San Francisco Health Plan℠

Provider Manual

Revised July 2025

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Introduction

1. Purpose of the Manual

This Provider Manual is a reference tool designed to provide guidance to San Francisco Health Plan (SFHP) providers and medical groups in the implementation and administration of the benefit programs offered by SFHP. If the terms of your Medical Group, Hospital, or Ancillary Provider Agreement differ from the information contained in this Manual, your Provider Agreement will supersede this Manual.

This is a combined manual for the Medi-Cal (MC) 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 "(*HW only)".

The Provider Manual is proprietary to San Francisco Health Plan. SFHP will update this manual on a regular basis, and at least annually, to incorporate program, administrative, and regulatory changes as they occur.

An annual review of this Manual is conducted by the appropriate committees, including SFHP's Quality Improvement and Health Equity Committee (QIHEC). Both the QIHEC and the Member Advisory Committee are invited to advise on the content of this manual, and receive regular updates to clarify new and revised policies it contains. Committee review is acknowledged in committee minutes.

2. History and Who We Are

San Francisco Health Plan (SFHP) is an NCQA Accredited Medicaid HMO Health Plan that was created in 1994 by the City and County of San Francisco to provide services in a managed care system for residents who qualify for Medi-Cal. We enrolled our first member in 1997, and today have over 190,000 members.

Since 1997, we have expanded to three programs in addition to Medi-Cal.

Our first expansion occurred in 1998 when we were chosen as the Healthy Families Program community provider plan for San Francisco. In 2013, the State of California approved the expansion of the Medi-Cal program to transition all Healthy Families Program members into the Medi-Cal program by the end of 2013.

In 1999, we created California's first health plan program for In-Home Supportive Services (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 health coverage for children from age 0 to age 19, in San Francisco. The Healthy Kids HMO program was combined with Medi-Cal in 2019.

Secure Provider Website: Verify eligibility and PCP for any date of service, ee the status of your claims and submit Prior-Authorization requests

As of January 1, 2024, the Medi-Cal program contract with the Department of Health Care Services (DHCS) will be a new contract, for the first time since 2004. With this new contract, DHCS further implements the California Advancing and Innovating Medi-Cal (CalAIM), a framework that encompasses broad-based delivery system, program, and payment reform across the Medi-Cal program. CalAIM is an innovative and long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory. CalAIM shifts Medi-Cal to a population health approach.

SFHP's Provider Manual incorporates these important changes that our providers must also be aware of and incorporate into the care and services provided to SFHP Medi-Cal members.

3. Mission Statement

The mission of San Francisco Health Plan is to improve health outcomes of the diverse San Francisco communities through successful partnerships.

San Francisco Health Plan's Core Values

Serve with Respect

We respect all those we work with, including members, providers, external partners, clients, and each other. Serving with respect ensures we are accountable, courteous, and responsive to a wide range of interests and needs.

Strive to Excel

We strive for excellence in everything we do, from ensuring quality services to our members, supporting our provider network, running efficient operations, and acting with integrity.

Work as a Team

We work as a team within and across departments to ensure quality service to our members, providers, and community partners.

San Francisco Health Plan's Three Strategic Pillars

Quality, Access and Health Equity

The organizational mission and primary responsibility of SFHP is to improve the health and wellbeing of our members and community.

Sustainability and Value

With a continuing emphasis on financial strength and sustainability, SFHP will seel to leverage its financial strategy to deliver excellence and vlue to members and the community.

Partnership to Impact Community Health

SFHP will prioritize the deepening of health and other social service provider relationships at all levels of the organization, actively engage community partners in efforts to understand and maxmize Medi-Cal reform and expansion opportunities.

4. Financial Arrangements and Financial Oversight of Providers

Financial Agreements

SFHP reimburses most medical groups and hospitals with 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.

A Remittance Summary/Capitation Report accompanies each PMPM capitation payment, 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 individual SFHP members can be checked via the Internet at the SFHP secure website **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. Reviews are performed on an annual basis and establish compliance with fiduciary obligations, statutory requirements, and 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, assist with member grievances, etc.

Customer Service Telephone
1(415) 547-7800 or **1(800) 288-5555**
1(415) 547-7830 or **1-888-883-7347** TDD/TTY

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 telephonic interpreting services. San Francisco Health Plan also uses the California Relay Services for those who are speech or hearing impaired.

Teladoc®

SFHP encourages providers to inform SFHP members about the availability of free telehealth (via video or telephone) consultations through Teladoc® when triage and screening within 30 minutes is not possible. 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. Records of telehealth services provided are shared with the member's PCP, unless the member objects. Teladoc® physicians can prescribe some medications, but not controlled substances. SFHP members 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, 7 days a week. A one-time registration and health history questionnaire via telephone or online is required. SFHP members may access Teladoc® services by calling **1(800) 835-2362** or visiting sfhp.org/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.

Provider Relations Department

Hours of Operation: Monday through Friday, 8:30am to 5:00pm

Contact Provider Relations for any questions or concerns about provider issues, network and contracting, credentialing, or payment disputes. Contact us also for any panel management or data requests about your patients.

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

San Francisco Health Plan (SFHP) contracts with five medical groups, and seven hospitals for clinical services. Individual practitioners, allied health care providers, and clinics participate in the

SFHP network through one of these groups. All SFHP members are assigned to one of the following Patient Networks:

All American Medical Group (**AMG**)

Brown & Toland Physicians (**BTP**)Community Clinic Network (**CLN**)

Hill Physicians Medical Group (**HIL**)

Jade Health Care Medical Group (**JAD**)

North East Medical Services (**NEM**)

NEMS with San Francisco Health Network (**NMS**)

San Francisco Health Network (**SFN**)

SFHP Direct Network (**SDN**)*

University of California, San Francisco (**UCS**)

* SDN is a patient network specifically for two kinds of SFHP Member:

1. Dual-eligible Medicare and Medi-Cal beneficiaries (“medi-medi”) who join SFHP after January 1, 2023
2. All members who are residents of long-term care (LTC), Subacute Care and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD) facilities.

Contracted Hospitals

Patient Network	Hospital
AMG	Chinese Hospital 845 Jackson Street San Francisco, CA 94133 **1(415) 982-2400**
SFN **CLN** **NMS**	Zuckerberg San Francisco General Hospital and Trauma Center 1001 Potrero Avenue San Francisco, CA 94110 **1(415) 206-8000**

Patient Network	Hospital
BTP HIL NEM	California Pacific Medical Center (CPMC) – Mission Bernal Campus 3555 Cesar Chavez Street San Francisco, CA 94110 **1(415) 600-6000** Pacific Campus 2333 Buchanan Street San Francisco, CA 94115 **1(415) 600-6000** Davies Campus 44 Castro Street San Francisco, CA 94115 **1(415) 600-6000** Van Ness Campus 1101 Van Ness Ave San Francisco, CA 94109 **1(415) 600-6000**
JAD	Chinese Hospital 845 Jackson Street San Francisco, CA 94133 **1(415) 982-2400**

Patient Network	Hospital
UCS	UCSF Medical Center, Parnassus 505 Parnassus Avenue San Francisco, CA 94143 **1(415) 476-1000** UCSF Medical Center, Mt. Zion 1600 Divisadero Street San Francisco, CA 94115 **1(415) 567-6600** UCSF Medical Center, Mission Bay 1825 4th Street San Francisco, CA 94158 **1(415)353-3000**
Available by Referral Only	AHMC Seton Medical Center 1900 Sullivan Avenue Daly City, CA 94015 **1(650) 992-4000** AHMC Seton Coastside 600 Marine Blvd., Moss Beach, CA 94038 **1(650) 563-7100** UCSF Health St Francis Hospital 900 Hyde Street San Francisco, CA 94109 **1(415) 353-6000** UCSF Health St Mary's Hospital 450 Stanyan Street San Francisco , CA 94117 **1(415) 668-1000**

Ancillary Providers

Ancillary Providers, such as non-acute facilities, transportation providers, dialysis facilities, home health agencies, etc. can be found through the Provider Directory search tool at the link below:

https://sfhp.healthtrioconnect.com/public-app/consumer/provdir/entry.page

Prior Authorization and Claims Matrix

Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
BTP	Professional: Brown & Toland Phone **1(415) 972-6000** Mail claims to: PO Box 72710, Oakland, CA 94612- 8910 Facility & DME: SFHP Phone **1(415) 547-7818 ext. 7115** Mail claims to: P.O. Box 194247, San Francisco, CA 94119	All UM decisions: Brown & Toland Phone **1(415) 972-6002** Faxes: Outpatient: **1(415) 972-6012** IP (in-network): **1(415) 972-4248** IP (out-of-network): **1(415) 972-4239** **Transportation: SFHP 1(415)547-7807**	**1(415) 547-7800**
AMG	Professional: Astrana Health Submit Claims to Astrana Health Provider Portal at: https://provider-portal.astranahealth.com/login Office Ally Payer ID: AAMG1 Mail to: 1600 Corporate Center Drive, Suite 106 Monterey Park, CA 91754 Facility, DME, Non- Emergency Transport and Emergency Transportation: CCHP provider.services@cchphealthplan.com Phone 1(415) 955-8800 Fax 1(415) 955-8812 Mail claims to: 445 Grant Ave, Suite 700 San Francisco, CA 94108	All UM decisions: Astrana Health Submit referrals at Astrana Health on Provider Portal at: https://provider-portal.astranahealth.com/login Phone **1(415) 216-0088** **Faxes** Routine & Retro: **1(415) 390-6754** Urgent: **1(415) 663-5197** IP Acute and SNF: **1(415) 390-5735** **Transportation: 1(415)590-7418**	**1(415) 547-7800**
CLN and SFN	All claims: SFHP Phone **1(415) 547-7818 ext. 7115** Mail claims to: P.O. Box 194247 San Francisco, CA 94119	All UM decisions: SFHP Phone **1(415) 547-7818 ext. 7080** Outpatient Fax: **1(415) 357-1292** Inpatient Fax: **1(415) 547-7822** **Transportation: SFHP 1(415)547-7807**	**1(415) 547-7800**

Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
HIL	Professional: Hill Physicians Phone **1(800) 445-5747** Mail claims to: PO Box 8001 Park Ridge, IL 60068 Facility & DME: SFHP Phone **1(415) 547-7818 ext. 7115** Mail claims to: PO Box 194247 San Francisco, CA 94119	All UM decisions: Hill Physicians Phone **1(800) 445-5747** UM/Authorizations fax: 1**(925) 820-4311** Inpatient Face Sheets: **1(925) 362-6577** **Transportation: SFHP 1(415)547-7807**	**1(415) 547-7800**
JAD	Professional: Astrana Health Submit Claims to Astrana Health Provider Portal at: https://provider-portal.astranahealth.com/login Office Ally Payer ID: NMM07 Mail claims to: 1600 Corporate Center Drive, Suite 106 Monterey Park, CA 91754 Facility, DME, Emergency and Non-Emergency Transportation: CCHP provider.services@cchphealthplan.com Phone 1(415) 955-8800 Fax 1(415) 955-8812 Mail claims to: 445 Grant Ave, Suite 700 San Francisco, CA 94108	All UM Decisions: Astrana Health Submit referrals to Astrana Health on Provider Portal at: https://provider-portal.astranahealth.com/login Phone: **1(415) 216-0088** Routine fax: **1(415) 523-9552** Urgent fax: **1(415) 523-9553** IP Acute and SNF fax: **1(415) 691-8023** **Transportation: 1(415)590-7418**	**1(415) 547-7800**
NEM	All claims: NEMS MSO Phone **1(415) 352-5186, Option 2** Fax **1(866) 930-2290** Mail claims to: P.O. Box 1548 San Leandro, CA 94577	All UM decisions: NEMS MSO Phone **1(415) 352-5186, Option 1** Fax **1(415) 398-2895** **Transportation: 1(415)352-5179**	**1(415) 547-7800**

Patient's Medical Network	Who processes claims?	Who makes UM decisions?	Member Grievance Line
NMS (NEMS with SFHN)	All claims: NEMS MSO Phone **1(415) 352-5186, Option 2** Fax **1(866) 930-2290** Mail claims to: P.O. Box 1548 San Leandro, CA 94577	All UM decisions: NEMS MSO Phone **1(415) 352-5186, Option 1** Fax **1(415) 398-2895** **Transportation: 1(415)352-5179**	**1(415) 547-7800**
SDN and UCS	All claims: SFHP Phone **1(415) 547-7818 ext. 7115** Mail claims to: P.O. Box 194247 San Francisco, CA 94119	All UM decisions: SFHP Phone **1(415) 547-7818 ext. 7080** Outpatient Fax: **1(415) 357-1292** Inpatient Fax: **1(415) 547-7822** **Transportation: SFHP 1(415)547-7807**	**1(415) 547-7800**

Non-Specialty Mental Health Benefit Managed by Carelon

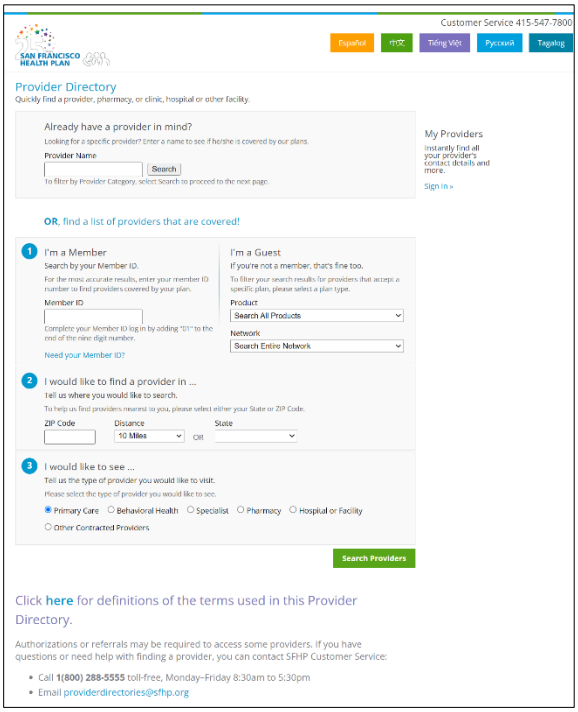
All Networks	All claims: Carelon Phone **1(855) 371-8117** Mail claims to: 5665 Plaza Drive, Suite 400, Cypress, CA 90630	All screening/UM: Carelon Phone **1(855) 371-8117** Fax**: 1(866) 422-3413**	**1(855) 371-8117**

Vision Benefit Managed by VSP

All Networks	All claims: VSP Phone **1(800)742-6907, Option 3** Mail claims to: P.O Box 385018 Birmingham, Alabama 35238-5018	All screening/UM:VSP Phone **1(800) 877-7195**	

7. Provider Directories

San Francisco Health Plan publishes provider directories for each line of business (Medi-Cal and Healthy Workers HMO). These directories are available to members and providers at any time. If you would like a copy of a provider directory, please email **info@sfhp.org** or call **1(415) 547-7818 ext. 7101.** The provider directories are also available and searchable on the SFHP website homepage or at **https://sfhp.healthtrioconnect.com/public-app/consumer/provdir/entry.page**



8. Oversight of Delegated Functions

SFHP authorizes certain functions and activities to medical groups, health plans, specialty health plans, and behavioral health organizations. SFHP gives these Delegates the authority to act on its behalf and regulated by 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 functions or activities are peformed according to the SFHP's contract obligations, state requirements, and NCQA standards. SFHP oversees the delegates' activities through annual audits and other monitoring activities. If SFHP identifies instances or patterns of non-compliance with requirements, a Corrective Action Plan (CAP) is requested from the Delegate. SFHP may reclaim or "de-delegate" its authority to carry out any delegated function or activity at any time. Failure to correct deficiencies or non-response to CAP requests may result in: a reduction or discontinuation of member assignment; transfer of existing membership to other providers; exclusion from SFHP's pay-for-performance program; diversion of patient requests for assignment or services to other providers; withholding of any combination of capitation/ Provider Incentive Program/ grant monies in part or in full; disenrollment from SFHP's provider network; de-delegation of delegated activities; and/or termination of the provider agreement.

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

SFHP has policies and procedures to routinely monitor its Delegates' performance. Providing *medical services* is not a delegated function, as the provision of these

services are not within the scope of work of a Health Plan. However, SFHP is responsible for ensuring that medical services are provided in compliance with SFHP's contract with the Department of Health Care Services (DHCS), applicable laws and regulation, and with evidence-based standards of clinical practice.

As a prerequisite for delegation of any Plan function, SFHP requires that the prospective delegate engage in a pre-delegation audit.

Upon completion of the predelegation audit, SFHP and the prospective delegate implement a written agreement outlining delegated functions and activities. The agreement describes the responsibilities of the Delegate for each delegated function or activity and all required reports.

In all delegation agreements, the SFHP 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

. Six to twelve months after implementation of a new Delegate contract, and annually thereafter, SFHP conducts an audit that includes the review 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: policy review, submission of periodic progress reports, and/or evaluation of the effectiveness of an improvement effort through subsequent audits.

SFHP maintains a Provider Network Oversight Committee that is responsible for evaluation, review, and recommendation of decision of sanction or disciniplary action that may be imposed as a result of a delgates failure to execute the functions and responsibilities described in the delegation agreement..

9. Medical Group Meetings and Provider Site Visits

SFHP conducts regular meetings with contracted organizations throughout the year. The meetings are designed to address any variety of issues, updates, announcements, and ad-hoc topics that are relevant to the day-to-day operations of each organization. SFHP also routinely visits provider sites as-needed and as-requested.

For additional information or to request a visit by a Provider Representative, please contact the Provider Relations Department at **1(415) 547-7818 ext. 7084** or **provider.relations@sfhp.org**.

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) and Healthy Workers HMO (HW) programs. Each program has its own eligibility and enrollment guidelines. Individuals must be deemed eligible for these programs prior to enrolling with SFHP.

Each program is administered by an agency separate from SFHP.

Medi-Cal

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 three 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 services only) 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 the SFHP Service Center provides in-person enrollment assistance for Medi-Cal, 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 C-CHIP, CalWORKS, TANF, and SSI. SFHP Providers are not authorized to distribute enrollment or disenrollment forms; providers should refer beneficiaries with questions about enrollment to the DHCS Enrollment Contractor, and should refer questions about SFHP to SFHP member services.

Application Resources:

- Apply online at **benefitscal.com** or **coveredca.com/apply/**
- Apply over the phone or in person
  Toll-free **1(855) 355-5757**
  1440 Harrison Street
  San Francisco, CA 94103
  Monday through Friday, 8:00am to 5:00pm
- SFHP Service Center
  7 Spring St.
  San Francisco, CA 94104
  Monday through Friday, 8:30am to 5:00pm
  1(800) 288-5555 to schedule an appointment
- Submit application by mail or email
  Human Services Agency
  PO BOX 7988
  San Francisco, CA 94120
  SFMedi-Cal@sfgov.org

HealthyWorkers HMO℠

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 Health Network (SFHN) 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 **1(415) 243-4477.**
- Temporary, Exempt As-Needed Employees should contact the Department of Human Resources at **1(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 three Medi-Cal managed care plans that maintains a contract with the California Department of Health Care Services (DHCS) to provide comprehensive Medi-Cal benefits to Medi-Cal enrollees in San Francisco. Anthem Blue Cross and Kaiser (under specific conditions) are the other Medi-Cal managed care plans for San Francisco. Certain populations, including adults, families with children, dual-eligible Medicare/Medi-Cal members, 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.

In San Francisco, individuals required to enroll in Medi-Cal managed care are offered a choice of SFHP and Anthem Blue Cross. Enrollment into Kaiser is subject to specific enrollment criteria and may be limited by an annual enrollment maximum. 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, Anthem Blue Cross and Kaiser 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. Verifying Eligibility: Web, Interactive Voice Response (IVR) 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 Portal at **sfhp.org** (select Provider Login)

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 through Friday, 8:30am to 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

Secure Provider Website: Verify eligibility and PCP for any date of service, ee the status of your claims and submit Prior-Authorization requests

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.

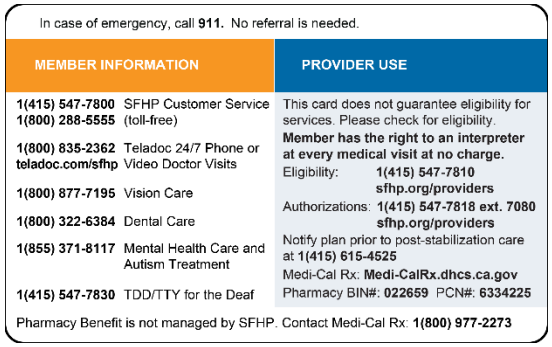
SFHP Medi-Cal ID Card


SAN FRANCISCO HEALTH PLAN

Member ID #: 12345678901
Member CIN #: 123456789
DOB: 26-Jan-74
Medical Group: San Francisco Health Network
Language: English
Hospital: Zuckerberg San Francisco General Hospital and Trauma Center

PAT LEE
Program: Medi-Cal
Clinic: Richard H. Fine People's Clinic
Primary Care Provider (PCP): Richard H. Fine People's Clinic
PCP Address: 1001 Potrero Avenue, San Francisco, CA 94110
PCP Phone #: 1(415) 547-7800
Show this ID card when you visit the doctor, hospital, or pharmacy.

CO-PAYMENTS:
NONE


In case of emergency, call 911. No referral is needed.

MEMBER INFORMATION		PROVIDER USE
1(415) 547-7800 1(800) 288-5555	SFHP Customer Service (toll-free)	This card does not guarantee eligibility for services. Please check for eligibility.
1(800) 835-2362 teladoc.com/sfhp	Teladoc 24/7 Phone or Video Doctor Visits	Member has the right to an interpreter at every medical visit at no charge.
1(800) 877-7195	Vision Care	Eligibility: 1(415) 547-7810 sfhp.org/providers
1(800) 322-6384	Dental Care	Authorizations: 1(415) 547-7818 ext. 7080 sfhp.org/providers
1(855) 371-8117	Mental Health Care and Autism Treatment	Notify plan prior to post-stabilization care at 1(415) 615-4525
1(415) 547-7830	TDD/TTY for the Deaf	Medi-Cal Rx: Medi-CalRx.dhcs.ca.gov Pharmacy BIN#: 022659 PCN#: 6334225

Pharmacy Benefit is not managed by SFHP. Contact Medi-Cal Rx: 1(800) 977-2273

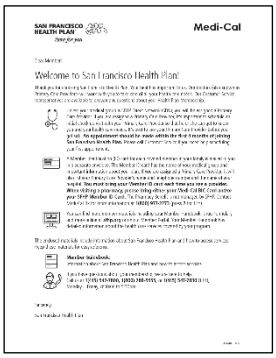
Medi-Cal Point of Service (POS) "Swipe" Devices

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, Kaiser, or Fee-for-Service, and will not indicate medical group or PCP assignment.

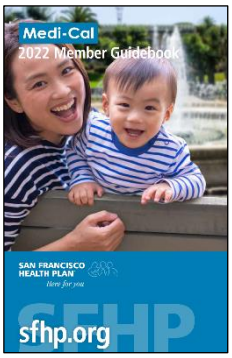
SFHP does not issue or participate in the use of POS "Swipe" devices for verifying eligibility. For information about the Medi-Cal POS, contact the Medi-Cal program, [medi-cal.ca.gov]

4. Membership Enrollment Materials

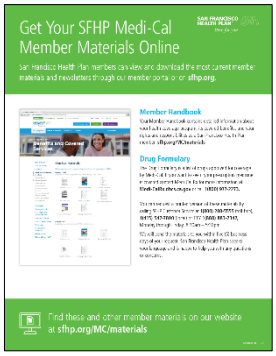
Each new Medi-Cal member is sent an enrollment Welcome Packet by SFHP. The packet includes:



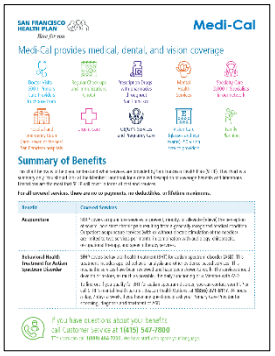
A new member welcome letter



A Member Guidebook

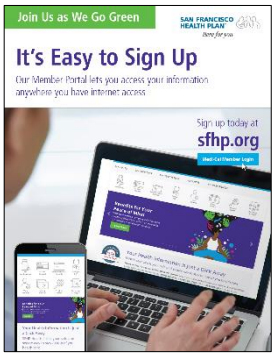


"In Lieu" flyer



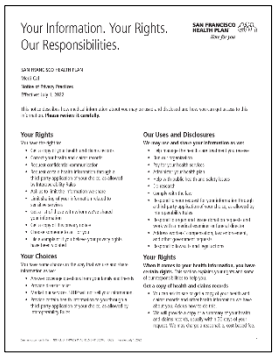
Summary of Benefits

Coordination of Benefits Information



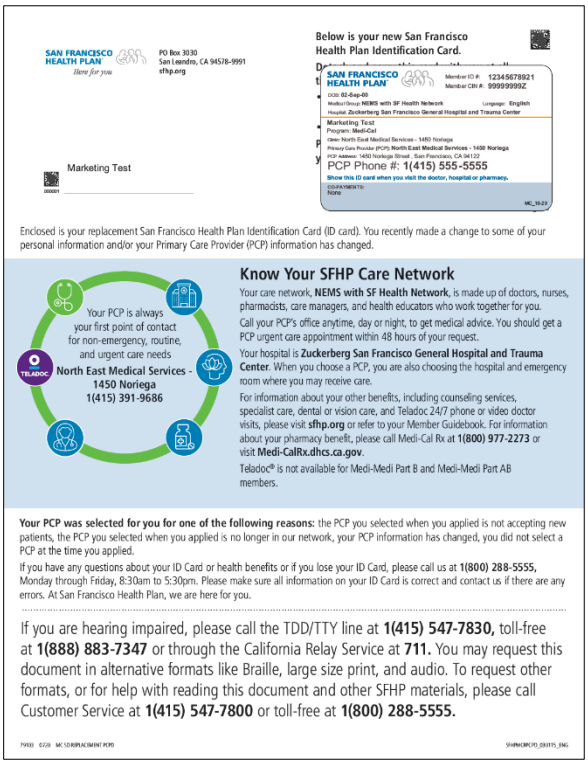
Member Portal Guide

Section 1557 Notice: Notice of Nondiscrimination, Language Services, and Methods for filing a Grievance



Notice of Privacy Practices

Each individual member is also sent an ID card and carrier 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.



5. PCP Selection, Assignment, and Change

At the time of enrollment, a new member is encouraged to select a PCP. When no selection is made, SFHP will automatically assign a PCP taking in to consideration 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 if the PCP is accepting new patients. PCP change requests made by the 15th day of the month will be effective on the first day of the following month. PCP changes requests should be directed to the SFHP Customer Service department.

6. Member Rights & Responsibilities

SFHP members have rights and responsibilities. Members are informed of their rights and responsibilities through member education materials. Please consult the Member Handbook (**sfhp.org/for-members/medi-cal/benefits/member-materials**) 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 (PCP) 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, providers, care received, and other other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).
- To receive care coordination.
- To request an appeal of an ABD, decisions to deny, defer, or limit services or benefits within 60 calendar days from the date on the Notice of Adverse Benefit Determination.
- To have an Authorized Representative or Provider appeal on the Member's behalf, with written consent from the Member.
- To receive oral interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language, free of charge.
- 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, , sexually transmitted disease services and Emergency Services inside or outside the SFHP network, without referral or Prior Authorization. pursuant to the federal law.
- To have access to Federally Qualified Health Centers, Rural Health Centers, Indian Health Care Providers outside of the SFHP network, pursuat to federal law.
- To request a State Hearing or Independent Medical Review (IMR), including information on the circumstances under which an expedited hearing or IMR is possible.
- To request continuation of benefits during an Appeal or State Hearing.
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record.
- To change Medi-Cal managaed care plans upon request, if applicable.
- 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 their condition and ability to understand.
- To receive a copy of their 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 retaliation or any adverse conduct SFHP, providers, subcontractors, or the State.
- To make recommendations regarding SFHP member rights and responsibilities policy.

- Right to oral interpretation 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 Manual.
- 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 Manual. 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** (local) or **1(800) 288-5555** (toll-free) for any questions or issues regarding member rights and responsibilities.

Health Education

SFHP ensures that members are 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, if available, 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 **sfhp.org/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**.

7. 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 that are assessed for proficient language capacity. When bilingual staff is 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 and SFHP Providers:

- No-cost linguistic services (through bilingual staff or interpreters) during face-to-face or telephonic contact with SFHP and their providers.
- Receive fully-translated documents in threshold and concentration languages such as health education materials, grievance letters, welcome packets, and marketing information. SFHP's Medi-Cal threshold languages include; English, Chinese (spoken: Cantonese; written: Traditional), Spanish, Vietnamese, Tagalog, 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, diversity, equity and inclusion trainings for providers, office personnel and medical group staff that 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 SPDs, Members with chronic conditions, Members with Specialty Mental Health needs, Members with intellectual and Developmental Disabilities, and Children with Special Health Care Needs. Trainings must include social drivers of health and disparity impacts on Member's health care.

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.**

8. 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 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 providers to meet their health care needs or provide referral to a provider who has access.

Terms of Coverage

1. Member Benefits and Member Copayments—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	sfhp.org/providers/provider-tools/benefits-grid/
HealthyWorkers HMO℠	sfhp.org/providers/provider-tools/benefits-grid/

2. 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 a 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 a 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.

Member Appeals and Grievances

1. Member Expressions of Dissatisfaction

The Department of Managed Health Care (DMHC) defines a grievance as any expression of dissatisfaction regarding SFHP and/or provider, including quality of care, concerns, disputes, and requests for reconsideration or appeal made by the member or the member's representative. When SFHP, delegated medical group, or provider is unable to determine whether a member's issue is a grievance or an inquiry, the member's issue must be considered a grievance.

SFHP categorizes expressions of dissatisfaction made by members into two categories: grievances and appeals. An appeal is a review of a request for a health care service that was previously denied, delayed or modified by SFHP or a delegated medical group. A grievance is an expression of dissatisfaction about any matter other than a decision by SFHP or delegated medical group to deny, delay or modify a health care service.

If providers are unable to quickly address an issue raised by a member, providers should provide the member with information on how to file a grievance or appeal with SFHP. Members, providers, or authorized representatives with the member's consent can file a grievance. SFHP provides PCPs and medical groups with copies of its grievance forms in English, Spanish, Chinese, Vietnamese, and Russian. Additional forms can be obtained by contacting SFHP or through the SFHP website at **sfhp.org/providers/provider-resources/grievance-process/ .**

Providers must make these forms available to members who desire to express their dissatisfaction with any of the covered areas of service. Providers can also direct SFHP members and their authorized representatives to file a grievance with SFHP by using one of the following methods:

Online by filling out this **Grievance Form.**

Call San Francisco Health Plan at **1(800) 288-5555,** Monday through Friday, 8:30am to 5:30pm, and request a Grievance Form.

Secure Provider Website: Verify eligibility and PCP for any date of service, ee the status of your claims and submit Prior-Authorization requests

The member may file a grievance in person. Our Service Center address is 7 Spring Street, San Francisco, CA 94104. Office Hours are Monday through Wednesday and Friday, 8:30am to 5:00pm; Thursday, 8:30am to 3:00pm. Call **1(800) 288-5555** to schedule an appointment.

Write a letter describing the problem and mail it to San Francisco Health Plan, Grievance Coordinator, P.O. Box 194247, San Francisco, CA 94119.

Download and complete a Grievance Form in the member's language:

English Spanish
Chinese Russian
Vietnamese Tagalog

Mailing information is included on the forms.

File a grievance through our secure member portal. Learn more about our member portal and sign up at **sfhp.org.** *The member should not send any personal health information through email.*

The member may also file a grievance directly through their doctor's office.

Upon receipt of the grievance or appeal, SFHP begins processing the grievance or appeal pursuant to its Member Grievances and Appeals policies and procedures. Other than Carelon, SFHP does not delegate processing of grievances and appeals to other entities.

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.

2. Member Grievances

Medi-Cal members may file a grievance about any matter other than a denial, delay or modification of a health care service at any time. Healthy Workers HMO members have 180 days following the incident or action that is the subject of the member's dissatisfaction to file a grievance. For expressions of dissatisfaction about denials, delays or modifications or a health care service, see the Member Appeals section below.

Within five (5) calendar days of receipt of a standard member grievance, SFHP (or SFHP's Delegate) sends an acknowledgment letter informing the member that SFHP received the grievance. SFHP works with the member, the provider, and the medical group to provide the member with a letter describing the resolution of the member's grievance within 30 calendar days of receipt of the grievance.

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 does not meet criteria for expedited processing, SFHP will provide a written notice to the member stating that the grievance will be processed within the standard 30 calendar days. 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 appeal. SFHP will make reasonable efforts to provide oral notice of the resolution to the member for expedited appeals.

SFHP staff may ask providers to provide additional information or directly respond to allegations brought forth in a member grievance. This may include medical records, a clear and concise written response addressing all allegations and questions, medical records, as well as any additional information that may be available from the member or provider. Providers must respond to SFHP staff by the requested due date or 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, as required by law. If a response is not to be provided expeditiously, providers must make reasonable effort to communicate the status of the grievance response to SFHP staff.

All members may also contact the Department of Managed Health Care about their grievance **at 1-888-HMO-2219,** TDD **1-877-688-9891** or at **http://www.hmohelp.ca.gov.** DMHC contact information is provided to members immediately upon receipt of an urgent grievance and if a grievance has been downgraded from expedited to standard timeframe processing. Medi-Cal members can get assistance from the State Medi-Cal Managed Care "Ombudsman Office" at **1(888) 452-8609.**

3. Member Appeals

Appeals are member and provider requests for review of a delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. SFHP or Delegate decisions are communicated 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 HMO members have 180 days from the date of the NOA to file an appeal with SFHP. Members have a right to request continuation of benefits while an Appeal is in progress.

Members can file a grievance that is **not** about a Notice of Action, as described in the Member Grievance section above.

Providers who are disputing a NOA 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.

Within 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 all of the clinical information relevant to the appeal. This may include the provider's authorization request and any accompanying clinical information, criteria used to determine the denial, 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. A physician who was not involved in the initial determination will review the appeal. The physician 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 medical review entity for review and decision. SFHP may implement the decision recommended by the external medical review entity.

SFHP's clinical criteria hierarchy are applied to appeals as described in SFHP Policy and Procedure

CO-57, "Utilization Management Clinical Criteria." The hierarchy is:

A) SFHP internally-developed and approved criteria
B) MCG Care Guidelines
C) (For Medi-Cal members only:) State/Federal (Medi-Cal/CMS) criteria. If no Medi-Cal Criteria is available, Medicare/CMS criteria can be consulted on a case-by-case basis.
D) Chief Medical Officer (CMO) or designee reviews evidence

The SFHP clinical grievance staff will send a Notice of Appeal Resolution letter to the member within 30 calendar days. For appeal decisions that are overturned, SFHP or Delegates will authorize services within 72 hours from the date of the Notice of Appeal Resolution.

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 does not meet criteria for expedited processing, SFHP will provide a written notice to the member stating that the appeal will be processed within the standard 30 calendar days. 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 from the time of receipt of the appeal. SFHP will make reasonable efforts to provide oral notice of the resolution to the member for expedited appeals.

Members may also contact the Department of Managed Health Care (DMHC) about their appeal at **1-888-HMO-2219,** TDD **1-877-688-9891** or at **http://www.hmohelp.ca.gov.** DMHC contact information is provided to members immediately upon receipt of an urgent appeal and if an appeal has been downgraded from expedited to standard timeframe processing. Medi-Cal members can get assistance from the State Medi-Cal Managed Care "Ombudsman Office" at **1(888) 452-8609.**

4. External Appeal Options

Members have external appeal options if they do not agree with the decision in the grievance resolution letter or Notice of Appeal Resolution. Medi-Cal, Healthy Workers HMO members can ask for an Independent Medical Review (IMR) and an outside reviewer that is not otherwise affiliated with SFHP will review the case. Medi-Cal members can also ask for a State Hearing and a judge will review their case. State Hearings are not available to Healthy Workers HMO members. Both State Hearings and IMRs are available to members at no cost.

In most cases, members are required to exhaust SFHP's appeal process prior to requesting an IMR or State Hearing. Exceptions to the requirement to exhaust SFHP's appeal process are described in the subsections below.

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 may be able to get free legal help by calling the Health Consumer Alliance's hotline at **1(888) 804-3536**. Members may also call Bay Area Legal Aid at **1(800) 551-5554**.

Medi-Cal State Hearings

A State Hearing is an administrative procedure by which members with a grievance can present their cases directly to a State of California judge for resolution. Only Medi-Cal members have the right to contact the Department of Health Care Services (DHCS) or the State Ombudsman's office to request a

State Hearing regarding a denial, delay or modification of a health care service. State Hearings are not available to Healthy Workers HMO .

Medi-Cal members may request a State Hearing without first appealing to SFHP is they have an expedited complaint or the member has waited more than 30 days for a resolution from SFHP.

Medi-Cal State Fair Hearing

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

Medi-Cal members can ask for a State Hearing by phone or in writing:

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

State Hearing forms are attached to Notice of Appeal Resolution letters. Members have a right to request continuation of benefits while a State Fair Hearing is in progress. Members may have representation at hearings. If the member needs an interpreter, an interpreter will be provided at no cost.

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 or within three (3) working days if an expedited hearing was granted.

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 Department of Managed Health Care (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 a member's complaint meets the criteria for IMR, physicians who are affiliated with DMHC's IMR organization will review the case to determine whether SFHP should cover the disputed health care services. If the member's complaint does not meet these criteria, DMHC will still review the case as a Consumer Complaint.

Medi-Caland Healthy Workers HMO Members may request an IMR regarding a decision by SFHP to deny, delay or modify a health care service from the within 180 days of the date of the Notice of Appeal Resolution. Members may qualify for IMR without first appealing to SFHP if they have an issue that requires expedited processing, the requested service was denied for experimental/investigational reasons, or the member has waited more than 30 days for a resolution from SFHP.

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. SFHP also attaches IMR application forms to Notices of Appeal Resolution.

When DMHC notifies SFHP that a request for a Consumer Complaint/IMR has been received, the SFHP must provide a response to the member's complaint 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. If the DMHC notifies the SFHP that a case qualifies for IMR, the relevant medical records must be submitted to DMHC's IMR organization within

three (3) business days for a standard request or within one (1) calendar day for an expedited request. If contacted by SFHP staff to provide medical records and supplemental documentation for a DMHC Consumer Complaint/IMR, providers and medical groups must provide SFHP with the documentation as soon as possible in order for SFHP to meet the DMHC's response deadlines.

DMHC's IMR organization will review the IMR case to determine whether the disputed health care service was medically necessary and whether SFHP should have authorized and covered the service. If ordered by DMHC to cover the service, the Utilization Management department at SFHP or the Delegate must authorize the service(s) and inform the member and the requesting provider the service(s) has been authorized. If the review was expedited, SFHP or the Delegate must immediately contact the member and provider by phone or fax, and send written notification within 24 hours of receipt of the IMR determination. If the service has already been rendered, any outstanding claims are reimbursed as directed.

Action	Expedited	Standard
DMHC notifies SFHP that member filed a complaint or applied for IMR	Within 48 hours after DMHC's receipt of the complaint/application	Within seven (7) calendar days after DMHC's receipt of complaint/application
SFHP submits a response to the member's complaint/IMR application to DMHC	Within 24 hours of DMHC notification	Within five (5) working days of DMHC notification
If DMHC determines that the case is eligible for IMR, SFHP submits medical records to DMHC IMR organization	Within one (1) calendar day of DMHC request for medical records	Within three (3) working days of DMHC request for medical records
DMHC's IMR organization makes determination	Within three days of receipt of records (usually 7 days from receipt of IMR application), may take longer for experimental care	Within 21 days of receipt of records (usually 30 days from receipt of IMR 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

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**
HealthyWorkers HMO℠	IHSS	**1(415) 243-4477**
	Department of Human Resources for as-needed employees of City and County of San Francisco	**1(415) 557-4942**

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 Medi-Cal member is eligible for disenrollment for complex medical conditions (as defined by state law – 22 CCR §53887) if they have:

- Been a SFHP member for 90 days or less;
- Are currently under treatment by non-SFHP provider; or
- 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. Health Care Options will process the disenrollment to determine if the member meets criteria

3. Medi-Cal Members in SNF, LTC, Subacute, or ICF-DD

A SFHP Medi-Cal member receiving care at a Skilled Nursing Facility (SNF), or other Long Term Care Center (LTC), Subacute Care or Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD) may be transferred to the SFHP Direct Network (SDN) if the SNF admission exceeds the month of admission and the following month.

When UM staff at a Delegated Group identify a qualifying admission that meets SFHP Custodial Care Criteria and is likely to exceed the month-of and month-after admission:

Delegated Group UM staff requests MC 171 form from facility (this form prompts aid code change to LTC aid code).

At least five (5) business days before the first day of the third month of admission, Delegated Group UM staff notify SFHP's UM staff via secure email to postacutehelp@sfhp.org. Notification includes authorization summary, clinical notes and information, projected length of stay (e.g., "greater than 6 months" or "12 months" is sufficient), rationale for projection, confirmation SFHP Custodial Criteria was applied and MC171 form (if available). SFHP UM staff will confirm within 5 business days if the member meets Custodial Criteria and will be transferred to SDN.

Until the date of transfer to SDN, the medical group remains responsible for the payment of the SNF costs, including the cost of custodial care..

SFHP's Long-term Services & Supports Liaison helps facilitate addressing claims, payment inquiries, and care transition related concerns. Email: LTSSLiaison@sfhp.org

The eligible member or other authorized individuals (as defined by state law– 22 CCR §53889(h)) may submit a disenrollment request to Health Care Options by mail or in person. Expedited disenrollments may also be submitted by facsimile or by phone. Health Care Options will process the disenrollment to determine if the member meets criteria. Phone: 1(800) 430-4263, https://www.healthcareoptions.dhcs.ca.gov/en

4. Member Disenrollment for Cause

Members may choose to submit a request to Health Care Options to disenroll from SFHP at any time.

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 wellbeing 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.

Health Services

Quality Improvement and Health Equity

1. Quality Improvement and Health Equity Program

The purpose of the SFHP Quality Improvement and Healthy Equity (QIHE) Program is to systematically monitor, evaluate, and improve the quality of care and services provided to members. The QIHE Program is designed to ensure that members have access to quality medical and behavioral health care services that are safe, effective, accessible, equitable, and meet their unique needs and expectations.

The QIHE Program Description and Work Plan outlines SFHP's infrastructure to support quality improvement as well as identifies annual goals. SFHP evaluates progress towards its goals at the end of each year through the creation of a QIHE Program Evaluation. The scope and goals of the QIHE Program are comprehensive and encompass major aspects of care and services within the SFHP health care delivery system, including clinical and non-clinical issues that affect its membership.

A copy of the QIHE Program Description and Work Plan as well as the QIHE Program Evaluation can be found in its entirety on SFHP's provider website located at https://www.sfhp.org/providers/improving-quality/qi-program-evaluations-results/

2. Provider Involvement in the QIHE Program

Provider cooperation in the QIHE Program is required to improve the quality of care and services for members including member experience. Providers must cooperate with all independent quality review and improvement activities required by their contracted medical group and SFHP pertaining to the provision of services to members. Providers must allow their contracted medical group and SFHP access to their facilities for the purposes of site review, case management and other quality management activities. Providers maintain the confidentiality of member information and records. SFHP may utilize provider performance data for quality improvement activities such as HEDIS and pay-for-performance.

Providers participate in the QIHE program through committee membership and data sharing. SFHP has numerous committees with provider leadership representation to provide guidance and support. Details on Quality Committee structure can be found in the QIHE Program Description and Work Plan on SFHP's provider website located at https://www.sfhp.org/providers/improving-quality/qi-program-evaluations-results/**.** SFHP informs its participating providers and members of its QIHE program and ongoing QI activities through the SFHP provider newsletter, the Provider Manual, and annual member mailing.

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

3. Measuring Quality

SFHP evaluates the overall effectiveness of the QIHE Program through a quarterly comprehensive evaluation process that results in an annual written report called the QIHE Program Evaluation, which is submitted to DHCS. The QIHE Program Evaluation includes an executive summary and a summary of all quality improvement measures, identifying significant trends and areas for improvement. For each measure in the QIHE Work Plan, the evaluation includes the following elements:

- Brief description of the QI measure and how it purports to improve care or service quality for SFHP members
- Numerical target(s) of the QI measure
- Activities that support the QI measure
- Barriers that impede the QI measure (target or activity) from demonstrating effectiveness
- Results based on data collected to monitor target
- Recommended interventions/actions to overcome barriers in the following year

Results of the QIHE Program Evaluation, in combination with information and priorities determined by SFHP Health Services leadership and staff, are reviewed and analyzed in order to develop an annual QIHE Work Plan. This comprehensive set of measures is divided into five activity domains:

1. Clinical Quality and Patient Safety
2. Quality of Service and Access to Care
3. Utilization Management
4. Care Coordination and Services
5. Quality Oversight

For more details, a copy of the QIHE Program Description and Work Plan as well as the QIHE Program Evaluation can be found in its entirety on SFHP's provider website located at https://www.sfhp.org/providers/improving-quality/qi-program-evaluations-results/

4. Member Incentive Program for Preventive Care

To encourage members to engage in their health care, SFHP offers the following member incentives:

$50 Gift Card	$50 gift card each for timely prenatal care, and a postpartum visit within 7-84 days after delivery
$50 Gift Card	$50 gift card for six well-child visits for children age 0-15 months
$50 Gift Card	$50 gift card for completing developmental screening for children 0-3 years
$50 Gift Card	$50 gift card for having first topical fluoride varnish applied for children 12-47 months per year
$50 Gift Card	$50 gift card for having second topical fluoride varnish applied for children 12-47 months in the same year

$50 gift card for Black-identifying members 45-75 years of age completing colorectal cancer screening

For more information about SFHP's member incentives, visit **https://www.sfhp.org/health-wellness/health-rewards/**

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5. Initial Health Appointment (IHA)

All Medi-Cal members must receive an Initial Health Appointment (IHA) within 120 days of enrollment, as mandated by DHCS.

- New SFHP members receive a mailing in their primary language encouraging them to make an appointment to complete the IHA.
- The results of the IHA must be documented in the member's medical record.
- 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 120 days of enrollment. As needed, SFHP requires a performance improvement plan for underperforming sites.

6. Pediatric and Adult Preventive Health Care Guidelines

An explanation of pediatric and adult coverage benefits is available to medical groups and provider offices in the Member Guidebook document (Medi-Cal, 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 (AAP) provides recommendations for preventive pediatric health care. AAP's full periodicity schedule can be found here: https://www.aap.org/periodicityschedule

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.**

The Advisory Committee for Immunization Practices (ACIP) publishes adult and pediatric immunization schedules. Members may access adult immunizations in network pharmacies, covered under SFHP's Outpatient Pharmacy Benefit for Medi-Cal.

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
- Tobacco use prevention and cessation (providers may also use the US Public Health Service tobacco clinical practice guidelines)

The USPTF's full list of recommendations is available at **uspreventiveservicestaskforce.org**.

Medi-Cal members are entitled to the entirety of preventive services identified as USPSTF "A" and "B" recommendations. These preventative services should be provided to eligible patients in the schedule recommended by the USPSTF. 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

Secure Provider Website: Verify eligibility and PCP for any date of service, ee the status of your claims and submit Prior-Authorization requests

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.

Providers are instructed to document the following regarding preventive care services:

- Screening services provided, and results thereof
- Referral for diagnosis and treatment
- Results of diagnosis and treatment services
- Outreach and follow-up activities to assure that members have received needed services
- Notation of refusal of services by member, parent, or guardian
- At each non-emergency encounter, providers are encouraged to inform adult members of overdue preventative care items and required to do so for pediatric members.

7. Medi-Cal for Kids & Teens

Medi-Cal for Kids & Teens benefit, formerly known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), provides comprehensive and preventative, diagnostic, and treatment services to

eligible children and youth under age 21.

Care covered by Medi-Cal includes:

- Physical health services, including primary care and specialist visits
- Mental health and drug or alcohol treatment services, including therapy
- Dental check-ups and follow-up services
- Vision services, including eyeglasses
- Hearing services
- COVID-19 testing and treatment
- Medical equipment and supplies, including durable medical equipment
- Medication
- Lab tests, including blood tests to check lead levels, and any needed follow-up care
- Physical, occupational, and speech therapy
- Home health services, including nursing care (requires a Prior Authorization from SFHP)
- Hospital and residential treatment
- For teens/young adults:
    - Sexual and reproductive health services
    - Pregnancy check-ups
- All other needed medical services that can be covered under Medi-Cal (known as “medically necessary services”) as determined by the medical provider

Transportation to and from medical appointments or to pick up mediation, medical equipment, and supplies

For more information visit https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx

8. 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.

9. Blood Lead Screening

Protecting children between the 6 to 72 months of age from lead exposure is important to lifelong good health. Lead exposure can cause damage to the brain and nervous system, slowed growth and development, learning and behavior problems, and hearing and speech problems. The most important step that can be taken is to prevent lead exposure before it occurs.

Providers must follow the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines and do the following:

- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
- Order or perform blood lead screening tests on all child members in accordance with the following timelines, and report the service to the health plan as **CPT 83655**:
    1. At 12 months and at 24 months of age.
    2. When the network provider performing a Periodic Heath Assessment (PHA) becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter
    3. When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
    4. At any time a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
    5. If requested by the parent or guardian
- Providers and all delegate medical groups are required to report blood lead results to the Child Lead Poisoning Prevention Branch (CLPPB).
- Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines
- Network providers are not required to perform a blood lead screening test if either of the following applies. Provider should document the contraindication in the patient's medical record.
    1. In the professional judgement of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
    2. If a parent, guardian, or other person with legal authority to withholdconsent for the child refuses to consent to the screening.

SFHP sends a report to each medical group every quarter containing members who are expected to have

screening or tests. Providers are advised to test that child and/or provide anticipatory guidance to parent/guardian recorded in the medical record.

Utilization & Case Management

1. Authorization Requests and Referrals

SFHP conducts utilization management (UM) by reviewing authorization requests to determine whether the requested benefits are covered under our programs and by applying clinical criteria to make evidence-based medical necessity determinations.

Prior Authorization is not required for emergency services and sensitive services (family planning, sexually transmitted disease services, HIV testing) regardless of where services are received. Basic prenatal care, OB/GYNs and family medicine providers for routine and preventive care, preventive services, and a number of other services do not require prior authorization, but must be received from providers affiliated with the member's assigned medical group.

It is the responsibility of the provider to establish coverage eligibility and medical group assignment prior to the delivery of services. This avoids the possibility of a provider being denied reimbursement for services already rendered. SFHP recognizes that certain circumstances (e.g., emergency services, retroactive eligibility) may make submission of an authorization request prior to service impossible.

Medical groups delegated to provide UM services establish their own policies and procedures, including those for retrospective authorization, provided that they comply with SFHP contractual obligations, applicable regulatory requirements, and with National Committee on Quality Assurance (NCQA) standards.

UM decision making is based only on appropriateness of care and services, and existence of coverage. Authorizations are contingent upon the member's eligibility and benefit program and are not a guarantee of payment. The provider is responsible for verifying the 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 utilization review 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 the existence of coverage.

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

- Secure Provider Portal: **sfhpprovider.healthtrioconnect.com/**
- Web: **sfhp.org/providers/**
- IVR: **1(415) 547-7810**
- SFHP Member Services: **1(800) 288-5555**

For members in the UCS, SFN, CLN, and SDN groups, providers can look up authorization requirements by service name or code at sfhp.org/providers/authorizations/code-lookup .

Providing Authorized Services in Good Faith:

SFHP and its Delegates will not rescind or modify authorizations after the provider renders the service in good faith and pursuant to the authorization, provided that the member's eligibility was active at the time services were rendered. SFHP and its Delegates will not rescind authorizations if it subsequently cancels a Member's subscriber contract, or if SFHP subsequently determines that it did not make an accurate determination of the Member's eligibility.

In the case of a Medi-Cal Member who is retroactively disenrolled from SFHP—but retains Medi-Cal eligibility

through Fee-for-Service (FFS) Medi-Cal or another Medi-Cal managed care plan—SFHP either does not pay for the services or, if SFHP has already paid the provider, seeks overpayment recovery. The provider should seek reimbursement from Medi-Cal FFS or the other Medi-Cal managed care plan. DHCS has opined that paying for pre-authorized services rendered to Medi-Cal beneficiaries who are no longer Members on the date of service would be expanding benefits under the Medi-Cal managed care and contrary to the intent of Health & Safety Code Section 1371.8.

Services that Do Not Require a Prior Authorization:

The following services do not require a prior-authorization from any provider in the United States:

- Emergency care including emergency medical transportation
- Family planning services
- Outpatient abortion services
- HIV testing and the treatment of sexually transmitted infections (STIs)

The following services do not require a prior-authorization if obtained within the patient's medical group:

- Non-emergent transportation from facility to facility
- Urgent Care provided at an Urgent Care Center
- Preventive services
- Referrals to specialists
- Standing referrals to specialty care
- Behavioral and Mental health

Tracking Unutilized Authorizations

SFHP requires providers and Delegates to have an established specialty referral system to track and monitor referrals requiring prior authorization and follow up for specialty referrals.

Delegates 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 covered services are not available in-network or are not available within a timeframe that is compliant with the timely access standards, SFHP or the delegated medical group may choose to facilitate services to an out-of-network provider as appropriate. The cost to the member cannot be greater than it would be if the service was furnished in-network.

2. Inpatient Concurrent Review and Care Transitions

Repatriation

San Francisco Health Plan will assist with the safe transfer of of members assigned to the San Francisco Health Network (SFN) or Community Health Network (CLN) to Zuckerberg San Francisco General Hospital (ZSFGH) ("repatriation"). All SFN and CLN members should receive services at ZSFGH. SFHP inpatient Nurses are available by phone at **1(415) 615-4525,** 7 days a week from 8:30am to 9:00pm to manage inpatient review and repatriation of SFN and CLN members.

Non-contracted Hospitals:

Non-contracted hospitals are required to notify SFHP of a member's inpatient admission within 24 hours, or, if the notification period ends on a weekend or holiday, by 5:00pm the next business day. SFHP requires timely notification of acute admissions from the admitting hospital using either the inpatient notification phone line at **1(415) 615-4525** or fax line at **1(415) 547-7822.** Voicemail and fax are available 24/7. Communications received after business hours are returned the next business day. Communications

received after midnight Monday through Friday are returned the same business day.

The front of SFHP member ID cards indicate the name of the member's assigned hospital. If a member is admitted without the notification required by law, claims may be denied.

Care Transitions

SFHP's Care Transition (CT) program supports coordination of care as members move from one level of care to another. The CT Team collaborates with hospital staff to ensure safe discharge planning by conducting patient outreach through pre- and post-discharge calls and onsite visits. The goals and priorities are:

- Care Coordination
- Reduce hospital and emergency department readmissions
- Ensure care is provided in medical group, and within network, as appropriate
- Ensure members are connected with medically necessary services, Care Management services, and community support services upon discharge, as appropriate
- Quality Improvement

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, SFN and CLN members. The SFHP Clinical Operations (CO) Nurse Team, Complex Medical Case Management, and Care Transitions staff collaborates internally and with the acute care and SNF facilities to ensure that the member is connected with medically necessary services, and support services in the community upon discharge. In collaboration with the San Francisco Health Network (SFHN), SFHP also coordinates timely post discharge follow-up.

SFHP confirms that the required Pre-Admission Screening and Resident Review (PASRR) process has been completed as a component of hospital discharge planning and admission planning when a member is admitted to a SNF.

3. 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 the line of business as follows:

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)*.

The following non-specialty mental health services are covered when medically necessary and provided by PCPs or licensed mental health professionals in the Carelon 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. Screening for alcohol misuse and substance use disorder and, to members who screen positive for hazardous consumption, providing counseling and referral to additional treatment as appropriate;
5. Psychiatric consultation; and

6. Outpatient laboratory, drugs, supplies and supplements
7. 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).

SFHP partners with Carelon and College Health IPA ("CHIPA") to administer these "***non-specialty mental health services***." All of the above non-specialty mental health services are managed by Carelon except for outpatient laboratory and supplies, which are covered directly by SFHP, and prescribed drugs and supplements, which are covered by Medi-Cal Rx.

Carelon
Member and Provider Services: **1(855) 371-8117**
Fax: **1(562) 402-2666**
TDD/TTY: **1(800) 735-2929**
Carelon Provider Manual is available at the URL below. There is plan-specific information for San Francisco Health Plan in Appendix 3:
https://www.carelonbehavioralhealth.com/providers/resources/provider-handbook

For mild to moderate mental health covered services for adults, 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 Behavioral Health Services (SFBHS) for specialty mental health services when a mental health diagnosis covered by the SFBHS results in significant impairment.

For members under age 21, medically necessary non-specialty mental health services are covered regardless of severity of the impairment. The number of visits is not limited as long as the child/adolescent member meets medical necessity criteria.

SFHP Medi-Cal members who need mental or behavioral health services can see their PCP for assessment or to confirm a mental health diagnosis, and to evaluate for medical causes of symptoms before referral. However, neither referral nor authorization are not required to seek care for mental or behavioral health. In order to assess whether a Medi-Cal member needs nonspecialty- versus specialty mental health services, PCPs may use the behavioral health screening tool available online at: https://www.sfhp.org/providers/our-network/mental-health/

PCPs may also have members contact Carelon for a telephonic screening, or providers may contact Carelon to provide clinical data to make determinations regarding level of care.

When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a Carelon mental health provider for mild to moderate impairment of mental, emotional, or behavioral functioning or to SFBHS 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 Carelon and are instead provided by San Francisco Behavioral Health

Services (SFBHS) to Medi-Cal beneficiaries who meet criteria.

Providers should refer Medi-Cal members to SFBHS for specialty mental health services.

San Francisco 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

SFHP members may self-refer for specialty mental health and substance abuse services by calling the SFBHS Access Hotline at **1(800) 870-8786** for triage. Members may also self-refer, by walking-in to any SFBHS network behavioral health center. The mental health provider, with the member's consent, coordinates care with the member's other treating providers.

Healthy Workers HMO

Mental health and substance use disorder services are available to Healthy Workers HMO members through SFBHS. Providers should refer Healthy Workers HMO members to SFBHS for mental health and substance use disorder services outside of their scope of practice.

San Francisco 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

SFHP members may self-refer for mental health and substance use disorder services by calling the SFBHS Access Hotline at **1(800) 870-8786** for triage. Members may also self-refer, by walking-in to any SFBHS network behavioral health centers. The mental health provider, with the member's consent, coordinates care with the member's other treating providers.

SFHP educates PCPs and medical groups about its procedures for referring members to mental health and substance use disorder services. San Francisco Behavioral Health Services distributes a copy of its directory to SFHP and provider offices annually. SFBHS providers are also searchable on SFHP's provider directory at **sfhp.org**.

Dyadic Care Services

On January 1, 2023, Medi-Cal launched the new Dyadic Care and Family Therapy Benefit through APL 22-029. This expands the availability of child development services and family supports for Medi-Cal beneficiaries.

The name "Dyadic Care" refers to a two-generation approach to health care. These covered services take advantage of the periodicity of the well-child visit, and the provider-patient relationships available in those special visits, to offer family therapy without the need for a mental health diagnosis.

Behavioral health clinicians and even nonclinical staff can provide Dyadic Behavioral Health services - including family training, child development counseling, community supports, and psychoeducation – to parents and/or caregivers of Medi-Cal enrollees, when it benefits the health of the child.

San Francisco Health Plan's behavioral health vendor, Carelon (formerly Beacon), reimburses the following Dyadic Services procedures, delivered since 1/1/2023:

Preventive behavioral health services provided to patients aged 0 to 20 years and/or their caregivers:

- Dyadic Behavioral Health (DBH) Well-Child Visits (H1O11)
- Comprehensive Community Support Services (H2015)
- Psychoeducation (H2027)
- Child Development Training and Counseling (T1027)

Assessment, screening and counseling provided to a parent or caregiver:

- ACE screening (G9919, G9920)

- Alcohol and drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (G0442, H0049, H0050)
- Brief emotional/behavioral assessment (96127)
- Depression screening (G8431, G8510)
- Behavior assessments and interventions (96156, 96167, 96168, 96170, and 96171)
- Psychiatric diagnostic evaluation (90791, 90792)
- Tobacco cessation counseling (99406, 99407)

Provider questions can be directed to the Carelon National Provider Service Line at 800-397-1630, or by email to provider.inquiry@Carelon.com.

4. 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 have the authority to consent to abortions, birth control (except sterilization), care for rape or 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, be notified, and can have access to those records.

5. Denial of Authorization Request for Medical Services

Please see section 4, Member Grievances and Appeals.

6. Continuity of Care

To ensure availability and continuity of covered medical and behavioral care, SFHP requires its participating providers, medical groups, hospitals and individual practitioners to continue delivering covered services to members as specified after SFHP, or a delegated group, terminates a provider contract. SFHP also requires its participating providers to allow newly-enrolled members to continue care with a non-participating provider in certain situations as specified below.

Terminated and non-participating providers who are rendering services for continuity of care purposes are compensated at rates similar to current contracting rates used by SFHP and/or the assigned medical group for similar services. SFHP and/or the assigned medical group are not required to continue services if the terminated or non-participating provider does not accept these rates.

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.

A member may be eligible to continue to receive services from terminated Providers if, at the time of the Providers' termination, the member is being treated for one of the following conditions:

- For Members with with an Acute Condition where sudden illness occurs due to inury or other onset of symptoms due to an illness,

injury, or other medical problems that requires prompt medical attention.Terminated providers shall provide covered services for the duration of the Acute Condition.

- For Members with a serious chronic condtion due to a disease, illness, or other medical problems or disorders that continue without full cure,worsens over time or requires ongoing treatment to maintain remission or prevent deterioration. The terminated provider shall provide covered services:
    - For the time necessary to complete a course of treatment and to arrange for a safe transfer to a SFHP provider. SFHP's consultation with the Member and the terminated Provider will be consistent; or
    - For a period of time not to exceed twelve (12) months from the date of the Provider contract termination.
- For Members being treated for their pregnancy (including immediate postpartum care), terminated providers shall provide covered services through the duration of the pregnancy and the immediate post-partum period.
- For Members being treated for a maternal mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, terminated providers shall provide Covered Services for up to 12 months from diagnosis or from the end of pregnancy, whichever is later.
- For Members being treated for a terminal illness.Terminated providers shall provide covered services through the duration of the terminal illness.
- For Members who are children from birth to 36 months of age.Terminated Provider shall provide covered services that do not exceed over 12 months from the date of the Provider contract termination.
- Surgery or other procedure that have been authorized by SFHP or assigned deletged group as part of a documented course of treatment.That has been recommended and documented by the terminated provider to occur within 180 days of provider's contract termination date. SFHP or the assigned delegated group shall allow the terminated provider to provide surgery or other procedures as authorized.

New Member Continuity of Care

SFHP requires that covered services be obtained from contracted providers of the member's assigned delegated group. A newly-enrolled member may continue to receive treatment from a non-contracted provider or hospital. If the member was receiving care from the non-contracted provider at the time of enrollment for any of the following conditions:

- An Acute Condition at the time of enrollment, SFHP or the assigned medical group shall allow the non-participating provider to provide covered services for the duration of the acute condition.
- A Serious Chronic Condition at the time of enrollment, SFHP or the assigned medical group shall allow the non-participating provider to provide covered services:
    - For a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a SFHP provider. Determined by SFHP in consultation with the Member and the non-participating Provider and consistent with good professional practice; or
    - For a period of time not to exceed twelve (12) months from the effective

date of coverage for the newly-enrolled member.

- For new members who are being treated for their pregnancy at the time of enrollment (including immediate postpartum care), SFHP or the assigned delegated group shall allow the non-participating provider to provide the Covered Services through the duration of the pregnancy and the immediate post-partum period.
- For Members who are being treated for a maternal mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, terminated providers shall provide covered services for up to one year after delivery.
- For new members who are being treated for a terminal illness at the time of enrollment, SFHP or the assigned medical group shall allow the non-participating provider to provide covered services through the duration of the terminal illness.
- For new members who are children from birth to 36 months of age at the time of enrollment, SFHP or the assigned delegated group shall allow the non-participating provider to provide Covered Services, not to exceed 12 months from the effective date of coverage.
- For a surgery or other procedure that has been authorized by SFHP or assigned delegated group as part of a documented course of treatment. That has also been recommended and documented by the non-participating provider to occur within 180 days of effective date of coverage for a newly-enrolled member.SFHP or the assigned medical group shall allow the non-participating provider to provide the surgery or other procedure as Authorized.

In addition, Medi-Cal members may receive Continuity of Care for up to 12 months from their date of enrollment with SFHP if the member:

- Is assigned to a mandatory aid code and is transitioning to SFHP from Medi-Cal Fee-for-Service,
- Has a non-contracted specialty mental health services (SMHS) psychologist or psychiatrist, but no longer qualifies for SMHS,
- Transitioned to SFHP from Covered California, or
- Was being treated by a non-contracted Behavioral Health Treatment (BHT) provider from a Regional Center at the time of enrollment with SFHP.

7. Transportation Services

SFHP Medi-Cal members can get transportation at no cost to and from Medi-Cal covered services. Member pays no co-payment. Medi-Cal covered services are:

- Health visits for medical, dental, mental health, and substance use care
- Picking up medical supplies or prescription drugs from the pharmacy.

SFHP covers two types of transportation:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)

Non-Emergency Medical Transportation (**NEMT**)

NEMT is available when member is not able to use public transportation to get to health visits. NEMT uses an ambulance, gurney/litter van, wheelchair van, or air transport. NEMT helps members who need support getting in and out of their vehicle and/or need medical supervision during the trip.

Non-Medical Transportation (**NMT**)

NMT services are available when members confirm that they have no other way to get to covered health services. NMT can be arranged if patient does not

need medical supervision or support from the driver. NMT uses a car, taxi, bus, or other public or private way of getting to the medical visit.
No prescription is needed to use NMT. Physician does not need to fill out a form.
Request for NMT must be approved by SFHP and arranged at least ten (10) business days before patients scheduled visit.

SFHP has partnered with **Modivcare** to enhance transportation scheduling and coordination. Modivcare has a network of transportation vendors. SFHP is responsible for transportation services for members in SFN, CLN, HILL, BTP, UCSF, and SDN Medical Groups. For members with NEMS, NMS, AAMG, and JADE, please contact the Medical Group to identify and authorize transportation services.

Providers have the option to request transportation on behalf of a member online through the TripCare portal or over the phone.

To request transportation through the online portal, you will need to register for a TripCare account. After registering, you may request transportation services for member appointments.

Providers can:

- Review patient panel for SFHP members who require transportation for appointments, and schedule rides through TripCare.
- Both NEMT and NMT can be arranged through TripCare.
- If you prefer to request a ride over the phone or have questions about a ride, you may call Modivcare directly at 1(866) 529–2128, 24 hours a day, 7 days a week.
- Coverage of the transportation benefit will remain the same.
- A Physician Certification Statement (PCS) Form will be required for transportation from a facility (hospital, SNF etc.) to home. A PCS is required for NEMT requests prior to requesting a ride. For more information regarding NEMT, please see our FAQ guide.
- A prescription (PCS Form) is not required for NMT requests.
- An SFHP member, a family member, caregiver, or medical facility staff member can call to arrange a patient's transportation.

For more information regarding NEMT and NMT, please visit our Transportation Services page.

7. Direct Access to OB/GYN Services

A member may self-refer to any SFHP network obstetrician/gynecologist or family practice physician within their medical group for gynecological and obstetric services. A member is not required to obtain prior approval from another provider, SFHP, or the delegated medical group to make an appointment or obtain direct access to an obstetric and gynecological or family practice physician for obstetric or gynecological services. Treatment and procedures beyond the appointment may require prior authorization.

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 members may also choose an SFHP obstetrician or gynecologist as their PCP if the obstetrician or gynecologist meets SFHP criteria for designation as a PCP.

8. Doula Services

DHCS defines doulas as birthworkers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons. Medi-Cal members have access to doula

services before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

Doula services do not require a prior authorization. An initial course of care for typical services is covered by standing recommendation from Med-Cal. If more than usual services are needed, a licensed practitioner provides a recommendation. This recommendation can be written in the member's medical record, covered by a provider's standing order, or handed to the member as a signed standard form to bring to the doula.

Medi-Cal members are eligible for a recommendation if they are pregnant, or were pregnant in the past year, and would either benefit from doula services or if they request doula services.

Doulas are part of the member's care team. Hospitals and birthing centers should not present barriers to accompanying members for delivery, regardless of outcome (live birth, stillbirth, abortion, or miscarriage).

9. Voluntary Termination of Pregnancy

SFHP Medi-Cal members may self-refer to any provider for **outpatient** abortion services without prior authorization. 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.

SFHP Healthy Workers HMO members may self-refer to any provider who is contracted with their medical group for **outpatient** abortion services without prior authorization. **Outpatient** abortion services provided from a provider outside of the member's assigned medical group or a non-contracted provider will require prior authorization. **Inpatient** abortion services requires prior authorization for Medi-Cal and Healthy Workers HMO members.

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.

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.

10. Sexually Transmitted Infection (STI) and HIV Testing

SFHP Medi-Cal members may self-refer to any provider for outpatient services without prior authorization.

Healthy Workers HMO members may self-refer to any provider who is contracted with their assigned medical group for outpatient services without prior authorization. Outpatient services provided by a non-contracted provider or a provider outside of their assigned medical group will require prior authorization.

Related services that are confidential and do not require prior authorization include:

- Contraceptive management.
- Pregnancy testing (for obstetric services, see Utilization Management, Section 8 – Direct Access to OB/GYN Services).
- 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.

Note: 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: **sfcityclinic.org**.

11. Family Planning—Adult Sterilization and Consent

San Francisco Health Plan (SFHP) ensures that sterilization services provided to its male and female members meet federal requirements, including a minimum age of 21, an informed consent process, and, for Medi-Cal and members. Provisions for a waiting period that is at least 30 days but not more than 180 days between the date of the written informed onsent and the date of sterilization. In addition, consent must be voluntary and the individual must not be coerced to employ sterilization or any particular method of sterilization.

Under Medi-Cal, vasectomies and tubal ligations are family planning services. Medi-Cal members of childbearing age may access these services from any provider, including outof--network providers without prior authorization.

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. A copy of the Consent Form must be submitted with the claim in order to be eligible for reimbursement.

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.

12. Gender Confirmation Services (Transgender Services)

Treatment for gender dysphoria is a covered benefit when medically necessary. Requests for services should be from specialists experienced in providing care to transgender individuals and in accordance with nationally recognized guidelines. Clinical guidance for the treatment of gender dysphoria is found in the most current "Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health (WPATH) on the WPATH website (**wpath.org**).

Nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria:

- Mental and behavioral health services
- Hormone therapy
- A variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender.

A service or the frequency of services available to a transgender recipient cannot be categorically limited. All medically necessary services must be provided in a timely manner. Limitations and exclusions, medical necessity determinations and/or appropriate utilization management criteria that are non-discriminatory may be applied.

13. Emergency Department and Urgent Care Services

An emergency medical condition is defined as a medical condition manifesting itself by acute

symptoms of sufficient severity (e.g., severe pain) such that the member reasonably believed 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, or
- Serious dysfunction of any bodily organ or part.

Emergency services include medical screening, examination, and evaluation by a physician, or -- to the extent permitted by applicable law -- by another 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. A "psychiatric medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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 determined by the examining physician. The examining physician determines the treatment required to stabilize the patient.

In routine and non-urgent situations, authorization by SFHP or the Delegate is required after completing the medical screening exam and stabilizing the condition. If there is no response within 30 minutes of the authorization request, the Emergency Room/ Department will proceed with treatment. Documentation and proof of the Emergency Department's attempt to reach SFHP or the Delegate and failure of response within 30 minutes of the first contact attempt will be accepted as authorization to diagnose and treat.

SFHP also covers 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 County. For emergency services obtained by a Medi-Cal member outside of the United States, SFHP covers only emergency services requiring hospitalization in Canada and Mexico. Should a member require reimbursement for an 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.

14. Members Admitted to Lower Level of Care (LLOC) Facilities

LTC services are provided at skilled nursing facilities (SNF), adult sub-acute, pediatric sub-acute, long-term acute care and intermediate care facilities [referred to as lower level of care (LLOC)].

LTC is a Medi-Cal covered benefit. SFHP and its Delegated Groups are responsible for medically necessary services for the month of admission and the month following admission. Members who require Custodial Care for longer than two months are usually transferred to SFHP Direct Network (SDN). For details and instructions on this process, see "Member Transfers/Disenrollments" in this Manual.

15. Major Organ Transplant

SFHP coverage of organ transplants depends on line of business, as detailed below. Organ transplants determined to be experimental or investigational are not a covered benefit by SFHP.

Medi-Cal

SFHP members who are eligible and pre-authorized for major organ transplants are reassigned to SFHP's direct network, UCSF, for coordination of their operation and for one year afterwards.

Kidney and cornea transplants are not considered "major" organ transplants; coverage of these surgeries are the responsibility of SFHP or the delegated group, and these Medi-Cal members will not be reassigned within SFHP.

Providers should send prior authorization requests for members who are under age 21 and in need of *any* organ transplant, including kidney and cornea, to California Children's Services Program (CCS).

SFHP and its delegated groups are responsible for the costs of covered medical care until the effective date of reassignment, including the costs of transplant evaluation, organ acquisition and bone marrow search.

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 SFHP, until the effective date of the member's disenrollment.

Healthy Workers HMO

Major organ transplants are covered for Healthy Workers HMO including the cost of the transplant evaluation and the costs associated with procurement of a donor organ. There is no co-payment.

Healthy Workers HMO members who are under age 21 may also be eligible to receive transplant services through CCS.

16. Mastectomy Length of Stay

SFHP and its medical groups allow the length of a hospital stay associated with mastectomy and lymph node dissection to be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. SFHP and its medical groups do not require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following these procedures.

17. 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 as they 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 includes:

- 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.

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 at **sfhp.org/providers/our-network/community-based-adult-services/**

For information, please contact the centers to arrange for a visit, or call the IOA at **1(415) 750-4111.**

18. Services for Chronic Pain

For Medi-Cal Members age 18 and up with chronic pain, acupuncture and chiropractic services are available. Medi-Cal members who also have Medicare Part B Coverage are not eligible.

Acupuncture:

Benefits are managed by SFHP and all Delegated Groups for those who seek acupuncture services. Acupuncture services are only available for treatment of chronic pain. Providers and patients can use SFHP's Provider Online Search Tool at SFHP.org or use their group's directory to find participating acupuncturists.

Chiropractic:

Chiropractic spinal manipulation services for diagnoses of back and neck pain only are accessed by members directly. Provider referral is welcome but not necessary. Participating chiropractors in San Francisco County and neighboring counties can be found by calling American Specialty Health (ASH Plans of California) at 1(800) 678-9133 or using the ASH provider directory online.

19. Second Opinion

San Francisco Health Plan (SFHP) ensures its members have access to second opinions from qualified health care professionals. Members have the right:

- 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 does not exceed 72 hours.
- To see the second opinion report.

SFHP will approve a member's or practitioner's request for a second opinion from a qualified health care professional 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, 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 plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- 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 members may request a second opinion from any qualified PCP or qualified specialist within the same medical group. If a qualified specialist is *not* available within the medical group, SFHP or a Delegate may authorize an out-of-medical-group visit. If no specialist is available within the SFHP network, SFHP or a Delegate may authorize a visit with an out-of-network specialist. Please see Policy & Procedure CO-22: Authorization Requests for standard procedures and timeframes.

If the member previously requested a second opinion and is requesting another opinion, the CMO or MD reviews the case.

- The CMO or MD reviews the initial opinion for diagnosis or treatment in question along with the second opinion.
- The CMO or MD determines whether the opinion or treatment is the same between the two providers.
- If the CMO or MD determines there is a difference between the two opinions, then the request for an additional opinion is authorized.
- If the CMO or MD determines that there is no difference between the two opinions, then the request is denied and no further requests for additional opinions shall be authorized.

If the request for a second opinion is denied, the member is notified in writing and provided with options to file a grievance or appeal.

When SFHP delegates utilization management, the Delegate implements this second opinion policy and must accommodate referrals to other medical groups and to out-of-network specialists if necessary, as described in this section.

20. 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 authorization requests, when regular use of a specialist is medically appropriate.

Members with **HIV/AIDS** are eligible for a standing referral to an identified HIV/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 a HIV/AIDS specialist, upon request.

21. Notice of Action (NOA) Standards

SFHP ensures members receive timely, consistent, and correct information regarding the management of their medical care, including information about their rights to appeal denials, modifications, or deferrals of care. SFHP sets standards for the content of Notice of Action (NOA) letters and also establishes timeframes for notifying members and practitioners of the UM decisions as mandated by federal and state law,regulations and guidance set forth by Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) accreditation guidelines. SFHP distributes NOA letter templates to its delegated medical groups, including templates in threshold languages.

SFHP and Delegated Medical Groups shall notify members of a decision to approve, deny, defer, or partially deny requests for Prior Authorization by providing written notification (NOA) to members and/or their authorized representative. All NOA letters in English will be written at the sixth (6th) grade reading level. The review and signature of a licensed physician is required for all denials involving medical necessity determinations (or a licensed pharmacist for pharmacy denials). NOA letters addressing benefit restrictions or exclusions may be signed by a UM Nurse or Medical Director.

In the event the member has other primary health coverage (e.g., Medicare, commercial), SFHP will issue a written NOA informing the member and/or the member's authorized representative of the denial of coverage. Such denials are considered benefit exclusions and may be signed by a UM Nurse or Medical Director.

Authorization Type	Time from receipt of the request to decision:	Provider and member notified at the time of the decision within:
Routine Pre-service	SFHP approves, denies, partially denies or defers a request within five (5) business days from the receipt of the request.	Five (5) business days of the receipt of the request.
Routine Pre-service – Extension	If additional information is necessary to render a decision, the authorization decision timeframe can be extended by 14 calendar days from the receipt of the request. SFHP notifies the provider and the member in writing of what information is required and when a decision will be rendered. If necessary information is incomplete or not received within 12 calendar days, the request is denied. If the member, provider, or SFHP determines that additional time is warranted on behalf of the member, an additional 14 calendar days (28 calendar days total from the receipt of the request) may be granted.	14 calendar days of the receipt of the request. If the decision is extended by an additional 14 calendar days, provider and member notification is made within 28 calendar days from the receipt of the request.
Urgent Pre-service	Emergency care: No prior authorization required. Non-emergency urgent/expedited care: Within 72 hours of receipt of the request.	72 hours of the receipt of the request.
Urgent Pre-service – Extension	If additional information is necessary to render a decision, the authorization timeframe may be extended once by 48 hours. SFHP notifies the provider and the member in writing within 24 hours of the receipt of the request of what information is required. A decision is rendered within 48 hours of the receipt of the additional information. If the requested information is not received within 48 hours, the request is denied.	48 hours of the receipt of the additional information or at the expiration of the timeframe to provide the additional information.
Routine Concurrent (i.e., ongoing ambulatory services)	SFHP approves, denies, partially denies, or defers a request within five (5) business days from the receipt of the request. Care cannot be discontinued until the member's treating provider has been notified of SFHP's decision and a care plan has been agreed upon with the treating provider that is appropriate for the member's medical needs.	Five (5) business days from the receipt of the request.

Authorization Type	Time from receipt of the request to decision:	Provider and member notified at the time of the decision within:
Routine Concurrent – Extension	If additional information is necessary to render a decision, the authorization decision timeframe can be extended by 14 calendar days from the receipt of the request. SFHP notifies the provider and the member in writing of what information is required and when a decision will be rendered. If necessary information is incomplete or not received within 12 calendar days, the request is denied. If the member, provider, or SFHP determines that additional time is warranted on behalf of the member, an additional 14 calendar days (28 calendar days total from the receipt of the request) may be granted.	48 hours of the receipt of the additional information, not to exceed 14 calendar days from the receipt of the request If the decision is extended by an additional 14 calendar days, provider and member notification is made within 28 calendar days from the receipt of the request.
Urgent Concurrent (i.e. inpatient facility or hospital stays)	Within 72 hours of receipt of the request/notification.	Provider: In writing within 24 hours from the decision, but not to exceed 72 hours. Member: In writing, within 24 hours from the decision, but not to exceed 72 hours (excluding approvals)
Urgent Concurrent – Extension	Not applicable	Not applicable
Retrospective	Within 30 calendar days of receipt of the request.	Provider: 30 calendar days of the receipt of the request. Member: Denial and deferral letters only within 30 calendar days of receipt of the request.
Retrospective – Extension	Within 15 calendar days from receipt of necessary information or on expiration of extension. Member/provider given 45 days to respond to request for additional information.	Provider: 15 calendar days of receipt of additional information or on expiration of the extension. Member: Denial and deferral letters only within 15 calendar days of receipt of additional information or on expiration of the extension.
Hospice – Inpatient Only	Within 24 hours of receipt of the request.	24 hours of receipt of the request.

22. Medi-Cal Rx Pharmacy Benefit

SFHP members in all health insurance programs have pharmacy benefits. The pharmacy benefit covers outpatient, self-administered medications that are listed in the program formularies. Medications that are administered by licensed practitioners in the 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 pharmacy benefit for Medi-Cal members is administered by Medi-Cal Rx, a DHCS program independent from SFHP. The formulary for Medi-Cal members is called the Contract Drug List (CDL). For information about the Medi-Cal Rx benefit, to find a pharmacy, or to find drugs in the CDL, visit the program's web site at **medi-calrx.dhcs.ca.gov/home/.** You can also call, email, or chat with Medi-Cal Rx agents 24/7 from the program's web site (click "contact us" at the top).

23. Healthy Workers HMO Pharmacy Benefit

The formulary for members in Healthy Workers HMO is managed by the SFHP pharmacy services department with oversight from the SFHP Pharmacy and Therapeutics Committee (P&T), a sub-committee of the SFHP Quality Improvement and Health Equity Committee.

Some medications are excluded from the pharmacy benefit. These include compounded medications, erectile dysfunction medications, infertility medications, and medications used for cosmetic purposes.

A link to the Healthy Workers HMO formulary is available on the provider portal in online searchable and printable formats. The formulary contains guidance regarding need for prior authorizations, clinical approval criteria, and/or limitations such as age or quantities.

Some drugs on the Healthy Workers HMO formulary 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). It is important to provide all clinical information available that is pertinent to the request; such as chart notes and laboratory results, so that the request can be fully reviewed as quickly as possible. 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 five-day supply of the following types of covered outpatient drugs in an emergency situation: opioids, opioid dependency medications, immunosuppressants, anticonvulsants, antibiotics, anticoagulants, antidepressants and asthma-rescue bronchodilators.

Pharmacy Prior Authorization request forms may be found on the SFHP website at **sfhp.org/providers/pharmacy-services/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) 461-2778** for requests. Call our Pharmacy Benefits Manager (PBM) Magellan at **1(800) 424-4331** to submit a verbal request.
2. Submit request online using the Online Pharmacy Prior Authorization Request Form available at https://www.sfhp.org/providers/pharmacy-services/prior-authorization-requests/

SFHP maintains a retail pharmacy network and a specialty pharmacy network. The retail network consists of open-door pharmacies in SF and the surrounding five counties. Specialty drugs (biologics,

and other high cost therapies) must be processed through one of the network Specialty pharmacies. The SFHP Specialty Pharmacy Network consists of US Bioservices as a national specialty source, and Mission Wellness Pharmacies as a local specialty source

For provider questions about the Healthy Workers HMO pharmacy network or for assistance with pharmacy claims processing, contact the pharmacy benefits manager, Magellan, at **1(800) 424-4331.**

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

24. 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 or SFHP. Certain Groups for whom Care Management activities are not delegated may refer members to the SFHP Care Management Department programs below. To refer a member, please call the SFHP Referral Intake Line at **1(415) 615-4515.**

The Community-Based Care Management and Time Limited Care Coordination Programs provide community-based case management and coordination with 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.

The SFHP Complex Care Management program is in alignment with NCQA standards for Complex Care Management and is available for eligible members of all medical groups. Eligible members include 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.

25. Enhanced Care Management

Enhanced Care Management is a Medi-Cal benefit available to members with certain complex health conditions, including those who are:

- Individuals experiencing homelessness.
- Adults with high healthcare utilization.
- Adults diagnosed with Serious Mental Illness or Substance Use Disorder.
- Adults living in the community who are at risk for long term care institutionalization.
- Nursing facility residents transitioning to the community.
- Individuals transitioning from incarceration.
- Pregnant and postpartum individuals who are at risk for adverse perinatal outcomes who are subject to racial and ethnic disparities.

Enhanced Care Management is a foundational component of CalAIM and is intended to increase coordination between medical and behavioral health services/systems, create infrastructure to support multi-system coordination and care delivery, and address homelessness/unstable housing, and transitioning from incarceration back into the community of eligible members. ECM providers deliver comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community social supports.

For more information about Enhanced Care Management, visit **sfhp.org** To refer a member, please call the SFHP Referral Intake Line at **1(415) 615-4515** or email **caremanagement_referrals@sfhp.org.**

26. Transitional Care Services

The goal of Transitional Care Services is to provide care coordination to prevent gaps in services, care and support while members transition between levels of care. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care(LTC) settings.

Dedicated Care Managers are responsible for providing transitional care services to high-risk members, which include collaboration with the discharging facility, assistance with scheduling appointments and referrals to other programs, such as ECM if appropriate. The program lasts for 30 days post discharge or until the member is connected to all needed services and supports. To refer a member, please call the SFHP TCSI Intake Line at **1(415) 615-4550** or email **TCS_Referrals@sfhp.org**.

Additionally, inpatient facilities provide lower-risk members with the TCS intake phone number upon discharge by including it in their discharge documents. Lower-risk members are welcome to call the TCS intake phone number should they need assistance post discharge.

27. 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 Provider 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.

Community Resources

A stand-alone document about these resources, the Provider Resource Guide, is available at SFHP.org.

Please contact SFHP's LTSS Liaison at LTSSLiaison@sfhp.org if you would like assistance in arranging referrals to community resources such as mental health and SUD treatment, developmental services, dementia, palliative care, dental care, personal care services, and Long-Term Services and Support (LTSS).

1. Breast Pump and Lactation Services

SFHP promotes breastfeeding through its health education program, and provides services for the mother or the child that support the establishment and maintenance of lactation. SFHP covers hospital-grade electric breast pump rentals, with authorization, and non-hospital-grade electric breast pump purchase and rental, pumping kits, lactation counseling, and lactation management aids, without authorization. SFHP covers human breast milk when medically necessary.

SFHP requires prior authorization of hospital-grade electric breast pump rentals. No prior authorization is required for the purchase or rental of a non-hospital-grade breast pump. No prior authorization is required for human breast milk.

2. California Children's Services

California Children's Services (CCS) is a statewide program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with certain CCS-eligible medical conditions. Services provided under the CCS program are authorized and 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-eligible 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

333 Valencia St, 4th Floor
San Francisco, CA 94103
Telephone: **1(628) 217-6700**
Fax: **1(628) 217-6701**

Once a member is referred to CCS, eligibility status with CCS can be checked by contacting CCS at **1(628) 217-6700.**

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, including the month of delivery. 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.** You can also go to the website for more information **cdph.ca.gov/CPSP**

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

The PCP 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.

SFHP providers must assess the risk of treatment resistance or noncompliance with drug therapy for each SFHP Member who requires placement on anti-tuberculosis drug therapy. The following groups are at risk for treatment resistance or noncompliance:

- Have demonstrated multiple drug resistance (Isoniasid (INH) and Rifampin)
- Whose treatment has failed or patient has relapsed post treatment of a prior regimen
- Have significant functional impairment due to mental illness or substance abuse
- Elderly, Children and adolescents with active TB
- HIV positive patients
- Admitted to a hospital for TB
- Members with unmet housing needs
- Members with language and/or cultural barriers
- 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.

SFHP covers TB screening, diagnosis, treatment, and follow-up, following evidence-based guidelines. 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. SFHP Pharmacy provides medications for TB treatment as medically necessary, including medications that are part of the TB DOT services.

Tuberculosis Control Section
San Francisco General Hospital
2460 22nd Street,
TB Clinic Building 90, 4th Floor
San Francisco, CA 94110
Phone: **1(415) 206-8524**
Fax: **1(415) 206-4565**

For current TB screening and treatment guidelines visit **sf.gov/tuberculosis-resources-for-health-professionals** or **sfhp.org**.

5. Early Start

Infants and toddlers (up to 36 months of age) who have a developmental delay, 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 through the Golden Gate Regional Center (GGRC)). 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 referred to GGRC will receive intake and evaluation to determine eligibility for services. If a child

is found to be ineligible for services, families are encouraged to call the local Family Resource Center for more information about community resources. A child at age 3 will graduate from Early Start; they may be eligible for continued services through GGRC, as well as special education services through the school district.

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, but not limited to:

- Occupational and Physical Therapy
- Assistive Technology
- Audiology
- Speech and language services
- Family training and counseling
- Speech therapy

The medical group and PCP are responsible for identifying and referring children who may be eligible to receive services from the Early Start program. Providers will coordinate with the Early Start Program to determine the medically necessary diagnostic and preventative services and treatment plans for members and provide all necessary member information to GGRC to ensure appropriate care coordination, in compliance with all privacy laws.A SFHP member who is eligible for Early Start services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination and provision of medically necessary services.

Medical group physicians and case managers may refer to Early Start by contacting Golden Gate Regional Center's Intake Unit via phone, fax or email

Phone: **1(888) 339-3305**
Fax: **1(888) 339-3306**
Email: **intake@ggrc.org**

Providers can download the Early Start Referral Form at: **ggrc.org/services/applying-for-services**

Golden Gate Regional Center office can be contacted at:

1355 Market Street, Suite 220
San Francisco, CA 94103
Phone: **1(415) 546-9222**

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

6. Genetically Handicapped Persons Program (GHPP)

GHPP is a state-funded program that may provide additional care coordination and services to eligible Medi-Cal members age 21 years old or older with hereditary conditions. Eligible conditions include Diseases of the Blood (hemophilia, sickle cell disorders, blood factor deficiencies) Cystic Fibrosis, and metabolic and neuromuscular disorders (Wilson's disease, phenylketonuria as examples).

More information on how to apply for GHPP services and eligibility can be found at **dhcs.ca.gov/services/ghpp/Pages/default.aspx**

7. Golden Gate Regional Center

Golden Gate Regional Center (GGRC) is a nonprofit private organization that contracts with the State Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities/delays. 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.
- Additionally, individuals at risk of having a child with a developmental disability may be eligible for referral for genetic diagnosis, counseling and other prevention services.

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 GGRC.

GGRC provides services for developmentally disabled/delayed persons and their families, including:

- Living skills training
- Family support & training
- Respite care
- Day care
- Supportive living services and housing placement (residential care, or assisted living)
- Advocacy for the protection of legal, civil and service rights
- Lifelong individualized planning and service coordination
- Supportive employment/vocational programs

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,continued medical care and provide all necessary member information to GGRC to ensure appropriate care coordination, in compliance with all privacy laws.

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: **1(415) 546-9222**

For additional information and referral forms, you can visit the GGRC website at **ggrc.org**.

8. 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 **sfcityclinic.org**.

9. 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 **westside-health.org**.

10. Home and Community-Based Services (HCBS)

HCBS programs are adminsted by DHCS and authorized under the Medi-Cal program. HCBS programs provide long-term community-based services and supports to eligible members in the community

rather than in an institution. Services provided include: homemakers for chores, home health aides and/or nurses, family training, vehicle adaptation, respite care, day habitation, transportation and more.

Providers must continue to provide Covered Services to a member when the member is enrolled in HCBS and collaborate with the program(s). The HCBS providers may include:

- HCB Alternatives Waiver agencies
- HCBS programs for Individuals with Developmental Disabilities
- Assisted Living Waiver (ALW)
- Regional Centers
- Multipurpose Senior Service Program (MSSP)
- Medi-Cal Waiver Program agencies and
- California Community Transitions lead organizations

For referral and eligibility review contact Golden Gate Regional Center at **1(415) 546-9222.** For more information visit **dhcs.ca.gov/services/ltc/Pages/DD.aspx.**

11. 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.

The medical group and PCPs are required to coordinate and collaborate 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 when school is not in session.

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 can be reached at: **1(415) 759-2222.**

12. 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**
ioaging.org/services/all-inclusive-health-care

San Francisco Adult Day Services Network at **1(415) 808-7371** or **sfhsa.org/services/connection-community/adult-day-programs**

13. 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 **dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-%28HCB%29-Alternatives-Waiver.aspx**.

14. Women, Infants, and Children (WIC) Supplemental Nutrition Program

Women, Infants, and Children (WIC) Supplemental Nutrition Program is a nutrition/food program that helps people who are pregnant, breastfeeding, recently had a baby or was recently pregnant, and children under the age of five to eat well and stay healthy. WIC eligibility is determined by federal income guidelines. Medi-Cal, CalFresh, and CalWORKs members may be adjunctively eligible. Services include a WIC card to purchase healthy foods, nutrition education and information, breastfeeding education, support, and supplies (including breast pumps), and referrals to health care and community services.

SFHP is not financially responsible for any of the WIC services provided to its members. An 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.

Health care providers can refer to WIC in a number of ways:

- By submitting a referral via EPIC

- By referring members to any WIC clinic; current locations and contact information can be found here: https://sf.gov/wiclocations
- By visiting their website: https://sf.gov/wic

Referrals must be appropriately documented in the member's medical records and include relevant information including the member's current hemoglobin and hematocrit laboratory values. Providers must share relevant information from the member visits, including without limitation, height and weight measurements, blood lead values for Infants and Children, and health conditions when requested by WIC for care coordination.

All WIC referral forms and answers to frequently asked questions can be found here: https://sf.gov/information/healthcare-providers

15. Community Support Services

Community Support Services are a key feature of CalAIM aimed to improve quality of life and health outcomes of Medi-Cal beneficiaries by addressing clinical and non-clinical needs. Community Supports can help with things like moving between care settings, finding housing, and getting healthy meals.

SFHP currently covers these Community Supports:

- Medical Respite: Members receive short-term residential care if they no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and their condition would be exacerbated by an unstable living environment.
- Sobering Center: This is an alternative destination for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. A sobering center provides these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.
- Medically Tailored Meals: Members will receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. These meals are designed by Registered Dietitian Nutritionists (RDN) and support referring providers in treating chronic illness, targeting specific nutritional needs of the patient while reducing barriers associated with food insecurity.
- Housing Transition Navigation services : This service focuses on members experiencing homelessness or are at risk of experiencing homelessness, receive help to find, apply for, and secure housing.
- Housing Deposits: Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically-necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.
- Housing Tenancy Sustaining Services: Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.
- Home Modifications: Members receive physical modifications to their home to ensure their health and safety and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.
- Community Transition (NF Transition to Home): Members transitioning from a nursing facility to a private residence where they will be responsible for their own expenses, receive funding for set-up services such as security deposits, set-up fees for utilities, and health-related appliances, such as air conditioners, heaters, or hospital beds.

Each Community Support Service has unique eligibility criteria. If you are serving a member who might benefit from these services, you can review criteria and referral instructions at www.sfhp.org/providers/our-network/community-supports/ ..

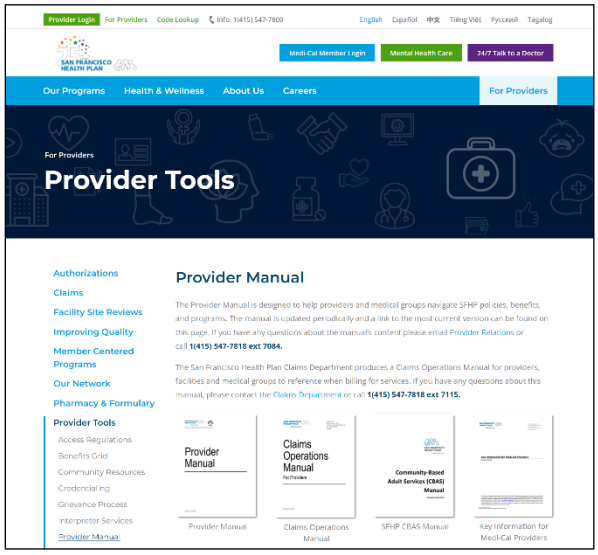
Claims and Encounter Data Reporting

1. Medical Group Claims Contract Matrix

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

2. Claims Manual

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: https://www.sfhp.org/providers/provider-tools/provider-manual/



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

3. Encounter Data and Reporting Process

SFHP requires delegated groups to submit 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.

Delegated Groups that participate in SFHP's reinsurance program are responsible for submitting complete and timely encounter data to SFHP so that the reinsurance carrier is fully aware of all reinsurance claims.

4. 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.

5. Provider Dispute Resolutions

The Provider Dispute Resolution (PDR) mechanism offers providers dissatisfied with the processing or payment of a claim, a method for resolving problems. A dispute must be submitted in writing **within 365 days of the plans last action or inaction date**. 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 dispute. For further instructions on how to file an dispute, please seesfhp.org/providers/claims/provider-disputes/ **.** SFHP has its own form that can be used to submit a PDR at: **sfhp.org/files/providers/Provider_Dispute_Form.pdf**

Supporting Documentation

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 information such as:

- Claim number and/or authorization number
- Reason for dispute
- 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
- Copy of medical records, if disputing for medical necessity

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 PDR forms and disputed claims for reconsideration and appeal to:

San Francisco Health Plan
Attn: PDR UNIT
P.O. Box 194247
San Francisco, CA 94119-4247

6. Punitive Action Against the Provider is Prohibited

San Francisco Health Plan ensures that punitive action is not taken against a provider who either requests a dispute resolution or supports a member's appeal.

7. California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF)

SFHP is required by DHCS APL 23-013 to track and report the status of SFHP's network DxF execution of the DxF Data Sharing Agreement (DSA). The goal of the DxF is to ensure that every Californian, as well as the health *and human service* and governmental entities who serve them, can access information needed to provide safe and effective care *for all Californians*, regardless of where in the state they are located. The DxF advances health

equity for all Californians by facilitating the secure and appropriate exchange of health and social services information.

Entities required to sign the DSA can access the DxF signing portal on the CalHHS Center for Data Insights and Innovation website at: https://signdxf.powerappsportals.com/

The CalHHS DxF Frequently Asked Questions is available at: https://www.chhs.ca.gov/wp-content/uploads/2023/01/Data-Exchange-Framework-FAQ-2023-1-23.pdf

Capitation/Payments

1. Description of Process

Capitation is paid in arrears. Payment is made on the 15th of the current month 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. The data includes member name, SFHP ID, CIN ID, level code, capitation rate, PCP ID, and PCP name. Digital rosters 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 Accounts Payable at accountspayable@sfhp.org

Provider Website and Portal

1. What's on the Website

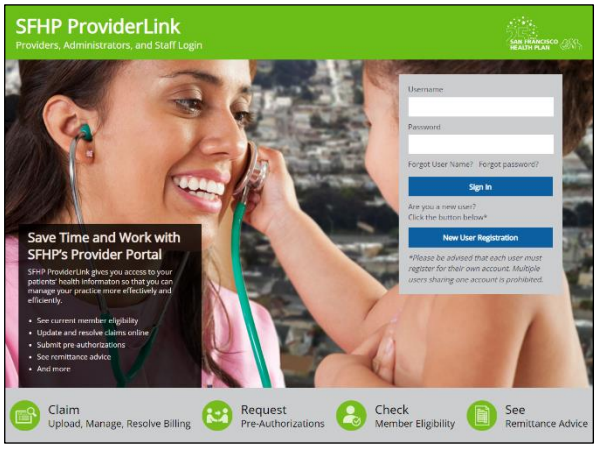
San Francisco Health Plan maintains a comprehensive website with information and tools for providers, members, and the community. Some features of particular interest to providers are:

- Health Education Library with downloadable materials in English, Spanish, Chinese, Russian, and Vietnamese on a variety of topics
- Health Education Classes Listings
- SFHP Authorization, Grievance and other forms
- Code Lookup Tool for authorization requirements for members in the UCS, SFN, CLN, and SDN groups
- 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 **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 ProviderLink at **sfhp.org** is a fast and secure way for providers and their staff to verify a member's eligibility, download member rosters, submit a claim, view remittance advice, and check authorization status for their practice, and more.



Registration for User ID and Password

Every person should have their own User ID. Do not share your User ID and Password, or your account will be deactivated.

- Go to **sfhp.org**

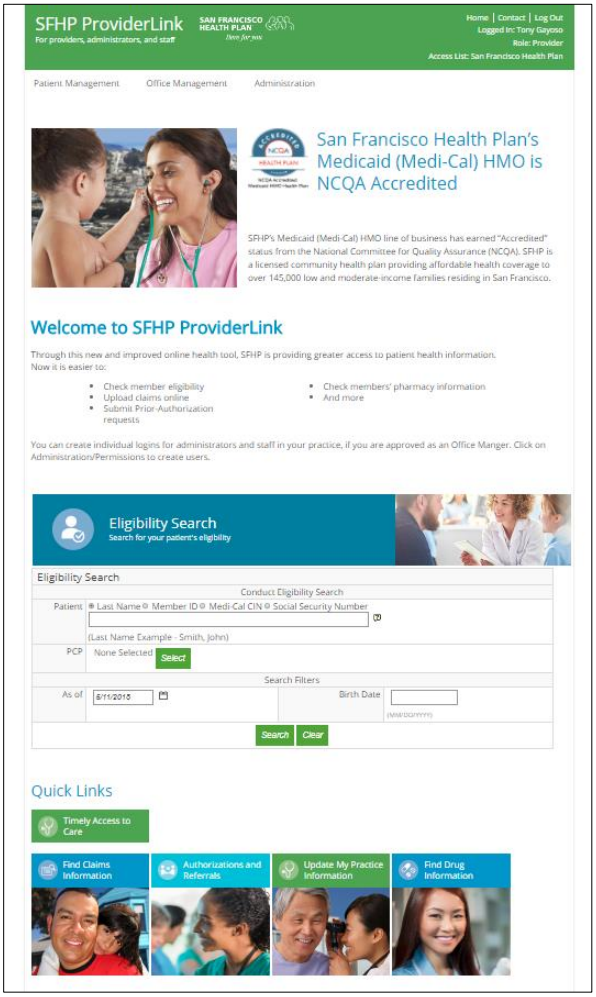
Secure Provider Website: Verify eligibility and PCP for any date of service, ee the status of your claims and submit Prior-Authorization requests

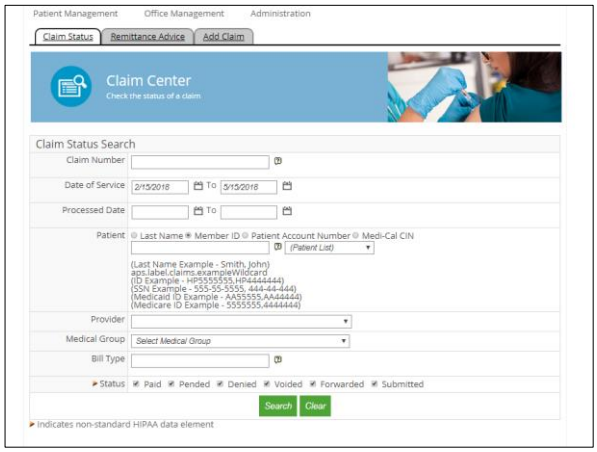
- Select “Provider Login”
- Click on “New User Registration”
- Fill in requested information
- Click Submit.

The Provider Relations department will validate your registration, and if accepted, will activate your chosen username and password within 3 business days. We will notify you by email when this is complete.

Standard Features:

- Check member eligibility and Health Homes Program status
- View claims status
- Void & resubmit claims
- View remittance advice





Additional Features:

- Download current member rosters in Excel format
- Request authorizations
- Check authorization status
- View patient prescription history
- Add new users

To obtain access to these features, email **provider.relations@sfhp.org** or call **1(415) 547-7818 ext. 7084.**

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) and the California Medical Records Privacy Act. 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 preventive care and CHDP/EPSDT required services in conjunction with other providers as necessary.
- 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 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
- Screening annually for alcohol misuse and substance use disorder and, to members who screen positive for hazardous consumption, providing counseling and referral to additional treatment as appropriate.
- 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, or access to a mechanism for admitting patients with a hospitalist.

3. PCP Assignments and Monitoring

A PCP can only be assigned members within the age range of their scope of practice. 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 DMHC and DHCS regulatory standards of 1 PCP: 2000 members and 1 Specialist: 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 Provider Relations Department at **1(415) 547-7818 ext. 7084** or Customer Service Department at **1(415) 547-7800,** and are encouraged to follow up in writing with any available information:

Secure Provider Website: Verify eligibility and PCP for any date of service, ee the status of your claims and submit Prior-Authorization requests

- 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 providers. Results of the survey and recommendations for improvements are shared with the SFHP Quality Improvement Committee, Governing Board, and Executive Team through the annual summary report. All SFHP contracted providers and their affiliated groups can view or obtain a copy of the survey by calling Provider Relations at **1(415) 547-7818 ext. 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's Policy regarding the Breakdown in the 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 member will be reassigned to a new PCP site.

7. Specialist Responsibilities

Specialists are required to coordinate 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 Teladoc to speak with a licensed physician at **1(800) 835-2362** or by visitng **sfhp.org/teladoc**. Members can get a phone or video consultation with a

Teladoc physician 24 hours a day and 7 days a week in 30 minutes or less. Members can also 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. Records of telehealth services provided are shared with the member's PCP, unless the member objects.

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 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 ID Card mailing. Members also receive a Member Handbook in the Welcome Packet that informs them 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. Providers and Medical Groups are informed of these requirements through the SFHP Provider Manual and reinforce standards through Joint Administrative Meetings (JAMs) with providers and Provider Monthly Updates.

Criteria	Standard
Adult and child Initial Health Appointments	Within 120 calendar days (for children aged 18 months or younger, SFHP requires an IHA (complete history and physical examination) within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger whichever is less.)
Initial prenatal care appointments	Within 14 calendar days
Emergency care	Immediately
Access to after-hours care	SFHP 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*

Criteria	Standard
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, when a practice can offer appointments within the same day, on the next business day, or on any other day if the member prefers not to accept the offer.

"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 access requirements through the SFHP Provider Manual and in Joint Administrative Meetings (JAMs) with providers and 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
- Members who cannot reach their PCP's office during or after business hours may contact Teladoc by calling **1(800) 835-2362** or by visitng **sfhp.org/teladoc**. Members can get a phone or video consultation with a telehealth physician 24 hours a day and 7 days a week in 30 minutes or less. This service is free of charge and is language interpreter services are available. Records of telehealth services provided are shared with the member's PCP, unless the member objects. Teladoc's California-licensed physicians can:
    - Treat simple medical conditions
    - Prescribe some types of medications, but not controlled substances
    - Instruct members to see their regular PCP or specialist for follow-up care
    - Assess whether the member needs to go to the emergency room or needs urgent care
- SFHP also provides 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 describing 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, coordinate payment with the out-of-network practitioner and ensure 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 QIHEC 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 monitoring as described in our Monitoring Accessibility of Provider Services 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 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 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 Provider Satisfaction Survey tool. In cases where the function is delegated, Delegated Groups are required to use the 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 appointments
- 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 are presented to QIHEC regularly 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. Telehealth Services

A provider rendering covered services via Telehealth must be a licensed provider in the State of California and enrolled as a Medi-Cal Provider or Non- Physician Medical Practitioner affiliated with an enrolled Medi-Cal Provider group. All providers may establish new patient relationships via Telehealth visits.

Providers are required to explain the following to Members in addition to documenting consent and prior to initial delivery of Covered Services via Telehealth:

- The Member's right to access Covered Services delivered via Telehealth in-person.
- The use of Telehealth is voluntary and can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal services in the future.
- The availability of Non-Medical Transportation to in-person visits
- The potential limitation or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.

DHCS has created a model Member consent language for MCPs and Providers to use, which can be found on the DHCS website.

The provider is not required to be present with the Member at the originating site unless determined Medically necessary by the Provider at the distant site. Existing covered services may be provided via a Telehealth modality only if all the following criteria are met:

- The treating Provider believes the Covered Services being provided are clinically appropriate to be delivered via Telehealth.
- The Member has provided verbal or written consent.
- The Medical Record documentation states that the services via Telehealth meet the procedural definition of components of the Covered Service.
- The Covered Services provided via Telehealth meet all state and federal laws regarding confidentiality of health care information and a member's right to their own medical information.

Synchronous interactions - Effective January 1, 2024, all Providers furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:

- Offer those same services via in-person, face-to-face contact.
- Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different Provider arrange for that care.

All providers may establish new patient relationships via synchronous video Telehealth visits. All providers may establish new patient relationships via audio-only synchronous interaction only if one or more of the following criteria applies:

- The visit is related to sensitive services, Civil Code section 56.06(n).
- The Member requests an audio-only modality.
- The Member attests they do not have access to video.

FQHCs, including Tribal FQHCs, and RHCs may establish new patient relationships through an asynchronous store and forward modality if visits meet all the following conditions:

- The Member is physically present or at an intermittent Provider site.
- An employe or Subcontractor of the Provider creates the patient's Medical Records at the originating site.
- The Provider determines that the billing Provider can meet the applicable standard of care.
- A Member who receives covered services via Telehealth must otherwise be eligible to receive in-person services from the Provider.

Not a covered service- services that require in-person presence such as: operating room or while member is under anesthesia, where direct visualization or instrumentation of bodily structure is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

10. Provider Preventable Conditions

The DHCS requires SFHP to report and to adjust payment for Provider Preventable Conditions (PPCs). 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.

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:

1. Fax to SFHP Utilization Management at **1(415) 357-1292.**
2. 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.

Credentialing and Provider Information

1. Practitioner Credentialing/ Recredentialing

All licensed independent practitioners who provide care to SFHP members, including physician and non-physician medical practitioners, must meet SFHP's credentialing, screening, and enrollment requirements to be accepted to and maintain good standing in the SFHP network. SFHP credentialing standards are based on federal and California state requirements, and comply with SFHP's contract with DHCS. SFHP uses NCQA credentialing standards to guide this process. Re-credentialing of providers must occur at least every three years.

The practitioner credentialing process includes a comprehensive screening against federal and state sanctions databases, as well as verification of the practitioner's training and education, which may include assessment of quality indicators such as member complaints and facility site reviews. SFHP also requires that its medical groups have ongoing procedures to monitor and act to address issues of quality of care and service.

2. 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. These requirementsinclude direct supervision by a licensed physician, who has a contract with SFHP or its Delegates. Supervision may 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 follow 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 NPMP Protocol establishes the scope of practice 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 to practice in the state of California. 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.

3. Organizations

SFHP requires that every contracted provider be subject to an initial assessment of credentials 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.

4. Delegation of Credentialing

When SFHP delegates the credentialing function, SFHP is accountable to ensure that the Delegate performs the function or activity according to industry standards and federal and state regulations. Delegated groups must keep complete and current provider files on file for each provider it contracts with or employs.

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.

5. Downstream Sub-Contracting

All agreements between Delegates and their 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 Delegate, 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 Delegate 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 should SFHP determine that the subcontractor is not providing

services in a manner that meets SFHP's reasonable approval.

6. Provider Network

Delegates, Clinics, and Individually-Contracted Providers (ICPs) are to provide SFHP with a provider roster on at least a quarterly basis, pursuant to a mutually agreed-upon schedule. Additionally, all changes must be forwarded to SFHP in an expedient and timely manner. All all credentialing and provider training activities must be completed before a provider is sent to SFHP for activation.

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 (if different from M-F 9:00am-5:00pm)
- 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
- Affiliated 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 verify 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 ext. 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.

Providers should notify Provider Relations at least 45 calendar days in advance when they are changing their clinical location. When such notice is not possible, Provider Relations should be notified as soon as possible.

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

The 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.

If a PCP is affiliated with more than one contracted medical group and terminates their affiliation with a medical group or groups but remains in the SFHP network, the affected members will remain assigned to that PCP through one of the PCP's remaining affiliated group or groups. SFHP will notify members of their medical group reassignment accordingly.

Reporting Provider Directory Inaccuracies

Please notify SFHP of any provider directory inaccuracies 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 **www.sfhp.org.** Anyone can report potential inaccuracies.

SFHP will investigate the potential inaccuracy and will contact the affected provider no later than five (5) business days after receipt 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, if necessary, within thirty (30) business days.

7. Provider Orientation and Training

Delegates are responsible for new provider training and education to be completed no later than ten days after the provider's effective date with SFHP.

An electronic version of the training and attestation is available on the SFHP web site. Training covers the following topics:

- SFHP Programs
- Eligiblity
- Access to Care
- Referrals, Prior Authorization, and Appeal to UM Decisions
- Members' Rights, including the right to full disclosure of healthcare information and the right to actively participate in healthcare decisions
- Member Complaints and Grievances
- Benefits
- Initial Health Appointments (IHA)
- Cooridination of Care for Medi-Cal Members
- DHCS Waiver Programs
- Health Education
- Cultural and Linguistic Services
- Seniors and Persons with Disabilities

SFHP regularly communicates with and updates the Delegates of policy changes, new Medi-Cal program requirements, provider/member survey results and other quality improvement outcome information through mechanisms such as special mailings, Provider Newsletters, and/or Joint Administrative Meetings (JAMs) attended by each medical group.

8. Provider Profile Reporting

Some Delegates use Provider Profiles from SFHP in their credentialing process.

This document is available upon request from any Delegate and includes:

- The Reporting Period
- Provider Name (PCP or Specialist)
- Detailed description of any issue as identified from a grievance or PQI
- Date received
- Outcome of the grievance or PQI

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.

Facility Site Reviews (FSRs)

1. Overview

Per the California Department of Health Care Services (DHCS) All Plan Letter 22-017, all Medi-Cal Managed Care Primary Care Provider (PCP) sites must pass a full scope site review with a minimum score of 80%. This review should be conducted as part of the initial credentialing process and every 36 months thereafter. New PCP sites must pass the the site review before receiving any SFHP Medi-Cal member assignments.

The site review is comprised of three separate components:

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

Copies of the review tools and guidelines can be found on the SFHP web site at https://www.sfhp.org/providers/facility-site-reviews/ or obtained by calling the Provider Relations Department at **1(415) 547-7818 ext.7084**

2. FSR and MRR Standards

SFHP follows DHCS standards when conducting and scoring FSRs and MRRs. These guidelines are delineated in DHCS APL 22-017, which can be accessed here:

DHCS APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review

FSRs and MRRs are conducted by Nurse Reviewers from SFHP, Delegated Groups, or Anthem Blue Cross (ABC), or Health Plan of San Mateo (HPSM). The DHCS may also conduct site FSRs and MRRs as part of Managed Medi-Cal Division (MMCD) monitoring activities.

When a new practitioner contract is being established, an initial FSR is completed; this site review does not include a MRR. An initial FSR is required prior to the PCP receiving any SFHP member assignments. Thereafter, periodic FSRs are repeated every three years. If a PCP site relocates, or a provider has moved to a new site that does not

have a current FSR, a new FSR must be conducted within 60 days of notification of the move. FSRs may also 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 practitioner 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 practitioner does not have sufficient assigned Medi-Cal managed care members to complete the required 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 will be adjusted accordingly. At PCP sites that document patient care performed by multiple PCPs in the same record, and there is a "shared" medical record system, the nurse reviewer must review a minimum of ten records if two or three PCPs share records, 20 records if four to six PCPs share records, and 30 records if seven or more PCPs share records.

Per DHCS APL 22-017, focused reviews are conducted at the discretion of SFHP to monitor providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions..

Scope of Reviews

The FSR contains six categories: 1) Access/Safety, 2) Personnel, 3) Office Management, 4) Clinical Services, 5) Preventive Services, and 6)Infection Control.

The MRR contains three general categories: 1) Format, 2) Documentation, and 3) Coordination of Care; and three specific preventive categories: 1) Pediatric Preventive, 2) Adult Preventive, and 3) Obstetrics (OB)/Comprehensive Perinatal Services Program (CPSP) Preventive.

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 30 calendar days of the CAP issue date. There are 14 Critical Elements that are reviewed in the FSR:

1. Exit doors and aisles are unobstructed and egress (escape) is accessible;
2. Airway management equipment, including oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag, are present onsite;
3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia, are present onsite. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of engineered sharps injury prevention (ESIP) needles/syringes and alcohol wipes;
4. Only qualified/trained personnel retrieve, prepare or administer medications;
5. Office practice procedures are utilized onsite that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;
6. Only lawfully authorized persons dispense drugs to patients;
7. Drugs and vaccines are prepared and drawn only prior to administration;

8. Personal protective equipment is readily available for staff use;
9. 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;
10. Needlestick safety precautions are practiced onsite;
11. Staff demonstrate/verbalize necessary steps to ensure sterility and/or high level disinfection of equipment;
12. Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill;
13. Spore testing of autoclave/steam sterilizer with documented results (at least monthly); and
14. Management of positive mechanical, chemical, and biological indicators of the sterilization process.

PCP sites that do not correct cited deficiencies and/or areas of concern within timelines established by DHCS will be reviewed by the SFHP Physician and Peer Review Advisory Committee (PAC) and are subject to termination from SFHP's provider network.

All FSR and MRR information is documented in the Facility Site Review software database, Healthy Data Systems (HDS).

3. Physical Accessibility Review Survey

The Physical Accessibility Review Survey serves to assess provider sites level of accessibility requirements established by the Americans with Disabilities Act (ADA). The DHCS requires SFHP to evaluate accessibility at PCP sites, high-volume specialist and ancillary services locations, and CBAS centers using attachment tools FSR-C, FSR-D, or FSR-E. The results of the FSR-C, FSR-D, and FSR-E are published in SFHP's Provider Directory for member reference.

FSR-C, FSR-D, FSR-E reviews follow the same three year cycle requirement as the FSR-A & FSR- B. The FSR-C, FSR-D, and FSR-E guidelines are delineated in DHCS APL 15-023 and PL 12-006, which can be accessed here:

DHCS APL15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers

DHCS PL 12-006 Revised Facility Site Review Tool

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 three indicators:

- A height adjustable exam tables that lowers to between 17 inches and 19 inches from the floor to the top of the cushion;
- Space next to the height adjustable exam table for a wheelchair or scooter to approach, park, and transfer or be assisted to transfer onto the table; and
- A weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient.

The Physical Accessibility Review Survey information is documented in the Facility Site Review software database, Healthy Data Systems (HDS), and in the Provider Directories.

4. FSR and MRR Resources and Tips

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 interview, which takes less than 1-2 hours. The MRR consists of a thorough review of a random selection of patient records and can take 2-6 hours or more depending on the number of records reviewed.

SFHP Nurse Reviewers have a number of resources available at at https://www.sfhp.org/providers/facility-site-reviews/ to help providers successfully pass the FSR and MRR. FSR and MRR self-assessment checklists, copies of DHCS FSR and MRR tools and standards, or any other educational or training materials on all FSR and/or MRR elements can be customized to each site.

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

1. Access/Safety
   a. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia, are present onsite. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes. Sites must include a medication dosage chart with the kit and have documentation of checking the expiration of emergency kit contents and operation status at least monthly.
2. Clinical (Laboratory)
   a. Laboratory test procedures are performed according to current site-specific CLIA certificate. It is important to understand that your laboratory must be in compliance with all applicable federal, state, and local laboratory laws. Therefore, your site must have BOTH a CLIA Certificate and a Registration or License from the California Department of Human Services (DHS) Field Services Division of Laboratory Science. It might help to remember: the CLIA is a Federal regulation, and the Registration or License is a State regulation. For Clinical Laboratory Registration (Waived or PPMP testing) forms, go to: https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/Home.aspx
3. Infection Control
   a. When assessing a site's isolation procedures during an airborne precaution, per DHCS the acceptable minimum amount of time after the patient has vacated the exam room that the door must be left closed is one (1) hour to allow enough time for room air to settle for proper disinfection. After one (1) hour, the staff may then proceed to disinfect the surfaces with an approved tuberculocidal disinfectant. When entering the room before the appropriate time has elapsed, staff shall wear a mask, preferably an N-95 mask for protection.
   b. Disinfectant solutions used on site must be effective in killing HIV, HB, and TB. For a list of the Environmental Protection Agency's (EPA) Registered Antimicrobial Products, please go to: https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

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

1. Documentation
   a. Advanced Health Care Directives (AHCD)

i. 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.
ii. 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.
iii. User-friendly AHCD forms are available in several languages on the PREPARE for YOUR Care website: https://prepareforyourcare.org/en/prepare-for-your-care/advance-directive/advance-directive-welcome

2. Adult and Pediatric Preventive Criteria
   a. Tuberculosis/TB Screening and Risk Assessments:
      i. All pediatric Medi-Cal patients must be screened for TB risk with testing, if indicated, at 1, 6, and 12-months old and annually thereafter.
      ii. All adult Medi-Cal patients must be screened for TB risk with testing, if indicated, at the time of Initial Health Appointment (IHA) and at subsequent periodic health evaluations.
      iii. TB Symptom and Risk Assessment forms can be found on here
      iv. For detailed information, please visit: Tuberculosis Information for Medical Providers or Tuberculosis Screening Guidelines
   b. Periodic Health Evaluations are a required service and must be in accordance with the American Academy of Pediatrics (AAP) Bright Futures and US Preventive Services Task Force (USPSTF) recommendations. Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner.
   c. Immunizations:
      i. Pediatric and adult immunizations must be given according to ACIP guidelines. Vaccination status must be assessed and documented in the member's medical record;
      ii. Vaccine administration is documented, including name, manufacturer, date of administration, and lot number of each vaccine, in accordance with the National Childhood Vaccine Injury Act;
      iii. Vaccine Information Statement (VIS) must be given (or presented and offered) and the VIS publication date are documented in the medical record;
      iv. Providers must utilize the California Immunization Registry (CAIR) or local immunization registry to ensure member's immunization records are up to date

Please contact the SFHP Facility Site Review team at fsr@sfhp.org, if you would like additional information about the FSR process and requirements.

Fraud, Waste and Abuse Prevention and Detection Program

1. Overview

San Francisco Health Plan's 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, Waste and Abuse Prevention and Detection Program ("Program Integrity"). This Program is updated annually to reflect current developments in the law and accepted practices.

The purpose of the San Francisco Health Plan Program Integrity 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.

Under the False Claims Act (FCA), a health care provider is liable if it "knowingly" causes a "false claim" to be presented to the government or "knowingly" makes a false statement to obtain payment of a "false

claim." A claim is simply a request for payment. A false claim is a request for payment that is somehow untrue.

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. Abuse may also result in unauthorized payments or benefits, but is considered to have occurred without the intent to commit fraud.

Common types of fraud within managed care include, but are not limited to:

- 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 audits performed 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 QIHE 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 and Regulatory Affairs Department

The Compliance and Regulatory Affairs Department is responsible for the Compliance Program and related policies and procedures. The Compliance and Regulatory Affairs Department is responsible for investigating all allegations for fraud, 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, waste or abuse, or if you have questions, please contact the Compliance Hotline at **1(800) 461-9330.** 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 program_Integrity@sfhp.org.

6. Electronic Visit Verification

All Network Providers of Personal Care Services (PCS) and Home Health Care Services (HHCS) are required to comply with federal Electronic Visit Verification (EVV) requirements when rendering PCS and HHCS. Such providers must capture and transmit EVV data to the California EVV Aggregator. For more information on these requirements, consult DHCS All-Plan Letter 22-014.

SFHP monitors Network Providers to ensure compliance with these requirements. Claims reimbursement may be withheld or need to be returned to SFHP for visits that cannot be validated by EVV.

Glossary

Abbreviation	Description
AMG	All American Medical Group
BTP	Brown & Toland Physicians
CAHPS	Consumer Assessment of Health Care Providers and Systems
CAP	Corrective Action Plan
CLN	Community Clinic 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
HILL	Hill Physicians Medical Group
HW	Healthy Workers HMO
IHA	Initial Health Appointment
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

Abbreviation	Description
QI	Quality Improvement
PCP	Primary Care Provider
QIHEP	Quality Improvement and Health Equity Plan
SF BHS	San Francisco Behavioral Health Services
SFHP	San Francisco Health Plan
SFN	San Francisco Health Network
TCS	Transitional Care Services
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).

Revision Log (2 years prior to this edition)

Date	Section	Changes
Jan- 2024	Behavioral Health	Added Dyadic Care Services
	Medi-Cal for Kids & Teens	EPSDT is now Medi-Cal for Kids and Teens
	Throughout Manual	Removed Kaiser for Health Plan
	Enhanced Care Management	Added Additional Populations of focus
	Community Supports	Added additional Community Supports
	Member Incentives	Updated Member Incentives
	Facility Site Review	Scope Changes and Updates
	Telehealth Services	Additional requirements
	Mission Statement	Updated Strategic Pillars
	Initial Health Appointment	Removed Assessment requirements
	CalHHS DxF	Added Section
	Revision Log	Redesigned Revision Log to clarify affected sections
Jan 2025	Provider Network Overview	Updated delegate contact information in UM and Claims matrix
	Medi-Cal Members in SNF, LTC, Subacute, or ICF-DD	Added procedures for member disenrollment
	UM and Case Management	Added Transportation Services, added Transitional Care Services
July 2025	Quality Improvement & Health Equity	Updated Member Incentive Program for Preventive Care
	Utilization & Care Management	Added PASRR requirement and authorization code lookup link
	Facility Site Review	Updated links and removed SHA/IHEBA requirements
	Fraud Waste and Abuse	Updated program name and outline