Dear Doctor,

Welcome to Simply Healthcare Plans a Medicaid Reform Provider Network. We are pleased that you have decided to participate in our plan specifically for Medicaid Members.

Simply Healthcare Plans takes a positive approach toward managing Medicaid Members by working collaboratively with their Primary Care Physician to support a system of optimal utilization management and clinical quality. We believe that this system of management is the formula for our mutual success.

This Provider Manual highlights the key points related to Medicaid Reform and Simply Healthcare Plans. The Provider Manual does not constitute a contract. It is intended to be a guideline to facilitate and inform you and your staff of what the Florida Medicaid Reform Health Plan is about, what we need from you, and what you can expect from Simply Healthcare Plans. By following the guidelines outlined in this manual, we can assist you in providing caring, responsive service for your Medicaid Members.

We look forward to a lasting, productive future with you and your staff. If you need assistance, we are only a telephone call away.

Sincerely,

Marcio Cabrera, President

Simply Healthcare Plans, LLC.

1701 Ponce de Leon Blvd. Ste 400, Coral Gables FL 33134
A. 1 MEDICAID REFORM HEALTH PLAN

OVERVIEW AND GOALS

The Agency for Health Care Administration (AHCA) has implemented the Medicaid Reform Program in the counties of Broward and Duval. At the close of the first year of implementation, Medicaid Reform shall be extended to Nassau, Clay and Baker counties. Simply Healthcare Plans provides services to children, family populations, aged and disabled individuals family members as mandated by the Agency for Health Care Administration (AHCA). Medicaid Reform is expected to transform the Medicaid program by empowering Medicaid Recipients to take control of their health care, providing more choices for Recipients, and enhancing their health status through increased health literacy and incentives to engage in healthy behaviors.

The principles governing Medicaid Reform are:

- Patient Responsibility and Empowerment
- Marketable Decisions
- Bridging Public and Private Coverage; and
- Sustainable Growth Rate
- Supporting community based enterprises and outreach services

These principles will empower Simply Healthcare Plans Enrollees’ flexibility to Specialized Providers, and facilitate program management for government. One of the key goals of Simply Healthcare Plans and Medicaid Reform is to expand the health care choices for Medicaid Enrollees and enhance access to medical services.

Simply Healthcare Plans Medicaid Reform Health Plan providers shall receive the following reports and support services:

- Case Management of Members
- Provider Services Representatives
- Management Membership Reports
- Paid Claims Report
- Paid Pharmacy Report
- Claims Analysis Report
- Utilization Review Nurses on site for most Medicaid Reform patients in the hospital
- Care Coordinator/Member Outreach

Simply Healthcare Plans Medicaid Reform Health Plan providers shall be eligible for assignment of new patients.

Simply Healthcare Plans shall disseminate bulletins as needed to incorporate any needed changes to the Provider Manual.

Simply Healthcare Plans Cultural Competency

Simply Healthcare Plans has a complete cultural competency plan as part of the Utilization Management Program to improve our Enrollees’ health outcomes and quality of care, and to reduce racial and ethnic health care. The plan follows The National Standards on Culturally and
Linguistically Appropriate Services (CLAS) to educate our employees, enrollees, and providers on the importunacy of communication in a preferred language and respect for cultural health beliefs. These standards are also used to inform Enrollees about their rights to receive effective, understandable, and respectful care that is provided in a manner in which their cultural health beliefs are in their preferred language.

Simply Healthcare Plans Enrollee Services Department will provide educational and informational materials about our plan in English and in other languages. Translation and interpreter services are available for all Enrollees’ who speak another language. Enrollee Services can provide written materials such as large print, audio tape or Braille (for the Blind) upon request. Simply Healthcare Plans’s Providers are prohibited from discriminating against different types of patients based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, source of payment or health status. The health 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.

Simply Healthcare Plans Website
http://www.simplyhealthcareplans.com/

Simply Healthcare Plans’s website allows Providers to access a very rich source of information. On the homepage, Providers can access the “Providers” page and download the most current versions of the following:

Provider Manual

Provider Forms
- Simply Healthcare Plans Referral/Authorization Form
- Medical Release Form
- Expectant Mother Notification Form
- Abortion Certification Form
- Sterilization Consent Form
- Domestic Violence Assessment Tool
- Request for Change of Member Information Form
A.2 IMPORTANT CONTACTS AND INFORMATION

Main Telephone (877) 777-787
Member Services Department (877) 577-9043
Provider Services (877) 915-0551
TDD (For the hearing and speech impaired): 711 Florida Relay

Member ID Card
A.3 MEDICAID PROBLEM SOLVING RESOURCES
A REFERRAL GUIDE TO DETERMINE ELIGIBILITY INTO MEDICAID

MEDICAID ELIGIBILITY

CONTACT:
DEPARTMENT OF CHILDREN AND FAMILIES (DCF)
at the local Public Benefits Service Center.
For the Closest Center, Call 954-267-2000

To request a new Medicaid ID card if the original is lost, stolen or never received.

To obtain information regarding eligibility for any of the State of Florida Public Benefits Programs.

To apply for any of the State of Florida public benefits programs.

Contact DCF: 866-762-2237 or www.dcf.state.fl.us/ess

CONTACT DCF Adult Payments 954-267-2000

To obtain information regarding Nursing Homes application and/or placement.

To obtain assistance for senior citizens, and individuals who have a disability.

To obtain information about hospice and Medicaid expansion waivers.

MEDICAID SERVICES

CONTACT AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Consumer Relations Office 954-267-2000

To find out what medical services Medicaid covers, and the limitations to Medicaid services.

To obtain the names of medical providers who will accept Medicaid patients.

Call Medicaid Consumer Relations: 954-267-2000:

To inquire about finding a Medicaid provider (until enrolled in a Medicaid HMO or Medicaid Health Care Reform Plan).
To report a problem, such as inappropriate provider billing for covered services or refusal to provide services (due to a Third Party Insurance on file).

To ask questions about Medicaid co-payments.

To ask questions about Medicaid covered services.

Increase the number of prescriptions a person may receive under Medicaid. (Refer to a local pharmacy)

Call Medicaid Health Care Reform Plan at 866-454-3959:

To obtain information or if there are any concerns about Medicaid Health Care Reform call.

To change from one Medicaid Health Care Reform Plan provider to another Medicaid Health Care Reform provider.

To report a problem with a Medicaid Health Care Reform Plan provider.

Call Medicaid Options Choice Counseling Hotline at 866-454-3959:

To ask about Medicaid HMO’s or the HMO’s.

To initially enroll in a Medicaid HMO, Medicaid Health Care Reform Plan, or the HMO.

To switch from Medicaid Health Care Reform Plan to a Medicaid HMO or to a HMO.

To switch from a Medicaid HMO to the Medicaid Health Care Reform Plan or to a HMO.

To switch from one Medicaid HMO to another Medicaid HMO.

When Should a Call be Referred to Department of Children and Families

Call 954-267-2000

Issue a duplicate Medicaid card or replace a lost Medicaid card.

Apply for Medicaid and public benefits.

Fix Medicaid file problems. (recipient not on file, duplicate PIN’s, incorrect date of death on file…..)

Change any information on FMMIS (Florida Medicaid Management Information System).

B.1 MEDICAID REFORM HEALTH PLAN COVERED SERVICES AND REQUIREMENTS

GENERAL SERVICES

It is agreed that Simply Healthcare Plans will provide patient management for the following services for each patient:
• Advanced Registered Nurse Practitioner Services
• Ambulatory Surgical Centers
• Birth Center Services
• Child Health Check-Up Services
• Chiropractic Services
• Community Mental Health Services
• County Health Department Services
• Dental Services
• Dermatology Services
• Dialysis Services
• Durable Medical Equipment and Medical Supplies
• Emergency Room Services
• Family Planning Services
• Federally Qualified Health Center Services
• Freestanding Dialysis Centers
• Hearing Services
• Home Health Services
• Laboratory Services
• Licensed Midwife Services
• Physician Services
• Physician Assistant Services
• Podiatric Services
• Primary Care Case Management Services
• Prescribed Drug Services
• Rural Health Clinic Services
• Targeted Case Management
• Therapy Services
• Transplant Services
• Transportation Services
• Vision Services
• X-Ray Services including portable x-rays

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
• Render Services and Administer Benefits in accordance to Medicaid Guidelines
• 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 SimplyCaid members
• One (1) Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) for every 750 SimplyCaid 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 Section 8 of this Handbook
• Have a procedure for non-compliant members: documentation and verbal or written notification to the member
• Provide regular appointments for adult healthcare, assessments and treatment, as indicated, or upon request for those members twenty-one (21) years of age and older
• Perform physical examinations within 72 hours or immediately if required for children taken into protective custody, emergency shelter or into the foster care program by the Department of Children and Families (DCF)
• Provide Child Health Check-Ups (CHCUP) as per the approved guidelines (Refer to CHCUP section below)
• Provide immunizations as per the approved guidelines
• Participate in the Vaccines for Children (VFC) program for members eighteen (18) years of age and younger (Refer to Children’s Vaccines section below)
• Providers will administer only VFC-supplied vaccinations for all members eighteen (18) years of age and younger that are supplied free to the provider through the VFC Program
• Provide immunization information to the Department of Children and Families (DCF) upon receipt of the member’s written permission and DCF’s request, for members requesting temporary cash assistance from the DCF
• 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 that are available to the member 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 or indicated
• 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

Responsibilities of All Providers and subcontractors
The remainder of this section identifies responsibilities for all Plan providers. The following are responsibilities for 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
- 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 participating facilities cannot provide the necessary level of care. Authorization 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 environmentally safety/hygiene regulations, as per city, state and federal regulations
- Promptly respond promptly 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
- 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 AHCA 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 Compliance Officer 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.
• 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
EMERGENCY SERVICES

The following guidelines shall be utilized for emergency care and services:

Participating Provider is required to ensure adequate accessibility for health care twenty-four (24) hours per day, seven days per week. The Enrollee should call their PCP first if they have an emergency, or go to the closest emergency room or any other emergency setting if they have an emergency like:

- Heavy blood loss
- Heart attack
- Severe cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- Loss of breath
- Broken bones

Enrollees are instructed to call their PCP as soon as possible when they are in a hospital, or have received emergency care.

If the emergency room doctor treating the Enrollee states to the Enrollee that the visit is not an emergency, the Enrollee will be given the choice to stay and get medical treatment or follow up with their primary care physician. If the Enrollee decides to stay and receive treatment and it has been determined that the care is not deemed medically necessary the services will be denied and will not be a covered benefit.

If the Enrollee is treated for an emergency, and the treating doctor recommends treatment after the Enrollee is stabilized, the Enrollee will be instructed to call their Simply Healthcare Plans PCP.

If the Enrollee is away from home and has an emergency, they are instructed to go to the nearest emergency room, any emergency setting, of their choice. In such situations, the Enrollee should call their PCP as soon as possible.

Simply Healthcare Plans shall not deny claims for emergency services and care received at a Hospital due to lack of parental consent. In addition, Simply Healthcare Plans shall not deny claims for treatment obtained when a primary care physician or a representative of Simply Healthcare Plans instructs the Enrollee to seek Emergency Services and Care.

Simply Healthcare Plans or the provider affiliated with the plan shall not:

- Require prior authorization for an Enrollee to receive transportation or treatment for Emergency Services and Care;
- Specify or imply that Emergency Services and Care are covered by Better Health only if secured within a certain period;
- Encourage the provider to use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered or;
• Deny claims based on a failure by the Enrollee or the Hospital to notify Better Health before, or within a certain period after, Emergency Services and care were given.

Out-of-Area Emergencies

Enrollees should go to the nearest ER for care. Enrollees can use any hospital for emergency services. Please call your PCP within (24) hours of going to the ER so they can help you get the care you need.

All services, except for emergencies, must be authorized to ensure payment. If the facility does not accept your Simply Healthcare Plans card, you may receive a bill. If you receive a bill, send the bill and copies of all supporting documents related to the hospital, treatment and procedure to:

Simply Healthcare Plans
PO Box 211665
Eagan, MN 55121

Post-Stabilization

These are covered services Enrollees receive after ER care. These services keep the Enrollee’s condition stable. Post-stabilization care services are provided and covered without prior authorization (24) hours a day, seven (7) days a week.

If the Enrollee needs this kind of care:
• Enrollee must notify Simply Healthcare Plans if they have called 911 or gone to the ER.
• Enrollee must notify Simply Healthcare Plans WITHIN (24) HOURS.

Simply Healthcare Plans Case Managers can help the Enrollee receive the care they need. A friend or family member can call for the Enrollee.

BEHAVIORAL HEALTH SERVICES

The Behavioral health services that the Enrollee is covered for include inpatient and outpatient hospital services and psychiatric doctor services. The Enrollee and their family can also get a wide range of mental health and case management services. The following services in the community, of the Enrollee, the services include:

• Individual, family, and group therapy
• Social rehabilitation
• Day treatment for adults and children
• Evaluations
• Treatment planning
Call PsychCare Behavioral Health Services at 800-221-5487 if the Enrollee requires additional assistance. The Staff will coordinate the Enrollees care.

**What to Do If the Enrollee Is Having A Problem:**

If the Enrollee has the following feelings or problems, the Enrollee should be instructed to contact a Behavioral Health Provider:

- Constantly feeling sad
- Feelings of hopeless and/or helpless
- Feelings of guilt
- Difficulty sleeping
- Poor appetite
- Loss of interest
- Difficulty concentrating
- Constant pain such as headaches, stomach and backaches

The Enrollee does not need to call the PCP for a referral for an appointment. An approval for services will be given at the time of the Enrollees call. If the Enrollee utilizes a provider without getting an approval, they are held responsible to pay the bill.

**Help for Enrollees Out of the Service Area:**

First, the Enrollee should decide if they are having a true behavioral health emergency. The Enrollee should “call 911” or go to the nearest emergency room for attention. If the Enrollee requires emergency Behavioral Health help outside the plan’s service area Behavioral Health should be notified. The Enrollee should also call their PCP and follow-up with your doctor within 24 to 48 hours. For out-of-area emergency care, when the Enrollee is stable, plans will be made for transfer to an in-network facility.

**Obtaining Behavioral Health Services:**

If the Enrollee requires assistance in finding a Behavioral Health Provider in their area, you can call PsychCare Behavioral Health Services at **800-221-5487**.

Enrollee will be given the names of several providers in the local community from which the Enrollee can choose to call for an appointment. The Enrollee can also choose a different behavioral health care coordinator or direct service behavioral health care provider within the Plan if one is available.

**Behavioral Health Limitations:**

Adults can get up to 45 inpatient days a year and up to 365 days of emergency patient care, including behavioral health.
For children under the age of 21 and pregnant adults, the health plan is responsible for providing emergency admissions and get up to 365-days inpatient days a year, including behavioral health. Pregnant substance abusers can get up to 28 days of Inpatient Substance abuse treatment.

The health plan will provide the following services in accordance with Medicaid guidelines and the Behavioral Health Services Coverage and Limitation Handbook:

- Inpatient Hospital Services for Behavioral Health and substance abuse Conditions
- Outpatient Hospital Services for Behavioral Health and substance abuse Conditions
- Mental Health physician services
- Community Mental Health Services
- Mental Health Targeted Case Management
- Mental Health Intensive Targeted Case Management

If the Enrollee or their family member have a substance abuse problem, the Enrollee should call their local Medicaid provider. The Behavioral Health staff will be able to assist the Enrollee with a referral.

The following services are not covered by the plan:

- Specialized therapeutic Foster Care;
- Therapeutic Group Care Services;
- Behavioral Health Overlay Services;
- Community Substance Abuse Services
- Residential Care
- Sub-acute Inpatient Psychiatric Program (SIPP) Services
- Clubhouse Services;
- Comprehensive Behavioral Assessment; and
- Florida Assertive Community Treatment Services (FACT)

After Hours Care:

If the Enrollee requires care after regular office hours (except for emergencies), they must contact Simply Healthcare Plans’s behavioral health provider. Providers are required to have coverage for patients 24 hours a day, seven days a week.

The Enrollee should always call their behavioral health provider. The PCP or mental health provider can give treatment directions by telephone, prescribe medication, or ask the Enrollee to come to the provider office, refer to an emergency facility or to another provider for treatment. The Enrollee may also seek healthcare at a participating urgent care facility.

Urgent Care Facilities:
Sometimes the Enrollee may have a medical problem that is not serious and the provider’s office is closed. If the PCPs’ office is closed, the Enrollee can select Behavioral Health providers who have later office hours. The Enrollee also can use urgent care centers as appropriate.

**Hospital Care:**

Simply Healthcare Plans Enrollees, may receive health care from participating hospitals. If the Enrollee needs to go to the hospital, the following information should be kept in mind:

- If hospital care is required within the service area, the PCP will arrange for admission to a Simply Healthcare Plans hospital.
- The PCP should make sure the Enrollee is admitted to a Simply Healthcare Plans hospital.
- Hospital services, including inpatient (overnight stay) and outpatient (one day only) services require the PCP to notify Simply Healthcare Plans.
- Simply Healthcare Plans will pay claims for covered services at participating hospitals when the PCP has notified Simply Healthcare Plans.
- The PCP should call Simply Healthcare Plans Enrollee Services if there are any questions about prior notification.
- Simply Healthcare Plans will pay claims for Emergency Medical Services.

**CHILD HEALTH CHECK-UP (CHCUP)**

It is agreed that the Simply Healthcare Plans provider shall provide a health screening evaluation that shall consist of comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status; comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for Enrollees beginning at three (3) years of age or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate.

For Children/Adolescents who the PCP identifies through blood lead screenings as having abnormal levels of lead, Simply Healthcare Plans, shall provide Case Management follow-up services as required in Chapter Two (2) of the Child Health Check-Up Services Coverage and Limitations Handbook. Screening for lead poisoning is a required component of health screening. Simply Healthcare Plans shall require all Providers to screen all Enrolled Children for lead poisoning at twelve (12) and twenty-four (24) months of age. In addition, Children/Adolescents between the ages of twenty-four (24) months and seventy-two (72) months of age must receive a screening blood lead test if there is no record of a previous test. Simply Healthcare Plans shall authorize additional diagnostic and treatment services determined to be Medically Necessary to a Child/Adolescent diagnosed with an elevated blood lead level. Simply Healthcare Plans, shall recommend, but shall not require, the use of paper filter tests as part of the lead screening requirement.

Simply Healthcare Plans and the Primary Care Provider shall inform Enrollees of all testing/screenings due in accordance with the periodicity schedule specified in the Medicaid Child
Health Check-Up Services Coverage and Limitations Handbook. The Primary Care Provider shall contact Enrollees to encourage them to obtain health assessment and preventative care. Simply Healthcare Plans primary care physicians shall receive a letter that identifies the Enrollees who’s periodic screenings are due within the thirty (30) day period as identified according to the periodicity schedule. The primary care physician is expected to review the list and follow up with that Enrollee who does not have an appointment scheduled.

The Primary Care Provider shall refer Enrollees to appropriate service Providers within four (4) weeks of the examination for further assessment and treatment of conditions found during the examination. Simply Healthcare Plans shall ensure through monitoring of CHCUP that the referral appointment is scheduled for a date within six (6) months of the initial examination, or within the time periods set forth in Section (VII, D) which identifies the appropriate waiting times and geographic access.

The Primary Care Provider of Simply Healthcare Plans shall offer scheduling assistance and Transportation to the Enrollees in order to assist them to keep, and travel to medical appointments.

The CHCUP program includes the maintenance of a coordinated system to follow the Enrollee through the entire range of screening and treatment, as well as supplying CHCUP training to medical care Providers. Simply Healthcare Plans shall provide an in-service on the CHCUP guidelines on initial participation of in-servicing and thereafter as deemed necessary. Simply Healthcare Plans shall provide continuous education to primary care physicians and specialists in the form of newsletters and fliers.

Simply Healthcare Plans shall monitor the primary care physicians encounter submissions to determine if the physician is adhering to the guidelines of the agency for CHCUP. Encounter submission errors shall be identified by monitoring of the preventive medicine codes submitted to Simply Healthcare Plans’s designated vendor on a timely basis. The primary care physician will receive a report from Simply Healthcare Plans based on the periodicity schedule of documented visits for CHCUP. Simply Healthcare Plans shall request to audit the charts of primary care physicians that fail to submit encounters for child health check-ups, if the physician has not adhered to the policy (identified as non-compliant physicians) Simply Healthcare Plans shall appropriately place physician on a plan of corrective action.

Simply Healthcare Plans shall achieve a CHCUP screening rate of at least sixty CHCUP (60%) and (80%) participation rate for those Enrollees who are continuously enrolled for at least eight (8) months during the Federal Fiscal Year (October 1 – September 30) in accordance with section 409.912, F.S. The screening compliance rate shall be based on the CHCUP screening data reported by the Primary Care Provider and due to the Agency by January 15 following the end of each Federal Fiscal Year as specified in Section XII, Reporting, of the Contract.

Any data reported by the Primary Care Provider that is found to be inaccurate shall be disallowed by the Agency and the Agency shall consider such findings as being in violation of the Contract and may sanction the Primary Care Provider accordingly.

Simply Healthcare Plans shall adopt annual screening and participation goals to achieve at least an eighty percent (80%) CHCUP screening and participation rate. For each Federal Fiscal Year that the Provider’s within the Network does not meet the eighty percent (80%) screening and participation rate, it must file a Corrective Action Plan (CAP) with the Agency no later than February 15 following the Federal Fiscal Year being reported.
Simply Healthcare Plans shall require the Primary Care Provider to follow the following guidelines based on the recommendations of the USPSTF. The judgment of the provider and coverage, reimbursement, state or federal law and other extenuating circumstances may differ from these guidelines.

CHILDREN AGES ONE THROUGH TEN YEARS OF AGE

This chart outlines the appropriate health screening of Simply Healthcare Plans Enrollees.

<table>
<thead>
<tr>
<th>TYPE OF SCREENING</th>
<th>TIMING OF SCREENINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Checkup Visits</td>
<td>Within three days of initial hospital discharge At 1,2,4,6,9,12,18 and 24 months of age At 3,4,5,6,7,8, and 10 years of age</td>
</tr>
<tr>
<td>Height and Weight</td>
<td>With each checkup</td>
</tr>
<tr>
<td>Head Circumference</td>
<td>With each checkup through 24 months of age</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td>Before initial neonatal hospital discharge At 3 thru 4 years of age and with every checkup thereafter</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>At ages 3 and 4 and with every checkup thereafter</td>
</tr>
<tr>
<td>State Metabolic Screening</td>
<td>Between 2 and 6 days of age At hospital discharge, if later than 6 days</td>
</tr>
<tr>
<td>Lead Testing Screening</td>
<td>At 9,12 and 24 months of age Between 3 and six years of age, if child has not received screening.</td>
</tr>
</tbody>
</table>

IMMUNIZATIONS

Simply Healthcare Plans Primary Care Providers shall:
• Provide immunizations in accordance with the Recommended Childhood immunization schedule for the United States, or when medically necessary for the Enrollee's health;

• Provide for the simultaneous administration of all vaccines for which an Enrollee under the age of 20 is eligible at the time of each visit; and

• Follow only true contraindications established by the Advisory Committee on Immunization Practices ("ACIP"), unless:

• In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or

• The particular requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions.

• Simply Healthcare Plans expects and will direct the Providers to participate in the Vaccines for Children Program ("VFC") (12)

• The Provider is expected to provide documentation that they are enrolled in the Vaccine for Children's Program (VFC);

• Simply Healthcare Plans shall direct those Providers that are directly enrolled in the VFC program to maintain adequate vaccine supplies;

• Providers are expected to provide immunization information to DCF for Enrollees requesting temporary cash assistance from DCF, upon request by DCF and receipt of the Enrollee's written permission, in order to document that the Enrollee has met the immunization requirements for Enrollees receiving temporary cash assistance.

See Section 1905(r) (1) of the Social Security Act. The VFC is administered by the Department of Health, Bureau of Immunizations, and provides vaccines at no charge to physicians and eliminates the need to refer children to CHDs for immunizations.

*See Attachment Schedule of Immunization Requirements identified by Department of Health and Human Services*Center for Disease Control and Prevention

**ADULT HEALTH SCREENING**

Adult Preventive Screening Beginning at Age 21

**Elements and Guidelines to Follow Are Listed Below:**

**Risk Screening:**

Screening to identify high-risk individuals, assessing family Medical and social history required. Screening for the following risks are included as a minimum: Cardiovascular Disease, Hepatitis, HIV/AIDS, STDS and TB.
Interval History:

Interval histories are required with preventive health care. Changes in medical, emotional, and social status are documented.

Immunizations:

Immunizations are documented and current. If immunization status is not current, this is documented with a catch up plan. Immunizations are required as follows:

Influenza, annually beginning at age 65 years, TD Booster every 10 years; Pneumococcal vaccine beginning at age 65. When an individual has received a Pneumococcal Vaccination prior to the age of 65 years and it has been 5 years since the vaccination, they should be revaccinated.

Height and Weight:

Documented height and weight is required for all preventive health care visits and at least:
- every 5 years: ages 21-40 years
- every 2 years: beginning at age 41 years

Vital Signs:

Pulse and blood pressure are required for all preventive health care visits and at least:
- every 5 years: ages 21-40 years
- every 2 years: beginning at age 41 years

Physical Exam:

Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are:

- general appearance
- skin
- gums/dental/oral
- eyes/ears/nose/throat
- neck/thyroid
- chest/lungs
- cardiovascular
- breasts
- abdomen/GI
- genital/urinary
- musculoskeletal
- neurological
- lymphatic

If non-compliance or refusal is documented, the risk associated with the non-compliance must be documented.
Cholesterol Screening:
Screening required every 5 years for:
Men beginning age 35
Women beginning age 45
(Earlier if any risk factor for Cardiovascular Disease)

Visual Acuity Testing:
Visual acuity testing, at a minimum, documents the Patient’s ability to see at twenty feet. Referrals for testing must be documented.

Hearing Screening:
Test or inquire about hearing periodically/once a year.

Electrocardiogram:
Periodically after age 40-50 (or as primary care deems medically appropriate)

Colorectal Cancer Screening:
Colorectal cancer screening must be documented beginning at 50 years of age.
Risk Factors: First – degree relatives or personal history of colorectal cancer, personal history of female genital or breast cancer, familial adenomatous polyposis, Gardner’s syndrome, Hereditary non-polyposis colo-rectal cancer, chronic inflammatory bowel disease.

Pap Smear:
Pap smears annually for three consecutive years until three consecutive normal exams are obtained, then every 2-3 years. May stop at age 65 if patient has had regularly normal smears up to that age.

Mammography:
Required as appropriate for age:
- Baseline between ages 35 and 40
- Every 1 to 2 years for women age 40 and above.
- Earlier and/or more frequent for women at high-risk.
Prostate Exam Screening:

U.S. Preventive Services Task Force/ December 2002

The evidence is insufficient to recommend for, or against routine screening for prostate cancer using PSA testing or digital rectal examination. The USPSTF found good evidence that PSA can detect early-stage prostate cancer but mixed, inconclusive evidence that early detection improves health outcomes. Insufficient evidence to determine whether the benefits outweigh the risks (of biopsies, complications and anxiety), especially in a cancer that may never affect the patient’s health.

If early detection improves health outcomes, the population most likely to benefit from screening will be men aged 50 to 70 who are average risk, and men older than 45 who are at increased risk (African American men and men with a family history of a first-degree relative with prostate cancer. Benefits may be smaller in Asian Americans, Hispanics, and other racial and ethnic groups that have a lower risk of prostate cancer. Older men and men with other significant medical problems who have a life expectancy of fewer than 10 years are unlikely to benefit from screening.

American College of Physicians 2004

Selected testing in 50-69 year-olds, provided that the risks, benefits and uncertainties are understood with the current evidence, it is difficult to justify screening in men 70 and over.

Education Guidance:

Health education and guidance must be documented. Educational needs are based on risk factors identified through personal and family medical history and social cultural history and current practices.

Osteoporosis:

Screening for women age 65 and older; begin at age 60 if at increased risk for osteoporosis fractures. Perform DEXA Scan for serial monitoring. Every 2 years, special conditions may need more frequent monitoring. All perimenopausal women should have a DEXA Scan after a fracture if test has not been performed recently.

Expanded Services:

Expanded services are those services offered by Simply Healthcare Plans, and approved in writing by the Agency. These services are in excess of the amount, duration and scope of those services listed in the plans Covered Services. The services Simply Healthcare Plans offers include adult dental, vision and hearing. These services do have specific limitations, no co-pays for routine care, and there is no prior authorization required. The Enrollee has the ability to contact the Vendor directly to coordinate their medical care.

Family Planning Services:

Simply Healthcare Plans shall provide family planning services for enabling Enrollees to make comprehensive and informed decisions about family size and/or spacing of births. The Primary Care Provider shall provide the following services: planning and referral, education and
counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Provider General Handbook Services Coverage and Limitations Handbook. Policy requirements include:

The Participating Provider shall furnish services on a voluntary and confidential basis.

Simply Healthcare Plans, shall allow Enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid covered implants, where there are no medical contra-indications.

The Participating Provider shall render the services to Enrollees under the age of eighteen (18) provided the Enrollee is married, a parent, pregnant, has written consent by a parent or legal guardian, or in the opinion of a physician, the Enrollee may suffer health hazards if the services are not provided.

Simply Healthcare Plans shall allow each Enrollee to obtain family planning services from any provider and require no Prior Authorization for such services.

Simply Healthcare Plans Participating Primary Providers/OB shall make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling and services for family planning to all women and their partners. Simply Healthcare Plans, shall direct Providers to maintain documentation in the Enrollees Medical Records to reflect this provision.

**Hysterectomies, Sterilizations and Abortions**

The Participating Provider of Simply Healthcare Plans shall maintain a log of all hysterectomy, sterilization and abortion procedures performed for its Enrollees. The log must include, at a minimum, the Enrollee’s name and identifying information, date of procedure, and type of procedure. (Refer to Section F of this book for forms).

**Hysterectomies:**

Simply Healthcare Plans shall cover hysterectomies when they are non-elective and medically necessary. Non-elective, medically necessary hysterectomies must meet the following requirements to be a covered service:

- The Enrollee or her representative must have been informed verbally and in writing that the hysterectomy shall render her permanently incapable of reproduction.

- The Enrollee or her representative, if any, has signed and been given a copy of the Acknowledgement of Receipt of Hysterectomy Information form. (Refer to Hysterectomy Acknowledgment Form located on the Agency’s website).

- The Hysterectomy Acknowledgement Form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
Sterilization:

Non-therapeutic sterilizations must be documented with a completed Consent Form (See HHS Sterilization Consent Form located on the fiscal agent’s web site) which shall satisfy federal and state regulations. Non-therapeutic sterilization is any procedure or operation that has the primary purpose of rendering an individual permanently incapable of reproducing and is neither:

- A necessary part of the treatment of an existing illness or injury; nor
- Medically indicated as an accompaniment of an operation of the female genitourinary tract.

The Enrollee must be at least 21 years of age, mentally competent, and not institutionalized in a correctional, penal, rehabilitative or mental facility. The patient must wait at least 30 days after signing the consent form to have the operation, except in the instances of premature delivery or emergency abdominal surgery that takes place at least 72 hours after consent is obtained.

The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances, which affects the patient’s state of awareness. The consent is effective for 180 days from the date the consent form is signed by the patient. A new consent form is required if 180 days have passed before the surgery is provided.

Abortions:

May be performed because the life of the mother is or would be endangered if the fetus were carried to term and must be documented in the medical record by the attending physician stating why the abortion is necessary; or if the pregnancy is the result of an act of rape or incest. Abortions must be documented with a completed Abortion Certification Form (see Abortion Certification Form, located on the fiscal agent’s web site) which shall satisfy federal and state regulations.

Maternity Care and Services:

The Participating Providers of Simply Healthcare Plans must provide the most appropriate and highest level of quality care for pregnant Enrollees. Required care includes the following:

Pregnancy testing and a nursing assessment with referrals to a physician, physician’s assistant or nurse practitioner for comprehensive evaluation; case management through the gestational period according to the client; referral and follow-up. The OB Provider is expected to schedule a return visit at least every four weeks until the 32nd week, every two weeks until the 36th week, and every week thereafter until delivery, unless the member’s condition requires more frequent visits. For Enrollees who fail to keep appointments, the plan must contact the members as soon as possible and arrange for their necessary and continued prenatal care. The provider is required to assist the Enrollee in making delivery arrangements.

- Simply Healthcare Plans shall ensure that the Provider uses the DOH prenatal risk form (DH Form 3134), which can be obtained from the local County Health Department (CHD).
• Simply Healthcare Plans shall ensure that the Provider retains a copy of the completed screening instrument in the Enrollee's Medical Record and provides a copy to the Enrollee.

• Simply Healthcare Plans shall ensure that the Provider submits the completed DH Form 3134 to the CHD in the county in which the prenatal screen was completed within ten (10) Business Days of completion.

Simply Healthcare Plans (Participating Providers) shall collaborate with the Healthy Start Care Coordinator within the Enrollee's county of residence to assure the appropriate care is delivered.

The Provider shall complete the Florida Healthy Start Infant (Postnatal) Risk Screening Instrument (DH Form 3135) with the Certificate of Live Birth and transmits the documents to the CHD in the county in which the infant was born within ten (10) Business Days of completion.

Simply Healthcare Plans shall ensure that the Participating Provider retains a copy of the completed DH Form 3135 in the Enrollee's Medical Record and provides a copy to the Enrollee.

Pregnant Enrollees or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

• If the referral is to be made at the same time the Healthy Start risk screen is administered, the Provider may indicate on the risk screening form that the Enrollee or infant is invited to participate based on factors other than score; or;

• If the determination is made subsequent to risk screening, the Participating Provider may refer the Enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis;

• Substance Abuse or Domestic Violence (Refer to section F Domestic Violence Assessment Tool);

Nutrition Assessment and Counseling:

Simply Healthcare Plans will ensure the provider provides nutrition assessment and counseling to all pregnant Enrollees. Nutrition assessment/counseling should include the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding and by the proper use of breast milk substitutes. Simply Healthcare Plans shall ensure the provider of service makes a mid-level nutrition assessment. The Enrollee shall have access to individualized diet counseling and a nutrition care plan which may be provided by the Public Health nutritionists if appropriate, nurses or physicians following nutrition assessments. The person providing counseling must document the nutrition care plan in the Enrollee's medical record.

Simply Healthcare Plans providers are expected to refer all pregnant women, breast-feeding and postpartum women, Infants and Children up to age five (5) to the local WIC office. The Participating Provider of Simply Healthcare Plans shall provide:

• A completed Florida WIC program Medical Referral Form with the current height or length and weight (taken within 60 Calendar Days of the WIC appointment);
• Hemoglobin or hematocrit; and;

• Any identified medical/nutritional problems;

• For subsequent WIC certifications, Simply Healthcare Plans shall ensure that Providers coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.

Simply Healthcare Plans shall educate the Participating Provider of the eligibility of those individuals who are eligible for the (WIC) benefits, which include the following classifications:

• Pregnant Women
• Women who are breast-feeding infant(s) up to one year postpartum
• Women who are non-breast feeding up to six months postpartum
• Infants under the age of one (1)
• Children under the age of (5)
• Each time the Participating Provider completes a WIC Referral Form,
• Simply Healthcare Plans shall ensure that the Provider gives a copy of the WIC Referral Form to the Enrollee and retains a copy in the Enrollees Medical Record.

Simply Healthcare Plans shall ensure that the Providers provide all women of childbearing age receive HIV counseling and offer them HIV testing. (14)

Simply Healthcare Plans shall ensure that it's Providers, in accordance with Florida law, offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at twenty-eight (28) to thirty-two (32) weeks.

Simply Healthcare Plans shall ensure that it's Providers attempt to obtain a signed objection if a pregnant woman declines an HIV test. (16)

Simply Healthcare Plans shall ensure that all pregnant women who are infected with HIV are counseled about and offered the latest antiretroviral regimen recommended by The U.S. Department of Health & Human Services. (17)

The guidelines for HIV Counseling are available by contacting The Florida Department Health of, Bureau of HIV/AIDS at 850-245-4334 or; the CDC Website: http://www.cdc.gov

Simply Healthcare Plans shall ensure that providers encourage all Medicaid eligible women receiving prenatal care be screened for the Hepatitis B surface antigen (HBsAG) early in each pregnancy, preferably during the first prenatal visit. Women who are HBsAg-positive shall be referred to Healthy Start regardless of their Healthy Start screening score.

Infants born to HBsAg positive mothers shall receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B Vaccine series. These infants shall be tested for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series. Infants born to mothers who are HBsAg positive shall be referred to Healthy Start regardless of their Healthy Start screening score.
All HBsAg-positive prenatal or postpartum women, their infants, and contacts shall be reported to:

State Health Office Immunization Program (HSDI) at
2020 Capital Circle S.E. Bin #A 11,
Tallahassee, Fl 32399-1719 or faxed to
850-922-4195

Information collected for each individual shall include name, date of birth, race, ethnicity, address, ex (infants and contacts), laboratory test performed and date sample collected, EDC, whether or not prenatal care was received (Prenatal woman) and immunization dates (infants and contacts). Use of the Perinatal Hepatitis B Case and Contact Report (DH Form 1876) is strongly encouraged but not required. The form may be obtained from the Department of Health at the above address.

Simply Healthcare Plans shall ensure that the PCP maintains all documentation of Healthy Start screenings, assessments, findings, and referrals in the Enrollees’ Medical Records.

Simply Healthcare Plans shall provide the most appropriate and highest level of Quality care for pregnant Enrollees, including, but not limited to, the following:

Prenatal Care – Participating Providers of Simply Healthcare Plans, are expected to:

- Require a pregnancy test and a nursing assessment with referrals to a Physician, PA or ARNP for comprehensive evaluation;
- Require a pregnancy test and a nursing assessment with referrals to a Physician, PA or ARNP for comprehensive evaluation;
- Require Case Management through the gestational period according to the needs of the Enrollee;
- Require any necessary referrals and follow-up;
- Schedule return prenatal visits at least every four (4) weeks until the thirty-second (32nd) week, every two (2) weeks until the thirty-sixth (36th) week, and every week thereafter until delivery, unless the Enrollees’ condition requires more frequent visits;
- Contact those Enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;
- Assist Enrollees in making delivery arrangements, if necessary; and
- Ensure that all Providers screen all pregnant Enrollees for tobacco use and make certain that the Providers make available to the pregnant Enrollees smoking cessation counseling and appropriate treatment as needed.
- Ensure the provision of safe and adequate nutrition for infants by promoting
breastfeeding and the use of breast milk substitutes;

- Offer a mid-level nutrition assessment;

- Provide individualized diet counseling and a nutritional care plan by a public health nutritionist, a nurse or physician following the nutrition assessment and;

- Documentation of the nutritional care plan in the Medical Record by the person providing counseling.

B.2 UTILIZATION MANAGEMENT FOR SIMPLY HEALTHCARE PLANS
MEDICAID HEALTH CARE REFORM PROGRAM

The Program

The physician is responsible for coordinating and managing the delivery of covered medical services to the enrolled Members. The Physician also coordinates and manages the delivery of specialty health care services, including those identified through Child Health Check Up Program (CHCUP). Simply Healthcare Plans will identify patterns of over-utilization and under-utilization by Enrollees and for addressing potential problems identified as a result of these analyses. The Participating Provider of Simply Healthcare Plans shall report Fraud and Abuse information identified through the Utilization Management program to the Agency’s contract manager.

Simply Healthcare Plans will require the Participating Provider to request for Enrollees to obtain a second medical opinion when deemed appropriate; and Simply Healthcare Plans shall be responsible for authorizing claims for such services in accordance with section 641.51, F.S. (Service Authorization protocols for Prior Authorization and denial of services; the process used to evaluate prior and con-current authorization; mechanisms to ensure consistent application of

17 U.S. Department of Health & Human Services, Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal
review criteria for authorization decisions; consultation with the requesting Provider when appropriate).

The purpose of the Utilization Management Program is to improve early access to high quality and appropriate levels of care using a comprehensive case management and utilization review program. The Care Management program consists of on-site hospital case management, as well as obstetric, individual (catastrophic) and complex (disease state management). Out of area, patients are case managed telephonically with the attending physician or lead nurse. Operating concurrently with pre-authorization of referrals identification and precertification of hospital services, the Program insures that health care services provided to Members are medically appropriate and delivered in a timely manner.

Utilization Management Goals

- Assist members in resolving problems as expeditiously as possible, with the most positive impact and least disruption to their lives.
- Improve the coordination of the sequence of care by,
- Insuring communication with the member, family, facility, Attending Physician, PCP and other providers.
- Improve the quality of member care through identification and communication of potential quality issues to quality improvement management.
- Identify members considered to be high risk in terms of requiring complicated continuing care and to assure case management intervention and tracking.
- Identify and review key indicators for tracking potential over and under utilization and refer to the utilization management committee for corrective follow-up.

Methods of Utilization Review

Prospective Review: Is an integral component of managed care that allows for detailed evaluation of the requested health care services prior to the delivery of services.

Prospective review is provided for the following:

- In-Patient admissions services
- Out-patient/specialist referral services
- Ancillary/home health service
- Skilled nursing and Sub-acute services
- Referral Management

Concurrent Review: Is the review of health care services, including medical appropriateness, level of care and alternatives, at the time the services are being rendered. This process is the responsibility of the Case Manager.

Retrospective Review: Is the review of medical necessity, appropriateness and quality of care after the services have been rendered.
Denial of Authorizations

Simply Healthcare Plans shall provide written confirmation of all denials of authorization to providers.

Simply Healthcare Plans will request to be notified, but shall not deny claims payment solely on lack of notification for the following:

- Inpatient emergency admissions within ten (10) days; Obstetrical care (at first visit)
- Obstetrical admission exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for cesarean section and,
- Transplants.

Simply Healthcare Plans shall ensure that all decisions to deny a Service Authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by Health Professionals who have the appropriate clinical expertise in treating the Enrollee’s condition or disease.

Medical Services: The following medical services require notification to and intervention from the Utilization Management Team at Simply Healthcare Plans:

- In-Patient Hospital Admissions
- Direct/Urgent Hospital Admissions
- Non-Urgent/elective Hospital Admissions
- Outpatient Surgical Procedures
- Skilled Nursing/Sub-acute/Acute Rehabilitation Facilities
- Home Health & DME Services Second Opinion Services

Case Management

Case Management is a comprehensive, innovative, Enrollee centered process of identifying medical and social needs and resources, which will meet the level of care for the catastrophically ill/injured, or medical fragile Enrollee. The appropriate referral and scheduling assistance of Enrollees needing specialty health care/transportation services including those identified through Case Management screenings, provider referrals and Child Health Check-Up Program (CHCUP) Screenings. Simply Healthcare Plans will review the determination of the need for non-covered services and referral of the Enrollee for assessment and referral to the appropriate service setting (to include referral to WIC and Healthy Start) utilizing assistance as needed by the area Medicaid office.

Coordinated Hospital/institutional discharge planning that includes post-discharge care; including skilled, short-term, skilled nursing facility care as deemed appropriate.
The program is also a mechanism for direct access to specialists for Enrollees identified as having special health care needs, as is appropriate for their condition and identified needs.

The catastrophically ill, injured or medically fragile Enrollee is that Enrollee who requires an intensive and complex combination of medical services or who is “technologically” dependent. The categories of conditions that are managed by Case Management include but are not limited to the following:

**Individual/Catastrophic**
- Transplants
- HIV/AIDS

**Disease Management**
- Diabetes
- Asthma
- Congestive Heart Failure
- Hypertension
- High Risk OB

In all cases, there is a detailed assessment completed on the Enrollee to identify any necessary services. Coordination of care is arranged through the Case Management Coordinator and communicated back to the Physician. Simply Healthcare Plans will assure appropriate ongoing treatment reflecting the highest standards of medical care designed to minimize further deterioration and complication of the Enrollee.

**Pharmacy Management**

Simply Healthcare Plans acknowledges that the Medicaid Reform requires, Simply Healthcare Plans to provide one (1) licensed pharmacy per 2,500 Enrollees. Simply Healthcare Plans may deem it necessary to comprise A Pharmaceutical Therapeutic Committee, which will be responsible for the development of a program to examine the Medicaid Pharmacy Paid claims, and develops management reports to assist physicians in controlling pharmaceutical costs. The committee would be comprised of medical, pharmaceutical and financial representatives whose functions are to review drug utilization based on therapeutic effectiveness and cost containment.

**Referral Management**

Simply Healthcare Plans has an existing state-of-the-art information system that captures all Medicaid (Primary Care Physician) requested specialty referrals and provide authorization numbers for claims payment processing. The authorizations can be requested in three (3) ways:

- Calling Simply Healthcare Plans’s 877-915-0551 Intake Referral line,
- By faxing the request to the 877-915-0553,
- Directly from Simply Healthcare Plans’s website: www.simplyhealthcareplans.com

The Agency requires that the Simply Healthcare Plans PCP for the medically necessary treatment of services listed as follows shall coordinate prior authorization of specialty and ancillary services:
- Advanced Registered Nurse Practitioner Services
- Ambulatory Surgical Center Services
- Birth Center Services
- County Health Department Services
- Chiropractic Services
- Dermatology Services
- Durable Medical Equipment Services
- Child Health Check Up Services
- Federally Qualified Health Center Services
- Home Health Services
- Hospital Inpatient Services
- Hospital Inpatient Services
- Hospital Outpatient Services
- Laboratory Services
- Licensed Midwife Services
- Physician Services
- Physician Assistant Services
- Podiatric Services
- Prescribed Drug Services
- Rural Health Clinic Services
- Therapy Services
- X-Ray Services including portable x-ray

The review and assessment of these services by the physician’s office between and before services are rendered includes, but is not limited to:

- Enrollee eligibility
- Enrollee Medicaid Reform benefit coverage
- Compliance to Medicaid Reform
- Medical Necessity
- Plan of treatment
- Place of service
- Level of care
- Length of stay
- Standards of care
- Severity of illness
- Intensity of service

Retrospective review of all referrals received from Simply Healthcare Plans PCP’s will be cross-matched to claims paid data, every month.

Specialty providers who are consistently not following Medicaid guidelines will receive a letter from the Simply Healthcare Plans Provider to ensure future conformity to Medicaid Reform guidelines. A Simply Healthcare Plans Provider Account Manager has sample letters that can assist your office staff.
Medical Necessity Standards, Guidelines and Criteria

Medically Necessary Services and/or supplies, means the use of services or supplies as provided by a hospital, skilled nursing facility (SNF), physician, or other providers required to identify or treat a covered Enrollee:

- Consistent with the symptoms or diagnosis and treatment of the covered Enrollee’s condition, disease or illness.
- Appropriate with regards to standard of good medical practice,
- Not solely for the convenience of the covered Enrollee, the Physician, hospital or other health care provider and,
- The most appropriate supply or level of care, which can be safely provided to the covered Enrollee.

Standards, Guidelines & Criteria: Medical necessity is determined during the review processes by using clinical standards, guidelines and criteria.

---

B.3 MEDICAID REFORM QUALITY OF CARE STANDARDS

Providers will adhere to the quality standards established by Medicaid and Simply Healthcare Plans:

Adult Health Screening

Simply Healthcare Plans recognizes that giving adults periodic health screenings improves long-term outcomes for Enrollees. During these screenings, providers are afforded opportunities to conduct risk assessments, diagnose problems and furnish treatments that improve the quality of the Enrollee’s life. Simply Healthcare Plans will provide or manage services such that a health screening will be performed, if due, on Enrollees 21 years or older in accordance with the recommendations in the Medicaid Provider Handbook.

Childhood Immunizations

Simply Healthcare Plans promotes immunizations as an effective intervention to prevent infections in children. The Simply Healthcare Plans Primary Care Provider will provide or manage services such that children will receive vaccinations for Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Varicella, Pneumococcal, Inactivated Polio, Haemophilus influenza B, and Hepatitis B according to the recommended immunization schedule issued by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the U.S. Public Health Service and/ or the Academy of Family Physicians.
Child Health Check Up

Simply Healthcare Plans realizes that periodic well-child visits furnish providers with an excellent opportunity to assess children for past medical history, developmental history and behavioral health status; comprehensive unclothed physical examination; developmental; and nutritional assessment. The physician will also provide laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for Enrollees beginning at three (3) years of age or earlier as indicated); vision screening, including objective testing as required and hearing screening. Simply Healthcare Plans has adopted the goal of over 80% of Enrollees must receive Child Health Check Up screenings by age one month; during two, four, six nine, twelve, fifteen and eighteen months of age; and once per year for ages two through twenty years of age. The Simply Healthcare Plans Primary Care Provider will provide or manage services such that all recipients under 21 years of age will receive any appropriate Child Health Check Up screenings. (Refer to page 32)

Comprehensive Diabetes Care

Diabetic Retinal Examinations: Simply Healthcare Plans is committed to reducing the incidence of diabetes-induced blindness in Simply Healthcare Plans Enrollees. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association, and the American Academy of Ophthalmology, the Simply Healthcare Plans Primary Care Provider will provide or manage services such that recipients with a history of diabetes will receive at least one fundoscopic exam every 12 months.

Glycosylated hemoglobin (HA1c) Levels: Simply Healthcare Plans acknowledges that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects from diabetes. Glycosylated hemoglobin (HA1c) is one laboratory indicator of how well an Enrollee's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the Simply Healthcare Plans Primary Care Provider will provide or manage services such that Enrollees with a history of diabetes will receive glycosylated hemoglobin (HA1c) determination at least twice a year.

Lipid Levels: Simply Healthcare Plans recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinmias and diabetes mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, the Simply Healthcare Plans Primary Care Provider will provide or manage services such that Enrollees with a history of diabetes will receive lipid and lipoprotein determination annually. If any anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

Nephropathy

The Simply Healthcare Plans Primary Care Provider screening for nephropathy is to delay or prevent loss of renal function through early detection and initiation of effective therapies, and to manage complications in those identified with a renal disease. The Primary Care Provider will manage the Enrollee by identifying evidence of a positive test for protein in the urine (microalbuminuria testing). Enrollee is to be monitored for the disease, including end stage renal disease, chronic renal failure and renal insufficiency or acute renal failure and referred to a nephrologist as deemed medically necessary.
Congestive Heart Failure

Simply Healthcare Plans is aware that today there is effective options for treating heart failure and its symptoms. Treatment plans may include lifestyle changes, medications and a special heart failure pacemaker or combinations of these options are available. Simply Healthcare Plans recognizes that with early detection, symptoms can be reduced and many heart failure patients are able to resume normal active lives.

The Simply Healthcare Plans Primary Care Provider will provide or manage care of the CHF Enrollee by:

- prescribing and monitoring an ACE inhibitor, angiotensin II receptor blockers (ARB), and diuretic, and reviewing the contraindications of those medications prescribed. An Echocardiogram should be performed annually, and the Enrollee should be instructed and educated on his or her disease.

Asthma

Simply Healthcare Plans recognizes that asthma is a common chronic condition that affects children and adults the Primary Care Provider will be expected to measure the Enrollees lung function and assess the severity of asthma and to monitor the course of therapy based on the following:

- Educate the Enrollee of the contributing environmental control measures to avoid or eliminate factors that precipitate asthma symptoms or exacerbations.

- Comprehensive pharmacologic therapy for long-term management designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations.

- Education that fosters a partnership among the Enrollee, his or her family and clinicians.

Hypertension

Simply Healthcare Plans recognizes that the Primary Care Provider can assist the Enrollee by checking blood pressure at every opportunity and by counseling Enrollee and their families about preventing hypertension. The Enrollee would benefit from general advice on healthy lifestyle habits, in particular a healthy body weight, moderate consumption of alcohol and regular exercise. The Primary Care Provider is expected to document in the medical record the confirmation of hypertension and identify if the Enrollee is at risk for hypertension.

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>TOPIC</th>
<th>WEBSITE LINK</th>
<th>INFORMATION PROVIDED</th>
</tr>
</thead>
<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>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>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>
<tr>
<td>Musculoskeletal Disorders</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#musculo">http://www.ahrq.gov/clinic/cps3dix.htm#musculo</a> Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#musculo">http://www.ahrq.gov/clinic/tfchildcat.htm#musculo</a></td>
<td>Multiple musculoskeletal related disorders topics regarding screening and counseling</td>
</tr>
<tr>
<td>Obstetric and Gynecological Conditions</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#obstetric">http://www.ahrq.gov/clinic/cps3dix.htm#obstetric</a></td>
<td>Multiple OB/GYN related topics regarding prevention, screening and counseling</td>
</tr>
<tr>
<td>Perinatal Care</td>
<td>Adolescents and Children <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#perinatal">http://www.ahrq.gov/clinic/tfchildcat.htm#perinatal</a></td>
<td>Multiple perinatal care related topics regarding screening</td>
</tr>
<tr>
<td>Vision and Hearing Disorders</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#vision">http://www.ahrq.gov/clinic/cps3dix.htm#vision</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#vision">http://www.ahrq.gov/clinic/tfchildcat.htm#vision</a></td>
<td>Multiple vision and hearing related disorder topics regarding screening</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#misc">http://www.ahrq.gov/clinic/cps3dix.htm#misc</a></td>
<td>COPD related screening information and dental and periodontal disease counseling</td>
</tr>
<tr>
<td>TOPIC</td>
<td>WEBSITE LINK</td>
<td>RESOURCE</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diabetes</td>
<td><a href="http://care.diabetesjournals.org/content/32/Supplement_1">http://care.diabetesjournals.org/content/32/Supplement_1</a></td>
<td>American Diabetes Association, Diabetes Care, Standards of Diabetes Care Jan – 2009</td>
</tr>
<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, 2009</td>
</tr>
<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>
Mammography Screening

Simply Healthcare Plans recognizes that breast cancer is one of the most common malignances affecting women. Early detection and treatment of breast cancer improves the probability of long-term survival. Mammography screening is one technique used for detection of breast cancer. The Simply Healthcare Plans Primary Care Provider will provide or manage services such that female Enrollees will receive mammography screening consistent with the recommendations of Medicaid, American Cancer Society, and US Preventive Services Task Force: Required as appropriate for age:

- Baseline between ages 35 and 40,
- Every 1 to 2 years for women age 40 or older,
- Earlier and/or more frequent for women at high-risk.

Cervical Cancer Screening

Simply Healthcare Plans is committed to reducing the incidence of cervical cancer. Early detection and treatment of cervical cancer improves the probability of long-term survival. Cervical Cancer can be detected in its early stages by regular screening using a Papanicolaou (Pap) test. Consistent with the recommendations by the American College of Obstetricians and Gynecologists, American Medical Association, American Cancer Society and the U.S. Preventive Services Task Force, the Simply Healthcare Plans Provider will provide or manage services such that female Enrollees between the ages of 18 and 64 years, or if younger than 18 years, who have been sexually active, will receive at least one Pap test every two years.

Postpartum Care

Simply Healthcare Plans recognizes the importance of check-ups after delivery for female Enrollees to insure their health. Simply Healthcare Plans is committed to providing adequate and on-going follow-up and preventive care of the postpartum female recipient. The Simply Healthcare Plans Provider will be expected to ensure the Enrollee receives a postpartum examination within six (6) weeks after delivery. The Simply Healthcare Plans Provider must supply voluntary family planning, including a discussion of all methods of contraception as deemed appropriate. The Enrollee should be educated by the Provider on the enrollment and continuing care of the newborn through the CHCUP program component.

Access to Care

Simply Healthcare Plans will require Participating Primary Care Physicians to ensure adequate accessibility for health care twenty-four (24) hours per day, seven days per week. The Enrollee shall access care for an emergency service, urgent care, routine sick care and well care based on the standards below:

Urgent Care: Medicaid Enrollee must be seen within one (1) day. Urgent Care should be provided for those problems, which, though not life threatening, could result in serious injury or disability unless medical attention is received (high fever, animal bites, fractures, severe pain) or do substantially restrict an Enrollee’s activity (infectious illness, flu, respiratory ailments etc).
Routine Sick Enrollee Care: Enrollee must be seen within (1) week. Non-emergent complaints that do not restrict an Enrollees activity or are chronic in nature.

Well Care Visit: Enrollee must be seen within one (1) month. A routine medical visit for one of the following services, Child Health Check Up (CHCUP), family planning, routine follow up to a previously treated condition or illness, adult physician and other routine visit.

Low Birth Weight

Simply Healthcare Plans recognizes that socioeconomic status is one of many factors that affect the incidence of low birth weight infants (where a birth weight less than 2,500 grams is considered low). While many factors that affect birth weight are beyond a provider’s control, many variables may be influenced through timely and appropriate prenatal care. Consistent with recommendations in Medicaid, the Simply Healthcare Plans Primary Care Provider will provide or manage services such that timely and early prenatal care will be initiated during the first trimester of pregnancy or, if the Enrollee is pregnant when enrolling with the provider, within four weeks of enrollment.

Domestic Violence

Simply Healthcare Plans providers shall routinely screen their Enrollees for signs of domestic violence, and shall provide referral services to applicable community domestic violence prevention agencies. Simply Healthcare Plans recognizes that domestic violence is a significant public health problem. The Primary Care Provider will be expected to screen for domestic violence coercive behaviors associated with domestic violence include the following: (Refer to Enrollee Assessment Tool in Section F)

- Actual or threatened physical injury
- Sexual assault
- Psychological abuse (intimidation, threats)
- Economic control
- Progressive social isolation

The Simply Healthcare Plans Provider will be expected to assess the safety of the Enrollee and help the Enrollee identify a plan for safety including information about community referrals before she leaves the office.

Smoking Cessation

Simply Healthcare Plans providers are expected to provide smoking-cessation screening and education to Enrollees by:

- Enrollee made aware of and recognizes dangerous situations,
- Enrollee learning to anticipate and avoid temptation,
- Provide basic information to the Enrollee about smoking and successful quitting,
- Encourage the Enrollee to quit,
- Provider to communicate care and concern,
- Provider to encourage the patient to talk about the quitting process.
Alcohol and Substance Abuse

Simply Healthcare Plans Primary Care Provider is expected to screen Enrollees for signs of substance abuse as part of prevention evaluation. Targeted Enrollees may be asked to attend community or plan substance abuse programs. Simply Healthcare Plans will educate providers on screening requirements. (Refer to Enrollee Assessment Tool)

B.4 QUALITY IMPROVEMENT

Overview

SHP maintains an active Quality Improvement Program (QIP) that provides structure and processes for our ongoing commitment to proved and continually improve upon the care and services that are offered to our members. The QIP goals are based upon our ongoing evaluation of programs and services offered; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Program Goals

The goals of the QIP include but are not limited to:

- Develop, implement and maintain systems and programs that monitor, measure and improve the health care outcomes and service levels within identified member populations
- Ensure access to qualified, competent providers
- Engage member/legal guardians in the education, managing and improving their current health state
- Promote a safe, culturally-sensitive delivery of health care that promotes appropriate, efficient and effective use of resources and supports the physician-patient relationship
- Ensure the coordination of and transition of care needs are identified and provided to our members
- Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies
- Encourage and use feedback from stakeholders to improve reporting methods and information availability in relevant, timely manner
- Utilize a multidisciplinary committee approach to facilitate the success of the QIP goals, improve organizational communication and ensure the participation of contracted community providers in the development/review of the clinical aspects of programs and services

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:
  - SHP’s Healthy Pregnancy Program;
  - SHP’s High-Risk Pregnancy Program;
  - Children’s Wellness Program;
  - Diabetes Management Program;
  - CHF Management Program;
Chronic Care Improvement Program; Chronic Kidney Disease Program.
- Preventative Care and Clinical Practice Guidelines
- Measurement of Clinical and Service Quality; HEDIS, CAHPS®, Provider Satisfaction Survey, Member Satisfaction Survey, and key quality metrics

SHP offers disease management programs to help you understand and manage a chronic health condition you may have. Our team of health care professionals, including your PCP, will help you with your health care needs. They will arrange for home health care and medical supplies needed to manage your condition, if needed. For more information on disease management programs available, please call Member Services.

Other Resources for you to assist our members
- Domestic Violence Hotline- Florida: 1-800-500-1119. 24 h./day, 7 days/week
- Alcoholic Anonymous – In Dade: 305-461-2425
- Narcotics Anonymous – In Dade: 305-620-3875
- Florida Quit for Life – 1-877-822-6669 to quit smoking
- www.smokefree.gov for online resources, information and booklets on how to quit smoking.
- www.greattowait.com : great website for advice on abstinence and pregnancy prevention

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 QI 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 QI 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 Correction 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 CRC 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 under utilization 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 or a designee 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 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 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 Provider Complaints, for Second Level Appeals. There is no further appeal for the decision of the second level appeal.

B.5 MEDICAID HEALTH CARE REFORM SERVICE PROVISIONS

Medical Records

It is agreed that Simply Healthcare Plans providers will:

Maintain a unified patient medical record for each Simply Healthcare Plans (Medicaid Reform Enrollee) that shall include, at a minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness, medical necessity and timeliness of services performed, referred or authorized under this Agreement. Enrollee visit data must include history and physical, plan of treatment, diagnostic tests, therapies and prescribed regimens, follow-up, referrals and results from referrals, and other aspects of Enrollee care including ancillary services. Each Enrollee’s record must be legible and maintained in detail consistent with standard medical and professional practice, which facilitates effective internal and external peer review, medical audit, and adequate follow-up treatment.

- Document in the Enrollee’s records all authorizations for services that are provided by other providers along with reports from the treating providers.
- Document in the medical record monitoring of HIV/AIDS specific diagnosis testing such as blood counts.
- Document in the medical record, for infants, under the Simply Healthcare Plans (Medicaid Reform Health) Provider’s care, all Agency required Healthy Start services.
- Document in the Medical record all Agency required Healthy Start services, referral to the Special Supplemental Food Program for Women, Infants and Children, and counseling.
- Transfer the Simply Healthcare Plans Enrollee’s medical record to the new primary care provider if requested in writing and authorized by the Enrollee to the new primary care provider or the Agency.
- Retain a unified Enrollee medical record for each patient for (5) years from the date of service. Providers may convert paper records to microfilm, microfiche, or data base records, and must be legible when printed or viewed.
- Allow authorized state and federal staff or their authorized representatives to audit the Enrollee’s medical records.

Advance Directives

Simply Healthcare Plans shall require the primary care physician to have accessible written pamphlets or information within the practice to educate the Enrollee. Simply Healthcare Plans will
require the Primary Care Physician to incorporate the advance directive as a part of the Enrollees medical records. The primary care physician will be expected to document the Enrollee’s responses to the advance directive inquiries. The advance directive forms will be readily available to aid the physician in adhering to the education process, a living will and information regarding a health care surrogate designation and an anatomical donation.

**Twenty-Four Hour Coverage**

It is agreed that Simply Healthcare Plans Provider’s will provide or arrange for coverage for services, consultation, or approval for referrals 24 hours per day, seven days per week. This coverage must consist of an answering service, call forwarding provider call coverage or other customary means approved by the Agency. The chosen method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the Simply Healthcare Plans provider for a clinical decision. The after-hours coverage must be accessible using the medical office’s daytime telephone number.

**Authorization and Referrals**

It is agreed that the Simply Healthcare Plans Provider will provide authorizations and referrals for the Enrollee when medically necessary and appropriate. The provider to whom the Enrollee is referred must be a Medicaid provider unless Medicaid does not cover the prescribed treatment. The Simply Healthcare Plans provider must provide the referral provider with his Simply Healthcare Plans authorization number that will be given at the time services are authorized. All authorizations and referrals must be documented in the Enrollees medical record along with the report from the treating provider. Some services may require prior authorization or require prior authorization for services that may exceed the service limitations such as:

- Chiropractic
- Community mental health services
- Custom wheelchairs
- Dental
- Durable medical equipment and medical supplies
- Hearing
- Home Health
- Hospital
- Optometric
- Out-of-state referrals for hospital services prior to scheduling
- Prescribed drug service
- Physician
- Podiatry
- Transportation
- Visual

Provide post authorization to public providers for the provision of the following services:

- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases,
- The provision of immunizations,
• School health services as listed above;

• Services rendered on an urgent basis (Services rendered on an urgent basis are those health care services needed to immediately relieve pain or distress for medical problems such as injuries, nausea, fever and services needed to treat infectious diseases and other similar conditions).

• Public providers are not required to obtain prior authorization from a Simply Healthcare Plans Provider if providing the above services.

• Public providers are expected to provide Simply Healthcare Plans providers with the results of the office visit, including test results. (according to Florida Statute)

• Provide post authorization to County Health Departments for the provision of emergency shelter medical screenings provided for clients of the Department of Children and Family.

Refer Enrollees to the appropriate provider facility for dental and/or transportation services.

Authorize appropriate follow-up consultation and/or treatment for the duration of an illness subsequent to making a referral to a specialist for consultation and/or treatment of a specific condition. This shall include services rendered by the specialist and referrals made by the specialist for related services.

Simply Healthcare Plans Enrollees may receive up to twenty-four visits per calendar year for services by Simply Healthcare Plans participating Chiropractors without prior authorization by the primary care provider. These visits include a new patient visit, manipulation of the spine and spinal X-rays any further visits shall require authorization by the primary care provider. Medicaid does not reimburse for massages or heat treatments.

Simply Healthcare Plans Enrollees may receive up to four visits per calendar year for reimbursable services by Medicaid participating Podiatrists without prior authorization from the primary care provider. Any further visits shall require authorization by the primary care provider. The services include routine foot care if the Enrollee is under a physicians care for a metabolic disease, circulatory impairment, or has conditions of desensitization of the legs.

Patient Acceptance

It is agreed that the Simply Healthcare Plans providers will accept Enrollees pursuant to the terms of the contractual agreement, including both assignments and voluntary enrollments up to the limit set by the Agency and the Simply Healthcare Plans provider.

Accept patients that are transferred, on an emergency basis, from one Simply Healthcare Plans Provider to another. The accepting provider shall perform the management service without the management fee for the balance of the acceptance month to preclude payment of two management fees for the same patient in the same month.
ARNP’s and PA’s

It is agreed that the Simply Healthcare Plans Provider will supervise ARNPs and PAs who are used to expand the provider’s Medicaid Reform patient limit as listed in the Manner of Service Provision section 15 a, d, and e.

Marketing

It is agreed that if the Simply Healthcare Plans provider wishes to use materials and announcements that reference Medicaid she/he will submit such materials to the Simply Healthcare Plans Marketing Management so that the Agency (Medicaid) office may review and approve prior to use. Outreach strategies may include, but are not limited to, brochures, fact sheets, posters, handouts and presentations. The use of any unauthorized technique to recruit Medicaid Reform (Simply Healthcare Plans) Enrollees is strictly prohibited. Offers of material or financial gain may not be made to anyone as an incentive to enroll.

Training

It is agreed that Simply Healthcare Plans providers will arrange for attendance by the appropriate staff to participate in training of Medicaid (Healthcare Reform) and Simply Healthcare Plans policy and billing procedures necessary to operate within the Simply Healthcare Plans Provider network. Attendance of this training is necessary before patient enrollment and provider assignment begins.

Disease Management Initiatives

It is agreed that the Simply Healthcare Plans provider will cooperate to the greatest extent possible with disease management initiatives that have contracted with Simply Healthcare Plans and the Agency to provide disease management services to Medicaid (Simply Healthcare Plans) Enrollees. A plan of assessment and treatment should be on file for each Enrollee with a chronic disease and shall contain sufficient information to explain the progress of treatment.

Provider Change of Status

It is agreed that the Provider will notify Simply Healthcare Plans within (10) working days of changes in writing on the providers letterhead of change of provider phone number, mailing/location address, and addition or deletion of providers or provider extenders. If there is a significant change such as ownership, the Provider is required to notify Simply Healthcare Plans and the Agency within sixty days of the change.

Hospital Privileges

It is agreed that the Simply Healthcare Plans provider will maintain hospital privileges as required for the performance of the Simply Healthcare Plans provider’s practice.
Primary Care Services Billing Number

It is agreed that the Simply Healthcare Plans provider will provide and bill for primary care services using their assigned Medicaid provider number. This number must be a working number used for the billing of office visits and related procedures. It may not be solely used as a referral number.

Hospital Affiliated Medicaid Providers

It is agreed that hospital affiliated Medicaid providers may not bill outpatient charges for office visits and related procedures. Primary care services provided in hospital-owned outpatient clinics and satellite facilities cannot be billed on the UB-92 claim form. Physician services must be billed to Simply Healthcare Plans’s Designated Vendor utilizing the HCFA 1500 claim form.

Enrollee Utilization and Cost Reports

It is agreed that the Simply Healthcare Plans Provider will review patient utilization and performance management reports provided by Simply Healthcare Plans or the Agency and advise Simply Healthcare Plans and the Agency of any noted errors, omissions or discrepancies.

Limits on Number of Enrollees

Simply Healthcare Plans Providers (M.D.s, D.O.s) may have no more than 1,500 Enrollees per each participating full time equivalent primary care provider plus 750 Enrollees per each full time equivalent primary care Advanced Registered Nurse Practitioner or Physician Assistant under their supervision; or the number specified by the Primary Care Provider, whichever is less.

- Simply Healthcare Plans Providers (M.D.s, D.O.s) practicing at more than one location may have no more than the sum of 1,500 Enrollees per each full-time equivalent primary care provider.

- A Simply Healthcare Plans Provider can limit the number of Enrollees that the providers’ facility or practice serves and accept or reject Enrollees according to the policies of the facility or practice identified by the Agency.

- A Simply Healthcare Plans Provider may increase their number of Enrollees at anytime, upon approval of the Agency, (not to exceed the maximum number of Enrollees per FTE of provider and their supervised ARNP’S and PA’s) by sending written request to the Medicaid unit in the area Medicaid office.

- Enrollment of Simply Healthcare Plans assigned enrollees will be updated monthly. There may be a possible variance from time to time in excess of the limits previously specified.

- Infectious Disease providers may function as PCP’s for specialty plan
Enrollee Choice of Provider

The Agency will permit Enrollees to choose from among participating primary care providers or group providers. Providers shall be required to accept Enrollees who have chosen them up to the limit approved in the Manner of Service Provision section of this Agreement 15 a, b, c and d.

Each Enrollee who does not choose a provider will be assigned to a participating provider in the Enrollees county of residence.

Enrollees will be permitted to change their primary care providers or group providers upon request utilizing Simply Healthcare Plans Enrollee Services established procedures.

Enrollee Disenrollment by Provider

Simply Healthcare Plans Providers may secure the disenrollment of an Enrollee by notifying the Enrollee by certified mail and sending a copy of the letter to the Agency (area Medicaid Office). Enrollees may be disenrolled only if the provider/patient relationship is not satisfactory or if the primary care provider feels a specialist can better serve the Enrollees medical needs. The Provider must continue to provide services to the Enrollee until the Enrollee disenrollment process is complete and the Enrollee is enrolled with another Simply Healthcare Plans provider, which may take from two to six weeks.

Enrollments and Disenrollments

Simply Healthcare Plans will offer each Enrollee a choice of PCPs; after making a choice, each Enrollee shall have a single PCP. Simply Healthcare Plans will ensure a PCP is assigned closest to the Enrollees’ home, address, Zip Code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender. The Enrollees’ have a right to disenroll or change Health Plans without cause during the ninety (90)-change window, and to disenroll with cause thereafter.

Simply Healthcare Plans shall provide written notice via mail to the Enrollees, by the first day of the Enrollees participation of the following:

- The Enrollees PCP assignment;
- The Enrollees ability to choose a different PCP;
- A list of Participating Providers from which to make a choice and;
- The procedures for changing PCPs

Simply Healthcare Plans shall permit Enrollees to change PCPs at any time.

The effective date of an disenrollment of an Enrollee shall be the last Calendar Day of the month in which disenrollment was made effective by the Agency or Simply Healthcare Plans, but in no case shall disenrollment be later than the first (1st) Calendar Day of the second (2nd) month following the month in which the Enrollee or Simply Healthcare Plans files the disenrollment request. If the Agency or Simply Healthcare Plans fails to make a disenrollment determination within its timeframe, the disenrollment will be considered approved.
Participation of Employees of Group Providers

Employees of a group with more than one location must practice at the site under which they have enrolled for the number of hours indicated in the Provider Agreement for Participation with Simply Healthcare Plans.

Group providers are required to have each employee who participates in Medicaid as a primary care provider, Advanced Registered Nurse Practitioner or Physician Assistant to have an active Medicaid provider number.

Group providers must have Enrollees’ assigned to the group provider and not directly to the primary care providers who are employed by the group provider. However, a group provider may internally assign Enrollees’ in any fashion they wish as long as it does not exceed 1,500 Enrollees’ per each full time equivalent primary care provider (M.D., D.G.) and 750 Enrollees’ per each full time primary care Advanced Registered Nurse Practitioner or Physician Assistant.

Provision of Enrollee Data and Reports

It is agreed that the Agency and Simply Healthcare Plans will:

Provide the Provider with a listing of Enrollees’ for each month. All Enrollee information contained on the report is strictly confidential and under no circumstances shall the information be duplicated and/or provided to anyone for any purpose other than fulfilling the terms of the Provider agreement. The Agency and Simply Healthcare Plans will govern receipt and use of the enrollment information.

Critical Incident Reporting

Simply Healthcare Plans will require that Providers report any serious incidents to Simply Healthcare Plans such as:

- Enrollee Death: suicide, homicide or abuse/neglect
- Enrollee injury or illness
- Sexual Battery
- Medication Errors – acute care
- Medication Errors – children
- Enrollee Suicide Attempt
- Altercations requiring Medical Interventions

Fraud and Abuse

Simply Healthcare Plans shall have a designated compliance officer who will be accountable for fraud and abuse. Simply Healthcare Plans will investigate any unusual incidents such as:

- Falsified encounter or service reporting
- A pattern of overstated reports or up coded levels of service
- Falsifying or destroying clinical record documentation
- Misrepresentation of medical information to justify Enrollee referrals
- False statements as it applies to credentialing or recredentialing information
- Charging Enrollees’ for covered services
B.6 SPECIAL PROVISIONS

Simply Healthcare Plans Termination (General)

If the Provider ceases participation in Simply Healthcare Plans's network, Simply Healthcare Plans shall send written notice to the Enrollees' who have chosen the Provider as their Primary Care Provider. The Provider is expected to submit in writing to Simply Healthcare Plans a letter of termination; this notice shall be issued ninety (90) Calendar Days prior to the effective date of the termination and no more than ten (10) Calendar days after Simply Healthcare Plans will notify receipt or issuance of the termination notice the Enrollee.

If the Enrollee is in Prior Authorized ongoing course of treatment with any Provider who becomes unavailable to continue to provide services, Simply Healthcare Plans shall notify the Enrollee in writing within ten (10) Calendar Days from the date Simply Healthcare Plans becomes aware of such unavailability.

The Provider requirements to provide notice prior to the effective dates of termination shall be waived in instances where the Provider becomes physically unable to care for Enrollees' due to illness, death, relocation from the service area and fails to notify Simply Healthcare Plans, or when the Provider fails credentialing. Under these circumstances, notice shall be issued immediately upon Simply Healthcare Plans becoming aware of the circumstances.

Termination of Participating Providers in a Group

Group providers must notify Simply Healthcare Plans in writing as stated on (1) of Providers who may cease participation within the Group or individual Providers who may leave the Group for a specific reason. Advanced Registered Nurse Practitioner or Physician Assistant employees leave the employ of the group provider or no longer functions as a primary care provider. If after 90 days, new staff has not been hired to support the group Provider Medicaid enrollment within the guidelines specified in the Manner of Service Provisions. Possible reassignment of Enrollees' may be necessary.

Provider Complaint Process

Simply Healthcare Plans shall thoroughly investigate each Provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Simply Healthcare Plans’s written policies and procedures. Providers may communicate their issues or dissatisfactions verbally through the Provider Services telephone lines or the written complaint regarding the dispute, which may be submitted within (45) calendar days of the oral resolution communicated to the Provider. A dispute may include network services, Enrollee concerns, and claims as it relates to the Electronic Remittance Voucher (ERV) or contractual concerns. The Provider must provide supporting documentation to accompany the dispute.

If the Provider is not satisfied with the response relating to the First Level of Appeal, he/she may make a written appeal to the Second Level, which must be submitted to the Plan within (45)
days of receipt of written notification. The Provider will be notified within (30) calendar days of the final decision. If a Provider is not satisfied with the response relating to the Second Level of Appeal, he/she may make a written appeal to the Plan within (45) calendar days of receipt of the written notification of the Second Level. The Provider will then have the ability to file Third Level of Appeal. The complaint will go before a Committee for discussion and resolution, the Provider may be present to plead their circumstances bringing any supporting material or information that may support his/her position. If the Provider is not satisfied with the Third Level of Appeal, Peer Review and or Medical Advisory Committee, he/she may submit the dispute to binding arbitration in accordance with the rules and regulations of the American Arbitration Association.

Sanctions

The Agency shall impose any of the following sanctions on a provider or a person for violation of any acts described in section 409.913 (14) F.S. Examples of sanctionable violations are the following: (Refer to Medicaid Provider General Handbook for specifics).

Providers’ license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state.

The provider has failed to make available or refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of AHCA, the Attorney General, a state attorney, or the federal government.

The provider has not furnished or made available such Medicaid-related records as AHCA has found necessary to determine whether Medicaid payments were due and the amounts thereof.

The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered.

Credentialing and Re-credentialing

Simply Healthcare Plans is responsible for credentialing and recredentialing of its Provider network, criteria for all professional Providers must meet the Agency’s Medicaid participation Standards.

Simply Healthcare Plans will follow the Agency’s criterion which includes:

- Verification that Provider is an approved Medicaid Provider.
- Active licensure shall suffice in lieu of verification of education, training and professional liability coverage guidelines.
- No receipt of revocation or suspension of the Provider’s State License by the Division of Medical Quality Assurance, Department of Health.
- No ongoing investigations by Medicaid Program Integrity, Medicaid Fraud and Control Unit, Medicare, Medical Quality Assurance, or other governmental entities.
• Simply Healthcare Plans Provider files will document the education expertise prior training and ongoing service training for each staff member or Provider rendering Behavioral Health Services.

• Good standing privileges at the Hospital designated as the primary admitting facility by the PCP or if the Provider does not have admitting privileges, good standing of privileges at the Hospital by another physician with whom the PCP has entered into an arrangement for Hospital coverage.

• Valid Drug Enforcement Administration (DEA) certificates.

• A good standing report on credentialing site visit survey.

• Attestation to the correctness/completeness of Provider’s application.

• Statement regarding any history of loss or limitation of privileges or disciplinary activity.

• Current curriculum vitae, which includes at least five (5) years of work history.

CULTURAL COMPETENCY PROGRAM

Overview

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.

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: 

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.

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.

Enrollee Grievance Procedure

An Enrollee of Simply Healthcare Plans has the right to file a grievance or appeal when they are dissatisfied with their Providers or the medical care they have received.

The section below is taken from Simply Healthcare Plans's Enrollee Grievance and Appeal procedure as set forth in the Simply Healthcare Plans Enrollee Handbook. This information is provided to you so that you may assist the Simply Healthcare Plans Enrollee in this process should they request your assistance. Please contact your Provider Contracting Representative should you have questions about this process.

Simply Healthcare Plans has Representatives who will handle all Enrollee Grievances and Appeals. A special set of records is kept with the reason, date and results. Simply Healthcare Plans keeps these records in the central office. Upon review of the nature of the complaint, the Enrollee Services Department will determine which of the two processes: grievance or appeals will be followed.

Grievance

Is an expression or dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled at the Plan’s level, including access to the Medicaid Fair Hearing Process. The Enrollee/Provider has the right to make a written or verbal grievance within 1 year of the incident. The grievance process may take up to 90 days. However, Simply Healthcare Plans will try to resolve the grievance as quickly as the Enrollee’s health condition permits. An extension of up to (14) calendar days may be requested.

A letter informing the Enrollee of the outcome of the grievance will go out within 90 days from the date Simply Healthcare Plans receives the request. If more time is needed, the Enrollee and Simply Healthcare Plans must agree on it. If other information is needed, Simply Healthcare Plans will give 14 extra days to make a decision. Simply Healthcare Plans will send the Enrollee/Provider a letter advising about the extra time. A notice of disposition shall include the results and the date of resolution of the Grievance, and for the decisions not wholly in the Enrollees favor, the notice of disposition shall include a notice of the right to request a Medicaid Fair Hearing if applicable.

Filing Grievance or an Appeal

If you have questions or an issue, call Simply Healthcare Plans Enrollee Service at 877-577-9043.
If you are not happy with the answer you get from Enrollee Services, you can file a Grievance/Appeal. You can get a form from the plan or you can send a letter to the Plan. If you request a form from the Plan, it will be mailed within three working days. The Enrollee can also request assistance from Simply Healthcare Plans in completing the form.

All Grievance/Appeals will be considered. The Enrollee can have someone help them with the process whether it is a Provider or someone you choose.

The Enrollee has the right to continue services during the grievances and appeal process. If the Enrollee chooses to continue the services, and the decision of the Grievance and Appeal Committee is not in their favor, the cost may have to be paid for by the Enrollee for services incurred.

The Grievance Form must have the following information completed:

- Name, address, telephone number, an ID number
- Facts and details of the series of events that occurred and what was the Enrollee or Provider recourse utilized to resolve the issue or complaint.
- What resolution is the Enrollee/Provider looking for
- Signature
- Date

Appeal

Can be submitted in writing or verbal but must be followed up in writing within 30 days of the date you receive denial. You have up to one year to file an appeal if the denial is not in writing. You have the right to make a written or verbal appeal, however it must be followed up in writing within 30 days of the date you receive a written denial. You have up to one year to file an appeal if the denial is not in writing. The appeal process may take up to 45 days. However, Simply Healthcare Plans will resolve your appeal as quickly as your health condition requires. A letter telling you the outcome of your appeal will go out within 45 days from the date Simply Healthcare Plans receives your request. If more time is needed, you and Simply Healthcare Plans must agree upon it. If other information is needed, Simply Healthcare Plans will have 14 extra days to make a decision. Simply Healthcare Plans will send you a letter advising the Enrollee/Provider about the extra time.

Expedited Process

You have the right to make an expedited verbal or written Grievance or Appeal. If you have a problem that is putting your life or health in danger, you or your legal spokesperson can file an "urgent" or expedited" appeal. These appeals are handled within 72 hours. The Enrollee/Provider must inform the designated person handling the inquiry that the issue is an "urgent" or "expedited" appeal. The Enrollee/Provider may request an expedited appeal by calling Simply Healthcare Plans at 1 (800) 514-4561. If is determined that it is not an expedited process, it will go through the normal process.

Medicaid Fair Hearing

If the Enrollee is not happy with Simply Healthcare Plans Grievance or Appeal decision, he/she may ask for a Medicaid Fair Hearing. You have up to 90 days after receiving the denial letter to
request a hearing. To request a Medicaid Fair Hearing contact the Department of Children and Families at the:

**Office of Appeals Hearings,**
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
1 (850) 488-1429

If the Enrollee chooses this service, they will give up the right to have a Subscriber Assistance Program review their case.

The Enrollee will have the right to continue to receive benefits during a Medicaid Fair Hearing. The Enrollee can request to continue to receive benefits by calling our Enrollee Service Department at 1 (800) 514-4561. If the decision is not in the favor of the Enrollee, they may have to pay for the benefits. The Enrollee has the right to review your case before and during the appeal process.

**Subscriber Assistance Program**

If the Enrollee is not satisfied with Simply Healthcare Plans Appeal or Grievance decision, they may ask for a review by the Subscriber Assistance Program. You have one (1) year from receipt of the final decision letter to request this review. If you had Medical Fair Hearing on your case, you give up the right to have the Subscriber Assistance Program review your case.

**Agency for Health Care Administration**
**Subscriber Assistance Program**
Building 1, MS # 26
2727 Mahan Drive, Tallahassee, Florida 32308
1(850) 412-4502 or 1(888) 419-3456 (toll free)

**B.6 SIMPLY HEALTHCARE PLANS METHOD OF PAYMENT**

Simply Healthcare Plans will reimburse for services that are determined medically necessary and do not duplicate another provider’s service. The Provider is expected to submit an encounter each time an Enrollee is seen in their office for medical care. The provider is expected to submit the services rendered on the revised CMS-1500 (08-05) claim form. The updated guidelines for processing claims and detailed instructions are found on the Medicaid fiscal agent’s website at: [http://floridamedicaid.acs-inc.com](http://floridamedicaid.acs-inc.com)

The organization will be accountable for overseeing and ensuring that the Provider understands Simply Healthcare Plans’s and Florida Medicaid’s Covered Services provided to Enrollees and that all contracted providers are reimbursed for correct, authorized, and clean claims according to the Florida Medicaid Fee Schedule for reimbursement.

Out of network, providers will be paid on a Fee-For-Service basis for authorized services provided to Simply Healthcare Plans Enrollees. The plan will require out-of-network providers to coordinate with the respect to payment, and ensure that the cost to the Enrollee is no greater than it would be if the covered services were furnished within the network.
Simply Healthcare Plans will ensure Providers are prohibited from balance billing Simply Healthcare Plans Members, in accordance with Section 641.315 of the Florida Statutes.

Service Reimbursement

It is agreed that the plan will process claims and/or the Agency shall provide Medicaid reimbursement for medical services rendered by the Simply Healthcare Plans provider in accordance with the standard Medicaid fee schedule amount less any applicable co-payments. For those Simply Healthcare Plans providers eligible for cost-based reimbursement (e.g. county health departments, federally qualified health centers and rural health clinics), the Agency will provide Medicaid reimbursement in accordance with the provider’s established encounter rate.

Claims are to be submitted to Simply Healthcare Plans at:

Simply Healthcare Plans, LLC
PO Box 211665
Eagan, MN 55121

Electronic Submissions #20488 (Emdeon)
Electronic Submissions # Payer ID 00199 (Availity)
Enrollee Rights and Responsibilities

As a Simply Healthcare Plans Enrollee, you have certain rights and responsibilities that are important for you to understand. They do not change your healthcare plan coverage. If you have any questions about your healthcare coverage, call Simply Healthcare Plans Enrollee Services.

You Have the Right To:

- Be treated with respect and in a manner that recognizes your need for privacy and dignity.
- Get help or an answer in a prompt, kind, and responsible manner.
- Know the name of your healthcare PCP or other Simply Healthcare Plans PCPs treating you.
- Know the rules and regulations that apply to your condition.
- Get access to medical treatment or provide, regardless of race, national origin, religion, physical handicap or source of payment.
- Get information about your healthcare plan and any coverage.
- Get information by your healthcare provider of your diagnosis, prognosis and plan-of-treatment alternatives and risks in terms you understand.
- Get information about the PCP or medical provider in your healthcare plan.
- Get information from your healthcare professional about any treatment you may receive; to have your healthcare professional request your consent for all treatment, unless there is an emergency and your life and health are in serious danger. (If written consent is required for procedures, such as surgery, be sure, you understand the related risks and why the procedure or treatment is needed.)
- Receive, upon request, all of the information and necessary counseling on the availabilities of financial resources for your care.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Be informed if the treatment that you are receiving is experimental and to be given the opportunity to consent or to refuse.
- Be informed about available patient support services, including an interpreter.
- Refuse treatment and be advised of the probable results of your decision. Simply Healthcare Plans encourages you to discuss your objections with your healthcare professional.)
• Select a PCP of your choice from within the Simply Healthcare Plans network of providers. If you need information on how to change your PCP, call Simply Healthcare Plans Enrollee Services.
• Express a complaint about Simply Healthcare Plans and/or the care you received and to receive a timely response.
• Initiate the grievance procedure if you are not satisfied with Simply Healthcare Plans’s decision regarding your complaint.
• Be informed about and to have written Advance Directives.
• Have medical records and information kept in private, except as provided by law.
• Simply Healthcare Plans shall make information available upon request regarding the structure and operation of Simply Healthcare Plans and any physician incentive plans as set forth in 42 CFR 438.10(g) (3).

You Have The Responsibility To:

• Learn about Simply Healthcare Plans covered services by reading and referring to the Enrollee handbook. Please call Simply Healthcare Plans Enrollee Services when you have questions or concerns about your coverage at (800) 514-4561 or TDD (711) Florida Relay.
• Understand fully the information provided by Simply Healthcare Plans about your healthcare coverage.
• Know the proper use of Simply Healthcare Plans’s services and procedures.
• Provide your PCP or any Simply Healthcare Plans provider correct and complete information about your health.
• Present your Simply Healthcare Plans Enrollee ID card when receiving services and not allow the illegal use of your Enrollee ID card.
• Treat all Simply Healthcare Plans PCPs and other medical providers and staff respectfully and courteously and to follow their’ rules on patient care and conduct.
• Consult your PCP for his or her direction prior to receiving healthcare unless it is an emergency and your life and health are in serious danger.
• Keep your appointments and call your PCP or any other healthcare provider of Simply Healthcare Plans office if you will be late or unable to keep an appointment.
• Pay all charges for non-covered services.
• Establish a continuous and satisfactory relationship with your PCP.
• Ask questions of your PCP or any healthcare provider of Simply Healthcare Plans and understand the results if you refuse to comply.
• Provide honest and complete information to those providing care and to Simply Healthcare Plans.
• Express your opinions, concerns or complaints to your healthcare provider and to Simply Healthcare Plans Enrollee Services.
• Notify your Simply Healthcare Plans PCP or any other health care provider of any advance directives you may have. Give your assigned PCP your Advance Directives.

C. SIMPLY HEALTHCARE PLANS CLAIMS MANAGEMENT

Simply Healthcare Plans LLC will reimburse based on Medicaid guidelines for those services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

• Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
• Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
• Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational
• Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
• Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or a service does not, in itself, make such care, goods or services medically necessary or a covered service.

Medicaid will not reimburse a physician and the following provider types for the same procedure, same recipient, and same date of service:

• Advance registered nurse practitioner
• Chiropractor
• County health department
• Federally qualified health center
• Licensed midwife
• Physician assistant
• Podiatrist
• Registered nurse first assistant
• Rural health clinic
• Schools

Medicaid will reimburse only one visit per physician or physician group, per recipient, per day, except for emergency services.

Certain procedure codes have service frequency and diagnosis limitations based on utilization control measures.

For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may bill only a professional component fee (PC).

The maximum fee is intended to pay the physician for performing the complete procedure including both the technical and professional components. It can be billed only when the same provider performs all technical and professional components.

Medicaid does not reimburse for services furnished to recipients when they are out of the country.

Outpatient hospital services consist of preventive, diagnostic, therapeutic or palliative care under the direction of a physician or dentist at a licensed acute care Hospital. Outpatient hospital services include Medically Necessary emergency room services, dressings, splints, oxygen and physician ordered services and supplies for the clinical treatment of a specific diagnosis or treatment.

Simply Healthcare Plans shall provide Emergency Services and Care as Medically Necessary.

Simply Healthcare Plans shall have a procedure for the authorization of dental care and associated ancillary medical services provided in an outpatient hospital setting if that care meets the following requirements:

• Is provided under the direction of a dentist at a licensed Hospital; and
• Is Medically Necessary; or
• Simply Healthcare Plans shall pay for any Medically Necessary duration of stay in a non-contracted facility which results from a medical emergency until the HMO can safely transport the Enrollee to a Simply Healthcare Plans participating facility.

Filing a Claim Electronically
Providers submitting claims electronically should receive an acknowledgement from WebMD or their current clearinghouse; if you experience any problems with your transmission please contact your local clearinghouse representative.

Encounter Submission
Providers should submit encounter data following all claims protocols on submissions and timeliness. All providers are required to submit encounter claims for all visits with appropriate coding.
**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 six (6) months 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 AHCA.

**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 Medicaid reimbursement rate established for the hospital or provider.

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

**Medicaid Program**
For SHP Medicaid Plan Participating providers, SHP is authorized to take whatever steps necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contract or(s) as a participating provider of the health plan.
and that the provider’s submission of encounter data is accepted by the Florida MMIS and/or the state’s encounter data warehouse.

**The Pricing Modifiers Guidelines for Physician Services:**

22, 24, 25, 26, 50, 52, 55, 56, 59, 76, 77, 78, 79, 99, LT/RT, and TC

**Modifier 22:** Unusual Services. Should be used to identify when a service exceeds the usual service as described.

- Documentation must be submitted along with the claim to indicate why additional reimbursement is being requested.

**Modifier 24:** Separate Evaluation and Management (E&M) services. Should be used when the same physician or physician group performs an E&M service during the post-operative period for a reason unrelated to the original procedure.

- Documentation must be submitted with the claim.

**Modifier 25:** Separate Evaluation and Management (E&M) services. Should be used for a significant, separately identifiable evaluation and management service by the same physician or physician group on the same day of the procedure or other service.

- Documentation must be submitted with the claim.

**Modifier 26:** Professional Component. Should be used when the professional component is reported separately. Acceptable procedure codes billable for professional component are identified in the fee schedule.

**Modifier 50:** Bilateral Procedure. Should be used to identify bilateral procedures performed during the same operative session. These services will be reimbursed at 150% of the maximum allowable procedure code fee.

- Documentation must be submitted with the claim.

**Modifier 52:** Reduced Services. Should be used when a service or procedure is partially reduced or eliminated at the physician’s discretion. Reimbursement for this service is 90% of the maximum allowable fee of the CPT code.

**Modifier 59:** Distinct Procedural Service. Should be used to indicate that a procedure or service was distinct or independent from other service performed on the same day.

**Modifier 55:** Postoperative Management Only. Should be used to identify the postoperative component of patient management. Reimbursement for this service is 30% of the maximum allowable fee of the CPT.

- Documentation must be submitted with the claim.

**Modifier 56:** Preoperative Management Only. Should be used to identify the preoperative component including preoperative care and evaluation of patient management. Reimbursement for this service is 20% of the maximum allowable fee of the CPT.

**Modifier 76:** Repeat Procedure by Same Physician. Should be used when the same physician who performed the original procedure repeats a procedure. This modifier is only valid for radiology CPT codes (70000-79999).
Modifier 77: Repeat Procedure by another Physician. Should be used when another surgical procedure is performed on the same date of service. This modifier is only valid for radiology CPT codes (70000-79999)

Modifier 99: Multiple Modifiers. Should be used when two or more pricing modifiers are applicable to one CPT code line.

Modifier LT/RT: Left and Right Radiology Modifiers. Should be used to indicate left (LT) or right (RT) radiology procedures. These modifiers are only valid for radiology CPT codes 7000-79999.re.

- Documentation must be submitted with the claim.

Modifier TC: Technical Component – Radiology. Should use when the radiological technical component is reported separately. CPT codes reimbursable with a technical component are radiology CPT codes 70000-79999 in the Physician office setting only.

Simply Healthcare Plans requires that if there are any claim discrepancies you may contact the Provider Help Line at 800-514-4561 for assistance.
D. ENROLLEE COVERED SERVICES

Enrollees may receive covered services that are performed, prescribed or directed by a participating provider. The Enrollee must receive your healthcare services from a participating PCP or medical provider. It is the Enrollees' responsibility to make sure that their healthcare PCP or health care provider participates in the plan. You can look in the Simply Healthcare Plans provider directory to refer the Enrollee to the appropriate Provider for care. For network changes, you also may call Simply Healthcare Plans Enrollee Provider Services to verify the provider you have chosen for the Enrollee is a Simply Healthcare Plans PCP or participating medical provider of services.

In addition, if one of our providers in our network does not want to perform a service or make a referral of service because of moral or religious objections, neither the provider nor Simply Healthcare Plans is required to provide information on how and where to obtain the service. See information below:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Checkup</strong></td>
<td></td>
</tr>
<tr>
<td>Health and Development History</td>
<td>Covered services</td>
</tr>
<tr>
<td>Examination</td>
<td>Physical assessment</td>
</tr>
<tr>
<td>Nutritional assessment</td>
<td></td>
</tr>
<tr>
<td>Routine immunizations update</td>
<td>10 visits during the first two years, then one visit per year from 2 to 20 years of age</td>
</tr>
<tr>
<td>Laboratory tests (including lead Screening)</td>
<td></td>
</tr>
<tr>
<td>Vision screening</td>
<td>No co-pay</td>
</tr>
<tr>
<td>Hearing screening</td>
<td>*Hearing Aids are limited to one per ear in 3 yrs.</td>
</tr>
<tr>
<td>Dental Screening</td>
<td></td>
</tr>
</tbody>
</table>

| **Health Education and Development Assessment** |         |

<table>
<thead>
<tr>
<th><strong>Children’s Dental</strong></th>
<th>Medicaid-covered services and expanded benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>All routine, surgical, fillings, extractions, orthodontic, dentures and repairs under 21 years of age</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Adult Dental</strong></th>
<th>Medicaid-covered services and adult dental expanded benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic dental services for adult’s Age 21 years or older</td>
<td>Adult services include medically necessary emergency dental procedures to alleviate pain limited to emergency or infection.</td>
</tr>
</tbody>
</table>
Emergency dental shall be limited to emergency oral examinations, necessary radiographs, extractions, incisions and drainage of abscesses

Adult dental services also shall include dentures, partial dentures and related services (one upper and lower per lifetime)

Expanded benefit include Adult dental cleanings up to 2 cleanings per year

### Physician-Professional Services

**Physician visits**

Medicaid-covered services

**Preventive care visits**

No co-pay

**Diagnosis Treatment and/or services**

### Newborns

Coverage for first three months of life (newborn must be enrolled in Simply Healthcare Plans)

### Independent Lab and X-ray Services

Medicaid-covered services

No co-pay

Requires PCP referral

### Adult Health Screening

Medicaid-covered services

One visit per year

No co-pay

### Outpatient Hospital Services

**Emergency room visits**

No approval required/notify your PCP or call 911

**Non-Emergency visits**

No co-pay

**Lab tests and X-rays**

No co-pay – PCP Approval Required

### Outpatient Hospital Services Continued:

**Medical supplies**

Medicaid-covered services

(including cast and splints)
Oxygen and blood transfusion
Outpatient surgical procedures
Physical therapy

**Inpatient Hospital Services**

Services are covered and include but are not limited to, rehabilitation hospital care (which are counted as inpatient hospital days), medical supplies, diagnostic and therapeutic services use of facilities, drugs and biologicals, room and board, nursing care and all supplies and equipment necessary to provide adequate care in a hospital setting.

Inpatient services do not include inpatient care for psychiatric, mental health (Baker Act and non-Baker Act), and substance abuse. *(Refer to Behavioral Health Care)*

**Inpatient services require authorization.**

*Limitations*

Medicaid reimbursement for inpatient hospital care for adults age 21 and older is limited to 45 days per state fiscal year (July 1 though June 30). There is no limit on the number of days that Medicaid can reimburse for recipients under age 21.

**Emergency Services**

Includes post-stabilization services

Provides emergency transportation (ambulance) to the hospital

Post-stabilization services are covered without prior authorization (services that are medically necessary after an emergency medical condition has been stabilized)

No co-pay

**Transportation**

To and from appointments and Non-emergency care

Medicaid-covered services

No co-pay

**Prescribed Drug Services**

Prescription drugs and pharmacy

Use the Medicaid Preferred Drug Listing (PDL) Enrollee must use a Medicaid participating pharmacy.

Medicaid does not reimburse for any over the counter products, *(see PDL for Exceptions)*
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td><em>Limitations</em> (1) course of nicotine replacement therapy of (12) weeks of duration per year which may include patches or nicotine gum. Enrollee needs to coordinate with plan for services.</td>
</tr>
<tr>
<td><strong>Diabetes Supplies &amp; Education</strong></td>
<td>Medically appropriate and necessary equipment, supplies and services used to treat diabetes, including outpatient self-management training and educational services. Medicaid-covered services and supplies. No co-pay.</td>
</tr>
<tr>
<td><strong>Supply Visit and Supplies</strong></td>
<td>Home Care. Medicaid-covered supplies.</td>
</tr>
<tr>
<td><strong>Dialysis Facility Services (Freestanding)</strong></td>
<td>Includes labs, dialysis, supplies and ancillary. Medicaid covered services and supplies one treatment per Enrollee per day up to three times per week. Home dialysis limited to one treatment per Enrollee per day. If the Enrollee requires additional treatment, the Enrollee’s PCP or nephrologist’s must make the determination and authorization will be given.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) and Prosthetics</strong></td>
<td>Medicaid covered services and supplies. Medical necessity for DME must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge. The physician must sign the documentation as it relates to the diagnosis.</td>
</tr>
<tr>
<td><strong>Home Healthcare Services</strong></td>
<td>Medicaid-covered services and expanded meals. Services provided by registered nurse or licensed practical nurse, private-duty nursing, personal care services, therapy (OT, PT, SP), medical supplies,</td>
</tr>
</tbody>
</table>
appliances and DME

*Private duty for persons 21 years and younger must be authorized
Limited to four visits by nurses and/or aides per day and 60 visits by nurses and/or aides per lifetime
No Co-pay

Expanded Meals
Home delivered meals when requested by a physician and when in-home support is present for up to 1 meal per day for up to 10 days of discharge from a hospital

<table>
<thead>
<tr>
<th>Prosthetic Devices</th>
<th>Medicaid-covered services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart pacemakers, artificial limbs and eyes</td>
<td>Some customized orthotics and prosthetics can be authorized for patients in nursing facilities and for persons 21 years of age or younger</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dressings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Splints, casts and braces</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid-covered services</td>
</tr>
<tr>
<td>Counseling and referral services by a Participating Psychiatrist or a community health center</td>
</tr>
<tr>
<td>No PCP or referral is required.</td>
</tr>
<tr>
<td>No co-pay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapy Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid-covered services</td>
</tr>
<tr>
<td>Evaluations and visits up to a maximum 14 units per week and daily treatment may not exceed 4 units of service per day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing Services (Adults &amp; Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid-covered services</td>
</tr>
<tr>
<td>Diagnostic testing, hearing aids, hearing aid evaluations, hearing aid</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>fitting and dispensing, hearing</td>
</tr>
<tr>
<td>aid repairs and accessories (within</td>
</tr>
<tr>
<td>limits)</td>
</tr>
<tr>
<td><strong>Vision Care and Medical Eye Care</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Dermatology Services</strong></td>
</tr>
</tbody>
</table>
|                                     | 24 visits per calendar year
<table>
<thead>
<tr>
<th><strong>Transplant Services</strong></th>
<th>Medicaid-covered organ transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covers pre-and post-transplant for services even if the transplant itself is not a covered service</td>
<td></td>
</tr>
<tr>
<td>Adult heart, liver and lung transplants require prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Donor services for solid or bone marrow transplant procedures even if the donor is Medicaid eligible is not covered.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Family Planning Services</strong></th>
<th>Medicaid-covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>No referral needed. This service can be obtained by any Simply Healthcare Plans provider and does not require prior authorization</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interpreter Services</strong></th>
<th>Includes services for vision or impaired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are free of charge for all foreign hearing-languages</td>
<td></td>
</tr>
</tbody>
</table>

| **Over the Counter (OTC) Drugs** | Up to $25 in items per head of household each month for selected Over the Counter drugs and/or health supplies |

<table>
<thead>
<tr>
<th><strong>Adult Nutritional Therapy</strong></th>
<th>Nutritional assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 visits per year</td>
<td></td>
</tr>
</tbody>
</table>

Refer to The Medicaid Covered Summary of Services Program:

**Long Term Care**

Must be ordered by a PCP. There are three levels of nursing facility care skilled and intermediate I and II, the CARES unit recommends the level of care for Enrollees. The Department of Health, Children Medical Services, and (CMAT) recommends the level of care for Enrollees under the age of 21.
Hospice

Once an Enrollee is placed to receive Hospice Care, Medicaid will not reimburse for other Medicaid services that treat the terminal condition. Medicaid will cover services that are required for conditions that are totally unrelated to the terminal condition.

Maternity Services

Maternity services include the following:

- Nursing assessment and counseling
- Florida’s Healthy Start Prenatal Risk Screening
- Nutritional assessments
- Delivery and follow-up care
- Florida’s Healthy Start Infant (Postnatal) Screening and follow-up care

The Women, Infant and Children (WIC) Program includes referrals for all pregnant, breast-feeding and postpartum women, and infants and children up to 5 years of age. The Enrollee should Contact their Medicaid Choice Counselor for more information.

E. MEDICAID REFORM FORMS AND DOCUMENTS

Samples of the following forms and assessment tools are included in this section:

Simply Healthcare Plans Referral Form
Domestic Violence Assessment Tool
Provider Accessibility Tool
Abortion Certification Form
Sterilization Consent Form
Practitioner Disease Report Form
Immunizations Vaccination Schedules
Enhanced Benefits Brochure/Universal Form
Medical Release Form
Simply Healthcare Plans ID Card
QUICK AUTHORIZATION FORM  

***Valid for 90 DAYS***
VALID ONLY FOR: 1. NETWORK SPECIALIST CONSULTATIONS; 2. FREE-STANDING DIAGNOSTIC FACILITIES. DO NOT USE FOR HOSPITALS, ASC'S, OR PRENATAL CARE. DO NOT WRITE IN OTHER CODES!
PRECERTIFICATION IS REQUIRED FOR SERVICES/CODES NOT LISTED BELOW.
PLEASE FAX FORM TO SPECIALIST/PROVIDER AND/OR GIVE COPY TO THE MEMBER

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
<th>Issue Date</th>
<th><em><strong><strong><strong><strong><strong><strong>VALID FOR 90 DAYS</strong></strong></strong></strong></strong></strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>First Name</td>
<td>SSN/ID#</td>
</tr>
<tr>
<td>Plan Type (select one):</td>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE PHYSICIAN INFORMATION</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>REFERRED TO PROVIDER INFORMATION</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Address (State, City, Zip):</td>
<td>Appt Date:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>Number of Visits (max of 3):</td>
<td>Procedure Code (required):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnosis:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code:</td>
<td></td>
</tr>
</tbody>
</table>

PCF Signature (required):

SPECIALIST OFFICE VISITS

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td></td>
</tr>
<tr>
<td>Gynecology</td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td></td>
</tr>
<tr>
<td>Fracture Care</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td></td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td></td>
</tr>
<tr>
<td>Adenoidectomy</td>
<td></td>
</tr>
</tbody>
</table>


This form certifies that participating plan providers are eligible for reimbursement for only the services listed above. According to the plan's healthcare plan, subject to all exclusions, limitations (if any), definitions and other provisions outlined by the Plan. The actual amount of benefits is determined when a claim is submitted and eligibility is determined. Precertification for services rendered in the hospital setting may only be obtained by contacting Simply Healthcare Plan's Utilization Management Department.
Simply Healthcare Plans ID: _____________________   Telephone: ____________
Member DOB: _____
Member Name: _____________________________________________

### Referring Physician Information
- PCP Name: ____________________________________________
- PCP ID #: _____________________   Telephone: ________
- Referring Physician Name: ________________________________
- Referring Physician Telephone: (______) _______ ______
- Referring Physician Fax Number: (______) _______ ______

### Patient Services
- **Inpatient Services:**
  - Hospital Admissions
  - Acute Rehabilitation Admissions
  - Skilled Nursing Facility (SNF) Admissions
  - Birthing Centers
  - 23 Hour Observation

- **Outpatient Surgical Services:**
  - Hospital
  - Ambulatory Surgical Center

- **Outpatient Services Performed at a Hospital:**
  - Colonoscopy
  - Endoscopy
  - Wound Care
  - Hyperbaric Oxygen Treatment
  - All Therapy and Rehabilitative Services

- **Outpatient Services:**
  - PET Scans
  - MRA
  - Chemotherapy
  - Physical Therapy
  - Radiation Therapy
  - Sleep Studies
  - Occupational Therapy
  - Respiratory Therapy
  - Wound Care
  - MRI
  - Total OB Care
  - Speech/Language Pathology
  - Durable Medical Equipment (DME)
  - Skilled Nursing Services, Including Home Health, Home Health

### Authorization Information
- **Initial Request**  □  **2nd Request**  □  **3rd Request**  □

- **Is This Request Related to an Accident?**
  - □ Yes  □ No
- **MVA**  □  **Worker’s Compensation**  □

- **Does This Member Have Other Insurance Coverage?**
  - □ Yes  □ No
- **Medicare**  □  **Other (Specify):** __________________________

### Prior Authorization
- **Please Fax To**: Simply Healthcare Plans (305) 408-5810 or (800) 283-2117
- **For STAT/Urgent Requests**, it is suggested that requests be called to the Simply Healthcare Plans Pre-Certification Telephone Queue at (800) 887-6888, Extension 2271

### For Simply Office Use Only
- **Date Request Received:**
- **Status:**
  - □ Approved — Authorization #: _______________________
  - □ Denied (Reason): _____________________________
  - □ Pended (Reason): _____________________________

### Prior Authorization is NOT a Guarantee of Payment
MEDICAL / BEHAVIORAL COMMUNICATION FORM

Date: ___________________________
Member Name: __________________ Member Phone No.: _____________
Healthplan: _______________ ID No.: ____________

REFERRAL REASON

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Referring Nurse/Case Manager: ____________________________
Phone No.: __________________________ Fax No.: _____________

RESPONSE

Contact Nurse/Case Manager: ____________________________
Phone No.: __________________________ Fax No.: _____________

Please fax to:
Psychcare at 305.279.4344
Healthplan Name: ____________________________ at Fax No.: _____________
Pregnancy Notification Form

PLEASE COMPLETE AND FAX TO SHP AT 1-800-283-2117 WITHIN 2 WORKING DAYS OF THE FIRST PRENATAL VISIT

MEMBER’S DEMOGRAPHIC INFORMATION

Last name:___________________ First Name_________________ Maiden name___________________

SHP ID #:___________________ SSN _____ - _____ - _____ Medicaid ID #:___________________
D.O.B.________

Address:_____________________________ City_________________ State____ Zip code____________

Phone:_____________________ Mobile or other phone #:_________________ Preferred language:__________

Gravida___ Para___ LMP_____ EDC ___ Blood type ___ Date of last birth___ Ectopic pregnancies?__

<table>
<thead>
<tr>
<th>MEDICAL INFORMATION REGARDING OB RISKS - Please check all that apply: Current Pregnancy</th>
<th>Previous Pregnancies</th>
<th>N/A ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes ___ Hypertension___</td>
<td>Diabetes ___ Hypertension ___</td>
<td></td>
</tr>
<tr>
<td>Smoking ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperemesis ___</td>
<td>Pre-eclampsia ___ Incompetent cervix ___</td>
<td></td>
</tr>
<tr>
<td>Multiple pregnancy ___</td>
<td>Placenta previa ___</td>
<td></td>
</tr>
<tr>
<td>Immunosuppressed ___</td>
<td>Imunosuppressed ___</td>
<td></td>
</tr>
<tr>
<td>Preterm labor ___ ETOH or drugs ___</td>
<td>Pre-term labor ___ wks. Pre-term delivery ___ wks.</td>
<td></td>
</tr>
<tr>
<td>HIV testing? ___ HIV counseling? ___</td>
<td>Prior C Section?Yr. ___ Reason ________________________________</td>
<td></td>
</tr>
<tr>
<td>Cervical or uterine anomalies ___</td>
<td>Prev. spontaneous abortion ___ wks</td>
<td></td>
</tr>
<tr>
<td>Other _________________</td>
<td>Prev. fetal demise ___ wks. Prev. uterine surg. ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Previous birthweight &lt; 2500 Gm ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other_______________</td>
<td></td>
</tr>
</tbody>
</table>

Medical/Social Problems:

Asthma ___ Heart disease ___ Neurologic illness ___ Renal disease ___ Anemia ___
Domestic violence ___
STD’s _____________________

Healthy Start Referral done? ___ WIC Referral done? ___
Comments or other pertinent information________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

___________________________
OB-GYN/MIDWIFE INFORMATION
Provider’s Name:_________________ Telephone #________________ Fax
#________________
Office contact name:_________________________
Date of first prenatal appointment:_____________
Referring provider:______________________ Referring provider phone
#:____________________

Please review your Provider Handbook for all Pregnancy Requirements; the Healthy Start
Risk Screening must be completed at the first prenatal visit and WIC referral must be
offered. Please fax copies of all completed forms to SHP OB Coordinator at 1-800-887-6888
ext. 5882. Please advise the member to contact DCF for notification of her pregnancy and
obtain the Unborn ID number, and later call SHP with this number.
INCIDENT REPORT FORM - PRIVILEGED AND CONFIDENTIAL

Please complete the following:

Product: (circle one) Medicaid Medicare Commercial
MEMBER NAME: ____________ MEMBER NUMBER: ____________ DOB______ SEX____

INITIAL DIAGNOSIS: ___________________ INITIAL ICD-9 CM CODE: __________

INCIDENT TIME: _____ INCIDENT DATE: __________ INCIDENT LOCATION: __________

FACILITY NAME (If hospitalized): ____________ ADMISSION TIME & DATE: __________

ADMITTING DX & ICD-9 / CPT CODE: ____________ WAS A PHYSICIAN CALLED? _____
PCP: ____________ SCP: __________________

WITNESS (ES):
_________________________________________________________________________

WITNESS (ES) LOCATING INFORMATION:
_________________________________________________________________________

PHYSICAL FINDINGS/DIAGNOSIS:
_________________________________________________________________________

Give a clear concise description of the incident including time, date, and exact location:
_____________________________________________________________________________
___________________________________________________________________________

FINAL DX ICD-9 / CPT CODES: _________________________________

Attach information if more space is needed.

REPORT PREPARED BY:
NAME: ___________________ POSITION: ____________ SIGNATURE: __________

Date of Report: ____________ Time of Report: ____________

INCIDENT REPORTS MUST BE SENT TO RISK MANAGEMENT WITHIN 3 CALENDAR DAYS
PLEASE CALL SHP’S RISK MANAGER BEFORE FAXING
Domestic Violence (DV) Screening/Documentation Form

Date ___________________ Patient ID# __________________________

Patient Name ________________________________________________

Provider Name ______________________________________________

Patient Pregnant? □ Yes □ No

Examination Findings:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Assess Patient Safety
□ yes □ no Is abuser here now?
□ yes □ no Is patient afraid of partner?
□ yes □ no Is patient afraid to go home?
□ yes □ no Has physical violence increased in severity?
□ yes □ no Has partner physically abused children?
□ yes □ no Have children witnessed violence in the home?
□ yes □ no Threats of suicide? By whom: __________________________
□ yes □ no Is there a gun in the home?
□ yes □ no Alcohol or substance abuse?
□ yes □ no Was safety plan discussed?

Referrals
□ Hotline number given 1-800-799-7233
□ Legal referral made
□ Shelter number given
□ In House Referral. Describe:
___________________________________________________________________
□ Other referral made. Describe:
___________________________________________________________________

Reporting
□ Law enforcement report made
□ Child protective services report made
□ Adult protective services report made

Photographs
□ yes □ no Consent to be photographed?
□ yes □ no Photographs taken?

Accessibility Audit Form

Provider Name: __________________________

Provider Address: __________________________

DV Screen
□ DV+ (Positive)
□ DV? (Suspected)
Provider Phone No.: ___________________________

Name/title of person at provider’s office verifying appointment availability

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date  (mm/dd/yy)  Time

Urgent Care
Routine Sick Patient Care
Well Care Visit

Date Completed
Simply Healthcare Plans
Rep

Please complete the section below, in the event that an on-site review has not been scheduled.

I certify that the information provided below is true and accurate.

Name: ___________________________
Title: ___________________________
Date: ___________________________
Signature: ______________________
SECTION I
1. Recipient's Name: _______________________________________________________

2. Address:________________________________________________________________

3. Medicaid Identification Number: __________________________________________

SECTION II
4. On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:
   □ The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
   □ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
   □ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

   I have documented in the patient's medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. __________________________________  6. ____________________________
   Physician's Name  Physician's Signature

7. __________________________________  8. ____________________________
   Physician's Medicaid Provider Number  Date of Signature

   August 2001
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from ____________________________ (doctor or clinic) for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will be done within at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: __________ Month Day Year

I, ________________, hereby consent of my own free will to be sterilized by ____________________________ (doctor) by a method called ____________________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: ____________________________ (Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form.

Signature: ____________________________ Date: __________ Month Day Year

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

- Hispanic or Latino
- Race (mar one or more):
- American Indian or Alaska Native
- Asian
- Black or African American
- Hawaiian or Other Pacific Islander
- White

INTERPRETER’S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter’s Signature: ____________________________ Date: __________

PHYSICIAN’S STATEMENT

Shortly before I performed a sterilization operation upon ____________________________ (name of individual) on __________ date of sterilization __________, I explained to him/her the nature of the sterilization operation ____________________________ (specify type of operation) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of person obtaining consent: ____________________________ Date: __________

Facility: ____________________________ Address: ____________________________

Physician’s Signature: ____________________________ Date: __________
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.

**Patient Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>M</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Social Security Number (no dashes)</th>
<th>Area Code + Phone Number (no dashes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

**Disease Specific Information**

<table>
<thead>
<tr>
<th>Dates of Onset: (MM/DD/YYYY)</th>
<th>Disease Fatal?</th>
<th>Patient hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hospital Name:**

[ ] Medicare Number or Insurance:

**REPORT IMMEDIATELY UPON**

- Initial Suspicion 24/7 by Phone
- Diagnosis 24/7 by Phone

(Disease or Condition Reporting for HIV/AIDS and HIV exposed newborns: please report per forms indicated in FAC, 64D-31)

**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.

**Patient Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>M</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Social Security Number (no dashes)</th>
<th>Area Code + Phone Number (no dashes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

**Disease Specific Information**

<table>
<thead>
<tr>
<th>Dates of Onset: (MM/DD/YYYY)</th>
<th>Disease Fatal?</th>
<th>Patient hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hospital Name:**

[ ] Medicare Number or Insurance:

**REPORT IMMEDIATELY UPON**

- Initial Suspicion 24/7 by Phone
- Diagnosis 24/7 by Phone

(Disease or Condition Reporting for HIV/AIDS and HIV exposed newborns: please report per forms indicated in FAC, 64D-31)

**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.

**Patient Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>M</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Social Security Number (no dashes)</th>
<th>Area Code + Phone Number (no dashes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

**Disease Specific Information**

<table>
<thead>
<tr>
<th>Dates of Onset: (MM/DD/YYYY)</th>
<th>Disease Fatal?</th>
<th>Patient hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hospital Name:**

[ ] Medicare Number or Insurance:

**REPORT IMMEDIATELY UPON**

- Initial Suspicion 24/7 by Phone
- Diagnosis 24/7 by Phone

(Disease or Condition Reporting for HIV/AIDS and HIV exposed newborns: please report per forms indicated in FAC, 64D-31)

**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.

**Patient Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>M</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Social Security Number (no dashes)</th>
<th>Area Code + Phone Number (no dashes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

**Disease Specific Information**

<table>
<thead>
<tr>
<th>Dates of Onset: (MM/DD/YYYY)</th>
<th>Disease Fatal?</th>
<th>Patient hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hospital Name:**

[ ] Medicare Number or Insurance:

**REPORT IMMEDIATELY UPON**

- Initial Suspicion 24/7 by Phone
- Diagnosis 24/7 by Phone

(Disease or Condition Reporting for HIV/AIDS and HIV exposed newborns: please report per forms indicated in FAC, 64D-31)
This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/recs/acip)

American Academy of Pediatrics
(http://www.aap.org)

American Academy of Family Physicians
(http://www.aafp.org)
This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

### FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012

<table>
<thead>
<tr>
<th>Vaccine ▼</th>
<th>Age ▼</th>
<th>Birth</th>
<th>1 month</th>
<th>2 months</th>
<th>3 months</th>
<th>4 months</th>
<th>6 months</th>
<th>9 months</th>
<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19–23 months</th>
<th>2–3 years</th>
<th>4–6 years</th>
</tr>
</thead>
</table>
| Hepatitis B (HepB) vaccine | (Minimum age: birth) | At birth: | • Administer monovalent HepB vaccine to all newborns before hospital discharge. | • For infants born to hepatitis B surface antigen (HBsAg)—positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit). | • If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother’s HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week). | Doses after the birth dose: | • The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks. | • Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose. | • Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3). | • The minimal interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose. | 7. | Influenza vaccines. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV] for most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see MMWR 2010;59(No. RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf. | • For children aged 6 months through 8 years: | — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season. | — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations. | 8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months) | • The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose. | • Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years. | 9. Varicella (VAR) vaccine. (Minimum age: 12 months) | 3 months have elapsed since the first dose. | • For children aged 12 months through 12 years, the recommended minimum interval between doses is 2 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid. | 10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months) | • Administer the second (final) dose 6 to 18 months after the first. | • Unvaccinated children 24 months and older at high risk should be vaccinated. See MMWR 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf. | • A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired. | Meningococcal conjugate vaccines, quadrivalent (MCV4). (Minimum age: 9 months) | • For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic meningococcal disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart. | • For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/anatomical asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart. | • For children with anatomic/anatomical asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses. | • See MMWR 2011;60:72–6, available at http://www.cdc.gov/mmwr/pdf/rr/rr6003.pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/schedules/pdfs/schedules/resolutions/06-11mening-mcv4.pdf, and MMWR 2011;60:1391–2, available

### Notes
- [1] Doses are monovalent 5a and pentavalent 5b. For 19–23 months, see footnote [10].
- [2] For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic meningococcal disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
- [3] For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/anatomical asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
- [4] For children with anatomic/anatomical asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.

<table>
<thead>
<tr>
<th>Vaccine ▼</th>
<th>Age ▼</th>
<th>Birth</th>
<th>1 month</th>
<th>2 months</th>
<th>3 months</th>
<th>4 months</th>
<th>6 months</th>
<th>9 months</th>
<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19–23 months</th>
<th>2–3 years</th>
<th>4–6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotavirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parvovirus B19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### References
should be administered at age 4 through 6 years.
• The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

at http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf, for further guidance, including revaccination guidelines.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

Department of Health and Human Services • Centers for Disease Control and Prevention
FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])

<table>
<thead>
<tr>
<th>Vaccine ▼</th>
<th>Age ▶</th>
<th>7–10 years</th>
<th>11–12 years</th>
<th>13–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (Td) vaccine. (Minimum age: 10 years for Boostrix and 11 years for Adacel)</td>
<td>Age</td>
<td>1 dose (if indicated)</td>
<td>3 doses</td>
<td>1 dose (if indicated)</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]). (Minimum age: 9 years.)</td>
<td>Age</td>
<td>Complete 3-dose series</td>
<td>Complete 3-dose series</td>
<td>Booster at 18 years old</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Age</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib) vaccine.</td>
<td>Age</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
</tr>
<tr>
<td>Hepatitis A (Hep A) vaccine.</td>
<td>Age</td>
<td>See footnote</td>
<td>See footnote</td>
<td>See footnote</td>
</tr>
<tr>
<td>Hepatitis B (Hep B) vaccine.</td>
<td>Age</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>Age</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>Age</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
</tr>
<tr>
<td>Varicella</td>
<td>Age</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
<td>Complete 2-dose series</td>
</tr>
</tbody>
</table>

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.
   - For children aged 6 months through 8 years:—For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.—For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
   - For children aged 11 or 12 years.

2. Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]). (Minimum age: 9 years.)
   - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
   - The vaccine series can be started beginning at age 9 years.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).

3. Meningococcal conjugate vaccines, quadrivalent (MCV4).
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
   - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
   - If the first dose is administered at age 16 years or older, a booster dose is not needed.
   - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
   - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.

4. Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).
   - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see MMWR 2010;59(No.RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - Administer 1 dose to persons aged 9 years and older.

5. Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).
   - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See MMWR 2010;59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
   - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.

6. Hepatitis A (Hep A) vaccine.
   - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See MMWR 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
   - Administer 2 doses at least 6 months apart to unvaccinated persons.

7. Hepatitis B (Hep B) vaccine.
   - Administer the 3-dose series to those not previously vaccinated.
   - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
   - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).
   - The final dose in the series should be administered at least 6 months after the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child’s current age.
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.

9. Measles, mumps, and rubella (MMR) vaccine.
   - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.

10. Varicella (VAR) vaccine.
    - For persons without evidence of immunity (see MMWR 2007;56(No. RR-4), available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.
This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

Department of Health and Human Services • Centers for Disease Control and Prevention

FIGURE 3. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States • 2012

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dose 1 to dose 2</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis&lt;sup&gt;2&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Haemophilus influenzae type b</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;5&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>9 months</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;7&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

Persons aged 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dose 1 to dose 2</td>
</tr>
<tr>
<td>Tetanus, diphtheria/ tetanus, pertussis</td>
<td></td>
<td>4 weeks</td>
</tr>
<tr>
<td>Human papillomavirus&lt;sup&gt;10&lt;/sup&gt;</td>
<td>9 years</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;5&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>9 months</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;7&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 months</td>
<td>3 months</td>
</tr>
</tbody>
</table>

</table>
1. **Rotavirus (RV) vaccines** ([RV-1](#)[Rotarix] and [RV-5](#)[Rota Teq]).
   - The maximum age for the first dose in the series is 14 weeks, 1 day; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 was administered for the first and second doses, a third dose is not indicated.

2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.**
   - The fifth dose is not necessary if the fourth dose was administered at age 46 years or older.

3. **Haemophilus influenzae type b (Hib) conjugate vaccine.**
   - Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
   - If the first 2 doses were PRP-OMP ([PedvaxHIB](#) or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.

4. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously, or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.
   - Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See [MMWR 2010:59(No. RR-11)](http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for further guidance.

5. **Inactivated poliovirus vaccine (IPV).**
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - IPV is not routinely recommended for U.S. residents aged 19 years or older.

6. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])
   - See Figure 1 (“Recommended immunization schedule for persons aged 0 through 18 years”) and Figure 2 (“Recommended immunization schedule for persons aged 7 through 18 years”) for further guidance.

7. **Measles, mumps, and rubella (MMR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years.

8. **Varicella (VAR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

9. **Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.**
   - For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
   - An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.

10. **Human papillomavirus (HPV) vaccines** ([HPV4](#)[Gardasil] and [HPV2](#)[Cervarix]).
    - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
    - Use recommended routine dosing intervals for vaccine series catch-up; see Figure 2 (“Recommended immunization schedule for persons aged 7 through 18 years”).
Introducing the Enhanced Benefits Account Program

Florida Medicaid has a new program called the Enhanced Benefits Account Program. This program is designed to reward you for taking part in activities that can improve your health. These activities, known as healthy behaviors, will allow you to earn credits that you can later use to buy health-related items at the pharmacy. Everyone enrolled in a Florida Medicaid Reform Plan is eligible and will be enrolled. This program provides an additional benefit to the benefits provided by your reform health plan.
Who is eligible?
If you are enrolled in a Florida Medicaid Reform Health Plan, you are eligible to earn and use credits in the Enhanced Benefits Account Program. If you are enrolled with a reform health plan that offers another over-the-counter benefit, you are still eligible for the Enhanced Benefits Account program and may receive benefits from both programs.

How do you earn credits?
You earn credits by taking part in a healthy behavior. Healthy behaviors may be offered by your health plan, community center, or other not-for-profit organizations. The program records your participation in two ways:

- Your health plan reports when you visit the doctor or have a procedure that is an approved healthy behavior to earn credit.
- You submit an Enhanced Benefits Universal Form to your health plan that shows you participated in an approved healthy behavior outside of your health plan. See the list of healthy behaviors in this brochure and how they are reported.

What can you buy with the credits you earn?
Credits in your account may be used to buy certain health-related items. Items include first aid supplies, cough and cold medication, dental supplies, and many other over-the-counter items. See the list of health related products and supplies provided on the Florida Medicaid website at http://ahca.myflorida.com/Medicaid/Enhanced_Benefits. You may also call the Enhanced Benefits Call Center at 1-866-421-8474 for a list of approved products.

Where can you use your credits?
You may use your credits at any Florida Medicaid participating pharmacy.

What is the Enhanced Benefits Universal Form?
The Enhanced Benefits Universal Form is used to record an approved healthy behavior that is not provided by your health plan.

How do you get the Enhanced Benefits Universal Form?
The Enhanced Benefits Universal Form is available:

- On the Florida Medicaid Reform website at http://ahca.myflorida.com/Medicaid/Enhanced_Benefits and
- From your health plan website or through the health plan customer service number listed in this brochure.

Can the Enhanced Benefits Universal Form be submitted for healthy behaviors not listed on the Form?
No. Only behaviors listed on the Universal Form will be processed as credit when the Universal Form is used. See the list of healthy behaviors in the brochure to find those approved for submission using the Enhanced Benefits Universal Form.

How will credit be earned for behaviors not listed or submitted on the Enhanced Benefits Universal Form?
Approved healthy behaviors that are not listed on the Enhanced Benefits Universal Form will be reported to the Agency by your health plan.

How do you get more information?
Go to the Agency’s website at http://ahca.myflorida.com/Medicaid/Enhanced_Benefits. You may also call the Enhanced Benefits Call Center at 1-866-421-8474.
List of Approved Healthy Behaviors That Allow You to Earn Credits

<table>
<thead>
<tr>
<th>Behavior Name</th>
<th>Enhanced Benefits Universal Form Needed?</th>
<th>Credit Amount Per Behavior</th>
<th>Behavior Limit Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Dental Exam</td>
<td>No Need*</td>
<td>$25.00</td>
<td>2</td>
</tr>
<tr>
<td>Childhood Vision Exam</td>
<td>No Need*</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Childhood Preventive Care (age-appropriate screenings and immunizations)</td>
<td>No Need*</td>
<td>$25.00</td>
<td>Any combination, up to 5</td>
</tr>
<tr>
<td>Childhood Wellness Visit</td>
<td>No Need*</td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>Keep all primary care appointments</td>
<td>No Need*</td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>Keep all primary care appointments</td>
<td>No Need*</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Mammogram</td>
<td>No Need*</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>PAP Smear</td>
<td>No Need*</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Colonoscopy Screening</td>
<td>No Need*</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Adult Vision Exam</td>
<td>No Need*</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Adult Dental Cleaning (Preventive Services)</td>
<td>Yes</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Disease management participation</td>
<td>Yes</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol and/or drug treatment program participation</td>
<td>Yes</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol and/or drug treatment program 6 month success</td>
<td>Yes</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Stop Smoking&quot; program participation</td>
<td>Yes</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>&quot;Stop Smoking&quot; program 6 month success</td>
<td>Yes</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Weight loss program participation</td>
<td>Yes</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Weight loss program 6 month success</td>
<td>Yes</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Exercise program participation</td>
<td>Yes</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Exercise program 6 month success</td>
<td>Yes</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Flu Shot when recommended by physician</td>
<td>Yes</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Compliance with prescribed maintenance medications</td>
<td>No Need*</td>
<td>$7.50</td>
<td>4</td>
</tr>
</tbody>
</table>

* No need to complete an Enhanced Benefits Universal Form, your health plan will report this activity.

Example: If you have a vision exam, you earn $25 in credits.

List of Products and Supplies Covered by the Enhanced Benefits Account Program

- Antacids
- Antidiarrheals
- Bandages and Wound Dressings
- Braces and Related Health Aids
- Cough and Cold Preparations
- Dental Products
- Ear Drops and Wax Removal
- Eye Drops
- Laxatives
- Multivitamins (Children and Adults)
- Nose Drops
- Over-the-Counter Pain Medications
- Over-the-Counter Vaginal Preparations
- Shampoos
- Stomach Acid Reducers like Pepcid AC and Prilosec
- Over-the-Counter Sunscreens
- Topical Over-the-Counter Creams and Lotions
- Vaporizers and Hot Water Bottles
- Hearing Aid Batteries

http://ahca.myflorida.com/Medicaid/Enhanced_Benefits
A Florida Medicaid Reform Specialty Health Plan Sponsored by the Agency for Health Care Administration

**Five Easy Steps To Earn Credits**

1. You participate in an approved healthy behavior.
2. You submit a completed Enhanced Benefits Universal Form or your provider submits a claim to your health plan.
3. Your health plan reports the behavior to the Agency.
4. The Agency approves the credits, updates your account and mails you a statement.
5. You may begin using the credits you have earned.

If you want to use your credits to buy an approved health product or supply, you must wait until the program sends you an account balance letter stating that credits are in your account. It may take up to 90 days after you complete a healthy behavior before the credits show up in your account.

**Florida Medicaid Health Plan Contact Information**

**Broward Only**

AMERIGROUP COMMUNITY CARE
Attention: Healthy Behaviors
4200 West Cypress Street, Suite 900
Tampa, FL 33607
1-800-287-8221
1-866-588-4761 Fax
www.myamerigroupp.com

VISTA HEALTHPLAN, INC.
P.O. Box 95-9011
MS SR115
Sunrise, FL 33343-9011
1-800-977-5865
954-858-3200 Fax
www.vistahealthplan.com

HUMANNA FAMILY
3301 10th Avenue
Miami, FL 33027
1-800-897-5851
1-877-258-5994 Fax

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.
P.O. Box 95-9011
MS SR115
Sunrise, FL 33343-9011
1-800-977-7391
954-858-3200 Fax
www.vistahealthplan.com

PREFERRED MEDICAL PLAN, INC.
4500 SW 88th Street
Coral Gables, FL 33134
1-800-767-5553 or 305-487-8573
305-689-4094 Fax
www.pmplan.com

CMSI-BROWARD
1525 NW 167th Street,
Suite 103
Miami, FL 33169
1-866-209-5022

SOUTH FLORIDA COMMUNITY CARE NETWORK
1525 NW 167th Street, Suite 103
Miami, FL 33169
1-866-899-8828
North Broward Hospital District
954-767-5504 Fax
Miami-Dade Healthcare System
954-602-2810 Fax
www.sfccn.org

**Duval Only**

FLORIDA NETPASS, LLC
801 East Hallandale Beach Boulevard,
Suite 200
Hallandale, FL 33009
1-877-377-1273
1-800-635-0148 Fax
www.floridanetpass.com

PEDIATRIC ASSOCIATES HEALTH PLAN
2700 West Cypress Creek Road,
Suite D-116
Fort Lauderdale, FL 33309
954-302-6100
954-302-6140 Fax
www.pediatricassociates.com

TOTAL HEALTH CHOICE
5001 SW 132 Avenue, Suite 200
Miami, FL 33183
1-800-213-1133
305-408-5861 Fax
www.totalhealthchoiceonline.com

FREEDOM HEALTH PLAN
P.O. Box 152697
Tampa, FL 33687
1-888-766-0946
727-471-2108 Fax
www.freedomhealth.com

**Broward/Duval/Baker/Clay/Nassau**

CMS DUVAL/PED-I-CARE
1711 SW 16th Avenue, Building A
Gainesville, FL 32608
1-866-576-2450
352-395-6038 Fax
http://pedicare.pedufsu.edu

SHANDS JAX D/B/A FIRST COAST ADVANTAGE
580 West 8th Street, F-20
Jacksonville, FL 32209
904-244-9036
904-244-9409 Fax
www.firstcoastadvantage.com

**Broward/Duval**

HEALTHEASE
P.O. Box 31370
Tampa, FL 33613-3170
1-800-278-0656
813-262-2802 Fax
www.wellcare.com

STAYWELL
P.O. Box 31370
Tampa, FL 33613-3170
1-866-334-7927
813-262-2802 Fax
www.wellcare.com

UNIVERSAL HEALTHCARE
150 2nd Avenue North, Suite 400
St. Petersburg, FL 33701
1-866-460-0842
727-822-3566 Fax
www.uhnvhc.com

For more information call the Enhanced Benefits Call Center @ 1-866-421-8474
# Florida Medicaid Reform
## Enhanced Benefits Universal Form

### Instructions:
- **Step 1:** Participate in an approved healthy behavior listed below.
- **Step 2:** Fill in all areas of this form and sign.
- **Step 3:** If the healthy behavior has a line under it, write the name of the behavior that has taken place.
- **Step 4:** Have this form signed by the provider/sponsor of the healthy behavior.
- **Step 5:** Mail or fax the completed and signed form to your health plan. See contact list on page 2.

### Beneficiary's Information:
- **Beneficiary's Florida Medicaid ID#**
- **Beneficiary's Health Plan ID#**
- **Beneficiary's Last Name**
- **Date of Birth (mm/dd/yyyy)**
- **Beneficiary's First Name**
- **Beneficiary's Address**
- **City**
- **State**
- **Zip**

### Healthy Behavior Participation:
(check single behavior)
- Congestive Heart Failure Disease Management Program (EB 001)
- Diabetes Disease Management Program (EB 002)
- Asthma Disease Management Program (EB 003)
- HIV/AIDS Disease Management Program (EB 004)
- Hypertension Disease Management Program (EB 005)
- Other Disease Management Program (EB 006)
- Flu Shot (EB 007)
- Adult Dental Cleaning (preventive services) (EB 008)
- Alcoholic Treatment Program (EB 009)
- Alcoholic Treatment Program 6 Month Success (EB 109)
- Narcotic Treatment Program (EB 010)
- Narcotic Treatment Program 6 Month Success (EB 110)
- Smoking Cessation (EB 011)
- Smoking Cessation 6 Month Success (EB 111)
- Exercise Program (EB 012)
- Exercise Program 6 Month Success (EB 112)
- Weight Management (EB 013)
- Weight Management 6 Month Success (EB 113)

### Medicaid Beneficiary Signature __________________________ Date ______________________

### Provider/Sponsor Information
- **Date(s) of Participation:** Start Date __________ End Date __________
- **Name** __________________________
- **Phone #** __________________________
- **Organization Name** __________________________
- **Address** __________________________
- **Signature** __________________________

### Provider/Sponsor and Beneficiary Certification:
I certify that the information provided on this form is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information I can be lawfully punished for fraud. I understand that the information will be kept confidential in accordance with Florida and federal law.

### For Plan Use Only
- **Date Received:** __________________________
- **Complete Form:** __________________________
- **Incomplete Form:** __________________________
- **Notified if Incomplete:** __________________________
Information about the form

- This form may be completed by the beneficiary or the provider/sponsor of the qualifying behavior on behalf of the beneficiary.
- This form must be completed in full in order to be processed (signatures from the provider and beneficiary are required for processing).
- The beneficiary should make and keep a copy of the completed and signed form for their records.
- Participation of a healthy behavior is determined by the provider/sponsor of the healthy behavior.
- Only one healthy behavior, up to the set limit for each behavior, is allowed for each form.
- If you have any questions or concerns about the form or the Enhanced Benefit program, please visit the Florida Medicaid Reform website at http://ahca.myflorida.com/Medicaid/Enhanced_Benefits. You may also contact the Enhanced Benefits Call Center at 1-866-421-8474.

Florida Medicaid Health Plan Contact Information

<table>
<thead>
<tr>
<th>Broward Only</th>
<th>Duval Only</th>
<th>Broward/Duval/Baker/Clay/Nassau</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMERIGROUP COMMUNITY CARE</strong>&lt;br&gt;Attn: Healthy Behaviors&lt;br&gt;4200 West Cypress Street, Suite 500&lt;br&gt;Tampa, FL 33607&lt;br&gt;1-800-827-4221&lt;br&gt;1-866-386-4761 Fax&lt;br&gt;www.amerigrouplcp.com</td>
<td><strong>CMS DUVAL/PED-CARE</strong>&lt;br&gt;1101 SW 16th Avenue, Building A&lt;br&gt;Gainesville, FL 32608&lt;br&gt;1-866-376-2466&lt;br&gt;352-955-6618 Fax&lt;br&gt;<a href="http://pedicare.peds.ufl.edu">http://pedicare.peds.ufl.edu</a></td>
<td><strong>UNITED HEALTHCARE OF FLORIDA, INC.</strong>&lt;br&gt;495 North Keller Road, Suite 200&lt;br&gt;Maitland, FL 32711&lt;br&gt;1-888-216-0015&lt;br&gt;407-697-7100 Fax&lt;br&gt;www.uhcmedicaid.com</td>
</tr>
<tr>
<td><strong>VISTA HEALTHPLAN, INC. (BUENA VISTA)</strong>&lt;br&gt;P.O. Box 99-9011 MS SR1115&lt;br&gt;Sunrise, FL 33345-9011&lt;br&gt;1-866-897-9863&lt;br&gt;954-898-3200 Fax&lt;br&gt;www.visithealthplan.com</td>
<td><strong>SHANDS JAX D/B/A FIRST COAST ADVANTAGE</strong>&lt;br&gt;580 West 8th Street, Suite 70&lt;br&gt;Jacksonville, FL 32209&lt;br&gt;904-444-9016&lt;br&gt;904-244-0400 Fax&lt;br&gt;www.firstcoastadvantage.com</td>
<td><strong>ACCESS HEALTH SOLUTIONS</strong>&lt;br&gt;400 Sawgrass Corporate Parkway, Suite 100&lt;br&gt;Sunrise, FL 33325&lt;br&gt;1-866-291-6171&lt;br&gt;1-866-851-4330 Fax&lt;br&gt;www.accessmsps.com</td>
</tr>
<tr>
<td><strong>HUMANA FAMILY</strong>&lt;br&gt;3501 SW 16th Avenue&lt;br&gt;Miramar, FL 33027&lt;br&gt;1-800-867-5823&lt;br&gt;1-877-258-5904 Fax</td>
<td><strong>TOTAL HEALTH CHOICE</strong>&lt;br&gt;8201 SW 137 Avenue, Suite 200&lt;br&gt;Miami, FL 33183&lt;br&gt;1-800-273-1100&lt;br&gt;305-208-3033 Fax&lt;br&gt;www.totalhealthchoiceonline.com</td>
<td><strong>PREFERRED MEDICAL, INC.</strong>&lt;br&gt;4950 SW 8th Street&lt;br&gt;Coral Gables, FL 33144&lt;br&gt;1-888-790-9990&lt;br&gt;385-684-9094 Fax&lt;br&gt;www.preferredmed.com</td>
</tr>
<tr>
<td><strong>VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.</strong>&lt;br&gt;P.O. Box 99-9011 MS SR1115&lt;br&gt;Sunrise, FL 33345-9011&lt;br&gt;1-866-957-3136&lt;br&gt;954-898-3200 Fax&lt;br&gt;www.visithealthplan.com</td>
<td><strong>FREEDOM HEALTH PLAN</strong>&lt;br&gt;P.O. Box 158267&lt;br&gt;Tampa, FL 33684&lt;br&gt;1-888-790-9990&lt;br&gt;727-471-2096 Fax&lt;br&gt;www.freedominhealth.com</td>
<td><strong>CMS NORTHERN FLORIDA, INC.</strong>&lt;br&gt;9000 North Point Road, Suite 100&lt;br&gt;Tallahassee, FL 32305&lt;br&gt;1-866-376-2466&lt;br&gt;352-955-6618 Fax&lt;br&gt;<a href="http://pedicare.peds.ufl.edu">http://pedicare.peds.ufl.edu</a></td>
</tr>
<tr>
<td><strong>PREFERRED MEDICAL, INC.</strong>&lt;br&gt;9501 SW 9th Street&lt;br&gt;Coral Gables, FL 33144&lt;br&gt;1-800-762-5531 or 305-447-8373&lt;br&gt;385-684-9094 Fax&lt;br&gt;www.preferredmed.com</td>
<td><strong>CMS BROWARD</strong>&lt;br&gt;1525 NW 167th Street, Suite 103&lt;br&gt;Miami, FL 33169&lt;br&gt;1-866-209-5022</td>
<td><strong>CMS NORTHERN FLORIDA, INC.</strong>&lt;br&gt;1101 SW 16th Avenue, Building A&lt;br&gt;Gainesville, FL 32608&lt;br&gt;1-866-376-2466&lt;br&gt;352-955-6618 Fax&lt;br&gt;<a href="http://pedicare.peds.ufl.edu">http://pedicare.peds.ufl.edu</a></td>
</tr>
<tr>
<td><strong>SOUTH FLORIDA COMMUNITY CARE NETWORK</strong>&lt;br&gt;1525 NW 167th Street, Suite 103&lt;br&gt;Miami, FL 33169&lt;br&gt;1-866-897-4826&lt;br&gt;North Broward Hospital District&lt;br&gt;954-762-8100 Fax&lt;br&gt;www.sffcn.org</td>
<td><strong>CMS DUVAL/PED-CARE</strong>&lt;br&gt;1101 SW 16th Avenue, Building A&lt;br&gt;Gainesville, FL 32608&lt;br&gt;1-866-376-2466&lt;br&gt;352-955-6618 Fax&lt;br&gt;<a href="http://pedicare.peds.ufl.edu">http://pedicare.peds.ufl.edu</a></td>
<td><strong>CMS NORTHERN FLORIDA, INC.</strong>&lt;br&gt;9000 North Point Road, Suite 100&lt;br&gt;Tallahassee, FL 32305&lt;br&gt;1-866-376-2466&lt;br&gt;352-955-6618 Fax&lt;br&gt;<a href="http://pedicare.peds.ufl.edu">http://pedicare.peds.ufl.edu</a></td>
</tr>
</tbody>
</table>

**Broward/Duval**

**HEALTHSEAS**<br>P.O. Box 31370<br>Tampa, FL 33682-3370<br>1-800-278-0656<br>813-262-2802 Fax<br>www.wellcasu.com

**STAYWELL**<br>P.O. Box 31370<br>Tampa, FL 33682-3370<br>1-866-334-7927<br>813-262-2802 Fax<br>www.wellcasu.com

**UNIVERSAL HEALTH CARE**<br>150 2nd Avenue North, Suite 400<br>St. Petersburg, FL 33701<br>1-866-690-8842<br>727-827-3556 Fax<br>www.univhc.com

12/2007
Authorization for Release of Medical Information

Primary Care Physician request release of Enrollee’s medical record, when medically necessary.

To Simply Healthcare Plans Care, Inc,

I, __________________________________________ authorize/ do not authorize (Member Name) (Circle one)

(Primary Care Provider)

To release an initial summary and progress notes on my health condition to my behavioral healthcare, substance abuse treatment, or other medical or clinical information. I also know that this authorization allows setting up a continuing plan of care and information to be released to my behavioral healthcare provider and to Simply Healthcare Plans or its designee as may be needed to administer my healthcare coverage.

I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I also understand that I may cancel this authorization at any time by written notice to the above named treatment provider and Simply Healthcare Plans, Inc.

SIGNATURE: _______________________________ DATE: __________________

(If minor, signature of parents or guardian)

WITNESS: _______________________________ DATE: __________________
F. MEDICAID REFORM DEFINITIONS AND ACRONYMS

1. **Abandoned Call** — A call in which the caller elects an option and is either not permitted access to that option or disconnects from the system.

2. **Abuse** — Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program.

3. **Action** — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure of the HMO to act within ninety (90) days from the date the HMO receives a Grievance, or 45 days from the date the HMO receives an Appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network.

4. **Advance Directive** — A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

5. **Advanced Registered Nurse Practitioner (ARNP)** — A licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.


7. **Agent** — An entity that contracts with the State to perform administrative functions, including but not limited to: Fiscal Agent activities; outreach and education, eligibility and Enrollment activities; Systems and Technical support.

8. **Ancillary Provider** — A Provider of ancillary medical services who has contracted with a HMO to provide ancillary medical services to the HMO's Enrollees.

9. **Authoritative Host:** — A system that contains the master or “authoritative” data for a particular data type, e.g. Enrollee, Provider, HMO, etc. The Authoritative Host may feed data from its master data files to other systems in real time or in batch mode. Data in an Authoritative Host is expected to be, or 45 days from the date the HMO receives an Appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network.

10. **Automatic Assignment (or Auto-Assign)** — The Enrollment of an eligible Medicaid Recipient, for whom Enrollment is mandatory, in a Health Plan chosen by AHCA or its Agent, and/or the assignment of a new Enrollee to a PCP chosen by the Health Plan.
11. **Appeal** — A request for review of an Action, pursuant to 42 CFR 438.400(b).

12. **Baker Act** — The Florida Mental Health Act, pursuant to Sections 394.479 through 394.484, Florida Statutes.


14. **Behavioral Health Care Case Manager** — An individual who provides mental health care Case Management services directly to or on behalf of an Enrollee on an individual basis in accordance with 65E-15, F.A.C., and the Medicaid Targeted Case Management Handbook.

15. **Behavioral Health Care Provider** — A licensed mental health professional, such as a "Clinical Psychologist," or registered nurse qualified due to training or competency in mental health care, who is responsible for the provision of mental health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide Behavioral Health Services to Enrollees.

16. **Subscriber Assistance Program** — An external grievance program, similar to the Beneficiary Assistance Program, available to Medicaid Reform recipients that will allow an additional avenue to resolve a grievance.

17. **Benefits** — A schedule of health care services to be delivered to Enrollees covered by the HMO as set forth in Section V and Section VI of this Contract.

18. **Blocked Call** — A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up behind a defined threshold.

19. **Business Days** — Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded.

20. **Calendar Days** — All seven (7) days of the week.

21. **Capitation Rate** — The per member per month amount, including any adjustments, that is paid by the Agency to a capitated HMO or Health Plan for each Medicaid Recipient enrolled under a contract for the provision of Medicaid services during the payment period.
22. **Case Management** — A process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an Enrollee's health needs using communication and all available resources to promote quality cost-effective outcomes. Proper Case Management occurs across a continuum of care, addressing the ongoing individual needs of an Enrollee rather than being restricted to a single practice setting.

23. **Cause** — Special reasons that allow Mandatory Enrollees to change their Health Plan option outside their Open Enrollment period. May also be referred to as "Good Cause."

24. **Centers for Medicare & Medicaid Services (CMS)** — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children's Health Insurance Program under Title XXI of the Social Security Act.

25. **Certification** — The process of determining that a facility, equipment or an individual meets the requirements of federal or State law, or whether Medicaid payments are appropriate or shall be made in certain situations.

26. **Child Health Check-Up Program (CHCUP)** — A comprehensive and preventative health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in Children/Adolescents. Policies and procedures are described in the Child Health Check-Up Services Coverage and Limitations Handbook.

27. **Children/Adolescents** — Enrollees under the age of 21.

28. **Children & Families Services Program Office** — Also referred to as the Children & Families Safety & Preservation Program Office, located in the DCF; the State agency responsible for overseeing programs that identify and protect abused and neglected Children and attempt to prevent domestic violence.

29. **Choice Counselor/Enrollment Broker** — The State’s contracted or designated entity that performs functions related to outreach, education, counseling, Enrollment, and Disenrollment of Potential Enrollees into a Health Plan.

30. **Choice Counseling Specialists** — Certified individuals authorized by an Agency-approved process who provide one-on-one information to Medicaid Recipients, to assist the Medicaid Recipients in choosing the Health Plan that best meets their health care needs, and those of their family.

31. **Cold Call Marketing** — Any unsolicited personal contact with a Medicaid Recipient by the HMO, its staff, its volunteers or its vendors with the purpose of influencing the Medicaid Recipient to enroll in the HMO or either to not enroll in, or disenroll from, another Health Plan.
32. **Continuous Quality Improvement** — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

33. **Contract** — The agreement between the HMO and the Agency to provide Medicaid services to Enrollees, comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

34. **Contracting Officer** — The Secretary of the Agency or his/her delegate.

35. **Cost Effective** — The HMO’s per-member, per-month costs to the State, including, but not limited to, FFS costs, administrative costs, and case-management fees, must be no greater than the State’s costs associated with capitated Health Plans.

36. **County Health Department (CHD)** — CHDs are organizations administered by the Department of Health for the purpose of providing health services as defined in Chapter 154, F.S., which include the promotion of the public’s health, the control and eradication of preventable diseases, and the provision of primary health care for special populations.

37. **Coverage & Limitations Handbook (Handbook)** — A document that provides information to a Medicaid Provider regarding Enrollee eligibility, claims submission and processing, Provider participation, covered care, goods and services, limitations, procedure codes and fees, and other matters related to participation in the Medicaid program.

38. **Covered Services** — Those services provided by the HMO in accordance with this Contract, and as outlined in Section V Covered Services and Section VI Behavioral Health Care in this Contract.

39. **Crisis Support** — Services for persons initially perceived to need emergency mental health services, but upon assessment, do not meet the criteria for such emergency care. These are acute care services that are available twenty-four (24) hours a day, seven (7) days a week, for intervention. Examples include: mobile crisis, crisis/emergency screening, crisis hot-line and emergency walk-in.

40. **Direct Ownership Interest** — The ownership of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicaid provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid, or health related services under the social services program.

41. **Direct Service Behavioral Health Care Provider** — An individual qualified by training or experience to provide direct behavioral health services under the supervision of the HMO's medical director.
42. **Disease Management** — A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease Management supports the physician or practitioner/patient relationship and plan of care; emphasized prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

43. **Disenrollment** — The Agency approved discontinuance of an Enrollee’s Enrollment in a HMO.

44. **Disclosing Entities** — A Medicaid provider, other than an individual practitioner or group of practitioners, or a fiscal agent.

45. **Downward Substitution of Care** — The use of less restrictive, lower cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in an Enrollee’s plan of treatment, provided as an alternative to higher cost services. For services related to mental health, Downward Substitution of Care may include care provided by private practice psychologists and social workers, psycho-social rehabilitation, Medicaid community mental health services or Medicaid mental health targeted Case Management, and other services considered clinically appropriate, more cost-effective and less restrictive.

46. **Durable Medical Equipment (DME)** — Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the Enrollee’s home.

47. **Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)** See Child Health Check Up Program.

48. **Emergency Behavioral Health Services** — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination, and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

49. **Emergency Medical Condition** — 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 jeopardy to the health of a patient, including a pregnant woman or fetus;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

(a) With respect to a pregnant woman:
- That there is inadequate time to affect safe transfer to another Hospital prior to delivery;
- That a transfer may pose a threat to the health and safety of the patient or fetus;
- That there is evidence of the onset and persistence of uterine contractions or rupture other membranes, Section 395.002.F.S.

50. **Emergency Services and Care** — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services and Care includes the care or treatment that is necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the facility.

51. **Enhanced Benefit** — An activity or behavior identified by the State as beneficial to the health of an individual and designated to earn a credit in the Enhanced Benefit Program.

52. **Enhanced Benefit Account** — The individual account resulting from an Enrollee earning rewards for healthy behaviors under the Enhanced Benefit Program.

53. **Enhanced Benefit Program** — A program offered through Medicaid Reform whereby Enrollees are rewarded, through individual Enhanced Benefit Accounts, for healthy behaviors.

54. **Enrollee** — A Medicaid Recipient currently enrolled in the HMO.

55. **Enrollment** — The process by which an eligible Medicaid Recipient becomes an Enrollee in a Health Plan.

56. **Enrollee Suicide Attempt** — An act which clearly reflects an attempt by an Enrollee to cause his or her own death, which results in bodily injury requiring medical treatment by a licensed care professional.

57. **Expanded Services** — A HMO covered service for which the HMO receives no direct payment from the Agency.
58. **Expedited Appeal Process** — The process by which the Appeal of an Action is accelerated because the standard time-frame for resolution of the Appeal could seriously jeopardize the Enrollee’s life, health or ability to obtain, maintain or regain maximum function.

59. **External Quality Review (EQR)** — The analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a Health Plan.

60. **External Quality Review Organization (EQRO)** — An organization that meets the competence and independence requirements set forth in federal regulations 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations or both.

61. **Federal Fiscal Year** — The United States government’s fiscal year starts October 1 and ends on September 30.

62. **Federally Qualified Health Center (FQHC)** — An entity that is receiving a grant under section 330 of the Public Health Service Act, as amended (also see Section 1905 (1) (2) (B) of the Social Security Act). FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and mental health services.

63. **Fee-for-Service (FFS)** — A method of making payment by which the Agency sets prices for defined medical or allied care, goods or services.

64. **Fiscal Agent** — Any corporation, or other legal entity, that enters into a contract with the Agency to receive, process and adjudicate claims under the Medicaid program.

65. **Fiscal Year** — The State of Florida’s Fiscal Year starts July 1 and ends on June 30.

66. **Florida Medicaid Management Information System (FMMIS)** — The information system used to process Florida Medicaid claims and payments to Health Plans, and to produce management information and reports relating to the Florida Medicaid program. This system is used to maintain Medicaid eligibility data and provider enrollment data.

67. **Florida Mental Health Act** — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others).

68. **Fraud** — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.
69. **Full-Time Equivalent Position (FTE)** — The equivalent of one (1) full-time employee who works 40 hours per week.

70. **Good Cause** — See Cause.

71. **Grievance** — An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Enrollee's rights.

72. **Grievance Procedure** — The procedure for addressing Enrollee's grievances.

73. **Grievance System** — The system for reviewing and resolving Enrollee Grievances and Appeals. Components must include a Grievance process, an Appeal process and access to the Medicaid Fair Hearing system.

74. **Health Assessment** — A complete health evaluation combining health history, physical assessment and the monitoring of physical and psychological growth and development.

75. **Health Care Professional** — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, Physician Assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, Registered or practical Nurse (including nurse practitioner, clinical nurse specialist, certified Registered Nurse anesthetist and certified nurse midwife), a licensed certified social worker, registered respiratory therapist and certified respiratory therapy technician.

76. **Health Fair** — An event conducted in a setting that is open to the public or segment of the public (such as the "elderly" or "schoolchildren") during which information about health-care services, facilities, research, preventative techniques or other health-care subjects is disseminated. At least two (2) health-related organizations that are not affiliated under common ownership must actively participate in the Health Fair.

77. **Health Maintenance Organization (HMO)** — An organization or entity licensed in accordance with Section 641 of the Florida Statutes or in accordance with the Florida Medicaid State plan definition of an HMO.

78. **Health Plan** — An entity that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of Providers, which deliver services and frequently shares financial risk. For the purposes of this Contract, a Health Plan has also contracted with the Agency to provide Medicaid services under the Florida Medicaid Reform program, and includes health maintenance organizations authorized under chapter 641 of the Florida Statutes, exclusive provider organizations as defined in chapter 627 of the Florida Statutes, health insurers authorized under chapter 624 of the Florida Statutes, and Provider Service Networks as defined in Section 409.912, Florida Statutes.
79. Hospital — A facility licensed in accordance with the provisions of Chapter 395, Florida Statutes or the applicable laws of the state in which the service is furnished.

80. Hospital Services Agreement — The agreement between the HMO and a Hospital to provide medical services to the HMO's Enrollees.

81. Indirect Ownership Interest — Ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of five percent (5%) or more in the disclosing entity. Example: If “A” owns ten percent (10%) of the stock in a corporation that owns eighty percent (80) of the stock of the disclosing entity, “A’s” interest equates to an eight percent (8%) indirect ownership and must be reported.

82. Individuals with Special Health Care Needs — Adults and Children/Adolescents, who face physical, mental or environmental challenges daily that place at risk their health and ability to fully function in society. Factors include individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and Children/Adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

83. Information I Structured Data: - Data that adhere to specific properties and Validation criteria that are stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set;

    Document: Information that does not meet the definition of structured data includes text, files, spreadsheets, electronic messages and images of forms and pictures.

84. Information System(s) — A combination of computing hardware and software that is used in:

   (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or

   (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
85. **Insolvency** — A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceeds its assets.

86. **Licensed** — A facility, equipment, or an individual that has formally met state, county, and local requirements, and has been granted a license by a local, state or federal government entity.

87. **Licensed Practitioner of the Healing Arts** — A psychiatric nurse, Registered Nurse, advanced registered nurse practitioner, Physician Assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

88. **List of Excluded Individuals and Entities (LEIE)** — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal health care programs.

89. **Managed Behavioral Health Organization (MBHO)** — A behavioral health-care delivery system managing quality, utilization and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

90. **Mandatory Assignment** — The process the Agency uses to assign Potential Enrollees to a Health Plan. The Agency automatically assigns those Mandatory Potential Enrollees who did not voluntarily choose a Health Plan.

91. **Mandatory Enrollee** — The categories of eligible beneficiaries who must be enrolled in a Health Plan.

92. **Mandatory Potential Enrollee** — A Medicaid Recipient who is required to enroll in a Health Plan, but has not yet chosen a Health Plan in which to enroll.

93. **Market Area** — The geographic area in which the HMO is authorized to market and/or conduct pre-enrollment activities.

94. **Marketing** — Any activity or communication conducted by or on behalf of any Health Plan to a Medicaid Recipient who is not Enrolled with the Health Plan, that can reasonably be interpreted as intended to influence the Medicaid Recipient to enroll in the particular Health Plan, or either to not enroll in, or disenroll from, another Health Plan.

95. **Marketing Representative** — A person who provides information, pre-enrollment assistance, or otherwise promotes a Health Plan. Marketing Representatives shall be limited to licensed insurance agents.

96. **Medicaid Area** — The specific counties designated by the Agency.
97. **Medicaid** — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations there under, as administered in the State of Florida by the Agency under 409.901 et seq., F.S.

98. **Medicaid Recipient** — Any individual whom DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

99. **Medicaid Reform** — The program resulting from Chapter 409.91211, F.S.

100. **Medical Record** — Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.

101. **Medically Necessary or Medical Necessity** — Services that include medical or allied care, goods or services furnished or ordered to:

   **Meet the following conditions:**

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

102. Medicare — The medical assistance program authorized by Title XVIII of the Social Security Act.

103. Meds AD — Those recipients up to 88% of FPL with assets up to $5,000 for an individual and $6,000 for a couple without Medicare and those with Medicare that are not receiving institutional care, hospice care, or home and community based services.

104. Newborn — A live child born to an Enrollee, who is a member of the HMO.

105. Non-Covered Service — A service that is not a Covered Service/Benefit.

106. Nursing Facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services.

107. Open Enrollment — The sixty (60) day period before the end of an Enrollees Enrollment year, during which an Enrollee may choose to change Health Plans for the following Enrollment year.

108. Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a twenty-four (24) hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

109. Overpayment — Includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

110. Participating Specialist — A physician, licensed to practice medicine in the State of Florida, who contracts with the HMO to provide specialized medical services to the HMO’s Enrollees.

111. Peer Review — An evaluation of the professional practices of a provider by the provider’s peers in order to assess the necessity, appropriateness and quality of care furnished as such care is compared to that customarily furnished by the provider’s peers and to recognized health care standards.

112. Penultimate Saturday — The Saturday preceding the last Saturday of the month.

113. Penultimate Sunday — The Sunday preceding the last Sunday of the month.
114. **Pharmacy Benefits Administrator** — An entity contracted to or included in a health plan accepting pharmacy prescription claims for enrollees in the plan, assuring these claims conform to coverage policy and determining the allowed payment.

115. **Physician's Assistant** — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.


117. **Portable X-Ray Equipment** — X-ray equipment transported to a setting other than a hospital, Clinic or office of a physician or other Licensed Practitioner of the Healing Arts.

118. **Post-Stabilization Care Services** — Covered Services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized in order to maintain the condition, or to improve or resolve the Enrollees condition pursuant to 42 CFR 422.113.

119. **Potential Enrollee** — Pursuant to 42 CFR 438.10(a), an eligible Medicaid Recipient who is subject to Mandatory Assignment or may voluntarily elect to enroll in a given Health Plan, but is not yet an Enrollee of a specific Health Plan.

120. **Pre-Enrollment** — The provision of Marketing and educational materials to a Medicaid Recipient and assistance in completing the Request for Benefit Information (RBI).

121. **Pre-Enrollment Application** — See Request for Benefit Information.

122. **Prepaid Health Plan** — A Health Plan reimbursed on a prepaid basis.

123. **Primary Care** — Comprehensive, coordinated and readily-accessible medical care including: health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

124. **Primary Care Case Management** — The provision or arrangement of Enrollees' primary care and the referral of Enrollees for other necessary medical services on a 24-hour basis.

125. **Primary Care Provider (PCP)** — A HMO staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioners, physician assistants or other specialty approved by the Agency, who furnishes Primary Care and patient management services to an Enrollee.
126. **Prior Authorization** — The act of authorizing specific services before they are rendered.

127. **Protocols** — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

128. **Provider** — A person or entity that has a Medicaid Provider agreement in effect with the Agency, and a contractual agreement with the HMO.

129. **Provider Contract** — An agreement between the HMO and a health care Provider as described above.

130. **Provider Service Network** — A network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

131. **Public Event** — An event sponsored for the public or segment of the public by two (2) or more actively participating organizations, one (1) of which may be a health organization.

132. **Quality** — The degree to which a Health Plan increases the likelihood of desired health outcomes of its Enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

133. **Quality Enhancements** — Certain health-related, community-based services that the Health Plan must offer and coordinate access to for its Enrollees, such as children's programs, domestic violence classes, pregnancy prevention, smoking cessation, or substance abuse programs. Health Plans are not reimbursed by the Agency for these types of services.

134. **Quality Improvement (QI)** — The process of monitoring and assuring that the delivery of health care services are available, accessible, timely, Medically Necessary, and provided in sufficient quantity, of acceptable Quality, within established standards of excellence, and appropriate for meeting the needs of the Enrollees.
135. **Quality Improvement Program (QIP)** — The process of assuring the delivery of health care is appropriate, timely, accessible, available and Medically Necessary.

136. **Registered Nurse (RN)** — An individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

137. **Request for Benefit Information (RBI)** — The form completed by a Potential Enrollee with the assistance of a Health Plan representative and submitted by the Health Plan to the Choice Counselor/Enrollment Broker to initiate the receipt of information for the Enrollment process; also known as Pre-Enrollment Application.

138. **Residential Services** — As applied to DJJ, refers to the out-of-home placement for use in a level 4, 6, 8 or 10 facility because of a delinquency disposition order; also referred to as a Residential Commitment Program.

139. **Risk Assessment** — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

140. **Rural** — An area with a population density of less than 100 individuals per square mile, or an area defined by the most recent United State Census as rural, i.e. lacking a metropolitan statistical area (MSA).

141. **Rural Health Clinic (RHC)** — A clinic that is located in an area that has a health-care provider shortage. An RHC provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and mental health services. An RHC employs contracts or obtains volunteer services from licensed health care practitioners to provide services.

142. **Sales Activities** — Actions performed by an agent of any Health Plan, including the acceptance of Pre-Enrollment Applications and Requests for Benefit Information, for the purpose of Enrollment of Potential or new Enrollees.

143. **Screen or Screening** — Assessment of an Enrollees physical or mental condition to determine evidence or indications of problems and need for further evaluation or services.

144. **Service Area** — The designated geographical area within which the HMO is authorized by the Contract to furnish Covered Services to Enrollees.

145. **Service Authorization** — The HMO’s approval for services to be rendered. The process of authorization must at least include a HMO Enrollees or a Provider’s request for the provision of a service.

146. **Service Location** — Any location at which an Enrollee obtains any health care service provided by the HMO under the terms of the Contract.
147. **Share of Cost-Savings** — Potential payment to the HMO when amount of the savings pool exceeds the administrative allocation to the HMO as determined through a reconciliation process.

148. **Sick Care** — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

149. **Span of Control** — Information systems and telecommunications capabilities that the HMO itself operates or for which it is otherwise legally responsible according to the terms and Conditions of this Contract. The HMO span of control also includes Systems and telecommunications capabilities outsourced by the HMO.

150. **Special Supplemental Nutrition Program for Women, Infants & Children (WIC)** Program administered by the Department of Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to an Enrollee family that includes a pregnant woman or infant certified eligible to receive Medicaid.

151. **State** — State of Florida.

152. **Subcontract** — An agreement entered into by the HMO for provision of administrative services on its behalf.

153. **Subcontractor** — Any person or entity with which the HMO has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

154. **Surface Mail** — Mail delivery via land, sea, or air, rather than via electronic transmission.

155. **Surplus** — Net worth, i.e., total assets minus total liabilities.

156. **System Unavailability** — As measured within the HMO’s information systems Span of Control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “Enter” or other function key.


158. **Temporary Assistance to Needy Families (TANF)** — Public financial assistance provided to low-income families.
159. **Transportation** — An appropriate means of conveyance furnished to an Enrollee to obtain Medicaid authorized/covered services.

160. **Unborn Activation** — The process by which an unborn child, who has been assigned a Medicaid ID number is made Medicaid eligible upon birth.

161. **Urban** — An area with a population density of greater than 100 individuals per square mile or an area defined by the most recent United State Census as urban, i.e. as having a metropolitan statistical area (MSA).

162. **Urgent Behavioral Health Care** — Those situations that require immediate attention and assessment within twenty-three (23) hours even though the Enrollee is not in immediate danger to himself/herself or others and is able to cooperate in treatment.

163. **Urgent Care** — Services for conditions, which, though not life threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or do substantially restrict an Enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

164. **Validation** — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

165. **Vendor** — An entity submitting a proposal to become a HMO contractor.

166. **Violation** — A determination by the Agency that a Health Plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing Medicaid Health Plans. Each day that an ongoing violation continues shall be considered, for the purposes of this Contract, to be a separate Violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to Enrollees shall be considered, for purposes of this Contract, to be a separate Violation. As well, each day that a Health Plan fails to furnish necessary and/or required medical services or items to Enrollees shall be considered, for purposes of this Contract, to be a separate Violation.

167. **Voluntary Enrollee** — An Enrollee that is not mandated to enroll in a Health Plan, but chooses to enroll in a Health Plan.

168. **Voluntary Potential Enrollee** — A Potential Enrollee that is not mandated to enroll in a Health Plan, and is not yet Enrolled in a Health Plan.

169. **Well Care Visit** — A routine medical visit for one (1) of the following: CHCUP visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness.
ACRONYMS

ADL    Activities of Daily Living
ADM    Alcohol, Drug Abuse & Mental Health Office of the Florida Department of
       Children & Families (aka SAMH — listed below)
ALF    Assisted Living Facility
APD    Agency for People with Disabilities
BBA    Balanced Budget Act of 1997
CAP    Corrective Action Plan
CARES  Comprehensive Assessment & Review for Long-Term Care Services
CDC    Centers for Disease Control
CHD    County Health Department
CMS    Centers for Medicare & Medicaid Services
CFR    Code of Federal Regulations
CHCUP  Child Health Check-Up Program
CPT    Physicians’ Current Procedural Terminology
DCF    Department of Children & Families
DFS    Department of Financial Services
DHHS   United States Department of Health & Human Services
DOH    Department of Health
DJJ    Department of Juvenile Justice
DEA    Drug Enforcement Administration
DME    Durable Medical Equipment
EDI    Electronic Data Interchange
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDT</td>
<td>Eastern Daylight Time</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis &amp; Treatment Program</td>
</tr>
<tr>
<td>EQR</td>
<td>External Quality Review</td>
</tr>
<tr>
<td>EQRO</td>
<td>External Quality Review Organization</td>
</tr>
<tr>
<td>EST</td>
<td>Eastern Standard Time</td>
</tr>
<tr>
<td>FAC</td>
<td>Florida Administrative Code</td>
</tr>
<tr>
<td>FARS</td>
<td>Functional Assessment Rating Scale</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-For-Service</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent Position</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Health Plan Employer Data and Information Set</td>
</tr>
<tr>
<td>HIPPA</td>
<td>Health Insurance Portability &amp; Accountability Act</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>HSA</td>
<td>Hernandez Settlement Agreement</td>
</tr>
<tr>
<td>IBNR</td>
<td>Incurred but not reported</td>
</tr>
<tr>
<td>LEIE</td>
<td>List of Excluded Individuals &amp; Entities</td>
</tr>
<tr>
<td>MBHO</td>
<td>Managed Behavioral Health Organization</td>
</tr>
<tr>
<td>MPI</td>
<td>The Agency’s Bureau of Medicaid Program Integrity</td>
</tr>
<tr>
<td>ODBC</td>
<td>Open Database Connectivity</td>
</tr>
<tr>
<td>PCCB</td>
<td>Per capita capitation benchmark</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>PIP</td>
<td>Performance Improvement Plan</td>
</tr>
<tr>
<td>HMO</td>
<td>Provider Service Network</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality Improvement Program</td>
</tr>
<tr>
<td>RBI</td>
<td>Request for Benefit Information</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposal</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>SAMH</td>
<td>Alcohol, Drug Abuse &amp; Mental Office of the Florida Department of Children &amp; Families (aka ADM- listed above)</td>
</tr>
<tr>
<td>SFTP</td>
<td>Secure File Transfer Protocol</td>
</tr>
<tr>
<td>SIPP</td>
<td>Statewide Inpatient Psychiatric Program</td>
</tr>
<tr>
<td>SOBRA</td>
<td>Sixth Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>SQL</td>
<td>Structured Query Language</td>
</tr>
<tr>
<td>TGCS</td>
<td>Therapeutic Group Care Services</td>
</tr>
<tr>
<td>UM</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>WIC</td>
<td>Special Supplemental Nutrition Program for Women, Infants &amp; Children</td>
</tr>
</tbody>
</table>
H. 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 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 ongoing 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 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.
- See Provider Manual for other related information.
I. 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.