PROVIDER pulse

Johns Hopkins Health Plans Provider Newsletter

WINTER 2025

JOHNS HOPKINS HEALTH PLANS

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

// INTRODUCTION

"Winter forms our character and brings out our best."
— Tom Allen

The other day when I was shoveling snow, my neighbor finished cleaning off her car and said to me, "This a classic winter. Haven't had one of these here in a while."

We've been spoiled the last couple years by relatively mild winters, it's true. Yet even snow and ice have not daunted our mission at Johns Hopkins Health Plans to deliver high-quality, cost-effective health care and services to our members. The expertise and excellence of our providers help us to do our best for our members and families day in and day out.

We thank our provider network for your abiding partnership and dedication.

—Jayne Blanchard, Editor

// POLICIES AND PROCEDURES

Quarterly Medical Policy Changes Effective April 18, 2025

The Johns Hopkins Health Plans Medical Policy Advisory Committee has approved changes to our existing medical policies.
View the Medical Policy Updates*

Revised policies this quarter include:

- **CMS20.04** — Thermography
- **CMS23.07** — Infertility Treatment and Fertility Preservation (Formerly Infertility Evaluation and Treatment)
- **CMS16.19** — Prenatal Obstetrical Ultrasounds
- **CMS03.12** — Cosmetic & Reconstructive Services
- **CMS19.05** — Solid Organ Transplantation
- **CMS24.08** — Gender Affirming Treatments and Procedures
- **CMS16.15** — Pediatric Feeding Programs
- **CMS24.06** — Non-Emergency Transportation

Retired policies this quarter include:

- **CMS22.01** — Minimally Invasive Treatment for Varicosities

To view the full descriptions of these policies, please visit the Medical Policies section of the Johns Hopkins Health Plans website on or after the effective date or call Provider Relations at 888-895-4998 (Option 4).

*If the link to this PDF breaks, please visit our Communications Repository.

Procedure Codes Authorization Changes

Effective April 14, 2025, Johns Hopkins Health Plans has approved the following changes to Prior Authorization (PA) and No Prior Authorization (NPA) requirements for the selected procedure codes listed below.

Authorization Change from PA to NPA for US Family Health Plan (USFHP):

- Code 91110: Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report.

Authorization Change from PA to NPA for Advantage MD, Priority Partners and USFHP:

- Code 71271: Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s). NOTE: There is an age restriction of 50-80 years and a quantity limit of one (1) per year.

This code list is provided for reference purposes only and may not be all-inclusive. The listing of a code does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service.

The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply. Please refer to the Johns Hopkins Prior Authorization Lookup (JPAL) tool in the Availity and HealthLINK portals to check and verify prior authorization requirements for outpatient services and procedures. Prior authorization requirements are subject to change.

Quarterly New Code Review Effective April 14, 2025

Please note the following authorization requirements status (Prior Authorization [PA], No Prior Authorization [NPA] and Non-Covered [NC]) for the codes listed in the chart below for Advantage MD, Employer Health Programs (EHP), Priority Partners, and US Family Health Plan (USFHP) health plans.

Quarterly New Codes Review Chart Effective April 14, 2025

Prior Authorization Process

- Please use our secure online portal, Availity, to submit electronic prior authorization requests for Advantage MD, Priority Partners and EHP. For codes subject to prior authorization through EviCore, providers should submit prior authorization requests via the eviCore portal through Availity, the EviCore portal directly, or if the portal cannot be accessed, by calling EviCore at 866-220-3071.
- For USFHP, submit prior authorization requests to the Johns Hopkins Health Plans Utilization Management department using these dedicated fax numbers: 410-424-2602 or 410-424-2603.

Changes to Emergency Department Review Policy and Sudden and Serious List

The Johns Hopkins Health Plans Reimbursement and Coding Committee (RAC) approved changes to the Sudden and Serious List, which is a list of ICD-10s for which emergency department (ED) payment does not require medical review. The list pertains to health plans for Employer Health Programs, Priority Partners and US Family Health Plan.

Please view the current version here: Sudden and Serious Diagnosis Codes Chart

NOTE: The current list contains an addendum with codes that were deleted* on Feb. 1, 2025.

To view the full descriptions of policies, please visit the Resources and Guidelines section of the Johns Hopkins Health Plans website on or after the effective date or call Provider Relations at 888-895-4998 (Option 4).

*If the link to this PDF breaks, please visit our Communications Repository.

New Prior Authorization Requirements for Certain Medications

Effective March 15, 2025, Johns Hopkins Health Plans will require prior authorization to determine medical necessity for several provider-administered medications under Advantage MD, Employer Health Programs (EHP) and Priority Partners. These requirements affect members of all ages.

Priority Partners Prior Authorization Requirements
EHP Prior Authorization Requirements
Advantage MD Prior Authorization Requirements

For certain drug classes, Advantage MD, EHP and Priority Partners have preferred drug lists. These preferred drugs are indicated on the Preferred Medical Injectable Drug List included at the above links. The comprehensive lists of provider-administered medications that require prior authorization for these health plans are also available on the Johns Hopkins Health Plans website for your reference.

Submitting Medical Injectable Prior Authorization Requests:

- Providers may submit electronic prior authorization requests through NovoLogix using the secure Availity provider portal.
- If Availity is not able to be accessed, providers may contact NovoLogix for assistance by calling 844-345-2803 (Priority Partners and EHP) or 800-932-7013 (Advantage MD).

Johns Hopkins Health Plans New Reimbursement Policies Effective Date: March 15, 2025

Johns Hopkins Health Plans has released its notification of the new reimbursement policies as follows:

(RPC.043) Advanced Laboratory Testing Policy — New

- Johns Hopkins Health Plans allows for reimbursement of covered advanced laboratory testing (e.g., biomarker testing, molecular pathology, genetic testing, etc.) when billed in accordance with the member's applicable plan and coverage criteria on the date of service.
- Certain tests identified by Johns Hopkins Health Plans can only be performed only once in a patient's lifetime or once per pregnancy, as determined by the health plan.

- Laboratories submitting claims for reimbursement are responsible for obtaining all supporting documentation from the ordering, referring and/or servicing provider when requested by Johns Hopkins Health Plans. For proper reimbursement, documentation must clearly establish and support medical necessity for each test ordered.
- Laboratory tests determined to be experimental, investigational or unproven (E/I/U) by Johns Hopkins Health Plans are ineligible for payment.
- Providers are responsible to verify the member's coverage and benefits and/or obtain a prior authorization before services are rendered; authorization is not a guarantee of payment.

(RPC.044) Age and Gender/Sex Based Codes Policy — New

- Johns Hopkins Health Plans will process claims assigned with age and gender/sex designations based on the modifier or code description.
- Johns Hopkins Health Plans may reject or deny claims if necessary information to process the claim is missing or if there's a mismatch between the procedure, modifier and/or diagnosis code and the reported age or gender/sex of the patient.
- Johns Hopkins Health Plans will utilize code-editing programs and post-pay algorithms to identify codes reported with the inappropriate age of a patient or inappropriate gender/sex of a patient.
- Johns Hopkins Health Plans recognizes and allows the use of modifier KX when there is gender/sex procedure or diagnosis conflict. Modifier KX alerts us that there is a known conflict, but still allows the claim to process.

(RPC.045) Once In a Lifetime (OIL) Procedures and Services Policy — New

- The OIL policy limits the frequency of reimbursement for certain items, tests, services and/or procedures identified by Johns Hopkins Health Plans which can be performed, reported and/or reimbursed only once during a patient's lifetime. OIL claims are subject to review.
- Some services and procedures, as identified by Johns Hopkins Health Plans, are not limited to a single CPT/HCPCS code, as "Code Families," which are a group of CPT/HCPCS codes that describe the same or similar type of service, may also represent them. The CPT manual also contains groups of codes describing different approaches or methods to accomplish similar results. These codes are generally mutually exclusive of one another.
- Johns Hopkins Health Plans will utilize the "first in, first out" payment methodology, when multiple providers bill for the same OIL service or procedure for the same member.

To view the **Johns Hopkins Health Plans Reimbursement Policies**, please go to: HopkinsHealthPlans.org > For Providers > Policies > Reimbursement Policies

// CLAIMS AND BILLING

Important D-SNP Notice: Billing and Services

In light of ongoing billing missteps, we would like take this opportunity to review proper ways to bill D-SNP plan members.

- Per the Advantage MD participating provider agreement, participating providers may not deny services to D-SNP members.
- Providers may not bill D-SNP members for any services covered under the D-SNP plan.
  - » Providers would need to bill Medicaid for the 20% that the D-SNP members would typically be responsible for, or accept the 80% payment from Advantage MD as full payment for the covered services.
- If a provider is not registered with Maryland Medicaid, we recommend they sign up so they can bill for services provided to D-SNP members.
- The D-SNP member may not be billed and is held harmless.
- Balance billing D-SNP members is prohibited.

Fee Schedule Updates

Fee schedule updates are received each quarter. Johns Hopkins Health Plans configures these updates in the claims payment systems accordingly the month these updates are received. As reimbursement is based on these fee schedules for Employer Health Programs, Advantage MD, Priority Partners and US Family Health Plan, this may result in slower processing times while the system updates are being made in order to ensure accurate payment, but claims will be paid within the required time frame.

// PHARMACY

2025 Changes to Medicare Part D and Plan Prescription Still Applicable to Advantage MD Members

Effective **Jan. 1, 2025**, several important changes took effect for Medicare Part D and Advantage MD prescription drug benefits. Providers need to be aware that these changes are still in place for Medicare and Advantage plans until further notice.

Key Changes to Medicare Part D for 2025:

1. **Coverage Gap Phase Is Eliminated.** In previous years, the Coverage Gap (also called the donut hole) was a coverage stage where members' cost shares for generic and brand name drugs increased to 25%. In 2025, the gap is gone. After reaching their out-of-pocket maximum, Advantage MD members with prescription drug coverage will enter the catastrophic coverage phase and will pay nothing for covered Part D medications for rest of the year.
2. **Out-of-Pocket Maximum Reduced to $2,000.** Medicare Part D enrollees will enjoy a reduction of their annual out-of-pocket cost share maximum for their prescription medications to $2,000.
3. **The Medicare Prescription Payment Plan.** Members will have the option to "smooth" their prescription drug costs over the plan year by paying monthly installments rather than having to pay out-of-pocket costs for medications all at once at the pharmacy. This can help members who may be living on lower, fixed monthly income to avoid higher out-of-pocket expenses the first few months of the year.

Advantage MD made the following changes to its Part D pharmacy benefits in 2025 that may affect members:

1. **Deductible for Certain Medications.** An annual deductible of **$590** will apply for all **Tier 3 through Tier 5** prescription drugs (except D-SNP and HMO Tribute plans).
2. **New Co-Insurance for Tier 3 and Tier 4 Drugs.** The cost share for Tier 3 and Tier 4 drugs will shift from a copay to a **25% co-insurance** once the deductible has been fulfilled.

NOTE: The Inflation Reduction Act of 2023 mandates a $35 cap for Part D-covered insulin. The $35 insulin cap is still in effect in 2025.

1. A one-month supply of Part D-covered insulin is capped at $35.
2. A three-month supply costs up to $105.
3. Advantage MD members do not pay a deductible for insulin.

Pharmacy Formulary Update

A variety of pharmacy information and resources are available to you on the Johns Hopkins Health Plans website and the Priority Partners, Employer Health Programs (EHP), US Family Health Plan (USFHP) and Advantage MD pharmacy pages. 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 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 Johns Hopkins Health Plans Pharmacy department at 888-819-1043 for questions or concerns for Priority Partners, EHP and USFHP. Call 877-293-5325 (Option 2) for questions or concerns regarding Advantage MD.

Pharmacy websites to bookmark:

- **EHP**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > EHP > Pharmacy and Formulary
- **Priority Partners**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > Priority Partners > Pharmacy and Formulary
- **USFHP**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > US Family Health Plan > Pharmacy and Formulary
- **Advantage MD**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > Advantage MD > Pharmacy and Formulary

// QUALITY IMPROVEMENT UPDATES

It's CAHPS® Survey Season!

We want to thank you and your staff for the exceptional service you provide to our Johns Hopkins Health Plans members all year round — and to remind you that now through June is CAHPS survey time.

Johns Hopkins Health Plans has developed a CAHPS Provider Toolkit packed with information on selected measures, tips and resources for you and your Advantage MD patients. Download the CAHPS Provider Toolkit on the Provider Engagement: Performance and Quality Resources page of our website.

Please consider integrating this checklist into your triage workflow, either through print copies or into the electronic health record system.

CAHPS is the acronym for **C**onsumer **A**ssessment of **H**ealthcare **P**roviders and **S**ystems. The CAHPS annual survey, given to a random sample of health plan members, measures the member's experience on the quality of health services that they receive in their provider's office.

Providers are an integral part of the survey process, since most of the CAHPS questions deal directly with the patient's experience in the provider office. Thanks again for being partners with us to deliver high-quality health services to our members.

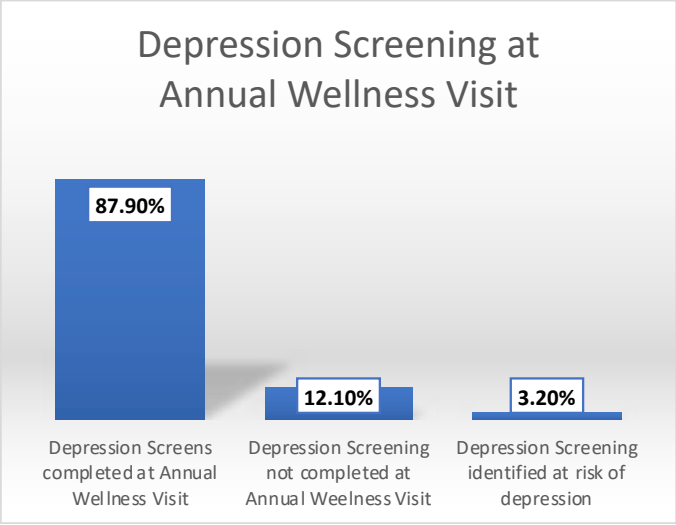
Engaging in conversations with patients about these topics throughout the year, and particularly before survey distribution, is crucial. These discussions play a pivotal role in enhancing patient experiences, improving health outcomes, increasing retention rates and influencing Star Quality Ratings and CMS payments to providers and health plans.

Triage Checklist

PCP follow-up	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Questions
☐	Have you had a flu shot this season? If no, would you be interested in getting one today?
☐	Are you experiencing challenges in obtaining needed care? such as scheduling a specialist appointment or securing a referral?
☐	Would you like to schedule your next routine care visit before you leave today?
☐	Are you experiencing any delays or have questions about tests, treatments, or services you are receiving?
☐	Do you have any questions or issues regarding the medications you are taking?
☐	Do you feel like you are receiving the right level of support to manage your care?
PCP follow-up	**Health Outcomes Survey (HOS) Patient Questions**
☐	Have you experienced a fall in the last year? Or do you feel as though you're having any trouble with balance?
☐	Have you had any problems controlling your bladder in the past 6 months?
☐	Have you been experiencing emotional challenges, such as feeling down, disinterested, or anxious?
☐	Do you feel as though your level of energy has interfered with your social and/or physical activities? How often?
☐	Are you experiencing any pain that limits your physical activity?
☐	How many times a week are you active, with increased heart rate, for at least 30 min?

Exploring the Rate of Depression Screening at Adult Annual Wellness Visits for USFHP Members

"An internal analysis showed that 87.90% USFHP beneficiaries are getting screened for depression as part of their annual wellness visit."



Methods: 315 cases were randomly selected from sample of adult annual wellness visits and chart documentation was reviewed for the visit – encounter notes, questionnaires and after visit summary with a 95/5 confidence/margin of error. *Ambulatory Retrospective Review (ARR)

The Johns Hopkins Health Plans Quality of Care Department performs retrospective chart reviews of various outpatient standard of care measures annually to assure that US Family Health Plan (USFHP) beneficiaries are receiving evidence-based care. Recent results showed that 87.90% of adult USFHP beneficiaries who had an annual wellness visit in February 2023 were screened for depression as part of the visit.

The U.S. Preventive Services Task Force (USPSTF) recommends annual depression screening. After the results were adjusted to include beneficiaries with a documented depression screening in the 11 months prior to the annual wellness visit, but not screened at the annual wellness visit, 91.10% of beneficiaries were screened for depression within a 12-month (1 year) period.

Of the 277 beneficiaries screened for depression at the annual wellness visit, 10 (3.60%) were deemed at risk for depression; 100% of the beneficiaries indicated at-risk were provided education and a plan of care was put into place.

It is expected that all adult USFHP beneficiaries are screened for depression annually.

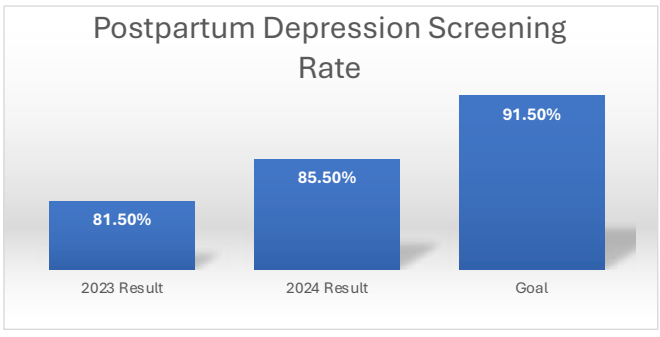
To accomplish this goal the providers of beneficiaries who were not screened for depression received informational letters. USFHP expects the letters will increase provider understanding of the USPSTF recommendation for depression screening and the importance USFHP places on mental health well-being.

NOTE: The USPSTF 2016 Depression Screening recommendation, used for this chart review, was updated June 20, 2023: USPSTF Final Recommendation Statement "Depression and Suicide Risk in Adults: Screening." June 20, 2023. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults

Follow Up: USFHP Works to Improve Postpartum Depression Screening

The 2023 US Family Health Plan (USFHP) Post-Partum Depression Screening Ambulatory Retrospective Review found documentation of screening for 81.5% of beneficiaries with a postpartum visit within 84 days of delivery. The 2023 findings, and a goal to improve the rate of screening by 10%, were shared with providers in the Winter 2024 issue of *Provider Pulse*, the Johns Hopkins Health Plans provider newsletter.

The Office of Quality & Transformation (OQT) reviewed charts of beneficiaries who delivered in May, June and July 2024. Of the 78 charts reviewed, 97.4% (76/78) completed postpartum visits within 84 days of delivery.



Of those 76 beneficiaries, 85.5% (65/78) were screened for postpartum depression. This is a 4-percentage point improvement and falls short of the goal to improve the rate of screening by 10%.

Without identification and treatment of postpartum depression, there can be both short- and long-term effects on both the mother and child (USPSTF, 2019). USFHP recognizes mental health is an integral part of an individual's well-being and

supports care that leads to improved mental health. Timely diagnosis and treatment are a strong step toward assuring our beneficiaries' experience the best health possible.

Goal: 91.5% postpartum depression screening rate

ACOG Perinatal Depression Screening guidelines recommend depression screening for beneficiaries during their third trimester of pregnancy and once again in the first seven weeks postpartum.

Striving toward a 10% improvement in the rate of screening for postpartum depression, the OQT will review beneficiaries who deliver in April, May and June 2025 for documentation of the screening.

// BENEFITS AND PLAN CHANGES

Member Benefit Reminder: Behavioral Health Services Available Through UpLift

If your Employer Health Programs, Advantage MD and US Family Health Plan members seek behavioral health services, please advise them that they can use UpLift providers at in-network coverage.

UpLift is a virtual behavioral health practice that expands access to behavioral health providers. This online platform can help patients quickly and easily access quality mental health care. Providers can refer their patients to Uplift or members can self-refer.

About UpLift

- UpLift supplements the existing network of quality behavioral health care providers available to members, adding more therapists and psychiatrists.
- The UpLift platform makes finding the right care simple by matching a therapist or psychiatrist according to personalized needs and provider specialties, allowing members to filter searches for different results. While UpLift is primarily virtual, some providers offer in-person appointment options.
- The interface allows members to schedule an appointment with a psychiatrist or therapist as soon as the next day and no further out than two weeks.
- Member cost shares for UpLift providers are the same as all in-network behavioral health care services.
- Members can self-refer or providers can now refer members to UpLift to locate a provider in the UpLift network. Refer members to joinUpLift.co to learn more and to find a provider.

Telehealth Code Changes for USFHP

Please note the following codes will change from No Prior Authorization (NPA) to Not Covered (NC) for US Family Health Plan (USFHP).

NC code changes for USFHP effective March 7, 2025:

- **98008:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- **98009:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **98010:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- **98011:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Advantage MD Offers In-Home Health Assessments

Advantage MD collaborates with Signify Health and Complex Care Solutions to offer eligible Advantage MD members in-home health assessments.

During this no-cost visit, members will meet with a Certified Registered Nurse Practitioner or higher to review their medication and medical history, track vital signs and address specific health questions. This visit serves as a comprehensive health exam that mirrors what occurs during the annual wellness exam, but does not replace the annual wellness visit. Virtual visits are also available.

Eligible members may receive a $25 gift card for participating. If eligible, a representative from Advantage MD, Signify Health or Complex Care Solutions will reach out to schedule the visit. Results from the assessment will be shared with both the member and their primary care physician.

New Laboratory-Developed Test Codes for USFHP

Per the TRICARE® Operations Manual (TOM), selected new codes on the Laboratory Developed Test (LDT) codes list (see below) are now covered and require prior authorization for USFHP.

LDT codes requiring prior authorization beginning March 25, 2025:

- **0312U** — Autoimmune diseases (e.g., systemic lupus erythematosus [SLE]) analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent
- **0334U** — Oncology (solid organ) targeted genomic sequence analysis formalin-fixed paraffin embedded (FFPE) tumor tissue DNA analysis 84 or more genes interrogation
- **0422U** — Oncology (pan-solid tumor) analysis of DNA biomarker response to anti-cancer therapy using cell-free circulating DNA biomarker comparison to a previous baseline pre-treatment
- **81479** — Unlisted molecular pathology procedure
- **81599** — Unlisted multianalyte assay with algorithmic analysis

LDT codes requiring prior authorization beginning April 14, 2025:

- **81445** — Genomic sequence analysis in solid organ tumors
- **81449** — Targeted genomic sequence analysis panel, solid organ neoplasm, 5-50 genes
- **81450** — Targeted genomic sequence analysis panel for hematolymphoid neoplasms or disorders, evaluating DNA and possibly RNA alterations in five to 50 genes
- **81451** — Genomic sequence analysis panel used for hematolymphoid neoplasms or disorders and involves interrogation for sequence variants, copy number variants or rearrangements and RNA analysis
- **81456** — Targeted genomic sequence analysis panel performed to evaluate patient specimens for RNA alterations in 51 or more genes related to solid organ cancers or blood/lymph disorder

Prior authorization process for USFHP:

Submit prior authorization requests to the Johns Hopkins Health Plans Utilization Management department using these dedicated fax numbers: 410-424-2602 or 410-424-2603.

// REMINDERS

Priority Partners Accreditation Update

As you probably are aware, the National Committee for Quality Assurance (NCQA) suspended the health plan accreditation status of Priority Partners on Feb. 18, 2025, pending re-survey. In response, on Feb. 28, the Maryland Department of Health (MDH) implemented sanctions against Priority Partners.

We would like to clarify the accreditation issue and its impacts to our providers. Most importantly:

- The Priority Partners MCO plan is not suspended; our NCQA accreditation is suspended.
- Priority Partners is still able to operate as normal. The plan is not being shut down.
- Current members will not lose their coverage, and they do not have to select another MCO.
- Provider contracts with Priority Partners are not affected.

Enrollment Impact

- Enrollment for new members is frozen at this time.
- The enrollment freeze does not impact family unity enrollment or continuity of care.
- Newborns of Priority Partners members will continue to be automatically enrolled with Priority Partners.

How you can help

- If Priority Partners members reach out to you with questions, assure them they will not lose their coverage and they do not have to select another MCO. They can continue to use their benefits and access care, no action needed.
    - » Please be aware that MDH has notified current members that they have the option to change plans from March 17, 2025, to May 16, 2025. Current members do not have to switch.
- Continue to see your Priority Partners patients. We continue to operate business as usual, and we will continue to process and pay claims as normal.

What we are doing

- We voluntarily reported the issues and our action plan to NCQA and MDH.
- We proactively developed a corrective action plan to address the issues. Much of the corrective action work has already been completed, and we expect the rest to be completed in the second quarter of 2025.
- Once all issues are fully resolved, Johns Hopkins Health Plans and Priority Partners will work with NCQA on the timing of a re-survey.

We take this situation very seriously and are working to restore full accreditation as quickly as possible. Quality is one of our guiding principles; we have full confidence in the services we provide to our members and health care providers.

Reminder: Provider Education Requirement for Advantage MD D-SNP

Johns Hopkins Health Plans would like to take this opportunity to remind providers in the Advantage MD D-SNP (HMO) plan of the mandatory training requirement.

Providers must take the D-SNP training when initially contracted to participate in the plan network. Then every year, providers in the Advantage MD D-SNP network are required to go through the training and fill out the training attestation form.

- Visit the provider website to sign up for **2025 D-SNP Training Dates.**
- The presentation is available on our website's **Provider Education** page.
- Providers must submit the training attestation form after review of this training presentation. Access the form provided at the end of the presentation or by going to the Forms page on HopkinsHealthPlans.org and clicking on "Model of Care Provider Training Attestation Online Form (D-SNP)" under Advantage MD.

Reminder to Update Provider Demographic Information

If there are any demographic changes for your practice or facility, you are required to notify the Johns Hopkins Health Plans Provider Maintenance department 30 days prior to the change via your delegated roster.

If you do not have a delegated credentialing agreement, please use the Provider Information Update form, which can be submitted electronically online, or the PDF can be emailed or faxed.

Please also be sure to include any changes in panel status (accepting new patients or not), as we want to ensure we are reflecting correct access information for our members. In addition, please confirm email addresses, as Johns Hopkins Health Plans communicates provider notices via email.

- **Delegated Rosters:** Follow the established process for submitting notification of any provider changes and confirm whether the provider is accepting new patients or not.
- **Digital Submission of the Provider Information Update Form (preferred):** Submit the **Online Digital Provider Information Update Form** directly from the provider website.
- Email Submission: Fill out the Provider Information Update Form* and email it to **ProviderChanges@jhhp.org**. This mailbox is monitored daily to collect and process all provider changes.
- **Fax Submission:** Use this method **only** if you are using a Social Security number in place of aTax ID number. Complete the **Provider Information Update Form*** and fax to 410-762-5302 to ensure identity protection. Do not send digitally or by email.

Please call Provider Relations at 888-895-4998 (Option 4) with any questions about the provider changes reporting process.

NOTE: Please submit W-9 requests to w9requests@jhhp.org.

*This form is located on HopkinsHealthPlans.org, under For Providers and then under the Forms section of the Resources and Guidelines page.

Please Use Correct Mailing Addresses for New Claims and Provider Refund Checks

Johns Hopkins Health Plans' Mail Services department has informed us of an ongoing issue with new Employer Health Programs (EHP) and Priority Partners claims going to incorrect mailing addresses.

In 2022, Johns Hopkins Health Plans switched the transfer of new claims to our vendor, Cognizant. In addition, provider refund checks must be mailed to the lockbox address (see below), not to Johns Hopkins Health Plans' Hanover, Maryland address.

EHP Claims

Mail new claims only with a date of service on or after 12/1/2022 to:

EHP
P.O. Box 4227
Scranton, PA 18505

Electronic submission is recommended; payer ID 52189 or submit via Availity.

Priority Partners Claims

Mail new claims only with a date of service on or after 9/1/2022 to:

Priority Partners MCO
P.O. Box 4228
Scranton, PA 18505

Electronic submission is recommended; payer ID 52189 or submit via Availity.

Provider Refund Checks

Mail provider refund checks for both EHP and Priority Partners to:

Johns Hopkins Health Plans
P.O. Box 412856
Boston, MA 02241-2856

MDH Taps Carelon as Behavioral Health Services Vendor

Carelon Behavioral Health is the current Medicaid behavioral health services vendor for the Maryland Department of Health (MDH). Carelon replaced Optum Health Maryland as of Jan. 1, 2025.

Resources:

- **Learn more:** Please refer to this document to learn about the Carelon transition and to these provider FAQs for general information on the new behavioral health services vendor.
- **Email:** During the transition period, Carelon is triaging provider questions through this email: Provider.Relations.MD@carelon.com.

Priority Partners providers can also enroll in Carelon's Provider Digital Front Door, home base for all provider resources. The Provider Digital Front Door allows Priority Partners providers to:

- Submit authorizations and search for prior authorizations
- Check claim statuses
- Check eligibility and benefits
- Submit appeal requests

Sign up for Carelon provider alerts.

Network Access Standards

Johns Hopkins Health Plans 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 Primary care provider (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

Service	Appointment Wait Time (Not More Than):
History and 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

US Family Health Plan

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

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
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	Immediate
Behavioral health emergency	Immediate

For Your Reference

Provider Relations

Phone 888-895-4998
410-762-5385
Fax 410-424-4604
Monday through Friday, 8 a.m. to 5 p.m.

Provider Demographic Changes and Updates:
If there are any changes in your practice or facility, you are **required** to notify the Johns Hopkins Health Plans Provider Relations department by email at ProviderChanges@jhhp.org or by using the online Provider Information Update Form.

Care Management Referrals
caremanagement@jhhp.org or 800-557-6916

DME (Durable Medical Equipment)
Fax 410-762-5250

Availity Provider Portal
www.availity.com/essentials-for-health-plans
800-282-4528

HealthLINK@Hopkins
www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/healthlink

Johns Hopkins Health Plans Corporate Compliance
410-424-4996
Fax 410-762-1527
compliance@jhhp.org

Fraud, Waste & Abuse
FWA@jhhp.org

Utilization/Care Management
410-424-4480
800-261-2421
Fax 410-424-4603 (Referral not needing medical review)

- Inpatient
  Fax 410-424-4894
- Outpatient medical review
  Fax 410-762-5205

Advantage MD

Websites
Providers: HopkinsHealthPlans.org
Members: HopkinsMedicare.com

Customer Service (Provider): Eligibility, Claims Status or Provider Payment Dispute

- PPO Products
  Phone 877-293-5325
  Fax 855-206-9203
  TTY 711
- HMO Products
  Phone 877-293-4998
  Fax 855-206-9203
  TTY 711

Dental Services
DentaQuest at: 844-231-8318

Medical Claims Submission
Advantage MD
P.O. Box 3537
Scranton, PA 18505

Medical Payment Disputes
Advantage MD
P.O. Box 3537
Scranton, PA 18505

Pharmacy Services
877-293-5325

Prior Authorization
Medical Management: 855-704-5296
Behavioral Health: 844-363-6772

Silver&Fit®
(Plus and Group Members Only)
877-293-5325

TruHearing
(Plus and Group Members Only)
877-293-5325

Vision Services
Superior Vision at 800-879-6901

EHP

Websites
Members: ehp.org
Providers: HopkinsHealthPlans.org

Customer Service (Provider)
800-261-2393
410-424-4450
Suburban Hospital Customer Service
866-276-7889

Care Management
800-261-2421
410-424-4480
Fax 410-424-4890

Dental – Delta Dental
800-932-0793

Health Education
800-957-9760

Medical Appeals Submission
Attn: Appeals Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-762-5304

Medical Claims Submission
Attn: Adjustments Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-424-2800

Mental Health and Substance Disorder Services
800-261-2429
410-424-4476

Cigna
800-261-2393

Pharmacy (Mail Order Only)
888-543-4921

Pharmacy Provider Prior Authorization for Medical Necessity
(Fax numbers may vary). Refer to provider website: hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/ehp

Utilization Management
800-261-2421
410-424-4480

**Not applicable to all EHP members. Consult specific schedule of benefits.*

Priority Partners

Websites
Members: ppmco.org
Providers: HopkinsHealthPlans.org
800-654-9728

Customer Service (Provider)
800-654-9728

Dental (Maryland Healthy Smiles Dental Program)
855-934-9812

HealthChoice
800-977-7388

Health Education
800-957-9760

Medical Appeals Submission
Johns Hopkins Health Plans
Appeals Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-762-5304

Medical Claims Submission
Johns Hopkins Health Plans
Adjustments Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-424-2800

Mental Health Services
Carelon Behavioral Health
800-397-1630 or
carelonbehavioralhealth.com/providers

Outreach
410-424-4648
888-500-8786

Provider First Line
410-424-4490
888-819-1043

Referrals
866-710-1447
Fax 410-424-4603

Substance Disorder Services
Carelon Behavioral Health
800-397-1630 or
carelonbehavioralhealth.com/providers

USFHP

Websites
USFHP: hopkinsusfhp.org
TRICARE: tricare.mil
Formulary: hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/pharmacy

Customer Service (Provider)
(benefit eligibility, claims status)
410-424-4528
800-808-7347

Appointment Locator Service
888-309-4573
Members can speak to and work with staff that can help them find urgent and routine appointments with mental health and substance disorder professionals.

Care Management
410-762-5206
800-557-6916

Health Education
800-957-9760
healtheducation@jhhp.org

Inpatient Utilization Management
Fax 410-424-2602

Outpatient Utilization Management
Fax 410-424-2603

Medical Appeals Submission
Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: USFHP Appeals

Medical Claims Submission
Johns Hopkins Health Plans
PO Box 830479
Birmingham, AL 35283
Attn: USFHP Claims

Mail Order Pharmacy
410-235-2128 (Maryland residents)
800-345-1985 (Non-Maryland residents)

Mental Health/Substance Disorder Services
410-424-4830
888-281-3186

Office of Quality & Transformation
410-424-4538

Performance Improvement/Risk Management
410-338-3610

Superior Vision
800-879-6901

United Concordia Dental
800-332-0366
Under a separate agreement, the plan has arranged for members to receive dental services from selected community dentists under a discounted fee structure.

PRPULSE19-WINTER 2025

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

PROVIDER pulse

JOHNS HOPKINS HEALTH PLANS

Johns Hopkins Health Plans
7231 Parkway Dr., Suite 100
Hanover, MD 21076