Provider Manual
Florida Statewide Medicaid Managed Care
Managed Medical Assistance and Florida Healthy Kids

Provider Services: 1-844-405-4296
www.simplyhealthcareplans.com/provider
www.clearhealthalliance.com/provider

Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Medicaid contract. Clear Health Alliance is a Managed Care Plan with a Florida Medicaid contract. Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members. AIM Specialty Health is a separate company providing utilization review services on behalf of Simply Healthcare Plans, Inc.

SFL-PM-0001-18
How to apply for participation
If you’re interested in applying for participation with Simply, please visit
http://www.simplyhealthcareplans.com/provider or www.clearhealthalliance.com/provider, or call our Provider Services team at 1-844-405-4296.
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1 INTRODUCTION

Welcome
Simply Healthcare Plans, Inc. and Clear Health Alliance (Simply) would like to welcome you to the Florida Statewide Medicaid Managed Care and Florida Healthy Kids provider network family. We are pleased you joined our network, which represents some of the finest providers in the country.

We bring the best expertise available nationally to operate local, community-based health care plans with experienced local staff to complement our operations. We are committed to helping you provide quality care and services to our members.

We believe hospitals, physicians and other providers play a pivotal role in managed care, and we can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. All network providers are contracted with Simply through a Participating Provider Agreement.

Note: This manual provides standards for services to Simply and Clear Health Alliance members enrolled in the Medicaid Managed Care, Medicaid Specialty Plan and Florida Healthy Kids programs. If a section of the manual applies only to a specific program, that program will be indicated. If there is no such indication, the information is applicable to all programs.

This provider manual does not apply to members of the Medicare Advantage or the SMMC Long-Term Care (LTC) program. For more information about providing services to Medicare Advantage members, call 1-866-805-4589. For more information about providing services to LTC members, call 1-877-440-3738.

The LTC provider manual is posted online at www.simplyhealthcareplans.com/provider.

Updates and Changes
The most updated version of this provider manual is available online at www.simplyhealthcareplans.com/provider or www.clearhealthalliance.com/provider. To request a printed copy of this manual at no cost, call Provider Services at 1-844-405-4296, and we’ll be happy to send you a copy.

The provider manual, as part of your Participating Provider Agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the agreement between you or your facility and Simply, the agreement shall govern.

In the event of a material change to the provider manual, we will make all reasonable efforts to notify you in advance of the change through web-posted newsletters, fax communications and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications including but not limited to bulletins and newsletters.
2 OVERVIEW

Who Is Simply?
As a leader in managed health care services for the public sector, we provide health care coverage exclusively to low-income families, children and pregnant women. We participate in the Florida Healthy Kids, Statewide Medicaid Managed Care (SMMC) Long-Term Care, SMMC Managed Medical Assistance programs, and Clear Health Alliance. Clear Health Alliance is a Medicaid specialty plan for people living with HIV/AIDS. References to Simply in this manual include Clear Health Alliance unless otherwise indicated.

Mission
Together, we are transforming health care with trusted and caring solutions.

Strategy
Our strategy is to:
- Improve access to preventive primary care services by ensuring the selection of a primary care physician who will serve as provider, care manager and coordinator for all basic medical services.
- Improve the health status and outcomes of members.
- Educate members about their benefits, responsibilities and the appropriate use of health care services.
- Encourage stable, long-term relationships between providers and members.
- Discourage medically inappropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral health care.
- Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

Summary
The Florida legislature created a new program called Statewide Medicaid Managed Care (SMMC). As a result, the Agency for Health Care Administration (AHCA) has changed how some individuals receive health care from the Florida Medicaid program. Two components make up the SMMC program:
- The Florida Managed Medical Assistance (MMA) and specialty program
- The Florida Long-Term Care (LTC) Managed Care program

The goals of the MMA program are to provide:
- Coordinated health care across different health care settings.
- A choice of the best-managed care plans to meet recipients’ needs.
- The ability for health care plans to offer different, or more, services.
- The opportunity for recipients to become more involved in their health care.

The goals of the LTC program are to:
- Provide coordinated LTC services to members across different residential living settings.
- Enable members to remain in their homes through the provision of home-based services or in alternative placement, such as assisted living facilities.

For more information on the LTC program, please refer to our LTC provider manual at www.simplyhealthcareplans.com/provider.
The MMA program was implemented in all Florida regions on August 1, 2014. These changes are not due to national health care reform or the Affordable Care Act. Medicaid recipients who qualify and are enrolled in the MMA program will receive all health care services other than long-term care through a managed care plan.

In 1990, the state of Florida created the Florida Healthy Kids Corporation, a nonprofit organization, to administer the Florida Healthy Kids program. Through this program, parents can get affordable health care coverage for eligible children ages 5 through 18.
3  QUICK REFERENCE INFORMATION

Call Provider Services for precertification/notification, network information, member eligibility, claims information, inquiries, and recommendations you may have about improving our processes and/or managed care program.

Simply Phone Numbers

<table>
<thead>
<tr>
<th>Department/Function</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Provider Services</td>
<td>1-844-405-4296 (phone)</td>
</tr>
<tr>
<td></td>
<td>1-800-964-3627 (fax)</td>
</tr>
<tr>
<td>TTY number</td>
<td>711</td>
</tr>
<tr>
<td>Automated Provider Inquiry Line for Member Eligibility</td>
<td>1-844-405-4296</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI) Hotline</td>
<td>1-800-590-5745</td>
</tr>
<tr>
<td>Member Services (including the 24/7 NurseLine)</td>
<td>Medicaid: 1-844-406-2396 (TTY 711)</td>
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<td></td>
<td>FHK: 1-844-405-4298 (TTY 711)</td>
</tr>
<tr>
<td></td>
<td>Clear Health Alliance: 1-844-406-2398 (TTY 711)</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>1-844-405-4296</td>
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Other Telephone Numbers

<table>
<thead>
<tr>
<th>Organization/Program</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>eyeQuest (vision)</td>
<td>1-888-696-9551</td>
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<tr>
<td>Beacon Health (behavioral health services)</td>
<td>1-844-280-9633 for Clear Health Alliance</td>
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<tr>
<td></td>
<td>1-844-375-7215 for MMA</td>
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<tr>
<td>20/20 Hearing Care Network, Inc.</td>
<td>1-877-393-2272</td>
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<tr>
<td>Vaccines for Children (for MMA only)</td>
<td>1-800-483-2543</td>
</tr>
<tr>
<td>Immunization Registry (SHOTS)</td>
<td>1-877-888-SHOT (1-877-888-7468)</td>
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<tr>
<td>It's Great to Wait Pregnancy Prevention Program</td>
<td>1-866-232-3309</td>
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<tr>
<td>Healthy Start Program</td>
<td>1-800-541-BABY (toll free)</td>
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<td></td>
<td>1-386-758-1135 (or the local health department)</td>
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<tr>
<td>Women, Infants, and Children and Nutritional Service</td>
<td>1-800-342-3556</td>
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<tr>
<td>Florida Quiltine (smoking cessation)</td>
<td>1-877-U-CAN-NOW (1-877-822-6669)</td>
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<tr>
<td>eviCore Healthcare (radiology authorization)</td>
<td>1-727-319-6199</td>
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<tr>
<td>Express Scripts (pharmacy benefit manager)</td>
<td>1-800-824-0898</td>
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<td>LabCorp</td>
<td>1-800-877-5227</td>
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<tr>
<td>Elder Abuse Hotline</td>
<td>1-800-96-ABUSE (1-800-962-2873)</td>
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<tr>
<td>LogistiCare (transportation)</td>
<td>1-866-372-9794</td>
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<tr>
<td>Health Network One</td>
<td>1-888-550-8800</td>
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Simply Provider Websites

Visit our websites at www.simplyhealthcareplans.com/provider or www.clearhealthalliance.com/provider for the full complement of online provider resources. They feature online provider inquiry tools for real-time information about member eligibility, prior authorization requirements, claims status, claims resubmission and claims disputes. You can also submit demographic changes and provider rosters.

In addition, the websites have other resources and materials to help you work with us, including provider forms, a Preferred Drug List, a list of drugs requiring prior authorization, provider manuals, referral directories, a
Provider newsletter, electronic remittance advice and electronic funds transfer information, updates, and clinical practice guidelines.

**Provider Experience Program**

To thank you for the quality of care you give our members, we work to continuously increase service quality for you. Our Provider Experience program, focused on claims payment and issue resolution, does just that! **Call 1-844-405-4296 with claims payment questions or issues.** The Provider Experience program support model connects you with a dedicated resource team to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact and issue-resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communications to keep you informed of your inquiry status.

Our representatives are available Monday to Friday, 8 a.m. to 7 p.m. ET (excluding state holidays). Additional staff is available after-hours for authorization inquiries and requests.

**Ongoing Provider Communications**

To ensure you are up-to-date with information required to work effectively with us and our members, we provide frequent communications in the form of faxes, provider manual updates, newsletters and information posted to the website.

The additional information below will help you in your day-to-day interactions with Simply.

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<tr>
<th>Department/Function</th>
<th>Additional Details</th>
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<tr>
<td><strong>Member Eligibility</strong></td>
<td>Contact the Provider Inquiry Line at <strong>1-844-405-4296</strong> or visit our provider websites.</td>
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<tr>
<td><strong>Member Enrollment/Disenrollment</strong></td>
<td>Medicaid recipients can enroll in Simply online at <a href="http://www.flmedicaidmanagedcare.com">www.flmedicaidmanagedcare.com</a> or by calling <strong>1-877-711-3662</strong> (TTY <strong>1-866-467-4970</strong>). Florida Healthy Kids members should contact the Florida Healthy Kids Corporation at <strong>1-800-821-5437</strong>.</td>
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<td><strong>Notification/Precertification</strong></td>
<td>Precertification requests may be submitted:</td>
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<td>• Online: <a href="http://www.simplyhealthcareplans.com">www.simplyhealthcareplans.com</a> or <a href="http://www.clearhealthalliance.com/provider">www.clearhealthalliance.com/provider</a> (for fastest processing)</td>
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<td>• By phone: <strong>1-844-405-4296</strong></td>
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<td>• By fax: <strong>1-800-964-3627</strong></td>
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<td>The following data is required for complete notification/precertification:</td>
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<td></td>
<td>• Member ID</td>
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<td></td>
<td>• Legible name of referring provider</td>
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<td></td>
<td>• Legible name of individual referred to provider</td>
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<td>• National provider identifier and/or tax ID number</td>
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<td>• Number of visits/services</td>
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<td>• Date(s) of service</td>
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<td>• Diagnosis</td>
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<td>• CPT/HCPCS codes</td>
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<td>Department/Function</td>
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<td>In addition, clinical information is required for precertification. Referral and authorization forms are available on our provider websites.</td>
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<td>Claims Information</td>
<td><strong>Submit paper claims to:</strong>&lt;br&gt;Simply Healthcare Plans, Inc.&lt;br&gt;Florida Claims&lt;br&gt;P.O. Box 61010&lt;br&gt;Virginia Beach, VA 23466-1010</td>
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<td></td>
<td><strong>Electronic claims payer IDs:</strong>&lt;br&gt;○ Availity (formerly THIN)&lt;br&gt;• Simply = SMPL&lt;br&gt;• Clear Health Alliance = CLEAR</td>
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<td>• For EDI assistance, providers may call the EDI hotline at 1-800-590-5745.</td>
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<td>• Timely filing is within six months of the date of service or discharge from an inpatient facility or the date the nonparticipating provider was furnished with the correct name and address of the plan when applicable.</td>
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<td>• For other commercial, non-Medicare-insurer crossover claims, timely filing is 90 days after the final determination of final payer, and is three years for Medicare crossover claims.</td>
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<td>• Simply provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and authorization status, which is available through our provider websites.</td>
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<td>• If you’re unable to access the internet, you may receive claims, eligibility and authorization status over the phone by calling our toll-free, automated Provider Services line at 1-844-405-4296.</td>
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<tr>
<td>Medical Authorizations Appeal Information</td>
<td>• Providers may submit a medical authorizations-related appeal within 45 calendar days from the date of an adverse determination. Within three business days of receipt of a complaint, Simply will notify the provider (verbally or in writing) the complaint has been received and the expected date of resolution. They will:&lt;br&gt;</td>
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<td>• Document why a complaint is unresolved after 15 days of receipt and provide written notice of the status to the provider every 15 days thereafter.</td>
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<td>• Resolve all complaints within 90 days of receipt.</td>
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<td>• Provide written notice of the disposition and basis of the resolution to the provider within three business days of resolution.</td>
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<td><strong>Submit medical appeals to:</strong>&lt;br&gt;Simply Healthcare Plans, Inc.&lt;br&gt;Medical Appeals&lt;br&gt;P.O. Box 62429&lt;br&gt;Virginia Beach, VA 23466-2429</td>
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<tr>
<td>Payment Dispute</td>
<td>• Providers have 90 calendar days from the date of the final determination of the primary payer to file a written complaint for claims issues. Within three business days of receipt of a claim complaint, Simply will notify the provider (verbally or in writing)</td>
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<td>Department/Function</td>
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<td>the complaint has been received and the expected date of resolution. Within fifteen (15) days of receipt of a claim dispute, Simply will provide written notice of the status of the dispute to the Agency and provider. In accordance with Section 641.3155 F.S., Simply will resolve all claims complaints within 60 days of receipts and provide written notice of the disposition and basis of the resolution to the provider within three business days of resolution.</td>
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<tr>
<td>• Our Provider Experience program also helps you with claims payment and issue resolution. Just call <strong>1-844-405-4296</strong> and select the Claims prompt.</td>
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<tr>
<td>• File a payment dispute to: Simply Healthcare Plans, Inc. Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599</td>
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<tr>
<td>Provider grievances that are not related to claims payment should be submitted in writing to: Simply Healthcare Plans, Inc. Grievance and Appeals Team 4200 W. Cypress St., Suite 900 Tampa, FL 33607</td>
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<tr>
<td>• Providers have 45 calendar days from the day of occurrence to file a written grievance.</td>
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<td>• Case managers are available from Monday to Friday, 8 a.m. to 5 p.m. ET.</td>
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<tr>
<td>• For urgent issues, assistance is available after normal business hours, on weekends and on holidays through the Provider Services line at <strong>1-844-405-4296</strong>.</td>
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<tr>
<td>• For Clear Health Alliance case managers, call <strong>1-855-459-1566</strong>.</td>
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<tr>
<td>• For links to the <em>Preferred Drug Lists (PDLs)</em>, pharmacy PA criteria, and pharmacy PA forms, go to the <em>Pharmacy</em> section on our provider websites.</td>
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<tr>
<td>• You can initiate PA requests by:</td>
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<tr>
<td>o Calling the Simply Pharmacy department at <strong>1-877-577-9044</strong></td>
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<tr>
<td>o Faxing completed pharmacy PA forms to Simply at <strong>1-877-577-9045</strong> for retail pharmacy requests and <strong>1-844-509-9862</strong> for medical injectable requests.</td>
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<tr>
<td>o Submitting electronic PA requests through <a href="https://www.availibility.com">https://www.availibility.com</a>.</td>
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4 PRIMARY CARE PHYSICIANS

Primary Care Physicians

The PCP serves as the entry point into the health care system for the member. The PCP must be a physician or network provider/subcontractor who provides or arranges for the complete care of his or her patients, including but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, case management, and maintaining continuity of care. The PCP’s responsibilities include, at a minimum:

- Managing the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid Fee-for-Service.
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients for services that may be available through Fee-for-Service Medicaid.
- Processing patient referrals within three business days of an office visit to ensure timely care;
- Advising members to schedule appointments for services requiring referrals at least one week after the PCP visit to allow for processing.
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Seeing newly enrolled pregnant members within 30 days of enrollment.

The PCP may practice in a solo or group setting or may practice in a clinic (for example, a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC] or outpatient clinic).

Simply encourages enrollees to select a PCP who provides preventive and primary medical care as well as authorization and coordination of all medically necessary specialty services. Members are encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment. For more information on appointment availability standards, see the Access and Availability section.

FQHCs, RHCs and County Health Departments may function as a PCP.

Providers must arrange for coverage of services to assigned members:

- 24 hours a day, 7 days a week, in person or by an on-call physician.
- By answering emergency telephone calls from members within 30 minutes.
- By providing a minimum of 20 office hours per week of personal availability as a PCP.

Provider Specialties

Physicians with the following specialties can apply for enrollment with Simply as a PCP:

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced registered nurses
- Nurse practitioners
- Practitioners certified as specialists in family practice/pediatrics
- FQHCs and RHCs
- Obstetricians/gynecologists (OB/GYNs) (for women when they are pregnant)
- Infectious Disease providers (CHA only)

The provider must be enrolled in the Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with Simply. PCPs must also be registered in the Vaccines for Children (VFC) program and obtain all vaccines for our eligible members through the VFC program. Please note, Title XXI MediKids members are not eligible for vaccines through the VFC program.
A provider must be a board-certified pediatrician, family practitioner or physician extender working under the direct supervision of a board-certified practitioner if he or she wishes to practice as a Florida Healthy Kids PCP (unless granted an exemption by the Florida Healthy Kids Corporation board of directors).

Our primary care network may also include PCPs who: 1) have recently completed a residency program in pediatrics or family practice approved by the National Board for Certification of Training Administrators of Graduate Medical Education programs and 2) are eligible for but have not yet achieved board certification. If a PCP does not achieve board certification within the first three years of initial credentialing, we will remove that provider from our network and reassign members to a board-certified PCP.

All PCPs in our network must provide all covered immunizations to Simply members and be enrolled in the Florida State Health Online Tracking System (SHOTS), the statewide immunization registry.

**Primary Care Physician Onsite Availability**

Simply is dedicated to ensuring access to care for our members, and this depends on the accessibility of network providers. Simply network providers are required to abide by the following standards:

- PCPs must offer telephone access to member 24 hours a day, 7 days a week.
- A 24-hour telephone service may be utilized. The service may be answered by a designee, such as an on-call physician or nurse practitioner with physician backup, an answering service, or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within 30 minutes.
- The PCP or another physician/advanced registered nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the referral/precertification guidelines.
- It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

For more information on access and availability standards, see the **Access and Availability** section.

**Provider Termination/Disenrollment Process**

Providers may cease participation with Simply for either involuntary or voluntary reasons. Involuntary termination occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include illness and/or death. A notice to affected members will be issued immediately upon the health plan becoming aware of the situation.

Providers must give timely notice of voluntary contract termination per the required timeframes in their Simply contracts but not to exceed 90 calendar days. Should a provider cease participation for a voluntary reason such as retirement, a written notice to the affected members will be issued no less than 90 calendar days prior to the effective date of the termination and no more than 10 calendar days after receipt or issuance of the termination notice.

If a member is in a preauthorized, ongoing course of treatment with the provider who suddenly ceases participation as a result of death, illness or Medicaid exclusion, we’ll notify the member in writing within 10 calendar days from the date we become aware of the provider’s network status.
Member Enrollment

Members who meet the state’s eligibility requirements for participation in managed care are eligible to join Simply. Members are enrolled without regard to their health status. Members are enrolled for a period of 12 months, contingent upon continued eligibility.

The member may request disenrollment without cause at any time during the 120 days following the date of the member’s initial enrollment with Simply or with agency approval. Unless the member loses eligibility or submits an oral or a written disenrollment request to change managed care plans for cause, the member remains enrolled in a health plan for the remainder of the 12-month period.

Simply will ensure all written and oral disenrollment requests are promptly referred to Florida Statewide Medicaid Managed Care (SMMC). When we receive a written request, we’ll send a letter notification to the member within three business days that advises to call SMMC enrollment and disenrollment services at 1-877-771-3662 (TTY 1-866-467-4970).

For member enrollment for Florida Healthy Kids, call 1-800-821-KIDS (5437).

Involuntary Disenrollment

Simply may request involuntary disenrollment of a member under the following conditions:

- Member’s Medicaid ID card is fraudulently used.
- Falsification of prescriptions by a member.
- Member takes part in disruptive and abusive behavior not related to a member’s behavioral health condition.

Action related to a request for involuntary disenrollment conditions must be clearly documented in the member’s records and submitted to the local Simply Provider Operations department. The Agency for Health Care Administration (AHCA) will be responsible for reviewing, approving and processing all requests for disenrollments.

The documentation must include attempts to bring the member into compliance. A member’s disruptive and/or abusive behavior resulting in their failure to be in compliance with their treatment plan must be documented prior to submitting a request for involuntary disenrollment to AHCA. The member must have received at least one verbal and one written warning regarding the implications of his or her actions including involuntary disenrollment.

For any action to be taken, it is mandatory that copies of all supporting documentation from the member’s file are submitted with the request.

In addition to the reasons cited in Rule 59G-8.60 (o), F.A.C., if the member is an American Indian or Alaskan Native as defined in 42 CFR 438.14(a), that constitutes a cause for disenrollment.

Simply must be notified before transferring a member out of a physician's practice.

Newborn Enrollment

All providers are responsible for reporting member pregnancies to us to initiate the unborn child’s Medicaid eligibility process and ensure appropriate case management.
Simply is responsible for all Medicaid-eligible newborns of enrolled members. This includes payment of medically necessary services and well-child care for the newborn from the date of his or her birth regardless of the mother’s continued enrollment in the plan (unless the newborn is disenrolled).

For all pregnant members we’re aware of, we’ll submit a request to Department of Children and Families (DCF) for the assignment of an inactive Medicaid ID for the unborn child. When the baby is born, we’ll submit a request to DCF to activate the Medicaid ID to ensure plan enrollment and claims payment. For babies born without a Medicaid ID, we’ll submit a request to DCF for a presumptive eligible newborn Medicaid determination to obtain a Medicaid ID for the baby.

**Members Eligibility Listing**

The PCP can review his or her panel of assigned members online; to receive a listing of assigned panel members by mail on the first day of each month, the PCP must request the list from his or her Provider Relations representative. The list will consist of Simply members who have chosen the PCP’s office to provide services. If a member calls to change his or her PCP, the change will be effective the next business day. The PCP should verify that each Simply member receiving treatment in his or her office is on the membership listing. If a PCP does not receive the listing in a timely manner, he or she should contact a Provider Relations representative. For questions regarding a member’s eligibility, providers can access our provider websites or call the automated Provider Inquiry Line at 1-844-405-4296.

**Member ID Cards**

The ID card identifies the member as a participant in the Simply program. Providers should verify member eligibility and plan enrollment prior to rendering services via the state’s Florida Medicaid Management Information System (FMMIS) and/or the Simply provider portal.

The ID card will include the following:
- The member’s ID number
- The member’s name (first and last names and middle initial)
- The member’s enrollment effective date
- Toll-free phone numbers for information and/or authorizations
- Toll-free 24/7 NurseLine information (accessible 24 hours a day, 7 days a week)
- Descriptions of procedures to be followed to obtain emergency or specialty services
- The PCP’s name, address and telephone number
- Pharmacy claims processing information
- A phone number for nonparticipating providers to access billing information

**Americans with Disabilities Act Requirements**

Simply policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:
- Street-level access.
- An elevator or accessible ramp into facilities.
- Access to a lavatory that accommodates a wheelchair.
- Access to an examination room that accommodates a wheelchair.
- Handicapped parking space(s) that are clearly marked, unless there is street-side parking.

**Medically Necessary Services**

Medically necessary health services mean health services that are:
- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
• Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs.
• Consistent with the generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational.
• Reflective of the level of service where care can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide.
• Furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker or the provider.

For services furnished in a hospital on an inpatient basis, medical necessity means appropriate medical care cannot be effectively given 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, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Continuity of Care: New Members

Simply provides continuation of services until the member’s PCP, or behavioral health provider as applicable, reviews the member’s treatment plan.

We’ll honor any written documentation of prior authorization of ongoing covered services for a period of up to 60 days after the effective date of enrollment or until the member’s PCP (or behavioral health provider, as applicable) reviews the member’s treatment plan, whichever comes first. For all members, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided the services were prearranged prior to enrollment with Simply:
• Prior existing orders
• Provider appointments (i.e., transportation, dental appointments, surgeries, etc.)
• Prescriptions (including prescriptions at nonparticipating pharmacies)
• Prior authorizations
• Treatment plan/plan of care

We won’t delay service authorization if written documentation is not available in a timely manner; however, we’re not required to approve claims for which we haven’t received written documentation.

The following services may extend beyond the 60-day continuity of care period, and we’ll continue the entire course of treatment with the member’s current provider as described below:
• Prenatal and postpartum care — We’ll continue to pay for services provided by a pregnant member’s current provider for the entire course of a pregnancy including the completion of a woman’s postpartum care six weeks after birth regardless of whether the provider is in the Simply network.
• Transplant services — We’ll continue to pay for services provided by the current provider for one year post-transplant regardless of whether the provider is in the Simply network.
• Oncology (radiation and/or chemotherapy services) — We’ll continue to pay for services provided by the current provider for the duration of the current round of treatment regardless of whether the provider is in the Simply network.
• Hepatitis C treatment drugs — We’ll continue to pay for the full course of therapy.

No service will be denied for absence of authorization in circumstances where care was in place prior to the transition date.
The continuity of care provisions stated above apply to both participating and nonparticipating Simply providers.

**Continuity of Care: Provider Termination**

Simply allows members to continue receiving medically necessary services from a non-for-cause terminated provider and will process claims for services rendered to such members, until the member selects another provider, for a minimum of 60 days after termination of the provider contract. For continuity of care services under these circumstances, Simply will continue to abide by the same contract terms in place prior to contract termination.

For members moving enrollment from one Florida Healthy Kids subsidized plan to another Florida Healthy Kids subsidized plan (without a break in coverage), there is a 60-day continuity of care period.
5 SIMPLY HEALTH CARE BENEFITS AND COPAYMENTS

Simply Covered Services

Any modification to covered services will be distributed via a provider update by mail, fax, provider newsletter, provider manual addendum and/or contractual amendment. Covered services include those listed below and may vary by product.

Statewide Medicaid Managed Care services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage/Limitations</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions Receiving Facility Services</td>
<td>As medically necessary and recommended by us.</td>
<td>Required</td>
</tr>
<tr>
<td>Services used to help people who are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>struggling with drug or alcohol addiction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Services</td>
<td>We cover blood or skin allergy testing and up to 156 doses per year of allergy shots.</td>
<td>Not required</td>
</tr>
<tr>
<td>Services to treat conditions such as sneezing</td>
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<tr>
<td>or rashes that are not caused by an illness</td>
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</tr>
<tr>
<td>Ambulance Transportation Services</td>
<td>Covered as medically necessary.</td>
<td>Required for nonemergent transportation services</td>
</tr>
<tr>
<td>Ambulance services are for when members</td>
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<tr>
<td>need emergency care while being transported</td>
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<tr>
<td>to the hospital or special support when</td>
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<tr>
<td>being transported between facilities</td>
<td></td>
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</tr>
<tr>
<td>Ambulatory Detoxification Services</td>
<td>As medically necessary and recommended by us.</td>
<td>Required</td>
</tr>
<tr>
<td>Services provided to people who are</td>
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<tr>
<td>withdrawing from drugs or alcohol</td>
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</tr>
<tr>
<td>Ambulatory Surgical Center Services</td>
<td>Covered as medically necessary.</td>
<td>May be required</td>
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<tr>
<td>Surgery and other procedures that are</td>
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<tr>
<td>performed in a facility that is not the</td>
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<tr>
<td>hospital (outpatient)</td>
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</tr>
<tr>
<td>Anesthesia Services</td>
<td>Covered as medically necessary.</td>
<td>Not required</td>
</tr>
<tr>
<td>Services to keep you from feeling pain</td>
<td></td>
<td></td>
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<tr>
<td>during surgery or other medical procedures</td>
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</tr>
<tr>
<td>Assistive Care Services</td>
<td>We cover 365/366 days of services per year.</td>
<td>Required</td>
</tr>
<tr>
<td>Services provided to adults (ages 18 and</td>
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<tr>
<td>older) help with activities of daily living</td>
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<tr>
<td>and taking medication</td>
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<tr>
<td>Behavioral Health Assessment Services</td>
<td>We cover:</td>
<td>Not required</td>
</tr>
<tr>
<td>Services used to detect or diagnose mental</td>
<td>• One initial assessment per year.</td>
<td></td>
</tr>
<tr>
<td>illnesses and behavioral health disorders</td>
<td>• One reassessment per year.</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Overlay Services</td>
<td>• Up to 150 minutes of brief</td>
<td></td>
</tr>
<tr>
<td>Behavioral health services provided to</td>
<td>behavioral health status assessments (no more than</td>
<td></td>
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<tr>
<td>children (ages 0 to 18) enrolled in a DCF</td>
<td>30 minutes in a single day).</td>
<td></td>
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<tr>
<td>program</td>
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</tbody>
</table>

We cover 365/366 days of services per year, including therapy, support services and aftercare planning | Required |
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage/Limitations</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular Services</strong></td>
<td>We cover the following as prescribed by your doctor:</td>
<td>May be required for cardiac testing and surgical procedures</td>
</tr>
<tr>
<td>Services that treat the heart and circulatory (blood vessels) system</td>
<td>- Cardiac testing &lt;br&gt;- Cardiac surgical procedures &lt;br&gt;- Cardiac devices</td>
<td></td>
</tr>
<tr>
<td><strong>Child Health Services Targeted Case Management</strong></td>
<td>Child must be enrolled in the DOH Early Steps program.</td>
<td>Required</td>
</tr>
<tr>
<td>Services provided to children (ages 0 to 3) to help them get health care and other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>We cover:</td>
<td>Not required</td>
</tr>
<tr>
<td>Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles and organs</td>
<td>- One new patient visit. &lt;br&gt;- 24 established patient visits per year. &lt;br&gt;- Maximum of one visit per day. &lt;br&gt;- X-rays. &lt;br&gt;- Ultrasound or electrical stimulation.</td>
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</tr>
<tr>
<td><strong>Clinic Services</strong></td>
<td></td>
<td>Not required</td>
</tr>
<tr>
<td>Health care services provided in a county health department, federally qualified health center or a rural health clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Florida Medicaid reimburses for services as a result of a recipient participating in a clinical trial in accordance with the service-specific coverage policy when the services:</td>
<td>Required</td>
</tr>
<tr>
<td>Biomedical or behavioral research studies on human participants designed to answer specific questions about biomedical or behavioral interventions including new treatments and known interventions that warrant further study and comparison.</td>
<td>- Are covered under the Florida Medicaid program &lt;br&gt;- Would otherwise be provided to a recipient who is not participating in a clinical trial &lt;br&gt;- Are related to complications or side effects arising during the clinical trial &lt;br&gt;- Are not expected or unique to the experimental or investigational treatment &lt;br&gt;- Are not covered by the clinical trial sponsor</td>
<td></td>
</tr>
<tr>
<td><strong>Community-Based Wrap-Around Services</strong></td>
<td>As medically necessary and recommended by us.</td>
<td>Required</td>
</tr>
<tr>
<td>Services provided by a mental health team to children who are at risk of going into a mental health treatment facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crisis Stabilization Unit Services</strong></td>
<td>As medically necessary and recommended by us.</td>
<td>Not required</td>
</tr>
<tr>
<td>Emergency mental health services that are performed in a facility that is not a regular hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
<td>PA</td>
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</tr>
<tr>
<td><strong>Dialysis Services</strong></td>
<td>Medical care, tests and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys.</td>
<td>As prescribed by a treating doctor, we cover: • Hemodialysis treatments • Peritoneal dialysis treatments</td>
</tr>
<tr>
<td><strong>Drop-In Center Services</strong></td>
<td>Services provided in a center that helps homeless people get treatment or housing</td>
<td>As medically necessary and recommended by us.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment and Medical Supplies Services</strong></td>
<td>Medical equipment is used to manage and treat a condition, illness or injury. Durable medical equipment is used over and over again and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away.</td>
<td>Some service and age limits apply. Call 1-844-406-2396 (TTY 711) for more information.</td>
</tr>
<tr>
<td><strong>Early Intervention Services</strong></td>
<td>Services to children ages 0 to 3 who have developmental delays and other conditions</td>
<td>We cover: • One initial evaluation per lifetime, completed by a team. • Up to three screenings per year. • Up to three follow-up evaluations per year. • Up to two training or support sessions per week.</td>
</tr>
<tr>
<td><strong>Emergency Transportation Services</strong></td>
<td>Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency</td>
<td>Covered as medically necessary.</td>
</tr>
<tr>
<td><strong>Evaluation and Management Services</strong></td>
<td>Services for doctor’s visits to stay healthy and prevent or treat illness</td>
<td>We cover: • One adult health screening (check-up) per year. • Well-child visits, based on age and developmental needs. • One visit per month for people living in nursing facilities. • Up to two office visits per month for adults to treat illnesses or conditions.</td>
</tr>
<tr>
<td><strong>Family Therapy Services</strong></td>
<td>Services for families to have therapy sessions with a mental health professional</td>
<td>We cover up to 26 hours per year of family or individual therapy services, one hour per day.</td>
</tr>
<tr>
<td><strong>Family Training and Counseling for Child Development</strong></td>
<td>As medically necessary and recommended by us.</td>
<td>Required</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
<td>PA</td>
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<td>----------------------------------------------</td>
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</tr>
<tr>
<td><strong>Services to support a family during their child’s mental health treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal Services</strong></td>
<td>Covered as medically necessary.</td>
<td>May be required for diagnostic tests and procedures</td>
</tr>
<tr>
<td>Services to treat conditions, illnesses or diseases of the stomach or digestion system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Genitourinary Services</strong></td>
<td>Covered as medically necessary.</td>
<td>May be required for diagnostic tests and procedures</td>
</tr>
<tr>
<td>Services to treat conditions, illnesses, or diseases of the genitals or urinary system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group Therapy Services</strong></td>
<td>We cover up to 39 hours per year.</td>
<td>Not required</td>
</tr>
<tr>
<td>Services for a group of people to have therapy sessions with a mental health professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>We cover hearing tests and the following as prescribed by a doctor:</td>
<td>Required for cochlear implants and bone anchored hearing aids</td>
</tr>
<tr>
<td>Hearing tests, treatments and supplies that help diagnose or treat problems with hearing. This includes hearing aids and repairs.</td>
<td>- Cochlear implants.</td>
<td></td>
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<tr>
<td></td>
<td>- One new hearing aid per ear, once every three years repairs.</td>
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<tr>
<td></td>
<td>- Up to three pairs of ear molds per year.</td>
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<tr>
<td></td>
<td>- One fitting and dispensing service per ear every three years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- One hearing test every three years to determine the need for hearing aid and the most appropriate hearing aid.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Up to two newborn hearing screenings for recipients under 12 months of age; a second screening may be performed only if the recipient does not pass the first hearing screening in one or both ears.</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td>We cover:</td>
<td>Required</td>
</tr>
<tr>
<td>Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury</td>
<td>- Up to four visits per day for pregnant recipients and recipients ages 0 to 20.</td>
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</tr>
<tr>
<td></td>
<td>- Up to three visits per day for all other recipients.</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
<td>PA</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Hospice Services</strong></td>
<td>Medical care, treatment and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.</td>
<td>Covered as medically necessary.</td>
</tr>
<tr>
<td><strong>Individual Therapy Services</strong></td>
<td>Services for people to have one-to-one therapy sessions with a mental health professional</td>
<td>We cover up to 26 hours per year of family or individual therapy services, one hour per day.</td>
</tr>
<tr>
<td><strong>Infant Mental Health Pre and Post Testing Services</strong></td>
<td>Testing services by a mental health professional with special training in infants and young children</td>
<td>As medically necessary and recommended by us.</td>
</tr>
</tbody>
</table>
| **Inpatient Hospital Services**                  | Medical care members get while in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment used to treat members | We cover the following inpatient hospital services based on age and situation:  
  - Up to 365/366 days for recipients ages 0 to 20.  
  - Up to 45 days for all other recipients (extra days are covered for emergencies). | Required for elective inpatient admissions |
<p>| <strong>Integumentary Services</strong>                       | Services to diagnose or treat skin conditions, illnesses or diseases                  | Covered as medically necessary.       | Requires PCP referral                |
| <strong>Laboratory Services</strong>                          | Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases | Covered as medically necessary.       | Required for genetic testing          |
| <strong>Medical Foster Care Services</strong>                 | Services that help children with health problems who live in foster care homes         | Must be in the custody of the Department of Children and Families. | Required                             |
| <strong>Medication Assisted Treatment Services</strong>       | Services used to help people who are struggling with drug addiction                   | Covered as medically necessary.       | Not required                         |
| <strong>Medication Management Services</strong>               | Services to help people understand and make the best choices for taking medication   | Covered as medically necessary.       | Not required                         |
| <strong>Mental Health Partial Hospitalization Program Services</strong> | Treatment provided for more than three hours per day, several days per week, for people who are recovering from mental illness | As medically necessary and recommended by us. | Required                             |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage/Limitations</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Targeted Case Management</strong></td>
<td>Services to help get medical and behavioral health care for people with mental illnesses</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Covered as medically necessary.</td>
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</tr>
<tr>
<td><strong>Mobile Crisis Assessment and Intervention Services</strong></td>
<td>A team of health care professionals who provide emergency mental health services, usually in people’s homes</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>As medically necessary and recommended by us.</td>
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<tr>
<td><strong>Neurology Services</strong></td>
<td>Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system</td>
<td>May be required for diagnostic tests and procedures</td>
</tr>
<tr>
<td></td>
<td>Covered as medically necessary.</td>
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</tr>
<tr>
<td><strong>Nonemergency Transportation Services</strong></td>
<td>Transportation to and from all medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles</td>
<td>PA is required for out-of-state travel and transfers between hospitals or facilities.</td>
</tr>
<tr>
<td></td>
<td>Through LogistiCare, we cover the following services for recipients who have no other means of transportation: • Out-of-state travel. • Transfers between hospitals or facilities. • Escorts when medically necessary.</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Facility Services</strong></td>
<td>Medical care or nursing care that members get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term.</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>We cover 365/366 days of services in nursing facilities as medically necessary.</td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy Services</strong></td>
<td>Occupational therapy includes treatments that help members do things in their daily life, like writing, feeding themselves, and using items around the house.</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>For children ages 0 to 20 and for adults under the $1,500 outpatient services cap, we cover: • One initial evaluation per year. • Up to 210 minutes of treatment per week. • One initial wheelchair evaluation per five years. • Up to two casting and strapping applications per day. • One therapy re-evaluation every five months. For people of all ages, we cover: • Follow-up wheelchair evaluations, one at delivery and one six months later.</td>
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</tr>
<tr>
<td><strong>Oral Surgery Services</strong></td>
<td>Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Covered as medically necessary.</td>
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<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
<td>PA</td>
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<tr>
<td><strong>Orthopedic Services</strong></td>
<td>Services to diagnose or treat conditions, illnesses or diseases of the bones or joints</td>
<td>Covered as medically necessary.</td>
</tr>
</tbody>
</table>
| **Outpatient Hospital Services**| Medical care members get while in the hospital but not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment used to treat members | • Emergency services are covered as medically necessary.  
• Nonemergency services cannot cost more than $1,500 per year for recipients ages 21 and over. | Required for nonemergency services |
| **Pain Management Services**    | Treatments for long-lasting pain that does not get better after other services have been provided | • Covered as medically necessary. Some service limits may apply.  
• Up to 12 facet joint injections in a six-month period  
• Up to four percutaneous radiofrequency neurolysis in a four-month period | Required |
| **Physical Therapy Services**   | Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition | For children ages 0 to 20 and for adults under the $1,500 outpatient services cap, we cover:  
• One initial evaluation per year.  
• One therapy re-evaluation every five months.  
• Up to two casting and strapping applications per day.  
• Up to 210 minutes of treatment per week.  
• One initial wheelchair evaluation per five years.  
For people of all ages, we cover:  
• Follow-up wheelchair evaluations, one at delivery and one six months later. | Required |
| **Podiatry Services**           | Medical care and other treatments for the feet | We cover:  
• Up to 24 office visits per year.  
• Foot and nail care.  
• X-rays and other imaging for the foot, ankle and lower leg.  
• Surgery on the foot, ankle or lower leg. | Not required |
<table>
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<th>Service</th>
<th>Coverage/Limitations</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescribed Drug Services</strong></td>
<td>We cover:</td>
<td>Authorization required for some drugs</td>
</tr>
</tbody>
</table>
| This service is for drugs that are prescribed by a doctor or other health care provider | • Up to a 31-day supply of drugs, per prescription.  
• Refills, as prescribed.  
• Up to two 72-hour emergency supplies per prescription within 30 consecutive days.                                                                 |                                  |
| **Private Duty Nursing Services**            | We cover up to 24 hours per day.                                                                                                                                                                                        | Required                         |
| Nursing services provided in the home to people ages 0 to 20 who need constant care   |                                                                                                                                              |                                  |
| **Psychological Testing Services**           | We cover 10 hours of psychological testing per year.                                                                                                                                                                   | Required                         |
| Tests used to detect or diagnose problems with memory, IQ or other areas                  |                                                                                                                                              |                                  |
| **Psychosocial Rehabilitation Services**     | We cover up to 480 hours per year.                                                                                                                                                                                      | Required                         |
| Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores. |                                                                                                                                              |                                  |
| **Radiology and Nuclear Medicine Services**  | • Covered as medically necessary.  
• Up to two biophysical profiles per pregnancy.  
• One fetal echocardiography per pregnancy; up to two follow-up tests for high-risk pregnancy.  
• One mammography screening per year.  
• Up to three obstetrical ultrasounds per pregnancy. | May be required                   |
| Services that include imaging such as X-rays, MRIs or CAT scans. They also include portable X-rays. |                                                                                                                                              |                                  |
| **Regional Perinatal Intensive Care Center Services** | Covered as medically necessary.                                                                                                                                                                                        | Not required                     |
| Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions |                                                                                                                                              |                                  |
| **Reproductive Services**                    | We cover family planning services. Members can get these services and supplies from any Medicaid provider; they do not have to be a part of our plan. PA is not required; these services are free. These services are voluntary and confidential, even for members under 18 years old. | Not required                     |
| Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help plan family size. |                                                                                                                                              |                                  |
| **Respiratory Services**                     | We cover:                                                                                                                                                                                                             | May be required for diagnostic tests and procedures |
| Services that treat conditions, illnesses or diseases of the lungs or respiratory system | • Respiratory testing.  
• Respiratory surgical procedures.  
• Respiratory device management.                                                                                                                                     |                                  |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| **Respiratory Therapy Services**                 | Services for recipients ages 0 to 20 to help members breathe better while being treated for a respiratory condition, illness or disease | We cover:  
  • One initial evaluation per year.  
  • One therapy re-evaluation per six months.  
  • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day). | Not required |
| **Self-Help/Peer Services**                      | Services to help people who are in recovery from an addiction or mental illness      | As medically necessary and recommended by us.       | Required     |
| **Specialized Therapeutic Services**             | Services provided to children ages 0 to 20 with mental illnesses or substance use disorders | We cover:  
  • Assessments.  
  • Foster care services.  
  • Group home services. | Required     |
| **Speech-Language Pathology Services**           | Services that include tests and treatments to help members talk or swallow better    | For children ages 0 to 20, we cover:  
  • Communication devices and services.  
  • Up to 210 minutes of treatment per week.  
  • One initial evaluation per year.  
  • One re-evaluation every five months.  

For adults, we cover:  
  • One communication evaluation per five years. | Required     |
| **Statewide Inpatient Psychiatric Program Services** | Services for children with severe mental illnesses that need treatment in the hospital | Covered as medically necessary for children ages 0 to 20. | Required     |
| **Substance Abuse Intensive Outpatient Program Services** | Treatment provided for more than three hours per day, several days per week, for people who are recovering from substance use disorders. | As medically necessary and recommended by us.       | Required     |
| **Substance Abuse Short-term Residential Treatment Services** | Treatment for people who are recovering from substance use disorders. | As medically necessary and recommended by us.       | Required     |
| **Therapeutic Behavioral On-Site Services**      | Services provided by a team to prevent children ages 0 to 20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility. | We cover up to nine hours per month.               | Required     |
## Service

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<thead>
<tr>
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<th>PA</th>
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</thead>
<tbody>
<tr>
<td><strong>Transplant Services</strong></td>
<td>Services that include all surgery and pre- and post-surgical care.</td>
<td>Required</td>
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<tr>
<td></td>
<td>Covered as medically necessary.</td>
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<tr>
<td><strong>Visual Aid Services</strong></td>
<td>Visual aids are items such as glasses, contact lenses and prosthetic (fake) eyes.</td>
<td>May be required for prosthetic devices</td>
</tr>
<tr>
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<td>When prescribed by a doctor, we cover:</td>
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<tr>
<td></td>
<td>- Two pairs of eyeglasses for children ages 0 to 20.</td>
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<tr>
<td></td>
<td>- Contact lenses.</td>
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<tr>
<td></td>
<td>- Prosthetic eyes.</td>
<td></td>
</tr>
<tr>
<td><strong>Visual Care Services</strong></td>
<td>Services that test and treat conditions, illnesses and diseases of the eyes</td>
<td>May be required for procedures and some tests</td>
</tr>
<tr>
<td></td>
<td>Covered as medically necessary.</td>
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</table>

## Florida Healthy Kids Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations</th>
<th>Copays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Services</strong></td>
<td>Simply must authorize all admissions.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>The length of the patient stay is determined based on the medical condition of the member in relation to the necessary and appropriate level of care.</td>
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<tr>
<td></td>
<td>Room and board may be limited to semi-private accommodations unless a private room is considered medically necessary or semi-private accommodations are not available.</td>
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<tr>
<td></td>
<td>Private duty nursing is limited to circumstances where such care is medically necessary.</td>
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<td></td>
<td>Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.</td>
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<tr>
<td></td>
<td>Inpatient services do not include experimental or investigational procedures defined as a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria as determined by Simply:</td>
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<tr>
<td></td>
<td>- Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials.</td>
<td></td>
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<tr>
<td></td>
<td>- Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular patient is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy in comparison to conventional alternatives.</td>
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<tr>
<td></td>
<td>- Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and</td>
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<tr>
<td>Benefit</td>
<td>Limitations</td>
<td>Copays</td>
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<tr>
<td>Benefit defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.</td>
<td>Emergency Services Includes visits to an emergency room or other licensed facility within the U.S. and its territories if needed immediately due to an injury or illness and delay means risk of permanent damage to the member’s health. Covered services also mean inpatient and outpatient services furnished by a qualified provider, per §1932(b)(2) and 42 CFR 438.114(a), and are needed to evaluate or stabilize an emergency medical condition.</td>
<td>$10 per visit; waived if admitted or authorized by PCP</td>
</tr>
<tr>
<td>Maternity Services and Newborn Care Includes maternity and newborn care, prenatal and postnatal care, initial inpatient care of adolescent participants including nursery charges and initial pediatric or neonatal examination</td>
<td>• The infant is covered for up to three days following birth or until the infant is transferred to another medical facility, whichever occurs first. • Coverage may be limited to the fee for vaginal deliveries.</td>
<td>None</td>
</tr>
<tr>
<td>Organ Transplantation Services Includes pretransplant, transplant and postdischarge services and treatment of complications after transplantation</td>
<td>• Coverage is available for transplants and medically related services if deemed necessary and appropriate by the Organ Transplant Advisory Council or the Bone Marrow Transplant Advisory Council as may be applicable.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Services Preventive, diagnostic, therapeutic, palliative care, and other services provided to a</td>
<td>• Services must be provided directly by Simply or through pre-approved referrals. • The PCP must provide the routine hearing screening and immunizations.</td>
<td>$5 per office visit; no copay for well-child</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations</td>
<td>Copays</td>
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</tbody>
</table>
| member in the outpatient portion of a health facility licensed under  | • Family planning is limited to one annual visit and one supply visit each 90 days.  
| Chapter 395                                                            | • Chiropractic services are provided in the same manner as in the Florida Medicaid program.  
|                                                                        | • Podiatric services are limited to one visit per day, totaling two visits per month for specific foot disorders.  
|                                                                        | • Dental services must be provided by an oral surgeon for medically necessary reconstructive dental surgery due to injury.  
|                                                                        | • Treatment for temporomandibular joint (TMJ) disease is specifically excluded.  
|                                                                        | • Abortions may only be provided in the following situations:  
|                                                                        |   - The pregnancy is the result of an act of rape or incest.  
|                                                                        |   - A physician finds the abortion is necessary to save the life of the mother.  
|                                                                        | • Outpatient services do not include experimental or investigational procedures defined as a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria as determined by Simply:  
|                                                                        |   - Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular member is the subject of ongoing phase I, II or III clinical trials.  
|                                                                        |   - Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular member is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy in comparison to conventional alternatives.  
|                                                                        |   - Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.  
|                                                                        | • All services must be provided directly by Simply or upon approved referral.  
|                                                                        | • Covered services include inpatient and outpatient services for mental and nervous disorders as defined in the most recent edition of the *Diagnostic and* Inpatient: none  
<p>|                                                                        | Mental Health Services                                                                                                          | Outpatient: $5 per visit |
|                                                                        | Includes inpatient and outpatient care for psychological or psychiatric evaluation, diagnosis and care, preventive care, or routine vision and hearing screenings |                 |</p>
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</thead>
</table>
| Treatment by a licensed mental health professional | *Statistical Manual of Mental Disorders* published by the American Psychiatric Association.  
- Such benefits include psychological or psychiatric evaluation, diagnosis and treatment by a licensed mental health professional meeting the requirements of Section 3-2-2(C) of the state contract.  
- Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services, will not be any less favorable than those for physical illnesses generally. | |
| **Substance Use Services**  Includes coverage for inpatient and outpatient care for drug and alcohol abuse, including counseling and placement assistance |  
- All services must be provided directly by Simply or upon approved referral.  
- Covered services include inpatient, outpatient and residential services for substance disorders.  
- Such benefits include evaluation, diagnosis and treatment by a licensed professional meeting the requirements of Section 3-2-2(C) of the state contract.  
  - Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services, will not be any less favorable than those for physical illnesses generally. | Inpatient: none  
Outpatient: $5 per visit |
| **Therapy Services**  Includes physical, occupational, respiratory and speech therapies for short-term rehabilitation where significant improvement in the member’s condition will result |  
- All treatments must be performed directly or as authorized by Simply.  
- Therapy services are limited to up to 24 treatment sessions within a 60-day period per episode or injury, with the 60-day period beginning with the first treatment. | $5 per visit |
| **Home Health Services**  Includes prescribed home visits by both registered and licensed practical nurses to provide skilled nursing services on a part-time intermittent basis |  
- Coverage is limited to skilled nursing services only.  
- Meals, housekeeping and personal comfort items are excluded.  
- Services must be provided directly by Simply.  
- Private duty nursing is limited to circumstances where such care is medically appropriate. | $5 per visit |
| **Hospice Services**  Includes reasonable and necessary services for palliation or management of a member’s terminal illness | Services required for conditions totally unrelated to the terminal condition are covered to the extent that such services are otherwise covered under this contract. | $5 per visit |
| **Nursing Facility Services**  Covered services include regular nursing services, rehabilitation services, drugs and biologicals, medical supplies, and the use of appliances and equipment furnished by the facility |  
- All admissions must be authorized by Simply and provided by a Simply-affiliated facility.  
- Participant must require and receive skilled services on a daily basis as ordered by an in-network physician.  
- The length of the member’s stay is determined by the medical condition of the member in relation to the | None |
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</tr>
</thead>
</table>
| Benefit | necessary and appropriate level of care, but it cannot be more than 100 days per contract year.  
- Room and board is limited to semi-private accommodations unless a private room is considered medically necessary or semi-private accommodations are not available.  
- Specialized treatment centers and independent kidney disease treatment centers are excluded.  
- Private duty nurses, television and custodial care are excluded.  
- Admissions for rehabilitation and physical therapy are limited to 15 days per contract year. | |
| Durable Medical Equipment and Prosthetic Devices | Equipment and devices must be provided by an authorized Simply supplier.  
- Covered prosthetic devices include artificial eyes, limbs, braces and other artificial aids.  
- Low vision and telescopic lenses are not included.  
- Hearing aids are covered only when medically indicated to assist in the treatment of a medical condition. | None |
| Refractions | The member must have failed vision screening by their PCP.  
- Corrective lenses and frames are limited to one pair every two years unless head size or prescription changes.  
- Coverage is limited to frames with plastic or SYL nontinted lenses. | $5 per visit; $10 for corrective lenses |
| Pharmacy | This benefit includes all prescribed drugs covered under the Florida Medicaid program.  
- Simply is responsible for the coverage of any drugs prescribed by the member’s dental provider under FHK.  
- Brand name products are covered if a generic substitution is not available or where the prescribing physician indicates a brand name is medically necessary.  
- All medications must be dispensed through Simply or a Simply-designated pharmacy.  
- All prescriptions must be written by the member’s PCP, Simply-approved specialist or consultant physician, or the member’s dental provider. | $5 per prescription for up to a 31-day supply |
| Transportation Services | Transportation services must be in response to an emergency situation. | $10 per service |
Enhanced Benefits

Simply has decided to offer a group of enhanced benefits. The expanded services identified below are additional benefits not included in the Florida MMA/Florida Healthy Kids (FHK) core benefits.

Simply waives all copays for Statewide Medicaid Managed Care Managed Medical Assistance members; providers are prohibited from charging Medicaid member copays for covered services.

Copays are not waived for Florida Healthy Kids members; providers are responsible for collecting copays from Florida Healthy Kids members, and the amount paid by Simply will be the contracted amount less any applicable copays.

Members identified as Native Americans or Alaskan Natives are prohibited from paying any cost-sharing amounts, including copays.

Statewide Medicaid Managed Care Managed Medical Assistance Enhanced Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>30 minutes of treatment once weekly for up to three months; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Behavioral Health Day Services/Day Treatment</td>
<td>Additional 10 units per year of day treatment; one day per week, up to 52 per year of day care services; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Drug Screening)</td>
<td>Additional eight behavioral health-related medical services per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Medication Management)</td>
<td>Additional eight behavioral health-related medical services per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Verbal Interaction)</td>
<td>Additional eight behavioral health-related medical services per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Behavioral Health Screening Services</td>
<td>One additional per year; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Cellular Phone Service</td>
<td>One Lifeline Smart phone benefit per member, 18 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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<tr>
<td><strong>Chiropractic</strong></td>
<td>Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs. Eligible members will receive 35 additional visits per year; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Computerized Cognitive Behavioral Analysis</strong></td>
<td>Health and behavior assessment (i.e., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires) Unlimited through Simply's online well-being tool; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Doula services</strong></td>
<td>Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring; postnatal assessment and follow-up care; home visit for newborn care and assessment Unlimited per pregnancy; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Electric Stimulators (pain management)</strong></td>
<td>Transcutaneous electrical nerve stimulation (TENS) device for pain management Members 21 years and older</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>Hearing assessment, hearing aid assessment and hearing aids for in or behind the ear  • One evaluation per two years  • One assessment per two years  • One hearing aid per ear per two years  • Members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Home Delivered Meals — Post-Facility Discharge (Hospital or Nursing Facility)</strong></td>
<td>Home delivered meals including preparation (per meal) Two meals per day for seven days; must be after three-day or more surgical hospital stay; members 18 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Home Health Nursing/Aide Services</strong></td>
<td>Nursing services and medical assistance provided in members’ homes to help them manage or recover from a medical condition, illness or injury One additional unit of service per day; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Housing Assistance</strong></td>
<td>Supported housing, per month $500 per lifetime for homeless individuals; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Substance Abuse Intensive Outpatient Treatment</strong></td>
<td>Alcohol and/or drug services; intensive outpatient Three hours per day, three days per week, nine hours per week, maximum eight weeks; pregnant women 21 to 54 years of age</td>
<td>Required</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Massage Therapy</strong></td>
<td>Therapeutic procedures involving massage, mobilization, manipulation or manual traction for pain relief</td>
<td>Eight units (two hours) per year for eligible members, 21 years of age and older, with acute musculoskeletal pain</td>
</tr>
<tr>
<td><strong>Meals — Nonemergency Transportation Day-Trips</strong></td>
<td>Nonemergency transportation and meals for members and required escort to medically necessary doctor visits greater than 100 miles each way</td>
<td>$200 per day; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Newborn Circumcision</strong></td>
<td>Circumcision</td>
<td>One per lifetime within first 28 days of birth</td>
</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>Nutritional counseling, dietician visit</td>
<td>Six visits per year for eligible members</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>Evaluation moderate complexity</td>
<td>One evaluation and re-evaluation per year; up to seven therapy treatment units per week; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Services</strong></td>
<td>Medical care members get while they are in the hospital but not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat members.</td>
<td>$200 additional per year, excluding lab services; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Over-the-Counter Benefit</strong></td>
<td>Cough, cold and allergy medications, vitamins and supplements, ophthalmic/otic preparations, pain relievers, gastrointestinal products, first aid care, hygiene products insect repellent (DEET and non-DEET), oral hygiene products, skin care</td>
<td>Limited to $25 per household per month</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>Evaluation moderate complexity</td>
<td>One evaluation and re-evaluation per year; up to seven therapy treatment units per week; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Prenatal Services — Prenatal/Perinatal Visits</strong></td>
<td>Breast pump rental for breast feeding, Antepartum management: 14 visits for low-risk pregnancies and 18 visits for high-risk pregnancies, Postpartum care: Three visits within 90 days following delivery</td>
<td>Breast pump: one per two years; rental only</td>
</tr>
</tbody>
</table>

* Refer to online quick tool for exact requirements by CPT code.
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Visit Services for Adults</strong></td>
<td>Unlimited visits for members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Services for doctor’s visits to stay healthy and prevent or treat illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Supplies</strong></td>
<td>Members 21 years and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Supplies needed for use of approved positive airway pressure device</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>One per year for members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>• Initial evaluation and re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respiratory therapy visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech Therapy/Speech Language Pathology</strong></td>
<td>One evaluation/re-evaluation per year; up to seven therapy treatment units per week; one AAC evaluation/re-evaluation per year; up to 30 minutes AAC fitting adjustment and training sessions per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>• Evaluation/re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evaluation of swallowing function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Speech therapy visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Augmentative and alternative communication (AAC) initial evaluation/re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• AAC fitting, adjustment and training visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapy — Art</strong></td>
<td>Unlimited visits for members receiving behavioral health services</td>
<td>Required</td>
</tr>
<tr>
<td>Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient’s disabling mental health problems, per session</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine — Pneumonia (Pneumococcal)</strong></td>
<td>Adults 21 to 64 years of age when medically necessary; adults 65 years or older</td>
<td>Not required</td>
</tr>
<tr>
<td>• Pneumococcal conjugate vaccine 13 valent intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pneumococcal polysaccharide vaccine 23 valent adult or immunosuppressed dosage subcutaneous or intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine — Influenza</strong></td>
<td>Members 21 years of age or older; unlimited per pregnancy</td>
<td>Not required</td>
</tr>
<tr>
<td>• Influenza virus vaccine split virus preservative free intramuscular, 90656</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Influenza virus vaccine, 90664, 90666, 90667, 90668</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Administration of vaccine, G0008</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine — Shingles (Varicella-Zoster)</strong></td>
<td>One vaccine per member per lifetime, for members 60 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>• Zoster shingles vaccine live</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Subcutaneous/medicine-immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine — TDaP</strong></td>
<td>One vaccine per pregnancy; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Tetanus diphtheria toxoids acellular pertussis vaccine (TDaP) intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td>One exam per year; one frame per year; six months of contact lenses with prescription; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Eye exam exclusively to screen visual acuity without need of reported vision problem,</td>
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</tr>
</tbody>
</table>
### Service Coverage/Limitations

<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>illness, disease or injury; contact lenses;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Waived Copayments</strong></td>
<td>Members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>The plan waives copays on the following</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services: birthing center; chiropractic;</td>
<td></td>
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<tr>
<td>community behavioral health; FQHC;</td>
<td></td>
<td></td>
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<tr>
<td>inpatient and outpatient hospital;</td>
<td></td>
<td></td>
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<tr>
<td>independent labs; nonemergency transportation;</td>
<td></td>
<td></td>
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<tr>
<td>ARNP; optometrist; physician assistant;</td>
<td></td>
<td></td>
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<tr>
<td>physician; podiatrist; portable X-ray;</td>
<td></td>
<td></td>
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<tr>
<td>RHC; registered nurse first assistant</td>
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</tbody>
</table>

### Specialty Enhanced Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage/Limitations</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture</strong></td>
<td>30 minutes of treatment once weekly for up to three months; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>30 minutes of acupuncture services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Day Services/Day Treatment</strong></td>
<td>Additional 10 units per year of day treatment; one day per week, up to 52 per year of day care services; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Behavioral health day treatment or day care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Medical Services (Drug Screening)</strong></td>
<td>Additional eight behavioral health-related medical services per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Behavioral health medical services (alcohol and other drug screening specimen collection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Medical Services (Medication Management )</strong></td>
<td>Additional eight behavioral health-related medical services per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Medication management for behavioral health or substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Medical Services (Verbal Interaction)</strong></td>
<td>Additional eight behavioral health-related medical services per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Behavioral health medical services (verbal interaction), mental health or substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Screening Services</strong></td>
<td>One additional per year; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Behavioral health screening services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
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</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Cellular Phone Service</strong></td>
<td>Members can sign up for the Lifeline program and receive a free smart phone, free monthly minutes, a minimum of 500 MB of data and text messaging. Members receive free minutes for calls to and from a selected toll-free customer service phone number.</td>
<td>One Lifeline Smart phone benefit per member, 18 years of age and older</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs</td>
<td>Eligible members will receive 35 additional visits per year; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Computerized Cognitive Behavioral Analysis</strong></td>
<td>Health and behavior assessment (for example, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)</td>
<td>Unlimited through Simply's online well-being tool; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Doula services</strong></td>
<td>Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring; postnatal assessment and follow-up care; home visit for newborn care and assessment</td>
<td>Unlimited per pregnancy; members 21 years of age and older</td>
</tr>
<tr>
<td><strong>Electric Stimulators (pain management)</strong></td>
<td>Transcutaneous electrical nerve stimulation (TENS) device for pain management</td>
<td>Members 21 years and older</td>
</tr>
</tbody>
</table>
| **Hearing Services**                         | Hearing assessment, hearing aid assessment and hearing aids for in or behind the ear | - One evaluation per two years  
- One assessment per two years  
- One hearing aid per ear per two years  
- Members 21 years of age and older | Required |
<p>| <strong>Home Delivered Meals — Post-Facility Discharge (Hospital or Nursing Facility)</strong> | Home delivered meals, including preparation (per meal) | Two meals per day for seven days; must be after three-day or more surgical hospital stay; members 18 years of age and older | Required |
| <strong>Home Health Nursing/Aide Services</strong>        | Nursing services and medical assistance provided in members’ homes to help them manage or recover from a medical condition, illness or injury | One additional unit of service per day; members 21 years of age and older | Required |</p>
<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Housing Assistance</td>
<td>$500 per lifetime for homeless individuals; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>Eight units (two hours) per year for eligible members, 21 years of age and older, with acute musculoskeletal pain</td>
<td>Required</td>
</tr>
<tr>
<td>Meals — Nonemergency Transportation Day-Trips</td>
<td>$200 per day; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Newborn Circumcision</td>
<td>One per lifetime within first 28 days of birth</td>
<td>Not required</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Six visits per year for eligible members</td>
<td>Not required</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>One evaluation and re-evaluation per year; up to seven therapy treatment units per week; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>$200 additional per year, excluding lab services; members 21 years of age and older</td>
<td>Required*</td>
</tr>
<tr>
<td>Over-the-Counter Benefit</td>
<td>Limited to $25 per household per month</td>
<td>Not required</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>One evaluation and re-evaluation per year; up to seven therapy treatment units per week; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage/Limitations</td>
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<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Prenatal Services — Prenatal/Perinatal Visits</strong></td>
<td>Breast pump: one per two years; rental only</td>
<td>Required</td>
</tr>
<tr>
<td>• Breast pump rental for breast feeding</td>
<td></td>
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</tr>
<tr>
<td>• Antepartum management: 14 visits for low-risk pregnancies and 18 visits for high-risk pregnancies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Postpartum care: three visits within 90 days following delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Visit Services for Adults</strong></td>
<td>Unlimited visits for members 21 years of age and older</td>
<td>Not required</td>
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<tr>
<td>Services for doctor's visits to stay healthy and prevent or treat illness</td>
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</tr>
<tr>
<td><strong>Respiratory Supplies</strong></td>
<td>Members 21 years and older</td>
<td>Not required</td>
</tr>
<tr>
<td>Supplies needed for use of approved positive airway pressure device</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>One per year for members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td>• Initial evaluation and re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respiratory therapy visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech Therapy/Speech Language Pathology</strong></td>
<td>One evaluation/re-evaluation per year; up to seven therapy treatment units per week; one AAC evaluation/re-evaluation per year; up to 30 minutes AAC fitting adjustment and training sessions per year; members 21 years of age and older</td>
<td>Required</td>
</tr>
<tr>
<td>• Evaluation/re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evaluation of swallowing function</td>
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<td></td>
</tr>
<tr>
<td>• Speech therapy visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• AAC initial evaluation/re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• AAC fitting, adjustment and training visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse — Intensive Outpatient Treatment</strong></td>
<td>Three hours per day, three days per week, nine hours per week, maximum eight weeks; members 21 to 54 years of age</td>
<td>Required</td>
</tr>
<tr>
<td>Alcohol and/or drug services; intensive outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapy — Art</strong></td>
<td>Unlimited visits for members receiving behavioral health services</td>
<td>Required</td>
</tr>
<tr>
<td>Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine — Pneumonia (Pneumococcal)</strong></td>
<td>Adults 21 to 64 years of age when medically necessary; adults 65 years or older</td>
<td>Not required</td>
</tr>
<tr>
<td>• Pneumococcal conjugate vaccine 13 valent intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pneumococcal polysaccharide vaccine 23 valent adult or immunosuppressed dosage subcutaneous or intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine — Hepatitis B</strong></td>
<td>All adults who have not been previously vaccinated are eligible to receive the vaccine.</td>
<td>Not required</td>
</tr>
<tr>
<td>Hepatitis B vaccine, adult dosage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
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<td>Prior Authorization</td>
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</tr>
<tr>
<td><strong>Vaccine — Human Papilloma Virus</strong>&lt;br&gt;HPV vaccine</td>
<td>All adults ages 21 to 26 who have not previously received the vaccine are eligible.</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Vaccine — Influenza</strong>&lt;br&gt;• Influenza virus vaccine split virus preservative free intramuscular, 90656&lt;br&gt;• Influenza virus vaccine, 90664, 90666, 90667, 90668&lt;br&gt;• Administration of vaccine, G0008</td>
<td>Members 21 years of age or older; unlimited per pregnancy</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Vaccine — Meningococcal</strong>&lt;br&gt;Meningococcal conjugate vaccine serogroups A, C, Y, W-135 tetravalent intramuscular</td>
<td>All adults with HIV who have not been previously vaccinated are eligible to receive two primary doses at least two months apart and be revaccinated every five years.</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Vaccine — TDaP</strong>&lt;br&gt;Tetanus diphtheria toxoids acellular pertussis vaccine (TDaP) intramuscular</td>
<td>All pregnant members are eligible to receive two primary doses at least two months apart and revaccination every five years; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Vision Services</strong>&lt;br&gt;Eye exam exclusively to screen visual acuity without need of reported vision problem, illness, disease or injury; contact lenses; frames</td>
<td>One exam per year; one frame per year; six months of contact lenses with prescription; members 21 years of age and older</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Waived Copays</strong>&lt;br&gt;The plan waives copays on the following services: birthing center; chiropractic; community behavioral health; FQHC; inpatient and outpatient hospital; independent labs; nonemergency transportation; ARNP; optometrist; physician assistant; physician; podiatrist; portable X-ray; RHC; registered nurse first assistant</td>
<td>Members 21 years of age and older</td>
<td>Not required</td>
</tr>
</tbody>
</table>

**Florida Healthy Kids Expanded Benefits**
- $10 a month to buy certain personal care items and over-the-counter (OTC) medicines
- $100 for hypoallergenic bedding (if medically needed)
- Six months of free fitness and healthy behavior coaching for members 7 to 13 years of age
- A free mouth guard for children who play contact sports
- Our 24-hour Nurse HelpLine to answer medical questions anytime at **1-866-864-2544** (TTY 711)

**Taking Care of Baby and Me Program**
When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That’s why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me® program — a comprehensive case management and care coordination program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files,
claims data, lab reports, hospital census reports, provider notification of pregnancy and delivery notification forms, and self-referrals. Once pregnant members are identified, we act quickly to mitigate obstetrical risk and ensure the appropriate levels of care and case management services are provided. We offer:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Rewards to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers also collaborate with community agencies to ensure mothers have access to necessary services, including transportation; home visitor programs; breastfeeding support and counseling; and the Women, Infants and Children (WIC) program.

As part of the Taking Care of Baby and Me program, members are also offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit www.myadvocatehelps.com.

**Prenatal Program**
A Taking Care of Baby and Me prenatal package is sent to all identified pregnant members and includes a pregnancy book, other resources and information on the Healthy Rewards program. Through the Healthy Rewards program, pregnant women receive a reward for attending a prenatal visit in the first trimester or within 42 days of enrollment with Simply. Members can use this $20 reward at various retailers, such as Walmart. They will also receive a $20 reward for attending at least six prenatal care visits. Members can visit www.simplyhealthcareplans.com/HealthyRewards and www.clearhealthalliance.com/HealthyRewards or call 1-877-868-2004 (TTY 711) for more information.

**Postpartum Program**
After delivery, the member will also receive a Taking Care of Baby and Me postpartum packet that includes a booklet with information on how to care for their newborn, postpartum depression, and other resources and information on the Healthy Rewards program. Upon completing the postpartum check between 21 and 56 days post-delivery by her doctor, the member qualifies for a $20 reward. Encourage your member to take their baby to the doctor 3 to 5 days after birth; the infant may also be eligible for rewards. Members can visit www.simplyhealthcareplans.com/HealthyRewards and www.clearhealthalliance.com/HealthyRewards or call 1-877-868-2004 (TTY 711) to learn more.

Notification of pregnancy and delivery to Simply at 1-800-964-3627 is required at the first prenatal visit. Taking Care of Baby and Me provides care management to:

- Improve the member’s level of knowledge about her pregnancy.
- Create systems that support the delivery of quality care.
- Measure and maintain or improve member outcomes related to the care delivered.
- Facilitate care with providers to promote collaboration, coordination and continuity of care.

**You and Your Baby in the NICU**
For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post-Traumatic Stress Disorder (NICU PTSD) program. Parents receive education
and support so they are involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. We provide parents with an educational resource outlining successful strategies they may deploy to collaborate with the care team. The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. This program will support mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

Quality Enhancement Program
Simply offers quality-enhanced programs for the benefit of members and providers. These include:
1. Children’s programs — We provide regular general wellness programs for ages birth to 5 years, or we make a good faith effort to involve members in existing community children’s programs.
   a. We rely on providers seeing children to provide prevention and early intervention services for at-risk members. We approve claims for services recommended by the early intervention programs when they are covered services and medically necessary.
   b. We offer annual training to providers (through monthly provider agendas, the Simply website, etc.) that promote proper nutrition, breastfeeding, immunizations, wellness, prevention and early intervention services.
2. Domestic violence programs — We require PCPs to screen members for signs of domestic violence and require PCPs to offer referral services to applicable domestic violence prevention community agencies.
3. Pregnancy prevention — We conduct pregnancy prevention programs or make a good faith effort to involve members in existing community pregnancy prevention programs. These programs will be targeted toward teen enrollees but be open to all ages.
4. Prenatal/postpartum pregnancy programs — We provide regular home visits by a home health nurse or aide and offer counseling and educational materials to pregnant and postpartum members who are not in compliance with the health plan’s prenatal and postpartum programs. We will coordinate our efforts with the local Healthy Start care coordinator to prevent duplication of services.
5. Smoking cessation — We provide smoking cessation counseling to members. We provide participating PCPs with a quick reference card to help identify tobacco users and support delivery of effective smoking cessation interventions. Please see the “Smoking Cessation Program” section below.
6. Substance abuse programs — We offer annual substance abuse screening training to our providers. In addition, several screening tools and other resources are available on our provider website to help providers identify substance abuse and make appropriate referrals.
   a. At a minimum, all PCPs are required to screen members for signs of substance abuse as part of prevention evaluation at the following times:
      i) During initial contact with a new member
      ii) During routine physical examinations
      iii) During initial prenatal contact
      iv) When the member displays serious overutilization of medical, surgical, trauma or emergency services
      v) When documentation of emergency room visits suggests the need
   b. Providers identifying patients with substance abuse needs should refer patients to community substance abuse programs.

Encounter submission is critical to ensuring the quality of services by validating the work providers perform. To obtain credit for services rendered, all providers must submit encounters when including providers contracted under a capitated arrangement.
Well-Child Visits/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Statewide Medicaid Managed Care Managed Medical Assistance Members

Simply members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit and within 24 hours for newborns. Simply members are eligible to receive these services from birth to age 20. For EPSDT members, if a service is medically necessary, it must be covered, regardless of whether the service is on the fee schedule or not. This applies to all EPSDT members under 21 years of age.

Note: EPSDT requirements are applicable to Medicaid.

The program provides the following:

- Comprehensive health and development history
- Physical and mental development assessment
- Comprehensive unclothed physical examination
- Age-appropriate immunizations
- Appropriate laboratory tests
- Health education

Newborn well-child services should be performed for newborns in the hospital and then at the following ages:

- 3 to 5 days old
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

In the child’s second year of life, he or she should see a PCP at 15 months, 18 months and 24 months of age. During the span of a child’s third year of life until age 20, the child should be seen by his or her PCP at least on an annual basis. Simply educates our members about these guidelines and monitors encounter data for compliance.

Simply recommends that participating providers who treat children under the age of 21 utilize the American Academy of Pediatrics Bright Futures well-child forms to ensure all aspects of an EPSDT visit are captured. The forms are at https://brightfutures.aap.org (Tools and Resources).

Simply requires providers to:

- Participate in the EPSDT program if they treat children under the age of 21.
- Provide all needed initial, periodic and interperiodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with the Florida Agency for Health Care Administration’s approved Medicaid administrative regulation Sect. III C.9.b and the periodicity schedule provided by the American Academy of Pediatrics (AAP).
- Refer members to an out-of-network provider for treatment if the service is not available within our network.
- Provide vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Provide vaccinations in conjunction with EPSDT/well-child visits; providers are required to use vaccines available without charge under the Vaccine for Children (VFC) program for Medicaid children 18 years of age and younger (excludes MediKids).
- Address unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits.
• Request a prior authorization for a medically necessary EPSDT special service in the event other health care, diagnostic, preventive or rehabilitative services or treatment, or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Florida Medicaid program.

• Monitor, track and follow up with members:
  o Who have not had a health assessment screening.
  o Who miss appointments, to assist them in obtaining an appointment.

• Ensure members receive the proper referrals to treat any conditions or problems identified during the health assessment, including tracking, monitoring and following up with members to ensure they receive the necessary medical services.

• Assist members with transition to other appropriate care for children who age-out of EPSDT services.

Simply recommends that participating providers who administer immunizations to children under the age of 18 utilize the Centers for Disease Control (CDC) Immunization Schedule for Persons Aged 0 through 18. This schedule is located at [www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html).

**Well-Child Visits Reminder Program**

Based on Simply claims data, we send a list of members who may not have received wellness services according to schedule to the members’ PCPs each quarter. Additionally, we mail information to these members encouraging them to contact their PCPs’ offices to set up appointments for needed services. Please note:

• The specific service(s) needed for each member is listed in the report; reports are based only on services received during the time the member is enrolled with Simply.

• Services must be rendered on or after the due date in accordance with federal EPSDT and state Department of Health guidelines. In accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements.

• This list is generated based on Simply claims data received prior to the date printed on the list; in some instances, the appropriate services may have been provided after the report run date.

• To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to the Simply Claims department at:
  Simply Healthcare Plans, Inc.
  Florida Claims
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

**Blood Lead Testing Requirements**

During every well-child visit for children between the ages of 6 months and 6 years, the PCP should screen each child for lead poisoning. Simply requires all PCPs to test for high blood lead levels assuring compliance with CMS requirements. These requirements state that all Medicaid enrollees must have a blood lead test performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months, up to 72 months, should receive a blood lead test if there is no past record of a test.

We encourage providers to contact Medtox to receive supplies to test children’s blood lead levels in their offices. With a simple finger prick and a drop of blood on the filter paper from Medtox, the member will not have to go to another provider/lab to have the services done. Once you return the sample by mail, Medtox will send you the results and bill Simply for the test.

For those children who have a blood level greater than or equal to 10, continued testing is required until the blood level is below 10.
Vaccines for Children for Medicaid Recipients

The VFC program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to pay. VFC was created by the Omnibus Budget Reconciliation Act of 1993 as an entitlement program to be a required part of each state’s Medicaid plan. The program was officially implemented in October 1994.

Funding for the VFC program is approved by the Office of Management and Budget and allocated through CMS to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines at a discount and distributes them to grantees (that is, state health departments and certain local and territorial public health agencies) that then distribute them at no charge to those private physicians’ offices and public health clinics registered as VFC providers.

Simply requires our providers to participate in the VFC program and have sufficient vaccine supplies. For additional information on the VFC program, visit https://www.cdc.gov/vaccines/programs/vfc/index.html.

Family Planning Services

Members have direct access to both network and non-network providers for all family planning services, including exams, assessments and traditional contraceptive devices. Services are not covered for members under the age of 18 unless they are married, a parent, pregnant or will suffer health hazards if services are not provided. FHK coverage of family planning is limited to one annual visit and one visit for a supplier every 90 days. Oral and injectable contraceptives and condoms are always covered for MMA members 12 and older and FHK members 10 and older.

Healthy Behaviors Rewards Program

We offer programs to members who want to stop smoking, lose weight or address any drug abuse problems, and we reward members who join and meet certain goals. Our Healthy Behaviors Rewards Programs include:

- Smoking cessation program.
- Weight management program.
- Alcohol and substance abuse program.
- Health education advisory committee.
- Maternal child program.
- Dental program.
- Immunization programs.

Setting Healthy Goals

The Simply Healthy Behaviors Rewards program exists to help our members. Together, we make a plan and set goals to beat tough health issues. For example, for alcohol and substance abuse and smoking cessation, we offer help and support through coaching and participation in community groups. For weight management and nutrition, we offer help and support from a nurse in making healthy exercise and food choices.

Resources and Tools

The Florida Quitline is a toll-free, telephone-based tobacco use cessation service. Any person living in Florida who wants to try to quit smoking can use the Quitline. The following services are available through the Quitline:

- Counseling sessions
- Self-help materials
- Counseling and materials in English and Spanish
- Translation service for other languages
- Pharmacotherapy assistance
• TDD service for the deaf or hard of hearing

Online Resources

<table>
<thead>
<tr>
<th>Website</th>
<th>Resource Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="https://smokefree.gov">https://smokefree.gov</a></td>
<td>A cravings journal, information on medicines to help members quit, <em>Pathways to Freedom for African Americans</em> and <em>Guía para Dejar de Fumar</em> (Spanish resource)</td>
</tr>
<tr>
<td><a href="http://www.ffsonline.org">www.ffsonline.org</a></td>
<td>American Lung Association’s Freedom from Smoking Program</td>
</tr>
<tr>
<td><a href="https://quitnet.com">https://quitnet.com</a></td>
<td>Additional resources, including support to quit, Information about why to quit and how to get help</td>
</tr>
<tr>
<td><a href="http://quitsmokingsupport.com">http://quitsmokingsupport.com</a></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.cancer.gov/cancertopics/factsheet/tobacco/cessation">https://www.cancer.gov/cancertopics/factsheet/tobacco/cessation</a></td>
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</tr>
</tbody>
</table>

**Online Continuing Education for Physicians**
Providers can receive continuing education training online through these resources:
• MAHP Oral Health and Tobacco Cessation Educational Program for Primary Care Providers
• Treating Tobacco Use and Dependence through the Wisconsin Medical School
• [www.medscape.com](http://www.medscape.com)
• Tobacco Cessation Podcasts for Physicians

**Printed Resources for Members**
We offer the following printed resources you can share with members:
• You Can Quit Smoking
• Tobacco Use — Breaking the Habit
• Tobacco Use — Reasons to Quit

**Printed Resources for Providers**
• Quick Reference Guide: Treating Tobacco Use and Dependence

All member materials are available on the member website, and provider materials are on the provider website.

**Audiology Services**

Simply provides the following audiology services:

<table>
<thead>
<tr>
<th>Code/Mod</th>
<th>Description</th>
<th>Unit Length</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5090</td>
<td>Dispensing fee, unspecified hearing aid</td>
<td>1 handling</td>
<td>6 every 12 months</td>
</tr>
<tr>
<td>92557/52</td>
<td>Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)</td>
<td>1 re-evaluation</td>
<td>6 every 12 months</td>
</tr>
<tr>
<td>92592</td>
<td>Hearing aid check; monaural</td>
<td>1 analysis</td>
<td>6 every 12 months</td>
</tr>
<tr>
<td>92592/52</td>
<td>Hearing aid recheck; monaural</td>
<td>1 recheck</td>
<td>6 every 12 months</td>
</tr>
<tr>
<td>92552</td>
<td>Pure tone audiometry (threshold); air only</td>
<td>1 test</td>
<td>6 every 12 months</td>
</tr>
<tr>
<td>92567</td>
<td>Tympanometry (impedance testing)</td>
<td>1 test</td>
<td>6 every 12 months</td>
</tr>
<tr>
<td>Code/Mod</td>
<td>Description</td>
<td>Unit Length</td>
<td>Frequency</td>
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<tr>
<td>92587</td>
<td>Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)</td>
<td>1 test</td>
<td>No limit</td>
</tr>
<tr>
<td>92588</td>
<td>Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)</td>
<td>1 test</td>
<td>No limit</td>
</tr>
<tr>
<td>92585</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
<td>1 test</td>
<td>No limit</td>
</tr>
<tr>
<td>92585/52</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
<td>1 test</td>
<td>No limit</td>
</tr>
<tr>
<td>92584</td>
<td>Electrocochleography</td>
<td>1 test</td>
<td>1 per implant</td>
</tr>
<tr>
<td>92626</td>
<td>Evaluation of auditory rehabilitation status; first hour</td>
<td>1 test</td>
<td>10 per year</td>
</tr>
</tbody>
</table>

**Outpatient Laboratory and Radiology Services**

All outpatient laboratory tests should be performed at a network facility outpatient lab or at one of the Simply preferred network labs (LabCorp) unless the test is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test. Visit the CMS website at [https://www.cms.hhs.gov](https://www.cms.hhs.gov) for a complete list of approved accreditation organizations under CLIA. AIM Specialty Health® (AIM) provides diagnostic radiology management services and will provide precertifications for CAT scans, MRA, MRI, nuclear cardiology and PET scans. Contact AIM at 1-800-252-2021 or [www.aimspecialtyhealth.com](http://www.aimspecialtyhealth.com) for more information.

**Pharmacy Services**

The Simply pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to national pharmacy chains and many independent retail pharmacies.

**Covered Drugs**

The Simply Pharmacy program uses a Preferred Drug List (PDL). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. To prescribe medications that do not appear on the PDL, you may initiate an electronic prior authorization request through [https://www.availity.com](https://www.availity.com). Prescribers may also call Pharmacy Services at 1-877-577-9044 or fax a completed Pharmacy Prior Authorization Form to 1-877-577-9045 for retail pharmacy requests and 1-844-509-9862 for medical injectable requests. Please refer to the Pharmacy Prior Authorization Form, MMA and Florida Healthy Kids PDLs, and prior authorization criteria links on our provider website.

**Drugs Requiring Prior Authorization**

Providers are strongly encouraged to write prescriptions for preferred products as listed on the appropriate PDL for that member (either MMA or FHK). If a member cannot use a preferred product because of a medical condition, providers are required to contact Simply Pharmacy Services to obtain prior authorization. To request prior authorization, call the Pharmacy department at 1-877-577-9044 or fax a completed Pharmacy Prior Authorization Form (available on the provider website) to 1-877-577-9045 for retail pharmacy requests and 1-844-509-9862 for medical injectable requests. You may also initiate electronic prior authorization requests through [https://www.availity.com](https://www.availity.com). Providers must be prepared to provide relevant clinical information regarding the member’s need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria.
Over-The-Counter Drugs
Simply provides coverage of several OTC drugs when accompanied by a prescription. The following are examples of covered OTC medication classes. Providers should consult the MMA and FHK PDLs for specifics on covered products and limits:

- Analgesics/antipyretics
- Antacids
- Antifungals, topical
- Antifungals, vaginal
- Antihistamines
- Antihistamine-decongestant combinations
- Emergency contraceptives
- Cough and cold preparations
- Iron replacement supplements
- Laxatives
- Pediculicides
- Respiratory agents (including spacer devices)
- Select vitamins and multi-vitamins

Excluded Drugs
The following drugs are examples of medications that are excluded from the pharmacy benefit:

- Weight control
- Anti-wrinkle agents (for example, Renova)
- Drugs used for cosmetic reasons or hair growth
- Drugs used for experimental or investigational indication
- Erectile dysfunction drugs to treat impotence
- Drugs that duplicate therapy

Informed Consent for Psychotherapeutic Medications for Children (Statewide Medicaid Managed Care Managed Medical Assistance Members)
Pursuant to F.S.A. 409.912(13), the Agency for Health Care Administration (AHCA) may not pay for a psychotropic medication prescribed for a child under the age of 13 years in the Medicaid program without the express and informed consent of the child’s parent or legal guardian. The physician must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.

The psychotherapeutic drugs affected are antipsychotics, antidepressants, anti-anxiety medications and mood stabilizers. Anti-convulsants and ADHD medications (that is, stimulants and nonstimulants) are not included at this time. A signed Informed Consent Form must be presented to the pharmacy with each new prescription for an affected drug for a member under 13 years of age. Consent forms are available at http://ahca.myflorida.com/medicaid/prescribed_drug/med_resource.shtml.

Carved Out Medications
The following medications are carved out of the Statewide Medicaid Managed Care Managed Medical Assistance program and must be billed to Medicaid Fee-For-Service. Additional information is available from the clinical help desk at Magellan PBM, they may be reached at 1-800-603-1714.

Exondys 51 and Spinraza:
- For coverage, fax prior authorization request to the Agency’s PBM Magellan using the Spinraza or Exondys 51 fax forms found on the Agency’s website

Factor for the treatment of Hemophilia
- Coverage provided through the Comprehensive Statewide Hemophilia Disease Management Program

Copies of the consent form must be maintained in the member’s medical records.
Behavioral Health Services

Overview
Pursuant to the Simply contract with AHCA and the state MMA plan, Simply will provide coverage, via its subcontractor Beacon Health Strategies, for a full range of behavioral health care services (that is, treatment for psychiatric and emotional disorders), including community mental health services and mental health targeted case management services to all members in contracted counties. Simply will provide coverage of mental health and alcohol and drug treatment for Florida Healthy Kids members residing in the counties in which Simply participates as part of the member’s behavioral health benefit.

Primary and Specialty Services
PCPs are encouraged to screen members for behavioral health and alcohol and drug abuse conditions as part of the initial assessment, or whenever there is a suspicion a member may have a behavioral health condition.

A PCP can offer covered behavioral health and/or alcohol and drug abuse services when:
- Services are within the scope of the PCP’s license.
- The member’s current condition is not so severe, confounding or complex as to warrant a referral to a mental health and alcohol and drug abuse provider.
- The member is willing to be treated by the PCP.
- Services are within the scope of the benefit plan.

PCPs are encouraged to educate members with behavioral health and/or alcohol and drug abuse conditions about the nature of the condition and its treatment. As appropriate, PCPs are also encouraged to educate members about the relationship between physical and behavioral health and alcohol and drug abuse conditions.

Referral for Mental Health and Alcohol and Drug Abuse Conditions
Members may self-refer, or providers may direct members to the Simply network of behavioral health care providers.

Experienced behavioral health care clinicians are available 24 hours a day, 7 days a week by calling the Provider Inquiry Line (1-844-405-4296) to assist with identifying the closest and most appropriate behavioral health service.

Behavioral Health Claims
Submit paper behavioral health claims to:
Beacon Health Options
Claims Department
P.O. Box 1850
Hicksville, NY 11802-1850

Electronic behavioral health claims may be submitted through the Simply contracted clearinghouses. To initiate the electronic claims submission process or obtain additional information, please contact the Simply Electronic Data Interchange (EDI) Hotline at 1-800-590-5745.

Behavioral Health Emergency Services
Behavioral health emergency services are those services that are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination pursuant to Section 394.463, F.S., and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization. Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:
• The member is suicidal.
• The member is homicidal.
• The member is violent with objects.
• The member has suffered a precipitous decline in functional impairment and is unable to take care of his or her activities of daily living.
• The member is alcohol- or drug-dependent and there are signs of severe withdrawal.

In the event of a behavioral health and/or alcohol and drug abuse emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or behavioral health and alcohol and drug abuse crisis service facility. An emergency dispatch service or 911 should be contacted if the member is a danger to his or her self or others and is unable to go to an emergency setting.

Behavioral Health Medically Necessary Services
Simply defines medically necessary behavioral health services as those that are:
• Reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, behavioral or developmental effects of an illness, condition, injury or disability; and assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age.
• Reasonably expected to provide an accessible and cost-effective course of treatment or site of service that is equally effective in comparison to other available, appropriate and substantial alternatives and is no more intrusive or restrictive than necessary.
• Sufficient in amount, duration and scope to reasonably achieve their purpose as defined in federal law.
• Of a quality that meet standards of medical practice and/or health care generally accepted at the time services are rendered.

Behavioral Health Coordination of Care
Simply, through its contracted providers and case management services, will be responsible for the coordination and active provision of continuity of care for all members. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. Additionally, if applicable, Simply will coordinate medical and behavioral health services.

The exchange of medical information facilitates behavioral and medical health care collaboration. For example, if the PCP obtains the member’s consent via the Authorization for Release of Information form, the form is completed and sent to the behavioral health care provider. The behavioral health care provider may use the release as necessary for the administration and provision of care.

Simply behavioral health providers are mandated to utilize the Functional Assessment Rating Scale (FARS) and Children’s Functional Assessment Rating Scale (CFARS), which are the outcome measures used by the state of Florida for Medicaid providers. CFARSs are administered for patients ages 6 to 17 and FARSs are administered for patients ages 18 and older. FARS/CFARS assessments are required to be completed at admission, every six months after admission (as long as the member remains a patient) and at discharge.

A FARS/CFARS should not be completed for members who: 1) only receive a one-time assessment service and are immediately discharged or 2) are served in medication-only settings. Additionally, FARS is not required when a member is admitted and discharged from a crisis stabilization unit. Changes to any other level of service will require administration of the FARS.
Free Training and Certification Websites
Note that only staff with certification should be providing assessment services. Free trainings are available online:
- CFARS: [https://samh-fars.dcf.state.fl.us/cfars/cfars_home.aspx](https://samh-fars.dcf.state.fl.us/cfars/cfars_home.aspx)
- FARS: [https://samh-fars.dcf.state.fl.us/fars/fars_home.aspx](https://samh-fars.dcf.state.fl.us/fars/fars_home.aspx)

The behavioral health care provider is required to note contacts and collaboration efforts in the member’s chart as well as determine whether referral assistance is needed for the member for noncovered services.

When the member has seen a behavioral health care provider, that provider is required to send a copy of a completed *Coordination of Care and Treatment Summary Form* to both Simply and the member’s PCP. This form is available on our provider website.

If a PCP refers a member to a contracted behavioral health care provider, the PCP will fax a copy of a completed *Coordination of Care and Treatment Summary Form* to the designated behavioral health care fax (1-800-505-1193) and to the behavioral health care provider.

The behavioral health care provider will send initial and quarterly (or more frequently if clinically indicated) summary reports of the member’s behavioral health status to the member’s PCP. The PCP will be contacted if there is a change in the behavioral health treatment plan. The PCP will contact the behavioral health care provider and document the information on the *Coordination of Care and Treatment Summary Form* if the member’s medical condition could reasonably be expected to affect the member’s mental health treatment planning or outcome.

Self-Referral Services
The following services do not need a referral from a PCP:
- Emergent care (regardless of network status with Simply)
- Family planning (regardless of network status with Simply)
- Behavioral health assessments (nonparticipating providers must seek prior approval from Simply)
- OB care (nonparticipating providers must seek prior approval from Simply)
- Well-woman/GYN care (nonparticipating providers must seek prior approval from Simply)
- EPSDT/well-child services (nonparticipating providers must seek prior approval from Simply)
- Tuberculosis, STD, HIV/AIDS testing and counseling services (regardless of network status with Simply)

Member Rights and Responsibilities
Florida law requires that providers or health care facilities recognize the rights of members while they are receiving medical care and that members respect the health care provider’s or health care facility’s right to expect certain behavior on the part of members. Members may request a copy of the full text of this law from their health care provider or health care facility. The following is a summary of the member’s rights and responsibilities (see Section 381.026, Florida Statutes).

Patients’ Rights
Patients have a right to:
- Be treated with respect and with due consideration for dignity and privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for their care.
- A right to receive information about the organization, its services, its practitioners and providers...
A right to make recommendations regarding the organization’s member right and responsibilities policy
Know what member support services are available, including whether an interpreter is available if they don’t speak English.
Know what rules and regulations apply to their conduct.
Receive information on available treatment options and alternatives, presented in a manner appropriate to their conditions and ability to understand, regardless of cost or benefit coverage.
Be given the opportunity to be involved in decisions involving their health care, except when such participation is contraindicated (not recommended) for medical reasons.
Refuse treatment.
Be given health care services in line with federal and state regulations.
Be given, upon request, full information and necessary advice of available financial help for their care.
Receive, upon request, before treatment, a reasonable estimate of charges for medical care.
Receive a copy of a reasonably clear and easy-to-understand itemized bill and, upon request, have the charges explained.
Impartial access to medical treatment or accommodations, no matter of race, national origin, religion, physical handicap or source of payment.
Treatment for any emergency medical condition that will get worse from not getting the proper treatment.
Know if medical treatment is for experimental research and give consent or refusal to be involved in that research.
File grievances regarding any violation of their rights, as stated in Florida law, through the grievance procedure to the health care provider or health care facility that served them and to the appropriate state licensing agency.
Be free from any form of restraint (control) or seclusion used as coercion (force), discipline, convenience or retaliation (revenge).
Ask for and get a copy of their medical records and ask that those records be updated or corrected.

Patients’ Responsibilities
Patients have the responsibility to:
Provide their health care provider, to the best of their knowledge, correct and complete information about present complaints, past illnesses, hospitalizations, medications (including over-the-counter products), dietary supplements, any allergies or sensitivities, and other matters relating to their health.
Report unexpected changes in their conditions to their health care providers.
Report to their health care providers whether they understand a planned action and what is expected of them.
Participate in developing the mutually agreed upon treatment plan recommended by their health care provider and follow the plan and instructions.
Keep appointments and, when not able to for any reason, tell the health care provider or health care facility.
Understand their actions if they refuse treatment or don’t follow the health care provider’s instructions.
Inform their providers about any living wills, medical powers of attorney or other directives that could change their care.
Make sure the needs of their health care are met as quickly as possible.
Follow health care facility rules and regulations about member care and conduct.
Behave in a way that is respectful of all health care providers and staff as well as of other members.

First Line of Defense Against Fraud
General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse
As a recipient of funds from federally and state-sponsored health care programs, we each have a duty to help prevent, detect and deter fraud, waste and abuse. Simply’s commitment to detecting, mitigating and preventing
fraud, waste and abuse is outlined in our Corporate Compliance Program. Electronic copies of this policy and the Simply Code of Business Conduct and Ethics are available at [www.simplyhealthcareplans.com/provider](http://www.simplyhealthcareplans.com/provider) and [www.clearhealthalliance.com/provider](http://www.clearhealthalliance.com/provider).

As part of the requirements of the federal Deficit Reduction Act, each Simply provider is required to adopt Simply policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state-funded health care programs in which Simply participates.

As a Simply provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. You can report suspected fraud by calling [1-844-405-4296](tel:1-844-405-4296).

To report suspected fraud or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at [1-888-419-3456](tel:1-888-419-3456) or complete a [Medicaid Fraud and Abuse Complaint Form](https://apps.ahca.myflorida.com/mpicomplaintform), which is available online at [https://apps.ahca.myflorida.com/mpicomplaintform](https://apps.ahca.myflorida.com/mpicomplaintform). If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Inspector General’s Fraud Rewards Program. You can call the Inspector General’s office at [1-850-414-3990](tel:1-850-414-3990) (local) or [1-866-866-7226](tel:1-866-866-7226) (toll-free). The reward may be up to 25% of the amount recovered or a maximum of $500,000 per case ([Florida Statutes Chapter 409.9203](https://www.leg.state.fl.us/statutes/?Chap=409&Sec=9203)). You can talk to the Attorney General’s office about keeping your identity confidential and protected.

To meet the requirements under the Deficit Reduction Act, you must adopt the Simply fraud, waste and abuse policies and distribute them to any of your staff or contractors. If you have questions or would like to have more details concerning the Simply fraud, waste and abuse detection, prevention and mitigation program, please contact [1-844-405-4296](tel:1-844-405-4296).

**Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse**

Health care fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types so you can be the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following:

**Provider Fraud, Waste and Abuse**
- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can help prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

**Member Fraud, Waste and Abuse**
- Benefit sharing
- Collusion
- Drug trafficking
• Forgery
• Illicit drug seeking
• Impersonation fraud
• Misinformation and/or misrepresentation
• Subrogation and/or third-party liability fraud
• Transportation fraud

To help prevent fraud, waste and abuse, providers can educate members about the types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse.

One of the most important steps to help prevent member fraud is reviewing the Simply member ID card; it’s the first line of defense against fraud. Simply may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member even if that patient presents a Simply member ID. Providers should take measures to ensure the cardholder is the person named on the card. Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Simply member ID at all times, and report any lost or stolen cards to Simply as soon as possible.

We believe awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste or abuse and working with members to protect their Simply ID cards can help prevent fraud, waste and abuse. We encourage our members and providers to report any suspected instance of fraud, waste or abuse by calling Member Services at 1-844-406-2396 or Provider Services at 1-844-405-4296. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Simply will make every effort to maintain anonymity and confidentiality.

**HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

Simply strives to ensure that both Simply and contracted providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers must have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations.

• We recognize our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Simply.
  o Please note, privacy regulations allow the transfer or sharing of member information, which may be requested by Simply to conduct business and make decisions about care (such as a member’s medical record), to make an authorization determination, or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

• Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Simply, verify the receiving fax number is correct, notify the appropriate staff at Simply and verify the fax was appropriately received.

• Email (unless encrypted) should not be used to transfer files containing member information to Simply (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.
• Use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, post office box or department at Simply.
• The Simply voicemail system is secure and password-protected. When leaving messages for Simply associates, only leave the minimum amount of member information required to accomplish the intended purpose.
• When contacting Simply, please be prepared to verify the provider’s name, address and tax identification number, national provider identifier or Simply provider ID.
6 MEMBER MANAGEMENT SUPPORT

Welcome Call
As part of our member management strategy, Simply offers a welcome call to new members. During the welcome call, new members are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs such as scheduling an initial checkup.

Appointment Scheduling
Through our participating providers, we ensure members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a Simply member’s needs and requests in a timely manner, per the guidelines outlined in the Access and Availability section.

24/7 NurseLine
The Simply 24/7 NurseLine is designed to support providers by offering information and education to members after hours about medical conditions, health care and prevention. Members can call 1-844-406-2396 — This number is also listed on the member’s ID card. We provide triage services and help direct members to appropriate levels of care. This ensures members have an additional avenue of access to health care information when needed. Features of the 24/7 NurseLine include:
- Availability 24 hours a day, 7 days a week.
- Information based on nationally recognized and accepted guidelines.
- Free translation services for 150 different languages and for members that are deaf or hard of hearing.
- Education for members regarding appropriate alternatives for handling nonemergent medical conditions.
- Faxing of the member’s assessment report to the provider’s office within 24 hours of receipt of a call.

Interpreter Services
Interpreter services are available if needed (including language translation services and Braille). Contact Provider Services at 1-844-405-4296.

Health Promotion
Simply strives to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and then disseminated to our members, and health education classes are available through in-network community organizations and providers.

Ongoing projects that offer our members education and information regarding their health include:
- A newsletter to members at least once a year.
- Creation and distribution of a Simply health education tool newsletter used to inform members of health promotion issues and topics.
- Health Tips on Hold — educational telephone messages that play while the member is on hold.
- A monthly member calendar of health education programs.
- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards).
- Relationship development with community-based organizations to enhance opportunities for members.
- Available community resources via the Simply website at www.simplyhealthcareplans.com.
Case Management

Case management is designed to proactively respond to a member’s needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified (usually through initial health risk assessment process, a predictive model, precertification, admission review, and/or provider or member request), the Simply nurse helps to identify the appropriate case management program and any medically appropriate alternative methods or settings in which care may be delivered.

A provider, on behalf of the member, may refer them to case management. The clinician will work with the member, provider and/or the hospital to identify the necessary:

- Intensity level of case management services needed.
- Appropriate alternate settings where care may be delivered.
- Health care services required.
- Equipment and/or supplies required.
- Community-based services available.
- Communication required (that is, between the member and PCP).

During an admission, the Simply inpatient clinician will assist the member, utilization review team, and PCP and/or hospital in developing the discharge plan of care, ensuring that the member’s medical needs are met, and linking the member with community resources and Simply programs for outpatient case and/or disease management.

Please note, a Simply case manager cannot perform services that are limited to providers, such as overriding a prior authorization requirement for prescription medications.

HIV/AIDS Specialty Care

Clear Health Alliance provides members with comprehensive case and disease management. Our program includes care coordination across the continuum of care as well as secondary and tertiary prevention interventions. These services are based on a comprehensive, multidisciplinary and system-wide approach that encompasses evidence-based guidelines, practitioner practice and member empowerment strategies to improve members’ health outcomes.

CHA’s case management and care coordination staff work with the member’s provider, often an HIV specialist (see Credentialing), to ensure adherence with HIV antiretroviral therapy and medical care visits. This includes coordination of care for:

- Appointments with primary and specialist providers.
- Transportation.
- Other assistance as needed to facilitate care for members including surrogate decision makers if the enrollee is not capable of making his or her own decisions but does not have a legal representative or authorized representative available.

Case managers address the acuity level and service the unique needs of each member. They score the results of Health Risk Assessments and assign a member risk category. This category is based on specific disease stratification algorithms and may be assigned to include low, moderate or high score. Results guide the development of the individualized care plan, and the corresponding interventions designed to improve compliance and health outcomes and prevent acute events. Care plans are:

- Created in collaboration with the member/caregiver, legal guardian or other legally authorized individual.
- Based on member stratification.
- Designed to address interventions that:
- Improve member ability to adhere to the physician/provider treatment plan.
- Improve self-management.
- Decrease health risks.

We share the care plan with the primary and/or specialist provider(s) for review and feedback. We document, note and/or adjust the care plan as applicable based on any feedback obtained. And when a member receives services from a community agency (i.e., Ryan White) with member approval, we share the established care plan as appropriate with the case managers in these agencies to ensure all issues are addressed and there is no duplication of services.

Clear Health Alliance allows HIV specialists, including infectious disease providers, to be PCPs, which is unique to our plan and increases access to care. These providers, marked with a red ribbon in our provider directory, receive additional training in longitudinal management of HIV/AIDS and frequent comorbidities and bring experience, expertise and cultural sensitivity to our members. These providers are acutely aware of the incidence and implications of physical and behavioral health comorbidities, and they’ve developed robust integrated processes to deliver whole-person care.

Clear Health Alliance works closely with our primary care partners to build capacity for integrated care and expand member access to routine screening and follow-up for behavioral health conditions. Nationwide, more than half of patients seek treatment for behavioral health conditions from their PCPs, with non-psychiatrists writing more than three-fourths of antidepressant prescriptions. The presence of several mental health and substance use diagnoses are known to be common among people living with HIV/AIDS. Clear Health Alliance requires PCPs to routinely screen members for a range of behavioral health and substance use conditions as part of routine, preventive care. We provide our PCPs with the tools and expertise needed to complete the screenings, and we reimburse PCPs for routine screenings. Screening requirements are included in our provider contracts and in this provider manual.

We make many valid and reliable screening tools for behavioral health conditions easily accessible on our provider website ([www.clearhealthalliance.com/provider](http://www.clearhealthalliance.com/provider)) and train PCPs on the appropriate use of them. Examples of these tools include:

- Depression screening: *Patient Health Questionnaire-9 (PHQ-9)*
- ADHD screening: Conners rating forms, Vanderbilt scale, Barkley scale
- Psychosocial problems screening: *The Pediatric Symptom Checklist*
- *Mood Disorder Questionnaire*
- Anxiety screening: *Generalized Anxiety Disorder-7*
- SUD screening: *CAGE-AID*
- Mini-Cognitive Assessment Instrument
- Comprehensive training on SBIRT
- The “5 A's” model for treating tobacco use and dependence

**Disease Management Services**

Disease management services are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The programs include a holistic, member-centric care management approach that allows case managers to focus on multiple needs of members.

Disease management (DM) services include but are not limited to:

- Behavioral health
  - Bipolar disorder
- Oncology (active and post-treatment)
- End of life (palliative program)
In addition to our condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with weight management and smoking cessation services.

**Program Features**

- Proactive identification processes
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models to include physician and support in treatment planning
- Continuous self-management education
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with primary and ancillary providers regarding patient status

Simply DM programs are based on nationally approved clinical practice guidelines, located on our provider website. A copy of the guidelines can be printed from the website, or you can contact Provider Services at 1-844-405-4296 to receive a printed copy.

**Who is Eligible?**

All members with the above conditions/diagnoses are eligible for DM services. Members are identified through efforts that include but are not limited to continuous case finding, welcome calls, claims mining and referrals.

As valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/surveillance as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs, and we provide telephonic and/or written updates regarding patient status and progress.

**DM Provider Rights and Responsibilities**

The provider has the right to:

- Have information about Simply, including provided programs and services, our staff, and our staff’s qualifications and any contractual relationships.
- Decline to participate in or work with the Simply programs and services for his or her patients, depending on contractual requirements.
- Be informed of how Simply coordinates our interventions with treatment plans for individual patients.

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1 Managed by the health plan’s Case Management department.
2 Managed by the health plan’s Case Management department for MMA members only.
• Know how to contact the person responsible for managing and communicating with the provider’s patients.
• Be supported by the organization to make decisions interactively with patients regarding their health care.
• Receive courteous and respectful treatment from Simply staff.
• Communicate complaints regarding the DM program as outlined in the Simply provider complaint and grievance procedure.

Hours of Operation
Simply case managers are licensed nurses and are available Monday to Friday, 8 a.m. to 5 p.m. ET. Confidential voicemail is available 24 hours a day.

Contact Information
Call 1-888-830-4300 to reach a case manager, or refer to our provider website for additional information about DM. Members can obtain information about our DM program by visiting http://www.simplyhealthcareplans.com/Medicaid and www.clearhealthalliance.com/member or calling 1-888-830-4300.

Health Management: Healthy Families
Healthy Families is a six-month program for children 7 to 17 years of age who are overweight, obese, or at risk of becoming overweight or obese. Healthy Families includes coaching using motivational interviewing, lifestyle education and written materials to support member-identified goals. Refer members to the program by calling 1-844-421-5661.

Health Education Advisory Committee
The health education advisory committee, sometimes called the member advisory committee, provides advice to Simply regarding member health education and outreach program development. The committee strives to ensure materials and programs meet cultural competency requirements and are both understandable to the member and address the member’s health education needs.

The committee’s responsibilities are to:
• Provide input into the annual review of policies and procedures, the QM program results and outcomes, and future program goals and interventions.
• Identify health education needs of the membership based on review of demographic and epidemiologic data.
• Assist the health plan in decision-making in the areas of member grievances, marketing, member services, case management, outreach, health needs, performance improvement projects and cultural competency.
• Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
• Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program.
• Review the health education plan and make recommendations on health education strategies.

Women, Infants and Children Program
The Women, Infants and Children (WIC) program impacts the health of mothers and children in the medically needy population. Optimal nutritional status during pregnancy and early childhood provides the best chance for the future of Floridians. Medicaid recipients eligible for WIC benefits include the following classifications:
• Pregnant women
• Women who are breastfeeding infant(s) up to one year postpartum
• Women who are not breastfeeding up to six months postpartum
• Infants under the age of 1
• Children under the age of 5

Network providers are expected to coordinate with the WIC program. Coordination includes referral to the local WIC office for all infants and children up to age 5 and pregnant, breastfeeding and postpartum women.

WIC Referrals
Simply providers are required to refer all infants and children up to age 5 and pregnant, breastfeeding and postpartum women to the local WIC office. Providers are required to send WIC:
• 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.
• Any identified medical and/or nutritional problems.

For each subsequent WIC certification, providers are required to coordinate with the local WIC office to provide the above referral data from the most recent EPSDT visit. Each time providers complete the WIC referral form, they are required to give a copy to the patient and keep a copy in the patient’s medical record. Providers should keep a copy of these documents in the medical record to provide evidence the required process has taken place.

Members may apply for WIC services at their local WIC agency service. Please call Provider Services at 1-844-405-4296 for the agency nearest to the member. For more information, please visit http://doh.state.fl.us/family/wic.

Pregnancy-Related Requirements

Prenatal Risk Screening
Providers seeing Simply members for pregnancy-related diagnoses must:
• See the pregnant member within 30 days of enrollment.
• Complete Florida’s Healthy Start prenatal risk screening instrument for each pregnant member as part of her first prenatal visit as required by Section 383.14, F.S., Section 381.004, F.S., and 64C-7.009, F.A.C.*
  o Use the Department of Health prenatal risk form (DH Form 3134), which can be obtained from the local County Health Department (CHD).
  o Retain a copy of all documentation of Healthy Start screenings, assessments, findings and referrals in the enrollees’ medical records.
  o Submit the completed DH Form 3134 to the CHD in the county in which the prenatal screen was completed within ten business days of completion of the screening.
• Collaborate with the Healthy Start care coordinator within the member’s county of residence to assure risk-appropriate care is delivered.

* Pregnant members 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 member or infant is invited to participate based on factors other than score.
• If the determination is made subsequent to risk screening, the 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 B, substance abuse or domestic violence.
Infant Risk Screening
Providers must complete Florida’s Healthy Start infant (postnatal) risk screening instrument (DH Form 3135) with the certificate of live birth and transmit the documents to the CHD in the county in which the infant was born within five business days of the birth. Providers must retain a copy of the completed DH Form 3135 in the patient’s medical record and provide a copy to the patient.

HIV Testing
Providers are required to give all women of childbearing age HIV counseling and offer them HIV testing (see Chapter 381, F.S.).

- Providers, in accordance with Florida law, must offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 to 32 weeks of pregnancy.
- Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test (see Section 384.31, F.S. and 64D-3.019, F.A.C.)
- For those women who are infected with HIV, providers must offer and provide counseling about the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (as per the Public Health Service Task Force Report titled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States). To receive a copy of the guidelines, contact the Department of Health, Bureau of HIV/AIDS, at 1-850-245-4334 or visit https://aidsinfo.nih.gov/guidelines.

Hepatitis B Screenings
Providers are required to:

- Screen all pregnant members receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit.
- Perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant members who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection; this test shall be performed at the same time the other routine prenatal screenings are ordered.
- Report all HBsAg-positive women to the local CHD and to Healthy Start regardless of their Healthy Start screening score.

Hepatitis B and Hepatitis B Immune Globulin Vaccines

- Infants born to HBsAg-positive members must receive Hepatitis B immune globulin and the Hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and complete the Hepatitis B Maxine vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.
- Providers must test infants born to HBsAg-positive members for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
- Providers must report to the local CHD a positive HBsAg result in any child 24 months or younger within 24 hours of receipt of the positive test results.
- Providers must refer infants born to members who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening scores.

Testing Positive for Hepatitis B
Providers are required to:

- Report to the perinatal Hepatitis B prevention coordinator at the local CHD all prenatal or postpartum patients who test HBsAg-positive.
- Report said patients’ infants and contacts to the perinatal Hepatitis B prevention coordinator at the local CHD.
• Report the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or EDC, whether or not the enrollee received prenatal care, and immunization dates for infants and contacts.

• Use the perinatal Hepatitis B case and contact report (DH Form 1876) for reporting purposes.

Providers are required to provide the most appropriate and highest level of quality care for pregnant members, including but not limited to the following:

• Prenatal care
  o Complete a pregnancy test and a nursing assessment with referrals to a physician, physician assistant or advanced registered nurse practitioner for comprehensive evaluation.
  o Complete case management through the gestational period according to the needs of the member.
  o Ensure any necessary referrals and follow-up.
  o Schedule return prenatal visits at least every four weeks until week 32, every two weeks until week 36 and every week thereafter until delivery unless the member’s condition requires more frequent visits.
  o Contact those members who fail to keep their prenatal appointments as soon as possible and arrange for their continued prenatal care.
  o Assist members in making delivery arrangements if necessary.
  o Screen all pregnant members for tobacco use and make smoking cessation counseling and appropriate treatment available as needed.

• Nutritional assessment/counseling — Providers are required to:
  o Supply nutritional assessment and counseling to all pregnant members.
  o Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast-milk substitutes.
  o Offer a mid-level nutrition assessment.
  o Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or a physician following the nutrition assessment.
  o Keep documentation of the nutrition care plan in the medical record by the person providing counseling.

• Obstetrical delivery — Simply has developed and uses generally accepted and approved protocols for both low-risk and high-risk deliveries, which reflect the highest standards of the medical profession, including Healthy Start and prenatal screening, and requires all providers use these protocols:
  o Providers must document preterm delivery risk assessments in the enrollee’s medical record by the 28th week.
  o If the provider determines the member’s pregnancy is high-risk, the provider’s obstetrical care during labor and delivery must include preparation by all attendants for symptomatic evaluation and as the member progresses through the final stages of labor and immediate postpartum care.

• Newborn care — Providers are required to supply the highest level of care for the newborn beginning immediately after birth. Such level of care shall include but not be limited to the following:
  o Instilling prophylactic eye medications into each eye of the newborn
  o When the mother is Rh-negative, securing a cord blood sample for type Rh determination and direct Coombs testing
  o Weighing and measuring the newborn
  o Examining the newborn for abnormalities and/or complications
  o Administering 0.5 mg of vitamin K
  o Calculating an Apgar score
  o Assessing any other necessary and immediate need for referral in consultation with a specialty physician, such as the Healthy Start (postnatal) infant screen
  o Administering any necessary newborn and infant hearing screenings (must be conducted by a licensed audiologist pursuant to Chapter 468, F.S.; a physician licensed under Chapters 458 or 459, F.S.; or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist)
• Postpartum care — The provider is required to:
  o Administer a postpartum examination for the member between 21 and 56 days post-delivery.
  o Supply voluntary family planning, including a discussion of all methods of contraception as appropriate.
  o Ensure eligible newborns are enrolled with Simply and that continuing care of the newborn is provided through the EPSDT program component.

Healthy Start Program

Healthy Start is a national program that provides comprehensive developmental services for pregnant women, infants and preschool children up to age 3. We collaborate with community Healthy Start programs to provide timely and age-appropriate health screening and referrals for routine health services.

  • Simply provides each member with a community-based PCP.
  • Simply encourages Healthy Start staff to refer members to see their PCP for screenings and health services.
  • Simply supports timely and complete immunization of all children.
  • Simply supports routine dental, vision and hearing exams for members.
  • Simply encourages physical exams in accordance with the EPSDT periodicity schedule.
  • Simply supports personal hygiene as part of the child’s daily routine through age-appropriate educational programs.
  • The Simply Member Services staff, nurse case managers and Health Promotion staff coordinate the delivery of services for children and work with their caretakers to eliminate barriers to timely health care.

Local Health Department

Simply work collaboratively with local health departments. Members have access to any county health department without authorization for the following services:

  • Diagnosis and treatment of sexually transmitted diseases and other communicable diseases, such as tuberculosis and HIV.
  • Immunizations.
  • Family planning services and related pharmaceuticals.
  • School health services listed above and services rendered on an urgent basis by such providers.
  • Adult Screening Services
  • Well-Child visits
  • Medical Primary Care Services
  • Registered Nurse Services
7 PROVIDER RESPONSIBILITIES

Medical Home
The PCP is the foundation of the medical home, responsible for providing, managing and coordinating all aspects of the member’s medical care and providing all care that is within the scope of his or her practice. The PCP is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a medical home.

Simply promotes the medical home concept to all of its members. The PCP is the member and family’s initial contact point when accessing health care. The PCP relationship with the member and family, together with the health care providers within the medical home and the extended network of consultants and specialists with whom the medical home works, have an ongoing and collaborative contractual relationship. The providers in the medical home are knowledgeable about the member and family’s special and health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation or specialty/hospital services or for health and health-related services by the PCP through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through a planned feedback mechanism with the PCP, who receives them into the medical home for continuing primary medical care and preventive health services.

Providers’ Bill of Rights
Each health care provider who contracts with the Florida Agency for Health Care Administration (AHCA) and/or Florida Healthy Kids or subcontracts with Simply to furnish services to members will be assured of the following rights:

- To advise or advocate (within the lawful scope of practice) on behalf of a member who is his or her patient for the following:
  - The member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs to decide among all relevant treatment options
  - The risks, benefits and consequences of treatment or nontreatment
  - The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions

- To receive information on the grievance, appeal and fair hearing procedures

- To have access to the Simply policies and procedures covering the authorization of services

- To be notified of any decision by Simply to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested

- To challenge, on behalf of Medicaid members, the denial of coverage of or payment for medical assistance

- To be free from provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment

- To be free from discrimination for participation, reimbursement or indemnification when acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification

Responsibilities of the PCP
The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs health and RHCs may be included as PCPs. Some of the PCP’s responsibilities are listed below:

- All Florida Healthy Kids PCPs must be board-certified pediatricians or family practice physicians.
• All PCPs must provide coverage 24 hours a day, 7 days a week, and regular hours of operation must be clearly defined and communicated to members.
• All PCPs must provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special health care requirements.
• The PCP is the coordinator of all care. Therefore, the PCP agrees to ensure continuity of care to Simply members and arrange for the provision of services when the PCP’s office is not open. Documentation of emergency room visits, hospital discharge summaries or operative reports are to be obtained by the PCP and maintained in the medical record.
• The PCP agrees to practice in his or her profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities, and not discriminate against anyone based on his or her health status.
• The PCP must conduct a health assessment of all new enrollees within 90 days of the effective date of enrollment.
• When clinically indicated, the PCP agrees to contact Simply members regarding appropriate follow-up of identified problems and abnormal laboratory, radiological or other diagnostic findings.
• The PCP must establish office procedures to facilitate the follow-up of member referrals and consultations. The PCP is responsible for obtaining and maintaining in the medical record the results or findings of consultant referrals. If findings were communicated through telephonic consultation, a summary of the findings and name of the specialist must be documented.
• The PCP must participate in any system established by Simply to facilitate the sharing of medical records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor’s consultation, examination and drugs for STDs in accordance with Section 384.30 (2), F.S.).
• The PCP agrees, when the need arises, to contact Simply regarding interpretive services via AT&T or other service for members who may require language assistance.
• If a new PCP is added to a group, Simply must approve and credential the provider before the provider may treat members. Notification of changes in the provider staff is the responsibility of the provider’s office and must be communicated to Simply in writing.
• The PCP agrees to participate and cooperate with Simply in quality management, utilization review, continuing education and other similar programs established by Simply.
• The PCP agrees to participate in and cooperate with the Simply grievance and appeal procedures when Simply notifies the PCP of any member complaints or grievances.
• Balance billing for a covered service is not permitted. An Florida Healthy Kids member can only be billed for applicable copays if the copay was not collected at the time the service was rendered.
• If a PCP agreement with Simply is terminated, the PCP must continue care in progress during and after the termination period for up to six months until a provision is made by Simply for the reassignment of members. Pregnant members can continue receiving services through postpartum care. Payment for covered services under this continuity of care period will be made in accordance with the rates effective in the provider’s participating agreement at the time of termination.
• The PCP may opt to go bare and not carry malpractice liability insurance but must follow the requirements under F.S. 458.320.
• The PCP must comply with all applicable federal and state laws regarding the confidentiality of member records.
• The PCP must certify to Simply, upon credentialing and recredentialing, that their active patient load does not exceed 3,000 (including all commercial, Medicare, Florida Healthy Kids, other SMMC plan and children’s medical services patients). Patients are defined as active when the PCP sees them at least two times a year.
• The PCP agrees to develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
• The PCP agrees to establish appropriate policies and procedures to fulfill obligations under the Americans with Disabilities Act (ADA).
• The PCP agrees to support and cooperate with the Simply Quality Management Program to provide quality care in a responsible and cost-effective manner.
• The PCP agrees to provide HIV counseling and offer HIV testing to all members of childbearing age.
• The PCP agrees to refer pregnant women or infants to Healthy Start and WIC programs within 30 days of enrollment.
• The PCP agrees to provide counseling and education in support of Medicaid quality and benefit enhancement (QBE) services, which include children’s programs, domestic violence, pregnancy prevention (including abstinence), prenatal/postpartum care, smoking cessation and substance use programs. The PCP agrees to include information on the programs and community resources encouraged by Simply.
• The PCP agrees to provide counseling and offer the recommended antiretroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs regardless of their screening scores.
• The PCP agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the PCP agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.
• The PCP agrees to inform Simply if he or she objects to the provision of any counseling, treatments or referral services on religious grounds.
• The PCP agrees to treat all members with respect and dignity, provide them with appropriate privacy, and treat members’ disclosures and records confidentially, giving members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.
• The PCP agrees to provide members with complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, regardless of whether members have completed an advance directive, except when contraindicated for medical reasons.
• The PCP agrees to an adequate and timely communication among providers and the transfer of information when members are transferred to other health care providers. The PCP agrees to obtain a signed and dated release allowing for the release of information to Simply and other providers involved in the member’s care.
• The PCP agrees to physically screen members taken into the protective custody, emergency shelter or foster care programs by the Department of Children and Families (DCF) within 72 hours or immediately if required.
• The PCP must ensure food snacks or services provided to members meet their clinical needs and are prepared, stored, secured and disposed of in compliance with local health department requirements.
• The PCP agrees that provisions will be made to minimize sources and transmission of infection in the office.
• The PCP agrees to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality member care.
• The PCP agrees that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care.
• The PCP is enrolled in the Florida state Health Online Tracking System (SHOTS) statewide registry. Providers should bill Medicaid Fee-for-Service directly for immunizations provided to Title XXI MediKids participants.
• The PCP agrees to provide immunization information to the DCF upon receipt of members’ written permission and DCF’s request for members requesting temporary cash assistance from the DCF.
• The PCP agrees to attempt to obtain medical records on any member(s) receiving services from a non-network provider with the proper release specific to any diagnosis signed by the member. These services include but are not limited to family planning, preventive services and sexually transmitted diseases.
• The PCP agrees to maintain vaccines safely and in accordance with specific guidelines, to provide member immunizations according to professional standards, and to maintain up-to-date member immunization records.
Medicaid PCPs must enroll in the VFC program. Vaccines from the VFC program must only be used for Medicaid members who are 0 to 18 years of age, excluding MediKids members. Florida Medicaid requires vaccines for children from birth to 20 years of age. Simply will cover the provision of these vaccines as medically necessary.

- The PCP for MediKids members must bill the Medicaid Fee-for-Service program for all vaccines administered to Florida Healthy Kids members and bill Simply for reimbursement of the vaccine administration fee on the administration code(s).

- The PCP for Florida Healthy Kids members should use his or her own purchased vaccine supply and bill the Florida Medicaid program for the vaccine. PCP shall bill Simply for the administration. PCP for Florida Healthy Kids members should use his or her own vaccine supply and bill Simply for the vaccine and administrative fee. PCPs for Florida Healthy Kids will be enrolled in the Florida State Health Online Tracking System (SHOTS) statewide registry. Providers should bill Medicaid Fee-for-Service directly for immunizations provided to Title XXI MediKids participants.

- The PCP agrees to reach out to members to schedule an appointment for postdischarge or after they are notified the member went to the emergency room.

- The PCP agrees to assist with Clear Health Alliance eligibility verification through provision of HIV status verification when available.

It is important that PCPs do not send Simply members to local health departments for immunizations. Florida Healthy Kids members are required to receive their immunizations from their PCPs to ensure continuity of care, timeliness and accurate recordkeeping.

Role of the PCP

- Each Medicaid and Florida Healthy Kids member will select or be assigned a PCP at the time of enrollment. Medicaid membership is limited to 1,500 members per full-time PCP and may be increased by 750 members for each advanced registered nurse practitioner (ARNP) or physician assistant (PA) affiliated with the physician. The maximum is a 3,000 active patient load for all populations (including but not limited to Medicaid FFS, children’s medical services, other SMMC plans and Kidcare/Florida Healthy Kids).

- The PCP coordinates the member’s health care needs through a comprehensive network of specialty, ancillary and hospital providers.

- For new members, the provider will contact each new member within 60 days of enrollment to perform an initial health risk assessment.

- The provider must notify Simply if he or she is unable to contact the member within the 90-day enrollment period. Simply will send a release form to Medicaid members for the purpose of Simply and state agency review. Once a release has been signed, the PCP will request records from previous care providers. The PCP will use the previous medical records and the health risk assessments to identify members who have not received age-appropriate preventive health screenings (Child Health Check-Ups) for children from birth through 20 years of age according to the standards established by the American Academy of Pediatrics and endorsed by AHCA. Health screenings for adults will meet Simply standards, including those standards established by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force. When external regulating agencies impose more stringent health screening standards, the PCP is required to comply with those standards.

- The PCP is responsible 24/7 for providing or arranging all covered services, including prescribing, directing and obtaining appropriate authorizations of all care for members who have been assigned to the PCP. After-hours coverage consists of an answering service, call forwarding, provider call coverage or other customary means approved by Simply. The chosen method must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision.

- To the extent necessary, the PCP is responsible for coordinating coverage for members with an alternate Simply network physician. All financial arrangements must be made between the PCP and covering
physician. The PCP is also responsible for notifying Simply in writing two weeks prior to his or her absence of the duration of the absence and the physician who will be providing the coverage. The covering physician must be a Simply network physician.

- All PCPs and physician extenders (ARNPs, PA) must be credentialed by Simply or one of the Simply delegated credentialing entities. All personnel assisting in the provision of health care services to members are to be appropriately trained, qualified and supervised in the care provided.
- PCPs must notify their Provider Relations representative when a new provider joins the practice.
- Anytime a new provider joins a practice, that individual must be credentialed with the plan and cannot see members until the credentialing process is completed. Nonemergent services must not be provided by a noncredentialed physician, and such services will not be covered by Simply. The PCP is responsible for the direct training and supervision of medical assistants. Duties of the medical assistant will be strictly limited to those identified in F.S. Section 458.3485.
- All PCP facilities must have handicap accessibility, adequate space, supplies, good sanitation and fire safety procedures in operation.
- The PCP will only collect copays from Florida Healthy Kids members when applicable and permitted under state and federal law. The PCP must not charge any member for missed appointments.
- PAs and ARNPs may not be assigned as the PCP for Simply members.

**Physician Extenders**

Physician extenders (for example, ARNPs, PAs) must be credentialed prior to seeing Simply members. They must clearly and appropriately identify themselves as an ARNP or PA to the member. Office staff must appropriately refer to and identify physician extenders as ARNPs or PAs.

Supervising physicians must review, sign and date PA medical record entries within seven days in accordance with F.A.C. 64B8-30.012 (3). Record entries of ARNPs do not require cosigning.

**Background Checks**

All Simply providers must have a Level 2 criminal history background screening completed prior to joining the Simply network. This includes the provider’s subcontractors or any employees or volunteers of their subcontractors who meet the definition of “direct service provider” to verify that these individuals do not have disqualifying offenses as provided for in F.S. Section 430.0402 as created and F.S. Section 435.04. Any subcontractor, employee or volunteer of a subcontractor meeting the definition of a “direct service provider” who has a disqualifying offense is prohibited from providing services to the elderly as set forth in F.S. Section 430.0402.

**Abuse, Neglect and Exploitation**

All Simply providers are required to report elder abuse, neglect and exploitation of vulnerable adults to the statewide Elder Abuse Hotline at 1-800-96ABUSE (1-800-962-2873).

- Simply direct-service providers are also required to complete abuse, neglect and exploitation training including training on how to identify victims of human trafficking.
- Per s.408.812, F.S., Simply providers are required to report suspected unlicensed assisted licensed facilities and adult family care homes to AHCA and Simply.

**Abuse** means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental or emotional health. Abuse includes acts and omissions.

**Exploitation** of a vulnerable adult means a person who:
• Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses or endeavors to obtain or use, a vulnerable adult’s funds, assets or property for the benefit of someone other than the vulnerable adult.
• Knows (or should know) the vulnerable adult lacks the capacity to consent and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

Neglect of an adult means the failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and behavioral health of the vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision and medical services that a prudent person would consider essential for the well-being of the vulnerable adult. The term neglect also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. Neglect is repeated conduct or a single incident of carelessness that produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

Identifying Victims of Human Trafficking

The following is a list of potential red flags and indicators of human trafficking. If you see any of these red flags, contact the National Human Trafficking Hotline at 1-888-373-7888 to report the situation or for specialized, victim services referrals.

The presence of these red flags is an indication that further assessment may be necessary to identify a potential human-trafficking situation. This list is not exhaustive and represents only a selection of possible indicators. Also, the red flags in this list may not be present in all trafficking cases and are not cumulative. Indicators reference conditions a potential victim might exhibit.

Common work and living conditions:
• Is not free to leave or come and go as they wish
• Is in the commercial sex industry and has a pimp/manager
• Is unpaid, paid very little or paid only through tips
• Works excessively long and/or unusual hours
• Is not allowed breaks or suffers under unusual restrictions at work
• Owes a large debt and is unable to pay it off
• Was recruited through false promises concerning the nature and conditions of their work
• High security measures exist in the work and/or living locations (i.e., opaque windows, boarded-up windows, bars on windows, barbed wire, security cameras, etc.)

Poor mental health or abnormal behavior:
• Is fearful, anxious, depressed, submissive, tense, nervous or paranoid
• Exhibits unusually fearful or anxious behavior after bringing up law enforcement
• Avoids eye contact

Poor physical health:
• Lacks medical care and/or is denied medical services by employer
• Appears malnourished or shows signs of repeated exposure to harmful chemicals
• Shows signs of physical and/or sexual abuse, physical restraint, confinement or torture

Lack of control:
• Has few or no personal possessions
- Is not in control of their own money, has no financial records or bank account
- Is not in control of their own identification documents (ID or passport)
- Is not allowed or able to speak for themselves (a third party may insist on being present and/or translating)

Other:
- Claims of just visiting and inability to clarify where they’re staying/address
- Lack of knowledge of whereabouts and/or of what city they’re in
- Loss of sense of time
- Has numerous inconsistencies in their story

Note: According to federal law, any minor under the age of 18 engaging in commercial sex is a victim of sex trafficking, regardless of the presence of force, fraud or coercion.

Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through Simply must be accessible to all members.

Simply is dedicated to arranging access to care for our members. The ability of Simply to provide quality access depends on the accessibility of network providers. Providers are required to adhere to the following access standards:

<table>
<thead>
<tr>
<th>Service</th>
<th>Access Requirement</th>
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<tbody>
<tr>
<td>Emergent or emergency visits</td>
<td>Immediately upon presentation</td>
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<tr>
<td>Urgent, nonemergency visits, medical or behavioral health</td>
<td>MMA/Specialty&lt;br&gt;  - Within 48 hours of request for services that do not require prior authorization&lt;br&gt;  - Within 96 hours of request for services that do not require prior authorization&lt;br&gt;Florida Healthy Kids&lt;br&gt;  - Emergency care shall be provided immediately.&lt;br&gt;  - Urgently needed care shall be provided within twenty-four (24) hours.</td>
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<tr>
<td>Nonurgent medical</td>
<td>MMA/Specialty&lt;br&gt;  - Within 14 days of request for ancillary services for the diagnosis or treatment of injury, illness or other health condition&lt;br&gt;  - Within 30 days of request for a primary care appointment&lt;br&gt;  - Within 60 days of request for a specialist appointment after the appropriate referral is received by the specialist&lt;br&gt;Florida Healthy Kids&lt;br&gt;  - Routine care of enrollees who do not require emergency or urgent care shall be provided within seven calendar days of the enrollee’s request for services.&lt;br&gt;  - Routine physical examinations shall be provided within four weeks of the enrollee’s request.&lt;br&gt;  - Follow-up care shall be provided as medically appropriate.</td>
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<tr>
<td>Nonurgent, behavioral health</td>
<td>MMA/Specialty&lt;br&gt;  - Seven days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment&lt;br&gt;  - 14 days for initial outpatient behavioral health treatment</td>
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<tr>
<td>Service</td>
<td>Access Requirement</td>
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<tr>
<td>Florida Healthy Kids</td>
<td>• Seven calendar days for routine care</td>
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<td>• Four weeks for routine physical exams</td>
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<td>• As medically appropriate for follow-up care</td>
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Providers must also ensure member access to a follow-up appointment within seven days of discharge.

Providers may not use discriminatory practices, such as preference to other insured or private-pay patients, separate waiting rooms, or appointment days.

Simply will routinely (no less than quarterly) monitor adherence to the access care standards, including monitoring PCPs, specialists and behavioral health providers. We will report results for Medicaid PCPs to AHCA.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

• Have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes.
• Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP; someone must be available to answer the designated provider’s telephone; another recording is not acceptable.
• Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Simply network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are not acceptable:

• Only answering the office telephone during office hours
• Only answering the office telephone after hours by a recording that tells members to leave a message
• Answering the office telephone after hours by a recording that directs members to go to an emergency room for any services needed
• Answering the office telephone with an answering machine that does not explain what to do in an emergency (for example, dial 911, etc.)
• Returning after-hours calls outside of 30 minutes

**Member Missed Appointments**

Simply members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Simply requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Simply members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. Simply staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP. Please note that the provider agrees not to charge a member for missed appointments.
Noncompliant Simply Members

Simply recognizes that providers may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment, and/or making or appearing for appointments, please call Provider Services at 1-844-405-4296. Members should be referred to the Simply for case management services.

PCP Transfers

To maintain continuity of care, Simply encourages members to remain with their PCP. However, members may request to change their PCP for any reason by contacting Member Services at 1-844-406-2396. The member’s name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

Covering Physicians

During a provider’s absence or unavailability, the provider needs to arrange for coverage for his or her members. The provider will either: 1) make arrangements with one or more network providers to provide care for his or her members or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. Covering providers must have an active limited or fully enrolled Medicaid ID number.

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including without limitation, any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider’s adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider’s behalf.

Specialist as a PCP

Under certain circumstances, when a member requires the regular care of the specialist, a specialist may be approved by Simply to serve as a member’s PCP. The criteria for a specialist to serve as a member’s PCP include the member having a chronic, life-threatening illness or condition of such complexity whereby:
- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation, including contractual obligations and credentialing; provide access to care 24 hours a day, 7 days a week; and coordinate the member’s health care, including preventive care. When such a need is identified, the member or specialist must contact the Simply Member Services department and complete a Specialist as PCP Request Form. A Simply case manager will review the request and submit it to the Simply medical director. Simply will notify the member and the provider of its determination in writing within 30 days of receiving the request. Should Simply deny the request, Simply will provide written notification to the member and provider outlining the reason(s) for the denial of the request within one day of the decision. Specialists serving as PCPs will continue to be paid fee-for-service while serving as the member’s PCP. The designation cannot be retroactive.
Note: Clear Health Alliance allows certain specialists, such as Infectious Disease providers, to serve as a PCPs for Clear Health Alliance members.

**Specialty Referrals**

To reduce the administrative burden on the provider’s office staff, Simply has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist physician or other health care provider to request an extended authorization.

The provider can request an extended authorization by contacting the member’s PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity-of-care provisions in the provider’s contract with Simply will apply. The provider may renew the authorization by submitting a new request to the PCP. Additionally, Simply requires the specialist physician or other health care provider to provide regular updates to the member’s PCP (unless acting also as the designated PCP for the member). Should the need arise for a secondary referral, the specialist physician or other health care provider must contact Simply for a coverage determination.

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Simply network, the referring physician will request authorization from Simply for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider’s application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the Simply medical appeal process.

Providers may contact case management to facilitate referrals to services outside our network or services provided through interagency agreements. The case manager will assist as needed to meet the member’s additional supportive care needs such as food, bank, legal or housing assistance; support groups/psychosocial counseling; clinical trials; and outpatient substance abuse-related programs geared towards the issues and concerns of our members.

**Second Opinions**

A member, parent, and/or legally appointed representative or the member’s PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion will be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the provider referral directory) or with precertification from a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Simply may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
• When denied coverage is appealed
• When an experimental or investigational service is requested

When we request a second opinion, we'll make the necessary arrangements for the appointment, payment and reporting. Simply will inform the member and the PCP of the results of the second opinion and the consulting provider’s conclusion and recommendation(s) regarding further action.

Specialty Care Providers
To participate in our programs, providers must be enrolled in Florida Medicaid and have an active limited or fully enrolled Medicaid ID number. Providers must also be a licensed provider by the state before signing a contract with Simply.

Simply contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a PCP within the network (see Role and Responsibility of the Specialty Care Provider). In addition to sharing many of the same responsibilities as the PCP (see Responsibilities of the PCP), the specialty care provider provides services that includes but is not limited to the following:
• Allergy and immunology services
• Burn services
• Community behavioral health (for example, mental health and substance abuse) services
• Cardiology services
• Clinical nurse specialists, psychologists and clinical social workers (that is, behavioral health)
• Critical care medical services
• Dermatology services
• Endocrinology services
• Gastroenterology services
• General surgery
• Hematology/oncology services
• Neonatal services
• Nephrology services
• Neurology services
• Neurosurgery services
• Ophthalmology services
• Orthopedic surgery services
• Otolaryngology services
• Perinatal services
• Pediatric services
• Psychiatry (adult) assessment services
• Psychiatry (child and adolescent) assessment services
• Trauma services
• Urology services

Role and Responsibility of the Specialty Care Provider
Members may self-refer to a participating specialist provider, including mental health and substance abuse providers. Obligations of the specialist include but are not limited to the following:
• Complying with all applicable statutory and regulatory requirements of the Medicaid program
• Accepting all Simply members who self-refer or are directed to the specialist provider for care
- Submitting required claims information
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member’s PCP on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member’s PCP when scheduling a hospital admission or scheduling any procedure
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist will:
- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on a Fee-For-Service (FFS) basis; provide coordination necessary for referrals to other specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers.
- Provide 24/7 coverage and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special health care requirements.
- Participate in the systems established by Simply that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Participate and cooperate with Simply in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established by Simply.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to members.
- Participate in and cooperate with the Simply complaint and grievance processes and procedures; Simply will notify the specialist of any member grievance brought against the specialist.
- Not balance bill members.
- Continue care in progress during and after termination of his or her contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with OSHA standards.
- Make best efforts to fulfill the obligations under the ADA applicable to his or her practice location.
- Support, cooperate and comply with the Simply Quality Management Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Simply if a member objects for religious reasons to the provision of any counseling, treatment or referral services.
- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments that may be self-administered.
• When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
• Have a policy or procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
• Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.
• Agree that any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.

Specialty Care Providers Access and Availability
Simply will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he or she has a provider agreement with Simply to provide specialty services to members. For more information on our access and availability guidelines, refer to the Access and Availability section.

Open-Access Specialist Providers
Members may self-refer to the network providers listed below without a PCP referral. Providers should establish processes for the identification of the member’s PCP and forward information concerning the member’s evaluation and treatment to the PCP after obtaining consent from the member as appropriate under legal requirements.
• Chiropractors
• Podiatrists
• Dermatologists
• OB/GYN

Cultural Competency
Cultural competency refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of individuals, and protects and preserves the dignity of each. This includes individuals with limited-English proficiency and those with disabilities regardless of gender, sexual orientation or gender identity. Simply promotes cultural competency. We collect information regarding the cultural differences of our members and provide training opportunities to staff and network providers, helping them learn ways to interact effectively with members. Staff and provider cultural competency is monitored as part of the Quality Improvement process.

Simply has a comprehensive, written Cultural Competency Plan describing how we ensure:
• Services are provided in a culturally competent manner to all members, including those with limited English proficiency.
• Providers, employees and systems effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, affirms and respects their worth and protects and preserves the dignity of each individual regardless of gender, sexual orientation or gender identity.

For more information on our cultural competency program, please refer to the provider website.

Marketing
When it comes to marketing, you need to be aware of and comply with the following:
• Providers are permitted to make available and/or distribute Simply-approved marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates.

• Providers are permitted to display posters or other materials in common areas such as the provider’s waiting room. Marketing may not be conducted in areas where patients primarily intend to receive health care services or are waiting to receive health care services.

• Long-term care facilities are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.

We will provide education, outreach and monitoring to ensure you are aware of and comply with the following:

• To the extent a provider can assist a recipient in an objective assessment of his or her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

• Providers may not:
  o Offer marketing/appointment forms.
  o Make phone calls or direct, urge or attempt to persuade recipients to enroll in a managed care plan based on financial or any other interests of the provider.
  o Mail marketing materials on behalf of a managed care plan.
  o Offer anything of value to induce recipients/enrollees to select them as their provider.
  o Offer inducements to persuade recipients to enroll in the managed care plan.
  o Conduct health screening as a marketing activity.
  o Accept compensation directly or indirectly from the managed care plan for marketing activities.
  o Distribute marketing materials within an exam room setting.
  o Furnish the managed care plan with lists of their Medicaid patients or the membership of any managed care plan.

• Providers may:
  o Provide the names of the managed care plans with which they participate.
  o Make available and/or distribute managed care plan marketing materials.
  o Refer their patients to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid area office.
  o Share information with patients from the Agency’s website or the CMS website.
  o Distribute printed information provided by the managed care plan to their patients comparing the benefits of all of the different managed care plans with which the providers contract.

• Provider affiliation information
  o Providers may announce new or continuing affiliations with the managed care plan through general advertising (for example, radio, television, websites).
  o Providers may make new affiliation announcements within the first 30 calendar days of the new provider agreement.
  o Providers may make one announcement to patients of a new affiliation that names only the managed care plan when such announcement is conveyed through direct mail, email or phone.
  o Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider contracts.
  o Any affiliation communication materials that include managed care plan-specific information (for example, benefits, formularies) must be prior approved by the Agency.

**Member Records**

Providers are required to maintain medical records for each patient in accordance with the medical record requirements below and with 42 CFR 431 and 42 CFR 456. A permanent medical record will be maintained at the
primary care site for every member and be available to the PCP and other physicians. Medical records shall include the quality, quantity, appropriateness and timeliness of services performed.

Providers are required to have a designated person in charge of medical records. This person’s responsibilities include but are not limited to:

- The confidentiality, security and physical safety of records.
- The timely retrieval of individual records upon request.
- The unique identification of each patient’s record.
- The supervision of the collection, processing, maintenance, storage and appropriate access to the usage of records.
- The maintenance of a predetermined, organized and secured record format.

**Medical Record Standards**

Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.

All patient medical records are to reflect all aspects of patient care, including ancillary services. Providers must follow the medical record standards set forth below for each member’s medical records as appropriate:

- Include the enrollee’s identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship or responsible party if applicable
- Maintain each record legibly and in detail
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications and any other health conditions
- Include all services provided (this includes but is not limited to family planning services, preventive services and services for the treatment of sexually transmitted diseases)
- Record the presence or absence of allergies and untoward reactions to drugs, current medications and/or materials in a prominent and consistent location in all clinical records; this information should be verified at each patient encounter and updated whenever new allergies or sensitivities are identified
- Ensure all entries are dated and signed by the appropriate party
- Indicate in all entries the chief complaint or purpose of the visit, the objective, diagnoses, and medical findings or impression of the provider
- Indicate in all entries the studies ordered (for example, laboratory, X-ray, electrocardiogram) and referral reports
- Indicate in all entries the therapies administered and prescribed
- Record all medications prescribed and documentation or medication reconciliation, including any changes in prescription and nonprescription medication with name and dosage when available
- Include in all entries the name and profession of the provider rendering services (for example, MD, DO), including the provider’s signature or initials
- Include in all entries the disposition, recommendations, instructions to member, evidence of follow-up and outcome of services
- Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for children under the age of 13
- Ensure all records contain an immunization history and documentation of body mass index
- Ensure all records contain information relating to the member’s use of tobacco products and alcohol and/or substance abuse
- Ensure all records contain summaries of all emergency services and care and hospital discharges with appropriate and medically indicated follow-up
- Document referral services in all members’ medical records
- Include all services provided such as family planning services, preventive services and services for the treatment of sexually transmitted diseases
• Ensure all records reflect the primary language spoken by the member and any translation needs of the member
• Ensure all records identify members needing communication assistance in the delivery of health care services
• Ensure all records contain documentation of the member being provided with written information concerning his or her rights regarding advance directives (that is, written instructions for living will or power of attorney) and whether or not he or she has executed an advance directive.
  o Note: Neither the health plan nor any of its providers can require, as a condition of treatment, the member to execute or waive an advance directive. The health plan must maintain written policies and procedures for advance directives.
• Maintain copies of any advance directives executed by the member
• Enter in the patient’s clinical record and appropriately sign or initial significant medical advice given to a patient by telephone or online, including medical advice provided after hours
• Clearly contrast any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research with entries regarding the provision of nonresearch-related care
• Review and incorporate into the record in a timely manner all reports, histories, physicals, progress notes and other patient information such as laboratory reports, X-ray readings, operative reports and consultations
• Document a summary of past and current diagnoses or problems, including past procedures if a patient has had multiple visits/admissions or the clinical record is complex and lengthy
• Include a notation concerning cigarettes if present for patients ages 12 and older (abbreviations and symbols may be appropriate)
• Provide health education to the member
• Screen patients for substance abuse and document in the medical record as part of a prevention evaluation during the following times:
  o Initial contact with a new member
  o Routine physical examinations
  o Initial prenatal contact
  o When the member evidences serious overutilization of medical surgical, trauma or emergency services
  o When documentation of emergency room visits suggests the need

The following requirements must also be met regarding the patient’s medical records:
1. **Consultations, referrals and specialist reports** — Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans, including timely notification with patient or responsible party (adult).
2. **Emergencies** — All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP’s panel must be noted.
3. **Hospital discharge summaries** — Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient’s current medical condition.
4. **Security** — Providers must maintain a written policy and are required to ensure medical records are safeguarded against loss, tampering, alteration, destruction, or unauthorized or inadvertent use.
5. **Storage** — Providers must maintain a system for the proper collection, processing, maintenance, storage, retrieval and distribution of patient’s records. Also, the records must be easily accessible to personnel in the provider’s office and readily available to authorized personnel any time the organization is open to patients.
6. **Release of information** — Written procedures are required for releasing information and obtaining consent for treatment.

7. **Documentation** — Documentation is required setting forth the results of medical, preventive and behavioral health screenings as well as all treatment provided and the outcome of such treatment, including significant medical advice given to a patient by telephone.

8. **Multidisciplinary teams** — Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.

9. **Integration of clinical care** — Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
   - Screening for behavioral health conditions, including those which may be affecting physical health care and vice versa, and referral to behavioral health providers when problems are indicated.
   - Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
   - A written release of information that will permit specific information-sharing between providers.
   - Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

10. **Domestic violence** — Documentation of screening and referral to the applicable community agencies is required.

11. **Consent for psychotherapeutic medications** — Pursuant to F.S. 409.912(13), providers must document informed consent from the parent or legal guardian of members younger than age 13 who are prescribed psychotherapeutic medications and must provide the pharmacy with a signed attestation of this documentation. Pharmacies are required to obtain and keep these consents on file prior to filing a psychotherapeutic medication.

12. **Behavioral health services provided through telemedicine** — Documentation of behavioral health services provided through telemedicine is required. Such documentation must include:
   - A brief explanation of the use of telemedicine in each progress note.
   - Documentation of telemedicine equipment used for the particular covered services provided.
   - A signed statement from the enrollee or the enrollee’s representative indicating the choice to receive services through telemedicine. This statement may be for a set period of treatment or for a one-time visit, as applicable to the service(s) provided.
   - For telepsychiatry the results of the assessment, findings and practitioner(s) plan for next steps.

Simply will periodically review medical records to ensure compliance with these standards. Simply will institute actions, including corrective actions for improvement, when standards are not met.

**Patient Visit Data**

At a minimum, documentation of individual encounters must provide adequate evidence of the following:

1. Date of service; name, signature and profession (for example, MD, OD, RN) of the person(s) providing the service; type of service provided; department of facility (if applicable); chief complaint; changes in medications with name and dosage; disposition; recommendations or instructions provided; and documentation of missed or cancelled appointments

2. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints

3. For patients receiving behavioral health treatment:
o Documentation that includes at-risk factors such as danger to self and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health

o A documented assessment that is done with each visit relating to client status/symptoms and that may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period, along with the type and units of service provided

o A treatment plan that includes the member and/or parent or guardian’s preferences for treatment, identifies reasonable and appropriate objectives, provides the necessary services to meet the objectives, and includes a retrospective review to confirm that care provided and its outcomes were consistent with the approved treatment and member’s needs

o Documented therapies and other prescribed regimens; and show evidence of family involvement as applicable and include evidence that the family was included in therapy sessions when appropriate

4. An admission or initial assessment that includes current support systems or lack of support systems

5. A plan of treatment that includes activities/therapies to be carried out and goals to be met

6. Diagnostic tests

7. For follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks, months or PRN (as needed) the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits

8. Referrals and results, including all other aspects of patient care, such as ancillary services

Simply will systematically review medical records to ensure compliance with these standards. We will share the results of our audits and institute actions for improvement when standards are not met.

We maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 438.3110, which states that records must be retained for ten years from the date of termination of Simply’s SMMC contract with AHCA and retained further if records are under review or audit until the audit or review is complete. Prior approval from Simply is required for the disposition of records if subcontract is continuous, per 438.4.u.

**Misrouted Protected Health Information**

Providers and facilities are required to review all member information received from Simply to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be inadvertently misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately notify Simply upon receipt of the information, not forward or copy the documents, and destroy the misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, they should call Provider Services at 1-844-405-4296 for help.

**Advance Directives**

Simply respects the right of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Simply adheres to the Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A
durable power of attorney for health care (that is, durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate.

Member Services and Outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. Simply will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive. Member Services and Outreach associates will assist members regarding questions about advance directives; however, no Simply associate may serve as witness to an advance directive or as a member’s designated agent or representative.

Simply notes the presence of advance directives in the medical records when conducting medical chart audits.

**Telemedicine**

If we approve you to provide services through telemedicine, you must implement telemedicine fraud and abuse protocols that address:

- Authentication and authorization of users.
- Authentication of the origin of the information.
- The prevention of unauthorized access to the system or information.
- System security, including the integrity of information that is collected, program integrity and system integrity.
- Maintenance of documentation about system and information usage.

When providing services through telemedicine:

- The telecommunication equipment and telemedicine operations must meet the technical safeguards required by 45 CFR 164.312 where applicable.

You must comply with HIPAA and other state and federal laws pertaining to patient privacy.
8 MEDICAL MANAGEMENT

Medical Review Criteria

Simply is a wholly owned subsidiary of Anthem, Inc., and Anthem has its own nationally recognized medical policy process for all of its subsidiary entities. Anthem medical policies, which are publicly accessible on the subsidiary websites, are the primary benefit plan policies for determining whether services are considered to be 1) investigational/experimental, 2) medically necessary, and 3) cosmetic or reconstructive.

A list of the specific Clinical Utilization Management Guidelines used is posted and maintained on the Simply provider website and can be obtained in hard copy by written request. These policies will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede Anthem medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and clinical utilization management criteria.

Simply uses MCG care guidelines for inpatient concurrent reviews except for those hospitals where the contract states differently. Unless superseded by state Medicaid or CMS requirements, all nonbehavioral health, behavioral health outpatient precertification requests, and behavioral health concurrent reviews will be determined using Anthem’s Medical Policies and Clinical Utilization Management Guidelines.

We work with network providers to develop clinical guidelines of care for our membership. The medical advisory committee assists us in formalizing and monitoring guidelines.

If we utilize noncommercial criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and when and how often the criteria will be evaluated and updated.

Precertification/Notification Process

Simply may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services.

Precertification is defined as the prospective process whereby licensed clinical associates apply designated criteria against the intensity of services to be rendered and a member’s severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

Notification is defined as faxed, telephonic or electronic communication received from a provider informing Simply of the intent to render covered medical services to a member. There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.
Notification should be provided prior to rendering services. For services that are emergent or urgent, notification should be given within 24 hours or the next business day.

**Utilization Management Decision Making**

Simply, as a corporation and as individuals involved in utilization management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Simply does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

**Access to UM Staff**

- UM staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls at **1-844-405-4296**. Staff are available Monday to Friday, 8 a.m. to 7 p.m. ET (excluding state holidays) to assist with inquiries and problems related to the provision of services and claims. The helpline is additionally staffed after-hours to respond to authorization requests.
- Staff can receive inbound communication regarding UM issues after normal business hours at **1-844-405-4296**. Our after-hours answering service will ensure providers can leave a message for our managers, nurses or the medical director as appropriate.
- Staff identify themselves by first name/first initial of last name, title and organization name when initiating or returning calls regarding UM Issues.
- TDD/TTY services are available by dialing **711**.
- Language assistance, such as interpreter services, is available by calling Provider Services at **1-844-405-4296**.

**Preventive Care Guidelines**

Simply uses nationally recognized preventive care, evidence-based clinical practice information, guidelines and protocols. This information is on the provider website to ensure fair, consistent and quality health care services and treatment are provided to members.

The following are links to the HIV/AIDS-specific guidelines:

|-----------|---------------------------------------|
Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents

Treatment adherence services are available through Simply. Case managers communicate the information to members, and information is made available to all PCPs.

Clinical Criteria

Using nationally recognized standards of care, Simply works with providers to develop clinical policies and guidelines for the care of our membership. The medical advisory committee (MAC) oversees and directs Simply in formulating, adopting and monitoring guidelines. We must review and revise the guidelines at least every two years or whenever the guidelines change.

The clinical practice guidelines are based on guidelines developed by industry specialty associations and organizations, including but not limited to:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Cancer Society
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians
- American Diabetes Association
- American Lung Association
- American Medical Association
- Centers for Disease Control and Prevention
- Department of Health and Human Services Commission
- National Institutes of Health
- U.S. Preventive Services Task Force

The criteria provide a system for screening proposed medical care based on member-specific best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include:

- Acute care (adult and pediatric)
- Rehabilitation
- Subacute care
- Home care
- Surgery and procedures
- Imaging studies and X-rays

Simply utilization reviewers use these criteria as part of the precertification of scheduled admission, concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization. These criteria are reviewed at least annually.

Visit our provider website to review and download a copy of the clinical practice guidelines. You may also call Provider Services at 1-844-405-4296 to request a hard copy, and we will gladly mail it to you.
Simply is available 24/7 to accept precertification requests. When a request is received from the physician via telephone, online submission or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse. The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with our Clinical UM Guidelines criteria, a Simply reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history. Decisions on urgent requests (that is, expedited service authorizations) will be made within two business days.

If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician upon request to discuss the case.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Two requests for additional information will be made over a 48-hour period. If information is not received within the specified time period, the request will be denied. If the medical director denies coverage of the request, the appropriate denial letter (including the member’s appeal rights) will be mailed to the requesting provider, the member’s PCP and the member.

If the medical director denies the request for coverage, the appropriate notice of proposed action will be mailed to the requesting provider, the member’s PCP, the facility and the member.

Please note: EPSDT rules apply for obtaining authorization for medically necessary services for MMA members under the age of 21 and will be followed when the service:
- Is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook or the Florida Medicaid Coverage Policy Associated Florida Medicaid fee schedule.
- Is not a covered service of the plan.
- Amount, frequency or duration exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Interactive Care Reviewer

Our Interactive Care Reviewer (ICR), which is accessed online at https://www.availity.com, is the preferred method for submitting preauthorization requests; it offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use this tool to make inquiries and check on the status of previously submitted requests, regardless of how they were sent (phone, fax, ICR or other online tool). Capabilities and benefits of the ICR include:
- Initiating preauthorization requests online — eliminating the need to fax. The ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
- Viewing real-time results for common procedures with immediate decisions.
You can access the ICR under **Authorizations and Referrals** on the Availity Portal. For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox and Safari.

The ICR is not currently available for:
- Transplant services.
- Services administered by vendors, such as AIM Specialty Health and OrthoNet LLC. For these requests, follow the same preauthorization process you use today.

We’ll update our website as additional functionality and lines of business are added throughout the year.

**Hospital and Elective Admission Management**

Simply requires precertification of all inpatient elective admissions. The referring primary care provider (PCP) or specialist physician is responsible for precertification. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Simply Medical Management department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Simply to verify benefits and process the precertification request. For services that require precertification, Simply makes case-by-case determinations that consider the individual’s health care needs and medical history in conjunction with medical necessity criteria.

The hospital can confirm that an authorization is on file by calling the Simply automated Provider Inquiry Line at **1-844-405-4296** or accessing our secure website. If coverage of an admission has not been approved, the facility should call Simply at **1-844-405-4296**. Simply will contact the referring physician directly to resolve the issue.

**Emergent Admission Notification Requirements**

Simply prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Simply of emergent admissions within one business day. Simply Medical Management staff will verify eligibility and determine benefit coverage. No prior authorization is required for emergency admissions.

Simply is available 24/7 to accept emergent admission notification at **1-844-405-4296**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets the criteria, a Simply reference number will be issued to the hospital. Two requests for clinical information will be made over a 48-hour period if clinical information was not provided with notification. If information is not received within 72 hours of the initial request, the request will be denied. If the notification documentation provided is incomplete or inadequate, Simply will not approve coverage of the request and will notify the hospital to submit the additional necessary documentation. If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, member’s PCP and the member.

**Nonemergent Outpatient and Ancillary Services: Precertification and Notification Requirements**

Simply requires precertification for coverage of selected nonemergent outpatient and ancillary services (see the chart below). To ensure timeliness of the authorization, the expectation is for the facility and/or provider to provide the following:
- Member name, DOB and ID
• Name, phone and fax number, TIN (or NPI and address) of the physician performing the elective service
• Name of the facility and telephone number where the service is to be performed
• Date of service
• Member ICD-10 diagnosis
• Name of elective procedure to be performed with CPT code
• Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

For more information on prior authorization and notification requirements, refer to the Simply Health Care Benefits and Copays and our provider website.

Inpatient Reviews

Inpatient Admission Review
We’ll review all inpatient hospital admissions, including urgent and emergent admissions, within 24 hours of admission notification. The Simply utilization review clinician determines the member’s medical status through communication with the hospital’s utilization review department. Appropriateness of stay is documented and concurrent review is initiated. Cases may be referred to the medical director, who renders a decision on the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the Care Management program.

Inpatient Concurrent Review
Each network hospital will have an assigned Utilization Management (UM) nurse. Each UM nurse will conduct a concurrent review of the hospital medical record using EMR, phone or onsite at the facility if indicated, to determine the authorization of coverage for a continued stay.

When a Simply UM nurse reviews the medical record at the hospital, he or she also attempts to meet with the member and family to discuss any discharge planning needs and verify that the member or family is aware of the PCP’s name, address and telephone number. The UM nurse will conduct continued stay reviews and review discharge plan needs.

When the clinical information received meets medical necessity criteria, approved continued stay days will be communicated to the hospital. The request for the clinical information needed will be communicated to the designated department within the hospital. Simply asks that the hospital reviewer provide only the necessary information being requested.

Upon discharge Simply UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member’s PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

Simply will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation, and C-section or vaginal deliveries. Exceptions are made by the medical director.
If the medical director denies coverage for an inpatient stay request based on appropriate criteria and after attempts to speak to the attending physician, the appropriate notice of action will be mailed to the hospital, the member’s PCP and the member.

**Discharge Planning**

Discharge planning is designed to assist the provider in the coordination of the member’s discharge when acute care (that is, hospitalization) is no longer necessary.

When long-term care is necessary, Simply works with the provider to plan the member’s discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as:

- A hospice facility
- A convalescent facility
- A home health care program (for example, home IV antibiotics)

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow Anthem *Clinical UM Guidelines*. Authorizations include, but are not limited to, home health, durable medical equipment, pharmacy, follow-up visits to practitioners or outpatient procedures.

**Confidentiality of Information**

Utilization Management (UM), case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including the HIPAA. Information is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct UM and related processes.

**Emergency Services**

Simply provides a 24/7 NurseLine with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Simply does not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements:

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.
Emergency response is coordinated with community services, including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member’s chart the results of the emergency medical screening examination. Simply will compensate the provider for the screening, evaluations and examination that are reasonable and calculated to assist the health care provider in determining whether or not the patient’s condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (that is, whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Simply. If the emergency department is unable to stabilize and release the member, Simply will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Simply concurrent review nurse will implement the concurrent review process to ensure coordination of care.

**Urgent Care**

Simply requires its members to contact their PCP in situations where urgent, unscheduled care is necessary. Precertification with Simply is not required for a member to access a participating urgent care center.
9 QUALITY MANAGEMENT

Quality Management Program

Overview
Simply maintains a comprehensive Quality Management (QM) program to objectively monitor and systematically evaluate access to care and the quality and appropriateness of care and services rendered, to promote quality of care and patient outcomes (see 42 CFR 438.340 and 438.330). The scope and content of the program reflects the demographic and epidemiological needs of the population served. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

Members and providers have opportunities to make recommendations for areas of improvement. The QM program goals and outcomes are available, upon request, to providers and members. The easiest way for providers to access this information is by going to the provider website, and members can go to the member website.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan’s specific population occurs on an annual basis. This includes not only age and gender distribution, but also a review of utilization data — inpatient; emergent/urgent care; and office visits by type, cost and volume. This information is used to define areas that are high-volume or problem-prone.

There is a comprehensive committee structure in place with oversight from the Simply governing body. Not only are the traditional medical advisory committee (MAC) and credentialing committee in place, but a community/member advisory committee and health education advisory committee are also integral components of the quality management committee (QMC) structure.

Quality of Care
All physicians, advanced registered nurse practitioners and physician assistants are evaluated for compliance with pre-established standards as described in the Simply credentialing program.

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance.

Reviews are accomplished by QM coordinators and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members.

Results are submitted to the Simply QM department and incorporated into a profile.

The Simply quality program includes review of quality-of-care issues identified for all care settings. QM staff use peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys, member complaints, and other information to evaluate the quality of service and care provided to our members. In addition, Simply reviews and analyzes adverse or critical incidents to identify and work to eliminate potential and actual quality of care and/or health and safety issues.

Use of Performance Data
Practitioners and providers must allow Simply to use performance data in cooperation with our quality improvement program and activities.
Quality Management Committee

The purpose of the QMC is to maintain quality as a cornerstone of Simply culture and to be an instrument of change through demonstrable improvement in care and service. The QMC’s responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structure that ensure accreditation compliance.
- Review and accept corporate and local QM policies and procedures as appropriate.
- Analyze, review and make recommendations regarding the planning, implementation, measurement and outcomes of clinical/service quality improvement studies.
- Address and resolve any problems/issues identified but not included in a process improvement program.
- Coordinate communication of QM activities throughout the health plans.
- Review and analyze HEDIS® and CAHPS® data and action plans for improvement.
- Review, monitor and evaluate program compliance against Simply, state, federal and accreditation standards.
- Review and approve the annual QM Program Description and work plan.
- Provide oversight and review of operational indicators.
- Assure interdepartmental collaboration, coordination and communication of quality improvement activities.
- Measure compliance to medical and behavioral health practice guidelines.
- Monitor continuity of care between medical and behavioral health services.
- Monitor accessibility and availability with cultural assessment.
- Make information publicly available to members and practitioners about our actions to improve patient safety.
- Make information available about our quality improvement program to members and practitioners; members and providers can request the program by calling Customer Service.
- Assure practitioner involvement through direct input from our MAC or other mechanisms that allow practitioner involvement.
- Provide communication to and from the BOD regarding strategic direction for the QM plan.

Medical Advisory Committee

The MAC has multiple purposes. It:

- Assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care.
- Monitors practice patterns to identify appropriateness of care and for improvement/risk prevention activities.
- Identifies opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions.
- Oversees the peer review process, which provides a systematic approach for the monitoring of quality and the appropriateness of care.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS is a registered trademark of the Agency for Healthcare Research and Quality. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
• Conducts a systematic process for network maintenance through the credentialing/recredentialing process.
• Advises health plan administration in any aspect of health plan policy or operation affecting network providers or members.
• Approves and provides oversight of the peer review process, the QM program and the utilization review program.
• Oversees and makes recommendations regarding health promotion activities.

The MAC’s responsibilities are to:
• Utilize an ongoing peer review system to assess levels of care and quality of care provided.
• Monitor practice patterns to identify risk prevention activities and the appropriateness of care.
• Review, provide input and approve evidence-based clinical protocols and guidelines to facilitate the delivery of quality care and appropriate resource utilization.
• Review clinical study designs and results.
• Develop and approve action plans and recommendations regarding clinical quality improvement studies.
• Consider and act in regard to physician sanctions.
• Review, provide input for, and approve policies and procedures for credentialing/recredentialing, QM, utilization management and disease/case management.
• Review and provide feedback regarding new technologies.
• Oversee the compliance of delegated services.
• Review and provide input to credentialing and recredentialing policies and procedures; clinically oriented quality management policies and procedures; utilization management policies and procedures; and disease/case management policies and procedures.
• Review and provide feedback regarding new technologies.
• Oversee compliance of delegated services.

Provider Orientation and Education

QM coordinators are available to provide a thorough orientation of Simply review standards. Educational sessions can be scheduled at a provider’s convenience. The QM staff is also available to furnish providers with a thorough explanation of review findings during an exit conference on the day of the review. If a provider’s schedule does not allow for sufficient time on the day of the review, we can schedule a follow-up appointment. Experience has taught that provider participation in orientation and education sessions helps improve standards’ compliance, and therefore decreases the frequency for required reviews.

Medical Record Documentation Review Standards

<table>
<thead>
<tr>
<th>Administrative Component</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elements and References</strong></td>
<td>Record organized and legible and easily accessible to the health care practitioners and personnel</td>
</tr>
<tr>
<td>NCQA guidelines</td>
<td></td>
</tr>
<tr>
<td>AHCA contract</td>
<td></td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Member ID of file</td>
</tr>
<tr>
<td>NCQA guidelines</td>
<td>Personal identifying data (name, gender, DOB)</td>
</tr>
<tr>
<td>AHCA contract</td>
<td></td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Primary language</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Evidence of access to an interpreter, or translator if evidence of a gap in language communication</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>All records for members 21 years and older must contain:</td>
</tr>
<tr>
<td>FL Statute 765.110</td>
<td>• Documentation the member was provided written information on their rights regarding advanced directives (written instructions for living will or durable power of attorney).</td>
</tr>
<tr>
<td>Elements and References</td>
<td>Guidelines</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>AHCA contract</td>
<td>Copy of advance directives</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Documentation of whether or not the member has executed an advance directive. When an advance directive exists, a copy must be maintained in the record.</td>
</tr>
<tr>
<td>NCQA guidelines</td>
<td>Patient ID on each page</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>All entries dates and signed by appropriate party</td>
</tr>
<tr>
<td>FL Regulation 64B8-30.012</td>
<td>All entries include the name and profession of the provider rendering the services, including the signature or initials of the provider.</td>
</tr>
<tr>
<td>FL Regulation 64B8-30.012</td>
<td>Applies to both licensed and nonlicensed personnel.</td>
</tr>
<tr>
<td>FL Regulation 64B8-30.012</td>
<td>All physician assistant signatures must be reviewed, cosigned and dated by a supervising physician within seven days. ARNP notes do not require cosigning.</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>All entries include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up and outcome of services</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Documentation of the express written and informed consent of the member’s authorized representative prescriptions for psychotropic medication (that is, antipsychotics, antidepressants, antianxiety medications and mood stabilizers) prescribed for a member under the age of 13 years</td>
</tr>
<tr>
<td></td>
<td>The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription.</td>
</tr>
<tr>
<td></td>
<td>The prescriber must ensure completion of an appropriate attestation form.</td>
</tr>
<tr>
<td>Simply</td>
<td>Test accomplished and filed</td>
</tr>
<tr>
<td>NCQA guidelines</td>
<td>Follow up on missed/cancelled appointment</td>
</tr>
<tr>
<td>Simply</td>
<td>Signed HIPAA Information Form</td>
</tr>
<tr>
<td>Simply</td>
<td>Telephone or email communications</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Translation or other communication assistance needs</td>
</tr>
<tr>
<td>AHCA contract</td>
<td>Legal guardian/responsible party (If applicable)</td>
</tr>
<tr>
<td>NCQA guidelines</td>
<td>No white out or alterations in documentation</td>
</tr>
<tr>
<td>Simply</td>
<td>Record provided timely for review</td>
</tr>
<tr>
<td>Simply</td>
<td>Retention of active records/retirement of inactive records</td>
</tr>
</tbody>
</table>
## General Medical Care

<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| Assessment              | - Medical history and physical exam  
| AHCA contract           | - Chief complaint/subjective  
| USPSTF                   | - Past medical history  
|                         | - Past surgical history  
|                         | - Past social history (tobacco, ETOH, drugs)  
|                         | - Family history  
|                         | - Blood transfusion history  
|                         | - Health risk assessments, if applicable  
|                         | - Allergies or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location, verified at each patient encounter and updated to reflect new allergies and sensitivities.  
|                         | - Diagnosis or medical impression consistent with symptoms and H&P  
|                         | - Medications, including over-the-counter products and dietary supplements recorded.  
|                         | - Evidence that the needs of the caregiver have been assessed and addressed (if applicable).  
|                         | - Documentation of emergency care encounters in the member record with appropriate medically indicated follow-up.  |
| Treatment plan          | - Treatment plans are consistent with diagnosis.  
|                         | - The working diagnoses are consistent with findings in the current history and physical exam.  
|                         | - Plan of care, studies ordered, testing and procedures are appropriate to the clinical needs.  
|                         | - Documentation of patient participation in treatment and follow-up with recommendations.  
<p>|                         | - Absence of clinically unnecessary diagnostic or therapeutic procedures.  |</p>
<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient visit/patient notes</td>
<td>• Date and department if department applicable</td>
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<tr>
<td>documentation</td>
<td>• Chief complaint or purpose of the visit</td>
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<td></td>
<td>• Clinical objective findings/vital signs/BMI (If BMI is over 29.9, an</td>
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<td>appropriate diagnosis of obesity and subsequent treatment are</td>
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<td>documented.)</td>
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<td>• Current review and reconciliation of current medications</td>
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<td>(prescription and nonprescription, including over-the-counter and dietary),</td>
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<tr>
<td></td>
<td>if applicable, with name and dosage</td>
</tr>
<tr>
<td></td>
<td>• Diagnosis or impression</td>
</tr>
<tr>
<td></td>
<td>• Studies ordered (i.e., labs, EKGs, X-rays)</td>
</tr>
<tr>
<td></td>
<td>• Care rendered and therapies administered</td>
</tr>
<tr>
<td></td>
<td>• Disposition, recommendations and instructions given to patient</td>
</tr>
<tr>
<td></td>
<td>• Authentication and verification of contents by health care professional</td>
</tr>
<tr>
<td></td>
<td>• Documentation regarding missed/cancelled appointments</td>
</tr>
<tr>
<td></td>
<td>• Signature of health care professional</td>
</tr>
<tr>
<td></td>
<td>• Problems with service providers, with a planned course of action noted</td>
</tr>
<tr>
<td></td>
<td>• Documentation of all services provided if any (that is, family planning,</td>
</tr>
<tr>
<td></td>
<td>STD treatment)</td>
</tr>
<tr>
<td></td>
<td>• Any notation in the clinical record indicating diagnostic or therapeutic</td>
</tr>
<tr>
<td></td>
<td>intervention as part of clinical research is clearly contrasted with</td>
</tr>
<tr>
<td></td>
<td>entries regarding the provision on nonresearch-related care</td>
</tr>
<tr>
<td></td>
<td>• Discussions with the patient concerning the necessity, appropriateness</td>
</tr>
<tr>
<td></td>
<td>and risks of proposed care, surgery or procedure, as well as discussions</td>
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<tr>
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<td>of treatment alternatives and advanced directives, if applicable. The</td>
</tr>
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<td></td>
<td>medical record will contain documentation that the member was provided</td>
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<td>with written information on their rights regarding advance directives</td>
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<td></td>
<td>(written instructions for living will or power of attorney) and whether</td>
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<td>or not the member has executed an advance directive.</td>
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<td></td>
<td>• Documentation supporting that health education and wellness promotion</td>
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<td></td>
<td>services have occurred within the context of a clinical visit or not</td>
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<td></td>
<td>• Evidence of chronic illness management or acute care documentation</td>
</tr>
<tr>
<td>Elements and References</td>
<td>Guidelines</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Coordination of care/follow-up/outreach</td>
<td>• Are consultants used appropriately?</td>
</tr>
<tr>
<td></td>
<td>• Consultations promptly reviewed and followed</td>
</tr>
<tr>
<td></td>
<td>• Evidence of follow-up when significant problems and/or abnormal laboratory or radiologic findings have been identified</td>
</tr>
<tr>
<td></td>
<td>• Obtained medical record/OV from PCP/specialties</td>
</tr>
<tr>
<td></td>
<td>• Provided medical record to a health care professional</td>
</tr>
<tr>
<td></td>
<td>• All records must contain record of ER and hospital D/C summaries, with appropriate medical indication for follow-up (if applicable)</td>
</tr>
<tr>
<td></td>
<td>• Evidence of appropriate and timely referrals</td>
</tr>
<tr>
<td></td>
<td>• For records with multiple visits/admissions or complex and lengthy: diagnostic summaries utilized in accordance with organization policies and procedures</td>
</tr>
<tr>
<td></td>
<td>• Evidence all clinical information is available to authorized personnel any time the organization is open to patients</td>
</tr>
<tr>
<td></td>
<td>• Evidence community resources are utilized, if applicable</td>
</tr>
<tr>
<td></td>
<td>• Evidence that provider has read/consulted last office encounters or visits to other providers</td>
</tr>
<tr>
<td></td>
<td>• Evidence of incorporation of records from previous providers, transitions of care and summaries when a member is being transferred to a new provider or consultant. Evidence of attempts to collect records from previous providers, specialists or consultants</td>
</tr>
</tbody>
</table>

| Supporting documentation               | • Problem list maintained, including significant illnesses and medical conditions |
|                                         | • Immunization history included                                              |
|                                         | • Reports, histories and physicals, progress notes, and other patient information (lab reports, X-ray readings, op reports and consultations) were reviewed |
|                                         | • Significant problems followed up on and incorporated in the record in a timely manner |
|                                         | • Significant patient advice given by phone, online and/or provided after-hours is entered in the clinical records and appropriately signed or initialed |
|                                         | • Release of information contained in medical record                         |
|                                         | • Treatment records from another current or transferring provider are present if applicable |
|                                         | • Evaluation or member participation with provider recommendations             |
|                                         | • Documentation/evidence of preventive care                                   |
|                                         | • Evidence of end-of life care if applicable                                 |
**Adult Preventive Component**

PCPs are responsible for contacting new members and conducting preventive health care within 90 days of enrollment. Member contacts and attempted contacts must be documented.

<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| Adult preventive component | - Complete medical history for new members  
- Complete physical exam for new members |

| High risk behaviors and anticipatory guidance | AAP  
AHCA contract | - Tobacco/cigarette query  
- Alcohol query  
- Substance abuse query  
- HIV/STD/hepatitis risk query  
- Safe sex practices  
- Nutrition guidance  
- Injury/safety prevention  
- Violence/abuse query  
- Social/emotional health/depression  
- Activity/exercise query |

| Measurements/vitals | AAP  
AHCA contract | - BP/pulse/respiration/temperature  
- Weight  
- Height  
- BMI |

| Screening | AAP  
AHCA contract | - Cholesterol  
- EKG  
- Diabetes screening  
- Abdominal aortic aneurysm screening  
- TB  
- Osteoporosis screening  
- Menopause at physician discretion  
- Vision screening  
- Hearing screening  
- Dental health screening  
- Chlamydia (all sexually active females under 26 years as well as others at risk)  
- Breast exam/mammography  
- Pap smear |

| ACS | - Colorectal cancer  
- Prostate examination/PSA  
- Skin cancer  
- HIV counseling and offer of HIV testing for females of child-bearing age |
## Pediatric and Adolescent Component

<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric and adolescent preventive guidelines AHCA contract APA USPSTF AAP immunizations</td>
<td>Complete history and physical exam for new members</td>
</tr>
<tr>
<td>All required immunizations</td>
<td>Evidence of provider participation in FL SHOTS</td>
</tr>
<tr>
<td>Measurements</td>
<td>Height Weight BMI (annually) Head circumference</td>
</tr>
<tr>
<td>Sensory screening</td>
<td>Vision screening Hearing screening</td>
</tr>
<tr>
<td>General screening</td>
<td>Lead testing at 12 months and 24 months of age H&amp;H at 12 months of age Urinalysis Hereditary and metabolic screening</td>
</tr>
<tr>
<td>Procedures: at risk</td>
<td>TB testing Cholesterol screening HIV/STD/hepatitis Pelvic exam/Pap smear Sickle cell test</td>
</tr>
<tr>
<td>Child abuse</td>
<td>Screening Suspected and reported</td>
</tr>
</tbody>
</table>
### Diabetes Component (Not Applicable to Florida Healthy Kids)

<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| Diabetes component exam ADA, Standards of Medical Care in Diabetes, 2005 | Elements of the baseline medical history include the following:  
- Current symptoms  
- History of glucose control (results of prior A1C records and lab studies related to the diagnosis of diabetes)  
- Results of glucose self-monitoring  
- Exercise history  
- Eating patterns, nutritional status, weight history, growth and development in children and adolescents  
- Previous treatment programs and diabetic education  
- All current medications, including over-the-counter  
- Frequency, severity of acute complications such as ketoacidosis and hypoglycemia  
- Symptoms and treatment of chronic eye, kidney, nerve, foot, GI, GU, heart and vascular complications  
- Risk factors to include smoking, alcohol use, hypertension, obesity, dyslipidemia and family history  
- Lifestyle, cultural, psychological and economic factors that might affect management of diabetes  
- Eating pattern, nutritional status, weight, height  
- DKA frequency, hypoglycemia  
- BP at every routine visit and below 130/80  
- Annual dilated eye exam  
- Thyroid palpation annually  
- Skin examination  
- Neurologic/foot examination annually  
- Obesity management for BMI > 24 |
| Education |  
- Education on nutrition  
- Education on physical activity |
| Laboratory examination |  
- HbA1C every three months for abnormal results, every six months for normal results  
- Liver function tests (annually)  
- Test for micro albuminuria (annually)  
- Serum creatinine and GFR  
- LDL control (< 100 mg/dL) |
| Immunization |  
- Influenza vaccine annually  
- Pneumococcal vaccine (per guidelines) |
| High-risk screening annual |  
- Advise all patients not to smoke  
- Advise all patients on alcohol consumption  
- Referrals if needed |
<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| **Initial prenatal care** | - Pregnancy test and nursing assessment with referrals for comprehensive evaluation  
- First prenatal visit within first trimester  
- First prenatal visits within 42 days of Simply enrollment  
- First trimester visit within three weeks of a pregnancy diagnosis via +human chorionic gonadotropin (HCG) or US  
- First trimester visit within three weeks of a pregnancy diagnosis via +HCG or US  
- Second trimester visit within two weeks of a pregnancy diagnosis via +HCG or US  
- Third trimester visit within one week of a pregnancy diagnosis via +HCG or US  
- Evidence of contact if the member fails to keep appointment and arrange for continued prenatal care as soon as possible  
- Evidence of care coordination or case management through the gestational period according to the needs of the member |
| **Pregnancy history and risks** | - Gravida and para  
- (Rh) status  
- Type of delivery  
- Gestational age at delivery  
- Anesthesia  
- Length of labor  
- Birth outcome/risks  
- Maternal complications  
- Sex/weight of child |
| **Medical/surgical and psychosocial history** | - Serious accidents  
- Operations  
- Infections  
- Illness  
- Substance abuse  
- Mental health  
- Screening for depression  
- Gynecological conditions  
- Infertility  
- Stress  
- Living situations  
- Socioeconomic evaluation |
| **Prenatal care** | - Genetic screening and counseling  
- Provider documented preterm delivery risk assessments in the member’s medical record by week 28  
- Evidence of any necessary referrals and follow-up, if applicable  
- Evidence of assistance to member in making delivery arrangements, if necessary |
<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
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</thead>
</table>
| Nutritional screening and counseling | • Dietary intake  
• Hydration  
• Prenatal vitamins  
• Weight loss/gain  
• Elimination  
• Food/shelter resources  
• Evidence provider promoted safe/adequate infant nutrition by promoting breastfeeding and use of breast milk substitutes  
• Provider offered midlevel assessment  
• Member provided individualized diet counseling and care plan by a public health nutritionist, a nurse or physician following the nutrition assessment  
• Documentation of nutrition care plan on medical record by the person providing the counseling  
• WIC referral (children up to 5 years old, preg BF, postop) with the current height and weight taken within 60 days of the WIC appointment and including Hb and Hct and nutritional problems  
• For subsequent WIC certifications, Simply ensures providers coordinate with the local WIC office to provide the above referral data from the most recent CHCUP  
• Copy to member provided each time a referral is made |
| Risk behaviors/exposure assessments and referrals | • Tobacco use/smoking cessation counseling and treatment if needed  
• Alcohol  
• Chemical dependency  
• HIV/STD/hepatitis/HIV risks (initial visit/38-32 weeks if high-risk)  
• All women of childbearing age are provided with HIV counseling and offered HIV testing  
• Evidence of a completed Practitioner Disease Report Form (DH Form 2136) and evidence this document has been submitted to the perinatal hepatitis B prevention coordinator at the local CHD for all prenatal or postpartum members and their infants who test HBsAg-positive  
• Evidence the provider performed a second HBsAg test between 28 and 32 weeks of pregnancy for members who tested negative at the first prenatal visit but considered to be high-risk for hepatitis B infection  
• Screening of signs of domestic violence and referral services offered, as applicable  
• Safe sex practices  
• Sexual abuse  
• Safety risks/environmental/occupational  
• HIV test (initial visit/28 weeks/32 weeks)  
• Signed objection or attempt if member declined HIV test  
• Infected member was counseled and offered latest recommended ART regime  
• Offered appropriate education and referral for treatment, including smoking cessation counseling, if needed |
<table>
<thead>
<tr>
<th>Elements and References</th>
<th>Guidelines</th>
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<tbody>
<tr>
<td><strong>Physical exam</strong></td>
<td>Each physical exam must include:</td>
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<tr>
<td></td>
<td>• A comprehensive ROS</td>
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<tr>
<td></td>
<td>• Safe sex practices</td>
</tr>
<tr>
<td></td>
<td>• A focused OB/GYN examination</td>
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<td></td>
<td>• An assessment of presenting c/o</td>
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<td></td>
<td>• EDD confirmation</td>
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<tr>
<td></td>
<td>• 18 to 20 week EDD update</td>
</tr>
<tr>
<td><strong>Ongoing/follow-up prenataal care visits</strong></td>
<td>• Schedule return visits every four weeks until 28/32 weeks gestation</td>
</tr>
<tr>
<td></td>
<td>• Schedule every two weeks until 36 weeks gestation; every week thereafter until delivery, more frequent if required</td>
</tr>
<tr>
<td></td>
<td>• Evidence of preterm risk assessments by week 28</td>
</tr>
<tr>
<td></td>
<td>• Evidence of follow-up to members who failed appointments ASAP</td>
</tr>
<tr>
<td></td>
<td>• Evidence of offering assistance in making delivery arrangements if needed</td>
</tr>
<tr>
<td><strong>Obstetrical screening</strong></td>
<td>Each ongoing prenatal visit must include:</td>
</tr>
<tr>
<td></td>
<td>• Weeks’ gestation</td>
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<tr>
<td></td>
<td>• Fundal heights</td>
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<td>• Presentation</td>
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<td>• FHR</td>
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<td>• Fetal movement</td>
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<td></td>
<td>• Preterm labor s/s</td>
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<td>• Cervical exam</td>
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<td>• Blood pressure</td>
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<td></td>
<td>• Urine albumin/glucose</td>
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<tr>
<td></td>
<td>• Problems/comments</td>
</tr>
<tr>
<td><strong>Immunizations (schedule)</strong></td>
<td>• Document communicable disease(s)</td>
</tr>
<tr>
<td></td>
<td>• Immunization history</td>
</tr>
<tr>
<td><strong>Treatment plans</strong></td>
<td>• High-risk patient</td>
</tr>
<tr>
<td></td>
<td>• Specialty physician care</td>
</tr>
<tr>
<td></td>
<td>• Dental care</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic testing and counseling</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy education and counseling</td>
</tr>
<tr>
<td><strong>Healthy Start Prenatal Risk Screen (DH Form 3134)</strong></td>
<td>• Copy of the Healthy Start instrument present on the medical record</td>
</tr>
<tr>
<td></td>
<td>• Evidence a copy provided to the member</td>
</tr>
<tr>
<td></td>
<td>• Evidence that the provider submitted the prenatal risk assessment to the CHD in the county where the prenatal screen was completed within 10 business days of completion</td>
</tr>
<tr>
<td></td>
<td>• Referral for services regardless of score (member invited to participate or direct referral based on risk factors)</td>
</tr>
<tr>
<td>Elements and References</td>
<td>Guidelines</td>
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</tbody>
</table>
| Prenatal Zika virus screen        | • All pregnant women with a history of travel to an area with ongoing Zika virus transmission should be tested for infection  
• If positive or inconclusive, consider serial fetal ultrasounds and amniocentesis  
• If negative, one fetal ultrasound should be performed to detect microcephaly or intracranial calcifications  
• If microcephaly or intracranial calcifications are present, retest pregnant women and consider amniocentesis  
• If negative for microcephaly or intracranial calcifications, continue with routine prenatal care |
| Postnatal risk screen             | • Evidence of transmission of *Healthy Start (Postnatal) Risk Screening Instrument Certificate of Live Birth* to the County CHD within five business days of the birth.  
• If the referral is made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score.  
• If the determination is made subsequent to risk screening, the provider may refer the member 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 B, substance abuse or domestic violence. |
<p>| Delivery care                     | • If the provider determines the member’s pregnancy is high risk, documentation will evidence that the provider’s obstetrical care during labor and delivery included preparation by all attendants for symptomatic evaluation and that the member progresses through the final stages of labor and immediate postpartum care. |</p>
<table>
<thead>
<tr>
<th>Elements and References</th>
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</thead>
</table>
| Postpartum              | • Postpartum  
                          • Date of delivery  
                          • Infant's birth weight and measuring  
                          • Gestational age at birth  
                          • Evidence of inspecting the newborn for abnormalities and/or complications  
                          • Type of delivery: vaginal, Cesarean  
                          • The postpartum visit occurs within 21 to 56 days after the delivery date (six weeks of delivery)  
                          • Postpartum physical assessment: BP, weight, pelvic exam, abdomen/breast exam  
                          • Education and postpartum changes  
                          • Personal health habits  
                          • Family planning (including contraception methods as appropriate)  
                          • Newborn care (that is, eye meds/APGAR, administration of 5 mg of vitamin K) weight and measuring, inspection for abnormalities or complications  
                          • Evidence of continuing care of the newborn is provided through the CHCUP program component and documented in the child’s medical record  
                          • If the mother is Rh negative: evidence of securing a cord blood sample for type Rh determination and direct Coombs test  
                          • Sexual activity  
                          • Nutrition  
                          • Depression addressed  
                          • Referral for community resources for mother and child made as appropriate  
                          • If member tested positive for HBsAg: evidence of referral to the perinatal hepatitis B prevention coordinator at the local CHD  
                          • Evidence the infants born to HBsAg-positive members receive hepatitis B immune globulin (HBIG) and the hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and complete the hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States  
                          • Evidence that infants born to HBsAg-positive members for HBsAg and hepatitis B surface antibodies (anti-HBs) are tested six months after the completion of the vaccine series to monitor the success or failure of the therapy  
                          • Evidence the informant born to the member who tested positive for HBsAG was referred to the Healthy Start regardless of screening score  
                          • Evidence of provider report to the local CHD of any positive HBsAg results in any child age 24 months or less within 24 hours of receipt of the positive test results |
<table>
<thead>
<tr>
<th><strong>HIV/AIDS Component</strong></th>
<th><strong>Elements and References</strong></th>
<th><strong>Guidelines</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV/AIDS guidelines</td>
<td>Medical record contains date of first positive HIV test?</td>
</tr>
<tr>
<td></td>
<td>Initial history</td>
<td>Patient had a previous HIV test? If so, when was the last test result?</td>
</tr>
<tr>
<td></td>
<td>HIV Medicine Association of the Infectious Diseases Society of America (IDSA)</td>
<td>Patient received care for HIV?</td>
</tr>
<tr>
<td></td>
<td>Centers of Disease Control and Prevention</td>
<td>Patient has current CD4 (T-cell) count?</td>
</tr>
<tr>
<td></td>
<td>World Health Organization (WHO)</td>
<td>Chart contains lowest/highest CD4 count?</td>
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<tr>
<td></td>
<td></td>
<td>Chart contains first viral load count?</td>
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<tr>
<td></td>
<td></td>
<td>Chart contains current viral load count?</td>
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<tr>
<td></td>
<td></td>
<td>Medical records contain lab results verifying HIV/AIDS status?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is participating in research studies?</td>
</tr>
<tr>
<td>HIV-related illnesses</td>
<td></td>
<td>Patient has had any opportunistic infection(s) (PCP, MAC, Cryptococcal meningitis, TB, etc.)</td>
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<tr>
<td></td>
<td></td>
<td>Patient has had cancer(s)?</td>
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<tr>
<td></td>
<td></td>
<td>TB Test TST or Interferon-gamma release assay (IGRA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient has had a positive TB result?</td>
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<tr>
<td></td>
<td></td>
<td>Patient is taking anti-TB medications?</td>
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<tr>
<td></td>
<td></td>
<td>Patient is taking HIV medications now?</td>
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<tr>
<td></td>
<td></td>
<td>Patient has missed doses in the past three days?</td>
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<tr>
<td></td>
<td></td>
<td>Patient is complaining of side effects?</td>
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<tr>
<td></td>
<td></td>
<td>HIV viral load or CD 4 counts while the patient was taking their medication?</td>
</tr>
<tr>
<td>Complete past medical and surgical histories</td>
<td></td>
<td>Evidence of documented information</td>
</tr>
<tr>
<td>OB/GYN/women’s health</td>
<td></td>
<td>Pap test and result</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LMP</td>
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<td></td>
<td></td>
<td>Breast examination/mammogram</td>
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<tr>
<td></td>
<td></td>
<td>Yeast infections/UTI</td>
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<tr>
<td></td>
<td></td>
<td>G/P/A/LB history</td>
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<tr>
<td></td>
<td></td>
<td>HIV test during any pregnancy?</td>
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<tr>
<td></td>
<td></td>
<td>Positive HIV in children</td>
</tr>
<tr>
<td>Anorectal history</td>
<td></td>
<td>Anal Pap test and results</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anal warts history</td>
</tr>
<tr>
<td>Urologic history</td>
<td></td>
<td>Urinary tract infections</td>
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<tr>
<td></td>
<td></td>
<td>Prostate infection or enlargement</td>
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<td></td>
<td></td>
<td>PSA test and results</td>
</tr>
<tr>
<td>Complete STD history</td>
<td></td>
<td>Oral health examination</td>
</tr>
<tr>
<td>Dental oral care</td>
<td></td>
<td>Dentures</td>
</tr>
<tr>
<td>Eye care</td>
<td></td>
<td>Vision examination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dilated retinal examination</td>
</tr>
<tr>
<td>Medication list maintained</td>
<td></td>
<td>Evidence of documented information</td>
</tr>
<tr>
<td>Allergies/untoward reactions visibly documented (refer to general medical)</td>
<td>• Evidence of documented information</td>
<td></td>
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</tr>
</tbody>
</table>
| Immunizations | • Pneumovax, Tdap, Flu, H1N1  
• Hepatitis A, Hepatitis B, Chicken Pox, MMR |
| Health-related behaviors | • Tobacco use  
• ETOH use/drug or substance abuse  
• Exercise  
• Diet (raw milk, raw eggs, raw meat, raw fish, caffeine) |
| Gender identity: male/female/sex change | • Evidence of documented information |
| General sexual/sexual practices | • Sex with men, women or both/anal/vaginal/oral sex  
• Protection used during sex? |
| HIV prevention | • Patient’s partner(s) have HIV?  
• Patient uses condoms or some other barrier? |
| Family history | • Evidence of documented information |
| Social history | • Evidence of documented information |
| Mental health history | • Evidence of documented information |
| ROS: (tired, fever, night sweats, anorexia) etc. | • Evidence of documented information |
| PE: VS/BMI/nourishment/well or ill appearing | • Evidence of documented information |
| Assessment | • Evidence of documented information |
| Plan | • Evidence of documented information |
| HIV education | • Evidence of documented information |
**Long-Term Care Component (Not Applicable to Florida Healthy Kids)**

<table>
<thead>
<tr>
<th>Elements and References</th>
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</tr>
</thead>
</table>
| Long-term care AHCA contract | • Member demographic data, including emergency contact information; guardian contact data if applicable; permission forms; and copies of assessments, evaluations, and medical and medication information  
• Copies of eligibility documentations, including level of care determinations by CARES  
• Identification of the member’s PCP  
• Information from quarterly face-to-face visit that addresses at least the following:  
  o The member’s current medical/functional/behavioral health status, including strengths and needs  
  o Identification of family/informal support system or community resources and their availability to assist the member, including barriers to assistance  
  o The member’s ability to participate in the review and/or who case manager discusses service needs and goals with if the member was unable to participate  
  o An assessment of the member’s environment, including fall risk screening, and/or other special needs  
  o Environmental and/or other special needs (i.e., safety risks, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to the bathroom, temperature)  
• Evidence of needs assessments  
• Evidence of plan of care  
• Documentation of member’s responses to HCBS settings requirements queries  
• Documentation of interaction and contacts (including telephone contacts and member-specific correspondence) with member, family of members, PCP, service providers, or other individuals related to provision of services  
• Documentation of issues relevant to the member remaining in the community with supports and services consistent with his or her capacities and abilities (includes monitoring achievement of goals and objectives as set forth in the plan of care)  
• Residential agreements between the facility(ies) and the member  
• Problems with service providers, with a planned course of action noted  
• Record of service authorizations  
• Documentation the member received and signed, if applicable, all required plan and program information (including copies of the member handbook, provider directory, etc.)  
• Documentation of the discussion with the member on the procedures for filing complaints and grievances  
• Documentation of the choice of PDO, initially, annually and upon reassessment |
• Documentation of the signed Participant Agreement for PDO (if applicable)
• Notices of adverse benefit determination sent to the member regarding denial, termination, reduction or suspension of services
• Proof of submission to DCF of the completed CF-ES 2506A form (Client Referral/Change) and CF-ES 2515 form (Certification of Enrollment Status HCBS)
• Copy of documentation that member/authorized representative was advised regarding how to report the contingency plan and other documentation that indicates the unplanned gaps in authorized service delivery
• Copy of the disaster/emergency plan for the member’s household that considers the special needs of the member
• Documentation of choice between institutional and HBCS services

Medical Record Review Documentation Standards References

<table>
<thead>
<tr>
<th>Medical Record Review Documentation Standards</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, Recommendations for Preventive Pediatric Health Care, March 2000</td>
<td></td>
</tr>
<tr>
<td>American Academy of Pediatrics, Committee on Infectious Diseases, Recommended Childhood and Adolescent Immunization Schedule: United States, 2005</td>
<td></td>
</tr>
<tr>
<td>American Cancer Society, Guidelines for Colorectal Cancer Screening for Individuals at Average Risk, Reviewed 2003</td>
<td></td>
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<tr>
<td>Florida Agency for Health Care Administration, Medicaid Contract</td>
<td></td>
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<tr>
<td>National Committee of Quality Assurance</td>
<td></td>
</tr>
<tr>
<td>Simply Provider Manual</td>
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<tr>
<td>U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 3rd Edition</td>
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</tbody>
</table>

Infection Prevention

For our providers to ensure members are treated in a safe and sanitary environment, you must implement nationally recognized infection control guidelines, such as those through the CDC. The infection prevention program’s purpose is to identify and prevent infections and maintain a sanitary practice environment.

Your office staff must be educated on:
• A process for identifying and preventing infections through activities such as proper hand hygiene and safe injection practices.
• A process for the management of identified hazards, potential threats, near misses, and other safety concerns; this includes monitoring of products including medications, reagents and solutions that carry an expiration date.
• Being aware of and a process for the reporting of known adverse incidents to the appropriate state and federal agencies when required by law to do so.
• A process to reduce and avoid medication errors.
• Prevention of falls or physical injuries involving patients, staff and all others.

You must have a written emergency and disaster preparedness plan to address internal and external emergencies to ensure member safety, including an evacuation plan.

You must provide for accessible and available health services, ensuring information about services when provider practices are not open.
Simply and our providers must comply with applicable state and local building codes and regulations; applicable state and local fire prevention regulations, such as the NFPA 1010 Life Safety Code, 2000 edition, published by the National Fire Protection Association, Inc.; and applicable federal regulations.

Provider practice sites must:
- Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire.
- Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall.
- Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of member and staff, in case of an emergency.
- Have stairwells protected by fire doors when applicable.
- Provide examination rooms, dressing rooms and reception areas that are constructed and maintained in a manner ensuring member privacy during interviews, examinations, treatment and consultation.
- Operate in a safe and secure manner.
- Have provisions to reasonably accommodate disabled individuals.
- Have provisions to safeguard member privacy, accessibility and member rights.
- Ensure they have the necessary personnel, equipment, supplies and procedures to deliver safe care and handle medical and other emergencies that may arise.
- Hold periodic drills and have periodic instruction of all staff in the proper use of safety, emergency and fire-extinguishing equipment.
- Ensure that staff has been trained on infection control, OSHA and Universal Precautions.
- Establish a safety program and an emergency disaster plan.

These items will be reviewed during site review for each cycle of credentialing and recredentialing. All items will be scored using the practitioner site office tool.

Risk Management

Risk management is defined as the identification, investigation, analysis and evaluation of risks and the selection of the most advantageous method of correcting, reducing or eliminating identifiable risks.

Our risk management program is intended to protect and conserve the human and financial assets, public image and reputation of the provider of care and/or the organization from the consequences of risks associated with members, visitors and employees at the lowest reasonable cost:
- To minimize the incidents of legal claims against the provider of care and/or organization.
- To enhance the quality of care provided to members.
- To control the cost of losses.
- To maintain patient satisfaction with the provider of care and the organization.

The scope of the risk management program is organization-wide. Each member of the medical care team has an equally important role to play in minimizing the occurrence of incidents. All providers of care, agents and employees of Simply have the affirmative duty to report adverse or untoward incidents (potential or actual) on an incident report form and to send that report to specific personnel for necessary follow-up.

The activities of the risk manager will contribute to the quality of care and a safer environment for members, employees, visitors and property, as well as to reduce the cost of risk to the provider of care and the organization.
These activities are categorized as those directed toward loss prevention (pre-loss) and those for loss reduction (post-loss).

The primary goal of pre-loss activity is to correct, reduce, modify or eliminate all identifiable risk situations, which could result in claims and litigation for injury or loss. This can be accomplished through:

- Providing ongoing education and training programs in risk management and risk prevention.
- Participating in safety, utilization review, quality assessment and improvement activities.
- Interfacing with the medical staff to ensure communication and cooperation in risk management.
- Exchanging information with professional organizations, peers and other resources to improve and update the program.
- Analyzing member grievances that relate to member care and the quality of medical services for trends and patterns.

The primary goal of post-loss activity is the selection of the most advantageous methods of correcting identifiable risks and claim control. This can be accomplished through an effective and efficient incident reporting system.

**Internal Incident Reporting System**
All Simply employees are educated on the Internal Incident Reporting System, which establishes the policy and procedure for reporting adverse incidents and includes: the definition of adverse incidents, access to the incident reporting form, appropriate routing and the required time frame for reporting incidents to the risk manager. Provider input and participation in the QM process further emphasizes the identification of potential risks in the clinical aspects of member care.

**Definitions**

**Adverse incident** — occurs during the delivery of managed care plan covered services that:
- Are associated in whole or in part with medical intervention rather than the condition for which such intervention occurred.
- Are not consistent with or expected to be a consequence of such service provision.
- Occur as a result of service provision to which the patient has not given his informed consent.
- Occur as a result of any other action or lack thereof on the part of the facility, staff or the provider.
- Causes injury to a member.

**Injury** — any of the following outcomes when caused by an adverse incident:
- Death
- Fetal death
- Brain damage
- Spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention that is not consistent with the routine management of the patient’s case or patient’s preexisting physical condition
- Any condition requiring surgical intervention to correct or control
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care

**Critical incident** — events that negatively affect the health, safety or welfare of a member, including the following:
- Abuse/neglect/exploitation
• Altercations requiring medical intervention
• Elopement
• Escape
• Homicide
• Major illness
• Medication errors
• Sexual battery
• Suicide
• Suicide attempt
• Unexpected death

Reporting Responsibilities
• All participating and direct service providers are required to report adverse incidents to the managed care plans within 48 hours of the incident. The managed care plan must ensure all participating and direct service providers are required to report adverse incidents to the Agency immediately but not more than 24 hours of the incident. Reporting will include information such as the enrollee’s identity, description of the incident and outcomes, including the current status of the enrollee.
• Simply will immediately report to the (DCF) any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s.39.201 and Chapter 415, F.S. The DCF Adult Protective Services Program has the responsibility for investigating allegations of abuse, neglect and exploitation of elders and individuals with disabilities. The Abuse Hotline number is 1-800-96-ABUSE (1-800-96-22873).
• Additionally, Simply reports any adverse and critical incidents to AHCA monthly.

Procedural Responsibilities
• The provider staff member involved in observing or first discovering the unusual incident or a Simply staff member who becomes aware of an incident is responsible for initiating the incident report. Reports will be fully completed on the incident report form and will provide a clear, concise, objective description of the incident. The director of the department involved in observing the risk situation will assist in the completion of the form, if necessary.
• All incident reports resulting in serious or potentially serious member harm will be forwarded to the risk manager or risk manager designee immediately.
• Incident reports are logged and date-stamped.
• The National Customer Care department associate is responsible for initiating incident reports for member grievances that relate to an adverse or untoward incident.
• Simply employees refer quality of care and quality of service issues to our QM department. The QM department may solicit information from other departments and/or providers during clinical reviews.
• The QM committee will review all pertinent safety-related reports.
• The QM committee, MAC and/or peer review committee will review pertinent member-related reports.
• Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee’s case file, that is designated as confidential. Such file will be made available to the Agency upon request.
• A member incident report will be kept in a risk management computerized file, and the report will not be photocopied or carbon copied. Employees, providers and agents are prohibited from placing copies of an incident report in the medical record. Employees, providers and agents are prohibited from making a notation in the medical record referencing the filing of an incident report.
• The risk manager will communicate with department directors and managers to provide follow-up as appropriate. If corrective action is needed on the part of a Simply employee, the Human Resources department will execute it.
The risk manager will follow up on all incidents pertinent to quality to determine causes and possible preventive interventions.

The risk manager will keep statistical data of incidents for analysis purposes.

The risk manager will keep incident reports in computerized files for no less than 10 years and longer for audits or litigation as specified elsewhere in the MMA contract.
  o Florida Healthy Kids records will be retained for a period of at least ten years following the term of Simply’s Florida Healthy Kids contract with Florida Healthy Kids Corporation, except if an audit is in progress or audit findings are yet unresolved, in which case records will be kept until all tasks are completed.

Incident Report Review and Analysis

- The risk manager will review all incident reports and analyze them for trends and patterns. This includes the frequency, cause and severity of incidents by location, practitioner and type of incident.
- The risk manager will have free access to all health maintenance organization or provider medical records.
- The incident reports will be utilized to develop categories of incidents that identify problems.
- Once problems become evident, the risk manager will make recommendations for corrective actions, such as procedure revisions.

An incident report is an official record of the incident and is privileged and confidential in all regards. No copies will be made of any incident report for any reason, other than those situations authorized by applicable law.

Credentialing

Simply credentialing policies and procedures incorporate the current National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Managed Care Organizations as well as the Florida Department of Health (FDOH) requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract.

Simply will accept the provider’s copy of the Council for Affordable Quality Healthcare (CAQH) applications in lieu of a Simply application form.

Each provider agrees to submit for verification all requested information necessary to credential or recredential physicians providing services in accordance with the standards established by Simply. Each provider will cooperate with Simply as necessary to conduct credentialing and recredentialing pursuant to our policies, procedures and rules.

Credentialing Requirements

Each provider, applicable ancillary/facility and hospital will remain in full compliance with the Simply credentialing criteria as set forth in our credentialing policies and procedures and all applicable laws and regulations. Each provider, applicable ancillary/facility and hospital will complete the Simply application form upon request. Each provider will comply with other such credentialing criteria as may be established by Simply.

We’re authorized to take whatever steps necessary to ensure each provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of Simply, and the provider’s submission of encounter data is accepted by the Florida Medicaid Management Information Systems and/or the state’s encounter data warehouse. Each provider must supply us with his or her active, enrolled or limited-enrolled Medicaid ID number.

Simply requires each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997.
**Credentialing Procedures**

We are committed to operating an effective, high-quality credentialing program. We credential the following provider types:

- Medical doctors
- Doctors of osteopathy
- Doctors of dental surgery
- Doctors of pediatric medicine
- Doctors of chiropractic
- Physician assistants
- Optometrists
- Dentists
- Nurse practitioners
- Certified nurse midwives
- Licensed professional counselors/social workers
- Psychologists
- Physical/occupational therapists
- Speech/language therapists
- Other applicable or appropriate mid-level providers
- Hospitals and allied services (ancillary) providers

During recredentialing, each provider must show evidence of satisfying policy requirements and must have satisfactory results relative to Simply measures of quality of health care and service.

We have a credentialing committee and MAC for the formal determination of recommendations regarding credentialing decisions. The credentialing committee will make decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. The oversight rests with the MAC.

The Simply credentialing policy is revised periodically based on input from several sources, including but not limited to the credentialing committees, the health plan medical director, the Simply chief medical officer, and state and federal requirements. The policy will be reviewed and approved as needed but at a minimum annually.

The provider application contains the provider’s actual signature that serves as an attestation of the credentials summarized on and included with the application. The provider’s signature also serves as a release of information to verify credentials externally. We are responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information obtained by Simply during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement documents compliance with Simply managed care policies and procedures.

All providers have the right to inquire about the status of their applications. They may do so by: 1) phone, 2) fax, 3) contact through their Provider Relations representative or 4) in writing.

As an applicant for participation with Simply, each provider has the right to review information obtained from primary verification sources during the credentialing process. Upon notification from Simply, the provider has the right to explain information obtained that may vary substantially from that provided and to provide corrections to any erroneous information submitted by another party. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

Currently, the following verifications are completed, as applicable, prior to final submission of a practitioner file to the health plan medical director or credentialing committee. To the extent allowed under applicable law or state agency requirements, per NCQA standards and guidelines, the medical director has authority to approve clean files without input from the credentialing committee. All files not designated as a clean file will be presented to the credentialing committee for review and decision regarding participation.
In addition to the submission of an application and the execution of a Participating Provider Agreement, the following must be reviewed and approved by the credentialing committee or the medical director:

1. **Board certification** — Verification by referencing the American Medical Association Provider Profile, American Osteopathic Association, the American Board of Medical Specialties, American Board of Podiatric Surgery, and/or American Board of Podiatric Orthopedics and Primary Podiatric Medicine. PCP does not achieve board certification within the first three years of initial credentialing for Florida Healthy Kids, insurer must remove the PCP from its FHKC panel and reassign any Florida Healthy Kids provider or present the provider to Florida Healthy Kids for review under the exemption process.

2. **Verification of education and training** Verification by referencing board certification or the appropriate state-licensing agency. Proof of the provider’s medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.

3. **Verification of work history** — The practitioner must submit a curriculum vitae documenting work history for the past five years. Any gaps in work history greater than six months must be explained in written format and brought to the attention of the medical director and credentialing committee as applicable.

4. **Hospital affiliations and privileges** — To the extent allowed under applicable law or state agency requirements, verification of clinical privileges in good standing at a Simply network hospital may be accomplished by the use of an attestation signed by the provider. If attestation is not acceptable, hospital admitting privileges in good standing are verified for the practitioner. This information is obtained in the form of a written letter from the hospital, roster format (multiple practitioners), internet access or by telephone contact. The date and name of the person spoken to at the hospital are documented.

5. **State licensure or certification** — Verification of state license information to ensure that the practitioner maintains a current legal license or certification to practice in the state. This information can be verified by referencing data provided to Simply by the state via roster, telephone or the internet.

6. **DEA number** — Verification of the Drug Enforcement Administration (DEA) number to ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service (NTIS) data. If the practitioner is not required to possess a DEA certificate but does hold a state-controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online or internet data, if applicable.

7. **Professional liability coverage** — To the extent allowed under applicable law or state agency requirements, verification of malpractice coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits, and the effective and expiration dates of such malpractice coverage. If attestation is not acceptable, the practitioner’s malpractice insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the malpractice insurance carrier. Practitioners are required to maintain professional liability insurance in specified amounts.

8. **Professional liability claims history** — Verification of an applicant’s history of professional liability claims, if any, reviewed by our credentialing committee to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant and information available from the National Practitioner’s Data Bank (NPDB). The credentialing committee’s policy is designed to give careful consideration to the medical facts of the specific cases, total number and frequency of claims in the past five years, and the amounts of settlements and/or judgments.

9. **CMS sanctions** — Verification that the practitioner’s record is clear of any sanctions by CMS. This information is verified by accessing the NPDB.

10. **National Provider Identifier (NPI)** — Simply requires each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997.
11. **Verification of Medicaid Eligibility** – Simply will ensure that providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements.

12. **Active Patient Load Attestation** — Attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children’s Medical Services, SMMC plans, Medicare, KidCare, and commercial coverage) is no more than 3,000 patients per physician. An active patient is one that is seen by the provider a minimum of two times per year.

13. **Disclosures – attestation and release of information** — The Simply provider application will require responses to the following:
   a. Reasons for the inability to perform the essential functions of the position with or without accommodation. Any physical or behavioral health problems that may affect the provider’s ability to provide health care.
   b. Any history or current problems with chemical dependency or alcohol or substance abuse
   c. History of license revocations, suspension, voluntary relinquishment, probationary status, or other licensure conditions or limitations
   d. History of conviction of any criminal offense other than minor traffic violations
   e. History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
   f. History of complaints or adverse action reports filed with a local, state or national professional society or licensing board
   g. History of refusal or cancellation of professional liability insurance
   h. History of suspension or revocation of a DEA or CDS certificate
   i. History of any CMS sanctions
   j. Attestation by the applicant of the correctness and completeness of the application
   k. Written explanation of any issue identified; these explanations are presented with the provider’s application to the Credentialing Committee

14. **NPDB** — The NPDB is queried against applicants and the Simply contracted providers. The NPDB will provide a report for every practitioner queried. These reports are shared with the medical director and the credentialing committee for review and action as appropriate. The Federation of State Medical Boards for doctors of medicine, doctors of osteopathy and physician assistants is queried to verify any restrictions/sanctions made against the practitioner’s license. The appropriate state-licensing agency is queried for all other providers. All sanctions are investigated and documented, including the health plan’s decision to accept or deny the applicant’s participation in the network.

15. **Office location review** — At the time of initial credentialing, for PCPs and high-volume specialists, a Simply provider representative will complete a site visit for each office location of all providers to determine whether the provider’s office can accommodate the members and meets all requirements.

16. **Recredentialing** — At the time of recredentialing (every three years), information for PCPs from quality improvement activities and member complaints is presented for credentialing committee review.

Simply will fully enroll/onboard providers within 60 days of receipt of a complete and clean application. This means providers must complete and provide all required elements on our **Florida Market Application Submission Checklist** to establish a clean application receipt date, which will then determine our 60-day turnaround time for credentialing.

The provider will be notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the provider. Providers have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.
The decision to approve or deny initial participation will be communicated in writing within 60 days of the credentialing committee’s decision, and for Medicaid, prior to the 60 days onboarding deadline. To the extent allowed under applicable law or state agency requirements, per NCQA standards and guidelines, the medical director may render a decision regarding the approval of clean files without benefit of input from the credentialing committee. In the event the provider’s continued participation is denied, the provider will be notified by certified mail. If continued participation is denied, the provider will be allowed 30 days to appeal the decision.

**Additional Considerations**

We encourage those providers who wish to be participating providers for Clear Health Alliance, and who are not credentialed by the American Academy of HIV Medicine (AAHIVM) or recognized by the Florida/Caribbean AIDS Education and Treatment Centers (AETC), to do so and refer them accordingly.

While all providers are required to undergo credentialing, we give particular focus to providers serving in the primary care role for our members with HIV/AIDS. We include an *Education/Training Attestation* for participation as an HIV/AIDS PCP in the credentialing packet, which includes the qualifications described below.

Participation as an HIV/AIDS-designated PCP requires that the provider attest that they meet the criteria to care for our members in one of the following ways:

- Be credentialed as an AAHIVM HIV specialist by the American Academy of HIV Medicine (www.aahivm.org)
- Be board-certified in the field of infectious disease and, if not certified in the past year through the American Board of Medical Specialties, has clinically managed a minimum of 25 patients in the preceding 12 months as well as successfully completed a minimum of 10 hours of continuing medical education (CME) with at least five hours related to antiretroviral therapy in the past year
- Be recognized by the Florida/Caribbean AIDS Education and Training Center as having sufficient clinical experience and additional ongoing training in HIV/AIDS to be considered a specialist.

**Credentialing Organizational Providers**

The provider application contains the provider’s actual signature, which serves as an attestation that the health care facility agrees to the assessment requirements. Providers requiring assessments are as follows: hospitals; home health agencies; skilled nursing facilities; nursing homes; ambulatory surgical centers; and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting. The provider’s signature also serves as a release of information to verify credentials externally. Currently, the following steps are completed in addition to the application and network provider agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state licensing agency. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization’s participation in the network.

We contract with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (for example, acute, transitional or rehabilitation) should be accredited by The Joint Commission (TJC), Health Care Facilities Accreditation Program (HFAP) or the American Osteopathic Association (AOA). The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program (CHAP). Nursing homes should be accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care (AAAHC) should accredit ambulatory surgical centers.
If facilities, ancillaries or hospitals are not accredited, Simply will accept a copy of a recent state or CMS review in lieu of performing an onsite review. If accreditation or copy of a recent review is unavailable, an onsite review will be performed.

- A copy of the malpractice insurance face sheet is required. Organizations are required to maintain malpractice insurance in the amounts specified in the provider contract and according to Simply policy.
- We will track a facility’s/ancillary’s reassessment date and reassess every 36 months as applicable.
  Requirement for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.

The organization will be notified, either by phone or in writing, if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the organization. Organizations have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee, if so requested.

The decision to terminate an organization’s participation will be communicated in writing via certified mail.

**Delegated Credentialing**

We will ensure the quality of our credentialing program through direct verification and through delegation of credentialing functions to qualified provider organizations. Where a provider group is believed to have a strong credentialing program, we may evaluate a delegation of credentialing and recredentialing. The provider group must have a minimum of 100 in scope practitioners.

The Enterprise Delegation Oversight & Management department will review the prospective delegate’s written credentialing policies and a randomized sample of practitioner files to ensure compliance with contractual, state and federal, as well as NCQA standards. Steps, if any, are identified where the group’s credentialing policy does not meet the Simply standards. We will perform or arrange for the group to perform the Simply credentialing steps not addressed by the group.

We will perform a pre-delegation audit of the group’s credentialing program.

- A compliant score is between 95 percent and 100%. If the potential delegate has a compliant status and approved by the regional Credentialing Committee, they will be added to the annual audit schedule no more than 12 months from the pre-delegation date.
- A partial compliance score is between 80% and 94%. If the potential delegate has a partial compliance score and approved by the regional Credentialing Committee, any identified deficiencies will be tracked to closure via a corrective action plan (CAP). If the delegate contract is not executed within six months of the pre-delegation audit, the delegate must submit a new pre-delegation audit request.
- If the delegate scores below 80% and denied by the regional Credentialing Committeeee, the audit is considered a fail. The delegate can submit for reconsideration after a waiting period of six months from the pre-delegation audit date. When a final delegation decision has been made, notice of the audit findings and, if applicable, corrective action plan (CAP) request will be provided to the prospective delegate.

The group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results and monitored monthly. The CAP must be acceptable to Simply and completed within the mutually agreed upon time frame but not to exceed 90 days of the submission.

If there are serious deficiencies, we will recommend the regional Credentialing Committee deny the delegation. Simply is responsible for oversight of any delegated credentialing arrangement and schedules appropriate reviews. The reviews are held annually at a minimum.
**Peer Review**

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are to:

- Participate in the implementation of the established peer review system, which reviews a provider’s practice methods and patterns, morbidity and mortality rates, and all grievances filed relating to medical treatment.
- Evaluate the appropriateness of the care rendered and implement corrective action if needed.
- Review and make recommendations regarding individual provider peer-review cases.
- Work in accordance with the executive medical director.

Should investigation of a member grievance result in concern about a physician’s compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee’s decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the QM committee.

Simply has a peer review committee, which has the following responsibilities:

- Evaluating the appropriateness of care rendered by our contracted providers
- Reviewing provider’s practice methods and patterns
- Evaluating provider performance, trends in quality of care and service issues
- Developing and analyzing plan wide audits.

If the medical advisory committee cannot convene, the peer review committee may also serve as the Simply’s provider advisory council, providing input and recommendations to the plan about clinical guidelines, QM trilogy documents, credentialing reports, PIPS, process improvements, quality indicators, performance measures, HEDIS, and provider satisfaction survey tools and results.

The peer review policy is available upon request.

**Quality Measurement Standards for Providers and Requirements for Exchange of Data**

Simply and Clear Health Alliance contract with an NCQA-certified software vendor, which produces eligible populations, analyzes compliance/noncompliance and reports rates for the following measures:

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<th>Measure Description</th>
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<td>Measure Indicator</td>
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<tr>
<td>CBP</td>
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10 MEMBER APPEAL AND GRIEVANCE PROCEDURES

Overview

Simply has a formal appeal and grievance process to handle disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see the Provider Payment Disputes section.

The appeal process is the procedure for addressing member appeals, which are requests for review of an adverse benefit determination. Adverse benefit determinations are defined as the following:

- 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 part, of a payment for a service
- The failure to provide services in a timely manner as defined by the state
- The failure of the plan to act within the time frames provided in Sec. 438.408(b)

Members have the right to tell Simply if they are not happy with their care or the coverage of their health care needs by calling Member Services Monday to Friday, 8 a.m. to 7 p.m. ET. These are called grievances and appeals:

- A grievance is when a member is unhappy about something besides his or her health benefits. A grievance could be about a doctor’s behavior or about information the member should have received but did not.
- An appeal is a formal request from a member to seek a review of an adverse benefit determination made by Simply.

Complaints and Grievances

Simply has a process to solve complaints and grievances. If a member has a concern that is easy to solve and can be resolved within 24 hours, Member Services can help. If the concern cannot be handled within 24 hours and needs to be looked at by our grievance coordinator, the concern is noted and turned over to the grievance coordinator.

A complaint or grievance must be given orally or in writing any time after the event happened.

To file a complaint or grievance, the member can call Member Services at 1-844-406-2396 (TTY 711) or write us a letter regarding the concern and mail it to:

Simply Healthcare Plans, Inc.
Grievance Coordinator
4200 W. Cypress St., Suite 900
Tampa, FL 33607-4173

Members can have someone else help them with the grievance process. This person can be:

- A family member.
- A friend.
- A doctor.
- A lawyer.

The member must give written permission in order for someone else to file a grievance or an appeal on his or her behalf.
If a member needs help filing the complaint, Simply can help. He or she can call Member Services at **1-844-406-2396 (TTY 711)**.

If the member or member’s representative would like to speak with the grievance coordinator to give more information, they should tell Member Services when the complaint is filed or put it in a letter.

Once Simply gets the grievance (oral or written), we send the member a letter within three business days, telling them the date we received the grievance.

**What happens next?**
1. The grievance coordinator reviews the concern.
2. If more information is needed or you have asked to talk to the coordinator, the coordinator will call the member or the designated representative.
3. If you have more information to give us, you can bring it to us in person or mail it to:
   Simply Healthcare Plans, Inc.
   Grievance Coordinator
   4200 W. Cypress St., Suite 900
   Tampa, FL 33607-4173
4. Medical concerns are looked at by medical staff.
5. Simply will tell the member the decision of the grievance within 30 calendar days from the date we received the grievance.

**Medical Appeals**
There may be times when Simply says it will not pay, in whole or in part, for care that a member’s doctor recommended. If we do this, a member or someone on behalf of a member (with the member’s written consent) can appeal the decision. A medical appeal is when Simply is asked to look again at the care being asked for that we said we will not pay for. Members must file for an appeal within 60 days from the date on the letter that says Simply has denied, limited, reduced, suspended or terminated services. Simply will not hold it against the member or the doctor for filling an appeal.

The member can have someone else help them with the appeal process. This person can be a family member, friend, doctor or lawyer. Write this person’s name on the appeal form and fill out a request to designate a personal representative form.

Members can ask us to send you more information to help them understand why we would not pay for the service you requested.

**I want to ask for an appeal. How do I do it?**
An appeal may be filed verbally or in writing within 60 calendar days of when the member gets the notice of adverse benefit determination. The date of the oral notice will be the date Simply received the notice.

There are four ways to file an appeal:
1. Write us and ask to appeal.
2. Call Member Services at **1-844-406-2396 (TTY 711)**.
3. Send a fax to **1-866-216-3482**.
   Email us at flmedicaidgrievances@simplyhealthcareplans.com.
What else do I need to know?
If the member wants someone else to help with the appeal process, let us know, and we will send the member a form for that.

When Simply receives an appeal, we will send the member a letter within three business days notifying them of the receipt of the appeal request.

The member or the representative may talk to the doctor who looks at the appeal to give more information. We can arrange for the member to talk to this person or you can mail it to us.

Members may ask for a free copy of the guidelines, records or other information used to make the denial and/or appeal decision.

We will notify the member of the decision within 30 calendar days of getting the appeal request. If we reduce coverage for a service a member is receiving and the member wants to continue to get the service during the appeal, the member can call Simply to ask for continuation of benefits. The member must call within 10 days of the date of the letter that tells him or her Simply will not pay for the service.

If you or the member has more information to give us, you can bring it in person or mail it to the address below. Also, the member can look at your medical records and information on this decision before and during the appeal process.

The time frame for an appeal may be extended up to 14 calendar days if:
- The member asks for an extension.
- Simply finds additional information is needed, and the delay is in the member’s interest.

If the time frame of the appeal is extended other than at the member’s request, Simply will call the member on the same day and notify the member in writing within two calendar days of when the ruling is made. If a member has a special need, Simply will give additional help to file the appeal.

Please call Member Services at 1-844-406-2396 (TTY 711), Monday to Friday, 8 a.m. to 7 p.m. ET.

Where do I mail my letter?
Mail all medical information and medical necessity appeals to:

Simply Healthcare Plans, Inc.
Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

What can I do if Simply still will not pay?
The member, or representative on the member’s behalf with the member’s written consent, has a right to ask for a state fair hearing. Members must complete the appeal process before requesting a Medicaid fair hearing. If the member would like to request a fair hearing, he or she must do so no later than 120 days from the date of the notice of plan appeal resolution letter.

The Medicaid Hearing Unit is not part of Simply. They look at appeals of Medicaid members who live in Florida. If you contact the Medicaid Hearing Unit, we will give them information about your case, including the information you have given us.
Members have the right to ask to receive benefits while the hearing is pending. To do so, they can call Member Services toll free at 1-844-406-2396 (TTY 711).

Note: Members cannot ask for a Medicaid fair hearing if they have MediKids or FHK. These members should request a review from the state.

How do I contact the state for a state fair hearing?
You can contact the Medicaid Hearing Unit at:
Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

What can I do if I think I need an urgent or expedited appeal?
Members can ask for an urgent or expedited appeal if they or their physician think the time frame for a standard appeal process could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function.

Members can also ask for an expedited appeal by calling Member Services toll free at 1-844-406-2396 (TTY 711), Monday to Friday, 8 a.m. to 7 p.m. ET.

We must respond to the expedited request within 48 hours after we receive the appeal request, whether the appeal was made verbally or in writing.

If the request for an expedited appeal is denied, the appeal will be transferred to the time frame for standard resolution, and the member will be notified orally by close of business on the same day and a written notice will be sent within two calendar days.

If you have any questions or need help, please call Member Services toll free at 1-844-406-2396 (TTY 711), Monday to Friday, 8 a.m. to 7 p.m. ET.
11 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Electronic Submission
Simply encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services. Electronic claims submission is available through:
- Availity (formerly THIN) — claim payer ID:
  - Simply = SMPLY
  - Clear Health Alliance = CLEAR

The advantages of electronic claims submission are as follows:
- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

The guide for EDI claims submission is located on our provider website. The EDI claim submission guide includes additional information related to the EDI claim process. To initiate the electronic claims submission process or obtain additional information, please contact the Simply EDI Hotline at 1-800-590-5745.

Paper Claims Submission
Providers also have the option of submitting paper claims. Simply uses optical character reading (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:
- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Simply staff for claims information allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black-and-white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed CMS-1450 or CMS-1500 (08-05) within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

Paper claims must be submitted within 180 days of the date of service and submitted to the following address:
Simply Healthcare Plans, Inc.
Florida Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010
**Encounter Data**

Simply maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Simply for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless other arrangements are approved by Simply. Data will be submitted in a timely manner, but no later than 180 days from the date of service.

**Encounter data** should be submitted to the following address:

Simply Healthcare Plans, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to:

- Preventive services (for example, childhood immunization, mammography, Pap smears).
- Prenatal care (for example, LBW, general first trimester care).
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders).

Compliance is monitored by the Simply utilization and quality improvement staff, coordinated with the medical director and reported to the quality management committee on a quarterly basis. The primary care provider (PCP) is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination from the network.

**Claims Adjudication**

Simply is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 CMS-1450 or successor forms; provider services should be submitted using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing Simply. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Simply will not pay any claims submitted using noncompliant billing codes. Simply reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within 180 days from the date the service is rendered; for inpatient claims filed by a hospital, submit claims within 180 days from the date of discharge unless contract timeframes state otherwise.
- In the case of other insurance (crossover claim submission), the claim must be received within 90 days of receiving a response from the primary payer’s determination or three years for Medicare crossover claims.
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 180 days from the date the eligibility is added and Simply is notified of the eligibility/enrollment. Claims submitted after the 180-day filing deadline will be denied.

After filing a claim with Simply, review the *Explanation of Payment (EOP)*. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim at [https://www.availity.com](https://www.availity.com) or through the Provider Inquiry Line at
If the claim is not on file with Simply, resubmit your claim within 180 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

**International Classification of Diseases, 10th Revision (ICD-10) Description**

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:
- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

**Clean Claims Payment**

A clean claim is a request for payment for a service rendered by a provider that:
- Is submitted by the provider in a timely manner
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS-1450, or successor forms thereto, or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by Simply

Clean claims are adjudicated within 20 days (for electronic) or 40 days (for paper) of receipt. If Simply does not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and mail an EOP Monday through Saturday, which delineates the status of each claim that has been adjudicated during the previous week. Upon receipt of the requested information from the provider, we must complete processing of the clean claim within 30 business days.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be returned to the Simply contracted clearinghouse that submitted the claim.

In accordance with state requirements, we will pay at least 90% of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 days of the date of receipt. We will pay at least 99% of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 90 days of the date of receipt. The date of receipt is the date Simply receives
the claim as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

**Claims Status**

You can visit the provider website or call the automated Provider Inquiry Line at 1-844-405-4296 to check claims status.

High-dollar claims may be placed in a prepayment pending status to enable third-party vendor (Equian) claims review. An itemized bill may be requested for claims review, only if otherwise indicated in your contract.

**Provider Reimbursement**

**Increased Medicaid Payments for Primary Care Physicians and Eligible Providers**

In compliance with the Patient Protection and Affordable Care Act (PPACA), as amended by Section 1202 of the Health Care and Education Reconciliation Act, Simply reimburses eligible Medicaid primary care providers (PCPs) at parity with Medicare rates for qualified services in calendar years 2013 and 2014.

If you meet the requirements for the PPACA enhanced physician reimbursement and haven’t yet submitted a completed attestation, you should do so as soon as possible to qualify for enhanced payments. Visit the provider website for links to information and instructions.

**Simply Process for Supporting Enhanced Payments to Eligible Providers**

As set forth in "Section 1202" of the PPACA:

- Conditioned upon the state of Florida requiring and providing funding to Simply, Simply will provide increased reimbursement to Medicare levels or some other federal or state-mandated level for specified CPT-4 codes for primary care services furnished with dates of service in 2013 and 2014 by providers who have attested to their eligibility to receive such increased reimbursement as set forth in “Section 1202” of the PPACA.
- Such CPT-4 codes will be paid in accordance with the requirements of PPACA, and the state and will not be subject to any further enhancements from Simply or any other source.

**Provider Responsibilities with Regard to Payments**

If you completed the attestation process as required by the state, the following procedures and guidelines apply to you regarding payments received from Simply:

- If you are a group provider, entity or any person other than the eligible provider who performed the service, you acknowledge and agree you will direct any and all increased reimbursements to such eligible providers or otherwise ensure such eligible providers receive direct and full benefit of the increased reimbursement in accordance with the final rule implementing PPACA.
- You also acknowledge and agree you will provide Simply with evidence of your compliance with this requirement upon request.

**Electronic Funds Transfer and Electronic Remittance Advice**

Simply offers electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers can elect to receive Simply payments electronically through direct deposit to their bank accounts. In addition, providers can select from a variety of remittance information options, including:

- ERA presented online and printed in your location.
- HIPAA-compliant data file for download directly to your practice management or patient accounting system.
- Paper remittance printed and mailed by Simply.

Some of the benefits providers may experience include:
• Faster receipt of payments from Simply.
• The ability to generate custom reports on both payment and claim information based on the criteria specified.
• Online capability to search claims and remittance details across multiple remittances.
• Elimination of the need for manual entry of remittance information and user errors.
• Ability to perform faster secondary billing.

To register for ERA/EFT, please visit our provider website.

**PCP Reimbursement**

Simply reimburses PCPs according to their contractual arrangement.

**Specialist Reimbursement**

Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Simply.

Specialty care providers will obtain PCP and Simply approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP’s referral or beyond the scope of self-referral permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification and receipt of the required claims and encounter information to Simply.

**Overpayment Process**

Refund notifications may be identified by two entities: 1) Simply and its contracted vendors or 2) the providers.

Once an overpayment has been identified by Simply, Simply will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment. Providers have up to 60 days to dispute an overpayment. If a refund check is not received, the identified overpayment will offset against future claims payments. Notification of overpayment will be submitted to facility claims within 30 months and to physician claims within 12 months.

The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount. If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form is located on the provider website. The submission of the *Refund Notification Form* will allow us to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at **1-844-405-4296** and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, Simply will notify the provider of the overpayment, then commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.
The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the Healthcare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Provider Complaint System

Our provider complaint system allows you to dispute Simply policies, procedures or any aspect of our administrative functions, including proposed actions. You have 45 calendar days from the date of the occurrence to file a written complaint regarding the dispute. Complaints will be resolved fairly – consistent with health plan policies and covered benefits.

Process for Filing and Submitting a Formal Complaint

You can file a written formal complaint with us via email, fax, mail or in person. Any supporting documentation should accompany the grievance. For assistance with filing a complaint, call Provider Services at 1-844-405-4296.

We will:
- Allow 90 days for providers to file a written complaint.
- Notify the provider (in writing) within three business days of receipt that we have received the complaint and include an expected date of resolution.
- Document why a complaint is unresolved after 15 days of receipt and provide written notice of the status to the provider every 15 days thereafter.
- Resolve all complaints within 90 days of receipt and provide written notice of the disposition as well as the basis of the resolution within three business days of the resolution.

Simply keeps all provider complaints confidential to the extent permitted under applicable law. We will not penalize a provider for filing a complaint.

Provider Complaint Review

Upon receipt of a complaint with supporting documentation, we will thoroughly investigate the complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Simply written policies and procedures. The account executive/manager or director is responsible for resolution of unresolved issues. We will communicate resolution of the issue in writing.

Provider Payment Disputes

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and Simply for reason(s) including but not limited to:
- Denials for timely filing.
- Simply failure to pay timely.
- Contractual payment issues.
- Lost or incomplete claim forms or electronic submissions.
• Requests for additional explanation as to services or treatment rendered by a provider.
• Inappropriate or unapproved referrals initiated by providers (for example, a provider payment dispute may arise if a provider was required to get authorization for a service, did not request the authorization, provided the service and then submitted the claim).
• Provider appeals without the member’s consent.
• Retrospective review after a claim denial or partial payment.
• Request for supporting documentation.

Responses to itemized bill requests, submission of corrected claims and submission of coordination of benefits/third-party liability information are not considered payment disputes. These are considered correspondence and should be addressed to Claims Correspondence.

No action is required by the member. Payment disputes do not include medical appeals.

Providers will not be penalized for filing a payment dispute. All information will be confidential. The Payment Dispute Unit will receive, distribute and coordinate all payment disputes. To submit a payment dispute, please complete the payment dispute form located on the provider website and submit it to:

Simply Healthcare Plans, Inc.
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

The network provider should file a payment dispute within 90 calendar days of the paid date of the EOP by submitting a written request with a written explanation of what is in dispute and why. Include supporting documentation, such as an EOP, a copy of the claim, medical records or contract page.

The Payment Dispute Unit will research and determine the current status of a payment dispute. A determination will be made based on the available documentation submitted with the dispute and a review of Simply systems, policies and contracts. Any payment dispute received with supporting clinical documentation will be retrospectively reviewed by a registered nurse. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the plan medical director for further review and resolution.

A Level I determination letter will be sent to the provider within 30 calendar days from receipt of complete payment dispute information. The response will include the following information:
• Provider name and Simply ID
• Date of initial filing of concern
• Written description of the concern
• The decision
• Further dispute options

If a provider is dissatisfied with the Level I payment dispute resolution, the provider may file a Level II payment dispute. This should be a written dispute and submitted within 30 days of receipt of the Level I determination letter.

If a provider is dissatisfied with the Level II payment dispute resolution, the provider may appeal the Simply decision to Maximus (the vendor for AHCA for provider disputes).
Application forms and instructions on how to file claims are available from Maximus directly. For information updates, call Maximus at 1-800-356-8151 and ask for the Florida Appeals Process department.

**Coordination of Benefits**

State-specific guidelines will be followed when coordination of benefits (COB) procedures are necessary. Simply agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Simply plan.

Simply and our providers agree the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When Simply is aware of these resources prior to paying for a medical service, we will avoid payment by either rejecting a provider’s claim and redirecting the provider to bill the appropriate insurance carrier or, if Simply does not become aware of the resource until sometime after payment for the service was rendered, by pursuing postpayment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

Simply will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched postpayment to determine likely cases with multiple letters and phone calls being made to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor, ACS Recovery Services.

We will require members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at 1-844-405-4296.

**Billing Members**

**Overview**

Before rendering services, providers should always inform members that the cost of services not covered by Simply will be charged to the member.

A provider who chooses to provide services not covered by Simply:

- Understands Simply only reimburses for medically necessary services, including hospital admissions and other services.
- Obtains the member’s signature on the client acknowledgment statement, which specifies the member will be held responsible for payment of services.
- Understands he or she may not bill or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

Simply members must not be balance-billed for the amount above that which is paid by Simply for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure to submit a claim timely, including claims not received by Simply
- Failure to submit a claim to Simply for initial processing within the six-month filing deadline
- Failure to submit a corrected claim within the 180-day filing resubmission period
- Failure to appeal a claim within the 90 day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
• Errors made in claims preparation, claims submission or the appeal process

**Client Acknowledgment Statement**
A provider may bill a Simply member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:
• The member requests the specific service or item
• The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

> “I understand that, in the opinion of [provider’s name], the services or items that I have requested to be provided to me on (dates of service) may not be covered under Simply as being reasonable and medically necessary for my care or may not be a covered benefit. I understand that Simply has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Simply medically necessary standards for my care or are not a covered benefit.”

Signature: __________________________
Date: __________________________

**Accessing Claim Status, Member Eligibility and Authorization Determinations**
Simply recognizes that for you to provide the best service to our members, we must share with you accurate, up-to-date information. To access claim status, member eligibility and authorization determination (24 hours a day, 365 days a year):
• Access [https://www.availity.com](https://www.availity.com), which features our online provider inquiry tool for real-time claim status, eligibility verification and precertification status. You can also submit a claim or precertification, print referral forms or directories, or obtain a member panel listing. Detailed instructions for use of the online provider inquiry tool are located on the provider website.
• Call the toll-free, automated Provider Inquiry Line at [1-844-405-4296](tel:1-844-405-4296) for real-time member status, claim status and precertification status. This option also offers the ability to be transferred to the appropriate department for other needs, such as seeking advice in case/care management.
APPENDIX A: FORMS

The following forms are available on the provider website. You may download them for your use as needed.

Referral and Claim Submission Forms
- Authorization Request Form
- Maternity Notification Form
- Child Health Check-Up 221 Form and Claim Instructions — This form and instructions are available at www.fdhc.state.fl.us/medicaid or by calling 1-800-289-7799
- Specialist as a PCP Request Form
- CMS-1500 (08-05) Claim Form
- UB-04-Claim Form

Precertification Forms
- Precertification Information Required for Hysterectomy
- Precertification Information Required for Gastropasty
- Precertification Information Required for Tonsillectomy, Adenoidectomy, Adenotonsillectomy

Provider Grievances and Appeals Forms
- Provider Payment Dispute and Correspondence Submission
- Provider Medical Necessity Appeal Form
- Grievance Form

Medical Record Documentation Forms
- Adult Health Form
- Oral Lead Risk Form – English
- Oral Lead Risk Form – Spanish
- Incident Report Form
- Inpatient Medical Review Form
- Advance Directive – English
- Advance Directive – Spanish
- Durable Power of Attorney – English/Spanish
- Living Will – English/Spanish
- Site Review Form

Other Forms
- Florida Assisted Living Facility Form
- Authorization Request Form
- Pharmacy Prior Authorization Forms
- Incident Report Form
- Sterilization Consent Form
- Hysterectomy Acknowledgement Form
- Abortion Certificate Form
- Provider Payment Dispute Form

Pharmacy Synagis Order Form
- Synagis Enrollment Form

Behavioral Health Forms
- Behavioral Health Outpatient Treatment Form
• Behavioral Health Outpatient Treatment Report C Form
• Request for Authorization – Psychological Testing Authorization Form
• Behavioral Health Neuropsychological Testing Form

Hysterectomy and Sterilization Forms
• Acknowledgement of Receipt of Hysterectomy Information
• Consent to Sterilization Form

Cost Containment Form
• Refund Notification Form