SFHP is the only health plan for HK members. To remain in the program, an annual premium must be paid to the program; premium assistance is available. Additionally there are co-pays for certain services. Eligibility is determined by the HK program located at SFHP. To remain in the program, children must renew coverage every 12 months.

To apply:

Healthy Kids P.O. Box 194247 San Francisco, CA 94119 Phone: 1(415) 777-9992 [http://www.sfhp.org/visitors/programs/healthy_kids/](http://www.sfhp.org/visitors/programs/healthy_kids/)

Healthy Workers (HW)
HW is a health coverage program partly administered by SFHP. It is offered to providers of In-Home Support Services (IHSS) and a select category of temporary, exempt as-needed
employees of the City and County of San Francisco. HW members have access to medical services through the San Francisco Department of Public Health (DPH) in San Francisco. Eligibility is determined through the IHSS Authority or the Department of Human Resources and is based on length of time employed and hours worked.

To apply:
IHSS Public Authority (for IHSS providers)
Phone: 1(415) 243-4477
http://www.sfihsspa.org/content.asp?CT=6&CC=0

Department of Human Resources (for temporary, exempt as-needed employees of the City and County of San Francisco)
Phone: 1(415) 557-4942.
http://www.sfhp.org/visitors/programs/healthy_workers/

2. Medi-Cal and Health Care Options; Fee-For-Service vs. SFHP
Once a person becomes eligible for a public health program, enrollment into SFHP occurs and is slightly different for each program.

For HK and HW beneficiaries, enrollment into SFHP will occur immediately following eligibility, typically the 1st of every month. MC beneficiaries are provided the option to choose between SFHP and Anthem Blue Cross and enrollment into SFHP (if chosen) may be changed from month to month.

MC beneficiaries who are part of MC Managed Care choose one of two health plans; SFHP or Anthem Blue Cross. Enrollment into a health plan is carried out by a statewide third-party administrator, Health Care Options (HCO). Enrollment into a health plan usually takes from 15 to 45 days from the effective date of MC eligibility. Health Care Options also provides information to MC beneficiaries about health plan options through local HCO representatives and are located at the MC or CalWORKs offices.

As of July 1, 2011, most seniors and persons with disabilities with only Medi-Cal must now choose a Medi-Cal health plan and can no longer remain on “regular Medi-Cal,” also referred to as “fee-for-service MC.” Seniors and person with disabilities on MC also enroll and disenroll from health plans through HCO. Please note that seniors and persons with disabilities with MC and Medicare, also known as “duals,” or “Medi-Medi,” do not have to choose a health plan and may remain on “regular Medi-Cal.”

Health Care Options (HCO):
Health Care Options is the statewide third-party administrator for MC Managed Care. They can provide information on enrollment, disenrollment and MC Managed Care Health Plans.

Health Care Options
Phone: 1(800) 430-4263

As of January 1, 2013, Healthy Families members will be transitioned into the Medi-Cal program. This means that children in HFP with SFHP, will still be in SFHP, but will now be in a new category of the Medi-Cal program for children up to the 250% federal poverty level.

3. Community Relations Requests
The Community Relations Department at SFHP participates in community outreach to increase access to health care among San Francisco residents. Additionally, the Community Relations staff offers free presentations on San Francisco public health coverage options for community-based organizations, service agencies, and health centers.
To request SFHP brochures, presentations, or to have SFHP participate at a community event, please contact the Community Relations Department at 1(415) 615-4257 or at CommunityOutreach@sfhp.org. Advance notice of 2-3 weeks is normally required for presentations and 45 days for community events.

The Golden Gate to Health Insurance (GGHI) Network is a project of the Community Relations Department aimed at supporting the efforts of Certified Application Assistors (CAAs) and others who assist families with accessing health programs. The GGHI Network provides updates on various health programs, offers program eligibility trainings, and provides application assistance tools through bimonthly luncheons, quarterly newsletters, and occasional educational events. Visit the GGHI Network sections of the website to learn more, http://www.sfhp.org/community.


How to check eligibility
When a SFHP member seeks medical care, it is essential that the provider office verify the member’s eligibility, assigned PCP, and medical group. Failure to verify eligibility may result in non-payment of claims. SFHP makes final determination of a member’s eligibility for the date of service at the time of receipt of the claim.

Note: Possession of a SFHP ID Card does not guarantee eligibility. However, once eligibility is confirmed, the SFHP ID Card can identify the member’s assigned PCP and medical group.

The following table provides a summary of the methods to verify eligibility.

<table>
<thead>
<tr>
<th>To Verify Eligibility and Enrollment:</th>
</tr>
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<tbody>
<tr>
<td>1. Ask for the member’s SFHP ID Card</td>
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<tr>
<td>2. Check eligibility using the Provider Secure Website at <a href="http://www.sfhp.org/providers/">www.sfhp.org/providers/</a></td>
</tr>
<tr>
<td>OR Call the SFHP Interactive Voice Response system (IVR) at 1(415) 547-7810, 24 hours a day 7 days a week.</td>
</tr>
<tr>
<td>OR Call the SFHP Customer Service Department at 1(415) 547-7800 Monday-Friday, 8:30am-5:30pm</td>
</tr>
</tbody>
</table>

SFHP systems will report: SFHP Enrollment Status, Medical Group Affiliation, current PCP Assignment and eligibility history

Note: Do not rely upon POS or other non-SFHP systems to determine member assignment, as they will not identify medical group or designated PCP.

How to Use the Interactive Voice Response (IVR) System
The SFHP Interactive Voice Response (IVR) system allows 24-hour access to member eligibility, medical group and PCP assignment.

To verify eligibility, providers must provide:
ID Number from the front of the member’s SFHP ID card (if SFHP ID Card is not available, use the member’s Social Security number or Medi-Cal Client Index Number (CIN))
Identification Cards
Each SFHP member receives an ID card to present to providers as a means of verifying eligibility for covered services. In addition, Medi-Cal members are issued a state Benefit Identification Card (BIC). As neither card guarantees eligibility, SFHP recommends that where possible providers first use the SFHP ID card to determine eligibility.

Medi-Cal Point of Service (POS) “Swipe” Devices
Use of a Medi-Cal Point of Service (POS) swipe device will only alert the provider that the MC member is part of SFHP, Anthem Blue Cross, or fee-for-service, and will not indicate medical group or PCP assignment.

SFHP does not issue or participate in the use of POS “Swipe” devices for verifying eligibility. For information about the Medi-Cal POS, contact the Medi-Cal program, www.medi-cal.ca.gov.

5. Membership Enrollment Materials
The head of the household is sent an enrollment packet by SFHP, which identifies family members who have been enrolled in SFHP. The packet includes:

- A new member welcome letter
- A Member Handbook (Evidence of Coverage – EOC)
- A San Francisco Health Plan Provider Directory
- Other current promotional and educational material

Each individual member is also sent an ID card that identifies his or her PCP and a medical group. Language-appropriate materials are sent based upon the information that SFHP receives from the program’s enrollment coordinator.

6. PCP Selection, Assignment, and Change
At the time of enrollment, a new member is encouraged to select a PCP. When this does not happen, SFHP will automatically assign a PCP following an assignment algorithm that takes into account the members place of residence, primary spoken language, and other similar factors. SFHP members who are auto-assigned to a PCP may select another PCP. All members may change PCPs upon request. In most cases, PCP changes will be effective on the first day of the following month. Changes are made through SFHP’s Customer Service department.

7. Member Rights & Responsibilities
SFHP members have rights and responsibilities. Members are informed of their rights and responsibilities through SFHP member materials. Please consult the SFHP Evidence of Coverage or Member Handbook for detailed responsibilities and rights governing each line of SFHP business.
Member Rights
San Francisco Health Plan members have the right to:

- Be treated respectfully regardless of race, religion, age, gender, culture, language, appearance, sexual orientation, and disability and transportation ability.
- Get a clear explanation of how to obtain all health services available.
- Receive good and appropriate medical care including emergency services from any health care provider, preventive health services and health education.
- Receive enough information to help make a knowledgeable decision before receiving treatment.
- Know and understand medical conditions, treatment plans, expected outcomes, and the effects these have on daily living.
- Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.
- Have the meaning and limits of confidentiality explained.
- Choose a personal doctor, nurse practitioner or physician assistant to provide or arrange for all the needed care.
- Obtain a referral for a second opinion.
- Have confidential health records, except when disclosure is required by law or permitted in writing. With adequate notice, the right to review medical records with personal doctor/nurse practitioner.
- Be fully informed about SFHP’s appeal and grievance procedures; understand how to use them, and how to present my appeal in person without fear or interruption of health care.
- Make decisions regarding my care - including the decision to discontinue treatment.
- Have written instructions about care prepared in advance, called “Advance Directives”.
- Participate in establishing public policy of SFHP.

Additionally, SFHP Medi-Cal members have the right to:

- Seek confidential and sensitive services for minors.
- Seek consultation and treatment of sexually transmitted diseases from a provider outside the SFHP network.
- Seek family planning services from any provider.
- Request a State Fair Hearing and to receive information on the circumstances under which an expedited fair hearing is possible.
- Receive written member informing materials in alternative formats including Braille, large type print and audio format upon request.
- Be free from any form of restraint or seclusion used as a form of coercion, discipline, convenience or retaliation.
- Choose a personal doctor/nurse practitioner at an Indian Health Clinic or a Federally Qualified Health Center.

San Francisco Health Plan members have the responsibility to:

- Read all San Francisco Health Plan materials immediately after they are enrolled so they understand how to use their San Francisco Health Plan benefits, and ask questions when necessary.
- Follow the provisions of their San Francisco Health Plan Membership as explained in their San Francisco Health Plan Evidence of Coverage.
- Maintain their good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
- Follow the treatment plans their personal doctors/nurse practitioners develop for them and consider and accept the potential consequences if they refuse to comply with treatment plans or recommendations.
• Make and keep medical appointments and inform their personal doctor/nurse practitioner ahead of time when they must cancel.
• Communicate openly with their personal doctor/nurse practitioner so they can develop a strong partnership based on trust and cooperation.
• Ask questions if they do not understand something or if they are unsure about the advice they are given.
• Treat all San Francisco Health Plan staff and health care providers respectfully and courteously.
• Present their Member ID card at every medical appointment or hospitalization.
• Report lost or stolen Member ID cards to the San Francisco Health Plan Customer Service Department.
• If applicable, pay any premiums, co-payments and charges on time.

Contact the San Francisco Health Plan Customer Service Department at 1(415) 547-7800 (locally) or 1(800) 288-5555 (toll free) for any questions or problems regarding member rights and responsibilities.

Health Education
SFHP members must be provided with health education services at no cost. Health education services include but are not limited to primary and obstetrical care, clinical preventive services, education and counseling, and patient education and clinical counseling. These services can be provided through:
• Individual classes
• Group classes
• Workshops
• Support groups
• Peer education programs
• Disease management programs
• Educational materials

Health education services may include:
• Educational interventions designed to help members to access appropriate care
• Educational interventions that cover behaviors such as:
  o Tobacco use and cessation
  o Alcohol and drug use
  o Injury prevention
  o HIV/STI prevention
  o Family planning
  o Immunizations
  o Dental care
  o Nutrition
  o Weight control and physical activity
  o Parenting
• Educational interventions designed to assist members to follow self-care regimens and treatment therapies for existing medical conditions, chronic disease, or health conditions including:
  o Pregnancy
  o Asthma
  o Diabetes
  o Substance abuse
  o Tuberculosis
  o Hypertension
Medical groups must maintain a list of all health education classes and services that take place within their network and inform the Project Manager of Health Education and Cultural/ Linguistic Services of any changes or updates.

Requests for printed materials and additional educational resources are to be directed towards the Project Manager of Health Education and Cultural Linguistic Services at: 
HE&CLS_SFHP@sfhp.org
8. Cultural and Linguistic Services

All non-English monolingual and limited English proficient members of SFHP must have linguistic services available to them for all member service inquiries and medically-related visits. Interpreters must also include sign language interpreters and telecommunication devices for the deaf (TDD). Interpreter services at non-SFHP points of contact, translation of non health plan related documents into identified threshold languages, and cultural awareness trainings are the delegated responsibility of each medical group. The medical group must maintain a list of contracted interpreter service agencies and inform SFHP of changes or updates. The medical group and/or providers are required to coordinate interpreter services during appointment scheduling in order to ensure that an interpreter is available at the time of the appointment.

SFHP members have a right to:

- Interpreter services at no charge on a 24 hour basis at all points of contact, including signers and telecommunication devices for the deaf
- Not use friends, family members, or minors as interpreters unless specifically requested by the member after he/she has been informed that he/she may receive interpreter services at no charge
- Request face-to-face or telephone interpretation services
- Receive fully translated informing documents in threshold and concentration languages such as Customer Service guides, grievance and Notice of Action letters, welcome packets and marketing information
- Receive informing documents in alternative formats such as Braille or large sized print upon request
- Receive referrals to culturally and linguistically appropriate community services
- File grievances or complaints if linguistic needs are not met

The medical group must have a policy and procedure that includes, but is not limited to the following:

- Description of member’s rights to interpreter services that is consistent with SFHP policies
- Description of the use of bilingual providers and office staff
- Description of how providers will access, arrange, and document the use of interpreters at key points of contact when bilingual providers and staff are not available
- Description of how individuals requesting interpreter services will be offered/matched with the same interpreter to ensure continuity of care to the extent possible
- Identification of multiple modes of interpreter services available to members on a 24-hour basis, including on-site and face-to-face and telephonic interpreter services
- Description of how providers/clinics handle requests made by clients to use family or friends as interpreters.
- Description of ongoing cultural awareness trainings for providers, office personnel and medical group staff that have direct contact with Limited English Proficiency (LEP) enrollees and process for documenting its completion.
- Description of major topics covered in cultural awareness trainings including, but not limited to working with LEP enrollees and with interpreters; identifying cultural groups and their beliefs about illnesses, traditional health beliefs, language, and literacy needs; and working with Seniors and Persons with Disability.
- Description of how informing documents that are non-SFHP related will be translated and/ or made available in alternative formats.
- Procedure for identifying language capability of providers and staff who provide linguistic services, including a method of assessment of interpreter skills, documentation of the number of years of employment as an interpreter or translator, documentation of completion of interpreter training or other reasonable documentation of interpreter capability

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The medical group must inform and train providers and clinic staff regarding:

- Medical group policies and procedures regarding how to access and utilize interpreter services.
- Methods for working effectively with Limited English Proficiency enrollees and with interpreters.
- Methods for working with Seniors and Persons with Disability.
- Need to document primary language and need for language and/or interpretation services by a non English proficient - or limited English proficient member in the medical record.
- Need to document the member’s refusal to accept the services of a qualified interpreter.
- Medical group policy and procedures for translating medical group or provider specific vital documents (e.g. Informed Consent for medical procedures) and making such materials available in alternative formats (e.g. Braille).

SFHP monitors the medical group’s compliance with Cultural and Linguistic Services through review of medical group policies and procedures, Member Grievance logs, and the relevant sections of the DHS Medical Record Review/Facility Site Review.

Questions and requests for further information should be directed to the Project Manager of Health Education and Cultural/ Linguistic Services at: HE&CLS_SFHP@sfhp.org

9. Services for Members with Disabilities

The following criteria must be met for American with Disabilities Act (ADA) compliance and is assessed during the facility site review:

- Wheelchair access
- Water availability
- Elevator with floor selection within reach
- Pedestrian ramps with a level landing at the top and bottom of the ramp
- Designated parking
- Access in waiting rooms, exam rooms and bathroom; and
- Exam table access

When SFHP providers are located at sites that do not meet the Americans with Disabilities Act requirements, the medical group must assist the provider and the member with special arrangements to allow access to their providers to meet their health care needs or provide referral to a provider who has access.
Section 3: Terms of Coverage

1. Member Benefits—Summary of benefits for each LOB
Each SFHP line of business has a distinct summary of benefits. For the most up-to-date summary of benefits, please visit the SFHP website at the following links:

- Healthy Kids: [http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx](http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx)
- Healthy Workers: [http://www.sfhp.org/members/programs/healthy_workers/benefits_and_services.aspx](http://www.sfhp.org/members/programs/healthy_workers/benefits_and_services.aspx)

2. Member Copayments
Each SFHP line of business has distinct copayments. For the most up to date copayment information, please visit the SFHP website at the following links:

- Healthy Kids: [http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx](http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx)
- Healthy Workers: [http://www.sfhp.org/members/programs/healthy_workers/benefits_and_services.aspx](http://www.sfhp.org/members/programs/healthy_workers/benefits_and_services.aspx)

3. Non-covered Services and Member Liability
   **Non-Covered Services**
   Members can be financially responsible for non-covered services only if the provider obtains a written acknowledgment from the member or member’s parent or guardian prior to providing any non-covered service. The member must agree in writing that they will be financially responsible for the non-covered service. If the provider does not obtain this written acknowledgement before the non-covered service is delivered, then the provider will be responsible for the charges associated with the non-covered service. Each written acknowledgement must be specific for the non-covered service provided.

   **Member Liability**
   Members cannot be held responsible for the financial costs of any covered and authorized medical services.
Section 4: Member Appeals and Grievances

1. Member Grievances
SFHP members may file a grievance by contacting the SFHP Customer Service Department, filing a grievance online, or completing a SFHP Grievance Form provided by their PCP or medical group. SFHP Customer Service representatives are available to help members file a grievance and provide interpreter services or help find a patient advocate, when needed.

To find a patient advocate:
State of California, Office of the Patient Advocate
980 9th Street, Suite 8017
Sacramento, CA 95814
Toll Free: 1(866) 466-8900

A grievance is any expression of dissatisfaction regarding the plan and/or provider, including quality of care, concerns, disputes, and requests for reconsideration or appeal made by the member or the member’s representative. Where the Plan, delegated medical group, or provider is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

SFHP works with the member, the provider, and the medical group to resolve member grievances within 30 calendar days of receipt, in accordance with all DMHC and DHCS regulations. Through this process, the member is informed of their rights in the grievance process, including how they may appeal the resolution offered by the plan or request an independent hearing.

Grievances can be submitted online (www.sfhp.org/members/report_a_problem/), by mail, phone, or fax, to:
San Francisco Health Plan
Attn: Grievance Coordinator
P.O. Box 194247
San Francisco, CA 94119
Phone: 1(800) 288-5555
Phone: 1(415) 547-7800
Fax: 1(415) 547-7825

SFHP provides PCPs and medical groups with copies of its Grievance Forms in threshold languages. Additional forms can be obtained by contacting SFHP or through the SFHP website at http://www.sfhp.org/providers/provider_resources/grievance_process.aspx. Providers must make these forms available to members who desire to express their dissatisfaction with any of the covered areas of service.

Members may also ask for an independent medical review (IMR) from the Department of Managed Health Care (DMHC) if they or their provider believe that SFHP or their medical group has improperly denied, modified, or delayed health care services. Details on the IMR process are in section 3 below.

Timeframes for Member Grievances
If a member receives a Notice of Action from San Francisco Health Plan, the member has three options. (A Notice of Action is a formal letter telling the member that a medical service has been denied, deferred, or modified.)

- Members have ninety (90) days from the date on the Notice of Action to file an appeal of the Notice of Action with San Francisco Health Plan
- Members may request a State Hearing regarding the Notice of Action from the Department of Social Services (DSS) within ninety (90) days.
- Members may request an Independent Medical Review (IMR) regarding the Notice of Action from the Department of Managed Health Care (DMHC).
Members may file an appeal with San Francisco Health Plan regarding a Notice of Action and request a State Hearing regarding that Notice of Action at the same time. However, an IMR may not be requested if a State Hearing has already been requested for that Notice of Action. Members can also file a grievance that is **not** about a Notice of Action. Members must file a grievance within one hundred and eighty (180) days from the date the incident or action occurred which caused the member to be dissatisfied.

### 2. Member Denial Appeals

San Francisco Health Plans maintains a Member Grievances and Appeals policy and procedure. SFHP medical groups, except for Kaiser Permanente Medical Group, are not delegated for grievance resolution.

SFHP members or their representatives may file a grievance with the San Francisco Health Plan Customer Service Department by mail, phone, fax, email, or through our website. In addition, a member’s provider(s) may file a grievance on behalf of the member or themselves by contacting SFHP’s Customer Service through the mail, phone, fax, email or through our website.

Providers who are not representing a member, may appeal a Notice of Action from San Francisco Health Plan through the Provider Appeal process by contacting Utilization Management Department through email or fax.

<table>
<thead>
<tr>
<th>SFHP Department</th>
<th>Mail Address</th>
<th>Phone/Fax</th>
<th>Email</th>
<th>Website</th>
</tr>
</thead>
</table>
| Customer Service        | San Francisco Health Plan Attn: Customer Service   | **Phone**: 1(415) 547-7800 or toll free at 1(800) 288-5555  
**Fax**: 1(415) 547-7825 | memberservices@sfhp.org | www.sfhp.org member section on left side: Report a Problem leads to the grievance form |
|                         | P.O. Box 194247 SF, CA 94119                      |                                  |                               |                                      |
| Utilization Management  | San Francisco Health Plan Attn: Utilization Management P.O. Box 194247 SF, CA 94119  | **Phone**: 1(415) 547-7818 ext. 400 Fax: 1(415) 357-1292 | authorizations@sfhp.org | www.sfhp.org Provider Contacts section under Contact Us |

Definition of an “appeal grievance” is a request to reconsider an initial grievance decision or a denial decision that was made by SFHP or one of its medical groups.

San Francisco Health Plan’s clinical grievance staff collects from SFHP or from its utilization management delegated medical groups all of the clinical information from the provider’s authorization request, clinical information that was submitted with their authorization request, any additional information that may be available from the member or provider and the denial, deferral or modification of care letter sent by SFHP or its medical group. This information is reviewed by the SFHP’s Chief Medical Officer (CMO) or Physician Designee who may overturn the original denial made by SFHP. SFHP CMO or Physician Designee may uphold the medical group’s denial. SFHP ensures that a different physician from the one that made the original decision will review any decision made by the plan to deny or modify an authorization request. This review may be sent to an outside contracted entity for review and decision. This outside reviewer may overturn or uphold the initial SFHP decision. SFHP will abide by that decision.

The SFHP clinical grievance staff will send a resolution letter to the member within 30 calendar days. It will be sent in the member’s identified language and with the appropriate language.
Independent Medical Review Application (IMR) form. The member may appeal this decision through a State Fair Hearing (Medi-Cal members only) or an IMR. The resolution letters contains the phone numbers and/or forms to precede with these appeal processes.

**Prohibited Punitive Action Against Provider** – SFHP is prohibited from taking punitive action against any provider who either requests an expedited resolution or supports a member’s appeal. SFHP may not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient; for the member’s health status, medical care, or treatment options, including any alternative treatment that may be self-relevant treatment options, for the risks, benefits and consequences of treatment or non-treatment for the member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

### 3. Department of Managed Health Care (DMHC) Independent Medical Review (IMR)

A member, member’s representative, or physician may request an Independent Medical Review (IMR) with the DMHC whenever SFHP or the medical group denies, modifies, or delays authorizations of drugs, devices, procedures or other therapies because they are not considered medically necessary or because they are considered experimental or investigational or if claims are denied for out-of-network emergency or urgent services.

The member is informed that the IMR process is available after the Plan’s grievance and appeal process is exhausted, or 30 calendar days after a grievance is filed, whichever is sooner. The member is also informed of the availability of an expedited review if the qualifying conditions are met.

When DMHC notifies the Plan that a request for an IMR has been received, the SFHP Compliance Department reviews the Request for Health Plan Information form and returns the form, health plan response, and any supplemental documentation to DMHC within three (3) calendar days for a standard request, or within one (1) calendar day for an expedited request, or as otherwise indicated by DMHC in the Department Request for Health Plan Response form.

When the DMHC notifies the Plan that a case qualifies for an IMR, SFHP will work with SFHP staff, the medical group and its providers to obtain all relevant medical records. Compliance staff will forward the information to DMHC. Relevant medical records must be submitted within three (3) business days for a standard request, within one (1) calendar day for an expedited request, or as otherwise indicated by DMHC in the Department Request for Health Plan Response form.

DMHC has a toll-free telephone number, 1(888) HMO-2219, and a TDD line, 1(877) 688-9891, for the hearing and speech impaired. DMHC’s website, [http://www.hmohelp.ca.gov](http://www.hmohelp.ca.gov), has complaint forms, IMR application forms, and instructions.

IMR submissions include:

- A written response that fully addresses all issues raised in the complaint
- A copy of the plan’s original response sent to the enrollee regarding the complaint
- Medical records relevant to the patient’s condition for which the proposed therapy has been recommended and any other pertinent documentation that is in the Plan or medical group’s possession
- Copies of any relevant document(s) used by the Plan or medical group to reach the conclusion that the proposed therapy should not be covered
- A statement by the Plan explaining the rationale for the denial
- Any member or provider statement in support of the request for coverage
- Written correspondence, including letters and e-mails, between the Plan, medical group, provider or enrollee.
Telephone logs or other documentation of telephone communication between the Plan, medical group, provider or enrollee

When DMHC notifies SFHP of its IMR determination that the service was medically necessary, the Compliance Department informs the SFHP CMO and any relevant staff involved in the case. Within five (5) working days of the Department’s decision, the Utilization Management department at SFHP or the medical group must authorize the service(s) and inform the member and the provider the service(s) has been authorized. If the review was expedited, SFHP immediately contacts the member and provider by phone or fax, and sends written notification within one business day.

If the service has already been rendered, any outstanding claims are reimbursed as directed.

<table>
<thead>
<tr>
<th>Action</th>
<th>Expedited</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMHC notifies physician and SFHP if application is eligible</td>
<td>Within 48 hours after receipt of application</td>
<td>Within seven days after receipt of application</td>
</tr>
<tr>
<td>SFHP returns the Health Plan Information Form to DMHC</td>
<td>Within one (1) calendar day of DMHC notification</td>
<td>Within three (3) working days of DMHC notification</td>
</tr>
<tr>
<td>SFHP submits medical records to IMR</td>
<td>Within one (1) calendar day of DMHC notification</td>
<td>Within three (3) working of DMHC notification</td>
</tr>
<tr>
<td>SFHP provides additional information to IMR</td>
<td>Within one day of receipt</td>
<td>Within one day of receipt</td>
</tr>
<tr>
<td>IMR makes determination</td>
<td>Within three days of receipt of records, may take up to seven days for experimental care</td>
<td>Within 21 days of receipt of records</td>
</tr>
<tr>
<td>DMHC issues written decision</td>
<td>Within one day of receipt of IMR determination</td>
<td>Within three days of receipt of IMR determination</td>
</tr>
<tr>
<td>SFHP or medical group authorizes or pays for approved treatment</td>
<td>Within 24 hours of receipt of IMR determination</td>
<td>Within five (5) working days of receipt of IMR determination</td>
</tr>
</tbody>
</table>

4. State Fair Hearings

Medi-Cal members alone have the right to contact the Department of Health Care Services (DHCS) or the State Ombudsman’s office to request a State Fair Hearing.

A State Fair Hearing is an administrative procedure by which members with a grievance can present their cases directly to the State of California for resolution.

For grievances pertaining to dissatisfaction with a Notice of Action (NOA), members may request a State Hearing regarding the NOA from the Department of Social Services (DSS) within ninety (90) days from the date on the NOA. Members may file an appeal with SFHP regarding a Notice of Action and request a State Hearing regarding that Notice of Action at the same time.

State Fair Hearing
California Department of Social Services State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430
Phone: 1(800) 952-5253 (Voice)
1(800) 952-8349 (TDD)
Fax number: 1(916) 651-5210 or 1(916) 651-2789
Section 5: Member Transfers/Disenrollments

1. Disenrollment Agencies
Please address disenrollment requests to the appropriate agency:

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Agency</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>Health Care Options</td>
<td>1(800) 430-4263</td>
</tr>
<tr>
<td>Healthy Workers</td>
<td>IHSS Department of Human Resources for as-needed employees of City and County of San Francisco</td>
<td>1(415) 243-4477</td>
</tr>
<tr>
<td>Healthy Kids</td>
<td>SFHP</td>
<td>1(415) 547-7800</td>
</tr>
</tbody>
</table>

Providers with questions regarding the disenrollment process may call the SFHP UM department at 1(415) 547-7818 ext. 7080 and ask for the disenrollment coordinator.

2. Medi-Cal Disenrollment for Complex Medical Conditions
A SFHP Medi-Cal member is eligible for disenrollment for complex medical conditions (as defined by state law) if they have been a SFHP member for 90 days or less, are under treatment by non-SFHP provider, and started or was scheduled for treatment before their SFHP effective date.

Disenrollment requests received from members are the responsibility of the Utilization Department of the medical group (refer to Medical Group and UM matrix on page 9) and are directed to Health Care Options at 1(800) 430-4263 for processing.

3. Medi-Cal Member Disenrollment for Skilled Nursing Care
A SFHP Medi-Cal member may be disenrolled from Medi-Cal managed care and receive care at a Skilled Nursing Facility (SNF) through fee-for-service Medi-Cal, if the SNF admission exceeds the month of admission and the following month. Disenrollment, if requested and approved, may become effective on the first day of the second month following the member’s month of admission to a SNF. Please note that hospice services are covered services and are not considered LTC services, regardless of the member’s expected or actual length of stay in a nursing facility.

Disenrollment for SNF admissions is the responsibility of the SFHP UM Department. Delegated groups must notify SFHP of all members admitted for long term care by submitting notification of admission by fax to 1(415) 547-7822. Until the date of disenrollment, the medical group retains responsibility for the payment of the SNF costs, including the cost of custodial care.

4. Medi-Cal Member Disenrollment for Major Organ Transplant
SFHP Medi-Cal members who are eligible and pre-authorized (Treatment Authorization Request approved by Medi-Cal) for major organ transplants are disenrolled from managed Medi-Cal into fee-for-service Medi-Cal. Major organ transplants include bone marrow, heart, liver, lung, heart/lung, small bowel, combined liver and kidney and combined liver and small bowel.

Disenrollment for Major Organ Transplants at UCSF are the responsibility of the UCSF Transplant Center. Contact 1(415) 353-1066 or 1(415) 353-8776. Disenrollment for Major Organ Transplants at CPMC are the responsibility of the CPMC Organ Transplant Team. Contact
1(415) 600-1031. The provider must also submit a treatment authorization request (TAR) to the Medi-Cal Field Office when appropriate.

5. **Member Disenrollment for Cause**

Members may voluntarily request to Health Care Options to self-disenroll from SFHP coverage at anytime.

Members may also be disenrolled by SFHP if the member:
- Provided information that is materially false or misrepresented on any enrollment application or any other health plan form
- Permitted a non-Member to use his or her Member ID to obtain service and benefits
- Obtained or attempted to obtain services or benefits under SFHP by means of false, materially misleading, or fraudulent information, acts or omissions
- Engaged in disruptive behavior to SFHP personnel or the providers of services (when such conduct is not corrected after written notice by the SFHP)
- Threatened the life or well being of SFHP personnel or the providers of service.

Until a member’s disenrollment becomes effective, it is the medical group’s responsibility to authorize and pay for all medically necessary services, and the provider’s responsibility to provide all medically necessary services.

The medical group or provider is responsible for notifying SFHP and providing relevant documentation required for member disenrollment.
Section 6: Medical Management

Subsection 1: Quality & Performance Improvement

1. Quality & Performance Improvement Program

San Francisco Health Plan is committed to continuous quality improvement of its health care delivery system. The purpose of the San Francisco Health Plan Quality & Performance Improvement (QI) Program is to establish comprehensive methods for systematically monitoring, evaluating and improving the quality of the care and services provided to San Francisco Health Plan members.

San Francisco Health Plan (SFHP) provides preventive, primary, perinatal, specialty, emergency and ancillary health care services to members in the ambulatory, inpatient and home care settings. It assures that eligible members have access to medical and social services that are provided by the San Francisco Department of Public Health and other public and community agencies.

San Francisco Health Plan contracts with health care providers, including organized medical groups and their associated hospitals, to provide members with medical services. SFHP utilizes the medical group structure to facilitate the communication of standards, contractual requirements and policies and procedures to participating practitioners.

San Francisco Health Plan retains full responsibility for its Quality & Performance Improvement Program. In certain instances, San Francisco Health Plan may partially or fully delegate authority for activities described in this program to medical groups. San Francisco Community Behavioral Health Services ("CBHS") contracts directly with the State or is fully delegated to provide specialty mental health services to eligible SFHP members. SFHP covers outpatient mental health services that are within the scope of the Primary Care Physician, and non specialty mental health services (definitions for “non specialty mental health” services are still pending from DHCS at the time of this revision). SFHP develops and implements policy and procedure, UM-29: Behavioral Health Services to ensure that members who need specialty mental health services (services outside the scope of practice of Primary Care Physicians) are referred to and are provided mental health services.

Under the leadership of the SFHP Governing Board, the Quality & Performance Improvement Program is developed and implemented through a QI committee structure. The QI committee structure, with the central involvement of the SFHP Medical Director, assures ongoing and systematic interaction between the health plan and its key stakeholders: members, medical groups and practitioners.

Goal and Objectives

The goal of the Quality & Performance Improvement Program is to assure that San Francisco Health Plan provides high-quality care and services to members by creating and pursuing opportunities to improve the performance of our health care delivery system. To achieve this goal, SFHP establishes objectives and identifies quality improvement activities that allow it to monitor, evaluate and improve performance. These objectives and activities include:

- Improving the health status of the health plan population membership through
  - Implementing preventive care and health promotion programs
  - Implementing programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by the health plan population
• Educating members and providers about effective health management strategies and programs
• Involving physicians and other health professionals in the process of establishing clinical guidelines and programs, designing clinical quality improvement studies and evaluating results
• Review of our written clinical practice guidelines to assure they are current, based on sound clinical principles, comply with current standards of medical practice and are consistently applied
• Measurement of practitioner performance against HEDIS standards
• Execution and analysis of member and provider satisfaction surveys, complaints, grievances and appeals concerning quality of care
• Coordinating care with other public and community agencies providing clinical, ancillary and social services to SFHP members
• Review of HEDIS and other quality indicators to identify opportunities for clinical quality improvement initiatives.

• Providing continuity and coordination of care through review, evaluation, and/or implementations regarding the following:
  o Policies and procedures concerning case management, initial health assessments, referral and follow-up care, discharge planning and transition of care for compliance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  o Medical record audits to monitor appropriate follow-up care and referral practices, including monitoring the coordination of care between the primary practitioner, specialist physicians, mental health practitioners and public and community agencies providing clinical and social services to SFHP members
  o Member and provider satisfaction surveys, complaints, grievances and appeals concerning continuity and coordination of care
  o Denials and modifications of care
  o Corrective action plans that address specific or systemic issues concerning continuity and coordination of care.

• Providing access to care and service through evaluation and monitoring of:
  o Access and availability standards and policies for compliance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  o Geographic access for SFHP members to primary care practitioners, and other health care services
  o Wait time for routine, urgent, specialist, prenatal and emergency care appointments
  o Patient wait times in the practitioner’s office
  o Hours of operation and availability of after-hours care
  o Provider telephone triage systems, including emergency care instructions
  o Telephone access to SFHP Customer Service
  o The number of primary physician practices are open to new members
  o Facilities’ ability to meet standards of access for people with disabilities
  o Procedures, including member and provider education, that promote access to sensitive services
  o The cultural and linguistic needs of the SFHP population, and maintaining appropriate services, including providing member materials that are written at the appropriate reading level and available in threshold languages, and providing interpreters and bilingual staff where members rely on face-to-face or telephonic contact to obtain services
  o Member and provider satisfaction surveys, complaints, grievances and appeals concerning access to care
  o Incidents when payment for care is denied and modifications of care
  o Implementation of corrective action plans that address specific or systemic issues concerning access and availability of care and services.
• Assuring member rights and responsibilities through review, evaluation, and/or implementations regarding the following:
  o Our statement of member rights and responsibilities to all members and providers in compliance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  o Ongoing member education on the rights and responsibilities of SFHP membership
  o Specific policies that address the member’s right to confidentiality and minor’s rights
  o Member and provider satisfaction surveys, complaints, grievances and appeals concerning member rights and responsibilities
  o Our process for formal complaints, grievances and appeals for compliance of with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  o Corrective action plans that address specific or systemic issues in providing members rights and responsibilities.

• Assuring member satisfaction through review and actions based on:
  o Member complaints, appeals and grievances, and identifying trends
  o Requests to change practitioners, and identifying trends
  o Member satisfaction surveys and identifying priority areas for improvement
  o Corrective action plans that address specific or systemic issues adversely affecting member satisfaction.

• Assuring that health care practitioners are appropriately credentialed and recredentialed and all organizational providers meet accreditation standards through review, evaluation and/or implementation of:
  o Credentialing and recredentialing policies and procedures for compliance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  o Credentialing and recredentialing recommendations, potential quality of care issues and disciplinary actions
  o A mechanism for due process for practitioners who are subject to adverse actions
  o Facility site and medical record reviews on all primary care practitioners prior to credentialing and recredentialing in accordance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  o Accreditation of institutional providers, or reviewing for compliance with industry standards
  o Member satisfaction surveys, complaints and grievances concerning provider performance
  o Corrective action plans that address specific or systemic provider performance issues.

• Assuring timely communication of standards and requirements to participating medical groups and organizational providers through distribution of and training related to:
  o SFHP operations manuals that are revised and updated as needed
  o New and revised policies and procedures, and legislative and regulatory requirements as they occur
  o Preventive care and other clinical practice guidelines
  o Results of quality monitoring activities, audits and studies, including member and provider satisfaction survey results
  o The beginning training of new providers.
SFHP Network Operations Manual

- Assuring effective and appropriate utilization management of health care services, including medical, pharmaceutical and behavioral health care services, through review, evaluation, and/or implementations regarding the following:
  - Our utilization management program, policies and procedures for compliance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards
  - Utilization management criteria and policies to assure they are current, based on sound clinical principles, and are consistently applied
  - Utilization rates, coordination and continuity of care indicators, quality of care issues and risk management activity
  - The timeliness of utilization management decisions, including expedited appeals
- Monitoring over-utilization and under-utilization through:
  - Medical record audits
  - Reviewing member and provider satisfaction surveys, complaints, grievances and appeals concerning denials, delays or modifications of care
  - Utilization Management reports
  - Pharmacy utilization reports
  - HEDIS use of services measures
  - Implementing corrective action plans that address specific or systemic utilization management issues.
- Assuring that responsibilities delegated to medical groups meet Plan standards through review, evaluation, and actions regarding:
  - All SFHP policies and procedures that proscribe oversight of delegated activities
  - An annual written document outlining performance expectations and routine reporting requirements that is signed by both the Plan and the medical group
  - Quarterly reports and an annual audits of all delegated activities for compliance with Plan standards, policies and procedures
  - The Plan’s authority to:
    - Accept or reject the qualifications of all network providers, approve new practitioners and sites, terminate or sanction practitioners, and to report serious quality deficiencies to appropriate authorities
    - Accept or reject all decisions to deny or modify care
    - Review new technologies and alter the member’s benefit under the Plan
    - Conduct and decide the final level of appeals and to respond to any complaint or appeal the member elects to address directly to the Plan
  - Corrective action plans when deficiencies are noted, and evaluating the results within a specified timeframe and until corrective actions are complete.
- Evaluating the overall effectiveness of the Quality & Performance Improvement Program through an annual, comprehensive evaluation process that results in a written report which is submitted to the Department of Health Care Services (“DHCS”) on an annual basis. The written report includes the following:
  - An assessment of the accomplishments, as well as the obstacles, encountered in implementing the annual plan
  - An evaluation of areas where improvements in care or service were achieved as a result of quality improvement activities
  - An evaluation of areas where improvements in care or service were not achieved and a further effort is warranted
  - An evaluation of each quality improvement activity
  - A summary of all quality indicators, identifying significant trends and priority areas for improvement
  - A critical review of the organizational resources involved in the Quality & Performance Improvement Program, including an evaluation of the effectiveness and efficiency in use of resources
  - A review of changes in the health care environment and its regulatory standards.
- Using the annual evaluation to update the Quality & Performance Improvement Program and develop an annual Quality Improvement Work Plan that includes:
Objectives for the year and program scope
- Planned activities for the year, including internal quality improvement projects in areas where opportunities exist for significant, measurable improvements in clinical care and health care services
- Mechanisms to track key quality indicators and to monitor the effectiveness of corrective action plans and quality improvement projects in addressing previously identified issues
- Timeframes for each activity
- Person responsible for each activity
- A plan to evaluate the QI program on an annual basis.

2. Quality Committee Structure
A 19-member Governing Board directs the San Francisco Health Plan. The Governing Board includes physicians and other health care providers, beneficiaries, health and government officials, and labor representatives. The Board is responsible for the overall direction of the Plan, including its Quality Improvement Program. The Governing Board meetings are open for public participation.

The SFHP Quality Improvement Committee is a standing committee of the San Francisco Health Authority Governing Board. It is responsible for reviewing and approving the annual QI Work Plan and Evaluation, and for providing oversight of the Plan’s quality improvement activities. It is the main forum for member and provider participation in assuring the quality of SFHP’s delivery system.

The SFHP Quality Improvement Committee is also the main forum for oversight of SFHP’s health care delivery system. It reviews and approves the Plan’s utilization management and case management policies, its clinical guidelines and studies, and the activities of all entities delegated for utilization management services.

SFHP also relies on a Pharmacy and Therapeutics Committee and the Physician Advisory/Peer Review/Credentialing Committee to implement and oversee its QI Program.

The Pharmacy and Therapeutics Committee assures that the Plan administers its pharmacy benefit in a manner that is consistent with sound clinical principles and processes, and that it complies with current standards of practice. It reviews and makes recommendations about the Plan’s formulary and its pharmaceutical and therapeutic treatment guidelines.

The Physician Advisory/Peer Review/Credentialing Committee provides input and recommendations to SFHP on standards of care, clinical programs and guidelines and quality initiatives. The Peer Review committee serves to address concerns or identified problems related to issues of quality of medical care. It also reviews any Medical Board of California accusations and decisions/resolutions for providers within our network. Additionally, it reviews credentials and approves practitioners for participation in the SFHP network and reviews the credentialing policies and activities of entities delegated for credentialing. The Peer Review Committee meets at least annually to evaluate its work and to review credentialing and recredentialing policies and activities of all delegated entities.

SFHP Staff Responsibilities
The Health Improvement Team is a cross-departmental forum that is accountable for implementing the annual QI Work Plan. It is organized to provide inter-disciplinary involvement in assuring the quality of medical care and services provided to SFHP’s membership. It monitors quality indicators and plans, implements and evaluates the Plan’s quality improvement activities. It develops policies and procedures to assure compliance with SFHP standards, legislative mandates, contractual obligations and, where possible, NCQA standards. It coordinates oversight of all delegated activities and monitors the implementation of corrective action plans. Based on its activities, it provides summary data, analysis and recommendations to the QIC.
San Francisco Health Plan staff is responsible for implementing the QI Program include:

- The SFHP **Chief Executive Officer (CEO)** is accountable to the Governing Board for the QI Program.
- The SFHP **Chief Medical Officer (CMO)** has the main responsibility for leading the Quality Improvement Committee, Physician Advisory and Peer Review and Credentialing Committee and the Pharmacy and Therapeutics Committee, and for all quality improvement studies and activities. The CMO carries out these responsibilities with support from at least the following staff: Health Improvement Director, Manager of Clinical Quality, Project Manager of Health Education and Cultural and Linguistic Services, and Grievance Specialist.

- The SFHP **CMO and the Medical Management Department** are responsible for:
  - Coordinating all clinical studies, programs and activities
  - Facilitating quality improvement efforts and providing the research skills needed to analyze data and measure the significance of trends
  - Providing clinical oversight for delegated functions, including utilization management, case management, medical record reviews and facility site reviews
  - Conducting needs assessments and designing and implementing the Plan’s health education and health promotion initiatives
  - Proposing the QI Program, Work Plan and Evaluation, providing regular reports and assuming other functions that assist the QI committees to meet their objectives.
  - Assuring member access and availability of care.

- The **Medical Management Department** and the **Customer Service Department** are responsible for ensuring member rights and responsibilities. They assure full compliance with all policies concerning member rights. The Medical Management Department assures the timely resolution of complaints and appeals. Both departments respond to the questions and concerns of members and providers. Medical Management maintains tracking logs that allow trending of member and provider concerns, and plays a role in identifying systemic problems that adversely affect SFHP members.

- The **Provider Relations Department** is responsible for those aspects of the QI Program that relate to evaluation of provider qualifications and performance. It is also responsible for provider orientation and education and conducting and analyzing provider satisfaction surveys.
San Francisco Health Plan complies with the HEDIS, CAHPS and Quality Improvement Project requirements from the California Department of Health Care Services (CDHCS) and Managed Risk Medical Insurance Board (MRMIB).

3. Quality Improvement Programs, Quality Initiatives and Measuring Quality

Quality Improvement Projects (QIPs)
Under the direction of the CMO, the Health Improvement Department (formerly known as “Quality and Performance Improvement Department”) will participate in at least two QIPs including the CDHCS Statewide Quality Improvement Collaborative. The QI Department will measure and analyze relevant clinical issues, take action to improve performance, and assess the effectiveness through systematic follow-up.

Topics for QIPs will be evaluated using the following criteria:
- Sufficient data exists for meaningful analysis.
- At-risk population can be identified.
- Clinical practice guidelines or treatment standards are available.
- Measurable indicators and goals can be developed.
- The plan is able to make or direct improvement in care or service.

QIP measurements will be evaluated against established benchmarks including but not limited to:
- NCQA mean and percentile rates for Medicaid and commercial populations.
The Minimum Performance Levels (MPL) and Highest Performance Levels (HPL) established by the California Department of Health Care Service results for Medi-Cal Managed Care Plans.

Healthy People 2010 goals.

When opportunities for improvement are found, peer committees, other appropriate groups of providers or SFHP staff will use QI tools to:

- Establish causal factors.
- Develop action plans and improvement strategies or other responses.
- Complete an evaluation of the effectiveness of interventions.

The CMO will report results of QIPs to the QIC and the Governing Board either at the time completed or as part of the annual evaluation.

QIPs are reported to CDHCS annually using the NCQA QIA form.

4. Measuring Quality

HEDIS Reporting – External Accountability Set (EAS) Performance Measures

The Health Effectiveness Data Information Set (HEDIS) SFHP will report all EAS performance measures required by CDHCS and MRMIB following current NCQA guidelines and timelines. State-mandated HEDIS reporting must be accomplished by June 15th each year.

SFHP’s HEDIS measures are audited by Health Services Advisory Group (HSAG) for the Medi-Cal line of business. CDHCS require HEDIS audits to validate the quality and accuracy of the plan’s HEDIS data.

SFHP licenses NCQA-certified HEDIS software for HEDIS reporting.

SFHP contracts with Registered Nurses and nonlicensed chart abstractors to perform medical records collection; abstract HEDIS measure specific data according to NCQA guidelines, and enter results into HEDIS software.

SFHP HEDIS data includes electronic claims or encounter data received from:

- Delegated primary provider groups and networks.
- Delegated vision providers
- A pharmacy benefit management (PBM) vendor

Key steps in HEDIS data collection and reporting process include:

- Identify Members who qualify for inclusion in each HEDIS measure based on enrollment period, age, or diagnosis.
- Select a statistically significant sample of qualifying Members for each measure denominator.
- Identify administrative positives through claims, lab and encounter data.
- Members with proof of the HEDIS service are counted in the HEDIS measure rate without need for further data acquisition.
- Any Member not counted administratively will require medical record review at one or more provider offices.
- Identify from eligibility and claims data the most likely provider (MLPs) for each remaining Member for whom medical record review is required.
- Review medical records at provider offices for the remaining Members in the HEDIS sample.
- Report findings to the CDHCS, NCQA and MRMIB.

Annual HEDIS results are reported to the QIC and, by the Chief Medical Officer and Director of Health Improvement, to the Governing Board. Results are compared with:
SFHP Network Operations Manual

- Minimum Performance Level (MPL) and High Performance Level (HPL) for each measure as established by CDHCS and MRMIB.
- Rates achieved by other Medi-Cal plans.
- SFHP past performance for the same HEDIS measures.

SFHP will submit a corrective action plan to CDHCS for measures that fall below the CDHCS designated minimum performance level. SFHP follows the procedures outlined above for Quality Improvement Projects when carrying out a corrective action plan to address measures that fall short of CDHCS standards.

CAHPS (Consumer Assessment of Healthcare Providers and Systems)
CAHPS patient experience surveys are an important mechanism to understand the drivers of member dissatisfaction, and to help SFHP develop programs to address these issues. SFHP will participate in CAHPS as scheduled by the Managed Medi-Cal Division of the Department of Health Care Services (MMCD). SFHP also periodically administers our own CAHPS satisfaction surveys, to be able to collect data at the member and provider level, and share this data with providers to help improve patient satisfaction.

The SFHP Business Intelligence team is responsible for submitting CAHPS sample files for Medi-Cal to the CDHCS designated NCQA-certified HEDIS auditor for verification. Once the Medi-Cal CAHPS files are validated by the NCQA-certified HEDIS auditor, the HI coordinator is responsible for submitting the files to the CDHCS designated CAHPS survey vendor according to the NCQA timeline.

Quality Improvement Initiatives
Promoting Preventive Care
Promoting timely preventive care is a core component of SFHP’s Quality Improvement Program. SFHP’s goal is to be among the top ten percent of Medicaid health plans nationally for clinical measures, to ensure that our members get the right care at the right time. We have programs for members to remind and encourage them to seek care. In addition, we have programs for providers to help them keep track and bring in patients due for services. Below is a summary of our preventive health programs:

Preventive Care for Infants and Toddlers
- **Immunization reminder card**: Families with children turning 6, 12, 15 and 18 months of age receive an immunization reminder card with educational messages about vaccinations.
- **Immunization member incentive**: We mail families with children turning 13 months an offer for a $50 gift card for completing all immunizations on time.
- **Immunization reminder phone blasts**: Families receive three recorded telephone calls at 12, 13, and 22 months reminding them to bring their children in for well-checks and immunizations.
- **Outreach lists for providers**: We offer PCPs outreach lists of members due for well-checks and immunizations.
- **Support for the Bay Area immunization registry**: We support the San Francisco Immunization Coalition in spreading the use of the Bay Area Immunization Registry through outreach to provider sites and offering financial assistance to clinics that agree to use the registry.
Annual Check-Ups for Children

- **Well-child visit member incentive:** Families with a child between three and six receive a birthday card from SFHP, offering them $25 gift card for bringing their child in for an annual check-up.
- **Well-child visit phone blast:** Along with the birthday card, families receive a recorded telephone message encouraging them to take their child to the doctor and take advantage of our member incentive.

Preventive Health for Women

- **Well-woman preventive health mailing:** Upon enrollment and then once per year, our female members aged 27 and over receive a brochure with preventive health care guidelines for women and health education messages. The mailer also includes a promotion for our prenatal incentive program for members who may be pregnant.
- **Young-woman preventive health mailing:** Members between 16 and 26 years old receive a mailing similar to our well-woman mailing upon enrollment and annually thereafter. The mailing includes additional health information for younger women a promotion for our prenatal incentive program for members who may be pregnant.
- **Pap smear reminder card:** Members overdue for a Pap smear, according to our encounter data, receive a reminder card encouraging them to check with their provider about when they should be screened.
- **Mammogram reminder card:** Members overdue for a mammogram according to our encounter data receive a reminder card encouraging them to check with their doctor about when they should be screened.

Improving Chronic Care

SFHP implemented a chronic disease management program to promote high quality of care for asthma, diabetes, hypertension, and hyperlipidemia. Below is a summary of our initiatives:

- **Diabetes member reminder card:** All diabetic members receive a reminder card encouraging them to complete the screening tests such as HbA1c, cholesterol, microalbumin, foot exam, blood pressure, and eye exam.
- **Diabetes incentive program:** We send an incentive offer to members identified as moderate and high risk diabetics. Members who completed all the required screening tests receive a $25 gift certificate.
- **Eye exam reminder card:** We send a reminder card to diabetic members who have not had an eye exam in the past 12 months. Members are given a list of VSP providers who speak their language. The card includes a “fax-back” form for the eye care provider to fill out and fax back to the PCP for their records.
- **Incentive payments for population management:** Through a program called the “Practice Improvement Program,” SFHP provides incentive payments to safety net clinics and medical groups for improvement on measures of chronic care, such as percentage of patients with diabetes who received an HbA1c test in the past year. Other chronic condition measures included are measures for care of chronic pain, HIV lab tests completion, and Hepatitis B vaccination. Through this program, we provide technical assistance in two ways:
o **Provider support:** SFHP offers education and technical assistance to improve care for diabetic patients.

o **Chronic disease registry support:** SFHP offers support for clinics interested in implementing or expanding the use of chronic disease registries.

- **Improving Asthma Care:** The goal of the asthma disease management program is to help our members control their asthma though appropriate medication and self management support. SFHP provides educational materials to members. We support our providers by providing asthma supplies free of charge.

- **Asthma supplies:** We supply provider practices with free spacers, peak flow meters, and hypoallergenic mattress cover sets in multiple Strength in Numbers: a program that provides financial incentives, technical assistance and reporting to providers who reach specific performance thresholds for HEDIS diabetes indicators and other chronic care conditions they select.

- **Healthier Living Program:** The Healthier Living Program (also known as the Chronic Disease Self-Management Program) is a workshop series in which people with different chronic diseases attend together. It teaches the skills needed in the day-to-day management of treatment and to maintain and/or increase life’s activities. Workshops run once a week for six weeks and are offered on a regular basis to all members with a chronic condition. SFHP has specifically partnered with the supportive housing site Kelly Cullen Community to implement ongoing workshops for residents.

- **Texting for Health:** The DMTxt Program is a health text-messaging program for members with a diabetes diagnosis. Those who opt in to the program receive three to four health-related, interactive text messages a week on topics including diabetes care and recommended health screenings, stress management, healthier eating, physical activity, and weight management.

5. **Initial Health Assessment (IHA)**

An “Initial Health Assessment” is the initial comprehensive preventive clinical visit with a primary care practitioner. DHCS requires that primary care providers (PCP) complete an Initial Health Assessment (IHA) for new SFHP members within 60 calendar days of enrollment for any new member 18 months of age and younger and 120 calendar days of enrollment for all other ages. The IHA, at a minimum, includes a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. It enables the member’s PCP to assess and manage the acute, chronic, and preventative health needs of the member.

The IHA consists of a member’s comprehensive history including, but not limited to:

- History of present illness
- Past medical history
- Social history
- Review of organ systems
- Comprehensive physical
- Preventative services as recommended by U.S. Preventive Services Taskforce, American Academy of Pediatrics and American College of Obstetrics and Gynecology; as appropriate
- Mental status exam
- Staying Healthy Assessment (SHASHASHA), a behavioral risk assessment tool
- Diagnoses and plan of care

The IHA has specific parameters that are mandated by the California Department of Health Services Medi-Cal Managed Care Division and listed in the SFHP Medical Group Operations Manual. For members under 21, the IHA includes that the CHDP age appropriate assessment due for each child at the time of enrollment is accomplished at the IHA, which includes all up-to-date immunizations. WIC referrals are made for children under five years old.

For members 21 and over the adult history and physical exam should include at least:
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- Blood pressure
- Height, weight, Body Mass Index (BMI) and screening for obesity
- Cholesterol for men 35 and older and women 45 and older
- Breast exam and mammograms for women 40 and older
- Pap smear for sexually active women
- Chlamydia screening for high risk women and all sexually active women under the age of 25
- TB risk assessment by Mantoux skin test, chest x-ray or risk assessment review
- Staying Healthy Assessment (SHA) using DHCS or deemed tools.

For any findings or risk factors identified in the IHA, necessary diagnostic, treatment and follow-up services will be initiated as soon as possible, but no later than 60 calendar days following discovery of the problem requiring follow-up.

Exceptions to the necessary completion of the IHA with 120 days of enrollment are as follows:
- If all elements of the IHA were completed with 12 months prior to the member’s effective date of enrollment and the PCP has documented in the medical record that all findings have been reviewed and updated accordingly
- The member was not continuously enrolled in the plan for the required number of days
- The member was disenrolled from the plan before an IHA could be performed
- The member, including emancipated minors or a member’s parent or guardian refused an IHA; 5. The member missed a scheduled appointment with the PCP and at least two additional documented attempts to reschedule have been unsuccessful.
- At least three outreach attempts have been made using all available member contact information provided with enrollment (mail, phone and/or email), have been unsuccessful, and these attempts have been documented in the member’s record.

Members are asked to arrange this appointment in the New Member Information Packet mailed to them upon enrollment. Additionally, at 45-60 days after enrollment, SFHP sends IHA reminder cards to members, as well as New Member Summary reports to PCPs, encouraging each party to contact the other to schedule IHA appointments.

Medical groups are responsible for the training of practitioners regarding the IHA process. This includes the need to document all components of the IHA, or any other applicable IHA exemption, in the member’s medical record in a timely manner. SFHP Provider Relations Department is responsible for oversight and support of provider trainings. The Provider Relations Department requires that the medical groups actively encourages the scheduling of IHAs and following up on missed appointments for IHAs.

The medical group and provider compliance in completing the IHA is monitored through an annual IHA rate, medical record audits and Healthcare Effectiveness Data and Information Set (HEDIS) measures of well-child and well-adolescent visits.

6. Staying Healthy Assessment (SHA) Tools

The DHCS Staying Healthy Assessment (SHA) is designed to help providers routinely screen for behavioral risks, and initiate appropriate health education referrals, services, and interventions to increase the use of preventive services and promote health. SFHP requires PCPs and/or clinic sites to implement the DHCS SHA tool, or to have an alternative tool deemed by DHCS.

Clinics/providers who wish to use an internally developed risk assessment tool must submit the tool to SFHP for approval (deeming) based on the Department of Health Services Medi-Cal Managed Care Division criteria.

The SHA tool/questionnaire must be offered to all new members at visits that occur within 120 days of enrollment or at the first scheduled non-acute visit. Existing members who have never answered the questionnaire must be offered the assessment tool at their next non-acute visit.
The DHCS SHA tool is a series of five, self-administered questionnaires designated for the following age groups:
- 0-3 years
- 4-8 years
- 9-11 years
- 12-17 years
- 18 years and older (re-administered at least every 5 years)

The SHA tool must be re-administered when the member moves into the next age-designated category. However, for youth 12-17, it is recommended that the SHA be re-administered at each annual visit.

SFHP provides PCPs copies of the SHA forms in English, Spanish, and Chinese. For monolingual members who speak a language other than these three languages, limited English proficient members, or low-literate Medi-Cal members, help should be offered in completing the questionnaire. The assistance must be documented in the appropriate place on the questionnaire and placed in the medical record. Member refusal to complete the questionnaire must also be documented in the medical record.

PCPs are responsible for reviewing the SHA questionnaire with the member on the visit in which the member or parent/guardian completes the questionnaire. All SHA tools must remain in the member’s confidential medical record. SFHP monitors compliance with the SHA requirements using the Department of Health Services Facility Site and Medical Record Review process.

A SHA (Staying Healthy) Handbook that describes program requirements and includes copies of the assessment tool, tip sheets for patients, talking points for providers, and health education and community resources for referrals is distributed by SFHP and is available upon request. For additional information about the SHA program or to request training or copies of forms, contact SFHP’s Project Manager of Health Education, Cultural, and Linguistic Services at: he&cls_sfhp@sfhp.org.

7. Pediatric and Adult Preventive Health Care Guidelines

SFHP pediatric and adult coverage benefits and guidelines are available to the medical groups and provider offices on our website in two areas:
- Evidence of Coverage document (Medi-Cal, Healthy Kids and Healthy Workers)
- SFHP’s Pediatric Preventive Health Care Guidelines (based on the American Academy of Pediatrics and ACIP vaccine guidelines) and Adult Preventive Health Care Guidelines (based on the U.S. Preventive Health Services Task Force)

Pediatric Health Care Guidelines include guidelines for:
- The Initial Health Assessment and Staying Healthy Assessments
- Complete history and physical
- Height, weight, head circumference, and BMI percentile measurement
- Blood pressure screening
- Vision and hearing screening
- Nutritional assessment
- Dental assessment and referral
- Lab tests such as Blood Lead Testing, Hct & Hgb, and urinalysis
- TB screening
- Sexually Transmitted Infections, including Chlamydia screening
- Developmental screening
- Rubella Antibody screening
Subsection 2: Utilization & Case Management

1. Family Planning—Adult Sterilization and Consent
SFHP assures that reproductive sterilization services provided to its male and female members meet all federal requirements, including 1) services are provided only to members 21 and older, and 2) an informed consent process and provisions for a waiting period (as determined by the member’s insurance program) before services are rendered. Medi-Cal members are subject to a
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30-day waiting period. Additionally, consent is not only voluntary and fully informed, but the individual must also be allowed to make a free selection of the method for sterilization.

SFHP requires completion of the State of California Health and Welfare Consent Form (PM 330) before providing a sterilization procedure to a SFHP Medi-Cal member. The physician performing the sterilization service must ensure that the Consent Form (PM 330) is signed and completed.

The physician must document the informed consent process in the medical record and include the signed Consent Form (PM 330) in the medical record. Claims for sterilization must have a copy of the PM-330 attached or payment will be denied.

Consent procedures and requirements for patient waiting periods can be found in Title 22 Section 51305.1-51305.8

2. Authorization Requests and Referrals

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member’s eligibility and are not a guarantee of payment. The provider is responsible for verifying member’s eligibility on the dates of service.

Please verify eligibility by using one of the following methods for each date of service:

1. Web: www.sfhp.org/providers/
2. IVR: 1(415) 547-7810
3. SFHP Member Services: 1(800) 288-5555

The following services do not require a prior-authorization:

- Emergency care (in or out-of-area) including emergency medical transportation
- Preventive services (in-medical group)
- Mastectomy (in-medical group)
- Standing referrals to specialty care
- Family planning services*
- HIV testing and the treatment of sexually transmitted infections (STI)*

* For these services, Medi-Cal members may see any provider who accepts Medi-Cal without a referral or authorization. For Healthy Kids or Healthy Workers, the member must use the family planning, HIV testing and sexually transmitted disease services provided by their medical group. Referral or authorization may be required for some procedures.

Abortion services are available to all SFHP members without referral or authorization. Authorization for general anesthesia associated with abortion services is not required by SFHP, however a Medical Group may require that prior authorization is required. SFHP requires prior authorization for provider requests for inpatient hospitalization for the performance of an abortion. Medi-Cal members are encouraged to see an abortion provider within their medical group, but may see any provider who accepts Medi-Cal without a referral or authorization. For Healthy Kids or Healthy Workers, the member must use the abortion services provider in their medical group.

Obstetric and gynecological services, including basic prenatal care and support services, are available to SFHP members from practitioners associated with their medical group without prior authorization or referral. The member will deliver at the hospital with which her medical group is affiliated; therefore the PCP and obstetric provider must be within the same medical group.

Hospice inpatient care requires an authorization, however, the response time will be 24 hours or less. Please follow the prior authorization procedure for hospice inpatient care.
Specialty Care Authorizations
SFHP requires providers and medical groups to have an established specialty referral system to track and monitor referrals requiring prior authorization and follow up for specialty referrals. Medical groups should review all open authorizations twice a year and follow up with the provider and the member where appropriate to ensure member receives necessary specialty services.

3. Inpatient Concurrent Review and Repatriation

San Francisco Health Plan has 24/7 coverage for utilization management, specifically to assist repatriation back to San Francisco General for members assigned to that hospital (members in the Community Health Network or CHN, including Healthy Workers). All members receiving primary care at Department of Public Health or clinics within the SF Community Clinic Consortium are in the CHN network, and should receive services at San Francisco General Hospital. Our nurses are available to facilitate Emergency Department to Emergency Department 24/7 (and Inpatient to Inpatient when possible from Monday to Friday by midnight and 8:00AM-4:30PM on weekends, except the holidays) repatriation for our Community Health Network (CHN) members.

We encourage you to notify us immediately to begin the repatriation.
- To contact a UM nurse for possible repatriation call 1(415) 615-4525.
- To check patient eligibility please call 1(415) 547-7810 or use the secure Provider Portal at www.sfhp.org/providers/

Non-contracted Hospitals:
Non-contracted hospitals are required by CA Health and Safety Code (Section 1262.8) to contact SFHP prior to the provision of post-stabilization care and inpatient admission, so that SFHP can repatriate medically stable CHN members back to their assigned hospital, San Francisco General Hospital. SFHP members have the name of the assigned hospital located on the front of their member card. If our member is admitted without notification as required by law, claims are subject to denial. SFHP nurses are available 24 hours a day, 7 days a week, to receive notifications in real time and manage repatriation back to San Francisco General Hospital.

4. Behavioral Health
SFHP PCPs are responsible for providing behavioral health services, including diagnosis and treatment, within their scope of practice. Members with behavioral health needs beyond the scope of practice of the PCP or members who need substance abuse services are eligible for services at Community Behavioral Health Services (CBHS).

SFHP members may self-refer for behavioral health and substance abuse services by calling the CBHS Access Hotline for triage. Members may also self-refer, by walking-in to any CBHS network behavioral health centers. When members receive behavioral health services, either by referral from the PCP or by self-referral the mental health provider coordinates care with the PCPs managing the physical health care needs of the member with the consent of the member.

SFHP educates PCPs and medical groups about its procedures for referring members to mental health and substance abuse services. Community Behavioral Health Services annually distributes a copy of their directory to SFHP and provider offices.

San Francisco Community Behavioral Health Services
1380 Howard Street
San Francisco, CA 94103
1(415) 255-3737 Access Hotline
1(888) 246-3333 Toll Free
1(415) 206-8125 Psychiatric Emergency Services
5. Care of Adolescents and Minors
Minors have the right to control the disclosure of their medical records related to services for which they have the authority to consent. In California, minors 12 years of age and older do have the authority to consent to abortions. Guardian consent or notification for abortion services is not required.
Under the Family Code, minors 12 years and older do have the right to consent to mental health services, treatment for STIs, treatment for rape or sexual assault, and treatment for drug and alcohol abuse.

6. Denial of Authorization Request for Medical Services
Members or member representatives, please see Member Grievances and Appeals Section, including information on the IMR process.

Providers or provider representatives, please see Provider Appeals Procedure in Section 10: Provider Policies.

7. Continuity of Care

Current Member Continuity of Care
If a member is receiving care from a SFHP provider whose contract with the member’s medical group or SFHP terminates while the member is under treatment, SFHP or the delegated medical group’s Utilization Management department authorizes medically necessary and appropriate treatment by that provider for up to 12 months. Members may be eligible for continuity of care with a terminated provider if they are being treated for the following conditions:
- Treatment for acute conditions. The provider shall provide the completion of covered services for the duration of the acute condition.
- For members who are undergoing a course of treatment for a serious chronic condition. The provider shall provide the completion of covered services:
  i. For a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a SFHP provider, as determined by SFHP in consultation with the member and the terminated provider and consistent with good professional practice; or
  ii. Not to exceed twelve (12) months from the date of the Provider contract termination
- Pregnancy (including all three trimesters and post-partum care)
- Terminal illness, provider shall provide the completion of covered services through the duration of the terminal illness.
- A newborn child between birth and 36 months. Completion of covered services shall not exceed 12 months from the effective date of coverage
- A surgery or other procedure that has been authorized by SFHP and documented to occur within 180 days of the contract termination or within 180 days of the effective coverage under SFHP

New Member Continuity of Care
While SFHP requires that covered services be obtained from contracted providers of the medical group, if a newly-enrolled member is being treated for an acute condition by a non-contracted provider, then to the limited extent required by state law, the newly-enrolled member may enroll with SFHP and continue to receive treatment from the non-contracted provider. A member may request continued care from a provider, including a hospital, if at the time of enrollment, the member was receiving care from a non-contracted provider for any of the following conditions:
- Treatment for acute conditions
- An acute exacerbation of a chronic disease
SFHP Network Operations Manual

- Pregnancy, except during the first and second trimester periods, but including immediate post-partum period
- A newborn child, in the first 30 days, under mother’s enrollment
- A terminal illness for the duration of the terminal illness, on a case-by-case basis
- A covered service authorized by SFHP and occurring within 180 days of the provider’s contract termination or within 180 days of the effective coverage under SFHP

New Medi-Cal Members from Healthy Families Transition Continuity of Care (aid codes 5C and 5D only)
The goal is to transition members to In Network Medical Group (IMG) as soon as safely possible. When a member’s provider is not within SFHP’s network, SFHP Provider Relations will determine the feasibility and willingness of the provider to be included in SFHP’s network by following the steps below:

- Coordinates for a period of up to 12 months after enrollment in SFHP provided:
  - Non-participating provider will accept SFHP or Medi-Cal rates, whichever is greater.
  - Non-participating provider does not have quality of care issues by following the SFHP or Medical Group standard credentialing process.
- If the above conditions are met, SFHP Provider Relations staff will execute a letter of agreement or contract with the provider.
- If the non-participating provider refuses or refuses to provide cooperate with SFHP’s attempt to determine if any quality of care issues exist, SFHP will require the member to transfer care to a network provider.

8. Family Planning- Direct Access to OB/GYN Services
A SFHP member may self refer to any SFHP network obstetrician/gynecologist or family practice physician within their medical group for gynecological and obstetric services. A SFHP member shall not be required to obtain prior approval from another provider, SFHP, or the delegated medical group prior to making an appointment and obtaining direct access to an obstetric and gynecological or family practice physician for obstetric or gynecological services.

The obstetrician/gynecologist or family practice physician is required to communicate with the member’s primary care provider regarding the member’s condition, treatment, and any need for follow-up care. SFHP or its medical groups shall reimburse any physician providing the above services according to their existing reimbursement policy. See “Care of Adolescents and Minors” for information about abortion.

9. Emergency Department and Urgent Care Services
An emergency medical condition is defined as one that is manifested by acute symptoms of sufficient severity (e.g., severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in one of the following situations:

- Placing the health of the individual (or, in case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services also include any psychiatric emergency and related medical condition(s).

Emergency services include medical screening, examination, and evaluation by a physician, or -- to the extent permitted by applicable law -- by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it
does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility.

Emergency services also include an additional screening, examination, and evaluation by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

In all instances when a member presents at an emergency room for diagnosis and treatment of illness or injury, pre-established guidelines for hospitals require appropriate triage of the severity of illness/injury.

Authorization is not required for emergency situations as defined by the examining physician. The examining physician determines required treatment to stabilize the patient.

In routine and non-urgent situations, treatment authorization by the PCP is required after completing the medical screening exam and stabilizing the condition. If the PCP does not respond, the Emergency Room/Department will proceed with treatment. Documentation and proof of the Emergency Department’s attempt to reach the PCP and medical group and failure of response within 30 minutes of the first contact attempt will be accepted as authorization to diagnose and treat.

SFHP benefits include the dispensing of a sufficient supply of medications to cover the member’s treatment until the member can be reasonably expected to have a prescription filled.

**Out-of-Area Emergency Services**

SFHP covers emergency services outside of San Francisco. For emergency services outside of the United States, the Plan covers only emergency services requiring hospitalization in Canada and Mexico. Should a member require reimbursement for the emergency service, the member must provide SFHP or the delegated medical group with complete documentation of their condition and the care provided. Complete documentation includes the following information:

- Description of the problem/complaint/symptoms/condition that the member was experiencing that led them to believe that this event was a medical emergency
- Diagnosis of condition (from a copy of office chart emergency room/physician report)
- Treatment that occurred at the emergency center
- Any treatment recommended as follow-up, if any
- A copy of the receipt or credit card that shows proof of payment by member

**10. Skilled Nursing Care (Medi-Cal)**

SFHP network medical groups are responsible for payment for Medi-Cal members admitted to Skilled Nursing Facilities (SNF) for the month of the admission and the following month or until disenrollment is approved. Please note that hospice services are covered services and are not considered SNF services, regardless of the member’s expected or actual length of stay in a nursing facility.

A SFHP member may be disenrolled from Medi-Cal managed care and receive skilled nursing care through fee-for-service Medi-Cal, if the SNF admission exceeds the month of admission and the following month. Disenrollments, if requested and approved San Francisco Health Plan, may become effective on the first day of the second month following the member’s month of admission to a LTC facility.

Disenrollment for SNF admissions are the responsibility of the SFHP UM Department. Delegated groups must notify SFHP of all members admitted for skilled nursing care by submitting
notification of admission by fax to 1(415)547-7822. Until the date of disenrollment, the medical group retains responsibility for the payment of LTC costs.

11. Major Organ Transplant (Medi-Cal)
SFHP Medi-Cal members who are eligible and pre-authorized by Medi-Cal for major organ transplants are disenrolled from managed Medi-Cal into fee-for-service Medi-Cal. Details on disenrollment policies for Major Organ Transplant can be found in Section 5 of this document: Member Transfers/Disenrollments.

SFHP Medi-Cal members receive corneal and kidney transplants within network and are not disenrolled from the Plan. Medi-Cal and Healthy Kids transplant services may be covered by California Children Services (CCS) until 21 years of age.

12. Mastectomy Length of Stay
SFHP and its medical groups do not require prior authorization for mastectomy or for any predetermined length of stay. The appropriate length of stay for mastectomy associated with the procedure is determined by the physician in consultation with the patient and consistent with sound clinical principles and practices.

13. Community Based Adult Services
Community Based Adult Services (CBAS) is a Medi-Cal benefit that provides long-term community-based care for frail elders and disabled adults at nine certified CBAS centers. Basic CBAS benefits include nutrition services, professional nursing care, therapeutic activities (i.e. physical therapy, social therapy, etc), social services, personal care services, and group and individual activities. Effective October 1, 2012, CBAS is a Medi-Cal managed care benefit. SFHP may determine eligibility for qualified members.
14. Second Opinion
SFHP members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within medical group, a referral is provided within SFHP’s network. If the qualified specialist is not available in the SFHP network, SFHP will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member.

SFHP provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner’s advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

SFHP educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request.

Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member’s condition and that does not exceed 72 hours
- To see the second opinion report

15. Standing Referral to Specialty Care
A member with a life threatening, degenerative and disabling condition is eligible for a standing referral that allows the specialist to act as the care coordinator in lieu of the PCP. The member continues to see the PCP for problems unrelated to the qualifying condition(s).

SFHP and its medical groups issue standing referrals for specialty care when medically necessary. A standing referral reduces or eliminates the need for repeated PCP authorization, when regular use of a specialist is medically appropriate.

Members with HIV/AIDS are eligible for a standing referral to an identified AIDS specialist who acts as their primary care provider and coordinator of care. SFHP case management staff will assist with identification of and referral to an HIV/AIDS specialist, upon request.
16. Sensitive Services - Voluntary Termination of Pregnancy

SFHP Medi-Cal members are encouraged to receive abortion services from a provider within their medical group but may self-refer to any provider that is contracted with their medical group or outside of their medical group and SFHP’s provider network for outpatient abortion services.

SFHP non-Medi-Cal members in the Healthy Workers and Healthy Kids programs may self-refer to any provider that is contracted with their medical group for outpatient abortion services.

Outpatient abortion services are not subject to prior authorization, medical justification or any other utilization management procedures. SFHP requires prior authorization for provider requests for inpatient hospitalization for the performance of an abortion. Authorization for general anesthesia associated with abortion services is not required by SFHP, however a Medical Group may require that prior authorization is required.

Note: If the member’s medical group does not have a provider of abortion services, the medical group arranges for services and pays all professional fees, facility fees and the reasonable cost of related transportation or lodging if needed. SFHP will assist any provider or member to access abortion services.

17. Sensitive Services - STI and HIV Testing

SFHP Medi-Cal members are encouraged to receive sensitive services from a provider within their medical group but may self-refer to any provider that is contracted with their medical group or outside of their medical group and SFHP’s provider network for outpatient sensitive services. SFHP non-Medi-Cal members in the Healthy Workers and Healthy Kids programs may self-refer to any provider that is contracted with their medical group for outpatient sensitive services.

All sensitive services are confidential and include:

- HIV testing, education, counseling and follow-up services
- Sexually Transmitted Disease/Sexually Transmitted infection (STI) screening, diagnosis, treatment and counseling and follow-up services

Infants, children and adolescents under the age of 21, who are confirmed HIV positive, may be eligible for California Children’s Services (CCS).

Anyone 12 years of age or older, may obtain STI and HIV services without parental consent or disclosure.

18. Notice of Action Standards

To ensure that SFHP members receive timely, consistent, and accurate information regarding the management of their medical care and are informed about their rights to appeal denials or modifications of care, Medical Groups must use the DHCS developed Notice of Action (NOA) format for services denied, modified, delayed or terminated/reduced. SFHP will provide the medical groups with translations of the letters into threshold languages for printing on the Medical Group letterhead. In addition, the medical group must use the updated version of the “Your Rights” form, the form to file a State Hearing and the current Independent Medical Review form. SFHP also sets timeframes for responding to requests for authorization and notifying members and practitioners of utilization management decisions.

Denial letters should use a 6th grade literacy level and must include:

- A statement in threshold languages stating: If you need help translating this or any help, please call San Francisco Health Plan at 1(800) 288-5555
- Date letter is sent to member
- Member name and identifying information
• Date of request for authorization
• Service that was requested
• Requesting practitioner name and phone number
• Reason for denial or modification; this requires reference to EOC language for benefit denials, and reference to medical criteria or guidelines for medical necessity denials, written in clear concise language
• The signature of a licensed physician if payment for the service was denied because of a medical necessity determination
• An offer to send a copy of the guidelines/decision making criteria used and contact information (name and phone number) for further questions
• If appropriate, alternative care that the medical group proposes with instructions to member about how to access the proposed service
• Informing language on appeal rights and how to gain assistance in the member’s primary language
• Invitation and instructions on appealing the medical group’s decision with contact information. The phone numbers must be in bold.
• Informing language about expedited review and contact information, and a statement that eligibility and non-disputed services are not affected by the denial or appeal process

If payment for a service is denied because of a medical necessity determination, or if it is experimental or investigational, informing language about the Department of Managed Health Care’s (DMHC) independent medical review process must be provided. Application and other forms must be included when the member reaches the final level of appeal or the appeal has been opened for 30 days.

The DMHC mandated language states:

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1(415) 547-7800 or at 1(800) 288-5555 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 1(888) HMO-2219 and a TDD line 1(877) 688-9891 or the California Relay Service 1(800) 735-2929 for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.”

Distribution: When sending a Notice of Action letter, the medical group must copy the member and the requesting practitioner. Include the reviewer’s phone number on the copy of the denial letter that is sent to the requesting practitioner.
The medical group must adhere to mandated timeframes when notifying members and practitioners of authorizations, modifications and denials.

<table>
<thead>
<tr>
<th>Type of Decision</th>
<th>Decision Timeframe</th>
<th>Provider Notification Timeframe</th>
<th>Written Denial Notification Timeframe</th>
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<tbody>
<tr>
<td>Routine authorization requests</td>
<td>Five business days of receipt of necessary information</td>
<td>24 hours of making the decision</td>
<td>Two working days</td>
</tr>
<tr>
<td>Pre-certification of urgent care</td>
<td>Three business days of receipt of necessary information</td>
<td>24 hours of making the decision</td>
<td>Two working days</td>
</tr>
<tr>
<td>Concurrent review of inpatient,</td>
<td>Five working days or less after obtaining all necessary information</td>
<td>24 hours of making the decision</td>
<td>Two working days</td>
</tr>
<tr>
<td>intensive outpatient and residential behavioral care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care for Chronic Illnesses</td>
<td>Five business days of receipt of necessary information</td>
<td>One working day</td>
<td>One working day</td>
</tr>
<tr>
<td>Retrospective review</td>
<td>Thirty calendar days after obtaining all necessary information</td>
<td>Five working days</td>
<td>Thirty calendar days</td>
</tr>
</tbody>
</table>

**Oversight of Denials**: SFHP provides oversight of the utilization management activities of the contracted medical groups by requiring the medical groups to submit quarterly denial/deferral and appeal logs, and by reviewing denial letters during the annual oversight audits.

### 19. Pharmacy Benefit

San Francisco Health Plan provides pharmacy benefits for members in all SFHP health insurance programs. For all health insurance programs the pharmacy benefit covers outpatient, self-administered medications that are listed in the program formularies. Medications that are administered in the physician’s office are part of the medical benefit and follow the responsibility divisions as outlined in the Medical Group Claims and UM Matrix on page 9.

The formulary for SFHP Medi-Cal and Healthy Kids members is managed by the pharmacy services department at SFHP with oversight from the SFHP Pharmacy and Therapeutics Committee, a sub-committee of the SFHP Quality Improvement Committee. The formulary for SFHP Healthy Workers members is managed by the pharmacy services department of the San Francisco Department of Public Health.
For provider questions about the pharmacy network or for assistance with pharmacy claims processing, the below pharmacy benefits managers should be contacted.

<table>
<thead>
<tr>
<th>Program</th>
<th>Pharmacy Benefits Manager (PBM)</th>
<th>PBM Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFHP Medi-Cal or Healthy Kids</td>
<td>PerformRx</td>
<td>1(888) 989-0091</td>
</tr>
<tr>
<td>SFHP Healthy Workers</td>
<td>MedImpact</td>
<td>1(800) 788-2949</td>
</tr>
</tbody>
</table>

For information about program-specific pharmacy benefits, exclusions or the pharmacy network visit [www.sfhp.org](http://www.sfhp.org) or contact the SFHP Pharmacy Department at 1(415) 547-7818 x7085.

### 20. Pharmacy Authorizations

SFHP has established a list of drugs that require prior authorization. When prescribing such drugs, the physician, physician's representative or the pharmacist completes a pharmacy prior authorization (PA) request form and submits it to the contracted Pharmacy Benefits Manager(s) for review (see Forms section). Pharmacy PA requests will be processed in accordance with SFHP criteria. All pharmacy prior authorization requests will be responded to within 24 hours or one business day of receipt made by telephone or other telecommunication device. SFHP will also provide at least a 72-hour supply of a covered outpatient drug in an emergency situation.

Pharmacy Prior Authorization request forms may be found on the SFHP website at [http://www.sfhp.org/providers/provider_resources/download_forms.aspx](http://www.sfhp.org/providers/provider_resources/download_forms.aspx)

A prior authorization request may be submitted by the prescriber or pharmacist to SFHP in three ways:

1. Download and fax prior authorization request forms to 1(855) 811-9330 for standard requests or (855) 811-9331 for urgent requests.
2. Call our Pharmacy Benefits Manager (PBM) PerformRx at 1(888) 989-0091 to submit a verbal request.
3. Submit request online using the Online Pharmacy Prior Authorization Request Form available at [http://www.sfhp.org/providers/formulary](http://www.sfhp.org/providers/formulary)

For further information on the pharmacy prior authorization process, visit [www.sfhp.org](http://www.sfhp.org) or contact the SFHP Pharmacy Department at 1(415) 547-7818 x7085.

### 21. Case Management

Case management is a collaborative process that identifies, assesses, plans, coordinates, monitors, and evaluates the options and services required to meet the member’s health and human services needs. It is characterized by advocacy, communication, and resource management, and promotes quality and cost-effective interventions and outcomes. (CMSA, Case Management Society of America)

SFHP conducts case management and also delegates case management functions to its medical groups and primary care providers for services obtained within and outside of the medical group’s network.

The primary care provider (PCP), acting as the member’s case manager, may initiate referrals. The PCP makes referrals when the member’s health needs require specialty services. SFHP identifies members for referral to Case Management from several sources which include but are not limited to UM data, pharmacy data, and referrals from providers. Case Management triggers may include but are not limited to the following:

- AIDS diagnosis
- Recent discharge from acute care
- Admission to a hospital three or more times in twelve months
22. Disease Management

Disease Management is a multidisciplinary, systematic approach to health care delivery that:
(1) includes all members of the chronic disease population; (2) supports the physician-patient
relationship and plan of care; (3) optimizes patient care through prevention,
protocols/interventions based on professional consensus, demonstrated clinical best practices
or evidence-based interventions, and patient self-management; and (4) continuously evaluates
health status and measures outcomes with the goal of improving overall health, thereby
enhancing quality of life and lowering the cost of care. (Source: Disease Management
Association of America)

1. SFHP identifies populations that may require disease management through medical
encounter data, claims data, pharmacy claims and from case management activities.
2. SFHP develops a disease management program that at a minimum provides education
and tools for the member and PCP to assist in managing the chronic disease.
3. SFHP informs all medical groups and primary care providers of health education
materials and disease management tools available for members with chronic disease
states by including this policy in the Network Operations Manual and by articles in the
provider newsletter.
4. SFHP informs members of health education materials available to assist in
self-management of their chronic disease in the member newsletter.

Subsection 3: Community Resources

1. Breast Pump and Lactation Services
San Francisco Health Plan provides new mothers with free electric breast pumps, lactation
supplies, counseling, and human breast milk if medically necessary. These services require
a provider’s prescription. Services are free for the first 60 days, but may be continued if
medically justified. For more information, call San Francisco Health Plan Customer Services
at 1(800) 288- 5555.
2. California Children’s Services

California Children’s Services (CCS) provides special medical care for children less than 21 years of age who have physical disabilities and complex medical conditions. Services provided under the CCS program are reimbursed through the CCS program. SFHP is not financially responsible for the CCS services provided to its members. A SFHP member who is eligible for CCS services remains enrolled with SFHP, and the PCP coordinates and continues to provide care for all needs unrelated to the CCS condition. The member’s PCP is responsible for all primary care and other services unrelated to the CCS-eligible condition.

Physicians and medical group staff are responsible for identification, referral, and case management of members with CCS eligible conditions. Until eligibility is established with the CCS program, the PCP and medical group continue to provide medically necessary covered services related to the CCS eligible condition.

Eligible conditions include such physical disabilities and complex medical conditions as sickle cell anemia, cancer, diabetes, HIV, major complications of prematurity, etc.

The member’s clinical information and the CCS referral form are sent to:

California Children’s Services
30 Van Ness Avenue, Suite 210
San Francisco, CA 94102
Telephone: 1(415) 575-5700
Fax: 1(415) 575-5790

Once a member is referred to CCS, their eligibility status with CCS can be checked online by registering through the CCS website at https://cmsprovider.cahwnet.gov/CMSPIP/piplogin.jsp.

3. Comprehensive Perinatal Services Program (CPSP)

The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal reimbursement program that funds a wide range of services for pregnant women, from conception through 60 days postpartum. Medi-Cal providers may apply to become approved CPSP providers. In addition, to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education from approved CPSP providers. This approach has shown to reduce both low birth weight rates and health care costs in women and infants. For more information, call the San Francisco Department of Public Health, Maternal, Child and Adolescent Health, Perinatal Services Coordinator at 1(415) 575-5681.

4. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT provides the following services to qualified persons under 21:

- Routine well child checks through the Child Health and Disability Prevention Program
- Diagnosis and treatment for persons with specific medical conditions
- Private duty nursing
- Physical, occupational and speech therapies
- Pediatric day health care facilities

For more information call San Francisco Children’s Medical Services at 1(415) 575-5700.

5. TB/Direct Observed Therapy (DOT) for the Treatment of Tuberculosis

The primary care physician is responsible for annual tuberculosis screening of SFHP members. If a member is found to be positive, the Department of Public Health’s TB Control Unit will provide consultation, screening, evaluation of SFHP members and contacts with Tuberculosis.
In addition, the TB control until provides trained personnel to assist SFHP members who are eligible for direct observed therapy (DOT) services. TB DOT program staff will provide direct observation of the ingestion of prescribed anti-tuberculosis medications. Elderly and persons with language and/or cultural barriers can also be referred to DOT. In addition, members with memory or cognitive disorders or those too ill for self management can be referred.

This program provides, delivers, and oversees the outpatient treatment of selected patients with active tuberculosis (TB) who meet one of the following criteria:

- Have demonstrated multiple drug resistance (INH and Rifampin)
- Whose treatment has failed or patient has relapsed post treatment
- Have significant functional impairment due to mental illness or substance abuse
- Children and adolescents with active TB
- HIV positive patients
- Admitted to a hospital for TB
- Homeless patients
- Patients who fail to keep appointments
- Referral to TB DOT

Medical group staff and physicians forward medical records, consult reports, and appropriate laboratory findings for members who meet the above criteria to the local TB Control Program for evaluation and treatment for DOT services.

A SFHP member who is eligible for DOT services remains enrolled with SFHP. The medical group and PCP maintain responsibility for coordination of services and for continued medical care.

Tuberculosis Control
Program San Francisco
General Hospital Bldg. 90,
4th Floor (Ward 94)
Telephone: 1(415) 206-8524
Fax: 1(415) 648-8369


6. Early Start

Infants and children under three years of age who have a developmental delay or disability or an established risk condition with a high probability of resulting in a delay may be eligible to receive early intervention, or “Early Start”, services in California through Golden Gate Regional Center.

All infants and toddlers suspected of having a developmental concern including those "at risk" will receive intake and evaluation from their local regional center to determine eligibility for services. Regional centers will facilitate each family's access to local Family Resource Center's Prevention Resource & Referral Services.

Eligible children for Prevention Resource & Referral Services are ages birth through 35 months, who are at substantially greater risk for a developmental disability but who would otherwise be ineligible for services through the Early Start Program newly referred families whose infants or toddlers are "at risk" for developmental delay or disability will receive the following services through Family Resource Centers (FRCs):

- Information
- Resources
- Referrals
- Targeted outreach
Infants or toddlers under 3 years of age with solely a visual, hearing, or severe orthopedic impairment, may be eligible to receive early intervention, or “Early Start” services in California through their local educational agency.

Early Start provides a wide range of services including speech therapy. For a list of Early Start services, please visit Golden Gate Regional Center at www.ggrc.org.

The medical group and primary care physicians are responsible for coordination of services with the Early Start Program and financially responsible for covering the initial evaluation and two speech sessions per month. Speech therapy sessions in excess of two per month and other therapy services may be covered by the Early Start Program. A SFHP member who is eligible for Early Start services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.

Medical group physicians and case managers may refer to Early Start by contacting:
Golden Gate Regional Center
875 Stevenson Street, 6th Floor
San Francisco, CA 94103
(415) 546-9222

Additional information about the Early Start Program can be found at www.dds.ca.gov/earlystart

7. Genetically Handicapped Persons Program (GHPP)
GHPP is a state-funded program that coordinates care and pays medical costs for eligible persons age 21 years old or older with genetically-transmitted diseases such as hemophilia, cystic fibrosis, and sickle cell disease, as well as metabolic disorders such as Phenylketonuria (PKU). For more information, call 1(916) 327-0470 or 1(800) 639-0597 or visit their website at www.dhs.ca.gov/pcfh/cms/ghpp/.

8. Golden Gate Regional Center
Golden Gate Regional Center (GGRC) is a nonprofit private corporation that contracts with the State Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. According to Title 17, Section 54000 of the California Code of Regulations, a “Developmental Disability” is defined as a disability that is attributable to
• Mental retardation;
• Cerebral palsy;
• Epilepsy;
• Autism; or
• Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

To be eligible for services, a person must have a disability that begins before the person’s 18th birthday, be expected to continue indefinitely and present a substantial disability as defined in Section 4512 of the California Welfare and Institutions Code. Eligibility is established through diagnosis and assessment performed by regional centers.

Some of the services and supports provided by the regional centers include:
• Information and referral
• Assessment and diagnosis
• Counseling
• Lifelong individualized planning and service coordination
• Purchase of necessary services included in the individual program plan
• Resource development
• Outreach
SFHP Network Operations Manual

- Assistance in finding and using community and other resources
- Advocacy for the protection of legal, civil and service rights
- Early intervention services for at risk infants and their families
- Genetic counseling
- Family support
- Planning, placement, and monitoring for 24-hour out-of-home care
- Training and educational opportunities for individuals and families
- Community education about developmental disabilities

San Francisco Health Plan is not financially responsible for the GGRC services provided to its members. A SFHP member who is eligible for GGRC services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.

Medical group physicians can refer to GGRC by contacting:
Golden Gate Regional Center
875 Stevenson Street, 6th Floor
San Francisco, CA 94103
1(415) 546-9222

For additional information you can visit the GGRC website at www.ggrc.org.

9. HIV Counseling, Education, and Testing
San Francisco City Clinic provides confidential HIV counseling, education, testing and follow-up services. Infants, children, and adolescents under age 21 who are confirmed HIV positive may be eligible for CCS. For more information on HIV Counseling, Education and Testing contact San Francisco City Clinic at 1(415) 487-5500 or visit www.sfcityclinic.org.

10. HIV/AIDS Waiver Program
This program provides Medi-Cal recipients with a written diagnosis of symptomatic HIV or AIDS with case management, in-home skilled nursing care, home-delivered meals, and non-emergency transportation. Qualified persons cannot be simultaneously enrolled in either the Medi-Cal hospice or the AIDS Case Management Program. For more information, call West Side Community Services at 1(415) 355-0311, Option 8 or www.westside-health.org.

11. Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver
HCBS-DD is one of 6 waiver programs available to Medi-Cal members. The purpose of this program is to provide in-home care and support to persons with disabilities. Services provided include: homemakers for chores, home health aides and/or nurses, family training, vehicle adaptation, respite care, day habitation, transportation and more. For referral and eligibility review contact Golden Gate Regional Center at 1(415) 546-9222. For more information visit www.dhcs.ca.gov/services/ltc/Pages/DD.aspx.

12. Local Education Agency
The San Francisco Unified School District’s Local Education Agency (LEA) provides services in San Francisco schools for low-income children (3-18 years of age) with one or more of the following conditions:
- Vision or Hearing Impairment
- Orthopedically Challenged
- Developmentally Delayed
Children who have received the Early Start (ES) or Golden Gate Regional Center (GGRC) services are assessed between 2–3 years of age for referral to the San Francisco Unified School District Special Intake Unit for continued assistance.

Medical group physicians and the ES or GGRC must obtain written consent from the parents prior to referral and to release any clinical information.

Services provided during the school year, under the LEA program are reimbursed by the San Francisco Unified School District. San Francisco Health Plan is not financially responsible for the LEA services provided to its members. A SFHP member who is eligible for LEA services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care. As LEA provides services during the school year only, SFHP and its medical groups authorize and provide medically necessary services during the summer months.

LEA services include:
- Nutritional assessment and non-classroom nutritional education
- Education and psychosocial assessments
- Developmental assessments
- Speech services
- Audiology services
- Physician and occupational therapy
- Medical transportation
- School health aides

Local Education Agency, Special Education Therapy Unit -- Telephone: 1(415) 759-2895 or 1(415) 379-7693

13. Multipurpose Senior Service Program (MSSP)

The Multipurpose Senior Service Program (MSSP) provides in-home care to members as an alternative to placing them in an institution. The County’s Department of Aging administers the program. Services are available to physically disabled or aged members over 65 years of age who would otherwise require care at skilled nursing facility (SNF) or intermediate care facility (ICF) level. MSSP assists with a wide array of services that include:
- Personnel (nurses, home health aides, social workers, senior companions)
- Home Safety Modifications
- Legal Assistance
- Meal Delivery
- Housing
- Counseling and Crisis Intervention
- Transportation
- Assistance with Eviction or Elder Abuse
- Respite Care

Medical group staff and physicians identify and refer potentially eligible members to the MSSP for evaluation who are:
- Aged 65 years or older
- Eligible for Medi-Cal
- Residents of San Francisco

The medical group staff and physicians case manage and assist with the coordination and communication of services between the MSSP and Adult Day Health Care Center. Services provided under the MSSP program are reimbursed by the San Francisco County Department of Aging. San Francisco Health Plan is not financially responsible for the MSSP services provided to its members. A SFHP member who is eligible for MSSP services remains enrolled with SFHP,
and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.

The PCP or specialist submits appropriate medical records and the MSSP referral to:
   Institute on Aging for Multipurpose Senior Service Program and Adult Day Health Care
   3626 Geary Boulevard, Second Floor
   San Francisco, CA  94118
   1(415) 750-4150 or 1(415) 750-5330
   www.ioaging.org
San Francisco Adult Day Services Network at 1(415) 808-7371 or www.sfadultday.org.

14. Nursing Facility Waiver Program
Nursing Facility Waiver services are provided to Medi-Cal recipients of any age who need in- home assistance with activities of daily living, protective supervision, private duty nursing, environmental adaptation, and case management. For more information, call 1(916) 552-9400 or visit their website at www.dhs.ca.gov/mcs/mcpd/rdb/HCBWU.

15. Sexually Transmitted Infections (STI) Testing
San Francisco City Clinic provides confidential STI prevention, screening, diagnosis, treatment, and counseling. Services for SFHP members do not require prior authorization or referral from their primary care provider. Anyone 12 years and older may obtain STI testing services without parental consent or disclosure. For more information, call the San Francisco City Clinic at 1(415) 487-5500 or visit their website at: www.sfcityclinic.org.

16. Women, Infants, and Children (WIC)
Women, Infants and Children (WIC) is a nutrition/food program that helps women who are pregnant, breastfeeding or have recently had a baby, and children under the age of five to eat well and stay healthy. WIC eligibility is determined by federal income guidelines. Medi-Cal and many Healthy Kids members are eligible. Services include free food vouchers, nutrition education and breastfeeding support. WIC eligible members must be referred by their PCP or OB-GYN. WIC uses federal income guidelines to determine who is clinically and financially eligible.

San Francisco Health Plan is not financially responsible for any of the WIC services provided to its members. A SFHP member who is eligible for WIC services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care for members enrolled in WIC.

Medical group physicians can refer to WIC in a number of ways:
   • By calling 1(888) WIC-WORKS or 1(888) 942-9675 for an appointment or in San Francisco 1(415) 575-5788
   • By visiting their website at http://www.sfdph.org/dph/comupg/oprograms/PHP/WIC/WIC.asp
   • By referring members to any WIC Center (See WIC Brochure for current locations)
Section 7: Claims and Encounter Data Reporting

1. Medical Group Claims Matrix
Please refer to page 9 of this manual for the UM and Claims Matrix.

2. Claims Information

Any questions regarding claims should be directed to the SFHP Claims Department at 1(415) 547- 7818 x7115 or claims@sfhp.org.

3. CHDP - PM 160 Forms
Each participating provider must report all well child visits using the Confidential Screening/Billing Report PM-160 Information Only form. SFHP and delegated medical groups educate providers regarding the importance of a complete and timely submission of the PM-160. Medical Groups and providers are to submit the CHDP/PM-160 informational only forms to San Francisco Health Plan’s Claims Department. The Plan forwards the original forms to the State CHDP office and local CHDP Program on a monthly basis.

Send CHDP/PM-160 informational only forms to:

San Francisco Health Plan
Attn: Claims Department
P.O. Box 194247
San Francisco, CA 94119

4. Encounter Data and Reporting Process (see Medical Group Matrix)
SFHP requires that medical groups submit to SFHP Encounter Data (reports regarding the provision of Capitated Services to Members) on a monthly basis. These reports are to be submitted by the date set forth in the annual delegation agreement. Encounter data shall be maintained and submitted in the formats required by the DHCS Managed Care Encounter Data Dictionary and SFHP policy.

SFHP can receive and send 837 encounter and claims files as well as 834 eligibility files. An Electronic Data Exchange (EDI) implementation takes a minimum of 45 days from the time the first test file is received from a provider or a provider’s clearinghouse. Additional time is needed to confirm file layout and obtain companion guide acceptance from each party. After sign off is received from each party regarding the X12 transaction, then both parties can schedule a regular submittal date for the data.

5. Contact information for Training, Technical Issues and Comments
Please contact the SFHP Production Services Department at 1(415) 547-7800 or production.services@sfhp.org with questions.

6. Immunizations/Vaccines by LOB and Medical Group
San Francisco Health Plan covers vaccines and immunizations according to the American Academy of Pediatrics guidelines. Vaccines for Medi-Cal members under age 18 must be obtained through the Vaccines for Children (VFC) program. To contact VFC for enrollment or to order additional vaccinations call 1(877) 243-8832. Questions about all other vaccine and
im Immunization payments should be directed to your contracted medical group. San Francisco Health Plan Provider Relations is also available for immunization questions at 1(415) 547-7818 x7084 or provider.relations@sfhp.org.

7. Provider Dispute Resolutions
The SFHP Provider Dispute Resolution mechanism offers providers dissatisfied with the processing or payment of a claim, resubmission of a claim, or a claim adjustment, a method for resolving problems.

A dispute must be submitted in writing within 365 days of the plan’s action or inaction. Do not submit a dispute if the claim is in a pending status. The provider may also include additional information that may affect the outcome of the appeal. For further instructions on how to file an appeal, please contact SFHP Claims Department at 1(415) 547-7818 x7115, Monday through Friday, 9:00am – 4:00pm.

Supporting Documentation
Necessary documentation should be submitted with each dispute to allow for a thorough review of the dispute. It is very important that all supporting documentation be legible. Include applicable attachments such as:
- Claim number, if applicable
- Copy of Other Coverage EOB’s/RAs or denials
- Copy of all correspondence to and from SFHP to document timely follow-up
- Copy of authorizations

Verification of Timely Submission
The only acceptable documentation to verify timely submission of a claim is a copy of a SFHPExplanation of Benefits (EOB) or any dated correspondence from SFHP containing a Claim control number with a Julian date.

Resolution and Written Determination
San Francisco Health Plan will resolve each provider dispute or amended dispute in a written determination within 45 days of receipt of the dispute.

Send all claim reconsiderations and appeals to:
San Francisco Health Plan
Attn: PDR UNIT
P.O. Box 194247
San Francisco, CA 94119

8. Prohibited Punitive Action Against the Provider
San Francisco Health Plan ensures that punitive action is not taken against the provider who either requests an expedited resolution or supports a member’s appeal.
Section 8: Capitation/Payments

1. Description of Process
Capitation is paid in arrears. Payment is made on the 15th for the previous month of coverage. For example, capitation for the month of January is paid on February 15th. Along with the capitation check, SFHP provides a capitation roster on a CD or flat file. The data includes member name, SFHP ID, CIN ID, level code, capitation rate, PCP ID, and PCP name. This CD is encrypted and password protected to be in compliance with HIPAA regulations. Flat files are placed on a secure FTP site. The remittance supportive documents will show a summary of the capitation payment calculation, including membership for the current month as well as retroactive months.

2. Contact information for Payment Questions
Any inquiry related to the capitation payment received can be directed to the Accounts Payable Accountant at 1(415) 615-4219.
Section 9: Provider Website and Portal

1. What’s on the Website?
San Francisco Health Plan maintains a comprehensive website with information and tools for providers, members, and the community. Some features of particular interest to providers are:

- Health Education Library with downloadable materials in English, Spanish, Chinese and Vietnamese on a variety of topics
- Health Education Classes Listings
- Current Events and Meetings in San Francisco
- SFHP Authorization, Grievance and other forms
- Access to the Provider Secure Website to check Claims, Eligibility, PCP and Authorization Status
- Provider Newsletters
- Searchable Provider Directory
- SFHP Drug Formulary
- Information on Quality Improvement Programs’
- Benefit Summaries and Evidence of Coverage
- Community Resources
- Best Practices and Clinical Guidelines

Please visit www.sfhp.org for more information and to learn more about the resources available on the SFHP website.

2. Services Available
San Francisco Health Plan’s Provider Secure Website, www.sfhp.org/providers, is a fast and sure way for providers and their staff to verify a member’s eligibility, download member rosters, and check authorization status for their practice. To access the web site and create an account, follow the steps in the “Registering for Access to the Provider Portal” section below.

3. Registering for Access to the Provider Portal
Registration for User ID and Password
Basic Feature—this feature allows you to Verify Member Eligibility & PCP and Search for Claims:

- Go to www.sfhp.org/providers
- Select “Provider Secure Login”
- Click on “Sign up here”
- Fill in requested information for steps 1-6
- Choose a USERNAME for step 7
- Click Finish.

Your password will be sent to you via the e-mail that you submitted in the registration process. The Provider Relations department will activate your chosen username and password within 3 business days and notify you by email when this is complete.

Additional Features:

- View current member roster
- Download current member rosters in Excel format
- Check authorization status

To obtain access to these features, email provider.relations@sfhp.org or call 1(415) 547-7818 x7084.
**Checking Member Eligibility**
- Go to [www.sfhp.org/providers](http://www.sfhp.org/providers)
- Select “Provider Secure Login”
- Enter Username and Password
- Click on “Login”
- Click on “Verify Member Eligibility & PCP”
- “Member Search” will open in a new window—please ensure that your browser is not blocking pop ups
- Enter last name, member ID, or Medi-Cal CIN, in addition to any other information to limit search by
- Click on “Search”
- Click on “View Details” next to member’s name to view eligibility information

**Search for Claims**
- Go to [www.sfhp.org/providers](http://www.sfhp.org/providers)
- Select “Provider Secure Login”
- Enter Username and Password
- Click on “Login”
- Click on “Search for Claim”
- “Claim Search will open in a new window—please ensure that your browser is not blocking pop ups
- Enter required fields in addition to any other information to limit search by
- Click “Search”

**Search for Authorizations**
- Go to [www.sfhp.org/providers](http://www.sfhp.org/providers)
- Select “Provider Secure Login”
- Enter Username and Password
- Click on “Login”
- Click on “Search for Authorization”
- “Authorizations Search” will open in a new window—please ensure that your browser is not blocking pop ups
- Enter required date fields in addition to any other information to limit search by
- Click “Search”

**Download Patient Roster in Excel Format**
- Go to [www.sfhp.org/providers](http://www.sfhp.org/providers)
- Select “Provider Secure Login”
- Enter Username and Password
- Click on “Login”
- Click on “View Current Patient Roster” if you are an SFHP primary care provider
- “Member Roster” will open in a new window—please ensure that your browser is not blocking pop ups
- Click “Download Excel” and the roster will open in Excel

**4. Contact information for Questions**
If you have questions regarding this site please contact Provider Relations – 1(415) 547-7818 x7084 or [provider.relations@sfhp.org](mailto:provider.relations@sfhp.org).


Section 10: Provider Policies

1. Confidentiality of Medical Information

SFHP establishes standards for its staff, providers and contractors for handling medical information in a manner that protects member rights and complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These standards include:

- SFHP adult members are entitled to inspect their patient records upon written request to the health care provider, to prepare a specified addendum to their records, and to require the health care provider to attach that addendum to their record.
- SFHP, its providers and contractors disclose only the minimum amount of protected medical information needed to accomplish the intended purpose of the disclosure.
- SFHP, its providers and contractors prohibit the intentional sharing, sale or use of medical information for any purpose not necessary to provide health care services to the patient, except as specified by law. No disclosures are made to employers.
- SFHP, its providers and contractors obtain member consent for sharing medical information regarding sensitive services. Sensitive services include family planning services, services related to sexually transmitted diseases, HIV/AIDS services, and mental health and chemical dependency services. A minor’s consent is required to disclose sensitive information to his/her parents.
- When a member consents to the disclosure of confidential medical information, the consent is for the release specified information to a specified person for specified purposes and for a specified timeframe, and may be revoked.
- SFHP, its providers and contractors educate their staff and the members of their quality improvement committees about their confidentiality policies, require signed confidentiality statements, and take strong actions when violations occur.

For all other services, SFHP, its providers and contractors disclose individually identifiable medical information only for the reasons listed here or as allowed by law. Any other release of individually identifiable medical information requires specific member consent.

Allowable disclosures without patient consent include:

- To provide clinical care
- To allow for pharmacy benefit management
- To determine the appropriate payment for covered services
- To perform utilization management functions, including independent medical review
- To perform quality improvement activities; confidential medical information that is reviewed as part of audits, HEDIS data collection, accreditation surveys, peer review or for credentialing must remain on site, and cannot be further disclosed
- To comply with judicial, statutory and regulatory requirements, including a court order, for the purpose of a coroner’s investigation under specified circumstances, or under compelling circumstances to protect the safety of an individual
- If authorized by the SFHP Quality Improvement Committee, for the purpose of research, public health or related initiatives, under the condition that it cannot be further disclosed.

SFHP, its staff, its providers and its contractors adopt procedures that include:

- Medical records and other confidential information are stored in a secured area, and are accessible only to staff members with a business need to access the information
- Electronic records are password protected
- Medical records are stored for at least seven years; a child’s medical record is kept until the child is 19 years of age, and then for an additional seven years
- Confidential information is shredded prior to disposal
- Only assigned staff handles medical information and medical records
2. PCP Responsibilities

The PCP is the overall coordinator of care for the San Francisco Health Plan member. Responsibilities of the PCP include, but are not limited to:

- Assuring reasonable access and availability to primary care services
- Providing all preventive care and CHDP/EPSDT required services
- Providing access to urgent care
- Providing 24-hour coverage for advice and referral to care
- Making appropriate referrals for specialty care
- Providing coordination and continuity of care after emergency care, out-patient, in-patient, and tertiary care referrals, including
  - Providing referral, coordination and continuity of care for members needing mental/behavioral health services, drug and alcohol detoxification and treatment services, or referrals for seriously medically impaired and seriously emotionally disturbed members to the San Francisco Community Behavioral Health Services
  - Providing referral, coordination and continuity of care for members requiring Direct Observed Therapy for uncontrolled tuberculosis
  - Providing referral, coordination and continuity of care for members requiring services from California Children Service (CCS), Early Start, Golden Gate Regional Center (GGRC), and Local Education Agency (LEA)
  - Providing referral, coordination and continuity of care for members requiring hospice care
- Case managing members or referring members for case management services as necessary
- Requesting authorizations for specialty care or services as necessary from the medical group or outside the medical group’s network as necessary
- Communicating authorization decisions to the member
- Assisting the member in making appointments or other arrangements for specialty care or procedures
- Tracking and following up on referrals that are made

Primary care providers must have hospital admitting privileges with a network hospital.

If a member is hospitalized emergently at a non-network hospital, the PCP arranges transfer to a network hospital once the member is medically stable.

3. PCP Assignments and Monitoring

Primary care providers can only be assigned members within the age range of their specialty.

For instance, a PCP with a Pediatric specialty may not see members over age 21.

Please reference the table below for age limitations by specialty:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>0-21 years old (0 months – 252 months)</td>
</tr>
<tr>
<td>Pediatric Clinic</td>
<td>0-21 years old (0 months – 252 months)</td>
</tr>
<tr>
<td>Pediatric Adolescent Medicine</td>
<td>0-24 years old (0 months – 288 months)</td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td>10-24 years old (110 months – 288 months)</td>
</tr>
<tr>
<td>Family Medicine/Practice</td>
<td>0 years and older (0 months – 1320 months)</td>
</tr>
<tr>
<td>General Clinic</td>
<td>0 years and older (0 months – 1320 months)</td>
</tr>
<tr>
<td>Adult Clinic</td>
<td>18 years and older* (216 months – 1320 months)</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>18 years and older* (216 months – 1320 months)</td>
</tr>
<tr>
<td>General Practice</td>
<td>18 years and older* (216 months – 1320 months)</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>55 years and older (660 months – 1320 months)</td>
</tr>
</tbody>
</table>

*Younger members may be assigned if they are legally emancipated minors

San Francisco Health Plan evaluates the member-to-primary care provider ratio and member age assignments within each medical group on a monthly and annual basis. SFHP ensures that provider capacity meets Knox Keene and Department of Health Care Services (DHCS) regulatory
standards of 1 PCP: 2000 members and 1 Specialist MD: 1200 members. SFHP also considers expected member demand and required geographical access standards in analyzing provider ratios. SFHP ensures that it contracts with a sufficient number of providers and that its contracted provider network has adequate capacity and availability of licensed health care providers to offer our members appointments that meet the standards set forth in the DMHC Timely Access Standards.

4. Provider Complaint Procedure
SFHP has a Provider Complaint Procedure for the receipt, handling and resolution of provider complaints regarding San Francisco Health Plan services, operations or procedures, other than disputes regarding claims payment, disputes regarding authorization actions, or member grievances.

Providers may register a complaint by calling the SFHP Provider Relations Department at 1(475) 547-7818 x7084 or Customer Service Department at 1(415) 547-7800, but must follow up in writing with the following information:

- Description of the problem, including all relevant facts
- Names of people involved
- Date of occurrence
- Supporting documentation

SFHP will notify the provider and acknowledge the complaint within 3 business days of receipt of the written information. Providers are informed in writing of resolution of the complaint forty-five (45) calendar days, or SFHP will document for the provider reasonable efforts to resolve it.

5. Provider Appeals Procedure
Providers may appeal authorization denials for clinical services that did not meet administrative policy requirements, medical criteria, or other reason(s), and were denied by the SFHP Medical Director, Physician Designee, or designated UM staff. Provider appeals should be submitted in writing to SFHP’s UM department by fax, e-mail, or U.S. mail, and be accompanied by a completed Provider Request for an Appeal form. The request for appeal form is available on-line at www.sfhp.org/providers (click on “Downloadable Forms”). Both contracted and non-contracted providers have the right to appeal the authorization review determination, except in the following instances:

- The appeal is submitted more than 90 calendar days following the date of the Notice of Action (NOA).
- The denial was based on untimely notification for inpatient admission.
- The service was not covered by Medi-Cal (under the Evidence of Coverage) at the time of the authorization request.
- If the appeal is regarding an authorization that is the responsibility of a delegated medical group, the SFHP UM department will follow the delegated medical group’s appeal process.

Provider appeals are reviewed under one of the two categories: Administrative Denials or Clinical Authorization Denials. If the dispute is submitted on behalf of an enrollee or a group of enrollees, the dispute shall be handled within the member grievance process.

The time frame for SFHP to resolve an appeal begins upon receipt of all necessary information.
- For Routine Appeal Requests:
  - The provider shall submit an appeal no later than 90 calendar days following the date of the Notice of Action (NOA).
  - SFHP shall confirm receipt of the appeal within 5 business days of receiving the appeal.
  - SFHP shall notify the provider of the decision regarding the appeal no later than 30 business days following receipt of all necessary information.
SFHP shall notify the provider in writing of the decision within 5 business days of reaching a decision.

- For Expedited Appeal Requests:
  - The provider shall submit an appeal no later than 10 calendar days following the date of the Notice of Action (NOA).
  - SFHP shall confirm receipt of the appeal within 5 business days of receiving the appeal.
  - SFHP shall notify the provider of the decision regarding the appeal no later than 15 business days following receipt of all necessary information.
  - SFHP shall notify the provider in writing of the decision within 5 business days of reaching a decision.

6. Provider Satisfaction Survey
SFHP conducts Provider Satisfaction Surveys to measure providers’ satisfaction with the Plan. The survey is conducted among contracted primary care providers. Results of the survey and recommendations for improvements are shared with the SFHP Governing Board and Executive Team through the annual summary report. All SFHP contracted providers and their affiliated medical groups can view or obtain a copy of the survey by calling Provider Relations at 1(415) 547-7818 x 7084 or emailing provider.relations@sfhp.org.

7. Provider Initiated Changes to Patient Assignment
A provider can initiate a PCP change at any time, via a call with the member in the office to the SFHP member services department (when the member consents) or via the “Breakdown in Physician/Patient Relationship” procedure when a provider would like a member involuntarily reassigned to a new PCP.

If a member is in a PCP office, the provider may call SFHP Customer Service at 1(415) 547-7800 and request a PCP change with the member on the phone line to provide consent.

Note: It is the responsibility of the PCP to provide services up to 30 days after the initiation of the switch or until the switch takes place, whichever happens first.

If a breakdown in physician/patient relationship occurs for any reason and the PCP determines care for the member would best be performed at another PCP site, the PCP should notify SFHP in writing. A letter describing the breakdown should be sent to the member as well as San Francisco Health Plan. Letters should be sent to:

San Francisco Health Plan  
Attn: Provider Relations Department  
P.O. Box 194247  
San Francisco, CA 94119

Once SFHP receives the notice of breakdown in relationship, the Provider Relations Department will work with the medical group and SFHP Customer Service Department to reassign the member to a new PCP site.

8. Specialist Responsibilities
Specialists are required to coordinate the member's care with the member’s PCP. Specialists are required to communicate their assessments, care provided, and management recommendations to the member’s PCP within one week of treating the referred patient.

9. Provider Access, Availability and Appointments
Provider offices and clinics shall meet the following access and availability standards for scheduling appointments, and tracking telephone services. Members must have 24-hour access
to PCP services at all times. SFHP encourages members to call their PCP with all questions or concerns, however, if the provider is not available, members are instructed to call SFHP’s 24/7 Nurse Advice line at 1(877) 977-3397. The nurse advice line is staffed by registered nurses who can assist with advice, next steps and potential triage. Kaiser members are to call Kaiser’s 24/7 Call Center at 1(415) 833-2200 to speak to an advice nurse who can give advice and instruct members to go to the urgent care center if needed.

**Appointment Access Procedures**

SFHP members make appointments for adult and child initial health assessments, preventive care appointments, children’s preventive periodic health assessments, routine primary care, urgent care by calling their assigned Primary Care Practitioner (PCP). The PCP is responsible for referring members to specialty services. Members may self-refer to prenatal care and can call any in-network OB/GYN provider for an initial prenatal care appointment. Members are informed of their assigned PCP in the SFHP New Member Welcome Packet. Members also receive a Member Handbook in the Welcome Packet that informs members of how to access services, including directions to call 911 or go to an Emergency Room in the case of an emergency.

**Access Standards**

San Francisco Health Plan (SFHP) and its providers shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member’s condition consistent with good professional practice. SFHP establishes and maintains provider networks, policies and procedures, and quality assurance monitoring systems sufficient to ensure compliance with clinical appropriateness standards. SFHP ensures that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the member’s condition and in compliance with the requirements of the DMHC Timely Access Regulations. SFHP requires its providers to comply with the following access standards. We inform providers and Medical Groups of these requirements through the SFHP Provider Network Operations Manual, and reinforce standards in Joint Administrative Meetings (JAMs) with providers and our Provider Monthly Updates.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult and child Initial Health Assessments</td>
<td>Within 120 calendar days (for children aged 18 months or younger, SFHP requires an IHA (complete history and physical examination) within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger whichever is less.)</td>
</tr>
<tr>
<td>Initial prenatal care appointments</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Immediately</td>
</tr>
<tr>
<td>Access to after-hours care</td>
<td>SFHP (and delegated medical group Kaiser, for Kaiser members) will provide telephone or screening services by telephone communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee’s need for care.</td>
</tr>
<tr>
<td>Urgent Care - for services not requiring a prior authorization</td>
<td>Within 48 hours of the request*</td>
</tr>
<tr>
<td>Urgent Care - for services requiring a prior authorization</td>
<td>Within 96 hours of request*</td>
</tr>
<tr>
<td>Non-urgent Primary Care</td>
<td>Within 10 business Days of request**</td>
</tr>
<tr>
<td>Non-Urgent appointments with Specialist Physicians</td>
<td>Within 15 business Days of the request* *</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Non-Urgent appointments with non-physician mental health care provider</td>
<td>Within 10 business Days of the request**</td>
</tr>
<tr>
<td>Non-Urgent Ancillary Services (for diagnosis or treatment)</td>
<td>Within 15 business days of request**</td>
</tr>
<tr>
<td>Telephone Triage or Screening Waiting Time</td>
<td>Not to exceed 30 minutes*</td>
</tr>
<tr>
<td>Wait time to speak to a SFHP customer Service representative during normal business hours</td>
<td>Not to exceed 10 minutes</td>
</tr>
</tbody>
</table>

* **Exception 1**: appointment may be extended if the referring/treating and/or triage licensed health care provider determines and notes in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee

**Exception 2**: Exception 1 plus Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialist for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of practice.

Providers may demonstrate compliance with the primary care time elapsed standards through implementation of standards, processes and systems providing advanced access to primary care appointments.

Advanced access: means the provision, by an individual provider, or by the medical group to which a member is assigned, of appointments with a primary care physician, or other qualified primary care provider, or other qualified primary care provider such as a nurse practitioner or physician’s assistant, within the same or next business day from the time an appointment is requested, and advanced scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.

“Triage” or “Screening” as defined by DMHC means the assessment of an enrollee’s health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee’s need for care.

**Procedures for ensuring access**
Providers and Medical Groups are informed of these requirements through the SFHP Network Operations Manual and in Joint Administrative Meetings (JAMs) with providers and our Provider Monthly Updates.

**Telephone Triage Procedures**
SFHP providers must maintain standard protocols and guidelines for processing calls from patients that include:

- When the call should be immediately transferred to a physician on duty
- When the patient should be instructed to go to the emergency room
- Notification of emergency medical services (911) for emergency situations
- After-hours availability instructions
- SFHP providers must maintain reasonable hours of operation and provide 24-hour access
SFHP will provide members with a contracted Nurse Advise Line (NAL). The NAL will be available 24/7 for 365 days/year and maintain standard protocols and guidelines for processing calls from members that include the following:

- Clinical assessment and education
- Determination of when the call warrants immediate consultation with the on-call supervisor and "Determination of when the call warrants immediate consultation with the NAL physician"
- Determination of when the patient should be instructed to go to the emergency room
- Notification of emergency medical services (911) for emergency situations
- Faxed information to the member’s provider as to who called, the nature of the call and actions taken by the NAL
- NAL waiting time not to exceed 30 minutes

**Missed appointments**

SFHP physicians must have processes in place to follow-up on missed appointments that include at least the following:

- Notation of the missed appointment in the Member’s medical record
- Review of the potential impact of the missed appointment on the Member’s health status including review of the reason for the appointment by a licensed staff member of the physician’s office.
- The appointment shall be promptly rescheduled in a manner that is appropriate for the member’s health care needs, and ensures continuity of care consistent with good professional practice, and consistent with all regulatory requirements.
- Notation in the chart describing follow-up for the missed appointment including one of the following actions: no action if there is no effect on the Member due to the missed appointment, or a letter or phone call to the Member as appropriate given the type of appointment missed and the potential impact on the Member. The chart entry must be signed or co-signed by the Member’s assigned PCP or covering physician.
- Three attempts, at least one by phone and one by mail must be made in attempting to contact a Member if the Member’s health status is potentially at significant risk due to missed appointments. Examples include Members with serious chronic illnesses, Members with test results that are significant (e.g., abnormal PAP smear) and Members judged by the treating physician to be at risk for other reasons. Documentation of the attempts must be entered in the Member’s medical record and copies of letters retained.

**24-hour access to care**

24-hour access to care must include:

- A licensed physician or mid-level provider working under the supervision of the physician is available for contact after-hours, either in person or via telephone.
- All contacts must be documented in the member’s permanent medical record.
- All documentation must be forwarded to the member’s PCP of record.
- After-hours contact must include appropriate triage for emergency care.

**Unusual specialty services**

SFHP shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within the SFHP network, when determined medically necessary.

**Ensuring members receive services that are objected to by the provider**

SFHP will respond with timely referrals and coordination, provided at no additional expense to DHCS, in the event that a benefit/covered service is not available from one of our providers because of religious, ethical or moral objections to the covered service. SFHP will follow the Member Grievances and Appeals Procedure to acknowledge and resolve the member’s
complaint. The SFHP Care Management Department will be responsible for making a timely referral and coordinating care for the member.

**Monitoring Access**

SFHP monitors provider compliance with access to care standards using the following procedures:

- On a quarterly and annual basis, SFHP reports on grievances patterns and trends by provider group, line of business, and category. Reports are brought to the Quality Improvement Committee and the Governing Board for review.
- SFHP utilizes data from Medi-Cal and CAHPS patient satisfaction results to identify potential access issues and areas for improvement. CAHPS results are brought to QIC for review as soon as they are available.
- SFHP monitors access to specialty services for the Community Health Network through regular reports on appointment wait times by specialty area.
- SFHP monitors provider compliance with wait time standards, telephone triage procedures, 24-hour availability, and missed appointment procedures through Facility Site Review and Medical Record Reviews as stated in our Facility Site Review and Medical Record Review Policy and through annual oversight audits and stated in our Oversight of Functions Delegated to Medical Groups Policy.
- SFHP monitors providers’ compliance with urgent PCP and Specialty appointments (with and without prior authorization), and non-urgent ancillary care standards through the administration of the ICE Provider Appointment Availability annual survey. In cases where this function is delegated, Medical Groups are required to use a tool, which at a minimum, includes questions similar to those in the ICE Provider Availability survey. These Medical Groups are required to conduct this evaluation annually, and to report results to SFHP by February 28 of every year.
- SFHP monitors providers’ satisfaction regarding compliance with the access standards through a set of questions in the plan’s annual provider satisfaction survey. The questions posed to providers are at a minimum, similar to those in the ICE Provider Satisfaction Survey tool. In cases where the function is delegated, Medical Groups are required to use the ICE Provider Satisfaction Survey questions or similar questions. The survey is conducted on an annual basis to primary care providers.
- SFHP monitors enrollees’ satisfaction with providers’ compliance with the timely access standards through the administration of an annual survey that includes, at a minimum, the questions from the “Clinician-Group CAHPS ambulatory survey.” In cases where this function is delegated, medical groups are required to utilize a survey that includes questions modeled after the Clinician-Group CAHPS survey. The CCHRI/CA Pay for Performance Patient Assessment Survey (PAS) qualifies as a valid survey instrument and methodology provided that results are at the medical group county level.

The Director of Health Improvement jointly with the Provider Relations Department is responsible for designing and implementing access studies to monitor wait times for:

- Adult and child initial health assessments
- Preventive care appointments and children’s preventive periodic health assessments
- Routine primary care
- Initial prenatal care
- Routine specialty referrals
- Urgent care

Results from access studies will be presented to QIC quarterly for review.

If a provider or medical group is found to be out of compliance the following actions will be taken:

- The provider or medical group will be required to submit a corrective action plan to SFHP for approval and monitoring.
- SFHP Quality Improvement Committee will be notified.
Efforts will be made by SFHP to review network adequacy and ensure appropriate service levels.

10. Provider Preventable Conditions
The Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) for the State Plan Amendment (SPA) to require reporting and to adjust payment for Provider Preventable Conditions (PPCs). Starting July 1, 2012, federal law and regulations require all providers to report PPCs that occur in inpatient and outpatient settings.

A provider must report the occurrence of any PPC in any Medi-Cal patient that did not exist prior to the provider initiating treatment. A provider must report the occurrence regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the PPC. Reporting a PPC for a Medi-Cal beneficiary does not preclude the reporting of adverse events, pursuant to Health and Safety Code (H&S Code), Section 1279.1, to the California Department of Public Health (CDPH).

A provider reports a PPC by completing and submitting the Medi-CalProvider-Preventable Conditions (PPC) Reporting Form (DHCS 7107). Providers must submit the form within five days of discovering the event and confirming that the patient is a Medi-Cal beneficiary.

If the beneficiary is enrolled in the fee-for-service (FFS) Medi-Cal program, the form must be sent to the DHCS Audits and Investigations Division. If the beneficiary is enrolled in a Medi-Cal Managed Care Plan (MCP), the provider must report the PPC to the beneficiary’s managed care plan.

Medi-Cal FFS will adjust payment for PPCs, as required by the Patient Protection and Affordable Care Act (PPACA), Section 2702, and as defined by the Code of Federal Regulations, Title 42, parts 447, 434 and 438. Medi-Cal will not adjust payment for PPC-related claims when the provider notes that the PPC existed prior to the provider initiating treatment for the patient. Payment adjustment will be limited to PPCs that would otherwise result in an increase in payment and to the extent that DHCS can reasonably isolate for nonpayment the portion of payment directly related to the PPC.

As specified by federal regulations, PPCs are recognized as Other Provider-Preventable Conditions (OPPCs) in all health care settings and Health Care-Acquired Conditions (HCACs) in inpatient hospital settings only.

To report a PPC related to a member of San Francisco Health Plan, please complete and fax the Medi-CalProvider-Preventable Conditions (PPC) Reporting Form (DHCS 7107) to Utilization Management at 1(415) 357-1292.
Section 11: Physician Credentialing and Recredentialing

1. Non-Physician Medical Practitioners

Non-Physician Medical Practitioners (NPMP) with a valid, current license or certificate from the State of California may serve as the provider of primary care services for SFHP members under these conditions:

- The scope and requirements of practice for NPMP providing primary care services for SFHP are established by the Board of Registered Nursing or the Division of Allied Health Professionals of the California Medical Board. They include supervision by a licensed physician, who has a contract with the medical group. Supervision may be direct or include the use of medical policies and protocols established by the physician.
- The supervising physician does not have to be physically present when the NPMP is seeing patients, but must be available either on-site or by telephone.
- The supervising physician will complete the provider information letter for each non-physician medical practitioner in accordance with CCR, Title 22, Section 51240(d)(1)-(2) and will report any changes to DHCS within 30 days. The provider information letter is effective for a period of 12 months and reviewed by SFHP or the delegated medical group at the time of the Facility Site Review or oversight audit.
- If the NPMP does not have members assigned and only sees members assigned to their supervising physician, SFHP and its delegated groups follows the MMCD Policy Letter 02-03 requirements for credentialing NPMPs. If the NPMP accepts members assigned to them for primary care, the NPMP must be fully credentialed as outlined in the SFHP Credentialing and Recredentialing Policy and Procedure.

A Non-Physician Practitioner Protocol establishes the scope and limitations of services to be provided by the NPMP, including the following:

- Standing orders that will be kept on file at the supervising physician office/clinic
- Guidelines as required by Title 16. Section 1470 for registered nurses, and Title 16. Section 1399.541 for Physician Assistants
- Physician assistants must have progress notes co-signed as required by the state for the scope of practice for physicians’ assistants

Supervisor Requirements

The designated physician supervisor and a designated alternate physician supervisor must possess a valid Physician and Surgeon’s license. In addition, the supervising physician must also maintain:

- For Nurse Midwives: A current practice in obstetrics
- For Physician Assistants: Approval of the Division of Allied Health Professionals of the California Medical Board

Supervisory physicians may not supervise or oversee greater than the following fulltime equivalent NPMPs: Four NPMPs in any combination that does not include more than four Nurse Practitioners, three Nurse Midwives or four Physician Assistants.

2. Physician Credentialing/Recredentialing

All licensed independent practitioners who provide care to SFHP members, including physician and non-physician medical practitioners, must meet SFHP credentialing standards to be accepted into and to maintain good standing in the SFHP network. SFHP credentialing standards are based on federal and California requirements, and comply with SFHP’s contract with the Department of Health Care Services. Re-credentialing must occur at least every three years.
The physician re-credentialing process includes an assessment of quality indicators such as member complaints and medical record review scores. SFHP also requires that its medical groups have ongoing procedures to monitor and act to address issues of quality of care and service.

SFHP requires that mid-level medical practitioners see SFHP patients only when their credentials and scope of practice comply with the relevant California codes governing their profession. This requirement applies to nurse practitioners, nurse midwives, clinical nurse specialists and physician assistants.

SFHP requires that every contracted provider be subject to an initial assessment and re-assessment every three years. The assessment is structured to confirm that the organization is in good standing with regulatory bodies and meets the standards of an accreditation agency or has been audited against appropriate standards. This requirement applies to organizations like hospitals, home-health agencies, skilled nursing facilities and nursing homes, and free-standing surgical sites. Participating medical groups must keep complete and current provider files on file for each provider it contracts with or employs.

When SFHP delegates the credentialing function to a medical group or hospital, SFHP is accountable to assure that the medical group or hospital performs the function or activity according to its standards. SFHP details specific credentialing requirements in a delegation agreement to each medical group, and audits all medical groups or contracted hospitals annually to assure that the credentialing program meets SFHP standards. The audit may review policies and procedures, examine credentialing files, credentialing committee minutes and, when problems are identified, require corrective action.

Medical groups or hospitals may sub-delegate credentialing to a NCQA Certified Verification Organization (CVO) or its affiliated hospital. Sub-delegation occurs when a delegate of the Plan gives a third entity the authority to carry out a function.

To sub-delegate credentialing, the medical group must inform SFHP and provide a copy of the sub-delegation agreement for SFHP to review and approve. The sub-delegated hospital must hold Joint Commission (JCAHO) accreditation with no major deficiencies regarding the credentialing process and found in compliance with SFHP standards in pre-contractual and annual audits.

If a medical group sub-delegates to its affiliated hospital, the medical group must conduct annual credentialing oversight. The findings and any corrective action plans of this oversight must be forwarded to SFHP. The medical group must have a written contract with the CVO and is not required to perform a pre-contractual audit.

When credentialing is delegated or sub-delegated, SFHP retains the authority to accept or reject the qualifications of all network providers, approve new practitioners and sites, terminate or sanction practitioners, and report serious quality deficiencies to appropriate authorities.

**Downstream Sub-Contracting**

All agreements between the medical group and sub-contractors must be in writing and shall include specific provisions ensuring that such sub-contractors (e.g. Credentialing Verification Organizations):

- Comply with all SFHP standards, policies and procedures
- Seek payment for covered and authorized services from the medical group and under no circumstances seek payment from SFHP or the member
- Do not surcharge or balance bill members for covered and authorized services
- Cooperate with and participate in SFHP’s Quality Improvement, Utilization Management, and Member grievance and appeals processes
Upon request, the medical groups will submit to SFHP copies of the sub-contractors’ contracts. Payment rates may remain confidential. SFHP shall have the right to terminate a subcontractor’s services for any member should SFHP determine that the subcontractor is not providing services in a manner that meets SFHP’s reasonable approval.

3. Provider Network

Medical groups must forward all provider network information to SFHP in a timely manner. SFHP has criteria that will prevent a provider’s record from being activated unless all credentialing and provider training information are received from the medical group.

To add a primary care provider, specialist, or a mid-level practitioner, or an additional address for an existing SFHP provider, the medical group is responsible for completing the SFHP Provider Add Form and SFHP Attestation Form, available by calling 1(415) 547-7818 x7084 or emailing provider.relations@sfhp.org. The form may be submitted via email or fax to the number/address listed on the form.

Provider Information Changes or Terminations
If a medical group needs to correct or change information on an existing contracted provider, the SFHP Provider Status Change Form, available by calling 1(415) 547-7818 x7084 or emailing provider.relations@sfhp.org, should be emailed or faxed to provider relations to the number/address listed on the form as soon as the medical group is aware of the changes.

Examples of changes include:
- Provider phone number or address changes
- Spelling correction or change
- Provider specialty correction or change or
- Provider participation termination – from SFHP or from a specific SFHP line of business.

If a contracted SFHP provider wants to terminate affiliation with SFHP, he or she must submit termination notification to his or her medical group. The medical group is responsible for notifying SFHP of provider terminations in a timely fashion. Terminations are effective no earlier than the first of the month following 30 days notice and must be submitted on the SFHP Provider Status Change Form.

The medical group is responsible for choosing another provider to assume the terminating providers’ members. The medical group must inform SFHP Provider Relations Department of the reassignment decision. SFHP will notify members of this information by sending a new SFHP ID card. Members have the option of selecting another PCP should they choose not to accept the new provider assigned by SFHP.

4. Provider Orientation and Training

Medical groups are responsible for provider training and education within ten days after the provider’s start date. SFHP regularly updates the medical group staff with health plan information for dissemination to appropriate providers in their network.

SFHP provides each organization with a Network Operations Manual. The manual provides the framework and detail of SFHP’s program requirements. In addition, SFHP regularly communicates with and updates the medical groups with policy changes, new program implementations, provider/member survey results and other quality improvement outcome information through mechanisms such as special mailings, Provider Newsletters, Plan Collaborating with Provider Meetings (PCP M) at the sites, and/or Joint Administrative Meetings (JAM) attended by representatives of each medical group.

New provider training must be completed within the first ten days of the provider’s addition to the medical group, and a signed attestation of training must be retained in the credentialing file in
order for the provider to see SFHP members. An electronic version of the attestation is available on the SFHP web site. Training must cover the following topics:

- Medi-Cal Eligibility and Benefits
- Member Rights as listed in this manual
- In and Out-of-Network Authorization Process and Second Opinion Referrals
- Provider and Member Grievance and Appeal Process
- After Hours Access/Appropriate Referrals to the Emergency Department
- Direct Access to OB/GYNs
- Case Management Services
- Child Health and Disability Prevention (CHDP) and Comprehensive Perinatal Services Program (CPSP) Services
- Coordination of care for:
  - California Children’s Services (CCS)
  - Mental Health and Substance Abuse Services (SFCBHS)
  - Dental Benefits
  - Women, Infants, and Children’s Program (WIC)
  - Local Education Agencies (LEA)
  - Golden Gate Regional Center (GGRC) and Early Start
- Health Education Services
- Independent Medical Review (IMR)
- Initial Health Assessment (IHA)
- Staying Healthy Assessment (SHA)
- SFHP Drug Formulary
- Sterilization Services (PM-330 Forms)
- Sensitive Services
- Summary of SFHP Network Operations Manual
- Translator and Interpreter Service

5. Provider Profile Reporting
San Francisco Health Plan will send a Provider Profile to medical groups upon request for use in their credentialing process. The profiles can be sent to the Medical Director and/or Quality Improvement Director as follows:

- 1st Quarter of the year (January 1 – March 31, 201x) on April 15th
- 2nd Quarter (April 1 – June 30, 201x) on July 15th
- 3rd Quarter (July 1 – September 30, 201x) on October 15th
- 4th Quarter (October 1 – December 31, 201x) on January 15th the following year

This document includes:

- The Reporting Period
- Provider Name (PCP or Specialist)
- Detailed description of the issue as identified from a grievance or potential quality of care case
- Date received
- Outcome of the grievance or potential quality of care issue and
The medical groups are asked to place a copy of this report and the accompanying attachments in the credentialing file of any provider identified on this report and to review the grievance or potential quality case information at the time the provider is recredentialed. Any potential quality of care case is forwarded to the medical group at the time it is identified by SFHP. The medical group will be asked to supply medical records, claims/billing information, authorization screens or other information to SFHP so that the SFHP Medical Director can review all of the information available before making a decision to take the issue to Physician Advisory Committee/Peer Review or closing the case as no quality of care issue.

<table>
<thead>
<tr>
<th>REPORTING PERIOD</th>
<th>PROVIDER NAME</th>
<th>ISSUE AS IDENTIFIED FROM GRIEVANCES AND POTENTIAL QUALITY OF CARE CASES</th>
<th>DATE</th>
<th>OUTCOME OF GRIEVANCE OR POTENTIAL QUALITY OF CARE ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter (January – March)</td>
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<tr>
<td>2nd Quarter (April – June)</td>
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<td>3rd Quarter (July – August)</td>
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<tr>
<td>4th Quarter (September – December)</td>
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For Example:
Section 12: Facility Site and Medical Record Reviews (FSR, MRR, and FSR-C)

1. Access for Members with Disabilities
San Francisco Health Plan believes that seniors and people with disabilities (SPDs) should be able to find a path through the complex healthcare system, allowing them to access the medical care and services they need. The idea of PATH (Providing Access to Health Care) was created as a project to investigate the feasibility of SFHP and our network of providers to attract and support this population, and provide better service than Fee-for-Service Medi-Cal. Increasing voluntary enrollment of SPDs aligns with SFHP’s mission to provide and expand access and improve the quality of health care for the residents of San Francisco.

SFHP has worked with the Disability Rights Education and Defense Fund (DREDF) and the Mayor’s Office on Disabilities to create a resource guide, which provides detailed information to assist the provider offices and medical groups to understand what accommodations, equipment and devices some people with disabilities might need to ensure they receive quality health care services. The guide provides not only a definition of terms, and in some cases illustrations, but also presents additional technical information that the offices can use to work with this population.

Please contact SFHP’s provider relations department at provider.relations@sfhp.org for this brochure, staff training, and other resources to work with this population.

2. State Policy & Procedure regarding provider office FSR-C
SFHP follows DHCS guidelines in administering the Facility Site Review – Attachment C primary care, high volume specialist, and high volume ancillary provider access reviews. Those guidelines are delineated in:
- DHCS (MMCD) facility site review – attachment C tool and guidelines
- DHCS Policy Letter 12-006

FSR-C reviews are conducted by SFHP, its medical groups and Anthem Blue Cross. These reviews can be performed by non-clinical trained staff.

3. State Policy & Procedure regarding provider office FSR and MRR
SFHP follows DHCS guidelines in administering Facility Site and Medical Record Reviews for network PCPs. Those guidelines are delineated in:
- DHCS (MMCD) facility site review tool and guidelines
- DHCS (MMCD) medical record review tool and guidelines
- DHCS Policy Letter #02-02

Facility site and medical record reviews are conducted by SFHP, its certified nurse reviewers at the medical groups and Anthem Blue Cross. The Department of Health Care Services (DHCS) may also conduct site FSRs and MRRs as part of Managed Medi-Cal Division (MMCD) monitoring activities.

Facility site reviews must be conducted pre-contractually and prior to the PCP treating SFHP members and are repeated every three years or whenever the office has gone through a renovation.

Medical record reviews are conducted within 180 days of active status as a PCP and are repeated every three years. Ten (10) medical records are reviewed for each provider within 90 days of the date on which members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the new provider does not have sufficient assigned Medi-Cal managed care plan members to complete a review of 10 medical records. If at the end
of the 180 days there are still fewer than 10 assigned members, a medical record review shall be completed on the total number of records available and the scoring adjusted accordingly.

The provider will receive a DHCS (MMCD) Certified Quality Provider Site certificate from SFHP when the provider has passed the facility site and medical record reviews with a score of 80% or greater and has a completed and approved corrective action plans, if required by the score.

Focused or interim reviews are conducted between the full scope reviews to target previously identified deficiencies and/or areas of concern identified by the plan or at sites with a failing score (below 80%) or had critical element deficiencies. Primary Care Provider sites that do not correct cited deficiencies and/or areas of concern are subject to termination from SFHP’s Contracted Network.

Medical groups are expected to educate their providers on these requirements and facilitate SFHP and their reviewers’ access to the provider sites and medical records.

Copies of the review tools and guidelines can be found on the SFHP web site at www.sfhp.org/providers/resources or obtained by calling the SFHP’s Sr. Clinical Compliance Manager at 1(415) 615-4205.

3. Components of Facility Site Review and Medical Record Review
San Francisco Health Plan (SFHP) and the certified nurse reviewers at our delegated medical groups have a number of resources available to help providers successfully pass the DHCS medical record review:

- Survey Survival Toolkits
- Resource list for equipment, scale calibration, cleaning products that meet all DHCS requirements, etc.
- TB Screening and Risk Assessment forms
- Advanced Health Care Directives in threshold and other languages
- Vaccine Information Statements and immunization documentation forms for offices without web accessibility
- SFHP Grievance forms for offices without web accessibility
- Blood Borne Pathogen Prevention training requirements

There are four main reasons that providers fail the medical record review portion of their reviews:

1. Annual Tuberculosis/TB Screening and Risk Assessments:
   - Must be performed annually in San Francisco for members of any age, as TB related deaths increased by 30% in 2007
   - SFHP and the San Francisco TB Control Unit have created a 1-page Annual TB Risk Exposure Assessment form to be completed and filed in the members' chart
   - SFHP has a stamp: “TB Risk Assessed: (for date)” for charts
   - SFHP has progress notes that include a box to check off for TB risk screening
   - A link to the TB website for screening and treatment guidelines is on SFHP’s website: http://www.sfhp.org/providers/provider_resources/clinical_guidelines.aspx

2. Advanced Health Care Directives (AHCD):
   - AHCD forms may be downloaded at 5th grade reading level from SFHP’s website, where they are available in English, Chinese, Spanish and Russian: http://www.sfhp.org/providers/provider_resources/download_forms.aspx
   - Providers are required to share this document with all members who are 18 years of age or older
   - Providers are not required to see that they are fully executed, however they must document the date that they were given, refused or executed in the chart

3. Vaccine Information Statements (VIS) distribution and documentation:
   - VIS are developed by the Centers for Disease Control and Prevention (CDC) and are mandated by federal law for childhood and adult vaccinations.
Before a vaccine can be administered, providers must give the patient, parent/guardian the most current copy of the VIS, and ensure adequate time to read it prior to the administration of the vaccine.

The date that the VIS was given must be recorded in the chart.

The publication date of the VIS must be recorded in the chart.

To download the most current versions of the VIS in any of 25 languages go to www.immunize.org/vis or call Provider Relations at 1(415) 547-7818 x 7084.

4. Staying Healthy (SHA) / Individualized Behavioral Health Behavioral Assessments (IHEBA):

The DHCS mandates that all members receive an SHA for new patients along with their Initial Health Assessment (IHA) within 120 days of enrollment with the SFHP and existing patients at their next non-acute care visit. For children aged 18 months or younger, SFHP requires an IHA (complete history and physical examination) within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger whichever is less.

The DHCS tools are available in our threshold languages and for ages:
- 0-6 months of age (completed by the parent once during this age bracket)
- 7-12 months of age (completed by the parent once during this age bracket)
- 1-2 years of age (completed by the parent once during this age bracket)
- 3-4 years of age (completed by the parent once during this age bracket)
- 5-8 years of age (completed by the parent once during this age bracket)
- 9-11 years of age (completed by the parent once during this age bracket)
- 12-17 years of age (self-completed annually to address changing risk status)
- 18 and older (self completed every 5 years)

In addition to the single questionnaire for adults, DHCS created a second questionnaire to address the unique needs of seniors, after the mandatory enrollment of SPDs into Medi-Cal managed care. They must be reviewed and the provider must:
- Document an intervention for any item checked in the center column or skipped
- Inquire and document why a question was skipped
- Date and initial the form with the date(s) reviewed

Use the codes at the bottom of the form for each intervention:
- C - counseling, ED - education materials; R - referral; F - follow-up needed, SPN - see progress notes; more than one code may be used

Patients may decline filling out this form; providers should document their decline and the date.

Contact the Sr. Clinical Compliance Manager at 1(415) 547-7818 x7084 or email provider.relations@sfhp.org, if you would like additional information, have questions or would these educational handouts and materials.
# Section 13: Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BTP</td>
<td>Brown &amp; Toland Physicians</td>
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<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Health Care Providers and Systems</td>
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<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
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<tr>
<td>CCHCA</td>
<td>Chinese Community Health Care Association</td>
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<tr>
<td>CHN</td>
<td>Community Health Network</td>
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<tr>
<td>DHCS</td>
<td>Department of Health Care Services</td>
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<td>DMHC</td>
<td>Department of Managed Health Care</td>
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<td>EDI</td>
<td>Electronic Data Interchange</td>
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<tr>
<td>EOC</td>
<td>Evidence of Coverage</td>
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<tr>
<td>FSR</td>
<td>Facility Site Review</td>
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<td>HCO</td>
<td>Health Care Options</td>
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<tr>
<td>HECUP</td>
<td>Health Education Compensation Program</td>
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<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
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<tr>
<td>HF</td>
<td>Healthy Families</td>
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<tr>
<td>HK</td>
<td>Healthy Kids</td>
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<tr>
<td>HILL</td>
<td>Hill Physicians Medical Group</td>
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<tr>
<td>HW</td>
<td>Healthy Workers</td>
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<tr>
<td>IHA</td>
<td>Initial Health Assessment</td>
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<tr>
<td>IHEBA</td>
<td>Individual Health Education and Behavioral Assessment or &quot;Staying Healthy&quot;</td>
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<td>IHSS</td>
<td>In Home Support Service Public Authority</td>
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<td>IMR</td>
<td>Independent Medical Review</td>
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<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
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<tr>
<td>LEA</td>
<td>Local Education Agency</td>
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<td>LOB</td>
<td>Line of Business</td>
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<td>MC</td>
<td>Medi-Cal</td>
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<tr>
<td>MRMIB</td>
<td>Managed Risk Medical Insurance Board</td>
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<td>MRR</td>
<td>Medical Record Review</td>
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<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<td>NEMS</td>
<td>North East Medical Services</td>
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<tr>
<td>NPMP</td>
<td>Non-Physician Medical Practitioner</td>
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<tr>
<td>PATH</td>
<td>Providing Access to Health Care</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>QIP</td>
<td>Quality Improvement Plan</td>
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<tr>
<td>SFCBHS</td>
<td>San Francisco Community Behavioral Health Services</td>
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<td>SFHP</td>
<td>San Francisco Health Plan</td>
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<tr>
<td>SHA</td>
<td>Staying Healthy Assessment</td>
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<tr>
<td>UCSF</td>
<td>University of California, San Francisco</td>
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<tr>
<td>VFC</td>
<td>Vaccines for Children</td>
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<tr>
<td>ASC X12</td>
<td>The Accredited Standards Committee (ASC) X12 is a set of uniform standards for inter-industry electronic exchange of business transactions-electronic data interchange (EDI).</td>
</tr>
</tbody>
</table>
Section 14: Appendix

1. Denial Letter Templates
   a) Medi-Cal member Delay, Denial and Modify letter templates
   b) Non-MC member Delay, Denial and Modify letter templates

2. Grievance Forms

3. Long Term Care Disenrollment Form

4. Pharmacy Authorization Form

5. Provider Add Form

6. Provider Status Change Form

7. Provider Attestation Form

8. Stop Loss Form

9. UM Authorization Form

10. Provider Appeal Form

11. Medi-CalProvider-PreventableConditions(PPC)ReportingForm (DHCS 7107)? Or link?