Did you know that half of hospital readmissions are deemed to be preventable? Twenty-five percent of discharged patients are readmitted within a month, and most within the first two weeks. The most common readmission diagnoses relate to heart failure, acute myocardial infarction and pneumonia, and the cost to Maryland hospitals: $1 billion annually.

Readmissions are similar to revolving doors. But it’s the patient who goes round and round. To help reduce this cycle, the Maryland Health Services Cost Review Commission is offering financial incentives to hospitals that succeed in cutting readmission rates.

Providers will play a key role in making this happen. While research shows readmissions are usually the result of multiple failures across the health care spectrum, providers are in a unique position to help hospital patients avoid return stays.

A few simple steps by providers can make a big difference. For instance, it’s been shown that scheduling a follow-up for a discharged patient within a week of leaving the hospital greatly decreases the chances of readmission.

It’s also vital that patients receive a phone call within three days of discharge to discuss their condition, rehabilitation steps and to review resources they can contact if problems develop.

Discharged patients also need to be educated about their medications. It’s important to check that they have all the medical supplies and scheduled treatments they will need, including physical therapy, occupational therapy or home nursing. Few of them will remember the care instructions they received in the hospital so provider reinforcement is crucial.

The transition from hospital to home care can be bumpy. Patients get confused about self-treatment. They may have trouble handling routine aspects of their care. They forget there’s no button to press that will summon a nurse.

There’s another key tool now available to providers. It’s a statewide electronic alert system from the Maryland Health Information Exchange, called CRISP, which delivers real-time data on a patient’s hospital admissions, discharges and emergency room visits. Some hospitals are giving CRISP access to dictations, laboratory, radiology and other test results too.

Through CRISP, providers can receive up-to-the-minute electronic reports on their patients’ medical situation and respond as soon as the emails reach them. The goal is more informed decisions, better patient care, improved outcomes and enhanced efficiency.

Providers who sign up receive secure email alerts from CRISP when one of their active patients is admitted, discharged or receives emergency room treatment. In many instances, CRISP can provide physicians with relevant clinical data, medical histories and discharge summaries to help them coordinate patient care.

For now, this real-time notification is free to physicians requesting inclusion in the program. There’s good reason to participate; it makes it easier for all of us to be proactive in scheduling follow-up treatment and office visits, to keep informed about what’s happening to our patients and to know that their hospital records are just a computer click away.

You can get more information or sign up for the CRISP Encounter Notification System (ENS) by calling 877-952-7477 or by sending an email message to HIE@crisphealth.org. See page 4 for additional CRISP information.
ARE YOU AT RISK?

Although Electronic Health Records (EHRs) make a provider’s job easier, they can also pose significant risk for fraud. Functions such as cut-and-paste, exploding notes, or templates can misrepresent the level of service rendered and leave dangerous information in the patient record.

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) will be conducting an audit of electronic health records as part of their 2013 Work Plan. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Therefore, the OIG will be looking at provider’s documentation practices associated with improper payments.

The American Health Information Management Association (AHIMA) has provided guidelines to assist providers in understanding how EHRs can put them at risk for fraud. To learn more please see: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp

Health Education Program Schedule for 2013

The Johns Hopkins HealthCare Health Education Program offers a number of classes for our members. Classes vary from weight management for adults and children, to asthma and diabetes education. If you have a member who could benefit from one of these programs, make sure you give them our health educator’s names and phone numbers.

<table>
<thead>
<tr>
<th>Location and Program</th>
<th>Class Dates/Times:</th>
<th>Class Description</th>
<th>Instructor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JHCP White Marsh: Diabetes Conversation Mapping</td>
<td>Wednesdays June 5th – June 26th 1:00 p.m. – 2:30 p.m.</td>
<td>Basic diabetes education and group interaction</td>
<td>Katie Powell 410-762-1632</td>
</tr>
<tr>
<td>JHCP EBMC: MOVE! 6 weeks</td>
<td>Wednesdays June 5th – July 10th 10:00 a.m. – 12:30 p.m.</td>
<td>Adult Weight Management</td>
<td>Karen Stewart 410-762-5318</td>
</tr>
<tr>
<td>JHCP EBMC: Way to Go Kids! 6 weeks</td>
<td>Thursdays June 6th – July 18th 3:00 p.m. – 4:30 p.m.</td>
<td>Children’s Weight Management ages 9-14</td>
<td>Karen Stewart 410-762-5318</td>
</tr>
<tr>
<td>JHCP Odenton: Asthma 1 day Class</td>
<td>Thursday June 20th 12:00 p.m. – 2:00 p.m.</td>
<td>Asthma education and management for children ages 7-12 and their families.</td>
<td>Katie Powell 410-762-1632</td>
</tr>
<tr>
<td>JHCP Frederick: MOVE! 6 weeks</td>
<td>Tuesdays July 16th – August 20th 4:00 p.m. – 6:00 p.m.</td>
<td>Adult Weight Management</td>
<td>Karen Stewart 410-762-5318</td>
</tr>
<tr>
<td>YMCA of Salisbury: Way to Go Kids! 6 weeks</td>
<td>Thursdays July 18th – August 22nd 4:00 p.m. – 5:30 p.m.</td>
<td>Children’s Weight Management ages 7-14</td>
<td>Katie Powell 410-762-1632</td>
</tr>
<tr>
<td>JHCP Dundalk: MOVE! 8 weeks</td>
<td>Tuesdays August 6th – September 24th 5:30 p.m. – 7:00 p.m.</td>
<td>Adult Weight Management</td>
<td>Katie Powell 410-762-1632</td>
</tr>
<tr>
<td>JHCP White Marsh: CDSM 6 weeks</td>
<td>Wednesdays August 7th – September 11th 12:30 p.m. – 2:30 p.m.</td>
<td>Chronic Disease Self Management Program</td>
<td>Katie Powell 410-762-1632</td>
</tr>
</tbody>
</table>
CRISP is Here

Johns Hopkins HealthCare (JHHC) has signed a contract with Chesapeake Regional Information System for Our Patients (CRISP). CRISP is Maryland’s statewide Health Information Exchange and receives real time data from 47 hospitals in the state pertaining to emergency room visits and admissions. Once the messages are sent to JHHC daily, we will send the data to the identified members’ primary care provider.

As of May, JHHC will deliver these reports through our File Transfer Agent in HealthLINK. These reports will be sent daily and will assist the PCP in ensuring patients are receiving appropriate care. The data is limited to Employer Health Programs (EHP) and Priority Partners members. For additional information please contact Provider Relations at 888-895-4998.

Modifiers Tell the Story

A modifier provides the means to report or indicate that a service or procedure performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also inform third-party payers of circumstances that may affect the way payment is made. Johns Hopkins HealthCare recommends following the 2013 American Medical Association CPT coding guidelines when submitting claims that require the use of modifiers. Consider using a modifier when the CPT code does not complete the story.

Are You Prepared?

Did you know that Evaluation and Management (E&M) services have been identified as a high risk for overpayment by multiple regulatory agencies including the Maryland Department of Health and Mental Hygiene (DHMH) and the Department of Health and Human Services Office of the Inspector General (OIG)? Regulators and payers are continuing to focus audits of E&M services.

There are three base components used in coding Physician E&M services: history of present illness; examinations; and medical decision making. The documentation provided in the patient medical record defines the level of each base component which, when added together, determines the level of the E&M visit.

The overarching requirement for all E&M services is based upon supporting documentation for the medical necessity for the visit. The best way to know if your documentation measures up is to conduct a self-audit. Please follow the links below to the Novitas E&M score sheet along with the Centers for Medicare and Medicaid documentation guidelines for E&M services at: https://www.novitas-solutions.com/em/pdf/scoresheets/8985.pdf

HEDIS Opportunity Reports Reminder

Even as we wait for the final 2012 results, sights are set on improving the scores in 2013. Delivery of practice specific member opportunity reports began in February. These reports provide our network PCP’s with a listing of members assigned to their practice with gaps in care. It is important to code correctly on the claims and ensure services are rendered by December 31, 2013. Please reference your 2013 HEDIS and Value Based Purchasing (For Priority Partners Only) Tip Sheet for proper coding on the measures for Priority Partners, Employer Health Programs (EHP) and Johns Hopkins US Family Health Plan (USFHP). Please contact Provider Relations at 888-895-4998 if you have any further questions.
# MEDICAL POLICY UPDATES

<table>
<thead>
<tr>
<th>MEDICAL POLICY AND/OR PROCEDURE</th>
<th>ACTIONS, COMMENTS AND REPORTING GUIDELINES</th>
<th>POLICY STATUS AND EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS10.005</strong> Applied Behavioral Analysis</td>
<td>New Policy. Applied Behavioral Analysis (ABA) medically necessary after medical review for members meeting certain criteria for Autism spectrum disorder (ASD).</td>
<td>Effective 3/01/13 Investigational and medically necessary criteria for a related CPT® and HCPCS® codes.</td>
</tr>
<tr>
<td><strong>CMS13.045</strong> Maternal DNA plasma sequencing for aneuploidy</td>
<td>New Policy. MaterniT21 or other such tests medically necessary for women with abnormal ultrasound or triple screen suggestive of Trisomy 21.</td>
<td>Effective 12/07/12 Investigational and medically necessary criteria for CPT® reporting code 85999.</td>
</tr>
<tr>
<td><strong>CMS14.04</strong> Neuropsychological Assessment</td>
<td>Revision of Policy. Neuropsychological Assessment. Policy has been retired. Refer to Interqual * evidence-based clinical content for future coverage guidance.</td>
<td>Effective 3/01/13 Retired. This policy has been retired. Adjudication of related claims will be determined using Interqual * evidence-based clinical content.</td>
</tr>
<tr>
<td><strong>CMS18.03</strong> Radiofrequency Ablation (RFA)</td>
<td>Revision of Policy. Radiofrequency Ablation (RFA) medically necessary after medical review for members meeting certain criteria for facet or sacroiliac joints or radicular pain without a definitive cause.</td>
<td>Effective 3/01/13 Investigational and medically necessary criteria for a related CPT® and HCPCS® codes.</td>
</tr>
<tr>
<td><strong>CMS19.11</strong> Transcranial Stimulation for Treatment of Depression and Other Psychiatric / Neurologic Disorders</td>
<td>New Policy. Transcranial Magnetic Stimulation (TMS) medically necessary after medical review for members meeting certain criteria for major depressive disorder, and bipolar disorder.</td>
<td>Effective 12/07/12 Investigational and medically necessary criteria for CPT® reporting codes 90867, 90868, 90869.</td>
</tr>
</tbody>
</table>

*Policies can be found at the following website: http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/policies/medical%20policies/medicalpolicies.html
On behalf of Priority Partners Managed Care Organization, Johns Hopkins HealthCare LLC is pleased to inform you that effective with dates of service January 1, 2013 and beyond, you will be able to submit a separate claim for the postpartum visit for Priority Partners members and receive $25.00 in reimbursement.

This quality initiative is driven by a specific postpartum HEDIS measure. In order to be eligible for payment, the postpartum visit must be rendered within the specified HEDIS timeline of 21-56 days after delivery; therefore, providers will need to bill with Category II CPT Code 0503F on the claim form in order to be reimbursed $25.00 for this service.

Please note that this service is only payable when performed within 21-56 days after the delivery date in order to meet HEDIS specifications.

If you should have any questions regarding this quality initiative please contact your Provider Relations Network Manager at 1-888-895-4998. Working in tandem with you, the health care provider, we look forward to providing the best possible care for our members.

$25.00 Reimbursement for OB/GYN Providers

The Priority Partners’ Pharmacy & Therapeutics (P&T) Committee recently reviewed Linzess, Xtandi, and Tudorza. These products were not added to the formulary. The committee reviewed two agents for the treatment of Ph+ CML, Bosulif and Synribo (C9297). Both agents will require prior authorization consistent with the National Comprehensive Cancer Network (NCCN) guidelines for use.

As you may know, generic buprenorphine/naloxone tablets (generic Suboxone) recently became available on the market. The generic tablets have been added to the Priority Partners formulary. Doses less than 2 tablets per day (total 16 mg/4 mg per day) will not require prospective prior authorization. Brand-name Suboxone Films will be removed from Priority Partners formulary effective June 1, 2013.

From the Pharmacy

The Maryland Department of Health and Mental Hygiene (DHMH) has decided to remove the responsibility for coverage of hospital and anesthesiologist services for dental services performed in the Outpatient Department (OPD) of a hospital from the Managed Care Organizations (MCOs) with an effective dates of service on or after January 1, 2013.

These services will be covered and reimbursed by the Medical Assistance fee for service program. The actual dental services performed in the OPD and rendered by the dentist, will remain the responsibility of DentaQuest, the Administrative Service Organization (ASO) for the Maryland Healthy Smiles Dental Program.

The Medicaid Program does not preauthorize services rendered in an outpatient setting of a hospital. Currently, there are no anesthesiology procedure codes that must be preauthorized. Dental offices must follow the current preauthorization process DentaQuest has in place for dental services. If a dental service requires preauthorization and the dental provider does not get authorization for those services from DentaQuest, the claim for those services will deny.

If you have questions regarding this transmittal, please contact Shelly Lehner, Deputy Director for the Acute Care Administration at 410-767-8787.

Payment Rendered to Maryland Healthy Smiles Participants
Healthy Kids/EPSDT Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federal requirement that mandates that states cover certain benefits for Medicaid recipients from birth through 20 years of age.

In Maryland, the preventive care component of the EPSDT Program is known as the Healthy Kids Program. Preventive health care services allow for early identification and treatment of health problems before they become medically complex and costly to treat.

It is important to note that the Maryland Healthy Kids Program must certify all Primary Care Providers (PCPs) who plan to serve Medicaid/MCHP children and young adults less than 21 years of age.

For additional information regarding Healthy Kids Program certification, please visit http://dhmh.maryland.gov/epsdt/healthykids. We encourage those providers who are certified to visit the website as well. It provides other valuable information including the Maryland Schedule of Preventive Health Care and provider forms that offer guidance in continuing to provide the best health care to Priority Partners members in addition to meeting the regulatory requirements of the Healthy Kids/EPSDT program.

New Electronic 1184 Process

It is the responsibility of hospitals to complete the Hospital Report of Newborns (1184) form. This is a DHMH mandate, and is vital to a newborn enrolling with Medicaid and obtaining an eligible Medicaid number.

Priority Partners would like to remind all hospitals that they should be following and completing the process in a timely manner. A newborn is not enrolled with Medicaid until the DHMH 1184 newborn processing through e-Medicaid has been completed and processed before the newborn leaves the hospital to ensure an appointment can be made with their pediatrician. Without timely enrollment, a newborn will not have access to needed services and providers will not get paid. For provider application and password support, call 410-767-5340.

Lab Services and Methadone Maintenance

Labs should not bill Medicaid FFS or the MCO’s for drug testing related to methadone maintenance recipients. Drug testing is included in the bundled payment for methadone maintenance services and thus should not be billed separately by the Methadone Maintenance Clinic or an outside lab service. If the Methadone Maintenance Clinic sends labs to an outside lab service, the Methadone Maintenance Clinic must pay the lab provider themselves. For questions regarding this information, please contact Earl Tucker at the DHMH at 410-767-4078 or tuckere@dhmh.state.md.us

Increase in E & M Services and Rates

Effective January 1, 2013 the Department of Health and Mental Hygiene (DHMH) has increased the rates for certain Evaluation & Management (E&M) services (CPT codes 99201-99499) to 100% of the 2013 Maryland Medicare rate, calculated by the Centers for Medicare and Medicaid (CMS), in accordance with 42CFR Part 438, 441, and 447. This increase applies to primary care and specialty providers. Providers paid by Value Options are excluded from the fee increase.

In addition, the DHMH has increased the payment rate for the administration of vaccines under the Vaccines for Children Program (VFC). Providers must continue to bill using the appropriate CPT code with an –SE modifier.

The Federal and State government increased rates to encourage provider participation in the Medicaid program to prepare for Medicaid expansion on January 1, 2014.
Priority Partners Changed My Life

He was suffering from extremely high blood pressure, high cholesterol levels, sleep apnea, thyroid disease, and was diagnosed with diabetes. His knees and ankle joints hurt when he walked and he was short of breath.

John Thomas knew what was on the line. With his health deteriorating, so was his quality of life. And on top of all his comorbidities, John’s weight was just shy of 500 pounds.

John knew something had to change; that he had to change. And he has.

John’s blood pressure is 117/67. His cholesterol levels have dropped, his diabetic medication has been changed from 2000 mg a day to 200 mg a day. And yes, he’s lost weight. John has shed an incredible 130 pounds since November.

The day he had bariatric surgery was the day his life changed forever.

“I have learned incredible self-discipline over the past few months. That’s not an easy task for me,” said John. “But I feel good and I’m happy with my progress.”

John has learned more about nutrition over the past few months than he ever did before. He knows what he can eat and what he can’t eat. He drinks almost 130 ounces of water a day, and adds high protein drinks at least three times a day. He eats more fruits and vegetables, and knows that this is what he needs to do in order to reach his goal weight.

Johns hasn’t only changed his nutritional habits, but he’s added exercise to his routine. He swims several times a week, and is getting some walking in too.

“Priority Partners has really helped me out with transportation to many of the appointments. Everybody I’ve worked with since I’ve had my surgery have been just great. I’m excited about my future, and this Priority Partners is making sure I’ll have a future,” stated John.

Well Child Visits – Don’t Miss the Opportunity

Managing a busy patient practice can be very challenging at times, especially when you add in all the demands by health plans, regulatory reporting requirements, medical record audits. Here are some tips to decrease missed annual well visit exams and decrease the medical record audit demands.

5 Ways to Prevent Missed Opportunities
1. Medication Refills: When a member come in for medication, make this an opportunity to schedule the annual well exam.
2. Immunizations: When a member calls for their child’s immunization, schedule their annual exam or perform it when they get their immunization.
3. Contraceptives & Screenings: When members call for an appointment for contraceptives, plan for the annual well visit.
4. Multiple visits: If a member calls for an appointment and has had previous visits in the current year and has not had their annual exam.
5. Well Visits/Annual Exams: These exams are often missed. Components of a well visit can be among multiple sick visits or doing an immunization or medication check.

Missed Coding Opportunities

Work with your staff responsible for billing and identify the codes for an annual well visit. It can be used with multiple diagnoses with a modifier. Your provider representative can help you find the appropriate resources for improving audit coding. This will decrease the constant demands for medical record review audits.
Over the past two years, Johns Hopkins HealthCare’s (JHHC) Employer Health Programs (EHP) has been focusing our efforts on increasing use of generic medications. When the program was conceived in late 2010, the prescription drug plan spent $2 million per year on branded proton pump inhibitors (PPI’s), more than any other group of medications. That cost has now decreased by half, resulting in meaningful savings for employers and patients who use generic versions of PPIs.

Officials who oversee JHHC’s drug benefits point to the PPI’s as a great example of the opportunity to save money for members and the plans by prescribing therapeutic equivalents, or options that are chemically different, but have the same effect as brand-name drugs.

“You can practice good medicine and still practice good resource stewardship,” says Dr. Robert Kritzler, deputy chief medical officer, JHHC, which administers EHP and its prescription drug plans. He says that Hopkins providers are generally aware of therapeutic equivalents, “but it’s not front of mind. Doctors prescribe out of habit.”

Kritzler is among a group of Hopkins providers and leaders who continue to encourage greater prescribing of therapeutic equivalents and the willingness of physicians to broach this alternative with patients, as a means to rein in the overall costs to the drug plans.

As straightforward as it might seem for providers to choose alternatives that are less expensive but equally effective and safe, physicians acknowledge that it can be more difficult in practice. Time constraints, a reluctance to discuss monetary issues with patients, the constantly shifting nature of drug plan formularies, and concerns about patient care, among other factors, make the cost savings hard to realize.

Based on feedback from physicians and residents, EHP has developed a drug guide that allows prescribers to find cost-effective alternatives from their mobile phones. The drug guide is available to all prescribers at no cost by visiting m.jhhc.com/drugguide.

Over the coming months, you can expect to see more from EHP to encourage members and prescribers to select alternative generic medications.

### From the Pharmacy

The EHP Pharmacy & Therapeutics Committee reviewed utilization of Abilify and Seroquel XR, atypical antipsychotic medications also indicated as adjuncts to traditional antidepressants in patients with unipolar major depression. Abilify will be moved to Tier 3 (highest copay) effective May 1, 2013 and members who are starting low-dose Abilify for depression will be required to have tried a first-line antidepressant. In addition, both Abilify and Seroquel XR will have a quantity limit of one tablet per day.

### Urgent Care Center - Patient First

Effective April 1, 2013 Patient First will be participating with EHP for Primary Care Services at both their Maryland and Pennsylvania practice locations. Patient First will remain a participating provider and will continue to offer urgent care services in both states.
It was an ordinary evening in an ordinary home. Christina (Chrissy) Callender was playing with her 2-year-old granddaughter in the living room. One moment she was laughing. A moment later, stepping backward on a chew toy, she felt her foot roll, heard a snap and before she knew it, she was sprawled out on the floor.

In normal circumstances, Dean, Chrissy’s husband, would have helped her up and driven her to the hospital. However, he was recovering from a torn tricep on one arm, and a broken wrist on the other, so Chrissy took control.

“After a few seconds I started barking out orders. I told my daughter to take my granddaughter out of the room. I didn’t want to scare her. Then I told Dean to call 9-1-1.”

Once the ambulance arrived, the EMTs stabilized Chrissy and transported her to Baltimore-Washington Medical Centers’ emergency room. Within a short time, Chrissy had an x-ray and the ER doctor confirmed the break in her foot. She was placed in a medical boot walking cast, shown how to use crutches, and given her prescriptions. She gave the administration clerk her EHP insurance card, processed her information, and Chrissy was home within an hour and a half.

But Chrissy’s story didn’t end there. She still had to go to work, and using the crutches was more of a hindrance than a help. Luckily her orthopedist gave her a prescription for a Roll-A-Bout, a knee walker that would make it easier for Chrissy to move around.

Chrissy called EHP customer service to inquire about a Roll-A-Bout. Chrissy was then put in contact with an EHP care coordinator who worked on Chrissy’s behalf, and got her the equipment she needed.

“I love the Roll-A-Bout. It gives me freedom. I don’t have to rely on a ton of people. I don’t want to take away from their workday by asking favors.”

“My health care experience overall has been a ten. I’m not one to complain; I usually just go with the flow. And I’m sure EHP just loves me and my husband,” she said with a laugh. “We are quite the pair.”
For members who have coverage under both Johns Hopkins US Family Health Plan (USFHP) and Medicare, the following criteria apply:

- Medicare cannot be billed for services which are covered by USFHP
- Members filing Medicare claims or who have claims filed on their behalf are in violation of the conditions of participation for USFHP and are subject to disenrollment
- Members who have coverage under both USFHP and Medicare may only use Medicare benefits for non-covered USFHP services, such as chiropractic care or ESRD
- Members utilizing Medicare for benefits covered under USFHP are subject to disenrollment

As of September 1, 2012 LabCorp is considered a participating laboratory provider with the Johns Hopkins US Family Health Plan (USFHP). LabCorp has convenient locations throughout the state for members to be referred to. Listings of their locations can be found at www.labcorp.com

Members of the Johns Hopkins US Family Health Plan (USFHP) recently received a mailing encouraging them to complete a Health Risk Assessment. Members who complete an assessment will receive a Personal Wellness Profile (PWP). The PWP is an individualized report designed to identify health risks and provide healthy lifestyle recommendations. The information shared is confidential and will only be used to generate the member’s personal report and identify wellness opportunities that are free benefits. Please talk with your USFHP members about this important assessment and persuade them to complete it. As an incentive, one out of every 25 members who complete an assessment will win a $50 gift card! If you have questions or would like a copy of assessment or the PWP please contact our Health Promotion and Wellness Unit at 800-957-9760. Members can also complete the form online at www.hopkinsmedicine.org/usfhp.
Meet Angela Young…a senior provider relations coordinator for Johns Hopkins HealthCares’ (JHHC) Provider Relations Department. Angela is responsible for supporting the Provider Relations network manager by assisting providers within the designated territory assignment which includes Walgreens Network Health Services and all Johns Hopkins entities including Johns Hopkins University’s School of Medicine; Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital and Johns Hopkins Home Care Group.

Angela also supports the network manager by managing incoming inquiries regarding contractual agreements, trending claims issues, fee schedule inquiries and responds to emails, phone calls, and incoming letters for internal and external providers.

Angela has been at JHHC since 2005, and was an administrative coordinator and network coordinator before being promoted to her current position in February 2012.

If Angela can assist you with any questions or concerns, please don’t hesitate to contact her at AYoung@jhhc.com or 410-424-4758.