Provider News

sunshine health

We're here to help

For more information about these topics, go to the "Provider News" section on SunshineHealth.com or call Provider Services at 1-844-477-8313.

Key

- **Medicaid, Long Term Care, Child Welfare**
- **Healthy Kids**
- **Ambetter**
- **Allwell**

Update Your Information

We partner with LexisNexis Risk Solutions and American Medical Association (AMA) Business Solutions to confirm accurate provider directory information, which is required by federal and state laws. Accurate, updated practice data enables us to market you in our provider directories and give members the information they need to access care.

If we do not receive updated provider information from you, we may be required to suppress your organization in our directories.

LexisNexis Risk Solutions or AMA Business Solutions will email you on our behalf requesting your attestation in the Verify Health Care Portal. This is a secure website where you can update your pre-populated information quickly and easily. If your information has changed, please be sure to update it in the portal. Attestations are due within two weeks of receipt of the request. If you have questions about the portal or need help, the email will include contact information for assistance.

DR. KATHERINE FRIEDEBACH
CHIEF MEDICAL OFFICER

Welcome Our New Chief Medical Officer

Dr. Katherine Friedebach has joined Sunshine Health as our new Chief Medical Officer.

Dr. Friedebach's diverse medical experience will help us continue to improve our quality and performance measures. She is a family physician with over 15 years of clinical experience in both rural and urban settings.

She previously served as the Chief Clinical Officer of a Federally Qualified Health Center (FQHC) in Missouri, during which time the center expanded services to three sites, achieved Patient Centered Medical Home (PCMH) accreditation and fully integrated physical and behavioral health services. She has been with our parent company, Centene Corporation, since 2013.

She will be working on several new initiatives this year to help us better support providers in closing care gaps and engaging our members in care. Learn more about her in this Q&A.

Q: Tell us a little about yourself.

I am a board-certified family physician. I practiced and did almost all of my training in the Kansas City and Central Missouri area. I started practicing medicine in a hospital-owned clinic near my hometown, a rural community of about 1,000 people. From there, I took a position as the chief medical officer of an FQHC. That's what ignited my passion for serving vulnerable populations. I was able to see firsthand how a model of care for at-risk patients can make a tremendous difference in their lives. From there, I joined Centene's Sunflower Health Plan as chief medical director.

Q: What career accomplishments are you most proud of?

During my health center days, we were one of the first FQHCs in Missouri to get NCQA PCMH accreditation. At Sunflower Health Plan, I'm very proud of our NCQA commendable status. Additionally, Sunflower accomplished the highest customer satisfaction of the three managed care organizations in KanCare. I'm also proud of our partnership with the state. Over the course of the program, KanCare demonstrated an increase in preventive screening utilization and a decrease in unnecessary hospital and ER visits. It demonstrates that managed care can be very effective in helping members access care in the most appropriate setting, resulting in improved healthcare outcomes and reduced cost.

In this issue

ALL PRODUCTS

New Provider Services Help Line

We've launched a new Provider Services help line to better serve you. You can call **1-844-477-8313** from 8 a.m. to 8 p.m. Monday through Friday to get answers to your questions about any Sunshine Health product: Medicaid, Child Welfare, Long Term Care, Ambetter (Marketplace), Healthy Kids and Allwell (Medicare).

Provider calls to our main number, 1-866-796-0530, will be routed to the new Provider Services help line.

We can help:

- Verify member eligibility, PCP assignment or benefits
- Provide assistance with provider portal usage
- Add providers to an existing contract
- Check credentialing status
- Verify authorizations
- Provide instructions on submitting claims
- Provide instructions on how to register for electronic payments
- Check on claim status
- Clarify a claims denial reason and review denied claims

Our new Provider Services help line is just one way we're committed to serving you better in 2019.

MEDICAID

Submitting UB-04 Claims for Hospice Care

What You Need to Know

Sunshine Health claim edits are standard HIPAA edits and align with AHCA standards. Having all fields accurate and complete on your claims will allow prompt adjudication and payment, and eliminate denials and the need to resubmit claims.

Statement Covered Period and Total Covered Days

- Statement Covered Period (UB-04 Form Locator 6): Identifies the span of service dates included in a bill. These date spans may not overlap with previous submitted claims unless it is related to a Corrected Claim Bill Type.
- Admission Date (UB-04 Form Locator 12): Must be the same as the effective date of hospice elections or change of election.
- Patient Discharge Status: Must indicate the discharge status as of the discharge date billed.
- Total Covered Days: The number of days covered by the plan. Total covered days for Room and Board must equal the Total Days in the Statement Period if the member is continually receiving services and has not been discharged.
    - Exception: The day of discharge is not reimbursable for Room and Board. If a member is discharged the total days should not include the discharge day.
        - Example: Member "X" resides in a nursing facility and elects hospice. Member "X" started hospice 1/1/18 was discharged from hospice on 1/31/18.
          The Statement Period 1/1/18-1/31/18
          The Total Covered Days: 30 (the discharge day is not included in the covered days count)

Share of Cost (SOC):

- Value Codes for Patient Responsibility (UB04 Form Locator 39-41): If the hospice patient has a monthly patient responsibility, enter value code 31 and the full monthly amount. The amount entered should be the amount for the entire month even when billing a partial month.
- If there is an update to the member's share of cost, the provider must submit a corrected claim within 90 days from original paid/denied date.

Billing Corrected Claims:

- All corrected claims should be free of handwritten or stamped verbiage, and submitted on a standard red and white UB-04 form along with the original EOP.

CONTINUES ON NEXT PAGE

- Any UB-04 forms received that do not meet the CMS printing requirements will be rejected and sent back to the provider or facility upon receipt.
- In addition to submitting corrected claims on a standard red and white form, the previous claim number should be referenced in field 64 of the UB-04 as outlined in the NUCC guidelines. The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04.
- Omission of these data elements may cause inappropriate denials, and/or delays in processing and payment.

Timely Filing Guidelines:

- Clean Claims must be submitted within 180 days from the service date.
- Corrected Claims must be submitted within 90 days of the date of the Explanation of Payment (EOP) (Original claim paid/denied date).
- Claims reconsiderations/appeals and disputes must be submitted within 90 days of the date of the Explanation of Payment (EOP) (Original paid/denied date).

Medicaid payment policy update

We are updating our Medicaid payment policies regarding inpatient professional claims. Effective Feb. 1, 2019, inpatient professional claims will be denied for members whose stays were deemed not medically necessary.

To ensure your inpatient professional claims are paid, please verify that the services rendered meet the requirements for medical necessity.

AMBETTER, ALLWELL

Readmission Policy Changes Effective March 1, 2019

As a part of the Affordable Care Act (ACA), Congress mandated that CMS reduce hospital readmissions through certain payment incentives.

Sunshine Health is implementing a 30-Day Readmission Payment Policy, CC.PP.501, for our Ambetter (Marketplace) and Allwell (Medicare) members to improve quality of care, promote more clinically effective and cost efficient healthcare, and encourage safe hospital discharge.

The policy will be effective with respect to initial admissions occurring on and after March 1, 2019, and subsequent readmissions that are related to the initial admissions.

For more information call Provider Services at 1-844-477-8313, or reference the policy on SunshineHealth.com. Click “For Providers,” then under the “Provider Resources” tab on the left, open the “Clinical & Payment Policies” page.

MEDICAID

Medicaid Preferred Drug List Updates

The Florida Medicaid Pharmaceutical and Therapeutics Committee meets quarterly and gives recommendations to the Agency for Health Care Administration (AHCA) for updates to the Preferred Drug List (PDL). The following changes were effective beginning Oct. 1, 2018. View the complete Preferred Drug List at the link on SunshineHealth.com under "Pharmacy."

Added Medications

- Alkeran (oral)
- Amantadine tablet (oral)
- Doxepin (topical)
- Doxercalciferol (oral)
- E.E.S. 200 suspension (oral)
- Econazole (topical)
- Gilenya (oral)
- Gleevec (oral)
- Invokamet (oral)
- Jardiance (oral)
- Makena auto injector (subcutaneous)
- Nexavar (oral)
- Retacrit (injection)
- Sutent (oral)
- Synjardy (oral)
- Valcyte solution (oral)
- Valcyte tablet (oral)
- Votrient (oral)
- Xigduo XR (oral)
- Xtandi (oral)
- Zytiga (oral)

Removed Medications

- Celontin (oral)
- Dermotic (otic)
- Diastat (rectal)
- Diastat Acudial (rectal)
- Dilantin 30mg capsule (oral)
- Erythromycin Ethylsuccinate 200 suspension (oral)
- Fanapt tablet (oral)
- Fanapt Titration pack (oral)
- Hectorol (oral)
- Peganone (oral)
- Prudoxin (topical)
- Sulfatrim suspension (oral)
- Zonalon (topical)

AMBETTER

Oncology Program to Launch March 1

The Ambetter from Sunshine Health Oncology program launch date has changed to **March 1, 2019**. New Century Health will begin managing Sunshine Health Marketplace members for chemotherapy treatments beginning March 1, 2019.

This change **did not** impact the Sunshine Health Medicaid program implementation, which began Jan. 1, 2019. All chemotherapy treatment requests for Sunshine Health Medicaid members beginning on or after Jan. 1, 2019, should be routed to New Century Health for review and prior authorization.

Questions? Call your dedicated New Century Health Network Manager at 1-888-999-7713, Option 6 for further assistance. You may also contact Sunshine Health's Provider Services help line at 1-844-477-8313.

ALL PRODUCTS

Policy Changes Effective March 1, 2019

Sunshine Health periodically updates our policies and procedures related to utilization management processes, payment and coverage policies.

Sunshine Health publishes its Payment Policies to inform providers about acceptable billing practices and reimbursement methodologies for certain procedures and services.

These policies are based on medical literature and research, industry standards and guidelines as published and defined by the American Medical Association's Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), and public domain specialty society guidance, unless specifically addressed in the fee-for-service provider manual published by the state of Florida or regulations.

Our Payment and Clinical Policies are located in Provider Resources (Manuals, Forms & Resources) on our website at SunshineHealth.com.

Number	Policy Name	Policy Description	Line of Business
CC.PP.060	Not Medically Necessary Inpatient Services	The purpose of this policy is to define payment criteria for medical professional services when the inpatient facility admission is denied as not medically necessary.	Medicaid and Healthy Kids
CC.PP.061	Non-obstetrical Pelvic and Transvaginal Ultrasounds	The purpose of this policy is to define payment criteria for multiple non-obstetrical ultrasound images in a single session.	Medicaid, Healthy Kids, Medicare, Marketplace
CC.MP.161	Monitored Anesthesia Care for Gastrointestinal Endoscopy	This policy outlines the indications for when Monitored Anesthesia Care is considered medically necessary Gastrointestinal Endoscopy.	Medicaid, Healthy Kids, Medicare, Marketplace
CC.PP.063	Place of Service Mismatch	The purpose of this policy is to identify instances in which a procedure code is billed with an inappropriate place of service per CPT/ HCPCS guidelines.	Medicaid, Healthy Kids, Medicare, Marketplace

Please remember that it is your responsibility to communicate this change to your downstream providers or any providers associated with your Tax Identification Number (TIN).

ALLWELL

Model of Care Provider Training

Please ensure you have completed your mandatory 2018 training, the Allwell from Sunshine Health Model of Care module. The Centers for Medicare and Medicaid Services (CMS) require that Medicare Advantage Organizations (MAOs) and Medicare-Medicaid Plans (MMPs) inform network providers and practitioners about the requirements to complete annual training.

Access our Model of Care training at SunshineHealth.com/providers/resources. Please use this training module to better understand our clinical philosophy and general approach to the delivery of care to our members. Training must be completed within 90 days of contracting, hiring or becoming a delegated entity, and annually thereafter.

If you need additional information, please contact Provider Services.

ALL PRODUCTS

NCQA Increases PCMH Pricing

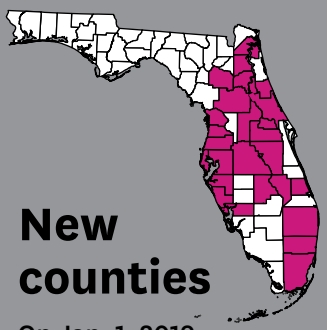
The National Committee on Quality Assurance (NCQA) increased the cost to become recognized as a Patient Centered Medical Home (PCMH) on Jan. 1, 2019.

The price increase for each practice is dependent upon the number of providers and practice sites. For a small practice with two physicians, the increase is $250 (from $500 to $750) per doctor. The price per physician decreases with a larger number of doctors. Discounts are based on the number of physicians and locations.

Providers in network with Sunshine Health seeking PCMH recognition for the first time are eligible for a 20% Partners in Quality discount. This discount is available to any size practice.

As of today, prices for PCMH certification through the Accreditation Association of Ambulatory Health Care (AAAHC) and The Joint Commission (TJC) remain the same as in 2018.

Questions? Call Jill Metlin, MS, CPHQ, Director, Quality Improvement/PCMH at 904-646-6247 or email jmetlin@centene.com.



New counties

On Jan. 1, 2019, Ambetter expanded to four new counties.

Our service areas with new counties highlighted: Alachua, Broward, Charlotte, Citrus, Clay, Duval, Flagler, Hernando, Highlands, Hillsborough, Lake, Manatee, Marion, Miami-Dade, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Saint Lucie, Sarasota, Seminole and Volusia.

AMBETTER

Coverage for New Members Began Jan. 1, 2019

Ambetter From Sunshine Health offers a variety of plans on the Health Insurance Marketplace to meet your patients' needs and budgets. **Please remind your office staff about your participation in Ambetter.** Here are some tools to help you serve our members:

My Health Pays rewards

Ambetter members earn reward dollars for taking charge of their health. Ambetter's My Health Pays™ program rewards members for completing healthy activities, like $50 for getting an annual wellness exam.

Ensure your staff has details on the My Health Pays™ rewards program by visiting Ambetter.SunshineHealth.com and clicking "Rewards Program" under the Health & Wellness tab.

Training

We offer a variety of provider training and orientation webinars. Visit http://bit.ly/Ambettertraining.

PCP assignment

We encourage new members to choose a PCP. If they don't select a PCP, we assign them one. View a current list of your Ambetter patients on our secure online portal at https://ambetter.sunshinehealth.com/provider-resources.html.

Questions? Visit Ambetter.SunshineHealth.com or call us at 1-844-477-8313.

MEDICAID

Provider Network Performance Evaluation

Sunshine Health evaluates its provider network performance on a continual basis to align with contractual requirements, member needs and company goals.

Evaluation criteria includes:

- **Completing required trainings to ensure compliance with AHCA Contract requirements.** Required trainings can be found on SunshineHealth.com under "Provider Resources."
- **Meeting appointment standards.**
    - Primary Care Providers (PCPs): Urgent care should be provided within 48 hours for services not requiring prior authorization and within 96 hours for services requiring prior authorization; routine and preventive visits within 30 days; and a post hospital discharge follow-up visit within seven days.
    - Ancillary providers: Care provided within 14 days of initial request for diagnosis, or treatment of injury, illness, or other health condition.
    - Specialists: Urgent care should be provided within 48 hours for services not requiring prior authorization and within 96 hours for services requiring prior authorization; new patient visits within 60 days; and a post hospital discharge follow-up visit within seven days.
    - Maternity providers: Prenatal visits within four weeks until 32 weeks pregnant; every two weeks until 36 weeks pregnant; every week until delivery after 36 weeks; and postpartum visit within 21 to 56 days after delivery.
    - Behavioral health: Non-life threatening emergency care within six hours; urgent visit within 48 hours; initial visit for routine care within 10 business days; routine follow-up to routine care within 30 calendar days; post hospital discharge follow up visit within seven days; and after-hours answered by live person.
    - Non-emergency transportation vendors: 90% of trips resulting in member arriving to scheduled appointment on time; not more than 0.2% of requests resulting in a missed trip; 85% of unscheduled trips fulfilled within three hours of the request; 90% of scheduled Leg A trip requests fulfilled within 15 minutes of scheduled pickup time; and 90% of scheduled Leg B trip requests fulfilled within 30 minutes of scheduled pickup time.
- **Availability of after-hours care**
- **Certification as Patient Centered Medical Home (PCMH)**
- **Engaging new members**
- **Member loyalty**
- **Quality of care**
- **Cost of care**
- **Value-based purchasing (VBP)**
- **Potentially Preventable Events**
- **Birth Outcomes**

For more information about these evaluation metrics, go to the "Provider News" section on SunshineHealth.com.

MEDICAID, LONG TERM CARE, CHILD WELFARE

Continuity and Coordination of Care

All new Medicaid members have a Continuity of Care (COC) period in which Sunshine Health can help transition members who have been receiving care through a non-participating Sunshine Health provider to a participating provider. This is very important, as our new members enroll in Sunshine Health from another health plan or from Medicaid Fee-For-Service.

Information regarding Continuity and Coordination of Care for New Members can be found in Provider Resources (Manuals, Forms & Resources) on our website at SunshiHehealth.com, or contact Provider Services for questions at 1-844-477-8313.

ALL PRODUCTS

What to Know About Risk Adjustment

Your role in risk adjustment is essential. Providers are the largest source of medical data for all risk adjustment models.

Risk adjustment is the process by which health plans are reimbursed based on the health status of their members. It helps match payment to risk by estimating healthcare expenses based on the disease conditions ascribed to the population. The state and Centers for Medicare & Medicaid Services use risk adjustment to more accurately pay health plans for the predicted healthcare cost of their members. Risk adjustment helps identify patients who may need disease management intervention as well as gaps in clinical documentation. Accurate and efficient documentation improves collaboration between health plans and providers, which helps improve care plans and treatment strategies, with the ultimate goal of better health outcomes.

Risk adjusted payment depends on accurate diagnosis coding on claims and complete medical record documentation.

Providers should follow general documentation requirements and review the Official ICD-10-CM Guidelines for Coding and Reporting along with E&M Service guidelines regarding chronic conditions. When generating progress notes, providers must include support for what is coded and billed (ICD-10-CM, CPT, and HCPCS) and show medical necessity. Progress notes must stand alone, be complete and contain legible signature and credentials.

This is the first in an educational series on risk adjustment. For more information, visit “Provider News” on SunshineHealth.com.

HHAeXchange Portal Increases Workflow Efficiencies and Helps Meet EVV Mandate

Sunshine Health has partnered with HHAeXchange for our payer services to increase efficiency and meet the new Electronic Visit Verification (EVV) mandate. Effective Dec. 1, 2018, the HHAeXchange portal became the preferred method for authorization information and billing.

The portal allows you to:

- Receive patient demographics and authorizations electronically in real-time from multiple managed care organizations (MCOs).
- Have real-time, two-way messaging with multiple MCOs.
- Bill multiple MCOs for confirmed visits.
- Eliminate denials with pre-bill scrubbing.
- Manage schedules online in real-time.
- To electronically track time and attendance.
- Interface with your agency management system/EVV system (Open Model).
- Be prepared for EVV compliance when the state mandate takes effect in October 2019.

Phase	Rollout	Region	Counties
1	Dec. 1, 2018	9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
		10	Broward
		11	Miami-Dade, Monroe
2	Jan. 1, 2019	5	Pasco, Pinellas
		6	Hardee, Highlands, Hillsborough, Manatee, Polk
		7	Brevard, Orange, Osceola, Seminole
		8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
3	Feb. 1, 2019	1	Escambia, Okaloosa, Santa Rosa, Walton
		2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
		3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
		4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia

With the recent Agency for Health Care Administration (AHCA) announcement that the EVV mandate for Medicaid Managed Care recipients is delayed to Oct. 1, 2019, providers will have the opportunity to benefit from the HHAeXchange Portal as EVV is phased in.

Providers have three options for entering visits into HHAeXchange:

- Option 1 – Use your existing EVV and import that data into HHAeXchange
- Option 2 – Use Free EVV tools from HHAeXchange
- Option 3 – Not ready for EVV? Use the Free HHAeXchange Quick Timesheet Entry Screen

Sunshine Health will follow the state's Regional Rollout Schedule for providers to begin using the HHAeXchange Portal.