San Francisco Health Plan℠

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Key Information for Medi-Cal Providers

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This document highlights some of San Francisco Health Plan's (SFHP) programs and requirements and meets the new provider training requirements set forth by the Department of Healthcare Services (DHCS). **This document is for training purposes only. It does not replace or change contractual obligations between Providers and SFHP and more comprehensive information available in the SFHP Provider Manual and on the SFHP web site www.sfhp.org/providers.** Should you find any discrepancies between this document and the Provider Manual, please follow the Manual's specifications. SFHP also has specific policies and procedures for each subject highlighted in this document. If you have any questions regarding the information following, please contact SFHP's Provider Relations Department at 415-547-7818 ext. 7084.

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Section 1: Introduction

1.1 Welcome to the SFHP Provider Network

San Francisco Health Plan (SFHP) is a local, not-for-profit, Knox-Keene licensed health plan providing affordable health care coverage to low-income residents of San Francisco. The SFHP network includes several independent medical groups and their affiliated hospitals. Most of the utilization management, credentialing, and claims processing functions are delegated to these contracted groups.

Providers must promptly notify their medical group of any changes in their practice location, hours of operation, or if they plan to terminate their relationship with their medical group or SFHP. In these instances, the provider must first submit termination notification to their Provider Group at least 30 calendar days' notice, or sooner if possible. 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.

Effective January 1, 2023, SFHP members assigned to SFHP Direct Network (SDN), which is a patient network specifically for two kinds of SFHP members:

- Dual-eligible Medicare and Medi-Cal beneficiaries ("Medi Medi") who join SFHP after January 1, 2023
- All members in long-term care (LTC) who are residents of skilled nursing facilities (SNFs)

Section 2: Contact Information

2.1 Claims Department

Providers in the Brown and Toland, AAMG, Hill, Jade, and NEMS networks may contact their medical group for assistance with any questions related to claims and reimbursement.

Providers in the UCSF, SFHN, and CLN networks and independent clinics and providers may contact SFHP for assistance with any questions related to claims and reimbursement.

SFHP Claims Contact Information:
Hours of Operation: Monday through Friday, 8:30am to 5:00pm

SFHP Claims Telephone: 1(415) 547-7818 ext. 7115

2.2 Customer Service Department

The Customer Service Department is available to assist with any general questions about member benefits, eligibility, covered services, claims payments, etc.

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

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

2.3 Provider Network Operations Department

Please contact the Provider Network Operations department for any questions or concerns about provider issues, network and contracting, credentialing, payment disputes, etc.

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

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

2.4 Telemedicine

Primary Care Providers (PCPs) and clinics are always the first point of contact for our members' routine and urgent care. However, when members cannot see you or get to you, they can receive care from a doctor from anywhere using their phone, smartphone app, or computer with our FREE telemedicine service, Teladoc.

Teladoc physicians are available 24 hours a day, seven days a week, year-round. The average wait time for a Teladoc appointment is under 10 minutes. Teladoc physicians can prescribe medications but will not prescribe controlled substances.

After the consultation, Teladoc will fax a summary of the visit (Clinical Consult Report) to the member's PCP/clinic.

To access services, members can go to teladoc.com/SFHP, call 1(800) 835-2362, or download the Teladoc smartphone app.

2.5 Utilization Management Department

Providers in the Brown and Toland, AAMG, Hill, Jade, and NEMS networks may contact their medical group for questions about prior authorizations and inpatient concurrent review.

Providers in the UCSF, SFHN, and CLN networks and independent clinics and providers may contact SFHP for questions about prior authorizations and inpatient concurrent review.

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

SFHP UM Telephone: 1(415) 547-7818 ext. 7080

SFHP UM Email: authorizations@sfhp.org

2.6 Member Complaints and Grievances

SFHP categorizes expressions of dissatisfaction made by members into two categories: grievances and appeals. 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. 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.
Accordance with California Code of Regulations (28 CCR 1300.68) and the DHCS guideline (APL 21- 011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates).

For more information about SFHP's grievance process, visit the webpage: https://www.sfhp.org/providers/provider-tools/grievance-process/ or contact SFHP's customer service team at 1(415) 547-7800 or 1(800) 288-5555.

2.7 Services Covered by Other Entities ("Carved Out Services")

When a member qualifies for services that are carved out of the Plan coverage and may be covered through another entity, San Francisco Health Plan requires the remittance advice from the other entity before considering reimbursement. Examples of these entities include, but are not limited to:

- Non-Specialty Mental Health* (NSMH) and Behavioral Health Treatment (BHT)-covered by Carelon Behavioral Health
- Specialty Mental Health Services* (SMHS) and Inpatient services -provided through SF County Mental Health
- California Children's Services — Services are reimbursed through CCS
- Golden Gate Regional Center
- Dental Services — Services provided through Denti-Cal
- Vision Services, including refraction – Service are reimbursed through VSP
- Non-Emergency Transportation (NEMT) — services provided through ModivCare.

See sfhp.org website (for Providers) and the Provider Manual for additional information.

Below is the contact information for services covered by other entities by Lines of Business:

Medi-Cal

Non-Specialty Mental Health	Carelon Behavioral Health Members Line: 1(855) 371-8117 Website: Carelon Behavioral Health
Autism Services	Carelon Autism Services Group 1(855) 834-5654
Specialty Mental Health	San Francisco Behavioral Health Services 1(888) 246-3333
Vision	VSP 1(800) 877-7195
Dental	Denti-Cal Members: 1(800) 322-6384
Non-Emergency Transportation (NEMT) **New Requests:** Transportation Coordinator	FAQ Telephone: 1(415) 547-7807 Email: nemt@sfhp.org FAX: 1(415) 357-1292 SFHP NEMT Physician Certification Statement (PCS) Form
Reauthorizations:	Send updated PCS Form via fax to: 1(415) 357-1292

Section 3: Our Programs

3.1 Healthy Workers (HW) HMO Program

Healthy Workers HMO Program is a health coverage program partly administered by SFHP. It is offered to individuals providing 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). Eligibility is determined through the IHSS Authority or the Department of Human Resources and is based on length of time employed and hours worked.

3.2 Medi-Cal Services

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

3.3 Member Incentive Programs

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

$50 Gift Card	$50 gift card for First Health Visit within 120 days (4 months) of the member joining SFHP. A new member is someone who has not been enrolled in Medi-Cal in the last 12 months.
$50 Gift Card	$50 gift card for members with asthma, diabetes, or hypertension to visit their PCP.
$25 Gift Card	$25 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 aged 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 topical fluoride varnish applied for children 12-47 months.
$50 Gift Card	$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 our website: Incentives Available to Members or send an email to HealthEducation@sfhp.org .

3.4 Provider Incentive Programs

All licensed primary care, behavioral health, and vision health providers are eligible to participate in some short-term intervention and incentive programs. For details of current opportunities and interventions, visit our page on Improving Quality, Provider Incentives at www.sfhp.org/providers/improving-quality/provider-incentives/ .

Section 4: Eligibility

4.1 Eligibility and PCP Assignment

Eligibility can change from month-to-month. Although SFHP members are issued ID cards, **providers are responsible for verifying member eligibility on the day of service and prior to providing care**.

SFHP providers have three options for verifying eligibility:

- SFHP Secure Provider Portal found on our web site at www.sfhp.org/providers
- Interactive Voice Response 415-547-7810
- Customer Service Department at 415-547-7800, Monday-Friday, 8:30am-5:30pm

Questions regarding member's PCP assignment status can also be directed to Customer Services at (415) 547-7800 or 1-800-288-5555 between the hours of 8:30 am and 5:30 pm, Monday through Friday.

4.2 PCP Selection, Assignment, and Change

At the time of enrollment, new members are encouraged to select a PCP. When this does not happen, SFHP will automatically assign a PCP following an assignment algorithm that considers the member's place of residence, primary spoken language, and other similar factors. SFHP members who are auto assigned to a PCP may select another PCP at any time. All members may change PCPs to a PCP of their choosing who is accepting new patients. In most cases, PCP changes will be effective on the first day of the following month. Changes are made through SFHP's Customer Service department.

4.3 Children's Presumptive Eligibility (CPE)

The Child Health and Disability Prevention Program (CHDP) Gateway has been rebranded as the Children's Presumptive Eligibility (CPE) Portal. CPE is a means for all Medi-Cal providers who complete the enrollment and training process to grant temporary, full-scope coverage to eligible applicants who do not have Medi-Cal and meet all other eligibility requirements. As a Qualified CPE Provider (QP), the Medi-Cal provider must meet all of the licensing/credentialing requirements and complete the CPE training via the CPE provider portal . The provider is then approved to participate in Presumptive Eligibility (PE) and submit enrollment transactions on behalf of applicants.

First-time users of the MLP must complete a one-time registration. After logging in, you will be able to view the course catalog and sign up for training events. Detailed instructions about the registration process and how to access webinar classes are available in the Medi-Cal Learning Portal Provider User Guide or go to the Medi-Cal Learning Portal.

Once registered, you will want to choose the training event for CPE and NGPE named: "***Overview of Children's Presumptive Eligibility (CPE) and Newborn Gateway Presumptive Eligibility (NGPE) Recorded Webinar (CNPE104RW)***". A direct link to this event is available here: link

A summary of general CPE eligibility requirements are the same as they were under CHDP Gateway and include the following:

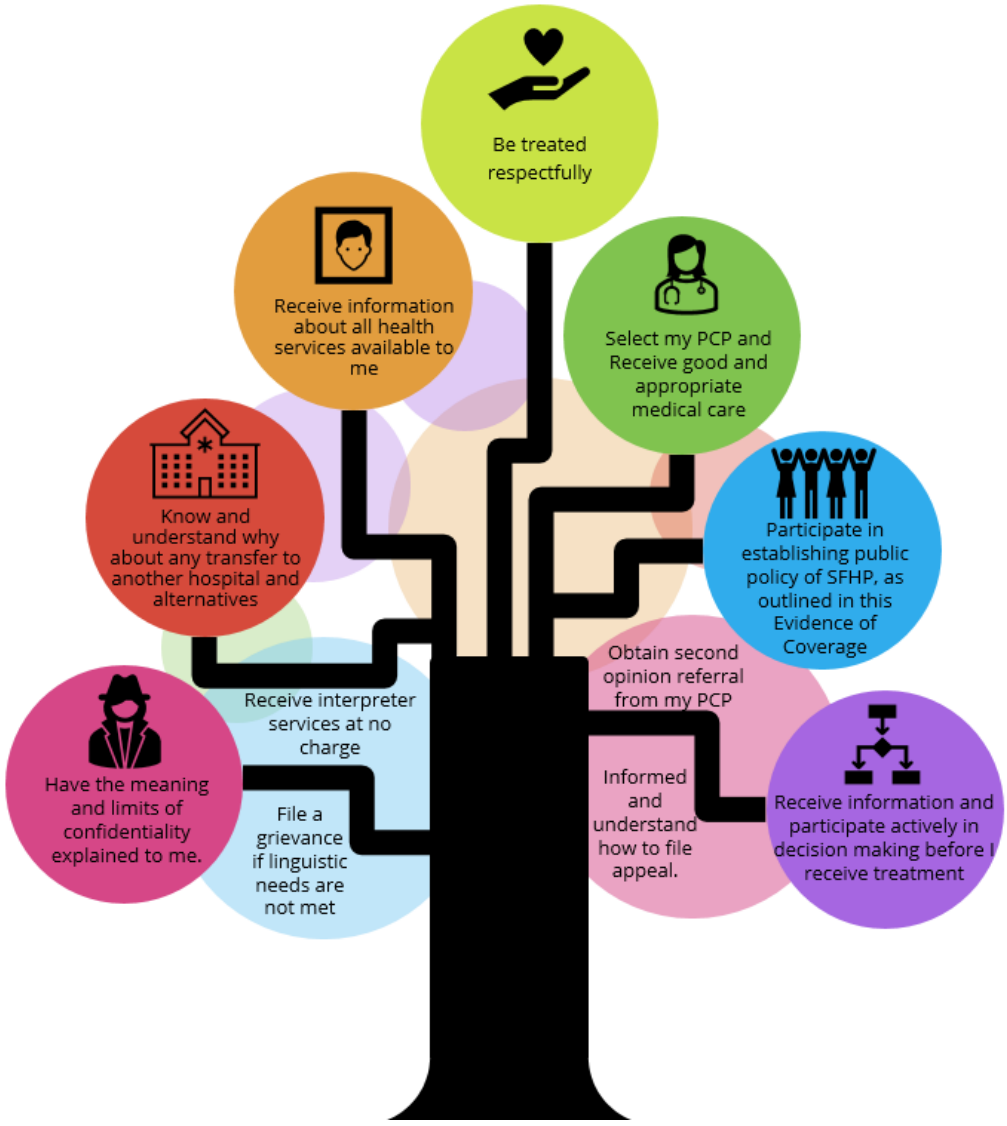
- Under the age of 19
- A California resident

- Not currently receiving Medi-Cal
- Income is below the monthly limit for household size
- Have not exceeded two PE enrollment periods in the last 12 months
- An infant with a mother on Medi-Cal or Medi-Cal Access Program (MCAP) aid code (Newborn Gateway)

4.4 Member Rights

SFHP members have rights and responsibilities. Members are informed of their rights and responsibilities through member education materials. Please consult the Member Guidebook for detailed responsibilities and rights governing each line of SFHP business.

For Medi-Cal: www.sfhp.org/programs/medi-cal/benefits/member-materials/
DHCS Contract, Exhibit A, Attachment III, Section 5.1 Link
For Healthy Workers HMO: www.sfhp.org/programs/healthy-workers/benefits/member-materials/



4.5 Newborn Coverage

For the Managed Medi-Cal program, newborns are covered for eligible services under their mother's membership during the month of birth and the month following. Healthy Workers HMO covers newborns for only 30 days following birth.

Section 5: Access to Care

5.1 After-Hours Access to Care

All PCPs are required to have phone coverage 24 hours a day, 7 days a week. After-hours access must include triage for emergency care and directions to call 9-1-1 for an emergency medical condition. A physician or mid-level provider must be available for contact after-hours, either in person or via telephone. All after-hours member calls must be documented in the member's permanent medical records. If a provider who is not the member's PCP treats the member, the treating provider must forward documentation of services received to the member's PCP.

Telephone Availability	All Provider Types	• Voice message must provide instructions to call 911 or the Emergency Room. • Voice message call back not to exceed 30 min. • Voice message must provide a call back number.

5.2 Appointment Availability

The California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) set forth access requirements for all health plans and their contracted providers which include maintaining availability standards for appointments. Additional details on appointment availability can be found on the SFHP website at https://www.sfhp.org/providers/provider-tools/access-regulations/

APPOINTMENT TYPE	PROVIDER TYPE	STANDARD
Routine Care	PCP	10 business days
	Specialty	15 business days
	Ancillary	15 business days
	Mental Health	10 business days
Urgent Care	All Provider Types	48 hours
		96 hours if Prior Authorization is needed
Prenatal Care	PCP	14 calendar days
Wait Time in Provider Office	All Provider Types	Not to exceed 30 min
Time to Answer Phone at Provider Office	All Provider Types	Not to exceed 10 min

5.3 Emergency Services and Urgent Care

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the member/enrollee 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,
- Serious dysfunction of any bodily organ or part,

A “psychiatric emergency 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.

Emergency services include medical screening, examination, and medical and psychiatric evaluation by a physician, or – to the extent permitted by applicable law – by other appropriate personnel under the supervision of a physician, and within the scope of his/her licensure and clinical privileges, to determine if an emergency medical condition or active labor exists. 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 are also considered emergency services.

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

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

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

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

Section 6: Referrals, Prior Authorization, and Appeal to UM Decisions

6.1 Referrals

In most cases, PCPs must refer SFHP members to specialists within their medical group network. In some instances, a specific specialty may not be available within the medical group's network. When this occurs, contact your medical group to find an appropriate specialist. Your medical group should provide you with a list of contracted specialists and referral forms if required.
Beginning in 2025 for Medi-Cal plans, a follow-up will be required when members are referred for crucial health care services and community resources recommended to them. Essentially, this will "close the loop" on recommended care and services to meet their needs. This requirement comes to Medi-Cal Plans as part of the CalAIM Population Health Management initiative. (Source)

6.2 Appeal of UM Decisions

Medi-Cal members have 60 calendar days from the date of the Notice of Action (NOA) to file an appeal with SFHP. Providers may assist members in appealing authorization denials for clinical services that do not meet administrative policy requirements, medical criteria, or other reason(s), and were denied by SFHP or a delegated medical group's Medical Director or designated physician. Member appeals should be submitted in writing to SFHP's Grievance & Appeals department by fax, e-mail, or U.S. mail, and be accompanied by a completed Grievance Form. The Grievance Form is available on-line at https://www.sfhp.org/providers/provider-tools/grievance-process/ (click on "GRIEVANCE FORM" in the member's language at the bottom of the page).

Contracted and non-contracted providers 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 the website at https://www.sfhp.org/providers/claims/provider-disputes/ or contact the claims department directly at 1(415) 547-7818 ext. 7115, Monday-Friday, 8:30am – 5:30pm.

SFHP will send a Notice of Appeal Resolution to the member within 30 calendar days. If the appeal 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 bodily function, a resolution will be provided within 72 hours.

If the member is dissatisfied with the appeal resolution, providers may assist members in seeking external review of the appeal by requesting a State Fair Hearing (for Medi-Cal members only) or applying for an Independent Medical Review (IMR) from the Department of Managed Health Care.

State Fair Hearing Forms are attached to Notice of Appeal Resolution letters for Medi-Cal members. 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)

Medi-Cal and Healthy Workers HMO members can request an IMR by calling DMHC's toll-free telephone number, 1(888) HMO-2219, or 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.

6.3 Closed Loop Referrals – See Section 10.0

6.4 Medical Group Prior Authorization and Claims

Almost half of SFHP members are assigned to delegated medical groups who process claims and make UM decisions on behalf of SFHP. These include:

- All American Medical Group (formerly CCHCA)
- Brown and Toland Physicians (BTP)
- Hill Physicians
- Jade Health Care Medical Group
- North East Medical Services (NEMS)

For delegated groups, the most up to date contact information on prior authorizations and claims is available in the Provider Manual (link) and on the SFHP website (link).

All requests for Prior Authorization must be sent to your medical group. Contact your medical group for a current list of services requiring Prior Authorization. Requests for non-emergent services subject to prior authorization should be submitted at least 14 calendar days prior to the anticipated service date.

6.5 Prior Authorization Exceptions

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

6.6 Policies Governing Clinical Protocols

SFHP's clinical criteria hierarchy are applied to utilization management and 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 review of evidence

Section 7: Benefits

7.1 Behavioral Health Services

7.1.1 Mental Health Care

San Francisco Health Plan covers outpatient mental health services for Medi-Cal members with mild to moderate conditions.

There is a policy for No Wrong Door for Mental Health Services that ensures that Medi-Cal beneficiaries receive timely mental health services without delay regardless of the delivery system where they seek care, and that beneficiaries can maintain treatment relationships with trusted providers without interruption.

This policy allows members who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the member is transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, members may receive coordinated, non-duplicative services in multiple delivery systems, such as when a member has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

Carelon manages behavioral health services for all SFHP Medi-Cal members, including non-specialty (mild to moderate) mental health services, and behavioral health therapy (BHT) for members under age 21 diagnosed with Autism Spectrum Disorder.

Mild to moderate mental health benefits include:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing, when clinically indicated to evaluate a mental health condition (prior authorization required)
- Outpatient services for the purpose of monitoring drug therapy
- 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
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements (continuation of current benefit)
- Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications

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.

To refer a member for mental health services, call Carelon’s toll-free Access Line at (855) 371-8117 or carelonbehavioralhealth.com .

Carelon providers should reach out to Carelon directly if they have any questions. They can use the phone number or website listed here.

Carelon
Member and Provider Services: 1(855) 371-8117; Fax: 1(562) 402-2666; TDD/TTY: 1(800) 735-2929

See Carelon Flyer, What Primary Care Physicians Need to Know (link) for more information.

For additional resources, see:
DHCS All Plan Letter (APL) 22-005, No Wrong Door For Mental Health Services Policy
Behavioral Health Information Notice (BHIN) No: 22-011

7.1.2 Specialty Mental Health Service Members

Specialty Mental Health Services include outpatient and inpatient services to treat serious mental health conditions and substance abuse. SFHP and Carelon do not cover Specialty Mental Health Services for Medi-Cal members, but San Francisco Behavioral Health Services (SFBHS) provides these services.

To refer a member for specialty mental health services, call SF BHS at 1(888) 246-3333. If you are not sure how serious a mental health condition is, call Carelon Behavioral Health at 1(855) 371-8117 (toll-free) or 1(800) 735-2929 (TDD/TTY), 24 hours a day, 7 days a week and they will link the member to the best organization for their needs.

7.1.3 Behavioral Health Treatment for Medi-Cal Members Under Age 21

San Francisco Health Plan (SFHP) members under the age of 21 have access to Behavioral Health Treatment (BHT) services. BHT includes Applied Behavior Analysis (ABA) and other services that have been reviewed and have been shown to work.

ABA is a therapy that can help children with autism and some other behavioral issues. ABA can help children with communication, social skills, recall, and attention. ABA providers work with families to help their children.

A member may qualify for Behavioral Health Treatment (BHT) if they meet the below criteria:

- Under 21 years of age
- Have a diagnosis of Autism Spectrum Disorder or other behavioral issues
- Have behaviors that make home or social life hard. Some examples are anger, violence, self-harm, running away, problems playing or communicating.

To refer a member for mental health services, call Carelon's toll-free Access Line at (855) 371-8117 or carelonbehavioralhealth.com.

7.1.4 Dyadic Services and Family Therapy Benefit

Dyadic Services are mental health services for more than one person in the family. If a child, teenager, or adult in a family is experiencing a behavioral health situation, it can affect other people in the family too. Dyadic care can help both the person who is experiencing behavioral health challenges and other family members.

SFHP offers Dyadic Services for children under 21 and their parent(s) or caregiver(s). They can get care in-person or by phone or video.

A referral is not required for these services and appointments can be made with Carelon Behavioral Health at 1(855) 371-8117 (toll-free) or 1(800) 735-2929 (TTY).

7.2 Blood Lead Screening & Testing (CLPP Provider Educational Material and Training)

Childhood Lead Poisoning Prevention programs (CLPPs) focus on comprehensive partnerships that include outreach and education to ensure providers understand mandates they are required to follow when it comes to childhood lead

screening and testing. The vision of CLPP is for a healthy, lead-safe environment where all children can achieve their full potential. The mission is to eliminate childhood lead poisoning by identifying and caring for children who are lead-burdened and preventing environmental exposures to lead.

Senate Bill (SB) 184 authorized the Department of Health Care Services (DHCS) to transition the Child Health and Disability Prevention (CHDP) Program effective July 1, 2024; however, CLPP activities were preserved.

California Department of Public Health Childhood Lead Poisoning Prevention Branch
Contact Number: 510-620-5600
https://www.cdph.ca.gov/programs/clppb
Please send questions and requests to: CLPPB_Provider_Outreach@cdph.ca.gov

7.3 Chiropractic and Acupuncture

Chiropractic services are available through American Specialty Health (ASH) for Medi-Cal members for Spinal manipulation services for diagnoses of back and neck pain only. American Specialty Health is at 1(800) 678-9133 or 1(877) 710-2746 TDD/TTY, and at https://www.ashlink.com/ash/sfhp.

Acupuncture benefits are available for Medi-Cal members for treatment of chronic pain. Benefit limits may apply for members 21 and over. There are no benefit limits for services obtained through EPSDT.

Healthy Workers HMO members do not have coverage for acupuncture or chiropractic care.

7.4 Dental Services

For Medi-Cal members aged 20 years and younger, dental services are provided by Denti-Cal. A pediatric Medi-Cal member can self-refer for dental services and should call Denti-Cal at 1-800-322-6384 for questions. A dental screening (by the PCP) is part of the Initial Health Appointment and CHDP check-ups.

Healthy Workers HMO members who are IHSS Independent Providers have dental coverage through Liberty Dental via IHSS/Public Authority. Refer IHSS Independent Providers to the IHSS/Public Authority if they have questions regarding their dental coverage or need to enroll in the dental plan. Healthy Workers HMO members currently enrolled with Liberty Dental can call 1-888-703-6999 to find a participating dental provider.

7.4.1 Fluoride Varnish

Fluoride varnish is a form of topical fluoride that is now available to dentists, physicians, nurses, and medical assistants to prevent tooth decay.

- Fluoride vanish may be applied during a routine office visit for San Francisco Health Plan Medi-Cal members under six years of age.
- It does not need refrigeration and has a shelf life of about two years.
- The application requires no special equipment and is easier and more conveniently applied using 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 children these young, medical providers offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish.

7.5 Doula Services

Doulas are birth workers who provide health education and advocacy - as well as physical, emotional, and non-medical support – to pregnant and postpartum persons before, during and after childbirth.

Medi-Cal members can get services from doulas who qualify to provide doula services through Medi-Cal. This means that qualifying doulas can now contract with SFHP to provide services to SFHP members.

Covered doula services:

- One initial visit.
- Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

For more details on covered and non-covered services, refer to the Medi-Cal Provider Manual for Doulas or contact the SFHP Provider Relations department.

7.6 Foster Children

Children in foster care and adults formerly in foster care up to age 26 are covered under the Medi-Cal program.

Senate Bill (SB) 184 authorized the Department of Health Care Services (DHCS) to transition the CHDP Program effective July 1, 2024; however, Health Care Program for Children in Foster Care (HCPCFC) was preserved as a standalone, locally self-administered program. This means that for foster care children/youth not enrolled in a managed care plan, systematic coordination of services and comprehensive care management will continue to be provided through the HCPCFC.

For more information about San Francisco's HCPCFC program, please contact them directly at (415) 558-2656 or NOD.Line@sfgov.org.

7.7 Medi-Cal for Kids & Teens (EPSDT) Services

By law, the Department of Health Care Services (DHCS) is responsible for providing full-scope early and periodic screening, diagnostic, and treatment services to Medi-Cal beneficiaries under the age of 21. California refers to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as Medi-Cal for Kids & Teens. This benefit allows enrolled members (under age 21) to receive any medically necessary treatment or procedure, regardless of whether or not Medi-Cal covers it.

Medi-Cal providers (medical, dental, and mental health providers) should inform Medi-Cal beneficiaries (under age 21), or their parents, about the following:

- Why preventive services and screenings are important
- What services are offered under Medi-Cal for Kids & Teens
- Where and how to get services
- Services are free
- Free transportation and help scheduling are available

Providers should present these five items in clear language:

- In person
- By phone (using dialogue and scripts)
- By written materials
    - Evidence of coverage documents
    - Beneficiary handbooks
    - Related materials

For help communicating with beneficiaries, see the Resources page.

All Medi-Cal providers of Medi-Cal for Kids and Teens members are required to complete the DHCS Medi-Cal for Kids & Teens Provider Training through the DHCS Provider Portal. To review the material, here is a link to the current PowerPoint slide deck (link).

Additional information can be found at: link

7.8 Pharmacy Benefits

For information about program-specific pharmacy benefits visit https://www.sfhp.org/providers/pharmacy-services/ or contact the SFHP Pharmacy Services Department at 1(415) 547-7818 x 7085.

For Medi-Cal Members:

Effective January 1, 2022, the pharmacy benefit for SFHP Medi-Cal members transitioned to a state-wide system used to administer pharmacy benefits, known as Medi-Cal Rx. SFHP will continue to manage inpatient medical and institutional care for Medi-Cal members, including medications administered in these settings.

Prior Authorization Submission Options for Medi-Cal Rx
Prior Authorization (PA) requests for prescription drugs and some medical supplies for Medi-Cal beneficiaries will be adjudicated by Medi-Cal Rx.

To submit a request, providers can:

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

Providers can call 1(800) 977-2273 for assistance with SFHP Medi-Cal members.

For Healthy Workers HMO:

For questions about the pharmacy network or for assistance with pharmacy claims processing for SFHP Healthy Workers, the Pharmacy Benefits Manager is Magellan RX and can be contacted at 1(800) 424-4331.

7.9 Substance Use Disorder Needs

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.

7.10 Vision Benefits

Vision Service Plan (VSP) administers vision benefits for SFHP Medi-Cal and Healthy Workers HMO members. Optometry services are a vision benefit and are available every 24 months. Ophthalmology services are a medical benefit through SFHP and there is no age restriction for these services for any line of business.

Providers can refer a member to a participating VSP provider. For questions regarding vision benefits or to find a VSP provider, members can contact VSP at 1(800) 438-4560, visit www.vsp.com or contact SFHP's Customer service at 1(800) 288-5555.

Section 8: Special Arrangement Services

Services listed below should be provided to Medi-Cal members without a referral or authorization in order to protect patient confidentiality and promote easy access. Special Arrangement Services include family planning, screening, and treatment for sexually transmitted infections (STI), HIV testing, and abortion. Medi-Cal members may go outside of their medical group network for these services, except for prenatal care. For Healthy Workers HMO, the member is encouraged to use family planning, HIV testing, and sexually transmitted disease services provided by their medical group, and referral or authorization may be required.

8.1 Abortion (Voluntary Termination of Pregnancy)

Abortion services are available to all SFHP members without referral or authorization. Outpatient abortion services are not subject to prior authorization, medical justification, or any other utilization management procedures. Inpatient hospitalization for the performance of an abortion requires prior authorization. Authorization for general anesthesia associated with abortion services is not required by SFHP; however, a medical group may require prior authorization.

8.2 Minor Consent Services

Members of any age have the right to access some services without parental consent. Medical records and/or information regarding medical treatment specific to these services will not be released to parents and guardians, without the minor's consent. These services include treatment for:

- Sexual assault, including rape
- Drug and alcohol abuse (note: methadone treatment requires guardian notification and consent)
- Pregnancy, including abortions
- Family planning services (note: sterilization requires guardian notification and consent)
- Sexually transmitted diseases

8.3 Sterilization Services

California law requires that people who request sterilization (surgery that will end their ability to have children) complete a form (PM-330) attesting that they are giving informed consent for this procedure. These forms must be completed and signed prior to the surgery and filed in the medical record. Medi-Cal members may not waive the 30-day waiting period. A copy of the form must be attached to the claim when submitted for payment. Please consult your medical group or call SFHP for any clarification.

Section 9: Health Assessments

9.1 Immunizations

Immunization programs are designed to increase both childhood immunization rates and the number of members who are fully immunized. The Advisory Committee on Immunization Practices (ACIP) has recommended immunizations for all children as well as adult members.

Providers should be working with the CAIR program, so all immunization information is obtained by CAIR whether by inputting data, upload, or transfer of information. All members should be notified by the PCP of the use of the California Immunization Registry (CAIR) to monitor immunizations administered to all members. This program allows members to receive the appropriate immunization based on age at the appropriate timeframe.

When immunizations are given, the PCP must also distribute the Vaccine Information Statement (VIS) that educates on the vaccines administered prior to having their vaccines administered.

All pediatric providers must participate in the Vaccines for Children (VFC) program.

Contact the FSR team at fsr@sfhp.org if you have any questions on the immunization requirements.

9.2 Initial Health Appointment (IHA)

An IHA is an initial comprehensive preventive clinical visit with a primary care practitioner. DHCS requires that PCPs complete an IHA with new SFHP members within 120 calendar days of enrollment for all ages. PCPs are strongly encouraged to review their monthly eligibility list available on the SFHP provider portal and to proactively contact their assigned members to make an appointment for an IHA within the timeframe allowed. A thorough IHA enables the member's PCP to assess and manage the acute, chronic, and preventative health needs of the member.

The IHA process also includes an initial Health Risk Assessment (HRA) to evaluate the member's health and social needs, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH). The HRA is used as a basis to develop the member's individual care plan.

The IHA should include but is not limited to the following specific screenings:

- A comprehensive past medical and psycho-social history
- Preventive services
- Comprehensive physical exam
- Diagnoses and plan of care
- Developmental and behavioral assessment
- Vaccines as recommended by the ACIP
- Documented parental anticipatory guidance and Blood Lead Level testing for pediatric members
- Dyadic Services and Family Therapy Benefit

The PCP's office is responsible for making and documenting all attempts to contact assigned members. Members' medical records must reflect the reason for any delays in performing the IHA including any refusals by the member to have the exam.

An initial health appointment is not necessary under the following conditions:

- If the new member is an existing patient of the PCP (but new to us) with an established medical record

showing baseline health status. This record must include a documented IHA within the past 12 months prior to the member's enrollment and sufficient information for the PCP to provide treatment.
- If the new member is not an existing patient, transferred medical records can also meet the requirements for an IHA if a completed health history is included.
- If the new member refuses to schedule an IHA. The refusal must be documented in the member's medical record.

Additional information is available at https://www.sfhp.org/wp-content/files/providers/forms/IHA_Tip_Sheet.pdf

Contact the FSR team at fsr@sfhp.org if you have any questions on the IHA requirements.

9.3 Preventive Services

San Francisco Health Plan (SFHP) approves, adopts, and distributes evidenced-based clinical practice guidelines based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics, Advisory Committee on Immunization Practices (ACIP), and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. The practice guidelines are promoted to providers and members to improve health care quality and reduce unnecessary variation in care. SFHP's clinical practice guidelines are also reviewed and approved by SFHP's Quality Improvement and Health Equity Committee.

Diagnostic preventive procedures include, but are not limited to:
- Adult preventive services recommendations.
- Recommendations for preventive pediatric health care.
- Recommended adult immunization schedule for ages 19 years or older.
- Recommended child and adolescent immunization schedule for ages 18 years or younger, United States.

The above organizations make recommendations based on reasonable medical evidence. SFHP reviews the guidelines annually for content accuracy, current primary sources, new technological advances, and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. SFHP encourages providers to utilize these guidelines to improve the health of our members.

Additional information on these clinical guidelines can be found at https://www.sfhp.org/providers/improving-quality/clinical-guidelines/

9.3.1 Preventive Services Panel Management Data

On a quarterly basis, PNO notifies applicable Network Providers who are responsible for the care of the identified child member of regulatory requirements to test that child and provide anticipatory guidance. The EPSDT Screening & Blood Lead Screening report contains the following data:

- All child members who have no record of receiving a BLL test.
- The age(s) at which the required BLL tests were missed, including for children without any record of completed BLL tests at each age.
- All members under age 21 and their preventative screenings and immunization status.

9.3.2 Pediatric Preventive Services Well-Child Screening

Provider Training Carve-Out for Some Well-Child Screening Topics

The cessation of the CHDP program has passed responsibility for primary care provider trainings related to preventive healthcare services to the managed care plans. These trainings include vision, audiometric, and anthropometric screening procedures, as well as providing training on fluoride varnish treatments and blood lead screening. This service will be provided to primary care providers through the Facility Site Review process. The training modules will be accessible from the SFHP Provider Training Learning Management System (LMS)

Section 10: Coordination of Care for Medi-Cal Members

10.1 Closed-Loop Referrals

A referral from a primary care physician (PCP) to a specialist results in a completed specialty appointment with results available to the PCP. This is defined as "closing the referral loop". As health systems grow more complex, regulatory bodies increase vigilance, and reimbursement shifts towards value, closing the referral loop becomes a patient safety, regulatory, and financial imperative. (Source)

Beginning in 2025 for Medi-Cal plans, a follow-up will be required when members are referred for crucial health care services and community resources recommended to them. Essentially, this will "close the loop" on recommended care and services to meet their needs. This requirement comes to Medi-Cal Plans as part of the CalAIM Population Health Management initiative. (Source)

10.2 California Children's Services (CCS)

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services for children aged 21 years and younger who have CCS-eligible physical disabilities and complex medical conditions. Services provided under the CCS program are reimbursed through the CCS program. SFHP is not financially responsible for the CCS services provided to its members. A SFHP member who is eligible for CCS services remains enrolled with SFHP, and the PCP coordinates and continues to provide care for all needs unrelated to the CCS condition.

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.

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

Send the member's clinical information and the CCS referral form to:

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.

10.3 Children and Youth with Special Health Care Needs (CYSHCN)

Children with Special Health Care Needs (CSHCN) are "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally".

Medical groups and primary care physicians are responsible for ensuring that CSHCN are identified, assessed, receive care coordination or care management, receive all medically necessary follow-up services, and have timely access to

specialties, subspecialities, ancillary providers, specialized equipment and supplies and community resources to address the member's special health care needs.

10.4 Chronic Conditions Health Needs

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.

Members with more complex health needs may qualify for extra services focused on care coordination. The SFHP Complex Care Management (CCM) 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.

If you feel your patient would benefit from Care Management services, please contact the Care Management intake line at 415-615-4515 or email us at caremanagement_referrals@sfhp.org to connect with a member of our team.

10.5 Community Health Worker

Community Health Workers are available to provide additional support to Medi-Cal members experiencing certain health issues or needs. They can assist members with getting health screenings, health education, connecting to services, and one on one support.

For additional information on these services, please check the SFHP website at https://www.sfhp.org/programs/medi-cal/benefits/community-health-worker-services/ or call SFHP Customer Service at 1(800) 288-5555, TTY 1(888) 883-7347 (Monday-Friday 8:30am – 5:30pm).

10.6 Comprehensive Perinatal Services Program (CPSP)

The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal reimbursement program that funds a wide range of services for pregnant women, from conception through 60 days postpartum. Medi-Cal providers may apply to become approved CPSP providers to be reimbursed for these additional services. 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

10.7 Early Start Program (ES)

Infants and children, up to 36 months of age, who have a developmental delay or disability or an established risk condition with a high probability of resulting in a delay may be eligible to receive early intervention, or “Early Start", services through Golden Gate Regional Center (GGRC). For a list of Early Start services, please visit GGRC’s website (link).

The medical group and primary care physicians are responsible for coordination of services with the Early Start Program.

A SFHP member who is eligible for Early Start services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.

Medical group physicians and case managers may refer to Early Start by contacting Golden Gate Regional Center's 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: http://www.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 www.dds.ca.gov/earlystart

10.8 Enhanced Care Management

Enhanced Care Management (ECM) is a statewide Medi-Cal managed care plan (MCP) benefit that provides person-centered, community-based care management to the highest need members. It is the highest care management tier of the Medi-Cal MCP Population Health Management continuum. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. Enhanced Care Management makes it easier for members to get the right care at the right time in the right setting and receive comprehensive care that goes beyond the doctor's office or hospital.

Enhanced Care Management is available to specific groups (called "Populations of Focus"), including Justice-involved individuals. SFHP is also continuing to add more populations who can access these services.

SFHP's Justice-Involved Liaisons are available to help with ECM provider assignment and to answer your questions about ECM services to support the Justice-Involved population. To contact a Justice-Involved Liaison, visit website.

Additional information about ECM eligibility criteria is available at website, DHCS ECM Policy Guide. , and ECM and Community Supports to learn more.

10.9 Targeted Case Management

Targeted Case Management (TCM) means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

10.10 Golden Gate Regional Center (GGRC)

Golden Gate Regional Center (GGRC) is a nonprofit private corporation that contracts with the State Department of Developmental Services to provide or coordinate services and support for individuals with developmental disabilities.

To be eligible for services, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present "a substantial disability" as defined in Title 17, Section 54001 of the California Code of Regulations. Eligibility is established through diagnosis and assessment performed by regional centers.

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 and for continued medical care.

Medical group physicians and case managers may refer members 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**

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 www.ggrc.org.

10.11 Local Education Agency (LEA)

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 with one or more of the following conditions:

- Vision or Hearing Impairment
- Orthopedically Challenged
- Developmentally Delayed

Children who have received the Early Start (ES) or Golden Gate Regional Center (GGRC) services are assessed between 2–3 years of age for referral to the San Francisco Unified School District Special Intake Unit for continued assistance.

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

Services provided during the school year, under the LEA program, are reimbursed by the San Francisco Unified School District. San Francisco Health Plan is not financially responsible for the LEA services provided to its members.

A SFHP member who is eligible for LEA services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care. As LEA provides services during the school year only, SFHP and its medical groups authorize and provide medically necessary services during the summer months.

LEA services include:

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

Local Education Agency, Special Education Services can be reached at: 1(415) 759-2222.

10.12 Medical Home

The American Academy of Pediatrics describes a medical home as an approach to providing comprehensive and high-quality primary care that is delivered or directed by a well-trained primary care or specialty physician who helps to manage and facilitate essentially all aspects of care for the child. A medical home should be the following:

- Accessible: Care is easy for the child and family to obtain, including geographic access and insurance accommodation.
- Family-centered: The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family.
- Continuous: The same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care.
- Comprehensive: Preventive, primary and specialty care are provided to the child and family.
- Coordinated: A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.
- Compassionate: Genuine concern for the well-being of a child and family are emphasized and addressed.
- Culturally Effective: The family and child's culture, language, beliefs, and traditions are recognized, valued, and respected.

Providers can check for a member’s PCP and associated medical group by looking up the member’s eligibility on the SFHP Provider Portal or calling SFHP’s customer service team at 1-415-547-7800.

10.13 Women, Infants, Children Program (WIC)

WIC is a nutrition/food program that helps pregnant, breastfeeding, or postpartum persons, and children less than 5 years of age to eat well and stay healthy. WIC eligibility is determined by federal income guidelines and Medi-Cal members are eligible. Services include free food vouchers, nutrition education, and breast-feeding support.

Medical group physicians can refer to WIC in a number of ways:

- By submitting a referral via EPIC, where available
- By visiting their website at **sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/default.asp**
- By referring members to any WIC Center; current locations can be found here: https://sf.gov/wiclocations

All WIC referral forms and answers to frequently asked questions can be found here: https://sf.gov/information/healthcare-providers
All WIC referral forms can be found on the website: **sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/WICRefForms.asp**

Section 11: DHCS Waiver Programs

11.1 Genetically Handicapped Persons Program

Genetically handicapped persons program is a state-funded program that may provide additional care coordination and services for eligible persons aged 21 years old or older with genetically transmitted diseases such as hemophilia, cystic fibrosis, and sickle cell disease, as well as metabolic disorders such as Phenylketonuria (PKU). More information on how to apply for GHPP services and eligibility can be found at https://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx

11.2 HIV/AIDS Waiver Program

HIV/AIDs 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 https://westside-health.org/

11.3 Home and Community-Based Services for the Developmentally Disabled (HCBS-DDS)

HCBS-DD provides in-home care and support to persons with disabilities. Services provided include homemakers for chores, home health aides and/or nurses, family training, vehicle adaptation, respite care, day habitation, transportation and more. For referral and eligibility review contact Golden Gate Regional Center at (415) 546-9222. For more information visit https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx

11.4 Multi-Purpose Senior Services Program (MSSP)

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. 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 MSSP and Adult Day Health Care
3626 Geary Boulevard, Second Floor
San Francisco, CA 94118
1(415) 750-4150 or 1(415) 750-5330
https://www.ioaging.org/companioa/www.ioaging.org

San Francisco Adult Day Services
Network 1(415) 808-7371

11.5 Nursing Facility Waiver

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 HCBS Waiver

Section 12: Health Education

12.1 Health Education and Member Education on Preventive Services

SFHP members must be provided with health education services at no cost. Health education services include but are not limited to primary and obstetrical care, clinical preventive services, education, and counseling.

These services can be provided through:

- Individual classes
- Group classes
- Workshops
- Support groups
- Peer education programs
- Disease management programs
- Educational materials

Health education services may include educational interventions designed to help members to access appropriate care or educational interventions that cover specific behaviors or are designed to assist members to follow self-care regimens and treatment therapies for existing medical conditions, chronic disease, or health conditions.

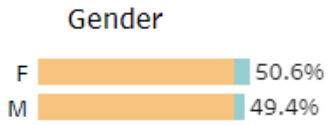
Visit SFHP's website at www.sfhp.org to access SFHP's Health Education Library. Health education resources are available in SFHP's threshold languages (English, Chinese, Spanish, and Vietnamese). If you would like more information about health education, please contact SFHP Population Health Program Manager at 415-615-5149 or email HealthEducation@sfhp.org.

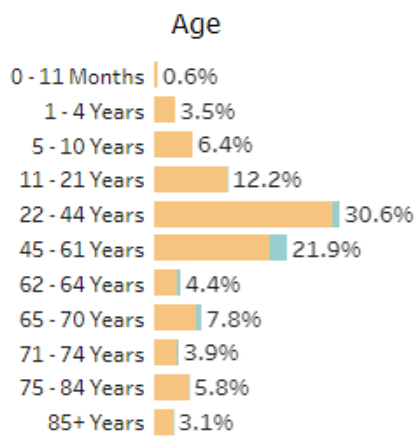
Section 13: Serving Your Diverse Population

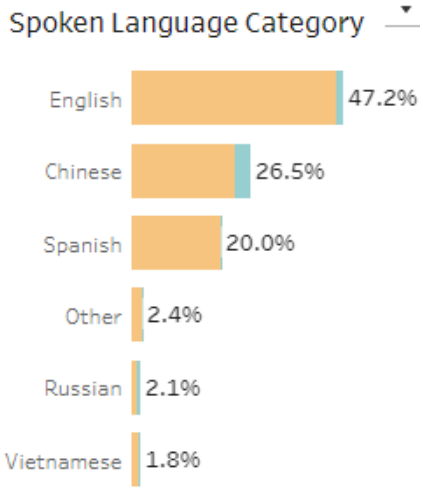
13.1 About SFHP Membership Demographics

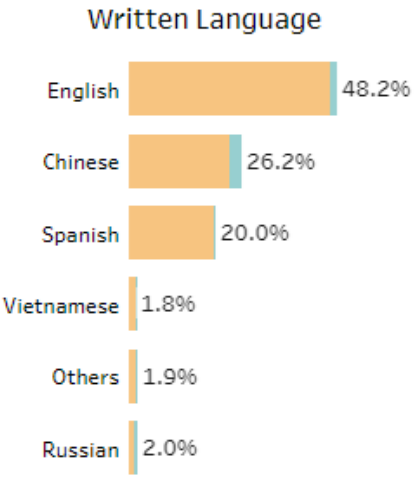
- SFHP members come from many racial/ethnic groups
- Approximately half of SFHP members have Limited English Proficiency (LEP)

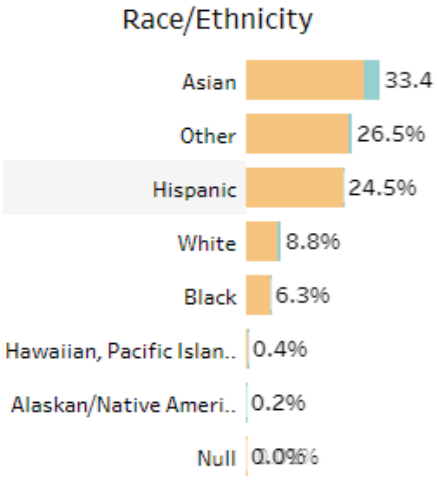
As of October 2024:











13.2 Social Drivers of Health Impacts

The World Health Organization (WHO), defines SDOH as, “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” They are non-medical factors and forces that can influence health, including economic stability, physical environment, education, food, social and community context, and access to health care.

SFHP members face many of the complex challenges facing California’s most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

Risk stratified and segmented (RSS) assessments are completed annually for all individuals and at that time its methodology is assessed for bias, completeness, and accuracy. With the RSS process, individuals are assessed and offered care coordination, care management or complex care management services based on their RSS and assessment. Individuals qualifying for ECM are kept separate and in queue for that program’s services. Individuals may be reassigned to another level of care should the score change and or the clinical assessment indicates a different level of care is needed.

SFHP uses SDOH indicators as a proxy measure for continuous performance evaluation of individuals and risk stratified and segmented (RSS) outputs. The RSS process is applied to all Medi-Cal enrolled individuals upon enrollment into the plan, when their health risk profile changes, and throughout the year.
Segmented individuals are categorized into Low Risk, Medium-Rising Risk and High-Risk Groups for assessment, referrals, and additional resources.

13.3 Diversity, Equity, and Inclusion Training (Sensitivity, Diversity, Communication Skills, and Cultural Competency Training

Cultural competency enables improved communication between Providers and Medi-Cal members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes. SFHP puts people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value for all people's health and well-being.

The DHCS DEI training program will include the following requirements[1];

- Promotes access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and
- Information about the Health Inequities and identified cultural groups in the SFHP service area, which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends for the patient's treatment; and language and literacy needs.

DEI training is required for all new MCP staff, Subcontractors, Downstream Subcontractors, and Network Providers serving MCP Members within 90 days of start date.[2] The objective is to teach participants an enhanced awareness of diverse imperatives and issues related to improving access and quality of care for MCP Members.

13.4 Cultural and Linguistics Training

Professional interpreter services for medical encounters must be offered to non-English speaking or limited English proficient SFHP members. Members have the right to receive oral interpreter services on a 24-hour basis at no cost to them. Interpreter services may be provided through an in-person interpreter or telephone language service.

Your medical group is required to provide this service to SFHP Medi-Cal members. You must document a member's preferred language (if other than English) in the medical record. You must document the request and refusal of language/interpretation services in the member's medical record. You should discourage members from using friends, family and minors as interpreters.

13.4.1. Linguistic Services Terms

Limited English Proficient (LEP): When an individual cannot speak, read, write, or understand the English language at a level that permits him or her to interact effectively with clinical or non-clinical staff in a healthcare setting.

Language Access Services: Language access services is the collective name for any service that helps an LEP patient obtain the same access to and understanding of health care as an English speaker would have. This can include the use of bilingual staff and interpreters. It also includes the provision of

[1] 2024 Managed Care Boilerplate Contract, Exhibit A Attachment III Section 5.2.11.C Diversity, Equity, and Inclusion, pp. 339-340
[2] Contract Section: 3.2 Provider Relations, Deliverable Identifier R.0083, Operational Readiness Requirement, Exhibit A Attachment III Section 5.2.11.C Diversity, Equity, and Inclusion

translated documents.

Interpretation: The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language, taking the cultural and social context into account.

Translation: The conversion of a written text into a corresponding written text in a different language.

13.4.2 Why is Linguistic Access Important?

Accurate communication between patient and health care provider is essential for proper diagnosis, treatment, and patient compliance.
It also:

- Helps reduce health disparities
- Helps improve quality of care and patient satisfaction
- Makes business sense
- Is important for compliance with federal and state requirements

Linguistic Access Reduces Health Disparities.
Patients with language barriers:

- Experience more outpatient drug complications
- Experience an increase in other medical problems and lower medication compliance
- More likelihood of serious side effects
- More likelihood of unnecessary and invasive tests

Business Value Linguistic Access.

- Reduce medical errors
- Increase patient satisfaction
- Increase compliance
- Decrease costs for diagnostic testing
- Reduce unnecessary admissions
- More efficient member interactions
- Better community relations

13.4.3 Regulations Mandating the Use of Interpreters for LEP Members

Federal	State
• Title VI of the Civil Rights Act of 1964 • EMTALA • Hill-Burton Act • Executive Order 13166 • CMS	• DMHC, SB853 • DHCS (Medi-Cal)

13.4.4 DHCS Medi-Cal Interpreter Services Requirements

- Interpreter services, including sign language, must be available 24/7 at no charge to SFHP members
- The following should be documented in the medical record:
    - Member's preferred language

    - If member wants family to interpret (although this should be discouraged)
    - Member's refusal of interpreter services
- Discourage the use of friends or family members as interpreters (unless specifically requested by the member after being offered professional interpreter services at no charge)
- Minors, under 18 years old, accompanying members shall not be used as interpreters
- Members have the right to file grievances or complaints if linguistic needs are not met
- Interpreters and bilingual staff should be qualified (assessed for language capacity)
- Site must have written Interpreter Services policy which includes the languages spoken by bilingual providers and staff

13.4.5 Asking about Language Preference

How you ask a member about their language will affect the response you receive:

"You won't need an interpreter, will you?"

Asking the question this way discourages the member, or the person who is making the appointment, from asking for the language assistance that he or she may need.

"What language do you speak at home?"

This question will get you information about the member's home language, but ignores the possibility that the member may be bilingual in English as well.

"Will an interpreter be needed? In what language?"

Members may say no because they believe they must either bring their own interpreter or have a family member interpret.

In what language do you prefer to receive your health care?"

Asking the question this way will provide you with information on the language the member feels they need to speak in a health-related conversation.

If the answer is a language other than English, you can plan to have language assistance available for the member, and you should add this information to the record.

13.4.6 Best Practices for Providing Interpreter Services

Working with Interpreters on-site

- Greet the member first, not the interpreter.
- Face and talk to the member directly.
- Speak at an even pace in short segments.
- Speak in standard English and avoid medical terminology and jargon.
- Ask one question at a time.
- Avoid interrupting the interpretation.
- Do not make assumptions about the member's education level. An inability to speak English does

not necessarily indicate a lack of education.

Working with Interpreters by phone

- Avoid using family, friends, or minors as interpreters
  - They may withhold information from member from embarrassment, protection, emotional involvement
  - May have their own agenda
  - With children, it may lead to parent disempowerment, role reversal
  - Can cause guilt & trauma
  - May not be familiar with medical vocabulary
  - Serious mistakes can occur
- When working with an interpreter over the phone, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room.
- When the interpreter comes onto the line, let the interpreter know who you are, who else is in the room, what sort of office practice this is, what sort of appointment this is.
- For example, "Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam."
- Give the interpreter the opportunity to quickly introduce him/herself to the patient.
- If you point to a chart, a drawing, a body part, or a piece of equipment, verbalize what you are pointing to as you do it.

Documenting Language Preference

It is important to record information on interpreter needs and language preference in the member's medical record.

Basic: Add a color or letter code to the member's chart, noting that he or she needs an interpreter. Designate a code or color for each language.

Better: Add the information under "Notes" in a member's entry in your member database, so that when a receptionist calls up the member's record to make an appointment, the information about the need for an interpreter and the language can be noted as well.

BEST: Add a question on your patient registration form or in your practice management system. Not only will you know when a member is scheduled that they will need an interpreter, you will also be able to track how many members you have who speak a particular language and how often they are seen.

13.4.7 What is Culture?

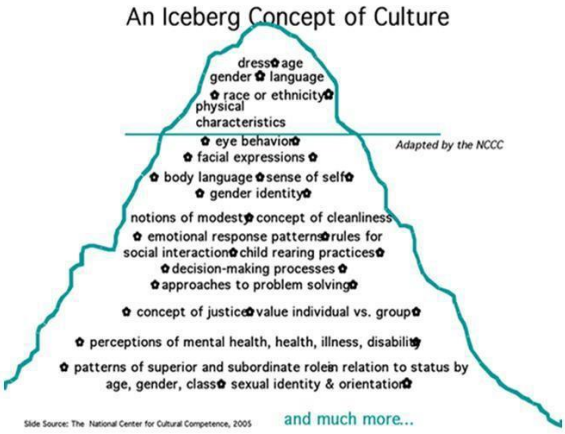
Culture consists of a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that is shared among members of a particular group, and that group members use to interpret their experiences of the world.

- **Cultural awareness** is being cognizant, observant, and conscious of similarities and differences among and between cultural groups.
- **Cultural and linguistic competence** is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that **enables effective work** in cross-cultural situations.

- **Cultural humility** is a commitment and active engagement in a **lifelong process** that individuals

enter into on an ongoing basis with patients, communities, colleagues, and with themselves.

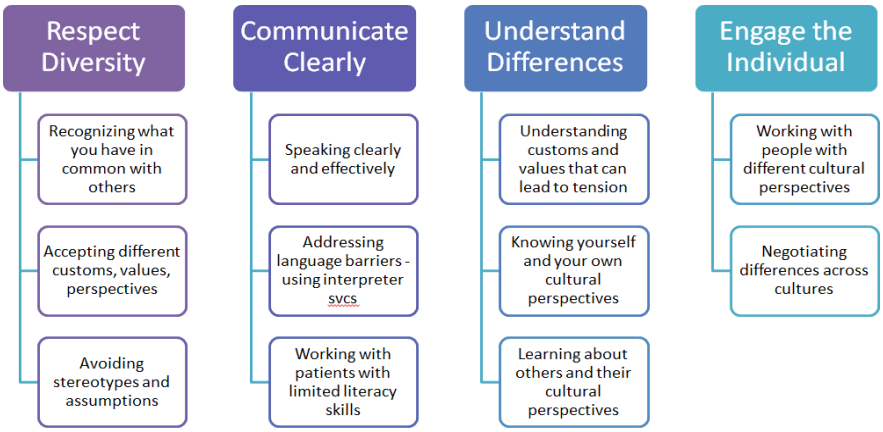
Influences can be above or below the surface, seen and unseen



What is Cultural Competence in Health Care?

- Recognition that people of different cultures have different ways of communicating, behaving, interpreting, and problem-solving.
- Recognition that cultural beliefs impact member's health beliefs, help-seeking activities, interactions with health care professionals, health care practices, and health care outcomes, including adherence to prescribed regimens.

Tips for Cross Cultural Communication



Source: QualityInteractions

13.5 Health Needs of Diverse Populations

13.5.1 Health Needs of LGBTQ+ People and Communities

- SFHP's members have diverse sexual orientations, which may impact their relationship with health care and their health needs.
  - Many LGBTQ+ people do not disclose their sexual orientation or gender identity because they do not feel comfortable, or they fear receiving substandard care.
  - What can we offer for the unique needs of LGBTQ+ people? Examples:
    - Identify your own LGBTQ+ perceptions and biases.
    - Understand and check your own biases and respect differences to create a safe environment.
    - Learn about sexual and gender minority health inequities, and consider them in your care of individuals. CME-eligible education is available at the National LGBTQIA+ Health Education Center at lgbtqiahealtheducation.org.
- Transgender terms and health needs for transgender patients:
  - Cisgender – people whose gender identity and gender expression align with their assigned sex at birth
  - Transgender – people whose gender identity and/or gender expression differs from their assigned sex at birth. A transgender person *may or may not* choose to alter their bodies hormonally and/or surgically.
  - If it's relevant to your scope of practice, understand the potential difference between each patient's gender expression and their physiological risks, screenings, preventive and acute care.
  - Ask and use your patient's correct gender pronouns to signal mutual respect and affirming their identity.

13.5.2 Health Needs of Transgender People (Gender-affirming Care)

Gender-affirming care refers to treatment provided to address incongruence between a person's gender assigned at birth and their gender identity. Gender affirming care is a covered Medi-Cal benefit when medically necessary. Requests for gender affirming care should be from specialists experienced in providing culturally competent care to transgender and gender diverse individuals and should use nationally recognized guidelines.

Criteria for gender-affirming care and therapy are provided in guidelines from several organizations, including the AAP, the Endocrine Society, and 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). (Website www.wpath.org)

DHCS has also offered guidance on the health need of this population. These guidelines can be found by following the link.

13.5.3 Tips for Working with Transgender Patients

- Treat transgender people as you would want to be treated.
- Always refer to transgender people by the name and pronoun that corresponds to their gender identity.
- If you are unsure about the person's gender identity, ask:
- *"How would you like to be addressed?"*
- *"What name would you like to be called?"*
- Focus on care rather than indulging in questions out of curiosity

- The presence of a transgender person in your treatment room is not an appropriate "training opportunity" for other health care providers.
- It is inappropriate to ask transgender patients about their genital status if it is unrelated to their care.
- Never disclose a person's transgender status to anyone who does not explicitly need information for care.

Source: Transgender Law Center

13.5.4 Health Needs of Seniors and Persons with Disabilities (SPD)

Meeting the individual accommodation needs of SPDs to the extent possible ensures the following:

- *The practice provides appropriate and effective care*
- *Compliance with the federal Americans with Disabilities Act (ADA) and Section 504 of the 1973 Rehabilitation Act.*
- *The ADA and Section 504 require that healthcare services provide certain accommodations that ensure equitable and non-discriminatory access to care.*

SFHP Member Statistics

- *70% of SFHP members with disabilities live with 2+ chronic conditions and 16% of these members have diabetes (compared with 7% in gen. pop.)*
- *About 25% have 4+ chronic conditions*
- *30% of beneficiaries with disabilities receive treatment for mental health conditions annually*

Accommodations: What Members May Need

- Physical accessibility
- Effective communication
- Sign language interpreters, assistive listening devices, print materials in accessible formats
- Policy modification (for example, to allow more time for an office visit)
- Accessible medical equipment

Dimensions of Disability

- Disease/ Multiple Medication
- Hearing Impairment
- Physical Impairment
- Cognitive Impairment/Mental Health
- Caregiver Burden
- Visual Impairment
- *Source: US Dept. of Health and Human Services, 2007*

Examples of Preferred Terms

- He had polio
- A person who uses a wheelchair
- She has a disability
- A person with a spinal curvature

- He was stricken with or a victim of polio
- Confined to a wheelchair, wheelchair-bound
- She is crippled
- Hunchback, Humpback

Interacting with Seniors

- Avoid ageist assumptions when providing information and recommendations about care.

- Offer information in a clear, direct, and simple manner.
- Do not assume limitations exist just based on age.
- Recognize the senior as the expert in their own life.

Quote from a senior activist:

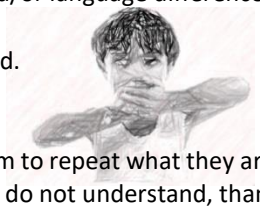
"*As Seniors we know our capabilities and energy are diminishing but want to retain the right to limit ourselves when the time comes, and not have young people put those limitations on us, to make them feel better.*"

13.5.5 Health Needs of People with Physical Disabilities

- Mobility and physical disabilities range from people who have mild to those with significant limitations.
- If shaking hands is appropriate, do so. People with limited hand use or who use prosthesis can usually shake hands. If people have no arms, lightly touch their shoulder.
- When speaking to a person using a wheelchair or scooter for more than a few minutes, try to find a seat or kneel so you are at the same eye level.
- Ask for permission before moving someone's cane, crutches, walker, or wheelchair.

13.5.6 Health Needs of People with Speech Disabilities

- Some (not all) people with limited speech have difficulty understanding what people say to them because of their disability, age, a hearing loss, cognitive difficulties, and/or language differences.
- Do not raise your voice. People with speech disabilities can hear you.
- Always repeat what the person tells you to confirm that you understood.
- Ask questions one at a time. Give individuals extra time to respond.
- Pay attention to pointing, gestures, nods, sounds, eye gaze, and blinks.
- If you have trouble understanding a person's speech, it is ok to ask them to repeat what they are saying, even three or four times. It is better for them to know that you do not understand, than to make an error.



13.5.7 Health Needs of People with Visual Disabilities

- People can have a range of visual disabilities, from having no vision to people who have low vision and may be able to read large print.
- When offering help, identify yourself and let people know you are speaking to them by gently touching their arm.
- If you leave people's immediate area, tell them so they will not be talking to empty space.
- Speak directly facing the person. Your natural speaking tone is sufficient.
- When giving directions, be specific. Clock clues may be helpful, such as "the desk is at 6 o'clock." When guiding a person through a doorway, let them know if the door opens in or out and to the right or to the left.
- People who are blind or have visual impairments may request (from SFHP) print materials in accessible formats such as digital, audio, large print, or Braille.

13.5.8 Health Needs of People with Intellectual and Developmental Disabilities

- An intellectual or developmental disability can affect a person's understanding, memory, language,

judgment, learning and related information processing and communication functions. These disabilities include individuals with intellectual disabilities, head injury, strokes, autism, Alzheimer's disease, and emotional disabilities.

- Offer information in a clear, concise, concrete, and simple manner.
- If you are not being understood, modify your method of communicating. Use common words and simple sentences.
- Allow time for people to process your words, respond slowly, or in their own way.
- Make sure the person understands your message.

13.5.9 Health Needs of Unsheltered Homeless People (Street Medicine)

Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing homelessness delivered directly to them in their own environment.

Street medicine provider refers to a licensed medical provider who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas). These providers are subject to all standard credentialing and enrollment requirements.

If the street medicine Provider has the ability to provide Primary Care services on the street, they may choose to serve as the Member's assigned PCP upon Member election.

Effective for dates of service on or after October 1, 2023, Medi-Cal providers may use POS code 27 for street medicine, in addition to the previously announced POS codes for street medicine: 04 (homeless shelter), 15 (mobile unit), and 16 (temporary lodging). For more information about billing for street medicine, please see All Plan Letter 22-023.

13.5.10 Health Needs of People with Specialty Mental Health Needs

After determining a member meets the needs for mental health care, such as through a Health Risk Assessment (HRA) that evaluates mental health needs, an appropriate referral can be made with San Francisco Behavioral Health Services (SF BHS) with specialty treatment programs.

Services for specialty mental health conditions are provided by San Francisco Behavioral Health Services (SF BHS). To refer a member for specialty mental health services, call SF BHS at 1(888) 246-3333.

13.5.11 Health Needs of People with Substance Use Disorder

After determining a member meets the needs for Substance Use Disorder services, an appropriate referral can be made with San Francisco Behavioral Health Services (SF BHS) with specialty treatment programs.

Services for specialty alcohol and drug abuse are provided by San Francisco Behavioral Health Services (SF BHS). To refer a member for specialty mental health services, call SF BHS at 1(888) 246-3333.

Section 14: Other

14.1 Coding Requirements

To receive the payments, providers and billing staff should stay informed and seek educational opportunities about the appropriate codes to use from industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

In addition to customary coding practices, certain Medi-Cal programs may have additional requirements. Refer to the DHCS/Medi-Cal Provider Manual, or the SFHP Claims section of the website for more information at https://www.sfhp.org/providers/claims/ .

Identifying member risk and need through whole person care approaches while considering Social Determinants of Health (SDOH) requires consistent and reliable coding data. While the DHCS encounter data system accepts and allows for providers to use all ICD-10-CM SDOH codes, DHCS seeks to prioritize the use of a set of 25 pertinent SDOH codes to maximize the capture of SDOH data that can be found on the SFHP website (link).

14.2 Data Collection and Reporting Requirements for Providers

Provider data has broad applications across SFHP and is collected from a variety of sources: provider onboarding and credentialing documentation, provider rosters, provider change requests, annual provider attestation, claims reporting, encounter data, lab results, and case management data. Data received from providers must follow protocols for timeliness, consistency, and accuracy for use in reporting and claims payment, and providers agree to submit such data pursuant to standards defined by SFHP.

Providers shall supply SFHP with necessary reports and information to enable SFHP to meet federal and state legal and contractual reporting requirements, including without limitation, data reporting requirements to DHCS, reports pertaining to Covered Services provided to members or provider's financial resources.

14.3 Medical Record Documentation for Providers

Each provider office is responsible for maintaining adequate medical records of member care and each member has a legible, detailed, well-organized, confidentially stored, and easily retrievable medical record. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of an agreement with SFHP, including the period required by the Knox-Keene Act and Regulations and Medicare and Medi-Cal programs.

If an unauthorized disclosure of member information occurs, providers are to notify SFHP immediately upon discovery by calling SFHP's toll-free 24-hour Compliance Hotline at **1(800) 461-9330**.

New Provider Training Attestation Form

By signing below, I_____attest that I have received materials and training on the following subjects:

☐Covered Services
☐Policies and Procedures for clinical protocols governing Prior Authorization and Utilization Management
☐Carved Out Services
- How to access and refer out Members

☐DHCS Waiver Programs
☐Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age
☐Medical record documentation and coding requirements
☐Existing health plan data collection and reporting requirements
☐Quality improvement programs to ensure required preventive services are offered and provided, including but not limited to, training on Population Health Management Program requirements (i.e., Care management services) including closed loop referrals;
☐Health education resources
☐Provider and Member incentive programs
☐Access to Care
- Appointment waiting time standards and ensuring telephone, translation and language access is available for Members during hours of operation.

☐Coordination of Care
- Secure methods of sharing information between providers involved in care
- How to access contact information for providers and members

☐Member Rights, including all rights as outlined in the DHCS Contract in Exhibit A, Attachment III, Section 5.1 (Member Services)
☐Diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training)
☐Health needs of:
- The Seniors and Persons with Disabilities (SPD) population
- Members with chronic conditions
- Members with Specialty Mental Health service needs
- Members with Substance Use Disorder needs
- Members with intellectual and developmental disabilities
- Children with special health care needs

☐Social Drivers of Health and disparity impacts on Members' health care

Signature	Date
Print Name	
Address, City, St, Zip	

[i] SFHP Policy PR-03, New Network Provider Training, page 2, LINK