SAN FRANCISCO HEALTH PLAN
Here for you

February 1, 2024

UPDATES INCLUDE:

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Transitional Care Services (TCS) - Care Coordination Services

TCS is a requirement by DHCS and is defined as care coordination services provided to members transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home-or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings. For high risk members, this is accomplished by ensuring that a single point of contact, a care manager, can assist members throughout their transition and ensure all required services are complete. SFHP and its partners are accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements.

The discharging facilities must complete a discharge planning process that:

- *Engages members, and/or members' parents, legal guardians, or Authorized Representatives, as appropriate, when being discharged.*

- *Uses a consistent assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes.*
- *Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals.*
- *Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.*
- *This must include a medication reconciliation upon discharge that includes education and counseling about the member's medications.*
- *Coordinates care with the member's designated family caregiver(s) and post-discharge providers.*

The care manager must coordinate and ensure completion of the following critical TCS tasks:

- Coordinating with Discharging Facility to ensure member engagement and comprehensive information sharing and coordination of care:
  - *Risk Assessment: The care manager must assess member's risk for adverse outcomes to inform needed TCS.*
  - *Discharge Instructions: Care Managers must review a copy of the discharging facility's discharge instructions, including the medication reconciliation completed upon discharge. After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure all questions are answered.*
  - *Discharge Summary and Clinical Information Sharing: Care Managers must receive and review a copy of the discharging facility's discharge summary and must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.*

- Necessary Post-Discharge Services and Follow-Ups:
  - *Support and follow-up post-discharge are critical aspects for the care manager responsible for TCS, including the following tasks:*
  - *Member Outreach: The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement.*
  - *Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge.*
  - *SUD and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition.*
  - *Medication reconciliation, post discharge.*
  - *Completion of referrals to social service organizations, necessary at-home services (DME, home health, etc.) and connection to community supports as needed.*

For members already enrolled in ECM at the time of the transition, the member's assigned ECM care manager must provide all TCS. Many high-risk members in transition will meet criteria for ECM for the first time and at any time in the TCS process, the member may be referred to ECM and/or Community Supports . The TCS team can refer members by leveraging the current process involving the SFHP CM Intake line.

SFHP has officially launched our January 2024 ECM and Community Supports services.

What's new:
We added 2 new ECM Populations of Focus:

- Birth Equity (for adults and youth)
- Justice-Involved (for adults and youth), post-release services

We added 4 new Community Supports, and expanded our Medically Tailored Meals program to include the option of Medically Supportive Groceries:

- Community Transition Service / Nursing Facility Transition to Home
- Home Modifications
- Housing Deposits
- Housing Tenancy Sustaining Services

Referral forms for all services are available at the following link: Provider Forms - San Francisco Health Plan (sfhp.org).

CalAIM News - Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD)

Effective January 1, 2024, all Medi-Cal members receiving long-term custodial or subacute care and members residing in an Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD) setting, will be enrolled with a managed care plan (MCP) during active eligibility.

LTC Custodial care became a carve-in for SFHP January 2023. SFHP will also assume financial and administrative responsibility for all patients in Custodial and Sub-Acute status in a Skilled Nursing Facility (SNF), who enter a third calendar month. ICF/DD members are SFHP's responsibility upon admission. For patients assigned to capitated partners, the administrative & financial responsibility for institutional care will remain with capitated partners during short-term admissions (discharged before the third month begins) and for the first two months of long-term admissions. These members will then be assigned to the San Francisco Direct Network (SDN) when their admission enters the third month.

If you have any questions, you may contact SFHP's Long-term Services and Supports Liaison, LTSSLiaison@sfhp.org .

Kaiser Network Termination at SFHP

Kaiser Foundation Health has a direct contract with DHCS effective January 1, 2024. SFHP no longer offers a Kaiser Network for our members. Members that were in the SFHP-Kaiser Network, have all been transitioned to Kaiser Permanente's direct network in 2024. Members were not required to make any changes and were automatically enrolled in Kaiser Foundation Health Plan for Medi-Cal coverage. There are no changes to medical coverage or benefits. Kaiser will manager their Medi-Cal plan. Patients primary care provider (PCP) and hospital at Kaiser has remained the same. Members received 30/90 day notice

Continuity of Care - For members receiving certain services from SFHP, Kaiser will continue to work with the patients, providers, and SFHP to make sure members continue to get the care they need.

For any members that want to switch to another health plan or back to SFHP for their Managed Care Medi-Cal plan, they can call Medi-Cal Health Care Options at **1(800) 430-4263** (TTY **1(800) 430-7077**), weekdays from 8:00am – 6:00pm. Or visit https://www.healthcareoptions.dhcs.ca.gov/.
You can also visit the DHCS website to learn more about these changes.
Frequently Asked Questions
Continuity of Care - Frequently Asked Questions
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Facility Site Review Provider Pearls

Child Health and Disability Prevention Program (CHDP)

The Child Health and Disability Prevention (CHDP) Program will cease to operate effective July 1, 2024. This is part of the comprehensive California Advancing and Innovating Medi-Cal (CalAIM) Initiative designed to support whole-person, integrated care that is high in quality, care is timely, is person centered, equity focused, and data driven. Managed Care Plans (MCP) will take on several responsibilities that had been conducted by CHDP. Primary care providers are encouraged to become aware of how these changes might impact clinics and practice operations. The CHDP Transition Plan is still evolving. This chart may help you to identify key areas of change with areas highlighted in green that involve Facility Site Review operations. Over the next months, more information will be forthcoming as these new MCP responsibilities take shape and are implemented.

Pre-CHDP Transition (Until June 30, 2024)	**Post-CHDP Transition (Effective July 1, 2024)**
CHDP Gateway/Children's Presumptive Eligibility Providers (CPE)	**Children's Presumptive Eligibility (CPE) Portal**
CHDP program counties will process all received applications by June 30, 2024.	The CHDP Gateway, which is used by Medi-Cal providers to establish presumptive eligibility into Medi-Cal, will be rebranded as the Children's Presumptive Eligibility (CPE) Portal effective July 1, 2024. Health Plans will provide more information.
Communication and Trainings with Providers and MCPs	**Communication and Trainings with Providers and MCPs**
As soon as possible and prior to March 1, 2024, CHDP program counties must be working in collaboration with their local MCPs to provide existing CHDP program provider trainings and	MCPs will conduct trainings for network providers on required preventive healthcare services, Medi-Cal for Kids and Teens services, formally known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), such as vision, audiometric and

Provider Site Reviews and Provider Site Relocations	**Provider Site Reviews and Provider Site Relocations**
Local CHDP program counties will continue to accept provider site relocations AND they will continue to perform provider site reviews June 30, 2024.	The MCP Facility Site Review team will conduct provider site reviews effective July 1, 2024, that will audit criteria consistent with the retired CHDP auditing tools.
Newborn Hearing Screening Program (NHSP)	**Newborn Hearing Screening Program (NHSP)**
The CHDP program currently assists DHCS NHSP's contracted Hearing Coordination Centers (HCC) by following up with the families of babies who have failed hearing screenings and have not kept their appointments for rescreening or diagnostic evaluation or have become unreachable by the provider and HCC.	DHCS is revising the procedures and flow of processes in the HCC Tracking and Monitoring Procedure Manual to have the HCCs notify the baby's primary care physician (PCP) when an initial hearing screen is not passed rather than waiting to notify the PCP by letter when an evaluation appointment is not kept.
Records Retention	**Records Retention**
State and federal law requires local programs and CHDP program providers to retain records of each service rendered under the program for a period of ten years from the date of service or from the date of completion of any audit, whichever is later.	Same ten-year requirement.
Childhood Lead Poisoning Prevention (CLPP) Program	**Childhood Lead Poisoning Prevention (CLPP) Program**
-Participating local CHDP-CLPP programs are to communicate and share all CHDP-CLPP program training materials with their local MCPs and CDPH's CLPP Branch by March 1, 2024. -Medical Record Reviews (MMR) requirements align with the specific CHDP-CLPP chart review requirements to ensure there is no loss in services.	CHDP-CLPP program responsibilities will be transitioned to the MCPs, as they are already responsible for conducting blood lead screenings for MCP enrollees and chart audits as part of regular Facility Site and MRRs, which includes lead screening reviews and provider trainings.
Local County Websites	**Local County Websites**
Local CHDP program counties will repurpose their websites to reflect other resources that are available to beneficiaries post the CHDP program transition.	Websites should direct users to the DHCS CHDP transitions website including the corresponding county HCPCFC webpage .
HCPCFC Public Health Nurse (PHN) Program Administrator	**HCPCFC Public Health Nurse (PHN) Program Administrator**
The Health Care Program for Children in Foster Care (HCPCFC)	The HCPCFC PHN Program Administrator will assume all new and previously CHDP program conducted administrative and supervisory responsibilities pertaining to HCPCFC on or before July 1, 2024.
CHDP Program County Resources	**CHDP Program County Resources**
Alternative resources and further information regarding the transition of specific activities to existing delivery systems will be updated on the CHDP program webpage in the coming months.	The health plan will be updating our website, provider training materials, provider training methods, health plan processes and workflows, to deliver transitioned requirements in ways providers and staff can utilize become familiar with all the changes. Stay tuned for communications both from the health plans and DHCS.

Additional References:
Child Health and Disability Prevention Program Activities in Fiscal Year 2023-2024
Child Health and Disability Prevention Program Transition Website
Child Health and Disability Prevention Program Transition
Welfare & Institutions Code 14124.1
42 CFR 438.3
42 CFR 200.334
CHDP Director/Deputy Director Training Modules

If you have any questions, your FSR team is here to help. Please find contact information below.

"Provider Pearls" are monthly articles written with the intent to help you prepare for the California Department of Health Care Services (DHCS) FSR review processes. If a clinic manager, office manager, nurse manager, or operations person, can take the time to independently self-monitor clinic practices with the aid of SFHP checklists and DHCS standards at least annually, we can all work together to strive toward improved quality standards in office practice operations.

For any questions about the Facility Site Review or Medical Record Review processes or tools, please contact fsr@sfhp.org.

Pharmacy Updates

Quarterly Formulary and Prior Authorization (PA) Criteria Changes

Changes to the SFHP formulary and prior authorization criteria have been approved by the SFHP Pharmacy and Therapeutics (P&T) Committee on January 17, 2024. The summary of formulary and prior authorization criteria changes is available on the SFHP website at (https://www.sfhp.org/about-us/committees/pharmacy-and-therapeutics-committee/). A complete list of approved formulary and prior authorization criteria are available on SFHP website at (https://www.sfhp.org/providers/pharmacy-services/sfhp-formulary/). All changes are effective February 20, 2024. For formulary or criteria information please visit our website or call SFHP pharmacy department at 415-547-7818 ext. 7085, option 3.

1(415) 547-7818 ext. **7084** or Provider.Relations@sfhp.org
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