sunshine health

Cenpatico
Improving Lives

PROVIDER MANUAL

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IMPROVING LIVES

Improving Lives is more than our tagline. It's our commitment to the members and providers we serve. We are behavioral health experts that deliver quality results and improve outcomes.

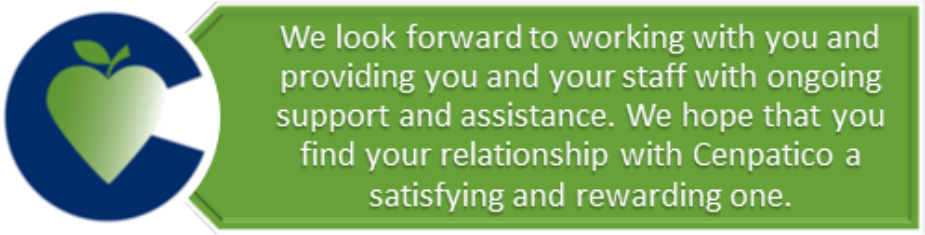
Welcome to Cenpatico®*

Welcome to the Cenpatico Provider Network. We look forward to a long and mutually rewarding partnership as we work together in the delivery of mental health and/or substance use disorder services to our members in the State of Florida. Member care is a collaborative effort that draws on the expertise and professionalism of all involved. An experienced provider network is essential to provide consistent, superior services to our members. We collaborate with providers to ensure that our members are receiving services in alignment with evidence-based practices which result in the most effective clinical treatment. To achieve our goal, Cenpatico builds strong, long-term relationships with our provider network.

We view our relationships with our provider network as a partnership. We look forward to a long and mutually rewarding partnership as we work together in the State of Florida.Our role in that partnership includes providing tools, training and technical assistance to ensure successful outcomes, not only for our members, but also our providers with regard to timely and accurate claims payment.

This Manual provides a description of Cenpatico's treatment philosophy and the policies and procedures administered in support of this philosophy. It also describes the requirements Network Providers/Practitioners (Providers) must adhere to in the delivery of services and administrative processes, which were developed in collaboration with our clients, industry standards and our accreditation body; NCQA. It has been developed to answer your questions about Cenpatico's program and to explain how we manage the delivery of mental health and/or substance use disorder services to the members we serve. This Manual will also provide you with specific and detailed information about the Cenpatico service delivery system within the State of Florida.

Cenpatico will provide bulletins, as needed; to incorporate any needed changes to this Manual online at www.cenpatico.com/providers. We offer a wealth of resources for our providers on our website including this Manual, provider forms, etc.

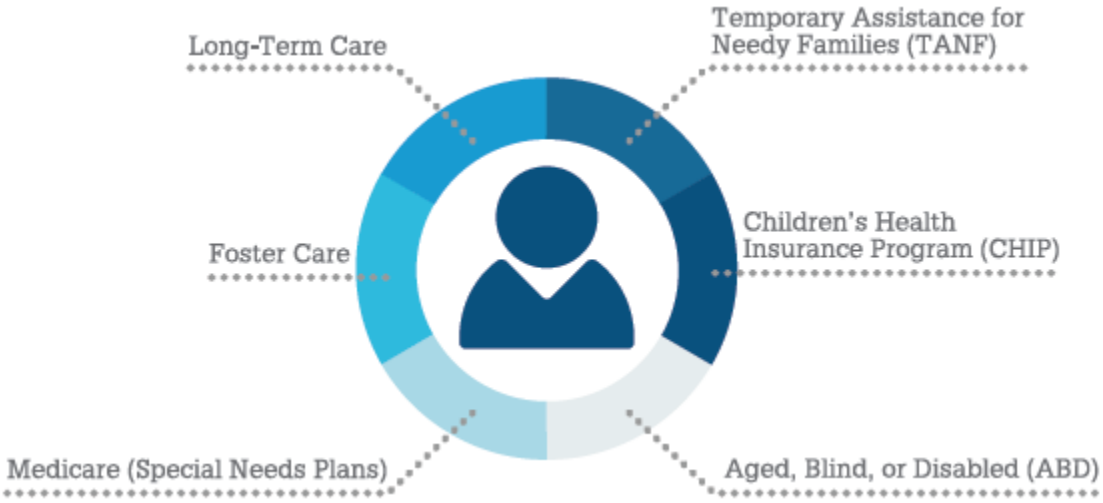


**Cenpatico Behavioral Health, LLC*

ABOUT CENPATICO

Cenpatico offers agencies, health plans and States solutions to administer healthcare services more effectively. Our specialties include managed care solutions for Behavioral Health, Community Re-Entry, Foster Care, Specialized School Services, Specialty Therapy and Rehabilitation Services programs.

We are a national leader in care management. Our members receive care from local teams that truly understand the specific needs of their communities. We continually introduce innovative clinical initiatives and network strategies designed to create quality service delivery systems. Our members are enrolled in publicly-funded programs including:



Cenpatico is a wholly owned subsidiary of Centene Corporation®, headquartered in St. Louis, Missouri. Centene is a top managed care company that powers Cenpatico's information systems. Centene offers our clients an advantage when creating special options for their members.

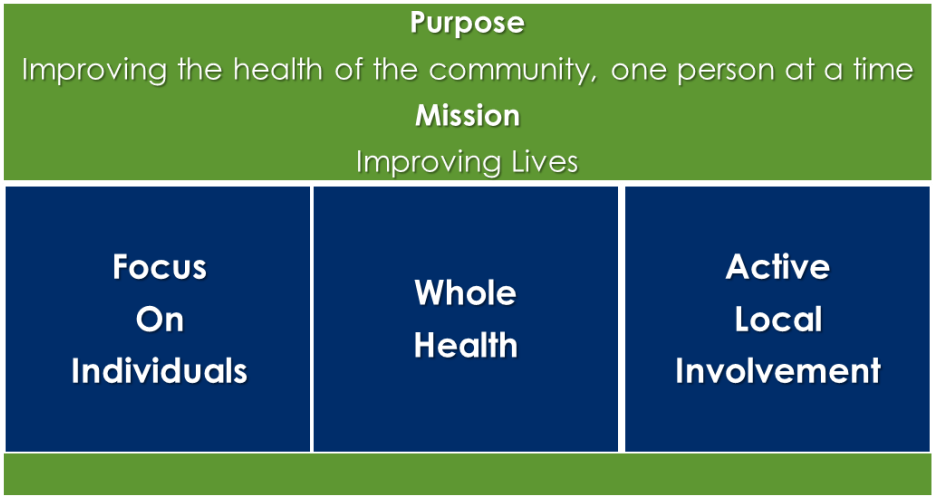
Cenpatico Managed Care Philosophy

Cenpatico is strongly committed to the philosophy of providing appropriate treatment at the least restrictive level of care that meets the member's needs. We believe that individualized consideration and evaluation of each member's treatment needs are required for optimal medical necessity determinations. Unless inpatient treatment is strongly indicated and meets Medical Necessity Criteria, outpatient treatment is generally considered the first choice treatment approach. Many factors support this position:

- Outpatient treatment allows the member to maximize existing social strengths and supports, while receiving treatment in a setting least disruptive to normal everyday life.
- Outpatient treatment maximizes the potential of influences that may contribute to treatment motivation, including family, social, and occupational networks.
- Allowing a member to continue in occupational, scholastic, and/or social activities increases the potential for confidentiality of treatment and its privacy. Friends and associates need not know of the member's treatment unless the member chooses to tell them.
- Outpatient treatment encourages the member to work on current individual, family, and job-related issues while treatment in ongoing. Problems can be examined as they occur and immediate feedback can be provided. Successes can strengthen the member's confidence so that incremental changes can occur in treatment.

At Cenpatico, we take privacy and confidentiality seriously. We have processes, policies and procedures to comply with applicable Federal and State regulatory requirements.

{ We appreciate your partnership with Cenpatico and maintaining the highest quality and most appropriate level of care for our members. }



Our Core Beliefs

Cenpatico's core beliefs drive every decision we make as we work to improve the lives of our Members.

We continuously monitor all aspects of our business, including utilization and case management trends and projections, provider network composition and adequacy, quality and performance improvement, and overall Member population behavior and outcomes.

> We offer a complete picture of the systems of care for our Members, turning data into actionable information to support continuous improvement.

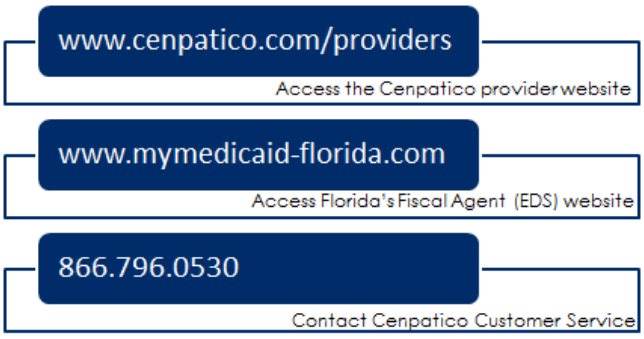
Coordination between Sunshine Health and Cenpatico

Sunshine Health is a managed care organization, (MCO) contracted with the Florida Agency for Health Care Administration, (AHCA) to serve Medicaid and other government services program members. Sunshine Health has developed the expertise to work with Medicaid members to improve their health status and quality of life. Together, our number one priority is the promotion of healthy lifestyles through preventive healthcare. We accomplish this goal by partnering with the providers who oversee the healthcare of Sunshine Health members.

Medicaid is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children. Medicaid is different in every state.

The statewide Medicaid Managed Care (SMMC) program has two different components: The Florida Long Term Care Managed Care Program and the Florida Managed Medical Assistance Program. Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance Program will receive all healthcare services other than Long Term Care through a managed care plan.

Sunshine Health and Cenpatico work together to assure quality behavioral health services are provided to all Members. This coordination includes participation in Quality Improvement committees for both organizations, and planned focus studies conducted conjointly for physical and behavioral healthcare services.



Additionally, Cenpatico works to educate and assist physical health and behavioral health providers in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to the Health Plan on a monthly basis and is shared with Health Plan's QI committee quarterly. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency.

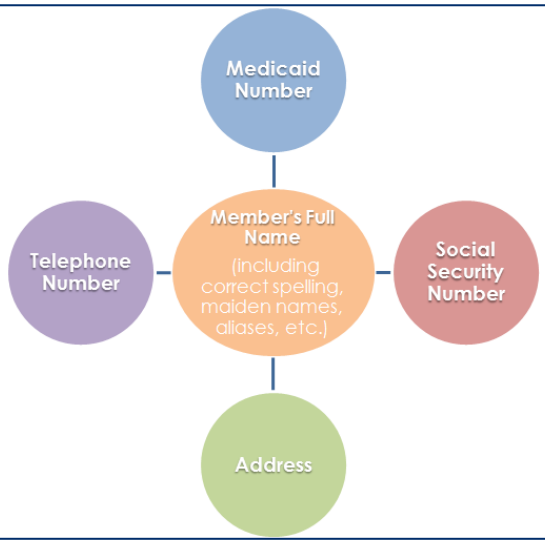
Cenpatico manages and reimburses claims for the covered behavioral health benefits of Sunshine Health members throughout the State of Florida. Sunshine Health serves members statewide in Florida.

For specific information about serving children in the child welfare population, please refer to the Cenpatico Child Welfare Provider Manual.

Eligibility for Sunshine Health Plan

The Florida Agency for Healthcare Administration (AHCA) is responsible for determining eligibility of persons applying for Managed Medical Assistance (MMA). Persons interested in applying for the MMA Program can be referred to the Agency for Health Care Administration.

Member eligibility in Managed Medical Assistance is effective on the first calendar day of a month, and may be confirmed by any of the provided Eligibility Verification systems.



Verifying Member Enrollment

Providers are responsible for verifying eligibility every time a member schedules an appointment as well as when they arrive for services. Cenpatico Customer Service will assist you with determining member eligibility. Customer Service Representatives, available during regular

business hours, have access to current member eligibility information. Providers should use any of the provided options to verify member enrollment.

When you call to check eligibility, please have available as much of the member's information as possible.

Until the date of enrollment with Sunshine Health, Cenpatico is not financially responsible for services the prospective member receives. In addition, Cenpatico is not financially responsible for services members receive after their coverage has been terminated. However, in an acute hospital setting, the payor at the time of admission is the payor for the entire length of the stay, regardless of enrollment while inpatient.

Cenpatico has the capability to receive ANSI X12N 270 eligibility inquiries and generate ANSI X12N 271 health plan eligibility response transaction through Sunshine Health. For more information on conducting these transactions electronically, please contact our EDI department.

Sunshine Health Plan

1301 International Parkway
Suite 400
Sunrise, Florida 33323

Phone: 866.796.0530
TDD/TYY: 800.955.8771

http://www.sunshinehealth.com/

Important Numbers

Department	Phone	Fax
Prior Authorization / Utilization Management	866.796.0530	866.694.3649
Network Development / Provider Relations	866.796.0530	
Appeals	866.796.0530	866.796.0523
Grievances / Complaints	866.796.0530	866.796.0523
Quality Management / Incident Reports	866.796.0530	866.694.3649
Credentialing	866.694.3735	866.694.3735
Claim Support	877.730.2117	

Verify Member Eligibility

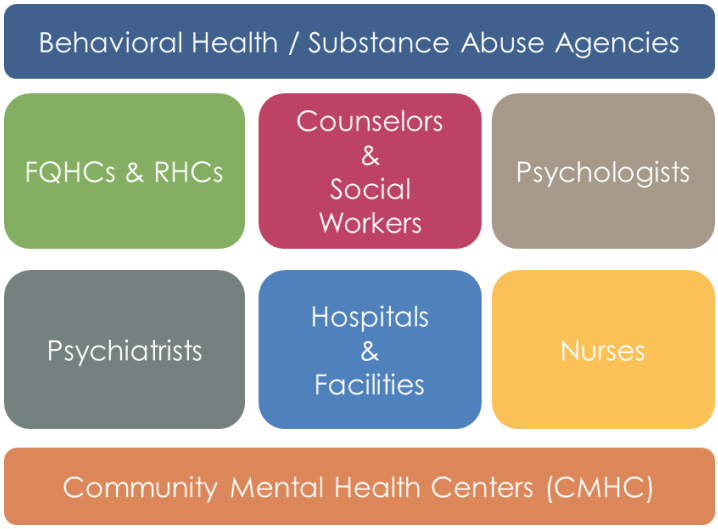
State Fiscal Agent (EDS)Website
http://mymedicaid-florida.com/

MEMBER ID CARDS

PROVIDER NETWORK PARTICIPATION

Cenpatico Contracts with behavioral health Providers that consistently meet or exceed Cenpatico clinical quality standards.

The Cenpatico Provider network may consist of the following types of Providers:



Cenpatico contracts its provider network to support and meet the linguistic, cultural and other unique needs of every individual Member, including the capacity to communicate with Members in languages other than English and communicate with those Members who are deaf or hearing impaired.

Contracting with Cenpatico

Cenpatico consistently monitors network adequacy. Network Providers are selected on the following standards:

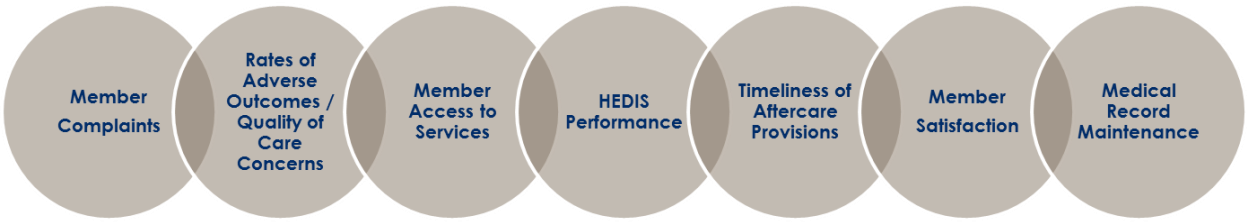
- Clinical expertise
- Ability to accept new patients
- Potential for high volume referrals
- Specialties that best meet our Members' needs
- Geographic location considering distance, travel time, means of transportation and access for Members with physical disabilities

Cenpatico does not require Providers to sign exclusive agreements as a condition of contracting. Additionally, we have no stipulations in our agreements requiring Providers to participate in multiple product lines. If you have questions or need additional clarification regarding this policy, please contact your Network Manager.

Cenpatico's policy is not to use incentives that encourage barriers to care and services. Cenpatico will not make decisions regarding hiring, promoting, or terminating its Providers or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. Cenpatico employees, Medical Directors, and clinical consultants who conduct utilization management (UM) activities are compensated through hourly fees or salaried positions. Cenpatico does not permit or provide compensation, bonuses, or incentives to employees or agents based on a Per Member Per Month (PMPM) date, the amount of volume of adverse determinations, reductions or limitations on inpatient days or lengths of stay, benefits, services, or frequency of contacts with healthcare Providers and patients. UM decision making is based on medical necessity, the appropriateness of care and service and existence of coverage.

Provider Performance

Cenpatico monitors Provider performance to ensure quality care is provided to Cenpatico Members. Cenpatico's Quality Improvement Team evaluates Provider performance using the following indicators:



If at any time a provider demonstrates negative trends in Member complaints, adverse outcomes/quality of care concerns, and/or Member access rates, Cenpatico's Quality Improvement team presents appropriate provider data/information to the Cenpatico Peer Review Committee for review. Upon recommendation from the committee, Cenpatico may issue a corrective action plan (CAP) for any Provider not meeting performance standards. The CAP is monitored by the Quality Improvement team and evaluated by the Peer Review committee. Cenpatico adopts a collaborative approach to the development and maintenance of Provider CAPs and provides technical assistance to Providers. Failure to comply with the CAP and demonstrate adherence to CAP action items could result in further compliance action, up to and including termination from the Cenpatico network.

PROVIDER ACCESS & DENSITY STANDARDS

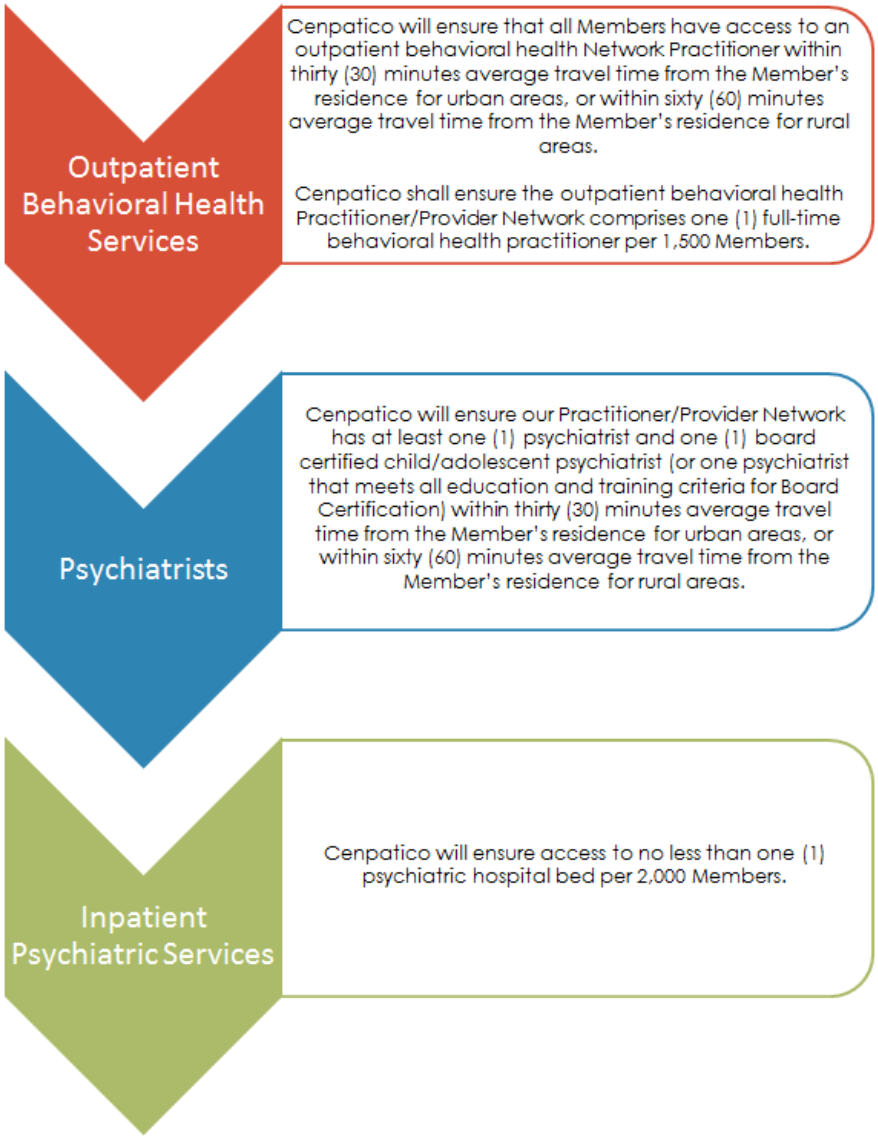
Sunshine Health Members may access behavioral health and substance use disorder services through several channels. Members do not need a referral from their Primary Care Physician (PCP) to access covered behavioral health and substance use disorder services. Caregivers or medical consenters may self-refer Members for behavioral health services.

Cenpatico adheres to National Commission for Quality Assurance (NCQA) and State accessibility standards for Member appointments. Providers must make every effort to assist Cenpatico in providing appointments within the following timeframes:

Type of Care	Appointment Availability	Provider Type
Routine – treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting.	Within fourteen (14) calendar days	Specialist
Urgent – is defined as a non-life threatening situation, but should be treated within twenty-four (24) hours. Urgent care services are not subject to prior authorization or precertification.	Within twenty-four (24) hours	Specialist
Emergent/Non-Life Threatening – defined as inpatient and outpatient services furnished by a qualified Provider needed to evaluate/stabilize a behavioral health condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care to result in injury to self or bodily harm to others; placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction to any bodily organ or part; serious harm to self or others due to an alcohol or drug abuse emergency; with respect to a pregnant woman having contractions – (i) that there is not adequate time to affect a safe transfer to another hospital before delivery, or (ii) that	All non-life threatening emergencies are to be directed to the Emergency Room	Specialist, Hospital

transfer may pose a threat to the health or safety of the woman or unborn child.		
Discharge (from hospital/acute care)	Within seven (7) days of discharge	Specialist

If you cannot offer an appointment within these timeframes, please refer the Member to the Cenpatico Service Center so the Member may be rescheduled with an alternative Provider who can meet the access standards and the Member's needs. Adherence to these standards is monitored with telephone auditing. Providers shall ensure that services provided are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the Member's behavioral health condition dictates.



PROVIDER DATA MANAGEMENT

Providers will offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees and shall ensure Members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit Members from accessing services. Providers should call the Cenpatico Provider Relations department at 866-796-0530 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new Members or meet the access standards can result in suspension and/or termination from the network. All changes in a Provider's status will be considered in the re-credentialing process.

Providers are required to successfully complete the credentialing process prior to being accepted as a Cenpatico Network Provider. Only credentialed and contracted Providers may render services to Cenpatico Members as an in-network Provider. We credential Providers in accordance with our credentialing policies and procedures and in accordance with specific criteria required by NCQA.

Credentialing

Providers must submit at a minimum the following information when applying for participation with Cenpatico:

- Completed, signed, and dated Standardized Credentialing Application or CAQH (Council for Affordable Quality HealthCare) application
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and Provider's name or evidence of compliance with State regulations regarding malpractice coverage
- Copy of current Drug Enforcement Administration (DEA) registration certificate, if applicable
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted License to practice in the State of Florida
- Current copy of specialty/board certification certificate, if applicable
- Current copy of Art Therapy certification, if applicable
- Curriculum vitae listing, at a minimum, a five-year work history
- Signed and dated Release of Information form
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training

- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of enumeration letter issued by National Plan and Provider Enumeration System (NPI)
- Completed Cenpatico Provider Specialty Profile
- Disclosure of Ownership and Controlling Interest Statement, if applicable

Facilities must submit at a minimum the following information when applying for participation with Cenpatico:

- A complete signed and dated application
- List of current professional Mental Health/Substance Use Disorder staff privileged to admit and/or treat patients in your facility, (include license type, address, telephone numbers, and social security numbers) that you would recommend that we contact for membership on Cenpatico's Individual Provider Panel
- Copy of The Joint Commission/CARF/COA/AOA accreditation letter with dates of accreditation in addition to a list of all practice locations covered under the applicable accreditation body
- Copy of the State or local license(s) and/or certificate(s) under which your facility operates
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of current Drug Enforcement Administration (DEA) registration certificate, if applicable
- Copy of professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year)
- Listing of satellite locations and services offered at each location (include copies of accreditation, license, insurance, CLIA, and DEA certificate, if applicable)
- Copy of Credentialing Procedures
- Copy of NDMS (National Disaster Medical System) agreement, if applicable
- Disclosure of Ownership and Controlling Interest Statement, if applicable
- Facilities contracted under a Cenpatico Facility Agreement that list a rendering NPI in box 24-J of the claim form that is different than the Facility's billing NPI (box 33-A), must submit an electronic (Excel) roster of clinicians rendering covered services with their credentialing materials

Non-Accredited Facilities must include the following in addition to the items above:

- Copy of State or local Fire/Health Certificate
- Copy of Quality Assurance Plan
- Description of Aftercare or Follow-up Program
- Organizational Charts including staff to patient ratio

Council for Affordable Quality HealthCare (CAQH)

www.CAQH.org 866-796-0530

Cenpatico subscribes to the CAQH to streamline the Credentialing/Re-credentialing process. We strongly suggest that our providers enroll with CAQH as it streamlines the credentialing process for practitioners. If you are interested in having Cenpatico retrieve your credentialing/re-credentialing application from CAQH, or if you are not enrolled with CAQH, Cenpatico can assist you with contacting CAQH for enrollment. Once a CAQH Provider ID number is assigned, you can visit the CAQH website or call the help desk, to complete the credentialing application. There is no cost for Providers to participate with CAQH and submit their credentialing applications.

Provider Rosters

Cenpatico requires a listing of rendering employed professional behavioral health staff privileged to admit and/or treat patients. This list must include the Provider's license type, address, telephone numbers, NPI number, and social security numbers. Each NPI number must be registered with AHCA. As this list is displayed in the Provider Directory, Cenpatico must be notified of any updates to this listing to ensure accuracy. In addition, please note that the information provided may be accessed by Cenpatico for network accessibility and Member referral services. Providers should submit the listing to provider_change@cenpatico.com

Re-Credentialing

Providers will be re-credentialed every 36 months from the initial credentialing date in accordance with the current NCQA standard CR4 unless otherwise dictated by State law. Providers will receive notice that they are due to be re-credentialed well in advance of their expiration date and, as such, are expected to submit their updated information in a timely fashion. Failure to do so could result in suspension and/or termination from the network. Quality indicators including but not limited to, complaints, appointment availability, critical incidents, and compliance with discharge appointment reporting will be taken into consideration during the re-credentialing process.

Cenpatico will verify the following information submitted for Credentialing and/or Re-Credentialing:

- License through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) and HIPDB claims
- Five years of work history
- Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS – Excluded Parties Listing)

Once the application is completed, the Cenpatico Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

It is the Provider's responsibility to notify Cenpatico of any of the following within ten (10) days of the occurrence:

- Lawsuits related to professional role
- Licensing board actions
- Changes to NPI and TIN
- Malpractice claims or arbitration
- Disciplinary actions before a State agency and Medicaid/Medicare sanctions
- Cancellation or material modification of professional liability insurance
- Member complaints against Practitioner
- Changes in fiscal address and/or billing address
- Any situation that would impact a Provider's ability to carry out the provisions of their Formal Written Agreement ("Agreement") with Cenpatico, including the inability to meet Member accessibility standards, changes or revocation with DEA certifications, hospital staff changes or NPDB or Medicare sanctions

Site Visits

Any entity executing a Facility Agreement will require an accreditation from The Joint Commission/CARF/COA/AOA. In the event such entity is not accredited, a site visit will be required as a component of the credentialing process. Failure to pass the site visit will result in the facility being ineligible to participate in the Cenpatico network, in which case the Provider will be notified by mail.

Additionally, Providers may also have a site visit conducted by a Cenpatico representative as part of the credentialing/re-credentialing process. Failure to pass the site visit may result in a Corrective Action Plan (CAP) that must be satisfied before being considered for admission to the network. Providers are subject to an on-site visit at any time with or without cause. Cenpatico reserves the right to conduct Provider site visit audits. Site visits may be conducted as a result of Member dissatisfaction or as part of a chart audit. The site visit auditor reviews the quality of the location where care is provided and will evaluate the accessibility and adequacy of the treatment and waiting areas.

Provider Verification

Provider's State identification information, license, TIN, legal entity name, doing business as (D.B.A) and other pertinent information must be valid and verified with the Florida Department of Community Health. Any discrepancies between the Provider information and the State file must be validated by the Provider and the State.

National Provider Identifier (NPI)

A National Provider Identifier or NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers. The transition to the NPI was mandated as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The NPI number can be obtained online through the National Plan and Provider Enumeration System (NPPES) pages on CMS's website. Turnaround time for obtaining a number is from 1 to 20 days.

Medicaid Number

Providers are required to obtain a Medicaid number in order to provide covered services for a Medicaid product. This Medicaid number can be obtained through the State Medicaid office. Please note that Cenpatico will verify this information. All Provider information on file with Florida Agency for Healthcare Administration will be utilized for authorization of covered services and claims payment.

Medicare Number

Providers are required to obtain a Medicare number in order to provide covered services for Medicare. Please reference CMS and Medicare Provider Enrollment for additional information. All Provider information on file with CMS will be utilized for authorization of covered services and claims payment. Please note that Cenpatico will verify this information via CMS.

Right to Review and Correct Information

All providers participating in the Cenpatico Network have the right to review the information obtained and used by Cenpatico to evaluate the provider credentialing/re-credentialing application. This includes information obtained from any outside primary sources such as the National Practitioner Data Bank(NPDB)– Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Composite State Board of Medical Examiners and other State board agencies. This does not allow a Provider to review references, personal recommendations, or other information that is peer review protected.

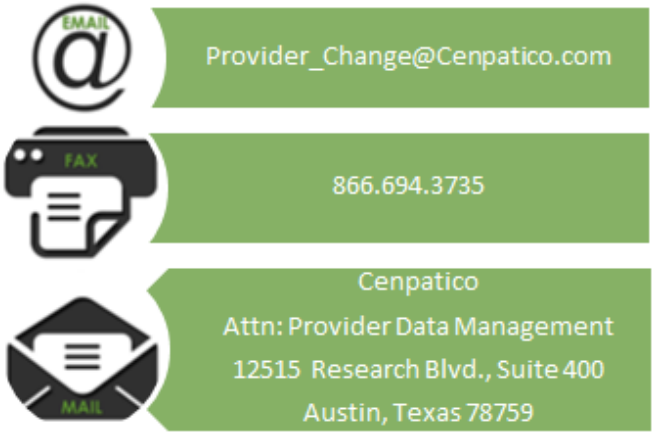
Should a Provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or if any information gathered as part of the primary source verification process differ from that submitted by a Provider, the Provider has the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Cenpatico Credentialing Department. Upon receipt of this information, the Provider will have fourteen (14) days to provide a written explanation detailing the error of the difference in information. The Cenpatico Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Status Change Notification

Providers must notify Cenpatico immediately of any change in licensure and/or certifications that are required under federal, State or local laws for the provision of covered behavioral health/substance use disorder services to Members, if there is a change in Provider's hospital privileges, or if there is a change in panel status (open/closed panel). All changes in a Provider's status will be considered in the re-credentialing process.

Provider Demographic/Information Updates

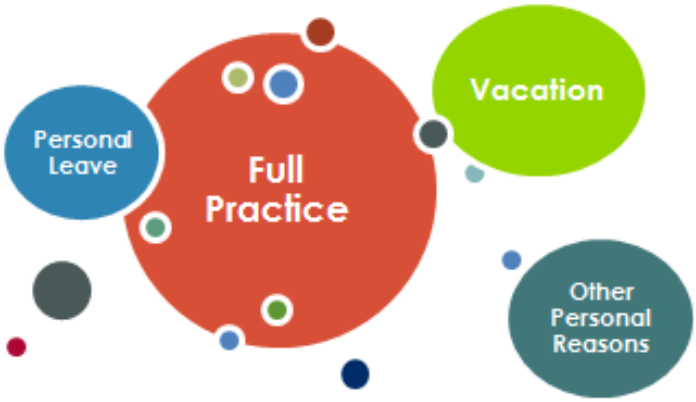
Providers should advise Cenpatico with as much advance notice as possible, of any demographic/information updates. Provider information such as address, phone and office hours is used in our Provider Directory, and having the most current information accurately reflects our Provider Network.



Please notify Cenpatico immediately of any updates to your Tax Identification Number, service site address, phone/fax number, and ability to accept new referrals in a timely manner so that our systems are current and accurately reflect your practice. In addition, we ask that you please respond to any questionnaires or surveys regarding your referral demographics, which may be requested from time to time.

Please use the Provider Change Form located on the Cenpatico website to notify us of any changes.

Referral Periods



Providers are required to notify Cenpatico when they are not available for appointments. Providers may place themselves in a "no referral" hold status for a set period of time without jeopardizing their overall network status. Providers must call or write to the Cenpatico Provider Relations department to set up a "no referral" period. Providers must have a start date and an end date indicating when they will be available again for referrals. A "no referral" period will end automatically on the set end date. "No referral" is set up for Providers for the listed reasons. The Cenpatico Provider Relations Department can be reached at 866.796.0530.

Reporting and Metric Requirements

Providers may be required to submit to Cenpatico timely reports or performance metrics as required by Sunshine Health's contract with the Florida Agency for Health Care Administration and/or Cenpatico's requirements for NCQA accreditation. Such metrics shall include, but are not limited to: Provider rosters by service location; compliance rates with timely ambulatory follow-up after a hospitalization; average number of days to receive an emergent appointment; average number of days to receive a routine appointment; network adequacy and similar measures. Cenpatico and Providers shall work together to find solutions if performance standards are not met.

Network Suspension and Termination

New applicants who are denied participation in the Cenpatico Network have the right to request a reconsideration of the decision in writing within fourteen (14) days of formal notice of denial. All written requests must include additional supporting documentation in favor of the applicant's reconsideration for participation. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two (2) weeks of the final decision.

If a Network Provider has been suspended or terminated by Cenpatico, he/she may contact the Cenpatico Provider Relations department at 866.796.0530 to request further information or discuss how to appeal the decision.

For a formal appeal of the suspension or termination of contract privileges, the Provider should send a written request. Please note that the written request should describe the reason(s) for

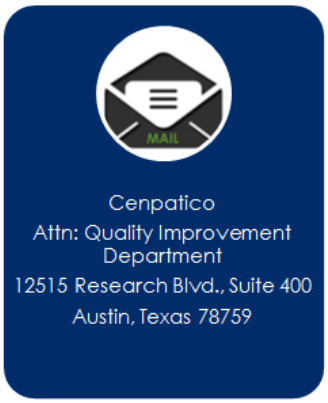
requesting and include any supporting documents. This request must be postmarked within thirty (30) days from the receipt of the suspension or termination letter to comply with the appeal process. Cenpatico will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the Provider with the notification of suspension/termination or you may request a copy by calling 866.796.0530.

Each Provider will be given a copy of their fully executed Agreement with Cenpatico. The Agreement will indicate the Provider's effective start date and the initial Term and Renewal Term provisions in Cenpatico's Provider network. The Agreement will also indicate the cancellation/termination policies. There is no "right to appeal" when either part chooses not to renew the Agreement.

Provider Request to Terminate

Providers requesting to terminate from the network must adhere to the Termination provisions set forth in their Agreement with Cenpatico. This notice can be mailed or faxed to the Provider Relations Department. The notification will be acknowledged by Cenpatico in writing and the Provider will be advised on procedures for transitioning Members if indicated.

Cenpatico fully recognizes that a change in a Provider's participation status in Cenpatico's Provider network may be challenging for Members. Cenpatico will work closely with the terminating Provider to address the Member's needs and to ensure a smooth transition as necessary. A Provider who terminates his/her contract with Cenpatico must notify all Cenpatico Members who are currently in care at the time and who have been in care with that Provider during the previous six (6) months. Treatment with these Members must be completed or transferred to another Cenpatico Provider within three (3) months of the notice of termination, unless otherwise mandated by State law. The Provider needs to work with the Cenpatico Care Management Department to determine which Members might be transferred, and, which Members meet Continuity of Care Guidelines to remain in treatment.



Cenpatico's Right to Terminate

Please refer to your Agreement with Cenpatico for a full disclosure of causes for termination. As stated in your Agreement, Cenpatico has the right to terminate the Agreement by giving written notice to the Provider upon the occurrence of any of the following events:

- Termination of Cenpatico's obligation to provide or arrange mental health/substance use disorder services for Members;
- Restriction, qualification, suspension or revocation of Provider's license, certification or membership on the active medical staff of a hospital or Cenpatico participating Provider group;
- Provider's loss of liability insurance required under the Agreement with Cenpatico;
- Provider's exclusion from participation in Cenpatico programs;
- Provider's exclusion from participation in the Medicare or Medicaid program;

- Provider's insolvency or bankruptcy or Provider's assignment for the benefit of creditors;
- Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Provider's submission of false or misleading billing information;
- Provider's failure or inability to meet and maintain full credentialing status with Cenpatico;
- Provider's breach of any term or obligations of the Agreement;
- Any occurrence of serious misconduct which brings Cenpatico to the reasonable interpretation that a Provider may be delivering clinically inappropriate care; or
- Provider's breach of Cenpatico Policies and Procedures.

Discontinuation

A Provider may be discontinued if required elements and prime source verification cannot be obtained by Cenpatico. An application may be discontinued if it meets the following criteria:

1. Provider non-responsive to three (3) Provider Data Management outreach attempts for missing or incomplete items
2. Application has been aging thirty (30) days from receipt of initial documentation

Prior to discontinuing any Provider application, Cenpatico will notify Provider/Practitioner of its intent to discontinue. The Provider/Practitioner will then have five (5) business days to respond with the required items for Provider application completion. If the application has been discontinued, the applicant is notified in writing that their application will not be processed. This written notification includes the reason for the determination. Following notification, the applications and documentation submitted to Cenpatico will be destroyed in accordance with NCAQ standards.

PROVIDER EDUCATION & TRAINING

Cenpatico will reach out to new Providers, groups and facilities to offer an initial orientation within thirty (30) calendar days of being placed on active status. Additional trainings are provided, upon request, to all Providers and their staff regarding the requirements of their contract and special needs of the Enrollees. Cenpatico shall also conduct ongoing trainings, as deemed necessary by Sunshine Health or the Agency for Health Care Administration (AHCA), in order to ensure compliance with program standards and their contract. Cenpatico will post information, updates, bulletins and other pertinent information on its website.

Clinical Training

Cenpatico offers Providers a variety of clinical training opportunities that support their ability to provide quality services to Members. The Clinical Training program is committed to achieving the following goals:

- Promote Provider competence and opportunities for skill-enhancement
- Promote Recovery & Resiliency
- To sustain and expand the use of Evidence Based practices (e.g. Trauma Focus Cognitive Behavioral Therapy, Art Therapy, Motivational Interviewing, Stages of Change, Impact Model, and Positive Psychology)

Clinical trainings for Providers will be offered at various times throughout the year and network Providers can also contact Cenpatico to request additional clinical trainings or topics specific to your organization. Clinical trainings may be offered live or webinar format.

ELECTRONIC TRANSACTIONS & FUNCTIONALITY

Our provider website allows Providers and office staff access to key information at their convenience, 24 hours a day / 7 days a week. Providers may register to gain access to secure functionality which includes; Member eligibility verification, electronic Professional and Institutional claims submission and status checks, access to training information, claim adjustments, online EOPs (Explanation of Payment), secure messaging, downloadable forms and important links. Cenpatico distributes its Member Rights and Responsibilities to Members and Providers upon enrollment and annually thereafter. They can also be found on our website.

Electronic Claims Submission

In the best interests of our Providers, State clients, Members, and our own internal operations, Cenpatico's preferred mechanism for claim submission is through Electronic Data Interchange (EDI). An electronically filed claim leads to a faster, more accurate process; allows the use of the information sooner in care of our Members; and is better for our environment. Our experiential data shows that when Providers prepare and submit claims electronically, the time from service to submission to Cenpatico is abbreviated by more than ***half*** the time compared to claims submitted on paper. This means that we obtain the data earlier, can process the claim faster, our Case Managers can utilize the information sooner in the care of our Members, and we can display the information sooner to our Providers. Our technology allows us to validate much of the data submitted at the earliest possible stage in the process, which results in more accurate and complete data received.

We do recognize that Provider capabilities related to submitting electronic claims vary based on a Provider's technological support and expertise. We also recognize smaller Providers face unique challenges. This is why we support a growing variety of online, EDI, and Electronic Funds Transfer (EFT) for claim payment options so each Provider can select the best approach for their practice.

Direct Data Entry (DDE) Claim Form

Our website allows for the HIPAA compliant entry of individual *professional* and *institutional* claims via *form templates* directly through our Provider Portal. When claims are submitted utilizing this interactive template on our portal, the data goes through the same rigor for data and field validation as do HIPAA 837 transactions.

When a Provider submits a ***professional*** claim via our online Direct Data Entry (DDE) form, we will receive and process the claim within ***two (2) business days*** of receipt, providing a preliminary status of paid, denied, or pending along with the corresponding reason codes and descriptions. Final status, indicating payments and denials will be received on the next check run. Pended claims will be finalized within required timely payment regulations. This method of claims filing (along with any other electronic form of claims submission) reduces paper and improves the timeliness of claims data, as well as providing the obvious direct benefit to the submitting Provider. This service level is made possible through the integration of our Provider Portal, *EDIFECS,* and *AMISYS Advance*, our core claims processing system.

Claim Adjustments and Additional Claim Information

Providers can submit claim adjustments and additional information electronically on our Provider website, such as an Explanation of Benefit (EOB) from another insurance carrier further ensuring that claim submission are complete. The ability to submit this information electronically enables faster overall turnaround time (TAT) in claim adjudication and payment.

HIPAA 837 Batch Claims

Cenpatico supports the online submission of HIPAA 837 batch claims directly through our Provider website. Supporting this feature is our EDICECS Ramp Manager tool which facilitates the process for EDI on-boarding. EDICECS Ramp Manager is an interactive tool that allows Providers to test their EDI transactions directly with us and, once approved, certify them for direct submission of HIPAA 5010 claim transactions to us. EDIFECS Transaction Manager, another component of our EDIFECS system, will allow Cenpatico to continuously monitor Provider EDI submission patterns which help to ensure consistent levels of EDI service. Beyond claim and remit transactions, Providers connecting directly via EDI will receive direct assistance from our EDI Help Desk to implement the broader HIPAA transaction set, including 270/271 Eligibility Inquiry and Response; the 276-277 Claim Status Inquiry and Response; the 278 Service Authorization Request

and Response; and (for Providers sufficiently equipped) HL7 based transactions, such as the Continuity of Care Document (CCD) and Scheduling Interface Unsolicited (SIU) for collaborative scheduling.

HIPAA 837 Professional & Institutional EDI Claims

Cenpatico supports *over 60 trading partners* across 13 states who file HIPAA 837 EDI claims on behalf of our Providers. In fact, we will accept claims from any clearinghouse that meets our performance and service quality standards and can implement our HIPAA companion guides.

Electronic Funds Transfer (EFT)

Like EDI claims submission, Electronic Funds Transfer (EFT) via the Automated Clearinghouse (ACH) affords both our Providers and HSHP administrative and financial efficiencies, and we actively encourage our Providers to sign up for one of the three EFT options we offer:

Emdeon ePayment

- Our providers will be able to go to the ePayment site, register, and set up their bank account for EFT. Once set up, the provider can view remittance information online on the ePayment site and/or download a HIPAA 835 ERA transaction file for import and processing as detailed information into the provider's practice management system and/or financial system, to support the provider's accounts receivable processing. Providers who use EMDEON's practice management hosted service or submit their claims to us via EMDEON, will also be able to take advantage of the "integration" efficiencies ePayment supports.

PayFormance

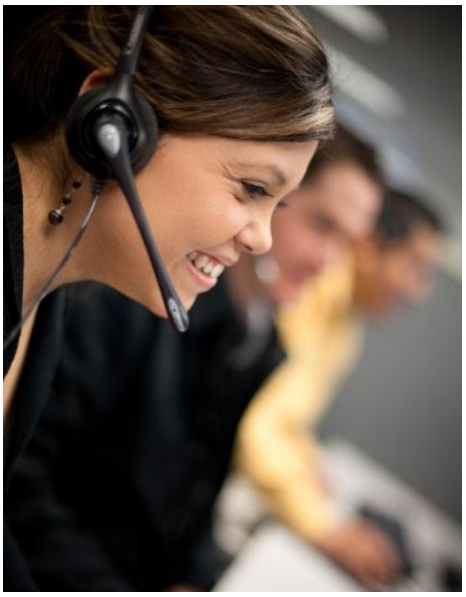
- PayFormance offers our providers a comprehensive payment management solution which is "clearinghouse agnostic". PayFormance supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, and provides online capability for viewing detailed remittance information, as well as the ability to download HIPAA 835 electronic remittance files directly to the provider's practice management system and/or financial system (as above).

Electronic Remittance (ERA)

- Providers can view ERAs through our Provider Portal and can request a printed version of their electronic remittance advice.

To initiate EFT directly with Cenpatico, complete a Cenpatico EFT Agreement. Upon acceptance, Cenpatico will deposit payment for claims directly into the assigned bank account.

CUSTOMER SERVICE & STANDARDS OF CARE



Cenpatico operates a toll free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel, Monday through Friday 8:00 AM – 8:00 PM EST. After-hours services are available during evenings, weekends and holidays.

The Cenpatico Customer Service Department strives to support the mission statement in providing quality, cost-effective behavioral health services to our customers. We strive for customer satisfaction on every call by doing the right thing the first time and we show our integrity by being honest, reliable and fair.

The Customer Service Department's primary focus is to facilitate the authorization of covered services for Members for treatment from a specific clinician or clinicians. The Customer Service Department provides the Member with information about Providers and assists the Member in selecting a Provider who can meet their specific needs. Licensed clinicians on staff in the Clinical Department are available to provide referrals and assessment of the level of urgency of a caller presenting special needs.

In addition to working with Members, the Cenpatico Customer Service department assists Providers with the following:

Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

After Hours Coverage- NurseWise

NurseWise is Cenpatico's after-hours nurse referral line through which callers can reach both customer service representatives and bilingual nursing staff. NurseWise provides nurse referrals and assessment and after-hours phone coverage seven (7) days per week including holidays for Cenpatico Members.

The NurseWise referral service provides Members and Providers with the following:

- Provide referrals after hours
- Verify Member eligibility
- Crisis Interventions
- Emergency assessment for acute care services
- After hours emergency refills
- Documentation and notification of inpatient admissions that occur after hours
- Assistance with determining the appropriate level of care in accordance with clinical criteria, as applicable.

Interpretation/Translation Services

Cenpatico is committed to ensuring that staff are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, Cenpatico provides or coordinates the following:

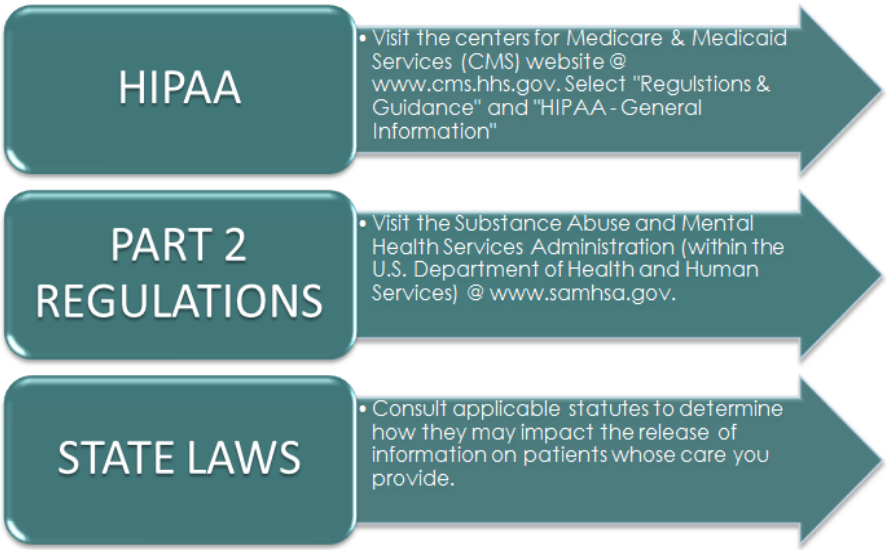
- Customer Service is staffed with Spanish and English bilingual personnel.
- Trained professional language interpreters, including American Sign Language, can be made available face-to-face at your office if necessary, or telephonic, to assist Practitioners/Providers with discussing technical, medical, or treatment information with Members as needed.

Key Information: To access interpreter services for Cenpatico Members, contact Customer Service at 866.796.0530.

Federal and States Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol/substance use disorder treatment and communicable

disease records. For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and Providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.



However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance use disorder treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still, other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

Contracted Providers within the Cenpatico network are independently obligated to know, understand and comply with these laws. Cenpatico takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Cenpatico Privacy Officer by phone or in writing with any questions about our privacy practices. Please instruct any Member to contact Member Services with any questions they may have about our privacy practices.

No Show Appointments/Hold Harmless

A "no show" is defined as a failure to appear for a scheduled appointment without notification to the Provider with at least twenty-four (24) hours advance notice. No show appointments must be recorded in the Member record. A "no show" appointment may never be applied against a Member's benefit maximum. Sunshine Health Members may not be charged a fee for a "no show" appointment.

Member Treatment Requirements

Providers are required to:

- Refer members with known or suspected physical health problems or disorders to the Member's PCP for examination and treatment;

- Only provide physical health services if such services are within the scope of the clinical licensure;
- Providers (facilities and community mental health centers) must ensure Members that are discharging from an inpatient psychiatric setting or crisis stabilization unit (CSU), are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient appointment must be set before discharge and must occur within (7) seven days of Member's discharge from an inpatient psychiatric setting or crisis stabilization unit, and must be scheduled with a licensed mental health practitioner;
- Contact Members who have missed appointments within twenty-four (24) hours to reschedule;
- Ensure all Members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language;
- Make referrals or admissions of Members for covered behavioral health services only to other Participating Healthcare Practitioners/Providers (those that participate in the Sunshine Health or Cenpatico Provider Network), except as the need for Emergency Care may require, or where Cenpatico specifically authorizes the referral, or as otherwise required by law
- Comply with all State and federal requirements governing emergency, screening and post-stabilization services; and
- Provide Member's clinical information to other Practitioners/Providers treating the Member, as necessary to ensure proper coordination and treatment of Members who express suicidal or homicidal ideation or intent, consistent with State law.

Provider Standards of Practice

Providers are requested to:

- Submit all documentation in a timely fashion;
- Comply with Cenpatico's Utilization Management Programs;
- Cooperate with Cenpatico's QI Program (e.g., allow review of or submit requested charts, receive feedback);
- Support Cenpatico access standards
- Use the concept of Medical Necessity and evidence-based Best Practices when formulating a treatment plan and requesting ongoing care;
- Coordinate care with other clinicians as appropriate, including consistent communication with the PCP as indicated in the Cenpatico QI Program;
- Assist Members in identifying and utilizing community support groups and resources;
- Maintain confidentiality of records and treatment and obtain appropriate written consents from Members when communicating with others regarding Member treatment
- Notify Cenpatico of any critical incidents;
- Notify Cenpatico of any changes in licensure, any malpractice allegations and any actions by your licensing board (including, but not limited to, probation, reprimand, suspension or revocation of license);
- Notify Cenpatico of any changes in malpractice insurance coverage;
- Complete credentialing and re-credentialing materials as requested by Cenpatico; and
- Maintain an office that meets all standards of professional practice.

Provider Office Standards

Cenpatico requires the following;

- Office must be professional and secular.
- Signs identifying office must be visible.
- Office must be clean, and free of clutter with unobstructed passageways.
- Office must have a separate waiting area.
- Waiting area must have adequate seating to support the current Member volume.
- Clean restrooms must be available.
- Office environment must be physically safe.
- Providers must have a professional and fully-confidential telephone line and twenty-four (24) hour availability.
- Member records and other confidential information must be locked up and out of sight during the work day.
- Medication prescription pads and sample medications must be locked up and inaccessible to Members.

The Provider's office must have evidence of the following:

- Child Abuse and HIPAA Privacy posters are posted in the Provider's waiting room/reception area;
- The Provider has a complete copy of the Patient's Bill of Rights and Responsibilities, available upon request by a Member, at each office location; and
- The Provider's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area.

Abuse and Neglect Reporting

Providers are required to report all incidents that may include abuse and neglect consistent with the Department of Human Services Act, the Adults with Disabilities Domestic Abuse Intervention Act and the Abused and Neglect Child Reporting Act. Reports regarding elderly Enrollees who are over the age of 60 will be reported to the State Department of Aging by using the Elder Abuse Hotline number. Cenpatico will offer training to Providers about the signs of abuse or neglect.

Advance Directives

Cenpatico is committed to ensuring that its Members know of, and are able to avail themselves of their rights to execute Advance Directives. Cenpatico is equally committed to ensuring that it's Providers and office staff area aware of, and comply with their responsibilities under federal and state law regarding Advance Directives.

Providers must ensure that adult Members or Member representatives over the age of eighteen (18) years receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers must document such information in the permanent Member medical record. Cenpatico recommends:

- The first point of contact in the Provider office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.

- If the member has executed an Advance Directive, the first point of contact should ask the Member to bring a copy of the Directive to the Provider's office and document this request.
- An Advance Directive should be included as a part of the Member's medical record, including mental health Directives.
- If a Behavioral Health Advance Directive exists, the Provider should discuss potential emergencies with the Member and/ or family members (if named in the Advance Directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an Advance Directive has not been executed, the first point of contact within the office should ask the Member if they desire more information about Advance Directives.
- If the Member requests further information, Member Advance Directive education/ information should be provided.

An Advance Directive form can be found on the American Academy of Family Physicians'® website at:
http://www.aafp.org/afp/1999/0201/afp19990201p617.pdf.

INTEGRATED CARE

Cenpatico and Sunshine Health encourage and support collaborative efforts among primary care physicians and other medical/surgical healthcare Providers and mental health Providers. We support whole-person health care because physical conditions and mental illness are not independent phenomena and the treatment of both must be coordinated.

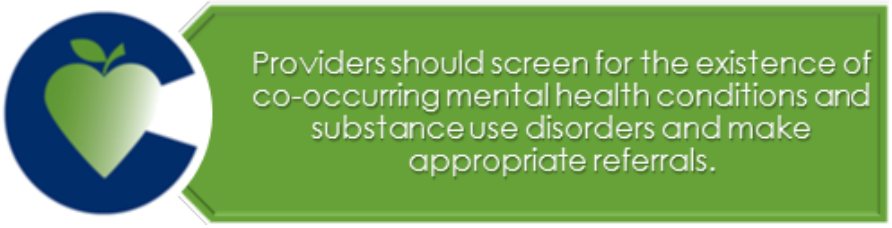
Physical health conditions can and often do exacerbate mental health conditions or can trigger mental health issues, such as depression following a cardiac event. Mental health conditions can and often do impact physical health conditions. For example, a person with depression may lack the motivation or energy to follow the physical therapists recommendations for rehab after a surgery.

The treatment and medication regimens for physical and mental health conditions can interact negatively. For example, many psychotropic medications can cause weight gain, which can exacerbate metabolic syndrome or diabetes.

Even differential diagnosis can be complicated if the assessment fails to consider potential physical causes for apparent mental conditions, such as psychosis-like symptoms triggers by high liver enzymes in Members with liver disease.

Communication with the Primary Care Physician

Sunshine Health encourages primary care physicians (PCPs) to consult with their Members' behavioral health/substance use disorder Providers. In many cases the PCP has extensive knowledge about the Member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with Member consent, when required.
Providers can identify the name and number for a Member's PCP on the front-side of the Member ID Card. Practitioners/Providers should refer Members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.



Providers should communicate not only with the Member's PCP whenever there is a behavioral health/substance use problem or treatment plan that can affect the Member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may also be providing service to the Member. Examples of some of the items to be communicated include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes;
- The Member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;
- The Member has lab work indicating need for PCP review and consult;
- The Member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with heart attack symptoms); and
- The Member's progress toward meeting the goals established in their treatment plan.

Cenpatico provides a form for your convenience in communicating with PCP and other Providers, which is available on the Cenpatico website. Cenpatico recommends that you use all available communications means to coordinate treatment for Members in your care. All

communication attempts and coordination activities must be clearly documented in the member's medical record.

Cenpatico requires that Providers report specific clinical information to the Member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the Member, it is the Providers responsibility to keep the Member's PCP abreast of the Member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the Member requests this information not be given to their PCP, the Provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP;

- A copy or summary of the intake assessment;
- Results of any lab work or adverse findings from lab work;
- The Member's diagnosis(es);
- Written notification of Member's progress toward treatment goals and any treatment plan goals that are not met due to Member noncompliance (if applicable);
- Member's completion of treatment;
- The results of an initial psychiatric evaluation, and the initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
- The results of functional assessments.

Caution must be exercised in conveying information regarding substance use disorders, which is protected under separate federal law. Cenpatico monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Preventative Behavioral Health Programs

Cenpatico offers preventative behavioral health programs for our Members. A brief description of the programs including who is eligible to participate is listed below. Cenpatico encourages you to refer your Members to the programs directly when you see an unmet need. If you would like more information about these programs or if you have suggestions as to how we can improve our preventative behavioral health programs please contact the Quality Improvement department at 866.796.0530.

The Perinatal Depression Screening Program offers screening to Members who are pregnant or have recently delivered to identify those who would benefit for treatment for depression. We send a copy of the Edinburgh Depression screening instrument to all pregnant women. Each Member who completes the survey and returns it to Cenpatico receives a letter from Cenpatico informing them of their screening results and how to access help if appropriate. If a Member screens positive for depression while pregnant or after delivery, our staff attempts outreach to

assist the Member in finding resources. Cenpatico outreaches to the medical Provider as well to assure the Member has the care needed.

The Depression Disease Management program focuses on early screening and intervention for Members with depression as a primary diagnosis and for Members with primary physical health issues and where underlying depression may exacerbate their physical health symptoms. This program is evidenced based, following the IMPACT model of evidenced based depression care. The program utilizes key IMPACT components such as systematic use of the PHQ-9 and behavior activation. For 2013, the disease management program will include additional IMPACT components, including relapse prevention planning prior to Members ending participation in the DM program. The program will also include targeted primary care physician (PCP) Member service plan staffing to provide technical assistance on stepped care and the IMPACT tenants of treating to goal.

In addition to the Edinburgh Depression screening tool, Cenpatico utilizes a variety of evidence-based, nationally recognized Behavioral Health screening tools such as those endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). These include, but are not limited to, the Patient Health Questionnaire (PHQ-9), Mood Disorder Questionnaire, CAGE, GAD-7, and Vanderbilt Assessment Scales.

Cenpatico appreciates your assistance in promoting these preventative behavioral health programs.

Florida Mental Health Act of 1971-The Baker Act

The Baker Act allows for involuntary examination (emergency or involuntary commitment). The Baker Act can be initiated by judges, law enforcement officials, or mental health professionals. There must be evidence that the person; (a) has a mental illness (as defined in the Baker Act) and (b) is a harm to self, harm to others, or self-neglectful (as defined in the Backer Act). Examinations may last up to 72 hours and occur in over 100 Florida Department of Children and Families designated receiving facilities statewide.

Providers are encouraged to contact Cenpatico at the onset of administering court ordered services (although such contact shall not be a prerequisite for payment). Cenpatico's Utilization Managers will obtain a copy of the Court order from the Provider and will scan it into the Utilization Management System. If the Court order is for a service that typically requires prior-authorization, Utilization Management will create an authorization and send a letter to the Provider notifying them of the approval.

Services that require authorization or notification per Cenpatico guidelines require authorization prior to claims submission.

To ensure accurate claims payment, the Provider of care should call 866-796-0530 to verify Court ordered services are authorized.

In the event that prior authorization is not secured and a Court Ordered/Baker Act service is denied, the claim can be resubmitted through the reconsideration process and will be reprocessed accordingly with the written clinical or Court documentation.

Court Ordered Commitments

A Member who has been ordered to receive treatment under the provisions of the Baker Act must receive the services ordered by the Court of competent jurisdiction. Any modification or termination of services must be presented to the Court with jurisdiction over the matter for determination. Cenpatico cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court-ordered Commitment for Members. The Member can only appeal the commitment through the court system.

To assure services are not inadvertently denied, Network Providers must contact Cenpatico at 866-796-0530 and provide telephonic or written clinical information as well as a copy of the Court order.

TELEMEDICINE

Cenpatico will follow the AHCA benefit coverage for telemedicine services as noted in the AHCA Medicaid Services Coverage and Limitations Handbook for behavioral health services, dental services, and Practitioner services.

Non-Reimbursable Telemedicine Services

Cenpatico will follow the AHCA guidelines on non-reimbursable telemedicine services. Cenpatico will not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services.

Non-reimbursable services include:

- Telephone conversations

- Video cell phone interactions
- Electronic mail messages
- Facsimile transmissions
- Telecommunication with the Enrollee at a location other than the spoke site
- Stored and forwarded visits and consultations that are transmitted after the Enrollee or Practitioner is no longer available.

Evaluation of Practitioner Requests to Provide Telemedicine Services

When a Practitioner requests the ability to provide telemedicine services to Members, the Practitioner must submit information for Cenpatico's consideration prior to being approved to do those services for Sunshine Heath Enrollees. Only Providers who meet the requirements specified in the AHCA contract are eligible to provide services through telemedicine at the spoke and hub sites.

That information that the Practitioner must provide to Cenpatico includes the following:

- Information which verifies that the equipment used meets the definition of telecommunication equipment as defined in the AHCA contract and that the telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable.
- A list of the services planned to be provided through telemedicine, which must be limited to the specific procedures and settings allowed by AHCA.
- Attestation that the telemedicine services will be provided to Enrollees only in the Practitioner's office settings. The Practitioner must provide Cenpatico with the list of specific office sites in which telemedicine services will be provided.
- Attestation that the Practitioner complies with HIPAA and other state and federal laws pertaining to patient privacy.
- Attestation that before telemedicine services are provided, the Enrollee will be given the choice of whether to access services through a face-to-face or telemedicine encounter, and that they document the choice in the Enrollee's medical/clinical record; and that should the Enrollee decide to receive telemedicine services, the Enrollee's medical record includes documentation that telemedicine services were provided. In addition to the attestation, the Practitioner must provide their policy and procedure for medical record documentation of the choice given and the provision of the telemedicine services.

Once Cenpatico receives the documents noted above from an interested Practitioner, the information will be reviewed by the Provider Relations Representative. If there is a question related to the information provided, the Provider Relations Representative will contact the Practitioner for the needed information.

Once a decision on the Practitioner's request to provide telemedicine services has been made by Cenpatico, the Practitioner will be notified. Only Practitioners approved by Cenpatico to perform telemedicine services will be reimbursed for those services. The Cenpatico medical record documentation audits for Practitioners approved for telemedicine services will look for

the applicable documentation of choice offered to Enrollees and the documentation of the telemedicine services provided.

BENEFITS, COVERED SERVICES & AUTHORIZATIONS

Cenpatico shall provide a full range of medically necessary behavioral health services authorized under the State Plan and specified in the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook and the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook. Covered services include:

- Inpatient hospital services for behavioral health conditions, including Substance Use Disorders
- Outpatient hospital services for behavioral health conditions, including Substance Use Disorders
- Psychiatric physician services for behavioral health conditions, including Substance Use Disorders
- Community behavioral health services for mental health conditions
- Community behavioral health services for substance use disorder conditions
- Mental Health/Substance Use Targeted Case Management
- Mental Health/Substance Use Intensive Targeted Case Management
- Specialized therapeutic foster care
- Therapeutic group care services
- Comprehensive behavioral health assessment
- Behavioral Health overlay services in child welfare settings
- Residential Care for Mental Health Conditions and Substance Use disorder conditions
- Statewide Inpatient Psychiatric Program (SIPP) services for individuals under age eighteen

For a listing of service codes, limitations, and authorization requirements, please refer to the Florida Covered Professional Services and Authorization Guidelines on the Cenpatico website, www.cenpatico.com. Providers should refer to their Provider Agreement with Cenpatico to identify which services they are contracted and eligible to provide. All services performed must be medically necessary.

MEDICAL RECORDS

Cenpatico requires treatment records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review. Treatment record standards are adopted that are consistent with the National Committee for Quality Assurance. The standards facilitate communication, coordination and continuity of care and promote efficient, confidential and effective treatment. Medical records must be prepared in accordance with all applicable State and Federal rules and regulations and signed by the medical professional rendering the services. Cenpatico requires the confidentiality of medical records in accordance with 42 CFR, Part 431, Subpart F. This includes confidentiality of a minor's

consultation, examination, and treatment for a sexually transmissible disease in accordance with s. 384.30(2), F.S.

Medical Record Guidelines

Cenpatico requires compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA). Cenpatico's minimum standards for Practitioners/Provider medical record keeping practices include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information. The following thirteen (13) elements reflect a set of commonly accepted standards for behavioral health treatment record documentation.

1. Each page in the treatment record contains the patient's name or ID number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the treatment record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.
4. The record is legible to someone other than the writer.
5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status and the results of a mental status exam, are documented.
7. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
9. A medical and psychiatric history is documented, including previous treatment dates, Provider identification, therapeutic interventions and responses, and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
10. A DSM diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary Providers and health care institutions are included, as appropriate.
12. Informed consent for medication and the patient's understanding of the treatment plan are documented.
13. Progress notes describe the patient's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and

coordination of care activities, as appropriate. Dates of follow-up appointments or discharge plans are noted.

Records and Documentation

Providers need to retain all books, records and documentation related to services rendered to members as required by law and in a manner that facilitates audits for regulatory and contractual reviews.

The Provider will provide Cenpatico, Sunshine Health, as well as applicable state and federal regulatory agencies, access to these documents to assure financial solvency and healthcare delivery capability and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information. Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and or non-renewal of an Agreement with Cenpatico.

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information used to provide assessment and treatment services. You may access sample forms Providers are encouraged to use for Members on the Cenpatico website.

As part of our ongoing quality improvement program, clinical records will be audited to assure the quality and consistency of Provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the Member must sign an authorization for release. You may access this form on the Cenpatico website. Chart Audits of member records will be evaluated in accordance with these criteria. Clinical records require documentation of all contacts concerning the Member, relevant financial and legal information, consents for release/disclosure of information, release of information to the Member's PCP, documentation of Member receipt of the Statement of Member's Rights and Responsibilities, the prescribed medications with refill dates and quantities, including clear evidence of the informed consent, and any other information from other professionals and agencies. If the Provider is able to dispense medication, the Provider must conform to drug dispensing guidelines set forth in Sunshine Health's drug formulary.

Providers shall retain clinical records for Members for as long as is required by applicable law. These records shall be maintained in a secure manner, and must be retrievable upon request.

CONFIDENTIALITY & PRIVACY

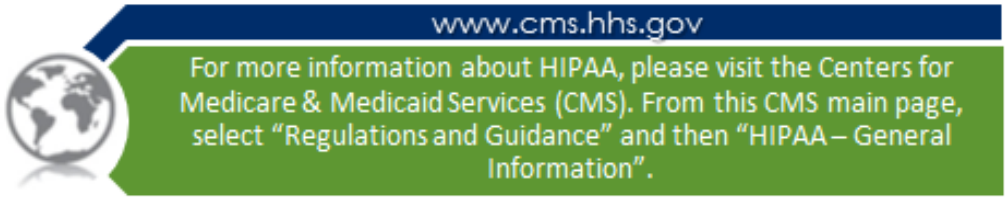
Cenpatico abides by applicable Federal and State laws which govern the use and disclosure of mental health information and alcohol/substance use disorder treatment records.

Similarly, Cenpatico contracted Providers are independently obligated to comply with applicable laws and shall hold confidential all member records and agree to release them only when permitted by law, including but not limited to 42 CFR 2.00 et seq., when applicable.

Health Insurance Portability and Accountability Act (HIPAA)

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), which was signed into law in 1996, require the implementation of measures to standardize electronic transactions in the healthcare industry while protecting the security and privacy of health information used or disclosed in any medium, including oral communications.

As covered entities under these regulations, network Providers are obligated to comply with them and any other applicable federal/state laws governing the use and disclosure of mental health information.



Cenpatico takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable confidentiality/privacy laws.

Please contact the Cenpatico Privacy Officer by phone or in writing with any questions about our privacy practices. Please instruct any Member to contact Member Services with any questions they may have about our privacy practices.

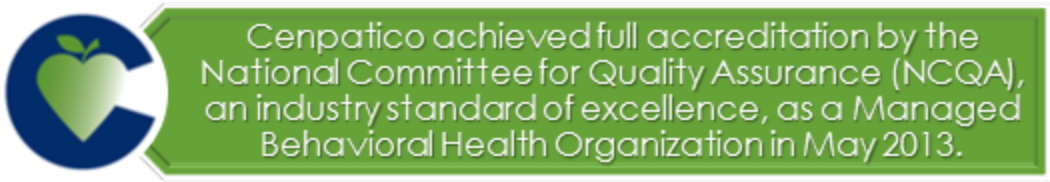
QUALITY IMPROVEMENT

We are dedicated to providing quality services and programs that improve the lives of our Members. The Cenpatico Quality Improvement (QI) program utilizes the principles of Continuous Performance Improvement (CPI). This approach allows us to implement focused, rapid improvement interventions that are data driven and Member focused.

Our QI Program is highly integrated with clinical services, access issues pertaining to Providers and services, credentialing, utilization, Member satisfaction, Provider satisfaction, PCP communications and administrative office operations, as well as Sunshine Health's Quality Improvement Program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

We embrace a culture of quality across the organization. The systematic approach to the use of industry standard quality metrics allows for creative, targeted initiatives designed to continually drive performance and improve Member outcomes. In order to meet our objectives, Providers must participate and adhere to our programs and guidelines.

Our website contains a wealth of information and we encourage you to visit www.cenpatico.com/providers, where you will find information about Cenpatico's Quality Program. This includes descriptions of Cenpatico's clinical and service quality initiatives and an evaluation of our performance.



Civil Rights

Cenpatico provides covered services to all eligible Members regardless of Age, Race Religion, Color, Disability, Sex, Sexual Orientation, National Origin, Marital Status, Arrest or Conviction, or Military Participation.

All medically necessary covered services are available to all Members. All services are provided in the same manner to all Members. All persons or organizations connected with Cenpatico who refer or recommend Members for services shall do so in the same manner for all Members.

Monitoring Clinical Quality

Each year, and at various intervals throughout the year, Cenpatico audits and measures the following:

- Access standards for care;
- Adherence to Clinical Practice Guidelines;
- Treatment record compliance;
- Communication with PCPs and other behavioral health Practitioners;
- Critical Incidents;
- Member safety;
- Member confidentiality;
- High-risk Member identification, management and tracking;
- Discharge appointment timeliness and reporting;
- Re-admissions;
- Grievance procedures;
- Potential over- and under-utilization;
- Provider satisfaction;
- Member satisfaction; and
- Completion of Functional Assessments

How Cenpatico Monitors Quality

Cenpatico conducts surveys as well as initiatives that monitor quality. These activities may include any of the following:

- Provider satisfaction surveys;
- Behavioral Health HEDIS measure performance;
- Medical treatment record reviews;
- Grievance investigation and trending;
- Review of potential over- and under-utilization;

- Member Satisfaction Surveys;
- Outcome tracking of treatment evaluations;
- Access to care reviews;
- Appointment availability;
- Discharge follow-up after inpatient or partial hospitalization reporting;
- Crisis Response;
- Monitoring appropriate care and service;
- Provider quality profiling; and
- Outcome of functional assessments.

Findings are communicated to individual Providers and Practitioner groups for further discussion and analysis to reinforce the goal of continually improving the appropriateness and quality of care rendered. Cenpatico may request action plans from the Provider. Findings are considered during the re-credentialing process.

Provider Participation in the QI Process

Cenpatico Providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided.

Providers are expected to meet Cenpatico's performance requirements and ensure Member treatment is efficient and effective by:

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility
- Cooperating with Cenpatico's complaint review process
- Participating in Provider satisfaction surveys; and
- Cooperating with reviews of quality of care issues and critical incident reporting.

In addition, Providers are invited to participate in Cenpatico's QI Committees and in local focus groups.

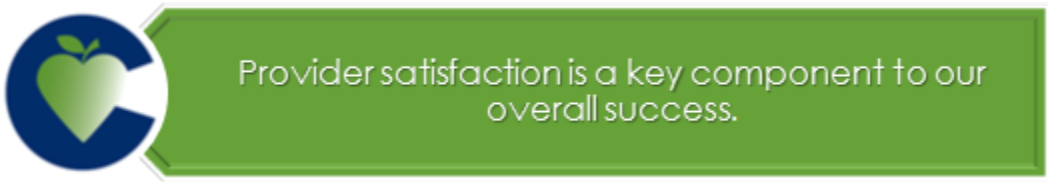
Member Concerns about Providers

Members who have concerns about Cenpatico Providers should contact Cenpatico to register their concern. All concerns are investigated, and feedback is provided on a timely basis. It is the Provider's responsibility to provide supporting documentation to Cenpatico if requested. Any validated concern will be taken into consideration when re-credentialing occurs, and can be cause for termination from Cenpatico's Provider Network.

Monitoring Satisfaction

Satisfaction surveys are conducted periodically by Cenpatico. These surveys enable Cenpatico to gather useful information to identify areas for improvement. Providers may be requested to participate in the annual survey process. The survey includes a variety of questions designed to address multiple facets of the Providers experience with our delivery system should call the Cenpatico Provider Relations department at 866.796.0530 to address concerns as they arise.

Feedback from Providers enables Cenpatico to continuously improve systems, policies and procedures.



Critical Incident Reporting

A Critical Incident is defined as any occurrence which is not consistent with the routine operation of a Mental Health/Substance Use Disorder Provider. It includes, but is not limited to injuries to Members or Member advocates, suicide/homicide attempt by a Member while in treatment, death due to suicide/homicide, sexual battery, medication errors, Member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

Providers will follow the AHCA process and requirements for submission of all critical incidents. Upon receipt and notification of critical incident review requests from AHCA, Cenpatico will require Providers to participate in the Cenpatico quality review process.

CULTURAL COMPETENCY

Cultural Competency within the Cenpatico Network is defined as, "a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members."

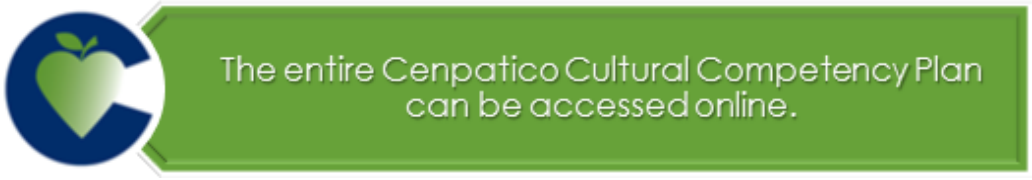
Cenpatico is committed to the development, strengthening and sustaining of healthy Provider/ Member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, Members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

The Cenpatico vision for culturally competent care is:

- Care is given with the understanding of, and respect for, the Member's health related beliefs and cultural values
- Cenpatico staff respect health related beliefs, interpersonal communication styles and attitude of the Members, families and communities they serve
- Each functional unit within the organization applies a trained, tailored approach to culturally sensitive care in all Member communications and interactions
- All Cenpatico Providers and Practitioners support and implement culturally sensitive care models to Cenpatico Members
- The Cenpatico goal for culturally sensitive care is:
    - To support the creation of a culturally sensitive behavioral health system of care that embraces and supports individual differences to achieve the best possible outcomes for individuals receiving services

Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them
- Care is provided with consideration of the Members' race/ethnicity and language and its impact/ influence on the Members' health or illness
- Office staffs that routinely come in contact with members have access to and participate in cultural competency training and development
- The office staff responsible for data collection makes reasonable attempts to collect race and language specific Member information
- Treatment plans are developed and clinical guidelines are followed with consideration of the Members' race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, Spanish or other prevailing languages within the region



Health Disparity Facts

- Government-funded insurance consumers face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Consumers are more likely to experience long wait times to see healthcare Providers.
- African American Medicaid consumers experience longer waits in emergency departments and are more likely to leave without being seen.
- Consumers are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Consumers that are children are less likely to receive childhood immunizations.

- Patient race, ethnicity and socioeconomic status are important indicators of the effectiveness of healthcare.
- Health disparities come at a personal and societal price.

Understanding the Need for Culturally Competent Services

Research indicates that a person has better health outcomes when they experience culturally appropriate interactions with Providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of a Member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Member's feelings of being insulted or treated rudely;
- Member's reluctance and fear of making future contact with the Provider's office;
- Member's confusion and misunderstanding;
- Non-compliance by the Member;
- Member's feelings of being uncared for, looked down upon and devalued;
- Parents' hesitance to seek help for their children;
- Unfilled prescriptions;
- Missed appointments;
- Provider's misdiagnosis due to lack of information sharing;
- Wasted time for the Member and Provider; and/or
- Increased grievances or complaints.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Cenpatico is committed to helping you reach this goal.

Take the following into consideration when you provide services to Members:

- What are your own cultural values?
- How do/can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy and family definitions?

COORDINATION OF CARE

Cenpatico's coordination of care process is designed to ensure the coordination and continuity of care during the movement between Providers and/or settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved Providers and between Providers and patients/caregivers.

Continuity of healthcare means different things to different types of caregivers and can be of several types:

- Continuity of information. Information on prior events is used to provide care that is appropriate to the patient's current circumstance.
- Continuity of personal relationships. Recognizing that an ongoing relationship between patients and Providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management.

Inpatient Notification Process

Inpatient Providers (including Crisis Stabilization Units) are required to notify Cenpatico of emergent and urgent admissions (Emergency Behavioral Healthcare) no later than the next business day following the admission. Authorization is required to track inpatient utilization, enable care coordination, initiate discharge planning and ensure timely claim(s) payment.

Emergency Behavioral Healthcare requests indicate a condition in clinical practice that requires immediate intervention to prevent death or serious harm (to the Member or others) or acute deterioration of the Member's clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the Member's safety. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavioral and is time limited in intensity and duration (usually occurs in seconds or minutes, rarely hours, rather than days or weeks). Thus, elements of both time and severity are inherent in the definition of an emergency.

All inpatient admissions require authorization (with the exception of Baker Act admissions). The number of initial days authorized is dependent on Medical Necessity and continued stay is approved or denied based on the findings in concurrent reviews.

Members meeting criteria for inpatient treatment must be admitted to a contracted hospital or crisis stabilization unit. Members in need of emergency and/or after hours care should be referred to the nearest participating Provider for evaluation and treatment, if necessary.

The following information must be readily available for the Cenpatico Utilization Manager when requesting initial authorization for inpatient care:

- Name, age, health plan and identification number of the Member
- Diagnosis, indicators and nature of the immediate crisis
- Alternative treatment provided or considered
- Treatment goals, estimated length of stay and discharge plans
- Family or social support system
- Current mental status

Outpatient Notification Process

Providers must adhere to the Covered Professional Services & Authorization Guidelines available on the Cenpatico website, when rendering services. Cenpatico does not retroactively authorize treatment.

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

For those outpatient services that require authorization, the Provider must complete an Outpatient Treatment Request (OTR) form and submit online or fax the completed form to Cenpatico at 866.694.3649 for clinical review. Please refer to www.cenpatico.com/providers to obtain the OTR form or to submit electronically. Providers may call the Customer Service department at 866.796.0530 to check status of an OTR. Providers should allow up to seven (7) calendar days to process non-urgent requests.

IMPORTANT:

- The OTR must be completed in its entirety. The DSM diagnosis (es) as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
- Cenpatico will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Failure to submit a completed OTR can result in delayed authorization and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.

Cenpatico's utilization management decisions are based on Medical Necessity and established Clinical Practice Guidelines. Cenpatico does not reimburse for unauthorized services and each Agreement with Cenpatico precludes Providers from balance billing (billing a Member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Cenpatico's authorization of covered services is an indication of Medical Necessity, not a confirmation of Member eligibility, and not a guarantee of payment.

Guidelines for Psychological Testing

Prior authorization is required for psychological testing for either inpatient or outpatient services. Testing, with prior-authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

It is important to note that:

- Testing will not be authorized by Cenpatico for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment (96101 and 96102) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the Practitioner is contracted and credentialed with Cenpatico.
- Providers should submit a request for Psychological Testing that includes the specific tests to be performed. Providers may access Cenpatico's Psychological Testing Authorization Request Form on the Cenpatico website, www.cenpatico.com/providers.

Cenpatico's Utilization Management Program

The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 8:00 p.m. Eastern Standard Time (EST). Additionally, clinical staff is available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number 866.796.0530. The Cenpatico Utilization Management team is comprised of qualified, licensed behavioral health professionals whose education, training and experience are commensurate with the Utilization Management reviews they conduct.

Cenpatico is committed to compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, the Interim Final Rule and the subsequent Final Ruling.

Cenpatico will ensure compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to MH/SUD benefits and non-quantitative limits (NQTLS). Cenpatico administers benefits for Substance Use Disorder (SUD) and/or services for mental health conditions as designated and approved by the contract and Plan benefits. MHPAE does not preempt State law, unless law limits application of the act. We support access to care for individuals seeking treatment for Mental Health conditions and Substance Use Disorders and believe in a "no wrong door" approach. Our strategies, evidentiary standards and processes for reviewing treatment services are no more stringent than those in use for medical/surgical benefits in the same classification when determining to what extent a benefit is subject to NQTLs.

The Cenpatico Utilization Management Program strives to ensure that:

- Member care meets Cenpatico Medical Necessity Criteria;
- Treatment is specific to the Member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided comply with Cenpatico quality improvement requirements; and, utilization management policies and procedures are systematically and consistently applied; and
- Focus for Members and their families' centers on promoting resiliency and hope.

Cenpatico's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Cenpatico's Medical Necessity Criteria are used for the approval of medical necessity; plans of care that do not meet Medical Necessity guidelines are referred to a Florida licensed physician advisor for review and peer-to-peer discussion.

Cenpatico conducts utilization management in a timely manner in order to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. Utilization Management files includes the date of receipt of information and the date and time of notification and resolution.

Cenpatico's Utilization Management Department is under the direction of our licensed Medical Director or physician designee(s). The Utilization Management Staff regularly confer with the Medical Director or physician designee on any cases where there are questions or concerns.

The Utilization Management's decision-making process is based on appropriateness of care and service and existence of coverage. Cenpatico does not reward Practitioners or other individuals for issuing denials of coverage or services. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when Medical Necessity Criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health Practitioners providing treatment for the Member.

Cenpatico uses *Interqual* criteria for mental health for both adult and pediatric guidelines. *Interqual i*s a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes. Cenpatico utilizes the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for substance use disorder Medical Necessity Criteria. Additionally, Cenpatico has adopted the Florida State Medicaid Manual service descriptions and medical necessity guidelines for all community-based services.

ASAM and the *Interqual* criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Community-Based Services criteria can be found on the Cenpatico website.

ASAM, *Interqual* and our Community Based Services criteria are reviewed on an annual basis by the Cenpatico Provider Advisory Committee that is comprised of Network Providers as well as Cenpatico clinical staff.

Cenpatico is committed to the delivery of appropriate service and coverage and offers no organizational incentives, including compensation, to any employed or contracted UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Concurrent Review

Cenpatico's Utilization Management Department will concurrently review the treatment and status of all Members in inpatient (including crisis stabilization units and Statewide Inpatient Psychiatric Program (SIPP)) and partial hospitalization through contact with the Member's attending physician or the Provider's Utilization and Discharge Planning departments. The frequency of review for all higher levels of care will be determined by the Member's clinical condition and response to treatment. The review will include evaluation of the Member's current status, proposed plan of care and discharge plans.

Retro Authorization

By standard practice, Cenpatico does not provide retro-authorization, however there are certain unique circumstances in which there may be an exception. If your claim was denied because you did not have an authorization number or if you failed to receive authorization for a service provided, please send a request in writing for a Retroactive Authorization, explaining in detail the reason for providing services without an authorization.

Retro Authorizations will only be granted in rare cases, such as eligibility issues. All requests for retro authorizations must be submitted within 180 days of the date of service and should include a cover letter explaining why authorization was not obtained. You should provide medical records that will be used to determine if medical necessity was met for the services provided.

Repeated requests for Retro authorizations will result in termination from the Cenpatico Provider network due to inability to follow policies and procedures.

Notice of Action (Adverse Determination)

When Cenpatico determines that a specific service does not meet criteria and will therefore not be authorized, Cenpatico will submit a written notice of action (or, denial) notification to the treating network Practitioner or Provider rendering the service(s) and the Member. The notification will include the following information/ instructions:

- The reason(s) for the proposed action in clearly understandable language.
- A reference to the criteria, guideline, benefit provision or protocol used in the decision, communicated in an easy to understand summary.
- A statement that the criteria, guideline, benefit provision or protocol will be provided upon request.
- Information on how the Provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating Provider to discuss the determination.

- Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the Member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal.
- The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued and the circumstances under which the Member may be required to pay the costs of these services.

Peer Clinical Review Process

If the Utilization Manager is unable to certify the requested level of care based on the information provided, they will initiate the peer review process.

For both mental health and substance use disorder service continued stay requests, the physician or treating Practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. When a determination is made where no peer-to-peer conversation has occurred, a Provider can request to speak with the Clinical Consultant who made the determination within one (1) business day.

The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/her scope, or when a healthcare Practitioner provides good cause in writing.

As a result of the Peer Clinical Review process, Cenpatico makes a decision to approve or deny authorization for services. Treating Practitioners may request a copy of the Medical Necessity Criteria used in any denial decision. Copies of the Cenpatico Medical Necessity Criteria are available on our website. If you would like a paper copy of the criteria, contact Customer Service.

The treating Practitioner may request to speak with the Peer Reviewer who made the determination after any denial decision. If you would like to discuss a denial decision, contact Cenpatico.

Appeals Process

For cases where authorization has been denied because the case does not meet the necessary criteria, the Appeals Process, described in your denial letter is the appropriate means of resolution.

Discharge Planning

Follow-up after hospitalization is one of the most important metrics monitored by Cenpatico in an effort to help Members remain stable and to maintain treatment compliance after discharge. Follow-up after discharge is monitored closely by the National Committee for Quality Assurance (NCQA), which has developed and maintains the Healthcare Effectiveness Data and Information Set (HEDIS).

While a Member is at an inpatient Provider receiving acute care services, Cenpatico's Utilization Managers and Case Managers work with the Provider's treatment team to make arrangements for continued care with outpatient Practitioners. Every effort is made to collaborate with the outpatient Practitioner to assist with transition back to the community and a less restrictive environment as soon as the Member is stable. Discharge planning should be initiated on admission.

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled with a licensed behavioral health clinician to occur within seven (7) calendar days after discharge. Cenpatico's Care Coordination and Case Management staff follow-up with the Member prior to this appointment to remind him/her of the appointment. If a Member does not keep his/her outpatient appointment after discharge, Cenpatico asks that the Practitioner inform Cenpatico as soon as possible. Upon notification of a no-show, Cenpatico's Care Coordination staff will follow up with the Member and to assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Psychotropic Medications

Cenpatico will monitor psychotropic medication usage in partnership with Sunshine Health to identify any medications for physical conditions prescribed by psychiatric Practitioners as well as to review psychotropic medications prescribed by primary care physicians (PCP).

A comprehensive evaluation to include a thorough health history, psychosocial assessment, mental status exam and physical exam should be performed before beginning treatment for a mental or behavioral disorder.

The role of non-pharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self-injurious behavior, physical aggression that is acutely dangerous to others, or severe impulsivity endangering the Member or others; or when there is marked disturbance of psycho-physiological functioning (such as profound sleep disturbance), marked anxiety, isolation or withdrawal.

Psychotropic Medications (Children under 5)

Cenpatico will monitor the prescribing of psychotropic medication for all children under age five (5). Psychotropic medications must be prescribed for sixty (60) or more days to be considered active treatment and to be considered in need of determining the appropriateness of the medication regimen.

Continuity of Care

When Members are newly enrolled and have been previously receiving behavioral health services, Cenpatico will continue to authorize care for no more than sixty (60) calendar days after the effective date for members enrolled on the Medicaid Plan to minimize disruption and promote continuity of care. Cenpatico will work with non-participating Practitioners/Providers (those that are not contracted and credentialed in Cenpatico's Provider Network) to continue treatment or create a transition plan to facilitate transfer to a participating Cenpatico Provider.

In addition, if Cenpatico determines that a Member is in need of services that are not covered benefits, the Member will be referred to an appropriate Provider and Cenpatico will continue to coordinate care including discharge planning.

Cenpatico will ensure appropriate post-discharge care when a Member transitions from a State institution and will ensure appropriate screening, assessment and crisis intervention services are available in support of Members who are in the care and custody of the State.

Cenpatico network staff can also arrange a Single Case Agreement (SCA) when it becomes necessary to utilize out-of-network Providers (Providers not contracted with Cenpatico) to provide covered services. Cenpatico will utilize out-of-network Providers, if necessary, to meet the Member's clinical, accessibility or geographical needs when the network is inadequate for their specific situation. Before utilizing an out-of-network Provider, Cenpatico makes every attempt to refer Members to participating Providers who are contracted and credentialed with Cenpatico.

Single Case Agreements are required for the purposes of addressing the following:

- Insufficient network accessibility within the Member's geographic area;
- Providers are not available with the appropriate clinical specialty or are unable to meet special need(s) of the specific Member;
- Providers do not have timely appointment availability;
- It is clinically indicated to maintain continuity of care;
- Transition of care from an established out-of-network Provider to a participating Cenpatico Provider.

Case Management (CM)

The Case Management Department provides a unique function at Cenpatico. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance and facilitate positive treatment outcomes through the proactive identification of Members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. Cenpatico Case Managers are licensed behavioral health professionals with at least three years' experience in the mental health field.

Cenpatico's Intensive Case Management functions include:

- Early identification of Members who have special needs;
- Assessment of Member's risk factors and needs;
- Contact with high-risk Members discharging from hospitals to ensure appropriate discharge appointments are arranged and Members are compliant with treatment;
- Active coordination of care linking Members with behavioral health Practitioners and as needed medical services; including linkage with a physical health Case Manager for Members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed;
- Development of a case management plan of care;
- Referrals and assistance to community resources and/or behavioral health Practitioners; and
- For Members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, Cenpatico offers Care Coordination.

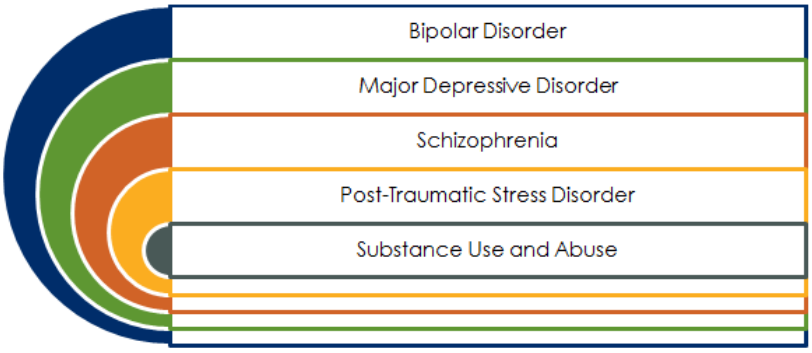
Cenpatico's Care Coordinators are not licensed clinical staff and cannot make clinical decisions about what level of care is needed or assess Members who are in crisis.

Cenpatico's Care Coordination functions include:

- Coordinate with Sunshine Health, Member advocates or Providers for members who may need behavioral health and substance use disorder services;
- Assist Members with locating a Provider;
- Serve as a resource to inpatient discharge planners needing services for Members;
- Coordinate requests for out-of-network Providers by determining need/access issues involved; and
- Facilitate all requests for inpatient psychiatric consults for Members in a medical bed.

Clinical Practice Guidelines

Cenpatico has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to treatment of:



For children, Cenpatico has adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/Hyperactivity Disorder. Clinical Practice Guidelines may be accessed through our website, or you may request a paper copy of the guidelines by contacting your Network Manager or by calling 512-406-7200. Copies of our evidence-based practices can be obtained in the same manner.

As a part of Cenpatico's clinical quality evaluation process, Cenpatico's QI Department evaluates Practitioner adherence to the ADHD CPG at least annually using the HEDIS Management of Children with ADHD measure. Feedback on performance and identified areas for improvement are provided to Practitioners and posted on the Cenpatico website.

Compliance with clinical practice guidelines is assessed annually as part of the quality process.

CLAIMS

Cenpatico adjudicates claims for Covered Services for Covered Persons. Claims with a primary diagnosis not related to behavioral health or substance use disorders may be denied. If Providers receive such a denial, please evaluate the service performed. If the Covered Services are performed by a licensed behavioral health Provider, please resubmit with an appropriate primary diagnosis. Claims for medical conditions or services should be submitted to Sunshine Health.

Cenpatico Claims Department Responsibilities

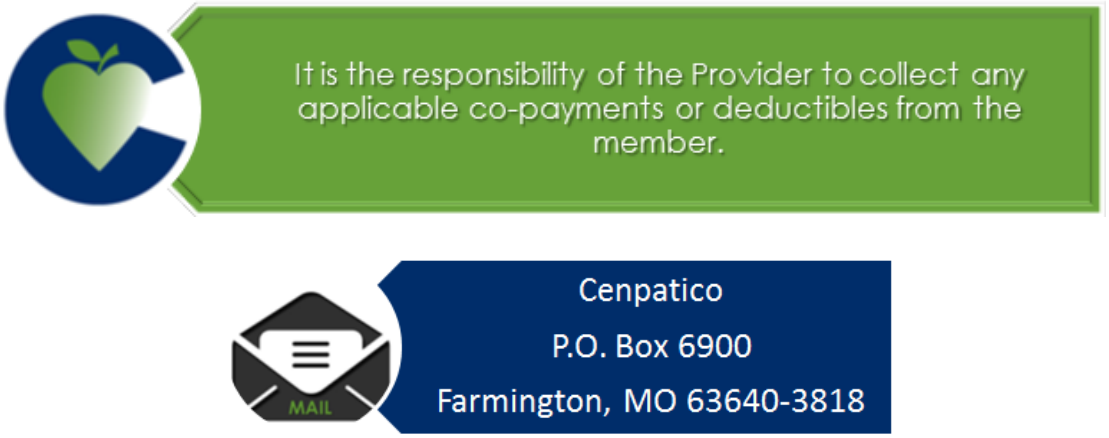
Cenpatico's claims processing responsibilities are as follows:

- To reimburse Clean Claims (see Clean Claim section below) within the timeframes outlined by the Florida Agency for Healthcare Administration; and
- To reimburse interest on claims in accordance with the guidelines outlined in the Prompt Pay Statute.

Claims eligible for payment must meet the following requirements:

- The Member is effective (eligible for coverage through Sunshine Health on the date of service;
- The service provided is a covered service (benefit of Sunshine Health) on the date of service; and,
- Cenpatico's prior-authorization processes were followed.

Cenpatico's reimbursement is based on clinical licensure, covered service billing codes and modifiers, and the compensation schedule set forth in the Provider's Agreement with Cenpatico. Reimbursement from Cenpatico will be accepted by the Provider as payment in full, not including any applicable copayments or deductibles.



Clean Claim

Unless otherwise defined in the Agreement, a clean claim is a claim submitted on an approved or identified claim format (CMS-1500 or CMS-1450 ("UB-04") or their electronic equivalents or successors that contains all data fields required by Cenpatico and the State, for final adjudication of the claim. The required data fields must be complete and accurate. A Clean Claim must also include Cenpatico's published requirements for adjudication, such as: NPI Number, Tax Identification Number or medical records, as appropriate.

Claims lacking complete information are returned to the Provider for completion before processing or information may be requested from the Provider on an Explanation of Benefit (EOB) form. This will cause a delay in payment.

Explanation of Payment (EOP)

An Explanation of Payment (EOP) is provided with each claim payment or denial. The EOP will detail each service being considered, the amount eligible for payment, copayments/ deductibles deducted from eligible amounts and the amount reimbursed.

Timely Filing

Please submit claims immediately after providing services. Claims must be received within six (6) months, or 180 days, of the date the service(s) are rendered. Claims submitted after this period will be denied for payment.
Please submit a Clean Claim on a CMS-1500 Form or a CMS-1450 Form ("UB-04") or their electronic equivalents or successors. A Clean Claim is one in which every line item is completed in its entirety.

Please ensure the rendering Practitioner's/Provider's NPI number is listed in field 24J if you are billing with a CMS-1500 Form or field 56 if you are billing with a CMS-1450 ("UB-04") Form.

Providers must submit claims to the correct address for processing and reimbursement.

Common Claims Processing Issues

It is the Provider's responsibility to obtain complete information from Cenpatico and the Member and then to carefully review the CMS-1500, or its successor claim form and/or CMS-1450 ("UB-04"), or its electronic equivalents or successors claim form, prior to submitting claims to Cenpatico for payment. This prevents delays in processing and reimbursement.

Some common problem areas are:

- Failure to obtain prior-authorization
- Federal Tax ID number not included
- Rendering Provider's NPI number not included in field 24J (CMS-1500) or field 56 (CMS-1450) Insufficient Member ID Number. Providers are encouraged to call Cenpatico to request the Member's Medicaid ID prior to submitting a claim
- Present on Admission information not included on inpatient claims
- Visits or days provided exceed the number of visits or days authorized
- Date of service is prior to or after the authorized treatment period
- Provider is billing for unauthorized services, such as the using the wrong CPT Code
- Insufficient or unidentifiable description of service performed
- Member exceeded benefit limits
- Claim form not signed by Provider
- Multiple dates of services billed on one professional claim form (CMS-1500, or electronic equivalents or successor claim form) are not listed separately
- Diagnosis code is incomplete or not specified to the highest level available – be sure to use 4th and 5th digit when applicable

- Hand written claims are often illegible and require manual intervention, thereby increasing the risk of error and time delay in processing claims.

Services that are not pre-certified and require prior-authorization may be denied. Cenpatico reserves the right to deny payment for services provided that were/are not medically necessary.

Imaging Requirements for Paper Claims

Cenpatico uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

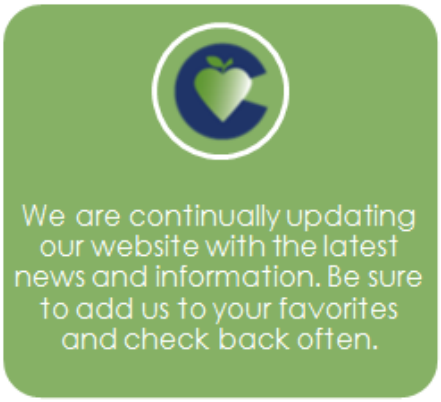
- Submit all claims in a 9"x12" or larger envelope
- Complete forms correctly and accurately with black or blue ink only (or typewritten)
- Ensure typed print aligns properly within the designated boxes on the claim form
- Submit on a proper form; CMS-1500 or CMS-1450 ("UB04")
- Whenever possible refrain from submitting hand written claims

- Use red ink on claim forms
- Circle any data on claim forms
- Add extraneous information to any claim form field
- Use highlighter on any claim form field
- Submit carbon copied claim forms
- Submit claim forms via fax

Web Portal Claim Submission

Cenpatico also offers our contracted Providers and their office staff the opportunity to register for our Secure Web Portal. You may register by visiting http://provider.cenpatico.com/ and creating a username and password. Once registered you may begin utilizing additional available services:

- Submit both Professional and Institutional claims
- Check claim status
- View and print Member eligibility
- Contact us securely and confidentially



EDI CLEARINGHOUSES

Electronic Data Interchange (EDI) is a method for transferring data between different computer systems or computer networks. Providers may choose to submit their claims through a clearinghouse. Cenpatico accepts EDI transactions through the following vendors using:

Payer ID 68068

Allscripts	Availity	Emdeon	Practice Insight	Relay Health	Smart Data Solutions
Allscripts 800.845.6592	Availity 800.282.4548	Emdeon 800.845.6592	Practice Insight 713.333.6000	Relay Health 800.527.8133	Smart Data Solutions 855.650.6590

BILLING POLICIES

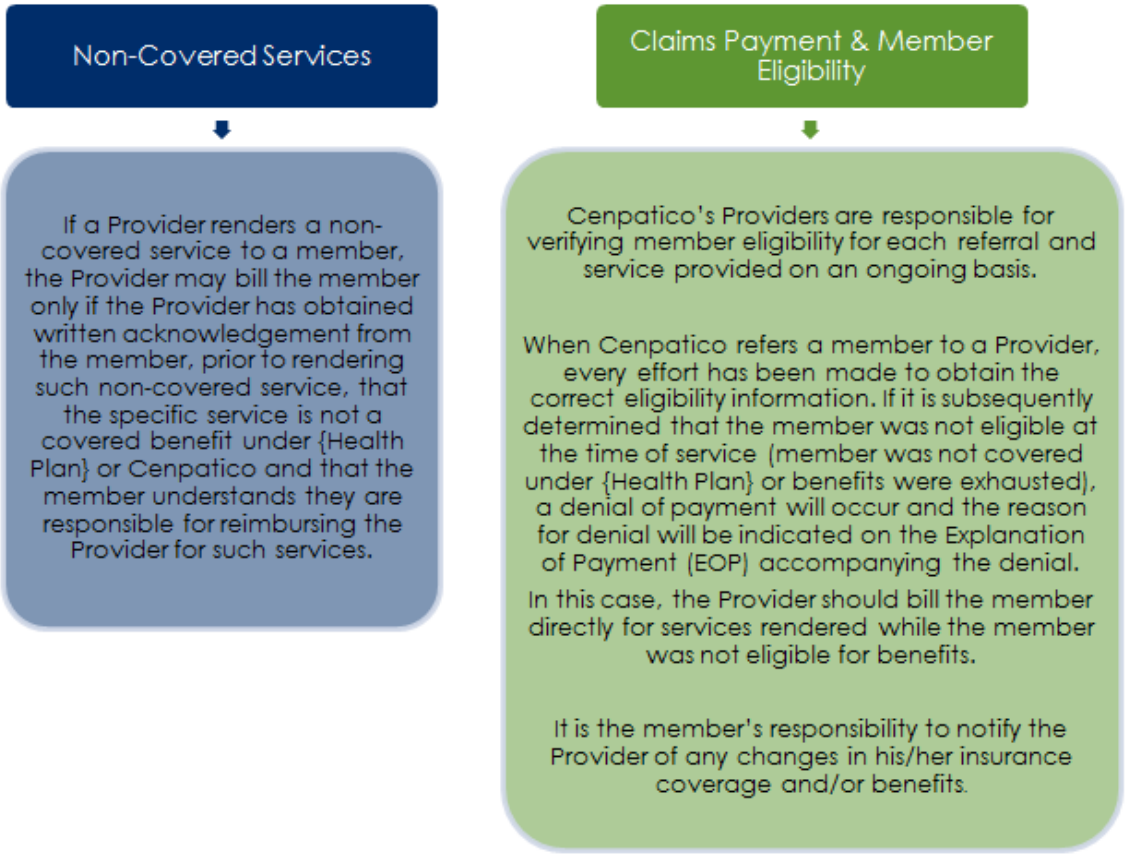
The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all healthcare Providers and payers to use universal standards for electronic billing and administrative transactions (healthcare claims, remittance advice [RA], eligibility verification requests, referral authorizations and coordination of benefits).

Member Hold Harmless

Under no circumstances is a Member to be balance billed for covered services or supplies. If the Provider uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for anything other than specified un-met deductible or co-payments (if any).

Please Note:

- A Provider's failure to authorize the service(s) does not qualify/allow the Provider to bill the Member for service(s)
- Sunshine Health Members may not be billed for missed sessions ("No-Show")
- Providers can bill a Member only if they provide proof that they attempted to obtain Member insurance identification information within one hundred and eighty (180) days of service



Claim Status

Please do not submit duplicate bills for authorized services. If your Clean Claim has not been adjudicated within forty-five (45) days, please call Cenpatico's Claims Customer Service department to determine the status of the claim.

To expedite your call, please have the following information available when you contact Cenpatico's Claims Customer Service department:

- Member Name
- Member Date of Birth
- Member ID Number
- Date of Service
- Procedure Code Billed
- Amount Billed
- Cenpatico Authorization Number
- Provider's Name
- Provider's NPI Number
- Provider's Tax Identification Number

Claim Reconsideration

If a claim discrepancy is discovered, in whole or in part, the following action may be taken:

Call the Cenpatico Claims Support Liaisons at 1-877-730-2117. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of our Claims Support Liaisons.

When a Provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim should be submitted on a paper claim form. When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as **RESUBMISSION** along with the original claim number written at the top of the claim. Failure to mark the claim may result in the claim being denied as a duplicate. Corrected resubmissions should be sent to:

For issues that do not require a corrected resubmission the Adjustment Request Form can be utilized. The Claims Support Liaison can assist with determining when a corrected resubmission is necessary and when an Adjustment Request Form can be utilized.

If your claim was denied because you did not have an authorization, please send a request in writing for a retroactive authorization, explaining in detail the reason for providing services without an authorization to:

Cenpatico
12515-8 Research Blvd., Suite 400
Austin, TX 78759

Retro authorizations will only be granted in rare cases. Repeated requests for retro authorizations will result in termination from the network due to inability to follow policies and procedures. If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Service Center and ask the representative to extend the end date on your authorization.

If a Resubmission has been processed and you are still dissatisfied with Cenpatico's response, you may file a claims appeal of this decision by writing to the address listed below.

Cenpatico Claims Dept

PO Box 6000

Farmington, MO 63640-3809

Note: Appeals must be filed in writing. Place APPEAL within your request. In order for Cenpatico to consider the appeal it must be received within forty-five (45) days of the date on the EOP which contains the denial of payment that is being appealed unless otherwise stated in your contract.

If you are unable to resolve a specific claims issue through these avenues then you may initiate the Payment Dispute Process. Please contact your Cenpatico Provider Relations Representative about your specific issue. Please provide detailed information about your efforts to resolve your payment issue. Making note of which Cenpatico staff you have already spoken with will help us assist you. Steps 1-4 should be followed prior to initiating the Payment Dispute Process. After contacting Provider Relations at the address below, your dispute will be investigated.

COMPLAINTS, GRIEVANCES & APPEALS

If the time arises when a Provider or Member disagrees with any of Cenpatico's policies or services or would like to request a review of an unfavorable determination, they may file a complaint, grievance or appeal.

What is a Provider Complaint?

A complaint is defined as any dissatisfaction, expressed by a Provider orally or in writing, regarding any aspect of Cenpatico's operations, including but not limited to, dissatisfaction with Cenpatico's administrative policies.

What is a Member Complaint?

A Complaint is dissatisfaction about any matter other than an action. An action is defined as the denial or limited authorization of a requested service; the reduction, suspension or termination of a previously authorized service; or denial in whole or in part, of payment for a service. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Practitioner or employee, or failure to respect the Member's rights.

Cenpatico has established and maintains a Grievance system for the identification and prompt resolution of Member and Provider complaints that complies with applicable Federal and State laws and regulations. A Complaint can be filed by a provider, member or any person acting on the Member's behalf. Cenpatico's QI Department is available to assist Providers, Members or Member representatives with initiating a Complaint. Complaints can be filed in writing or by calling 1-866-796-0530.

Cenpatico Providers and members have one (1) year from the date of the action to file a Complaint. Cenpatico has thirty (30) days to resolve a Member complaint and fifteen (15) days to resolve a Provider complaint. When a decision is not wholly in the Member's favor, the resolution letter must contain the Notice of the Right to a State Fair Hearing and the information necessary to file for a State Fair Hearing. No punitive action will be taken against a Provider who files a Complaint on behalf of a member.

WASTE, ABUSE & FRAUD

Cenpatico is committed to the ongoing detection, investigation and prosecution of waste, abuse and fraud (WAF).
In February 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law and created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act (the Act). The MIP is the first comprehensive Federal strategy to prevent and reduce Provider fraud, waste and abuse in the Medicaid program.

WASTE

Is the use of healthcare benefits or dollars without real need. For example, prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.

ABUSE

Practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Health Plan program, including, but not limited to practices that result in unnecessary cost to the Health Plan program for services that are not Medically Necessary, or that fail to meet professionally recognized standards for healthcare. It also includes Enrollee practices that result in unnecessary cost to the Health Plan program.

FRAUD

An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Health Plan program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or State healthcare fraud laws. Examples of provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and practitioners/providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

Cenpatico, in conjunction with its management company, Centene Corporation, operates a WAF unit. If you suspect or witness a Provider inappropriately billing or a Member receiving inappropriate services, please call our anonymous and confidential hotline at 866-685-8664. Cenpatico and Centene take reports of potential WAF seriously and investigate all reported issues.

512-406-7200

Providers may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone.

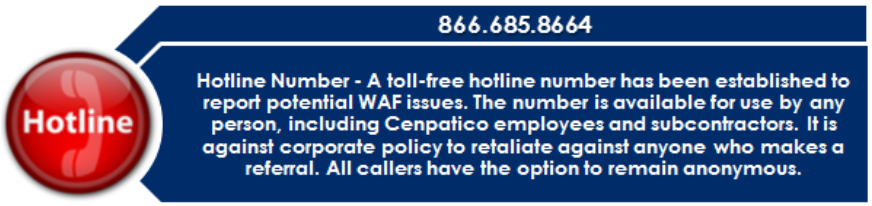
Authority and Responsibility

The President/CEO and Vice President, Compliance of Cenpatico share the overall responsibility and authority for carrying out the provisions of the compliance program. Cenpatico, in conjunction with Sunshine Health, is committed to identifying, investigating, sanctioning and prosecuting suspected WAF.

The Cenpatico Provider Network shall cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations by Sunshine Health, at the Provider and/or subcontractor's own expense.

Cenpatico staff, its Provider Network and their personnel and/or subcontractor personnel, shall immediately refer any suspected WAF to the Medicaid Fraud Control Unit of Florida within the Office of the Attorney General at the following address:

Medicaid Fraud Control Unit
Office of the Attorney General
State of Florida
The Capitol PL-01
Tallahassee, FL 32399
Phone: 866.966.7226
Voice/TTY: 850.414.3935
Florida Relay (TTY): 800.955.8771
Email: http://myfloridalegal.com/contact.nsf/contact?Open&Section=Attorney_General

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