2024 Provider Manual

Advantage MD

JOHNS HOPKINS HEALTH PLANS

Revised 4/24

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OUR PHILOSOPHY

Advantage MD has three strategic principles regarding health care:

Medical care is a respected, sacred trust and privileged relationship that develops between patient and doctor.

Each patient is treated with dignity and respect. Advantage MD values patient confidentiality and vows to service each patient's health care needs efficiently and professionally.

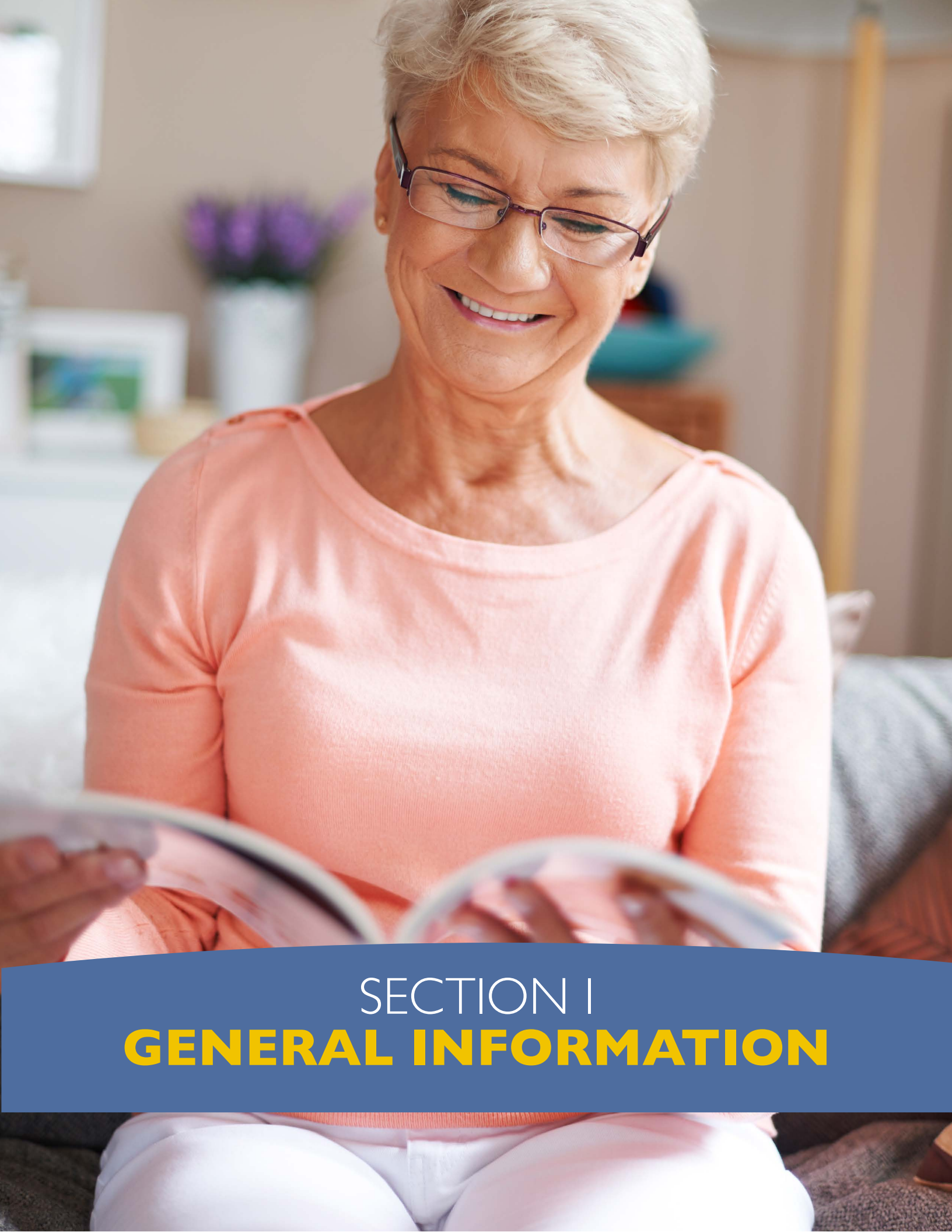
Each plan member is Advantage MD's most important member.

This provider manual gives you important details about information concerning the roles of the provider and office staff in the delivery of health care to our members and your patients. This provider manual provides critical information regarding provider and plan responsibilities and should be used in conjunction with your Hopkins Health Advantage Medicare contract.

MEDICARE ADVANTAGE (PART C)

In 2003, additional legislation was signed to create Medicare Advantage plans that replace and cover all the benefits in traditional Medicare Part A and Part B. Medicare Advantage plans (Part C) provide all Part A (hospital) and Part B (medical) coverage and must cover all medically necessary services.

A member must be enrolled in Medicare Part A and B to join Medicare Advantage plans. These plans are part of the government's Medicare program, but they are offered and managed through approved private insurers, such as Johns Hopkins Advantage MD, and may offer plan extras (dental and vision) not found in original Medicare.



SECTION I
GENERAL INFORMATION

PLAN OVERVIEW

Johns Hopkins Health Plans offers multiple Medicare Advantage products:

- Johns Hopkins Advantage MD (HMO)
- Johns Hopkins Advantage MD PPO and PPO Plus (PPO)
- Johns Hopkins Advantage MD PPO Premier (Available only in Montgomery County, Maryland)
- Johns Hopkins Advantage MD Group (PPO) (eligibility restrictions apply)
- Johns Hopkins Advantage MD D-SNP (HMO) (See Section 5 for description)
- Johns Hopkins Advantage MD Tribute (HMO) (Available only in Anne Arundel, Baltimore, Montgomery, Howard, and Frederick counties, Maryland)
- Johns Hopkins Advantage MD Select (HMO) (Available only in Arlington, Fairfax City, Falls Church City)
- Johns Hopkins Advantage MD PPO Primary (PPO) (Available only in Anne Arundel, Baltimore, Montgomery, Howard, and Frederick counties, Maryland)

All plans include Medicare Part D prescription drug coverage for Medicare-eligible residents in 10 counties throughout Maryland. These counties include:

- Anne Arundel
- Baltimore
- Carroll
- Frederick
- Howard
- Montgomery
- Somerset
- Washington
- Wicomico
- Worcester

MEDICARE ADVANTAGE ENROLLMENT PERIODS

Initial Enrollment Periods

- Initial Enrollment Periods
  - » Seven-month period
    - Three months before the month the member turns 65, the month the member turns 65, or three months after the member turns 65
- Annual Election Period
  - » October 15 through December 7
    - Coverage takes effect on January 1
- Medicare Advantage Open Enrollment Period
  - » January 1 through March 31
    - Members of Medicare Advantage plans can switch to other Medicare Advantage Plans or to Original Medicare
- Special Enrollment Periods
  - » Member moves out of service area
  - » Plan leaves Medicare program or reduces service area

MEMBER RIGHTS, MEMBER RESPONSIBILITIES

Members have the right to:

- Be treated with dignity and respect at all times.
- Be protected from discrimination.
- Have their personal and health information kept private.
- Get information in a way they understand from Medicare, health care providers, and contractors.
- Get clear and simple information about Medicare to help them make health care decisions.
- Have their questions about Medicare answered.
- Have access to doctors, specialists, and hospitals.
- Learn about their treatment choices in clear language they can understand, and participate in treatment decisions.
- Get health care services in a language they understand and in a culturally sensitive way.
- Get emergency care when and where they need it.
- Get a decision about health care payment, coverage of services, or prescription drug coverage.
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.
- File complaints (sometimes called "grievances"), including complaints about the quality of their care.
- Choose health care providers within the plan, so they can get the health care needed.
- Get a treatment plan from their doctor.
- Know how their doctors are paid.
- Request an appeal to resolve differences with their plan.
- File a complaint (called a "grievance") about other concerns or problems with their plan.
- Get a coverage decision or coverage information from their plan before getting services.

Before members get an item, service, or supply, they can call your plan to find out if it will be covered or get information about your coverage rules. They can also call their plan if they have questions about home health care rights and protections. The plan must tell them if they ask.

Members have the responsibility to:

- **Get familiar with their covered services and the rules they must follow to get these covered services.** Use the Evidence of Coverage booklet to learn what is covered for members and the rules they need to follow to get their covered services. Chapters 3 and 4 give the details about their medical services, including what is covered, what is not covered, rules to follow, and what they pay. Chapters 5 and 6 give the details about their coverage for Part D prescription drugs. If they have any other health insurance coverage or prescription drug coverage in addition to our plan, they are required to tell us. Please tell members to call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - » We are required to follow rules set by Medicare to make sure that they are using all of their coverage in combination when they get their covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug

benefits they get from our plan with any other health and drug benefits available to them. We'll help them coordinate their benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- **Tell their doctor and other health care providers that they are enrolled in our plan.** Show their plan membership card whenever they get their medical care or Part D prescription drugs.
- **Help their doctors and other providers by giving them information, asking questions, and following through on their care.** To help their doctors and other health providers give them the best care, learn as much as they are able to about their health problems and give them the information they need about them and their health. Make sure members follow the treatment plans and instructions that they and their doctors agree upon. Make sure you know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements

  Be sure to ask if they have any questions. Their doctors and other health care providers are supposed to explain things in a way they can understand. If they ask a question and they don't understand the answer they are given, they need to feel empowered to ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect them to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.

- **Pay what they owe.** As a plan member, they are responsible for these payments:
  - » In order to be eligible for our plan, they must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan

    For most of their medical services or drugs covered by the plan, they must pay their share of the cost when they get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what they must pay for their medical services. Chapter 6 tells what they must pay for their Part D prescription drugs. If they get any medical services or drugs that are not covered by our plan or by other insurance they may have, they must pay the full cost.

    If they disagree with our decision to deny coverage for a service or drug, they can make an appeal. Please see Chapter 9 of the Evidence of Coverage for information about how to make an appeal.

  - » If they are required to pay a late-enrollment penalty, they must pay the penalty to keep their prescription drug coverage.
  - » If they are required to pay the extra amount for Part D because of their yearly income, they must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if they move.** If they are going to move, it's important to tell us right away by calling Customer Service (phone numbers are printed on the back cover of this booklet). **If they move outside of our plan service area, they cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help them figure out whether they are moving outside our service area. If they are leaving our service area, they will have a Special Enrollment Period when they can join any Medicare plan available in their new area. We can let them know if we have a plan in their new area.

- **If they move within our service area, we still need to know** so we can keep their membership record up to date and know how to contact them.

  If they move, it is also important to tell Social Security (or the Railroad Retirement Board). They can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Customer Service for help if they have questions or concerns.** We also welcome any suggestions they may have for improving our plan. Phone numbers and calling hours for Customer Service are printed on the back cover of the Evidence of Coverage.

For more information on how to reach us, including our mailing address, please see Chapter 2.

MEMBER HOLD HARMLESS

Participating providers are prohibited from balance billing Advantage MD members including, but not limited to situations involving non-payment by Advantage MD, Advantage MD's breach of its Agreement, or insolvency of Advantage MD. Providers cannot bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons other than Advantage MD, acting on behalf of members for covered services pursuant to the Participating Provider's Agreement. The provider is not prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable member's benefit plan.

GENERAL CONTACT INFORMATION

Eligibility, Claims Status or Provider Payment Dispute

Advantage MD Customer Service

PPO Products

Phone 877-893-5325
Fax 855-206-9203
TTY 711

HMO Products

Phone 877-293-4998
Fax 855-206-9203
TTY 711

Hours of Operation

Oct. 1 through Mar. 31
Monday through Sunday, 8 a.m. to 8 p.m.

Apr. 1 through Sept. 30
Monday through Friday, 8 a.m. to 8 p.m.

Provider Relations

(For demographic changes, contract status and fee schedule questions)

Phone 888-895-4998
410-762-5385
Fax 410-424-4604

Monday through Friday, 8 a.m. to 5 p.m.

Websites

Providers HopkinsHealthPlans.org
Members www.hopkinsmedicare.com

Availity Provider Portal

Johns Hopkins Health Plans uses Availity Essentials as its secure, real-time provider portal. Provider offices can view remittances, validate eligibility and benefits and track claims with ease.

Please Note: As we transition fully to the new provider portal, our current portal, **HealthLINK**, will still be available so providers can access needed functions and resources.

**First time users must register for an account. If you need assistance with registration, please contact Provider Relations at 888-895-4998.*

Mailing Address for Paper Medical Claims

Advantage MD

P.O. Box 3537
Scranton, PA 18505

Mailing Address for Medical Payment Disputes

Advantage MD

P.O. Box 3537
Scranton, PA 18505

SECTION 2
PROVIDER RESPONSIBILITIES

PRIMARY CARE PROVIDER

A Primary care provider (PCP) is a physician or nurse provider who manages the primary and preventive care of Advantage MD members and acts as a coordinator for specialty and inpatient care.

ROLES AND 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 that care directly or refers the member to the appropriate in-network 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.

Providers give or arrange for the provision of covered services for members in a manner consistent with professionally recognized health care standards and Advantage MD procedures such as:

- Providing timely, accessible health care to members.
- Emergency Care – a sudden, severe onset of illness or a medical problem requiring immediate attention. The member should receive care immediately.
- Urgent Care – a sudden, severe onset of illness or a medical problem requiring attention within 24 hours. The member should be seen the same day or within 24 hours.
- Non-Urgent/Non-Emergent – within seven days
- Routine Care – a medical problem or illness that is ongoing but presents no immediate medical danger or acute distress. The member should be scheduled as soon as the PCP has an opening in his/her schedule, but no later than 30 calendar days.
- Health Maintenance – Preventive care services should be scheduled within 30 calendar days.
- Maintaining coverage for emergency services 24 hours-a-day, 7 days a week with a participating provider. PCPs are required to have one of the following mechanisms in place to ensure proper after-hours coverage for their practice:
  - » Provider has an answering service with specific instructions on how the member can reach the provider directly for urgent services and how to access emergency services
  - » Pager service to gain access to the provider with specific instructions on how the member can reach the provider directly for urgent services and how to access emergency services
  - » Answering machine with specific instructions on how the member can reach the provider directly for urgent services and how to access emergency services
- Cooperating and complying with Advantage MD utilization management procedures.
- Cooperating and complying with all Advantage MD quality management policies and procedures and performance improvement activities.

- Not differentiating or discriminating in the treatment of members on the basis of source of payment for covered services, gender, age, race, color, religion, origin, place of residence, economic or health status, disability, or medical condition, including mental as well as physical condition, claims experience or medical history.
- Complying with credentialing and re-credentialing requirements.
- 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.

ROLE OF SPECIALTY CARE PROVIDERS

- Obligations of the specialist also include the following:
- Complying with all applicable statutory and regulatory requirements of the Medicare program
- Meeting eligibility requirements to participate in the Medicare program
- Accepting all members referred to him or her if the referrals are within the scope of the specialist's practice
- Submitting required claims information
- Arranging for coverage with other network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (when required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit
- Notifying both the PCP and Advantage MD, as well as requesting precertification from Advantage MD as appropriate, when scheduling a hospital admission or any other procedure requiring Advantage MD's approval

AVAILABILITY STANDARDS FOR PROVIDERS

A PCP must have their primary office open to receive Advantage MD members five days and for at least 20 hours per week. The PCP must ensure that coverage is available 24-hours-a-day, seven-days a week. A PCP must arrange for coverage during absences with another Advantage MD participating provider in an appropriate specialty that is documented on the Provider Application and agreed upon in the Provider Agreement.

ACCESS STANDARD GUIDELINES

Service	Appointment Wait time *(not more than)*
PCP Routine/Preventive Care	30 calendar days
PCP Non-Urgent (Symptomatic)	Seven (7) calendar days
PCP Urgent Care	Immediate/Same Day
PCP Emergency Services	Immediate/Same Day
Specialist Routine	30 calendar days
Specialist Non-Urgent (Symptomatic)	Seven (7) calendar days
Behavioral Health Routine Initial	10 business days
Behavioral Health Routine Follow-up	30 calendar days
Behavioral Health Urgent	Immediate
Behavioral Health Emergency	Immediate
Office Wait Time	30 minutes

* The access standards are based on CMS guidelines

MEDICAL RECORD STANDARDS

Advantage MD requires the following items in members' medical records:

- Identifying member information.
- Identification of all providers participating in the member's care and information regarding services furnished by these providers.
- A problem list, including significant illnesses and medical and psychological conditions.
- Presenting complaints, diagnoses, and treatment plans.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions).
- Information on advanced directives.
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the member relevant to the particular treatment.

Note: Unless otherwise specifically stated in your provider services agreement, medical records will be provided at no cost to Advantage MD members.

ADVANCE MEDICAL DIRECTIVES

The Federal Patient Self-Determination Act ensures the patient's right is to participate in health care decision-making, including decisions about withholding resuscitative services, and declining or withdrawing life sustaining treatment. In accordance with guidelines established by CMS, and our own policies and procedures, Advantage MD requires all participating providers to have a process in place pursuant to the intent of the Federal Patient Self-Determination Act.

The member may inform all providers contracted directly or indirectly with Advantage MD that the

member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his or her medical record.

If the PCP or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he or she must advise the member and Advantage MD. Advantage MD and the PCP and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Federal Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To make sure that providers maintain the required processes regarding Advance Directives, Advantage MD conducts periodic patient medical record reviews to confirm that the required documentation exists.

If a member requests additional information, please refer them to **www.hopkinsmedicare.com** or Customer Service:

- Advantage MD PPO, PPO Plus & Group – 877-293-5325
- Advantage MD HMO – 877-293-4998

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 Johns Hopkins Health Plans Participating Provider Agreement and Hopkins Health Advantage Payor Addendum.

At Advantage MD, we know our members' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our members' personal information. Advantage MD does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued provider to Advantage MD, we want you to know the steps we have taken to protect the privacy of our members. This includes how we gather and use their personal information. Advantage MD's privacy practices apply to all of Advantage MD's past, present, and future members.

When a member joins an Advantage MD Medicare Advantage plan, the member agrees to give Advantage MD access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium.

Access to PHI allows Advantage MD to work with providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the members' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows Advantage MD to look at how care is delivered and carry out programs to improve the quality of care Advantage MD's members receive. This information also helps Advantage MD manage the treatment of diseases to improve our members' quality of life.

Advantage MD's members have additional rights over their health information. They have the right to:

- Send Advantage MD a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Advantage MD's member to the source of the information.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.
- Receive an accounting of Advantage MD's disclosures of their medical information, except when those disclosures are for treatment, payment, or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect member PHI. To discuss any breaches of the privacy of our members, please contact our Corporate Compliance office at 420-424-4996 or fax 410-762-1527, or email compliance@jhhp.org

PCP ASSIGNMENT

Advantage MD PPO, PPO Plus, PPO Primary, PPO Premier & Group Plans

Selection of a PCP is not required; however, members are encouraged to select a PCP in order to:

- Ensure they have a medical home upon enrollment and
- Facilitate coordination of care

PCPs will not be identified on the member's ID card. You can verify the member's PCP by:

- Calling Customer Service at 877-293-5325 or by accessing your HealthLINK@Hopkins account
  - » Members may be advised to contact Customer Service to update their PCP information
- If a participating provider is not the member's selected PCP, that participating provider may still see the patient at the in-network benefit level
- PCPs will receive monthly reports in regards to their member panel

Advantage MD HMO and HMO Tribute Plans

Member selection of a Primary Care Physician PCP is required in order to:

- Ensure they have a medical home upon enrollment
- Facilitate coordination of care
- Ensure referrals for all specialty services to an in-network provider

If a PCP is not selected by the member at time of enrollment, a PCP will be assigned for the member.

PCPs will be identified on the member's ID card. You can verify the member's PCP by:

- Calling Customer Service at 877-293-4998 or by accessing your HealthLINK@Hopkins account
- PCPs will receive monthly reports in regards to their member panel

Advantage MD HMO does not provide out-of-network benefits.

REFERRAL REQUIREMENTS

Advantage MD PPO, PPO Plus, PPO Primary, PPO Premier & Group Plans

- Referrals are not required

Advantage MD HMO, HMO Tribute and HMO Select Plans

- PCP referrals are required for specialty services
- Referrals should be to an in-network specialty provider only
- There is no out-of-network coverage for the HMO
- PCPs are required to provide the member with a referral advising the reason for referral, including the referring primary care provider's NPI. In Maryland, please use the Maryland Uniform Consultation Referral Form. In Virginia, for the Advantage MD Select (HMO) plan, the PCP would be required to provide the member with a referral form advising the reason for referral including the referring primary care provider's NPI.

CLOSING PATIENT PANELS

When a participating PCP elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against Advantage MD members by closing their patient panels for Advantage MD members only, nor may they discriminate among Advantage MD members by closing their panel to certain product lines. **Providers who decide that they will no longer accept new patients must notify Advantage MD's Provider Relations Department, in writing, at least 30 days before the date on which the patient panel will be closed or the time frame specified in your contract.**

(See General Contact Information, Section I)

SPECIALTY PROVIDERS

A specialty provider is a medical provider 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 PCP
- 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.

COMMUNICATION AMONG PROVIDERS

The PCP should provide the specialist with relevant clinical information regarding the member's care.

The specialist must provide the PCP with information about his/her visit with the member in a timely manner.

The PCP must document in the member's medical record his/her review of any reports, labs, or diagnostic tests received from a specialist.

BEHAVIORAL HEALTH

Behavioral Health provides comprehensive mental health and substance abuse services to its members. The goal is to treat the member with the most appropriate care at the right time, the right place, and at the right level.

Advantage MD's network is comprised of mental health and substance abuse services and providers who identify and treat members with behavioral health care needs. Integration and communication among behavioral health and somatic health providers is most important. Advantage MD encourages and facilitates the exchange of information between and among physical and behavioral health providers. Member follow-up is essential. High-risk members are evaluated and encouraged to participate in Advantage MD's behavioral health focused care management program where education, care coordination, and support are provided to increase member knowledge and encourage compliance with treatment and medication. Advantage MD works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

Behavioral Health Services

Behavioral Health services are available and provided for the early detection, prevention, treatment, and maintenance of the member's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a member may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

Behavioral Health services include:

- Access to Advantage MD's Customer Service for orientation and guidance
- Routine outpatient services to include psychiatrists, addicitionologists, licensed psychologists, licensed and certified clinical social workers (LCSWs), and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice
- Psychiatric evaluation and psychosocial assessment
- Individual and group psychotherapy
- Psychological testing according to established guidelines and needs
- Inpatient hospitalization
- Inpatient and outpatient detoxification treatment
- Medication management
- Partial hospitalization programs

Responsibilities of Behavioral Health Providers

The responsibilities include but are not limited to:

- Provide treatment in accordance with accepted standards of care
- Provide treatment in the least restrictive level of care possible
- Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the member
- Direct members to supportive community resources as needed to maintain or increase member's functionality and ability to remain in the community

Responsibilities of the Primary Care Physician

The PCP can participate in the identification and treatment of the member's behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues
- Treating members with behavioral health care needs within the scope of his/her practice and according to established Clinical Practice Guidelines. These can be members with comorbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but require treatment.
- Johns Hopkins Health Plans has adopted Clinical Practice Guidelines developed by specialty groups, associations, and other medical organizations as the foundation for our population health programs.
  The complete list of adopted guidelines and web links to download copies is available on the provider section of the **Johns Hopkins Health Plans** website. **Clinical practice guidelines** and **preventative health guidelines** policies are available on our website.

- Consultation and/or referral of complex behavioral health patients or those not responding to treatment
- Communication with other somatic and behavioral health providers on a regular basis

Access to Care

- Members may access behavioral health services as needed:
- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice. They may request a referral to a behavioral health practitioner. Referrals, however, are not required to receive most in-network mental health or substance abuse services.
- Members and providers can call Advantage MD Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations.

Ensuring Equitable Access to Medicare Advantage Services

Per 42 CFR § 422.112 Access to services, Advantage MD and its network of providers must provide services in a culturally competent manner and promote equitable access to all enrollees, including the following:

- People with limited English proficiency or reading skills.
- People of ethnic, cultural, racial, or religious minorities.
- People with disabilities.
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
- People living in rural areas and other areas with high levels of deprivation.
- People otherwise adversely affected by persistent poverty or inequality.

PROVIDER RELATIONS

The Provider Relations Department is a collective team of professionals who act as liaisons between Johns Hopkins Advantage MD and our participating provider network. The network is divided into geographic territories and specialty areas, and each territory is assigned to a contracting network manager and coordinator.

Provider education is an essential responsibility of the department. Your network manager, upon request, will train you and your office staff regarding the Advantage MD program and its benefits.

The Provider Relations team has the following additional responsibilities:

- To develop and provide support services to new and established contracted providers for the purpose of contract education, compliance, and problem solving, and to ensure satisfaction with Advantage MD.
- To provide liaison support internally for provider related issues, including questions or concerns regarding contracts and operations.

- To develop educational materials and/or mailings as needed.
- To develop and maintain provider manual outlining general information specific to Advantage MD policies and procedures applicable to health care professionals.
- Present contracted providers to members via current and accurate online and hard-copy provider directories.
- Identify and pursue opportunities for provider network expansion and enhanced member access to health care.

Provider Relations can be reached by phone at 888-895-4998, or by fax at 410-424-4604.

CHANGES IN PROVIDER INFORMATION

Tax Identification Number

If you have a change in your tax identification number, you are required to notify us immediately. To ensure accurate IRS reporting, the W-9 submitted to Advantage MD must match the information submitted to the IRS. When you notify us of a change to your tax identification number (TIN), please follow these steps:

- If you do not have a current version of the IRS W-9 form, you may download it from their website.
- Complete and sign the W-9 form, following instructions exactly as outlined on the form.
- Include the effective date.
- On a separate sheet of paper, tell us the date you want the new number to become effective (when Advantage MD should begin using the new number).
- Send the completed form with the effective date by fax to 410-424-4604 or mail to:

Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Provider Relations Department

Provider Directory:[1]

Advantage MD is required by CMS to maintain an accurate and up-to-date provider directory. The provider must cooperate with Advantage MD to ensure that your information in the provider directory is accurate and complete. If Advantage MD does not receive cooperation with the verifying provider's current information, the provider may be removed from Johns Advantage MD's provider directory.

[1] Medicare Managed Care Manual Ch.3 §100.4 and HPMS Memo dated August 13, 2015

Changes to provider demographic information (i.e. telephone number, address, suite number, etc.) must be updated in CAQH. All other provider updates must be submitted to Provider Relations, via email to ProviderChanges@jhhp.org or through our online Digital Provider Information Update Form. You can also mail or fax changes using your provider letterhead to:

Advantage MD

Attn: Provider Relations Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax: 410-762-5302

Providers must notify Advantage MD's Provider Relations Department within 30 days of any change in the information set forth in the provider directory, including any change in the provider's ability to accept new patients.

Failure to update CAQH or notify Provider Relations of a change within the timeline set forth may result in claims denial.

PROVIDER COMMUNICATION

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

- *Provider Pulse* – a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories, and news pertaining to our four lines of business, including Advantage MD.
- Johns Hopkins Health Plans Website – **HopkinsHealthPlans.org**
- Advantage MD Website – **www.hopkinsmedicare.com**
- **Medicare Advantage Provider Directories** – includes providers' cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. Please visit the Advantage MD Provider Directory page at **https://medicareadvantage.healthtrioconnect.com/public-app/consumer/provdir/entry.page**

AVAILITY PROVIDER PORTAL

Johns Hopkins Health Plans uses Availity Essentials as its secure, real-time provider portal. Provider offices can view remittances, validate eligibility and benefits and track claims with ease.

The following functions are available for providers as part of the first phase:

- Member eligibility requests and benefit information
- Electronic claims submission
- Claims status

- Remittance and claims payment information
- Insights into financial and administrative transactions

In addition, the new portal will offer the following resources:

- Access to commonly used forms, customer service numbers for our plans, policies and procedures and more.
- Johns Hopkins Health Plans communications and provider education presentations.

Please Note: As we transition fully to the new provider portal, our current portal, **HealthLINK**, will still be available so providers can access needed functions and resources.

If you need assistance with registration, contact your Network Manager or Provider Relations at 888-895-4998.

PROVIDER MARKETING GUIDELINES

The marketing guidelines have been designed to assist Advantage MD providers who have contracted with Medicare Advantage plans, such as Advantage MD, to determine what marketing and member outreach activities are permissible under the Centers for Medicare & Medicaid Services (CMS) guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering, or attempting to steer an undecided potential member toward a specific plan, or limited number of plans, offered either by the plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting plans to market to possible enrollees or assisting in enrollment decisions.

The following is a general guideline to assist Advantage MD providers who have contracted with multiple Medicare Advantage plans and accept Medicare FFS members to determine what marketing and member outreach activities are permissible under the CMS guidelines.

Providers Can:

- Provide the names of Plans/Part D Sponsors with which they contract and/or participate (see section 70.11.2 for additional information on provider affiliation)
- Provide information and assistance in applying for the Low Income Subsidy (LIS)
- Make available and/or distribute plan marketing materials in common areas
- Refer their patients to other sources of information, such as State Health Insurance Assistance Program (SHIP)s, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS' website at **http://www.medicare.gov** or 800-MEDICARE
- Share information with patients from CMS' website, including the "Medicare and You" handbook or "Medicare Options Compare" (from **http://www.medicare.gov**), or other documents that were written by or previously approved by CMS

Providers Cannot:

- Offer scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider

- Mail marketing materials on behalf of Plans/Part D Sponsors
- Offer anything of value to induce enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications within an exam room setting

CULTURAL COMPETENCY

- Health care professionals must provide information regarding treatment options in a culturally competent manner, including the option of no treatment.
- Health care professionals must ensure that enrollees with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.
  - » This includes those members with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.
  - » Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

ANTI-DISCRIMINATION RULES

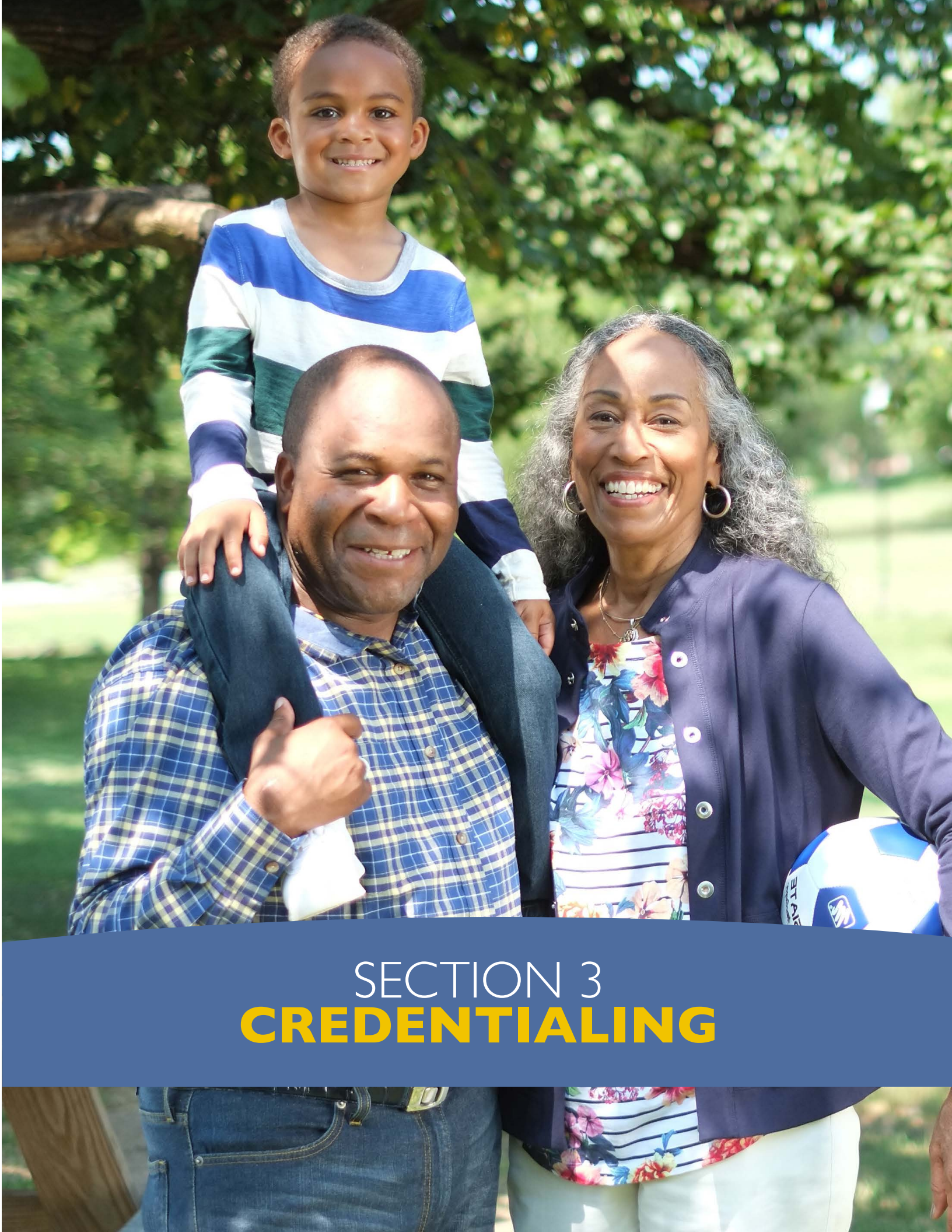
Providers may not discriminate against enrollees based in their payment status, e.g., QMB (Qualified Medicare Beneficiary). Medicare providers may not refuse to serve an enrollee because they receive assistance with Medicare costsharing from a state Medicaid program. For more information, please refer to the CMS website: **https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf**

COMMUNICATION SERVICES

Johns Hopkins Health Plans provides free tools and services to people with disabilities to communicate effectively. Johns Hopkins Health Plans also provides free language services to people whose primary language isn't English (e.g. qualified interpreters and information written in other languages). These services can be obtained by calling the Customer Service number on their member ID card.

You may also contact Johns Hopkins Medicine International for assistance.

- **Language Assistance**
- **Language Services**



SECTION 3
CREDENTIALING

The Johns Hopkins Health Plans Credentialing Program is dedicated to the careful selection and credentialing of providers for inclusion in the Advantage MD provider network. Johns Hopkins Health Plans credentialing criteria defines the licensure, education, and training criteria providers must meet to be considered for inclusion into the Advantage MD participating network.

Prior to becoming Advantage MD network participants, all providers must successfully complete the credentialing process. Providers are requested to submit information, subject to verification by Johns Hopkins Health Plans, to support and provide evidence of appropriate education, training, clinical experience, licensure, professional liability insurance, clinical associations, and professional history. Johns Hopkins Health Plans verifies the submitted information and obtains additional information from the National Provider Data Bank (NPDB), Office of the Inspector General (OIG), state licensing boards, medical specialty boards, and professional certification boards.

The Special Credentials Review Committee (SCRC), a committee of the Board of Directors of Johns Hopkins Health Plans, reviews the providers' credentialing file. 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.

Johns Hopkins Health Plans's 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 nondiscriminatory practices are followed.

CREDENTIALING REQUIREMENTS

All providers and facility/hospitals that are required to be credentialed must remain in full compliance with Johns Hopkins Health Plans credentialing criteria as set forth in the Johns Hopkins Health Plans 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 (re-credentialing event) for as long as the provider or facility/hospital remains an active participant in the Advantage MD provider network.

TYPES OF PROVIDERS REQUIRING CREDENTIALING

Providers who practice in outpatient settings are required to be credentialed. The types of providers that must be credentialed by Johns Hopkins Health Plans prior to participating in the Advantage MD provider network include but is not limited to:

- Primary Care Physicians (medical and osteopathic)
- Specialty Physicians (medical and osteopathic)
- Podiatrists
- Certified Nurse Providers
- Physician Assistants
- Certified Nurse Midwives
- Chiropractors

- Physical Therapists
- Audiologists
- Speech Therapists
- Occupational Therapists
- Clinical Psychologists (doctoral)
- Clinical Social Workers
- Marriage and Family Therapists
- Optometrists
- Organizations including hospitals, home health agencies, skilled nursing facilities (SNF), and free-standing surgical centers

CREDENTIALING PROVIDERS

Initially, provider applicants must submit the Maryland Uniform Credentialing Form (MUCF) to apply for participation. The MUCF is available through the Council for Affordable Quality Healthcare (CAQH) on their website. Providers, who wish to use the online application via CAQH, but are not members of CAQH, may become a member by requesting an invitation through Johns Hopkins Health Plans. There is no cost to the provider for using CAQH. For additional information, questions,
or concerns, please contact Provider Relations at 410-762-5385, or at 888-895-4998.

Alternately, the provider may request a hard-copy MUCF from Johns Hopkins Health Plans or go online to the Maryland State website at **https://insurance.maryland.gov/Insurer/Pages/HealthCareProviders.aspx** and download the MUCF.

The hard copy application must be returned to Johns Hopkins Health Plans for processing.

The provider's application must be complete including all service locations from which the provider will provide medical service to Advantage MD 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 provider must respond to all disclosure questions pertaining to clinical and professional experience and history.

Upon receipt of the application, the provider 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 provider 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 provider is also notified if Johns Hopkins Health Plans 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 Advantage MD provider network or termination of ongoing participation.

Providers have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Providers 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 at 888-895-4998, for their geographic area. The mailing address for Johns Hopkins Health Plans is:

Johns Hopkins Health Plans
Attn: Credentialing Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
410-424-4619

Currently, the following verifications are completed in addition to the collection of the application information and validation of the contractual relationship between Johns Hopkins Health Plans and the provider. These verifications are performed in accordance with the National Committee for Quality Assurance (NCQA), state and federal guidelines and regulations:

- Current licensure as an independent vendor in the state where service will be rendered
- Education – degrees, internship, residency and fellowship programs completed relevant to current licensure
- Medical board certification
- Professional certification
- Work history for the past five 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.
- Verification of Medicare participation

The provider 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 Johns Hopkins Health Plans since the prior credentialing event is also included in the credentialing file and is 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 that 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 Johns Hopkins Health Plans via the 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 an attestation that the health care 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 corrective 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 NCQA, and 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 on Accreditation of Healthcare Organizations (JCAHO), Community Health Accreditation Program (CHAP), Healthcare Facilities Accreditation

Program (HFAP), the American Osteopathic Association (AOA), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Commission on Accreditation of Rehabilitation Facilities (CARF)

- For nonaccredited organizations, Johns Hopkins Health Plans will accept a state assessments/evaluations or CMS review
- Onsite review for organizations without accreditation or State/CMS review
- Professional liability/malpractice insurance
- Verification of Medicare participation

RE-CREDENTIALING

Re-credentialing is performed at a minimum of every three years. During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by Johns Hopkins Health Plans 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 an organization's participation, will be communicated in writing within sixty (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.

PROVIDER NOTIFICATION TO JOHNS HOPKINS HEALTH PLANS

The provider or organization must notify Johns Hopkins Health Plans in writing within five (5) 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 Johns Hopkins Health Plans immediately
- Provider learns that he/she/it has become a defendant in any malpractice action relating to a member who also names Johns Hopkins Health Plans 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 Johns Hopkins Health Plans 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 Johns Hopkins Health Plans immediately
- There is a change in the provider's business address or telephone number

- Provider becomes incapacitated such that the incapacity may interfere with patient care for twenty-one (21) consecutive days; notification of any such action must be furnished in writing to Johns Hopkins Health Plans 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 the provider's ability to carry out the 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, and relevant payor, for cause or other remedial action, as Johns Hopkins Health Plans in its sole discretion deems appropriate.

IMMEDIATE TERMINATION OF PARTICIPATION

Johns Hopkins Health Plans may terminate a Participating Provider Agreement immediately "for cause." Examples of
"for cause" termination may be defined as but not limited to:

- Fraud
- Patient abuse
- Incompetence
- Loss of licensure
- Loss of participation status in state, federal, Medicare or Medicaid payor programs (including when a provider chooses to opt-out of the Medicare program)

VOLUNTARY TERMINATION OF PARTICIPATION

Either the provider or Johns Hopkins Health Plans may voluntarily terminate the Participating Provider Agreement with written notice to the non-terminating party at least ninety (90) days prior to the effective date of termination. The provider will continue to provide or arrange for services for any members prior to the effective date of termination and, if possible, following termination for any member whose medical condition requires a continuing course of treatment where alternative arrangements have not been made. Provider Relations will work with the terminating provider to ensure continuity of care for the member.

TRANSITION OF CARE UPON PROVIDER TERMINATION

The Johns Hopkins Health Plans Participating Provider Agreement requires all providers to give at least 90 days advance notice of contract termination. Johns Hopkins Health Plans notifies members affected by the termination of a primary care provider specialist or practice group at least 30 calendar days prior to the effective date of termination or within thirty 30 calendar days of notification from the provider, and assists the member(s) in selecting a new provider.

In some cases, member(s) 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, Johns Hopkins Health Plans 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. If you have additional questions, please contact Provider Relations at 410-762-5385 or 888-895-4998.

JOHNS HOPKINS HEALTH PLANS PROVIDER APPEALS PROCESS

Should a provider or organization be terminated from the network, or otherwise not be approved for participation through the re-credentialing process, the provider has the right to appeal the SCRC's decision, consistent with Johns Hopkins Health Plans's credentialing policies and procedures.

The provider has no appeal right if the cause of termination was due to:

- Revocation or loss of licensure
- Conviction of fraud
- Initial credentialing is denied

The provider has thirty (30) calendar days to submit the request for a first-level appeal following notification of an adverse decision regarding the provider's participation status with Johns Hopkins Health Plans. Johns Hopkins Health Plans will then notify the provider of receipt of the request for an appeal.

The credentialing department designee will convene an appeal panel comprised of three qualified clinicians who represent the provider community within the Advantage MD provider network. At least two of the panelists will be a clinical peer of the appellant. (For the purpose of this requirement, a clinical peer is a provider who holds the same licensure and specialty as the appellant.) 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 for termination or corrective action(s) precludes the individual from serving as a panelist.

The panel will review the appeal information submitted by the appellant and render a recommendation to the SCRC to uphold or overturn the initial decision. The SCRC decision will be rendered within 30 calendar days from receipt of the appeal request.

If the SCRC and the panel decide to uphold the initial termination decision, the provider may request a second-level appeal and request the opportunity for a personal hearing. Personal appearance hearings will be scheduled at the convenience of the hearing panelists and the provider but not to exceed 60 calendar days from the receipt by Johns Hopkins Health Plans of the second-level appeal request. The provider has the right to be represented by an attorney or another person of the provider's choice during the appeal process. In lieu of a personal hearing, the provider may opt for a second panel decision with no personal appearance. The panelist in

this situation will render a recommendation to the SCRC within 30 days of receipt of the second-level appeal. In either situation (personal appearance or appeal panel), the panelists render a recommendation to the SCRC to either uphold or overturn the initial decision. The SCRC decision will be rendered within 30 calendar days from the date of the second-level appeal. Second-level appeals are final and binding.

Panelists for the second-level appeal are selected as described above in the first-level appeal. Subsequent to the decision of any appeal panel, the provider will be notified in writing via First Class U.S. Postal Service Certified Mail of the SCRC's decision.

PROVIDER PROVISIONS

Please note that a number of provisions remain constant, and are as follows:

- Providers will not attempt to collect from members any amounts in excess of the allowed benefit.
- Providers may not collect up-front, except for deductibles, co-insurance, copays and/or services that are not covered.
- Providers will bill their usual and customary charges.
- Providers will bill Advantage MD directly using current CPT procedure, ICD-10 diagnosis codes, HCPCS and/or DRG coding, and not ask members to bill Advantage MD for their services.
- Providers will cooperate with Advantage MD, to the extent permitted by law, in maintaining medical information with the express written consent of the insured, and in providing medical information requested by Advantage MD when necessary to coordinate benefits, quality assurance, utilization review, third party claims and benefit administrations. Advantage MD agrees that such records shall remain confidential unless such records may be legally released or disclosed. Unless otherwise specified, medical records shall be provided at no cost.
- For non-covered services, physicians and providers will look to the member for payment, as long as a Waiver of Liability form was signed by the member prior to the rendering of the non-covered service, and member was aware the service would be non-covered.
- Unless otherwise specified in your contract, Advantage MD does not pay more than billed charges. The allowable will be based on the lesser of the allowed benefit specified in the physician/provider contract, or the billed amount.

For specific contract provisions, please refer to your direct contract or to the negotiating entity that contracted on your behalf.

When a provider chooses to be designated as a primary care provider (PCP), he/she agrees to provide and coordinate health care services for Advantage MD members. PCPs shall refer members to participating network specialists for services the PCP is unable to provide. The PCP will also be responsible for reviewing the treatment rendered by the specialist. The PCP's responsibility as the manager and coordinator of the member's care is as follows:

- The PCP provides all primary preventative health care services, except the annual gynecological exam should the member choose to seek this service from a participating women's health care specialist.
- When specialized care is medically necessary, the PCP will facilitate a referral to a specialist or specialty facility.

- The PCP will coordinate care and share appropriate medical information with Advantage MD and any specialty provider to whom they refer their patients.
- The PCP may delegate care coordination to another provider if both the member and the other provider agree. This will be clearly documented in the PCP's clinical record.
- The PCP will forward copies of the completed Advance Directive forms for their patient to Advantage MD's Customer Service Department. They will also document in a prominent place in their patient's records if an individual has executed an Advance Directive.
- Will notify Advantage MD in writing when practice is closed to new patients.
- Will arrange for call sharing with a network physician or provider 24 hours a day, seven days a week.
- Will notify Advantage MD of any changes in call share coverage.
- Will notify Advantage MD when asking a member to seek treatment elsewhere.

SECTION 4
BENEFITS & SERVICES

BENEFIT OVERVIEW

Johns Hopkins Health Plans offers multiple Medicare Advantage products:

- Johns Hopkins Advantage MD (HMO)
- Johns Hopkins Advantage MD Tribute (HMO) (Available only in Anne Arundel, Baltimore, Montgomery, Howard, and Frederick counties, Maryland)
- Johns Hopkins Advantage MD Select (HMO) (Available only in Arlington, Fairfax City, Falls Church City)
- Johns Hopkins Advantage MD PPO
- Johns Hopkins Advantage MD Plus (PPO)
- Johns Hopkins Advantage MD Primary (PPO) (Available only in Anne Arundel, Baltimore, Montgomery, Howard, and Frederick counties, Maryland)
- Johns Hopkins Advantage MD PPO Premier (Available only in Montgomery County, Maryland)
- Johns Hopkins Advantage MD Group (eligibility restrictions apply)

The following page contains an at-a-glance view of some plan benefits. For full benefits please see the EOC for each plan.

2024 Advantage MD PPO Plans					
Medical Benefits (Partial Listing, in-network)*	**PPO**	**PPO Plus**	**PPO Premier**	**PPO Primary**	**PPO Group**
Monthly Plan Premium	$90	$120	$291	$0	$175
Maximum Out-of-Pocket	IN: $7550 OON: $11,300	IN: $7550 OON: $11,300	IN: $7550 OON: $11,300	IN: $7,500 OON: $11,300	IN: $3,000 OON: $10,000
Medical Deductibles	None	None	None	$800 IN/OON	$100
Primary Care Provider Visit	$5 copay	$0 copay	$0 copay	$0 copay	$5 copay
Specialist Visit	$50 copay	$40 copay	$25 copay	$40 copay	$35 copay
Referrals	Not Required	Not Required	Not Required	Not Required	Not Required
Urgent Care	$40 copay	$40 copay	$40 copay	$50 copay	$40 copay
Emergency Care	$90 copay	$90 copay	$90 copay	$95 copay	$75 copay
Inpatient Hospital Stay	$330 copay per days 1-6; $0 per days 7 and beyond	$330 copay per days 1-6; $0 per days 7 and beyond	$200 copay per days 1-5; $0 per days 7 and beyond	$350 copay per days 1-5; $0 per days 6 and beyond	$250 copay per days 1-7; $0 per days 8 and beyond
Prescription Drug Benefits (30-day supply)					
Deductible	None	None	None	None	None
Preferred Generic	$4 copay	$4 copay	$0 copay	$5 coapay	$4 copay
Generic	$12 copay	$12 copay	$10 copay	$20 copay	$12 copay
Preferred Brand	$47 copay	$47 copay	$40 copay	$47 copay	$42 copay
Non-Preferred Drug	$100 copay	$100 copay	$90 copay	$100 copay	$92 copay
Specialty Tier	33% of the cost	33% of the cost	33% of the cost	33% of the cost	33% of the cost
Mail Order Available	Yes	Yes	Yes	Yes	Yes

* For out-of-network benefits, members pay a percentage for most covered services. The Johns Hopkins Advantage MD (HMO) has not out-of-network benefits, except in emergency situations (please see Chapter 3 of the EOC for further details).

2024 Advantage MD HMO Plans			
Medical Benefits (Partial Listing, in-network)*	**HMO**	**HMO Tribute**	**HMO Select (VA Plan)**
Monthly Plan Premium	$20	$0	$0
Maximum Out-of-Pocket	IN: $7550	$6,400	$7,500
Medical Deductibles	None	None	None
Primary Care Provider Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$45 copay	$50 copay	$40 copay
Referrals	Required, Specialist Visit Only	Required, Specialist Visit Only	Required, Specialist Visit Only
Urgent Care	$50 copay	$40 copay	$55 copay
Emergency Care	$100 copay	$ 95 copay	$100 copay
Inpatient Hospital Stay	$350 copay per days 1-5; $0 per days 6 and beyond	$350 copay per days 1-5; $0 per days 6 and beyond	$350 copay per days 1-5; $0 per days 6 and beyond
Prescription Drug Benefits (30-day supply)			
Deductible	None	N/A	None
Preferred Generic	$0 copay	N/A	Generic: $0 copay
Generic	$10 copay	N/A	$10 copay
Preferred Brand	$47 copay	N/A	$47 copay
Non-Preferred Drug	$100 copay	N/A	$100 copay
Specialty Tier	33% of the cost	N/A	33% of the cost
Mail Order Available	Yes	N/A	Yes

* For out-of-network benefits, members pay a percentage for most covered services. The Johns Hopkins Advantage MD (HMO) has not out-of-network benefits, except in emergency situations (please see Chapter 3 of the EOC for further details).

TELEMEDICINE

Johns Hopkins OnDemand Virtual Care, a new telemedicine platform, optimizes member experience in response to needs created and illuminated by the pandemic. Advantage MD members can use this on-demand service to talk to a doctor right away after hours, on weekends, or while traveling.

The platform is staffed by Johns Hopkins Medicine doctors as much as possible and TelaDoc physicians when JHM doctors are unavailable. Enhanced access to providers will help ensure members receive needed care.

UpLift is a virtual behavioral health practice that expands access to providers. The interface also allows members to schedule an appointment with a psychiatrist or therapist as soon as the next day, and no further out than two weeks. While UpLift is primarily virtual, some providers offer in-person appointment options.

Primary care providers can refer members to **UpLift** to locate a provider in the UpLift network, in addition to referrals to other network providers.

SUMMARY OF BENEFITS

For detailed information about Advantage MD benefits, please refer to our Summary of Benefits (SOB) on our website at:

https://www.hopkinsmedicare.com/compare/

For detailed information about Advantage MD Group, please visit our website at:

http://www.advantagemdgroup.com/

EVIDENCE OF COVERAGE

For detailed information regarding a member's Evidence of Coverage (EOC), please click on one of the links to review the Advantage MD EOC's or go to **https://www.hopkinsmedicare.com/members/member-resources-2024/**.

For Advantage MD HMO plan members:

https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-hmo-001_508.pdf

For Advantage MD HMO Tribute plan members:

https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-tribute_508.pdf

For Advantage MD Select plan members:

https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-select_508.pdf

For Advantage MD D-SNP plan members:

https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-dsnp_508.pdf

For Advantage MD PPO plan members:
https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-ppo_508.pdf

For Advantage MD PPO Primary plan members:
https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-primary_508.pdf

For Advantage MD PPO Plus plan members:
https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-plus_508.pdf

For Advantage MD PPO Premier members:
https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-premier_508.pdf

For Advantage MD Group plan members:
http://www.advantagemdgroup.com/

PRIOR AUTHORIZATION GUIDELINES

Through the Johns Hopkins Prior Authorization Lookup tool (JPAL), providers may check and verify prior authorization requirements for services and procedures. Located in the HealthLINK portal, JPAL offers a user-friendly way for providers to look up prior authorization requirements without needing to call Customer Service.

Providers can simply click on the JPAL link in HealthLINK to access this tool.

- Search by specific procedure code or procedure description.
- Search results are organized by procedure code, modifier, procedure description, and individual line of business.
- Clicking on the procedure code link or on any line of business link brings up specific details, such as the rules pertaining to prior authorization for each line of business and access to the medical policy document.

Note: JPAL is a way to look up prior authorization requirements only; it does not handle prior authorization requests. Please follow Johns Hopkins Health Plans's policies and procedures as usual to request an authorization:

- Confirm the status of all procedures before delivery of service.
- If prior authorization status is unclear, submit an authorization request.
- Authorizations are not a guarantee of payment.

Prior authorizations for post-acute services, outpatient physical therapy beyond the first 12 visits, outpatient occupational therapy beyond the first 12 visits, radiology and cardiology imaging services will be provided through eviCore Healthcare. Prior authorizations for provider administered medical injectables (Part B drugs) will be provided through NovoLogix. Important information, documents and forms can be found on the Johns Hopkins Health Plans-evicore and NovoLogix web portal, located in **Availity**.

SITE OF SERVICE

One way to control costs is to reduce the number of procedures performed in regulated space that would be just as effective in lower-cost facilities such as ambulatory surgery centers.

We are collaborating with leaders in Johns Hopkins Medicine to develop mutual solutions: enabling patients to have necessary procedures while ensuring that care is as cost-effective as possible for our members and our organization alike. Services and codes required under the site of service initiative will be added quarterly.

EXCLUDED SERVICES

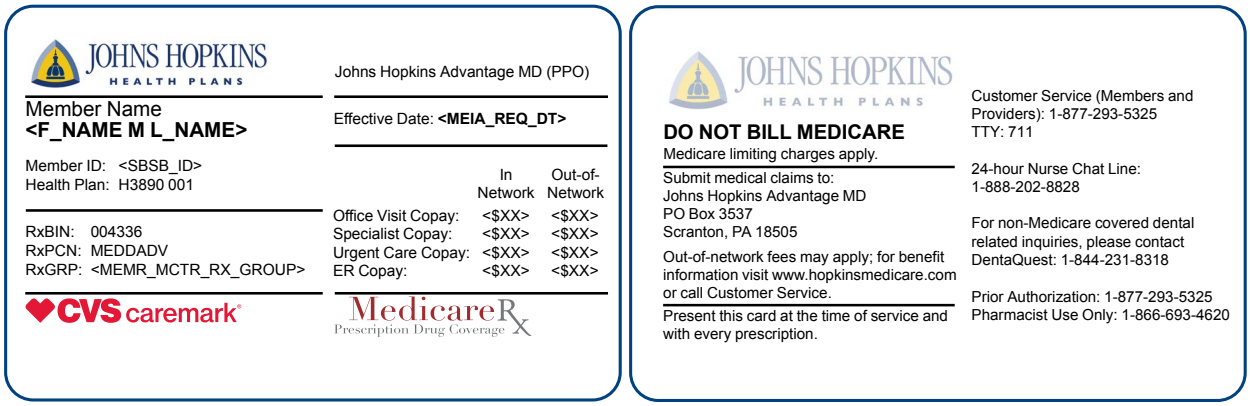
In addition to any exclusion or limitations described in the member's EOC, Advantage MD does not cover under the Original Medicare Plan, the following items and services:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are other wise listed by our plan as a covered service
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare & Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our plan and the Original Medicare Plan to not be generally accepted by the medical community
- Surgical treatment of morbid obesity unless medically necessary or covered under the Original Medicare Plan
- Private room in a hospital, unless medically necessary
- Private duty nurses
- Personal convenience items, such as a telephone or television in a member's room at a hospital or skilled nursing facility
- Nursing care on a full-time basis in a member's home
- Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating, using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered
- Homemaker services
- Charges imposed by immediate relatives or members of the member's household
- Meals delivered to the member's home
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance unless medically necessary
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance

- Routine dental care (i.e., cleanings, fillings, or dentures) or other dental services unless otherwise specified in the EOC. However, non-routine dental services received at a hospital may be covered
- Chiropractic care is generally not covered under the plan with the exception of manual manipulation of the spine and is limited according to Medicare guidelines
- Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease
- Supportive devices for the feet. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC
- Eyeglasses, with the exception of after cataract surgery, routine eye examinations, radical keratotomy, LASIK surgery, vision therapy, and other low vision aids and services unless otherwise specified in the EOC
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the member's Part D benefit. Please see the formulary for details
- Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies
- Acupuncture
- Naturopath services
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the plan, the plan will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount

Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

ADVANTAGE MD IDENTIFICATION CARD SAMPLES



ELIGIBILITY VERIFICATION

All participating providers are responsible for verifying a member's eligibility at each and every visit. Please note that member data is subject to change. CMS retroactively terminates members for various reasons. When this occurs, the Advantage MD's claim recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question.

Please verify member eligibility by the following methods:

Calling Advantage MD PPO, PPO Plus, PPO Premier, PPO Primary and Group Customer Service

You must call the health plan to verify eligibility. Please call Customer Service at 877-293-5325. You can also verify eligibility through your HealthLINK account at **https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/healthlink**. Click on the EHP/Priority Partners/Advantage MD Login page.

Calling Advantage MD HMO and Advantage MD Tribute HMO Customer Service

You must call the health plan to verify eligibility. Please call Customer Service at 877-293-4998. You can also verify eligibility through your HealthLINK account at **https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/healthlink**. Click on the EHP/Priority Partners/Advantage MD Login page.

Asking For the Member's Identification Card

Each member is provided with an individual member identification card that includes the member's identification number, plan, certain copayment information, and effective date. Since changes do occur with eligibility, the card alone does not guarantee that the member is eligible. Therefore, it is imperative to check eligibility.

SILVER&FIT® EXERCISE AND HEALTHY AGING PROGRAM

The Silver&Fit program is designed for older adults and is provided at no additional cost for members who choose the Advantage MD plan. With this program, members may choose from two enrollment options.

Work out at a participating fitness facility, or choose to work out in the comfort and privacy of their home using the Silver&Fit Home Fitness program.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Connected! and The Silver Slate are trademarks of ASH and used with permission herein. All programs and services are not available in all areas.

To obtain additional information on fitness centers in the area available to Advantage MD members, providers can refer members to Customer Service at 877-293-5325 (PPO, PPO Plus, PPO Premier, PPO Primary and Group) or 877-293-4998 (HMO and HMO Tribute) direct them to the Silver&Fit website at **www.silverandfit.com**.

MY ADVOCATE

My Advocate is a program designed to help members find financial assistance to reduce their medical expenses. Advantage MD is working with My Advocate to help identify qualifying members for financial assistance programs.

My Advocate is handled by our vendor, Change Healthcare, which performs outreach calls to members to assist them with the application process. My Advocate will assist with the initial application and also make sure members complete their annual recertification. This service is available to all members.

TRUHEARING PROGRAM

TruHearing is an exclusive hearing aid savings program for all Advantage MD plans members. On average, members can save hundreds of dollars off the cost of a hearing aid. Members can visit any TruHearing locations nationwide.

To obtain additional information on TruHearing providers in the area available to Advantage MD members, providers can contact Customer Service at 877-293-5325 (PPO, PPO Plus, PPO Premier, PPO Primary and Group) or 877-293-4998 (HMO and HMO Tribute).

SECTION 5

ADVANTAGE MD (HMO) DUAL ELIGIBLE SPECIAL NEEDS (D-SNP) PLAN

INTRODUCTION

Thank you for participating in the Advantage MD (HMO) Dual Eligible Special Needs (D-SNP) Plan. This chapter gives you the information you and your office staff need to partner with us to help improve our members' health and well-being under this plan.

Please note that unless otherwise described in this chapter, all other chapters in the Provider Manual apply to the Advantage MD HMO D-SNP plan.

D-SNP BACKGROUND

Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans that enroll members who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX). The purpose of the plan is to integrate Medicare and Medicaid benefits for members to ensure they are receiving care across the continuum of need.

Advantage MD (HMO) D-SNP with Medicare Part D plan is offered in ten (10) counties in Maryland:

- Anne Arundel
- Baltimore
- Carroll
- Howard
- Frederick
- Montgomery
- Somerset
- Washington
- Wicomico
- Worcester

The plan serves the following Medicaid Coverage Groups:

- QMB (Qualified Medicare Beneficiary)
- QMB+ (Qualified Medicare Beneficiary Plus)

"Dual eligible beneficiaries" describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the Qualified Medicare Beneficiary (QMB) Program. The QMB Program helps pay for Part A and/or Part B premiums, deductibles, co-insurance, and co-payments.

All providers are prohibited from billing QMB individuals for all Medicare deductibles, co-insurance, or copays (except Part D). All Medicare and Medicaid payments received for services rendered to QMB individuals are considered payment in full. Providers are subject to sanctions if they bill a QMB individual for amounts above the sum total of all Medicare and Medicaid payments (even when Medicaid pays nothing).

All providers must accept assignment for Part B services furnished to dual eligible beneficiaries. Assignment means that the Medicare-allowed amount (Physician Fee Schedule amount) constitutes payment in full for all Part B-covered services provided to beneficiaries. For more information visit: **https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-dsnp_508.pdf**

Providers would need to bill Medicaid for the 20% that the D-SNP members would typically be responsible for or accept the 80% payment from Advantage MD as full payment for the covered services.

PLAN BENEFITS

Advantage MD D-SNP Benefits are defined in the plan's **Evidence of Coverage (EOC)**. This document is provided to each member and is published on our website at **https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-dsnp_508.pdf**

The following list is a sampling of available benefits. For specific benefits and details, providers should consult the current EOC document for D-SNP or view the charts below.

- Medical and behavioral health services
- Part D Pharmacy Prescription Drug program
- Assistance provided to members for coordinating and accessing their Medicaid benefits
- D-SNP additional Benefits:
  - » Fitness programs
  - » Over-the-Counter (OTC) medication catalog
  - » Home meals delivery after inpatient discharge
  - » Dental care
  - » Routine vision
  - » Hearing
  - » 24/7 nurse-advice line
  - » Transportation support to medical appointments
  - » My Advocate

Helpful Resources:

- EOC for Advantage MD D-SNP members: **https://www.hopkinsmedicare.com/wp-content/uploads/2024-eoc-dsnp_508.pdf**
- Information about Maryland Medical Assistance program benefits: **https://dhs.maryland.gov.**
- Members may apply for the Maryland Assistance Program online at myDHR (**https://mydhrbenefits.dhr.state.md.us**) or in person at one of the Department of Health Services' (DHS) 24 local departments of social services.

Johns Hopkins Advantage MD (HMO) D-SNP Benefit Highlights Advantage MD is the primary insurance payer (80%) and Medicaid is the secondary payer (20%). Providers must not charge individuals enrolled in the QMB program for cost-sharing.	
	Member Cost Share
Inpatient	$0
PCP	$0
Specialist / Other Health Professional Services	$0
Outpatient Hospital ASC	$0
Emergency	$0
Urgent Care	$0
OT/PT/ST	$0
Outpatient Substance Abuse (Individual and Group)	$0
Diagnostic X-ray	$0
Prescription Drug Benefits	
Deductible	$505 *Does not apply for most low-income subsidy (LIS) members
All Covered Medications	*Most members will pay LIS copay, which will be less than 25%
Mail Order Available	Yes
Preventive Dental	2 Cleanings, 1 Oral exam, 2 X-rays per year
Comprehensive Dental	$2,500 Maximum
Vision	Routine eye exam Up to $400 routine eyewear every year
Hearing Aids	$1,500 maximum every two years.
Transportation	24 One-way trip rides
OTC	$200 per calendar quarter via a catalog
Meals	3 meals a day post discharge for five days (15 meals)
Fitness	$0 Annual Member Fee & Home Fitness Kit

D-SNP EXCLUDED SERVICES

In addition to any exclusion or limitations described in the member's EOC, Advantage MD D-SNP does not cover the following items and services under the Original Medicare Plan:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our plan as a covered service
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare & Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our plan and the Original Medicare Plan to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary or covered under the Original Medicare Plan
- Private room in a hospital, unless medically necessary
- Private duty nurses
- Personal convenience items, such as a telephone or television in a member's room at a hospital or skilled nursing facility
- Nursing care on a full-time basis in a member's home
- Custodial care, unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating, using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Homemaker services
- Charges imposed by immediate relatives or members of the member's household
- Meals delivered to the member's home (unless specified by member EOC)
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance, unless medically necessary
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care (i.e., cleanings, fillings, or dentures) or other dental services unless otherwise specified in the EOC. However, non-routine dental services received at a hospital may be covered.
- Chiropractic care is generally not covered under the plan with the exception of manual manipulation of the spine and is limited according to Medicare guidelines.
- Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.

- Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease
- Supportive devices for the feet. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Hearing aids and routine hearing examinations, unless otherwise specified in the EOC
- Eyeglasses, with the exception of after cataract surgery, routine eye examinations, radical keratotomy, LASIK surgery, vision therapy, and other low vision aids and services, unless otherwise specified in the EOC
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy, unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies
- Acupuncture
- Naturopath services
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the plan, the plan will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount.

Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, nonauthorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

DUAL SPECIAL NEEDS MEMBERSHIP ELIGIBILITY

D-SNP members are those who are eligible for both Medicare and Medicaid (dual eligible).

- Qualify for Medicare because of age (65 or older) or due to a disability.
- Eligible for Medicaid because they meet the requirements to qualify for Medicaid in the State of Maryland.
- Enrolled in QMB or QMB+

This dual population often has substantial health and social support needs.

Medicaid eligibility can be obtained by using the Maryland Medicaid Eligibility Verification System (EVS) at **www.emdhealthchoice.org**.

If you do not have access to the system, contact Johns Hopkins Health Plans Provider Relations at 410-767-5503 or 877-293-4998.

DEFINITION AND DESCRIPTION OF QMB AND QMB+:

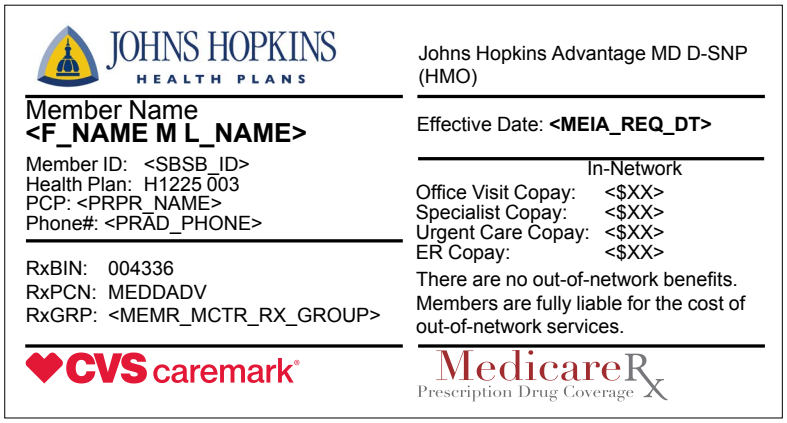
Qualified Medicare Beneficiary (QMB Only) A "QMB" is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed three times the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance, and copays (except for Part D). QMBs who do not qualify for any additional Medicaid benefits are called "QMB Only." Providers may not assess a QMB deductibles, copays, or co-insurances.

Qualified Medicare Beneficiary Plus (QMB+) A "QMB+" is an individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in Maryland. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

Providers may not assess a QMB deductibles, copays, or co-insurances. Qualified Medicare Beneficiary Plus (QMB+) A "QMB+" is an individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the state. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

ADVANTAGE MD D-SNP IDENTIFICATION CARD

Front



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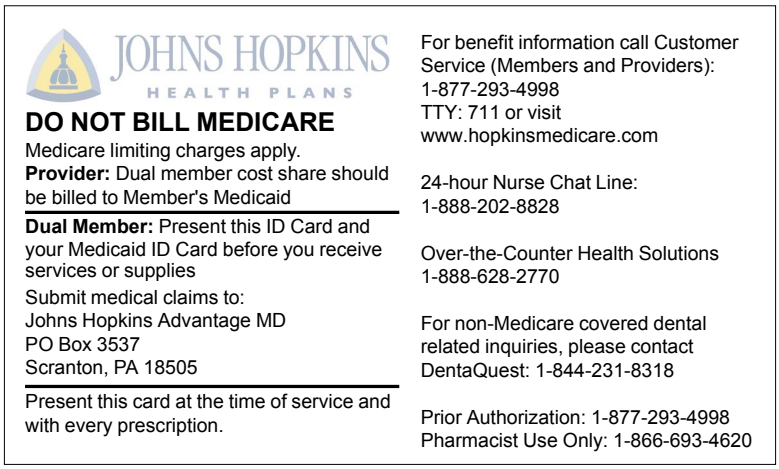

Calling Advantage MD HMO Customer Service

You must call Advantage MD to verify member eligibility. Please call Customer Service at 877-293-4998. You can also verify eligibility through your Availity account at **Availity.com**.

Asking for the Member's Identification Card

Each member is provided with an individual member identification card that includes the member's identification number, plan, certain copay information and effective date. Since changes do occur with eligibility, the card alone does not guarantee that the member is eligible. Therefore, it is imperative to check eligibility.

PROVIDER RESPONSIBILITY TO COORDINATE MEMBER COST SHARE

All providers are prohibited from requesting payment for all deductibles, co-insurance or copays from Advantage MD (HMO) D-SNP members at time of service. All Medicare and Medicaid payments received for services rendered to D-SNP members are considered payment in full. Providers are subject to sanctions if they bill a D-SNP member for amounts above the sum total of all Medicare and Medicaid payments (even when Medicaid pays nothing).

All providers must accept assignment for Part B services furnished to dual eligible beneficiaries. Assignment means that the Medicare-allowed amount (Physician Fee Schedule amount) constitutes payment in full for all Part B-covered services provided to beneficiaries.

For more information about dual eligible categories and benefits, please refer to the CMS website: **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf**

Providers are prohibited from billing, charging, collecting a deposit, seeking compensation or remuneration from, or having any recourse against any Johns Hopkins Advantage MD (HMO) D-SNP member for fees that are the responsibility of Advantage MD D-SNP. Providers can accept Advantage MD D-SNP payment as payment in full or seek additional payment from the appropriate state source.

COORDINATION OF MEMBER CARE

Coordination for patients with complex health care needs often involves multiple participants who individually provide specialized knowledge, skills, and services*, and who together potentially provide a comprehensive, coherent, and continuous response to a patient's unique care needs.

As the primary care provider or a specialist participating in the member's care you are a key participant in ensuring your patients care needs are identified and received. Advantage MD D-SNP is here to assist you and your patients with getting the most from their Medicare and Medicaid benefits as dually eligible participants.

Effective care coordination depends on participants in patient care activities having access to information about available resources, if you or your patient's need assistance you can contact Advantage MD for assistance in coordinating care and benefits at 877-293-4998.

D-SNP MODEL OF CARE

As per the Johns Hopkins Health Plans - Provider Participation Agreement, providers agree to hold members harmless under the following terms:

In 2008, CMS issued the final regulation "Medicare Improvements for Patients and Providers Act of 2008," known as "MIPPA." This regulation mandated that all Special Needs Plans have a filed and

approved Model of Care by Jan. 1, 2010. The Patient Protection and Affordable Care Act reinforced the importance of the SNP Model of Care as a fundamental component by requiring NCQA review and approval.

CMS mandates that each D-SNP have a Model of Care (MOC). The MOC is an evidenced- based care management program that facilitates the early and on-going assessments, the identification of health risks and major changes in the health status of D-SNP customers. The D-SNP MOC provides structure and describes the coordination of care and benefits and services targeted to improve the overall health of our D-SNP customers.

The MOC also serves to ensure that the unique needs of our SNP customers are identified and appropriately addressed. The Advantage MD D-SNP MOC identifies five key care management components:

1. **D-SNP population –** Description of the unique characteristics of our overall and most vulnerable D-SNP customers.
2. **Care coordination –** The D-SNP staff structure, the Health Risk Assessment (HRA), Individualized Care plan (ICP), Interdisciplinary Care Team (ICT) and Care Transition process, all of which identify the services and benefits offered through this plan and are available to our D-SNP customers. The wide range of services is targeted to help our SNP customers achieve their optimal health and improve the connection to care
3. **Provider Network –** Providers with specialized expertise correspond to the target population in our D-SNP program and collaborate with the ICT and contribute to a beneficiary's ICP. It also explains how network providers use evidence-based medicine, when appropriate and care transition protocols.
4. **MOC Quality Measurement and Performance Improvement –**The overall quality improvement plan and goals for the D-SNP population; this section of the MOC includes clinical and customer satisfaction goals, as well as on-going performance evaluation of the D-SNP MOC.
5. **The D-SNP MOC Training Program –** Developed by Advantage MD D-SNP to comply with the CMS (Medicare) mandate to conduct initial and annual training for Johns Hopkins Health Plans staff and participating providers. Completion of the D-SNP MOC training is required. Go to the **Provider Education** page of the Provider website to access the **training**.

   Please complete the **Johns Hopkins Health Plans D-SNP Model of Care (MOC) Provider Training Attestation Form** located on the Forms page under "Advantage MD."

   Follow the instructions to complete and submit the **online form**. The completed form will be automatically transmitted to Provider Relations and providers will be emailed a receipt.

KEY D-SNP CARE MANAGEMENT ACTIVITIES

Johns Hopkins Advantage MD has implemented the following four Care Management programs to ensure that member needs are consistently met:

1. **Health Risk Assessment (HRA)**
   - Identifies member's clinical, functional, cognitive, and social needs upon initial onboarding and updated annually
   - Assists in development of Individualized Care Plan (ICP) and coordinating of members needs with Interdisciplinary Care Team (ICT)
2. **Individualized Care Plan (ICP)**
   - Using information from HRA, interviews with members, provider input, etc., a plan to address member's individualized health care and Social Determinants of Health (SDoH) needs.
3. **Interdisciplinary Care Team (ICT)**
   - Comprised of member's Care Management team, primary care provider, specialists, and caregiver, the ICT coordinates care to support the member's health care goals
   - Focused on the members' medical, behavioral health, functional, cognitive and SDoH needs, the ICT works together to optimizes member's health outcomes
4. **Transition Care Management**
   - Working with the member's ICT, the Case Management team provides support to effectively and safely transition members from one level of care to another (i.e., hospital to home)

All D-SNP members receive the above care management services.

PROVIDER'S ROLE IN D-SNP MEMBER CARE MANAGEMENT

Along with the other role and responsibilities outlined in this manual. Providers are also key members of the D-SNP Interdisciplinary Care Team, providers collaborate and coordinate with the D-SNP Care Management Team to improve members' health care outcomes.

Providers caring for Advantage MD D-SNP members are asked to support members' health care outcomes by:

- Communicating with member's Care Management team on patient-specific issues
- Notifying Care Management team of care transitions, i.e., hospital or skilled nursing facility admissions
- Reviewing members' Care Plans and provide feedback on additional goals areas or areas of focus for the member
- Explaining to Hopkins Health Advantage D-SNP members, the role of the Care Management team
- Outreaching to the Advantage MD Care Management team when you need assistance on managing/ coordinating member's health care needs, including addressing SDoH issues

D-SNP PRESCRIPTION DRUG PROGRAM

- Advantage MD D-SNP members have their own formulary, which is different from the formularies for PPO and HMO. Provider should check the **formulary** for covered drugs prior to prescribing for D-SNP members.
- Most D-SNP members will have low-income subsidy (LIS) and therefore the deductible and 25% co-insurance for drugs will not apply. Members will be responsible for the lessor of their LIS copay or the 25% co-insurance.
- D-SNP members cannot obtain diabetic supplies from a pharmacy. Members must order diabetic supplies from a Johns Hopkins Health Plans Durable Medical Equipment (DME) company. For a list of participating DMEs, call Customer Service.

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

Advantage MD will operate a quality and performance improvement program to include program goals that will support population specific goals, HEDIS measures and member satisfaction drivers. The D-SNP Quality program goals and their effectiveness in supporting the program will be reviewed at least annually. Based on that analysis evaluation, goals may be revised, and new goals developed. Providers are a key component of supporting not only the care management of our members, but also to support quality initiatives to improve members' health care outcomes.

SECTION 6
PHARMACY MANAGEMENT

PART D DRUG FORMULARY

Advantage MD offers comprehensive prescription drug benefit with coverage in all therapeutic classes, as indicated by the Medicare Part D rules and regulations.

Medications that are covered under the pharmacy benefit can be found online on the Advantage MD Pharmacy & Formulary page of our website at: **https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/advantage-md/pharmacy_formulary/index.html**

The formularies were created under the guidance of physicians and pharmacists representing most specialties. The Pharmacy and Therapeutics Committee (P&T) evaluates the needs for most members, use of products, and costeffectiveness as factors to determine the formulary choices. In all cases, available bioequivalency data supply and therapeutic activity are considered. Formulary coverage includes all therapy classes used to treat Medicare covered conditions. The website formulary is updated frequently with any changes that have been made.

Advantage MD utilizes multiple formularies which have different cost-sharing tiers. The member's plan determines which benefit and formulary apply. Please note, the same drugs may not be in all formularies, and the drugs may be in different tiers (Tier 2 vs. Tier 3). Please review the applicable formulary and corresponding Cost Sharing Tiers (copays) to confirm coverage.

FORMULARY COST SHARING TIERS

Every drug on the plan's formulary is in one of five costsharing tiers.

Cost Sharing Tier 1	Preferred Generic Drugs	Lowest cost share
Cost Sharing Tier 2	Generic Drugs	Low cost share
Cost Sharing Tier 3	Preferred Brand Drugs	Intermediate cost share
Cost Sharing Tier 4	Non-Preferred Drugs	Higher cost share
Cost Sharing Tier 5	Specialty Tier Drugs	Highest cost share

Maintenance medication on Cost Sharing Tier 1 may be obtained for up to day a 100-day supply and maintenance medication on Cost Sharing Tier 2 through Tier 4 may be obtained for a 90-day supply. A three-month supply of maintenance medication on Tiers 1 and 2 are available at a reduced copay through CVS/caremark mail order and retail pharmacies. A three-month supply of maintenance medication on Tiers 3 and 4 are available at a reduced copay through CVS/caremark mail order only. Specialty Tier Drugs are limited to a 30-day supply at 33% co-insurance. Advantage D-SNP may obtain up to a 90-day supply for all covered medications.

The above Cost Sharing Tiers apply while the patient is in the Initial Coverage Stage. However, once their total drug costs for the year reach $5,030 they move into the Coverage Gap Stage (donut hole). Please note, the Coverage Gap is different for Advantage MD PPO and Advantage MD HMO.

- PPO members pay 25% of the cost for brand name drugs and generic drugs.
- HMO members continue to pay $0 for Tier 1 drugs in the Coverage Gap stage and will pay 25% of the cost for brand name drugs and generic drugs for Tiers 2 through 5.

They remain in the Coverage Gap Stage until their out-of-pocket drug costs reach $8,000. Then they move into the Catastrophic Coverage Stage where they would pay $0 for all covered Part D drugs. These numbers change on an annual basis per Center for Medicare and Medicaid Services (CMS) guidelines.

Giving More People "Extra Help"

Beginning in 2024, as apart of the Inflation Reduction Act, there will no longer be a partial program in the Low-Income Subsidy program. Full benefits will be offered to people with Medicare with limited resources and incomes up to 150 percent of the federal poverty level, which in 2023 is $21,870 per year for an individual. With full benefits, the majority, if not all, of out-of-pocket costs for prescription medications will be covered. People who qualify for Extra Help will pay:

- No deductible
- No premium
- Fixed lower copays for certain medications

If a members income for 2024 is below $22,000 ($30,000 for married couples), they may qualify for lower prescription drug costs. Many people qualify for "Extra Help" with Medicare Part D (drug coverage) and don't even know it.

Insulins for Reduced Copays

Advantage MD HMO, HMO D-SNP, PPO, PPO Plus, PPO Premier, and PPO Primary plans offer reduced insulin copays. Reduced Insulin Copays: A one month supply of Part D covered insulin will be available to members for $35. Insulin will be $35 for a one-month supply and up to $105 for a three-month supply with additional savings for mail order. Low Income Subsidy (LIS) members will pay the lessor of their normal LIS copay or $35.

PART D UTILIZATION MANAGEMENT

Advantage MD utilizes CVS/Caremark's Clinical Operations team for review of Coverage Determination and Exception requests. The CVS/Caremark Clinical Operations team is available for clinical consultations with clinical pharmacists.

The following methods of Utilization Management are utilized:

- **Prior Authorization (PA):** Medications that require prior authorization will only be approved when medical record documentation proves the member's clinical circumstances meet the criteria established by our P&T committee and approved by the Center for Medicare and Medicaid Services (CMS).
- **Step Therapy (ST):** Medications that require step therapy will only be approved when we have documentation that the member has tried and failed our preferred alternative medications or the member's health would be jeopardized by trying our preferred alternative medications first.
- **Quantity Limits (QL):** Medications with quantity limits will generally be limited to encourage dose optimization and limited to the FDA approved dosing quantities.

Please refer to the formulary when prescribing for Advantage MD members. Though most medications on the formulary are covered without the above Utilization Management, some will require you to obtain an authorization.

Formulary Exception may be requested when medical condition warrants use of certain medications not on the formulary. Quantity Exception may be requested when medical condition warrants use of quantities greater than listed quantities for each drug. Step Therapy Exception may be requested when there is contraindication to the prerequisite medication or there is documented trial and failure of prerequisite medication. Tier Exception may be requested to provide the drug at a lower cost-sharing tier when the drugs at a lower copayment level have been tried and failed or are contraindicated. Tier 5 (Specialty Tier) medications are exempt from tier exception. Clinical documentation should be provided to support all requests.

HOW TO FILE A COVERAGE DETERMINATON FOR PART D MEDICATION

A Coverage Determination (CD) is any decision that is made by or on behalf of a Part D plan sponsor regarding payment or benefits to which a member believes he or she is entitled. Coverage Determinations may be received verbally or in writing from the member's prescribing physicians. Fax Coverage Determination forms to 855-633-7673 or contact Customer Service at 877-293-5325 for PPO and 877-293-4998 for HMO.

The address is:

Advantage MD
c/o CVS Caremark Part D Services Coverage Determination & Appeals Dept.
P.O. BOX 52000 MC 109
Phoenix, AZ 85072-2000

You can reach us 24 hours a day, 7 days a week. Please visit our website to obtain forms or send your request electronically

If necessary, our reviewers will contact you by phone or fax to request additional information. Please note that the call may come from a CVS/Caremark representative. To eliminate the need for additional outreach when processing coverage determination requests, follow the tips below:

- Prior to submitting a request, review the Centers for Medicare & Medicaid Services (CMS) approved prior authorization criteria, available on our website, to ensure you understand what information needs to be provided.
- Always include the patient's diagnosis and attach supporting documentation when it's available. Examples of supporting documentation include chart notes and laboratory results.

A provider will receive the outcome of a Coverage Determination by fax no later than seventy-two (72) hours after receipt for standard requests or receipt of the supporting statement, and no later than twenty-four (24) hours after receipt for urgent requests or receipt of the supporting statement. Unless approved, the following information will be provided: 1) the specific reason for the denial taking into account the member's medical condition, disabilities and special language requirements, if any; 2) information regarding the right to appoint a representative to file an appeal

on the member's behalf; and 3) a description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process.

If you do not agree with our coverage determination decisions, you may request a Redetermination (Appeal).

HOW TO FILE A PART D APPEAL

If unfavorable, a Part D appeal can be filed within 60 calendar days after the date of the Coverage Determination decision. Advantage MD will ask for a statement and select medical records from the prescriber if a member requests a Part D appeal. For an expedited appeal, Advantage MD will provide a decision no later than seventy-two (72) hours after receiving the appeal, and for a standard appeal, the timeframe is seven (7) days. If the request is regarding payment for a prescription drug the member already received, an expedited appeal is not permitted. Part D Appeals may be received in writing or verbally or from the member's prescribing providers. Fax appeals to 855-633-7673 or call 877-293-5325 for PPO and 877-293-4998 for HMO.

The mailing address is:

Advantage MD
c/o CVS Caremark Part D Services Coverage Determination & Appeals Dept.
P.O. BOX 52000 MC 109
Phoenix, AZ 85072-2000.

Please visit our website at **HopkinsHealthPlans.org** to obtain forms or to send your request electronically via our online **Coverage Determination Form**.

TRANSITION POLICY

Under certain circumstances, Advantage MD offers up to a 30-day temporary (transition) supply of a drug when it is not on the formulary or when it is restricted. In these circumstances both members and providers will receive a transition letter explaining the situation and provide options.

PHARMACY NETWORK

Advantage MD uses the CVS Caremark network of pharmacies nationwide including most home infusion, long-term care, and retail chain and independent pharmacies in Maryland. Changes to the pharmacy network may occur throughout the year and annually between plan years. Please visit our website to use our pharmacy locator to easily find participating pharmacies

MAIL ORDER PHARMACY

One of the most important ways to improve the health of our members is to make sure they receive and take their medications as you prescribe. Our mail order pharmacy, CVS/caremark, can help. CVS/caremark sends a three-month supply of maintenance medications in one fill making it easier for the patient by only having to fill four times a year. In addition, a three-month

supply of maintenance medication is available through CVS/caremark mail order at a reduced copay. This means your patient can fill a 90-day supply for only two times the retail copay—saving them an equivalent of four retail copays per year. Talk to your patients today about mail order pharmacy with CVS/caremark for better health and health care spending. Providers and staff can contact CVS/caremark at 877-293-5325 for PPO or 877-293-4998 for HMO, 24 hours a day, 7 days a week.

CUSTOMER SERVICE

For any Part D medication related inquiries or to find a pharmacy, please contact Customer Service toll-free at 877-293-5325 for PPO or 877-293-4998 for HMO, 24 hours a day, 7 days a week.

OVER-THE-COUNTER PRODUCTS

Advantage MD will provide an over-the-counter (OTC) benefit for members in PPO Primary, HMO, HMO Select, HMO Tribute and HMO D-SNP. A wide selection of drugs, supplies, and self-care products are provided without a prescription through the plan's OTC benefit. Examples of OTC items include, but are not limited to:

- First aid and medical supplies
- Cough, cold and allergy
- Pain relievers and sleep aids
- Personal care
- Antacids, digestive care and laxatives
- Vitamins and minerals
- Eye, ear, and dental care
- Skin care
- Mobility and safety

Members can select and order OTC products from the Advantage MD OTC Catalog. Advantage MD covers:

- HMO D-SNP: Up to $200 every three months
- HMO: Up to $60 every three months
- HMO Tribute: Up to $35 every three months
- HMO Select: Up to $150 every three months
- PPO Primary: Up to $50 every three months

Any unused amount does not carry over to the next period. Available products and brands may change throughout the year and are subject to availability. Certain products are identified in the catalog as Dual-Purpose. Members are instructed to discuss these dual-purpose items with their prescriber since they are medicines and products that can be used for either a medical condition or for general health and well-being. Providers should discuss all OTC products with their patients but do not need to submit anything to the plan. The Advantage MD catalog for OTC items is available

online at **www.hopkinsmedicare.com**. The OTC catalog contains a complete listing of all plan-covered OTC drugs, supplies, and self-care products and the price of each item. Members can have OTC products mailed to their homes once a quarter after placing an order online at **www.cvs.com/otchs/amd** or via the OTC Program call center at 1-888-628-2770.

PART B PRESCRIPTION DRUGS

The following Part B medications may be obtained at a network pharmacy after the member presents their Advantage MD member ID card:

- Diabetes testing supplies (test strips, meter, lancets, lancing devices, control solution)
- Drugs administered through covered durable medical equipment (DME), such as a nebulizer or infusion pump in the home (prior authorization required)
- Certain oral anti-cancer medications
- Anti-emetic drugs administered within 48 hours of chemotherapy (prior authorization required)
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant (prior authorization required)

Other drugs may be covered under Part B in certain limited situations. Contact customer service for additional information. For question regarding Part B provider administered medications, see below section. Advantage MD Tribute members must obtain Part B medications from their providers or DME vendor.

Advantage MD Tribute members must obtain Part B medications from their providers or DME vendor.

PART B PROVIDER-ADMINISTERED MEDICAL INJECTABLES

Medical injectable drugs are not self-administered by the patient. These are drugs that usually are injected or infused at a physician office, hospital outpatient facility, or ambulatory surgical center. This does not apply to self-administered medications usually dispensed at the pharmacy directly to the patient. Some medications covered by Advantage MD require prior authorization (or pre-authorization) and/or step therapy. If prior authorization is required for identified drug, an organization determination must be submitted.

How To Find List of Codes That Require Prior Authorization

Prior to administering medical injectables, please check the drug list on the provider website or JPAL to determine which medical injectable HCPCS Codes/J Code requires prior authorization.

After obtaining prior authorization, providers may supply these medications and bill the health plan for the medication and related administration using HCPCS Codes or J codes. Plan's criteria for medical injection medications may be found on Johns Hopkins Health Plans.

How To Find List of Codes That Require Step Therapy

Step therapy means that preferred products must be used before non-preferred agents. The provider may request an exception to the step therapy for specific circumstances that warrant a need for a non-preferred product. All preferred and non-preferred Part B drugs are identified on the Biosimilars-first **Medical Preferred Drug List**. Look for the drug on the list. If it is listed as a Preferred Product, it does not require step therapy. If a non-preferred product is required, an organization determination must be submitted.

How To File an Organization Determination for Part B Medical Injectable Medication

Providers may submit prior authorization requests and check status of a prior authorization electronically by accessing the NovoLogix platform through the Availity portal at **Availity.com**.

Providers may also contact NovoLogix at **800-932-7013.**

The Status of request **will be available in the NovoLogix portal.** A provider will also receive the outcome of an Organization Determination by fax no later than seventy-two (72) hours after receipt for standard requests or receipt of the supporting statement, and no later than twenty-four (24) hours after receipt for urgent requests or receipt of the supporting statement. Unless approved, the following information will be provided: 1) the specific reason for the denial taking into account the member's medical condition, disabilities and special language requirements, if any; 2) information regarding the right to appoint a representative to file an appeal on the member's behalf; and 3) a description of both the standard and expedited redetermination processes and time frames including conditions for obtaining an expedited redetermination and the appeals process. If you do not agree with our organization determination decisions, you may request a Reconsideration (Appeal).

COVERED VACCINES

Advantage MD covers Part B vaccines and vaccine administration for Medicare recipients at the pharmacy* and the provider's office. Advantage MD covers Part D vaccines and vaccine administration for Medicare recipients at the pharmacy only. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D, and those covered under either Medicare Part B or Part D coverage.

**Advantage MD Tribute members must obtain Part B vaccines from their provider's office.*

VACCINES AND VACCINE ADMINISTRATION COVERAGE UNDER MEDICARE PART B (MEDICAL)

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia and COVID-19 vaccine
- Influenza virus vaccine

Members may receive Part B vaccinations at either the pharmacy* or the provider's office.

**Advantage MD Tribute members must obtain Part B vaccines from their provider's office.*

VACCINES AND VACCINE ADMINISTRATION COVERAGE UNDER MEDICARE PART D (PHARMACY) BENEFITS

Medicare Part D generally covers vaccines not available under Medicare Part B. For example, Medicare Part D covers the Shingles Vaccine (Shingrix®) and Tdap Vaccine (Adacel® and Boostrix®). Medicare Part D vaccines are listed in the Advantage MD formulary. Our plans cover most Part D vaccines at no cost to our beneficiaries.

Members may receive Part D vaccinations at the pharmacy. Please refer the member to the pharmacy for any vaccine other than influenza or pneumonia.

VACCINES COVERED UNDER EITHER PART B (MEDICAL) OR PART D (PHARMACY) BENEFIT COVERAGE

Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B would be covered under Part D. Vaccines that may be Part B or Part D require prior authorization and include:

- Hepatitis B vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids
- Rabies vaccine

PHARMACY QUALITY PROGRAMS

Patient Medication Adherence

As part of our Medication Adherence Program, you may receive communications from us and our partners to in efforts to improve patients' health outcomes. Our pharmacy benefit manager, CVS/caremark may send you fax notifications as a courtesy to help optimize patient medication adherence. When you receive these notifications, we request that you review the information and take action as appropriate to help improve medication adherence for your patient. Below describes a sample of the communications that provide targeted outreach to prescribers in an effort to drive medication adherence and includes the recommended action for each.

- **90-Day Prescription Conversion Fax Request**
  Requests conversion of eligible 30-day maintenance medications (diabetes and cardiovascular) to 90-day supply. Review member and medication and if clinically appropriate, send a new 90-day supply prescription to the patient's pharmacy via electronic prescription system, fax, or phone. Communicate these changes to your patient.
- **Off Therapy Prescriber Fax**
  Notifies prescribers that their patient may have stopped using their medication. The prescriber fax is triggered when a refill for the program drug is overdue. Discuss your patient's therapy and reasons for nonadherence as soon as possible to promote continued use of the medication as directed.
- **First Fill Drop Off Prescriber Fax**
  Notifies prescribers that their patient may have not refilled their medication. The prescriber fax is triggered if the member does not obtain a refill after the first fill of the program drug. Discuss your patient's therapy and reasons for not refilling the new medication as soon as possible to promote continued use of the medication as directed. If your patient requests more information on adherence to medication, tips for taking medication, or specific, disease-state information, you may refer the patient to log into www.caremark.com and click the "Learn About Medications" tab.

Medication Therapy Management

Medication Therapy Management (MTM)-eligible members are offered a free comprehensive medication review (CMR) annually. In the welcome letters sent to the eligible members, CVS/Caremark explains the importance and benefits of a CMR, including receiving a Medication List and Recommended To-Do List. Members may review their Medication List and Recommended To-Do List with their primary care provider at their next appointment. After the completion of the CMR, any potential drug therapy problems (DTPs) that are identified are sent to the prescribing provider and/or PCP by mail or fax. In addition to the CMR, providers may also receive targeted medication reviews (TMRs) quarterly. The TMRs are completed electronically to look for specific DTPs. If any DTPs are identified, a letter may be mailed or faxed to the provider. Please encourage your patients who receive a welcome letter to participate in our MTM program.

Safety and Monitoring Program

Members with potential overutilization or inappropriate utilization of medications with the potential for high abuse and acetaminophen (APAP) toxicity are identified based on approved criteria and reports are produced monthly. Members meeting the approved criteria are referred to the CVS

Caremark Safety and Monitoring System program for review. The CVS Caremark clinical staff review claims data and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, the case manager will, at a minimum, send written notification to all prescribers by fax requesting information pertaining to the medical necessity of the current narcotic regimen. CVS Caremark will reach out to discuss the case and the prescribers must reach consensus if action is required. In the most severe cases, to assist with control of overutilization, point-of-sale edits may be implemented or other interventions may be pursued. Per Center for Medicare and Medicaid Services (CMS), pharmacy and/or prescriber lock-ins may be implemented for Part D enrollees to address utilization issues with frequently abused drugs (FAD).

Drug Utilization Review (DUR)

Johns Hopkins Advantage MD completes a monthly review of drug utilization data to determine the effectiveness, potential dangers, and/or interactions of the medication(s). Concurrent Drug Utilization Review (cDUR) ensures that a review of the prescribed drug therapy is performed before each prescription is dispensed, typically at the point-of-sale or point of distribution and Retrospective Drug Utilization Review (rDUR) evaluates past data.

Concurrent Drug Utilization Review (cDUR)

The following cDUR edits will occur at point-of-sale at the pharmacy:

- **Seven-day Opioid Naïve Edit**
  - » This safety edit reject limits the initial opioid prescription fill for the treatment of acute pain to no more than a seven days supply. Therefore, if an opioid naïve patient attempts to fill more than a seven days supply of an opioid, the prescription will reject at the pharmacy.
  - » Exemptions to this are patients with a cancer diagnosis, residence in a Long-Term Care facility, Hospice, Palliative Care, and patients who are not opioid naïve.
  - » Pharmacies may request opioid prescribers to submit a Coverage Determination for prescriptions for opioid naïve members when days supply exceeds seven days.
- **Cumulative Morphine Milligram Equivalent (cMME) Edit (aka Care Coordination Edit)**
  - » This rejection will occur if the cMME dose is **greater than 90mg** and the Part D Enrollee has received opioid prescriptions from three or more prescribers in the previous 108 days.
  - » This rejection may be overridden by the pharmacist but they may contact the prescriber for confirmation or request prescribers to submit a Coverage Determination.
- **Duplicate Long-Acting Opioid Edit**
  - » This rejection will occur when prescribed drugs have the same therapeutic effects as medication(s) the Part D Enrollee is currently taking (i.e. member is filling two or more long-acting opioids).
  - » This rejection may be overridden by the pharmacist but they may contact the prescriber for confirmation.
- **Opioid/Benzodiazepine Drug Interaction Edit**
  - » This rejection will occur when interacting drug combinations are identified (i.e. member is filling opioids and benzodiazepines).
  - » This rejection may be overridden by the pharmacist but they may contact the prescriber for confirmation.

Johns Hopkins Advantage MD expects that network prescribers respond to pharmacy outreach related to opioid safety alerts in a timely manner. This includes expecting network prescribers to educate their on-call staff on how to respond to inquiries by the pharmacist during non-office hours. These point-of-sale edits are safety edits and not intended as prescribing limits.

Retrospective Drug Utilization Review (rDUR)

Johns Hopkins Advantage MD tracks and trends all drug utilization data on a regular basis to enable clinical staff to determine when some type of intervention may be warranted. Targeted providers and/ or members will receive information regarding quality initiatives by phone, fax, or mail. Current rDUR studies that may be communicated to members or providers include:

- Overutilization of controlled substances
- Failure to refill prescribed medications
- Narcotic safety including potential abuse or misuse
- Use of medications classified as high risk for use in the older population.
- Multiple prescribers and pharmacies

Letters to members will focus on the rationale for medication adherence and/or the safety issues involved. Letters to providers will include the rationale of the particular concern being addressed and will include all claims data for the selected calendar period applicable to that initiative. For any initiative, if a provider indicates that they did not write a prescription that has been associated with them or that they were not providing care for the member at the time the prescription under investigation was written, please notify Johns Hopkins Advantage MD using the contact information on the letter. A multidisciplinary team develops and determines the direction of pharmacy quality initiatives and the initiatives come from a variety of sources, including but not limited to, claims data analysis, Centers for Medicare & Medicaid Services (CMS) guidance, Pharmacy Quality Alliance (PQA), Food and Drug Administration (FDA) notifications, drug studies, and publications.

SECTION 7
CARE MANAGEMENT

CARE MANAGEMENT

Care Management is intensive coordination and evaluation of care that is appropriate when a member's health care needs are of high acuity and/or the member is at risk of repeat admissions and emergency room (ER) visits. Care Management programs monitor, evaluate, and coordinate appropriate health care services for Advantage MD members, ensuring quality care in a cost-effective manner. Advantage MD is committed to becoming the leader in care management population health solutions.

Care management services are voluntary and are provided at no cost to the member. Our care management model promotes prevention skills, performs health risk identification, and encourages member adherence. We help our members to get the right care, in the right place, at the right time. We are here to support all members wherever they are on the health continuum.

Member Identification

Members are identified for targeted care management interventions through the following means:

- Claims and encounters
- Pharmacy data
- Laboratory data
- PCP, hospital staff, and other referrals from the health care team
- Utilization management staff
- Member self-referral
- Predictive modeling using ACGs (Adjusted Clinical Groups) and other predictive modeling tools; developed by Johns Hopkins HealthCare Solutions

REFERRAL FOR CARE MANAGEMENT

To refer a patient for care management services, call 800-557-6916, Monday through Friday, 8 a.m. to 5 p.m. You can also email caremanagement@jhhp.org. All referrals must include:

- Referral source name and phone number
- Name of member
- Member's current phone number
- Date of birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within two business days.

SERVICE AREAS

Behavioral Health

For members living with a mental health condition such as anxiety, depression, substance use disorders, or autism spectrum disorder, we provide care management services, which includes access to confidential care coordination support.

Behavioral health care managers assist members through their treatment needs. Care managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists, and create plans to support self-management.

Complex Care

Complex care management provides evidence-based interventions for members with high complexity and/or multiple chronic conditions. Care managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists, and create plans to support self-management of chronic conditions to minimize exacerbations.

Health Education

Johns Hopkins Health Plans's Health Educators advocate, encourage and teach about healthy lifestyles and living well with a chronic condition. They provide health education classes and activities; develop and distribute health-related newsletters, fact sheets, and brochures; and collaborate with care managers in providing member education to reinforce members' treatment plans.

Preventive Care

We provide care and resources for members with health risks to stabilize health and prevent development of significant care need. The care management team engages health care providers, closes gaps in care, and promotes self-management of health and wellness.

Transitional Care

Care Managers can provide members with assistance navigating the health care system following a health event such as an emergency room (ER) visit, hospitalization, new diagnosis or significant life event. Care managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists.

SECTION 8
CLAIMS

CLAIMS SUBMISSION

While Advantage MD prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact the Change Healthcare support team at 866-506-2830 for registration support.

The payor ID number for Advantage MD is **66003**.

All completed paper claims forms should be forwarded to the address noted below:

Advantage MD
P. O. Box 3537
Scranton, PA 18505

NDC is required for payment of part B medical injectable medication administered by the provider. Please include the NDC on the claim form.

TIMELY FILING

As an Advantage MD participating provider, you have agreed to submit all claims within 180 days of the date of service. Claims submitted with dates of service beyond 180 days are not reimbursable by Advantage MD. Please note that specific timely filing requirements for Virginia plans are included in the provider contracts.

CLAIM FORMAT STANDARDS

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912**

Advantage MD can only pay claims that are submitted accurately.. The provider is at all times responsible for accurate claims submission. While Advantage MD will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

Note on submission of Part B Medical Injectable: NDC on claim is required for payment of part B medical injectable medication administered by provider.

CLAIM PAYMENT

Advantage MD pays clean claims according to contractual requirements and CMS guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety.A defect or impropriety includes, without limitation, lack of data fields required by Advantage MD orsubstantiating documentation, or a particular circumstance requiring special handling or treatment,which prevents timely payment from being made on the claim.

The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particularcircumstances requiring special treatment that prevents timely payment from being made on the claimIf additional substantiating documentation involves a source outside of Advantage MD, the claim is not considered clean.

PAYMENT INTEGRITY

About the Johns Hopkins Health Plans Payment Integrity Department

Claims must be billed and paid in accordance with laws, regulatory requirements, CMS billing guidelines, provider contracts, and Johns Hopkins Health Plans reimbursement policies. The Johns Hopkins Health Plans Payment Integrity Department ("Johns Hopkins Health Plans Payment Integrity") works to identify, recover and prevent inaccurate, erroneous and/or fraudulent claims payments through numerous activities during the life cycle of a claim. For example, Johns Hopkins Health Plans Payment Integrity engages in subrogation activities, coordination of benefits, activities to detect and identify erroneous payments, improper payments, duplicate payments and/or overpayments, hospital billing audits, data mining in an effort to confirm compliance with enrollment requirements, payment policies, coding/billing rules and/or provider contracts and activities to detect fraud, waste and abuse.

Access Availity for Claims Adjudication Details

Johns Hopkins Health Plans offers details on claims adjudication, including reasons for adjustments, on **Availity** – our secure, online web portal for Johns Hopkins Health Plans members and their in-network providers. Providers can conveniently access information including status of submitted claims, reasons for adjustments on previously paid claims, and additional details related to claims disposition. This information is also available on the Explanation of Payment supplied to providers.

Recoupment, Offset, and/or Adjustments of Erroneous Payments

The Parties shall comply with applicable laws, regulations, and Payor Program requirements related to the recoupment, offset, refund and/or adjustment of erroneous payments, which includes, but is not limited to, erroneous payments, improper payments, duplicate payments, overpayments due to coordination of benefit, suspected provider fraud, improper coding/billing, eligibility issues and other incorrect payments (collectively "Erroneous Payments"). The timeframes for the recoupment, offset, refund and/or adjustment for any Erroneous Payments are set forth in the chart on the following page:

Reason for Retraction	Duplicate Claims	Coordination of Benefits	Suspected Provider Fraud	Payment Error	Improper Coding/ Billing	Eligibility
Advantage MD	36 months from Date of Payment, or unlimited in cases of suspected fraud.	18 months from Date of Service.	Unlimited.	12 months from Date of Payment.	36 months from Date of Payment, or unlimited in cases of suspected fraud.	Unlimited.

If a Provider identifies an Erroneous Payment on its own, then Provider shall voluntarily refund such Erroneous Payments to Johns Hopkins Health Plans within thirty (30) days of Provider's discovery of an Erroneous Payment regardless of the cause of such Erroneous Payment, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful.

If Johns Hopkins Health Plans Payment Integrity identifies an Erroneous Payment, then Johns Hopkins Health Plans Payment Integrity will provide written notice of such Erroneous Payment to Provider. Provider shall refund the Erroneous Payment to Johns Hopkins Health Plans Payment Integrity within thirty (30 days) following the date of Johns Hopkins Health Plans Payment Integrity's written notice to Provider.

If refund of the Erroneous Payment is not received by Johns Hopkins Health Plans Payment Integrity from the Provider within the thirty (30) days following the date of Johns Hopkins Health Plans Payment Integrity's notice, then Johns Hopkins Health Plans Payment Integrity shall be entitled to recoup, offset and/or adjust to collect such Erroneous Payment against any claims payments due and payable to Provider under the applicable Payor Program in accordance with applicable laws, regulations and Payor requirements. In such event, Provider agrees that all future claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes.

Should the provider disagree with any determination that Provider has received an Erroneous Payment, Provider shall have the right to dispute such determination under the procedures in the Provider Claims/Payment Dispute Process section of the Provider Manual. Johns Hopkins Health Plans Payment Integrity reserves the right to recoup the Erroneous Payment amount during the dispute process unless prohibited by applicable laws, regulations and/or Payor requirements. Johns Hopkins Health Plans Payment Integrity reserves the right to employ a third party collection agency in the event of non-payment by Provider of an Erroneous Payment.

NON-PAYMENT OR CLAIM DENIAL

Any denials of coverage or non-payment for services by Advantage MD will be addressed on the provider's Remittance Advice (RA). An adjustment/denial code will be listed per each billed line

if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the RA. Per your contract, the member may or may not be billed for services denied by Advantage MD.

The member may not be billed for a covered service when the provider has not followed the Advantage MD procedures. In some instances, providing the needed information may reverse the denial (i. e., referral form with a copy of the RA, authorization number, etc.). When no benefits are available for the member, or the services are not covered, the RA will alert you. Providers may only bill the member when the RA states there is member responsibility.

PAYMENT DISPUTE PROCESS

A request for review for a provider payment dispute must be received within 90 business days of the date of the denial letter for a medical necessity denial, or the date of denial listed on the EOP for a claims dispute. If the dispute is not received in a timely manner, it will not be processed.

Providers must submit a letter that includes the reason(s) for the request to Advantage MD to overturn or modify payment. Please provide supporting documentation, along with the **Advantage MD Participating Provider Post-Service Payment Dispute Submission Form.**

If a participating provider disagrees with how the claim has processed, they may submit one request for additional review in the following scenarios:

- Overpaid or underpaid per contract
- Clinical review for medical necessity (must include relevant medical support). Most common examples of disputes requiring a medical necessity review:
    1. Inpatient days denied on concurrent review. Note days that have been approved but the provider wants a different level of care will not be reviewed.
    2. Surgeries where the provider request change in codes due to something that occurred during the surgery.
    3. No authorization obtained when provider has given an acceptable reason for being unable to request an authorization.

Send this form with a letter explaining your reason for dispute, supporting documentation, and relevant medical records, if clinical review is requested. Please submit one form per member payment dispute. This form should be completed by Advantage MD participating providers only.

Advantage MD
Attention: Provider Disputes
P. O. Box 3537
Scranton, PA 18505
Or FAX to 855-206-9206

For clinical/medical necessity denials, clinical documentation relevant to the decision will be reviewed by a registered nurse. Established clinical criteria will be applied to the dispute. After review, the dispute may be approved or forwarded to the Plan's medical director for further review and resolution.

A determination letter will typically be sent to the provider within 90 business days from receipt. If the decision is made to adjust the claim to allow full reimbursement, an EOP will be mailed to the provider. If the decision is made to partially adjust the claim or uphold the previous decision, a response letter will be mailed to the provider.

The determination made by Advantage MD of these requests are final and the provider has no further recourse.

NOTE:

- Responses to requests for itemized bills, submissions of corrected claims and submissions of COB/third-party liability information should be sent through the standard Claims Process (see Claims section above)
- Billing submission denials related to maximum units (MUE), invalid code/diagnosis codes, and LCD/NCD denials require submission of corrected claims. This denial type is not eligible for review in the dispute process.
- If this is related to a pre-service request, please see Appeals and Grievance Process section in this manual. A dispute is an internal process established between the provider and Advantage MD. It does not follow the appeal process.

A determination will be made based on the available documentation submitted with the dispute, a review of Advantage MD systems, policies and contracts; as well as CMS billing and coding guidelines. A determination will be sent to the provider within 90 business days from receipt of the dispute. If the decision is made to adjust the claim to allow full reimbursement, the provider will receive an updated remittance advice. If the decision is made to partially adjust the claim or uphold the previous decision, a payment dispute response letter will be provided to the contact listed on the form.

PARTICIPATING PROVIDER POST-SERVICE PAYMENT DISPUTE WITH REQUEST FOR CLINICAL REVIEW

Request for Medical Necessity Review

- A request for clinical/medical necessity review is between the health care participating provider and Advantage MD for reason(s) including but not limited to:
- Lack of authorization/authorization discrepancy
- Medical necessity

Providers have the opportunity throughout the concurrent review process to provide information to the Plan regarding a member's acuity including but not limited to changes in bed placement within the facility's setting. The Advantage MD Plan does not make retrospective adjustments at the bed level.

Advantage MD will render a decision within 90 business days and the provider will be notified by letter. If the denial is overturned, the claim will be reprocessed.

Request for Administrative Review

Administrative denials are made when a contractual requirement is not met, such as late notification of admission or lack of precertification.

Requests for administrative review must address the reason for the denial (i. e. , why precertification was not obtained) and all relevant extenuating circumstances. All administrative reviews will require the submission of full medical records.

If Advantage MD overturns the administrative denial the case is also reviewed for medical necessity and, if approved, the claim will be reprocessed and the provider will be notified. Advantage MD will render a decision within 90 business days.

COORDINATION OF BENEFITS

Please note: Do not bill Medicare for services covered through Advantage MD.

GENERAL DEFINITIONS FOR COORDINATION OF BENEFITS AND SUBROGATION GUIDELINES

Coordination of Benefits (COB): Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred (100) percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.

Order of Benefit Determination Rule: Rules which, when applied to a particular member covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that member. A plan will be determined to have primary or secondary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.

Primary: This carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.

Secondary: This carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

Allowable Expense: Any expense customary or necessary for health care services provided as well as covered by the member's health care plan.

Conclusion: COB is applying the NAIC rules to determine which plan is primarily responsible and plan would be in a secondary position when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations.

Medicare Secondary Payer: The MSP provisions protect the Medicare Trust Fund by ensuring Medicare does not pay for items and services when other health insurance coverage is primarily responsible for paying. The MSP provisions apply to situations where Medicare is not the primary or first payer of claims. Coordination of Benefits (COB) allows plans that provide coverage for a person with Medicare to determine their respective payment responsibilities. The Benefits Coordination & Recovery Center (BCRC) collects, manages, and reports other insurance coverage for Medicare beneficiaries. Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the BCRC to coordinate the information.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on you or a family member's current employment,who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD).
- If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
- If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE®[1] never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

BASIC NAIC RULES FOR COB

Birthday Rule: The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both members have the same date of birth, the plan which covered the member the longest is considered primary.

DUAL ELIGIBILITY BENEFICIARIES

"Dual eligible beneficiaries" describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the Qualified Medicare Beneficiary (QMB) Program. The QMB Program helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments.

All providers are prohibited from billing QMB individuals for all Medicare deductibles, coinsurance, or copayments. All Medicare and Medicaid payments received for services rendered to QMB individuals are considered payment in full. Providers are subject to sanctions if they bill a QMB individual for amounts above the sum total of all Medicare and Medicaid payments (even when Medicaid pays nothing).

All providers must accept assignment for Part B services furnished to dual eligible beneficiaries. Assignment means that the Medicare-allowed amount (Physician Fee Schedule amount) constitutes payment in full for all Part B-covered services provided to beneficiaries.

For more information about dual eligible categories and benefits, please refer to the CMS website: **https://www. cms. gov/Outreach-and-Education/Medicare-Learning-Network-MLN/ MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance. pdf**

[1]TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

SECTION 9

APPEALS AND GRIEVANCE PROCESS

PARTICIPATING PROVIDERS

- A participating provider does not have standard appeal or grievance rights; if authorized by the member, a participating provider can file a pre-service standard appeal or grievance on the member's behalf.
- An Authorization of Representative form for a standard appeal or grievance must be completed and on file with Advantage MD.
- A participating provider has appeal rights for an expedited (fast) appeal.
  - » An expedited appeal is a situation where a participating provider believes and can provide information that the patient's health is in immediate need of care, the service or the item.
  - » The expedited appeal option is not available for medical services or items already provided.
  - » A provider can verbally request a fast appeal by calling 877-293-5325 (PPO members) or 877-293-4998 (HMO members) or submit a written request via fax to 410-424-2806.
  - » A response will be provided to the fast appeal within 72 hours.
  - » For more information on the Medicare Advantage Appeals and Grievance process, please visit the **Medicare Managed Care Appeals & Grievances | CMS** section of the CMS manual.

NON-CONTRACTED PROVIDERS

A non-contracted provider, on his or her own behalf, may request a reconsideration for a denied claim only if the non-contracted provider completes a Waiver of Liability (WOL) statement, which provides that the non-contracted provider will not bill the enrollee regardless of the outcome of the appeal.

- The appeal must be filed within 60 calendar days from the date of the notice of the initial determination.
- Request should include: the name of the enrollee, information identifying which denial is being appealed, and contact information for the appellant.

Mail to:
Advantage MD Appeals
P.O. Box 8777
Elkridge, MD 21075
Phone: PPO: 877-293-5325, **HMO:** 877-293-4998; TTY users may call 711
Fax: 410-424-2806

Must include a completed & signed Waiver of Liability form which can be found here:
hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/advantage-md/forms.html

MEMBER APPEALS AND GRIEVANCES

All appeals and grievances received by Advantage MD will be resolved in a timely manner. Inquiries that involve issues that are subject to appeal will be routed through either the standard or expedited appeal process. Advantage MD members have the right to file a grievance. Situations for which a grievance may be filed include but are not limited to:

- Services
- Dissatisfaction with the office experience such as excessive wait times, provider/staff behavior or demeanor, or inadequacy of facilities
- Quality of care

Advantage MD members have the right to appeal any decision about Advantage MD's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside of the service area or emergency services worldwide
- A denied claim for any health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Advantage MD
- Services not received, but believed to be the responsibility of Advantage MD
- A reduction or termination of a service a member feels medically necessary

In addition, a member may appeal any decision related to a hospital discharge. In this case, a notice will be given to the member with instructions for filing an appeal. The member will remain in the hospital while the appeal documentation is reviewed. The member will not be held liable for charges incurred during this period, regardless of the outcome of the review. Please refer to the Advantage MD Evidence of Coverage (EOC) for additional benefit information.

When requested by the health plan, providers must participate in the resolution of member grievances. Advantage MD may request an expedited response (within 24 hours depending upon the urgency of the grievance) in order to ensure timely resolution of the member's grievance.

SECTION 10
QUALITY IMPROVEMENT

INTRODUCTION

The Quality Improvement (QI) department at Johns Hopkins Health Plans is dedicated to ensuring our Medicare Advantage (MA) beneficiaries receive the highest quality health care services. Medicare QI program strategy supports the "whole person model of care"[1] and leverages processes that can be measured, analyzed, improved and controlled to implement this approach.

MISSION OF QI PROGRAM AT JOHNS HOPKINS HEALTH PLANS

Johns Hopkins Health Plans is guided by its mission to optimize the health of individuals, populations, and communities through innovations and science-based solutions that advance the mission of Johns Hopkins Medicine (JHM). The vision of Johns Hopkins Health Plans is to be the leader in the translation of evidence-based solutions into population health programs and products that drive proven results and empower individuals and communities to achieve good health. The QI program aligns with the mission and vision of Johns Hopkins Health Plans as well as supports organizational strategic priorities.

QI PROGRAM GOALS AND OBJECTIVES

The QI program goals focus on improving health care outcomes while ensuring Advantage MD meets the regulatory standards that measure these results. Given the comprehensive nature of the standards, Johns Hopkins Health Plans has defined four core QI objectives to which all of the QI programs and initiatives are aligned:

- Improve Beneficiary Experience
- Improve Safety of Clinical Care
- Improve Quality of Clinical Care
- Enhance Quality of Service

QI PROGRAM DESCRIPTION

The goal of the QI program is to monitor clinical care, service and experience provided to our beneficiaries while proactively identifying opportunities for prioritizing, improving and implementing QI activities. The primary activities of the QI program focus on preventive care and disease management including chronic conditions such as Diabetes.

The QI Program generates various deliverables annually, including a program description, work plan, and program evaluation. The QI work plan includes detailed information including but not limited to a timeline, accountable stakeholders, and milestones for the planned activities among others. Planned activities focus on quality and safety of clinical care, quality of service, and beneficiary experience initiatives for the upcoming year, which are measurable and tracked regularly.

[1] Department of Health Care Services. (2020). Whole Person Care Pilots. Retrieved from https://www.dhcs.ca.gov/provgovpart/Documents/CAWPCEvalDesignCMSApproval.pdf

QI PROGRAM EVALUATION

The annual program evaluation is a formal report summarizing the overall effectiveness of the QI program including activities, initiatives and studies carried out during the calendar year. The program evaluation includes:

- Trending analyses of the measures/metrics and comparison to the established performance thresholds such as the Centers for Medicare & Medicaid Services (CMS) Star cut points for MA.
- Measure and trending of Healthcare Effectiveness Data and Information Set (HEDIS®), Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS®), and Health Outcomes Survey (HOS) data to identify improvement and enhancement opportunities
- Root cause and barrier analyses for areas where the goal(s) was/are unmet
- Recommendations for future goals and activities to support QI objectives

CONTINUOUS QUALITY IMPROVEMENT

Continuous quality improvement (CQI) in health care is defined as "a structured organizational process for involving people in planning and executing a continuous flow of improvement to provide quality health care that meets or exceeds expectations"[2]. CQI serves critical role in addressing the individual as well as community health and wellness needs thus supporting overall population health improvement goals. The prioritization of QI initiatives within the QI program are guided by the beneficiary needs, which is collected through various modalities such as the MCAHPS and HOS surveys, Quality of Care (QoC) reviews, beneficiaries' complaints and appeals, as well as overall health outcomes measured by HEDIS performance. The QI program uses the CQI process and models to guide the development as well as evaluation of quality initiatives to improve beneficiary health, experience, and QoC.

[2]McCalman, J., Bailie, R., Bainbridge, R., McPhail-Bell, K., Percival, N., Askew, D., & Tsey, K. (2018). Continuous quality improvement and comprehensive primary health care: a systems framework to improve service quality and health outcomes. Frontiers in public health, 6, 76.

*29CFR §825.125- Definition of health care provider

**According to 45 CFR 60.3[Title 45 -Public Welfare Subtitle a-Department of Health and Human Services Subchapter a-General Administration -Part 60 -National Practitioner-Data Bank for Adverse Information on Physicians and Other Health Care Practitioners-Subpart a- General Provisions], a health care practitioner means "an individual other than a physician or dentist, who is licensed or otherwise authorized by a State to provide health care services."

QI INITIATIVES

Quality initiatives are focused actions taken by the Health Plan, provider or practitioner with the goal of improving the quality of health care services, access to care, and beneficiary health outcomes. QI initiatives identification is driven by activities that include, but are not limited to, the following areas:

- CMS Star Ratings performance
- HEDIS measures performance
- Beneficiary satisfaction survey performance, such as the MCAHPS survey
- HOS measures performance
- Pharmacy measures performance
- QoC reviews
- Monitoring beneficiary appeals, complaint and grievance data
- Data analysis and reporting, particularly from programs involving asthma care, diabetes treatment and screening programs (mammography, immunizations, etc.)
- Utilization Management (UM) data
- Provider quality performance data

STAR RATINGS PROGRAM

The Star Ratings Program support CMS's ongoing efforts to "put the patient first in all of our programs"[3]. As part of this effort, patients should be empowered to work with their health care providers to make health care decisions that are best for them. An important component of this effort is to provide Medicare beneficiaries and their families with meaningful information about quality, access and cost to assist them in being informed and active health care consumers.

CMS publishes the "Medicare Part C and D Star Ratings" each year to measure the quality of health and drug services received by beneficiaries enrolled in MA, MA-PDs (Medicare Advantage and Prescription Drug Plans) and Prescription Drug Plans (PDPs or Part D plans). The Star Ratings capture the experiences of beneficiaries as well as assist them in finding the best plan for them. The overall and measure level ratings ranges from 1 Star (lowest) to 5 Stars (highest).

The Star Ratings Program consists of two parts, Part C and Part D for MA-PDs, however only Part C is applicable for MAs and only Part D is applicable for PDPs. The program consists of four key measure types, as noted in figure. 1:

1. Clinical Quality measures:
   - » HEDIS (in Part C)
   - » Pharmacy (in Part D)
2. Administrative measures such as audits, appeals, etc. (Part C and D)
3. Beneficiary Perception measures (Part C and D)
4. QI measures (Part C and D)

[3] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-Star-Ratings-Fact-Sheet-.pdf

The program is further divided into several domains for Part C and Part D that consists of individual measures as a single unit of measurement. Individual measures are assigned specific weights; they can be single-weighted, triple-weighted, four times weighted or five times weighted with higher weights allocated to measures such as beneficiary experience measures (at 4X) that align with the guiding principle of the program. Triple-weighted measures are typically related to a health plan's ability to manage chronic conditions and keep beneficiaries healthy. Certain diseases that are prevalent in this demographic are captured across multiple measures.

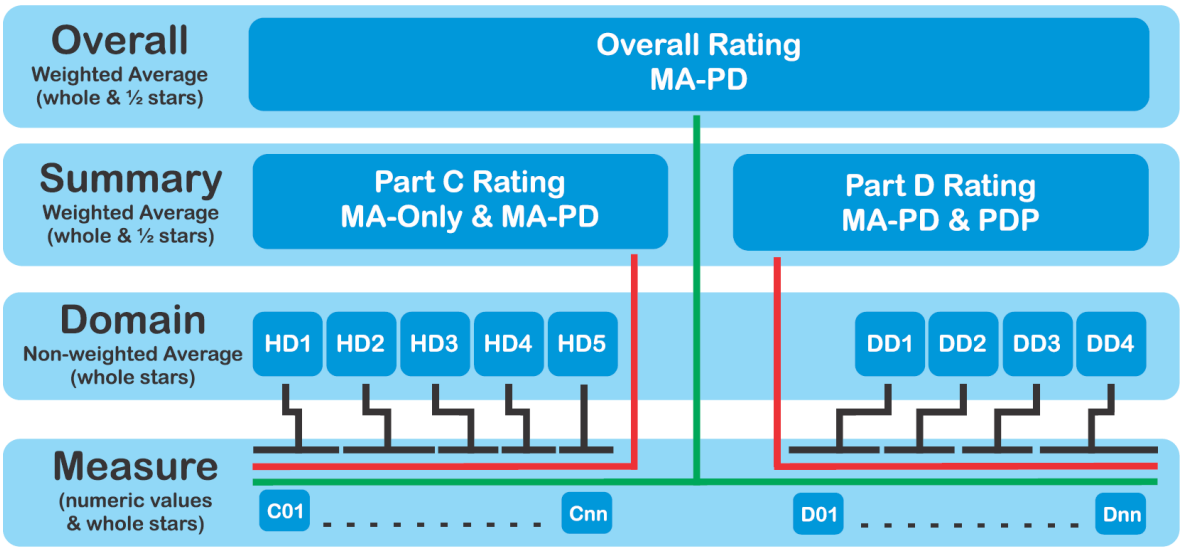

Figure 14: The four levels of Star Ratings that are calculated and reported publicly annually.

HEDIS is a set of 92 core measures with several sub measures that can provide information about the quality of a health plan. Star Ratings program captures a select few HEDIS measures across preventive and chronic condition management categories as well as readmissions and transition of care. The Johns Hopkins Health Plans QI Department coordinates all QI activities associated with the interventions, collection, validation, and submission of HEDIS data as well as other beneficiary experience data. Johns Hopkins Health Plans has contracted with the National Committee for Quality Assurance (NCQA) certified vendor to conduct an external HEDIS audit to ensure compliance with the data collection processes and validation of data prior to submission. Johns Hopkins Health Plans has Information Technology (IT) resources with strict security controls enabling confidential transmission of data via Interactive Data Submission System (IDSS) tool to NCQA.

CMS collects information about Medicare beneficiaries' experiences through the **CAHPS®** survey. All versions of the survey have a nearly identical set of core questions; each version also includes additional questions related to the enrollees' experiences with their own particular plan type. The survey is administered annually by an external NCQA certified survey vendor per protocol outlined in the MCAHPS technical specifications.

The Medicare Health Outcome Survey **(HOS)** is the first patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather valid, reliable,

[4]https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical Notes-Oct-10-2019.pdf

and clinically meaningful health status data from the MA program to use in QI activities, pay for performance (P4P), program oversight, public reporting, and to improve health. All Managed Care Organizations (MCO) with Medicare contracts must participate. The survey uses patient-reported outcomes over a 2.5 year time span to measure health plan performance. Each spring a random sample of Medicare beneficiaries are surveyed from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees. Two years later, the same beneficiaries are surveyed again to collect follow up data. The survey measures if the beneficiaries are "better than expected", "same", or "worse than expected".

CMS uses its contractor, Acumen, LLC, for the analyses of Medicare data to generate the rates for the medication adherence measures in Part D. The Pharmacy Quality Alliance (PQA) maintains the PQA-endorsed performance measures and updates the technical specifications for the measures annually. PQA also shares new measures that are endorsed by PQA with CMS and provides some technical guidance on the use of the measures within the plan ratings. CMS tests updates to PQA-endorsed measure specifications and drug-code lists and implements them as they deem appropriate. Five PQA measures will be included in the 2023 Medicare Part D Star Ratings (i.e., 2021 Calendar Year):

- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Medication Therapy Management (MTM) Program Completion Rate for CMR
- Statin Use in Persons with Diabetes

CHRONIC CARE IMPROVEMENT PROGRAM

MAOs are required to conduct chronic care improvement program (CCIP) initiatives as mandated by CMS. CCIP initiatives are intended to promote effective chronic disease management and improvement of care and health outcomes for beneficiaries with chronic conditions. A CCIP is conducted over a period of three years and deploys CQI process and models such as Lean, Six Sigma, Plan-Do-Study-Act (PDSA), etc.

Currently, Advantage MD has one ongoing CCIP for Preferred Provider Organization (PPO) and one for Health Maintenance Organization (HMO), focused on Diabetes management respectively.

BENEFICIARY SAFETY PROGRAM

The beneficiary safety program outlines the QI program's plan for monitoring QoC, disparities of care, and analyzing outcomes of QI initiatives and studies related to beneficiary safety. The QI program also works in collaboration with JHM to promote quality clinical outcomes and prevent harm to beneficiaries. Beneficiary safety activities performed throughout the organization include, but are not limited to, the following:

- QoC reviews (clinical, behavioral, and pharmacy)
- Monitoring of beneficiary member complaints/grievances
- Medical record chart audits identified through Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) software

- Monitoring for quality and appropriateness of beneficiary member care (Care Management)
- Referral of potential adverse events as identified through review of concurrent services for hospitalized beneficiaries (Utilization Management)
- Provider credentialing activities (Credentialing)
- Safety activities associated with regulatory compliance oversight

ROLE OF PROVIDERS IN THE QI PROGRAM

Providers play a key role in developing, implementing and monitoring various QI and patient safety activities in collaboration with the Health Plan. Studies have demonstrated that the Health Plan-Provider joint QI efforts yield better outcomes and improve beneficiary satisfaction when compared to independent QI activities developed by either a provider or a health plan. This collaborative approach involves sharing provider performance data and participation in health plan led QI initiatives to meet Johns Hopkins Health Plans QI goals and objectives outlined above. Below are a few examples of the provider's role in the health plan quality program:

- Review quality opportunity reports and take action to improve clinical outcomes as measured by HEDIS measures
- Collaborate with the health plan to resolve beneficiary complaints regarding access to care, QoC, provider service, or other quality/cost/access issues
- Provide medical records as requested for HEDIS, QoC investigations, or other medical record audits
- Collect and share quality relevant information such as performance data for the purposes of joint quality initiatives
- Participate in beneficiary satisfaction initiatives, including improving access to care

A number of providers are routinely invited to participate in health plan QI committees. The perspectives from participating providers are valuable in evaluating clinical efficacy and improving provider as well as beneficiary satisfaction. In addition, Advantage MD relies on participating providers to offer feedback on clinical practice guidelines, preventive health guidelines, and medical and pharmacy policy.

SECTION 11
MEDICAL MANAGEMENT

MEDICAL MANAGEMENT

The Medical Management program is designed to focus on utilization management (UM) including behavioral health processes that enable Johns Hopkins Health Plans to coordinate efficient and effective medical care for its members. The Medical Management program mission is to improve the lives of plan members by providing access to high-quality, cost-effective, member-centered health care in support of the Johns Hopkins medicine mission of patient care, teaching and research.

MEDICAL MANAGEMENT PROGRAM GOALS

- Ensure that our members' rights and privacy are recognized, safeguarded, and protected;
- Assess the utilization of health care resources and ensure that care is accessible and provided in a seamless, efficient, and effective manner at the most appropriate level of service;
- Provide a system of prospective, concurrent and retrospective review to determine the medical necessity and/or appropriateness and efficiencies of health care rendered in all settings;
- Ensure continuity and consistency of benefit and clinical criteria administration;
- Identifying patterns of over- and under-utilization among providers and facilities and under-utilization of resources;
- Evaluate the outcomes, reportable events and patient and provider satisfaction with the utilization management process to assure highly effective and safe care;
- Ensure that services and care rendered to members meet all accreditation and regulatory requirements;
- Evaluate the overall effectiveness of the program annually; and
- Continually evaluate the metrics, as measured by national and regulatory external utilization and/or quality benchmarks, which supports the achievement of goals and support the development of interventions to improve opportunities.

MEDICAL MANAGEMENT DEPARTMENT FUNCTIONS

- Prior authorization
- Concurrent review
- Discharge planning
- Continuity of care

CLINICAL REVIEW CRITERIA

Advantage MD is committed to maintaining the health and wellness of all members through UM, ensuring that care is provided at the right time and in the right setting. The Medical Management department evaluates requests for services regarding medical care, behavioral health, and substance abuse treatment based on nationally recognized evidence based clinical criteria or guidelines and local healthcare delivery options. Prior authorization is required for certain services and review of requests for authorization for elective hospital admissions as outlined in the Evidence of Coverage (EOC). All review decisions are based upon active enrollment, benefit coverage, and appropriate care and service. Nurses, Pharmacists, Behavioral Health Specialists, and Physicians administer the UM department policies. Medical Management evaluates requests for services regarding medical care, behavioral health, and substance abuse treatment based on Medicare guidelines and nationally recognized evidence-based clinical criteria or guidelines and local health care delivery options.

ACCESSIBILITY

Medical Management staff is accessible at least eight hours daily (with the exception of holidays), between 8 a. m. to 5 p. m. Eastern Time, Monday through Friday. In order to adhere to CMS turnaround times, as identified in Chapter 13 of the Medicare Managed Care Manual, the medical management department has limited weekend hours. A confidential voicemail and secure fax capabilities will be provided during and after regular hours of operation. The Medical Management department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Furthermore, language assistance/ interpretation is available for members.

MEDICAL MANAGEMENT CONTACT INFORMATION

Phone 844-560-2856
Fax 855-704-5296

BEHAVIORAL HEALTH CONTACT INFORMATION

Phone 844-340-2217
Fax 844-363-6772

EMERGENCY SERVICES

An emergency is a condition in which a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Emergency services do not require prior authorization. If a member is admitted from the emergency room to inpatient, the hospital is required to notify Advantage MD within 48 hours of the admission or next business day.

UTILIZATION MANAGEMENT PROCESS

The Medical Management utilization management process complies with CMS regulations for Medicare Advantage health plans as outlined in Chapter 13 of the Medicare Managed Care Manual (CMS. gov).

UTILIZATION MANAGEMENT

Overview

Advantage MD, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and services and existence of coverage.
- Advantage MD does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits. .
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service
- Access to UM Staff is available. Advantage MD associates are available at least eight hours a day during normal business hours, Monday through Friday, for inbound communications regarding UM inquiries. Health plan UM associates are available eight hours a day, Monday through Friday, during normal business hours, excluding some state and federal holidays. NCC clinical services unit associates are available 24 hours a day, seven days a week. Advantage MD offers TDD/TTY services for deaf, hard of hearing or speech-impaired members. For all members who request language services, Advantage MD provides services free of charge through bilingual staff or interpreter to help members with UM issues.

Criteria and Clinical Information for Medical Necessity

Johns Hopkins Health Plans medical policies, which are publicly accessible on its website **HopkinsHealthPlans.org,** are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for all Johns Hopkins Health Plans lines of business.

InterQual™ criteria is used to determine medical necessity for all levels of care. In the absence of licensed InterQual criteria, Advantage MD may use Johns Hopkins Health Plans medical policies. A list of the specific Johns Hopkins Health Plans medical policies and clinical UM guidelines used will be posted and maintained on the **Johns Hopkins Health Plans website** and can be obtained in hard copy by written request. The policies described above support precertification requirements, acute inpatient care, clinical- appropriateness, claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, National and Local Coverage Determinations are provided by Centers for Medicare & Medicaid Services (CMS) and will

supersede InterQual and Johns Hopkins Health Plans medical policy. Medical technology is constantly evolving, and Johns Hopkins Health Plans reserves the right to review and periodically update medical policy and utilization management criteria. The Johns Hopkins Health Plans Utilization Management department reviews the medical necessity of medical services using:

- National and Local Coverage Determinations provided by Centers for Medicare and Medicaid Services (CMS)
- Johns Hopkins Health Plans medical policies
- InterQual

Advantage MD follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the For Providers section of the Johns Hopkins Health Plans website at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/policies**

These procedures apply to:

- Precertification
- Concurrent reviews
- Retrospective reviews

Only a medical director/physician reviewer may make an adverse determination (denial) based on medical necessity. Requests for services/care should include current applicable and appropriate ICD and CPT codes and relevant clinical information. Appropriate clinical information includes:

- Office and/or hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic testing results
- Treatment plans and progress notes
- Psychosocial history
- Consultation notes
- Operative and pathological reports
- Rehabilitation evaluations
- Estimated/anticipated length and/or frequency of treatment

Referral/Precertification Process

Referrals to in-network specialists are not required for payment; however, Advantage MD highly recommends PCPs supply the member with instructions for follow-up care. Visit the **For Providers** section of our website to download a *Personalized Treatment Plan* form under > Forms.

Precertification and Notification — General

Covered services require notification and/or precertification prior to services being rendered.

Notification is a communication received from a provider informing Advantage MD of the intent to render covered medical services to a member. For services that are emergent or urgent, notification should be provided within 24 hours or by the next business day.

- Notification is received by telephone, fax or electronically.
- Member eligibility and provider status (in-network and out-of-network) is verified.

Precertification is the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered and a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

Services requiring precertification include but are not limited to:

- Elective inpatient admissions, including skilled nursing facilities (SNF), acute rehabilitation, behavioral health and substance detox
- Select outpatient and specialty care provided outside of the PCP's scope of practice
- High-tech radiology
- Durable medical equipment
- Home health services
- All behavioral health inpatient services
- Out-of-network services (applicable to HMO members, or PPO members when the provider is requesting in network benefit).

To verify whether or not a particular service requires precertification, visit the Johns Hopkins Prior Authorization Lookup tool (JPAL), a provider resource to check and verify precertification and prior authorization requirements for outpatient services and procedures. Located in the **Availity** and **HealthLINK** portals, JPAL offers a user-friendly way for providers to look up prior authorization requirements.

If a delay in service, treatment, procedure, or discharge is identified during the process of utilization review for an inpatient stay, and the delay will result in, or is anticipated to result in an overall extended length of stay, the hospital days resulting from the delay in service/treatment/procedure/discharge will be denied.

Precertification is **not** required for the following medically necessary covered services:

- Routine laboratory tests (excluding genetic testing)
  - » HMO members must use a contracted provider. Prior authorization is required for a non-contracted provider
  - » PPO members must use a contracted provider to receive in network benefits. Out of network benefits will apply to services performed by a non-contracted provider.

- Routine X-rays, EKGs, EEGs or mammograms
  - » HMO members must use a contracted provider. Preauthorization is required for a non-contracted provider
  - » PPO members must use a contracted provider to receive in-network benefits. Out of network benefits will apply to services performed by a non-contracted provider.
- Office-based behavioral health services such as individual therapy and medication management

The Associate Chief Medical Officer will periodically review and revise this list with the expectation that additional services will be added as practice patterns of the network warrants.

Appointment of Representative

A representative of a member may request services on behalf of a member either via phone or fax with a completed Appointment of Representative form signed by the member. **The Appointment of Representative** form is also available on the Advantage MD member website.

Authorizations include, but are not limited to transportation, home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.

Utilization Management – Outpatient Services – Medical and Behavioral Health

Outpatient Precertification

Precertification is required and must be requested at a minimum of 72 hours before the service/procedure is expected to be provided. This applies to the following types of care (this list may be modified periodically):

- Prior authorizations for post-acute services, outpatient physical therapy beyond the first 12 visits, outpatient occupational therapy beyond the first 12 visits, radiology and cardiology imaging services will be provided through the vendor eviCore Healthcare.
- Home health care
- Skilled nursing or extended care facilities
- DME
- Cardiac rehabilitation
- Outpatient diagnostic radiology
- Behavioral health IOP, PHP, TMS, or ECT
- In addition, for HMO plans, precertification is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider or for PPO members when the provider is requesting in network benefit.

  For precertification requirements for behavioral health services, please fax to 844-363-6772 or call 844-340-2217.

Medical Exception and Prior Authorization Process

For information regarding prior authorization for provider administered Part B medications, refer to Section 6 of this manual.

Precertification Determination Time Frames

For services that require precertification, Advantage MD will make a determination in a timely manner so as not to adversely affect the health of the member. The determination will be made within 14 calendar days of the date of the initial request for standard requests.

For urgently needed services, expedited decisions will be made within 72 hours. Per CMS, expedited organization determination is "when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy."[1]

[1] Medicare Managed Care Manual Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans).

Utilization Management – Inpatient Services – Medical and Mental/Behavioral Health

Inpatient care refers to medical treatment that is provided in a hospital or other facility and requires a stay of at least two midnights.

Inpatient Admission Notification Time Frames

- All elective admissions must receive prior approval through Utilization Management at least 72 hours prior to the admission or scheduled procedure.
- Urgent and emergent admissions require notification to Advantage MD within 48 hours, or by the next business day of admission, whichever comes last.

The following information should be provided to the Utilization Management department for precertification at our dedicated fax numbers: 844-240-1864 or 855-704-5297:

- Member's name
- Member's address
- Member's Advantage MD ID number
- Member's date of birth
- Member's PCP
- Scheduled date of admission and/or surgery
- Name of hospital
- Member's diagnosis
- Attending provider
- Clinical information (if applicable)

All Advantage MD members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. Advantage MD will not pay for any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each member's case will be examined individually in this respect.

The following are not acceptable reasons for an admission before surgery:

- Member, provider or hospital convenience
- Routine laboratory or X-ray
- NPO (i. e. , nothing by mouth)
- Distance or transportation to the hospital
- Most preps

Upon notification, Advantage MD reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the member's medical condition, medical criteria and practice standards.

Specialist Referrals

Referrals to in-network specialists should be provided by the member's primary care provider for the HMO plan. PPO members do not need a referral to see an in-network provider and may utilize out of network benefits to see an out of network provider.

Inpatient Admission Review

- All medical and mental/behavioral health inpatient hospital admissions, including those that are urgent and emergent, will be reviewed for medical necessity within 72 hours of the facility notification to Advantage MD.
- Clinical information for the initial (admission) review will be requested by Advantage MD at the time of the admission notification.
- For all admissions, the facilities are required to provide the requested clinical information within 24 hours of that request If all clinical information is not received within 24 hours of notice of admission, the request for authorization of admission will be reviewed by the medical director for medical necessity with any and all available clinical information.

Inpatient Concurrent Review

For all inpatient admissions, the concurrent review clinician will conduct a review of the medical records electronically or by telephone to determine the authorization of coverage for a continued stay.

- The concurrent review clinician will conduct reviews for each continued stay day and will review discharge plans.
- Determination of approved/denied days and coverage will be communicated to the facility for the continued stay.
- The Advantage MD concurrent review clinician will help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

Discharge Planning

Discharge planning is designed to assist the provider with coordination of the member's discharge when acute care (i. e. , hospitalization) is no longer necessary.

When a lower level of care is necessary, Advantage MD works with the provider to help plan the member's discharge to an appropriate setting for extended services.

Discharge plan authorizations follow the applicable nationally recognized clinical criteria or guidelines and documentation requirements.

INFORMATION USED TO MAKE UM DECISIONS

The Medical Management department will review or may request, information relevant to any UM decision for coverage used to determine medical necessity UM staff gathers pertinent information that may include any/all of the following:

- The procedure/treatment type/length of stay requested, procedure code(s) and diagnosis code(s)
- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychological history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- Individual clinical circumstances and history

The type of service requested determines which medical documentation or criteria will be required. When sufficient information is not available to make a determination, every effort is made to obtain the necessary information within the specified time frame. If the Medical Management department cannot obtain all relevant documentation, it must make or recommend a decision to the client/health plan based on the material available.

TIMELINESS OF UM DECISION-MAKING

Timely UM decisions are critical for the safety and quality of care provided to our membership.

Decisions are made in a timely manner to accommodate the urgency of the members' clinical situation, thereby minimizing disruption and/or delay to the provision of health care services.

Timeliness standards for decision through notification for utilization management approvals and denials are outlined in **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective August 3, 2022.**

- **Standard Organization Determination:** The determination will be made as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date the organization receives the request.
- **Extended Timeframe:** The health plan may extend the time frame to make a determination up to 14 additional calendar days if requested, and justified, to allow the member or the organization time to provide additional information.
- **Expedited Organization Determination:** A written or oral request to expedite a determination may be made by a member or any provider, when they believe that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. If the Plan decides to expedite the request, the determination must be rendered expeditiously, but no later than 72 hours after receiving the request.

Explanation of Determination: Peer-to-Peer

Upon faxed notification of a denial, the member's treating physician can request a telephone call with the medical director to explain the rationale for the determination decision. The treating physician may also obtain guidance on additional information that may be needed to successfully appeal the determination, but a denial decision cannot be overturned during this phone call.

The request for this telephone call must be made within two (2) business days of the faxed notification of denial for inpatient/concurrent review cases, or within three (3) business days of the faxed notification of denial for outpatient/preservice review cases, and the telephone call must take place within two (2) business days of the request. To initiate this request, the physician may contact Advantage MD at 888-401-3592 from 8:30 a. m. to 5:00 p. m. Eastern time.

APPEALS PROCESS

Member appeals are processed in accordance with Medicare guidelines as outlined in Chapter 13 of the Medicare Managed Care Manual (CMS. gov). A provider may act on behalf of a member during the appeals process with the member's permission.

NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

The Notice of Medicare Non-Coverage (NOMNC) letter is a CMS approved patient letter that a provider must deliver to a Medicare Advantage patient receiving covered services in a Skilled

Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF). The letter notifies the member, in writing, that the member's Medicare health plan and/or provider have decided to terminate the member's covered care and, as a result of the termination of services, the member has appeal rights. The NOMNC must be delivered to a patient at least two (2) calendar days before Medicare covered services end OR the second to last day of service if care is not being provided daily.

The form may be found on the CMS website **https://www.cms.gov/medicare/medicare-general-information/bni/downloads/instructions-for-notice-of-medicare-non-coverage-nomnc.pdf**

SECTION 12
COMPLIANCE

COMPLIANCE WITH CONTRACT, FEDERAL, STATE AND LOCAL LAWS AND REGULATIONS AND CMS INSTRUCTIONS

Provider will comply with Advantage MD's contract with Centers for Medicare and Medicaid Services (CMS) and all federal, state and local laws and regulations and CMS Instructions, including but not limited to:

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse ("FWA"), including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq.) and the anti-kickback statute (42 U.S.C.1320a-7); and
2. HIPAA Administrative simplification rules at 45 CFR parts 160, 162, and 164.

DISCRIMINATION AGAINST MEMBERS

Providers will not deny, limit, or condition the coverage or furnishing of benefits to members on the basis of any factor that is related to health status, including, but not limited to medical condition, including mental health as well as physical illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability. Provider shall comply with Section 1557 of the Affordable Care Act (42 USC 18116) and all applicable implementing regulations, including but not limited to providing required notices and meeting applicable accessibility standards.

In addition, Provider 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 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.

FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES COMPLIANCE[1]

Advantage MD (also referred to as "Plan") is committed to meeting all requirements of applicable federal, state and local laws and regulations, as well as the CMS instructions and guidance specific to the Medicare Advantage Part C and Part D (MAPD) programs. This includes those provisions related to oversight of Advantage MD's First Tier, Downstream and Related Entities (FDRs) to which the provisions of administrative or healthcare services have been delegated. Under applicable law and regulation, health care providers providing services to members of the Advantage MD Plan are FDRs.

CMS defines an FDR as the following:

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage program or Part D program. (See 42 CFR §423.501)

Downstream Entity[2] is any party that enters into an written agreement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant, or a Part D plan sponsor or applicant, and a first tier entity. These written agreements continue down to the level of the ultimate provider of both health and administrative services. (See 42 CFR §423.501)

Related Entity is any entity that is related to an Medicare Advantage Organization or Part D sponsor by common ownership or control and

1. ***Performs some of the Medicare Advantage Organization or Part D plan sponsor's management functions under contract or delegation;***
2. ***Furnishes services to Medicare enrollees under an oral or written agreement; or***
3. ***Leases real property or sells materials to the Medicare Advantage Organization or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See 42 CFR §423.501).***

FDRs are required to follow all contract provisions related to sub-delegation and any Advantage MD policies relating thereto. Sub-delegation occurs when a Advantage MD First Tier Entity has given another entity the authority to carry out a delegated responsibility that the Plan initially delegated to that First Tier Entity.

[1] Medicare Managed Care Manual Ch. 21 §40 (42 CFR 422.503(b)(4)(vi), 422.504(i), 422.504(b)(4)(vi), 422.505(i))

[2] Medicare Managed Care Manual Ch. 21 §50.6.6

STANDARD OF CONDUCT[3]

Advantage MD requires that all FDRs, including Provider, supporting the Medicare Advantage and Part D Prescription Drug Program either adopt and abide by the Advantage MD Code of Conduct or implement a code of conduct that incorporates requirements consistent with Advantage MD's Code of Conduct. A copy of the Plan's Code of Conduct can be located in the Resource and Guidelines All Health Plan provider section of the Johns Hopkins Health Plans website at: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines**.

The Provider's Code of Conduct must set forth your overarching principles and values by which you operate. It must also provide the standards by which your employees, independent contractors, and downstream and related entities (subcontractors) will conduct themselves, including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations and policies.

All employees, independent contractors, and downstream and related entities (subcontractors) of Provider are required to comply with all applicable laws, whether or not specifically addressed in the Code of Conduct. This includes reporting of issues of non-compliance and potential FWA. Provider must provide guidance to its employees, independent contractors, and downstream and related entities (subcontractors) regarding how to report potential compliance issues. In addition, it is the responsibility of Provider to ensure that all reported issues are promptly addressed and corrected.

Upon the discovery of a compliance deficiency, either through Provider's internal compliance activities or notification by Advantage MD, FDRs must promptly address, correct and report the deficiency in accordance with CMS rules, regulations and guidance.

Provider's Code of Conduct should include provisions to ensure employees and independent contractors (including managers, officers, and directors) as well as downstream and related entities (subcontractors) responsible for the administration or delivery of the Medicare benefits are free from any conflict of interest in administering or delivering Medicare benefits. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage.

Provider's Code of Conduct should be distributed to employees, independent contractors, and downstream and related entities (subcontractors) within 90 days of hire or contracting, when there are updates to the Code of Conduct, and annually thereafter. Provider must require that all employees, independent contractors, and downstream and related entities (subcontractors), as a condition of employment or contracting, sign a certification that they have read and agree to comply with all written compliance policies and procedures and the Code of Conduct within 90 days of date of hire and annually thereafter. These certifications must be retained by Provider for 10 years from the date of termination of the agreement between Advantage MD and CMS and shall be made available to Advantage MD or CMS upon request.

[3] Medicare Managed Care Manual Ch. 21 §§ 50.1.1,50.1.3, and 50.3.1 (42 CFR 422.503(b)(4)(vi)(A) and 422.504(b)(4)(vi)(A))

GENERAL COMPLIANCE AND FRAUD, WASTE AND ABUSE EDUCATION[4]

All Provider employees (including temporary or volunteer), independent contractors, and downstream and related entities (subcontractors) must complete required annual compliance and fraud, waste and abuse (FWA) training if they are involved in the administration or delivery of the Medicare Program benefits pursuant to the Provider's agreement with Advantage MD (i.e., provide any medical, administrative, or other services directly to Advantage MD members or to the Plan in connection with its contract with CMS). All such individuals should receive training within 90 days of initial hire or contracting and annually thereafter.

To ensure consistency and reduce burden on FDRs, including Provider, CMS has developed a web-based training module that FDRs must use to satisfy the Medicare compliance and FWA training requirement. It is available on CMS' Medicare Learning Network (MLN Provider Compliance website): **https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/providercompliance.html**

CMS has developed an attestation on the last page of the training that can be utilized as documentation evidencing completion of the training. This attestation must be available for each individual required to complete the compliance and FWA training, upon request by Advantage MD or CMS.

Provider must maintain a log of employees, independent contractors, and downstream and related entities (subcontractors) who are required to take the training (both at the time of initial hire or contracting and on an annual basis) and all such individuals who have completed the training. This information must be maintained by Provider for 10 years from the date of termination of Advantage MD's contract with CMS.

It is important to note that individuals and entities that are enrolled in the Medicare Program, such as Provider, or accredited as Durable Medical Equipment Prosthetics, Orthotics and Supplies ("DMEPOS") providers are deemed to have met the FWA training requirements set forth in this Section; however, CMS General Compliance program training must nevertheless be completed.

REPORTING FWA[5]

Advantage MD takes its responsibility seriously to protect the integrity of the care its members receive, its Health Plan, and the Medicare Advantage Program it administers. Reporting is essential for the prevention, detection and correction of FWA. Advantage MD has numerous methods by which a report can be made.

- Anonymous reports can be made to Advantage MD's 24/7 toll free hotline at 844-SPEAK2US (844-773-2528). To the extent possible, reports are kept confidential. Anonymous reporting and Spanish interpretation services are available through the Compliance Hotline, SPEAK2USADVANTAGEMD.

[4] 42 CFR 422.503 (b)(4)(vi)(3), Medicare Managed Care Manual Ch. 21 §50.3.2 (42 CFR 422.503(b)(4)(vi)(C) and 423.504(b)(4)(vi)(C),and HPMS Memos dated 6/17/15 Update – Reducing the Burden of Compliance Program Training Requirements and 2/10/16 Additional Guidance Compliance Training Requirements and Audit Process Update

[5] Medicare Managed Care Manual Ch. 21 §50.4 (42 CFR 422.503(b)(4)(vi)(D) and 423.504(b)(4)(vi)(D))

- **By Mail:** Payment Integrity Department,
  Attention: FWA, 7231 Parkway Drive, Suite 100,
  Hanover, MD 21076
- **Phone:** 410-424-4971
- **Fax:** 410-424-2708
- **Email:** FWA@jhhp.org

Advantage MD takes seriously its responsibility to protect your reporting of actual or suspected fraud and abuse. No employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, the Plan has enacted zero-tolerance policies and annually trains all personnel on their obligation to uphold the highest integrity when handling compliance related matters. All employees, independent contractors, and downstream and related entities (subcontractors) of Provider are required to comply with all applicable laws, whether or not specifically addressed in the Code of Conduct, and must report issues of non-compliance and potential FWA through the appropriate mechanisms established by Provider without fear of retaliation. Any individual who reports a compliance concern has the right to remain anonymous and Advantage MD commits to enforcing this right.

Provider must provide guidance to employees, independent contractors, and downstream and related entities (subcontractors) regarding how to report potential compliance issues.

Provider must ensure that reported issues are promptly addressed and corrected. It is important that any and all concerns relating to Advantage MD are reported to the Plan either directly or through Provider's procedures for referring issues to Medicare Advantage Plan Sponsors. Failure to report a possible violation or suspected FWA that Provider knows about may result in investigation of Provider and potentially disciplinary action.

CMS defines fraud as: knowingly and willingly executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.[6]

Health care fraud examples include but are not limited to the following:

- Misrepresentation of the type or level of service provided;
- Misrepresentation of the individual rendering service;
- Billing for items and services that have not been rendered;
- Billing for services that have not been properly documented;
- Billing for items and services that are not medically necessary;
- Seeking payment or reimbursement for services rendered for procedures that are integral to other procedures performed on the same date of service (unbundling); and
- Seeking increased payment or reimbursement for services that are correctly billed at a lower rate (up-coding).

[6] Medicare Managed Care Manual Chapter 21 §20 Definitions and 18 USC §1347

Abuse is defined by CMS as actions that may, directly or indirectly result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.[7]

Both fraud and abuse can expose an FDR, including Provider, to criminal and civil liability.

REPORTING OF OTHER COMPLIANCE CONCERNS[8]

Provider, and its employees, independent contractors and downstream and related entities (subcontractors) are required to report concerns about actual, potential or perceived misconduct to the Johns Advantage MD Corporate Compliance Department at the numbers/addresses noted above.

Any concerns about program noncompliance or suspected FWA should always be reported to the Advantage MD Compliance Department using the contact information listed at the beginning of this section. Immediately below is a list of examples of such reporting. The list is not intended to be all inclusive:

- HIPAA violations that impact Advantage MD members.
- Allegations that the complainant has been contacted by "someone" from Advantage MD requesting personal or medical information.
- Instances where Medicare Advantage requirements (e.g., timeframes, appropriate enrollee notifications, marketing guidelines, etc.) are not being met.
- Instances where Provider becomes aware that an individual or entity involved with the Advantage MD Medicare Advantage program has become excluded from participation in federal programs.

For ***reporting all other issues*** to Advantage MD, please contact 877-293-5325. Immediately below is a list of examples of such reporting. The list is not intended to be all inclusive.

- Quality of care received from an Advantage MD contracted provider or any entity
- Access to care
- Coverage decision (medical or pharmacy)
- Filing a grievance

[7] Medicare Managed Care Manual Chapter 21 Section 20

[8] Medicare Managed Care Manual Ch. 21 §50.4 (42 CFR 422.503(b)(4)(vi)(D) and 423.504(b)(4)(vi)(D))

OIG AND GSA EXCLUSION SCREENING[9]

As an FDR of Advantage MD, Provider is prohibited from employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 CFR 1001.1901). Upon hiring or contracting and monthly thereafter, Provider is required to verify that its employees (including temporary and volunteer), independent contractors, and downstream and related entities (subcontractors) are not excluded by comparing them against the Department of Health and Human Services ("DHHS") Office of the Inspector General ("OIG") List of Excluded Individuals and Entities ("LEIE") and the General Services Administration ("GSA") System Award Management ("SAM") Database. Upon discovery of an excluded individual, Provider must provide immediate disclosure to Johns Hopkins Advantage MD. No payment will be made by Johns Hopkins Advantage MD for any item or service furnished by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion. To assist Provider with implementation of the OIG/GSA Exclusion process, links to the OIG and GSA exclusion websites and descriptions of the lists are set forth below.

SAM – **www.sam.gov**

The Excluded Parties List System ("EPLS") is maintained by the GSA, now a part of the System for Awards Management ("SAM"). The EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States.

LEIE – **http://exclusions.oig.hhs.gov**

This list is maintained by HHS OIG and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

OFFSHORING[10]

The term "Offshore" refers to any country that is not one of the fifty (50) United States, the District of Columbia or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands). Subcontractors that are considered Offshore may be either American-owned companies with certain portions of their operations (including those related to their agreement with Advantage MD) performed outside of the United States or foreign-owned companies with their operations performed outside of the United States ("Offshore Subcontractors").

[9] Medicare Managed Care Manual Ch. 21 §50.6.8

[10] CMS HPMS Memos dated: July 23, 2007, September 20, 2007 and August 26, 2008: Regarding Offshoring of PHI Outside the United States(copies of memos are available on the Plan's provider **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines**

The FDR must ensure its employees have read and understand all requirements pertaining to the regulations for services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies. Consistent with CMS direction, this applies to entities the FDR may contract or sub-contract with to receive, process, transfer, handle, store or access beneficiary protected health information (PHI) in oral, written or electronic form. Prior to an FDR sub-delegating any Advantage MD Medicare related-work, the FDR is required to provide notification of such action, provide all information necessary for Advantage MD to comply with all CMS offshoring requirements and comply with all sub-delegation requirements. A copy of CMS' Offshore Attestation may be found on the Plan's provider website at: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines**

MEDICAL RECORD DOCUMENTATION

Provider must maintain members' medical record documentation in a manner that is current, detailed, organized, promotes effective and confidential patient care and quality review, and meets generally accepted standards and established goals for medical record keeping. To access and review the Plan's Medical Record Documentation Policy in its entirety to which Provider is subject, please click on the following hyperlink: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines**

RECORD RETENTION AND INSPECTION OF RECORDS FOR AUDIT PURPOSES[11, 12]

FDRs, including Provider, must comply with Medicare laws, regulations, and CMS instructions (42 CFR 422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years. Documents and data submitted to CMS must be certified (based on best knowledge, information and belief) as being accurate, complete and truthful.

In accordance with Chapter 11 of the Medicare Managed Care Manual, the Department of Health and Human Services, or their designees have the right to:

- Inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s), first-tier and downstream entities involving transactions related to the CMS contract with Plan as specified above under §110.4.4 of Chapter 11;
- Inspect, evaluate, and audit any pertinent information and for any particular contract period through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Failure to allow access may result in a referral of the Plan Sponsor and/or FDR to law enforcement and/or implementation of other corrective actions, including intermediate sanctioning.

[11] Medicare Managed Care Manual Ch. 21 §50.3.2 §50.6.11 and Ch. 3 §100.4

[12] Medicare Managed Care Manual Ch. 21 §50.6.6

CMS MEDICARE ADVANTAGE PROGRAM AUDITS[13]

The CMS Medicare Parts C and D Oversight and Enforcement Group (MOEG) conducts Part C and Part D program audits to ensure that its Plan Sponsors are appropriately delivering benefits to Medicare beneficiaries and are safeguarding beneficiaries' access to medically necessary services and prescription drugs. CMS program audits evaluate Plan compliance with a number of mandated requirements including but not limited to Advantage MD's oversight of its FDRs.

During the MOEG audit, Providers will be requested to: submit documentation demonstrating oversight of FDRs and compliance with CMS requirements. Providers should be "audit ready" at all times.

Documents that should be available for immediate audit to meet CMS required timeframes and formats include but are not limited to:

- Evidence of compliance and FWA training,
- Evidence of OIG/Exclusion list checks,
- Documents related to FDRs ongoing monitoring and auditing,
- Copies of detailed corrective actions/performance improvement plans in response to identified issues,
- Timelines demonstrating implementation of corrective actions, and
- Other documentation CMS may request to demonstrate Johns Hopkins Advantage MD's effective oversight of FDR activities.

PRIVACY/RELEASE OF MEMBER INFORMATION AND/OR RECORDS AND/OR CONFIDENTIALITY

It is the policy of Advantage MD 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) and HITECH Act.

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 deceased) 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.

[13] Medicare Managed Care Manual Ch. 21 §50.6.11

CONFIDENTIALITY

Advantage MD FDRs are expected to maintain internal policies and procedures within their offices and/or entities to prevent the unauthorized use and/or inadvertent disclosure of confidential information. These internal policies and procedures must be in compliance with all applicable federal and state regulations and in accordance with the terms of the Participating Provider Agreement and Payor Addendum.

SECTION 13
HEALTH PLAN RESPONSIBILITIES

Unless otherwise exempted by CMS, Advantage MD may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by Advantage MD Medicare on the basis of any factor related to health status. This includes, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Advantage MD will cover emergency and urgently needed services from any licensed provider. Advantage MD must make timely and reasonable payment to or on behalf of our members for the following services obtained from a provider or supplier that does not contract with Advantage MD where services are covered by Advantage MD:

- Ambulance services dispatched through 911 or its local equivalent.
- Maintenance and post-stabilization care services.
- Services for which coverage has been denied by Advantage MD and found (upon appeal) to be services the member was entitled to have furnished or paid for by Advantage MD. Advantage MD will cover renal dialysis for those temporarily out of Advantage MD's service area. Advantage MD will cover influenza and pneumococcal vaccination with no copay. Advantage MD must provide for continuation of member health care benefits for all members, for the duration of the contract period for which CMS payments have been made:
- For members who are hospitalized on the date its contract with CMS terminates or, in the event of an insolvency, through discharge.

If Advantage MD suspends or terminates an agreement under which the physician provides services to Advantage MD members, Advantage MD will give the affected provider written notice of the following:

- The reasons for the action including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Advantage MD.
- The affected physician's right to appeal the action and the process and timing for requesting a hearing.

Advantage MD will ensure that the majority of the hearing network members are peers of the affected physician.

If Advantage MD suspends or terminates a contract with a physician because of deficiencies in the quality of care, Advantage MD will give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities that include National Practitioner Data Bank and Health Integrity Practitioner Data Bank (NPDB/ HIPDB).

ANTI-DISCRIMINATION

Consistent with the requirements of the Medicare Managed Care Manual, Chapter 6, Section 50, the policies and procedures concerning provider selection and credentialing, and the requirement that all Medicare-covered services be available to all MA plan members and MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

ADVICE TO MEMBERS

An MA organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a member and enrolled under an MA plan about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

JOHNS HOPKINS
HEALTH PLANS

Customer Service: 877-293-5325 (PPO) | 877-293-4998 (HMO)

HopkinsHealthPlans.org

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