Provider Manual
Section 2.0
Administrative Procedures

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2.0 Administrative Procedures

2.1 Enrollee Eligibility

Most individuals meeting the AHCA eligibility criteria for Medicaid are assigned to an MCO in the region. DCF determines Medicaid eligibility for:

- Parents, caretakers, or relatives of children
- Children
- Pregnant women
- Former foster care individuals
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving Supplemental Security Income (SSI)

Individuals may apply for assistance online at: http://www.myflorida.com/accessflorida/.

*If you have any questions regarding eligibility criteria, contact Provider Services at 844-243-5181.

2.2 Lighthouse Health Plan Assignment

AHCA assigns eligible beneficiaries to Lighthouse either as part of an automatic assignment process developed by AHCA, or after the beneficiary selects Lighthouse on their enrollment application.

Once assigned to Lighthouse, Lighthouse sends the enrollee a welcome kit that includes the following:

- Welcome letter
- Enrollee identification card
- Health Risk Assessment (HRA)
- Enrollee Handbook

2.3 Choosing a Primary Care Provider (PCP)

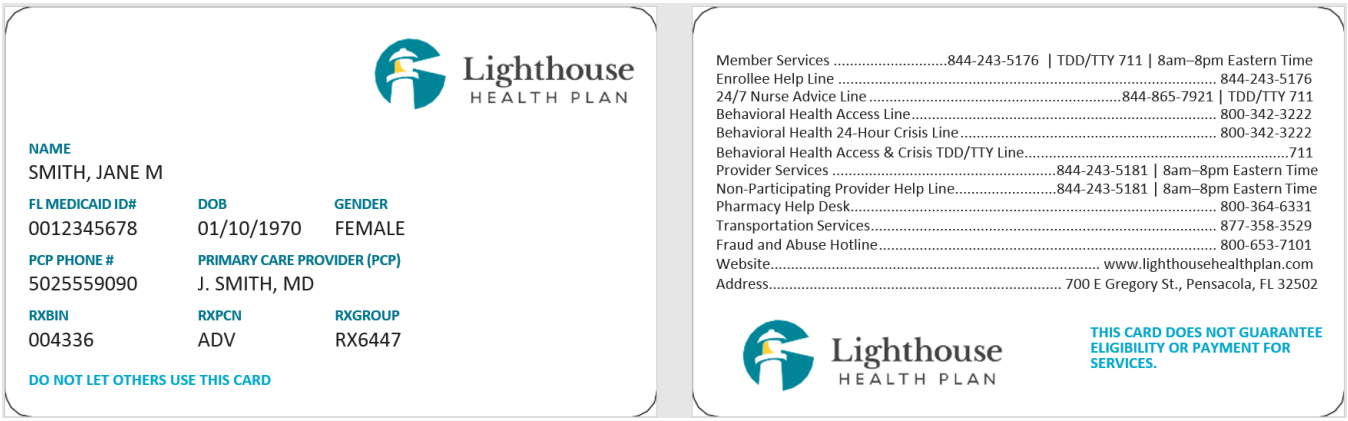
Making sure enrollees have a medical home is at the heart of Lighthouse's approach to managed care. The PCPs, in their role as the medical home, provide enrollees with primary and preventive care and arrange other medically necessary services for enrollees. Therefore, Lighthouse acts quickly to make sure that enrollees are linked to a medical home. Enrollees enrolled in Lighthouse must either choose a PCP or they will be assigned a PCP within Lighthouse's network.

2.3.1 Changing PCPs

Enrollees may change their PCP selection at any time by calling Lighthouse Member Services at 844-243-5176.

2.4 Identification Cards

Lighthouse issues an identification card for each enrollee. Enrollees are advised to keep their ID card with them at all times.



ID cards contain the following information:

- Enrollee's name and date of birth;
- PCP group name and telephone number;
- Florida Medicaid identification number (also serves as Lighthouse member ID number);
- Lighthouse contact information; and
- Claims filing address.

2.4.1 Enrollee Identification and Eligibility Verification

Lighthouse enrollee eligibility varies by month. Therefore, each participating provider is responsible for verifying enrollee eligibility with Lighthouse prior to each visit.
Providers may verify eligibility using the following methods:

Online – Log into www.lighthousehealthplan.com then select the Providers tab.

Telephone – Call Lighthouse's interactive voice response (IVR) system at 844-243-5181.

2.5 Health Education and Special Programs

Lighthouse may refer enrollees to health education classes that are provided by either health agencies/ providers or by Lighthouse. Providers who identify enrollees who could benefit from education for a specific condition (e.g. pregnancy, asthma, congestive heart failure, or diabetes) may call 844-243-5176 for class information and schedules. Enrollees also have access to health topics through an audio health library that includes pre-recorded messages on topics that provide information about preventing illness, identifying warning signs, and administering self-care. An enrollee may call the 24-Hour Nurse Advice Line to access the audio health library (see Section 2.6.3).

2.5.1 Healthy Behaviors Rewards Program

Healthy Behaviors Rewards Program is a program offered by Lighthouse in accordance with s.409.973(3), F.S., which encourages and rewards behaviors designed to improve the enrollee's overall health. Please direct our enrollees to the enrollee portion of our website for more information on Healthy Behaviors Rewards Program. This information can be found at www.lighthousehealthplan.com , select the Members tab then the Using Your Benefits drop down.

Enrollees with chronic conditions may need help addressing behaviors that negatively impact their conditions, such as obesity, smoking, or having a sedentary lifestyle. Health coaches educate enrollees about healthy diets, exercise, and smoking cessation, and coaches may also refer enrollees to support lines, community classes, and support groups such as:

- Local smoking cessation classes
- The state's Tobacco Free Florida website and Quit Coach support line
- Chronic Disease Self-Management Programs
- Local weight management and nutrition classes

If an enrollee needs additional help and encouragement with healthy behaviors, the coach may make a referral to the local care management team. The Community Health Worker contacts the enrollee either by phone or in-person to provide assistance. Examples of assistance include arranging participation in classes, accessing transportation, and helping coordinate care.

The health coach also helps enrollees access covered benefits that support self-management, such as smoking cessation products, medications, and equipment (nebulizers or inhalers, etc.). The coach works with the enrollee's PCP and, when prior authorization is required, UM staff.

2.5.2 Enrollee incentives

Lighthouse also actively encourages healthy behaviors and adherence to recommended care for its enrollees. In addition to Lighthouse's enrollee education efforts, enrollees can earn incentives when they engage in activities that not only improve their health, but also decrease the risk of PPEs.

Enrollees may earn $25 per qualifying activity up to a maximum of $50 a year that is distributed on a reloadable debit card. Qualifying activities are:

- Prenatal and postnatal visits (must attend all prenatal and postnatal visits with a provider)
- Well child visits (must attend all well child visits per Bright Futures/American Academy of Pediatrics, AAP, for age)
- Closing care gaps (must have all necessary care gaps closed based on age, gender, and race)
- Comprehensive diabetes care (must be compliant with appropriate care for diagnosis: eye exam, foot exam, and HbA1c)
- Medication compliance for people with asthma (if identified as asthmatic through care programming, must be compliant with medication regimen and provider visits)
- Compliance with psychotropic medication regimen (if identified through care programming, must be compliant with medication regimen and provider visits)
- Participation and graduation from specific care management program
- Dental visit and completed treatment plan
- Successful participation in a medically-approved smoking cessation
- Successful participation in a medically-directed weight loss program
- Successful participation in a medically-approved alcohol or substance abuse recovery program

2.6. Translator and Interpreter Services

2.6.1 Help for Those with Impaired Vision or Hearing or in Need of Interpreter Services

The Enrollee Handbook is available in alternative formats for enrollees with visual impairments. Additionally, for enrollees with hearing impairments who use a Telecommunications Device for the Deaf, Lighthouse's TDD/TTY number for Enrollee Services is 711. Providers must coordinate interpreter services for Lighthouse enrollees as needed. Members may contact interpreter services directly by calling 1-855-854-8691, Code L221. Providers may also contact Lighthouse Member Services directly at 1-844-243-5176 for assistance with interpretation services.

2.6.2 24-Hour Nurse Advice Line and Audio Health Library

PCPs can encourage enrollees to talk with a nurse 24 hours a day, 7 days a week by calling the 24-Hour Nurse Advice Line at 844-865-7921| TDD/TTY 711. Through the same number, Lighthouse enrollees may access an audio health library of over 35 categories of health care topics, including:

Allergies and Immune System	Medicines
Blood and Cancer	Mental and Behavioral Health
Bones, Muscles, and Joints	Men's Health
Brain and Nervous System	Pain Management
Cancer	Physical and Sports Medicine
Heart and Blood Vessels	Pregnancy
Children	Preventive Health
Mouth and Teeth	Respiratory and Lung Problems
Diabetes	Sexual and Reproductive Health
Diet and Exercise	Skin
Digestive System	Sleep Disorders
Ear, Nose, and Throat	Social and Family
Eyes	Surgery
General Health	Tests and Diagnostic Procedures
Hormones	Urinary Problems
Infectious Disease	Women's Health
Injuries	

Additionally, for enrollees with hearing impairments who use a Telecommunications Device for the Deaf, the TDD/TTY number for the Nurse Advice Line is 711.

2.7 Credentialing/Re-Credentialing Process

2.7.1 Initial Application Process

To join the Lighthouse network, an application and credentialing process must take place.

This can be initiated by calling our Provider Services department at 844-243-5181. Lighthouse will send you a provider application packet and work with you to become credentialed, and, if approved, contracted Lighthouse network provider. Providers can also fill out a Provider Enrollment Request form online at www.lighthousehealthplan.com.

Lighthouse participates with CAQH. Providers who are participating with this common credentialing application database should include their CAQH provider ID number with documents submitted to Lighthouse.

The policies and procedures regarding selection and retention do not discriminate against providers who service high-risk populations who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.

2.7.1.1 Providers

New providers must include, at a minimum, the following information:

- A letter requesting that provider be added to the contract
- Completed Provider Application or a CAQH number should be provided
- A current and valid license to practice
- Valid DEA and CDS certification(s), if applicable
- Education and training
- Board certification status, if applicable
- Work history, minimum of 5 years
- A history of professional liability claims that resulted in settlement or judgment paid on behalf of the provider
- State sanctions, restrictions on licensure, or limitations on scope of practice
- Medicare and Medicaid sanctions
- Reasons for inability to perform the essential functions of the position
- Documentation identifying a lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary actions
- Current malpractice insurance coverage
- Current and signed attestation confirming the correctness and completeness of the application. Information collected on the application must be no more than six (6) months old on the date the provider is approved by the plan. If using CAQH, the attestation must be no more than ninety (90) days old upon submission of the request for credentialing

Lighthouse will verify that a level II background check was performed, pursuant to s. 409.907, F.S., to validate the eligibility of Lighthouse Medicaid treating providers not currently enrolled in the fee-for-service program. Per Section 435.04(1)(a), F.S., level 2 screening standards include, but need not be limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement, and

national criminal history records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.

Site visits are performed for all primary care providers, OB/GYNs, and un-accredited ancillary facilities. The site visit will evaluate appearance, accessibility, record keeping, and safety procedures. A satisfactory score of >80% must be obtained prior to finalizing the credentialing process.

Once the application is completed, the Lighthouse Credentialing Committee will render a final decision on the provider's acceptance/denial. Providers will be notified of the decision within 60 days from the date of the committee meeting.

Providers must be credentialed prior to accepting or treating enrollees. PCPs cannot accept enrollee assignments until they are fully credentialed.

2.7.2 Providing Services Prior to Becoming a Credentialed Lighthouse Provider

If a provider determines an enrollee must be seen prior to the assignment of a Provider ID number and notification of the receipt of a completed and signed application by Lighthouse, the provider must obtain an authorization from Lighthouse's UM department in order to receive payment for services. Please note that an authorization for service does not guarantee payment.

2.7.3 Re-credentialing Process

All providers who require credentialing will be re-credentialed at least every 36 months. Providers may be re-credentialed earlier than 36 months if other quality or service data has identified the need for an earlier review.

2.7.4 Credentialing Committee

Lighthouse's Credentialing Committee is composed of participating providers in the network and chaired by the Health Plan's CMO or designated **Medical Director (MD)**. The Committee reviews each applicant and votes on acceptance for participation, denial for participation, requesting additional information, creation of a provider corrective action plan, and/or a modifying a provider's participation status (e.g. a re-credentialing date of less than three years). The Committee does not base its decision on a provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or types of patients. The Committee may request additional information from a provider if there are areas in which further clarification is needed prior to making a decision. Providers being reviewed where additional information is needed are considered non-participating until a final decision is reached by the Committee. The Health Plan's CMO or designated MD may implement immediate administrative restrictions for any provider that the CMO or MD believes could harm the health and safety of enrollees.

2.7.5 Provider Rights

Providers have the right to review information obtained from outside sources (e.g. malpractice insurance carriers, state licensing boards, etc.) and to correct erroneous outside source information that was used to support the provider's credentialing application. Upon request, during the credentialing or re-credentialing process, providers also have the right to be informed of the status of their application.

To request information obtained by outside sources, or to correct erroneous information, contact Lighthouse Credentialing Department at 844-243-5181. When requesting a correction of erroneous information, contact Lighthouse Credentialing Department *within 7 business days* of receipt of the requested outside source information that was used to support your credentialing application.

Should Lighthouse decide to deny or terminate a provider from participation with Lighthouse, the provider will receive notification of the decision. The notification will include the reasons for the denial or termination, the provider's rights to appeal and to request a hearing within 30 days of the date of the denial notice, and a summary of the provider's hearing rights.

2.8 Provider Terminations/Changes in Provider Information

2.8.1 Provider Terminations

A provider desiring to terminate his/her participation with Lighthouse must refer to their Lighthouse contract for specific information about terminating.

2.8.2 Changes in Provider and Demographic Information

Providers are required to provide prior written notice to Lighthouse's Provider Relations department of any changes in information regarding their practice. Such changes include:

- Physical Address changes, including satellite offices
- 1099 mailing address
- Group name or affiliation
- Billing address
- Telephone and fax number

Tax Identification Number (new W-9 required)

2.8.3 Panel Closings/Opening

Lighthouse recognizes that PCPs may occasionally need to limit the number of patients in their practices in order to deliver quality care. To request a panel be closed, PCPs must:

- Provider a 60-day advance written notice to Provider Relations
- Maintain the panel of Lighthouse enrollees who were assigned to the PCP before closing of the panel

If a PCP wishes to re-open his/her panel, a written notice must be sent to Provider Relations with a specific effective date.

2.8.4 Enrollee Dismissals from PCP Practices

PCPs have the right to request an enrollee's disenrollment from their practice and request the enrollee be reassigned to a new PCP for the following circumstances:

- Incompatibility of the PCP/patient relationship;
- Enrollee has not utilized a service within one year of enrollment in the PCPs practice, and the PCP has documented unsuccessful contact attempts by mail and by phone on at least six (6) separate occasions during the year; or
- Inability to meet the medical needs of the enrollee.

PCPs do not have the right to request an enrollee's disenrollment from their practice in the following situations:

- A change in the enrollee's health status or need for treatment;
- The enrollee's utilization of medical services;
- An enrollee's diminished mental capacity; or
- An enrollee's disruptive behavior that results from the enrollee's special health care needs unless the behavior impairs the PCP's ability to provide services to the enrollee or others.

Disenrollment requests shall not be based on the grounds of race, color, national origin, handicap, age, or gender.

Disenrollment requests must be submitted to Lighthouse and sent via fax to Provider Enrollment at 844-243-5181. Requests must include provider name, provider group ID number, enrollee name, enrollee ID number, reason for disenrollment request, and effective date. Enrollees are disenrolled from the PCP's practice once all required information is received. Questions regarding this process may be directed to Provider Services at 844-243-5181 or your Provider Relations Representative.

Disenrollment requests meeting Lighthouse's requirements as stated above are reviewed, determined to be appropriate, and processed within five (5) business days of receipt by Provider Services. The disenrollment effective date must be at least thirty (30) days from the request date to allow for the enrollee's transition to a new PCP unless extenuating circumstances necessitate an immediate effective date.

The initial PCP must continue to serve the enrollee until the new PCP assignment becomes effective, barring ethical or legal issues. The enrollee has the right to appeal such a transfer via Lighthouse's formal appeal process.

If a PCP's request does not meet the above stated requirements, the appropriate Provider Relations Representative will contact the PCP directly to discuss why.

Please note this process does not apply to "age-out" disenrollment for pediatric practices.

2.9 Provider Complaints & Disputes

Providers have the right to file a dispute regarding the Managed Care Plan's policies, procedures, or any aspect of a Managed Care Plan's administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

Providers do not have appeal rights through the enrollee plan appeals process.

2.9.1 How do Providers File a Complaint?

1. Non-Claim issues, Lighthouse shall:

    a) Allow providers forty-five (45) days from the date the non-claim issue occurred to file a written Complaint.
    b) Within three (3) business days of receipt of a Complaint, notify the provider (verbally or in writing) that the Complaint has been received and the expected date of resolution;
    c) Document why a complaint is unresolved within fifteen (15) days of receipt and provide written notice of the status to the provider;
    d) Provide written notice of the status to the provider every fifteen (15) days thereafter; and
    e) Resolve all Complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution. Lighthouse shall maintain a complete and accurate record of all Complaints and shall make such records available upon request of the Agency.

2. Claim issues, in accordance with 641.3155 Florida Statutes, Lighthouse shall:

    a) Allow providers ninety days (90) from the date of the final determination of the primary payer to file a written Complaint for claims issues;
    b) Within three (3) business days of receipt of a claim Complaint, notify the provider (verbally or in writing) that the Complaint has been received and the expected date of resolution;
    c) Within fifteen (15) days of receipt of a claim Complaint, provide written notice of the status of the Complaint to the Agency and to the provider. For claims issues that require additional time to research, Lighthouse must submit a written request to the Agency within three (3) business days of receipt of the Complaint that includes:
        i. An explanation for the need of an extension; and
        ii. The expected time needed beyond the fifteen (15) days for research and response.
        iii. Approval is contingent upon Agency review.

e) d) Lighthouse must provide written notice of the status to the provider every fifteen (15) days thereafter; and in accordance with 641.3155, F.S., resolve all claims Complaints within sixty

(60) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

Providers must return any overpayment to Lighthouse at the address set forth in this Manual within sixty (60) days after the date on which the overpayment was identified, as well as notify Lighthouse in writing of the reason for the overpayment. (42 CFR 438.608 (d)(2)).

Submit Provider Complaints to:

Type of Appeal	Timing of Appeal	Address
Claims Payment Issues	Must be submitted within ninety (90) calendar days of last process date of claim.	Lighthouse Health Plan PO BOX 211156 Eagan, MN 55121
Non-Claims Issues	Must be submitted within forty-five (45) calendar days of last process date of claim.	Lighthouse Health Plan PO BOX 211156 Eagan, MN 55121
Contractual Issues	Must be submitted within ninety (90) calendar days of the occurrence of the contractual issue being appealed.	Lighthouse Health Plan PO BOX 211156 Eagan, MN 55121
Credentialing Denial or Credentialing or Quality Network Termination	Must be submitted within thirty (30) calendar days of the adverse benefit determination. Provider may request a hearing.	Lighthouse Health Plan PO BOX 211156 Eagan, MN 55121
Overpayment Recovery and Recoupment	Must be submitted within 60 calendar days from postmark date or electronic delivery date of written notice of overpayment recovery request.	Lighthouse Health Plan PO BOX 211156 Eagan, MN 55121

Appeals submitted after the times listed above will be denied for untimely filing.

At no time will punitive or retaliatory action be taken against a provider for filing a Complaint or for supporting an enrollee appeal.

2.10 Enrollees' Rights

Enrollees are informed of their rights and responsibilities through the Enrollee Handbook. Lighthouse providers are also expected to respect and honor enrollees' rights.

The rights of our enrollees include, without limitation, the right to:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy;
- Receive a prompt and reasonable response to questions and requests;
- Know who is providing medical services and who is responsible for his or her care;
- Know what patient support services are available, including an interpreter if the patient does not speak English;
- Know what rules and regulations apply to his or her conduct;
- Be given, by the health care provider, information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis;
- To participate in the decision-making process about their health care;
- Discuss medically necessary treatment options regardless of cost or insurance coverage;
- Refuse any treatment, except as otherwise provided by law;
- Be given full information and necessary counseling on the availability of known financial resources for care;
- Receive, prior to treatment, a reasonable estimate of charges for medical care;
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained;
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment;
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment;
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research;
- Express complaints or file an appeal regarding the care received or the health plan services;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- Request a second medical opinion;
- Request and receive a copy of his or her medical records, and request that they be amended or corrected;
- Knowledge that medical information is confidential, secured and shared on when required by law or with the patient's informed consent; and

- Receive information about and make recommendations about Lighthouse Health Plan, its services, providers and Enrollee Rights and Responsibilities policy.

The responsibilities of Lighthouse enrollees include the responsibility to:

- Give Lighthouse Health Plan and health care providers accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health;
- Report unexpected changes in his or her condition to the health care provider;
- Participate in developing a mutually agreed upon treatment goals, to the degree possible;
- Listen to provider(s), follow instructions and ask questions;
- Report to the health care provider whether he or she understands a planned course of action and what is expected of him or her;
- Keep appointments and, when unable to do so, notify the health care provider or facility;
- Mutually agree and follow the treatment plan recommended by the health care provider;
- Be responsible for his or her actions if treatment is refused or if the patient does not follow the health care provider's instructions;
- Ensure financial responsibilities are carried out;
- Treat health care staff with respect;
- Follow health care facility conduct rules and regulations;
- Use the emergency room only for life-threatening/life-altering emergencies;
- Inform care manager with any change in demographics (i.e., address, phone number, etc.); and
- Report fraud, waste and abuse.

2.11 Enrollee Grievances and Appeals

2.11.1 What is Appealable?

Enrollees have the right to appeal any Lighthouse decision involving an adverse benefit determination. An adverse benefit determination as defined by federal and state law:

2.11.1.1 Adverse Benefit Determination

The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; the failure of the Managed Care Plan to act within ninety (90) days from the date the Managed Care Plan receives a grievance, or thirty (30) days from the date the Managed Care Plan receives an appeal; for a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network; and the denial of an enrollee's request to dispute a financial liability.

2.11.1.2 No Retaliation for Filing an Appeal

At no time will punitive or retaliatory action be taken against an enrollee for filing an appeal or a provider for supporting an enrollee appeal.

2.11.2 How Does an Enrollee File an Appeal?

All requests must be submitted within sixty (60) calendar days from the date on the ***Notice of Adverse Benefit Determinations (NABD)***.

If the enrollee's request for appeal is submitted after sixty (60) calendar days from the date on the NABD, then good cause must be shown in order for Lighthouse to accept the late request. Examples of good cause may include:

- The enrollee was seriously ill and was prevented from receiving a timely appeal;
- There was a death or serious illness in the enrollee's immediate family; or
- Pertinent records were destroyed or damaged by fire or other accidental cause.

2.11.2.1 Method of Appeal

Enrollee appeals can be either oral or in writing.

For oral filings, the time frames for resolution begin on the date the oral or *verbal* filing was received by Lighthouse.

2.11.2.2 Authorized Representative

An individual who has the legal authority and written consent to make decisions on behalf of an enrollee or potential enrollee in matters related to the Managed Care Plan.

A provider shall not be an authorized representative without the enrollee's written consent for the specific adverse benefit determination that is being appealed or that is the subject of a state fair hearing. The written consent shall be signed and dated by the enrollee no earlier than the date of the adverse benefit determination taken by Lighthouse.

2.11.2.3 Help for Enrollee's with Filing an Appeal

Enrollees may request assistance with the appeal process including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability. To obtain this assistance, enrollees shall contact the Appeal Department Enrollee at 844-243-5176.

2.11.2.4 Acknowledgement of Receipt of the Appeal

Within five (5) working days of receiving an appeal, Lighthouse will send the enrollee a written notice that the appeal has been received and the expected date of resolution.

Continuance of Services during an Appeal

An enrollee may request continuation of medical services during the appeals process. To do this:

- The enrollee must file their appeal with us within ten (10) calendar days of the Notice of Adverse Benefit Determinations (NABD) or within ten (10) days after the date the service will be reduced, suspended or stopped, whichever is later;
- The appeal involves an action taken to reduce, suspend, or stop a service already approved;
- The service must have been ordered by an authorized Provider; and
- The original time period covered by the approval has not yet ended.

2.11.2.5 Expedited Appeals

An expedited review process is available for an enrollee when the standard resolution time frame could place the enrollee at risk or seriously compromise the enrollee's health or well-being, or seriously jeopardize the enrollee's life, physical or mental health; or jeopardize an enrollee's ability to attain, maintain, or regain maximum function. Expedited appeals are resolved within seventy-two (72) hours of receipt of the request. If Lighthouse denies a request for an enrollee request for an expedited appeal, the appeal will be resolved within thirty (30) calendar days of receipt of the original request for appeal. Lighthouse will give the enrollee prompt oral notice of the decision to deny expedition of the appeal. Lighthouse will follow up with a written notice within two (2) calendar days of the denial.

2.11.2.6 Conduct of the Review

The review will be conducted by an individual who was not involved in the initial decision. Appeals that involve denials for lack of medical necessity, the denial of expedited resolution of the appeal, or clinical issues will be conducted by health care professionals who have the appropriate clinical expertise concerning the condition or the disease under appeal.

Enrollees shall be given an opportunity to present evidence, testimony, and allegations of fact or law, in person as well as in writing, and will take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

2.11.2.7 Resolution of the Standard Appeal

All enrollee appeals are resolved within thirty (30) calendar days of receipt of the appeal, unless the time period is extended by fourteen (14) calendar days upon request of the enrollee or a request made by Lighthouse. If Lighthouse requests the extension, Lighthouse will provide the enrollee with oral notice of the reason for the delay by end of business on the day of the determination and with written notice of the reason for the

delay within two (2) calendar days. Enrollee's will receive a written notice of the resolution of the appeal. The notice will include the right to request a Subscriber Assistance Review or a State Fair Hearing.

2.11.2.8 Enrollee Requests for a State Fair Hearing

If an enrollee is not satisfied with the appeal resolution, the enrollee has the right to request a State Fair Hearing. The enrollee must exhaust the Lighthouse internal appeal process prior to requesting a State Fair Hearing. Requests for a State Fair Hearing must be made in writing - postmarked or filed - with AHCA within one hundred twenty (120) days of the notice of the appeal decision. Requests for a State Hearing should be forwarded to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906
(877) 254-1055 *(toll-free)*
239-338-2642 *(fax)*
MedicaidHearingUnit@ahca.myflorida.com

2.11.2.9 What is a Complaint or Grievance?

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

Enrollee Grievance — An expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care; the quality of services provided; aspects of interpersonal relationships, such as rudeness of a provider or of a Managed Care Plan employee; failure to respect an enrollee's rights; or an enrollee dispute of an extension of time proposed by the Managed Care Plan to make an authorization decision.

2.11.2.10 No Retaliation for Filing a Complaint or Grievance

At no time will punitive or retaliatory action be taken against an enrollee for filing a grievance or a provider for supporting an enrollee grievance.

2.11.2.11 How do Enrollee's file a Complaint or Grievance?

Lighthouse shall resolve complaints by close of business on the business day following receipt of a complaint. If a complaint is not resolved within one business day following receipt, Lighthouse shall enter the complaint as a grievance.

Grievances are investigated, resolved, and closed within ninety (90) calendar days of receipt.

2.11.2.12 Method of Filing of Grievance:

Grievances can be submitted either orally or in writing.

Submit Enrollee Grievances to:

Lighthouse Health Plan
PO BOX 211156
Egan, MN 55121

Grievance staff are available at 844-824-8675 Monday through Friday from 8am – 8pm EST/ 7am-7pm CST.

2.11.2.13 Acknowledgement of Receipt of the Grievance:

Within five (5) working days of receipt of a grievance, Lighthouse will provide the enrollee with a written notice that the grievance has been received and the expected date of resolution.

2.11.2.14 Resolution of the Grievance

All enrollee grievances are resolved within ninety (90) calendar days of the date the grievance was received. Enrollees will receive a resolution letter that includes the information considered in investigating the grievance, the findings, and the conclusions based on the investigation and the disposition of the grievance.

Resolution may be extended by up to fourteen (14) calendar days if the enrollee requests the extension, or if we determine there is a need for additional information and the extension is in the enrollee's interest. For any extension not requested by the enrollee, Lighthouse will provide oral notification of the reason for the extension and mail the written notice within two (2) calendar days of the decision to extend the timeframe.

2.11.2.15 Enrollee Co-Payment Provision

If co-payments are waived as an expanded benefit, the Provider must not charge enrollees co-payments for Covered Services; and if co-payments are not waived as an expanded benefit, the amount paid to Providers will be the contracted amount, less any applicable co-payments. Late fees for Medicaid Intuitional Care Programs (ICPs), Hospice, and Assisted Living Facilities (ALFs) shall be charged to Lighthouse enrollees.