Santa Clara Family Health Plan™

PROVIDER MANUAL

Medi-Cal Plan & Dual Eligible Special Needs Plan (a Medicare Medi-Cal Plan) 2022

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by email at **ProviderServices@scfhp.com**,
or visit **www.scfhp.com**.

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Section 1: Introduction

About Santa Clara Family Health Plan (SCFHP)

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 more than 300,000 people through our Medi-Cal health care plan and our Dual Eligible Special Needs Plan (D-SNP), a Medicare Medi-Cal Plan.

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.

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 D-SNP lines of business. This manual is available online at https://www.scfhp.com/for-providers/provider-resources/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.

Disclaimer

The information provided in this manual is intended to be informative and assist providers participating in the SCFHP Medi-Cal and D-SNP Plans. 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 1, 2022** 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 **D-SNP** lines of business. While much between the two is the same, differences between the Medi-Cal and D-SNP products will be clearly identified. Whether you are contracted to see our Medi-Cal or D-SNP membership, this manual will cover many of the relevant parts for both lines of business.

This is an electronic manual that includes a series of hyperlinks directing you to external resources, to corresponding sections within, and email addresses to follow up with any questions you may have. Please let us know at ProviderServices@scfhp.com if there's anything wrong or if you'd like to see any changes considered to 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 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 belonging to 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 (QIC)**: Responsible for the review of and advisement related to SCFHP's performance of contracted providers, quality of care, and utilization of services provided.
- **Utilization Management Committee**: Consists of healthcare professionals who develop criteria for determining medical necessity, delegation, and utilization activities.
- **Compliance Committee**: Charged with 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 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 medications.
- **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 (D-SNP)**: The D-SNP Consumer Advisory Board (CAB) engages consumers and caregivers in Santa Clara County in the implementation and evaluation of operations and policies of the D-SNP Plan (HMO D-SNP).

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 specified SCFHP members.
- **Claims**: Responsible for adjudicating all claims and responding to provider requests related to claims.
- **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.
- **Long Term Services and Support**: Collaborates with and provides support to long-term services and support providers.

- **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, oversees the Pharmacy Benefit Manager (PBM), develops and implements evidence-based clinical programs and medication therapy management (MTM) programs and services, 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 NCQA and HEDIS guidelines.
- **Utilization Management**: 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?
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?

Composite Measures	Survey Items Included in the Composite
	- 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:

  Santa Clara Family Health Plan
  Attn: Compliance Officer
  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:
        (i) Enrollment freeze – auto assignment, member selection, or both;
        (ii) De-delegation of delegated functions (with necessary and commensurate reduction in capitation payment);
        (iii) 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
        (iv) 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 Curriculum Vitae.
- **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 1stand 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 12.
- 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 35.

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)

The California Department of Health Care Services (DHCS) requires all providers contracted as PCPs to pass a complete 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, and 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, Nurse Reviewers must complete the initial MRR of the new PCP 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 record, and there is a "shared" medical record system, the Nurse Reviewer must review a minimum of 10 records if 2-3 PCPs share records, 20 records if 4-6 PCPs share records, and 30 records if 7 or more PCPs share records. 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/

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%, a Conditional Pass is a score of 80-89%, and a Not Pass is anything under 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.

Provider Training, Education & Resources

Providers are required to participate in SCFHP's provider education and training efforts. These efforts include but are not exclusive to:

- New Provider Orientation
- The Annual Training Packet
- Long-Term Services & Supports (LTSS)
- Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT)
- Cultural & Linguistic Services

Several of these resources can be found on the provider training page (https://www.scfhp.com/for-providers/provider-resources/provider-training/) of the SCFHP website. The details to follow present a deeper dive into the more substantive measures presented to new and continuing providers.

Provider Orientation

Each contracted provider, whether under SCFHP Direct or by joining a delegated affiliation, must complete New Provider Orientation within 10 days of the new contract effective date or credentialing date. The Provider Network Operations team will reach out to SCFHP Direct providers to plan and schedule the Orientation presentation while providers contracted with SCFHP by way of delegated affiliation will receive their New Provider Orientation from their respective delegate administrators. These expectations are set by the DHCS.

Cultural & Linguistic Services

Clinical and non-clinical bilingual staff members who interact with limited English proficiency (LEP) members should be documented and assessed as a qualified interpreter. Assessment may include, but is not limited to:

1) Written or oral assessment of bilingual skills
2) Documentation of the number of years of employment the individual has an interpreter/translator
3) Documentation of successful completion of a specific type of interpreter training program
4) Other reasonable alternative documentation of interpreter capability

SCFHP will audit for compliance during Facility Site Review audits.

Qualified interpreting services are available through SCFHP at no cost to providers nor members. This includes telephonic and face-to-face interpreting services as well as American Sign Language. Please print and make available to staff page 32 of the Cultural Competency Training Toolkit.

Training & Monitoring

SCFHP offers cultural competency resources and trainings on a variety of topics to providers and office staff at least annually. Training methods include, but are not limited to, a Cultural Competency Training Toolkit, New Provider Orientation, in-service training, field visits, provider newsletters, faxes, mailings, and special trainings. Training topics include but are not exclusive to:

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

Providers are required to develop and distribute to all patient-facing staff policies and procedures that address the cultural and linguistic requirements listed in this provider manual. Providers are also responsible for education and oversight to ensure full compliance with state and federal laws and provide annual attestation upon request. Please refer to the Cultural Competency Training Toolkit for additional details.

Annual Update

Each year, the Provider Network Operations team distributes to SCFHP Direct and delegate administrators an "Annual Training Packet" filled with details on programs, policies, and procedures that are new, revised, or otherwise identified as high priority elements. Signed attestations are collected from providers or applicable administrators of each location visited at the time of distribution to confirm the information has been received and will be passed on to all applicable providers. This information is made available on the provider training website as well.

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. Providers eager to learn more about

SCFHP's programs, policies, or procedures are encouraged to contact the Provider Network Operations at ProviderServices@scfhp.com team to set up the desired training session(s).

Enrollment & Eligibility

Eligibility Criteria

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

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

Enrollment Process

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

Medi-Cal	D-SNP (A Medicare Medi-Cal Plan)
SCFHP offers application assistance at our SCFHP Blanca Alvarado Community Center. Our bilingual Community Health Workers will help your patient through the Covered California enrollment process. SCFHP Blanca Alvarado Community 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.	Enrollment in D-SNP is voluntary. Eligible beneficiaries may choose to enroll in a D-SNP plan, choose a different Medicare-Medi-Cal plan, enroll in a Medicare Advantage plan (their Medi-Cal plan may change), or remain in Original Medicare and their Medi-Cal plan will be SCFHP.. A member or their representative can begin the D-SNP enrollment process by: • Phone SCFHP D-SNP: **1-888-202-3353** (TTY: **711**) • Online www.scfhp.com/D-SNP • In-person SCFHP Blanca Alvarado Community 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 by using the Automated Eligibility Verification System (https://www.medi-cal.ca.gov/mcwebpub/login.aspx). 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 https://www.scfhp.com/for-providers/provider-resources/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.

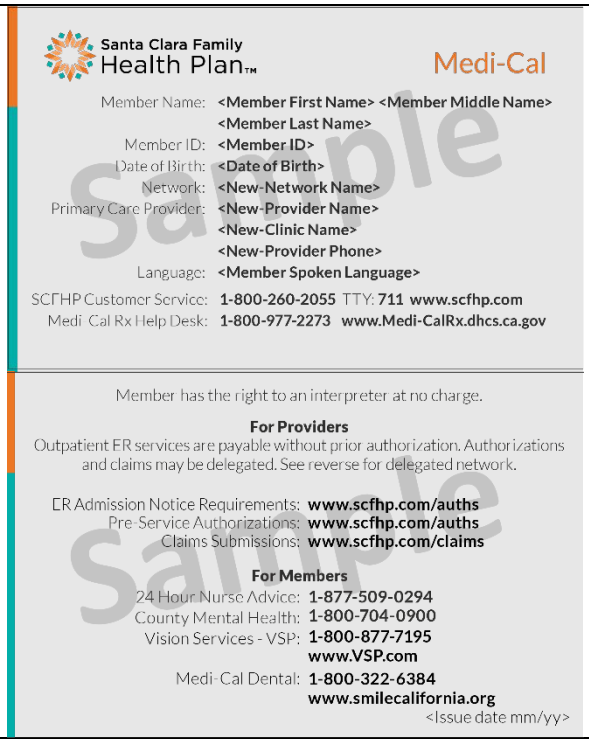
    After which point the service will be able to:

    - 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 the Provider Network Operations team.

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 D-SNP Member ID cards below.

Medi-Cal	D-SNP
	**Coming Soon**

Retroactive Changes

Circumstances may arise in which retroactive adjustments may be made to your eligibility list. By way of illustration, this may happen when there is a retroactive change made by the DHCS to the named 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. To that end, SCFHP has adopted *Member Rights & Responsibilities* that each member receives in their SCFHP Medi-Cal Member Handbook (Evidence of Coverage) or their SCFHP D-SNP Plan Member Handbook (Evidence of Coverage). Please submit your request to Provider Network Operations at ProviderServices@scfhp.com if you would like to receive printed copies of our 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, NPI, state license number, clinic location(s), 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 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 is the responsible payer 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. In more specific terms, 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.

Electronic Data Interchange (EDI)

SCFHP requires all contracted providers to bill applicable claims electronically. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 Portal in the Eligibility Section.

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	D-SNP
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 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.	D-SNP 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 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 D-SNP 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

Medi-Cal	D-SNP
	• 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	D-SNP
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 the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. 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 D-SNP 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 section on page 78 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 D-SNP 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:

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

Billing & Claim Disputes

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 a **D-SNP** claim outcome within 120 calendar days from SCFHP's remittance advice. SCFHP will investigate the dispute and issue a written resolution within 60 calendar days for a contracted provider or 30 calendar days for a non-contracted provider from the date the dispute is received.

Medi-Cal** and **D-SNP** 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. Second level claim disputes are resolved and responded to in writing within 30 working days from the date of receipt.

Marketing

Compliance with Laws & Regulations

Medi-Cal	D-SNP
Marketing of 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 Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411. Under program rules, network providers may not distribute any marketing materials or make such materials or forms available to individuals eligible to enroll in a Medi-Cal plan unless the materials meet the marketing guidelines and are first submitted to SCFHP and DHCS/DMHC for review and approval.	Marketing of D-SNP plans is regulated by the CMS and DHCS. Providers must adhere to all applicable laws, regulations, CMS guidelines and DHCS guidelines regarding D-SNP plan marketing, as specified under sections 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; the Medicare Communications & Marketing Guidelines (MCMG) (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual); and the California supplement to the MCMG – Marketing Guidance for California Medicare-Medicaid Plans. Examples of allowable and prohibited SCFHP/Provider marketing activities are listed below, however we suggest contacting SCFHP prior to any potential marketing initiatives to confirm which activities (or level of provider participation) may be considered marketing, and to ensure an understanding of compliance expectations.

Acceptable Marketing Methods

As a **Medi-Cal** or **D-SNP** 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 material that will 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 material to beneficiaries that has 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 a **Medi-Cal** or **D-SNP** health care provider, you may NOT:

- Coerce, threaten, or intimidate patients into making a particular selection.
- Tell patients they could lose their benefits if they do not choose a particular health plan.
- 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 race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.
- Sign an enrollment application for the member.

- Provide marketing presentations by a health plan or provider's staff at primary care sites.
- 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 regulatory approval. **Providers must submit drafts of any proposed member informing materials and a readability report demonstrating 6th grade reading level to the SCFHP Marketing Department 90 days prior to distribution**.

Benefits

Medi-Cal	D-SNP Plan
Upon enrollment and annually, SCFHP Medi-Call 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.	The D-SNP Plan 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 D-SNP 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 D-SNP benefit package. Providers may not bill D-SNP 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 or other providers wish to receive copies of the SCFHP Medi-Cal Member Handbook (EOC) or SCFHP D-SNP Plan Member Handbook (EOC). You can also access on www.scfhp.com under D-SNP Member Materials* or Medi-Cal Forms & Documents.

*Please note D-SNP member material will not be available until September 2022.

SCFHP In the Community

Blanca Alvarado Community Resource Center

Named after a local community leader and social justice advocate, the Santa Clara Family Health Plan Blanca Alvarado Community Resource Center is a convenient, welcoming, and safe space committed to advancing the health of SCFHP members and East San José residents. In collaboration with community partners, the Center offers community-responsive and culturally competent health and wellness programs that expand access to resources and promotes SCFHP's vision — health for all.

The CRC is in the Capitol Square Mall of East Santa Clara County at 408 North Capitol Avenue in San José. Please visit the CRC website to learn more about the CRC, its positive impact on the community, and how it can be utilized to the benefit of providers and members alike.

Grievance & Appeals

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

Grievance means any written or oral expression of dissatisfaction, regarding the plan and/or provider, including quality of care concerns, and 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 **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 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 D-SNP expedited grievances within 24 hours of receipt.

Quality of Care Grievances

Medi-Cal	**D-SNP**
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	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:

Medi-Cal	D-SNP
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. • 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**.	• 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. 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.

Medi-Cal	D-SNP
	• 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**, 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

- 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 (D-SNP)

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

Standard Appeals (D-SNP)

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. Unfavorable

determinations on D-SNP appeals are automatically forwarded to the Independent Review Entity.

Expedited Appeals (D-SNP)

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. Unfavorable determinations on D-SNP 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 D-SNP 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 D-SNP 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.
- 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 https://www.scfhp.com/grievance-form

Section 3: Your Role as a Provider

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 Assessment (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 (CPSP)
- 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 Assessment (IHA)

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

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. Infants should have assessments scheduled according to the AAP's Recommendations for Preventive Pediatric Healthcare. To help the PCP meet these timelines, we provide a list of new or re-enrolled members each month in Provider Link.

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

- A comprehensive history, including medical, social, psychological, and family background as well as lifestyle habits, such as tobacco, alcohol, nutrition/diet, exercise, and sexual activity.
- A complete physical and mental status examination to assess and diagnose acute and chronic conditions.
- Age-specific assessments and preventive services, including administering necessary immunizations (if this is not possible, appointments for appropriate services should be scheduled, with the date noted in the medical record) of referrals
- Diagnoses and plan of care.
- Staying Healthy Assessment (SHA) form completed and signed by the PCP annually for adults and seniors, or completed and signed by the PCP at each age band for pediatrics.

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

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

Assessment Tools for Performing the IHA

To help PCPs fulfill the IHA requirements, we provide copies of various professional standards, guidelines, and age-appropriate screening/assessment tools including age-stratified SHA forms 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.

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

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 initial health assessment (IHA) reviews 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, 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)

Assessing your Member's Level of Health Education

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

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

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

After reviewing the completed form, PCPs may refer patients to health education classes through SCFHP or provide them with copies of their own educational materials. Be sure to check out the Health Education section in this manual for more.

The SHA is available in multiple languages on the SCFHP website. Please contact the Health Education team if you have any questions about the IHEBA form or other tools for assessing health education needs.

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 complexity are such that 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.

Appointment or Type of Service	Criteria	Standard Access Timeframe
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	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.

• Mental Health condition • Lab and radiology monitoring	

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.
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.”

Appointment or Type of Service	Standard Access Requirements
	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 a three (3) day advance notice for all non-urgent requests.

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

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

Non-Medical Transportation (NMT)

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

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	D-SNP
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 **D-SNP** 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	D-SNP
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	D-SNP
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	D-SNP
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	D-SNP
• 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 and focus on the whole person approach to identify members at-risk, and to provide strategies, programs and services to mitigate or reduce that risk. The plan also aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions.

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 Assessment (IHA)
    - Individual Health Education Behavioral Assessment (HEBA);
    - 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)

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:

- 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 – Facilitate care transitions between the hospital, nursing homes, other treatment facilities, and home

- Member and Family Supports – Support the self-management and decisionmaking efforts of members and their family and/or support team
- Referral to Community and Social Supports – Connect members to community and social services, including housing

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.

Pharmacy Benefit

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

Drug Formulary

Medi-Cal	D-SNP
Medi-Cal Rx has a formulary called the Contract Drug List (CDL). For more information, visit Medi-Cal's website.	The SCFHP D-SNP List of Covered Drugs is updated monthly and can be viewed by visiting the Pharmacy page on SCFHP's website. **Please note D-SNP member material will not be available until September 2022*.

Formulary Exclusions

Formulary exclusions include but may not be exclusive 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 Implantation (DESI) products,
- Used for cosmetic reasons,
- Bulk chemicals including those used for compounding, and
- Drugs purchased outside of the United States and its territories.

Out-of-Pocket Payments

D-SNP members may have $0 copay for covered drug on the Covered Drug List.Drugs Requiring a Coverage Determination or Formulary Exception

- Non-formulary drugs (drugs not on the Covered Drug List).
- Drugs that require a Prior Authorization.
- Drugs that has a Step Therapy.
- Request is more than the quantity limit restriction.
- Safety edit 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 questions, please contact MedImpact via phone at **1-800-788-2949**.

Drugs Administered by Physicians/Clinics

Medi-Cal	D-SNP
Medi-Cal Rx will be 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 clinical providing the drug for administration under the medical benefit.

Transition Fill Policy

When a new **D-SNP** member tries to fill a non-formulary drug or drug with utilization management restriction within the first 90 days of enrollment, they will be eligible for a 31-day transition fill in the retail pharmacy network. This will also apply to members in long-term care (LTC) and 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

D-SNP members may use MedImpact Direct Pharmacy for mail order. Members who take prescribed medications regularly can have their drug delivered at no cost. For more information, please visit MedImpact Direct at 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. Depending on the health plan a member belongs to Medi-Cal, the 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 as part of the Initial Health Assessment (IHA), and regularly thereafter. 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	D-SNP
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 D-SNP 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 D-SNP member should receive services. A benefit of the D-SNP 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 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**.

Medi-Cal	D-SNP
	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 Medi-Cal beneficiaries as part of the Initial Health Assessment, and regularly thereafter 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). Under the Coordinated Care Initiative (CCI), SCFHP is responsible for administering and coordinating the benefits listed below:

- Long-term care in a nursing facility, including skilled, subacute and long-term custodial care
- Community-Based Adult Services (CBAS)
- In-Home Supportive Services (IHSS), which is authorized by the County

The service below is a carve out as of January 1, 2022:

- Multipurpose Senior Services Program (MSSP)

Long-Term Care (LTC)

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

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

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

LTC Referrals and Prior Authorization

The SCFHP 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.

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).

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 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 IPC. If a change in level of service is indicated on the request for reauthorization of CBAS services, SCFHP may conduct a face-to-face interview with the member to verify appropriateness of service. 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 408 792-1600 and 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 MLTSS Help Desk via email.

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. Contact information:

Sourcewise is available by phone at **1-408-350-3252** or online.

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), and the Healthcare Effectiveness Data and Information Set (HEDIS) designed and 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 Accreditation for the Medi-Cal line of business, an accreditation already achieved for the ~~Cal MediConnect~~D-SNP 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 end.

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 (Medi-Cal)

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 eight of the Community Supports and will incrementally offer the additional six Community Supports by July 1, 2023. To be eligible, members must meet eligibility criteria as defined by the DHCS and it varies by Community Supports.

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.

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. Providers will report the case to the local health officer for the jurisdiction where the member resides by the required 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.

You can find more information on local reporting and forms here.

Immunizations

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 member should be assessed for TB risk during their Initial Health Assessment. 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 eNewsletter, 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 (eg infant/child CPR, first aid, car seat safety)
- Stress Management
- Anger Management
- Parent Education
- Prenatal & Postpartum Education
- Sexual Health
- Health Programs for children (eg 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
Customer Service 8:30 AM to 5:00 PM, Monday through Friday	1-800-260-2055
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
Kaiser Permanente	
Customer Service	1-800-464-4000
Authorizations	1-800-464-4000,1 (Phone)
Claims Address	Kaiser Foundation Health Plan Attention: Claims Administration Department PO Box 12923 Oakland, California 94604
Claims Inquiries	1-800-390-3510

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

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
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

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

Physicians Medical Group of San Jose (PMG)	
Authorizations	1-408-937-3645
Provider Network Operations	1-408-565-8358
Claims Address	Excel MSO, Physicians Medical Group of San Jose PO Box 1997 San Leandro, California 94577
Claims Inquiries	1-408-937-3620
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
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

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

Santa Clara Family Health Plan™

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