Santa Clara Family Health Plan™

PROVIDER MANUAL 2025

Medi-Cal Plan & DualConnect Plan (HMO D-SNP)
A Medicare Medi-Cal Plan

For more recent information or other questions, contact
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Provider Manual

Section 1: Introduction

About Santa Clara Family Health Plan

Welcome to the Santa Clara Family Health Plan (SCFHP) network of providers.

SCFHP is a local, community-based health plan dedicated to creating opportunities for better health and wellness for all. In partnership with providers and community organizations since 1997, we work to ensure everyone in Santa Clara County has access to equitable, high-quality health care. With a strong commitment to integrity, outstanding service, and support for our community, we serve nearly 300,000 people through our Medi-Cal health care plan and SCFHP DualConnect (HMO D-SNP) (SCFHP DualConnect), our Dual Eligible Special Needs Plan (D-SNP).

Our provider network is a critical component in serving our mission. Our goal with this manual is to offer providers a variety of tools to reduce the administrative burdens assumed with serving the best care to SCFHP members.

This manual is for providers contracted directly with our Medi-Cal and SCFHP DualConnect lines of business. This manual is available online at http://www.scfhp.com/provider-training. Providers may view, download, and print the most recent version of the provider manual available. We want this manual to be a useful guide to providers and staff. Please connect with SCFHP Provider Network Operations at ProviderServices@scfhp.com if you have any questions, need assistance, or have any suggestions for making this manual better.

Our mission

SCFHP's mission is to improve the well-being of our members by addressing their health and social needs in a culturally competent manner and partnering with providers and organizations in our shared commitment to the health of our community.

Our vision

Health for all – a fair and just community where everyone has access to opportunities to be healthy.

Disclaimer

The information provided in this manual is intended to be informative and assist providers participating in SCFHP Medi-Cal and SCFHP DualConnect. Unless otherwise specified in the Provider Contract, the information contained in this manual is not binding upon SCFHP and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Contract between the provider or the provider's contracting organization and SCFHP, the Provider Contract shall govern.

Should this Provider Manual be revised, SCFHP will make reasonable efforts to notify contracted providers of these changes through provider memos, provider newsletters and other provider communication. Information contained in this manual version published September 12, 2024 supersedes all preceding versions.

This manual is not intended to be a complete statement of all SCFHP policies or procedures. Other policies and procedures not included in this manual may be posted at www.scfhp.com, maintained offline in SCFHP policy and procedure systems, or published in targeted communications. These targeted communications include, but are not limited to letters, memos, and newsletters.

There may be instances in this manual provided as a sample or example. This information is illustrative and not intended to be used or relied upon in any circumstance or instance.

This manual does not contain legal, tax, or medical advice. Please consult other advisors for such advice.

How to Read the Manual

This manual contains important information on SCFHP's **Medi-Cal** and **SCFHP DualConnect** lines of business. While much between the two is the same, differences between the Medi-Cal and SCFHP DualConnect products will be clearly identified. Whether you are contracted to see our Medi-Cal or SCFHP DualConnect members, this manual will cover many of the relevant parts for both lines of business.

This is an electronic manual that includes hyperlinks directing you to external resources, corresponding sections within the manual, and email addresses to follow up with us if you have questions. Please contact us at ProviderServices@scfhp.com if there is anything wrong or if you would like to suggest future changes to help us make this manual better.

Section 2: Plan Administration

Governing Board and Committees

The Santa Clara County Health Authority is an independent public agency that governs Santa Clara Family Health Plan (SCFHP). Appointed by the County Board of Supervisors, the 10-member Governing Board seeks to improve access to quality healthcare, maintain and preserve a healthcare safety net for Santa Clara County, and ensure the fiscal integrity of SCFHP. The Governing Board has duties, powers, and responsibilities authorized under the Welfare and Institutions Code section 14087.38 and Ordinance NS-300.576. Complementary to the Governing Board is an array of committees, each of which are subject to the provisions of the Ralph M. Brown Act. The following represents a list of these advisory and standing committees that support the Governing Board along with a brief description of the role and responsibilities for each.

SCFHP Governing Board Committees

- **Executive and Finance Committee**: Responsible for developing and reviewing SCFHP's fiscal policy and financial performance for the Governing Board.

Advisory & Standing Committees

- **Quality Improvement Committee & Health Equity (QIC):** Oversee SCFHP's Quality Improvement and Health Equity Program, which is an organization-wide commitment to utilize a systematic approach to quality, using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including individuals with special needs.
- **Utilization Management Committee**: Consists of healthcare professionals that develop criteria for determining medical necessity, delegation, and utilization activities.
- **Compliance Committee**: Responsible for monitoring organizational performance to ensure compliance with internal and external laws, rules, and regulations.
- **Credentialing Committee**: Oversees the credentialing of and practice patterns for all practitioners and providers.
- **Provider Advisory Council (PAC)**: Comprised 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.
- **Pharmacy & Therapeutics Committee**: Composed of actively participating physicians, pharmacists, and other health care professionals and staff who serve in an evaluative, educational, and advisory capacity to SCFHP in all matters that pertain to the use of pharmaceuticals.

- **Consumer Advisory Committee (Medi-Cal)**: A group of community advocates, traditional and safety-net providers, and SCFHP Medi-Cal members, their parents, or guardians who help SCFHP and the Governing Board establish and maintain links to the community to better serve their cultural and linguistic needs.
- **Consumer Advisory Board (SCFHP DualConnect)**: The SCFHP DualConnect Consumer Advisory Board (CAB) engages consumers and caregivers in Santa Clara County in the implementation and evaluation of operations and policies of the SCFHP DualConnect.

Business Units of Santa Clara Family Health Plan

Santa Clara Family Health Plan is run by a cross-functional array of business units, each of which whose function is summarized below.

- **Behavioral Health**: Maintains collaborative relationships with behavioral health providers who provide services to SCFHP members.
- **Case Management**: Leads collaboration and coordination of care for SCFHP members.
- **Claims**: Responsible for adjudicating all claims and responding to provider requests related to claims.
- **Community Based Programs**: Identify and address social drivers of health (SDOH) through engagement with community based providers and offer a set of services and supports that members need and want across the continuum
- **Community Engagement:** The Community Engagement (CE) Department connects and engages with health plan members and visitors to advance their health and well-being.
- **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.
- **Contracting**: Develops, negotiates, and executes provider contracts while analyzing data on the financial impact of contract proposals.
- **Credentialing**: Oversees credentialing and re-credentialing of SCFHP's contracted providers.
- **Customer Service**: Public-facing team that interacts with providers and members alike to triage and provide assistance for identified questions and issues.
- **Enrollment & Eligibility**: Manages enrollment and eligibility processes of SCFHP members for SCFHP Direct and delegated networks.
- **Executive Office**: Organizational leadership providing strategic direction of the health plan including but not exclusive to financial, legal, operational, and public relations arms.

- **Finance**: Facilitates the processing of non-claims payments, assists with check status or reissuance, issues 1099s to providers, and administers Risk Adjustment activities and education.
- **Grievance and Appeals**: Provides intake of and resolution for grievances and appeals submitted by members and providers alike.
- **Health Education**: Facilitates the creation and delivery of educational material to members, providers, and practitioners.
- **Information Technology**: Oversees enterprise systems and facilitates exchange of data between internal units and external agencies and organizations.
- **Marketing and Communications**: Manages all member-informing materials to comply with regulatory guidance and provides oversight on its use. Creates SCFHP promotional materials to promote SCFHP, general health and wellness, and foster membership retention and growth.
- **Pharmacy**: Manages the SCFHP pharmacy benefit and evidence-based clinical programs, oversees the Pharmacy Benefit Manager (PBM) and medication therapy management (MTM) programs, and ensures medical necessity of pharmacy services.
- **Provider Network Operations**: Provider relations team responsible for facilitating provider orientation and training, other educational material, and field visits to keep providers apprised of recent events and developments that have direct impact on the care provided to members.
- **Provider Performance**: Facilitates the creation and implementation of SCFHP's Provider Performance Program (PPP), an initiative with a defined series of metrics and corresponding goals that providers and delegates work towards meeting for the improved health of SCFHP's member population.
- **Quality Improvement**: Leads the evaluation and tracking of quality, safety, and outcomes of member care through such mechanisms as the performance of quality studies based on CMS Stars, NCQA, and HEDIS guidelines.
- **Utilization Management**: Uses evidence-based guidelines to evaluate medical necessity and clinical appropriateness of health care services, procedures, and utilization including prior authorization, concurrent review, and discharge planning.

Regulatory Oversight

Audits

SCFHP undergoes a series of audits performed by business units within SCFHP and organizations and agencies external to SCFHP. Audits may be performed by one or more of SCFHP's internal business units including but not exclusive to Oversight, Provider Network Operations, and Quality Improvement. SCFHP will strive to let providers and practitioners know of planned audits in advance of their happening to allow for preparation. Audits at times require providers and practitioners to provide their

effort, records, and other resources as determined necessary to fulfill the intended purpose. Providers may not bill members, SCFHP, nor any parties designated or contracted by SCFHP for costs accrued or resources utilized in preparation of, during, or subsequent to any audits.

Medical Records Review ("Chart Chase")

Medical records may be requested from providers by SCFHP or parties delegated by SCFHP for purposes including but not exclusive to the Medical Record Review (MRR) portion of Facility Site Review (FSR), investigation of Grievance & Appeals, Quality Improvement Programs, Healthcare Effectiveness Data and Information Set (HEDIS) objectives, risk adjustment, compliance with industry guidelines, and audits performed by or on behalf of regulatory agencies. Providers may not seek reimbursement from SCFHP nor third parties designated by SCFHP for any related costs.

Medical Record Standards

The medical record is a critical source of patient data, documenting among other elements diagnostic details and related treatments rendered to the presenting member. It is important that the medical record be current, detailed, and organized to promote effective continuity of care.

SCFHP requires providers to follow guidelines and standards presented in the:

1) DHCS Medical Record Review Guidelines
2) National Committee for Quality Assurance (NCQA) Managed Care Organizations Standards for Medical Records
3) CMS Medicare Guidelines

In addition to the particulars presented within the links above, providers should know that:

4) Medical records are to be stored in a secured area that is only accessible to office staff with direct patient care responsibilities on a need-to-know basis,
5) Inactive records are to be stored in a secure location for no fewer than 10 years;
    a. Records belonging to members under the age of 18 must be maintained until:
        i. Member reaches age 21 plus the statute of limitations or
        ii. 24 years of age, and
6) All records must be protected from loss, tampering, destruction, alteration, and unauthorized or inadvertent disclosure of information.

Clinical information *cannot* be released without prior written approval from the patient or their parent/guardian. Exceptions to this written approval include but are not exclusive to instances in which regulatory criteria for disclosure of information without authorization are met.

All-Plan Letters (APL) and Dual Plan Letters (DPL)

The Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) release formal communications known as All Plan Letters (APL) and Dual Plan Letters (DPL) to Managed Care Plans (MCP) like SCFHP that cover circumstances within their respective purviews. Where information contained in these APLs may be applicable to a provider or provider organization, SCFHP will make every effort to share these details with providers by one or more of facsimile, email, phone call, or postage communications. Providers are welcome to review the most recent release from the DHCS and DMHC. These communications relay significant operational and regulatory changes that require timely compliance from providers and plans alike.

Regulatory Surveys

Consumer Assessment of Healthcare Providers & Systems (CAHPS)

The Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey is a consumer satisfaction survey that health plans including SCFHP are required by the Centers for Medicare and Medicaid Services to administer annually. SCFHP CAHPS survey is administered by SPH Analytics, with results carrying a direct impact on both the SCFHP's NCQA accreditation(s) and the CMS Medicare Part C & D Star Ratings. Survey performance may also carry significant downstream results by way of rate setting and related reimbursements to SCFHP from funding agencies down to providers. To understand how a provider can provide a positive member experience by measure of the survey is to understand the survey itself. Questions in the CAHPS survey cover:

Composite Measures	Survey Items Included in the Composite
Getting Needed Care	• In the last 6 months, how often was it easy to get the care, tests or treatment you needed? • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Composite Measures	Survey Items Included in the Composite
Getting Appointments and Care Quickly	• In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic? • Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Doctors Who Communicate Well	• In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? • In the last 6 months, how often did your personal doctor listen carefully to you? • In the last 6 months, how often did your personal doctor show respect for what you had to say? • In the last 6 months, how often did your personal doctor spend enough time with you?
Care Coordination	• In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Getting Needed Prescription Drugs	• In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?

SCFHP is invested in the success of the provider. Please connect with us at ProviderServices@scfhp.com to learn more about how you might affect positive change in the member experience.

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.

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

Fraud, Waste, and Abuse

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program or to falsely obtain any of the money or property owned by, or under the custody or control of, any health care benefit program. *Example: Submission of claims for services not rendered.*

Waste: Misuse of resources, poor, or inefficient practices that result in unnecessary cost. *Example: Overutilization of services.*

Abuse: Actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. *Example: A provider unintentionally misrepresenting facts to obtain payment.*

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
- Submitting false or misleading information about services performed
- 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 such as degree and licensure information
- 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, Waste, Abuse, or Non-Compliance

Reporting potential fraud, waste, abuse, or non-compliance 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 you for reporting a compliance concern in good faith or for cooperating in any government or law enforcement authority's investigation.

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

- Hotline at 1-408-874-1450
- Fax at 1-408-874-1970
- Email: ReportFraud@scfhp.com
- Or mail to:

    ATTN: Compliance Officer
    Santa Clara Family Health Plan
    PO Box 18880
    San Jose, California 95158

SCFHP has a strict no-tolerance policy for retaliation or retribution against any employee, provider, or contractor who in good faith reports suspected FWA. Employees, providers, and contractors are also protected from retaliation for False Claims Act complaints, as well as any other applicable anti-retaliation protections.

Delegation Program Description

SCFHP holds a Knox-Keene license to provide managed health care coverage to members. SCFHP may contract with provider groups and delegate certain administrative duties ("Delegated Activities") to certain contracted health plans, Independent Practice Associations ("IPAs"), and provider groups, referred collectively as Delegates. Delegated Activities may involve one or a combination of functions including utilization management, provider credentialing and re-credentialing, quality management and improvement, member experience, population health management, network management, claims processing, and related compliance activities.

SCFHP shall ensure that Delegates perform Delegated Activities according to its obligations in its contracts between SCFHP and Delegate in accordance with guidance and regulations from Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the Centers for Medicare and Medicaid Services (CMS), associated regulatory guidance, and the National Committee for Quality Assurance (NCQA).

SCFHP oversees the Delegated Activities through regular audits and monitoring reports, and Joint Operating Committee meetings. If issues are identified, Delegates are required to implement Corrective Action Plans (CAPs) to correct the deficiency.

Delegate is responsible for oversight of any activities that are sub-delegated. SCFHP retains authority to approve any sub-delegation and request or conduct oversight activities of sub-delegates.

SCFHP retains final authority to provide any delegation, and may revoke in whole or in part, delegation of any function or activity at any time if delegate does not perform in accordance with contractual obligations, State and Federal regulations, or NCQA standards.

The Delegation Program includes:

a. Reports
    - Description: SCFHP requires Delegate to provide monitoring reports on a regular basis to demonstrate performance at expected levels for each Delegated Activity.
    - Expectation: The reports that are required of Delegates are identified in a list provided on an annual basis specific to each Delegated Activity. The list identifies the type and frequency of required reports. Delegates are also required to provide any additional data and/or reports requested by SCFHP necessary to monitor activities related to Corrective Action Plan.

b. Dashboard
    - Description: SCFHP maintains and utilizes a ‘Delegation Dashboard’ to track and trend key performance metrics of Delegates on a quarterly basis. The results are shared and discussed internally at the Delegation Oversight Workgroup, as well as shared with Delegates at Joint Operating Committee (JOC) meetings.
    - Expectation: The expectation is that Delegates will provide data in a timely manner, and participate in discussions regarding the key performance metrics at JOC meetings.

c. File Reviews
    - Description: On-going performance of Delegated Activities is evaluated through routine monitoring of reports, an annual audit, and by performing file reviews as required for effective oversight.
    - Expectation: Delegates shall comply with file review requests and requirements.

d. Communication regarding delegated activities/requirements
    - Description: Delegated Activities are to be performed in accordance with the most current State and Federal regulatory requirements, NCQA accreditation standards, and SCFHP policies and procedures.
    - Expectation: When accreditation standards and/or regulatory requirements change, SCFHP notifies Delegates in writing and Delegates shall take all necessary steps to demonstrate compliance within required timeframes. When there is conflicting guidance from NCQA standards and State or Federal regulatory requirements, the more stringent standard or requirement shall apply.

e. Annual audit requirements
    - Description: SCFHP monitors Delegate performance by examination of reports, and an annual review, through a review of policies, procedures, program descriptions, evaluations, reports and file review, as necessary for the specific Delegated Activity.
    - Expectation: Delegate will provide required documentation within ten business days of requests. Onsite or remote audits will be scheduled at mutually convenient times no less than every twelve months.

f. Audit results/Corrective Action Plans (CAPs)
    - Description: A summary of audit results, including observations and findings, will be provided to Delegate upon completion of the annual audit.
    - Expectation: Delegates will review the initial audit results, and provide responses within X days of receipt. SCFHP shall review Delegate responses and provide final audit results within X days of receipt of the Delegate response. If no response is received from Delegate within the required timeframes, the initial audit results will be considered final. Delegate will develop a Corrective Action Plan (CAP) in response to audit findings within ten business days for approval by SCFHP. Once approved, Delegates will implement the correction(s) within 30 calendar days or otherwise mutually agreed upon date if the situation cannot be corrected to the satisfaction of the SCFHP. SCFHP can request further CAPs, temporarily suspend Delegated Activities, or terminate all or part of the Delegated Activities. If Delegate does not take corrective action, or fails to meet improvement goals, SCFHP reserves the right to revise the Delegation Agreement and scope or

revoke the Delegation Agreement altogether and cease contracting for services.

g. Additional remedies for Non-compliance
    - Description: In addition, or in the alternative to any other remedy, SCFHP may impose Sanctions against Delegate that are reasonably necessary to address Delegate's failure to comply with Delegated Activities, with or without a CAP in place.
    - Expectation: Sanctions may only be imposed following written notice to Delegate of an identified deficiency and a sixty-day period for Delegate to cure such deficiency. Sanctions available to SCFHP to address specific identified deficiencies include:
        1) Enrollment freeze – auto assignment, member selection, or both;
        2) De-delegation of delegated functions (with necessary and commensurate reduction in capitation payment);
        3) The ability to require Delegate to engage and pay for an external auditor, or other consultant for Delegate to correct the identified deficiency(ies); and/or
        4) Pass through of financial penalties assesses by regulatory agencies.

Credentialing & Re-credentialing

Participation Requirements

SCFHP has established criteria and the sources used to verify criteria for the evaluation and selection of providers for participation in the SCFHP network. This section contains information for providers on topics including initial participation, recredentialing, and continuing their participation in the SCFHP network.

Providers must continue to satisfy all applicable requirements for participation as stated within this manual and this section in parallel with all other effected contracts and documentation provided by SCFHP.

A credentialing application will be deemed incomplete if at any time a provider fails to meet or provide proof of meeting predetermined criteria. Providers who fail to meet or provide such proof will not have the right to submit an appeal. The overall credentialing process takes approximately 45 days.

Elements required for a complete credentialing application may include:

- **Application**: Provider must return a complete and signed credentialing application issued by SCFHP to perform a comprehensive review of the applying

provider's credentials. The most efficient way to complete the application is by way of the Counsel for Affordable Quality Healthcare (CAQH) at https://proview.caqh.org/. Additional instruction related to the CAQH option can be found here. The provider from their CAQH profile would authorize SCFHP to access the credentialing profile created. Alternative to the electronic submission, paper applications may also be submitted in typeface or ink.

- **License, Certification, or Registration**: Provider must present a current, active, valid copy and unrestricted license, certification, registration or business license to practice in their specialty.
- **DEA or CDS Certificate**: Provider must present a current, active, valid copy, unrestricted Drug Enforcement Agency (DEA) license.
- **Professional Liability Insurance**: Provider must present a current, active, valid copy of a professional liability malpractice insurance face sheet with minimums no less than $1,000,000 per occurrence or $3,000,000 annual aggregate, or a

    - Current, active, valid copy of a property comprehensive general liability insurance (premises) face sheet with minimums no less than $100,000 per occurrence or $300,000 annual aggregate.

- **Education and Training**: Providers will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty.
- **Residency Training**: Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing.
- **Fellowship Training**: A provider not board certified in their specialty of practice must have completed a fellowship program from an accredited training program in the specialty named.
- **Board Certification**: Board certification in the specialty in which the Provider is practicing is preferred but not required. Verification of board certification is primary source verified directly with the American Board of Medical Specialties.
- **Work History**: Provider must supply trailing five (5) years of relevant work history on the application or curriculum vitae. Relevant work history is defined as a working health professional.
- **Malpractice History**: Provider must supply a history of malpractice and professional liability claims and settlement history as defined in the application.
- **Hospital Privileges:** Provider must list all current hospital privileges on their credentialing application. Each current privilege must be in good standing.
- **Attestation**: Providers must complete a questionnaire and sign an attestation affirming to the accuracy of each question answered.
- **Release of Information/Acknowledgments Form**: Provider must supply a signed Release of Information/Acknowledgments Form.
- **Curriculum Vitae (CV)**: Provider must supply a current CV.

- **Applicable copy/ies of**:

    - Clinical Laboratory Improvement Amendments (CLIA) or Waiver
    - Child Health and Disability Prevention (CHDP) Certificate
    - Comprehensive Perinatal Services Program (CPSP) Certificate
    - Educational Council of Foreign Medical Graduates (ECFMG) Certificate
    - Current board certification from the American Board of Medical Specialties or American Board of Podiatric Surgery

Credentialing Application & Primary Source Verification

SCFHP's contracted Credentialing Verification Organization (CVO) conducts application collection, review, and primary source verification of the required criteria in compliance with NCQA Credentialing and Recredentialing Standards. Once SCFHP receives the completed files from the CVO, the credentialing process proceeds as follows:

- The completed file and supporting documentation are reviewed by SCFHP's credentialing analyst, department manager, Chief Medical Officer, Medical Director, and Credentialing Committee.
- Upon approval of the above-mentioned parties, the Contracting Department generates a contract, after which point both the contract and welcome letter are sent to the provider within sixty (60) days of the Committee's decision.
- 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.
- A copy of the completed contract is then returned to the provider. A new provider orientation and training must be conducted within 10 days of the effective ("active") date of the contract. SCFHP's Provider Network Operations team will reach out to SCFHP Direct providers while providers in delegated relationships will receive orientation from their delegate administrators.
- Primary care providers must also complete a Facility Site Review (FSR), conducted by a certified Nurse Reviewer, before the credentialing process is finalized.
- Provider is recredentialed every three years based on the date of the initial Credentialing Committee approval date.

Contractual Requirements for Credentialing & Regulatory Compliance

The provider who signs the SCFHP agreement also adheres to the requirement that each provider working for the signing provider is and will continue to be properly licensed by the State of California, through services including but not exclusive to the DHCS' Provider Application and Validation for Enrollment (PAVE) system. Providers

represent that each 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 any services.

In addition, should a provider fail to meet the credentialing standards, or if named provider loses license, certification, or privileges are revoked, suspended, expired, or not renewed, SCFHP must ensure that the named provider does not provide any services to SCFHP members.

Any conduct that could adversely affect the health or welfare of a member will result in written notification that the named provider is not to provide services to our members until the matter is resolved to our satisfaction. The significance of such misconduct may result in termination of contract up to and including report(s) made to regulatory agencies.

Certification Regarding Debarment, Suspension, Ineligibility, or Voluntary Exclusion

The provider contract makes specific mention of this certification as 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 Rights & 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 this Provider Manual. Provider shall also openly discuss treatment options, risks, and benefits with members without regard to coverage issues.

- Participate in each program of which the provider is qualified and has been requested by SCFHP to participate.
- Not unfairly differentiate or discriminate in the treatment of members or in the quality of services delivered to members 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 grievance and appeals procedures. Provider must 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 applicable regulatory agencies.
- Maintain standards for documentation of medical records and confidentiality for medical records. Medical information shall be provided to SCFHP where appropriate and without violation of applicable state and federal laws regarding the confidentiality of medical records. Such information shall be provided without cost to SCFHP nor any third-party acting on SCFHP's behalf.
- 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 members 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 members after any termination or other expiration of provider's SCFHP agreement. Nothing contained in this document 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 member to disenroll from SCFHP and will not directly, or indirectly, solicit any member to enroll in any other health plan, PPO, or any other like-agency.
- Permit representatives of SCFHP, including utilization review, quality improvement, and provider services 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 members to whom provider is a party to, and to 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 members.

- Uphold all applicable member rights and responsibilities as outlined in the Provider Contract, Evidence of Coverage (EOC), and the Provider Manual.
- Provide for timely transfer of member clinical records if a member 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.
- 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 members 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. Additional medical record retention information is available on page 13.
- Maintain appointment availability in accordance with Timely Access & Availability (TAA) Standards.
- Agrees 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 member or persons (other than SCFHP) acting on the member's behalf. This provision shall not prohibit provider from collecting from members for co-payments, or coinsurance, or fees for non-covered services delivered on a fee-for-service basis to members, provided that member has agreed prospectively, in writing, to assume financial responsibility for the non-covered services. More information on Balance Billing can be found on page 41.

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 member population.

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

Facility Site Review (FSR)

Per APL 22-017, the California Department of Health Care Services (DHCS) requires all providers contracted as PCPs to pass a full scope site review with a minimum score of 80%. The FSR is required as an initial credentialing step and every-three-years thereafter during the re-credentialing process.

This consists of a Facility Site Review (FSR) and Medical Record Review (MRR) using FSR and MRR tools and standards created by the DHCS. The FSR and MRR field visit averages a total of 1 to 2 days for completion, depending on the complexity of the review and the number of charts reviewed.

The FSR is SCFHP's method of evaluating provider offices to ensure that compliance with local, state, and federal laws and regulations, as well as safety standards are met before the provision of medical services to plan members, both initially and on an ongoing basis.

FSRs and MRRs are conducted by Nurse Reviewers from SCFHP who are trained and certified by the DHCS to perform the audit. SCFHP collaborates with other local Medi-Cal Managed Care Plans (MCP) to share FSRs and avoid duplication of audits in providers' offices. FSR results and related sanctions imposed are shared among collaboration partners. The DHCS may also conduct FSRs and MRRs as part of Managed Medi-Cal Division (MMCD) monitoring activities.

When a new PCP is being established or a PCP has relocated to a new site that does not have a current passing FSR score, an initial FSR and an initial MRR needs to be completed. The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. SCFHP does not assign members to providers until their PCP sites receive a passing FSR score and completes the Corrective Action Plan (CAP) if applicable.

Once a PCP site passes the initial FSR and completes all CAPs, Nurse Reviewers must complete the initial MRR of the new PCP(s) site within 90 calendar days of the date SCFHP first assigns members. SCFHP may defer this initial MRR for an additional 90 calendar days only if the new PCP does not have enough assigned MCP members to complete the MRR on the required minimum number of medical records.

If, after 180 days following the assignment of members, the PCP still has fewer than the required number of medical records, SCFHP must complete the MRR on the total number of medical records it has available and adjust the scoring according to the number of medical records reviewed.

At PCP sites that document patient care performed by multiple PCPs in the same medical record, sees the same patients, and there is a “shared” medical record system, the Nurse Reviewer must review a minimum of 10 records if 1-3 PCPs share records, 20 records if 4-6 PCPs share records, and 30 records if 7 or more PCPs share records. In the event that there are multiple providers in one office that do not share medical records, each PCP must be reviewed separately and receive a separate score. A minimum of ten medical records must be reviewed per Provider. Documented evidence found in the hard copy (paper) medical record and electronic medical record are used for determining compliance.

SCFHP must conduct subsequent site reviews, consisting of an FSR and MRR, at least every three years, beginning no later than three years after the initial FSR. Interim reviews are required by DHCS to assess compliance with all Critical Elements between regular reviews. SCFHP may also conduct site reviews at any time if a quality-of-care issue is identified by other means, including but not exclusive to the submission of a grievance or appeal.

The Nurse Reviewer provides practitioners with a copy of the FSR and MRR tools and standards as well as other helpful documents prior to review. The Nurse Reviewer also provides technical assistance to help providers meet the review standards and requirements between cycles. Copies of the review tools, standards, FSR updates, and resources can be found on SCFHP website at: https://www.scfhp.com/for-providers/quality-improvement-program/tools-and-guidelines-for-fsr-and-mrr/

Scenarios that Require SCFHP to Conduct an Initial Site Review

Examples of these scenarios include, but are not limited to the following:

1) A new PCP site is added to SCFHP’s Network.
2) A newly contracted Provider joins/assumes a PCP site with a previous failing FSR and/or MMR score within the last 3 years.
3) A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last 3 years.
4) At the discretion of SCFHP, a separate site review may be conducted for solo practices/organizations.
5) Upon identification of multiple independent practices that occupy the same site, a separate site review must be completed for all PCP practices at that site and a unique alphanumeric DHCS Site ID must be assigned for each independent PCP practice at the site if ownership is different.
6) A change in ownership of an existing Provider site is planned and/or identified.

Provider Move

A provider planning to relocate must submit a completed Change Notification Form to Credentialing at credentialing@scfhp.com at least 30 days prior to the move for an FSR at the new location to be completed if needed.

Providers who do not provide timely notice may find their contract terminated and for PCPs their members reassigned. Delegated providers must follow relocation policies and procedures belonging to their respective delegate.

Corrective Action Plan (CAP) for Deficiencies

The CAP identifies the specific regulatory criteria the provider has not met in the FSR and MRR, as well as the specific actions required for compliance. This generally involves staff in-service training, creating or updating policies and procedures, submitting examples of compliant records or forms, or purchasing missing or outdated items. The Nurse Reviewer is available to assist providers in completing the CAP before the due date.

An Exempted Pass is a score of 90% or above without deficiencies in Infection Control, Pharmaceutical Services or Critical Element; a Conditional Pass is a score of 80-89% or 90% or above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control; and a Not Pass is a score below 80%. Corrective Action Plans (CAPs) are issued to PCPs who score less than 90% on the FSR or MRR, score less than 80% on any individual MRR section score (irrespective of overall MRR score), or have any deficiencies in Infection Control and/or Pharmaceutical Services or any Critical Element deficiencies.

Critical Element deficiencies and any other deficiencies requiring immediate attention must be completed in a CAP within 10 business days of the FSR. All other deficiencies must be completed in a CAP within 30 calendar days of the CAP issue date. Any Not Pass score requires the closure of the provider's panel and notification of stakeholders including the applicable delegate and the collaboration partner until the CAP expectations are met.

SCFHP may require a CAP regardless of score for other findings identified during the survey that require correction. A specific due date for completion is documented on the CAP and any necessary follow up is done by the Nurse Reviewer.

Non-Compliance or Failure

Providers who do not obtain a minimum passing score of 80% on the review for both the facility site and medical record review must complete any CAP no later than the due

date that appears on the CAP. SCFHP follows applicable timelines and sanctions mandated by the DHCS. Providers who do not comply with scheduling the FSR or completing CAPs timely are considered noncompliant and subject to administrative actions by or on behalf of SCFHP, including suspension or termination from the network.

The credentialing process may be paused depending on the outcome of the FSR/MRR and the amount of time needed to make the corrections defined in any CAP notice received. PCP sites that receive a failing score on either the FSR or MRR for two consecutive site reviews must receive a minimum passing score on the next FSR and MRR to remain in the provider network. If the PCP site fails on its third consecutive attempt, the PCP site must be removed from the provider network, and its members must be reassigned to other network providers, as appropriate and as contractually required.

Physical Accessibility Review Survey (PARs)

In addition to the FSR process, SCFHP is required to perform Physical Accessibility Review Survey (PARs) at provider locations for accessibility in accordance with the Americans with Disabilities Act (ADA). SCFHP recognizes that each location has unique challenges in meeting the ADA. Providers are not expected to make any upgrades or additions as a result of the PAR. While DHCS requires the use of a specific tool, the results of these assessments are only used in the Provider Directory to assist members in determining which locations are best suited to their needs. PARs may be conducted by the Nurse Reviewer during the FSR or any other staff person trained by SCFHP to carry out the review. The PAR has no score, will not result in any CAPs, nor will result in any sanction. **PARs does not affect credentialing**.

Providers who see a high volume of seniors and persons with disabilities are also reviewed, which includes specialists and ancillary providers including labs, dialysis providers, and community-based adult service (CBAS) locations. PARs are performed on a three-year cycle and are frequently done during the FSR visit to reduce operational disruption.

The initial PAR is a full review while the two that follow at year 3 and year 6 only require attestation that there have been no significant changes to the location since the last review. The review at year 9 returns to a complete review. Providers should submit a Change Notification Form immediately if the provider's location goes through a remodel or moves to a new location. This should be done within 30 days to maintain good standing and for the new facility to be reviewed.

Network Provider Training

SCFHP shall ensure that all network providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters and Policy letters. SCFHP shall conduct training for all network providers. Training must start within ten working days and be completed within 30 working days after SCFHP places a newly contracted network provider on active status. Network provider training may be conducted online or in-person. Records of attendance must be maintained to validate that network providers received training on a bi-annual basis.

SCFHP shall ensure that network provider training includes education on Covered Services, and policies and procedures for clinical protocols governing Prior Authorization and Utilization Management, and carved out services.

SCFHP shall conduct ongoing training, at least once every two years, for network providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for members less than 21 years of age; appropriate medical record documentation and coding requirements. This includes training on existing SCFHP data collection and reporting requirements; quality improvement programs to ensure required preventive services are offered and provided, and includes but is not limited to, training on Population Health Management Program requirements (i.e., Care management services) including closed loop referrals; health education resources and provider and member incentive programs.

SCFHP will immediately notify network providers when changes to its existing policies and procedures impact network providers' provision of Medi-Cal Covered Services to members.

Training must educate network providers on member access, including compliance with appointment waiting time standards and ensuring telephone, translation and language access is available for members during hours of operation. Training must also include education on secure methods for sharing information between SCFHP, network providers, subcontractors, downstream subcontractors, members, and other healthcare professionals. This includes training on ensuring providers have accurate contact information for the Member and all network providers involved in the member's care. SCFHP will provide training on how to refer and coordinate care for members who need access to non-Covered Services.

SCFHP shall ensure that network provider bi-annual mandatory training includes information on all member rights, and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency training). This process must also include an educational program for network providers regarding health needs to

include but not be limited to, the SPD population, Members with chronic conditions, Members with Specialty Mental Health service needs, Members with Substance Use Disorder needs, Members with intellectual and developmental disabilities, and Children with special health care needs. Trainings must include Social Drivers of Health and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by SCFHP health equity officer.

Trainings will be reviewed by SCFHP board of director's compliance and oversight committee and QIC routinely, but not less than biennially to ensure consistency and accuracy with current requirements, and SCFHP policies and procedures.
Providers are required to participate in SCFHP's provider education and training efforts. Required Trainings require all providers to sign attestations. Attestations can be signed during onsite visits or via SCFHP website www.scfhp.com. Provider trainings can also be found SCFHP website www.scfhp.com

Required Provider Trainings

- Early Periodic Screening, Diagnosis and Testing (EPSDT)
- New Provider Orientation
- Diversity, Equity, and Inclusion (DEI) Training
- Staying Healthy Assessment (SHA)

Additional Provider Trainings

SCFHP also offers trainings that are not required, but are available to providers to enhance their practice:

- Cultural Competency Toolkit
- Interdisciplinary Care Team (ICT) Training Overview
- ICT Training – Core Competencies
- New Provider Orientation
- Proposition 56 overview
- Screening, Brief Intervention, and Referral to Treatment
- Timely Access to Care
- Topical Fluoride Varnish

Provider Network Operations Team

The Provider Network Operations team update providers continuously throughout the year with new updates. There are onsite educational trainings, JOC calls, quality calls, newsletters sent out to all providers. The provider network operations team is open to collaborate efforts on any upcoming events that will meet the needs of the provider.

The Provider Network Operations team distributes to SCFHP direct and delegate administrators an “Training Packets” filled with details on programs, policies, and procedures that are new, revised, or otherwise identified as high priority elements.

Training On-Demand or by Request

If there exists any question or desire to learn more about a topic not found in SCFHP’s provider training web page, we welcome hearing from you. The Provider Network Operations team can assist with your requests. All providers are assigned a Provider Network Associate to assist with any issues or educational needs. The Provider Network Associates conduct onsite visits and if a provider would like an onsite visit please email ProviderServices@scfhp.com.

Advance Directive

Advance Directives is a written legal document that provides instructions on medical care and go into effect if the Member is unable to communicate their own wishes. Types of common advance directives include but are not limited to a living will and a durable power of attorney for healthcare.

Providers are required to comply with the provision of health care when a Member is incapacitated, in accordance with 42 CFR sections 422.128 and 4... 438.3(j), and the DHCS 2024 contract, Section 5.1.

SCFHP sets forth members rights and responsibilities and communicates its policies to its members, providers, and upon request, Potential members, including members rights to have a valid Advance Directive in place, and an explanation to members of what an Advance Directive is.

Enrollment & Eligibility

Eligibility Criteria

Residents of Santa Clara County wishing to enroll in SCFHP’s Medi-Cal or SCFHP DualConnect line of business must meet the criteria outlined in the columns below:

Medi-Cal	SCFHP DualConnect
Eligible individuals must be: **Adults 26 - 50 years old or older:** • Family income is within Medi-Cal guidelines	*Eligible individuals must be:* • 21 years of age or older • Have both Medicare Part A and Part B

• Resident of Santa Clara County • U.S. citizen or permanent legal resident **Children, young adults (younger than 26), and older adults (50 years or older) are eligible regardless of immigration status if:** • Resident of Santa Clara County • Have a family income no higher than 266 percent of the Federal Poverty Level **County residents may be automatically eligible for Medi-Cal if they receive cash assistance under one of the following programs:** • SSI/SSP (Supplemental Security Income/State Supplemental Program) • CalWORKs (California Work Opportunity and Responsibility to Kids). Previously called Aid to Families with Dependent Children (AFDC). • Refugee Assistance • Foster Care or Adoption Assistance Program.	• Eligible for full-scope Medi-Cal • Resident of Santa Clara County • U.S. citizen or permanent legal resident *Individual is <u>not</u> eligible for SCFHP DualConnect when:* • Younger than 21 years-of-age, • With partial benefits or other health coverage (OHC), and • Program of All-Inclusive Care for the Elderly (PACE) and AIDS Health Care Foundation enrollees (who must disenroll from those programs to be eligible for SCFHP DualConnect).

Enrollment Process

Enrollment in one of either SCFHP's Medi-Cal or SCFHP DualConnect lines of business involves two separate and distinct procedures:

Medi-Cal	SCFHP DualConnect
SCFHP offers application assistance at our SCFHP Blanca Alvarado Community Resource Center. Our bilingual Community Health Workers will help your patient through the Covered California enrollment process.	Enrollment in SCFHP DualConnect is voluntary. Eligible beneficiaries may choose to enroll in a DualConnect plan, choose a different Medicare-Medi-Cal plan, enroll in a Medicare Advantage plan (their Medi-Cal plan may change), or

SCFHP Blanca Alvarado Community Resource Center 408 N Capitol Avenue San Jose, California 95133 www.crc.scfhp.com Other Enrollment Resources: • Covered California • MyBenefits CalWIN • Santa Clara County Social Services Once their application is processed, if they qualify, they will receive a Medi-Cal benefits identification card and an Enrollment Choice Form to help them choose their health plan. They can choose SCFHP as their plan on their Enrollment Choice Form.	remain in Original Medicare and their Medi-Cal plan will be SCFHP. A member or their representative can begin the SCFHP DualConnect enrollment process by: • Phone SCFHP DualConnect: **1-888-202-3353** (TTY: **711**) • Online www.scfhp.com/SCFHP DualConnect • In-person SCFHP Blanca Alvarado Community Resource Center 408 N Capitol Avenue San Jose, California 95133 Members eligible for the Program of All-Inclusive Care for the Elderly (PACE) may choose to receive Medicare and Medi-Cal benefits through PACE.

Eligibility Verification

Providers are required to verify member eligibility prior to each encounter at the time of service. This includes screening for Other Health Coverage. Possession of an SCFHP Member ID card alone neither guarantees eligibility to receive care covered by SCFHP nor guarantees the provider will be paid for the services/procedures rendered that day. Neither does a referral nor authorization mean that a member is eligible for service. Eligibility changes month-to-month.

SCFHP offers two complementary solutions to verify eligibility:

- **SCFHP Online Provider Portal (Provider Link)**: Provider Link, available 24 hours-per-day, 7 days-per-week, is the most convenient method for checking eligibility. Available by visiting https://providerportal.scfhp.com, providers are encouraged to view the “Provider Portal 101” training deck available at http://www.scfhp.com/provider-training to learn both how to register for and use Provider Link. Provider Link features a catalogue of additional tools for providers

to use, including but not exclusive to member eligibility lists, gaps-in-care (GIC) health care quality reports, and claims information.

- **SCFHP Interactive Voice Response (IVR) Phone System**: The IVR is also available 24 hours-per-day, 7-days-per-week. Using the IVR you may verify eligibility for the current month as well as the three months preceding by calling **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 and SCFHP identification number,
    - Member date of birth, and
    - Month of service.

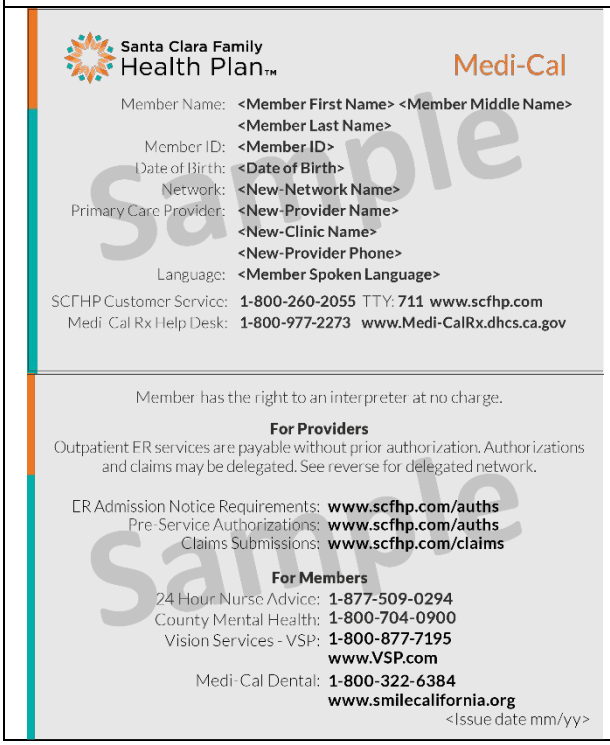
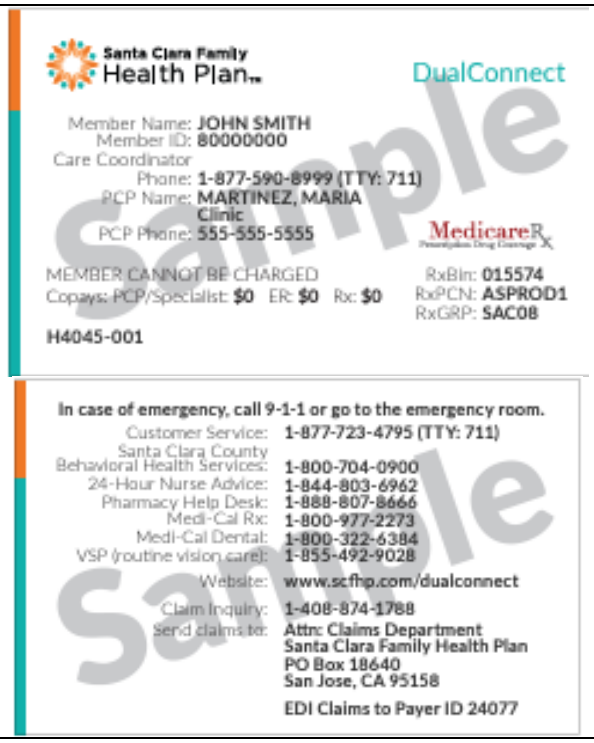
    After which point the service will be able to:

    - Confirm eligibility for the month requested,
    - Provide the name and phone number of the member's PCP,
    - Provide the phone number of the PCP's Medical Group authorization department,
    - Give you a confirmation number, and
    - Request confirmation via fax of claims processed.

Questions related to either resource may be directed to ProviderServices@scfhp.com.

Member Identification Card

Members are required to present their Member ID cards to the provider at check-in. This is to enable the provider to confirm member eligibility for the health care service or procedure to be rendered on the date of service. You can review illustrative copies of both the Medi-Cal and SCFHP DualConnect Member ID cards below.

Medi-Cal	SCFHP DualConnect
	

Retroactive Changes

Circumstances may arise in which retroactive adjustments may be made to your eligibility list. For example, this may happen when there is a retroactive change made by Medi-Cal to a specific member's eligibility status.

Member Rights & Responsibilities

SCFHP joins our providers, practitioners, and medical service suppliers in acknowledging that each member is an individual with unique healthcare needs and that we must respect each member's personal dignity. SCFHP has adopted *Member Rights & Responsibilities* that each member receives in their SCFHP Member Handbook (Evidence of Coverage).

Santa Clara Family Health Plan (SCFHP) Medi-Cal Plan Member Rights & Responsibilities

SCFHP members have certain rights and responsibilities. Rights are what a member can expect to receive, including needed treatment and information. Responsibilities are what SCFHP expects members to do as an SCFHP member. The next two lists explain these rights and responsibilities.

Member Rights

SCFHP members have these rights:

- To receive needed and appropriate medical care, including preventive health services and health education.
- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To receive fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about SCFHP's member rights and responsibilities policy.
- To be able to choose a primary care provider within SCFHP's networks.
- To have access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for SCFHP's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost oral interpretation services for their language.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To request a State Hearing, if a service or benefit is denied and you have already file an appeal with SCFHP and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll from SCFHP and change to another health plan in the county upon request.
- To access minor consent services.

- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b) (12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by SCFHP, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Service Facilities, midwifery services, Rural Health Centers, sexually transmitted disease services and emergency services outside SCFHP's networks pursuant to the federal law.
- To take part in establishing SCFHP's public policy, by attending and/or joining the SCFHP Consumer Advisory Committee.
- To make recommendations regarding the organization's member rights and responsibilities policy.

Member Responsibilities

SCFHP members have these responsibilities:

- To carefully read all SCFHP materials as soon as you enroll so you understand how to use SCFHP's services.
- To carry your SCFHP ID card and your Medi-Cal Benefits Identification Card (BIC) with you at all times and show it to all providers and pharmacies when getting services.
- To ask questions when you do not understand something about your coverage or medical care.
- To follow the rules of SCFHP membership as explained in this Member Handbook.
- To be responsible for your and your children's health.
- To talk to your health care provider so you can develop a strong relationship based on trust and cooperation.
- To call your health care provider when you need routine or urgent health care.
- To report unexpected changes in your health to your PCP.

- To ask questions about your medical condition. Make sure you understand the answers, what you are supposed to do, and participate in developing mutually-agreed upon treatment goals (to the extent possible).
- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- To follow the treatment plan you and your health care provider create together, and know what might happen if you do not follow the treatment plan.
- To make and be on time for medical appointments. Let your health care provider know at least 24 hours before your scheduled appointment if you need to cancel.
- To tell SCFHP about any changes in: address; phone number; and changes in any other health care coverage you might have. Tell SCFHP about these changes as soon as you know them or within 10 days of these changes.
- To call or write SCFHP as soon as possible if you feel you were improperly billed or if the bill is wrong.
- To treat all SCFHP personnel and health care providers with respect and courtesy.
- To submit requests for claims reimbursement for covered services within the required time period.
- To be honest in your dealings with SCFHP and its plan providers. Do not commit fraud or theft or do anything that threatens the property of SCFHP or the property or safety of any of its representatives, plan providers, plan providers' employees, or agents.
- To report wrongdoing. You are responsible for reporting health care fraud or wrongdoing to SCFHP. You can do this without giving your name by calling the SCFHP Compliance Hotline at 1-408-874-1450, go to www.scfhp.com, or you can call the California Department of Health Care Services (DHCS) Medi-Cal Fraud and Abuse Hotline toll-free at 1-800-822-6222.

Please submit your request to Provider Network Operations at ProviderServices@scfhp.com if you would like to receive printed copies of our Medi-Cal or SCFHP DualConnect Member Handbooks or the Member Rights & Responsibilities.

Provider Directory Requirements

SCFHP is required to provide and maintain a public-facing directory of contracted providers, practitioners, hospitals, ancillary services, and pharmacies for stakeholders to reference based on their needs. Contracted providers are required to ensure that SCFHP has accurate directory information for you and your office. Details providers are required to provide and to ensure accuracy of include but are not exclusive to name, specialty, board certifications, language fluencies, race/ethnicity, NPI, state license number, clinic location(s), language services available through practices, phone number, after-hours phone number if it defers from the main number, fax number(s), website if applicable, office hours, accessibility options, and hospital affiliations; All

Enhanced Care Management providers' population of focus are listed in the Provider Directory. All of this information is collected in the initial credentialing process and all providers are required to attest to the accuracy of their reported provider directory information according to Section 1367.27 of the Health and Safety Code.

Should any element of a provider's directory information change, providers are required to complete a Change Notification Form and return as soon as possible to SCFHP as instructions on the form indicate. When a Change Notification Form is received, SCFHP will validate and verify the information in a timely manner before applying the updated information as it was received.

Members, potential members, other providers, and the public at large may also report provider directory inaccuracies by completing the Directory Update Form available on the SCFHP website.

Claims & Billing Information

Medi-Cal Claims Delegation

This section focuses primarily on how providers in the SCFHP Direct network or for which SCFHP affiliate is the responsible payer(s) are to process and submit claims. Providers with delegate affiliations can visit the "Submit a claim or dispute" page of the SCFHP website. Delegated providers should consult their respective claims teams to identify the requirements related to their service agencies.

Balance Billing

Providers may not bill any member for any portion of costs related to services provided. A provider may not balance bill a member in such cases including but not exclusive to:

- The difference between the charge amount and the SCFHP fee schedule,
- When a claim has been denied for late submission, unauthorized service, or service deemed not medically necessary,
- When claims are pended for review by SCFHP,
- A no-show fee, or
- A fee for transferring or copying medical records.

Any questions related to billing SCFHP members should be relayed to ProviderServices@scfhp.com.

Newly Enacted Statutes effective January 1, 2025

The All Plan Letter 24-023 details the newly established statutory requirements enforced by the Department of Managed Health Care (DMHC) for SCFHP. For more information, please refer to APL 24-023 at DMHC website at https://www.dmhc.ca.gov/.

AB 1936 (Cervantes, Ch. 815, Stats. 2024)
AB 1936 requires health plans, including Medi-Cal managed care plans (pending federal approvals), to enhance maternal mental health programs by incorporating specific screening requirements.

- Requires, by January 1, 2025, a plan's existing maternal mental health program to consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider.

AB 2105 (Lowenthal, Ch. 822, Stats. 2024)

- Requires plans' health care service plan contracts issued, amended, or renewed on or after January 1, 2025, to provide coverage for prophylaxis, diagnosis, and treatment for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature.

- Requires PANDAS/PANS to be coded as autoimmune encephalitis until the American Medical Association and the federal Centers for Medicare and Medicaid Services create and assign a specific code or codes for PANDAS/PANS. After the creation of that code or codes, PANDAS/PANS may be coded as autoimmune encephalitis, PANDAS, or PANS. If PANDAS or PANS is known by a different common name in the future, it may be coded under that name and this section shall apply to that disorder or syndrome.

Immediate Postpartum Contraception Billing (AB 2129)

Overview:
AB 2129 requires health plans covering maternity benefits to authorize providers to separately bill for immediate postpartum contraception (IUDs or contraceptive implants) when provided before discharge from a **general acute care hospital or licensed birth center**. These services must be reimbursed separately and **cannot be bundled** into general obstetric payments. The bill does not alter enrollees' rights to direct access to women's health services, including contraceptive care and informed consent.

Provider Contract & Compliance Requirements:
Santa Clara Family Health Plan (SCFHP) will:

- Authorize separate billing for devices, implants, and associated professional services.

- Ensure provider contracts do not bundle these services into obstetric payments.
- Update claims policies, provider contracts, and related documents to reflect compliance.
- Submit necessary filings to the **Department of Managed Health Care (DMHC)**, including updated claims procedures and provider contract templates.
- Review and, if necessary, amend provider agreements to ensure alignment with AB 2129 requirements.

AB 2843 (Petrie-Norris, Ch. 971, Stats. 2024)—Health Care Coverage: Rape and Sexual Assault

- Prohibits plans from requiring any of the following to provide the required coverage: (1) an enrollee to file a police report on the rape or sexual assault; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape or sexual assault.

AB 3059 (Weber, Ch. 975, Stats. 2024)—Human Milk

- Applies to all plans that cover basic health care services.
- Specifies that the provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Section 1635) is a basic health care service.

AB 3221 (Pellerin, Ch. 760, Stats. 2024)—DMHC: Review of Records

- Requires, effective January 1, 2025, all records, books and papers of a plan, management company, solicitor, solicitor firm, and any provider or subcontractor providing health care or services to a plan, management company, solicitor, or solicitor firm to be open to inspection, including through electronic means, by the Director.
- Requires, to the greatest extent feasible, all records, books, and papers to be furnished in a format that is digitally searchable.

Electronic Data Interchange (EDI)

SCFHP requires all contracted providers to bill applicable claims electronically. The Health Insurance Portability and Accountability Act of 1996 requires that SCFHP adopt standards for specific financial health care transactions. The HIPAA-mandated national standard format for transactions is the ANSI ASC X12N.

Providers should work with their EDI partner on how to submit Coordination of Benefits (COB) information electronically to ensure faster processing of claims.

SCFHP accepts the following claims-related transactions formats:

- ASC X12N 837 (005010X222) Professional

- ASC X12N 837 (005010X223) Facility

No other electronic formats are valid for the billing of medical 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**. If you require clearinghouse submission assistance, please contact:

- Change HealthCare Customer Service at: **1-800-845-6592**, or
- Office Ally at: **1-866-575-4120**, **Option 1**

Approved Claim Forms

Claims that cannot be submitted electronically may use the following approved forms for submitting claims:

- CMS 1500 (Professional Claims) or
- UB-04 (Facility Claims).

All claim forms must be signed, dated, include valid ICD-10, Current Procedural Technology (CPT) codes, and all other required information as defined by Medi-Cal or Medicare.

Please note that SCFHP does not accept claims submissions nor claim tracers by fax or email.

Other Health Coverage

Medi-Cal is the payer of last resort. Providers are required by law to exhaust the recipient's Other Health Coverage (OHC) before billing Medi-Cal. In situations where OHC utilization is not required before billing Medi-Cal, providers are encouraged to bill OHC first.

The following is a partial list of insurance that is not considered to be OHC:

- Personal injury and/or medical payment coverage covered under automobile insurance
- Life insurance
- Workers' compensation
- Homeowners insurance
- Umbrella insurance
- Accident insurance
- Income replacement insurance (for example, Aflac)

Providers should review whether a member has OHC prior to providing service. OHC information can be found on the SCFHP Provider Link in the Eligibility tab.

A member is required to utilize their OHC prior to Medi-Cal when the same service is available under the member's other health coverage. Providers are not allowed to deny Medi-Cal services based upon potential third party liability. If the recipient elects to seek services not covered by Medi-Cal, Medi-Cal is not liable for the cost of those services. To establish Medi-Cal's liability for a covered Medi-Cal service, the provider must obtain an acceptable denial letter from the OHC entity.

Reporting Other Health Coverage

State law requires Medi-Cal providers to notify the Department of Health Care Services (DHCS) if they believe a recipient is entitled to OHC. To update or modify OHC information, providers may use the secure OHC Processing Center Forms accessible on the OHC page of the DHCS website. Providers who are unable to use the online forms should call the Telephone Service Center (TSC) at **1-800-541-5555**. **Providers must report updates or modifications to the DHCS within 10 days of discovery**.

More information on OHC can be found at https://www.dhcs.ca.gov/services/Pages/OHCResources.aspx.

Billing Time Limits

Original (initial) claims should be received by the health plan or delegated group within six months from the date of service. Claims received beyond the six-month billing time limit that do not meet any of the delay reasons as presented in the Medi-Cal Provider Manual or CMS 1500 Submission and Timeliness Instructions may be reimbursed at a reduced rate or denied after 365 days from date of service.

Coordination of Benefits (COB) and Share of Cost (SOC)

With the exception of members in long-term care facilities with SOC, members with Medi-Cal SOC will be mandatorily enrolled in fee-for-service Medi-Cal.

Medi-Cal	SCFHP DualConnect
The member's Medi-Cal coverage through SCFHP is the payer of last resort. If a member has coverage through SCFHP and another health insurance program, the other insurance program is the primary payer. You should attempt to be reimbursed for services from any other	SCFHP DualConnect is a D-SNP health plan for people who qualify for both Medicare and Medi-Cal and Medi-Cal. Claims submitted by the provider are first adjudicated by SCFHP against the Medicare benefit as the primary benefit. Subsequently, the plan's claims

Medi-Cal	SCFHP DualConnect
health insurance program for which the patient is eligible (including Medicare) before submitting a claim to SCFHP. For members with other health insurance, if you receive payment from that carrier, you may bill SCFHP to allow for coordination of benefits. If the amount paid by the other carrier is more than SCFHP's allowable, no payment will be made. If SCFHP's allowable exceeds other carrier's payment, our reimbursement will be the difference between the SCFHP's allowable and the other health insurance carrier's payment.	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 (example: hearing aids) are denied under 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 SCFHP DualConnect 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, or • FBLBP (Black Lung Program).

Member's Financial Responsibility

SCFHP members shall never be held liable for any sums owed to a contracted provider, nor shall the provider bill, charge, collect a deposit or other sum, or seek reimbursement from an SCFHP member for covered services. Members may be held financially liable for any non-covered or excluded services. Otherwise SCFHP members do not have copayments for any covered benefits.

Pharmacy Claims

Medi-Cal	SCFHP DualConnect
Pharmacies must be enrolled as a Medi-Cal provider in the Department of Health Care Services (DHCS) Provider Application and Validation for Enrollment (PAVE) system. Enrolled pharmacies billing on a pharmacy claim including, but not limited to, outpatient drugs, Physician Administered Drugs (PADs), enteral nutrition products, and medical supplies should send claims to Medi-Cal Rx. For more information visit Medi-Cal Rx's website or call **1-800-977-2273**.	All claims from participating network pharmacies for members enrolled in SCFHP DualConnect should be processed through the plan's PBM, MedImpact, with the following information: • BIN: 015574, PCN: ASPROD1, GROUP: SAC08. To inquire about the status of a pharmacy claim, the pharmacy may call MedImpact at **1-800-788-2949**. See the Pharmacy Benefit section on page 104 for additional details.

Misdirected Claims

Claims received by SCFHP that are wholly a delegate's financial responsibility are forwarded to that delegate within ten (10) working days of receipt. Claims that include a combination of services belonging to SCFHP and to delegates are not forwarded.

Claims Inquiries

Providers participating in the SCFHP Direct and SCFHP DualConnect network should refer to the Eligibility Verification section of the manual for how to pursue claims inquiries using Provider Link or the Interactive Voice Response phone system.

Corrected Claims

Corrected claims must be submitted within the timeframes stated in the Provider Contract. The corrected claim may be submitted electronically using a claim frequency of 7 (corrected claim). Be sure to submit the entire claim. Submitting just the errant portion will result in denial and delay of reimbursement while the corrected claims process is repeated.

If you cannot submit electronically, you must use the CMS 1500 for professional or the UB-04 form for facility claims with the words "**CORRECTED CLAIM**" stamped on the front of the claim. Be sure to resubmit the entire claim including the appropriate claim forms and the Remittance Advice indicating the original request for the corrected claims and mail all of these documents to:

ATTN: Claims Department
Santa Clara Family Health Plan
PO Box 18640
San Jose, California 95158

Provider Billing & Claim Dispute Resolutions

A provider may dispute a **Medi-Cal** claim's outcome within 365 calendar days from SCFHP's remittance advice. SCFHP will investigate the dispute and issue a written resolution within 62 calendar days or 45 working days from the date the dispute is received.

Similarly, a provider may dispute **SCFHP DualConnect** claims outcome within 120 calendar days from SCFHP's remittance advice.

For contracted providers or non-contracted provider payment disputes, SCFHP will investigate the dispute and issue a written resolution within 60 calendar days for contracted providers, and 30 calendar days for a non-contracted providers (payment disputes only) from the date the dispute is received.

Non-contracted providers may submit an appeal for claims denials (not payment disputes) along with a Waiver of Liability (WOL) statement to Grievance and Appeals at PO Box 18880, San Jose, CA 95158 or fax it to **1-408-874-1962**. ***Medi-Cal*** *and* ***SCFHP DualConnect*** *disputes* ***should be submitted through the Submit a claim or dispute web page.***

Providers who receive a first level denial letter or an outcome that they believe to be unfavorable may forward the dispute to SCFHP's second level dispute process. Providers must submit their second level claim dispute within 30 working days of receiving their first level claims dispute decision from SCFHP.

DualConnect Dual-Eligible Special Needs Plan (D-SNP) Model of Care

Required Provider Training Overview

All Dual-Eligible Special Needs Plans (D-SNPs) are mandated to provide D-SNP Model of Care (MOC) training to their employed and contracted providers. The D-SNP MOC serves as an evidence-based framework used by Santa Clara Family Health Plan (SCFHP) to integrate benefits and ensure coordinated care for members

enrolled in the SCFHP DualConnect (HMO D-SNP) program. All providers must receive training on the SCFHP DualConnect MOC upon onboarding and annually thereafter.

Learning Objectives

- Gain a thorough understanding of the SCFHP DualConnect MOC.
- Develop a comprehensive knowledge of the key components of the D-SNP MOC.
- Understand the framework used to integrate benefits and coordinate care for D-SNP members.

At the end of this training, you will be able to:

- Identify and implement best practices associated with the D-SNP MOC.
- Describe actionable steps to improve health outcomes for SCFHP DualConnect members.
- Recognize the role of interdisciplinary care teams (ICT) in delivering coordinated care.

What is the D-SNP MOC?

D-SNPs are tailored Medicare Advantage plans designed to address the unique needs of beneficiaries in specific circumstances.

There are three types of SNPs:

- Chronic SNP (C-SNP): For members with severe or disabling chronic conditions
- Institutional SNP (I-SNP): For members requiring institutional-level care or an equivalent level of care while living in the community.
- Dual-Eligible SNP (D-SNP): For members who qualify for both Medicare and Medicaid.

The **Model of Care** (MOC) serves as SCFHP's comprehensive framework for delivering integrated care management programs to special needs members.'

It provides the foundation for ensuring:

- Quality care delivery.
- Care management policies and procedures.
- Operational systems that support member care and outcomes.

SNP MOC: 4 Domains and 15 Elements

MOC 1: Description of the D-SNP Population

- Element A. Description of Overall D-SNP Population
- Element B. Sub-Population: Most Vulnerable Beneficiaries

MOC 2: Care Coordination

- Element A. SNP Staff Structure
- Element B. Health Risk Assessment Tool
- Element C. Individualized Care Plan (ICP)
- Element D. Interdisciplinary Care Team (ICT)
- Element E. Care Transitions Protocols

MOC 3: D-SNP Provider Network

- Element A. Specialized Expertise
- Element B. Use of Clinical Practice Guidelines and Care Transition Protocols
- Element C. MOC Training for the Provider Network

MOC 4: Quality Measurement and Performance Improvement

- Element A. MOC Quality Performance Improvement Plan
- Element B. Measurable Goals and Health Outcomes for the MOC
- Element C. Measuring Patience Experience of Care (D-SNP Member Satisfaction)
- Element D. Ongoing Performance Improvement Evaluation of the MOC
- Element E. Dissemination of D-SNP Quality Performance Related to the MOC

D-SNP MOC Responds to Our Mission

SCFHP Commitments:

- To **improve the well-being** of our members by addressing their health and social needs in a culturally competent manner.
- Strive for **quality health outcomes** for all members.
- Support **Primary Care Providers (PCPs)** in executing effective care plans.
- **Educate, guide, and connect** members to health services and community resources.

SCFHP provides services to:

- Frail elderly individuals requiring specialized care.
- High health risk individuals facing significant health challenges.
- Low-income and those with limited socioeconomic resources.
- Individuals with multiple chronic and acute health conditions.
- Individuals at risk of non-compliance with medications and treatment plans.
- Isolated individuals who lack family support or social support systems.
- Individuals with limited English proficiency or low health literacy.
- Individuals facing barriers to accessing community resources and support services.

SCFHP offers a D-SNP

SCFHP DualConnect is an HMO D-SNP:

- Designed to serve individuals with both Medicare and Medicaid benefits.
- Exclusively available to residents of Santa Clara County.
- Enrollees have $0 out-of-pocket costs for covered medical services.

As of January 2025:

- SCFHP has 10,863 beneficiaries enrolled in SCFHP DualConnect in Santa Clara County.
- Santa Clara County is the sixth largest county in California with a total population of about 1.9 million and is a racially/ethnically diverse community.

Health Risk Assessment (HRA)

- The self-reported survey includes questions on **medical, psychosocial, cognitive, functional, and behavioral health** aspects**.**
- New enrollees are sent the initial HRA and given **30 calendar days** to complete it. The HRA is also administered **annually** or whenever there is a **change** in the members' condition or **transition** of care.
- If the HRA is not returned **within one month, following five** phone attempts, a second letter is sent, accompanied by a follow up call to complete the HRA telephonically.
- Members are stratified into risk categories to facilitate tailored care coordination.
- The HRA is shared with the Interdisciplinary Care Team (ICT), including the member, their caregiver, and their provider, ensuring collaborative care.
- The HRA serves as the **foundation for the Individualized Care Plan (ICP)**.

The Development of an Individualized Care Plan (ICP)

- HRA responses are utilized to develop and update the ICP.
- When members do not respond to the **HRA, claims and pharmacy data** are leveraged to create the ICP.
- The ICT evaluates and analyzes data to focus care efforts, improve quality, and optimize risk scores.
- The ICP is securely maintained and stored to ensure access for all care providers while adhering to HIPAA regulations and professional standards.
- **The ICP includes:**
    - Member's health care preferences.
    - Goals, objectives, and targets with detailed tasks and self-management strategies.
    - Interventions and services designed to address the member's unique and specific needs.
    - Documentation of whether time-bound goals have been met or remain unmet.

ICP Goal Model

ICP goals are based on the SMART Measurable Goal Model:

1. **Specific** – Clearly defines what the member is expected to learn or accomplish.
2. **Measurable** – Establishes a quantifiable goal with specific result that can be captured, reported, and documented in the ICP.
3. **Attainable** – Ensures the goal is realistic and achievable by the member, considering their abilities and circumstances.
4. **Relevant** – Links the goal directly to the member's health status and care plan objectives.
5. **Time-Bound** – Specifies a clear deadline or time period for achieving the goal, using defined dates, durations, or calendar benchmarks to motivate and evaluate progress.

Individualized Care Plan (ICP)

- **ICP Documentation Update:** The member's ICP will be updated in the care management system whenever there is a change in the member's health status or at a minimum annually.
- **Communication of ICP updates:** Any updates or changes to the ICP will be communicated to the member, caregiver(s), and PCP.
- **ICP Documentation Distribution:** A copy of the updated ICP will be sent to both the member and PCP to ensure consistent care coordination and follow-up.
- **Member Acknowledgement:** The member will be provided with an opportunity to review and acknowledged the updated ICP, ensuring they are an active participant in the planning and decision-making process.
- **ICP for Non-Responsive Members:** Members who do not respond to the Health Risk Assessment (HRA) will still receive an ICP, created based on available pharmacy and medical claims data.

Interdisciplinary Care Team (ICT)

D-SNP MOC Training: All staff are trained on the D-SNP MOC initially and a refresher training annually.

Case Manager as Primary Contact: The Case Manager serves as the primary point of contact for all ICT members, ensuring seamless communication and coordination of care.

The ICT Composition: The ICT will, at a minimum include the following key participants:

- The member
- A family member and/or caregiver, as approved by the member
- The County IHSS social worker, if the member is receiving In-Home Supportive Services (IHSS)
- A licensed SCFHP Care Coordination staff member
- The PCP

In addition to the previously listed ICT individuals, the ICT will also include individuals or providers actively involved in the member's care, with the member's approval and when appropriate including:

- Hospital discharge planner
- Nurse
- Social worker
- Nursing facility representative
- Specialized providers, including physician specialists, pharmacists, physical therapists, and occupational therapists
- The IHSS provider, if receiving IHSS
- The CBAS provider; if participating in Community-Based Adult Services (CBAS)
- The MSSP care manager, if enrolled in the Multipurpose Senior Services Program (MSSP) waiver program
- Behavioral health service provider
- Other relevant professionals, as needed
- While the member is at the center of the ICT, providers plays an integral role in ultimately determining the services the member may receive.
- The member's PCP serves as the primary clinical care coordinator and works closely with the case manager.
- The ICT supports care management by completing HRA, developing care plans, authorizing services, and addressing transitional care needs.
- The ICT collaborates with the member to stabilize medical conditions, improve adherence to the ICP and achieve ICP goals outlined in the ICP for optimal health and functional status.

Network Providers

- Ensure providers are fully credentialed in accordance with established policies and procedures.
- Participate in the member's ICT as required for coordinated care.
- Include relevant clinical information into the member's ICP to inform care decisions.
- Adhere to transition of care protocols to ensure seamless service delivery
- Utilize clinical practice guidelines to guide care and treatment decisions.
- Participate in regularly scheduled MOC training to stay current on best practices.
- Report on Stars and HEDIS outcomes to monitor and improve quality of care.
- Use satisfaction surveys to evaluate and report on member satisfaction with the MOC.

Care Coordination Activities

- Performs an assessment of medical, psychosocial, cognitive, functional, and mental health needs and status.
- Develops a comprehensive ICP based on assessment findings.
- Identifies barriers to goals and develops strategies to overcome them.

- Provides personalized education to promote optimal wellness.
- Promotes and encourages engagement in preventive care measures.
- Conducts post-discharge planning to ensure a smooth transition.
- Reviews and educates the member on medication regimen.
- Assists the member to access appropriate community resources.
- Provides support to the caregiver when member is unable to participate in care.
- Serves as a single point of contact during care transition process.

Transitions of Care

- Care transitions occur when a member moves from one health care provider or setting to another; such as a member was admitted to hospital and discharged to home, acute rehab, or skilled nursing facility.
- Transition of Care notices are sent to the member's PCP to ensure continuity of care.
- SCFHP will update the ICP if there are changes in the member's health status or during a care transition.
- SCFHP encourages members to schedule a follow-up appointment with their PCP within 5 days of discharge.

References

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326
- Model of Care Scoring Guidelines - https://snpmoc.ncqa.org/
- SCFHP Policies and Procedures

Marketing

Compliance with Laws & Regulations

SCFHP Medi-Cal	SCFHP DualConnect
Marketing of SCFHP Medi-Cal is regulated by the DHCS and DMHC. Providers must adhere to all applicable laws, regulations, DHCS guidelines, and DMHC guidelines regarding plan marketing, including but not limited to those specified in DHCS and/or DMHC All Plan Letters (APL, Title 22 California Code of Regulations (CCR) 53880 and 53881 and Welfare and Institutions Code	Marketing of SCFHP DualConnect is regulated by the CMS and DHCS. Providers must adhere to all applicable laws, regulations, CMS guidelines, and DHCS guidelines regarding 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, §423.2260, and §422.2266 et. seq.; the Medicare Communications & Marketing Guidelines (MCMG) (Chapter 3

Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411.	of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual); the Value-Based Insurance Design Model MCMG; and the DHCS D-SNP Policy Guide.

Under program rules, network providers may not distribute any SCFHP marketing materials or make such materials or forms available to individuals eligible to enroll in a plan unless the materials meet marketing guidelines, and are first submitted to SCFHP and DHCS/DMHC for review and approval.

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.

Acceptable Marketing Methods

As an **SCFHP Medi-Cal** and/or **SCFHP DualConnect** health care provider, you may:

- Tell your patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your patients to seek out and receive information and enrollment materials that help them select a health care plan for themselves and/or their family.
- Provide patients with the phone number of the outreach and enrollment or Customer Service departments of the plan(s) with which you are affiliated.
- Distribute SCFHP materials to beneficiaries that have already been reviewed and approved by SCFHP.
- Provide patients with the toll-free phone number of Health Care Options (HCO), the DHCS enrollment contractor (**1-800-430-4263**) and inform patients of locations and times when they may receive information from HCO about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information and activities, presentations, and problem resolution functions.

Prohibited Marketing Methods

As an **SCFHP Medi-Cal** or **SCFHP DualConnect** health care provider, you may NOT:

- Coerce, threaten, or intimidate patients into making a particular health plan selection.

- Tell patients they could lose their benefits if they do not choose a particular health plan.
- Tell patients they will be billed if they do no change to a particular health plan or provider.
- Make any reference to competing plans; one example would be comparing plans in a positive or negative manner.
- Copy sample enrollment forms with your name filled in and distribute them to patients, use photocopied blank forms, or use plan-printed enrollment forms.
- Make false or misleading claims, inquiries, or representations that:
    - Office staff are employees or representatives of the State or County.
    - A plan is recommended or endorsed by any State or County agency or any other organization.
    - The State or County recommends that a beneficiary enroll with a specific health plan.
- Offer or give any form of compensation, reward, or loan to a prospective enrollee to induce or procure beneficiary enrollment in a specific health plan.
- Use any list of beneficiaries obtained originally from confidential State, County, or health plan data sources or from the data sources of other contractors for enrollment purposes.
- Engage in marketing practices which discriminate against prospective members based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
- Sign an enrollment application for the member.
- Provide marketing presentations by a health plan or provider's staff at primary care sites.
- Conduct health screenings as a marketing activity.
- Accept compensation from a health plan for any marketing or enrollment activities.
- Make phone calls to direct, urge, or attempt to persuade patients to enroll in a specific plan based on financial or any other interests of the provider.
- Engage in any marketing activity on State or County premises or any other location not authorized in the health plan's marketing plan.
- Distribute unauthorized or unapproved material to beneficiaries.

Engaging in prohibited practices may result in requests for corrective action from SCFHP and sanctions including fines imposed by DHCS.

Member Informing Materials

Written member information materials provide members with essential information about access to and use of SCFHP-covered services. These materials must be developed in

accordance with all applicable regulatory requirements, including requirements for readability and accessibility, and must be submitted for prior regulatory approval.

Providers must submit drafts of any proposed member informing materials and a readability report demonstrating 6th grade reading level or lower to the SCFHP Marketing Department 90 days prior to distribution.

Benefits

SCFHP Medi-Cal	SCFHP DualConnect
Upon enrollment and on an annual basis, SCFHP Medi-Cal members are notified of the online availability of the Member Handbook (Evidence of Coverage). The Member Handbook contains a detailed summary of benefits as well as other useful information about their health plan.	SCFHP DualConnect coordinates all Medicare and Medi-Cal benefits, including Part D prescription drug coverage, in one health plan. Member benefits, as described in the Member Handbook, include medical care, prescription medications, behavioral health care, 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 SCFHP DualConnect 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 SCFHP DualConnect benefit package. Providers may not bill SCFHP DualConnect members for covered services, open bills, or balances in any circumstance, including when SCFHP has denied payment.

Please email Provider Network Operations at ProviderServices@scfhp.com should you wish to receive copies of the SCFHP Medi-Cal Member Handbook (EOC) or SCFHP DualConnect Member Handbook (EOC). You can also download a Member Handbook at www.scfhp.com under SCFHP DualConnect Member Materials or Medi-Cal Forms & Documents.

Grievance & Appeals

SCFHP responds promptly to complaints from either a provider or a member. Grievances impact provider performance. 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 rudeness of a provider or office staff. A complaint is the same as a grievance. A grievance can be filed at any time regardless of the date of the occurrence or issue.

Appeal is a formal request for SCFHP to reconsider an adverse benefit determination (e.g., denial, deferral, or modification of a decision about health care coverage) that a member believes he or she is entitled to receive.

Filing a Member Grievance

A member or his/her appointed representative may file a grievance at any time. Grievances may be submitted to SCFHP in one of the following ways:

- Submit an online form via SCFHP website: https://www.scfhp.com/for-members/grievance-and-appeal-process/.
- Call Customer Service at **1-800-260-2055**, or TTY **711**.
- Fill out the Grievance and Appeal Form or submit a letter by mail:

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

- By fax at 1-408-874-1962
- In person at Santa Clara Family Health Plan

All member grievances regarding a specific provider are reported to the Credentialing Department. The information is included in the physician's credentialing file and reviewed as part of the re-credentialing process.

Standard Grievances

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 from a provider or other stakeholder, including medical records necessary to appropriately resolve the issue.

SCFHP issues a resolution letter within 30 calendar days of receipt of the grievance.

Expedited Grievances

An expedited grievance may be requested in writing, by telephone, in person, or through our website. SCFHP is required to resolve Medi-Cal expedited grievances within 72 hours and SCFHP DualConnect expedited grievances within 24 hours of receipt.

Quality of Care Grievances

Medi-Cal	SCFHP DualConnect
Members have the right to file a complaint with SCFHP about quality of care. All such complaints are thoroughly investigated by identifying and requesting information (i.e., medical records) necessary to evaluate the complaint. Our CMO/Medical Director and Quality Improvement Department review all issues related to quality of care. Screening criteria for identifying quality of care related grievances, as established by our CMO/Medical Director, include the following circumstances: • Patient disagrees with the provider's treatment, i.e. medication prescribed and technique of examination. • Patient disagrees with the provider's diagnosis. • Patient reports that the provider failed or refused to refer him/her to a specialist or other appropriate health care provider. • Lack of availability of the provider (during or after office hours) resulting in an adverse outcome. • Provider did not provide covered and medically necessary service.	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: • By Telephone at 1-877-588-1123 or TTY 1-800-881-5980. • Submit a letter by mail: Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, Maryland 20701 • Website: www.livanta.com All such complaints submitted to SCFHP are thoroughly investigated by identifying and requesting information (i.e., medical records) necessary to evaluate the complaint. Our CMO/Medical Director and Quality Improvement Department review all issues related to quality of care. Screening criteria for identifying quality of care related grievances, as established by our CMO/Medical Director, include the following circumstances: • Patient disagrees with the provider's treatment, i.e.

Medi-Cal	SCFHP DualConnect
• Patient reports adverse results of treatment. • Patient reports that the provider refused to provide treatment or services. • Requested health care services were deferred, modified or denied. • Patient reports concern regarding alleged inappropriate behavior on the part of the provider. Members may submit a complaint about quality of care orally or in writing. Participating providers or members who have questions about the member grievance process should contact the Customer Service Department at **1-800-260-2055**.	medication prescribed and technique of examination. • Patient disagrees with the provider's diagnosis. • Patient reports that the provider failed or refused to refer him/her to a specialist or other appropriate health care provider. • Lack of availability of the provider (during or after office hours) resulting in an adverse outcome. • Provider did not provide covered and medically necessary service. • Patient reports adverse results of treatment. • Patient reports that the provider refused to provide treatment or services. • Requested health care services were deferred, modified or denied. • Patient reports concern regarding alleged inappropriate behavior on the part of the provider.

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 may be filed in any one of the following ways:

- Call Customer Service at **1-877-723-4795** (TTY: **711)**.
- Submit a written request by mail:

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

- By fax at 1-408-874-1962
- Submit a request electronically by visiting SCFHP's website at www.scfhp.com and completing a complaint form online.
- In person at the SCFHP office

Part D Expedited Grievance

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 30 calendar days of receipt of the grievance.

Medi-Cal Rx Grievance

Members enrolled as a beneficiary in the DHCS Medi-Cal Rx pharmacy benefit or their appointed representative can file a grievance or appeal (used interchangeably) by visiting The DHCS Medi-Cal Rx Forms and Information web page.

Filing an Appeal

A member, his/her appointed representative or a provider may file an appeal. Appeals should be submitted to SCFHP within 60 calendar days after receipt of a notice of an adverse notice of action.

Appeals Review Process

If a member, member's representative or provider is dissatisfied with determination decision made by SCFHP, the member, member's representative or provider (with written consent) may initiate an appeal. The request for an appeal must be made within 60 calendar days from the date of the adverse Notice of Action.

Services or benefits that were previously authorized, but terminated through a Notice of Action will continue to through the appeal process if the request for continuation is filed

- Within 10 calendar days of the Notice of Action, or
- Before the date SCFHP intends to terminate services, explained through the Notice of Action

Standard Appeals

A provider, member or his/her appointed representative may file an appeal. Appeals may be submitted to SCFHP in one of the following ways:

- Submit an online form via SCFHP website: https://www.scfhp.com/for-members/grievance-and-appeal-process.
- Call Customer Service at **1-800-260-2055**, or TTY **1-800-735-2929**.
- Fill out the Grievance and Appeal Form or submit a letter by mail:

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

- By fax at 1-408-874-1962
- In person at the SCFHP office

Upon receipt of the appeal from the member, SCFHP may notify the PCP (or the appropriate provider) and will request relevant information and medical records to make a determination.

Within 5 calendar days of receipt of a request for appeal, our Grievance and Appeals Department sends an acknowledgment letter to the member appointed representative or provider, as appropriate. Standard appeals are resolved within 30 calendar days. The member and the appropriate provider are notified in writing of the appeal resolution.

If SCFHP decides in favor of the member, we authorize, pay for or provide the requested service within 72 hours of the decision to overturn the denial.

Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing and an Independent Medical Review. Medi-Cal members are also advised of their right to seek assistance from the Ombudsman Program.

Expedited Appeals

Expedited appeals are available in time-sensitive situations in which waiting for 30 days for SCFHP to process a standard appeal would seriously jeopardize the member's life, health, or ability to regain maximum function. Expedited appeals may be initiated:

- Submitting an online form via SCFHP website: https://www.scfhp.com/for-members/grievance-and-appeal-process/.
- Calling Customer Service at **1-800-260-2055**, or TTY **1-800-735-2929**.
- Filling out the Grievance and Appeal Form or submit a letter by mail:

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

- By fax at 1-408-874-1962
- In person at the SCFHP office

When an expedited appeal is requested, our CMO/Medical Director evaluates the request and the person's medical condition to determine if the request meets the criteria.

If the request for expedited appeal is granted, SCFHP makes a decision on the appeal within 72 hours. A request for payment for a service already provided to a member is not eligible to be reviewed as an expedited appeal. The member, member's representative, and/or appropriate provider are notified of the appeal resolution verbally and in writing.

For decisions in the member's favor, the disputed service is authorized as soon as possible, but no later than 72 hours of the decision to overturn the denial. A written notice will be mailed to the member, member's representative and/or provider. We will also follow up with a phone call notifying the appellant of the decision.

Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing and an Independent Medical Review. This is sent within 72 hours. Medi-Cal members are also advised of their right to seek assistance from the Ombudsman Program.

Member Appeals (SCFHP DualConnect*)*

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

Standard Appeals (SCFHP DualConnect)

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 by mail:

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

- Fax at **1-408-874-1962**
- In person at the SCFHP office
- Submit a request electronically by visiting www.scfhp.com and completing a complaint form online.

Appeals involving organization determinations other than payment issues are resolved within 30 calendar days. Appeals involving payment issues are resolved and claims paid within 60 calendar days and written notification is sent to the appellant.

Note: Unfavorable determinations on SCFHP DualConnect appeals are automatically forwarded to the Independent Review Entity.

Expedited Appeals (SCFHP DualConnect)

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.

Note: Unfavorable determinations on SCFHP DualConnect appeals are automatically forwarded to the Independent Review Entity.

Members with Medi-Cal related appeals may request a State Fair Hearing only after filing receiving a Notice of Appeal Resolution of the Medi-Cal covered services and/or items (including IHSS).

The State Fair Hearing request must be filed within 120-calendar-days from the date of the Notice of Appeal Resolution.

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** or for TTY call **1-800-952-8349**.

Independent Review Entity (IRE)

A member may request a review by the independent review entity (IRE) when SCFHP issues an unfavorable decision of a Part D Appeal. 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.

Review by an 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 a SCFHP DualConnect 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 SCFHP DualConnect Member Handbook.

Provider Responsibility

SCFHP does not delegate authority or responsibility to providers for processing member grievances and appeals; however, we do require assistance from provider to help resolve member grievances and appeals by:

- Obtaining the member's written consent before filing an appeal.
- Immediately forwarding all member grievances or appeals to SCFHP for processing.
- Responding within designated timeframes to SCFHP's request for information relevant to the member's grievance or appeal.
- *If there is no provider response the PNA will follow-up via phone or drop in at the office to follow up.*
- Complying with all final determinations made by SCFHP about the grievance and/or appeal.
- Cooperating with SCFHP by promptly forwarding copies of all medical records and information pertinent to the disputed health care service, including any newly discovered relevant medical records or other information requested by our Medical Director or review committees.
- Maintain copies of the SCFHP grievance form in your office to provide to member's upon request. Grievance forms can be found at http://www.scfhp.com/medi-cal/forms-documents for Medi-Cal and http://www.scfhp.com/dc-member-materials for SCFHP DualConnect.

Section 3: Your Role as a Provider

Doula Services

Medi-Cal covers doula services, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Doulas serving Medi-Cal beneficiaries provide person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of beneficiaries while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

Definitions

Doula: Birth workers who provide health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth and abortion. Doulas are not licensed or clinical providers, and they do not require supervision.

Doula services: Doula services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period.

Evidence-based: A process whereby decisions are made and actions or activities are understood using the best evidence available with the goal of removing subjective opinion, unfounded beliefs or bias from decisions and actions. Evidence can include practitioner experience and expertise as well as feedback from other practitioners and beneficiaries.

Full-spectrum doula care: Prenatal and postpartum doula care, presence during labor and delivery and doula support for miscarriage, stillbirth and abortion. Doula care includes physical, emotional and other nonmedical care.

Postpartum period: Doulas may provide services for up to 12 months from the end of pregnancy. Beneficiaries are eligible to receive full-scope Medi-Cal coverage for at least 12 months after pregnancy.

Covered Services:

A recommendation for services authorizes all of the following:

- One initial visit.

- Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.
- The extended three-hour postpartum visits provided after the end of pregnancy do not require the beneficiary to meet additional criteria or receive a separate recommendation.

An additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice is required for up to nine additional postpartum visits billed with HCPCS code Z1038 (postpartum visit).

Doulas offer various types of support, including perinatal support and guidance; health navigation; evidence-based education and practices for prenatal, postpartum, childbirth and newborn/infant care; lactation support; development of a birth plan; and linkages to community-based resources. Coverage also includes comfort measures and physical, emotional, and other nonmedical support provided during labor and delivery and for miscarriage and abortion.

Claim Submission

Fee-for-service claims for doula services must be submitted by a doula enrolled in Medi-Cal or an enrolled doula group.

Place of Service

There are no Place of Service restrictions for doula services.

Billing Codes

Claims for doula services do not require a diagnosis code. The following codes may be used for all services listed above when submitting claims:

Prenatal and Postpartum Visits

- Z1032 – Extended initial visit 90 minutes
- Z1034 – Prenatal visit
- Z1038 – Postpartum visit
- T1032 – Extended postpartum doula support, per 15 minutes

The extended initial visit must be for 90 minutes to bill with Z1032. All visits are limited to one per day, per beneficiary. Only one doula may bill for a visit provided to the same beneficiary on the same day, excluding labor and delivery. One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery (including stillbirth), abortion or miscarriage support.

The prenatal visit or postpartum visit billed on the same calendar day as labor and delivery, abortion or miscarriage support may be billed by a different doula.

For extended postpartum visits lasting at least three hours, doulas may bill code T1032 (15 minutes per unit) for up to 12 units per visit, up to two visits (24 units) per pregnancy per beneficiary provided on separate days.

Labor and Delivery Support

- CPT® 59409 – Doula support during vaginal delivery only
- CPT 59612 – Doula support during vaginal delivery after previous caesarean section
- CPT 59620 – Doula support during caesarean section

Billing codes for support during labor and delivery are limited to once per pregnancy. Support during labor and delivery can be billed if this service is provided by a doula, whether or not the delivery results in a live birth.

Abortion or Miscarriage Support

- HCPCS T1033 – Doula support during or after miscarriage
- CPT 59840 – Doula support during or after abortion

Billing codes HCPCS code T1033 for miscarriage support and CPT code 59840 for abortion support are each limited to once per pregnancy.

Note: All claims must be submitted with the modifier XP (separate practitioner: a service that is distinct because it was performed by a different practitioner), appended to the billing code. This is to distinguish the claim from the services by the medical provider.

Informing a Beneficiary about Services by Non-Doula Providers

If a beneficiary requests or requires one of the pregnancy-related services listed below that is not covered under the doula benefit, the doula should inform the beneficiary that another Medi-Cal provider is able to render the requested service.

These services include, but are not limited to, the following Medi-Cal services that are **not part of the doula benefit**:

- Behavioral health services
- Belly binding after cesarean section by clinical personnel
- Clinical case coordination

- Health care services related to pregnancy, birth, and the postpartum period
- Childbirth education group classes
- Comprehensive health education, including orientation, assessment, planning
- (Comprehensive Perinatal Services Program services)
- Hypnotherapy (non-specialty mental health service)
- Lactation consulting, group classes, and supplies
- Nutrition services (assessment, counseling, and development of care plan)
- Transportation

Non-Covered Services

The following services for pregnant or postpartum beneficiaries are not covered as Medi-Cal doula services and are not covered under Medi-Cal:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on baby wearing
- Massage (maternal or infant)
- Still and Video Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

Doulas are not prohibited from teaching classes that are available at no cost to individuals, including Medi-Cal beneficiaries to whom they are providing doula services.

Documentation Requirements

Doula services require a written recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within the beneficiary's managed care plan.

The initial recommendation can be provided through the following methods:

- Written recommendation in beneficiary's record.
- Standing order for doula services by plan, physician group or other group by a licensed provider.
- Standard form signed by a licensed provider that a beneficiary can provide to a doula.

A second recommendation is required for additional visits during the postpartum period. A recommendation for additional visits during the postpartum period cannot be established by standing order. The additional recommendation authorizes nine or fewer additional postpartum visits, billed with HCPCS code Z1038.

Doulas are required to document the dates and time/duration of services provided to beneficiaries. Documentation should also reflect information on the nature of the care and service(s) provided and support the length of time spent with the beneficiary that day.

For example, documentation might state, “Discussed childbirth education with beneficiary and discussed and developed a birth plan for 1 hour.” Documentation shall be accessible to DHCS upon request.

Doula Minimum Qualifications:

All doulas must be at least 18 years old, possess an adult/infant CPR certification, and have completed basic HIPAA training.

In addition, a doula must meet either of the following qualification pathways:

Training Pathway:
Complete a minimum of 16 hours of training in the following areas:

- Lactation support
- Childbirth education
- Foundations on anatomy of pregnancy and childbirth
- Nonmedical comfort measures, prenatal support and labor support techniques
- Developing a community resource list

Provide support at a minimum of three births

Experience Pathway:
Or all of the following:

- At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
- Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula or community-based organization.
    - Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization or an enrolled doula.

Doulas must complete three hours of continuing education in maternal, perinatal and/or infant care every three years. Doulas shall maintain evidence of completed training to be made available to DHCS upon request.

Recommended Trainings:

Doulas need to be able to serve the unique needs of Medi-Cal beneficiaries. As such, supplemental training that is recommended but not required, includes, but is not limited to, the following:

- Perinatal support
- Hands-on support with clients
- Trauma-informed care
- Cultural sensitivity or competency, implicit bias or anti-racism or social determinants of
- health for birthing populations
- Perinatal mood and anxiety disorders
- Intimate partner violence
- Postpartum care/support
- Infant and newborn care
- Perinatal loss and bereavement support

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 including those from the American Academy of Pediatrics, the United States Preventive Services Task Force "A" and "B" recommended services, and the American College of Obstetricians and Gynecologists.
- Providing quality care.
- Coordinating referrals to specialists.
- Facilitating patients' access to treatment.
- Referring patients to health education classes.
- 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 a patient's Initial Health Appointment (IHA) 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 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 the PCP's 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 the PCP's office to assure that the visits actually occur.
- Screen for social determinants of health (SDOH) and intervene on the patients' behalf.

Standard of Care

Providers agrees to use best efforts in providing and/or arranging for the provision of Covered Services, and in performing its other duties under their Provider Contract in order to provide a standard of care in conformity with generally accepted medical practice standards in effect at the time of service. A provider may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Clinical Guidelines

The PCP is responsible for determining the medical needs of their assigned members. However, our Medical Department can assist providers 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); the scientific literature; reasonable 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
- Diabetes Coalition of California
- United States Preventive Services Task Force (USPSTF)

We also assist PCPs 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 at https://www.scfhp.com.

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

Please check out the SCFHP website for additional information and assistance with Clinical Practice Guidelines.

The Initial Health Appointment (IHA)

SCFHP's contract with the Department of Health Care Services (DHCS) require each new Medi-Cal member to receive their Initial Health Appointment (IHA) from the PCP within 120 days of enrollment per APL 22-030.

PCPs are required to conduct at least two (2) outreach efforts to schedule an IHA within 120 days of enrollment. Pregnant members must be scheduled for theirs as soon as possible following discovery of the pregnancy. To help the PCP meet these timelines, we provide a list of new or re-enrolled members each month in Provider Link.

The IHA 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.
- Assess and diagnose acute and chronic conditions as well as identify

risks.
- Age-specific assessments for the need for preventive screens or services, and health education.
- Diagnoses and plan for treatment for any diseases.

In addition:
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings will be required in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule Recommendations for Preventive Pediatric Health Care
- All preventive screenings for adults per Grade A and B recommendations from the United States Preventive Services Task Force (USPSTF) are required but all of these elements do not need to be completed during the IHA as long as members receive all required screenings throughout the course of their care
- Immunizations are administered according to CDC's most recent ACIP guidelines for adults and pediatrics. Providers are required to use CAIR.
- DHCS will be measuring primary care visits as a proxy for the IHA via Managed Care Accountability Sets (MCAS) measures (infant and child/adolescent well-child visits and adult preventive visits)
- For children enrolled in Medi-Cal Managed Care (MCMC) plans, primary care visits and childhood screenings will be the proxy for the IHA, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, SUD
- The baby is covered under the mom for the first and second month in which the baby is born. Santa Clara Family Health Plan will pay for 60 days after the birth of the baby. After 60 days coverage will start on the 1st of the month.
    - Example: If the baby is born on 02/15/2024, then is on their own effective 04/01/2024

Please note that the services described below do not meet the criteria for an IHA:
- Perinatal visits, other than the initial complete assessment of a pregnant woman according to ACOG guidelines.
- Specialty visits
- Urgent-care and/or emergency visits or services.

Assessment Tools for Performing the 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.

IHA 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 as recommended by ACOG.

Exemption of the IHA Requirement

The refusal by any member including emancipated minors or a member's parent or guardian of an IHA including all exemptions from the IHA requirement must be documented in the medical record. Additional details are available here.

Lead Screening

Lead toxicity can negatively impact the cognitive, motor, behavioral, and physical abilities of young children. The only way to determine lead exposure is through a blood lead screening. California state statutes and regulations impose specific responsibilities on health care providers doing periodic health care assessments on children between the ages of six months and six years. A Lead Screening Workflow resource is available within the Provider Tips Sheets and Best Practices web page. Additional details and requirements on blood lead screening are available in APL 20-016, with pertinent details including but not exclusive to:

1) Lead screening guidelines for children

   Providers must comply with the following lead screening guidelines:

   - Childhood Lead Poisoning Prevention Branch
   - California Department of Health Care Services (Blood Lead, Anticipatory Guidance)
   - CDC Guidelines (Lead Screening for Refugees)

   Providers must order or perform blood lead screening tests on all children in accordance with the following:

   - At 12 months and at 24 months of age.
   - When the provider performing a PHA becomes aware that a child who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
   - When the provider performing a PHA becomes aware that a child who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
   - At any time, a change in circumstances has, in the professional judgment of the provider, put the child at risk.
   - If requested by the parent or guardian.

2) Anticipatory guidance to caregivers

   Providers must provide written or oral anticipatory guidance to caregivers. The state has provided an example that can be used in English and in Spanish.

3) Documentation of offering lead screening and refusal

   Providers must document when a blood lead screening is offered to patients, whether the screening was refused and the reason for refusal. Providers must have the caregiver sign off indicating refusal of the screening. Medical record documentation is adequate if the appointment is completed through telehealth. SCFHP will audit medical records during Facility Site Review for evidence of documentation for offerings and refusals of lead screening.

4) Common procedural terminology

   Providers must use appropriate Common Procedure Terminology (CPT) coding to ensure accurate reporting of all blood lead screening tests.

   SCFHP expects providers to use CPT code 83655 for blood lead screening. If a capillary blood sampling (CPT code 36416) is used, the provider must submit an Online Blood Lead Reporting Form to the Childhood Lead Poisoning Prevention Branch and report their findings along with other information. More information on capillary blood sampling for lead screening can be found here.

5) Provider notification of missed blood lead testing SCFHP is required to provide quarterly notifications to providers with patients who have missed a blood lead screening. SCFHP will display this information on Provider Link, http://providerportal.scfhp.com, in the Gaps in Care section. If you do not have access to Provider Link or need help accessing it, please contact the Provider Network Operations team.

SCFHP providers are expected to follow the current guidelines related to Blood Lead Screening for Children. These guidelines are also available on the SCFHP website, www.scfhp.com.

Should you have any questions regarding this APL or SCFHP's expectations of providers, please contact the Provider Network Operations team.

Developmental Screening

Santa Clara Family Health Plan Network providers must follow the American Academy of Pediatrics (AAP) guidelines and recommendations at each well-child visit. AAP recommends developmental screenings must be administered regularly during each

well-child visit at the 9-, 18-, and 30-month visits (30-month screening may be done at 24 months). The developmental screenings are intended to track language, movement, thinking, behavior, and emotional development. Any concerns raised during surveillance should be promptly addressed. Screenings must include scoring and documentation using a standardized screening tool that meets criteria set forth by the American Academy of Pediatrics (AAP) and the Centers for Medicare and Medicaid Services (CMS). A Developmental Screening Workflow resource is available within the Provider Tips Sheets and Best Practices web page.

Use any of the following AAP-recommended tools to meet the requirements:

- Ages and stages questionnaire (ASQ) - 2 months to age 5
- Ages and stages questionnaire - 3rd edition (ASQ-3)
- Battelle developmental inventory screening tool (BDI-ST) - Birth to 95 months
- Bayley infant neuro-developmental screen (BINS) - 3 months to age 2
- Brigance screens-II - Birth to 90 months
- Child development inventory (CDI) - 18 months to age 6
- Infant development inventory - Birth to 18 months
- Parents' evaluation of developmental status (PEDS) - Birth to age 8
- Parents' evaluation of developmental status - Developmental milestones (PEDS-DM)

Patients with Special Care Needs

If the results of an IHA indicate the member has special health care needs, either physical, mental, behavioral, or developmental concerns, please document this in the patient's record and refer the person to the appropriate agencies 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 **1-877-590-8999** or for TTY dial **711** if you need assistance. Be sure to check out the Case Management section in this manual for additional detail.

Choosing a PCP

All SCFHP members are able to select a PCP of their own. When a member is unable to make a positive PCP selection, each is put through one of two auto assignment processes in the order of:

Medi-Cal Administrative Auto Assignment

For **Medi-Cal**, the first auto assignment step assigns each member who has not made a positive PCP selection to an administrative network in their initial month of enrollment. They will receive a member ID card that indicates "No PCP Selected." Providers may still see these members and submit related claims for payment based on their Provider Contract. Providers rendering service(s) to members with no PCP selection made are strongly encouraged to assist these members in selecting them as their PCP via SCFHP's member portal or by calling SCFHP's Customer Service line at **1-800-260-2055**. More information on administrative auto assignment is available here. If a member after their first month of enrollment has not yet made a positive PCP selection, they are auto-assigned to a PCP the second month using a quality-based auto assignment process.

Quality-Based Auto Assignment

While SCFHP excludes PCPs from the auto assignment process for Potential Quality Issue (PQI) levels, SCFHP also recognizes and rewards PCPs with additional member assignments for high quality care based on the preceding calendar year's (measurement period) quality results.

One Door Policy

Primary care providers affiliated with entities including but not exclusive to multiple plans, independent physician groups, medical groups will only be recognized as a PCP and assigned members through one (1) of those contractual relationships, or one door.

Timely Access & Availability (TAA) Standards

SCFHP adheres to timely access and availability requirements set by regulatory agencies based on appointment or type of service. A third party designated by SCFHP conducts a timely access and availability survey annually, contacting all providers within the SCFHP universe to verify these standards are being met. If and when timely access and availability standards are not met, SCFHP issues Corrective Action Plan (CAP)

letters to each deficient provider requiring them to take TAA training available on the SCFHP website and then attesting to the completion of training. Providers can review timely access and availability standards based on the provider's specialty, appointment type, and service type in the tables below.

Primary Care Providers

Appointment or Type of Service	Criteria	Standard Access Timeframe
Urgent Appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation.	Appointment offered within 48 hours of request.
Non-Urgent (Routine) Appointment	Immediate care is not needed. For example, this appointment type could be related to new health issues or a follow up for existing health problems.	Appointment offered within 10 business days of request.

Specialists

Appointment or Type of Service	Criteria	Standard Access Timeframe
Urgent Appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation.	Appointment offered within 96 hours of request.
Non-Urgent (Routine) Appointment	Immediate care is not needed. For example, this appointment type could be related to new health issues or a follow up for existing health problems.	Appointment offered within 15 business days of request.

Obstetrics & Gynecology

Appointment or Type of Service	Criteria	Standard Access Timeframe
First Prenatal Visit	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation.	Appointment offered within 48 hours of request.

Behavioral Health

Appointment or Type of Service	Criteria	Standard Access Timeframe
Non-Life Threatening Emergency Appointment.	Immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others.	Appointment offered within 6 hours of request
Urgent Appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation.	Appointment offered within 48 hours of request.
Non-Urgent (Routine) Appointment	An assessment of care is required with no urgency or potential risk of harm to self or others.	Appointment offered within 10 business days of request.
Follow-Up Routine Appointment	Follow up care is required for non-urgent/routine care.	Appointment offered within 30 business days of request.

Other Types & Facilities

Appointment or Type of Service	Criteria	Standard Access Timeframe
Ancillary	Diagnosis or treatment of injury, illness, or other health condition.	Appointment offered within 15 business days.
Pharmacy	Dispensing of a covered outpatient drug in an emergency situation.	Provide at least a 72-hour supply of a covered outpatient drug.
Skilled Nursing Facility (SNF)	Patients functional or medical complexities are such that the outcome would be compromised with less than daily skilled services.	Provide service within 5 business days.
Intermediate Care Facility (ICF)	Services for developmental disabilities.	Provide service within 5 business days.
Community Based Adult Services (CBAS)	The setting supports access to and receipt of services in the community to meet participants' needs.	Same as current *1115 Waiver*; providers to consider the urgency of the services needed to meet requirements on timely access to care and services.

Extended Appointment Waiting Time for Non-Urgent/Routine Appointments: The waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or health professional providing triage or screening services, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Rescheduling Appointments: When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care is consistent with professional and good practices.

Interpreter Services: Providers are required to offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency. Qualified translators should also be used when translating written content in paper or electronic form.

Preventive Care Access Requirements

Appointment or Type of Service	Standard Access Requirements
Appointments including, but not limited to: • Periodic follow-up • Standing referrals for chronic conditions • Pregnancy • Cardiac condition • Mental Health condition • Lab and radiology monitoring	May be scheduled in advance and must be consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his/her practice.

Telephone Access & In-Office Wait Times

Appointment or Type of Service	Standard Access Requirements
Patient incoming calls	Patient calls must be picked up within 60-seconds.
Telephone Triage & Screening	Patients must be offered a triage or screening 24-hours a day, 7 days a week **and** patient phone calls for medical related issues must be returned within 30 minutes.
Returning patient phone calls for non-medical related inquiries.	Patient phone calls should be returned within one (1) business day.

Appointment or Type of Service	Standard Access Requirements
In office wait time	Patients must be seen by the provider within 30 minutes or less from the scheduled appointment time.

After-Hours Accessibility

Appointment or Type of Service	Standard Access Requirements
Automated systems, office, or exchange/answering services	Must inform the patient that the provider will call-back within 30 minutes.
Life threatening situation	Automated systems must provide emergency 911 instructions, such as: • "Hang up and dial 911 or go to the nearest emergency room." Behavioral Health providers should include the number to the Santa Clara County Suicide and Crisis Hotline: • "Hang up and dial 911 or go to the nearest emergency room or call the Santa Clara County Behavioral Health center at **1-800-704-0900**."
Returning patient phone calls for non-medical related inquiries.	Patient phone calls should be returned within one (1) business day.
Urgent need to speak with a provider	Automated systems, office, or exchange/answering services must connect the member with an on-call provider or should direct the member on how to contact a provider after hours.

Network Adequacy Requirements

SCFHP and delegated networks are held to the following network adequacy requirements on a network-specific basis: The DHCS is required by federal and state

law to certify each Managed Care Plan's (MCP) aggregate network annually for a prospective review of the MCP's networks. For purposes of DHCS' Annual Network Certification (ANC), a network consists of Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and other providers that contract with an MCP, or its subcontractors for the delivery of Medi-Cal covered services. MCPs are required to annually submit ANC documentation to DHCS to demonstrate compliance with network adequacy requirements.

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

Medi-Cal covers ambulance and non-emergency medical transportation (NEMT) only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care. Non-medical transportation (NMT) is used for a recipient to obtain covered Medi-Cal services. NMT includes a minimum of a round trip transportation for a recipient to obtain covered Medi-Cal services by passenger car, taxicab or any other form of public or private conveyance. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated recipients by ambulance, litter van or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations, as these would be covered as NEMT.

Non-Emergency Medical Transportation (NEMT)

- 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**.
- Once SCFHP authorizes the prior authorization request for NEMT, the member may call SCFHP Customer Service to arrange transportation.
- SCFHP requires five (5) business days 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.

Interpreter & Translation Services

SCFHP provides foreign language and American Sign Language interpreters to members at all points of contact for any covered service at no cost to members or providers. Please see the Cultural & Linguistics section in this manual for additional details on how to use these services.

Provider Preventable Condition

Providers shall report critical incidents (critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical, or mental health, safety, or well-being of a member) within 24 hours of providing care to a Member by filling out the PQI form found on SCFHP website: https://www.scfhp.com/for-providers/quality-improvement-program/ and submitting it to SCFHP's Quality Improvement Department at pqi@scfhp.com. 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 SCFHP from paying for the treatment of PPCs, and payment adjustments may be applied to related claims. SCFHP must review all claim and encounter data to identify submitted PPCs and report them to the Audits and Investigation Division of the 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. Definitions of PPCs are available here.

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.

Providers should use the DHCS' secure online reporting portal to report PPCs to the DHCS. Managed Care Plan network providers should also report the PPC to the beneficiary's plan. Please see All Plan Letter (APL) 17-009 for more information for managed care plans.

Please note that reporting PPCs for Medi-Cal beneficiaries to the DHCS does not remove the reporting requirement of adverse events and healthcare-associated infections (HAI) to the California Department of Public Health, pursuant to Health and Safety Code sections 1279.1 and 1288.55.

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 notify SCFHP of the PPC or HCAC. 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:

- PA: Surgery wrong body part
- PB: Surgery wrong patient
- PC: Wrong surgery on patient

Please email the Provider Network Operations team at providerservices@scfhp.com with any related questions or concerns.

Section 4: Health Services

Authorizations

The information in this chapter is relevant for directly contracted providers and not SCFHP's delegated provider networks, which use their own authorization processes. Delegated provider networks may be located here: https://www.scfhp.com/for-providers/submit-a-claim-or-dispute/.

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.

Please contact the Utilization Management team by **1-408-874-1821** with any related questions or concerns.

SCFHP Review and Decision Process

Individual authorization requests are reviewed by the 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 Chief Medical Officer (CMO)/Medical Director may need to speak directly with the provider to discuss the request.

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

- MCG Health Guidelines
- Medi-Cal Provider Manual
- Medicare Benefit Policy Manual
- Noridian Medicare
- American College of Obstetricians and Gynecologists (ACOG) Guidelines
- United States Preventive Services Task Force (USPSTF): Guide to Clinical Preventive Services
- National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines

- American Academy of Family Physicians (AAFP)
- Centers for Disease Control and Prevention (CDC)
- United States National Library of Medicine database (MEDLINE and PubMed)
- Recommendations from actively participating board-certified specialists

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
- Clinical judgement
- Other relevant factors, per the physician's discretion.

Developing New Guidelines or Protocols

The UM Department maintains a list of expert specialists 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 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.

Routine Pre-Service Requests

For routine pre-service requests for procedures/services that can be pre-scheduled without risk of an adverse outcome to the member, SCFHP makes a determination within 5 business days of receipt of the request and appropriate documentation of medical necessity.

Medical Services or Procedures Requiring Prior Authorization (PA)

Medical services that require prior authorization from SCFHP are identified in our website.

Prescribing/treating/ordering physicians may request authorization by completing the appropriate electronic Prior Authorization Request (PAR) form, attaching clinical documentation to support the request, and submitting through Provider Link. Check out the Eligibility & Enrollment Section for details on using Provider Link.

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.

You may discuss any pertinent details with the Utilization Management Department by calling **1-408-874-1821**.

Prior Authorizations for Ancillary Services

When ancillary services such as home health care, medical supplies, rehabilitation services, and DME are required, the UM Department works with the physician to select an appropriate provider based on the member's medical needs and assists the provider and member with care management. Prior authorization is required for these services including documentation of medical necessity and a prescription signed by the ordering physician.

The PCP or prescribing physician should access Provider Link to complete the prior authorization process.

Ancillary services requiring a prior authorization are identified on the Medical Covered Services Prior Authorization Grid available here.

Major Organ Transplant (MOT)

All managed care plans are required to cover the MOT benefit for adult transplant recipients and donors, including related services such as organ procurement and living donor care. Managed care plans will not be required to pay for costs associated with pediatric transplants that qualify as a California Children's Services (CCS) condition. Additional information is available in the California Advancing and Innovating Medi-Cal (CalAIM) program website and All Plan Letter 21-015.

Emergency Care

For emergency inpatient admissions or emergency services, the hospital should contact SCFHP for verification of the member's eligibility. You may contact the UM Department by phone at **1-408-874-1821** or by fax at **1-408-874-1957**.

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

Contracted 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.

Hospital Inpatient Services

Admissions to an acute-care facility 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 90 days after the expected date of admission, with the exception of obstetric deliveries which do not require prior authorization.

Out-of-Network 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 us to confirm eligibility and obtain an 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 (post-stabilization).

Expedited Requests

Medi-Cal	SCFHP DualConnect
In medically urgent situations, you may request an expedited prior authorization review by faxing it to **1-408-874-1957**. Urgent authorization requests are reviewed within 72 hours of receipt. You will be notified of the decision by return phone call with a fax confirmation provided within 72 hours of the determination. If the faxed PAR is not urgent, it is considered to be a standard determination and will be processed within 5 business days. Urgent and standard requests may also be requested through the provider portal.	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. Urgent Medicare Part B drug requests are reviewed within 24 hours. If the faxed PAR is not urgent, it is processed within 14 calendar days. Urgent and standard requests may also be requested through the provider portal.

Direct Access Services (No Authorization Required)

Women's Health Services

A female member may elect to choose a participating 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, members may self-refer directly to a participating OB/GYN, or directly to a participating family practice physician and surgeon 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
- Abortion services

Annual Screening Mammography

SCFHP members may self-refer, within the provider group network, for an annual screening mammography. Providers are required upon request to provide members with a list of contracted mammography facilities.

Flu Vaccine

SCFHP members have direct access to an in-network physician for an annual flu vaccine. Providers are encouraged to inform your members about the availability of flu vaccines.

SCFHP members may also receive their flu vaccine through a Medi-Cal Rx enrolled pharmacy for **Medi-Cal** members or an SCFHP-contracted pharmacy for **SCFHP DualConnect** members.

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 recommended screening services for adults age 50-75.

If requested by a member, providers are required to provide members with a list of contracted providers who provide this service. Contracted providers can be found on our website.

Sensitive care

Minors may get the following service without a parent or guardian's permission if the member is 12 years old or older:

- Outpatient mental health care for sexual assault (no lower age limit) incest, physical assault, child abuse, thoughts of hurting themselves or others.
- HIV/AIDS prevention/testing/treatment.
- Sexually transmitted infections prevention, testing and treatment.
- Substance use disorder treatment services.
- Pregnancy.
- Family planning/birth control (including sterilization).

- Abortion services.

Minors and adults may choose any doctor or clinic for the following type of care:

- Family planning/birth control (including sterilization).
- Pregnancy testing and counseling.
- HIV/AIDS prevention and testing.
- Sexually transmitted infections prevention, testing and treatment.
- Sexual assault care.
- Outpatient abortion services.

The doctor or clinic does not have to be part of an SCFHP network. No referral or pre-approval (prior authorization) are required for these services.

Moral Objection

Providers have the right not to offer some covered services if they morally disagree with the services. Providers with a moral objection should help the member find another provider for the needed services. SCFHP can also work with the member to find a provider.

Obtaining a Second Opinion

Medi-Cal	SCFHP DualConnect
Members may receive a second opinion about a recommended procedure or service by way of their PCP submitting for a prior authorization. SCFHP's UM Department must review the request for medical necessity. Second opinions may be rendered only by a physician qualified to review and treat the medical condition in question. Authorizations to non-contracted providers or facilities will be approved only when the requested services are not available within the SCFHP network of contracted providers. 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.	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 or 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-contracted provider.

Medi-Cal	SCFHP DualConnect
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	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

Medi-Cal	SCFHP DualConnect
after the contract ends for the following conditions: • An acute condition • A serious chronic condition and/or a terminal illness • A pregnancy and care of a newborn child • Surgery or other procedure that has been authorized • Any other covered service dictated by good professional practice Continued care for a newly enrolled member may not exceed 12 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.	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 TTY call **711**.*

Medi-Cal	SCFHP DualConnect
• We send a written notice to members at least 30 calendar days before the effective termination date, and we offer assistance in selecting a new provider. For members receiving active treatment for an existing medical condition, continued access to the terminating provider is allowed for up to 90 calendar days.	

Member's Role in Prior Authorizations

SCFHP members (or their authorized representatives) are part of the prior authorization process and should be aware of the approved services and the turnaround times. Members must consult with their PCP before scheduling an appointment with any other physician, except for the self-referral services addressed earlier in Direct Access Services.

Members may request a second medical opinion and have the right to appeal to SCFHP if their PCP denies their request for referral to obtain a second medical opinion. Please review the Grievance & Appeals section for additional information.

Discharge Planning & Concurrent Review

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.

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

Retrospective Review

Retrospective review is the review of medical treatments, documentation, and billing after the service has been provided. In performing these reviews, SCFHP's 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

Health Plans, Medical Groups and IPAs that are delegated for utilization management are responsible for retrospective review of emergency department claims based on the following criteria:

- Coverage of emergency services to screen and stabilize the member 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, authorized the provision of emergency service.
- Appropriate physician review of presenting symptoms.
- The patient's discharge diagnosis.

Please check out the Urgent & Emergent Care section for details related to emergency services.

Case Management

SCFHP provides care coordination services to members, as needed, in accordance with their individual preferences and needs. SCFHP case management is delivered within a **Population Health Management (PHM)** framework, focusing on a **whole-person approach** to identify members at risk and implement strategies, programs, and services to mitigate or reduce those risks. The goal is to improve **physical and psychosocial well-being**, address **health disparities**, and provide cost-effective, **personalized solutions** to meet the unique needs of diverse member populations.

SCFHP's PHM strategy is **data-driven**, leveraging claims data, health risk assessments, and real-time provider insights to proactively identify high-risk

populations. The plan prioritizes **preventive care**, **chronic disease management**, and **maternal health interventions**, ensuring that vulnerable populations receive the support necessary to achieve **optimal health outcomes**. By incorporating **culturally competent care**, SCFHP addresses **social determinants of health** (SDOH) such as housing, transportation, and food security, which directly impact health and well-being.

A key component of PHM is the **integration of care across multiple providers and settings**. SCFHP collaborates with **primary care providers, specialists, hospitals, and community-based organizations** to develop **comprehensive, member-centered care plans**. This approach enhances **care coordination**, **reduces hospital readmissions**, and improves **access to critical services**, including behavioral health and maternity care.

SCFHP remains committed to **improving health equity** by reducing gaps in care and enhancing access to preventive services. Providers play an essential role in identifying at-risk members and coordinating with SCFHP to implement effective, **evidence-based interventions**. By integrating PHM principles into case management, SCFHP ensures members receive **personalized, high-quality care** while advancing broader **public health goals**.

Case Management provides a consistent method for identifying, addressing and documenting the health care and other support needs of our members along the continuum of care. Once a member has been identified for case management, care coordination staff will work with the member to:

- Complete a comprehensive Health Risk Assessment (HRA) of member needs
- Develop and implement an Individual Care Plan (ICP) in partnership with the member, their provider(s) and family or caregiver.
- Determine benefits and resources available to the member
- Facilitate identified referrals and collaborate with community providers
- Identify barriers to care
- Monitor and follow up on progress toward care plan goals

Types of Case Management Programs

1) Basic Case Management

    - Services are provided by the Primary Care Physician, in collaboration with the health plan
    - Initial Health Appointment (IHA)
    - Health Risk Assessment (HRA)
    - Identification of appropriate providers and facilities to meet member care needs
    - Direct communication between the provider and member/family;

- Member and family education, including healthy lifestyle changes when warranted;
- Coordination of carved out and linked services and referral to appropriate community resources

2) Complex Case Management

- Includes all elements of Basic Case Management services
- Intense coordination of resources to assist members to regain optimal health or improved functionality
- Collaborative management, with providers of acute or chronic illness, including emotional and social support issues by an Interdisciplinary Care Team (ICT) consisting of SCFHP care coordination staff, PCP, specialists, member, and member authorized representatives
- With member and PCP, development and continuous update of an Individual Care Plan (ICP) specific to members' individual needs and preferences

3) Transitions of Care

- Coordination of care of members moving between the inpatient and community setting
- Contact with the member or caregiver following a discharge for a face-to-face visit and medication reconciliation with the PCP

4) Long Term Services & Supports (LTSS) and LTC Transitions

5) Behavioral Health

- Coordination of behavioral health services for those that may or may not be connected to available behavioral health services

Referring Members for Case Management

SCFHP Case Management accepts referrals for any SCFHP-enrolled member and their caregiver in need of support, resources, and assistance related to the coordination of care and services for complex medical or behavioral health conditions and non-medical risk factors. Members can be referred to or can self-refer to case management without having to meet any program criteria. Care coordination services are at no cost to patients enrolled in SCFHP. Patients may choose to decline care coordination services at any time without losing health plan coverage.

Upon referral, SCFHP's Case Management team will attempt to:

- Connect with the patient to assess their needs;
- Determine the most appropriate level of case management intervention;
- Set goals for an individual care plan that integrates access to medical, behavioral health, long-term services benefits and support, and community resources.

Please complete a Health Risk Assessment and a referral form with any supporting documentation so our team can understand the needs of the member. Both forms can be found on the SCFHP website.
Examples of situations where patients should be referred for case management:

- Frequent ER visits or hospital admissions (3 or more in the past 12 months)
- Experiencing a transition in care
- Non-compliance with PCP visits, medications, or prescribed treatment for chronic conditions
- Complex medical and/or mental health conditions including progressive or degenerative diseases
- Diagnosis or conditions requiring a lengthy recovery period
- Significant impairments in one or more activities of daily living
- Other non-medical risk factors such as unstable housing, inadequate income, isolation, or lack of family or social supports

Case Management Partnership with PCPs

Case Management is a collaborative process including SCFHP care coordination staff, the member's Primary Care Provider (PCP), and other specialists, providers and caregivers identified by the member. In order to effectively deliver case management, SCFHP requires close communication between case managers and the PCP including:

- Completing a Health Risk Assessment (HRA) with the member
- Participation in Interdisciplinary Care Team (ICT) communications and meetings
- Development, update, and communication of Individual Care Plan (ICP) in writing or via phone.
- Informing members and encouraging PCP and/or specialist visits and discussion

Physicians are required to complete Core Competencies Training on an annual basis. Physicians will receive an invitation to participate in an Interdisciplinary Care Team (ICT) that is assembled to meet the needs of the Member and contribute to the development and administration of the members' Individual Care Plan.

Enhanced Care Management (Medi-Cal) Benefit

Enhanced Care Management (ECM) is a whole person care approach that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services. ECM is a collaborative and interdisciplinary

approach to providing intensive and comprehensive care management services to targeted individuals that is community based, interdisciplinary, high touch, and person centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

The ECM Provider serves as the central point for coordinating patient-centered care and works with the member and family support individuals to manage and coordinate the member's care and connect them to their providers and community and social services. ECM core services include:

- Outreach and Engagement- Identifying and engaging members who are eligible for ECM
- Assessment and Care Management Plan – Develop and update a Health Action Plan (HAP) to guide services and care
- Care Coordination – Coordinate care across all providers
- Health Promotion – Educate members about and support them in adopting healthy behaviors
- Transitional Care Services – Facilitate care transitions between the hospital, nursing homes, other treatment facilities, and home
- Member and Family Supports – Support the self-management and decision-making efforts of members and their family and/or support team
  Referral to Community and Social Supports – Connect members to community and social services.

SCFHP identifies members who are eligible for ECM and assigns them to ECM providers. ECM providers conduct outreach to assigned SCFHP members, engage them into enrolling into ECM, and deliver ECM services. Upon enrollment, members are assigned a Lead Care Manager who oversees the delivery of ECM services and:

- Works with members to develop and update the Health Action Plan (HAP)
- Ensures members have access to care coordination services, including case conferences to ensure coordination among providers
- Manages referrals, coordination, and follow-up to needed services and supports
- Supports members and their families during discharge from the hospital, nursing facilities, and treatment facilities
- Provides services in-person and accompanies members to appointments when needed

A referral form can be found on the SCFHP website. Please submit by secure email to ecm@scfhp.com or by fax to 1-408-874-1469. For more information on ECM, go to the SCFHP website or call 1-408-874-1452.

Community Health Worker (Medi-Cal) Benefit

CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health.

CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. Services include:

- Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
- Health Navigation: Providing information, training, referrals, or support to assist members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs.
    - Under Health Navigation, CHWs can also:
        - Serve as a cultural liaison or assist a licensed health care provider to participate in the development of a plan of care, as part of a health care team;
        - Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or o Help a Member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.
- Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a Member with connecting to appropriate services to improve their health.
- Individual Support or Advocacy: Assisting a Member in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

Services may be provided to a parent or legal guardian of a Member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider.

CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

A referral form can be found on the SCFHP website. Please submit by secure email to chw@scfhp.com or by fax to **1-408-874-1409**. For more information on CHW, go to the SCFHP website or call **1-408-874-1452**.

Pharmacy Benefit

SCFHP contracts with MedImpact, a Pharmacy Benefit Manager (PBM), which provides an extensive network of pharmacies throughout Santa Clara County for SCFHP DualConnect. Members may review a list of contracted pharmacies in the pharmacy directory found at www.scfhp.com.

Drug Formulary

Medi-Cal	SCFHP DualConnect
Medi-Cal Rx has a covered drug list called the Contract Drugs List (CDL). For more information, visit Medi-Cal Rx's website.	The SCFHP DualConnect List of Covered Drugs (Formulary) is updated monthly and can be viewed by visiting the Pharmacy page on SCFHP's website. The DualConnect List of Covered Drugs includes prescription drugs and non-drug products and items. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. For more information, visit Medi-Cal Rx's website.

Drug Coverage Exclusions

Drug coverage exclusions include but may not be limited to:

- Not approved by the United States Food & Drug Administration (FDA),
- Used as experimental or investigational drugs,
- Used to treat infertility,
- Products for cosmetic indications or reasons,
- Treatment of sexual dysfunction,
- Dietary supplements and medical foods,
- Drug Efficacy Study Implementation (DESI) products,

- Bulk chemicals including those used for compounding, and
- Drugs purchased outside of the United States and its territories.

Out-of-Pocket Payments

SCFHP DualConnect members have a $0 copay for covered drug on the List of Covered Drugs. Drugs that require a coverage determination or formulary exception include:

- Non-formulary drugs (drugs not on the List of Covered Drugs),
- Drugs that require a prior authorization,
- Drugs that have step therapy requirements,
- Drugs with quantity limit restrictions,
- Drugs that have safety edits, including those for opioids, benzodiazepines, and acetaminophen.

Procedures for Filing a Medicare Part D Coverage Determination (CD)

Procedures for filing a Medicare Part D coverage determination include:

- Download and complete the Medicare Part D Coverage Determination Request Form as instructed here, and fax to MedImpact at **1-858-790-7100**.
- For Part D-related coverage determination questions, please contact MedImpact via phone at **1-800-788-2949**.

Drugs Administered by Physicians/Clinics

Medi-Cal	SCFHP DualConnect
Medi-Cal Rx is responsible for Physician Administered Drugs (PADs) that are billed on a pharmacy claim by a pharmacy. For more information on Medi-Cal Rx please visit Medi-Cal Rx's website. PADs that are billed by a physician or clinic on a medical claim should be billed to SCFHP under the medical benefit.	Physician Administered Drugs (PADs) that are covered by Medicare Part B should be billed by the physician or clinic providing the drug for administration under the medical benefit.

Transition Fill Policy

When a new **SCFHP DualConnect** member tries to fill a non-formulary drug or drug with a utilization management restriction within the first 90 days of enrollment, they will be eligible for up to a 31-day supply transition fill in the retail pharmacy network. This

also applies to the following members: members in long-term care (LTC), renewing members when there is a formulary change between benefit years, and members who change treatment settings due to a change in their level of care.

Mail-Order Pharmacy

SCFHP DualConnect members may use Birdi Pharmacy for mail order. Members who take prescribed medications regularly can have their drug delivered by standard shipping at no cost. SCFHP does not cover expedited shipping for mail order prescriptions. Providers may fax prescriptions to **1-888-783-1773** or call **1-855-873-8739**.

Pharmacy Appeals

Information on Pharmacy Appeals may be found in the Grievance & Appeals section.

Urgent & Emergent Care

Urgent Care Services

Urgent care is provided when the member is temporarily absent from the SCFHP service area or when, as a result of an unforeseen non-emergent illness or injury, medical services are required without delay and the services could not be obtained reasonably through an appointment with member's assigned PCP.

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.

Emergency services and emergency inpatient admissions do not require prior authorization; however, the hospital **must** contact SCFHP to verify member eligibility.

Hospitals must contact SCFHP's UM Department within one business day of a member's admission through the emergency room. SCFHP's 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 an in-network hospital.

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 must contact the SCFHP UM Department as soon as possible to request prior authorization. SCFHP 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 covers all medically necessary, approved health care services to maintain the member's stabilized condition until the member is discharged or transferred.

Trauma Services

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

The provider reviews and authorizes 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 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

Once the treating physician has indicated that the patient is hemodynamically stable, or ready to be transferred out of critical care, 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 only to the first 48 hours after admission.

Family Planning, Pregnancy & Post-Partum Services

Family Planning

Family planning services are provided to determine pregnancy, temporarily delay pregnancy, or permanently prevent pregnancy. Family Planning Services for Medi-Cal members do not require prior authorization and may be obtained from any family planning provider. However, we encourage PCPs and OB/GYN specialists to promote

in-plan services by providing education, ensuring easy access to services, and establishing an environment in which the member feels free to talk to her physician.

As discussed in the Authorizations section of the manual, most women's health services may be accessed directly without referral or prior authorization.

The following family planning services are covered for Medi-Cal members. Services may be provided by contracted or out-of-plan providers who accept Medi-Cal.

- Health education and counseling necessary for a member to understand contraceptive methods and/or procedures proposed, and to make an informed choice
- Limited history and physical examination consistent with ACOG standards
- Services listed in Medi-Cal CPT Codes for Family Planning Services published by the DHCS
- Laboratory tests, when medically indicated, as part of the decision-making process in choosing contraceptive methods
- Diagnosis and initial treatment of sexually transmitted diseases, if medically indicated
- Screening of at-risk individuals for HIV, when indicated
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Provision of contraceptive pills, devices, supplies
- Tubal ligation and vasectomy
- Pregnancy testing and counseling
- Therapeutic abortions and related services

Excluded services include:

- Infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only

Pregnancy & Post-Partum

SCFHP covers comprehensive prenatal services provided by qualified providers, including PCPs, family practitioners, OB/GYN specialists, and organized outpatient clinics holding a valid Medi-Cal provider number and approved to provide comprehensive prenatal services.

Any provider offering prenatal services to our members should provide an organized, comprehensive prenatal service, including but not limited to supervision of all aspects of patient care including antepartum, intrapartum, and postpartum care.

Providers also are required to create and implement an Individual Care Plan (ICP) for each pregnant SCFHP member. The ICP facilitates the coordination of care and should be developed by the provider in consultation with the patient, and placed in the medical record.

The scope of prenatal services and guidelines for providing them should conform to the following published standards:

- Guidelines for Perinatal Care (most current edition); The American Academy of Pediatrics (AAP) and the American Congress of Obstetricians and Gynecologists (ACOG)
- Standards for Obstetric Services (most current edition); The American Congress of Obstetricians and Gynecologists (ACOG)
- Newborn Screening regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq
- Comprehensive Prenatal Service Program (CPSP) regulations as set forth in Title 22, Code of Federal Regulations (CFR)

As described in the guidelines above, medical records for pregnant members should include, at a minimum:

- Medical and pregnancy history
- Physical examination, including pelvic
- Initial and periodic laboratory tests
- Tobacco use or exposure screening and face-to-face tobacco cessation counseling session per quit attempt
- Medical risk assessment
- Proposed interventions or treatment plan, methods, timeframes, outcomes and objectives
- Proposed referrals, if applicable
- Obstetric re-assessment flow sheet
- A list of all staff involved in the patient's care

Special Programs for Children

SCFHP assists with coordinating referrals to special government-funded health programs that provide extra benefits for children who qualify. An SCFHP Medi-Cal member may be eligible for benefits from the Early and Periodic Screening, Diagnostic and Treatment program (ESPDT), the California Child Health and Disability Prevention Program (CHDP), Early Intervention Services Program (EIS), services from San Andreas Regional Centers (SARC) for children with developmental disabilities, or the California Children's Services (CCS) program for children with handicapping conditions. Each of these programs is described briefly below.

The child's PCP is responsible for referring them to these programs, as appropriate, and for providing normal primary care services separate from those covered by these programs. The PCP's fees are paid directly by the particular agency rather than by SCFHP. However, our UM nurse or case manager continues to work with the PCP and the outside agency to ensure that the patients' health care is coordinated and documented.

Identifying Members with Suspected or Diagnosed Developmental Conditions

Infants and children with the following conditions have a potential for being at risk for developmental disabilities, thus requiring Early Start services:

- Autism, or similar conditions
- Blindness or limited vision
- Spinal bifida
- Cancer
- Cerebral palsy
- Cleft palate
- Downs syndrome
- Epilepsy
- Hearing impairment
- Heart conditions
- HIV/AIDS
- Juvenile diabetes
- Lung disorders, including asthma and cystic fibrosis
- Mental retardation
- Neurologically impaired, spinal cord injuries
- Physical handicaps due to extensive orthopedic problems
- Seizures
- Sickle cell anemia

Referral Procedure for the Early Start Program & Regional Center Services

To make a referral to the Early Start Program, write, fax or call:

Santa Clara County Early Start Program
780 Thornton Way
San Jose, California 95128

Fax: **1-408-295-6104**
Referral Hotline: **1-800-404-5900**
Hours: 9:00 AM to 4:00 PM

Parents of children over 2.9 years of age with developmental disabilities should contact directly the school district of residence and local the San Andreas Regional Center for assistance.

Developmental Conditions

SCFHP makes every effort to assure that members with developmental conditions receive all medically necessary screening, preventive, and therapeutic services as early

as possible. If any of minor members fall 4-6 months below age-appropriate parameters or exhibit symptoms or conditions that indicate risk factors such as autism, cerebral palsy, mental delay or seizures, you are required by law to refer them to a San Andreas Regional Center (SARC).

SARC is part of a statewide system of 21 locally based regional centers that offer supportive services and programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs, and work with other agencies to provide the full range of early intervention services. Local regional centers can provide specific information on the services available in the member's service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Contact information for the local SARC office is:

San Andreas Regional Center
6203 San Ignacio Ave., Suite 200
San Jose, California 95119

Phone: **1-408-374-9960**
Intake Coordinator: **1-408-341-3475**
Fax: **1-408-376-0586**
Hours: 8:00 AM to 5:00 PM

Early and Periodic Screening, Diagnosis & Treatment (EPSDT)

Early and Periodic Screening, Diagnosis & Treatment (EPSDT) is a federally funded program for providing medically necessary services to correct or ameliorate a physical defect, mental illness or other medical condition in children aged 21 years or less. These services are federally mandated to ensure that eligible members receive appropriate screening, preventive, diagnostic and treatment services.

The EPSDT benefit includes the following screening services:

- Comprehensive health and developmental history (both physical and mental health development)
- Comprehensive unclothed physical exam
- Immunizations as appropriate
- Laboratory tests as appropriate
- Blood lead screening
- Health education, as appropriate, to provide information about the benefits of healthy lifestyles and practices as well as prevention of diseases and accidents
- Vision services; or a minimum of diagnosis and treatment for defects in vision, including eyeglasses)

- Dental services; or a minimum of relief of pain and infections, restoration of teeth and maintenance of dental health
- Hearing services; or a minimum of diagnosis and treatment for defects in hearing, including hearing aids
- Other necessary health care services as needed to correct or ameliorate defects, and physical/mental illnesses and conditions discovered through the screening services

You can learn more about this benefit by visiting the Medicaid EPSDT website.

California Child Health & Disability Program (CHDP) Services

California Child Health & Disability Program (CHDP) is funded at the state and federal level to ensure the provision of a pre-specified maximum number of preventive care visits for children under 21 years-of-age who are enrolled in Medi-Cal.

Services covered by CHDP include but are not exclusive to:

- Dental screening
- Developmental assessment
- Health and development history
- Immunizations
- Laboratory tests and procedures including tests for serum levels of lead so that case managers from the Public Health Department Lead Program may follow up and investigate the child's home setting, as indicated
- Nutritional assessment
- Periodic health examination
- Psychosocial screening
- Speech screening
- Vision screening

Additional details including periodicity schedules are currently available on the DHCS' CHDP website.

Early Start Program for Infants and Toddlers with Developmental Conditions

The Early Start Program is a collaboration between the San Andreas Regional Centers and the Santa Clara County Office of Education to provide medically necessary diagnostic and therapeutic services for infants and children aged 0-2.9 years of age who have developmental conditions.

During the IHA, PCPs identify those who have, or are at risk of acquiring, developmental delays or related conditions, including signs and symptoms of mental retardation, cerebral palsy, epilepsy or autism. California State legislation requires that PCPs refer children to Early Start Program for evaluation who are exhibiting a

significant developmental delay, have multiple risk factors, or have an established risk factor; moreover, the law requires that this referral take place within 48 hours of your assessment.

A developmental disability is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation that originates before the age of 18, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A developmental delay is an impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

Services are provided by SARC's Early Start Program and coordinated with assistance from SCFHP.

SCFHP is a resource for providers and members (or their parents/guardians) who have questions about services for disabled children and the Early Start Program. Parents may contact the Customer Service Department at **1-800-260-2055** for assistance with referrals.

Referral Procedure for the Early Start Program & Regional Center Services

To make a referral to the Early Start Program, write, fax or call:

Santa Clara County Early Start Program
780 Thornton Way
San Jose, California 95128

Fax: **1-408-295-6104**
Referral Hotline: **1-800-404-5900**
Hours: 9:00 AM to 4:00 PM

Parents of children over 2.9 years of age with developmental disabilities should contact directly the school district of residence and local the San Andreas Regional Center for assistance.

Coordination of Care with Regional Centers and Early Start Program

SCFHP continues to provide for the medical needs of members receiving services from SARC/Early Start and coordinates with the Center to assist with the development of a care plan, or in meeting the care plan that has been developed.

The PCP is part of the interdisciplinary team supporting the member's medical as well as psychosocial and environmental needs. Screening, preventive and medically necessary and therapeutic services that are a normally covered benefit are continued to be covered by SCFHP.

California Children's Services (CCS) Program

California Children's Services (CCS) Program is a state-funded program that pays for the medical care of children (aged 0-21 years) who have physically handicapping conditions. Conditions that qualify for CCS are those that limit or interfere with physical function but can be cured, improved, or stabilized. Examples include some birth defects, handicaps present at birth or developed later, and injuries from accidents or violence. These conditions may require treatment with medicine, surgery or rehabilitation. CCS manages the eligible health condition which includes referrals to the appropriate specialists and facilities for care.

Providers should refer SCFHP members with CCS medically-eligible conditions to CCS for case management and treatment of the particular condition. Notify our Utilization Management Department at **1-408-874-1821** about any potential CCS-eligible condition.

Please note that members under the care of CCS continue to remain enrolled in SCFHP for primary-care services and referrals unrelated to the CCS conditions. The PCP relationship remains intact for providing all primary care, medically necessary screening, diagnostic, preventative and treatment services unrelated to the member's CCS eligible condition, as well as forwarding any requested medical information the program(s) may request.

SCFHP staff help identify CCS eligible conditions through review of referrals, claims and encounters for diagnosis categories, as well as during hospital concurrent review. In addition, we work with providers, admitting physicians, hospital discharge planners, neonatologists, or hospital pediatricians, as appropriate, to ensure that potential candidates are referred to CCS.

SCFHP ensures that children in foster care and other out of home placement situations receive comprehensive, medically necessary services and preventative healthcare, especially when a child is placed outside the SCFHP service area. Additional questions can be directed to Utilization Management at **1-408-874-1821**.

Please go here for additional CCS Program information.

Behavioral Health

Assessment

PCPs are responsible for assessing the behavioral health of new Medi-Cal beneficiaries. Beneficiaries under the age of 21 years of age should be assessed using the Bright Futures Periodicity Schedule for access to EPSDT benefits to treat physical and behavioral health needs. The medical necessity criteria for impairment and intervention differs between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of specialty mental health services medical necessity is less stringent than it is for adults, therefore children with low levels of

impairment may meet medical necessity criteria for specialty services, whereas adults must have a significant level of impairment.

All encounters should include an assessment of current function of behavioral health needs, substance use, past and current trauma, and symptoms that interfere with daily living include, but limited to suicidal ideation, mania, and psychosis. Timely access to care and treatment is imperative; refer to the most appropriate level of care provider. For screening to behavioral health services, refer to the County of Santa Clara Behavioral Health Call Center at **1-800-704-0900**. For an emergency or crisis, providers may contact the Valley Medical Emergency Psychiatric Services for consultation at **408-885-6100** or dial 911.

How to Access Behavioral Health Services

Medi-Cal	SCFHP DualConnect
Members may access behavioral health care through direct referral from their primary care physician or specialist, through a behavioral health provider, or through Santa Clara County Behavioral Health Call Center. Inpatient and specialty mental health outpatient services for Medi-Cal beneficiaries is carved out of SCFHP and managed by County of Santa Clara Behavioral Health Services. Primary care physicians are encouraged to assess, treat, and maintain mild to moderate prescriptions for Medi-Cal beneficiaries. Most mild to moderate services do not require a prior authorization request for treatment. For assistance with referring members to mental health services, please contact Customer Service at **1-800-260-2055**.	SCFHP has partnered with community providers and County of Santa Clara Behavioral Health Services Department to provide behavior health services to SCFHP DualConnect members. For an emergency or crisis, providers may contact the Valley Medical Emergency Psychiatric Services for consultation at **1-408-885-6100**. A behavioral health provider will determine the most appropriate setting in which a SCFHP DualConnect member should receive services. A benefit of the SCFHP DualConnect program is assignment to a case manager provided by SCFHP Case Management Department. The case manager collaborates with medical and behavioral health providers to coordinate all behavioral health and medical needs of the member. Primary care physicians and behavioral health providers are a part of the Interdisciplinary Care Team (ICT) along with the member, SCFHP staff, and any other identified person the member would like to include. The goal of the care

Medi-Cal	SCFHP DualConnect
	team meeting is to evaluate member health and other needs that may affect health of the member and to document any changes or adjustments to the Individualized Care Plan (ICP). To access the SCFHP Case Management Department, both providers and members can call **1-408-874-1402**. Behavioral health providers are required to provide written feedback to the referring physician 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. 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 for mild to moderate symptomology. SCFHP Case Management Department coordinates outpatient services with the member, behavior health provider, and the primary care provider. A current list of contracted behavioral health providers is available at www.scfhp.com.

Substance Abuse Services

PCPs are responsible for assessing the substance use of new Medi-Cal beneficiaries using SABIRT (Screening, Assessment, Brief Intervention, and Referral to Treatment) to assess. If there is a beneficiary that has been identified that could benefit from substance use treatment, refer to Santa Clara County Gateway Call Center. Gateway Call Center will assess and refer to the most appropriate agency to provide the level of treatment using ASAM (American Society of Addiction Medicine) criteria.

Substance Use Treatment is carved out of SCFHP and is managed by the County of Santa Clara Department of Behavioral Health Services. The primary care physician remains responsible for medical care not related to substance use treatment. The substance use treatment team may need to coordinate care for medical conditions.

For an emergency or crisis, providers may contact the Valley Medical Emergency Psychiatric Services Office at **1-408-885-6100**. Beneficiaries should be referred to County of Santa Clara Gateway Call Center for referral to treatment options by calling **1-800-488-9919**, Monday through Friday, 8:00 AM to 5:00 PM.

Trauma Screening

Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences including abuse, neglect, and/or household dysfunction that occur by age 18. Screening for Adverse Childhood Events (ACEs) and toxic stress and providing targeted, evidence-based interventions can improve the efficacy and efficiency of health care. ACEs screening also better supports individual, family health, well-being and reduces long-term health costs. Effective January 1, 2020, the DHCS began paying Medi-Cal providers for conducting ACE screenings for children and adults up to age 65 with full-scope Medi-Cal. Medi-Cal providers must have taken a certified training and self-attested to completing the training to receive payment. A Trauma Screening Workflow resource is available within the Provider Tips Sheets and Best Practices web page.

There are three versions of the tool based on age, reporter, and format:

Tool	Age	Completed by
PEARLS for children	0-11	Caregiver
PEARLS for adolescents	12-19	Caregiver
PEARLS for adolescents	12-19	Adolescent

ACEs for adults	20+	Adult

Providers may screen members utilizing a qualifying ACEs questionnaire or PEARLS tool as often as deemed appropriate and medically necessary. However, SCFHP is only required to make payment once per year per child member screened and once per lifetime per adult member (through age 64) screened by that Provider using a qualifying ACEs questionnaire.

If you have screened your patient and there is a positive score, indicating a past or current risk factor that may result in poor health outcomes, you can:

- Ask your patient what they want to do, what they need
- Explore whether the patient would be interested in Family Therapy. Family Therapy is a benefit for all Medi-Cal beneficiaries, and this service must be rendered by a Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, or Licensed Marriage and Family Therapist. More information is available here.
- Make a referral to the county Call Center for Behavioral Health screening **1-800-704-0900**. Note: The call center does not coordinate services.
- Call Santa Clara Family Health Plan Case Management at **1-877-590-8999** for assistance with resources.
- Find local support and services at reduced or no cost using SCFHP's findhelp directory, including many but not all available supports.

Please visit the ACEs Aware website for additional details on utilizing the ACES tool or providing trauma-informed care.

Long-Term Services & Supports (LTSS)

SCFHP covers acute, primary, and rehabilitative care services, and Long Term Services and supports (LTSS). SCFHP is responsible for administering the benefits listed below:

- Long-term care in a nursing facility, including skilled, subacute and long-term custodial care
- Community-Based Adult Services (CBAS)

The services below are carved out benefits and administered by non-contracted providers but coordinated with SCFHP:

- In-Home Supportive Services (IHSS): administered by the County of Santa Clara
- Multipurpose Senior Services Program (MSSP): administered by Sourcewise.

Long-Term Care (LTC)

Long-term care (LTC): Provides non-skilled care (i.e., custodial care) that non-licensed personnel can safely perform. LTC assists with daily living, including:

- Assistance getting in and out of bed
- Assistance with feeding
- Assistance with bathing, toileting, and dressing

SCFHP recognizes that at times, Skilled Nursing Facilities (SNFs) may provide skilled care (Medicare) and offer prolonged stays for Medi-Cal and Sub-Acute services within the same facility.

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.

CalAIM Intermediate Care Facility for Developmentally Disabled Long-Term Care Carve-In

Under CalAIM, the Intermediate Care Facility for Developmentally Disabled (ICF/DD) transition to Medi-Cal managed care is intended to standardize ICF/DD services covered under managed care statewide, advance a more consistent and integrated system of managed care, and increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in ICF/DD Homes (including habilitative and nursing).

January 1, 2024 Transition

Effective January 1, 2024, all Medi-Cal managed care plans (MCPs) became responsible for covering the following ICF/DD services:

- Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home;
- Intermediate Care facility for the Developmental Disabled – Habilitative (ICF/DD-H) Home;
- Intermediate Care Facility for the Developmental Disabled – Nursing (ICF/DD-N) Home;

Note: ICF/DD-Continuous Nursing Care (ICF/DD-CN) Homes are not subject to the Long Term Care (LTC) Carve-In policy.

As of January 1, 2024, all residents of ICF/DD, ICF/DD-H, and ICF/DD-N Homes have transitioned from Fee-For-Service (FFS) Medi-Cal to Medi-Cal managed care. The ICF/DD Carve-In does not affect current payment rates that ICF/DD Homes (including habilitative and nursing) receive and the scope of the services under the ICF/DD benefit remains the same.

DHCS, in partnership with the California Department of Developmental Services (DDS), worked closely with the ICF/DD stakeholder workgroup to finalize policies and resources related to this ICF/DD Carve-In from FFS Medi-Cal to Medi-Cal managed care. All resources can be found under “Key Documents” section. As new or updated resources are published, they will be highlighted in the “Important Updates” section.

For addition resource please review the Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Carve-In Resource Guide on DHCS website ICF/DD Carve-In Resource Guide and the ICF/DD LTC Carve-In Frequently asked questions (FAQ) Intermediate Care Facility for the Developmentally Disabled Carve-In Frequently Asked Questions (FAQ).

LTC Referrals and Prior Authorization*

The SCFHP UM team processes authorization requests in a timely manner and in accordance with state and federal requirements.

To submit a prior authorization request, please complete and submit the electronic Authorization Request web form available on Provider Link along with supporting clinical documentation. Provider Link is available 24 hours-per-day, 7 days-per-week.

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

LTSS Benefits

Multipurpose Senior Services Program (MSSP)

A team of care managers (an RN and a Social Worker) provide:

- Individualized care planning
- Social and health care management
- Long term help arranging and coordinating needed services
- Monthly contact and quarterly home visits
- Purchase of services if needs cannot be met by low or no cost options

Eligibility:

- Age 65+ with disabilities
- Requires nursing facility level of care
- Unable to live at home safely without MSSP

Community-Based Adult Services (CBAS)

Provides individualized care and services in an outpatient facility up to 5 days/week.

Services include;

- Skilled nursing care
- Social services
- Therapies (PT, OT, ST)
- Personal care and assistance with activities of daily living
- Family/caregiving respite and training
- Nurtrition counseling and meals
- Transportation to and from home

Eligibility:

- Age 18+
- At risk for institutional care and have 1 or more chronic or most-acute medical, cognitive or mental health condition(s)
- Physician referral required

Nursing Facility (NF)

A facility that providers care for people who cannot safely live at home but who do not need to be in the hospital. Long-term care (LTC) is the provision of custodial care, a level of care that is the least intensive and is not at a skilled level. Medical, social, and personal care services that are needed regularly are provided in a licensed skilled nursing facilities (SNF) long-term care (LTC).

Eligibility:

- LTC/SNF placement is made through a physician/licensed health care provider referral

In-Home Supportive Services (IHSS)

IHSS is a State program available to eligible Medi-Cal beneficiaries and authorized by Santa Clara County Social Services Department. Once an application has been submitted, an IHSS social worked will conduct an in-home assessment to determine hours and services. IHSS recipients choose a care provider, usually a family member, friend, or someone selected through a Care Registry. IHSS recipients hire their own service providers, set schedules, and supervise the care they receive.

Services provided by the care provider may include:

- Domestic services: cleaning, grocery shopping, meal prep, errands, laundry
- Personal care: grooming, bathing, toileting
- Protective supervision specifically for people with impairment in memory, orientation, or judgment
- Paramedical services
- Heavy cleaning, yard hazard abatement, and teaching/demonstration (authorized under special circumstances and generally one-time or time-limited benefits)

Eligibility

- Must be aged 65+ OR blind OR has a disability that will last 12 months or longer
- Unable to live at home safely without help from a care provider
- Application must be signed by the patient and a licensed professional.

Other home and community based services are available to members with LTSS needs who meet eligibility. This includes Enhanced Care Management and Community Supports that may assist with needs such as home modifications, medically tailored meals, housing navigation and transitions across levels of care.

Supporting Patient Access and Availability to LTSS Benefits and Other Services

Your patients can apply for MSSP, CBAS, and IHSS as well as other services and supports on their own, or they can seek assistance from SCFHP Case Management (https://bit.ly/scfhpCaseManagement). Usually timely access to these programs and services improves when facilitated by the patient's case manager, ideally as part of an individualized care plan.

To contact SCFHP Case Management, call **1-877-590-8999** (TTY: **711**), Monday through Friday, 8:30 a.m. to 5 p.m.

When providers understand the LTSS programs, eligibility criteria, and application process, they can educate patients and their family or caregivers about them, and follow the appropriate referral process.

Who should be referred for LTSS?

Patients who:

- Need LTSS to support a transition from an inpatient or nursing facility stay to home
- Need social support
- Need assistance with daily activities
- Qualify for a nursing home but want to stay at home
- Need caregiver support
- Have issues with current LTSS services
- Indicate they need more support
- Have a history of repeated hospitalizations
- Request non-medical support

When should you contact the SCFHP LTSS team?

Providers may choose to work directly with the patient to facilitate LTSS applications, or they may reach out to the SCFHP LTSS team for assistance. The SCFHP LTSS Liaison is available to help with LTSS inquiries, including confirming eligibility for these programs, monitoring waitlists, and tracking deadlines for the submission of documents required for application.

If the patient will undergo care transition and the patient needs LTSS, it is recommended that the LTSS referral is initiated as soon as the discharge planning is identified. Application processes for these benefits can take one to three months or longer.

What are other reasons to coordinate with the SCFHP LTSS team?

If you think the patient needs more help deciding to apply for LTSS using:

- CBAS referrals – to encourage site visits
- IHSS or MSSP – to provide explanation on how it works and assistance with application
- NF – to coordinate on safe care transitions
- Community Supports

- Enhanced Care Management
- Home and Community Based Waiver Programs

If the patient's case manager needs help coordinating with LTSS providers or seeks help with finding other community resources or referrals for services and supports, such as access to food, non-medical transportation, personal care, and caregiver support.

Questions and comments may be directed via email to MLTSSHelpDesk@scfhp.com.

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.

*Prior Authorization Requests for CBAS Service**

CBAS providers must submit using the Provider Portal or fax to **1-408-874-1957** the following documents:

1) SCFHP Prior Authorization Form, and
2) Completed & signed Individual Plan of Care (IPC) DHCS 0020 Form, and
3) History and Physical Examination (H&P).
4) Completed Health Risk Assessment (HRA).

In order for CBAS services to be considered for up to a 12-month interval approval, CBAS providers must submit an Individual Care Plan (ICP) for all new members who complete a multidisciplinary team assessment, along with an HRA, and a prior authorization request form specifying the services recommended by the multidisciplinary team. Please submit all documents using the Provider Portal or fax to **1-408-874-1957.**

SCFHP 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 and SCFHP may:
    - Send a Request for Further Documentation form to the requesting CBAS provider if additional supporting documentation is needed.
    - Conduct a Face-to-Face CBAS Eligibility Determination.
    - Refer the case to a Medical Director or the Chief Medical Officer for review.

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 Individual plan of care (IPC). Please submit all documents prior to the expiration of the authorized period.

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

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:

- 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.

IHSS is administered by the Santa Clara County Social Services Agency, Department of Aging and Adults Services with responsibility for processing, authorizing, and monitoring In Home Supportive Services requests. The IHSS main line is **1-408-792-1600** and IHSS Application Readiness Unit fax **1-408 792-1603**. Application forms can be found here.

The SCFHP LTSS Team can assist case managers and providers with facilitating access to IHSS and navigating the application or reassessment process for SCFHP members. Please contact the LTSS Help Desk via email at MLTSSHelpDesk@scfhp.com.

The IHSS Public Authority is the employer of record for IHSS providers or independent providers (IPs). Contact information for the Public Authority is **1-408-350-3251**.

The Public Authority is managed through a contract with Sourcewise and their role is to:

- Maintain a registry of available, screened and qualified IHSS providers & provide access to it for prospective IHSS recipients as well as an URGENT CARE REGISTRY.
- Conduct IP enrollment, orientation, criminal background checks and training for providers.
- IHSS provider enrollment, orientation and training. Sourcewise is available by phone at **1-408-350-3252** or online.

Multipurpose Senior Services Program (MSSP)

Multipurpose Senior Services Program (MSSP) is an intensive case management program for people aged 65+ with disabilities who are eligible for nursing home placement, 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 institutionalization.

MSSP eligibility criteria:

- 65 years of age or older
- Live in Santa Clara County
- Be eligible for Medi-Cal and enrolled in a managed care plan
- Be certified for placement in a nursing facility

Referrals for MSSP:

- Contact Sourcewise (formerly Council on Aging) at **1-408-350-3200**.

Home Health Services

SCFHP covers medically necessary health care services in the member's permanent or temporary place of residence, when requested by the primary care/attending physician. Covered services include hospice care, home health care, and home infusion therapy.

Hospice

Hospice is specialized interdisciplinary health care designed to provide palliative care, services, equipment and supplies to alleviate the physical, emotional, social and spiritual discomforts of a terminal illness. This care is provided to members who are diagnosed with a terminal illness and are only expected to live six months or less. The member may elect to receive hospice care at home or in a Medi-Cal licensed facility. The facility and the hospice provider must have a contract with SCFHP and the care must be approved by SCFHP through the authorization process. The member may elect to revoke or discontinue hospice services at any time.

Home Health

Home health services include visits by registered nurses (RNs), licensed vocational nurses (LVNs), social workers, and home health aides and may include short-term intravenous infusion therapy, physical therapy, occupational therapy, speech therapy and respiratory therapy when prescribed by a licensed plan provider. The member must be confined to his/her home (“homebound”) and need intermittent skilled nursing or related therapies. Prior authorization and concurrent review are required for home health services. Written treatment plans are requested and reviewed to assist with case management of members. Durable medical equipment (DME) may be covered under a separate authorization when requested by a physician and provided in accordance with the treatment plan.

Home Infusion Therapy

Medically necessary home infusion therapy is a covered benefit through SCFHP. Treatment must be prescribed by a physician and be provided in accordance with a written treatment plan. Medical and prescription prior authorizations are required. The home health agency providing the care teaches the member and the supporting care providers how to administer products and maintain the infusion site. When the member’s conditions for outpatient infusion therapy is possible, the member’s care may be transferred to a contracted outpatient infusion therapy center.

Quality Improvement Programs

Quality Improvement (QI) Program Goals

The goal of the QI program is to support safe, appropriate, and effective care for all of our members.

Improvement processes are developed to meet the standards of state and federal agencies including but not exclusive to the CMS, DHCS, DMHC, the National Committee for Quality Assurance (NCQA), the CMS Medicare Advantage Part C and Part D Star Ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) which are deployed by the NCQA. SCFHP goals are accomplished through systematic monitoring and evaluation of the quality, safety, appropriateness, outcomes of, and satisfaction with the services provided to members. SCFHP actively pursues 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.

SCFHP requires all services from our staff and providers be made in a culturally and linguistically appropriate manner and available to all members, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.

You can learn more about the quality improvement program by visiting https://www.scfhp.com/for-providers/quality-improvement-program/ .

Quality Improvement and the NCQA

As per NCQA requirements, Providers and Practitioners must cooperate with SCFHP's quality improvement activities to improve:

- Quality of care
- Quality of services
- Member experience
- Clinical and Service measures related to quality improvement programs

Cooperation includes the collection and evaluation of performance data and participation in quality improvement programs. SCFHP may use provider or practitioner performance data for quality improvement activities.

Quality Improvement Activities

Providers **must** cooperate with SCFHP's Quality Improvement activities to improve the quality of care and services, meet regulatory quality standards, provide standards of care in accordance with U.S. Preventive Services Task Force ("USPSTF") and specialty boards, and create a positive Enrollee experience. Cooperation **includes** documentation, collection and evaluation of data and participation in SCFHP's QI programs. SCFHP may use provider's performance data for Quality Improvement activities.

Provider Performance Program (PPP) for Medi-Cal

In parallel with the member-centered Quality Improvement Program is the provider-centered Provider Performance Program. The PPP was developed by SCFHP to address the provider's specific role in rendering quality care to the member. Each year the PPP team, with guidance provided by cross-functional business units, evaluates year-over-year performance to identify any trends and characteristics deserving of improvement. From this review comes a list of quality metrics that providers are tasked with working on to address. PCPs are made aware of their respective with gaps-in-care lists that are updated and posted to their Provider Link portal (https://providerportal.scfhp.com/).

PCPs can learn more about their own *gaps in care* by visiting https://providerportal.scfhp.com/. Questions on the PPP program may be directed via email to the Provider Performance Program team at providerperformance@scfhp.com.

National Committee for Quality Assurance (NCQA) Accreditation

SCFHP is currently working towards NCQA Medicaid Accreditation for the Medi-Cal line of business, an accreditation already achieved for the Medicare side of operations. Providers contracted with SCFHP will notice language specific to the NCQA as a means to SCFHP's NCQA for both lines of business.

Proposition 56 Supplemental Payment Program

Proposition 56 is a measure passed by California voters in 2016 that placed an excise tax on tobacco products for fund expenditures including but not exclusive to programs administered by California's Department of Health Care Services (DHCS). The supplemental payment program that this tobacco tax funds has grown over time, with supplemental payments made available to eligible providers for such healthcare services as:

- Value based payments, inclusive of:
    - Prenatal pertussis vaccines
    - Prenatal care visit
    - Postpartum care visit
    - Postpartum birth control
    - Well child visits
    - Childhood vaccines
    - Blood lead screening
    - Dental fluoride varnish
    - High blood pressure control
    - Diabetes care
    - Persistent asthma control
    - Tobacco use screening
    - Adult influenza vaccine
    - Screening for clinical depression
    - Management of depression medication
    - Screening for unhealthy alcohol use
- A defined list of CPT codes physician services
- A defined list of family planning-related HCPCS codes
- Developmental screening
- Trauma screening (with additional requirements)

Proposition 56 supplemental payments are funded by the California state budget and administered according to DHCS rules. Providers are encouraged to visit the provider training page on the SCFHP website to learn more about the particulars of the Proposition 56 supplemental payment program.

California Advancing and Innovating Medi-Cal (CalAIM)

The California Advancing and Innovating Medi-Cal initiative is a derivative of the State's desire to:

1) Identify and manage member risk and need through whole person care while addressing social determinants of health,
2) move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and
3) improving quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

This will be achieved through seven core initiatives of:

1) Enhanced Care Management (ECM)
2) Community Supports (formerly in Lieu of Services, or ILOS)
3) Mandatory managed care populations
4) Population health management plan
5) Transition to Statewide Dual Eligible Special Needs Plans (D-SNP) and Managed Long-Term Services and Supports
6) Regional rates
7) NCQA accreditation for plans and delegates

This is just the beginning of an intentional, broad stroke effort by the State to make the managed care offerings from county to county more effective than they ever have been. The first two initiatives were effective January 1, 2022 – Enhanced Care Management (ECM) and Community Supports. Details on ECM are under Case Management. Details on Community Supports are under Addressing Social Needs.

Addressing Social Needs

Community Supports

Community Supports contributes to an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. Community Supports are medically-appropriate and cost-effective substitutes or settings versus costly state-paid health care services. They are not Medi-Cal benefits, but supplemental services paid by SCFHP that focus on addressing combined medical and social determinants of health needs to avoid higher levels of care and are typically

delivered by a different provider or in a different setting than traditional Medi-Cal benefits. Community Supports is one of many initiatives of CalAIM.

There are 14 DHCS-approved Community Supports. SCFHP currently offers 13 of the Community Supports and will incrementally offer the additional Community Support service by July 1, 2024. To be eligible, members must meet the specific eligibility criteria for each Community Support service as defined by the DHCS policy guide.

Community Supports Referral Process

A referral form can be found on the SCFHP website. Please submit through the Provider Portal, by **secure** email, by fax to **1-408-874-1985**, or by phone at **1-408-874-1929**. For more information on Community Supports, go to the SCFHP website or call **1-408-874-1929**.

Community Resources

SCFHP members face many barriers in the form of social determinants of health. In order to help remove these barriers, SCFHP contracts and partners with findhelp, a social care network that offers an online database of community resources specific to Santa Clara County. Community programs and services can be searched by social need, geographical area and more. Programs listed on findhelp are low to no cost.

Social Determinants of Health (SDOH) and Data Collection

Social Determinants of Health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The ICD-10 provides a number of codes that can be included in claims which can support identification of member health, social and risk needs, to ensure that members receive the specific services and programs that they require. The data can also aid providers in care planning and coordination, and will contribute to SCFHP's population needs assessment.

In August 2021, the DHCS released requirements for plans to collect reliable SDOH data. Providers are required to include the DHCS's Priority SDOH Codes on all submitted claims which includes:

Code	Description
Z55.0	Illiteracy and low-level literacy
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food

Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z59.811	Housing instability, housed with risk of homelessness
Z59.812	Housing instability, homelessness in past 12 months
Z59.819	Housing instability, unspecified
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Additional details related to Social Determinants of Health are available here.

Value-added SCFHP programs and services

YMCA of Silicon Valley Membership

This health and wellness program is offered to SCFHP members at no cost to encourage an active lifestyle and improve overall quality of life. All SCFHP Medi-Cal and DualConnect (D-SNP) members have access to a no-cost YMCA membership which includes:

- 600+ group exercise classes including yoga, Pilates, Zumba, cycling, TRX and aqua fitness led by certified instructors
- Cardio and strength training equipment, indoor and outdoor fitness studios, indoor and outdoor swimming pools, basketball gym, and wellness programs* to support you on your wellness journey.
- Access to a wellness coach

To enroll, members can visit any YMCA of Silicon Valley location and show their SCFHP member ID card. They can also sign up online at www.ymcasv.org/santa-clara-family-health-plan. Please encourage your patients to talk to their PCP before starting or changing their exercise routine. SCFHP members who are under 12 years old must be accompanied by an adult when visiting a YMCA.

*Non-standard services that call for an added fee are not part of the SCFHP Medi-Cal YMCA membership and will not be reimbursed by YMCA or SCFHP.

For additional information about the YMCA of Silicon Valley, visit www.ymcasv.org. Participation in this program is optional and does not change a member's healthcare coverage. The YMCA of Silicon Valley is not part of SCFHP.

Blanca Alvarado Community Resource Center

The SCFHP Blanca Alvarado Community Resource Center (CRC) is a convenient, welcoming, and safe space committed to advancing the health of SCFHP members and East San José residents. The CRC collaborates with safety-net agencies to offer community-responsive and culturally competent health and wellness programs and helps connect residents to resources. The Center has services available to both residents and SCFHP members. Services include:

- Free application assistance from our Community Health Workers who are friendly, bilingual, and certified enrollment counselors.
    - To schedule an appointment, patients can call the CRC at **408-874-1750**.
- Access to community resources and services, such as food, housing, and healthcare, by knowledgeable staff
- Free health education and fitness classes
- SCFHP member orientations
- In-person customer service for SCFHP members
- Access to care coordination for SCFHP members for services like case management, behavioral health, and finding a primary care physicians or specialist

The CRC is located at 408 North Capitol Avenue, in the Capitol Square Mall at North Capitol Avenue and McKee Road in San José. It is open Monday through Friday, 10:00 a.m. to 5:00 p.m. Visit crc.scfhp.com for the latest calendar of events and activities. For more information, call **408-874-1750**.

Public Health Services

Disease Surveillance

Title 17, California Code of Regulation (CCR) Reportable Diseases and Conditions, requires health care providers to report known or suspected cases of disease or condition. Reporting disease or condition helps public health agencies identify outbreaks before they become epidemics and guide public health decision-making.

It is the duty of every health care provider in attendance; or in instances when no health care provider is in attendance, the individual having knowledge of a case or suspected case of any of the diseases or conditions listed in the website below should make a report to the local health officer for the jurisdiction where the patient resides by the timeframe in accordance with Title 17, California Code of Regulation (CCR) § 2500,

§2593, §2641.5-2643.20, and §2800-2812. Healthcare providers must report diseases even if the laboratory has already reported.

Link to Reportable Disease and Conditions:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Reportable-Disease-and-Conditions.aspx

For more information on local reporting and forms, please visit:
https://publichealthproviders.sccgov.org/reporting

Immunizations

(Reminder: All providers are obligated under the state law to report all immunization data to the registry)

This section covers the billing procedures for the administration of vaccine/toxoids, and immune globulin, serum, or recombinant prophylaxis services.

Important Notice and TAR Requirement

All of the listed vaccines and respective CPT® codes may be billed if recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), for approved indications, dosages and usages. An approved Treatment Authorization Request (TAR) is required for off-label use to justify medical necessity. It must meet current standards of practice, current medical literature or treatment guidelines, in accordance with statutory requirements (California Code of Regulations [CCR] Title 22, Section 51313(c) (4). Billing codes and utilization management criteria are listed with each code. Experimental services are not a benefit (CCR, Title 22, Section 51303 (g). Investigational services are covered in accordance with statutory requirements (CCR, Title 22, Section 51303 (h). Authorization is required for dosages exceeding the maximum recommended dosages as approved by the FDA.

Reimbursement Methodology

Vaccines are reimbursed at the Medicare rate of reimbursement when established and published by the Centers for Medicare & Medicaid Services (CMS) or the pharmacy rate of reimbursement when the Medicare rate is not available. The Medicare rate is currently defined as average sales price (ASP) plus 6 percent. The pharmacy rate is currently defined as the lower of (1) the National Average Drug Acquisition Cost (NADAC) or, when the NADAC is not available, the wholesaler acquisition cost (WAC) plus 0 percent; (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC).

Billing Guidelines

According to national coding guidelines, providers should report immunization services by listing the applicable immunization administration CPT code(s) in addition to the

vaccine/toxoid CPT code(s). Reimbursement is determined by the cost of the immunization, plus the physician's administration fee. Only one administration fee will be reimbursed per immunization regardless of the quantity reflected on the claim line.

Descriptions provided for procedure codes are only provided to assist with context. Providers are expected to utilize and refer to the official code books when billing for specific procedure codes.

Special billing procedures apply to vaccines administered to persons under 19 years of age, who are eligible for the Vaccines For Children (VFC) Program. Since the VFC program supplies vaccine/toxoid product(s) at no cost to the provider, Medi-Cal will only reimburse a provider for the cost of administering a VFC-supplied dose. To bill Medi-Cal for the VFC dose administration fee, VFC providers shall report the vaccine/toxoid product code(s) with a modifier code of "SL", which identifies the service as a "state-supplied vaccine". Each CPT vaccine product code billed with a "SL" modifier is reimbursed separately for a VFC dose administration fee. Please refer to VFC section of the manual for additional details.

Vaccines/toxoids for a high-risk population must be reported with a modifier "SK". Providers must document in the Remarks field (Box 80)/Additional Claim Information field (Box 19), or on an attachment to the claim, the reason why the patient is considered high-risk.

All vaccines recommended by ACIP are a Medi-Cal benefit including for the purpose of employment, school, immigration or sports. In addition, if a beneficiary meets an ACIP-recommended indication, such as, age or a risk factor, Medi-Cal covers the indicated vaccine.

Immunizations are also covered under The Presumptive Eligibility for Pregnant Women (PE4PW) program which allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant recipients, pending their formal Medi-Cal application. PE4PW is designed for California residents who believe they are pregnant and who do not have Medi-Cal coverage for prenatal care. For additional details, please visit the Presumptive Eligibility for Pregnant Women section of the manual.

Vaccine Immunization Administration Codes

The following CPT codes are reimbursable for immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age:

- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
- 90474 each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure
- The following CPT codes are reimbursable for immunization services when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine.
- 90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
- 90461 each additional vaccine or toxoid component administered (list separately in addition to code for primary procedure)

Free Vaccines For Children (VFC) Program

Because the VFC program provides vaccine/toxoid product(s) at no cost to a VFC provider, Medi-Cal will only reimburse a VFC provider for the cost of administering a VFC dose and not for the dose itself. According to national CPT code guidelines, immunization services are usually reported by using both the vaccine/toxoid code(s) and the vaccine immunization administration code(s). To report a VFC immunization service to Medi-Cal, providers should list each administered vaccine/toxoid product code with a modifier code of “SL”, which identifies the dose as a “state-supplied vaccine”. A separate VFC administration fee will be reimbursed for each vaccine/toxoid product code that is listed with a “SL” modifier on the claim.

Medi-Cal does not reimburse for the cost of a vaccine product that is available through the VFC program but purchased from a non-VFC source and administered to a VFC-eligible person except when justified. A provider’s non-enrollment in the VFC program is not a justified exception. Valid exceptions include documented cases of a VFC vaccine supply shortage due to a disease epidemic, vaccine manufacturing or delivery problems, or instances when the beneficiary does not meet special circumstances required by the VFC program for the vaccine billed. Providers must indicate a justified exception requiring the administration of a non-VFC dose in the Remarks field (Box 80)/ Additional Claim Information (Box 19) of the claim.

Providers should not report immunization services with an Evaluation and Management (E/M) service code (for example, office, outpatient, or preventive medicine visit, etc.) unless the provider has also completed a significant and separately identifiable E/M service at the same time. The separate E/M service must be thoroughly documented in the beneficiary’s medical record, and the claim is subject to audit and recoupment of reimbursement.

Vaccines for Children Program

The Vaccines for Children Program (VFC) Program helps families by providing vaccines at no cost to providers who serve eligible children from birth through 18 years of age (California Department of Public Health, 2008-2024).

How the program works:

- Centers for Disease Control and Prevention contracts with vaccine manufactures to buy vaccines at reduced rates. Enrolled providers order federally funded vaccines through their state VFC program and receive routine (including influenza) at no cost.
- Reintegration of immunization and primary care to retain children who might otherwise be referred elsewhere
- California providers can enroll into the VFC program online at: https://eziz.org/vfc/enrollment/

Free Vaccines from Source Other than VFC Program

Providers bill CPT code 90471 (immunization administration; one vaccine) to Medi-Cal to be reimbursed for the administration of vaccines that are free to the provider through a source other than the VFC program, including doses purchased by public health departments. When billing code 90471, providers must indicate the vaccine administered and its source in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim. Code 90471 may not be billed in conjunction with other vaccine immunization codes (90284 thru 90749 and X5300 thru X7699) administered by the same provider, for the same recipient and date of service.

Infections or Communicable Disease

A current list of reportable communicable diseases as well as reporting forms is available here.

HIV/AIDS

All SCFHP members may receive confidential HIV testing and counseling services through our provider network or through the Santa Clara Public Health Department and family planning providers.

Members must sign a consent form before being tested for HIV. Out-of-network providers must make all reasonable efforts, consistent with current laws and regulations, to obtain the necessary signatures to report confidential test results to the member's PCP.

If a member tests positive for any STD, including HIV, the PCP is responsible for ongoing case management and for referring the member to the appropriate specialist for follow-up care. While an SCFHP member may self-refer to any provider for confidential HIV testing, he/she must always be referred back to the PCP for follow up, case management, and referral to the appropriate treatment specialist. Members with a diagnosis of HIV/AIDS should be referred to SCFHP Case Management for assessment.

Case management of members with HIV/AIDS must follow protocols as recommended by the CDC and National Institute of Health (NIH).

For information about HIV/AIDS from the CDPH Office of AIDS website.

Sexually Transmitted Disease & Infections Other than HIV

All STD/STIs must be reported to the Department of Public Health.

If a member tests positive for any other STD/STI, the PCP is responsible for ongoing case management and for referring the patient to the appropriate specialist for follow-up care.

All STD/STI test results are kept confidential and strictly limited to the disclosure of test results as required by HIPAA.

Additional information about reporting STD/STIs is available here.

Tuberculosis (TB) Diagnosis and Treatment

New members should be assessed for TB risk. Depending on the member's risk factors, PCPs should determine if any further testing is needed. TB risk assessments should be administered every year.

Management of Persons with Suspected/Confirmed TB

Information on the treatment and care of members with suspected or confirmed TB is available here.

The PCP is required to order appropriate diagnostic studies to determine the presence of active TB for any member. Further, the PCP is required for patients diagnosed with TB to develop a treatment plan to with the most effective therapy that lines up with current public health guidelines. The State requires the reporting of all members with confirmed or suspected TB to the California Department of Public Health (CDPH) by electronic transmission (including FAX), telephone, or mail within one working day of identification and Santa Clara County by calling **1-408-885-2440** or faxing **1-408-885-2331**.

Direct Observed Therapy

Members who are not compliant with the treatment regimen must be referred for DOT to the Santa County Public Health Department's TB Control Program at:

Tuberculosis (TB) Prevention and Control Program
Santa Clara County Public Health Department
976 Lenzen Avenue, Suite 1700
San Jose, California 95126

Phone: 1-408-792-1381
Fax: 1-408-885-2331

A member who has been referred for DOT must be seen monthly by their PCP or by the TB Clinic of the Santa Clara County Public Health Department for evaluation of medical status and to ensure consistent treatment.

Additional details on DOT may be found by visiting this website.

Continuing Medical Education for Providers

SCFHP seeks to empower providers with knowledge to keep each well positioned to provide members with the best care possible. As SCFHP schedules continuing medical education (CME) by schedule or by request, SCFHP will publish details of planned CME events in the provider newsletter, via faxed communications, phone calls, field visits, or postage. Providers are encouraged to submit topics for CME that they believe would be beneficial to them and their peers alike.

Health Education Programs for Members

SCFHP is dedicated to helping our members stay healthy and happy. We offer health education classes and resources 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.

Classes and Resources

Class and resource offerings include:

- Chronic Disease Self-Management for conditions like hypertension, asthma, and diabetes
- Smoking Cessation
- Exercise & Fitness
- Nutrition & Weight Management
- Safety Programs (e.g. infant/child CPR, first aid, car seat safety)

- Stress Management
- Anger Management
- Parent Education
- Prenatal & Postpartum Education
- Sexual Health
- Health Programs for children (e.g. pre-diabetes camp, asthma camp, and summer swim lessons)

Role of the Provider

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 posted on the SCFHP website.

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 **1-800-260-2055** 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 ID card. Customer Service Representatives are available Monday through Friday from 8:00 AM to 8:00 PM, holidays included.
- **Call the referral into the Customer Service Department**. You may submit a referral via telephone by calling the Customer Service Department at **1-800-260-2055**. While a provider referral is normally not required for most classes, SCFHP Health Education accepts referrals when providers prefer SCFHP reaches out to the patient directly. 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 here, in the Provider Forms & Documents section. 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. An electronic version of the form is also available on Provider Link. 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

- Additional services:

    - Members can request an in-person interpreter if we do not have a class available in their preferred language.
    - Members can request transportation services to most health education classes by calling our Customer Service line (5 business days' advance notice is required).

Health Education for Providers

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

Section 5: Provider Toolkit

Desktop Guide

SCFHP Customer Service	
SCFHP Provider Portal (Provider Link) 24 hours-per-day, 7 days-per-week	https://providerportal.scfhp.com
SCFHP Interactive Voice Response (IVR) System 24 hours-per-day, 7 days-per-week	1-800-720-3455
Medi-Cal Customer Service 8:30 AM to 5:00 PM, Monday through Friday	1-800-260-2055 (TTY:711)
DualConnect Customer Service 8:00 AM to 8:00 PM, 7 days-per-week	1-877-723-4795 (TTY: 711)
Telephone Interpretation Services 24 hours-per-day, 7 days-per-week	1-888-898-1364
TDD Hearing Impaired Phone Line 8:30 AM to 5:00 PM, Monday through Friday	1-800-735-2929
Nurse Advice Line 24 hours-per-day, 7 days-per-week	1-877-509-0294

SCFHP Direct	
Authorizations	https://providerportal.scfhp.com 1-408-874-1821 (Phone) 1-408-874-1957 (Fax) 1-408-376-3548 (Fax)
Provider Network Operations	1-408-874-1753
Claims Address[1]	Santa Clara Family Health Plan PO Box 18640 San Jose, California 95158
North East Medical Services (NEMS)	
Authorizations	1-415-352-5045 (Phone) 1-415-398-2895 (Fax)
Provider Network Operations	1-415-352-5186
Claims Address	North East Medical Services Attention: MSO Claims 2171 Junipero Serra Boulevard, Suite 600 Daly City, California 94014
Claims Inquiries	1-415-352-5186

[1] Providers are required to submit claims electronically where possible.

Palo Alto Medical Foundation (PAMF)	
Authorizations	https://providerportal.scfhp.com 1-408-874-1821 (Phone) 1-408-874-1957 (Fax) 1-408-376-3548 (Fax)
Provider Network Operations	1-408-874-1753
Claims Address[2]	Santa Clara Family Health Plan PO Box 18640 San Jose, California 95158
Physicians Medical Group of San Jose (PMG)	
Authorizations	1-408-937-3600 Option 2
Provider Network Operations	1-408-937-3600
Claims Address	Excel MSO, Physicians Medical Group of San Jose PO Box 1997 San Leandro, California 94577-1997
Claims Inquiries	1-408-937-3600

[2] Providers are required to submit claims electronically where possible.

Premier Care of Northern California (PCNC)	
Authorizations	1-877-216-4215
Provider Network Operations	1-877-216-4215
Claims Address	Conifer Health Solutions PO Box 260830 Encino, California 91426
Claims Inquiries	1-877-216-4215
Stanford Hospitals & Clinics (SHC)	
Authorizations	https://providerportal.scfhp.com 1-408-874-1821 (Phone) 1-408-874-1957 (Fax) 1-408-376-3548 (Fax)
Provider Network Operations	1-408-874-1753
Claims Address[3]	Santa Clara Family Health Plan PO Box 18640 San Jose, California 95158

[3] Providers are required to submit claims electronically where possible.

Valley Health Plan (VHP)	
Authorizations	1-408-885-4647
Provider Network Operations	1-408-885-2221
Claims Address	Valley Health Plan PO Box 28407 San Jose, California 95159
Claims Inquiries	1-408-885-4563
Language Interpretation Services	
Spanish	1-408-808-6151
Vietnamese	1-408-808-6152
Other (Including Tagalog/Chinese)	1-408-808-6150