Provider Manual

Last revision: June 2018

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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 HMO (HK), and Healthy Workers HMO (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 140,000 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 HMO program. Numerous other counties have followed our lead by creating similar programs.

In 2002, we launched the Healthy Kids HMO 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

From 2011 until 2014, SFHP was the Third-Party Administrator for the SF PATH (San Francisco Provides Access to HealthCare) health access program, a state and federally-funded program that provided 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 Strategic Anchors

- 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. 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 HMO, 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.

5. Contact Information

SFHP Administrative Contact Information

San Francisco Health Plan (SFHP)

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 or 1-888-883-7347 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.

Teladoc

When triage and screening within 30 minutes is not possible, SFHP encourages providers to inform SFHP members about the availability of free telehealth (via video or telephone) consultations through Teladoc. Teladoc is staffed by California-licensed physicians who can treat for simple medical problems, determine whether patients should seek urgent or emergent services, or instruct patients to seek follow-up care with their regular treating physician. Teladoc physicians can prescribe some medications, but not controlled substances. SFHP members who are assigned to Kaiser or who have more than Medicare Part A are not eligible for Teladoc. Eligible SFHP members can receive care within 30 minutes, 24 hours a day and 7 days a week. A one-time registration via telephone or online is required. SFHP members may access Teladoc services by calling **1(800) 835-2362** or visiting **www.sfhp.org/members/teladoc**

Nurse Help Line

San Francisco Health Plan's Nurse Help 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

6. Provider Network Overview

Contracted Medical Groups

San Francisco Health Plan (SFHP) contracts with nine 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 (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)
- Jade Health Care Medical Group (JAD)
- Kaiser Foundation Health Plan (KSR)
- North East Medical Services (NEMS)
- NEMS with San Francisco Health Network (NMS)
- University of California, San Francisco (UCSF)

Contracted Hospitals

Network	Hospital	Address	General Phone Number
CCHCA	Chinese Hospital	845 Jackson Street San Francisco, CA 94133	1(415) 982-2400
CHN NMS	Zuckerberg San Francisco General Hospital and Trauma Center	1001 Potrero Avenue San Francisco, CA 94110	1(415) 206-8000
BTP HILL NEM	California Pacific Medical Center (CPMC) - St. Luke's Campus	3555 Cesar Chavez Street San Francisco, CA 94110	1(415) 647-8600
KSR	Kaiser Permanente Medical Center	2425 Geary Blvd San Francisco, CA 94115	1(415) 833-2000
JAD	Chinese Hospital	845 Jackson Street San Francisco, CA 94133	1(415) 982-2400
NEM	CPMC - California Campus	3700 California Street San Francisco, CA 94118	1(415) 600-6000
NEM	CPMC - Pacific Campus	2333 Buchanan Street San Francisco, CA 94115	1(415) 600-6000
NEM	CPMC - Davies Campus	44 Castro Street San Francisco, CA 94115	1(415) 600-6000
UCS	UCSF Medical Center, Parnassus	505 Parnassus Avenue San Francisco, CA 94143	1(415) 476-1000
UCS	UCSF Medical Center, Mt. Zion	1600 Divisadero Street San Francisco, CA 94115	1(415) 567-6600

Ancillary Vendors

Ancillary Providers can be found through the Provider Directory search tool at the link below:
https://sfhp.healthtrioconnect.com/public-app/consumer/provdir/entry.page?setlocale=en

Medical Group Prior Authorization and Claims Matrix

Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
BTP	**Professional: BTP** Phone 1(415) 972-6000 Mail claims to: PO Box 72710, Oakland, CA 94612-8910 **Facility & DME: SFHP** Phone 1(415) 547-7818 x7115 Mail claims to: P.O. Box 194247, SF, CA 94119	**All UM decisions: BTP** Phone 1(415) 972-6002 Fax 1(415) 972-6011	1(415) 547-7800
CCHCA	**Professional, Non-Emerg. Trans.: NEMS MSO** 1(415) 352-5186, option 2; Fax 1(866) 930-2290 Mail claims to: CCHCA Claims Department, P.O. Box 2118, San Leandro, CA 94577 **Facility, DME, Emergency Transportation: CCHP** Phone 1(415) 955-8800 Fax 1(415) 955-8812 Mail claims to: 445 Grant Ave, Suite 700, SF, CA 94108	**All UM decisions: NEMS MSO** Phone 1(415) 352-5186, option 1 Fax 1(415) 398-2895	1(415) 547-7800
CHN	**All claims: SFHP** Phone 1(415) 547-7818 x7115 Mail claims to: P.O. Box 194247, SF, CA 94119	**All UM decisions: SFHP** Phone 1(415) 547-7818 x400 Outpatient Fax: 1(415) 357-1292 Inpatient Fax: 1(415) 547-7822	1(415) 547-7800
HILL	**Professional: HILL** Phone 1(800) 445-5747 Mail claims to: PO Box 8001, Park Ridge, IL 60068 **Facility & DME: SFHP** Phone 1(415) 547-7818 x7115 Mail claims to: PO Box 194247, SF, CA 94119	**All UM decisions: HILL** Phone 1(800) 445-5747 UM/Authorizations fax: 1(925) 820-4311 Inpatient Face Sheets: 1(925) 362-6577	1(415) 547-7800
JAD	**All Claims: CCHP** Phone 1(415) 955-8800 Fax 1(415) 955-8812 Mail claims to: 445 Grant Ave, Suite 700, SF, CA 94108	**All UM Decisions: CCHP** Phone 1(877) 208-4959 Fax 1(415) 398-3669	1(415) 547-7800
KSR	**All claims: Kaiser** Member Services 1(800) 390-3510 Mail claims to: 2425 Geary Blvd, SF, CA 94115	**All UM decisions: Kaiser** Phone 1(415) 833-2801 Fax 1(415) 833-2657	1(800) 464-4000
NEMS	**All claims: NEMS MSO** Phone 1(415) 352-5186, Option 2 Fax 1(866) 930-2290 Mail claims to: 369 Broadway Street, SF, CA 94133	**All UM decisions: NEMS MSO** Phone 1(415) 352-5186, Option 1 Fax 1(415) 398-2895	1(415) 547-7800
NEMS with SFHN	**All claims: NEMS MSO** Phone 1(415) 352-5186, Option 2 Fax 1(866) 930-2290 Mail claims to: 369 Broadway Street, SF, CA 94133	**All UM decisions: NEMS MSO** Phone 1(415) 352-5186, Option 1 Fax 1(415) 398-2895	1(415) 547-7800
UCSF	**All claims: SFHP** Phone 1(415) 547-7818 x7115 Mail claims to: P.O. Box 194247, SF, CA 94119	**All UM decisions: SFHP** Phone 1(415) 547-7818 x400 Outpatient Fax: 1(415) 357-1292 Inpatient Fax: 1(415) 547-7822	1(415) 547-7800
Non-Specialty Mental Health Benefit Managed by Beacon Health Strategies			
All Networks except Kaiser	**All claims: Beacon** Phone 1(855) 371-8117 Mail claims to: 5665 Plaza Drive, Suite 400, Cypress, CA 90630	**All screening/UM: Beacon** Phone 1(855) 371-8117 Fax: 1(866) 422-3413	1(855) 371-8117

7. Provider Directories

San Francisco Health Plan publishes provider directories for each line of business (Medi-Cal, Healthy Kids HMO, and Healthy Workers HMO). 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 ext. 7084. The provider directories are also available and searchable on the SFHP website at https://sfhp.healthtrioconnect.com/public-app/consumer/provdir/

8. 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), the Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA) 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.

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 ensure that SFHP routinely monitors its delegates' 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), applicable laws and regulation, 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 Oversight Committee will discuss the case. The Provider Network Oversight 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.

9. 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

Public Health Insurance Program Eligibility

SFHP arranges health care services for its members enrolled in the Medi-Cal (MC), Healthy Kids HMO (HK) and Healthy Workers HMO (HW) programs. Each program has its own eligibility and enrollment guidelines and prior to enrolling at SFHP, individuals must be deemed eligible by these programs prior to joining SFHP as a member.

Each program is administered by an agency separate from SFHP, with the exception of Healthy Kids HMO which is administered jointly by the San Francisco Department of Public Health and SFHP and regulated by the Department of Managed Health Care (DMHC).

Medi-Cal (MC)

Medi-Cal provides free and low-cost health care coverage services to low income adults, families with children, pregnant women, seniors, people with disabilities, children in foster care and adults formerly in foster care up to age 26. Certain populations, including adults, families with children, and seniors and people with disabilities, are required to enroll in Medi-Cal managed care, while other Medi-Cal enrollees, such as those with a Share of Cost, do not receive their Medi-Cal services through a managed care plan and remain in fee-for-service Medi-Cal. SFHP is one of two Medi-Cal managed care plans authorized by the California Department of Health Care Services (DHCS) to serve Medi-Cal members in San Francisco.

There are different types of Medi-Cal coverage, ranging from limited scope coverage (such as pregnancy related only services) to full scope coverage that is inclusive of primary, specialty, behavioral health, acute care services, vision and dental.

All SFHP Medi-Cal members have full scope Medi-Cal coverage. For most SFHP members, such as adults and seniors and people with disabilities, there is no cost sharing (premiums or copays). A small percentage of children over the age of 1 year in families with incomes above 160% of the federal poverty level pay low cost premiums.

Individuals can apply for Medi-Cal in person, online, via mail or over the telephone. In addition, SFHP is a Certified Medi-Cal Managed Care Enrollment Entity and our Service Center provides in person enrollment assistance for Medi-Cal, HK, HSF and Covered CA. Medi-Cal eligibility is determined by eligibility workers at the San Francisco Human Services Agency (HSA). Additionally, SFHP members may be enrolled in Medi-Cal due to their enrollment in other social services programs, such as CalWORKS, TANF, and SSI.

Application Resources:

- Apply online at https://www.mybenefitscalwin.org/ or http://www.coveredca.com/apply/

- Apply over the phone or in person
  Toll Free (855) 355-5757
  1440 Harrison Street
  San Francisco, CA 94103
  Monday - Friday from 8:00 a.m. to 5:00 p.m.

- SFHP Service Center
  7 Spring St.
  San Francisco, CA 94104
  Monday – Friday from 8:30 a.m. to 5:00 p.m.

(415) 777-9992 to schedule an appointment

- Submit application by mail or email
  Human Services Agency
  PO BOX 7988
  San Francisco, CA 94120
  SFMedi-Cal@sfgov.org

Healthy Kids HMO (HK)
HK is a health insurance program funded by the City and County of San Francisco for low to moderate income children ages 0 through 18 (inclusive) in San Francisco that are ineligible for other public health insurance programs. HK provides comprehensive health, vision and dental services to children in families with incomes up to 322% of the Federal Poverty Level regardless of immigration status. SFHP provides eligibility determination for HK at the SFHP Service Center. HK assesses modest premiums and copays and financial assistance is available via premium assistance. SFHP is the only health plan that serves HK members in the City and County of San Francisco.

To apply:
SFHP Service Center
7 Spring St.
San Francisco, CA 94104
Monday – Friday from 8:30 a.m. to 5:00 p.m.
(415) 777-9992 to schedule an appointment

Healthy Workers HMO (HW)
HW is a health insurance program 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. For IHSS Public Authority employees, eligibility is determined through the IHSS Public Authority and for IHSS Consortium employees, eligibility is determined through Homebridge. Eligibility for temporary, exempt as-needed employees is determined by the Department of Human Resources and is based on length of time employed and hours worked.

To apply:

In-Home Supportive Services (IHSS) Employees should contact IHSS Public Authority at **(**415) 243-4477.

IHSS Consortium employees should contact the Homebridge at (415) 255-2079 or (800) 283-7000.

Temporary, Exempt As-Needed Employees should contact the Department of Human Resources at (415) 557-4942.

2. Medi-Cal and Health Care Options; Fee-For-Service vs. Medi-Cal Managed Care

The San Francisco Health Plan is one of two Medi-Cal managed care plans that maintains a contract with the California Department of Health Care Services to provide comprehensive Medi-Cal benefits to Medi-Cal enrollees in San Francisco. Anthem Blue Cross is the other Medi-Cal managed care plan that is contracted with the DHCS for San Francisco. Certain populations, including adults, families with children, and seniors and people with disabilities, are required to enroll in Medi-Cal managed care, while other Medi-Cal enrollees, such as those with a Share of

Cost, do not receive their Medi-Cal services through a managed care plan and remain in fee-for-service Medi-Cal. Individuals with dual Medicare and Medi-Cal coverage, sometimes referred to as "Medi-Medi" or "duals" are not required to enroll in Medi-Cal managed care. However, duals may choose to enroll in Medi-Cal managed care.

In San Francisco, populations required to enroll in Medi-Cal managed care are offered a choice of SFHP and Anthem Blue Cross. Enrollment into a health plan is carried out by a statewide third-party administrator, Health Care Options (HCO). HCO provides information to Medi-Cal beneficiaries about their SFHP and Anthem Blue Cross health plan options through local HCO representatives and are located at the MC or CalWORKs offices. Enrollment into a health plan usually takes from 15 to 45 days from the effective date of MC eligibility. Once enrolled in a health plan, Medi-Cal members may change their health plan on a monthly basis.

Health Care Options (HCO):
Health Care Options is the statewide third-party administrator for Medi-Cal Managed Care. HCO can provide information on enrollment, disenrollment and Medi-Cal Managed Care Health Plans.
Phone: 1(800) 430-4263

3. Community Relations Support Towards Access

SFHP Community Relations supports SFHP's efforts towards universal coverage, quality care and access, and exemplary service to its members and providers. By partnering with the diverse community based organization and public entities that serve our members and providers, the Community Relations team works to increase access to quality health care in San Francisco. The Community Relations team 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 communityrelations@sfhp.org.

4. Verifying Eligibility: Web, Interactive Voice Response and Point-of-Service (POS) Machines

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.

To Verify Eligibility and Enrollment:
1. Ask for the member's SFHP ID Card

2. Check eligibility using the Provider Secure Website at www.sfhp.org/providers/ **OR** Call the SFHP Interactive Voice Response system (IVR) at 1(415) 547-7810, 24 hours a day 7 days a week. **OR** Call the SFHP Customer Service Department at 1(415) 547-7800 Monday-Friday, 8:30am-5:30pm
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 to a PCP who is accepting new patients. 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, with dignity, no matter what your gender, culture, language, appearance, sexual orientation, race, disability and transportation ability is, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan, our services, including Covered Services, our practitioners and providers and your rights and responsibilities..
- To be provided information about all health services available to you, including a clear explanation of how to get them.
- To be able to choose a primary care provider within the Contractor's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To be able to have candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- To voice complaints or grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record.

- To disenroll upon request. Beneficiaries that can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs; and members with special health care needs.
- To access Minor Consent Services.
- To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Contractor, providers or the State.
- To make recommendations regarding our member rights and responsibilities policy.
- Right to oral interpretation should be at no cost to the member

San Francisco Health Plan members have the responsibility to:

- Carefully read all SFHP materials immediately after you are enrolled so you understand how to use your SFHP benefits.
- Ask questions when needed.
- Follow the provisions of your SFHP membership as explained in this Handbook.
- Be responsible for your health understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Follow the treatment plans your provider develops for you and consider and accept the possible consequences if you refuse to follow with the treatment plans or recommendations.
- Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
- Make and keep medical appointments and let your provider know ahead of time when you must cancel.
- Communicate openly with your provider so you can develop a strong partnership based on trust and cooperation.
- Offer suggestions to improve SFHP.
- Help SFHP and your providers maintain accurate and current medical records by providing information promptly about changes in address, family status, other health plan coverage, and information needed to provide you with care.
- Notify SFHP as soon as possible if you are billed inappropriately or if you have any complaints.
- Treat all SFHP staff and health professionals respectfully and courteously.
- As required by Medi-Cal Program, pay any premiums, co-payments and charges for non-covered services on time.
- You may refuse, for personal reasons, to accept procedures or treatment recommended by your medical group or primary care provider. If you refuse to follow a recommended treatment or procedure, your medical group or primary care provider will let you know if he or she believes that there is no acceptable alternative treatment. You may seek a second opinion as provided in this Handbook. If you still refuse the recommended treatment or procedure, then SFHP has no further responsibility to provide any alternative treatment or procedure that you seek.
- Using your ID cards properly.
  Bring your SFHP ID card, a photo ID, and your Medi-Cal ID card with you when you come in for care
- Telling us if you receive care at a non-SFHP contracted facility/provider.

- If you require an interpreter, you should request an interpreter in advance prior to your appointment.

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 can be provided through:

- Point of service interventions (during or following an encounter, upon discharge from hospital, etc.)
- 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 address risk-reduction and healthy lifestyles, such as:
    - Nutrition
    - Weight control and physical activity
    - Tobacco use and cessation
    - Alcohol and drug use
    - Injury prevention
    - HIV/STI prevention
    - Family planning
    - Parenting
    - Immunizations
    - Dental care
- Educational interventions designed to assist members to follow self-care regimens and treatment therapies for chronic disease and other health conditions, including:
    - Pregnancy
    - Asthma
    - Diabetes
    - Tuberculosis
    - Hypertension
    - Substance abuse

Medical groups must maintain a member-accessible list of all health education classes and services that take place within their network and inform the Program Manager, Population Health of any changes or updates. SFHP also maintains a Health Education Library with low-literacy health education resources on a variety of health topics in all of SFHP's threshold languages. Visit http://www.sfhp.org/members/health-wellness/health-education-library/ for more information.

Requests for printed materials and additional educational resources are to be directed towards the Program Manager of Population Health at: HealthEducation@sfhp.org or 1(415) 615-5149.

8. Cultural and Linguistic Services

All non-English, monolingual, hearing impaired, and Limited English Proficient (LEP) SFHP members must have access to no-cost linguistic services for all member service inquiries, and at all medically-related visits. Linguistic services may be provided by bilingual staff who are assessed for proficient language capacity. When bilingual staff are not available, interpreter services must be provided by a face-to-face interpreter, telephone language line, TDD/TTY service, or Video Monitoring Interpretation (VMI).

Members have a right to the following cultural and linguistic services from SFHP:

- No-cost linguistic services (through bilingual staff or interpreters) during face-to-face or telephonic contact with SFHP.
- Receive fully-translated documents in threshold and concentration languages such as health education materials, grievance letters, welcome packets, and marketing information. As of January 1st, 2015, SFHP's Medi-Cal threshold languages include English, Chinese (spoken: Cantonese; written: Traditional), Spanish, and Vietnamese. The Healthy Kids HMO threshold languages are English, Chinese (spoken: Cantonese; written: Traditional), and Spanish. The Healthy Workers HMO threshold languages are English, Chinese (spoken: Cantonese; written: Traditional), Spanish, and Russian.
- 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.

SFHP delegates the responsibility for providing interpreter services at all medical points of contact to its medical groups. Providing ongoing cultural awareness trainings to all staff and providers who interact with SFHP members is also a 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.

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

- Description of member's rights to 24-hour, no-cost interpreter services that is consistent with SFHP policies.
- Description of the use of bilingual providers and office staff, including policies for assessing bilingual staff language capacity. Assessment may include language capacity testing upon hiring, documenting the number of years of employment as an interpreter, completion of interpreter training, or completion of the ICE self-assessment tool.
- Description of how providers will access, arrange, and document the use of interpreters when bilingual providers and staff are not available. This includes spoken language and sign language services in modalities such as in-person, via phone, TDD/TTY, or video.
- Description of how the member's preferred language and refusal of interpreter services is documented in the medical record. The use of family members or friends as interpreters must be discouraged.
- Description of ongoing cultural awareness trainings for providers, office personnel and medical group staff who interact with members, and the process for documenting its completion. Training curriculum should cover the following topics, at a minimum: language access policies and procedures, working with interpreters and LEP members, cross-cultural communication strategies, strategies to address health literacy needs and health beliefs, strategies for working with Seniors and Persons with Disabilities.

SFHP monitors the medical group's compliance with Cultural and Linguistic Services through review of medical group policies and procedures in the annual audit process, member grievance review and trending, and the relevant sections of the DHS Medical Record Review/Facility Site Review.

Questions and requests for further information should be directed to the Program Manager of Population Health at: HealthEducation@sfhp.org or 1(415) 615-5149.

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:

- Medi-Cal: http://www.sfhp.org/members/programs/medi-cal/benefits_and_services.aspx
- Healthy Kids HMO: http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx
- Healthy Workers HMO: 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:

- Medi-Cal: http://www.sfhp.org/members/programs/medi-cal/benefits_and_services.aspx
- Healthy Kids HMO: http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx
- Healthy Workers HMO: 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

Other than cost-sharing, such as applicable copayments and deductibles, 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 and their authorized representatives may file a grievance by contacting the SFHP Customer Service Department, in person, 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 St., Ste. 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. A grievance must be filed within 180 calendar days following any incident or action that is the subject of the members' dissatisfaction. (Please note that SFHP has a separate process for Member Appeals and different filing deadlines may apply. Please reference the Member Appeals section for more information.)

With five (5) calendar days of receipt of a standard member grievance, SFHP sends an acknowledgment letter informing the member that SFHP received the 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.

A grievance may be expedited if it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major body function. If the grievance meets criteria for expedited processing, SFHP will provide a written statement to the member about the disposition or pending status of the grievance within three (3) calendar days of receipt of the grievance by SFHP.

SFHP staff may ask providers to provide additional information or directly respond to allegations brought forth in a member grievance. Providers must respond to SFHP staff as expeditiously as possible in order for SFHP to provide members with a resolution within 30 calendar days or 3 calendar days for expedited grievances.

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 at www.sfhp.org/about-us/grievance-form/ or via SFHP HealthLink, the Medi-Cal member portal.

Grievances can be submitted by mail, phone, or fax, to:

Grievance Coordinator
San Francisco Health Plan
P.O. Box 194247
San Francisco, CA 94119
Phone: 1(800) 288-5555
Phone: 1(415) 547-7800
Fax: 1(415) 547-7825

Grievances can be filed in person at:
San Francisco Health Plan
Service Center
7 Spring Street
San Francisco, CA 94104

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.

Discrimination Prohibited – Providers are prohibited from discriminating against a SFHP member on the grounds that the member filed a grievance or appeal. 28 CCR § 1300.68(b)(8).

2. Member Appeals

SFHP maintains a Member Grievances and Appeals policy and procedure. SFHP medical groups, except for Kaiser Foundation Health Plan, are not delegated for appeal resolution.

Appeals are defined as requests to change a previous decision made by SFHP or its Delegates. SFHP or Delegate decisions are provided to the member in writing in a Notice of Action (NOA), a formal letter informing the member that a medical service has been denied, partially denied, or deferred. Medi-Cal members have sixty (60) days from the date of the NOA to file an appeal with SFHP. Healthy Workers HMO and Healthy Kids HMO members have 180 days from the date of the NOA to file an appeal with SFHP.

SFHP members or their authorized representatives may file an appeal with the San Francisco Health Plan in person, by mail, phone, fax, email, or through our website. In addition, provider(s) may file an appeal on behalf of the member with the member's consent by contacting SFHP's Customer Service through the mail, phone, fax, email or through our website.

Providers who are disputing a Notice of Action for the purposes of getting reimbursement for services already rendered may request review through the Provider Dispute Resolution Process. Please refer to the Provider Dispute Resolution section of this manual.

SFHP Department	Mail Address	Phone/Fax	Email	Website
Customer Service	San Francisco Health Plan Attn: Customer Service P.O. Box 194247 San Francisco, CA 94119	**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: *Report a Problem* leads to the grievance form
Utilization Management	San Francisco Health Plan Attn: Utilization Management P.O. Box 194247 San Francisco, 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*

With five (5) calendar days of receipt of a standard appeal, SFHP sends an acknowledgment letter informing the member and/or provider that SFHP received the appeal. San Francisco Health Plan's clinical grievance staff collects from SFHP, or from the respective delegated medical group for which utilization management is delegated, all of the clinical information relevant to the appeal. This may include the provider's authorization request and any accompanying clinical information, the deferral or modification of care letter sent related to the denial, as well as any additional information that may be available from the member or provider. SFHP staff may ask providers to provide additional information or directly respond to allegations brought forth in a member appeal. Providers must respond to SFHP staff as expeditiously as possible in order for SFHP to process the appeal within the timeframes required by law. An MD who was not involved in the intial determination will review the appeal. The MD reviews the available documentation and determines whether or not to uphold the original determination. SFHP may elect to send the appeal review to an external contracted entity for review and decision. SFHP may implement the decision recommended by the external contracted entity.

The SFHP clinical grievance staff will send a Notice of Appeal Resolution letter to the member within 30 calendar days. It will be sent in the member's preferred language if the member's language is English or one of SFHP's threshold languages. Information and forms regarding external appeal options (such as State Fair Hearings and Independent Medical Reviews) will be attached to the Notice of Appeal Resolution letter.

An appeal may be expedited if it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major body function. If the appeal meets criteria for expedited processing, SFHP will provide a written statement to the member about the disposition or pending status of the grievance within three (3) calendar days of receipt of the grievance.

In most cases, members are required to exhaust SFHP's appeal process prior to requesting an IMR or State Hearing. The following no-cost options may be available to SFHP members who wish to dispute a Notice of Action:

- Only Medi-Cal Members may request a State Hearing within 120 days of the mailing of the "Notice of Appeal Resolution" letter. Members may request a State Hearing without first appealing to sFHP is they have an expedited complaintor the member has waited more than 30 days for a resolution from SFHP.
- Medi-Cal, Healthy Kids HMO, and Healthy Workers HMO Members may request an Independent Medical Review (IMR) regarding the Notice of Action from the Department of Managed Health Care (DMHC) within 180 days from the date of the Notice of Appeal Resolution. Please see the Department of Managed Health Care (DMHC) Independent Medical Review (IMR) section. Members may qualify for IMR without first appealing to SFHP if they have an expedited complaint, the requested service was denied for experimental/investigational reasons, or the member has waited more than 30 days for a resolution from SFHP.

Medi-Cal members may ask for both an IMR and a State Hearing at the same time. However, if a Medi-Cal member asks for a State Hearing first and the State Hearing has already taken place, the member cannot ask for an IMR.

Members can also file a grievance that is **not** about a Notice of Action. Please reference the Member Grievance section.

Discrimination Prohibited – Providers are prohibited from discriminating against a SFHP member on the grounds that the member filed a grievance or appeal. 28 CCR § 1300.68(b)(8).

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) or Consumer Complaint

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. If the member's complaint do not meet these criteria, DMHC will still process the case as a Consumer Complaint.
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, has complaint forms, IMR application forms, and instructions. Consumer Complaint and IMR forms are available in multiple languages.

In most cases, SFHP must provide a decision or grievance resolution to the member within 30 days before the member can apply for IMR. Members do not need to participate in SFHP's grievance process prior to applying for an IMR for review of an urgent issue. IMR is not available to Medi-Cal members who have presented a disputed health care service service for resolution by the Medi-Cal State Fair Hearing process.

If SFHP determines upon receipt of a non-expedited Comsumer Complaint/IMR that the member's issue has not been processed through the SFHP grievance process, SFHP can request that the Consumer Complaint/IMR request be returned to SFHP for review. DMHC informs the member 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. SFHP will then process the member's complaint through the SFHP grievance process within 30 days of the date of receipt of the Consumer Complaint/IMR request.

When DMHC notifies the SFHP that a request for a Consumer Complaint/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 five (5) business days for a standard request, or within 24 hours of DMHC notification for an expedited request, or as otherwise indicated by DMHC in the Department Request for Health Plan Response form.

When the DMHC notifies the SFHP that a case qualifies for a Comsumer Complaint/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.

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 24 hours of receipt of IMR determination.

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

Action	Expedited	Standard
DMHC notifies physician and SFHP if application is eligible	Within 48 hours after receipt of application	Within seven (7) calendar days after receipt of application
SFHP returns the Health Plan Information Form to DMHC	Within 24 hours of DMHC notification	Within five (3) workingcalendar days of DMHC notification
SFHP submits medical records to IMR	Within one (1) calendar day of DMHC notification	Within three (3) working days of DMHC notification
SFHP provides additional information to IMR	Within one day of receipt if requested by DMHC	Within five (5) calendar days or less if requested by DMHC
IMR makes determination	Within three days of receipt of records (usually 7 days from receipt of application), may take longer for experimental care	Within 21 days of receipt of records (usually 30 days from receipt of application)
DMHC issues written decision	Within one (1) day of receipt of IMR determination	Within three (3) days of receipt of IMR determination
SFHP or medical group authorizes or pays for approved treatment	Within 24 hours of receipt of IMR determination	Within five (5) working days of receipt of IMR determination

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.

Members may request a State Hearing from the Department of Social Services (DSS) within 120 days of the mailing of the "Notice of Appeal Resolution.

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

If the case is presented at a hearing before a DSS administrative law judge, the DSS judge generally makes a final decision within 90 days from the date of filing a request for hearing.

Section 5: Member Transfers/Disenrollments

1. Disenrollment Agencies

Please address disenrollment requests to the appropriate agency:

Line of Business	Agency	Telephone Number
Medi-Cal	Health Care Options	1(800) 430-4263
Healthy Workers HMO	IHSS Department of Human Resources for as-needed employees of City and County of San Francisco	1(415) 243-4477 1(415) 557-4942
Healthy Kids HMO	SFHP	1(415) 547-7800

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 – 22 CCR §53887) if he/she has 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.

The eligible member or other authorized individuals (as defined by state law– 22 CCR §53889(h)) should submit a disenrollment request to Health Care Options by mail or in person. Expedited disenrollments may also be submitted by facsimile or by phone. Heath Care Options will process the disenrollment to determine if the member meets criteria

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. Members enrolled in hospice are not disenrolled from Medi-Cal managed care.

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 remains responsibile 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. Kidney and cornea transplants are not considered "major organ transplants;' the cost of these surgeries are the responsibility of of SFHP or the delegated medical group, and these Medi-Cal members should not be disenrolled.

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.

Medi-Cal managed care members who are disenrolled into fee-for-service Medi-Cal due to a major organ transplant may be re-enrolled into Medi-Cal managed care 12 months after the transplant. Members enrolled in SFHP's non-Medi-Cal lines of business are not disenrolled

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 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: Health Services

Subsection 1: Quality & Performance Improvement

1. Quality Improvement Program

San Francisco Health Plan is committed to continuous quality improvement of its health care delivery system. The purpose of the SFHP Quality 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. The QI Program is designed to ensure that members have access to quality health care services that are safe, effective, and meet their needs.

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 for Specialty Mental Health Services for SFHP Medi-Cal members and is fully delegated to provide mental health services to eligible Healthy Worker HMO and Healthy Kids HMO members. SFHP covers outpatient mental health services that are within the scope of the Primary Care Physician for all SFHP members, and non-specialty mental health services for Medi-Cal members.

Under the leadership of the SFHP Governing Board, the Quality Improvement Program is developed and implemented through thye Quality Improvement Committees . The QI Committee, under the leadership of the SFHP Chief Medical Officer, assures ongoing and systematic interaction between the health plan and its key stakeholders: members, medical groups and practitioners.

The QI Program objectives and outcomes are detailed in the QI Work Plan included as an appendix in each year's Plan. Each program objective is monitored at least quarterly and evaluated at the end of each year. Measures and targets are selected based on volume, opportunities for improvement, risk, organizational priorities, and evidence of disparities.

The scope and goals of the QI Program are comprehensive and encompasses major aspects of care and services in the SFHP delivery system, and the clinical and non-clinical issues that affect its membership. These include:

- Improving the health status of our members
- Ensuring continuity and coordination of care
- Assuring access and availability of care and services
- Ensuring member knowledge of rights and responsibilities
- Assuring that health care practitioners are appropriately credentialed and re-credentialed
- Ensuring timely communication of DHCS standards and requirements to participating medical groups and organizational providers
- Assuring effective and appropriate utilization management of health care services, including medical, pharmaceutical, and behavioral health care services
- Providing complex case management
- Providing culturally and linguistically appropriate services
- Providing a disease management program
- Providing health education resources
- Ensuring patient safety

- Ensuring excellent member experience of care
- Assuring that responsibilities delegated to medical groups meet plan standards
- Evaluating the overall effectiveness of the QI Program through an annual, comprehensive program evaluation
- Use of the annual evaluation to update the QI Program and develop an annual QI Work Plan

2. Providers Involvement in the QI Program

Providers cooperate with all independent quality review and improvement activities required by their contracted medical group or SFHP pertaining to the provision of services to members. Providers allow their contracted medical group and SFHP access to their facilities for the purpose of site review, case management and other quality management activities. SFHP may utilize practitioner or provider performance data for quality improvement activities such as HEDIS and pay for performance.

San Francisco Health Plan contracts with health care providers, including organized medical groups and their associated hospitals, to provide members with medical care. SFHP maintains responsibility for communicating regulatory and contractual requirements, and policies and procedures to participating network providers. SFHP retains full responsibility for its Quality Improvement Program, and does not delegate quality improvement oversight except in certain instances.

Providers are involved in the QI program through committee membership and data sharing. SFHP has numerous committees with provider leadership representation to provide guidance and support, see the Quality Committee Structure for details.
SFHP informs its participating providers and members of its QI program and ongoing QI activities through the SFHP provider newsletter, the Network Operations Manual, and annual member mailing.

Provider may, in good faith, communicate with a Member regarding any and all available treatment options related to Member. Provider provides information regarding treatment options (including the option of no treatment) to all Members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and individuals with physical or mental disabilities, in a culturally-competent manner. Providers use best efforts to ensure that Members with disabilities have effective communication with Provider in making decisions regarding treatment options.

Provider cooperation in QI Program is required regardless of members' benefit coverage limitations.

3. 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 that meets six times a year. It is the main forum for oversight of SFHP's health care delivery system and for member and provider participation in assuring the quality of the delivery system. The committee is responsible for reviewing and approving the annual QI Program and Quality Improvement (QI) Evaluation, and for providing oversight of the Plan's quality improvement activities. SFHP brings new programs designed for quality improvement to the QIC to ensure the committee members contribute to the planning, design,

and implementation of new programs. SFHP maintains an annual calendar to ensure that key SFHP QI activities are brought to the QIC for ongoing review. This includes review and approval of policies and procedures related to quality improvement and delegation oversight. SFHP maintains minutes of each QIC meeting, provides them to the Governing Board for review and approval, and submits these to DHCS on a quarterly basis. The QIC meetings are open to the public. In addition, QIC agendas and minutes are published on SFHP's website.

A **Pharmacy and Therapeutics Committee** comprised of network physicians and pharmacists convene quarterly to review and approve the SFHP Formulary and approval criteria for covered outpatient prescription medications. The P&T Committee is responsible for annual approval of the pharmacy clinical policies and procedures for formulary, prior authorization, monitoring of utilization rates and timeliness of reviews, and DUR processes. The committee meets quarterly and on an ad hoc basis and reports to the QIC.

The Physician Advisory/Peer Review/Credentialing Committee (PAC) provides comments and recommendations to SFHP on standards of care and peer review. The PAC serves to address concerns or identified problems related to issues of quality of medical care and provider/practitioner safety. The Medical Board Hot Sheet is reviewed by SFHP monthly to ensure that any identified providers with investigations or actions are brought to the PAC for review. The PAC also reviews credentials, approves practitioners for participation in the SFHP network, and reviews the credentialing policies and activities of entities delegated for credentialing. The PAC meets every two months and reports to the QIC in closed session.

SFHP Staff Responsibilities

The **Health Services (HS) department** has primary accountability for implementing the annual QI Program and corresponding QI Work Plan. The department is organized to provide inter-disciplinary involvement in assuring the quality of medical care and services provided to SFHP's membership. Health Services staff monitors quality indicators, and implements and evaluates the Plan's quality improvement activities. Health Services' staff develop and comply with policies and procedures describing SFHP standards, legislative and regulatory mandates, contractual obligations and, as applicable, NCQA standards. Based on the QI Work Plan activities, HS staff provide summary data, analysis, and recommendations to the QIC.

The **Health Services 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 Health Services Department assures the timely resolution of complaints and appeals. Both departments respond to the questions and concerns of members and providers. Health Servicesmaintains 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 Network Operations (PNO) Department** is responsible for those aspects of the QI Program that relate to evaluation of provider qualifications and network performance. The PNO department coordinates oversight of all delegated activities and monitors the implementation of corrective action plans. It is responsible for new provider orientation and education, facility site reviews and conducting and analyzing provider satisfaction surveys. Also, the PNO department is responsible to ensure SFHP's provider network can adequately meet the needs of SFHP's membership including analysis of provider to member ratios, availability of high impact and high volume specialist and executing letters of agreement for ad hoc request for services outside of SFHP's contract provider network.

The **Compliance and Regulatory Affairs Department** is responsible for assuring that Health Services Policies remain compliant with Federal, State, and NCQA requirements. This department provides direction on upcoming All Plan Letters (APL) and the impact on operations. All Plan Letters (APLs) are the means by which the state of California conveys information or

interpretation of changes in policy or procedure at the Federal or State levels, and provides instruction to contractors, if applicable on how to implement these changes on an operational basis. A representative of the Compliance and Regulatory Affairs department presents policies to the Quality Improvement Committee as appropriate.

4. Measuring Quality

San Francisco Health Plan evaluates the overall effectiveness of the Quality Improvement Program through an annual, comprehensive evaluation process that results in a written report, which is submitted to DHCS. The report includes an executive summary and a summary of all quality indicators, identifying significant trends and areas for improvement. For each item in the QI Work Plan, the evaluation includes the following elements:

- Brief description of the QI activity/intervention and how it purports to improve care or service quality.
- Target(s) of the QI activity/intervention
- Measures / Metrics used to demonstrate the efficacy of the QI activity/intervention
- Results
- Barriers that impeded the QI activity from demonstrating effectiveness
- Recommended interventions/actions to overcome barriers in the following year

Results of the annual evaluation, in combination with information and priorities determined by the HS leadership and staff, are reviewed and analyzed in order to develop an annual QI Work Plan (Appendix I). This comprehensive set of measures and indicators is divided into six domains:

1. Clinical Quality and Patient Safety
2. Quality of Service and Access to Care
3. Utilization Management
4. Care Coordination and Services for Members with Complex Health Needs
5. Delegation Oversight
6. Quality Improvement Committee Activities

Identification of Important Aspects of Care

SFHP identifies priorities for improvement based on regulatory requirements, NCQA standards, data review, and provider and member identified opportunities in the key domains of Clinical Quality & Patient Safety, Quality of Service & Access to Care, Utilization Management, Care Coordination & Services for Members with Complex Health Needs, and Delegation & Oversight. Particular attention is paid to those areas that are high risk, high volume, high cost or problem prone.

The QI Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. The QI Program uses the following method to improve performance:

1. Establish targets and/or benchmarks for key indicators within each domain
2. Systematically collect data
3. Analyze and interpret data at least annually
4. Identify opportunities for improvement
5. Prioritize opportunities
6. Establish improvement objectives in support of priorities
7. Design interventions based on best practices or previous interventions
8. Implement and track progress of interventions
9. Measure effectiveness of interventions based on progress toward standards or benchmarks

Data Systems and Sources

- ***Health Effectiveness Data and Information Set (HEDIS)***

The External Accountability Set Performance Measures, a subset of HEDIS, are calculated, audited and reported annually as required by DHCS. Depending on the measure and per DHCS mandate, measures utilize administrative data (claims, encounters, supplemental lab sources) and data collected via chart review. HEDIS Compliance Audit services are provided by the Health Services Advisory Group (HSAG) per DHCS mandate. Final results are reported to DHCS, and submitted to NCQA via the Interactive Data Submission System (IDSS).

- ***Consumer Assessment of Healthcare Providers and Systems (CAHPS)***

SFHP evaluates member experience annually through CAHPS survey. Primary care clinics and medical groups are rewarded for improvement in CG-CAHPS (CAHPS Clinician & Group Surveys) via SFHP's Practice Improvement Program (PIP). Provider groups either conduct their own CG-CAHPS survey or SFHP conducts the survey on their behalf. Additionally, Health Plan CAHPS is conducted every three years by DHCS and, as of 2014, annually by SFHP.

- ***Practice Improvement Program (PIP)***

Medical groups and outpatient clinics participating in the PIP program may select to self-report data for some of the measures included in the measure set. From the PIP 2016 Program Guide, these measures include:

- Clinical Quality Domain: Diabetes HbA1c Test, Diabetes HbA1c <8, Diabetes Eye Exam, Routine Cervical Cancer Screening, Routine Colorectal Cancer Screening, Labs for Patients on Persistent Medications, Smoking Cessation Intervention, Controlling High Blood Pressure, Adolescent Immunizations, Childhood Immunizations, Well Child Visits for Children 3-6 Years of Age
- Patient Experience Domains that are impacted by Clinic Operations: Third Next Available Appointment, Show Rate, Office Visit Cycle Time, Staff Satisfaction, CG-CAHPS
- Systems Improvement Domain: Expanding Access to Service, Follow-Up Visit After Hospital Discharge, Comprehensive Chronic Pain Management

5. Member Incentive Program for Preventive Care

SFHP monitors and reports on a variety of HEDIS measures focused on preventive services for women and pediatric populations. These include:

- Cervical Cancer Screenings
- Prenatal and Postpartum Care
- Childhood Immunization Status – Combo 3
- Immunizations for Adolescents – Combo 1
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents

To encourage members to receive high priority services, SFHP offers the following incentives:

- $50 gift card for childhood immunizations before age 2
- $25 gift card each for timely prenatal care, and a postpartum visit within 21-56 days after delivery
- $25 gift card for a well-child visit for children age 3-6
- $25 gift card each for a diabetes eye exam, and additional diabetes screenings (HbA1c, blood pressure, monitoring for nephropathy)

- $25 gift card for a blood pressure check for members with hypertension
- $25 gift card for completing an asthma control test for members with asthma

For more information about SFHP's member incentives, visit http://www.sfhp.org/providers/member-incentives/ or email SFHP's Program Manager of Population Health at HealthEducation@sfhp.org.

6. Patient Safety

SFHP is committed to the safety of its members. Current patient safety initiatives include the following:

- **SFHP Pain Management Program** – SFHP conducts trainings for providers and clinic staff on opioid prescribing managing pain safely. SFHP is working with external and internal experts to provide clinical and non-clinical pain management resources to the community. SFHP also co-leads the San Francisco Safety Net Pain Management Workgroup and has pain management as a standing topic on the SFHP Pharmacy & Therapeutics Committee.

- **Medication Therapy Management (MTM) Program** – Throughout fiscal year 2015-16, SFHP is working to develop telephonic medication reconciliation and a teaching intervention program for Medi-Cal members discharged from acute inpatient facilities with specific disease states (i.e. congestive heart failure, pneumonia, COPD). Comprehensive medication reviews and medication teaching will be performed for targeted members to increase medication adherence and comprehension. SFHP's Care Coordination Pharmacist will also perform MTM outreach for selected high risk Disease Management Community Based Care Management, and Complex Medical Case Management members. More information on this program can be found on our website, at www.sfhp.org/providers/pain-management
- **Nurse Advice Line -** The Nurse Advice Line is a service that provides members with 24/7 telephonic access to a health care professional. During a call, a nurse assesses the caller's symptoms, determines the appropriate level of care needed, suggests a self-care plan, if appropriate, or directs the members to a physician, or if necessary, urgent or emergency care. The service is available to all SFHP members, with interpretation services available as needed. SFHP receives monthly activity reports and evaluates the member encounter data to monitor the quality of the member interactions.
- **Discharge Planning –** San Francisco Health Plan (SFHP) manages members in the acute or Skilled Nursing Facility (SNF) care setting and creates a plan of action to create a medically safe and effective transition to an alternate level of care for all UCSF and Out of Medical Group CHN members. The SFHP UM Nurse Coordinators, Complex Medical Case Management, and Care Coordination staff collaborates internally and with the acute care and SNF facilities to ensure that discharge needs are met. These include medically necessary care services, and support services in the community for the member upon discharge. In collaboration with the San Francisco Health Network (SFHN), SFHP also coordinates timely post discharge follow-up.

7. Initial Health Assessment (IHA) and Staying Healthy Assessment

All newly-enrolled Medi-Cal members are expected to receive an Initial Health Assessment (IHA) within 120 days of enrollment as mandated by DHCS. SFHP sends monthly reports to providers with demographic information about these new members, asking providers to outreach to these members to conduct an Initial Health Assessment. New members receive a mailing in their primary language encouraging them to make an appointment to receive this service. SFHP

monitors performance against this requirement by analyzing claims and encounter data to calculate the percentage of new members who receive an IHA visit within the DHCS-required periods. These results are then analyzed by medical group and clinics. As needed, SFHP requires a performance improvement plan for underperforming sites.

Providers are also required to administer the age-appropriate Staying Healthy Assessments, with state-approved questions designed to identify behavioral and other significant risk factors to be addressed by the PCP. SFHP ensures compliance with this requirement through facility site reviews and medical record reviews in compliance with Medi-Cal guidelines. SFHP provides training to providers about these assessments, and facilitates deeming of equivalent tools upon provider request.

In addition to the assessment above, all members over eighteen are required to have an annual screening for alcoholism, based on recommendations from the U.S. Preventive Services Task Force, with follow-up detailed assessment questions and brief interventions, when appropriate.

8. Pediatric and Adult Preventive Health Care Guidelines

SFHP pediatric and adult coverage benefits are available to the medical groups and provider offices via in the Evidence of Coverage document (Medi-Cal, Healthy Kids HMO and Healthy Workers HMO). SFHP refers providers to the following primary sources for preventive health guidelines: American Academy of Pediatrics (AAP), Advisory Committee for Immunization Practices (ACIP), and the U.S. Preventive Health Services Task Force (USPSTF).
The American Academy of Pediatrics provides recommendations for preventive pediatric health care in the following areas:

- History
- Measurements
- Sensory screening
- Developmental and behavioral assessment
- Physical examination
- Procedures (such as blood screening, blood lead screening, and tuberculosis testing)
- Oral health (fluoride varnish)
- Anticipatory guidance

The Advisory Committee for Immunziation Practices (ACIP) publishes adult and pediatric immunization schedules.

The US Preventive Health Services Task Force provides recommendations for adult preventive care including, but not limited to:

- Cancer screening (colorectal cancer, cervical cancer, breast cancer, etc.)
- Screening for chronic conditions (diabetes, high blood pressure)
- Obesity screening and counseling for nutrition and physical activity
- Depression screening
- HIV and STI screening and counseling
- Alcohol misuse and tobacco use screening and behavioral counseling

Recommendations with a grade of “A” are recommended by the USPSTF because there is a high certainty that the net benefit is substantial. Those with a grade of “B” are also recommended because there is a high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial. Services with a grade of C, D, or I are not recommended, and therefore not covered by SFHP.

Providers are instructed to document any parent or guardian or member refusals of any preventive services listed above, such as immunizations, blood lead screening, etc.

9. Fluoride Varnish

Fluoride Varnish is a Medi-Cal benefit that is a simple, cost-effective, proven method of preventing Early Childhood Caries (ECC) in children under the age of 6.ECC is the most common chronic childhood illness in the US and is largely preventable. Young children in San Francisco experience ECC at a higher rate than the national average, with low-income children at the highest risk. Fluoride Varnish application in the primary care setting for children under the age of 6 has been endorsed by the AAP, became a USPSTF recommendation in 2014, and has been a Medi-Cal benefit since 2006.

Important Fluoride Varnish information and considerations:

- Fluoride Varnish should be applied to children's teeth in the primary care setting, beginning at the first tooth eruption through age 5, up to three times per year
- Fluoride Varnish may be applied by any trained staff member
- The application requires no special equipment and is easy to apply with a prepackaged single use (unit dose) tube, which comes with a disposable applicator brush. It is swabbed directly onto the teeth in less than three minutes and sets within one minute of contact with saliva.
- Since many dentists are not willing to see young children, medical providers offer the best hope for preventing and controlling tooth decay through the application of Fluoride Varnish.
- If you are a CHDP provider seeking provider/staff training, please contact Margaret Fisher, RDHAP, BS, Oral Health Consultant from the San Francisco CHDP at (415) 575-5719. If you are a CHDP provider, she can set up 1-2 hour training in your office. If you are not a CHDP provider, please contact Abby Wolf, RN, PHN, SFHP Nurse Specialist, at awolf@sfhp.org or (415) 615-5100.
- For more information about children's oral health and Fluoride Varnish, please visit: http://www2.aap.org/commpeds/dochs/oralhealth/EducationAndTraining.html

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 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 California Code of Regulations Section 51305.1-51305.4, 51305.6-51305.7

2. Authorization Requests and Referrals

Utilzation Management (UM) decision making is based only on appropriateness of care and services, and existence of coverage. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's benefits and eligibility on the dates of service.

SFHP and its delegated medical groups do not reward or provide financial incentives to individuals performing utlization review services for issuing denials of coverage. There are no financial incentives for UM staff or independent medical consultants to encourage utilization review decisions that result in denials or underutilization. UM decisions are based solely on appropriateness of care and service, and existence of coverage.

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
- Urgent Care provided at an Urgent Care Center
- Preventive services (in-medical group)
- Referrals to specialists within 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 HMO or Healthy Workers HMO, the member must use the family planning, HIV testing and sexually transmitted disease (STD) 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 prior authorization for general anesthesia related to abortion. 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 HMO or Healthy Workers HMO, members must use the abortion services providers in their medical group.

Obstetric and gynecological (OBGYN) 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. Members may seek obstetrical and gynecological physician services directly from a SFHP obstetrician and ynecologist or directly from a SFHP family practice physician who is designated by SFHP as providing OBGYN services. SFHP members may also choose a SFHP obstetrician and gynecologist as their PCP if the obstetrician and gynecologist meets SFHP criteria for designation as a PCP.

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.

Out-of-Network Services
If SFHP or Delegated Medical Groups are unable to provide a necessary and covered service to a member in-network, the SFHP or Delegates, as applicable, adequately and timely cover these services out-of network, for as long as SFHP or Delegates are unable to provide the service. SFHP or Delegates, as applicable, coordinates payment with the out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network.

3. Inpatient Concurrent Review and Repatriation

San Francisco Health Plan has 24/7 coverage for inpatient utilization management, specifically to assist repatriation back to Zuckerberg San Francisco General (ZSFG) for members assigned to that hospital (members in the Community Health Network or CHN, including Healthy Workers HMO). 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 ZSFG. 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, seven (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 additional behavioral health services.

Behavioral health services available to members are dependent on SFHP line of business:

Medi-Cal

SFHP covers outpatient care for Medi-Cal members with mild to moderate dysfunction from a mental health disorder, as defined by the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. SFHP administers these "***non-specialty mental health services***" through Beacon Health Options ("Beacon") and College Health IPA ("CHIPA"). SFHP contracts with Beacon and CHIPA to process mental health-related claims and to assist SFHP Medi-Cal members in accessing mental and behavioral heath services.

Beacon Health Options
Member or Provider Services: (855) 371-8117
Fax: (562) 402--2666
TTY: (800) 735-2929
Beacon Provider Manual: https://www.beaconhealthoptions.com/providers/dashboard/

SFHP Medi-Cal members who need mental or behavioral health services should see their PCP for appropriate referral. Assessment is required to confirm a mental health diagnosis, and to evaluate for medical causes of symptoms before referral. In order to assess whether a SFHP Medi-Cal member needs non-specialty versus specialty mental health services, PCPs may use the behavioral health screening tool available in this Network Operations Manual or online at www.beaconhealthoptions.com under "Providers" and "Tools" and submit to Beacon in order to register services. PCPs may also have members contact Beacon for a telephonic screening or providers may contact Beacon to provide clinical data to make determinations regarding level of care.

The following non-specialty mental health services are covered when medically necessary and provided by PCPs or licensed mental health professionals in the Beacon provider network within the scope of their practice:

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation; and
5. Outpatient laboratory, drugs, supplies and supplements (excluding medications listed in the Medi-Cal Provider Manual at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan_z01.doc). Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

All of the above services are managed by Beacon except for outpatient laboratory, drugs, supplies and supplements, which are covered directly by SFHP.

Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and
3. Refer adults to San Francisco Community Behavioral Health Services (CBHS) for specialty mental health services when a mental health diagnosis covered by the MHP results in significant impairment; or refer children under age 21 to SFHP for specialty mental health services when they meet the criteria for those services.

When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a Beacon mental health provider for mild to moderate impairment of mental, emotional, or behavioral functioning or to CBHS for moderate to severe impairment.

Specialty mental health services are defined as services for patients with mental health diagnoses and severe dysfunction from these diagnoses. Specialty mental health services and substance use disorder services are not covered by SFHP or Beacon and are instead provided by Community Behavioral Health Services (CBHS) to Medi-Cal beneficiaries who meet criteria.

SFHP members may self-refer for specialty mental health and substance abuse services by calling the CBHS Access Hotline (1-800-870-8786) for triage. Members may also self-refer, by walking-in to any CBHS network behavioral health centers. When members receive specialty 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.

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

Healthy Kids HMO and Healthy Workers HMO
Mental health and substance use disorder services are available to HK and HW members through San Francisco Community Behavioral Health Services (CBHS).

SFHP members may self-refer for mental health and substance use disorder services by calling the CBHS Access Hotline (1-800-870-8786) for triage. Members may also self-refer, by walking-in to any CBHS network behavioral health centers. When members receive mental 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 use disorder services. Community Behavioral Health Services annually distributes a copy of its 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

There are services that minors do not need parental consent to receive. 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 of any age do have the authority to consent to abortions, birth control (except sterilization), rape, sexual assault, and diagnosis and treatment for pregnancy.Guardian consent or notification for these services is not allowed or required
Minors 12 years and older have the right to consent to mental health services, treatment for STIs, HIV testing (except when deemed incompetent, treatment for rape or sexual assault, and treatment for drug and alcohol abuse, except for methadone treatment,without guardian notification and consent. For sterilization procedures, however, the minor's guardian must consent and be notified and can have access to those records.

6. Denial of Authorization Request for Medical Services

Please see section 4, Member Grievances and Appeals.

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 may authorize 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

Although SFHP requires that covered services be obtained from contracted providers of the member's assigned 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
- 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

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 his/her 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 its 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 his/her 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 by DHCS. 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. Members enrolled in hospice are not disenrolled from Medi-Cal managed care.

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,, may become effective on the first day of the month following the member's month of admission and month after the admission to a LTC facility.

Requesting 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 remains responsible for the payment of LTC costs.

11. Major Organ Transplant

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, Healthy Kids HMO, and Healthy Workers HMO transplant services may be covered by California Children Services (CCS) until 21 years of age. SFHP and its delegated medical groups are responsible for the cost of covered medical care, including the cost of transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollment. SFHP does not guarantee the availability of a donor organ, and is not responsible for location of a donor or donor organ.

SFHP and its delegated medical groups are responsible for the cost of transplant-associated medical and hospital care for a donor or prospective donor, even if the donor is not a member of SHFP.

Organ transplants determined to be experimental or investigational are not a covered benefit of Medi-Cal, Healthy Kids HMO, or Healthy Workers HMO.

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 (CBAS)

Adult Day Health Care (ADHC) is provided to Medi-Cal qualified older adults and/or adults with disabilities (18 years and older) through Community-Based Adult Services (CBAS), as a medical model of care, in an outpatient day program (Monday through Friday). CBAS provides a comprehensive package of health, therapeutic and social services . The services are designed to prevent or delay unnecessary institutionalization and to keep individuals as independent as possible to age in the community. Services are provided in

a multicultural setting by a team of health care providers with capacity to speak the language of the people they serve. CBAS include the following services:

- An individual assessment and care plan
- Professional nursing services
- Physical, occupational and speech therapies
- Mental health services
- Therapeutic activities
- Social services and case management
- Personal care
- Therapeutic diet and nutritional counseling
- Transportation to and from the participant's residence and the ADHC center
- Other services, such as dementia care, Alzheimer's care, caregiver support, and peer support. Please contact the centers for these and other services they may provide.

The following are the ADHC centers in San Francisco providing CBAS services:

Center Name and Languages	Center Address	Phone Number
Bayview Hunters Point Adult Day Health Care Center Languages: English, Spanish	1250 LaSalle Avenue	(415) 826-4774
Circle of Friends Adult Day Health Care Languages: English, Russian	1550 Steiner Street	(415) 614-2233
Golden State Adult Day Health Care Languages: English, Russian, Chinese dialects	738 La Playa Street	(415) 387-2750
L'Chaim Adult Day Health Care Languages: English, Russian	2534 Judah Street	(415) 449-2900
Self-Help for the Elderly Adult Day Services Languages: English, Chinese dialects, Vietnamese,	408 22nd Avenue	(415) 677-7556
SteppingStone Golden Gate Day Health Languages: English, Chinese dialects, Spanish, Tagalog, and Japanese	350 Golden Gate Avenue	(415) 359-9210
SteppingStone Mabini Day Health Languages: English, Chinese dialects, Tagalog, Spanish, Korean, Vietnamese	55 Mabini Street	(415) 882-7301
SteppingStone Mission Creek Day Health Languages: English, Chinese dialects, Tagalog, Spanish, Russian	930 Fourth Street	(415) 974-6784
SteppingStone Presentation Day Health Languages: English, Chinese dialects, Korean, Russian, Vietnamese, Spanish, and Tagalog	301 Ellis Street	(415) 923-0245

Each center provides services in their clients' languages. Eligibility for CBAS is determined by SFHP through the Institute on Aging (IOA). If you would like to refer someone for an evaluation, please submit the referral form for CBAS located on the SFHP Web site here: http://www.sfhp.org/providers/download-forms/community-based-adult-services/

For information, please contact the centers above to arrange for a visit, or all the IOA at (415) 750-4111.

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, or 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.

SFHP non-Medi-Cal members in the Healthy Workers HMO and Healthy Kids HMO programs may self-refer to any provider who 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

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- Sexually Transmitted Infection (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 for outpatient sensitive services. SFHP non-Medi-Cal members in the Healthy Workers HMO and Healthy Kids HMO programs may self-refer to any provider who 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(STD)/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:

- Date letter is sent to member
- Member name and identifying information
- Service that was requested
- Requesting practitioner name and phone number
- Reason(s) 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
- 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

The following attachments must accompany the NOA:

- "Your Rights" document containing information on how to appeal the medical group's decision and how to request expedited review. The Your Rights document informs members how to file an appeal with SFHP or the Department of Managed Health Care (DMHC)and, for Medi-Cal members, how to request a State Fair Hearing. Note that the phone numbers and website information for the Department of Managed Health Care must be in **bold**.
- A document compliant with DHCS All Plan Letters 17-006 and 17-0011 that contains taglines informing members about free interpreter services in English, Arabic, Armenian, Chinese, Hindi, Hmong, Japanese, Korean, Cambodian, Farsi, Lao, Punjabi, Russian, Spanish, Tagalog, Thai and Vietnamese.
- A non-discrimination notice complaint with DHCS All Plan Letters 17-006 and 17-0011.

If the medical group denies a service that would otherwise be covered based on a determination that the service is experimental or investigational, the medical group must also include a copy of the DMHC independent medical review application, an envelope addressed to the DMHC and a Physician Certification form.

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.

Type of Decision	Decision Timeframe	Provider Notification Timeframe	Written Denial Notification Timeframe
Routine Pre-Service Non-Urgent	Five business days of receipt of necessary information	24 hours of making the decision	Two business days
Routine Pre-Service Urgent	72 hoursof receipt of necessary information	24 hours of making the decision	Two business days
Concurrent Non- Urgent review of (ongoing ambulatory services)	Five business days or less after obtaining all necessary information	24 hours of making the decision	Two business days
Concurrent – Urgent (review of inpatient acute care, long-term care, SNF, acute rehab).	24 hours of receipt of the request	24 hours of receipt of the request	Two business days
Retrospective/Post-Service review	30 calendar days of receipt of the request	30 calendar days of receipt of the request	30 calendar days

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 in section 1.7: Provider Network.

The formulary for SFHP members, with the exception of the Kaiser group, is managed by the SFHP pharmacy services department with oversight from the SFHP Pharmacy and Therapeutics Committee, a sub-committee of the SFHP Quality Improvement Committee.

For provider questions about the pharmacy network or for assistance with pharmacy claims processing, the below pharmacy benefits managers should be contacted.

Program	Pharmacy Benefits Manager (PBM)	PBM Phone Number
SFHP Medi-Cal, Healthy Kids HMO, or Healthy Workers HMO	PerformRx	1(888) 989-0091

For information about program-specific pharmacy benefits, exclusions or the pharmacy network visit www.sfhp.org or contact the SFHP Pharmacy Department at 1(415) 547-7818 x 7085.

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/formulary/prior-authorization-requests/

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 1(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/prior-authorization-requests/

For further information on the pharmacy prior authorization process, visit www.sfhp.org or contact the SFHP Pharmacy Department at 1(415) 547-7818 x 7085.

21. Case Management

Basic Case Management Services are provided by the primary care provider, in collaboration with SFHP. Complex Case Management Services are provided by the primary care provider, in collaboration with Delegated Medical Groups / SFHP. Certain Medical Groups for whom Care Management activities are not delegated may refer to either of the two SFHP Care Management

Department programs below. To refer a member, please call the SFHP Referral Intake Line at 415- 615-4515.

Community Based Care Management and Time Limited Care Coordination Programs: These SFHP care management programs provide community-based case management and coordination to community referrals for identified high-risk, high-utilizing members as well as members who are identified as high risk based on the Health Risk Assessment.

SFHP Complex Care Management: This program is in alignment with NCQA standards for Complex Care Management and is available for eligible members of all medical groups, except Kaiser. Eligible membersinclude those with complex or poorly controlled medical conditions. Case managers collaborate with the member and PCP to ensure coordination of services, management of barriers to care, and enhancement of self-care knowledge and skills.
To refer a member to Complex Care Management, please call the SFHP Referral Intake Line at 415- 615-4515.

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 under 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.

SFHP requires prior authorization of services that may be CCS eligible. SFHP may deny for lack of prior authorization if CCS does not accept the case and the provider has not requested prior authorization from SFHP.

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, t eligibility status with CCS can be checked by contacting CCS at 1(415)-575-5700.

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)558-4040. .

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 medically necessary treatment for persons with specific medical, dental, vision, hearing, and mental health conditions
- Private duty nursing
- Physical, occupational, and speech therapies
- Non-medical transportation when traveling to or from a medical appointment, for a screening, and/or for needed treatment services covered under the EPSDT program
- Some EPSDT-covered services, such as pediatric day health care facilities are covered through Fee-for-Service Medi-Cal and not through managed care

The CHDP program oversees the screening and follow-up components of the EPSDT program for Medi-Cal eligible children and youth. For more information call 1 (415) 575-5712.

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 Unit 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, basic case management, 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
For current TB screening and treatment guidelines visit whttps://www.sfcdcp.org/tb-control/ or www.sfhp.org.

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. A developmental delay exists if there is a delay of 33 % or more between the infant’s/toddler’s current level of functioning and the expected level of developmental for his or her age in one or more of the following developmental areas: Cognitive, Physical (including fine/gross motor, vision or hearing), Communication, Social or Emotional, or Adaptive.

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 36 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 are 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’s s Intake Unit via phone, fax or email
Phone: 1-888-339-3305
Fax: 1-888-339-3306
Email: intake@ggrc.org

Providers can fax the Early Start Referral Form (found at http://www.ggrc.org/services/applying-for-services) to the fax number above.

Medical group physicians and case managers may contact the San Francisco County’s Golden Gate Regional Center office at:
1355 Market Street
Suite 220
San Francisco, CA 94103
Phone: 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 can coordinate care and pay 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 http://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx

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 any of the following conditions:

- intellectual disability;
- Cerebral palsy;
- Epilepsy;
- Autism; or

- Disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability.

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 by Title 17, Section 54001 of the California Code of Regulations. . 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
- 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 and case managers may refer by contacting Golden Gate Regional Center’s s Intake Unit via phone, fax or email:
Phone: 1-888-339-3305
Fax: 1-888-339-3306
Email: intake@ggrc.org

Medical group physicians and case managers may contact the San Francisco County’s Golden Gate Regional Center office at:
1355 Market Street
Suite 220
San Francisco, CA 94103
Phone: 415-546-9222

For additional information and referral forms, 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 starting at age three, school-age children in grades K-12, and transition services for eligible students up to age 22)
PCPs are required to coordinate and cooperate with the LEA in the development of an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

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 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 Services: 1(415) 759-2222

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
https://www.sfhsa.org/services/connection-community/adult-day-programs.

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 HMO 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; current locations can be found here: https://www.sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/WIClocations.asp
- All WIC referral forms can be found on the website: https://www.sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/WICRefForms.asp

Section 7: Claims and Encounter Data Reporting

1. Medical Group Claims Matrix

Please refer to section 1.7: Provider Network of this manual for the UM and Claims Matrix.

2. Claims Information

SFHP Claims Department maintains a full manual of all relevant claims submission, coordination of benefit, and dispute resolution and appeal procedures in the San Francisco Health Plan Claims Operations Manual. Please reference the claims manual at: http://www.sfhp.org/files/PDF/providers/Claims_Ops_Provider_Manual.pdf.

Any questions regarding claims should be directed to the SFHP Claims Department at 1(415) 547-7818 x 7115 or claims@sfhp.org.

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. Reinsurance/Stop Loss

Delegated Medical Groups are responsible for identifying and reporting potential and actual stop loss cases as they occur so that the reinsurance carrier is notified in a timely manner.

The medical group's UM staff identifies potential reinsurance cases and initiates the SFHP carrier's Excess of Loss Reporting forms when any one of the following occur:

- Organ transplant, which are a benefit under the applicable SFHP program, and includes but is not limited to solid organ, bone marrow (autologous and allogenic) and peripheral stem cell services
- High-tech cardiovascular care
- Cancer care
- High-risk maternity and neonatal care
- Severe trauma, including burns
- Other catastrophic illnesses such as Acquired Immune Deficiency Syndrome (AIDS)
- Dialysis
- Acute inpatient stay of 20 or more days; skilled nursing facility stay of 50 or more days
- Care is estimated to have reached 50% of reinsurance attachment points. For example, 50% of $12,500 for professional services (includes physician visits, outpatient lab, office injectables, and radiology services among other services) or 50% of $65,000 in facility fees (including care at acute inpatient hospitals, extended care facilities, skilled nursing facilities, sub-acute care facilities, and rehabilitation or ventilator management facilities).

6. 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.

7. 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 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 ext. 7084 or provider.relations@sfhp.org.

8. 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 plans action or inaction. Do not submit a dispute if the claim is in a pend 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, 9am – 4pm.

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 SFHP Explanation 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

9. 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
- 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 x 7084.

Checking Member Eligibility

- Go to 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
- 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
- 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
- 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 x 7084 or 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 (TB)
    - Providing referral, coordination and continuity of care for members requiring services from California Children Service (CCS), Early Start, Golden Gate Regional Center (GGRC), and the 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
- Utilizing and maintaining results of a comprehensive risk assessment tool for all pregnant women that is comparable to American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services program (CPSP) standards

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

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:

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

*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(415) 547-7818 x 7084 or Customer Service Department at 1(415) 547-7800, and are encouraged to follow up in writing with any available 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 5 business days of receipt of the written information. Providers are informed in writing of resolution of the complaint thirty calendar days, or SFHP will document for the provider reasonable efforts to resolve it.

5. Provider Satisfaction Survey

SFHP conducts an annual Provider Satisfaction Survey 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.

6. Provider-Initiated Changes to Patient Assignment

A provider can initiate a PCP change at any time.

If a member is in a provider office and consents to the change, 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.

If the member needs to be dismissed from a practice involuntarily, procedures are outlined in SFHP Policy PNO-PR-14: "Breakdown in Physician/Patient Relationship."
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.

Providers should have a written policy for their own practice to determine the need to dismiss a patient. Patient dismissal may not be a consequence of patient race, color, national origin, sex, sexual orientation, gender identity,or disability.

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

San Francisco Health Plan
Attention 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.

7. 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.

8. 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.

Criteria	Standard
Adult and child Initial Health Assessments	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

Criteria	Standard
	periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger whichever is less.)
Initial prenatal care appointments	Within 14 calendar days
Emergency care	Immediately
Access to after-hours care	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.
Urgent Care - for services not requiring a prior authorization	Within 48 hours of the request*
Urgent Care - for services requiring a prior authorization	Within 96 hours of request*
Non-urgent Primary Care	Within 10 business Days of request**
Non-Urgent appointments with Specialist Physicians	Within 15 business Days of the request* *
Non-Urgent appointments with non-physician mental health care provider	Within 10 business Days of the request**
Non-Urgent Ancillary Services (for diagnosis or treatment)	Within 15 business days of request**
Telephone Triage or Screening Waiting Time	Not to exceed 30 minutes°
Wait time to speak to a SFHP customer Service representative during normal business hours	Not to exceed 10 minutes

***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.

Hours of Operation

SFHP providers must maintain reasonable hours of operation and provide 24-hour access. SFHP providers must offer hours of operation to Medi-Cal members that are no less than hours of operation offered to other patients, including non-SFHP members, commercial health plan members, and Medi-Cal FFS beneficiaries.

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 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.

Access to medically necessary services when in-network providers are unavailable

If SFHP or Delegated Medical Groups are unable to provide a medically necessary and covered service to a member in-network, the SFHP or Delegates, as applicable, adequately and timely cover these services out-of network, for as long as SFHP or Delegates are unable to provide the service. SFHP or Delegates, as applicable, coordinates payment with the out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network.

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 Outcomes 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.

9. 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-Cal Provider-Preventable Conditions (PPC) Reporting Form. 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 the Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form. You should send to two entities:

- Fax to SFHP Utilization Management at 1(415) 357-1292.
- You must also submit directly to DHCS using the online form.

In addition to provider reporting, SFHP reviews encounter data quarterly for evidence of PPCs and reports any PPCs to the DHCS Audits and Investigations Division.

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. SFHP uses NCQA credentialing standards to gude this process. 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

Provider groups and Individually-Contracted Providers (ICPs) are instructed to provide SFHP with a provider roster on at least a quarterly basis, pursuant to a mutually agreed-upon schedule. In addition, they must forward all provider network changes 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.

Provider Roster Requirements and Verification Process

Provider Roster must be reviewed and updated on at least a quarterly basis. Any changes must be forwarded to SFHP pursuant to the mutually agreed-upon time frame. The provider roster includes, but is not limited to, the following information about Participating Providers or ICPs:

- Name
- National Provider Identification (NPI) Number
- California License Number and Type
- Phone Number
- Address
- Hours of Operation
- Email Address (if available)
- Currently accepting new patients (yes/no)
- Specialty and/or practice area
- Board Certification
- Gender
- Date of Birth
- Languages spoken by the provider
- Languages spoken by qualified medical interpreters on the provider's staff
- Provider group or other affiliation
- Afilliated hospital and/or admitting privileges to a contracted hospital
- (for physicians) Medical school attended
- (for physicians) Residency completed
- (for NPMPs) Supervising physician

SFHP uses the information provided for reporting to regulatory agencies and to create provider directories. SFHP reviews and updates the provider roster, providing at least annual notification to Provider Groups and semi-annual notification to ICPs. The notification to Provider Groups and ICPs includes the following:

- Information that SFHP has in its provider directories regarding the ICP or Provider Group's participating providers
- A statement that failure to respond to the notification may result in a delay of payment or reimbursement of a claim
- Instructions about how to submit an updated directory of Participating Providers, and/or SFHP Provider Status Change form via fax, email or online to update the information in the provider directory, if necessary.

Within thirty business days of receipt of the notification, SFHP requires an affirmative response from the Provider Group or ICP acknowledging the notification was received and verifying the information, or providing updated information. If SFHP does not receive an affirmative response and confirmation from the Provider Group or ICP about the directory information within thirty business days, SFHP will verfy whether the provider's information is correct or requires updates within fifteen (15) business days. If SFHP is unable to verify whether the Participating Provider or

ICP information is correct or requires updates, SFHP will notify the Participating Provider or ICP ten (10) business days in advance of removal from the provider directories. If the Participating Provider or ICP does not respond at the end of the 10-business day notice period, the Participating Provider or ICP will be removed from the provider directory.

SFHP documents the receipt and outcome of each attempt to verify the information.

SFHP may delay payment or reimbursement owed to Provider Group or ICP if the Provider Group or ICP fails to respond to SFHP's attempts to verify information. No more than 50% of the next scheduled capitation payment for up to one calendar month can be delayed for providers who receive compensation on a capitated basis. Provider Groups will not be subject to payment delay if they have documented and can present evidence of attempts to provide information to SFHP and confirm that provider should be deleted from the provider directories. SFHP will notify provider group or ICP ten (10) business days before delaying payment or reimbursement. SFHP will reimburse the full amount of any delayed payment no later than three (3) business days after receipt of the information at issue, or at the end of a one calendar month delay if the Provider Group or ICP fails to provide the information requested.

Additions to the Provider Network

Provider Groups must notify SFHP of new Participating Providers through the submission of provider network information files on at least a quarterly basis. If the Provider Group is delegated for credentialing, SFHP has criteria that will prevent a new Participating Provider's record from being activated until all credentialing and provider information are received from the Provider Group.

To add a primary care provider, specialist, or a NPMP, or an additional address for an existing SFHP provider, the Provider Group or ICP is responsible for completing the SFHP Provider Add Form and SFHP Attestation Form, available by calling 1(415) 547-7818x 7084 or emailing provider.relations@sfhp.org. The form may be submitted via email or fax to the number/address listed on the form. Providers may also notify SFHP in alternate written or electronic formats that include all information requested by the forms.

Provider Information Changes or Terminations

If a Provider Group or ICP needs to correct or change information on an existing contracted provider, the SFHP Provider Status Change Form, available by calling 1(415) 547-7818 x 7084 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.

Provider Groups and ICPs are required to notify Provider Relations within five (5) business days when a provider is not accepting new patients, or is currently accepting new patients when previously not accepting new patients.

If a contracted SFHP provider wants to terminate affiliation with SFHP, he or she must first submit termination notification to his or her Provider Group. The Provider Group or ICP 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 Provider Group or ICP 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.

SFHP requires providers who are not accepting new patients and are contacted by a member or potential member seeking to become a patient to direct the member or potential enrollee to SFHP and to DMHC to report a potential inaccuracy with SFHP's provider directory.

Reporting Provider Directory Inaccuracies

Please notify SFHP of any provider directory inaccuraries by contacting SFHP's Provider Relations by telephone or in writing, by emailing providerdirectories@sfhp.org, or by submitting a report through a secure online form available at https://secure.sfhp.org/sfhpemail/contact_form.aspx?id=pd. Anyone can report potential accuracies.

SFHP will investigate the potential inaccuracy within 30 business days and will contact the affected provider no later than five (5) business days after recipt of the report. Providers are required to cooperate with SFHP in investigating possible inaccuracies in the provider directories, including providing information or verification within timeframes that enable SFHP to correct the information, if necessary, within thirty (30) business days.

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
    - Children in foster care
- 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
- Cultural and Linguistics Training

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 Chief Medical Officer and/or Director of Provider Network Operations.

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

For Example:

REPORTING PERIOD	PROVIDER NAME	ISSUE AS IDENTIFIED FROM GRIEVANCES AND POTENTIAL QUALITY OF CARE CASES	DATE	OUTCOME OF GRIEVANCE OR POTENTIAL QUALITY OF CARE ISSUE
1st Quarter (January – March)				
2nd Quarter (April – June)				
3rd Quarter (July – August)				
4th Quarter (September – December)				

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 Chief Medical Officer 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.

Section 12: State of California Department of Health Care Services (DHCS) Facility Site Reviews (FSRs)

1. FSR Overview

Per DHCS Policy Letter 14-004, all Medi-Cal Managed Care Primary Care Provider (PCP) sites must pass a Full Scope FSR with a minimum score of 80% as part of the initial credentialing process and every 36 months thereafter for continued participation in Medi-Cal Managed Care. New PCP sites must pass the FSR before receiving any SFHP Medi-Cal patient assignments.

The FSR is comprised on 3 separate reviews:

1. FSR-A: Facility Site Review Survey (FSR)
2. FSR-B: Medical Record Review (MRR)
3. FSR-C: Physical Accesibility Review Survey (PARS)

Medical groups are expected to educate their providers about FSR requirements and facilitate Nurse Reviewer access to PCP 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 Jackie Hagg, RN, MSN, SFHP's FSR Nurse Specialist at (415) 615-5637.

2. FSR and MRR Guidelines

SFHP follows DHCS guidelines when conducting and scoring FSRs and MRRs. These guidelines are delineated in DHCS Managed Medi-Cal Division Policy Letter 14-004, which can be accessed here:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

FSRs and MRRs are conducted by Nurse Reviewers from SFHP, its delegated medical groups, or Anthem. The Department of Health Care Services (DHCS) may also conduct site FSRs and MRRs as part of Managed Medi-Cal Division (MMCD) monitoring activities.

FSRs must be conducted as part of the initial credentialing process and prior to the PCP receiving any SFHP member assignments. FSRs are repeated every three years, whenever the office has gone through a renovation, and whenever a provider has moved to a new site that does not have a current FSR. FSRs may be conducted more frequently at SFHP's discretion.

MRRs 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 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 MRR shall be completed on the total number of records available and the scoring adjusted accordingly. In provider offices that have more than one provider and the providers share members the following number of medical records are reviewed:

Number of providers	Number of medical records for review
0-3 providers	10 medical records
4-6 providers	20 medical records
7 or more providers	30 medical records

Per DHCS Policy Letter 14-004, focused reviews are conducted at the discretion of SFHP and/or its delegate for sites with a previous failing score and/or previously identified concerns for patient safety.

Corrective Action Plans (CAPs) are issued to PCPs who score less than 90% on the FSR or MRR, score less than 80% on any individual MRR section score (irrespective of overall score), or have any deficiencies in Infection Control and/or Pharmaceutical Services, or any Critical Element deficiencies. Critical Element deficiencies and any other deficiencies requiring immediate attention must be addressed in a CAP within 10 business days of the FSR. All other deficiencies must be addressed in a CAP within 45 calendar days of the CAP issue date.There are nine Critical Elements that are reviewed in the FSR:
1) Exit doors and aisles are unobstructed and egress (escape) is accessible;
2) Airway management equipment, appropriate to practice and populations served, is present onsite;
3) Only qualified/trained personnel retrieve, prepare or administer medications;
4) Office practice procedures are utilized onsite that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;
5) Only lawfully authorized persons dispense drugs to patients;
6) Personal protective equipment is readily available for staff use;
7) Needlestick safety precautions are practiced onsite;
8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping; and
9) Spore testing of each autoclave/steam sterilizer is completed (at least monthly), with documented results.

PCP sites that do not correct cited deficiencies and/or areas of concern within timelines established by DHCS are subject to termination from SFHP's Contracted Network.

The Physical Accessibility Review Survey has now been electronically documented in this last review period for all sites as of 2018. The information is documented in the Facility Site Review softaware database, Healthy Data Systems (HDS), and in the Provider Directories.

3. Physical Accessibility Review Survey (FSR-C) Guidelines

The FSR-C was developed by DHCS and implemented in 2011 to assess the level of ADA accessibility at PCP sites, as well as high volume specialist sites. The FSR-C is used for informational purposes only and never requires a Corrective Action Plan. The results of the FSR-C are published in SFHP's Provider Directory for member refeference.

SFHP follows DHCS guidelines when conducting FSR-C reviews. These guidelines are delineated in DHCS Policy Letters 15-023 and 12-006.

Provider offices/clinics are evaluated as either "basic" (meet all indicators)or "limited" (missing one or more access indicators). They are also identified as having medical equipment access or not. A site has medical equipment access if they meet the following two indicators:

- An accessible scale for a patient in a wheelchair/scooter, with activity limitations, or needing a scale that exceeds a standard weight scale, and
- A height adjustable exam tables that lower to 17 inches.

Our website and provider directories list further access by indicator:

- Parking (P)
- Exterior of the building (EB)
- Interior of the building (IB)
- Restroom/exam room (R/E)
- Exam table & scales (ME)

4. Components of the FSR and MRR

The FSR and MRR are conducted for all Medi-Cal Managed Care PCPs in the State of California to ensure consistent compliance with DHCS clinical and administrative guidelines.

The FSR consists of an onsite clinic walkthrough and brief interview and the MRR consists of a thorough review of a random selection of patient charts.The FSR and MRR consist of six individual sections.

FSR:
Access and Safety
Personnel
Office Management
Clinical Services
Preventive Services
Infection Control

MRR:
Format
Documentation
Continuity/Coordination of Care
Pediatric Preventive
Adult Preventive
OB/CPSP

SFHP Nurse Reviewers have a number of resources available to help providers successfully pass the FSR and MRR:

- FSR self-assessment checklist
- Resource list for equipment, scale calibration, and cleaning products that meet DHCS requirements
- TB Screening and Risk Assessment forms
- Staying Healthy Assessment information and training materials
- Advanced Health Care Directives in threshold and other languages
- Current ACIP Immunization Schedules
- 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 and materials

Sections of the MRR that are commonly found to be deficient:

1. Tuberculosis/TB Screening and Risk Assessments
    - All pediatric Medi-Cal patients must be screened for TB risk with testing, if indicated, at each health assessment
    - All adult Medi-Cal patients must be screening for TB risk with testing, if indicated, at the time of Initial Health Assessment (IHA) and at subsequent periodic health evaluations. The Mantoux skin test, or other approved TB infection screening test, is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. Adults already known to have HIV or are significantly immunosuppressed require annual TB testing.
    - For detailed information, please visit: http://sfcdcp.org/tbinfoforproviders.html or http://www.ctca.org/index.cfm?fuseaction=menu&menu_id=5008
    - Universal TB Risk Assessment to identify asymptomatic **adults** latent TB infection testing published by CA TB Controllers Association on 4/17/15: http://www.ctca.org/fileLibrary/file_734.pdf
2. Advanced Health Care Directives (AHCD)

- Providers are required to offer information about AHCD to patients 18 years or older and emancipated minors. Evidence that this information has been offered must be documented in the patient's chart.
- Providers are not required to ensure the AHCD is fully executed, however they must document the date the information was given/reviewed, refused or executed in the chart.A copy of the AHCD must be available for auditing if executed.
- User-friendly AHCD forms are available in several languages on the Institute for Healthcare Advancement website: http://www.iha4health.org/our-services/advance-directive/

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 or 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 (415) 547-7818 ext. 7084.
4. Staying Healthy Assessment (SHA) / IndividualHealth Education Behavioral Assessment(IHEBA)
   - Please see page 44 for detailed information about the SHA.
   - The SHA is DHCS's IHEBA. Effective April 1, 2014, DHCS mandates that all Medi-Cal Managed Care PCPs administer the SHA to new patients, as part of their Initial Health Assessment (IHA), within 120 days of enrollment with SFHP. Existing patients should complete the SHA at their next periodic health evaluation.
   - The SHA should be re-administered according to the following periodicity table developed by DHCS:

SHA PERIODICITY TABLE

	Administer	Administer /Re-Administer		Review
Questionnaire Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam *(after entering new age group)*	Every 3-5 Years	Annually *(Intervening Years)*
0 - 6 Mo	√			
7 - 12 Mo	√	√		
1 - 2 Yrs	√	√		√
3 - 4 Yrs	√	√		√
5 - 8 Yrs	√	√		√
9 -11 Yrs	√	√		√
12 - 17 Yrs	√	√		√
Adult	√		√	√
Senior	√		√	√

   -

Please contact Jackie Hagg, RN, MSN, 1(415) 615-5637 or contact the SFHP Provider Relations team at 1(415) 547-7818 x 7084 or provider.relations@sfhp.org, if you would like additional information about the FSR process and requirements.

Section 13: Fraud, Waste and Abuse Prevention and Detection Program

1. Overview

San Francisco Health Plans Fraud, Waste and abuse program focuses on review of standards, program evaluation, and education to ensure policies and practices are consistent with contractual, regulatory and statutory requirements.

2. Program Outline

In an effort to comply with applicable regulations, ensure proper business practices and to deter fraudulent activities, SFHP has developed the Fraud and Abuse Prevention and Detection Program ("the Program"). This Program is not static but rather will be updated annually to reflect current developments in the law and accepted practices.
The purpose of the San Francisco Health Plan Anti-Fraud Program is to:

- Protect SFHP's ability to deliver health care services to members through the timely detection, investigation, and prosecution of fraud;
- Develop and implement a process to protect SFHP from internal fraud and from external fraud by providers, vendors, enrollees, and others;
- Provide avenues to report documented fraudulent activities to the appropriate authorities;
- Outline procedures for the detection, reporting and managing of incidents of suspected fraud;
- Coordinate the practices and procedures for the detection, investigation, prevention, reporting, correcting and prosecution of fraud with Federal, State, and local regulatory agencies and law enforcement;
- Continually identify best practices used by other health plans or providers to improve the SFHP Anti-Fraud Program; and
- Provide Fraud, Waste, and Abuse Awareness education and training to employees, members, contracted providers, and vendors to facilitate in the timely detection and investigation of fraud, waste, or abuse.

3. Definition of Fraud, Waste and Abuse

Health care fraud is defined as an intentional deception or misrepresentation that an individual or entity makes knowing that the deception or misrepresentation could result in some unauthorized benefit to the individual, entity, or some other party. Medi-Cal considers fraud to be an "intentional attempt by some providers, and in some cases beneficiaries, to receive unauthorized payments or benefits from the program". Abuse may also result in unauthorized payments or benefits, but is considered to have occurred without the intent.
Common types of fraud within managed care include submission of false claims for services not performed, or for services different than those performed,, denial of medically necessary services, deceptive enrollment practices, and receipt of services an individual is not entitled to receive.

4. SFHP Departmental Responsibilities

Claims Department: In the payment of claims there is a potential for health care fraud. The Compliance and Regulatory Affairs Department will work with representatives from the claims department to review claims periodically in order to search for potentially fraudulent claims, using an established auditing tool. The Compliance and regulatory Affairs Department will keep a written record of all random audits of claims and any employee reports of non-compliant or fraudulent provider conduct.

Health Services Department: This department is responsible for utilization, pharmacy and case management, as well as for the development and implementation of the QI Program and Work

Plan. This department oversees critical functions performed by contracted providers including case review, quality management and medical record review. The employees performing these functions are in a position to detect occurrences of fraudulent or abusive activities by Members and Providers. Suspected incidences of fraud or abuse discovered by Medical Management personnel will be documented and referred to the Compliance Officer for assessment.

Compliance Department: The Compliance Department is responsible for the Compliance Program and related policies and procedures. The Compliance Department is responsible for investigating all allegations for fraud, working in collaboration with other SFHP departments. If necessary, the Compliance Officer submits the mandated reports about fraud and abuse cases to State and federal agencies.

5. Reporting

To report cases of fraud or abuse, or if you have questions, please contact the Compliance Hotline at 1(800)461-9330, or online at convercent.com/Report. The Compliance Hotline is available 24-hours per day 7 days per week and reports can be made anonymously. Questions can also be emailed to the Compliance Department at compliance@sfhp.org.

Section 14: Glossary

Abbreviation	Description
BTP	Brown & Toland Physicians
CAHPS	Consumer Assessment of Health Care Providers and Systems
CAP	Corrective Action Plan
CCHCA	Chinese Community Health Care Association
CHN	Community Health Network
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
EDI	Electronic Data Interchange
EOC	Evidence of Coverage
FSR	Facility Site Review
HCO	Health Care Options
HEDIS	Healthcare Effectiveness Data and Information Set
HK	Healthy Kids HMO
HILL	Hill Physicians Medical Group
HW	Healthy Workers HMO
IHA	Initial Health Assessment
IHEBA	Individual Health Education and Behavioral Assessment or "Staying Healthy"
IHSS	In Home Support Service Public Authority
IMR	Independent Medical Review
JAD	Jade Health Care Medical Group
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEA	Local Education Agency
LOB	Line of Business
MC	Medi-Cal
MRR	Medical Record Review
NCQA	National Committee for Quality Assurance
NEMS	North East Medical Services
NPMP	Non-Physician Medical Practitioner
QI	Quality Improvement
QIP	Quality Improvement Plan
SFCBHS	San Francisco Community Behavioral Health Services
SFHP	San Francisco Health Plan
SHA	Staying Healthy Assessment
UCSF	University of California, San Francisco
VFC	Vaccines for Children
x12 (ASC x12)	The Accredited Standards Committee (ASC) X12 is a set of uniform standards for inter-industry electronic exchange of business transactions-electronic data interchange (EDI).

Section 15: Revision Log

Date	Section	Changes
Feb 2014	5.2	Update to Medi-Cal Disenrollment for Complex Medical Condition
	6.2.11	Added language to Major Organ Transplant Section
Mar 2014	7.5	Added Reinsurance/Stop Loss section
	13	Added Fraud, Waste and Abuse Prevention and Detection Program
Sep 2014	5.4	Update to Medi-Cal Disenrollment for Major Organ Transplant
Oct 2014	4.3	Updates IMR/Consumer Complaint Process
Feb 2015	6.1.2	Revision to provider involvement in QI program
	6.3.2	Revised CCS section
Sep 2015	6.2.5	Added language to Care of Adolescents and Minors
Nov 2015	6.1.9	Revised Fluoride Varnish section
Jan 2016	12.1-12.4	Revised FSR Overview, FSR and MRR Guidelines, PARS Guidelines, and Components of FSR and MRR
Feb 2016	1.9	Addition of Oversight Committee for delegation
	2.1	Removal of section; moved some material to other sections
	4.1	Member Grievance Process Update
	4.2	Member Appeals Process Update; Provider NOA Request process updated
	10.9	Added sub-section Provider Operating Hours; Added sub-section Access to medically necessary services when in-network providers are unavailable
	13.2	Updated Program Outline
	13.5	Removed Prevention Section
	2.1-2.3	Revision of sections
	6.1.1	Renaming Quality Improvement Program; Revisions to section
	6.1.2	Revision to provider involvement in QI program
	6.1.3	Updates to QIC, P & T, and PAC Committees
	6.1.4	Revision of Measuring Quality
	6.1.4 A	Added section Identification of Important Aspects of Care
	6.1.4 B	Added section Data Systems and Sources
	6.1.5	Renamed section Preventative Care and revised content
	6.1.6	Added Patient Safety section
	6.1.7	Combined IHA section and SHA section
	6.1.8	Revised Pediatric and Adult Preventive Health Care Guidelines
	6.2.16	Revised Sensitive Services – Voluntary Termination of Pregnancy section
	6.2.17	Revised Sensitive Services – STI and HIV testing section
	6.2.18	Revised NOA Standards
	6.2.2	Added language about Out of Network Services
	6.2.21	Revised Case Management section
	6.2.4	Added information about behavioral health and Beacon Health Strategies
	6.2.7	Removed Healthy Families to Medi-Cal COC transition information
Mar 2016	6.2.2	Added language to Authorization Requests and Referrals
May 2016	11.3	Added Provider Roster Requirements and Verification Process and Additions to Provider Network; Added Reporting Provider Directory Inaccuracies
	11.5	Updated Provider Profile Reporting
	6.1.2	Revision to provider involvement in QI program
Jun 2016	10.5	Removed Provider Appeals Procedure section
Jul 2016	2.8	Revision of member rights under Cultural and Linguistic Services Program
	10.2	Added to PCP Responsibilities section
Aug 2016	6.2.13	Revised CBAS information
	6.3.4	Revised EPSDT section
Jan-17	10.7	Revised Provider-Initiated Changes to Patient Assignment
Mar-17	6.3.12	Updated LEA section
Mar-18	All	Addition of Jade Health Care network
Jun-18	1.6	Added Teladoc for telemedicine
	1.8	Corrected URL for provider directory
	2.3	Removed Golden Gate to Health Insurance (GGHI)
	2.7	Revision to Member Rights and Responsibilities
	2.10	Section content moved to UM (6.2.8) and Access (10.8) sections

Date	Section	Changes
	6.2.7	Healthy Families transition no longer applicable
	6.2.18	Required inclusions in a Notice of Action
	6.3.6	Added definition of developmental delay
	6.3.12	Added ages covered
	10.2	If a member is hospitalized out of network, it is not a responsibility of the member's PCP to arrange repatriation
	10.4	Providers are not required to follow up on a verbal complaint in writing

Section 16: 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**