2024 Provider Manual

Employer Health Programs

JOHNS HOPKINS
HEALTH PLANS

Our Philosophy

Employer Health Programs (EHP) is founded on three guiding principles.

Medical care is a sacred trust and privileged relationship between patient and doctor that must be respected.

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

Each plan member is EHP's most important member.

We put this philosophy to work every day in the way that we manage the care of our members and process your claims.

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Section I:
INTRODUCTION

Introduction

Employer Health Programs (EHP) views our providers as valuable resources for the success of the EHP program. Your continued independence, clinical freedom and satisfaction are essential to the program's overall effectiveness. This Provider Manual is intended to maximize the value of the program for you and your EHP members by enhancing your knowledge of how to effectively administer its policies and procedures.

This manual has been updated and should be used as a reference and source document for both providers and their office personnel. EHP will continue to update the manual based on changes within the program or the needs of providers and/or members.

It is important to understand that this manual clarifies various provisions of the EHP Payor Addendum that you have already signed and is incorporated as part of that document. In the event that a conflict is identified between a provision of this manual and the EHP Payor Addendum, the EHP Payor Addendum will always take precedence.

As an EHP provider, you've joined a team of professionals dedicated to cost-effective, patient-centered, quality health care, and it's our goal to keep you informed.

Overview

Johns Hopkins Health Plans was founded in 1994 as a joint venture between The Johns Hopkins Hospital and the Johns Hopkins University School of Medicine.

In 1996, the Johns Hopkins Health System created Employer Health Programs (EHP) as a vehicle to provide health benefits for its employees. EHP is a way for employers to self-fund their benefits programs (as opposed to purchasing insurance). Johns Hopkins Health Plans is the administrator (often called a third party administrator or TPA) of these benefit programs for EHP clients.

Johns Hopkins Health Plans provides a wide spectrum of products and services for more than 43,000 EHP members. Our provider network consists of more than 14,000 primary and specialty care providers and more than and 30 hospitals in Maryland. Members also have access to a nationwide network of providers and hospitals through the Cigna PPO network. Members can search for a provider in the Cigna PPO network by visiting **https://sarhcpdir.cigna.com/web/public/consumer/directory/search?consumerCode=HDC016**. Providers may also call 866-494-4872 for more information.

Johns Hopkins Health Plans is currently contracted with the following employer groups:

- Broadway Services, Inc.
- Howard County General Hospital/TCAS
- Johns Hopkins Bayview Medical Center
- The Johns Hopkins Health System Corporation
- The Johns Hopkins Hospital
- Sibley Memorial Hospital
- Suburban Hospital

Each plan is tailored to meet the needs of each individual client.

Section II:
PROVIDER INFORMATION

Primary Care Provider

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

Roles and Responsibilities

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

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

- Providing timely, accessible health care to members
- Providing PCP accessibility standards for members
- Emergency – A sudden, severe onset of illness or a medical problem requiring immediate attention. The member should receive care immediately.
- Urgent – 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.
- Routine – 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 within three weeks.
- Health Maintenance – Timely preventive care services should be provided based on established guidelines. Covered services are defined in benefit plan documents and links to national and society guidelines are available on the Johns Hopkins Health Plans **Medical Policy** site.
- Behavioral Health—Refer new or existing members to the Emergency Department within six hours of notification of a non–life-threatening behavioral health situation.
- 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:
    1. An answering service with specific instructions on how the member can reach the practitioner directly for urgent services and how to access emergency services.
    2. Mobile phone with protocols for how the member can reach the practitioner directly for urgent services and how to access emergency services
    3. Answering machine/voicemail with specific instructions on how the member can reach the practitioner directly for urgent services and how to access emergency services
- Cooperating and complying with Johns Hopkins Health Plans utilization management procedures
- Cooperating and complying with all Johns Hopkins Health Plans 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.

Confidentiality

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

Specialty Providers

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

Responsibilities of the specialty provider include:

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

As a courtesy, a dedicated Specialty Appointment Line is available to all EHP members. This service helps members navigate and schedule new specialty appointments with a Johns Hopkins provider.

This line is not intended to guarantee members a specific turnaround time to be seen, but will ensure that when it's possible, EHP members will be seen within a reasonable period of time for their specific health issue.

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.

Network Access Standards

Johns Hopkins Health Plans complies with state regulations designed to help make sure our plans and providers can give members access to care in a timely manner. These state regulations require us to ensure members are offered appointments within the following time frames:

EHP

Service	Appointment wait time (not more than):
History & Physical Exam	Ninety (90) calendar days
Routine Health Assessment	Thirty (30) days
Non-urgent (Symptomatic)	Seven (7) calendar days
Urgent Care	Twenty-four (24) hours
Emergency Services	Twenty-four (24) hours
Behavioral Health Routine Initial	Ten (10) business days
Behavioral Health Routine Follow-up	Thirty (30) calendar days
Behavioral Health Urgent	Forty-eight (48) hours
Behavioral Health Emergency	Six (6) hours

Provider Services (Customer Service)

Representatives from the Customer Service department respond to and document all member and provider telephone calls, written comments and requests. Provider complaints are forwarded to the Provider Relations department for investigation and resolution. Member complaints are forwarded to the Complaints and Grievances department.

Provider Relations

The Provider Relations department is a collective team of professionals who act as liaisons between Johns Hopkins Health Plans 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. The department can be reached by phone at 888-895-4998.

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

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

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

Provider Communication

Support information such as updated policies, 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 sources include:

- *Provider Pulse* is a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories, and news pertaining to our four health plans, including EHP.
- *MyEHP* is a member newsletter that is produced three times a year. It features human interest stories, resource information, health tips, and a host of other information suited for the member.
- EHP providers may visit **HopkinsHealthPlans.org** to find useful and updated information such as the provider manual, policies, forms, guidelines, announcements, and a host of other information specifically developed for the EHP provider network community.

Changes in Provider or Site Status

Changes to provider information (i.e., telephone number, address, covering physicians, etc.) must be submitted to Provider Relations, via fax or mail, on the provider's letterhead. When possible, notification of changes should be made at least thirty (30) days in advance of the change.

Additions, deletions, or other changes to the provider's office information must be communicated in writing to Johns Hopkins Health Plans Provider Relations as soon as possible via email at ProviderChanges@jhhp.org or through our online **Digital Provider Information Update Form**. Provider Information Update form. You can also mail or fax changes to:

Johns Hopkins Health Plans
Attn: Provider Relations
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax: 410-762-5302

Credentialing

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

Prior to becoming Johns Hopkins Health Plans 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 Practitioner Data Bank (NPDB), Office of the Inspector General (OIG), General Services Administration (GSA), state licensing boards, medical specialty boards, and professional certification boards to compile a complete and full credentialing file.

The provider's credentialing file is reviewed by the Special Credentials Review Committee (SCRC), a committee of the Board of Directors of Johns Hopkins Health Plans. 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 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 (recredentialing event) for as long as the provider or facility/hospital remains an active participant in the Johns Hopkins Health Plans EHP provider network.

Types of Providers Requiring Credentialing

Practitioners 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 EHP provider network include, but are not limited to:

- Primary care physicians (medical and osteopathic)
- Specialty physicians (medical and osteopathic)
- Podiatrists
- Certified nurse practitioners
- Physician assistants
- Certified nurse midwives
- Chiropractors
- Physical therapists
- Audiologists
- Speech therapists
- Occupational therapists
- Clinical psychologists (doctoral)
- Clinical social workers
- Professional counselors
- Marriage and family therapists
- Optometrists
- Organizations including hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers

Credentialing Practitioners

Initially, practitioner applicants must submit the Maryland Uniform Credentialing Form (MUCF) to apply for participation. The MUCF is available through the Council for Affordable Quality Healthcare (CAQH) on their website. Practitioners, 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. Contact Provider Relations at 410-762-5385 or at 888-895-4998.

Alternately, the practitioner may request a hard copy MUCF from Johns Hopkins Health Plans or go online to the **Maryland state website** and download the MUCF.

The hard copy application must be returned to Johns Hopkins Health Plans for processing. The practitioner's application must be complete including all service locations from which the practitioner will provide medical service to EHP patients, education including residency and fellowship programs, clinical experience(s) for at least the past five years, malpractice/professional liability insurance coverage, medical and professional certifications held, licenses held for at least the past five years, DEA and CDS registrations, clinical affiliations with facilities/ hospitals, malpractice claim history, and contact information. The application must be signed and dated by the applicant including an attestation that serves as a release of information and a statement that the information contained within the application is true and accurate. Additionally, the practitioner must respond to all disclosure questions pertaining to clinical and professional experience and history.

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

The practitioner is also notified if 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 EHP provider network or termination of ongoing participation.

Practitioners have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Practitioners also have the right to explain any information that may vary substantially from that provided and/or may correct any erroneous information that has been collected. They may do so by telephone, fax, email, or correspondence to the credentialing department, or the network manager 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 practitioner. These verifications are performed in accordance with the National Committee for Quality Assurance (NCQA)and state and federal guidelines and regulations:

1. Current licensure as an independent vendor in the state where service will be rendered
2. Education – degrees, internship, residency, and fellowship programs completed, relevant to current licensure
3. Medical board certification
4. Professional certification
5. Work history for the past five (5) years (gaps of six (6) months or greater must have explanation of the gap)
6. Hospital admitting privileges (clinical associations)
7. DEA registration and CDS certification as appropriate for scope of practice
8. Professional liability insurance

9. Malpractice activity and history
10. Federal, Medicare, or Medicaid sanctions
11. Disciplinary actions by licensing boards, educational institutions, professional organizations, or medical service providers including facilities

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

1. History of chemical dependency and substance or alcohol abuse
2. History of license revocations or disciplinary actions
3. History of criminal convictions other than minor traffic violations
4. History of loss or limitation to clinical privileges
5. History of complaints filed with local, state, or national societies or licensing boards
6. History of refusal or cancellation of professional liability insurance
7. History of federal, Medicare, or Medicaid sanctions including restrictions on DEA or CDS
8. 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 sixty (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 thirty (30) days to appeal the decision. See "Johns Hopkins Health Plans Provider Grievance Process."

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:

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

3. Any limitations or exclusions imposed by the federal government, or Medicare or Medicaid entity
4. 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)
5. For non-accredited organizations, Johns Hopkins Health Plans will accept a state assessments/evaluations or CMS review
6. Onsite review for organizations without accreditation or state/CMS review
7. Professional liability/malpractice insurance

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.

Organizations have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Organizations also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. Such requests may be done by telephone, fax, email, or correspondence to the credentialing department at 410-424-4619 or the senior network manager at 888-895-4998, responsible for this type of organization. The mailing address for Johns Hopkins Health Plans is:

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

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. See "Johns Hopkins Health Plans Provider Grievance Process."

Provider Notification to Johns Hopkins Health Plans

The practitioner 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:

1. 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.
2. 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.
3. Provider is disciplined by a state licensing board or a similar agency.

4. 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.
5. 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.
6. There is a change in the provider's business address or telephone number.
7. 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.
8. There is any change in the nature or extent of services rendered by the provider.
9. Provider's professional liability insurance coverage is reduced or canceled.
10. There is any other act, event, occurrence, or the like that 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 Participating Provider 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

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 following termination for any member whose medical condition requires a continuing course of treatment where alternative arrangements have not been made.

Johns Hopkins Health Plans Provider Grievance Process

Should a practitioner or organization be terminated from the network or otherwise not be approved for participation through the recredentialing 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 EHP provider network. At least one 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 thirty (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 sixty (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 thirty (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 thirty (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.

Transition of Care Upon Provider Termination

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

In some cases, member(s) may be able to continue care with a terminated practitioner for a short period of time after the practitioner 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.

Important Contact Information

EHP Customer Service
800-261-2393
410-424-4450

Cigna PPO Network
https://sarhcpdir.cigna.com/web/public/consumer/directory/search?consumerCode=HDC016 or 866-494-4872

Mental Health and Substance Abuse Services
800-261-2429
410-424-4476

EHP Care Management
800-261-2421
410-424-4480
410-424-4890 (fax)

Care Management
800-557-6916
caremanagement@jhhp.org
410-424-4885 (fax)

Medical Management Fax Numbers
Inpatient Initial: 410-424-2770 (fax)
Inpatient Concurrent: 410-424-4894 (fax)
Non-Urgent Outpatient: 410-762-5205 (fax)
Urgent Outpatient: 410-424-2707 (fax)

Corporate Compliance
410-424-4996 (fax)
410-762-1527
compliance@jhhp.org

Provider Relations
888-895-4998
410-762-5385
410-424-4604 (fax)

Appeals
410-762-5383

Health Education
800-957-9760

Pharmacy Provider Prior Authorization for Medical Necessity
Fax numbers may vary. Refer to provider website: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/ehp/pharmacy-formulary**

www.ehp.org

HopkinsHealthPlans.org

Network Hospitals

Johns Hopkins Health Plans has contracts with the majority of hospital facilities within Maryland. For a complete and up-to-date listing of EHP participating hospitals, please refer to the provider search tool at HopkinsHealthPlans.org

Availity Essentials: Provider Portal

As part of our continuing effort to boost efficiency and streamline processes, Johns Hopkins Health Plans introduces a new provider portal developed in collaboration with our vendor, Availity.

Availity Essentials is a secure, real-time platform that connects providers with payers to help providers manage medical benefits and insurance claims. The portal allows providers to view remittances, validate eligibility and benefits and track claims with ease. The impetus for the switch to Availity Essentials is to lighten administrative burdens while engaging with Johns Hopkins Health Plans, giving providers time back in their day to deliver exceptional patient care.

Johns Hopkins Health Plans is taking a phased approach with the new provider portal. The following functions are available for providers:

- 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:
- Providers can access commonly used forms, find customer service numbers for our plans, review policies and procedures and more.
- Providers can keep up to date on our communications and provider education presentations.

For more information, visit **availity.com**

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.

Billing and Claims

Office Visit Copayment

Providers should collect the applicable office visit copayment and/or deductible from the member at the time of service. Providers should note that copayment amounts are variable and different plans may have different copayment amounts or no copayment at all.

Coinsurance

Network providers providing service to members are encouraged to collect any applicable coinsurance after EHP has made payment to the physician. The physician remittance will indicate the member's coinsurance liability.

Claims Submission

Claims should be filed using a standard CMS 1500 or UB-04 claim form. Claims must be submitted within **180 days** of the date of service.

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

Billing for Non-Covered Services

A network provider may not require payment from a member for any excluded services that the member received from the network provider, and the member is "held harmless" unless the following scenarios apply. Excluded or excludable services may include statutory exclusions (e.g., cosmetic procedures, certain durable medical equipment items or supplies) or services considered to be unproven or experimental. Providers are required to check member benefits and eligibility, and follow all applicable prior authorization requirements, as Hold Harmless provisions apply.

A network provider may not require payment from the member for any non-covered services that the member received from the network provider (i.e., the member will be held harmless), except as follows:

- If the member did not inform the provider that he or she was an EHP member, the provider may bill the member for services provided.
- If the member was informed that the services were excluded or excludable and he/she agreed in advance in writing to pay for the services, the provider may bill the member.

An agreement to pay must be evidenced by written records. "Written records" must include a statement or letter written by the provider or member prior to receipt of the services, acknowledging that the services were excluded or excludable, including a description of the service(s), the payment amount and agreement to pay for them, signed by the member and the provider.

General agreements to pay, such as those signed by the member at the time of admission, are not evidence that the member knew specific services were excluded or excludable.

Timely Filing

Paper and electronic claims, as well as corrected claims, must be filed within 180 calendar days of date of service. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Timely filing requirements are defined in the provider agreement. EHP will deny claims submitted after the filing deadline. Corrected claims may be submitted electronically, please follow CMS guidelines.

If you are submitting your claims on paper and would like to submit electronically, or would like to receive payment electronically, contact our EDI Analyst at EDI@jhhp.org or 410-424-4710. You can also submit and check the status of claims through **Availity**, the secure, online web portal for Johns Hopkins Health Plans providers and EHP members. Contact Provider Relations at 888-895-4998 to learn more.

The mailing address for EHP claims is:
EHP
P.O. Box 4227
Scranton, PA 18505

Under some circumstances, the following attachments may be requested in order for a claim to be processed:

- A referral or consultant treatment plan
- Treatment plans, which may be required for certain specialty services such as physical therapy
- An explanation of benefits statement from the primary payor
  - **Required if EHP is the secondary payor**
- A Medicare Remittance Notice
  - **Required if the claim involves Medicare as a primary payor**
- A description of the procedure or service, which may include the medical record
  - **May be required if a procedure or service rendered has no corresponding CPT or HCPCS code**
- Operative notes
  - **May be required if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82**
- Anesthesia records documenting the time spent on the service
  - **May be required if the claim for anesthesia services rendered includes modifiers P4 or P7**
- Documents referenced as contractual requirements in a global contract
  - **May be required if there is a global contact between Johns Hopkins Health Plans and a health care practitioner, hospital, or person entitled to reimbursement**
- An ambulance trip report
  - **May be required if the claim is for ambulance services submitted by an ambulance company licensed by the Maryland Institute for Emergency Medical Services Systems**
- Office visit notes
  - **May be required if the claim includes modifier 21 or 22, or an audit of the health care practitioner, hospital, or person entitled to reimbursement demonstrated a pattern of fraud, improper billing, or improper coding**
- Admitting notes, except in the case of emergency services rendered in accordance with Health-General Article, 190701(d) a 19-712.5 Annotated Code of Maryland
  - **May be required if the claim for services provided is outside of the time or scope of the authorization or when there is an authorization in dispute**
- Physician notes, except in the case of emergency services rendered in accordance with Health-General Article, 190701(d) a 19-712.5 Annotated Code of Maryland
  - **May be required if the claim for services provided is outside of the time or scope of the authorization or when there is an authorization in dispute**
- Itemized bill, except in the case of emergency services rendered in accordance with Health-General Article, 190701(d) a 19-712.5 Annotated Code of Maryland
  - **May be required if the service is rendered in a hospital and the hospital claim does not have prior authorization for admission or is inconsistent with Johns Hopkins Health Plans concurrent review determination rendered before the delivery of services regarding the medical necessity of the service**

Payment Integrity

The 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 Essentials 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 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 time frames for the recoupment, offset, refund and/or adjustment for any Erroneous Payments are set forth in the chart below:

Reason for Retraction	Duplicate Claims	Coordination of Benefits	Suspected Provider Fraud	Payment Error	Improper Coding/Billing	Eligibility
EHP	36 months from Date of Payment, or unlimited in cases of suspected fraud	18 months from Date of Payment	Unlimited	36 months from Date of Payment	36 months from Date of Payment	24 months from Date of Payment

If a Provider identifies an Erroneous Payment on its own, then the 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, noncompliant 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 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 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 nonpayment by Provider of an Erroneous Payment.

Provider Claims/Payment Dispute Process

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and EHP for reason(s) including but not limited to:

- Rejected untimely filing of claim
- Coordination of benefits (EOB of primary carrier required)
- Itemized bill requested
- Invoice attached/MUE denial
- Overpaid/underpaid per contract
- Fee schedule
- Contract rate
- Not duplicate claim
- Authorization on file (authorization number required)
- Referral attached

Responses to itemized bill requests, and submission of COB/third-party liability information should also be sent with the Provider Claims/Payment Dispute and Correspondence Submission Form.

No action is required by the member. **Payment disputes do not include medical appeals.** Providers will not be penalized for filing a payment dispute. All information will be confidential in accordance with EHP's policies and/or applicable law or regulation. The Adjustments department will receive, distribute and coordinate all payment disputes. To submit a payment dispute, complete the *Provider Claims/Payment Dispute and Correspondence Submission Form* located in the Forms section in the back of this manual or **online** and mail to:

Johns Hopkins Health Plans
Adjustments Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Or fax to 410-424-2800.

EHP must receive the payment dispute within 90 business days of the paid date of the explanation of payment (EOP). The provider must submit **a written request, including an explanation of the issue in dispute, the reason for dispute and supporting documentation** such as an EOP, a copy of the claim, medical records or contract page.

The Adjustments department will research and determine the current status of a payment dispute. A determination will be made based on the available documentation submitted with the dispute and a review of EHP systems, policies and contracts.

A determination will be sent to the provider within 30 business days from receipt of the payment dispute. 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 payment dispute response letter will be mailed to the provider. The response letter will include:

- Provider name
- Member name, ID number and date of birth
- Date of service
- Claim number
- Dispute number
- Date of initial filing of concern
- Written description of the concern
- Decision
- Further dispute options

Remittance Advice Statement

The items listed below correspond with the Remittance Advice Form that EHP currently follows. Together, they provide specific information regarding the review and interpretation of the EHP remittance advice. This remittance is used for all providers who submit claims to Johns Hopkins Health Plans. Thus, there may be sections that are not applicable for posting and reconciliation of certain claims.

Payee . . . . . The name and address of the payee as indicated on the submitted claim

Check Date . . . . . The date the check (if any) was prepared

Payee Number . . . . . The payee's tax identification number

Check Number . . . . . The number of the check (if any)

Date of Service . . . . . The "from" and "to" dates submitted on the claim

Procedure Code . . . . . Procedure or revenue code which best describes the service(s) rendered

Billed Amount . . . . . The amount identified by the provider as a charge for a service or procedure

Charges Above Max . . . The portion of the billed amount that is in excess of the established fee maximum for the procedure. This amount is not a member liability.

Disallowed Amount . . . . The dollar value of a service that is not eligible for payment

Allowed Amount . . . . . The amount eligible for payment

Deduct/Copay/Coins . . Identifies the member's liability for cost-sharing features (deductible, copayment and/or coinsurance) of the program

Other Insurance Paid . . The total dollar amount paid by any other insurance carrier or Medicare

Subscriber Liability . . . . The dollar amount that the provider may collect from the subscriber. This amount includes any applicable deductible, copayment, coinsurance,

and charges for noncovered services.

Net Payable . . . . . The total dollar amount being paid for the procedure. The allowed amount minus deductible, copayment/coinsurance minus other insurance paid equals net payable.

Remark Code. . . . . The code number that identifies a message to the provider regarding payment of the claim. Codes are defined at the end of the remittance.

Patient Name . . . . . The name of the member for whom services were provided

ID . . . . . The member's 11-digit identification number assigned by EHP. The ID number should always be referenced when contacting EHP regarding a claims matter or the status of a member.

Account Number . . . . . The member's account number derived from the CMS 1500 form or the UB-04 form

Claim Number. . . . . The number assigned to a specific claim by claim number should always be referenced when contacting EHP regarding a claim's matter.

Provider Name . . . . . The name of the provider who provided services for submitted claim

Provider ID. . . . . The identification number assigned to the specific provider submitting the claim

Line of Business . . . . . The code indicating in which lines of business the patient is a member. EHP's line of business code is E.

Claim Total. . . . . The total dollar value of all individual line items submitted on a single claim

Payable Total. . . . . The total of all payable claims included in the remittance advice

Remittance Total . . . . . The overall total of all claims included in the remittance advice

Remark Code. . . . . Definition of all remark codes indicated on the remittance

Coordination of Benefits

Benefits will be coordinated when members are covered under both EHP and another health care benefit plan. When EHP is considered the primary coverage, EHP will reimburse the full amount for covered medical services, which is the physician's billed charge or the contracted fee schedule (less any applicable copayment, coinsurance, or deductible), whichever is less.

When EHP is secondary, it will reimburse the physician the difference between the benefit paid by the primary plan and the amount that would be paid under the EHP plan in the absence of other coverage.

If EHP is the secondary plan, only covered expenses up to the plan's fee schedule may be covered. Any applicable copays, coinsurance or deductibles under the two plans still apply.

The plan of the member's employer is the primary plan. To determine benefits for covered dependent children, the plan of the parent whose birthday falls earliest in the year is the primary plan for children. In the case of children whose parents are legally separated or divorced, a court order setting responsibility for health care expenses supersedes the birthday rule.

When EHP is the secondary plan, it will deem the primary plan to have made all benefit payments that would have been made had the member complied with all of the rules of the primary plan. For example, if you fail to submit a claim in a timely manner to the primary plan or do not get the required authorization for treatment, EHP will make its secondary payment based on the payment the primary plan would have made if the claim was submitted on time or the required authorization was obtained.

When EHP is secondary, it will reimburse the physician for covered services in conjunction with the primary plan so that the two programs pay no more than 100% of the charges or the EHP fee maximum, whichever is less. EHP will never pay more than it would have as the primary program. In either case, the physician cannot balance bill the member.

Providers should submit a claim to the primary insurance carrier for each date of service, then submit a claim to EHP with the primary insurance remittance for the same date of service. The primary insurance remittance must include the denial reason and denial explanation. The claim must be submitted with the primary insurance remittance within 180 calendar days of the primary remittance date.

Member Complaints and Grievances

A complaint is a written or verbal expression of dissatisfaction. EHP members may submit complaints to EHP via phone by calling customer service at 410-424-4450 or 800-261-2393. Members may also submit a complaint in writing to:

EHP
Attn: Member Complaints and Grievances Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Time frames for resolution of a member complaint are:

- Administrative complaint. . . . . 30 days after the complaint is filed
- Emergency medical complaint . . . . . 24 hours after complaint is filed
- Non-emergency medical complaint . . . . . 5 days after the complaint is filed

Providers are expected to participate in the resolution of member complaints related to access to care, quality of care, quality of service and office site quality. EHP may request an expedited response (24 hours to five calendar days, depending upon the urgency of the complaint) in order to ensure timely resolution of the member's complaints.

Complaint Reconsideration Process

If a member is dissatisfied with the initial resolution of a complaint, the member may submit a verbal or written request for reconsideration of the original resolution of a complaint. A resolution will be sent to the member within 30 days from when the reconsideration was filed.

Provider Complaint Process

Providers may contact their Provider Relations network manager to file a complaint. The Provider Relations department can be reached by phone at 410-762-5385 or 888-895-4998 or by fax at 410-424-4604.

Appeals Process

Johns Hopkins Health Plans will reconsider denial decisions upon request by an EHP member, member's guardian or participating provider.

Appeals generally fall into two categories:

- Administrative appeals are usually the result of an automatic denial.
- Automatic denials entail a simple decision based on fact.

Examples of automatic denials include:

- The patient is not a member.
- The member was not eligible at the time service was rendered.
- The claim was submitted with incorrect coding.
- The claim was denied for failure to meet the timely filing requirements.
- The service is not covered by the plan.
- The service is obtained from a nonparticipating provider without prior authorization (for specific plans).
- The service is in a category where benefits have been exhausted.
- Any payment issues regarding overpayment/underpayment.
- Any COB request.

Providers, members, or member's guardians may appeal or request a reversal or an adjustment of a denied or paid claim. All administrative appeals must be received within 90 business days of the date of the denial. All appeals should clearly state the reason for the appeal.

Claims resubmitted without documentation identifying the claim as an appeal or corrected claim will be reprocessed and automatically rejected as a duplicate claim. The provider must submit a separate appeal letter or appeal form for each member claim that is being appealed.

All appeals should be faxed to 410-762-5304 or mailed to:

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

Medical appeals (emergency and non-emergency) generally involve some interpretation or judgment.

Examples of medical denials include:

- Questions of medical necessity
- Administration of benefit plan design
- Matters requiring clinical decision-making

Most appeals of Utilization Management denials fall into this category unless it is demonstrated that a factual error occurred. Medical appeals (emergency and non-emergency) will be reviewed by a health plan medical director.

Provider Appeal Requests Process

Administrative Appeals Versus Clinical Medical Necessity Appeals

A clinical/medical necessity and administrative appeal is any appeal between the health care provider and EHP for reason(s) including but not limited to:

- Emergency room visit
- Observation
- Code review/claim check
- Level of care
- Out of network
- Not a covered benefit
- Lack of authorization/authorization discrepancy
- Medical necessity
- Pharmacy claims
- Preservice claims

Administrative Appeals

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical information was not submitted).

If EHP overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed or the requester will be notified of the action that needs to be taken.

Clinical/Medical Necessity Appeals

A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied before services are rendered (preservice) and care denied after services are rendered (postservice), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

EHP offers a medical necessity appeal process that provides members, member representatives and providers the opportunity to request and participate in the re-evaluation of adverse actions. The member, member representatives and providers will be given the opportunity to submit written comments, medical records, documents or any other information relating to the appeal. EHP will investigate each appeal request, gathering all relevant facts for the case before making a decision.

Both administrative and clinical/medical necessity appeals must be received within 90 business days of the date on the denial letter. The provider must submit **an appeal letter, including the reason for appeal, and supporting documentation** including medical records.

Clinical documentation relevant to the decision will be retrospectively reviewed by a licensed/registered nurse. Established clinical criteria will be applied to the appeal. After retrospective review, the appeal may be approved or forwarded to the plan medical director for further review and resolution.

A determination will be sent to the provider within 30 business days from receipt of the appeal request. 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, an appeal request response letter will be mailed to the provider. The response letter will include:

- Provider name
- Member name, ID number and date of birth
- Date of service
- Claim number
- Dispute number
- Date of initial filing of concern
- Written description of the concern
- Decision
- Further dispute options

Please fill out the *Provider Appeal Submission Form, Clinical/Medical Necessity Appeals Only* **form**, which is in this manual under the Forms section or online.

The form and other related clinical information should be filled out and mailed to:

Johns Hopkins Health Plans
Appeals Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Or fax to 410-762-5304.

Emergency Medical Appeal

In cases where the PCP or attending physician believes that noncoverage of a treatment, procedure, or service (which has been given or is proposed to be given) will have an immediate adverse effect on the health of the member, the member's guardian, the PCP, or the attending physician may request an immediate Emergency Medical Appeal by contacting the Utilization Management department at 800-261-2421.

Non-Emergency Medical Appeal

In cases which relate to the health of a member, but do not qualify as an emergency medical appeal, a provider, member, or member's guardian may request an appeal by contacting the Appeals Department in writing.

The time frame for a response to an appeal is as follows:

- Urgent/emergent preservice appeal. . . . . 36 hours
- Non-urgent preservice appeal. . . . . 15 calendar days
- Non-urgent postservice . . . . . 30 calendar days

All appeals must be received within ninety (90) business days of the date of denial.

Prospective, Concurrent and Retrospective Review

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

- Patient demographic information
- Attending physician and facility
- Date of procedure
- Procedure proposed
- Diagnosis
- Pertinent clinical data

Requests that do not meet standardized clinical criteria are referred to the medical director for review and a determination. The decision is communicated by phone and in writing within two working days of the determination. Potential denials are referred to the medical director for a final determination. The denial is given in writing to the attending physician, the PCP, and the member, if the member is adversely affected by the decision.

Certain types of admissions are referred to a Utilization Management clinician to obtain the following types of information:

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

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

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

Utilization Management

EHP is committed to maintaining the health and wellness of its members by encouraging preventive services and ensuring that members receive quality medical services in the appropriate settings.

EHP plans do not require a PCP or referrals in order to obtain benefits.

The PCP and the member together should determine the best course of health care services for that member. Members are asked to select a PCP from the EHP provider network, which can be accessed through our website.

The PCP will refer to another provider when the patient requires treatments that are outside the scope of the PCP's practice.

In exceptional circumstances, where a specialist physician is providing comprehensive care for a member, the specialist may be designated as the member's PCP. The member, the member's original PCP, and the member's specialist PCP must all concur. The designation of a specialist as a PCP must be approved by the medical director and be reapproved on an annual basis. The member, PCP, or specialist may terminate the arrangement at any time by notifying the medical director. Under the agreement, the specialist is responsible for providing all primary care services and coordination of referrals. Under the agreement, the specialist is not required to coordinate specialty care with the original PCP.

Overview

EHP, 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 service and existence of coverage.
- EHP 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. EHP 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. EHP offers TDD/TTY services for deaf, hard of hearing or speech-impaired members. For all members who request language services, EHP provides services free of charge through bilingual staff or interpreter to help members with UM issues.
- NICU admissions or a readmissions following a NICU graduation up to one year of age authorization requests should be sent to ProgenyHealth. Do not send to Johns Hopkins Health Plans's UM department.

  For EHP NICU Admission, use the **Newborn Notification Form** and fax the request with clinical information to ProgenyHealth: 888-400-4636.

  For EHP Prior Pediatric Readmission (within 1 year of NICU discharge), fax notification and clinical information to ProgenyHealth: 888-400-4636.

  Providers can use the same **Authorization Request Form** they currently submit to Johns Hopkins Health Plans for this purpose.

  Please call ProgenyHealth at 888-832-2006 for more information.

Criteria and Clinical Information for Medical Necessity

Johns Hopkins Health Plans Utilization Management utilizes clinical review criteria for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

Johns Hopkins Health Plans' medical policies, which are publicly accessible on its **website**, provide clinical review criteria primarily for outpatient services.

InterQual criteria are used to determine medical necessity for acute inpatient care and may also be used for outpatient procedures. EHP may also use Johns Hopkins Medical Plans medical policies or clinical utilization (UM) guidelines. A list of the specific Johns Hopkins Health Plans medical policies 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 will support prior authorization 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 policies and must be considered first when determining eligibility for coverage. EHP Summary Plan Descriptions will supersede InterQual, Johns Hopkins Health Plans medical policy, and Johns Hopkins Health Plans clinical UM criteria. Medical technology is constantly evolving, and Johns Hopkins Health Plans reserves the right to review and periodically update medical policies and utilization management criteria.

CVS Caremark® NovoLogix is authorized by Johns Hopkins Employer Health Programs (EHP) to administer the prior authorization process for certain outpatient medical injectable drugs. NovoLogix clinical team reviews the medical necessity of medical injectable drugs using:

* CVSCAREMARK clinical policies adopted by the Health Plan.

EHP members have access to the Cigna PPO network for medical coverage in and out of Maryland as a secondary network. EHP contracts take precedence over Cigna contracts for providers contracted in both networks.

Cigna PPO network providers are considered in-network providers for EHP members.

Maryland providers are included in the Cigna PPO network for all EHP plans. Providers in the Cigna PPO network are contracted in all U.S. states.

The Cigna PPO network is for medical services only. Routine vision and dental providers are excluded. Telemedicine medical services from providers in the Cigna PPO network are covered.

EHP providers should call EHP Customer Service at 800-261-2393 for assistance.

For information regarding prior authorization for provider administered medications, refer to Section 2 of this manual.

EHP 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 Providers and Physicians section of the Johns Hopkins Health Plans website at https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/policies/

These procedures apply to:

- Prior authorization
- 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/or HCPCS 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
- Patient characteristics and information
- Estimated/anticipated length and/or frequency of treatment

Referral/Prior Authorization Process

Referrals to in-network specialists are not required for payment; however, EHP 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 Communications Repository > Forms.

Prior Authorization and Notification

General

Some covered services require **prior authorization** prior to services being rendered, while other covered services require notification prior to being rendered.

Notification is a communication received from a provider informing EHP 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) are verified.

Prior authorization 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 prior authorization include but are not limited to:

- Elective inpatient admissions
- Select outpatient and specialty care provided outside of the PCP's scope of practice
- High-tech radiology
- Durable medical equipment
- Home health services
- Skilled nursing facilities
- Out-of-network services

To verify whether or not a particular service requires prior authorization, visit our website for the most recent guidelines.

Providers may also view prior authorization requirements through the Johns Hopkins Prior Authorization Lookup tool (JPAL), a resource that checks and verifies prior authorization requirements for services and procedures. Located through **Availity**, 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 **Availity** 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.

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

- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or contracted laboratory
- Routine X-rays, EKGs, EEGs or mammograms at a network specialist office with referral, at a free-standing radiology facility or at some network hospitals

The medical director will periodically review and revise this list with the expectation that additional services will be added as practice patterns of the network warrants.

Prior Authorization Determination Time Frames

For services that require prior authorization, EHP 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 two business days of receipt of necessary clinical information, but no later than 15 calendar days from the date of the initial request.

Inpatient Utilization Management

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

UM is provided for all members in acute or subacute settings. InterQual criteria is used to review length of stay, intensity of service, and severity of illness. UM evaluates for possible movement to lower levels of care without compromising the plan of care or promotion of health.

Our UM clinical staff collaborate with the discharge planners in assuring that a safe discharge and appropriate follow-up is in place. Referrals to case management programs are made based on review of the member's post discharge needs and/or chronic conditions. Johns Hopkins Health Plans medical directors are available for consultation in difficult or complicated cases and will consult with the attending physician when needed to develop the most appropriate plan of care for the member. 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, or discharge will be denied.

Inpatient Services

Inpatient Admission Prior Authorization

Notification/prior authorization requirements are as follows:

- Except for an emergency admission, the admitting physician is responsible for contacting EHP to obtain prior authorization for a hospital admission.
- The hospital is responsible for notifying EHP and the Department of Mental Health and Hygiene of the birth of a child in accordance with the admission time frames noted below.
- For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify EHP within 24 hours or by the next business day. These circumstances are considered separate, new admissions and are not part of the mother's admission.

Inpatient Admission Notification Time Frames

- All elective admissions must receive prior approval at least 72 hours prior to the admission or scheduled procedure.
- Urgent and emergent admissions require notification to EHP within 48 hours or by the next business day following the presentation of emergency services.

The following information should be provided to the UM department for prior authorization via fax at 410-424-4894 or 410-424-2770:

- Member's name
- Member's address
- Member's EHP 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 EHP members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. EHP 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

**Reliable evidence refers to published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, equipment, treatment, or procedure; or the written informed consent used by the treatment facility or by another facility studying substantially the same drug, device, equipment, treatment, or procedure.*

Upon notification, EHP 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.

Inpatient Specialist Referrals

Referrals to in-network specialists are not required for payment; however, EHP highly recommends PCPs supply the member with instructions for follow-up care. The *Personalized Treatment Plan* form can be found in the Forms section in the back of this manual or **online**.

Inpatient Admission Review

- All medical inpatient hospital admissions, including those that are urgent and emergent, will be reviewed for medical necessity within one business day of the facility notification to EHP.
- Clinical information for the initial (admission) review will be requested by EHP at the time of the admission notification.
- For medical admissions, the facilities are required to provide the requested clinical information within 24 hours of that request.
- If the information is not received within 24 hours, an administrative adverse determination (i.e., a denial) will be issued.
- EHP will adhere to NCQA determination and notification time frames for inpatient reviews.

Upon fax notification of the intention to a denial for inpatient/concurrent review cases, the member's treating physician can request a physician-to-physician review to provide additional information not previously submitted to EHP.

The request for this review must be made within 24 hours two (2) business days of the fax notification of intent to deny denial, and the review must take place within four (4) business days of fax notification of denial. To initiate this request the physician may contact EHP at 800-261-2421 from 8:00 a.m. to 5:00 p.m. Eastern time.

Inpatient Concurrent Review

Each network hospital will have an assigned concurrent review clinician. 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 continued stay reviews daily and will review discharge plans unless the member's condition is such that it is unlikely to change within the upcoming 24 hours and discharge-planning needs cannot be determined.
- When the clinical information received meets the applicable nationally recognized clinical criteria, or guidelines, approved days and bed-level coverage will be communicated to the facility for the continued stay.
- The EHP 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.
- EHP will authorize covered length of stay one day at a time based on the clinical information provided to support the continued stay. Additional information may be requested in order to make a determination, and must be provided within 24 hours of the request. If the information is not received within the 24 hours, an administrative adverse determination (i.e., a denial) will be issued.

If there is a determination that a request does not meet medical necessity, a notification of denial will be faxed to the treating physician. The member's treating physician can request a physician-to-physician review to provide additional information not previously submitted to EHP.

The request for this review must be made within three business days of the date of the fax notification of denial. An additional two business days will be allowed for the conversation (for a total of five business days). To initiate this request, the physician may contact EHP at 800-261-2421 from 8:30 a.m. to 5:30 p.m. Eastern Time.

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, EHP works with the provider to help plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as:

- Hospice facility
- Skilled nursing facility
- Home health care program (e.g., home IV antibiotics)

When the provider identifies medically necessary services for the member, EHP will assist the provider and the discharge planner in providing timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow the applicable nationally recognized clinical criteria or guidelines and documentation requirements. Authorizations include, but are not limited to transportation, home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.

Outpatient Services

Outpatient Prior Authorization

Prior authorization is required for some services, procedures and durable medical equipment/supplies (DME/DMS). Requests for these services/procedures/DME/DMS should be received at the Plan at least 72 hours before they are to be delivered to the member.

Prior authorization requirements can be verified by using the JPAL tool located in **Availity** or by calling Customer Service at 800-261-2393.

For Prior authorization requirements for behavioral health services, please call 410-424-4845 or 800-261-2429 8 a.m. to 5 p.m.

Prior Authorization Requirement Review and Updates

EHP will review and revise policies when necessary. The most current policies are available on the Johns Hopkins Health Plans website.

Second Opinions

EHP will provide for a second opinion from a qualified health care professional within the network or, if necessary, arrange for the member to obtain one outside the EHP network.

EHP may also request a second opinion at its own discretion. This includes but is not limited to the following scenario:

- A second opinion review of the case will be performed by the EHP medical director before a transfer to an intermediate care facility or a long-term care facility is implemented.

When EHP requests a second opinion, EHP will make the necessary arrangements for the appointment, payment and reporting. Once the second opinion is completed, EHP will inform the member and the PCP of the results and the consulting provider's conclusion and recommendation(s) regarding further action.

Confidentiality of Records

All patient records and related information are considered confidential and will be protected as such throughout the course of all operations and communications.

Experimental Treatment

Experimental treatment is defined as the use of any treatment, procedure, equipment, device, drug, or drug usage that the plan administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency, and effectiveness that has not received or is awaiting endorsement for general use within the medical community by government oversight agencies or other appropriate medical specialty societies at the time services are rendered.

The plan administrator will make a determination on a case-by-case basis, using the following principles as generally establishing that something is experimental:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished
- If the drug, device, equipment, treatment, or procedure, or the patient informed consent document utilized with the drug, device, equipment, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
- If reliable evidence* shows that the drug, device, equipment, treatment, or procedure is the subject of ongoing Phase II clinical trials; is the subject of research, experimental study, or the investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
- If reliable evidence* shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

The UM department can be reached at 410-424-4480 or 800-261-2421.

Referrals

The PCP has the responsibility to provide and arrange for all health care services for his or her EHP members. Authorization for a more inclusive list of services requiring outpatient referral or prior authorization information is posted on the EHP **website**.

Common referrals/prior authorizations include but are not limited to:

- Inpatient admissions
- Speech therapy
- Home health care
- Out-of-area coverage

Members are encouraged to select a PCP for preventive care coordination. However, notification/authorization for services listed above should be requested by treating physicians.

Procedures

PCPs or their designated staff may refer a member by telephone, fax, or mail.

Telephone Referrals

Members may be referred by telephone 24 hours a day, seven days a week, by calling 410-424-4480, 800-261-2421 or by fax to 410-424-4894. The following will be requested:

- Member name
- Member ID number
- Specialist name
- Diagnosis
- Time span of referral
- Ancillary service limitation

The PCP is responsible for determining when a member's health care needs require a referral to a specialty care provider. The PCP is responsible for arranging all member referrals and specialty care. A referral is valid for **one year** from the date it was written. The PCP must include the number of visits and date span. If not included, the referral will default to one visit in one year. Refer to our Outpatient Referral Guidelines posted on the Johns Hopkins Health Plans website.

Referral Information for Specialists

The specialist must follow the specific referral provided by the PCP. A consult and treat referral from the member's PCP allows the specialist to render services within their specialty to treat the member for the condition specified by the PCP on the referral. This includes ancillary services such as laboratory, radiology, physical and occupational therapy, as well as specialized procedures including the treatment plan and recommendations.

These referrals do not include additional referrals from a specialist to another specialist or to specialty clinics. The specialist must contact the Utilization Management department for any services that require prior authorization.

Members Can Self-Refer

All EHP members can self-refer to a specialist. The specialist may coordinate services directly. However, an inpatient admission requires prior authorization by the Utilization Management department.

Written Referrals

The completion of a referral form is required for a referral. The form provides written documentation for the PCP, the member and the specialist physician. To refer a member in writing, one copy of the completed referral form should be given to the member. The second copy should be forwarded to the specialist, and the third copy should be mailed or faxed to EHP at 410-424-4894.

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 III:
COVERED BENEFITS

Overview of Services

EHP is committed to high-quality, cost-effective health care. Below is a list of services provided for most of our plan members. We offer a variety of cost-effective plans, meaning that specific covered services and copays may vary.

Plan Designs

EHP provides benefits for many employers, each plan offering specific covered benefits and services, prescription drug coverage, and copayment amounts. Regardless of the plan, EHP does not cover services not performed by a physician; services covered by worker compensation; automobile accidents; services deemed experimental, investigational, or not medically necessary by EHP; or services listed as non-covered benefits listed in the Summary Plan Description (SPD).

- PPO plans – member self-refers to participating physicians and/or providers, or member self-refers to nonparticipating physicians and/or providers
- EPO plans: Coverage is offered for in-network benefits only. Members may only use providers and facilities in the EHP network (including the Cigna PPO network) and the EHP Preferred network. Members may be responsible for all costs for out-of-network care.

Refer to the specific plan's Schedule of Benefits for details.

For additional details on our plans and particular plan offerings, contact Customer Service at 410-424-4450 or 800-261-2393.

Schedule of Benefits

- **Johns Hopkins EHP PPO**
- **Johns Hopkins EHP EPO**
- **Johns Hopkins EHP DPC**
- **BSI PPO Plan**

Benefit Chart

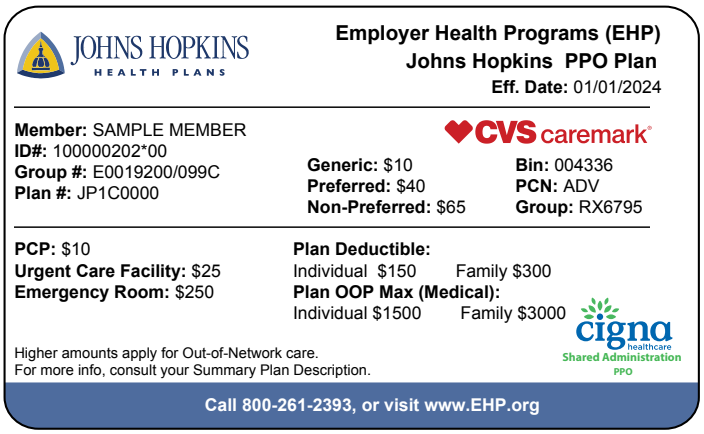
BENEFIT	COVERAGE
Treatment of Illness	Primary care visit (PCP) Diagnostic services and treatment Specialty care office visit
Preventive Services	General physical exam Diagnostic services Well-child care Mammogram GYN exam Colonoscopy
Immunizations	For common communicable diseases
Laboratory and X-ray	Laboratory tests Imaging exams X-ray exams and ultrasound
Urgent Care Emergency Room	See Schedule of Benefits for specific coverage.
Pharmacy	Prescription drug benefits vary among EHP employer groups. For details, please refer to the EHP pharmacy formulary available at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/ehp/pharmacy-formulary**
Dental	Dental care coverage differs for EHP plan members depending on the employer to which they are associated. *** This benefit varies among plans***
National Network	EHP offers a national network of providers in and outside the state of Maryland through Cigna PPO. Call EHP Customer Service department for more information or visit Cigna PPO at **https://hcpdirectory.cigna.com/web/public/consumer/directory/search**

Selecting or Changing a PCP or OB/GYN

When members enroll in Johns Hopkins EHP, the member and each family member are encouraged to choose and establish a relationship with a PCP from our extensive network. Members can select a PCP for themselves and a different PCP for each of their covered dependents.

Members wishing to select a PCP may make a selection at the time of enrollment or call EHP Customer Service at 410-424-4450 or 800-261-2393. The PCP change will become effective the date a member requests a change.

Sample EHP ID Card



*ID cards vary from one employer group to another.

UpLift: Virtual Behavioral Health Care Program

Johns Hopkins Health Plans is improving access to behavioral health care through a virtual provider called **UpLift**. With approximately 450 licensed providers serving Maryland, Virginia, District of Columbia, New Jersey and Florida, UpLift is available for EHP members. Care offered is mainly virtual, but there are limited in-person appointments. UpLift offers:

- Individual and family counseling
- Psychiatric services and medication management
- Virtual care for patients aged 13 and older
- PCP care coordination
- 24-hour crisis support for UpLift members
- Appointments within 1 to 2 days for counseling
- Appointments within 5 days for psychiatric services and medication management

How to Access UpLift Services:

- EHP members can self-refer and join directly at **joinuplift.co**.
- Providers can refer their patients to UpLift by faxing a request to 866-298-5907.
- Providers and members can call UpLift directly at 888-380-2028.

Telemedicine

EHP members have a new option for accessing care via telemedicine. Johns Hopkins OnDemand Virtual Care (powered by Teladoc) will give members access to an urgent care medical visit 24/7 from the comfort of their home or anywhere they may travel nationwide. Johns Hopkins Health Plans encourages members to utilize their primary care provider when possible, but Johns Hopkins OnDemand Virtual Care will be an alternative option to quickly access needed care.

The Johns Hopkins OnDemand Virtual Care service is as an online telemedicine platform for both adult and pediatric patients. It is available to members through mobile app, computer or tablet.

The service is intended for minor care concerns that don't require lab work, such as colds, rashes and pink eye.

The service is not for medical emergencies. If a patient is experiencing a medical emergency, they should call 911 or go to the nearest emergency room.

Pharmacy Management

EHP prescription benefits may vary. Please refer to Plan's formulary on the website.

Pharmacy coverage may vary by employer group.

For employer groups with the EHP prescription benefit, the following is a list of benefits covered under the EHP prescription drug plan:

- Drugs approved by the FDA that require a prescription from a physician or other lawful prescriber, unless specified otherwise
- Compounded medications of which at least one ingredient is a prescription drug and the compounded drug is not a copy of a commercially FDA-approved drug product
- Insulin
- Disposable insulin syringes and needles for self-administered injections
- Blood/urine test strips and lancets

The following types of medications are examples of exclusions from the EHP prescription drug plan benefit:

- Medications to treat cosmetic conditions resulting from the normal aging process
- Medications whose sole use include treatment of hair loss, hair thinning, and any other related conditions
- Medications that are not approved for treatment of a medical condition by the FDA
- Vitamins (except those vitamins which by law require a prescription)
- Covered drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescription in excess of the number of refills specified by the prescriber or by law
- Medications dispensed for any illness or injury covered by any federal, state, or local government workers' compensation act, or occupational disability law
- Immunization agents, biological sera, blood, or blood plasma
- Drugs labeled "Caution-Limited by Federal Laws to Investigational Use" or experimental drugs, even though a charge is made to the member
- Non-legend drugs, except those listed on the EHP pharmacy formulary (list of covered drugs)
- Medications that are to be taken by or administered to the member while the member is a patient in a licensed hospital, rest home, sanitarium, or extended care facility, convalescent hospital, nursing home, or similar institution
- Medication delivery implants, devices, or durable medical equipment (except hypodermic needles and syringes for self-administered injections)
- Herbal, mineral, and nutritional supplements
- Legend drugs and non-legend drugs that are not approved by the FDA for commercial distribution in the U.S.

EHP Pharmacy Formulary

The EHP pharmacy formularies may vary and are available at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/ehp/pharmacy-formulary**. As a guide for the health care providers, each formulary includes a list of preferred pharmaceuticals. The formularies are updated on a regular basis, including when a new generic or brand-name medication becomes available and as discontinued drugs are removed from the marketplace. The EHP formularies are subject to change at any time. Formulary updates are posted on the website quarterly and as changes occur.

Copay Tier

Some EHP Members covered by the EHP pharmacy benefit have a three-tier drug benefit. Each tier has a different copay or out-of-pocket expense. Members are responsible for a portion of the cost of their medications.

The three-tier copayment benefit consists of the following tiers:

- **Tier One: Generic (lowest copay).** Generic drugs have the lowest out-of-pocket cost for members and are usually placed on Tier 1. Generic products are displayed in the formulary in *lowercase italics*.
- **Tier Two: Preferred brand drugs (middle tier copay).** Preferred brand-name drugs have a significant safety or efficacy advantage compared to similar agents. These agents have an intermediate out-of-pocket cost for members. These products are usually placed on Tier 2 and are displayed in the formulary in CAPITAL LETTERS.
- **Tier Three: Non-preferred brand (higher copay).** Non-preferred brand-name drugs do not have a significant clinical advantage in terms of effectiveness, safety and clinical outcomes compared to similar agents. These drugs have higher out-of-pocket cost for members. In most cases, there will be Tier 1 or Tier 2 alternatives for products found in this tier. Non-preferred brand-name drugs covered under the pharmacy benefit are not displayed in the formulary and may process in Tier 3.

Generic Substitution

EHP encourages use and prescribing of generic medications. Brand-name drugs with generic equivalents may be excluded in some formularies, depending on member's benefit. If the prescriber or member chooses a brand-name drug with a generic equivalent, the member may be required to pay a higher copay. If a member or a provider requests a brand-name drug for which a generic equivalent is available, the member may pay the Tier 3 copay plus the difference between the brand and generic cost. Copays for members covered under the EHP pharmacy benefit vary by employer plan design. Please view the EHP formularies available at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/ehp/pharmacy-formulary**.

Prior Authorization

Certain medications require prior authorization before coverage is approved to assure medical necessity, clinical appropriateness, and/or cost effectiveness. Coverage of these drugs is subject to specific criteria approved by the Pharmacy and Therapeutics Committee. Established criteria are based on medical literature, physician expert opinion, and Food and Drug Administration (FDA) approved labeling information.

Providers may request prior authorization electronically at **www.caremark.com/wps/portal/HEALTH_PRO_PRIOR_AUTH_INFO** or by calling CVS/Caremark's Prior Authorization department at 800-294-5979.

Quantity Limits (MDL)

Certain prescription medications have specific dispensing limitations for quantity and maximum dose. These dispensing limitations are based on generally accepted guidelines, drug label information approved by the FDA, current medical literature and input from a committee of physicians and pharmacists. The three types of quantity limits include the following:

- Coverage limited to one dose per day for drugs that are approved for once daily dosing
- Coverage limited to specific number of units over a defined time frame
- Coverage limited to approved maximum daily dosage

When medically necessary, an exception to quantity limits can be requested. If your patient's medical condition warrants use of quantities greater than the listed quantities for each drug, you may request prior authorization for a higher quantity. Providers may request prior authorization electronically at **www.caremark.com/wps/portal/HEALTH_PRO_PRIOR_AUTH_INFO** or by calling CVS/Caremark's Prior Authorization department at 800-294-5979.

Step Therapy

Certain covered medications are required to satisfy specific step therapy criteria. Step therapy criteria simply means that for certain drug products, members must first have tried one or more prerequisite medications to treat their condition before other medications are covered through their benefit.

When medically necessary, providers may request an exception to the step therapy requirement and ask for prior authorization. Providers may request prior authorization electronically at **https://www.caremark.com/wps/portal/HEALTH_PRO_PRIOR_AUTH_INFO** or by calling CVS/Caremark's Prior Authorization department at 800-294-5979.

Retail Pharmacy Network

Johns Hopkins EHP, through CVS/Caremark Inc., offers a nationwide pharmacy network that includes most chain and independent pharmacies. The retail pharmacy network includes over 64,000 pharmacies nationwide. Visit www.caremark.com to locate a participating network pharmacy.

Mail Order Services

For employer groups with the EHP prescription benefit, mail order services are provided by CVS/Caremark. This service offers a convenient and cost-effective option for EHP members to obtain medications that they take on an ongoing basis. Members can receive up to a 90-day supply of chronic use medications and have these medications delivered to the location of their choice. For additional information, visit www.caremark.com.

Specialty Medications

Specialty medications are usually high-cost prescription medications used to treat complex chronic conditions. These drugs typically require special storage and handling and may not be readily available at a local pharmacy. Specialty medications may also have side effects that require pharmacist and/or provider monitoring.

Specialty Medications – Pharmacy Benefit: Are self-administered and processed through the member's pharmacy benefit. These medications are available at a local retail or specialty pharmacy and may require prior authorization. You may find a list of these self-administered specialty medications and their specific authorization requirements on the EHP formulary. Use the Prior Authorization form to request prior authorization for self-administered specialty medications.

Specialty Medications – Medical Benefit: Are administered by a provider or under supervision of a provider and processed through the member's medical benefit. Providers may supply these medications and bill the health plan for the medication and related administration using HCPCS Codes or J codes. CVS Caremark® NovoLogix is authorized by Johns Hopkins Employer Health Programs (EHP) to administer the prior authorization process for certain outpatient medical injectable drugs. NovoLogix clinical team reviews the medical necessity of medical injectable drugs using CVSCAREMARK clinical policies adopted by the Health Plan.

To find the HCPCS Codes that require medical necessity prior authorization visit our website or JPAL on Availity.com.

Providers may submit prior authorization requests electronically by **accessing the NovoLogix platform through the Availity** portal. Providers may also contact Novologix **by phone at 844-345-2803.**

PrudentRx Program

EHP has partnered with CVS Health and PrudentRx on a program that will help EHP members save money when they fill eligible specialty medications. All specialty medications on the PrudentRx drug list are subject to a 30% coinsurance. However, if a member is participating in the PrudentRx program, they will have a $0 out-of-pocket responsibility for the covered specialty medication prescription.

Participation in the program includes enrollment in an available manufacturer copay assistance program for the specialty medication being taken. Medications on the PrudentRx Drug list may only be obtained from Johns Hopkins Outpatient Pharmacies and CVS Specialty Pharmacies.

Please note the PrudentRx drug list is subject to change, and is updated quarterly.

Section IV:
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 EHP members, ensuring quality care in a cost effective manner.

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) developed by the Johns Hopkins Bloomberg School of Public Health

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 (2) 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.

Members with asthma or diabetes are eligible for the No-Pay Copay benefit. When they participate in are Management services, EHP will waive the copay for most asthma and diabetes medications.

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 member's treatment plans.

Maternal Child Health

Maternal child health Care Management provides support to high-risk prenatal and postpartum members, newborns and children. We offer health education, community resources, and care coordination and promote access to quality health care services. We strive to contact and engage with members as soon as possible to address barriers that may be adversely affecting a member's health.

Care Management services for NICU graduates is delegated to ProgenyHealth for the first year of life. ProgenyHealth care managers assist with the discharge planning process. ProgenyHealth's neonatologists, pediatricians and neonatal nurse care managers work closely with the NICU facility to promote healthy outcomes for premature and medically complex newborns.

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 and coordinate care with providers and specialists.

Section V:
QUALITY IMPROVEMENT

Introduction

The Quality Improvement (QI) department at Johns Hopkins Health Plans is dedicated to ensuring our EHP beneficiaries receive the highest quality health care services. EHP is a self-funded health plan that currently serves more than 43,000 plan members in Maryland, Southern Pennsylvania and Northern Virginia. The QI program strategy supports the EHP goals to optimize individual wellness and health outcomes for beneficiaries by leveraging processes that can be measured, analyzed, improved and controlled to implement this approach.

Mission of the QI Program

Johns Hopkins Health Plans is guided by its mission to empower our members and communities on their journey to good health. The vision of Johns Hopkins Health Plans is to be a national leader in provider-sponsored health plans and solutions. The QI program aligns with the mission and vision of Johns Hopkins Health Plans and supports organizational strategic priorities.

QI Program Goals

The QI program goals focus on improving health care outcomes while ensuring EHP meets the accreditation and 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 Objectives

The QI objectives are developed annually based on identified opportunities for prioritizing, improving, and implementing QI activities. Opportunities for improvement and subsequent initiatives are identified throughout various QI workgroups, data analysis, and organizational priorities. The QI department aligns objectives using continuous quality improvement, adhering to regulatory and accreditation bodies. Additional objectives are developed throughout the year as needed and are based upon gap analysis of Healthcare Effectiveness Data and Information Set (HEDIS®), and Value Based Purchasing (VBP), as well as evaluation of Consumer Assessment of Healthcare Providers and Systems (CAHPS), member and provider complaints data, and other quality-related data.

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.

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 National Committee for Quality Assurance (NCQA) Quality Compass benchmarks for Commercial plans
- Trending analyses of HEDIS and CAHPS data to identify improvement and enhancement opportunities
- Root cause and barrier analyses for areas where where warranted
- 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"[1]. CQI serves a 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 is guided by the beneficiary needs which are collected through various modalities such as the CAHPS survey, 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.

[1] 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.

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:

- NCQA Quality Compass for Commercial plans measures performance
- HEDIS measures performance
- Beneficiary satisfaction survey performance, such as the CAHPS survey
- 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 data
- Provider quality performance data

Accreditation

Johns Hopkins Health Plans has achieved accreditation status with nationally recognized entities for health care quality. Accreditation in health care means the healthcare organization is meeting regulations and standards set by an external accreditation organization. Health care accreditation organizations such as the NCQA create a set of standards with the help of industry experts. NCQA is an independent nonprofit organization that works to improve health care quality through the administration of measures, programs, accreditation and evidence-based standards. The standards cover everything from training materials, to data retention, to equipment maintenance. In order for a healthcare organization to achieve accreditation, they must prove compliance with the standards.

NCQA accreditation represents quality, consistency, and reliability of care for all members as it is the most rigorous and comprehensive health insurance accreditation program. Annually, NCQA makes adjustments to its standards to respond to feedback from plans, policy makers, providers, patients and others. To prepare for accreditation, health care organizations must do a comprehensive assessment of processes, policies, and procedures, and anything else related to accreditation standards. This allows them to identify any areas where there are gaps in compliance. The QI department is currently working with various Johns Hopkins Health Plans departments to collect documents for the 2023 Renewal Survey.

HEDIS and CAHPS

HEDIS is a set of more than 90 high-level measures with various submeasures that can provide information about the quality of a health plan. HEDIS measures evaluate performance 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 an 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.

The CAHPS program is an initiative to utilitize standardized surveys of patients' experiences with ambulatory and facility-level care in commercial and Medicaid plans. Surveys were developed with the Agency for Healthcare Research and Quality (AHRQ). CAHPS data address areas such as patient ease of obtaining information from a health plan; timeliness of service; and speed and accuracy of claim processing. CAHPS results offer an indication of how well health care organizations meet member expectations. [2]

[2] CAHPS overview. Retrieved from https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/about-cahps/

* 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."

Member Safety Program

The member 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 Johns Hopkins Medicine 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 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. Johns Hopkins Health Plans encourages providers to fully know their role in the health plan quality program which includes the following:

- 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, EHP relies on participating providers to offer valuable feedback on clinical practice guidelines, preventive health guidelines, and medical and pharmacy policy.

Looking Ahead

Delivering quality medical services to our beneficiaries is the hallmark of Johns Hopkins Health Plans, and we rely on our network providers to do this. Johns Hopkins Health Plans's Provider Relations department is dedicated to the partnerships we've established within our provider network and encourages network providers to continue to look for ways to improve outcomes for our beneficiaries. Some outcome improvements include utilizing best practices, access to care and closing care gaps.

Johns Hopkins Health Plans has set certain expectations in place for our provider network, and it is expected that our providers are meeting the expectations, including following policies and procedures. For providers that do excel in meeting expectations, Johns Hopkins Health Plans will re-evaluate performance rates, which may include rate increases. Johns Hopkins Health Plans strives for continued excellence in services provided by our network providers which in return benefits the provider network, Johns Hopkins Health Plans and, more importantly, the beneficiaries.

Member Rights and Responsibilities

We value our members as a part of the EHP health care family. Members have the following rights and responsibilities:

Members have the right to:

- Be treated with respect for their dignity and privacy.
- Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage.
- Receive information, including information on treatment options and alternatives, in a manner they can understand.
- Participate with providers in decisions regarding their health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of medical records and request that they be amended or corrected as allowed.
- Exercise member rights and to know that the exercise of those rights will not adversely affect the way that EHP or our providers treat patients.
- File complaints, appeals, and grievances about the organization or the care we provide.
- Request that ongoing benefits be continued during appeals (although members may have to pay for the continued benefits if our decision is upheld in the appeal).
- Receive a second opinion from another provider in EHP's network if members disagree with their provider's opinion about the services that they need. Members can contact us at 800-261-2393 for help with this.
- Receive other information about us such as how we are managed. Members may request this information by calling 800-261-2393.
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's member rights and responsibilities policy.

Members have the responsibility to:

- Carry their membership card at all times and know their eligibility status with EHP. If they lose your card, they can obtain a new one by calling Customer Service, or from their HealthLINK@Hopkins account.
- Follow their plan's referral and prior authorization guidelines and polices.
- Cancel appointments if they are unable to keep them.
- Pay any applicable copay, co-insurance, and deductible at the time of service.
- Report any other health insurance coverage to their provider and to EHP.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their provider.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Section VI:
COMPLIANCE

Compliance with Contract, Federal, State and Local Regulations

Provider is expected to conduct all of his/her/its activities related to the provision of health care services to members in the Johns Hopkins EHP in full compliance with your participating provider agreement and all federal, state, and local laws and regulations 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 (/uscode/text/31/3729) et seq.), and the anti-kickback statute (section 1128B(b)) of the Act)
2. HIPAA administrative simplification rules at 45 CFR parts 160, 162 (/cfr/text/45/160), and 164 (/cfr/text/45/164)

Provider is also expected to conduct his/her/its activities in compliance with this provider manual and EHP's policies and procedures.

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 and 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.

In addition, providers will not:

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

Transparency in Coverage

The federal Transparency in Coverage rules require EHP to begin posting pricing information for covered items and services. This pricing information can be used by third parties, such as researchers and application developers, to help consumers better understand the costs associated with their health care.

The Transparency in Coverage rules requires the disclosure of price and benefit information directly to consumers and to the public. The initial requirements of the 2022 ruling include providing Machine-Readable Files containing the following sets of costs for items and services:

1. Negotiated rates for in-network providers
2. Historical allowed amounts and billed charges for out-of-network providers
3. Negotiated rates and historic net prices for prescription drugs

More requirements, such as a price comparison tool, go into effect in 2024.

The Departments of Labor, HHS, and the Treasury (Departments) are of the view that transparency in health coverage requirements will strengthen America's health care system by giving health care consumers, researchers, regulators, lawmakers, health innovators, and other health care stakeholders the information they need to make, or assist others in making, informed decisions about health care purchases. More information can be found at **https://www.cms.gov/healthplan-price-transparency**.

Medical Record Documentation and Retention

Providers 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 plans' Medical Record Documentation Standards Policy in its entirety to which the providers are subject with respect to EHP members, please click on the following hyperlink: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines** (See: Medical Record Documentation Standards Policy).

Providers are required to comply with all applicable federal and state laws and regulations and participating provider agreement terms and conditions regarding document retention.

Audit Process

EHP, or a designee, has the right to conduct audits of your records with respect to services provided to members. Providers must comply with all applicable laws, regulations, and the participating provider agreement regarding cooperation, assistance and provision of audit information as requested, and maintenance of records. All documents and/or data submitted for audit must be certified by providers (based on best knowledge, information, and belief) as being accurate, complete, and truthful.

Audits look for practices that result in unnecessary costs or under or over-utilization of services, including audits to identify improper payments, payment for services that do not meet appropriate standards of care, errors, duplicate or redundant charges, unbundled services, lack of substantiating documentation, etc.

Audits may be conducted on site or may be conducted as desk audits.

Privacy and Release of Member Information and/or Records

It is the policy of Johns Hopkins Health Plans 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 the HiTECH Act.

Providers are expected to maintain policies and procedures within their offices to protect the privacy of and to prevent the unauthorized or inadvertent use and disclosure of confidential information. Providers' policies and procedures must be in accordance with all applicable federal and state laws and regulations and your participating provider agreement.

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 HIPAA Privacy Rule permits providers to disclose protected health information to a health plan for health care operations of the health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164 .506(c)(4). Health care operations includes care management, utilization review activities, and similar activities. See 45 CFR 164 .501 (definition of health care operations). Thus, providers may disclose protected health information for care management and/or utilization purposes. Providers may also disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

Standard of Conduct

In order to affect Johns Hopkins Employer Health Programs' commitment to the highest legal and ethical standards, EHP has adopted Johns Hopkins HealthCare's (Johns Hopkins Health Plans) Code of Conduct. A copy of Johns Hopkins Health Plans's Code of Conduct can be found at: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines/**. Providers are required to either adopt and abide by the Johns Hopkins Health Plans Code of Conduct or implement a code of conduct that incorporates requirements consistent with Johns Hopkins Health Plans's Code of Conduct.

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 subcontractors of the provider are required to comply with all applicable laws, whether or not specifically addressed in the Code of Conduct in that compliance is everyone's responsibility. This includes reporting of issues of non-compliance and potential fraud, waste or abuse. Providers must provide guidance to their employees, independent contractors, and subcontractors regarding how to report potential compliance issues. In addition, it is the responsibility of the provider to ensure that all reported issues are promptly addressed and corrected.

The provider's Code of Conduct should include provisions to ensure employees and independent contractors (including managers, officers, and directors), as well as subcontractors responsible for the administration or delivery of benefits, are free from any conflict of interest in administering or delivering benefits to EHP members. 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.

General Compliance and Fraud, Waste and Abuse Education

It is strongly recommended that providers and their employees, independent contractors, and subcontractors receive training in the identification and prevention of fraud, waste, and abuse (FWA). Free training is available on CMS' Medicare Learning Network (MLN Provider Compliance website): www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html. The CMS Medicare Parts C and D Fraud, Waste, and Abuse and General Compliance training provide a comprehensive overview. In addition, Johns Hopkins Health Plans' website, HopkinsHealthPlans.org, contains educational resources for providers.

Reporting Fraud, Waste and Abuse

EHP takes its responsibility to protect the integrity of the care its members receive, its health plan, and the program it administers seriously. Reporting of FWA is essential for its prevention, detection, and correction. There are numerous methods by which a report relating to FWA can be made.

Reports of actual or suspected FWA involving EHP can be made to Johns Hopkins Health Plans's Compliance department. Individuals making a report may do so anonymously using the contact information below. All reports are taken seriously and investigated and to the extent possible kept confidential.

- **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

Providers are responsible for reporting all incidents of actual and/or suspected FWA.

No Johns Hopkins Health Plans employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, Johns Hopkins Health Plans 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 subcontractors of the 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 the provider without fear of retaliation. Any individual who reports a compliance concern has the right to remain anonymous, and EHP commits to enforcing this right.

Providers are responsible for providing guidance to your employees, independent contractors, and subcontractors regarding how to report potential compliance issues. Providers are responsible for promptly addressing and correcting all issues brought to their attention. Providers are required to notify the Johns Hopkins Compliance department of any issues involving EHP. Failure to report any possible violation or suspected FWA that provider knows about may result in investigation of the provider and potentially disciplinary action.

Fraud is defined 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.

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)
- Seeking increased payment or reimbursement for services that are correctly billed at a lower rate (up-coding)

Abuse is defined as actions that may, directly or indirectly, result in unnecessary costs, 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.

Waste is defined as the overutilization of services or other practices that, directly or indirectly, result in unnecessary costs.

Both fraud and abuse can expose a provider, contractor, or subcontractor to criminal and civil liability. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

[1] ***SAM*** *– 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.* ***www.sam.gov***

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

Providers are responsible for implementing methods to prevent FWA. Listed below are some common prevention techniques. This list is not meant to be all-inclusive.

- Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities[1]
- Validate all member ID cards prior to rendering service
- Ensure accuracy when submitting bills or claims for services rendered
- Submit appropriate referral and treatment forms
- Avoid unnecessary drug prescription and/or medical treatment
- Report lost or stolen prescription pads and/or fraudulent prescriptions

Reporting of Other Compliance Concerns

Providers, and their employees, independent contractors, and subcontractors are required to report concerns about actual, potential, or perceived misconduct to the Johns Hopkins Health Plans Corporate Compliance department at the numbers/addresses noted above.

Any concerns about program noncompliance or suspected FWA should always be reported to the Johns Hopkins Health Plans Compliance department using the contact information listed in the Reporting Fraud, Waste, and Abuse section above. Immediately below is a list of examples of such reporting. The list is not intended to be all inclusive:

- HIPAA violations such as, but not limited to, inappropriate use and disclosure of protected health information (PHI) or personally identifiable information (PII), breach, or suspected identify theft that impact EHP members and/or providers
- Allegations that the complainant has been contacted by someone representing themselves as a Johns Hopkins Health Plans or EHP employee inappropriately requesting member PHI or PII
- Instances where the provider becomes aware that an individual or entity involved with EHP has become excluded and/or debarred from participation in federal and/or state programs

For reporting all other issues, contact EHP Customer Service at 800-261-2393. 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 EHP-contracted provider or any entity
- Access to care
- Coverage decision (medical or pharmacy)
- Filing a grievance

Section VII:
FORMS

Provider Claim/Payment Dispute Form

https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/all_plans/claims-and-payment-disputes.pdf

Provider Appeal Request Form

https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/all_plans/provider-appeal-submission-form.pdf

Psychological Testing Form

https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/all_plans/psych-testing-form.pdf

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