MedStar Family Choice

Maryland HealthChoice Program

Provider Newsletter

1st Quarter 2025

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Prescription copayments

- Most formulary (covered) brand name or generic medicines there is a copay (cost) of $1.00
- A few formulary (covered) brand medicines will have a copay (cost) of $3.00, these are marked as "Tier 2" on the formulary
- For HIV/AIDS medicine you will have a copay (cost) of $1.00.
- There is NO cost for family planning options (condoms, IUD, birth control pills, etc.).
- Non-formulary (non-covered) brand name medicines will have a copay (cost) of $3.00.

Please note that the following MedStar Family Choice members will not have a copay for their medicine.

- Members under the age of 21
- Members who are pregnant people
- Members who are in hospice care (programs that give special care to people who are near the end of life and have stopped treatment to cure or control their illness/disease).
- Members who are Native Americans

If the member is taking a medicine for mental health or certain seizure medicines, that coverage is not through MedStar Family choice, but through the State of Maryland. These medicines are not paid for by MedStar Family Choice; the State of Maryland decides which medicines are covered and any costs for those prescriptions. **Please review the Maryland Department of Health preferred drug list for the listing of covered medications**.

MedStar Family Choice is always members secondary insurance. The member should tell their doctor they have two types of insurance so they can make sure the medicine prescribed is approved by both of their insurance companies. If the member has other insurance, they should give both cards to the pharmacist. The members' other insurance will pay for most of the costs and MedStar Family Choice will pay for the difference between the costs from their primary insurance and the amount of copay the member would have from MedStar Family Choice.

Provider Demographic Changes

All general provider changes, including changes in office demographics, must be submitted to MedStar Family Choice no less than 30 days prior to the desired effective date on the notice.

Changes to Tax ID numbers require 45 days written notice from the provider. MedStar Family Choice will confirm receipt of the Tax ID notice in writing within 30 days after acceptance of the Tax ID change. The Tax ID

change may result in a new provider contract. Please contact your Provider Relations Associate for any questions you may have.

The MedStar Family Choice Provider Web Portal serves as a quality control mechanism allowing providers to view their information in our system. Your provider information is communicated to the MedStar Family Choice members/enrollees and provider community

via our Find a Provider website. Other systems within MedStar Family Choice also use this information to process authorizations and claims and issue reimbursement checks.

To access the user guide for the MedStar Family Choice Provider Web Portal, click on the following link: **https://providerportal.medstarfamilychoice.com/images/MFCImages/userguide/MFCProviderPortal_UserGuide.pdf**

Provider web portal services include the following:

- New user registration
- Password reset
- Provider and group changes
- Review summary of changes
- Quarterly data validations
- Provider web portal user guide

Visit the MedStar Family Choice Provider Web Portal at **https://providerportal.medstarfamilychoice.com** to register.

Before registering, you will need to have access to the following information:

- Group DBA (doing business as) Name
- Group Tax ID
- Group Type II NPI (Group NPI)

To complete the registration process:

- Click on New User Request
- Enter your group administrator ID (email) currently on file with MedStar Family Choice
- You will receive an email to complete the registration

For problems with registration, send a detailed email to the following email:
Maryland - **mfc-providerrelations2 @medstar.net**.

Please note: Provider terminations are not considered changes, and a 90-day written notice is required as per participation agreements.

If you have an existing relationship with Change Healthcare/ECHO Health, Inc., are enrolled in ECHO Payments Simplified and receive ACH/EFT, a paper check by mail, or virtual credit card as payment for submitted claims, reach out to ECHO Health Inc. to update any changes to the address for where payments and 1099's should be sent.

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.

Health Choice 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 14 days of 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 60 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 on page 6.

Reminder: EPSDT Laboratory Screening tests must be documented in the patient's medical records, which includes electronic medical records.

MedStar Family Choice

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 assessment

- Tuberculosis risk assessment at 1 month, 6 months, 12 months and then annually.
- Lead risk assessment at 6 months and at every well-visit until age 6.
- 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 and then annually.
- STI/HIV risk assessment at age 11 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.health.maryland.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 immunization and care

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 instances of non-compliance. Fraud, waste, and abuse are forms of non-compliance which could be committed by a provider, member, or even an employee of the managed care organization. Fraud is when someone knowingly does something wrong or dishonest in an attempt to obtain healthcare benefits for themself or someone else or when a provider submits inappropriate claims to obtain payments. Waste is when too many, or unnecessary tests or procedures are ordered that lead to extra costs. Abuse describes provider behaviors that do not follow sound financial, business, or medical practice and result in unnecessary costs or do not meet a standard of care. 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 **mfc-providerrelations2@medstar.net**
- 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 do 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 30 days from the receipt of the audit findings letter and should be sent to:

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

Providers are required to comply with these audits. If overpayments related to incorrect, fraudulent or abusive billing or inadequate documentation have been identified, we will notify you of our findings and the process to retract the payments. MedStar Family Choice is required to notify the Maryland Department of Health (MDH) Office of the Inspector General - Health (OIG-H) of our audit findings and identified overpayments. Credible allegations of fraud are also reported to the Maryland Office of the Attorney General, Medicaid Fraud and Vulnerable Victims Unit (MFVVU). MDH OIG-H or the MFVVU 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. To coordinate an in-office interpreter by way of in-person, telephonic or video, complete the **https://www.medstarfamilychoice. com/-/media/project/mho/mfc/mfc/pdf/interpreter-request-form-04182021.pdf** and email to **MFCProviderRelations2@Medstar.net**. For questions regarding the process email Provider Relations at **MFCProviderRelations2@Medstar.net** or contact Provider Services at **800-261-3371**.

2024 EPSDT results are in

Calendar Year 2023

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 2022, MFC had a total composite score of 90%, which is three percentage points below the HealthChoice Aggregate score of 93%. MFC's composite score for CY 2022 was 95%.

MedStar Family Choice results for 2024 (CY 2023):

- 91% in Health and Development History
- 96% in Comprehensive Physical Exam
- 73% in Laboratory Test/At-Risk Screenings
- 88% in Immunizations
- 95% in Health Education/Anticipatory Guidance

MFC met the minimum compliance threshold for four of the five components and was below the threshold for one of the five components. The Laboratory Tests/At-Risk Screenings component had the most significant decrease and did not meet the minimum compliance threshold of 80%.

Qlarant has identified the following opportunities for improvement for MFC:

- The Recorded Maternal Depression Screening Tool (59%) and the Recorded Developmental Screening Tool (76%) displayed the most significant declines, compared to MY 2022, by 22 and 20 percentage points, respectively.
- MY 2023's composite score fell below the MDH-established threshold by seven percentage points (73%), which will require the submission of a CAP. MSFC scored below the MDH-established minimum compliance threshold (80%) in 12 of the 16 elements. Compared to MY 2022, MSFC declined in 14 of the 16 elements. The 3-5 Year Blood Lead Test displayed the most significant decrease of 31 percentage points, from MY 2022 (100%) to MY 2023 (69%).

- MSFC fell below the HealthChoice Aggregate scores in all of the 14 elements. Compared to MY 2022, MSFC displayed a decline in all 14 elements, ranging in decreases from one to 16 percentage points. Compared to MY 2022, the most significant decline in scoring was displayed with the Influenza (62%) and Assessed Immunizations Up to Date (75%) elements with a decline of 15 and 16 percentage points, respectively.

For more detailed audit findings, a copy of the 2023 EPSDT Statewide Executive Summary can be found **here**.

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.

If you are unable to print a copy of any of the EPSDT forms, please contact **Maryland Healthy Kids Program at 410-767-1836** or click **here**.

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

My HEDIS® 2023 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 2023, Calendar Year 2023, as well as our proposed focus for HEDIS MY 2024, 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.

NCQA HEDIS Compliance Audit™ is a trademark of the Nation Committee for Quality Assurance (NCQA). HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

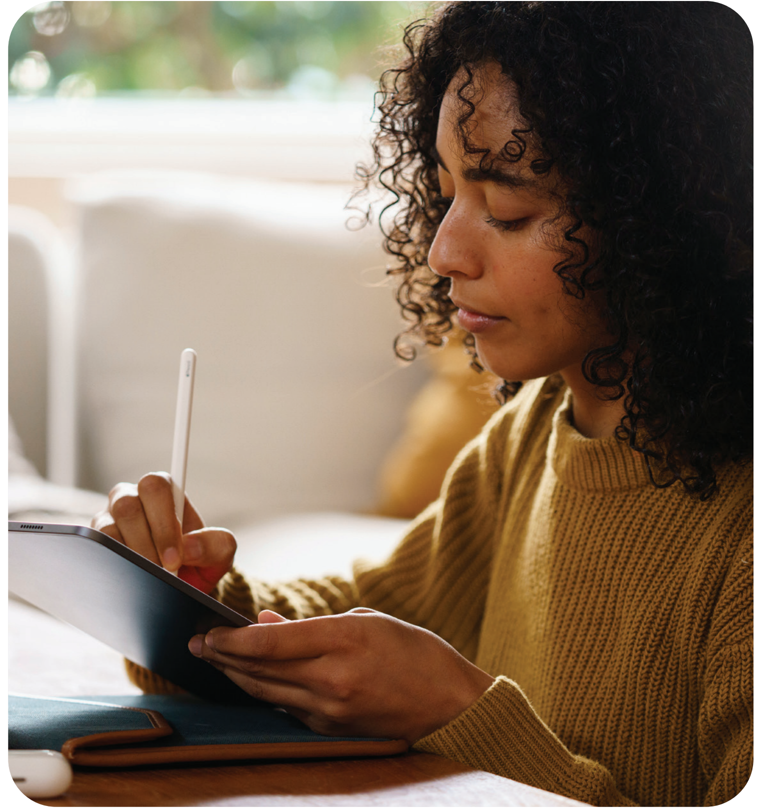
Gynecological services available for members

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.

Prior authorizations 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 **mfc-providerrelations2@medstar.net**, to request a listing of participating gynecologists.

Ensure patient privacy and security

"The HIPAA Privacy and Security Rules regulate what can and cannot be done with health information. These Rules cover protected health information (PHI) in any medium, including electronic protected health information (ePHI). In addition to HIPAA, providers must comply with other applicable federal, state, and local laws and requirements which govern privacy. 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 not be visible by the public.
- 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 information technology.
- 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 devices when away.
- Implement multi-factor authentication to help secure access to devices.
- 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** 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:

- Amyotrophic Lateral Sclerosis (ALS)
- Hemophilia
- Lymphatic and Hematopoietic (blood) system disorders
- Guillain-Barre Syndrome
- Liver Failure
- Burns > 20% of total body surface area
- Hemiplegia
- Sickle Cell Disease with Severe Crisis
- Cancer/Tumors
- Cerebrovascular Accident (Stroke)
- Osteomyelitis
- Sepsis
- Transplants
- Acute trauma with complex care coordination needs
- 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:

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

Utilization Management and Prior Authorization Review Process

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.

Pre-authorization decisions are based on nationally recognized criteria, such as Inter-Qual, Medicare, and professional society 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 Medical Reviewers pharmacist for medical necessity. We do not offer any financial incentives for issuing denials of coverage of care or rendering decisions that result in underutilization. UM decision making is based only on appropriateness of care and services and existence of coverage. 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**.

Provider Claim Dispute and Appeal Process

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** . Concerns about equal access or discrimination may be reported by emailing **mfc1557coordinator@medstar.net**.

MedStar Family Choice provides certain services, utilizes Maryland Relay for the hearing impaired, and performs site visits to confirm handicap accessibility." I don't see an advantage to including it. Each provider is independently responsible for providing interpreter and translator services to its patients.

2025 Population Health Incentive Program (PHIP) based on CY 2024 data

The HealthChoice Population Health Incentive Program (PHIP) helps to ensure that managed care organizations (MCOs) in the HealthChoice program give the best care to their members. In the PHIP, an MCO may be eligible for an incentive payment for the following performance measures:

- Asthma Medication Ratio- Total (5-64)
- Hemoglobin A1c Control for Patients with Diabetes- HbA1c (poor) Control (>9%)
- Hemoglobin A1c Control for Patients with Diabetes- HbA1c Control (<8%)
- Risk of Continued Opioid Use 31+ Days- Total (ages 18-65)
- Lead Screenings for Children (ages 0-2)
- Improving timeliness of prenatal care and post-partum follow up care
- Avoidance of antibiotic treatment for acute bronchitis and bronchiolitis

An MCO may earn two types of incentives:

- A performance incentive payment; and
- An improvement incentive payment.

As stated, measures are based on the HEDIS results. MCOs can receive additional payment (incentive) based on the results.

Proposed Focus for 2025

MedStar Family Choice will continue to focus on these areas for the next year as we believe there is an opportunity to continuously improve care for our members.

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 **mfc-providerrelations2@medstar.net**, 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.

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 **mfc-providerrelations2@medstar.net**.

CHANGES BELOW ARE EFFECTIVE AS OF APRIL 1, 2025

Additions:

- Buprenorphine Films and Patches* (generics for Belbuca and Butrans)
- Cimzia (certolizumab pegol) starter and maintenance kits*
- Diclofenac ophthalmic solution
- Fluticasone/Salmeterol Diskus (generic for Advair Diskus)
- Itovebi (inavolisib)
- Potassium Citrate/Citric Acid solution 1100/334 mg/5 ml
- Nypozi (filgrastim biosimilar)
- Steqeyma* and Yesintek* new biosimilars of Stelara (ustekinumab)
- Vivotif (oral typhoid vaccine)
- Zepbound* (tirzepatide) - ONLY covered for Obstructive Sleep Apnea in non-diabetics, may not be covered for weight loss without OSA.

**Denotes that Prior Authorization is required. Please see the PA Table on the MedStar Family Choice website for details of the requirements for approval and guidance on submission of clinical information*

Removals:

- Zarxio (filgrastim biosimilar – replaced by Nypozi)

Prior Authorization Removals:

- Omnipod external insulin pumps
- Tobramycin for nebulization

When and how to seek prior authorization

Not all services or medications require prior authorization! MedStar Family Choice wants to make it easy for your to know **When and how** to seek prior authorization if required.

1. Go to **www.medstarfamily.com**
2. Scroll to the **MedStar Family Choice-Maryland** area
3. Click on **Healthcare Providers**

Non-Pharmacy Requests	Pharmacy Requests
1. Under the **Preauthorization and Utilization Management** tile, click on **View Preauthorization and Utilization Management**	1. Under the **Pharmacy and Formulary** tile, click on **View Prescription Information**
2. You will now see **Forms and Additional Information**	2. You are now on the **Pharmacy and Prescription Information** page. Click on MedStar Family Choice Formulary to see if your desired medication requires prior authorization (PA)
3. Click on **List of services that require pre-authorization** to see the services that require a pre-authorization.	3. If the medication needs a PA, click on **Prior Authorization Table and Step Therapy** on the **Pharmacy and Prescription Information** page to see the PA criteria for your medication.
4. On the **Forms and Additional Information** page, select and complete the form that applies to your needed service.	4. If you need a PA form: go to the **Pharmacy and Prescription Information** page and scroll down to Prior Authorization forms
5. Several forms may be completed in the web browser then printed or downloaded to your computer and completed. They are the: **a. Prior authorization (non-pharmacy) request form** **b. DME authorization form** **c. Prior authorization-home health services request form**	5. Which form to pick: a. For **medications that require a PA** or that are **Non-Formulary**, pick **General Medication Prior Authorization Form** b. For **Opioids**, use the **Opioid Prior Authorization Form** c. For **Hepatitis C medications**, use the **Hepatitis C Prior Authorization Form**

Pro tips

DON'T MAKE THE MISTAKE OF LEAVING OUT INFORMATION!
Complete each line fully.

- Provide a contact person's name and phone-preferably the person to whom any questions should be directed. **Please provide a DIRECT or BACK LINE number**.
- If a procedure is being done in a hospital or ambulatory surgery center, provide the facility name and NPI number.
- ICD-10 codes and CPT or HCPCS codes are required, along with number of units or visits being requested.
- If the request is for a medication, indicate its name, dose and frequency. *If it is for a non-formulary medication, **you must indicate what formulary options have been tried and failed***.
- If something is being requested out-of-network, either document on the form or supply a letter of medical necessity to justify the reasoning behind the out-of-network request.
- **Attach all clinical notes/medical records, pertinent radiology studies**, and lab results to support the request for service. **The PA form does not substitute for clinical notes**.

Once the form is complete, combine it with supporting medical records, radiology or lab studies and **fax it to 410 933-2274**. One of our experienced clinical staff will review the request and make a medical necessity determination.

If you follow this process and send all the required information, we will process your request for authorization within two business days of receipt for non-pharmacy authorizations, and within twenty-four (24) hours for outpatient pharmacy authorizations.

MedStar Family Choice

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.