MedStar Family Choice

Maryland HealthChoice Program

Provider Newsletter

1st Quarter 2023

In This Issue

Important information regarding redetermination

As of April 1, 2023, Maryland Medicaid will resume eligibility renewals (also called redeterminations) to determine if individuals and their family members qualify for coverage through Medicaid or the Maryland Children's Health Insurance Program (MCHP). Over the course of the next 12 months, all Medicaid recipients will receive a renewal notice. (Please note that not everyone is up for renewal at the same time.)

What you can do to help your patients prepare

You can help by reminding your patients who have Medicaid to:

Update their contact information with the state, ensuring their mailing address, phone number, email or other contact information is correct. Your patients can go to MarylandHealthConnection.gov or call **855-642-8572** to update their contact information. Recipients can also go to their local Department of Social Services or Local Health Department for assistance.

Check their mail and email for information from the state about coverage and renewal requirements

Complete their renewal application promptly and return it to their state to help avoid a gap in coverage. Individuals who enroll for benefits through the Maryland Health Connection have 45 days to respond. Individuals who enroll through my MDTHINK because they are aged, blind, or disabled will have 60 days to respond.

Things to note

MedStar Family Choice is also offering support and information directly to our members to help prepare them for Medicaid redetermination. Our members will receive various forms of communication to remind them to complete their renewal when it is their turn. Phone, email, mail, texts, and social media are just a few ways in which we will outreach to our Medicaid members.

Flyers are available on the Maryland Department of Health resource page (link below). We encourage you to distribute these flyers to your Medicaid patients to help them keep their health insurance coverage.

If a patient or their family member no longer qualifies for Medicaid or MCHP, they may be able to buy a health plan through the Maryland Health Benefit Exchange or their employer

For more details on redeterminations, go to **https://health.maryland.gov/mmcp/pages/medicaidcheckin-providers.aspx** for additional information. This site will be continuously updated. Please be sure to check here often for the most current information and resources related to Maryland Medicaid Redetermination.

Know our access and availability standards

MedStar Family Choice providers must offer hours of operation to MedStar Family Choice members consistent with the items below and the provider's specialty.

HealthChoice regulations require providers to adhere to the following guidelines for appointment scheduling:

- Well-child assessments and routine and preventative primary care appointments:
- 30 days from request
- Routine specialist follow-up appointments: 30 days from request
- Newborn visits: Within three to five days after discharge from the hospital
- Routine dental, lab, and X-rays: 30 days from request
- Initial assessment of pregnant and postpartum women and those requesting family planning services: 10 business days from request
- As a reminder, providers must also maintain: 24/7 phone coverage; for example, 911 and an answering service and/or answering machine with directions for emergency care
- Urgent care appointments within 48 hours of request If the doctor that sees the member is not available, another doctor in the practice should see the member. If there is no availability, an explanation as to why and alternative options for care should be provided to the member.
- Office hours for MedStar Family Choice members must be equivalent to the office hours offered to commercial, Medicare, or other Medicaid patients
- Patient wait time may not exceed 30 minutes after the scheduled appointment time to be seen for regular office visits (this does not apply to patients who are added to the schedule last minute and advised that they will be seen at the first available time).

Throughout the year, MedStar Family Choice will monitor our provider network for adherence to these requirements. In addition, MDH conducts secret shopper activities on a regular basis. In the event your office is identified as not meeting the requirements above during a MedStar Family Choice or Government Program Secret Shopper Campaign, you will be contacted by Provider Relations.

Maryland EPSDT (Healthy Kids) Program

The state of Maryland requires all managed care organizations to adhere to and undergo an annual audit of the Maryland Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Healthy Kids Standards. To assist you with the state EPSDT requirements and audit, please check out our **quick reference checklist below.**

MedStar Family Choice

MedStar Family Choice EPSDT Quick reference

Maryland EPSDT (Healthy Kids)

The state of Maryland **requires** all managed care organizations (MCO's), such as, Medstar Family Choice, to adhere to and undergo an annual audit of the Maryland Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Healthy Kids standards. Here is a checklist to assist you with the state EPSDT requirements and audit.

EPSDT laboratory screening tests

* 2 metabolic screenings (PKU) - first test completed 24 hours after birth.
* Lead and anemia screenings at ages 12 and 24 months.
* Dyslipidemia screening once between ages 9-11 years, 18-20 years.
* HIV testing - 1 test between 15 and 18 years.

EPSDT risk assessments

- ✓ Tuberculosis risk assessment at 1 month, 6 months, 12 month and then annually.
- ✓ Lead risk assessment at 6 months and at every well visit until age 6 years.
- ✓ Autism screening required at the 18 month and 24-30 month visits.
- ✓ Heart disease risk assessment at 2 years and annually.
- ✓ Anemia risk assessment at age 11 years and then annually.
- ✓ STI/HIV risk assessment at age 11 years and then annually.
- ✓ Maternal depression screening when the child is 1 month, 2 months, 4 months, and 6 months of age.
- ✓ Substance abuse screening beginning at age 11 years (or younger, if indicated) and then annually.
- ✓ Mental Health & Depression screenings beginning at 4 years (or younger if indicated) and then annually.

We're here to help

For more information about EPSDT requirements, go to mmcp.healthmary and.gov > EPSDT

Reminders

- Update immunizations, screenings, and assessments in the medical record
- Vaccine history is updated and completed
- A documented referral to a dentist should begin at age 1 and annually
- Enroll in the Vaccines for Children (VFC) program and the Maryland immunization registry (ImmuNet) to update the child's immunization history
- DOCUMENT all refusals of immunizations & care

MedStar Family Choice

Welcome new providers to MedStar Family Choice

MedStar Family Choice would like to welcome the following new providers to our network!

Horizon Eye Physicians LLC

MedStar Franklin Square Family Planning (Obstetrics and Gynecology, Baltimore County)

Privia Medical Group The McCuiston Group (Pediatrics, Washington)

Towson Integrative Health LLC (Chiropractic Medicine, Baltimore County)

In addition, we welcome the following ancillary provider groups into the network:

Ambulatory Surgery Center: MedStar Health Endoscopy Center - Silver Spring LLC

Durable Medical Equipment: Neurotech NA Inc, Zoll Laboratory Services LLC

Infusion/Injectables: InfuCare Rx LLC, Factor One Source Pharmacy LLC

Avoid timely filing denials

A clean claim must be received by MedStar Family Choice within 180 days from the date of service. After 180 days, any claim submitted will be denied as untimely and the claim will not be paid. If the claim is first submitted to another insurance carrier (Commercial, Medicaid fee-for-service, etc.), claims must be submitted within 180 days from the date of the Explanation of Payments (EOP) of the primary carrier. It is always required that the provider submit the EOP with the claim once they receive it.

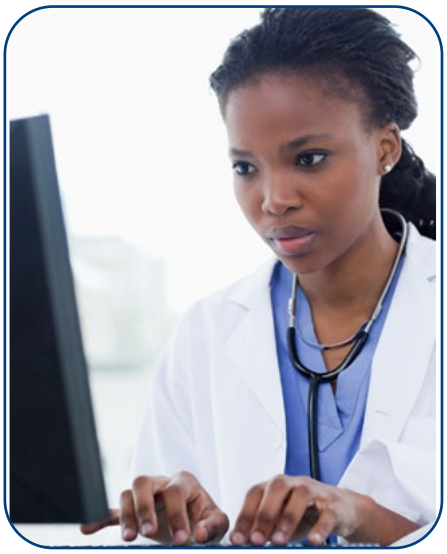
MedStar Family Choice does not accept billing system printouts as proof that a claim was filed in a timely manner. Providers should make every effort to submit their claims as soon as possible. This allows providers additional time to submit corrected new claims within the 180-day timeframe.

Report fraud, waste and abuse

MedStar Family Choice and MedStar Health have compliance programs in place to monitor and detect noncompliance. Fraud, waste, and abuse is a form of noncompliance which could be committed by a provider, member, or even an employee of the managed care organization. As a MedStar Family Choice provider, it is your responsibility to report incidents of fraud, waste, or abuse.

Providers suspecting fraud and abuse must report this immediately by contacting MedStar Family Choice. There are numerous ways in which providers can report compliance issues:

- Contact the Compliance Director at **410-933-2283**
- Contact Provider Relations at **800-905-1722**
- Contact the MedStar Health Corporate Integrity Hotline at **877-811-3411**
- A strict non-retaliation policy is in place for reporting known or suspected fraud, waste, and abuse. Some common examples of fraud, waste, and abuse are:
- Billing for a service that was never performed
- Billing for a service that was rendered by another practitioner
- Unbundling of procedures
- Up-coding
- Performing unnecessary procedures
- Altering or forging a prescription
- Allowing others to use a member's ID card for care
- Inappropriate use of Medicaid resources
- Pass-through billing



Many billing errors are oversights and are not indicators of fraudulent activity. However, fraud, waste, and abuse does occur. MedStar Family Choice implements actions to monitor, identify, and deter these types of activities. We regularly monitor and audit claims submissions and encounter data. Routine and random billing and documentation audits are conducted and as a MedStar Family Choice provider, you are required to comply with these audits and submit medical records as requested.

Audit findings, including a summary of overpayments identified, are shared with providers and appeal rights are afforded if there is disagreement with the audit findings. Appeals must be filed in writing within 90 days from the receipt of the audit findings letter and should be sent to:

MedStar Family Choice
Attention: Director of Medicaid Contract Oversight and Vendor Delegation
5233 King Ave
Suite 400
Baltimore, MD 21237

Providers are subject to comply with these audits. If overpayments related to fraudulent or abusive billing have been identified, we may retract those payments made to providers. MedStar Family

Choice is required to notify the Maryland Department of Health (MDH) Office of Inspector General and Medicaid Fraud Control Unit (MFCU) of the retraction. MDH or the MFCU may perform its own investigation. Penalties such as fines, loss of licensure, or imprisonment can occur for providers found guilty of fraudulent activity.

Please note: When in the course of regular business, as part of an internal compliance program, or as a result of a self-audit, a provider determines that payments made to the provider were in excess of the amount due from MedStar Family Choice, the provider is obligated to report and return the improper amounts within 60 days of recovery.

Interpreter services are available

Cultural and linguistic differences can create barriers between providers and patients. These barriers may hinder healthcare professionals from understanding patient needs. Providers can positively enhance a patient-physician relationship by:

- Being focused on the patient during the visit.
- Asking clear and concise questions.
- Following up with additional questions to ensure the member understands the provider's instructions.

For members that are hearing impaired or not proficient in English, MedStar Family Choice will provide telephonic interpretation services and/or professional on-site interpreters. Please contact our Care Management department at **800-905-1722, option 2**, to schedule telephonic translation services or call Provider Relations at **800-905-1722, option 5**, to coordinate an in-office interpreter.

2022 EPSDT results are in

Calendar Year 2021

Each year, the Maryland Department of Health (MDH) evaluates the quality of care (QOC) provided to Maryland medical assistance recipients enrolled with a HealthChoice Managed Care Organization (MCO). The MDH contracts with Qlarant to serve as the External Quality Review Organization (EQRO). Beginning with the calendar year 2007 services, Qlarant began performing an annual medical record review of preventive services performed according to Maryland's Schedule of Preventive Health Care for HealthChoice children up to the age of 20.

Five components are used to assess each MCO. The components reviewed are as follows: Health and Developmental History; Comprehensive Physical Examination; Laboratory Tests/At-Risk Screenings; Immunizations; and Health Education/Anticipatory Guidance.

Each element requires a minimum performance score of 80%. In CY 2021, MFC had a total composite score of 90%, which is two percentage points below the HealthChoice Aggregate score of 92%. MFC's composite score for CY 2020 was also 90%.

MedStar Family Choice results for 2022 (CY 2021):

- 95% in Health and Development History
- 96% in Comprehensive Physical Exam
- 77% in Laboratory Test/At-Risk Screenings
- 85% in Immunizations
- 93% in Health Education/Anticipatory Guidance

MFC met the minimum compliance threshold for four out of the five components and sustained or improved in four out of five components in CY 2021. The Laboratory Tests/At-Risk Screenings component had the most significant increase of four percentage points compared to CY 2020; however, the score remained below the MDH-established minimum compliance threshold of 80%.

Qlarant has identified the following opportunities for improvement for MFC:

- Laboratory Tests/At-Risk Screenings did not meet the MDH-established compliance threshold.
- Health Education/Anticipatory Guidance decreased from CY 2020 to CY 2021.
  The Conducted Anemia Risk Assessment element had a significant decline from CY 2020 to CY 2021.
- The Recorded Maternal Depression Screening element had a significant decrease compared to the previous year and remained below the threshold of 80%.
- The Rotavirus element had a significant decline in score from the previous year.
- The Documented Referral to Dentist element decreased from the previous year and is now below the 80% threshold.

For more detailed audit findings, a copy of the 2022 EPSDT Statewide Executive Summary can be found here: **https://health.maryland.gov/mmcp/healthchoice/SiteAssets/Pages/HealthChoice-Quality-Assurance-Activities/2022%20EPSDT%20Statewide%20Executive%20Summary.pdf**

Please note that MedStar Family Choice EPSDT certified providers are required to follow the MDH Immunization Schedule, and they should ensure that their patients receive the required screening and laboratory tests as outlined in the Maryland HealthChoice Well Child Care Schedule. MFC EPSDT certified providers are also strongly encouraged to use the Maryland Healthy Kids Program's age-appropriate encounter forms, risk assessment forms, and questionnaires that are designed to assist with documenting preventative services according to the Maryland Schedule of Preventive Health Care. The Maryland Immunization registry (ImmuNet) is also available as an online resource that can be used to check a child's immunization history.

MDH makes helpful forms available for use by providers on their website at **https://mmcp.health.maryland.gov/epsdt/healthykids/Pages/Encounter-Forms.aspx.**

If you are unable to print a copy of any of the EPSDT forms, you can contact MFC Provider Relations Department at **800-905-1722, option 5**, and a sample will be provided.

MedStar Family Choice would like to thank all of our providers for your continued cooperation in our efforts to improve our EPSDT scores.

My HEDIS® 2021 scores are available

Completing an NCQA HEDIS Compliance Audit™ has been required of managed care organizations (MCOs) operating in Maryland since 2001. Under the HealthChoice regulations, the MCOs report designated subsets of the Medicaid HEDIS measures. MedStar Family Choice benchmarks its performance against the Maryland Medicaid plans and the NCQA Means and Percentiles Report. NCQA accredits and certifies a wide range of healthcare organizations and manages the evolution of HEDIS.

The Maryland Department of Health and NCQA require plans to submit all measures required for Medicaid plans in order to retain NCQA accreditation and other measures at the Department's discretion. MedStar Family Choice continues to score high compared to the Maryland Medicaid average for many measures.

To see the scores above the Maryland average for HEDIS MY 2021, Calendar Year 2021, as well as our proposed focus for HEDIS MY 2022, please visit Bit.ly/MFCHEDIS. MedStar Family Choice would like to thank you for your cooperation and assistance in getting our members into care.

As we continue to improve and strive for high scores, your dedication to quality health care is very much appreciated.

Gynecological services available for members

Female MedStar Family Choice members may schedule all gynecological care, including Pap smears and annual and/or routine gynecological examinations, with either a primary care physician or a participating gynecologist without a referral. This includes all in-network primary care providers and gynecologists.

Referrals and prior authorization are required for all out-of-network providers, including primary care and gynecologists. If a member decides to utilize an in-network gynecologist for gynecologic services, please direct the member to a MedStar Family Choice gynecologist by utilizing our Find-a-Provider online directory at MedStarFamilyChoice.com or contact MedStar Family Choice Provider Relations at **800-905-1722, option 5**, to request a listing of participating gynecologists.

Ensure patient privacy and security during (and after) the COVID-19 national emergency

The HIPAA Privacy and Security Rules regulate what can and cannot be done with certain types of health information. In addition to HIPAA, providers must comply with other applicable federal, state, and local laws which govern privacy requirements. The U.S. Department of Health and Human Services (HHS) has continued to emphasize that the protections of the HIPAA Privacy and Security Rules are not set aside during the COVID-19 national emergency. The HIPAA Privacy Rule covers protected health information (PHI) in any medium. The HIPAA Security Rule covers electronic protected health information (ePHI). A few simple steps can help protect patient privacy daily. These tips include:

- Do not leave PHI in areas where it can be viewed or accessed by unauthorized individuals.
- Sign-in sheets should not state the reason for the patient's medical appointment.
- Face sheets should be turned toward the wall if patient charts are outside of an examination room.
- Keep confidential conversations at a low level and away from non-secure devices (such as certain smart devices) which record communications.
- Adhere to minimum necessary requirements when leaving information on voicemails.
- Computers/workstations should be in an area that minimizes accidental/unauthorized viewing of patient information.
- Assign strong passwords to computer systems.
- Do not share user IDs or passwords.
- Do not post passwords in or around workstations where they can be viewed easily by others.
- Always log off or lock computers/workstations when away from the workstation.
- Secure ePHI through encryption.
- Save PHI to the appropriate locations and regularly back up your data.
- Properly dispose of any documents containing PHI in shredders or special destruction boxes so they are unreadable, indecipherable, and otherwise cannot be reconstructed.

Visit the HHS website at **HHS.gov** and **HealthHit.gov** for more information regarding HIPAA.

Case management services and other benefits available

MedStar Family Choice offers case management services provided by highly qualified nurses, social workers and coordinators. These professionals assist members in the management of their complex bio-psycho-social needs. This is done telephonically by educating the member on disease self-management, facilitating access to health- care and connecting the member to needed resources within the community. Case managers work closely with providers to ensure that their patients receive appropriate and timely healthcare. The Case Management staff will frequently contact providers to obtain clinical information and to ensure that services needed were received. It is very important that MedStar Family Choice hears back from providers as quickly as possible to prevent delay in patient's receipt of follow up care, referral to specialists, medications and DME.

Types of Case Management Services

Complex Case Management (CCM) MedStar Family Choice provides Complex Case Management Services to our most complex and highest risk members that include but is not limited to:

Members experiencing a critical event or diagnosis that requires care coordination or extensive use of resources. A critical event or diagnosis includes, but is not limited to the following:

1. Amyotrophic Lateral Sclerosis (ALS)
2. Hemophilia
3. Lymphatic and Hematopoietic (blood) system disorders
4. Guillain-Barre Syndrome
5. Liver Failure
6. Burns > 20% of total body surface area
7. Hemiplegia
8. Sickle Cell Disease with Severe Crisis
9. Cancer/Tumors
10. Cerebrovascular Accident (Stroke)
11. Osteomyelitis
12. Sepsis
13. Transplants
14. Acute trauma with complex care coordination needs
15. Complex psycho-social or behavioral needs

Members designated by the state as a 'Special Needs Population.' Per COMAR 10.09.65.04B, Special Needs Populations are identified as the following non- mutually exclusive populations:

1. Children with special health care needs.
2. Individuals with a physical disability.
3. Individuals with a developmental disability.
4. Pregnant and postpartum women.
5. Individuals who are homeless.
6. Individuals with HIV/AIDS.
7. Children in State supervised care.

Comprehensive Case Management Services

Comprehensive Case Management Services are available to MedStar Family Choice adult and pediatric members with certain medical conditions.

Inclusion criteria for adult members include but is not limited to:

- High Risk Pregnancy
- Diabetes
- Asthma
- COPD
- Hypertension
- Cardiovascular Disease
- HIV
- Substance Use Disorder
- Social Issues/Mental Health

Inclusion criteria for pediatric members include but is not limited to:

- Diabetes
- Asthma
- Obesity
- Epilepsy
- Chronic Lung Disease
- Cardiovascular Disease (CAD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Depression
- Anxiety
- Substance Abuse
- Other Mood Disorder

Transition Care Case Management Services

Transition Care Case Management is a service provided by MedStar Family Choice to assist your patient, identified as high risk for readmission when transitioning from the hospital to home. This service is provided by Registered Nurse Case Managers who work closely with your patient to assist with adherence to the discharge plan order by the hospital care team, locating providers, scheduling follow-up appointments and assisting with transportation if needed. This service is offered for 30 days, and if after that time your patient requires further assistance, they will be referred to one of our other case management services.

Rare and Expensive Case Management (REM) Services

For your patients with a diagnosis that makes them eligible for REM, MedStar Family Choice case managers reach out to the member and provide education about the Maryland Medicaid REM Program. If the member is agreeable, the REM application is completed and submitted to the MDH REM unit. If you have a patient that has a REM qualifying diagnosis, please contact the Case Management Department by calling **800-905-1722, option 2.**

Enrollment

Members of MedStar Family Choice do not have to enroll in our Complex Case Management, Comprehensive Case Management, Transition Care, or REM Services. They are automatically included in the programs when they are identified as meeting qualifying criteria. Membership in all services is voluntary and members have the option to decline or stop participating at any time. A copy of this information provided to members can be obtained by contacting the MedStar Family Choice Case Management Department.

To refer your MedStar Family Choice patient to any of the above services, please fax your referral to **410-933-2274** or call our Case Management Department at **800-905-1722, option 2**. available Monday through Friday from 8:30 a.m. to 5:00 p.m. Any faxes or voice messages received after hours will be handled the next business day.

We are available Monday through Friday from 8:30 a.m. to 5:00 p.m. Any faxes or voice messages received after hours will be handled the next business day.

Other benefits available for MedStar Family Choice members

Free Smartphone

A free smartphone with 4.5 GB of data and 350 monthly minutes, unlimited text messages, and free calls to MedStar Family Choice. For more information, call **877-631-2550**.

Resource Connection

A case manager can connect your patients with resources in their community to assist them with mental and/or substance abuse needs, utility turn offs, food assistance, and emergency shelters.

Educational Materials

Flyers and handouts with information on chronic conditions are available to MedStar Family Choice members. The information is written in easy-to-understand language. A case manager is available to answer your patient's questions and concerns, and to advise on wellness incentives that may be available to them.

Coordinate Care

A case manager can assist your patient with locating a PCP and/or specialist in their area, as well as scheduling appointments and coordinating transportation based on your patient's needs. For more information, call **800-905-1722, option 2.**

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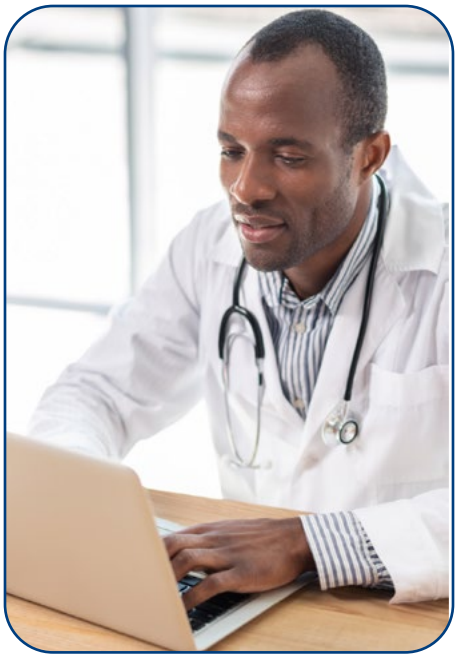
How utilization management-authorization review works



To ensure that members receive proper health care, MedStar Family Choice follows a basic pre-authorization process. To request pre- authorization, all appropriate ICD-10s/CPT/HCPCS and supporting clinical information must be included with the provider's request. Requests for authorization can be included on the Maryland Uniform Consultation Referral Form or the MedStar Family Choice Prior Authorization (Non- Pharmacy or Pharmacy) Request form with clinical information attached. Our experienced clinical staff reviews all requests, and pre-authorization decisions are based on nationally recognized criteria, such as Inter-Qual and Medicare guidelines. Additional authorization criteria utilized by MedStar Family Choice can be found at **MedStarFamilyChoice.com** in our utilization management (UM) criteria policy.

Member needs that fall outside of standard criteria are reviewed by our physician staff for plan coverage and medical necessity. We do not specifically reward practitioners or other individuals for issuing denials of coverage of care. UM decision making is based only on appropriateness of care and services and existence of coverage. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization. Providers may request a written copy of the criteria used in the decision-making process by contacting the UM department at **800-905-1722, option 2**, **then option 1**, Monday through Friday, from 8:30 a.m. to 5 p.m. Authorization requests should be made no less than five to seven business days in advance of the service.

Please allow up to two business days for MedStar Family Choice to process a complete non-pharmacy authorization request. Requests are considered complete when all necessary clinical information has been received from the provider. The final decision is made within 14 calendar days from the initial request for authorization, whether or not all clinical information has been received. For all Outpatient Pharmacy authorization requests MedStar Family Choice must make a decision and notification within twenty-four (24) hours of receipt of the request. To comply with this stringent turnaround time, clinical information to support the request must be submitted at the time of the original submission. For members with urgent authorization needs, physicians or a physician's staff member should contact MedStar Family Choice Care Management at **410-933-2200** or **800-905-1722, option 2, then option 1**. If MedStar Family Choice denies the pre-authorization request, the provider and member will receive a copy of the denial. In addition, the denial letter will indicate that the treating provider may contact the MedStar Family Choice physician who made the decision to discuss the case by calling **800-905-1722, option 2, then option 1**.

Provide equal access to appointments

Civil rights are personal rights guaranteed and protected by the U.S. Constitution and federal laws. The Biden Administration recently also signed an executive order outlining a policy committed to preventing and combating discrimination based on gender identity or sexual orientation.

Nondiscrimination laws and regulations prohibit discrimination and require covered entities like providers to provide individuals an equal opportunity to participate in

a program activity regardless of race, color, national origin, age, disability, sex, or (under certain conditions) religion.

Providers must provide the same access standards for all patients, regardless of the payer source. An example of discrimination includes offering fewer hours to Medicaid recipients than to commercial members or Medicaid fee for service members. Services may not be denied or performed in a different manner because of discrimination. Members may not be subjected to segregation or separate treatment in violation of a law, regulation, or another requirement.

In accordance with Title VI of the Civil Rights Act, MedStar Family Choice provides

translation services, utilizes Maryland Relay for the hearing impaired, and performs site visits to confirm handicap accessibility. Providers must ensure that patients with disabilities or who require an interpreter are provided with these services as needed and free of charge. Providers can contact MedStar Family Choice for assistance by contacting our Provider Relations Department at **mfc-providerrelations2@medstar.net** or **800-905-1722, option 5**. Concerns about equal access or discrimination may be reported by emailing mfc1557coordinator@medstar.net.

Value-based purchasing 2022 results based on CY 2021

Value-Based Purchasing is a program created by the Maryland Department of Health (MDH). It makes sure that managed care organizations (MCOs) in the HealthChoice program give the best care. There were 7 quality measures in this program for the 2021 measurement. Most measures are based on the HEDIS results. MCOs can receive additional payment (incentive) or pay fines (disincentive) based on the results. MedStar Family Choice received one incentive and four disincentives for Value-Based Purchasing in 2021 .

Proposed Focus for 2023

MedStar Family Choice focuses on areas for the next year where we feel there is an opportunity to improve care for our members. MedStar Family Choice will focus on:

- Diabetes testing, especially for A1C control
- Asthma medications
- Prenatal and Postpartum Care

Know the rights and responsibilities of our members

MedStar Family Choice members have certain rights and responsibilities. These rights and responsibilities are reviewed annually. These member rights and responsibilities can be found in our Provider Manual and the Member Handbook; both can be found on our website at **MedStarFamilyChoice.com.** Please contact MedStar Family Choice Provider Relations at **800-905-1722, option 5**, with any questions and comments or to request a hard copy of all materials.

MedStar Family Choice members have the right to:

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

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

As a HealthChoice member, they have the responsibility to:

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

MedStar Family Choice formulary update

Details of the prior authorization criteria are available on the MedStar Family Choice Pharmacy webpage with the other pharmacy protocols. For more information, please call the MedStar Family Choice Provider Relations department at **800-905-1722, option 5.**

CHANGES BELOW ARE EFFECTIVE AS OF MARCH 1, 2023

Additions:

- KRAZATI (adagrasib)CALQUENCE (acalabrutinib)XULTOPHY (insulin degludec and liraglutide)PRALUENT (alirocumab) RETACRIT (epoetin alfa-epbx)DEXCOM G7FLUOCINOLONE ACETONIDE BODY OIL 0.01%FLUOCINOLONE ACETONIDE SCALP OIL 0.01%0

*Please see the PA Table on the MFC website for details of the requirements for approval and guidance on submission of clinical information

Removals STIMATE

Removals of Prior Authorization:

- None

Managed Drug Limitations & Step Therapy:**

- None

* Details of the prior authorization criteria are on the MedStar Family Choice website in the Prior Authorization Table.

** Details of the step therapy criteria are on the MedStar Family Choice website in the Step Therapy Table.

EPSDT (Healthy Kids) Reminder

- June to September 2023 MFC and Qlarant will be requesting members records for the annual EPSDT Audit.
- On site provider audits performed by Qlarant will take place July 1 – August 31, 2023.

MedStar Health

Maryland HealthChoice Program

The MedStar Family Choice newsletter is a publication of MedStar Family Choice. Submit new items for the next issue to MedStar Family Choice at **mfc-providerrelations2@medstar.net.**

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It's how we treat people.