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# ADVANTAGE MD PROVIDER MANUAL



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# OUR PHILOSOPHY

Johns Hopkins Advantage MD has three strategic principles regarding health care....

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

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

*Each plan member is Advantage MDs most important member.*

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

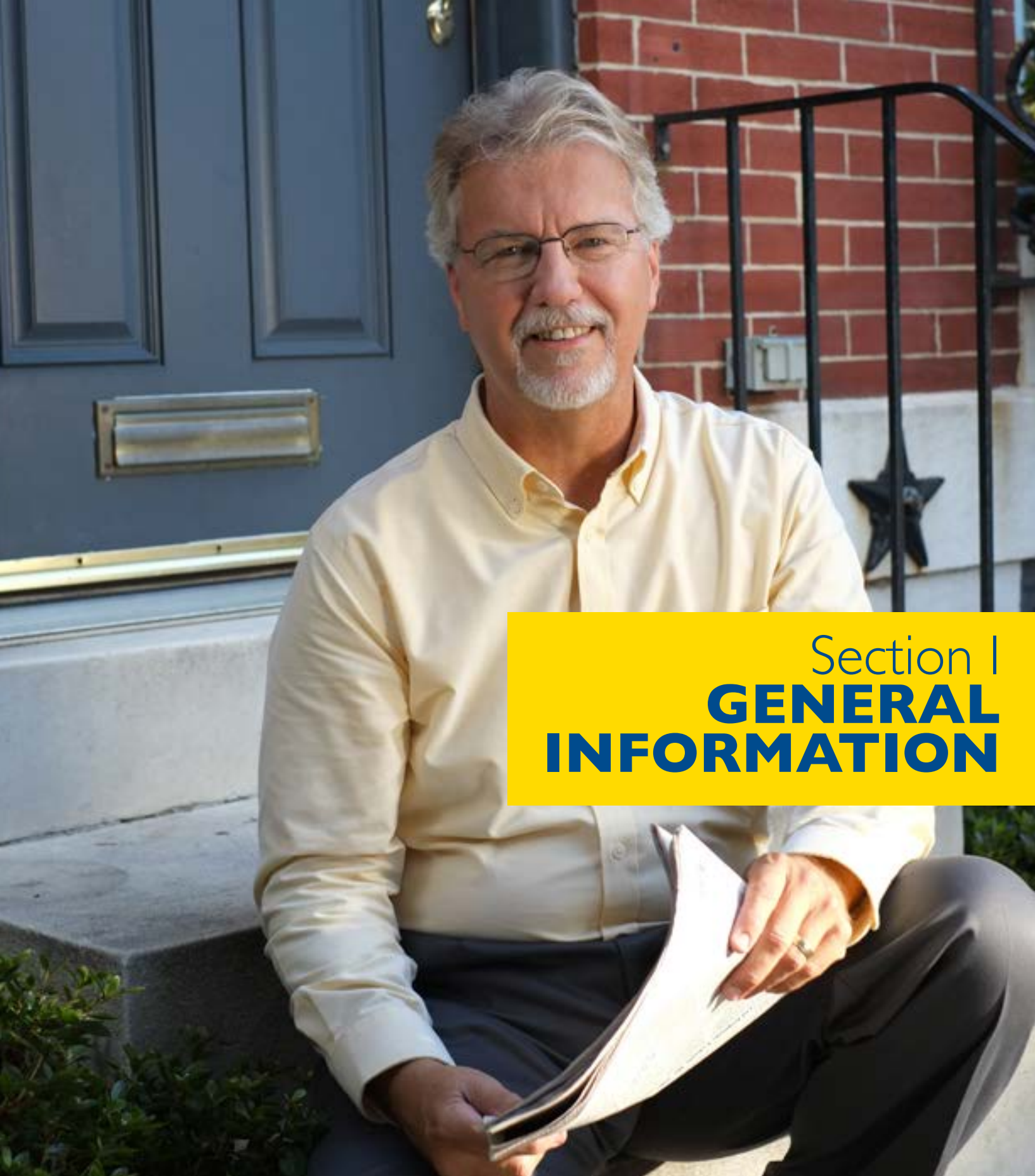
**ADVANTAGE MD**  
Johns Hopkins Medicine Medicare Plan



## MEDICARE ADVANTAGE (PART C)

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

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



Section I  
**GENERAL  
INFORMATION**



## PLAN OVERVIEW

Johns Hopkins HealthCare offers multiple Medicare Advantage products:

- Johns Hopkins Advantage MD (HMO)
- Johns Hopkins Advantage MD PPO and PPO Plus (PPO)
- Johns Hopkins Advantage MD PPO Premier (Available in Montgomery County, Md. only)
- Johns Hopkins Advantage MD Group (PPO) (eligibility restrictions apply)

All plans include Medicare Part D prescription drug coverage for Medicare-eligible residents in 12 counties throughout Maryland. These counties include:

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

## MEDICARE ADVANTAGE ENROLLMENT PERIODS

### Initial Enrollment Periods

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

## MEMBER RIGHTS, MEMBER RESPONSIBILITIES

### Members have the right to:

- Be treated with dignity and respect at all times.
- Be protected from discrimination.
- Have their personal and health information kept private.
- Get information in a way they understand from Medicare, health care providers, and contractors.



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

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

## Members have the responsibility to:

- **Get familiar with their covered services and the rules they must follow to get these covered services.** Use the Evidence of Coverage booklet to learn what is covered for members and the rules they need to follow to get their covered services. Chapters 3 and 4 give the details about their medical services, including what is covered, what is not covered, rules to follow, and what they pay. Chapters 5 and 6 give the details about their coverage for Part D prescription drugs. If they have any other health insurance coverage or prescription drug coverage in addition to our plan, they are required to tell us. Please tell members to call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - > We are required to follow rules set by Medicare to make sure that they are using all of their coverage in combination when they get their covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits they get from our plan with any other health and drug benefits available to them. We’ll help them coordinate their benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell their doctor and other health care providers that they are enrolled in our plan.** Show their plan membership card whenever they get their medical care or Part D prescription drugs.

- **Help their doctors and other providers by giving them information, asking questions, and following through on their care.** To help their doctors and other health providers give them the best care, learn as much as they are able to about their health problems and give them the information they need about them and their health. Make sure members follow the treatment plans and instructions that they and their doctors agree upon. Make sure you know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements.

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

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect them to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- **Pay what they owe.** As a plan member, they are responsible for these payments:
  - > In order to be eligible for our plan, they must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.

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

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

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

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

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

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

## MEMBER HOLD HARMLESS

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

## GENERAL CONTACT INFORMATION

### Eligibility, Claims Status or Provider Payment Dispute

#### Johns Hopkins Advantage MD Customer Service

##### PPO Products

Phone 877-893-5325

Fax 855-206-9203

TTY 711

##### HMO Products

Phone 877-293-4998

Fax 855-206-9203

TTY 711

##### *Hours of Operation*

Oct. 1 through Feb. 14

Monday through Sunday, 8 a.m. to 8 p.m.

Feb. 15 through Sept. 30

Monday through Friday, 8 a.m. to 8:30 p.m.

## Provider Relations

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

Phone 888-895-4998

410-762-5385

Fax 410-424-4604

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

## Websites

Providers [www.jhhc.com](http://www.jhhc.com)

Members [www.hopkinsmedicare.com](http://www.hopkinsmedicare.com)

## HealthLINK@Hopkins

HealthLINK@Hopkins is a secure, online web portal for Johns Hopkins Advantage MD members and in-network providers. For additional information, please visit our website:

[http://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/healthlink/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/healthlink/)

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

## Mailing Address for Paper Medical Claims

### Johns Hopkins Advantage MD

P.O. Box 3537

Scranton, PA 18505

## Mailing Address for Medical Payment Disputes

### Johns Hopkins Advantage MD

P.O. Box 3537

Scranton, PA 18505



Section 2  
**PROVIDER  
RESPONSIBILITIES**



## PRIMARY CARE PROVIDER (PCP)

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

## ROLES AND RESPONSIBILITIES

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

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

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

- Not differentiating or discriminating in the treatment of members on the basis of source of payment for covered services, gender, age, race, color, religion, origin, place of residence, economic or health status, disability, or medical condition, including mental as well as physical condition, claims experience or medical history.
- Complying with credentialing and re-credentialing requirements.
- Providers must maintain a member medical record that accurately reflects the preventive, routine, and specialty care provided. All records pertaining to a member's care must be in one central medical record. The member's name must be on each page of notes, lab results, and consults, and the provider must initial and date each test or lab result indicating it has been reviewed.

## ROLE OF SPECIALTY CARE PROVIDERS

Obligations of the specialist also include the following:

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

## AVAILABILITY STANDARDS FOR PROVIDERS

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

## ACCESS STANDARD GUIDELINES

Service	Appointment Wait time (not more than)
PCP Routine/Preventive Care	30 calendar days
PCP Non-Urgent (Symptomatic)	Seven (7) calendar days
PCP Urgent Care	Immediate/Same Day
PCP Emergency Services	Immediate/Same Day
Specialist Routine	30 calendar days
Specialist Non-Urgent (Symptomatic)	Seven (7) calendar days
Behavioral Health Routine Initial	10 business days
Behavioral Health Routine Follow-up	30 calendar days
Behavioral Health Urgent	48 hours
Behavioral Health Emergency	6 hours
Office Wait Time	30 minutes

\*The access standards are based on CMS guidelines

## MEDICAL RECORD STANDARDS

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

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

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

## ADVANCE MEDICAL DIRECTIVES

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



The member may inform all providers contracted directly or indirectly with Advantage MD that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his or her medical record.

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

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

If a member requests additional information, please refer them to [www.hopkinsmedicare.com](http://www.hopkinsmedicare.com) or Customer Service:

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

## CONFIDENTIALITY

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

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

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

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

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

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

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

## PCP ASSIGNMENT

### **Advantage MD PPO, PPO Plus & Group Plans**

Selection of a Primary Care Physician (PCP) is not required however members are encouraged to select a PCP in order to:

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

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

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

### **Advantage MD HMO Plan**

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

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

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

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

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

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

## REFERRAL REQUIREMENTS

### **Advantage MD PPO, PPO Plus & Group Plans**

- Referrals are not required

### **Advantage MD HMO Plan**

- PCP referrals are required for specialty services
- Referrals should be to an in-network specialty provider only
- There is no out-of-network coverage for the HMO
- PCPs should complete referrals in HealthLINK and provide the member with a copy OR
- Complete the Maryland Uniform Consultation Referral Form, provide a copy to the member, and fax to JHHC at 410-424-4036

## CLOSING PATIENT PANELS

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

*(See General Contact Information, Section I)*

## SPECIALTY PROVIDERS

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

Responsibilities of the specialty provider include:

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

## TREATMENT REPORT FROM THE SPECIALIST TO PCP

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

## COMMUNICATION AMONG PROVIDERS

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

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

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

## BEHAVIORAL HEALTH

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

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

### **Behavioral Health Services**

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

Behavioral Health services include:

- Access to Advantage MD's Customer Service for orientation and guidance
- Routine outpatient services to include psychiatrists, addictionologists, licensed psychologists, licensed and certified clinical social workers (LCSWs), and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice
- Psychiatric evaluation and psychosocial assessment

- Individual and group psychotherapy
- Psychological testing according to established guidelines and needs
- Inpatient hospitalization
- Inpatient and outpatient detoxification treatment
- Medication management
- Partial hospitalization programs

## Responsibilities of Behavioral Health Providers

The responsibilities include but are not limited to:

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

## Responsibilities of the Primary Care Physician

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

- Screening and early identification of mental health and substance abuse issues
- Treating members with behavioral health care needs within the scope of his/her practice and according to established Clinical Practice Guidelines. These can be members with comorbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but require treatment
- JHHC 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 [jhhc.com](http://jhhc.com) website. **Clinical practice guidelines** and **preventative health guidelines** policies are available [here](#).
- Consultation and/or referral of complex behavioral health patients or those not responding to treatment
- Communication with other somatic and behavioral health providers on a regular basis

## Access to Care

Members may access behavioral health services as needed:

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

## PROVIDER RELATIONS

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

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

The Provider Relations team has the following additional responsibilities:

- To develop and provide support services to new and established contracted providers for the purpose of contract education, compliance, and problem solving, and to ensure satisfaction with Advantage MD.
- To provide liaison support internally for provider related issues, including questions or concerns regarding contracts and operations.
- To develop educational materials and/or mailings as needed.
- To develop and maintain provider manual outlining general information specific to Advantage MD policies and procedures applicable to health care professionals.
- Present contracted providers to members via current and accurate online and hard-copy provider directories.
- Identify and pursue opportunities for provider network expansion and enhanced member access to health care.

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

## CHANGES IN PROVIDER INFORMATION

### Tax Identification Number

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

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

**Johns Hopkins HealthCare LLC**

7231 Parkway Drive, Suite 100

Hanover, MD 21076

Attn: Provider Relations Department

## Provider Directory:<sup>1</sup>

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

**Changes to provider demographic information (i.e. telephone number, address, suite number, etc.) must be updated in CAQH. All other provider updates must be submitted to Provider Relations, via email to [ProviderChanges@jhhc.com](mailto:ProviderChanges@jhhc.com). You can also mail or fax changes using your provider letterhead to:**

### Johns Hopkins Advantage MD

Attn: Provider Relations Department  
7231 Parkway Drive, Suite 100  
Hanover, MD 21076  
Fax: 410-424-4604

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

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

<sup>1</sup> Medicare Managed Care Manual Ch.3 §100.4 and HPMS Memo dated August 13, 2015

## PROVIDER COMMUNICATION

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

- Provider Pulse – a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories, and news pertaining to our four lines of business, including Advantage MD.
- Johns Hopkins HealthCare Website – [www.jhhc.com](http://www.jhhc.com)
- Advantage MD Website – [www.hopkinsmedicare.com](http://www.hopkinsmedicare.com)

## HEALTHLINK@HOPKINS ONLINE WEB PORTAL

HealthLINK@Hopkins is a secure, online web portal for Johns Hopkins Advantage MD members and in-network providers.

As a provider you can:

- Submit claims and search for existing claims
- Review or download electronic remittance advice
- Search for members based on name, member ID, PCP or DOB

- Retrieve reports, such as member rosters
- Check status of referrals
- Directly enter referrals for specialty services
- Send secure messages to Customer Service

***\*First time users of HealthLINK must register for an account. If you need assistance with registration, contact your Network Manager or Provider Relations at 888-895-4998.***

## PROVIDER MARKETING GUIDELINES

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

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

### **Providers Can:**

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

### **Providers Cannot:**

- Offer scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of Plans/Part D Sponsors
- Offer anything of value to induce enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications within an exam room setting



## CULTURAL COMPETENCY

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

## ANTI-DISCRIMINATION RULES

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



Section 3  
**CREDENTIALING**



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

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

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

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

## CREDENTIALING REQUIREMENTS

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

## TYPES OF PROVIDERS REQUIRING CREDENTIALING

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

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

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

## CREDENTIALING PROVIDERS

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

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

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

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

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

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

Providers have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Providers also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. They may do so by telephone, fax, email, or correspondence to the Credentialing Department, or the network manager at 888-895-4998, for their geographic area. The mailing address for JHHC is:

### **Johns Hopkins HealthCare LLC**

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

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

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

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

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

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

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

## CREDENTIALING ORGANIZATIONAL PROVIDERS

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

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

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

Currently, the following verifications are completed in addition to collection of the application information. These verifications are performed in accordance with the NCQA, and state and federal guidelines and regulations:

- Current licensure as health care delivery organization as an independent vendor in the state where service will be rendered
- Any restrictions to a license imposed by the licensing agency
- Any limitations or exclusions imposed by the federal government, or Medicare or Medicaid entity
- Accreditation status with nationally recognized entities for health care quality including but not limited to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Community Health Accreditation Program (CHAP), Healthcare Facilities Accreditation Program (HFAP), the American Osteopathic Association (AOA), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Commission on Accreditation of Rehabilitation Facilities (CARF)
- For non-accredited organizations, JHHC will accept a state assessments/evaluations or CMS review
- Onsite review for organizations without accreditation or State/CMS review
- Professional liability/malpractice insurance
- Verification of Medicare participation

## RE-CREDENTIALING

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

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

## PROVIDER NOTIFICATION TO JHHC

The provider or organization must notify JHHC in writing within five (5) days, unless otherwise stated below, following the occurrence of any of the following events:

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

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

## IMMEDIATE TERMINATION OF PARTICIPATION

JHHC may terminate a Participating Provider Agreement immediately “for cause.” Examples of “for cause” termination may be defined as but not limited to:

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

## VOLUNTARY TERMINATION OF PARTICIPATION

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

## TRANSITION OF CARE UPON PROVIDER TERMINATION

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

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

More information about your obligations upon contract termination is located in your provider agreement. If you have additional questions, please contact Provider Relations at 410-762-5385 or 888-895-4998.



# JHHC PROVIDER APPEALS PROCESS

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

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

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

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

The credentialing department designee will convene an appeal panel comprised of three qualified clinicians who represent the provider community within the Advantage MD provider network. At least two of the panelists will be a clinical peer of the appellant. (For the purpose of this requirement, a clinical peer is a provider who holds the same licensure and specialty as the appellant.) Knowledge of the matter shall not preclude any individual from serving as a member of the panel; however, involvement with any earlier decision concerning the initial determination for termination or corrective action(s) precludes the individual from serving as a panelist.

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

If the SCRC and the panel decide to uphold the initial termination decision, the provider may request a second-level appeal and request the opportunity for a personal hearing. Personal appearance hearings will be scheduled at the convenience of the hearing panelists and the provider but not to exceed 60 calendar days from the receipt by JHHC of the second-level appeal request. The provider has the right to be represented by an attorney or another person of the provider's choice during the appeal process. In lieu of a personal hearing, the provider may opt for a second panel decision with no personal appearance. The panelist in this situation will render a recommendation to the SCRC within 30 days of receipt of the second-level appeal. In either situation (personal appearance or appeal panel), the panelists render a recommendation to the SCRC to either uphold or overturn the initial decision. The SCRC decision will be rendered within 30 calendar days from the date of the second-level appeal. Second-level appeals are final and binding.

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

## PROVIDER PROVISIONS

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

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

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

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

- The PCP provides all primary preventative health care services, except the annual gynecological exam should the member choose to seek this service from a participating women's health care specialist.
- When specialized care is medically necessary, the PCP will facilitate a referral to a specialist or specialty facility.
- The PCP will coordinate care and share appropriate medical information with Advantage MD and any specialty provider to whom they refer their patients.
- The PCP may delegate care coordination to another provider if both the member and the other provider agree. This will be clearly documented in the PCP's clinical record.
- The PCP will forward copies of the completed Advance Directive forms for their patient to Advantage MD's Customer Service Department. They will also document in a prominent place in their patient's records if an individual has executed an Advance Directive.
- Will notify Advantage MD in writing when practice is closed to new patients.
- Will arrange for call sharing with a network physician or provider 24-hours-a-day, seven-days-a week.
- Will notify Advantage MD of any changes in call share coverage.
- Will notify Advantage MD when asking a member to seek treatment elsewhere.



Section 4  
**BENEFITS  
& SERVICES**



# BENEFIT OVERVIEW

Johns Hopkins HealthCare offers multiple Medicare Advantage products:

- Johns Hopkins Advantage MD (HMO)
- Johns Hopkins Advantage MD PPO
- Johns Hopkins Advantage MD Plus (PPO)
- Johns Hopkins Advantage MD PPO Premier (Available only in Montgomery County, Md.)
- Johns Hopkins Advantage MD Group (eligibility restrictions apply)

Below is an at-a-glance view of some plan benefits. For full benefits please see the EOC for each plan.

2020 Advantage MD Plans					
Medical Benefits (Partial Listing, in-network)*	HMO	PPO	PPO Plus	PPO Premier	PPO Group
<b>Monthly Plan Premium</b>	\$0 to \$25	\$60	\$90	\$350	\$175
<b>Maximum Out-of-Pocket</b>	IN: \$6,700	IN: \$6,700 OON: \$10,000	IN: \$6,700 OON: \$10,000	IN: \$1,500 OON: \$5,000	IN: \$3,000 OON: \$10,000
<b>Medical Deductibles</b>	None	None	None	None	\$100
<b>Primary Care Provider Visit</b>	\$5 copay	\$10 copay	\$5 copay	\$0 copay	\$5 copay
<b>Specialist Visit</b>	\$50 copay	\$50 copay	\$50 copay	\$10 copay	\$35 copay
<b>Referrals</b>	Required, Specialist Visit Only	Not Required	Not Required	Not Required	Not Required
<b>Urgent Care</b>	\$40 copay	\$40 copay	\$40 copay	\$20 copay	\$40 copay
<b>Emergency Care</b>	\$90 copay	\$90 copay	\$90 copay	\$50 copay	\$75 copay
<b>Inpatient Hospital Stay</b>	\$310 copay per days 1-6; \$0 per days 7 and beyond	\$310 copay per days 1-6; \$0 per days 7 and beyond	\$310 copay per days 1-6; \$0 per days 7 and beyond	\$200 copay per admission	\$250 copay per days 1-7; \$0 per days 8 and beyond
Prescription Drug Benefits (30-day supply)					
<b>Deductible</b>	None	\$350 (tiers 3, 4, & 5)	\$350 (tiers 3, 4, & 5)	None	None
<b>Preferred Generic</b>	\$0 copay	\$7 copay	\$4 copay	\$3 copay	\$4 copay
<b>Generic</b>	\$10 copay	\$15 copay	\$12 copay	\$10 copay	\$12 copay
<b>Preferred Brand</b>	\$47 copay	\$47 copay	\$47 copay	\$40 copay	\$42 copay
<b>Non-Preferred Drug</b>	\$100 copay	\$100 copay	\$100 copay	\$90 copay	\$92 copay
<b>Specialty Tier</b>	33% of the cost	26% of the cost	26% of the cost	33% of the cost	33% of the cost
<b>Mail Order Available</b>	When ordering 90-day supply	When ordering 90-day supply	When ordering 90-day supply	When ordering 90-day supply	When ordering 90-day supply

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

## SUMMARY OF BENEFITS (SOB)

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

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-summary-of-benefits\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-summary-of-benefits_508.pdf)

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

<http://www.advantagemdgroup.com/>

## EVIDENCE OF COVERAGE (EOC)

For detailed information regarding a member's Evidence of Coverage (EOC), please click on one of the links to review the Advantage MD EOC's.

For Advantage MD HMO plan members:

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-hmo-001\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-hmo-001_508.pdf)

For Advantage MD HMO plan members (Baltimore City Residents):

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-hmo-002\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-hmo-002_508.pdf)

For Advantage MD PPO plan members:

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-ppo\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-ppo_508.pdf)

For Advantage MD PPO Plus plan members:

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-plus\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-plus_508.pdf)

For Advantage MD PPO Premier members:

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-premier\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-eoc-premier_508.pdf)

For Advantage MD Group plan members:

<http://www.advantagemdgroup.com/>

## PREAUTHORIZATION GUIDELINES

To verify benefit coverage, please call 877-293-5325. For detailed preauthorization information, please go to:

For Johns Hopkins Advantage MD HMO plan members:

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-pa-criteria-hmo\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-pa-criteria-hmo_508.pdf)

For Johns Hopkins Advantage MD PPO, PPO Plus, and Group plan members:

[https://www.hopkinsmedicare.com/wp-content/uploads/2020-pa-criteria-ppo\\_508.pdf](https://www.hopkinsmedicare.com/wp-content/uploads/2020-pa-criteria-ppo_508.pdf)

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

Providers can simply click on the JPAL link in [HealthLINK](#) to access this tool.

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

**Note:** JPAL is a way to look up preauthorization requirements only; it does not handle preauthorization requests. Please follow JHHC's policies and procedures as usual to request an authorization:

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

## EXCLUDED SERVICES





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

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

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

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

# ADVANTAGE MD IDENTIFICATION CARD SAMPLES

 <b>ADVANTAGE MD</b> <small>Johns Hopkins Medicine Medicare Plan</small>		Johns Hopkins Advantage MD (PPO)																
Member Name <b>F_NAME M_INIT L_NAME</b>		Effective Date: <b>MEIA_REQ_DT</b>																
Member ID: SBSB_ID Health Plan: H3890 001		<table border="1"> <thead> <tr> <th></th> <th>In Network</th> <th>Out-of-Network</th> </tr> </thead> <tbody> <tr> <td>Office Visit Copay:</td> <td>\$XX</td> <td>\$XX</td> </tr> <tr> <td>Specialist Copay:</td> <td>\$XX</td> <td>\$XX</td> </tr> <tr> <td>Urgent Care Copay:</td> <td>\$XX</td> <td>\$XX</td> </tr> <tr> <td>ER Copay:</td> <td>\$XX</td> <td>\$XX</td> </tr> </tbody> </table>			In Network	Out-of-Network	Office Visit Copay:	\$XX	\$XX	Specialist Copay:	\$XX	\$XX	Urgent Care Copay:	\$XX	\$XX	ER Copay:	\$XX	\$XX
	In Network	Out-of-Network																
Office Visit Copay:	\$XX	\$XX																
Specialist Copay:	\$XX	\$XX																
Urgent Care Copay:	\$XX	\$XX																
ER Copay:	\$XX	\$XX																
RxBIN: 004336 RxPCN: MEDDADV RxGRP: RX_GROUP		 																
 <b>ADVANTAGE MD</b> <small>Johns Hopkins Medicine Medicare Plan</small>		Customer Service (Members and Providers): 1-877-293-5325 TTY: 711																
<b>DO NOT BILL MEDICARE</b> Medicare limiting charges apply.		24-hour Nurse Chat Line: 1-888-202-8828																
Submit medical claims to: Johns Hopkins Advantage MD PO Box 3537 Scranton, PA 18505		For non-Medicare covered dental related inquiries, please contact DentaQuest: 1-844-231-8318																
Out-of-network fees may apply; for benefit information visit <a href="http://www.hopkinsmedicare.com">www.hopkinsmedicare.com</a> or call Customer Service.		Prior Authorization: 1-877-293-5325 Pharmacist Use Only: 1-866-693-4620																
Present this card at the time of service and with every prescription.																		

## ELIGIBILITY VERIFICATION

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

Please verify member eligibility by the following methods:

You must call the health plan to verify eligibility. Please call Customer Service at 877-293-5325.

You must call the health plan to verify eligibility. Please call Customer Service at 877-293-4998.

You can also verify eligibility through your HealthLINK account at <http://www.jhmc.com/advantagemd>. Click on the EHP/Priority Partners/Advantage MD Login page.

### Asking For the Member's Identification Card

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

## SILVER&FIT EXERCISE AND HEALTHY AGING PROGRAM

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

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

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



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

## TRUHEARING PROGRAM

TruHearing is an exclusive hearing aid savings program for Advantage MD Plus plan members. On average, members can save hundreds of dollars off the cost of a hearing aid. Members can visit any of over 4,800 TruHearing locations nationwide.

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

## Section 5 **PHARMACY PRESCRIPTION BENEFIT**



## PART D DRUG FORMULARY

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

Medications that are covered under the pharmacy benefit can be found online on the Advantage MD Pharmacy & Formulary page of our website at: [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/our\\_plans/advantage-md/pharmacy\\_formulary/](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/advantage-md/pharmacy_formulary/)

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

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

## FORMULARY COST SHARING TIERS

Every drug on the plan's formulary is in one of five cost-sharing tiers. .

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

Maintenance medication on Cost Sharing Tier 1 through Cost Sharing Tier 4 may be obtained for a 90-day supply. A three-month supply of maintenance medication on Tiers 1 and 2 are available at a reduced copay through CVS/caremark mail order and retail pharmacies. A three-month supply of maintenance medication on Tiers 3 and 4 are available at a reduced copay through CVS/caremark mail order only. Specialty Tier Drugs are limited to a 30-day supply at 33% co-insurance for HMO members and 26% for PPO members.

Advantage MD PPO members have a \$350 deductible on their Tier 3, Tier 4, and Tier 5 drugs. This means they pay the full cost of drugs on Tier 3, Tier 4, and Tier 5 until they reach the \$350 deductible. Once the \$350 deductible has been reached, the Cost Sharing Tiers above will apply.

The deductible does not apply to drugs on Tier 1 and Tier 2. The Cost Sharing Tiers above will apply from the beginning of the plan year for drugs on Tier 1 and Tier 2.

After the Deductible Stage (deductible applies for PPO only), the above Cost Sharing Tiers apply while the patient is in the Initial Coverage Stage. However, once their total drug costs for the year reach \$4,020 they move into the Coverage Gap Stage (donut hole). Please note, the Coverage Gap is different for PPO and HMO.

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

They remain in the Coverage Gap Stage until their out-of-pocket drug costs reach \$6,350. Then they move into the Catastrophic Coverage Stage where they would pay the larger amount of 5% of the cost of the drug or \$3.60 for a generic drug and \$8.95 for all other drugs. These numbers change on an annual basis per Center for Medicare and Medicaid Services (CMS) guidelines.

## PART D UTILIZATION MANAGEMENT

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

The following methods of Utilization Management are utilized:

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

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

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

## HOW TO FILE A COVERAGE DETERMINATION

A Coverage Determination (CD) is any decision that is made by or on behalf of a Part D plan sponsor regarding payment or benefits to which a member believes he or she is entitled. Coverage Determinations may be received verbally or in writing from the member's prescribing physicians. Fax Coverage Determination forms to 855-633-7673 or contact Customer Service at 877-293-5325 (option 2) for PPO and 877-293-4998 (option 2) for HMO.

The address is:

### **Johns Hopkins Advantage MD**

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

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

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

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

A provider will receive the outcome of a Coverage Determination by fax no later than seventy-two (72) hours after receipt for standard requests or receipt of the supporting statement, and no later than twenty-four (24) hours after receipt for urgent requests or receipt of the supporting statement. Unless approved, the following information will be provided: 1) the specific reason for the denial taking into account the member's medical condition, disabilities and special language requirements, if any; 2) information regarding the right to appoint a representative to file an appeal on the member's behalf; and 3) a description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process.

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

## HOW TO FILE A PART D APPEAL

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

Fax appeals to 855-633-7673 or call 877-293-5325 (option 2) for PPO and 877-293-4998 (option 2) for HMO.

The mailing address is:

**Johns Hopkins Advantage MD**

c/o CVS Caremark Part D Services Coverage Determination & Appeals Dept.

PO. BOX 52000 MC 109

Phoenix, AZ 85072-2000.

Please visit our website at [www.jhhc.com](http://www.jhhc.com) to obtain forms or to send your request electronically.

## TRANSITION POLICY

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

## PHARMACY NETWORK

Advantage MD uses CVS/caremark network of pharmacies that includes over 65,000 pharmacies nationwide including most home infusion, long-term care, and retail chain and independent pharmacies in Maryland. Changes to the pharmacy network may occur throughout the year and annually between plan years. Please visit our website to use our pharmacy locator to easily find participating pharmacies

## MAIL ORDER PHARMACY

One of the most important ways to improve the health of our members is to make sure they receive and take their medications as you prescribe. Our mail order pharmacy, CVS/caremark, can help. CVS/caremark sends a three-month supply of maintenance medications in one fill making it easier for the patient by only having to fill four times a year. In addition, a three-month supply of maintenance medication is available through CVS/caremark mail order at a reduced copay. This means your patient can fill a 90-day supply for only two times the retail copay—saving them an equivalent of four retail copays per year. Talk to your patients today about mail order pharmacy with CVS/caremark for better health and health care spending. Doctors and staff can contact CVS/caremark at 877-293-5325 (option 2) for PPO or 877-293-4998 (option 2) for HMO, 24 hours a day, 7 days a week.

## CUSTOMER SERVICE

For any Part D medication related inquiries or to find a pharmacy, please contact Customer Service toll-free at 877-293-5325 (option 2) for PPO or 877-293-4998 (option 2) for HMO, 24 hours a day, 7 days a week.

## PART B PRESCRIPTION DRUGS

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

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

Other drugs may be covered under Part B in certain limited situations. For Part B drugs and injectable medications provided incidental to a physician's service contact Customer Service toll-free at 877-293-5325 (option 1) for PPO or 877-293-4998 (option 1) for HMO for additional information.

## COVERED VACCINES

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

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

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine

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

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

Medicare Part D generally covers vaccines not available under Medicare Part B. For example, Medicare Part D covers the Shingles Vaccine (Shingrix) and Tdap Vaccine (Adacel and Boostrix). Medicare Part D vaccines are listed in the Advantage MD formulary.

Members may receive Part D vaccinations at either the pharmacy or the provider's office. Members pay differently depending on how and where they get the Part D vaccination.

Providers who do not have access to Part D vaccine on the formulary can call the prescription into a participating pharmacy. The member can either pick up the vaccine from the pharmacy and take it to the provider's office for administration, or the pharmacy can administer the vaccine to the member.

- If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the plan for processing and reimbursement. The member will be responsible for their coinsurance or copayment at the pharmacy.
- If the member takes the vaccine to the provider's office, the member is responsible for their coinsurance or copayment for the vaccine at the pharmacy and the entire cost of the administration at the provider's office. The member can then ask Advantage MD to pay our share of the administration cost by using the procedures that are described in Chapter 7 of the member's Evidence of Coverage (EOC). They will be reimbursed the amount they paid less their normal coinsurance or copayment for the administration of the vaccine less any difference between the amount the provider's office charges and what we normally pay.

Providers who have access to a Part D vaccine on the formulary can administer the Part D vaccine at the provider's office. However, when an Advantage MD member receives a Part D vaccination at the provider's office, the member is responsible for the entire cost of the vaccine and the cost of administration. The member can then ask Advantage MD to pay our share of the cost by using the procedures that are described in Chapter 7 of the member's EOC. They will be reimbursed the amount they paid less their normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the provider's office charges and what we normally pay.

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

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

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

## Patient Medication Adherence

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

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

## Medication Therapy Management

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

## Safety and Monitoring Program

Members with potential overutilization or inappropriate utilization of medications with the potential for high abuse and acetaminophen (APAP) toxicity are identified based on approved



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

## Drug Utilization Review (DUR)

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

### Concurrent Drug Utilization Review (cDUR)

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

- **Seven-day Opioid Naïve Edit**
  - > In the Center for Medicare and Medicaid Services (CMS) 2019 Call Letter, all Part D sponsors are required to implement a safety edit reject to limit initial opioid prescription fills for the treatment of acute pain to no more than a seven days supply. Therefore, if an opioid naïve patient attempts to fill more than a seven days supply of an opioid, the prescription will reject at the pharmacy.
  - > Exemptions to this are patients with a cancer diagnosis, residence in a Long-Term Care facility, Hospice, Palliative Care, and patients who are not opioid naïve.
  - > Pharmacies may request opioid prescribers to submit a Coverage Determination for prescriptions for opioid naïve members when days supply exceeds seven days.
- **Cumulative Morphine Milligram Equivalent (cMME) Edit (aka Care Coordination Edit)**
  - > This rejection will occur if the cMME dose is **greater than 90mg** and the Part D Enrollee has received opioid prescriptions from four or more prescribers in the previous 180 days.
  - > This rejection may be overridden by the pharmacist but they may contact the prescriber for confirmation or request prescribers to submit a Coverage Determination.
- **Duplicate Long-Acting Opioid Edit**
  - > This rejection will occur when prescribed drugs have the same therapeutic effects as medication(s) the Part D Enrollee is currently taking (i.e. member is filling two or more long-acting opioids).
  - > This rejection may be overridden by the pharmacist but they may contact the prescriber for confirmation.

- **Opioid/Benzodiazepine Drug Interaction Edit**

- > This rejection will occur when interacting drug combinations are identified (i.e. member is filling opioids and benzodiazepines).
- > This rejection may be overridden by the pharmacist but they may contact the prescriber for confirmation.

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

### **Retrospective Drug Utilization Review (rDUR)**

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

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

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

## PROVIDER REQUIREMENTS

Per CMS, effective January 1, 2019, Part D Prescribers must be enrolled in Medicare or have a valid opt-out affidavit on file with the applicable Medicare Administrative Contractor (MAC) to prescribe Part D drugs. For more information, visit the [CMS.gov Part D Prescriber Enrollment](https://www.cms.gov/PartD/PrescriberEnrollment) page at:

**[Go.cms.gov/PrescriberEnrollment](https://www.cms.gov/PrescriberEnrollment)**



Section 6  
**CARE MANAGEMENT**



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

Members will be screened by the Care Management staff for appropriate services upon enrolling in Advantage MD. Additionally, members may be screened upon referral for specialty care, admission to an inpatient facility, or upon referral by the member, provider or family.

## CARE MANAGEMENT

Johns Hopkins Advantage MD is committed to becoming the leader in care management population health solutions.

Our care management model promotes prevention skills, performs health risk identification, and manages member compliance to avoid costly treatments. We not only outreach to the sickest members to stabilize and manage conditions, we guide healthy members further along the prevention path. Through our four main service areas of Preventive, Complex, Transition, and Behavioral, we catch 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

## SERVICE AREAS

### Preventive Health

Services are provided to members showing a potential risk, an anticipated risk, or a known risk, with the intent to prevent that risk from becoming a significant care need. Includes health and wellness promotion such as exercise, nutrition and screenings, but these services are also designed to stabilize a member's health to prevent it from worsening.

Qualified health care professionals will provide assistance to help close gaps in care, which may include: annual wellness visits, screenings, monitoring labs to ensure therapeutic levels of a medication, earlier intervention, and engagement with a health care provider to proactively manage

a potential health exacerbation based on clinical indicators (i.e. elevated blood pressure and HbA1c that are not within range). Services include:

- Health maintenance and prevention reminders to promote self-management skills
- Health education
- Recommendations on how to manage and maintain overall health and wellness

## Complex Care

Complex care management is the intensive level of intervention in the population health continuum and provides care management services for members with one or more complex medical conditions and over or under utilization of health care services. Johns Hopkins Advantage MD recognizes that individuals often have two or more health problems that can be well served by evidence-based care management.

We provide services to adults with asthma, diabetes, cardiovascular conditions, chronic obstructive pulmonary disease, sickle cell, cancer, pain management, Alzheimer's, rehabilitative needs, HIV/AIDS, seizure disorders, developmental disabilities, chronic kidney disease and chronic lung disease.

Services include:

- Complex Care Management Assessment completed on all members
- Coordinate transitions of care that do not fit within the Transitional Care Services model
- Coordinate care with PCPs, specialists, DME/service providers
- Support self-management
- Address barriers and gaps in care by creating innovative solutions and involving community resources
- Assist with pharmacy preauthorizations, medical necessity reviews and quality of care referrals
- Education on signs and symptoms of worsening disease
- Identify appropriate level of care

## Transition of Care

Provided following a health event, such as a recent hospitalization, the diagnosis of an illness, a life-changing event, or a decision to receive long-term care services.

Designed to assist members and their loved ones with coordinating a set of clinical resources and navigating the complexities of the health care system. We call these services our Transition of Care program.

Services include:

- Coordination of durable medical equipment and supplies
- Medication management and reconciliation
- Appointments with providers (existing and newly identified)
- Understanding diagnosis
- Establish a relationship with providers

## Behavioral Health

For members living with a mental health condition such as depression, autism spectrum disorder, anxiety or addiction, we provide care management services. Advantage MD's benefits may include access to confidential care coordination support.

These clinicians use a unique team approach to assist you through your treatment needs. Services include coordination with all providers, treatment resources, and health coaching.

Advantage MD's behavioral health services can be obtained by calling 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m.

## OTHER SERVICES

### Health Coaching

The Health Coaching program is an evidence-based lifestyle management and disease prevention program. The target population includes members who have well managed chronic conditions or are at risk for developing chronic conditions.

Risk factors may include: hypertension, high cholesterol, obesity and pre-diabetes. The program focuses on the areas of smoking cessation, weight loss, nutrition, fitness and stress management. Improvements in these areas have been shown to reduce the frequency and length of hospitalizations and over the long term should reduce the incidence of chronic health conditions.

### Health Education

The health education program provides educational seminars to promote awareness of health, increase knowledge, and provide members with the skills and tools needed to improve their health.

Health educators plan, deliver, and evaluate behavior modification programs with the goal of improving overall health outcomes and reducing disability. In addition to offering awareness through health education tables, waiting room literature and bulletin boards, the health education staff also offers a catalog of classes specific to the needs of individual sites. These classes are developed and/or approved by nationally known institutes and associations, such as the National Institute of Aging, American Heart Association, American Diabetes Association, American Cancer Association and others.

Health coaching and health education services can be accessed by calling our Health Promotion and Wellness team at 800-957-9760.

## REFERRAL FOR CARE MANAGEMENT

Care Management services are voluntary and are provided at no cost to the member. Members identified with certain needs may be automatically enrolled, but are not obligated to participate in these programs. Providers wishing to initiate Care Management services can make a referral via email at [caremanagement@jhhc.com](mailto:caremanagement@jhhc.com) or by calling 410-762-5206 or 800-557-6916. Monday through Friday from 8 a.m. to 5 p.m. Voicemail messages received after normal business hours will be addressed the following business day.

All referrals must include:

- Name of member
- Date of birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within two business days.



Section 7  
**CLAIMS**





## CLAIMS SUBMISSION

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

The payor ID number for Advantage MD is 66003.

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

### **Johns Hopkins Advantage MD**

P.O. Box 3537  
Scranton, PA 18505

## TIMELY FILING

As an Advantage MD participating provider, you have agreed to submit all claims within 180 days of the date of service. Claims submitted with dates of service beyond 180 days are not reimbursable by Advantage MD.

## CLAIM FORMAT STANDARDS

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: <https://www.cms.gov/manuals/downloads/clm104c12.pdf>

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

## CLAIM PAYMENT

Advantage MD pays clean claims according to contractual requirements and CMS guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by Advantage MD or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Advantage MD, the claim is not considered clean.

## NON-PAYMENT OR CLAIM DENIAL

Any denials of coverage or non-payment for services by Advantage MD will be addressed on the provider's Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the RA. Per your contract, the member may or may not be billed for services denied by Advantage MD.

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

## PAYMENT DISPUTE PROCESS

- Provider payment disputes, such as requests for adjustment, must be submitted within 90 business days of the date of denial.

If a provider disagrees with the way a claim was processed, the provider may contact Customer Service at 877-293-5325 for PPO and 877-293-4998 for HMO, or send the request in writing to:

### **Johns Hopkins Advantage MD Payment Disputes**

P.O. Box 3537  
Scranton, PA 18505

Dispute decision is processed within 30 days.

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

- Corrected claim
- Rejected untimely filing of claim
- Coordination of benefits (EOB of primary carrier required)
- Itemized bill requested
- Invoice attached/MUE denial
- Overpaid/underpaid per contract
- Clinical review for medical necessity
- Administrative denial (must include documentation of extenuating circumstances to be reviewed)

Responses to itemized bill requests, submission of corrected claims and submission of COB/third-party liability information should also be sent with the **JH Advantage MD Participating Provider Post-Service Payment Dispute Submission Form**.

Providers will not be penalized for filing a payment dispute. To submit a payment dispute, complete the **Johns Hopkins Advantage MD Participating Provider Post-Service Payment Submission Form** located online at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/forms.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html) and mail to:

### **Johns Hopkins Advantage MD**

Payment Disputes  
P.O. Box 3537  
Scranton, PA 18505

Or fax to 855-206-9206

Johns Hopkins Advantage MD must receive the payment dispute within 90 business days of the denial of services for clinical and administrative denials or the initial 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, along with the JH Advantage MD Participating Provider Post-Service Payment Dispute Submission Form.

After research and determination of 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 Johns Hopkins Advantage MD systems, policies and contracts.

A determination will be sent to the provider within 45 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.

## COORDINATION OF BENEFITS (COB)

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

## GENERAL DEFINITIONS FOR COORDINATION OF BENEFITS AND SUBROGATION GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

## BASIC NAIC RULES FOR COB

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

## DUAL ELIGIBILITY BENEFICIARIES

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

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

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

For more information about dual eligible categories and benefits, please refer to the CMS website: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare\\_beneficiaries\\_dual\\_eligibles\\_at\\_a\\_glance.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf)



Section 8  
**APPEALS AND  
GRIEVANCE PROCESS**



## PARTICIPATING PROVIDERS

- A participating provider does not have appeal or grievance rights; however, if authorized by the member, a participating provider can file a pre-service appeal or grievance on their behalf.
- Authorization of Representative form must be completed and on file with Johns Hopkins Advantage MD.

## PROVIDER REQUEST FOR CLINICAL REVIEW

### **Clinical Review Request for Administrative Denial vs. Clinical Medical Necessity Denial**

A request for clinical review for a clinical/medical necessity or administrative denial is between the health care provider and Johns Hopkins Advantage MD for reason(s) including but not limited to:

- ER
- Observation
- Level of care
- Out of network
- Not a covered benefit
- Lack of authorization/authorization discrepancy
- Medical necessity
- Pre-service claims

### **Administrative Denial**

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 or lack of precertification.

Request for clinical review for administrative denials must address the reason for the denial (i.e., why precertification was not obtained) and all relevant extenuating circumstances).

If Johns Hopkins Advantage MD 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 Denials**

A request for clinical review of a medical necessity denial is the request for a review of an adverse decision. This includes requests to review adverse decisions of care denied before services are rendered (preservice) and care denied after services are rendered (post-service), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

Both requests for clinical review for an administrative or clinical/medical necessity denial 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, along with the **JH Advantage MD Participating Provider Post-Service Payment Dispute Submission Form**.

Clinical documentation relevant to the decision will be reviewed by a licensed/registered nurse. Established clinical criteria will be applied to the appeal. After 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 45 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 determination made by Johns Hopkins Advantage MD of these requests for clinical review of appeals are final and the provider has no further recourse for dispute.

Please fill out the JH Advantage MD Participating Provider Post-Service Payment Dispute Submission Form, which is available online at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/forms.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html).

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

### **Johns Hopkins Advantage MD**

P.O. Box 3537  
Scranton, PA 18505

Or fax to 855-206-9206

## **Precertification Determination Time Frames**

For services that require precertification, Advantage MD will make a determination in a timely manner so as not to adversely affect the health of the member. The determination will be made within 14 calendar days of the date of the initial request for standard requests. For urgent services, expedited decisions will be made within 72 hours. Per CMS, expedited organization determination is “when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee’s life, health, or ability to regain maximum function in serious jeopardy.”<sup>1</sup>

## **Utilization Management – Inpatient Services – Medical and Behavioral Health**

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

### **Inpatient Admission Notification Time Frames**

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

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



The following information should be provided to the Utilization Management department for precertification at our fax number: 844-240-1864

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

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

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

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

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

## **Specialist Referrals**

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

## **Inpatient Admission Review**

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

## Inpatient Concurrent Review

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

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

## Discharge Planning

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

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

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

## MEMBER APPEALS AND GRIEVANCES

All appeals and grievances received by Advantage MD Customer Service will be resolved in a timely manner. Inquiries that involve "appealable" issues will be routed through either the standard or expedited appeal process. In situations where a member is not in agreement with the resolution, the member must submit a written request for reconsideration. All other written correspondence received by Advantage MD will be documented and routed through the appropriate appeal or grievance channels.

Advantage MD members have the right to file a grievance. Situations for which a grievance may be filed include but are not limited to:

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

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

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

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

When requested by the health plan, providers must participate in the resolution of member grievances. Advantage MD may request an expedited response (24 hours to 5 calendar days, depending upon the urgency of the grievance) in order to ensure timely resolution of the member's grievance.



Section 9  
**QUALITY IMPROVEMENT**



The Johns Hopkins HealthCare (JHHC) Quality Improvement (QI) Program is designed to achieve the highest level of performance when compared to industry benchmarks. The QI Program is accountable to national benchmarks as evidenced by involvement with the National Committee for Quality Assurance (NCQA) accreditation and Healthcare Effectiveness Data and Information Set (HEDIS®) programs.

## MISSION OF THE QUALITY IMPROVEMENT PROGRAM

The JHHC QI Program activities support and promote the JHHC mission to improve the lives of our plan members by providing access to high quality, cost effective, member-centered health care. In addition, the JHHC QI Program supports the Johns Hopkins Medicine mission to improve the health of the community and the world by setting the standard of excellence in medical education, research, and clinical care. The JHHC QI Program uses nationally recognized measures of quality as follows:

- Agency for Healthcare Research and Quality (AHRQ)
- National Quality Forum (NQF)
- National Committee for Quality Assurance (NCQA) standards for quality and member safety

## CONTINUOUS QUALITY IMPROVEMENT

The QI Program functions within the Institute for Healthcare Improvement's Triple Aim Initiative framework ([www.ihl.org](http://www.ihl.org)) which requires development of quality improvement designs that simultaneously pursue the following three dimensions:

- Improve patient experience of care (including quality and satisfaction);
- Improve the health of populations; and
- Reduce the per capita cost of health care.

The QI program uses the Continuous Quality Improvement (CQI) and Lean Six Sigma models to guide the development and evaluation of initiatives to improve patient health, experience, and quality of care in alignment with the Triple Aim Initiative.

## QUALITY IMPROVEMENT PROGRAM GOALS

The Quality Improvement program goals are as follows:

- Be a high quality health plan as measured by CMS STARS
- Improve the quality and safety of clinical care and service, including behavioral health services provided to members
- Support and promote the Advantage MD mission to improve the lives of members by providing access to high quality and member-centered health care
- Promote utilization of the principles of CQI and Lean Six Sigma
- Utilize data, outcome studies and evidence-based criteria to analyze, monitor, evaluate, and report clinical quality and member safety

- Support programs and initiatives lead by other JHHC departments through the provision of quality data and analytics
- Serve a culturally and linguistically diverse membership through customer service and marketing lead activities
- Serve members with complex health needs through the care management and special needs programs
- Support coordination of activities and audits that demonstrate compliance with applicable regulatory and accreditation requirements

## MEMBER SAFETY PROGRAM

Advantage MD has embraced the innovative patient safety model developed by the Johns Hopkins Medicine Armstrong Institute of Patient Safety and Quality in order to promote quality improvement and patient safety activities. The Armstrong Institute is working to advance the science of safety and quality through an array of projects and initiatives. The Quality Improvement Director attends Armstrong Institute Quality Improvement and Patient Safety committees and shares information regarding patient outcomes (HEDIS<sup>®</sup> and CMS STARS), patient satisfaction, and patient safety trends.

The member safety program outlines Advantage MD's plan for monitoring quality of care, disparities of care, and tracking outcomes of QI initiatives and studies related to safety. Activities of the Member Safety Program include but are not limited to the following activities:

- Quality of care reviews (clinical, behavioral and pharmacy quality issues)
- Medical record chart audits of potential quality issues identified through Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator software
- Safety activities associated with accreditation and regulatory compliance oversight

When requested by the health plan, providers must participate in the quality care process. Advantage MD may request an expedited response (24 hours to 5 calendar days, depending on the urgency of the quality of care case) in order to ensure timely resolution.

## QUALITY IMPROVEMENT OBJECTIVES

QI objectives are developed annually as a result of the analysis of quality initiatives and studies. Additional objectives are developed throughout the year as needed and are based upon gap analysis of HEDIS<sup>®</sup>, Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>), Health Outcome Survey (HOS), CMS STARS, Behavioral Health Survey (ECHO), complaint data, and other quality-related data.

## HEDIS<sup>®</sup>, CAHPS<sup>®</sup>, HOS & STARS

HEDIS<sup>®</sup> measures performance on important dimension of care and service. HEDIS<sup>®</sup> consists of 58 high level measures with up to 133 total sub measures. This may vary from year to year. The QI Department coordinates all activities associated with the collection, validation, and submission

of HEDIS® data. JHHC has contracted with an NCQA-certified vendor to conduct external HEDIS® audit to ensure compliance with data collection processes and validation of data prior to submission. JHHC has Information Technology (IT) resources with strict controls allowing for the confidential transmission of data via Interactive Data Submission System (IDSS) tool to NCQA.

The CAHPS® survey is designed to capture information regarding member experience with network providers and health plan operations. Surveys are administered annually by an external NCQA-certified survey vendor per protocol as defined in the current HEDIS Specifications Volume 3.

The Health Outcomes Survey (HOS) is a survey that uses patient-reported outcomes over a 2.5 year time span to measure health plan performance. Each spring a random sample of Medicare beneficiaries are selected from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees and is surveyed. Two years later, these same members are surveyed again to collect follow up data. The survey measures if the beneficiaries are “better than expected”, “same”, or “worse than expected”.

The Centers for Medicare and Medicaid Services (CMS) developed the Star ratings system to evaluate Medicare Advantage (MA) and Prescription Drug Plan's (PDP) quality and performance. CMS' objectives for the Star ratings system include: to provide quality and performance information to Medicare beneficiaries, public reporting/transparency of data, identify potential audit candidates, and reward high quality plans and eliminate low performing plans. Star ratings are calculated based on data collected on performance measures drawn from the following sources: HEDIS, CAHPS, HOS, CMS administrative data and audits, and Part D measures.

The Star rating system for MA and PDPs is categorized into two parts, Part C and Part D.

## **Part C**

- Staying Healthy
- Managing Chronic (Long Term) Conditions
- Member Experience with the Health Plan
- Complaints, Access Problems and Improvement
- Customer Service

## **Part D**

- Drug Plan Customer Service
- Complaints Access Problems, and Improvement
- Member Experience with Drug Plan
- Drug Pricing and Patient Safety

Star measures are allocated a weight based on the classified category. Individual measures can be single-weighted, 1.5-weighted, or triple-weighted, with higher weight allocated to those measures that CMS deems most important. Triple-weighted measures are typically related to a health plan's ability to manage chronic illnesses and keep members healthy. Certain diseases appear in multiple measures.

# CHRONIC CARE IMPROVEMENT PROGRAM (CCIP) AND QUALITY IMPROVEMENT PROGRAM (QIP)

The CCIP will focus on the topic: Promote Effective Management of Chronic Disease. The program serves as the vehicle to improve care and health outcomes for enrollees with chronic conditions. The model used for this initiative is based on the Plan-Do-Study-Act (PDSA) quality improvement model.

The QIPs is an initiative that aims to improve health outcomes and/or enrollee satisfaction and address one or more of the CMS Quality Strategy Goals.

The Care Management Department has existing programs related to the required CCIP and QIP topics. Existing Care Management programs will be updated, as needed, in order to meet the requirements of the CCIP and QIP as required by the Medicare Managed Care Manual (Chapter 5, Section 20.1).

## QUALITY IMPROVEMENT INITIATIVES

A quality initiative is a focused action that is taken by the health care organization, provider or practitioner with the goal of improving the quality of health care services, access to care, and member health outcomes.

QI initiatives are identified through analysis of data that include, but are not limited to, the following areas:

- HEDIS® results
- Member Satisfaction Survey results (CAHPS®)
- HOS
- CMS STARs
- Quality of Care (QOC) reviews
- Provider Satisfaction Survey results
- Utilization Management data
- Pharmacy and medical claims data
- Member complaint data

Multiple factors are considered during initiative development to include the prospective impact to members, as well as the likelihood that measurable improvement will occur. In light of differences in the populations served across Maryland, the QI Department also considers national health care campaigns deemed significant and supported by the various regulatory agencies governing JHHC product lines (i.e. Department of Health and Human Services' Partnership for Patients and Million Hearts campaigns) during the initiative development process. QI initiatives and projects are routinely monitored and revised as appropriate through the QI Work Plan.



## QUALITY IMPROVEMENT ANNUAL PROGRAM DESCRIPTION AND WORK PLAN

The QI Work Plan is a dynamic document that reflects planned activities for the upcoming year in addition to objectives and goals related to those activities. The program description is updated annually, or more frequently, if necessary. The work plan is routinely evaluated and updated as recommended, by JHHC QI committees. Various departments at JHHC are responsible for action items in this work plan. Both the QI program description and work plan are approved annually through the Quality Improvement Committees, and then ultimately by the JHHC Board of Directors, and are submitted to regulatory agencies as required.

## QUALITY IMPROVEMENT PROGRAM EVALUATION

On an annual basis, a multidisciplinary team evaluates the outcomes of quality initiatives and studies and the overall effectiveness of the QI Program. The QI Evaluation is approved by QI Committees, with ultimate approval by the JHHC Board of Directors, and is submitted to regulatory agencies as required.

## PROVIDER'S ROLE

Providers are expected to cooperate with health plan quality improvement, patient safety, and performance improvement activities to improve the quality of care, quality of service, and member experience. Providers are also expected to allow the health plan to use performance data for the purposes of quality improvement initiatives. Examples of the provider's role in the health plan quality program include the following:

- Review quality reports and take action to improved clinical outcomes as measured by HEDIS® and CMS STARS
- Collaborate with the health plan to resolve member complaints regarding access to care, quality of care, provider service or other issues upon request
- Provide feedback on the health plan via provider satisfaction surveys
- Provide medical records as requested for HEDIS®, quality of care investigations, or other medical record audits
- Collect and share quality and performance data for the purposes of joint quality initiatives
- Participate in member satisfaction initiatives, including improving access to care
- Respond to quality of care complaints and provide requested medical records in an expedited manner depending upon the urgency of the complaint (24 hours to 5 calendar days)
- Participate in quality improvement committees upon request

A number of providers are invited to participate in quality improvement committees. Their perspective as participating providers is valuable in evaluating and improving clinical effectiveness, provider satisfaction and member satisfaction. Advantage MD also relies on participating providers to provide feedback on clinical practice guidelines, preventive health guidelines, medical policy and pharmacy policy.

If you are interested in obtaining additional information about the quality improvement program, including a copy of the full Quality Improvement program description, please contact your Provider Relations Network Manager.

Section 10  
**MEDICAL  
MANAGEMENT**



## MEDICAL MANAGEMENT

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

## MEDICAL MANAGEMENT PROGRAM GOALS

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

## MEDICAL MANAGEMENT DEPARTMENT FUNCTIONS

- Preauthorization
- Concurrent review
- Discharge planning
- Continuity of care
- Appeals

## CLINICAL REVIEW CRITERIA

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

## ACCESSIBILITY

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

## MEDICAL MANAGEMENT CONTACT INFORMATION

Phone 844-560-2856

Fax 855-704-5296

## BEHAVIORAL HEALTH CONTACT INFORMATION

Phone 844-340-2217

Fax 844-363-6772

## EMERGENCY SERVICES

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

# UTILIZATION MANAGEMENT PROCESS

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

## UTILIZATION MANAGEMENT

### Overview

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

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

### Criteria and Clinical Information for Medical Necessity

Johns Hopkins HealthCare LLC (JHCC) medical policies, which are publicly accessible on its website [www.jhcc.com](http://www.jhcc.com), are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for all JHCC lines of business.

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

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

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

- National and Local Coverage Determinations provided by Center of Medicare and Medicaid Services (CMS)
- JHHC medical policies
- McKesson InterQual

Advantage MD follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the For Providers section of the JHHC website at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/policies/](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/policies/)

These procedures apply to:

- Precertification
- Concurrent reviews
- Retrospective reviews

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

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

## Referral/Precertification Process

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

### Precertification and Notification — General

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

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

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

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

Services requiring precertification include but are not limited to:

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

To verify whether or not a particular service requires precertification, visit our website for the most recent [guidelines](#).

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

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

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.

### **Appointment of Representative**

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



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

## **Utilization Management – Outpatient Services – Medical and Behavioral Health**

### **Outpatient Precertification**

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

- Home health care
- Skilled nursing or extended care facilities
- DME
- Cardiac rehabilitation
- Outpatient diagnostic radiology
- Behavioral health IOP, PHP/TMS, or ECT

Please visit our website for the most recent **Outpatient Referral Guidelines**.

- In addition, for HMO plans, precertification is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider or for PPO members when the provider is requesting in network benefit.

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

### **Precertification Requirement Review and Updates**

Advantage MD will review and revise policies when necessary. The most current policies are available on the **JHHC website**.

## **INFORMATION USED TO MAKE UM DECISIONS**

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

- The procedure/treatment type/length of stay requested, procedure code(s) and diagnosis code(s)
- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychological history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers

- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- Individual clinical circumstances and history

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

## TIMELINESS OF UM DECISION MAKING

Timely UM decisions are critical for the safety and quality of care provided to our membership. Decisions are made in a timely manner to accommodate the urgency of the members' clinical situation, thereby minimizing disruption and/or delay to the provision of health care services. Timeliness standards for decision through notification for utilization management approvals and denials are outlined in Chapter 13 of the Medicare Managed Care Manual (CMS.gov).

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

## APPEALS PROCESS

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

## NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

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

The form may be found on the CMS website <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>



Section 11  
**COMPLIANCE**



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

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

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

## DISCRIMINATION AGAINST MEMBERS

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

In addition, Provider will not:

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

# FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES COMPLIANCE<sup>1</sup>

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

CMS defines an FDR as the following:

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

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

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

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

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

<sup>1</sup> Medicare Managed Care Manual Ch. 21 §40 (42 CFR 422.503(b)(4)(vi), 422.504(i), 422.504(b)(4)(vi), 422.505(i))

<sup>2</sup> Medicare Managed Care Manual Ch. 21 §50.6.6

## STANDARD OF CONDUCT<sup>3</sup>

Johns Hopkins Advantage MD requires that all FDRs, including Provider, supporting the Medicare Advantage and Part D Prescription Drug Program either adopt and abide by the Johns Hopkins Advantage MD Code of Conduct or implement a code of conduct that incorporates requirements consistent with Johns Hopkins Advantage MD's Code of Conduct. A copy of the Plan's Code of Conduct can be located in the Resource and Guidelines All Health Plan provider section of the JHHC website at: [http://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/).

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

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

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

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

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

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

## GENERAL COMPLIANCE AND FRAUD, WASTE AND ABUSE EDUCATION<sup>4</sup>

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

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

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

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

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

## REPORTING FWA<sup>5</sup>

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

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

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

<sup>5</sup> Medicare Managed Care Manual Ch. 21 §50.4 (42 CFR 422.503(b)(4)(vi)(D) and 423.504(b)(4)(vi)(D))



- Call the Department at 410-762-1575 or toll free at 844-697-4071;
- E-mail Johns Hopkins Advantage MD Compliance Department at: **MedicareCompliance@jhhc.com**; or
- Write to the Medicare Compliance Officer at:

**Johns Hopkins Advantage MD Compliance Department**

Attn: Medicare Compliance Officer

7231 Parkway Drive, Suite 100

Hanover, MD 210760

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

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

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

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

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

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

<sup>6</sup> Medicare Managed Care Manual Chapter 21 §20 Definitions and 18 USC §1347

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

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

## REPORTING OF OTHER COMPLIANCE CONCERNS<sup>8</sup>

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

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

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

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

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

<sup>7</sup> Medicare Managed Care Manual Chapter 21 Section 20

<sup>8</sup> Medicare Managed Care Manual Ch. 21 §50.4 (42 CFR 422.503(b)(4)(vi)(D) and 423.504(b)(4)(vi)(D))

## OIG AND GSA EXCLUSION SCREENING<sup>9</sup>

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

### SAM – [www.sam.gov](http://www.sam.gov)

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

### LEIE – <http://exclusions.oig.hhs.gov>

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

## OFFSHORING<sup>10</sup>

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

<sup>9</sup> Medicare Managed Care Manual Ch. 21 §50.6.8

<sup>10</sup> CMS HPMS Memos dated: July 23, 2007, September 20, 2007 and August 26, 2008: Regarding Offshoring of PHI Outside the United States (copies of memos are available on the Plan’s provider [http://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/))

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

## MEDICAL RECORD DOCUMENTATION

Provider must maintain members' medical record documentation in a manner that is current, detailed, organized, promotes effective and confidential patient care and quality review, and meets generally accepted standards and established goals for medical record keeping. To access and review the Plan's Medical Record Documentation Policy in its entirety to which Provider is subject, please click on the following hyperlink: [http://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/)

## RECORD RETENTION AND INSPECTION OF RECORDS FOR AUDIT PURPOSES<sup>11, 12</sup>

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

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

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

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

<sup>11</sup> Medicare Managed Care Manual Ch. 21 §50.3.2 §50.6.11 and Ch. 3 §100.4

<sup>12</sup> Medicare Managed Care Manual Ch. 21 §50.6.6

## CMS MEDICARE ADVANTAGE PROGRAM AUDITS<sup>13</sup>

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

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

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

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

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

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

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

<sup>13</sup> Medicare Managed Care Manual Ch. 21 §50.6.11

## CONFIDENTIALITY

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



Section 12  
**HEALTH PLAN  
RESPONSIBILITIES**



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

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

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

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

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

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

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

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



## ANTI-DISCRIMINATION

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

## ADVICE TO MEMBERS

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

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

**ADVANTAGE MD**  
Johns Hopkins Medicine Medicare Plan



Customer Service: 877-293-5325

[www.hopkinsmedicare.com](http://www.hopkinsmedicare.com)