

Provider Manual



WELCOME TO SUNSHINE HEALTH – LONG TERM CARE

Sunshine Health - Long Term Care is a managed care organization (MCO) contracted with the Florida Agency for Health Care Administration (AHCA) to serve Medicaid, Long Term Care, and other government services program Enrollees. Sunshine Health has developed the expertise to work with Long Term Care Enrollees to improve their health status, quality of life and the provision of quality services to meet the care needs of Enrollees. We tailor our approaches to deliver covered services and benefits with effectiveness, efficiency and accountability to meet and address challenges faced by LTC Enrollees. Sunshine Health works to accomplish this by partnering with ancillary providers who provide the services that are necessary to meet the care needs of our Long Term Care Enrollees.

Centene Corporation® (Centene) provides Long Term Care services to Enrollees in designated regions of Florida as Sunshine Health. Centene and its wholly owned health plans have a long and successful track record offering managed care services. Sunshine Health serves our Florida Enrollees consistent with our core philosophy that quality healthcare is best delivered locally. Sunshine Health is an organization that is committed to building collaborative partnerships with providers.

Medicaid is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children. Medicaid is different in every state.

The Statewide Medicaid Managed Care (SMMC) program has two different components: The Florida Long Term Care Managed Care Program and The Florida Managed Medical Assistance Program. Medicaid recipients who qualify and become enrolled in the Florida Long Term Care Managed Care Program will receive Long Term Care services through a Long Term Care managed care plan. Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance Program will receive all health care services other than Long Term Care through a managed care plan.

Sunshine Health - Long Term Care has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity and appropriateness of care
- Provide service delivery in a cost-effective manner

At Sunshine Health, we strive to provide our Enrollees with improved health status and outcomes. We strive to improve Enrollee and provider satisfaction in a managed care environment.

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Sunshine Health in reaching these goals and look forward to your active participation.

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SUNSHINE HEALTH GUIDING PRINCIPLES

- High quality, accessible, cost-effective Enrollee care
- Integrity, operating at the highest ethical standards
- Mutual respect and trust in our working relationships
- Communication that is open, consistent and two-way
- Diversity of people, cultures and ideas
- Innovation and encouragement to challenge the status quo
- Teamwork and meeting our commitments to one another

Sunshine Health allows open Provider/Enrollee communication regarding appropriate treatment and service alternatives. Sunshine Health does not penalize providers for discussing medically necessary, appropriate care or treatment options with the Enrollees.

SUNSHINE HEALTH'S APPROACH

Recognizing that a strong health plan is predicated on building mutually satisfactory associations with providers, Sunshine Health is committed to:

- Working as partners with participating providers
- Demonstrating that healthcare is a local issue
- Performing its administrative responsibilities in a superior fashion

All of Sunshine Health's programs, policies and procedures are designed to minimize the administrative responsibilities in the management of care, enabling the provider to focus on the care needs of our Enrollees.

SUNSHINE HEALTH'S PLAN SUMMARY

Sunshine Health's philosophy for Florida Medicaid and Long Term Care Enrollees is to provide access to high quality, culturally sensitive healthcare services by combining the talents of providers with a highly successful, experienced managed care administrator. Sunshine Health believes that successful managed care is the delivery of appropriate, medically necessary services, rendered in the appropriate setting - not the elimination of such services.

It is the policy of Sunshine Health to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable federal and state laws.

Sunshine Health takes the privacy and confidentiality of our Enrollees' health information seriously. We have processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. If you have any questions about Sunshine Health's privacy practices, please contact our Privacy Officer at **1-877-211-1999**.

SUNSHINE HEALTH – LONG TERM CARE AT A GLANCE

For your ease, we have included this Reference guide to assist you in the day-to-day operations of your office.

SUNSHINE HEALTH - LONG TERM CARE

1301 International Pkwy
Suite 400
Sunrise, FL 33323

www.sunshinestatehealth.com

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Department	Telephone Number
Provider Services/Claims	1-877-211-1999
Enrollee Services	1-877-211-1999 1-800-955-8770 (TDD/TTY)
Case Management	1-877-211-1999
NurseWise/Envolve People Care, Inc. (24/7 Availability)	1-877-211-1999 (Say Nurse)
Cenpatico/Envolve People Care, Inc.(Behavioral Health)	1-877-211-1999

ELECTRONIC CLAIMS SUBMISSION

SUNSHINE HEALTH
c/o Centene EDI
800-225-2573, ext 25525
Or by e-mail to: EDIBA@centene.com

SUBMIT CLAIM DISPUTES TO:

SUNSHINE HEALTH
Attn: Disputes
PO Box 3070
Farmington, MO 63640-3823

SUBMIT APPEALS TO:

SUNSHINE HEALTH
Attn: Appeals and Grievance Coordinator
1301 International Pkwy
Suite 400
Sunrise, FL 33323

SUBMIT PAPER CLAIMS TO:

SUNSHINE HEALTH TANGO PLAN
Attn: Claims
PO Box 3070
Farmington, MO 63640-3823

SUBMIT BEHAVIORAL HEALTH CLAIMS TO:

SUNSHINE HEALTH
Attn: Claims PO Box 6900
Farmington, MO 63640-3818

SUBMIT OPTICAL CLAIMS TO:

OPTICARE VISION/Envolve Vision Benefits, Inc.
P.O. BOX 7548
ROCKY MOUNT, NC 27804

IVR SYSTEM

A new Interactive Voice Response (IVR) system has been designed to make our great provider service even better.

What's great about the IVR system?

- It's free and easy to use!
- Provides you with greater access to information, including eligibility and claims status
- Available 24 hours, 7 days a week

Most subscribers may begin using the new IVR System by simply calling **1- 877-211-1999**.

WEBSITE

By visiting www.sunshinehealth.com you can find information on:

- Provider Directory
- Frequently Used Forms
- EDI Companion Guides
- Billing Manual
- Provider Manual
- Submit Claims On-Line
- Managing EFT

Sunshine also offers our contracted providers and their office staff the opportunity to register for our secure provider website in just **3 easy steps**. Here, we offer tools which make obtaining and sharing information easy!

Through the secure site you can:

- View and print Enrollee eligibility
- Check claim status
- Submit claims
- Contact us securely and confidentially

We are continually updating our website with the latest news and information so save www.sunshinehealth.com to your favorites and check our site often.

PROVIDER RESPONSIBILITIES

LONG TERM CARE PROVIDER

The Provider is required to adhere to the responsibilities outlined below.

- Provide Sunshine Health enrollees with a professionally recognized level of care and efficiency consistent with community standards, consistent with Sunshine Health's clinical and non-clinical guidelines and within the practice of your professional license;
- Abide by the terms of your Agreement;
- Comply with all Plan policies, procedures, rules and regulations, including those found in this Provider Manual;
- Maintain confidential medical records consistent with Sunshine Health's Medical Records Standards, medical record keeping guidelines, and applicable HIPAA regulations;
- Maintain a facility that promotes enrollee safety;
- Participate in Sunshine Health's quality improvement program initiatives;
- Participate in provider orientations and continuing education;
- Abide by the ethical principles of your profession;
- Notify the plan if you are undergoing an investigation, or agree to written orders by the State licensing Agency;
- Notify the plan if there is a change of status with Enrollee Eligibility.
- Ensure you have staff coverage to maintain service delivery to enrollees.

VERIFICATION OF ENROLLEE ELIGIBILITY

Provider is responsible to verify whether an individual seeking Covered Services is a Covered Person. If Sunshine Health determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under the Agreement, and Provider may bill the individual or other responsible entity for such services.

COVERED PROVIDER SERVICES

The Provider is responsible for supervising, coordinating, and providing all authorized care to each assigned enrollee. In addition, the provider is responsible for ensuring the receipt of an authorization for all services from the enrollee's case manager, maintaining continuity of each enrollee's care and maintaining the enrollee's medical record, which includes documentation of all services provided by the provider as well as the enrollee or responsible party's signature for receipt of covered services.

Covered Long Term Care Services Include:

Adult Companion Care– Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

Adult Day / Adult Day HealthCare Services – Services provided pursuant to Chapter 429, Part III, F. S. Services furnished in an outpatient setting, encompassing both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems, and planned group therapeutic activities. Adult day health services include nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks, and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service.

Adult Day Health Care (ADHC)- providers shall conform to the HCB Settings Requirements as required by the Agency for Health Care Administration (AHCA). Provider ADHC will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities. Enrollees accessing Adult Day Health Care services in Provider's ADHC shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options. Choice of daily activities, physical environment, with whom to interact, access to telephone and unlimited length of use, eating schedule, activities schedule and participation in facility and community activities, the ability to have right to privacy, right to dignity and respect, freedom from coercion and restraint and opportunities to express self through individual initiative, autonomy, and independence

Assistive Care Services – An integrated set of 24-hour services only for Medicaid-eligible residents in assisted living facilities, adult family care homes and residential treatment facilities.

Assisted Living – A service comprising personal care, homemaker, chore, attendant care, companion care, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility, licensed pursuant to Chapter 429 Part I, F.S., in conjunction with living in the facility. Service providers must ensure that enrollees reside in a facility offering care with the following home-like environmental characteristics: choice of private or semi-private rooms; choice of roommate for semi-private rooms; locking door to living unit; access to telephone as well as length of use; flexible eating and snack preparation schedule; and participation in facility and community activities of their choice. Home-like environmental characteristics also include the ability to have: unlimited visitation and personal sleeping schedule.

This service includes twenty-four (24) hour onsite response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Assisted living services may also include: physical therapy, occupational therapy, speech therapy, medication administration and periodic nursing evaluations. The LTC plan may arrange for other authorized service providers to deliver care to residents of assisted living facilities in the same manner as those services would be delivered to a person in their own home. ALF administrators, direct service personnel and other outside service personnel

such as physical therapists have a responsibility to encourage enrollees to take part in social, educational and recreational activities they are capable of enjoying. All services provided by the assisted living facility shall be included in a care plan maintained at the facility with a copy provided to the enrollee's case manager. The LTC plan shall be responsible for placing enrollees in the appropriate assisted living facility setting based on each enrollee's choice and service needs.

Attendant Care – Attendant Care services are both supportive and health-related hands-on-care services specific to the needs of the individual. Attendant Care services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant Care services may include skilled nursing care or personal care to the extent permitted by state law. Housekeeping activities incidental to the performance of care may also be furnished as part of this activity. This service can be authorized when the recipient's mental or physical condition requires assistance with medically related needs.

Behavioral Management – This service provides behavioral health care services to address mental health or substance abuse needs of long-term care plan enrollees. These services are in excess of those listed in the Community Behavioral Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook. The services are used to maximize reduction of the enrollee's disability and restoration to the best possible functional level and may include, but are not limited to: an evaluation of the origin and trigger of the presenting behavior; development of strategies to address the behavior; implementation of an intervention by the provider; and assistance for the caregiver in being able to intervene and maintain the improved behavior.

Caregiver Training Services – Training and counseling services for individuals who provide unpaid support training, companionship or supervision to enrollees. For purposes of this service, an individual is defined as any person, family enrollee, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to an enrollee. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the enrollee at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the enrollee. All training for individuals who provide unpaid support to the enrollee must be included in the enrollee's plan of care.

Home Accessibility Adaptation Services - Physical adaptations to the home required by the enrollee's care plan which are necessary to ensure the health, welfare, or safety of the enrollee or which enable the enrollee to function with greater independence in the home or without which the enrollee would require institutionalization. Such adaptation may include the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities or installation of plumbing systems to accommodate the medical equipment or supplies, which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair, or central air conditioning. Adaptations which add to the total square footage of the home are not included in this benefit. All services must be provided in accordance with state and local building codes.

Home Delivered Meals - Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance each meal is designed to provide a minimum thirty-three and three tenths percent (33.3%) of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

Hospice - Services are forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill recipients and their families. Hospice care focuses on palliative care rather than curative care. An individual is considered to be terminally ill if he has a medical diagnosis with a life expectancy of six (6) months or less if the disease runs its normal course.

Intermittent and Skilled Nursing – Intermittent or part-time nursing services provided by a registered nurse or licensed practical nurse. The scope and nature of these services do not differ from skilled nursing furnished under the State Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services under this waiver. Services listed in the plan of care that are within the scope of

Florida's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee's plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.

Homemaker Services – General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

Medical Equipment and Supplies – Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

Medication Management / Administration Services – Medication administration can only be provided by licensed nurses. Assistance with self-administered medications whether in home or in a facility, can be provided either by a licensed nurse or, with a documented request and informed consent, an unlicensed staff enrollee. Pursuant to 400.4256, F.S., assistance with self-administration of medications includes taking the medication from where it is stored and delivering to the enrollee; removing a prescribed amount of medication from the container and placing it in the resident's hand or another container; helping the resident by lifting the container to his or her mouth; applying topical medications; and keeping a record of when a resident receives assistance with self-administration of his or her medications. Medication Management includes review by the licensed nurse of all prescriptions and over-the-counter medications taken by the enrollee, in conjunction with the enrollee's physician. The purpose of the review is to assess whether the enrollee's medication is accurate, valid non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications are being assessed and prevented.

Nutritional Assessment / Risk Reduction Services – An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications that are essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation.

Nursing Facility Services – Services furnished in a health care facility licensed under Chapter 395 or Chapter 400, F.S. per the Nursing Facility Coverage and Limitation Handbook.

Personal Emergency Response System (PERS) – The installation and service of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility. PERS services are generally limited to those enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.

Personal Care Services – Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's

family.

Respite Care Services – Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility, or assisted living facility.

Occupational Therapy – Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the enrollee's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

Physical Therapy – Treatment to restore, improve or maintain impaired functions by using activities and chemicals with heat, light, electricity or sound, and by massage and active, resistive, or passive exercise when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

Respiratory Therapy – Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems and bronchopulmonary drainage, breathing exercises, and chest physiotherapy.

Speech Therapy - The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

Transportation – Non-emergent transportation services shall be offered in accordance with the enrollee's plan of care and coordinated with other service delivery systems. This non-emergency transportation service includes trips to and from services offered by the LTC managed care program.

PROVIDER AVAILABILITY

Availability is defined as the extent to which Sunshine Health contracts with the appropriate type and number of Providers necessary to meet the needs of its enrollees within defined geographical areas. Sunshine Health has implemented several processes to monitor its network for sufficient types and distribution of Providers.

Provider availability is analyzed annually by the Sunshine Health Provider Relations (PR) Department and QI. Sunshine Health ensures that its network has sufficient facilities, service locations and personnel to provide covered services. Sunshine Health offers an appropriate range of services and accessible services to meet the needs of the maximum enrollment level and maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s. 1932(b)(5) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. Sunshine Health does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. The Member Services Department analyzes enrollee surveys and enrollee complaint data to address AHCA and federal requirements regarding the cultural, ethnic, racial, and linguistic needs of the enrollee. The Quality Improvement Department tracks and trends enrollee and provider complaints quarterly and monitors other data (such as appointment availability audits, after hours use of the enrollee hotline and enrollee and provider satisfaction surveys) that may indicate the need to increase network capacity.

Summary information is reported to the Clinical Quality Committee for review and recommendation and is incorporated into Sunshine Health's annual assessment of quality improvement activities. The Clinical Quality Committee will review the information for opportunities for improvement.

PROVIDER ACCESSIBILITY

Sunshine Health staffs their telephone help line twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization requests. Sunshine Health staffs the telephone help line so that Sunshine Health can respond to Provider questions in all other areas, including but not limited to the Provider complaint system, Provider responsibilities, etc., between the hours of 8:00 am and 8:00 pm EST or EDT as appropriate, Monday through Friday, excluding State holidays. Sunshine Health ensures that after regular business hours the Provider services line (not the Prior Authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify Enrollment for an Enrollee with an Emergency or Urgent Medical Condition. The requirement that Sunshine Health provides information to providers about how to verify Enrollment for an Enrollee with an Emergency or Urgent Medical Condition shall not be construed to mean that the provider must obtain verification before providing Emergency Services and Care.

REFERRALS

Case Managers determine the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting (to include referral to WIC) with assistance, as needed, by the area Medicaid office.

Sunshine Health ensures that case managers are required to provide community referral information on available services and resources to meet the needs of enrollees who are no longer eligible for the long-term care component of the SMMC program.

If a service is closed because the Managed Care Plan has determined that it is no longer medically necessary, the enrollee must be given a written Notice of Action regarding the intent to discontinue the service that contains information about his/her rights with regards to that decision.

When the enrollee's enrollment will be changed to another Managed Care Plan, the case manager must coordinate a transfer between the managed care plans. This includes transferring case management records from the prior twelve (12) months to the new managed care plan.

The case manager is responsible for notification of and coordination with service providers to assure a thorough discharge planning process and transition case management. The case manager is responsible for providing referrals to community resources if the enrollee is no longer Medicaid eligible.

PROVIDER TERMINATION

Providers should refer to their Sunshine Health contract for specific information about terminating from Sunshine Health.

OTHER PROVIDER RESPONSIBILITIES

- Provide culturally competent care
- Maintain confidentiality of medical information

Assisted Living Facility Service Providers: Assisted living facilities will support the enrollee's community inclusion and integration by working with the managed care organization's case manager and enrollee to facilitate the enrollee's personal goals and community activities. Additionally, waiver enrollees residing in assisted living facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms;
- Roommate for semi-private rooms;
- Locking door to living unit;
- Access to telephone and length of use;
- Eating schedule; and
- Participation in facility and community activities.

Ability to have:

- Unlimited visitation; and
- Snacks as desired.

Ability to:

- Prepare snacks as desired; and
- Maintain personal sleeping schedule.

NATIONAL PROVIDER IDENTIFIER (NPI)

Sunshine Health requires each provider to have a unique Florida Medicaid provider number. Sunshine Health requires each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider contract shall require providers to submit all NPIs to the Managed Care Plan within fifteen (15) business days of receipt. This identifier will allow for one number for a provider. You will no longer need to have multiple provider numbers for the different health plans you are contracted. Sunshine Health will require that all typical providers submit an NPI for billing, performing, attending, ordering, facility, and referring providers. Atypical providers for Long Term Care services such as home delivered meals; home accessibility adaptation and personal emergency response are encouraged to obtain an NPI.

PROVIDER ASSISTANCE WITH PUBLIC HEALTH SERVICES

Sunshine Health is required to coordinate with public health entities regarding the provision of public health services. Providers must assist Sunshine Health in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving enrollees to the local public health entity, as defined by state law.
- Referring to the local public health entity for tuberculosis contact investigation, evaluation and the preventive treatment of persons with whom the enrollee has come into contact.
- Referring enrollees to the local public health entity for STD/HIV contact investigation, evaluation and preventive treatment of persons whom the enrollee has come into contact.
- Provide all women of childbearing age HIV counseling and offer them HIV testing at the initial prenatal care visit, and again at 28 to 32 weeks. All women who are infected with HIV are counseled about and offered the latest antiretroviral regimen.
- Screen all pregnant enrollees for the Hepatitis B surface antigen.
- Referring enrollees for Women, Infant and Children (WIC) services and information sharing as appropriate.
- Assisting in the collection and verification of race/ethnicity and primary language data.

CULTURAL COMPETENCY

Cultural competency within the Sunshine Health Network is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethics groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner,”

Sunshine Health is committed to the development, strengthening and sustaining of healthy provider/enrollee relationships. Enrollees are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, enrollees are at risk for sub-optimal care. Enrollees may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Sunshine Health as part of its credentialing and site visit process will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider’s in developing culturally competent and culturally proficient practices.

Network providers must ensure the following:

- Enrollees understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Care is provided with consideration of the enrollees’ race/ethnicity and language and its impact/influence of the enrollees’ health or illness.
- Staff that routinely comes in contact with enrollees has access to and participate in cultural competency training and development.
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific enrollee information. Staff will also explain race/ethnicity categories to a enrollee so that the enrollee is able to identify the race/ethnicity of themselves and their children.
- Care plans are developed and clinical guidelines are followed with consideration of the enrollees race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, Spanish, and all other prevalent non-English languages if required by AHCA.

NEED FOR CULTURALLY COMPETENT SERVICES

The Institute of Medicine report entitled "Unequal Treatment" along with numerous research projects reveal that when accessing the healthcare system, people of color are treated differently. Research also indicates that a person has better health outcomes when they experience culturally appropriate interactions with providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of an Enrollee begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Non-compliance
- Feelings of being uncared for, looked down on and devalued
- Unfilled prescriptions
- Wasted time
- Increased grievances or complaints

PREPARING CULTURAL COMPETENCY DEVELOPMENT

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of the Enrollees you are servicing. Sunshine Health is committed to helping you reach this goal. Take into consideration the following as you provide care to the Sunshine Health enrollee:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your Enrollees?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?

The complete Sunshine Health Cultural Competency Plan can be viewed or downloaded online at www.sunshinehealth.com and a hard copy may be obtained at no cost to you by contacting Provider Services at 1-877-211-1999.

MEDICAL/CASE RECORDS

MEDICAL/CASE RECORDS AND ADVANCE DIRECTIVES

Sunshine Health providers must keep accurate and complete medical/case records for each Enrollee in accordance with 42.CFR 456. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under contract with Sunshine Health. Records shall include all reports from Participating Health Care Providers and all documentation required by applicable law, regulations, professional standards and the Provider Manual. Such records will enable providers to render the highest quality healthcare service to Enrollees. They will also enable Sunshine Health to review the quality and appropriateness of the services rendered. Sunshine Health providers are required to document in the Covered Person's medical or case record whether the Covered Person has executed an advanced directive and agrees to comply with all federal and State laws regarding advance directives. To ensure the Enrollee's privacy, medical records should be kept in a secure location. Medical/case records of Covered Persons are required to be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records to ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA). See Enrollee Rights section of this manual for policies on Enrollee access to medical records.

In addition to keeping and maintaining an adequate record system, Sunshine Health providers are required to record services, charges, dates, and all other commonly accepted information elements for Covered Services rendered to Covered Persons. Provider is also required to maintain books, records and documents (including electronic storage media) sufficient to reflect income and expenditures of funds provided by Health Plan and/or the Agency or the Department per contract agreement guidelines. Records shall be maintained for a period not less than six (6) years from the close of the LTC Contract or longer as required by law and retained further if the records are under review or audit until the review or audit is complete. In such case the records shall be retained for ten (10) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of this contract, at no additional cost to Health Plan or Department. Upon demand, at no additional cost to Health Plan, the Agency or the Department, the Provider will facilitate the duplication and transfer of any records or documents during the required retention period. Records shall be subject at all reasonable times to inspection, review, copying or auditing by Health Plan, Federal, State or other personnel duly authorized by the Agency or the Department as necessary and specifically pursuant to 45 CFR 92.36(i) (1) and s.20.55. F. S. Provider may be required to provide financial and compliance audit results at the request of Sunshine Health, the Agency or the Department. The provider will cooperate fully in any investigation by the Agency, MPI, MFCU or other state or federal entity and in any subsequent legal action that may result from such an investigation involving the contract.

MEDICAL/CASE RECORDS RELEASE

All Enrollee medical/case records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical/case records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Written authorization is required for the transmission of the medical/case record information of a current Sunshine Health Enrollee or former Sunshine health Enrollee to any provider not connected with Sunshine Health.

MEDICAL/CASE RECORDS AUDITS

Sunshine Health, Department of Health & Human Services (DHHS), Agency for Health Care Administration (AHCA), Department of Elder Affairs (DOEA), Medicaid Program Integrity (MPI), and Medicaid Fraud Control Unit (MFCU) shall have access and the right to inspect, evaluate and audit at reasonable times, to pertinent books, financial and medical/case records, and documents, papers and records of the Provider relating to the health care services provided to Covered Persons for Covered Services or financial transactions.

MEDICAL MANAGEMENT

MEDICAL NECESSITY

The Sunshine Health Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. During business hours, the provider should contact:

Medical Management/Case Management

1-877-211-1999

Web address: www.sunshinehealth.com

Medical Necessity:

FS 409.9131 (2) (b) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

1. General Provisions

a. The Managed Care Plan may place appropriate limits on a service on the basis of medical necessity as follows:

(1) In the provision of nursing facility services and mixed services, the Managed Care Plan shall ensure services meet the medical necessity criteria defined in 59G-1.010, F.AC.

(2) In the provision of all other LTC services, the Managed Care Plan shall ensure that services meet all of the following:

(a) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

(b) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;

(c) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And, one of the following:

(d) Enable the enrollee to maintain or regain functional capacity; or

(e) Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

Medically Necessary services include medical or allied care, goods or services furnished or ordered to:

- Meet the following conditions:
 - Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
 - Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
 - Be consistent with the generally accepted professional medical standards as determined by the Medicaid program and not be experimental or investigational;
 - Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
 - Be furnished in a manner not primarily intended for the convenience of the Enrollee, the Enrollee's caretaker or the provider.
- Medically necessary or Medical necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Information necessary for authorization of covered services may include but is not limited to:

Adult Day Health Care (ADHC)- providers shall conform to the HCB Settings Requirements as required by the Agency for Health Care Administration (AHCA). Provider ADHC will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities. Enrollees accessing Adult Day Health Care services in Provider's ADHC shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options. Choice of daily activities, physical environment, with whom to interact, access to telephone and unlimited length of use, eating schedule, activities schedule and participation in facility and community activities, the ability to have right to privacy, right to dignity and respect, freedom from coercion and restraint and opportunities to express self through individual initiative, autonomy, and independence.

- Enrollee's name, ID number
- Physician's name and telephone number
- Facility name, if the request is for facility services
- Assessed need for service

If additional information is required, a Sunshine Health Case Manager will notify the caller of the specific information needed to complete the authorization process.

Sunshine Health affirms that case management decision making is based only on appropriateness of care and service and the existence of coverage.

Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Enrollee.

Failure to obtain authorization for services may result in payment denials.

CASE MANAGEMENT

CASE MANAGEMENT RESPONSIBILITIES

Each long term care Enrollee is assigned a Case Manager. The role of the Case Manager is to provide Enrollee specific plans of care, in accordance with AHCA requirements for the SMMC program. Case Managers focus on organizing, securing, integrating, and modifying the resources necessary to maximize and support the wellness and autonomy of the Enrollee through case management.

Sunshine Health is responsible for the management of care and continuity of care for all Enrollees. Sunshine Health maintains written case management and continuity of care protocols that include the following minimum functions:

FS 409.9131 (2) (b) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

2. General Provisions

b. The Managed Care Plan may place appropriate limits on a service on the basis of medical necessity as follows:

- (3) In the provision of nursing facility services and mixed services, the Managed Care Plan shall ensure services meet the medical necessity criteria defined in 59G-1.010, F.AC.
- (4) In the provision of all other LTC services, the Managed Care Plan shall ensure that services meet all of the following:
 - (a) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
 - (b) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
 - (c) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And, one of the following:

- (d) Enable the enrollee to maintain or regain functional capacity; or
- (e) Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

CONTINUITY OF CARE

The Medical Management/Case Management Department allows Enrollees in active treatment to continue care with a terminated treating provider when such care is Medically Necessary, through completion of treatment of a condition for which the Enrollee was receiving care at the time of the termination, until the Enrollee selects another treating Provider, or during the next Open Enrollment period. None of the above may exceed sixty (60) calendar days after the termination of the Provider's contract. Provider claims for services rendered to such recipients during the sixty (60) calendar day period will continue to be processed.

Notwithstanding the provisions in this subsection, a terminated provider may refuse to continue to provide care to an Enrollee who is abusive or noncompliant.

For continued care under this subsection, the Medical Management Department and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

The requirements set forth in this subsection shall not apply to providers who have been terminated from Sunshine Health for Cause.

Sunshine Health is responsible for the Case Management and Continuity of Care of all Enrollees. Special efforts are made to identify Enrollees who have high risk conditions such as asthma, HIV/AIDS, diabetes, congestive heart failure and hypertension to ensure:

- Timely access to care
- Continuity of Enrollee's care
- Coordination and integration of care

Procedures that implement the above functions are designed to accommodate the specific cultural and linguistic needs of all Enrollees. In the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.

PRIOR-AUTHORIZATION AND REFERRAL PROCESS

The provider must obtain prior authorization from the plan for each claim submitted for Plan covered services for which prior authorization is required.

Prior authorization is required for all Long Term Care services.

Identification:

1. *Direct referral sources for case management include but are not limited to:*

- PCP
- Specialist
- Hospital Case Manager
- Prior Authorization or Utilization Review Staff
- Other Plan Staff such as the Enrollee Advocate or Internal Case Manager
- Enrollee/Authorized family Enrollee or guardian

These referrals are considered high priority and are directed promptly to a Case Manager to perform an individual needs assessment within one business day.

2. *The Health Economics Unit* generates reports on a monthly basis to identify Enrollees for screening for case management. Reports include but are not limited to the following:

- Frequent Admissions: Two (2) admissions within twelve months with the same or related diagnosis.
- Frequent ED Visits: Three or more ER visits in the past six (6) months.
- Catastrophic Cases: Hospital admission with a LOS greater than 15 days, congenital anomalies or birth defects, major traumas, possible transplants, or two or more chronic conditions.
- Cost of Claims:
 - Among the top three (3) percent of utilizers
 - Annual ambulatory care cost of \$10,000 or more
 - Annual inpatient cost of \$25,000 or more
- Pharmacy:
 - Enrollees taking four (4) or more prescription medications
 - Enrollees hospitalized for adverse medication reaction
 - Current need for routine ongoing physical or behavioral services.

DISCHARGE PLANNING

Discharge planning activities will be initiated by the Case Manager. The Sunshine Health Medical Management/Case Management Department will coordinate the discharge planning efforts with the facility's Utilization and Discharge Planning Departments or Social Services Department in order to ensure that Sunshine Health Enrollees receive appropriate post facility discharge care. The Case Manager is responsible for the notification of and coordination with service providers to assure a thorough discharge planning process and transition case management. All covered services must be coordinated and authorized by the Enrollee's Case Manager.

CHRONIC AND COMPLEX CONDITIONS

Sunshine Health provides individual case management services for Enrollees who have chronic, complex, high-risk, high-cost or other catastrophic conditions. Enrollees with special healthcare needs are included in the chronic and complex case management-care coordination program. The Sunshine Health Case Manager will work with all involved providers to coordinate care, provide referral assistance, and other support as required. Sunshine Health also uses disease management programs and associated practice guidelines and protocols for Enrollees with chronic conditions, including conditions such as asthma, cancer, diabetes, HIV/AIDS, congestive heart failure and hypertension.

ABUSE, NEGLECT AND EXPLOITATION

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities. If the investigation required the Enrollee to move from his/her current locations, Sunshine Health will coordinate with the investigator to find a safe living environment or another participating ALF of the Enrollee's choice.

Abuse can be reported by calling the Florida Abuse Hotline, which is a statewide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873)

Sunshine Health ensures that all staff and providers including home and community based providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the Enrollee's identity, description of the incident and outcomes including current status of the Enrollee. If the event involves a health and safety issue, the Managed Care Plan and Case Manager will arrange for the Enrollee to move from his/her current location or change providers to accommodate a safe environment and provider of the Enrollee's choice. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the Enrollee's case file, that is designated as confidential. Such file shall be made available to the Agency upon request. Enrollee quality of care issues must be reported to and are solution coordinated with the Managed Care Plan's Quality Management Department.

SUNSHINE HEALTH DISEASE MANAGEMENT PROGRAMS

As a part of the Sunshine Health medical management quality improvement efforts, evidence-based disease management programs are offered to Enrollees. Components of the programs available include but are not limited to:

- Increasing coordination between the medical, social and educational communities
- Severity and risk assessments of the population.
- Profiling the population and providers for appropriate referrals to providers, including dental and/or behavioral health providers.
- Ensuring active and coordinated physician participation.
- Identifying modes of delivery for coordinated care services such as; home visits, clinic visits, and phone contacts depending on the circumstances and needs of the Enrollee and his/her family.
- Increasing the Enrollee's and Enrollee's caregiver ability to self-manage chronic conditions.
- Coordination with Sunshine Health case manager and intensive case management program.

To refer a Enrollee to any Disease Management Program call:

**Sunshine State Health Plan
1-877-211-1999**

Follow the prompts to Disease Management Programs.

ASTHMA/COPD PROGRAM

The COPD (chronic obstructive pulmonary disease) program, provided by Envolve PeopleCare, is designed to help the member to identify and address issues and barriers that impact their understanding and management of the member's COPD. The program also helps the member identify and address lifestyle behaviors that can improve his/her symptoms. The health coach contacts the member's by phone to provide education and support to assist the member in managing COPD.

Components of the program include:

- Medication comprehension and how to take them
- Managing symptoms
- Proper use and maintenance of respiratory equipment
- Improving exercise tolerance
- Education to enhance understanding and compliance
- Special consults with a program registered respiratory therapist or chronic condition health coach, if needed

The COPD Disease Management Program targets Sunshine Health enrollees with COPD who are over the age of 35 and meet any of the following conditions:

- One or more primary COPD ER visits and/or inpatient days;
- Two or more primary or secondary COPD claims
- One primary or secondary COPD claims and one or more primary or secondary 496 claims; and
- One primary or secondary 496 or COPD claim and one or more claims for inhaled bronchodilators, home O2, Ipratropium, Spiriva, primary Co Pulmonale or lung reduction surgery.

Enrollees are identified for enrollment based on medical and pharmacy claim data. Enrollees may also be referred to the program by a physician, case manager, or self referral.

Sunshine Health's Asthma Disease Management Program utilizes evidence-based guidelines sponsored by the National Asthma Education and Prevention Program, education, care assessment, in home visits for high risk enrollees unable to be reached by telephone, initial phone visits, physician communication, and follow-up visits as indicated by the enrollee's ability to self-manage and remain compliant with the plan of care.

DIABETES PROGRAM

The diabetes program, provided by Envolve PeopleCare, is designed to help the member to identify and address issues and barriers that impact their understanding and management of his/her diabetes. The health coach contacts the member's by phone to provide education and support to assist the member in managing diabetes. The diabetes program is based on adult and pediatric diabetes guidelines.

Components of the program include:

- Importance of understanding and taking diabetes medications
- Self-blood sugar testing
- Recognizing signs of low and high blood sugar levels
- Diet and activity counseling
- Recommended diabetes testing
- Special consults with a program certified dietitian, if needed

CANCER-ONCOLOGY PROGRAM

Sunshine Oncology Case Management program is an integrated comprehensive cancer education and support program that uses member-focused approaches to improve compliance and quality of life. This is achieved by:

- Case Managing the disease symptoms and side effects
- Providing optimal care coordination
- Ensuring appropriate healthcare service delivery based on a adherence to *Nationally Recognized Oncology Guidelines for Cancer Care
- Promoting appropriate treatment, compliance and continuity of care in the most cost effective venue.

(Nationally Recognized Guidelines may include but are not limited to: Interqual, NCCN, ASCO, NCI, ACS, etc.)

Sunshine Oncology Program consists of a patient centric primary Case Manager model with an integrated team approach to educate and support participants. The program consists of a team of Oncology Clinical Professionals, who interact directly with the Member and caregivers.

ALZHEIMER'S/DEMENTIA PROGRAM

Sunshine Alzheimer's/Dementia program is an integrated comprehensive education and support program that uses member-focused approaches to improve health outcomes and member/caregiver quality of life. This is achieved by:

- Case Managing the disease symptoms and side effects
- Providing optimal care coordination
- Ensuring appropriate healthcare service delivery based on a adherence to *Nationally Recognized NIA treatment Guidelines for Care of a participant with Alzheimer's or Dementia
- Promoting appropriate treatment, compliance and continuity of care in the most cost effective venue.
- Providing Caregiver support

Sunshine State Alzheimer's Dementia Program consists of a patient centric primary Case Manager model with an integrated team approach to educate and support participants. The program consists of a team of Professionals, who interact directly with the Member and caregivers.

HIV/AIDS PROGRAM

Sunshine Health's HIV program assists enrollees obtain and coordinate specialized medical care for people with HIV or AIDS illness, receive medication therapy management support, and services to address psycho-social needs associated with the disease-state. The care manager will contact enrollees to provide education and coordination of services that address the unique needs of enrollees who may benefit from HIV/AIDS care. The focus is to assist the enrollee and their family/caregiver in living with HIV/AIDS through self-management, adherence to pharmacotherapy plan of care and strong connection with treating providers.

To refer a enrollee to any case management or disease management program call:

Sunshine Health Plan
1-877-211-1999

Follow the prompts to Disease Management Programs.

HIV/AIDS PROGRAM

- (5) End of life issues including information on advance directives.

Sunshine Health's Palliative Care care management program assists enrollees obtain and coordinate specialized medical care for chronic and end of life illnesses such as Alzheimer's disease, dementia, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cancers and other more serious and chronic illnesses. When working with enrollees the program will be referred to as Supportive Care Management to minimize confusion with hospice services. The care manager will contact the enrollee or care giver to provide education and coordination of services that address the unique needs of enrollees who may benefit from palliative care. The focus is to assist the enrollee and their family/caregiver in obtaining information and support in support of shared decision making. If a palliative care consult was not ordered by the treating physician, the care manager will facilitate discussions with the member's treating physician regarding a palliative care referral.

PREVENTIVE AND CLINICAL PRACTICE GUIDELINES AND PROTOCOLS, INCLUDING CHRONIC CARE

Sunshine Health preventive and clinical practice guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Improvement Program (QIP). The guidelines are based on valid and reliable clinical evidence formulated by nationally recognized professional organizations or government institutions, such as the NIH or a consensus of healthcare professionals in the applicable field. The guidelines consider the needs of the Enrollees, are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. Sunshine Health preventive and clinical practice guidelines are available on its website and are mailed to practitioners as part of disease management or other quality program initiatives. The guidelines are available on request to Enrollees. Sunshine Health Enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with these guidelines. These guidelines are used for both preventive services as well as for the management of chronic diseases.

Preventive and Chronic disease guidelines include, but are not limited to:

- Guidelines for Diagnosis and Management of Asthma
- Clinical Practice Guidelines for General Diabetes Care
- Clinical Practice Guidelines for Special Management Considerations in Gestational Diabetes
- Clinical Practice Guidelines for Preventive Health Maintenance of Sickle Cell Patients
- Guidelines for Detection of Chronic Kidney Disease
- Guidelines for Routine Ante partum Care

The Sunshine Health website provides access to new clinical practice guidelines as well as any updates or revisions to existing guidelines.

EMERGENCY SERVICES

EMERGENCY CARE SERVICES DEFINED

Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Prior authorization is not required for emergency and post stabilization services.

NURSEWISE/Envolve People Care, Inc.®

Our Enrollees have many questions about their health, their provider and access to emergency care. Our health plan offers a nurse line service to encourage Enrollees to talk with their physician and to promote education and preventive care.

NurseWise/Envolve People Care, Inc. is our 24-hour nurse line for Enrollees. The Registered Nurses provide basic health education, nurse triage and answer questions about urgent or emergency access, all day long. The staff often answers questions about pregnancy and newborn care. In addition, Enrollees with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Enrollees may use NurseWise/Envolve People Care, Inc. to request information about providers and services available in your community after the health plan is closed. Providers can use it to verify eligibility any time of the day. The NurseWise/Envolve People Care, Inc. staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls in a web-based data system using Barton Schmitt, M.D. triage protocols for pediatrics and McKesson proprietary of products to perform triage services for adults. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer our Enrollees access to an RN every day. If you have any additional questions, please call Provider Services or NurseWise/Envolve People Care, Inc. at **1-877-211-1999**.

Emergency Services area covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. *Urgent or Emergency Care is not subject to prior authorization or pre-certification. Emergency Services must be provided by a qualified Provider regardless of network participation.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY FOR SUNSHINE HEALTH

The eligibility requirements listed below must be met. Only recipients age eighteen (18) years or older who have been determined by CARES to meet the nursing facility level of care are eligible for the long-term care component of the SMMC program.

Mandatory Populations

Eligible recipients age eighteen (18) or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

- Temporary Assistance to Needy Families (TANF)
- SSI (Aged, Blind and Disabled)
- Institutional Care
- Hospice
- Low Income Families and Children
- MEDS (SOBRA) for children born after 9/30/83 (age 18 – 20)
- MEDS AD (SOBRA) for aged and disabled
- Protected Medicaid (aged and disabled)
- Full Benefit Dual Eligible (Medicare and Medicaid FFS)
- Full-Benefit Dual Eligible enrolled in Part C-Medicare Advantage plan that is not fully liable for all Medicaid services under the SMMC AHCA Program
- Medicaid Pending for Long-Term Care Managed Care HCBS waiver services
- Individuals who age out of Children's Medical Services and meet the following criteria
 - Received care from Children's Medical Services prior to turning age 21 years old
 - Age 21 years and older
 - Cognitively intact
 - Medically complex
 - Technologically dependent

Voluntary Populations

Eligible recipients eighteen (18) years or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

- Traumatic Brain and Spinal Cord Injury waiver
- Project AIDS Care (PAC) waiver
- Adult Cystic Fibrosis waiver
- Program of All-Inclusive Care for the Elderly (PACE) plan enrollees
- Familial Dysautonomia waiver
- Model waiver (age 18 – 20)
- Development Disabilities waiver (iBudget)
- Medicaid for the Aged and Disabled (MEDS AD) – Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled – enrolled in Developmental Disabilities (DD) waiver
- Recipients with other creditable coverage excluding Medicare

Excluded Populations

Recipients in any eligibility category not listed above are excluded from enrollment in a Managed Care Plan. This includes, but is not limited to, recipients in the following eligibility categories:

- Presumptively eligible pregnant women
- Medically Needy
- Family planning waiver
- Women enrolled through the Breast and Cervical Cancer Program
- Emergency shelter/Department of Juvenile Justice (DJJ) residential
- Emergency assistance for aliens
- Qualified Individual
- Qualified Medicare beneficiary (QMB)
- Special low-income beneficiaries (SLMB)
- Working disabled
- Full-Benefit Dual Eligible enrolled in Part C- Medicare Advantage Dual Special Needs Plan
- Full-Benefit Dual Eligible enrolled in Part C- Medicare Advantage Plan that are fully liable for all Medicaid Services covered under the SMMC AHCA Program

In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Managed Care Plan:

- Recipients residing in residential commitment facilities operated through DJJ or mental health treatment facilities;
- Recipients residing in DD centers including Sunland and Tacachale
- Children receiving services in a prescribed pediatric extended care center (PPEC)
- Children with chronic conditions enrolled in the Children's Medical Services Network
- Recipients in the Health Insurance Premium Payment (HIPP) program

VERIFYING ENROLLMENT

Providers are responsible for verifying eligibility before providing services.

**Call 1-877-211-1999 to reach the IVR System for quick eligibility verification
or check online at www.sunshinehealth.com
(must have provider login)**

Sunshine Health has the capability to receive an ANSI X12N 270 health plan eligibility inquiry and generate an ANSI X12N 271 health plan eligibility response transactions through Sunshine Health. Providers also may verify enrollee enrollment through Sunshine Health's website at www.sunshinehealth.com. For more information on conducting these transactions electronically contact:

**Sunshine State Health Plan
C/o Centene EDI Department
1-800-225-2573
or by e-mail at:
EDIBA@centene.com**

Until the actual date of enrollment with Sunshine Health, Sunshine Health is not financially responsible for services the prospective enrollee receives. In addition, Sunshine Health is not financially responsible for services enrollees receive after their coverage has been terminated.

ENROLLMENT/COMMUNITY OUTREACH GUIDELINES FOR SUNSHINE HEALTH PROVIDERS

Sunshine Health's contract with AHCA defines how Sunshine Health and its providers present and advertise the program. AHCA requires providers to submit to Sunshine Health samples of any community outreach materials they intend to distribute, and to obtain state approval prior to distribution or display. Sunshine Health Provider Relations staff will submit these materials to AHCA within two (2) business days of receipt, and will send Providers written notice of approval or of any changes required by AHCA within two (2) business days of receiving notice from AHCA.

Sunshine Health Provider Relations staff will give an overview of the community outreach plan to all network providers and their staff and present them with the AHCA Policy and Procedure Guidelines on General Outreach and Enrollment. This will define what a provider may or may not do in regards to reaching out to our enrollees. Sunshine Health will also use approved communication tools to educate providers on plan-specific information such as claims processing and systems technologies.

Provider communication tools will include brochures, directories, booklets, handbooks, newsletters, letters and videos. Some specific examples of the tools Sunshine Health might use include:

- Provider orientation meetings/town hall meetings
- Provider newsletters
- Quarterly site visits
- Provider manual
- Provider directory
- Informational letters and flyers to be included in EOP and other mailings
- Claims material describing how to accurately file claims
- Interactive Web portal

Provider Outreach Material Do's and Dont's

- Providers may display health plan specific materials in their own office.
- Providers may announce a new affiliation with a health plan and give their patients a list of health plans with which they contract.
- Health Care providers may co-sponsor events; such as health fairs and advertise with SSHP in indirect ways; such as TV, radio, posters, fliers and print advertisement.
- Providers may distribute information about non-health plan specific health care services and the provision of health, welfare and social services by the State of Florida or local communities as long as any inquiries from prospective enrollees are referred to enrollee services or the Agencies choice counselor/enrollment broker.
- Providers cannot orally or in writing compare benefits or provider network among Health Plans other than to confirm whether they participate in a Health Plan network.
- Providers cannot furnish lists of their Medicaid patients to Health Plans with which they contract or any other entity, nor can providers furnish other Health Plans enrollee ship list to any Health Plan, nor can providers assist with Health Plan enrollment.

DOMESTIC VIOLENCE

Sunshine Health enrollees' may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that providers are vigilant in identifying these enrollees. Enrollee Services can help enrollees identify resources to protect them from further domestic violence. Sunshine Health's case management staff may assist members or member's parent or legal guardian to identify community resources for families dealing with child or domestic violence.

For Florida residents, you may refer victims of domestic violence to the National Domestic Violence Network hotline, at **1-800-799-SAFE (7233)** for information about local domestic violence programs and shelters within the state of Florida.

Providers should report all suspected domestic violence as described. **State law requires reporting by any person if he or she has reasonable cause to believe that an elder or person with disabilities has been subjected to abuse, neglect or exploitation. Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report any suspected abuse, neglect or exploitation to the Department of Children and Families in the appropriate county or by calling the Abuse Hotline at 1-800-96-ABUSE.**

BILLING AND CLAIMS

GENERAL BILLING GUIDELINES

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Sunshine Health for payment of covered services.

It is important that providers ensure Sunshine Health has accurate billing information on file. Please confirm with your Provider Relations Department that the following information is current in our files:

- **Provider Name** (as noted on his/her current W-9 form)
- **Provider nine (9) digit Medicaid Number**
- Provider National Provider Identifier (NPI)
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- **Tax Identification Number**

Providers must bill with their NPI number in box 24J if applicable. Sunshine Health will return claims when billing information does not match the information that is currently in our files. **Claims missing the requirements in bold will be returned**, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be entered into the system.

We recommend that providers notify Sunshine Health in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The enrollee is effective on the date of service
- The service provided is a covered benefit under the enrollee's contract on the date of service
- Referral and prior authorization processes were followed

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

Providers must submit, all claims and encounters within 180 days of the date of service, unless Sunshine Health or its vendors created the error. The filing limit may be extended for newborn claims, and where the eligibility has been retroactively received by Sunshine Health, up to a maximum of 365 days. When Sunshine Health is the secondary payer, Sunshine Health must receive the claim within ninety (90) days of the final determination of the primary payer.

All requests for reconsideration or adjustment to paid claims must be received within 90 calendar days from the date the notification of payment or denial is received.

ELECTRONIC CLAIMS SUBMISSION

Network providers are encouraged to participate in Sunshine Health's Electronic Claims/Encounter Filing Program. The plan has the capability to receive an ASC X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ASC X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

**Sunshine State Health Plan
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDIBA@centene.com**

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

ON-LINE CLAIM SUBMISSION

For participating providers who have internet access and choose not to submit claims via Electronic Data Interchange (EDI), Sunshine State Health Plan has made it easy and convenient to submit claims directly to us on our website at www.sunshinehealth.com

You must request access to our secure site by registering for a user name and password and have requested Claims access. If you do not have an ID, sign up to obtain one today. Requests are processed within 2-business days.

There are five easy steps to submitting a claim. You may view web claims, allowing you to re-open and continue working on saved, un-submitted claims and this feature allows you to track the status of claims submitted using the web site.

PAPER CLAIMS SUBMISSION

For Sunshine Health enrollees, all claims and encounters should be submitted to:

**Sunshine State Health Plan
P.O. BOX 3070
Farmington, MO 63640-3823
ATTN: CLAIMS DEPARTMENT**

IMAGING REQUIREMENTS

Sunshine Health uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- **Do** use the correct PO Box number
- **Do** submit all claims in a 9" x 12", or larger envelope
- **Do** type all fields completely and correctly
- **Do** use black or blue ink only
- **Do** submit on a proper original red claim form . . . CMS 1500 or UB 04

Dont's

- **Don't** submit handwritten claim forms
- **Don't** use red ink on claim forms
- **Don't** circle any data on claim forms
- **Don't** add extraneous information to any claim form field
- **Don't** use highlighter on any claim form field
- **Don't** submit photocopied claim forms as they will not be accepted
- **Don't** submit carbon copied claim forms
- **Don't** submit claim forms via fax

CLEAN CLAIM DEFINITION

A clean claim means a claim received by Sunshine Health for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Sunshine Health.

NON-CLEAN CLAIM DEFINITION

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the

provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

WHAT IS AN ENCOUNTER VERSUS A CLAIM?

You are required to submit an encounter or claim for each service that you render to a Sunshine Health enrollee.

- If you are the provider for a Sunshine Health enrollee and receive a monthly capitation amount for services, you must file a “proxy claim” (also referred to as an “**encounter**”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the “proxy claim” or “**encounter**” is paid at zero dollar amounts. **It is mandatory that your office submits encounter data.** Sunshine Health utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by the State of Florida and by Centers for Medicare and Medicaid Services (CMS).
- A **claim** is a request for reimbursement either electronically or by paper for any medical service. A **claim** must be filed on the proper form, such as CMS 1500 or UB 04. A **claim** will be paid or denied with an explanation for the denial. For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim.

PROCEDURES FOR FILING A CLAIM/ENCOUNTER DATA

Sunshine Health encourages all providers to file claims/encounters electronically. See “Electronic Claims Submission” for more information on how to initiate electronic claims/encounters.

Please remember the following when filing your claim/encounter:

- All documentation **must** be legible
- All participating providers must submit claims or encounter data for every enrollee within the timely filing limit which is 180 days of the date of service.
- Provider must ensure that all data and documents submitted to Sunshine Health, to the best of your knowledge, information and belief, are accurate, complete or truthful
- All claims and encounter data must be submitted on either an original form CMS 1500, UB 04, or by electronic media in an approved format. Copies of claim forms will not be accepted.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims
- Providers must submit all claims and encounters within 180 days of the date of service, unless Sunshine Health or its vendors created the error.
- All requests for reconsideration or adjustment to paid claims must be received within 90 days from the date the notification of payment or denial is received
- When submitting claims where other insurance is involved, a copy of the EOB or rejection letter from the other insurance carrier must be attached to the claim
- Sunshine Health enrollees’ must **never** be billed by any provider for **covered services** unless the criteria listed under “Billing the Enrollee” is met
- In a Worker’s Compensation case for which Sunshine Health is not financially responsible, the provider should directly bill the employer’s Worker’s Compensation carrier for payment
- **Non-par providers only:**

- Claims will not be denied based solely on the period between date of service and the date of clean claim submission unless that period exceeds 365 days.

For all contracts with reimbursement for services based on AHCA's Medicaid fee for service rates, please note the following:

Any reference to the "Medicaid fee for service rates," "Medicaid fee schedule," "Medicaid state exempt rates" or similar term contained in any contract is a reference to the applicable fee schedule used by AHCA as of the date of service to determine payment under the Medicaid FFS Program.

Updates to such Medicaid fee schedules (for all provider types and in any form, including but not limited to, Medicaid Bulletins) shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by AHCA of such fee schedule updates, or (ii) the effective date of such fee schedule updates as determined by AHCA. Medicaid fee schedule rate revisions shall be applied by Sunshine

CLAIM RESUBMISSIONS, ADJUSTMENTS AND DISPUTES

All requests for claim reconsideration or adjustment must be received within 90 calendar days from the date of notification of payment or denial. Prior processing will be upheld for reconsiderations or adjustments received outside of the 90 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Pending or retroactive enrollee eligibility. The claim must have been received within 6 months of the eligibility determination date.
- Mechanical or administrative delays or errors by Sunshine Health or AHCA.
- The enrollee was eligible however the provider was unaware that the enrollee was eligible for services at the time services were rendered.

Consideration is granted in this situation only if all of the following conditions are met:

- The provider's records document that the enrollee refused or was physically unable to provide their Medicaid card or information.
- The provider can substantiate that a claim was filed within 180 days of discovering Medicaid Plan eligibility.
- No other paid claims filed by the provider prior to the receipt of the claim under review.

When submitting a paper claim for review or reconsideration of the claims disposition, a copy of the EOP must be submitted with the claim, or the claim must clearly be marked as **"RE-SUBMISSION and include the original claim number."** Failure to **boldly** mark the claim as a resubmission and include the claim number (or include the EOP) may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline. The Claim Dispute Form can be located on the provider website at http://www.sunshinehealth.com/files/2008/12/SSHP_CLAIM_ADJUSTMENT_REQUEST_FORM_01_12pdf.pdf

Mail Requests for Reconsideration to:

Sunshine State Health Plan
Attn: LTC Reconsideration
PO Box 4001
Farmington, MO 63640-4401

Providers may submit in writing, with all necessary documentation, including the EOP for consideration of additional reimbursement.

A response to an approved adjustment will be provided by way of check with an accompanying EOP.

All disputed claims will be processed in compliance with the claims payment resolution procedure as described in this Provider Manual.

COMMON BILLING ERRORS

In order to avoid rejected claims or encounters always remember to:

- Always bill the primary diagnosis in the first field
- Use the CPT-4 or billing codes found on the authorization or referral.
- Submit all claims/encounters with the proper provider NPI and /or Tax ID Number
- Submit all claims/encounters with the enrollee's complete Medicaid number

CLAIM PAYMENT

Clean claims will be adjudicated (finalized as paid or denied) within twenty (20) days EDI and forty (40) days paper of the receipt of the claim. However, Clean Claims submitted electronically for Nursing Facility and Hospice services will be paid or denied within ten (10) days.

No later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet Clean Claim requirements, Sunshine Health will pend the claim and request additional information through the Sunshine Health Explanation of Benefits for all outstanding information such that the claim can be deemed clean. Upon receipt of all the requested information from the provider, Sunshine Health will complete processing of the claim within thirty (30) days.

Claims pended for additional information must be closed (paid or denied) by the 35th calendar day following the date the claim is pended if all requested information is not received prior to the expiration of the 35-day period. Sunshine Health will send providers written notification via the Explanation of Benefits for each claim that is denied, including the reason(s) for the denial, the date contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

Sunshine Health shall process, and finalize, all appealed claims to a paid or denied status within (30) business days of receipt of the Appealed Claim. Sunshine Health shall finalize all claims, including appealed claims. Appealed claims mean claims regarding which a provider files a request for informal claims payment adjustment or a claim complaint with Sunshine Health.

Note: It is the provider's responsibility to check their audit report to verify that Sunshine Health has accepted their electronically submitted claim.

BILLING FORMS

Providers submit claims using standardized claim forms whether filing on paper or electronically.

Submit claims for professional services and durable medical equipment on a CMS 1500 or electronically. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing:

- Full enrollee name
- Enrollee's date of birth
- Valid enrollee identification number
- Use one claim form for each recipient
- **Enter one procedure code and date of service per claim line.**
- Use the same claim form for all services provided for the same recipient, same provider, and same date of service
- If dates of service encompass more than one month, a separate billing form must be used for each month
- Complete service level information:
 - Date of service
 - Diagnosis
 - Place of service
 - Procedural coding (appropriate billing codes)
 - Charge information and units
- Servicing provider's name, address and Medicaid Number
- Provider's federal tax identification number
- Identify the Health Plan – "Sunshine Health – LTC Plan" – where is this to be filled out on a claim?
- All mandatory fields must be complete and accurate

QUALITY ENHANCEMENTS

In addition to the covered services the Health Plan also offers Quality enhancements programs to enrollees as specified below:

Address safety concerns in the home and fall prevention;

Provide Disease Management, including education on the enrollee assessment of health risks and chronic conditions;

Discuss end of life issues, including information on advanced directives; and

Ensure that Case Managers and providers screen for domestic violence and offer referral services to applicable domestic violence prevention community agencies.

PATIENT RESPONSIBILITY

Patient Responsibility — The cost of Medicaid long-term care services not paid for by the Medicaid program, for which the enrollee is responsible. Patient responsibility is the amount enrollees must contribute toward the cost of their care. This is determined by the Department of Children and Families' Economic Self Sufficiency only and is based on income and type of placement.

The provider must look solely to Sunshine Health for compensation for services rendered with the exception of nominal cost sharing and patient responsibility pursuant to the Medicaid State Plan. and the Medicaid Provider

General and Coverage and Limitations Handbook: Handbooks have been removed from AHCA's website.

1. If a capitated Managed Care Plan, then to the capitated plan for compensation
2. If a FFS or MMA LTC Plan, then to the Agency or its Agent, unless the service is a transportation service for which Sunshine Health receives a capitation payment from the Agency. For such capitated transportation services, Sunshine Health requires providers to look solely to the Plan for compensation.

ENROLLEE FINANCIAL RESPONSIBILITY

The Managed Care Plan shall have policies and procedures to ensure that, where applicable, enrollees residing in Assisted Living Facility and Nursing Facilities are assessed for patient responsibility by DCF and pay their patient responsibility. Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility. The Managed Care Plan is responsible for collecting its enrollees' patient responsibility. The Managed Care Plan may transfer the responsibility for collecting its enrollees' patient responsibility to the residential facilities and compensate these facilities net of the patient responsibility amount. If the Managed Care Plan transfers collection of patient responsibility to the provider, the provider contract must specify complete details of both parties' obligations in collection of patient responsibility. The Managed Care Plan must either collect patient responsibility from all its providers or transfer collection to all providers. The Managed Care Plan must have a system in place to track the receipt of patient responsibility at the enrollee level. This data must be available upon request by the Agency. The Managed Care Plan or its providers shall not assess late fees for the collection of patient responsibility from enrollees.

COMPLETING A CMS 1500 FORM

All medical claims are to be submitted on the CMS 1500.

The CMS 1500 claim form is required for:

- All professional services "including specialists"
- Individual practitioners
- Non-hospital outpatient clinics
- Transportation providers
- Ancillary Services
- Durable Medical Equipment
- Non-institutional expenses
- Professional and/or technical components of hospital based physicians and Certified Registered Nurse Anesthetists (CRNAs)
- Home Health Services

CMS 1500 STANDARD PLACE OF SERVICE CODES

Place of Service Codes

00 -10	Not in Use
11	Office
12	Home
13	Assisted Living Facility
14	Adult Family Care Home
15-20	Not in Use
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27 – 30	Not in Use
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35 – 40	Not in Use
41	Not Valid
42	Not Valid
43 – 50	Not in Use
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Immediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57 – 60	Not in Use
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63, 64	Not in Use
65	End Stage Renal Disease Treatment Facility
66 – 70	Not in Use
71	State or Local Public Health Clinic
72	Rural Health Clinic
73 – 80	Not in Use
81	Independent Laboratory
82 – 98	Not in Use
99	Other Unlisted Facility

COMPLETING A UB 04 CLAIM FORM

A UB 04 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only), nursing home services.

Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

BILLING THE ENROLLEE

Sunshine Health reimburses only services that are covered and authorized by the Case Manager. Providers can bill an enrollee for services that are not covered by Sunshine Health or Medicaid Fee-for-Service.

ENROLLEE ACKNOWLEDGEMENT STATEMENT

A provider may bill an enrollee for a claim denied as not being medically necessary, not a covered benefit, or the enrollee has exceeded the program limitations for a particular service only if the following condition is met:

CREENTIALING

CREENTIALING REQUIREMENTS

Prior to the service being rendered, the provider has obtained and kept a written **Enrollee Acknowledgement Statement** signed by the client that states:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under AHCA as being reasonable and medically necessary for my care. I understand that Sunshine Health through its contract with the AHCA determines the medical necessity of the services or items that I request and receive. I

CREENTIALING REQUIREMENTS

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by Sunshine Health, as well as government regulations and standards of accrediting bodies.

Notice: In order to maintain a current provider profile, providers are required to notify Sunshine Health of any relevant changes to their credentialing information in a timely manner.

Providers must submit at a minimum the following information when applying for participation with Sunshine Health:

- a. A completed Facility Provider Application to include active NPI, Tax ID and active Medicaid and Medicare ID numbers if available.
- b. A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications
- c. No revocation, moratorium or suspension of the provider's state license by the Agency or the Department of Health, if applicable;
- d. A satisfactory level II background check pursuant to Chapter 435 F.S. and s. 408.809, F.S., for all providers not currently enrolled in Medicaid's fee-for-service program;
 - (1) Providers referenced above are required to submit fingerprints electronically following the process described on the Agency's Background Screening website. Sunshine Health shall verify Medicaid eligibility through the background screening system.
 - (2) Sunshine Health will not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
 - (3) Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening.
 - (4) Individuals listed in s. 409.907(8)(a), F. S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.

- e. Providers are required to issue a disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106);
- f. Providers are required to provide evidence of their professional liability claims history;
- g. Providers are required to provide Worker's Compensation Insurance or Worker's Exemption Form.
- h. Explanation for any sanctions imposed on the provider by Medicare or Medicaid;
- i. The provider is required to issue their Medicaid ID number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form.
- j. Providers shall notify Sunshine Health at least forty-five (45) days in advance of his or her inability to accept additional covered persons under Sunshine Health agreements. Sunshine Health prohibits all providers from intentionally segregating enrollees from fair treatment and covered services provided to other non-Medicaid enrollees.

Sunshine Health providers should refer to their contract for complete information regarding their obligations and reimbursement.

CREDENTIALING COMMITTEE

The Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial and termination. The committee bases decisions solely on business needs, completeness of the applicant's file, and review of any sanctions or malpractice, as applicable, and not on race, ethnic/national identity, gender, age, or sexual orientation, or on type of procedure or plan type in which the provider specializes.

Committee meetings are held at least monthly and more often as deemed necessary.

FAILURE OF AN APPLICANT TO ADEQUATELY RESPOND TO A REQUEST FOR ASSISTANCE MAY RESULT IN TERMINATION OF THE APPLICATION PROCESS.

Site visits are performed at all Assisted Living and Adult Family Care Homes and Adult Day Care Centers during the initial credentialing process and at recredentialing. A satisfactory review must be completed prior to finalization of the credentialing and recredentialing process. If the provider site visit is less than satisfactory the provider may be subject to rejection and/or continued review until compliance is achieved. Site review evaluates home like environment, accessibility, resident care, and safety procedures among other items.

RE-CREDENTIALING

To comply with Accreditation Standards, Sunshine Health conducts the recredentialing process for providers at least every three (3) years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the provider's licensure, sanctions, or certification, which may affect the ability to perform services the provider is under contract to provide. This process includes all providers and/or facilities previously

credentialed to practice within the Sunshine Health network.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as state licensure, malpractice insurance, a copy of certificate of cultural competency training, etc. that have expiration dates prior to the next review process.

A provider's agreement may be terminated if at any time it is determined by Sunshine Health's Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.

A provider's agreement may be terminated if at any time it is determined by Sunshine Health's Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.

RIGHT TO REVIEW AND CORRECT INFORMATION

All providers participating with Sunshine Health have the right to review information obtained by Sunshine Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the State of Florida State Board of Medical Examiners and Florida State Board of Nursing for Nurse Practitioners. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Sunshine Health Credentialing Department. Upon receipt of this information, the provider will have fourteen 30 days to provide a written explanation detailing the error or the difference in information to Sunshine Health. Sunshine Health's Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

All providers have the right to be informed of the status of their application upon request to the Credentialing Department.

RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS

New provider applicants who are declined participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within thirty (30) days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in Sunshine Health. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within 60 days of the final decision.

QUALITY IMPROVEMENT

QUALITY IMPROVEMENT PROGRAM

Sunshine Health's culture, systems and processes are structured around its mission to improve the health of all enrolled Enrollees. The Quality Improvement Program (QIP) utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all Enrollees, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. The purpose of the QIP program is to plan, implement, and monitor ongoing efforts that demonstrate improvements in Enrollee safety, health and satisfaction.

Sunshine Health recognizes its legal and ethical obligation to provide Enrollees with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Sunshine Health will provide for the delivery of quality care with the primary goal of improving the health status of its Enrollees. Where the Enrollee's condition is not amenable to improvement, Sunshine Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Enrollee. This will include the identification of Enrollees at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Sunshine Health's QIP supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its Enrollees.

Sunshine Health will also disseminate bulletins as needed for changes to the Provider Manual.

PROGRAM STRUCTURE

The Sunshine Health *Board of Directors* (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to Enrollees. The BOD oversees the QI program and has established various committees and ad-hoc committees to monitor and support the QI program.

The *Quality Improvement Council* (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered and to continuously enhance and improve the quality of care and services provided to Enrollees. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve Enrollee outcomes, and the education of Enrollees, providers and staff regarding the QI, UM, and Credentialing programs. The QIC has delegated clinical quality review to the Clinical Quality Committee (CQC).

The *Clinical Quality Committee* (CQC) is a physician-driven sub-committee of the QIC, whose primary function is to perform oversight of clinical care and medical services delivered to Sunshine Health Enrollees, review clinical quality activities of sub-committees and make recommendations to the QIC as required to improve clinical quality.

The following sub-committees report directly to the Clinical Quality Committee:

- Credentialing Committee
- Pharmacy and Therapeutics Committee
- Utilization Management / Physician Performance Committee
- Peer Review Committee (Ad Hoc Committee)
- Specialty Advisory Committees (Ad Hoc Committee)

QUALITY IMPROVEMENT PROGRAM GOALS AND OBJECTIVES

Sunshine Health's primary quality improvement goal is to improve Enrollees' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Quality Improvement **goals** include but are not limited to the following:

- A high level of health status and quality of life will be experienced by Sunshine Health Enrollees;
- Network quality of care and service will meet industry-accepted performance standards;
- Sunshine Health services will meet industry-accepted standards of performance;
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Sunshine Health's functional areas;
- Enrollee satisfaction will meet Sunshine Health's established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with Immunizations, Prenatal Care, Diabetes, Asthma, Early Detection of Chronic Kidney Disease and EPSDT Guidelines. (Early Periodic Screening, Diagnosis and Treatment Program). Sunshine Health will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance;
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Sunshine Health's Quality Improvement Program **objectives** include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standard performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standard health outcome measures;
- To allocate personnel and resources necessary to:
 - support the quality improvement program, including data analysis and reporting
 - meet the educational needs of Enrollees, providers and staff relevant to quality improvement efforts;
- To seek input and work with Enrollees, providers and community resources to improve quality of care;
- To oversee peer review procedures to address deviations in medical management and healthcare practices and devise action plans to improve care quality;

- To establish a system to provide frequent, periodic quality improvement information to participating providers to support them in their efforts to provide high quality healthcare;
- To recommend and institute “focused” quality studies in clinical and non-clinical areas, where appropriate.

QUALITY IMPROVEMENT PROGRAM SCOPE

The scope of the QI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Sunshine Health's Enrollees. Sunshine Health's QI program incorporates all demographic groups, care settings, and services in QI activities, including preventive care, primary care, specialty care, acute care, short-term care, Long Term Care (depending upon the Sunshine Health's products), and ancillary services, and Sunshine Health operations. To that end, Sunshine Health's QI program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and recredentialing)
- Behavioral healthcare within AHCA benefits
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over utilization and review of new technology
- Compliance with Enrollee confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Plan after-hours telephone accessibility
- Enrollee satisfaction
- Provider satisfaction
- Enrollee Grievance System
- Provider Complaint System
- Enrollee enrollment and disenrollment
- Department performance and service
- Patient Safety
- Marketing practices.

INTERACTION WITH FUNCTIONAL AREAS

The QI Department maintains strong working relationships with key functional areas within the health plan such as Health Economics, Provider Network Services, Enrollee Services and Connections, Utilization Management, Regulatory Compliance, the Provider Complaint Coordinator, and the Appeals and Grievance Coordinator. Quality is integrated throughout Plan, and represents the strong commitment to quality of care and services for Enrollees.

- *Health Economics* and the QI Department work together to ensure that data integrity is maintained in the study design of quality initiatives and reported data is accurate, timely and validated.
- *Provider Network Services* and the QI Department work together to verify that clinical materials distributed to providers are understandable and useful, and that providers understand the Enrollees' rights and responsibilities and treat enrolled Enrollees accordingly. These departments also coordinate efforts for appropriate access and availability through ongoing monitoring.
- *Enrollee Services, Connections* and QI staffs collaborate in relation to Enrollee Satisfaction survey activities, including performance improvement projects. The QI and Enrollee Services/Connections departments work collaboratively to maintain performance data related to CHCUP outreach activities and any other QI activities related to Enrollee services functions, including call center functions, are tracked, trended and used as a tool to identify opportunities for performance improvement, as appropriate.
- *Utilization Management* provides utilization management, case management and disease focused services to enrolled Enrollees. UM staff identify and refer quality concerns to the QI department for investigation; the UM staff recommend benefits enhancements and participate in QI activities and projects.
- *Regulatory Compliance* and the QI Department work together so Sunshine Health's new initiatives comply with State contract and accreditation requirements for NCQA.
- *Appeal and Grievance Coordinator* and the Provider Relations Department work closely with the QI department so that: any grievance related to a quality of care issue is promptly investigated; grievances and second-level reviews of grievances and administrative reviews are handled timely; data collection and reporting is in compliance with relevant contractual and regulatory requirements; and reporting to appropriate quality committees occurs.

PROVIDER INVOLVEMENT

Sunshine Health recognizes the integral role practitioner involvement plays in the success of its quality improvement program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Sunshine Health encourages PCP, Behavioral Health, on key quality committees such as, but not limited to, the CQC, QIC, Credentialing Committee, P&T Committee, Peer Review Committee and select ad hoc committees.

PERFORMANCE IMPROVEMENT PROCESS

Sunshine Health's QI Council reviews and adopts an annual QI Program and QI Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. As part of this approach, the Vice President of Medical Affairs (VPMA), or designee, and the Vice President of Enrollee and Provider Services (VPMPS), in conjunction with the QI Department, determine the scope and frequency of QI initiatives (clinical and non-clinical performance improvement projects, focus studies, etc.). Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Other initiatives will be selected to test an innovative strategy. Each initiative topic will reflect distinctive regional emphasis on populations and cultures. Once a QI topic is selected, the QI Department, in conjunction with specific functional

areas as appropriate, will present the proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to Plan's Enrollees and network providers.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Plan to monitor improvement over time.

Plan utilizes a ten-step methodology recommended by Health Care System for Managed Care: A Guide for States to implement its quality improvement initiatives. However, there may be opportunities for improvement identified in which a modified version of this process may be used.

The development and selection of clinical performance improvement projects is delegated to the Clinical Quality Committee (CQC) due to its clinical representation. The QIC is delegated the development and selection of non-clinical performance improvement projects due to its representation of key functional areas within the organization affecting services. The QIC continues to monitor progress of clinical PIPs as well via regular reporting via CQC. The Sunshine Health Quality Improvement Program allows for continuous performance of quality improvement activities through analysis, evaluation and improvement in the delivery of healthcare provided to all Enrollees, and has established mechanisms to track issues over time.

Annually, Sunshine Health develops a Quality Assessment Performance Improvement (QAPI) Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QI Committee as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.

The QAPI Work Plan is used by the QI Department to manage projects and by the QI committees and sub-committees, and Sunshine Health Board of Directors to monitor progress. The Work Plan is modified and enhanced throughout the year with approval from the state and QIC. Modifications are reported to the Board of Directors and appropriate QI committees.

At any time, Sunshine Health providers may request information on Sunshine Health's quality program including a description of the QI Program and a report on Sunshine Health's progress in meeting the QAPI Program goals by contacting Sunshine Health's Quality Improvement Department.

FEEDBACK ON PROVIDER SPECIFIC PERFORMANCE

As part of the quality improvement process, performance data on each provider is reviewed and evaluated. This may be done by the Credentialing Committee and/or other committees involved in the quality improvement program. This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency and in-office waiting time;
- Preventive care, including Well-child exams, immunizations, lead screening, cervical cancer screening, breast cancer screening, and screening for detection of chronic diseases such as diabetes and kidney disease;

- Enrollee complaint and grievance data;
- Utilization management data including referrals/1000 and bed days/1000 reports;
- Sentinel events and/or adverse outcomes;
- Compliance with clinical practice guidelines.

HEALTH EFFECTIVENESS DATA INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of the AHCA contract. AHCA holds Sunshine Health accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse Enrollee ship.

HEDIS consists of 20+ Effectiveness of Care type measures as well as Access to Care and Use of Services measures for which the health plan contractually reports rates to the State of Florida based on claims and/or medical record review data.

As both the State and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. State purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in Preventive Health outreach to its Enrollees. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, annual Pap test, treatment of pharyngitis, treatment of URI, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of Enrollee medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include: comprehensive diabetes care, control of high-blood pressure, immunizations, prenatal care, and well-child care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

Sunshine Health will contract with a national medical record review vendor, to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for Sunshine Health. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Enrollee/patient. The Medical Record Review vendor will sign a HIPAA compliant Business Associate Agreement with Sunshine Health which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

Understand the specifications established for each HEDIS measure.

Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation. Chart documentation must reflect the services provided.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact Sunshine Health Quality Improvement Department at **1-866-796-0530**.

**CONSUMER ASSESSMENT OF HEALTHCARE
PROVIDER SYSTEMS (CAHPS) SURVEY**

This is a Enrollee satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to Enrollees by an NCQA certified survey vendor. The adult CAHPS survey provides information on the experiences of Medicaid Enrollees with the MCO services and gives a general indication of how well the MCO meets Enrollees' expectations. Global rating questions reflecting overall satisfaction include rating of personal doctor and rating of specialist seen most often. Composite scores summarize responses in key areas such as getting care quickly, getting needed care, and shared decision making. Enrollee responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

PROVIDER SATISFACTION SURVEY

Sunshine Health conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Sunshine Health, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

FEEDBACK OF AGGREGATE RESULTS

Aggregate results of studies and guideline compliance audits are presented to the QI Committee. Participating physician Enrollees of the QIC provide input into action plans and serve as a liaison with physicians in the community. Aggregate results are also published in the quarterly provider newsletter or a special provider mailing may be distributed.

At least annually, a provider relations specialist meets with primary care providers and high volume specialists to review policies, guidelines, indicators, medical record standards, and provide feedback of audit/study results. These sessions are also an opportunity for providers to suggest revisions to existing materials and recommend priorities for further initiatives. When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, Sunshine Health disseminates the materials through an in-service training program to upgrade providers' knowledge and skills. The Sunshine Health Medical Director and Pharmacist conduct special trainings and meetings to assist physicians and other providers with quality and service improvement efforts.

WASTE ABUSE AND FRAUD (WAF) SYSTEM

Sunshine Health takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with state and federal laws. Sunshine Health in conjunction with its management company, Centene Corporation, successfully operates a waste, abuse and fraud unit. Sunshine Health performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims chapter of this manual. The WAF unit performs back end audits which in some cases may result in prosecution and/or recoupment of previously paid monies.

Some of the most common errors seen are:

- Use of incorrect billing code
- Not following the service authorization
- Procedure code not being consistent with provided service
- Excessive use of units not authorized by the case manager

In order to prevent Enrollee's from card sharing, Sunshine Health recommends that providers obtain a copy of a photo ID as part of the Enrollee's record.

If you suspect or witness a provider inappropriately billing or a Enrollee receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-877-211-1999. To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which available online at: <https://apps.ahca.myflorida.com/InspectorGeneral/fraudcomplintform.aspx>. If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-866-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of \$5,000,000 per case). Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected. Sunshine Health and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

AUTHORITY AND RESPONSIBILITY

The Sunshine Health Compliance Officer has overall responsibility and authority for carrying out the provisions of the compliance program.

Sunshine Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Sunshine Health provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

PROVIDERS BILL OF RIGHTS

Sunshine Health Providers shall be assured of the following rights:

- A Healthcare Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Enrollee who is his/her patient for the following:
 - The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - Any information the Enrollee needs in order to decide among all relevant treatment options.
 - The risks, benefits, and consequences of treatment or non-treatment.
 - The Enrollee's right to participate in decisions regarding his/her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance and Appeal procedures.
- To have access to Sunshine Health's policies and procedures covering the authorization of services.
- To be notified of any decision by Sunshine Health to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge on behalf of Sunshine Health Enrollees, the denial of coverage of, or payment for, medical assistance.
- Sunshine Health provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

ENROLLEE RIGHTS & RESPONSIBILITIES

Enrollees are informed of their rights and responsibilities through the Enrollee Handbook. Sunshine Health providers are also expected to respect and honor Enrollee's rights.

Sunshine Health Enrollees have the following rights and responsibilities:

- To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law.
- To receive information about Sunshine Health providers and Enrollee rights and responsibilities.
- To participate with their providers in making decisions regarding their healthcare. This includes the right to refuse services.
- To exercise these rights without adversely affecting the way Sunshine Health and its providers treat the Enrollees.
- To receive the following materials:
 - Enrollment notices
 - Information materials
 - Instructional materials
 - Available treatment options and alternatives, in a manner and format that may be easily understood.
- To receive family planning services from any participating Medicaid doctor without prior authorization.
- To get information about your rights and responsibilities, as well as the Sunshine Health providers and services.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS. And to receive healthcare services that are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. (Also 42 CFR 438.206 & 438.210).
- To request and receive a copy of your medical/case record. (Also 45 CFR 164.524).
- To request that your medical/case record be corrected (Also 45 CFR 164.526).
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To receive assistance from both Florida Medicaid and Sunshine Health in understanding the requirements and benefits of the health plan.
- To receive notice if Sunshine Health will not provide services due to moral or religious reasons within 30 days before the service.
- To receive services in a culturally competent manner, including Enrollees with limited English ability and diverse cultural and ethnic backgrounds.
- As a potential Enrollee, to receive information about the basic features of managed care; which populations may or may not enroll in the program and Sunshine Health's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information about Sunshine Health, its benefits, services and providers.
- To receive information on the following:
 - Benefits covered.
 - Procedures for obtaining benefits, including any authorization requirements.
 - Cost sharing requirements.
 - Service area.
 - Names, locations, telephone numbers and non-English languages spoken by current Sunshine Health providers.

- Any restrictions on Enrollee's freedom of choice among network providers.
 - Providers not accepting new Enrollees.
 - Benefits not offered by Sunshine Health but available to Enrollees and how to obtain those benefits, including how transportation is provided.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To choose a provider and to change to another provider at any time.
- To receive timely access to care.
- To get care from a provider not in Sunshine Health's network if your doctor and case manager says the care is medically needed and is not available from one of our providers.
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law (Also 45 CFR 164.524).
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive information on the Grievance, Appeal and Medicaid Fair Hearing procedures.
- To voice grievances or file appeals about Sunshine Health decisions that affect their privacy, benefits or the care provided.
- To file for a Medicaid Fair Hearing and receive documents used in a Fair Hearing at no cost to the Enrollee.
- To expect their medical/case records and care be kept confidential as required by law.
- To make an advance directive, such as a living will.
- To choose a person to represent them for the use of their information by Sunshine Health if they are unable to.
- To receive translation services free of charge for all non-English languages.
- To be notified that oral interpretation is available and how to access those services.
- To receive a complete description of disenrollment rights at least annually.
- To received detailed information on emergency and after-hours coverage, to include, but not limited to:
 - What constitutes an emergency medical condition, emergency services, and post-stabilization services.
 - That Emergency Services do not require prior authorization.
 - The process and procedures for obtaining Emergency services.
 - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
 - Enrollee's right to use any hospital or other setting for emergency care.
 - Post-stabilization care services rules in accordance with Federal guidelines.
- To make recommendations regarding Sunshine Health's Enrollee rights and responsibilities policy.
- To inform Sunshine Health of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with Sunshine Health procedures to the best of their ability.
- To call or contact Sunshine Health to obtain information and have questions clarified.
- To provide information (to the extent possible) that Sunshine Health and its practitioners and providers need in order to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers.
- To inform your Case Manager on reasons you cannot follow the agreed upon plan of care.
- To understand your health problems and participate in developing mutually agreed-upon goals to the degree possible.
- To keep your medical appointments and follow-up appointments.
- To access preventive care services.
- To follow the policies and procedures of Sunshine Health and the State Medicaid program.
- To be honest with providers and treat them with respect and kindness.

- To follow the steps of the appeal process.
- To notify Sunshine Health, DCF and your providers of any changes that may affect your enrollment, healthcare needs or access to benefits. Some examples may include:
 - If you have a baby.
 - If your address changes.
 - If your telephone number changes.
 - If you are covered by another health plan.
 - If you have a special medical concern.

COMMUNITY OUTREACH

Community Outreach - The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare, and social services or social assistance programs offered by the State of Florida or local communities.

COMMUNITY OUTREACH AND MARKETING

Sunshine Health's community outreach representative(s) may provide community outreach materials at health fairs/public events as noticed by the Managed Care Plan to the Agency. The main purpose of a health fair/public event shall be to provide community outreach and shall not be for the purpose of Medicaid Managed Care Plan marketing.

Prohibited Activities

Sunshine Health is prohibited from engaging in the following non-exclusive list of activities:

- Marketing for enrollment to any potential Enrollees or conducting any pre-enrollment activities not expressly allowed in contract with Agency;
- Any of the prohibited practices or activities listed in s. 409.912, F.S.;
- Engaging in activities not expressly allowed under this Contract for the purpose of recruitment or enrollment;
- Practices that are discriminatory, including, but not limited to, attempts to discourage enrollment or re-enrollment on the basis of actual or perceived health status, in accordance with ss. 409.912 and 409.91211, F.S.;
- Direct or indirect cold call marketing or other solicitation of Medicaid applicants and recipients, either by door-to-door, telephone or other means, in accordance with Section 4707 of the Balanced Budget Act of 1997 and s. 409.912, F.S.;

- Activities that could mislead or confuse Medicaid recipients or misrepresent the Managed Care Plan, its community outreach representatives or the Agency, in accordance with s. 409.912, F.S. No fraudulent, misleading or misrepresentative information shall be used in community outreach, including information about other government programs. Statements that could mislead or confuse include, but are not limited to, any assertion, statement or claim (whether written or oral) that:
 - The Medicaid recipient must enroll in the Managed Care Plan to obtain Medicaid or to avoid losing Medicaid benefits;
 - The Managed Care Plan is endorsed by any federal, state or county government, the Agency, CMS or any other organization that has not certified its endorsement in writing to the Managed Care Plan;
 - Community outreach representatives are employees or representatives of the federal, state or county government, or of anyone other than the Managed Care Plan or the organization by whom they are reimbursed;
 - The state or county recommends that a Medicaid recipient enroll with the Managed Care Plan; and/or
 - A Medicaid recipient will lose benefits under the Medicaid program or any other health or welfare benefits to which the person is legally entitled if the recipient does not enroll with the Managed Care Plan.
- Granting or offering any monetary or other valuable consideration for enrollment;
- Offering insurance, such as, but not limited to, accidental death, disenrollment, disability or life insurance;
- Enlisting assistance of any employee, officer, elected official or agency of the state in recruitment of Medicaid recipients except as authorized in writing by the Agency;
- Offering material or financial gain to any persons soliciting, referring or otherwise facilitating Medicaid recipient enrollment. The Managed Care Plan shall ensure that its staff do not market the Managed Care Plan to Medicaid recipients at any location including state offices or DCF ACCESS center;
- Giving away promotional items in excess of \$5.00 retail value. Items to be given away shall bear the Managed Care Plan's name and shall be given away only at health fairs/public events. In addition, such promotional items must be offered to the general public and shall not be limited to Medicaid recipients;
- Providing any gift, commission or any form of compensation to the enrollment broker, including its full-time, part-time or temporary employees and subcontractors;
- Discussing, explaining or speaking to a potential Enrollee about Managed Care Plan-specific information other than to refer all Managed Care Plan inquiries to the Enrollee services section of the Managed Care Plan or the Agency's enrollment broker;
- Distributing any community outreach materials without prior written notice to the Agency except as otherwise allowed under Permitted Activities and Provider Compliance subsections;
- Distributing any marketing materials not expressly allowed under this Contract;
- Subcontracting with any brokerage firm or independent agent as defined in Chapters 624-651, F.S., for purposes of marketing or community outreach;
- Paying commission compensation to community outreach representatives for new Enrollees. The payment of a bonus to a community outreach representative shall not be considered a commission if such bonus is not related to enrollment or Enrollee ship growth; and
- All activities included in s. 641.3903, F.S.

Permitted Activities

Sunshine Health may engage in the following activities upon prior written notice to the Agency:

- Sunshine Health may attend health fairs/public events upon request by the sponsor and after written notification to the Agency as described in sub-item 4, Community Outreach Notification Process, below.
- Sunshine Health may leave community outreach materials at health fairs/public events at which the Plan participates.

- Sunshine Health may provide Agency-approved community outreach materials. Such materials may include Medicaid enrollment and eligibility information and information related to other health care projects and health, welfare and social services provided by the State of Florida or local communities. Sunshine Health staff, including community outreach representatives, shall refer all inquiries to the Enrollee services section of the Plan or the Agency's enrollment broker. Agency approval of the script used by the Sunshine Health must be obtained before usage.
- Sunshine Health may distribute community outreach materials to community agencies.

PROVIDER COMPLIANCE

Sunshine Health ensures, through provider education and outreach that its health care providers are aware of and comply with the following requirements:

- Health care providers may display Managed Care Plan-specific materials in their own offices.
- Providers may announce a new affiliation with a Managed Care Plan and give the Enrollees a list of managed care plans with which they contract.
- Providers shall not furnish lists of their LTC Enrollees to the Managed Care Plan with which they contract, or any other entity, nor can providers furnish other managed care plans' membership lists to the Managed Care Plan, nor can providers assist with Managed Care Plan enrollment.

For the Managed Care Plan, providers may distribute information about non-Managed Care Plan-specific health care services and the provision of health, welfare and social services by the State of Florida or local communities, as long as any inquiries from prospective Enrollees are referred to the Enrollee services section of the Managed Care Plan or the Agency's enrollment broker.

ENROLLEE GRIEVANCES

MEMBER COMPLAINTS

Federal law requires Medicaid managed care organizations to have internal grievance procedures under which Medicaid enrollees or providers acting as their authorized representatives may challenge a denial of coverage or payment for medical assistance. These procedures must include an opportunity to file a complaint, grievance, and/or an appeal to seek a Medicaid Fair hearing.

IMPORTANT DEFINITIONS FOR MEMBER GRIEVANCES

The following are some definitions related to the member grievance process:

A “**complaint**” is the lowest level of problem resolution and provides Sunshine Health an opportunity to resolve a problem without its becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system within 24 hours.

A “**grievance**” is an expression of dissatisfaction about any matter other than an “action.” For example, a member would file a grievance if the member has a problem with issues such as:

- The quality of your care
- Waiting times for appointments
- Waiting time to be seen while in a doctor's office
- The way your doctor or their staff behave

An “**action**” is the denial or limit by Sunshine Health of services requested by the member or their provider.

- This can include the level of service, example: outpatient vs. inpatient hospital care.

- It can also include a reduction, suspension or termination of a service that was already authorized for the member.
- It can mean the denial of all or part of the payment for a service or failure to provide the service in a timely manner.
- It can also mean Sunshine Health failure to act on a grievance or appeal the member requested within 90 days of receiving the request.

An “**appeal**” is a request for a review of an action.

For example:

- If we refuse to cover or pay for services you think we should cover, the member may file an appeal.
- If one of our contracted providers refuses to give the member a service the member thinks should be covered, the member may file an appeal.
- If the member thinks we are stopping their coverage of a service **too soon**, the member may file an appeal.
- With the member’s written permission, a provider or the members authorized representative may also file an appeal for the member.

Sunshine Health is required to keep track of all complaints, appeals, and grievances in order to report data to the State on a monthly basis. This information is used to improve our service to our members.

FILING A GRIEVANCE WITH SUNSHINE HEALTH

If a member is dissatisfied with Sunshine Health for any reason, other than an action, (as noted above) the member or their authorized representative may file a grievance. This may be done orally by calling Member Services 1-877-211-1999, or in writing. The member cannot be disenrolled or penalized in any way if they file a grievance.

Sunshine Health will send the member a letter acknowledging their grievance and will provide a resolution within 90 calendar days of receiving the grievance. The member may file a grievance at any time. The member or the member’s authorized representative may request an extension if necessary and if this is in the member’s best interest. An extension can be made for up to fourteen (14) days. The Grievance and Appeals department is available to assist the member Monday through Friday, 8:00 a.m. to 5:00 p.m. The Member Services hours are extended from 8:00 a.m. - 8:00 p.m. EST.

If a member would like to contact us in writing, please address your letter to:

**Sunshine Health Grievance & Appeals Coordinator
1301 International Pkwy
Suite 400
Sunrise, FL 33323
Fax: 866-534-5972**

Be sure to contact our Member Services Department if the member has questions, needs any help or has additional information to submit about their grievance. The member may call Member Services at 1-877-211-1999. Members who have a behavioral health complaint or grievance may call Member Services at 1-877-211-1999 and select the behavioral health option.

EXHAUSTION OF THE GRIEVANCE PROCESS

If you still have questions or concerns about the quality of medical care you receive, call AHCA’s Consumer Hot Line at 1-888-419-3456.

MEMBER APPEAL PROCESS

The member may file an appeal of a decision by within sixty (60) calendar days of receipt of Sunshine Health’s Notice of Adverse Benefit Determination.

An appeal can be filed orally or in writing. Our Member Services staff can assist the member with this in any way. Oral appeals must be followed by a written, signed appeal request within ten (10) calendar days of the oral filing. Sunshine Health will send the member a notice to remind them that they must file a written appeal within ten (10) business days of receiving their oral request for appeal. If the member needs help completing their written appeal, please call Member Services at 1-877-211-1999. Translators and interpreters will help them, if they need help, with no charge to the member.

Sunshine Health's timeframe to resolve a member's appeal begins on the date that we receive their oral request. Sunshine Health will resolve the member's appeal within thirty (30) calendar days from the date Sunshine Health received their initial request, unless they have requested an "expedited" appeal. This timeframe can be extended up to fourteen (14) calendar days if the member requests it or Sunshine Health finds there is a need for additional information, and the delay is in the member's best interest. Sunshine Health will notify the member in writing within five (5) business days of determining the need for an extension, if we need an extension. Sunshine Health will notify the member within 14 days of the original resolution date.

If the resolution to the member's appeal is in their favor, Sunshine Health will provide the services as quickly as their condition requires.

EXPEDITED APPEAL PROCESS

The member may ask for an "expedited or urgent" appeal if taking the time for a standard resolution could seriously jeopardize your life, health or ability to attain, maintain or regain maximum function.

The member may file an "expedited" appeal orally or in writing. The member does not need to follow-up this request in writing.

If the member or their physician files an "expedited" appeal, Sunshine Health will determine if the request meets expedited criteria, if yes:

- Inform the member of the limited time available to present your evidence and allegation of fact or law, in person or in writing;
- Resolve each expedited appeal and give the member notice as quickly as their condition requires, but within 72 hours after Sunshine Health receives their appeal;

Provide member with a written notice of the resolution; and provide oral notice to the member by close of business on the day of disposition

If Sunshine Health's denies the member request for an "expedited" appeal, Sunshine Health will:

- Transfer the member's appeal to the standard timeframe of no longer than thirty (30) calendar days from when Sunshine Health receives the request for an expedited appeal.
- Grant a fourteen (14) day extension if in the member's best interest.
- Provide oral notice to the member by close of business on the day of disposition.
- Provide the member with written notice of the denial within five (5) business days.

CONTINUATION OF BENEFITS:

The Managed Care Plan shall continue the enrollee's benefits during the plan appeal if all of the following occur:

- (1) The enrollee or the enrollee's authorized representative files the request for a plan appeal timely
- (2) The plan appeal involves the termination, suspension, or reduction of previously authorized course of treatment;
- (3) The services were ordered by an authorized provider;
- (4) The period covered by the original authorization has not expired; and
- (5) The enrollee timely files for continuation of benefits

If the final resolution of the plan appeal is upheld, the Managed Care Plan may recover the cost of services furnished to the enrollee while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.

MEDICAID FAIR HEARING

The member has the right to ask for a fair hearing any time up to 120 days after the Notice of Plan Appeal letter is mailed. The member's case manager can assist, if they have one. The member may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration

Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
Phone: 877-254-1055 (toll free)
Fax: 239-338-2642

Sending an email to: MedicaidHearingUnit@ahca.myflorida.com

The written request for a Medicaid fair hearing must include the following information:

- Member name
- Member number that is on the Sunshine Health plan ID card or the member's Medicaid number
- A phone number where the member or their authorized representative can be reached

The member may also include the following information if available:

- Why they think we should change the decision
- Any medical information to support the request
- Who the member would like to help with the fair hearing

HOW TO ASK FOR SERVICES TO CONTINUE DURING A FAIR HEARING

If the member was receiving services during the plan appeal, file the request for services to continue with the Office of Appeal Hearings no later than 10 days after the Notice of Plan Appeal Resolution was mailed OR on or before the first day that services were scheduled to be reduced, suspended, or terminated, whichever is later. The member must tell the hearing officer if they want their services to continue.

If services are continued and our decision is upheld in a fair hearing, we may ask the member to pay for the cost of those services. We will not take away the member's Medicaid benefits. We cannot ask the member's family or legal representative to pay for the services.

SUBSCRIBER ASSISTANCE PROGRAM (SAP)

If the member does not like the plan appeal decision, they have one year after the final decision letter to request a review by the Subscriber Assistance Program (SAP). The member must finish the appeal process first. If the member asks for a fair hearing, they cannot have a SAP review.

The member may ask for a SAP review by calling or writing to:

Agency for Health Care Administration
Subscriber Assistance Program
2727 Mahan Drive, Mail Stop #45
Tallahassee, FL 32308
850-412-4502
888-419-3456 (toll-free)

After getting the SAP request, the Agency for Health Care Administration will tell the member in writing that they received the SAP request.

SPECIAL SERVICES TO ASSIST WITH ENROLLEES

Sunshine Health has designed its programs and trained its staff to ensure that each Enrollee's cultural needs are considered in carrying out Sunshine Health operations. Providers should remain cognizant of the diverse Sunshine Health population. Enrollees' needs may vary depending on their gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your Enrollees. Sunshine Health is always available to assist your office in providing the best care possible to the Enrollees.

There are several services that are also available to the Enrollees to assist with their everyday needs. Please see the description below.

INTERPRETER/TRANSLATION SERVICES

Sunshine Health is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its Enrollees. In order to meet this need, Sunshine Health is committed to the following:

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with Enrollees as needed.
- Providing Language Line services that will be available twenty-four (24) hours a day, seven (7) days a week in 140 languages to assist providers and Enrollees in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Sunshine Health is notified in advance of the Enrollee's scheduled appointment in order to allow for a more positive encounter between the Enrollee and provider, telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested.
- Providing TDD/TTY access for Enrollees who are hearing impaired through 1-800-955-8770.
- Sunshine Health's medical advice line, NurseWise/Involve People Care, Inc., provides 24 hours access seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Enrollee Services and Health Education materials in alternative formats as needed to meet the needs of the Enrollees, such as audio tapes or language translation, all alternative methods must be requested by the Enrollee or designee.

Providers must call Enrollee Services at 1-877-211-1999 if interpreter services are needed. Please have the Enrollee's ID number; date/time service is requested and any other documentation that would assist in scheduling interpreter services.

PROVIDER RELATIONS ASSISTANCE

PROVIDER RELATIONS DEPARTMENT

The Provider Relations Department at Sunshine Health is designed around the concept of making your experience with Sunshine Health a positive one by being your advocate within Sunshine Health. Provider Relations is responsible for providing the services listed below which include, but are not limited to:

- Maintenance of existing Sunshine Health Provider Manual
- Development of alternative reimbursement strategies
- Researching of trends in claims inquiries to Sunshine Health
- Network performance profiling
- Ongoing provider education, training, and updates via provider visits, mailings and fax blast to ensure compliance with program standards and the Contract
- Initial training to all providers and their staff regarding the requirements of Contract with Sunshine Health and special needs of Enrollees will be conducted within thirty (30) calendar days of a newly contracted provider or provider group with active status.

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of service to Sunshine Health Enrollees.

To reach a Provider Relations Specialist for your area contact:

**Provider Relations
Department 1-877-211-1999**

The Provider Services toll free help line staff is available to you and your staff to answer questions, listen to your concerns, assist with Enrollees, respond to your Sunshine Health inquiries, connect you to the Sunshine Health Provider Relations Specialist for your area and other services as you request.

PROVIDER COMPLAINTS

Providers have the right to appeal policies/procedures and any decision made by Sunshine Health, including complaints on claims payments. A complaint may be filed telephonically or in writing by contacting Sunshine Health Provider Services at:

**Sunshine State Health
Plan 1301 International
Pkwy
Suite 400
Sunrise, FL 33323
ATTN:
ProviderServices**

As a part of the provider complaint system, Sunshine Health has dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems. Providers are allowed forty-five (45) calendar days to file a written complaint for issues that are not about claims. Within three (3) business days of receipt of a complaint, Sunshine Health notifies the provider (verbally or in writing) that the complaint has been received and the expected date of resolution. Sunshine Health thoroughly investigates each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying written policies and procedures. Sunshine Health documents why a complaint is unresolved after fifteen (15) calendar days of receipt and provide written notice of the status to the provider every fifteen (15) calendar days thereafter. For complaints resolved within ninety (90) calendar days of receipt, a written notice of the disposition and the basis of the resolution to the provider will be issued to the provider within three (3) business days of resolution. Sunshine Health ensures that executives with authority to require corrective action are involved in the provider complaint process.



1301 International Parkway
Suite 400
Sunrise, Florida 33323
1-877-211-1999
SunshineHealth.com