

Johns Hopkins US Family Health Plan USFHP



Provider Manual 2010





The Johns Hopkins US Family Health Plan
Provider Manual is a guide to our plan.

The manual includes an overview of the plan with specific
information on:

Primary Care Provider and Specialist Responsibilities
Services and Benefit Information
Claims payments and reimbursements
Care Management Services
Referral Guidelines
Compliance Regulations

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SECTION I

Overview

JOHNS HOPKINS US FAMILY HEALTH PLAN

The Johns Hopkins US Family Health Plan (USFHP) is a managed care program sponsored by the Department of Defense (DoD) as a designated provider of TRICARE Prime. The Plan offers comprehensive TRICARE Prime health care benefits to members of the uniformed services and is modeled after a health maintenance program similar to an “HMO.”

With this model, members select a primary care provider (PCP) as their medical provider. The PCP works with the member to oversee their entire health care. Johns Hopkins USFHP is the only TRICARE Prime option that gives members access to Johns Hopkins primary care physicians, specialists, and facilities in addition to a contracted network of community providers.

TRICARE Prime is a managed care option for active duty family members (ADFM) and retired service members. TRICARE Prime members are assigned a primary care physician (PCP) who provides and coordinates care, maintains, patient health records and refers members to specialists, if necessary. Specialty care must be arranged and approved by Johns Hopkins USFHP to be covered under TRICARE Prime.

ADFM are not responsible for any co-payments. ADFM enrolled in Johns Hopkins USFHP do not have co-payments except for pharmacy co-payments, or when enrolled in Extended Health Care Option (ECHO). Retirees and their families without Medicare B coverage enrolled in TRICARE Prime are responsible for co-payments when seeking care from a network provider.

Johns Hopkins USFHP currently has numerous sites throughout the Maryland and southern Pennsylvania area, and offers benefits to active duty family members and military retirees and their family members.

Johns Hopkins supports the mission of USFHP by:

- Providing quality health care for uniformed service members;
- Having well cared for and extremely satisfied members;
- Demonstrating quality, value, and operational effectiveness to a growing member population; and
- Continuing as a permanent and respected health care partner in the Military Health System.

Primary care management coupled with strong case and disease management programs ensure that the Plan provides best value health care services in support

of the Military Health System. Because of our focus on comprehensive health care management, Johns Hopkins USFHP does not offer the point-of-service option available under other TRICARE Prime programs.

Johns Hopkins USFHP has provided health care services to members of all ages, including Medicare-eligible members, since 1993. Today, we continue our long-standing history of service and commitment to caring for members of all ages.

The Johns Hopkins USFHP TRICARE Prime offers the following:

- No enrollment fee for active duty family members
 - Nominal co-pays per office visit (retirees/family members)
 - No co-pay per office visit (active duty family members or retirees w/Medicare)
 - Guaranteed appointments (access standards)
 - PCP supervises and coordinates care
 - Away from home emergency coverage
- **Johns Hopkins USFHP Plan**
The Johns Hopkins US Family Health Plan is a “Designated Provider” of the TRICARE Prime benefit and a permanent part of the Military Health System. The US Family Health Plan offers the same uniform benefit and cost structure under TRICARE Prime as the Managed Care Support Contractors, and additional enhanced benefits offered only to our members. The Johns Hopkins Medicine excellence-in-care sets the US Family Health Plan apart from other plans.
 - **TRICARE Prime**
TRICARE Prime, the DoD sponsored military managed health care program, provides enhanced primary and preventive services with nominal cost sharing to military members and their families. The program was implemented in this region in 1998 to expand access to health care and control costs. Under TRICARE Prime, members are required to select a Primary Care Provider (PCP) who is responsible for coordinating all their health care, including specialty referrals. Members who enroll with TRICARE Prime may choose one of three networks:
 - Military Treatment Facilities (MTFs),
 - Managed Care Support Contractor (MCSC) provider network, or
 - US Family Health Plan/ TRICARE Prime network (e.g., Johns Hopkins).

SECTION II

Provider Information

PRIMARY CARE PROVIDERS (PCP)

A Primary Care Provider (PCP) is a physician or nurse practitioner who manages the primary and preventive care of a Johns Hopkins USFHP member and acts as a coordinator for specialty referrals and inpatient care.

Role and General Responsibilities

Primary care includes comprehensive health care, support services and encompasses care for acute illness, minor accidents, follow-up care for ongoing medical problems, and enhanced preventive health care. The PCP either provides the care directly or refers the member to the appropriate service or specialist when treatments are outside the scope of the PCP's practice. The PCP's office is responsible for identifying sources of specialty care, making referrals and coordinating that care.

Medical Record Documentation

Providers must maintain a member medical record that accurately reflects the preventive, routine, and specialty care provided. All records pertaining to a member's care must be in one central medical record. The member's name must be on each page of notes, lab results, and consults, and the provider must initial and date each test or lab result indicating it has been reviewed.

The DoD may request to review a member's medical record. If the member has signed a consent form to medical information, the PCP must submit copies of the entire medical record or portions thereof as specified on the release form.

Confidentiality

Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information according to the terms of the Participating Provider Agreement and Payor Addendum.

SPECIALTY PROVIDERS

A specialty provider is a medical practitioner who specializes in a branch of medicine or surgery, such as cardiology or neurosurgery. When outside the scope of the PCP's practice, the PCP refers the member to the appropriate service or specialist.

Responsibilities of the Specialty Provider include:

- Provision of specialty services upon referral by the Primary Care Physician.
- Recommending appropriate treatment plans and providing written reports to the referring PCP to ensure continuity of care.

Treatment Report from the Specialist to PCP

The PCP should receive an initial report of services and treatment which may be oral as long as a written report is provided to the PCP within 10 calendar days from the date of service or sooner if the member's condition warrants a shorter time frame.

PROVIDER SERVICES (Customer Service)

Representatives from the Customer Service Department respond to and document all member and provider telephone calls, written comments and requests. Complaints are forwarded to the complaints and grievance department. Acting as the member's advocate, representatives investigate informal member complaints. If the member is dissatisfied with the result of the investigation and feels a need to file a formal complaint or grievance, the department will provide information about how to proceed with a written appeal.

PROVIDER RELATIONS

The Provider Relations Department is a collective team of professionals who are liaisons between Johns Hopkins HealthCare and our participating provider network. The network is divided into geographic territories and specialty areas, and each is assigned a Network Manager and Coordinator.

The Provider Relations team is responsible for network development, maintenance and education. Network development includes soliciting new providers in service areas and specialty areas to accommodate the needs of our growing membership.

The department is also responsible for network maintenance including updates and changes to provider information, account set-up, and fee schedules.

Provider education is an essential responsibility of the department. Your Network Manager, upon request, will train you and your office staff regarding the Plan's program and its benefits.

Provider Communication

Support information such as updated policies, procedures, guidelines, or resources can be accessed through the provider manual, provider newsletter, the website or through a variety of mailings. Communication opportunities include:

- The Johns Hopkins USFHP Provider Manual is a guide to our plan. The manual includes an overview of the plan as well as information on PCP and specialist responsibilities, service and benefit information, claims payment and reimbursement, Care Management services and referral guidelines.
- "Hopkins Across the Board" is a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories and news pertaining to our three lines of business, including Johns Hopkins USFHP.
- Johns Hopkins USFHP providers may utilize the website to find useful and updated information such as the annual provider manual, policies, forms, guidelines, announcements, and a host of other information specifically developed for the Johns Hopkins USFHP network community at: www.hopkinsmedicine.org/usfhp

Changes in Provider or Site Status

Additions, deletions, or other changes to the provider's office information must be communicated in writing to the territory Network Manager or Coordinator as soon as possible via mail or fax.

Johns Hopkins HealthCare
6704 Curtis Court
Glen Burnie, MD 21060
Attn: Provider Relations Department
Fax: 410-424-4604

The JHHC provider agreement requires all providers to give at least 90 days advance notice of contract termination. JHHC notifies members affected by the termination of a primary PCP or practice group at least thirty (30) calendar days prior to the effective termination date or within thirty (30) calendar days of notification from the provider, and assists them in selecting a new provider.

In some cases members may be able to continue care with a terminated provider for a short period of time after the provider leaves the network. If this situation applies, JHHC will discuss this with you at the time of your termination.

More information about your obligations upon contract termination is located in your provider agreement. A summary is not only listed in this manual, but can be referenced on the website as well. If you have additional questions, please contact Provider Relations at 410-762-5385 or 888-895-4998.

National Disaster Medical System (NDMS)

The Johns Hopkins US Family Health Plan is encouraging all acute-care medical/surgical hospitals in our provider network to become members of the National Disaster Medical System (NDMS). Contracted providers who are eligible for NDMS participation are encouraged to become part of this disaster recovery initiative. The Johns Hopkins US Family Health Plan will provide program information to all eligible providers and include reminders periodically through our provider newsletter and on our website.

The NDMS is a federally coordinated system that augments the nation's medical response capability. The NDMS supplements an integrated national medical response capability of assisting State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts.

The National Response Framework utilizes the NDMS as part of the Department of Health and Human Services, Office of Preparedness and Response, under Emergency Support Function #8 (ESF #8), Health and Medical Services, to support federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters including:

- natural disasters
- major transportation accidents
- technological disasters
- acts of terrorism including weapons of mass destruction events

For more information, please review the NDMS Recruitment link at:

www.hhs.gov/aspr/opeo/ndms/index.html

Provider Notification to JHHC

The provider or organization must notify JHHC in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- Provider's license to practice in any state is suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to JHHC immediately
- Provider learns that he/she or the organization has become a defendant in any malpractice action relating to a member who also names JHHC as a defendant, or receives any pleading, notice or demand of claim or service of process relating to such a suit, or is required to pay damages in any such action by way of judgment or settlement
- Provider is disciplined by a state licensing board or a similar agency;
- Provider is sanctioned by or debarred from participation with Medicare/Medicaid; notification of any such action must be furnished in writing to JHHC immediately
- Provider is convicted of a felony relating directly or indirectly to the practice of medicine; notification of any such action must be furnished in writing to JHHC immediately
- Change in provider's business address or telephone number
- Provider becomes incapacitated such that the incapacity may interfere with patient care for 21 consecutive days; notification of any such action must be furnished in writing to JHHC immediately
- Any change in the nature or extent of services rendered by the provider
- Provider's professional liability insurance coverage is reduced or canceled
- Any other act, event, occurrence or the like which materially affects provider's ability to carry out provider's duties under the agreement.

The occurrence of one or more of the events listed above may result in the termination of the Provider Participation Agreement for cause or other remedial action, as JHHC in its sole discretion deems appropriate.

Termination of Participation

Provider Agreements may be terminated by JHHC, effective immediately "For Cause." Examples of "for cause" may be defined as but not limited to:

- Fraud
- Patient abuse
- Incompetence
- Loss of licensure
- Loss of participation status in State or Federal Payor Programs (Medicare, Medicaid).

Contractual Terminations

Either the provider or JHHC may terminate the Provider Agreement with written notice to the non-terminating party at least 90 days prior to the termination date. The provider will continue to provide, or arrange for services for members prior to the effective date of termination and following termination for any member whose medical condition requires a continuing course of treatment where alternative arrangements have not been made.

Right to Appeal Termination

No appeal rights are available if there is a:

- Revocation of license
- Conviction of fraud
- Initial credentialing is denied

Providers who are eligible for appeal must submit their request in writing within 30 calendar days of their original termination. The Chief Medical Director will convene an appeal panel comprised of three qualified practitioners. At least one practitioner is a clinical peer of the appealing provider who is not otherwise involved in JHHC network management operations activities. For the purpose of this requirement, a clinical peer is a provider with the same type of license.

The panel shall not include any individual who is in direct economic competition with the affected provider or who is professionally associated with or related to the provider or who otherwise might directly benefit from the outcome.

Knowledge of the matter shall not preclude any individual from serving as a member of the panel; however, involvement with any earlier decision concerning the initial determination or corrective action will require the individual to remove him/herself from the panel.

Within ten (10) calendar days of either a first or second level panel review, and after reviewing any written statements submitted by the provider and any other relevant information, the panel will render a decision. The Chief Medical Director or designee will notify the affected provider in writing within five (5) calendar days of the panel's decision. This notice will be sent either by certified mail return receipt requested or FedEx.

If the provider requests a second review, the provider is subject to the following:

- There is no right to personal appearance before the panel;
- The burden of proof remains with provider to explain their actions or lack of actions;
- The provider may submit a written statement for the panel's consideration;
- The provider may submit the written statements of others for the panel's consideration;
- The provider may submit other documents relevant to the determination; and

A determination by the Second Level Review Panel is final with no further appeal rights.

CREDENTIALING

The Johns Hopkins HealthCare (JHHC) Credentialing Program is dedicated to the careful selection and credentialing of practitioners for inclusion in the Johns Hopkins USFHP provider network. JHHC credentialing criteria defines the licensure, education, and training criteria practitioners must meet to be considered for inclusion into the participating network.

Prior to becoming JHHC network participants, all providers must successfully complete the credentialing process. Providers are requested to submit information, subject to verification by JHHC, to support and provide evidence of appropriate education, training, clinical experience, licensure, professional liability insurance, clinical associations, and professional history. JHHC verifies the submitted information and obtains additional information from the National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), Office of Inspector General (OIG), General Services Administration (GSA), state licensing boards, medical specialty boards, professional certification boards, and HireRight (USIS) to compile a complete and full credentialing file.

The provider's credentialing file is reviewed by the Special Credentials Review Committee (SCRC), a committee of the Board of Directors of JHHC. It is the responsibility of the SCRC to approve the participation status of all applicants. Notification is sent to the provider at the conclusion of the SCRC activity informing the provider of the outcome of the SCRC decision.

JHHC does not discriminate on the basis of race, ethnicity, national origin, gender, age, sexual orientation or type of procedure or patient in which the provider specializes. The credentialing process and decision-making are monitored to ensure non-discriminatory practices are followed.

CREDENTIALING REQUIREMENTS

All providers and facility/hospitals that are required to be credentialed must remain in full compliance with JHHC credentialing criteria as set forth in the JHHC credentialing policies and procedures, and with all applicable Federal, state and local laws and regulations. Each provider or facility/hospital must complete an appropriate application as an applicant for initial participation and minimally every three years thereafter (recredentialing event) for as long as the provider or facility/hospital remains an active participant in the Johns Hopkins USFHP provider network.

TYPES OF PROVIDERS REQUIRING CREDENTIALING

The following types of providers must be credentialed by JHHC prior to participating in the Johns Hopkins USFHP provider network:

- Primary Care Physicians (medical and osteopathic)
- Specialty Physicians (medical and osteopathic)
- Podiatrists
- Certified Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Chiropractors
- Physical Therapists
- Audiologists
- Speech Therapists
- Occupational Therapists
- Clinical Psychologists (doctoral)
- Clinical Social Workers
- Professional Counselors
- Marriage and Family Therapists
- Optometrists
- Organizations including Hospitals, Home Health Agencies, Skilled Nursing Facilities, and Free-Standing Surgical Centers

CREDENTIALING PRACTITIONERS

Initially, practitioner applicants must submit the Maryland Uniform Credentialing Form to apply for participation. The form is available on the Johns Hopkins USFHP website at:

www.hopkinsmedicine.org/bin/u/j/UCF_2007_version.pdf

The hard copy application must be returned to JHHC for processing.

The practitioner's application must be complete including all service locations from which the practitioner will provide medical service to Johns Hopkins USFHP members, education including residency and fellowship programs, clinical experience(s) for at least the past five years, malpractice/professional liability insurance coverage, medical and professional certifications held, licenses held for at least the past five years, DEA and CDS registrations, clinical affiliations with facilities/hospitals, malpractice claim history, and contact information.

The application must be signed and dated by the applicant including an attestation that serves as a Release of Information and a statement that the information contained within the application is true and accurate. Additionally, the practitioner must respond to all disclosure questions pertaining to clinical and professional experience and history.

The mailing address is:

Johns Hopkins Healthcare LLC
6704 Curtis Court
Glen Burnie, Maryland 21060
Attn: Credentialing Department

Upon receipt of the application, the practitioner is notified of receipt of the application and that the credentialing process has been initiated. Any outstanding documentation needed to complete the credentialing file that the practitioner must submit will be noted in the notification. Examples include legal documents to augment malpractice claims, licensing board disciplinary actions, or disbarment or restriction of privileges by any Federal, State or local jurisdiction or other health care-related entity with which the applicant had a professional relationship.

The practitioner is also notified if JHHC identifies any discrepancies between the information included in the application and information obtained during the credentialing process from outside sources (e.g., NPDB, OIG, etc.). Adverse information pertaining to the clinical competence, professional judgment, compliance with state or federal regulations, patient safety, or contractual compliance may be grounds for refusal of acceptance into the Johns Hopkins USFHP provider network or termination of ongoing participation.

Practitioners have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Practitioners also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. They may do so by telephone, fax, email, or correspondence to the credentialing department or the network manager for their geographic area.

Currently, the following verifications are completed in addition to collection of the application information and validation of the contractual relationship between JHHC and the practitioner. These verifications are performed in accordance with the TriCare Operations Manual, National Committee for Quality Assurance (NCQA), URAC, State and Federal guidelines and regulations:

- Current licensure as an independent vendor in the state where service will be rendered
- Education including degrees, internship, residency and fellowship programs completed relevant to current licensure
- Medical Board Certification
- Professional Certification
- Work History for the past five (5) years (gaps of six (6) months or greater must have explanation of the gap)
- Hospital admitting privileges (clinical associations)
- DEA registration and CDS certification as appropriate for scope of practice
- Professional liability insurance
- Malpractice activity and history
- Federal, Medicare or Medicaid sanctions
- Disciplinary actions by licensing boards, educational institutions, professional organizations, or medical service providers including facilities.
- Criminal history background check including National Sex Offender Registry (USIS/HireRight)

The practitioner is requested to provide responses to disclosure questions related to:

- History of chemical dependency and substance or alcohol abuse
- History of license revocations or disciplinary actions
- History of criminal convictions other than minor traffic violations
- History of loss or limitation to clinical privileges
- History of complaints filed with local, state or national societies or licensing boards
- History of refusal or cancellation of professional liability insurance
- History of Federal, Medicare or Medicaid sanctions including restrictions on DEA or CDS
- Reasons for the inability to perform essential functions of the position with or without accommodation(s)

During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by JHHC since the prior credentialing event is also included in the credentialing file and subject to consideration for ongoing participation.

The decision to approve initial or continued participation, or to terminate a provider's participation, will be communicated in writing within 60 days of the SCRC's decision. In the event the provider's participation or continued participation is denied, the provider will be notified by certified mail. If continued participation is denied, the provider will be allowed 30 days to appeal the decision.

CREDENTIALING ORGANIZATIONAL PROVIDERS

Organizational providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

Organizational providers must complete a credentialing application, available directly from JHHC via the senior network manager responsible for the type of organization that is applying. The credentialing application requires the signature of the organization's authorized representative and serves as evidence that the healthcare facility/organization agrees to the assessment requirements. The authorized representative's signature also serves as a release of information to verify credentials externally.

Upon receipt of the application, the organization is notified of receipt of the application and that the credentialing process has been initiated. Any outstanding documentation that will be needed to complete the credentialing file that the organization must submit will be noted in the notification. Examples include legal documents to augment malpractice claims history, licensing board disciplinary actions and/or correction action plans, or disbarment or restriction of privileges by any Federal, State or local jurisdiction or other health care-accreditation entities.

Currently, the following verifications are completed in addition to collection of the application information. These verifications are performed in accordance with the TriCare Operations Manual, National Committee for Quality Assurance (NCQA), URAC, State and Federal guidelines and regulations:

- Current licensure as health care delivery organization as an independent vendor in the state where service will be rendered
- Any restrictions to a license imposed by the licensing agency

- Any limitations or exclusions imposed by the Federal government, or Medicare or Medicaid entity
- Accreditation status with nationally recognized entities for health care quality including but not limited to the Joint Commission, Community Health Accreditation Program, Healthcare Facilities Accreditation Program, the American Osteopathic Association, the Accreditation Association for Ambulatory Health Care, and the Commission on Accreditation of Rehabilitation Facilities
- For non-accredited organizations, JHHC will accept a state assessments/evaluations or CMS review
- Onsite review for organizations without accreditation or state/CMS review.
- Professional liability/malpractice insurance

RE-CREDENTIALING

Re-credentialing is performed at a minimum every three years. During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by JHHC since the prior credentialing event is also included in the credentialing file and subject to consideration for ongoing participation.

Organizations have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Organizations also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. Such requests may be done by telephone, fax, email, or correspondence to the credentialing department or the senior network manager responsible for this type of organization.

The decision to approve initial or continued participation or to terminate an organization's participation will be communicated in writing within 60 days of the SCRC's decision. In the event the organization's participation or continued participation is denied, the organization will be notified by certified mail. If continued participation is denied, the organization will be allowed 30 days to appeal the decision.

CONTACT INFORMATION

Provider Services (benefit eligibility, claims status)

410-424-4528

800-808-7347

Eligibility Verification/Enrollment

410-424-4780

Mental Health/Substance Abuse

410-424-4476

800-261-2429

Care Management

410-424-4480

800-261-2421

Health Educator

410-762-5348

866-931-1870

Pharmacy Services

888-819-1043

Quality Improvement

410-424-4882

Provider Relations

410-762-5385

888-865-4998

Performance Improvement/Risk Management

410-338-3610

Defense Enrollment Eligibility Reporting System (DEERS)

800-538-9552

831-655-8317 fax

***Appointment Locator Service**

888-309-4573

*Members can speak to and work with staff that can help them find urgent and routine appointments with Mental Health and Substance Abuse Professionals.

Dental Care

800-332-0366

Dental Value Network (DVN) - Under a separate agreement, the Plan has arranged for members to receive dental services from selected community dentists under a discounted fee structure.

Web Site AddressesUSFHP - www.hopkinsmedicine.org/usfhpTRICARE - www.tricare.mil**Claims Submission**

Johns Hopkins US Family Health Plan

Claims Department

P.O. Box 33

Glen Burnie, MD 21060-0033

Attn: Claims Department

Appeals Submission

Johns Hopkins US Family Health Plan

Appeals Department

P.O. Box 33

Glen Burnie, MD 21060-0033

Attn: Appeals Department

NETWORK HOSPITALS

Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401
443-481-1000

Bowie Health Center
15001 Health Center Drive
Bowie, MD 20716
301-262-5511

Carroll Hospital Center
200 Memorial Avenue
Westminster, MD 21157
410-848-3000

Frederick Memorial Hospital
400 West 7th Street
Frederick, MD 21701
240-566-3300

Garrett County Memorial Hospital
251 North Fourth Street
Oakland, MD 21550
301-533-4000

Gettysburg Hospital
147 Gettys Street
Gettysburg, PA 17325
717-334-2121

Greater Baltimore Medical Center
6701 N. Charles Street
Baltimore, MD 21204
443-849-2000

Harford Memorial Hospital
501 S. Union Avenue
Havre de Grace, MD 21078
443-843-5000

Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910
301-754-7000

Howard County General Hospital
5755 Cedar Lane
Columbia, MD 21044
410-740-7890

Johns Hopkins Bayview Medical Center
4940 Eastern Avenue
Baltimore, MD 21224
410-550-0100

Johns Hopkins Hospital
600 N. Wolfe Street
Baltimore, MD 21287
410-955-5000

Kennedy Krieger Institute
707 N. Broadway
Baltimore, MD 21205
443-923-2792

Laurel Regional Hospital
7300 Van Dusen Road
Laurel, MD 20707
410-792-2270

Montgomery General Hospital
18101 Prince Phillip Drive
Olney, MD 20832
301-570-8500

Mt. Washington Pediatric Hospital
1708 W. Rogers Avenue
Baltimore, MD 21209
410-578-5334

NETWORK HOSPITALS (cont.)

North Arundel Hospital
203 Hospital Drive
Glen Burnie, MD 21061
410-768-0230

Prince George's Hospital Center
3001 Hospital Drive
Cheverly, MD 20785
301-583-4053

Shady Grove Adventist Hospital
9901 Medical Center Road
Rockville, MD 20850
301-279-6000

St. Agnes Hospital
900 Caton Avenue
Baltimore, MD 21229
410-386-6000

St. Joseph's Medical Center
7601 Osler Drive
Towson, MD 21204
410-337-1000

Suburban Hospital
8600 Old Georgetown Road
Bethesda, MD 20814
301-896-3100

Upper Chesapeake Medical Center
500 Upper Chesapeake Drive
Bel Air, MD 21014
443-643-1000

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
301-891-7600

Washington County Hospital
251 E. Antietam Street
Hagerstown, MD 21740
240-313-9940

York Hospital
1001 South George Street
York, PA 17405
717-851-2345

For an updated listing of Johns Hopkins Community Physicians sites and Urgent Care Center locations, please refer to our website at www.jhhc.com.

SECTION III

Care Management

CASE MANAGEMENT

Case Management is intensive coordination and evaluation of care that is appropriate when a member's health care needs are of high acuity and/or a member is at risk of repeat admission and emergency room (ER) visits. Disease Management is a form of Case Management that is disease specific. The Case Management and Disease Management Programs monitor, evaluate, and coordinate appropriate health care services for Johns Hopkins USFHP members, ensuring quality care in a cost effective manner. JHHC Case Management utilizes claims, pharmacy and adjusted clinical groups data to analyze members. Therefore, correct coding is essential in order to utilize data in the most effective manner.

Members will be screened by the Case Management staff for case management services upon enrolling in Johns Hopkins USFHP, applying for disability, referral for specialty care, admission to an inpatient facility, receiving services outside the Primary Care Physician's office, and upon referral by the provider, patient or family.

POPULATION HEALTH INITIATIVE

As part of its ongoing commitment to quality care, JHHC provides a comprehensive case management program – *Population Health Initiative* for Johns Hopkins USFHP members. Case Management is intensive coordination and evaluation of care that is appropriate when a member's health care needs are of high acuity and/or a member is at risk of repeat admissions and ER visits. The JHHC case management program is an integral component of a population health approach to providing services to benefit members with acute and chronic conditions. *The Population Health Initiative* was developed to give members individual support and services that are needed to help them understand and self-manage their medical conditions. Assistance is offered on two levels, depending on the member's need.

The Complex Case Management and Disease Management programs monitor, evaluate, and coordinate appropriate health care services for the Johns Hopkins USFHP members, ensuring quality care in a cost effective manner. JHHC Case Management utilizes claims, pharmacy and adjusted clinical groups to analyze members. Therefore, correct coding is essential in order to utilize data in the most effective manner.

Members are screened by the Case Management staff for case management services upon enrolling in Johns Hopkins USFHP, referral for specialty care, admission to an inpatient facility, multiple ER visits, receiving services outside the PCP's office, or upon referral by the provider, patient or family.

Members will receive case management services when:

- Admitted to acute or rehabilitation facilities
- Receiving outpatient treatments of a complex nature
- Receiving complex in-home care
- Data demonstrates member has extensive healthcare needs
- The physician, member or family request case management

Case managers work closely with members, their providers, and all members of the health care team to share information essential to achieving the best possible health. Case managers help members to improve their health by:

- Assessing each member's physical, psychosocial, spiritual and financial needs
- Educating members on ways to manage their health for both acute and chronic conditions
- Assisting with referrals to specialty providers
- Coordinating care with our health education department, home health and other health and community agencies
- Providing ongoing communication to check members' progress and review for continuing services
- Providing education of advance care planning

REFERRAL FOR CASE MANAGEMENT

Providers wishing to initiate Case Management services can either e-mail population health @jhhc.com or call 410-762-5206 or 800-557-6916.

All referrals to Case Management must include;

- Name of patient
- Date of Birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within five business days.

Please do not send the following to Case Management:

- Bills
- Authorizations
- Pre-authorizations
- DME/Home care referrals
- Provider referrals

COMPLEX CASE MANAGEMENT PROGRAM

Complex case management is the highest level of intervention in the population health management continuum. Complex case management is provided for adults and children with Diabetes and Asthma, as well as all adults with Chronic Obstructive Pulmonary Disease (COPD) and Cardiovascular Disease. Once a member is identified with complex medical conditions, or a special need, our highly qualified staff of nurses and social workers assist the member with coordinating services, accessing available resources and serving as a member advocate.

Upon referral to complex case management, the case manager completes a comprehensive general and condition specific assessment. A care plan and a self-management plan are completed for all USFHP members in Level One Complex Case Management within the first 30 days of opening the member's case. The care plan and self management plan is based on an evaluation of the member's health status, including co-morbidities, clinical history, utilization history, current and past medications, activities of daily living, mental health status, status of life planning activities, cultural and linguistic needs caregiver resources, an evaluation of available benefits and barriers to care. In addition, to the general assessment and depression screen, the case manager assesses quality of life and the member's motivation to change.

Key content within the Johns Hopkins HealthCare adopted preventive and non-preventive clinical practice guidelines that demonstrate a strong association to improve health outcomes as indicated in the evidence-based medical literature is incorporated into the assessments, care plan and self-management plan. This content is shared with practitioners in communication between the complex case managers and practitioners.

Case management is also available for the following:

- High-risk pregnancy
- Children with special needs
- HIV/AIDS
- End stage renal disease - for members on dialysis
- Cancer
- Member with rehabilitation needs

CASE MANAGEMENT PROGRAMS

PARTNERS WITH MOM

“Partners with Mom” is a maternity case management program that targets high risk moms with a history or current symptoms of Asthma, Diabetes, Preterm Labor, Substance Abuse, Hypertension and/or adolescent pregnancy. Pregnant mothers with other high-risk OB diagnoses that may benefit from case management interventions are also considered for inclusion in the program. Through early identification and intervention, the program has reduced antepartum admissions, decreased NICU births, and improved maternal/fetal outcomes. “Partners with Mom” RN case managers are available for onsite high-risk clinic sessions to provide the critical resources and services needed. Case managers work closely with the provider and patient to improve compliance, coordinate care and maximize favorable outcomes.

PEDIATRIC HEALTH PARTNERS

This program for children provides RN case management for children with special needs such as sickle cell, genetic syndromes, neurological problems, complications from prematurity, obesity, and transplants. The case managers actively interface with multiple sub-specialty providers, home health community agencies and the school system, as applicable, to meet the specific physical, psychosocial and emotional needs of the developing child and family across the continuum of childhood.

PHYSICAL REHABILITATION

Comprehensive case management is provided for members who are disabled due to neurological disease or physical injuries via our Rehabilitation case management program. Included is regular contact with the Rehabilitation RN case manager to develop and implement a coordinated plan of care, which includes primary care, specialty care, rehabilitation providers, specialty DME providers and community services. The mission of this program is to promote wellness, minimize preventable complications and maximize functional abilities.

OMEGA LIFE

Omega Life is a palliative care program for cancer patients facing a potentially life-threatening illness. When a patient is faced with a new or a recurrent issue with cancer, the role of the RN case manager is that of educator, health system navigator, symptom monitor, and communicator with the PCP and various specialists. When the patient doesn't know who to call, he or she can speak to the Omega Life case manager, who is available 8a-9p daily. This case manager can access various other disciplines such as social work and pastoral care to support the patient either to discharge or through hospice according to the patient's condition, needs and preferences.

POSITIVE HEALTH PARTNERS

Positive Health Partners, the HIV/ AIDS case management program employs RNs and social work case managers, as well as an outreach substance abuse coordinator that are experienced in the standards of HIV care. The case managers target interventions according to the patient's specific needs. Interventions for patients requiring case management needs include frequent contact to monitor medication adherence and DME needs; monitoring appointment adherence; providing culturally sensitive education about HIV-related issues; monitoring labs related to anti-retroviral therapy and trending collected data to analyze population level trends. For social needs, case managers connect members with community resources and services.

INTEGRATED RENAL SOLUTIONS/END STAGE RENAL DISEASE

Integrated Renal Solutions (IRS) provides case management for members with end-stage renal disease (ESRD) who have begun dialysis. The case manager, a RN with a background in ESRD, provides bi-monthly visits to members during the hemodialysis treatment or during the monthly office visit when the member has peritoneal dialysis. During these encounters information/education is provided regarding options for renal replacement therapy (hemodialysis, peritoneal dialysis and transplantation), and the challenges and advantages of each modality. In addition, adequacy of dialysis is monitored based on the National Kidney Foundation Dialysis Outcomes Quality Initiative

Guidelines (DOQUI). The case manager collaborates with the appropriate providers to achieve and maintain these quality standards. The case manager also assists the member in preventing complications and with problem solving related to dialysis treatment, access care, medications, and management of the primary diagnosis. In addition to the bi-monthly visits, the case manager is available to members and providers via phone, fax and e-mail.

OTHER POPULATION HEALTH-BASED SERVICES INCLUDE:

- Periodic communication of educational materials targeted specifically to the member's health status, chronic/complex condition, diet, exercise, and stress management and focused on increasing self-management skills and preventing complications
- Communication of information to the member and health care practitioner(s) based on data obtained from medical and pharmacy claims, including prescription medication history
- Utilization of the TeleWatch Patient Monitoring System which allows members to enter data about their health status from the comfort of their home for certain conditions. TeleWatch provides information to help the JHHC care manager and their physician monitor their condition
- Outreach to selected members upon discharge from an inpatient facility to ensure coordination of follow-up, assistance in obtaining needed durable medical equipment, and assistance accessing services and community resources
- Assistance to members transitioning from hospital to a post-acute care facility to home by working with providers, members and their families concerning discharge planning, care coordination, and member and family education
- Assistance with access to behavioral health services, provided by JHHC Treatment Coaches that assist initiating care and accessing behavioral health care services. You can access this service directly by calling the toll-free number (888) 309-4573
- "Appointment Locator Assistance" for USFHP members, including one-on-one assistance with locating and/or scheduling mental health and substance abuse services. You can access this service by calling the toll free number 888-309-4573

We encourage members to take advantage of the services provided by our JHHC Population Health Initiative Programs.

Our Population Health Initiative services are voluntary and are provided at no cost to the member. Members identified with certain needs may be automatically enrolled but are under no obligation to participate in these programs.

MEMBER IDENTIFICATION

Members are identified for targeted disease management interventions through the following mechanisms:

- Claims and encounters
- Pharmacy data
- Laboratory data
- Health Risk Assessments

PCP referrals may be called into the Disease Management Department at 410-424-4894.

SCREENING

The clinical screener, a registered nurse fully qualified and knowledgeable about the case management we have to offer, will work collaboratively with the PCP to assess whether the member meets inclusion criteria for the program. The clinical screener will then contact the member directly. Case management is voluntary and the member can withdraw from the program at any time.

TREATMENT PLANNING

The Case Manager will review the case with the PCP and record a brief medical history, identify what health promotion and maintenance services are currently being provided, and what alternative care is appropriate for this member. The Case Manager and the PCP will determine what additional services, and/or alternative care would benefit the member.

If needed, the Case Manager implements the new services including:

- discussion with the member
- setting up services with network providers
- determining data elements to be collected and time frames for re-evaluation

Data will routinely be collected (using concurrent and retrospective review and reporting) to evaluate the effectiveness and efficiency of care.

The PCP will work with the Case Manager by communicating any significant changes in the member's condition, problems with service delivery, and working with alternative care opportunities for the member.

The Case Manager will enter significant changes into a database regarding the member's health status, new treatments or services and continually insure the appropriate level of care management is in place.

The Case Manager will communicate regularly with any health care team members involved in the member's care to ensure the care remains a covered benefit, and recommend changes to the plan of care to the PCP.

Identified patient care issues outside established medical policy guidelines will be brought to the attention of the PCP/admitting physician and the JHHC Medical Director.

ADDITIONAL SERVICES FOR OUR MEMBERS

NurseLine

Members can call the Johns Hopkins USFHP NurseLine to speak directly to a registered nurse any time of the day or night. Nurses will answer questions and provide information to members about their medical concern(s).

USFHP NurseLine: 866-444-3008

Health Information Library (HIL)

Health Information Library (HIL) is a pre-recorded library of health topics designed to provide members with information about health topics ranging from mild illnesses to injuries to more serious medical conditions.

Call 866-444-3008 PIN 382

Nurse Chat

Nurse Chat is a free service for members who prefer to use the Internet to obtain general health information. Nurse Chat provides live access to registered nurses. Nurse Chat Line Live at www.nurselinechat.com/jhfcusfhp - then click on the Nurse Live Chat icon.

Non-Emergency Urgent Care in the Plan Area

For non-emergency medical conditions requiring prompt attention, members need to contact their PCP before seeking care. If they call after office hours, their call will be directed to the after-hours service to provide them with information or authorize treatment at a specific medical facility.

Non-Emergency Urgent Care outside the Plan Area

If a member becomes ill or injured and requires urgent, but not emergency, care while traveling, call your PCP office during regular office hours or after-hours service. For advice, you may contact the 24-hour nurse line at the number on the back of your Member ID card. You must be referred by your PCP prior to seeking care to ensure that the care will be covered by the Plan.

Emergency Services out of the Country or at Sea

If a member becomes ill or injured while in another country or at sea and requires urgent care, they can go to the nearest emergency room or medical facility to receive the necessary treatment. The hospital or facility may demand immediate payment; if they do, the member needs to ask for treatment information, bills and receipts. Within seven (7) days of their return, the member will need to submit itemized bills and receipts to the Customer Service Department along with an explanation of the services and the identification information from their Johns Hopkins USFHP identification card.

QUALITY IMPROVEMENT

The Quality Improvement Program at JHHC provides a comprehensive process for improving the quality and safety of clinical care and services provided to our members. The program is dedicated to ensuring the JHHC mission to improve the lives of our plan members by providing access to high-quality, cost-effective, member centered healthcare. It is a continuous process by which clinical and service quality is: assessed, opportunities for improvement are identified, action is implemented, and effectiveness of interventions are evaluated. The entire program is reviewed and evaluated by the quality improvement committees annually. This evaluation is used by the committees to indentify priorities for the following year.

Providers are expected to participate in the quality improvement activities of the health plan. These activities include monitoring clinical effectiveness through HEDIS and other data collection activities, review of complaints, assessment of provider satisfaction through an annual survey, assessment of medical record documentation through audits of member records, and quality improvement initiatives. Providers may be asked to collaborate with the health plan on patient safety or quality improvement projects.

In addition, a number of providers are invited to participate on our quality improvement committees. Their perspective as participating practitioners is valuable in evaluating and improving clinical effectiveness, provider satisfaction, and member satisfaction. JHHC also relies on input from participating providers in development of preventive care guidelines and clinical practice guidelines.

If you are interested in receiving the full description of the QI Program, or information on our progress on meeting our goals, please contact your network manager.

The Mission of the Quality Improvement Program is to:

- Ensure that all activities meet accreditation standards, state and federal regulations and contract requirements.
- Evaluate services and care delivery with respect to outcomes (e.g. member and provider satisfaction)
- Analyze plan outcomes as compared to national industry benchmarks
- Identify opportunities for improvement in both the clinical and service areas
- Evaluate the overall effectiveness of the program on a yearly basis

The Quality Improvement Objectives are:

- To continue to monitor member and provider satisfaction and identify opportunities for improvement through data analysis from the annual Member and Provider Satisfaction Surveys
- To maintain Full Accreditation status through continued compliance with URAC Health Network standards
- To improve Claims Processing by keeping the percent of claims processed in less than 30 days above 90 percent while maintaining accuracy scores above 98 percent
- To meet or exceed organizational performance standards for Customer Service.
- To monitor participation of Johns Hopkins USFHP members in the various Disease Management programs
- To continue to monitor the HEDIS measures annually as selected by the US Family Health Plan Alliance
- To identify and develop actions plans for those opportunities for improvement identified through the NQMC auditing process
- To maintain compliance with the Comprehensive Quality Management Program (TOM Ch.7, Sect. 4) through the JHHC Quality of Care Referral & review process
- Identify the appropriate method to monitor consult report timeliness
- To monitor health improvement activities as reported in the previous year's Comprehensive Quality Improvement Work plan

QUALITY IMPROVEMENT INITIATIVES

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of health care performance measures that is developed and maintained by the National Committee for Quality Assurance (NCQA). Examples of HEDIS measures are Comprehensive Diabetes Care, Childhood Immunizations, yearly Well Child Exams for Children Ages 3-6 and yearly Adolescent Well Care Exams.

Consumer Assessment Health Plan Surveys

Member satisfaction surveys developed by NHCQA are completed on an annual basis. Approximately 1,500 members are contacted yearly for the survey.

QUALITY IMPROVEMENT COMMITTEES

The Johns Hopkins Health Care Quality Improvement Committees are designed to address client and consumer requirements and needs. Each committee has distinct responsibilities and the membership includes the appropriate stakeholders and subject matter experts.

Participating Plan Providers

JHHC relies on interactions and recommendations from participating plan providers to develop preventive care guidelines, clinical pathways, practice guidelines and action plans for quality improvement initiatives. Feedback from providers is a critical element in the Quality Improvement Program. Therefore, participating providers serve as members of clinical quality improvement committees and clinical QI activities are communicated to providers via newsletters, mailings to individual providers, and group education/communication sessions.

Board of Directors

The JHHC Board of Directors has the final authority and responsibility for the quality of health care and services provided to members. Annually, the Board reviews the results of the previous year's Quality Improvement Program and approves the Quality Improvement Plan for the following year. The Board has delegated ongoing monitoring of the Quality Improvement Plan to three committees:

- Quality Improvement Oversight Committee (QIOC), which provides oversight and coordination of all clinical quality improvement activities
- Professional Advisory Committee (PROFAC), which provides oversight and coordination of all Priority Partners quality improvement activities
- Process Management Team (PMT), which provides oversight and coordination of all service and process quality improvement activities

QUALITY IMPROVEMENT OVERSIGHT COMMITTEE (QIOC)

Role

The Quality Improvement Oversight Committee maintains oversight and approves the Quality Improvement Program and Work Plan. It also implements and monitors the Quality Improvement Initiatives as directed by the Board of Directors.

Responsibilities

- Monitor sub-committee activities through reports by chairpersons
- Review annually and adopt preventive health, practice guidelines, and activities
- Approves the Quality Improvement Annual Program
- When available, evaluate HEDIS and other audit data related to quality measures and provide recommendations for improvement

- Delegate any of the above activities to sub-committees or ad hoc work groups with appropriate oversight
- Monitor ongoing activities supporting accreditation.
- Review Quality of Care activities

PROCESS MANAGEMENT TEAM (PMT)

Role

The Process Management Team identifies opportunities to improve the overall operational performance of the organization, develops necessary procedures and makes recommendations to the organization's executive staff.

Responsibilities

- Provide a forum for all functional areas to identify/present opportunities to improve organizational performance that affect multiple functional areas
- Approves non-clinical Quality Improvement Projects
- Establishes goals for operational performance
- Monitors progress in meeting quality improvement goals
- Reviews proposed departmental policies and procedures that affect or are impacted by other functional areas
- Make recommendations for new policies and procedures
- Distributes approved departmental procedures to other departments
- Reviews customer service performance data
- Analyzes trends in member complaints and identifies organizational opportunities for improvement
- Ensures organizational compliance with accreditation standards
- Reviews annual Member and Provider Satisfaction Survey results and makes recommendations to the Board of Directors, as indicated, for organizational improvement strategies

JHHC SCIENTIFIC & BENEFIT ADVISORY COMMITTEE (SABAC)

Role

The Johns Hopkins HealthCare LLC's Scientific Assessment & Benefits Advisory Committee's primary responsibility is to review and evaluate current and new, unique or unusual medical technology for safety and efficacy, and to formulate recommendations regarding coverage for services not identified as a benefit or exclusion in Summary Plan Descriptions, coverage certificates or member handbooks. The term "medical technology" refers to procedures, treatments, services, devices or therapeutics that may or may not have medical efficacy.

Responsibilities

Advisory, with respect to:

- Medical technology review
- Benefits review for inclusion in Summary Plan Descriptions, coverage certificates or member handbooks
- Development & recommendations for approval of utilization review criteria for the organization to the appropriate oversight committees
- Review and approve all UM criteria annually

CREDENTIALING COMMITTEE

Role

The Johns Hopkins HealthCare LLC Credentialing Committee has primary responsibility to review all credentialing and recredentialing files and make recommendations regarding individual providers interested in affiliating with Johns Hopkins HealthCare LLC.

Responsibility

- Reviews all materials relevant to a candidate regarding credentialing and recredentialing matters as identified in credentialing policies and procedures.
- Completes necessary peer review during credentialing and recredentialing process.
- Applies existing criteria to each file and make a formal recommendation to the Special Credential Review Subcommittee regarding each candidate.
- Reviews and revises all policies and procedures related to all credential and recredentialing activities, at a minimum biannually.
- Reviews and revises all policies and procedures related to credentialing delegation oversight.
- Monitors delegation oversight activities and makes recommendations regarding delegation to the Special Credentials Review Committee (SCRC).

SPECIAL CREDENTIALS REVIEW COMMITTEE (SCRC)

Role

The Special Credential Review Subcommittee (SCRS) is a subcommittee of the JHHC Board of Directors. The SCRS has final authority for decisions on credential applications.

Responsibility

- Review and discuss credentialing application and related information.
- Approve or disapprove applications submitted by providers for participation status.
- Annual review and approval of credentialing policies and procedures.
- Review delegation oversight and make determinations regarding delegation.

UTILIZATION MANAGEMENT COMMITTEES (UMC)

Role

To oversee utilization management activities at JHHC, to promote continuity of care and optimize member benefits, to monitor medical expense cost overruns, and over- and under-utilization of services.

Responsibilities

- Ensure accurate administration of benefits
- Oversees tasks of the Utilization Review Department
- Compiles medical management data into annual reports and presents them to the QIOC or PROFAC
- Coordinates provider satisfaction survey
- Evaluates access to care and oversees improvement initiatives
- Identifies trends in over and under utilization of services and recommends improvement initiatives for areas identified
- Review and revise annually the Utilization Management Plan

PHARMACY AND THERAPEUTICS COMMITTEE

Role

The Pharmacy and Therapeutics Committee is primarily responsible for the oversight and monitoring of pharmacy Utilization Management and Quality Improvement activities.

Responsibilities

- Reviews and approves policies and procedures concerning the appropriate use of drugs
- Reviews and approves educational activities related to drug use
- Manages the preferred drug list
- Reviews and approves the quality assurance programs designed to maintain appropriate drug prescribing, distribution, and administration of drugs
- Reviews and approves adverse drug event monitoring programs
- Reviews and approves the Drug Use Evaluation (DUE) process
- Reviews reports and literature used to support and develop drug use management programs
- Distributes Committee decisions to all staff members involved in direct patient care

INPATIENT UTILIZATION MANAGEMENT

The Utilization Management Program is designed to focus on processes that will enable Johns Hopkins USFHP to coordinate efficient and effective medical care to its members. The underlying tenant of the utilization strategy is that the PCP is the best individual to determine what care should be provided and to coordinate that care for members.

Utilization Management (UM) is provided for all patients in acute or sub-acute settings. Integral criteria are used to review length of stay, intensity of service, and severity of illness. UM evaluates for possible movement to lower levels of care without compromising plan of care or promotion of health. Professional nurses review with the attending physician, case managers and/or social workers in the facilities. On-site RN review is provided at The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. All other facilities are reviewed telephonically. The nurses collaborate with the discharge planners in assuring that a safe discharge and appropriate follow-up is in place. Referrals to the case management/disease management programs are made based on review of the member's post discharge needs and/or chronic conditions. Johns Hopkins HealthCare medical directors are available for consultation in difficult or complicated cases and will consult with the attending physician when needed to develop the most appropriate plan of care for the member.

QUALITY MANAGEMENT

The purpose of the Quality Improvement Program at JHHC is to provide a comprehensive process for the management of potential and actual quality of care and service related issues. It is dedicated to ensuring the JHHC mission of providing an excellent managed care infrastructure, thereby striving to improve the quality of patient care while reducing the cost. It is a continuous process by which quality is assessed, opportunities for improvement are identified, corrective action plans are implemented, and effectiveness is evaluated.

Healthcare Quality Improvement is a continuous process undertaken to ensure that individuals and groups of patients receive care of the highest standards, and represents current best practices. These processes maximize member satisfaction and safety; optimize healthcare outcomes and overall improved provider satisfaction with the health plan services.

The scope of the Quality Improvement Program is to improve areas involving both the service component and clinical aspects of care. This effort encompasses the continuum of the care delivery system: inpatient, outpatient, skilled nursing, rehabilitation, and emergency services. It also includes the services that encompass monitoring; customer service, member satisfaction, and provider satisfaction with health plan services. In all activities, the Quality Improvement Program ensures compliance with applicable accreditation standards, and state and federal regulations.

The Board of Directors of Johns Hopkins HealthCare LLC is responsible for the overall Quality Improvement Program. In meeting this responsibility, the Board has delegated oversight of the Quality Improvement Program to the President. The Senior Director of Quality Improvement and Member Initiatives is responsible for implementation and monitoring of the Quality Improvement Program.

The program is reviewed annually to assure achievement of goals established by the Quality Improvement Committees, QIOC (Quality Improvement Oversight Committee, PMT (Process Management Team) and PROFAC (Professional Advisory Committee). The results will be analyzed to determine the effectiveness of the interventions for improvement in patient care and service outcomes. The plan, its objectives and activities will be revised or enhanced for the upcoming year as directed by the analysis of the data collected. This evaluation will take into account the various program descriptions and work plans. The revised Quality Improvement Program is presented to the Board of Directors annually once approved by the Quality Improvement Committees. Once approved internally, the plan, including appropriate addendum is forwarded to regulatory agencies as required.

PROSPECTIVE, CONCURRENT, & RETROSPECTIVE REVIEW

Prospective Reviews are performed for elective inpatient services, outpatient surgery (in ambulatory centers and hospitals) and specific drugs. Care Management requires the following information:

- demographic
- attending physician and facility
- date of procedure
- procedure proposed
- diagnosis
- pertinent clinical data

Requests that do not meet standardized clinical criteria are referred to the Medical Director for review and a determination. The decision is communicated by phone and in writing within two working days of the determination.

Potential denials are referred to the Medical Director for a final determination. The denial is given verbally and in writing to the attending physician, the PCP, and the member, if the member is adversely affected by the decision.

Certain types of admissions are referred to a Care Coordinator to obtain the following types of information:

- Description and duration of signs and symptoms
- Significant tests performed including dates, results and recommendations as applicable
- Family history
- Plan of treatment

These cases are reviewed by the Care Coordinator. In consultation with the Medical Director, if the case does not meet medical criteria or if services could be provided in a less intense setting, the Coordinator or Medical Director will notify the PCP within two working days to advise and discuss alternatives.

If criteria for emergency admission are not met, the case will be referred to the Medical Director for review. Determination will be made within 24 hours after receipt of required information. The member and PCP are notified via telephone and in writing if criteria are not met and informed of the appeal process.

SECTION IV

Benefits

SUMMARY OF HEALTHCARE BENEFITS

Johns Hopkins USFHP provides a comprehensive range of preventive, diagnostic and treatment services as defined by the DoD and the TRICARE Prime benefit. Although a specific benefit or service may be listed as covered, it will be provided and paid for only if, in the judgment of the provider, it is medically necessary for the prevention, diagnosis, or treatment of an illness or condition. No oral statement of any personnel shall modify or otherwise affect these benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan. (See *benefits chart below*).

Summary of Costs & Benefits			
	Cost for Active Duty Family Members	Cost for Retirees, Family Members and Survivors	Cost for Retirees and Family Members Enrolled in Medicare Part B
Enrollment Fee	\$0	\$230 individual \$460 family	\$0 (with proof of Part B enrollment)
Outpatient Services			
Office visits	\$0	\$12	\$0
Maternity care (prenatal, postnatal)	\$0	\$0	\$0
Well-child care (birth to age 6)	\$0	\$0	\$0
Routine physical examinations	\$0	\$0	\$0
X-ray and lab tests ¹	\$0	\$0	\$0
Ambulatory surgery (same day)	\$0	\$25	\$0
Physical therapy (when medically necessary)	\$0	\$12	\$0
Cardiac Rehabilitation ⁹	\$0	\$12	\$0

Inpatient Services			
Hospitalization (semi-private room and board)	\$0	\$11 per day/\$25 minimum charge for admission	\$0
Maternity care (prenatal, delivery, postnatal hospital and professional services)	\$0	\$11 per day/\$25 minimum charge for admission	\$0
Physician services	\$0	\$0	\$0
General nursing services	\$0	\$0	\$0
Diagnostic tests including lab/X-ray	\$0	\$0	\$0
Operating room, anesthesia and supplies	\$0	\$0	\$0
Medically necessary supplies and services	\$0	\$0	\$0
Physical therapy (when medically necessary)	\$0	\$0	\$0
Mental Health Services			
Outpatient care individual (subject to medical review) ²	\$0	\$25 per visit	\$0
Outpatient care group (subject to medical review) ²	\$0	\$17 per visit	\$0
Partial hospitalization mental health (up to 60 days per fiscal year)	\$0	\$40 per day	\$0
Inpatient hospital psychiatric care (subject to medical review) ³	\$0	\$40 per day	\$0
Substance Abuse Treatment			
Outpatient care (individual) ⁴	\$0	\$25 per visit	\$0
Outpatient group/family therapy	\$0	\$17 per visit	\$0

Inpatient services (up to 7 days for detoxification per year) ⁵	\$0	\$40 per day	\$0
Inpatient rehabilitation (up to 21 days per year) ⁵	\$0	\$40 per day	\$0
Other Services			
Ambulance services (when medically necessary)	\$0	\$20 per occurrence	\$0
Dental Care - basic preventive	Reduced fees	Reduced fees	Reduced fees
Durable medical equipment	\$0	20%	\$0
Emergency room services ⁶ (including out of the area)	\$0	\$30	\$0
Comprehensive eye examination (1 per year)	\$0	\$0	\$0
Family planning services	\$0	\$12	\$0
Radiation/chemotherapy office visits	\$0	\$12	\$0
Prescription drugs (retail and mail order) ⁷	\$3 generic \$9 brand name \$22 Non-pref brand name	\$3 generic \$9 brand name \$22 Non-pref brand name	\$3 generic \$9 brand name \$22 Non-pref brand name
Skilled nursing facility care	\$0	\$11 per day/\$25 minimum charge per admission	\$0
Home health care (part-time skilled nursing care)	\$0	\$12 per visit	\$0
Out of area (emergency services only)	\$0	\$30	\$0
Catastrophic cap	\$1,000 per enrollment yr.	\$3,000 per enrollment yr.	\$3,000 per enrollment yr.
Enrollment fee	\$0	\$230 individual ⁸ \$460 family ⁸	\$0 (with proof of Part B enrollment)

FOOTNOTES TO CHART:

1. If lab services are provided on the same day as the office visit, and a co-pay is collected for the visit, no additional co-pay will be collected. No co-pay will be collected when services are billed and provided as clinical preventive services. Exceptions: co-pay may be required for certain radiation oncology, vascular and pulmonary procedures and studies. Contact Customer Service for details.
2. One hour of therapy, no more than two times per week, when medically necessary. Includes in-home services.
3. With authorization, up to 30 days per enrollment year for adults (age 19+); up to 45 days per enrollment year for children under age 19; up to 150 days of residential treatment for children and adolescents.
4. Exclusive of drug maintenance programs.
5. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.
6. Unless you are admitted to the hospital, in which case only the inpatient co-payment applies.
7. Prescription drug availability is limited to drugs prescribed by a Plan provider and covered as a Plan benefit. Availability of non-emergency prescriptions when out of the area is also limited. Over-the-counter medications and supplies are not covered. Retail vendor for prescriptions is Rite Aid Pharmacy.
8. Medicare-eligible enrollees showing evidence of current Part B payment do not have to pay the enrollment fee.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment may be covered if deemed medically necessary. DME must be authorized by the PCP, and purchased, or rented from a Plan provider. Co-payments are applied for retirees and their family members who do not carry Medicare Part B. Active duty family members and retirees with current medical Part B do not have to pay the co-payment for covered durable medical equipment.

PHARMACY SERVICES

The pharmacy network is comprised of all Rite Aid Pharmacies in Maryland, Washington, D.C., Virginia, West Virginia, and Pennsylvania. Members are required to fill all prescriptions at either a Rite Aid Pharmacy in any of these states or through the Rite Aid mail order pharmacy. Retail prescriptions may be filled for up to a 30-day supply and mail order up to a 90-day supply. However, members may fill up to a 90-day supply at a Rite Aid Pharmacy for the same co-pay as mail order.

MEDICATIONS

The following are covered pharmacy benefits:

- Most Food and Drug Administration-approved prescription medications
- Compounded medications of which at least one ingredient is a prescription drug
- Insulin
- Insulin syringes and needles
- Blood/Urine test strips
- Lancets
- Alcohol swabs

The following medications are not covered under Johns Hopkins USFHP:

- Medications to treat cosmetic conditions resulting from normal aging process
- Medications whose sole use is to stimulate hair growth
- Medications for investigational use
- Medications for obesity and/or weight reduction
- Medications for smoking cessation
- Homeopathic and herbal preparations
- Multivitamins, except, prenatal vitamins for females up to 45 years of age
- Fluoride preparations
- Over-the-counter medications, with the exception of insulin products and diabetic supplies
- Yohimbine


GENERIC DRUG POLICY



When available, the use of therapeutically equivalent generic drugs is required. Generic drugs will be dispensed in accordance with the FDA Orange Book "AB" rating. In the event a prescriber requires a brand name drug that is available generically, the prescriber must indicate "DAW" and write a clinical reason on the prescription for the use of the drug. Refer to the JHHC/USFHP preferred drug list for a complete listing of preferred drugs.

CO-PAYMENTS

Type of Drug	Co-payment for up to a 90-day supply
Generic	\$3
Preferred Brand	\$9
Non-preferred brand	\$22

JOHNS HOPKINS USFHP SAMPLE IDENTIFICATION CARD

 JOHNS HOPKINS MEDICINE		A TRICARE Prime designated provider.
US FAMILY HEALTH PLAN		
		JHCP AT WYMAN PARK (410) 338-3000
USFHP Member Member #: 000000000000 Effective: 02/01/2006 Office Co-pays: \$12.00 RX Co-pays: Gen \$3.00 RAHSRXS BIN# 610014	02/11/1940 F FX Member #: RXU999999*02 Plan #: 5 ER Co-pay: \$30.00 Brand \$9.00 Non Pref \$22.00	
(See reverse side for important member information.)		

US Family Health Plan MEMBER INFORMATION		
EMERGENCY CARE: If you are experiencing a life-threatening emergency, call 911 or proceed to the nearest emergency room. You must notify your primary care provider within 24 hours of an emergency room visit and any follow-up care must be pre-approved. If you are unsure if your condition is life-threatening, call your primary care provider first.		
AFTER-HOURS CARE: Call our NurseLine - Answers for Your Health Questions 24 Hours a Day: 366-444-3008, PIN 382 or call your primary care provider's after-hour service.		
MENTAL HEALTH SERVICES: 1-888-281-3186.		
BENEFITS: For information, call Customer Service at 410-424-4528 or 1-800-808-7347.		
HOSPITAL PROVIDER INFORMATION Call the plan five days prior to an elective admission or outpatient procedure to obtain certification. If patient holds other commercial health insurance, bill that carrier as primary. DO NOT BILL MEDICARE except for ESRD and services not covered by the US Family Health Plan. Billing Address: Johns Hopkins Medical Services Corporation Attn: Claims Department, P.O. Box 33, Glen Burnie, MD 21060-0033		

ACCESS STANDARDS

To ensure that illness is evaluated in a timely manner, members must have access to PCP services either by appointment or telephone, 24 hours a day, seven days a week.

When a provider's office is closed, the Plan offers After Hours Triage, a program staffed by RNs and backed up by PCPs. The nurses triage, advise, and authorize use of urgent care facilities and emergency rooms using standardized protocols. Additionally, a staff physician is on call for After Hours Triage 24 hours a day to provide medical oversight, advice and consent under appropriate circumstances.

The following accessibility guidelines are to be followed by all providers:

- **Emergency** - the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to the life, limb, or sight, and requires immediate medical treatment, or which manifests painful symptoms requiring immediate palliative effort to relieve suffering. In an emergency, in the absence of care, the member could reasonably be expected to suffer serious impairment or death. Examples of emergencies are heart attack, severe chest pain, cerebrovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, suicidal tendencies, and other acute conditions. During office hours, the PCP is required to coordinate emergency services and notify Care Management that the emergency admission is authorized. After hours, the member should call the After Hours Triage Nurse who will advise the member about where and when to obtain care.
- **Urgent** - a sudden, severe onset of illness or a medical problem requiring attention within 24 hours. With an urgent problem, the member should be seen that same day or within 24 hours.
- **Routine** - a medical problem or illness that is ongoing but presents no immediate medical danger or acute distress.
- **Health Maintenance** - well visits and preventive care services.

APPOINTMENT AVAILABILITY

Wait times for Primary Care Appointments

Appointment Type and Standard (Not to Exceed)

Health Assessment - 4 weeks

Routine Visit - 1 week

Urgent - 24 hours

SPECIALTY CARE APPOINTMENTS

- Access determined by PCP based on nature of care required.
- Wait time no longer than four (4) weeks
- Travel time no longer than one hour.

Travel Time to PCP's Office

A member's travel time should not exceed the TRICARE Prime standard of 30 minutes from home to the delivery site. JHHC shall require members electing to enroll, but residing outside the 30-minute travel time area to sign written documentation informing the member of his/her choice and that the member voluntarily waived the 30-minute access standard.

Office Wait Time

The wait time in the office in non-emergency situations shall not exceed 30 minutes.

MENTAL HEALTH AND SUBSTANCE ABUSE

What is Covered

The plan provides medically and psychological necessary services for the diagnosis and treatment of substance abuse and mental health conditions provided by licensed professionals including psychiatrists, psychologists, social workers, substance abuse counselors and Licensed Clinical Professional Counselors. Covered services include:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual, family and group therapy)
- Hospitalization (including inpatient professional services) subject to medical review
- Marital Counseling
- Appointment Locator

Johns Hopkins USFHP members may self-refer to a participating mental health provider for the first eight outpatient mental health visits by calling 410-424-4830 or 888-281-3186. All subsequent services must be authorized by the Plan. Members also have access to an appointment locator service. By calling 888-309-4573, members can speak to and work with staff that can help them find urgent and routine appointments with mental health and substance abuse professionals.

Treatment for chemical and alcohol dependency at approved inpatient or outpatient treatment facilities is covered when pre-authorized by the Plan. Both detoxification and rehabilitation days are counted toward mental health maximums. Substance abuse rehabilitation services are limited to one admission per year, with a lifetime maximum of three admissions.

What Is Not Covered

Mental health and substance abuse services require Plan certification of medical necessity. Every effort is made to assist members with the necessary services at the right level of care. There are exclusions to the Plan. The following are examples of excluded services:

- Opioid replacement therapy such as methadone
- Sexual Functioning Disorders
- Support services and/or groups not conducted by a licensed professional
- Learning disabilities, including psychological testing for academic and intelligence testing

Ambulance Service

Benefits are provided for medically necessary life-sustaining ambulance transport when the use of any other method of transportation is inadvisable. If a retiree over age 65 or a retiree family member does not carry Medicare Part B, the co-payment is \$20 per occurrence for ambulance services. Active duty family members and retirees with current Medicare Part B do not have a co-payment for ambulance.

Diagnostic Services

If authorized by your primary care physician or specialist, the following are covered without an additional co-payment:

- Pathology/lab services
- Nuclear medicine services
- Cardiovascular studies

REFERRALS

The PCP is responsible for determining when a member's health care needs require a referral to a specialty care provider. The PCP is responsible for arranging all member referrals and specialty care. A referral is valid for **one year** from the date it was written. The PCP must include the number of visits and time. If not included, the referral will default to one visit in one year. See the Referral Guidelines on the following page, or refer to the Johns Hopkins USFHP website at: www.hopkinsmedicine.org/usfhp.

MENTAL HEALTH REFERRALS

A referral from the Primary Care Physician **is not** required for Mental Health Services. The member may self-refer to a Johns Hopkins USFHP network provider for up to eight outpatient visits a year. Members, who wish to self-refer to a network provider, should be instructed to contact Mental Health Services at 888-281-3186 to obtain the names of network Mental Health providers. Mental health network providers are located on the campus of Johns Hopkins Bayview Medical Center and Johns Hopkins Hospital, and throughout the area where primary care sites are located.

When a member self-refers, the mental health provider should notify the PCP of the referral. To ensure continuity of care and a complete medical record, the mental health specialist must submit a treatment report to the PCP within 10 days of the initial session. The treatment plans from the mental health provider should be mailed or faxed to:

Baymeadow Health Services
P.O. Box 0268
Glen Burnie, Maryland 21060
(410)-424-4891 fax

REFERRALS TO OUT-OF-NETWORK PROVIDERS

All referrals to Out-of-Network Providers must be pre-authorized by the Medical Director and are limited to services that cannot be provided in the network.

Referral Supervision and Coordination for Specialty Care

The PCP must make an initial diagnosis prior to referring the member for specialty services. Once a member is referred to a specialty provider, the PCP must provide ongoing oversight. Subsequent specialty referrals need to be approved by the PCP. Except in the case of a medical emergency, the PCP refers specialty and tertiary services within the Johns Hopkins Network, or according to the referral patterns appropriate for the site. The Practice Manager is responsible for overseeing compliance with appropriate referral patterns.

US Family Health Plan (USFHP) Outpatient Referral and Pre-Authorization Guidelines

Important Information

- This list is not all inclusive and is subject to Tricare Prime benefit changes
- To verify benefit coverage call 1-800-896-7347
- All CPT Codes classified limited by the American Medical Association require Pre-Authorization (i.e. 9999, 9977)
- All services rendered by non-participating providers require Pre-Authorization
- All procedures performed in Ambulatory Surgery Centers (Place of Service 24) require a referral to be submitted to the health plan. Fax clinical documentation for services that require Pre-Authorization to 410-762-5205
- For additional information about USFHP, refer to the website at www.jhhs.com

No Referral or Pre-Authorization Required

- To ensure coordination of care, the referring physician must provide the member with a referral or script detailing the specialist services needed. No paperwork needs to be submitted to the health plan

Laboratory Services (In-network providers only) Radiology Services (In-network providers only)	Annual Routine Vision Screening (In-network providers only; Vision Eye Clinic and/or Block Vision providers)
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Referral Required

- This section lists the services that require a referral from the PCP or referring physician, which must be submitted to the Care Management department
- Fax the universal referral form to Outpatient Intake Services at 410-424-4603
- For urgent requests, (delay will seriously jeopardize the life or health of a member, or severe pain) mark URGENT on fax or call Care Management at 1-800-261-2421 or 410-424-4480
- Members are required to obtain a paper referral from their PCP prior to seeking specialty office care

Ambulance (non-emergent) Ambulatory Surgery Center (Place of Service 24) Dialysis Occupational Therapy - Initial 12 visits	Physical Therapy - Initial 12 visits Routine Foot Care - only covered benefit for PVD & Diabetic Smoking Cessation Counseling	Specialty Office Visits Urgent Care Centric Wound Clinic - Initial 10 visits
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Pre-Authorization Required

- The health plan will perform Medical Review of requested services before they are rendered
- Fax pertinent clinical documentation to Medical Review at 410-762-5205
- The requesting provider will be notified of all Pre-Authorization decisions
- Fax documentation for all Durable Medical Equipment (DME)/Durable Medical Supplies (DMS) to Medical Review at 410-762-5250
- For urgent requests, (delay will seriously jeopardize the life or health of a member, or severe pain) mark URGENT on fax or call Care Management at 1-800-261-2421 (insert) or 410-424-4480

Abortions, Bili Ursalithening Acne Surgery Adrenocorty/Adrenoplasty Antigenes Chemocycle Implantation (bone) Biofeedback Biopsy/Plasty, Bone Pin(s), Entropion, Ectropion Bone Anchored Hearing Devices Bones Type A and B Breast Reductions Bunionectomy Capsule Endoscopy Cardiac Exercise Program - patients with PVD Cardiac Rehabilitation Carpal Tunnel Surgical Decompression Clinical Trials (including NCI trials) Cochlear Implants Continuous Glucose Monitoring CT Heart / Angiography Developmental Delay Programs including Autism Dens Scans	Diabetic Education DME/DMS* ECHO - Extended Care Health Option External Counterpulsation Feeding Programs Genetic Testing Gynecomastia Surgery Hearing Aids (only active duty family members covered) Home Health Care Hoop(s) Hyperbaric Oxygen Therapy Laser Treatment for Portulaca MEG/MSI - Magnetomography MRI of Breast Neuropsychological Testing Neurostimulation Nutrition Counseling Occupational Therapy >12 visits Orthotics* Orthopedic Stimulation for Fractures PAVA - Pto therapy and Photochemotherapy	Physical Therapy >12 visits PET - Positron Emission Tomography Potentially Cosmetic Procedures* Prosthetics Pulmonary Rehabilitation Pulse Dye Laser for Port Wine Stain Rhinoplasty Sclerotherapy Septoplasty Skin Tag Removal Sleep Study (home only) Speech Therapy TMO Treatment Transplants (except organ) Ultrasound/CT Scan for Bone Density Uroctomy/Poletharyngoplasty Wristless Wrist Ligament Virtual Colonoscopy Wound Clinic > 10 visits Wound Vac
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Behavioral Health

- Members call 410-424-4830 or 1-888-201-3186
- Providers call 410-424-4845 or 1-800-261-2420
- Fax treatment plan to 410-424-4830
- For Behavioral Health Provider & Appointment Locator Program call 1-888-305-4373
- For services which require Pre-Authorization the Health Plan will perform Medical Review before they are rendered

No Referral Required Counseling and Psychiatric Services - Initial 8 visits Alcohol and Drug Treatment - Initial evaluation	Pre-Authorization Required Alcohol and Drug Treatment - continued care Ambulatory Detox Electro Convulsive Therapy IOP - Intensive Outpatient Program	Pre-Authorization Required Counseling and Psychiatric Services > 8 visits Psychological Testing
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Commonly Requested Non-Covered Services

- The following services are not part of the Tricare Prime benefit

Abortions, elective Acupuncture Artificial Insemination Autopsy Bed Boards Bed Tray Table Breast Ductal Lavage and Fiberoptic Biopsy Cystography III OPT Codes (see Tricare policy for exceptions) Oligospermic Treatment Oral Pads Cosmetic Procedures Cryopreservation (reproductive) Diapers (including pull-ups and Depends) Ductless Breast Compressor Tomography Exercise Conditioning Program (inhaler training) Exercise Equipment and Devices Exhaled Nitric Oxide Measurement Extracorporeal Shockwave Therapy for Plantar Fasciitis	Eye Exercises (visual training/orthoptics) Eye Glasses / Lenses Focal DNA Food Supplements (oral) Harvesting Eggs/Sperms Heating Pads or Lamp Hot Water Bottle Ice Bags Immunizations for Elective Travel Infertility Services In Vitro Fertilization Infant Formulas IDET - Intraductal Electrothermal Therapy Intraoperative Health Services/Equipment (not FDA approved) LASIK Eye Surgery LASIP - Laser Assisted Intraocularly Light Box Therapy - Seasonal Affective Disorder (SAD)	Massage Therapy Maternity Treatment PET - Positron Emission Tomography for Dementia Private Duty Nursing Pulse Electrical Stimulation for OA of the Knee Radiofrequency Ablation for Lower Back Pain Raised Toilet Seats Reductive Cervical Surgery Sex Change Procedure Shoes (orthopedic) Sterilization Reversal Structural Modification to the home Tricare Excluded Procedures Vitamin and Mineral Supplements (oral) Weight Management Programs Wheelchair Tray Table Wheelchairs/Wheelpool Bath Equipment
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Resources

- The following resources may be helpful in meeting the needs of the USFHP member

Care Management - call 1-800-261-2421 or 410-424-6480
 Customer Service - call 1-800-896-7347 or 410-424-4328
 Dental (Discount Network) - call United Concordia at 1-800-332-0366
 Extended Health Care Option Program (ECHO) - call 1-800-261-2421, option 3 then option 5
 Health Education - call 1-866-391-1870
 Pharmacy Pre-Authorization Requests - call Pharmacy Department at 1-888-819-1043, option 4
 Retail Pharmacy Locations - call Rita Aid at 1-800-742-3243 or visit www.ritaid.com
 USFHP Website - www.hopkinsmedicine.org/usfhp
 TRICARE Policy Manual is at <http://manual.tricare.mil/>

*For related coding documents, please go to www.jhhs.com, Providers & Physicians, USFHP, Resources & Guidelines.

Revised 1/15, Effective July 2015

Requirements for Network Specialists

When a PCP refers a Johns Hopkins USFHP member for specialty care, the specialist must follow the PCP's specific referral. If the specialist wishes to perform services broader or different in scope than that on the referral, including referral to another specialist, the specialist must obtain further authorization from the PCP.

Pre-authorizations

Pre-authorization is required for:

- all inpatient, selected outpatient, and ambulatory services
- certain specific drug treatments
- selected durable medical equipment
- home health care
- hospice
- ambulance
- selected ambulatory services

Pre-authorization is required for all out-of-network services. The PCP must get authorization from Care Management. The PCP should call or FAX the Inpatient Coordinator with the following information: PCP name and contact number, along with any information substantiating the need to use an out-of-network hospital or provider. This information will be given to the Inpatient Care Coordinator (nurse) for review process. The request is then forwarded to the Medical Director for a final decision. If approved, the Intake Coordinator will call the specialist and/or hospital with authorization. If not approved, the Intake Coordinator will contact the PCP to refer the member to an in-network provider or hospital.

To contact Care Management regarding pre-authorization for Out-of-Network Services, call 410-424-4480 or 800-261-2421 and select Option 1 or fax the information to 410-424-4606.

Pre-admission Review is required for all elective admissions and ambulatory surgeries and an initial length of stay is assigned. The Medical Director reviews for approval or denial all cases that do not meet criteria.

All elective and urgent Inpatient Admissions must be pre-authorized. The PCP should complete the pre-authorization form two weeks prior to the requested admission date for an elective admission and within 72 hours of the requested admission date for an urgent admission.

Provisional Covered Benefits

Specific surgical procedures/diagnoses that may be a provisionally covered benefit are referred to the Medical Director for determination of coverage. The PCP and member will be advised of the determination within two working days. Either may appeal this decision.

Ambulatory Care

All proposed admissions are reviewed to determine if the service could be provided in an ambulatory setting. The Nurse Care Coordinator, after consultation with the Medical Director, will notify the PCP of an adverse decision and discuss alternatives.

Out of Network Services

If a member becomes ill or injured, and requires care while outside the Plan service area (but within the continental United States), that care will be covered by the Plan if authorized by the PCP or Nurse Care Coordinator.

Members who are outside of the Plan service area (central Maryland) may seek emergency care by calling their regular health center for a referral to an approved facility. In a life-threatening situation, members should go to the nearest emergency room. Members who received emergency care without a referral must be coordinated through JHHC and the PCP.

SECTION V

Exclusions

GENERAL EXCLUSIONS

The Plan does not provide coverage and will not pay for:

- Services not considered medically necessary or clinically appropriate for diagnosis and treatment as determined by a physician.
- Services or procedures that are experimental or of a research nature
- Any services (including vaccinations) provided for employment, licensing, immigration, recreational travel, or other administrative reasons.
- Care or supplies not furnished or prescribed by a Plan provider.
- Cosmetic, plastic, or reconstructive surgery not related to medical treatment.
- Most custodial or convalescent care (caring for someone's daily needs, such as eating, dressing and simple bandage changes) in an institution or home.
- Routine dental care and dental X-rays, treatment of teeth, gums, alveolar process or gingival issues, cranial mandibular disorders, and other issues related to the joint.
- Services provided or charges incurred prior to the effective date of coverage under the Plan.
- Services provided or received after the date coverage is terminated under the Plan.

Note: This list is not all-inclusive and additional limitations may exist.

EXTENDED CARE HEALTH OPTION (ECHO)

Extended Care Health Option (ECHO) provides financial assistance only for active-duty family members with specific qualifying mental or physical conditions. Some conditions include the following: (please note this is not an all-inclusive list)

- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability
- Extraordinary physical or psychological condition causing the beneficiary to be homebound
- Moderate or severe mental retardation
- Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems)
- Serious physical disability

Note: Johns Hopkins USFHP does not participate in the Autism Demonstration.

ECHO BENEFITS

ECHO benefits, services and supplies are not available through the basic Johns Hopkins US Family Health Plan (USFHP) program. ECHO benefits provide such coverage as:

- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Medical and rehabilitative services
- In-home respite care services (can only be used in a month when at least one other ECHO benefit is being received):
 - ECHO respite care – up to 16 hours per month (limited to the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam)
 - EHHC respite care – up to eight hours per day, five days per week for those who qualify Note: The EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a skilled nursing facility
- Training to use assistive technology devices
- Institutional care when a residential environment is required
- Special education (which can include applied behavioral analysis)
- Transportation under certain limited circumstances (includes the cost of a medical attendant when needed to safely transport the beneficiary)

All ECHO services require pre-authorization through Johns Hopkins USFHP Care Management.

ECHO ELIGIBILITY PROCESS

For general questions, potential ECHO or family members may call the USFHP customer service telephone number at 410-424-4528 or 1-800-808-7347. USFHP also has a dedicated ECHO Care Coordinator who will assist members by answering more detailed questions regarding the eligibility and enrollment process.

To enroll in the ECHO program, members must be currently enrolled in Johns Hopkins USFHP, enrolled in the Exceptional Family Member Program (EFMP) of their branch of service and provide medical documentation that a qualifying condition exists. USFHP will grant provisional ECHO enrollment (for 90 days) while the sponsor completes the EFMP forms. Upon receipt of the application and documentation, members will receive a decision letter with their eligibility status.

ECHO COSTS

Active-duty sponsors pay a cost-share that is based on their pay grade and is separate from other USFHP program cost-shares. The monthly cost-share is one fee per sponsor, not per ECHO beneficiary.

Pay Grade	Monthly Cost-Share
E-1 to E-5	\$25
E-6	\$30
E-7, O-1	\$35
E-8, O-2	\$40
E-9, WO, W-1, CWO-2, O-3	\$45
CWO-3, CWO-4, O-4	\$50
CWO-5, O-5	\$65
O-6	\$75
O-7	\$100
O-8	\$150
O-9	\$200
O-10	\$250

The maximum government cost-share is \$36,000 per fiscal year (October 1-September 30)* for training, rehabilitation, special education (which can include applied behavioral analysis), assistive technology devices, institutional care, and transportation to and from institutions or facilities (under certain limited circumstances). The maximum cost-share for all other ECHO benefits combined is \$2,500 per month.

Sponsors are responsible for the cost of ECHO benefits that exceed the above limits.

Note: The ECHO Home Health Care (EHHC) is not subject to the \$2,500 per month or \$36,000 per fiscal year maximum government cost-share. The sponsor's cost-share does not count toward the annual catastrophic cap. ECHO costs cannot be shared between family members. For additional information about ECHO, you can visit: www.tricare.mil/ or www.hopkinsmedicine.org/usfhp/.

SECTION VI

Claims and Appeals

CLAIMS SUBMISSION AND PROCESSING

Network Providers are required to bill for all services and submit fee-for-service claims on a CMS 1500 form or UB 04 within 180 days of the date of service. Appeals for denied claims or requests for reconsideration for repayment must be submitted within 90 working days of the date of the denial.

- Code all services with CPT (Current Procedural Terminology) codes; code all diagnoses with the 5-digit ICD-9-CM codes or DSM-IV codes for psychiatric disorders to the highest level of specificity for the current year.
- Routine clean claims are processed within 30 days.

Submit the completed claim to:

Johns Hopkins US Family Health Plan
 P.O. Box 33
 Glen Burnie, MD 21060-0033
 Attn: Claims Department

OTHER HEALTH INSURANCE

Under the law, TRICARE benefits are payable only for charges remaining unpaid after all other health coverage, except Medicaid and other programs identified by TRICARE Management Activity (TMA), have paid benefits. TMA has identified the following programs as being secondary to TRICARE:

- Medicaid,
- Indian Health Service,
- State Victims Assistance/Crime Compensation Plans,
- Maternal and Child Health Program and
- Veterans Administration.

If other coverage exists, TRICARE coverage is available only as secondary payor, and only after a claim has been filed with the other plan and a payment determination issued. This must be done regardless of any provisions contained in the other coverage. When TRICARE is secondary, it will reimburse the physician for covered services in conjunction with the primary plan so that the two programs pay no more than 100% of charges or the JHHC fee maximum, whichever is less. JHHC will never pay more than it would have as the primary payor. In either case, the physician may not balance bill the member.

LACK OF PAYMENT BY OTHER HEALTH INSURER

TRICARE will not pay amounts that have been denied by the other coverage because the claim was not filed timely with the other coverage or the member failed to meet some other requirement of coverage. When such a claim is received, JHHC will develop the claim for a statement from the other coverage as to how much would have been paid had the claim met the other coverage's requirements. If such a statement is provided to JHHC by the member, the claim will be processed as if the other coverage actually paid the amount shown on the statement. If no such statement is received, the claim will be denied.

WAIVER OF BENEFITS

TRICARE members may not waive benefits due from their double coverage plans. If a double coverage plan provides benefits for services, a claim must be filed with the double coverage plan. Refusal by the member to claim benefits from the other coverage must result in a denial of TRICARE benefits.

MEDICARE LEAKAGE

For members with coverage under both Medicare and US Family Health Plan, Medicare cannot be billed for services covered by US Family Health Plan. Providers filing Medicare claims, or who have claims filed on their behalf, are in violation of the conditions of participation for the US Family Health Plan and are subject to disenrollment.

Members having coverage under both Medicare and US Family Health Plan may only use Medicare benefits for non-covered US Family Health Plan services (such as ESRD and chiropractic care). Providers billing Medicare for services covered under the US Family Health Plan are subject to termination from the US Family Health Plan network. Federal regulations preclude the Federal Government from paying twice for services.

APPEALS

Appeals should be sent to:

Johns Hopkins US Family Health Plan
 P.O. Box 33
 Glen Burnie, MD 21060-0203
 Attn: Appeals Department

FACTUAL DETERMINATIONS

- Denial determinations based on coverage limitations contained in 32 CFR 199, the TRICARE Policy Manual and other TRICARE guidance are considered factual determinations. If it is determined that the service or supply is covered but is not medically necessary, the denial will be a medical necessity determination
- Providers must appeal within 90 business days after date of denial
- JHHC will send written notice of its reconsideration determination within 30 calendar days of receipt of the appeal.

MEDICAL APPEALS

When Care Management denies a service or treatment to a network provider, they have two (2) levels of appeal. To avoid conflict of interest situations, JHHC will not allow a provider or committee member to review health care services or make denial determinations if he/she has been professionally involved, or where judgment may be perceived as compromised. A physician of like specialty will review all denials of coverage for medical necessity. An initial denial determination is final and binding unless it is reconsidered and revised through a formal written appeal.

Items that cannot be appealed by the provider include:

- allowable charge
- member (member) eligibility
- network provider/contract disputes
- provider not authorized
- ineligible member
- factual determination (not a covered service or benefit; see benefit plan).

SECTION VII

Compliance

MEMBER RIGHTS AND RESPONSIBILITIES

We value the members of our Johns Hopkins US Family Health Plan (USFHP) health care family. Our members have the following rights and responsibilities, and these are written for them.

You have the right to:

- Be treated with respect for your dignity and privacy.
- Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage.
- Receive information, including information on treatment options and alternatives in a manner you can understand.
- Participate in decisions regarding your healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Exercise your rights and to know that the exercise of those rights will not adversely affect the way that USFHP or our providers treat you.
- File complaints, appeals, and grievances with us.
- Request that ongoing benefits be continued during appeals (although you may have to pay for the continued benefits if our decision is upheld in the appeal).
- Receive a second opinion from another doctor in USFHP's network if you disagree with your doctor's opinion about the services that you need. Contact us at 1-800-808-7347 for help with this.
- Receive other information about us such as how we are managed. You may request this information by calling 1-800-808-7347.
- Receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

You have the responsibility to:

- Carry your membership card with you at all times and know your eligibility status with USFHP. If you lose your card, you can obtain a new one by calling Customer Service.
- Follow your plan's referral and prior authorization guidelines and policies.
- Cancel doctor's appointments if you cannot keep them.
- Pay any applicable co-pay, coinsurance, and deductible at the time of service.
- Report any other health insurance coverage to your doctor and to USFHP.
- Report any communicable diseases, family history, problem with substance abuse, and any other information your doctor may need in order to provide adequate care.

- Cooperate with health care providers and follow their instructions.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Health Information and Personal Privacy

Members have the right to communicate with health care providers and the Plan in confidence and to have the confidentiality of their individually identifiable health care information protected.

Members have the right to expect that all records and communications about their care are confidential and will not be released without their written permission, except when release is required or authorized by federal or state law.

Health information concerning members will be secured from unauthorized access.

Members have the right to review, copy, and request amendments to their own medical and Plan records.

Members have the right to every consideration of their privacy and confidentiality of information, within the limits of the law. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. Those not directly involved in their care must have their permission to be present. Their legal representative has the right to access information contained in the medical record within the limits of the law.

Members have the right to personal privacy in the course of receiving medical care, including privacy in the exam rooms, offices, labs, procedure rooms, and all other clinical areas. Members have the right to expect that all appropriate courtesies and cautions will be extended by staff, especially when disrobing and after having disrobed.

Choice of Health Care Providers

Members have the right to a choice of health care providers that is sufficient to ensure access and high-quality health care.

Access to Emergency Services

Members have the right to access emergency services when and where the need arises. The Plan provides payment when a member presents to an emergency department with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in placing the member's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Participation in Treatment Decisions

Members have the right and responsibility to participate fully in all health care decisions. Members who are unable to participate fully in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators. Members have the right, as permitted by law, to have a designated representative decision maker in the event members should become incapable of making an informed decision.

Members or their legal representatives have the right to obtain from their health care provider complete and current information about their diagnosis, treatment and prognosis in words members can understand.

Members or their legal representatives have the right to participate in decisions about the intensity and scope of their treatment, within the limits of the organization's philosophy and mission and applicable law and regulation.

Members have the right to expect reasonable continuity of care.

Members have the right to express their wishes regarding their future health care by way of a living will or advance directives. Members have the right to be educated and informed about advance directives. The advance directive will be documented in their medical record.

Members have the right to expect their health care provider to abide by their advance directive to the extent provided by law.

Members have the right to refuse treatment to the extent permitted by law. Members have the right to be informed of the medical consequences of refusing treatment.

Members have the right to participate in the consideration of ethical issues that arise in their health care.

Appeals, Complaints and Grievances

Members have a right to a fair and efficient process for resolving differences with the Plan and health care providers including a system of internal review and an independent system of external review.

Members have the right to express complaints and concerns about the quality of their care without fear of reprisal or compromise of future access to care.

Nondiscrimination and Respect

Members have the right to be treated with dignity and respect, to receive care without regard to race, color, creed, religion, sex, age, national origin, sexual orientation, or disability. Members have the right to access to an interpreter when members do not understand the language of the community.

Members have the right to respectful, responsive care directed to fostering their comfort and dignity, providing appropriate treatment for primary and secondary symptoms as desired by members or their designated representative, appropriately managing pain and responding to members and their family's psychosocial, spiritual, and cultural concerns.

MEMBER RESPONSIBILITIES

Members are responsible for becoming knowledgeable about their health plan coverage including all covered benefits, limitations, and exclusions. Members are also responsible for becoming knowledgeable about US Family Health Plan policies and procedures including rules regarding the use of emergency services, the use of network providers, and referral and authorization requirements. Members are responsible for following the administrative and operational procedures of the Plan and all health care providers.

Members are responsible for providing accurate and complete information about present complaints, past illness, and allergies, hospitalizations, medications, and other matters relating to their health. Members are responsible for reporting unexpected changes in their condition to their health care provider.

Members are responsible for making it known whether they clearly comprehend a contemplated course of action and what is expected. Members are also responsible for clearly communicating wants and needs.

Members are responsible for working with the health care provider to develop a treatment plan and for following the recommended treatment plan. Members are also responsible for the consequences of refusing treatment or failing to follow instructions provided by their health care provider.

Members are responsible for keeping appointments and, when unable to do so, for notifying the appropriate health care professional.

Members are responsible for being considerate of the rights and property of

other patients and health care personnel.

Members are responsible for informing the Plan of any change in name, address, phone number, or other health insurance information and for maintaining up-to-date information in the Defense Enrollment Eligibility Reporting System (DEERS).

Members are responsible for informing their health care provider if they have an advance directive, living will, or a durable power of attorney for health care or similar documents.

Members are responsible for informing health care providers of problems with their care so that they may assist members in resolving them.

Members are responsible for maintaining healthy habits and avoiding knowingly the spread of disease.

Members are responsible for using the Plan's internal complaints, grievances, and appeals processes to address concerns.

Members are responsible for recognizing the risks and limits of medical care and the human fallibility of the health care professional.

Members are responsible for reporting wrongdoing, fraud, and abuse to the appropriate Plan or legal authorities.

Members are responsible for being aware of the health care provider's duty to be reasonably efficient and equitable in providing services.

MEDICAL RECORD DOCUMENTATION

JHHC ensures that the medical records of all primary care practitioners in our network are maintained in a manner that is current, detailed, organized, permits effective and confidential patient care and quality review, and meets established goals for medical record keeping by conducting medical record documentation audits. The medical record documentation standards are available to all practitioners and appropriate staff via the plan website. The standards include a requirement for a member specific record that includes the member name or identification number on each page of the record.

JHHC has developed performance goals for reviews of medical record documentation that include best practices, acceptable and not acceptable ranges. Practitioners that score in the “not acceptable” range will be required to submit a corrective action plan (CAP). Practitioners will be notified in writing of audit results. A copy of all correspondence related to the Medical Record Documentation audit will be included in the practitioner’s file. The audit results will be analyzed and presented to the appropriate Quality Improvement Committee.

MEMBER ELIGIBILITY VERIFICATION

All TRICARE eligible members listed in the DoD’s Enrollment Eligibility Reporting System (DEERS) database as eligible for military health care benefits may enroll in TRICARE Prime. These non-active duty individuals include the spouse, former spouse and children of active duty personnel, retirees and their spouses and children, survivors and former spouses. The Plan may not enroll active duty members.

Before providing services, a provider should verify eligibility by calling Provider Services at 410-424-4528 or toll free at 800-808-7647 in Maryland.

MEMBER ENROLLMENT AND DISENROLLMENT

TRICARE-eligible members may enroll in TRICARE Prime at any time during the year simply by completing an enrollment application and paying an enrollment fee, if applicable. No eligible member who lives in the geographic service area shall be denied enrollment, re-enrollment, or be required to disenroll because of a prior or current medical condition.

A member should choose a PCP (internist, family practitioner, or pediatrician) based upon personal choice and/or residence zip code. Once accepted into the practice, the member agrees to obtain all routine care from the PCP or another provider to whom the member is referred to by the PCP.

Once enrolled, the member will be issued a Johns Hopkins USFHP identification card. The enrollment period will be in effect for 12 months. If the member becomes dissatisfied with their PCP, the member may choose another primary care physician from the network. The member should contact Customer Service to initiate the change. Those members changing primary care sites will receive an updated identification card.

Disenrollment is the responsibility of the member and may occur at the end of the 12-month period or when moving out of the area. A member who requests early disenrollment, for reasons other than moving out of the area, may not re-enroll in TRICARE Prime for 12 months.

COMPLIANCE WITH CONTRACT, FEDERAL, STATE AND LOCAL REGULATIONS

Providers will comply with all Federal, State and Local requirements. However, providers will not:

- Make distinctions in the provision of services based on age, sex, disability, race, color, religion or national origin.
- Deny a member any service, benefit or availability of a provider based on age, sex, disability, race, color, religion or national origin.
- Provide a service or benefit that is different, or provide in a different manner or on a different schedule, from any other member for any reason other than medical necessity and/or capacity.
- Segregate or separate treatment based on age, sex, disability, race, color, religion or national origin.
- Treat a member differently from others in receiving any covered service or benefit that is offered to other members.
- Treat a member differently from others in receiving any covered service or benefit that is offered to other members.
- Treat a member differently from others in order to provide a service or benefit.
- Assign times or places to obtain services based on age, sex, disability, race, color, religion or national origin.

PRIVACY AND RELEASE OF MEMBER INFORMATION AND/OR RECORDS

It is the policy of Johns Hopkins to protect the privacy rights of all patients, health plan members, employees, students and donors; to maintain the confidentiality of patient information, health plan information, medical records, research information and business operations; and to comply with all applicable laws and regulations, including the Privacy Regulations under the Health Insurance Portability and Accountability Act (HIPAA).

Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information according to the term of the Participating Provider Agreement and Payor Addendum.

The privacy and security components of HIPAA provide broad reaching protections for individually identifiable health information. The transaction and code sets component to HIPAA requires conformity to precise rules in the electronic transmission of financial health information. The Johns Hopkins community has taken steps to ensure that we comply with these requirements regarding the use, disclosure, security, and transmission of an individual's (alive or dead) health information in any form (e.g., on paper, transmitted electronically, recorded or spoken), the treatment of their health condition, and/or the billing/payment for their health services.

MEMBER SAFETY

Providers will be encouraged to participate in Plan sponsored Patient Safety programs. The Plan encourages optimizing patient outcomes and communication through the implementation of a patient safety program that will provide an evidence-based approach utilizing information, people, and resources to achieve the best clinical quality outcomes and the prevention of medical errors and patient harm. The DoD currently uses a comprehensive set of evidence based and field-tested tools and strategies called Team Strategies & Tools to enhance Performance & Patient Safety (TeamSTEPPS™) that are applicable to any healthcare setting.

CONFIDENTIALITY

Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information according to the terms of the Participating Provider Agreement and Payor Addendum.

COMMUNICATION WITH COVERED PERSON

JHHC welcomes all opportunities for the provider community to speak freely with their members or other designated parties connected to this organization. Participating practitioners are encouraged to discuss treatment options with members, **regardless of benefit coverage limitations**. You should explain the pros and cons of each treatment option so the member can make an informed decision.

PEER TO PEER CONVERSATION

After a provider receives a verbal notification of a denial, but before an actual written notification has been sent to the provider, the provider has the right to discuss determinations with the Medical Director, according to the Johns Hopkins HealthCare Policy entitled: Medical Review for Initial Determination.

AUTHORIZATION NOTIFICATION

When a provider requests an authorization for a member, and Johns Hopkins HealthCare approves that authorization, we ask that you notify the member that their authorization has been approved.

HEALTHY PEOPLE 2010

Healthy People 2010 are a set of health objectives for the Nation to achieve over the first decade of the new century. It can be used by many different people, States, communities, professional organizations, and others to help them develop programs to improve health.

Healthy People 2010 builds on initiatives pursued over the past two decades. The 1979 Surgeon General's Report, *Healthy People*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Both established national health objectives and served as the basis for the development of State and community plans. Healthy People 2010 are a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

Healthy People 2010 are designed to achieve two overarching goals:

- **Increase Quality and Years of Healthy Life**
The first goal of Healthy People 2010 is to help individuals of all ages increase life expectancy and improve their quality of life.
- **Eliminate Health Disparities**
The second goal of Healthy People 2010 is to eliminate health disparities among different segments of the population.

Examples of focus area goals are:

- **Cancer:**
Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.
- **Disability and Secondary Conditions:**
Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population.

- **Food Safety:**
Reduce food borne illnesses.

For additional information, access the website at: www.healthypeople.gov

THIRD PARTY LIABILITY

It is the policy of Johns Hopkins HealthCare to do the following:

- **US Family Health Plan Payor Status.** If other health insurance coverage exists, Plan coverage is available only as a secondary payor (except in cases involving Medicaid, Indian Health Services, and Veteran's Administration) and only after a claim has been filed with the double coverage plan and a payment determination issued. A double coverage payment determination must be issued regardless of any provisions contained in the other coverage. As secondary payor, the Plan's liability is no greater than it would have been in the absence of double coverage and does not extend to non-covered services. The Plan is responsible for the lower of the amount it would have paid as primary payor or the balance after the other health insurance has paid.
- **Primary Payor Disputes.** As a TRICARE Prime Designated Provider, under Federal Law, Title 10, U.S.C., Chapter 55, Section 1079 (j)(1), the US Family Health Plan always serves as the secondary payor when double coverage applies. The Plan does not compromise its secondary payor status unless directed to do so by TRICARE Management Activity (TMA). The Plan attempts to resolve all disputes over primary payor status directly with the double coverage plan and maintains written documentation of all dispute resolution efforts.
 - For Plan members with double coverage and Medicare, it is the policy of the US Family Health Plan to accept reduced payments from the other health insurance plan that recognizes its primary status but only pays an amount that supplements the benefit payable by Medicare if Medicare would otherwise be primary. This policy is in accordance with all TRICARE Management Activity directives. When a payor refuses to recognize its primary status and to issue referrals or preauthorization accordingly, the Plan issues the referral or pre-authorization and documents the payor dispute in its records.

- **Lack of Payment by Other Health Insurer.** The Plan is prohibited from paying amounts denied by the other health insurer because the claim was not filed in a timely manner or because the member failed to satisfy some other requirement. If a statement from the other health insurer regarding how much would have been paid had all requirements been met is provided to the Plan, the claim may be processed as if the other health insurer actually paid the amount shown on the statement. If no such documentation is provided, the Plan must deny the claim.
- **Prohibition on Waiving OHI Benefits.** Members may not waive benefits due from any Insurance Plan or Medical Service or Health Plan. If a double coverage plan provides, or may provide, benefits for a service, a claim must be filed with the double coverage plan. Refusal by the member to claim benefits from other health insurance must result in a denial of Plan benefits.
- **Determination of Double Coverage.** The Plan maintains accurate and current other health insurance information in order to coordinate double coverage benefits. All double coverage information is verified with the member and the other health insurance plan. When the Plan is aware of the existence of an effective double coverage plan, the other health insurance plan must submit evidence of processing with the claim before the Plan adjudicates the claim as secondary payor.
- **Marketing and Enrollment Limitations.** The Plan does not intentionally market to and enroll Military Health System (MHS) members who have other health insurance or are enrolled in the MHS direct care system. Marketing efforts are directed toward those MHS members listed on the DEERS data file provided by the government. MHS members covered under the Federal Employee Health Benefits Plan (FEHBP) may enroll in the Plan after providing proof that they have elected to suspend their FEHBP coverage in accordance with 5 CFR Part 890 or they may join the plan without suspending coverage and they will be counted towards the allowed members with OHI.
- **Timely Filing.** The timely filing limit for COB claims is 180 days from the date the primary insurance adjudicated the original claim.
- **Court Order.** US Family Health Plan is primary except in circumstances listed above. The Plan will dispute any court orders stating otherwise and pay as secondary.

WORKER 'S COMPENSATION

TRICARE benefits are not payable for work-related illnesses or injury that is covered under a Worker's Compensation program. The TRICARE member may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. The member must apply for Worker's Compensation benefits. Failure to apply does not change the TRICARE exclusion.

FRAUD AND ABUSE

Abuse generally describes incidents and practices that may directly or indirectly cause financial loss to the Government under TRICARE or to TRICARE members. Abuse is defined in 32 CFR 199.2. Providers have obligations to furnish services and supplies under TRICARE at the appropriate level and only when and to the extent medically necessary as determined under 32 CFR 199.9. The quality must meet professionally recognized standards of health care and be supported by adequate medical documentation as may reasonably be required to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. A provider's failure to comply with these obligations can result in sanctions. Abuse situations are a sufficient basis for denying all or any part of TRICARE cost-sharing of individual claims.

ABUSE, under TRICARE, includes but is not limited to the following:

- A pattern of waiver of member (patient) cost-share or deductible.
- Improper billing practices, such as charging TRICARE members rates for services and supplies that are in excess of those charges routinely charged by the provider to the general public, commercial health insurance carriers, or other federal health benefit entitlement programs for the same or similar services. (Dual fee schedules – one for TRICARE members and one for other patients or third-party payers. Such as, billing other third-party payers the same as TRICARE is billed but accepting less than the billed amount as reimbursement.)
- Pattern of submitting claims for non-medically necessary services or, if medically necessary, not to the extent rendered. Battery of diagnostic tests are given when, based on the diagnosis, fewer tests were needed.
- Care of inferior quality. Consistently furnishing medical or mental health services not meeting accepted standards of care.
- Failure to maintain adequate medical or financial records.

- Refusal to allow the Government (TRICARE Management Activity) or its contractors access to records related to TRICARE claims.
- Billing substantially in excess of customary or reasonable charges unless it is determined by TMA that the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities when it is accepted medical practice to make an extra charge in such cases.
 - Unauthorized use of the term “TRICARE “ in private business.

Fraud is defined in 32 CFR 199.2. -under TRICARE, includes but is not limited to the following:

Submitting TRICARE claims (including billings by providers when the claim is submitted by the member) for services, supplies, or equipment not furnished to, or used by, TRICARE members. Examples:

- billing or claiming services when the provider was on call and did not provide any specific medical care to the member;
- providing services to an ineligible person and billing or submitting a claim for the services in the name of an eligible TRICARE member;
- billing or submitting a TRICARE claim for an office visit for a missed appointment; or
- billing or submitting a TRICARE claim for individual psychotherapy when a medical visit was the only service provided.

Billing or submitting a TRICARE claim for costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items. Examples:

- billing for TRICARE claims for services which would be covered except for the frequency or duration of the services, such as billing or submitting a claim for two one-hour psychotherapy sessions furnished on separate days when the actual service furnished was a two-hour therapy session on a single day;
- spreading the billing or claims for services over a time period that reduces the apparent frequency to a level that may be cost shared by TRICARE;
- charging to TRICARE, directly or indirectly, costs not incurred or reasonably allowed to the services billed or claimed under TRICARE, for example, costs attributable to non-program activities, other enterprises, or the personal expenses of principals; or

- Billing or submitting a claim on a fee-for-service basis when in fact a personal service to a specific patient was not performed and the service rendered is part of the overall management of, for example, the laboratory or x-ray department.
- Breach of a provider participation agreement, which results in the member (including parent, guardian, or other representative) being billed for amounts, which exceed the TRICARE-determined allowable charge or cost.
- Misrepresenting dates, frequency, duration or description of services rendered, or of the identity of the recipient of the services or the individual who rendered the services.
- Submitting falsified or altered TRICARE claims or medical or mental health patient records, which misrepresent the type, frequency, or duration of services or supplies or misrepresent the name(s) of the individuals who provided the services or supplies.
- Duplicate billings or TRICARE claims, including billing or submitting TRICARE claims more than once or the same services, billing or submitting claims both to TRICARE and other third-parties (such as other health insurance or government agencies) for the services, without making full disclosure of material facts or immediate, voluntary repayment or notification to TRICARE upon receipt of payments which combined exceed the TRICARE-determined allowable charge of the services involved.
- A provider misrepresenting his or her credentials. A provider concealing information or business practices, which bear on his/her qualifications for authorized TRICARE provider status, such as a provider representing that he or she has a qualifying doctorate in clinical psychology when the degree is not from a regionally accredited university.

Reciprocal Billing: Billing or claiming services that were furnished by another provider or furnished by the billing provider in a capacity other than as billed or claimed. For example, practices such as the following:

- One provider performing services for another provider and the latter bills as though he had actually performed the services (e.g. a weekend fill-in);
- providing service as an institutional employee and billing as a provider for the services;
- billing for professional services when the services were provided by another individual who was an institutional employee;
- billing for professional services at a higher provider profile than would be paid for the person actually furnishing the services, (for example, bills reflecting that an M.D. or Ph.D. performed the services when

- services were actually furnished by a licensed social worker, psychiatric nurse, or marriage and family counselor); or
- an authorized provider billing for services which were actually furnished by an unauthorized or sanctioned provider.
 - Submitting TRICARE claims at a rate higher than a rate established between TRICARE and the provider, if such a rate has been established. For example, billing or claiming a rate in excess of the provider's most favored rate limitation specified in a residential treatment center agreement.
 - Arrangements by providers with employees, independent contractors, suppliers, or others that appear to be designed primarily to overcharge the TRICARE through various means (such as commissions, fee-splitting, and kickbacks) used to divert or conceal improper or unnecessary costs or profits.
 - Agreements or arrangements between the supplier and recipient (recipient could be either a provider or member, including the parent, guardian, or other representative of the member) that result in billings or claims, which include unnecessary costs or charges to TRICARE.