UNIVERSITY of MARYLAND
HEALTH PARTNERS

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Provider Manual

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Introduction to the Provider Manual

HealthChoice is Maryland's Medicaid managed care program. Overseen by the Maryland Department of Health (MDH), the HealthChoice program serves most Medicaid participants. These individuals are enrolled in one of the participating managed care organizations (MCOs). Each MCO has policies and procedures that providers who deliver services to members must adhere to. While each MCO has its own policies and procedures, many program elements apply to all providers, regardless of the MCO. The purpose of this manual is to explain those program elements and be a useful reference for providers who participate in the HealthChoice program.

The manual is divided into six sections:

Section I - General Information. This section provides general descriptive information on the HealthChoice program including, but not limited to, program eligibility, MCO reimbursement policies, continuity of care and transportation.

Section II - Provider Responsibilities. This section discusses expectations of all providers, regardless of MCO affiliation.

Section III - HealthChoice Benefits and Services. This section provides a listing of the benefits that are and are not the responsibility of all MCOs that participate in HealthChoice. This section briefly outlines some of the optional benefits that University of Maryland Health Partners may provide. This section also identifies benefit limitations and services that are not the responsibility of University of Maryland Health Partners.

Section IV - Rare and Expensive Case Management (REM). Members with certain diagnoses may disenroll from University of Maryland Health Partners and receive their services through the REM program. This section details the REM program.

Section V - MDH Quality Improvement Program and MCO Oversight Activities. MDH conducts numerous quality improvement activities for the HealthChoice program. This section reviews DHMH's quality improvement activities. These activities are separate from quality improvement activities that University of Maryland Health Partners may engage in.

Section VI - Corrective Managed Care. This section discusses the steps that should be taken if a member is determined to have abused MCO pharmacy benefits.

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Section I
General Information

The Maryland HealthChoice Program

HealthChoice is Maryland's Medicaid managed care program. Almost three-quarters of the Medicaid population and the Maryland Children's Health Program (MCHP) are enrolled in this Program. The HealthChoice Program's philosophy is based on providing quality cost-effective and accessible health care that is patient-focused.

HealthChoice Eligibility

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

- Individuals who receive Medicare;
- Individuals age 64 1/2 or over;
- Individuals who are eligible for Medicaid under spend down;
- Medicaid participants who have been or are expected to be continuously institutionalized for; more than 30 successive days in a long term care facility or in an institution for mental; disease (IMD);
- Individuals institutionalized in an intermediate care facility for persons with intellectual disabilities (ICF-MR);
- Participants enrolled in the Model Waiver;
- Participants who receive limited coverage, such as women who receive family planning; services through the Family Planning Waiver, or Employed Individuals with Disabilities Program;
- Inmates of public institutions, including a State operated institution or facility;
- A child receiving adoption subsidy who is covered under the parent's private insurance;
- A child under State supervision receiving adoption subsidy who lives outside of the State; or
- A child who is in an out-of-State placement.

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

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

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

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

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

Provider Reimbursement

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

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

University of Maryland Health Partners is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid participant's enrollment in our MCO. We are however, responsible for reimbursement to providers for professional services rendered during the remaining days of the admission.

University of Maryland Health Partners Medical Record Documentation

University of Maryland Health Partners has adopted the National Committee for Quality Assurance (NCQA) guidelines for medical record documentation as the required minimal standards for complete and accurate medical record reporting.

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.

3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under - or overutilization of consultants.
17. If a consultation is requested, there a note from the consultant in the record.
18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. Hospital discharge summaries.
21. A list of current medications and dosages.
22. Emergency care received.
23. Documentation, if available, of a member's executed advance directives.
24. Other aspects of care, including ancillary services.
25. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).

26. There is evidence that preventive screening and services are offered in accordance with the University of Maryland Health Partners's practice guidelines.

Records Storage and Release of Medical Records

Providers shall maintain medical records for University of Maryland Health Partners members for a minimum of ten (10) years after the medical record is made. Paper medical records shall be located in an office with access restricted to authorized staff; electronic medical records shall be on a computer or other device with appropriate security such as passwords or data encryption. Members are to be forwarded copies of their medical records upon written request.

Self-Referred and Emergency Services

University of Maryland Health Partners will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility;
- Family planning services except sterilizations;
- School-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. A school based health center reporting form can be found at the end of this section;
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in an MCO;
- Initial medical examination for children in state custody;
- Annual Diagnostic and Evaluation services for members with HIV/AIDS;
- Renal dialysis provided at a Medicare-certified facility;
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge; and
- Services performed at a birthing center, including an out-of-state center located in a contiguous state.

Self-Referred Services for Children with Special Healthcare Needs

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

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

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

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

Primary Care Provider (PCP) Contract Terminations

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

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

Continuity of Care

As part of the HealthChoice Program design, we are responsible for providing ongoing treatments and patient care to new members until an initial evaluation is completed and we develop a new plan of care.

The following steps are to be taken to ensure that members continue to receive necessary health services at the time of enrollment into University of Maryland Health Partners:

- Appropriate service referrals to specialty care providers are to be provided in a timely manner.
- Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those that the member was receiving upon enrollment into University of Maryland Health Partners are to be continued during this transition period.
- If, after the member receives a comprehensive assessment, we determine that a reduction in or termination of services is warranted, we will notify the member of this change at least 10 days before it is implemented. This notification will tell the member that he/she has the right to formally appeal to the MCO or to the Department by calling the MCO or the HealthChoice Member Help Line at 1-800-284-4510. In addition, the notice will explain that if the member files an appeal within ten days of our notification, and requests to continue receiving the services, then we will continue to provide these services until the appeal is resolved. You will receive a copy of this notification.

- MCOs must adhere to the continuity of care requirements outlined in The Maryland Insurance Administration's Bulletin 14-22 http://www.mdinsurance.state.md.us/sa/news-center/life--health-bulletins-current-2006.html

Specialty Referrals

- We will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits as required by COMAR 10.09.66 and 10.09.67.
- If a specialty provider cannot be identified contact us at (410-779-9359 / 800-730-8543) or the Provider Hotline (800-766-8692) for assistance.

Transportation

You may contact the Local Health Department (LHD) to assist members in accessing non-emergency transportation services. University of Maryland Health Partners will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.

Members Rights and Responsibilities

Members have the right to:

- Be treated with respect to your dignity and privacy by health care providers, their staff and all individuals employed by University of Maryland Health Partners.
- Receive information, including information on treatment options and alternatives regardless of cost or benefit coverage, in a manner you can understand.
- Take part in decisions about your health care; including the right to refuse treatment. If you are under 18 and married, pregnant or have a child, you can expect that you will be able to participate in and make decisions about your and/or your child's health care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Talk to your Primary Care Provider about your medical record, request and get a copy of your medical records; or ask that these records be amended or changed as allowed.
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Exercise your rights and to know that the use of those rights will not badly affect the way that University of Maryland Health Partners or our providers treat you.
- File appeals and grievances with us about our organization or the care we provide, including requesting an independent review of a decision to deny or limit coverage.
- File appeals and grievances with the State.
- Receive a State fair hearing.
- Request that ongoing benefits be continued during an appeal or state fair hearing however, you may have to pay for the continued benefits if our decision is upheld in the appeal or hearing.
- Know you or your provider cannot be penalized for filing a grievance or appeal.
- Get a second opinion from a UMHP provider or arrange for a second opinion from a doctor outside the network if you do not agree with your doctor's opinion about the services that you need. Call us at 1-410-779-9369 or 1-800-730-8530 for help with this. TTY users should call 711.
- Have information about how University of Maryland Health Partners is managed, including our services, policies and procedures, providers, and member rights and responsibilities, and any changes made. Call us at 1-410-779-9369 or 1-800-730-8530 for help with this. TTY users should call 711.
- Make recommendations regarding our member rights and responsibilities.

- Expect that your records and communications will be treated confidentially and not released without your permission.
- Choose your own Primary Care Provider, choose a new Primary Care Provider and have privacy during a visit with your Primary Care Provider.
- Get help from someone who speaks your language.

Members have the responsibility to:

- Be involved in your health care and work with your doctors about recommended care.
- Understand your health problems and participate in developing mutually agreed upon treatment goals.
- Call University of Maryland Health Partners if you have a problem or concern with your health care services and need help.
- Tell your doctor as soon as possible after you get emergency treatment.
- Treat your providers, their staff and University of Maryland Health Partners employees with respect and dignity.
- Tell your doctor about your symptoms and problems and ask questions when you do not understand.
- Follow the instructions and plan of care agreed upon by you and your provider(s).
- Talk to your providers about any problems you may have in following their directions.
- Cooperate with your doctors and University of Maryland Health Partners to the extent possible, supply the information needed in order to provide care.
- Call University of Maryland Health Partners before seeing a new Primary Care Provider and let us know that you would like to change your Primary Care Provider.
- Make and keep appointments and be on time. Always call if you need to cancel an appointment or if you will be late.

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**	
Student Name: **DOB:** **MA Number:** **SS Number:**	**Date of Visit:** **Type of Visit:** ☐ **Acute/Urgent** ☐ **Follow Up** ☐ **Health Maintenance**	**ICD-9 Codes**
Provider Name/Title:		**CPT Codes**
T: P: RR: BP: PF: PaO2: Hgt: Wgt: BMI: Rapid Strep Test: - Hgb: BGL: U/A:	**Drug Allergy:** ☐ **NKDA**	
	Current Medications:	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable** ☐ **See health history** ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, +landmarks, +light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent:

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
☐ Normal dentition without caries
☐ Pertient:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:
Labs Ordered:
Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

DHMH 7/2009/ch

For MCO formulary info, find MCO website at: http://dhmh.state.md.us/mma/healthchoice/

Section II

Provider Responsibilities

Reporting Communicable Disease

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

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

- The provider report must identify the disease or suspected disease and demographics on the member including the name age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH1140) as directed by COMAR 10.06.01.
- With respect to patients with tuberculosis, you must:

    - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.

    - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by MDH.

Other Reportable Diseases and Conditions

- A single case of a disease of known or unknown etiology that may be a danger to the public health, as well as unusual manifestation(s) of a communicable disease, are reportable to the local health department.
- An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.

Reportable Communicable Diseases - Laboratory Providers

Providers of laboratory services must report positive laboratory results as directed by Health - General Article §18-205, Annotated Code of Maryland.

In order to be in compliance with the Maryland HIV/AIDs reporting Act of 2007, Laboratory providers must report HIV positive members and all CD4 test results to the Health Department by using the member's name. The State of Maryland HIV/ CD4 Laboratory Report Form MDH 4492 must be used. The reporting law and the revised reporting forms may be found at the following website:

https://phpa.health.maryland.gov/IDEHASharedDocuments/what-to-report/MD_Lab_Reporting_Form_rev0507.pdf

Laboratories that perform mycobacteriology services located within Maryland, must report all positive findings to the Health Officer of the jurisdiction in which the laboratory is located. For out-of-state laboratories licensed in Maryland and performing tests on specimens from Maryland, the laboratory may report to the Health Officer of the county of residence of the patient or to the Maryland MDH, Division of Tuberculosis Control within 48 hours by telephone (410) 767-6698 or fax (410) 669-4215.

We cooperate with LHDs in investigations and control measures for communicable diseases and outbreaks.

Appointment Scheduling and Outreach Requirements

In order to ensure that HealthChoice members have every opportunity to access needed health related services, In addition to the MCOs, PCPs must develop collaborative relationships with the following entities to bring members into care:

- University of Maryland Health Partners
- Specialty care providers; and
- The Local Health Department's Administrative Care Coordination Units (ACCU)

Prior to any appointment for a HealthChoice member you must call EVS at 1-866-710-1447 to verify their eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.

The Centers for Medicare/Medicaid (CMS), prohibits providers from billing Medicaid participants including for missed appointments.

Initial Health Appointment for HealthChoice Members

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

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

- For pregnant and post-partum women who have not started to receive care, the initial health visit must be scheduled and the women seen within 10 days of a request.

- As part of the enrollment process the State conducts a Health Services Needs assessment as described in 10.09.63.03. A member who has an identified need must be seen for their initial health visit within 15 days of University of Maryland Health Partners's receipt of the completed Health Risk Assessment (HRA).

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the member, or laboratory findings indicate possible substance use disorder, you are to refer the member to the Behavioral Health System.

We will, before referring an adult member to the local health department, make documented attempts to ensure that follow-up appointments are scheduled in accordance with the member's treatment plan by attempting a variety of contact methods, which may include written correspondence, telephone contact and face-to-face contact.

Services for Children

For children younger than 21 years old, we shall assign the member to a PCP who is certified by the EPSDT Program, unless the member or member's parent, guardian, or care taker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified. In this case the non-EPSDT provider is responsible for ensuring that the child receives well childcare according to the EPSDT schedule.

Wellness Services for Children Under 21 Years

Providers shall refer children for specialty care as appropriate. This includes:

- Making a specialty referral when a child is identified as being at risk of a developmental delay by the developmental screen required by EPSDT; is experiencing a delay of 25% or more in any developmental area as measured by appropriate diagnostic instruments and procedures; is manifesting atypical development or behavior; or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; and
- Immediately referring any child thought to have been abused physically, mentally, or sexually to a specialist who is able to make that determination.

You are to follow the rules of the Maryland Healthy Kids Program to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The Program requires you to:

- Notify members of their due dates for wellness services and immunizations**.**
- Schedule and provide preventive health services according to the State's EPSDT Periodicity Schedule and Screening Manual.

- Refer infants and children under age 5 and pregnant teens to the Supplemental Nutritional Program for Women Infants and Children (WIC). Provide the WIC Program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. When new vaccines are approved by the Food and Drug Administration, the VFC Program is not obligated to make the vaccine available to VFC providers. Therefore, under the HealthChoice formulary requirement (COMAR 10.09.67.04D(3)), we will pay for new vaccines that are not yet available through the VFC.

Members under age 21 are eligible for a wider range of services under EPSDT than the adult population. PCPs are responsible for understanding these expanded services (see Section III Benefits) so that appropriate referrals are made for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

Appointments must be scheduled at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

Healthy Kids (EPSDT) Outreach and Referral to LHD

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

For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, care givers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care:

- Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, by telephone, and through face-to-face contact.
- Notify our case management unit at **410-779-9359 or 800-730-8543** for assistance with outreach as defined in the Provider Agreement.
- Schedule a second appointment within 30 days of the first missed appointment.
- Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by making a referral to the ACCU of the LHD. Use the Local Health Services request form (See https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx
- After referring to the ACCU, work collaboratively with the ACCU and University of Maryland Health Partners to bring the child into care. This collaborative effort

will continue until the child complies with the EPSDT periodicity schedule or receives appropriate follow-up care.

Special Needs Populations

The State has identified certain groups as requiring special clinical and support services from their MCO. These special needs populations are:

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

Services Every Special Needs Population Receives

In general, to provide care to a special needs population, it is important for the PCP and Specialist to:

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

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

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps

members find information about their condition or suggests places in their area where they may receive community services and/or referrals.
- All of our providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special Needs Population - Outreach and Referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care may be referred to the local health department for specific outreach efforts, according to the process described below.

If the PCP or specialist finds that a member continues to miss appointments, University of Maryland Health Partners must be informed. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the local health department in the jurisdiction where the member lives.

Within 10 days of either the third consecutive missed appointment, or you becoming aware of the patient's repeated non-compliance with a regimen of care, whichever occurs first, you should make, a written referral to the LHD ACCU using the Local Health Services Request Form (See https://mmcp.dhmh.maryland.gov/pages/Local-Health-Services-Request-Form.aspx). The ACCU will assist in locating and contacting the member for the purpose of encouraging them to seek care. After referral to the ACCU, University of Maryland Health Partners and our providers will work collaboratively with the ACCU to bring the member into care.

Services for Pregnant and Post-Partum Women

University of Maryland Health Partners and our providers are responsible for providing pregnancy-related services, which include:

- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment (MPRA) form
- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Development of an individualized plan of care, which is based upon the risk assessment and is modified during the course of care if needed;
- Case management services;
- Prenatal and postpartum counseling and education;
- Basic nutritional education;
- Special substance abuse treatment including access to treatment within 24-hours of request and intensive outpatient programs that allow for children to accompany their mother;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women;

- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers;
- Post-partum home visits;
- Referral to the ACCU.

The PCP, OB/GYN and University of Maryland Health Partners are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC) and the local health departments' ACCU. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Pregnancy-related service providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times.

You must:

- Schedule prenatal appointments in a manner consistent with the ACOG guidelines.
- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850 (sample attached) for each pregnant member and submit it to the Local Health Department in the jurisdiction in which the member lives within 10 days of the initial visit.
- For pregnant members under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for members who miss prenatal appointments.
- Refer to the WIC Program.
- Refer pregnant and postpartum members who are in need of treatment for a substance use disorder for appropriate substance abuse assessments and treatment services through the Behavioral Health System.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct pregnant members to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit.
- Instruct the pregnant member to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant member's choice of pediatric provider in the medical record.
- Advise pregnant member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", MDH 1184 and get the newborn enrolled in HealthChoice.

MARYLAND PRENATAL RISK ASSESSMENT

REFER TO INSTRUCTIONS ON BACK BEFORE STARTING

Date of Visit: ____/ _____/ _____

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

Provider NPI#: __ __ __ __ __ __ __ __ __ __ Site NPI#: __ __ __ __ __ __ __ __ __ __

Client Last Name: _____ First Name: _____ Middle:

House Number: _____ Street Name: _____ Apt: _____ City: _____ County

(If patient lives in Baltimore City, leave blank): _____ State: _____ Zip Code: _____ Home

Phone #: _____-___-_____ Cell Phone#: _____-____-_____ Emergency Phone#: _____- _____-_

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

Name/Relationship

Race:

___ African-American or Black
___ Alaskan Native ___ American Native
___ Asian More than 1 race
___ Native Hawaiian or other Pacific Islander
___ Unknown ___ White

Language Barrier? ___ Yes ___ No

Specify Primary Language _____

Hispanic? ___ Yes ___ No

Marital Status:

___ Married ___ Unmarried ___ Unknown

Payment Status (Mark all that apply):

_____ Private Insurance, Specify:
_____ MA/HealthChoice
MA #:
Name of MCO (if applicable): _____
_____ Applied for MA Specify Date: ____ /____ /
_____ Uninsured

Educational Level

Highest grade completed: _____ GED? ___ Yes ___ No

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

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

Other source of prenatal care: _____

Trimester of 1st prenatal visit: ___1st _____2nd ____3rd

LMP: _____/ _____/ _____Initial EDC: _____/ _____/ _____

Complete all that apply

_____# Full-term live births
_____# Pre-term live births
_____# Prior LBW births
_____# Spontaneous abortions
_____# Therapeutic abortions
_____# Ectopic pregnancies
_____# Children now living

Check all that apply

____History of pre-term labor
____History of fetal death (> 20 weeks)
____History of infant death w/in 1 yr of age
____History of multiple gestation
____History of infertilitly treatment
____First pregnancy

Psychosocial Risks: Check all that apply.

_____Current pregnancy unintended
_____Less than 1 year since last delivery
_____Late registration (more than 20 weeks gestation)
_____Disability (mental/physical/developmental), Specify _____
_____History of abuse/violence within past 6 months
_____Tobacco use, Amount _____
_____Alcohol use, Amount _____
_____Illegal substances within past 6 months
_____Resides in home built prior to 1978, ____Rent _____Own
_____Homelessness
_____Lack of social/emotional support
_____Exposure to long-term stress
_____Lack of transportation
_____Other psychosocial risk (specify in comments box)
_____None of the above

COMMENTS ON PSYCHOSOCIAL RISKS:

Medical Risks: Check all that apply.

Current Medical Conditions of this Pregnancy:

_____Age ≤15
_____Age ≥ 45
_____BMI < 18.5 or BMI > 30
_____Hypertension (> 140/90)
_____Anemia (Hgb < 10 or Hct < 30
_____Asthma
_____Sick cell disease
_____Diabetes: Insulin dependent ___Yes _____No
_____Vaginal bleeding (after 12 weeks)
_____Genetic risk: specify _____
_____Sexually transmitted disease, Specify _____
_____Last dental visit over 1 year ago
_____Prescription drugs
_____History of depression/mental illness, Specify_____
Depression assessment completed? ___Yes _____No
_____Other medical risk (specify in comment box)

COMMENTS ON MEDICAL RISKS:

Form Completed By: _____

Date Form Completed: ____/ _____/ _____

DO NOT WRITE IN THIS SPACE

9005

Maryland Prenatal Risk Assessment Form Instructions

Purpose of Form: **Identifies pregnant woman who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by public health nurses and social workers through the local health departments. Services may include resource linkage, psychosocial/environmental assessment, reinforcement of the medical plan of care, and other related services.**

Form Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for ALL pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

NEW - Enter both the provider and site/facility NPI numbers.
Print clearly; use black pen for all sections. Press firmly to imprint.
White-out previous entries on original completely to make corrections.

If client does not have a social security number, indicate zeroes.
Indicate the person completing the form.

Review for completeness and accuracy.

Faxing and Handling Instructions:

Do not fold, bend, or staple forms. ONLY PUNCH HOLES AT TOP OF FORM IF NECESSARY. Store forms in a dry area.

Fax the MPRAF to the local health department in the client's county of residence. To reorder forms call the local **ACCU**.

Definitions (selected): Data may come from self-report, medical records, provider observation or other sources.

DEFINITIONS	
Alcohol use	Is a "risk-drinker" as determined by a screening tool such as
Current history of abuse/violence	Includes physical, psychological abuse or violence within the client's environment
Exposure to long-term stress	For example: partner-related, financial, safety, emotional
Genetic risk	At risk for a genetic or hereditary
Illegal substances	Used illegal substances within the past 6 months (e.g. cocaine, heroin,
Lack of social/emotional support	Absence of support from family/friends. Isolated
Language barrier	In need of interpreter, e.g. Non-English speaking,
Oral Hygiene	Presence of dental caries, gingivitis, tooth loss
Preterm live birth	History of preterm birth (prior to the 37th gestational
Prior LBW birth	Low birth weight birth (under 2,500 grams)
Sickle cell disease	Documented by medical
Tobacco use	Used any type of tobacco products

Client's Local Health Department Addresses (rev 03/2014) (FAX to the ACCU in the jurisdiction where the client resides)

Mailing Address	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 1 Harry S. Truman Parkway, Ste 200 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU HealthChare Access Maryland 201 E. Baltimore St, Ste. 1000 Baltimore, MD 21202	410-649-0526 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887- 4381 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd, P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St., P.O. Box 10 Denton, MD 21629	410-479-8023 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, P. O. Box 845 Westminster, MD 21158-0845	410-876-4940 Fax: 410-876-4959
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5145 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway, P.O. Box 1050 White Plains, MD 20695	301-609-6803 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-228-3223 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3341 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7692 Fax: 301-334-7771
Harford County ACCU 34 N. Philadelphia Blvd. Aberdeen, MD 21001	410-273-5626 Fax: 410-272-5467
Howard County ACCU 7180 Columbia Gateway Dr. Columbia, MD 21044	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7039 Fax: 410-778-7019
Montgomery County ACCU 1335 Piccard Drive, 2nd Floor Rockville, MD 20850	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9201 Basil Court, Room 403 Largo, MD 20774	301-883-7231 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4481 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St., P.O. Box 316 Leonardtown, MD 20650-0316	301-475-4951 Fax: 301-475-4350
Somerset County ACCU 7920 Crisfield Highway Westover, MD 21871	443-523-1740 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6568
Worcester County ACCU 9730 Healthway Dr. Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

Dental Care for Pregnant Members

Dental services for pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 1-888-696-9596 if you have questions about dental benefits.

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:

- A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care, unless the 48 hour (uncomplicated vaginal delivery) / 96 hour (uncomplicated cesarean section) length of stay guaranteed by State law is longer than that required under the Guidelines.
- If a member must remain in the hospital after childbirth for medical reasons, and she requests that her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.
- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by State law, a home visit must be provided.
- When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Post-natal home visits are to be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn, and must include:

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

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

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

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Children with Special Health Care Needs

University of Maryland Health Partners will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers as specified in the special provisions and guidelines detailed on Page 7 of Section I.
- Log any complaints made to the State or to University of Maryland Health Partners about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the State's HealthChoice Help Line.
- Work closely with the schools that provide education and family services programs to children with special needs.
- Ensure coordination of care for children in State-supervised care. If a child in State-supervised care moves out of the area and must transfer to another MCO, the State and University of Maryland Health Partners will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

Children with HIV/AIDS are eligible for enrollment in the REM Program. All other individuals with HIV/AIDS are enrolled in one of the HealthChoice MCOs.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care. To qualify as an HIV/AIDS specialist, a health care provider must meet the criteria specified under COMAR 10.09.65.10.B.
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance abuse treatment within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.
- The LHD will designate a single staff member to serve as a contact. In all instances, providers will maintain the confidentiality of client records and eligibility information, in accordance with all Federal, State and local laws and regulations, and use this information only to assist the participant in receiving needed health care services.

Case management services are covered for any member who is diagnosed with HIV. These services are to be provided, with the member's consent, to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected members with the full range of benefits (e.g. primary mental health care, and somatic health care services), as well as referral for any additional needed services, including, behavioral health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:

- Initial and ongoing assessment of the member's needs and personal support systems, including using a multi-disciplinary approach to develop a comprehensive, individualized service plan;
- Coordination of services needed to implement the plan;
- Periodic re-evaluation and adaptation of the plan, as appropriate; and
- Outreach for the member and their family by which the case manager and the PCP track services received, clinical outcomes, and the need for

additional follow-up.

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

If a member initially refuses HIV case management services, the services are to be available at any later time if requested by the member

Individuals with Physical or Developmental Disabilities

Before placement of an individual with a physical disability into an intermediate or long-term care facility, University of Maryland Health Partners will assess the needs of the individual and the community as supplemented by other Medicaid services. We will conduct a second opinion review of the case, performed by our medical director, before placement. If our medical director determines that the transfer to an intermediate or long-term care facility is medically necessary and that the expected stay will be greater than 30 days, we will obtain approval from the Department before making the transfer.

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

University of Maryland Health Partners contracts with Language Service Associates to provide interpreter services for American Sign Language during office visits. Interpreter service can be arranged by contacting University of Maryland Health Partners's Member Services Department at 800-730-8543. Interpreter service is at no charge to you or to the member. Telephone assistance is provided by Telecommunication Relay Services. You can access them by calling 711 then provide the member's telephone number.

Individuals who are Homeless

If an individual is identified as homeless, we will provide a case manager to coordinate health care services.

Adult Members with Impaired Cognitive Ability / Psychosocial Health History

Support and outreach services are available for adult members needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

University of Maryland Health Partners Support Services (Outreach)

A University of Maryland Health Partners Member Services representative places a welcome call to all new members and conducts an initial health risk assessment. During the welcome call, the representative encourages the member to schedule their initial appointment with their PCP and helps them make the appointment if needed. University of Maryland Health Partners sends reminders for periodic preventive health appointments. On a monthly basis, University of Maryland Health Partners will provide PCPs with a list of members due for preventive visits. Case managers also provide outreach to Special Needs members to ensure that the clinical and psychosocial needs of the member are met. Refer to the Special Needs Population sections in this manual for details.

Providers should contact University of Maryland Health Partners for assistance with reaching non-compliant members and those members that are difficult to reach. University of Maryland Health Partners's outreach resources work collaboratively with the LHD and the provider to bring members into care.

Requests for outreach services may be submitted telephonically or by faxing a request:

Phone 1-800-730-8543 / 410-779-9359 Fax 410-779-9336

A case manager coordinates services among the member, PCP, specialists, and other healthcare vendors. Services are arranged in a manner that is consistent with covered benefits and services, and regularly monitored to ensure timely delivery.

University of Maryland Health Partners – Referral Authorization Process

Referral Guidelines

In order to reduce the administrative burden on providers, University of Maryland Health Partners does not require notification or completion of referral forms. PCPs may simply refer members to specialists, provided that such referrals are in-network specialists. Any referrals to out-of-network providers will require prior authorization from University of Maryland Health Partners. When referring a

member for specialty care, the PCP must document the referral in the member's medical record.

After Hours and Emergency Care

Members are not required to contact their PCP in emergent/urgent situations. The emergency room staff will triage the member to determine whether or not an emergency exists. However, the PCP must provide telephone coverage 24 hours per day/7 days a week.

Authorization Guidelines

University of Maryland Health Partners requires prior authorization for all inpatient admissions and certain outpatient services. To request prior authorization, the admitting or referring physician, or the facility or provider rendering the service can submit the request in one of the following ways:

- via fax to 410-779-9336
- via telephone at 1-800-730-8543 / 410-779-9359.
- Soon you will also be able to submit authorizations via our website at www.UMHealthPartners.com

Upon receipt of a prior authorization request, University of Maryland Health Partners will verify member eligibility and benefits. We will make case-by-case determinations based on the individual's health care needs and medical history, in conjunction with nationally-recognized standards of medical care. If medical necessity criteria are not met on the initial review, the referring provider may discuss the case with a University of Maryland Health Partners physician who is in the same or similar specialty prior to the determination. If the request is denied, the appropriate denial letter (including the member's appeal rights) will be mailed to the requesting provider, member's PCP, and the member.

To ensure timeliness of prior authorization requests, the requesting provider should include the following information:

- Member name and ID number
- Name, telephone and fax of the facility or provider who will be rendering the service
- Proposed date(s) of service
- Diagnosis with ICD10 code
- Name of procedure(s) with CPT-4 code
- Medical information to support the request
    - Signs and symptoms
    - Past and current treatment plans, including response to treatment plans
    - Medications, along with frequency and dosage

Please visit www.UMHealthPartners.com, or call 1-800-730-8543 / 410-779-9359 for the most current version of prior authorization guidelines.

Inpatient Admission Review

University of Maryland Health Partners reviews inpatient admissions within one business day of notification. We determine the member's status through:

- Onsite review, when indicated
- Communication with the hospital's utilization review department

We then document the appropriateness of stay and refer specific diagnoses to our Health Services department for care coordination or case management.

Inpatient Concurrent Review

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital when indicated
- Via telephone or fax

We conduct select continued stay reviews daily and review discharge plans. Our Utilization management (UM) clinician will also try to meet with the member and/or family to:

- Discuss any discharge planning needs
- Verify they know the PCP's name and address

We authorize the covered length of stay one day at a time. Our medical director can make exceptions for severe illness and course of treatment or when it is pre-determined by state law. Examples include:

- ICU, CCU
- C-section or vaginal deliveries

We will communicate approved days and bed level coverage to the hospital for any continued stay.

Discharge Planning

University of Maryland Health Partners's utilization management (UM) clinician coordinates our members' discharge planning needs with:

- Hospital utilization review/discharge planning staff
- The attending physician
- The University of Maryland Health Partners Services department

The attending physician, in concert with our UM clinician or Health Services Representative, coordinates the member's follow up care with the member's PCP.

For ongoing care, we work with the provider to plan discharge to an appropriate setting such as:

- Hospice
- Convalescent care
- Home health care program
- Skilled nursing facility

Authorization Grid

Please visit www.UMHealthPartners.com, or call 1-800-730-8543 / 410-779-9359 for the most current version of prior authorization guidelines.

Service	Prior Authorization Guidelines
Abortion Services	Covered by the State only if the following conditions apply: • The member will have serious physical or mental health problems or could die if she has the baby • The member is pregnant because of rape or incest and reported the crime. • The baby will have very serious health problems. Note: Women eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.
Acupuncture for Substance Abuse	No prior authorization required.
Allergy	No prior authorization required.
Audiology	Not covered for adults 21 years of age or older
Bariatric Surgery	Prior authorization is required.

Service	Prior Authorization Guidelines
Cardiology	No prior authorization is required.
Cardiac Catheterization	No prior authorization is required for office based procedures
Chemotherapy	No prior authorization is required
Chiropractic	No prior authorization is required. (Benefit is limited to children under 21 years of age when needed for EPSDT services)
Circumcision	No prior authorization is required
Clinical Trials	Prior authorization is required
Dermatology	No prior authorization is required for E&M or Testing Cosmetic procedures require prior authorization
Diagnostic Testing	Prior authorization is required for PET
Diabetic supplies	No prior authorization required
Diabetic shoes	No prior authorization required
Durable Medical Equipment	No prior authorization is required for DME below $500 Prior authorization is required for all DME that exceeds $500 Prior authorization is required for all rental DME equipment DME rentals are capped at the purchase price
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit	No prior authorization is required PCPs are required to use the EPSDT schedule and to document the visits Note: vaccine serum is received under the Vaccines for Children (VFC) program
Emergency Room	No prior authorization is required Note: University of Maryland Health Partners must be notified within 24 hours or the next business day if a member is admitted to the hospital through the emergency room
ENT Services (Otolaryngology)	No prior authorization is required for office based services
Endocrinology	No prior authorization is required
Family Planning	No prior authorization is required Members may self-refer for family planning services
Gastroenterology	No prior authorization is required for office based services or ambulatory surgery center
General Surgery	No prior authorization is required for office based or ambulatory surgery center
Gynecology	No prior authorization is required for office based services
Hearing Aids	Covered by the State for <21

<table>
<tr><th>Service</th><th>Prior Authorization Guidelines</th></tr>
<tr><td>Hearing Screening</td><td>Not A Covered Benefit for >21 years of age

Covered by the State for <21 years of age per EPSDT guidelines</td></tr>
<tr><td>Hematology</td><td>No prior authorization is required</td></tr>
<tr><td>Home Health Care</td><td>Authorization is not required for initial evaluation, but additional services require authorization
• DME and Supplies are covered per authorization guidelines</td></tr>
<tr><td>Hospital Admissions</td><td>Prior authorization is required for all elective admissions
University of Maryland Health Partners must be notified within 24 hours or one business day of any emergent admissions</td></tr>
<tr><td>Hospital – Outpatient Services</td><td>Prior authorization is required</td></tr>
<tr><td>Long Acting Reversible Contraceptives (LARC)</td><td>Order the contraceptive from CVS/Caremark for delivery to your office.

The following brands are covered (with quantity limits):

<u>Type</u> <u>Brand Name</u> <u>Authorization Required</u>
Implant Implanon Yes
Implant Nexplanon Yes
Injectable Depo-Provera No
IUD Mirena Yes
IUD Skyla Yes
Transdermal Ortho Evra No</td></tr>
<tr><td>Medical Supplies</td><td>No prior authorization is required for disposable medical supplies</td></tr>
<tr><td>Nephrology</td><td>No prior authorization required, including dialysis</td></tr>
<tr><td>Neurology</td><td>No prior authorization is required</td></tr>
<tr><td>Nutrition Counseling</td><td>Prior authorization is required</td></tr>
<tr><td>Observation</td><td>University of Maryland Health Partners must be notified within 24 hours or one business day of any admissions that resulted from observation services.
Maximum allowed stay in observation unit – 24 hours</td></tr>
<tr><td>Obstetrical Care</td><td>No prior authorization is required</td></tr>
</table>

Service	Prior Authorization Guidelines
	Please notify University of Maryland Health Partners within 24 hours following the first OB visit for referral to case management
Occupational Therapy	Prior authorization is required for adults over 21 years of age. Covered by the State for children under 21 years of age. Initial Evaluation and Management visit to determine treatment plan does not require authorization
Oncology	No prior authorization is required
Ophthalmology	No prior authorization is required for office based services Services that are considered cosmetic are not covered benefits
Oral and Maxillofacial Surgery	Prior authorization is required.
Orthopedics	No prior authorization is required
Out of Area/Out of Network Care	Prior authorization is required except for emergency care and MDH self-referred services
Outpatient/Ambulatory Surgery (ASC)	No prior authorization is required except for Pain Management and Cosmetic Procedures
Pain Management	Prior authorization is required Initial Evaluation and Management visit to determine treatment plan does not require authorization
Perinatology	No prior authorization is required
Plastic Reconstructive Surgery	Prior authorization is required
Podiatry	No prior authorization for Podiatry Services for: Medically necessary services, Diabetes care services specified in COMAR 10.09.67.24 and Routine foot care for enrollees, 21 years old or older with vascular disease affecting the lower extremities
Private Duty Nursing	Prior authorization is required
Pulmonology	No prior authorization is required
Physical Rehabilitation (inpatient)	Prior authorization is required
Physical Therapy (outpatient)	Prior authorization is required for adults over 21 years of age Initial Evaluation and Management visit to determine treatment plan does not require authorization

Service	Prior Authorization Guidelines
	(Physical Therapy for <21 years old is covered by the State of Maryland and not University of Maryland Health Partners)
Radiology	See Diagnostic Testing
Rheumatology	No prior authorization is required
Skilled Nursing Facility	Prior authorization is required
Sleep Studies	No prior authorization is required
Speech Therapy	Prior authorization is required Initial Evaluation and Management visit to determine treatment plan does not require authorization
Sterilization	Prior authorization is required for outpatient services or services provided in an ambulatory surgery center - Provider must submit a completed consent form and Medicaid Form (MA-30) for sterilizations - Reversal of sterilization is not a covered benefit
Urology	No prior authorization is required
Urgent Care Center	No prior authorization is required
Women's Health Specialist	No prior authorization is required

Affirmative Statement About Incentives

Utilization Management (UM) decision making is based on appropriateness of care and service and existence of coverage. University of Maryland Health Partners does not specifically reward practitioners or individuals for issuing denials of coverage or care. UM decision makers do not receive financial incentives to encourage decisions that result in under-utilization. University of Maryland Health Partners does not compensate practitioners or individuals for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in underutilization.

Utilization Management Criteria

Providers may request a copy of UMHP's Utilization Management criteria by contacting our UM Department at 410-779-9359 / 800-730-8543.

UM staff are available during normal business hours from 8:00 am - 5:00 pm, there is an after-hours on call nurse available for UM issues. Staff identifies themselves

by name, title and organization when initiating or returning calls regarding UM issues.

Members needing TDD/TYY services may dial 711 and language assistance services are available as needed for members to discuss UM issues.

Clinical Practice Guidelines

UMHP's Provider Advisory Committee (PAC) reviews and approves the Clinical Practice Guidelines yearly. The latest Clinical Practice Guidelines are available at www.UMHealthPartners.com under the "For Providers" section.

University of Maryland Health Partners Claims Submission Guidelines

Claims for University of Maryland Health Partners members may be submitted in one of the following methods:

Electronically (preferred method) through our Clearinghouse;
EMDEON – Payor ID 45281

Paper using a CMS 1500 or UB04
Mail paper claims to: University of Maryland Health Partners of Maryland, Inc.
P.O. Box 1572
Bowie, MD 20717-1572

All claims, whether paper or electronic, should be submitted using standard clean claim requirements including, but not limited to:

Member name and address
Member ID Number
Place of Service
Provider Name
Provider NPI
Diagnosis (ICD10) code(s) and description(s)
Applicable CPT/Revenue/HCPCS codes
Applicable modifier(s)

Claims must be filed within 180 days of the date of service.

If you would like additional information relative to University of Maryland Health Partners's claims submission guidelines, please call our Provider Relations Department at 800-730-8543 or visit our website at www.UMHealthPartners.com.

University of Maryland Health Partners offers ePayment which replaces paper-based claims payments with electronic fund transfer (EFT) payments that are directly deposited into your bank account. Once enrolled you will be able to search, view and print images of the Electronic Remittance Advice (ERA) or download HIPAA formatted 835 ERA files to simplify payment posting. For

additional information contact EMDEON at 800-506-2830.

Subrogation

University of Maryland Health Partners requires providers to seek reimbursement from the responsible third party when a third party is liable (TPL), for example motor vehicle accidents or workmen's compensation claims. If a potential TPL claim is submitted to University of Maryland Health Partners, it will be paid normally. If, however, it is later discovered that a third party is liable for the charges University of Maryland Health Partners will retract any monies paid and send the provider a letter advising them to bill the responsible party.

Coordination of Benefits

Coordination of Benefits (COB) means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

By law, the Medicaid program (and the respective MCO's that are administering the program) is the payor of last resort. If the provider accepts an amount less than the Medicaid payment amount as payment in full by the payor, then UMHP cannot be billed for the balance. If under the primary payor the member has a co-payment, coinsurance or deductible obligation, UMHP will reimburse the member's liability the lesser of the primary payor's fee schedule or the Medicaid fee schedule.

Medicaid Fee Schedule – Non Priced Codes

Any procedure code with a payment of $0.00 is a non-covered service. Invoices are required for any CPT / HCPCS codes that are listed with the following notes in the reimbursement section: BR (By Report) or IC (Individual Consideration)

Ambulatory Surgery Center Facility Billing – Must be billed on UB-04 or successor forms.

Home Health – Must be billed on a UB-04 or successor forms**.**

National Drug Code (NDC)

Providers must report a valid 11-digit NDC number and the quantity administered on the CMS-1500 claim form. This includes physician-administered drugs for immunizations and radiopharmaceuticals.

Provider must report the NDC/quantity when billing for drugs using –A, -J, and –Q codes, as well as certain CPT codes.

Providers must report the actual NDC number on the package or container from which the medication was administered.

It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits. The number format to list should be 5-4-2 (five digits, hyphen, four digits, hyphen, two digits)

The following qualifiers are used when reporting NDC unit/basis of measurement:

F2	**International Unit**
GR	**Gram**
ML	**Milliliter**
UN	**Unit**

Fraud and Abuse Prevention

University of Maryland Health Partners is committed to ensuring that University of Maryland Health Partners Staff, Subcontractors and Network Providers perform administrative services and deliver health care services in a manner reflecting compliance with statutes, regulations and contractual obligations. Further, University of Maryland Health Partners is committed to fulfilling its duties with honesty, integrity, and high ethical standards as a Maryland Medicaid MCO. University of Maryland Health Partners supports the government in its goal to decrease financial loss from false claims and has, as its own goal, the reduction of potential exposure to criminal penalties, civil damages, and administrative actions.

In the context of the University of Maryland Health Partners Compliance Plan, fraud is considered an act of purposeful deception or misrepresentation committed by any person to gain an unauthorized benefit. Abuse committed by a health care provider means activities that are inconsistent with standard fiscal, business, or medical practices that result in unnecessary cost to a government health care program or other health care plan, or that fail to meet professionally recognized standards for health care. Abuse can also include beneficiary practices that may result in unnecessary cost to the Medicaid program.

The University of Maryland Health Partners Compliance Plan and associated training is posted on our website at www.UMHealthPartners.com. Familiarity with, and adherence to, the plan and completion of training is required of all University

of Maryland Health Partners staff, subcontractors, network providers and their staff.

Audits are performed on a routine, scheduled basis to monitor for compliance with requirements associated with Title XIX Programs, to include documentation practices, the University of Maryland Health Partners Provider Manual and Provider Agreement. Routine monitoring activity includes comparative data analysis on areas such as service utilization and outcomes. Routine reviews focus on identified high-risk or problem areas, ensuring that providers are eligible to participate in Medicaid, ensuring members are properly enrolled in Medicaid, and ensuring documentation supports submitted claims data.

University of Maryland Health Partners will perform a minimum level of random reviews in accordance with standards established in collaboration with MDH, in which a selected universe of beneficiaries will be contacted for interviews and clinical records will be reviewed to identify possible errors or evidence of abuse and/or fraud.

Audits are also performed following the identification of an area of concern which may suggest possible abusive or fraudulent activity. Such referrals may come from internal and external sources, unusual trends in claims or other data, provider self-disclosures, and other ongoing monitoring activity. University of Maryland Health Partners seeks to ensure the integrity of the Medicaid program by investigating any suspected fraud and abuse. Provider fraud and abuse can include:

- Billing more than once for the same service
- Falsifying records
- Performing inappropriate or unnecessary services
- Billing or charging Medicaid enrollees for covered services
- Provider staff misrepresenting credentials
- Denial of care
- Confidentiality violations
- Any other Provider action that places a Member in jeopardy
- Any other Provider action that violates Federal/State or other applicable regulations

In working with its providers, University of Maryland Health Partners will identify opportunities for improvement and will assess compliance with utilization policies and procedures. When opportunities for improvement are noted, University of Maryland Health Partners will work with the specific provider or will incorporate its findings into the implementation of performance measures. If the process identifies issues with program integrity, University of Maryland Health Partners will follow-up with providers, utilize corrective action plans when indicated, recoup

overpayments or report abusive or fraudulent claiming to the Medicaid Fraud and Control Unit.

University of Maryland Health Partners provides a toll free access line 24 hours a day, 7 days a week to ensure the immediacy of provider reporting of suspected fraud and abuse. University of Maryland Health Partners will comply with all state and federal mandatory or statutory regulatory requirements with respect to fraud and abuse. The hotline number is 410-779-9323. Callers may remain anonymous, if they prefer. However, it is the University of Maryland Health Partners policy that neither University of Maryland Health Partners nor the provider may retaliate against anyone who identifies oneself and reports any incidence or suspicion of Medicaid fraud or abuse.

Non-Discrimination

Covered Services are provided to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of Provider practice.

Members and non-Members should be treated equitably.

No discrimination against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Covered Services required, or any other grounds prohibited by law.

Compliance with the Americans with Disabilities Act of 1990 (ADA)

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services. These statutes require medical care providers to make their services available in an accessible manner.

The ADA requires access to medical care services and the facilities where the services are provided. Private hospitals or medical offices are covered by Title III of the ADA as places of public accommodation. Public hospitals and clinics and medical offices operated by state and local governments are covered by Title II of the ADA as programs of the public entities. Section 504 covers any of these that

receive federal financial assistance, which can include Medicare and Medicaid reimbursements. The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504.

Both Title II and Title III of the ADA and Section 504 require that medical care providers provide individuals with disabilities:

- full and equal access to their health care services and facilities; and
- reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e. alter the essential nature of the services).

Culturally Competent Care

Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction.

Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds.

Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location.

Providers should contact member services for coordination of linguistic services through bilingual staff, telecommunication for the deaf, and use of the language line.

Primary Care Provider – Panel Reports

Primary care providers will receive monthly panel reports after the 5th business day of the month via one of the following methods:

- Real time member rosters through the University of Maryland Health Partners Provider Portal (lookup individual members and print PDF of the full roster)
- Fax, e-Mail or Mail

Example of Panel Report:

Panel Report
July 2014

riversidehealth

PCP Provider	MEMBER FULL NAME	MAID	DOB	AGE	EFFDATE	Gender	Phone	Address	City	State	ZIP	EPSDT Visit Needed July	EPSDT Visit Needed August
Watson, John H	Babar, Eleph	123456789	7/1/2014	0	05/15/2014	M	301-867-5309	1600 Pennsylvania Ave	Silver Spring	MD	20903		Y
Watson, John H	Holmes, Sherlock	123456789	6/1/2013	1	12/15/2013	M	410-867-5309	221 B Baker Street	Greenbelt	MD	20720		
Watson, John H	Clayton, John	123456789	8/1/2011	2	05/15/2014	M	301-867-5309	4059 Mount Lee Drive	Hollywood	MD	21014		Y
Watson, John H	Hingis, Martina	123456789	9/1/2010	4	03/24/2014	F	301-867-5309	2 Macquarie Street	Sydney	MD	20782		
Watson, John H	Bedelia, Amelia	123456789	8/4/2012	28	07/19/2013	F	301-867-5309	34th and 5th Avenues	Takoma Park	MD	20912		Y
Watson, John H	Moya, Carlos	123456789	09/16/1965	49	02/21/2014	M	410-867-5309	10 Downing Street	Hyattsville	MD	20783		
Watson, John H	Kuerten, Gustavo	123456789	02/06/1989	25	03/09/2014	M	301-867-5309	1060 West Addison Street	Whiteford	MD	21160		

Access and Availability

Participating providers must:

- Provide coverage 24 hours a day, 7 days a week.
- Ensure another on-call participating provider is available when the provider is unavailable.
- The hours of operation offered to UMHP Members shall not be less than those offered to commercial members.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- Respond to after-hours emergency phone calls within 30 minutes and urgent phone calls within one hour.

Type of Appointment	Standard Access Requirement
Initial appointment	Within 90 Days
New enrollee (high risk)	Within 15 Days of receipt of HRA(Health Risk Assessment)
Family Planning Services and Initial assessments of pregnant and post-partum woman	Within 10 Days
Well Child	Within 30 Days
Initial newborn visit	Within 3-5 Days of Discharge
Routine/Symptomatic	Within 7 Days
Preventive Care	Within 30 Days

Dental, Optometry, Lab and X-ray appointments	Within 30 Days
Dental, Optometry, Lab and X-ray appointments (Urgent)	Within 48 Hours
Urgent visit	Within Same Day
Emergency	Immediately

All family members needing appointments will be given approximately concurrent or consecutive appointments.

Members shall wait no longer than 1 hour in the waiting room to be seen for scheduled appointments.

School Based Health Center Services

The medical encounter form must be sent by the school based health center within three (3) business days or within the same day if the member requires follow-up care by the PCP within one (1) week of being seen by the school based health center.

See sample encounter form Section IV Addendum 1

Dispute Resolution - Contractual

Disputes Covered: This policy applies exclusively to all disputes arising from the performance or interpretation of the Agreement, including, any alleged cause of action, including without limitation claims for breach of any contract or covenant (express or implied); tort claims; claims for discrimination; violations of confidentiality or breaches of trade secrets; and/or claims for violation of any federal, state or other governmental law, statute, regulation or ordinance, and whether based on statute or common law.

Should any disputes covered by this policy arise by and/or between a party to the Agreement, by either University of Maryland Health Partners or the Provider, the parties shall first endeavor to resolve the dispute through negotiation. The following guidelines shall be incorporated in the negotiations:

- All negotiations shall incorporate commercially reasonable business practices, good faith, and fairness between the parties; and
- If applicable, any and all mutually agreeable decisions reached by the parties that may alter or otherwise amend the Agreement shall be memorialized in writing pursuant to the "Amendments" section of the Agreement.

If the matter is not resolved to the satisfaction of either party, Provider or University of Maryland Health Partners may submit the matter in controversy to non-binding arbitration.

The non-binding arbitration shall take place in Maryland under the rules of the American Arbitration Association ("AAA")by an arbitrator agreed upon in writing by the parties; provided, however, that either party may, at its sole discretion, seek injunctive relief in the courts of any jurisdiction as may be necessary and appropriate to protect its proprietary or confidential information. In the event the parties cannot agree upon the choice of an arbitrator, each party shall appoint one individual representative and the two party representatives shall, between themselves, chose an arbitrator.

The arbitrator shall render a non-binding decision and award within 30 days after the close of the arbitration hearing or at any later time on which the parties may agree. The award shall be in writing and signed and dated by the arbitrator and shall contain express findings of fact and the basis for the award. Judgment upon the award of the arbitration is non-binding.

The parties agree to share equally the AAA administrative fees and the arbitrator's fees and expenses. All other costs and expenses associated with the arbitration, including, without limitation, each party's respective attorneys' fees, shall be borne by the party incurring the expense.

Credentialing / Re-Credentialing

University of Maryland Health Partners performs provider credentialing prior to the inclusion of practitioners in the network and recredentials them on a three year cycle. Our credentialing standards are compliant with NCQA and the State of Maryland requirements.

UMHP uses the credentialing information from the Council for Affordable Quality Healthcare (CAQH) or the state approved credentialing application.

All primary care offices must undergo a site evaluation as part of their credentialing / recredentialing.

Providers have the following rights related to the credentialing process:

- To review the information submitted to support your credentialing application
- To correct erroneous information
- To be informed of the status of your credentialing or recredentialing application, upon request.

- To be notified if the information obtained during the credentialing process varies substantially from the information provided by the practitioner.
- To receive notification of the credentialing / recredentialing decision within 60 calendar days of the credentialing committee's decision.

To have the credentialing information remain confidential except as otherwise provided by law.

Section III

HealthChoice Benefits and Services

OVERVIEW

- University of Maryland Health Partners must provide a complete and comprehensive benefit package that is equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not University of Maryland Health Partners responsibility) are still available for HealthChoice members. Medicaid will reimburse these services directly, on a fee-for-service basis. (see page 63)

- A HealthChoice PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.

- A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. We are responsible for reimbursing out-of-plan providers who have furnished these services to our members. (See Self-Referred Services Section- Page 65)

- Only benefits and services that are medically necessary are covered.

- HealthChoice members may not be charged any co-payments, premiums or cost sharing of any kind, except for the following:

    - Up to a $3.00 co-payment for brand-name drugs;
    - Up to a $1.00 co-payment for generic drugs; and
    - Any other charge up to the fee-for-service limit as approved by the Department.
      (University of Maryland Health Partners **does not** charge co-pays for either brand or generic drugs.)

- We do not impose pharmacy co-payments on the following:
    - Family planning drugs and devices;
    - Individuals under 21 years old;
    - Pregnant women; and
    - Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs.
- Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program

The pharmacy cannot withhold services even if the member cannot pay the co-payment. The member's inability to pay the co-payment does not excuse the debt and they can be billed for the co-payment at a later time.

Covered Benefits and Services - (Listed Alphabetically)

Audiology Services for Adults

These services are only covered when part of an inpatient hospital stay

Blood and Blood Products

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

Case Management Services

Case management services are covered for members who need such services including, but not limited to**,** members of special needs populations, which consist of the following non-mutually exclusive populations:

- Children with special health care needs;
- Individuals with a physical disability;
- Individuals with a developmental disability;
- Pregnant and post-partum women;
- Individuals who are homeless;
- Individuals with HIV/AIDS; and
- Children in State supervised care.

If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO.

A case manager will perform home visits as necessary as part of University of Maryland Health Partners case management program, and will have the ability to respond to a member's urgent care needs during this home visit.

Dental Services for Children and Pregnant Women

These services are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 1-888-696-9596 if you have questions about dental benefits.

Diabetes Care Services

University of Maryland Health Partners covers all medically necessary diabetes care services. We cover diabetes care services for members who have been diagnosed with diabetes that include:

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

Dialysis Services

Members in HealthChoice who suffer from End Stage Renal Disease (ESRD) are eligible for REM. To be REM-eligible on the basis of ESRD, members must meet one of the following sets of criteria:

- Children (under 21 years old) with chronic renal failure (ICD-10 codes N18.1-N18.6) diagnosed by a pediatric nephrologist; and
- Adults (ages 21-64) with chronic renal failure with dialysis (ICD-10 code Z992)**.**

For those members needing dialysis treatment who are enrolled in University of Maryland Health Partners, dialysis services are covered, either through participating providers or, members can self-refer to non-participating Medicare certified providers.

Disease Management

Disease management is available for members with chronic conditions including: Diabetes and Asthma

DMS/DME

- Authorization for DME and/or DMS will be provided in a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 7 calendar days from the date of the initial request.

- Disposable medical supplies are covered, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the member.

- Durable medical equipment is covered when medically necessary including but not limited to all equipment used in the administration or monitoring of prescriptions by the member. We pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from University of Maryland Health Partners, as long as the member remains Medicaid eligible during the 90-day time period.

- Speech augmenting devises are paid for by the State on a fee-for service basis.

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

For members under 21 years of age, all of the following EPSDT services are covered:

- Well-child services provided in accordance with the EPSDT periodicity schedule by an EPSDT-certified provider, including:
  - Periodic comprehensive physical examinations;
  - Comprehensive health and developmental history, including an evaluation of both physical and mental health development;
  - Immunizations;
  - Laboratory tests including blood level assessments;
  - Vision, hearing, and dental screening; and
  - Health education.

- EPSDT partial or interperiodic well-child services and health care services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions, which services are sufficient in amount, duration, and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:

    - Chiropractic services;
    - Nutrition counseling;
    - Audiological screening when performed by a PCP;
    - Private duty nursing;
    - Durable medical equipment including assistive devices; and
    - Any other benefit listed in this section.

- Providers are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC nutritional program, early intervention services; School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services (located at local health departments).

Family Planning Services

Comprehensive family planning services are covered, including:

- Office visits for family planning services;
- Laboratory tests including pap smears;
- Contraceptive devices; and
- Voluntary sterilization.

Home Health Services

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

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

- Occupational therapy services;
- Speech pathology services; and
- Medical supplies used in a home health visit.

Hospice Care Services

Hospice care services are covered for members who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, in a long-term care facility, or at home.

Hospice providers should inform their Medicaid participants (or patients applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCOs with whom they contract so that they can make an informed choice.

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

Inpatient Hospital Services

Inpatient hospital services are covered.

For special rules for length of stay for childbirth (See Page 26).

Laboratory Services

Diagnostic services, and laboratory services performed by providers who are CLIA certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, Genotypic, phenotypic, or HIV/AIDS drug resistance testing used in treatment of
HIV/AIDS are reimbursed directly by the Department and must be rendered by a Department approved provider and be medically necessary.

Long-term Care Facility Services/Nursing Facility Services

Long-term care facilities include chronic hospitals, chronic rehabilitation hospitals, and nursing facilities. The first 30 days in a long-term care facility are the responsibility of University of Maryland Health Partners, subject to specific rules.

When a member is transferred to a long-term care facility and the length of the member's stay is expected to exceed 30 days, medical eligibility approval of the Department of Health (MDH) for long-term institutionalization must be secured as soon as possible.

We cover the first thirty days or until MDH medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are not followed, our financial responsibility continues until the State's requirements for the member's disenrollment are satisfied. In order for a member to be disenrolled from University of Maryland Health Partners based on a long-term care facility admission, all of the following must first occur:

- An application**,** MDH 3871, for a Departmental determination of medical necessity must be filed (If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission).

- MDH must determine that the member's long-term care facility admission was medically necessary in accordance with the State's criteria.

- The member's length of stay must exceed 30 consecutive days.

- We must file an application for disenrollment with MDH, including documentation of the member's medical and utilization history, if requested.

Once an individual has been disenrolled from University of Maryland Health Partners, the services they receive in a qualifying long-term care facility will be directly reimbursed by the Maryland Medical Assistance program, as long as the participant maintains continued eligibility.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are not considered an interruption of University of Maryland Health Partners covered 30 continuous days in a long term care facility as long as the member is discharged from the hospital back to the long term care facility.

An individual with serious mental illness, or intellectual disability or a related condition may not be admitted to a nursing facility unless the State determines that nursing facility services are appropriate. For each member seeking nursing facility admission, a Pre-admission Screening and Resident Review (PASRR) ID Screen must be completed. The first section of the ID Screen exempts a member if NF admission is directly from a hospital for the condition treated in the hospital

and, the attending physician certifies prior to admission to the NF that the member is likely to require less than 30 days of NF services.

If a member is not exempted, complete the ID Screen to identify whether the member screens positive for behavioral illness or intellectual disability. If the member screens negative, refer to Adult Evaluation and Review Services (AERS) located in the local health department for a STEPS assessment to help identify alternative services to NF placement.

A member admitted to an Intermediate Care Facility - Mental Retardation (ICF-MR) is disenrolled from University of Maryland Health Partners immediately upon admission to the facility, and we retain no responsibility for the member's care.

If we place a member in a licensed nursing facility that is not a Maryland Medical Assistance Program provider, Medicaid cannot pay the facility for services. Upon MCO disenrollment, the patient may transfer to a nursing home that accepts Medicaid payment.

If a member under age 21 is admitted into an ICF-A, we are responsible for medically necessary treatment for as many days as required.

Outpatient Hospital Services

Medically necessary outpatient hospital services are covered.

Oxygen and Related Respiratory Equipment

Oxygen and related respiratory equipment are covered.

Pharmacy Services

We will expand our drug formulary to include new products approved by the Food and Drug Administration (COMAR 10.09.67.04D(3)) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drug rated as P (priority) by the FDA will be added to the formulary. Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided in a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 7 calendar days from

the date of the initial request. If the service is denied, University of Maryland Health Partners will notify the prescriber and the member in writing of the denial (COMAR 10.09.71.04).

When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests (COMAR 10.09.67.04F(2)(a)). The State expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

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

- Legend (prescription) drugs;
- Insulin;
- Contraceptives;
- Latex condoms and emergency contraceptives (to be provided without any requirement for a provider's order);
- Non-legend ergocalciferol liquid (Vitamin D)
- Hypodermic needles and syringes;
- Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy, or gastrostomy tube;
- Enteric coated aspirin prescribed for treatment of arthritic conditions;
- Nonlegend ferrous sulfate oral preparations;
- Nonlegend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for members under age 12;
- Formulas for genetic abnormalities;
- Medical supplies for compounding prescriptions for home intravenous therapy;
- Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider.
- Most behavioral health drugs are on SMHS formulary and are to be paid by SMHS.
- Most HIV/AIDS drugs are paid directly by the State

University of Maryland Health Partners drug utilization review program is subject to review and approval by MDH, and is coordinated with the drug utilization review program of the Behavioral Health Service delivery system.

Limitations: neither the State nor the MCO cover the following:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight; or

Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition.

Except for specialty drugs, members are not required to use mail-order pharmacy providers. If a specialty drug is available in a community pharmacy and a member requests to obtain the prescription through the community provider, we will honor the request.

Physician and Advanced Practice Nurse Specialty Care Services

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

Specialty care services covered under this section also include:

- Services performed by non-physician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision;

- Services provided in a clinic by or under the direction of a physician or dentist; and

- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

University of Maryland Health Partners shall clearly define and specify referral requirements to all providers.

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary.

- PCPs must follow our special referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition which:

    - Has significant potential or actual impact on health and ability to function;
    - Requires special health care services; and

- Is expected to last longer than 6 months.

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

Podiatry Services

University of Maryland Health Partners provides its members medically necessary podiatry services as follows:

- For members younger than 21 years old
- Individuals with diabetes receive the diabetes care services specified in COMAR 10.09.67.24
- Routine foot care for members 21 years old or older with vascular disease affecting the lower extremities

Primary Care Services

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

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

For female members, if her PCP is not a women's health specialist she may see a women's health specialist within University of Maryland Health Partners, without a referral, for covered services necessary to provide women's routine and preventive health care services

Primary Behavioral Health Services (mental health and substance use disorders)

- We cover primary behavioral health services required by members, including clinical evaluation and assessment, provision of primary behavioral health services, and/or referral for additional services, as appropriate.

- The PCP of a member requiring behavioral health services may elect to treat the member, if the treatment, including visits for Buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Neither the PCP nor University of Maryland Health Partners may bill the Behavioral Health System for the provision of such services because these services are included in the HealthChoice capitation rates.

- When, in the PCP's judgment, a member's need for behavioral health treatment cannot be adequately addressed by primary behavioral health services provided by the PCP, the PCP should, after determining the member's eligibility (based on probable diagnosis), refer the member to the Behavioral Health System, 800-888-1965,for specialty behavioral health services.

Rehabilitative Services

Rehabilitative services including but not limited to medically necessary physical therapy for adults are covered. For members under 21 rehabilitative services are covered by University of Maryland Health Partners only if part of a home health visit or inpatient hospital stay. All other rehabilitative services for members under 21 must be billed Medicaid fee-for-service.

Second Opinions

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

Transplants

Medically necessary transplants are covered.

Vision Care Services

Medically necessary vision care services are covered.

University of Maryland Health Partners is responsible to provide at a minimum:

- One eye examination every 2 years for members age 21 or older; or

- For members under 21, at least one eye examination every year in addition to EPSDT screening, one pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate, and contact lenses, if eyeglasses are not medically appropriate for the condition.

Benefit Limitations

The following are not covered under HealthChoice:

- Services that are not medically necessary.

- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state).

- Services that are beyond the scope of practice of the health care practitioner performing the service.

- Abortions. (Available under limited circumstances through Medicaid fee-for-service.)

- Autopsies.

- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities.

- Services provided outside the United States.

- Dental services for adults, unless pregnant.

- Diet and exercise programs for weight loss except when medically necessary.

- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial as specified in COMAR 10.09.67.26-1.

- Immunizations for travel outside the U.S.

- In vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

- Lifestyle improvements (physical fitness programs, nutrition counseling, smoking cessation) unless specifically included as a covered service.

- Medication for the treatment of sexual dysfunction.

- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is younger than 12 years old.

- Non-legend drugs other than insulin and enteric-coated aspirin for arthritis.

- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

- Orthodontia except when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction.

- Ovulation stimulants.

- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis.

- Private duty nursing for adults 21 years old and older.

- Private hospital room unless medically necessary or no other room available.

- Purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, other than for members younger than 21 years old.

- Reversal of voluntary sterilization procedure.

- Services performed before the effective date of the enrollee's coverage.

- Therapeutic footwear other than for a member who qualifies for diabetes care services or for a member who is younger than 21 years old.

- Transportation services that are provided through Local Health Departments. University of Maryland Health Partners will assist members to

secure non-emergency transportation through their local Health Departments. Additionally, we provide non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available. The following is a list of the transportation contact numbers for each county:

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	http://www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-3835	410-396-6422	410-649-0521	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-4381	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8023	http://dhmh.maryland.gov/carolinecounty
Carroll	410-876-2152	410-876-4813	410-876-4940	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5145	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-7917	301-609-6803	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-228-3223	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-1725	301-600-3341	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-9431	301-334-7695	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7567	https://www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1648	http://www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4481	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-6772	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1766	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5654	http://talbothealth.org
Washington	240-313-3200	240-313-3264	240-313-3290	http://dhmh.maryland.gov/washhealth
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-632-9230	http://www.worcesterhealth.org/

Medicaid Covered Services That Are Not The Responsibility of University of Maryland Health Partners

The following services are paid by the State on a fee-for-service basis:

- Specialty Behavior Health Services including specialty mental health and substance use disorders
- The remaining days of a hospital admission following enrollment in the MCO if the recipient was admitted to the hospital before the date of the recipient's enrollment;
- Long-term care services except for those outlined in COMAR 10.09.67.07B and COMAR 10.09.67.12A;
- Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with developmental disabilities.
- Related Conditions (ICF/IID) services;
- Personal care services;
- Medical day care services, for adults and children;
- The following HIV/AIDS services:
    - Genotypic, phenotypic, or other HIV/AIDS drug resistance testing used in the treatment of HIV/AIDS, if the service is rendered by a Department-approved provider; and medically necessary;
    - Viral load testing used in treatment of HIV/AIDS; and
    - Antiretroviral drugs in American Hospital Formulary Service therapeutic class 8:18:08 used in the treatment of HIV/AIDS;
- Audiology services including the purchase, examination, or fitting of hearing aids and supplies, and tinnitus masker for members younger than 21 years old;
- Cochlear implant devices for members younger than 21 years old;

- Physical therapy, speech therapy, occupational therapy, and audiology services when:
    - The member is younger than 21 years old; and
    - The services are not part of home health services or an inpatient hospital stay;
- Augmentative communication devices;
- Dental:
    - Services for members younger than 21 years old and pregnant women; and
    - Surgery fees for the facility and general anesthesia for pregnant women and members younger than 21 years old;
- Abortions except when a woman has been determined eligible for Medical Assistance benefits due to her pregnancy;
- Emergency transportation;
- Transportation services provided through grants to local governments.
- Services provided to members participating in the State's Health Home Program

Self-Referral Services

Members can elect to receive certain covered services from out-of-plan providers. University of Maryland Health Partners will cover these pursuant to COMAR 10.09.67.28. The services that a member has the right to access on a self-referral basis include:

- Family planning services including office visits, diaphragm fitting, IUD insertion and removal, special contraceptive supplies, Norplant removal, depo-provera-FP, latex condoms, and PAP smear.
- Certain school-based healthcare services including diagnosis and treatment of illness or injury that can be effectively managed in a primary care setting, well child care and the family planning services listed above.
- Initial medical examination for a child in State-supervised care.

- Unless University of Maryland Health Partners provides for the service before a newborn is discharged from the hospital, the initial examination of a newborn before discharge, if performed by an out-of-network on-call hospital provider.

- Annual Diagnostic and Evaluation Service (DES) visit for a member diagnosed with HIV or AIDS.

- Continued obstetric care with her pre-established provider for a new pregnant member.

- Renal dialysis services.

- Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site by the same out of plan provider at the same location as the self-referred service.

- A newly enrolled child with a special health care need may continue to receive medical services directly related to the child's medical condition under a plan of care that was active at the time of the child's initial enrollment, if the child's out-of-plan provider submits the plan of care to University of Maryland Health Partners for review and approval within 30 days of enrollment (For additional information, see Page 27).

- Emergency services as described in COMAR 10.09.66.08 B.

- Services performed at a birthing center located in Maryland or a contiguous state.

Optional Services **Provided by University of Maryland Health Partners**

BENEFIT	WHAT IT IS	HOW WILL THE SERVICE BE PROVIDED
ADULT DENTAL	University of Maryland Health Partners will provide preventative and restorative dental benefits to all adult eligible members with an annual cap of $250 per member. The benefit will include exams, x-rays, and extractions.	The service will be administered through DentaQuest, a national dental benefits administrator and their statewide network of dentists.

ADULT VISION	University of Maryland Health Partners will provide one pair of glasses every two years to all Adult eligible members. The mandatory HealthChoice benefit allows for adults to receive a vision exam every two years. UMHP will provide for one pair of glasses in the event the exam outlines the need for glasses. The cost of eyeglasses frames will be limited to $125 per pair.	The service will be administered through Superior Vision, a national vision services administrator and their statewide network of optometrists and ophthalmologists.
ACUPUNCTURE	University of Maryland Health Partners will provide acupuncture services to members diagnosed with a substance abuse addiction. The benefit will be limited to 2 treatments per week up to 16 treatments per year.	The service will be provided by a limited number of contracted providers in Baltimore City.
Over the Counter Medications and Supplies (OTC)	University of Maryland Health Partners will provide members with a $15 per quarter OTC benefit for such items such as aspirin, band aids, cold suppressants, ointments, vitamins and herbal supplements. These items must be prescribed by a physician.	The service will be provided by University of Maryland Health Partners's pharmacy benefit manager, CVS Caremark, a national PBM. All members will present their prescription for service to the participating network pharmacy to receive their OTC item(s). CVS Caremark will reimburse the pharmacy for service and will track each member's quarterly expenditure, not to exceed $15.

Section IV

Rare and Expensive Case Management (REM) Program

RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

Overview

The Maryland Department of Health (MDH) administers a Rare and Expensive Case Management (REM) program to address the special needs of waiver-eligible individuals diagnosed with rare and expensive medical conditions. The REM program, a part of the HealthChoice Program, was developed to ensure that individuals who meet specific criteria receive high quality, medically necessary and timely access to health services.
Qualifying diagnoses for inclusion in the REM program must meet the following criteria:

- Occurrence is generally fewer than 300 individuals per year;
- Cost is generally more than $10,000 on average per year;
- Need is for highly specialized and/or multiple providers/delivery system;
- Chronic condition;
- Increased need for continuity of care; and
- Complex medical, habilitative and rehabilitative needs.

Medicaid Services and Benefits

To qualify for the REM program, a member must have one or more of the diagnoses specified in the Rare and Expensive Disease List at the end of this section. The members may elect to enroll in the REM Program, or to remain in University of Maryland Health Partners if the Department agrees that it is medically appropriate. REM participants are eligible for fee-for-service benefits currently offered to Medicaid-eligible participants not enrolled in MCOs as well as additional, optional services, which are described in COMAR 10.09.69. All certified Medicaid providers other than HMOs, MCOs, ICF-MRs and IMDs are available to REM participants, in accordance with the individual's plan of care.

Case Management Services

In addition to the standard and optional Medicaid services, REM participants have a case manager assigned to them. The case manager's responsibilities include:

- Gathering all relevant information needed to complete a comprehensive needs assessment;
- Assisting the participant with selecting an appropriate PCP, if needed;
- Consulting with a multi-disciplinary team that includes providers, participants, and family/care givers, to develop the participant's plan of care;

- Implementing the plan of care, monitoring service delivery, and making modifications to the plan as warranted by changes in the participant's condition;
- Documenting findings and maintaining clear and concise records;
- Assisting in the participant's transfer out of the REM program, when and if appropriate.

Care Coordination

REM case managers are also expected to coordinate care and services from other programs and/or agencies to ensure a comprehensive approach to REM case management services. Examples of these agencies and programs are:

- Developmental Disability Administration - coordinate services for those also in the Home and Community-based Services Waiver;
- MDH - Maternal Child Health Division on EPSDT - guidelines and benchmarks and other special needs children's issues;
- AIDS Administration - consult on pediatric AIDS;
- DHR - coordinate Medical Assistance eligibility issues; coordinate/consult with Child Protective Services and Adult Protective Services; coordinate with foster care programs;
- Department of Education - coordination with the service coordinators of Infants and Toddlers Program and other special education programs;
- Behavioral Health Administration - referral for behavioral health services to the Specialty Mental Health System, as appropriate, and coordination of these services with somatic care.

Referral and Enrollment Process

Candidates for REM are generally referred from HealthChoice MCOs, providers, or other community sources. Self-referral or family-referral is also acceptable. Referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis (es). A registered nurse reviews the medical information: in order determine the member's eligibility for REM. If the Intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source.

If the Intake nurse determines that the member has a REM-qualifying diagnosis, the nurse approves the member for enrollment. However, before actual enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services in the fee-for service environment. If not, the case is referred to a case manager to arrange a PCP in consultation with the member .

If the PCP will continue providing services, the Intake Unit then calls the member to notify of the enrollment approval, briefly explain the program, and give the member an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. At the time of member notification, The Intake Unit also ascertains if the member is receiving services in the home, e.g., home nursing, therapies, supplies, equipment, etc. If so, the case is referred to a case manager for service coordination. We are responsible for providing the member's care until they are actually enrolled in the REM program. If the member does not meet the REM criteria, they will remain enrolled in University of Maryland Health Partners

For questions or to request a REM Referral Form, please call telephone number 800-565-8190. Referrals may be faxed to the REM Intake Unit at 410-333-5426 or mailed to the following address:

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

Table of Rare and Expensive Diagnosis

ICD10	ICD 10 Description	AGE LIMIT
B20	Human immunodeficiency virus (HIV) disease	0-20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0-64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0-64
C96.6	Unifocal Langerhans-cell histiocytosis	0-64
D61.01	Constitutional (pure) red blood cell aplasia	0-20
D61.09	Other constitutional aplastic anemia	0-20
D66	Hereditary factor VIII deficiency	0-64
D67	Hereditary factor IX deficiency	0-64
D68.0	Von Willebrand's disease	0-64
D68.1	Hereditary factor XI deficiency	0-64
D68.2	Hereditary deficiency of other clotting factors	0-64
E70.0	Classical phenylketonuria	0-20
E70.1	Other hyperphenylalaninemias	0-20
E70.20	Disorder of tyrosine metabolism, unspecified	0-20
E70.21	Tyrosinemia	0-20
E70.29	Other disorders of tyrosine metabolism	0-20
E70.30	Albinism, unspecified	0-20
E70.40	Disorders of histidine metabolism, unspecified	0-20
E70.41	Histidinemia	0-20
E70.49	Other disorders of histidine metabolism	0-20
E70.5	Disorders of tryptophan metabolism	0-20
E70.8	Other disorders of aromatic amino-acid metabolism	0-20
E71.0	Maple-syrup-urine disease	0-20
E71.110	Isovaleric acidemia	0-20
E71.111	3-methylglutaconic aciduria	0-20
E71.118	Other branched-chain organic acidurias	0-20
E71.120	Methylmalonic acidemia	0-20
E71.121	Propionic acidemia	0-20
E71.128	Other disorders of propionate metabolism	0-20
E71.19	Other disorders of branched-chain amino-acid metabolism	0-20
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0-20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0-64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0-64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0-64
E71.313	Glutaric aciduria type II	0-64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0-64
E71.318	Other disorders of fatty-acid oxidation	0-64
E71.32	Disorders of ketone metabolism	0-64
E71.39	Other disorders of fatty-acid metabolism	0-64
E71.41	Primary carnitine deficiency	0-64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0-64

E71.50	*Peroxisomal disorder, unspecified*	*0-64*
E71.510	*Zellweger syndrome*	*0-64*
E71.511	*Neonatal adrenoleukodystrophy*	*0-64*
E71.518	*Other disorders of peroxisome biogenesis*	*0-64*
E71.520	*Childhood cerebral X-linked adrenoleukodystrophy*	*0-64*
E71.521	*Adolescent X-linked adrenoleukodystrophy*	*0-64*
E71.522	*Adrenomyeloneuropathy*	*0-64*
E71.528	*Other X-linked adrenoleukodystrophy*	*0-64*
E71.529	*X-linked adrenoleukodystrophy, unspecified type*	*0-64*
E71.53	*Other group 2 peroxisomal disorders*	*0-64*
E71.540	*Rhizomelic chondrodysplasia punctata*	*0-64*
E71.541	*Zellweger-like syndrome*	*0-64*
E71.542	*Other group 3 peroxisomal disorders*	*0-64*
E71.548	*Other peroxisomal disorders*	*0-64*
E72.01	*Cystinuria*	*0-20*
E72.02	*Hartnup's disease*	*0-20*
E72.03	*Lowe's syndrome*	*0-20*
E72.04	*Cystinosis*	*0-20*
E72.09	*Other disorders of amino-acid transport*	*0-20*
E72.11	*Homocystinuria*	*0-20*
E72.12	*Methylenetetrahydrofolate reductase deficiency*	*0-20*
E72.19	*Other disorders of sulfur-bearing amino-acid metabolism*	*0-20*
E72.20	*Disorder of urea cycle metabolism, unspecified*	*0-20*
E72.21	*Argininemia*	*0-20*
E72.22	*Arginosuccinic aciduria*	*0-20*
E72.23	*Citrullinemia*	*0-20*
E72.29	*Other disorders of urea cycle metabolism*	*0-20*
E72.3	*Disorders of lysine and hydroxylysine metabolism*	*0-20*
E72.4	*Disorders of ornithine metabolism*	*0-20*
E72.51	*Non-ketotic hyperglycinemia*	*0-20*
E72.52	*Trimethylaminuria*	*0-20*
E72.53	*Hyperoxaluria*	*0-20*
E72.59	*Other disorders of glycine metabolism*	*0-20*
E72.8	*Other specified disorders of amino-acid metabolism*	*0-20*
E74.00	*Glycogen storage disease, unspecified*	*0-20*
E74.01	*von Gierke disease*	*0-20*
E74.02	*Pompe disease*	*0-20*
E74.03	*Cori disease*	*0-20*
E74.04	*McArdle disease*	*0-20*
E74.09	*Other glycogen storage disease*	*0-20*
E74.12	*Hereditary fructose intolerance*	*0-20*
E74.19	*Other disorders of fructose metabolism*	*0-20*
E74.21	*Galactosemia*	*0-20*
E74.29	*Other disorders of galactose metabolism*	*0-20*
E74.4	*Disorders of pyruvate metabolism and gluconeogenesis*	*0-20*

E75.00	*GM2 gangliosidosis, unspecified*	*0-20*
E75.01	*Sandhoff disease*	*0-20*
E75.02	*Tay-Sachs disease*	*0-20*
E75.09	*Other GM2 gangliosidosis*	*0-20*
E75.10	*Unspecified gangliosidosis*	*0-20*
E75.11	*Mucolipidosis IV*	*0-20*
E75.19	*Other gangliosidosis*	*0-20*
E75.21	*Fabry (-Anderson) disease*	*0-20*
E75.22	*Gaucher disease*	*0-20*
E75.23	*Krabbe disease*	*0-20*
E75.240	*Niemann-Pick disease type A*	*0-20*
E75.241	*Niemann-Pick disease type B*	*0-20*
E75.242	*Niemann-Pick disease type C*	*0-20*
E75.243	*Niemann-Pick disease type D*	*0-20*
E75.248	*Other Niemann-Pick disease*	*0-20*
E75.25	*Metachromatic leukodystrophy*	*0-20*
E75.29	*Other sphingolipidosis*	*0-20*
E75.3	*Sphingolipidosis, unspecified*	*0-20*
E75.4	*Neuronal ceroid lipofuscinosis*	*0-20*
E75.5	*Other lipid storage disorders*	*0-20*
E76.01	*Hurler's syndrome*	*0-64*
E76.02	*Hurler-Scheie syndrome*	*0-64*
E76.03	*Scheie's syndrome*	*0-64*
E76.1	*Mucopolysaccharidosis, type II*	*0-64*
E76.210	*Morquio A mucopolysaccharidoses*	*0-64*
E76.211	*Morquio B mucopolysaccharidoses*	*0-64*
E76.219	*Morquio mucopolysaccharidoses, unspecified*	*0-64*
E76.22	*Sanfilippo mucopolysaccharidoses*	*0-64*
E76.29	*Other mucopolysaccharidoses*	*0-64*
E76.3	*Mucopolysaccharidosis, unspecified*	*0-64*
E76.8	*Other disorders of glucosaminoglycan metabolism*	*0-64*
E77.0	*Defects in post-translational mod of lysosomal enzymes*	*0-20*
E77.1	*Defects in glycoprotein degradation*	*0-20*
E77.8	*Other disorders of glycoprotein metabolism*	*0-20*
E79.1	*Lesch-Nyhan syndrome*	*0-64*
E79.2	*Myoadenylate deaminase deficiency*	*0-64*
E79.8	*Other disorders of purine and pyrimidine metabolism*	*0-64*
E79.9	*Disorder of purine and pyrimidine metabolism, unspecified*	*0-64*
E80.3	*Defects of catalase and peroxidase*	*0-64*
E84.0	*Cystic fibrosis with pulmonary manifestations*	*0-64*
E84.11	*Meconium ileus in cystic fibrosis*	*0-64*
E84.19	*Cystic fibrosis with other intestinal manifestations*	*0-64*
E84.8	*Cystic fibrosis with other manifestations*	*0-64*
E84.9	*Cystic fibrosis, unspecified*	*0-64*
E88.40	*Mitochondrial metabolism disorder, unspecified*	*0-64*

E88.41	*MELAS syndrome*	*0-64*
E88.42	*MERRF syndrome*	*0-64*
E88.49	*Other mitochondrial metabolism disorders*	*0-64*
E88.89	*Other specified metabolic disorders*	*0-64*
F84.2	*Rett's syndrome*	*0-20*
G11.0	*Congenital nonprogressive ataxia*	*0-20*
G11.1	*Early-onset cerebellar ataxia*	*0-20*
G11.2	*Late-onset cerebellar ataxia*	*0-20*
G11.3	*Cerebellar ataxia with defective DNA repair*	*0-20*
G11.4	*Hereditary spastic paraplegia*	*0-20*
G11.8	*Other hereditary ataxias*	*0-20*
G11.9	*Hereditary ataxia, unspecified*	*0-20*
G12.0	*Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)*	*0-20*
G12.1	*Other inherited spinal muscular atrophy*	*0-20*
G12.21	*Amyotrophic lateral sclerosis*	*0-20*
G12.22	*Progressive bulbar palsy*	*0-20*
G12.29	*Other motor neuron disease*	*0-20*
G12.8	*Other spinal muscular atrophies and related syndromes*	*0-20*
G12.9	*Spinal muscular atrophy, unspecified*	*0-20*
G24.1	*Genetic torsion dystonia*	*0-64*
G24.8	*Other dystonia*	*0-64*
G25.3	*Myoclonus*	*0-5*
G25.9	*Extrapyramidal and movement disorder, unspecified*	*0-20*
G31.81	*Alpers disease*	*0-20*
G31.82	*Leigh's disease*	*0-20*
G31.9	*Degenerative disease of nervous system, unspecified*	*0-20*
G32.81	*Cerebellar ataxia in diseases classified elsewhere*	*0-20*
G37.0	*Diffuse sclerosis of central nervous system*	*0-64*
G37.5	*Concentric sclerosis (Balo) of central nervous system*	*0-64*
G71.0	*Muscular dystrophy*	*0-64*
G71.11	*Myotonic muscular dystrophy*	*0-64*
G71.2	*Congenital myopathies*	*0-64*
G80.0	*Spastic quadriplegic cerebral palsy*	*0-64*
G80.1	*Spastic diplegic cerebral palsy*	*0-20*
G80.3	*Athetoid cerebral palsy*	*0-64*
G82.50	*Quadriplegia, unspecified*	*0-64*
G82.51	*Quadriplegia, C1-C4 complete*	*0-64*
G82.52	*Quadriplegia, C1-C4 incomplete*	*0-64*
G82.53	*Quadriplegia, C5-C7 complete*	*0-64*
G82.54	*Quadriplegia, C5-C7 incomplete*	*0-64*
G91.0	*Communicating hydrocephalus*	*0-20*
G91.1	*Obstructive hydrocephalus*	*0-20*
I67.5	*Moyamoya disease*	*0-64*
K91.2	*Postsurgical malabsorption, not elsewhere classified*	*0-20*

N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64
Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64

Q07.03	*Arnold-Chiari syndrome with spina bifida and hydrocephalus*	*0-64*
Q30.1	*Agenesis and underdevelopment of nose, cleft or absent nose only*	*0-5*
Q30.2	*Fissured, notched and cleft nose, cleft or absent nose only*	*0-5*
Q31.0	*Web of larynx*	*0-20*
Q31.8	*Other congenital malformations of larynx, atresia or agenesis of larynx only*	*0-20*
Q32.1	*Other congenital malformations of trachea, atresia or agenesis of trachea only*	*0-20*
Q32.4	*Other congenital malformations of bronchus, atresia or agenesis of bronchus only*	*0-20*
Q33.0	*Congenital cystic lung*	*0-20*
Q33.2	*Sequestration of lung*	*0-20*
Q33.3	*Agenesis of lung*	*0-20*
Q33.6	*Congenital hypoplasia and dysplasia of lung*	*0-20*
Q35.1	*Cleft hard palate*	*0-20*
Q35.3	*Cleft soft palate*	*0-20*
Q35.5	*Cleft hard palate with cleft soft palate*	*0-20*
Q35.9	*Cleft palate, unspecified*	*0-20*
Q37.0	*Cleft hard palate with bilateral cleft lip*	*0-20*
Q37.1	*Cleft hard palate with unilateral cleft lip*	*0-20*
Q37.2	*Cleft soft palate with bilateral cleft lip*	*0-20*
Q37.3	*Cleft soft palate with unilateral cleft lip*	*0-20*
Q37.4	*Cleft hard and soft palate with bilateral cleft lip*	*0-20*
Q37.5	*Cleft hard and soft palate with unilateral cleft lip*	*0-20*
Q37.8	*Unspecified cleft palate with bilateral cleft lip*	*0-20*
Q37.9	*Unspecified cleft palate with unilateral cleft lip*	*0-20*
Q39.0	*Atresia of esophagus without fistula*	*0-3*
Q39.1	*Atresia of esophagus with tracheo-esophageal fistula*	*0-3*
Q39.2	*Congenital tracheo-esophageal fistula without atresia*	*0-3*
Q39.3	*Congenital stenosis and stricture of esophagus*	*0-3*
Q39.4	*Esophageal web*	*0-3*
Q42.0	*Congenital absence, atresia and stenosis of rectum with fistula*	*0-5*
Q42.1	*Congen absence, atresia and stenosis of rectum without fistula*	*0-5*
Q42.2	*Congenital absence, atresia and stenosis of anus with fistula*	*0-5*
Q42.3	*Congenital absence, atresia and stenosis of anus without fistula*	*0-5*
Q42.8	*Congenital absence, atresia and stenosis of other parts of large intestine*	*0-5*
Q42.9	*Congenital absence, atresia and stenosis of large intestine, part unspecified*	*0-5*
Q43.1	*Hirschsprung's disease*	*0-15*
Q44.2	*Atresia of bile ducts*	*0-20*
Q44.3	*Congenital stenosis and stricture of bile ducts*	*0-20*
Q44.6	*Cystic disease of liver*	*0-20*
Q45.0	*Agenesis, aplasia and hypoplasia of pancreas*	*0-5*
Q45.1	*Annular pancreas*	*0-5*
Q45.3	*Other congenital malformations of pancreas and pancreatic duct*	*0-5*

Q45.8	*Other specified congenital malformations of digestive system*	*0-10*
Q60.1	*Renal agenesis, bilateral*	*0-20*
Q60.4	*Renal hypoplasia, bilateral*	*0-20*
Q60.6	*Potter's syndrome, with bilateral renal agenesis only*	*0-20*
Q61.02	*Congenital multiple renal cysts, bilateral only*	*0-20*
Q61.19	*Other polycystic kidney, infantile type, bilateral only*	*0-20*
Q61.2	*Polycystic kidney, adult type, bilateral only*	*0-20*
Q61.3	*Polycystic kidney, unspecified, bilateral only*	*0-20*
Q61.4	*Renal dysplasia, bilateral only*	*0-20*
Q61.5	*Medullary cystic kidney, bilateral only*	*0-20*
Q61.9	*Cystic kidney disease, unspecified, bilateral only*	*0-20*
Q64.10	*Exstrophy of urinary bladder, unspecified*	*0-20*
Q64.12	*Cloacal extrophy of urinary bladder*	*0-20*
Q64.19	*Other exstrophy of urinary bladder*	*0-20*
Q75.0	*Craniosynostosis*	*0-20*
Q75.1	*Craniofacial dysostosis*	*0-20*
Q75.2	*Hypertelorism*	*0-20*
Q75.4	*Mandibulofacial dysostosis*	*0-20*
Q75.5	*Oculomandibular dysostosis*	*0-20*
Q75.8	*Other congenital malformations of skull and face bones*	*0-20*
Q77.4	*Achondroplasia*	*0-1*
Q77.6	*Chondroectodermal dysplasia*	*0-1*
Q77.8	*Other osteochondrodysplasia with defects of growth of tubular bones and spine*	*0-1*
Q78.0	*Osteogenesis imperfecta*	*0-20*
Q78.1	*Polyostotic fibrous dysplasia*	*0-1*
Q78.2	*Osteopetrosis*	*0-1*
Q78.3	*Progressive diaphyseal dysplasia*	*0-1*
Q78.4	*Enchondromatosis*	*0-1*
Q78.6	*Multiple congenital exostoses*	*0-1*
Q78.8	*Other specified osteochondrodysplasias*	*0-1*
Q78.9	*Osteochondrodysplasia, unspecified*	*0-1*
Q79.0	*Congenital diaphragmatic hernia*	*0-1*
Q79.1	*Other congenital malformations of diaphragm*	*0-1*
Q79.2	*Exomphalos*	*0-1*
Q79.3	*Gastroschisis*	*0-1*
Q79.4	*Prune belly syndrome*	*0-1*
Q79.59	*Other congenital malformations of abdominal wall*	*0-1*
Q89.7	*Multiple congenital malformations, not elsewhere classified*	*0-10*
R75	*Inconclusive laboratory evidence of HIV*	*0-12 months*
Z21	*Asymptomatic human immunodeficiency virus infection status*	*0-20*
Z99.11	*Dependence on respirator (ventilator) status*	*1-64*
Z99.2	*Dependence on renal dialysis*	*21-64*

Section V

MDH Quality Improvement and MCO Oversight Activities

Quality Assurance Monitoring Plan

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

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

The Department has adopted a variety of methods and data reporting activities to assess MCO service quality to Medicaid members. These areas include:

- Health Service Needs screening conducted by the enrollment broker at the time the participant selects an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs.

- A complaint process administered by Department staff.

- A complaint process administered by University of Maryland Health Partners

- A review of each MCO's quality improvement processes and clinical care through an annual systems performance review performed by an External Quality Review Organization (EQRO) selected by the Department. The audit assesses the structure, process, and outcome of each MCO's internal quality assurance program.

- The annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures designed by the National Committee

for Quality Assurance. The measures are audited by an independent entity and results are reported to MDH.

- The annual collection and evaluation of a set of performance measures identified by the Department.

- An annual member satisfaction survey using the Consumer Assessment of Health Plans Survey (CAHPS)

- Monitoring of preventive health, access and quality of care outcome measures based on encounter data.

- Development and implementation of HealthChoice outreach plan.

- A review of services to children to determine our compliance with federally required EPSDT standards of care.

- The annual production of a Consumer Report Card.

Quarterly Complaint Reporting

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

University of Maryland Health Partners Member Hotline

University of Maryland Health Partners maintains a member services unit that operates a member services hotline Monday through Friday from 8:00 am through 5:00 pm. This unit handles and resolves or properly refers members' inquiries or complaints to other agencies. Additionally, we provide members with information about how to access our member services unit and consumer services hotline to obtain information and assistance. The number for members is 800-730-8530 and for providers is 800-730-8543 / 410-779-9359.

University of Maryland Health Partners Member Complaint Policy and Procedures

University of Maryland Health Partners has written complaint policies and

procedures whereby an member who is dissatisfied with the MCO or its network may seek recourse verbally or in writing from the HealthChoice Help Line staff. University of Maryland Health Partners must submit its written internal complaint policy and procedures to the Department for its approval.

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

University of Maryland Health Partners includes in its written internal complaint process the procedures for registering and responding to appeals and grievances in a timely fashion. These procedures include resolving emergency medically related grievances within 24 hours, non-emergency medically related grievances within 5 days and administrative grievances within 30 days. In addition, the written procedures:

1. Require documentation of the substance of the complaints and steps taken to resolve;
2. Include participation by the provider, if appropriate;
3. Allow participation by the ombudsman, if appropriate;
4. Ensure the participation of individuals within the MCO who have the authority to require corrective action;
5. Include a documented procedure for written notification on the outcome of our determination.
6. Include a procedure for immediate notice to the Department of all disputed denials of benefits or services in emergency medical situations;
7. Include a procedure for notice to the member through an Adverse Action Letter that meets the approval of the Department of all disputed denials, reductions, suspensions, or terminations of services or benefits;
8. Include an appeal process which provides, at its final level, an opportunity for the member to be heard by our Chief Executive Officer, or their designee;
9. Include a documented procedure for reporting of all complaints received by us to appropriate parties; and
10. Include a protocol for the aggregation and analysis of complaints and grievance data and use of the data for quality improvement;

No punitive action will be taken against the member for making a complaint against us or the Department.

Appeals

If the member wants to file an appeal with us, they have to file it within 90 business days from the date of receipt of the denial letter.

You can also file an appeal for them if the member signs a form giving you permission. Other people can also help the member to file an appeal such as a family member or a lawyer.

When the member files an appeal, or at any time during our review they should be sure to provide us with any new information that they have that will help us make our decision.
When reviewing the member's appeal we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease
- Not use the same MCO staff to review the appeal who denied the original request for service
- Make a decision about administrative appeals within 30 days

If the member's doctor or University of Maryland Health Partners feels that the member's appeal should be reviewed quickly due to the seriousness of the member's condition, the member will receive a decision about their appeal within three business days of receipt of the request.

The appeal process may take up to 44 days if the member asks for more time to submit information or if we need to get additional information from other sources. We will send the member a letter if we need additional information.

If the member's appeal is about a service that was already authorized and they were already receiving, they may be able to continue to receive the service while we review their appeal. The member should contact us at 800-730-8530 / 410-779-9359 if they would like to continue receiving services while their appeal is reviewed. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Once we complete our review, we will send the member a letter letting them know our decision. If we decide that they should not receive the denied service, that letter will tell them how to file another appeal through us or ask for a State Fair Hearing.

Grievances

If the member's complaint is about something other than not receiving a service, this is a grievance. Examples of grievances would be, not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone

who works at University of Maryland Health Partners or at the doctor's office.

If the member's grievance is:

- About an urgent medical problem that they are having, it will be solved within 24 hours
- About a medical problem but it is not urgent, it will be solved within 5 days
- Not about a medical problem, it will be solved within 30 days

If a member would like a copy of our official complaint procedure or if they need help filing a complaint, they can call 800-730-8530 / 410-779-9359**.**

University of Maryland Health Partners Provider Complaint Process

University of Maryland Health Partners wants to have a positive working relationship with all of our health care providers. We recognize that we may not always be able to achieve this goal and want to hear from our providers when they are dissatisfied with an administrative process within University of Maryland Health Partners. A University of Maryland Health Partners provider may file a grievance at any time in writing or by calling any University of Maryland Health Partners staff member.

Grievances are managed by the UMHP Appeals and Grievances (A&G) Department. Grievances are accepted verbally or in writing by any University of Maryland Health Partners staff person and then routed to the A&G Department. All grievances are responded to in writing; acknowledged within 5 business days of receipt; investigated by the department that is the subject of the grievance, and resolved within 30 calendar days of receipt. All provider grievances are logged, categorized and on completion, are evaluated by the Appeals and Grievances Committee and the Quality Improvement Committee for patterns and/or trends.

If a provider is not satisfied with the actions taken by University of Maryland Health Partners in addressing the grievance, they may contact the State's Complaint Resolution Unit at 1-800-284-4510 for further action.

University of Maryland Health Partners Provider Appeal Process

A provider may appeal a decision by University of Maryland Health Partners to deny or partially deny payment of services rendered. An appeal must be filed within 180 days of the date of the denial of payment.

University of Maryland Health Partners will acknowledge an appeal in writing within 5 business days of receipt. University of Maryland Health Partners will resolve an appeal in writing within 30 days of receipt.

University of Maryland Health Partners will provide a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. University of Maryland Health Partners will permit the provider the opportunity before and during the appeal process to examine the appeals case file including medical records and any other documents and records. When reviewing the appeal, University of Maryland Health Partners will consider a full investigation of the substance of the appeal including any clinical aspects. University of Maryland Health Partners will appoint a new reviewer, who was not involved with the initial determination, is not a subordinate of any person involved in the initial determination and is of the same or similar specialty as typically treats the medical condition or performs the procedure on appeals of an adverse determination.

Notification of the Outcome of Appeal

When the outcome of the appeal is known, the results and the date of the appeal resolution will be provided in writing to the provider. The resolution letter will contain the rationale for the determination, the credentials of the reviewer involved in the determination, and the opportunity for a second level appeal.

Second Level Appeal

At a second level review, Provider Claim Appeal disputes related to a denial based on medical necessity that remain unresolved subsequent to the Provider Appeal is reviewed by a physician contracted by University of Maryland Health Partners, who is not a Network Provider. The contracted physician resolving the Claim Payment Appeal dispute holds the same specialty or a related specialty as the Appealing Provider. The contracted physician's determination is binding by University of Maryland Health Partners and the Appealing Provider.

The provider must notify University of Maryland Health Partners of their request for a second level appeal within 15 business days of the date of the letter noting the outcome of the appeal. University of Maryland Health Partners will acknowledge the request for a second level appeal in writing within 5 days of receipt. A

meeting between the University of Maryland Health Partners Chief Executive Officer or designee, the provider and a provider who was not involved in the case is scheduled. University of Maryland Health Partners appoints a new reviewer who was not involved with the initial determination, is not a subordinate of any person involved in the initial appeal determination and is of the same or similar specialty as typically treats the medical condition or performs the procedure. The selected reviewer receives all documentation used in the initial appeal process for review and any additional information provided for the second level of review. During the informal meeting the appellant, the reviewer and the Chief Executive Officer, or his/her designee, review the evidence and a determination is made by the reviewer. The appellant is notified in writing of the decision. This is the final level of appeal with University of Maryland Health Partners.

University of Maryland Health Partners will pay a claim within 30 days of the appeal decision when a claim denial is overturned.

University of Maryland Health Partners will not take punitive action against a provider for utilizing the provider appeal process.

Independent Review Organization (IRO)

The Department contracts with an IRO for the purpose of providing the final level of appeal for providers who are appealing medical necessity denials. Some of the requirements of the IRO include:

- Providers must exhaust all levels of the MCO appeal

- By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases).
- The IRO only charges **after** making the case determination. If the decision upholds the MCO's denial, you must pay the fee. If the IRO reverses the MCO's denial, the MCO must pay the fee. The web portal will walk you through submitting payments.
- The review fee is $425

More detailed information on the IRO process can be found at https://mmcp.dhmh.maryland.gov/pages/IRO-Information.aspx

The IRO does not handle appeals for mental health or substance use disorder services provided through the Specialty Behavioral Health System.

State's Quality Oversight: Complaint and Appeal Processes

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

HealthChoice Help Line

The HealthChoice Help Line is available Monday through Friday from 8:00 AM to 5:00 PM. The toll free telephone number is: 1-800-284-4510 or TDD at 1-800-735-2258 for the hearing impaired.

Help Line staff are trained to answer questions about the HealthChoice Program. Help Line staff will:

- Direct members to our member services line when needed (MCO insert phone number);
- Attempt to resolve simple issues by contacting us or other parties as needed; and
- Refer medical issues to the State's Complaint Resolution Division for resolution.

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

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

HealthChoice Provider Hotline

The Provider Hotline provides HealthChoice providers access to MDH staff for grievances and inquiries. Provider Hotline staff respond to general inquiries and resolves complaints from providers concerning member access and quality of care as well as educating providers about the HealthChoice Program. The telephone number for the Provider Hotline is 1-800-766-8692; TDD 1-800-735-2258. We will not take any punitive action against you for accessing the Provider Hotline.

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

HealthChoice Complaint Resolution Division

Complex medical issues are referred to the Complaint Resolution Division. The division resolves complaints by:

- Advocates on the caller's behalf to obtain resolution of the issue.
- Communicates with our staff, providers, and advocacy groups to resolve the issue and /or secure possible additional community resources for the member's care when needed.
- Assists members and providers in navigating the MCO system.
- Utilizes the local health department Administrative Care Coordination Unit and Ombudsman Program to provide localized assistance.
- Facilitates working with us and our providers to coordinate plans of care that meet the members' needs.
- Coordinates Coordinating the State appeal process relating to a denied covered benefit or service for the member.

Ombudsman/Administrative Care Coordination Unit (ACCU) Program

The Department operates an Ombudsman/ACCU Program for the purpose of investigating disputes between members and managed care organizations referred by the Department's complaint unit. The ombudsman educates members about the services provided by University of Maryland Health Partners and their rights and responsibilities in receiving services from us. When appropriate, the ombudsman may advocate on the member's behalf including assisting the member to resolve a dispute in a timely manner, using our internal grievance and appeals procedure.

The Ombudsman/ACCU program is operated locally in each county of the State, under the direction of the Department. In most jurisdictions, local health departments carry out the local ombudsman function. A local health department that desires to serve as both the county ombudsman and as a MCO subcontractor must first secure the approval of the Secretary of the Department and of the local governing body. In addition, a local health department may not subcontract the ombudsman program.

Local ombudsman programs include staff with suitable experience and training to address complex issues that may require medical knowledge. When a complaint is referred from the Department's complaint unit, the local ombudsman

may take any or all of the following steps,
as appropriate:

- Attempt to resolve the dispute by educating the MCO or the member;
- Utilize mediation or other dispute resolution techniques;
- Assist the member in negotiating our internal complaint process; and
- Advocate on behalf of the member throughout our internal grievance and appeals process.

All cases referred to the Ombudsman/ACCU, will be resolved within the timeframe specified by the Department's Complaint Resolution Unit or within 30 days of the date of referral.

The local ombudsman does not have the authority to compel us to provide disputed services or benefits. If the dispute is one that cannot be resolved by the local ombudsman's intervention, the local ombudsman will refer the dispute back to the Department for resolution. A local health department may not serve as ombudsman for cases in which the dispute between the member and us involves the services of the local health department as a MCO subcontractor. The Department conducts a periodic review of the Ombudsman Program activities as part of the quarterly and annual complaint review process.

Departmental Dispute Resolution

When a member does not agree with the MCO's decision to deny, stop, or reduce a service, the member can appeal the decision. The member can contact the EHL at 1-800-284-4510 and tell the representative that they would like to appeal the MCO's decision. The appeal will be sent to a nurse in the Complaint Resolution Unit. The Complaint Resolution Unit will attempt to resolve the issue with the MCO in 10 business days. If it cannot be resolved in 10 business days, the member will be sent a notice that gives them a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review. When the Complaint Resolution Unit is finished, working on the appeal, the member will be notified of their findings.

If the Department disagrees with our determination, it may order us to provide the benefit or service immediately.

If the Department agrees with our determination to deny a benefit or service, it will issue written notice within 10 business days to the member, stating the grounds for its decision and explaining the member's appeal rights. The member may exercise their right to an appeal by calling 1-888-767-0013 or by completing the Request for a Fair Hearing form attached to their appeal letter and sending it to:

Susan J. Tucker, Executive Director
Attn: Dina Smoot
Office of Health Services
201 W. Preston Street, Room 127
Baltimore, MD 21201

Member Appeal

A HealthChoice member may exercise their appeal rights pursuant to State Government Article, §10-201 et seq., Annotated Code of Maryland. A member may appeal a Departmental decision that: (1) agrees with our determination to deny a benefit or service; (2) denies a waiver-eligible individual's request to disenroll; or (3) denies a member eligibility in the REM program.

The member may appeal a decision to the Office of Administrative Hearings. In appeals concerning the medical necessity of a denied benefit or service, a hearing that meets Department established criteria, as determined by the Department, for an expedited hearing, shall be scheduled by the Office of Administrative Hearings, and a decision shall be rendered within 3 days of the hearing. In cases other than those that are urgent concerning the medical necessity of a denied benefit or service, the hearing shall be scheduled within 30 days of receipt by the Office of Administrative Hearings of the notice of appeal and a decision shall be rendered within 30 days of the hearing The parties to an appeal to the Office of Administrative Hearings under this section will be the Department and the member, the member's representative or the estate representative of a deceased member. We may move to intervene as a party aligned with the Department.

We will provide all relevant records to the Department and provide witnesses for the Department, as required.

Following the hearing, the Office of Administrative Hearings issues a final decision. The final decision of the Office of Administrative Hearings is appealable to the Board of Review pursuant to Health-General Article,§ 2-201 to 2-207, Annotated Code of Maryland. The decision of the Board of Review is appealable to the Circuit Court, and is governed by the procedures specified in State Government Article, §10-201 et seq., Annotated Code of Maryland.

University of Maryland Health Partners's Quality Management

Overview

This is the Quality Assurance Plan (QAP) for University of Maryland Health Partners; a managed care organization founded to meet the healthcare needs of Maryland's HealthChoice members. It is the goal of University of Maryland Health Partners to provide a quality and performance improvement program that is continuous, systematic, and data driven and designed to monitor, measure, evaluate, and improve the quality of health care services delivered to HealthChoice members. In collaboration with the State of Maryland (Department), CMS and Delmarva, the External Quality Review Organization (EQRO), University of Maryland Health Partners will operationalize a robust and meaningful quality and performance improvement program that is consistent with access and quality standards for members, including those with special health needs, and complies with all applicable federal laws and laws of the State of Maryland.

University of Maryland Health Partners has selected clinical and access standards using HEDIS® and Non-HEDIS® measures to achieve their objective of providing quality of care to its members. The Quality Assurance Program Description (QAPD) is organized and written so staff members and providers can understand the program's goals, objectives and structure. University of Maryland Health Partners updates the QAPD annually. A copy is available to providers upon request.

Scope

Quality is the core concept that drives each department at University of Maryland Health Partners. The organization has developed process measures to assure optimal performance for each department and systematically collects data to measure outcomes. This includes, but is not limited to, Health Services, Provider Relations, Credentialing, Compliance, Member Services, Appeals and Grievance, and Claims. Special attention is given to high volume, high-risk areas of care and service for our population and to all facets of care and service for the special needs populations. Health promotion and health management activities are also an integral part of the Quality Improvement Program (QIP).
The scope of the quality plan includes the following:

- Measure performance against key monitors for quality improvement (clinical and non-clinical) as identified by the Quality Improvement Program (QIP) and activities identified in the Quality Improvement Work Plan.
- Review of the quality and utilization of clinical care and service, including inpatient and outpatient care provided by hospitals, practitioners, health care professionals and ancillary providers.

- Ensure compliance with applicable regulatory and contractual requirements including state and federal regulations
- Analyze, identify and address continuity and coordination of care.
- Analyze, identify and address areas of under and over-utilization.
- Monitor, identify and investigate potential Quality of Care/Quality of Service (QOC/QOS) issues. Implement improvement actions as needed.
- Analyze, identify and address areas that will improve patient safety.
- Analyze, identify and address member and practitioner satisfaction information.
- Analyze, identify and address access to and availability of care, including Special Needs Population
- Solicit member and provider input on performance and QI activities.

Responsibility and Accountability

The Board of Directors (BOD) of University of Maryland Health Partners has ultimate accountability for the development and implementation of the quality program. The governing body of University of Maryland Health Partners is the Board of Directors. The Board's participation with quality issues is not direct. The Quality improvement committee structure is comprised of senior management leadership. The BOD has delegated the day-to-day oversight of the program to the Quality Improvement Committee. The clinical program is under the direction of the Chief Medical Officer, a Maryland licensed board certified physician, who is responsible for its implementation. The Quality Improvement Committee is responsible to provide QIC minutes, written reports from the QIC and the QIC's subcommittees at least annually. The Utilization Management Program is responsible to the Board through the Quality Improvement Committee and is under the direction of the University of Maryland Health Partners Chief Medical Officer who is responsible for decision-making. The Vice President of Health Services oversees the day-to-day function of the Utilization Management Department. The Board approves all documents pertaining to the quality program including the Quality Assurance Program Description (QAPD), the Quality Improvement Work Plan (QIWP), and the annual Quality Improvement Evaluation (QIE).

Monitoring

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators to monitor is derived from as many sources as appropriate. The quality indicators are measurable, based on reasonable research, and use current and accepted quality methodologies. Examples of monitoring indicators may include: tracking and trending of inpatient or outpatient acute or chronic conditions, access performance measurements, or

unique specific indicators as identified from local epidemiology or demographics.

a. QA Studies- Using the NCQA approved QIA methodology and form
b. Trending of clinical and service indicators and other performance data, including HEDIS® and CAHPS® results
   i. The effectiveness of the plan's clinical improvement activities are most often assessed through HEDIS® Effectiveness of Care Measures and the Value Based Purchasing Measures. However, University of Maryland Health Partners may use other measurement methodologies, as appropriate, when a unique indicator is selected for improvement
c. Demonstrated improvement in quality
d. Areas of Deficiency
e. Recommendations for Corrective Action Plans (CAPs)
f. An evaluation of overall effectiveness

Quality Studies and other monitoring quality indicators will be added to the QI Work Plan and presented to the PAC, and reported to the QIC.

Goals and Objectives – Quality Assessment Plan (QAP)

University of Maryland Health Partners strives to continuously improve the care and service provided by our health care delivery system. University of Maryland Health Partners's Maryland Medicaid Quality Assessment Plan (QAP) the overarching goals for the quality plan include:

- The Systematic improvement in the quality of health care
- Respect for the patient-physician relationship
- Member-focused innovation
- Compassion for people
- Honesty and integrity

For the first year of operation, University of Maryland Health Partners has established the following more specific goals and objectives:

Goal: Provide effective monitoring and evaluation of patient care and services to ensure that care provided by health plan practitioners/providers meets the requirements of good medical practice and is positively perceived by health plan members and health care professionals.

Goal: Evaluate and disseminate clinical and preventive practice guidelines. Monitor performance of practitioners and providers against Evidence-based Medicine. Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/recredentialing, peer review, etc.).

Goal: Assure timely access to and availability of appropriate quality services for the population served

- Objective: Ensure qualified individuals and organizations including those with the qualifications and experience appropriate to service members with special needs provide services.
- Objective: Ensure the safety of all members in all treatment settings.
- Objective: Improve the health service delivery system by implementing policies and work processes to conduct access, availability, quality, utilization, care coordination, credentialing, compliance and fiscal monitoring using defined standards.
- Objective: Establish outcome measures and begin to collect data to improve the medical and mental health of individuals served by University of Maryland Health Partners.

Goal: Encourage and mentor providers and plan staff in the implementation of the quality program and the methods to ensure compliance with University of Maryland Health Partners policies and guidelines and support a provider and community culture of quality improvement.

- Objective: Implement programs that support all University of Maryland Health Partners staff in application of quality methodology through structured education, training and mentoring.
- Objective: Establish performance measures tied to practitioner and provider reimbursement.
- Objective: Implement a rigorous delegation oversight process to include pre-delegation review, structured oversight and reporting and corrective actions as needed.
- Objective: Provide adequate infrastructure and resources to support a quality culture.

Goal: Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up. Identify and monitor important aspects of care and services, quality indicators, problems, and concerns about health care services provided to members. Implement and conduct a comprehensive Quality Improvement Program. Recognize that opportunities for improvement are unlimited.

Goal: Provide ongoing feedback to health plan members and practitioners regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities. Support re-measurement of effectiveness and continued development and implementation of improvement interventions.

Goal: Assure community involvement in maintaining and improving member health though a comprehensive community/provider partnership.

- Implement a structured education program for staff, practitioners/providers, members, and the community in best practices/evidence based practices.

- Establish the processes for coordination and collaboration of care between providers, University of Maryland Health Partners and the members we serve.

Initiatives

UMHP Heath's quality plan plays a key role in infusing a quality mindset to the following functions and concepts within University of Maryland Health Partners:

- To promote and incorporate quality into University of Maryland Health Partners's organizational structure and processes.
    1. Facilitate a partnership between members; practitioners, providers and health plan staff for the continuous improvement of quality health care delivery.
    2. Clearly define roles, responsibilities and accountability for the quality program.
    3. Continuously improve communication and education in support of these efforts.
    4. Consider and facilitate achievement of public health goals in the areas of health promotion and early detection and treatment.

- Provide effective monitoring and evaluation of patient care and services that ensures care provided by University of Maryland Health Partners practitioners/providers meets the requirements of good medical practice and is positively perceived by health plan members and health care professionals.
    1. Evaluate and disseminate clinical and preventive practice guidelines.
    2. Monitor performance of practitioners and providers against Evidence-based Medicine.
    3. Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/re-credentialing, peer review, etc.).
    4. Survey UMHP's members and practitioners' satisfaction with the quality of care and services provided.
    5. Complete Performance Improvement Projects for Medicaid specific QI projects
    6. Develop, define, and maintain data systems to support quality improvement activities and encourage data-driven decision-making.
    7. Provide disease management programs that improve the quality of life for chronically ill members.

- To ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.

1. Identify and monitor important aspects of care and services, quality indicators, problems, and concerns about health care services provided to members.
2. Implement and conduct a comprehensive Quality and Performance Improvement Program.
3. Recognize that opportunities for improvement are unlimited.
4. Provide ongoing feedback to University of Maryland Health Partners members and practitioners regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities.
5. Support re-measurement of effectiveness and continued development and implementation of improvement interventions.

- To coordinate quality improvement, risk management and patient safety activities.
    1. Aggregate and use data to develop quality improvement activities.
    2. Provide a regular means by which risk management is included in the development of quality improvement initiatives.
    3. Identify, develop and monitor key aspects of patient safety

- To maintain compliance with local, state and federal regulatory requirements and accreditation standards.
    1. Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
    2. Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.

Work Plan

In order to meet each program's annual quality improvement objectives and maintain the mission of this Quality Improvement Plan, a comprehensive work plan has been created. This work plan outlines activities for each program with responsibilities across multiple departments. The QIWP is a dynamic document that is updated frequently and reflects the progress on quality improvement activities throughout the year.

Quality of Care Issues

In the course of their daily responsibilities, University of Maryland Health Partners staff screen patient encounters for potential quality of care issues or adverse events. All such occurrences are reported to the Quality Improvement department for follow up. The information is reviewed and acted upon as

directed by the physician advisors. The results are tracked in a database to allow for trending.

University of Maryland Health Partners monitors member experience with its services and identifies areas of potential improvement. University of Maryland Health Partners resolves complaints regarding the quality of care delivered by a participating network provider.

Data Collection and Analysis

Data is collected from multiple sources. These sources may include, but are not limited to the following: medical record review; administrative claims data; pharmacy claims data; member and provider surveys; complaints and grievance data; and clinical data. The security, integrity, and confidentiality of all patient information is maintained according to University of Maryland Health Partners's policies and procedures as well as state and federal regulations. Performance data is used to set quality goals and objectives.

VI. Corrective Managed Care

Pharmacy Lock-In Program

University of Maryland Health Partners has implemented a Pharmacy Lock-In Program to address the potential misuse and/or abuse of controlled drugs for members that meet the following criteria: Six (6) prescriptions for controlled drugs, three (3) different prescribers and/or three (3) different pharmacies during a thirty (30) day period.

When enrolled in the Lock-In program members are required to receive all prescriptions from one pharmacy. The pharmacy selected will be the one most used by the member.

Members and their Primary Care Providers will receive notification of the pharmacy lock-in as well as information on their appeal rights and ability to request a different pharmacy.

If a member attempts to fill a prescription at other than the designated pharmacy they will receive a rejection message stating, "R50 Non-Matched Pharmacy Nbr Member Pharmacy Override Exclusion"

Prescribers will receive a Drug History Profile listing the details on their prescribing history and a Prescriber Response Letter that allows the prescriber to provide feedback to UMHP on the members' treatments.

UNIVERSITY of MARYLAND HEALTH PARTNERS

Appeals and Grievance Form

Use this form if you want to tell us you have a complaint or when you don't agree with a decision we made about your health care (an appeal). For help with this form, please call us at 1-410-779-9369 or 1-800-730-8530. TTY users should call 711. Our Member Services staff can talk to you Monday to Friday from 8 am to 5 pm.

Member Name: _____ Member ID: _____Today's Date_____

Member ID Number: _____

Phone Number: Home: _____ Cell: _____Other:_____

Please tell us why you are filing this complaint:

□ You don't agree with an decision we made not to cover a service your doctor asked for (appeal)
□ You have a complaint (grievance)
Tell us more (you can attach a separate piece of paper if you need more room)

_____
_____
_____

Name of Member's Primary Care Provider Name (if applicable):_____

Date(s) of Service (if needed) _____

It may take us up to 30 days to get back to you.
Do you or your doctor think that waiting 30 days could be bad for your health?
□ Yes □ No
If yes, please tell us why (you can attach a separate piece of paper if you need more room)

_____
_____
_____

Signature of UM Health Partners Member:

_____

Please fax the form to 410-779-9367 or mail it to:

University of Maryland Health Partners
Attention: Appeals & Grievances Department
1966 Greenspring Drive, Suite 100
Lutherville-Timonium, MD 21093

If you are NOT the University of Maryland Health Partners member, but are filing this on behalf of the University of Maryland Health Partners member, complete this section. Unless you are the parent of the member, federal and state laws require us to get official authorization for you to represent our member. If the University of Maryland Health Partners member has not signed this document, you need to attach a completed Appointment of Representative Form; a letter from our member letting us know that you can represent them; proof of guardianship; or Durable Power of Attorney for Health Care.

Signature of Representative: _____Your Name: _____

Relationship to Member:

_____

Phone Number: Home: _____ Cell: _____Other:_____

University of Maryland Medical System Health Plans

In 2015, the University of Maryland Medical System (UMMS) acquired Riverside Health Inc. As part of the acquisition, the University of Maryland Medical System Health Plans is the new parent company offering Medicaid and Medicare health plans.

"The acquisition of Riverside Health will pave the way for UMMS to enter the Medicaid and Medicare managed care market in Maryland. We are very fortunate to draw on Riverside Health's expertise and infrastructure as we move ahead toward offering a benefit plan including a Medicare Advantage product. Offering insurance products fits well with our model to be a comprehensive health services provider to the people of Maryland and beyond."

Robert A. Chrencik, President and Chief Executive Officer of University of Maryland Medical System

"Riverside Health was founded with the goal of improving health care for the most vulnerable by bridging the gaps between providers and payors. Joining UMMS provides us the opportunity to create synergies to continuously improve the services we provide our members."

Mark Puente, President and Chief Executive Officer of University of Maryland Medical System Health Plans

(formerly Riverside Health, Inc.)

University of Maryland Health Partners

University of Maryland Health Partners is a Medicaid Managed Care Organization that serves members in the Maryland HealthChoice program.

The Maryland Department of Health (MDH) provides Medical Assistance, also called Medicaid coverage to individuals determined to be categorically eligible or medically needy. Medicaid coverage is automatically given to individuals receiving certain other public assistance, such as Supplemental Security Income (SSI), Temporary Cash Assistance (TCA), or Foster Care.

University of Maryland Health Advantage

University of Maryland Health Advantage is an HMO and HMO-SNP Plan with a Medicare contract and a State of Maryland Department of Health (Medicaid) program contract. Enrollment in University of Maryland Health Advantage depends on contract renewal. University of Maryland Health Advantage offers greater value than original Medicare, with lower out-of-pocket costs.

Medicare Advantage Prescription Drug Plan (HMO)

- For those with Medicare Parts A & B only

Medicare Advantage Dual Eligible Special Needs Plan (HMO-SNP)

- For those with both Medicare (Parts A & B) and Medicaid (not enrolled in Medicaid Managed Care)

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