PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

FALL/WINTER 2019

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

This newsletter features important information pertaining to providers in the JHHC network: Priority Partners, Johns Hopkins Employer Health Programs (EHP), Johns Hopkins US Family Health Plan (USFHP), and Johns Hopkins Advantage MD. Please contact your Provider Relations coordinator with any questions about this information.

// INTRODUCTION

"Autumn seems that season of beginning."- Truman Capote

The "-ber" months at Johns Hopkins HealthCare bring a cornucopia of beginnings as our health plans commence the annual enrollment period. We are also busy putting the finishing touches on our new programs, benefits and procedures that will go into effect on January 1, 2020.

In this issue of *Provider Pulse*, we want to make you aware of a new addition to the Advantage MD family for 2020, Advantage MD PPO Premier, an exclusive plan for members of Montgomery County, Md. We also have important updates on our observation policy, and our reimbursement policies for physician assistants and for transfers from hospitals to skilled nursing facilities (SNFs).

As always, we appreciate your efforts and continued collaboration. Thank you for the work you do day in and day out to provide quality, committed care to our members across all of our health care plans. Without you, we wouldn't be JHHC.

–Editor, Provider Pulse

// CLAIMS AND BILLING

Claims Submission Reminder

Recently, we have received claims either without a rendering provider or with the billing provider as the rendering provider.

To process claims more quickly and efficiently, please make sure that any time you submit a claim for a professional service, you submit both the name (Box 31) and the NPI number (Box J) of the provider who is rendering the service stated on the claim.

// POLICIES AND PROCEDURES

JHHC Reimbursement Policy Update

An adjustment to the regulatory requirements for the **Physician Assistant Policy** for Priority Partners went into effect November 1, 2019.

In order to comply with Maryland COMAR 10.09.55.06 Physician *Assistants Authority – Payment Procedures,* and COMAR 10.09.02.07 E Physicians' Services Authority – Payment Procedures, Priority Partners MCO will be updating its' payment methodology for Physician Assistants as follows:

1. Services rendered Incident to or Shared/Split with supervising physician will be paid: **PPMCO:** in accordance with state guidelines, the lesser of the providers' customary charge (unless the service is free to individuals not covered by Medicaid); or an amount equal to 100% of the then current Maryland Medicaid Professional Services Fee Schedule.
2. Services rendered by the Physician Assistant assisting in surgery must be billed with the appropriate modifier (AS, 80, or 82) and will be paid at the lesser of the actual charge or: **PPMCO:** in accordance with state guidelines, modifiers 80 or 82 for assisted surgery must be used, and pay an amount equal to 20% of the fee for the surgical procedure.

To view the JHHC Reimbursement Policies, please go to: **JHHC.com > For Providers > Policies > Reimbursement Policies**. If you have questions, please contact Provider Relations at 888-895-4998.

Preauthorization No Longer Required for Observation

Effective immediately for all lines of business (Johns Hopkins EHP, Johns Hopkins USFHP, Priority Partners, and Johns Hopkins Advantage MD), **preauthorization is no longer required for observation after the first 24 hours.**

It is expected that for the vast majority of patients, disposition will occur within 24 hours of placement in observation status. Up to 48 hours of outpatient observation care may be required in certain circumstances.

Observation hours exceeding 48 hours (24 hours for Priority Partners members) will be denied.

Please refer to Policy Number CMS11.03 for more information on this medical policy.

Lab Payments Limited to Valid CLIA Certification

JHHC would like to remind you that payment for in-office laboratory services is limited to only those services for which your practice holds a valid Clinical Laboratory Improvement Amendments (CLIA) certification to perform. Providers should not perform laboratory services outside of the scope of their CLIA certification. Additionally, providers may only bill for laboratory services performed in the office and may not bill for services performed at an outside laboratory. More information about the CLIA program can be found on the CMS website at www.cms.gov/clia.

Important reminders about CLIA certification:

- CLIA standards are not exclusive to Medicare. They are applied nationally to all entities providing lab services.
- A CLIA certificate is required for in-office urine dipstick testing.
- Your contract with JHHC requires you to only bill for services that you have rendered. Additionally, if you are treating Priority Partners patients, it is important to note that Maryland Medicaid does not allow for billing of purchased services.
- A CLIA certificate is location-specific. You must obtain a certificate for every location where lab services are performed. Additionally, if you move locations you must immediately notify your appropriate state agency to have your new location certified.

Automatic Authorization From an Acute Inpatient Facility to a Skilled Nursing Facility (SNF) for Advantage MD Members

JHHC will automatically approve the transfer of an **Advantage MD** member from an acute inpatient facility for up to five (5) days in an in-network* Skilled Nursing Facility (SNF) when the following conditions are met:

- Inpatient request for SNF provides **treatment setting AND treatment type.**
- A valid diagnosis is provided.
- The receiving SNF has been identified by the hospital.

Note: This procedure change went into effect August 27, 2019.

SNF Auto Authorization Process

Hospital's Responsibility:

- **Identify** the SNF where the member will be transferred.
- **Provide** the appropriate supporting clinical documentation to JHHC once the SNF is identified.
- **Fax** a request for the SNF transfer. Requests must be accompanied by complete clinical documentation, hospital contact information, and fax number. When requests are received without clinical documentation, intake staff will fax the hospital and request the required documentation.
- Clinical documentation **must include** at a minimum:
  - PT and OT notes
  - Wound management
  - Respiratory management
  - Progress notes
  - History and physical
- **Bed level** must be entered at the time of the request
  - If a request is received without a bed level, JHHC will enter the case at the lowest level.
- When a member requires **non-emergent ambulance transportation to a SNF,** the hospital must also submit a *separate* ambulance request when it is medically necessary for the member.
  - **Non-emergent ambulance transportation requests require the submission of a Physician Certification statement** from the hospital. Requests submitted without this form will be pended for clinical review.

Where to Submit SNF and Transfer Requests

Once the hospital has identified the receiving SNF and gathered the required clinical documentation, the hospital should submit the request for the Advantage MD member requiring SNF services.

- Fax the request to **410-424-2703.**
- A dedicated Utilization Management (UM) nurse is available at **410-762-5210** to answer questions.

When the conditions outlined above are completed and JHHC approves the 5 days, a Concurrent Review Task is created for the appropriate UM reviewer with a case follow-up date. An approval letter is sent to the member along with a fax to the hospital. If the conditions are not met, the request will be pended for a UM nurse to review.

What If the SNF Request is for More Than 5 Days?

- If JHHC receives a request beyond the 5-day automatic approval, the Utilization Management department will reach out to the hospital as part of their concurrent review for medical necessity.

***NOTE:** If Advantage MD HMO members request an out-of-network SNF, the request will be pended for a UM nurse to review.

Payment Methodology

Johns Hopkins Advantage MD will administer reimbursement for SNFs based on one hundred percent (100%) of the Centers for Medicare and Medicaid Services (CMS) Patient Driven Payment Model (PDPM), according to defined Core-Based-Statistical Areas (CBSA) subject to all applicable modifiers and coding guidelines, upon receipt of a timely filed clean claim, less any copayment and/or deductible owed by the member pursuant to the applicable Membership Agreement. This reimbursement policy went into effect October 1, 2019.

Future reimbursement adjustments will be related to PDPM based on timing of CMS updates.

Additional information related to this program can be found at: www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-03-15-SNF-VBP.html

The revised assessment schedule under the PDPM, as finalized in the FY 2019 SNF PPS final rule (83 FR39229), will be utilized to the extent CMS updates the PDPM assessment schedule. The provider will follow the most current schedule as determined by CMS.

Refer Your Advantage MD Patients to New Diabetes Prevention & Management Programs

Johns Hopkins Advantage MD is asking for your help to identify patients who could benefit from two new online programs, designed to prevent or manage diabetes.

DECIDE

DECIDE is a literacy-adapted, self-paced, self-management program that helps adults learn how to change everyday behaviors to better manage their type 2 diabetes. The program – which takes a participant between two-and-a-half and six months to complete – enhances health behavior change, coaches patients in person or online, and improves clinical outcomes. **Please refer your patients who struggle to manage their diabetes.**

act2

act2 is an interactive, year-long support and engagement program. The goal is to empower individuals who have been diagnosed with prediabetes to take charge of their health as they work with a personal coach to lose weight gradually (5% to 7% body weight), build physical activity into their daily routine, understand good nutrition and healthy eating habits, develop skills for behavior change, and stay motivated. **Please refer your patients at high risk of developing type 2 diabetes.**

Online Referral Process (You can refer eligible members beginning January 2020.)

Members cannot be enrolled in both programs, and they cannot self-refer, though they may be referred by JHHC Care Management. If your patients would benefit from one of these programs, please refer them to us in one of the following three ways:

Phone: 866-809-2073
Email: HopkinsDiabetes@healthy.works
Online: bit.ly/hopkinsdiabetes

For all referrals, please include the following information:

- Patient's name; address; home phone #; mobile phone #; email address
- Referring provider's name; NPI #; office address; office phone #; mobile phone #; email address

For more information on DECIDE and act2, call 866-809-2073.

Laboratory Developed Tests (LDT) Codes Preauthorization Update for USFHP

Effective November 1, 2019, changes were made to Laboratory Developed Tests (LDT) codes for Johns Hopkins US Family Health Plan (USFHP). The affected codes are covered and require preauthorization. To view the new codes, former LDT codes and different findings, please visit jhhc.com > For Providers > Resources and Guidelines, and click the LDT Codes link under USFHP.

Please note: Preauthorization is not a guarantee of payment. Final determination is based on benefit eligibility.

Recent CPT Code Changes

Applied Behavior Analysis (ABA) Code Change

Plan affected: Johns Hopkins Employer Health Programs (EHP)
Change: Service no longer covered
Effective: October 30, 2019

- **CPT code 97154:** Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes. Changed from prior authorization required to service not covered.

Urology Code Change

Plans affected: Priority Partners and Johns Hopkins US Family Health Plan (USFHP)
Change: Code removal/replacement
Effective: October 1, 2019

- **CPT code 54000:** Incision procedures on the penis. Removed from the site-of-service initiative and replaced with CPT code 54001 (Slitting of prepuce, dorsal or lateral [separate procedure]; except newborn). Preauthorization is required for CPT code 54001 when the service is performed in an outpatient hospital setting (Place of Service 22).

Urology Code Change

Plans affected: Johns Hopkins US Family Health Plan (USFHP)
Change: Covered with no prior authorization required
Effective: November 8, 2019

- **CPT code 41520:** Frenoplasty (surgical revision of frenum). Changed from not covered to prior authorization not required.

Introducing Advantage MD PPO Premier for Montgomery County Members

Advantage MD PPO Premier is an exclusive PPO plan available **only** to residents of Montgomery County, starting January 1, 2020. PPO Premier replaces the PPO and PPO Plus plans formerly offered to these members.

Advantage MD PPO Premier offers:

- No deductibles
- Same smmber cost shares in- and out-of-network
- Flexibility to see any doctor in- or out-of-network
- Freedom to visit any doctor in the United States for the same in-network cost sharing
- Low pharmacy copayments and comprehensive formulary
- Many benefits beyond original Medicare, including coverage of
  - » Acupuncture
  - » Chiropractic services
  - » Preventive and comprehensive dental care
  - » Vision exams and eyewear
  - » Hearing exams and aids
  - » Worldwide emergency and urgent services
  - » Fitness center access or at-home fitness kits

Impact for Montgomery County Advantage MD members

- Coverage for current members (approximately 1,500) in either Advantage MD PPO or PPO Plus will end on Dec. 31, 2019. Members received a notification/letter from Advantage MD in early October outlining the service area reduction in Montgomery County and their options for selecting a new plan.
  - » Along with Advantage MD PPO Premier, Montgomery County members also have the option of choosing Advantage MD HMO, our lower-cost plan that offers a closed network and requires members to coordinate their care through a designated PCP by obtaining a referral for all specialty services from an in-network provider (exceptions include emergency and urgent care services).

- Any health care services these members have with you or another provider will be covered through Dec. 31, 2019. As of Jan. 1, 2020, no services, prescriptions or supplies will be covered under their current Advantage MD coverage.
- Unless the patient selects new coverage, they will be automatically moved to Original Medicare on Jan. 1, 2020 and their prescription benefit will end.
- If they stay with Advantage MD under another plan, they can still see you as an in-network provider, although their cost shares may change.
- If a patient asks you about this change, please refer them to call the customer service number on the back of their member ID card.
- If a member selects a new Medicare plan, their provider and/or pharmacy network may change. Their new plan may or may not be contracted with you.

USFHP Adds Walter Reed Center to Network for Specialty Services

In partnership with the Defense Health Agency, Johns Hopkins US Family Health Plan has added Walter Reed National Military Medical Center (WRNMMC) to its provider network.

Effective Dec. 1, Johns Hopkins USFHP members will be able to use WRNMMC for the following specialty care: pulmonary, general surgery, cardiothoracic surgery, and vascular surgery. Members do not have to use WRNMMC for any of their health care, but they have the option.

To use WRNMMC for one of the approved specialties, members must receive a referral from their provider. At this time, only Johns Hopkins Community Physicians providers can refer members to WRNMMC. We expect that other in-network providers will be able to refer members to the facility at a later date.

To refer a Johns Hopkins USFHP member to WRNMMC, please fax the referral to 301-319-8555.

WRNMMC has an obligation to prioritize active duty service members. Patients will be queued for care along with retirees, dependents, and other non-Department of Defense external partner patients based on capacity. Patient referrals will go through the External Partnership Referral Office (EPRO) in an effort to expedite and prioritize care within the DOD system. Please keep this in mind when considering the needs of your patient.

WRNMMC is the nation's largest joint military medical center providing care to military beneficiaries in the Washington, D.C. area. It's location in Bethesda, MD is a convenient location for many Johns Hopkins USFHP members in the national capital region.

Outpatient Referral and Preauthorization Guidelines Effective October 1

The Outpatient Referral and Preauthorization Guidelines clearly outline the requirements for many outpatient services for our Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners and US Family Health Plan (USFHP) members. These guidelines are updated every quarter and posted to the JHHC website.

To ensure that the most-up-to-date referral and preauthorization guidelines for outpatient services are being followed, visit www.jhhc.com> For Providers> Resources and Guidelines.

Below is a summary of the changes to the Outpatient Referral and Preauthorization Guidelines that went into effect **October 1, 2019:**

Johns Hopkins EHP:

- Preauthorization required for Extracorporeal Shockwave Therapy for Plantar Fasciitis
- Preauthorization required for Minimally Invasive Treatments of Varicosities
- No Preauthorization required for Observation after the first 24 hours
- Provider-Administered Specialty Medications Preauthorization Required Section added

Priority Partners:

- Preauthorization required for Extracorporeal Shockwave Therapy for Plantar Fasciitis
- Preauthorization required for Minimally Invasive Treatments of Varicosities
- Site of Service Preauthorization Section added (This section lists the services that require preauthorization in all outpatient hospital setting – place of service 22.)
- Provider-Administered Specialty Medications Preauthorization Required Section added

Johns Hopkins USFHP:

- Preauthorization required for Extracorporeal Shockwave Therapy for Plantar Fasciitis
- Preauthorization required for Minimally Invasive Treatments of Varicosities
- Site of Service Preauthorization Section added (This section lists the services that require preauthorization in all outpatient hospital setting – place of service 22.)

- Provider-Administered Specialty Medications Preauthorization Required Section added

Johns Hopkins Advantage MD:

- No changes this quarter

New Diabetes Prevention Program for Priority Partners

We encourage providers in the Priority Partners network to offer members the National Diabetes Prevention Program (National DPP) lifestyle change program – a benefit that became effective for Priority Partners members on September 1, 2019. Those eligible for reimbursement for offers will be reimbursed for this.

The National DPP Lifestyle Change Program is an evidence-based program established by the Centers for Disease Control and Prevention (CDC) to prevent or delay the onset of type 2 diabetes through healthy eating and physical activity. Only CDC-recognized type 2 diabetes prevention programs may enroll with Medicaid to administer the program.

The Medicaid diabetes prevention program will be known as the HealthChoice Diabetes Prevention Program (HealthChoice DPP). For more information about DPP provider enrollment, please refer to the HealthChoice DPP Manual.

Priority Partners Eligibility Criteria

To be eligible, members must:

- Receive services through Priority Partners
- Be between 18-64 years old
- Be overweight or obese (Body Mass Index (BMI) of ≥ 25 kg/m2; ≥ 23 kg/m2, if Asian)
- Have an elevated blood glucose level OR a history of gestational diabetes mellitus (GDM), meaning the enrollee has:
  - » Fasting glucose of 100 to 125 mg
  - » Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 198 mg/dl
  - » A1C level of 5.7 to 6.4; or
  - » Clinically diagnosed GDM during a previous pregnancy.

Pregnant women and members previously diagnosed with type 1 or type 2 diabetes are not eligible to participate in the program.

Please email any questions regarding Maryland's HealthChoice DPP or DPP provider enrollment qualifications to **mdh.medicaidDPP@maryland.gov**

// QUALITY CARE

The Importance of Utilization Management

The aim of the JHHC Utilization Management (UM) Program is to improve the lives of our members by providing access to high quality, cost-effective, member-centered care. JHHC's utilization management decisions are based on appropriate care and existence of coverage.

- JHHC does not give financial incentives to staff that reward denials or promote under-utilization of services.
- JHHC does not make decisions about hiring, promoting or terminating practitioners or JHHC staff based on the likelihood that the practitioner or JHHC staff member supports denials of benefits.

You may request a copy of the UM criteria or benefit guidelines used in the decision of any case. If you would like to request a copy of UM criteria or benefits guidelines used, discuss any denial of care with a JHHC physician reviewer, or make a UM request or request for care for Priority Partners, EHP, or USFHP, please contact a UM staff member at **410-424-4480** or **800-261-2421,** Monday through Friday, 8 a.m. to 5 p.m. For Advantage MD, contact **844-560-2856** Monday through Friday, 8 a.m. to 6 p.m. and weekends and holidays, 9 a.m. to 1 p.m.

Messages may be left after hours, and will be returned on the next business day for routine requests. For concurrent inpatient admissions, a UM registered nurse is on-call after hours, including weekends and holidays, to assist with urgent admissions and discharge planning.

Transitions in Care- Pediatric to Adult

Patients should transition from pediatric to adult care between ages 18 and 21. Planning should begin even before that. JHHC encourages members to start taking control of their health care before turning 18 by scheduling their own appointments, refilling their medications and learning about their health history.

During appointments for your adolescent patients, help them learn their responsibilities and ensure they understand care instructions. If your patient has special needs, you should also talk to them and their parent or guardian about school, work, housing, and life skills.

Consider the health and needs of your patient and help guide them into the right care for their future. Support tools are available from the Got Transition website at **gottransition.org**.

Behavior Health Care Management Program

JHHC's Care Management department's Behavioral Health Care Management program is designed to assist and support members struggling with persistent mental health diagnoses and/or substance abuse issues, in addition to helping them manage their overall medical needs.

Members of Johns Hopkins Advantage MD, Johns Hopkins US Family Health Plan (USFHP) and Johns Hopkins Employer Health Programs (EHP) are eligible for the program.

Behavioral health care managers in JHHC's Care Management department are licensed and certified clinical social workers. They review the behavioral health plan benefits with the member and offer coordination with extensive community resources and support.

Two primary services offered by our behavioral health care management clinicians are medication reconciliation and care coordination. These clinicians work collaboratively with the members' primary care providers and the plan's care team to deliver comprehensive care management services to members. Often, members enrolling in this program contend with severe and persistent mental illness, along with other significant medical conditions.

Behavioral health rounds and care management rounds are two avenues we use within the program to share information and arrange case consultations with medical directors. This rounds process helps to ensure our members receive excellent care management service delivery.

Priority Partners continues to offer behavioral health services through Beacon Health Services. To support our Priority Partners members with behavioral health conditions, Care Management is currently working to develop a consultative Behavioral Health Care Management program for them. The goal of this program is to help Priority Partners members connect and build relationships with Beacon Health Services, which will ensure these members receive support and guidance in managing their behavioral health needs.

The Utilization Management and Care Management behavioral health teams work together to make sure members in all lines of business receive the quality services they need and are entitled to under their health plan.

CAHPS® Member Satisfaction Survey Results for 2019

CAHPS®, or Consumer Assessment of Healthcare Providers, is a member satisfaction survey in which the objective is to capture information about consumer-reported experiences with health care. The focus of the survey is to measure how well plans are meeting member expectations, determine which areas of service have the greatest effect on overall member satisfaction, and identify areas of opportunity for improvement.

Members were asked to rate timeliness, quality of services, and satisfaction with their practitioners and with their health plan overall. Topics included in the survey are Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Coordination of Care, Getting Needed Prescription Drugs, and the ratings of Health Care, Personal Doctor, Specialist, and Health/Drug Plan. The survey is conducted annually according to CMS protocol by a CMS certified vendor.

We are developing improvement initiatives with the help of participating physicians and welcome your input. Providers can help improve member satisfaction, enhance member communication, and encourage members to participate in shared decision making through the use of tools such as the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Toolkit. For more information, visit the **AHRQ website**.

Advantage MD

Advantage MD is trying to achieve the overall rating of 4 Stars at the contract level. To do this, our Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Health Outcome Survey (HOS) scores need to be at the average of 3.5 Stars with no measure at 1 or 2 Stars levels.

The CAHPS program is an annual survey to support and promote the assessment of consumers' experiences with health plan across various care domains such as access, communications, etc. The HOS, a three-year effort, assesses the ability of a Medicare Advantage organization to maintain or improve the physical and mental health of its members over time.

Physician partners can drive performance on the important CAHPS and HOS quality measures by reminding/following and addressing specific patient concerns during their virtual or in-person visits.

	2020 Star Ratings Measures (Weight in X)	Actual 2020 Stars (PPO)	Actual 2020 Stars (HMO)
CAHPS	Annual Flu Vaccine (1)	4	3
	Getting Needed Care (1.5)	2	1
	Getting Appointments and Care Quickly(1.5)	2	3
	Customer Service (1.5)	3	3
	Rating of Health Care Quality (1.5)	4	3
	Rating of Health Plan (1.5)	1	2
	Care Coordination (1.5)	3	3
	Rating of Drug Plan (1.5)	1	2
	Getting Needed Prescription Drugs (1.5)	1	4
HOS	Improving or Maintaining Physical Health (3X)	NA	NA
	Improving or Maintaining Mental Health (3X)	NA	NA
	Monitoring Physical Activity (1x)	4	NA
	Reducing the Risk of Falling (1x)	2	NA
	Improving Bladder Control (1X)	4	NA

NOTE: CAHPS Measure Set will be 2x for 2021 Stars or 2019 Measurement Year (exception Annual Flu Vaccine, which stay as 1x).

Priority Partners MCO (PPMCO)

The table below shows trended data for the last three years and compares it to the National Committee for Quality Assurance (NCQA) Quality Compass®* benchmarks. PPMCO's quality work plan goal is to meet the 75th percentile benchmark ranking.

Composite Measure and Overall Ratings	2017	2018	2019
Goal Met or Exceeded (≥75th percentile)			
Rating of Health Care	90th	90th	90th
Rating of Personal Doctor	90th	90th	90th
Rating of Health Plan	90th	90th	75th
Coordination of Care	25th	50th	75th
On track with National Averages (≥50th percentile)			
Getting Care Quickly	25th	90th	50th
Needs Improvement (≤25th percentile)			
Getting Needed Care	50th	50th	25th
Customer Service	50th	75th	25th
Rating of Specialist	25th	90th	NA

The survey results indicate that members gave positive scores for the ratings of Health Care, Personal Doctor, and Health Plan and the category Coordination of Care. Opportunities for improvement were identified for Access to Care, Rating of Specialist, and Customer Service.

US Family Health Plan (USFHP)

The table below shows trended data for the last three years and compares it to the National Committee for Quality Assurance (NCQA) Quality Compass®* benchmarks. USFHP's work plan goal is to meet the 90th percentile benchmark ranking.

Composite Measure and Overall Ratings	2017	2018	2019	Quality Compass Percentile Ranking
Goal Met or Exceeded (≥90th percentile)				
Getting Needed Care	92.0%	94.2%	90.9%	90th
Rating of Health Care	88.6%	89.0%	86.3%	90th
Rating of Health Plan	88.1%	86.7%	86.4%	90th
Rating of Personal Doctor	90.0%	91.3%	89.1%	90th
Rating of Specialist	88.8%	89.9%	88.7%	90th
Coordination of Care	88.0%	91.3%	89.4%	90th
Customer Service	90.0%	90.3%	93.3%	90th
On track with National Averages (≥75th percentile, but < 90th 'percentile)				
Getting Care Quickly	89.1%	88.0%	89.3%	75th
Needs Improvement (≤75th percentile)				
How Well Doctors Communicate	97.1%	97.5%	96.3%	67th
Claims Processing	87.5%	88.4%	89.7%	50th

The survey results indicate that How Well Doctors Communicate and Claims Processing are areas of opportunity for improvement.

Employer Health Programs (EHP)

The table below shows trended data for the last three years and compares it to the National Committee for Quality Assurance (NCQA) Quality Compass® benchmark*. EHP's quality work plan goal is to meet the 75th percentile benchmark ranking.

Composite Measure and Overall Ratings	2017	2018	2019	Quality Compass PercentileRanking
Goal Met or Exceeded (≥75th percentile)				
Rating of Personal Doctor	79.7%	83.2%	83.3%	75th
On track with National Averages (≥50th percentile)				
Rating of Health Care	73.3%	75.1%	79.5%	50th
Coordination of Care	76.4%	83.5%	82.9%	50th
Rating of Specialist	80.4%	86.3%	83.9%	50th
Needs Improvement (≤25th percentile)				
How Well Doctors Communicate	94.2%	94.8%	95.2%	34th
Getting Needed Care	78.8%	80.5%	84.1%	< 25th
Getting Care Quickly	75.4%	79.7%	81.9%	< 25th
Claims Processing	85.4%	82.3%	83.0%	< 25th
Rating of Health Plan	63.1%	55.9%	53.0%	25th
Customer Service	80.7%	82.8%	81.3%	N/A

The survey results indicate that there are opportunities to improve How Well Doctors Communicate, Getting Needed Care and Care Quickly, Claims Processing, and Customer Service.

The annual CAHPS® survey will be conducted again in the spring of 2020.

// PHARMACY

Priority Partners Now Requires Prior Authorization for Certain Provider Administered Medications

JHHC will require prior authorization to determine medical necessity for the following newly added provider administered medications (procedure codes are listed below). These new requirements impact members of all ages for Priority Partners and became effective October 1, 2019.

Prior authorizations are required as of October 1, 2019 for:

Impacted procedure codes

- J0800* (H.P. Acthar Gel®)
- J1950* (Lupron Depot®)
- J9218* (Leuprolide®)
- J9217* (Eligard®, Lupron®)
- J2796* (Nplate®)
- J9226* (Supprelin LA®)
- J3316* (Triptodur®)
- J9356* (Herceptin Hylecta®)

NOTE: An asterisk (*) indicates that these codes require medical necessity authorization only (not site of service).

Also effective October 1, 2019, Renflexis® (Q5104) will be the preferred agent for members initiated on infliximab therapy. Similarly, Fulphila® (Q5108) and Udenyca® (Q5111) will be preferred agents for members initiated on pegfilgrastim therapy. Renflexis, Fulphila, and Udenyca will continue to require prior authorization for Plan coverage.

Prior Authorization Process

For prior authorization requests, submit the **Medical Injectable Prior Authorization** form along with clinical supporting documentation via fax to 410-424-2801.

NOTE: A **complete list of the HCPCS Codes** for all specialty medications that require prior authorization is available on our website.

Pharmacy Formulary Update

A variety of pharmacy information and resources are available to you on the JHHC, Priority Partners, EHP, USFHP and Advantage MD websites. These include information related to the pharmacy formulary, pharmaceutical restrictions or preferences, requesting a benefit exception, step therapy, generic substitution and other pharmacy management procedures.

The pharmacy formularies are specific to each plan and are updated regularly to include new medications and the latest safety information. For additional information on the pharmacy formularies and updates for each plan, use the links listed below. You can also contact the JHHC Pharmacy Department at 888-819-1043 for questions or concerns for Priority Partners, EHP, and USFHP. Contact 877-293-5325 (option 2) for questions or concerns for Advantage MD.

Pharmacy websites to bookmark:

- **Johns Hopkins Employer Health Programs (EHP)**
  Jhhc.com > For Providers > Our Health Plans > EHP > **Pharmacy and Formulary**
- **Priority Partners**
  Jhhc.com > For Providers > Our Health Plans > Priority Partners > **Pharmacy and Formulary**
- **Johns Hopkins US Family Health Plan (USFHP)**
  Jhhc.com > For Providers > Our Health Plans > US Family Health Plan > **Pharmacy and Formulary**
- **Johns Hopkins Advantage MD**
  Jhhc.com > For Providers > Our Health Plans > Advantage MD > **Pharmacy and Formulary**

// REMINDERS

Deadline for ePREP Enrollment Portal is Dec. 1, 2019

According to our records, your practice has not registered with ePREP, Maryland's provider enrollment portal. To comply with the new federal rule, **providers must register with ePREP by December 1, 2019.** After Dec. 1, claims payments from unregistered providers will not be reimbursed by the state.

Federal rules require that all Priority Partners providers enroll with the state's Medicaid agency. To continue receiving Medicaid reimbursable funds, you must submit an electronic application through the online electronic **P**rovider **R**evalidation and **E**nrollment **P**ortal (ePREP). Enrollment is mandatory even if you do not participate with fee-for-service Medicaid.

For additional information and to complete your application, please visit **health.maryland.gov/ePREP** or call 844-4MD-PROV.

NOTE: Providers contracted with multiple MCOs only need to enroll one time with the state's ePREP system.

Network Access Standards

JHCC complies with state regulations designed to help make sure our plans and providers can give members access to care in a timely manner. These state regulations require us to ensure members are offered appointments within the following time frames:

Priority Partners

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

Employer Health Programs (EHP)

Service	Appointment wait time (not more than):
History & Physical Exam	Ninety (90) calendar days
Routine health assessment	Thirty (30) days
Non-urgent (symptomatic)	Seven (7) calendar days
Urgent Care	Twenty-four (24) hours
Emergency Services	Twenty-four (24) hours

Johns Hopkins US Family Health Plan

Service	Appointment wait time (not more than):
Well patient	Twenty-four (24) hours
Specialist	Four (4) weeks
Routine	One (1) week
Urgent	Twenty-four (24) hours
Office Wait Time	Thirty (30) minutes

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Service	Appointment Wait time (not more than):
PCP Routine/Preventive Care	Thirty (30) calendar days
PCP Non-Urgent (Symptomatic)	Seven (7) calendar days
PCP Urgent Care	Immediate/Same Day
PCP Emergency Services	Immediate/Same Day
Specialist Routine	Thirty (30) calendar days
Specialist Non-Urgent (Symptomatic)	Seven (7) calendar days
Office Wait Time	Thirty (30) minutes

Behavioral Health (all plans)

Service	Appointment Wait time (not more than):
Behavioral Health Routine Initial	Ten (10) business days
Behavioral Health Routine Follow-up	Thirty (30) calendar days
Behavioral Health Urgent	Forty-eight (48) hours
Behavioral Health Emergency	Six (6) hours

Changes to Pharmacy Copays in 2020 for USFHP

Prescription drug copays will change for US Family Health Plan (USFHP) members beginning January 1, 2020. The new copay increases are listed below:

- Mail-Order Pharmacy (Home Delivery) – 90-day supply
  - » Generic drug copay: increase from $7 to $10
  - » Brand-name drug copay: increase from $24 to $29
  - » Non-formulary* drugs: increase from $53 to $60
- Walgreens Pharmacy – 30-day supply
  - » Generic drug copay: increase from $11 to $13
  - » Brand-name copay: increase from $28 to $33
  - » Non-formulary copay: increase from $53 to $60

**Non-formulary means that the drug is not on TRICARE's list of fully covered medications.*

JHHC to Begin Using Text Messaging to Reach Advantage MD Members

Beginning in October 2019, Advantage MD members will receive text messages pertaining to **medication adherence** — specifically: diabetes, cholesterol and hypertension medications.

Johns Hopkins HealthCare (JHHC) wants to make you aware of this new text messaging program in case your Advantage MD patients mention receiving text messages from us.

Text Messaging and Advantage MD Members

Studies conducted by the Pew Research Center have found:

- 84% of Americans 65 and older are using a cellphone
- 94% of mobile users over 70 text regularly

Medicare plans can now incorporate data-driven insights to deliver crucial information that targets key membership segments. These automated and dynamically tailored conversations drive individual and population-level behavioral change, which improves member experience and positively impacts Star ratings performance.

Engaging members about their health status and informing new members about benefits and services is key to achieving our CMS Star rating goals. The CMS Star ratings increasingly impact member retention and growth and contribute to robust provider incentives. JHHC's Advantage MD plans need effective and efficient solutions to drive positive member experience and better health outcomes.

For More Information

Questions concerning the Advantage MD text messaging program may be directed to your designated Provider Engagement Liaison.

Credentialing Mailbox

A friendly reminder about JHHC's credentialing mailbox address. If you need to check on a credentialing status, please contact the Credentialing Department at this address:

Credentialing@jhhc.com

This mailbox is checked frequently.

Encourage Members to Get Their Flu Shot

Flu season is underway, and hopefully, many of your JHHC members have already received their flu vaccine. If not, there are still a few months of peak flu season to get through, and the sooner patients are protected, the better.

Please encourage your patients to get a flu shot this year, especially those with susceptible immune systems, such as young children and older adults. Additionally, please listen to any concerns that your patients have about the vaccine and discuss the vaccine's safety and importance with them.

For your reference, here are the places that all JHHC members can receive a no-cost flu shot:

Advantage MD: Provider's office or a network pharmacy

EHP: Provider's office, network pharmacy, or out-of-network pharmacy (member pays full cost and may submit for reimbursement)

Priority Partners: Provider's office or network pharmacy (all members), or community pharmacy (age 19 and older)

USFHP: Provider's office (all members) or a Walgreens pharmacy (age 9 and older)

Flu Campaign

Advantage MD has launched comprehensive multi-channel (e.g., mailer, magnet, texting, member newsletter) flu tactics to impact the performance on the key Star (CAHPS) measure for annual flu vaccination. These tactics will also mitigate the impact of the illness and associated complications as it relates to our members health and wellbeing.

Important notice:
Please distribute this information to your billing departments.

PRPULSE8-Fall/Winter 2019

PROVIDER pulse

JOHNS HOPKINS MEDICINE
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Johns Hopkins HealthCare
7231 Parkway Dr., Suite 100
Hanover, MD 21076