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Johns Hopkins Health Plans Provider Newsletter

WINTER 2024

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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

What's In Store Throughout 2024

If there's a mantra that applies throughout Johns Hopkins Health Plans in 2024, it is "strategic change." This means change, not just for the sake of change, but meaningful transformations and adjustments that will raise our level of services, processes and quality that we provide to our members and providers.

We could not do this without the commitment to excellence and partnership we encounter every day with our providers. We thank you for your contributions to the important work that lies ahead of us and for all we've achieved together in past years.

For All Johns Hopkins Health Plans: Availity Provider Portal Expansion

As previously communicated, Johns Hopkins Health Plans is putting Availity into service in phases.

Phase I, which includes member eligibility requests and benefit information, electronic claims submission, claims status, remittance and claims payment information for Priority Partners, Employer Health Programs (EHP) and Advantage MD, as well as additional provider resources, went live in October 2023.

Phase II of Availity

The next phase is targeted to start in second quarter of 2024.

- Those providers currently on iExchange are the first group of providers to be trained and start using Availity for electronic submission of prior authorization requests to the Johns Hopkins Health Plans Utilization Management (UM) team for Priority Partners, EHP and Advantage MD. Providers in the test group can also check authorization status in Availity.
- Training for the test group is expected to begin in the spring of 2024. iExchange for this group will be turned off when the group of providers completes training and then switches over to Availity for submissions of prior authorization requests to Johns Hopkins Health Plans.
- Availity's prior authorization functions will then be available for the rest of the provider network. Training is scheduled to occur in May; details are forthcoming.
- Once Phase II implementation is complete, Availity becomes the chosen method for all providers to submit prior authorization requests to the UM team for Priority Partners, EHP and Advantage MD.
  - » Faxes for prior authorization requests will be accepted for US Family Health Plans (USFHP) until Availity is up and running for USFHP, and the expected timeframe is later in 2024.
  - » If, for some reason, a prior authorization request cannot be submitted through Availity, faxes to Johns Hopkins Health Plans' UM department can be used as a backup method.
  - » NOTE: Please check JPAL for prior authorization requirements before services are rendered.

Payer Platform

If your health system is on EPIC, Payer Platform can also be used for electronic submission of prior authorization requests for Priority Partners, EHP, Advantage MD and USFHP in 2024. If Payer Platform is implemented, it will be your primary means of submitting prior authorization requests to UM.

Alternate methods, such as Availity and fax, would be used only if Payer Platform is unavailable. For more information on Payer Platform, please see the **feature explanation**.

Please let your Provider Relations representative know if you are interested in employing Payer Platform for your facility/facilities and/or groups and to start the implementation process.

Other Availity updates:

- Access the eviCore portal directly through Availity now (without having to log into HealthLINK).
- The Novologix portal is directly accessible through Availity.
- Submission of payment disputes and medical necessity appeals through Availity for Priority Partners and EHP (without having to log into HealthLINK) became active at the end of January 2024.
- For Advantage MD, please continue to fax or mail claim or clinical disputes until further notice.
- For USFHP, please continue to use HealthLINK for electronic submission of claim disputes and medical necessity appeals, or submit by fax or mail, until further notice.

Introducing UpLift Virtual Behavioral Health Services

All plan members of **Advantage MD, Employer Health Programs (EHP) and US Family Health Plan (USFHP)** have access to behavioral health providers in the UpLift network.

- UpLift is a virtual behavioral health practice that expands access to mental health providers. The interface also allows members to schedule an appointment with a psychiatrist or therapist as soon as the next day, and no further out than two weeks.
- UpLift supplements the existing network of quality behavioral health care providers available to members, adding more therapists and psychiatrists.
- The UpLift platform also 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. Member cost-shares for UpLift providers are the same as all in-network behavioral health care services.
- Members can self-refer or providers can refer members to UpLift to locate a provider in the UpLift network. Refer members to join **UpLift.co** to learn more and to find a behavioral health provider.

Advantage MD

- **Northern Virginia Presence.** Johns Hopkins Advantage MD expands into Northern Virginia — Fairfax, Arlington and Falls Church, to be specific — with Advantage MD Select (HMO). The plan features lower monthly premiums than PPO plans, a robust HMO network, lower out-of-pocket costs, vision and dental care, prescription drug support and more!
- **Coverage for Insulins.** Changes include reduced copays on insulins for all Advantage MD plans, a cap of $35 per month on Part D-covered insulins, no deductibles for insulins and additional savings with three-month mail order deliveries of insulin.
- **Further Part D Improvements.** There will no longer be a partial program in the Low-Income Subsidy program.
    - Full benefits will be offered to people who have Medicare with limited resources and incomes up to 150% of the federal poverty level, which in 2023 is $21,870 per year for an individual.
    - People who qualify for Extra Help will pay no deductible, no premium, fixed lower copays for certain medications.
    - The 5% prescription cost-sharing obligation for Part D has been eliminated. When someone on Medicare has spent $3,100, they will enter what's called the catastrophic phase of their benefit. In this phase, the member will have no cost-sharing of prescription drugs for the remainder of the year.
- **Help With Transportation.** Round Trip is a transportation company that offers health-related rides to our members; 24 one-way trips will be available for members to get rides to doctor appointments, pick up pharmacy prescriptions, etc. Available to HMO Select and D-SNP members only. Other Advantage MD plans may offer transportation options—members can view their benefit summaries for more information.

Employer Health Programs (EHP)

PrudentRx Program:

Effective Jan. 1, 2024, EHP has added Caremark's PrudentRx program, which will help members save money when they fill eligible specialty medications.

- All medications on the **PrudentRx Specialty Drug List** are subject to a 30% coinsurance. However, if a member is participating in the PrudentRx program, they will have a $0 out-of-pocket responsibility for the covered specialty medication prescription.
- Participation in the program includes enrollment in an available manufacturer copay assistance program for the specialty medication being taken. Medications on the PrudentRx Specialty Drug List may only be obtained from Johns Hopkins Outpatient Pharmacies and CVS Specialty Pharmacies.
- Please note the following:
    - The PrudentRx Specialty Drug List is subject to change, and updated monthly.
    - PrudentRx became available Jan. 1, 2024 for Johns Hopkins Health System and other entities only. Broadway Services is expected to include the benefit starting July 1, 2024.

Priority Partners

Maternal Health Focus

- **Centering Pregnancy** is an evidence-based group prenatal care model for low-risk pregnancies. Facilitators support a cohort of eight to ten individuals of similar gestational age through a curriculum of ten 90- to-120-minute interactive group perinatal care visits that largely consist of discussion sessions covering medical and nonmedical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care. Please see MDH Transmittals PT30-23 and PT61-23 and the MDH Medicaid Centering Pregnancy Provider Information webpage for more information.
- **HealthySteps,** a ZERO TO THREE program, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages 0 to 3 years and their families are screened and placed into a tiered model of risk-stratified supports, including care coordination and on-site intervention. A HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening and provide successful interventions, referrals and follow-up to the whole family. The HealthySteps Specialist screens all children ages 0 to 3 years and their families to place them into the appropriate tier of services. For more information on Healthy Steps, please visit the MDH website or refer to Transmittal PT30-23.
- **Home visiting services** are designed for pregnant people to get the care and support they need to have a healthy pregnancy and healthy child. These services are usually provided in the home by a specially trained professional or a nurse. After pregnancy, your home visitor will continue to support the Priority Partners member and their child up to their second or third birthday, depending on the program. These services are free.
- **A doula, or birth worker,** is a trained professional who provides physical, emotional and informational support to birthing parents. This support can happen before, during and after birth. Doulas serving Priority Partners members will provide person-centered care that supports their racial, ethnic and cultural diversity.

US Family Health Plan (USFHP)

Behavioral Health Assessment Audit

US Family Health Plan is working with TRICARE on a process for auditing network behavioral health/mental health providers' documentation of standardized measures in the areas of:

- Post-traumatic stress disorder (PTSD)
- Anxiety disorders
- Depressive disorders

The assessment audit is in compliance with TOM Chapter 7, Section 6, Para 8. (CDRL A090).

Records to audit the completion of these assessments may be requested for services starting in Oct. 1, 2023, at the start of the new contract year.

Behavioral Health Assessments

Specified assessments must be completed for all behavioral health settings and/or discharge from:

- Outpatient Mental Health (MH) and Substance Use Disorder (SUD)
- Opioid Treatment Programs (OTP)
- Intensive Outpatient Programs (IOPs)
- Partial Hospitalization Programs (PHPs)
- Psychiatric Residential Treatment Centers (RTCs)
- Inpatient/Residential Substance Use Rehab Facilities (SUDRFs)

For more information about the BH requirements and resources for USFHP providers, please visit our dedicated webpage on the Johns Hopkins Health Plans provider website.

Preconception and Prenatal Screenings

USFHP covers preconception and prenatal carrier screening for the following conditions:

- Cystic fibrosis
- Spinal muscular atrophy
- Fragile X syndrome
- Tay-Sachs disease
- Hemoglobinopathies
- Conditions linked with Ashkenazi Jewish descent

The TRICARE® benefit will cover one test per condition throughout the beneficiary's lifetime, regardless of risk status.

- Codes 81200, 81205, 81209, 81242, 81250, 81251, 81260, 81290, 81330, 81361, 81362, 81363, 81364, 81412, 81443 and 0236U are covered with prior authorization.

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// POLICIES AND PROCEDURES

New CPT® Codes Requiring Prior Authorization

Johns Hopkins Health Plans requires prior authorization for the selected medical procedure and equipment codes listed below. This requirement affects members of all ages enrolled in these plans.

- Quarterly New Codes Requiring Prior Authorization for EHP and USFHP Effective Feb. 19, 2024
- Quarterly New Codes Requiring Prior Authorization for Advantage MD and Priority Partners Effective March 6, 2024

The eviCore prior authorization process for Advantage MD and Priority Partners:

- 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.

Prior authorization process for EHP:

- Submit prior authorization requests to the Johns Hopkins Health Plans Utilization Management (UM) department using these dedicated fax numbers: 410-424-4894 or 410-424-2770.

Prior authorization process for USFHP:

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

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 noncovered 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 tool (JPAL), located 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.

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Medical Policy Updates

The Johns Hopkins Health Plans Medical Policy Advisory Committee (MPAC) has approved new changes and additions to our existing medical policies.

- Medical Policy Changes effective Jan. 1, 2024:
  - **CMS07.05:** Gender Affirmation Treatment and Procedures — Revised
  - **CMS01.00:** Medical Policy Introduction — Revised
  - **CMS01.09:** Continuity of Care and Access to Non-Participating Providers — Revised
- Medical Policy Changes effective Feb. 1, 2024:
  - **CMS24.18:** Neuropsychological Testing — NEW!
  - **CMS24.11:** Incontinence Supplies — NEW!
  - **CMS11.01:** Clinical Practice Guidelines Policy — Revised
  - **CMS24.06:** Non-Emergency Ambulance Transportation — Revised
  - **CMS24.12:** Investigational and Experimental Services — Revised
  - **CMS15.04:** Foot Orthotics — Revised
  - **CMS19.08:** Speech Devices — Revised
  - **CMS22.06:** Vagus Nerve Stimulation for Depression — Revised
  - **CMS05.02:** Computed Tomography and Coronary Calcium Scoring — Revised
  - **CMS16.17:** Pulse Oximetry for Home Use — Retired
- Medical Policy Changes effective April 1, 2024:
  - **CMS07.03:** Genetic Testing (focused update) — Revised
  - **CMS23.07:** Infertility Evaluation and Treatment — Revised
  - **CMS03.12:** Cosmetic and Reconstructive Services — Revised
  - **CMS19.05:** Solid Organ Transplantation — Revised
  - **CMS16.19:** Prenatal Obstetrical Ultrasound — Revised
  - **CMS23.05:** Site of Service — Outpatient Surgical Procedures — Revised

- » **CMS22.01:** Minimally Invasive Treatment of Varicosities— Revised
- » **CMS16.15:** Pediatric Feeding Programs — Revised
- » **CMS20.04:** Thermography — Revised
- » **CMS24.08:** Gender Affirming Treatment and Procedures (EHP) — Revised
- » **CMS02.09:** Testing for Hereditary Breast and Ovarian Cancer Syndromes — Retired

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).

Current Reimbursement Policy Changes

Johns Hopkins Health Plans has released its notification of updated and new reimbursement policies that became effective Feb. 1, 2024:

(RPC.016) Observation Care Services — Updated

- Policy language updated; Key Definitions, Background, Coding and References sections updated and included.
- Consistent with CMS guidance, observation services are considered outpatient services. The place of service code should identify the patient's location as outpatient for the service billed.
- Observation services are not expected to exceed 48 hours in duration. Services reported over 48 hours in duration are seen as rare and exceptional cases and will be reviewed.
- Maryland Waiver Providers are to bill observation services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations and will be reimbursed under the HSCRC payment methodology.

(RPC.002) Non-Payment of Preventable Adverse Events (PAE) — Updated

- Policy language updated; Key Definitions, Background, Coding and References sections updated and included.
- Consistent with CMS, a Present on Admission (POA) Indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
- To ensure that billed items or services are covered and are reasonable and necessary, Johns Hopkins Health Plans may pend claims and conduct a review to prevent improper payment to providers.
- Maryland hospitals are exempt from DRG payment reductions. These hospitals have an agreement with CMS and the state of Maryland.

(RPC.022) Increased Services (Modifier -22) — Updated

- Policy language updated; Key Definitions, Background, Coding and References sections updated and included.
- Modifiers -22 and -63 cannot be billed on the same procedure code.
- In order to be considered for additional reimbursement, Modifier -22 may only be reported with a valid procedure code that has a global period of 0, 10 or 90 days on the Medicare Physician Fee Schedule (MPFS).
- Modifier -22 cannot be reported by a facility, as it is a "physician-only" code.

(RPC.023) Infants Less Than 4Kg (Modifier -63) — Updated

- Policy language and format updated.
- Johns Hopkins Health Plans will determine if requirements are met for an additional allowance for Modifier -63.
- Modifier -63 may be appended to procedure codes that do not include "neonate" or "infant" in its description.
- Key Definitions, Background, Coding and References sections updated and included.
- Policy only applicable to Employer Health Programs (EHP) and US Family Health Plans (USFHP).

(RPC.006) Gap Fill Fee Schedule — Updated

- Policy language and format updated.
- Providers are responsible for determining if a CPT/HCPCS code requires preauthorization.
- Key Definitions, Background, Coding and References sections updated and included.

REFERENCES:

- **CMS Regulations and Guidance**
- **COMAR — Maryland Department of Health, Maryland Medicaid Administration**
- **Medicare Claims Processing Manual Ch. 1 — General Billing Requirements**

- Medicare Claims Processing Manual Ch. 3 — Inpatient Hospital Billing
- Medicare Benefit Policy Manual Ch. 6
- Medicare Claims Processing Manual Ch. 12 — Physicians/Nonphysician Practitioners
- TRICARE® Reimbursement Manual

To view the Johns Hopkins Health Plans Reimbursement Policies, please go to hopkinshealthplans.org, and under "For Providers," go to Policies.

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// BENEFITS AND PLAN CHANGES

Telemedicine Services Reminder and Telehealth Update

Johns Hopkins OnDemand Virtual Care

Just a recap of telemedicine capabilities available to our members. Johns Hopkins OnDemand Virtual Care (powered by Teladoc) is an online telemedicine platform for both adult and pediatric patients. It is available to members through mobile app, computer or tablet.

Johns Hopkins Health Plans products supported:

- Advantage MD
- Employer Health Programs (EHP)
- Priority Partners
- US Family Health Plan (USFHP)*

*The service is only available to USFHP members on weekdays between 6 p.m. and 8 a.m. and anytime on weekends. During normal office hours, USFHP members should connect with their primary care manager.

- The service is intended for minor care concerns (ONLY) that don't require lab work, such as colds, rashes and pink eye. The service is not for medical emergencies. If a patient is experiencing a medical emergency, they should call 911 or go to the nearest emergency room.

NOTE: Johns Hopkins Health Plans encourages members to use their primary care provider when possible, but Johns Hopkins OnDemand Virtual Care is an alternative option to quickly access needed care.

Telehealth Change for USFHP

- Autism Care Demonstration (ACD) code telehealth coverage change for USFHP, effective Jan. 24, 2024:
  - » Certain ACD codes may not be conducted via telehealth. Per the TRICARE Manual Change 132, code 97155 may not be conducted via telehealth. In addition to code 97155, telehealth is not permitted for codes 97151, 97153, 97157 and 97158.
  - » A minimum of four sessions of CPT code 97155 must be completed within the six-month authorization period.
  - » For authorizations that are less than six months in duration, e.g., as a result of a PCS transition, a minimum of 50% of the authorized months must meet the requirement listed in paragraph 8.11.6.2.3.4.
  - » Note: In the absence of rendered direct treatment in a calendar month (CPT codes 97153, 97156, 97157 or 97158), CPT code 97155 is not required per paragraph 8.11.6.2.3.4. If the only CPT code rendered in a calendar month is CPT code 97151, then paragraph 8.11.6.2.3.4 is not applicable.
  - » Code 97155 is not authorized for greater than eight units (two hours) per day.
  - » To view the ACD regulation, please visit Autism Care Demonstration in the TRICARE manual.

// CLAIMS AND BILLING

Claims Editing System Updated Quarterly

As a reminder, our claims editing system is updated quarterly to include new edits or modifications/updates to existing edits. Please refer to our NCCI and MUE reimbursement policies for additional information.

Changes to Prior Authorization Requirement for Selected Procedure Codes

Please note the following prior authorization (PA) and no prior authorization required (NPA) changes for the following Johns

Hopkins Health Plans codes for Advantage MD, Priority Partners and US Family Health Plan (USFHP):

- DME code changes, effective March 1, 2024, for Advantage MD, Priority Partners and USFHP:
  - PA Changes
  - NPA Changes
- Advantage MD code changed to NPA, effective Feb. 19, 2024:
  - **G0108**: Diabetes outpatient self-management training services, individual, per 30 minutes
- USFHP codes changed to NPA (with a custom quantity limit of 4 per year), effective March 1, 2024:
  - **A6531**: Gradient compression stocking, below knee, 30-40 mm Hg, each
  - **A6532**: Gradient compression stocking, below knee, 40-50 mm Hg, each
  - **A6533**: Gradient compression stocking, thigh length, 18-30 mm Hg, each
  - **A6534**: Gradient compression stocking, thigh length, 30-40 mm Hg, each
  - **A6535**: Gradient compression stocking, thigh length, 40-50 mm Hg, each
  - **A6536**: Gradient compression stocking, full-length/chap style, 18-30 mm Hg, each
  - **A6537**: Gradient compression stocking, full-length/chap style, 30-40 mm Hg, each
  - **A6538**: Gradient compression stocking, full-length/chap style, 40-50 mm Hg, each
- Code changes effective March 15, 2024:

  Code change to NPA for Advantage MD
  - **A4222:** Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)

  Code change to NPA for Priority Partners
  - **91038:** Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)

  Code changes to NPA for Priority Partners and USFHP
  - **E0781:** Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
  - **E0572:** Aerosol compressor, adjustable pressure, light duty for intermittent use

  Code change to NPA for USFHP
  - **95249:** Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording

  Code changes to PA for USFHP
  - **99453**: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
  - **99454:** Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
  - **99457:** Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
  - **99458:** Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

USFHP Claims and Referrals Notice

USFHP would like to review with providers our processes for claims, referrals and prior authorization referrals.

Claims

- Claims must be submitted on CMS 1500 or UB-04 forms.
- Specialist or ancillary providers must include referring primary care provider's NPI in Box 17b of the CMS 1500 form.
- Rendering provider's NPI must be in Box 24J of CMS 1500 form.

- Referring primary care provider is also required to be noted in box 78/79 on the UB-04 form for outpatient hospital services that do not require an authorization.
- Submission must be within six months (180 calendar days) of the date of service. Some USFHP providers and facilities may have different time periods for claims submission — please abide by the terms outlined in your contract.

Referral and Prior Authorization Referrals

- Do not need to be sent to the plan.
- Can be sent directly to the specialist.
- Include the referring primary care provider's NPI on the script/referral that is sent to the specialist.
- Specialist will enter the referring primary care provider's NPI number in box 17b of the CMS 1500 form.
- Referring primary care provider is also required to be noted in box 78/79 on the UB-04 form for outpatient hospital services that do not require an authorization.

For more information see **Tricare Manual, Chapter 1, Section 7.1**.

// PHARMACY

Saving Patients Money With Real-Time Prescription Benefits Information at the Point of Care

Help your Johns Hopkins Health Plans members save money on their prescriptions with electronic health record (EHR) access to patient-specific drug coverage and out-of-pocket cost information.

The portion of health care costs shouldered by consumers is rising, and cost continues to be a barrier to medication adherence. In a recent survey, 84% of Americans said it would be helpful to know their prescription cost before they go to the pharmacy, and 64% said they would use prescription cost information to find lower-cost alternatives instead of forgoing treatment.[1]

With the rise of consumerism in health care, and the growth of high-deductible health plans, many pharmacy benefit managers (PBMs) and EHR system vendors are making patient-specific prescription benefits information available at the point of prescribing.

While the type of information provided by PBMs and the availability of this information across different EHR systems may vary, key attributes of a truly comprehensive real-time prescription benefits solution at the point of prescribing include:

- Knowing if the drug you want to prescribe is covered under your patient's prescription plan and what they will pay out-of-pocket (OOP) based on where they are in their deductible or coverage stage
- Seeing a list of clinically appropriate lower-cost brand and generic alternatives that you could consider prescribing to save your patients money
- Understanding which therapy options require prior authorization (PA) or have other restrictions like step therapy or quantity limits
- Initiating the PA process directly from your EHR and receiving a near real-time approval decision

Johns Hopkins Health Plans uses CVS Caremark as its PBM vendor. CVS Caremark's real-time prescription benefits capability is powered by the company's proprietary engine, Script Intelligence, and database of clinically mapped therapeutic alternatives.

The database displays up to five clinically appropriate lower-cost brand or generic alternatives with equal or better formulary status on the patient's specific pharmacy benefit design and the real-time OOP cost for each based on where they are in their deductible or coverage stages. In addition, information on any restrictions is displayed, such as whether or not a PA is required.

With real-time prescription benefits information, you have a more complete picture of your patient's actual cost and coverage to help you make more informed prescribing decisions. Additionally, the ability to instantly initiate a PA request, if needed, will help streamline and simplify the prescribing process.

There's no charge for the service; however, you will need the latest version of your patient's EHR.

The following systems and versions are providing real-time prescription benefits. **Please Note:** NextGen is a recent addition.

EHR and e-Prescribing Solutions Enabled

- ADP AdvancedMD
- Advanced Data Systems
- Allscripts
- Asembia
- Athena
- Bizmatics
- Cardinal Health
- CAREFORM

- Cerner
- Comtron
- CPSI
- CureMD
- DigiDMS
- DrFirst
- DrMed Solutions
- EIR SYSTEMS
- eMD
- eMedicalNotes
- EmedPractice-Medistat
- EnableDoc
- Epic
- Glenwood
- GreenwayIntergy
- H2H
- HenrySchein
- iMedica
- InstantDx
- Insync Healthcare Solution
- Integrity Onsite Docutap
- KAISER HAWAII
- Leum
- MD Toolbox
- MDLand
- MDOfficeManager
- MDSCRIPTS
- MedConnect
- Medical Office Solutions
- MedicalMine
- Meditab
- MedPlus
- MicroMerchant
- MiddlesetHS
- Modernizing Medicine
- MTBC
- NewCrop
- NextGen
- Novant Health
- Objective Medical Systems
- Office Ally
- OmniMD
- PPOC
- Practice Perfect
- PS AllegianceMD
- PS Practice Fusion
- RxNT
- Salinas Valley
- SSIMED
- STI Computer Services
- TechSoft
- Waiting Room Solutions

New accounts are added regularly, and this list might not represent all active accounts at a given time.

If you don't see your EHR vendor or version listed, contact your EHR vendor and tell them that your providers need patient-specific drug benefit and cost information in their e-prescribing workflow. Ask if they have contracted with Surescripts for real-time prescription benefits.

If you are not using the most recent version of your EHR's system, contact your EHR vendor account manager. For Epic users, contact your Epic account manager to confirm your upgrade go-live date and determine whether additional interfaces are needed. Work with your Surescripts account manager to complete the contract addendum.

Still having trouble accessing real-time prescription benefits? Contact your EHR vendor's help desk support line. For Epic users, work with your Ambulatory and Bridges TS representative and log a ticket with Surescripts.

[1.] CVS Health Morning Consult poll, July 23-25, 2018. The Morning Consult poll was conducted from July 23-25, 2018, among a national sample of 2,201 registered voters. The interviews were conducted online and the data were weighted to approximate a target sample of registered voters based on age, race/ethnicity, gender, educational attainment and region. Results from the full survey have a margin of error of plus or minus 2 percentage points.

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 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 Johns Hopkins Health Plans 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 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

New Prior Authorization Requirements for Certain Provider-Administered Medications

Effective April 1, 2024, Johns Hopkins Health Plans will require prior authorization to determine medical necessity for several provider-administered medication. These requirements affect members of all ages.

- Advantage MD Prior Authorization Requirements April 1
- EHP Prior Authorization Requirements April 1
- Priority Partners Prior Authorization Requirements April 1

NOTE: For certain drug classes, Employer Health Programs (EHP), Priority Partners and Advantage MD have a preferred drug list. This list has been updated for calendar year 2024. These preferred drugs are indicated on the Preferred Medical Injectable Drug List included at the above link. 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:

EHP and Advantage MD:

- Providers may submit electronic prior authorization requests through NovoLogix using the Availity secure provider portal. If Availity cannot be accessed, providers may contact NovoLogix for assistance by calling 844-345-2803.

Priority Partners:

- Providers may submit electronic prior authorization requests through NovoLogix using the Availity secure provider portal. If Availity cannot be accessed, providers may contact NovoLogix for assistance by calling 844-345-2803.
- If Availity is unavailable for some reason, providers may contact NovoLogix directly for assistance by calling 844-345-2803. Prior authorization forms for the provider-administered medical injectables can also be obtained from NovoLogix by calling 844-345-2803.

// QUALITY CARE

Results on Improving Diabetes Prevention Education Through Documentation for USFHP Members at Annual Wellness Visit

Recently, US Family Health Plan (USFHP) shared a Provider Toolkit to support providers in improving their rate of documentation of diabetes prevention education, with a goal to increase documentation by 20 percentage points over two years.

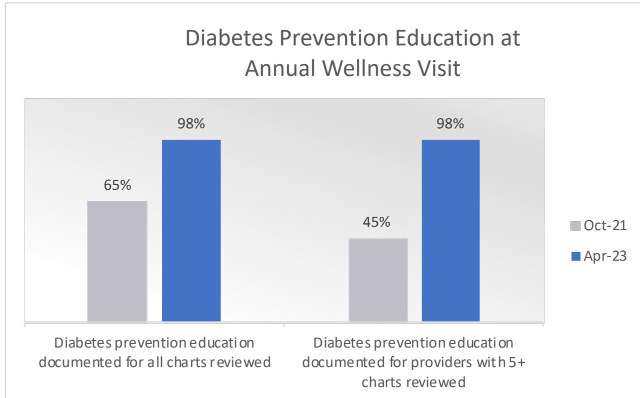
We are happy to report that this goal has been met. The rate of documenting diabetes prevention education improved from 65% to 98% **in one year.**

USFHP performs retrospective chart reviews of various outpatient standard of care measures annually to assure that members are receiving evidence-based care. Provider input interventions are established to improve care.

Results from the April 2023 chart review find 98% of beneficiaries with a BMI in the overweight or obese range receive patient education during their annual wellness visit. This is a 33-percentage point improvement over the October 2021 chart review.

- Providing diabetes prevention education to all patients who are overweight or obese meets or exceeds value-based practice measures.

- Members are more likely to continue behaviors that increase the risk of developing diabetes without targeted patient education about lifestyle modifications that can help prevent diabetes.

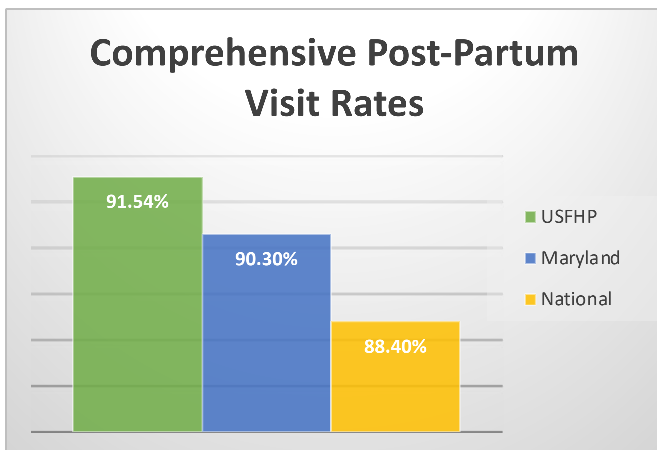


Keep up the great work! The next chart review to examine the documentation of diabetes prevention education will occur in spring 2024.

Postpartum Depression Screenings Important Due to Unique Stressors in USFHP Population

The US Family Health Plan (USFHP) 2023 annual retrospective review looked at screening for postpartum depression during the 84 days after the birth of a child. Without identification and treatment of postpartum depression, there can be both short- and long-term effects on both the mother and child. (USPSTF, 2019).

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.



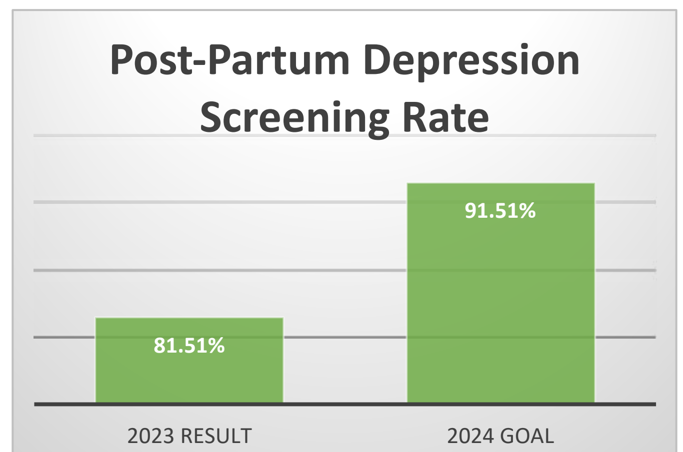
USFHP reviewed 130 OB charts from deliveries during the first quarter of calendar year 2022. Results show that 91.54% (119/130) of beneficiaries completed their comprehensive postpartum visit by day 84 after delivery. This rate exceeds both state and national rates. Of those 119 beneficiaries 81.51% (97/119) had documentation of postpartum depression screening and a follow up plan of care as appropriate.

> "Ideally, every new mom will be screened for postpartum depression within the 84 days after birth of their child."

USFHP is a military population, with a unique set of stressors women may not spontaneously express. The woman or her spouse may be deployed or preparing to deploy, they may be far from family and their support system and the mother or spouse may show signs of post-traumatic stress, which impacts their entire family. Additionally, women may have a past history of postpartum depression or preexisting mental health problems. The OB/GYN's close attention to the member's mental health status during the entire peripartum period will benefit them mentally and ensure a healthy mom, baby and delivery.

Ideally, every new mom will be screened for postpartum depression within the 84 days after birth of their child. USFHP encourages providers to check in on how new moms are coping through completion of a postpartum depression screening. The screening can be completed via phone, email or in person.

Raising awareness with the information in this article should help us reach the 2024 goal of improving the 2024 postpartum depression screening rate by 10 percentage points compared to the 2023 result. The next review will look at moms who delivered during the third quarter of CY 2024.



It's CAHPS® Survey Season!

We're taking this opportunity 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.

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.

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

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?

// REMINDERS

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 **2024 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 "D-SNP Attestation Form" under Advantage MD.

Important D-SNP Notice: Billing and Services

- 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.

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.

- **Digital submission of the Provider Information Update Form** *(preferred)*: Submit the **Online Digital Provider Information Update Form** directly from the provider website.
- **Delegated rosters:** Follow the established process for submitting notification of any provider changes and confirm if the provider is accepting new patients or not.
- 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 a Tax 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.

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

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

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

Ensuring Equitable Access to Advantage MD Services

Advantage MD and its network of providers must provide services in a culturally competent manner to promote equitable access to all enrollees, including the following:

- People who have limited English proficiency or reading skills
- People of ethnic, cultural, racial or religious minorities
- People who have disabilities
- People who identify as lesbian, gay, bisexual or other diverse sexual orientations
- People who identify as transgender, nonbinary and other diverse gender identities, or people who were born intersex
- People living in rural areas and other areas with high levels of deprivation
- People otherwise adversely affected by persistent poverty or inequality

The equitable access requirement is per CMS regulation 42 CFR § 422.112 Access to services.

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 (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

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

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

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

HealthLINK@Hopkins
hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/healthlink
NOTE: First time users must register for an account. If you need assistance with registration, please contact Provider Relations at 888-895-4998.

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
Optum Maryland
800-888-1965
Fax 855-293-5407

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
Optum Maryland
800-888-1965
Fax 855-293-5407

USFHP

Websites
USFHP: hopkinsusfhp.org
TRICARE: tricare.mil
FORMULARY: hopkinsusfhp.org

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

Quality Improvement
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.

PRPULSE15-WINTER 2024

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

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