



Santa Clara Family
Health Plan™

PROVIDER MANUAL

Cal MediConnect Plan (Medicare-Medicaid Plan)

Provider Network Management: **1-408-874-1788**

Monday through Friday, 8:30 a.m. to 5:00 p.m.

www.scfhp.com

Updated 05/2018

Provider Manual Revision History

Date	Version	Changes
01/14/2016	V2	Section 3, Page 8, Member Enrollment and Eligibility: Updated description of enrollment process for 2016.
01/14/2016	V2	Section 17, Page 48, Provider Complaints: Added phone number for information regarding provider disputes or complaints.
04/03/2017	V3	The Provider Manual was updated for Benefit Year 2017.
05/30/2018	V4	<ul style="list-style-type: none"> Section 2, Page 9, Responsibilities of Departments: Updated departments and placed in alpha order Section 3, Page 12, Member Enrollment & Eligibility: Updated headers, SCFHP eligibility verification process and retroactive member additions & deletions Section 4, Page 14, Access & Appointment Standards – Updated descriptions/content. No change to actual access requirements; Added information regarding transportation benefit Section 5, Page 17, Cultural and Linguistic Services – Content reorganized Section 8, Page 24 Claims & Billing Information – Updated information on submitting claims, approved claim forms, making claim inquiries and submitting corrected claims Section 9, Page 28 Authorizations - Removed list of ancillary services requiring a PA and referred to list on website; Updated timeframes for routine service requests; Added Concurrent Review and Discharge planning information; Added Retrospective Review information; Added Tracing a Prior Authorization Request; Updated Direct Access Services; Clarified that second opinions are required to be from a network provider. Section 11, Page 38, Population Health Management- (Previously this section was Behavioral Health Services) - Updated Model of Care with Population Health Management; Updated Case Management Program; Added Case Management Referrals Section 12, Page 39, Behavioral Health Services (Previously this section was Health Education Program) - Added IHA requirement

		<ul style="list-style-type: none"> • Section 13, Page 41 Health Education Program (Previously Section 13 was Model of Care) - Updated headers • Section 16, Page 54, Provider Roles & Responsibilities - Additional requirements for PCPs; Added information regarding requirements for Initial Health Assessment. • Section 18, Page 60, Member Rights and Responsibilities- Updated to be in compliance with NCQA requirements. • Section 21, Page 79 Quality Improvement Program – Updated committee and department references; Reformatted medical record standards, Updated Preventive Health Guidelines, Updated Health Assessment requirements; Updated references from SBIRT to AMSC • Section 24, Page 98, Credentialing & Recredentialing – Updated provider rights
--	--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

TABLE OF CONTENTS

Provider Manual Revision History	1
Section 1 Introduction.....	5
Section 2 Governing Board and Committees.....	6
Section 3 Member Enrollment and Eligibility	9
Section 4 Access and Appointment Standards.....	12
Section 5 Cultural and Linguistic Services	15
Section 5.1 Language Interpretation Services.....	15
Section 5.2 Translation Services	17
Section 5.3 Language of Proficiency	17
Section 5.4 Cultural and Linguistic Services Training.....	18
Section 5.5 Monitoring.....	18
Section 6 Marketing.....	19
Section 7 Benefit Summary	21
Section 8 Claims and Billing Information	22
Section 9 Authorizations.....	27
Section 10 Emergency, Urgent Care and Trauma Services	36
Section 11 Population Health Management.....	38
Section 12 Behavioral Health Services.....	40
Section 13 Health Education Program.....	42
Section 14 Managed Long-Term Services and Supports (MLTSS).....	45
Section 15 Pharmacy Services.....	51
Section 16 Provider Roles and Responsibilities.....	55
Section 17 Provider Complaints.....	60
Section 18 Member Rights and Responsibilities	61
Section 19 Member Grievances and Appeals.....	63
Section 20 Compliance & Fraud, Waste, and Abuse	71
Section 20.1 Goals and Standards of Conduct	71
Section 20.2 Fraud, Waste, and Abuse	72
Section 20.3 Federal False Claims Act.....	73
Section 20.4 Federal Laws Prohibiting False Claims under Medicare and Medicaid.....	74

Section 20.5 Annual Fraud Waste and Abuse (FWA) and General Compliance Awareness	76
Section 20.6 Health Insurance Portability and Accountability Act (HIPAA)	77
Section 20.7 Audit and Maintenance of Record	81
Section 20.8 Confidentiality	81
Section 21 Quality Improvement (QI) Program	82
Section 22 Provider Preventable Conditions	102
Section 23 Facility Site Review	103
Section 24 Credentialing and Recredentialing.....	104
Section 25 Provider Training, Education, and Resources	110

Section 1 Introduction

Welcome!

Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP) is licensed by the California Department of Managed Health Care (DMHC) as a health care service plan in the State of California pursuant to the Knox-Keene Health Care Service Plan Act of 1975 as amended (California Health & Safety Sections 1340 et seq.; the “Knox-Keene Act”). SCFHP is also approved by the California Department of Health Care Services (DHCS) to operate a prepaid Health Plan and is designated the Local Initiative for Santa Clara county under the Two-Plan Model established by DHCS pursuant to California Welfare and Institutions Code Sections 14087.3 et seq. (the “SCFHP Medi-Cal Plan”). Pursuant to this designation, SCFHP, among other obligations, agrees to arrange for the provision of specified health care services to eligible beneficiaries pursuant to the SCFHP Agreement with DHCS.

In coordination with the Center for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) developed a demonstration program called Cal MediConnect that provides comprehensive health services to individuals eligible for both Medicare and Medi-Cal (Dual Eligibles or Duals). The program aligns financial incentives to drive patient-centered care and rebalance the current health care system away from institutionalization and toward keeping patients at home. Effective January 1, 2015, Santa Clara Family Health Plan Cal MediConnect Plan (Medicare-Medicaid Plan) began serving enrolled dual eligible members.

Our provider network is a critical component in fulfilling SCFHP’s mission. Our goals with this manual are to give you tools to reduce your administrative burden and make sure you have all the necessary contact information for reaching SCFHP staff.

It is important to SCFHP that this manual be a useful guide for providers and their staff. Please direct any questions about this manual to the Provider Network Management Department at 1-408-874-1788.

SCFHP Mission

SCFHP is dedicated to improving the health and well-being of the residents of our area. Our mission is to provide high quality, comprehensive health-care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with select providers, we are a bridge between the health-care system and those who need health coverage.

Section 2 Governing Board and Committees

The SCFHP Governing Board: Santa Clara County Health Authority

The SCFHP Governing Board has duties, powers, and responsibilities authorized under the Welfare and Institutions Code section 14087.38 and Ordinance No. 300.576.

Committees of SCFHP

SCFHP has Governing Board and Oversight committees; at least one member of the Governing Board participates on each oversight committee. At no time can the number of SCFHP committee members be such that the committee is composed of a quorum of SCFHP Governing Board members. All committees are subject to the provisions of the Ralph M. Brown Act. Following is a list and brief description of responsibilities of these committees:

SCFHP Governing Board Committees

- **Executive and Finance Committee:** Responsible for developing, monitoring and reviewing SCFHP fiscal policy and financial performance for the Governing Board. This Committee has the authority to take action on behalf of the Governing Board in the event of a financial, operational, legal, personnel or public relations emergency.
- **Bylaws Committee:** Proposes changes to the SCFHP Bylaws to the Governing Board.
- **Audit Committee:** The Governing Board established a two-member Audit Committee, which is responsible for: hiring, setting compensation, and overseeing the activities of independent financial auditors; approving any non-audit activities of the independent audit firm; reviewing SCFHP's financial statements; approving the annual financial audit; and reporting on SCFHP's financial status to SCFHP's Governing Board.

Advisory and Standing Committees

- **Provider Advisory Committee:** Composed of contracted providers that act as an advisory body to assist SCFHP in achieving the highest quality of care for members of the health plan. The Committee addresses clinical and administrative topics that affect interactions between physicians/providers and SCFHP, discusses regional, state, and national issues related to enhancing patient care, provides input on health care services of SCFHP, provides input on the coordination of services between networks of SCFHP, provides input to improve communications, relations, and cooperation between physicians/providers and SCFHP, and provides expertise to SCFHP relative to their area of practice.
- **Quality Improvement Committee:** Comprised of contracted providers and groups who oversee the SCFHP Quality Improvement Program which uses systematic approach to quality using reliable and valid methods or monitoring, analysis,

evaluation and improvement in the delivery of health care provided to all members, including those with special needs.

- **Credentialing Committee:** Comprised of contracted physicians who oversee the credentialing of all practitioners and providers.
- **Utilization Management Committee:** Consists of health-care professionals who develop criteria for determining medical necessity, delegation, and utilization activities.
- **Pharmaceutical and Therapeutics Committee:** Comprised of contracted pharmacists and physicians who provide oversight of the SCFHP pharmacy program, plan formularies and clinical criteria to promote maximal health outcomes.
- **Consumer Affairs Committee:** Comprised of community and SCFHP members/parents/guardians enrolled in Medi-Cal or Healthy Kids, who provide community involvement and represent the interests of SCFHP members.
- **Consumer Advisory Board:** Comprised of members enrolled in SCFHP Cal MediConnect, and/or their caregivers. CAB members provide feedback on services, benefits, providers, issues and ways to improve the program, and share their experiences, helping us improve our services.

Responsibilities of Departments within SCFHP

SCFHP is organized as described below:

- **Claims:** Responsible for adjudicating all claims and responding to provider requests related to claims.
- **Credentialing:** Responsible for credentialing and re-credentialing SCFHP's contracted providers.
- **Compliance:** Responsible for promoting an ongoing culture that encourages ethical conduct and a commitment to compliance with the law in preventing fraud, waste, and abuse.
- **Cultural & Linguistic Services:** Responsible for providing members, physicians, and other health-care providers with a range of cultural and linguistic services to enhance patient-provider communications, and make possible effective delivery of health care to a diverse membership.
- **Customer Service:** Responsible for assisting and educating members.
- **Executive Office/Administration:** Responsible for the overall administration and strategic direction of the health plan. Finance, legal and government relations activities are included.
- **Grievance and Appeals:** Responsible for managing and helping to resolve member complaints and grievances. Staffs the Grievance Review Committee.

- **Health Education:** Responsible for providing members, physicians, and other health-care providers with quality health education.
- **Health Services:** Responsible for coordination of care, medical necessity, and clinical appropriateness of the health needs of your patients.
- **Information Technology:** Responsible for managing the information system services and implementing data exchanges with contracting providers.
- **Marketing:** Responsible for producing all SCFHP member and promotional materials, public relations, event and outreach planning and management, and other activities designed to attract and retain members.
- **Outreach:** Responsible for assisting families with the application process.
- **Pharmacy:** Responsible for managing and maintaining a formulary, overseeing the pharmacy benefit manager, monitoring medical necessity, and ensuring clinical appropriateness of pharmacy services.
- **Provider Network Management:** Responsible for provider contracting, provider database maintenance conducting initial and on-going training with providers to review plan policies and procedures and to assist with any identified problems or concerns.
- **Quality Improvement:** Responsible for monitoring, evaluating and improving the quality, safety, and outcomes of patient care through the performance of quality studies such as NCQA and HEDIS.

Section 3 Member Enrollment and Eligibility

Program Eligibility Criteria

To be eligible to enroll in Cal MediConnect, individuals must meet all of the following criteria:

- Reside in Santa Clara County
- 21 years of age or older
- Have both Medicare Part A and Part B, and
- Be currently eligible for full-scope Medi-Cal

Member Enrollment

Effective January 1, 2016, enrollment in CMC became voluntary. Eligible beneficiaries may choose to enroll in a Cal MediConnect plan, or remain in regular Medicare and join a Medi-Cal Managed Care Plan for their Medi-Cal benefits, including Long-Term Services and Supports. Alternatively, if eligible for the Program of All-Inclusive Care for the Elderly (PACE), a beneficiary may choose to receive Medicare and Medi-Cal benefits through PACE.

Member Disenrollment

Members may voluntarily disenroll from SCFHP Cal MediConnect at any time by contacting Medicare at **1-800-MEDICARE (1-800-633-4227)** or Health Care Options at **1-844-580-7272**. However, they must remain in a Medi-Cal Managed Care plan in order to receive Medi-Cal benefits.

Verification of Eligibility

Member eligibility and the benefits currently available to a member should always be verified prior to providing care. Even though an SCFHP member may have an SCFHP Cal MediConnect ID card, eligibility can change from month to month. A referral or authorization does not guarantee that a member is eligible at the time of service.

Eligibility Verification

When an individual seeks medical care, you must attempt to determine SCFHP enrollment status and Primary Care Provider (PCP) assignment. It would be prudent to do this at the time the patient presents for his/her appointment, i.e., before providing the service.

While you may use any one of the three methods listed below to verify enrollment, we recommend using one of the first two:

- **SCFHP Provider Portal:** The easiest and most convenient method for checking eligibility is through our portal, **Provider Link**, which can be found using the URL <https://providerportal.scfhp.com>. Provider Link is available 7-days a week, 24-hours a day. Instructions for registering for and using Provider Link are available on our website www.scfhp.com, by clicking on the page titles For Providers, then Provider Resources, the “NEW! Provider Portal Training” in the section of Frequently Used Links. If you need assistance please contact the Provider Network Management Department at 1-408-874-1788 or providerservices@scfhp.com.
- **SCFHP Automated Eligibility Verification:** Using this system, which is also available 7-days a week, 24-hours a day, you may verify eligibility for the current month as well as the past three months. You must have a touch-tone phone and call **1-800-720-3455**. The system can accept up to 10 requests per call.

To use the automated eligibility system, you must enter the following information using the phone keypad:

- Member name
- SCFHP Member ID number
- Member date of birth
- Month of service

The automated eligibility system:

- Confirms eligibility for the month requested
 - Provides the name and phone number of the member’s PCP
 - Provides the phone number of the PCP’s authorization department
 - Gives you a confirmation number
- **Member Identification (ID) Card:** All SCFHP members receive a member ID card that allows physicians and other health-care providers to identify patients as members of SCFHP. The identification card includes:
 - Member name and date of birth
 - Member SCFHP ID number
 - The back of the card contains SCFHP contact numbers as well as information for submitting claims.

A new member ID card will be issued in response to the report of a lost or stolen card.

Note: Possession of an SCFHP ID card does not guarantee eligibility. However, once eligibility is confirmed, the SCFHP ID card can identify the member’s assigned PCP.

Retroactive Member Additions and Deletions

Circumstances may arise in which members are retroactively added or deleted from a PCP's eligibility list. Examples include when a member requests a change in PCP assignment or there is a retroactive change in a member's eligibility status.

Section 4 Access and Appointment Standards

To ensure that members have timely access to medical care, SCFHP follows standards set by DHCS, a summary of which is shown in the chart below.

Timely Access to Non-Emergency Health Care Services		
Appointment Availability & Telephone Triage		
Licensed Health Care Provider	Service	Access Timeframe*
PCP, Specialist	<ul style="list-style-type: none"> Urgent Care Appointment Services not requiring a Prior Authorization Services requiring Prior Authorization 	<ul style="list-style-type: none"> Within 48 hours of request for appointment Within 96 hours of request for appointment
PCP and Non-Physician Mental Health Provider	<ul style="list-style-type: none"> Non-Urgent Appointment for the diagnosis or treatment of injury, illness or other health condition 	<ul style="list-style-type: none"> Within ten (10) business days of request for appointment*
Specialist and Ancillary Services	<ul style="list-style-type: none"> Non-Urgent Appointment for the diagnosis or treatment of injury, illness or other health condition 	<ul style="list-style-type: none"> Within fifteen (15) business days of request for appointment*
All	<ul style="list-style-type: none"> Preventive Care Appointment Periodic follow-up Standing referrals for chronic conditions Pregnancy Cardiac condition Mental Health conditions Lab and radiology monitoring 	<ul style="list-style-type: none"> May be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his/her practice.
PCP, Specialist	<ul style="list-style-type: none"> First Prenatal Visit 	<ul style="list-style-type: none"> Within two (2) weeks of request
All Licensed SCFHP Providers	<ul style="list-style-type: none"> Telephone Triage or Screening Services 	<ul style="list-style-type: none"> Available 24 hours a day, 7 days a week Call returned within 30 minutes

*Appointments may be extended if the referring or treating licensed health care provider or health professional providing triage or screening services, as applicable, acting within the scope of his/her practice and consistent with professionally recognized standards or

practice has determined and documented in the relevant record that a longer waiting time will not have a detrimental impact on the health of SCFHP's enrollee.

Appointment Rescheduling - When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Interpreter Services - Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. Interpreter services are available free of charge for any member who does not speak English or has limited English proficiency. You may offer these services either by telephone or on-site in your office, at your discretion. We offer assistance with both types of service. For more information, please see Section 5.1 Language Interpretation Services.

After Hours Care – DHCS requires plans to assure access to care after hours, on weekends and on holidays. Please be sure that your outgoing message during all non-business hours includes the following:

- Instructions to the caller on how to deal with a life threatening emergency
- Instructions on how to contact a covering provider
- The timeframe they should expect to hear back from a covering provider

After Hours Accessibility		
Telephone Triage		
Licensed Health Care Provider	Service	Access Timeframe*
PCP and Non-Physician Mental Health Provider	<ul style="list-style-type: none"> • What instructions would you give a caller who is dealing with a life threatening emergency? 	<ul style="list-style-type: none"> • Go to the nearest emergency room • Hang up and dial 911 • Hang up and dial 911 or go to the nearest emergency room
	<ul style="list-style-type: none"> • If the patient expresses an urgent need to speak with a clinician, is there a way to put them in touch with the physician or an on-call provider? 	<ul style="list-style-type: none"> • Yes
	<ul style="list-style-type: none"> • In what time frame can the patient expect to hear from the physician or on-call provider? 	<ul style="list-style-type: none"> • 30 minutes or less

In Office Wait Times – Members with scheduled appointments are expected to be seen within thirty (30) minutes of their scheduled appointments for all PCP, Specialist and Non-Physician Behavioral Health Providers.

The Department of Managed Health Care (DMHC) Timely Access Regulations (CCR 1300.67.2.2) became effective in January 2011. SCFHP conducts annual surveys to assess compliance with these standards.

Non-Emergency Medical Transportation and Non-Medical Transportation

We cover Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) when the member has a medical condition that does not allow him/her to travel by any other form of public or private conveyance without endangerment to his/her health. Authorized transportation may include public transportation (bus, light rail, etc.), vans, taxis, or other public or private transportation, ambulance, litter car, wheelchair van medical transportation or air transport services when needed to obtain covered medically necessary services and services that are carved out (e.g. dental services).

Non-Emergency Medical Transportation (NMT):

Prior authorization is required before arranging non-emergency transportation services, except in the cases of a transfer from an acute inpatient hospital to a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or from a SNF/ICF to an acute-care hospital. Physicians are required to complete a Physician Certification Statement (PCS) form to request specific types of transportation requests. SCFHP needs these forms for preapproval before NEMT services can be arranged.

- Completed forms should be faxed to 1-408-874-1957 or 1-408-376-3548.
- Once UM received and processed completed PCS forms, then patients can call SCFHP Customer Service to arrange transportation.
- SCFHP requires a 5-7 day advance notice for all non-urgent requests.

The designation of an appropriate transportation service will take into account the following:

- Member's medical and physical condition
- Urgency of the need for transportation
- Availability of transportation at the time of need

Non-Medical Transportation (NMT):

Non-Medical Transportation (NMT) Services do not require a PCS form. Patients must call SCFHP at least three (3) days prior to their scheduled appointments and provide an attestation that they do not have other transportation resources.

Section 5 Cultural and Linguistic Services

Cultural and linguistic competence is an on-going learning process, with the level of competence having a profound impact on the diverse communities within Santa Clara County. The direct relationship between culture, language, and health is complex and inextricably linked to the health status of individuals and subsequently communities. For this reason, it is essential that SCFHP and providers strive to ensure members receive culturally and linguistically competent health care services.

All health care providers are expected to ensure equal access to health care services for all members with communication disabilities and for all Limited English Proficient (LEP) members. Health care providers include but are not limited to medical, behavioral health, long-term services and supports, and pharmacy network providers.

Additionally, all health care providers shall comply with all of the provisions of linguistic and culturally sensitive services in accordance with SCFHP's policies. All health care providers shall address the special health care needs of all members, and shall ensure equal access and participation in federally funded programs to members with LEP or hearing, speech or vision impairment through the provision of bilingual or adaptive services. All providers are expected to:

- Honor the member's beliefs, traditions and customs;
- Recognize individual differences within a culture;
- Create an open, supportive, and responsive organization in which differences are valued, respected, and managed through:
- Completing cultural diversity training;
- Fostering attitudes and interpersonal communication styles which respect members' cultural backgrounds and are sensitive to their special needs; and
- Referring members to linguistically and culturally sensitive programs.

Section 5.1 Language Interpretation Services

Guide to Using Interpretation Services

SCFHP provides foreign language and American Sign Language interpreters to Cal MediConnect members at all points of contact for any covered service—at no cost to members or providers.

Telephonic Language Interpreters

Interpretation services are available for more than **170 languages**, and are available **24 hours a day, 7 days a week**. To access interpreting services:

1. Call Language Line Interpreter Services directly at **1-888-898-1364**
2. Press 1 for Spanish, Press 2 for all other languages and speak the name of the language.
3. Press 0 if you do not know the language you need.

4. An agent will come on the line. Provide the agent with:
 - Access code: Network providers use operator access code 8033.
 - Your first name
 - Your department and/or the office's name
 - The Member's SCFHP ID number

California Relay Service is available in English and Spanish for members with difficulty hearing.

- **TTY:**
English: 1-800-735-2929, or dial 711
Spanish: 1-800-855-3000
- **Voice:**
English: 1-800-735-2922
Spanish: 1-800-855-3000

Tips to Work with California Relay

California Relay Services is a telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled. Specially trained Communication Assistants (CAs) complete all calls and stay on-line to relay messages electronically over a text telephone (TT), called TTY for "teletype," or to relay messages verbally to hearing parties.

How to make a traditional VOICE relay call using Standard Telephone:

1. Call California Relay Services directly at 1-800-735-2929 (English) or 1-800-855-3000 (Spanish).
2. Give the CA the area code and telephone number you wish to call and any further instructions.
3. Talk to the CA as though you are speaking directly to the person you called (avoid saying "Tell him" or "Tell her").
4. Say "Go ahead," each time you have finished speaking.
5. Continue steps 3 and 4 throughout your call.
6. When you are done, say "GA to SK" (go ahead to stop keying), then hang up.

How to receive a traditional relay call:

1. Your phone rings and you answer it. A CA says, "Hello, this is California Relay Services, Communication Assistant # XXX with a relay call for this number."
2. You (or the staff member who answered the call) say "Go ahead."
3. The CA types your message to the TTY user and reads the reply to you.
4. Say "Go ahead," each time you have finished speaking.

5. Continue steps 3 and 4 throughout your call. When you are done, say “GA to SK” (go ahead to stop keying), then hang up.

How to make a traditional relay call using the TTY:

1. Dial California Relay Services directly at **1-800-735-2929** (English) or **1-800-855-3000** (Spanish)
2. Type the area code and telephone number you are calling.
3. The CA places your call and informs you of the call status: “ringing” or “busy.”
4. If the phone is answered, the CA relays the greeting s/he hears and then types “GA” for you to “Go ahead.”
5. The CA speaks what you have typed to the person you have called.

Continue with this process through the call. When you are ready to end your call, type “SK” for “stop keying” then hang up.

In-Person Language Interpreters

In-person interpreter services are available for more than 100 languages. If possible, please schedule an in-person interpreter at least 5 business days in advance. You need the following information when scheduling in-person interpreter services:

- Member’s name and date of birth
- Provider’s name and address
- Language needed
- Appointment date, time, and location
- Type of assignment (doctor’s check-up, surgery, consultation, etc.)
- Onsite contact (representative’s name, department, phone number, etc.)
- Preference, if any, for male or female interpreter

Call SCFHP Customer Service at **1-877-723-4795**, 8:30 am – 5:00 pm, Monday through Friday. Interpreters can be scheduled for any day/any time, but all in-person appointments, including in-person American Sign Language (ASL), must be set up during regular Customer Service business hours.

Section 5.2 Translation Services

SCFHP provides Limited English Proficient (LEP) members with written member informing materials in the member’s identified primary threshold language. The threshold languages for Cal MediConnect are English, Spanish, Vietnamese, Chinese and Tagalog. SCFHP provides translated member informing materials in Braille, Audio CD or Large Print on a standing basis, or ad hoc basis upon request.

Section 5.3 Language of Proficiency

Clinical and non-clinical bilingual staff members who interact with LEP members are required to be assessed using the Self-Assessment Language Capabilities tool.

Providers and office staff who rate themselves with speaking, reading, or writing capabilities below level 3 as defined on the Self-Assessment Language Capabilities should not use their bilingual skills or serve as interpreters and/or translators.

Qualified interpreting services are available through SCFHP. This includes telephonic and face-to-face interpreting services, including American Sign Language. Please refer to Section 5.1 Language Interpretation Services.

Section 5.4 Cultural and Linguistic Services Training

SCFHP offers cultural competency resources and trainings on a variety of topics to providers and office staff. Training methods include, but are not limited to, cultural competency training tool kit posted on the SCFHP website, provider orientation, in-services, meetings, quarterly visits, provider newsletters, faxes, mailing and special trainings. Trainings topics include:

- Knowledge of SCFHP's policies and procedures for cultural and linguistic services
- Communicating across language barriers
- Communicating with seniors and people with disabilities
- Increasing awareness of cultural diversity
- Maintaining language proficiency and qualifications of bilingual staff
- Ensuring 24-hour access to interpreting services at all points of contact, including after-hours services
- Documenting request/refusal of interpreting services in the medical record
- Filing a grievance if a patient's language needs are not met

A complete cultural competency training tool can be viewed or downloaded from SCFHP's website at www.scfhp.com/for-providers.

Section 5.5 Monitoring

Providers are required to develop and distribute policies and procedures that address all cultural and linguistic requirements listed in this provider manual. Providers are also responsible for provider and staff cultural and linguistic education and oversight to ensure full compliance with state and federal laws.

Section 6 Marketing

Compliance with Laws and Regulations

Marketing of Cal MediConnect plans is regulated by CMS and by DHCS. Providers must adhere to all applicable laws, regulations, CMS guidelines and DHCS guidelines regarding Cal MediConnect plan marketing, as specified under sections 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; the Medicare Marketing Guidelines (MMG) (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual); and the California supplement to the MMG – Marketing Guidance for California Medicare-Medicaid Plans. Examples of allowable and prohibited SCFHP/Provider marketing activities are listed below, however we suggest contacting SCFHP prior to any potential marketing initiatives to confirm which activities (or level of provider participation) may be considered marketing, and to ensure an understanding of compliance expectations.

Displaying Plan Marketing Materials

Under Cal MediConnect program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to enroll in a Cal MediConnect plan unless the materials meet the CMS and DHCS marketing guidelines and are first submitted to CMS and DHCS for review and approval.

CMS holds plan sponsors such as SCFHP responsible for any comparative/descriptive materials developed and distributed on behalf of the plan sponsor by their contracting providers. Providers can have CMS/DHCS approved SCFHP Cal MediConnect plan marketing materials in their office as long as the provider ensures all other participating health plans wishing to display appropriate materials are given the opportunity to do so. Plan marketing materials must be placed in compliant areas only, which include commons areas where patients are not receiving care or consultation, or waiting to receive care.

Plan-Related Marketing Activities

SCFHP requires its providers to understand their obligation to remain neutral when approached by beneficiaries with questions regarding SCFHP health plans, should a beneficiary seek advice. Providers must refrain from enrollment advisement and may not steer beneficiaries towards a particular plan.

Providers may assist beneficiaries in an objective assessment of his/her needs, and potential options to meet those needs. Providers are also permitted to assist beneficiaries with activities such as applying for Low-Income Subsidy (LIS) and may refer patients to informational resources such as the local Social Security Office or Medicare.

Long-term care facilities and chronic and psychiatric care hospitals are permitted to offer explanatory brochures about contracted Cal MediConnect plans to residents once the individual is stabilized. This proactive communication is permitted only for these types of providers/facilities.

In the event of a collaborative marketing activity between a representative of SCFHP and a provider, a provider may offer educational materials or answer questions from a health perspective, including describing plan types and Original Medicare, but may not directly market the SCFHP plan. Promotional items given on the part of the provider must be approved in advance by the SCFHP to ensure a clear separation exists between the provider and SCFHP regarding the provision of nominal gifts.

Some examples of prohibited marketing activities on the part of a provider include: accepting enrollment forms for an agent or for a specific plan, participating in the collection of leads information to support enrollment activities, making calls on behalf of an agent or a specific plan to steer toward that plan, making appointments for a sales consultation, or creating/sending unauthorized marketing materials to promote an agent or a specific plan. Please contact SCFHP regarding any potential marketing initiatives for consultation and approval.

Should SCFHP become aware of providers engaging in non-compliant sales or marketing activities of SCFHP plans, SCFHP will contact the provider for an inquiry and to research the situation. Remedial education or potential disciplinary actions may result based upon the issue at hand, outcome and impact to beneficiaries.

Section 7 Benefit Summary

SCFHP Cal MediConnect provides coordinated medical services to full dual eligible members through an established provider network. Member benefits, as described in the Member Handbook, include comprehensive Medicare and Medi-Cal covered medical, behavioral health and vision services, in addition to Long-Term Services and Supports (LTSS).

Providers look only to SCFHP for compensation of covered medical services rendered to an eligible Cal MediConnect member. Providers may not seek reimbursement from the member for a balance due, other than approved co-insurance or co-payment amounts as part of the member's Cal MediConnect benefit package. Providers may not bill Cal MediConnect members for covered services, open bills, or balances in any circumstance, including when SCFHP has denied payment.

To obtain a copy of the Member Handbook, please call Provider Network Management Department at **1-408-874-1788** or visit the SCFHP website, **www.scfhp.com**.

Section 8 Claims and Billing Information

The primary responsibility of our Claims Department is to adjudicate medical claims submitted by physicians, hospitals and other health care providers.

Claims Submission Electronic Data Interchange (EDI)

SCFHP requires that all contracted providers bill their claims electronically. SCFHP's EDI format conforms to the specifications of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires that SCFHP adopt standards for specific financial health care transactions. The HIPAA-mandated national standard format for transactions is the ANSO ASC X12N.

SCFHP accepts the following claims-related transactions formats:

- ASC X12N 837 (005010X222) Professional
- ASC X12N 837 (005010x223) Institutional

No other electronic formats are valid for the billing of professional or institutional claims to SCFHP.

SCFHP contracts with Change Healthcare and Office Ally for clearinghouse services. When submitting claims through Change HealthCare, Office Ally, or your own clearinghouse, please use SCFHP Payer ID number 24077. The daily cut-off time for same day claims submission is 5:00 p.m. Pacific time. If you require clearinghouse submission assistance, please contact:

- Change HealthCare Customer Service at: **1-866-742-4355**, or
- Office Ally at: **1-866-575-4120 Option 1**

Approved Claim Forms

In the event you are unable to submit claims in an electronic format, the following forms are approved for submitting claims:

- CMS 1500 - Valid for professional and ancillary services.
- UB-04 - Valid for both inpatient and outpatient hospital care and clinics.
- PM 160 - Valid for use only by Child Health & Disability Program (CHDP)-certified providers and only for Medi-Cal members.

All claim forms must be signed and dated.

Mailing Addresses for Submission of Claims:

Santa Clara Family Health Plan
P.O. Box 18640
San Jose, CA 95158

Billing Time Limits

Contracted providers must have their claims received by SCFHP within one year of the date of service. A claim received after one year is subject to denial. Claims are generally paid or denied within the timeframes established in your contract.

Coordination of Benefits

Cal MediConnect is a hybrid line of business that is comprised of benefits from both the federal Medicare program and the state Medi-Cal program. Claims submitted by the provider are first adjudicated by SCFHP against the Medicare benefit as the primary benefit. Subsequently, the plan's claims processing system coordinates benefits against the Medi-Cal benefit. Providers are not required to submit a second claim to SCFHP in order to coordinate the Medicare payment with Medi-Cal. This is done automatically by SCFHP.

Claims for services where there is no Medicare benefit, e.g. hearing aids, bypass the Medicare claims adjudication process and are processed as a Medi-Cal claim under the Medi-Cal benefit package.

In some instances, benefits received under the Cal MediConnect line of business are secondary. Another insurance may be primary when the member has:

- Group health insurance
- COBRA
- Liability insurance when services are related to an accident
- Workers' compensation services related to a workers' compensation injury
- VA authorized services
- Tricare
- FBLBP (Black Lung Program)

Member Financial Responsibility

A member shall never be held liable for any sums owed to a provider, nor shall the provider bill, charge, collect a deposit or other sum, or seek reimbursement from an SCFHP member for covered services. However, members may be held financially liable for any non-covered and/or excluded services. Cal MediConnect members do not have co-payments, coinsurance, or deductibles for any covered benefits.

Claims Inquiries

Providers may check on the status of a claim in a variety of ways.

- **SCFHP Provider Portal** – The best way to access information regarding claims status is through our provider portal, **Provider Link** using the URL

<https://providerportal.scfhp.com>. Instructions for registering and using the portal are available on the SCFHP website at www.scfhp.com. Click on Provider Resources, then download the NEW! Provider Portal Training in the section titled Frequently Used Links.

- **Call Customer Service** - Our Customer Service department is able to assist with telephone inquiries from providers about the status of their claims. Additional information about how to submit corrected claims and to file a dispute can also be found on our website at www.scfhp.com/claims.

Providers may contact SCFHP Customer Service Monday through Friday from 8:30 a.m. to 5:00 p.m. at **1-408-874-1788**. Providers also may call after hours and leave a message. An SCFHP representative will return after-hours calls the next business day. You may fax inquiries to **1-408-874-1925**.

- **X12N 276/277 Health Claim Status Inquiry & Response** - SCFHP contracts with Change HealthCare to perform this functionality. Please contact Change HealthCare if you are interested in implementing the 276/277 Health Claim Status Inquiry & Response file.

Corrected Claims

A corrected claim is where you identified missing information or misinformation on your original claim that resulted in a payment different than the one you expected. If you are submitting a “corrected claim,” it must be submitted within the timeframes outlined in your contract. Corrected claims may be sent to SCFHP through a clearinghouse for claims processing. Be sure to indicate it is a corrected claim and reference the claim number it is correcting. Submitting a corrected claim as a dispute or an appeal will not expedite the claims processing.

Corrected claims may also be submitted by mail or fax:

Attn: Claims Department—Corrected Claims
Santa Clara Family Health Plan
PO Box 18640
San Jose, CA 95158

Or

Fax to: **1-408-874-1925**

Attn: Claims Department—Corrected Claims

Claims Review (Claims Disputes)

In accordance with Medicare managed care regulations, contracted providers DO NOT have Medicare appeal rights for payment disputes. However, SCFHP has a review process in place to address any contracted provider claims issues. Requests for claims review by contracted providers, where the provider is dissatisfied with the outcome of

their claim, must be received by SCFHP within 120 days from the date of the remittance advice.

Please submit your request for review with a clear explanation of the basis upon which you believe the amount of payment and or denial is incorrect. Attach all applicable supporting documentation.

All requests for claims reviews should be submitted to:

Attn: Appeals—Claims Director
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
Or
Fax to: **1-408-874-1925**
Attn: Appeals—Claims Director

Claims reviews are responded to within 60 working days from the day of receipt of the dispute.

Pharmacy Claims

All claims from participating pharmacies for members participating in Cal MediConnect should be processed by SCFHP's Pharmacy Benefits Management (PBM). To inquire about the status of a pharmacy claim, the provider may call our PBM, MedImpact, at **1-800-788-2949**.

Misdirected Vision and Pharmacy Claims

All claims for optometry services, including eye appliances, should be submitted to Vision Service Plan (VSP). If these claims are inadvertently misdirected to SCFHP, SCFHP electronically forwards them to VSP through the use of an outbound 837P file.

All pharmacy claims, including Medicare Part D prescription claims and some Part B drugs, must be submitted electronically to our PBM, MedImpact. Pharmacy claims misdirected to SCFHP are redirected to MedImpact for processing.

Balance Billing

As a contracted provider with SCFHP, you must not bill an SCFHP member. You are generally prohibited by the terms of your contract and by state and federal law from billing SCFHP members for any costs related to services you provide.

You Must Not Balance Bill A Member:

- For the difference between the charge amount and the SCFHP fee schedule.
- When a claim has been denied for late submission, unauthorized service, or as not medically necessary.

- When claims are pending review by SCFHP.
- A no show fee.
- A fee for transfer/copying medical records.

Should you have any questions regarding billing SCFHP members, please contact SCFHP Provider Network Management at **1-408-874-1788**.

Section 9 Authorizations

Affirmative Statement about Financial Incentives

Santa Clara Family Health Plan affirms that:

- Utilization Management (UM) decision-making is based only on appropriateness of care and services and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
- Incentives, including compensation, for any person are not based on the quantity or type of denial decisions rendered.

For questions regarding this statement please call the Utilization Management Department at **408-874-1821**.

SCFHP Review and Decision Process

Individual authorization requests are reviewed by SCFHP's Utilization Management (UM) Department according to predetermined criteria, protocols, and the medical information from the physician or other provider. In some cases, the UM Department may need to contact the provider directly to request additional information, or the SCFHP CMO/Medical Director may need to speak directly with the provider to discuss the request.

We use the following standard guidelines for evaluating authorization requests and determining medical necessity and effectiveness of care:

- Milliman Care Guidelines
- American College of Obstetricians and Gynecologists (ACOG) Guidelines
- US Preventive Services Task Force (USPSTF): Guide to Clinical Preventive Services
- Manual of Criteria of Medi-Cal Authorizations
- Published guidelines of other national specialty boards
- Results of clinical studies contained in the National Library of Medicine (NLM) database (MedLine)
- Recommendations from actively participating board-certified specialists
- Clinical judgment
- Agency for Healthcare Research and Quality (AHRQ)

- National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS)
- American Academy of Family Physicians (AAFP)
- Centers for Disease Control and Prevention (CDC)

Since nationally developed guidelines are often designed to be appropriate for the uncomplicated patient, the following factors also may be considered when applying criteria to an individual patient's situation:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Member's desires
- Other relevant factors, per the physician's discretion

Providers may request criteria by calling the UM Department: **1-408-874-1821**.

Developing New Guidelines or Protocols

The UM Department maintains a list of expert specialists in the community who have agreed to assist with reviewing cases for which adequate criteria or protocols are not available. When these situations occur, the UM Department consults with a physician in the network who is considered an expert in his/her field.

The CMO/Medical Director also initiates the development of new service criteria for adoption by SCFHP.

Medical Services & Procedures Requiring Prior Authorization

Medical services that require prior authorization from SCFHP, including ancillary services, are identified in the **Cal MediConnect Medical Prior Authorization Grid** on our website, **www.scfhp.com**.

Prescribing physicians may request authorization by completing the **Prior Authorization Request (PAR) form**, attaching clinical documentation to support the request, and submitting it:

- By fax to 1-408-874-1957
- By mail:

Attn: UM Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

When a member requests a specific service, treatment, or referral to a specialist, it is the PCP's responsibility to determine medical necessity.

If the service requested is not medically indicated, discuss an alternative treatment plan with the member or his/her representative.

Contact SCFHP's UM Department at **1-408-874-1821** with questions.

Routine Pre-Service Requests

For non-urgent pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the member, SCFHP usually makes a determination within 5 days of receipt of the request and appropriate documentation of medical necessity. In exceptional circumstances, a decision may be deferred for an additional 14 days when the member or provider requests an extension.

Expedited Pre-Service Requests

In medically urgent situations, you may request an expedited PAR review by contacting our UM Department at **1-408-874-1821**, or by faxing the request to **1-408-874-1957**.

The request is reviewed and a final determination made in a timely fashion appropriate for the nature of the member's condition not to exceed 72 hours after the plan's receipt of the information. Information includes all information reasonably necessary and/or requested by the plan to make the determination. A verbal notification is communicated to the provider within 24 hours of the decision, followed by a written notification to member and provider mailed or faxed within 2 business days of the decision.

If the faxed PAR is not urgent, it is processed within 5 business days.

Emergency Care

For emergency inpatient admissions or emergency services, the hospital should contact SCFHP for verification of the member's eligibility. To check eligibility please follow the process outlined in Section 3 Member Enrollment and Eligibility of this manual.

Emergency/urgent services and emergency hospital admissions **do not** require prior authorization.

Contracting facilities are **obligated to notify** SCFHP of all inpatient admissions within one (1) business day following the admission to obtain authorization, and confirm the length of stay and level of care needed by the patient.

SCFHP conducts concurrent and retrospective medical case reviews.

Out-of-Network/Area Authorizations

In the event of an urgent/emergent medical situation outside of the SCFHP service area, it is the responsibility of the facility to contact SCFHP to confirm eligibility and service authorization.

Out-of-area medical services and admissions are concurrently reviewed by telephone, or are reviewed on a retrospective basis by review of the medical record as provided by the facility within 30 days of discharge. Arrangements for transfer back to the SCFHP network are initiated as soon as the member is stable for transfer.

Hospital Inpatient Services

Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery or surgical procedures require prior authorization. All requests must be accompanied by the appropriate medical documentation including, but not limited to:

- Laboratory test results
- X-rays
- Medical records
- Other reports that have relevance to the planned admission (e.g., pre-operative history and physical)

An admission that is pre-planned, with a date of expected admission, is valid for only 30 days after the expected date of admission, with the exception of obstetric deliveries.

Emergency and urgent admissions do not require prior authorization. SCFHP should be notified by the facility of emergency admissions within one business day.

Concurrent Review and Discharge Planning

Concurrent review is an assessment of medical necessity and appropriateness of health services being rendered for a patient's ongoing care.

Discharge planning is the coordination of a patient's anticipated continuing care needs after his/her discharge from a hospital or other institution. Initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Documented assessment, upon admission, of the patient's needs, which should include written notation of functional status as well as anticipated discharge disposition.
- Development of a written discharge plan, including evaluation of financial, psychosocial and potential post-hospital service needs, e.g., home health care, DME, and/or placement in a SNF or custodial-care facility.
- Timely referral to SCFHP's Case Management and Disease Management Programs as indicated.

Failure to provide required information may result in a denial of services.

Retrospective Review

Retrospective review is the review of medical treatments, documentation, and billing after the service has been provided. In performing these reviews, our UM Department evaluates the following:

- Eligibility verification.
- Determination of medical necessity.
- Appropriateness of admission.
- Length of stay.
- Level of care.
- Initiation of appropriate follow up for issues related to utilization, quality, and risk.
- Appropriateness of billing.
- Identification and resolution of claims-related issues as they involve medical necessity and SCFHP's claims payment criteria and guidelines.

Retrospective Review of Emergency Services

SCFHP conducts retrospective review of emergency department claims, criteria for which include:

- Coverage of emergency services to screen and stabilize the member without prior approval, in a situation where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
- Coverage of emergency services if an authorized representative, acting for the Medical Group/IPA, had authorized the provision of emergency service.
- Appropriate physician review of presenting symptoms.
- The patient's discharge diagnosis.

For additional information about emergency services, see Section 10 Emergency, Urgent Care and Trauma Services.

Tracking a Prior Authorization Request

SCFHP tracks all prior authorizations through completion of the "authorization to claims paid" cycle, to identify opportunities for improvement. By definition all authorizations is defined as:

- Contracted and non-contracted Prior Authorizations, and
- Behavioral health and non-behavioral health Prior Authorizations

SCFHP has a referral tracking system which tracks approved, modified and deferred medical and behavioral health prior authorizations to completion on an ongoing basis. All authorization requests are reviewed to claims paid on a monthly basis to ensure that:

- The patient received / or did not receive the service authorized (paid claim matches prior authorization)
- The patient received the service in a timely fashion (paid claim date of service is reviewed against the prior authorization date request)

On an annual basis, SCFHP UM staff complete outbound calls to a sample of members who do not yet have a paid claim against a prior authorized service to assess the reason for this gap. A quarterly analysis of authorization timeliness and completion is provided to the Utilization Management Committee for review and recommendations.

Interventions may include contact of a member or provider by the Plan's Case Manager or other Health Services staff telephonically, electronically or via mail for follow-up.

Reasons for incomplete authorizations or delay in the receipt of care for identified authorizations are monitored and where appropriate, identified opportunities to reduce member risk are acted upon. Possible reasons for incomplete "authorizations to claims paid" cycles may include:

- Member barriers
 - Transportation
 - Appointment availability
 - Miscommunication/misunderstanding
 - Educational need
 - Member refusal of treatment
- Administrative cause
 - Claim submission
 - Authorization notification

The UM Department refers members to Case Management when member barriers are identified. Interventions may include but are not limited to:

- Follow up with members
- Follow up with practitioners or providers
- Letter of education from practitioners or providers
- Request for information from practitioners or providers
- Referral to Case Management or Disease Management program

Providers are encouraged to contact SCFHP UM for any questions. Additionally, providers can monitor the status of a Prior Authorization Request by calling SCFHP's

Utilization Management Department at 408-874-1821. Providers may also send an email to the UM Help Desk at UMHELPDESK@scfhp.com.

Direct Access Services: No Authorization Required

Women's Health Services

A female member may choose an OB/GYN as her PCP for all medical services as long as that OB/GYN is contracted with SCFHP as a PCP. If the member's PCP is not an OB/GYN, the member may self-refer directly to a participating OB/GYN, or directly to a participating family practice physician who has been designated as an OB/GYN service provider, as long as the provider is within the same network as the PCP.

The following services may be provided:

- Annual OB/GYN examination, including Pap smear.
- Diagnosis and treatment of an acute gynecologic problem, including appropriate follow-up care.
- Prenatal care, delivery and post-partum care.
- Family planning services and/or abortion services.

Annual Screening Mammography

SCFHP members may self-refer for an annual screening mammography. Members may access a list of contracted mammography facilities on the SCFHP website, www.scfhp.com.

Flu Vaccine

SCFHP members have direct access to an in-network physician for an annual flu vaccine. Please inform your members about the availability of flu vaccines through your office.

SCFHP members may also receive their flu vaccine through most major pharmacy chains.

Colorectal Cancer Screening

SCFHP members have direct access to in-network physicians for colorectal cancer screening provided within the guidelines established by the US Preventive Services Task Force (USPSTF). This includes access to the following services for adults age 50-75:

- Annual screening with high-sensitivity fecal occult testing
- Or
- Sigmoidoscopy every 5 years with high sensitive fecal occult blood testing every 3 years
- Or
- Screening colonoscopy every 10 years.

If requested by a member, you are required to provide members with a list of contracted providers who provide this service. Contracted providers may be found on our website at www.scfhp.com.

Obtaining a Second Opinion

Members may receive a second opinion about a recommended procedure or service from a network provider without a prior authorization.

Second opinions may be rendered *only* by a physician qualified to review and treat the medical condition in question. An authorization is required before a member may see a non-contracted medical provider, and may be approved only when the requested services are not available within the SCFHP provider network.

If the provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and covered by SCFHP, the PCP must provide or arrange for the service.

Continuity of Care from a Terminating Physician or a Non-Contracted Provider

To ensure that medically necessary, in-progress, covered medical services are not interrupted due to the termination of a provider's contract, we assure continuity of care for our members, as well as for those newly enrolled individuals who have been receiving covered services from a non-contracting provider.

When a provider's contract is terminated or discontinued for reasons other than a medical disciplinary cause, fraud, or other unethical activity, a member may be able to receive continued care with him/her after the contract ends, as detailed in SCFHP's continuity of care policies located on the website, www.scfhp.com.

Continued care for a *newly enrolled member* for Medi-Cal covered services may not exceed twelve (12) months and for Medicare covered services may not exceed six (6) months from the initial effective date of coverage. For *current members*, the following guidelines apply:

- The provider must continue to treat the member and must accept the payment and/or other terms. Continued care with a terminated provider may be provided for up to 12 months for a serious chronic condition.
- For an acute or terminal condition, the services shall be covered for the duration of the illness.
- If a member is in the second or third trimester of pregnancy, treatment may extend through the post-partum period; coverage for care of the newborn child may extend through 36 months.

SCFHP sends a written notice to members at least 30 calendar days before the effective contract termination date and offers assistance in selecting a new provider.

Members should request continuity of care through SCFHP Customer Service by calling **1-877-723-4795**, or for the hearing and speech impaired TTY **1-800-735-2929**.

Section 10 Emergency, Urgent Care and Trauma Services

Emergency Services

Emergency services are covered services required by a member as the result of a medical condition that manifests as the onset of symptoms (including pain) so severe that a prudent layperson would expect the absence of immediate medical attention to:

- Place the health of the member in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.
- Induce an “active labor” in a pregnant woman requiring emergency delivery to avoid threat to the health and safety of either mother or child.

For emergency inpatient admissions or emergency services, the hospital should contact SCFHP for verification of the member’s eligibility. Emergency services do not require prior authorization.

The hospital must, however, contact SCFHP’s UM Department within 24 hours (or the next business day) of a member’s admission through the emergency room. Our UM Department then communicates with the admitting hospital and follows the member’s care until the member is discharged or sufficiently stabilized for transfer to a network hospital.

If the hospital does not receive authorization from SCFHP’s UM Department, emergent and/or urgent services necessitating admission are assumed to be authorized and shall be documented as such. However, once SCFHP becomes involved in the case, all subsequent services must be authorized in advance.

Post Stabilization Care

When the treating physician believes additional health care services are needed before a member can be safely discharged or transferred after stabilization of an emergency condition, the treating physician should contact our UM Department as soon as possible to request prior authorization. We will respond within 30 minutes of receiving the request for a pre-approval for post-stabilization/maintenance medical care; if no response is received, the physician may deem the request to be pre-approved/authorized.

SCFHP will cover all medically necessary, approved health care services to maintain the member’s stabilized condition until the member is discharged or transferred.

Urgent Care Services

Urgently needed services are covered services provided when the member is temporarily absent from a service area or when, as a result of an unforeseen illness or

injury, medical services are required without delay and the services could not be obtained reasonably through a normal appointment with a contracted provider.

Trauma Services

Trauma services are medically necessary covered services that are rendered at a state-licensed, designated trauma hospital—or a hospital specifically designated to receive trauma cases. Trauma services must meet identified county or state trauma criteria.

The provider will review and authorize such services; however, SCFHP may review related claims and medical records retrospectively to verify that trauma services were indeed delivered and that the services met trauma criteria.

The following provision criteria should be considered when authorizing trauma services:

- Trauma team activation.
- The trauma surgeon is the primary treating physician.
- The member's clinical status meets current Emergency Medical Services (EMS) protocols for identifying a trauma patient.

Once the treating physician has indicated that the patient is hemodynamically stable, or ready to be transferred out of the critical care area, trauma service status no longer applies.

Unless there is documented evidence of medical necessity indicating that trauma-level services must be continued, trauma services apply to only the first 48 hours after admission to hospital. Clinical management by members of the trauma team shall be the sole criteria used to determine and authorize continued trauma services care.

Section 11 Population Health Management

Santa Clara Family Health has a comprehensive Case Management program that is intended to promote access to appropriate, coordinated services that that members with case management needs may achieve optimal health and functionality. The Case Management team is comprised of Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs) and administrative Personal Care Coordinators (PCCs) who together, with the member and their PCP, focus on the coordination of psycho-social, medical, pharmacy and behavioral health services to assist members in navigating the health care system and ultimately improve their health outcomes. Member participation in the Case Management program is a voluntary. The program is available to the member for as long as the member chooses to participate.

Case Management

The SCFHP Case Management program is a multi-disciplinary service comprised of PCPs, medical specialists, nurses, social workers, care coordinators, and our community partners that provide the following services:

- Person-centered care
- Interdisciplinary Care Team meetings
- Health assessments
- Personal care planning that is member driven and collaborative
- Care coordination
- Connection to community and social support resources
- Telephonic and in-person member engagement
- Providing support across the health care continuum and during care transitions

Member participation in the Case Management Program is voluntary. The program is available to the member for as long as the member is requesting it.

Case Management Referrals

Referrals to SCFHP's case management team are accepted from members or their caregivers, practitioners or other external providers, hospital discharge planners, SCFHP internal staff (including customer service and utilization management) and/or community partners. All referrals will initially be assessed by case management staff to determine the appropriate level of case management support needed to coordinate care and services for medical, behavioral health and other non-medical risk factors.

A case management referral form is available on SCFHP's public website and all completed forms and supporting documentation may be submitted directly to the Case Management department by USPS mail delivery or by secure email to:

CaseManagementHelpDesk@scfhp.com. Case management referrals may be

requested verbally thru telephonic interaction by calling SCFHP's Customer Service department at 1-877-723-4795 and requesting case management support.

All case management referrals will receive an initial review within 72 hours of receipt.

Section 12 Behavioral Health Services

Behavioral Health

As part of the Initial Health Assessment of new Cal MediConnect members, the PCP should assess the member's behavioral health status.

During all patient encounters and throughout the course of a member's care, please watch for any signs of behavioral health issues or behavioral crisis such as severe depression, psychosis, substance use, etc. Refer any behavioral health care needs identified through this process to an appropriate behavioral health provider to ensure that the patient receives timely access to appropriate levels of medical care for behavioral illness, substance abuse, and the management of psychiatric medications.

How to Access Behavioral Health Services

SCFHP has partnered with community providers and Santa Clara County Mental Health Department to provide behavior health services to Cal MediConnect members.

For an emergency or crisis, both providers and members can call the Valley Medical Center Emergency Psychiatric Services Office at **1-408-885-6100**.

A behavioral health provider will determine the most appropriate setting in which a Cal MediConnect member should receive services. The SCFHP Case Management Department works directly with the behavioral health providers to coordinate all behavioral health and medical needs of the member. Each member is assigned to a case manager. To access the SCFHP Case Management Department, both providers and members can call **1-408-874-1821**. Case managers communicate with you via telephone, via encrypted email alerts and/or via the Provider Portal on the status of member. In addition, each member has an Interdisciplinary Care Team (ICT). Medical and behavioral health providers, members and their representatives participate in the care coordination process. The information collected by the ICT is documented in the member's Individualized Care Plan (ICP).

It is important for behavioral health providers to know that they are required to provide written feedback to the referring physicians within 2 weeks of the original referral (or immediately any time that a major status change occurs). Additionally, even if changes have not occurred, behavioral health providers are required to report a patient's current status to the PCP at least once every six (6) months and again within two (2) weeks of case closure.

Behavioral Health Services

Inpatient care is provided through the psychiatric health facility operated by the Santa Clara Valley Health and Hospital System. SCFHP has also contracted with other inpatient facilities to provide services.

Outpatient behavioral health services are provided by SCFHP's network of contracted providers. SCFHP Case Management Department coordinates outpatient services with the member, behavior health provider, and the primary care provider.

A current list of contracted providers is available at www.scfhp.com

Drug & Alcohol Treatment Services

For Cal MediConnect members, detoxification and drug dependency are a covered benefit. Access to care and coordination of drug and alcohol treatment services are facilitated by the SCFHP Case Management Department.

Once a member has been referred and accepted for treatment or detoxification, the PCP continues to be responsible for medical care not related to the drug or alcohol treatment. Medical detoxification generally is provided on an inpatient setting and administered under the member's medical benefit.

Substance abuse or chemical dependence may involve any of the following 10 classes of substances:

- Alcohol
- Amphetamines, including "crystal meth," some medications used in the treatment of attention deficit disorder (ADD), and amphetamine-like substances found in appetite suppressants
- Cannabis, including marijuana and hashish
- Cocaine, including "crack"
- Hallucinogens, including LSD, mescaline, and "ecstasy" (MDMA)
- Inhalants, including compounds found in gasoline, glue, and paint thinners
- Nicotine (considered a substance dependence rather than abuse per se)
- Opioids, including morphine, heroin, codeine, methadone, and synthetic pain medications such as oxycodone, hydrocodone, etc.
- Phencyclidine, including PCP, angel dust, ketamine
- Sedatives, hypnotics, and anxiolytic (anti-anxiety) agents, including benzodiazepines, barbiturates, prescription sleeping medications, and most prescription anti-anxiety medications

SCFHP covers PCP screening of SCFHP Cal MediConnect members for substance abuse during the Initial Health Assessment (IHA) and in all subsequent visits as appropriate.

For substance use issues, both providers and members can call the Department of Alcohol and Drug Services Gateway Program at **1-408-272-6518** or **1-800-488-9919**.

Section 13 Health Education Program

Purpose and Goals of Health Education Program

Santa Clara Family Health Plan, through our Health Education Program, is committed to improving and maintaining the health and wellness of our members through health promotion and disease management.

The goals of our Health Education Program are to:

- Encourage members' involvement with their primary care provider (PCP) in the management of their personal health.
- Increase the use of preventive health services.
- Encourage positive behavior change for high-risk behaviors.
- Increase members' knowledge and skills in coping with chronic conditions.

Scope of Health Education Program

At SCFHP, we offer health education classes and programs at no charge to all of our members in a culturally sensitive and linguistically appropriate manner. We provide facts and services that enable members to understand and manage their health. We also partner with a number of agencies within the community to provide health education classes and programs that best meet the needs of our membership. Health education services are designed to support our members in living healthier lives. Programs, classes, and materials are available in English, Spanish, Vietnamese, Chinese and Tagalog. Health education services include:

- Chronic disease self-management
- Asthma education and management
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes education and management
- Smoking cessation
- Quit Smoking Program
- Smoker's Helpline
- Exercise and Fitness
- Open gym membership at Indian Health Center
- Nutrition and weight management
- Family nutrition education
- Weight Watchers program

- Parenting education
- Basic parenting
- Safety programs
- First aid program
- CPR program

Role of Health Education

The Health Education Department ensures that:

- Members are informed about, and have access to information they need to improve and maintain a good quality of life.
- Physicians and other health care providers have the tools necessary to address the health education needs of individual patients to the best of their ability.
- Information regarding available services is accessible to health care providers and members.

Role of Providers

Physicians play a key role in referring members to health education classes and educating them on the use of their health education benefits. A patient who is identified as high risk through the ***Staying Healthy Assessment (SHA)*** tool would benefit from health education services. Physicians can review health education programs and services at www.scfhp.com. Physicians can review health education programs and services at www.scfhp.com.

How to Access Services and Refer Patients

Participating providers may refer patients for health education services using any of the following three methods:

- Encourage members to self-refer by calling the Customer Service Department.

We encourage providers to inform members that health education services are available free of charge. Members can call the Customer Service Department at **1-877-723-4795** to self-refer to a class or to ask questions about available services. The Customer Service telephone number is located on the member's SCFHP Cal MediConnect ID card. Customer Service Representatives are available Monday-Friday from 8:00 a.m. to 8:00 p.m., including holidays.

- Call the referral into the Customer Service Department.

You may submit a referral via telephone by calling the Customer Service Department at **1-877-723-4795**. Please be prepared to provide the following information:

- Patient's name
 - Patient's SCFHP member ID number
 - Patient's phone number
 - Provider's name
 - Provider's phone number
 - Provider's fax number
 - Health education service(s) requested
- Complete and submit the Health Education Referral Form.
This form can be found on our website, www.scfhp.com in the Provider Forms & Documents section, or you may call Provider Network Management at **1-408-874-1788** and request the forms to be delivered to your office. The form is easy to use, so office staff can assist with its completion and fax it to the Health Education Department. All instructions are detailed on the form. The following information is required:
 - Patient's name
 - Patient's SCFHP member ID number
 - Patient's phone number
 - Provider's name
 - Provider's phone number
 - Provider's fax number
 - Health education service(s) requested

Provider Education

At SCFHP, the Health Educator is available to educate providers and their staff on health education services if the provider office requests this service. Providers may contact the Health Education Department to request an in-service or more information on available SCFHP health education services.

Questions

For more information about our health education programs and services, please call SCFHP at **1-877-723-4795**, email healthed@scfhp.com and/or visit the Health Education section of our website at www.scfhp.com.

Section 14 Managed Long-Term Services and Supports (MLTSS)

What is MLTSS?

Historically, Medi-Cal managed care plans covered acute, primary, and rehabilitative care services, but not LTSS. Under the Coordinated Care Initiative (CCI), SCFHP is responsible for administering and coordinating expanded LTSS benefits. Beginning July 1, 2014, the first component of CCI took effect—Managed Long-Term Services and Supports (MLTSS).

Expanded Medi-Cal benefits under the health plan now include the following LTSS programs:

- In-Home Supportive Services (IHSS)
- Community-Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Long-term care in a nursing facility, including skilled, subacute and long-term custodial care

What is Long-Term Care (LTC)?

Long-term care (LTC) is the provision of medical, social, and personal care services that are not available in the community and are needed regularly due to a mental or physical condition. Services are provided in a skilled nursing facility (SNF).

A skilled nursing facility (SNF) is a licensed facility with the staff and equipment to provide nursing care and/or rehabilitative services at different levels as needed. The levels of care can vary, but usually include subacute care, skilled care and long-term care.

- Subacute care: Needed by a patient who does not require hospital acute care, but who requires more intensive skilled care than is provided to the majority of patients in a skilled nursing facility. Example: A patient on a ventilator or receiving IV antibiotics. Note that subacute care can also be provided in a dedicated subacute care facility.
- Skilled care: For people who are physically disabled and/or require a high level of care. Skilled care services are prescribed by a physician or certified nurse practitioner. Example: A person discharged from the hospital to a SNF for rehab from a broken hip.
- Long-term care (LTC): Provides what is called “custodial care,” a level of care that is the least intensive care and is not skilled care.

LTC Referrals and Prior Authorization

The SCFHP Medical Management Department processes authorization requests in a timely manner and in accordance with state and federal requirements. SCFHP Authorizations Department is available by telephone every business day from 8:30 a.m. – 5 p.m. at **1-408-874-1808**.

Please leave a message including your phone number and you will receive a call back from a department member within one (1) business day.

To submit a prior authorization request, please complete the **Authorization Request form**, attach supporting clinical documentation, and fax it to the SCFHP Medical Management Department at **1-408-874-1957**. This fax number can be used to send authorization and utilization inquiries and requests to SCFHP during and outside of business hours.

Prior authorization requests should be accompanied by medical records to assist SCFHP's clinical reviewers with determining whether the requests meet SCFHP's criteria for coverage.

What are Community-Based Adult Services (CBAS)?

CBAS is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries enrolled in a managed care plan. CBAS targets at-risk patients who need extra supervision and support in order to remain living in their homes or communities and to prevent emergency room visits, hospitalizations, and other institutionalization.

CBAS Referrals and Prior Authorization

Upon receipt of a new member inquiry, CBAS providers must fax the following documents to **1-408-874-1975**.

- CBAS referral form
- Medical necessity form completed by the member's primary care provider

SCFHP Medical Management staff will review all documentation and schedule a face-to-face interview with the member at a location convenient for the member. The face-to-face interview must be scheduled within 14 days of submitting a CBAS referral; otherwise a new referral is required. The face-to-face interview must be completed within 30 days of submitting a CBAS referral.

Face-to-face CBAS Eligibility Determination

The member and CBAS provider are informed of the decision as soon as the face-to-face interview is completed and an eligibility determination is made. Should SCFHP Medical Management staff determine the member does not meet eligibility criteria for

CBAS services, a denial letter is sent along with grievance and appeal rights. Should the member meet eligibility criteria for CBAS services, SCFHP Medical Management staff will authorize the CBAS provider to perform a 3-day multidisciplinary team assessment. CBAS providers receive a prior authorization form with a designated authorization number for billing for assessment days.

Prior Authorization Requests for CBAS Level of Service

In order for CBAS services to be considered for 6-month intervals, CBAS providers must submit an Individual Care Plan (ICP) for all new members who complete a multidisciplinary team assessment, along with a prior authorization request form specifying the level of service recommended by the multidisciplinary team. Please fax all documents to **1-408-874-1975** or mail to:

Attn: LTSS Authorizations
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

SCFHP Medical Management staff informs CBAS providers within five (5) business days of the decision to approve, modify, or deny prior authorization requests.

- If SCFHP cannot make a decision within five (5) business days, a 14 day delay letter is sent to the member and CBAS provider, during which time, SCFHP Medical Management staff may:
 - Send a Request for Further Documentation form to the requesting CBAS provider if additional supporting documentation is needed.
 - Refer the case to a Medical Director or the Chief Medical Officer for consultation and review.
 - Refer the case to case management for assessment and participation in recommendations.
- If the prior authorization request is denied or modified, the member is sent a **Notice of Action letter**, along with grievance and appeal rights, within 48 hours of the decision. CBAS providers are notified of the decision within 24 hours.

CBAS Reassessment

In order for a member to continue receiving CBAS services, CBAS providers must submit a new prior authorization request form specifying the recommended level of service, along with an updated Individualized Care Plan. Reauthorization is an administrative process and may be accomplished without a face-to-face interview. If a change in level of service is indicated on the request for reauthorization of CBAS services, SCFHP Medical Management staff may conduct another face-to-face interview with the member to verify appropriateness of service.

Please fax all documents to **1-408-874-1975** or mail to:

Attn: LTSS Authorizations
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Fax or mail prior to the expiration of the previously authorized 6-month period.

If a member no longer requires CBAS services, CBAS providers complete a CBAS Discharge Plan of Care.

Expedited Referrals

An expedited referral process is available to members who are in a hospital or nursing facility and whose discharge plan includes CBAS, or for members who are at immediate risk of admission to a nursing facility. Upon receipt of such referral, SCFHP Medical Management staff immediately schedule a face-to-face interview at the hospital or skilled nursing facility and complete the face-to-face interview within five (5) business days. Written documentation of medical necessity is obtained from the attending physician.

For more information, please refer to SCFHP's relevant policies on www.scfhp.com.

What is Multipurpose Senior Services Program (MSSP)?

MSSP provides social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement. The services must be provided at a cost lower than that for nursing facility care. ‘

To be eligible, members must be:

- An active member of SCFHP Cal MediConnect
- 65 years of age or older
- Living within a site's catchment area
- Receiving Medi-Cal under an appropriate aid code
- Able to be served within MSSP's cost limitations
- Appropriate for care management services
- Certifiable for placement in a nursing facility

MSSP services include:

- Case management

- Personal care services
- Respite care (in-home and out-of-home)
- Environmental accessibility adaptations
- Housing assistance, minor home repair, etc.
- Transportation
- Chore services
- Personal emergency response system (PERS)/communication device
- Adult day care/support center
- Protective supervision
- Meal services - congregate/home-delivered
- Social reassurance/therapeutic counseling
- Money management
- Communication services: translation/interpretation

MSSP Referral Process

Please fax referrals to Sourcewise MSSP program at 1-408-289-1880.

What are In-Home Supportive Services (IHSS)?

The IHSS program provides payment for non-medical in-home care for qualified individuals who are unable to remain safely in their homes without this assistance. Members must be evaluated by a social worker to be determined financially and functionally eligible. Eligible members must be:

- An active member of SCFHP Cal MediConnect.
- Citizen of the United States or a qualified alien, and a California resident.
- Over 65 years of age, or disabled, or blind (disabled children also eligible).
- One of the following:
 - Current recipient of Supplemental Security Income/State Supplementary Payment (SSI/SSP); or
 - Meet all the eligibility criteria for SSI/SSP except that your income is in excess of the SSI/SSP income levels; or
 - Meet all the eligibility criteria for SSI/SSP, including income, but do not receive SSI/SSP; or
 - Medi-Cal recipient who meets SSI/SSP disability criteria.
- Live in a residence, not an institution.

- Determined at risk for institutionalization based on initial IHSS screen.

The Public Authority by Sourcewise maintains responsibility for processing, approving/authorizing, and monitoring IHSS requests. Call 1-408-792-1600.

Section 15 Pharmacy Services

SCFHP Formulary

The SCFHP Formulary (List of Covered Drugs) is a list of preferred generic and brand-name medications in various therapeutic classes that are covered under the SCFHP pharmacy benefit. The Formulary, also called the Drug List, exists to allow our providers and clinicians to determine the safest, most effective, and least costly drug therapy possible.

The Drug List is located on our website:

<https://www.scfhp.com/healthcareplans/calmediconnect>. It is updated on the first day of each month with changes and annually for the beginning of each benefit year. If there are any negative formulary changes during the benefit year, they are listed here on our website: <https://www.scfhp.com/healthcareplans/calmediconnect/list-covered-drugs-formulary>.

The Drug List applies only to drugs provided by an SCFHP network pharmacy and processed through SCFHP's Pharmacy Benefit Manager (PBM) and does not apply to drugs used in inpatient settings or furnished by a provider.

Formulary Review

The Drug List is reviewed and updated based on comprehensive data on efficacy and safety available from evidence-based clinical studies, and for which evidence of performance in overall use in a variety of therapeutic settings has been established. The decisions are also based on the Centers for Medicare & Medicaid Services (CMS) Medicare Part D formulary requirements and Department of Health Care Services (DHCS) contract requirements.

The SCFHP Pharmacy and Therapeutics Committee meets once per quarter to develop and maintain the Drug List to ensure that it remains responsive to the needs of our members and providers. The committee is composed of physicians from various medical specialties and pharmacists, whose role is to evaluate clinical drug reviews concerning safety, effectiveness, and costs, and decide on the most cost-effective drugs in each class to be on the Drug List.

Formulary Exclusions

Brand name drugs that are FDA approved and equivalent generic drugs are available, except select "narrow therapeutic index" drugs:

- Drugs not listed in the Drug List
- Drugs removed from the Drug List by the P&T Committee as allowed by CMS
- All drugs bearing a label: "Caution – limited by federal law to investigational use," or experimental drugs

- Drugs used to promote fertility or to treat sexual dysfunction
- Drugs used for cosmetic indications
- Most prescription vitamins and minerals, except prenatal vitamins and pediatric multivitamins with fluoride and fluoride preparations
- Alcohol, heroin detoxification, and dependency treatment drugs (i.e. Suboxone)

Prior Authorization Process

SCFHP encourages providers to prescribe formulary drugs whenever possible. However, when a provider elects to prescribe a non-formulary drug, a **Part D Coverage Determination Request Form** must be completed by the pharmacy or physician and **faxed to MedImpact at 1-858-790-7100**, who will process the PA on behalf of SCFHP. Determinations of approval or denial for prior authorization requests are provided within 72 hours as long as all of the information required to make a decision is provided. Providers can request an urgent review if medically necessary and a determination will be made within 24 hours. Note: For urgent prior authorization requests, please check the “Urgent” box on the PA form.

All required fields of the **Coverage Determination Request Form** should be completed to avoid delay in the review of the request. Incomplete or illegible forms will be returned or pended for clarification or additional information. If a prior authorization request is approved, the pharmacy may adjudicate the claim online as directed by the PA fax-back message from SCFHP. There is no need for a prior authorization number. **For questions about PA status, please call MedImpact at 1-800-788-2949.** For all other questions, please call the SCFHP Pharmacy Department at **1-408-874-1796**.

For a copy of the Part D Coverage Determination Form, please visit www.scfhp.com or call MedImpact at **1-800-788-2949**.

Drugs Administered by Physicians/Clinics

Any drug administered by a physician or clinic, including injectable anti-neoplastic medications, may be billed as a medical claim by the physician or clinic and/or by the dispensing pharmacy providing the drug for such administration.

Specialty Drug Program

Specialty drugs are high-cost drugs that may be used to treat complex medical conditions. Prior authorization may be required prior to drug dispensing. For more information on which drugs require PA, please see our formulary online at **www.scfhp.com** or call the SCFHP Pharmacy Department at **1-408-874-1796**.

Transition Fill Policy

When a new member tries to fill a non-formulary drug or drug with utilization management restriction within the first 90 days of enrollment, they will be eligible for a

30 day transition fill in the retail pharmacy network. This will also apply to renewing members when there is a formulary change between benefit years. Members in long-term care (LTC) are eligible for a 91 day fill consistent with dispensing increment (unless the enrollee presents with a prescription written for less), with refills provided if needed during the first 90 days of a member's enrollment in the plan.

Members who receive a transition fill will be sent a written notice within three business days that they received a one-time transition fill and be given information about the next steps to take if they would like to continue on that medication.

Formulary Legend

Utilization Management Restrictions		
Abbreviation	Description	Explanation
PA	Prior Authorization	Member is required to get prior authorization from SCFHP Cal MediConnect before filling the prescription for this drug.
PA BvD	Prior Authorization for Part B vs Part D Determination	This drug may be eligible for payment under Medicare Part B or Part D. The member is required to get prior authorization from SCFHP Cal MediConnect to determine that this drug is covered under Medicare Part D before filling the prescription for this drug.
PA-HRM	Prior Authorization Restriction for High Risk Medications	This drug has been deemed by CMS to be potentially harmful and therefore, a High Risk Medication for Medicare beneficiaries 65 years or older. Members age 65 years or older are required to get prior authorization from SCFHP Cal MediConnect before filling the prescription for this drug.
PA NSO	Prior Authorization for New Starts Only	New members or existing members who just starting this medication are required to get a prior authorization from SCFHP Cal MediConnect before filing the prescription for this drug.

QL	Quantity Limit	SCFHP Cal MediConnect limits the amount of this drug that is covered per prescription or within a specific time frame.
ST	Step Therapy	Before SCFHP Cal MediConnect will provide coverage for this drug, the member must first try another drug(s) to treat the medical condition. This drug may only be covered if the other drug(s) does not work for the member.
*	Not a Part D Drug	This drug is a non-Part D drug covered by Medi-Cal.
LA	Limited Access Drug	This prescription may be available only at certain pharmacies. For more information call Customer Service at 1-877-723-4795 , 7 days a week, 8 a.m. to 8 p.m., including holidays. TTY/TDD users call 1-800-735-2929 .

Section 16 Provider Roles and Responsibilities

The Primary Care Provider (PCP)

The PCP's role is vital in the overall coordination of health care for each member and in providing routine and preventive health care services, including:

- Assessing each individual's health status.
- Providing and documenting preventive services in accordance with established criteria
- Providing quality care
- Coordinating referrals to specialists
- Facilitating patients' access to treatment
- Referring patients to health education classes and educating them on the use of their health education benefits.
- Providing basic case management services in collaboration with SCFHP's case management department including at a minimum:
 - Assisting with the identification of patients in need of case management services
 - Completing each patient's Initial Health Assessment and reviewing responses related to potential needs for care coordination
 - Communicating directly with the member, family and/or SCFHP case management staff
 - Participating in initial and ongoing training and education related to SCFHP's case management and care coordination services
- Assuring that members in your practice are not discriminated against in the delivery of services, both clinical and non-clinical, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment.
- Assuring that no unnecessary or redundant medical services are being provided.
- Identifying and following any member who has missed or cancelled his/her appointments.
- Establishing a system for tracking and identifying any clinical problems unique to your particular patient population. The system should focus on patients who require special attention, i.e., those for whom regular doctor visits are imperative and warrant special attention from your office to assure that the visits actually occur.

For your convenience, all policies addressing the role of providers, expectations, and services are available on our website. In addition, more detailed information about the authorization and referral process is contained in **Authorizations**.

Clinical Practice Guidelines

As PCP you are responsible for determining the medical needs of your assigned members. However, if you wish, our Medical Department will assist you in adapting Clinical Practice Guidelines for providing preventive care and care for acute and chronic physical/mental illnesses.

Such guidelines should be consistent with established national guidelines (where available); scientific literature; evidence-based medicine; current standards for best-practices as established by experts; and federal/state laws and regulations.

Below are examples of some of the national professional organization guidelines we use (listed in alphabetical order):

- Advisory Committee on Immunization Practices (ACIP)
- Agency for Healthcare Research and Quality (AHRQ)
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Obstetricians and Gynecologists (ACOG)
- American Diabetes Association (ADA)
- Centers for Disease Control and Prevention (CDC)
- Child Health and Disability Prevention Program (CHDP)
- Department of Health Services Comprehensive Perinatal Services Program (CPSP)
- Diabetes Coalition of California
- US Preventive Services Task Force Guidelines (USPSTF)

We also assist providers in communicating Clinical Practice Guidelines to members through our physician/provider committees, newsletters, targeted member mailings, consumer meetings and focus groups, outreach events, educational programs, and the SCFHP website (www.scfhp.com).

We ensure compliance with these guidelines through chart-review audits such as annual HEDIS abstraction, and through periodic reviews of medical records at providers' offices.

For further details on assistance with Clinical Practice and Preventive Health Guidelines, see the SCFHP website.

The Initial Health Assessment (IHA)

As part of our contractual agreements, each new Cal MediConnect member must receive an Initial Health Assessment from their PCP.

We require that a good-faith effort be made by the PCP to conduct this initial assessment within 120 days of enrollment or, for pregnant members, as soon as possible after discovery of the pregnancy; for infants, the assessments should be scheduled in accordance with AAP periodicity recommendations. To help the PCP meet these timelines, we provide a list of new or re-enrolled members each month.

The initial history and physical examination helps establish relationships with patients in a non-crisis situation, and is an important aspect of a preventive medicine program. Generally, an IHA is comprised of:

- A comprehensive history, including medical, social, psychological and family background as well as lifestyle habits, such as tobacco, alcohol, nutrition/diet, exercise, and sexual activity.
- A complete physical examination to assess the member's present health status, including possible acute, chronic and/or preventive health needs.
- Age-specific assessments and services, including administering necessary immunizations (if this is not possible, appointments for appropriate services should be scheduled, with the date noted in the medical record).
- Screening for TB or other communicable diseases.
- Recommendations for health education and mental-health services.

Please note that the services described below *do not meet the criteria* for an IHA:

- A visit for evaluation and/or management of a specific problem.
- Perinatal visits, other than the initial complete assessment of a pregnant woman according to ACOG guidelines.
- Urgent-care and/or emergency visits or services.

Assessment Tools for Performing an IHA

To help PCPs fulfill the IHA requirements, we provide copies of various professional standards, guidelines, and age-appropriate screening/assessment tools on our website, www.scfhp.com.

Initial Health Assessment for Pregnant Members

The examination of a newly enrolled pregnant member must include a comprehensive OB/GYN and medical examination as well as an assessment of nutritional, psychosocial, and health-education needs.

PCPs may wish to take advantage of the Comprehensive Perinatal Services Program—a State program that integrates nutrition, psychosocial and health-education services and related case coordination with basic obstetrical services.

SCFHP Encourages Members to Schedule an IHA

We inform members of the availability and importance of an IHA via the Evidence of Coverage (EOC) booklets, which are mailed to each member shortly after enrollment. We also mail a welcome letter to each new member on behalf of our PCPs, which mentions the value of an IHA.

We are obligated by regulatory authorities to report our members' rates of compliance with the requirement for an Initial Health Assessment.

Scheduling IHA's: Failed Attempts and Missed Appointments

After at least two attempts have been made to contact the member to schedule an IHA without success, further attempts are not required. Likewise, if a member has missed a scheduled appointment and an attempt to reschedule has been unsuccessful—or if the member has missed a second scheduled appointment—no further attempts to schedule an IHA are required. However, all attempts should be documented in the member's medical record.

Exemption to the IHA Requirement

If any member—including emancipated minors, or a member's parent or guardian—refuses an IHA, this should be documented in the member's medical record with a statement signed by the member. If a member refuses to sign a statement, please note this in the medical record. *All exemptions from the IHA requirement should be appropriately documented in the medical record or in another identifiable format.*

For additional details, see relevant SCFHP policies at www.scfhp.com.

Assessing Your Patient's Level of Health Education

The Individual Health Education Behavioral Assessment (IHEBA) is a valuable tool for early detection of possible risks to patients' health and well-being. Also known as the "Staying Healthy Assessment," the IHEBA will reveal health education needs by providing a quick, overall perspective on the person's living conditions, health practices, behaviors, attitudes, beliefs, lifestyle and social environment, and cultural and linguistic needs.

The IHEBA form is age-specific and available in multiple languages. It can be copied onto the reverse side of the well-visit form, thus permitting the provider to capture all the necessary information on a single sheet of paper. The IHEBA is easy for a member, parent or designated representative to complete while waiting for his/her IHA. (Please note that, since the form is age-specific, a new version may need to be completed again at future visits as younger patient's age.)

The IHEBA form should be completed for a new member within 120 days of enrollment, and updated annually for patients under 18 and every 3-5 years for patients over 18. If a member declines to complete the IHEBA assessment, please be sure to document this in the member's medical record.

After reviewing the completed form, PCPs may refer patients to health education classes through SCFHP, or provide them with copies of their own educational materials. Section 13 Health Education Program contains a description of the health education classes we offer our members.

The SHA is available in multiple languages on the SCFHP website. If you have any questions about the IHEBA form or other tools for assessing health education needs, please contact our Health Education Department at **1-408-874-1847**.

Patients with Special Health-Care Needs

If the results of an IHA indicate the member has special health-care needs—either physical, mental, behavioral, or developmental problems—please document this in the patient's record and refer the person to the appropriate agencies outside the SCFHP network to facilitate continuity of care, coordination of care, and case management.

All pertinent results from an IHA must be documented in the patient's medical record, including:

- Diagnosis of and treatment for any disease or health condition identified.
- Proposed (or provided) counseling, anticipatory guidance and interventions for risk factors detected.
- Other preventive, diagnostic or treatment follow-up services as needed.
- Referrals made to specialists or other providers.
- Proposed or scheduled revisit date.
- Provisions for continuation or initiation of all services necessary to treat preexisting conditions, including initiation or continuation of specialty care.
- If the IHA was actually conducted during a previous visit, note the patient's health status in his or her medical record, as this documentation will serve as evidence of an IHA.

SCFHP employs nurses who are trained in case management, disease management, and chronic care, any of whom can answer questions and assist you or your staff in obtaining special health-care services for your patients. Please call **1-408-874-1821** if you need assistance. For further information, see Section 11 Population Health Management.

Section 17 Provider Complaints

Overview

Providers may submit written complaints regarding SCFHP's services, operations, or procedures to the Provider Network Management Department on the SCFHP website at **www.scfhp.com**. Provider complaints will be handled in accordance with SCFHP's policies and procedures. For more information or if you have questions about submitting a claim or dispute, contact the Provider Network Management Department at **1-408-874-1821**.

Provider Request for Review

A provider may be dissatisfied or concerned about how a claim was processed. Providers have the right to request a review of the claim by SCFHP's Claims Management Department. The request for review may be submitted in writing and must include the following:

- Provider's name
- Claim number
- Description of concern

Requests for review should be sent by mail:

Attn: SCFHP Claims Director
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

By email: **claimsappeals@scfhp.com**

By fax: **1-408-874-1725**

Medical Appeals and Grievances

A provider has the right to file an appeal on any of the procedures that deal with the review of adverse coverage or organization determinations, including delay in providing, arranging, or approving healthcare services. A reconsideration is a medical service appeal and a redetermination is a Part D Drug appeal. These appeals are treated as member appeals and follow the member appeal process as discussed in **Member Grievances and Appeals**.

Section 18 Member Rights and Responsibilities

In partnership with our physicians and medical service suppliers, SCFHP acknowledges that each patient is an individual with unique health-care needs and we respect each patient's personal dignity. Based on this premise, we have adopted a list of patient rights and responsibilities, listed in the Member Handbook given to every member upon enrollment.

If you would like to receive printed copies of the Member Handbook, please contact our Provider Network Management Department at **1-408-874-1788**.

Member Rights and Responsibilities

Member rights and responsibilities are described in full in SCFHP's Cal MediConnect Member Handbook and include the following:

Rights:

- To get information in a way that meets their needs.
- To be treated with respect, fairness, and dignity at all times.
- To get timely access to covered services and drugs.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To get protection of their personal health information.
- To have access to their medical records.
- To receive information about their plan, network providers, and covered services.
- To not receive a bill for covered services
- To leave the Cal MediConnect plan at any time.
- To participate with their provider in making decisions about their health care.
- To make complaints or file an appeal about:
 - Their health plan
 - Any care they receive
 - Any covered service or benefit ruling that the health plan makes.
- To make recommendations regarding SCFHP's member rights and responsibilities policy.

Member Responsibilities:

- To read the Member Handbook to learn about covered services and drugs.
- To inform the health plan about any other health insurances.
- To bring their member ID card when they get services or drugs.

- To understand their health problems so they can communicate with their doctors and other health care providers and participate in developing mutually agreed upon treatment goals to the degree possible.
- To be considerate.
- To supply information (to the extent possible) that the health plan and its network providers need in order to provide care.
- To follow plans and instructions for care that they have agreed to with their provider.
- To pay what they owe.
- To inform the health plan if they move.
- To contact Customer Service if they have any questions.

Section 19 Member Grievances and Appeals

Member Grievances

SCFHP responds promptly to complaints from either a provider or a Cal MediConnect member. Two types of formal complaints may be submitted by or on behalf of member: a grievance and an appeal.

Grievance means any written or oral expression of dissatisfaction, regarding the plan and/or provider, including quality of care concerns and shall include a complaint, dispute, and request for reconsideration or appeal made by a member or the member's representative to the plan or to any entity with delegated authority to resolve grievances on behalf of the plan. A complaint is the same as a grievance.

Appeal means the processes established both within the plan and through recognized external organizations to ensure that a member can request and obtain reconsideration of any SCFHP decision or proposed resolution to a reported grievance and/or a plan decision to defer, deny, or modify medical services. A member or his/her appointed representative (acting on member's behalf) may file an appeal.

If a Cal MediConnect member has a complaint regarding SCFHP or any of its contracted providers, the member may contact Customer Service at **1-877-723-4795**. Member complaints are documented and forward to the Grievance and Appeals Department for resolution.

Filing a Grievance

To help ensure that our members' rights are protected, all Cal MediConnect members are entitled to a grievance and appeal process. If a member wants to file a grievance, they can do so in one of the following ways:

- Submit an online form via SCFHP website: [**www.scfhp.com**](http://www.scfhp.com).
- Call Customer Service at **1-877-723-4795**, or TTY **1-800-735-2929**.
- By mail:

Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

- Contact CMS at **1-800-633-4227** or TTY **1-877-486-2048**.

If member has a problem or concern about their long-term services and supports, they can contact:

- SCFHP Customer Service at **1-877-723-4795** or TTY **1-800-735-2929**
- Cal MediConnect Ombuds Program at **1-855-501-3077**

- Department of Managed Health Care (DMHC) at **1-888-466-2219** or TTY **1-877-688-9891**
- In-Home Supportive Services (IHSS) at **1-408-792-1600**

Timelines for the Member Grievance and Appeal Process

Standard Grievances

A member has 90 calendar days to file a grievance. Once a standard grievance is filed, the Grievance and Appeals Department mails an acknowledgement letter within 5 calendar days of receipt of the grievance. Grievances are investigated by identifying and requesting relevant information, including medical records, necessary to make a determination.

SCFHP issues a resolution letter within 30 calendar days of receipt of the grievance. SCFHP may extend the timeframe for resolution up to 14 calendar days if the member requests the extension or if SCFHP justifies a need for additional information before making a decision.

Expedited Grievances

A member can request an expedited grievance in writing, by telephone, or through our website. An expedited grievance may be requested only under the following circumstances:

- Expressing dissatisfaction with SCFHP denying the member's request for expedited review of a medication or medical service request
- Expressing dissatisfaction with SCFHP extending a member's request for medical services

SCFHP is required to respond by telephone within 24 hours of receipt of a request for an expedited grievance.

Quality of Care Grievances

Members have the right to file a complaint about quality of care with SCFHP or with California's Quality Improvement Organization (QIO), Livanta, LLC. Members may contact Livanta, LLC at:

- Telephone: 1-877-588-1123, TTY 1-800-881-5980
- Mail:

Livanta, LLC
680 West Oquendo Road, Suite 202
Las Vegas, NV 89118

- Website: www.livanta.com

Member Appeals

There are two types of Level 1 Appeals: standard appeal or expedited appeal.

Standard Appeals

A member may submit an appeal or may ask his/her doctor, or other provider or appointed representative, to submit an appeal on behalf of the member. To submit an appeal, a member or his/her provider or appointed representative can:

- Call Customer Service at 1-877-723-4795 or TTY 1-800-735-2929.
- Submit a written request via mail or fax:
Attn: Appeals and Grievances
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
- Fax: 1-408-874-1962
- Submit a request electronically by visiting SCFHP's website at www.scfhp.com and completing a complaint form online.
- Submit a request electronically by visiting Medicare's website at www.medicare.gov.

Within five (5) calendar days of receipt of a request for appeal, SCFHP sends an acknowledgement letter to the member or member's representative. Appeals involving organization determinations other than payment issues are resolved within 30 calendar days. The member and the appropriate provider are notified in writing of the appeal resolution. Appeals involving payment issues are resolved and claims paid within 60 calendar days and written notification is sent to the appellant.

Expedited Appeals

A member, an appointed representative, or a provider on behalf of a member may request that an appeal of a coverage denial, discontinuation, or modification be expedited. SCFHP resolves expedited appeals within 72 hours. SCFHP notifies the member verbally and mails a written resolution letter within 72 hours of receipt of the appeal request.

Members with Medi-Cal related grievances and appeals may request a State Fair Hearing at any time during the grievance process for Medi-Cal covered services and items (including IHSS). A member has 90 calendar days to ask for a State Fair Hearing from the date the incident or action occurred which caused the member to be

dissatisfied. The State Fair Hearing request must be filed within 90-calendar-days from the date of the Notice of Action.

There are two ways to request a State Fair Hearing:

1. Member may complete the **Request for State Fair Hearing** on the back of the notice of action and submit it:
 - To the county welfare department at the address shown on the notice.
 - To the California Department of Social Services:
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430
 - To the State Hearings Division at fax number **1-916-651-5210** or **1-916-651-2789**.
2. Member may call the California Department of Social Services at **1-800-952-5253**. TTY users should call **1-800-952-8349**.

Independent Medical Review

If SCFHP upholds its initial adverse determination—or fails to make a determination within the required timeframe—the member’s appeal is automatically sent to the independent review entity (IRE) for review. The IRE is the independent review entity contracted with CMS to review SCFHP’s adverse decisions regarding an appeal.

The IRE sends written notification of the determination to both the member and the provider who submitted an appeal on the behalf the member. For standard appeals, the IRE is required to send the response within 30 calendar days of the decision; for payment appeals, within 60 calendar days; and for expedited appeals, within 72 hours of the decision. The written notice of the IRE’s decision must tell the member about his/her right to a hearing before an administrative law judge and must include the administrative law judge’s address.

Review by an Administrative Law Judge

If a member or appointed representative disagrees with the IRE’s decision, he/she may request a hearing before an administrative law judge. Such a request must be submitted in writing within 60 calendar days from the date of the notice of the IRE’s decision. For a hearing to be scheduled, the amount in dispute must meet the established CMS dollar threshold.

The Administrative Law Judge’s decision must be provided in writing and, if negative, must inform the member of his/her right to have the case reviewed further by the Medicare Appeals Council. The judge’s notification letter must include the address for the Medicare Appeals Council.

Review by the Medicare Appeals Council

A member, appointed representative, or SCFHP may request a review by the Medicare Appeals Council if he/she is dissatisfied with the administrative law judge's decision. This request must be sent to the Medicare Appeals Council in writing within 60 calendar days from the date of the notice of the administrative law judge's decision. The Council notifies all parties of its decision, in writing, within 60 calendar days of receipt of the appeal request and must provide the address of the federal district court to facilitate further appeal.

Review by a Federal District Court

In the case of disagreement with the decision of the Medicare Appeals Council, a member, an authorized representative, or SCFHP may request a review by a federal district court. For a hearing to be scheduled, the amount of the disputed service or claim must meet a minimum dollar amount determined by CMS. The request must be sent, in writing, within 60 calendar days of the date of the notice of the Medicare Appeal Council's decision.

Complaints Related to Part D

Part D grievances are filed for formal complaints related to something other than adverse coverage determinations, while appeals are made when a member wants a coverage decision to be reconsidered (a request for redetermination)—e.g., which drugs are covered or how much we will pay for a particular drug.

Filing a Part D Grievance

A member or his/her appointed representative may file a grievance if he/she has a problem with either SCFHP or one of our contracted pharmacies that is not related to coverage for a specific drug. Examples include: waiting times when filling a prescription; the behavior of a pharmacist or other contracted providers; an inability to reach a pharmacy by phone or obtain needed information; the cleanliness or condition of a pharmacy.

Grievances must be filed within 60 calendar days of the event that led to the complaint. Grievances may be filed in any one of the following ways:

- Call Customer Service at 1-877-723-4795, or TTY 1-800-735-2929.
- Submit a written request via mail or fax:

Attn: Appeals and Grievances
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
- Fax: 1-408-874-1962

- Submit a request electronically by visiting SCFHP's website at www.scfhp.com and completing a complaint form online.

Part D Expedited Grievances

The member/appointed representative can request an expedited grievance if they disagree with a health plan decision not to give a fast coverage decision or a fast appeal. SCFHP responds to this type of grievance by telephone within 24 hours of the time that we receive the complaint.

Part D Standard Grievance

Once a member has filed a standard grievance, SCFHP must respond within 72 hours for a coverage decision and within 14 days for reimbursement for Part D.

Filing a Part D Appeal

A member or representative may request an appeal within 60 calendar days from the date of notice of an adverse coverage determination. Such appeals may be submitted in one of the following ways:

- Call Customer Service at **1-877-723-4795**, or TTY **1-800-735-2929**.
- Submit a written request via mail or fax:
Attn: Appeals and Grievances
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
- Fax: **1-408-874-1962**
- Submit a request electronically by visiting SCFHP's website at www.scfhp.com.

Part D Expedited Appeal

The member or appointed representative can request an expedited appeal if the standard 7-day time frame could seriously jeopardize the member's life, health, or ability to regain maximum function. SCFHP responds within 72 hours of receipt of the request.

Part D Standard Appeal

When a member or appointed representative requests a standard appeal, SCFHP notifies the provider of our receipt of the request and requests information and medical records relevant to the appeal so that SCFHP can make a fair determination. Additional information may be required from other providers involved in the member's treatment. After all relevant documentation has been collected, all documentation is forwarded to a

qualified local physician, who reviews the case and makes an independent determination.

When a standard appeal involves a payment issue that has been reconsidered in favor of the member, SCFHP processes the request and issues a payment within 30 calendar days of receiving the request.

SCFHP notifies both the provider and the member of the decision verbally, within seven (7) calendar days of receiving the appeal.

An Independent Review Entity (IRE)

A member may request a review by the independent review entity (IRE). The request must be sent in writing to the IRE within 60 calendar days after the date of SCFHP's decision. The IRE is an independent organization hired by Medicare and is not connected with SCFHP. The IRE completes a careful review of the health plan decision, and decides whether the decision should be changed.

For standard appeals, the IRE has 7 calendar days to notify the member and provider of its decision; for expedited appeals, the IRE has 72 hours to notify the member and provider of its decision.

Administrative Law Judge (ALJ)

If a member or representative is not satisfied with a decision made by the IRE, the member may request a hearing before an administrative law judge specified in the IRE's notice. The request must be made in writing within 60 days of the IRE decision. The ALJ makes a decision as soon as possible. If the ALJ decides in favor of the member, SCFHP must pay for services within 60 days of receiving the decision.

Review by the Medicare Appeals Council

A member, appointed representative or SCFHP may request a review by the Medicare Appeals Council if he/she is dissatisfied with the administrative law judge's decision. This request must be sent to the Medicare Appeals Council in writing within 60 calendar days from the date of the notice of the administrative law judge's decision. The Council notifies all parties of its decision, in writing, within 60 calendar days of receipt of the appeal request and must provide the address of the federal district court to facilitate further appeal.

Review by a Federal District Court

In the case of disagreement with the decision of the Medicare Appeals Council, a member, an authorized representative, or SCFHP may request a review by a federal district court. For a hearing to be scheduled, the amount of the disputed service or claim must meet a minimum dollar amount determined by CMS. The request must be sent, in writing, within 60 calendar days of the date of the notice of the Medicare Appeal Council's decision.

When Member Disagrees with Hospital Discharge

A member remaining in the hospital who wishes to appeal SCFHP Cal MediConnect's discharge decision that inpatient services are no longer necessary may request an immediate review with the Quality Improvement Organization (QIO).

For detailed information on the appeals processes, see the Appeals and Grievances section in [Cal MediConnect Member Handbook](#).

Section 20 Compliance & Fraud, Waste, and Abuse

SCFHP is committed to maintaining a working environment that complies with ethical standards, contractual obligations, and all applicable laws and regulations.

SCFHP recognizes that federal agencies responsible for enforcement of Medicare and Medi-Cal laws and regulations applicable to healthcare providers require organizations to develop and implement corporate compliance programs. SCFHP's Compliance Program is designed to comply with this requirement and contributes to this purpose by:

- Stating SCFHP's commitment to regulatory compliance and legal conduct.
- Identifying, reporting, and preventing non-compliance and illegal activities.
- Providing training about internal compliance-oriented controls to promote compliance with state and federal laws, rules and regulations, as well as internal policies and procedures that are used to ensure compliance.
- Providing an environment that allows employees and providers to identify problems, that directly addresses problems, and that fairly disciplines non-compliant behavior.

Section 20.1 Goals and Standards of Conduct

SCFHP's Compliance Program goal is to meet CMS/DHCS requirements by ensuring the following processes and standards are in place:

- Leadership engagement in all processes
- Internal controls
- Monitoring, auditing, and reporting
- Proper oversight of delegated entities
- Risk assessment and management
- Prompt and effective corrective actions
- Effective training
- Ensuring there are documents, facts and evidence to support outcomes
- Continuous operational improvements to protect member rights (e.g., enrollment operations, appeals and grievances)
- Earliest possible detection and correction
- Quantifiable results

Section 20.2 Fraud, Waste, and Abuse

Fraud is the intentional use of false statements to cheat another person or company out of something of value. It includes any act that constitutes fraud under state and federal law.

Waste is any unnecessary cost that results from poor or inefficient practices.

Abuse is an activity that goes against sound business, monetary, or medical practices. Abuse may include practices by providers, members, or customers that result in unnecessary costs to the health plan.

Suspicious Activity is any activity that you think is fraudulent, wasteful, or abusive.

SCFHP has established a comprehensive program to prevent, detect, and correct fraud, waste, and abuse by employees, members, employers, brokers, providers, contractors, and subcontractors of SCFHP. Under this program, SCFHP works to promote a sense of integrity and vigilance by means of comprehensive anti-fraud education for such individuals and entities. This program also provides procedures for prevention, detection, auditing, monitoring, investigation and follow-up.

Examples of Suspicious Activity by Providers/Brokers:

- Billing for services or supplies that were not provided
- Unbundling or upcoding to maximize payments
- Performing unnecessary procedures, tests or prescribing additional and unnecessary treatments (over-utilization) or more expensive than indicated medications (drug diversion); unnecessary follow-up services
- Balance billing members for services
- Lying about credentials
- Billing for “phantom” patients who do not exist and did not receive services

Examples of Suspicious Activity by Members/Non-Members:

- Changing, forging, or altering a prescription
- Changing medical records
- Changing referral forms
- Letting someone else use their ID card to get medical services
- Misrepresentation of eligibility status
- Identity theft
- Prescription drug diversion and inappropriate use
- Resale of medications on the black market
- Prescription stockpiling

- Doctor shopping

Reporting Potential Fraud

Reporting potential fraud may be done through the compliance hotline, email, or letter via fax or mail. Provide as much detail as possible. For example, the names and dates of parties involved in the activity, description of the issues in question and code of conduct violations. SCFHP will not discriminate or retaliate against any employee or agent of SCFHP for reporting a compliance concern or for cooperating in any government or law enforcement authority's investigation or prosecution.

You can call the toll-free hotline, email, or send us a letter via fax or mail at:

Hotline: 1-408-874-1450

Fax: 1-408-874-1970

Email: ReportFraud@scfhp.com

Address:

Attn: Compliance Officer
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Section 20.3 Federal False Claims Act

The federal False Claims Act is the government's primary weapon in the fight against health care fraud. The majority of funds recovered come from False Claims Act suits or settlements. The federal False Claims Act permits a person who learns of fraud against the United States Government to file a lawsuit on behalf of the government against the person or business that committed the fraud. If the action is successful, the person filing the lawsuit ("plaintiff") is rewarded with a percentage of the recovery. These persons are often referred to as whistleblowers. Successful whistleblowers can receive anywhere from fifteen percent (15%) to fifty percent (50%) of the total amount recovered.

Who can be a plaintiff?

Any person may bring a lawsuit called a "*qui tam* action" regardless of whether he or she has "direct" or first-hand knowledge of the fraud. However, if substantially the same allegations or transactions alleged in the claim were publicly disclosed, the court may dismiss the claim.

What types of fraud qualify?

When a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he or she is not otherwise entitled, that person has committed fraud. This usually—although not always—involves money. However, under the False Claims Act, fraud has a much wider and more inclusive meaning.

Under the Act, the defendant need not have actually known that the information it provided to the government was false. It is sufficient that the defendant supplied the

information to the government either: (a) in "deliberate ignorance" of the truth or falsity of the information; or (b) in "reckless disregard" of the truth or falsity of the information.

Thus, if a defendant should have known that its representations to the government were not true or accurate, but did not bother to check, such recklessness may constitute a violation of the Act. Likewise, if a defendant deliberately ignores information which may reveal the falsity of the information submitted to the government, such "deliberate ignorance" may constitute a violation of the Act.

What are the penalties for violations of the False Claims Act?

Persons who violate the False Claims Act can be liable for civil monetary penalties of not less than \$5,500 but no more than \$11,000, plus three times the government's damages with respect to each false claim, and the costs of the civil action (e.g., attorneys' fees, etc.). However, under new health care reform laws, certain types of violations can also carry a civil penalty of up to \$50,000 per claim. Additionally, the government may opt to include other civil and criminal laws in the suit which impose monetary penalties for submitting false claims.

What protection is there for a plaintiff who brings an action?

The False Claims Act provides protection to employees, agents, or contractors who are retaliated against by an employer because of the employee's, agent's or contractor's participation in a *qui tam* action. The protection is available to any employee, agent, or contractor who is fired, demoted, threatened, harassed, or otherwise discriminated against by his or her employer because the employee, agent, or contractor investigates, files, or participates in a *qui tam* action.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

California has a False Claims Act that is similar to the federal False Claims Act.

Section 20.4 Federal Laws Prohibiting False Claims under Medicare and Medicaid

Other federal laws include stern civil and criminal penalties against individuals and entities that participate in federal health care programs, including Medicare and Medicaid (as Medicaid is federally funded, in part), and who falsify claims. Civil penalties apply to any person or entity, knowingly presenting or causing to present a claim that is for a medical or other item or service:

1. That is part of a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided.
2. That the person knows or should know the claim is false or fraudulent.

3. That is presented for a physician's service by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service:
4. Was not licensed as a physician.
5. Was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing).
6. Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified.
7. Was furnished during a period in which the person was excluded from the program under which the claim was made.
8. Is for a pattern of medical or other items or services that a person knows or should know are not medically necessary.

This law states that any such person or entity shall be subject to a civil money penalty of not more than \$10,000 for each item or service plus not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a state agency because of such claim. (Refer to **42 U.S.C. §§ 1320a-7a.**)

The law also states that any person or entity is guilty of a felony, who:

- Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program.
- At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.
- Having knowledge of the occurrence of any event affecting (a) his/her initial or continued right to any such benefit or payment, or (b) the initial or continued right to any such benefit or payment of any other individual in whose behalf he/she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
- Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.
- Presents or causes to be presented a claim for a physician's service for which payment may be made under a federal health care program and knows that the individual who furnished the service was not licensed as a physician.

- For a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a state plan, if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

Any such person or entity convicted thereof shall be fined not more than \$25,000 or imprisoned for not more than five years or both. (Refer to **42 U.S.C. §§ 1320a-7b.**)

The law also allows for the exclusion of individuals and entities from participation in any federal health care program if they are convicted of fraud under federal or state law (a) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—(i) in connection with the delivery of a health care item or service, or (ii) with respect to any act or omission in a health care program operated by or financed in whole or in part by any federal, state, or local government agency; or (b) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any federal, state, or local government agency. (Refer to **42 U.S.C. § 1320-7.**)

Section 20.5 Annual Fraud Waste and Abuse (FWA) and General Compliance Awareness

Training Requirement

On an annual basis, all providers are required to take an acceptable FWA and general compliance training or administer their own “in-house” FWA and general compliance training program which shall include, but not be limited to, the topics listed below. All providers are required to submit an executed FWA and general compliance awareness attestation confirming their organization’s compliance with this requirement.

“In-house” FWA training shall include the following elements:

- Definitions of fraud and abuse
- Federal False Claims Act and State False Claims Act
- Anti-Kickback Statute/Stark Law
- HIPAA privacy and information security requirements
- Entities/individuals excluded from doing business with the federal government Office of Inspector General (OIG) exclusion lists
- Obligations of the provider and related entities to have appropriate policies and procedures to address fraud and abuse
- Process for reporting to SCFHP suspected fraud and abuse
- Protections for providers, vendors and employees who report suspected fraud and abuse
- “In-house” general compliance training shall include the following elements:

- The role of the Compliance Officer and/or the compliance committee
- Code of conduct
- Ethical principles governing your organization
- Examples of noncompliance that an employee might observe
- An overview of how to ask compliance questions, request compliance clarification or report suspected or detected noncompliance

Section 20.6 Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is the Health Insurance Portability & Accountability Act of 1996 (August 21, 1996), Public Law 104-191. Also known as the Kennedy-Kassebaum Act, the Act includes a section, Title II, entitled Administrative Simplification, requiring:

- Improved efficiency in health care delivery by standardizing electronic data interchange.
- Protection of confidentiality and security of health data through setting and enforcing standards.
- More specifically, HIPAA called upon the Department of Health and Human Services (DHHS) to publish rules that ensure:
 - Standardization of electronic patient health, administrative, and financial data.
 - Unique health identifiers for individuals, employers, health plans, and health care providers.
 - Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information (ePHI) the covered entity creates, receives, maintains, or transmits. It also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers and other electronic devices. The Security Rule is intended to be scalable; in other words, it does not require specific technologies to be used. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

Privacy Rule

The Privacy Rule is intended to protect the privacy of Protected Health Information (PHI) in the hands of covered entities, regardless of whether the information is or has been in electronic form. The Privacy Rule:

- Gives patients new rights to access their medical records, restrict access by others, request changes, and to learn how patient's health information has been accessed.
- Restricts most disclosures of Protected Health Information to the minimum needed for healthcare treatment, payment, and business operations.
- Provides that all patients are formally notified of covered entities' privacy practices.
- Enables patients to decide if they will authorize disclosure of their PHI for uses other than treatment or healthcare business operations.
- Establishes criminal and civil sanctions for improper use or disclosure of PHI.
- Establishes requirements for access to records by researchers and others.
- Requires that business associate agreements with business partners and vendors contain language that safeguards their use and disclosure of PHI.
- Implements a comprehensive compliance program, including:
 1. Conducting an assessment to determine gaps between existing information practices, policies, and HIPAA requirements.
 2. Reviewing functions and activities of the organization's business partners to determine where Business Associate Agreements are required.
 3. Developing and implementing enterprise-wide privacy policies and procedures to implement the regulations.
 4. Assigning a Privacy Officer who will administer the organizational privacy program and enforce compliance.
 5. Training all members of the workforce on HIPAA and organizational privacy policies.
 6. Updating systems to ensure they provide adequate protection of patient data.

The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH")

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) made a number of significant changes to HIPAA. Final regulations implementing much of HITECH were released in January 2013. The following are some of the changes impacting covered entities such as providers. Providers are encouraged to review HITECH and its implementing regulations to understand all possible impacts.

Breach Notification Rules

Prior to HITECH, the HIPAA Privacy Rule required that a provider only "mitigate" harmful effects known to the provider from an improper release of Protected Health Information

(PHI). HITECH has expanded what a provider must do in the event of the “breach” of the security or privacy of an individual’s PHI, requiring both the patient involved, and media outlets in certain cases, to be notified of the breach. HITECH also created requirements that apply directly to a provider’s business associates (BA) in the event of such a breach.

Covered entities, including providers, must demonstrate that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
- The unauthorized person who used the PHI or to whom the disclosure was made.
- Whether the PHI was actually acquired or viewed.
- The extent to which the risk to the PHI has been mitigated.

How do the Breach Notification Regulations Apply?

The Breach Notification Regulations only apply to “unsecured” PHI. For PHI to be secured, it must be rendered unusable, unreadable, or indecipherable to unauthorized persons.

PHI that does not meet these standards is “unsecured.” A use or disclosure of PHI that is not permitted under the Privacy Rule may trigger the notifications required under the Breach Notification Regulation.

What Must a Covered Entity or Business Associate do if a Breach Occurs?

The provider must provide written notification to the affected individuals within a sixty (60) calendar day period following the discovery of the breach. If a BA learns of a breach, it is required to notify the provider so that the provider can notify the individuals involved. The 60-day timeframe begins when the provider, in the exercise of reasonable diligence, should have known of the breach.

In addition to notifying affected individuals, the following items are important:

- If a breach affects more than 500 people, providers must inform the media about the breach.
- Providers are also required to provide notice to Department of Health and Human Services (DHHS), which will publicize the breach on its website.
- For breaches affecting less than 500 people, providers are required to keep an annual log of any breaches and notify DHHS within 60 days of the start of the next calendar year.

Business Associates Directly Regulated Under HIPAA

Business associates (BAs) have historically had to comply with certain HIPAA requirements solely as a result of their agreements with providers. If a BA breached its obligations, it would only be liable to the provider under that contract and it would not be

subject to direct oversight or penalties by DHHS. HITECH has increased the stakes for compliance for BAs.

As a result of this change, BAs are subject to a host of obligations:

- In addition to the breach notification obligations, they are directly subject to parts of the HIPAA Security Rule requiring the use of technical, physical and administrative safeguards to ensure the confidentiality of electronic PHI.
- BAs must understand the requirements of the Security Rule, what types of safeguards are acceptable and how the safeguards should be implemented.
- BAs must directly comply with a host of standards found in the Privacy Rule, including using and disclosing PHI only as permitted under the Privacy Rule.¹⁹¹
- Providers can be penalized directly by DHHS and other enforcement agencies.

Enhanced Enforcement Options and Increased Penalties for Noncompliance

HITECH significantly expanded options for HIPAA enforcement. For example, State Attorneys General have been empowered, since February 2009, to bring civil actions against persons who violate HIPAA if the Attorney General believes the violation threatens state residents. DHHS also conducts audits of providers and BAs to ensure their compliance with the Privacy and Security Rules.

In addition, HITECH:

- HITECH expanded regulators' ability to impose criminal penalties for violating HIPAA.
- HITECH imposed increased penalties. For example, while the maximum fine that could be imposed for identical violations in a one year period was \$25,000 under the previous rule, HITECH permits fines of up to \$1.5 million for identical violations within the same year. The enhanced civil penalties are linked to the Provider's level of culpability.
- HITECH eliminated certain defenses that could be raised in the past against HIPAA violations. No longer can parties avoid penalties by claiming that they did not have actual or constructive knowledge of the violation.

Together with the new obligations discussed above, these enhanced penalties have increased the risks of noncompliance.

Other Notable Points about HITECH

HITECH expanded the disclosures for which providers must maintain an accounting to include disclosures for treatment, payment and health care operations, if the disclosures for those purposes are made through an electronic health record.

Providers are required to agree to an individual's restriction on disclosures of their PHI to a health plan if the disclosure is for payment or health care operations purposes and it pertains solely to services for which the provider involved was paid in full out-of-pocket.

Significantly less leeway exists for providers to engage in marketing or fundraising activities.

Section 20.7 Audit and Maintenance of Record

You must have books and records including, but not limited to, financial, accounting, administrative and patient medical records and prescription drug files available to support any activity SCFHP. All parties are required to have their records available for a 10-year period after SCFHP terminates its contract with CMS/DHCS or the completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS). This allows CMS/DHCS to evaluate the quality, appropriateness and timeliness of services, the facilities used to deliver the services and other functions and transactions related to CMS/DHCS requirements. It applies to all parties in relation to service performed, reconciliation of benefit liabilities and determination of amounts payable.

Section 20.8 Confidentiality

All providers must ensure the confidentiality and accuracy of the medical records or other health and enrollment information of members and must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records or other health or membership information. The provider shall not sell, release, or otherwise disclose the name or address of any member to any third party for any purpose, including scientific study.

Practitioners and providers must maintain records in an accurate and timely manner and ensure timely access for members who wish to examine their records. Confidential patient information that is protected against disclosure by federal or state laws and regulations may only be released to authorized individuals.

Section 21 Quality Improvement (QI) Program

QI Program Goals

The goal of the QI program is to support, foster, and promote continuous quality improvement for the safety and satisfaction of care for all of our members and in organization-wide performance. Quality improvement activities are developed and maintained within the limits of the resources available to SCFHP and our participating providers.

Improvement processes are also developed to meet the requirements of state and federal agencies such as the California Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and standards, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), and the Quality Improvement System for Managed Care (QISMC). These goals are accomplished through the systematic monitoring and evaluation of the quality, safety appropriateness, outcomes, and satisfaction of the services provided to members and through the active pursuit of opportunities for improvement to the health care delivery system.

We strive to ensure that members:

- Have a choice of practitioners and providers.
- Are served with cultural sensitivity and linguistic competency.
- Receive necessary health education.
- Are assisted with and informed about using the health care system appropriately and effectively.
- We also require that all services from our staff and providers be made available to all members, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability—and that such services are provided in a culturally and linguistically appropriate manner.

For more information about our QI Program, see SCFHP's relevant policies at [**www.scfhp.com**](http://www.scfhp.com).

Structure of the QI Program

The QI Program operates under the direction of the Manager of Quality Improvement who works in close collaboration with the CMO/Medical Director, sub-committees reporting to the Chief Medical Officer, and other SCFHP staff as indicated. The SCFHP Governing Board and the Chief Executive Officer support all QI activities.

QI Committees and Sub-Committees

SCFHP's QI Committee is charged with overseeing the development, implementation, and effectiveness of the QI Program. The Committee is accountable to the SCFHP Governing Board.

Several committees assist with various aspects of improving the quality of our services and those of our network providers, including:

- Credentialing Committee
- Compliance Committee
- Grievance Review Committee
- Pharmacy & Therapeutics Committee
- Utilization Management Committee

In addition to the QI Committee and sub-committees, the **Provider Advisory Committee** and the **Consumer Advisory Committee** convene regularly to review and discuss QI activities. Recommendations related to QI activities are discussed with the CMO, and/or the CEO as applicable for appropriate follow up on specific activities. These committees ultimately report to the Governing Board.

Implementation and Coordination of the QI Program

Because quality is a critical company-wide goal, the resources and efforts of senior and other management staff—including the CEO, COO, Chief Medical Officer/Medical Director—are essential for optimal implementation of the QI Program. The teams that participate in the Quality Improvement Program include:

- Quality Improvement
- Utilization Management
- Pharmacy
- Provider Network Management
- Customer Service
- Claims
- Grievance and Appeals
- Health Education
- Culture and Linguistic Services
- Information Technology

Evaluation of the QI Program

To evaluate the effectiveness of our QI process, the QI Committee conducts an annual evaluation of all aspects of the program. The Committee reports its findings and recommendations for improvement to the Chief Medical Officer and CEO. The final report is sent to the Governing Board for ratification. A work plan is also developed each year and ratified by the Governing Board, after which the QI Department sends quarterly reports to both the Committee and the Governing Board.

Finally, the QI Director, in collaboration with the Chief Medical Officer/Medical Director, prepares an annual report of the entire QI Program for approval by the QI Committee and ratification by the Governing Board. The annual report summarizes all QI activities and identifies areas where improvement in quality and outcomes have been measured and documented. If any deficiencies are noted, they are reported to the QI Committee and the Governing Board, with suggestions for specific actions to improve the process in the subsequent year.

Quality Improvement Program Design (QIP)

The QIP is designed to include operational planning, internal and external quality control in the provider network, and quality improvement activities. QI activities related to provider performance are conducted in compliance with state and federal regulations. This medical QI process addresses the following components:

- Aspects of care and service
- Delegated review
- Focus studies
- Development of an action plan
- Establishment of thresholds
- Internal QI Program
- Credentialing/re-credentialing or peer review of contracted provider performance
- Potential quality of care issues
- Quality indicators
- Risk management
- Review of providers sites and medical records

We are obligated by both federal and state regulations to review all participating PCP sites and medical records to verify that sites have the capacity to provide clinical services effectively and safely.

Our Chief Medical Officer/Medical Director is ultimately responsible for all site review activities, and we do not delegate to any other entities the task of conducting reviews of facilities or medical records.

For further details on site and record reviews, refer to SCFHP's QI policies available at www.scfhp.com.

Medical Records Standards for the Provider's Office/Clinic

The medical record is an important source of patient data. It documents the health care provided to the patient by the providers. Therefore, it is important that the medical record be current, detailed and organized to promote effective continuity of patient care, promote efficient and effective treatment and facilitate quality review.

The following guidelines/standards for patient medical records are based upon SCFHP Physician and Medical Service Operating Manual/Quality Improvement Program, SCFHP's most current Adult and Pediatric Preventive Health Guidelines, the Department of Health Care Services Facility Site Review Criteria and from the National Committee for Quality Assurance (NCQA) Managed Care Organizations Standards for Medical Records.

1. All active medical records must be stored in a secured area that is accessible only to office staff who have direct patient care responsibilities.
2. Inactive records are stored for a minimum of 7 years and may be kept in a location off-site. Children's records must be saved until the child reaches 21 plus the statute of limitations or 24 years of age.
3. All records must be protected from loss, tampering, destruction, alteration, and unauthorized or inadvertent disclosure of information.
4. Clinical information cannot be released without prior written approval of the patient or parent/guardian. Exceptions to written approval and signed release of medical records information may be made if regulatory criteria for disclosure of information without authorization are met.

Medical Record Standards

1. Format Criteria
A. An individual medical record is established for each member. <ul style="list-style-type: none">• "Family charts" are not acceptable.
B. Member's Identification is on each page. <ul style="list-style-type: none">• Identification includes first and last name and/or a unique member number.
C. Individual personal biographical information documented. <ul style="list-style-type: none">• If member refuses, "Refusal" is noted in the medical record.• Includes date of birth, current address, home/work phone numbers, and name of parent(s) /legal guardian if member is a minor
D. Emergency Contact is identified.

<ul style="list-style-type: none"> • If a patient refuses, “Refusal” is noted in the medical record. • If an adult member has no contact, “None” is documented. • If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts.
E. Medical records are consistently organized.
F. Chart contents are securely fastened.
G. Printed chart contents are securely fastened, attached or bound to prevent medical record loss.
H. Electronic medical record information is readily available.
I. Member’s assigned primary care physician (PCP) identified <ul style="list-style-type: none"> • Assigned PCP is <i>always</i> identified.
J. Primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing-impaired persons are prominently noted. <ul style="list-style-type: none"> • Member refusal of interpreter services documented • Family or friends should not be used as interpreters, unless specifically requested by the member.
2. Documentation Criteria
A. Allergies are prominently noted. <ul style="list-style-type: none"> • In a consistent location in the medical record • If no known allergies or adverse reactions, “No Known Allergies” (NKA, NKDA), or Ø is documented.
B. Chronic problems and/or significant conditions are listed. <ul style="list-style-type: none"> • Encouraged to be on a separate “problem list” page
C. Current continuous medications listed <ul style="list-style-type: none"> • Encouraged to be on a separate “medication list” page and includes medication name, strength, dosage, route (if other than oral), and frequency • Discontinued medications are noted on the medication list or in progress notes.
D. Signed <i>Informed Consents</i> are present when any invasive procedure is performed <ul style="list-style-type: none"> • For medical treatment, operative, and invasive procedures, and for release of medical information • Human sterilization requires DHCS Consent Form PM 330.

<p>E. Advanced Health Care Directive information offered (Adults, 18 years/older Emancipated Minors)</p> <ul style="list-style-type: none"> • Document: Offered information and/or executed
<p>F. Entries are made in accordance with acceptable legal medical documentation standards</p> <ul style="list-style-type: none"> • All entries are signed, dated, and legible. • Signature includes the first initial, last name and title. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). • Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. • Electronic signatures are documented and protected.
<p>G. Errors are corrected according to legal medical documentation standards.</p> <ul style="list-style-type: none"> • There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. • The S.L.I.D. rule is one method used to correct documentation errors: Single Line, Initial, Date. (Omit the written word “error”). • Error corrections for EMR should include the log-in process and whether the EMR allows for corrections to be made after entries are made.
<p>3. Coordination/Continuity of Care Guidelines Criteria</p>
<p>A. History of present illness documented at each visit.</p>
<p>B. Working diagnoses are consistent with findings at each visit.</p>
<p>C. There is evidence of Health Plan and/or other agency Individual Care Plan for high risk members.</p>
<p>D. A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis.</p>
<p>E. Instructions for follow-up care documented</p>
<p>F. Return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed).</p>
<p>G. Unresolved and/or continuing problems addressed in subsequent visit(s)</p> <ul style="list-style-type: none"> • Until problems are resolved or a diagnosis is made. • Each problem need not be addressed at every visit.
<p>H. There is evidence of practitioner review of consult/referral reports and diagnostic test results.</p>

<ul style="list-style-type: none"> • Consultation reports and diagnostic test results are documented for ordered requests. • Evidence of review may include the physician's initials or signature on the report, notation in the progress notes, or other EMR- or site-specific method of documenting physician review. • Abnormal test results/diagnostic reports have explicit notation in the medical record. • Documentation includes member contact or contact attempts, follow-up treatment, instructions, return office visits, referrals, and/or other pertinent information.
<p>I. There is evidence of follow up of specialty referrals made and results/reports of diagnostic tests, when appropriate.</p> <ul style="list-style-type: none"> • Consultation reports and diagnostic test results documented for ordered requests • Abnormal test results have explicit notation in the medical records, including attempts to contact the member/guardian for follow-up treatment, etc. • Missed or broken appointments for diagnostic procedures, lab tests specialty appointments and/or other referrals are noted and include attempts to contact the member/parent and results to follow up actions.
<p>J. Missed primary care appointments and outreach efforts/follow-up contacts are documented.</p> <ul style="list-style-type: none"> • Documentation includes incidents of missed/broken appointments (cancellations or "No Shows" with the PCP office). Attempts to contact the member and/or parent/guardian (if minor) and the results of follow-up actions are also documented.

Preventive Health Guidelines

The following section outlines SCFHP's Preventive Health Guidelines for pediatric, adult and perinatal patients. These guidelines are adopted from the American Academy of Pediatrics (AAP), the United States Preventive Services Task Force (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG).

1. Pediatric Preventive Guidelines Criteria 0-21
<p>A. Childhood Immunizations</p> <ul style="list-style-type: none"> • Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on

<p>Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.</p> <ul style="list-style-type: none"> The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
<p>B. Blood Lead Screening</p> <ul style="list-style-type: none"> Blood lead level (BLL) testing done at 12 months and 24 months of age Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch – 408-992-4900. Children with confirmed BLL's >20µg/dl must be referred to CCS.
<p>C. Dental Assessment</p> <ul style="list-style-type: none"> Inspection of the mouth, teeth, and gums are performed at every health assessment visit. A child is referred to a dentist at any age if a problem is detected or suspected. Beginning at age 3 years, all children are referred annually to a dentist.
<p>D. Dental Caries Prevention</p> <ul style="list-style-type: none"> For infants and children up to age 5 years: <ul style="list-style-type: none"> Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
<p>E. Depression Screening</p> <ul style="list-style-type: none"> Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.
<p>F. Gonorrhea Prophylactic Medication</p> <ul style="list-style-type: none"> Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
<p>G. Hearing Screening</p> <ul style="list-style-type: none"> Non-audiometric screening for infants/children (2 months - 3 years) includes family and medical history, physical exam, and age-appropriate screening. Audiometric screening for children and young adults (3-21 years) is done at each health assessment visit.

<ul style="list-style-type: none"> • A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.
<p>H. Hemoglobinopathies Screening</p> <ul style="list-style-type: none"> • Screening for sickle cell disease in newborns.
<p>I. Hepatitis B Screening</p> <ul style="list-style-type: none"> • Screening for hepatitis B virus infection in persons at high risk for infection.
<p>J. HIV Screening</p> <ul style="list-style-type: none"> • Screening for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
<p>K. Hypothyroidism</p> <ul style="list-style-type: none"> • Screening for congenital hypothyroidism in newborns.
<p>L. Nutrition Assessment</p> <ul style="list-style-type: none"> • Screening includes 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). • At-risk children under 5 years of age referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program
<p>M. Obesity Screening</p> <ul style="list-style-type: none"> • Screening for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
<p>N. Phenylketonuria Screening</p> <ul style="list-style-type: none"> • Screening for phenylketonuria in newborns.
<p>O. Sexually Transmitted Infections Counseling</p> <ul style="list-style-type: none"> • Intensive behavioral counseling for all sexually active adolescents and adults who are at increased risk for sexually transmitted infections.
<p>P. Skin Cancer Behavioral Counseling</p> <ul style="list-style-type: none"> • Counseling children, adolescents and young adults ages 10 to 24 years who have fair skin, about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
<p>Q. Tobacco Use Interventions</p>

<ul style="list-style-type: none"> Interventions including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
<p>R. Tuberculosis Screening</p> <ul style="list-style-type: none"> All children screened for risk of exposure to tuberculosis (TB) at each health assessment visit. The Mantoux skin test, or other approved TB infection screening test, is administered to children identified at risk, if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. For all positive skin tests, there is documentation of follow-up care.
<p>S. Vision Screening</p> <ul style="list-style-type: none"> Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors.
<p>2. Adult Preventive Guidelines Criteria (18 yrs and older)</p>
<p>A. Abdominal Aortic Aneurysm</p> <ul style="list-style-type: none"> One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
<p>B. Adult Immunizations</p> <ul style="list-style-type: none"> Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member. Name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries. The date Vaccine Information Statement (VIS) given (or presented and offered) and the VIS publication date are documented in the medical record.
<p>C. Alcohol Misuse Screening and Treatment</p> <ul style="list-style-type: none"> Adults 18 years or older screened for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
<p>D. Aspirin Preventive Medication</p> <ul style="list-style-type: none"> Initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years with a >10% 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

<p>E. Blood Pressure (BP) Screening</p> <ul style="list-style-type: none"> • BP measurement documented in adults aged 18 years or older, including those without known hypertension, at least once every 2 years if BP <120/80, annually if BP 120-139/80-89 • Obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
<p>F. BRCA Risk Assessment and Genetic Counseling/Testing</p> <ul style="list-style-type: none"> • Screening women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of the several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). • Women with positive results should receive genetic counseling and, if indicated after counseling BRCA testing.
<p>G. Breast Cancer Preventive Medications</p> <ul style="list-style-type: none"> • Engaging in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk • For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
<p>H. Breast Cancer Screening</p> <ul style="list-style-type: none"> • A routine screening mammography with or without clinical breast examination completed every 1 to 2 years for women age 40 years and older.
<p>I. Cervical Cancer Screening</p> <ul style="list-style-type: none"> • Cervical cancer screening in women ages 21 to 65 years with cytology (Pap Smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
<p>J. Chlamydia Screening</p> <ul style="list-style-type: none"> • Screening for chlamydia in sexually active women age 24 years or younger • Screening for women older than 25 years of age if the practitioner determines that the patient is at increased risk for infection.
<p>K. Colorectal Cancer Screening</p> <ul style="list-style-type: none"> • All adults are screened from age 50-75 years to include: <ul style="list-style-type: none"> ▪ Annual screening with high-sensitivity fecal occult testing <u>OR</u> ▪ Sigmoidoscopy every 5 years with high sensitive fecal occult blood testing every 3 years <u>OR</u>

<ul style="list-style-type: none"> ▪ Screening colonoscopy every 10 years.
<p>L. Depression Screening</p> <ul style="list-style-type: none"> • Screening for depression in the general adult population, including pregnant and postpartum women. • Implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
<p>M. Diabetes Screening</p> <ul style="list-style-type: none"> • Screening for abnormal blood glucose as part of cardiovascular risk assessments in adults aged 40 to 70 years who are overweight or obese. • Offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
<p>N. Falls Prevention in Older Adults</p> <ul style="list-style-type: none"> • For community-dwelling adults age 65 years and older who are at increased risk for falls: <ul style="list-style-type: none"> ○ Exercise or physical therapy ○ Vitamin D supplementation
<p>O. Folic Acid Supplementation</p> <ul style="list-style-type: none"> • All women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg of folic acid.
<p>P. Gonorrhea Screening</p> <ul style="list-style-type: none"> • Screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
<p>Q. Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease</p> <ul style="list-style-type: none"> • Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
<p>R. Hepatitis B Screening</p> <ul style="list-style-type: none"> • Screening for hepatitis B virus infection in non-pregnant adolescents and adults in persons at high risk for infection.
<p>S. Hepatitis C Screening</p> <ul style="list-style-type: none"> • Screening for hepatitis C virus (HCV) infection in persons at high risk for infection. • One-time screening for HCV infection to adults born between 1945 and 1965

<p>T. HIV Screening</p> <ul style="list-style-type: none"> • Screening for HIV infection in adolescents and adults ages 15 to 65 years. • Screening for younger adolescents and older adults who are at increased risk for infection.
<p>U. Intimate Partner Violence Screening</p> <ul style="list-style-type: none"> • For women who do not have signs or symptoms of abuse: <ul style="list-style-type: none"> ○ Screening for women of childbearing age for intimate partner violence, such as domestic violence. ○ Provider or refer women who screen positive to intervention services
<p>V. Lung Cancer Screening</p> <ul style="list-style-type: none"> • Annual screening for lung cancer with low-dose tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
<p>W. Obesity Screening and Counseling</p> <ul style="list-style-type: none"> • Screening for all adults for obesity • Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.
<p>X. Osteoporosis Screening</p> <ul style="list-style-type: none"> • Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 54-year-old white woman who has no additional risk factors.
<p>Y. Sexually Transmitted Infections Counseling</p> <ul style="list-style-type: none"> • Intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
<p>Z. Skin Cancer Behavioral Counseling</p> <ul style="list-style-type: none"> • Counseling children, adolescents and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
<p>AA. Statin Preventive Medication</p> <ul style="list-style-type: none"> • Adults with no history of cardiovascular disease (CVD) (i.e. symptomatic coronary artery disease or ischemic stroke) use a low-to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met:

	<ul style="list-style-type: none"> i. Ages 40 to 75 years ii. Have 1 or more CVD risk factors iii. Have a calculated 10-year risk of a cardiovascular event of 10% or greater <ul style="list-style-type: none"> • Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years. •
BB.	<p>Tobacco Use Counseling and Interventions</p> <ul style="list-style-type: none"> • Ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.
CC.	<p>Syphilis Screening</p> <ul style="list-style-type: none"> • Screening for syphilis infection in persons who are at increased risk for infection.
DD.	<p>Tuberculosis Screening</p> <ul style="list-style-type: none"> • Screening for latent tuberculosis infection in populations at increased risk.
3. Perinatal Preventive Guidelines Criteria	
A.	<p>AFP/Genetic Screening offered (<i>Member participation is voluntary</i>)</p> <ul style="list-style-type: none"> • The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period documented • Testing only through CDPH designated labs through CDPH Expanded AFP Program • Genetic Screening documentation includes: <ul style="list-style-type: none"> ▪ Family history ▪ Triple marker screening tests ▪ Member's consent or refusal to participate
B.	<p>Bacteriuria Screening</p> <ul style="list-style-type: none"> • Screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
C.	<p>Breastfeeding Interventions</p> <ul style="list-style-type: none"> • Interventions during pregnancy and after birth to support breastfeeding.
D.	<p>Depression Screening</p> <ul style="list-style-type: none"> • Screening for depression in pregnant and postpartum women.

<ul style="list-style-type: none"> Implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
<p>E. Family Planning Evaluation</p> <ul style="list-style-type: none"> Family Planning counseling, referral, or provision of services documented
<p>F. Folic Acid Supplementation</p> <ul style="list-style-type: none"> All women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg of folic acid.
<p>G. Gestational Diabetes Mellitus Screening</p> <ul style="list-style-type: none"> Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
<p>H. Hepatitis B Screening</p> <ul style="list-style-type: none"> Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
<p>I. HIV Screening</p> <ul style="list-style-type: none"> Screening all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
<p>J. HIV-related services offered (<i>Member participation is voluntary</i>)</p> <ul style="list-style-type: none"> The offering of prenatal HIV information, counseling, and HIV antibody testing documented unless a positive HIV test already documented or AIDS diagnosed by a physician Providers are not required to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. If documented, must be in accordance with confidentiality and informed consent regulations.
<p>K. Referral to WIC and assessment of Infant Feeding status</p> <ul style="list-style-type: none"> All plan members referred to WIC and documented in the medical record. Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period.
<p>L. Intimate Partner Violence Screening</p> <ul style="list-style-type: none"> For women who do not have signs or symptoms of abuse: <ul style="list-style-type: none"> Screening for women of childbearing age for intimate partner violence, such as domestic violence. Provide or refer women who screen positive to intervention services.

<p>M. Preeclampsia Prevention</p> <ul style="list-style-type: none"> • Use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
<p>N. Preeclampsia Screening</p> <ul style="list-style-type: none"> • Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
<p>O. Postpartum Comprehensive Assessment</p> <ul style="list-style-type: none"> • Postpartum reassessment includes: <ul style="list-style-type: none"> ▪ Medical exams ▪ Nutrition (mother and infant) ▪ Psychosocial ▪ Health education within 4-8 weeks postpartum • Document missed appointments; attempts to contact patient and/or outreach activities •
<p>P. Rh Incompatibility Screening</p> <ul style="list-style-type: none"> • Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. • Repeated Rh (D) antibody testing for all unsensitized Rh(d)-negative women at 24 to 28 weeks' gestation unless the biological father is known to be Rh (D)-negative.
<p>Q. Syphilis Screening</p> <ul style="list-style-type: none"> • Screening all pregnant women for syphilis infection.
<p>R. Tobacco Use Counseling</p> <ul style="list-style-type: none"> • Asking all pregnant women about tobacco use. • Advising them to stop using tobacco • Providing behavioral interventions for cessation to pregnant women who use tobacco.

Health Assessments

Health assessments are a core requirement of the Cal MediConnect program. This includes an Initial Health Assessment, Staying Healthy Assessments and Periodic Assessments. The following information outlines the expectations regarding completion of the assessments for Pediatric, Adult and Perinatal members. Primary Care Providers, Perinatal Care Providers and Non-Physician, Mid-Level Practitioners can provide these assessments. Completion of the assessments are to be contained in the member's primary medical record and completed in an accurate and comprehensive manner. Initial Health Assessments are to be completed within 120 calendar days of enrollment.

1. Pediatric Health Assessments

A. Initial Health Assessment (IHA) includes H&P

- Completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems.
- If IHA is not present, the member refusal, missed appointments and contact attempts to reschedule are documented in the medical record

B. Staying Healthy Assessment (SHA) (Initial and Subsequent)

- If the member refuses to complete SHA, the refusal is documented on the SHA form.
- An age-appropriate SHA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial SHA.
- Age-appropriate physical exams according to most recent AAP schedule. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. AAP scheduled assessment must include all components required by the Child Health and Disability Program (CHDP) for the lower age nearest to the current age of the child including:
 - Height and weight are documented at each well child exam, including head circumference for infants up to 24 months.
 - BMI percentile is plotted on an appropriate CDC growth chart for each well exam ages 2-20 years.
 - Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral.
 - Anticipatory guidance includes age appropriate counseling/health education provided to parent or pediatric member.
 - Tobacco and Drug/Alcohol Habit assessment
 - Evidence of referrals to the Early Start programs
 - Evidence of communication and acknowledgement of HP and SARC on Early Start referrals/follow-up
 - STI screening on all sexually active adolescents including chlamydia for females

2. Adult Health Assessments

A. Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)

<ul style="list-style-type: none"> • New members: The IHA consists of an H&P and a SHA completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. • The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. • If an H&P and/or initial SHA is not present, member's refusal, missed appointments or other reason must be documented.
<p>B. Subsequent Staying Healthy Assessment (SHA)</p> <ul style="list-style-type: none"> • An age-appropriate SHA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial SHA.
<p>C. Periodic Health Evaluation</p> <ul style="list-style-type: none"> • In accordance with current USPSTF Adult Preventive Health recommendations • Additional periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner.
<h3>3. Perinatal Health Assessments</h3>
<p>A. Initial Comprehensive Assessment (ICA)</p> <ul style="list-style-type: none"> • The ICA, completed within 4 weeks of entry to prenatal care, includes the following obstetric/medical assessments: <ul style="list-style-type: none"> ○ Health and obstetrical history (past/current) ○ Physical exam: includes breast and pelvic exam ○ Lab Tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen ○ Nutrition Counseling Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation ○ Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources ○ Health Education: Language and education needs ○ Screening for Hepatitis B Virus during their first trimester or prenatal visit, whichever comes first. ○ Screening for Chlamydial Infection: All pregnant women ages 25 and younger and older pregnant women who are at increased risk are screen for Chlamydia during their first prenatal visit
<p>B. Second Trimester Comprehensive Re-Assessments</p> <ul style="list-style-type: none"> • Obstetric/Medical, Nutrition, Psychosocial and Health Education assessments are completed during the 2nd trimester. • Conduct screening for asymptomatic bacteriuria with urine culture at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

<p>C. Third Trimester Comprehensive Re-assessment</p> <ul style="list-style-type: none"> • Obstetric/Medical, Nutritional, Psychosocial and Health education reassessments are completed during the 3rd trimester. • Screening for Strep B between 35th and 37th week of pregnancy
<p>D. Prenatal care visit periodicity according to most recent ACOG standards</p> <ul style="list-style-type: none"> • For a 40-week uncomplicated pregnancy: Document missed appointments, attempts to contact patient, and/or outreach activities
<p>E. Individualized Care Plan (ICP)</p> <ul style="list-style-type: none"> • ICP documentation includes specific obstetric, nutrition, psychosocial and health education, risk problems/conditions, interventions, and referrals.

Alcohol Misuse Screening and Counseling (AMSC)

As part of the comprehensive preventive care program, effective with dates of service on or after January 1, 2014, SCFHP reimburses PCPs for annual alcohol misuse screening of adults over 18 years of age and provides persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or provide appropriate referrals to behavioral health and/or alcohol use disorder services as medically necessary

The requirements for AMSC are outlined in **DHCS MMCD All Plan Letter 17-016**. Members who meet criteria for an alcohol use disorder must receive referrals to treatment by either the County or a DHCS-certified treatment program.

The DHCS AMSC website has background information and multiple resources such as training, screening tools, and other helpful links pertaining to AMSC.

Adopted Clinical and Preventative Guidelines

Santa Clara Family Health Plan uses clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances. These clinical practice guidelines are also used in related programs such as disease and population management.

Practice guidelines are developed from scientific evidence or a consensus of health care professionals in the particular field.

Practice guidelines are reviewed and updated at least every two years and more frequently when updates are released by the issuing entity. Santa Clara Family Health Plan monitors compliance and member outcomes related these clinical guidelines for quality improvement initiatives.

These clinical practice guidelines are intended to assist providers in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances.

The guidelines are not intended to replace clinical judgment but are provided to assist our practitioners with making decisions about a range of clinical conditions. The treating practitioner should make the ultimate decision in determining the appropriate treatment for each patient.

These guidelines are available on the web site under clinical guidelines in the provider resources section. www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx.

Section 22 Provider Preventable Conditions

The Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) require providers to report provider-preventable conditions (PPCs). Federal law prohibits Santa Clara Family Health Plan (SCFHP) from paying for the treatment of PPCs, and payment adjustments may be applied to involved claims. Furthermore, SCFHP must review all claim and encounter data to identify submitted PPCs and report them to the Audits and Investigation Division of DHCS.

There are two categories of PPCs: other provider preventable conditions (OPPCs) occurring in all health care settings and health care acquired conditions (HCACs) in inpatient acute care hospital settings only.

For any SCFHP member, providers must report the occurrence of PPCs that did not exist prior to the provider initiating treatment. Additional DHCS reporting information can be found here: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.

All contracted providers are required to report directly to SCFHP the occurrence of OPPCs and HCACs for any SCFHP member. Providers must complete **DHCS form 7107, PPC Reporting Form** and send it to SCFHP, Attn: Quality Improvement Manager via secure fax at **1-408-874-1461**. The form must be completed within 5 days of discovering the event and confirming the patient is a Medi-Cal beneficiary through SCFHP. The form is to be completed only for a PPC that occurred during the course of treatment, not for those PPCs that were already present when treatment began. The PPC form includes detailed instructions and is located at: http://files.medi-cal.ca.gov/pubsdoco/Forms/dhcs_7107.pdf.

All claims/encounters submitted to SCFHP for treatment of PPCs should also be identified on the claim/encounter form or file. Submitting PPCs on a claim or encounter form or file does not waive the requirement to submit **PPC Reporting Form 7107** to SCFHP. HCACs must utilize diagnosis codes and in some cases, procedure codes, to indicate any corresponding complication (CC) or major complication or co-morbidity (MCC) related to the PPC.

For OPPCs, one of the following modifiers is required:

1. PA: Surgery wrong body part
2. PB: Surgery wrong patient
3. PC: Wrong surgery on patient

Please refer any questions on this mandated reporting to SCFHP Provider Network Management Department at **1-408-874-1788**.

Section 23 Facility Site Review

SCFHP conducts facility site reviews (FSRs) for new PCPs at the time of initial credentialing, and every three years thereafter as part of the re-credentialing process, regardless of the status of other accreditation and/or certifications.

There are three components to the FSR process:

1. The site review survey
2. The medical record review survey
3. The physical accessibility review survey

The site review survey and medical record review survey are scored reviews. The site review survey reviews the physical aspects of the site for basic requirements in areas such as: safety, regulatory compliance, and infection control. The medical record review survey is conducted three to six months after initial member linkage, and as part of re-credentialing along with the site review survey, and focuses entirely on medical record review. The physical accessibility review survey is not a scored review, and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs). This review is not scored and is used for informational purpose only.

For more information on facility site reviews, please see SCFHP's site review policies available at **www.scfhp.com**.

Section 24 Credentialing and Recredentialing

Participation Requirements

Provider must complete, sign, and return a credentialing application along with a copy of their Tax Payer Identification Form (W-9) and current copies of all the information below, as applicable:

- Copy of current medical license or business license
- Copy of current DEA license
- Copy of professional liability insurance (malpractice) face sheet (required limits are \$1,000,000 per occurrence/\$3,000,000 annual aggregate)
- Copy of Property Comprehensive General Liability Insurance (Premises) face sheet (required limits are \$100,000 per occurrence/\$300,000 annual aggregate)
- Completed and signed attestation questionnaire
- Signed Release of Information/Acknowledgments Form
- Curriculum Vitae
- Copy of current Clinical Laboratory Improvement Amendments (CLIA) or Waiver (if applicable)
- Copy of current Child Health and Disability Prevention (CHDP) Certificate (if applicable)
- Copy of current Comprehensive Perinatal Services Program (CPSP) Certificate (if applicable)
- Copy of Educational Council of Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- Copy of current board certification from the American Board of Medical Specialties or American Board of Podiatric Surgery (if applicable)

Once SCFHP receives the required information, the credentialing process proceeds as follows:

1. The plan verifies the information provided (National Provider Identifier, license status, etc.).
2. The application and supporting documentation are reviewed by SCFHP's Credentialing Verification Organization (CVO), Contracting and Credentialing Analyst, Contracting and Credentialing Manager, Chief Medical Officer, Medical Director and Credentialing Committee.
3. Upon approval of the above-mentioned parties, the Contracting Department generates a contract. The contract and welcome letter are sent to the provider within sixty days of the committee's decision.

4. The contract effective date shall be the first of the month following countersignature by SCFHP's Chief Executive Officer, if signed between the 1st and the 20th of the month. If the contract is signed after the 20th then the effective date shall be the first of the next month.
5. A copy of the completed contract is then returned to the provider. A new provider orientation and training must be scheduled within 10 days of the effective date of the contract.
6. Primary care providers must also have a facility site review, conducted by a certified SCFHP Quality Improvement Nurse, before the credentialing process is finalized.
7. Provider is re-credentialed every three years, based on the date of the initial Credentialing Committee approval date.

Provider Directories

Provider consents to SCFHP using the following information in rosters and other marketing materials that SCFHP may publish to ensure compliance with laws and regulations of provider directories and on-line web searches: name, National Provider Identification number, California license number and type of license, admitting privileges, if any, at hospitals and ambulatory surgery centers contracted with SCFHP, network tier to which the provider is assigned, if any, office email address, practice location(s), phone number, office hours, language skills, type of practice, willingness to accept patients, Board Certified status, availability of handicapped access, and availability of public transit to provider's office(s).

Providers shall notify SCFHP within five (5) business days of making any changes to Provider's willingness to accept new patients or any changes to demographic information.

Provider shall advise enrollees and potential enrollees that they may report potential directory inaccuracies to SCFHP and the Department of Managed Health Care.

Provider Rights

Communications

SCFHP accepts requests for information related to credentialing or recredentialing via phone (408) 376-2000; fax (408) 376-3537; email credentialing@scfhp.com; or mail.

Right to Review

Providers have the right to review information obtained by SCFHP for the purpose of evaluating their credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to the review of information contained in references, recommendations, peer-review information or other sources that are protected by law from disclosure.

Providers may request to review such information at any time by sending a written request to SCFHP's Credentialing Department. The Credentialing Department will respond to the provider within 5 business days, notifying them of the date and time when such information will be made available for review at SCFHP's office.

Right to Notification of Discrepancies & to Correct Erroneous Information

SCFHP will promptly notify a provider when information obtained by primary sources varies substantially from information provided on the provider's application or when SCFHP or its CVO has difficulty obtaining information needed to complete credentialing.

If a provider believes that erroneous information has been supplied to SCFHP by primary sources, the provider may correct such information by submitting written notification to the Credentialing Department.

1. Providers must submit a written notice, along with a detailed explanation to the Credentialing Department within two (2) business days of SCFHP's notification to the provider of a discrepancy or within one (1) business day of a provider's review of his/her credentials file.
2. Upon receipt of notification from the provider, SCFHP will re-verify the primary source information in dispute. If the primary source information has changed, corrections will be made immediately to the credentials file.
3. The provider will be notified in writing that the correction has been made to his/her credentials file.

If, upon review, the primary source information remains inconsistent with the provider's notification, the Credentialing Department will so notify the provider via certified letter.

The provider may then provide proof of correction by the primary source body to SCFHP's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Providers may inquire about the status of their credentialing/recredentialing application by sending a written request by letter to SCFHP's Credentialing Department.

The provider will be notified in writing by fax, email or letter no more than seven (7) business days. SCFHP will provide information pertaining to:

- The status of the credentialing/recredentialing application
- Information regarding discrepancies or missing information
- Whether the credentials file is ready for the next credentialing committee meeting

The date of the credentialing committee when the credentials file will be presented to the committee.

Contractual Requirements for Credentialing and Regulatory Compliance

By signing your contract you agree that you, and any providers working for you, are and will continue to be properly licensed by the State of California. Additionally, you represent that you are qualified and in good standing in terms of all applicable legal, professional, and regulatory standards. Providers who are excluded from participation in Medi-Cal or Medicare programs by the U.S. Department of Health and Human Services may not contract with SCFHP to provide services under the Cal MediConnect program.

If you fail to meet the credentialing standards or, if your license, certification, or privileges are revoked, suspended, expired, or not renewed, SCFHP must ensure that you do not provide any services to our enrollees. Any conduct that could adversely affect the health or welfare of an enrollee will result in written notification that you are not to provide services to our enrollees until the matter is resolved to our satisfaction.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

Your contract references this certification in Section 7 of the Agreement. SCFHP qualifies as a contractor receiving funding from the federal government. Any such contractor is required to represent to the government that they and their subcontractors have not been debarred, suspended, or made ineligible. By completing and signing the attestation questionnaire and the Release of Information/Acknowledgements Form of the California Participating Physician Application, you certify that you are eligible to participate in our program and receive funds provided by the government. This form must be signed and returned with your agreement. Pursuant to this certification and your agreement with SCFHP, should you or any provider with whom you hold a sub-contract become suspended or ineligible, you shall notify SCFHP immediately.

General Responsibilities

Providers must:

- Render medically necessary services in accordance with the provider's scope of practice, the SCFHP contract, the applicable benefit plan, SCFHP's policies and procedures, and other requirements set forth in the Provider Manual.
- Provider shall also openly discuss treatment options, risks and benefits with enrollees without regard to coverage issues.
- Participate in all programs in which the provider is qualified and has been requested to participate.
- Not unfairly differentiate or discriminate in the treatment of enrollees or in the quality of services delivered to enrollees on the basis of membership in SCFHP, age, national origin, sex, sexual preference, race, color, creed, marital status, religion, health status, source of payment, economic status, or disability.
- Cooperate with SCFHP's enrollee grievance and appeals procedures. Provider will provide grievance, dispute, and appeal information as required by the Centers for Medicare and Medicaid Services, the California Department of Health Care Services and other appropriate regulatory agencies.

- Maintain standards for documentation of medical records and confidentiality for medical records. Medical information shall be provided to SCFHP, as appropriate, and without violation of pertinent state and federal laws regarding the confidentiality of medical records. Such information shall be provided without cost to SCFHP.
- Actively participate in and comply with all aspects of SCFHP's quality improvement programs and protocols.
- Understand and acknowledge that various governmental agencies with appropriate jurisdictions have the right to monitor, audit, and inspect reports, quality, appropriateness and timeliness of services provided under your contract with SCFHP.
- Comply fully and abide by all rules, policies, and procedures that SCFHP has established regarding credentialing of network providers.
- Remain responsible for ensuring that services provided to enrollees by provider and its personnel comply with all applicable federal, state and local laws, rules and regulations, including requirements for continuation of medical care and treatment of enrollees after any termination or other expiration of provider's SCFHP agreement. Nothing contained herein shall be construed to place any limitations upon the responsibilities of the provider and its personnel under applicable laws with respect to the medical care and treatment of patients or as modifying the traditional physician/patient relationship.
- Not advise or counsel any subscriber group or enrollee to disenroll from SCFHP and will not directly or indirectly solicit any enrollee to enroll in any other health plan, PPO, or other health care or insurance plan.
- Permit representatives of SCFHP, including utilization review, quality improvement, and provider network management staff, upon reasonable notice, to inspect provider's premises and equipment during regular working hours.
- Immediately notify SCFHP of any malpractice claims involving any current or former enrollees to whom provider is a party as well as provide information specifying settlement of adjudication within fourteen (14) calendar days of the provider being notified of such action.
- Comply with all applicable local, state, and federal laws governing the provision of medical services to enrollees.
- Uphold all applicable enrollee rights and responsibilities as outlined in the Member Handbook and the Provider Manual.
- Provide for timely transfer of enrollee clinical records if an enrollee selects a new primary care physician, or if the provider's participation in the SCFHP network terminates.
- Respond to surveys to assess provider satisfaction with SCFHP and identify opportunities for improvement.

- Participate on a Quality Improvement Committee, or act as a consultant in peer review processes, as requested.
- Cooperate with SCFHP Quality Improvement activities, and allow SCFHP to use provider's performance data for quality improvement activities.
- Notify SCFHP in advance of any change in office address, telephone number, or office hours.
- Notify SCFHP at least ninety (90) calendar days in advance, in writing, of any decision to terminate their relationship with SCFHP or with the participating provider group. SCFHP will assist in notifying affected enrollees of termination and will assist in arranging coordination of care needs.
- Retain all medical records for a minimum of ten (10) years from the last contracting period or last audit, whichever is latest.
- Maintain appointment availability in accordance with SCFHP standards.
- Agree that in no event including, but not limited to, nonpayment by SCFHP, insolvency of SCFHP, or breach of provider's agreement, shall provider or its personnel bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have recourse against a enrollee or persons (other than SCFHP) acting on the enrollee's behalf. This provision shall not prohibit provider from collecting from enrollees for co-payments, or coinsurance or fees for non-covered services delivered on a fee-for-service basis to enrollees, provided that enrollee has agreed prospectively in writing to assume financial responsibility for the non-covered services.

General Considerations

Provider selection is based on the availability of providers meeting minimum criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act, and availability of culturally and linguistically competent staff to meet the needs of the enrollee population.

In the event that a participating physician is not available with the skills required to meet an enrollee's needs, the plan will authorize a non-participating provider at no additional out of pocket expense to the enrollee.

Section 25 Provider Training, Education, and Resources

Providers are required to participate in Santa Clara Family Health Plan (SCFHP)'s provider education and training efforts.

The following training courses are offered on SCFHP's website.

- Long-Term Supportive Services (LTSS)
- Stay Healthy Assessment (SHA)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Model of Care
- Cultural Competency which includes:
 - Communication across Language Barriers
 - Communication with Seniors and with People with Disabilities
 - Increasing Awareness of Cultural Diversity

We also offer a variety of services to help providers effectively coordinate and manage each member's care, including the following:

- **Continuing Medical Education (CME) courses:** SCFHP notifies providers of accredited continuing medical education classes applicable to our population, including CME courses in cultural and linguistic competency.
- **Interpreter services:** We contract with an interpreter services company to provide telephone interpreting services at no charge to providers or members. We will also help to arrange on-site, face-to-face interpreter services. See Section 5.1 Language Interpretation Services for details.
- **Orientation field calls for new providers:** Our Provider Network Management staff conducts orientation and training with all newly contracted providers. In addition, providers may request orientation field calls for newly hired staff.
- **Telephone network support services:** You may call us at **1-408-874-1788**—a dedicated provider telephone line—for assistance with policies, procedures, clarification of covered benefits, and/or complaints, or to schedule a training session at your office. If our staff is not able to address a specific issue, we will forward your call to the correct staff member, or we will research your question and call you back.
- **Training for PCPs and specialists:** The Provider Network Management Department schedules visits to your office to integrate plan policies and procedures, assist with any problems or concerns you or your staff have, and listen to feedback about your satisfaction with participation in SCFHP health plans.
- **Information available on SCFHP website:** The policies, procedures, forms and documents referenced in this handbook can be found at **www.scfhp.com/for-**

providers. This page is the hub of information for providers, including the latest memos, regulatory updates, and training opportunities.

