Orientation Goals

• To provide overview of Simply Healthcare Plans
• To provide overview of Clear Health Alliance
• To provide an update on the Florida Medical Assistance Program (MMA)
• To review the following program components
  – Enrollment
  – Provider Responsibilities
  – Health Services
  – Pharmacy
  – Claims
  – Provider Portal
  – Grievance and Appeals
  – Cultural Competency
  – Provider Marketing Do’s and Don’ts
  – Fraud, Waste and Abuse
• Questions
Simply Healthcare - Who We Are

• A Florida company, founded in 2009 with headquarters in Coral Gables and offices in Tampa and Sunrise.

• 700+ employees serving approximately 250,000 Medicare and Medicaid beneficiaries with the support of 7,000 providers in 60 Florida counties.

• Products include Medicaid; Clear Health Alliance, an HIV/AIDS Medicaid Specialty Plan; and Medicare: HMO, POS and ISNP/DSNP.

• In 2012 launched an innovative new Medicaid Specialty Plan, Clear Health Alliance, to serve the state’s growing population of individuals living with HIV/AIDS. It currently operates in 16 counties.

• In 2013 approved Medicare offerings in thirteen counties.

• AAAHC three year reaccreditation awarded in 2013.
Earvin “Magic” Johnson and Simply Healthcare Plans have joined together to promote our health plan and the power to choose!
About Clear Health Alliance

- An HIV/AIDS Medicaid SPECIALTY Plan offered by Simply Healthcare Plans (SHP)
- Expanded Benefits
- Extensive network with HIV experienced providers/specialists
  - Participating providers include primary and specialty care doctors, hospitals, ancillary providers and pharmacies.
- Can only accept Medicaid recipients living with HIV/AIDS.
- Voluntary or State-mandated enrollment.
...the Clear Health Alliance team has PROVEN experience in HIV Disease

- Medical Director with HIV Disease experience
- Clinical Pharmacist (Pharm D.) with HIV/AIDS Disease experience
- Managed Care Coordinators with extensive HIV/AIDS care management experience with Ryan White and PAC Waiver clients
- Provider Relations Specialty/Community Outreach/Community Relations
- Dedicated Clear Health Alliance Member Services Team
Medical Director

Network Development Specialist

Clinical Pharmacist

Managed Care Coordinators

Supporting You and Your Patients/Clients …our members
Support Ryan White/PAC Waiver Case Managers

- Hospitals Admissions
  - ✓ Alert member’s RW or PAC case manager
  - ✓ Discharge summaries to PCP when available

- Expanded Plan Benefits
  - ✓ Use Plan benefits first, SAVING RW funds

- Interdisciplinary Care Team
  - ✓ Family doctors, caregivers, family members, legal representatives, and case managers
Florida Managed Medical Assistance Program Overview (MMA)

The Florida Legislature created a new program called “Statewide Medicaid Managed Care.” As a result, the Agency for Health Care Administration (AHCA) has to change how some individuals receive health care from the Florida Medicaid program.

• The changes are “not” due to National Health Care Reform or the Affordable Care Act.

• Medicaid Managed Care consists of:
  – Florida Long-Term Care Managed Care Program
  – Florida Managed Medical Assistance Program (MMA)

• 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.

• When will these changes occur:
  – The MMA Program will be available in all areas by October 1, 2014.
What are the Goals of the Florida Managed Medical Assistance Program?

- The goals of Florida Managed Medical Assistance are to provide:
  - Coordinated health care across different healthcare settings.
  - A choice of the best managed care plans to meet recipients’ needs.
  - The ability for health care plans to offer different, and expanded, benefits and services.
  - The opportunity for recipients to become more involved in their health care.
How will enrollees learn of the changes?

- **Recipients will receive a letter from the State of Florida**
  - Notifies enrollee whether they are required to enroll in the Florida Managed Medical Assistance Program
  - Includes instructions on how to choose a plan (if enrollment is required)

- **Information on participating plans and service providers will be available**
  - Before the Florida Managed Medical Assistance Program begins to help eligible recipients choose the plan that best fits their needs.
What Happens if a Recipient Who Is Required to Enroll Does Not Select a Plan?

• Recipients are encouraged to choose the managed care plan that best meets their needs; however, if a recipient who is required to enroll does not choose a plan within 30 days, AHCA will automatically enroll the recipient into a managed care plan. Before automatically enrolling the recipient into a managed care plan, AHCA will consider:

• Whether the plan is able to meet the recipient’s needs; and

• Whether the recipient has previously received services from one of the plan’s primary care providers.
How Recipients Can Enroll

- **Online**
  - Go to the Florida Statewide Medicaid Managed Care website at [www.flmedicaidmanagedcare.com](http://www.flmedicaidmanagedcare.com) or [http://www.myflorida.com/accessflorida](http://www.myflorida.com/accessflorida)

- **By Phone**
  - Call Medicaid Choice Counseling Helpline toll-free at 1-877-711-3662

*Due to HIPAA privacy regulations, Choice Counselors may only speak with the state approved individual or an approved individual on the case.*

**Notify the Plan of ANY difficulties so we can improve.**
Expanded Benefits

• Benefits are paid according to the Florida Medicaid Coverage and Limitations Handbooks
• Medicaid Co-Payments are waived

• Expanded Primary Care Visits for Non-Pregnant Adults (No Prior Authorization Required)
  – Primary Care Provider Office Visit limited to one (1) per day (Procedure Codes 99201 to 99205 and 99211 to 99215)

• Expanded Physician Home Visit (Prior Authorization Required)
  – Expanded home visit by a primary care specialty provider for medically homebound patients; additional 2 visits per month limited to one (1) visit per day (Procedure Codes 99341 to 99350)

• Expanded Prenatal/Perinatal Visits (No Prior Authorization Required)
  – An additional postpartum visit within 8 weeks of delivery (Procedure Code 59430)
  – An additional four (4) follow-up prenatal visits (Procedure Code H1000) for non-high risk pregnant women.

• Expanded Outpatient Hospital Services (Prior Authorization Required)
  – Speech Therapy for Adults - limited to a maximum of one (1) Evaluation and 3 therapy visits a week for 3 weeks (9 visits total) for adults 21 and older.
Expanded Benefits (cont’d)

- Expanded Vision Services (Prior Authorization Required)
  - Medically Necessary Eye Glasses (V2020, V2100, V2200)-one (1) additional pair every 2 calendar years

- Expanded Hearing Services (No Prior Authorization Required)
  - One (1) preventive adult hearing screening per calendar year (Procedure Codes V5008 or 92551)

- Pneumonia Vaccine (Prior Authorization Required)
  - Pneumonia vaccine and administration will be covered in accordance with the recommendations of the Advisory Committee for Immunization Practices (ACIP) (Procedure Code 90732, G0008-Adm)

- Shingles Vaccine (Prior Authorization Required)
  - Shingles vaccine and administration will be covered in accordance with the recommendations of the Advisory Committee for Immunization Practices (ACIP) (Procedure Code 90736, 90471)

- Post Discharge Meals (Prior Authorization Required)
  - Two (2) home delivered meals per day after a hospital discharge, limited to up to five (5) calendar days for enrollees with no in-home support present and when requested by a physician.
Expanded Benefits (cont’d)

- **Nutritional Counseling-Modified** (Referral and subject to Prior Authorization)
  - Adult Nutritional Counseling with a licensed nutritionist, limited to 15 visits/year (97802, 97803)

- **Medically Related Lodging and Food** (Prior Authorization Required)
  - Per diem reimbursement for cost of overnight stays and meals for an enrollee travelling more than 120 miles to get medically necessary covered care not available closer to the enrollee’s home. If the enrollee is a child age 20 years or under, an additional per diem reimbursement may be authorized for a parent or caregiver.
  - The benefit is the lesser of reimbursement of cost or $70 per day of which no more than $25 can be reimbursement for meals. Reimbursement for overnight stay in the home of friends or relatives is not eligible. Reimbursement is not available for caregivers or family during days that the enrollee is an inpatient in a medical facility.

- **Expanded Home Health Visits for Non-Pregnant Adults** (Prior Authorization Required)
  - Three (3) additional personal care visits (Procedure Code T1021)

- **Over the Counter Medication/Supplies** (No Prior Authorization Required)
  - OTC and/or first aid supplies up to $25.00 per household per month.
Expanded Benefits (cont’d)

- **Expanded Adult Dental Services (No Prior Authorization Required)**
  - One (1) cleaning per 6 months (D1110)
  - Two (2) preventive-Exam/Oral Evaluation/12 months (D0120)
  - One (1) preventive-Exam/Oral Evaluation/36 months (D0150)
  - Two (2) simple Extractions per year by a general dentist (D7140)
  - One (1) comprehensive x-ray/6months
  - Two (2) preventive X-Rays/12 months (D0220, D0230, D0270, D0272-D0274)

- **Circumcisions (No Prior Authorization Required)**
  - Circumcisions for newborns up to 12 weeks after birth (54150, 54160, 54161)

- **Influenza Vaccine - Adults (No Prior Authorization Required)**
  - Influenza Vaccine (90656, 90664, 90666, 90667, 90668) and administration (G0008)
Expanded Benefits (cont’d)

• Home and Community Based Services  (Prior Authorization Required)
  – Homemaker Services, available post-discharge, if prescribed by a physician, when no in-home support is available (Procedure code: 55130)
  – Limited to up to two (2) visits of up to two (2) hours each within a seven (7) day post discharge period.
  – Only applies to Clear Health Alliance Members
Enrollment
How to Verify Eligibility

• It is very important that you verify eligibility at least once a month. Patients may keep their cards during months when they are not eligible for Medicaid, so please check monthly for status via Provider Services or Provider Portal.

• Please check for status by calling the Plan Provider Services Number at: 1-877-915-0551, select Option 1.
Provider Responsibilities
Medical Record Documentation

• Providers are responsible for maintaining medical records which meet all applicable Federal, State and regulatory standards
  – More details can be found in Section 10 of the Provider Handbook

• Medical records must be maintained in accordance with HIPAA requirements for privacy and protection.

• Simply Healthcare performs periodic medical record reviews in order to ensure that all standards are consistently met.
Timely Access Standards

• The Plan must assure that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis according to the following standards:
  – Urgent Care – within one (1) day of the request;
  – Sick Care – within one (1) week of the request; and
  – Well Care Visits – within one (1) month of the request

• After-Hours, Weekends and Holiday Services:
  – To ensure accessibility and availability of care, PCPs must provide one of the following:
    • 24-hour answering service;
    • Answering system with an option to page the physician; or
    • A staff nurse with access to the PCP or on-call physician.
Child Health Check-UP

PCPs must offer Child Health Check-Up Services. A Child Health Check-Up is a comprehensive, periodic health screening consisting of the following services:

- Comprehensive health and developmental history (including past medical history, developmental history and behavioral health status)
- Comprehensive unclothed physical examination
- Developmental assessment
- Nutritional assessment
- Appropriate immunizations (based on recommended Childhood Immunization Schedule for the United States)
- Lab testing (blood and lead testing)
- Health Education
- Dental Screening (direct referral to a dentist for enrollees beginning at age three or earlier as indicated) and one fluoride varnishing treatment
- Vision Screening
- Described in Section 4 of the Provider Handbook
Vaccines For Children Program

• Providers are encouraged to participate in the Vaccines For Children Program (VFC) administered by the Department of Health Bureau of Immunization.

• The VFC program:
  – Provides vaccines at no charge to the physicians; and
  – Eliminates the need to refer children to County Health Departments for immunizations.

• Described in Section 4 of the Provider Handbook
Healthy Start Program

• The Plan must establish programs and procedures to improve pregnancy outcomes and infant health, including:
  – Coordination with the Healthy Start program
  – Immunization programs,
  – Referrals to Special Supplemental Nutrition Program for Women, Infants, and Children, and
  – Children’s Medical Services for children with special health care needs.

• Providers must offer Florida’s Healthy Start prenatal risk screening to each pregnant enrollee as part of her first prenatal visit.

• Described in Section 6 of the Provider Handbook
Going Digital

- The importance of functioning in an electronic environment.
- Encouraged… possibly mandated by Medicare and Medicaid.
- Provides platform for meeting meaningful use and patient centered medical home criteria.
- Facilitates improved HEDIS reporting and Medicare “Stars” requirements.
Electronic Health Record (EHR) Meaningful Use

As a result of the American Recovery and Reinvestment Act (ARRA) eligible Medicaid professionals and hospitals, are offered financial incentives, through Medicaid, for the implementation and meaningful use of certified health record technology in the management of patient populations.

- Florida’s Electronic Health Record Incentive Program has been helping doctors and hospitals to go digital since 2011.

- Through the Medicaid EHR Incentive Program incentive payments are available to Eligible Professionals (EPs) as they:
  - Adopt
  - Implement; or
  - Upgrade to certified EHR technology in their first year of participation.
Electronic Health Record (EHR) Meaningful Use

• Each stage of Meaningful Use includes a set of standards, implementation specifications, and certification criteria for EHR technology. The five priorities of Meaningful Use are:
  – Improving safety, quality and efficiency while reducing health disparities;
  – Engaging patients and families in their care;
  – Improving care coordination;
  – Improving population and public health;
  – Ensuring privacy and security of personal health information.

• Providers can choose Medicaid EHR Incentive Program or the Medicare EHR Incentive Program.

• Eligible professionals can only participate in one of the programs.

• If a professional chooses to participate in the Medicaid EHR Incentive Program, she/he can participate in only one state’s program in any given year.

To obtain additional information, visit the CMS website
or visit Florida Medicaid website http://ahca.myflorida.com/Medicaid/EHR/index.shtml
Direct Secure Messaging

You should enroll in the Florida Health Information Exchange Direct Secure Messaging (DSM) Service.

- DSM is a secure, encrypted email service that enables users to send and receive messages and attachments containing protected health information (PHI).
- DSM is free for you and your staff and does not require any special software.
- What are the benefits of DSM:
  - Secure and efficient method for two-way communication and transmission of protected health information (PHI)
  - Supports meaningful use by enabling electronic exchange of clinical information
- Who can use DSM:
  - Hospitals, surgery centers, SNFs, Community Mental Health Centers and Hospices
  - State agencies
  - Managed Care Organizations and their business associates
  - Individual providers and their staff
  - Other individuals that have a need to transmit PHI
Register for DSM

To register for and obtain additional information about DSM:

- Providers can visit the DSM registration website at: https://www.florida-hie.net

- An authorized representative (officer/organization director) will need to complete the Identity Verification form.
Health Services
Services that **DO NOT** Require Prior Authorization or QAF

- Visits for dermatology, podiatry, chiropractic, gynecological and well care
- Family Planning
- Participating office/free standing laboratory tests at labs consistent with CLIA guidelines
- Emergent transportation services
- Urgent or emergent care at participating Urgent Care centers or any Emergency Room
- County Health Departments (CHD), FederallyQualified Health Centers (FQHC), Rural Health Clinics and federally funded migrant health centers when providing certain services
A referral or prior notification is a request by a PCP or a participating specialist for a member to be evaluated and/or treated by a participating specialty physician and/or facility. The Plan uses two types of forms and processes:

- **Quick Authorization Form (QAF)**
  - Services included on the Quick Authorization Form (QAF) do not require a referral or authorization by the Plan.
  - Primary Care Physicians (PCP’s) can refer a member to a participating specialist and for many frequently requested services and procedures at free-standing facilities using the Plan’s Quick Authorization Form (QAF), without contacting the health plan for prior authorization.
  - The PCP or specialist ordering the consultation or test is required to fax or mail a copy of the completed QAF to the participating provider or facility that will be providing the service(s), or provide a copy to the member so that it is presented at the time of the service.

- **Described in Section 5 of the Provider Handbook**
Quick Authorization Form

No Prior Authorizations

Broad range of services and procedures that do not require prior authorization from PCP
Prior Authorizations

• Prior authorization (pre-service requests)
  – Allows for the use of quality, cost-efficient covered health care services
  – Helps to ensure that effective transition of care planning is done so that members receive
    the most appropriate level of care within the most appropriate setting.
  – Prior authorization must be obtained for all services not included on the
    Quick Authorization Form (QAF).

• Described in Section 5 of the Provider Handbook
Prior Authorization or Notification Process

- **Routine/Standard**
  - Requests are processed within seven (7) calendar days of the Plan receiving the authorization request and having received all supporting clinical information.
  - The timeframe may be extended up to seven (7) additional calendar days if enrollee or provider requests extension or additional information is needed.

- **Expedited/Urgent**
  - Requests are processed within forty-eight (48) hours of Plan receiving the request and having all supporting clinical information.
  - The timeframe may be extended up to two (2) additional business days if enrollee or provider requests extension or additional information is needed.

If the Expedited request requires immediate attention, where the 48 Hour Expedited time frame may jeopardize the Member’s health, PLEASE DO NOT FAX THE REQUEST. Call the Toll-Free Provider Services Telephone number: (877) 915-0551 Option 2.
Prior Authorization or Notification Process (cont’d)

- The Referral & Authorization Form must be accompanied by supporting clinical information for medical necessity determination.
- An authorization number will be provided, via fax, to the PCP, specialist and other provider(s) that will provide services to the member, when the request is completed and approved.
- All authorization requests and documentation of supporting clinical information will be entered and maintained within the Plan’s computer system for future reference and claims payment.

Prior Authorization Requests are to be made through the Plan’s UM Pre-Certification Department via the Provider Portal, Phone or Fax (800) 283-2117 (Simply) or (855) 461-0629 (Clear Health Alliance)

https://shpcws.tzghosting.net/tzg/cws/registration/registrationLogin2.jsp?pl=s hp
https://shpcws.tzghosting.net/tzg/cws/registration/registrationLogin2.jsp?pl=cha
**Prior Authorization Form**

### Request for Services Requiring Pre Authorization

**Telephone Number 1-877-915-0551, Option 2 / Fax 1-855-461-0629**

| Member Name: | | Member ID #: | | Member DOB: | | | | Telephone: ( ) |
| PCP ID #: | | PCP Name: | | | | | | Telephone: ( ) |

**Referring Physician Name:**

**Contact Person:**

**Referring Physician Telephone:**

**Referring Physician Fax Number:** ( )

**Appointment Date:**

**Request Type:** Standard

**IMPORTANT NOTE:**

- Is this request related to an accident? □ YES       □ NO
- Does this member have other insurance coverage? □ YES       □ NO

The following services require pre-authorization – please submit supporting clinical documentation to determine medical necessity:

#### Inpatient Services:

- Hospital Admissions
- Wound Care

#### Outpatient Services:

- Hospital
- Ambulatory Surgical Center
- Outpatient Services Performed at a Hospital:
  - Chemotherapy
  - Physical Therapy
  - Total OB Care
  - Sleep Studies
  - Wound Care
  - Speech, Occupational or Respiratory Therapies
  - Infusion Therapy
  - Infusion Therapy
  - Home Health Services

### SPECIAL NOTE:

- **PET Scans**
- **MRIs**
- **Hyperbaric Oxygen Treatment**
- **Medicare/DMEs**

**CPT Codes:**

**Diagnosis (ICD-9):**

**Referral to:**

**Referral to Provider ID #:**

**Referral to Fax #:** ( )

**In Network** ○ **Out of Network**

The reader of this fax is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution, or copying of this fax and attachments is prohibited. If you have received this fax in error, please notify the sender by calling the above number and destroy this message and attachments immediately. Jan 2014.

**PRIVACY NOTICE:** This communication, including attachments, is intended for the recipient(s) named above and may be used only by the intended recipient(s). If you are not the intended recipient(s), or an authorized agent of the intended recipient(s), please notify the sender by calling the above number and destroy this message and attachments immediately. Jan 2014.
Continuity of Care/ Care Coordination

- Medicaid recipients that enroll with the Plan may have been enrolled with another managed care plan, a PSN, or the state Medicaid or MediPass program.

- The Plan is responsible for:
  - The management and continuity of medical and behavioral health care for all enrollees.
  - Coordination of care for new enrollees transitioning into the Managed Care Plan.

- In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Plan will be responsible for the continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers.

- As a provider, we encourage you to help facilitate the continuity of care process by notifying us if you have a member with ongoing treatment needs. Please call us at (877) 915-0551 Option 2.
Continuity of Care/ Care Coordination (cont’d)

• The Plan will:
  – Provide continuation of services until the enrollee’s PCP or behavioral health provider reviews the enrollee’s treatment plan, which shall be no more than sixty (60) calendar days after the effective date of enrollment.
  – Maintain written care coordination/case management and continuity of care protocols.
  – Maintain written protocols for identifying, assessing and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care.
Case Management/ Care Coordination

Our protocols include:

• Assisting members with complex medical issues, high service utilizers and intensive healthcare needs by
  – Identifying, assessing and implementing specific health interventions.

• Conducting comprehensive assessments such as
  – health risk surveys
  – caregiver support
  – transportation needs
  – medication needs
  – educational needs

• Implementing specific interventions
  – Incorporate evidence based guidelines
  – Identify co-morbid mental health status issues
  – Coordinate with the PCP
Case Management / Care Coordination (cont’d)

- Implementing specific interventions (cont’d)
  - Referral and Appointment assistance
  - Specialty care services
  - Transportation services
  - Services identified through a CHCUP screening
  - Determination of community non covered services including:
    - WIC, Health Start or others
    - Outreach and case management program for pregnant members
    - Helping mom select PCP for unborn child in third trimester

- Coordinating hospital/institutional discharge planning

- Monitoring members with ongoing medical conditions to coordinate services for routine and community services

- Coordinating the member’s behavioral health services
• The Plan shall be responsible for the provision of medically necessary behavioral health evaluation and treatment services to enrollees regardless of settings.

• Services in long-term care settings will require coordination with other entities including LTC Managed Care Plans and providers, Medicare plans and providers, and state-funded programs and services.

For a complete review of the Care Coordination program please visit our website or download a copy of our Provider Handbook at:

www.simplyhealthcareplans.com

www.clearhealthalliance.com
Coordination of Behavioral Health Services

• Behavioral health referrals and services are coordinated through Psychcare. Providers are encouraged to contact Psychcare when looking to refer a member:

  Toll Free: 1-800-221-5487
  Via the web at www.psychcare.com,
  or
  Use the PsychCare Referral Form (Found on the web in the Forms Section)
  Fax at: (800) 370-1116

• If a member was receiving mental health or psychiatric treatment before joining the Plan, please call Psychcare or Provider Services at 877-915-0551, option 2, so that the care is not interrupted.
We Need Your Help!!

• Providers (PCPs or Obstetricians) should notify the Plan of any pregnant member within 2 business days of the first prenatal visit and/or positive pregnancy test. This will assist in the following:
  – Identifying members for inclusion in the Prenatal Program.
  – Identifying potential High Risk OB members who may benefit from the High-Risk Pregnancy Program.

• Providers must complete the Pregnancy Notification Form, whether the pregnancy was identified through medical history, examination, testing or otherwise.

Please go to our website to download the form:

http://www.simplyhealthcareplans.com/providers

http://www.clearhealthalliance.com/providers.html
Disease Management

• In addition to the Care Management Programs the Plan has disease management programs to assist the member when they have the following conditions;
  – Cancer
  – Diabetes
  – Asthma
  – Congestive Heart Failure
  – Hypertension
  – HIV/AIDS
  – OB/Pregnancy

• If you have members that could benefit from one of these programs please contact your representative to learn more.
Pharmacy
Prescription Drug Benefit Overview

- The Plan provides coverage of preferred drugs through the prescription drug program.
- The goal of the Plan’s prescription drug program is to provide safe, appropriate, accessible, and cost effective drugs to its members.
- The Pharmacy Services Department operates to ensure positive drug therapy outcomes for its members by working in collaboration with plan providers and members.
Medicaid Preferred Drug List (PDL)

- During the first year of operation, the Plan will use AHCA’s Medicaid Preferred Drug List.

- The formulary will be developed and programmed utilizing the complete Medicaid drug file containing all covered NDCs and drug coverage programming.

- Prior authorization, step therapy, and protocols will not be more restrictive than those listed on AHCA’s website.
Extensive Drug Formulary

• All Anti-Retroviral Medications/HIV Regimens including latest FDA approved STRIBILD and TIVICAY (Not yet in Medicaid Formulary)

• Support available by Clinical Pharmacist

• Extensive network of pharmacies available (Open Pharmacy)—Retail pharmacies like Walgreens, Commcare, etc. including clinic-based pharmacies contracted with Plan

• Available at www.simplyhealthcareplans.com and www.clearhealthalliance.com
Prior Authorization (PA)

- To ensure appropriate utilization, selected medications may require authorization to be eligible for coverage.
- These drugs are designated in the Formulary List by (PA).
- In order for a patient to receive coverage for a medication requiring authorization, the physician or their designee must provide information to the Plan’s Pharmacy Services Department for pharmacy and medical review by completing and faxing a Prior Authorization Request Form.
Quantity Level Limits (QL)

• For certain drugs, we limit the amount of the drug that the Plan will cover. These are controls placed on the quantity of certain drugs prescribed.

• Quantity Level (QL) limits will determine the number of pills, tablets, etc. dispensed when a member fills a prescription.

• These quantities are determined by the Pharmacy & Therapeutics Committee and are based on FDA-approved guidelines for dosage and administration of drugs.

• The Plan provides 30-day supply for medications.

• A member or a member’s physician may request an exemption for a drug with a Quantity Limit (QL) restriction by submitting a Prior Authorization Request Form.
Some drugs require another drug to be used first in order to be eligible for coverage. This is called Step Therapy Protocol (STP).

- A member or a member’s physician may request an exemption for a drug that requires Step Therapy.
- The member’s physician must submit a Prior Authorization Request Form to be reviewed by Pharmacy Services and the Medical Director.
Authorization Request Review

- **Standard Timeframes and Notice Requirements for Authorization Requests:**
  - Upon receipt of an Authorization Request, the plan will notify the requestor of the decision verbally and follow up with written notification no later than 72 hours after the receipt of the request.
  - For expedited requests the Plan will notify the requestor of the decision verbally and follow up with written notification no later than 24 hours after the receipt of the request.

- **Authorization Approval/Denial Process:**
  - Upon approval, an approval letter will be sent to member’s prescriber.
  - Upon denial, a denial letter will be sent to the member and the prescriber.
    The denial notice will include reason for the denial, information about the right to appeal.
Claims/EFT Process
Claims Overview

The primary focus of our Claims Department is to process claims in a timely manner. We strive to follow AHCA guidelines for processing claims and payment. These guidelines are contained in the AHCA Provider Handbook or may be viewed online by going to AHCA’s website:


Claims Submission:

- Claims may be submitted to the Plan electronically or, if necessary, via paper forms CMS-1500 or UB-04.

  Electronic Submission:
  - Availity - Payor ID #00199
  - Emdeon - Payor ID #27094

  Paper submission may be sent to:
  - Simply Healthcare Plans or Clear Health Alliance
  - Attn: Claims Department
  - PO Box 21535 • Eagan, MN 55121

Described in Section 16 of the Provider Handbook
Methods of Reimbursement

- The Plan offers Electronic Funds Transfer (EFT) and Virtual Credit Card (VCC) services via Emdeon.

- The EFT and VCC process optimizes cash flow by having faster access to funds.
  - If you are a participating provider you can receive payments via your preferred method.
  - If you are not registered with Emdeon and have a Point of Sale Device, you will receive payments via the VCC process.
  - If you are not registered with Emdeon and do not have a Point of Sale Device you will receive a paper check.

- Providers can register by enrolling in Emdeon ePayment with three (3) easy steps:
  1. Pick an enrollment method and initiate enrollment by:
     - Enrolling online; or
     - Completing the Emdeon ePayment Enrollment and Authorization Form
  2. Confirm Deposit to Verify Account
  3. Start using Emdeon Payment Manager to Search, View, Download and print electronic remittance advice (ERAs)
Provider Portal

Provider Portal Features:

- Register Provider
- Check Member Eligibility
- Search for Claims Status
- Submit Referral/Authorization
- Search Referral/Authorization Status
- Download PCP Roster

To learn more, go to:

www.simplyhealthcareplans.com and click the Providers tab
www.clearhealthalliance.com and click the Providers tab
Grievance and Appeals
Grievance and Appeals Program

The Plan's Provider Grievance and Appeals program provides network providers the opportunity to express dissatisfaction about authorization/referrals and claims determination and to request a re-review and re-determination on the initial adverse decision made, as well as about any other administrative complaints you may have.

• **Complaints** – Plan providers may contact us via telephone, electronic mail, regular mail or in person to file a provider complaint.
  
  – Providers are encouraged to first communicate any concerns or dissatisfaction about the Plan’s process or decision verbally through the Provider Services Helpline at: **(877) 915-0551 Monday – Friday 8:00am – 7:00pm EST**
  
  – A complaint is not considered formal until it is written and signed by the provider.

• **Grievance** - Plan providers may express dissatisfaction about a service/administrative issue.
Grievance and Appeals Program

• Appeals – Plan network providers may appeal an authorization, referral or claim determination and request a review and redetermination on the initial adverse decision made. Providers may submit written appeals to the plan.
  – Within 45 days from the denial disposition on a referral, authorization, grievance adverse determination;
  – Within 1 year (365 calendar days) from the date of service for a claim adverse decision.

• For more detailed information about grievance and appeals please refer to your Provider Handbook.

Written grievances and/or appeals must be sent to the following address:
Simply Healthcare Plans/Clear Health Alliance
Attn: Provider Appeals Coordinator
1701 Ponce de Leon Blvd
Coral Gables, FL 33134-4414
Toll Free Fax: (877) 577-0114
Cultural Competency
Cultural Competency Plan

We are committed to ensuring that services are provided in a culturally competent manner to all enrollees, including all services and settings for those with limited English proficiency.

- You are responsible for adhering to the standards of our Cultural Competency Program.
  - Providers can review additional information on SHP CCP and Standards on our website: [http://www.simplyhealthcareplans.com](http://www.simplyhealthcareplans.com)
  - Providers can also review standards and additional information on The Office of Minority Health website: [http://minorityhealth.hhs.gov/templates/browse.aspx](http://minorityhealth.hhs.gov/templates/browse.aspx)

- Sensitivity training is offered to our CHA Providers. Contact your provider representative for more information.
Provider Marketing Do’s and Don’ts
Provider Marketing Do’s and Don’ts

Healthcare providers MAY

- Make available or distribute Managed Care Plan marketing material in their offices as long as you display all plans in which you participate.
- May refer your patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
- Share information with patients from the Agency or CMS website.
- Display posters or other materials in common areas, such as the provider’s waiting room.
- To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so.
- Should the recipient seek advice, provider may engage in discussions with recipient.
- Announce a new affiliation with a health plan within 30 days of the new provider agreement.
- May announce new or continuous affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).
- May make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
- Additional direct mail or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.
- Any affiliation communication materials that include Managed Care Plan specific information (e.g., benefits, formularies) must be prior approved by AHCA.
Provider Marketing Do’s and Don'ts

Healthcare providers MAY NOT

- Offer marketing/appointment forms
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of the Managed Care Plan
- Offer anything of value to induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in the Managed Care Plan.
- Conduct health screenings as a marketing activity.
- Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
- Distribute marketing materials within an exam room.
- Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.
Fraud and Abuse
What is Fraud and Abuse?

- **Fraud** refers to a false action that is used to gain something of value (Example: Billing for services that were not provided)

- **Abuse** refers to incidents or practices that are inconsistent with sound and accepted medical, business or fiscal procedures (Example: Services that are not needed)
Responsibilities

The Plan

• has policies and procedures for prevention, detection, reduction, correction and reporting of healthcare fraud and abuse in compliance with all state and federal requirements
• is obligated to report any suspected cases.

Providers

• should comply with all applicable laws and regulations
• must ensure that they complete Fraud and Abuse Training and educate their staff
• should report violations and suspected violations on the part of any entity providing care or services to our members.

The Bureau of Medicaid Program Integrity wants to prevent Fraud and Abuse. They check on providers who may be trying to commit fraud with the Medicaid Program.
Reporting Fraud and Abuse

What You Can Do

• If you think an individual or provider is committing fraud or abuse we encourage you to report it to the Plan’s hotline or to our Special Investigations Unit.
• The Plan’s hotline is available 24 hours a day, 7 days a week.
• Callers do not need to give their names. All calls are investigated and remain confidential.

  Toll-free hotline: 1-877-253-9251
  Email: SIU@simplyhealthcareplans.com or SIU@clearhealthalliance.com

Attorney General’s Fraud Rewards Program

• Must result in a fine, penalty, or forfeiture of property from a doctor or other health care provider
• Report by phone to 1-866-966-7226 (toll-free) or 850-412-3990.
• Reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case

You can talk to the Attorney General's Office about keeping your identity confidential and protected.
Reporting Fraud and Abuse

- Providers can also report suspected cases of fraud and abuse directly to the agencies listed below:
  - To report suspected fraud and/or abuse in Florida Medicaid, you may contact the Consumer Complaint Hotline
    **Toll-free: 1-888-419-3456**
    or
  - Complete a Medicaid Fraud and Abuse Complaint Form which is available online
Reference Documents

The following links can be accessed from our websites:

- Provider Manual
- Provider Portal
- AHCA Provider Handbooks
- Quick Authorization Form (QAF)
- Quick Reference Guide (QRG)
- Forms
- Florida Managed Medical Assistance Program: Program Overview
- www.simplyhealthcareplans.com
- www.clearhealthalliance.com
Web Site/Resources
Web Site/Resources
Questions