Dear Provider:

Please allow us to extend a personal greeting in welcoming you to Simply Healthcare Plans. Attached you will find your Simply Healthcare Plans, Inc. (SHP) Provider Handbook that has been written to specifically meet the requirements to administer the Plan’s products, services, policies and procedures and to supplement the provider agreement.

Simply Healthcare Plans is a health maintenance organization (HMO) that has a contract with the the Center for Medicare and Medicaid Services (CMS) to provide the health needs of Medicare beneficiaries enrolled with our plan.

Medicare is a health insurance program for people age 65 or older, under age 65 with certain disabilities, and all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

SHP offers an appropriate and accessible range of preventive, primary care, and specialty services to meet the needs of its Medicare enrollees, and maintains a sufficient number, mix and geographic distribution of providers. It is a prepaid, comprehensive system of health care delivery.

We have designed this handbook to assist you in the processes that include your responsibilities as a Primary Care Physician (PCP), as a specialist or vendor, as well as protocols for prior authorization and referrals, medical necessity standards and practice protocols, including guidelines that address treatment of chronic and complex conditions, covered and emergency services, claims and encounter submissions, member rights and responsibilities and many other important functions and information. It is all outlined for you in the Table of Contents.

There are times when updates to this handbook may be required, due to regulatory changes or internal policy revisions/updates. When this occurs we will advise you if it is a new (add) or revised (replace) change - you will simply have to add or replace the specific information in the handbook.

You may request additional copies of the Handbook at no charge from your Provider Relations representative. The Handbook is also available in our website at www.simplyhealthcareplans.com, located within the Provider section.

Thank you for actively participating in the delivery of quality health care services to our members. We encourage you to contact us if you have any suggestions for improving the services that we provide.

Sincerely,

Simply Healthcare Plans, Inc.

2016
Simply Healthcare Plans Mission Statement

To strive to improve the quality of life and health care of our members through our commitment to member satisfaction, professional excellence and service to our members in a caring and compliant manner.
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<th>Department</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Provider Relations Department</td>
<td>9250 W. Flagler Street, Suite 600</td>
</tr>
<tr>
<td></td>
<td>Miami, FL 33174-3460</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-877-915-0551 Option 4</td>
</tr>
<tr>
<td></td>
<td>Fax number: 786-441-4601</td>
</tr>
<tr>
<td>Member Services Department</td>
<td>9250 W. Flagler Street, Suite 600</td>
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<tr>
<td></td>
<td>Miami, FL 33174-3460</td>
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<tr>
<td></td>
<td>Phone: 1-877-577-0115</td>
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<tr>
<td></td>
<td>Fax number: 305-401-4600</td>
</tr>
<tr>
<td>Utilization Management:</td>
<td>9250 W. Flagler Street, Suite 600</td>
</tr>
<tr>
<td>Referrals/Pre-Certification</td>
<td>Miami, FL 33174-3460</td>
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<tr>
<td>Special Information:</td>
<td>Phone: 1-877-915-0551 Option 2</td>
</tr>
<tr>
<td></td>
<td>Fax number: 1-800-283-2117</td>
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<tr>
<td>Care Management Services</td>
<td>9250 W. Flagler Street, Suite 600</td>
</tr>
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<td></td>
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<tr>
<td></td>
<td>Phone: 1-855-431-1606</td>
</tr>
<tr>
<td></td>
<td>Fax number: 786-441-4607 or 1-877-577-0117</td>
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<tr>
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<td>Inpatient Services</td>
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<td></td>
<td>Auth Request Fax number: 1-800-283-2117</td>
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<tr>
<td></td>
<td>Clinical Information Fax number: 305-408-5882</td>
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<td>Pharmacy Department</td>
<td>9250 W. Flagler Street, Suite 600</td>
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<tr>
<td></td>
<td>Phone: 1-877-915-0551 Option 5</td>
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<tr>
<td></td>
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<td>Claims Department</td>
<td>Simply Healthcare Plans, Inc.</td>
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<tr>
<td></td>
<td>Attn: Claims</td>
</tr>
<tr>
<td></td>
<td>PO BOX 21535</td>
</tr>
<tr>
<td></td>
<td>Eagan, MN 55121</td>
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<tr>
<td></td>
<td>Phone: 1-877-915-0551 Option 3</td>
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<td>Behavioral Health Services</td>
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<td><a href="https://www.beaconhealthoptions.com">https://www.beaconhealthoptions.com</a></td>
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<tr>
<td></td>
<td>10200 Sunset Drive</td>
</tr>
<tr>
<td></td>
<td>Miami, FL 33173</td>
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<tr>
<td></td>
<td>• Toll-Free Telephone Number: 1-800-221-5487</td>
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<tr>
<td></td>
<td>• Toll-Free Fax Number: 1-800-370-1116</td>
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<td></td>
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<td><a href="http://www.beaconhealthstrategies.com">www.beaconhealthstrategies.com</a></td>
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<tr>
<td>Toll-Free Telephone Number: 1-877-468-5581</td>
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<tr>
<td>Provider Toll-Free Fax Number:</td>
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<tr>
<td>Authorizations &amp; Referrals (Standard):</td>
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<tr>
<td>888-313-2883 or 262-241-7150</td>
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<tr>
<td>Authorizations &amp; Referrals (Emergency): 262-387-3736</td>
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<td>Claims: 262-834-3452</td>
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<td>Credentialing: 262-241-4077</td>
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<tr>
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<tr>
<td>Toll-Free Fax Number: 262-387-3735</td>
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<tr>
<td>Member Portal Information: <a href="http://www.dentaquest.com/state-plans/regions/florida/flmemberpage">http://www.dentaquest.com/state-plans/regions/florida/flmemberpage</a></td>
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<th>Laboratory Services</th>
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<tr>
<td>Toll-Free Telephone Number: 1-866-697-8378</td>
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<tr>
<td>Website: <a href="http://www.questdiagnostics.com">http://www.questdiagnostics.com</a></td>
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<tr>
<td>Local Telephone Number: 1-561-455-9002</td>
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<tr>
<td>Provider Toll-Free Fax Number: 1-800-523-3788</td>
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<td>Provider Portal Information: <a href="http://www.premiereyecare.net">www.premiereyecare.net</a></td>
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<th>Access2Care (Central Florida)</th>
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<tr>
<td></td>
<td>• Toll-Free Telephone Number: 1-866-411-8914</td>
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<tr>
<td></td>
<td>• Website: <a href="http://www.access2care.net/">http://www.access2care.net/</a></td>
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<td>• Toll-Free Telephone Number: 1-888-326-0388</td>
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<th>Grievance &amp; Appeals Department</th>
<th>9250 W. Flagler Street, Suite 600</th>
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<tr>
<td></td>
<td>Miami, FL 33174-3460</td>
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<td>Phone: 1-877-577-0115</td>
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<td>Fax number: 305-408-5880</td>
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<th>Credentialing Department</th>
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<td>Miami, FL 33174-3460</td>
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<td></td>
<td>Phone: 1-877-915-0551 Option 4</td>
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<td>Fax number: 305-408-5887</td>
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<th>Fraud Waste and Abuse Reporting</th>
<th>9250 W. Flagler Street, Suite 600</th>
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<tr>
<td></td>
<td>Miami, FL 33174-3460</td>
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<tr>
<td></td>
<td>Phone: 1-866-847-8247</td>
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<td></td>
<td>Fax number: 305-408-5858</td>
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Responsibilities of Health Plan – Reference **Policy # ADM001**

Contract Requirement through Policies, Standards and Manuals – Reference **Policy#: PR002-SHP**
Section 2. Member Enrollment, Eligibility and Disenrollment

Member Eligibility and Enrollment
Medicare beneficiaries are eligible to enroll in a Medicare Advantage Plan with Part D if they are entitled to Medicare Part A, enrolled in Medicare Part B and eligible for Medicare Part D.

Member Eligibility
Simply Healthcare Plans (SHP) provider contracts place the responsibility for eligibility verification on the provider rendering those services. A member's eligibility status can change at any time.

Providers may confirm current eligibility through the following processes:
- Access the SHP website at www.simplyhealthcareplans.com,
- Under “Providers” login to our Provider Portal and request eligibility information.
- For any questions, contact the SHP Member Services Department at 1-877-577-0115.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is never a guarantee of coverage or payment. See your Provider Agreement for additional details.

Providers should consider requesting and copying a member’s identification card, along with additional proof of identification, such as a photo ID, and file them in the patient’s medical record.

Ineligible for Membership
The following categories of recipients who are ineligible for membership:
- Individuals who are medically determined to have ESRD prior to completing the health plan enrollment election.
- Individuals enrolled in a Medicare PDP (Prescription Drug Plan) cannot be simultaneously enrolled in an MA-PD (Medicare Advantage Prescription Drug) Plan.
- Individuals residing outside of the health plan’s service area.
- Individuals who do not agree to abide by the rules of the plan.
- Individuals not enrolled with both Medicare Part A, Part B and Part D.
- Individuals who are not lawfully present in the United States or when the beneficiary lives abroad.

Assignment of Primary Care Physician
Each member selects a Primary Care Physician (PCP) upon enrollment. The PCP functions as a “gatekeeper” arranging for all of the member’s healthcare needs for primary, specialty and ancillary services by promoting quality and continuity of care.

Member Listing
The PCP office will receive a monthly active member listing by the end of the first week of each month. The list consists of those Simply Medicare members who have chosen the PCP office to provide them with PCP services. Please verify that all Medicare patients receiving treatment in your office are on your membership listing. If you do not receive your list by the date mentioned above, please contact your assigned Provider Service Executive. If there are any questions regarding a patient’s eligibility, please contact Simply’s Provider Operations Department at the number in the Key Contact List.

Inpatient Hospital Services
Inpatient hospital services include all items and medically necessary services which provides appropriate care during a stay in a participating hospital. These services include room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. Simply Healthcare Plans shall be responsible for Part A inpatient care to members who at the time of disenrollment are under inpatient care until the time of his/her discharge.
Simply Healthcare Plans shall not be responsible for coverage of Part A inpatient services for inpatient care already being provided at the time of enrollment of a member. The hospital would have to bill either the member insurance carrier prior to Simply Healthcare Plans or Medicare directly.

**Simply Healthcare Plans Member Identification Card**

Member identification cards are intended to identify plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member’s name, identification number, Primary Care Physician’s name and telephone number, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for verification of the current eligibility of the cardholder.

Please refer to SAMPLE Simply Healthcare Plans Member Identification Card:

![Sample Card Image]

**Enrollment Options for Medicare Beneficiaries:**

- Enroll in a Medicare Advantage Plan that has prescription drug coverage (MAPD);
- Enroll in a standalone Prescription Drug Plan (PDP) for the prescription drug coverage, and receive health care coverage from traditional Medicare;
- Enroll in a Medicare Advantage Plan (MA) that doesn’t have prescription drug coverage.
- Enroll in a Medicare Supplement Insurance (Medigap) policy.

There are six (6) types of Election Periods during which individuals may make enrollment changes for MA plans:

- The Annual Election Period (AEP);
- Initial Enrollment Period for Part D (IEP for Part D);
- The Initial Coverage Election Period (ICEP);
- The Open Enrollment Period for Institutionalized Individuals (OEPI);
- All Special Election Periods (SEP); and
- The Medicare Advantage Disenrollment Period (MADP).

**Annual Election Period (AEP)**

AEP is from October 15th through December 7th of each year. During the AEP the member may enroll or disenroll from an MA plan. Changes made would take effect January 1st of the following year.

**Initial Enrollment Period for Part D (IEP for Part D)**

The Initial Enrollment Period for Part D (IEP for Part D) is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when he or she is entitled to Part A OR is enrolled in Part B, AND permanently resides in the service area of a Part D plan.
Initial Coverage Election Period (ICEP)
The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual’s first entitlement to both Medicare Part A and Part B and ends on the later of:

1) The last day of the month preceding entitlement to both Part A and Part B, or;
2) The last day of the individual’s Part B initial enrollment period.

The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.

Special Enrollment Periods (SEP)
Special election periods constitute periods outside of the usual IEP, AEP or MADP when an individual may elect a plan or change his or her current plan election.

- Change in Residence
- MA contract violation, MA Non-renewal or Terminations
- SEPs for Exceptional Conditions, Employer/Group Health Plan
- Individuals who disenroll if CMS sanctions an MA plan
- Individuals enrolled in Cost Plans that are Non-renewing their contracts
- Individuals in the Program of All-Inclusive Care for the Elderly (PACE)
- Dual-Eligible individual(s) or individuals who lose their dual-eligibility
- Individuals who dropped a Medigap Policy when they are enrolled for the first time in an MA plan, and who are still in a “trial period”
- Individuals with ESRD whose entitlement determination is made retroactively
- Individuals whose Medicare entitlement determination is made retroactively
- MA SEPs to Coordinate with Part D Enrollment Periods
- Individuals who have an involuntary loss of creditable coverage, not including a loss due to failure to pay plan premiums
- Individuals who lose Special Needs Status
- Individuals who belong to a Qualified State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility
- Non-Dual Eligible Individuals with LIS (Low Income Subsidy) and Individuals who lose LIS
- Enrollment into a Chronic Care SNP (Special Needs Plan) and Individuals Found Ineligible for a Chronic Care SNP
- Disenrollment from Part D to Enroll in or Maintain other Creditable Coverage
- Enrollment in an MA plan or PDP with a Plan Performance Rating of five (5) stars
- SEP for Non-U.S. Citizens who become Lawfully Present
- SEPs for Beneficiaries Age 65
- Individuals entering, residing or leaving a long term care facility

Note: Unless they show proof of “creditable coverage”, people with Medicare who do not enroll in a drug plan when they are first eligible will likely have to pay a penalty if they choose to enroll in a drug plan later.

Medicare Advantage Disenrollment Period (MADP)
MA plan enrollees have an annual opportunity to prospectively disenroll from any MA plan and return to Original Medicare between January 1st and February 14th of every year. The effective date of a disenrollment request made using the MADP will be the first of the month following receipt of the disenrollment request. A request made in January will be effective February 1st, and a request made in February will be effective March 1st.

Simply’s Medicare Advantage Plans
- Simply More: The traditional Medicare Advantage Plan that offers a comprehensive array of benefits specially designed to fit your healthcare needs
- Simply Extra: Our Premium Give-Back plan offers benefits and services above traditional Medicare with a Part B premium reduction of up to $59.50.
• Simply Complete: It is our Dual Special Needs Plan (D-SNP), a specialized Medicare plan which benefits are designed for people with special healthcare needs. The members must have Medicare and Medicaid. The care and coordination of care for these members is guided through the Model of Care of this Plan; our care managers assist the members obtaining benefits from both sources.

• Simply Comfort: It is our Institutional Equivalent Special Needs Plan (IE-SNP) for eligible individuals living in the community who require and institutional level of care based on the State of Florida’s CARES assessment. This type of Special Needs Plans may restrict enrollment to individuals who reside in an ALF (Adult Living Facility) if necessary, to ensure uniform delivery of specialized care. The care and coordination of care for these members is guided through the Model of Care of this Plan. If you are a provider for this plan, you have or will receive training on the IE-SNP Model of Care.

• Simply Care: It is an Institutional SNP (I-SNP) for eligible individuals designed for people who live in an institution or who need a level of care that is usually provided in a nursing home. Its benefits are designed for people with special healthcare needs. The care and coordination of care for these members is guided through the Model of Care of this Plan.

Please note that benefits vary in each different plan.
Section 3. Marketing Guide

Specific Guidance about Provider Promotional Activities

Refer to the Chapter 3: Medicare Marketing Guidelines, § 70.11.1 to § 70.11.5 for more detailed information. As used in specific guidance about provider activities, the term “provider” refers to all providers contracted with Simply Health Plans (SHP) and their sub-contractors, including but not limited to: pharmacists, pharmacies, physicians, hospitals, and long term care facilities. Simply shall ensure that any provider contracted with the plan (and its sub-contractors) performing functions on the plan sponsor's behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agrees to the same restrictions and conditions that apply to Simply through its contract, and shall prohibit them from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of providers, offered either by Simply or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents).

CMS is concerned with the provider activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan vs. acting as the beneficiary's provider.
- Providers may face conflicting incentives when acting as a plan representative.

It is recognized that plan sponsors have agreements with providers in connection with plan activities and it is expected that those agreements address marketing activity in a manner consistent with Medicare regulations. This includes ensuring that if a provider advertises non-health related items or services, the advertisement makes it clear that those items/services are not covered by the plan sponsor. To the extent that the plan sponsor ensures that a provider assists a beneficiary in an objective assessment of his/her needs and potential options to meet those needs, the plan sponsor may use providers for such activities. Providers may engage in discussions with patients should a patient seek advice and providers must remain neutral when assisting with enrollment decisions and you cannot:

- Offer scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade patients to enroll in a specific plan based on financial or any other interests
- Mail marketing materials on behalf of plan sponsors
- Offer anything of value to induce plan enrollees to select them as their provider
- Offer inducements to persuade patients to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities
- Distribute materials/applications within an exam room setting

Providers are allowed to:

- Provide the names of Plans/Part D Sponsors with which they contract and/or participate
- Provide information and assistance in applying for the LIS
- Make available and/or distribute plan marketing materials in common areas
- Refer your patients to other sources of information, such as SHIPs, plan marketing representatives, the State Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/ or 1-800-MEDICARE

Share information from CMS’ website, including the “Medicare and You” Handbook or “Medicare Options Compare” (from http://www.medicare.gov), or other documents that were written by or previously approved by CMS.
Following are requirements associated with provider activities. The plan sponsor shall ensure that any provider contracted with the plan (and its subcontractors) complies with these requirements:

1. **Provider Activities and Materials in the Health Care Setting**
   Beneficiaries often look to their health care professionals to provide them with information regarding their health care choices. To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary’s needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MA-PD enrollment applications). However, providers cannot accept enrollment applications.

   Providers also cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

   Providers may inform prospective enrollees where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, http://www.medicare.gov, or 1-800-MEDICARE.

   The “Medicare and You” Handbook or “Medicare Compare Options” (from http://www.Medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plans should advise co-contracted providers of the provisions of these rules.

2. **Plan Activities and Materials in the Health Care Setting**
   Plans or plan agents may conduct sales activities in health care settings as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services from or interact with pharmacy providers and obtain medications.

   Plans are prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients primarily receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, pharmacy counter areas (where patients interact with their clinical team and receive treatment) and dialysis center treatment areas (where patients interact with their clinical team and receive treatment).

   The prohibition against conducting marketing activities in health care setting extends to activities planned in these settings outside of normal business hours.

   Only upon request by the beneficiary are plan sponsors permitted to schedule appointments, only with beneficiaries residing in long-term care facilities. Providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or facilities distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials they should do so knowing it must accept future requests from other plan sponsors with which it participates. Providers are also permitted to display posters or other materials in common areas such
as the waiting room. Additionally, plan sponsors may provide materials to long-term care facilities to provide materials in admission packets announcing all plan contractual relationships.

SNP plans may provide to long term care facility staff, for distribution to residents that meet the I-SNP criteria, an explanatory brochure for each I-SNP with which the facility contracts. The brochure may have a reply card or telephone number for the resident or responsible party to call to request a meeting or to receive additional information.

3. Provider Affiliation Information

Providers may announce new affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., radio, television or websites). New affiliation announcements are those providers who have entered into a new contractual relationship with Simply. Providers may make a new affiliation announcement once, within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one plan may occur only once when, such announcement is conveyed through direct mail, email, telephone or advertisement and patients do not need to be notified that other plans are accepted. Continuing Affiliation announcements may be made through direct mail, email, phone or advertisement from providers to their patients and must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates.

4. SNP Provider Affiliation Information

Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider’s affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and may include specific information about the SNP and must include the appropriate disclaimer (refer to section 50 on the Marketing Guidelines for appropriate disclaimer). This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

5. Comparative and Descriptive Plan Information

Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plans must determine a lead plan to coordinate submission of these materials to CMS for review.

6. Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service Providing Third-Party

Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party (e.g., SHIPs, State agency or independent research organizations that conduct studies). For more information on non-benefit/non-health service providing third party providers refer to section 40.8.3 in the Medicare Marketing Guidelines.

Sample Can/Cannot List for Provider Interactions with Potential Plan Enrollees:

Providers contracted with plans (and their subcontractors) can:

- Provide the names of health plans with which they contract and/or participate (See “Provider Affiliation Information” for additional information on affiliation).
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
• Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as the providers offer the option of making available and/or distributing marketing materials to all plans with which they participate.
• Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Offices, CMS’s Web site at http://www.medicare.gov/, or calling 1-800-MEDICARE.
• Print out and share information with patients from CMS’s Web site.

Providers contracted with plans (and their contractors) cannot:
• Mail marketing materials on behalf of plan sponsors.
• Distribute materials/applications within an exam room setting
• Offer scope of appointment forms
• Accept Medicare enrollment applications
• Make phone calls or direct, urge or attempt to persuade patients to enroll in a specific plan based on financial or any other interests
• Offer anything of value to induce plan enrollees to select them as their provider
• Offer inducements to persuade patients to enroll in a particular plan or organization
• Conduct health screening as a marketing activity
Accept compensation directly or indirectly from the plan for beneficiary enrollment activities
Section 4. Provider Responsibilities

Overview
This section of the Provider Handbook addresses the responsibilities of Simply Healthcare Plans (SHP) participating physicians, which will include standards that address non-discrimination, access to care, Primary Care Physician (PCP) offices Plan services, PCP responsibilities, member confidentiality, medical record documentation, member outreach information, and others.

Non-Discrimination
In applying all of the expected standards identified in this section, participating providers agree to adhere to non-discrimination against any member and that all members will receive fair and consistent treatment regardless of:

- Race, Ethnicity, National origin, Religion or Genetic information
- Sex or Sexual orientation
- Mental or physical disabilities
- Age
- Source of payment

Access to Care
The Plan is committed to ensure that members are provided timely access to care. To ensure that all health care services are provided in a consistent, timely manner Primary Care Physician (PCP) or designated covering health care provider must be available twenty-four (24) hours a day/seven days a week/365 days a year, for members requiring emergency services. This access availability may be provided by telephone. PCP responsibility includes any member that is assigned as a patient to him/her. Access standards are noted below:

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Access to Care Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Care Visit</td>
<td>Within one (1) month of the initial request</td>
</tr>
<tr>
<td>Routine Sick Care</td>
<td>Within one (1) week of the initial request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within one (1) day of the initial request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Available by telephone 24/7/365</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room</td>
</tr>
</tbody>
</table>

The Plan routinely monitors providers’ adherence to access –to-care standards and appointment wait times through secret shopper calls. Providers not meeting one or more of these standards will receive an in-service. We will re-audit to assure compliance. Continued noncompliance will result in the request for a corrective action plan.

*In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Support from SHP to the PCP Offices
SHP will provide support to its participating PCP offices in the form of services including, but not limited to:

- Support from Provider Relations, Member Services, Utilization Management, Claims, Community Outreach, Care Management, Disease Management, Chronic Care Improvement Program
- Information and assistance with care managing your members, including discharge planning
- Access to available health care resources through the Plan’s participating network of providers, hospitals, and ancillary services

Primary Care Physician (PCP) Responsibilities
The following is a summary of responsibilities that are required of PCP’s providing services to Simply Healthcare Plans members:

- Ensure 24/7/365 availability as outlined in the Access to Care section noted above
• Identify, coordinate, and supervise the delivery and transition of care needs/services to each SHP member
• Ensure newly enrolled members receive an initial office visit and health assessment within ninety (90) days of enrollment in the Plan and assignment to the PCP
• Maintain a ratio of members to full-time equivalent (FTE) health care providers, as follows:
  • One (1) FTE physician per 1,500 Simply members
  • One (1) Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) for every 750 Simply members above 1,500 members
• Ensure members utilize Plan participating network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
• Provide preventative healthcare screening services, as per nationally recognized guidelines/protocols—see links in this Handbook
• Practice according to nationally recognized, evidence-based guidelines. Links to some guidelines are provided on this Handbook
• Have a procedure for non-compliant members: medical record documentation of verbal or written notification to the member
• Provide regular appointments for adult healthcare, assessments, and treatment, as indicated, or upon request for members.
• Ensure members are aware of the availability of medical non-emergency transportation and/or public transportation, where available, by contacting Member Services for assistance.
• Ensure translation services are available for those members requiring translation needs, including members requiring services for the deaf, by contacting Member Services for assistance.
• Ensure members are aware of available community services/resources by contacting Member Services or a Care Manager
• Provide access to the Plan, or its designee, to examine thoroughly the Primary Care offices, books, records, and operations of any related organization or entity.
• Provide access to the Plan, or its designee, to conduct medical record audits, as per regulatory requirements
• Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Health Care Effectiveness Data and Information Set) service
• Submit encounters on a CMS 1500 Form

Adult Health Screening
An adult health screening should be performed to assess the health status of all SHP members twenty-one (21) years of age or older. The adult member should receive an appropriate assessment and interventions, as indicated or upon request.

Providers are encouraged to review valuable Vaccines & Immunizations information on the Department of Health and Human Services, Center for Disease Control and Preventions website, which provides recommended vaccines and schedules for adults at: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html#laminated.

The screening should also include: screening for domestic violence, smoking, and substance abuse. Members with these problems should be referred to the pertinent programs, described later in the Handbook. You may also call the UM Department for more information.

Immunizations
Covered Medicare Part B services include:
• Pneumonia vaccine
• Flu shots, once a year in the fall or winter
• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
• Other vaccines if you are at risk and they meet Medicare Part B coverage rules

We also cover some vaccines under our Part D prescription drug benefit.
Domestic Violence and Abuse Screening
Physicians should identify indicators of domestic violence and abuse, including physical, psychological, sexual and substance abuse.

If you suspect domestic violence or abuse:
- **Abuse Hot Line**: To report suspected abuse, neglect or exploitation of elderly or disabled adults, call the toll-free number for the Florida Abuse Hotline 1-800-96-ABUSE (962-2873) or TDD 1-800-453-5145.
- **Domestic Violence Hotline**: To report domestic violence or to seek help, call the toll-free number (800) 500-1119. Members can also call themselves if they need help.
- **Substance Abuse and Mental Health**:
  - Contact the Plan’s Behavioral Health Provider, Beacon at 1-800-221-5487
  - You may also contact the Utilization Management Department and ask to speak with a Nurse Case Manager;
  - Alcoholic Anonymous- In Dade: 305-461-2425, [www.aammiamidade.org](http://www.aammiamidade.org);

Smoking Cessation
Physicians provide an important role in helping members make decisions about their health care. The Plan offers a smoking cessation program that will help members break both the physical and psychological addiction to cigarettes.

For your members who smoke or desire to quit smoking, including smokeless tobacco products, please call or ask the member to call the Member Services Department or a Simply Care Manager. The Care Manager will educate the member on resources that offer assistance, as well as the options available to the member through services provided by SHP. Additionally, the Plan can assist OB providers when they identify pregnant members who are at risk as a result of smoking.

Providers are encouraged to review valuable information and educational materials available through the following Websites:

Members may also call Florida Quit for Life at 1-877-822-6669 for information on classes and resources to quit smoking.

Members with Special Health Care Needs
The Primary Care Physician (PCP) is essential for identifying members with special needs. These members are defined as persons who face physical, mental or environmental challenges daily that increase their health risks and ability to fully function in society. Examples of members with special needs may include, but are not limited to:
- Members with complex medical problems
- Members with mental retardation or related conditions
- Members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders
- Members with disabilities resulting from years of chronic illness
- Members with certain environmental risk factors, such as homelessness or family problems, that lead to the need for placement in foster or facility care

Physicians who render health care services to Plan members identified as having special health care needs will be responsible to:
- Assess the member and develop a treatment/care plan
- Coordinate, review and update the plan of care with the member/legal representative or caregiver
- Identify and coordinate all transition of care needs, including direct access through standing referrals or approved visits, as indicated for the member’s health care needs
- Coordinate services with the Plan and member’s case/disease manager as appropriate, as well as, other health care or community services to share information to prevent duplication of services and provide early identification of the member’s needs
- Ensure the member’s privacy is protected as appropriate during the coordination process

Living Will and Advance Directives
The law indicates that each Plan member age 18 years or older of sound mind receive information and have the opportunity to sign an Advance Directive Acknowledgment Form to make their decisions known in advance. This will allow a member to designate another person to make decisions for them if they should become mentally or physically unable to do so.

Advance Directive forms should be made available in provider’s offices and discussion with the member as well as the completed forms should be documented and filed in the member’s medical record. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

Also refer to the Advanced Directives subsection in Section 7, Members’ Rights and Responsibilities.

After-Hours, Weekends and Holiday Services
The PCP must be available after regular office hours, weekends, and holidays to offer advice and to assess any condition that might require immediate care. This includes referral to the nearest hospital emergency room or urgent care center in the event of a serious illness.

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service; or
- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.

The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office’s daytime telephone number. After-hours, the office telephone number may be forwarded to the provider’s on-call cellphone number. However, the daytime office telephone number may not refer the member to a separate telephone number for after-hours coverage. Accessibility should take place in one call. If the caller has to make note of a second number, hang up and then place a second call that is considered a delay in accessibility.

The Plan routinely monitors providers’ adherence to after-hours access standards through secret shopper calls. Providers not meeting the after-hours standard will receive an in-service. We will re-audit to assure compliance. Continued noncompliance will result in the request for a corrective action plan.

PCP Coverage
The Primary Care Physician (PCP) will notify the Plan, in writing, of anytime that he will be on leave from his/her practice. This may include vacation, medical leaves, etc. He/she is responsible for coordinating medical coverage by a participating, credentialed Plan provider for his/her members during the leave and of advising the Plan as to who will be covering and the dates of coverage.

The PCP should assist the Plan in coordinating the transition of care needs and accepting the transfer of members receiving care out of network or out of the Plan’s service area if the transfer is considered medically acceptable by the Plan physician and/or the out-of-network attending physician.

Physician Panel Changes
If a PCP decides to close his/her panel to new members or to accept transferring of SHP members, the PCP must complete the following steps:

- Submit a written request to SHP providing at least sixty (60) calendar days prior to the effective date of closing his/her panel
Maintain his/her panel open to all SHP members who were provided services prior to the closing of his/her panel.

When a re-open date is determined, then he/she will submit written notice to SHP of the specific effective date of his/her panel re-opening; the effective date will be the first day of the following month.

Additionally, when reviewing the panel size of the PCP, SHP reserves the right to close the PCP’s panel if the PCP has more than 1,500 members assigned and does not have additional physicians or mid-level practitioners (ARNP or PA) to treat members. (Refer to PCP Responsibilities noted above).

The PCP should not close the panel to SHP members while having their panel open to other Medicare health plans.

**PCP’s Request to Disenroll a Member from their Panel**

A Plan physician or provider may not seek or request to terminate a member on his/her panel or transfer a member to another health care provider based on the member’s medical condition, the amount or type of care required by the member or the cost of covered services required by the member.

If a member is approved for transfer, the membership acceptance must be without regard to color, gender, race, religious belief, national origin or handicap of the member.

It is the responsibility of the provider to document in the member’s medical record his/her efforts to develop and maintain a successful professional/member relationship, as well as the failure of members to show for their appointments and the failure to follow the plan of care prescribed. In addition, providers may request assistance from Member Services in contacting the member or referring him/her to Care Management in cases of non-compliance.

If it is determined that a successful professional/member relationship cannot be established or maintained, the physician or provider will notify SHP in writing of the problem, with detailed supporting written documentation. The PCP will continue to provide medical care to the SHP member, until the time that the Plan has reviewed and transferred the member from the physician’s or provider’s panel to a new physician or provider and notified the PCP that a transfer has been completed. SHP and CMS will be monitoring such activities.

For a PCP to request to disenroll a member from their panel for non-compliance, the following needs to occur and there needs to be documentation on the medical record:

1. Reasons for failure to establish and maintain a relationship with the patient
2. The PCP has made every effort to help the member in correcting the situation, i.e., failure to show to appointments (at least 3 consecutive appointments within 6 months) or failure to follow the plan of care
3. The PCP has notified the member and SHP via certified mail of his/her intention to terminate the doctor-patient relationship. The letter must state the intended effective date (at least 30 days after the date on the letter) and information that the PCP will continue to provide care until the date of change, as well as instructions to obtain additional assistance and change of PCP by calling the SHP Member Services number on the back of their SHP ID card.

**Diagnosis and Treatment of Tuberculosis**

All providers are required by law to report all tuberculosis suspects and/or cases with 72 hours of diagnosis to the health department in the county in which the patient lives or your office is located. For codes, see Florida Administrative Code 64D03.

**Responsibilities of All Providers**

The following are responsibilities of all participating physicians and providers:

- Preserve all members dignity and observe the rights of members which include, but are not limited to:
- Members’ awareness and understanding their diagnoses, prognoses and expected outcomes of recommended medical, surgical, and medication regimens
- No discrimination, in any manner, between Plan members and non-Plan members
- Fully disclosing to members their treatment options and allow them to be involved in treatment planning
• Informing members of specific healthcare needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health
• Coordinate with SHP to ensure that members with special needs have an ongoing primary care giver responsible for coordinating the health care services provided to the member; this may be the PCP or, if indicated, a participating specialist
• Be responsive and cooperate with Simply’s Care Managers, who may contact the provider to share information and coordinate the care of members
• For members of Simply’s Special Needs Plans, the providers must participate in the Interdisciplinary Care Team meetings, usually conducted telephonically.
• Refer to a participating Plan specialist or other health care provider for services or treatment outside of his/her normal scope of practice
• Only refer members to non-participating physician or providers if a participating physician or provider is not available or in the event of an emergency. An authorization is required except in an emergency.
• Admit members only to participating hospitals, SNFs and other inpatient care facilities except in an emergency or if network facilities cannot provide the necessary level of care. Authorization by the health plan required except in emergencies
• Ensure that all member records and information will be treated confidentially, as per HIPAA guidelines/requirements
• Member records or information are not to be released without the written consent of the member or legal guardian, except as allowed or needed and within compliance with state and federal law
• Identify members that are in need of services related to children’s health, domestic violence, abuse, pregnancy prevention, pre and postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to Plan-sponsored or community-based programs
• Maintain an office that complies with environmental safety/hygiene regulations, as per city, state and federal regulations
• Promptly respond to SHP requests for medical records in order to comply with regulatory requirements
• Always inform SHP in writing within 24 hours of any revocation or suspension of the physician or provider’s suspension, limitation or revocation of the license, certification or other legal credential authorizing him/her to practice and prescribe within the State of Florida
• Inform SHP in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his or her status with the Plan
• Do not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any SHP member, subscriber, or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a “fee-for-service” basis. Non-covered services are services not covered in the member’s Plan contract
• Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable, and provide a copy of the certificate to the Plan
• Refer the member to community based services/support groups, where available
• Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan’s Quality Improvement Guidelines
• Utilize either disposable equipment or proper sterilization methods for instruments used to perform procedures
• Ensure the office staff is trained on the proper use of safety, emergency and fire extinguishing equipment
• Maintain a comprehensive emergency plan, including cardiopulmonary resuscitation (CPR), and an evacuation plan on which all office personnel are instructed
• Have emergency medications on hand (i.e., Epi-pen and ambu bag at a minimum) in case an emergency occurs while a member is in the office
• Timely communicate clinical information between Plan providers. Communication will be monitored during medical/chart review
• Make available to all authorized federal and state oversight agencies, including but not limited to CMS and the Florida Attorney General, any and all administrative, financial and medical records and data relating to the delivery of items and services to SHP members and access to any place of business
• Report any suspected cases of healthcare fraud, waste, and abuse on the part of members, associates, employees or any providers, pharmacies, suppliers, outreach, and any other areas to SHP's SIU Manager at 1-877-253-9251. More information on Section 15.

• Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Health Care Effectiveness Data and Information Set) service
• Submit encounters on a CMS 1500 form to the plan’s claims department

Physician Use of Health Care Extenders (ARNP’s and PA’s)
Physicians must, in accordance with federal and state regulations and accepted professional standards, use physician extenders appropriately. Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) may provide health care services to members within the scope or practice established by the rules and regulations of the State of Florida and SHP guidelines.

The physician will:
• Assume responsibility, to the extent of the law, when supervising ARNP’s and PA’s
• Inform SHP of all their healthcare extenders and provide their licenses and other credentialing documentation to the Plan
• Ensure that the ARNP’s or PA’s scope of practice does not extend beyond statutory limitations
• Ensure that ARNP’s and PA’s always identify themselves as such and not allow the members to assume that the health care professional providing care is a physician
• Provide treatment for any member that is in need of health care services that extends beyond the ARNP’s or PA’s statutory limitations and/or scope of knowledge
• Honor all member requests to be seen by a physician, rather than the ARNP or PA
• Ensure that ARNP’s or PA’s refer SHP members who require consultation and/or treatment services to the appropriate participating Plan specialist or facility
• Ensure that all required state and/or national licenses/certifications are current at all times

Additional Specialist Responsibilities
• Specialists are responsible for treating SHP members referred to them by the PCP and communicating with the PCP and/or SHP’s Utilization Management Pre-Certification Department for authorization requests.
• Be responsive and cooperate with Simply’s Care Managers, who may contact the provider to share information and coordinate the care of members
• For members of Simply’s Special Needs Plans, the providers must participate in the Interdisciplinary Care Team meetings, usually conducted telephonically.
• Specialists may not refer a member to another Plan specialist; care must be coordinated through the PCP.
• NOTE: The management of postsurgical care is the responsibility of the operating surgeon.

Member Information and Confidentiality
All consultations or discussions involving the member will always be conducted discreetly and professionally in accordance with all applicable state and federal laws, including HIPAA Privacy and Security regulations. All health care personnel should receive initial and annual refresher training on HIPAA Privacy and Security regulations. All practices are recommended to have in place:
• A privacy officer identified on staff
• A policy and procedure in place for confidentiality of members’ Protected Health Information (PHI)
• Documentation that the practice is following the procedures and are obtaining appropriate authorization forms from members prior to the release of PHI, as required by applicable state and federal law

All members have the right to confidentiality, and any health care professional or individual person who deals directly or indirectly with the member or his/her medical record must honor this right.

When an individual enrolls in the Plan, federal law allows the health care provider permission to release his or her medical records to SHP, members of the provider network or agencies conducting regulatory or accreditation reviews and business associates.
The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or health plan may use or disclose the members’ PHI. HIPAA regulations require each provider and health plan to give an NPP to each new patient or member accordingly.

Changes in Provider Information
Prior notice to the Plan is required for any changes in the information below and according to the terms of your contract.

- 1099 Mailing Address
- Physical or billing address
- Tax Identification Number or Entity Affiliation (W-9 required) – 60 days’ notice
- Group name or affiliation
- Telephone and/or fax number
- E-mail address

Provider Termination
In addition to the information included in the Provider Agreement with the Plan, the provider must adhere to the following terms:

- Any contracted provider must ensure at least ninety (90) calendar days prior written notice to SHP of “without cause” termination of a contracted provider's participation. Please refer to your contract for the details regarding the specific required days for providing termination notice.
- Unless otherwise provided in the termination notice, terminations occur on the last day of the month. For example: A termination letter is dated September 15th. The required notice is ninety (90) days. Termination is therefore effective on December 31st.

Providers who receive a termination notice from the Plan may submit an appeal within thirty (30) calendar days of the receipt of the termination notice. The appeals notice must be submitted in writing to the Grievance and Appeals Coordinator, to SHP’s address.

SHP shall notify the provider and members in his/her active care at least sixty (60) days before the effective date of the suspension or termination of a provider from the network. If the termination was “for cause”, SHP shall provide to all appropriate agencies the reasons for termination.

In cases in which a patient’s health is subject to imminent danger due to a provider’s action or inaction or a physician’s ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency, notice to all parties shall be immediate.

Notification to Members of Provider Termination
The plan makes a good faith effort to provide at least thirty (30) calendar day’s written notice of a provider’s termination to all members who are seen on a regular basis by that provider before the termination effective date, regardless of the reason for the termination. The Plan may provide member notification in less than thirty (30) days as a result of a provider’s death or exclusion from the federal health programs.

When a termination involves a PCP, all Simply members who are patients of that PCP are notified of the termination.

Provider-Required Incident Reporting
Reporting is required in the event of an adverse or untoward incident that occurs to a Plan member whether occurring in a facility of one of the Plan providers or arising from health care prior to admission to a facility which may result in:

- Enrollee death
- Enrollee brain damage
- Enrollee spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention, which is not consistent with the routine
management of the patient’s case or patient’s preexisting physical condition
• Any condition requiring surgical intervention to correct or control
• Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care
• Any condition that extends the enrollee’s length of stay
• Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility

**These incidents must be reported to the Plan’s Risk Management Department on the Incident Report Form, which is located in the Forms section of this handbook.**

Unusual incidents that occur on the property of the provider should be reported to the designated individual at the provider’s office, who will document and report the incident to the Plan’s Risk Management Department. The following are examples of potential risk management cases:
• An incident/injury/slip and fall of a SHP member, accompanying person or caregiver at a Plan’s participating provider premises
• A SHP member, accompanying person or caregiver who becomes abusive (physically or verbally) at the Plan’s participating provider premises
• Other incidences that are required to be communicated to the Plan include any of the following that involve a Plan member:
  • A medication error or a reaction to medication or procedure, requiring treatment
  • A theft or loss of medical records or electronic devices containing PHI from the provider’s office or property
  • Malfunction or damage of equipment during treatment
  • Accusations of malpractice by a patient or family member
  • Non-compliance with potential to be life-threatening

These incidents must be reported to the Plan’s Risk Management Department on the Incident Report form, which is located in the Forms section of this handbook.

Further reporting to the Plan’s insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan’s Risk Manager. Providers are reminded that they must report to AHCA, serious and negative incidences that occur in their practicing offices and facilities.

Delegated Providers
Delegation is the formal process by which Simply Healthcare Plans, Inc. provides an entity (Delegate) the authority to perform certain functions on its behalf. A function may be fully or partially delegated.

• A full delegation allows all activities of the function to be delegated.
• A partial delegation allows some activities to be delegated.

SHP may delegate the authority to perform a function, however the Plan is ultimately accountable for all functions performed within its purview, whether performed by the Plan itself, a delegated entity or by any sub-delegates.

Simply Healthcare Plans, Inc. (SHP or the Plan) Delegation Program is a component of SHP’s Compliance Program. This program’s intent is to assure quality of care and service from contracted entities with delegated functions, prior to delegation of any function, and to assure compliance with all the Federal, State and organizational requirements (CMS, AHCA (“the Agency” or BMHC), and AAAHC) related to the delegated function. The Delegation Program describes the Plan’s process for performing an objective and systematic review of all networks or entities with delegated functions in a consistent manner.

What is an FDR?
The following is the current CMS definitions to define First Tier, Downstream, and Related Entities:

• First Tier Entity: Is any party that enters into a written arrangement, acceptable to CMS, with a Medicare
Advantage Organization or Part D plan sponsor or applicant to provide administrative services to a Medicare eligible individual under the Medicare Advantage Program or Part D Program.

- **Downstream Entity:** Is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

- **Related Entity:** Means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:
  1. Performs some of the Medicare Advantage Organization or Part D plan Sponsor’s management functions under contract or delegation; or
  2. Furnishes services to Medicare enrollees under an oral or written agreement; or
  3. Leases real property or sells materials to the Medicare Advantage Organization or Part D Plan sponsor at a cost of more than $2,500 during a contract period.

The primary purpose of First Tier, Downstream or Related Entity (FDR) oversight is outline the accountability, structure and process for monitoring of operations including program management of any functions supported by FDR and for support of administration and benefits within SHP. The Plan strives to continuously improve the process, structure and outcomes of the program.

As a CMS contractor, Simply Healthcare Plans, Inc. (SHP) may assign the authority and responsibility to carry out an activity that is otherwise performed by SHP which may include, but is not limited to the following: Pharmacy Benefit Management (PBM), Claims, sales, credentialing, and Medication Therapy Management, Utilization Management, and disease management. Simply retains full accountability for all FDRs activities and conducts an annual audit of first tier, downstream and related entities (FDR) to ensure contractual standards and Centers for Medicare and Medicaid Services (CMS) regulatory requirements as well as other federal and state requirements are met.

Simply will monitor and oversee FDR entities performance of FDR activities on an ongoing basis but no less frequent than annually through the use of the assessment review tools and audits. Simply will institute corrective action and/or may revoke assignment of duties when it determines that a FDR or vendor is unable or unwilling to carry out the responsibilities of FDRs.

The Plan does not delegate the following functions:

- Member Grievance and Appeals
- Non-Participating Provider Appeals
- Enrollment
- Fulfillment
- Community Outreach

**Simply Healthcare Plans, Inc. Delegation Oversight Program**

The SHP Delegation Oversight Program is divided into three phases as follows:

- **Phase 1:** Pre-assessment
  - Phase 1.a Pre-Assessment Documents
  - Phase 1.b Pre-Assessment Review
- **Phase 2:** Oversight and Monitoring
- **Phase 3:** Delegation

Upon the identification of a provider/vendor whom the Plan desires to delegate the performance of a function such as Provider Credentialing, Network Development and Servicing, Claims Payment, Case Management, and Authorization processes; the Plan’s Delegation Oversight Department is notified by the Internal business unit(s) (i.e., Provider Relations) via e-mail communication to the designated e-mail group: delegationoversight@simplyhealthcareplans.com. The communication must include the following elements in order for the delegation oversight auditors to be able to initiate contact with the provider/vendor:

- Date of the Request
- Name of the Requestor (SHP employee) and Title
- Department
- Name of the Vendor delegation is being requested for:
- Services to be Delegated
- Functions to be Delegated
- Line of Business
- Plan Name(s)
- Service Area
- Effective Date Delegation is being requested for
- Is the Vendor currently participating with the plan: SHP CAID/SHP/CHA/SHP MCARE/ ALL
- Vendor Contact Information to Initiate the Pre-Assessment: (Primary and Secondary Contact Required)
  - Name
  - Title
  - Telephone Number
  - E-mail Address

Within twenty four (24) hours from receiving the notification the process for the delegation pre-assessment review is initiated as follows:

Phase 1: Pre-Assessment
Includes a process for the pre-assessment and review of documentation to determine the provider’s/vendor’s ability to perform the delegated function in accordance with federal and state guidelines (CMS, AHCA’s). This phase shall take place prior to the effective date of contract delegation. During this phase providers/vendors are notified of any requirements for the reporting of quality indicators and operational metrics, according to the function delegated and service provision of the same contract.

- Phase 1.a Pre-Assessment Documents
  Includes but is not limited to the following:
  1) Policies and procedures;
  2) Financial, Regulatory Filings and Documents;
  3) Committee Minutes;
  4) Provider Credentialing Records;
  5) Evidence of Required Employee Background Screening;
  6) Employee Trainings, etc., as applicable.

- Phase 1.b: Pre-assessment Review
  The purpose and goal of the pre-assessment review is to determine the delegated entities ability to perform the delegated function; to assess financial stability of the company; and to assess the provider network accessibility. It consists of a desktop review documentation and an on-site visit, if necessary.

  The following documents may be received and reviewed by SHP (depending on the function(s) delegated), prior to the effective date of the contract, and/or effective date of the delegation:

1) General Administrative/Finance
   - Articles of Incorporation
   - Certificate of Insurance for all types of business. In example, general liability insurance, works comp liability insurance.
   - Licenses (certificates and permits required to conduct business)
   - Record Retention
   - Financial Statements-Most Current audited and un-audited
   - Copy of Confidentiality Policy concerning patient specific information and handling of release of member/patient information
   - Policy on record retention and Destruction
   - Copy of HIPAA Policies and Procedures and corresponding staff training
Policy on accessibility for handicapped patients
Cultural Competency Program
Fraud, Waste and Abuse Program and corresponding policies and procedures
Emergency preparedness and recovery plan
Organizational Chart of the applicable departments responsible for delegated functions.
Incident Report Policies and Procedures

2) Delegated Function: Provider Contracting/Servicing
   - Provider Contract- Template
   - Provider Manual
   - Provider Complaint System Policy and Procedures
   - Provider Network: Numbers and GEO locations of provider network
   - Health Service Delivery (HSD) Tables
   - Copy of organizations protocol for assuring provider 24 hours, 7 days a week accessibility
   - Provider Directory listing
   - Description of the methods used to monitor quality of service provided by network providers, including access standards (timeframe for obtaining an appointment, wait times, etc.)
   - Emergency Care
   - Urgent Care
   - Routine Care Sick Patient Care
   - Well Care Visit
   - Follow Up Dental Services

3) Delegated Function: Utilization Management (UM)
   - The UM Program description including policies and procedures explaining the entity’s policy on provision of care to members upon practitioner/provider termination.
   - UM Work Plan.
   - Policy and Procedure for UM Processes, processing timeframes and notification requirements accordingly.
   - Policy on monitoring over and underutilization.
   - UM authorization/referral criteria/guidelines.
   - Ability to generate Member and Provider Notification letters.
   - UM Committee Minutes.
   - Compliance with CMS Pre-Service Standard and Expedited Organization Determinations Audit Protocols Reporting.

4) Delegated Function: Credentialing/Re-Credentialing
   - Policies and procedures for credentialing and re-credentialing of physicians/facilities/employees, as applicable; to include a detailed description of credentialing criteria which must be compliant with CMS, AHCA and accrediting body requirements.
   - Description of the steps in the provider profiling process and how results are used in the re-credentialing process.
   - Credentialing Committee Minutes

5) Delegated Function: Quality Management
   - A copy of the most recent accreditation findings, if surveyed.
   - Quality Committee structure
   - Quality Management Program Description and corresponding policies and procedures (demonstrating Peer Review Process)
   - Current Year-QM Work Plan
   - Evaluation of the effectiveness of the quality management program for the past year (i.e., Quality Indicators; QM Work Plan evaluations; HEDIS scores; CHCU Rates; Quality Improvement initiatives with noted improvement in care and service; initiatives in progress)
• Medical/Dental record documentation standards
• Access And Availability Standards
• Methods utilized to evaluate treatment outcome
• QM Committee Meeting Minutes
• Peer Review Committee Meeting Minutes (Can be blinded)

6) Delegated Function: Claims
• Claims processing policies and procedures indicating processing timeframes, and notification requirements.
• Ability to generate claims aging reports
• Ability to generate Claims Payment Reports
• Ability to Report Phone Stats to include hold times, abandonment rates, and call response rate for claims department
• Compliance with CMS Payment Organization Determinations Audit Protocols

7) Delegated Function: Member Services
• Customer Service Call Center Requirements
  • Hours of Operation
• Member Services policies and procedures that address handling, documentation, tracking and monitoring of member calls (inquiries, complaints, Organization Determinations, Grievances and Appeals, etc.), and the ability to transfer to the plan any issues not delegated.
• Ability to report Phone Stats to include hold times, abandonment rates, and call response rates
  • Staffing Ratio to meet help line standards
• Member Services Staff training process; and training manual
• Member Telephonic Scripts
• HIPAA Compliance - Policy and Procedure Review
• Member Confidentiality/Release of PHI - Policy and Procedure Review
• Review of Policies and Procedures that describes process to follow when a potential Quality of Care issues is identified.
• Review of Policies and Procedures that describes process to follow when a potential Fraud, Waste and Abuse situation is reported or identified.

Upon completing the Pre-Assessment review, the results are presented to the Plan’s Delegation Oversight Committee for a disposition. If approved, the plan moves forward with the execution of the corresponding Delegation Contract Addendum. The provider group/entity is advised of the pre-Assessment results, any necessary observation noted, and receives education about the process.

Phase 2. Oversight and Monitoring
Phase 2 includes the annual audit of the delegated vendor functions. On a yearly basis the Delegation Oversight Unit delivers a Delegate Annual Audit Schedule document that includes all the Plan delegates, the delegated services, their functions and the date when they are due for an annual audit. Delegates receive the Annual Audit Notice Letter advising them of the annual audit requirements, the time-frame, the audit and the scope of the audit and the name and contact information of the Delegation Oversight Unit auditor who will be conducting the audit. The annual audit is conducted utilizing the Delegation Audit Tools developed by the Delegation Oversight Unit and reviewed and approved by the Delegation Oversight Committee. The tools outline:

• Contract: Outlines the regulation/guideline/contract section applicable for review.
• Contract Requirements: Provides the descriptions of the indicators and requirements established for auditing and monitoring of the providers/vendors.
• Scoring: This section is used by the Delegation Oversight Auditor to indicate if the vendor complied with the requirements or not or if is not applicable for review. The table below identifies the scoring keys:
###Documents Submitted
This section is for the entity to indicate the documents submitted by the entity as supporting evidence of compliance with the requirements being audited. The entity needs to provide the name of the document(s) indicating the title, the section and the page number were the information is listed on the document. In addition, the actual document must be embedded on the Audit Tool.

###Comments
This section will indicate any comments or notes made by the auditor for the specific requirement that required observations to be addressed to the delegate. For example, in the event that the score field indicates that the requirement was partially met or not met, the comment field will reflect the observations made by the auditor in order for the entity to take note and make the necessary updates/corrections. The audit will also provide the timeframe the Plan requires the entity to resubmit the corrections.

Once the information is submitted back by the delegate with all the required information, the audit tool and the supporting evidence are reviewed; the Delegation Oversight Auditor will then proceed to complete the Annual Audit Tool overall score which is listed at the end of such document and will indicate the following:

<table>
<thead>
<tr>
<th>Simply Healthcare Plans, Inc. Annual Audit Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delegated Entity:</strong></td>
</tr>
<tr>
<td><strong>Results for &lt;insert the section reviewed&gt;</strong></td>
</tr>
<tr>
<td><strong>Values:</strong> Met = 1 Not Met = 0</td>
</tr>
<tr>
<td>Score</td>
</tr>
<tr>
<td>Fully Met</td>
</tr>
<tr>
<td>Partially Met</td>
</tr>
<tr>
<td>Not Met</td>
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<tr>
<td>Not Applicable</td>
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<tr>
<td>Total # Elements</td>
</tr>
<tr>
<td>Total # Applicable Elements</td>
</tr>
<tr>
<td>Percent of Elements Met</td>
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<tr>
<td>Final score percentage</td>
</tr>
<tr>
<td>Number of fully met elements</td>
</tr>
<tr>
<td>Number of Partially met elements</td>
</tr>
<tr>
<td>Number of Not Met elements</td>
</tr>
<tr>
<td>Number of elements not applicable</td>
</tr>
<tr>
<td>Total number of elements reviewed</td>
</tr>
<tr>
<td>Total number of applicable elements</td>
</tr>
<tr>
<td>Percent of elements met</td>
</tr>
<tr>
<td>Name of the auditor who conducted the review</td>
</tr>
</tbody>
</table>

The compliance benchmark that must be met for the Medicare Line of Business is 95%.

###Observations/Recommendations
The Delegation Oversight Auditor will include any observations or recommendations that need to be taken into consideration by the delegate, however these do not require a corrective action. The Delegation Auditor will provide a timeframe for the delegate to provide evidence of appropriate and adequate process improvement/enhancement made as a result of the observations or recommendations noted by the audit.

###Corrective Actions
Should a provider be found to be out of compliance with a standard or regulation, and/or fails to submit required documents, reports or files, the same provider will be required to take corrective action within a designated time frame. This corrective action may be subject to the approval of the Delegated Services Committee, Compliance Committee and or the Quality Management Committee.
A report of the findings and the issuance of non-compliance notices or the implementation of a CAP is prepared and presented to the Delegation Oversight Committee. The Committee reviews and approves the corrective action request and will monitor the progress during every committee meeting until the Committee approves closure of the CAP. The Committee may request (should there be a need) for a re-review or audit of the same provider/vendor prior to the one year interval (i.e., 3 months, 6 months, etc.).

The delegated provider/entity is responsible for the completion of the CAP, per the established time frames. The CAP response date shall be indicated on the CAP documents. In the event the provider/entity does not comply with the CAP by the time allowed, the provider/entity may be subject to any of the following:

- Implementation of a supplemental or revised CAP
- Imposition of fines and passing of any liquidated damages imposed to the Plan,
- Suspension of Delegation until such time that provider/entity is able to demonstrate ability to comply, submit a CAP, and close out all items on CAP
- Termination of the delegated function

Phase 2.a Ongoing Monitoring -Oversight Documents
Phase 2 of the Delegation Program also includes on ongoing regular monitoring via the delegated entity’s submission of required reports and data files as follows, and as applicable:

- Report of phone stats to include call hold times, abandonment rates, and call response rate for Claims, Provider Operations, Member Services, as applicable,
- Provider encounter files
- Provider Network Files
- Claims aging/claims payment reports
- Provider Credentialing Reports
- Member Complaint Logs (when Member Services Delegated)
- Authorization /Referrals Log/Reports (TAT/Denial Rate, etc.)
- Case Management Logs (as applicable)
- Minutes of entity’s Quality Assurance and Improvement Committee meetings
- Minutes of Credentialing Committee meetings
- Report of quality indicators
- Results of provider satisfaction surveys
- Submission of data for AHCA Reports in the format specified by the Plan and/or the governing Agency.
- Part C Reporting Requirements and Technical Specifications – Organization Determinations.
- 2015 CMS Audit Protocols Templates Accordingly

Phase 3. De-delegation
Phase 3 includes the de-delegation of a function in the event the provider/vendor is not fulfilling obligations and/or recommendations of the plan; and consistently demonstrates non-compliance with regulations. This phase in the delegation program includes de-delegation of a function or all functions. De-delegation would occur in instances when a provider is found to be non-compliant with the organization’s policies and procedures, state and federal regulations, AHCA, and/or is found to be in breach of the contract with SHP.

When the Delegation Oversight Committee recommends de-delegation of a function or all functions from a provider, a report is presented to the Compliance Committee and the Quality Management Committee for approval of the de-delegation.

The Delegation Oversight Director will coordinate the effective date of the de-delegation with the following corresponding departments, as appropriate:

- Provider Relations
- Quality Management
- Credentialing
- Utilization Management
- Member Services
Simply Healthcare Plans will develop a plan of action for the transitioning of the delegated function(s) back to the Plan and will assure that there is no lapse in the delivery of care to members.

Delegation Oversight Committee (DOC)
The Delegation Oversight Committee’s goal is to oversee the health plan’s specific policies, programs and procedures to ensure compliance with state/federal statutes and regulations including but not limited to those specific to Medicare and Medicaid Services (CMS), the Agency for Health Care Administration (AHCA) and Simply Health Care Plan’s Contractual requirements. The DOC promotes and ensures delegates are in compliance with applicable laws, rules and regulations with respect to the delegated responsibilities. The DOC will conduct activities in a manner that maintains and protects the confidentiality of plan information. All documents are proprietary information and utilized in the appropriate forum.

The Delegated Services Committee is comprised of members representing various Simply Healthcare Plans’ departments:

- Chief Medical Officer – (ad hoc)
- Delegation Oversight (Chair) – Director of Delegation Oversight
- Representative, Provider Operations
- Representative, Provider Administration
- Representative, Quality Management
- Representative, Health Services (HS)
- Representative, Risk Management
- Representative, Member Services / Grievances & Appeals
- Representative, Claims
- Representative, Regulatory Compliance
- Representative, Credentialing

All activities of the delegation oversight activities are coordinated and reported via the Delegated Oversight Committee (DOC). The DOC reports to the Compliance Committee and QI Committee. All delegated activities are reported to the Board of Directors (BOD).

Delegation Contract/Addendum Provisions
All delegation amendments negotiated and executed between the Plan and delegated providers/entities must specify the following:

- The Plan retains the right to rescind delegation without cause and the conditions under which this may be done.
- Clearly defined responsibilities of the provider group/entity and the Plan.
- The entity agrees to sign the HIPAA Business Associate Agreement (BAA) prior to having access to the Plan members’ PHI.
- Requirement that all services are to be performed by the delegated provider group/entity in accordance with requirements/standards specified by the Plan, state laws, applicable Medicare laws, regulations, CMS instructions and accreditation organization standards.
- Requirement that the delegated provider group/entity notify the Plan of any:
  - Material change in the provider group/entity’s performance of a delegated function; and/or
  - Sanctions received from state regulators, federal regulators, or accreditation organizations.
- Statement of the Federal or State Agency’s and the Plan’s right to conduct audits of the delegated provider group/entity as necessary.
- Process for the Plan to evaluate the delegated provider group/entity’s performance which includes monitoring of reports, frequency of performance, and approval of the appropriate program description and work plan.
- Acknowledgement that the Plan is authorized to implement corrective action plans with the delegated provider group/entity for identified deficiencies of the delegated provider group/entity.
• Remedies available to the Plan if the delegated provider group/entity does not fulfill its contractual obligations. Remedies may include corrective action plans, fines, passing of liquidated damages imposed by CMS and the Agency and suspension or revocation in part or all of the delegated functions.
• Reporting requirements, specifying the frequency and content of reporting to the Plan.
• Provision that sub-delegates are subject to the terms of the agreement between the provider group/entity and the Plan, including the right of the Plan to review and/or audit compliance performance of the sub-delegate.
• Requirement that downstream provider contracts comply with all federal and state laws, applicable Medicare and Medicaid laws, accreditation requirements, the Plan requirements and contractual elements.
• Nothing contained in the amendment is intended to be a financial incentive or payment which directly or indirectly acts as an inducement for the delegated provider/entity to limit medically-necessary services.
• Indemnification language
• In the event the Plan financially penalized, including but not limited to fines and interest and/or sanctioned by any state or federal agency as a direct result of the delegated entity's or any of its employees or independent contractor's failure to adhere to the standards and procedures described in the amendment, The Plan will forward to the delegated entity documentation of such and the delegated entity shall reimburse the Plan the full amount of such financial penalty imposed, including without limitation any attorney's fees included as a result of such action and penalty by a state or federal agency.
• Termination language.

Delegated Provider Downstream Contract Content
The delegate, and when applicable its subcontractors, will make available to SHP samples of contracts with physicians and other downstream providers and ensure compliance with the legal and regulatory contractual requirements, including HIPAA regulations. Delegate is not required to make available to SHP contractual provisions relating to financial arrangements with delegate's physicians and providers.

When requested, the Delegate will provide templates of their downstream contracts for auditing purposes.

Physician and provider contract content should include, but should not be limited to the following provisions:

• Notification of physician/specialist/specialist group’s termination: The contract executed between the delegate and specialist/specialist group must state either the delegate or SHP will be responsible for notifying the affected members of the termination.
• Physicians/providers cooperate with quality improvement (QI) activities.
• SHP and delegate have access to physician/provider medical records to the extent permitted by state and federal law.
• Physicians/providers need to maintain the confidentiality of member information and records.
• Physicians/providers may freely communicate with members about their treatment, regardless of benefit coverage limitations.
• A listing of all individuals or entities that are party to the written agreement.
• Definitions for termination used in the contract referenced above.
• Conditions for participation as a participating provider.
• Obligations and responsibilities of the delegate and the participating provider, including any obligations for the participating provider to participate in the delegate's management, quality improvement, complaint, or other programs.
• Events that may result in the reduction, suspension, or termination of network participation privileges.
• The specific circumstance under which the network may require access to member's medical records as part of the delegate's programs or health benefits.
• Health care services to be provided and any related restrictions.
• Requirements for claims submission and any restrictions on billing of members.
• Participating provider payment methodology and fees.
• Mechanisms for dispute resolution by participating providers.
• Term of the contract and procedures for terminating the contract.
• Requirements with respect to preserving the confidentiality of patient health information.
Prohibitions regarding discrimination against members.
Physicians and providers agree to hold members harmless and not bill more than their coinsurance/copays or indemnity balances that are the member’s responsibility under his/her Plan.

Note: Health plans, first tier, and downstream entities are prohibited from employing or contracting with Individuals excluded from participation in Medicare.

Sub-Delegation
Simply Healthcare Plans, Inc. (SHP) Delegates must have prior written approval for any sub delegation by the Delegate of any functions and/or activities. In addition, note that SHP must notify CMS of any location outside of the United States or a United States territory that receives processes, transfers, stores or accesses Medicare Beneficiary protected health information in oral, written or electronic form.

If the Delegate subcontracts with another entity (“Subcontractor”) to perform any portion of any delegated function, with SHP’ prior written approval and 90 days prior to the anticipated effective date, The Delegate will provide documentation and demonstrate oversight of such entity by Delegate. The Evaluation of the Subcontractor’s capacity to perform the delegated activities prior to the execution of the contract must be presented to SHP for final approval. SHP retains the right to perform its own evaluation of the Subcontractor prior to approval. The Delegate will create a mutually-agreed upon contract between Delegate and Subcontractor which must include the following:

- The responsibilities to be delegated to the Subcontractor and those retained by the Delegate.
- A requirement that the delegated functions are to be performed in accordance with SHP’ and Delegate’s requirements, state and federal rules, laws and regulations, and Accreditation Organization standards.
- The Subcontractor must notify the Delegate of any material change in the Subcontractor’s performance of delegated functions.
- Submission of periodic performance reports as required by SHP and the Delegate.
- The Subcontractor must have SHP’/Delegate’s prior written approval for any further delegation and those functions will be subject to the terms of the written agreement between the Subcontractor and Delegate and SHP and in accordance with state and federal rules, laws and regulation and Accreditation Organization standards.
- The remedies, including revocation of the delegation available to Delegate if the Subcontractor does not fulfill its obligation.
- Delegate is responsible for providing adequate oversight of the Subcontractor and any other downstream entities, including oversight of compliance program requirements. SHP retains the right to perform additional evaluation and oversight of the Subcontractor, if deemed necessary by SHP. Furthermore, SHP retains the right to modify, rescind, or terminate at any time any one or all delegated activities hereunder, regardless of any sub delegation that may have been previously approved.

Systems and File and Record Retention
The delegate will furnish any and all staffing and systems necessary to receive eligibility data from SHP and will provide all required data by state and federal laws, rules and regulations, and SHP. The documents will include without limitation claims and encounters, credentialing, utilization review/management, quality improvement and other documentation records, files or data pertaining to functions delegated. The records must be maintained for a period of (10) years.

Grievance and Appeals
SHP Members’ expedited and standard grievance and appeals are not delegated, including appeals made by physicians/provider on behalf of the member. SHP maintains all member rights and responsibility functions.

SHP will handle all non-participating Provider Appeals for claims payments and denials.

If a Delegate receives a member grievance and/or appeal this must be submitted to the SHP’s Grievance and Appeals Department as soon as possible for processing. Please refer to the Important Contact information section of this manual.
Medicare Risk Adjustment
The CMS-Hierarchy of Conditions Categories (HCCs)/Risk Adjustment model strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage Organizations, such as Simply Healthcare Plans ("Simply"), based on the health status of their Members. Accurate payments to Medicare Advantage Organizations help to ensure that providers are paid appropriately for the services rendered to Members and provide incentives to enroll and treat less than healthy individuals.

Importance of HCC/Risk Adjustment to Providers
While procedure codes are important for provider reimbursement of services to fee-for-service Medicare beneficiaries, the HCC/risk adjustment payment model relies on ICD-10CM diagnosis code specificity.

Provider Responsibilities:
1) Maintain Accurate and Complete Medical Record Documentation
   - Quality documentation leads to correct code specificity and accurate risk adjusted payment.
   - Includes main reason for episode of care, all co-existing, acute and chronic conditions, and pertinent past conditions that impact clinical evaluation and therapeutic treatment.
   - Document co-existing conditions during a face-to-face encounter at least once during reporting period.
   - Document fully the specified type of common conditions, if known. For example, specific type of anemia, pneumonia, depression, etc.

2) Report Claims and Encounter Data in a Timely Manner
   Under the HCC/risk adjustment model, providers must submit the following elements to Simply:
   - ICD-10 CM diagnosis code
   - Service from date
   - Service through date
   - HIC # of the member

3) Report ICD-10CM Diagnosis Codes to the Highest Level of Specificity and Report These Codes Accurately
   a) Combination codes
      - Related conditions that can be expressed with one code. (e.g. Hypertensive heart or renal conditions)
      - "Code also" instructs when more than one code are needed. (e.g. Diabetic manifestations)
   b) Digit specificity or coding to the fourth or fifth digit impacts risk adjustment payment. (e.g. MI and Diabetes)
   c) Do not code:
      - Symptoms that are common to the main diagnosis
      - "History of" codes that are no longer pertinent to the current problem
      - "Rule out" codes of outpatient and physician visit

4) Alert Simply of Any Erroneous Data That Has Been Submitted and Correcting the Data in a Timely Manner.
Risk Adjustment Validation Data

5) Risk adjustment data validation is the process of verifying that a diagnosis code submitted by Simply to CMS is supported by medical record documentation. CMS validates medical records to ensure payment integrity and accuracy.

6) Steps in the Data Validation Process:
   - CMS selects a sample of Simply members and requests medical records from the health plan.
   - Simply requests member medical records from providers.
   - Simply sends the requested medical records to the CMS validation contractor for validation.

7) Provider Responsibilities:
   - Consistently follow general principles of medical record documentation.
   - Ensure all documentation to support a reported diagnosis on a given date or range of dates is provided.
   - Include supporting documents referred to in the encounter notes, such as test results or problem lists.
   - Respond quickly and send all records in an organized, secure and confidential manner.
Payment Arrangements
Financial arrangements concerning payment to providers for services to Medicare members are set forth in each provider’s agreement with SHP. SHP does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. Incentives and payments must in accordance with this policy or with Medicare Advantage regulations.

Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.
Section 5. Utilization Management Department

Overview
Simply Healthcare Plans (SHP), Utilization Management (UM) Department will be responsible for the following processes:

- Receive notifications of admissions and other services
- Referrals and Quick Authorization Form
- Prior Authorizations (Pre-service requests)
- Concurrent Review of acute, sub-acute and skilled nursing facility admissions
- Discharge planning assistance
- Care Management services, including case management, disease management, chronic care and transition of care needs

SHP members are entitled to confidentiality of Protected Health Information (PHI). The UM Department will ensure that all member documents containing personal and medical data are maintained in a confidential manner compliant with HIPAA Privacy Regulations and all state and federal confidentiality regulations.

Notification
Notifications are either communications to the Plan, either telephonically or written, that inform the Plan of a service(s) requested or rendered or an admission to a facility. These include acute inpatient, observation status, acute inpatient rehabilitation, skilled nursing facility (SNF), and custodial care admissions.

Notification to the Plan of prenatal services is required within two (2) working days of the first prenatal visit. This enables the Plan to identify members for inclusion in the Prenatal Program and identify potential High Risk OB members who may benefit from the High-Risk Pregnancy Program.

Referrals or Prior Notifications
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. SHP uses two types of forms and processes:

1) Quick Authorization Form (QAF):
   For those services included on the SHP Quick Authorization Form (QAF) (see the Forms Section of this handbook) a referral is NOT required for participating providers. Primary Care Physicians (PCP’s) can refer a member to a participating specialist and to many frequently requested services and procedures at free-standing facilities with the Simply Healthcare Plans Quick Authorization Form (QAF) without contacting the health plan for prior authorization.
   IMPORTANT NOTE: Communication with the Plan prior to the provision of care is not necessary when using the QAF; however, all inpatient services, outpatient hospital services (including diagnostics), and ASC services do require an authorization (see section below).
   Prenatal care referrals are NOT to be made using the QAF.

   **The QAF form is not valid for any inpatient or outpatient hospital services or for any consultations or procedures not listed on the form, or for out-of-network providers.**

   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 to give a copy to the member so that it is presented at the time of the service.

Services that Do NOT Require Prior Authorization or QAF:
- 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), Federally Qualified Health Centers, Rural Health Clinics and federally funded migrant health centers when providing:
  - Vaccines
• STD diagnosis/treatment
• Rabies diagnosis/immunization
• Urgent services

2) Prior Authorizations:
Prior authorization (pre-service requests) allows for the use of quality, cost-efficient covered health care services and 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) for PCP’s (see section above) that require an authorization.

SHP’s UM Department evaluates requests for services/procedures and makes determinations based on medical necessity, covered benefits and appropriateness based on Medicare National and Local Coverage Determinations, SHP’s approved utilization criteria National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) is used and evidence-based, nationally recognized clinical guidelines. Only a Medical Director may issue an adverse determination, with the exception of denials due to benefit issues. No provider or any other individual or SHP employee or associate is rewarded for issuing denials of coverage or care. Financial incentives will NOT encourage decisions that would result in underutilization nor are incentives to create barriers to care and services.

Prior Authorization Requests are to be made through the SHP’s UM Pre-Certification Department.

Prior Authorization or Notification Process:
• Providers are to fax the Referral & Authorization Form (refer to Forms Section) to the SHP’s Utilization Management Pre-Certification Department at Fax number 1-800-283-2114 or by calling the Pre-Certification Telephone Queue 1-877-915-0551, option 2.
  • Routine (NOT STAT/URGENT) requests are generally processed within 3 - 4 days and never processed in more than fourteen (14) calendar days of the Plan receiving the authorization request and having received all supporting clinical information.

  STAT/URGENT requests are processed within seventy-two (72) hours of the Plan receiving the request and having received the supporting clinical information. SHP strives to process the urgent requests as soon as possible.

Note: STAT/URGENT Authorizations should be CALLED IN to the SHP Pre-Certification Authorization Telephone Queue and NOT faxed, and the caller should identify the request as “STAT/URGENT”. These requests should always meet the defined medical criteria for such which are:

  STAT/URGENT= Any condition that could place the member’s life, health, or ability to regain maximum function in serious jeopardy.

• Each Referral & Authorization Form received from the provider’s offices will be date and time- stamped, manually or electronically and is reviewed for completeness, eligibility, benefits, PCP and specialist network affiliation
• 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 SHP computer system for future reference and claims payment
When faxing a Prior Authorization Request, the SHP Referral & Authorizations Form must be completed. The requesting provider is reminded to include:

- Member demographic information (i.e. name, sex, DOB, SHP Member Number)
- Provider demographic information
- Requesting provider (i.e. name, SHP Provider Number, phone number, fax number, contact person)
- Referred-to specialist/facility (i.e. name, SHP Provider Number, address, phone number, fax number, date of service, and identification if PAR (Plan participating provider/facility) or Non-PAR (not a Plan participating provider/facility)
- Diagnoses for authorization request, including ICD-10 Code(s)
- Procedure(s) for authorization request, including CPT/HCPCS Code(s)
- Number of visits requested, frequency and duration
- Pertinent medical history and treatment, laboratory and/or radiological data, physical examinations/referrals that support the medical necessity for the requested service(s)

Requests that do not meet medical necessity, based upon approved criteria are reviewed by the Medical Director for a final determination. The Medical Director may conduct a peer-to-peer discussion with the requesting provider, if indicated.

Services and procedures that require prior Plan Notification and must be provided in a SHP participating facility* include but are not limited to:

- Inpatient and Observation Admissions, as noted above
- Admission to any rehabilitation, LTAC or skilled nursing facility
- All surgical procedures, inpatient or outpatient
- Services and items:
  - Allergy (immunotherapy), except for those services identified on the QAF
  - Ambulance transportation (non-emergency)
  - Amniocentesis
  - Cardiac and pulmonary rehabilitation programs
  - Court-ordered services
  - Chemical therapy
  - Dialysis
  - DME, including apnea monitors and bili-blankets
  - Upper endoscopies and colonoscopies at hospitals
  - Genetic testing
  - Gamma Knife, Cyberknife
  - Hearing aids
  - Home Health Services
  - Hospice care
  - Hyperbaric Oxygen Therapy (HBO)
  - Investigational and experimental procedures and treatments
  - IV Infusions
  - Laboratory services in POS 22 (outpatient surgical setting) and 24 (freestanding outpatient surgical facility
  - Lithotripsy
  - Mental Health (See Mental Health Section)
  - Nutritional counseling
  - MRI’s, MRA’s
  - Oral Surgery
  - Oxygen therapy and equipment
  - Out-of-Network Services
  - Pain Management and or Pain Injections
  - PET Scans
Emergency Services

Emergency services are not subject to prior authorization requirements and are available to our members 24hrs. /7 days a week, 365 days.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Simply Healthcare Plans (SHP) shall not:

- Require prior authorization for an enrollee to receive pre-hospital transport or treatment or for emergency services and care;
- Deny payment for treatment obtained when a representative of the SHP instructs the enrollee to seek emergency services.
- Specify or imply that emergency services and care are covered by the Plan only if secured within a certain period of time;
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
- Deny payment based on a failure by the enrollee or the hospital to notify SHP before, or within a certain period of time after, emergency services and care were given.
- Deny claims for emergency services and care received at a hospital due to lack of parental consent.

Pre-hospital and hospital-based trauma services and emergency services and care will be authorized. SHP shall cover all screenings, evaluations, and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member has an emergency medical condition. If the provider determines that an emergency medical condition does not exist, SHP is not required to cover services rendered subsequent to the provider’s determination unless authorized by the Plan.

If the provider determines that an emergency medical condition exists, and the enrollee notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is an enrollee of SHP, the hospital must make a reasonable attempt to notify the enrollee’s PCP, if known, or SHP, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, does not know the enrollee’s PCP, or has been unable to contact the PCP, the hospital must notify SHP as soon as possible before discharging the enrollee from the emergency care area; or notify the Plan within twenty four (24) hours or on the next business day after the enrollee’s inpatient admission.

If the hospital is unable to notify SHP, the hospital must document its attempts to notify the Plan, or the circumstances that precluded the hospital’s attempts to notify the Plan. SHP shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.
SHP shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until the Plan can safely transport the member to a participating facility. SHP may transfer the member, in accordance with state and federal law, to a participating hospital that has the capability to treat the member’s emergency medical condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer, and that determination is binding.

**Emergencies at Out-of-State Hospitals**

Emergency services provided in out-of-service area and out-of-the-country hospitals are reimbursable when an emergency arises from an accident or illness, the health of the recipient would be endangered if the care or services were postponed until he returned to service area or if the health of the recipient would be endangered if he undertook travel to return to Florida.

**Post-stabilization Care Services**

Post-stabilization care services will be covered without authorization, regardless of whether the enrollee obtains a service within or outside the Plan’s network for the following situations:

- Post-stabilization care services that were pre-approved by SHP
- Post-stabilization care services that were not pre-approved by the Plan because SHP did not respond to the treating provider’s request for pre-approval within 72hrs after the treating provider sent the request
- The treating provider could not contact the Plan for pre-approval

The post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Plan can choose not to cover them if they are provided by a non-participating provider, except in those three circumstances identified above.

**Hospital Inpatient Services**

Inpatient services include, but are not limited to:

- Acute hospital and long term care hospital stays
- Rehabilitation hospital care
- Medical supplies, drugs and biologicals, diagnostic and therapeutic services
- Use of facilities, room and board, nursing care
- Inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergent and non-emergent conditions
- Physical therapy services when medically necessary and when provided during an enrollee’s inpatient stay.

**Prior Notification for Hospital Admissions**

All inpatient admissions, including maternity, acute hospital, skilled nursing facilities, rehabilitation facilities and hospice require notification to the Plan.

- Elective Admissions: Notification is required at least fourteen (14) calendar days prior to the scheduled procedure or admission.
- Emergency Admissions: Notification required within one (1) day of an emergency of urgent admission.
- Inpatient admission after Ambulatory Surgery: required within one (1) day of the inpatient admission.

**Non-Routine Dental Care Covered Under Outpatient Services**

Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician);

**Hospice**

To qualify for the Medicare hospice program, all recipients must:

- Be eligible for Medicare
- Be certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course
- Voluntarily elect hospice care for the terminal illness
• Sign and date a statement electing hospice care

Hospice is a program of care and support for people who are terminally ill. It is available as a benefit under Medicare Hospital Insurance (Part A). The focus of hospice is on care, not treatment or curing an illness. Emphasis is placed on helping people who are terminally ill live comfortably by providing comfort and relief from pain.

Some important facts about hospice are:
• A specially trained team of professionals and caregivers provide care for the “whole person”, including his or her physical, emotional, social and spiritual needs.
• Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s).
• Care is generally provided in the home
• Hospice isn’t only for people with cancer.
• Family caregivers can get support.

When all the requirements are met, the Medicare hospice benefit includes:
• Physician and nursing services
• Medical equipment and supplies
• Outpatient drugs or biological for pain relief and symptom management
• Hospice aide and homemaker services
• Physical, occupational and speech-language pathology therapy services
• Short term inpatient and respite care
• Social worker services
• Grief and loss counseling for the member and his or her family

When a member/patient enrolled in hospice receives care from your practice or facility, it is very important that all of the care be coordinated with their hospice physician. Once a Member is enrolled in hospice, Simply is not financially responsible for any services related to the hospice diagnosis. The Plan will continue to assist in coordination of the member’s care to the best of its ability, however, the payment process to provider’s changes.

For Hospice diagnosis-related care, providers need to bill the Medicare-approved hospice organization with which the patient is enrolled. For care not related to the hospice related diagnosis, that is a Medicare covered benefit, Simply participating providers need to bill the health plan. Non-participating providers need to bill Medicare’s Fiscal Intermediary. If a Member’s hospice is revoked during a month, you must continue to bill the hospice organization or the Fiscal Intermediary for CMS through the end of that month. Simply is responsible for additional benefits not covered by Medicare, i.e. the transportation benefit, dental and vision. Any claims received by Simply for Medicare-covered services that are related to the hospice diagnosis or that are not additional plan benefits, will be denied by the Plan.

Note: A member who has elected hospice and requires medical treatment for a non-hospice condition can do one of the following:

1) Use plan providers and services. In such a case, the member only pays Plan allowed cost-sharing, and the provider would directly bill Simply Healthcare Plans.
2) Use non-network providers and be treated under FFS. In such a case, if the service is not emergent/urgent care, the member would pay the total FFS allowed cost-sharing. The provider bills Medicare’s Fiscal Intermediary.

When hospice services are requested by a Member, confirmed with the Centers for Medicare & Medicaid Services (CMS) and updated in the Plan’s system, the Member is sent a new enrollment card reflecting a new group number beginning with RH*. This process may take time, depending on when the Hospice Form is received by CMS and when their system is updated.
It is important that your staff and/or billing company understands the process required to bill the Fiscal Intermediary for CMS for members of our Plan that are enrolled in hospice. Please communicate this information to your staff and/or billing company as appropriate.

Contact Information for the Fiscal Intermediary is as follows:
First Coast Service Options, Inc.
- Medicare Part A: Provider Contact Center- 1-(888) 664-4112

IVR System- 1-(877) 602-8816
- Medicare Part B: Provider Contact Center- 1-(866) 454-9007

IVR System- 1-(877) 847-4992

Additional Resources:
Medicare Claims Processing Manual- Chapter 11: Processing Hospice Claims (Revised: 4/28/10) Section 40.2.2 – Claims from Medicare Advantage Organizations

Observation Services
Observation services are those furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital’s nursing or other staff and are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered when provided by the order of a physician, criteria is met for Observation status, as per Medicare guidelines and when they are not followed by an inpatient admission, up to 48 hours.

Services for routine post-operative monitoring during a normal recovery period must not be billed as observation services. Hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient admissions. Observation services must be billed one claim per observation day, in the same manner as all other outpatient services. Consecutive days of observation must be billed one claim per day.

Out-of-Network Requests for Non-Emergency Services
SHP will provide timely approval or denial of authorization of out-of-network use through the assignment of a reference number. Written follow-up documentation of the decision will be sent to the out-of-network provider within one (1) business day from the request.

The member will be liable for the cost of unauthorized services from non-participating providers.

Mental Health
Mental health referrals and services are processed and determinations issued by Beacon, Simply’s behavioral health provider network. Inpatient mental health services will be covered for up to 190 days lifetime limit and will be provided in a Medicare-Certified facility. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when the members enroll in a Medicare Advantage Plan.

- By calling 1-800-221-5487
- Via the web www.beaconhealthoptions.com or https://provider.beaconhs.com
- By fax at 1-800-370-1116 Use the Beacon Referral Form (Refer to the Forms Section)

Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services.

Simply Healthcare Plans (SHP) mental health services include medically necessary evaluation, testing, counseling, therapy, rehabilitation and other related treatments. They include inpatient and outpatient hospital services and psychiatrists and psychologists; they may also be coordinated with the school system.
• Members will call Beacon to make appointments and obtain the names of several providers in their area. They may select an alternative behavioral health provider within the network and may receive care at doctor’s offices, community centers and in schools.
• If a member was receiving mental health or psychiatric treatment before joining SHP, please call Beacon or SHP Member Services so that the care is not interrupted.
• Services include individual, group and family therapy or evaluations, treatment planning, social rehabilitation, day treatment

Emergency Mental Health Services In and Outside of the Service Area
• Members are advised to call 911 or go to the nearest emergency room if they need emergency mental health care, and to call their PCP later as soon as they can.
• SHP will cover all emergency mental health care whether the member is in or outside the service area, at any time.
• Members may call Beacon at 1-800-221-5487 for assistance finding behavioral care in the area where they are
• After the initial emergency treatment, SHP will cover the post-stabilization care services, even without authorization. Crisis intervention services are covered.

Second Surgical Opinions
Medicare covers second surgical opinions in some cases for surgery that isn’t an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Standing Referrals for Members with Chronic and/or Disabling Conditions
Members with chronic and disabling conditions, which require ongoing specialty care, will be issued standing referrals to the appropriate specialists and/or services. The PCP needs to submit a referral for the course of treatment to be provided by a specialist and/or ancillary provider.

SHP may request reports on the ongoing status of the member’s condition from the provider.

Continuity and Transition of Care Needs
What if a specialist or another network provider leaves our plan?
Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens you will need to switch to another provider who is part of our plan’s network. If there is a significant change in your provider network, we will send you a letter notifying you of the change. The notification describes the changes in your provider network and the effective date of the change. The notification you will receive from us will contain specific information depending on the type of provider that is leaving the plan. If you are currently receiving active treatment from this specialist provider, your PCP will coordinate with the plan to coordinate prior approval for continuity-of-care services, until such time as it is medically safe to coordinate your transfer of care to a plan network provider specialist, as per Medicare guidelines.

Post Discharge Planning/Transition of Care
Discharge planning begins upon notification of an acute inpatient, observation status, rehabilitation or skilled nursing facility admission. Early identification and planning of the member’s transition of care needs is essential in providing quality discharge needs and ensuring that the member is discharged to the appropriate level of care to prevent readmissions and unscheduled transition of care.

SHP’s Concurrent Review Nurses will be responsible for working with the member, attending physician, the PCP, the hospital/facility staff, and all ancillary service providers in completing all discharge needs for the member. He/she will also identify any on-going care needs and refer, as indicated, to the SHP Care Management Team.

Care Management Services
SHP is committed to early identification of those members who may be at risk for health care needs/services. These members are identified through multiple resources which include, but are not limited to the Health Risk Assessment and Stratification, provider referrals, member/legal guardian self-referrals, Nursing, Social Services and other ancillary provider referrals, utilization and pharmacy data and others.
The SHP Care Management Team will regularly monitor members with ongoing medical conditions and coordination of services for over and underutilization patterns, and care needs, such that the following functions are addressed as appropriate:

- Serve as a liaison between the member and providers
- Ensure the member is receiving routine medical care and that the member has adequate support systems at home
- Identify and coordinate transition of care needs
- Provide and refer the member/legal guardian to available community resources as appropriate
- Communicating with other members of the Interdisciplinary Care Team (ICT), including providers and/or other health plans serving the member, the care plan for review and feedback and any identified special health care needs.

Those members that are identified or referred for Care Management Services will be assessed and at their risk level stratified for referral to on-going Care Management or Disease Management Programs.

SHP’s Care Management Team follows the Interdisciplinary Care Team (ICT) approach, with the Primary Care Physician (PCP) as the primary point of contact. The ICT includes providers and other professional disciplines or service representatives who are significantly involved in a member’s care. Together the ICT ensure coordination of care services focused on improving member health outcomes, care planning/transition of care needs and support for the member/legal guardian, caregiver and/or the family.

Individual Care Plans are developed with the support of the ICT in identifying specific problems or needs, interventions and goals. The member/legal guardian and/or caregiver are encouraged to actively participate in the development, implementation, and on-going review of the Care Plan.

Members may be referred to SHP’s UM Care Management Team by calling 1-800-887-6888 ext 2271 or faxing at 786-441-4607 or 1-877-577-0117.

**Simply Healthcare Plans (SHP) Utilization and Medical Criteria Resources**

The following sources are utilized by SHP in helping to make Plan determinations. These include, but are not limited to:

- CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- American College of Physicians guidelines
- Department of Health & Human Services, U.S. Preventative Services Task Force (USPSTF)
- Centers for Medicare and Medicare Services (CMS)
- National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Nationally recognized, evidence-based guidelines (See Section 8 of this Handbook)

**Adverse Determinations**

SHP follows all federal and state regulations and guidelines in making an authorization’s final determination. If the final determination is adverse (denial) for requested service(s) SHP will:

- Ensure that only a Medical Director may issue an adverse determination (denial), with the exception of denials due to benefit issues
- A written denial will be faxed to the provider and mailed to the member within two (2) working days after the subscriber or provider is notified of the adverse determination with information about the appeals process and utilization review criteria

Please see Section 14 for member appeals.
Section 6. Covered Services

Covered Services Include
Covered Services are subject to Authorization requirements, contact the Plan for details.

Care Management and Disease Management: Available to all members through the UM’s Care Management Department. Please contact the UM Care Management Department for information and to refer members.

Interpreter Services and Services for the Hearing or Vision Impaired – please call the Simply Healthcare Plans (SHP) Member Services number on the back of the member’s ID card. The services are free of charge.

Transplants – If medically necessary, covered by Medicare, and if the member has qualified as a transplant candidate Please contact the Plan for details.

Physician Services
Physician Services – Services when medically necessary for preventive, diagnostic or treatment of a particular illness. Services rendered by a participating physician including the member’s Primary Care Physician, Specialist, Chiropractor or Podiatrist. Contact the Plan for exclusions and details.

Podiatry Services – Medically necessary foot care provided by a participating podiatrist. Members are eligible for supplemental routine visit(s) every year.

Home Health Care - Includes medically necessary part-time or intermittent skilled nursing and home health aide services. All services must be provided by a participating provider and there are a limited amount of daily and weekly visits.

Inpatient Hospital Services – See Section 4.

Mental Health Services – Inpatient and outpatient hospital services for a number of psychiatric conditions, psychiatric physician services and Community Mental Health services. See our contact information for Beacon in Section 1.

Outpatient Services
Outpatient Services – Medically necessary medical or surgical services provided in an outpatient hospital setting, which include but are not limited to: physical therapy, occupational therapy, cardiac and pulmonary rehabilitation. All require prior authorization.

Ambulance Services: Covered for emergency transportation to the nearest appropriate facility. In non-emergent situations they are covered if the member’s condition is such that other means of transportation are contraindicated.

Diabetes and Education and Supplies – For all people who have diabetes and when medically necessary.

Durable Medical Equipment - Certain medical equipment for use at home, which includes but is not limited to: crutches, canes, walkers, commodes, wheelchairs, oxygen and oxygen-related equipment.

Emergency Services – Described in Section 4

Renal Dialysis – Outpatient Hospital Facility & Freestanding: Include dialysis-related supplies and routine laboratory tests and other necessary items. Services included all medically necessary services and procedures rendered by a participating provider.

Independent Laboratory Services and X-Rays - When ordered by a participating provider.

Preventive Services
Immunizations – Flu shots, Pneumonia vaccine, Shingles vaccine, Hepatitis B vaccine for those at risk. Members who are at risk and meet Medicare Part B coverage rules could be covered for other vaccines. Some vaccines are covered under the Part D benefit.
Prescription Drugs – Part B
Medicare Part B Prescription Drugs
These drugs are covered under Part B of Original Medicare. Members of Simply receive coverage for the following drugs through our plan. Some limitations, restrictions, coinsurance and/or copayments may apply.
- Drugs that usually are not self-administered by the patient and are injected or infused in a professional setting.
- Drugs taken using durable medical equipment (i.e., nebulizers) that is authorized by the Plan.
- Clotting factors, self-administered through injections if the member has hemophilia.
- Immunosuppressive Drugs, if the member was enrolled in Medicare Part A at the time of the organ transplant.
- Injectable osteoporosis drugs
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.

Prescription Drugs – Part D
Medicare Part D Prescription Drugs
COVERED: All plans are required to have formularies or preferred drug lists (PDLs) that address all medically necessary drugs. Six (6) drug classes of special concern have been specified in which all or substantially all drugs will be on a plan’s formulary: anti-neoplastic, anti-HIV/AIDS drugs, immunosuppressant, anti-psychotics, anti-depressants and anti-convulsants.

NOT COVERED: By law, there are certain types of drugs that Medicare must exclude from Part D: *barbiturates; benzodiazepines; drugs used for anorexia, weight loss or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals and over-the-counter drugs.

For your patients who have both Medicare and Medicaid, check with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs. Go to: www.cms.hhs.gov/States/EDC/list.asp#TopOfPage, to check which states cover these excluded drugs.

*Simply covers a few of the excluded barbiturates, benzodiazepines, and erectile dysfunction drugs. Please contact the Plan for details.

You may access the Simply’s Preferred Drug List on our website at http://simplyhealthcareplans.com/medicare/pharmacy/formulary/index.html


Additional Benefits
Dental Services: One cleaning every 6 months, one oral exam every 6 months and one dental x-ray once a year. The plan offers additional comprehensive dental benefits. Members can call the plan for assistance in locating a participating provider.

Hearing Services- Basic hearing evaluations and additional covered services including but not limited to: Up to 1 hearing aid per calendar year.

Vision Services- Services include but are not limited to: one visit per year for a routine exam and a plan coverage limit for eyeglasses, hardware or contact lenses. Please contact the Plan for details.
Transportation Non-Emergency – Covered by the Plan for medical care and to approved locations which are requested by the members Primary Care Physicians. Contact the Plan for restrictions and details.
Over the Counter (OTC) – Members of most of our plans are eligible for a monthly benefit to be used towards the purchase of over the counter (OTC) health and wellness products (non-prescription drugs) available through the plans OTC provider. For details please contact the plan.

Health and Wellness
The Plan offers health and wellness programs that address such concerns as fitness and nutrition. Please contact the Plan for further details.

- Silver and Fit®
- Meal Program
Section 7. Member Rights and Responsibilities

Overview
This section explains Simply Healthcare Plans (SHP) member’s rights and responsibilities, as is included in the SHP Member Handbook. Florida law requires health care providers and facilities to recognize member rights while they are receiving medical care or services and that the member respect the health care provider and facilities’ right to expect certain behavior on the part of the member.

Patient Rights must be posted in the provider’s office for all members to see. Contact a Provider Relations representative for a copy of the Patient Rights and Responsibilities document

Member’s Rights & Responsibilities
SHP Members have the right to:
- Be treated with courtesy and respect, and with due consideration of his/her dignity and privacy.
- Confidentiality regarding disclosures and the treatment of medical records.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be informed of access to after-hours and emergency care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of his or her medical records, and request that they be amended or corrected.
- Be furnished health care services in accordance with federal and state regulations.

The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

They also have the right to:
- Receive a prompt and reasonable response to questions and requests
- Know who is providing medical services and who is responsible for his/her care, including the credentials of the health care provider.
- Know what member support services are available, including whether an interpreter is available if he/she does not speak English
- Know what rules and regulations apply to his/her conduct
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained for services not covered by SHP
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Be informed that they can change providers if other qualified providers are available.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- Be advised if medical treatment is for purposes of experimental research and be able to give his/her consent or refusal to participate in such experimental research
- Express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him/her and to the appropriate state licensing agency
- be informed and be allowed to have a written Advanced Directives, as required by State and/or federal regulations
- be provided with appropriate information regarding absence of malpractice insurance company
SHP Members are responsible for:

- Providing to the health care provider, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health, including the use of over-the-counter medications and dietary supplements
- Reporting unexpected changes in their condition to the health care provider
- Reporting to the health care provider whether they comprehend a contemplated course of action and what is expected of them
- Following the treatment plan recommended by the health care provider
- Keeping appointments and, when they are unable to do so for any reason, for notifying the health care provider or health care facility
- Their actions if they refuse treatment or do not follow the health care provider’s instructions
- Assuring that the financial obligations of their health care are fulfilled as promptly as possible
- Following health care facility rules and regulations affecting patient care and conduct
- Inform the provider about any living will, power of attorney and any other directive that could affect their care.
- Be respectful of all health care professionals, staff as well as other patients.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by the provider.

Services for Translations and the Hearing Impaired

All SHP eligible and potential members whose primary language is not English are entitled to receive interpreter services through SHP at no cost to the member by calling SHP Member Services at 1-800-213-1133. For the hearing impaired, TTD/TTY is 711 Florida Relay.

Advance Directives

Advance Directives are an individual’s written choice for health care. Under Florida State Law, there are two types of directives, which are:

- Durable Power of Attorney for Health Care: This Advance Directive names another person to make medical decisions on behalf of the member when they cannot make choices for themselves. It may include plans about specific care a member wants or does not want and include information concerning artificial life support machines and organ donation. This form must be signed, dated and witnessed by a notary public to be valid.

- Directive to Physicians (Living Will): This Advance Directive usually states the member requests to die naturally without life-prolonging care and can also include information about specific medical care. This form would be used if the member could not talk and death would occur soon. This directive must be signed, dated and witnessed by two people who know the member well but are not relatives, possible heirs, or health care providers.

Written Advance Directives tell the health care provider how the members choose to receive medical care in the event they are unable to make end-of-life decisions. SHP providers must honor Advance Directives to the fullest extent permitted under Florida State Law.

Providers must document the presence of an Advance Directive in a prominent location within the member’s medical record. PCP’s must discuss Advance Directives with members and provide appropriate medical advice if the members desire guidance or assistance. Under no circumstances may any SHP Provider refuse to treat a member or otherwise discriminate against a member because the member has completed or refuses to complete an Advance Directive.

For members who are no longer able to make decisions and do not have an Advance Directive, the member’s legal guardian or family and provider should confer together to decide upon the best care for the member based on information they know about the member’s end-of-life plans.
Section 8. Preventative Care and Clinical Practice Guidelines

Overview
Simply Healthcare Plans (SHP) utilizes nationally recognized preventative care, evidence-based clinical practice information and clinical practice guidelines/protocols.

This information is made available to Plan providers to ensure fair, consistent, and quality health care services and treatment is provided to the members.

Below you will find links to these guidelines. For questions or comments, please contact the SHP Utilization Management Department at 1-800-887-6888 ext. 2271 or contact your Provider Relations Representative.

<table>
<thead>
<tr>
<th>Preventative Services</th>
<th>Website Link</th>
<th>Information Provided</th>
</tr>
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<tbody>
<tr>
<td>Multiple</td>
<td><a href="http://www.guideline.gov">www.guideline.gov</a></td>
<td>An initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>Cancer</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#cancer">http://www.ahrq.gov/clinic/cps3dix.htm#cancer</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#cancer">http://www.ahrq.gov/clinic/tfchildcat.htm#cancer</a></td>
<td>Multiple cancer related topics regarding prevention, screening, and counseling</td>
</tr>
<tr>
<td>Development and Behavior</td>
<td>Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#dev">http://www.ahrq.gov/clinic/tfchildcat.htm#dev</a></td>
<td>Development and behavior screening information</td>
</tr>
<tr>
<td>Heart and Vascular Diseases</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#heartvasc">http://www.ahrq.gov/clinic/cps3dix.htm#heartvasc</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#heartvasc">http://www.ahrq.gov/clinic/tfchildcat.htm#heartvasc</a></td>
<td>Multiple heart and vascular related topics regarding prevention, screening and counseling</td>
</tr>
<tr>
<td>Injury and Violence</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#injury">http://www.ahrq.gov/clinic/cps3dix.htm#injury</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#injury">http://www.ahrq.gov/clinic/tfchildcat.htm#injury</a></td>
<td>Multiple injury and violence related topics regarding screening and counseling</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#infectious">http://www.ahrq.gov/clinic/cps3dix.htm#infectious</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#infectious">http://www.ahrq.gov/clinic/tfchildcat.htm#infectious</a></td>
<td>Multiple infectious disease related topics regarding prevention, screening and counseling</td>
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<tr>
<td>Mental Health Conditions and Substance Abuse</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#mental">http://www.ahrq.gov/clinic/cps3dix.htm#mental</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#mental">http://www.ahrq.gov/clinic/tfchildcat.htm#mental</a></td>
<td>Multiple mental health and substance abuse related topics regarding screening and counseling</td>
</tr>
<tr>
<td>Metabolic, Nutritional and Endocrine Conditions</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#metabolic">http://www.ahrq.gov/clinic/cps3dix.htm#metabolic</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#metabolic">http://www.ahrq.gov/clinic/tfchildcat.htm#metabolic</a></td>
<td>Multiple metabolic, nutritional and endocrine related topics regarding prevention, screening and counseling</td>
</tr>
</tbody>
</table>
Musculoskeletal Disorders

Adults: http://www.ahrq.gov/clinic/cps3dix.htm#musculo
Adolescents: http://www.ahrq.gov/clinic/tfchildcat.htm#musculo

Multiple musculoskeletal related disorders topics regarding screening and counseling

Obstetric and Gynecological Conditions

Adults: http://www.ahrq.gov/clinic/cps3dix.htm#obstetric

Multiple OB/GYN related topics regarding prevention, screening and counseling

Perinatal Care

Adolescents and Children http://www.ahrq.gov/clinic/tfchildcat.htm#perinatal

Multiple perinatal care related topics regarding screening

Vision and Hearing Disorders

Adults: http://www.ahrq.gov/clinic/cps3dix.htm#vision
Children and Adolescents: http://www.ahrq.gov/clinic/tfchildcat.htm#vision

Multiple vision and hearing related disorder topics regarding screening

Miscellaneous

Adults: http://www.ahrq.gov/clinic/cps3dix.htm#misc

COPD related screening information and dental and periodontal disease counseling

### Clinical Practice Guidelines Reference Guide

<table>
<thead>
<tr>
<th>Topic</th>
<th>Website Link</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma (Adult and Pediatric)</td>
<td><a href="http://www.healthquality.va.gov/Management_of_Asthma_Adult_and_Pediatric.asp">http://www.healthquality.va.gov/Management_of_Asthma_Adult_and_Pediatric.asp</a></td>
<td>U. S. Department of Veterans Affairs, National Institutes of Health</td>
</tr>
<tr>
<td>Chronic Kidney Disease (CKD)</td>
<td><a href="http://www.healthquality.va.gov/Chronic_Kidney_Disease_Clinical_Practice_Guideline.asp">http://www.healthquality.va.gov/Chronic_Kidney_Disease_Clinical_Practice_Guideline.asp</a></td>
<td>U. S. Department of Veterans Affairs,</td>
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<tr>
<td>COPD</td>
<td><a href="http://www.healthquality.va.gov/Chronic_Obstructive_Pulmonary_Disease_COPD.asp">http://www.healthquality.va.gov/Chronic_Obstructive_Pulmonary_Disease_COPD.asp</a></td>
<td>U. S. Department of Veterans Affairs,</td>
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<tr>
<td></td>
<td><a href="http://www.guideline.gov/content.aspx?id=24035">http://www.guideline.gov/content.aspx?id=24035</a></td>
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<tr>
<td>Diabetes</td>
<td><a href="http://care.diabetesjournals.org/content/35/Supplement_1/S11.full">http://care.diabetesjournals.org/content/35/Supplement_1/S11.full</a></td>
<td>American Diabetes Association, Diabetes Care, Standards of Diabetes Care 2012</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td><a href="http://www.healthquality.va.gov/Dyslipidemia_LIPIDS.asp">http://www.healthquality.va.gov/Dyslipidemia_LIPIDS.asp</a></td>
<td>U. S. Department of Veterans Affairs,</td>
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<tr>
<td>Hemophilia</td>
<td><a href="http://www.wfh.org">www.wfh.org</a></td>
<td>World Federation of Hemophilia, Diagnosis and Treatment Guidelines, Last Updated February ’09</td>
</tr>
<tr>
<td></td>
<td><a href="http://aidsinfo.nih.gov/guidelines">http://aidsinfo.nih.gov/guidelines</a>;</td>
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<td><a href="http://www.faetc.org/Treatment/">http://www.faetc.org/Treatment/</a></td>
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<table>
<thead>
<tr>
<th>Condition</th>
<th>Resource</th>
<th>Source/Update Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease (IHD)</td>
<td><a href="http://www.healthquality.va.gov/Ischemic_Heart_Disease_IHD.asp">http://www.healthquality.va.gov/Ischemic_Heart_Disease_IHD.asp</a></td>
<td>U.S. Dept. of Veterans Affairs,Reviewed/ Updated Nov. 2009</td>
</tr>
</tbody>
</table>

Section 9. Medical Records Standards

Overview
All Simply Healthcare Plans (SHP) physicians are required to maintain a complete electronic or paper medical record for each SHP member, according to approved professional practice standards, as well as state and federal requirements. Records are required to be current, legible, detailed, confidential and organized to allow for effective and confidential member health care by all providers.

Medical Record requirements apply, but are not limited to, oral, written and electronic communication and information.

Requirements
Contracted providers are to have a person designated in charge of medical records whose responsibilities include, but are not limited to:

- The confidentiality, security and physical safety of records, in accordance with HIPAA privacy standards
- The timely retrieval of individual records upon request
- Having a unique identification of each member’s record
- The supervision of the collection, processing, maintenance, storage, retrieval and distribution of records; and
- The maintenance of a predetermined, secured and organized record format

The provider is responsible for documenting all evaluations, treatment, and services provided to the member. This documentation must include, but is not limited to:

- Family planning services, including discussion of all appropriate methods of contraception, counseling and services to all women and their partners
- Preventative health services
- Services for treatment of sexually transmitted diseases (STD’s)
- Ancillary, diagnostic and therapeutic services
- All services for which a member was referred to a specialist or ancillary provider
- Health Education and Wellness promotion services available and discussed

Medical record documentation, at a minimum, must be legible, detailed, and organized in a consistent manner that facilitates continuity of care and maintain the following documentation:

- Medical record documentation, at a minimum, must be legible, detailed and maintain the following documentation:
  - Member identification: Including name, member identification number, date of birth, sex, and legal guardian, if applicable
  - Medical history summary: Including current medications (both prescribed and over-the-counter), with dosages, dates of initial or refill prescriptions or samples, untoward reactions and allergies to foods and/or drugs (both prescribed and over-the-counter) or documentation that none are known, surgical procedures, past and current medical diagnoses or problems

Documentation for the current office visit, which will include, but is not limited to:

- Chief complaint or reason for the current visit
- Objective findings or observations
- Medical diagnosis or impression, including behavioral health conditions
- Treatment plan, which will include referrals to specialists or other ancillary services; laboratory, radiological or other studies/procedures ordered; all therapies or services administered or prescribed to the member, including dosages and dates of initial or refill prescriptions; disposition, recommendations, instructions to the member, including follow-up time frames for follow-up evaluation/care, evidence of whether there was follow-up and outcome of services
- Name and profession of the provider rendering the services (i.e. MD, DO, DDS, PA, ARNP), including the signature of the provider
- All entries in the medical record are to be dated and signed by the person who is making the documentation, with the profession (i.e. LPN, RN, PT) noted, if applicable
- All entries must be legible and maintained in detail.
- All telephone calls from the member/legal guardian are to be documented in the medical record and include:
  - The date/time the call was received and by whom;
  - The date/time the call was returned and by whom;
  - Fully detailed documentation of any advice, treatment/prescriptions or diagnosis/impression made and by whom, with name/title and signature of the person documenting.
- All member medical records are to include:
  - Documentation of the member’s primary language spoken and any translation services that are needed.
  - Documentation of any communication assistance needs that are needed for the delivery of health care services (i.e. sign language services for the deaf).
  - A current immunization history.
  - Member’s use of tobacco products or alcohol/substance abuse with documentation when referrals to cessation programs or behavioral services were offered and the member’s decision.
  - Summaries of all emergency care services and hospital discharge summaries with appropriate medical follow-up documented.
  - Documentation of all preventive care (i.e. women’s health care services, prostate examination, colonoscopy, etc.) that was recommended and ordered for the member (NOTE: If the member refuses the recommended care, this should be documented and the member should sign that he/she refused the recommended service).
  - Documentation that the member/legal guardian was provided with written information regarding Advance Directives, including:
    - End-of-life wishes (Do Not Resuscitate).
    - Living Will or Power of Attorney.
    - Whether or not the member/legal guardian has executed and Advance Directive.
    - *NOTE: Simply Healthcare Plans, nor any of its providers shall, as a condition of treatment, require the member/legal guardian to execute or waive an Advance Directive.
    - Copies of any advance directives executed by the member.
    - Documentation in the member’s medical record will clearly indicate diagnostic or therapeutic intervention(s) as part of clinical research (NOTE: This requirement does not hold SHP responsible for the payment of diagnostic or therapeutic intervention as part of clinical research.
    - A release document for each SHP member authorizing SHP to release medical information for facilitation of medical care.
    - A current problem list, including past and current diagnoses, procedures and surgeries, which will be used to provide continuity of care.
    - Documentation of health education and wellness promotion services, whether they occurred within the context of a clinical visit or not.
    - Providers must retain all the member’s medical records for a minimum of six (6) years.
    - Documentation is to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for the purpose of clarification, error correction, the addition of information not initially available and if certain unusual circumstance prevented the generation of a note at the time of service.

Medical Records Audits and Compliance
In order to comply with regulatory and accreditation requirements, the SHP Quality Management Department conducts medical records audits in physician offices. The members’ medical records will be reviewed for content and screenings, as applicable.

All providers with an aggregate audit score of 85% or lower are scheduled for their next review in six (6) months or more frequent as determined by their score and deficiencies found. All providers who scored less than 85% on an audit component directly related to the condition or diagnosis of the enrollee’s medical record reviewed is reviewed every six months or more frequently, until it is determined by the score that deficiencies have been remediated.

Physicians will be given preliminary results at the time of the audit. A final written report will be mailed to the provider within thirty (30) days. A corrective action plan may be required depending a three tiered hierarchy:
- Minimal Deficiencies Score is between 85% and 100% no remediation is required.
- Moderate Deficiencies Score is 75% to 84% and a score of 80 to 85% or more in all separate components the provider's documentation will be reviewed again in six (6) months.
- Serious Deficiencies Score is less 74% and a score of 79% or less in all separate components the provider will be required a corrective action plan.

It is the provider's responsibility to comply with Corrective Action Plans imposed as the result of any such audit or review.
Section 10. Quality Management

Overview
Simply Healthcare Plans (SHP) has developed this Quality Improvement Program based on care coordination for its enrollees. The includes the mission, vision and five core values set by the Quality Improvement Strategy for the Medicare Advantage (MA) and Prescription Drug Plan (PDP) Programs based on the 2001 Institute of Medicine (IOM) report. This Quality Improvement Program Plan strives to establish a culture of improving quality of care and services for all Medicare beneficiaries enrolled in the Plan.

The Quality Improvement Program Plan is the vehicle by which the leadership, management and governing body measures its level of performance and determine if organizational systems and processes must be modified based on performance results.

The Quality Improvement Program Plan (QIPP) is submitted to CMS as part of the contract and Special Needs Plans (SNPs) applications.

Program Goals:
The goals and objectives of the QI program have been created to establish a defined process which:

- Achieves the optimum quality health care through processes, structures and data management systems in place at the Plan.
- Improve the ability of the Plan, including all Special Needs Plans, to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner.
- Enhance care transitions across all healthcare settings and providers for SNP beneficiaries.
- Affirms that the Board of Directors has the ultimate authority, responsibility and accountability for the effectiveness of the QI program.
- Stresses prevention and effective management of diseases for all demographic groups.
- Maintains a framework by which specific activities can be delegated based on the contracted entity’s performance and provides systematic oversight of delegated functions.
- Measures the level of accessibility, availability, and continuity of coordination of care and facilitate Quality Improvement.
- Communicates all QI activities and outcomes achieved through the QI process throughout the organization including the providers, Board of Directors, management, staff, members and the community.
- Identifies and prioritizes strategies for improvement of care and service.
- Strives to improve and enhance its health care and delivery system in compliance with accepted medical practices and assesses the member acceptability, accessibility and continuity of health care and service.
- Cultivates a continuous Quality Improvement (CQI) management style that is woven throughout the organization with emphasis on; the member, measurement of key performance indicators, empowerment of employees, and a commitment to the improvement of health care and services.
- Reviews provider’s practice methods and patterns, morbidity/mortality rates, and all grievances filed against the provider relating to medical treatment.

The QIP works to achieve these goals through an evaluation process of clinical and service outcomes by measuring the effectiveness of internal processes and ongoing, active improvement interventions. Functional aspects of the QIP that contributes to a high level of clinical and service outcomes include, but are not limited to:

- Care Management Programs:
- Diabetes Management Program;
- CHF Management Program;
- Chronic Care Improvement Program;
- Preventative Care and Clinical Practice Guidelines
- Care Management and Model of Care for Special Needs Plans members

SHP offers disease management programs to help members understand and manage chronic health conditions they may have. For more information on disease management programs available, please call our Care Management Department.
Other Resources for you to assist our members

- Domestic Violence Hotline - Florida: 1-800-500-1119. 24 hrs./7 days a week
- Tobacco Free Florida – 1-877-822-6669 to quit smoking
- www.smokefree.gov for online resources, information and booklets on how to quit smoking.

The QIP includes ongoing screening of the members’ medical records to assure compliance with all regulatory and accreditation agency guidelines. In addition, the QIP will also conduct ongoing studies to document compliance with accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness, and continuity of patient care and services delivered by the provider and the Plan itself. As opportunities for improved documentation or patient care are identified, a plan of action will be developed and implemented. Providers may be asked to participate, when possible, in developing the plan of action because collaborative input will help provide a successful workable solution.

SHP’s Quality Management (QM) Department will assess, on an ongoing basis, the minimum guidelines of care required by regulatory agencies and accreditation organizations for medical record review, health screening and high-risk diagnoses; a representative from the Plan’s QM Department, or assigned Plan designee, will contact the provider’s office to schedule an appointment to review the items in the office. Upon completion of the review, the provider will have an exit meeting with the reviewer to have the findings presented to him/her. At that time any deficiencies found during the review will be outlined so as to assist the provider in making any necessary corrections. A Corrective Action Plan will be requested for all identified deficiencies.

Providers Right to Corrective Action, Fair Hearing Plan, and Reporting to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB

Providers have the procedural right to be heard and to appeal the Credentialing Committee or Peer Review Committee recommendations and actions, including the ones resulting in filing a report to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB.

SHP conducts an ongoing evaluation of services by providers in the plan’s contracted network to achieve and maintain high standards of professional practice within the discipline. In the event that the prevailing professional standard of care for a given provider is believed not to be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in the community, the Plan’s Peer Review Committee will be involved. Peer review may be initiated based on ongoing monitoring of utilization statistics and performance indicators that may indicate quality of care and service issues. Examples include aberrant referral patterns indicating over or underutilization or a trend in member complaints or documented incident reports involving the same provider.

The Peer Review Committee provides fair hearing appeal opportunity for providers and renders judgment in a timely manner and according to SHP’s policies and procedures. The Medical Director chairs the Peer Review Committee. Its membership is drawn from the provider network and includes peers of the provider being reviewed. All peer review activities and data collected are confidential pursuant to Florida State law.

The Plan supplies the providers with a summary of the rights in the hearing in accordance with the Health Care Quality Improvement Act of 1986, which include:

- Furnishing the physician with written notice of the proposed action, with the time, place and date of any hearing of the proposed
- The right to the hearing may be forfeited if the provider fails, without good cause, to appear
- In the hearing the provider has the right:
  - To representation by an attorney or other person of the physician’s choice
  - To have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated
  - To call, examine and cross-examine witnesses
  - To present evidence determined to be relevant by the Committee
  - To submit a written statement at the close of the hearing
- Upon completion of the hearing, they physician involved has the right
To receive the written recommendation of the Committee, including a statement for the basis of the recommendations (which SHP will send to the provider within ten (10) days)

To receive a written decision of the Plan, including a statement for the basis of the decision (which SHP will send to the provider within thirty (30) days)

* The provider needs to notify SHP of such representation at least ten (10) working days prior to the scheduled hearing. SHP may in those cases have legal representation present.

For those cases in which the provider does not agree with the Peer Review Committee’s decision, please see Section 14. There is no further appeal for the decision of the second level appeal.

Measurement of Clinical and Service Quality; HEDIS, CAHPS®, Provider Satisfaction Survey, Member Satisfaction Survey, and key quality metrics.

**CMS Star Rating**

The Centers for Medicare & Medicaid Services (CMS) uses a five-star rating system to measure Medicare beneficiaries’ experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS) and prescription drug plans (PDP). The scale ranges from one to five stars, where a rating of one star (“”) represents “poor” quality and five stars (*****) represents “excellent” quality. The program is a key component in financing health care benefits for MA plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA plans offered in their area.

**CMS Goals for the Five Star Rating System**

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS’ ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

**Healthcare Effectiveness Data and Information Set (HEDIS)**

HEDIS is a set of performance measures established by the National Committee for Quality Assurance (NCQA) for the managed care industry. Each year, Simply collects data from a randomly selected sample of members’ medical records for HEDIS. Medicare Advantage Plans are required to report their results annually to the Center for Medicare and Medicaid (CMS), NCQA, CMS and the Agency for Health Care Administration (AHCA) use this information to monitor the performance of health plans.

HEDIS contains eighty eight (88) measures across (7) “domains” of care:

- Effectiveness of care
- Access/availability of care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems


**Consumer Assessment of Healthcare Providers and Systems (CAHPS)**

The CAHPS survey (Consumer Assessment of Healthcare Providers and Systems) is conducted annually by the Centers for Medicare & Medicaid Services (CMS) to assess the experiences of beneficiaries in Medicare Advantage plans. The survey is typically conducted in early spring of the reporting year by mail, with telephonic follow-up for non-
responders. The CAHPS survey measures members’ experiences with the plan and its providers over the previous six months. The survey sample is drawn from all individuals who had been members of a plan for at least six months. Although beneficiaries provide ratings of their “plans,” the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract. Simply contracts with a CMS-approved Medicare vendor to conduct the survey. Results are produced annually and compared to national benchmarks.

The survey has approximately 95 questions with the results reported in composites. Some questions apply to member satisfaction related to the service provided by the health plan and some reflect the member’s perception of the patient-physician relationship or communication.

The health plan will devise Quality initiatives to assist our partners in providing quality healthcare to our members in order to achieve excellent health outcomes as well as scores.

** Tips for Providers **

- Encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Submit clinical data such as lab results to Simply.
- Communicate clearly and thoroughly; ask, “Do you have any questions?”
- Understand each measure you impact.
- Incorporate Health Outcomes Survey (HOS) questions into each visit. Find out more about HOS at http://www.hosonline.org/Content/SurveyInstruments.aspx.
- Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to identify opportunities for you or your office to have an impact: http://ma-pdpcahps.org/content/surveyinstruments.aspx.
Section 11. Cultural Competency Program

Overview
Simply Healthcare Plans (SHP) has a comprehensive Cultural Competency Program to ensure that the Plan will deliver culturally competent services that meet the diverse needs of all of its members and to ensure the provision of linguistic access and disability-related access to all members including those with limited English proficiency. In addition, SHP is committed to ensuring our providers fully recognize and care for and provide the culturally diverse needs of the members they serve.

The Cultural Competency Program documents how the individuals and systems within the SHP organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions, as well as those members with disabilities, in a manner that recognizes the values of the individuals and preserves the dignity of all.

Cultural competency training is included in all SHP employee and provider training, both upon initial joining SHP and, at a minimum, annually. This integrated approach was developed so that cultural competency becomes a part of our everyday thinking.

SHP endorses the view, as promoted by the federal government, that achieving cultural competence will help the Plan to improve services, care and health outcomes for its current members through improved understanding leading to better adherence and satisfaction and to increase market penetration by appealing to potential culturally and linguistically diverse members.

Five essential elements contribute to a system or organization’s ability to become more culturally competent. These include:

1) Valuing diversity
2) Having the capacity for cultural self-assessment
3) Being conscious of the dynamics inherent when cultures interact
4) Having institutionalized cultural knowledge
5) Having developed adaptations to service delivery reflecting an understanding of cultural diversity

These five elements should be manifested at every level of a culturally competent organization including policy-making, administration, and practice. Further these elements should be reflected in the attitudes, structures, policies, and services of the organization. (*Reference:* Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards a Culturally Competent System of Care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.)

SHP will review and update, if indicated, its Cultural Competency Program at a minimum of every year to ensure the Program is meeting the needs of the Plan’s members, employees, and the provider network.

Standards
SHP’s Cultural Competency Plan has integrated those standards as recommended by the U. S. Department of Health and Human Services and other agencies. The standards and additional information are available and may be viewed by going to the following website:  [http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15](http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15).

SHP conducts initial and ongoing organizational self-assessments of CLAS (Culturally and Linguistically Appropriate Services)-related activities and integrates cultural and linguistic competence-related measures into its internal audits, performance improvement programs, patient satisfaction assessments, conflict and grievance resolution and outcomes-based evaluations.

The standards include but are not limited to the following:

- To ensure that patients receive effective, understandable, and respectful care in a manner compatible with their cultural health beliefs and practices and preferred language
- To implement strategies to have at all levels of the organization a diverse staff and leadership representative of the demographic characteristics of the service area
To ensure that staff at all levels receive ongoing education and training in culturally and linguistically appropriate service delivery

To offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each member with limited English proficiency at all points of contact

To provide to members in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services

To assure the competence of language assistance provided to limited English proficient members by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient)

To make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area

SHP will strive to develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities

Program Goals
The overall goals of the SHP Cultural Competency Program are:

- Identify members early that have potential cultural or linguistic needs
- Ensure resources are available to meet language barriers and communication needs
- Improve communication to members for whom cultural and/or linguistic barriers exist
- Provide culturally sensitive, appropriate educational materials based on the member’s race, ethnicity and primary language spoken
- Decrease health care disparities in the minority populations where SHP delivers services
- Ensure providers and SHP employees are educated and value the diverse cultural and linguistic difference in the organization and populations served care

Program Components
SHP’s Cultural Competency Program includes, but is not limited to data analysis of SHP’s employee and provider network diversity, compliance review, SHP’s employee and provider training, linguistic services/resources, electronic media services/resources, performance improvement outcomes.

This CCP is organized around six core areas that represent the foundation for SHP-wide cultural competence and the activities associated with each of these areas:

- Foster Cultural Competence
- Build Community Partnerships
- Collect Diversity Data
- Measure Performance and Evaluate Results
- Reflect and Respect Diversity
- Ensure Effective Communication and Language Access

The Plan will assure that Plan employees, network providers and delegated contractors and subcontractors are culturally diverse and competent to interact with our culturally diverse members. As required, the Cultural Competency Plan (CCP) describes how providers, SHP employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual enrollees and protects and preserves the dignity of each. The National Standards on Culturally and Linguistically Appropriate Services (CLAS) is followed to educate our employees, enrollees, and providers on the importance of communication in a preferred language and respect for cultural health beliefs.

The Plan provides educational and informational materials regarding all available services in English and other languages. Translation and interpreter services are available through the Plan’s Member Services department for all enrollees who speak another language. Understanding and addressing poor health literacy among some Plan members has been identified as an important element in assuring organization-wide cultural competence. Communication challenges between members and providers may result in a provider’s inability to solicit a patient’s impression or input about their illness, making effective care more difficult and increasing patient frustration. The
provider may also be uncertain about the patient’s compliance to treatment. Educational material will be provided to all network providers and enrollees. Member Services can provide written materials such as large print, audio tape or Braille (for the Blind) upon request. Plan providers are prohibited from patient discrimination based on race, color, ethnicity, national origin, ancestry, religion, sex, marital status, sexual orientation, age, perception, and source of payment or health status. The Plan will provide community based medical linkage that supports racial and ethnic minorities and the disabled to ensure community resources are accessible to enrollees with special needs.

SHP will complete an annual evaluation of the effectiveness of the previous year’s CCP and will develop interventions for elements of the CCP that do not perform to expectations.

You may request a copy of SHP’s Cultural Competency Plan at no cost by calling SHP’s Provider Relations. A full copy of the plan is also available on the plan’s Provider Website.

Section 12. Credentialing

Overview
Simply Healthcare Plans (SHP) is responsible for all aspects of the credentialing and re-credentialing process for all providers who join or participate in the SHP Network. This process is under the QI Program and is designed to meet all regulatory and accreditation requirements and standards. In accordance with those standards, SHP members will not be referred or assigned to a provider until the credentialing process has been completed.

SHP recognizes and accepts the Council for Affordable Quality Healthcare’s (CAQH) credentialing information and application or SHP’s own practitioner application that includes specific profile elements as required by the State of Florida. SHP may contract with medical groups/IPA’s that have approved credentialing function capabilities as entities with delegated credentialing.

Required Information
As a practitioner requesting initial credentialing or re-credentialing with SHP, you are required to submit adequate information that will allow the Plan to complete a thorough evaluation which includes your background, experience, education and training; demonstrate the ability to perform as an SHP provider without limitations, including physical and mental health status as permitted by law.

If the application is incomplete in any way, you will receive a request from SHP, or its delegated entity, to provide the necessary information.

Timing and Frequency of Credentialing
The requirement for timeliness of credentialing a practitioner/provider is 180 calendar days from the date the applicant signs an attestation to the date of the credentialing committee’s final decision. The re-credentialing cycle is a 36-month (three-year) cycle.

Site Reviews
- Site reviews are required for the following provider offices:
  - All Primary Care Physicians (PCP’s), which include Family Practice, General Practice, Pediatrics, and Internal Medicine
  - High Volume OB/GYN’s Providers
- SHP’s Credentialing Department will receive the site review along with a practitioner’s credentialing application for processing. The provider must have a review score of 80% or greater to pass the review for the credentialing application process. In the event the provider does not receive a passing score and a corrective action plan is implemented, it is in the best interest of the provider to work with the site reviewer in developing the corrective action plan and correcting any deficiencies so as not to delay the credentialing process.

Credentialing Committee (CRC)
- All SHP providers must be credentialed and approved by the CRC prior to their contract becoming effective
- SHP’s Credentialing Review Committee (CRC) voting members are professional peers
- Once the requesting provider’s credentialing file is complete it is submitted to the CRC for review and decision
- If the CRC is unable to make a determination based on the available information in the file and requires additional information, the Credentialing Department will request such information on behalf of the CRC
- On occasion, the CRC may, in its sole discretion, request that an applicant requesting credentialing appear for an interview
- SHP’s Board of Directors has delegated the authority to approve or deny applicants who apply for credentialing through the CRC

Verification Process
The Credentialing Department is responsible for verification of the applicant's information including but not limited to medical license, education and training, NPDB, etc., as well as the provider’s and practice owner’s participation and
non-exclusion in government programs the OIG (Office of the Inspector General), and SAM (System for Award Management) prior to being presented to the CRC.

Sanctions
The Office of the Inspector General (OIG) and System for Award Management (SAM) maintains a sanction list that identifies but is not limited to those individuals found guilty of fraudulent billing, misrepresentation of credentials, and default on student loans, etc. Simply Healthcare Plans is required to review the OIG sanctions list with each new issuance of the monthly list and is prohibited from employing or contracting with any individual who is excluded from participation in the Medicare program. Providers identified on the lists will be validated before terminating the provider from the network. Sanctioned providers identified on the OIG or SAM list should not receive Medicare payments. There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

Reinstatement of a sanctioned provider or entity is not automatic. A provider who wants to regain participation in the Medicare program must apply for reinstatement and receive an authorized notice from the OIG that reinstatement has been granted.

Sanctions under Federal Health Programs and State Law
Providers must ensure no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by the provider.

Providers must disclose to PLAN whether they, a staff member or subcontractor have any prior violation, fine, suspension, termination or other administrative action taken by any of the following:

- Medicare or Medicaid laws
- The rules or regulations of the state
- The federal government
- Any public insurer

Providers must immediately notify PLAN of any imposed sanction on them or any staff member or subcontractor.

Opt-Out (Private Contract) Providers
Section 4507 of the Balanced Budget Act of 1997 permits a provider to opt out of Medicare for at least a two-year period. For a provider to opt out of Medicare, he or she must file an opt-out affidavit with his or her local Medicare Part B carrier. If the provider wishes to render services to Medicare beneficiaries, he/she must sign a private contract with each patient. When a provider opts out of Medicare, health care services rendered by the opt-out provider are not covered by Medicare, and no payments can be made to the provider or to the beneficiary, except for services for emergent and/or urgent care situations. Medicare will pay for covered, medically necessary services ordered by an opt-out provider but only if the provider has obtained a unique provider identifier number from Medicare and if the service is rendered by a provider who has not opted out.

Re-credentialing

- Once a provider is credentialed by the CRC to provide service for SHP’s members, re-credentialing will be performed every three (3) years
- The providers will receive a re-credentialing application in a Provider Profile format approximately four (4) to six (6) months prior to their credentialing expiration date. Only information that has changed since the last credentialing needs to be updated
- Failure of the provider to return the re-credentialing form to the Plan will result in an administrative termination from SHP’s Provider Network as a non-compliant provider
- Information that will be verified and presented to the CRC for re-credentialing include:
  
  - Basic qualifications continue to be met
  - Quality performance information (i.e. medical record reviews, member satisfaction surveys, Member Services reports)
• Participation and no exclusion in government programs and the OIG and SAM

• In the event a provider’s DEA and/or medical license expires prior to a provider’s next re-credentialing date, the provider will receive a request for the updated information. Failure to provide the requested information with the specified time frame will result in automatic suspension and/or termination from SHP’s Provider Network

**Organizational Provider Credentialing**
The Plan, credentials organizational providers in accordance with NCQA, CMS and state-specific requirements. The following providers require assessments:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Ambulatory surgical centers
- Behavioral health facilities

Additional providers may also be required to follow the credentialing process.

The following steps are included in the Plan’s Organizational Provider Credentialing process:

- A review and primary source verification of a current copy of the state license
- A review of any restrictions to a license are investigated and could impact your participation in the network
- A review and primary source verification of any Medicare or Medicaid sanctions
- A review and verification of nationally recognized accreditation organizations including but not limited to:
  - Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - Health Care Facilities Accreditation Program
  - American Osteopathic Association
  - The Commission on Accreditation of Rehabilitation Facilities
  - Community Health Accreditation Program
  - Accreditation Association for Ambulatory Health Care

If your facility, ancillary or hospital is not accredited, a copy of a recent state or CMS review may be submitted in lieu of performing an onsite review. If there is no current accreditation or a recent state or CMS review, the Plan will perform an onsite review.

Evidence of malpractice insurance, in amounts specified in the provider contract and in accordance with the Plan policy, must also be included at the time of contracting/credentialing.

The Plan will track an organization’s reassessment date and reassess every 36 months or sooner, as applicable. The requirements for re-credentialing are the same for reassessment as they are for the initial assessment. The organizational provider will:

- Be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted.
- Have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation.

**Provider’s Right to Review**
Providers have the right to review his/her credentialing file at any time. Please contact your Provider Relations representative if you wish to review your file.

**Provider’s Right to Notify and Correct Information**
In the event SHP receives information that conflicts with information given by the provider, SHP will notify the provider, in writing, immediately detailing the information in question.
The provider must submit a written response to the Plan within thirty (30) days of receiving the notification from SHP and must explain the discrepancy and correct any erroneous information or provide any proof that he/she may have available. This response is to be mailed to:

Simply Healthcare Plans
9250 W. Flagler Street, Suite 600
Miami, FL 33174-3460
Attention: Credentialing Department

If the provider fails to respond within thirty (30) days, the application process will be discontinued and the provider will not be approved for SHP Provider Network participation.

Provider’s Right to be Informed
Requests for application status update should be made by calling SHP’s Provider Relations Department or by regular mail or e-mail; SHP’s Provider Relations Department will respond to the request within three (3) working days.

SHP’s Provider Relations Department may share with the provider the status of the application in the credentialing process, however, they will not share with or allow a provider to review references, recommendations or other information that is peer-review protected.

Delegation of Credentialing
Provider groups with strong credentialing programs that meet the Plan’s credentialing standards may be evaluated for delegation. As part of this process, the Plan will conduct a pre-delegation assessment of a group’s credentialing policy and program, as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 90 percent compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within thirty (30) days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

The Plan is responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

Credentialing Appeals Process
Credentialing/Re-Credentialing applicants will be notified of a denial or limitation and/or restriction of credentials, or a decision of termination for cause. Applicants will have thirty (30) calendar days to appeal this decision in writing. The appeals process, as defined by the Plan’s Appeals Policy, includes the right to a fair hearing when there has been termination for cause. If the written appeal is not submitted within the 30 calendar day time frame, the appeal right will expire, and the initial determination will stand.

- If the credentialing/re-credentialing applicant has a current the Plan participation agreement that specifies a different time frame, the current contract language shall govern.
- The request for an appeal must set forth in detail those matters the credentialing/re-credentialing applicant believes were improperly determined by the health plan credentialing committee and/or medical director, as well as the specific reasons why the applicant believes the decision to be improper. The applicant may include any statement, documents or other materials to be considered by the hearing committee or appointed hearing officer prior to rendering a final decision.
- When a determination would lead to a contract termination, the hearing committee or appointed hearing officer shall meet within Thirty (30) calendar days of receipt of the appeals request to consider the appeal, unless a time extension is requested and mutually agreed upon by both parties, in accordance with the Plan policy.
- The credentialing/re-credentialing applicant shall be informed when the request for appeal has been received; if an informal hearing is being offered, the time, date and location of the informal hearing will also be communicated to the physician/practitioner no less than 14 calendar days prior to the date of the informal hearing; the physician/practitioner has the right to be represented by an attorney or other representative of his or her choice.
• The appeals process provides the right of the credentialing/re-credentialing applicant to appear in person before the hearing committee or appointed hearing officer, at which time the provider has the right to present his or her case.
• The credentialing/re-credentialing applicant will be notified in writing of the final decision, setting forth the reasons for the decision, within 15 days of the hearing committee or appointed hearing officer meeting.
• If the hearing committee or appointed hearing officer upholds a denial, the recommendation would be made to initiate termination procedures for the credentialing/re-credentialing applicant’s participation with PLAN.

Peer Review
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are to:
• Participate in the implementation of the established peer review system
• Review and make recommendations regarding individual provider peer review cases
• Work in accordance with the medical director

If an investigation of a member grievance results in concern regarding a physician’s compliance with community standards of care or service, the elements of peer review will be followed. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician and consults and informs the peer review committee as appropriate. The medical director informs the physician of the committee’s decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, including the Quality Management Committee.
Section 13. Participating Providers Complaints and Disputes

The Plan's administrative procedures allow participating providers in the Plan's network to express dissatisfaction regarding claims payment or administrative determinations. Participating providers need to express their dissatisfaction in writing to the Plan's Grievance and Appeals Department.

**Administrative Complaints:** Participating providers may submit complaints regarding administrative actions within 90 days of the occurrence/notification. A resolution to Administrative Complaint will be rendered and communicated to the provider within sixty (60) calendar days.

**Provider Liability Complaint:** A provider liability complaint is a request for the Plan to review a decision of a denied payment (without member liability) for services already rendered. If, as a participating provider, you would like to dispute a medical necessity determination regarding services of a Plan member, you may mail a written request, with relevant supporting clinical documentation, that shows why the denial or services should be reversed including a copy of the Explanation of Payment (EOP) to:

Simply Healthcare Plans  
Attn: Claims Department  
9250 W. Flagler Street, MS 100  
Suite 600  
Miami, FL 33174-3460

A resolution to the Provider Liability Complaint will be rendered and communicated to the provider within sixty (60) calendar days.

**Claims Payment Dispute:** Claim payment disputes that are the result of contractual issues between the provider and the Plan carry no member liability, and the member is held harmless for any payment over and above the applicable cost share.

If you believe the Plan has not paid for your services according to the terms of your provider agreement, submit a written request using the Provider Claim Review Form (Refer to Section 20: Forms) or by accessing http://simplyhealthcareplans.com/providers with supporting documentation, including a copy of the Explanation of Payment (EOP) and full explanation of why the payment should be reversed.

Submit payment disputes to:

Simply Healthcare Plans  
Attn: Claims Department  
9250 W. Flagler Street, MS 100  
Suite 600  
Miami, FL 33174-3460

A resolution to the Claims Payment Dispute will be rendered and communicated to the provider within sixty (60) calendar days.
Section 14. Member Grievance and Appeals

Definitions:

Complaint:
Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Grievance:
Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Quality Improvement Organization (QIO):
Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. The QIO’s review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient department, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIO’s also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and CORFs.

Appeal:
Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), reviews by the Medicare Appeals Council (MAC), and judicial review.

Reconsideration:
A member’s first step in the appeals process after an adverse organization determination; the health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Independent Review Entity:
An independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations.

Formal Grievance Process
Simply members have sixty (60) calendar days from the date of the occurrence to file a formal grievance to the health plan. Any member who has a grievance against Simply Healthcare Plans or its providers for any matter may submit an oral or a written statement of the grievance to Simply. A grievance form may be requested from the Member Services Department.
The oral or written grievance should include the following:

a) Member’s name and ID number
b) Summary of occurrence
c) Description of the requested assistance
d) The member’s signature
e) The date the grievance was signed

The written statement or the grievance form must be sent to the Grievance and Appeals Department at the following address or fax number:

Simply Healthcare Plans, Inc.
9250 W. Flagler St, Suite 600
Miami, Florida 33174-3460
Attn: Grievance & Appeals Department
Fax: 1-877-577-0114

Grievances will be resolved in accordance with the Medicare Managed Care Manual mandated by CMS.

Twenty four (24) hours for expedited grievances. Expedited grievances exist whenever:

- The health plan extends the time frame to make an organization/coverage determination or reconsideration or redetermination; or
- The health plan refuses to grant a request for an expedited organization/coverage determination, reconsideration or redetermination; or
- Life threatening situations.

Thirty (30) calendar days for standard grievances. Prompt appropriate action, including a full investigation of the grievance as expeditiously as the member’s case requires, based on the member’s health status, but no later than 30 calendar days from the date of the oral or written request is received, unless the case is extended.

Simply members will be referred to the Florida Medical Quality Assurance Inc., Florida’s Quality Improvement Organization (QIO), should the grievance be relating to the quality of care or service from the plan or its providers. Simply members may also send inquiries or call FMQAI directly at the following:

Kepro
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll-free Number: 1-844-455-8708
Fax Number: 1-844-834-7129

Medicare Reconsideration (Appeal)
A request for reconsideration (appeal) is a written request by the member (legal guardian, authorized representative, or power of attorney), or a non-participating provider, (who has signed a waiver indicating they will not seek payment from the member for the item or service in question). A physician who is providing treatment to the member, upon providing notice to the member, may request an expedited or standard reconsideration on the member’s behalf without having been appointed as the member’s authorized representative.

The request for a reconsideration of the plan’s initial determination to deny payment of a claim or authorize a service must be received within sixty (60) calendar days of receipt of an initial determination. A response of the decision determined by the plan for expedited cases will take no longer than 72 hours for situations where applying the standard time procedure could seriously jeopardize the enrollee’s life, health or ability to regain maximum function, thirty (30) calendar days for a standard service request and sixty (60) calendar days if the request is for the payment of a denied claim.

Formal Appeal Process:
1) Organization Determination
2) Appeal Reconsideration
4) Administrative Law Judge (ALJ) Hearing, if at least $130.00 is in controversy.
5) Medicare Appeals Council (MAC)
6) Judicial review, if at least $1,350.00 is in controversy.

**Appeal Reconsideration**

A request for reconsideration (appeal) is received within sixty (60) calendar days of the adverse initial determination.

The Grievance and Appeals Coordinator assigns the case to the Grievance and Appeals Specialist for research. The Grievance and Appeals Specialist acknowledges the request for reconsideration (appeal) within five (5) business days of receipt. If a member’s issue involves both an appeal and grievance, they will be worked simultaneously by the same Grievance and Appeals Specialist.

In all cases, payment of claims or authorization for services and notification to member or non-contracted provider must be made within, 72 hours for expedited request, thirty (30) calendar days for a standard request for a service and sixty (60) calendar days for payment of a denied claim. If adequate information to make a determination is not received within the allowed processing time, a determination must be made based on the information received. (An extension of up to fourteen (14) calendar days can be made if requested by the member or if the plan justifies the need for additional information and it is in the best interest of the member). Members will be advised of their right to file an expedited grievance should they not agree to the extension of their appeal case.

If a decision cannot be made or if the denial is upheld in whole, or in part, the entire file is forwarded along with written explanation of the decision to MAXIMUS Federal Services, Inc. for a new determination by the required timeframe for each type of case. The member/appointed representative/treating physician/non-contracted provider is notified verbally and followed-up in writing.

MAXIMUS advises the member/appointed representative/treating physician/non-contracted provider and the plan of its decision in writing within the required time frames depending on the level of the appeal stating the reason(s) for the decision and inform the member/non-contracted provider of his or her right to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration if the denial is upheld and the amount in controversy meets the appropriate threshold requirement.

If the denial is overturned by MAXIMUS, the request for a service is provided as expeditiously as the member’s health requires but no later than 72 hours for an expedited appeal, 14 calendar days for a standard service appeal or 30 calendar days for a standard claim appeals.

If the amount in controversy is at least $130.00, the member/non-contracted provider may appeal MAXIMUS’ decision by requesting a hearing before an Administrative Law Judge (ALJ). The request must be submitted in writing within sixty (60) days after the date of notice of the adverse reconsideration determination and must be filed with the entity specified in MAXIMUS’ reconsideration notice. If Simply receives a written request for an ALJ hearing from an enrollee, Simply must forward the enrollee’s request to MAXIMUS.

An adverse decision or case dismissed by the ALJ can be reviewed by the Medicare Appeals Council (MAC), either by its own action or as the result of a request form the member/non-contracted provider or Simply. If the MAC grants the request for review, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions. MAC review must be requested in writing within sixty (60) days of the ALJ adverse determination.

If the amount remaining in controversy is at least $1,350.00, the member/non-contracted provider of Simply may request a Judicial Review. The review must be requested in writing within sixty (60) days of the MAC’s adverse determination.

The entity which makes an initial reconsidered or revised determination may re-open the determination. Re-openings occur after a decision has been made. Re-openings may be granted:

- To correct an error
In response to suspected fraud
In response to the receipt of information not available or known to exist at the time the claim were initially processed

A re-opening is not an appeal right. A party may request a reopening even if it still has appeal rights, as long as the guidelines of the re-opening are met. For example, if a member receives an adverse determination, but later obtains relevant medical records, he or she may request a re-opening rather than a hearing before an ALJ. However, if the beneficiary did not have additional information and just disagreed with the reasoning of the decision, he or she must file an appeal. If a member requests a re-opening while he or she still has appeal rights, he or she will also file for the appeal and ask for a continuance until the re-opening is decided. If the re-opening is denied or the original determination is not revised, the party retains its appeal rights.

The party that filed the reconsideration may withdraw that request. The withdrawal must be filed in writing to the Plan, the Social Security Office or the Railroad Retirement Board office (for railroad retirees). The withdrawal will be acknowledged in writing by the Plan.
Section 15. Claims

Overview
The primary focus of Simply Healthcare Plans (SHP) Claims Department is to process claims in a timely manner. The Claims Department is proactive and works closely with the SHP Provider Operations and Utilization Management Departments in trying to resolve any claims-related issues.

Claims Submission
Claims are to be submitted to Simply Healthcare Plans with appropriate documentation by mail or filed electronically for CMS-1500 and UB-04 claims. For those members that may be assigned to a delegated medical group/IPA that does its own claims processing, please verify the “Remit To” address on the SHP Member ID Card. Providers billing SHP directly should submit claims to:

Simply Healthcare Plans, Inc.
Attn: Claims
PO BOX 21535
Eagan, MN 55121

Or via Availity:
Simply Healthcare Plans- Payer ID 00199

Or via Emdeon:
Simply Healthcare Plans- Payer ID 27094

Providers are expected to use good faith effort when billing SHP for services by using the most current coding (ICD-10, CPH, HCPCS, etc.) available. The following information is to be included on all claims submissions, electronic or paper:

1) Member’s name, date of birth, sex and ID number
2) Date(s) of service, place of service(s) and number of days or units, if applicable
3) Provider tax identification and NPI number
4) ICD-10 diagnosis codes by specific service to the highest level of specificity
5) Current CPT, revenue and HCPCS procedure code(s) with modifiers is appropriate
6) Billed charges per service(s) provided and total charges
7) Provider name and address, signature, and phone number
8) Information about other insurance coverage, Workers’ Compensation, accident or auto information, if available
9) Attach a detail description of the service or procedure for claim submitted with unlisted medical or surgical CPT or other revenue codes
10) For resubmissions and corrections of a claim, please submit a new CMS 1500 or UB-04 indicating the correction.

Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04 and must contain the information noted above. SHP will only process claims that are legible and filed on the appropriate claim form and containing the required data information. Claims filed that are incomplete, inaccurate, or untimely re-submissions may result in the denial of the claim.

Filing a Claim Electronically
Providers submitting claims electronically should receive an acknowledgement from Emdeon, Availity or their current clearinghouse; if you experience any problems with your transmission please contact your local clearinghouse representative.
**Timely Claim Submission**
- SHP providers will submit claims, as per Provider Contract, promptly to SHP for covered services rendered to the member.
- SHP as Primary payer: Within ninety (90) days of service or as per the terms of your contract.
- SHP as Secondary payer (if the Plan is not the primary payer under coordination of benefits): within ninety (90) days after final determination by the primary organization.
- Unless otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to SHP within these time limits will not be eligible for payment and the provider hereby waives any right to payment theretofore.

**Clean Claim**
All providers are required to submit clean claims. A clean claim is one that can go through the claims processing without obtaining additional information from the provider who provided the services or from a third party.

**Timely Claims Processing and Payment**
Clean claims payment will be paid to contracted providers in accordance with the timeframes specified in the contractual payment arrangement between the provider and SHP. Payment is subject to the minimum standards as set forth by CMS.

**Claims for Emergency Services**
SHP shall not deny claims for the provision of emergency services and care submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred and sixty five (365) days.

Reimbursement for services provided to an enrollee by a non-participating provider shall be the lesser of:
- The non-participating provider's charges
- The usual and customary provider charges for similar services in the community where the services were provided
- The amount mutually agreed to by the Plan and the non-participating provider within sixty (60) calendar days after the non-participating provider submits a claim; or
- The Florida Medicare reimbursement rate established for the hospital or provider.

Florida Medicare will reimburse one emergency room visit, per recipient, per day unless additional claims differ significantly in diagnosis or services provided.

**Coordination of Benefits (COB)**
Coordination of Benefits (COB) is the process used to process health care payments when a member has coverage with more than one insurer. When it is identified that a member has coverage with more than one insurer:

- Providers should first submit a claim to identified payers who have primary responsibility for payment of a claim before submitting a claim to SHP.
- When filing a claim to SHP, you must include a copy of the other insurance’s EOB with the claim.
- If SHP is the secondary insurance, SHP will pay the member’s responsibility after the primary insurance carrier has paid, not to exceed SHP’s contracted allowable rate.
- SHP may request a refund for COB claims paid in error for up to thirty (30) months from the original payment date.

**Third Party Liability**
Subrogation: SHP will pay claims for covered services when probable third party liability has not been established or third party benefits are not available to pay a claim. SHP will attempt to recover any third party resources available to members and shall maintain records pertaining to third party liability collections on behalf of members for audit and review.

Coordination of benefits: will be administered in accordance with applicable statutes and regulations.
Retroactive Eligibility Changes
A member's eligibility with a health plan may change retroactively if the individual's policy or benefit contract has been terminated, or SHP receives information that the patient is no longer a member of the Plan, or if the eligibility information we received turned out to be untrue.

A claim adjustment may be necessary if you have had claims in which the members have had retroactive eligibility changes. The Explanation of Payment (EOP) or Provider Remittance Advice (PRA) will show the reason for the claim adjustment.
Section 16. Information on Compliance & Fraud, Waste and Abuse

Simply Healthcare Plans (SHP) has policies and procedures towards the prevention, detection, reduction, correction and reporting of healthcare fraud, waste and abuse in compliance with all state and federal program integrity requirements.

SHP’s Special Investigation Unit Manager, oversees all the activities of our Fraud Waste and Abuse program and reports any possible violations to the proper agencies.

If you suspect a violation or an SHP member tells you of a possible violation please contact our Fraud Hotline at 1-866-847-8247, via fax to 786-441-4625, or email SIU@simplyhealthcareplans.com. For direct reporting of suspected fraud, waste or abuse, please use one of the following:


Fax: 1-800-223-8164

NBI MEDIC: 1-877-7SafeRX (1-877-772-3379)

www.OIG.HHS.gov/fraud or HHSTips@oig.hhs.gov

SHP instructs and expects all the employees, associates and providers to comply with all applicable laws and regulations and has procedures to report violations and suspected violations on the part of any employees, associates, persons or entities providing care or services to our members.

Examples of violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber’s DEA number or prescription pad, identity theft, or members’ fraud with medications.

SHP is obligated to report any suspected cases of healthcare fraud, waste or abuse to the regulatory agencies and/or contracted CMS vendors, (NBI MEDIC). SHP may also consider reporting the conduct to other government authorities such as the Office of Inspector General or the Department of Justice.

In addition, the Agency for Health Care Administration (AHCA), Office of the Inspector General (OIG), Bureau of Medicare Program Integrity in tandem with NBI MEDIC, audits and investigates providers suspected of overbilling or defrauding the Florida Medicare Program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Department of Justice. Program Integrity may also originate an investigation due to a complaint being filed.

Federal regulations require mandatory Compliance and Fraud, Waste and Abuse training to be completed by First Tier, Downstream and Related Entities (FDRs) as well as their employees, within ninety (90) days of hire/contracting and annually thereafter.

Records of the training must be maintained for a period of ten (10) years with copies available to the SHP Compliance Officer. These records must include the following as SHP, CMS or agents of CMS may request such records to verify that training occurred.

1) Materials used for classroom training;
2) Date(s) training was provided;
3) Methods of training provided or online training modules;
Training sign-in logs or employee attestations, or electronic certifications from the employees completing the training. Note: FDRs who are “deemed” to have met the FWA training and education requirements, are exempt from the above mandatory training, and will be required to submit copies of their certification to SHP. If you have Medicare billing privileges the FWA training was required to continue your participation in the Program.

If you or your employees have not taken the Compliance and or Fraud Waste and Abuse training, please log onto the SHP’s website under Providers click on “Provider Trainings” for the training materials. Please contact your representatives for additional instructions as needed.

As stated above, it is your responsibility and part of your contractual obligation to comply with all CMS program requirements for your continued participation with the plan. You must maintain record of completion. During a Plan and or CMS review, you will be asked to provide evidence of completion for our files. This material should be readily available and at the Plans request.

It is important that you review certain federal regulations:

1) The False Claims Act:
SHP has prepared its compliance programs so that its policies and procedures are consistent with the Federal Civil False Claims Act, which prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. The Act also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents.

When submitting claims data you must certify that the claims data is true and accurate to the best of your knowledge and belief. In addition, parties have a continuing obligation to disclose to the government any new information indicating the falsity of the original statement. Since SHP maintains ultimate responsibility for adhering to all terms and conditions of its contract with state and federal programs, SHP shall monitor its subcontractors for compliance with all applicable regulations.

2) The Anti-Kickback Statute:
Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal health care programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other Federal health care programs and subject to civil monetary penalties. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. SHP has policies and procedures employed to ensure that illegal remuneration is not permitted and shall specify follow-up procedures if they uncover unlawful remuneration schemes.

3) The Health Insurance Portability and Accountability Act (HIPAA):
HIPAA was enacted, among other things, for the purpose of improving the efficiency and effectiveness of health information systems through the establishment of standards and requirements for the electronic transmission of certain health information. As a result, there are standards for certain electronic transactions, minimum security requirements, and minimum privacy protections for individually identifiable health information that is held by covered entities (i.e., protected health information); national identifiers under HIPAA for providers, plans and employers. Covered entities include health plans, health care clearingshouses and certain health care providers (namely those that conduct covered transactions).

The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulations. The Centers for Medicare and Medicare Services (CMS) is the Departmental component responsible for implementing and enforcing the other HIPAA regulations.

HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule
We anticipate that you may have questions about whether the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule permits you to disclose your patients’ (our members’) medical information to us for these activities without written authorization from your patients.
Section 164.506(c) (4) of the Privacy Rule explicitly permits you to make this type of disclosure to Simply without a written authorization.

Additionally, the Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) has also made this point clear. It wrote in its December 3, 2002, Guidance on the Privacy Rule that: "A covered entity may disclose protected health information to another covered entity for certain health care operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the protected health information to another covered entity for certain health care operations activity."

Breach Reporting
Breach: The impermissible acquisition, access, use, or disclosure of Protected Health Information (PHI), which compromises the security and or privacy of such information, except where an unauthorized person, to whom such information is disclosed, would not reasonably have been able to retain such information.

It is the policy of the Plan to assure that all patient/member Protected Health Information (PHI), including electronic PHI, remains secure, confidential, and that it is only disclosed with proper authorization. Protected Health Information is individuals’ past, present, and future health information.

Types of PHI:
- Name
- Address
- Birth date
- Social security number
- Phone number
- Plan ID number
- Medical record number
- Admission/discharge dates
- Encounter dates, etc.
- Medicare/Medicaid ID numbers

Breaches could result from improper disposal of PHI, theft, loss, hacking, and because of other or unknown reasons. Contracted entities shall comply with all HIPAA privacy and security regulations and report HIPAA violations (breaches), to the Plan using the Plan’s HIPAA Breach Report Form, within 24 hours of discovery. (See the attached HIPAA Breach Report Form)
Section 17. Simply Healthcare Plans Special Needs Plan (SNP) Models of Care

Under the MMA (Medicare Modernization Act) of 2003, Congress created a new type of Medicare Advantage Plan so that Medicare beneficiaries with special needs would benefit with increased, focused coordination of care. These beneficiaries are usually older, with multiple medical conditions, often with social challenges, and therefore more care needs.

Special Needs Plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals identified by Congress. Simply has chosen to target the Medicare beneficiaries who are also eligible for Medicaid (Dual-Eligible) as well as members living in institutions such as nursing homes and members living in the community who require an institutional level of care based on the State of Florida’s CARES assessment.

The core of the SNP is to provide improved coordination, access, and continuity of care for this population. In addition, they will have the opportunity of enhanced benefits by combining those available through Medicare and Medicaid and other add-on benefits.

The SNP will focus on monitoring health status of the target population, identifying their needs, improving access to quality healthcare services and benefits, managing chronic diseases, avoiding inappropriate hospitalizations, and helping the members decrease their medical, mental, and social risks.

The Model of Care provides the structure for evidence-based care management, member outreach, coordination, improved access to care, benefits, and services with improved outcomes, communication and outcomes data and reporting requirements.

The Care Management team enrolls members who "opt-in" to receive Case Management and is responsible for coordinating Plan benefits, services and outreach as well as, to communicate with the member/legal guardian and other members of their Interdisciplinary Care Team (ICT).

All SNP members receive an initial Health Risk Assessment (HRA) within ninety (90) days of enrollment. Based upon the answers noted in the HRA, the member may be referred for additional Case Manager assessment/intervention at which time any identified health care needs would be identified, through the Comprehensive General Health Assessment tool, that screens for potential medical, medication, social, cognitive impairment, behavioral health, cultural and caregiver needs so access to affordable care services can be coordinated. Interventions and goals are appropriate to the member’s level of risk, with feedback and consensus from the Interdisciplinary Care Team (ICT).

You, the provider, are a vital member of the Interdisciplinary Care Team (ICT) and our Care Management Team will contact you to discuss the Care Plan of SNP members. The members and the Plan appreciate your invaluable input and support.

The Provider SNP Model of Care Training is located on Simply’s website Provider tab under “Useful Materials for Medicare Providers”. Please communicate with your provider relations representative once you complete your initial training and annual review. The training includes, but is not limited to:

1) SNP-Specific Target Populations
2) Plan differences
3) Interdisciplinary Care Team
4) Provider Roles and Obligations
5) Provider Training
6) Individualized Care Plans
7) Communication Network

Please speak to your representative if you have any questions or concerns regarding the training above or any additional required training.
Section 18. Infection Control and Prevention Plan

Infection prevention and control is the goal of Simply Healthcare Plans, Inc. All infection control policies and this plan are written for the protection of health plan members, personnel, providers, and visitors. Simply Healthcare Plans has developed this infection prevention and control program based on principals established through various nationally recognized organizations in infection control that include Centers for Disease Control (CDC), The Association for Professionals in Infection Control and Epidemiology (APIC), and The Healthcare Infection Control Practices Advisory Committee (HICPAC). The program is under the leadership of the Chief Medical Officer who reports to the Board of Directors. The Board and the Chief Medical Officer have appointed a Medical Director with a Master in Public Health to serve as the Infection Control Lead for Simply Healthcare Plans. This individual is supported by the health plan Chief Medical Officer, Medical Directors and the administrators and managers of the various provider offices to ensure appropriate education, monitoring, and surveillance of the prevention and control of infections. It is noted that the infection prevention and control processes are integrated into the QI Program of Simply Healthcare Plans.

The objectives of the infection control plan are as follows:

- To prevent, identify, minimize and manage infections and communicable diseases
- To establish and implement the policies and procedures related to the control of infections at provider offices.
- To provide a mechanism to prevent cross-contamination of members/patients.
- To provide Simply Healthcare Plans pertinent information, counsel, and advice in relation to infection control. This shall include evaluation of new equipment and procedures for cleaning, decontaminating, and sterilizing, if appropriate.
- To ensure cooperation between the health plan and the physician offices in reflecting the occurrence of any infections.
- To establish and implement the surveillance system for evaluating and reporting infections in members, staff, and physicians.
- To delegate authority to institute any appropriate control measures or studies when there is a reasonable danger to any member or staff/physicians.
- To maintain active participation of staff through orientation and in-services and other activities and to ensure staff are knowledgeable of their respective roles and responsibilities in the prevention and control of infections.

Process:

1. Prevention:
   This is most appropriately accomplished through orientation and training of staff in the physician offices and the implementation of policies and procedures as follows:

   - Appointment of an infection control qualified health care professional who, in addition to holding Medical Doctor Degree, holds a Master degree in Public Health.
   - Initial training during orientation (within thirty (30) days of hire) and annually thereafter of all staff, allied health professional, and physicians as a component of the provider network training on OSHA standards and infection control practices.
   - Provider offices are expected to adhere to the infection prevention and control policies and procedures of the health plan at all times.
   - The physician network is expected to evaluate the disinfecting agents used by contracted services to ensure that they are appropriate and effective.
   - Member education on an on-going basis related to infections.
   - Monitoring of employee illness trends.
   - Use of personnel protective equipment (PPE), as appropriate (gloves).
   - Have a sharps prevention program in place (see below).
2. Control:
Hand-washing procedures will be in place and provider offices will be trained in the techniques at new provider orientation.

- Policies related to hand-washing will be adopted and provider offices will be educated during orientation.
- Should any provider office in the network perform minor procedures using equipment that requires cleaning, high definition level cleaning or sterilization practices will be in place. Monitoring processes will be expected to be conducted.
- Controls related to the disposal of biohazardous waste and storage in appropriate containers.
- Monitoring the compliance with asepsis policies and procedures as outlined in OSHA standards.
- Adherence to cleaning standards of patient care areas prior to use, between patients, and at the end of each day. Such cleaning will include the wiping down of all patient related equipment, the exam table, counters, and surfaces using approved disinfecting wipes.
- Monitoring of employee illnesses.
- Environmental controls that include restriction of persons in patient care areas if identified as having a communicable disease.
- The Provider Manual of Simply Healthcare Plan will contain information on OSHA requirements, sharps injury protection, and hand-washing protocols.

3. Identification:
Identification is accomplished through a number of surveillance and monitoring processes as follows:

- Members are to be instructed by their providers to contact them in the event that symptoms of infection are identified such as from a site where blood was drawn.
- Provider office employee illness monitoring is conducted for trends.
- Awareness of community issues that may include outbreaks of communicable diseases.

4. Reporting:
Reporting is an important component of the Infection Prevention Control Plan. Steps of reporting would include the following:

- Reporting to local public health authorities as required by law and regulation (see Policy on Reporting of Reportable Conditions).
- Reporting of infections through completion of an adverse incident report.
- Reporting of office employee related exposures through the adverse incident reporting process.

**Sharps Prevention Program:**
Simply Healthcare Plans has a specific provider network program in place that ensures safety and the prevention of infections or contamination through its Sharps Prevention Program. The program includes the following parameters:

- Orientation of all provider office staff and the providers on the program within thirty (30) days of contracting.
- Articles on infection control may be provided in the newsletters on a periodic basis.
- The placement of sharp containers that are puncture proof throughout the provider offices in appropriate areas to be secure from tampering.
- Requirement for disposal of all intact needles and syringes in these sharp containers.
- Adherence to strict protocols on the safe use of needles related to re-capping that includes no bending or breaking of the needles from the syringes.
- Replacement of sharp containers when they are 2/3 full (to the line).
- Appropriate handling and disposal of the full containers using a recognized disposer contractor.
Section 19. Safety and Health Program

Introduction
The Simply Healthcare Plans, Inc. Safety and Health Program follows the Occupational Safety and Health Administration (OSHA) Safety and Health Program Management Guidelines and has incorporated CMS safety initiatives to ensure safe care for its members.

Simply Healthcare Plans’ Safety and Health Program contains 4 basic program elements:

- Management leadership with employee and provider network involvement
- Worksite analysis and provider office safety
- Hazard prevention and control
- Training

Under each element are numerous sub-elements. This program contains descriptions of how the program elements and sub-elements are designed and implemented. Specific documents resulting from program implementation will need to be kept in an organized fashion.

Management Leadership and Employee Involvement
Simply Healthcare Plans commits the necessary resources of staff, money, and time to ensure that all persons working or visiting are protected from injury and illness hazards. In addition, management visibly leads in the design, implementation, and continuous improvement of the organization’s safety and health activities. The Board of Directors has ultimate responsibility for the Safety and Health Program and reviews and approves the program based on input and recommendation by the Compliance Officer, Quality Management Steering Committee, and the QI Department.

The Compliance Officer ensures that all employees and providers are trained on this program and is designated as the Safety Officer.

Periodic evaluations of the overall Safety and Health Program are conducted to include evaluation of any required corrective action plans and the attainment of goals as appropriate.

The leadership and management of Simply Healthcare Plans ensures that all employees have clearly written safety and health responsibilities included within their job description, with appropriate authority to carry out those responsibilities. Simply Healthcare Plans ensures that all providers maintain a program of safety in treatment locations.

Simply Healthcare Plans ensures that at least several avenues exist for employee involvement in safety and health decision-making and problem-solving. These avenues may include serving on committees or ad-hoc groups, acting as safety observers, assisting in training other employees, analyzing hazards inherent in the workplace and devising methods and practices that protect against such hazards, and planning activities to heighten safety and health awareness. Management encourages involvement and expects safety protocols are followed by the provider network that ensure safety care and conditions for the members.

Provider Office Safety Requirements and Assessments
Simply Healthcare Plans supports a safe environment for its members. Providers are requested to maintain a safe work environment and to know that they may be inspected by Simply Healthcare Plans provider relations staff on a periodic basis. The following outlines requirements for a safe environment that must be maintained:

- Implementation of processes for the management of identified hazards, potential threats, near misses, and other applicable safety concerns
- Process for reporting of adverse incidents to Simply Healthcare Plans provider relations and/or Compliance Officer in accordance with state requirements
- Process in place to ensure a reduction and avoidance of medication errors
- Implementation of a program that ensures the prevention of falls and injuries of patients, staff, and visitors
• Implementation of a process of monitoring medications and equipment/supplies that may be subjected to a recall to ensure that the recalled item(s) is returned and as appropriate, patients are contacted.

All employees are trained to recognize hazards and to report any hazard they find to the Safety Officer so that the hazard can be corrected as soon as possible. All employee reports of hazards should be documented as an adverse incident report. Any near miss, first aid incident, or accident is investigated by the Risk Manager/Safety Officer. All investigations will be subjected to a root cause analysis to determine required interventions.

As part of the annual safety and health program evaluation, the site owner, a manager, and an employee review all near misses, first aid incidents, and entries on the OSHA 200 Log, as well as employee reports of hazards, to determine if any pattern exists that can be addressed. The results of this analysis are considered in setting the goal, objectives, and action plans for the next year.

Provider offices are responsible to train staff in infection control and prevention as well at the time of hire and annually thereafter.

Patient records are to be maintained in compliance with medical record documentation standards and records are to have a means of identification that is unique.

Each provider office is required to maintain an Emergency Preparedness Plan to include evacuation protocols and conduct drills at least quarterly (must include at least 1 CPR drill). Simply Healthcare Plans has an Emergency Plan for all potential emergencies, including fire, explosion, accident, severe weather, loss of power and/or water, and violence from an outside source.

Provider offices are required to ensure on-going monitoring for expired medications that may be maintained either in medication cabinets, refrigerators, or sample medication rooms.

**Hazard Prevention and Control**
Simply Healthcare Plans ensures that the Program is followed to protect persons at its administrative offices and provider network sites. Identified hazards will be eliminated when economically feasible. Provider network offices are expected to use barriers that protect persons from hazards that may include machine guards and personal protective equipment (PPE). Provider network offices will be expected to have sharps safety protocols and medical emergency procedures that ensure safety in the care delivery areas.

Simply Healthcare Plans ensures that the organization and its premises properly maintained to ensure safety and health. If maintenance needs exceed the capability of the worksite employees, contract employees are hired to do the work and are screened and supervised to ensure they work according to the organizations safety and health procedures.

All employees, including all levels of management, are held accountable for obeying the Simply Healthcare Plans safety and health rules. The following 3-step disciplinary process will be applied to everyone by the appropriate level of supervisor for any safety related infractions:

- Oral warning;
- Written reprimand;
- Dismissal.

Visitors, who violate safety and health rules and procedures, will be escorted from the premises. Persons needing emergency care are transported by ambulance to the hospital.

**Recalls**
As part of the processes to ensure safety, provider offices are required to have a process in place to determine if any medications, equipment, or supplies have been subjected to a recall. Should the provider office be notified of a recall, the following processes will be performed:
- Staff in the office will be notified of the recalled item
- Recalled item will be returned in accordance with instructions from the manufacturer
- Investigation to determine if the recalled item(s) had been prescribed or used with a patient
- Contact with the affected patient
- Documentation of response to the recalled item(s) to include disposition of the returned item

Training
Simply Healthcare Plans believes that employee and provider network involvement in the Safety and Health Program can only be successful when sufficient training is provide that ensures an understanding what their safety and health responsibilities and opportunities are and how to fulfill them. All new employees will receive training on the Safety and Health Program at the time of initial orientation and annually thereafter. The provider network will be provided information on safety and health expectations at the time of initial contracting and periodically thereafter through the Provider Manual, communications, and newsletters.
Section 20. Simply Healthcare Plans Forms

1. Provider Claims Review Form
2. Referral and Authorization Form
3. Quick Authorization Form
4. Beacon Referral Form
5. Incident Report Form
6. PCP Initiated Member Transfer Form
7. Appointment of Representative
8. HIPAA Breach Report Form
# Provider Claims Review Form

(Use a separate form for each patient)

<table>
<thead>
<tr>
<th>PROVIDER INFORMATION</th>
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<tbody>
<tr>
<td>Provider Name:</td>
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<tr>
<td>Provider Tax ID:</td>
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<tr>
<td>Contact Name:</td>
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<tr>
<td>Telephone:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>City:</td>
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<tr>
<th>PROVIDER TYPE</th>
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<tbody>
<tr>
<td>Professional</td>
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<tr>
<td>DME</td>
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<thead>
<tr>
<th>CLAIM INFORMATION</th>
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<tbody>
<tr>
<td>Enrollee Name:</td>
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<tr>
<td>Enrollee ID:</td>
</tr>
<tr>
<td>Claim Number(s):</td>
</tr>
<tr>
<td>Date of Service From</td>
</tr>
<tr>
<td>Disputed Amount:</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>REASON</th>
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<tbody>
<tr>
<td>No Authorization on File</td>
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<tr>
<td>Exceeds Authorization</td>
</tr>
<tr>
<td>Authorization Denial or Reduced Payment</td>
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</tbody>
</table>

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<tr>
<th>DESCRIPTION OF DISPUTE</th>
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</table>

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<tr>
<th>SUPPORTING DOCUMENTATION</th>
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</thead>
<tbody>
<tr>
<td>Authorization</td>
</tr>
<tr>
<td>Medical Records</td>
</tr>
<tr>
<td>Original Claim Form</td>
</tr>
</tbody>
</table>

Please return completed form with all relevant supporting documentation to: Simply Healthcare Plans, Grievances and Appeals, 9250 W. Flagler Street, MS 100, Suite 600, Miami, Fl. 33174
Referral & Authorization Form
Fax #: 1-800-283-2117

Please complete all areas on the form and attach pertinent clinical information to avoid delays.

Urgent is defined as potential impact to the health of the enrollee if referral is not completed within 72 hours.

TOTAL NUMBER OF PAGES IN THIS FAX INCLUDING THIS ONE: _____

Date: _________                          Contact Person: __________________________

Requesting Provider_________________ PCP NAME: ____________________ PROVIDER #: ________

Phone #:_____________________________        Fax #:___________________________________

☐ INTIAL REQUEST  ☐ URGENT  ☐ ROUTINE  ☐ REQUEST FOR AN EXTENSION

PATIENT INFORMATION

Member Name: ____________________________  Member ID #___________________  D.O.B__________

LOB: Medicare _____                       Medicare_____

Is the Referral related to an accident? ___Yes ___No    ___MVA    ___Workmen’s Comp

Other insurance name and policy, if any:_______________________________________________________

SPECIALIST OR OTHER SERVICING PROVIDER INFORMATION

Provider Name______________________________________                Provider ID___________________

Phone Number:______________________________________               Fax #:_______________________

Address:______________________________________________________________________________

Date of Service/Appt:______________        PAR____        Non-PAR____

CLINICAL INFORMATION

Diagnoses :______________________________________________________________________________

ICD-9 Codes:________________________________   CPT/HCPCS Codes: _____________________________

Procedures:_______________________________________________________________________________

Number of visits requested:_____ Duration_________Frequency____________________________________

If this is a request for an extension or a recurrent request, please state # of previous visits:_________________

TYPE OF SERVICE REQUESTED

☐ Bariatric Surgery  ☐ DME  ☐ Home Health  ☐ Hysterectomy*  ☐ MRI  ☐ MRA  ☐ PET Scan  ☐ PT/OT/ST


☐ Transplant Evaluation  ☐ Abortion*  ☐ Pain Management  ☐ Prenatal Notification

☐ Other________________________________________________________

☐ Out of Network (Please explain):___________________________________________________________

Name of Out-of-Network Provider and phone #:_________________________________________________

*Include State Requirements
**DERMATOLOGY CONT.**
- Excision Malignant
  - Lesion
    - 11600 – 11602
    - 11620 – 11642
    - 11640 – 11642
- Excision Intact
- Wound Closure/Repair
- Destruction of Lesion
- Destruction
- Biopsy Skin Lesion

**FRACTURE CARE**
- **ARM**
  - 23600, 24500, 24505
  - 24530, 24535, 24560, 24565
  - 24577, 24570, 24560, 24565
  - 25220, 25230, 25253, 25255, 25260, 25265
  - 25600, 25605, 25622, 25624, 25640, 25650
  - 25655, 25670, 25675, 25680
  - 25690, 29085

**RES-CASTING**
- 04001 – 04051
  - 29065, 29075, 29079, 29125
  - 29300, 29345, 29355, 29405
  - 29425, 29505, 29515, 29535
  - 29540, 29550

**X-RAY/DIAGNOSTICS**
- **HEA**
  - 74240 – 74249
  - 74000 – 74022
  - 73500 – 73660
  - 73000 – 73140
  - 72170 – 72190
  - 72192 – 72194
  - 72128 – 72130
  - 72121 – 72133
  - 72110 – 72116
  - 72190 – 72195
  - 72150 – 72159
  - 72140 – 72149
  - 72130 – 72139
  - 72100 – 72109
  - 72090 – 72095
  - 72080 – 72089
  - 72070 – 72079
  - 72060 – 72069
  - 72050 – 72059
  - 72040 – 72049

**GYNECOLOGY**
- Vaginal Irrigation
- Pap Smear
- Colposcopy without biopsy
- Colposcopy with biopsy
- Cystoscopy
- Thrush
- Pregnancy Test
- Wet Mount Stain, O&P, fungi
- IUD Removal
- Tissue Exam with KOH
- Peasary Fitting/Insertion
- Insertion, drug delivery implant
- Removal, drug delivery implant
- Removal with reinsertion, drug delivery implant

**OFFICE PROCEDURES**
- Injection of Tendon
- Drain/Injet Joint
- Laryngeal Endoscopy
- Control of Epistaxis
- Cystoscopy
- PVR
- Removal Impacted Ear Wax
- Nasal/Sinus Endoscopy
- Nasofaryngoscopy
- Removal Foreign Body/Ear
- Removal Foreign Body/Nose
- Insertion Non-Indwelling Catheter
- Insertion Indwelling Catheter
- Unna boot
- Binocular microscopy
- UA

**CT SCANS**
- Head or Brain
- Orbit, Sella, Posterior Fossa, Ear
- Neck Soft Tissue
- Thorax
- Thoracolumbar
- Thoracic Spine
- Lumbar Spine
- Spinal Manipulation
- Abdomen
- Pelvis
- Lower Extremities
- Upper Extremities
- Lower Extremities
- Ureteral
- Abdomen

**ULTRASOUND**
- Venous Doppler
- Extremity, Nonvascular
- Thyroid or Head/Neck
- Breast
- Transvaginal
- Abdominal
- Abdominal (Quadrant/Region/Organ)
- Retroperitoneal
- Pelvic
- Scrotal, Testicular
- Renal and Urinary Tract
- Transplanted Kidney
- **AR**
  - 20600, 20605, 20610
  - 20635, 20640, 20645, 20650
  - 20655, 20670, 20675, 20680
  - 20690, 20695, 20700

**SPECIALIST OFFICE VISITS**
- Excision Malignant
- Excision Intact
- Wound Closure/Repair
- Destruction of Lesion
- Destruction
- Biopsy Skin Lesion

**PULMONARY FUNCTION**
- Spirometry
- Vital Capacity
- Lung Volume, Gas
- Ear or Pulse Oxymetry
- Aerosol Therapy
- Carbon Monoxide
- Diffusing Capacity

**CARDIOLOGY TESTS**
- Electrocardiogram
- 93000

**INJECTIONS**
- Betamethasone
- Ceftriaxone Sodium, Per 250 Mg
- Dexamethasone
- Methylprednisolone J1020, J1030, J1040
- 20 mg, 40 mg, 80 mg
- Penicillin g benzathine, 100,000 units
- Triamcinolone Acetonide 10 mg J3001
- Testosterone Cypionate 100 mg J1070
- Therapeutic, prophylactic, or diagnostic injection

**NEUROLOGY**
- EEG
- 95812, 95816, 95819
- EMG
- 95885, 95886
- Muscle test one limb
- 95880
- Muscle test 2 limbs
- 95861
- Muscle test 3 limbs
- 95863
- Muscle test 4 limbs
- 95864
- Muscle test larynx
- 95865
- Muscle test hemidiaphragm
- 95866
- Muscle test cran ncrv uniat
- 95867
- Muscle test cran nerve bilat
- 95868
- Muscle test thor paraspinal
- 95869
- Muscle test nonparaspinal
- 95870
- Nerve Conduction Study
- 95990 – 95991

**DERMATOLOGY**
- Drainage Skin Abscess
- Excision - Debridement
- Biopsy Skin Lesion
- Shaving Dermal Lesion
- Excision Benign Lesion
- Excision Malignant
- Excision - Debridement
- Biopsy Skin Lesion
- Shaving Dermal Lesion
- Excision Benign Lesion
- Excision Malignant

**SIMPLY QAF 01_01_2012 III.**

For **participating** Primary Care Providers only to refer to a participating specialist or diagnostic center for the codes listed below.

Do not use for Hospitals, ASCs or for Prenatal care visits/treatment.

***VALID FOR 90 DAYS***

For questions, please call 1-877-915-0551, Prompt 2
<table>
<thead>
<tr>
<th>Section 1 Provider/Vendor/Facility Information (To be completed by Facility/Vendor/provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACILITY/VENDOR/PROVIDER NAME: ___________________________ PHONE NO. &amp; EXTENSION: ____________________</td>
</tr>
<tr>
<td>OFFICE OR GROUP NAME (IF APPLICABLE): ____________________</td>
</tr>
<tr>
<td>STREET ADDRESS/SUITE #: ________________________________</td>
</tr>
<tr>
<td>CITY: __________________ COUNTY: _______________ ST: ______ ZIP: ______________</td>
</tr>
<tr>
<td>PROVIDER PLAN ID#: __________________ PHONE NO./EXT: __________________</td>
</tr>
<tr>
<td>RISK MANAGER NAME: __________________ PHONE NUMBER/EXTENSION: __________________</td>
</tr>
<tr>
<td>RISK MANAGER E-MAIL: __________________ FAX#: __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2 Member Information (To be completed by Facility/Vendor/provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOB: Medicare ☐ Medicaid ☐</td>
</tr>
<tr>
<td>MEMBER NAME: ___________________ MEMBER ID: _______________ SEX: ______ DATE OF BIRTH: ____________</td>
</tr>
<tr>
<td>MEMBER ADDRESS: ___________________ MEMBER PH #: _______________ GUARDIAN Name __________________</td>
</tr>
<tr>
<td>DATE(s) of SERVICE: ____________________________</td>
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</tbody>
</table>

IF HOSPITAL/FACILITY:

- DATE OF ADMISSION: ____________ ADMITTING DIAGNOSIS: ___________________________ ICD-10 CODE(s): ____________
- CURRENT DIAGNOSIS: ___________________ ICD-10 Code(s): ___________________ (After event/incident, and if still at facility)
- DATE OF DISCHARGE: ___________________ DISCHARGE DIAGNOSIS: ___________________ ICD-10 CODE ____________
### Section 3 Incident Information
(To be completed by Facility/Vendor/provider)

#### INCIDENT DATE: ___________________ TIME: ___________________

**RELATED HEALTH CARE PROVIDER:**
- □ Pharmacy
- □ Physician Office
- □ Hospital-IP
- □ Hospital-OP
- □ Emergency Room
- □ Home Health
- □ Outpatient Facility
- □ Other

- □ Ambulatory Surgical Center
- □ Assisted Living Facility
- □ SNF
- □ Transportation
- □ DME
- □ Behavior Health/Facility
- □ Laboratory

#### INCIDENT BEING REPORTED: (*Medicaid Contract, ATT II, Section VII.F)
- □ Abuse /Neglect/Exploitation (Suspected)*
- □ Delay in Diagnosis/Care/treatment
- □ Medication Incident/Incorrect Administration of Drug*
- □ Fall/Trip Attended or Unattended
- □ Mbr Death-Suicide in Facility*
- □ Mbr Death-Homicide in Facility*
- □ Mbr Attempt- Suicide in Facility*
- □ Member Involvement with Law Enforcement*
- □ Member Elopement/Missing/Escape from facility*
- □ Suspected Unlicensed ALF or AFCH*
- □ Sexual/Physical Assault/Abuse/Battery*
- □ Infant Discharge to wrong family / Child Abduction
- □ Altercations in facility requiring medical Intervention*
- □ Other: ________________________________

#### SENTINEL/ADVERSE EVENTS:  Adverse Event is defined as an unexpected event involving death or serious physical or psychological injury or the risk thereof during a healthcare encounter which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Please indicate the Sentinel/Adverse event being reported:
- □ Unexpected Death/Fetal Death
- □ Severe Brain/Spinal Damage
- □ Serious Physical and psychological Injury
- □ Performance of surgical procedure on wrong patient or wrong side.
- □ Wrong surgical procedure performed
- □ Surgical repair of injuries from a planned surgical procedure.
- □ Surgical Procedure unrelated to diagnosis
- □ Suicide in an inpatient unit
- □ Performance of procedure to remove unplanned foreign Objects remaining from previous surgery
- □ Surgery Complication □ Unplanned transfer to ICU
- □ Unplanned Return to Surgery

**Note:**
If the incident involved a death, was the Medical Examiner notified? □ Yes □ No
Was an autopsy performed? □ Yes □ No

**MEDICAL EXAMINER NAME:** ___________________________
**TELEPHONE NUMBER:** __________________________
## RISK MANAGEMENT INCIDENT REPORT FORM

### Detailed Incident Description:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

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Equipment Involved in Incident:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Name and License numbers of all personnel and capacity in which they were directly involved with this incident. List SS# numbers and capacity of unlicensed personnel involved with the incident (i.e. ER, physician, attending physician, surgeon, etc.)

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

License number of witnesses or SS# of unlicensed witnesses:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Action Taken by Facility/Vendor/Provider to try to Mitigate Issue:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

### ICD 10 CM Codes: (TO BE COMPLETED BY RN or PROVIDER ONLY) if applicable

<table>
<thead>
<tr>
<th>Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD 10 Codes 01-99.9):</th>
<th>Accident, event, circumstances, or specific agent that caused the injury or event. (ICD 10 E-Codes)</th>
<th>Resulting Injury (ICD 10 Codes 800-999.9)</th>
</tr>
</thead>
<tbody>
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</table>

Full Name of Individual Completing Form: ___________________________  Title: ___________________________

Signature: ______________________________________________________  Date: _____________________________
### Section 4 Analysis and Corrective Action

<table>
<thead>
<tr>
<th>Analysis</th>
<th>(apparent cause) of this incident:</th>
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<tbody>
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Describe CAP (corrective action plan) including timeframes for CAP implementation:

<table>
<thead>
<tr>
<th>Incident Resolved?</th>
<th>If unresolved, explain how it will be resolved:</th>
</tr>
</thead>
<tbody>
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**PROVIDER/FACILITY/VENDOR:** Please fully complete Sections 1, 2 and 3 of this Incident Form and submit it immediately, never more than 24 hours from the date/time of the incident, to the Plan’s Risk Management Department via HIPAA Secure E-mail or Fax as follows:

**Risk Manager:** Deborah Polynice, LHCRM  **E-Mail:** dpolynice@simplyhealthcareplans.com  **Fax Number:** 786-441-8218

**You may also call:** 786-264-0786
Simply Healthcare Plans, Inc.
Physician Initiated Transfer Request Form (Page 1)

Member's/POA Name(s):__________________________________________________
ID Number:_________________________  Effective Date:_______________________
Date of Birth:_______________________  Phone: __________________________
Address: ______________________________________________________________
City, State, Zip: _________________________________________________________

1. Justification for proposal to transfer this member is as follows: (Cite specifics as to frequency and type of
demonstration disruptive, unruly, abusive or uncooperative behavior. Include details and sequence of
events. Use additional sheets if necessary.)
2. Mental status of member – behavioral health:
3. Functional status of member
4. Diagnosis and medical summary of member’s condition
5. Social supports systems available to member
6. Summary of efforts to resolve problem
7. Other options offered to member prior to consideration of transfer
8. Attach separate statement(s) medical records and other appropriate documentation, e.g. police report, from
requesting provider describing his/her experience with the member.

PCP/Group Name: ______________________________________________________
Provider Number________________________________________________________
PCP Contact Person: ________________ Phone: __________________________
Signature, PCP, or Administrator: ___________________________________________
Date: _________________________________________________________________

Please forward by either mail or fax to the following:

Simply Healthcare Plans, Inc.
9250 W. Flagler Street, Suite 600
Miami, FL 33174-3460
Attention: Provider Operations
Phone: 305-408-5700  Fax: 305-408-5765
Florida Department of Health, Practitioner Disease Report Form

Complete the following information to report the suspect or diagnosis of a disease which is reportable under Florida Administrative Code 64D-3.

Please check here if you would like more copies of the form.

Patient Information

Last Name

First Name

Date of Birth (MMDDYYYY)

Social Security Number (no dashes)

Area Code + Phone Number (no dashes)

Gender: □ Male □ Female

Pregnant: □ Yes, number of months: _____ □ No

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Race: □ White □ Black □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Unknown □ Other

Address

City

State

Zip Code

Disease Specific Information

Date of Onset: (MMDDYYYY)

Disease Fatal? □ Yes □ No

Patient hospitalized? □ Yes □ No

Discharge Date: (MMDDYYYY)

Hospital Name:

Medicaid Number or Insurance:

REPORT IMMEDIATELY UPON—-— = Initial Suspicions 24/7 by Phone

= Diagnosis 24/7 by Phone

(Disease or Condition Reporting for HIV/AIDS and HIV exposed newborns: please report forms per incidents indicated in F.A.C. 64D-3.)

□ Amebic encephalitis

□ Anaemia

□ Arsenic poisoning

□ Botulism, foodborne

□ Botulism, infant

□ Botulism, other/wound/unspecified

□ Brucellosis

□ California serogroup virus disease

□ Campylobacteriosis

□ Carbon monoxide poisoning

□ Chancroid

□ Chlamydia

□ Cholera

□ Ciguatera fish poisoning

□ Conjunctivitis, in neonates x14 days

□ Creutzfeldt-Jakob disease (CJD)

□ Cryptosporidiosis

□ Cystoisosporiasis

□ Dengue

□ Diptheria

□ Eastern equine encephalitis virus disease

□ Ehrlichiosis

□ Encephalitis, other (non-arboviral)

□ Enteric disease due to Escherichia coli 0157:H7

□ Enteric disease due to other pathogenic Escherichia coli

□ Giardiasis

□ Gonorrhea

□ Granuloma inguinale

□ Haemophilus influenzae, meningitis and invasive disease

□ Hansen's disease

□ Herpesvirus infection

□ Hepatitis B surface antigen positive in pregnant woman or child up to 24 months

□ Herpes simplex virus (HSV) in infants up to 80 days old

□ HSV anogenital in children x12 yrs

□ Human papillomavirus (HPV) anogenital in children x12 yrs

□ HPV-associated laryngeal papillomatosis in children x6 yrs

□ Influenza—due to novel or pandemic strains

□ Influenza—associated pediatric mortality in persons <18 yrs

□ Leptospirosis

□ Legionellosis

□ Leprosy

□ Listeriosis

□ Lyme disease

□ Lymphogranuloma Venerereum (LGV)

□ Malaria

□ Measles (Rubella)

□ Melioidosis

□ Meningitis, bacterial, cryptococcal, other mycotic

□ Meningococcal disease

□ Mercury poisoning

□ Mumps

□ Neurotropic shellfish poisoning

□ Nontuberculous mycobacterial disease

□ Plague

□ Poliomyelitis

□ Pneumocystis (Ornithospora)

□ Drug-resistant

□ Rabies, animal

□ Rabies, human

□ Rabies possible exposure (animal bite)

□ Rickettsial disease

□ Rocky Mountain spotted fever

□ Rubella (including congenital)

□ St. Louis encephalitis virus disease

□ Salmonellosis

□ Saxitoxin poisoning, including paralytic shellfish poisoning (PSP)

□ Severe acute respiratory syndromes (SARS)

□ Shigellosis

□ Smallpox

□ Staphylococcal aureus, mortality community associated

□ Staphylococcal aureus, intermediate or full resistance to vancomycin

□ Staphylococcus enterotoxin B

□ Streptococcal disease, invasive Group A

□ Streptococcal pneumoniae, invasive disease

□ Syphilis

□ Syphilis, pregnant or neonate

□ Tetanus

□ Toxoplasmosis, acute

□ Trichinellosis (Trichinosis)

□ Tuberculosis (TB)

□ Tularemia

□ Typhoid fever

□ Typhus fever

□ Vaccine disease

□ Varicella (chickenpox), date of vaccination:

□ Varicella mortality

□ Venezuelan equine encephalitis virus disease

□ Vibriosis, Vibrio infections

□ Viral hemorraghic fevers

□ West Nile virus disease

□ Western equine encephalitis virus disease

□ Yellow fever

□ Any case, cluster of cases, or outbreak not listed above that is of urgent public health significance

Provider Information

Name:

Address:

City, State, Zip:

Phone: ( ) FAX: ( )

E-mail:

County Health Department Information

Phone: ( ) FAX: ( )

Medical Information

Diagnosis Date: (MMDDYYYY)

Test Conducted? □ Yes □ No

Lab Name:

Lab Test Date: (MMDDYYYY)

Lab Results:

Test Method: (MMDDYYYY)

Treatment Provided? □ Yes □ No

Treatment:

Medical Record Number:
HIPAA BREACH REPORT FORM

PERSONAL AND CONFIDENTIAL

Date Breach Reported to /Received at Plan (Date of Discovery):
Date Breach Occurred (PHI accessed/transmitted/Dismissed) to unauthorized individual:

SECTION 1: Information for Person Reporting Breach

Name of person reporting Breach: ____________________________

Member ID# (If applicable) ________________

Complete Address: ______________________________________

City: ________________ State: ________________ ZIP Code: ________

Phone No. ____________________________

Plan Provider ID# (If applicable): __________________________

Apt/Suite #: __________________________

The person reporting the breach:

☐ A Member ☐ Parent of Member ☐ Spouse of Member

☐ Designated Member Representative ☐ A Subcontractor/Business Associate ☐ A Non-Par Provider

☐ Other Non-Related Individual that Received the PHI/ Breached Information

☐ Other (explain): __________________________

If individual reporting breach received mail for a Plan member, was the mail opened? ☐ YES ☐ NO

If yes, please complete this form using the information viewed in the mailing.

If no, complete this form, as best as possible, using the information available on the envelope.

SECTION 2: Demographics of the Member Whose PHI Was Disclosed by the Breach

Member No. 1


Line of Business: ☐ Medicare ☐ Medicaid

Name of person affected by Breach: __________________________

Member ID#: __________________________

Complete Address: ______________________________________

City: ________________ State: ________________ ZIP Code: ________

Apt/Suite #: __________________________

Did the breach include PHI for other Plan members? ☐ YES ☐ NO

If yes, please enter their information in Section 7 of this form.

SECTION 3: Member’s Personal Health Information That Was Accessed or Disclosed

☐ Name ☐ Address ☐ Phone Number ☐ Gender ☐ Date of Birth ☐ SSN ☐ Member Plan ID#

☐ Medicare# ☐ Medicaid # ☐ Other Insurance Information ☐ Diagnosis Code/Information ☐ Plan Name

☐ Procedure Code/Treatment Received ☐ Name of Providers ☐ Dates of Treatment/Service

☐ Other: ____________________________________________________________________
HIPAA BREACH REPORT FORM

PERSONAL AND CONFIDENTIAL

Section 4: Method of Breached PHI

Source of breached PHI:  □ Stolen Cell Phone  □ Stolen Desk Top Computer  □ Stolen Laptop

□ Stolen Tablet  □ E-mail  □ Phone  □ Public Conversation  □ Fax  □ Copier  □ Mail  □ SFTP/FTP Site

Section 5: Format of PHI Disclosed

□ Claim Form  □ Explanation of Benefit  □ Authorizations Letter  □ Member ID Card

□ Case Management /Disease Management Member Letter  □ QM Member Letter

□ Provider Termination Letter to Member  □ Claim Letter  □ New Member Mailing  □ E-mail

□ Disenrollment/Reinstatement/Member Letter  □ Enrollment Verification Letter

□ Other (Explain):

Section 6: Other Information

Who has viewed the information?

If disposed, how were it disposed of?  □ Trashcan (Intact as received)  □ Trashcan (Shredded into pieces)

□ Returned to Plan via mail/Post Office  □ Shredded

May the Plan send a representative to pick up the information?  □ YES  □ NO

If yes, when is best date and time for pick up?

Address for pick up?  Apt/Suite#: ____________

If no, can you please return the information back to the Plan?  □ YES  □ NO

If yes, when will it be returned?  How will it be returned?  □ Mail  □ In Person

If no, can the information be shredded and safely disposed of?  □ YES  □ NO

Section 7: Information on Person Completing This Form

Name:  Title:  Dept:

Phone Number:  Location:  □ Ponce  □ Douglas  □ Tampa  □ Other

Signature:  Date:
### SECTION 8: ADDITIONAL MEMBERS AFFECTED BY THE BREACH

<table>
<thead>
<tr>
<th>Me#2:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan:</strong></td>
<td>□ Simply Healthcare Plans, Inc.  □ Clear Health Alliance  □ Better Health,</td>
</tr>
<tr>
<td><strong>Inc. Line of Business:</strong></td>
<td>□ Medicare  □ Medicaid</td>
</tr>
<tr>
<td><strong>Name of person affected by breach:</strong></td>
<td>Member</td>
</tr>
<tr>
<td><strong>ID#: Complete Address:</strong></td>
<td>Apt/Suite</td>
</tr>
<tr>
<td>#: City:</td>
<td>State:</td>
</tr>
<tr>
<td>Code:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Me#3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan:</strong></td>
<td>□ Simply Healthcare Plans, Inc.  □ Clear Health Alliance  □ Better Health,</td>
</tr>
<tr>
<td><strong>Inc. Line of Business:</strong></td>
<td>□ Medicare  □ Medicaid</td>
</tr>
</tbody>
</table>
| **Name of person affected by breach:** | Member ID#:
| **Complete Address:** | Apt/Suite #: |
| City: | State: | ZIP Code: |

### ADDITIONAL COMMENTS/REMARKS/SUMMARY:

Please complete this HIPAA Breach Report Form in its entirety, and submit it to the Plan via a HIPAA secure E-mail or fax using the following information: Deborah L. Polynice, LHRM  E-MAIL: dpolynice@simplyhealthcareplans.com  or Phone Number: 786-264-0786  Fax Number: 786-441-8218

*This form must be submitted to the Plan within 24 hours* from the date/time or discovery of the breach. Revised: 10/2015