AmeriHealth Caritas Florida Subcontractor Training

Ensuring Compliance with the Agency for Health Care Administration

AmeriHealth Caritas Florida

Rev. 09/2023

Click Here to Begin

Delivering the Next Generation of Health Care

Self Directed Training Instructions

AmeriHealth Caritas Florida

- ✓ This is a self-directed training, which will allow you to move at your own pace.
- ✓ To move through the training, click the blue arrows at the bottom of the page.
- ✓ Some pages contain audio and some slides require you to read through the content or click on the links to review additional content.
- ✓ If you have any questions, please email your Delegation Oversight Coordinator.

Agenda of Topics

AmeriHealth Caritas Florida

1. Purpose and Objectives
2. Contractual Overview
3. Eligibility, New Enrollment, and Member Identification
4. Communications/Marketing
5. Credentialing
6. Network Adequacy
7. Utilization Management
8. Claims and Encounters
9. Call Metrics
10. Provider Complaints
11. Member Complaints/Grievances/Appeals
12. Compliance Training
13. Additional Requirements

Purpose and Objectives

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The purpose of this training is to educate AmeriHealth Caritas Florida's subcontractors on the scope of their duties and responsibilities as required by the Statewide Medicaid Managed Care (SMMC) contract to ensure compliance with contractual, regulatory, and accreditation requirements.

At the conclusion of this training, subcontractors will be able to communicate and train their staff and providers to:

- Comprehend the requirements and changes in the current SMMC Contract/AHCA Contract.
- Create and/or update their processes, policies, and procedures in accordance with the SMMC contract.
- Explain how Delegation Oversight monitors and manages the subcontractors.
- Adhere to the SMMC contractual requirements for delegated subcontractors.

Contractual Overview

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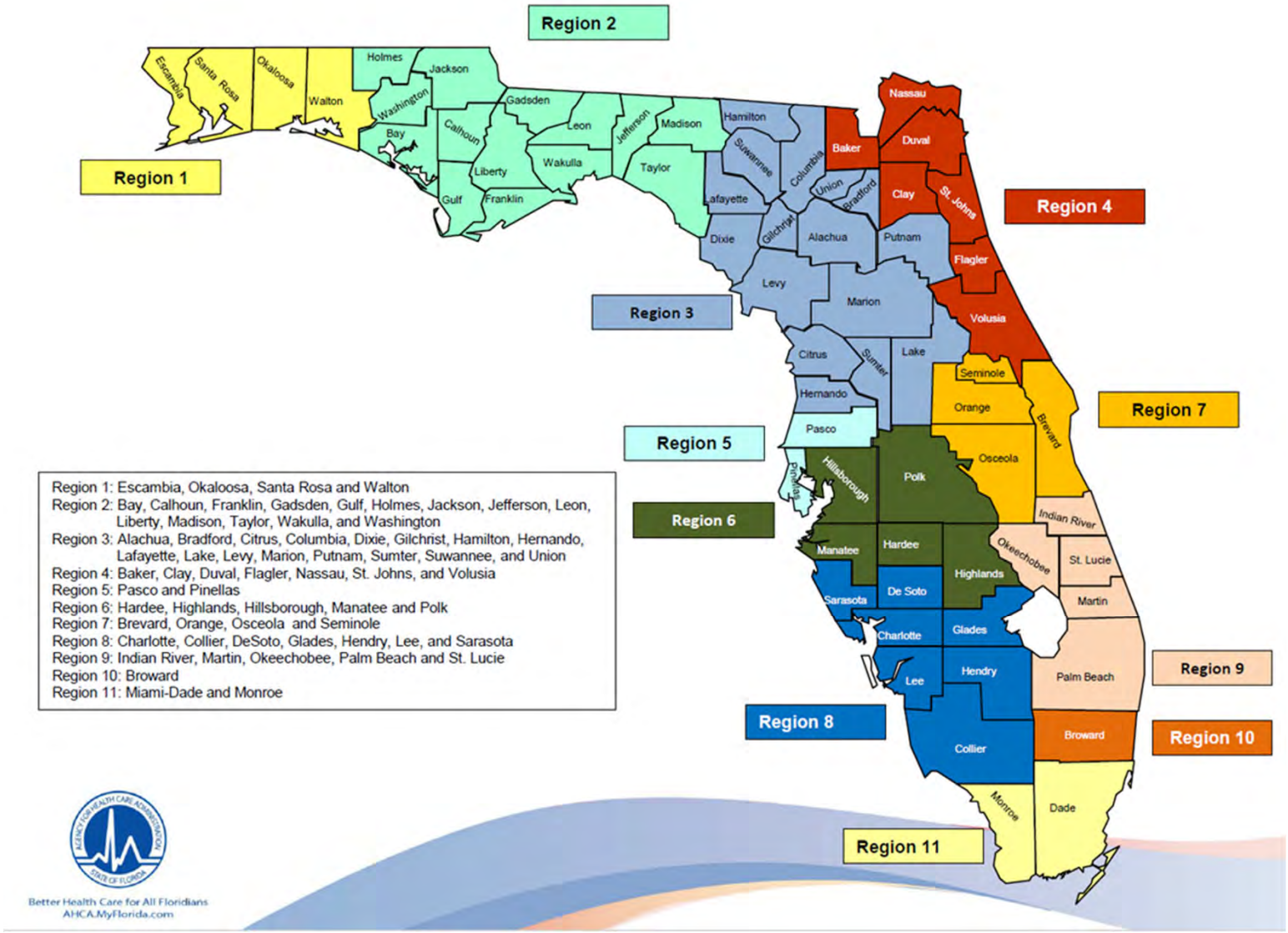
Region Chart

AmeriHealth Caritas Florida operates in regions 9 and 11.

Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie

Region 11: Miami-Dade and Monroe



Relationship

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Delegation Oversight

- Business Associate and Service Level Agreements
- Policies and Procedures
- Joint Operational Committee Meetings
- Regular Education and Training
- Performance Improvement and Corrective Action Plans

Education and Training

In accordance with the SMMC contractual requirements:

- AmeriHealth Caritas Florida shall train its subcontractors on the SMMC contract.
- AmeriHealth Caritas Florida subcontractors are required to train their staff and downstream providers on the SMMC contract requirements.
- Subcontractors will make their provider and staff training schedules available to AmeriHealth Caritas Florida. AmeriHealth Caritas Florida will request evidence of completed trainings.
- Subcontractors are required to conduct initial training with newly contracted providers or provider groups within 30 days of being placed in active status.

Delegation Oversight Overview

In accordance with the SMMC contract, regulatory and accreditation guidelines, AmeriHealth Caritas Florida works with its enterprise Delegation Oversight team to oversee its subcontractors.

Delegation Oversight monitors the implementation, ongoing performance, and operations of all Agency-approved delegated subcontractors. Delegation Oversight also serves as the liaison between subcontractors and AmeriHealth Caritas Florida's internal departments.

The ongoing support and oversight of activities is facilitated through the establishment of relationships with each of the subcontractors.

Monitoring

Delegation Oversight will ensure ongoing compliance with contractual requirements and state and federal laws, through an oversight process. All monitoring activities will occur continuously throughout the life of the contract and extend post-termination, during the run-out period. Below are a few of the monitoring activities performed by Delegation Oversight.

Eligibility, New Enrollment, and Member Identification

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Enrollee Eligibility

AmeriHealth Caritas Florida member eligibility is determined by the Agency for Health Care Administration (AHCA) and subject to daily changes. Subcontractors are required to update their databases within 24 hours after receipt of the data files from AmeriHealth Caritas Florida.

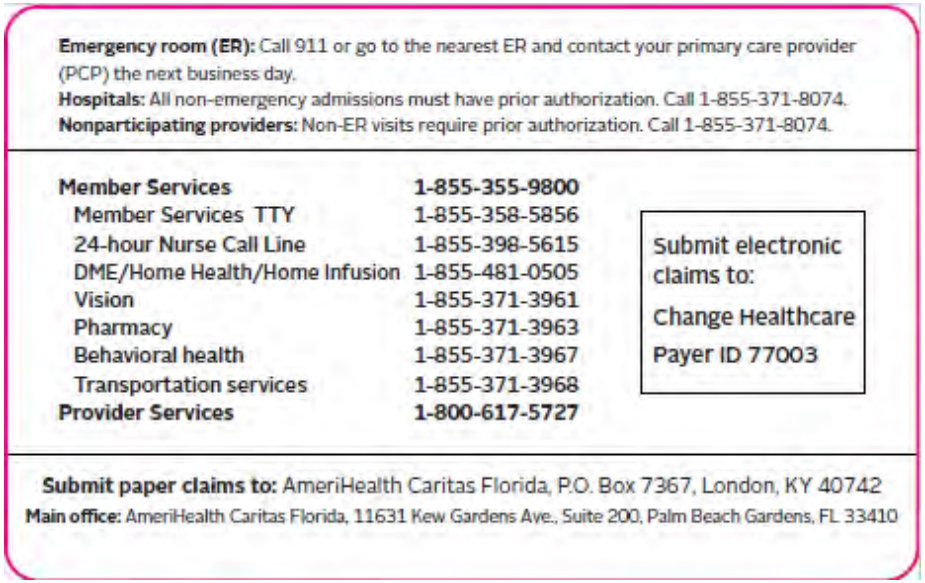
Subcontractors are responsible for verifying member eligibility before authorizing services and are required to train their downstream providers on the member eligibility verification process and various verification methods available to them.

If a member does not appear in the subcontractor's system, the subcontractor may verify eligibility by calling AmeriHealth Caritas Florida Provider Services at **1-800-617-5727** or accessing the Florida Medicaid Managed Information System (FMMIS).

Every AmeriHealth Caritas Florida member will get an AmeriHealth Caritas Florida member ID card. This card contains important member information including the member's name, AmeriHealth Caritas Florida ID Number, date of birth (DOB), PCP information and important contact numbers. Subcontractors shall educate their providers of the information included on the AmeriHealth Caritas Florida member ID card.

Member ID Cards

- New member ID cards includes:
  - The member's name and Medicaid ID number.
  - The member's primary care physician's name, street address, and phone number.
  - AmeriHealth Caritas Florida's name, address, and member help line number.
  - A telephone number that a nonparticipating provider may call for billing information.
  - Subcontractor contact center numbers.



Communications/Marketing

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Communications:
Enrollee Materials

Materials subject to AHCA review and approval, managed by AmeriHealth Caritas Florida Communications

Enrollee materials

- Agency approval of cobranded enrollee materials is required. Submit to plan at least seventy-five (75) days in advance of proposed use.
- AmeriHealth Caritas Florida conducts quality checks and annual audits for compliance with SMMC contract, state, and federal requirements, and adherence to AHCA-approved files.

Enrollee materials requirements

- All enrollee communications must be at or near the fourth (4th) grade comprehension level and subject to readability tests (4.9 or lower). Suitable readability tests include:
  - Fry Readability Formula;
  - Prose: The Readability Analyst;
  - Gunning Fog Index;
  - McLaughlin SMOG Index;
  - The Flesch-Kincaid Index; and/or
  - Other readability tests approved by the Agency.
- If membership (by county) meets the five percent (5%) threshold for language translation, AmeriHealth Caritas Florida/Subcontractor shall place the following alternate language disclaimer on all enrollee materials:
  - *This information is available for free in other languages. Please contact Member Services at **1-855-355-9800 (TTY 1-855-358-5856)***
    24 hours a day, seven days a week.
- All enrollee materials must be translated to Spanish and Haitian Creole.
- All enrollee materials for distribution must include the AmeriHealth Caritas Florida alternate language nondiscrimination notice.
- All enrollee materials for distribution must be cobranded with the AmeriHealth Caritas Florida logo.

Communications:
Enrollee Materials (continued)

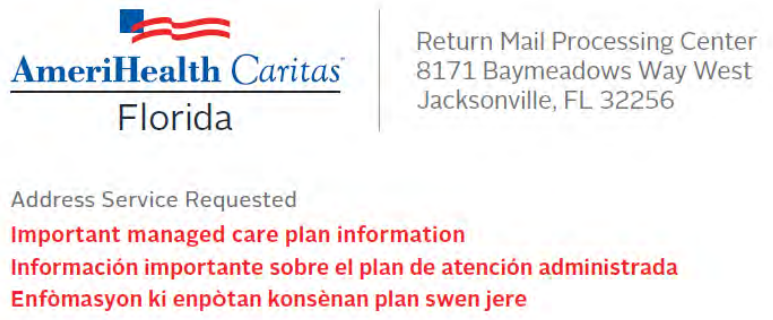
Requirements for Mailing Materials to Enrollees

Materials shall be provided to enrollees by mail or consistent with the enrollee's preferred method of contact.

- The outer envelope shall display one of the following four statements verbatim on the front of the envelope (example below):
  - Advertising pieces – "This is an advertisement".
  - Managed Care Plan information – "Important Managed Care Plan information".
  - Health and wellness information – "Health and wellness or prevention information".
  - Non-health or non-Managed Care Plan information – "Non-health or non-Managed Care Plan related information".
- The outer envelope shall include a request for address correction: "Address Service Requested".

If a dual window envelope is used, the "Address Service Requested" statement must show in the return address window and the correct translation of the applicable statement must show in the addressee window.

Every enrollee mailing shall ensure cobranding with the AmeriHealth Caritas Florida logo.



Provider Directory

- Subcontractor printed provider directory includes the following information:
  - Provider(s) names and group affiliations.
  - Street address (es).
  - Telephone numbers.
  - Website URLs, if the provider has a website.
  - Specialty credentials and other certifications, as applicable.
  - Whether the provider will accept new members.
  - The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
  - Office hours.
  - Specific performance indicators.
  - A statement that some providers may choose not to perform certain services based on religious or moral beliefs.
  - Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

Provider Directory (continued)

- Content accuracy may be validated in any of the following ways:
  - Roster validations.
  - Audit of online provider directory.
  - During secret shopping activities performed by members of the AmeriHealth Caritas Florida Compliance Department.
  - Tips received through the Rapid Response or Utilization Management Departments.
  - During credentialing or recredentialing process.
  - During a site visit review with a provider group.

Credentialing and Recredentialing

Ensuring Compliance with the Agency for Health Care Administration

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Credentialing and Recredentialing

- AmeriHealth Caritas Florida operates in compliance with the standards set forth by the National Committee for Quality Assurance (NCQA), Florida's Agency for Health Care Administration (AHCA), and federal and state regulations. The credentialing standards mandate that subcontractors credential their providers before they join their network and prior to offering health care services to AmeriHealth Caritas Florida members.
- If the subcontractor has delegated credentialing, then the subcontractor must ensure that all licensed providers are credentialed in accordance with the Plan and Agency's credentialing requirements. Subcontractor must timely notify Plan of changes in directory information.

Credentialing and Recredentialing (continued)

- ✓ Notification of credentialing decisions must be sent to the provider within 60 **calendar days** of the decision.
- ✓ Providers are recredentialed no later than 36 months thereafter.
- ✓ All subcontractor's providers must be enrolled in Medicaid and meet all provider requirements at the time services are rendered.
- ✓ The subcontractor shall require all providers to obtain an NPI number.
- ✓ The subcontractor must use criteria and verification practices designed to credential and re-credential its providers in a non-discriminatory manner.
- ✓ Subcontractors must use the Council for Affordable Quality Healthcare (CAQH) for its ProView® product application to collect data from providers as necessary to complete the credentialing process.

Network Adequacy

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Network Adequacy

AmeriHealth Caritas Florida (ACFL) submits a weekly Provider Network Verification (PNV) file in accordance with AHCA Contract Attachment II Section VIII.A.3 which is used by AHCA to determine compliance with contractual network ratio adequacy requirements. The specifications to the PNV will be provided by ACFL.

The pre- and post-PNV Error Reports must be worked weekly to ensure that critical error records pass the validation process and are counted in the network ratio adequacy requirements. In addition, records that receive a warning, must also be worked weekly. These records are currently not failing in the process, but that error code can be updated by AHCA from a warning to a critical error at any point.

Common Network Adequacy Errors

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1. Providers (practitioner, facility, or group) that only have a terminated license, Medicaid ID, and/or NPI not termed in a timely manner.
    - License (Practitioner/Pharmacy) Validation Resource https://mqa-internet.doh.state.fl.us/MQASearchServices/Home
    - License (facility) Validation Resource https://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx
    - Medicaid ID (P | F | G) Validation Resource http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCareRegistration/tabId/77/Default.aspx
    - NPI (P | F | G) Validation Resource https://npiregistry.cms.hhs.gov/
2. Practitioner and/or facility records with inaccurate, outdated, and/or blank credential dates.
    - Credential dates have to be updated after each credentialing cycle. Last credential date can't be greater than three years from the last day of the credential month.
    - Application Receipt Date must always be before Last Credential Date.
    - All practitioner and facility records must contain current credential cycle dates.

Common Network Adequacy Errors (continued)

1. Standardize address according to the United States Postal Service.
   - https://www.usps.com/
2. Practitioner/Group address mismatch data elements.
   - Matching Data Elements: Address line 1, Address line 2, City, State, Zip Code, and County. If any one of these data elements is different in any way between the practitioner and group the record will fail in the PNV process.
3. Active Network — No Active Service Location
   - Record contains an active In-Network Agreement ID, but do not have an active service location (primary, 001, 002, etc.).
4. Active Network — No Active Group Affiliation
   - Record contains an active In-Network Agreement ID, but not have an active group affiliation.

Common Network Adequacy Errors (continued)

AmeriHealth Caritas Florida provides our members with an updated online directory daily and a print directory monthly in accordance with AHCA Contract Attachment II Section V.B.9. The required directory data elements are illustrated below.

1. Provider name.
2. Group affiliation.
3. Street address.
4. Telephone number.
5. Website URL (if provider has a website).
6. Specialty.
7. Accepting new patients.
8. Cultural and linguistic capabilities.
9. Office hours.
10. Accommodations for people with physical disabilities.

Utilization Management

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Appointment Access

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Appointment Access Standards

Medicaid Managed Care guidelines dictate that subcontractors must monitor the following access standards on an annual basis.

General Appointment Scheduling for PCPs and Specialists	
Urgent examination	Within 1 day
Routine sick patient care	Within 1 week
Well-care visit	Within 1 month
Postpartum exam	Within 6 weeks of delivery

Emergency services must be provided immediately upon presentation, twenty-four hours a day, seven days a week (24/7).

Service Authorizations

Standard Authorization Decisions. Subcontractor shall provide standard authorization decisions within no more than seven days following receipt of the request for service. Subcontractor may extend the time frame for standard authorization decisions up to four additional days, if the member or the provider requests an extension, or if subcontractor justifies the need for additional information and shows how the extension is in the member's interest. (42 CFR 438.210(d)(1))

Expedited Authorization Decisions. Subcontractor shall provide expedited authorization decisions within no more than two days following receipt of the request for service. Subcontractor may extend the time frame for expedited authorization decisions up to one additional day, if the member or the provider requests an extension, or if subcontractor justifies the need for additional information and shows how the extension is in the member's interest. (42 CFR 438.210(d)(2))

Pharmacy Drug Authorization Decisions. Subcontractor shall provide pharmacy drug authorization decisions within no more than 24 hours following receipt of the request for authorization.

Clinical Decision-Making

As an SMMC requirement, subcontractors must comply with the “Inter-Rater Reliability” requirement.

1. Subcontractor shall conduct inter-rater reliability audits on all clinical professionals who review service authorization requests under the Contract. Subcontractor shall audit for consistency in decisions, which account for state and federal Medicaid requirements (e.g., EPSDT). At a minimum, subcontractor shall monitor one percent of service authorization decisions per reviewer per quarter.
2. **Each clinical reviewer must maintain an 85% accuracy rate.**

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Claims and Encounters

Claims Definitions

Clean claim -- a claim received in a nationally-accepted format, in compliance with standard coding guidelines, that can be processed without obtaining additional information from the provider of the service or from a third party.

Non-clean claim -- a claim requiring additional information from the provider of the service, or from a third party. Non-clean claims contain errors/omissions of data or require submission of additional medical records. In addition, non-clean claims may involve issues regarding medical necessity or those not submitted within the filing deadlines.

Encounter versus claim -- *Encounter data* is used to evaluate quality and utilization management. AmeriHealth Caritas Florida requires capitated providers to submit an encounter (also called a "proxy claim") or a claim for each service that you render to a health plan member. The information for each member visit must be submitted on a standard CMS-1500 or UB-04 form and completed with a dollar value. This is a requirement of the Centers for Medicare and Medicaid Services (CMS) and the state of Florida. A *claim* is a request for reimbursement either electronically or by paper for any medical service. Claims must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, a Remittance Advice (RA) will be mailed to the provider who submitted the original claim.

Claim Information

Billing forms. Subcontractors must instruct their providers to submit claims using standardized claim forms whether filing on paper or electronically. Refer to the appropriate provider handbook, issued by AHCA at http://ahca.myflorida.com/medicaid/review/index.shtml, to determine which claim form is appropriate for each type of service.

Third party liability. Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member. Please verify member eligibility prior to serving the member and verify third party sources prior to notifying AmeriHealth Caritas Florida.

Centers for Medicare & Medicaid Services (CMS) crossover claims. In accordance with guidance from CMS, they will automatically forward claims to AmeriHealth Caritas Florida for members who are dually eligible for both Medicare and Medicaid coverage. AmeriHealth Caritas Florida will coordinate with subcontractor on the payment adjustments. The subcontractor is responsible for Medicare co-insurance and deductibles for covered services and shall reimburse providers or members for Medicare deductibles and co-insurance payments made by the providers or members, according to Medicaid guidelines referenced in the Florida Medicaid Provider General Handbook.

The subcontractor shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three years.

Medicaid Well Child Visits — Child Health Check-Up Program (CHCUP). CHCUP services are the CPT Preventive Medicine Services Codes. In some cases, one or two modifiers are required to uniquely identify the service provided. Both the procedure code and modifiers listed must be completed on the claim to facilitate proper reimbursement. No modifiers other than the ones listed below are allowed when billing these services.

Claim Submission and Processing Policies and Procedures

Subcontractor shall establish and maintain written policies and procedures for processing claims submitted by its contracted providers for services rendered to AmeriHealth Caritas Florida members.

- The claims processing procedure shall comply with all applicable SMMC Requirements and Accreditation Standards.
- Subcontractors must follow SMMC directives for claims management and update these processes as mandated by AHCA.
- The subcontractor shall process claims and pay providers in compliance with federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent. (s. 409.967(2)(j), F.S.)
- Subcontractors must maintain all information and records created in connection with the performance of delegated claims management in accordance with the policies and procedures previously accepted by AmeriHealth Caritas Florida.

Claims Verification

Subcontractors will require that if data elements are missing or are invalid, provider claims will be rejected for correction and resubmission.

Claims (encounters) for capitated services provided to AmeriHealth Caritas Florida members must be submitted by the provider who performed the services to the subcontractor. Subcontractors will ensure that claims submitted by their providers are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification of member eligibility for services under AmeriHealth Caritas Florida during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the “out of plan” provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Florida Medicaid Program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the subcontractor.
- Verification of whether there is Medicare coverage or any other third party resource and, if so, verification that the subcontractor is the “payer of last resort”.

Claims Performance Metrics

The subcontractor shall have performance metrics, for quality, accuracy, and timeliness in regards to claims processing and claims payment. AmeriHealth Caritas Florida has established a process for measuring and monitoring, and for the implementation of interventions for improvement.

AmeriHealth Caritas Florida is required by state and federal regulations to capture specific data regarding services rendered to enrollees. As such, we ask that subcontractors instruct their providers to adhere to all billing requirements in order to ensure timely processing of claims

Claims Performance Metrics (Scorecard)

AmeriHealth Caritas Florida

CLAIMS MANAGEMENT	GOAL
Total Number of Claims Received	
Total Number of Claims Denied	
Claim Processing Standards / Timeliness of Payment (percentage)	95% of claims processed with no errors.
Claims Payment Timeliness	50% of all clean claims paid within seven (7) calendar days.
	70% of all clean claims paid within ten (10) calendar days.
	90% of all clean claims paid within twenty (20) calendar days.
Claims Acknowledgement Electronic	Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
Claims Acknowledgement Non-Electronic	Within fifteen (15) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.
Claims Payment Electronic (average days)	Pay or notify provider if denied or contested within 15 calendar days of receipt of clean claim.
Claims Payment Non-Electronic (average days)	Pay or notify provider if denied or contested within 20 calendar days after receipt of clean claim.
Paper Claims Adjudication	100% of all claims are adjudicated within 120 days.
Electronic Claims Adjudication	100% of all claims are adjudicated within 90 days.
System Availability	At least 99.5% of the time, contracted providers have access to claims processing system (excluding scheduled maintenance).

Claim Filing Deadlines

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Subcontractors will instruct their providers that original invoices must be submitted as per the terms of their provider contract, or as otherwise permitted by law, from the date services were rendered or compensable items were provided. Resubmission of previously denied claims with corrections and requests for adjustments must be submitted within the allowed time frame listed in their participating provider's contract, or as otherwise permitted by law, or as outlined in federal/state statutes.

Claims with explanation of benefits from primary insurers must be submitted within the following time frames:

- For third-party liability or coordination of benefits claims, the time filing limit is 90 days from the primary insurance explanation of benefits, or six months from date of service for secondary claim submission, whichever is greater.
- For Medicare coordination of benefit claims, the time filing limit is 12 months from the date of service or 6 months from the Medicare explanation of benefits, whichever is greater. Medicare crossover claims shall not be denied solely based on the date span between date of service and the date a clean claim was received, unless this period exceeds three years.

The subcontractor shall not deny claims submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 days.

Paper Claim Submission

For all non-electronically submitted claims for services, the subcontractor shall abide by the following process with its providers:

1) Within 15 days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.

2) Within 20 days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

3) Pay or deny the claim within 120 days after receipt of the claim. Failure to pay or deny the claim within 140 days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim.

Electronic Claim Submission

AmeriHealth Caritas Florida

For all electronically submitted claims for services, the Subcontractor shall abide by the following process with its providers:

1) Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

2) Pursuant to s. 409.982(5), F.S., within 10 business days of receipt of nursing facility and hospice clean claims, pay or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

3) Within 15 days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim.

4) Pay or deny the claim within 90 days after receipt of the non-nursing-facility/non-hospice claim. Failure to pay or deny the claim within 120 days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim. (s. 641.3155(3)(e), F.S.)

Claims Payments

All claims payment made by a Subcontractor to a provider must be accompanied by an itemized accounting of the claims included in the payment. The information should include, but not be limited to, the member' name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the subcontractor.

Claims Payment SMMC Standards

As mandated by AHCA, and as required by AmeriHealth Caritas Florida contractual service-level agreements (SLAs), subcontractor shall comply with the following SMMC standards regarding timely claims processing for their providers:

- The Managed Care Plan shall pay fifty percent (50%) of all clean claims submitted within seven (7) days.
- The Managed Care Plan shall pay seventy percent (70%) of all clean claims submitted within ten (10) days.
- The Managed Care Plan shall pay ninety percent (90%) of all clean claims submitted within twenty (20) days.

Subcontractor will report the result of these SLA on their monthly score card submissions. In the event the SLAs are not met, a root cause analysis along with a timeline for correction must be submitted. Subcontractor is subject to corrective actions and/or liquidated damages as determined by the AmeriHealth Caritas Florida Compliance Officer.

Providers may *not* bill a member for Medicaid-covered services for which a claim has been submitted, regardless of whether the claim has been paid or denied.

Call Metrics

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Member Call Center Metrics

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Subcontractor shall maintain member call center performance metrics at the following levels throughout the term of the subcontract, measured on a monthly basis:

- At least **90%** of calls are answered **within 30 seconds** (Service Level).
- At least **80%** of calls are resolved **within the first call** (without internal hard transfer or soft internal conference call or barge-in (First Call Resolution).
- Average hold time, after a call is answered, shall not exceed **60 seconds** (Average Hold Time).
- Average quality monitoring score resulting from call monitoring of all call center agents must be **95%** or greater. (Quality Assurance (QA) Monitoring).
- Average speed of answer does not exceed **30 seconds** (Average Speed of Answer).
- Percentage of inbound phone calls made to a call center that are abandoned by the enrollee or their representative before speaking to an agent is no more than **three percent** (Call Abandonment).
- Percentage of calls that are not allowed into the system, as reported from the telecommunications provider, is no more than **five-tenths of one percent (0.5%)** (Blockage Rate – Telecom Provider).
- Percentage of calls that are made into the system that are forced disconnects, as reported by the Automatic Call Distributer (ACD) software, is no more than **zero percent (0.0%)** (Call Blockage – System Reported).

Provider Call Center Metrics

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Subcontractor shall maintain provider call center performance metrics at the following levels throughout the term of the Subcontract, measured on a monthly basis:

- At least **90%** of calls are answered **within 30 seconds** (Service Level).
- At least **75%** of calls are resolved **within the first call** (without internal hard transfer or soft internal conference call or barge-in (First Call Resolution).
- Average hold time, after a call is answered, shall not exceed **90 seconds** (Average Hold Time).
- Average quality monitoring score resulting from call monitoring of all call center agents must be **95%** or greater. (Quality Assurance (QA) Monitoring).
- Average speed of answer does not exceed **30 seconds** (Average Speed of Answer).
- Percentage of inbound phone calls made to a call center that are abandoned by the provider or their representative before speaking to an agent is no more than **three percent** (Call Abandonment).
- Percentage of calls that are not allowed into the system, as reported from the telecommunications provider, is no more than **five-tenths of one percent (0.5%)** (Blockage Rate – Telecom Provider).
- Percentage of calls that are made into the system that are forced disconnects, as reported by the Automatic Call Distributer (ACD) software, is no more than **zero percent (0.0%)** (Call Blockage – System Reported).

Provider Complaints

Ensuring Compliance with the Agency for Health Care Administration

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Provider Complaints

AmeriHealth Caritas Florida maintains a provider complaints system in accordance with AHCA Contract Attachment II Section VIII.D.5 that allows the provider to dispute AmeriHealth Caritas Florida's policies, procedures, or any aspect of our administrative functions, including proposed actions, claims, billing disputes, and authorizations.

Should a provider disagree with a claims decision, the provider may participate in the Provider Complaint process.

Filing a Provider Complaint

- A provider may file a complaint in the following three ways:
  - Verbally.
  - Written.
  - In person.
- A provider must submit a complaint within 90 days of:
  - Remittance Advice.
  - Date of administrative issue.

Provider Complaint Types

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1. Claims/Billing — A provider disputes a decision where a claim has been denied for reasons other than authorization or disagrees with the payment amount. These include, but are not limited to the following:
   - Untimely filing.
   - Billing edits.
   - Benefit limitations.
   - Unlisted procedure codes/non-covered codes.
   - Fee schedule/reimbursement rates.
   - Provider contract questions/concerns.
2. Administrative — A provider disputes health plan administration or policies
3. Provider Complaints Generated by AHCA — A provider files a dispute with AHCA. This provider complaint type is managed by the Member Grievances and Appeals department.

Provider Complaint Resolution

Within 60 days from the receipt of the provider complaint, the Subcontractor will:

- Review and resolve the complaint.
- Document the resolution of the complaint in a database tracking system.
- Respond in writing to the provider with the resolution of the complaint within three business days of the resolution.

If the complaint remains unresolved after 30 days, the Subcontractor will notify the provider in writing of the delay and reason. This will be repeated every 30 days until the complaint is resolved.

Provider Complaint Resolution

Action	Responsibility	Timeframe
Provider complaint submission	Provider	**90 calendar days** from claim processed date (or date of occurrence for administrative complaints)
Provider complaint acknowledgement	Subcontractor	**3 business days** from date of receipt
Provider complaint status letter	Subcontractor	Within **30 calendar days** of receipt, and every 30 days thereafter until complaint is resolved
Provider complaint resolution	Subcontractor	**60 calendar days** from date of receipt
Written notice of resolution	Subcontractor	Within **3 business days** of provider complaint resolution

Provider Complaint Reporting

The Subcontractor will create monthly reports that detail the nature of complaints received, the timeline for the complaints, as well as resolutions using AHCA's **Provider Complaint/Appeal Report** template.

The report is to be submitted by the Subcontractor to the AmeriHealth Caritas Regulatory Reporting department by the **sixth of each month**. Any cases that fall out of compliance are identified and the root cause is communicated to the Regulatory Reporting team via email with the report submission.

Complaints, Grievances, and Appeals

Ensuring Compliance with the Agency for Health Care Administration

AmeriHealth Caritas Florida

Member Complaints

Complaint: Any oral or written expression of dissatisfaction by a member submitted to the Managed Care Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee, failure to respect the member's rights, Managed Care Plan administration, claims practices, or provision of services that relate to the quality of care rendered by a provider pursuant to the Managed Care Plan's contract. A complaint is a subcomponent of the grievance and appeal system.

Member Complaints Process

- AmeriHealth Caritas Florida will not delegate provider/member complaints to subcontractors.
- AmeriHealth Caritas Florida member material will direct member to contact Member Services with any questions or complaints.
- A member may reference their AmeriHealth Caritas Florida member ID card and contact a subcontractor's Call Center. The Call Center representative will initially assess the nature of the call.
- If the member expresses dissatisfaction or states that they are calling to address a complaint, the Subcontractor **must** "warm transfer" the call to AmeriHealth Caritas Florida's Member Services by calling **1-855-355-9800 (option 7)** for handling, resolution, and escalation of the complaint.
- **The complaint will be managed entirely by the AmeriHealth Caritas Florida Member Services representative.**
- If the complaint is not resolved by the end of the next business day, the member services representative will submit it to the Member Grievances and Appeals Department.
- Subcontractors are required to provide reasonable assistance to AmeriHealth Caritas Florida upon request in investigating and responding to member complaints and grievances as necessary.

Acknowledging Grievances

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. Any complaint that is not resolved by close of business the following business day automatically becomes a grievance.

- ✓ AmeriHealth Caritas Florida will send the enrollee an acknowledgement letter within five business days of receiving the grievance.
- ✓ AmeriHealth Caritas Florida will send a decision letter within 90 calendar days of receiving the grievance.
- ✓ In some cases, AmeriHealth Caritas Florida or the member may need more information. If the member needs more time to get information, he/she may request up to 14 additional calendar days.
- ✓ If AmeriHealth Caritas Florida needs more time, the member will be informed of the reason for the extension, in writing, within two calendar days.

Providers Appealing on Behalf of Member

A standard appeal may be submitted by a provider on behalf of the member. The provider, with member's consent, may call Member Services at **1-855-355-5856** or fax an appeal request to **1-855-358-5847.**

A provider may file an appeal orally or in writing within **60 calendar days** of the member's receipt of the Notice of Adverse Benefit Determination (NABD). Appeals filed orally must be followed with a written notice within 10 calendar days of the oral filing, except when an expedited resolution is required. The date of oral notice shall constitute the date of receipt.

Hours of operation are 24 hours a day, seven days a week (24/7).

Expedited Appeal

A member or his/her authorized representative, with the member's written consent, can request an expedited appeal when taking the time for a standard resolution could jeopardize the member's life; health; or ability to attain, maintain, or regain function. Expedited appeals are for health care services, not denied claims. To ask for an expedited appeal, the member or his/her authorized representative may call **1-855-371-8078**.

If AmeriHealth Caritas Florida denies a request for an expedited resolution of an appeal, AmeriHealth Caritas Florida shall provide oral notice by close of business on the day of disposition, and written notice **within two calendar days** after the disposition. The appeal will immediately be moved into the standard appeal timeframe, if it does not meet the criteria for an expedited appeal.

AmeriHealth Caritas Florida shall resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires, within state established time frames, **not to exceed 48 hours** after the request for expedited appeal is received. AmeriHealth Caritas Florida also shall provide oral notice by close of business on the day of disposition, and written notice **within two calendar days** of the disposition.

Medicaid Fair Hearing

A provider may seek a Medicaid Fair Hearing on behalf of the enrollee, with signed consent and only after exhausting AmeriHealth Caritas Florida's internal appeal process. Medicaid Fair Hearing must be requested **within one hundred twenty (120) calendar days** of the Notice of Adverse Benefit Determination (NABD).

Request for a Medicaid Fair Hearing must be submitted to the Agency for Health Care Administration:

Mail: Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Fort Myers, FL 33906

Phone: 1-877-254-1055
Fax: 1-239-338-2642
Email: MedicaidHearingUnit@ahca.myflorida.com

For more information on Appeal Hearings, please visit:

www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings

Compliance Training

Ensuring Compliance with the Agency for Health Care Administration

AmeriHealth Caritas Florida

Compliance Overview

All subcontractors are required to have a Compliance Program which consists of several components, including, but not limited to:

- Compliance and Anti-Fraud Plan in accordance with 42 CFR 438.608 and Florida Statute 409.91212, and
- Corresponding policies and procedures.

Additionally, subcontractors are required to complete annual compliance training. This includes training related to HIPAA, Compliance Laws, Code of Conduct & Ethics, Conflict of Interest, Security Training, Cultural Competency and Fraud, Waste and Abuse. These trainings may be administered by your company, or you may be required to complete AmeriHealth Caritas' compliance trainings in order to meet this contract requirement.

The Corporate Compliance Office of AmeriHealth Caritas is responsible for ensuring all subcontractors comply with annual compliance training requirements.

Privacy Requirements

Privacy requirements and guidelines are outlined in the Business Associate Agreement (BAA) with the subcontractor. Subcontractors should educate their employees on the privacy and reporting requirements identified in the BAA.

Reporting Requirement:
All Subcontractors shall immediately perform a breach risk assessment that considers, among other factors, the four (4) factors identified in 45 C.F.R. § 164.402. Subcontractor shall complete the risk assessment within forty-eight (48) hours of discovery of the Privacy or Security Event, and immediately report the findings of the risk assessment in writing to AmeriHealth Caritas Florida. The notification should include all elements identified in the BAA. The notification should be sent secure email with a confirmation by overnight delivery service or registered or certified mail placed in the mail no later than the following day.

Address to:
AmeriHealth Caritas Family of Companies
Privacy Office
200 Stevens Drive
Philadelphia, PA 19113

Email: Privacy@amerihealthcaritas.com

Additional Requirements

Ensuring Compliance with the Agency for Health Care Administration

Background Checks

- Subcontractors are subject to background screenings as required by Plan pursuant to the Agency Contract.
- The nature of work the subcontractor will perform under the Services Agreement will determine the level and scope of the background checks in accordance with Section 408.809 F.S.
- To ensure that all employees including managing employees that have direct access to personally identifiable information (PII), protected health information (PHI), or financial information have a County, State, and Federal criminal background screening comparable to a level 2 background screening as described in Section 435.04, F.S., completed with results prior to employment.
- Subcontractor must submit to the Plan or Agency upon request: (a) information on ownership and control in accordance with 42 CFR 455.104; (b) information related to business transactions in accordance with 42 CFR 455.105; and (c) information on persons convicted of crimes in accordance with 42 CFR 455.106.

Reporting (depends on delegated function)

AmeriHealth Caritas Florida

REPORT NAME	FREQUENCY
Achieved Savings Rebate (ASR) Financial Reports	Annually / Quarterly
ASR Claim Lags Template	Annually / Quarterly
ASR Financial Report	Annually / Quarterly
Actual Value of Enhanced Payment (AVEP) MMA Physician Incentive Program (MPIP) Report	Semi- Annually
Administrative Subcontractors and Affiliates Report	Quarterly
Adverse and Critical Incident Summary Report	Monthly
Annual Fraud and Abuse Activity Report	Annually
Appointment Wait Times Report	Quarterly
Claims Aging Report	Monthly
Denied/Suspended/Terminated Provider Report	Quarterly
Enrollee Complaints, Grievances and Appeals Report	Monthly
ER Visits for Enrollees without PCP/PDP Appointment Report	Annually
Hernandez Settlement Agreement Survey	Annually
Hernandez Settlement Ombudsman Log	Quarterly
Institution for Mental Diseases (IMD) Reimbursement Report	Semi-Annually
Inter-Rater Reliability (IRR) Report	Quarterly
Non-Emergency Transportation (NET) Timeliness Report	Monthly
PCP/PDP Appointment Report	Annually
Provider Complaint /Appeal Report	Monthly
Provider Network File	Weekly
Quarterly Fraud and Abuse Activity Report	Quarterly
Residential Psychiatric Treatment Report	Monthly
Service Authorization Performance Outcome Report	Monthly
Supplemental HIV/AIDS Report	Monthly
Suspected/Confirmed Fraud and Abuse Reporting	Variable
Suspected/Confirmed Waste Reporting	Quarterly

Contingency Plan

- AmeriHealth Caritas Florida has developed a comprehensive “Contingency Plan” to comply with the AHCA contractual requirements.
- All subcontractors must establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997) to meet its obligations.
- Subcontractors are required to provide quarterly, unaudited financial statements and an annual, audited financial statement.
- Subcontractors are subject to corrective action for failure to comply with contractual requirements.
- Financial statements will be discussed with the subcontractor at the time of the pre- and annual delegation audit. Ad hoc meetings will be scheduled if necessary.

Care is the **heart** of our **work.**

AmeriHealth Caritas Florida

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