PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

FALL 2018

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 is a second spring when every leaf is a flower," observes poet and philosopher Albert Camus.

Here at JHHC, it is a bright and busy time, as our health plans go through the annual open enrollment period and we give our providers and members advance notice of the benefit and process changes that will go into effect at the beginning of 2019 and beyond. Take a look at what's new from JHHC and what you can expect from us in the upcoming year.

This season's issue also contains a special insert devoted to our Quality Improvement (QI) initiatives. JHHC's QI Program supports and promotes our mission to optimize the health of individuals, populations and communities through innovations and science-based solutions.

We're also adding a new section to the newsletter on Reimbursement Updates, which will include helpful reminders for providers on the most effective and efficient way to bill JHHC.

As always, we appreciate your efforts and continued collaboration. We give thanks to you and 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 couldn't be JHHC.

–Jennifer Sandoval
AVP, Network Strategy & Innovation, Provider Relations

// CLAIMS AND BILLING

Upgrades to Remittance Advice Report

We have made upgrades to the paper Remittance Advice (RA) based on feedback from USFHP providers about prior versions of the report. The RA, which is generated through HEALTHsuite, explains and breaks down the claims check. Our improvements will make the reports to providers more consistent and accurate.

JHHC's new RA offers

- Information in an easy-to-understand format
- A more comprehensive presentation of data throughout the report
- More efficient data flow
- Less duplication and wasted paper

New columns and additional data sections

These additions give a more accurate picture of how a claim was processed and reflect any pricing adjustments to the billed amount:

- "Interest/Discount" column, which factors into the Net Payable total.
- "Disallowed Amount" column, which displays amounts not paid by the plan.
- "Subscriber Liability" column, which displays amounts owed by the member.
- "Charges Above Max" column, which shows pricing adjustments.

Claim section improvements

- The claim remark codes section has been updated so every code related to the claim will be reflected on the claim line.
- Only claim remarks that apply to a specific claim will be shown by claim number. All others will be displayed once per code.
- For adjusted or reversed claims, we have added a message under each of these claims to help the provider connect the information back to the original claim.

Overpayment section enhancements

For RAs with overpayments, we have added multiple elements so providers can better reconcile the remittance check and post the activity to their books. The changes include:

- An updated remark code description for the "COVR" code. This description now details the offset amount, the related claim and patient account number and any remaining balance due.
- A summary total of all dollars used to offset the overpayments. This will show up in "Adjustment from Prior Overpayments" and will equal the total offsets displayed in the remark code section.

// REIMBURSEMENT REMINDERS AND UPDATES

Reimbursement Updates

We're introducing a new section in *Provider Pulse* dedicated to the often-challenging process of properly billing JHHC. The topics for our initial column are how to submit corrected claims and the right bilateral codes.

Submitting Corrected Claims on Paper (CMS-1500 or UB-04 Forms)

- The claim itself must be marked or stamped "Corrected." Do not indicate this is a corrected claim on the cover sheet only.
  - » Box 22 should contain the appropriate resubmission code.
- The corrected claim must be the resubmission of the entire bill, not just individual line you wish to be adjusted. Please submit the entire claim—the original claim and the corrected portion of the claim.
  - » Resubmitting just one line of a corrected claim will result in JHHC processing just that line. The rest of the claim will be denied.

Bilateral Codes

When billing multiple units of CPT or HCPCS codes that are defined as unilateral, please be sure to review coding resources to see if a more appropriate bilateral code exists before submitting a unilateral code.

For example:

- CPT 73502 is a unilateral radiological exam of the hip.
- It would be incorrect to bill this code twice if performed on both hips.
- You would bill the more appropriate bilateral code (CPT 73521 or CPT 73522, depending on number of views).

Using these reimbursement tips will help to ensure your claims are processed in the most efficient and effective way possible.

// POLICIES AND PROCEDURES

Utilization Management Process Change: Discontinuation of Bed Logs

A new process for communicating concurrent review status of member inpatient days for Priority Partners, EHP, Johns Hopkins USFHP, and Johns Hopkins Advantage MD members went into effect Oct. 1, 2018. With this new process, facilities receive more timely and detailed notifications of concurrent review for all lines of business.

JHHC's Utilization Management (UM) department faxes notifications to facilities with each reviewed day for each inpatient member. Instead of the former daily log that listed the concurrent review status of all JHHC members at the facility, facilities now receive an individual fax on each member.

This fax has the JHHC letterhead and includes a cover sheet. The second sheet includes:

- The member's name, member ID, date of birth authorization #, and health plan (i.e., Priority Partners, Advantage MD, etc.)
- Admit and discharge dates as applicable
- Chart of each service, status, start and end dates, days/units, and bed level

Specific comments may also be entered requesting discharge plan and/or other detailed information about the member.

For more information about the new individual concurrent review fax, please call 888-895-4998.

Updated Process for Eligibility Status of Priority Partners Members

JHHC would like to remind providers that the most current eligibility status for Priority Partners members can be found using the Maryland Medicaid Eligibility Verification Line, also known as EVS, which is available 24 hours a day/7 days a week.

EVS can be reached by:

Phone: 866-710-1447

Web Address: MarylandHealthChoice website at https://encrypt.emdhealthchoice.org/emedicaid/

Beginning the first week of October, JHHC will automatically re-route all eligibility calls to EVS during our regular business hours of Monday – Friday, 8 a.m. to 5 p.m.

This change ensures that providers will have access to the most current information available on the eligibility status of our Priority Partners members. It will also allow our Customer

Service representatives to personally assist providers with inquiries about benefits, claims, and other issues that cannot be handled through our self-service options.

Don't forget that HealthLINK is the primary resource for JHHC providers. HealthLINK is JHHC's secure, online web portal for in-network providers to access information on members enrolled in EHP, Priority Partners, and Johns Hopkins Advantage MD health plans.

Through HealthLINK, providers can:

- Submit claims and search for existing claims
- Review electronic remittance advice or download onto a PC
- Search for members based on name, member ID, PCP or date of birth
- Receive reports, such as member rosters
- Check the status of referrals and authorizations
- Send secure messages to Customer Service

Prior Authorization Now Required for Certain Radiology Services

JHHC now requires prior authorization to determine medical necessity for certain MRI and CT scan radiology services (procedure codes are listed in the chart below). These new requirements went into effect Oct. 1, 2018 and impact members of all ages for all JHHC health plans—Priority Partners, EHP, USFHP, and Johns Hopkins Advantage MD.

Prior authorizations are required for:

- MRIs
  - » Lower extremity
  - » Brain
- CT scans
  - » Abdomen
  - » Pelvis
  - » Chest
  - » Sinus cavity

Impacted procedure codes

70486	70551	71250	73718	73721	74176
70487	70552	71260	73719	73722	74177
70488	70553	71270	73720	73723	74178

Note: The prior authorization policy for MRIs remains in effect for the codes listed above regardless of whether the codes change over time.

Prior Authorization Process

Please submit prior authorization requests to our Utilization Management department (UM) **only** via the fax numbers listed below.

- **Advantage MD:** 410-424-2621
- **EHP:** 410-762-5205
- **Priority Partners:** 410-762-5205 or 410-424-4603
- **USFHP:** 410-762-5205 or 410-424-4603

// QUALITY CARE

Behavior Health Care Management Program

In May 2018, JHHC's Care Management department launched a Behavioral Health Care Management program. Members from Johns Hopkins Advantage MD, Johns Hopkins US Family Health Plan (USFHP) and Johns Hopkins Employer Health Programs (EHP) are currently being enrolled in the program.

The service is designed to assist and support members struggling with mental health diagnoses and/or substance abuse issues, in addition to helping them manage their overall medical needs. Behavioral health coordinators in our Utilization Management department are masters-level social workers offering extensive community resources and support, as well as reviewing the behavioral health benefits plan with the member.

Medication reconciliation and care coordination are two primary services offered by our behavioral health clinicians. These clinicians work collaboratively with the members' primary care providers and the plan's care team to deliver comprehensive care management services to members with behavioral health conditions. 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 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.

Utilization Management

The aim of the JHHC Utilization Management (UM) program is to improve the lives of our plan 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 support 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 if you would like to make a UM request or request for care for Priority Partners, EHP, and 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.

Unplanned Readmissions: A Costly Indicator of Lower Quality Care

Adult members who follow an inpatient stay with an unnecessary unplanned hospital readmission for any diagnosis within 30 days not only incur significant costs, but also can indicate low quality care.

Our goal at the JHHC Health Services department is to reduce unplanned hospital readmission and post discharge emergency department visits, which in turn will help improve the quality of health care for our members.

The increase in readmission stays, and the fact that this is an important National Committee for Quality Assurance measure, informs our commitment to working together with our providers and members to reduce unnecessary readmissions.

Risk factors for unplanned readmission are many. However, they appear to be driven primarily by complications in the patient's health. Taking the appropriate steps to minimize complications will decrease readmissions.

Chronic diseases such as heart failure, COPD, diabetes mellitus, cancer, stroke and/or psychosis, depression, and other mental health issues generate the highest risks. Additional factors that play a role in 30-day unplanned readmissions include:

- Member's health condition at time of initial hospital discharge
- Level of transitional care planning and care coordination
- Gaps in clinical care
- Insufficient follow-up care
- Limited medication management

Research shows that most unplanned hospital readmissions are avoidable. Medical providers and facilities have a responsibility to keep their patients safe and on the road to recovery after discharge.

Patient complications that result in unplanned hospital readmissions can be minimalized through comprehensive discharge planning. Interventions used before and after discharge that reduce hospital readmissions include:

- Early and thorough discharge planning
- Case management services
- Education on self-management skills
- Medication management training
- Standardized tools.

Appropriate pre- and post-discharge interventions and arming the patient with knowledge about self-care will ensure the best overall quality care from their initial hospital stay through the transition to home and maintenance support for their condition. These tactics will decrease the likelihood of unplanned, unnecessary hospital readmissions, which benefit both members and providers.

Well-Care Visits Benefit Members and Providers

Annual comprehensive well-care visits are important for all members. These visits allow time to perform necessary preventive screenings, update immunizations, encourage healthy lifestyle habits, and maintain a relationship with your patient.

Although it is essential for all members to receive a well-care visit annually with their PCP or OB/GYN, the National Committee for Quality Assurance (NCQA) targets specific age groups for the well-care measures: W34 (3-6 years of age) and AWC (12-21 years of age).

For calendar year 2018, NCQA has made a few changes in the well-care measures. NCQA did not change the five submeasures required during a well-care visit. Instead, changes were made to what is considered acceptable for the submeasures.

The five submeasures and their changes are listed below:

1. **Health education/anticipatory guidance**
   - **Change:** Information regarding medications or immunizations or their side effects is not acceptable evidence of health education/anticipatory guidance.
2. **Health history**
   - **Change:** Historically, to satisfy the health history element a provider just needed to document one of the following: the member's allergies, immunization history, or medication history. Now the provider must document all three histories—allergy, health and medication.
3. **Mental developmental history**
   - **Change:** The notation of "consistent with stated age" or "appropriately responsive for age" is not acceptable evidence for mental developmental history unless it is linked to a mental developmental milestone.
4. **Physical developmental history**
   - **Change:** The notation of "well-developed and well-nourished" is no longer acceptable evidence of physical developmental history. Tanner stages are acceptable evidence of physical developmental history for the AWC measure, but are no longer acceptable evidence for physical development history in the W34 measure.
5. **Physical exam**
   - No change.

If you have any questions about these changes please reach out to your provider engagement liaison.

// PHARMACY

Find the Latest Formulary Information Online

A variety of pharmacy information and resources for each of our plans is available to you at www.jhhc.com > For Providers > **Our Health Plans.**

This includes 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, visit the following links:

- **Advantage MD formulary**
- **EHP formulary**
- **Priority Partners formulary**
- **USFHP formulary**

You may also call the JHHC Pharmacy department at 888-819-1043 for questions or concerns for Priority Partners, EHP, and Johns Hopkins USFHP, or call 877 -293 -5325 (option 2) for Advantage MD.

// BENEFITS AND PLAN CHANGES

Johns Hopkins Employer Health Programs (EHP) Changes for 2019

We would like to make you aware of EHP benefit and plan changes that go into effect **January 1, 2019.** These include new additions to the preferred provider network for the PPO plan and a new EPO offering. Complete schedules for all 2019 benefits are available on **JHHC.com**.

New Plan Offering — Exclusive Provider Organization (EPO) Plan

- JHHC is introducing a new EPO plan on Jan. 1, 2019. This plan will have only in-network benefits through the EHP network (including Multiplan out-of-state network*) and Johns Hopkins Preferred Network. Care outside the EHP network is not covered under the EPO plan, except for emergency care.
  - » Applies to **Johns Hopkins Health System/ Johns Hopkins Hospital and Bayview Hospital, Howard County General Hospital (HCGH), and Suburban Hospital**

New Additions to the Preferred Provider Network for the PPO Benefit Plan

- Greater Baltimore Medical Center (GBMC) and Anne Arundel Medical Center (AAMC) facilities and providers will join the Johns Hopkins Preferred Provider Network on Jan. 1, 2019.

- Applies to **Johns Hopkins Health System/Johns Hopkins Hospital, Bayview Hospital—Providers and Facilities (PPO and EPO)**
- Applies to **HCGH, Suburban and Sibley Hospitals—Facilities only (PPO and EPO)**

Additional EHP Plan Changes

- **HCGH 2019 PPO Plan Changes**
  - **Acupuncture**: Adding medically necessary services for pain control and therapeutic purposes. Removing the "Anesthesia only" restriction.
  - **Hospital Care:** Removing $40 copay for Observation Care professional fees for ER visits.
  - **Urgent Care**: Removing for physicians visits (Patient First locations only). Changing the Urgent Care copay to $40 for all urgent care facilities.
- **Bayview 2019 Plan Changes**
  - Salary tiers that determine deductibles and out-of-pocket amounts have changed for 2019. The plan codes are listed on the member ID cards.
  - The following chart shows the changes on the Bayview PPO schedule of benefits:
- **Suburban 2019 PPO Plan Changes**
  - **ER Copay:** $125 copay, then 90% of allowed amount; deductible waived (copay waived if admitted) for EHP Network Provider, Hopkins Affiliated Facility Network, and out-of-network providers.
  - 90% coverage for facility coverage at all Hopkins Preferred Facilities **EXCEPT for infusion therapy services**
  - **EHP Network Provider Hospital Inpatient Care (Facility Fees):** $100 copay per admission, then 80% of the allowed amount; deductible waived (for a service that Suburban doesn't provide: $100 copay per admission, then 90% of allowed amount deductible waived).
  - **EHP Network Provider Reproductive Health Inpatient Maternity Care and Delivery (Facility Fees):** $100 copay per admission, then 80% of the allowed amount; deductible waived (for a service that Suburban doesn't provide: $100 copay per admission, then 90% of allowed amount deductible waived).
  - **Infertility**: 50% of allowed amount; deductible applies (preauthorization required for all services and prescriptions; all criteria must be met; $30,000 lifetime maximum combined including prescription drugs, lab work, and x-rays; in vitro fertilization attempts limited to a maximum of three per lifetime within the $30,000 lifetime maximum.
  - **Hearing Aids:** 90% of allowed amount; deductible applies (for dependent children up to age 26; up to $1,400 per aid; preauthorization required); replacement aids once every 36 months, all networks combined.
  - **Private Duty Nursing**: Removed for 2019.
  - **PT/OT:** Sixty (60) visits per year maximum added for all networks combined; PT/OT preauthorization required for visits 13-60.
- **Sibley 2019 PPO Plan Changes**
  - **Nutritional Counseling:** Limited to 6 visits per plan year for all networks combined; additional visits must be preauthorized.
  - **Infertility:** 50% of allowed amount; deductible applies; preauthorization required for all services and prescriptions; all criteria must be met; $30,000 lifetime maximum combined including prescription drugs, lab work, and x-rays; in vitro fertilization attempts limited to a maximum of three per lifetime within the $30,000 lifetime maximum.
  - **Chiropractic:** The 12 years of age restriction has been eliminated.

**Multiplan is also available inside Maryland for Suburban (PPO and EPO) and Sibley (PPO) members.* Complete schedules for all 2019 benefits are available on JHHC.com.

Site of Service Change for ENT Services for Priority Partners and Johns Hopkins USFHP Members

Effective Nov. 7, 2018, JHHC will require prior authorization and clearance for medical necessity for certain Ear, Nose, and Throat (ENT) procedures performed in an outpatient hospital setting. This policy affects both Priority Partners and the Johns Hopkins US Family Health Plan (USFHP) and impacts members of all ages.

The outpatient hospital setting, classified by Place of Service 22, may also be known as "regulated space" within the state of Maryland. This change applies to all hospitals in the networks, both inside and outside of Maryland.

Procedure Codes

The affected procedure codes are listed below:

21188	29800	30140	30450	42820	42831	69433
21198	29804	30400	30460	42821	42835	69436
21199	30110	30410	30462	42825	42836	
21206	30115	30420	30430	30520	42826	69420
21299	30130	30435	42145	42830	69421	

Prior Authorization Process

Prior authorization requests to our Utilization Management department (UM) must be submitted **only** via the FAX numbers listed below:

- **Priority Partners: 410-762-5205 or 410-424-4603**
- **USFHP: 410-762-5205 or 410-424-4603**

For a listing of participating providers and freestanding ambulatory surgery centers, please go to **www.hopkinsmedicine.org/johns_hopkins_healthcare/provider_search.html** or access the HealthLINK portal at **ehp.healthtrioconnect.com/app/index.page** for Priority Partners members and **usfhp.healthtrioconnect.com/app/index.page** for USFHP members.

// REMINDERS

ePREP: A One-Stop Shop from the Maryland Department of Health

The Maryland Department of Health offers the convenience of their electronic Provider Revalidation and Enrollment Portal (ePREP)—your one-stop shop for enrollment, re-enrollment, revalidation, provider updates, and demographic changes.

Please visit **https://mmcp.health.maryland.gov/Pages/ePREP.aspx** for questions and instructions on credentialing. The Call Center can be reached at 844.4MD.PROV (844.463.7768).

Be Prepared for Quarterly Survey—Keep Your Information Current

JHHC conducts quarterly surveys on provider appointment access and the accuracy of provider information in our directory. We do this to comply with regulatory and accreditation requirements from the Center for Medicare and Medicaid Services, the Maryland Department of Health, the Defense Health Agency, and the National Committee for Quality Assurance.

Following the set guidelines, we randomly select 5% of the network listed in our provider directory for survey calls made in January, April, July, and October. Our vendor partner, WBA Research, conducts these surveys on our behalf.

Survey participants are selected per provider and location, which means a provider or location may be contacted more than once if there are multiple listings. The same is true for a single phone number listed for various locations, as the survey participant may be asked numerous times for the same information.

To avoid the possibility of being contacted repeatedly for our quarterly surveys, please keep your provider and location information updated in our directory. We encourage you to visit our website at **www.jhhc.com**, where you can view the online directory and access the **Provider Update** form to make any changes.

As a reminder, if your office does not regularly schedule or treat patients, you may request the record to be suppressed in the directory, where it will no longer be considered for assessment. If you have any questions or need further information, please contact Provider Relations at 888-895-4998.

Regulatory References: 32 CFR 199.17(p) (5) and 42 CFR 438.206; COMAR 10.09.66.05-09; Tricare Operations Manual (TOM) 6010.59-M, April 2015, Change 26 (May 30, 2018), Chapter 5, Section 1; Participating Provider Agreement, Section III, sub-sections I & K.

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, Preventative 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

Johns Hopkins Advantage MD

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
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
Office Wait Time	Thirty (30) minutes

// SPECIAL INSERT

JHHC Practitioner Quality Reference Guide

Key information about our quality initiatives

Johns Hopkins HealthCare (JHHC) provides health care services for four health plans: Priority Partners, Johns Hopkins Employer Health Programs (EHP), Johns Hopkins US Family Health Plan (USFHP), and Johns Hopkins Advantage MD.

Our websites, listed below, contain a wealth of information for our providers, as well as for our plan members. We continuously update our websites and encourage you to check them often for additional information and enhancements.

JHHC: www.jhhc.com
Priority Partners: www.ppmco.org
EHP: www.ehp.org
USFHP: www.hopkinsusfhp.org
Advantage MD: www.hopkinsmedicare.com

Quality Improvement

The Johns Hopkins HealthCare Quality Improvement program focuses on improving the quality of care and service delivered to our members, network providers, and purchasers. You can obtain more information about JHHC's Quality Improvement program and the progress made toward meeting improvement goals by visiting any of the websites listed above. Refer to the website(s) or the quarterly *Provider Pulse* provider newsletter throughout the year for updates on our progress on various measures, such as provider and member satisfaction surveys and HEDIS® clinical measures.

Introduction

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

Mission of the Quality Improvement Program

JHHC QI program activities support and promote the JHHC mission to optimize the health of individuals, populations and communities through innovations and science-based solutions .

In addition, the JHHC QI program supports the Johns Hopkins Medicine mission to improve the health of the community and the world by setting the standard of excellence in medical education, research, and clinical care. JHHC's QI program uses nationally recognized measures of quality as follows:

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

Continuous Quality Improvement

The QI program functions within the Institute for Healthcare Improvement's triple aim framework (www.ihi.org), which is to simultaneously:

1. Improve patient experience of care (including quality and satisfaction)
2. Improve the health of populations
3. Reduce the per capita cost of health care

The QI program uses the Continuous Quality Improvement (CQI) process to develop and evaluate initiatives to improve patient health, experience, and quality of care in alignment with the triple aim.

Quality Improvement Program Goals

The QI program goals are to:

- Be a top performing health plan in Maryland
- Improve the quality and safety of clinical care, including behavioral health, and services provided to members
- Support and promote the JHHC mission to optimize the health of individuals, populations and communities through innovations and science-based solutions
- Promote utilization of the principles of Continuous Quality Improvement (CQI)
- Utilize data, outcome studies, and evidence-based criteria in order to analyze, monitor, evaluate, and report clinical quality and member safety
- Support programs and initiatives lead by other JHHC departments through the provision of quality data and analytics
- Serve a culturally and linguistically diverse membership through customer service and marketing lead activities
- Serve members with complex health needs through the Care Management and Special Needs programs
- Support coordination of activities and audits that demonstrate compliance with applicable regulatory and accreditation requirements

Member Safety Program

JHHC has embraced the innovative patient safety model developed by the Johns Hopkins Medicine Armstrong Institute of Patient Safety and Quality in order to promote quality improvement and patient safety activities within its health plans. The Armstrong Institute is working to advance the science of safety and quality through an array of projects and initiatives.

The Director of Quality Improvement attends Armstrong Institute Quality Improvement and Patient Safety committees and shares information regarding patient outcomes, patient satisfaction, and patient safety trends.

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

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

Quality Improvement Objectives

QI objectives are developed annually as a result of the analysis of quality initiatives and studies. Additional objectives are developed throughout the year as needed and are based upon gap analysis of HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) complaint data, and other qualityrelated data.

HEDIS and CAHPS

HEDIS measures performance on important dimension of care and service. HEDIS consists of 60 to 75 measures, depending on product type, across eight domains of care. JHHC reports on approximately 22 to 30 measures/ sub-measures, which may vary from year to year and by product/line of business. The QI department coordinates all activities associated with the collection, validation, and submission of HEDIS data. JHHC has contracted with an NCQA-certified vendor to conduct external HEDIS audit to ensure compliance with data collection processes and validation of data prior to submission. JHHC has IT resources with strict controls allowing for the confidential transmission of data via Interactive Data Submission System (IDSS) tool to NCQA.

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

Quality Improvement Initiatives

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

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

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

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

Quality Improvement Annual Program Description and Work Plan

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

Quality Improvement Program Evaluation

On an annual basis, a multidisciplinary team evaluates the outcomes of quality initiatives and studies and the overall effectiveness of the QI program. The QI evaluation is approved by QI committees, with ultimate approval by the JHHC Board of Directors.

Providers' Role

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

- Review quality reports and take action to improved clinical outcomes as measured by HEDIS
- Collaborate with the health plan to resolve member complaints regarding access to care, quality of care, provider service, or other issues upon request
- Provide feedback on the health plan via provider satisfaction surveys
- Provide medical records as requested for HEDIS, quality of care investigations or other medical record audits
- Collect and share quality and performance data for the purposes of joint quality initiatives
- Participate in member satisfaction initiatives, including improving access to care
- Participate in quality improvement committees upon request

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

If you are interested in obtaining additional information about the QI program, including a copy of the full QI program description, please contact your provider network manager.

Care Management Programs: How to Self-Refer

JHHC's Care Management team offers a variety of population health programs to help members manage chronic health conditions, recover from serious illness and make healthy lifestyle changes. Our care management services are voluntary and are provided at no cost to the member. Members identified with certain needs may be automatically enrolled, but are under no obligation to participate in these programs. Details regarding the programs are located on each of our websites.

If you have questions about the programs or know a member who could benefit from these services, please make a referral by calling 410-762-5206 or toll free at 800-557-6916. We are available Monday through Friday, 8:30 a.m. to 5 p.m. Voicemail messages received after normal business hours will be addressed the following business day. We can also be contacted via email at **populationhealth@jhhc.com**. Please do not send any private health information via email.

Pharmacy Update

A variety of pharmacy information and resources are available to you on the JHHC, Priority Partners, EHP, USFHP and Advantage MD websites. This includes 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:

- **www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/pharmacy_formulary/index.html**
- **www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/priority_partners/pharmacy.html**
- **www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/usfhp/pharmacy.html**
- **www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/medicare-advantage/pharmacy_formulary/index.html**

Clinical Practice Guidelines

JHHC has adopted Clinical Practice Guidelines developed by specialty groups, associations, and other medical organizations as the foundation for our population health programs. The complete list of adopted guidelines, and web links to download copies, is available in the **For Providers** provider section of the JHHC's website.

Medical Record Documentation Standards

JHHC has adopted standards for medical record documentation, availability of records, and maintaining confidentiality of medical records. We assess compliance with these requirements during a review of primary care physician records through our quality improvement program, and compare performance to our goals. The standards are located in the provider manuals and can be referenced online.

Member Rights & Responsibilities

JHHC is committed to treating its members in a manner that respects their rights and responsibilities and clearly communicates our expectations to them. You can find a copy of the member Rights and Responsibilities statement for Priority Partners, EHP, USFHP, and Advantage MD in each of the member handbooks, the provider manuals for each product, and under the appropriate member section on each website.

Transitions in Care-Pediatric to Adult

Transition of care from pediatric to adult care begins at age 18. More information on what providers should do, what to include in the health care transition (HCT) plan, and how to meet the HCT needs of young adults with special needs is available at: **https://trayinc.cld.bz/JHHC-Across-The-Board-Summer-2016/6**. Support tools are also available from the Got Transitions website at **gottransition.org**.

Basic Information on Health Services

JHHC's Division of Health Services is committed to quality health care and partnership with our dedicated providers is key to achieving this goal. Health Services includes Care Management & Regional Care Teams, Medical Policy, Pharmacy, Quality Improvement, Appeals, and Utilization Management departments. Use the quick reference guide on **page 15** for additional resources and to reach Health Services departments.

Communication with Covered Persons

JHHC welcomes all opportunities for the provider community to speak freely with their members or other designated parties connected to this organization. Priority Partners, EHP, USFHP, and Advantage MD participating providers are encouraged to discuss treatment options with members. You should explain the pros and cons of each treatment option so the member can make an informed decision. According to your contract and/or the plan's provider manual, you may freely communicate with members about their treatment options regardless of benefit coverage limitations. Please note that this information is also posted on our websites. If you have additional questions regarding our policies, please contact the Provider Relations team at 410-762-5385 or 888-895-4998.

Health Care Fraud

JHHC wants to find and stop health care fraud waste and abuse. According to the Centers for Medicare & Medicaid Services, approximately $272 billion was lost in 2014 due to health care fraud. While a majority of claims payment errors are the result of mere oversights, there continues to be a small number of health care providers who intentionally engage in conduct intended to commit fraud.

Health care fraud is defined as any deliberate and dishonest act committed with the knowledge that it could result in an unauthorized benefit to the person committing the act, or someone else who is similarly not entitled to the benefit. Examples of health care fraud are:

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

How Can You Help As A Provider?

- Ensure that your medical record documentation supports the type and level of service(s) provided
- Validate all member ID cards prior to rendering service
- Ensure coding accuracy when submitting all bills or claims for services rendered

- Submit appropriate referral and treatment forms
- Avoid unnecessary drug prescription and/or medical treatment
- Report lost or stolen ID cards
- Verify member eligibility by calling the state's Eligibility Verification System (EVS) at 866-710-1447 (only applies to Priority Partners)
- Report all suspicions of fraud for Priority Partners, EHP, USFHP, or Advantage MD by the appropriate method below.

Priority Partners, EHP, and USFHP:

Call: 410-424-4996 or call 844-422-6957
and ask for the Compliance department
Write:
Corporate Compliance Department,
6704 Curtis Court, Glen Burnie, MD 21060
Email: Compliance@jhhc.com
Fax: 410-762-1527

Advantage MD:

Call: 410-762-1575 or call 844-697-4071
Write:
Johns Hopkins Advantage MD
Compliance Department
Attention: Medicare Compliance Officer
6704 Curtis Court
Glen Burnie, MD 21060
Email: MedicareCompliance@jhhc.com

What Happens To You If You Report A Concern?

JHHC takes its responsibility to protect your right to report seriously. No health plan employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, the health plan has enacted zero-tolerance policies and annually trains all personnel on their obligation to uphold the highest integrity when handling compliance related matters. Any individual who reports a compliance concern has the 'right' to remain nameless and JHHC commits to enforcing this right.

In an effort to deter these and other instances of fraud, the JHHC Corporate Compliance department routinely performs validation audits on statistical samples of claims. Assessments also include encounter and utilization data.

In addition, the JHHC Corporate Compliance department investigates all detected outliers and other deviations from standard practice as well as all allegations of health care fraud it receives from recipients and others, and reports substantiated allegations to the appropriate regulatory authorities. They may perform their own fraud investigation and take action against those who are found to have committed fraud.

Resources for Health Services Department	
Care Management	To request a Care Manager contact the Care Management department at Phone: 800-557-6916 or email: populationhealth@jhhc.com.
Regional Care Teams	Regional Care Teams are cross-functional teams of employees working together within an identified region of Maryland, and are focused on member and provider engagement. Each Regional Care Team will include employees from Provider Relations, Care Management, Utilization Management, Community Health Advocates, and the Medical Directors. Contact your Provider Relations Representative to learn more.
Medical Policy	For your convenience the JHHC Medical Policies are available online at the link below: https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/policies/
Pharmacy	The JHHC Pharmacy department can be reached by phone at: EHP, Priority Partners, USFHP: 410-424-4480 or 800-261-2421 Advantage MD: 877-293-5325 (option 2)
Appeals	To request an appeal of denied services refer to the provider appeal rights on the denial letter. Appeals can be Faxed to: 410-762-5304 or Mailed to: Johns Hopkins HealthCare Attn: Appeals Department 6704 Curtis Court Glen Burnie, MD 21060 Expedited Appeals: Pre-service and medication expedited appeals **only** may be called into the expedited verbal Appeals phone line: 410-762-5383
Utilization Management	Phone: EHP, Priority Partners, USFHP: 410-424-4480 or 800-261-2421 Fax: EHP, Priority Partners, USFHP: Inpatient General: 410-424-4894 Inpatient JHB: 410-762-5204 Inpatient JHH: 410-762-5203 Medical Review: 410-762-5205 Outpatient: 410-424-4603 DME Fax: 410-762-5250 Advantage MD Phone: 844-560-2856 Advantage MD Fax: 844-240-1864 Behavioral Health: 410-424-4845 or 800-261-2429 DME Provider Directory can be accessed at: https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/

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

PROVIDER pulse

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Johns Hopkins HealthCare
6704 Curtis Court
Glen Burnie, MD 21060