Sunshine State Health Plan Addendum
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Participating Provider Manual Addendum
Medicare Special Needs Plan (SNP)

Cenpatico administrates the behavioral health services for Advantage by Sunshine State Health Plan.

As a Cenpatico Medicare contracted provider for Advantage by Sunshine State Health Plan, you are required to follow a number of Medicare regulations and Centers for Medicare and Medicaid Services (CMS) requirements. Most of these requirements are described in your provider agreement and/or in the Cenpatico Provider Manual. This addendum to the Provider Manual includes information not described in those two documents or may help clarify them.

A current edition of the Provider Manual is available on the Cenpatico website at http://www.cenpatico.com/providers/fl-provider-tools/?state=Florida or by calling the Customer Service line at (866) 796-0530.

Also refer to the Advantage by Sunshine State Health Plan Evidence of Coverage for specific member benefits: http://advantage.sunshinestatehealth.com/advantage-medicare/benefits/evidence-of-coverage/

General Medicare Policies that must be followed by all Medicare Providers:

- You may not discriminate against Medicare Members in any way based on health status.
- You must ensure that members have adequate access to covered health services
- You must ensure that your hours of operations are convenient to the Member and do not discriminate against the Member for any reason.
- You will ensure necessary services are available to Members twenty-four (24) hours per day, seven (7) days per week.
- Services must be provided to Members in a culturally competent manner, including Members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- You will document in a prominent part of the Member's medical record, whether the Member has executed an advance directive.
- You must provide services in a manner consistent with professionally recognized standards of care.
- You must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- You must comply with any Cenpatico medical policies, QI programs and medical management procedures.
- You must cooperate with Cenpatico's procedures for handling Grievances, Appeals and Expedited Appeals.
- You must comply with Cenpatico's processes to identify access and establish treatment for complex and serious medical conditions.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Medicare members without CMS approval of the materials or forms.
- You will work with Cenpatico procedures to inform our members of healthcare needs that require follow up and provide necessary training in self-care.
- You must cooperate with Cenpatico to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make informed choice about their Medicare coverage.
- You must cooperate with Cenpatico in notifying members of provider contract terminations.
- You will cooperate with Cenpatico in disclosing quality and performance indicators to CMS.

- You must fully disclose to all members before providing a service, if you feel the service may not be covered by the plan. The member must sign an agreement of this understanding. If they do not, the claim may be denied and the provider will be liable of the coast of service.

Provider Responsibilities:

- All Providers must have a state identification number and National Provider Identifier (NPI). The Centers for Medicare and Medicaid Services (CMS) is implementing the NPI.
- Abide by the terms of your contract;
- Comply with all Cenpatico policies, procedures, rules and regulations, including those found in this Provider Manual;
- Maintain confidential medical records consistent with Cenpatico's Medical Records Standards, medical record keeping guidelines, state policies and applicable HIPAA regulations;
- Participate in Provider orientations and continuing education;
- Abide by the ethical principles of your profession;
- Notify Cenpatico if you are undergoing an investigation, or agree to written orders by the State Licensing Agency;
- Ensure you have a covering Provider during scheduled time off.

Continuation Area

Cenpatico may offer a continuation of services to members when they no longer reside in our service area and permanently move into the geographic area we designate as a continuation area. The intent to no longer reside in an area and permanently live in another area must be proven by valid documentation that establishes residency.

At a minimum, Cenpatico ensures that members with behavioral health coverage have access to an outpatient Behavioral Health Service Practitioner in the Network within 10 miles of the Member's residence for large metro areas, 30 miles for metro areas and 60 miles for rural areas. Outpatient Behavioral Health Service Practitioners must include Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient hospital departments.

Hospital Access

Cenpatico ensures that all Members have access to an Inpatient Psychiatric Care Hospital in the Provider Network within 10 miles of the Member's residence for large metro areas, 30 miles for metro areas and 60 miles for rural areas..

Adequate Access

Medicare requires that you ensure that members have adequate access to covered health services.

Termination of Provider

Providers and Cenpatico must provide the other at least 90 days written notice if electing to terminate our agreement without cause, or as described in your Provider participation agreement (if longer than 90 days). You agree to notify Cenpatico according to the terms outlined in your Provider Agreement.

Member Notification

You must cooperate with Cenpatico in notifying members of provider contract terminations.

Data Collection

Cenpatico is required to maintain a health information system that collects, analyzes and integrates all data necessary to aggregate, evaluate and report certain statistical data related to cost, utilization, quality and other data requested by CMS. As a Cenpatico provider, you are required to submit all data necessary to fulfill these requirements in a timely manner. You are required to certify, in writing, that the data submission to Cenpatico is complete and accurate, and truthful. This includes all data, including encounter data, medical records, or other information required by CMS. CMS requires that you maintain complete member records for a minimum of 10 years.

Member Surveys

CMS requires all Medicare contractors to participate in a member satisfaction survey and submit the results. Cenpatico surveys the members or their legal representative at least annually. This survey includes the level of member satisfaction with their providers, customer service, sales and marketing, and written information provided to the members. Upon request, Cenpatico will make the data available to the member, their physician or other healthcare providers.

Providing Services Not Covered by the Plan

You must fully disclose to all Advantage members, before providing a service, if you feel the service may not be covered by the plan. The member must sign an agreement of this understanding that includes a description and estimated cost of the service(s). If they do not, the claim may be denied and the provider would then be liable for the cost of the service.

Appointment Availability

Consistent with the CMS requirements, Appointment Availability Standards are listed below. Cenpatico Network Providers must have adequate office hours in order to accommodate appointments for Members using these standards:

Type of Care	Example	Appointment Availability	Provider Type
Emergency Care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: death, placing the Member's health in serious jeopardy, permanent impairment of bodily functions, serious dysfunction of any bodily organ or part.	Suicidal Psychotic Episode	Emergency appointments the same day or within 24 hours of the Member's phone call or other notification, or as medically appropriate	PCP, Specialist, Hospital, Behavioral Health
Urgent Care is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or	Panic Attack Severe Depressive Episode	Urgent care appointments within two (2) days of the Member's phone call	PCP, Specialist

treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.			
Initial Outpatient Behavioral Health Care is defined as routine appointments.	Self-referral or PCP referral for counseling	Within thirty (30) days of referral or Member's request	Behavioral Health Providers

Along with the above Appointment Scheduling Standards, CMS requires that a Member's waiting time at the office does not exceed 45 minutes unless an emergency occurs that would delay the physician. If the wait time is expected to be longer than 45 minutes, please inform the Member so they may choose to wait or reschedule their appointment.

Direct Access to Care
Cenpatico provides access, without a referral, any of the following services:

- **Service Coordination/Case Management Services**
  Cenpatico Care Coordinators and or Case manager supports the physician by tracking compliance with the case management plan and facilitating communication between the PCP, member, and the case management team. The case manager also facilitates referrals and linkages to community providers, such as local health departments. The managing physician maintains responsibility for the patient's ongoing care needs including necessary follow up and training in self-care. The Cenpatico Case Manager will work with the PCP and/or managing physician if the member is not following the plan of care or requires additional services.
- **Case Management Process**
  Service Coordination/Case management for our Medicare members includes the following key elements:
    - notifying the member their assignment to an Cenpatico Case manager
    - developing and implementing a care plan that accommodates the specific cultural and linguistic needs of the member
    - establishing treatment objectives and monitoring of outcomes
    - referring and assisting the member to ensure timely access to Providers
    - coordinating medical, residential, social, and other support services
    - monitoring care/services
    - revising the care plan as necessary and tracking care plan outcomes

To refer a member for Service Coordination and or Case management services, please call (866) 796-0530

Care Transition
Cenpatico works to coordinate care when our members move from one setting to another. The goal is to assure the continued quality of care and to minimize risks to the patient's safety.

Notifications - Facility
Hospitals must notify Cenpatico of the admission of Cenpatico members within one business day of the admission.

Cenpatico notifies the patient's clinician regarding a planned or unplanned transition of a member from any setting to any other setting.

BH Provider/PCP
The patient's clinician must provide the member's current care plan to the receiving facility within one business day of being notified of the transition.

Standard Service Authorization (Routine)
Prior authorization decisions for non-urgent services shall be made within fourteen (14) calendar

days of receipt of the request.

Expedited Service Authorization (Urgent)
Urgent/Emergent prior authorization decisions shall be made within seventy-two (72) hours of the request as long as all appropriate medical documentation is received with the request.

Covered Behavioral Health Services	• Outpatient mental health services • Outpatient substance abuse services • Partial Hospitalization Programs • Intensive Outpatient Programs • Inpatient mental health services There is a 190-day lifetime maximum benefit limit for Inpatient mental health services provided in a free-standing psychiatric facility. Inpatient mental health services provided in a medical/surgical facility are unlimited. Services that differ in coverage between Medicare and Medicaid may impact reimbursement. For example, community based services (H-codes) are not covered under Medicare but may be eligible for reimbursement under Medicaid. Partial Hospitalization is billed as individual services for Medicare but, where covered, as per diem services for Medicaid. Therefore the facility may need to determine which method of reimbursement to receive for partial hospitalization because the different reimbursement methodologies means that the service will deny under one of the programs as not covered.
Authorization Requirements	• **Par Providers** - No authorization is required for Diagnostic Evaluation (90791/90792) and up to five (5) subsequent routine outpatient visits (90832, 90846, 90847, 90853). Prior authorization will be required if additional sessions are needed. • Psych Testing, In-Home services, and Inpatient/Acute Care services require prior authorization. • Routine Medication Management (99201-99215) visits do not require prior authorization.

Prior Authorization for Medications
It is important to Cenpatico that our members receive their medications in a timely manner. Many medications do not require prior authorization, however, some medications do. Please refer to the Sunshine State Health Plan website for information regarding Preferred Drug List (PDL) and other pertinent pharmacy information:

http://www.sunshinestatehealth.com/for-providers/pharmacy/

http://www.sunshinestatehealth.com/files/2008/12/SSHP-FL-US-Script-Medication-Prior-Authorization-Request-Form.pdf

Emergency Prescription Supply Process
A 72-hour emergency supply of prescribed drugs must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or PA edit and would need prescriber prior approval.

Member Grievances
A Grievance is an expression of dissatisfaction with any aspect of Cenpatico, Advantage by Sunshine State Health Plan or a Provider's operation, provision of healthcare services, activities, or behaviors, other than an Organization Determination. A Member or Member's authorized representative may file a Grievance either orally or in writing. Members or their authorized representative may file a Grievance by contacting Member Services at 1-866-796-0530 or by submitting written notification to:

Advantage by Sunshine State Health Plan
Medicare Grievance & Appeal Dept.
P.O. Box 4000
Farmington, MO 63640-4400

Advantage by Sunshine State Health Plan will respond to all issues raised by Members **within thirty (30) calendar days** of receipt of the Grievance. Should Advantage by Sunshine State Health Plan or the Member request additional time to resolve the Grievance, Advantage by Sunshine State Health Plan will extend the resolution timeframe to **fourteen (14) additional calendar days** for resolution of the Grievance.

Appeals/Reconsiderations
An Appeal or Reconsideration is the request for review of an adverse Organization Determination (OD). An OD is the initial decision about whether we will provide the medical care or service you request, or pay for a service you have received. The review may be requested by telephone or in writing; however oral requests for an Appeal /Reconsideration within the standard timeframe must be confirmed in writing **within sixty (60) calendar days** of the date of the adverse OD. Members may request that Advantage by Sunshine State Health Plan review the adverse OD to verify if the right decision has been made. Who may file an Appeal / Reconsideration?

- Advantage by Sunshine State Health Plan Member
- Authorized representative of Advantage by Sunshine State Health Plan Member
- Provider acting on behalf of Member (with written Member consent)

Requests for an Appeal / Reconsideration must be made **within sixty (60) calendar days** from the date of the adverse OD. Advantage by Sunshine State Health Plan will send a written decision **within thirty (30) calendar days** after the request for an Appeal /Reconsideration is received by Advantage by Sunshine State Health Plan. This is subject to an authorized extension of **up to fourteen (14) calendar days**.

Expedited Appeal
If a decision on an Appeal is required immediately due to the Member's health needs, an Expedited Appeal may be requested. Advantage by Sunshine State Health Plan's decision will be provided **within 72 hours** of Advantage by Sunshine State Health Plan's receipt of the request for the review.

Assistance and Contacting Advantage by Sunshine State Health Plan
Advantage by Sunshine State Health Plan's Grievance & Appeal Coordinator is available to assist Members who need help in filing a Grievance or an Appeal or in completing any element in the Grievance or Appeal process. Members may seek assistance, initiate a Grievance or

request an Appeal by calling 1-866-796-0530.

Credentialing

Credentialing Requirements

Cenpatico credentialing of Providers is as required under the Code of Federal Regulations-42 CFR 422.204 and the Medicare Care Manual, Chapter 6.

Credentialing is required for all physicians, Licensed Clinical Social Workers, and other institutional providers who are permitted to practice to practice independently under State Law.

The credentialing must include a Completed Application and the copy of the required documents (license, DEA/CDS Certificate, current certificate of malpractice coverage, and any related training/board certification).

The following credentialing elements are to be verified:

- License
- DEA/CDS
- Education
- Board Certification
- Medical Malpractice Insurance
- National Practitioner Date Bank
- Licensure Sanction or Limitations
- Eligibility for Participation in Medicare (Excluded and Opt-out)
- During re-credentialing: Quality of Care Issues, Member Complaints

All information must be reviewed with 6 months (180 days) from the date of the Credentialing Committee's decision/determination for participation.

Credentialing of Health Delivery Organizations
(CMHCs and other Behavioral Health Providers/Facilities)

Prior to contracting with Health Delivery Organizations (HDO), Cenpatico verifies that the following organizations have been approved by a recognized accrediting body or meet Cenpatico standards for participation, and are in good standing with state and federal agencies:

- Hospital or Facility
- Community Mental Health Center (CMHC)

Cenpatico recognizes the following accrediting bodies*:

- CARF - Commission on Accreditation of Rehabilitation Facilities
- COA - Council on Accreditation
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations.
- NCQA - National Committee for Quality Assurance
- URAC - Utilization Review Accreditation Commission
- Council on Accreditation of Services for Family & Children

**This list may not be inclusive of all accrediting organizations.*

For those organizations that are not accredited, an on-site evaluation will be scheduled to review the scope of services available at the facility, physical plant safety, the Quality Improvement program, and Credentialing and Re-credentialing Policies and Procedures. Cenpatico may substitute a Center for Medicare and Medicaid Services (CMS) or state review in lieu of the site visit. Cenpatico would require the report from the organization to verify that the review has been performed and the report meets its standards. Also acceptable is a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection.

Coordinating Benefits for Dual Members
Members who are dually eligible are entitled to Medicare Part A and/or Part B and also are eligible for some form of Medicaid benefit. All Advantage members are dually eligible. They may also receive their Medicaid benefits through the health plan or they may be in the Medicaid fee for service program.

Services that are covered by both programs will be paid first under Medicare rules and the difference, or co-pays, will be processed under Medicaid rules. Medicaid also covers additional services (e.g., nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids). Benefits must still be coordinated between Medicare Advantage and Medicaid and claims for Medicaid payment will need to be submitted to Cenpatico after the Medicare portion has been adjudicated.

Please call the Claims Customer Service for assistance in coordinating the benefits for patients who are not our *Medicaid* members.

MEDICAID AND MEDICARE SNP PROGRAMS COORDINATING COVERAGE			
Benefit	**Medicare Advantage**	**Medicaid**	**SNP Copay**
Inpatient Mental Health Care			
Covered services include mental health care services that require a hospital stay; 190 days in a psychiatric hospital in a lifetime.		0% unless patient has reached lifetime maximum on Medicare; then 100% of Medicaid Rate.	$0
	Days 1-60: $0 copay	$0	$0
	Days 61–90: $283 per day	$283 per day	$0
	Days 91–190: $566 per day	$566 per day	$0
	Days 191 +: 0% coverage	100% Medicaid Rate	$0
Outpatient Mental Health Care/Substance Abuse Services			
Professional services (CPT codes)	50% coinsurance for each Medicare approved individual or group therapy visit	Remainder up to the Medicaid rate	$0
	20% of the Medicare approved amount for doctor/provider visits to diagnose, monitor, or change medications	Remainder up to the Medicaid rate	$0
Community Based Services (H-codes)	Not covered	May be eligible for Medicaid reimbursement up to the Medicaid amount	$0
Services performed by LPCs, LMFTs or Bachelor Level Providers	Not covered	May be eligible for Medicaid reimbursement up to the Medicaid amount	$0

Per Federal Code of Regulations 422.504(g)(1)(iii)
Provider agrees that for Medicare Advantage Members eligible for both Medicare and Medicaid, such Medicare Advantage Members shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. In such instances, Provider shall accept the Medicare Advantage plan payment as payment in full for the Medicare Parts A and B cost-sharing, or Provider shall bill the appropriate State source.

Cenpatico Quick Reference Guide (QRG)
for Members of Advantage by Sunshine State Health Plan

IMPORTANT CENPATICO PHONE NUMBERS

Authorizations Inquiries
(866) 796-0530

Claims Customer Service
(877) 730-2117

Provider Customer Service
(866) 796-0530

Outpatient Prior Authorization
FAX (866) 694-3649

Inpatient Notification
(866) 796-0530

After hours, weekends & holidays coverage is provided by NurseWise when contacting Cenpatico's Customer Service Team (866) 796-0530

WEBSITES

Our Website is available 24 hours a day, seven days a week, including holidays
www.cenpatico.com

Sunshine State Health Plan
www.sunshinestatehealth.com

CLAIMS SUBMISSION

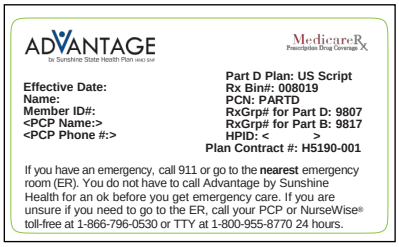
Claims must be submitted within 95 days of the date of service or as defined in your Cenpatico Medicare Advantage contract. Failure to do so will result in denial of claim.

Electronic Submissions:
EDI PAYOR ID: 68056

Paper Submissions:
Advantage by Sunshine State Health Plan
PO Box 3060
Farmington, MO 63640-3822

Appeals:
Advantage by Sunshine State Health Plan
PO Box 4000
Farmington, MO 63640-4400

ADVANTAGE CARD


ADVANTAGE
by Sunshine State Health Plan HMO SNP

MedicareRx
Prescription Drug Coverage

Effective Date:
Name:
Member ID#:
<PCP Name:>
<PCP Phone #:>

Part D Plan: US Script
Rx Bin#: 008019
PCN: PARTD
RxGrp# for Part D: 9807
RxGrp# for Part B: 9817
HPID: < >
Plan Contract #: H5190-001

If you have an emergency, call 911 or go to the **nearest** emergency room (ER). You do not have to call Advantage by Sunshine Health for an ok before you get emergency care. If you are unsure if you need to go to the ER, call your PCP or NurseWise® toll-free at 1-866-796-0530 or TTY at 1-800-955-8770 24 hours.


Member Services 1-866-796-0530, TTY 1-800-955-8770
Sun-Sat, 8 a.m. – 8 p.m.
http://advantage.sunshinestatehealth.com

Providers This card does not guarantee eligibility or authorization. For eligibility, call 1-866-796-0530 or NurseWise® at 1-866-796-0530. For prior auth or case management referral, call 1-866-796-0530. **For questions, pharmacists can call 1-866-399-0928.** For pharmacy prior auth, call 1-866-399-0928. All providers must bill Florida Medicaid for Medicare cost sharing.

Non-participating providers must obtain prior auth on all services, except for emergency care. Call 1-866-796-0530 for prior auth.

Claims submissions: Advantage by Sunshine Health
P.O. Box 3060, Farmington, MO 63640-3822

Services Requiring Prior Authorization:
All services by Non-Participating Providers of Advantage by Sunshine State Health Plan/Cenpatico

All services by a Facility including out-patient

Outpatient clinic visits require authorization after the first five visits per member per lifetime

Inpatient Admissions

Some Medications: confirm on the Sunshine State Health Plan website.

Pharmacy Links:
http://www.sunshinestatehealth.com/for-providers/pharmacy/

http://www.sunshinestatehealth.com/files/2008/12/SSHP-FL-US-Script-Medication-Prior-Authorization-Request-Form.pdf