HIGHMARK HEALTH OPTIONS

Quarterly Update for Providers

Summer 2022

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Contact us.

HHO Provider Services is the first line of communication for providers' questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling 1-844-325-6251 or emailing hho-depsresearch2@highmark.com.

2022 HEDIS® audit results.

Thank you for your assistance and flexibility during this year's Healthcare Effectiveness Data and Information Set (HEDIS) audit. Your cooperation and collaboration made the 2022 HEDIS successful.

The 2022 HEDIS audit results, which measured health care delivered during 2021, showed significant improvement in:

- Controlling high blood pressure
- Comprehensive diabetes care: A1c control <8%
- Comprehensive diabetes care: diabetic retinal eye exam
- Immunizations for adolescents
- Prenatal and postpartum care: postpartum care

In addition, several measures were identified as opportunities for improvement:

- Childhood immunization status
- Asthma medication ratio
- 30-day hospital readmission (not a HEDIS measure)

Highmark Health Options works side-by-side with providers to improve health outcomes. Some ways we have worked together to provide the best health outcomes include:

- Sending select members at-home A1c testing kits annually.
- Partnering with hospital systems to host women's health screenings.
- Scheduling appointments to close care gaps through targeted outreach to members.
- Provider partnering for asthmatic pediatric population for improved asthma control efforts.
- Health campaign messaging through billboards, bus ads, community posters, and church bulletins.
- Educating members through the Member Advisory Council, the Health Awareness Series, newsletters, and mailings.

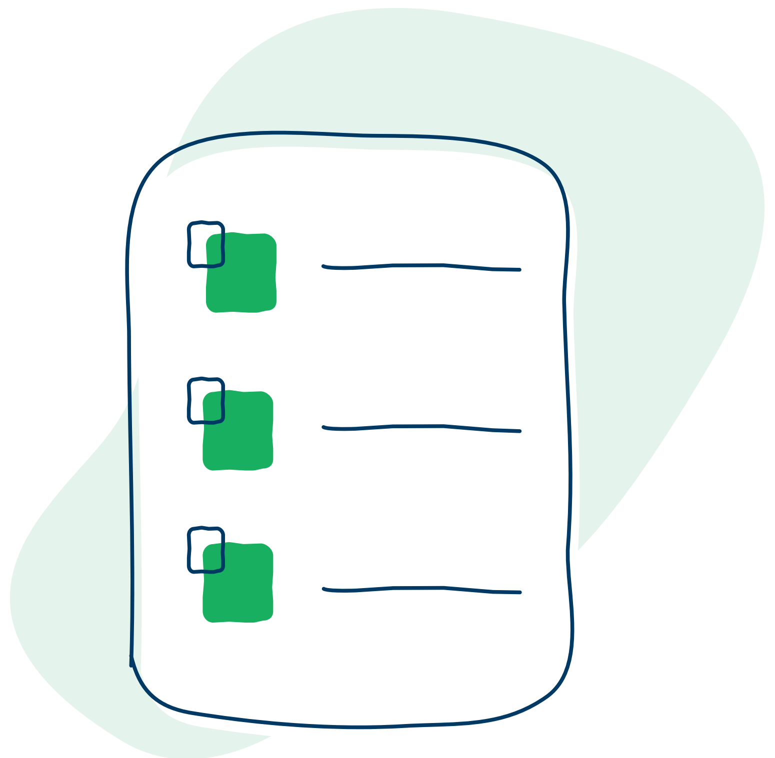
What is HEDIS?

NCQA-accredited health plans conduct a HEDIS audit to measure performance against industry benchmarks each year. The audit uses a wide variety of indicators to track measures, such as:

- Effectiveness of care
- Medication management
- Utilization management
- Preventive screenings

Results are then analyzed, trended over time, and compared to those of other health plans nationwide. Earlier this year, providers may have received a request from Highmark Health Options for their patients' medical records.

Providers with any questions about the HEDIS results can contact the Quality team at 1-844-325-6251.



2022 Member experience survey results.

The 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) results have arrived. Every year, Highmark Health Options members are selected at random and surveyed about their health care experience. The survey results highlight what members find most satisfying about their health care and offer insights into opportunities for improvement.

For the 2022 CAHPS survey, respondents reported being most satisfied with:

- How well doctors communicate (adult and child population)
- Customer service (adult and child population)
- Rating of health care (child population)
- Rating of specialist (child population)

The CAHPS survey also reported areas for improvement, such as:

- Rating of health care (adult population)
- Rating of specialist (adult population)

Providers can do the following to maintain and improve the CAHPS score for 2023:

- Gather and analyze patient feedback on their recent office visit.
- Regularly analyze appointment scheduling time frames rather than types of office visits.
- Advise members of available alternative methods of care, such as telehealth, urgent care, and follow-up care.
- Consistently review and discuss care plans with members and specialists.

Thank you for your continued collaboration to make our members happier and healthier.

Providers with any questions about the CAHPS results can contact the Quality team at 1-844-325-6251.

Care teams can partner with the Case Management team to provide collaborative care.

Providers are encouraged to work with Highmark Health Options to provide collaborative care for patients. Primary care physicians are required to work with Case Managers to ensure proper care is being provided and case status remains up to date. Case Managers can help:

- Assess a patient's situation and needs.
- Provide ongoing coordination to see that a patient's care needs are being met.
- Work with patients and their families to develop care plans to map out what kind of services they need, how often they are needed, and more.

Providers should work with Case Managers to provide the care a patient needs. Providers can contact Case Management with any questions at **1-844-325-6251.**

Use perinatal screenings to improve quality measures.

Providers offering perinatal care should be familiar with the quality measure guidelines. The guidelines recommend:

- A minimum of one prenatal visit within the first trimester visit (or 42 days of enrollment).
- Regular prenatal care visit throughout the pregnancy.
- A postpartum visit seven to 84 days after delivery.

Providers can improve their quality measures by asking patients about specific topics during their perinatal screening, such as:

- Exposure to environmental smoke
- Intimate partner violence
- Medications they are taking (prescribed and over-the-counter)
- Prenatal and postpartum depression (document the referral, when applicable, with notation of the depression scale used)
- Tobacco, alcohol, and illicit drug use (document the counseling or referral, when applicable)

Perinatal quality guidelines help with the healthy development of a fetus, healthy deliveries, and healthy postpartum outcomes. In addition, the guidelines can help reduce:

- Poor birth outcomes
- Low birth weights
- Infant and maternal mortality rates

Providers should complete and document perinatal screenings when caring for Highmark Health Options members. For more information, call Care Coordination at 1-844-325-6251.

Ensure patients are receiving their breast cancer screenings.

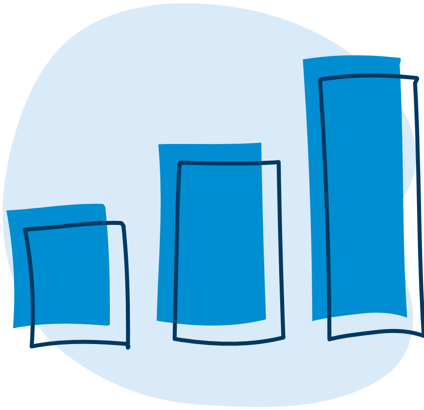
Providers should evaluate their processes for obtaining breast cancer screenings. Breast cancer screening is one of the quality measures providers are rated on. This measure is defined as the number of women ages 52–74 as of Dec. 31 of the measurement year who have received one or more mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis, which is a newer mammography technology using three-dimensional images) since Oct. 1 two years prior to the measurement year. Women who have had both breasts surgically removed and women in hospice any time during the measurement period are excluded from the measure.

Small changes could make a big difference.

Providers can screen patients more and improve their quality rates by:

- Creating alerts or flags in the medical record to remind staff to discuss breast cancer screening.
- Asking patients if they have already had a mammogram and get a copy to include in their medical record.
- Using preventive appointments, such as well visits or annual flu shots, as an opportunity to discuss breast cancer screening.
- Offering scheduling or referral assistance to patients. Providers can have standing referrals created for staff to give patients while they are in the office.
- Coming up with a schedule for screening to share with the patient. Having a schedule can help the patient plan for future appointments.

Although there is a risk for women receiving false positive results, regular breast cancer screenings are still effective in identifying a breast cancer threat and beginning treatment. Take time to discuss with patients the risks and benefits of mammograms and potential for false positives as part of the shared decision-making process. Regular screening is a great way to improve patients' lives.



Breast cancer statistics

According to the American Cancer Society, breast cancer is mostly diagnosed in people between ages 55 and 64. Breast cancer is the most common type of cancer in the United States and the fourth leading cause of cancer death. It has been estimated that one in eight American women will be diagnosed with breast cancer at some point in their lives.

Despite these numbers and nationwide promotion for screening, many women still worry about false positive results that lead to unnecessary biopsies. Research shows that there is up to a 54% overdiagnosis rate resulting in false positive screening results.

Providers with questions about breast cancer screenings can contact the Quality team at 1-844-325-6251.

References:

American Cancer Society. Cancer Facts and Figures.

Harms of breast cancer screening: systematic review to update the 2009 U.S. Preventive Services Task Force recommendation.

The provider's role in the Care Management program is important.

The Highmark Health Options Care Management team can partner with providers to reduce a patient's visits to the emergency department, help them avoid going back to the hospital, and support a personal plan of care for each patient. A team of nonclinical and clinical staff is available to:

- Address a patient's health issues.
- Link patients to services, such as helping them make appointments.
- Remind patients to go to their annual physicals.
- Review a patient's medications with them.

Providers can call Care Management at 1-844-325-6251.

Create healthier outcomes with cervical cancer screenings.

Regular cervical cancer screenings can help in the prevention and identification of cervical cancer in women. Over 8 million women have not followed through with getting screened for cervical cancer. Cervical cancer is preventable, but it takes a collaborative approach and dedicated patient education to reduce the care gaps.

Most cervical cancer is caused by the human papillomavirus (HPV) infection and requires a Pap test to detect. Providers can utilize each patient visit or contact as an opportunity to encourage patients get cervical cancer screenings. Cervical screening recommendations include:

- Women age 20 and younger: No screening recommended.
- Women ages 21–29: Screened every three years with cytology alone.
- Women ages 30–65: Screened every three years with cervical cytology alone, every five years with HPV testing alone, or every five years with cervical cytology plus HPV (co-testing).
- Women age 65 and older with adequate prior screening and no risk factors: No screening needed.
- Women who have had hysterectomies with cervical removal for reasons other than precancerous lesions: No screening needed.

According to the National Cancer Institute, there were greater than 13,000 estimated new cases of cervical cancer in 2018. Although the five-year survival rate for women diagnosed with cervical cancer is high at 66.2%, it is still important to encourage patients to have their regular Pap screenings. This helps to determine if they have cervical cancer, the stage of cervical cancer, and to initiate the most appropriate treatment options for healthier outcomes.

Providers with questions about cervical cancer screenings can contact the Quality team at 1-844-325-6251.

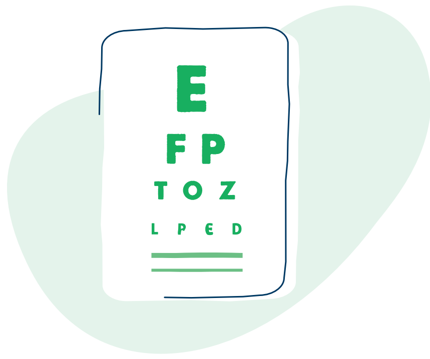
References:

American Cancer Society. (2014). CDC: Millions of Women Not Getting Cervical Cancer Tests.

National Cancer Institute. (n.d.). Surveillance, Epidemiology, and End Results Program. Cancer Stat Facts: Cervical Cancer.

The American College of Obstetrics and Gynecologist. (2018). Practice Advisory: Cervical Cancer Screening (Update).

Detect diabetic retinopathy early by offering eye tests to patients with diabetes.



Early detection and treatment of diabetic retinopathy can reduce the risk of severe vision loss by 90% in patients with diabetes. However, a high percentage of patients with diabetes never get screened or receive an annual diabetic eye test. Vision loss from diabetes is almost completely preventable, especially if patients receive an annual eye exam. With recent advances in telemedical screening technology, these quick and simple eye tests can be administered in the primary care setting, driving up screening rates and reducing the number of patients with vision loss.

The annual diabetic eye exam for diabetic eye diseases, such as diabetic retinopathy, is important to monitor the overall health of patients with diabetes. In addition, it can help improve quality measure compliance rates. While the comprehensive annual dilated eye exam is still considered a standard of care for patients with diabetes, most patients do not get a retinal scan for diabetes annually. Providers can identify at-risk patients early and can reduce the risk of vision loss by performing a diabetic eye test as a routine annual diagnostic.

Diabetic retinopathy statistics

Diabetic retinopathy is the leading cause of preventable blindness for people ages 20–65 in the United States. According to the American Diabetes Association, 37.3 million people have diabetes. The CDC estimates that only 40%–50% of patients with diabetes receive this important annual diabetic eye test.

Providers with questions about detecting diabetic retinopathy can contact the Quality team at 1-844-325-6251.

More medications can be prescribed as a 90-day supply.

For patients with chronic conditions, providers may be able to prescribe a 90-day supply of medication instead of a 30-day supply. This approach offers convenience and could lead to better medication adherence because patients would only need to refill their prescription four times a year.

The medications covered by this benefit treat ongoing conditions, such as asthma, depression, high cholesterol, and high blood pressure.

An updated list of medications available for a 90-day supply appears in the chart below. For patients to receive a 90-day supply, the prescription must be written for a 90-day supply. For example:

- Lisinopril 10 mg tablets, #90. Take 1 tablet by mouth daily.
- Metformin 500 mg tablets, #180. Take 1 tablet by mouth twice daily.
- Advair Diskus 250/50 mcg/dose, #3 Inhalers. Take 1 inhalation twice daily.

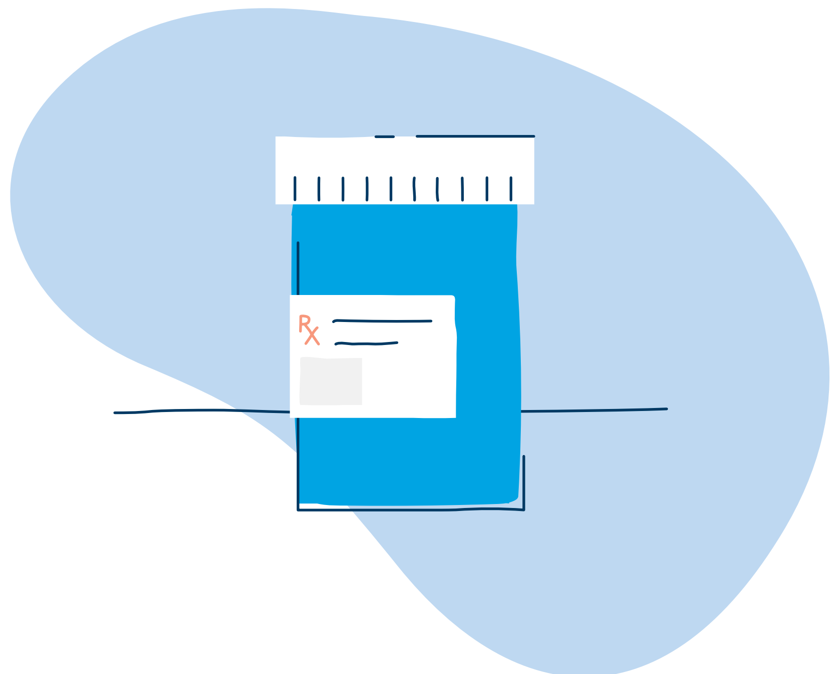
Covered Medications with a 90-Day Supply

- Advair Diskus
- Advair HFA Inhaler
- Alendronate Sodium Tablet
- Amlodipine Besylate Tablet
- Asmanex Twisthaler
- Atenolol Tablet
- Atorvastatin Tablet
- Benazepril Tablet
- Bisoprolol-Hydrochlorothiazide Tablet
- Budesonide Inhalation Solution 0.25mg, 0.5mg
- Carvedilol Tablet
- Citalopram Hydrobromide Tablet
- Clonidine Hydrochloride Tablet
- Dulera Inhaler
- Enalapril Tablet
- Escitalopram Tablet
- Flovent Inhaler
- Fluoxetine Capsules
- Furosemide Tablet
- Glimepiride Tablet
- Glipizide ER Tablet
- Glipizide Tablet
- Hydralazine Tablet
- Hydrochlorothiazide Tablet

Covered Medications with a 90-Day Supply

- Lisinopril Tablet
- Lisinopril-Hydrochlorothiazide Tablet
- Losartan Potassium Tablet
- Losartan-Hydrochlorothiazide Tablet
- Metformin Hydrochloride ER Tablet
- Metformin Hydrochloride Tablet
- Metoprolol Succinate Tablet
- Metoprolol Tartrate Tablet
- Montelukast Sodium Tablet
- Paroxetine Hydrochloride Tablet
- Pravastatin Sodium Tablet
- Prazosin Capsule
- Propranolol IR Tablet
- Pulmicort Flexhaler
- Quinapril Hydrochloride Tablet
- Ramipril Tablet
- Rosuvastatin Tablet
- Sertraline Hydrochloride Tablet
- Simvastatin Tablet
- Symbicort Inhaler
- Trazodone Tablet

Providers with questions about the medications that can be prescribed for the 90-day supply can contact the Pharmacy team at 1-844-325-6251.



Look out for medical record requests.

Highmark Health Options (HHO) providers are required to score at least 80% during medical record standard audits. Scores under 80% require HHO to schedule follow-up reviews to assess a provider's improvement. Repeated performance scores under 80% can lead to corrective action, which could include termination from the network.

These standards help verify that providers:

- Provide the expected level of care and associated documentation.
- Adhere to requirements for maintenance of confidential medical information and record keeping.
- Evaluate medical records in a consistent manner.

HHO has record standards developed for:

- PCPs and specialists
- Behavioral health providers

Some provider audits are conducted on an informal basis. These providers are selected randomly through records received for HEDIS and Delaware State Measure or remote EMR access capabilities. Other providers may be contacted to send in medical records for the audit.

Results are mailed within 45 calendar days of the review. Provider Relations is available at 1-844-325-6251, Monday–Friday, from 8 a.m.–5 p.m. to answer questions about the medical record standard audit process.

Nursing facilities are required to notify HHO of any changes in member condition.

Per contract requirement, nursing facilities are required to notify the Case Manager of any change in a member's medical or functional condition that could affect the member's level of care for the currently authorized level of nursing facility services. In addition, nursing facilities are required to notify the Case Manager when considering discharging a member. Providers should consult with the member's Case Manager to intervene in resolving issues and assist with the implementation of a discharge or transition plan.

Providers who do not know the Case Manager to contact with any change in condition or pending discharge for a patient in the facility can contact Provider Services at **1-844-325-6251** for assistance. Provider Services can help identify the facility's assigned point of contact or a member's Case Manager.

Note these prior authorization changes.

Providers must follow the prior authorization process for a subset of medications. Failure to obtain an authorization for these medications will result in a claim denial. Providers can view the most recent prior authorization reminder communication and most current list of affected medications online.

Important changes: The following medications/HCPCS codes no longer require authorization:

- Biosimilar products
- Oncology agents with the exception of reference products that require a trial of the biosimilar agent when clinically appropriate
  - Avastin (J9035), Neupogen (J1442), Neulasta (J2505), Remicade (J1745), Rituxan (J9312), Herceptin (J9355)

New Authorization requirements as of March 15, 2022:

- Aldurazyme (laronidase) J1931
- Aralast NP; Prolastin C; Zemaira (alpha 1- proteinase inhibitor [human]) J0256
- Berinert (c-1 esterase inhibitor human) J0597
- Cinryze (c-1 esterase inhibitor human) J0598
- Elaprase (idursulfase) J1743
- Elelyso (taliglucerase alfa) J3060
- Glassia (alpha 1 proteinase inhibitor) J0257
- Kanuma (sebelipase alfa) J2840
- Mepsevii (vestronidase alfa-vjbk) J3397
- Naglazyme (galsulfase) J1458
- Ruconest (c1 esterase inhibitor recombinant) J0596
- Tepezza (teprotumumab-trbw) J3241
- Vpriv (velaglucerase alfa) J3385
- Vyepti (eptinezumab-jjmr) J3032

New Authorization requirements as of July 15, 2022:

- Akynzeo (fosnetupitant-palonosetron) J1454
- Arixtra (fondaparinux sodium) J1652
- Depo-Testosterone (testosterone cypionate) J1071
- Durysta (bimatoprost implant) J7351
- Euflexxa (hyaluronan sodium) J7323
- Gel-One (hyaluronate sodium) J7326
- Gelsyn-3 (hyaluronate sodium) J7328
- Genvisc 850 (hyaluronate sodium) J7320
- Hemlibra (emicizumab-kxwh) J7170
- Humate-P (antihemophilic factor VIII/von willebrand factor, human) J7187
- Humira (adalimumab) J0135
- Hyalgan & Supartz FX (hyaluronate sodium) J7321
- Monovisc (hyaluronic acid) J7327
- NovoSeven RT (coagulation factor VIIA) J7189
- OrthoVisc (hyaluronic acid) J7324
- Reblozyl (luspatercept-aamt) J0896
- Recombinate; Kogenate FS; Advate; Helixate FS (factor VIII, recombinant) J7192
- Relistor (methylnaltrexone) J2212
- Spravato (esketamine nasal) S0013
- Tyvaso (treprostinil) J7686
- Vyondys 53 (golodirsen) J1429
- Wilate (antihemophilic factor VII/von willebrand factor human) J7183
- Xyntha (antihemophilic factor recombinant plasma/albumin free) J7185

These medications will be reviewed under the applicable miscellaneous procedure code until a permanent code is assigned.

Behavioral health providers can collaborate with Case Managers.

Behavioral health providers are required to work with Case Managers to ensure proper care is being provided and case status remains up to date. Behavioral health providers and the Case Management team can work together to provide collaborative care for patients.

Behavioral health providers should expect weekly calls or emails from LTSS staff. LTSS staff will coordinate and collaborate care on mutual cases. The objective is to ensure continuity of care as much as possible and to partner on holistic measures to meet patient needs.

Providers can contact Provider Services with any questions at 1-844-325-6251.

Work with the new LTSS transition of care (TOC) team.

Providers can now work with Highmark Health Options (HHO) new Transition of Care (TOC) team. TOC takes place each time a member moves from one health care provider or setting to another. The TOC team supports the process of transition from community to hospital, hospital to community, and hospital to skilled nursing facility for short-term rehab or long-term care for LTSS members.

HHO has incorporated both the Integrated Whole Person and the Coleman Transitions Care Models into the TOC approach.

- The Integrated Whole Person Care Model essentially takes the different pieces of the health care puzzle, including mental and physical health and health-related social needs, and fits them together to match a person's individual needs.
- The Coleman Care Transitions Model is a program in which patients with complex care needs and family caregivers receive specific tools and work with a Transition Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

The goals of the LTSS TOC team include:

- Assisting LTSS members with a smooth and safe transition between care settings.
- Assisting LTSS Case Managers by co-managing members admitted to inpatient settings until the member is discharged back to the community.
- Empowering member and/or family caregiver to develop self-care skills to help them assume a more active role in their health.
- Working with members with complex care needs to build self-management skills that will ensure their needs are met during the transition from hospital to home.
- Collaborating with providers to ensure timely health information data exchange.

Providers can contact Provider Services with any questions at 1-844-325-6251.

Reminder on the affirmative statement about provider incentives.

Financial incentives for utilization management (UM) decision-makers do not encourage decisions that result in underutilization. Highmark Health Options (HHO) UM decisions are based only on the appropriateness of care and services and the member's existence of coverage. Providers and other individuals are not rewarded by HHO for issuing denials of coverage or service.

Providers should be aware that HHO monitors for both overutilization and underutilization of care to:

- Prevent inappropriate decision-making.
- Identify causes and corrective action.
- Indicate inadequate coordination of care or inappropriate use of services.

HHO checks utilization activities to ensure members receive all appropriate and necessary care:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward providers or other individuals for issuing denials of coverage.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Providers can partner with HHO for wellness programs and linkage to services.

Highmark Health Options staff is available to partner with providers to provide comprehensive Care Management Services for all eligible Highmark Health Options members.

By working together, we can help patients reach their optimal health care outcomes. Nurses, social workers, and other health care staff are available to talk with providers to make sure patients receive the medical care and support they need.

Our multidisciplinary team is available to address any issues patients may have such as:

- Chronic conditions, e.g., asthma, heart or lung disease, diabetes, high blood pressure
- Mental health and substance use disorders
- Women's health

Community resources and programs are available to help patients stay well and manage their conditions. HHO staff can provide patients with ongoing disease education and management through our Lifestyle Management/Wellness Programs. More Lifestyle Management/Wellness Program information is available on the HHO website. Providers can contact Care Management with any questions at 1-844-325-6251.

The PCP Portfolio Report promotes quality and safety of care.

The PCP Portfolio Report helps identify ways we can work together to improve care quality and safety through information sharing. This report is available on NaviNet. The report is updated quarterly in January, April, July, and October.

The report compares providers to others in their peer groups and contains key utilization, pharmacy, and quality measures. Quality of care and services provided to our members is evaluated based on these measures. When outliers are found, we send a letter to providers to explain these findings.

Provider feedback is incorporated into these reports.

Note: The PCP Portfolio Report is not tied to any reimbursement or incentive and is designed exclusively to improve quality and safety of care.

For more information, contact Su-Linn Zywiol, Strategy Program Manager.

Provider network contacts.

Provider Services

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Provider Complaints
(not claims related)

HHO-ProviderComplaints@highmark.com
Phone: 1-844-228-1364
Fax: 1-844-221-1569

Statement of Members' Rights and Responsibilities.

The organization's member rights and responsibilities statement specifies that members have:

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Check out this useful information.

Atlas Systems Inc. continues to conduct quarterly outreach to verify provider data on Highmark Health Options' behalf.

Balance billing: Payment by Highmark Health Options is considered payment in full. Under no circumstance may a provider bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a member.

Medical records: Highmark Health Options may request copies of medical records from providers. If medical records are requested, the provider must supply copies at no cost within 30 calendar days of the request.

Taxonomy: Highmark Health Options requires that credentialed taxonomy be included for all billing, rendering/performing, and attending providers on an inbound claim.

Check out these tools.

Cultural Competency Toolkit: Highmark Health Options has assembled a list of resources and tools to assist you in providing care that is sensitive to the cultural and linguistic differences of our members.

Community Support offers a way to free or reduced-cost services in the community. Search for local support resources to access food, housing, transportation, utility assistance, medical care, job training, and more.

Visit the Highmark Health Options website for more resources and the latest updates.