PRIORITY PARTNERS

2024 | Provider Manual

Sponsored by Johns Hopkins Health Plans and The Maryland Community Health Systems

Introduction to the Provider Manual

THE MARYLAND HEALTHCHOICE PROGRAM

MEDICAID and HEALTHCHOICE

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO online at www.marylandhealthconnection.gov or by calling 855-642-8572 (TYY: 855-642-8572). Members are encouraged to select an MCO that their PCP participates with. If they do not have a PCP they can choose one at the time of enrollment. MCO members who are initially auto-assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice program's goal is to provide patient-focused, accessible, cost-effective, high quality health care. The state assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the state's quality initiatives and oversight of the HealthChoice program go to: https://health.maryland.gov/mmcp/healthchoice/Pages/Home.aspx

Providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. Priority Partners also encourages providers to actively participate in the Medicaid fee-for service (FFS) program. Beneficiaries will have periods of Medicaid eligibility when they are not active in an MCO. These periods occur after initial eligibility determinations and temporarily lapses in Medicaid coverage. While MCO providers are not required to accept FFS Medicaid, it is important for continuity of care. For more information on ePREP*, go to: **https://eprep.health.maryland.gov/sso/login.do?** All providers must verify Medicaid and MCO eligibility through the Eligibility Verification System (EVS) before rendering services.

*ePREP stands for Maryland Medicaid's electronic Provider Revalidation and Enrollment Portal (ePREP). Providers are responsible for updating their professional license information prior to license expiration in the ePREP portal. Active enrollment applies to providers (individuals and provider groups). For additional information and to complete your application, please visit **health.maryland.gov/ePREP** or call 844-4MD-PROV.

We do not prohibit or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient.

This manual is divided into 9 sections:

SECTION I – Introduction and General Information. This section provides general descriptive information on the HealthChoice program including, but not limited to, program eligibility, MCO reimbursement policies, continuity of care and member rights and responsibilities.

SECTION II – Outreach and Support Services, Appointment Scheduling, Early Periodic Screening Diagnostic and Treatment (EPSDT) Requirements and Special Populations. This section details Priority Partners outreach and support services, non-emergency transportation services, state support services and other information.

SECTION III – Member Benefits and Services. This section provides a listing of the benefits that are and are not the responsibility of all MCOs that participate in HealthChoice. This section briefly outlines some of the optional benefits that Priority Partners may provide. This section also identifies benefit limitations and services that are not the responsibility of Priority Partners and gives information on the Rare and Expensive Case Management (REM) program.

SECTION IV – Prior Authorization and Member Complaint, Grievance and Appeal Procedures. This section describes services requiring prior authorization, services not requiring prior authorization, prior authorization procedures, medical necessity criteria and other procedures and criteria.

SECTION V – Pharmacy Management. This section provides information on pharmacy benefit management, specialty pharmacy, prescriptions and the Priority Partners formulary, the Maryland Prescription Drug Monitoring Program, Corrective Managed Care Program and the Maryland Opioid Policy.

SECTION VI – Claims Submission, Provider Appeals, Quality Initiatives and Pay-for-Performance. This section covers the claims submission process, billing inquiries, the appeal process, quality initiatives and other claims and appeal information.

SECTION VII – Provider Services and Responsibilities. This section gives an overview of provider responsibilities, along with information on credentialing and re-credentialing, PCP responsibilities, contract terminations, specialty providers and other topics.

SECTION VIII – Quality Assurance Monitoring Plan and Reporting Fraud, Waste and Abuse. This section provides information on Priority Partners' assurance monitoring plan, as well as fraud, waste and abuse policies and procedures.

SECTION IX – Additional Priority Partners Information.

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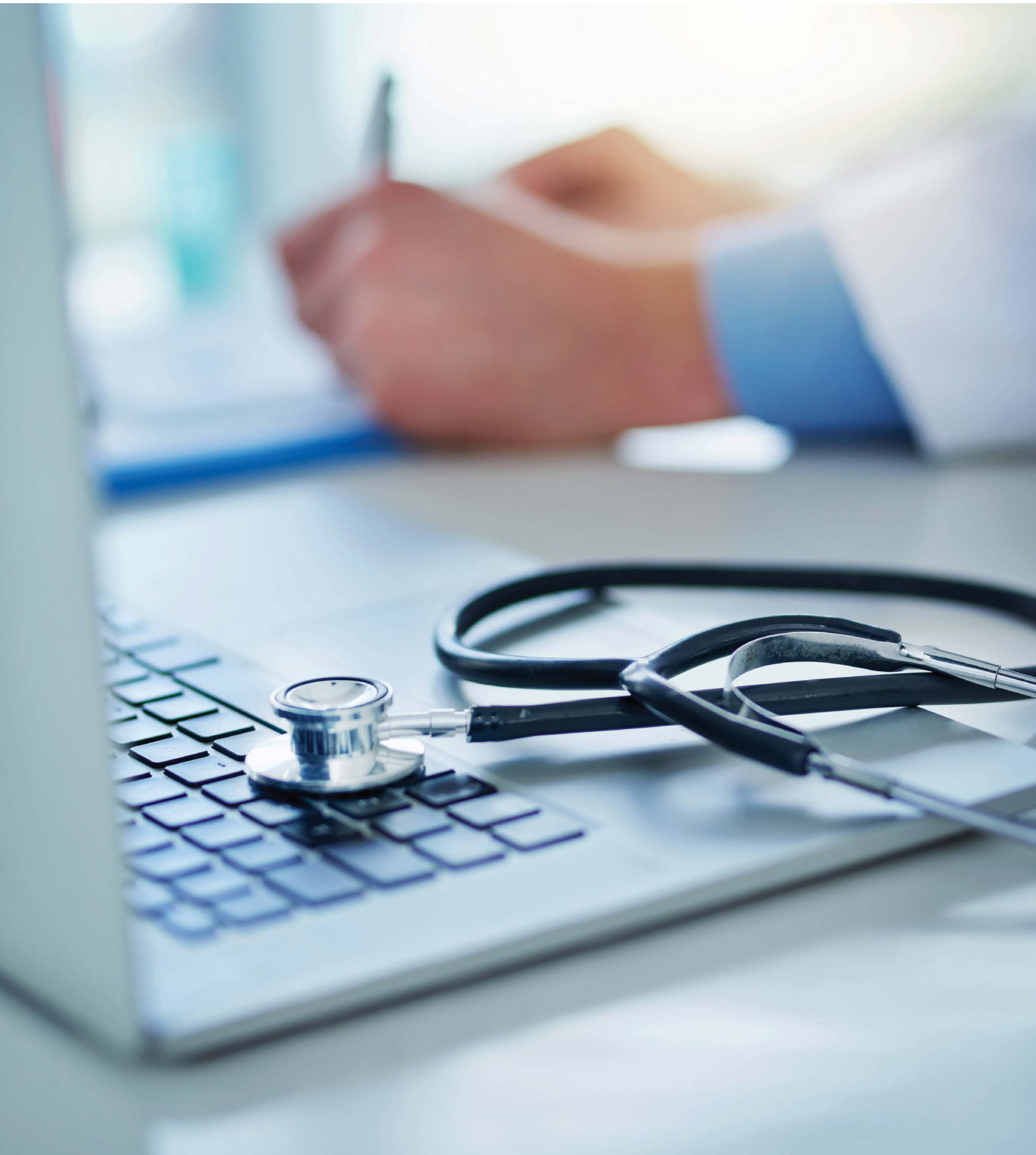
SECTION 1.
Introduction and General Information



MEDICAID AND THE HEALTHCHOICE PROGRAM

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program (MCHP). The HealthChoice program's philosophy is based on providing quality cost-effective and accessible health care that is patient-focused.

HEALTHCHOICE ELIGIBILITY

All individuals qualifying for Maryland Medical Assistance or MCHP are enrolled in the HealthChoice program, except for the following categories:

- Individuals who receive Medicare
- Individuals age 65 or over
- Individuals who are eligible for Medicaid under spend down
- Medicaid participants who have been or are expected to be continuously institutionalized for more than 90 successive days in a long-term facility or 30 days in an institution for mental disease.
- Individuals institutionalized in an intermediate care facility for people with intellectual disabilities (ICF-MR)
- Participants enrolled in the Model Waiver
- Participants who receive limited coverage, such as women who receive family planning; services through the Family Planning Waiver, or Employed Individuals with Disabilities Program
- Inmates of public institutions, including a state-operated institution or facility
- A child receiving adoption subsidy who is covered under the parent's private insurance
- A child under state supervision receiving adoption subsidy who lives outside of the state
- A child who is in an out-of-state placement

All Medicaid participants who are eligible for the HealthChoice program, without exception, will be enrolled in an MCO or in the Rare and Expensive Case Management program (REM). The REM program is discussed in detail in Section II.

Members must complete an updated eligibility application every year in order to maintain their coverage through the HealthChoice program.

HealthChoice members are permitted to change MCOs if they have been in the same MCO for 12 months or more.

HealthChoice providers are prohibited from steering members to a specific MCO. You are only allowed to provide information on which MCOs you participate with if a current or potential member seeks your advice about selecting an MCO.

Medicaid-eligible individuals who are not eligible for HealthChoice will continue to receive services in the Medicaid fee-for-service system.

OVERVIEW

- Priority Partners must provide a complete and comprehensive benefit package that is equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not Priority Partners responsibility) are still available for HealthChoice members. Medicaid will reimburse these services directly, on a fee-for-service basis.
- A Priority Partners PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring members to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.
- A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. We are responsible for reimbursing out-of-plan providers who have furnished these services to our members.
- Only benefits and services that are medically necessary are covered.
- HealthChoice members may not be charged any copayments, premiums or cost sharing of any kind, except for the following:
  - Up to a $3 copayment for brand-name drugs
  - Up to a $1 copayment for generic drug;
  - Any o ther charge up to the fee-for-service limit as approved by the MDH
- We do not impose pharmacy copayments on the following:
  - Family planning drugs and devices
  - Individuals under 21 years old
  - Pregnant members
  - Native American members
  - Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs.
  - Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program
  - The pharmacy cannot withhold services even if the member cannot pay the copayment. The member's inability to pay the copayment does not excuse the debt and they can be billed for the copayment at a later time.

MEMBER RIGHTS AND RESPONSIBILITIES

A. As a HealthChoice member, you have the right to:

- Receive health care and services that are culturally competent and free from discrimination.
- Have your dignity and privacy treated with respect.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Participate in decisions regarding your healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.

- Request copies of all documents, records, and other information free of charge, that was used in an adverse benefit determination.
- Exercise your rights, and that the exercise of those rights does not adversely affect the way the Managed Care Organizations (MCO), their providers, or the Maryland Department of Health treat you.
- File appeals and grievances with an MCO.
- File appeals, grievances, and State fair hearings with the State.
- Request that ongoing benefits be continued during an appeal or State fair hearing. However, you may have to pay for the continued benefits if the decision is upheld in the appeal or hearing.
- Receive a second opinion from another doctor within the same MCO, or by an out-of-network provider if the provider is not available within the MCO, if you do not agree with your doctor's opinion about the services that you need. Contact your MCO for help with this.
- Receive other information about how your MCO is managed, including the structure and operation of the MCO as well as physician incentive plans. You may request this information by calling your MCO.
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

B. As a HealthChoice member, you have the responsibility to:

- Inform your provider and MCO if you have any other health insurance coverage.
- Treat HealthChoice staff, MCO staff, and health care providers and staff, with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if you need to cancel an appointment.
- Show your membership card when you check in for every appointment. Never allow anyone else to use your Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call your MCO if you have a problem or a complaint.
- Work with your PCP to create and follow a plan of care that you and your PCP agree on.
- Ask questions about your care and let your provider know if there is something you do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.
- Update the State if there has been a change in your status.
- Provide the MCO and its providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform your caregivers about any changes to your Advance Directive.

C. Nondiscrimination Statement

It is the policy of all HealthChoice MCOs not to discriminate on the basis of race, color, national origin, sex, age, or disability. MCOs have adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of each MCO's nondiscrimination coordinator who has been designated to coordinate the efforts of each MCO in order to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for an MCO to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinators will maintain the files and records relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinators will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinators will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. Toll free: 800-368-1019 – TDD: 800-537-7697.

Complaint forms are available at: **https://www.hhs.gov/sites/default/files/civil-rights-complaint-form-0945-0002-exp-07312019.pdf**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

MCOs will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinators will be responsible for such arrangements.

D. Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires MCOs and providers to report their privacy practices to their members. The Notice of Privacy Practices informs members of their rights to privacy as well as the access and disclosure of their protected health information (PHI). Examples of PHI include medical records, medical claims/billing, and health plan records. If you feel that your privacy rights have been violated, you can file a complaint with your provider, MCO, or the U.S. Department of Health and Human Services.

To file a complaint, see the contact information below:
Provider: call your provider's office
MCO: call MCO Compliance Department
U.S. Department of Health and Human Services
Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Email: OCRComplaint@hhs.gov

In writing:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, DC 20201

PROCEDURE FOR SELECTING A PCP

Members have the right to select their PCP. Upon enrollment, the member may select a PCP from the Priority Partners provider directory or call Customer Service at 800-654-9728 for help in selecting a new provider. The member may consider the provider's specialty, accessibility, gender, ethnic background and languages spoken in the selection process.

DEFAULT ASSIGNMENT OF A PCP

Priority Partners provider network will be submitted to Customer Service to assist new members in selecting a PCP. Members who do not select a PCP will be assigned to one using the enrollment information provided (e.g., geographic proximity to the provider, age and language).

HIPAA AND MEMBER PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Priority Partners strives to ensure both Priority Partners and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers shall have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations:

- Priority Partners recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Priority Partners. However, privacy regulations allow the transfer or sharing of member information, which may be requested by Priority Partners to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Priority Partners, verify the receiving fax number is correct, notify the appropriate staff at Priority Partners and verify the fax was appropriately received.
- Internet email (unless encrypted) should not be used to transfer files containing member information to Priority Partners (e.g., Excel spreadsheets with claim information); such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box or department at Priority Partners.
- The Priority Partners voicemail system is secure and password protected. When leaving messages for Priority Partners associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting Priority Partners, please be prepared to verify the provider's name, address and tax identification number (TIN) or Priority Partners provider number.

MEMBER PRIVACY PRACTICES

Safeguarding Your Protected Health Information

Information We Provide To Our Members: Priority Partners Managed Care Organization is committed to protecting your health information. In order to provide treatment or to pay for your health care, Priority Partners will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information may be used for a variety of purposes. Priority Partners is required to follow the privacy practices described in this notice, although Priority Partners reserves the right to change our privacy practices and the terms of this notice at any time. You may request a copy of the new notice from Priority Partners Customer Service at 800-654-9728.

How Priority Partners May Use and Disclose Your Protected Health Information

The Priority Partners workforce will only use your health information when doing their jobs. For uses beyond what Priority Partners normally does, Priority Partners must have your written authorization unless the law permits or requires it. The following are some examples of our possible uses and disclosures of health information.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:

For treatment: Priority Partners may use or share your health information to approve, deny treatment and to determine if your medical treatment is appropriate. For example, Priority Partners health care providers may need to review your treatment plan with your health care provider for medical necessity or for coordination of care.

To obtain payment: Priority Partners may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.

For health care operations: Priority Partners may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors and regulators.

Other Uses and Disclosures of Health Information Required or Allowed by Law:

Information purposes: Unless you provide us with alternative instructions, Priority Partners may send appointment reminders and other materials about the program to your home.

Required by law: Priority Partners may disclose health information when a law requires us to do so.

Public health activities: Priority Partners may disclose health information when Priority Partners is required to collect or report information about disease or injury, or to report vital statistics to other divisions in the department and other public health authorities.

Health oversight activities: Priority Partners may disclose your health information to the MDH and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, accreditations, and licensure.

Coroners, medical examiners, funeral directors and organ donations: Priority Partners may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue procurement, donations or transplants.

Research purposes: In certain circumstances, and under supervision of an Institutional Review Board or other designated privacy board, Priority Partners may disclose health information to assist medical research.

Avert threat to health or safety: In order to avoid a serious threat to health or safety, Priority Partners may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Abuse and neglect: Priority Partners will disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or some other crime. Priority Partners may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Specific government functions: Priority Partners may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Families, friends or others involved in your care: Unless you say no, Priority Partners may share your health information with people as it is directly related to their involvement in your care. Priority Partners may share your health information if related to payment of your care. Unless you say no, Priority Partners may also share health information with people to notify them about your location, general condition, or death.

Worker's compensation: Priority Partners may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.

Lawsuits, disputes and claims: If you are involved in a lawsuit, a dispute, or a claim, Priority Partners may disclose your health information in response to a court or administrative order, subpoena, discovery request, investigation of a claim filed on your behalf, or other lawful process.

Law enforcement: Priority Partners may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.

You have a right to:

Request restrictions: You have a right to request a restriction or limitation on the health information Priority Partners uses or discloses about you. Priority Partners will accommodate your request, if possible, but is not legally required to agree to the requested restriction. If Priority Partners agrees to a restriction, Priority Partners will follow it except in emergency situations.

Request confidential communications: You have the right to ask that Priority Partners send you information at an alternative address or by alternative means. Priority Partners must agree to your request as long as
it is reasonably easy for us to do so.

Inspect and copy: You have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a fee for copying, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

Request amendment: You may request in writing that Priority Partners correct or add to your health record. Priority Partners may deny the request if Priority Partners determines that the health information is: (1) correct and complete; (2) not part of our records; or (3) not permitted to be disclosed. If you request an amendment to records that we did not create, we will consider your request only if the creator of the records in unavailable.

If Priority Partners approves the request for amendment, Priority Partners will amend the health information and inform you, and will tell others that need to know about the amendment in the health information.

Accounting of disclosures: You have a right to request a list of the disclosures made up of your health information after April 14, 2003. Exceptions are health information that has been used for treatment, payment, and operations. In addition, Priority Partners does not have to list disclosures made to you, made in connection with a permitted use or disclosure, based on your written authorization, made to your family, friends or others involved in your care, provided for national security, made to law enforcement officials or correctional facilities, or made as part of a limited data set (where all but a few identifiers are removed). There will be no charge for up to one such list each year.

Notice: You have the right to receive a paper copy of this notice and/or an electronic copy by email upon request.

For More Information

This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact the Priority Partners Corporate Compliance division at 410-424-4996 (local) or 844-422-6957 (toll-free).

To Report a Problem about our Privacy Practices

If you believe your privacy rights have been violated, you may file a complaint.

- You can file a complaint with Priority Partners Complaint Division by calling 410-424-4996 (local) or 844- 422-6957 (toll-free) or by mail:

  Johns Hopkins Health Plans
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076
  Attn: Priority Partners Corporate Compliance Department

- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call Priority Partners for the contact information. Priority Partners will take no retaliatory action against you if you make such complaints.

Effective Date: This notice became effective on April 14, 2003.

ANTI-GAG PROVISIONS

Providers participating with Priority Partners will not be restricted from discussing with or communicating to a member, enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

- Communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations
- Communications that is necessary or appropriate to maintain the provider-patient relationship while the member is under the participating physician's care
- Communications that relate to a member's or subscriber's right to appeal a coverage determination with which the provider, member, enrollee, or subscriber does not agree
- Opinions and the basis of an opinion about public policy issues

Participating providers agree that a determination by Priority Partners that a particular course of medical treatment is not a covered benefit shall not relieve providers from recommending such care as he/she deems to be appropriate nor shall such benefit determination be considered to be a medical determination.

Participating providers further agree to inform beneficiaries of their right to appeal a coverage determination pursuant to the applicable grievance procedures and according to law. Providers contracted with multiple MCOS are prohibited from steering recipients to any one specific MCO.

ASSIGNMENT AND REASSIGNMENT OF MEMBERS

Members can request to change their MCO one time during the first 90 days if they are new to the HealthChoice program as long as they are not hospitalized at the time of the request. They can also make this request within 90 days if they are automatically assigned to an MCO. Members may change their MCO if they have been in the same MCO for 12 or more months. Members may change their MCO and join another MCO near where they live for any of the following reasons at any time:

- If they move to another county where Priority Partners does not offer care
- If they become homeless and find that there is another MCO closer to where they live or have shelter which would make getting to appointments easier

- If they or any member of their family have a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family's MCO
- The member desires to continue to receive care from their primary care provider (PCP) and Priority Partners terminated the PCP's contract for one of the following reasons:
  - For reasons other than quality of care
  - The provider and Priority Partners cannot agree on a contract for certain financial reasons.
  - Priority Partners has been purchased by another MCO.
- Newborns are enrolled in the MCO the birthing parent was enrolled in on the date of delivery and cannot change for 90 days.

Once an individual chooses or is auto-assigned to Priority Partners and selects a PCP, Priority Partners enrolls the member into that practice and mails them a member ID card. Priority Partners will choose a PCP close to the member's residence if a PCP is not selected.

Priority Partners is required to provide PCPs with their rosters on a monthly basis. Please note that information changes frequently and should not be used to determine member eligibility. Priority Partners members may change PCPs at any time. Members can call Customer Service Monday-Friday from 8 a.m. to 5 p.m.at 800-654-9728 to change their PCP.

CREDENTIALING AND CONTRACTING WITH PRIORITY PARTNERS

The Johns Hopkins Health Plans credentialing process is an important component of the Johns Hopkins Health Plans Quality Assurance program. Johns Hopkins Health Plans' credentialing process is reviewed, at a minimum, annually by the Special Credentials Review Committee, Johns Hopkins Health Plans' credentialing governing body.

The goal of credentialing is to ensure that Johns Hopkins Health Plans has a qualified multidisciplinary practitioner panel to deliver safe, effective and appropriate care to its members. At the time of initial credentialing and prior to issuing approval all provider candidate applications undergo the following primary source verifications:

- Licensure
- Education
- Office of Inspector General
- Board certification (if applicable)
- Hospital affiliation

Practitioners are re-credentialed on at least an every three-year cycle.

Types of Providers Requiring Credentialing

- Hospitals-acute care, general and special
- Organ transplantation centers
- Organ transplant consortia

- Hospitals- psychiatric
- Hospitals – long term (tuberculosis, chronic care or rehabilitation,
- Skilled nursing facilities
- Residential treatment centers
- Other special institutional providers
- Freestanding ambulatory surgical centers
- Birthing centers
- Psychiatric partial hospitalization programs
- Hospice programs
- Substance-use disorder rehabilitation facilities

Types of Individual Professional Providers Requiring Credentialing

- Doctors of medicine
- Doctors of osteopathy

Types of Other Allied Health Professionals Requiring Credentialing

- Clinical psychologist
- Doctors of optometry
- Doctors of podiatry or surgical chiropody
- Certified nurse midwives
- Certified nurse practitioner
- Certified clinical social worker
- Certified psychiatric nurse specialist
- Certified physician assistants
- Certified registered nurse anesthetist
- Other individual paramedical providers
- Licensed registered physical therapists and occupational therapists
- Extramedical individual providers (certified marriage and family therapists, mental health counselors)

In order to facilitate timely re-credentialing, 120 days prior to the practitioner's expiration date, Johns Hopkins Health Plans' Credentialing department will pull out applications from the CAQH. Johns Hopkins Health Plans will only mail a blank current state of Maryland Uniform Credentialing Form (UCF) to the provider if the practitioner is not in CAQH. For your convenience, this state mandated form can be found at https://insurance.maryland.gov/Insurer/Pages/HealthCareProviders.aspx.

Practitioners are required to:

- Submit either a completed current copy of the UCF or a current downloaded CAQH application
- Correct and/or update any necessary information
- Attach the required documentation
- Ensure that all information is up-to-date and accurate before signing the authorization for release of information
- Return it in the envelope provided within 15 days of receipt

Continued network participation is dependent upon completion of the re-credentialing process within the established timeframe. Please contact your Provider Relations network manager at 410-762-5385 or 888-895-4998 or the Credentialing department at 410-424-4619 if you have questions about the credentialing process.

Rights to Appeal the Denial of Re-Credentialing

No appeal rights for a re-credentialing denial are available if there is a:

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

Providers who are eligible for appeal must submit their request in writing within 30 calendar days of the denial of their re-credentialing. The credentialing manager or designee will convene an appeal panel comprised of three qualified practitioners. At least one practitioner is a clinical peer of the appealing provider who is not otherwise involved in Johns Hopkins Health Plans network management operations activities. For the purpose of this requirement, a clinical peer is a provider with the same type of license. The panel shall not include any individual who is in direct economic competition with the affected provider or who is professionally associated with or related to the provider or who otherwise might directly benefit from the outcome.

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

Within 10 calendar days of either a first- or second-level panel review, and after reviewing any written statements submitted by the provider and any other relevant information, the panel will render a decision. The credentialing department designee will notify the affected provider in writing within five calendar days of the panel's decision. This notice will be sent either by certified mail return receipt requested or express mail with receipt of delivery.

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

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

PROVIDER REIMBURSEMENT

Payment is in accordance with your provider contract with Priority Partners (or with their management groups that contract on your behalf with Priority Partners). In accordance with the Maryland Annotated Code, Health General Article 15-1005, we must mail or transmit payment to our providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, we shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. We shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

Reimbursement for hospitals and other applicable provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates.

Priority Partners is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid participant's enrollment in Priority Partners. However, we are responsible for reimbursement to providers for professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

SELF-REFERRAL AND EMERGENCY SERVICES

Members have the right to access certain services without prior referral or authorization by a PCP. Priority Partners is responsible for reimbursing out-of-plan providers who have furnished these services to our members. The state allows members to self-refer to out-of-network providers for the services listed below. Priority Partners will pay out-of-plan providers the state's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility and medically necessary post-stabilization services
- Family planning services except sterilizations
- School-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. A school-based health center reporting form is linked here and can be found in Section IX of the manual and also at: **https://health.maryland.gov/mmcp/epsdt/healthykids/Pages/Encounter-Forms.aspx**.
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in Priority Partners
- Initial medical examination for children in state custody
- Annual diagnostic and evaluation services for recipients with HIV/AIDS
- Renal dialysis provided at a Medicare-certified facility
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge
- Services performed at a birthing center, including an out-of-state center located in a contiguous state

Self-Referred Services for Children with Special Health Care Needs

If a provider contracts with Priority Partners for any of the services listed above the provider must follow our billing and preauthorization procedures. Reimbursements will be paid the contracted rate.

Children with special health care needs may self-refer to providers outside of the Priority Partners network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in Priority Partners. Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- **New member:** A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into Priority Partners and we approve the services as medically necessary.

- **Established member:** A child who is already enrolled in Priority Partners when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We are obliged to grant the member's request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce, or terminate the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

MARYLAND CONTINUITY OF CARE PROVISIONS

Under Maryland insurance law, HealthChoice members have certain continuity of care rights. These apply when the member:

- Is new to the HealthChoice program
- Switched from another company's health benefit plan
- Switched to Priority Partners from another MCO

The following services are excluded from Continuity of Care provisions for HealthChoice members:

- Dental services
- Mental health services
- Substance use disorder services
- Benefits or services provided through the Maryland Medicaid fee-for-service program.

Prior Authorization for Health Care Services

If the previous MCO or company prior authorization services, Priority Partners will honor the approval if the member calls 800-654-9728. Under Maryland law, insurers must provide a copy of the prior authorization within 10 days of the member's request. There is a time limit for how long we must honor this prior authorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to Use Non-Participating Providers

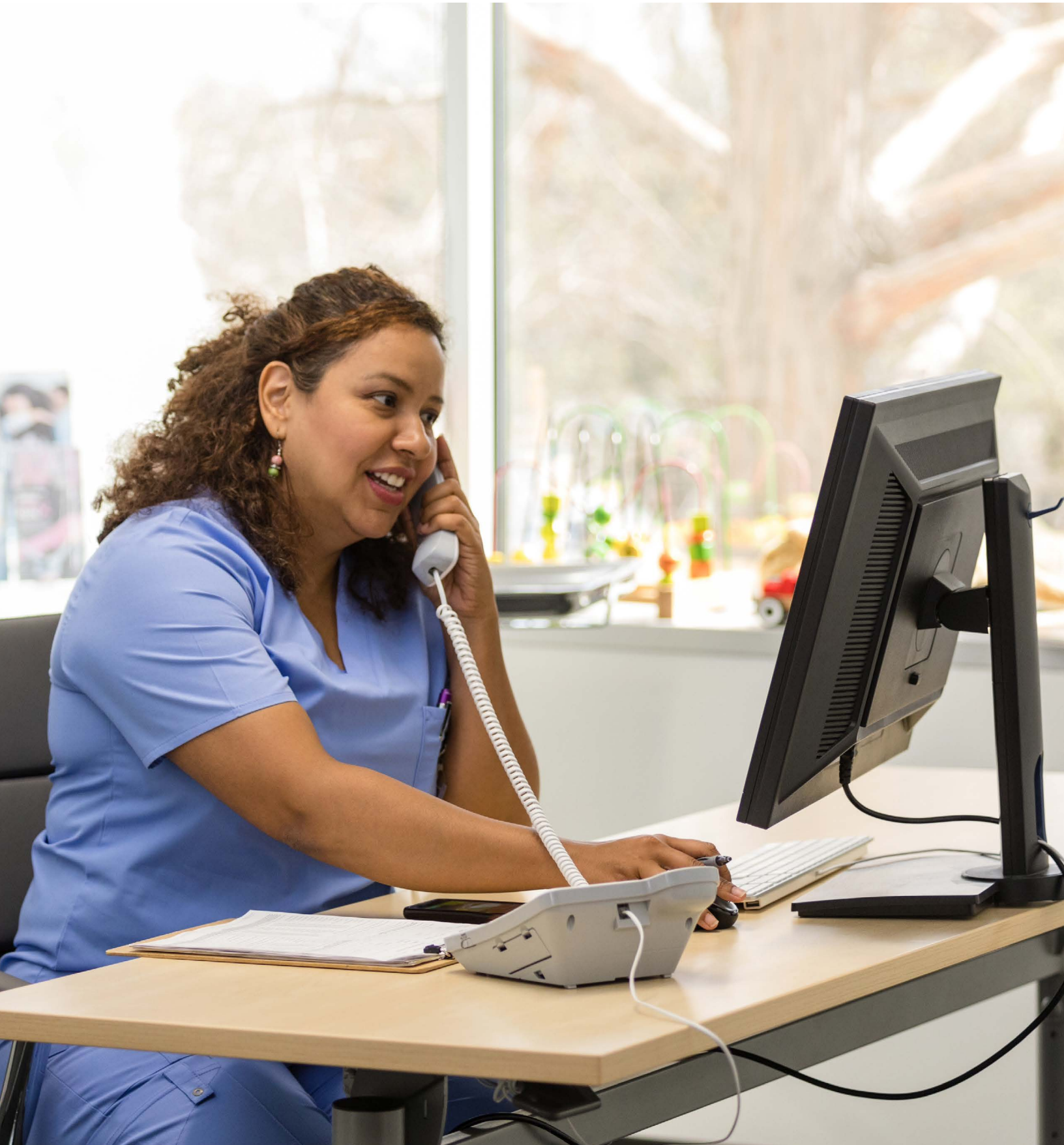
Members can contact Priority Partners to request the right to continue to see a non-participating provider. This right applies only for one or more of the following types of conditions:

- Acute conditions
- Serious chronic conditions
- Pregnancy
- Any other condition upon which Priority Partners and the out-of-network provider agree.

There is a time limit for how long we must allow the member to receive services from an out of network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care provider after the baby is born.

If the member has any questions they should call Priority Partners Customer Service at 800-654-9728 or the state's HealthChoice Help Line at 800-284-4510.

SECTION 11.
Outreach and Support Services, Appointment Scheduling, EPSDT and Special Populations



PRIORITY PARTNERS SUPPORT SERVICES

Member Services

Priority Partners' Member Services department provides clear communication mechanisms to expedite linkages to community-based resources that address the needs of our members. Requests for Member Services may be generated from members, PCPs, specialty providers, are care coordinators and case managers.

Requests for Member Services may be submitted, electronically (via the website) or by faxing in a completed Member Services Referral Form.

- Fax: 410-424-4030
- Email: referrals@jhhp.org

Notification of members for upcoming health maintenance activities and written reminders of appointment dates to ensure scheduling of initial appointment within specified guidelines for targeted populations.

- Follow-up on members who miss two consecutive health maintenance appointments by telephone or letter to include assistance with rescheduling appointments
- Schedule necessary and mandated referrals and collaborate with the local health department (LHD)
- Work with local Social Service departments in obtaining solutions to resolve social issues
- Work collaboratively with care coordinators in the coordination and implementation of member's care plans
- Coordinate and/or arrange transportation

Health Education

In addition to member and special needs services, the Priority Partners Health Education team is a resource for providers that include the following educational methods:

- Individual member health education for special needs populations and those referred by the PCP as having problems following a plan of care
- Provisions for individual and group health education and health promotion activities
- Participation in community-based health screening programs for Priority Partners' members
- Collaboration with care coordinators and case managers in providing member education, reinforcement of member participation in the treatment plan and follow-up of missed appointments
- Serve as a member advocate
- Facilitate member's participation on the Priority Partners' Consumer Advisory Board

For additional program information, a Priority Partners Health Educator can be contacted by calling 800-957-9760, or emailing healtheducation@jhhp.org.

STATE NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ASSISTANCE

If a member needs transportation assistance contact the Local Health Department (LHD) to assist members in accessing non-emergency medical transportation services (NEMT). Priority Partners will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.

LDHs are the primary sources of transportation services. Priority Partners will assist members to secure non-emergency transportation through their LHD. Additionally, we may provide non-emergency transportation to a covered service located in the closest county outside the member's residing county. The following is a list of the transportation contact numbers for each county.

County	Company	Telephone Number
Alleghany		301-759-5123
Anne Arundel		410-222-7152
Baltimore City	Problem Resolution	410-396-7635
	Enrollment & Scheduling	410-396-7633
	Facilities and Professional Offices	410-396-7634
Baltimore County	TransDev	410-783-2465
		410-887-2828
Calvert		410-414-2489
Caroline		410-876-4813
Carroll		410-876-4813
Cecil		410-996-5171
Charles		301-609-6923 or 301-609-6933
Dorchester		410-901-2426
Frederick		301-600-3364
Garrett	Garrett Enrollment & Scheduling	301-334-7726
	Issues & Concerns	301-334-7727
Harford		410-638-1671
Howard		877-312-6571
Kent		410-778-7025
Montgomery		301-856-9555
Prince George's		301-856-9555
Queen Anne's		443-262-4462 or 410-758-0720 ext. 4462
St. Mary's		301-475-4296
Talbot		410-819-5609
Washington		240-313-3264
Wicomico		410-548-5142 Opt. #1
Worcester		410-632-0092 or 410-632-0093

PRIORITY PARTNERS TRANSPORTATION ASSISTANCE

Under certain circumstances Priority Partners will assist the member in applying for transportation services through the LHD.

Priority Partners has revised its member transportation program with the goals of reducing no-shows and cancellations.

To assist members with transportation needs, Priority Partners has a transportation specialist who can help members apply for other services, such as Mobility and Paratransit, which are designed for people who are unable to use local bus, metro or light rail services. The transportation specialist also has access to community resources throughout Maryland to assist members with transportation.

Priority Partners will only provide transportation to medical appointments for Priority Partners members who cannot access specialty medical appointments, urgent and non-urgent PCP appointments or, accommodations for special needs populations participating in health education classes but only as a last resort. Members must exhaust all other available means of transportation (e.g. personal vehicles, family and friends, public transportation). Even then, this does not guarantee the request will be approved.

Accommodations can be made for special needs populations participating in health education classes. If you have additional questions about our transportation program, please call Priority Partners Member Services at 800-654-9728.

STATE SUPPORT SERVICES

The state provides grants to local health departments to operate Administrative Care Coordination/ Ombudsman services (ACCUs) to assist with outreach to certain non-complaint members and special populations as outlined below. MCOs and providers are encouraged to develop collaborative relationships with the local ACCU.

See the chart below for the local ACCU contact information. If you have questions call the Division of Community Liaison and Care Coordination at 410-767-6750, which oversees the ACCUs or the HealthChoice Provider Help Line at 800-766-8692.

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	https://health.maryland.gov/allegany/Pages/Home.aspx
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-649-0521	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-783-2465	410-887-8741	http://www.baltimorecountymd.gov/agencies/health

Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8023	410-479-8014	410-479-8189	https://www.carolinehd.org/home
Carroll	410-876-4940	410-876-4813	410-876-4941	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5145	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6803 301-609-6855 301-609-6760	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-228-3223	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3101 301-600-3364	301-600-3124	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7726	301-334-7771	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	https://www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899 240-777-5890	240-777-1648 240-777-1640 240-777-4322	http://www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1700	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3229	https://washcohealth.org/
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

SCHEDULING APPOINTMENTS

HealthChoice members must be scheduled for an initial appointment within 90 days of enrollment unless one of the following exceptions apply:

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and postpartum members who have not started to receive care, the initial health visit

must be scheduled and the member seen within 10 days of a request.

- As part of the MCO enrollment process the state asks the member to complete a Health Services Needs Information (HSNI) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of Priority Partners' receipt of the HSNI.
- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam.
- In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior, or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at 800-888-1965.

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:

Service	Appointment Wait Time (not more than):
Initial prenatal appointments	Ten (10) business days from request, or from the date the MCO receives a Health Risk Assessment (HRA) for the new enrollee (unless enrollee continues care with established provider and established provider concludes that no initial appointment is necessary), whichever is sooner.
Family planning appointments	Ten (10) days from the date enrollee requests appointment
High risk enrollee appointments	Fifteen (15) business days from MCO's receipt of the enrollee's completed HRA
Urgent Care appointments	Forty-eight (48) hours from date of request
Routine, Preventive Care, or Specialty Care appointments	Thirty (30) days from initial request or, where applicable, from authorization from PCP.
Initial newborn visits	Fourteen (14) days from discharge from hospital (if no home visit has occurred)
Initial newborn visits if a home visit has been provided	Within thirty (30) days from date of discharge from hospital
Regular optometry, lab, or x-ray appointments	Thirty (30) days from date of request
Urgent optometry, lab or x-ray appointments	Forty-eight (48) hours from date of request
Wait for enrollee inquiries on whether or not to use an emergency facility	Thirty (30) minutes
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

EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)

Priority Partners will assign children and adolescents under age 21 to a PCP who is certified by the EPSDT/ Healthy Kids program. If member's parent, guardian, or care taker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified, the non-EPSDT provider is responsible for ensuring that

the child receives well childcare according to the EPSDT schedule. If you provide primary care services to individuals under age 21 and are not EPSDT certified call 410-767-1836. For more information about the HealthyKids/EPSDT program and expanded EPSDT services for children under age 21 go to **https://health.maryland.gov/mmcp/epsdt/Pages/Home.aspx**.

Providers must follow the Maryland Healthy Kids/EPSDT program periodicity schedule and all associated rules to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The program requires you to:

- Notify members of their due dates for wellness services and immunizations.
- Schedule and provide preventive health services according to the state's EPSDT periodicity schedule and screening annual.
- Refer infants and children under age 5 and pregnant teens to the supplemental nutritional program for Women Infants and Children (WIC). Provide the WIC Program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines for Children (VFC) program. Many of the routine childhood immunizations are furnished under the VFC program. The VFC program provides free vaccines for health care providers who participate in the VFC program. We will pay for new vaccines that are not yet available through the VFC program.
- Schedule appointments at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

Members under age 21 are eligible for a wider range of services under EPSDT than adults. PCPs are responsible for understanding these expanded services. See Section III Member Benefits and Services for more information. PCPs must make appropriate referrals for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

Providers shall refer children for specialty care as appropriate. Referrals must be made when a child:

- Is identified as being at risk of a developmental delay by the developmental screen required by EPSDT
- Has a 25 percent or more delay in any developmental area as measured by appropriate diagnostic instruments and procedures
- Manifests atypical development or behavior
- Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

A child thought to have been physically, mentally, or sexually abused must be referred to a specialist who is able to make that determination.

EPSDT Outreach and Referral to LHD

For each scheduled Healthy Kids appointment, written notice of the appointment date and time must be sent by mail to the child's parent, guardian, or caretaker, and attempts must be made to notify the child's parent, guardian, or caretaker of the appointment date and time by telephone.

- For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, care givers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care.
- Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, by telephone, and through face-to-face contact.
- Schedule a second appointment within 30 days of the first missed appointment. Within 10 days of the child missing the second consecutive appointment, you can request assistance in locating and

contacting the child's parent, guardian or caretaker by calling Priority Partners at 800-6549728.

- You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form linked here and located in Section IX in the back of this manual.
- Continue to work collaboratively with Priority Partners and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or **receives appropriate** follow-up care.

Support and outreach services are also available to members that have **impaired cognitive ability or psychosocial problems such as homelessnes**s or other conditions likely to cause them to have difficulty understanding the importance of care instructions or difficulty navigating the health care system. You must notify Priority Partners if these members miss three consecutive appointments or repeatedly does not follow their treatment plan. We will attempt to outreach the member and may make a referral to the ACCU to help locate the member and get them into care.

SPECIAL POPULATIONS

The state has identified certain groups as requiring special clinical and support services from Priority Partners. These special needs populations are:

- Pregnant and postpartum members
- Children with special health care needs
- Children in state-supervised care
- Individuals with HIV/AIDS
- Individuals with a physical disability
- Individuals with a developmental disability
- Individuals who are homeless

To provide care to a special needs population, it is important for the PCP and specialist to:

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our case management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our providers:

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a special needs coordinator on staff to focus on the concerns and issues of special needs populations. The special needs coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the special needs coordinator call 800-654-9728.
- Providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations

promulgated under it).

Special Needs Population-Outreach and Referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care must be referred to Priority Partners. If a member continues to miss appointments, call Priority Partners at 800-654-9728. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the Local Health Services Request Form, which is linked here and also located at the back of this manual under section IX. The local ACCU staff will work collaboratively with Priority Partners to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for Pregnant and Postpartum Members

Prenatal care providers are key to assuring that pregnant members have access to all available services. Many pregnant members will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these members during pregnancy and for one year after delivery after which they will automatically be enrolled in the Family Planning Waiver Program. (For more information visit: https://health.maryland.gov/mmcp/Documents/Factsheet3_Medicaid%20Family%20Planning%20Program.pdf

Priority Partners and our providers are responsible for providing pregnancy-related services, which include:

- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care)
- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form, MDH 4850. (For updated form visit: https://health.maryland.gov/mmcp/Documents/Maryland%20Prenatal%20Risk%20Assesment%20-%20Revised%2010.4.22.pdf)
- An individualized plan of care based upon the risk assessment and which is modified during the course of care as needed
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers
- Case management services
- Prenatal and postpartum counseling and education including basic nutrition education;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant members.
- Doula support for prenatal visits, attendance at labor and delivery, and postpartum visits.
- Prenatal, postpartum, and infant home visits from pregnancy and childbirth up to two or three years of the child's age

The state provides these additional services for pregnant members:

- Special access to substance use disorder treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their parent

Encourage all pregnant members to call the state's Help Line for Pregnant Women at 800-456-8900. This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice, call us and also instruct them to call Priority Partners at 410-424-4965 or 800-654-9728.

Pregnant members who are already under the care of an out of network practitioner qualified in obstetrics may continue with that practitioner if they agree to accept payment from Priority Partners. If the practitioner is not contracted with us, a care manager and/or Member Services representative will coordinate services

necessary for the practitioner to continue the member's care until postpartum care is completed.

The prenatal care providers must follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephone, if possible, notice to member of the prenatal appointment dates and times. The prenatal care provider, PCP and Priority Partners are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC). Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850 during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. Priority Partners will pay for the initial prenatal risk assessment (use CPT code H1000).
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- At each visit provide health education relevant to the member's stage of pregnancy. Priority Partners will pay for this (use CPT code H1003 for Enriched Maternity Services). You may only bill for one unit of Enriched Maternity Services per visit. Refer pregnant and postpartum members to the WIC program.
- If under the age 21, refer the member to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days if a member misses a prenatal appointment. Call Priority Partners if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at 855-934-9812; TDD: 855-934-9816; website: http://member.mdhealthysmiles.com/ if you have questions about dental benefits.
- Refer pregnant and postpartum members in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated they are required to arrange for substance abuse treatment within 24 hours.
- Educate pregnant members on doula services or refer eligible members for home visits if medically necessary and appropriate.
- Record the member's choice of pediatric provider in the medical record prior to their eighth month of pregnancy. We can assist in choosing a PCP for the newborn. Advise the member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the *Hospital Report of Newborns, MDH 1184*. (The hospital must complete this form so Medicaid can issue the

newborns ID number.) The newborn will be enrolled in the postpartum member's MCO.

Date of Visit: _____/ _____/ _____

Provider Name:_____ Provider Phone Number: _____-_____-____

Client Last Name: _____ First Name: _____ Middle: ___

House Number: _____ Street Name: _____ Apt: _____ City:
County (If patient lives in Baltimore City, leave blank): _____ State: _____ Zip Code:
Home Phone #: _____-_____-_____ Cell Phone#: _____-_____-_____ Emergency Phone#:
- _____-_____

SSN: _____ - _____ - _____ DOB: _____ / ____ / _____ Emergency Contact: _____

Transferred from other source of prenatal care ? ___ Yes ___ No

If YES, date care began: _____/_____/ _____

Complete all that apply

_____# Full-term live births

_____# Pre-term live births

_____# Prior LBW births

Check all that apply

____History of pre-term labor

____History of fetal death (> 20 weeks)

____History of infant death w/in 1 yr of

Psychosocial Risks: Check all that apply.

_____Current pregnancy unintended

_____Less than 1 year since last delivery

_____Late registration (more than 20 weeks gestation)

_____Disability (mental/physical/developmental), Specify _____

_____History of abuse/violence within past 6 months

COMMENTS ON PSYCHOSOCIAL RISKS:

Medical Risks: Check all that apply.

Current Medical Conditions of this Pregnancy:

_____Age ≤15

_____Age ≥ 45

_____BMI < 18.5 or BMI > 30

_____Hypertension (> 140/90)

_____Anemia (Hgb < 10 or Hct < 30

_____Asthma

COMMENTS ON MEDICAL RISKS:

MARYLAND PRENATAL RISK ASSESSMENT

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:

A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care unless the 48 hour (uncomplicated vaginal delivery) / 96 hour (uncomplicated cesarean section) length of stay guaranteed by state law is longer than that required under the guidelines.

If a member must remain in the hospital after childbirth for medical reasons, and the member requests that

their newborn remain in the hospital while they are hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.

If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided. When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Postnatal home visits must be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a postpartum member and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse symptoms of the newborn
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the postpartum member
- Blood collection from the newborn for screening, unless previously completed
- Appropriate referrals
- Any other nursing services ordered by the referring provider.

If the member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Unless we provide for the service prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital physician before the newborn's hospital discharge is covered as a self-referred service.

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered under certain situations for breastfeeding members. Call us at 800-654-9728.

Children with Special Health Care Needs

Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in Priority Partners.

Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

New Member: A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into Priority Partners and we approve the services as medically necessary.

Established Member: A child who is already enrolled in Priority Partners when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We are obliged to grant the member's request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce, or terminate the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

For children with special health care needs Priority Partners will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the state or to Priority Partners about a child who is denied a service by us. We will inform the state about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the state's HealthChoice Help Line at 800-284-4510.
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

We will ensure coordination of care for children in state-supervised care. If a child in state-supervised care moves out of the area and must transfer to another MCO, the state and Priority Partners will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

We are required to provide the following services for persons with HIV/AIDS:

- An HIV/AIDS specialist is provided for treatment and coordination of primary and specialty care
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance use treatment is provided within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.
- Providers will maintain the confidentiality of client records and eligibility information, in accordance with all federal, state and local laws and regulations, and use this information only to assist the participant in receiving needed health care services.

Priority Partners will provide case management services for any member who is diagnosed with HIV. These services will be provided with the member's consent, and will facilitate timely and coordinated access to appropriate levels of care and support continuity of care across the continuum of qualified service providers. If a member initially refuses HIV case management services they may request services at a later time. The

member's case manager will serve as the member's advocate to resolve differences between the member and providers pertaining to the course or content of therapeutic interventions.

Individuals with Physical or Developmental Disabilities

Providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. We are responsible for accommodating hearing impaired members who require and request a qualified interpreter. We can delegate the financial risk and responsibility to our providers, but we are ultimately responsible for ensuring that our members have access to these services.

Before placement of an individual with a physical disability into an intermediate or long-term care facility, we will cooperate with the facility in meeting their obligation to complete a Pre-admission Screening and Resident Review (PASRR) ID Screen.

Homeless Individuals

Homeless individuals may use the local health department's address to receive mail. If we know an individual is homeless we will offer to provide a case manager to coordinate health care services.

RARE AND EXPENSIVE CASE MANAGEMENT PROGRAM

The Maryland Department of Health (MDH) administers a Rare and Expensive Case Management (REM) program as an alternative to the MCO for certain HealthChoice eligible individuals diagnosed with rare and expensive medical conditions. Medicaid Benefits and REM Case Management

To qualify for the REM program, the HealthChoice enrollee must have one or more of the diagnoses specified in the Rare and Expensive Disease List below. The enrollee may elect to enroll in the REM Program, or to remain in Priority Partners if the Department agrees that it is medically appropriate. REM participants are eligible for all fee-for-service benefits currently offered to Medicaid-eligible beneficiaries who are not eligible to enroll in MCOs. In addition REM participants may receive additional services which are described in COMAR 10.09.69.

The Participant's REM Case Manager Will:

Gather all relevant information needed to complete a comprehensive needs assessment; Assist the participant select an appropriate PCP, if needed; Consult with a multi-disciplinary team that includes providers, participants, and family/caregivers, and develop the participant's plan of care; Implement the plan of care, monitor service delivery, modify the plan as warranted by changes in the participant's condition; Document findings and maintain clear and concise records; Assist in the participant's transfer out of the REM program, when and if appropriate.

Referral and Enrollment Process

Candidates for REM are generally referred by their PCP, specialty providers, MCOs, but may also self-identify. The referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information: in order to determine the member's eligibility for REM. If the intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO.

If the intake nurse determines that the enrollee has a REM-qualifying diagnosis, the nurse approves the member

for enrollment in REM. Before the enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services through the Medicaid fee-for service program. If the PCP is unwilling to continue to care for the member the case is referred to a case manager to select a PCP in consultation with the member. If the PCP will continue providing services, the Intake Unit will explain the program and give the member an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. The MCO is responsible for providing the member's care until the REM enrollment process is complete.

For questions and referral forms call 800-565-8190; forms may be faxed to 410-333-5426 or mailed to:

REM Intake Unit
Maryland Department of Health
201 W. Preston Street, Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Diagnosis

ICD10	ICD 10 Description	Age Limit
B20	Human immunodeficiency virus (HIV) disease	0-20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0-64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0-64
C96.6	Unifocal Langerhans-cell histiocytosis	0-64
D61.01	Constitutional (pure) red blood cell aplasia	0-64
D61.09	Other constitutional aplastic anemia	0-64
D66	Hereditary factor VIII deficiency	0-64
D67	Hereditary factor IX deficiency	0-64
D68.0	Von Willebrand's disease	0-64
D68.1	Hereditary factor XI deficiency	0-64
D68.2	Hereditary deficiency of other clotting factors	0-64
E70.0	Classical phenylketonuria	0-20
E70.1	Other hyperphenylalaninemias	0-20
E70.20	Disorder of tyrosine metabolism, unspecified	0-20
E70.21	Tyrosinemia	0-20
E70.29	Other disorders of tyrosine metabolism	0-20
E70.30	Albinism, unspecified	0-20
E70.40	Disorders of histidine metabolism, unspecified	0-20
E70.41	Histidinemia	0-20
E70.49	Other disorders of histidine metabolism	0-20
E70.5	Disorders of tryptophan metabolism	0-20
E70.8	Other disorders of aromatic amino-acid metabolism	0-20
E71.0	Maple-syrup-urine disease	0-20
E71.110	Isovaleric acidemia	0-20
E71.111	3-methylglutaconic aciduria	0-20
E71.118	Other branched-chain organic acidurias	0-20
E71.120	Methylmalonic acidemia	0-20
E71.121	Propionic acidemia	0-20
E71.128	Other disorders of propionate metabolism	0-20
E71.19	Other disorders of branched-chain amino-acid metabolism	0-20

ICD10	ICD 10 Description	Age Limit
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0-20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0-64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0-64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0-64
E71.313	Glutaric aciduria type II	0-64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0-64
E71.318	Other disorders of fatty-acid oxidation	0-64
E71.32	Disorders of ketone metabolism	0-64
E71.39	Other disorders of fatty-acid metabolism	0-64
E71.41	Primary carnitine deficiency	0-64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0-64
E71.50	Peroxisomal disorder, unspecified	0-64
E71.510	Zellweger syndrome	0-64
E71.511	Neonatal adrenoleukodystrophy	0-64
E71.518	Other disorders of peroxisome biogenesis	0-64
E71.520	Childhood cerebral X-linked adrenoleukodystrophy	0-64
E71.521	Adolescent X-linked adrenoleukodystrophy	0-64
E71.522	Adrenomyeloneuropathy	0-64
E71.528	Other X-linked adrenoleukodystrophy	0-64
E71.529	X-linked adrenoleukodystrophy, unspecified type	0-64
E71.53	Other group 2 peroxisomal disorders	0-64
E71.540	Rhizomelic chondrodysplasia punctata	0-64
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20

ICD10	ICD 10 Description	Age Limit
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20
E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20
E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20
E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64

ICD10	ICD 10 Description	Age Limit
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64
E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64
F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20
G11.1	Early-onset cerebellar ataxia	0-20
G11.2	Late-onset cerebellar ataxia	0-20
G11.3	Cerebellar ataxia with defective DNA repair	0-20
G11.4	Hereditary spastic paraplegia	0-20
G11.8	Other hereditary ataxias	0-20
G11.9	Hereditary ataxia, unspecified	0-20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0-20
G12.1	Other inherited spinal muscular atrophy	0-20
G12.21	Amyotrophic lateral sclerosis	0-20
G12.22	Progressive bulbar palsy	0-20
G12.29	Other motor neuron disease	0-20
G12.8	Other spinal muscular atrophies and related syndromes	0-20
G12.9	Spinal muscular atrophy, unspecified	0-20
G24.1	Genetic torsion dystonia	0-20
G24.8	Other dystonia	0-20
G25.3	Myoclonus	0-5
G25.9	Extrapyramidal and movement disorder, unspecified	0-20
G31.81	Alpers disease	0-20
G31.82	Leigh's disease	0-20
G31.9	Degenerative disease of nervous system, unspecified	0-20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0-20

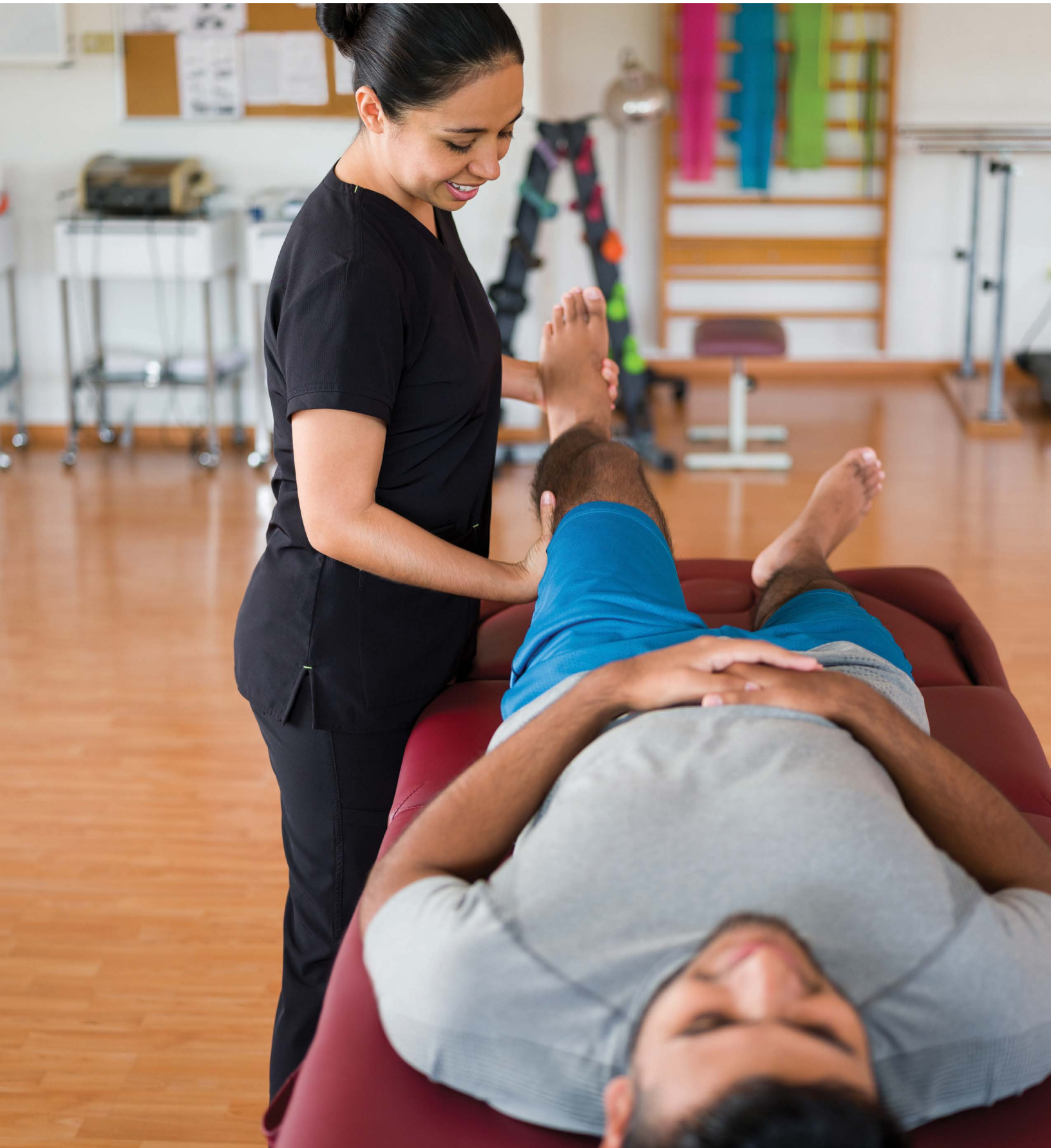
ICD10	ICD 10 Description	Age Limit
G37.0	Diffuse sclerosis of central nervous system	0-64
G37.5	Concentric sclerosis (Balo) of central nervous system	0-64
G71.00	Muscular dystrophy, unspecified	0-64
G71.11	Myotonic muscular dystrophy	0-64
G71.01	Duchenne or Becker muscular dystrophy	0-64
G71.02	Facioscapulohumeral muscular dystrophy	0-64
G71.09	Other specified muscular dystrophies	0-64
G71.2	Congenital myopathies	0-64
G80.0	Spastic quadriplegic cerebral palsy	0-64
G80.1	Spastic diplegic cerebral palsy	0-20
G80.3	Athetoid cerebral palsy	0-64
G82.50	Quadriplegia, unspecified	0-64
G82.51	Quadriplegia, C1-C4 complete	0-64
G82.52	Quadriplegia, C1-C4 incomplete	0-64
G82.53	Quadriplegia, C5-C7 complete	0-64
G82.54	Quadriplegia, C5-C7 incomplete	0-64
G91.0	Communicating hydrocephalus	0-20
G91.1	Obstructive hydrocephalus	0-20
I67.5	Moyamoya disease	0-64
K91.2	Postsurgical malabsorption, not elsewhere classified	0-20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20

ICD10	ICD 10 Description	Age Limit
Q04.3	Other reduction deformities of brain	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64
Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0-64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0-5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0-5
Q31.0	Web of larynx	0-20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0-20
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0-20
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0-20
Q33.0	Congenital cystic lung	0-20
Q33.2	Sequestration of lung	0-20
Q33.3	Agenesis of lung	0-20
Q33.6	Congenital hypoplasia and dysplasia of lung	0-20
Q35.1	Cleft hard palate	0-20
Q35.3	Cleft soft palate	0-20
Q35.5	Cleft hard palate with cleft soft palate	0-20
Q35.9	Cleft palate, unspecified	0-20
Q37.0	Cleft hard palate with bilateral cleft lip	0-20
Q37.1	Cleft hard palate with unilateral cleft lip	0-20
Q37.2	Cleft soft palate with bilateral cleft lip	0-20
Q37.3	Cleft soft palate with unilateral cleft lip	0-20

ICD10	ICD 10 Description	Age Limit
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0-20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0-20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0-20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0-20
Q39.0	Atresia of esophagus without fistula	0-3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0-3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0-3
Q39.3	Congenital stenosis and stricture of esophagus	0-3
Q39.4	Esophageal web	0-3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0-5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0-5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0-5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0-5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0-5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0-5
Q43.1	Hirschsprung's disease	0-15
Q44.2	Atresia of bile ducts	0-20
Q44.3	Congenital stenosis and stricture of bile ducts	0-20
Q44.6	Cystic disease of liver	0-20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0-5
Q45.1	Annular pancreas	0-5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0-5
Q45.8	Other specified congenital malformations of digestive system	0-10
Q60.1	Renal agenesis, bilateral	0-20
Q60.4	Renal hypoplasia, bilateral	0-20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0-20
Q61.02	Congenital multiple renal cysts, bilateral only	0-20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0-20
Q61.2	Polycystic kidney, adult type, bilateral only	0-20
Q61.3	Polycystic kidney, unspecified, bilateral only	0-20
Q61.4	Renal dysplasia, bilateral only	0-20
Q61.5	Medullary cystic kidney, bilateral only	0-20
Q61.9	Cystic kidney disease, unspecified, bilateral only	0-20
Q64.10	Exstrophy of urinary bladder, unspecified	0-20
Q64.12	Cloacal extrophy of urinary bladder	0-20
Q64.19	Other exstrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20
Q75.1	Craniofacial dysostosis	0-20
Q75.2	Hypertelorism	0-20
Q75.4	Mandibulofacial dysostosis	0-20
Q75.5	Oculomandibular dysostosis	0-20
Q75.8	Other congenital malformations of skull and face bones	0-20
Q77.4	Achondroplasia	0-20

ICD10	ICD 10 Description	Age Limit
Q77.6	Chondroectodermal dysplasia	0-1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0-1
Q78.0	Osteogenesis imperfecta	0-20
Q78.1	Polyostotic fibrous dysplasia	0-1
Q78.2	Osteopetrosis	0-1
Q78.3	Progressive diaphyseal dysplasia	0-1
Q78.4	Enchondromatosis	0-1
Q78.6	Multiple congenital exostoses	0-1
Q78.8	Other specified osteochondrodysplasias	0-1
Q78.9	Osteochondrodysplasia, unspecified	0-1
Q79.0	Congenital diaphragmatic hernia	0-1
Q79.1	Other congenital malformations of diaphragm	0-1
Q79.2	Exomphalos	0-1
Q79.3	Gastroschisis	0-1
Q79.4	Prune belly syndrome	0-1
Q79.59	Other congenital malformations of abdominal wall	0-1
Q89.7	Multiple congenital malformations, not elsewhere classified	0-10
R75	Inconclusive laboratory evidence of HIV	0-12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0-20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

SECTION III.
Member Benefits & Services



COVERED BENEFITS AND SERVICES

Priority Partners must provide comprehensive benefits equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service system. Only benefits that are medically necessary are covered.

Audiology Services for Children and Adults

Audiology services will be covered by Priority Partners for both adults and children. For individuals under age 21, bilateral hearing amplification devices are covered by Priority Partners. Bilateral hearing amplification devices are only covered for adults 21 and older when the individual has a documented history of using bilateral hearing aids before age 21.

Blood and Blood Products

Blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.

Care Management Services

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 Priority Partners 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

Referrals 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
- Referral source number
- Name of member
- Date of birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within two business days.

Care for Members with Special Needs

Care management is an intensive coordination and evaluation of care available to all members, including those whom are part of a special needs population, including:

- Children with special health care needs
- Children in state-supervised care
- Individuals with a physical disability
- Individuals with a developmental disability
- Pregnant and postpartum members
- Individuals who are homeless
- Individuals with HIV/AIDS
- Individuals with a need for substance abuse treatment

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 in coordination with our behavioral health vendor, Optum. Priority Partners' benefits includes access to confidential care coordination support. Behavioral health care managers assist members through their treatment needs. Care managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists, and create plans to support self-management.

Complex Care

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

Health Education

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

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, care coordination and promote access to quality health care services. We strive to contact and engage with members as soon as possible to solve barriers that may be adversely affecting a members' 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, coordinate care with providers and specialists.

Chiropractic Care

A covered benefit for children 6-20 years of age in the EPSDT program and adults enrolled in the REM program.

Clinical Trials Items and Services

We cover certain routine costs that would otherwise be a cost to the member. Refer to our Clinical Trials medical policy for more information at https://hpo.johnshopkins.edu/doc/fetch.cfm/qcLG5cQP.

Dental Services

The Maryland Healthy Smiles Dental Program (MHSDP), administered by SkyGen, provides comprehensive dental services which include diagnostic, preventative, restorative, endodontic, periodontic, and certain prosthodontic services; oral maxillofacial surgery; and sedation.

Diabetes Care Services

We cover all medically necessary diabetes care services. For members who have been diagnosed with diabetes we cover:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related durable medical equipment and disposable medical supplies, including:
  - Blood glucose meters for home use
  - Finger sticking devices for blood sampling
  - Blood glucose monitoring supplies
  - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood
  - Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Diabetes Prevention Program

Members are eligible to participate in an evidence-based diabetes prevention program established by the Centers for Disease Control and Prevention if they:

- Are 18 to 64 years old
- Overweight or obese
- Have an elevated blood glucose level or a history of gestational diabetes mellitus
- Have never been diagnosed with diabetes and
- Are not currently pregnant

Diagnostic and Laboratory Services

Diagnostic services and laboratory services performed by providers who are CLIA certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, genotypic, phenotypic, or HIV/AIDS drug resistance testing used in treatment of HIV/AIDS are reimbursed directly by the state.

Dialysis Services

We cover dialysis services either through participating providers or members can self-refer to non-participating Medicare certified providers. HealthChoice members with End State Renal Disease (ESRD) are eligible for the REM Program.

Durable Medical Services and Durable Medical Equipment

We cover medically necessary DMS/DME services. We must provide authorization for DME and/or DMS within a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. We must pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from Priority Partners, as long as the member remains Medicaid eligible during the 90-day time period.

We cover disposable medical supplies, including incontinence pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection. We cover all DMS/DME used in the administration or monitoring of prescriptions. We pay for breast pumps under certain circumstances in accordance with Medicaid policy.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

EPSDT services listed below are covered for members under 21 years of age :

- Well-child services provided in accordance with the EPSDT periodicity schedule by an EPSDT-certified provider, including:
  - Periodic comprehensive physical examinations
  - Comprehensive health and developmental history, including an evaluation of both physical and mental health development
  - Immunizations
  - Laboratory tests including blood level assessments
  - Vision, hearing, and dental screening
  - Health education
- The state must also provide or assure Priority Partners provides expanded EPSDT services and partial or inter-periodic well-child services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions. Services must be sufficient in amount, duration, and scope to treat the identified condition, and all must be covered subject to limitations only based on medical necessity. These include such services as:
  - Chiropractic services
  - Nutrition counseling (Prior authorization required)
  - Audiological screening when performed by a PCP

- Private duty nursing
- Durable medical equipment including assistive devices
- Behavioral health services

Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program. Providers are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC program, Early Intervention services; School Health-Related Special Education Services, vocational rehabilitation, and evidenced based home visiting services provided by community-based organizations.

Maryland Healthy Kids Preventive Health Schedule

Components	Infancy (months)							Early Childhood (months)							Late Childhood (yrs)						Adolescence (yrs)								
Health History and Development	Birth	3-5 d	1	2	4	6	9	12	15	18	24	30	36	48	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19/20
Medical and family history/update	X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history	X	X	X	→	→	→	→	→	→	→																			
Psycho-social/environmental assessment/update	X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools)[1]							X	→	→	X	X	→																	
Autism Screening										X	X	→																	
Mental health/behavioral assessment													X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance abuse assessment																					X	X	X	X	X	X	X	X	X
Depression Screening																					X	X	X	X	X	X	X	X	X
Physical Exam																													
Systems exam	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments[2]	O[2]	S	S	S	S	S	S	S	S	S	S	S	S/O	S/O	S/O	S/O	S	S	S/O	S	S/O	S	S/O	S	S	S/O	S	S	S/O	S
Oral/dentition assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing: Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing: Head Circumference	X	X	X	X	X	X	X	X	X	X	X																		
Measurements and graphing: BMI											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure[3]													X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Assessments by Questionnaire																													
Maternal Depression Screening			X	X	X	X																							
Lead assessment by questionnaire						X	X	X	X	X	X	X	X	X	X														
Tuberculosis *			X	→	→	X	→	X	→	→	X	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Heart disease/cholesterol *											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sexually transmitted infections (STI) *																					X	X	X	X	X	X	X	X	X
Anemia *																					X	X	X	X	X	X	X	X	X
Laboratory Tests																													
Newborn Metabolic Screening	X		X	→																									
Blood lead Test								X	→	→	X	→	→	→	→														
Anemia Hgb/Hct								X	→	→	X	→	→	→	→														
Dyslipidemia Test																			X	→	→							X	→
HIV Test																									X	→	→	→	
Immunizations																													
History of immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vaccines given per schedule	X	→	→	X	X	X	→	X	X	X	→	→	→	→	→	→	→	→	→	→	X	X	→	→	→	→	→	→	→
Fluoride Varnish Program[4]							X	X	X	X	X	X	X	X	X														
Health Education																													
Age-appropriate education/guidance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key : X Recommended; → Recommended if not previously done; S Subjective by history /observation; O Objective by standardized testing; * Counseling/testing recommended when positive

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. [1]Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual.-Screening required using standardized tools. [2]Newborn Hearing Screen follow-up recommended for abnormal results. [3]Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years. [4]The fluoride varnish may be administered by either a primary care provider or a dentist.

https://health.maryland.gov/mmcp/epsdt/pages/home.aspx ***Healthy Kids Program*** ***Effective 01/01/2018***

Family Planning Services

Comprehensive family planning services are covered, including:

- Office visits for family planning services
- Laboratory tests including pap smears
- All FDA-approved contraceptive devices, methods and supplies
- Immediate postpartum insertion of IUDs
- Oral contraceptives (must allow a 12-month supply to be dispensed for refills)
- Emergency contraceptives and condoms without a prescription
- Voluntary sterilization procedures (Sterilization procedures are not self-referred. A member must be 21 years of age and must use an in-network provider or have authorization for out-of-network care.)

Gender Affirming Services

We cover medically necessary gender affirming surgery and other somatic care for members with gender incongruence. Details about covered gender transition services can be found in our Gender Transition Medical Policy or at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/policies/medical-policies-disclaimer**.

Habilitative Services

We cover habilitative services when medically necessary for certain adults who are eligible for Medicaid under the Affordable Care Act (ACA). These services include: physical therapy, occupational therapy and speech therapy. If you have questions about which adults are eligible call 888-895-4998.

Home Health Services

Home health services are covered when the member's PCP or attending physician certifies that the services are necessary on a part-time, intermittent basis by a member who is homebound and requires home visits. Covered home health services are delivered in the member's home and include:

- Skilled nursing services including supervisory visits
- Home health aide services (including biweekly supervisory visits by a registered nurse in the member's home, with observation of aide's delivery of services to member at least every other visit)
- Physical therapy services
- Occupational therapy services
- Speech pathology services
- Medical supplies used in a home health visit

Hospice Care Services

Hospice care services can be provided in a hospice facility, in a long-term care facility, or at home. We do not require a hospice care member to change their out-of-network hospice provider to an in-network hospice provider. Hospice providers should make members aware of the option to change MCOs. MDH will allow new members who are in hospice care to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new member does not change their MCO, then the MCO to which the new member is currently enrolled must pay the out-of-network hospice provider.

Mobile Integrated Community Health

We cover Mobile Integrated Health services provided by approved EMS agencies for eligible adults. Through the Queen Anne's County Department of Health and Queen Anne's County Department of Emergency Services, members now have a variety of skilled health care professionals available to assist them with the tools and support they need to reach your personal health goals. Based on individual needs, they work with members in their homes to assess their situation and make referrals to appropriate community resources.

Referrals to the Mobile Integrated Community Health Pilot Program (MICH) may be identified through 911 calls or other sources. Participation in the program is voluntary and there is no fee for this service. A member of our team will contact members to arrange an appointment for a home visit.

A MICH visit may include:

- Past medical history
- Medication review
- Home safety check
- Discussing goals and ways to improve health
- Health education
- Physical assessment

Eligibility is adults 18 and over who live in Queen Anne's County. There is no fee for the home visit.

Inpatient Hospital Services

Inpatient hospital services are covered. Priority Partners is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in Priority Partners. We are, however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Nursing Facility Services

For members who were enrolled in Priority Partners prior to admission to a nursing facility, chronic hospital or chronic rehabilitation hospital and who meet the state's level of care (LOC) criteria, Priority Partners is responsible for up to 90 days of the stay subject to specific rules.

Outpatient Hospital Services

Medically necessary outpatient hospital services are covered. As required by the state, we limit observation stays to 24 hours.

Outpatient Rehabilitative Services

We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21 rehabilitative services are covered by Priority Partners when the service is part of a home health visit or inpatient hospital stay.

Oxygen and Related Respiratory Equipment

Oxygen and related respiratory equipment are covered.

Pharmacy Services and Copays

Priority Partners is responsible for most pharmacy services and will expand its drug formulary to include new products approved by the Food and Drug Administration (FDA) as it maintains a drug formulary that is at least equivalent to the standard benefits of the Maryland Medical Assistance Program. Priority Partners covers medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the Maryland Medicaid FFS Program's formulary and are the responsibility of the State. For drugs that are covered by Priority Partners, pharmacy copays are $1 for generic drugs, preferred brand name drugs, and drugs to manage HIV/AIDS. The pharmacy copay for non-preferred brand name drugs is $3. There are no pharmacy copays for children under the age of 21, pregnant members, individuals in long-term care facilities, Native Americans, or for family planning.

Plastic and Reconstructive Surgery

Priority Partners covers these services when the service corrects a deformity from disease, trauma, congenital or developmental anomalies or to restore body functions. Cosmetic surgery to solely improve appearance or mental health is not covered by the state or Priority Partners.

Podiatry Services

Priority Partners provides its members medically necessary podiatry services as follows:

- For members younger than 21 years old
- Routine foot care for members 21 years old or older with vascular disease affecting the lower extremities and for members with diabetes

Pregnancy-Related Care

Please see Section II-Special Populations.

Primary Care Services

Primary care is generally received through a member's PCP, who acts as a coordinator of care, and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits for which a member is eligible. In some cases, members will opt to access certain primary care services by self-referral to providers other than their PCPs, for example, school-based health centers. Primary care services include:

- Addressing the member's general health needs
- Coordination of the member's health care
- Disease prevention and promotion and maintenance of health
- Treatment of illness
- Maintenance of the members' health records
- Referral for specialty care

For female members: If the member's PCP is not a women's health specialist, she may see a women's health specialist within Priority Partners without a referral, for covered services necessary to provide women's routine and preventive health care services.

Primary Behavioral Health Services

Priority Partners covers primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for Buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the state's ASO at 1- 800-888-1965, Monday - Friday: 8:00 AM to 6:00 PM.

Second Opinions

If a member requests one, we will provide for a second opinion from a qualified health care professional within our network. If necessary, we will arrange for the member to obtain one outside of our network.

Specialty Care Services

Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when services are medically necessary and are outside of the PCP's customary scope of practice. Specialty care services covered under this section also include:

- Services performed by non-physician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision;
- Services provided in a clinic by or under the direction of a physician or dentist
- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary. PCPs must follow our special referral protocol for children with special health care needs who suffer from a moderate to severe chronic health condition which:

- Has significant potential or actual impact on health and ability to function
- Requires special health care services
- Is expected to last longer than 6 months

A child functioning at 25 percent or more below chronological age in any developmental area, must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the services ability to effect a permanent cure.

Telemedicine and Remote Patient Monitoring

Priority Partners offers telemedicine and remote patient monitoring services to the extent they are covered by the Medicaid FFS program.

Transplants

Medically necessary transplants are covered to the extent they are covered by the Medicaid FFS Program.

Vision Care Services

We cover medically necessary vision care services. We are required to cover one eye examination every two years for members age 21 or older; and for members under age 21, at least one eye examination every year in addition to EPSDT screening. For members under age 21 we are required to cover one pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate; contact lenses, must be covered if eyeglasses are not medically appropriate for the condition. Priority Partners members are entitled to one pair of glasses or contact lenses every two years. For more information, contact Superior Vision at 866-819-4298.

Optional Services Covered By Priority Partners

In addition to those services previously noted, Priority Partners currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. MCO optional services may change each calendar year. We may not discontinue or reduce these services without providing advance notification to the state.

Vision Care for Adults Age 21 and Older

Priority Partners offers coverage of one eye exam every year and one pair of eyeglasses or contact lenses every two years. A member may self-refer for these adult vision benefits by contacting Superior Vision directly at 866-819-4298.

Over-the-Counter Drugs

In addition to prescription benefits, Priority Partners covers some over-the-counter (OTC) medications as listed in the pharmacy formulary. These drugs are covered up to a maximum 30-day supply when ordered by a network provider. OTC products are restricted to generics whenever available. If both a prescription and OTC product are available, and clinically appropriate, providers are encouraged to prescribe OTC products.

Medicaid Benefits Covered by the State (not covered by Priority Partners)

- The state covers dental services for all members who receive full Medicaid benefits. The Maryland Healthy Smiles dental program is responsible for routine preventative services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires preauthorization by SKYGEN USA, the state's ASO. SKYGEN USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits call 855-934-9812.
- Outpatient rehabilitative services for children under age 21
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System
- Intermediate care facilities for individuals with intellectual disabilities or persons with developmental disabilities
- Personal care services
- Medical day care services, for adults and children
- Abortions (covered under limited circumstances – no federal funds are used-claims are paid through the Maryland Medical Care Program). If a member was determined eligible for Medicaid based on their pregnancy they are not eligible for abortion services.
- Emergency transportation (billed by local EMS)
- Non-emergency transportation services provided through grants to local governments
- Services provided to members participating in the state's Health Home program
- Certain high-cost low-volume drugs. Please see page 30 of the MDH provider manual.

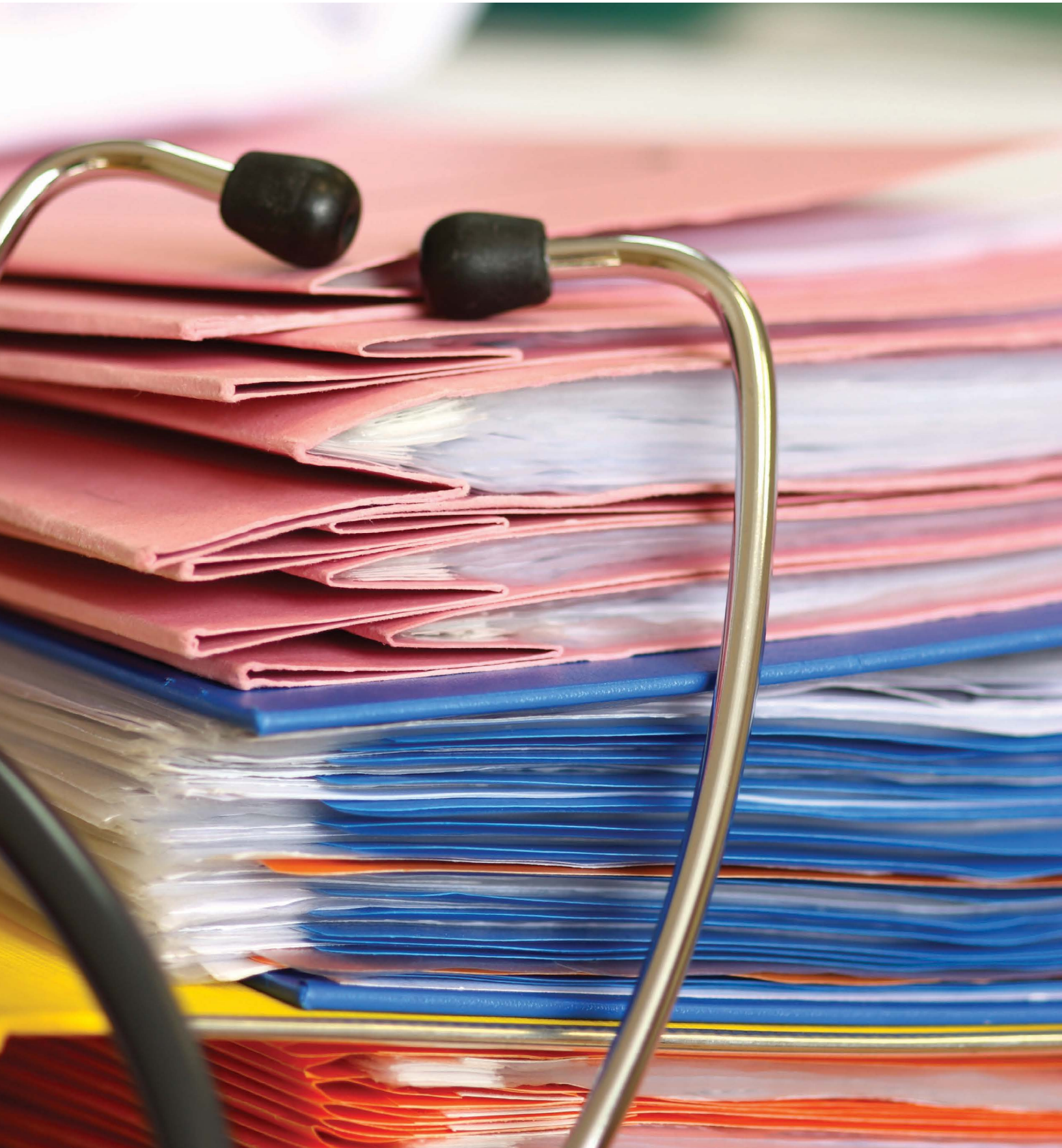
Benefit Limitations

Priority Partners does not cover these services except where noted and the state does not cover these services.

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid
- Services that are not medically necessary
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state)
- Services that are beyond the scope of practice of the health care practitioner performing the service
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities;
- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the state of Maryland unless the provider is part of Priority Partners network. Services may be covered when provided by an MCO network provider who has obtained the proper referral or preauthorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out-of-state provider is enrolled in Maryland Medicaid.
- Services provided outside the United States
- Immunizations for travel outside the U.S.

- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis
- Private hospital room is not covered unless medically necessary or no other room is available
- Autopsies
- Private duty nursing services for adults 21 years old and older
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction
- Ovulation stimulants, in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques
- Reversal of voluntary sterilization procedures
- Medications for the treatment of sexual dysfunction
- MCOs are not permitted to cover abortions. We are required **to assist members** in locating these services and we are responsible for related services (sonograms, lab work), but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service.
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy
- Diet and exercise programs for weight loss except when medically necessary
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified)
- MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). Priority Partners will assist members to access non-emergency transportation through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network. See Section I-Transportation Services.

SECTION IV.
Prior Authorization, Referrals, Member Complaint, Grievance & Appeal Procedures



SERVICES REQUIRING PRIOR AUTHORIZATION FOR MEDICAL NECESSITY

The following services listed below either require prior authorization, a referral or are direct access. For services that require prior authorization, the PCP and/or specialist must obtain authorization prior to rendering services. All services that require a referral must be on file prior to claims submission. All out-of-network providers require prior authorization.

- Fax for Inpatient Initial 410-424-2770
- Fax for Inpatient Concurrent 410-424-4894
- Fax for Non-urgent Outpatient: 410-762-5205
- Fax for Urgent Outpatient 410-424-2707
- Fax for DME. 410-762.5250
- Fax for Transplant/Bariatric 410-424-4046
- Fax for SNF 410-424-2703

Audiology Services for Children and Adults

Audiology services for children and adults require prior authorization and a referral from the member's PCP to the audiologist.

Physical/Occupational Therapy

For members over 21 years of age, a prior authorization is required after the first 12 visits. The initial six visits require the referral to be faxed to the Utilization Management department in order for an authorization number to be generated. For members 21-years-old and younger, services are carved out to the state.

Speech Therapy

For members over 21 years of age, prior authorization is not required for the initial 12 visits. For members 21-years-old and younger, services are carved out to the state.

Services Requiring Clinical Information for Prospective Review

- Admission to inpatient physical rehabilitation
- Admission to skilled nursing or transitional care facilities
- Admission to nonparticipating facilities by participating providers
- Procedures requiring medical benefit determination
- Services that are potentially investigational or experimental

Free Communication with Members

As stated in the Johns Hopkins Health Plans Participating Provider Agreement: Nothing in this agreement nor any payor addenda shall preclude or restrict a provider from discussing or communicating to covered persons, public officials, or other individuals, information that is necessary or appropriate for the delivery of health care services, including: communications that relate to treatment alternatives, REGARDLESS OF BENEFIT LIMITATIONS; communications that are necessary or appropriate to maintain the provider-patient relationship while the covered person is under the provider's care; communications that relate to a covered person's right to appeal a coverage determination with which the provider or covered person does not agree; and opinions and the basis of an opinion about public policy issues.

Hospital Notification

Hospitals are required to notify Priority Partners within 48 hours, or next business day, of a member's admission.

SERVICES NOT REQUIRING PRIOR AUTHORIZATION

This section lists the services that do not require a referral or prior authorization. For services provided by participating providers in-office (Place of Service 11), or ambulatory surgery centers (Place of Service 24) by specialties listed below, no notification or prior authorization is required. However, some services require prior authorization if performed in an outpatient hospital setting (Place of Service 22), please refer to JPAL in Availity for specific authorization requirements. These are general guidelines and are subject to change. Please review JPAL and our Medical Policies section of the Johns Hopkins Health Plans website for the most up-to-date and current information.

- Allergy
- Blood transfusions
- Cardiology
- Chiropractic services
- Coumadin clinics
- Dermatology
- Diabetic education
- Dialysis
- Endocrinology
- ENT/Otolaryngology
- Gastroenterology (some require preauthorization)*
- Gynecology
- Hematology
- Infectious disease
- Nephrology
- Neurology
- Oncology
- Ophthalmology (some require preauthorization)*
- Oral surgery

- Orthopedics
- Pain management
- Perinatology
- Podiatry
- Pulmonology
- Rheumatology
- Routine foot care – PVD/DM diagnosis only
- Urgent care centers
- Urology
- Vascular

PRIOR AUTHORIZATION/REFERRAL PROCESS

The Primary Care Provider (PCP) is responsible for determining when a member's health care needs exceed his/her scope of practice and directs the member's care to other providers to meet specific member care goals. Any primary care provider in the group of the assigned PCP on the member's Priority Partners identification card can write a referral for specialty care.

Referrals for all services must be made to participating Priority Partners providers. Consult the Priority Partners Provider Directory search function on **www.ppmco.org** for participating specialist, facility and ancillary providers.

Paper referrals to in-network specialists are not required to be submitted to Priority Partners for payment; however, the PCP must communicate to the specialist the reason for the referral. Priority Partners highly recommends PCPs supply the member with instructions for follow-up care. The Personalized Treatment Plan form can be found in the Forms Section IX in the back of this manual or online at **https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/ppmco/pp_personalized_treatment_plan.pdf**

The PCP must communicate to the specialist the reason for the referral.

Out-of-Network Care

All out-of-network care requires prior authorization from the Utilization Management department. Out-of-network care based on medical necessity require the approval of the Priority Partners' medical director.

Out-of-network care requests, with appropriate clinical information, should be faxed to Utilization Management Medical Review at 410-762-5205.

INPATIENT ADMISSIONS AND CONCURRENT REVIEW

The PCP may refer or admit within the network with prior authorization for medically necessary procedures/diagnoses.

Inpatient admissions which have not been preauthorized will be reviewed for medical necessity from the date of notification through discharge.

Once notification of an admission is received, and throughout the hospital stay, the utilization management staff will request clinical information on the patient to certify continued stay as an inpatient. If requested information is not received within two business days of the request, the days will be denied for lack of clinical information.

All elective admissions are reviewed to determine if the service could be provided in an ambulatory setting and meet the criteria. The care coordinator, based on consultation with the medical director, will notify the requesting provider of an adverse decision.

PERIOD OF PRIOR AUTHORIZATION

Prior authorizations are valid for the date span authorized. For services without a specific date, the prior authorization is valid for 60 days from the date of the receipt of the request. The member must be eligible for Medicaid and enrolled in Priority Partners on each date of service. For information about how to verify member eligibility, call 866-710-1447.

PRIOR AUTHORIZATION AND COORDINATION OF BENEFITS

Priority Partners may not refuse to preauthorize a service because the member has other insurance. Even if the service is covered by the primary payer, the provider must follow our prior authorization rules. Inpatient will preauthorize with coordination of benefits (COB), outpatient only preauthorizes if service is requested in a hospital setting.

Prior authorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSDT screening services, you are required to bill other insurers first. For these services, we will pay the provider and then seek payment from the other insurer.

MEDICAL NECESSITY CRITERIA

A "medically necessary" service or benefit must be:

- Directly related to diagnostic, preventive, curative, palliative, habilitative or ameliorative treatment of an illness, injury, disability, or health condition
- Consistent with current accepted standards of good medical practice
- The most cost-effective service that can be provided without sacrificing effectiveness or access to care
- Not primarily for the convenience of the member, the member's family or the provider.

Cases will be referred to the medical director for the following reasons

- Submitted documentation is unclear as to whether medical necessity criteria have been met
- Submitted documentation does not meet the medical necessity criteria

A decision will be made upon receipt of required documentation, within two days for non-urgent care, and one day for urgent care.

Members and providers will be notified in writing when services are denied partially or in full. The notification will include reasons for the denial, instructions on obtaining additional information, and the appeals process.

UTILIZATION MANAGEMENT

Overview

Priority Partners, 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.
- Priority Partners 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. Priority Partners 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.
- Priority Partners offers TDD/TTY services for deaf, hard of hearing or speech-impaired members. For all members who request language services, Priority Partners provides services free of charge through bilingual staff or interpreter to help members with UM issues.

Criteria and Clinical Information for Medical Necessity

Johns Hopkins Health Plans medical policies, which are publicly accessible on its website (**www.HopkinsHealthPlans.org**). InterQual® criteria is used to determine medical necessity for acute inpatient care. 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 request.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. State Medicaid contracts 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 policy and utilization management criteria. The Johns Hopkins Health Plans Utilization Management department reviews the medical necessity of medical services using:

- State guidelines
- Johns Hopkins Health Plans medical policies
- InterQual
- Johns Hopkins Health Plans clinical utilization management guidelines

Priority Partners 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-health-plans/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 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

Prior Authorization Process

Prior Authorization and Notification — General

Some covered services require prior authorization prior to services being rendered.

When a provider requests an authorization for a member, and Johns Hopkins Health Plans approves that authorization, the provider needs to notify the member that their authorization has been approved.

Prior authorization requests may be telephoned, faxed or mailed to the Utilization Management department.

Inpatient Initial	410-424-2770
Inpatient Concurrent	410-424-4894
Non-urgent Outpatient	410-762-5205
Urgent Outpatient	410-424-2707
Durable Medical Equipment	410-762-5250
Transplant/Bariatric	410-424-4046
NICU	888-832-2006

- NICU admissions or a readmissions following a NICU graduation up to one year of age authorization requests should be sent to Progeny Health. Do not send to Johns Hopkins Health Plans' UM department. Please call Progeny HealthCare at 888-832-2006 for more information.

SNF	410-424-2703

- SNF prior authorizations are handled by our vendor at eviCore. **https://www.evicore.com**

Mail to: Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Priority Partners Utilization Management

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
- Acute rehabilitation

Through the Johns Hopkins Prior Authorization Lookup tool (JPAL), providers may check and verify prior authorization requirements for services and procedures. Located in the **Availity** and **HealthLINK** portals, 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 to access this tool.

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

NOTE: JPAL is a way to look up prior authorization requirements only; it does not handle prior authorization requests. Please follow Johns Hopkins Health Plans' 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 freestanding 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, Priority Partners 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 14 calendar days from the date of the initial request or within 72 hours for an urgent request.

Prior authorizations for high tech radiology and cardiology, outpatient PT/OT, certain musculoskeletal procedures, imaging services and interventional pain procedures are reviewed and provided through the vendor eviCore healthcare. Important information, documents and forms can be found on the Johns Hopkins Health Plans-evicore web portal, located in Availity and HealthLINK.

Utilization Management – Inpatient Services

Inpatient Admission Preauthorization

Notification/prior authorization requirements are as follows:

- Except for an emergency admission, the admitting physician is responsible for contacting Priority Partners to obtain prior authorization for a hospital admission.
- The hospital is responsible for notifying Priority Partners and the Maryland Department of Health 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 Priority Partners within 24 hours or by the next business day. These circumstances are considered separate, new admissions and are not part of the birthing parent's admission.

Inpatient Admission Notification Time Frames

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

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

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

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

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

Upon notification, Priority Partners 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 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 Priority Partners.
- Clinical information for the initial (admission) review will be requested by Priority Partners 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 48 hours, an administrative adverse determination (i.e., a denial) will be issued.
- Priority Partners will adhere to NCQA determination and notification time frames for inpatient reviews.

Inpatient Concurrent Review

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 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 Priority Partners 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.
- Priority Partners 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 48 hours of the request. If the information is not received within the 48 hours, an administrative adverse determination (i.e., a denial) will be issued.

Exceptions to one-day-at-a-time authorizations may be made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days. Examples of confinements may include NICU, CCU, rehabilitation and cesarean section or vaginal deliveries. Exceptions are made by the medical director/physician reviewer.

Upon notification of the intent to deny inpatient/concurrent review cases, the member's treating physician can request a physician-to-physician review to provide additional information not previously submitted to Priority Partners.

A request for peer-to-peer review must be made within two (2) business days of the verbal notification of intent to deny, and the review must take place within four (4) business days of verbal notification of denial. To initiate this request the physician may contact Priority Partners at 800-261-2421 from 8 a.m. to 5 p.m.

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.

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, Priority Partners 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, Priority Partners 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.

Utilization Management – Outpatient Services

Outpatient Prior Authorization

Prior authorization is required and must be requested at a minimum of 72 hours before the service/procedure/etc. must be provided. This applies to the following types of care (the list is not all-inclusive and may be modified periodically):

- Home health care
- Hospice programs (notification only for outpatient hospice services)
- Skilled nursing or extended care facilities
- DME
- Cardiac rehabilitation
- Outpatient diagnostic radiology

In addition, prior authorization is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider.

For prior authorization requirements for behavioral health services, please refer to Optum at 800-888-1965.

Upon fax notification of the intention to deny for outpatient/pre-service requests, the member's treating physician can request a peer-to-peer review to provide additional information not previously submitted to Priority Partners.

The request for this review must be made within three (3) business days of the fax notification of intent to deny, and the review must take place within five (5) business days of fax notification of denial. To initiate this request the physician may contact Priority Partners at 800-261-2421 from 8 a.m. - 5 p.m. Eastern time.

Ambulatory Surgery Prior Authorization

Priority Partners is committed to providing quality, accessible health care in the most efficient manner. In most cases, certain outpatient services can be safely performed in a freestanding facility rather than a hospital outpatient setting. Therefore, certain types of outpatient surgery/services will require site-of-service prior authorization if hospital outpatient service is requested. Services that cannot be safely and effectively provided

at a freestanding site will be precertified at hospitals in these areas. These ambulatory surgical procedures must receive coverage approval through the Medical Management department at least 72 hours prior to the scheduled procedure.

Prior Authorization Requirement Review and Updates

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

CLINICAL GUIDELINES

Clinical Practice Guidelines

Priority Partners seeks to enrich the quality of clinical care for plan members by encouraging the use of clinical practice guidelines. Clinical practice guidelines are evidence-based recommendations for diagnosis, treatment and management of specific clinical circumstances. Clinical practice guidelines adopted by the plan were developed by nationally-recognized medical organizations and are reviewed every two years at minimum and updated when changes occur to ensure the most current version is provided.

Johns Hopkins Health Plans has adopted Clinical Practice Guidelines developed by specialty groups, associations, and other medical organizations as the foundation for our population health programs. The complete list of adopted guidelines and web links to download copies is available on the provider section of the HopkinsHealthPlans.org website. You may also refer to Johns Hopkins Health Plans' clinical practice guidelines and preventative health guidelines.

Please refer to the Resources and Guidelines section of our website to access the Clinical Practice Guidelines Policy, which includes the current list of guidelines along with embedded links to each resource: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines/clinical-practice-guidelines**

TIMELINESS OF DECISIONS AND NOTIFICATIONS TO PROVIDERS AND MEMBERS

Priority Partners makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the MDH. Priority Partners adheres to the following decision/notification time standards:

- Standard authorizations - within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days of the date of the initial request
- Expedited authorizations - no later than 72 hours after receipt of the request if it is determined the standard timeframe could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function
- Covered outpatient drug authorizations - within 24 hours by telephone to either authorize the drug or request additional clinical information

Priority Partners will send notice to deny authorizations to providers and members:

- Standard authorizations – within 72 hours from the date of determination
- Expedited authorizations – within 24 hours from the date of determination

OUT-OF-NETWORK PROVIDERS

When approving or denying a service from an out-of-network provider, Priority Partners will assign a prior authorization number, which refers to and documents the approval. Priority Partners sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. Refer to Section I for list of self-referred services which are services we must allow members to access out-of- network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Priority Partners makes such decisions on a case-by-case basis.

COMPLAINT, GRIEVANCE AND APPEAL PROCESS

Overview

Our Priority Partners member services line, 800-654-9728, can be reached Monday through Friday, 8 a.m. to 5 p.m. Member services resolves or properly refers members' inquiries or complaints to the state or other agencies. Priority Partners informs members and providers of the grievance system processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the Priority Partners website at www.Priority Partners.org.

Members or their authorized representatives can file an appeal or a grievance with Priority Partners orally or in writing. An authorized representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing. Providers will not be penalized for advising or advocating on behalf of an enrollee.

Standard preservice appeals require signed member consent for submission, either by signed letter or via Johns Hopkins Health Plans' **Authorization for Release of Health Information-Specific Request form**. If submitting with the form, send the original to the Compliance department and a copy of the form along with your appeal to the Appeal Intake department. Expedited appeals, due to their urgency, do not require a consent.

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

or Fax to 410-762-1527

Members and their representatives may also request any of the following information from Priority Partners, free of charge, to help with their appeal by calling 800-654-9728:

- Medical records
- Any benefit provision, guideline, protocol, or criterion Priority Partners used to make its decision
- Oral interpretation and written translation assistance; and
- Assistance with filling out Priority Partners appeal forms.

Priority Partners will take no punitive action for:

- Members requesting appeals or grievances
- Providers requesting expedited resolution of appeals or grievances
- Providers supporting a member's appeal or grievance

- Members or providers making complaints against Priority Partners or MDH.

Priority Partners will also verify that no provider or facility takes punitive action against a member or provider for using the appeals and grievance system. Providers may not discriminate or initiate disenrollment of a member for filing a complaint, grievance, or appeal with Priority Partners.

Our internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member's native language if the member is a member of a substantial minority. Priority Partners delivers a copy of its complaint policy and procedures to each new member at the time of initial enrollment, and at any time upon a member's request.

Quarterly Complaint Reporting

We are responsible for gathering and reporting information to the state about member appeals and grievances and our interventions and resolution to these appeals and grievances. The reports contain data on appeals and grievances in a standardized format and are submitted on a quarterly basis. To accomplish this, we are required to operate a Consumer Services Hotline and an internal complaint process.

Priority Partners Member Hotline

Priority Partners maintains a member services unit that operates a member services hotline Monday through Friday, 8 a.m. to 5 p.m. This unit handles and resolves or properly refers members' inquiries or complaints to other agencies and can be reached at 800-654-9728. Additionally, we provide members with information about how to access our member services unit and consumer services hotline to obtain information and assistance.

Priority Partners Member Grievance Procedures

A grievance is a complaint about a matter that cannot be appealed. Grievance subjects may include but are not limited to dissatisfaction with access to coverage, any internal process or policy, actions or behaviors of our employees or vendors or provider office teams, care or treatment received from a provider, and drug utilization review programs applying drug utilization review standards.

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed, or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for their health care needs.
- The member is dissatisfied with the help they received from the provider's staff or Priority Partners.

Examples of reasons to file a medical grievance include:

- The member is having issues with filling their prescriptions or contacting the provider.
- The member does not feel they are is receiving the right care for their condition.
- Priority Partners is taking too long to resolve the member's appeal or grievance about a medical issue.
- Priority Partners denies the member's request to expedite their appeal about a medical issue.

Grievances may be filed at any time with Priority Partners orally or in writing by the member or their authorized representative, including providers. Priority Partners responds to grievances within the following timeframes:

- 30 calendar days of receipt for an administrative (standard) grievance
- 5 calendar days of receipt for an urgent (medically related) grievance

- 24 hours of receipt for an emergent or an expedited grievance.

If we are unable to resolve an urgent or administrative grievance within the specified timeframe, we may extend the timeframe of the grievance by up to fourteen (14) calendar days if the member requests the extension or if we demonstrate to the satisfaction of the MDH, upon its request, that there is need for additional information and how the delay is in the member's interest. In these cases, we will attempt to reach you and the member by phone to provide information describing the reason for the delay and will follow with a letter within two (2) calendar days detailing the reasons for our decision to extend.

For expedited grievances, Priority Partners will make reasonable efforts to provide oral notice of the grievance decision and will follow the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all grievances within the specified processing timeframe. The notice of resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells members how to ask the state to review our decision and to obtain information on filing a request for a state fair hearing, if applicable.

Priority Partners Member Appeal Procedures

An appeal is a review by the Priority Partners or the MDH when a member is dissatisfied with a decision that impacts their care. Reasons a member may file an appeal include:

- Priority Partners denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
  - The treatment is not needed for the member's condition, or would not help you in diagnosing the member's condition.
  - Another more effective service could be provided instead.
  - The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
- Priority Partners limits, reduces, suspends, or stops a service that a member is already receiving. For example:
  - The member has been getting physical therapy for a hip injury and they have reached the frequency of physical therapy visits allowed.
  - The member has been prescribed a medication, it runs out, and they do not receive any more refills for the medication.
- Priority Partners denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean".
- Priority Partners fails to provide services in a timely manner, as defined by the MDH (for example, it takes too long to authorize a service a member or their provider requested).
- Priority Partners denies a member's request to speed up (or expedite) the resolution about a medical issue.

The member will receive a Notice of Adverse Benefit Determination (also known as a denial letter) from us. The Notice of Adverse Benefit Determination informs the member of the following:

- Priority Partners' decision and the reasons for the decision, including the policies or procedures which provide the basis for the decision
- A clear explanation of further appeal rights and the timeframe for filing an appeal
- The availability of assistance in filing an appeal
- The procedures for members to exercise their rights to an appeal and request a state fair hearing if

they remain dissatisfied with Priority Partners' decision

- That members may represent themselves or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them, in writing
- The right to request an expedited resolution and the process for doing so
- The right to request a continuation of benefits and the process for doing so

If the member wants to file an appeal with Priority Partners, they have to file it within 60 days from the date of the denial letter. Our denial letters must include information about the HealthChoice Help Line. If the member has questions or needs assistance, direct them to call 800-284-4510. Providers may call the state's HealthChoice Provider Help Line at 800-766-8692. If you would like to appeal a decision on a member's behalf, you must obtain the member's consent to appeal in writing and submit it to us.

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help Priority Partners make a decision, they may call Priority Partners at 800-654-9728 and ask for an extension.

Priority Partners may also request up to 14 additional days to resolve the appeal if we need to get additional information from other sources. If we request an extension, we will send the member a letter and call the member and their provider.

When reviewing the member's appeal we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease;
- Not use the same Priority Partners staff to review the appeal who denied the original request for service; and
- Make a decision within 30 days, if the member's ability to attain, maintain, or regain maximum function is not at risk.

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. Priority Partners resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition, and Priority Partners agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 72 hours from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard timeframe. Priority Partners will make a reasonable effort to provide verbal notification and will send written notification **within two (2) calendar days**.

Once we complete our review, we will send the member a letter letting them know our decision. Priority Partners will send written notification for a standard appeal timeframe, including an explanation for the decision, within 2 business days of the decision.

For an expedited appeal timeframe, Priority Partners will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision. If we decide that they should not receive the denied service, that letter will tell them how to ask for a state fair hearing.

Request to Continue Benefits During the Appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 days of receiving the denial notice at 800-654-9728 if they would like to continue receiving services while their appeal is reviewed. The service or benefit will continue until either the member withdraws the appeal or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Members or their designated representative may request to continue to receive benefits while the state fair hearing is pending. Benefits will continue if the request meets the criteria described above when the member receives the Priority Partners appeal determination notice and decides to file for a state fair hearing. If Priority Partners or the Maryland fair hearing officer does not agree with the member's appeal, the denial is upheld, and the member continues to receive services, the member may be responsible for the cost of services received during the review. If either rendering party overturns the Priority Partners denial, we will authorize and cover the costs of the service within 72 hours of notification.

State Fair Hearing Rights

A HealthChoice member may exercise their state fair hearing rights but the member must first file an appeal with Priority Partners. If Priority Partners upholds the denial the member may appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at 800-284-4510. If the member decides to request a state fair hearing we will continue to work with the member and the provider to attempt to resolve the issue prior to the hearing date.

If a hearing is held and the Office of Administrative Hearings decides in the member's favor, Priority Partners will authorize or provide the service no later than 72 hours of being notified of the decision. If the decision is adverse to the member, the member may be liable for services continued during our appeal and state fair hearing process. The final decision of the OAH is appealable to the Circuit Court, and is governed by the procedures specified in State Government Article, §10-201 et seq., Annotated Code of Maryland.

State HealthChoice Help Lines

If a member has questions about the HealthChoice Program or the actions of Priority Partners direct them to call the state's HealthChoice Help Line at 800-284-4510. Providers can contact the HealthChoice Provider Line at 800-766-8692.

Priority Partners Provider Complaint Process

The Provider Relations Department will receive provider inquiries, suggestions, and grievances directly from providers via email, provider satisfaction surveys, in person or by phone, mail or fax, as well as referrals from the Customer Service department, Credentialing department and the Complaint and Grievance department. The Provider Relations department will abide by all processing timelines as identified in regulatory standards. (Johns Hopkins Health Plans Policy #PNM.004, Provider Inquiries and Grievances).

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 Priority Partners for reason(s) including but not limited to:

- Rejected untimely filing of claim
- Eligible per EVS
- Coordination of benefits (EOB of primary carrier required)
- Itemized bill requested

- Invoice attached/MUE denial
- Overpaid/underpaid per contract
- Fee schedule
- Contract rate/SCA
- Not duplicate claim
- Authorization on file (authorization number required)
- Referral attached

Responses to itemized bill requests and submissions of COB/third-party liability information should also be sent with the Claims and Payment Dispute Form: **https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/all_plans/claims-and-payment-disputes.pdf**

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 Priority Partner'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 online at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/forms** and mail to:

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

Or fax to 410-424-2800

Priority Partners 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 Priority Partners 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

Provider Appeals Process

Johns Hopkins Health Plans will reconsider denial decisions upon request by a provider.

The appeals process is as follows:

- Providers may file an appeal to request reconsideration of a denial.
- Providers may only appeal post-service denials.
- Providers may submit preservice appeals for members. These are processed as member appeals and follow member appeals guidelines.
- If a provider is submitting a standard preservice appeal for the member, the provider will need a signed authorization form or written authorization from the member.
- Providers have two levels of appeal for postservice cases
- Providers will receive written acknowledgement within five business days of receipt of an appeal.
- The first-level appeal must be filed within 90 business days after notification of the denial.
- The second-level appeal must be filed within 20 business days after notification of the first-level appeal decision.
- The first- and second-level appeals will be resolved within 90 business days of receipt of the first-level appeal.
- Written notification of the appeal resolution decision will be generated and sent to the appellant within 30 days.
- Payment for claim denials that have been overturned after the appeal will be paid within 30 days. We will not take any punitive action against a provider for utilizing our provider complaint process. Appeals should be faxed or mailed to:

  Johns Hopkins Health Plans
  Attention: Appeals Department
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076
  Fax: 410 762-5304

Provider Appeal Requests Process

Administrative Appeals vs. Clinical Medical Necessity Appeals

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

- ER
- 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 Priority Partners overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed or the requestor 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.

Priority Partners 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. Priority Partners 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. 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 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

If a provider is dissatisfied with the Level I appeal resolution, the provider may file a Level II appeal in the form of a written appeal submitted and received by Priority Partners within 30 business days of the date of the Level I determination letter.

At the Level II the appeal is reviewed by the Priority Partners chief executive officer or his or her designee.

Please fill out the Provider Appeal Request Form-Clinical/Medical Necessity/Administrative Appeals Only form, which is located online at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/forms**

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

Reconsideration

If the treating physician would like to discuss their case with a physician reviewer for reconsideration of their original denial, the physician can call the Care Management department at 888-401-3592.

STATE'S QUALITY OVERSIGHT: COMPLAINT AND APPEAL PROCESSES

The HealthChoice and Acute Care Administration operate the central complaint investigation process. The HealthChoice Help Line and the Complaint Resolution and Provider Hotline Units are responsible for the tracking of both provider and member complaints and grievances called into the hotlines, or sent to the department in writing.

HealthChoice Help Line

The HealthChoice Help Line is available Monday through Friday from 7:30 a.m. to 5:30 p.m. The toll free telephone number is: 800-284-4510 or TDD at 800-735-2258 for the hearing impaired.

The Help Line staff is trained to answer questions about the HealthChoice program. Help Line staff will:

- Direct members to our member services line, 800-654-9728, when needed
- Attempt to resolve simple issues by contacting us or other parties as needed
- Refer medical issues to the state's Complaint Resolution Division for resolution

The Help Line has the capability to address callers in languages other than English either through bilingual staff or through the use of a language line service.

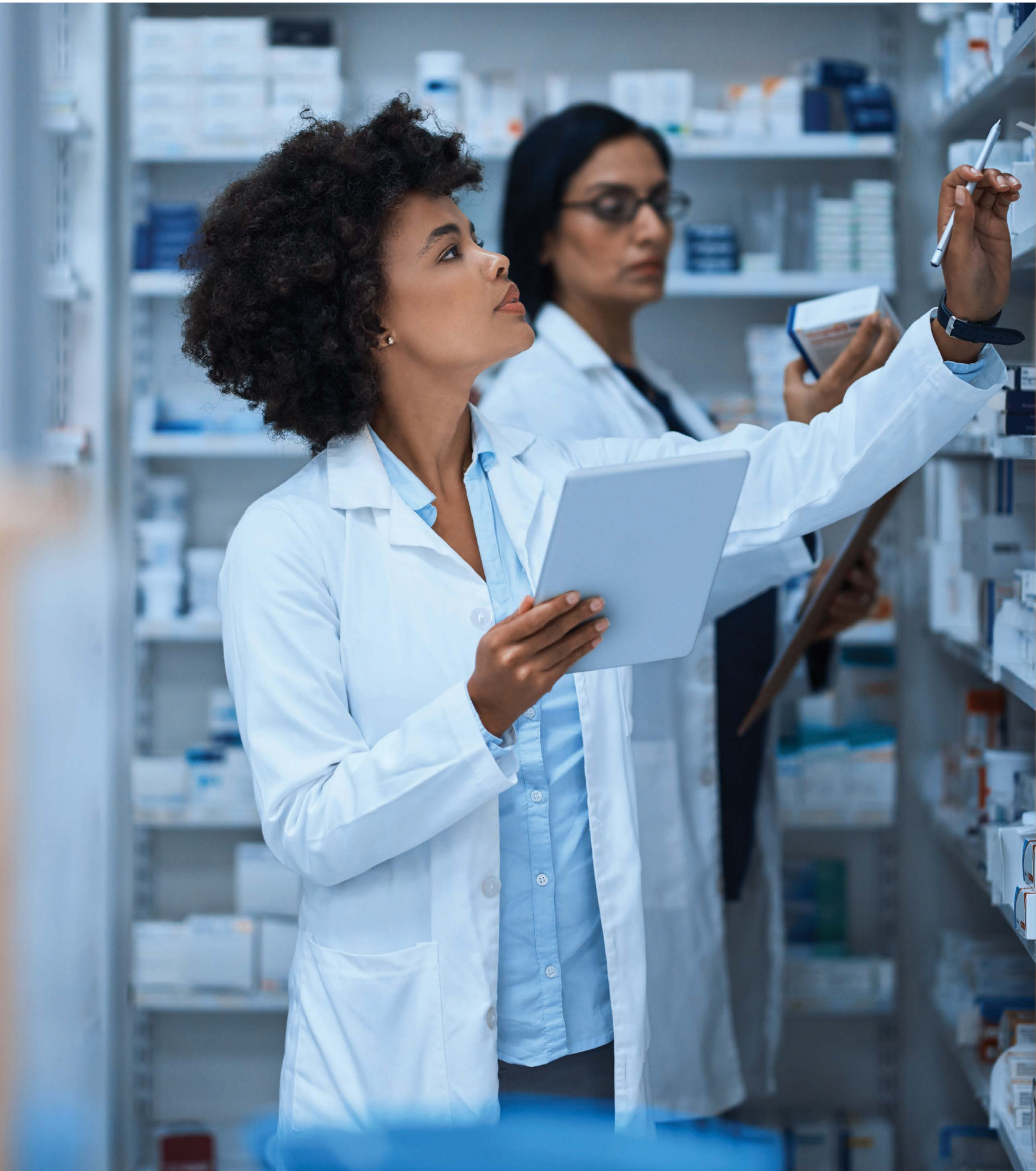
The Help Line uses an automated system for logging and tracking member inquiries and grievances. Information is analyzed monthly and quarterly to determine if specific intervention with a particular MCO is required or changes in state policies and procedures are necessary.

HealthChoice Provider Hotline

The Provider Hotline provides HealthChoice providers access to MDH staff for grievances and inquiries. Provider Hotline staff respond to general inquiries and resolves complaints from providers concerning member access and quality of care as well as educating providers about the HealthChoice Program. The telephone number for the Provider Hotline is 800-766-8692; TDD 800-735-2258. We will not take any punitive action against you for accessing the Provider Hotline.

As with the Help Line, provider inquiries and complaints are tracked and analyzed monthly and quarterly to determine if specific intervention with particular MCOs is required or changes in state policies and procedures are necessary.

SECTION V.
Pharmacy Management



PRIORITY PARTNERS PRESCRIPTION AND DRUG FORMULARY

Priority Partners has a closed formulary, which should be used when prescribing medication for members. Only those drugs listed in the formulary are covered. The drugs listed have been reviewed and approved by the Priority Partners Pharmacy and Therapeutics Committee, and were selected to provide the most clinically appropriate and cost-effective medications for patients who have their drug benefit administered through Priority Partners.

Priority Partners covers medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health and substance abuse medications are on the state's formulary and are the responsibility of the state. Effective January 1, 2020 HIV/AIDS drugs are covered by the Health Plan. Priority Partner's Formulary includes a listing of preferred products in the HIV therapeutic class.

In addition to prescription benefits, Priority Partners covers some over-the-counter (OTC) medications as listed in the pharmacy formulary. These drugs are covered up to a maximum 30-day supply when ordered by a network provider. OTC products are restricted to generics whenever available. If both a prescription and OTC product are available, and clinically appropriate, providers are encouraged to prescribe OTC products.

Pharmaceutical services and counseling ordered by an in-plan provider, by a provider to whom the member has legitimately self-referred (if provided onsite), or by an emergency medical provider are covered, including:

- Legend (prescription) drugs
- Insulin
- All FDA approved contraceptives (we may limit which brand drugs we cover)
- Latex condoms and emergency contraceptives (to be provided without any requirement for a provider's order)
- Non-legend ergocalciferol liquid (Vitamin D)
- Hypodermic needles and syringes
- Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy, or gastrostomy tube
- Enteric coated aspirin prescribed for treatment of arthritic conditions
- Non-legend ferrous sulfate oral preparations
- Non-legend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for members under age 12
- Formulas for genetic abnormalities
- Medical supplies for compounding prescriptions for home intravenous therapy

The following are not covered by the state or the MCO:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight
- Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition
- Medications for erectile dysfunction
- Ovulation stimulants

Priority Partners formulary is available at:
https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/pharmacy

Priority Partners' members must have their prescriptions filled at a network pharmacy. Priority Partners contracts with CVS/caremark to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Maryland Department of Health (MDH) is responsible for formulary management of most drugs used for behavioral health purposes, which are covered under the Medicaid Mental Health Formulary as well as Substance Use Disorder Medications. Drugs in these classes are carved out of the MCO pharmacy benefit and are payable as fee-for-service through Maryland Medical Assistance.

Request for Formulary Addition

The formulary is updated quarterly. To submit a request for consideration of an addition to the formulary, mail a request for formulary addition or deletion to:

Priority Partners
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Chairperson, Pharmacy and Therapeutics Committee

Or complete the online form available at: **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/pharmacy**

PRESCRIPTION COPAYS

There are no pharmacy copays for children under the age of 21, pregnant members, individuals in long-term care facilities, Native Americans, or for family planning. For member groups that are subject to copays, pharmacy copays amounts are:

- $1.00 per prescription for generic drugs and preferred brand name drugs
- $1.00 per prescription for HIV/AIDS drugs
- $3.00 per prescription for non-preferred brand name drugs

As a provider, it is critical to explain the proper utilization of pharmacy services to your patients, our members, including the following:

- It is important that members understand that they might need both their Priority Partners' identification card and their regular Medical Assistance ID card when filling a prescription.
- It is important for members to always use the same pharmacy within the Priority Partners network to fill all of their prescriptions. This enables the pharmacist to know about possible problems that may occur when a member is taking more than one medication.
- Members should always present their Priority Partners identification card when they have a prescription filled. They will also need to present their Medical Assistance ID card for drugs prescribed by their mental health provider.

OVER-THE-COUNTER PRODUCTS

In addition to prescription benefits, all over-the-counter (OTC) medications on the Priority Partners formulary list, up to a maximum 30- day supply, are covered by us with a written or verbal prescription from a network provider. A prescription is not required for coverage of condoms, Plan B, or generic Plan B. OTC products covered are restricted to generics when available. Brand names are provided as reference only. If both prescription and OTC products are available, you are encouraged to prescribe OTC products when clinically appropriate.

An Abbott blood glucose meter may be provided at no charge by the manufacturer. For more information on how to obtain a blood glucose meter, call: 1-866-224-8892 or log in **http://www.choosefreestyle.com/.**

PRIOR AUTHORIZATION

To assure medical necessity, clinical appropriateness, and/or cost effectiveness, certain medications listed on the formulary may be subject to prior authorization. Coverage of these drugs is subject to criteria approved by the Priority Partners P&T committee. Established criteria are based upon medical literature, physician expert opinion and FDA-approved labeling information.

Providers are strongly encouraged to write prescriptions for preferred products as listed on the Priority Partners formulary. If a drug is not listed on the formulary but the provider believes that a drug is medically necessary a medical exception must be requested. Coverage of a non-formulary drug may be approved if documentation is provided indicating that the formulary alternative is not medically appropriate.

To request prior authorization:

1. An electronic prior authorization (ePA) may be submitted using CoverMyMeds® and Surescripts. (**https://www.covermymeds.com/main/prior-authorization-forms/caremark/** for covermymed and to **https://providerportal.surescripts.net/ProviderPortal/cvs/login** for surescript)

Navigations steps are available on these links: CoverMyMeds and SureScript. (**https://www.caremark.com/portal/asset/Downloadable_CMM_Walkthrough.pdf** & **https://www.caremark.com/portal/asset/Downloadable_SS_Walkthrough.pdf**

2. If an ePA is not able to be submitted, a completed Pharmacy Drug-specific Prior Authorization Form (**https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/forms**) may be faxed to Priority Partners at the fax number listed on the form.

In cases where the required medication is not available or where the required medication does not have a drug-specific form, the Pharmacy Non-specific Drug Prior Authorization Form (**https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/Priority Partners/pp_prior_authorization_form.pdf**) may be used.

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.

Step therapy involves prescribing a safe, clinically effective, and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.

Please refer to the Step Therapy (ST) in the Pharmacy Formulary. If your patient's medical condition precludes the use of prerequisite medications, you may submit a Pharmacy Step Therapy Exception Prior Authorization Form to request a waiving of this requirement. The above prior authorization submission steps are also used to request a step therapy exception.

When medically necessary, an exception to a quantity limit can be requested. If your patient's medical condition warrants the use of a quantity greater than the listed quantity for a drug, you may submit a Pharmacy Quantity Limit Exception Prior Authorization Form to request coverage of a higher quantity. Please follow the above prior authorization steps when requesting a quantity limit exception.

Note: If a prescription was filled within 180 days prior to implementation of step therapy the member will not be affected by step therapy requirements and will not be required to switch medications.

QUANTITY LIMITS

Some prescription medications have specific dispensing limitations for quantity and maximum dose allowed per fill. These dispensing limitations are based on generally accepted guidelines, FDA-approved drug label information, current medical literature and input from a committee of physicians and pharmacists. The Priority Partners Pharmacy and Therapeutics Committee may place a limit on the amount of drug a plan participant may receive based upon cost and/or clinical reasons. The list of quantity limits may change. Please refer to the Priority Partners formulary for updated information at **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/pharmacy#formulary**.

All prescriptions are limited to a maximum 30-day supply per fill. Exceptions are medications for which the package size cannot be broken, for example, some contraceptive medications.

MARYLAND PRESCRIPTION DRUG MONITORING PROGRAM

Priority Partners complies with the Maryland Prescription Drug Monitoring Program (PDMP). The PDMP is an important component of the MDH initiative to halt the abuse and diversion of prescription drugs. The MDH has a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings The Maryland Department of Health does not collect data on any other drugs.

Pharmacies must submit data to the MDH at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the MDH is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories, and document compliance with therapeutic regimens.

New registration access to the MDH database (https://crisphie.my.site.com/PDMP/s/) is granted to prescribers and pharmacists who are licensed by the state of Maryland and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the MDH database must certify before each search that they are seeking data solely for the purpose of providing healthcare to current patients. Authorized users agree that they will not provide access to the MDH to any other individuals, including members of their staff.

CORRECTIVE MANAGED CARE PROGRAM

We restrict members to one pharmacy if they have abused pharmacy benefits. We follow the state's criteria for corrective managed care. The Corrective Managed Care (CMC) program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call 888-819-1043 Option 4 if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Priority Partners will work with the state in these efforts and adhere to the state's opioid preauthorization criteria.

[1]Instructions on calculating MME is available at: https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf

MARYLAND OPIOID PRESCRIBING GUIDANCE AND POLICIES

The following policies apply to both Priority Partners and Medicaid Fee-for-Service:

Policy

Prior authorization is required for long-acting opioids, fentanyl products, methadone for pain, and any opioid prescription that results in a patient exceeding 90 morphine milliequivalents (MME) per day.[1] A standard 30 day quantity limit for all opioids is set at or below 90 MME per day.

The CDC advises that "clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 MME/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." In order to prescribe a long-acting opioid, fentanyl products, methadone for pain and opioids above 90 MME daily, a prior authorization must be obtained every 6 months.

The prior authorization requires the following attestations:

- The provider has reviewed CDS prescriptions in the PDMP
- A patient-provider agreement
- Screening of patient with random urine drug screen(s) before and during treatment
- A naloxone prescription was given/offered to the patient/patient's household members.

Patients with cancer, sickle cell anemia or in hospice are excluded from the prior authorization process but they should also be kept on the lowest effective dose of opioids for the shortest required duration to minimize risk of harm. Priority Partners may choose to implement additional requirements or limitations beyond the state's policy.

Naloxone should be prescribed to patients that meet certain risk factors. Both the CDC and Centers for Medicaid and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids.[2] We encourage providers to prescribe naloxone - an opioid antagonist used to reverse opioid overdose - if any of the following risk factors are present: history of substance use disorder; high dose or cumulative prescriptions that result in over 50 MME; prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or other factors, such as drug-using friends/family.

Guidance:

Non-opioids are considered first line treatment for chronic pain. The CDC recommends expanding first line treatment options to non-opioid therapies for pain. In order to address this recommendation, the following evidence-based alternatives are available within the Medicaid program:

- NSAIDs
- Duloxetine for chronic pain
- Diclofenac topical
- Certain first line non-pharmacological treatment options (e.g. physical therapy):

[2] Instructions on calculating MME is available at: https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf CDC guidance: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm; and CMS guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf)

[3] A description of these substance use screening tools may be accessed at: http://www.integration.samhsa.gov/clinical-practice/screening-tools

Providers should prescribe the lowest effective dose and quantity of controlled drug substances (CDS). Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Providers should screen for substance use disorder. Before writing for an opiate or any controlled substance, providers should use a standardized tool(s) to screen for substance use. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an example of a screening tool.[3] Caution should be used in prescribing opioids for any patients who are identified as having any type of or history of substance use disorder. Providers should refer any patient whom is identified as having a substance use disorder to a substance use treatment program. Some MCOs have optional expanded coverage that is outlined in the attached document.

SBIRT is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables providers to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. The provision of SBIRT is a billable service under Medicaid.

Patients identified with substance use disorder should be referred to substance use treatment. Maryland Medicaid administers specialty behavioral health services through a single administrative services organization - Optum Maryland. If you need assistance in locating a substance use treatment provider, Optum Maryland may be reached at 800-888-1965. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at maryland.optum.com.

Providers should use the PDMP every time they write a prescription for CDS. Administered by MDH, the PDMP gives healthcare providers online access to their patients' complete CDS prescription profile. Practitioners can access prescription information collected by the PDMP at no cost through the CRISP health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other healthcare facilities. Providers that register with CRISP get access to a powerful virtual health record that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports and clinical documents, as well as PDMP data.

Providers should prescribe the lowest effective dose and quantity of controlled drug substances (CDS). Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

For more information about the PDMP, visit the MDH website: https://health.maryland.gov/pdmp/pages/home.aspx. If you are not already a registered CRISP user you can register for free at https://crisphie.my.site.com/PDMP/s/ usage is highly encouraged for all CDS prescribers and has become mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law) effective July 1, 2018.

If Priority Partners is implementing any additional policy changes related to opioid prescribing, Priority Partners will notify providers and beneficiaries.

PHARMACY NETWORK

- Priority Partners contracts with CVS/caremark to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.
- All in-network Maryland pharmacies may fill prescriptions for Priority Partners members.
- For specialty pharmacy services, Priority Partners contracts with CVS/caremark Specialty Pharmacy.

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 Priority Partners 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. To find the HCPCS Codes that require medical necessity prior authorization and site-of-service prior authorization, visit our website or JPAL on HopkinsHealthPlans.org. Prior authorization criteria is also be available on HopkinsHealthPlans.org.

Priority Partners uses the CVS Health-NovoLogix Platform to review prior authorization requests.

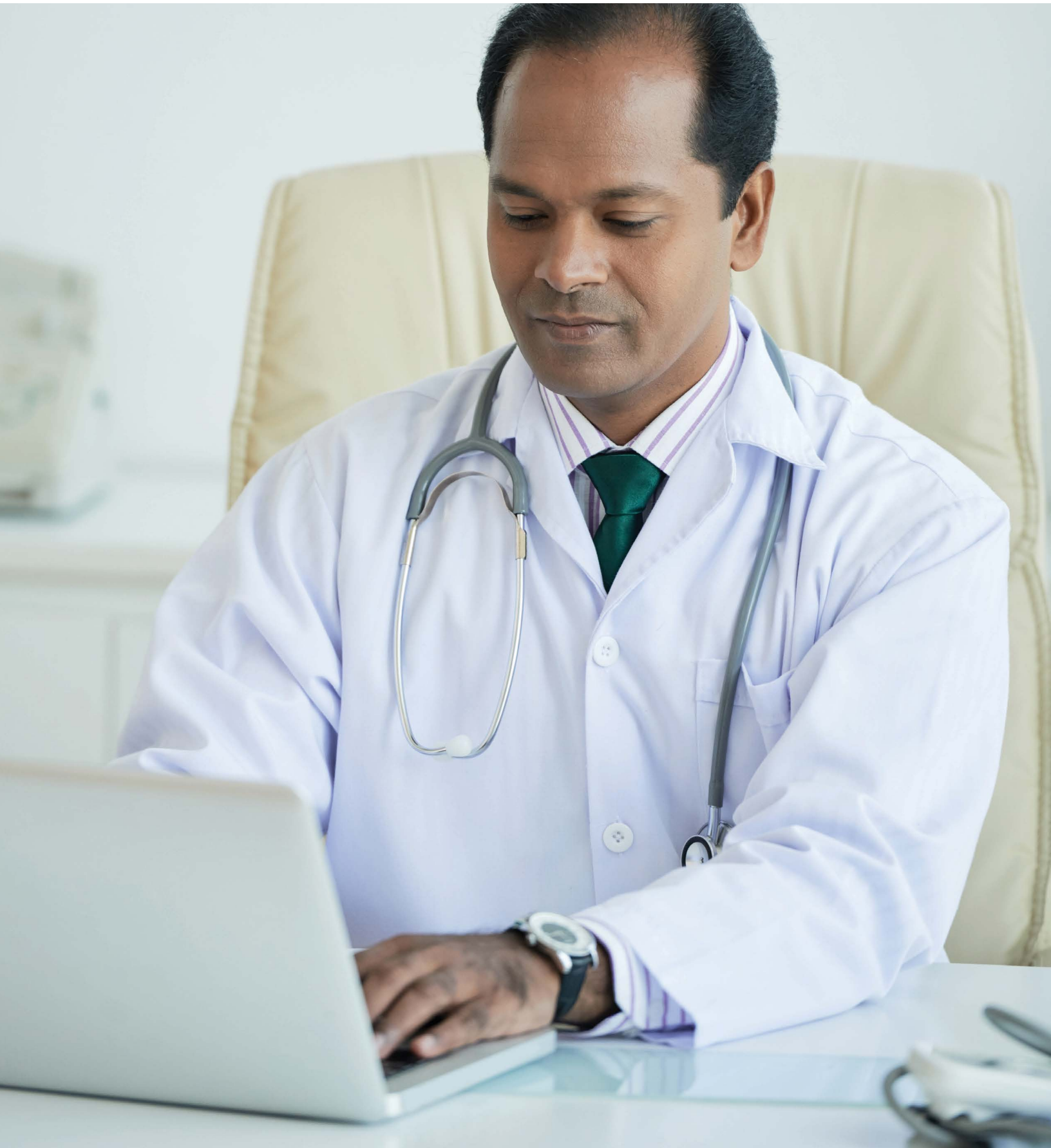
Providers may submit electronic prior authorization requests through NovoLogix using the Priority Partners Availity secure provider portal. If Availity is unavailable for some reason, providers may contact NovoLogix directly for assistance by calling 844-345-2803. Prior authorization forms for the provider-administered medical injectables can also be obtained from NovoLogix by calling 844-345-2803.

PRIOR AUTHORIZATION DETERMINATION TIME FRAMES

For formulary drugs requiring prior authorization under pharmacy benefit, a decision is faxed to the requesting provider within 24 hours of request. Details regarding approval of denial and next steps (how to speak with reviewer or how to appeal) are included in the letter that is faxed to the provider. For the prior authorization time frame of provider-administered Medical Injectables please refer to Section IV: Utilization Management (UM), prior authorization determination time frames section.

SECTION VI.

Claims Submission, Provider Appeals, Priority Partners Quality Initiatives and Pay-for-Performance



FACTS TO KNOW BEFORE YOU BILL

You must verify through the Eligibility Verification System (EVS) that participants are assigned to Priority Partners before rendering services. EVS can be reached at 866-710-1447.

- You are prohibited from balance billing anyone that has Medicaid including Priority Partners members.
- You may not bill Medicaid or Priority Partners members for missed appointments.
- Medicaid regulations require that a provider accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services.
- Any Medicaid provider that practices balance billing is in violation of their contract.
- For covered services Priority Partners providers may only bill us or the Medicaid program if the service is covered by the State but is not covered by the MCO.
- Providers are prohibited from billing any other person, including the Medicaid participant or the participant's family members, for covered services.
- HealthChoice participants may not pay for covered services provided by a Medicaid provider that is outside of their Priority Partners provider network.
- If a service is not a covered service and the member knowingly agrees to receive a non-covered service the provider MUST:
  - Notify the member in advance that the charges will not be covered under the program
  - Require that the member sign a statement agreeing to pay for the services and place the document in the member's medical record.
  - We recommend you call us to verify that the service is not covered before rendering the service.

BILLING AND INQUIRES

Physician Fees

Providers should bill their customary fee for covered services that are not reimbursable under capitation. These services will be reimbursed according to the terms of the Priority Partners Payor Addendum.

Coordination of Benefits/Copays

When Priority Partners' members have other insurance, including Medicare, the other insurance must be billed as the primary payor. As the secondary payor, Priority Partners is responsible to pay within our

allowable payment amount for copays, deductibles and other services covered under the HealthChoice benefit that are not covered under the primary plan. Priority Partners' members should not be billed for copays or deductibles. These charges should be billed directly to Priority Partners. Priority Partners does not routinely reimburse members for out-of-pocket expenses. To expedite claims payment, providers should first submit claims to the primary insurance carrier and then submit a claim to Priority Partners with the primary carrier remittance attached. Claims will be paid based on allowable payment amount.

Providers should submit a claim to the primary insurance carrier for each date of service, then submit a claim to Priority Partners 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.

Claims Submission

Claims or encounter data should be filed on a standard CMS 1500 claim form. Facilities should submit claims on a UB-04 form.

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

Claims must be submitted within 180 days of the date of service to the address below:

Priority Partners:
P.O. Box 4228, Scranton, PA 18505

If you would like to submit claims electronically, email EDI@jhhp.org for additional billing information.

Attachments to a CMS 1500 form or UB-04 form, which may be required, and the circumstances under which they may be requested are:

- A referral or consultant treatment plan
  - Referrals may be required for an appeal of a claim denied for failure to coordinate care with PCP. Treatment plans may be required for certain specialty services such as physical therapy, mental health, substance abuse treatment, etc.
- An explanation of benefits statement from the primary payor
  - Required if Johns Hopkins Health Plans is the secondary payor
- A Medicare Remittance Notice
  - Is 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 P5
- Documents referenced as contractual requirements in a global contract
  - May be required if there is a global contract 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) and 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) and19-712.5, Annotated Code of Maryland
  - May be required if the claim for services provided is outside the time or scope of the authorization, or when there is an authorization in dispute
- Itemized bill, except in the case of emergency services render in accordance with Health-General Article, §§190701(d) and 19-712.5, Annotated Code of Maryland
  - May be required if the service is rendered in a hospital and the hospital claim has no prior authorization for admission, or is inconsistent with Johns Hopkins Health Plans/Medicaid Services Coordinator concurrent review determination rendered before the delivery of services, regarding the medical necessity of the service
- Administrative days must be billed separately from acute hospital days on the DHMH 1288 form and must be attached.

Providers will ensure their medical documentation has the correct service and diagnoses that reflect their claim submissions.

Claims Resolution

Priority Partners is dedicated to providing timely resolution of claims. Priority Partners processes all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals. Providers must use HIPAA-compliant billing codes when billing by paper or electronically. When billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. Priority Partners will reject claims submitted with noncompliant billing codes. Priority Partners uses code editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Timely Filing

Paper and electronic claims, and corrected claims must be filed within 180 calendar days. 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. Priority Partners will deny claims submitted after the filing deadline. Corrected claims may be submitted electronically; please follow CMS guidelines.

Documentation of Timely Claim Receipt

Claims will be considered timely if submitted:

- By United States mail first class, return receipt requested or by overnight delivery service; you must provide a copy of the claim log that identifies each claim included in the submission
- Electronically; you must provide the clearinghouse-assigned receipt date from the reconciliation reports
- By hand delivery; you must provide a claim log identifying each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant

Payment Integrity

About the Johns Hopkins Health Plans Payment Integrity Department

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

Access Availity Provider Portal for Claims Adjudication Details

As part of our continuing effort to boost efficiency and streamline processes, Johns Hopkins Health Plans introduced 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 the new portal 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.

Recoupment, Offset, and/or Adjustments of Erroneous Payments

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

Reason for Retraction	Duplicate Claims	Coordination of Benefits	Suspected Provider Fraud	Payment Error	Improper Coding/Billing	Eligibility
Priority Partners	36 months from Date of Payment, or unlimited in cases of suspected fraud.	18 months from Date of Service.	Unlimited.	6 months from Date of Payment.	36 months from Date of Payment, or unlimited in cases of suspected fraud.	Unlimited.

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

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

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

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

Remittance Advice Statement

The items below correspond with the Remittance Advice Form. Together, they provide specific information regarding the review and interpretation of the Priority Partners Remittance Advice.

This remittance is used for all providers who submit claims to Priority Partners. 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/revenue code that best describes service 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's liability.
Disallowed Amount	The dollar value of a service which is not eligible for payment. A disallowed amount is not a deductible, coinsurance or copayment. It may represent that portion of the charge above the benefit maximum (and would not be a member's liability) and/or the charge for a non-covered procedure (which would be a member's liability).
Allowed Amount	The amount eligible for payment.
Deduct/Copay/ Coinsurance	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 which the provider may collect from the subscriber. This amount includes any applicable deductible, copayment, coinsurance and charges for non- covered services.
Net Payable	The total dollar amount being paid for the procedure. The allowed amount minus deductible/copayment/coinsurance minus other insurance paid equals the 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.
EPSDT	Indication whether billed procedure is related to Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services.
Provider Name	The name of the provider who provided services for a submitted claim.
Provider ID	The identification number assigned to the specific provider submitting the claim.
Line of Business	The code indicating in which line of business the patient is a member. Priority Partners' line of business code is 300.
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.

PROVIDER APPEAL OF DENIED CLAIMS

Denial of claims is considered a contractual issue between Priority Partners and the provider. Providers must contact Priority Partners directly. The Maryland Insurance Administration refers Priority Partners billing disputes to MDH. MDH may assist providers in contacting the appropriate representative at Priority Partners but MDH cannot compel Priority Partners to pay claims that Priority Partners administratively denied. See Section IV under the **Provider Appeal Process** heading for complete information on the Priority Partners provider appeals process and the proper forms to use for submission.

STATE'S INDEPENDENT REVIEW ORGANIZATION (IRO)

The MDH contracts with an IRO for the purpose of offering providers another level of appeal for providers who wish to appeal **medical necessity denial**s only. Providers must first exhaust all levels of the Priority Partners appeal process. By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases). The IRO only charges **after** making the case determination. If the decision upholds the Priority Partners denial, you must pay the fee. If the IRO reverses the Priority Partners denial, then Priority Partners must pay the fee. The web portal will walk you through submitting payments. The review fee is $425. More detailed information on the IRO process can be found at **https://health.maryland.gov/mmcp/Documents/Maryland%20IRO_Provider%20job%20aid.pdf#search=IRO**.

The IRO does not accept cases for review that involve disputes between the Behavioral Health ASO and Priority Partners.

QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Introduction

The Quality Improvement (QI) department at Johns Hopkins Health Plans is dedicated to ensuring our Medicaid beneficiaries receive the highest quality health care services administered by the Priority Partners Managed Care Organization, as defined by the HealthChoice Demostration (demo) program[1]. The Medicaid QI program strategy supports the **HealthChoice program primary goals (i.e., increase access to quality of health care with a patient-focused, comprehensive and coordinated care apporach and reduce overall health care spending)** by leveraging processes that can be measured, analyzed, improved and controlled to implement this approach.

[1] HealthChoice Demostration (demo) program. Retrieved from **https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice%20Monitoring%20and%20Evaluation/HealthChoice%20Post-Award%20Forum/2017/2017%20HealthChoice%20Post-Award%20Forum_Presentation.pdf#search=post%20award%20forum%20presentation**

Mission and Vision of Quality Improvement Program at Johns Hopkins Health Plans

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.

Quality Improvement Program Goals

The QI program goals focus on improving health care outcomes while ensuring Priority Partners 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 Member Experience
- Improve Safety of Clinical Care
- Improve Quality of Clinical Care
- Enhance Quality of Service

Quality Improvement Program Objectives

The QI objectives are developed annually based on implemented initiatives throughout various QI workgroups, data analysis, and organizational priorities. The QI department aligns all objectives with Johns Hopkins Health Plans' regulatory and accreditation bodies. All QI objectives are monitored as deemed appropriate by the QI workgroup and committee structure. Objectives include, but are not limited to:

- Continuously close the gaps to ensure accreditation. Ensure tracking for all internal and external CAPs.
- Complete all coordination and continuity of care projects with quantified evaluations.
- Implement planned member initiatives to improve overall performance of Healthcare Effectiveness Data and Information Set (HEDIS®) measures.
- Evaluate under/over-utilization and continuity and coordination of care through the Johns Hopkins Health Plans Cost of Care Workgroup and the Quality Assurance and Performance Improvement (QAPI) Committee.
- Identify and implement at least one initiative to improve member safety in collaboration with selected departments.
- Conduct regular updates of CAPs issued to delegates to both delegation oversight committee and Johns Hopkins Health Plans compliance oversight committee.
- Ensure timely and accurate reporting on delegation oversight.
- Provide facilitation on at least one member initiative targeted at improving selected Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure(s).

Quality Improvement Program Description

The goal of the QI program is to monitor clinical care, service and experience provided to our members 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.

Quality Improvement 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 (CY). The program evaluation includes:

- Trending analyses of the measures/metrics and comparison to the established performance thresholds such as the Maryland Department of Health (MDH)'s Population Health Incentive Program (PHIP) benchmarks
- Measure and trending of HEDIS and CAHPS, data to identify improvement and enhancement opportunities
- Root cause and barrier analyses for areas where warranted
- Recommendations for future goals and activities to support QI objectives

Continuous Quality Improvement (CQI)

CQI in health care is defined as "a structured organizational process for involving people in planning and executing a continuous flow of improvement to provide quality health care that meets or exceeds expectations"[2]. CQI serves critical role in addressing the individual as well as community health and wellness needs thus supporting overall population health improvement goals. The prioritization of QI initiatives within the QI program are guided by the beneficiary needs , which is collected through various modalities such as the 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.

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

Quality Improvement 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:

- PHIP program measures performance
- Provider satisfaction survey performance
- HEDIS measures performance
- Beneficiary satisfaction survey performance, such as the CAHPS survey
- Pharmacy and medical claims data
- QoC reviews
- Monitoring beneficiary appeals, complaint and grievance data
- Data analysis and reporting, for clinical condition management and key HEDIS measures and screening programs (mammography, immunizations, etc.)
- Utilization Management (UM) 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 health care organization is meeting regulations and standards set by an external accreditation organization. Health care accreditation organizations such as the National Committee for Quality Assurance (NCQA) create a set of standards with the help of industry experts. NCQA is an independent non-profit 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 health care 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.

Population Health Incentive Program (PHIP)

The MDH's PHIP program, previously known as VBP, is designed to provide incentives and disincentives to HealthChoice MCOs based on performance across access and quality of care, specifically, select HEDIS quality measures. The PHIP measures, which are primarily HEDIS or "HEDIS-like," and their performance thresholds (i.e., targets) are set annually by the MDH. Priority Partners develops annual strategy to achieve meaningful improvement on its PHIP measures performance that includes member and provider engagement dimensions. Provider participation in the QI program is integral to the success of Priority Partners' PHIP strategy. Providers receive monthly "Opportunity Reports" listing members with open PHIP care gaps. Providers are encouraged to use the reports to engage members to schedule the needed care.

HEDIS® and CAHPS®

HEDIS is a set of 90 high-level measures with various sub measures 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.

* 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."

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 a 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 a public/private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care in commercial Medicare and Medicaid plans. Surveys are developed with the Agency for Healthcare Research and Quality (AHRQ). CAHPS data addresses 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.

Beneficiary Safety Program

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

- QoC reviews (clinical, behavioral, and pharmacy)
- Monitoring of beneficiary member complaints/grievances
- Medical record chart audits identified through 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 QUALITY IMPROVEMENT 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:

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

- 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, Priority Partners 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' 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 have 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.

Encounter Data Reporting Requirements

MDH requires Priority Partners to submit data as set forth in the Annotated Code of Maryland 110.67.04.15. An encounter is any health care service rendered to an enrolled Medical Assistance recipient by a state- contracted MCO or subcontractor to the MCO. The regulations also state that encounter data must be submitted within 60 days after the last day of the month in which the service was rendered.

The encounter data is intended to reflect 100 percent of the medical services performed as well as the equipment, supplies and tests provided in the medical care of a member. That is, every service rendered to a Medicaid recipient by a provider for Priority Partners must be reported to MDH as an encounter record. In addition, any service for which Priority Partners pays on behalf of the Medicaid recipient (e.g. one for which the recipient has self-referred) must be reported as an encounter. These encounters include, but are not limited to: physician, inpatient, outpatient, long-term care, home health, pharmacy, vision, laboratory, durable medical equipment, disposable medical supplies and other medical practitioner services.

The data will be used for:

- Overall program assessment
- Quality assurance monitoring
- Rate-setting
- Generating federal and state reports on service utilization

In order for the MDH to comply with the state and federal requirements and to perform its necessary quality and financial analyses, it is imperative that encounter data be submitted accurately. It is the provider's responsibility to submit to Priority Partners encounter or claims data using the national standard 837 electronic format or a clean paper claim using the national standard CMS 1500 form for professional services or the UB-04 form for facility services for each service provided. It is Priority Partners' responsibility to submit the encounter data to the state within 60 calendar days after receipt of the claim from the provider.

SECTION VII.
Provider Services and Responsibilities

OVERVIEW OF PRIORITY PARTNERS PROVIDER RELATIONS

Delivering quality medical services to our members is the hallmark of Johns Hopkins Health Plans, and we rely on our network providers to do this.

Johns Hopkins Health Plans' Provider Relations department is dedicated to the partnerships we've established within our provider network. Provider Relations Network Managers and Coordinators work closely with providers and facilities to satisfy the needs of our program enrollees. These include but aren't limited to:

- Rate negotiation and services coordination for non-par providers/vendors
- Needs analyses for network expansions
- Orientation for new providers
- Routine office visits for ongoing training and assurance of contractual compliance
- Annual seminars on general and specific topics of interest
- Updated policies and procedure information
- Network management/monitoring for adequacy, access, appointment and availability
- Immediate response to inquiries, requests and/or issues
- Routine correspondence and communication

PRIORITY PARTNERS WEB PORTAL

Our secure web portal, **HopkinsHealthPlans.org**, gives our providers and facilities convenient, safe access to the following resources:

- Provider manuals
- Timely updates and announcements
- Forms
- *Provider Pulse*, our quarterly provider newsletter
- Availity Provider Portal
- Online provider directory
- Policies and procedures
- Compliance guidance
- Drug formularies
- Prior authorization
- Health care performance measures and more!

PROVIDER INQUIRIES AND UPDATES

If there are any changes in your practice or facility, you are **required** to notify Johns Hopkins Health Plans Provider Relations department by email at ProviderChanges@jhhp.org or through our online **Digital Provider Information Update Form**. You can also inform us of changes via the following:

- Phone: 410-762-4385
  888-895-4998
- Fax: 410-762-5302
- Mail: Johns Hopkins Health Plans
  Provider Relations
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076

RE-CREDENTIALING

At the time of re-credentialing (every three years), each provider must show evidence of satisfying these policy requirements and must have satisfactory results relative to the Priority Partners measures for quality health care and service.

Priority Partners started a credentialing committee and a medical advisory committee for the formal determination of recommendations regarding credentialing decisions. The credentialing committee makes decisions regarding participation of initial applicants and their continued participation at the time of re-credentialing. The oversight rests with the medical advisory committee. During re-credentialing, information for PCPs from quality improvement activities and member complaints is presented for credentialing committee review.

The provider will be notified by telephone or in writing if information obtained in support of the reassessment process varies substantially from the information submitted by the provider. Providers have the right to review the information submitted in support of the re-credentialing process and to correct errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.

OVERVIEW OF PROVIDER RESPONSIBILITIES

Affirmative Statement

Priority Partners ensures utilization management decisions are fair, independent, and according to approved criteria and available benefits. Utilization management decisions are based only upon appropriateness of care and service and the existence of coverage. Priority Partners does not specifically reward providers or other individuals for issuing denials of coverage of care, and financial incentives for utilization management decision-makers do not encourage decisions that result in utilization.

Nondiscrimination Statement

Priority Partners does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Priority Partners does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Priority Partners does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or

subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Priority Partners may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Priority Partners provides health coverage to members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact Priority Partners with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Priority Partners representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. Priority Partners documents, tracks and trends all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington DC 20201
- By phone at: 800-368-1019 (TTY/TTD: 800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Priority Partners provides free tools and services to people with disabilities to communicate effectively. Priority Partners 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.

Equal Program Access on the Basis of Gender

Priority Partners provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Priority Partners must also treat individuals consistently with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Priority Partners may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

PRIMARY CARE PROVIDERS (PCPS)

The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member. Members can choose a Physician, Nurse Practitioner or Physician's Assistant as their PCP. The PCP will act as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits.

The PCP is required to:

- Address the member's general health needs;
- Treat illnesses
- Coordinate the member's health care;
- Promote disease prevention and maintenance of health;
- Maintain the member's health records; and
- Refer for specialty care when necessary.

If a member's PCP is not a women's health specialist, Priority Partners will allow them to see a women's health specialist within the Priority Partners network without a referral, for covered services necessary to provide women's routine and preventive health care services. Prior authorization is required for certain treatment services.

SPECIALTY PROVIDERS

- We will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits as required by COMAR 10.67.06
- Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires Priority Partners to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, call 800-654-9728 or the Provider Hotline at 800-766-8692 for assistance.

ROLE OF SPECIALTY CARE PROVIDERS

Obligations of the specialist also include the following:

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

SECOND OPINIONS

If a member requests a second opinion, Priority Partners will provide for a second opinion from a qualified health care professional within our network. If necessary, we will arrange for the member to obtain one outside of our network.

MEDICAL RECORD DOCUMENTATION

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a Priority Partners member. Original medical records must be released only in accordance with federal or Maryland laws, court orders, or subpoenas.

Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

It is the policy of Johns Hopkins Health Plans to ensure that the medical records of network practitioners are maintained in a manner that is current, detailed, organized, permits effective and confidential patient care and quality review, and meets established goals for medical record keeping.

The Johns Hopkins Health Plans standards for medical record documentation include the following:

Confidentiality of medical records:

- Medical records are stored securely.
- Only authorized personnel have access to records.
- Medical practice has a policy that ensures the staff receives training in member information confidentiality.

Each medical record must include:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening
- Documentation of follow-up for all diagnostic, therapeutic, and ancillary services

Availability of medical records:

- Medical records are organized and stored in a manner that allows easy retrieval.
- Medical records are stored in a secure manner that allows access by authorized personnel only.

Johns Hopkins Health Plans will conduct medical record documentation reviews on a randomly selected sample of primary care practitioners. Those practitioners who document in EMR or who have received recognition in the National Committee for Quality Assurance's (NCQA) Physician Practice Connections Program will be excluded from reviews.

Johns Hopkins Health Plans has set the following performance goals for reviews of medical record documentation:

Best practice	80 percent to 100 percent
Acceptable	50 percent to 79 percent
Not acceptable	0 percent to 49 percent

Providers will ensure their medical documentation has the correct service and diagnoses that reflect their claim submissions.

PRIMARY CARE PROVIDER (PCP) CONTRACT TERMINATIONS

If you are a PCP and we terminate your contract for any of the following reasons, the member assigned to you may elect to change to another MCO in which you participate by calling the enrollment broker within 90 days of the contract termination:

- For reasons other than the quality of care or your failure to comply with contractual requirements related to quality assurance activities; or
- Priority Partners reduction of your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to Priority Partners by the MDH, and Priority Partners and you are unable to negotiate a mutually acceptable rate.

CONFIDENTIALITY AND ACCURACY OF MEMBER RECORDS

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a Priority Partners member. Original medical records must be released only in accordance with federal or Maryland laws, court orders, or subpoenas. Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (**https://www.hhs.gov/ocr/about-us/index.html**).

PROVIDER REQUESTED MEMBER TRANSFER

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask a member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a fair gearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

- The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:

  Johns Hopkins Health Plans-Priority Partners
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076
  Attn: Provider Relations
- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
- Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

REPORTING COMMUNICABLE DISEASE

Providers must ensure that all cases of reportable communicable disease that are detected or suspected in a member by either a clinician or a laboratory are reported to the LHD as required by Health – General Article, §§18- 201 to 18-216, Annotated Code of Maryland and COMAR 10.06.01 Communicable Diseases.

Any health care provider with reason to suspect that a member has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the member.

- The provider report must identify the disease or suspected disease and demographics on the member including the name, age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the MDH (DHMH-1140) as directed by COMAR 10.06.01.
- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours
  - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by MDH

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit http://www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within the hearing range of other patients.

ADVANCE DIRECTIVES

Providers are required to comply with federal and state law regarding advance directives for adult members. Maryland advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated. The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care
- Providing written information to adult members of provider-written policies concerning advance directives that include the provider's rights concerning conscientious objections
- Documenting in the member's medical record, whether or not the adult member has been provided the information and whether an advance directive has been executed

- Not discriminating against a member because of their decision to execute or not execute an advance directive and not making it a condition for the provision of care
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities
- Educate patients on advance directives (durable power of attorney and living wills)
- Encourage patients to utilize advance care planning documents
- MCOs are required to make the Advance Directives Information Sheet available during enrollment and in member publications, on their website, and at the member's request.

Advance directive forms, a guide to Maryland law, and frequently asked questions can be found at: Communications toolkit for the Advanced Directive Information Sheet can be found at: **https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx**.

CULTURAL COMPETENCY

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid. Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental, or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

Priority Partners expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid.

Cultural competency is the ability of individuals and systems to provide effective services to people of all cultures, races, ethnic backgrounds and religions in a manner that identifies affirms, values and respects the worth of the individuals while protecting and preserving the dignity of each.

Priority Partners members come from diverse cultural backgrounds. Sensitivity to cultural differences allows Priority Partners to recognize and avoid situations that may discourage a member from using services or following treatment plans.

The culture of poverty may also create lifestyle issues such as inability to afford telephone service, frequent residential moves, homelessness and attributes like low literacy or language barriers that make it difficult to effectively interact with members. Priority Partners believes positive member interactions may encourage members to use services more appropriately.

Cultural competency training is a requirement for participating providers in the Priority Partners network. HHS offers A Physician's Practical Guide to Culturally Competent Care, a free, online educational program accredited for physicians, physician assistants, and nurse practitioners. This HHS website offers CME/CE credit and equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve.

HEALTH LITERACY

Priority Partners is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. Providers must deliver services in a culturally effective manner to all members, including those with limited English proficiency (LEP) or reading skills.

INTERPRETATION SERVICES AND AUXILIARY AIDS

Interpreter services are available for all Priority Partners members regardless of their primary spoken language. Interpreter services also provide assistance to those who are deaf, hard of hearing, or have difficulty speaking.

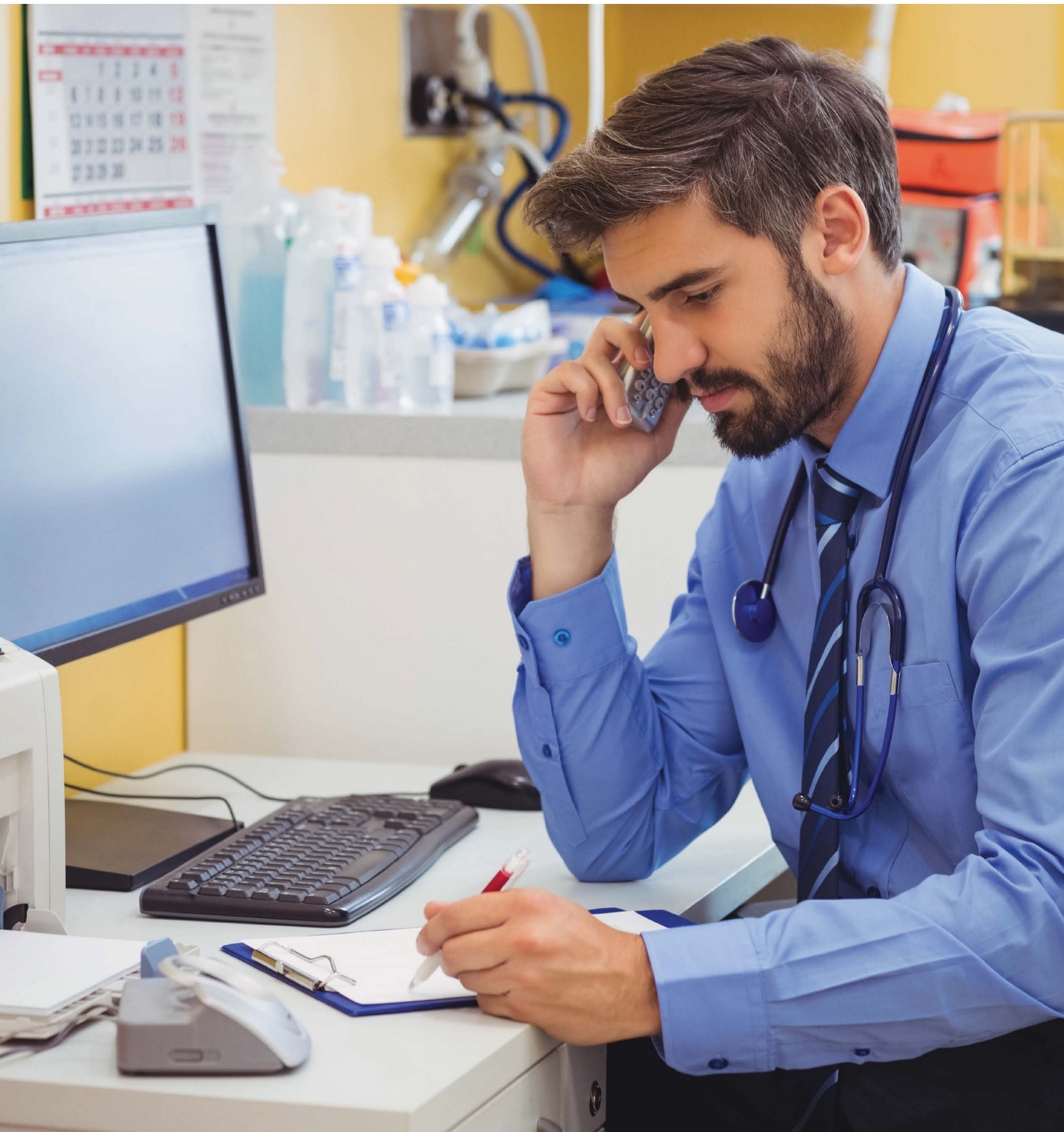
To request an interpreter, members can call Priority Partners Member Services. Individuals who are deaf, hard of hearing, or have difficulty speaking can use the Maryland Relay Service (711). Priority Partners is required to provide auxiliary aids at no cost to members when requested. Auxiliary aids include assistive listening devices, written material, and modified equipment/devices.

If your patient needs interpreter services for an appointment, they need to contact your office first. It is best to for patients to notify you in advance of an appointment to ensure there is enough time to set-up the interpreter service and to avoid a delay in their medical care services. In some situations, Priority Partners may help facilitate interpreter services for provider appointments. Patients can call Priority Partners Member Services if they have questions.

ACCESS FOR INDIVIDUALS WITH DISABILITIES

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity; or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways.

SECTION VIII.
Quality Assurance Monitoring Plan and Reporting Fraud, Waste and Abuse



QUALITY ASSURANCE MONITORING PLAN

The quality assurance monitoring plan for the HealthChoice program is based upon the philosophy that the delivery of health care services, both clinical and administrative, is a process that can be continuously improved. The state of Maryland's quality assurance plan structure and function support efforts to deal efficiently and effectively with any identified quality issue. On a daily basis and through a systematic audit of MCO operations and health care delivery, the MDH identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and provider feedback are an integral part of the managed care process and help to ensure that cost containment activities do not adversely affect the quality of care provided to members.

The MDH's quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to HealthChoice members is high quality, complies with regulatory requirements, and is rendered in an environment that stresses continuous quality improvement. Components of the MDH's quality improvement strategy include: establishing quality assurance standards for MCOs; developing quality assurance monitoring methodologies; and developing, implementing and evaluating quality indicators, outcome measures, and data reporting activities, including:

- Health Service Needs Information form completed by the participant at the time they select an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs. In the cases of prenatal and maternal health needs, providers need to fill out the **Maryland Prenatal Risk Assessment form**.
- A complaint process administered by MDH staff
- A complaint process administered by Priority Partners
- A systems performance review of each MCO's quality improvement processes and clinical care performed by an External Quality Review Organization (EQRO) selected by the MDH. The audit assesses the structure, process, and outcome of each MCO's internal quality assurance program
- Annual collection, validation and evaluation of the HEDIS, a set of standardized performance measures designed by the NCQA audited by an independent entity
- Other performance measures developed and audited by MDH and validated by the EQRO.
- An annual member satisfaction survey using CAHPS, developed by NCQA for the Agency for Healthcare Research and Quality.
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data.
- Development and implementation of an outreach plan.
- A review of services to children to determine compliance with federally required EPSDT standards of care.
- Production of a Consumer Report Card.
- An annual technical report that summarizes all quality activities

To report these measures to MDH, Priority Partners must perform chart audits throughout the year to collect clinical information on our members. Priority Partners truly appreciates the provider offices' cooperation when medical records are requested.

In addition to information reported to MDH, Priority Partners collects additional quality information. Providers may need to provide records for standard medical record audits that ensure appropriate record documentation. Our Quality Improvement staff may also request records or written responses if quality issues are raised in association with a member complaint, chart review, or referral from another source.

HEALTH CARE FRAUD AND ABUSE

Johns Hopkins Health Health Plans wants to find and stop health care fraud and abuse. It is estimated that billions of dollars are lost annually due to health care fraud and abuse. Johns Hopkins Health Plans takes its responsibility seriously to protect the integrity of the care its members receive, its health plans, and the federal and state programs it administers.

Fraud is defined as any deliberate and dishonest act committed with the knowledge that it could result in an unauthorized benefit to the person committing the act or someone else who is similarly not entitled to the benefit. Examples of healthcare fraud are:

- 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 practices that are inconsistent with accepted sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

- Misusing codes on a claim
- Charging excessively for services or supplies
- Billing for services that were not medically necessary

Both fraud and abuse can expose a provider or vendor to criminal and civil liability.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Priority Partners all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

You can also report provider fraud to the MDH Office of the Inspector General at 410-767-5784 or 866-770-7175), the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at 410-576-6521 (888-743-0023) or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

The Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all Maryland agencies responsible for services funded by Medicaid.

How Can I Help Prevent Fraud and Abuse?

- 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
- Report *all* suspicions of fraud by contacting one of the following:
  - **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

What Should You Do If You Suspect or Have Knowledge of Fraud and Abuse?

All Johns Hopkins Health Plans providers, subcontractors and vendors are required to report concerns about actual, potential or perceived misconduct to the Johns Hopkins Health Plans Payment Integrity department at the numbers/addresses noted above.

What Happens to Me If I Report a Concern?

Johns Hopkins Health Plans takes its responsibility to protect your reporting of actual or suspected fraud and abuse seriously. No 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.Any individual who reports a compliance concern has the right to remain anonymous and Johns Hopkins Health Plans commits to enforcing this right.

In an effort to deter these and other instances of fraud and abuse, the Johns Hopkins Health Plans Payment Integrity department routinely performs validation audits of claims and medical record documentation.

In addition, the Johns Hopkins Health Plans Payment Integrity department investigates all detected outliers and other deviations from standard practice as well as all allegations of health care fraud and abuse that it receives from recipients and others. The Payment Integrity department reports substantiated allegations to the appropriate regulatory authorities who may, in turn, perform its own fraud and/or abuse investigation and take action against those who are found to have committed health care fraud and/or abuse.

Relevant Laws

There are several relevant laws that apply to fraud, waste, and abuse:

The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval;
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government; or
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, **or remuneration** to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The Self-Referral Prohibition Statute (Stark Law) prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

The Red Flag Rule (Identity Theft Protection) requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

The Health Insurance Portability and Accountability Act (HIPAA) requires:

- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identification (NPIs) numbers

The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Priority Partners services through Maryland HealthChoice.

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Priority Partners providers will follow federal and Maryland laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Priority Partners services through Maryland HealthChoice.

Under the Maryland False Claims Act, Md. Code Ann., Health General §2-601 et. seq.
Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
- Automatic disbarment
- Prison time

Exclusion Lists & Death Master Report

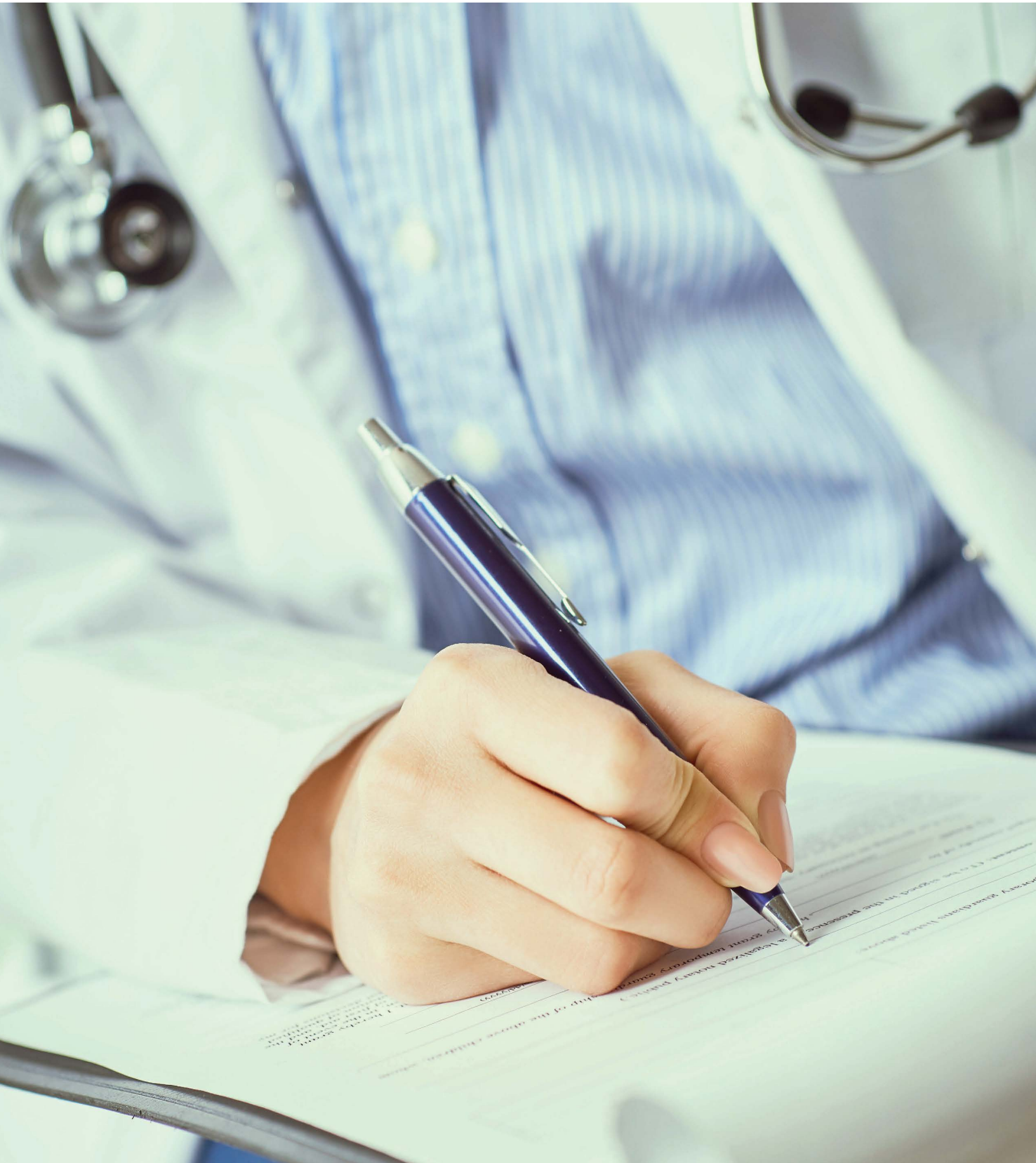
Priority Partners is required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, and any other such databases as the Maryland MMA Providers and other Entities Sanctioned List may prescribe.

Priority Partners does not participate with or enter into any provider agreement with any individual, or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers or who have been terminated from the Medicaid, or any programs by Maryland Department of Health for fraud, waste, or abuse. The provider must agree to assist [Priority Partners]as necessary in meeting our obligations under the contract with the Maryland Department of Health to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional Resources:

To access the current list of Maryland sanctioned providers follow this link: **https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx**

SECTION IX.
Additional Priority Partners Information



IMPORTANT PHONE NUMBERS

Priority Partners
800-654-9728

Provider First Line
410-424-4490
888-819-1043

Provider Relations
410-762-5385
888-895-4998
410-424-4604 Fax

Priority Partners (Referrals)
410-424-4603 Fax

Eligibility Verification System
866-710-1447

Mental Health Services
(Optum)
800-888-1965

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

Substance Abuse Services
(Optum)
800-888-1965

Vision Benefits
866-819-4298
compliance@jhhp.org

Johns Hopkins Health Plans Corporate Compliance
410-424-4996
410-762-1527 Fax

Outpatient Medical Review
410-762-5205 Fax

Utilization/Care Management
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

Inpatient
410-424-4894 Fax
410-424-2770 Fax

DME
410-762-5250 Fax

HealthChoice
800-284-4510

Health Education
800-957-9760

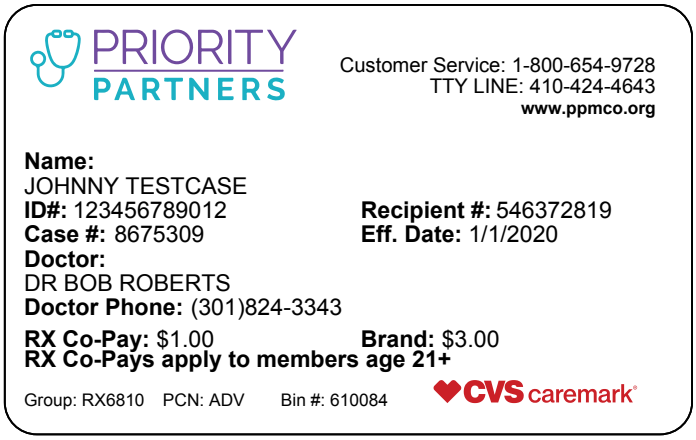
Outreach
410-424-4648
888-500-8786

Referral (Fax)
410-424-4603

Priority Partners Website
www.Priority Partners.org

Johns Hopkins Health Plans Website
HopkinsHealthPlans.org

PRIORITY PARTNERS IDENTIFICATION CARD


PRIORITY PARTNERS

Customer Service: 1-800-654-9728
TTY LINE: 410-424-4643
www.ppmco.org

Name:
JOHNNY TESTCASE
ID#: 123456789012 **Recipient #:** 546372819
Case #: 8675309 **Eff. Date:** 1/1/2020
Doctor:
DR BOB ROBERTS
Doctor Phone: (301)824-3343

RX Co-Pay: $1.00 **Brand:** $3.00
RX Co-Pays apply to members age 21+

Group: RX6810 PCN: ADV Bin #: 610084

CVS caremark

Benefits & Customer Service 1-800-654-9728
Call us before any inpatient admission or within 24 hours of urgent/emergency inpatient admission.
Maryland Health Connection 1-855-642-8572
Vision Benefits
Superior Vision 1-800-428-8789
Pharmacy Information 1-855-298-4258
Maryland Department of Health
HealthChoice Enrollee Help Line 1-800-284-4510
Behavioral Health 1-800-888-1965
Submit claims to: Priority Partners MCO
P.O. Box 4228
Scranton, PA 18505

IMPORTANT FORMS

Local Health Services Request Form

https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx

Maryland Prenatal Risk Assessment Form

https://health.maryland.gov/mmcp/Documents/Maryland%20Prenatal%20Risk%20Assesment%20-%20Revised%202_2022.pdf

Member Referral Form

https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/Priority Partners/pp_member_referral_form.pdf

Personalized Treatment Plan Form

https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/ppmco/pp_personalized_treatment_plan.pdf

Priority Partners Forms

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/priority-partners/forms

School-Based Health Center Health Visit Report Form

https://health.maryland.gov/mmcp/epsdt/healthykids/Pages/Encounter-Forms.aspx

PRMAN2-PP-04/2024

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PRIORITY PARTNERS

HopkinsHealthPlans.org

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