Community Care Plan

The Health Plan with a Heart

Community Care Plan's Florida Medicaid and Serious Mental Illness Specialty Plan

PROVIDER MANUAL

CCPcares.org

1-855-819-9506

10/01/26

1. Welcome to Community Care Plan 9

Key Contacts and Phone Numbers 10

Provision of Services 11

Medicaid in Florida 11

About CCP 13
Managed Medical Assistance (MMA) 13
Serious Mental Illness (SMI) 13
CCP's Core Principles and Fundamental Behaviors 14

CCP's Community Resource Center (CRC) 14
Free Services Offered at CCP Community Resource Centers (CRCs) 14
How to Find a CCP Community Resource Center 15

Informational Provider Tools 15
CCP Website 16
Provider Academy 16
Health Library 16
Secure Provider Portal 17
Member Benefits 17
Standard Benefits 17
Expanded Benefits 18
In Lieu of Services 19
Member Incentive Programs 23

2. Member Eligibility 24

Eligibility Determination 24
MMA 24
SMI 24

Member ID Cards 25
Sample CCP Enrollee ID Card 25

Verifying Member Eligibility 25
Methods to Verify Eligibility 25

3. Credentialing and Recredentialing 26

Credentialing Contact Information 26
Eligibility and Standards 26
Practitioner Credentialing 26
Provider Credentialing 27
Application Process 27
Recredentialing 27
Standards and Compliance 28
Quality Assurance 28

Credentialing Requirements for MMA 28
Background Screening 28
Requirements for Practitioners 28
Provider Requirements 30

Behavioral Health Facilities 30

Facilities 31
Additional Requirements for Accredited Facilities 31
Additional Requirements for Non-Accredited Facilities 31

Credentialing Committee **32**
Committee Meetings and Application Process ____ 32
Site Visits ____ 32
Ongoing Performance Monitoring ____ 32

Recredentialing **32**
Recredentialing Process ____ 32
Interim Credential Monitoring ____ 33
Termination of Agreement ____ 33

Right to Review and Correct Information **33**
Correcting Erroneous Information ____ 33
Application Status ____ 33

Right to Appeal Adverse Credentialing Determinations **33**
Request Process ____ 33

Practitioner Addition to Existing Practice **34**

Provider Address and Demographic Information Changes **34**
Notification Process ____ 35

4. Utilization Management ____ 36

Overview **36**
Non-Discrimination Policy ____ 36
Staff Compensation and Incentives ____ 36
Fraud, Waste, and Abuse Prevention ____ 37

UM Contact Information **37**

Clinical Practice Guidelines **37**

Emergency Services **37**

Services Requiring Prior Authorization **38**
Medical Necessity Definition ____ 39
Enrollment and Prior Authorization for Ongoing Services ____ 39
MMA Members ____ 39

Submitting Prior Authorization Requests **40**

Timeliness of Decision **40**

Non-Urgent Pre-Service Determination **41**

Urgent or Expedited Pre-Service Determination **41**

Urgent Concurrent and Post-Stabilization Determination **41**

Medical Necessity Review **41**
Medical Necessity of Services Under CHCUP/EPSDT ____ 43

Post-Service Decisions/Retrospective Review **43**

Continuity of Care **44**
Continuity of Care in New Members ____ 44
Continuity of Care Following Provider Termination ____ 44

5. Provider Requirements for Pregnant Members and Newborns ___ 45

Notice of Pregnancy **45**

Doula Expanded Benefit **45**
Other Benefits for Pregnant Members **46**
Florida Healthy Start Program **46**
Medical Record Documentation for Pregnant Members **47**
Root Cause Analysis (Pregnant Members with SMI) 47
Pregnancy-Related Care by Maternity Providers **48**
Hospital Service and Documentation Requirements for Newborns **48**
Infant Care Service and Documentation Requirements ..... Error! Bookmark not defined.
6. Provider Requirements for Treating Children and Youth **50**
Early and Periodic Screening, Diagnostic, and Treatment EPSDT and Well-Child Visits Program **50**
EPSDT covers: 50
Well-child visits (Child Health Check-Up Visits) include: 50
Lead Screening: 51
Provider Documentation of EPSDT Services: 51
Vaccines for Children Program **51**
Florida SHOTS **52**
Vaccines for Adults Program **52**
Nursing Facility Notification Requirements **53**
7. Member Complaints, Grievances, and Appeals **54**
Member Rights for Grievances and Appeals **54**
Definitions of a Member Complaint, Grievance, and Appeal **55**
Complaint 55
Grievance 55
Appeal 56
Filing Grievances and Appeals **56**
Enrollee Appeals 57
Medicaid Fair Hearing **57**
Trends of Complaints, Grievances, and Appeals **57**
Provider Assistance with Enrollee Grievances and Appeals **58**
GRIEVANCE/APPEAL DEPARTMENT 58
Expedited Appeals **58**
8. Concierge Care Coordination Model **59**
Case Management and Chronic Disease Management **60**
Case Management (CM) Program Overview 60
Integrated Medical and Behavioral Health Approach **61**
Identification of Members for Case Management and Condition Management **61**

Case Management Levels for Members **62**
Complex Case Management ____ 62
Emerging Complex Case Management ____ 62
Chronic Condition Management ____ 62
Health and Wellness Management ____ 62

Case Management for Serious Mental Illness Specialty Population **62**

Condition-Specific Programs **63**

HOPE Florida Program **64**

Health Snapshot **65**

Disease Management **65**

PCP Role **66**

Disease Manager's Role **66**

9. Quality Improvement ____ 67

Quality Improvement (QI) Program Overview **67**

Quality Improvement (QI) Program Goals and Activities **68**

Working With Our Providers **68**

Quality Improvement Committee and Sub-Committees **69**
Quality Improvement (QI) Committee and Sub-Committees Overview ____ 69
Quality Improvement (QI) Committee ____ 69
Credentialing Committee ____ 70
Provider Operations Committee ____ 70
Provider Advisory Committee ____ 70
Medical Operations Committee ____ 70
HEDIS Committee ____ 71
Information Technology Governance Committee ____ 71
Grievance And Appeals Committee ____ 71
Claims Committee ____ 72
Member Services Committee ____ 72

Quality Improvement Activities **72**
Monitoring Patient Safety/Quality Care ____ 72
Adverse Incident ____ 72
Serious Adverse Event (SAE) ____ 73

Monitoring Provider Access and Availability **73**
Timely Access Requirement ____ 74
Access Guidelines ____ 74
Monitoring Quality Outcomes ____ 74
State Performance Measures ____ 75
Member Satisfaction Surveys ____ 75
Provider Satisfaction Surveys ____ 75
Quality Studies/Improvement Projects ____ 76

Fraud, Waste and Abuse (FWA) **76**
Special Investigations Unit ____ 76
Office of Inspector General (OIG)/General Services Administration (GSA) Exclusion ____ 76
Provider Implementation of FWA Safeguards ____ 77
False Claims Act ____ 77
Health Care Laws ____ 77

Authority and Responsibility 78

10. Provider Roles, Rights, and Responsibilities 79

All CCP Providers' Responsibilities 79
PCP Responsibilities and Covered Services 81

Health Risk Assessment 81
Procedures 82
Provider Responsibilities 82
Monitoring and Compliance 83
Support and Resources: 83
Covered PCP Services 83

Provider Programs and Accountabilities 84
PCPs and the Patient-Centered Medical Home (PCMH) Program 84
Programs 85
Preferred Provider Group Program for High-Performing Providers 86
Recognition and Incentives 86
Monitoring and Evaluation 87
Provider Responsibilities 87

Coordination Between Physical and Behavioral Health 87
Special Considerations 88
Support and Assistance 88

Telemedicine 88

Responsibilities of Network Specialists 89

Responsibilities of Network Hospitals 89

11. Provider Administration 90

Provider Services and Support 90
Contact Information: 90

Provider Office Standards 90

Consumer Assistance Notice 90

Provider Training 91
Initial Training 91
Required Training 91
Behavioral Health Clinical Training 92

Provider Termination 92

Provider Marketing Activities 92

Medical Record Documentation 93

Cultural Competency 94
Provider Assistance with Cultural Competency Needs 94

PCP Member Panel Capacity 95
Panel Member Dismissal 95

Provider Coordination with Carve-out Public Health Services 96

Provider Complaints 97

12. Member Rights and Responsibilities 98
Advance Directives 99
13. Pharmacy Program 100
Pharmacy Benefit 100
Pharmacy Benefit Manager 101
Preferred Drug List 102
Newly Approved Medications 102
DESI or IRS Drugs 102
Controlled Substances 102
Hemophilia Medications 102
Dispensing Limits 102
Over-the-Counter (OTC) Items 103
Prior Authorization Process 103
Medications 103
Non-Specialty/Retail Medications 103
Specialty Medications 103
72-Hour Emergency Supply Policy 103
Exclusions 104
Psychotropic Medications 104
Medication Therapy Management (MTM) Services 104
14. Claims Coding and Billing 105
Risk Adjustment 105
Encounters 105
Electronic Data Interchange (EDI) 105
Required Provider Information 106
Coordination of Benefits 106
Claim Submission 106
Member Billing 106
Verification Procedures 106
Clean vs. Unclean Claims 107
Common Reasons for Claim Denial 107
Timely Claim Submission 107
Corrected Claims and Requests for Reconsideration/Claims Appeals and Disputes 108
Claims Payment: EFT and ERA 108
15. Code Editing 109
Code Editing Overview 109

CPT and HCPCS Coding Structure **109**
Level I HCPCS Codes 110
Level II HCPCS Codes 110
Miscellaneous/Unlisted Codes 110
Temporary National Codes 110
HCPCS Code Modifiers 110
International Classification of Diseases (ICD-10) 110
Revenue Codes 110

Edit Sources **111**

Code Editing and the Claims Adjustment Cycle **111**
Code Editing Principles 112
Edits 113

Administrative and Consistency Rules **115**
Prepayment Clinical Validation 115
Modifier 59 115
Modifier 25 116
Code Editing Assistant 116
Third-Party Liability 116

16. Serious Mental Illness **117**

Specialized Provider Education Requirements **117**
Behavioral Health and Substance Use 117
Treatment Adherence Services Available 118
Procedures for Required Use 118

Specialty Case Management Policies and Procedures **120**

Referral to Services **121**

Enrollee Access to Clinical Trials **121**

Coordination Protocols for Community Mental Health Centers **122**
Quality Measurement Standards and Data Exchange 122
Data Exchange 123

17. Medicaid Behavioral Health Services **124**

Documentation Guidance **124**
Applicable AHCA Coverage Policies 124
Medical Record Documentation Requirements 124
Behavioral/Mental Health Diagnosis 124
Patient Treatment Plan 124
Daily Progress Notes 124
General Documentation Checklist 125

1. Welcome to Community Care Plan

We are pleased to welcome you as a network provider in the Community Care Plan (CCP), Florida's first and longest-standing Provider Service Network (PSN). CCP was awarded a contract by Florida's Agency for Health Care Administration (AHCA) for the Statewide Medicaid Managed Care (SMMC) program, selected as an MMA and Serious Mental Illness plan for regions E, F, G, H, and I. These regions include Orange, Osceola, Brevard, Seminole, Palm Beach, Indian River, Martin, Okeechobee, St. Lucie, Collier, Charlotte, DeSoto, Glades, Hendry, Lee, Sarasota, Broward, Miami-Dade, and Monroe counties.

Since 1970, Florida Medicaid has provided healthcare coverage for income-eligible children, seniors, disabled adults, and pregnant women, funded by state and federal governments. By joining our network, you become part of a team dedicated to meeting the high standards our community expects.

In October 2013, AHCA awarded CCP to provide Medicaid services in the SMMC program as a capitated PSN. Established by the 2011 Florida Legislature through House Bill 7107, SMMC integrates managed care for all covered services, including long-term care, across the state.

Thank you for partnering with CCP. Your commitment to delivering quality medical care to our enrollees is valued, and together, we can achieve our shared goal of enhancing patient outcomes and fostering a healthier community.

This comprehensive provider manual is designed to facilitate your seamless integration into our network and ensure high-quality care for our enrollees. It is a vital resource, offering guidance on our operational procedures, policies, and collaborative approach to meeting our community's healthcare needs. Our commitment to excellence is reflected in our continuous efforts to support our providers with the tools and information necessary to navigate the complexities of managed care.

This manual answers many of your questions about CCP and how it works. It outlines the policies, procedures, and programs you have agreed to comply with, as presented in our Provider Services Agreement. We request your expertise to ensure the care provided to enrollees meets the performance standards and indicators outlined. Please review this material to understand your role in providing services to CCP enrollees and complying with program requirements.

A quick reference Important Contacts list is on the next page for your convenience. If you have questions or need further information about the program or policies contained in this manual, we encourage you to contact your Provider Relations Operations Representative.

Please note that this manual and its contents are subject to change. We will make every effort to inform you of significant changes to our policies and procedures through newsletters and alerts distributed via email, fax, and our website.

Our providers are crucial to our success as the first and longest-standing Provider Service Network in Florida, and we look forward to a rewarding business relationship.

Thank you,

Community Care Plan
The Health Plan with a Heart

Key Contacts and Phone Numbers

Community Care Plan MMA	
Community Care Plan 1643 Harrison Parkway Building H, Suite 200 Sunrise, Florida 33323	
Provider Operations	**60**
Phone: 1-855-819-9506 Email: ccp.provider@ccpcares.org	Phone: 1-866-899-4828
Credentialing	**Plan Link Web Portal**
Phone: 1-844-618-5773 Email: credentialingdept@ccpcares.org	Phone: 1-844-514-1494 Website: http://planlink.ccpcares.org/
Case Management	**Disease Management**
Phone: 1-866-899-4828	Phone: 1-866-899-4828
Claims and Billing	
Electronic Claims: Community Care Plan (CCP) Availity Payer ID: 59065	Mail claims with attachments to: CCP Claims Department PO BOX 841309 Pembroke Pines, FL 33084
Claim Timely Filing	**Claims Inquiries**
180 days from date of service or date	Phone: 1-866-899-4828
Prior Authorization Inquiries	**Fraud & Abuse Hotline**
Phone: 1-866-899-4828	Phone: 1-888-419-3456
Emergency 24/7 Behavioral Health Crisis Hotline	
1-877-400-4999 OR 2-1-1 Broward 1-954-372-1737	
Vendors	
Pharmacy	Prime Pharmacy Solution 1-800-424-7897
Home Health and DME	Coastal 1-855-481-0505
PT, OT, ST, Podiatry, & Dermatology	Emboss Specialty 1-888-550-8800 Option 2
Vision	South Florida Vision/2020/iCare 1-877-296-0799
Transportation	ModivCare 1-866-306-9358

Provision of Services

Community Care Plan (CCP) covered services are provided in accordance with the Florida Medicaid State Plan and are required to be medically necessary as defined in the Florida Medicaid Provider coverage policies (formerly handbooks). These services are provided up to the coverage limits specified by the Medicaid program. Detailed information on these limits can be found in the respective Florida Medicaid Coverage and Limitations Rules and Medicaid Fee Schedules, available at the following links:

- Florida Medicaid Coverage and Limitations Rules
- Medicaid Fee Schedules

Medicaid in Florida

Medicaid, funded by both state and federal governments, provides essential health coverage for low-income families and individuals. The program aims to improve the health of those who might otherwise lack access to medical care for themselves and their children.

In 2011, the Florida Legislature established the Florida Medicaid program as a statewide, integrated managed care system for all covered services, including long-term care, known as the Statewide Medicaid Managed Care (SMMC) program. This program is administered by the Florida Agency for Health Care Administration (AHCA), with most Florida Medicaid recipients enrolled in the SMMC program.

The SMMC program includes three components:

1. Managed Medical Assistance (MMA): Provides primary and acute medical services.
2. Long-Term Care (LTC): Offers long-term care services to eligible recipients.
3. Dental Program: Ensures access to dental services for Medicaid recipients.

Community Care Plan (CCP) operates as a Provider Service Network (PSN) and is committed to delivering high-quality healthcare services to Medicaid recipients. AHCA has approved CCP to provide MMA and SMI services in designated regions E-I, ensuring comprehensive care for our members.

Medicaid recipients who qualify and enroll in the Florida MMA program receive all necessary healthcare services, through their selected Medicaid health plan.

The minimum required MMA services, as specified by AHCA, include the following:

- Allergy Services: Rule 59G-4.013
- Ambulance Transportation Services: Rule 59G-4.015
- Ambulatory Surgical Center Services: Rule 59G-4.020
- Anesthesia Services: Rule 59G-4.022
- Assistive Care Services: Rule 59G-4.025
- Behavior Analysis Services: Rule 59G-4.125
- Behavioral Health Assessment Services: Rule 59G-4.028
- Behavioral Health Community Support Services: Rule 59G-4.031
- Behavioral Health Intervention Services: Rule 59G-4.370
- Behavioral Health Medicaid Management Services: Rule 59G-4.029
- Behavioral Health Overlay Services: Rule 59G-4.027
- Behavioral Health Therapy Services: Rule 59G-4.052
- Cardiovascular Services: Rule 59G-4.033
- Child Health Services Targeted Case Management: Rule 59G-8.700
- Chiropractic Services: Rule 59G-4.040
- County Health Department Services: Rule 59G-4.055
- Dialysis Services: Rule 59G-4.105
- Durable Medical Equipment and Medical Supplies: Rule 59G-4.070
- Early Intervention Services: Rule 59G-4.085
- Emergency Transportation Services: Rule 59G-4.015
- Evaluation and Management Services: Rule 59G-4.087
- Federally Qualified Health Center Services: Rule 59G-4.100
- Gastrointestinal Services: Rule 59G-4.026
- Genitourinary Services: Rule 59G-4.108
- Hearing Services: Rule 59G-4.110
- Home Health Services: Rule 59G-4.130
- Hospice Services: Rule 59G-4.140
- Inpatient Hospital Services: Rule 59G-4.150
- Integumentary Services: Rule 59G-4.032
- Laboratory Services: Rule 59G-4.190
- Medicaid Forms: Rule 59G-1.045
- Medical Foster Care Services: Rule 59G-4.197
- Mental Health Targeted Case Management: Rule 59G-4.199
- Neurology Services: Rule 59G-4.201
- Non-Emergency Transportation Services: Rule 59G-4.330
- Nursing Facility Services: Rule 59G-4.200
- Occupational Therapy Services: Rule 59G-4.318
- Oral and Maxillofacial Surgery Services: Rule 59G-4.207
- Orthopedic Services: Rule 59G-4.211
- Outpatient Hospital Services: Rule 59G-4.160
- Pain Management Services: Rule 59G-4.222
- Personal Care Services: Rule 59G-4.215
- Physical Therapy Services: Rule 59G-4.320
- Podiatry Services: Rule 59G-4.220
- Prescribed Drug Services: Rule 59G-4.250
- Private Duty Nursing Services: Rule 59G-4.261
- Provider Reimbursement Schedules and Billing Codes: Rule 59G-4.002

- Radiology and Nuclear Medicine Services: Rule 59G-4.240
- Regional Perinatal Intensive Care Center Services: Rule 59G-4.264
- Reproductive Services: Rule 59G-4.030
- Respiratory System Services: Rule 59G-4.235
- Respiratory Therapy Services: Rule 59G-4.322
- Rural Health Clinic Services: Rule 59G-4.280
- Specialized Therapeutic Services: Rule 59G-4.295
- Speech-Language Pathology Services: Rule 59G-4.324
- Statewide Inpatient Psychiatric Program: Rule 59G-4.120
- Therapeutic Group Care Services: Rule 59G-4.295
- Transplant Services: Rule 59G-4.360
- Visual Aid Services: Rule 59G-4.340
- Visual Care Services: Rule 59G-4.210

In addition to the AHCA-required benefits, the Managed Care Plan (MCP) may offer certain alternative services, known as "in lieu of services" (ILOS), when medically appropriate and with Agency approval. These optional services can substitute for standard covered AHCA benefits. If a provider believes a member may benefit from an in lieu of service, the member must provide their consent. These enhanced and in lieu of services are designed to address the unique needs of our members and help prevent the need for higher levels of care or more costly services in the future. For a comprehensive list of benefits and services that require prior authorization, please visit CCP's Services Requiring Authorization.

About CCP

Community Care Plan ("CCP"), the health plan with a heart, was created in 2000 as South Florida Community Care Network and is based in Sunrise, Florida. We are owned by two large, well-respected hospitals, Broward Health and Memorial Healthcare System. We serve members in Medicaid, Florida Healthy Kids, self-insured employee health plans, and uninsured programs (managed by SydCura, our third-party administration division). We strive to ensure that every community has access to equitable, high-quality affordable healthcare.

Our health plans go beyond doctor visits. They cover a wide range of health and medical benefits and offer an excellent choice of providers and community resources to help overall well-being. Our team also works hard to provide personal and exceptional customer service.

CCP maintains Health Plan and Health Equity by the National Committee for Quality Assurance (NCQA) for its Medicaid Health Plan. We are also accredited by the Accreditation Association for Ambulatory Healthcare as a Health Plan.

Managed Medical Assistance (MMA)

The Managed Medical Assistance (MMA) program provides primary and acute medical services to Medicaid recipients. This program aims to ensure that beneficiaries receive comprehensive medical care through a managed care system. MMA is designed to enhance access to healthcare, improve quality of care, and reduce unnecessary emergency room visits and hospitalizations by providing coordinated care through managed care plans.

Serious Mental Illness (SMI)

The Serious Mental Illness (SMI) program addresses the needs of Medicaid recipients with significant mental health conditions. SMI services are tailored to individuals with diagnoses such as schizophrenia, bipolar disorder, major depressive disorder, and other severe psychiatric conditions. The SMI program focuses on providing comprehensive mental health care to improve

patients' overall well-being and stability, thereby reducing the risk of hospitalization, and promoting community integration.

CCP's Core Principles and Fundamental Behaviors

To help achieve excellence in our community, CCP's Core Principles support our vision and mission, and our Fundamental Behaviors represent the behaviors expected of our employees.

Core Principles

- Quality: Improve clinical excellence to exceed industry standards and customer expectations.
- Customer Service: Provide an excellent experience and superior services to our customers.
- Community: Develop preeminent community partnerships to meet the health and social needs of our enrollees.
- People: Create a values-driven culture that attracts, retains, and promotes the best and brightest people, who are committed to CCP's mission and vision.
- Finance: Achieve financial results through the provision of quality healthcare services, provider relationships, community partnerships, new technology, and investment in the organization.
- Growth: Promote growth to enhance and sustain excellence in service delivery and to support infrastructure improvements.

Fundamental Behaviors

- Do the right thing, always
- Show people you care
- Make it happen
- Honor commitments
- Embrace lessons
- Wildly celebrate success

CCP's Community Resource Center (CRC)

CCP operates Community Resource Centers (CRCs) to support our members and the community at large, by providing a variety of free health and social services. Here are some specifics about what you might find at a CCP Community Resource Center:

Free Services Offered at CCP Community Resource Centers (CRCs)

    - Healthcare Access, Navigation and Care Coordination
    - Assistance with finding healthcare providers.
    - Help with scheduling medical appointments.
    - A space for telehealth visits
    - Resources who can assist with Marketplace and other medical coverages.
- Health Education and Wellness Programs
    - Educational workshops on topics like nutrition, diabetes management, and healthy living.
    - Prenatal and postnatal care programs.
    - Preventive health measures and wellness tips.
- Social Services and Support
    - Referrals to housing assistance programs, food pantries, and other community resources.
    - Support with applications for additional social services like SNAP (food stamps).

- Behavioral Health Services
    - Access to mental health resources, including counseling and therapy services.
    - Substance abuse programs and support groups.
- Community Engagement and Events
    - Health fairs, vaccination clinics, and community wellness events.
    - Opportunities to engage with local health and social service providers.
    - Exercise and nutrition classes
    - Financial literacy and employment readiness programs
- Computer Center
    - Access to computers and printers for job search, resume writing, and schoolwork.
- Member Services (CCP plan members only):
    - Assistance with Medicaid renewal
    - Help with resolving issues related to benefits and services.
    - Language assistance and translation services.
    - 1:1 visits with a care manager or CCP pharmacist

How to Find a CCP Community Resource Center

To locate a CCP Community Resource Center near you, you can:

1. Visit the Community Care Plan Website: The official CCP website provides detailed information on the locations of CRCs and the services offered.
2. Contact CCP Member Services: You can call the member services number on the patient's Medicaid card for information on the nearest CRC and the available services.
3. Check Local Listings: Many CRCs are listed in local directories and community resource guides, which can be found online or at public libraries.

For the most accurate and up-to-date information, it is best to contact CCP directly or visit our website, www.ourheart.org. This will ensure you get the correct locations, contact numbers, and details on the services provided at each CRC.

Informational Provider Tools

To keep our providers updated on new programs, requirements, and policies, CCP utilizes a variety of communication tools:

- Direct Communications
    - Regular updates are available in CCP's website and are shared via email, or fax.
- Orientation and Training
    - Comprehensive new provider orientation sessions.
    - Web-based training modules are accessible anytime.
- Secure Provider Portal
    - Access to member eligibility verification.
    - Tools to manage claims and authorizations.
    - Guest access to check member eligibility, claim status and appeals
- Online Resources: Community Care Plan - Resources (ccpcares.org)
    - Extensive materials available on our website, including:
        - Provider Directory
        - Provider Manual
        - Practice Guidelines
        - Provider Trainings
        - Provider Newsletter
- Interactive Workshops
    - Specialized provider workshops on focused topics

CCP Website

Providers can access detailed information about CCP's policies, procedures, training, and quality programs on the CCP website: Community Care Plan - Resources (ccpcares.org).

Additionally, providers may:

- Access Useful Tools and Guides
- Training and Portal Access – including guest access
- Sign up for electronic funds transfers (EFT)
- Utilize the "Find Your Provider Representative" tool to identify the Provider Representative assigned to your practice, group, or facility

Provider Academy

At Community Care Plan (CCP), we are committed to supporting the ongoing education and professional development of our network providers through our Provider Academy. The Provider Academy offers a range of educational resources, training programs, and workshops designed to enhance clinical knowledge, improve patient care, and promote best practices in healthcare delivery.

Key features of the Provider Academy include:

- Continuing Education: Access to accredited courses and seminars covering a variety of clinical topics, including disease management, treatment guidelines, and evidence-based practices.
- Clinical Updates: Regular updates on industry trends, new technologies, and emerging treatments to keep providers informed and up to date.
- Provider Workshops: Interactive workshops led by industry experts on specialized topics, such as care coordination, quality improvement, and patient engagement.
- Resource Library: A comprehensive library of educational materials, clinical guidelines, and reference tools to support providers in their daily practice.

Health Library

Community Care Plan (CCP) offers a comprehensive health library to empower providers with reliable health information and resources. Key features include:

- Educational Articles: Covering a wide range of health topics, from chronic diseases to mental health and wellness.
- Interactive Tools: Assess health risks, track progress, and make informed decisions about healthcare.
- Healthy Living Tips: Practical advice on nutrition, exercise, stress management, and sleep hygiene.
- Videos and Webinars: Featuring experts discussing important health issues, treatment options, and preventive measures.
- Health Assessments: Identify potential health risks and take proactive steps to improve health.
- FAQs and Resources: Address common health concerns and provide further support and guidance.

Secure Provider Portal

Community Care Plan (CCP) allows providers and their office staff to register for the secure provider portal, PlanLink via CCP's secure registration site. In the secure PlanLink portal, providers can access tools designed to streamline obtaining and sharing information. Providers and their staff can:

- Confirm member eligibility, benefits, and PCP assignment
- Submit prior authorization requests
- View authorization and claim status
- Submit electronic claim appeals and corrections
- Send messages to CCP securely and confidentially

Provider Portal Overview

Member Benefits

At Community Care Plan (CCP), we offer a comprehensive range of benefits and expanded benefits across our various products. These benefits may vary depending on the specific product. Expanded benefits refer to additional goods or services that we provide at no cost to our members, enhancing their healthcare experience.

In addition, certain covered services may require prior authorization to ensure appropriate utilization and coordination of care.

Standard Benefits

Community Care Plan (CCP) Florida Medicaid offers a comprehensive range of standard benefits to ensure our members receive quality healthcare services. These standard benefits are designed to meet the diverse needs of our Medicaid population and promote overall health and well-being. Our standard benefits include, but are not limited to:

- Advanced Practice Registered Nurse
- Ambulatory Surgical Center Services
  - Non-Emergency Dental Services in ASC and Outpatient Hospital Settings (Effective October 1, 2025): Beginning October 1, 2025, payment responsibility for non-emergency outpatient dental anesthesiology and sedation services performed in Ambulatory Surgical Centers (ASC) or hospital settings will move from Medicaid dental plans to Medicaid health plans. Dental plans will continue covering these services when provided in an office setting. Health and dental plans must ensure continuity of care for at least 60 days following the transition.
- Assistive Care Services
- Behavioral Health Services
- Birth Center and Licensed Midwife Services
- Clinic Services
- Chiropractic Services
- Child Health Check Up
- Immunizations
- Early Intervention Services
- Emergency Services
- Family Planning Services and Supplies
- Healthy Start Services
- Hearing Services
- Home Health Services and Nursing Care
- Hospice Services
- Hospital Services
- Laboratory and Imaging Services
- Medical Foster Care Services
- Medical Supplies, Equipment, Prostheses
- Orthoses
- Nursing Facility Services
- Optometric and Vision Services
- Physician Assistant Services
- Physician Services
- Podiatric Services

- Prescribed Drug Services
- Renal Dialysis Services
- Therapy Services
- Transportation Service

Expanded Benefits

Community Care Plan (CCP) Florida Medicaid goes beyond standard benefits by offering a range of expanded benefits to enhance the healthcare experience for our members. These expanded benefits are provided at no additional cost and are aimed at addressing the unique needs of our Medicaid population. Our expanded benefits may include, but are not limited to:

- Asthma Home Care
- Cellular Phone Services
- Disaster Relief Benefit
- Doula Services
- Financial Literacy
- Fitness Benefit
- Food Assistance
- Home Delivered Meals
- Housing Assistance
- Medication Assisted Treatment Services
- Member Support
- Mother and Baby Item Benefit
- Newborn Circumcision
- Transportation (includes non-emergency, non-medical, and/or caregiver transportation)
- Nutritional Counseling
- Opioid Use Disorder/Substance Use Disorder Support
- Over-The-Counter Medications and Supplies
- Prenatal Services
- Swimming Lessons
- Tutoring, Vocational Training, and/or Job Readiness
- Virtual Pregnancy and Lactation Support

Adult Expanded Benefits

- Activity Therapy
- Acupuncture
- Adult Additional Primary Care Services
- Adult Visual Aid and Hearing Services
- Behavioral – Assessment/Evaluation and Screening Services
- Behavioral – Intensive Outpatient Treatment
- Behavioral Health – Individual Therapy Sessions to Caregivers
- Behavioral Health Day Services/Day Treatment
- Behavioral Health Medical Services
- Caregiver Support, Education, and Training
- Chiropractic Services
- Computerized Cognitive Behavioral Therapy
- Financial Literacy
- Home Visit by a Clinical Social Worker
- Massage Therapy
- Medical Therapies
- Substance Abuse Treatment or Detoxification Services
- Therapeutic Behavioral On-Site Services
- Therapy/Psychotherapy
- Legal Guardianship Assistance
- Peer Support Counseling

In Lieu of Services

Service	In Lieu of Service	Coverage/Limitations	Prior Auth Required
Inpatient Detox Hospital Care	Ambulatory Detox	All ages with a substance use disorder and for whom ambulatory detoxification services can shorten the length of stay in an inpatient detoxification hospital or eliminate the need for an inpatient stay.	Prior Auth REQUIRED
Therapeutic Group Care or Statewide Inpatient Psychiatric Program	Community-Based Wrap-Around	Members 0-21 years old with a Serious Emotional Disturbance (SED) diagnosis who could benefit from community-based wraparound as a diversion to higher levels of residential care. Per day.	Prior Auth REQUIRED
Inpatient Psychiatric Hospital	Crisis Stabilization Units (CSU) †	All ages who meet medical necessity criteria and can be diverted from Inpatient Psychiatric Hospitalization, Emergency Room or Out of Home Placement. Maximum 15 days per month	Prior Auth REQUIRED

Service	In Lieu of Service	Coverage/Limitations	Prior Auth Required
Inpatient Detox Hospital	Detox or Addictions Receiving Facilities †	All ages for whom detoxification is indicated, meets ASAM Criteria Level 3.7 WM, and can be diverted from Inpatient Detoxification Hospitalization, Emergency Room or Out of Home Placement. Maximum 15 days per month	Prior Auth REQUIRED
Clubhouse	Drop-in Center	Members with a behavioral health diagnosis who could benefit from social skills support. Per day	Prior Auth NOT Required
Therapeutic Behavioral On-site(TBOS)	Family Training/Counseling for Child Development	Members 0-21 years old with a Serious Emotional Disturbance (SED) diagnosis whose caregivers could benefit from assistance. Per unit (1 unit = 15 minutes)	Prior Auth NOT Required
Inpatient Psychiatric Hospital	Specialty Psychiatric Hospitals †	All ages who meet medical necessity criteria and can be diverted from Inpatient Psychiatric Hospitalization, Emergency Room or Out of Home Placement. Maximum 15 days per month	Prior Auth REQUIRED

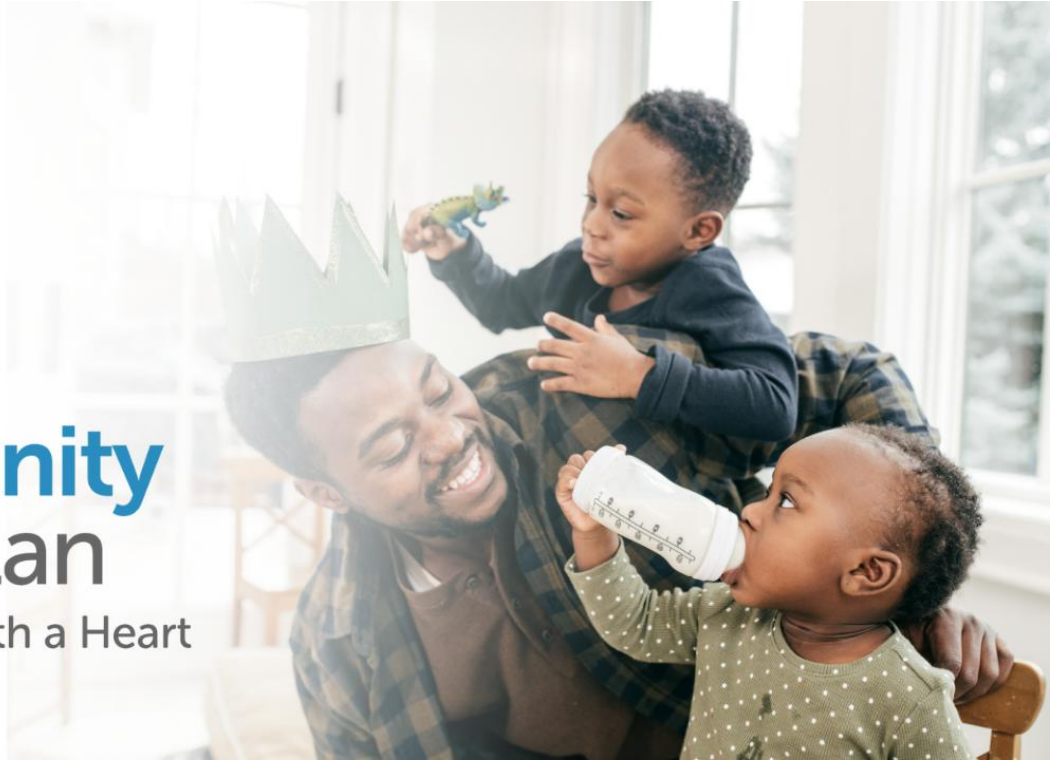
Service	In Lieu of Service	Coverage/Limitations	Prior Auth Required
Psychological Testing	Infant Mental Health Pre and Post Testing	Children ages 0-5 years old experiencing developmental delays, or having difficulty bonding with caregivers, who may benefit from specialized programs. Per unit (1 unit = 15 minutes)	Prior Auth NOT Required
Inpatient Hospital	Intensive Outpatient Mental Health		Prior Auth REQUIRED
Inpatient Psychiatric Hospital Care	Mental Health Partial Hospitalization Program (PHP)	All ages with mental health or substance use disorder(s) where PHP services can shorten the length of stay in an inpatient facility or eliminate the need for an inpatient stay.	Prior Auth REQUIRED
Emergency Behavioral Health Care	Mobile Crisis Assessment/Intervention	All ages who are experiencing a behavioral health crisis and may benefit from the service as a diversion to an inpatient admission, emergency room, or out of home placement.	Prior Auth NOT Required
Inpatient and Residential Stay or Statewide Inpatient Psychiatric Program	Multi Systemic Therapy	Members ages 12 -17 who are experiencing mental health issues, are at risk for or actively engaging in delinquent activity or substance misuse and are at risk for or in out of home placement. Per unit (1 unit = 15 minutes)	Prior Auth NOT Required

Service	In Lieu of Service	Coverage/Limitations	Prior Auth Required
Inpatient Psychiatric Care	Partial Hospitalization in a Hospital	All ages with mental health or substance use disorder(s) where PHP services can shorten the length of stay in an inpatient facility or eliminate the need for an inpatient stay. Per day	Prior Auth REQUIRED
Psychosocial Rehab	Self-help/Peer Services	All ages with mental health or substance use disorder(s). Per unit (1 unit = 15 minutes)	Prior Auth NOT Required
Inpatient Detoxification	Substance Abuse Intensive Outpatient Program (IOP)	Members with a substance abuse or mental health diagnosis who can benefit from a community-based treatment program to prevent, or reduce the need for, inpatient psychiatric and detoxification hospitalization and to reduce or stabilize symptoms and functional impairment of a substance use or co-occurring disorder. Per day	Prior Auth REQUIRED
Inpatient Detoxification Hospital Care	Substance Abuse Short-term Residential Treatment (SRT)	Any member with a substance abuse or mental health diagnosis that meets medical necessity criteria for Short Term Residential treatment. Maximum 15 days per event, three times in a calendar year	Prior Auth REQUIRED

Service	In Lieu of Service	Coverage/Limitations	Prior Auth Required
In-person visits for mental illness and substance use disorder	Telehealth visits		Prior Auth NOT Required
Psychotropic injection services provided by physician to adults	Psychotropic injection services provided by licensed nurses to adults		

Member Incentive Programs

Community Care Plan (CCP) Florida Medicaid offers member incentive programs to promote healthy behaviors and active participation in healthcare. These programs include challenges, workshops, and rewards for preventive care, care coordination, medication adherence, healthy pregnancies, smoking cessation, weight management, and more. Incentives encourage members to engage in their health and wellness journey actively. For details, review our Healthy Rewards.



Community Care Plan

The Health Plan with a Heart

2. Member Eligibility

Eligibility Determination

Medicaid eligibility in Florida is determined by the Department of Children and Families (DCF) or the Social Security Administration (SSA), which handles eligibility for individuals receiving Supplemental Security Income (SSI). DCF determines Medicaid eligibility for the following groups:

- Parents and Caretaker Relatives of Children
- Children
- Pregnant Women
- Former Foster Care Individuals
- Non-Citizens with Medical Emergencies
- Aged or Disabled Individuals Not Currently Receiving SSI

Community Care Plan (CCP) works closely with DCF and SSA to ensure eligible individuals receive the healthcare services they need.

MMA

Until the actual date of enrollment with Community Care Plan's Managed Medical Assistance (MMA), CCP is not financially responsible for services the prospective member receives. Additionally, CCP is not financially responsible for services members receive after their coverage is terminated. However, CCP is responsible for any member who is enrolled in CCP at the time of a hospital inpatient admission, even if the member changes health plans during that confinement.

SMI

The Serious Mental Illness (SMI) Plan is tailored to support members aged 6 and older who have one or more of the following conditions:

- Psychotic Disorders
- Bipolar Disorders
- Major Depression
- Schizoaffective Disorder
- Delusional Disorders
- Obsessive-Compulsive Disorder (OCD

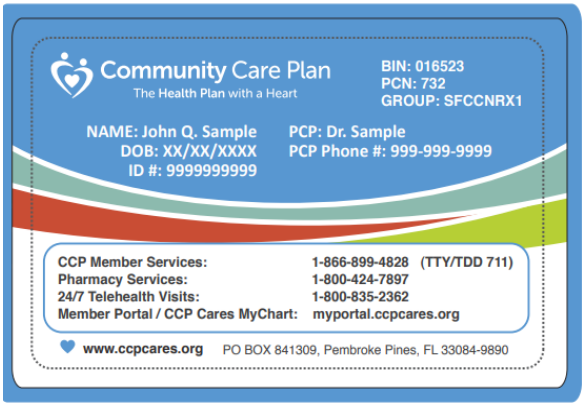
This plan is focused on delivering comprehensive care and support for individuals dealing with these significant mental health conditions.

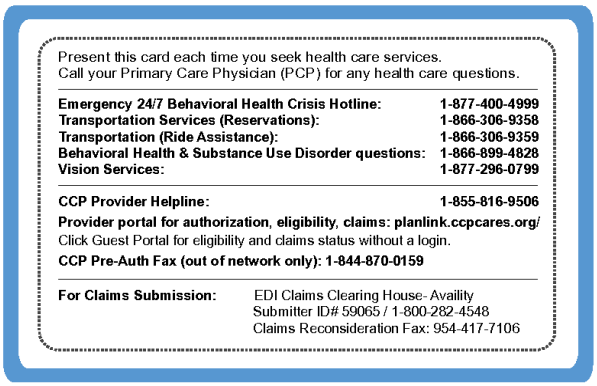
Member ID Cards

Each Community Care Plan (CCP) enrollee is issued an identification card, which serves to verify their identity and facilitate the verification of eligibility with CCP. However, it's important to note that simply having this card does not confirm active eligibility. Providers must confirm an enrollee's current eligibility status through the CCP Provider Web Portal (Login (mhs.net)) on the date of service. It is recommended that enrollees carry their identification cards consistently to ensure they can be properly identified and receive the services they are eligible for.

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.

Sample CCP Enrollee ID Card





Verifying Member Eligibility

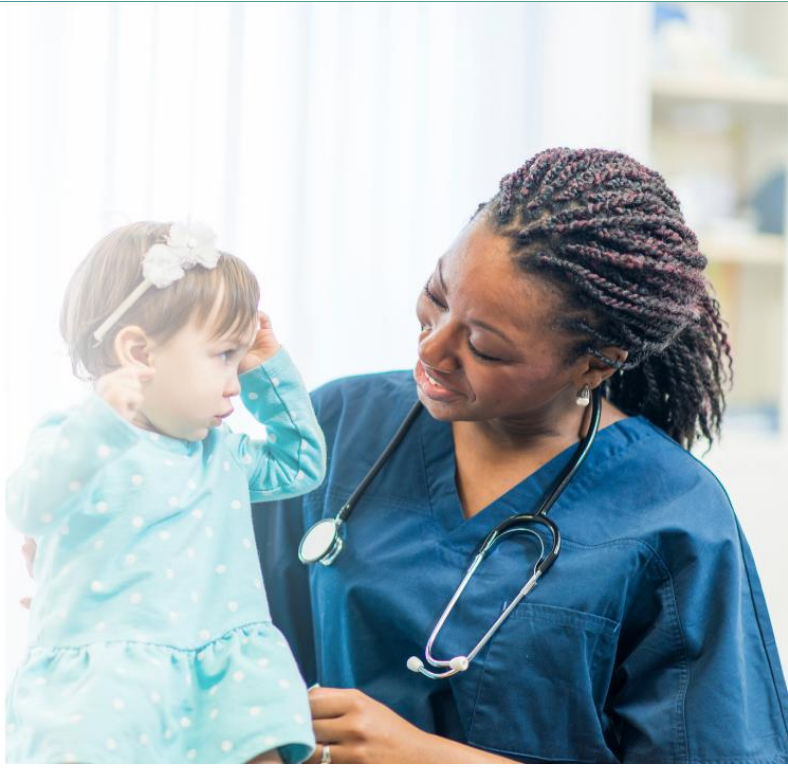
Community Care Plan (CCP) requires all providers to verify a member's eligibility before rendering any services. This verification must be completed each time a member schedules an appointment and again upon their arrival for services. Verifying eligibility is essential to ensure that the member is actively enrolled in the plan and that the services provided will be covered.

Even if a provider has received a referral or authorization number, it is still necessary to verify the member's eligibility, as a referral or authorization does not guarantee eligibility at the time of the visit. Providers should use the PlanLink provider portal to verify eligibility. If you are the Primary Care Provider (PCP) of record, your name will be displayed in the PlanLink portal as the member's "CCP-Assigned PCP," confirming your designation within the CCP network.

If a provider cannot confirm a member's eligibility or encounters any discrepancies, it is crucial to contact CCP's toll free help line before rendering services. This step helps avoid potential claim processing issues and ensures compliance with CCP's policies. By maintaining up-to-date eligibility verification practices, providers can ensure the seamless delivery of care and prevent unnecessary billing complications. Compliance with these verification requirements is an essential responsibility of all providers participating in the CCP network.

Methods to Verify Eligibility

Providers are encouraged to verify member eligibility using the CCP secure provider portal. Or, provider office staff without portal login credentials can quickly check member eligibility via the CCP Guest Eligibility Portal. To search, simply enter your group's tax ID, member's Medicaid ID number, date of birth, and legal sex. The results page also includes the member's PCP assignment and links to benefits and prior authorization information.



3. Credentialing and Recredentialing

CCP has established elevated standards for the selection and evaluation needed to maintain a high-quality care network of experienced, licensed practitioners and facilities that meet the qualifications and standards necessary to deliver services to our enrollees. The application process focuses on the review and verification of the below criteria.

Some practitioners and providers considered delegated entities follow CCP's policies and perform their own credentialing under the support and approval of CCP through a delegation contract with oversight by CCP.

Credentialing Contact Information

Phone: 844-618-5773
Credentialing E-mail: credentialingdept@ccpcares.org

Eligibility and Standards

- Eligibility: Practitioners and providers must meet the minimum qualifications outlined by the Florida Agency for Health Care Administration (AHCA), the National Committee for Quality Assurance (NCQA), and CCP.
- Credentialing Department: Responsible for verifying information from all medical, long-term care, and behavioral health practitioners and providers seeking contracts with CCP. This process applies to all lines of business, except for non-traditional long-term care providers.

Credentialing Application Completeness

- Application Submission: Providers must ensure that all required documentation is complete and uploaded within their CAQH profile or credentialing application file. Incomplete applications will not begin processing, which may result in delays.
- Resources: Detailed guidance and resource for completing credentialing applications are available on the CCP website at CCPcares.org

Practitioner Credentialing

- Includes physicians, advanced registered nurse practitioners, physician assistants, podiatrists, chiropractors, and therapists (occupational, physical, and speech).
- Verification of license, DEA registration, education, training, board certifications, hospital privileges, malpractice history, sanctions or exclusions, legal actions, Medicare opt-out status, Social Security Death Master File, Level 2 background check, unsanctioned ownership, and work history.
- Site visits are conducted for primary care physician (PCP) practices, obstetrics and gynecology (OB/GYN) practices, assisted living facilities, and adult family care homes.
- Final approval by a senior medical director and credentialing committee review if needed.

Provider Credentialing

- Includes hospitals, surgical centers, urgent care centers, diagnostic centers, living facilities, health centers, mental health centers, rehabilitation centers, skilled nursing facilities, home health agencies, durable medical equipment providers, home delivery meal providers, homemaker and companion services, hospice facilities, adult day care centers, adult family care homes, assisted living facilities, and contractors for pest control, home modification, and other services.
- Verification of the facility's license, accreditation, standing with regulatory agencies, and unsanctioned ownership.
- Site visits are conducted for non-accredited facilities, PCPs, and OB/GYNs.

Application Process

- Takes up to 60 days to complete the credentialing process for MMA providers, and up to 90 days for all other providers.
- Requires submission of various documents, including the CCP application or CAQH Provider Data Collection form, malpractice insurance policy or attested coverage amounts on application, W-9, board certification, CV, ownership disclosure, hospital privileges, DEA registration, and unrestricted medical license.
- Behavioral health practitioners must also submit a specialty profile and Accelerated Resolution Therapy (ART) certification, if applicable.

Recredentialing

All providers within the Community Care Plan (CCP) network must undergo recredentialing every three years to ensure ongoing compliance with our quality standards. This mandatory process requires the submission of updated licensure, board certifications, malpractice insurance, and any other necessary credentials. Providers must also report any changes in practice locations, ownership, or legal and disciplinary actions since their last credentialing.

As part of recredentialing, CCP reviews the provider's performance, including quality of care, member complaints, and adherence to CCP policies. Providers identified with deficiencies may need to complete additional training or corrective actions. Providers are responsible for meeting recredentialing requirements by the specified deadlines to avoid suspension or termination from the CCP network. Notifications of upcoming recredentialing will be provided in advance, and timely submission of all required documents is essential to maintaining network participation.

Standards and Compliance

- CCP adheres to federal and state laws, ethical business conduct standards, and privacy regulations (HIPAA).
- Ensures non-discrimination in accordance with ACA Section 1557.

Quality Assurance

- Focuses on quality, safety, and accessibility.
- Establishes performance standards for office-site criteria, physical accessibility, appearance, waiting room, examination room spaces, and medical/treatment record-keeping.

Credentialing Requirements for MMA

The credentialing and recredentialing processes ensure participating practitioners and providers meet the criteria established by CCP, government regulations, and the standards of accrediting bodies. To maintain a current profile, practitioners and providers are required to promptly notify CCP of any relevant changes to their credentialing information.

Background Screening

All providers within the Community Care Plan (CCP) network must ensure that all staff, both licensed and non-licensed, undergo appropriate background screening in accordance with federal and state laws, including those mandated by the Florida Agency for Health Care Administration (AHCA). This requirement applies to all individuals involved in the care of CCP members or those with access to their personal information.

Providers are responsible for completing the required background screenings before an individual begins employment and must have policies for regular re-screening to maintain compliance. Records of these screenings must be accurately maintained and available for review upon request. Any findings that could affect an individual's suitability to provide care must be reported immediately to CCP. Non-compliance with these requirements may result in corrective actions, including suspension or termination from the CCP network.

Requirements for Practitioners

Practitioners must submit, at a minimum, the following information when applying for participation with CCP:

- CCP standardized application or online universal application, called a Council for Affordable Quality Healthcare (CAQH) Provider Data Collection form.
- Signed and dated attestation (not older than 180 days) 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 and/or alcohol abuse problems; mental and physical competence; and the ability to perform the essential functions of the position, with or without accommodation.
- Signed and dated authorization and release of information form (not older than 180 days)
    - Copy of current malpractice insurance 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 updated W-9.
    - Current copy of specialty/board certification, if applicable.
    - Curriculum vitae that lists, at a minimum, the most current five-year work history including month and year.

- Disclosure of ownership form per practice location, listing any individuals or facilities having ownership or control of the entity of 5% or greater; as well as any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control of the disclosing entity.
- List of current hospital privileges at a CCP participating facility or covering physician agreement form if no hospital admitting privileges exist.
- Number of current Drug Enforcement Administration (DEA) registration certificates.
- Number of current unrestricted medical licenses to practice in the relevant state.
- Total patient load for all PCPs and OB/GYNs.

In addition to the preceding list of items, behavioral health practitioners must also submit:

- Completed provider specialty profile.
- Current copy of Accelerated Resolution Therapy (ART) certification, if applicable.

CCP verifies the following information submitted for credentialing/recredentialing purposes:

- State license through appropriate licensing agency
- DEA license through issuing agency
- Board certification or residency training and/or medical education
- National Practitioner Data Bank (NPDB)
- Hospital privileges in good standing at a participating CCP hospital
- Work history for the past five years
- Federal sanction activity, including Medicare/Medicaid services (Office of Inspector General System for Award Management)
- Completion of a site visit for all PCPs and OB/GYNs
- Fully or limited enrolled Medicaid ID
- Individual and/or Organization NPI
- State sanction activity, including Medicare/Medicaid final orders

Site visits are conducted in accordance with federal, state, and accreditation requirements. Focusing on quality, safety, and accessibility, performance standards and thresholds were established for:

- Office-site criteria
- Physical accessibility
- Physical appearance
- Adequacy of waiting room and examination room spaces
- Medical/treatment record-keeping criteria

- Site visits are conducted for:
  - Unaccredited facilities
  - Primary Care Physicians
  - Obstetrics/Gynecology
  - Other high-volume specialties as identified by CCP
  - During initial credentialing and recredentialing
  - After a complaint related to office site or quality of care concern

Provider Requirements

Providers are required to submit a credentialing application. Once received, CCP verifies the following information for credentialing and recredentialing purposes:

- Accreditations with accepted agencies for each facility
- Certificates of license and AHCA inspection reports
- Federal Medicare and Medicaid sanctions
- Federal tax identification number (TIN)
- Liability claims against the provider in the past five years
- Medicaid eligibility
- National provider identifier (NPI) number
- Past or current disciplinary or legal action by the state of Florida against the provider

Behavioral Health Facilities

Behavioral health facilities/agencies must submit the following information when applying for participation with CCP:

- A complete signed and dated application
- List of current professional mental health/substance use disorder staff recommended for membership in the individual provider panel who are privileged to admit and/or treat members in the facility. This list should include license type, address, telephone numbers, Social Security numbers, and Council for Affordable Quality Healthcare (CAQH) number
- Copy of accreditation letter with dates of accreditation, along with a list of all practice locations covered under the applicable accreditation body from one of the following:
- Joint Commission on Accreditation of Health Care Organizations (JCAHO)
- Commission on the Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- American Osteopathic Hospital Association (AOHA)
- Copy of the state or local license(s) and/or certificate(s) under which the facility operates
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of current malpractice insurance policy face sheet, including expiration dates, amounts of coverage, name of the liability carrier, insurance effective and expiration dates (month/day/year), and the provider's name
- List 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
- Disclosure of ownership and controlling interest statement, if applicable
- For facilities contracted under a facility agreement that list a rendering NPI in box 24j of the claim form that is different from the facility's billing NPI (box 33a): an electronic (Excel) roster of clinicians rendering covered services with their credentialing materials

Facilities with targeted case management supervisors (TCM) and/or child behavioral health assessors (CBHA) must include a signed form as noted in the relevant Medicaid manual as part of the credentialing and recredentialing process and submit the appendices with updated rosters.

Non-accredited facilities must include the following in addition to the items listed 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

Facilities

Facilities must submit, the following information when applying for participation with CCP:

- A completed facility provider application, signed and dated within the last six months, which includes active NPI, tax identification number, service location, and active Medicaid and Medicare identification numbers, if available
- Current licensing: Medical, facility, and/or business tax receipt, as applicable to provider type
- No revocation, moratorium, or suspension of the facility's state license by AHCA or the Department of Health, if applicable
- License numbers and credentials for all relevant staff, including but not limited to physical/occupational/speech/respiratory therapists, certified nursing assistants, registered nurses, and licensed practical nurses
- Level II background result completed within the past five years for all administrators, owners, or responsible individuals
- Affidavit of attestation of compliance and AHCA level II background screening results for facility administrator, owner, or individual in charge
- Current general and professional liability cover sheet and workers' compensation face sheet, or exemption sheet, as applicable, indicating coverage limits and expiration dates, showing facility name and licensed service location address
- Current disclosure of ownership form per facility location, listing any individuals or facilities having an ownership or control in the entity of 5% or greater
- Current Medicaid identification number or, if not enrolled with Medicaid, submission of registration number or documentation of submission of the Medicaid provider registration form
- Explanation for any sanctions imposed on the facility by Medicare or Medicaid
- Behavioral management service attestation form, if applicable
- Current W-9 form

Additional Requirements for Accredited Facilities

- Copy of accreditation letter with dates of accreditation, along with a list of all practice locations covered under the applicable accreditation body from one of the following:
- Joint Commission on Accreditation of Health Care Organizations (JCAHO)
- Commission on the Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- American Osteopathic Hospital Association (AOHA)
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable

Additional Requirements for Non-Accredited Facilities

- 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

CCP verifies the following information submitted for facility credentialing and/or recredentialing purposes:

- State license through appropriate licensing agency
- Sanction activity from Medicare/Medicaid via the OIG/LEIE, SAM database as well as AHCA for any sanctions/exclusions
- Completion of a site visit for all assisted living facilities, adult family care homes, and adult day care centers
- Background check with the AHCA clearinghouse for all administrators, owners, or responsible individuals for the facility

Once the credentialing/recredentialing process is completed, the CCP credentialing committee makes a final decision on acceptance/continuance following its next regularly scheduled meeting. Facilities are notified of the decision within 60 days from the date of the committee meeting.

Credentialing Committee

The CCP credentialing committee establishes criteria for practitioner and provider participation and termination. Decisions are based on business needs, the completeness of the applicant's file, and the review of any sanctions or malpractice history, without consideration of race, ethnic/national identity, gender, age, sexual orientation, or types of procedures or plans in which the provider specializes.

Committee Meetings and Application Process

- Meetings: Held at least monthly, or as needed.
- Response Time: Applicants must respond to requests for additional information within 30 days, or the application process will be discontinued. Reconsideration requires resubmission of all updated documentation.

Site Visits

- Timing: Conducted during initial credentialing, recredentialing, and changes or additions to office locations.
- Scope: Includes all PCPs, pediatricians, OB/GYNs, high-volume behavioral health providers, and non-accredited facilities.
- Evaluation: A score of 80% or greater is required. Scores below 80% may result in rejection or continued review. Evaluations cover appearance, accessibility, record-keeping, and safety.

Ongoing Performance Monitoring

- Monthly Inquiries: Monitor for new adverse actions by regulatory bodies.
- Reports Review: Monthly review of state Office of Inspector General reports to identify any newly sanctioned or excluded practitioners/providers.

Recredentialing

To comply with accreditation standards, CCP conducts the recredentialing process for practitioners and providers at least every three years from the initial credentialing decision.

Recredentialing Process

- Frequency: At least every 36 months.
- Review Elements: Changes in licensure, sanctions, certification, competence, or health status. Also includes provider-specific performance data, member complaints, grievances, and other quality improvement activities.

Interim Credential Monitoring

- Practitioner Updates: Between cycles, practitioners may need to provide current proof of credentials such as state licensure, malpractice insurance, DEA registration, or cultural competency training.
- Provider Reviews: Accreditation, licensure, Medicaid eligibility, AHCA inspection reports, and trends in complaints, grievances, or quality of care/services.

Termination of Agreement

A practitioner or provider's agreement may be terminated at any time if the CCP board of directors or the credentialing committee determines they no longer meet credentialing requirements.

Right to Review and Correct Information

All providers and practitioners with CCP have the right to review information obtained by CCP for their credentialing/recredentialing applications. This includes information from outside primary sources such as the National Practitioner Data Bank, malpractice insurance carriers, the Florida State Board of Medical Examiners, and the Florida State Board of Nursing for nurse practitioners. This does not include peer-review protected references, personal recommendations, or other confidential information.

Correcting Erroneous Information

- Discrepancies: Providers who believe any information used in the credentialing process is erroneous or differs from their submission have the right to correct it.
- Request Process: Submit a written request to the CCP Credentialing Department to release such information.
- Response Time: Information will be sent back via restricted delivery certified mail within 14 days of the request receipt.
- Correction Submission: Providers have 21 days to submit a written explanation detailing the error or discrepancy to CCP.
- Review: The credentialing committee includes this information as part of the credentialing/recredentialing process.

Application Status

Providers have the right to be informed of their application status upon request to the Credentialing Department.

Right to Appeal Adverse Credentialing Determinations

Practitioners and providers denied participation due to quality-of-care or liability claims can request reconsideration in writing within 30 days of the denial notice.

Request Process

- Submission: Written requests must include additional supporting documentation for reconsideration.
- Review Timeline: The Credentialing Committee will review the request at the next regular meeting, but no later than 60 days from receiving the additional documentation.
- Hearing Scheduling: If a hearing cannot be scheduled within six months due to unavailability, the request is considered withdrawn.
- Decision Notification: Applicants will receive a written response within 60 days of the final decision.

Practitioner Addition to Existing Practice

Contracted practices wishing to add a practitioner should email the Provider Demographic Form and the group's current W-9 to CCP.Provider@CCPCares.org. The Provider Operations department will confirm receipt and submit it to the credentialing department, which will request additional information if necessary. Note that all PCPs must complete a Patient Load Attestation Form.

Adding Facilities to an Existing Contract (for Hospital, Ancillary and Behavioral Health Facilities)

1. Please complete the appropriate Facility & Ancillary or Behavioral Health Credentialing Application:
    - Ensure the attached W-9 has been signed in the last 12 months
    - Ensure the application has been signed within the last 6 months
2. On Company Letterhead, please dictate:
    - Location Address of Performed Services
    - Billing Address of Performed Services
    - Main Phone # of the location
    - If the location should be listed in the health plan directory, specify all Health Plan Products to which the location should be added.
    - **Please Note:** Required to have an existing participating contract for the requested Line of Business (LOB)
3. Please complete the roster of Affiliated Providers

Next Steps:

- Once your email is received, a live representative will respond confirming receipt and informing you of the next steps.
- Once the credentialing process is completed, the Provider Representative emails the confirmation with approval letters and the effective date to the initial requester via email.

Provider Address and Demographic Information Changes

As a participating provider in the Community Care Plan (CCP) network, it is essential that you maintain accurate and up-to-date information for your practice to ensure effective communication, proper billing processes, and smooth member access to care. Providers are responsible for promptly notifying CCP of any changes to their address or demographic information, including office locations, mailing addresses, telephone numbers, fax numbers, or email addresses. Keeping this information current is crucial to avoid delays in payments, miscommunications, or disruptions that could affect patient care.

Furthermore, when new providers join your practice, it is important to inform CCP immediately and submit the necessary documentation to have the new provider added to the network. This ensures that the new provider is correctly listed in CCP's directories, can accept new members, and can serve the existing members without interruption. Similarly, if a provider leaves your practice, you must notify CCP as soon as possible to update the directories and prevent any potential confusion, claim denials, or inappropriate member assignments.

In addition to demographic changes, it is also necessary to inform CCP if your practice is no longer accepting new members. Accurate information regarding your capacity to accept new members helps prevent member frustration and ensures that CCP members can find the care they need in a timely manner.

In the event of a change in ownership of your practice, it is critical to report this to CCP promptly. Ownership changes can impact contract terms, billing information, provider listings, and member assignments, making timely communication essential to avoid service disruptions and ensure continued compliance with contractual obligations.

Notification Process

Providers should submit any changes to CCP's Provider Operations Department via email at CCP.Provider@ccpcares.org within 30 days of the change. CCP may request additional documentation to verify certain updates, such as ownership transitions or the addition of new providers. Failure to comply with these notification requirements may lead to administrative actions. The required documentation may be found in our website: Community Care Plan - Become a Provider (ccpcares.org). For any questions or assistance with the notification process, please contact your CCP Provider Operations representative.

CCP employs a specialized tool to monitor updates to provider demographic information from various reputable sources. This tool notifies CCP of any changes, prompting validation, and initiates electronic communication with providers, requesting self-validation of their information through a tailored survey. For providers who do not complete the electronic self-validation, a call campaign is conducted to ensure a thorough and comprehensive approach to the validation of all provider data.

4. Utilization Management

Overview

The Utilization Management (UM) program is designed to promote fair, impartial, and consistent utilization decisions and care coordination for health plan members. Our UM program aims to:

- Ensure Confidentiality: Safeguard the personal health information of our members.
- Enhance Practices: Initiate process improvement activities to continually refine our utilization management practices.
- Evidence-Based Decisions: Make decisions based on evidence, considering medical necessity, appropriateness, and the availability of benefits.
- Quality and Cost-Efficiency: Objectively monitor and evaluate the delivery of high-quality and cost-effective service.

Non-Discrimination Policy

We are committed to non-discrimination in providing services, regardless of an individual's race, color, national origin, sex, age, or disability. This includes ensuring that we do not wrongfully:

- Deny or limit coverage of an approved covered service, impose additional cost-sharing or other similar restrictions.
- Exclude or limit covered services related to gender treatment, as permitted under current State and Federal laws.
- Use discriminatory marketing practices or benefit designs.

Staff Compensation and Incentives

All UM employees must annually sign an affirmative statement regarding compensation. We prohibit compensation or incentives based on:

- The volume of adverse determinations.
- Reductions or limitations on lengths of stay, benefits, or services.
- Frequency of contact with healthcare practitioners or patients.

Fraud, Waste, and Abuse Prevention

Our UM policies and processes are integral in preventing, detecting, and responding to reports of fraud, waste, and abuse among practitioners and members. We collaborate closely with the compliance officer, risk manager, and CCP's special investigation unit to resolve any identified issues.

UM Contact Information

For inquiries or to request Utilization Management criteria, providers can contact CX at:

Phone: 1-866-899-4828
CCP Website: CCPcares.org - For Providers - Prior Auth Guidelines

Clinical Practice Guidelines

Our UM decisions are guided by various clinical practice guidelines to ensure appropriate care delivery, including but not limited to:

- Change Healthcare InterQual® Criteria: Utilized as a screening guide, not as a substitute for practitioner judgment.
- Florida Medicaid Coverage and Limitations Handbooks: Used to evaluate medical appropriateness and necessity.
- American Society of Addiction Medicine (ASAM): Guidelines for the treatment of substance use disorders.

Utilization review decisions adhere to these guidelines, medical necessity criteria Rule 59G-1.010 while also considering any special circumstances that may require deviations from standard criteria. The criteria in the clinical guidelines are used to ensure consistency. Guidelines are presented to the quality improvement committee for physician review and adoption, as appropriate. These Guidelines are updated at least every two (2) years or upon significant new scientific evidence or changes in national standards of care. View practice guidelines here.

Emergency Services

Emergency services are crucial in ensuring that members of Community Care Plan (CCP) receive timely and appropriate care during medical emergencies. Providers have several key responsibilities in the provision of these services. Emergency services are defined as those necessary for a medical condition that manifests with acute symptoms of sufficient severity, such as severe pain, where the absence of immediate medical attention could reasonably result in serious jeopardy to the individual's health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

CCP covers emergency services rendered by a qualified participating or non-participating provider until the member is stabilized. Providers must ensure that emergency services are available 24/7 without requiring prior authorization. In the event of a medical emergency, providers should deliver necessary care immediately. Post-service authorization and review will be conducted retrospectively to ensure coverage and medical necessity. Providers should notify CCP as soon as possible following the delivery of emergency services to facilitate appropriate follow-up care and ensure accurate claims processing.

Providers are responsible for promptly assessing the member's condition and providing stabilizing treatment or arranging for immediate transfer to a facility that can provide the necessary care. An appropriate medical screening examination must be performed to determine if an emergency medical condition exists. If such a condition is identified, the provider is responsible for rendering necessary stabilizing treatment or ensuring the member's safe transfer to an appropriate facility. If CCP determines that a medical emergency does not exist, CCP will reimburse the provider for any screening, evaluations, and examinations needed to make this determination, as defined by the requirements of the product in which the member is enrolled.

If the provider determines that an emergency medical or behavioral health condition exists, the facility to which the member was admitted is required to notify CCP within two (2) business days following the inpatient admission or after a Baker Act (BA52) psychiatric admission. If the facility is unable to notify CCP, it must document its attempts to notify CCP or the circumstances that prevented notification. Importantly, CCP does not deny payment for emergency services based on a facility's failure to comply with these notification requirements.

CCP covers any medically necessary stay in a non-participating facility resulting from a medical emergency until CCP can safely transport the member to a participating facility. The attending emergency physician or treating provider is responsible for determining when the member is stabilized for transfer. Providers must continue rendering medically necessary care until the member is safely transferred or discharged, regardless of the authorization status.

Coordination of care is essential following the provision of emergency services. Providers should work with the member's Primary Care Provider (PCP) and other relevant healthcare providers to ensure continuity of care, sharing relevant medical records and information to facilitate appropriate follow-up care. Emergency services must be billed in compliance with CCP's billing guidelines, with detailed documentation of the services provided, including the medical screening examination, treatment, and any transfer or discharge details.

Providers must also inform members of their rights and responsibilities regarding emergency services, including their right to access emergency care without prior authorization. It is important to educate members on when and how to seek emergency services and the importance of notifying their PCP following an emergency event. CCP will monitor the provision of emergency services to ensure compliance with federal and state regulations, as well as CCP's policies. Providers are expected to cooperate with CCP in this monitoring process, including providing access to relevant records and documentation. Non-compliance with emergency services responsibilities may result in corrective action, including reimbursement adjustments, contract termination, or other actions as deemed necessary by CCP.

Services Requiring Prior Authorization

Providers should refer to the Services Requiring Prior Authorization listing linked below to determine if prior authorization is needed for a specific service code. Providers may request authorizations through our secure provider portal PlanLink. The specific service requirements are integrated into many of these forms.

- Services Requiring Prior Authorization
- Provider Portal

Prior authorization requires the provider to make a formal medical necessity determination request to CCP before the service may be rendered.

Medical Necessity Definition

As defined in Rule 59G-1.010, F.A.C, "Medical necessity" or "medically necessary" refers to any goods or services provided in accordance with generally accepted standards of medical practice that are essential to alleviate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity. For Medicaid reimbursement, the agency is the final authority on medical necessity. In making these determinations, the agency must, as much as possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determinations must be based on the information available at the time the goods or services were provided.

Enrollment and Prior Authorization for Ongoing Services

Enrollees become effective in CCP either via a voluntary process (the individual elects CCP) or by an assigned process by AHCA when an individual does not choose a Medicaid managed care program. For both voluntary and assigned enrollees, written documentation of prior authorization of ongoing services will be honored for up to sixty (60) days after the effective date of enrollment in CCP or until CCP's PCP reviews the enrollee's treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment in CCP.
These services include:

- Prior existing orders (including Home Health and Durable Medical Equipment)
- Prior appointments and surgeries
- Prescriptions (including prescriptions at non-participating pharmacies)

CCP will not delay authorization if written documentation is not available in a timely manner.

MMA Members

For MMA members, prior authorization is generally required for:

- Non-emergency inpatient admissions
- Selected outpatient surgeries
- Durable medical equipment (DME)
- Home care services
- Hospice services
- Out-of-network services and providers
- High-tech radiology
- Specific behavioral health outpatient services

Serious Mental Illness (SMI) Members

For SMI members, prior authorization is required for:

- Non-emergency inpatient psychiatric admissions
- Intensive outpatient programs (IOP)
- Partial hospitalization programs (PHP)
- Residential treatment services
- Certain psychotropic medications
- Out-of-network behavioral health services
- High-tech radiology

Submitting Prior Authorization Requests

Providers must submit authorization requests through the Secure Provider Portal, PlanLink. Authorization requests submitted by fax for other medical and behavioral health services will not be processed unless PlanLink is temporarily technically unable to function, or the provider lacks Internet access.

Most Behavioral Health Outpatient Services do not require prior authorization. Providers should use the Pre-Auth Check Tool to determine if prior authorization is needed for a specific service code. To view these codes, select the Services Requiring Prior Authorization link and choose the product the CCP member is enrolled in.

For enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule, providers are asked to submit a prior authorization request through our secure provider portal PlanLink.

Requests for residential treatment (behavioral health or substance abuse) and admission into a State Inpatient Psychiatric Program, which require prior authorization, should be submitted via fax at 844-870-0159. Information and Prior Authorization Request Form is available on our web page Community Care Plan - Resources (ccpcares.org). DME and home-health requests related to hospital discharges should be faxed to Coastal Care Services.

Home Health Services must be ordered by the attending physician or primary care provider (PCP) at the time of discharge from a hospital or the community. The request should be faxed to Coastal either by the provider's office or the designated accepted entity as per CCP.

Coastal's Provider Services line is 833-204-4535

Please note that CCP has contracted home health care agencies. Enrollees may not directly seek services or call the companies. You need to seek authorization and coordinate the care with the enrollee. Practitioners, providers, and facilities must submit prior authorization requests for services in all lines of business within the following timeframes:

- Non-emergent/non-urgent pre-scheduled services requiring prior authorization: Within seven calendar days before the requested service date.
- Urgent or emergent inpatient admission: Within two business days following a medical admission or 24 hours following admission to a behavioral health facility.
- Emergent or urgent care services to stabilize a member: Prior authorization is not required.
- Hospice authorization requests for admissions that occur outside of business hours, including weekends and holidays: The following business day.

Timeliness of Decision

The CCP Utilization Management Department responds to requests for authorization within established timeframes as determined by NCQA guidelines and AHCA requirements for all Medicaid products.

Non-Urgent Pre-Service Determination

Determinations for non-urgent, pre-service medical, and behavioral health prior authorization requests are made within five calendar days of receiving the request. If CCP is unable to issue a decision due to matters beyond its control, it may extend the decision timeframe up to an additional four (4) calendar days.

For approved requests, the utilization management staff will provide written follow-up documentation to a non-participating provider within one (1) business day after determination.

Urgent or Expedited Pre-Service Determination

Determinations for urgent medical pre-service or expedited requests are made within 48 hours of receipt of the requests. If the utilization management staff requires additional information before issuing a determination, the staff may implement a one-time extension of one (1) additional calendar day.

If the request for authorization is approved, the utilization management staff will provide written follow-up documentation to a non-participating provider within one (1) business day after determination.

If the determination results in a denial, reduction, or termination of coverage, CCP will notify the requesting provider in writing within one business day. Written notification to the provider and member occurs within the same day or within the authorization review timeframe. The notification includes information about the member appeal process and the rationale used to make the adverse determination.

Urgent Concurrent and Post-Stabilization Determination

An urgent concurrent and post-stabilization request is a request for services made while the member is in the process of receiving care. An initial determination is issued within 48 hours of receipt of the request or 72 hours if additional information has been requested.

If the request is approved, the utilization management staff provides verbal or faxed notification within 24 hours. For continued inpatient stay requests, the practitioner and servicing facility may assume continued approval unless otherwise informed via a denial notification.

Medical Necessity Review

Upon receiving a request for service authorization from a practitioner or provider, a thorough review of the member's clinical information is conducted by a utilization management nurse or licensed clinician. This assessment encompasses various factors, including co-existing health conditions, psychosocial considerations, home environment, and support systems. The evaluation also incorporates AHCA MMA criteria for medical necessity, American Society of Addiction Medicine (ASAM) guidelines for substance use admissions, InterQual criteria, and other relevant guidelines such as those from Florida's Medicaid coverage and limitations policy or the Florida Department of Health.

Should the provided information not align with the applicable criteria, further review is undertaken by a medical director or qualified healthcare practitioner. In instances where a service is denied or restricted, the requesting provider retains the option to request a peer-to-peer review by contacting Member Services at 1-866-899-4828.

Prior authorization requires the provider or practitioner to make a formal medical necessity determination request to the CCP prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review. CCP's Medical Management Department reviews the Prior Authorization List regularly to determine if any services should be added or removed from the list. Such decisions are made in collaboration with the Provider Services Department. Providers are notified forty-five (45) days prior to any changes occur.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. All participating providers must use the provider portal, PlanLink, to request prior authorization of elective and scheduled services. The timeframes below comply with AHCA Requirements for decision-making. Turnaround times for authorization of requested services are as follows:

- Expedited requests will not exceed 2 business days.
- Standard requests will not exceed 5 calendar days.
- Retrospective / Post Service requests will not exceed 30 calendar days.

CCP has adopted utilization review criteria specific to the services provided, which include:

- Change Healthcare InterQual® level of care criteria. InterQual® is utilized as a screening guide and is not intended to be a substitute for practitioner judgment.
- As contractually indicated CCP will utilize the Florida Medicaid Coverage and Limitations Handbooks to evaluate requests for medical appropriateness/necessity.

American Society of Addiction Medicine (ASAM) Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, considering the special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used to approve medical necessity but not to deny services. The medical director reviews all potential denials of medical necessity.

When CCP Member Services receives a call from an enrollee or practitioner/provider regarding the UM process and authorization of care, the Member Services representative triages the call and warm transfers it to a UM nurse as needed. When addressing these calls, the UM staff will identify themselves by name, title, and organization name. This interaction will be documented in Tapestry via a Customer Relationship Management (CRM) record.

***Providers can request a copy of the Utilization Management criteria by contacting Member Services** at 866-899-4828*

Requests for services that do not meet criteria due to lack of information will be pended and returned to the requesting physician/provider's office for additional information. If, after receiving the additional information, InterQual® and other nationally recognized criteria and Medicaid Coverage and Limitations are still not met, the request will be forwarded to the Medical Director for review and determination. Practitioners can discuss any medical or behavioral UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Authorization will be required for all items listed on the Services Requiring Prior Authorization.

Providers may request authorization for medically necessary services to enrollees under the age of twenty-one (21) years when the service is not listed in the covered service in this manual or in the Florida Medicaid Coverage and Limitation Handbook, Florida Medicaid Coverage Policy or in the Medicaid Fee Schedule or if the service requested exceeds the amount, frequency, or duration of the published limitation. Any services on the authorization list that are rendered/performed without authorization from the health plan will be denied for lack of authorization. Authorization numbers will be assigned by CCP.

CCP, the health plan with a heart, wants you to know these important facts:

- Decision-making at CCP is based ONLY on the appropriateness of care and service and the existence of coverage.
- Community Care Plan does not reward practitioners, or other individuals for issuing denials of coverage.
- At CCP, our decisions are not connected to any financial incentive, and our staff is not encouraged to make decisions that result in underutilization.

Medical Necessity of Services Under CHCUP/EPSDT

The Child Health Check-Up Program (CHCUP), also known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program in Florida, offers comprehensive healthcare services to children under 21 years enrolled in Medicaid. Services covered under CHCUP/EPSDT must be deemed medically necessary to address the individual child's physical and mental health conditions.

In accordance with the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) requirements of 42 U.S.C. § 1396d(r) and all binding federal precedents interpreting it, Community Care Plan (the Plan) will, for Medicaid-eligible children under the age of twenty-one (21) years, pay for any "other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (42 U.S.C. 1396d(r)(5)). Community Care Plan will not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. Community Care Plan will process and authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.

Determinations of medical necessity for a child are made on a case-by-case basis, considering the child's unique needs. Providers may reach out to Member Services if they identify services not listed in the AHCA state benefit plan or exceeding benefit limits. The decision-making process factors in the child's long-term requirements, encompassing nutritional, social, developmental, mental health, and substance use disorder aspects. Experimental or investigational treatments are not covered under CHCUP/EPSDT.

Additional considerations for medical necessity under CHCUP/EPSDT include:

- Cost considerations, where services are not denied solely based on cost, but the cost-effectiveness of alternatives may be weighed during prior authorization.
- Approval of services in the most cost-effective mode if equally effective and available.
- Consideration of the child's quality of life.
- Delivery of services in the most integrated setting suitable for the child's needs.

Post-Service Decisions/Retrospective Review

CCP conducts retrospective medical necessity reviews for services rendered without prior authorization or timely notification in specific scenarios, including:

- Inpatient admissions when the member remains hospitalized.
- Outpatient services ongoing for a member still receiving services requiring authorization.
- Planned transplants pending completion.
- Hospice therapy for members under 21 years.

These reviews follow the same procedures outlined in the urgent pre-service decisions (expedited prior authorization) section. CCP does not conduct retrospective review determinations for already-rendered services. Medical providers may submit claims for processing, resulting in

denials marked as “services not authorized.” Providers may initiate the provider dispute (first level) resolution process post-denial receipt.

Continuity of Care

Continuity of Care in New Members

CCP facilitates the continuity of physical and behavioral health services for all new members to ensure uninterrupted care. This encompasses services previously authorized with non-participating providers. The continuity-of-care (COC) duration is ninety (90) days after the effective date of enrollment. The plan will provide continuation of services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan. The Plan will honor any written documentation of prior authorization of ongoing covered services for a period of up to ninety (90) days after the effective date of enrollment. Ongoing medical and behavioral health services or treatment may include:

- Behavioral health services
- Obstetrical care, with approval for all prenatal, delivery, and postpartum care from the current maternity provider and delivering facility, irrespective of trimester
- Prescriptions
- Previously ordered services, including transplant services (through the first transplant year) and ongoing rounds of radiation and/or chemotherapy
- Scheduled provider appointments and surgeries

The following services may extend beyond the ninety (90) day continuity of care period, and Community Care Plan will continue the entire course of treatment with the recipient’s current provider as described below:

- Prenatal and postpartum care – The Plan will continue to pay for services provided by a pregnant woman’s current provider for the entire course of her pregnancy, including the completion of her postpartum care (six (6) weeks after birth), regardless of whether the provider is in the Plan’s network.
- Transplant services (through the first-year post-transplant) – The Plan will continue to pay for services provided by the current provider for one (1) year post-transplant, regardless of whether the provider is in the Plan’s network.
- Oncology (Radiation and/or Chemotherapy services for the current round of treatment) – The Plan will continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the Plan’s network.
- Full course of therapy for Hepatitis C treatment drugs

Continuity of Care Following Provider Termination

Providers ending affiliation with CCP are obligated to provide medically necessary care for members for at least ninety (90) days post-termination across all lines of business. CCP allows members to continue receiving medically necessary services from non-cause terminated providers, processing claims for at least ninety (90) days or until members select alternative providers. Prior authorization is necessary for continuity of care upon provider termination.

Community Care Plan will allow pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the completion of postpartum care.

5. Provider Requirements for Pregnant Members and Newborns

Notice of Pregnancy

Practitioners must complete and submit to CCP a Notice of Pregnancy (NOP) Form for all pregnant members within thirty (30) days of the member's first prenatal visit and identify the estimated date of confinement and delivery facility. The NOP is crucial for ensuring timely access to prenatal care and support services. It helps us track and manage the member's care throughout the pregnancy to achieve the best outcomes for both the mother and the baby. Providers must ensure that the NOP includes accurate information regarding the estimated due date, any pre-existing conditions, and relevant medical history. The NOP Form may be accessed and submitted electronically via the Secure Email Address: ccp.pregnancy.notification@ccpcares.org.

From the NOP, we will assign a program Care Coordinator to educate the pregnant member, address barriers (particularly those that contribute to poor birth outcomes; arrange appointments, and link members to community resources, such as Florida Healthy Start and the Women, Infants, and Children (WIC) programs.

Doula Expanded Benefit

CCP offers an expanded benefit for doula services to support pregnant members throughout their pregnancy, labor, and postpartum period. Doulas provide continuous physical, emotional, and informational support, which has been shown to improve birth outcomes. To access this benefit, pregnant members should contact CCP to get a list of covered doulas.

Providers should inform patients about this benefit and assist them in initiating doula services if desired. Documentation of doula involvement should be included in the patient's medical record. Doulas receive referrals from Primary Care Physicians and Obstetrical and Gynecology (OB/GYN) providers. Doula services no longer require prior authorization, and members have an unlimited number of visits.

Other Benefits for Pregnant Members

In addition to doula services, CCP provides benefits to support pregnant members, including:

- OTC Benefit: Members receive $25 per month per household to purchase OTC medicines and medical supplies, including Prenatal Vitamins.
- Transportation Assistance: For prenatal visits and other pregnancy-related medical appointments.
- Nutritional Counseling: Available to help manage dietary needs during pregnancy.
- Breastfeeding Support: Access to lactation consultants and breastfeeding supplies.
- Breast Pump: Free breast pumps are covered for members over 21 years old, once per pregnancy. Two options are available: a single electric wearable pump (no prior authorization required) and a double electric hospital-grade rental (prior authorization required).
- Prenatal Education Classes: Covering childbirth preparation, newborn care, and breastfeeding.
- Case Management: Comprehensive care coordination support before, during, and after pregnancy.
- Papa Pals: Companionship and support during and after pregnancy.
- Phone App: A phone app providing pregnant women and new moms with 24/7 education and support
- Healthy Meal Delivery: New moms can receive home-delivered meals and are eligible for two meal benefits: up to 56 meals during pregnancy and an additional 56 meals after delivery, available up to one year postpartum.
- New Mom Package: New moms who attend a safe sleep class can receive a portable crib and video baby monitor.

Mental Health Services include depression and anxiety, among other conditions, before and after pregnancy. Providers should inform members about these benefits and assist them in accessing these services.

Florida Healthy Start Program

CCP partners with the Florida Healthy Start Program to offer comprehensive care coordination for pregnant members. This program provides risk screenings, care coordination, and enhanced services to promote healthy pregnancies and positive birth outcomes. Providers are encouraged to refer eligible members to the Florida Healthy Start Program early in their pregnancy. Participation in the program should be documented in the patient's medical record, including any interventions and outcomes. This voluntary program serves pregnant women until they reach their goals, or up to one year postpartum, and infants up to age 3 years, depending on resources and family consent. Practitioners managing the care of pregnant CCP members must follow AHCA requirements for the Healthy Start program and agree to:

- Collaborate with the Healthy Start care coordinator in the member's county of residence to ensure the delivery of risk-appropriate care
- Complete the AHCA-approved Healthy Start (prenatal) risk screening instrument and submit it to the county health department in the county where the prenatal screen was completed
- Refer all infants, children up to age 5 years, and pregnant, breast-feeding and postpartum women to the local WIC office
- Refer infants born to members who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening score

- Refer to case management those pregnant members or infants who have actual or potential factors associated with high risk, such as HIV, hepatitis B, substance abuse, domestic violence, or any other risky conditions

- Florida hospitals must file the Healthy Start (prenatal) risk screening instrument certificate of live birth with the county health department in the county where the infant was born. CCP agrees to educate providers on the following Healthy Start tasks and responsibilities:
- Use and submission of the Healthy Start (prenatal) risk screening instrument to the state health department in the county where the prenatal screen was completed within ten (10) business days of the screening
- Referrals of all infants, children up to age 5, and pregnant, breast-feeding and postpartum women to the local WIC office
- Referrals of infants born to members who test positive for the Hepatitis B surface antigen HBsAg to Healthy Start
- Documentation of Healthy Start screenings, assessments, findings, and referrals in the members' medical records

Medical Record Documentation for Pregnant Members

Accurate and thorough documentation of the medical records of pregnant members is essential. Providers must document:

- Enrollee's identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any)
- Information relating to the enrollee's use of tobacco, alcohol, and drugs/substances
- Summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up
- The primary language spoken by the enrollee and any translation needs of the enrollee
- Enrollees needing communication assistance in the delivery of health care services
- Contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for a living will or power of attorney), including information on Chapter 765, F.S., and whether the enrollee has executed an advance directive Neither CCP nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive
- Confirmation of pregnancy estimated due date along with completed Healthy Start risk screening instrument
- All prenatal visits, including vital signs, fetal heart tones, and growth parameters.
- Any complications or high-risk conditions, along with applicable laboratory results (including HIV, Hepatitis B-related documentation) and the corresponding management plans
- Patient education was provided, including nutritional advice, physical activity recommendations, and smoking cessation counseling
- Referrals to specialists, if necessary, and coordination of care
- Participation in additional support programs, such as the Florida Healthy Start Program and WIC.

Root Cause Analysis (Pregnant Members with SMI)

Within 14 days of the identification of a Pregnant Member on CCP's SMI plan, CCP will initiate a Root Cause Analysis for the following events:

- Suicide

- Victim of Homicide
- Baker Act of an enrollee aged twenty-one (21) years or younger
- Death of an enrollee within one year of delivery or pregnancy termination
- Death of an enrollee within one (1) year of life
- Victim of abuse, neglect, or exploitation as defined by Section 415.102, F.S.
- Sexual battery or altercation requiring medical intervention
- Resident elopement for enrollees in assisted care communities, as defined by Section 429.41, F.S.

The RCA will include a description of the event, health record review, case management investigation, and interviews to gather data that may not be present in health record documents, identification of causal factors, determination of root causes of causal factors, and actionable recommendations to prevent the event at the individual level and the population level. The RCA for each event should be completed within thirty (30) days of RCA initiation.

Pregnancy-Related Care by Maternity Providers

Maternity providers are responsible for offering comprehensive pregnancy-related care, including:

- Routine prenatal visits following the recommended schedule.
- Screening for gestational diabetes, preeclampsia, and other common pregnancy complications.
- Providing information and support for prenatal genetic screening if desired by the patient.
- Developing and documenting a birth plan in collaboration with the patient.
- Discussing nutritional concerns and/or making referrals for breastfeeding and/or breast milk substitutes, individualized nutritional counseling, nutritional assessment, and nutritional care plan.
- Screening for tobacco or substance use and offering counseling and treatments
- Offering postpartum care and ensuring continuity of care after delivery.

Providers must follow evidence-based guidelines and ensure all care is documented in the patient's medical record.

Hospital Service and Documentation Requirements for Newborns

Hospitals must adhere to specific service and documentation requirements for newborns, including:

- Performing a comprehensive newborn assessment immediately after birth and notes indicating the newborn's mother was mailed a copy of the Healthy Start risk screening instrument within 5 (five) business days.
- Documenting birth weight, length, head circumference, and APGAR scores.
- A cord blood sample was taken to determine Rh and the value of the Coombs test if the mother was Rh negative.
- Administering and documenting newborn screenings as mandated by state regulations.
- Providing and documenting standard doses of vitamin K, hepatitis B immune globulin (HBIG), and Hepatitis B vaccinations.
- Initiating and documenting breastfeeding or feeding plans.
- Ensuring all newborn care documentation is complete and transferred to the newborn's primary care provider upon discharge.

Infant Care Service and Documentation Requirements

For infant care, providers must ensure and document:

- Comprehensive well-baby visits following the recommended schedule, including a completed Healthy State infant (postnatal) Risk Screening instrument within five (5) days of birth, indicating that the infant's parent/guardian was given a copy of this Screening along with submission of this instrument to the local health department. Referrals are made to the Healthy Start program based on the infant's risk score or due to risk factors associated with the mother, such as HIV, hepatitis B, substance abuse, or domestic violence history.
- Documentation of growth parameters (weight, length, head circumference) at each visit.
- Administration and documentation of vaccines according to the immunization schedule.
- Screening for developmental milestones and early detection of potential health issues.
- Completed WIC program referral form including, at the time of the WIC referral, the infant's current height and weight along with laboratory results for hemoglobin or hematocrit levels, notes identifying any special medical or nutritional needs of the infant, and notes indicating that the parent/guardian was given a come of the completed WIC program referral form.
- Parents should be educated on infant care, safety, and nutrition, including the importance of timely childhood check-ups (CHCUP) and the dates and notes for the CHCUP visits.
- Coordination with specialists if any health concerns are identified.

For infants born to an HbsAg-positive mother:

- Laboratory test results for both HbsAg and hepatitis B surface antibodies (anti-HBs) at 6 months following the completion of the vaccine to monitor the success or failure of therapy and referral to Healthy Start and to the perinatal hepatitis B prevention coordinator.
- For infants who tested HbsAg positive, a copy of the Florida Department of Health form #2136 or documentation indicating the form was filed electronically is required.
- A copy of the report is sent to the local state health department indicating the positive HbsAg results for the infant before 24 months of age within 24 hours of receipt of positive test results. Report to the local state health department indicating member demographics, race, ethnicity, test results, and immunization dates.
- Providers should ensure that all infant care services are thoroughly documented in the medical record to facilitate continuity of care and ongoing monitoring of the infant's health and development.

See Chapter 6 for additional information on the EPSDT and CHCUP Programs.

6. Provider Requirements for Treating Children and Youth

Early and Periodic Screening, Diagnostic, and Treatment EPSDT and Well-Child Visits Program

Well-child visit (Child Health Check-Up Visits) is Florida's name for the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. This program ensures that infants, children, and adolescents under the age of 21 receive a comprehensive array of prevention, diagnostic, and treatment services as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. § 1396d(r)(5) and 42 CFR 441.50.

EPSDT covers:

- Regular physical exams
- Growth Measurements
- Immunizations (shots)
- Vision and hearing screenings
- Dental Screenings
- Other important tests and services
- Referral for diagnosis and treatment, if necessary

Well-child visits (Child Health Check-Up Visits) include:

- Medical History and Physical Examination: To assess the child's overall health and development.
- Vision and Hearing Screening: To identify any issues that may affect learning and development.
- Immunizations: To protect against preventable diseases.
- Developmental and Behavioral Assessment: To identify any developmental delays or behavioral concerns.
- Oral Health Assessment: Including referral to a dentist for preventive dental care.

Lead Screening:
All children 12 and 24 months of age are required to receive a blood lead screening test. If a child between the ages of 24 and 72 months does not have a record of a previous blood lead screening test, they must also receive one.

Provider Documentation of EPSDT Services:
Providers are responsible for completing these child health check-ups according to the Bright Futures Recommendations. Providers must ensure that all services are documented thoroughly in the medical record, including the date of service, findings, and any follow-up actions taken. PCPs or pediatricians may follow only true contraindications established by the Advisory Committee on Immunization Practices ("ACIP"), unless: in making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or the requirement is not in compliance with Florida law, including laws relating to religious or other exemptions.

Vaccines for Children Program

The Florida Vaccines for Children (VFC) program provides routine vaccines to eligible children under 19 years of age who are Medicaid-eligible, uninsured, underinsured, or American Indian/Alaska Native. The program aims to ensure that no child is denied immunizations due to an inability to pay. Key aspects include:

- Eligibility Verification: Providers must verify the child's eligibility for the VFC program at each visit.
- Vaccine Administration: Administer vaccines according to the recommended immunization schedule.
- Documentation: Maintain accurate records of vaccine administration, including the vaccine type, lot number, manufacturer, and administration site.
- Reporting: Submit vaccine usage reports as required by the VFC program guidelines.

Providers must also educate parents and guardians about the importance of vaccinations and address any concerns or questions they may have. Vaccines for Children (VFC) program. Information regarding the Vaccine for Children Program can be obtained directly by calling 1-800-483-2543 or clicking here.

VFC provides these vaccines at no cost to the member or physicians and eliminates the physicians' need to refer children to the local state health department. CCP does not reimburse for vaccines that are covered under this program but will pay the administrative fee. If a PCP does not routinely administer immunizations as part of their practice, the PCP may refer the child to the member's local state health department but must maintain a current record of the child's immunization status.

As immunizations are a required component of CHCUP screening services, an assessment of a child's immunization status should be made at each screening, and immunizations should be administered as appropriate. If a child is due for an immunization, it must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay should be documented in the child's record, and an appointment should be scheduled for the child to return for immunization later.

(Note that Title XXI MediKids enrollees do not qualify for the VFC program. Managed by AHCA, MediKids is the Florida KidCare program, which provides low-cost health insurance for children ages one through four. Providers should bill Medicaid fee-for-service directly for vaccines administered to Title XXI MediKids participants.)

Florida SHOTS

Florida SHOTS™ (State Health Online Tracking System) is a free, statewide, centralized online immunization registry that helps healthcare providers keep track of immunization records for children and adults. Key features include:

- Immunization Records Management: Securely store and access patients' immunization records.
- Reminder and Recall: Generate reminders for upcoming vaccinations and recall notices for overdue vaccinations.
- Data Entry: Enter immunization data directly into the system or through electronic data exchange from EHR systems.
- Reporting: Generate immunization reports for individual patients or for the practice.

Providers are required to:

- Enroll in Florida SHOTS™: Register to use the system and receive training if needed.
- Input Immunization Data: Ensure all administered vaccines are recorded in Florida SHOTS™ in a timely manner.
- Utilize Reminders: Use the system to send reminders to patients about upcoming or overdue vaccinations.
- Maintain Accuracy: Regularly update and verify the accuracy of the immunization records.

Providers may refer to the Florida Department of Health VFC website.

Vaccines for Adults Program

In accordance with the Inflation Reduction Act (IRA) of 2022 (P.L. 117-169) beginning October 1, 2023, Medicaid and Children's Health Insurance Program (CHIP) programs must cover vaccines that are approved by the FDA for use by adult populations and administered in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations. Coverage must be provided without member cost-share and must include any administration fees. The ACIP develops recommendations on how to use vaccines to control disease in the United States. The recommendations include the age(s) when the vaccines should be given, the number of doses needed, the amount of time between doses, and precautions and contraindications. CCP will follow these recommendations and contraindications established by the ACIP, unless:

- In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or
- The particular requirement is not in accordance with Florida law, including law relating to religious exemptions.

CCP requires contracted practitioners who administer vaccines to adults to participate in Florida's Vaccines for Adults (VFA) program. The Florida VFA program provides vaccines to our adult population to prevent infection with one of the potentially devastating diseases.
To be eligible to receive VFA vaccine, one must be an:

- Uninsured adult aged 19 years and older
- Underinsured adult aged 19 years and older

Nursing Facility Notification Requirements

SNFs must manage enrollees' daily needs based on individualized care plans and actively participate in transition planning with the Medicaid Managed Care Plan Care Coordinator. They are required to attend multidisciplinary team meetings to ensure coordinated care and conduct initial and regular assessments, updating care plans as necessary. SNFs must comply with PASRR requirements, maintaining all necessary records, and utilize the health plan's secure Provider Portal for information sharing. Prompt communication with the Care Coordinator regarding any changes in an enrollee's health status is essential. SNFs should also involve enrollees, their families, and, where applicable, public schools in care planning and transitions.

If a SNF fails to meet the required standards, Provider Operations will work with them to identify issues, develop an improvement plan, and monitor progress. Persistent non-compliance, after all remediation efforts have been exhausted, may result in the termination of the agreement between the SNF and the health plan.

Notification Requirements:

- Admission Notification: Notify CCP within 24 hours of a member's admission to the facility. This notification should include the member's demographic information, reason for admission, and anticipated length of stay.
- Discharge Notification: Inform CCP within 24 hours of a member's discharge from the facility. Provide details on the discharge plan, including any home health services or follow-up appointments.
- Significant Change in Condition: Report any significant change in a resident's condition to CCP and the member's primary care provider immediately. This includes changes that may require a reassessment of the care plan.
- Quarterly Updates: Submit quarterly updates on the member's status, including any changes in the care plan, progress, and any incidents or accidents.
- Care Plan Meetings: Invite CCP representatives to care plan meetings, particularly for high-risk members or those with complex needs.

Documentation of all notifications should be maintained in the member's medical record, including the date and time of notification, the person notified, and the details of the communication. This ensures clear communication and coordination of care between the nursing facility, CCP, and other healthcare providers.

Nursing facilities are required to notify the Department of Children and Families of any MMA member under the age of 18 years who is admitted to or discharged from their facility. The facility must submit a completed client referral/change form (DCF #2506A) to DCF within 10 business days of the admission and a completed client discharge/change notice (DCF #2506) to DCF within 10 business days of discharge.

Community Care Plan

The Health Plan with a Heart

7. Member Complaints, Grievances, and Appeals

Member Rights for Grievances and Appeals

Federal law mandates that Medicaid managed care organizations implement internal grievance procedures. These procedures allow Medicaid members or their authorized representatives to challenge denials of coverage or payment for medical assistance. Members can file a complaint, grievance, or appeal, and have the right to a Medicaid fair hearing or subscriber assistance hearing after completing the internal appeal process.

Providers must ensure that MediKids enrollees are informed of their appeal rights, as detailed in the provider handbook. These rights include the ability to appeal adverse benefit determinations, such as denials or service limitations. Providers should assist enrollees in understanding how to initiate an appeal, including the necessary steps, timelines, and the right to expedited appeals in urgent situations. The handbook will clearly explain the process, helping providers support enrollees throughout the appeal.

Providers can file a grievance or appeal on behalf of a member, but only with the member's written consent. Members can also write their own letter appointing their provider as their representative for the grievance or appeal and designate any other person to act as their representative.

If additional medical records are needed for the grievance or appeal, providers must respond within seven business days of the request. This ensures that member grievances or appeals are processed within the specified time frames.

Members have the right to:

- File Complaints: Regarding any aspect of care or service received.
- Submit Grievances: About dissatisfaction with care or services.
- Appeal Decisions: If they disagree with a service denial or limitation, or any other adverse decision made by CCP.
- Receive Information: About how to file complaints, grievances, and appeals.
- Fair and Timely Review: Of their complaints, grievances, and appeals.
- Be Free from Retaliation: For filing complaints, grievances, or appeals.
- Representation: By themselves or an authorized representative during the grievance and appeal process.

Definitions of a Member Complaint, Grievance, and Appeal

Complaint

A complaint is an informal expression of dissatisfaction with any aspect of CCP's services or care that can be resolved quickly and informally by CCP staff. Examples include dissatisfaction with wait times, staff behavior, or facility conditions. If a complaint is not resolved by the end of the following business day after it is received, it will become a formal grievance.

Grievance

A grievance is a formal expression of dissatisfaction about any matter with CCP's operations, services, or care that is not resolved at the complaint level. Grievances may involve issues such as appointment wait times, quality of care, interpersonal interaction with a doctor or his/her staff, or service delivery problems. If an enrollee is dissatisfied with services provided by CCP, you or the enrollee can call the CCP Member Services Department.

You can assist the enrollee to file the grievance with written permission by fax, email, by calling us toll-free at 866-899-4828, or by sending a letter to us at:

Community Care Plan
Attention: Grievance & Appeal Coordinator
1643 Harrison Parkway, Building H, Suite 200
Sunrise, Florida 33323

We will send the enrollee a letter approximately five (5) days after we receive the grievance to let him/her know their rights and our procedures. If we have resolved the grievance within that time, we will also tell the enrollee the result of our investigation.
Your office can duplicate our grievance form, which is included in this Provider Manual. If you need an additional copy, please contact your Provider Services Representative.
CCP must resolve grievances within 90 days of receipt. However, if the member needs additional information and the delay is in the member's best interest, the member may request to extend the resolution by up to fourteen (14) calendar days.

Appeal

An appeal is a formal request for review of an adverse decision made by CCP regarding coverage, benefits, or service provision. This includes denials of service, reductions in service, or unfavorable determinations of eligibility. CCP must resolve the standard appeal within 30 days and an expedited appeal within 48 hours. The member may request to extend the resolution by up to fourteen (14) calendar days if additional information is needed and the delay is in the member's best interest.

Providers may request an "expedited plan appeal" on their patients' behalf if they believe that waiting 30 days for a resolution would put their life, health, or ability to attain, maintain, or regain maximum function in danger. If CCP does not believe that the request qualifies as expedited, CCP will notify the member of the decision and will process the appeal under standard time frames. Expedited requests do not require a member's written consent for the provider to appeal on the member's behalf.

During the appeal process, the member has the right to continue with the service that is scheduled to be reduced, suspended, or terminated until a final decision is made if the appeal request is made within 10 days of the date of the denial letter.

Filing Grievances and Appeals

Members can file complaints, grievances, and appeals verbally or in writing by:

Phone	1-866-899-4828 from 8:00 a.m. – 7:00 p.m.
Mail	1643 Harrison Parkway Building H, Suite 200 Sunrise, Florida 33323
Email	grievancesandappeals@ccpcares.org
Fax	954-251-4848
In-Person	Visiting a CCP office and speaking directly with a representative

Steps for Filing:

1. Complaint: Contact Member Services to informally resolve the issue.
2. Grievance: Submit a formal grievance if the issue is not resolved through a complaint.
3. Appeal: File an appeal if dissatisfied with a decision regarding coverage or services.

A member may file an appeal orally. Oral appeals may be followed with a written notice within 10 calendar days of the oral filing. The date of oral notice shall constitute the date of receipt.

Documentation Required:

- Member's name, contact information, and identification number.
- Detailed description of the complaint, grievance, or appeal.
- Relevant dates, names of individuals involved, and any supporting documents.

Timeframes:

- Complaints: Complaints will be resolved by the close of business on the business day following receipt. If a complaint is not resolved within one (1) business day following receipt, it will turn into a formal grievance.
- Grievances: Acknowledged within 5 business days and resolved within 30 calendar days.
- Appeals: Acknowledged within 5 business days and resolved within 30 calendar days.

Enrollee Appeals

If the enrollee receives an Adverse Benefit Determination Letter, they have the right to appeal.

An action is:

- The denial or limited authorization of a requested service, including type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, or payment for a service
- The failure to provide services in a timely manner, as defined by the state
- The failure of CCP to act within the timeframes provided in Section 438.408

Medicaid Fair Hearing

If a member is dissatisfied with the outcome of an appeal, they have the right to request a Medicaid Fair Hearing. The enrollee must complete CCP's appeal process before asking for a Medicaid Fair Hearing, which is an opportunity to present their case before an impartial hearing officer. Medicaid fair hearings may be requested any time up to 120 days following the date on the notice of plan appeal resolution. The member must finish the appeal process first. Members can request a Fair Hearing by:

Phone	Contacting the Department of Children and Families (DCF) or the Agency for Healthcare Administration (AHCA) at 1-877-254-1055
Mail	Agency for Health Care Administration Medicaid Hearing Unit P.O. Box 60127 Fort Myers, FL 33906
Email	MedicaidHearingUnit@ahca.myflorida.com
Fax	1-239-338-2642
Online	Using the state's designated portal for filing Fair Hearing requests

The Fair Hearing will be scheduled, and members will be informed of the date, time, and location. During the hearing, members can present evidence, bring witnesses, and have representation. For more information, visit the CCP website.

Trends of Complaints, Grievances, and Appeals

CCP regularly reviews and analyzes trends in complaints, grievances, and appeals to improve service quality and member satisfaction. This involves:

- Data Collection: Systematic recording of all complaints, grievances, and appeals.
- Analysis: Identifying patterns, common issues, and root causes.
- Reporting: Regularly reporting findings to CCP management and relevant committees.
- Action Plans: Developing and implementing corrective action plans to address issues.
- Feedback Loop: Informing providers and staff of trends and necessary improvements.

By monitoring these trends, CCP aims to enhance overall service delivery, address systemic issues, and ensure a high standard of care for all members.

Provider Assistance with Enrollee Grievances and Appeals

The right to file a grievance or appeal belongs to the Enrollee. However, CCP recognizes that there are times the enrollee wants assistance from their provider to act on these rights. The following section explains that process.

GRIEVANCE/APPEAL DEPARTMENT
Office Hours: 8:00 a.m. – 5:00 p.m.
Phone: 1-866-899-4828 (Ask for Grievance/Appeal Coordinator)
Community Care Plan (CCP)
1643 Harrison Parkway, Building H, Suite 200
Sunrise, Florida 33323

If an enrollee is not satisfied with a service or provider and would like to file a complaint or grievance, he or she may do so by calling the CCP Member Services Department or submitting a grievance by using a CCP grievance form or a detailed letter. A copy of the form is attached (see page 41), and it can be duplicated for enrollee use. The following outlines the procedure. A complaint becomes a grievance after 24 hours if not resolved.

Expedited Appeals

Expedited appeals are appeals that need a faster review because of the enrollee's health. The criterion for an expedited appeal is that waiting for standard appeal resolution (within 30 days) could seriously jeopardize the enrollee's life, health, or ability to obtain, maintain, or regain maximum function. You or the enrollee can ask for a faster review (urgent appeal) by phone or by letter. We will notify you and the enrollee of our decision within 48 hours. We will try to call you and the enrollee about the results right away. We will also mail the enrollee a letter within two (2) working days.

The letter of appeal should be sent to CCP:

Community Care Plan
Attention: Grievance & Appeal Coordinator
1643 Harrison Parkway, Building H, Ste. 200
Sunrise, FL 33323

1-866-899-4828

No punitive action will be taken against a provider who files a grievance or an appeal on behalf of the enrollee or supports an enrollee's grievance or appeal. The grievance and appeal procedure is the same for all enrollees.

Community Care Plan

The Health Plan with a Heart

8. Concierge Care Coordination Model

CCP outlines the collaborative nature of care coordination across the continuum within that managed care system, based on our C3 Model.

The C3 Model ensures a holistic approach in which CCP members receive care across the continuum. It utilizes a dedicated C3 Nurse Manager and the support of the C3 Team members, which includes a representative from each CCP department.

The mission of CCP's C3 Program is to:

- Improve the quality of care to CCP's members within a managed care system of delivery
- Provide excellent concierge care services
- Positively impact the health and wellness of our community
- Deliver the right care, at the right time, in the right place, in an efficient, cost-effective manner.

C3 is a collaborative process driven by the implementation of appropriate courses of care based on clinical, evidence-based practice guidelines. The process features proactive, individualized coordination and the creation of an appropriate, cost-effective alternative for members, including those with case management, disease management, and preventive care needs.

CCP's C3 Model provides the necessary planning, implementation, coordination, evaluation, and monitoring required to meet the members' health needs. The care coordination process promotes quality of care and cost-effective outcomes by strategically aligning the C3 team members' roles and responsibilities.

The C3 team consists of a C3 Nurse Manager, a Medical Director, a Clinical Pharmacist, a Social Worker, the member's Primary Care Physician, the Provider Operations Department, the Behavioral Health nurse, Quality Management, Customer Service, and UM. The members of this team coordinate all their resources and efforts to succeed in meeting the members' health needs and, therefore, improving their quality of life.

To refer members for CM services, please call 1-866-899-4828 | TTY/TDD 711.

Case Management and Chronic Disease Management

CCP's Care Management (CM) and Chronic Disease Management (DM) programs are designed to support our members in achieving optimal health outcomes through a comprehensive, integrated approach. These programs focus on both clinical and non-clinical interventions, engaging members as active participants in their healthcare.

Case Management (CM) Program Overview

The philosophy of Community Care Plan's (CCP) Case Management Program was adopted from the aligned and approved definition of the Commission for Case Manager Certification (CCMC) and the American Case Management Association (ACMA), The definition reads, "Case Management is a dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value. The practice of case management is professional and collaborative, occurring in a variety of settings where medical care, mental health care, and social support are delivered. Services are facilitated by diverse disciplines in conjunction with the care recipient and their support system. In pursuit of health equity, priorities include identifying needs, ensuring appropriate access to resources/services, addressing social determinants of health, and facilitating safe care transitions.

The case management program and tools used to manage care were developed using evidence-based clinical practice guidelines and preventive health guidelines adopted by CCP. In accordance with NCQA standards, CCP considers case management an opt-out program; all eligible members have the right to participate or to decline.

Case Management consists of seven components:

1. Member Identification
2. Comprehensive Case Assessment
3. Individualized Care Plan Development/Update
4. Care Plan Implementation/Interventions
5. Care Plan Monitoring and Evaluation
6. Case Discharge
7. Evaluation/Outcomes

The mission of CCP's case management program is to assist members by:

- Facilitating timely receipt of appropriate services in the most appropriate setting
- Determining and accessing available benefits and resources
- Achieving optimum health, functional capability, and quality of life through improved management of their disease and/or condition
- Maximize benefits and resources through oversight and cost-effective utilization management
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals

Case management staff are available Monday through Friday from 8:30 AM to 5 PM EST, MMA/SMI: 1-866-899-4828

After-hours calls are directed to the 24-hour nurse line.

Integrated Medical and Behavioral Health Approach

The CCP leverages claims, authorizations, admission, discharge, and transfer (ADT) data, social determinants of health information, and insights from our care management assessments to identify members for case and disease management programs. Additionally, the Population Health and Care Coordination Management Department relies on referrals from CCP staff, including those from UM and member services, as well as referrals from members and/or their caregivers, community agencies, and physical and behavioral health providers or practitioners.

This platform assists CCP in identifying the appropriate case management integrated team or health and wellness program that best supports each member's needs. The population falls into four intervention tiers based on risk (severity), guiding the determination of suitable clinical programs and targeted interventions. Once an assessment determines a member has both medical and behavioral health needs, applicable care management staff – supported by this integrated team – is assigned to the member. Members identified as severely and persistently mentally ill or members in an emergency behavioral admission are automatically referred to a behavioral health care manager, who is a licensed behavioral health clinician.

This coordination includes joint operational and clinical processes focused on coordination with the various individual CBC lead agencies, supporting the continuum of care, and providing case management support using a trauma-informed care model.

CCP uses an integrated and interdisciplinary approach to case management, combining medical and behavioral health services to address the holistic needs of our members.
This includes:

- Collaborative Care: Ensuring coordinated care among primary care providers, specialists, and behavioral health professionals.
- Holistic Assessments: Conducting comprehensive assessments that encompass both physical and mental health aspects.
- Integrated Care Plans: Developing care plans that integrate medical, behavioral, and social determinants of health.
- Clear Communication: Maintaining consistent and effective communication among all members of the care team and the members.

Identification of Members for Case Management and Condition Management

CCP has developed a population-based algorithm that leverages claims, authorizations, admission, discharge, and transfer (ADT) data, social determinants of health data, and information from our care management assessments to identify members for care management programs. Additionally, the case management department accepts referrals from CCP staff, including utilization management and member services, as well as from members and/or their caregivers, community agencies, and providers or practitioners.

This platform aids CCP in identifying the most appropriate case management integrated team or health and wellness program to support each member's needs. The algorithm, run monthly, stratifies the population into four intervention tiers based on risk severity, facilitating the determination of suitable clinical programs and targeted interventions.

Providers may initiate a case management referral by calling
1-866-899-4828 | TTY/TDD 711

Members are identified for CM and DM through:

- Health Risk Assessments (HRA): Regular assessments to pinpoint high-risk members.
- Claims Data Analysis: Reviewing medical and pharmacy claims to detect patterns indicative of chronic or complex conditions.
- Provider Referrals: Receiving referrals from healthcare providers who recognize members in need of additional support.
- Self-Referrals: Allowing members to self-refer to CM and DM programs.

Case Management Levels for Members

CCP categorizes members into different levels of case management based on their needs. As their conditions change, members may move through these different levels or move to a higher or lower level of intervention.

Complex Case Management

- Target Members: Those with multiple chronic conditions, significant functional impairment, or high healthcare utilization.
- Services: Intensive care coordination, frequent follow-ups, and comprehensive care plans.

Emerging Complex Case Management

- Target Members: Those at risk of developing complex health conditions or showing early signs of multiple chronic issues.
- Services: Proactive management to prevent escalation, moderate care coordination, and targeted interventions.

Chronic Condition Management

- Target Members: Those with stable chronic conditions that require regular monitoring and support.
- Services: Regular check-ins, self-management education, and adherence support.

Health and Wellness Management

- Target Members: Those primarily needing preventive care and wellness support.
- Services: Health promotion, disease prevention education, and wellness programs.

Case Management for Serious Mental Illness Specialty Population

Members enrolled in CCP's MMA Plus program — defined as having MMA and Serious Mental Illness (SMI)— have care management provided in an efficient manner that supports person-centered care planning, ensures multidisciplinary clinical integration, and produces quality outcomes. Comprehensive members have extensive healthcare needs that span multiple areas. CCP provides:

- Personalized Care Plans: Tailored to address all aspects of the member's health.
- Multidisciplinary Teams: Including various healthcare professionals to deliver coordinated care.
- Resource Coordination: Connecting members with community resources, social services, and support programs.
- Ongoing Monitoring: Continuous assessment and adjustment of care plans to meet evolving needs.

The care manager will be assigned to work closely and integrate with the concierge care coordination team to address the needs and achieve the expected goals. The care coordinator is available to support the members, caregivers, and providers as needed.

The care coordinator meets all new members promptly after receiving notification of enrollment into the program to complete an initial comprehensive assessment. In collaboration with the member, their authorized representative, family member, PCP, and both network and non-network providers, the care coordinator develops, implements, and monitors a person-centered plan of care based on the member's strengths, needs, goals, preferences, and informal/natural supports. Adjustments to the care plan are made based on changes in the member's overall condition and medical necessity. During all member contacts, the care coordinator discusses the member's satisfaction and quality of care received from each provider.

Condition-Specific Programs

CCP offers condition-specific programs and/or health coaching to support members with specific health issues. These programs aim to provide targeted interventions and comprehensive support for managing chronic conditions.

Providers who believe their patients would benefit from such a program may send a care management referral by calling 1-866-899-4828.

CCP's CDM programs strive to:

- Enhance Access to Care: Ensure members can obtain quality care and appropriate services through coordinated healthcare needs.
- Educate and Empower Members: Provide support and education to members and caregivers to help them achieve maximum health potential and independence.
- Prevent Recurrent Crises: Identify and intervene early with members at risk of developing complex needs or experiencing acute illness episodes.
- Reinforce Provider Recommendations: Support and reinforce treatments and therapies recommended by providers.
- Facilitate Member Engagement: Encourage proactive involvement of members and caregivers in managing their health.
- Improve Overall Health and Wellness: Aim to improve members' quality of life, functional status, and overall health through comprehensive care coordination.

By participating in these programs, members receive personalized support and resources to manage their conditions effectively, leading to improved health outcomes and quality of life. See below some examples of what these programs can offer:

- Diabetes Management: Includes education, nutritional counseling, medication management, and regular monitoring to control blood sugar levels and prevent complications.
- Heart Failure Management: Focuses on medication adherence, lifestyle changes, symptom monitoring, and regular follow-ups to manage heart failure effectively.
- Asthma Management: Features asthma action plans, medication management, environmental control education, and regular assessments to control symptoms and improve quality of life.
- Behavioral Health: Provides counseling, medication management, crisis intervention, and coordinated care with primary healthcare providers to support mental health.
- Hypertension Management: Offers education on blood pressure control, medication adherence, lifestyle modifications, and regular monitoring to manage hypertension effectively.

For more information or to refer members for CM or DM services, please call CCP at 1-866-899-4828 | TTY/TDD 711.

Member Programs

CCP's Healthy Behaviors Program is designed to support members across the continuum of health, from wellness to managing one or more chronic conditions. Members can earn financial rewards by completing healthy behaviors, such as well-child visits, prenatal and post-partum care, diabetes management, follow-up after a behavioral health admission, and completing a Health Risk Assessment. For a current list of member incentives, please visit Rewards.

In addition to the above, CCP members can earn rewards for participating in smoking cessation, obesity management, or substance use disorder programs:

- Smoking Cessation: Our smoking cessation program is offered through local Area Health Education Centers (AHEC) and Tobacco Free Florida. Members will have access to group quit and virtual options to meet their individual needs. Nicotine replacement therapy is provided free of charge as part of this program. Enrollees who complete all sessions receive a gift card incentive for graduating from this program.
- Obesity Management (Enrollees with a BMI of ≥ 40): CCP provides three visits to a participating nutritionist at no cost to the enrollee. To ensure any weight loss program is medically supervised, members will have two visits with their Primary Care Provider to monitor health and progress. Members receive a gift card incentive upon successful completion of all visits.
- Substance Use Disorder: CCP offers an individualized substance use recovery program. Members are assigned a CCP Care Manager who coordinates services with participating substance use treatment programs and monitors adherence to their care plan in conjunction with the member's provider. Members who successfully complete the program and remain sober are eligible for an incentive.

For more information on these programs, please visit CCPcares.org or call us at 1-866-899-4828 | TTY/TDD 711.

HOPE Florida Program

In 2021, the Department of Children and Families launched the initiative Hope Florida: A Pathway to Prosperity which uses Hope Navigators to guide Floridians on an individualized path to prosperity, economic self-sufficiency, and hope by focusing on community collaboration between the private sector, faith-based community, nonprofits, and government entities to break down traditional community silos, to maximize resources and uncover opportunities.

Individuals who may benefit from Pathways to Prosperity include individuals receiving public assistance, children aging out of foster care, pregnant mothers contending with substance use disorder, and parents and families needing assistance. Some of the services provided by HOPE Navigators include identifying goals and barriers, referrals to local, community-based partners, and one-on-one support to develop a plan to achieve economic self-sufficiency. Providers can refer members to the HOPE Florida hotline at 1-833-GET-HOPE.

In 2022, the Florida Department of Elder Affairs launched the initiative, Hope Florida: A Pathway to Purpose that uses Hope Navigators to provide support for Florida's elders by increasing assistance for seniors in need while helping to facilitate opportunities for seniors looking to serve. The Department of Elder Affairs and the state's eleven (11) Area Agencies on Aging established their own Hope Navigators, who will further break down traditional community silos by uniting seniors and caregivers with community partners, giving seniors direct access to help locate immediate needs. In addition, the Hope Navigators will help identify ways for these seniors to find purpose, which could take the form of volunteering or mentoring through Hope Heroes. Providers may refer members to the Pathways to Purpose program at the HOPE Florida hotline at 1-833-GET-HOPE or for more information, email information@elderaffairs.org.

Health Snapshot

The purpose of the Health Snapshot (health risk assessment) is to help identify members who need CM/DM, may benefit from one or more healthy behavior programs, and/or are behind in periodicity screening as delineated by screening guidelines. Every month, CCP mails a Welcome Packet to all new members who join CCP. Included in the packet is the Health Snapshot for the member to complete and return directly to the CCP Member Services Department in the postage-paid, self-addressed envelope provided. Members are encouraged to Complete the online form: CCPcares.org/HRA.

The responses will be assessed to identify members who require CM services, who could benefit from a CCP DM program, or who have special health and related care coordination needs. Member Services will complete the appropriate referrals to initiate case or disease management for any members they assist. The Case Manager or Disease Manager assigned to the member's case will contact the PCP to review the form and initiate a plan of care.

CCP providers are contractually bound to complete the Health Snapshot within the member's first 90 days of enrollment.

Disease Management

Chronic Disease Management (CDM) is a comprehensive, integrated approach to care that focuses on both clinical and non-clinical interventions when and where they are likely to have the most impact. It is proactive and preventative in nature and engages the member and the provider as partners of the healthcare team. CCP will work with providers and members/caregivers to improve clinical outcomes and system efficiency. The goal is health management and illness avoidance as well as improved adherence to the treatment plan.

The CDM program is a collaborative process that facilitates the development and implementation of appropriate courses of care (based on clinical practice guidelines) to meet a member's healthcare needs. Standardized programs for Cancer, Sickle Cell, HIV, CHF, Diabetes, Hypertension, Asthma, Behavioral Health, and Substance Use Disorder have been developed. These programs include but are not limited to, practice guidelines, member education, provider education, and performance improvement measures. Additional CDM Programs may be developed for other chronic illnesses as the need is identified. Those members who would benefit from interaction with a C3 Care Coordinator but do not qualify for inclusion in established CDM Programs may be case-managed. Members can be referred by a PCP or can self-refer.

Goals of the program are:

- Provide a high standard of health care services coordination
- Provide education to Members/Caregivers that will promote healthy behaviors and improve self-management skills
- Work with providers utilizing a collaborative approach to enhance the effectiveness of disease management and care coordination process
- Improve the health status of the community
- Earn member/caregiver and provider satisfaction

Driven by our community's responsibility to positively impact the health and wellness of those we serve, our main goal is to establish a planned and systematic process to effectively and efficiently maintain the promotion and delivery of high-quality physical and behavioral health care to all members.

The purpose of our CDM program is to empower our members and their caregivers to manage the identified condition(s) optimally. This involves extensive education and outreach to assist members in adopting healthy behaviors, accessing healthcare services at the appropriate time and location, and tracking the metrics of their conditions.

- Developing and coordinating appropriate initiatives and interventions and/or alternative care in conjunction with the member, providers, and other members of the care team.
- Assuring COC and coordination of high-quality services to promote healthy behaviors and prevent complications of chronic diseases.
- Coordinating the optimization of health care resource utilization and ensuring the timely delivery of quality physical and behavioral health care services at the appropriate level of care.
- Promoting member and provider satisfaction with C3 DM education and care coordination processes.
- Promoting and assisting in coordinating health care access and delivery in accordance with local, state, federal, and accrediting agency standards.

Please note that CCP members may have participated in other CDM programs and will be transitioned into the CCP CDM program with the assistance of CCP care coordinators.

To refer members to the CDM program, please call CCP at 1-866-899-4828 | TTY/TDD 711.

PCP Role

- Primary responsibility for medical management of enrollee
- Identify and refer appropriate enrollees
- Ensure knowledge and implementation of accepted guidelines
- Interact with the care manager to develop plan of care
- Monitor enrollee progress toward expected outcomes
- Assist in education and adherence monitoring with the care manager and disease management program staff to develop performance improvement strategies and plans
- Maintain accurate and complete medical records

Disease Manager's Role

- Assess each referred enrollee and risk-stratify him/her
- Develop a plan of care based on the assessment and risk stratification in conjunction with the PCP
- Educate the enrollee
- Provide referrals to community resources
- Educate providers and their office staff
- Monitor enrollee adherence to plan of care
- Monitor enrollee outcomes
- Serve as a resource for benefit interpretation
- Facilitate and coordinate care

Please note that CCP enrollees may have participated in other disease management programs. They will now be part of the CCP Chronic Disease Management Programs, and CCP Care Managers will assist in the transition.

TO REFER ENROLLEES TO THE CHRONIC DISEASE MANAGEMENT PROGRAM, PLEASE UTILIZE THE FOLLOWING CONTACT INFORMATION:

Member Services: 1-866-899-4828 | TTY/TDD 711

9. Quality Improvement

Quality Improvement (QI) Program Overview

The Quality Improvement (QI) Program at CCP is designed to enhance the quality and safety of care provided to our members. It focuses on continuous monitoring, assessment, and improvement of healthcare services.

We're dedicated to delivering a well-designed and effectively implemented quality improvement program aimed at enhancing the health of all members. This program employs "plan, do, study, act" (PDSA) methodology, which involves reliable and valid methods for anticipating, identifying, monitoring, measuring, and evaluating members' healthcare needs, and taking effective actions to promote quality care. This systematic approach ensures a continuous cycle for assessing the quality and appropriateness of care and services.

The quality improvement program addresses the unique needs of members enrolled in the MMA and SMI Specialty Product programs. CCP updates this program annually, including an evaluation against the stated quality improvement work plan. The evaluation considers:

- Coordination between physical and behavioral health services
- Credentialing and recredentialing
- Cultural competency
- Delegated entity oversight
- Member and provider satisfaction
- Member complaints, grievances, and appeals
- Outcomes of case management
- Practitioner appointment availability and access
- Performance measures
- Potentially preventable admissions, readmissions, and emergency department events
- Birth outcomes
- Preventive health and chronic condition guidelines, including behavioral health
- Quality improvement studies
- Utilization management, including pharmacy

Quality Improvement (QI) Program Goals and Activities

The aim of CCP's Quality Improvement Program is to enhance the health status of its members by improving the quality of care, service efficiency, member satisfaction, and provider satisfaction. This encompasses care provided by all network or subcontracted vendors across all care settings.

Some of the activities included in the quality improvement program are:

- Adherence to preventive and clinical practice guidelines, with action plans to meet established performance targets.
- Implementation of case management programs to promote better member outcomes and best practices.
- Compliance with all applicable regulatory requirements and accreditation standards.
- Enhancement of member satisfaction scores.
- Reduction in potentially preventable events, improvement in birth outcomes, and better transition of members from facilities to the community.
- Improvement in processes that enhance clinical efficiency, promote effective utilization of healthcare resources, address identified care gaps, and focus on improved outcome management.
- Integration of quality improvement activities across CCP's functional areas.
- Regular monitoring and collaboration with the contracted network continuously improve the quality of care, health outcomes, patient safety, and services received by members.
- Protection of members' rights and responsibilities.

To achieve these quality goals, CCP offers a value-based payment structure, useful reports, and robust clinical support. Additionally, CCP aligns these quality goals with network performance and employs a focused strategy based on strong partnerships with network providers while continuously reviewing data to identify network provider performance and opportunities to support providers in improving member care.

The Quality Improvement Program evaluation includes a summary of all quality improvement activities noted in the annual quality improvement work plan. These findings are used to develop the following year's annual quality improvement program description. The QI evaluation is reviewed and approved by CCP's Quality Improvement Committee and Board of Directors. A short summary is available to providers and members on our website.

Working With Our Providers

CCP provides reports to our practitioners and providers that demonstrate their impact on the quality of care and the appropriate utilization of services. These reports are designed to be:

- Meaningful to the provider
- Relevant to the populations served
- Informative in assisting providers to impact care

Specific provider quality standards that are measured include:

- Member access to care
- Member satisfaction
- Utilization of services
- Quality of care and service (including HEDIS and non-HEDIS measures)
- Pharmacy utilization

Quality Improvement Committee and Sub-Committees

Quality Improvement (QI) Committee and Sub-Committees Overview

Quality permeates every aspect of CCP's operations, underscoring a steadfast dedication to delivering exceptional care and services to its members. The board of directors develops, executes, and assesses the quality improvement program, holding paramount responsibility and oversight for ensuring the quality of care and services provided to members.

Additionally, CCP's diverse array of committees, subcommittees, and ad-hoc committees actively contribute to the planning, decision-making, intervention, and evaluation processes, thereby bolstering support for its quality improvement program.

Quality Improvement (QI) Committee

The Quality Improvement Committee (QIC) is a high-level committee accountable to the Board of Directors. It receives support from various committees, including credentialing, Provider Operations, utilization management, claims, and enrollee services. On the clinical side, ad-hoc committees such as peer review and specialty advisory committees are established. Non-clinical side ad-hoc committees may include regional-level committees. The QI Committee oversees the overall QI Program, ensuring alignment with CCP's strategic goals and regulatory requirements.

The QIC and CCP's Board of Directors conduct an annual review and approval of the program description. The committee offers supervision and guidance to the quality improvement program, achieving this through:

- A comprehensive, plan-wide system for continuous, objective, and systematic monitoring
- Educating members, providers, and staff about quality improvement, utilization management, and credentialing programs
- Identifying, evaluating, and resolving process issues
- Recognizing opportunities for enhancing member outcomes

Utilization Management Committee

The Utilization Management Committee oversees the review and approval of medical necessity criteria, protocols, and utilization management policies and procedures. Meeting at least quarterly, the committee coordinates the annual review and revision of the utilization management program, work plan, and annual program evaluation, with subsequent approval by the quality improvement committee.

This committee actively monitors and analyzes relevant data to identify and rectify patterns of potential or actual inappropriate underutilization or overutilization that could affect healthcare services. This includes addressing potentially preventable events, birth outcomes, transitions of Comprehensive members from facilities to the community, coordination of care, and the appropriate use of services and resources. Additionally, it assesses member and practitioner/provider satisfaction with the utilization management process.

Furthermore, the committee provides ongoing evaluation of the appropriateness and effectiveness of practitioner/provider quality incentive payments, contributing to the modification and design of an appropriate quality incentive program.

Credentialing Committee

The Credentialing Committee is responsible for reviewing the qualifications and credentials of healthcare providers applying to participate or wish to continue participation in the network. The Credentialing Committee is tasked with the development and annual review of the credentialing program, including its related policies and procedures. This committee holds ultimate authority for the review and approval of licensed physicians and other healthcare professionals with an independent association with CCP. The committee also assesses and approves institutional and organizational providers, including nursing facilities, home health agencies, group homes, and assisted living facilities.

Provider Operations Committee

The Provider Operations Committee (POC) is a subcommittee of the Quality Improvement (QI) Committee at Community Care Plan (CCP). It focuses on improving provider operations to ensure high-quality care for our Medicaid and SMI populations. Chaired by the Senior Director of Provider Operations and Network Contracting/Development, the POC includes representatives from key departments and meets quarterly. Responsibilities include monitoring operational performance, addressing provider issues, and ensuring provider education aligns with CCP's goals. The POC also reviews and updates policies to stay compliant with regulations and supports overall quality improvement efforts by collaborating closely with the QI Committee. The POC submits quarterly reports to the QI Committee, highlighting key activities and outcomes, thus ensuring alignment with CCP's mission to enhance care delivery through effective provider operations.

Provider Advisory Committee

The Provider Advisory Committee, led by a CCP Medical Director, convenes quarterly to gather insights and feedback from practitioners and providers on various pertinent topics. The Provider Advisory Committee includes representatives from various provider groups who offer insights and feedback on the QI Program. These discussions cover a broad spectrum, including solutions proposed by practitioners and providers, enhancement opportunities in chronic condition management and preventive care, strategies to reduce potentially preventable events, effective member engagement methods, and initiatives to boost practitioner and provider performance in alignment with CCP and AHCA clinical performance objectives. Additionally, discussions encompass clinical and operational improvement projects, innovative programs like Integrated Behavioral Health Homes and Telehealth, reimbursement methodologies, training for practitioners and providers, satisfaction concerns, and issues related to claims and billing.

The committee has the authority to suggest the formation of ad hoc special clinical focus subcommittees to the QIC when specific clinical expertise is needed for certain types of care. These subcommittees report to the QIC, which is tasked with reviewing and establishing quality standards, benchmarks, performance goals, and practice guidelines to uphold the standardized, appropriate quality of care and compliance while also identifying any deviations from medical management standards.

Medical Operations Committee

The Medical Operations Committee contains subcommittees, which are active in program development, maintenance, and reporting effectiveness of care coordination. Comprised of SVP/Chief Medical Officer, VP of Medical Operations, Medical Directors, and directors of Quality, Pharmacy, C3, UM, Medical Economics. They oversee and monitor CCP's clinical areas. It identifies ongoing clinical initiatives and best practices to optimize processes and enhance the delivery of high-quality care. The committee provides strategic guidance to improve patient outcomes and operational efficiency. The committee oversees department activities from Quality, Pharmacy, C3, UM, and Medical Economics. This includes monitoring performance measures, analyzing prescription trends, overseeing case and disease management, and ensuring efficient

UM turnaround times. Medical Operations Committee is chaired by VP of Medical Operations, is assembled bi-monthly, and reports to the QIC.

HEDIS Committee

Comprised of CCP Chief Medical Officer, Medical Directors, senior leadership, QI Nurses, and contracted vendors, HEDIS Committee identifies and targets areas in the CCP delivery system for performance improvement, such as barriers identified by data monitoring and enrollee and provider input. It focuses on collaborative interventions with network providers and internal staff to ensure consistent delivery of high-quality care. The committee monitors ongoing interventions that impact HEDIS rates based on claims and supplemental data submissions throughout the measurement year. The HEDIS Committee is chaired by Quality, assembled bi-monthly, and reports to the QIC. It was generated from the QIC.

Information Technology Governance Committee

Comprised of CCP health information systems (IS) and IT leadership, Data Management staff, and other CCP leadership, IT Governance Committee resolves IS, IT, and data management issues. It identifies innovative technologies and best practices to streamline processes and enhance the delivery of care. The Chief Information Officer (CIO) facilitates the committee's quarterly meetings and reports to the QI Committee on a quarterly basis. Minutes are recorded and kept on file and are available upon request.

Grievance And Appeals Committee

As part of the Grievance and Appeal Process, CCP Grievance and Appeals (G&A) Committee affords enrollees who are dissatisfied with CCP's determination or disputes a service authorization denial their rights to a fair and impartial hearing in a timely manner. It is comprised of CCP leaders from Grievances and Appeals and UM departments and CCP enrollees.

The Grievance and Appeals Committee:

- Reviews grievances and appeals not resolved through prior efforts, or upon request by the enrollee.
- Provides the enrollee/representative with a reasonable opportunity for the enrollee to submit written comments, documents, or other information relating to the appeal.
- Allows the enrollee/representative the opportunity to examine the enrollee's case file, including medical records and other documents\records before and during the appeal process.
- Communicates the committee's determination in writing.

The Committee meets monthly as needed or more often to address expedited reviews. To maintain impartiality, the decision-makers involved with the G&A determinations will not have been involved in the previous level of review or decision-making and are health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease. Committee attendees with voting rights include Medical Directors for medical and medication issues and pharmacy staff (Pharm. D.) for medication issues. Aggregate data of grievances and appeals, including trends identified and remedial actions, are reported, reviewed, and discussed at QIC no less than quarterly.

Claims Committee

The Claims Committee is comprised of CCP senior leadership, Director of Claims, MMA Contract Managers, and Provider Services and Data Management staff. The committee oversees, investigates, and solves claims and IT related issues, such as standardized medical coding and changes related to the Fiscal Agent, HIPAA, and electronic billing. The Committee serves as a communicative and problem-solving body, and it oversights claims and information systems/data management issues. Minutes of all Claims committee meetings are recorded and kept on file and are available upon request. CCP's Claims Committee is chaired by the Director of Claims, is assembled quarterly and reports to the QI Committee on a quarterly basis.

Member Services Committee

The Member Services Committee is comprised of CCP senior leadership, Account Managers, and staff from Grievances and Appeals, Member Services (CX), Provider Operations (PO), and UM departments. The committee oversees CX department activities, including new enrollee onboarding, enrollee handbook development/revision, and enrollee education. The Member Services Committee is chaired by the Director Member Services, is assembled quarterly, and reports metrics to the QIC on a quarterly basis.

Quality Improvement Activities

Monitoring Patient Safety/Quality Care

Ensuring patient safety remains a central pillar of CCP's Quality Improvement Program. The process involves continuous monitoring and promotion of patient safety integrated across data analysis, incident reporting, outcome tracking, and other activities. A key focus is on identifying potential and actual quality-of-care events.

A potential quality-of-care issue encompasses any alleged act or behavior that:

- Poses a risk to the quality or safety of patient care
- Contravenes evidence-based standard practices
- Indicates a potential sentinel event, including a member's death

CCP employs multiple mechanisms to monitor such events, termed "adverse incidents" for MMA members and "Serious Adverse Events" for Specialty Plan members. These events are tracked through claims and self-reported channels.

Adverse Incident

An injury of an enrollee occurring during delivery of Managed Care Plan Covered services that is:

- Associated in whole or in part with service provision rather than the condition for which such service provision occurred; and is not consistent with or expected to be a consequence of service provision; OR
- Occurs because of service provision to which the patient has not given his informed consent OR
- Occurs as the result of any other action or lack thereof on the part of the provider's staff.

Staff must report identified incidents to the Risk Manager within 24 hours of knowledge of the incident. Providers must report to Risk Manager within 48 hours of the incident except the following entities which report under the facility's licensure requirements:

- HMOs and health clinics (s.641.55, F.S.)
- Ambulatory surgical centers and hospitals (s.395.0197, F.S.
- Assisted living facilities (s.429.23, F.S.
- Nursing facilities (s.400.147, F.S.
- Crisis stabilization units, residential treatment facilities (s.349.459, F.S.

Reportable incidents include the following:

- Enrollee Death
- Enrollee Brain Damage
- Enrollee Spinal Damage
- Permanent Disfigurement
- Fracture or Dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention which is
- not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Any condition requiring surgical intervention to correct or control
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care

Serious Adverse Event (SAE)

Critical events that negatively impact the health, safety, or welfare of an enrollee receiving MMA benefits:

- Suicide
- Victim of Homicide.
- Baker Act of an enrollee aged twenty-one (21) years or younger Enrollee Spinal Damage
- Death of an enrollee within one year of delivery or pregnancy termination.
- Death of an enrollee within one (1) year of life.
- Victim of abuse, neglect, or exploitation as defined by Section 415.102, F.S.
- Sexual battery or altercation requiring medical intervention.
- Resident elopement for enrollees in assisted care communities, as defined by Section 429.41, F.S

While the occurrence of such incidents does not necessarily indicate a significant quality-of-care issue, CCP monitors and analyzes trends in type, location, and other factors to ensure patient safety. Whenever a quality-of-care issue is identified, CCP may initiate further investigation and/or request a corrective action plan promptly.

Monitoring Provider Access and Availability

CCP sets standards for the number and geographic distribution of PCPs, specialists, hospitals, and other providers and practitioners while considering the special and cultural needs of its members. CCP evaluates provider accessibility, at least annually, to identify and address any deficiencies in the number and distribution of various types of providers and practitioners. CCP establishes appointment wait times for various types of PCP, specialist, and behavioral health care visits. At least quarterly, CCP monitors, assesses complaints and addresses any access issues with these established wait times.

Providers are expected to provide care to Enrollees in a timely manner. Enrollees value timely access to medical care. Community Care Plan monitors primary care appointment and after-hours

access and specialty care and behavioral health practitioner appointment accessibility annually against its standards, and initiates actions as needed to improve. Please see the results of the annual Provider Survey conducted by Community Care Plan related to access and availability.

Timely Access Requirement

Community Care Plan (CCP) monitors provider compliance with timely access requirements through member feedback, appointment availability surveys, and audits. The audit results are reported to AHCA on a quarterly basis. Primary care and specialty care appointment access is measured quarterly via a survey of physician offices, using a statistically valid sample or by surveying all provider offices for required specialties. High-volume and high-impact specialties, such as Oncology, OBGYN, and Primary Care (Internal Medicine, Family Practice, Pediatrics), are surveyed separately. Data collection is conducted via phone or fax surveys. Providers found non-compliant with these standards may face corrective actions, up to and including network termination.

Access Guidelines

As part of our commitment to ensuring high-quality care and access to necessary services for our members, Community Care Plan (CCP) has established the following guidelines for timely access to care. These requirements are designed to ensure that all members receive the care they need in a timely manner, in accordance with state and federal regulations, and best practices.

Urgent Medical/Behavioral Health Care Services

- Request for services not requiring pre-authorization: within forty-eight (48) hours of request
- Request for services requiring pre-authorization: within ninety-six (96) hours of request

Non-Urgent Care Services:

- Request for post-discharge from an inpatient behavioral health admission: within seven (7) days
- Request for initial outpatient behavioral health services: within fourteen (14) days
- Request for ancillary services related to the diagnosis or treatment of injury, illness, or other health condition: within fourteen (14) days
- Request for Primary care appointment: within thirty (30) days
- Request for specialist appointment: within sixty (60) days

Monitoring Quality Outcomes

CCP tracks key quality outcomes to measure the effectiveness of care and identify areas for improvement. The Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), serves as a pivotal tool utilized by over 90% of U.S. health plans to gauge performance across vital dimensions of care and service. These measures span five distinct domains:

- Effectiveness of care, encompassing preventive health and chronic care process and outcome metrics
- Access/availability of care ascertained through member surveys
- Experience of care, also evaluated through member surveys
- Utilization and relative resource utilization, covering inpatient and outpatient utilization
- Health plan descriptive information

These measures are captured via claims data or medical record review. For measures requiring medical record review, CCP communicates with providers regarding the selection of records. Many of these measures are integral to the provider quality incentive program, and CCP continually monitors compliance rates with the aim of improvement.

State Performance Measures

The Agency for Health Care Administration (AHCA) identifies a subset of HEDIS measures and establishes its own metrics for evaluating Managed Medical Assistance (MMA) and the SMI Specialty Product. The agency monitors plan performance differently for each program. For MMA and SMI, the focus primarily revolves around HEDIS, CHIPRA measures, or other metrics.

For Comprehensive members, the emphasis lies in the plan's capacity to provide timely services, ensure the safety of individuals in their homes or communities, and facilitate the transition of recipients from institutional settings to community environments. AHCA sets performance targets for these measures.

Member Satisfaction Surveys

CCP employs various survey tools to gauge member satisfaction, leveraging the insights to implement interventions aimed at improving members' perceptions of access to care and services both with network providers and with CCP.

CCP administers a validated CAHPS® survey annually to assess member satisfaction with healthcare, including providers and health plans. This survey examines specific aspects such as obtaining needed care, timeliness of care, provider communication, office staff courtesy, and customer service. The CAHPS® survey is distributed annually to randomly selected members.

The survey covers several areas, including care coordination, provider communication skills, health plan customer service, access to needed care, promptness of care, access to prescription drugs, and overall health plan rating.

Behavioral health member satisfaction is assessed annually through surveys conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). These surveys solicit feedback from adult members and families of youth members across various domains such as access to services, cultural sensitivity, general satisfaction, improved functioning, outcomes, participation in treatment planning, service quality/appropriateness, and social connectedness.

Provider Satisfaction Surveys

At Community Care Plan (CCP), we understand the critical importance of provider experience in delivering high-quality health care. To continuously improve our services and support, CCP conducts annual and post-service visit provider satisfaction surveys. Each year, we partner with a third-party organization to distribute an anonymous survey to all providers participating in our MMA Plus program. This annual survey collects comprehensive feedback on various aspects of our operations, helping us identify areas for improvement in provider communication, program structure, and operational processes.

In addition to the annual survey, CCP also sends surveys to providers after each service visit. These post-visit surveys offer immediate opportunities for providers to share their experiences and provide feedback on specific interactions, such as claims processing or provider operations. The surveys cover a range of topics, including the satisfaction with our call center staff, the effectiveness of care coordination, overall satisfaction with CCP, pharmacy services, provider relations, and utilization management.

We strongly encourage all providers to participate in these surveys, as your feedback is essential in guiding our efforts to enhance the provider experience and improve our program outcomes.

The insights gained from these surveys inform targeted interventions that contribute to operational excellence and the overall success of our network. We appreciate your commitment to delivering high-quality care to our members and value your partnership in this continuous improvement process.

Quality Studies/Improvement Projects

CCP's Quality Improvement Department persistently assesses patterns in preventive services utilization, chronic condition management, and other services to pinpoint precise areas for quality enhancement initiatives. Collaborative multi-disciplinary teams are assembled to scrutinize data, recognize obstacles, and craft action plans along with effective interventions. Annually, CCP executes four improvement projects employing the AHCA-mandated "plan, do, study, act" (PDSA) methodology. The outcomes of these projects are documented and reported to AHCA, subsequently reviewed with the CCP Provider Advisory Committee. These projects, which may entail provider involvement, vary from year to year, reflecting evolving priorities and concerns.

Fraud, Waste and Abuse (FWA)

Special Investigations Unit

CCP operates a Special Investigations Unit (SIU) committed to preventing, reducing, detecting, investigating, correcting, and reporting instances of fraud, waste, and abuse (FWA). CCP conducts regular audits to ensure compliance with billing regulations. These audits are completed using code editing software employed during the claim payment process and post-payment review software.

The SIU conducts both pre-payment and post-payment audits, which may lead to disciplinary actions against providers found to be involved in FWA. These actions may include:

- Civil and/or criminal prosecution
- Heightened utilization review
- Recovery of previously disbursed funds
- Provision of remedial education and training to prevent billing irregularities
- Termination of provider agreements or other contractual arrangements

Common FWA practices include billing add-on codes without primary CPT, submitting claims for services not rendered, using diagnosis or procedure codes inconsistent with a member's age or gender, excessive unit usage, benefit misuse, unbundling of codes, up-coding services, and using exclusionary codes.

Providers who suspect or witness inappropriate billing or services are encouraged to report anonymously and confidentially via the FWA hotline at 855-843-1106. Alternatively, they may contact the compliance officer by phone, 954-622-3482 or email, ccp.compliance@ccpcares.org.

Office of Inspector General (OIG)/General Services Administration (GSA) Exclusion

CCP requires network providers to conduct thorough checks on all staff, volunteers, temporary employees, consultants, board members, and contractors against the exclusion databases maintained by the Office of the Inspector General (OIG) or the General Services Administration (GSA). This verification process is in accordance with the stipulations outlined in §1128 and §1128A of the Social Security Act.

Network providers are prohibited from maintaining any affiliation with individuals or entities identified as affiliates, as defined in the Federal Acquisition Regulation at 48 CFR § 2.101, of a person outlined in 42 CFR § 438.610(a)(1). Furthermore, they must not engage subcontractors listed on the discriminatory vendor list maintained by the Department of Management Services, as per s.287.134 of the Florida Public Entities Crime Act.

Provider Implementation of FWA Safeguards

Federal program payments cannot be allocated for items or services provided or prescribed by an excluded provider or entity. Plans may not utilize federal or state funds to cover services, equipment, or medications recommended or dispensed by a provider, supplier, employee, contractor, or subcontractor excluded by the Office of the Inspector General (OIG) or the General Services Administration (GSA).

CCP will review the Office of the Inspector General's "List of Excluded Individuals and Entities (LEIE)" and the General Services Administration's "Excluded Parties List (EPLS)" — now termed "System for Award Management (SAM)" as well as AHCA's catalog of suspended and terminated providers before engaging any new employee, temporary employee, volunteer, consultant, governing body member, or subcontractor. This vetting process is conducted prior to hiring or contracting and is reiterated monthly thereafter. Providers and practitioners are required to implement safeguards against fraud, waste, and abuse, including training and internal monitoring processes.

False Claims Act

The False Claims Act holds individuals and entities accountable for improperly receiving or avoiding payment from the federal government. This Act expressly prohibits various actions, including:

- Knowingly submitting or causing the submission of a false claim for payment or approval.
- Knowingly creating, using, or causing the use of false records or statements that are essential to a false or fraudulent claim.
- Conspiring to violate the False Claims Act in any manner.
- Providing false certification regarding the nature or quantity of property intended for government use.
- Certifying the receipt of property on official documents without possessing complete knowledge of its accuracy.
- Intentionally purchasing government property from an unauthorized government official.
- Creating or using false records with the intent to avoid or reduce an obligation to pay or transfer property to the government.
- For more information regarding the False Claims act visit the Centers for Medicare and Medicaid Services website.

CCP complies with the False Claims Act.

Health Care Laws

CCP mandates and expects strict compliance with applicable laws and regulations from all its contractors and subcontractors. This includes adherence to various statutes such as the Anti-Kickback Statute, State and Federal False Claims Acts, Whistleblower Protection Act (Qui Tam lawsuits), Health Insurance Portability and Accountability Act (HIPAA), Stark Law, Social Security Act, and U.S. criminal codes.

CCP requires contractors and subcontractors to promptly report any violations or suspected violations committed by their employees, associates, or entities providing care or services to CCP members. These violations encompass a range of activities such as bribery, false claims, fraud conspiracy, theft, embezzlement, false statements, health care fraud, and more.

To ensure compliance, CCP provides Fraud, Waste, and Abuse (FWA) training materials on the website. Additionally, FWA training is a part of provider orientation material.

State and federal regulations necessitate mandatory compliance and FWA training completion within 30 days of hire/contracting and annually thereafter for contractors, subcontractors, and their employees. Records of completed training must be maintained and easily accessible upon request by CCP's compliance officer, AHCA, CMS, or their representatives. As part of the credentialing process, an attestation confirming the completion of FWA training is required.

Providers or their employees who have not undergone compliance and/or FWA training may access these resources by visiting CCP's website.

Direct Reporting of Fraud, Waste, and Abuse

CCP provides mechanisms for direct reporting of suspected fraud, waste, and abuse, ensuring confidentiality and protection for whistleblowers.

Providers may report suspected or confirmed fraud, waste, or abuse in the state Medicaid program through the following channels:

- AHCA consumer complaint hotline: 1-888-419-3456
- Florida Attorney General's Office: 1-866-966-7226
- Florida Medicaid Program Integrity Office: 1-850-412-4600

Complaint forms may be found on the AHCA website.

Authority and Responsibility

CCP's Vice President of Compliance has the responsibility and authority for executing the Compliance Program's provisions, particularly focusing on the prevention, detection, reduction, correction, and reporting of fraud, waste, abuse, and other non-compliance matters. CCP is strongly committed to taking appropriate actions, including sanctions and prosecution against suspected instances of fraud, waste, or abuse.

CCP's Network Development must fully cooperate in facilitating the availability of personnel, including subcontractor personnel, for various proceedings such as interviews, consultations, grand jury proceedings, pre-trial conferences, hearings, trials, and investigations. These obligations are to be fulfilled at the expense of CCP or the contractor/subcontractor.

10. Provider Roles, Rights, and Responsibilities

All CCP Providers' Responsibilities

Providers who participate in CCP shall render medical care to enrollees of CCP, pursuant to all laws and regulations applicable to the Provider and CCP, including all requirements of the Florida Medicaid Program, the Florida Medicaid Coverage and Limitation Handbook, and the CCP Provider Manual. Providers are responsible for delivering and managing healthcare services for members based on medical necessity criteria.

Additionally, practitioners and providers are responsible for the following:

- Notify CCP in Writing of Any Changes Within 30 Days of the Change:
  - Changes in practice ownership, name, address, phone number, National Provider Identifier (NPI), or federal tax identification numbers
  - Addition or departure of a physician from the practice
  - Loss or suspension of the provider's license to practice
  - Practice bankruptcy or insolvency
  - Suspension, exclusion, debarment, or other sanctions from state or federally funded healthcare programs
  - Indictment, arrest, or conviction for a felony or any criminal charge related to the practice
  - Material changes in, cancellation, or termination of liability insurance
  - Closing of the practice to new patients, and vice versa
  - Terminating affiliation with CCP

- Not Bill or Balance Bill Members: Providers must not bill or balance bill Medicaid recipients for covered services, regardless of the reimbursement amount from CCP. Providers also cannot bill members for missed appointments.
- Provide 24/7 Coverage: PCPs and specialists must offer access to covered medical services 24 hours a day, seven days a week. This includes answering member calls through a service that can connect the member to someone capable of making a clinical decision or reaching the PCP or treating behavioral health practitioner.
- Inform Members About Advance Directives: Providers must inform CCP members of their right to an advance directive and provide written information on state laws regarding their rights to accept or refuse treatment and the provider's policies on advance directives. Providers must document any discussions on advance directives and include a copy in the patient's file if available.
- Maintain Medical Records: Providers must have policies for maintaining a single, permanent medical record for each patient, protecting records from destruction, tampering, loss, or unauthorized use, and ensuring compliance with state and federal regulations. Records must be complete, legible, and follow standard practices.
- Provide Care: Providers must deliver care within their scope of practice, adhering to CCP's standards for access, availability, quality, and cultural competence. Providers should identify members needing translation or interpretation services and arrange for them through CCP.
- Participate in Quality Improvement Programs: Providers must engage with CCP in quality improvement initiatives and activities related to meeting regulatory requirements and contractual obligations.
- Not Discriminate: Providers must offer optimal care to members without discrimination based on age, race, gender, religion, national origin, disability, sexual orientation, payment source, veteran status, claims experience, social status, health status, or marital status.
- Supply Members with Complete and Accurate Information: Providers must give members complete and understandable information about diagnoses, treatment plans, or prognoses, inform them of non-covered services and their costs beforehand, and advise them of their rights to contact CCP regarding concerns or grievances.
- Maintain Confidentiality: Providers must keep members' protected health information (PHI) confidential according to HIPAA standards and provide necessary PHI to CCP when required for payment, treatment, quality assurance, regulatory, data collection, and reporting activities. Providers must contact the CCP Quality Improvement Department in case of a HIPAA violation.
- Submit Claims: Providers must submit complete and accurate claims conforming to Medicaid requirements within the specified time frames outlined in their contract and provide supporting documentation when necessary.
- Participate in Utilization Management: Providers must adhere to CCP's referral and prior authorization policies and cooperate with utilization management staff by providing required documentation or medical information.
- Provide Continuity of Care Following Provider Termination: Providers terminating their affiliation with CCP must continue providing medically necessary care for at least 60 days post-termination, ensuring a smooth transition for members to another provider.
- Report Adverse or Critical Incidents: Providers must report to CCP any critical or adverse incidents affecting a member's health, safety, or welfare, such as abuse, neglect, exploitation, major illness or injury, law enforcement involvement, elopement, or major medication errors.

- Report Abuse, Neglect, or Exploitation: Providers must immediately report any knowledge or suspicion of abuse, neglect, or exploitation including information on identifying victims of human trafficking. to the Florida Abuse Hotline or online via the Florida Department of Children & Families website. Providers must also ensure staff mandated to report such incidents are trained appropriately and refer victims of domestic violence to the National Domestic Violence Network hotline or local services.
- Participate in Training: Providers must participate in training mandated by regulatory authorities and/or CCP
- All participating providers in Community Care Plan's (CCP) network are required to refer members to the designated capitated vendor network for applicable services. Referrals to providers outside of the capitated network will be considered out-of-network and may result in claim denials unless prior authorization has been obtained for medical necessity or lack of network availability. Participating providers must ensure they are directing members to the appropriate capitated providers to maintain compliance with network requirements.

PCP Responsibilities and Covered Services

In addition to the general responsibilities outlined above, network PCPs must adhere to the following:

- Supervise, Coordinate, and Provide Primary Care: Deliver all primary care to each assigned member, including annual physicals, well-woman examinations, preventive care, and regular immunizations.
- Arrange for Covered Physician Services: Coordinate with other participating physicians to provide members with covered services as stipulated in their contract, ensuring effective communication with those treating providers.
- Adhere to Standards of Practice: Provide all covered physician services in line with generally accepted clinical, legal, and ethical standards, consistent with the PCP's licensure, qualifications, training, and experience recognized within the medical community where the PCP practices.
- Educate Members: Educate members on maintaining healthy lifestyles and preventing serious illnesses.
- Provide Preventive and Chronic Care Screenings: Conduct well-care and chronic care screenings and refer members to community health departments and other agencies in accordance with AHCA provider requirements and public health initiatives.
- Screen for Substance Use Disorders: Screen members for signs of alcohol or substance use disorder during:
    - Routine physical examinations
    - Initial contact
    - Initial prenatal contact
    - When emergency room visit documentation suggests the need
    - Evidence of serious over-utilization of medical, surgical, trauma, or emergency services

Health Risk Assessment

Health Risk Assessments (HRAs) within the Florida Medicaid HMO network are crucial for identifying the health risks and needs of Medicaid members. They enable targeted interventions and efficient resource allocation to improve overall population health. An HRA is a comprehensive evaluation of health risks and needs at the population level, identifying high-risk individuals and subgroups to inform care planning and resource allocation.

High-Risk Member: A Medicaid member identified through the PHRA as having a significant risk of adverse health outcomes due to chronic conditions, socioeconomic factors, or other determinants of health.

Procedures

- Data Collection:
  - Demographic Information: Collect data on age, gender, race, ethnicity, and socioeconomic status.
  - Health Status: Gather information on current health conditions, medical history, and family health history.
  - Lifestyle Factors: Assess lifestyle factors such as diet, physical activity, smoking status, alcohol consumption, and drug use.
  - Health-Related Social Needs: Evaluate social determinants, including housing instability, employment status, education level, and access to transportation.
- Risk Stratification:
  - Utilize predictive analytics and validated assessment tools to stratify members into risk categories (low, medium, high).
  - Factors considered in risk stratification include the number and severity of chronic conditions, medication adherence, and history of hospital readmissions
- Identification of High-Risk Members:
  - Identify high-risk members who may benefit from targeted interventions, such as case management, disease management, or social support services.
- Intervention Planning:
  - Develop individualized care plans for high-risk members, involving multidisciplinary care teams as needed.
  - Interventions may include medication management, chronic disease education, lifestyle modification programs, mental health services, and social support.
- Implementation and Follow-Up:
  - Implement care plans and coordinate services among primary care providers, specialists, and community resources.
  - Follow up regularly with high-risk members to monitor progress, adjust care plans as necessary, and ensure adherence to treatment recommendations.
- Evaluation and Reporting:
  - Continuously evaluate the effectiveness of interventions and adjust strategies based on outcomes.
  - Report findings to the Medicaid HMO for monitoring and quality improvement.

Provider Responsibilities

- Conduct Assessments: Providers are responsible for conducting thorough HRAs during initial patient visits, routine check-ups, and as needed based on changes in the member's health status.
- Document Findings: Providers must document all assessment findings in the member's medical record, ensuring accuracy and completeness.
- Develop Care Plans: Based on assessment results, providers must develop and implement individualized care plans, coordinating with other healthcare professionals and community resources.
- Follow-Up: Providers should conduct regular follow-ups to assess the effectiveness of care plans and adjust as necessary.

- Education and Training: Providers must stay informed about best practices in population health management and participate in ongoing training and education programs offered by the Medicaid HMO.
- Appointment Access: Providers must comply with the established guidelines for timely access to care.

Monitoring and Compliance

- Audit and Review: The Medicaid HMO will conduct periodic audits and reviews of PHRAs and care plans to ensure compliance with this policy and identify areas for improvement.
- Quality Metrics: Performance metrics related to population health outcomes, such as reduction in hospital readmissions and improved management of chronic conditions, will be monitored and reported.

Support and Resources:

- Technical Assistance: The Medicaid HMO will provide technical assistance and support to providers for implementing HRAs and developing effective care plans.
- Training Programs: Providers will have access to training programs focused on population health management, risk stratification, and care coordination.
- CCP Provider Academy: Provider Academy

By conducting comprehensive Health Risk Assessments, the Florida Medicaid HMO aims to enhance the quality of care for its members, improve health outcomes, and promote efficient use of healthcare resources.

Covered PCP Services

Network PCPs are required to provide CCP's members with covered services, including:

Health Risk Assessment:

- Screenings for tobacco use, body mass index (BMI), nutrition, exercise, or other lifestyle risks.
- Documentation and review of growth and development, safety issues, and drug/alcohol use.

Treatment Plan:

- This plan is developed collaboratively with the member, their parent, legal guardian, or other authorized person, and other treating specialists as appropriate. It is created for members seen for routine care or monitoring as well as those requiring extended or complex treatment.

Routine Office Tests:

- All tests are routinely performed in the PCP's office during an office visit.

Outpatient Services and Supplies:

- Any other outpatient services and routine office supplies normally within the scope of the PCP's practice.

Preventive Health Assessments:

- Assessments for gaps in preventive health screenings or visits and evidence-based treatment of chronic conditions.

Laboratory Specimen Collection:

- Collection of laboratory specimens.

Specialty/Injectable Drugs:

- Provision of high-cost specialty/injectable drugs as listed on the prior-authorization list.

Case Management Referrals:

- Identification and referral of members who may benefit from CCP's case management, health management, and lifestyle coaching programs.

Drug Regimen Oversight:

- Oversight of a member's entire drug regimen, including those prescribed by another provider, including behavioral health providers.

Periodic Health Assessments:

- Periodic health assessments and routine physical examinations.

Professional Medical Services:

- The PCP, nurses, and other personnel employed by the PCP provide professional inpatient and outpatient medical services. Services include the administration of immunizations, excluding the cost of biologicals.

Specialty Care Referrals:

- Referrals to specialty care physicians and other health providers with coordination of care and follow-up.

Home Care Supervision:

- Supervised home care/home infusion regimens involving ancillary health professionals provided by licensed nursing agencies.

Vision, Hearing, and Dental Assessments:

- Vision screening, hearing screening, and dental assessments.

Family Planning Services:

- Voluntary family planning services such as examinations, counseling, and pregnancy testing.

Well-Child Care:

- Well-child care and periodic health appraisal examinations, including all routine tests customarily performed in a PCP's office.
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) guidelines and procedures outlined in this provider manual.
- Well-child exams should be conducted according to the EPSDT periodicity schedule, CCP's preventive guidelines, and the recommendations of the American Academy of Pediatrics (AAP).

Provider Programs and Accountabilities

PCPs and the Patient-Centered Medical Home (PCMH) Program

At CCP, the primary care provider (PCP) is central to the member's healthcare experience, acting as the member's "medical home." This care model focuses on fostering a strong member-provider relationship, improving access and continuity of care, and ensuring smooth transitions between different care settings. It also encourages data collection and population health management while minimizing redundant services between PCPs and specialists. The Patient-Centered Medical Home (PCMH) model aims to deliver better care, achieve superior outcomes, reduce costs, and enhance satisfaction for both patients and physicians.

Key Characteristics of a PCMH:

- Personal Physician: Each member has a personal physician who leads a team-based medical practice.
- Coordinated and Integrated Care: Care encompasses physical and behavioral health, considering members' socio-economic conditions and cultural norms.
- Enhanced Access: Ensures that members have easy access to care.
- Quality and Safety: Prioritizes high-quality, safe medical care.
- Whole Person Orientation: Addresses the comprehensive health needs of members.

CCP recognizes PCMH certifications from the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC), and URAC. CCP also has incentive programs for PCMH providers and offers incentives to assist groups aiming to become PCMH accredited. For more information, please contact Provider Operations at CCP.Provider@ccpcares.org.

Programs

Community Care Plan is committed to fostering high-quality care and better health outcomes for our members through innovative Provider Programs, including Value-Based Care (VBC) initiatives. Our VBC programs are designed to incentivize providers who deliver efficient, effective, and patient-centered care, aligning reimbursement with the achievement of specific health outcomes and quality metrics.

The Agency for Health Care Administration (Agency) implemented the Medicaid Managed Care Physician Incentive Program (MPIP) effective for dates of service beginning October 1, 2016, in accordance with Florida Statutes, Section 409.967(2)(a). This statute mandates that managed care plans utilize effective care management to reallocate resources, ensuring that physicians are compensated at rates equivalent to or higher than Medicare rates for comparable services. The MPIP is structured to enhance compensation for specific physician categories who fulfill established qualifying criteria. These criteria are primarily based on essential access and performance standards, ensuring high-quality care for Medicaid beneficiaries. Through MPIP, the Agency aims to incentivize physicians to achieve better health outcomes and increased service accessibility. For comprehensive details on the program's design for each year, including eligibility requirements and performance benchmarks, please refer to the link below:

MMA Physician Incentive Program (MPIP)

Under our Value-Based Care initiatives, providers are encouraged to participate in programs that focus on comprehensive care coordination, preventive services, and chronic disease management. These programs include, but are not limited to, the Patient-Centered Medical Home (PCMH) model, which emphasizes enhanced access to care, integrated behavioral health services, and patient engagement. Providers are also incentivized to complete Social Determinants of Health (SDOH) surveys and Health Risk Assessments (HRA), as well as to share these results with our plan to better address the holistic needs of our members.

Moreover, we recognize the importance of extending access to care beyond traditional office hours and modalities. Providers offering telemedicine services and after-hours availability are supported through our VBC programs, ensuring members have timely access to care. Additionally, our programs promote the integration of behavioral health into primary care settings, reflecting our commitment to treating the whole person and improving overall health outcomes.

These Provider Programs are integral to our mission of improving the health and well-being of the communities we serve, and we encourage all providers to engage fully in these initiatives. For more information on a Value-Based Care contract, please contact our Provider Operations department via email at CCP.Provider@ccpcares.org. Through collaboration and shared accountability, we can achieve better care, better health outcomes, and lower costs for our members.

Preferred Provider Group Program for High-Performing Providers

A CCP program that rewards providers for delivering evidence-based care and achieving high-performance standards. The objective of this program is to recognize and support high-performing providers within CCP's network. High-performing providers deliver exceptional care, achieve superior patient outcomes, and maintain efficient operations, contributing significantly to the overall quality and effectiveness of the SMMC program. Criteria for High Performance: Providers are evaluated annually based on a combination of quality metrics, access, compliance with regulatory requirements, and operational efficiency.

Key performance indicators used to assess high performance include:

- Quality of Care:
  - Adherence to clinical guidelines and evidence-based practices
  - High rates of preventive care services (e.g., immunizations, screenings)
  - Effective management of chronic conditions (e.g., diabetes, hypertension)
- Access:
  - Performance on Potentially Preventable Admissions (PPA) and Potentially Preventable Visits (PPV)
  - Timely access to care and reduced wait times for appointments
  - Efficient use of resources and cost-effective care delivery
- Utilization:
  - Low rates of hospital readmissions and emergency room visits
  - Performance on Emergency Department (ED) visits and inpatient admissions
  - Effective coordination and continuity of care

Recognition and Incentives

High-performing providers are recognized through various incentives and support mechanisms designed to acknowledge their excellence and encourage continued high performance. These may include:

- Financial Incentives: Performance-based bonuses or enhanced reimbursement rates
- Public Recognition: Listing on the website, directory, and other publications as a high-performing provider
  - Awards or certificates of excellence presented at public events or meetings
- Professional Development: Invitations to participate in advisory committees or leadership councils
- Supportive Services:
  - Technical assistance for implementing quality improvement projects
  - Enhanced access to care management and patient support resources
  - Waived prior authorization requirements for certain procedures

Value-Based Care Program Incentives Include:

Primary Care Provider (PCP) Incentives:

- HEDIS Measures
- Patient-Centered Medical Home (PCMH)
- Social Determinants of Health (SDOH)
- Health Risk Assessments (HRA)
- Behavioral Health (BH) Integration
- Risk Adjustment

OB/GYN Incentives:

- SBIRT (Screening, Brief Intervention, and Referral to Treatment)
- Medication-Assisted Treatment (MAT)
- Utilization Metrics
- HEDIS Measures

Behavioral Health Incentives:

- HEDIS Measures
- PCP Integration

Monitoring and Evaluation

A robust evaluation process continuously monitors provider performance. This includes regular reviews of clinical outcomes, patient satisfaction surveys, and compliance audits. Providers receive feedback and guidance to help them maintain or improve their performance.

Provider Responsibilities

To be recognized as a high-performing provider, Medicaid HMO network providers must:

- Maintain accurate and up-to-date patient records
- Participate in quality improvement programs and initiatives
- Engage in ongoing professional development and training
- Collaborate with CCP and other providers to enhance care coordination
- Adhere to best practices and clinical guidelines

Coordination Between Physical and Behavioral Health

Effective coordination and continuity of care between behavioral and medical health services are crucial. This involves:

- Communication: Ensuring open lines of communication between medical and behavioral health professionals.
- Diagnosis and Treatment: Providing accurate diagnosis, treatment, and referral for behavioral disorders commonly seen in primary care.
- Medication Use: Making appropriate use of psychotropic medications.
- Access and Follow-Up: Managing treatment access and follow-up for members with coexisting medical and behavioral disorders.
- Preventive Programs: Implementing primary or secondary preventive behavioral healthcare programs.
- Special Needs: Addressing the needs of those with severe and persistent mental illness.

PCPs treating members with behavioral health needs should:

- Consult with behavioral health and substance use disorder providers regarding the member's medical condition, mental status, psychosocial functioning, and family situations when making referrals or during treatment.
- Use all available communication methods to coordinate treatment and document these methods in the member's medical record.

Behavioral health practitioners are expected to:

- Refer members with known or suspected untreated physical health problems to their PCP for examination and treatment to ensure continuity of care.
- With appropriate written consent from the member, keep the PCP informed about the member's treatment status and progress in a consistent and reliable manner, adhering to the requirements set forth in 42 CFR Part 2, when applicable.
- If a member requests that information not be shared with the PCP, document this refusal in the member's treatment record and, if possible, provide the reason.

Contracted behavioral health practitioners and providers should include the following information in their reports to the PCP:

- A copy or summary of the intake assessment.
- Member's completion of treatment.
- Results of an initial psychiatric evaluation and the initiation of major changes in psychotropic medication(s) within 14 days of the visit or medication order.
- Results of functional assessments.
- Written notification of the member's noncompliance with the treatment plan (if applicable).

Special Considerations

Practitioners should exercise caution when conveying information regarding behavioral health disorders, as this information is protected under federal law.

Support and Assistance

For assistance in identifying network providers or for care management support for a member, providers can contact Member Services 1-866-899-4828.

Telemedicine

Telemedicine refers to the delivery of healthcare services by a practitioner situated at a different location than the recipient, for purposes of evaluation, diagnosis, or treatment. Practitioners licensed within their scope of practice are eligible to provide telemedicine services. CCP reimburses for telemedicine services conducted through interactive telecommunications equipment, comprising audio and video capabilities enabling two-way, real-time, interactive communication between patient and practitioner. Providers must ensure that their telecommunication equipment and telemedicine operations comply with the technical safeguards mandated by 45 CFR § 164.312, where applicable.

Providers must adhere to the following requirements for billing telemedicine services:

- Conduct two-way, real-time interactive communication between patient and physician.
- Engage in audio and video interaction with the patient.
- Utilize technology compliant with HIPAA privacy requirements.
- Obtain informed consent from the patient for the use of telemedicine.
- Offer the patient the choice between accessing services through a face-to-face visit or telemedicine.
- Document the patient's choice for telemedicine in the medical record.
- Modifier GT must be included on the CMS-1500 claim form.

CCP does not reimburse providers for:

- Telephone conversations
- Chart reviews
- Electronic mail messages
- Facsimile transmissions

All CCP referral, notification, and prior authorization requirements remain applicable. Providers may provide and receive payment for covered, eligible telemedicine services rendered, in accordance with this manual and their scope of practice.

Responsibilities of Network Specialists

Specialists within the network are entrusted with several key responsibilities, including:

- Coordinating Care: Specialists are tasked with coordinating the member's care in collaboration with the Primary Care Provider (PCP). Provide appropriate records within five (5) business days. Obtain prior authorization for non-emergency inpatient admissions and specified services.
- Maintaining Communication: Specialists must maintain regular communication with the PCP to ensure alignment and continuity of care.
- Providing Reports: Specialists are required to furnish the PCP with comprehensive reports and relevant records within five business days of the member's consultation or appointment.
- Authorization: Specialists must adhere to prior authorization requirements.

Responsibilities of Network Hospitals

Responsibilities of Network Hospitals Network hospitals affiliated with CCP should refer to their contractual agreements for a comprehensive understanding of their obligations and reimbursement policies. In general, network hospitals are expected to:

- Assist CCP in identifying members at high risk for readmission and collaborate on discharge planning, including scheduling post-discharge follow-up appointments with the member's PCP or treating specialist prior to discharge.
- Communicate the clinical status of CCP members to aid in discharge planning.
- Notify the member's PCP immediately or no later than the close of the next business day following the member's visit to the emergency department.
- Notify CCP's Utilization Management Department of all maternity admissions upon admission, as well as all newborn deliveries on the same day as the delivery, and all non-maternity admissions by the close of the next business day.
- Obtain authorizations for all inpatient emergent or urgent admissions through CCP's Secure Provider Portal within two business days after the admission date.
- Obtain authorizations through CCP's Secure Provider Portal for all inpatient and outpatient services listed on the current prior authorization list, except for emergency stabilization services.
- Provide CCP's utilization management staff with access to the hospital's electronic medical record system, where applicable.
- Children's Hospitals participating in multidisciplinary clinics will offer coordination of care for medically complex children with:
- Three or more chronic conditions affecting multiple organ systems, severely impacting cognitive or physical functioning, and requiring medication, durable medical equipment, therapy, surgery, or other treatments.
- One life-limiting illness or rare pediatric disease as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

Community Care Plan

The Health Plan with a Heart

11. Provider Administration

Provider Services and Support

At Community Care Plan (CCP), we are committed to providing our network providers with comprehensive support and resources to ensure the delivery of high-quality care to our members.

Our Provider Operations Team is dedicated to supporting your practice by aiding with contract management and general operational support. They are your primary point of contact for any questions or issues you may encounter.

Contact Information:

- Phone: 1-855-819-9506
- Email: ccp.provider@ccpcares.org
- Hours: Monday to Friday, 8:00 AM to 5:00 PM

Provider Office Standards

CCP requires all office spaces to be professional, clean, free of clutter, and physically safe. In addition, offices must have visible signage, a separate waiting area with adequate seating, a fully confidential telephone line, and clean restrooms. Offices must also comply with the Americans for Disabilities Act (ADA) and have locked cabinets behind locked doors for storage of patient medical records, prescription pads, and sample medications. Compliance with these standards is noted during site visits.

Consumer Assistance Notice

CCP requires that all providers prominently display a consumer assistance notice in the office reception area. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration (AHCA)and the Department of Financial Services. The consumer assistance notice must also clearly offer to provide, upon request, the address and toll-free telephone number of CCP's Grievance Department.

Provider Training

Community Care Plan is committed to ensuring that all network providers are equipped with the knowledge and skills necessary to deliver high-quality care to our members. Comprehensive training programs are designed to keep providers informed about CCP policies, regulatory requirements, and best practices in patient care. The primary objectives of our provider training programs are to:

- Enhance provider understanding of CCP policies and procedures.
- Ensure compliance with regulatory and accreditation requirements.
- Support the delivery of high-quality, patient-centered care.
- Promote the integration of behavioral health and primary care.
- Encourage the adoption of innovative practices such as telemedicine and after-hours care.

Providers can access training materials and register for upcoming sessions through the CCP website. Recorded sessions and supplemental materials are also available for review at any time.

Providers are encouraged to contact the CCP Provider Operations team for more information or to suggest additional training topics.

Initial Training

The new provider orientation at Community Care Plan is designed to introduce providers to the organization's mission, vision, and values while familiarizing them with key policies and procedures. This comprehensive program includes an overview of the provider manual, guidance on claims submission and billing processes, and a walkthrough of the Provider Portal and online resources. The orientation also covers essential topics such as regulatory compliance, best practices in patient-centered care, and the integration of services like behavioral health and telemedicine. Through this orientation, new providers gain the knowledge and tools necessary to deliver high-quality care to Medicaid and SMI members, ensuring a smooth transition into the CCP network. Providers must complete this training within 30 days of joining the network.

Required Training

Providers must complete mandatory training sessions as specified by CCP. This includes training on documentation standards, quality improvement processes, and member rights regarding advance directives. Providers are also required to undergo regular updates and refresher courses to stay compliant with current healthcare standards and regulations. Additional trainings may be found in CCP Provider Academy.

In addition to the initial training, network providers are required to complete the following sessions:

- **Fraud, Waste, and Abuse:** Within the first 30 days of joining the network and annually thereafter.
- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):** Annually.
- **Abuse, Neglect, and Exploitation:** Regularly scheduled.
- **Behavioral Health Assessment Tools:** Training on assessment instruments and techniques for identifying individuals with unmet behavioral health needs, evidence-based practices, and the dependency system.
- **Trauma-Informed Care:** PCPs and behavioral health providers must complete this training, available via webinar or live session.
- **Cultural Competency:** All Providers must complete this training.

Behavioral Health Clinical Training

Behavioral health training ensures providers are equipped to handle the complexities of mental health care. CCP provides a variety of clinical behavioral health training aimed at enhancing practitioner competence, skill development, member recovery, resilience, and the use of evidence-based practices. Training topics include but are not limited to:

- Behavior management strategies
- Suicide risk assessment
- Signs and symptoms of mental illness
- Verbal de-escalation strategies for aggressive behavior
- Basics of trauma-informed care
- Effects of childhood trauma
- Documentation and reporting of behavioral health concerns

These clinical trainings are available throughout the year and may be provided in person or via webinar on the CCP website.

Provider Termination

Providers may be removed from CCP's network for a variety of reasons, such as failing to meet documentation standards, delivering inadequate service, or not adhering to contractual obligations. The termination process includes a comprehensive review to ensure all actions are justified and comply with regulatory standards. Practitioners should consult their CCP contracts for specific details on termination procedures. In general, medical providers who wish to terminate an individual practitioner within a practice or group should submit the termination request on official letterhead. This request should include the practitioner's name, tax identification number, NPI, termination date, and, if applicable, information regarding member transfer. The provider, practice, or group should contact their Provider Operations Representative for assistance. Alternatively, providers can reach out to CCP Provider Operations via email at ccp.provider@ccpcares.org.

Providers have the right to appeal an involuntary termination decision. Appeals must be submitted in writing within 30 days of receiving the termination notice. The CCP Provider Operations Committee will review appeals, and a decision will be communicated to the provider within 60 days.

Provider Marketing Activities

CCP's contract with AHCA dictates how CCP and its providers present and advertise the program. AHCA requires providers to submit samples of any community outreach materials to CCP for state approval before distribution or display. Providers should send these materials to CCP, which will forward them to AHCA within two business days and notify providers of approval or required changes within two business days of AHCA's response. Providers may:

- Assist potential enrollees with an objective assessment of their needs and potential options.
- Engage in discussions with patients seeking advice, while remaining neutral in enrollment decisions.
- Display posters or other materials in common areas, such as waiting rooms.
- Make available and/or display marketing materials, provided they also display materials from all managed care plans with which they participate and agree to accept future requests to display materials from other managed care plans.
- Inform patients about the managed care plans with which they participate.
- Refer patients to other information sources, such as CCP, an enrollment broker, or the local Medicaid office.
- Share information with patients from AHCA's or CMS's websites.

Providers may not:

- Accept compensation from CCP for marketing activities.
- Mail marketing materials on behalf of CCP.
- Display or distribute marketing materials within an exam room.
- Make phone calls or attempt to persuade recipients to enroll in a managed care plan based on the provider's financial or other interests.
- Offer anything of value to induce potential enrollees to select them as their provider.
- Offer inducements to persuade potential enrollees to enroll in CCP.
- Conduct health screenings as a marketing activity.
- Offer marketing/appointment forms.
- Provide CCP with lists of their Medicaid patients or the membership of any managed care plan.

Medical Record Documentation

Providers must adhere to proper guidelines for documenting member medical records to ensure that records:

- Are current, detailed, and organized.
- Include information on the quality, quantity, appropriateness, and timeliness of services rendered.
- Allow for evaluation of effective patient care and quality reviews.

Medical records must be legible, comprehensive, and contain the member's identifying information, such as name, identification number, date of birth, sex, and legal guardianship status if applicable. Additionally, they should include:

- Summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs, and current medications.
- Details of all services provided by practitioners, including family planning, preventive care, and treatment for sexually transmitted diseases.
- Copies of consent/attestation forms or court orders for prescribed psychotherapeutic medication for MMA members under 13.
- Documentation of referral services.
- Confirmation that the member received written information regarding advance directives, including copies of any executed advance directives.
- Entries dated and signed by the appropriate party.
- Chief complaint or purpose of the visit, along with objective diagnoses, medical findings, or provider impressions.
- Studies ordered (e.g., laboratory tests, x-rays, EKGs) and referral reports.
- Therapies prescribed and administered.
- Name and profession of the provider, along with their signature or initials.
- Disposition, recommendations, member instructions, evidence of follow-up, and service outcomes.
- Immunization history.
- Information on tobacco/alcohol/substance use.
- Details related to telemedicine services, including a brief explanation of use, equipment used, and member consent.
- Summaries of emergency services, hospital discharges, and indicated follow-up.

Additionally, records should include the member's primary language, translation needs, and communication assistance requirements. Providers must furnish member medical records to support utilization management and quality activities, including HEDIS, audits, quality studies, and improvement projects.

Cultural Competency

CCP's cultural competency plan ensures that members receive care that is sensitive to their cultural and linguistic needs, following the CLAS standards set by the Office of Minority Health at the Department of Health and Human Services. CCP evaluates its network's cultural competency through data analysis to maintain a diverse provider network that meets these needs.

To reduce racial and ethnic health disparities, CCP:

- Contracts with a culturally competent network.
- Provides language support.
- Educates staff, contracted providers, and vendors.

To engage members from diverse cultural backgrounds or those who do not speak English as their first language, CCP employs staff proficient in prevalent languages and knowledgeable about various cultures. Interpreter services are available to assist members during interactions with staff and practitioners.

The provider network team conducts annual assessments of members' cultural, ethnic, racial, and linguistic needs by comparing data from external and internal sources. This ensures alignment between membership needs and practitioner demographics, maintaining a culturally diverse network. Outcomes from these assessments are used to enhance the practitioner network as needed.

Newly credentialed practitioners and providers are invited to orientation sessions that include comprehensive training on cultural competency and sensitivity. Network providers can find more information about the cultural competency plan on the CCP website.

Provider Assistance with Cultural Competency Needs

CCP's Member Services staff and/or care managers are available to assist in arranging translation services for upcoming appointments or other necessary services. Various types of translation services are offered:

- Face-to-Face Interpreters: For members requiring face-to-face interpreters in languages other than English, CCP will facilitate a three-way call with the interpreter service vendor, provide relevant information about the member's needs, and schedule a suitable time and place for an interpreter to meet with the member.
- Telephonic Interpreters: CCP provides language translation services through a contracted vendor, available to members and all participating network practitioners and providers.
- Assistance for Deaf or Hearing-Impaired Members: CCP will utilize the relay service via three-way calling, furnish pertinent information about the member's needs, and schedule an interpreter to meet with the member for the appointment. This service requires at least two working days' notice before the appointment.
- Non-Urgent Requests for Interpreters: Providers may arrange sign language or foreign language interpreters for medical appointments by contacting Member Services.

In non-urgent cases, live, in-person translation is preferred over telephonic translation. Telephonic services are utilized only when an interpreter for the required language cannot be found in or near the specific area.

PCP Member Panel Capacity

All primary care providers (PCPs) have the right to specify the number of members they are willing to accept into their panel. CCP does not guarantee any provider a predetermined number of members.

If a PCP wishes to adjust the capacity of their practice, they must contact CCP Provider Operations at CCP.Provider@ccpcares.org.

Providers are required to notify CCP at least 45 days in advance if they are unable to accept additional members under the CCP agreements. CCP prohibits providers from intentionally segregating members from fair treatment and covered services provided to non-Medicaid members.

PCPs must confirm that their total active patient load does not exceed 3,000 active patients across all plans or services, including commercial insurance. An active patient is defined as one seen by the PCP at least three times per year. Each full-time equivalent PCP may not have more than 1,500 Medicaid patients, and each full-time equivalent advanced registered nurse practitioner may not have more than 750 patients in total.

Panel Member Dismissal

A primary care provider (PCP) may request the transfer of a member from their panel to another practice for the following reasons:

- Disruptive, unruly, threatening, or uncooperative behavior by the member or their parent/legal guardian, especially if unrelated to a physical or behavioral condition.
- Personality conflicts between the PCP/PCP staff and the member.
- Repeated disregard of medical advice.
- Repeated disregard of member rights.

However, a PCP may not request disenrollment for the following reasons:

- Previous inability to pay medical bills or outstanding account balances before the member's enrollment with CCP.
- Adverse changes in the member's health status or utilization of medically necessary services.
- Discrimination based on the member's race, color, national origin, sex, age, disability, political beliefs, or religion.

The PCP must initiate the process by sending a certified mail letter to the member, informing them of the request to dismiss them from the panel. All relevant documentation, including the PCP's letter and the certified mail receipt, should then be forwarded to Provider Operations at CCP.Provider@ccpcares.org for further review.

Upon receipt, the Member Services and Provider Operations departments may conduct interviews with the member, the provider or staff requesting disenrollment, and any other relevant providers. They may also involve other CCP departments as necessary to resolve the issue and review relevant medical records.

Provider Coordination with Carve-out Public Health Services

CCP is required to collaborate with entities providing public health services that are covered by Medicaid but not directly by CCP.

Providers should inform their patients of these services, which encompass the following:

- County Health Department (CHD) Certified Match Program: This initiative offers reimbursement to local state health departments for necessary nursing, medication administration, and social work services provided in schools to Medicaid-eligible students under 21 years old.
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services (HCBS) Waiver: The iBudget Waiver delivers home and community-based support to eligible individuals aged 3 and above with developmental disabilities, aiming to maintain independence and health while delaying institutionalization.
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver: This waiver provides support and services to eligible individuals aged 3 and above with Familial Dysautonomia, promoting health and independence while preventing institutionalization.
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID): These services offer round-the-clock medical and rehabilitative support to recipients diagnosed with an intellectual disability residing in intermediate care facilities.
- Medicaid Certified School Match (MCSM) Program: This program reimburses school districts for necessary services provided to disabled students under 21 years old, such as behavioral, nursing, and therapy services.
- Model Home and Community-Based Services Waiver: This waiver provides home and community-based services to medically complex or fragile children under 21 years old to delay or prevent institutionalization.
- Newborn Hearing Services: These screenings test all Medicaid-eligible newborns for hearing impairment, ensuring early detection and intervention.
- Prescribed Pediatric Extended Care (PPEC): These services offer skilled nursing interventions to Medicaid-eligible children with complex medical conditions.
- Program for All-Inclusive Care for Children (PACC): This program provides specialized palliative care support services for children under 21 years old diagnosed with life-threatening illnesses.
- Substance Abuse County Match Program: This program enables eligible counties to receive federal matching funds for Medicaid-funded substance abuse services.
- Hemophilia Factor-Related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program: Members requiring prescribed drugs for hemophilia or von Willebrand disease receive them through the Comprehensive Statewide Hemophilia Disease Management Program.
- PACE Services
- Florida Assertive Community Treatment (FACT) services

Provider Complaints

A provider complaint is any dissatisfaction or concern expressed by a healthcare provider regarding issues such as claims processing, contract terms, network participation, service authorizations, and interactions with CCP staff. Complaints may also relate to operational processes, provider directories, or other aspects of the provider's experience with CCP.

Providers may submit complaints through the following channels:

- Email a detailed description of the complaint to the Provider Operations team at CCP.Provider@ccpcares.org.
- Call the Provider Operations Hotline at 1-855-819-9506 and speak directly with a representative.
- Contact your assigned Provider Representative

CCP acknowledges receipt within three (3) business days and provides status updates every 30 days until the complaint is resolved. For non-claims complaints, providers shall submit their grievances within 45 days from the incident date. CCP will Resolve all complaints within ninety (90) days of receipt.

Each complaint undergoes a thorough investigation, adhering to applicable statutory, regulatory, and contractual provisions, including CCP's written policies and procedures. Health plan executives with corrective action authority are involved in the process.

Upon resolution, CCP sends a written notification to the provider within three (3) business days, acknowledging the complaint's resolution.

12. Member Rights and Responsibilities

As a recipient of Medicaid and a member of CCP, you have specific rights to ensure you receive high-quality care and respect. These rights include:

- Courtesy and Respect: To be treated with courtesy and respect by all healthcare providers and staff.
- Dignity and Privacy: To have your dignity and privacy respected at all times.
- Responsive Care: To receive prompt and helpful responses to your questions and requests.
- Provider Identification: To know who is providing your medical services and who is responsible for your care.
- Service Information: To receive information about available member services, including interpreter services if you do not speak English.
- Conduct Rules: To know what rules and laws apply to your conduct as a member.
- Informed Health Choices: To be provided with clear, understandable information about your diagnosis, necessary treatments, treatment options, associated risks, and benefits.
- Health Care Decisions: To make decisions about your health care, including the right to refuse treatment, except as otherwise provided by law.
- Financial Information: To receive information about other ways to help pay for your health care.
- Provider Acceptance: To know if your provider or facility accepts the Medicare assignment rate.
- Cost Information: To be informed in advance about the potential costs of services.
- Billing Information: To receive a copy of your bill and have the charges explained to you.
- Non-Discrimination: To receive medical treatment regardless of race, national origin, religion, disability, or payment source.
- Emergency Services: To receive treatment for any health emergency that will worsen without treatment.

- Experimental Treatment: To know if your medical treatment is part of experimental research and to agree or refuse participation.
- Complaint and Grievance: To file complaints when your rights are not respected and to appeal decisions about your services.
- Second Opinion: To request a second opinion if you disagree with your doctor.
- Medical Records Access: To get a copy of your medical records and request amendments or corrections if needed.
- Privacy of Records: To have your medical records kept private and shared only as required by law or with your consent.
- Advance Directives: To decide how you want medical decisions made if you are unable to make them yourself.
- Freedom of Speech: To speak freely about your healthcare and concerns without facing negative consequences.
- Protection from Abuse: To be free from any form of abuse, neglect, exploitation, or unnecessary restraints.
- Out-of-Network Services: To receive services from an out-of-network provider if the Plan cannot provide an in-network provider.
- Grievance and Appeal: To file grievances and appeal decisions regarding your services.
- Exercise of Rights: To freely exercise your rights without the Plan or its network providers retaliating against you.

Advance Directives

Primary Care Providers (PCPs) and other practitioners delivering care to members must ensure that adult members (18 years and older) receive information about advance directives (such as living wills or power of attorney) and are informed of their right to execute these directives. This information must be documented in the member's permanent medical record, along with confirmation that the member was provided with written information regarding advance directives.

Neither CCP nor its practitioners nor providers will condition care authorization or provision based on the presence or absence of an advance directive. Facilitating communication between members or their representatives and practitioners or providers is a priority, particularly in decisions regarding resuscitative services or life-sustaining treatment.

The following steps are recommended:

- Initial Inquiry: During the first appointment, ask if the member has an advance directive and document the response in their medical record. If the member does not have an advance directive, ask if they would like more information and document their interest.
- Education: Provide educational materials and information about advance directives if requested, and document this in the member's medical record.
- Document Handling: Request members with advance directives to bring a copy to the office and note this request in their medical record.
- Record Inclusion: Include the advance directive, including mental health directives, in the member's medical record. Discuss potential medical emergencies with the member and their designated representative and document these discussions.
- Provider Communication: Educate members on the importance of sharing advance directives with relevant healthcare providers, hospitals, and family members or caregivers.

Complaints related to non-compliance with advance directives or treatment decisions are reviewed as part of CCP's quality-of-care process. The Florida Health Care Association website.

13. Pharmacy Program

Pharmacy Benefit

CCP covers prescription drugs and certain over-the-counter (OTC) medications prescribed by CCP providers. Certain medications may require prior authorization or have limitations related to dosage, maximum quantities, or the member's age. CCP adheres to the Agency for Health Care Administration (AHCA)'s Preferred Drug List (PDL), also known as the formulary. The CCP Preferred Drug List (PDL).

In addition to medications available from retail pharmacies, CCP covers specialty injectable drugs or pharmaceuticals that can be administered in a physician's office or a member's home. These injectable drugs do not include immunizations provided in the PCP's office. Prime specialty pharmacy network providers are the preferred provider for biopharmaceuticals and specialty injectables for CCP.

While most drugs are covered through a member's prescription drug benefit, some drugs may be covered through a member's medical benefit. For a list of physician-administered drugs, refer to AHCA's Provider Reimbursement Schedules and Billing Codes website. Prior authorization may be required for some of these drugs. Providers can search for drugs requiring prior authorization, and prior authorization forms through a member's medical benefits using the CCP Pre-Auth Check Tool.

Pharmacy Benefit Manager

CCP contracts with Prime Pharmacy to administer the prescription drug benefit and process pharmacy claims for CCP members. Prime handles prior authorizations for certain prescription drugs subject to quantity limits (QL), age limits (AL), and other clinical requirements for approval. Providers should consult the CCP Preferred Drug List (PDL) for information on medication coverage limitations and prior authorization requirements.

Please follow these guidelines for efficient processing of your PA requests:

Prior Authorization Fax:	800-424-7913
Prior Authorization Phone:	800-424-7897
Mailing Address:	Community Care Plan (CCP) C/o Prime Therapeutics State Government Solutions LLC Attn: GV-4201 P.O. Box 64811 St. Paul, MN 55164-0811

When calling, please have patient information, including Medicaid ID number, complete diagnosis, medical history, and current medications readily available. Upon receipt of all necessary information, Prime will respond by fax or phone within 24 hours except during weekends and holidays. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific enrollee to receive this specific drug. If the request is denied, information about the denial will be provided to the prescribing provider.

CCP providers are requested to utilize the PDL when prescribing medication for patients covered by the CCP pharmacy program. Prime Pharmacy processes pharmacy claims. For assistance, pharmacies can contact the Prime help desk at 1-800-424-7897.

Functions performed by CCP:

- Benefit design consultation
- Prior authorization
- Drug utilization review

Functions performed by Prime Therapeutics:

- Benefit design consultation
- Claims processing
- Drug utilization review
- Pharmacy network management
- Mail-order pharmacy services
- Prior authorization review

Prime Pharmacy specialty pharmacy network participants are the preferred providers of biopharmaceuticals and specialty injectables for CCP. High-cost specialty injectables often require prior authorization for approval.

Preferred Drug List

The CCP Preferred Drug List (PDL) is located on the CCP website. CCP follows the Medicaid PDL, which provides detailed information on covered medications, when prior authorization is required, and age limitations. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of the physician, clinician, or pharmacist.
- Relieve the physician/clinician or pharmacist of any obligation to the member or others.
- Unapproved Use of Preferred Medications

Medication coverage is limited to FDA-approved, non-experimental indications. Drugs used for other indications may also be covered if recognized as safe and effective in current medical and pharmaceutical reference texts and evidence-based medicine. Experimental and investigational drugs, as well as drugs used for cosmetic purposes, are excluded from coverage.

Newly Approved Medications

Newly approved drug products are generally not added to the Preferred Drug List (PDL) during their first six (6) months on the market. During this initial period, access to these medications is considered for review through the Prior Authorization Process.

DESI or IRS Drugs

CCP does not cover Drug Efficacy Study Implementation (DESI) drugs and Identical, Related, and Similar (IRS) drugs, as they are classified as ineffective.

Controlled Substances

Prescribers of controlled substances must register and access the State "Prescription Drug Monitoring Program" (PDMP) database called E-FORCSE. Once registered, prescribers must use E-FORCSE to check a Medicaid member's utilization history for controlled substances before providing an opioid prescription. At a minimum, prescribers or their designees are required to review the database before prescribing a controlled substance (except for a non-opioid Schedule V) to a member 16 years of age or older. Providers can access E-FORCSE or the Florida Department of Health.

Hemophilia Medications

Since 2019 the Agency for Health Care Administration (AHCA) has contracted CVS Caremark to fulfill the responsibilities related to the Statewide Medicaid Comprehensive Hemophilia Management Program. For hemophilia factor-related drugs, CCP coordinates the care of its members through the Agency's Hemophilia Program.

Dispensing Limits

Medications may be dispensed up to a 34-day supply for most prescriptions and up to a 100-day supply for some maintenance medications. A total of 80% of the days supplied must have elapsed before a prescription can be refilled.

Age limits (AL) and quantity limits (QL) are noted on the Preferred Drug List (PDL) and/or the summary of drug limitations, available on the Pharmacy page of our website.

Over-the-Counter (OTC) Items

The CCP's Preferred Drug List (PDL)covers a selection of over-the-counter (OTC) medications. Members can obtain these OTC products through their prescription drug benefit by presenting a valid prescription at a network pharmacy. In addition, CCP offers an enhanced OTC benefit that includes first aid supplies, cold/cough medications, eye drops, antacids, pain relievers, personal care items, and much more.

Prior Authorization Process

Prior authorization (PA) forms are located on the CCP website. Providers or their representatives may access the forms for completion, fax them to the fax number provided at the bottom of the form or submit them electronically. The patient's clinical history related to the diagnosis and medication requested must be submitted with the PA forms to CCP's PBM Prime.

Medications

Medications requiring authorization are listed on the Preferred Drug List (PDL) with a "PA" notation. Medications not listed on the PDL also require prior authorization. Most injectables require prior authorization, except for certain preferred self-injectable medications such as some insulin products, glucagon, epinephrine anaphylactic kits, and provider-administered medroxyprogesterone IM.

Non-Specialty/Retail Medications

To efficiently process prior authorization requests for non-specialty/retail medications, providers should follow these steps:

- Submit requests electronically through Cover My Meds.
- Fax CCP PA form to 800-424-7913 for MMA
- Call: 800-424-7897 for MMA 8 a.m. to 9 p.m. Eastern, Monday through Friday

CCPs contracted PBM or CCP responds by fax or phone within the contracted turnaround time. If additional information is required, CCP or the PBM will contact the prescriber by fax to request it. If the request is denied, details about the denial will be provided to the clinician. A notice of adverse benefit determination letter will also be sent to the member and requesting provider outlining the reasons for the denial and information on member appeal rights.

Specialty Medications

Providers should complete the Prior Authorization Form for Specialty Medications and fax it to the appropriate number listed at the bottom to efficiently process prior authorization requests for specialty medications (such as biopharmaceuticals and high-cost specialty injectables). Non-specialty home infusion medications, including TPN and IV antibiotics, may be obtained through a contracted home infusion provider, which can be found through Find a Provider.

72-Hour Emergency Supply Policy

CCP's PBM responds to PA requests. State law allows pharmacies to dispense a 72-hour (three-day) supply of certain medications to a member awaiting a prior authorization determination in an emergency or when CCP PBM has not provided a response within 24 hours. Participating pharmacies are reimbursed for the medication, regardless of the ultimate approval or denial of the prior authorization request. The pharmacy may call Prime at 800-424-7897 for questions.

Exclusions

The following drug categories are excluded from the CCP Preferred Drug List and are not covered by the 72-hour emergency supply policy:

- Anorectics for weight loss (unless prescribed for an indication other than obesity)
- Anti-hemophilia products (billed as fee-for-service to Florida Medicaid)
- Cough and cold medications for members aged 21 years and over
- DESI ineffective drugs as designated by CMS
- Drugs covered under Medicare Part B and/or Medicare Part D
- Drugs used to treat infertility
- Experimental/investigational pharmaceuticals or products
- Erectile dysfunction products prescribed to treat impotence
- Hair growth restorers and other drugs used for cosmetic purposes
- Immunizing agents (except for influenza vaccine)
- Injectable drugs or infusion therapy and supplies (except those listed in the PDL)
- Injectable/oral drugs administered by the provider in the office, outpatient clinic, infusion center, or mental health center
- Nutritional supplements
- Oral vitamins and minerals (except those listed in the PDL)
- Over-the-counter (OTC) drugs (except those listed in the PDL)
- Prostheses, appliances, and devices (except products for diabetics and contraception)

Additionally, exceptions to the 72-hour emergency supply policy include instances where the refill is early, there are clinical issues that must be resolved, or if dispensing a temporary supply would pose a medical danger, as determined by the pharmacist.

Psychotropic Medications

Providers should conduct a comprehensive evaluation of a member before prescribing psychotropic medications, including a thorough health history, psychosocial assessment, mental status exam, and physical exam. Psychotropic medications include antipsychotics, antidepressants, antianxiety medications, and mood stabilizers.

CCP follows AHCA's Preferred Drug List for psychotropic medications. Providers should consider non-pharmacological interventions before prescribing psychotropic medications, except in urgent situations. For children, providers must especially consider non-pharmacological interventions before prescribing psychotropic medications. CCP monitors the prescribing of psychotropic medications for all children. Additionally, any prescription for psychotropic medication for a member under the age of 13 years (MMA) must be accompanied by express written and informed consent from the member's parent or legal guardian. Every new prescription for these members requires a new Informed Consent Form, which must be documented in the member's medical record and provided to the pharmacy with a signed attestation of this document with the prescription. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications are not included in the list of medications requiring informed consent.

Medication Therapy Management (MTM) Services

MTM Services are offered to CCP-eligible Medicaid enrollees (MMA and SMI). CCP provides MTM services to Medicaid members to help improve medication education and adherence. Members of the CCP Pharmacy team may reach out to network providers to share important medication information related to a member in your care. Medication-related concerns may be shared by mail, e-mail, or phone call. If you would like to recommend a member for an MTM review with CCP's Pharmacy team, please call 954-622-3200 to leave a message with our Member Services agent. Please state the concern(s), the member's full name, DOB, and CCP member ID number

14. Claims Coding and Billing

Risk Adjustment

Risk adjustment is crucial for determining expected treatment costs for members with various health conditions. Accurate risk adjustment relies on precise diagnostic coding according to CMS regulations and ICD-10-CM, CPT, and HCPCS guidelines. Providers must:

- Code diagnoses to the highest specificity.
- Ensure medical records are clear, concise, complete, and legible.
- Submit claims and encounter data promptly.
- Correct any erroneous data submitted and provide requested medical records promptly.
- Provide ongoing staff training on ICD coding for diagnoses.

Accurate diagnosis coding is essential for effective member management and compliance with risk adjustment data validation. Inaccurate or incomplete claims may be subject to retrospective review.

Encounters

Encounters document the care provided to members. Providers should ensure accurate documentation of all services rendered to facilitate proper billing and reimbursement. For capitated services, encounter data must be submitted to CCP using the applicable HIPAA transaction format. CCP collaborates with providers to ensure Medicaid participation and accurate, timely encounter data submission.

Electronic Data Interchange (EDI)

For electronic claims submission, adhere to HIPAA-compliant formats, including necessary CLIA information. Submit electronic claims through Availity, Payer ID 59065. EDI standardizes, streamlines, and secures claims submission and processing, ensuring compliance with regulatory requirements like HIPAA.

Availity provides a comprehensive range of resources to assist, train, and support providers in navigating its platform effectively. These resources ensure that providers have access to essential tools and information for managing claims, encounters, and other tasks.

Providers can use keywords such as "claims," "encounters," or "professional claim" to search for relevant topics, or they may go directly to the Claims & Encounters help section for specific guidance. Training topics are also searchable by keywords like "facility claim" or "professional claim." Additionally, providers can access specific training sessions, including the Professional Claim Training Demo and Facility Claims Training Demo.

For further support, providers can select **Help & Training | Availity Support** in the Availity Essentials navigation bar or contact support directly at **800-282-4548 (800-AVAILITY)**.

Required Provider Information

Providers must maintain current billing information with CCP to ensure accurate claims processing and reimbursement. Required information includes:

- Provider name (as per current W-9)
- National Provider Identifier (NPI)
- Group NPI (if applicable)
- Tax Identification Number (TIN)
- Physical location address
- Billing name and address

Notify CCP of any billing information changes at least 30-60 days in advance. Submit a new W-9 for address or TIN changes. Email W-9 forms to CCP Provider Operations at CCP.PROVIDER@ccpcares.org.

Coordination of Benefits

Providers should verify eligibility and supplementary carrier information for claims requiring coordination of benefits. Claims with primary and secondary coverage cannot be processed simultaneously. Medicaid is the payer of last resort. Submit claims to the primary payer first. For balances remaining after Medicare payment, submit Medicare evidence of payment to CCP.

Claim Submission

Submit claims in accordance with CMS billing requirements for paper, electronic, and web submissions. Claims must be submitted within 180 days from the date of service; claims submitted after 180 days will be denied. Ensure claims include all necessary information, such as enrollee ID, diagnosis codes, and authorization numbers.

Member Billing

Providers are prohibited from balance billing Medicaid recipients for covered services. Providers may bill for non-covered services if the member is notified in advance and agrees in writing. Repeated inappropriate billing may result in disciplinary action.

Verification Procedures

All claims must meet verification procedures, including required fields, 5010 validations, and the inclusion of CLIA numbers when applicable. Diagnosis codes must be specific, and the National Drug Code (NDC) must be included when relevant. Eligibility and authorization for services provided must be verified.

Clean vs. Unclean Claims

A clean claim satisfies all submission requirements and requires no further scrutiny. Unclean claims contain errors or omissions and may require additional information or correction before processing. Rejected claims lack essential data elements; denied claims fail due to incorrect billing codes or non-covered services.

Common Reasons for Claim Denial

To address common claim errors and improve processing efficiency, it's essential for providers to be aware of typical submission issues and how to avoid them. Many claims are denied due to incorrect or missing information, such as the National Provider Identifier (NPI), ZIP code, address, or NPI type. Claims may also be rejected if the NPI has expired according to the Provider Master List (PML). Providers should double-check all details before submission to ensure that the NPI, ZIP code, taxonomy code, and address are accurate and up to date.

Duplicate claims are another common reason for denials, often occurring when providers submit multiple claims for the same service or fail to use the appropriate Type of Bill code for corrected claims. To avoid this, providers should review the status of previous submissions to prevent resubmitting paid claims and use the correct Type of Bill code to indicate a correction.

Timely filing is also a key factor, as claims submitted after the deadline are typically denied. Awareness of filing deadlines and prompt submission are essential to avoid this issue. Another frequent cause of denial is the lack of prior authorization for services that require it. Before performing and submitting claims for certain procedures, providers should confirm if prior authorization is necessary and ensure that it is on file to prevent denial.

Additionally, various miscellaneous reasons, such as "patient not found," "insured subscriber not found," or "billed amount missing," can lead to denials. Ensuring the accuracy of patient and insured information, as well as verifying that all billing details are complete, can help in preventing these denials. For further assistance, providers can reach out to the claims support team. For inquiries related to prior authorization, providers may contact the support line at 866-899-4828. By addressing these common errors proactively, providers can streamline claim submissions and reduce delays in payment.

Timely Claim Submission

Submit claims within specific timeframes stipulated in your provider agreement to ensure timely processing. The filing limit for Medicare claims crossing over to Medicaid is 36 months from the date of service or 12 months from Medicare's adjudication date.

Guideline	Filing Deadline
Participating Providers	180 days from DOS or Discharge from a hospital setting
Plan as Secondary Payor	90 days from the primary determination
Medicare Crossover	36 months from original Medicare submission
Corrected Claims	90 days from denial
Return of Additional Information	90 days from denial

Corrected Claims and Requests for Reconsideration/Claims Appeals and Disputes
Submit corrected claims through the PlanLink provider portal within 90 days of the original explanation of payment. Requests for reconsideration should include supporting documentation when applicable. Providers will receive a revised explanation of payment if the original decision is overturned.

Guideline	Filing Deadline	Exception
Medical Necessity Appeals	90 days from EOB/Remit	365 days for underpayment disputes
Billing Dispute Appeals	90 days from EOB/Remit	
Authorization Appeals	90 days from EOB/Remit	

Claims Payment: EFT and ERA

CCP provides electronic funds transfers (EFTs) and electronic remittance advices (ERAs) at no charge. Providers can enroll in EFT/ERA services online.

Enrolling in Electronic Funds Transfer (EFT) offers numerous advantages to healthcare providers, streamlining payment processing and ensuring faster access to funds. By opting for EFT, payments are deposited directly into your bank account, significantly reducing the waiting time compared to traditional paper checks. This method also enhances security by lowering the risk of lost or stolen checks, making it a safer and more reliable option for receiving payments.

Additionally, EFT helps providers save on administrative costs, as there is no need to handle or process physical checks, which also supports environmental sustainability by reducing paper waste. The convenience of EFT is further highlighted by its detailed remittance advice, which simplifies payment tracking and aids in the reconciliation of financial records. Overall, EFT improves cash flow, saves time, and enhances financial management for healthcare practices.

15. Code Editing

Code Editing Overview

Code editing is critical to ensuring accurate and compliant medical billing. It involves applying rules and guidelines to medical claims to ensure that they are properly coded before submission for reimbursement. This system helps streamline the billing process, reduce the number of denied claims, and facilitate prompt and accurate payment.

CCP employs comprehensive, HIPAA-compliant clinical claims editing software to verify physician and outpatient facility coding. This software identifies, rectifies, and records coding errors in provider claim submissions before payment. Embedded with clinical logic, the software evaluates medical claims against industry standards and government regulations for correct coding. It follows a set of coding principles, akin to a "rule," and when a claim violates these principles, the software generates a recommendation called an "edit," prompting necessary adjustments to the claim.

While invaluable for ensuring provider adherence to correct coding, fully automated code editing software may not comprehensively assess all patient scenarios.

Consequently, CCP enhances this with validation performed by a team of skilled Claims Analysts. This method permits the review of exceptions to coding principles and may identify situations where additional reimbursement is appropriate. Exceptions to these principles might be necessary to align with our Policies and facilitate precise claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes form a crucial part of the Healthcare Common Procedure Coding System (HCPCS), which aims to standardize codes for precise claim reimbursement. This system comprises two standardized levels of coding.

Found within the Level I subset, Current Procedural Terminology (CPT) codes delineate medical procedures and terms conducted by healthcare providers. These codes are released annually by the American Medical Association (AMA), with regular updates, including additions, revisions, and deletions.

Level I HCPCS Codes

Level I HCPCS codes are comprised of the Current Procedural Terminology (CPT) codes. These are five-digit numeric codes maintained by the American Medical Association (AMA) and describe medical, surgical, and diagnostic services. They are widely adopted for reporting healthcare services and procedures.

Level II HCPCS Codes

Level II HCPCS codes are alphanumeric codes used primarily to identify products, supplies, and services not included in the CPT codes, such as durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS). These codes are maintained by the Centers for Medicare & Medicaid Services (CMS).

Miscellaneous/Unlisted Codes

Miscellaneous or unlisted codes are used when there is no specific CPT or Level II HCPCS code that accurately describes the service or item being billed. Providers must submit detailed documentation to support the use of these codes, as they require manual review.

Failure to submit these records results in a denial, prompting providers to include comprehensive medical documentation detailing the procedure performed. This documentation encompasses office notes, operative reports, pathology reports, and relevant pricing details. A registered nurse then scrutinizes these records to ascertain if a more specific code should have been used.

Furthermore, clinical validation involves identifying related procedures and services on the claim for accurate coding. For instance, if the miscellaneous code denotes the primary procedure, additional procedures integral to its completion should be factored into the reimbursement calculation.

Temporary National Codes

Temporary National Codes (also known as Q, K, and S codes) are a subset of the Level II HCCS coding system for reporting items or services that are not addressed by the existing permanent Level II HCPCS codes. These codes are considered temporary and may only be used until a permanent code is established. They consist of G, Q, K, S, H, and T code ranges.

These codes are often used for items or services covered by Medicare and Medicaid programs.

HCPCS Code Modifiers

Modifiers are two-character codes that provide additional information about the service or procedure performed. They indicate that a service or procedure has been altered by some specific circumstance but has not changed in its definition or code. Modifiers help in refining the coding process to ensure accurate billing.

International Classification of Diseases (ICD-10)

The ICD-10 is the 10th revision of the International Classification of Diseases, a medical classification list by the World Health Organization (WHO). It provides codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. ICD-10 codes are used for diagnosing patients and are essential for medical billing and coding.

Revenue Codes

Revenue codes are four-digit codes used on hospital bills to indicate the department or type of service provided. These codes are necessary for billing and reimbursement purposes as they specify the revenue center where the service was provided.

Edit Sources

The claims editing software application incorporates a comprehensive array of rules targeting coding inaccuracies, such as unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other inconsistencies. Each rule is anchored in widely accepted coding principles and informed by guidance reflecting the most probable clinical scenarios. CCP uses multiple sources for its code editing process, including but not limited to:

- CMS National Correct Coding Initiative (NCCI) Edits for both professional and facility claims, encompassing column 1/column 2 pairings, medically unlikely edits (MUEs), and outpatient code editor (OCE) edits, all designed to curtail erroneous code combinations and prevent incorrect payments
- CMS Claims Processing Manual and Medicaid NCCI Policy Manual
- CMS coding resources like HCPCS coding manuals, the national physician fee schedule, provider benefit manuals, claims processing manuals, the Medicare Learning Network (MLN), and provider transmittals
- Medically Unlikely Edits (MUEs)
- American Medical Association (AMA) resources, including their website, Coding with Modifiers, CPT Assistant, CPT Assistant archives, CPT Insider's View, CPT manual, CPT procedural code definitions, and HCPCS procedural code definitions, as well as principles of CPT coding
- Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs)
- State-specific provider manuals, fee schedules, and periodic updates; policies and procedures for billing professional and facility claims
- Billing guidelines issues by specialty provider organizations
- Internal CCP policies and guidelines

Code Editing and the Claims Adjustment Cycle

The claims adjustment cycle involves a comprehensive review and processing of claims to identify and correct errors before final adjudication. Code editing represents the final stage of this process, ensuring that claims comply with all coding and billing requirements prior to payment issuance. This systematic approach helps minimize claim denials and maintain compliance with CCP's policies.

After preliminary adjudication phases, such as benefits review and member/provider eligibility verification, claims proceed to code analysis. During the code editing cycle, each service line is meticulously examined by the code editing rules engine to confirm accurate coding. This process includes cross-referencing the prospective claim with other codes billed on the same claim and evaluating previously paid claims from the member/provider history. Based on the applied code edit, the software makes the following recommendations:

- Deny: The code editing rule suggests denying a claim line, providing the appropriate explanation code on the provider's explanation of payment, along with instructions for reconsideration or appeal.
- Pend: The code editing advises that the service line be pended for clinical review and validation, which may lead to a recommendation for payment or denial. The decision is documented in the provider's explanation of payment, with reconsideration or appeal instructions.

Code Editing Principles

The following represents a sample of edits applied to claims.

CMS National Correct Coding Initiative

The CMS National Correct Coding Initiative (NCCI) was developed to control erroneous coding and prevent inaccurate claims payment. CMS has designated certain combinations of codes, known as Column 1/Column 2 edits, that should never be billed together. The Column 1 code is the most comprehensive and includes reimbursement for the Column 2 code, which is considered an integral component.

NCCI edits consist of "procedure-to-procedure" (PTP) edits for physicians and hospitals and "medically unlikely" edits for professionals and facilities. While these codes typically should not be billed together, there are circumstances where an NCCI modifier may be added to the Column 2 code to indicate a significant and separately identifiable service. When these modifiers are billed, clinical validation is performed. CMS provides a more detailed explanation of the unbundling initiative on its website.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed PTP edits for practitioners and hospitals to detect incorrect claims. PTP practitioner edits apply to claims submitted by physicians, non-physician practitioners, and ambulatory surgical centers (ASC). PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers, and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers, and Facilities

Medically unlikely edits (MUEs) specify the maximum number of units that a provider would bill for a single member on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information, and clinical judgment.

Code Bundling Rules Not Sourced to CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules for the proper use of codes in their areas of expertise. These rules, which are publicly available, are based on procedure code definitions and relative value units. They are designed specifically for editing professional and outpatient facility claims.

Procedure Code Unbundling

Unbundling occurs when two or more procedure codes are used to report a service that should have been reported with a single, more comprehensive code. The less comprehensive code is denied.

Mutually Exclusive Editing

Mutually exclusive editing involves combinations of procedure codes that differ in technique or approach but result in the same outcome. These procedures may be anatomically impossible to perform together. Codes are considered mutually exclusive if an initial or subsequent service is billed on the same date of service. The procedure with the highest relative value unit (RVU) is considered reimbursable.

Incidental Procedures

Incidental procedures are those that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules concerning the payment of evaluation and management services during a procedure's global surgical period. The global surgery data is from the CMS Medicare Fee Schedule Database (MFSDB). Procedures are assigned a 0-day, 10-day, or 90-day global surgical period. Major procedures have a 90-day period, while minor procedures have a 0- or 10-day period. Evaluation and management services related to these procedures are not recommended for separate reimbursement within the specified period.

Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)

This rule applies to outpatient diagnostic services provided to a member within three days before the date of an inpatient admission, including the date of admission. If these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are bundled into the inpatient admission and are not separately reimbursable.

Multiple Code Rebundling

This rule checks if a provider billed two or more procedure codes when a single, more comprehensive code should have been used to represent all the services performed.

Edits

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the allowable number of times a single code can be reported. Some codes are limited to a specific number of uses on a single date of service, over a given period, or during a member's lifetime. State fee schedules also specify the permissible frequency for billing a procedure within a given period or over a member's lifetime. Code editing triggers a frequency edit when a procedure code is billed more than these guidelines allow.

Duplicate Edits

Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider that is a duplicate. The software also checks if another provider was paid for the same procedure for the same member on the same date of service. Additionally, it analyzes multiple services within the same range performed on the same day.

National Coverage Determination (NCD) Edits

CMS establishes guidelines to identify whether certain medical items, services, treatments, diagnostic services, or technologies are payable under Medicare. These rules evaluate diagnosis-to-procedure code combinations.

Anesthesia Edits

Anesthesia edits verify the accuracy of anesthesia services billed, including appropriate use of modifiers and adherence to guidelines for anesthesia time units. Anesthesia services billed with surgical procedure codes instead of anesthesia procedure codes are flagged.

Invalid Revenue to Procedure Code Editing

This editing ensures that the revenue code billed is appropriate for the procedure code submitted, preventing mismatches that could lead to claim denials. Revenue codes billed with incorrect CPT codes are flagged for correction.

Assistant Surgeon Edits

Assistant surgeon edits verify that the use of assistant surgeon modifiers is appropriate based on the procedure performed and the clinical scenario. Claims billed as an assistant surgeon without necessity are evaluated, considering appropriate modifiers.

Co-Surgeon/Team Surgeon Edits

Co-surgeon and team surgeon edits validate the billing of procedures that legitimately require the presence of multiple surgeons and ensure appropriate modifier usage. Guidelines determine reimbursement eligibility and percentage of surgeon's fee for assistant, co-surgeon, or team surgeon.

Add-on and Base Code Edits

These rules check for claims where an add-on CPT code was billed without the primary service CPT code. If the primary service code is denied, the add-on code is also denied. The rule also looks for instances where the primary code was billed in a quantity greater than one, where an add-on code should have been used for additional services.

Bilateral Edits

This rule checks for claims where the modifier 50 (indicating a bilateral procedure) has been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier 50.

Missing Modifier Edits

Missing modifier edits identify claims that lack necessary modifiers, which are essential for proper coding and reimbursement.

Payment and Coverage Policy Edits

Payment and coverage policy edits are designed to enhance claims processing effectiveness, ensuring that only correctly coded and medically necessary claims are paid in accordance with CCP's payment and coverage policies. These edits also provide transparency to providers regarding these policies. Policy development includes creating payment guidelines based on coding and reimbursement rules, as well as clinical policies based on medical necessity criteria. These policies are implemented through claims edits or retrospective reviews. When appropriate, these policies are posted on CCP's website for reference.

Claim Reconsiderations Related to Code Editing and Other Editing ++

Providers may request reconsideration of claims denied due to code editing. These requests must include comprehensive documentation, such as medical records, invoices, and any relevant information supporting the medical necessity and accuracy of the coding. Failure to provide this documentation will result in the original code edit or other edits being maintained. Claim reconsiderations due to claim editing are processed according to the provider claims reconsideration procedure outlined in this manual. When submitting claims for reconsideration, providers should include all pertinent medical records, invoices, and related information to facilitate the review. If providers disagree with a code edit or other edit, they must submit the relevant medical documentation; otherwise, the original edit decision will stand.

Administrative and Consistency Rules

These rules ensure that claims are consistent with administrative requirements and standardized coding practices, promoting uniformity and accuracy in billing. These rules focus on the validation of code sets and other data billed on the claim and are not reliant on clinical content. They do not interact with historically paid claims or other service lines on the prospective claim and include:

- Procedure code invalid rules: These rules assess claims for invalid procedure and revenue or diagnosis codes.
- Deleted codes: These rules examine claims for procedure codes that have been deleted.
- Modifier to procedure code validation: These rules detect invalid combinations of modifiers with procedure codes. They specifically analyze modifiers impacting payment, such as modifiers 24, 25, 26, 57, 58, and 59.
- Age rules: These rules flag procedures that are inconsistent with the member's age.
- Incomplete/invalid diagnosis codes: These rules identify diagnosis codes that are either incomplete or invalid.

Prepayment Clinical Validation

Prepayment clinical validation involves reviewing claims to pinpoint scenarios historically associated with increased improper payments. Claims are reviewed clinical accuracy before payment, ensuring that services billed are supported by medical records and clinical guidelines. CCP's clinical team analyzes information from the prospective claim and claims history to assess whether a modifier was likely used correctly based on the unique clinical scenario for a member on a specific date of service. CMS supports this prepayment review, and the clinical validation team relies on nationally published guidelines from CPT and CMS to determine the appropriateness of modifier usage.

Modifier 59

Modifier 59 is used to indicate a distinct procedural service. It should be used when procedures are not normally reported together but are appropriate under the circumstances. The National Correct Coding Initiative (NCCI) defines modifier 59 as primarily indicating that procedures or non-evaluation and management (E/M) services, typically not billed together, are appropriate under certain circumstances. According to the CPT manual, modifier 59 denotes a "Distinct Procedural Service," indicating when a procedure or service is distinct or independent from non-E/M services performed on the same day.

NCCI guidelines state that modifier 59 should not be used solely because different procedures or surgeries are performed or because of differences in CPT codes. It should be used if the procedures or surgeries occur at separate anatomic sites, during distinct patient encounters, or are conducted by different practitioners on the same date of service. NCCI defines different anatomic sites to encompass varying organs or lesions on the same organ but excludes treatment of contiguous structures of the same organ.

- CCP follows specific guidelines when assessing the correct usage of modifier 59:
- Diagnosis codes or clinical scenarios on the claim suggest treatment of multiple conditions or sites.
- Patient claim history indicates diagnostic testing on multiple body sites, potentially leading to procedures on various body areas.
- The claim history indicates that each procedure was performed by a different practitioner, during different encounters, or when unusual circumstances supported the appropriate usage of modifier 59.

To prevent incorrect denials, providers should include all applicable diagnosis and procedure codes on the claim, along with anatomical modifiers delineating the treated body areas.

Modifier 25

In accordance with the NCCI policy manual, both CPT and CMS state that modifier 25 is used to indicate a “significant, separately identifiable evaluation and management service by the same physician on the same day as another procedure or service”. Additional CPT guidelines specify that the E&M service must be significant and distinct from other services rendered, surpassing the routine pre-, intra-, and postoperative care associated with the performed procedure. CCP employs specific guidelines to determine the appropriate usage of modifier 25 and recommend reimbursement for the E&M service if any of the following conditions are met:

- The E&M service marks the initial encounter with the patient or involves the evaluation of a major condition.
- A diagnosis on the claim indicates the treatment of a separate medical condition in addition to the performed procedure.
- The patient's condition is deteriorating, evidenced by diagnostic procedures conducted on or around the service date.
- Other procedures or services administered for a patient on or around the same date indicate the necessity of an E&M service to assess the need for further services.

To prevent erroneous denials, the provider should assign all applicable diagnosis codes supporting additional E&M services.

Code Editing Assistant

CCP provides a code editing assistant tool to help providers understand and apply correct coding principles, ensuring compliance with coding guidelines and reducing claim denials. The tool can be found in the claim module under "claim editing tool."

The benefits of this tool include:

- Prospective access to appropriate coding and supporting clinical edit clarifications for services prior to claim submission.
- Proactive determination of the accurate code or code combination for billing purposes.

The tool assesses the correctness of the code or code combinations based on factors such as age, sex, location, and applicable modifiers. It serves as a hypothetical reference tool, applying coding logic exclusively, without considering historical claims information that might influence edit appropriateness.

This tool solely applies coding logic and does not factor in individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Determining whether a code is reimbursable or covered falls outside the tool's intended use.

Third-Party Liability

Third-party liability encompasses any health plan or carrier beyond Medicaid that may be responsible for covering all or part of a member's healthcare expenses. This includes individual, group, employer-related, self-insured or self-funded, commercial carriers, as well as automobile insurance and worker's compensation programs. CCP ensures that claims are processed considering any third-party resources available to the patient.

Providers under CCP are expected to exert reasonable efforts to ascertain the legal liability of third parties to cover services provided to CCP members. If a provider encounters challenges in obtaining cooperation from a member to identify potential third-party resources, they shall notify CCP of their unsuccessful efforts. CCP will collaborate with the provider to determine liability coverage. In cases where third-party liability coverage is confirmed post-service, CCP will coordinate with the provider to address any claims initially denied due to third-party liability, ensuring appropriate payment.

16. Serious Mental Illness

CCP is committed to empowering members with serious mental illness to take control of their overall health. Our Serious Mental Illness (SMI) Specialty Plan offers integrated behavioral, medical, and pharmacy services through a collaborative team-based approach. This includes coordination between behavioral and medical providers, licensed health clinicians, and pharmacists.

Members can rely on us for connections to essential social support services, including access to healthy foods, secure housing, and reliable transportation to appointments. Additionally, we offer extra benefits for our SMI members that extend beyond traditional healthcare.

The SMI Plan is designed to help members aged 6 years and up who may have one of the following conditions:

- Psychotic Disorders
- Bipolar Disorders
- Major Depression
- Schizoaffective Disorder
- Delusional Disorders
- Obsessive-Compulsive Disorder (OCD)

Specialized Provider Education Requirements

Requirements for care in accordance with the most recent clinical practice guidelines for treatment of the specialty condition.

Behavioral Health and Substance Use

Adopted Guidelines include:

- ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (AACAP)
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder (Historical Parameter) (AACAP)
- Practice Guidelines for the Treatment of Patients with Substance Use Disorders, (APA)
- Practice Guidelines for the Treatment of Patients with Panic Disorder, (APA)
- Practice Guidelines for the Treatment of Patients with Major Depressive Disorder, (APA)

- Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, (APA)
- Practice Guideline for the Treatment of Patients with Schizophrenia, (APA)
- Management of Children with Autism Spectrum Disorders, (AAP)
- Psychiatric Consultation Practice Guidelines (Academy of Psychosomatic Medicine)
- Florida Best Practice Psychotherapeutic Medication Guidelines for Adults (USF and Medicaid)
- Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents (USF and Medicaid)
- Case Management Society of America: Case Management Adherence Guidelines
- Practice Guidelines for the Treatment of Patients with Bipolar Disorder, (APA)
- American Society of Addiction Medicine Patient Placement Criteria
- American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders V
- Centers for Disease Control Opioid Prescription Guidelines for Chronic Pain Management
- CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Treatment Adherence Services Available

- Case Management/Care Coordination
- Enhanced Care Coordination
- MTM (Medication Therapy Management)

Members should reach Member Services at 1-866-899-4828 to be linked to these services, or Providers can complete a referral via the Contact Us area of the CCP Website.

Procedures for Required Use

Approved assessment instruments for treatment of the specialty condition and Procedures for Required Use. Assessment instruments should be employed for the appropriate patient population and by the appropriate Behavioral Health provider in accordance with their respective scope of practice. Assessment Instruments:

Schizophrenia:

- Kessler Psychological Distress Scale (K6+)
- Brief Psychiatric Rating Scale (BPRS)
- Positive and Negative Syndrome Scale (PANSS)
- Scale for the Assessment of Negative Symptoms (SANS)
- Comprehensive Assessment of Symptoms and History (CASH)
- Clinical Global Impression-Schizophrenia (CGI-SCH)
- Calgary Depression Scale for Schizophrenia (CDSS)

Bipolar Disorder:

- Young Mania Rating Scale (YMRS)
- Bech-Rafaelsen Mania Rating Scale (MAS)

Obsessive Compulsive Disorder:

- Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)

Panic Disorder:

- Panic Disorder Screener (PADIS)

Post-Traumatic Stress Disorder:

- Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
- PTSD Symptom Scale Interview (PSS-I and PSS-I-5)
- Structured Clinical Interview; PTSD Module (SCID PTSD Module)
- Structured Interview for PTSD (SIP or SI-PTSD)
- Treatment-Outcome Posttraumatic Stress Disorder Scale
- Davidson Trauma Scale (DTS)
- Impact of Event Scale – Revised (IES-R)
- Mississippi Scale for Combat-related PTSD (MISS or M-PTSD)
- Modified PTSD Symptom Scale (MPSS-SR)
- PTSD Checklist for DSM-5 (PCL-5)
- PTSD Symptom Scale Self-Report Version (PSS-SR)
- Short PTSD Rating Interview (SPRINT)

Borderline Personality Disorder:

- McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD)
- Connors Parent and Teacher Questionnaires
- Vanderbilt Assessment Scale for Teachers
- LOCUS
- CALOCUS
- ASAM
- Scales to assess risk for suicide (including protective factors)
- Scales to assess for sexually inappropriate behaviors
- Katz Index of Independence in Activities of Daily Living or COA
- PHQ-9
- Motivational Interviewing
- REALM-R Health Literacy Assessment
- Medicine Knowledge Survey
- Readiness-To-Change Ruler (and Follow-up Questions), Zimmerman, 2000
- Duke-UNC Functional Social Support Questionnaire
- Modified Morisky Scale
- Mihalik Criteria
- Stages of Change Continuum, DiClemente, 1998
- LACE
- PTSD Screener
- CRAFFT
- Pediatric Supplemental Assessment

PCP Criteria

The identification of mental health or substance abuse conditions, and referrals to the applicable behavioral health providers is an essential part of providing integrated care to all Community Care Plan members. To assist our primary care physicians in identifying members who may have potential behavioral health needs, the following are evidence-based screening tools that can be used:

- PHQ9: Depression screening tool for adults (PDF)
- PHQ-A: Depression screening tool for adolescents (PDF)
- CRAFFT: Screening tool for adolescent substance abuse (PDF)
- CAGE: Screening tool for identifying potential alcohol abuse (PDF)
- CAGE questionnaire (PDF)
- SBIRT: Screening, Brief Intervention, and Referral to Treatment for those with unhealthy alcohol and drug use (PDF)
- Edinburgh Postnatal Depression Scale – Microlearning External Link

Specialty Case Management Policies and Procedures

Specialty Case Management policies and procedures, including the role of the provider in the Specialty product's medical case management/care coordination services.

The provider is an integral part of the Concierge Care Coordination Model. Our top priority is to deliver personalized concierge-level services for every enrollee and provider. In addition, we have customized our services, reporting, and programs to serve as a facilitator and support vehicle to providers, giving them the data and tools to better care for our enrollees. CCP will ensure to:

- Work with providers utilizing a collaborative approach to enhance the effectiveness of case management and care coordination processes.
- Develop and coordinate appropriate initiatives, interventions, and/or alternative care in conjunction with the enrollee, providers, and other members of the care team.
- Support and reinforce physician-recommended treatments and therapies and coordinate referrals to other service providers for comprehensive care.
- Facilitate communication among the enrollee, their families and caregivers, health care providers, the community, and the health plan to enhance cooperation while planning for and meeting the health care needs of the enrollee
- Collaborate with providers' office staff and the primary care physicians and/or specialists in the development and communication of the enrollee's self-management plan
- When a provider identifies an enrollee in need of a CM program, they can communicate directly with a CCP Customer Services Coordinator, Provider Operations Representative, Medical Director, Clinical Pharmacist, Utilization Management Nurse, or C3 Care Coordinator via phone, e-mail, internal communication tool, fax, or during in-person visits.
- The C3 Care Coordinator frequently interfaces with physicians, providers, and other allied healthcare professionals as needed to complete assessments, individualized care plans, and evaluations, as well as to coordinate care in order to enhance health status and avoid complications and potentially preventable events. The C3 Care Coordinator shares the mutually agreed upon written plan of care and notification of program enrollment/ disenrollment with the enrollees' care team, as appropriate, via fax and/or email.

Referral to Services

Referral to Services, including services outside of the Specialty product's covered services and services provided through interagency agreements. CCP Care Coordinators are available to assist enrollees to obtain all needed services including those services that are outside of the Specialty Product's covered services and services provided through interagency agreements. Examples of these services and agencies include but are not limited to:

- Department of Children and Families (DCF)
    - Behavioral Health Managing Entities
    - Community-Based Care Lead Agencies
    - Homebuilders
    - Motivational Interviewing
    - Multisystemic Therapy
    - Parent-Child Interaction Therapy
    - Functional Family Therapy
    - Parents as Teachers
    - Brief Strategic Family Therapy
    - Healthy Families
    - Nurse Family Partnership
- Department of Veterans Affairs
- Department of Education for School-Based Services
- Department of Juvenile Justice
- Department of Corrections
- Department of Elder Affairs
- Alzheimer's Disease Initiative
- Homecare for the Elderly Program
- Federal Older Americans Act Program
    - Agency for Persons with Disabilities
    - Department of Health Title XXI: Children's Medical Services

Enrollee Access to Clinical Trials

Clinical trial coverage applies to SMI Specialty Plan enrollees only. Enrollee access to clinical trials, including coverage of costs for an enrollee's participation in clinical trials, is in accordance with Rule 59G – 1.036 (Florida Administrative Code). 59G-1.036 Clinical Trials.

(1) This rule applies to any person or entity prescribing or reviewing a request for Florida Medicaid covered services and to all providers of Florida Medicaid covered services who are enrolled in or registered with the Florida Medicaid program.

(2) Definitions.

Clinical Trials – Biomedical or behavioral research studies on human participants designed to answer specific questions about biomedical or behavioral interventions, including new treatments and known interventions that warrant further study and comparison.

(3) Coverage. Florida Medicaid reimburses for services as a result of a recipient participating in a clinical trial in accordance with the service-specific coverage policy when the services:

(a) Are covered under the Florida Medicaid program.

(b) Would otherwise be provided to a recipient who is not participating in a clinical trial.

(c) Are related to complications or side effects arising during the clinical trial.

(d) Are not expected or unique to the experimental or investigational treatment.

(e) Are not covered by the clinical trial sponsor. Rulemaking Authority 409.919 FS. Law Implemented 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.913 FS. History–New 4-4-16.

Coordination Protocols for Community Mental Health Centers

For the SMI Specialty product, coordination protocols for Community Mental Health Centers to ensure appropriate and comprehensive treatment planning that addresses the enrollee's medical and behavioral health needs.

CCP Care Coordinators and Social Workers facilitate the linkage and engagement of enrollees with Community Mental Health Centers where enrollees can receive integrated and comprehensive care. The Care Coordinator collaborates with the Community Mental Health Centers and any other public or private organizations that provide services to enrollees with SMI to ensure effective coordination of benefits, non-duplication of services, and that all needed and anticipated services are in place to ensure appropriate and comprehensive treatment planning.

CCP is driven by our community responsibility to positively impact the health and wellness of those we serve our main goal is to establish a planned and systematic process to maintain the promotion and delivery of high-quality physical and behavioral health care effectively and efficiently to all enrollees to:

- Provide a high standard of health care services coordination
- Provide education to Enrollees/Caregivers that will promote healthy behaviors and improve self-management skills
- Work with providers utilizing a collaborative approach to enhance the effectiveness of case management and care coordination process
- Improve the health status of the community
- Earn enrollee and provider satisfaction.

The role of the CCP Care Coordinator includes but is not limited to:

- Facilitation of communication among the enrollee, their families and caregivers, health care providers, the community, and the health plan to enhance cooperation while planning for and meeting the health care needs of the enrollee
- Acting as an educator for the enrollee, the healthcare team, and the community regarding the SMI program and specific healthcare issues
- Partnering with providers, enrollees, disease/care management team, and the community in assisting the member to reach the maximum achievable medical potential and maximum independence.

Quality Measurement Standards and Data Exchange

CCP uses both national quality measurements (i.e. NCQA/HEDIS, CMS Adult and Child Core Set), along with AHCA required quality measures. Quality Measurement Standards are divided into three categories: Structural, Process, and Outcome measures. Structural Measures focus on the provider's ability to provide high quality care including:

- Provider's EHR capabilities
- Board Certification
- Provider to Patient Ratio

Process Measures focus on the provider's impact on maintaining or improving health including:

- Percentage of enrollees with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use
- Percentage of enrollees who had a follow up for a behavioral health admission within 7 days
- Percentage of enrollees who received the appropriate lab testing for diabetes and schizophrenia

Outcome Measures focus on the providers ability to intervene on the enrollee's health status including:

- Reduction in ER/ IP admissions
- Percentage of enrollees who maintained adherence to their antidepressant medication
- Percentage of enrollees who engaged in Substance Use Disorder Treatment

Data Exchange

Data exchange between CCP and its providers focuses on standardized protocols, interoperability between data sharing systems, and enrollee/patient-centric approaches. These efforts enhance our C3 model and improve health outcomes.

17. Medicaid Behavioral Health Services

Documentation Guidance

Community Care Plan ("CCP") requires all Medicaid Behavioral Health Servicing Providers and Groups to follow Florida Agency for Health Care Administration ("AHCA") Medicaid Rules, Service-Specific Policies and guidelines. This Provider Guidance summarizes key requirements for Medicaid Behavioral Health Services.

Please refer to AHCA Adopted Rules at https://ahca.myflorida.com/medicaid/rules and Service-Specific Policies at https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies.

Applicable AHCA Coverage Policies

- 59G-4.028: Behavioral Health Assessment Services
- 59G-4.031: Behavioral Health Community Support Services
- 59G-4.052: Behavioral Health Therapy Services

Medical Record Documentation Requirements

Each AHCA Coverage Policy includes Section 6.0, "Documentation," which outlines both general (AHCA Rule 59G-5.020) and specific documentation requirements for services rendered. ***Failure to meet the AHCA documentation requirements may result in claim denial, overpayment recovery, and/or legal or regulatory action.***

Behavioral/Mental Health Diagnosis

- Must be issued by a licensed and/or properly supervised practitioner (M.D., D.O., or APRN) per Florida Statutes, Chapters 458, 459, or 464.
- A copy of the diagnosis must be maintained in the members' file for Assessment and Community Support Services.

Patient Treatment Plan

- Required for Therapy Services (59G-4.052).
- Must align with the requirements under Rule 59G-4.028 and be available for the requested date of service.

Daily Progress Notes

- Must adequately document each service/activity provided to the patient.
- Must adequately document the patient's progress toward treatment goals.
- Required across all three AHCA Behavioral Health service categories.

General Documentation Checklist

- Place of Service
- Date of Service
- Start and Stop Times (matching units billed)
- Documentation of Supervision (if applicable)
- Dated Signatures of Servicing and Supervising Providers

⚠ Per Rule 59G-5.020, inadequate, missing or untimely documentation or signatures may result in payment recoupment.