Member Handbook

Website: CMSPlan.floridahealth.gov

WELCOME

Thank you for choosing Children's Medical Services Managed Care Plan (CMS Plan) as your new Managed Care Plan. You became a CMS Plan member because you live in our service region and meet clinical eligibility. Because of where you live, your child falls under Ped-I-Care service region. Ped-I-Care works with Children's Medical Service Managed Care plan to help with your child's care.

This handbook tells you about CMS Plan CMS. It tells you about your benefits. It answers most of your questions. You can get CMS Plan information in other languages or formats. CMS Plan can help you. There is no cost to you. If you would like this handbook in your language, call Member Services at the number below.

We can help if you speak another language. We can interpret over the phone. If you need help to speak to your doctor, call Member Services. This will not cost you anything.

The CMS Plan keeps a list of all providers in our network. The list is called the Provider Directory. It is included in the package. The list can change. You can call Member Services for an updated list. Also, you could view it at: CMSPlan.floridahealth.gov.

Also included in this packet:

- Medical Release Form
- Health Needs Questionnaire

It is very important that you fill out the Medical Release Form and Health Needs Questionnaire. **Return these forms in the stamped envelope with our return address right away. The stamped envelope is in the welcome packet.** They will be used to help your doctor provide you with good care and service.

We are to help you. Call us with any question you have.

Thank you,

CMS Plan/Ped-I-Care Member Services Department

Please call the Member Services Department if you need information in large print, video, audio, or Braille.
Rele gratis, 1-866-376-2456, si ou bezwen enfòmasyon sa an kreyòl.

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ENROLLMENT PROCESS

Children's Medical Services Managed Care Plan (CMS Plan) serves children with special health care needs through age 20 and who are in Florida's Medicaid program. The Department of Health nurses use a clinical screening tool to decide clinical eligibility. CMS Plan is in all of Florida's 67 counties.

ENROLLMENT

To be in Children's Medical Services Managed Care Plan (CMS Plan) you must be able to get Medicaid and meet clinical eligibility. Medicaid will send you information on Managed Care Plans in your region. It is your choice to be in the CMS Plan. If you do not choose a plan, Medicaid will choose a plan for you.

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in CMS Plan or the state enrolls you in a plan, you will have 120 days from the date of your first enrollment to try the Managed Care Plan. During the first 120 days you can change Plans for any reason. After the 120 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine months. This is called "lock-in."

OPEN ENROLLMENT

Open Enrollment is when you can choose your Plan. This occurs each year. Medicaid will send you a letter before your open enrollment begins. If you do not choose a Plan, Medicaid will make a choice for you. You will stay in that Plan for the next year. If you meet clinical eligibility and have Florida Medicaid, you can enroll in the CMS Plan by calling the Choice Counselor at 1-877-711-3662 (TTY/TDD 1-866-467-4970).

If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment." You do not have to change Managed Care Plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you may change Managed Care Plans during your 60 day open enrollment period.

DISENROLLMENT

If you think there is a problem, tell us right away. Call Member Services. If you are a voluntary enrollee, you can disenroll at any time. Call the Choice Counselor at 1-877-711-3662 (TTY/TDD 1-866-467-4970). You will need your Medicaid ID number when you call.

If you are a mandatory enrollee and you want to change plans after the initial 120 day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change Managed Care Plans.

The following are state-approved good cause reasons to change Managed Care Plans:

1. The enrollee does not live in a region where the CMS Plan is authorized to provide services, as indicated in FMMIS.
2. The provider is no longer with the CMS Plan.
3. The enrollee is excluded from enrollment.
4. A substantiated marketing or community outreach violation has occurred.
5. The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
6. The enrollee has an active relationship with a provider who is not on the CMS Plan's panel, but is on the panel of another Managed Care Plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
7. The enrollee is in the wrong Managed Care Plan as determined by the Agency.
8. The CMS Plan no longer participates in the region.
9. The state has imposed intermediate sanctions upon the CMS Plan, as specified in 42 CFR 438.702(a)(3).
10. The enrollee needs related services to be performed concurrently, but not all related services are available within the CMS Plan network of doctors, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
11. The CMS Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
12. The enrollee missed open enrollment due to a temporary loss of eligibility.
13. Other reason per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.

Some Medicaid recipients may change Managed Care Plans whenever they choose, for any reason. To find out if you may change plans, call the Choice Counselor at 1-877-711-3662 (TTY/TDD 1-866-467-4970).

Your child may have to leave our plan. These are reasons why:

- Move out of service area
- Lose your Medicaid Benefits or clinical eligibility;
- Enroll in the Health Insurance Premium Payment (HIPP) program;
- Die;
- Enrollee in a category of excluded population; or
- Child turns 21

Also, we may request you off our plan. If you continue to do any of the following even when you have been told not to:

- Fraudulent use of your enrollee ID card (you will also be reported to Medicaid)
- Falsification of prescription; or
- Behave in a disruptive or abusive manner that is not related to a diagnosed health condition.

CHANGE IN STATUS

If you lose Medicaid or clinical eligibility, you will not be able to stay with Children's Medical Services Managed Care Plan (CMS Plan). Call the Department of Health's Children's Medical Services Nurse Care Coordinator (Care Coordinator) about clinical eligibility. Phone numbers are in the back of this handbook. Questions on Medicaid eligibility, to update your address and telephone number, call the Department of Children and Families at 1-866-762-2237 (online at http://www.myflorida.com/accessflorida/) or TTY/TTD 1-800-955-8771 and/or Social Security Administration at 1-800-772-1213 (online at http://www.ssa.gov/ere/ere_demo_public/html/EREMEREF/eFolder/erLogin.html) or TTY/TTD 1-800-325-0778.

- ♦

Please call member services if:

- ♦ You plan to move to another county;
- ♦ You are not living in Florida

SERVICES INFORMATION

Children's Medical Services Managed Care Plan (CMS Plan) ID CARD

You will get a CMS Plan identification card. This card gives other information about the CMS Plan. It will have your doctor's name and phone number. You should carry it with you all the time. If you change doctors you will get a new CMS Plan ID card. It will have your new doctor's or clinic's name on it. Call the CMS Plan Member Services Department if you need a replacement card. Bring your CMS Plan ID card with you to get medical care.

Do not let anyone else use your ID card. If you do, you may be responsible for their costs. You could also lose your eligibility for Medicaid.

FRONT

1. Member Name
2. Effective Date
3. Medicaid ID#
4. DOB
5. PCP Name
6. PCP Phone #

BACK

1. Important Phone #
2. Claims Address

Present this card each time you seek healthcare services.
Call your Primary Care Physician (PCP) for any health care questions.
For medical, dental, vision authorizations call: 1-800-492-9634
Mental Health & Substance Abuse Pre-Authorization or questions call: 1-800-492-9634 (PCP REFRRAL NOT REQUIRED)
Eligibility Verification and Claims: eInfoSource
(https://cms.einfosource.med3000.com or 800-664-0146
(This card is not proof of network enrollment)
Transportation call Access2Care: 1-866-867-0729

For Medical Claims:

CMS MMA Specialty Plan Title XIX
Attn: Claims
P.O. Box 981648
El Paso, TX 79998-1648

PRIMARY CARE PROVIDER (PCP)

You can choose your own PCP. You and your family may choose one or different doctors for each family member. Member Services can help you find a doctor who is part of our "network."

A list of PCPs can be found in the Provider Directory online at **CMSPlan.floridahealth.gov** or the package with this handbook. Your PCP may be one of the following:

- Family Practitioner
- General Practitioner
- Internal Medicine Practitioner
- Pediatrician

Your PCP will help you with most of your medical needs. This includes helping to get you appointments with other doctors. It also includes arranging hospital care. Your PCP manages your care with the specialists that care for you. You can get your entire well and sick care from your PCP. This includes non-emergency care, too.

CHANGING YOUR PCP

Children's Medical Services Managed Care Plan (CMS Plan) allows you to select any doctors in our network. When you joined CMS Plan, you may have selected a PCP. If you did not, we assigned you to a PCP in our network. You may change the PCP at any time or if:

- Your PCP is no longer in your area
- Because of religious or moral reasons, the PCP does not provide the services you seek
- You want the same PCP as other family members

Call Member Services and they will help you change your PCP quickly. They can help you find a doctor.

CONTINUITY AND COORDINATION OF CARE

You will be assigned a Nurse Care Coordinator (Care Coordinator). Your Care Coordinator can help with appointments. Your Care Coordinator can answer questions you have. Your Care Coordinator is there to help your child get care. Please use your Care Coordinator whenever you need to. Call your CMS Area Office to speak with your Care Coordinator. Your CMS Area Office phone number is in the back of this handbook. CMS Plan will let you know if your PCP or your PCP's office is no longer in our network. We will help you change your PCP. We will also let you know if a specialist you see regularly leaves our network. We will help you find another specialist. CMS Plan will honor services that have been approved prior to joining our Plan.

CMS Plan PROVIDERS

Our network works with many kinds of health care providers. This includes doctors, hospitals, and specialists. We keep a list of all the providers in our network. It is called a Provider Directory. A copy of the Provider Directory is in this package. You can get this list at our website or from Member Services. When you use a provider in the Provider Directory, you are "in network". The list has office hours, addresses and other information. You must get care in network except for emergency care. If the care you/your child needs is not available in network, tell your PCP. Your PCP will need to get an okay from CMS Plan.

You will need to pay for services that are not covered by Medicaid or CMS Plan. Your PCP has a list of these services. The doctor or facility can tell you what is covered by Medicaid or CMS Plan. They must tell you if you need to pay before you get services. You can call Member Services with questions.

For emergencies, call 911 or go to the nearest emergency room. You can do this without an okay. You don't need an okay from us for getting care at:

- Federally Qualified Health Centers
- School based clinics
- County Health Department

SCHEDULING APPOINTMENTS

After you sign up, make an appointment with you/your child's PCP. Make it right away if this is a new doctor. This helps the doctor to know about you/your child's history and health care needs. Even when you feel well, there are things your doctor can do to keep you healthy. When you call the PCP for an appointment, they will schedule your visit as soon as they can. Your appointment will depend on the current patient schedule. It will also depend on your health care needs.

The following guidelines are used when medical and dental appointments are needed:
For Urgent Care (when you need to see a doctor right away) — within (1) day of the request
For Sick Care (non-urgent care) — within one (1) week of the request
For Routine, Well Care (regular check-ups) — within one (1) month of the request

If you can't keep your appointment, please call your doctor right away. This will help you get another appointment sooner. It is also a courtesy to other patients who need to see the doctor. Your doctor will need a copy of your old medical records. Your doctor can get them from your previous doctor with your permission. This will help your new doctor get to know your past health history.

SPECIALIST APPOINTMENTS

You **do not** need a referral from your PCP before you see them.

NEWBORN ENROLLMENT AND NOTIFYING THE CHILREN'S MEDICAL SERVICES MANAGED CARE PLAN (CMS PLAN)

You need to let us know if you are pregnant or give birth. Call your Care Coordinator or Member Services. We will notify Department of Children and Families (DCF) of your pregnancy. You also need to tell your DCF Case Worker. When we hear about the birth, we will tell DCF. You also need to call the Choice Counselor at 1-877-711-3662 (TTY/TDD 1-866-467-4970) to tell them what managed care plan you want for your baby.

AFTER HOURS CARE

You should call your PCP's office anytime you need non-emergent care. You may need care when the doctor's office is closed. This includes when it is not your doctor's normal working hours and holidays. You should be able to reach your doctor at the same phone number you call when the office is open. You can discuss after hours care with your doctor.

GETTING CARE WHEN YOU ARE OUT OF THE AREA

When you are not in the service area, you must get an okay before you get care. You need to also do this for behavioral health services. You must ask CMS Plan for the okay. This is only for non-emergencies. To get the okay, call your CARE COORDINATOR or Member Services. You may need to pay for your care if you did not get the okay. This includes if you go outside of the USA. After you get care, call your CMS Plan doctor. This will help your doctor know your medical and follow-up needs. For emergencies, call 911 or go to the nearest emergency room. You can do this without an okay.

OUT OF NETWORK CARE

To receive treatment from a doctor not in our plan, you need an authorization from your PCP. Your PCP will need to call us to get an okay. This is only for non-emergencies.

POST STABILIZATION CARE

These services are to keep you from getting worse after an emergency. You can get these services within or outside of the CMS Plan "network". You can have these services without an okay from CMS Plan when:

1) The services were pre-approved by us;

2) The provider requested approval but did not get a response from us within an hour; or
3) The provider treating you could not contact us for pre-approval.

REQUESTING A SECOND OPINION

You have the right to have a second opinion for care. CMS Plan does cover it. You will need to call your PCP. They can help you get the okay. You can see an in network provider. Or you can see one outside the network at no cost to you. But the provider needs to be in the same service region. You need an Okay to do this before you go. It is the same for behavioral health. CMS Plan could deny for more than three requests of second opinions in a year. You could file an appeal if you are not happy with the decision.

OPEN ACCESS

Enrollees can go to the doctors below without calling the PCP for an okay. But they must be CMS Plan network providers.

1. Chiropractor – for the first ten (10) visits each Medicaid program year (up to 21 years of age)
2. Podiatrist – for the first four (4) visits each Medicaid program year.
3. Dermatologist – for the first five (5) visits each Medicaid program year
4. Obstetrician & Gynecologist – for an annual well-woman exam each Medicaid program year
5. Ophthalmologist & Optometrist – for eye exam and medical treatment

You will need to call your PCP if you need more visits than allowed. Your PCP will give you the okay if they feel you need to go. You can get Family Planning Services without the okay from CMS Plan. But you must go to a CMS Plan or Medicaid provider.

COMMUNICATION ASSISTANCE

We can help if you speak another language. We can interpret over the phone. We can help you speak to your doctor. We can get the written information in your language. Call Member Services. You can call Monday to Friday from 8:00am to 7:00pm EST. If you are blind or deaf, call TDD at 1-800-955-8771. These services will not cost you anything.

COST SHARING

There are no costs to you for approved CMS Plan services. You will need to pay for services CMS Plan doesn't cover. The doctor or facility must tell you if you will need to pay. **If you do receive a bill by mistake, do not ignore it.** Please call the MED3000 at (800) 664-0146 CMS for help. Ask to speak to "claims".

MANAGEMENT OF COMPLICATED AND CHRONIC DISEASES

Some people have an illness that can get worse if not watched closely by nurses and doctors. Your Nurse Care Coordinator is here to help. Call your CMS Area Office for more help.

MATERNAL/CHILD CASE MANAGEMENT

If you become pregnant, please call us right away at 1-844-514-3779. Getting care early is the best thing you can do for your baby to be. You can also get help 24 hours a day, 7 days a week from our Nurse Help Line. Their number is 1-844-514-3779. We will make sure you see a provider for care. Also, we can help you sign up to programs in the local area like Women, Infants and Children (WIC) and Healthy Start. Your OB Nurse will give you information by mail and phone to help you stay healthy. Also, you can call the Care Link line above to get other community information.

QUALITY ENHANCEMENTS

We can assist you in getting help with more than just medical care. This includes help to stay healthy. These programs include but are not limited to the following:

- Children's Programs
- Domestic Violence
- Pregnancy Prevention
- Prenatal/Postpartum Pregnancy Program
- Smoking Cessation
- Substance Abuse
- Community Based Programs

If you would like to learn more about these programs, call your Care Coordinator.

24/7 NURSE HELP LINE (CareNet)
It is a health information line. The help line is staffed with nurses. They are ready to answer your health questions 24 hours a day, every day of the year. These nurses are ready to help you.

The services listed below are available by calling the Help Line. The phone number is 1-844-514-3779.

- Medical advice
- Health information
- Answer to questions about your health
- Advice about a sick child
- Information about pregnancy

Not sure if you need to go to emergency room?
Sometimes you may not be sure if you or your child needs to go to an emergency room. Call the Help Line. They can help you decide where to go for care.

HEALTHY BEHAVIORS *Starting August, 2015*
CMS Plan offers three Healthy Behavior program to all members. The programs are below.

- Smoking Cessation to stop using tobacco
- Healthy Weight to lose weight
- Alcohol or Drug Abuse recovery program

For more information about Healthy Behaviors, please call your care coordinator.

If you have questions about your doctor and if the office has malpractice insurance, contact the doctor's office.

COVERED BENEFITS

Below are services that are covered by Children's Medical Services Managed Care Plan (CMS Plan). If you have questions about any services, call Member Services.

Benefit	Coverage	Limits
Child Health Check Up (CHCUP)	Services to enrollees under 21 years of age include: • Hearing, vision, and dental screening • Health and developmental history • Updating of routine immunizations • Referrals for more diagnosis and treatment as needed • Therapy services when needed and arranged by his/her doctor • Development and nutritional assessment	No Limit
Chiropractor	Enrollees can go to the doctors below without calling the PCP for an okay. But they must be CMS Plan network providers. Referral is needed for enrollees age 21 or younger.	24 Visits per year^
Dental Services	Children can get all dental services using our dental providers. Children get dental emergency care. There may be other benefits. This is based on what Medicaid allows. For some care, you will need to get an okay from us first.	No Limit
Diabetes Supplies and Education	Cover necessary equipment, supplies, and services used to treat diabetes. It includes outpatient self-management training and educational services if your PCP said you needed it.	No Limit^
Durable Medical Equipment	This is medical supplies you need to help you get well or help you with daily living. Your doctor must arrange it. The supplies or equipment you get are based on what Medicaid allows.	No Limit^
Emergency Services	Emergencies are problems that need care right away. This includes emergency behavioral health services. If you think you have an emergency call 911 or go to the nearest emergency room. You can get emergency care without an okay. The emergency room doctor may think you don't need help right away. If the doctor thinks that, he/she will tell you before helping you. If it is not an emergency, you will need to pay for your care. The exam to see if you need care right away will be covered.	No Limit^
Family Planning Services	You can get these services without an okay from the CMS Plan. But they need to be from a CMS Plan or Medicaid provider. Services for family planning include: • getting information; • education and counseling; • testing; • birth control; • help with spacing births; • sterilization if you need it for your health. Enrollees must get an okay from their parent or legal guardian. They do not need an okay when the enrollee is married, a parent, pregnant, or if their doctor thinks they need it for their health. Services for sterilization will not be given to enrollees: • less than 21 years old; • who are not mentally competent; • who are institutionalized in a correctional, penal, rehabilitative, or mental facility.	No Limit^
Hearing Service	Adults and children can get help for hearing problems. This may include testing, hearing aids and other treatment. The help you can get is based on what Medicaid allows.	One standard hearing aid every 3 years
Home Health	You can get help at home from nurses and others for medical and/or personal care. This would be from a home health care provider. You can get it when your doctor says you need it. Your doctor must also arrange it. The services you get are based on what Medicaid allows. This includes supplies your doctor says you need.	No limit^
Inpatient Hospital Care	CMS Plan must give the okay for you to go to the hospital. You don't need an okay for an emergency. This is for both medical and behavioral health services. The okay includes the room, nurses, and supplies.	No limit
Lab and X-Ray Services	All covered lab and x-rays must be ordered by your PCP. They must be done at participating facilities.	No Limit^

Maternal Care	The CMS Plan cares about our pregnant enrollees. The CMS Plan has special programs for them. Call Member Services for more information. Pregnant enrollees can pick one of our OB doctors or nurse midwives. The doctor or midwife will help with care while you are pregnant. He/she will also be there to deliver your baby. He/she will also look for things in the blood that may make you or your unborn child sick. All pregnant women will be given help to keep them and their unborn baby well. They will get the Florida's Healthy Start Prenatal Risk Screening. They may also be able to get the local Women, Infant, and Children (WIC) program. Ask your doctor or call the CMS Plan for information.	One visit per day
Outpatient Care	This would be at one of our hospitals or outpatient facilities. It can include tests and/ or procedures. It also includes behavioral health services. This would be done by one of our specialists.	No limit
Palliative Services: Partners in Care-Together for Kids (PIC-TFK)	(PIC-TFK) is a health program designed for children 20 years of age or younger. It enables children to receive curative care for potentially life limiting conditions and palliative services. Services must be provided by a hospice agency that has been approved to participate in the program/waiver. Services may include: expressive therapies for child and family, in-home and inpatient respite care, pain and symptom control, specialized personal care and therapeutic counseling for child and family.	Services are agreed to by the partnership and participating hospice agencies
Physician Services	Includes all regular and sick services and procedures rendered by a network provider.	One visit per day
Podiatrist	Enrollees can go to the doctors below without calling the PCP for an okay. But they must be CMS Plan network providers.	No Limit^
Prescription Drugs	May use network pharmacy or mail order program. Must be on the CMS Plan Preferred Drug List	No Limit^
Vision Care	You can have eye exam and eye glasses.	Child: Limit 2 pairs of glasses/per year
Therapy Services: • Physical • Respiratory • Occupational • Speech	All therapy services are covered for enrollees less than 21 years of age as long as it is medically necessary.	No limit
Transportation	You can get a ride to the doctor or other provider. This is for when it is not an emergency. To ask for this you can call TMS at their toll-free number 1866-411-8920-. If it is an emergency, you should call 911.	No Limit

^ Prior authorization & other limits may apply.

SERVICES NOT COVERED BY CMS Plan

For services we do not cover, authorization is needed. This will come from your PCP. You can call Member Services or your Care Coordinator if you have questions.

PRIOR AUTHORIZATION SERVICES

Prior authorization is for services that must be approved by CMS Plan. We will review the request from your doctor before you obtain the service or procedure. CMS Plan has policies and procedures to follow in making medical decisions. We will send you a letter if the services are denied. This is called a Notice of Action (NOA). The NOA will give you information on how to file an appeal and Medicaid Fair Hearing. Also, if we make any major changes to Prior Authorization, we will let you know.

PHARMACY

We cover prescription drugs when ordered by our doctors. You can visit our website for the most current Children's Medical Services Managed Care Plan (CMS Plan) Preferred Drug List. See your Provider Directory for a list of pharmacies near you or visit any pharmacy that takes Medicaid. If you need help to find a pharmacy, call us.

How do you get your prescriptions?

- Go to a network pharmacy or any pharmacy that takes Medicaid
- Give them your prescription order
- Show them your CMS Plan ID card

If you have questions about your prescription, call the provider who wrote the prescription, your Care Coordinator or pharmacy.

BEHAVIORAL HEALTH SERVICES

This help is for a mental health problem. Children can get help. You must get this help from one of our providers. This could be a doctor, nurse, psychologist or social worker. You can get other services based on what the health plan benefits allows.

The network for services is CMS Plan/Ped-I-Care. You can call us with questions about behavioral health services. You can ask our member services about which providers you can go to. Call Member Services if you think you have a behavioral health problem. Some things you may be feeling may be behavioral health symptoms. It is possible this may include feeling helpless, hopeless or worthless, always sad, can't sleep and loss of interest. It may include trouble concentrating, wanting to hurt yourself or others, or feeling angry or guilty. It is also possible that not being hungry or losing weight could be this type of problem.

The following services are covered by CMS Plan:

- Inpatient and outpatient for behavioral health conditions
- Psychiatric physician services
- Psychiatric specialty services
- Community mental health services for behavioral health or substance abuse conditions
- Mental Health Targeted Case Management
- Mental Health Intensive Target case Management
- Specialized therapeutic foster care
- Therapeutic group care services
- Comprehensive behavioral health assessment
- Behavioral health overlay services in child welfare settings
- Residential care
- Statewide Inpatient Psychiatric Program (SIPP) Services for individuals under age eighteen (18)

You do not need to call your PCP for a referral. CMS/Ped-I-Care is responsible for coordinating any behavioral health inpatient or outpatient services. Outpatient services can be provided by:

- a licensed behavioral health group;
- a community health center; or
- a Private behavioral health provider.

These centers are listed in your Provider Directory.

CMS coordinates emergency behavioral health services 24 hours a day, 7 days a week. An acute crisis can include any of the following symptoms:

- Likely danger to self and others,

- Presents threat to harm his/her wellbeing,
- Unable to carry out actions daily life due to so much functional harm
- Functional harm that could cause death or injury to self or others.

If you have any of the above symptoms, go to the nearest emergency room or call 911. If it is not an emergency, you will need to pay for your care. The exam to see if you need care right away will be covered.

CMS Plan is not responsible for non-emergency behavioral health services you get from provider not in our network. You must ask for an okay for any non-emergency services outside of our network.

When you call the provider to schedule an appointment, the following guidelines are used:

Urgent Care – within one (1) day of request
Sick Care – within one (1) week of the request
Well Care Visit – within one (1) month of the request

CMS provides case management services if you need it. This is called "intensive" or "mental health targeted" case management. CMS will have case management clinical staff to help you get the special services you need. The work closely with the Targeted Case Manager you may have through your provider. Call CMS if you want to choose a different case manager or direct service provider. They will help you get another one if it is possible.

Psychotropic Drug Consent Form
If your child is under 13 and takes psychotropic medication, talk to your child's doctor. You have to tell your doctor that it is ok for your child to take it. Florida law requires a signed consent form. The consent form is on our website. Our website is CMSPlan.floridahealth.gov Give the signed consent form to the doctor. The doctor needs to keep it in the medical record.

ENROLLEE RIGHTS AND RESPONSIBILITIES

We want you to get the best medical care. We want to help you get the care you need. For that, you have rights and responsibilities. Certain rights are provided for you by law (42 CFR 438.100; 42 CFR 438.102; 45 CFR 164.524 and 45 CFR 164.526).

YOUR RIGHTS:

- To be treated with respect, courtesy, and dignity.
- To protect your privacy.
- To ask questions and get answers you understand.
- To get the care and services covered by Medicaid.
- To get good medical care regardless of race, origin, religion, age, disability, or illness.
- To know about your treatment. To know what your options are. To decide about your care. You can refuse treatment.
- To ask for and get a copy of your medical records. To request your medical records be changed or amended. Changes can only occur as allowed by law.
- To get a second opinion from another doctor.
- To get service from out-of-network providers.
- To call 911 or go to the closest emergency room if you are having an emergency.
- To participate in experimental research.
- To change providers at any time. You can ask for another primary care doctor (PCP) or specialist.
- To file a complaint, grievance or appeal.
- To not be restrained or secluded to make you act a certain way or to get back at you.
- To get information about Advanced Directives, if you are over 18.
- To exercise your rights and not have it affect the way you are treated.
- To get information from Children's Medical Services Managed Care Plan (CMS Plan) in the format or language you need. Information like:
    - ❖ How we approve services (authorization/referral process, medical necessity);
    - ❖ How we make sure we keep getting better at what we do (Quality Improvement Program);
    - ❖ How we measure the quality of our services (Performance Measures);
    - ❖ The prescription drugs covered by CMS Plan;
    - ❖ How we keep your information confidential;
    - ❖ How we run the program. How we operate. Our policies; and
    - ❖ If we have any provider incentive plans.

You can get this information at CMSPlan.floridahealth.gov or call Member Services.

YOUR RESPONSIBILITIES:

- To call your PCP(s) before getting care unless it is an emergency. To call your PCP when you get sick and need care.
- To listen and work with your providers.
- To treat all health care providers and staff with respect, courtesy and dignity.
- To give them the information they need for your care.
- To talk to your doctor if you have questions or concerns
- To carry your ID card at all times.
- To call your doctor if you cannot make it to an appointment.
- To call Department of Children and Families if your address or telephone number changes.

- To tell us or Medicaid if you suspect fraud.

ADVANCE DIRECTIVES AND LIVING WILLS

Under Florida law, it is your right to decide what kind of care you want. This law makes sure your rights and wishes are carried out the way you want. You can decide what medical and behavioral health care you do and do not want if you get very sick. You can ask not to have certain help. You can also ask not to be kept alive with special care. If the law changes, we will let you know within 90 days of any change.

An advance directive is your written wishes. If you are 18 years of age or older you can write your wishes. There are two types of advance directives:

1) Living will – tell your doctor what kind of care you want or don't want
2) Health care surrogate – name someone to make health care choices for you

You may change or remove the living will at any time. Just make sure is signed and dated. It is not required by law to have a living will. The living will says who will make healthcare choices for you when you are not able to do so. You will not be discriminated against for not having an Advance Directive. Children's Medical Services Managed Care Plan does not limit the implementation of advance directives as a matter of conscience.

If you have one, your wishes will be carried out the way you want. Speak to your doctor about this. Your doctor can tell you about the forms to fill out. Call Member Services if you have questions. You can get the form at:
http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx

If your directive is not being followed, you can call the State's Complaint Hotline at 1-888-419-3456.

See page 22 for a copy of the Advance Directive Form.

PROTECTED HEALTH INFORMATION (PHI)

The federal government passed an act in 1996 to protect your health information. The act is called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is intended to help people keep their information private. We want to make sure that your Personal Health Information (PHI) is protected. We only use information when we need to in order to provide you with care. If you want to know more about how we protect your information, read the "Notice of Privacy" in your package.

FRAUD AND ABUSE

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:
https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Chapter 409.9203,

Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

CHILD ABUSE, NEGLECT AND EXPLOITATION

To report, call 1-800-96-ABUSE (1-800-962-2873)
TDD (Telephone Device for the Deaf): 1-800-453-5145

You should give details about what is causing the risk or harm. This will include:

- who was involved
- what happened
- when and where it happened
- why it happened
- any injuries
- what the victim(s) said happened
- any other details

The toll free number is available 24/7. Counselors are waiting to assist you.

COMPLAINTS, GRIEVANCES & APPEALS

COMPLAINTS

If you are not happy with our care or services, call Member Services at the number below. Please press 1 to speak to a person. We will try to resolve your issue. We will answer your questions. If you are still not happy, you can file a grievance. Also, a complaint becomes a grievance after 24 hours if not resolved.

You can file a complaint about many things. Here are a few examples:

- A doctor was rude to you.
- You are unhappy with the quality of care you received.
- You had to wait too long to see your doctor.
- You are not able to get information from the plan.
- You are concerned about your privacy or medical records.

GRIEVANCES

You can file a formal grievance orally or in writing. Your doctor can file it for you if you give your okay in writing. You must file your grievance within 1 year of the incident. Call Member Services if you need help**.** If you are deaf or blind, call our TDD line at 1-800-955-8771. Member Services is open between 8:00am and 7:00pm EST. You can talk with the Grievance Coordinator. Ask for a Grievance Coordinator from 8:30am to 5:00pm EST Monday to Friday.

You can mail a written grievance and any documentation you want to send with it to:

Ped-I-Care Grievance Coordinator
1701 SW 16th Avenue, Building A
Gainesville, FL 32608-1153

We will send you a letter within five (5) days after we received your grievance filed orally or in writing. We will send you a letter confirming we got your grievance within 5 days of receipt. If you request an expedited resolution, we will not send a letter. We will look at you grievance carefully. We have up to 90 days to take care of your grievance.

We might need more time if we need more information. We can take up to 14 more days to review if it is in your best interest. We will send you a letter telling you about this within five (5) days. The letter will include our reason for needing more time. If you need more time, you can ask for up to 14 more days. You can let us know in writing or by calling us. The extension is only for 14 calendar days in addition to the 90 days to review and resolve your grievance.

After we review your grievance, we will send you a letter with what we found. If you are not happy with what we told you, you can ask for an appeal or Medicaid Fair Hearing.

See Medicaid Fair Hearing on page 20.

APPEALS

If you are not happy with an "Action" from the Children's Medical Services Managed Care Plan (CMS Plan), you can appeal. An"action" is:

- The denial or limited authorization of service you asked for;
- The service you have been getting is stopped, reduced or changed;
- Medicaid will not pay for the service you asked for;
- You did not get the services you need quickly enough, per the Florida law.

When you get our action letter, you have 30 days to send your appeal from the date of the action letter. You can appeal by phone or in writing. If you appeal by phone, you MUST then send your appeal to us in writing within 10 days or the phone appeal request will not be accepted. Your doctor can file an appeal for you. But he/she must have your okay **in writing**. You may want to send other information with your written appeal. You can also ask your doctor for documentation. The written appeal needs to have member's name, member's identification number and phone number where we can reach parent or legal guardian. You can tell us why we should change the decision, any medical information to support your request and who you would like to help your appeal.

You can mail it to:

Ped-I-Care Medical Review Coordinator
1701 SW 16th Avenue, Building A
Gainesville, FL 32608-1153

We will tell you when we get your appeal. We will send you a letter within five (5) days. We will look at your appeal carefully. We have up to 45 days to take care of your appeal. If you appealed by writing only, the 45 days starts from the day we receive your letter. If you appealed by phone and then by letter, the 45 days start from the day you called.

We might need more time if we need more information. We can take up to 14 more days to review if it is in your best interest. We will send you a letter telling you about this within five (5) days. The letter will include our reason for needing more time. If you need more time, you can ask for up to 14 more days. You can let us know in writing or by calling us. The extension is only for 14 calendar days in addition to the 45 days to review and resolve your appeal.

The Appeal Committee will read your appeal carefully. We have up to 45 days to take care of your appeal. We will tell you our decision. We will send you a letter within two (2) days of our decision.

You can request an expedited appeal if you need a faster review because of your health. This is called an "Expedited Review." If you or your provider think that waiting 30 days for a decision could your life, health or your ability to attain, maintain, or regain maximum function in danger. You can ask for a faster review by phone or by letter but you need to make sure that you ask us to *expedite* the appeal. We will tell you and your provider our answer within 72 hours. We will try to call and let you know our decision. We will also send you a letter within three (3) working days after we receive the appeal decision. We may not agree that your appeal needs to be expedited, but you will be told of this decision. We will still process your appeal under normal time frames.

If you are not happy with what we told you, you can ask for a Medicaid Fair Hearing or the Subscriber Assistance Program.

During our review, you can give us information to help your case. You can give it to us in person or by letter. You can also look at your file anytime before a decision is made. Your file may have medical or other documents that we will use.

MEDICAID FAIR HEARING (MFH)

You do not have to wait for us to make our decision. You can ask for a MFH anytime. If you choose a MFH before completing our grievance and appeal process, you have 90 days from our notice of action. You can wait for our answer first. If you are not happy with what we tell you, you have 90 days from our final decision letter to ask for a MFH. If you choose a MFH before completing our grievance and appeal process, you cannot go back to our grievance and appeal process after the MFH.
You can ask for a hearing by contacting:

Department of Children and Families
The Office of Appeals Hearings
1317 Winewood Boulevard
Building 5, Room 255
Tallahassee, Florida, 32399-0700
Phone (850) 488-1429; Fax (850)487-0662; Appeal_Hearings@dcf.state.fl.us
http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings

You will receive a letter from the Office of Appeals Hearing. It will tell you when the MFH will take place. You can have someone speak for you at the hearing. If you want your doctor to speak for you at the hearing, you need to check with your doctor. In addition, you will need to inform the Hearing Officer.

CONTINUATION OF BENEFITS

You can ask us to continue your care during an appeal or hearing. If the final decision is in favor of CMS Plan and the denial of service stays, you may have to pay for the cost of the services. The enrollee may need to return the moneys for services paid while the appeal was pending if the services were continued only because of this request and decision is not in the enrollee's favor.

To continue your benefits, you must ask to continue benefits and:

- The appeal must involve the ending, suspension or reduction of a previously authorized service;
- The authorization must not have expired; and
- The services must be ordered by a CMS provider.

To continue the services during the appeal process, you must ask to continue benefits and:

- Send us a letter within 10 business days after the date of the denial letter; or
- Send us a letter within 10 business days after the effective date of the action.

If you request a MFH, you must ask to continue benefits and send the request with the Office of Appeal Hearings no later than 10 days after the date of the denial letter or before the first day the action will take place, whichever is later.

We will continue the services until one of the following happens:

1. You ask us to stop looking at your appeal.
2. After 10 business days from our action and you have not asked to continue services.
3. The decision from the hearing or appeal is in favor of CMS Plan.
4. The authorization ended or the authorized services are met.
5. The MFH office denies your appeal after the hearing is held.

SUBSCRIBER ASSISTANCE PROGRAM (SAP)

After completing the CMS's appeals process and you are still not happy with the decision, you can ask for a review by SAP. You must ask for the review within one year of our final decision letter. SAP will not accept a case that has been to a Medicaid fair hearing.

You can ask for a review by writing to:

The Agency for Health Care Administration
SubscriberAssistance Program
Building #3, MS #45
2727 Mahan Drive
Tallahassee, Florida 32308

You can also ask for a review by phone. Call toll-free 1-888-419-3456 or (850) 412-4502.

IMPORTANT PHONE NUMBERS

Children's Medical Services Managed Care Plan (CMS Plan)

Ped-I-Care works with CMS Plan in your area to help with your child's care	
CMS/Ped-I-Care Enrollee Services	1-866-376-2456
24/7 Nurse Help Line	1-844-514-3779
Medical, Dental, Vision, Behavioral Health	1-866-376-2456
State Compliance Hotline	1-855-843-1106
Children's Medical Services Local Area Offices	
Pensacola	1-800-381-3685
Panama City	1-800-299-4700
Tallahassee	1-800-226-2604
Gainesville	1-800-523-7545
Jacksonville	1-800-340-8354
Daytona Beach	1-866-827-5197
Ocala	1-888-326-7485
Orlando	1-800-226-6530
Tampa	1-813-396-9743
St. Petersburg	1-800-336-1612
Lakeland	1-863-413-3580
Melbourne	1-321-639-5888
MEDICAID Help Line	1-877-254-1055
Medicaid Local Area Offices	
Pensacola	1-800-303-2422
Jacksonville	1-800-273-5880
St. Petersburg	1-800-299-4844
Orlando	1-877-254-1055
Aging and Disability Resource Centers	**1-800-963-5337**
PSA 1	1-866-531-8011
PSA 2	1-800-96-ELDER
PSA 3	1-800-96-ELDER
PSA 4	1-888-242-4464
PSA 5	1-800-96-ELDER
PSA 6	1-800-96-ELDER
PSA 7	1-800-96-ELDER
OTHER IMPORTANT PHONE NUMBERS	
Choice Counselor: To change plan	1-877-711-3662
Department of Children & Families (Medicaid eligibility)	1-866-762-2237
Social Security Administration (Medicaid eligibility)	1-800-772-1213
Florida MPI Fraud & Abuse Hotline	1-888-419-3456
Abuse Hotline	1-800-962-2873
Subscriber Assistance Program	1-850-412-4502

Suggestions for CMS Plan, please email us at CMSPlan@flhealth.gov or use the email link on our website CMSPlan.floridahealth.gov

Living Will

Declaration made this _____ day of _____, 2 _____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____ (initial) I have a terminal condition,
or_____ (initial) I have an end-stage condition,
or_____ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do _____, I do not _____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.
In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.