San Francisco Health Plan℠

Provider Newsletter

July 2026

UPDATES INCLUDE:

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New Mailing Address for Paper Claims and PDRs

San Francisco Health Plan (SFHP) has implemented a new mailing address for paper claims submissions and Provider Dispute Requests (PDRs).

Effective immediately, please send all paper claims and PDRs to:

San Francisco Health Plan
Attn: Claims Department
P.O. Box 1509
San Leandro, CA 94577-1509

*This address is for **paper claims and PDR submissions only**.

Electronic claim submission processes remain unchanged. Providers should update their records to ensure all paper submissions are sent to the correct address and to avoid processing delays.

For questions or additional assistance, please contact your Provider Relations representative or email provider.relations@sfhp.org.

Access SFHP Medical Criteria

San Francisco Health Plan (SFHP) uses established, evidence-based medical criteria to promote consistent and appropriate clinical decision-making in support of high-quality, safe, and effective patient care.

SFHP is committed to ensuring transparency and easy access to the clinical guidelines used to support authorization determinations.

Access SFHP Medical Criteria Online

SFHP's medical necessity criteria are available on our website and can be accessed at: https://www.sfhp.org/providers/authorizations/sfhp-medical-criteria/

This page provides information on the clinical criteria and guidelines used to review authorization requests and determine medical necessity. It also outlines instructions for accessing the Milliman Care Guidelines (MCG).

On this page, you can review:

- Evidence-based medical necessity criteria used for prior authorization decisions
- Nationally recognized clinical guidelines adopted by SFHP

Questions?
If you have questions about SFHP's medical criteria or need assistance accessing the materials, please contact your provider relations representative.

Documentation Gaps in Expanding Care Models in Fraud, Waste, and Abuse (FWA)

This article addresses the increasing documentation expectations in expanding Managed Care programs. It highlights common documentation gaps that pose risks for fraud, waste, and abuse (FWA) and offers best practices for providers to ensure compliance and support payment.

As Managed Care programs grow and services expand, the quality of documentation has become critical. FWA issues in these areas stem from documentation deficiencies rather than the services themselves.

An Emerging FWA Risk Area
With the growth of Managed Care programs and expanded services such as care coordination, case management, virtual services, and community-based care, documentation expectations have also increased. FWA issues identified in these areas are the result of documentation quality rather than the services themselves.

Where Documentation Gaps Commonly Occur

1. Care Coordination

Documentation often lacks:

- Clear description of specific coordination activities performed
- Identification of who was involved (member, provider, external agency)
- Outcomes or next steps resulting from the coordination
- Connection between the activity and the member's care plan or condition

Common risk: Notes state that "care was coordinated" without explaining *what was done* or *why it was necessary*.

2. Case Management

Documentation may be:

- Overly templated or repetitive across multiple dates of service
- Missing individualized assessments or updates
- Not clearly aligned with member goals or changing needs

Common risk: Ongoing case management services billed without evidence of evolving needs, interventions, or progress.

3. Virtual or Community-Based Services

Documentation gaps include:

- Missing service modality (in-person, video, audio)
- Lack of location information (member and provider)
- Missing member consent when required

Common risk: Services billed as compliant without documentation showing they meet plan-specific or Medicaid requirements for virtual or community-based care.

Best Practices for Providers

To reduce risk, providers should:

✅ Use individualized, service-specific documentation

- ✅ Clearly link all services to medical necessity and care plans
- ✅ Document what was done, why it was needed, and the outcome
- ✅ Ensure time-based services include detailed activity descriptions
- ✅ Avoid over-reliance on templates or copy-and-paste notes
- ✅ Use end-of-charge-entry and documentation checklists

Key Takeaway for Providers
If it isn't clearly documented, it may be considered not performed or not payable—regardless of intent.
Strong, individualized documentation is essential to support payment, compliance, and continued participation in Managed Care programs.

If you suspect Fraud, Waste, or Abuse, you can report using the following ways:

- Email: **Program_Integrity@sfhp.org**
- Form: Online Complaint Form

Healthy Workers HMO Drug Formulary Change for Humira and interchangeable biosimilars: Effective July 1, 2026

Effective July 1, 2026, there will be changes to the preferred Humira biosimilars on the Healthy Workers HMO formulary. Humira will be excluded, and the preferred biosimilars will change. Please see below for the changes:

Current Formulary	Preferred interchangeable biosimilars effective 7/1/26
Humira (requires step therapy through preferred biosimilars)	Humira ***EXCLUDED***
Simlandi	**adalimumab-RYVK** *generic for Simlandi* (MedImpact's unbranded product is only available through Specialty by Birdi mail order pharmacy)
adalimumab-adaz	**adalimumab-AATY** *Generic for Yuflyma*

New starts must use the new preferred biosimilars starting on 7/1/26. Prior authorization (PA) is required.

Current utilizers will be authorized to continue their current treatment ("grandfathered") for **90 days only, until 10/1/26**. On and after 10/1/26, members will be switched to a formulary preferred interchangeable biosimilar by Specialty by Birdi mail order pharmacy.

The SFHP formulary is available at https://www.sfhp.org/providers/pharmacy-services/sfhp-formulary/. If you have any questions, please call SFHP Pharmacy Team at **1(415) 547-7818** or **1(800) 288-5555**, Monday through Friday, 8:30am to 5:30pm.

Basaglar® (Insulin Glargine) to Be Removed from the Medi-Cal Rx Contract Drugs List, Effective August 9, 2026

Effective August 9, 2026, Basaglar® (insulin glargine), NDC labeler code 00002, will be removed from the Medi-Cal Rx Contract Drugs List (CDL). Prescribers should consider alternate therapies that are listed on the CDL (such as Lantus® [insulin glargine] or insulin glargine-yfgn), if clinically appropriate. If a change in therapy is not appropriate, beginning August 9, 2026, providers should submit a prior authorization request demonstrating medical justification.

For more information, see the DHCS article.

Facility Site Review Provider Pearls

IHA Excellence: Closing the Loop - Enhancing IHA Referral Outcomes

This month, our Initial Health Appointment (IHA) Excellence series continues with a closer look at why referral lifecycle tracking is both a compliance imperative and a critical quality-of-care issue.

The IHA—a clinical intake visit owned by providers and required within 120 days of enrollment—includes preventive care, behavioral health screening, and the identification of Social Determinants of Health (SDOH). A primary function of the IHA is to foster early intervention by effectively flagging member needs, such as food insecurity or behavioral health risks, and ensure a seamless transition from identification to resolution. DHCS auditors have made it clear that a critical performance metric for managed care plans is the consistent execution of this referral process.

Currently, we often see this process stall at the referral stage. Because the state now mandates a “closed-loop” system that tracks risks through to successful service delivery, a lack of follow-through—or insufficient documentation—creates regulatory risk. More importantly, when the traceability of necessary interventions is lost, we cannot confirm that our most vulnerable members are receiving the care they need, leading auditors to question the adequacy of our response.

There is a clear expectation that every referral is actively managed and monitored through to completion. This article is intended to drive awareness and initiate conversations that align our processes. When we unify workflows, we ensure that every identified risk—regardless of its origin—flows into a single, trackable process. By identifying disconnected workflows, we can assign clear ownership, close service gaps, and ensure members receive timely, coordinated care. Importantly, a closed-loop system also reduces administrative burden for the clinic (e.g., fewer phone calls to check status, less time searching for missing specialist reports).

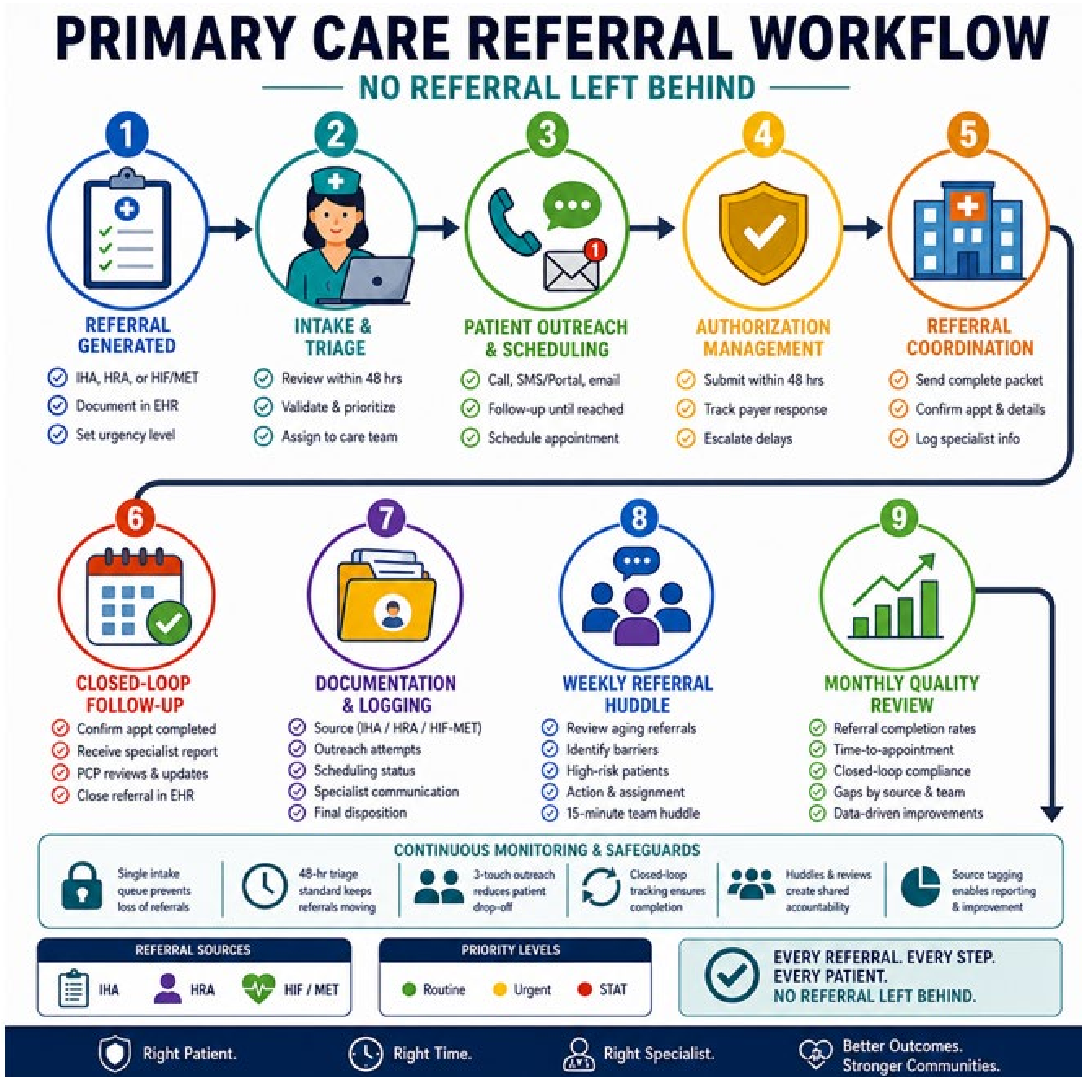
Primary care clinics can leverage the *Integrated Referral Lifecycle & Management Framework*—alongside the provided workflow graphic—as a diagnostic tool. By auditing operations against each of the nine stages, teams can systematically identify fragmentation, resolve bottlenecks, and close critical visibility gaps. By mapping internal procedures—such as intake, authorization, and closed-loop follow-up—to this framework, clinics can verify if they have established a "single source of truth" that ensures patient accountability and generates data for quality improvement. Ultimately, using this model as an evaluation scorecard allows clinic level management to transition from reactive referral management to a proactive, end-to-end system where every referral is transparently monitored, traced, and closed within essential clinical and payer-defined timeframes. [Best Practice Tip: Office leaders print the workflow graphic to use as a team huddle discussion guide.]

The Integrated Referral Lifecycle & Management Framework

Lifecycle Phase	Operational Stage	Key Action
Risk Identification	1. Referral Generated	Identify clinical needs and set urgency.
Referral Trigger	1. Referral Generated	Document request in the EHR.
Referral Placement	2. Intake & Triage	Validate and assign to the care team.
Referral Receipt	2. Intake & Triage	Acknowledge and prioritize the request.
Member Acceptance	3. Patient Outreach	Engage patient to confirm intent/needs.
Service Scheduling	3. Outreach & 4. Auth (if needed)	Book appointment and secure payer approval.
Service Completion	5. Referral Coordination	Confirm appointment and exchange records.
Outcome Documentation	6. Closed-Loop Follow-Up	Receive, review, and finalize in the EHR.
Lifecycle Traceability	7. Documentation & Logging	Record all attempts, communication, and status.
Tactical Oversight	8. Weekly Referral Huddle	Review aging referrals and address barriers.
Strategic Improvement	9. Monthly Quality Review	Analyze performance metrics and outcomes.

As a health plan, SFHP is committed to standardized workflows, system integration support, and accountability for referral outcomes. By working together

to target process remediation, we strengthen member trust, advance health equity, and reinforce our commitment to whole-person care.



Disclaimer: This workflow is a sample for educational purposes only. It is not a mandate and does not replace your organization's clinical policies or contractual obligations. Users are responsible for ensuring their specific processes remain compliant with all applicable state and federal regulations.

"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.*

Contacts:

SFHP Facility Site Review and Medical Record Review. Address questions to: fsr@sfhp.org.
SFHP Care Management for Providers (contacts found on website) link.

Please do not hesitate to contact Provider Relations at
1(415) 547-7818 ext. **7084** or Provider.Relations@sfhp.org
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