Dec. 2021

Provider Forum

HIGHMARK HEALTH OPTIONS

EE-0104-2021

Welcome

1. Suzanne Lufadeju
2. Melanie Anderson
3. Paula Victoria
4. Michael Stewart
5. Terri Krysiak
6. Desiree Charest
7. Nathan Steinberg
8. Saroeun Svay
9. Janet Watson
10. Meghana Desai
11. Shasmay Davenport
12. Carrie Nocentino
13. Donna Pendleton
14. Danielle Nugent
15. Kim York
16. Asia Lloyd

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Agenda

1. General Updates
2. Updates by Department
   - Behavioral Health Services
   - Care Coordination: Lifestyle Management/Wellness Programs
   - Claims
   - Fraud, Waste, and Abuse
   - Long Term Services and Supports
   - Pharmacy
   - Quality Improvement
   - Utilization Management
   - YMCA Diabetes Prevention Program
   - EPSDT
3. Contacting Provider Services
4. Open Forum

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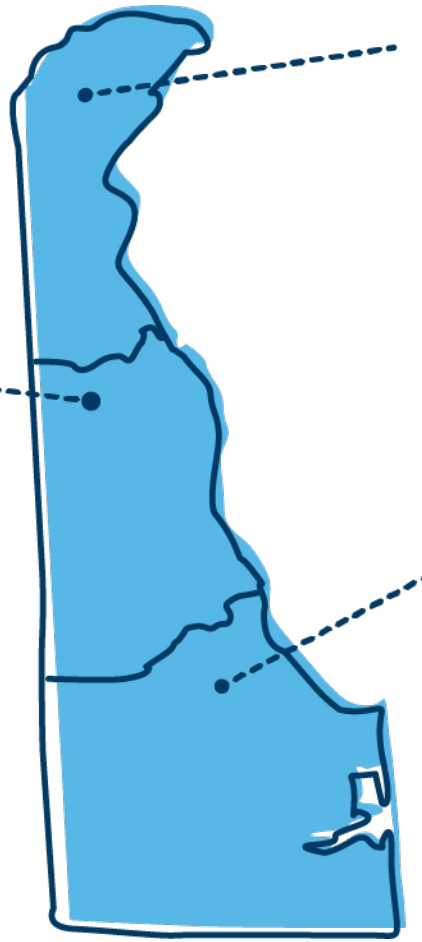
Section 1

General Updates

HIGHMARK HEALTH OPTIONS

Membership by County



New Castle County
89,239

Kent County
28,178

Sussex County
34,966

Total Members

152,383

As of Nov. 1, 2021

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Data and Definitions

- Atlas Systems, Inc. continues to conduct quarterly outreach to verify provider data on our behalf.
- Balance Billing: Payment by Highmark Health Options is considered payment in full.
  - Under no circumstance, including, non-payment by Highmark Health Options for approved services, may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Health Options member.

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Grievances

- A grievance is any expression of dissatisfaction, like a complaint, and can either be filed in writing or verbally.
- A grievance can be about any service that a member received from a provider or by Highmark Health Options.
- A grievance does not include a denial of benefits for health care services. Those matters are handled as appeals (see the appeals section of the Provider Manual).

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Medical Record Requests

- A member, or a member's authorized representative, shall have access to view and receive copies of the medical record or request medical records be transferred to a new PCP upon written request.
- Members are entitled to one free copy of their medical records.
- The fee for additional copies should not exceed the costs of time and materials used to compile, copy, and furnish such records.
- Request should be available or transferred within 10 calendar days of the written request and follow the specific procedures of the provider.

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Medical Record Requests, cont.

- Highmark Health Options may request copies of medical records from the provider.
- If Highmark Health Options requests medical records, the provider must provide copies of those records at no cost to Highmark Health Options.

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ADA Accessibility

HHO is collecting ADA accessibility information to ensure accurate information is reported to our members.

Information collected includes:

- Accessible Office, Parking, Entry
- Accessible Exam Rooms
  - A clear floor space, 30" x 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer.
  - Adjustable height accessible exam table lowers for transfers.
  - Accessible entry door has 32" minimum clear opening width with door open 90 degrees.

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ADA Accessibility

- Accessible Medical Equipment
  - Adjustable height exam table or chair
  - Transfer boards
  - Patient lifts
  - Staff able to transfer safely
- Large Print Materials
- Telecommunication Devices

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Culturally Competent Care

- Recognizes cultural and language differences in patients can improve their quality of life.
- Creates a collaborative and trusting patient-provider relationship to:
  - Improve health care outcomes.
  - Reduce health care access gaps.

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Culturally Competent Care

- The following resources can help build cultural competency and foster improved understanding and communication:
  - New! Culturally Competent Care Training Program Pilot
  - More educational resources on HHO website:
    - Assessments
    - Communications tools

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New: HHO Provider Portal

The new provider portal launches this winter, replacing NaviNet, the Enhanced Provider Portal, and parts of Highmark's Provider Resource Center.

What can you expect?

- Simplified navigation, including easier, immediate access to tools all in one place, accessible on both desktop and mobile.
- Pop-up notifications and personalized messages based on specialty.
- Secure digital forms instead of paper forms to download and fax or mail in.

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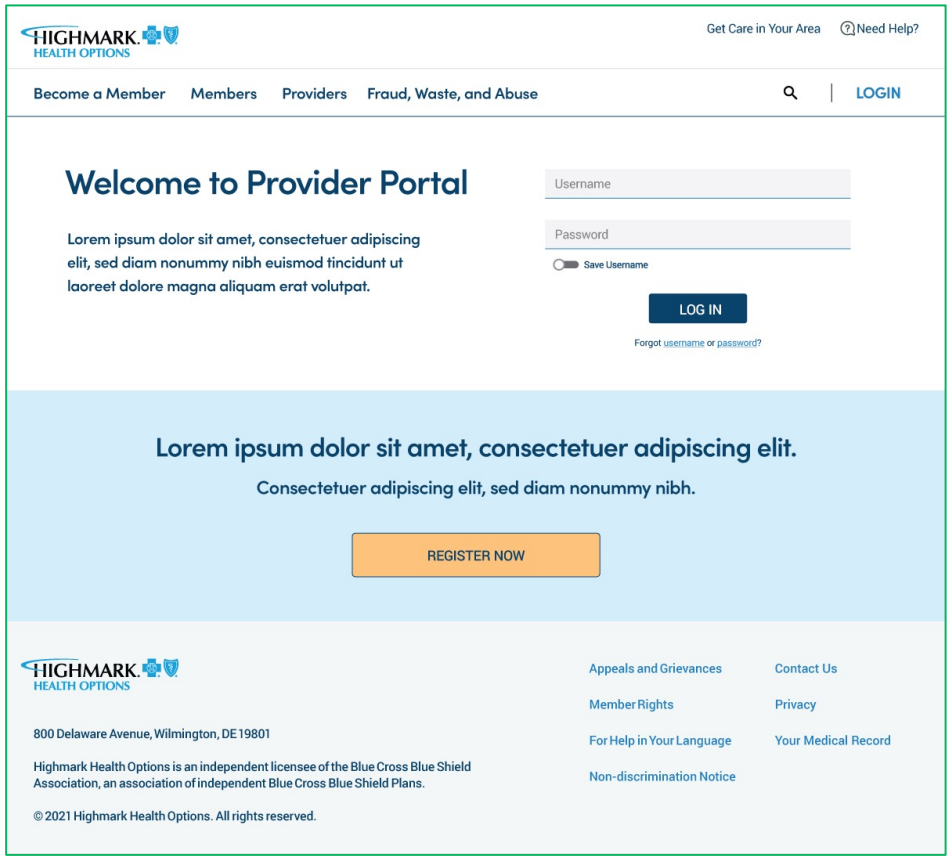
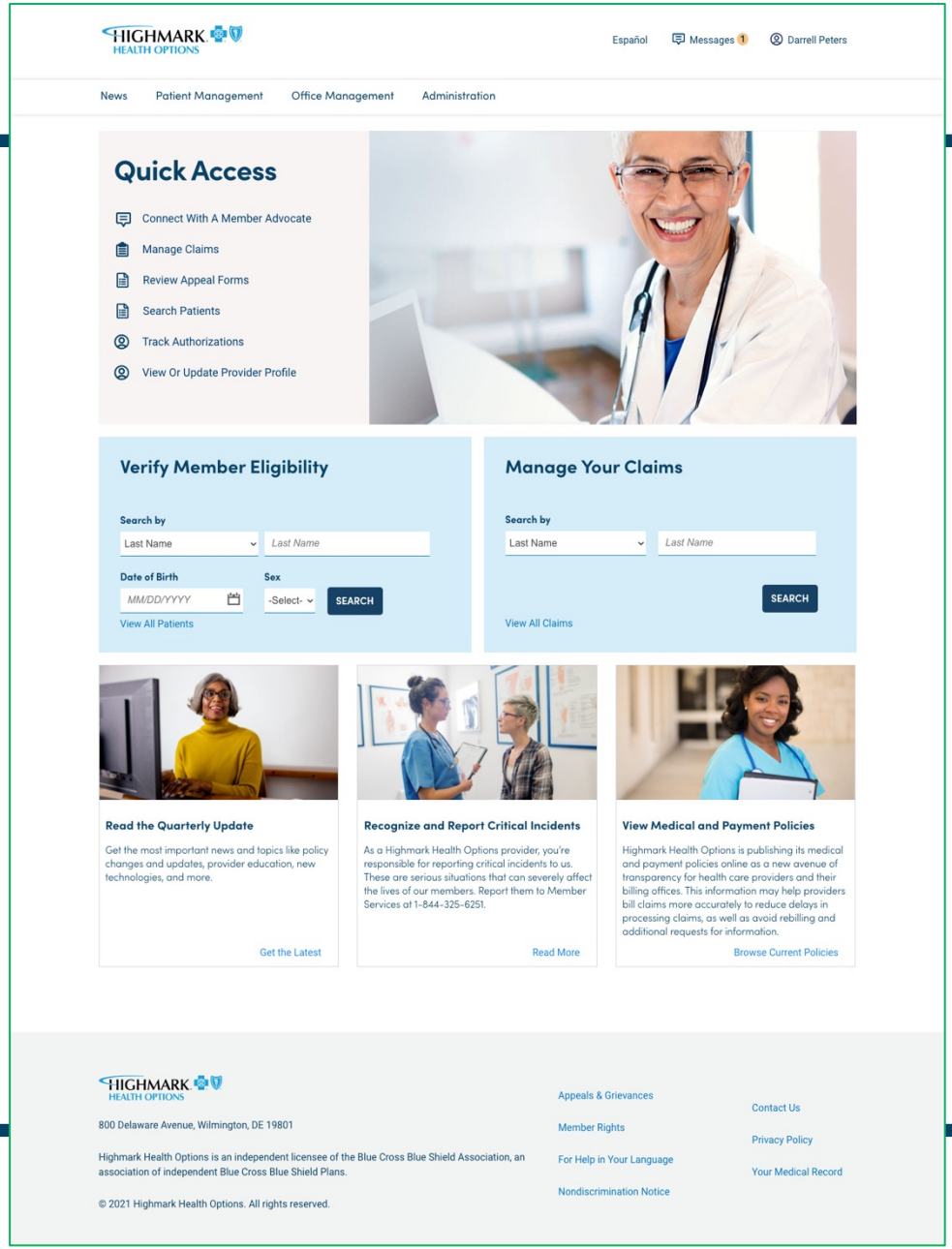
Sneak peak





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Authorization Request Changes

Effective Oct. 22, 2021, authorization submissions are no longer being accepted through NaviNet.

While the new provider portal is being developed, temporary manual processes will be in place for:

- Authorizations. Submit authorizations by calling Utilization Management at 1-844-325-6251, Monday–Friday, 8 a.m.–5 p.m.
- Appeals and claims disputes. Fax appeals and claims disputes to Appeals and Grievances at 1-844-207-0334.

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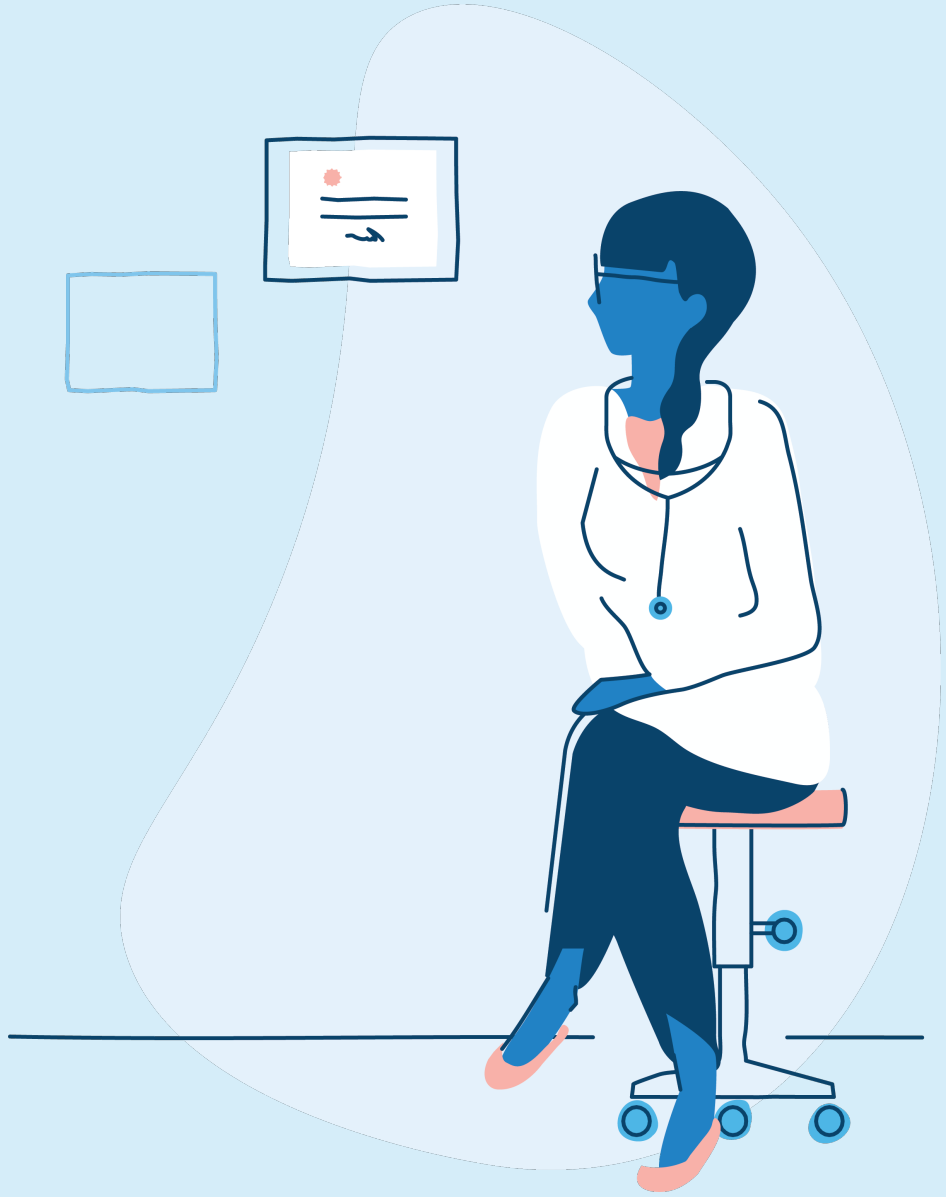
Authorization Request Changes

After Oct. 22 and during transition to the new provider portal, you can continue to use NaviNet for eligibility inquiry, claims inquiry, updates, and more.

The temporary manual process will be in place until new online tools are available.



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Prior Auth for Musculoskeletal Services

- Effective Nov. 1, 2021, Highmark Health Options will require prior authorization from eviCore for musculoskeletal (e.g., pain, joint, and spine) services.
- Services performed without prior authorization may not be reimbursed for the health care services listed below, and you may not seek reimbursement from Highmark Health Options members.

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Prior Auth for Musculoskeletal Services

Prior authorization is required for:

- Musculoskeletal services*

  *Note: eviCore will review any spine and joint surgery requested inpatient to determine medical necessity of both the services and the inpatient stay.

Services not subject to prior authorization:

- Musculoskeletal services performed in conjunction with a 23-hour observation or emergency room visit. Log in at evicore.com or call eviCore at 1-888-564-5492 between 7 a.m. – 7 p.m. local time.

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Office Standards: PCP and Specialists

Appointment Type	Example	Standard
Emergency Care	High temperature, persistent vomiting or diarrhea, or other sudden or severe onset of symptoms that do not require emergency room services.	Available same-day. Emergency services available 24/7.
Urgent Care	Persistent rash, recurring high-grade temp., non-specific pain, fever	Within 2 calendar days.
Routine Care	Treatment of chronic conditions	Within 21 days.

Additional Office Standards
Wait time in Waiting Room for Routine Care
Providers will not make a patient wait longer than 1 hour.
Office visits can be delayed when a provider prioritizes urgent cases. If a provider is delayed, patients must be notified ASAP. If 90+ min. wait, patient must be offered a new appointment.

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Office Standards: Prenatal Care

Appointment Type	Example	Standard
First Trimester Visit	Initial visit.	Within 3 weeks.
Second Trimester Visit	Initial visit.	Within 7 calendar days.
Third Trimester Visit	Initial visit.	Within 3 calendar days.
High Risk Pregnancy	Initial visit.	Within 3 calendar days.

Emergency services available 24/7.

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Office Standards: LTSS

Appointment Type	Standard
Minor Home Modification	No more than 60 calendar days
Home Delivered Meals	No more than 10 calendar days
Personal Care Attendant Services for New Members	No more than 10 calendar days
Personal Care Attendant Services for Members Currently Placed in a Nursing Facility and Transition to the Community	Immediately Upon Authorization

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Office Standards: Behavioral Health

Appointment Type	Example	Standard
Non-life threatening Emergency Care	Drug-induced involuntary muscle spasms, hypomania, intrusive thoughts.	Within 6 hours.
Immediate life-threatening Emergency Care	Immediate request for BH. Self harm, suicidal ideation. Includes mobile response teams.	Within 1 hour. Emergency services available 24/7.
Urgent Care	Acute major depression, panic disorder.	Within 24 hours.
Initial Visit for Routine Care	Outpatient, initial assessments, discharged from inpatient setting to community placement.	Within 7 calendar days.
Non-emergent or Follow-up Routine Care	Stress, general anxiety disorder.	Within 3 weeks.

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Section 2

Updates by Department

HIGHMARK HEALTH OPTIONS

Behavioral Health Services

Behavioral Health Services

- Highmark Health Options ensures that members have access to high-quality behavioral health (BH) services for treatment of mental health (MH) and substance use disorders (SUD) at a level of care within the least restrictive environment.
- An array of contracted providers offer services and supports for our members' BH/SUD needs across a continuum of care.
- Highmark Health Options Behavioral Health program adheres to the Mental Health Parity Act and Delaware Senate Bill 109 related to coverage for MH/SUD.

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Behavioral Health Services

- Highmark Health Options partners with our members, providers, community-based stakeholders, State agencies to develop care plans that support the members' BH needs, physical health needs, and overall wellness.
- Highmark Health Options supports members with managing BH needs through support with care management and utilization management, including appointment assistance, referral and linkage to services, access to wellness, resource coordination, and clinical care coordination.

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Behavioral Health Services

- Any Highmark Health Options provider can refer a member for BH care coordination.
- Call 1-844-325-6251 and select the clinical care coordination option.

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Behavioral Health Referral Scenarios

Some scenarios where BH coordination of care might be indicated:

- A person seeking help getting treatment for a mental illness or substance use disorder.
- A person with chronic comorbid medical and BH conditions who is being treated by multiple providers.
- A person who has frequent hospitalizations and emergency room admissions for conditions that could be safely and effectively treated at lower levels of care.
- A person with medical conditions that are being adversely impacted by a BH condition.

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Northern DE Behavioral Health Contacts

Mobile Crisis Intervention Services

14 Central Avenue, Fernhook Building
New Castle, DE 19720

- Staffed 24/7
- Serves all New Castle County and greater Smyrna in northern Kent County.
- Provides phone support, mobile outreach, and walk-in crisis services.

1-302-577-2484 or 1-800-652-2929

Psychiatric Emergency Services (CAPES)

Wilmington Hospital Emergency Department

- Staffed 24/7

1-302-320-2100

Recovery Innovations Recovery Response Center

659 East Chestnut Hill Road
Newark, DE 19713

- Staffed 24/7
- Offers facility-based crisis services for adults experiencing mental health or substance use crisis.

1-302-318-6070

Child Priority Response Services

- For children and teens under 18.

1-800-969-HELP or 1-800-969-4357

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Southern DE Behavioral Health Contacts

Mobile Crisis Intervention Services

700 Main Street
Ellendale, DE 19941

- Staffed 24/7
- Serves all of Sussex County and Kent County south of greater Smyrna.
- Provides phone support, mobile outreach, and walk-in crisis services.

1-800-345-6785

Recovery Innovations Recovery Response Center

700 Main Street
Ellendale, DE 19941

- Staffed 24/7
- Provides recovery support services and crisis stabilization services to divert people from inpatient hospitalization and communicate the message of hope and the possibility of recovery.
- The RRC Living Room is a crisis alternative where people having a difficult time can become a guest where they receive comfort and hope from a team of Peer Support Specialists in recovery.

1-302-424-5660

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Care Coordination: Lifestyle Management and Wellness Programs

HIGHMARK HEALTH OPTIONS

Lifestyle Management and Wellness Programs

- Provides patient education and other tools to reduce inpatient and emergency room utilization.
- Uses evidence-based guidelines and self-empowerment strategies.
- Increases patient adherence for immunizations, lab testing, medications, preventative screenings, and more.
- Supports the provider's plan of care and the provider-patient relationship.

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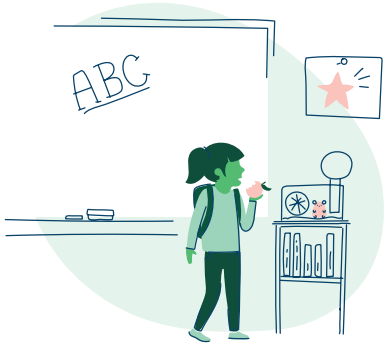
Lifestyle Management and Wellness Programs

Asthma

Cardiac

COPD



Diabetes

Healthy Weight Management

Maternal Outreach Management (MOM) Options Reward Program

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Program Eligibility

- Call Care Management Department at 1-844-325-6251, Monday-Friday, 8 a.m. – 5 p.m.
  - Request written material or Care Management for your patient with a chronic medical condition.
- Care Management staff will assess your patient's needs, assess the appropriate action, and communicate with you.

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MOM Options Program

- This prenatal program offers care coordination to reduce low birth weight, pre-term deliveries, and neonatal intensive care unit (NICU) admissions.
- Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women for proactive interventions.
- All pregnant members enrolled in Highmark Health Options are eligible, though members can opt out.

Appointment Tracker Brochure

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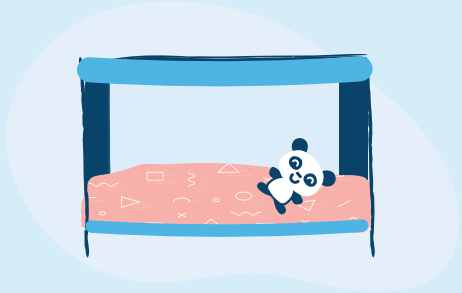
MOM Options Rewards

To qualify for a reward, patients must complete these activities:

- Go to every prenatal visit, starting at week 14.
- List appointment dates and have the brochure signed and dated by provider's office.
- Stay enrolled in Highmark Health Options.
- Mail the completed brochure no later than six weeks after birth.

Infant Car Seat



Pack 'n Play

Stroller

Baby Shower in a Box

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New Reward!

Baby Shower in a Box includes:

- 3-piece Hooded Towel Set
- ABC Magnet
- Baby Bath
- Baby Wipes
- Bibs 2-piece Set
- Bodysuit 5-piece Set
- Charlie's Kids Book
- Diapers
- Diaper Rash Ointment
- Grooming Kit
- Lotion
- Philips Soothie Pacifier
- Safety Kit
- Snack Cup
- Snapette Onesie
- Snoozzzette wearable blanket
- Snugette Baby Carrier

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Maternity Meals Program

- Highmark Health Options is partnering with Modivcare, the Food Bank of Delaware, and the state of Delaware to support members during their postpartum recovery.
- Patients may be eligible for food delivered to their doorstep for free if they:
  - Are enrolled in Highmark Health Options.
  - Delivered their baby through cesarean section.
  - Had their baby less than 8 weeks ago.

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Claims

HIGHMARK HEALTH OPTIONS

Top 5 Claim Denials

1. **Coordination of Benefits**
2. **Duplicate Claim**
3. **Non-Compensable**
4. **Invalid Diagnosis**
5. **Enrollment**

(Jan. 1, 2021 – Oct. 31, 2021)

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Claims Requirements

- Claims must be submitted for all services rendered using charted ICD 10 codes.
- All claims, including EPSDT claims, must be received within:
  - 120 days of the date of service.
  - 60 days from the date of remittance from a primary payer.
- Corrected claims or requests for review are considered if information is received within the 180-day follow-up period from the date on the Health Options remittance advice.

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Claims Requirements

- Tax ID, National Provider Identifier (NPI), and Taxonomy are required.
  - Taxonomy will be required for billing, rendering/performing and attending providers on all claims or the claim may be denied.
  - Group taxonomy numbers can be reviewed on NaviNet.
- All drug-specific claim information reported using the 837P and 837I electronic format must be reported with a HCPCS code, such as a J-code, and an 11-digit NDC code.
  - Claims submitted without both the appropriate HCPCS code and NDC will be rejected.

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Claims Submissions

- Preferred Method: Electronic Claims Submission.
  - Electronic data interchange (EDI) claims to Change Health (either directly or through a provider's clearinghouse or vendor).
- Payor ID: Change Health: 47181 Professional and Institutional.
- Send paper claim submissions on original CMS-1500 or UB-04 red ink claim forms to: Highmark Health Options, Attention: Claims Department, P.O. Box 890402, Camp Hill, PA 17089-0402.

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Fraud, Waste, and Abuse

HIGHMARK HEALTH OPTIONS

Fraud

- Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

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Waste

- Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

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Abuse

- Abuse is payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

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Prevent Fraud, Waste, and Abuse

- Conduct yourself in an ethical manner.
- Ensure accurate and timely data/billing.
- Ensure you coordinate with other payers.
- Keep up-to-date with FWA policies, procedures, standards of conduct, laws, regulations, and the CMS guidance.
- Look for suspicious activity.
- Verify all information provided to you.

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Prevent Fraud, Waste, and Abuse

- If fraud or abuse is suspected, it is your responsibility to contact Highmark Health Options' Fraud Hotline at 1-844-325-6256.
- The fraud hotline answers calls 24/7. It allows for confidential and anonymous reporting.
- Detailed information regarding the Federal False Claims Act and Provider Prohibited Acts can be found on the Highmark Health Options website.

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Long Term Services and Supports (LTSS)

HIGHMARK HEALTH OPTIONS

What is Long-Term Services and Supports

- An enhanced Medicaid benefit package that services members in the community (including assisted livings) and in nursing facilities.
- Eligibility determined by the state.
- A case management department made up of nurses, social workers, and certified case managers.
- Several cohorts make up the department.

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What is Long-Term Services and Supports

Case Management Outreach Schedule

- In the community (including residents of assisted living).
- In a nursing facility.
- All LTSS members.

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What is Long-Term Services and Supports

Service Plan Development

- Assist member in determining the medically necessary services needed to maintain functional independence and to meet their personal and healthcare goals.
- Care Plan Development

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Coordination with Case Management

Provider Collaboration is an integral part of the holistic approach to servicing our members

- Take note of who the member's case manager is
- Stay in contact with the case manager
- Case managers need to know about gaps in care
- Nursing Facility Staff: please be sure to invite your Health Options SPOC to all care plan meetings

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Coordination with Case Management

Our case managers are here to help.

- Reach out at any time to notify us of concerns, hospitalizations, changes in level of care, or if there is an urgent need.
- Working together improves outcomes for our vulnerable population.
- Please call our Support Center if you don't know who a member's case manager: 1-844-325-6258, Monday – Friday, 8 a.m. – 6 p.m.
- There is an on-call supervisor available for needs after business hours and on the weekend: 1-844-325-6251.
- Notify us of concerns/interruptions with services.

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Coordination with Case Management

Quality of Care and Quality of Service Issues

- If you identify a potential quality of care or quality of service issue you can report your concern to provider services for assistance with filing.

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Missed Hours Reporting

Missed Hours

- This replaces the previously required Late and Missed Visits reporting.
- Health Options must submit the missed hours report to the State monthly including a narrative of those providers that did and those providers that did not submit their report.
- Providers are required to submit their report for the prior month by the eighth of each month (this includes all completed and missed hours).
- The excel template on the Health Options website must be used and sent to: HHO_LTSS_AC_Visits@highmark.com.

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How to Make a Referral for LTSS

- If the member is enrolled in HHO, call the Care Coordination department to get them connected with a Care Coordinator. They can assist with the referral process and assist with any needs prior to the start of eligibility.
- If the member is **not** with HHO, call the Aging and Disability Resource Center (ADRC) at 1-800-223-9074.
  - Members must meet both medical and financial criteria to qualify for the LTSS program. The State will determine eligibility

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National Core Indicators

Aging and Disabilities (NCI-AD) Adult Consumer Survey

- Administered annually by DMMA.
- Evaluates the effectiveness and quality of LTSS services delivered to Delawareans.
- 18 domains are measured.
- You can impact Delaware's data!
- Member care is on a continuum with different touch points along the way.
- Visit www.nci-ad.org to view survey results.

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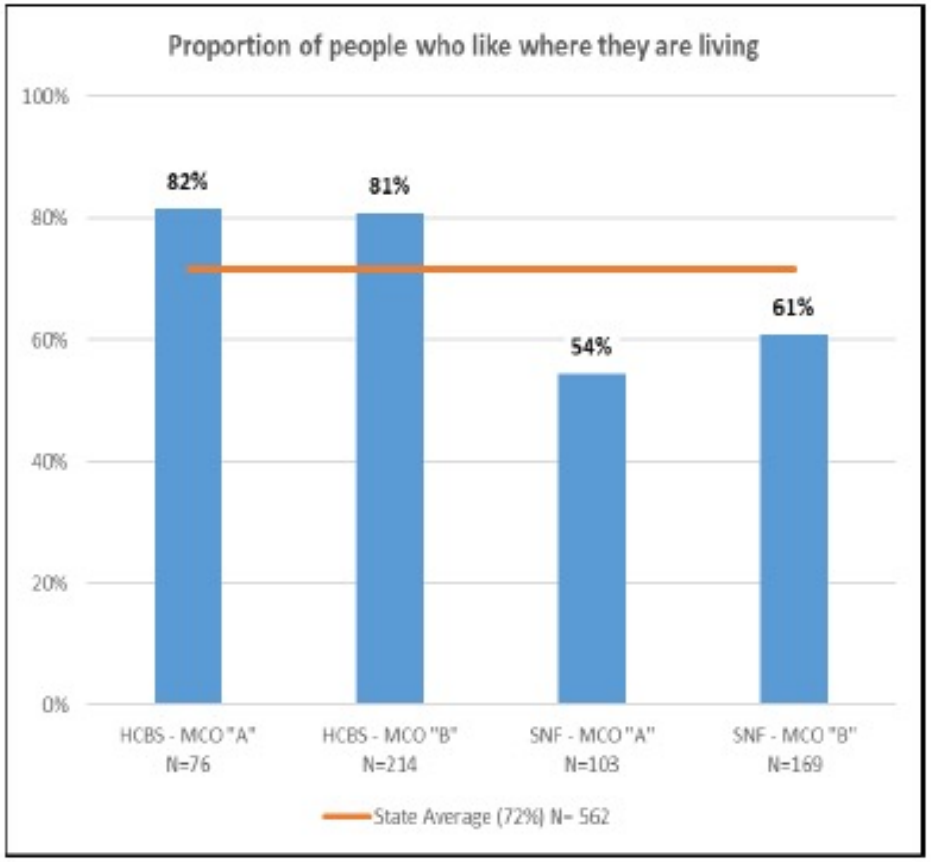
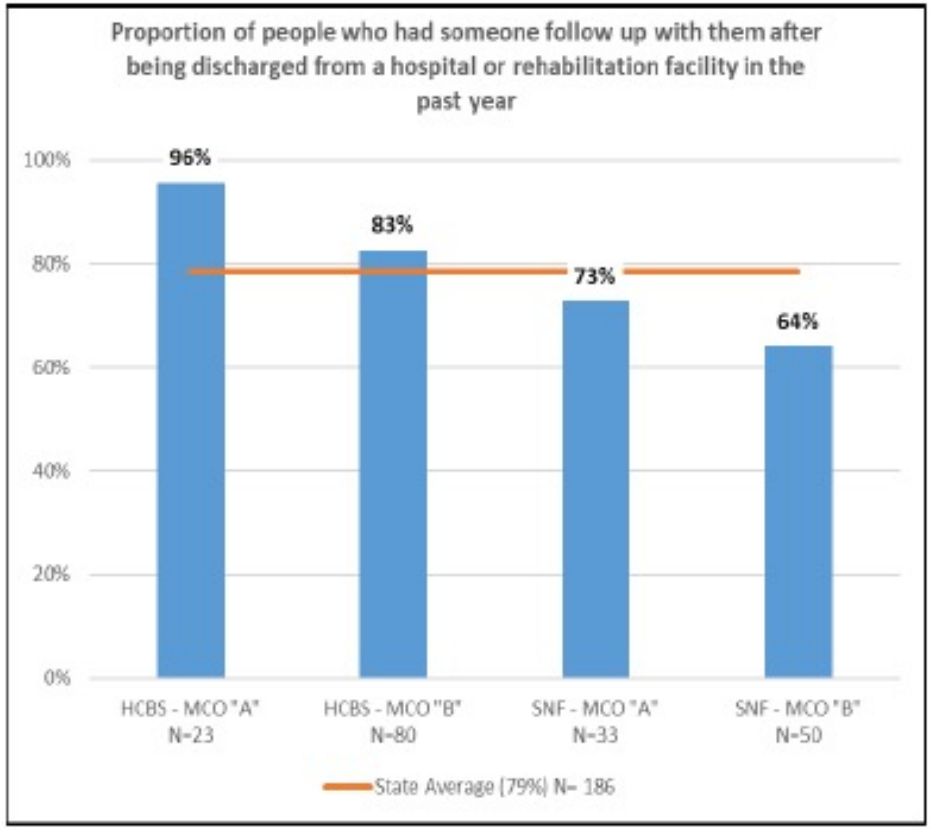
Survey Results





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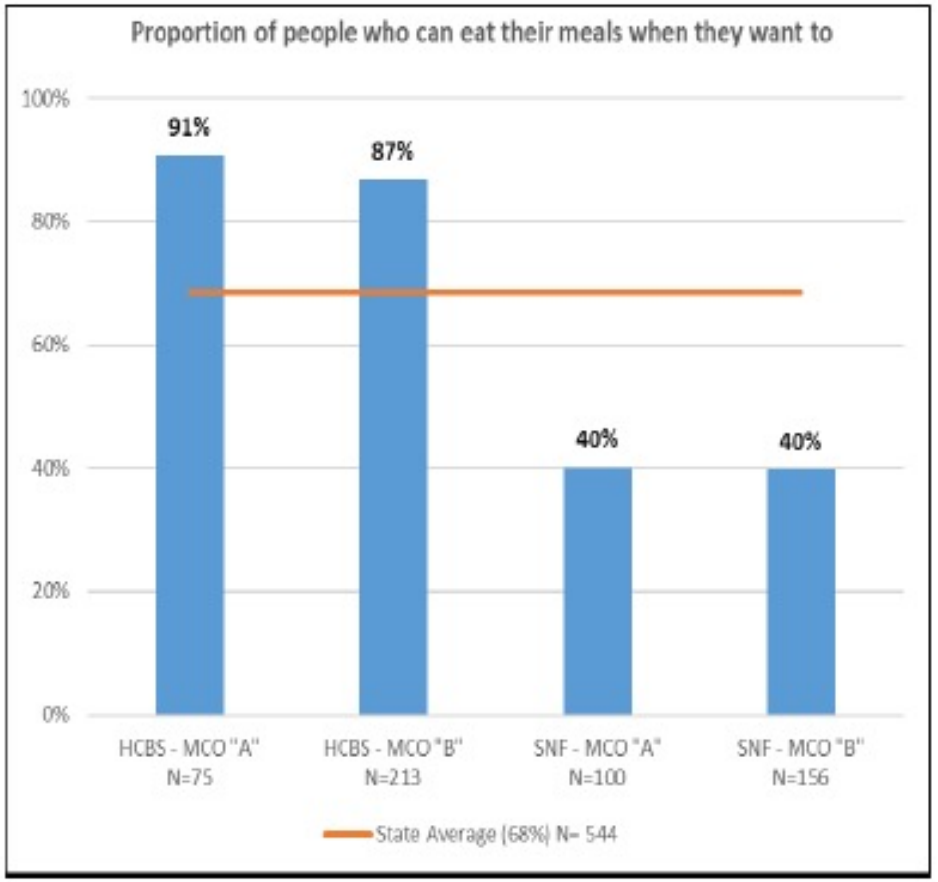
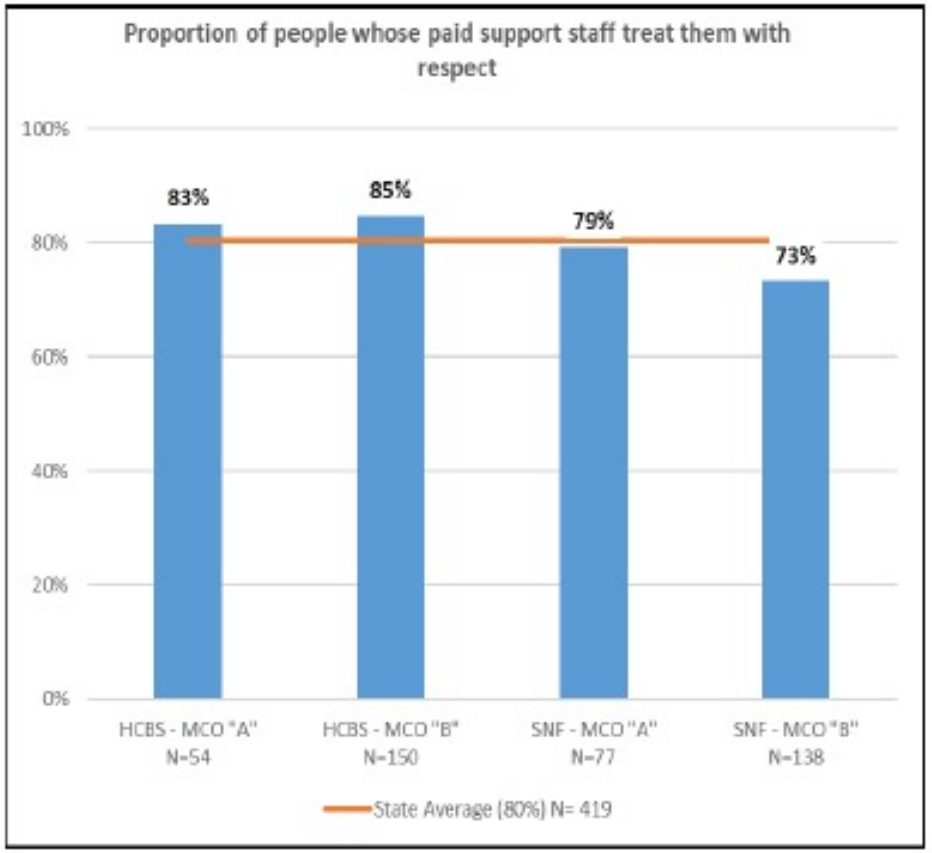
Survey Results





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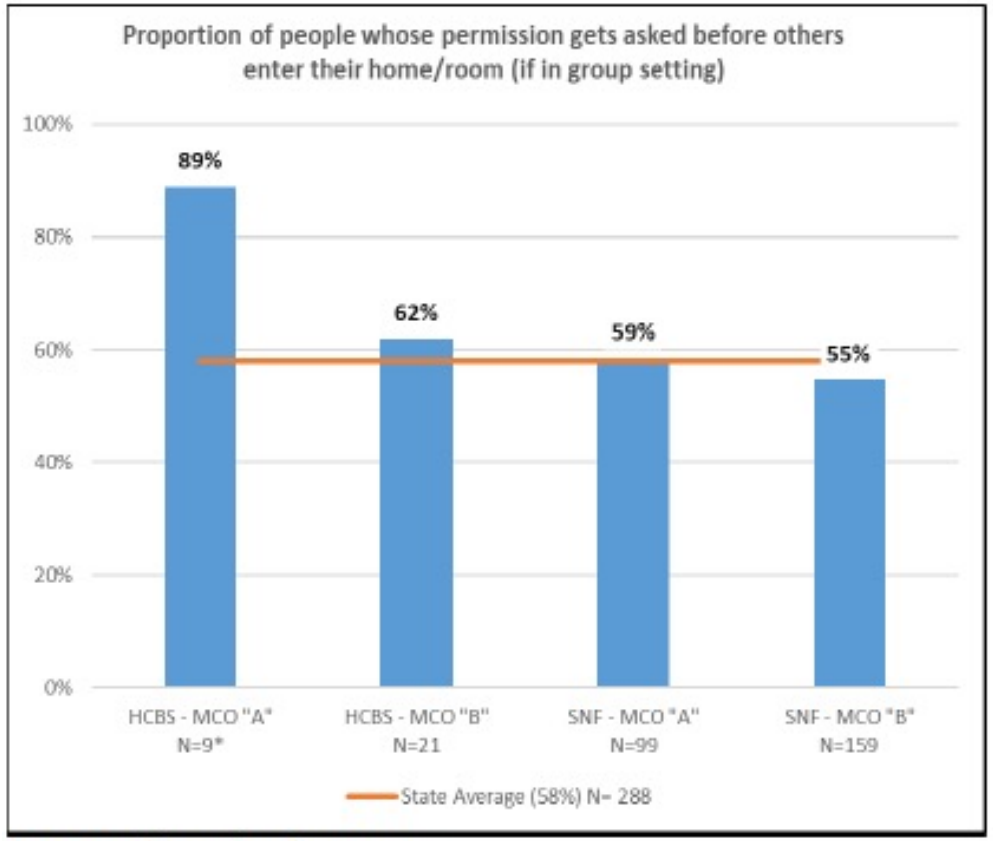
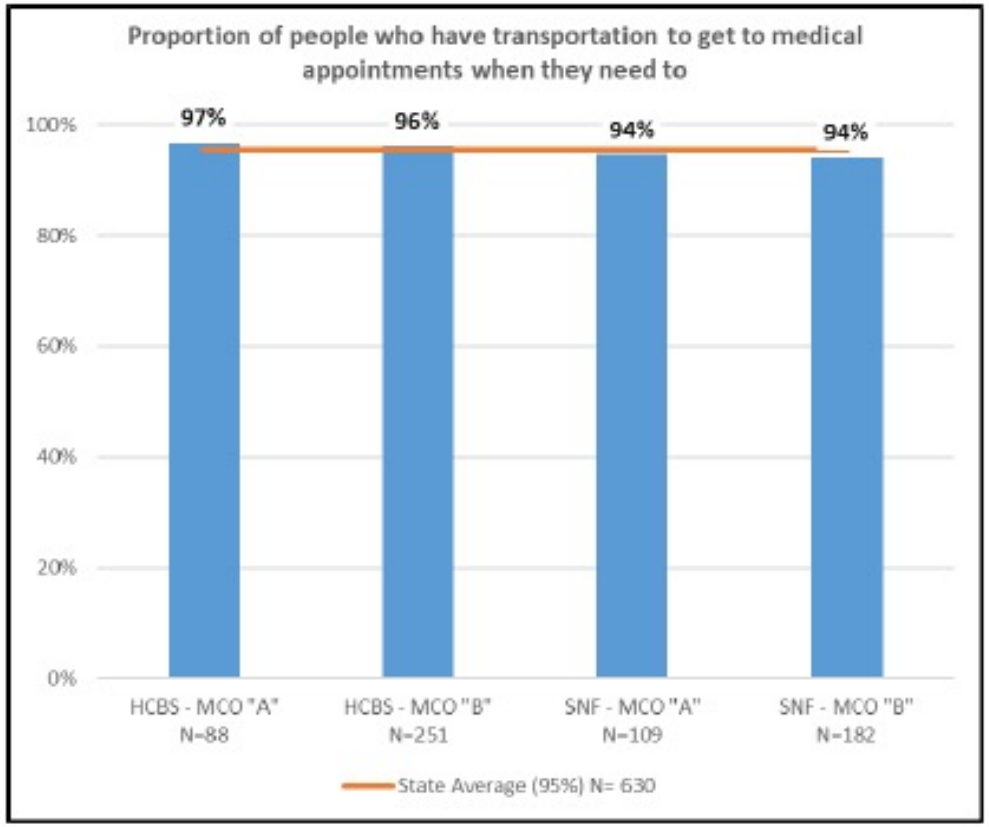
Survey Results



* Very small number of responses



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Contact the LTSS Department

- If you need to find out who a member's case manager is or have questions about authorizations, please call the LTSS Support Center at 1-844-325-6258, Monday – Friday, 8 a.m. – 6 p.m.
- General LTSS questions can be directed to Nick Duko, Program Manager, LTSS Case Management, Nicholas.Duko@highmark.com

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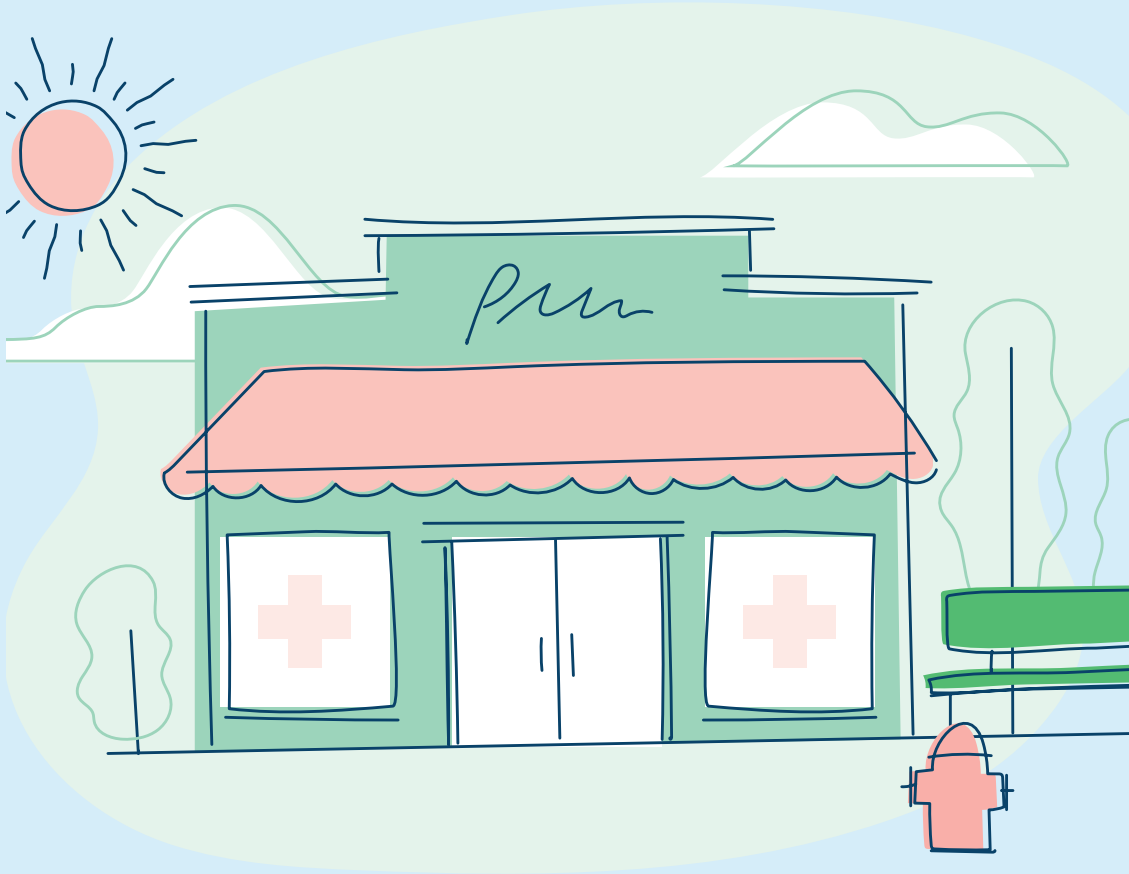
Pharmacy

HIGHMARK HEALTH OPTIONS

Pharmacy Services

- Retail pharmacy network includes most local, independent, and national chains.
- In 2017, specialty pharmacy network launched for medications requiring special monitoring, adherence, handling, or storage requirements.



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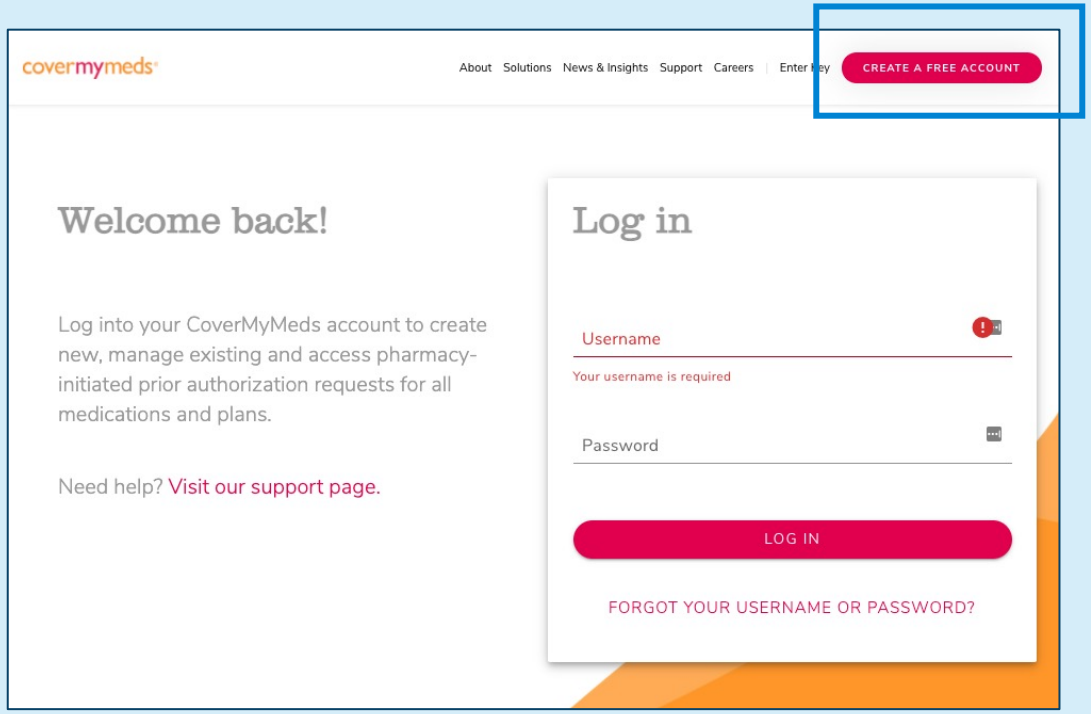
Electronic Prior Auths (ePA)

- CoverMyMeds platform provides two-way connectivity between prescribers and HHO RX.
- HHO RX utilization management system connects with CoverMyMeds and CVSHealth.
- HHO RX Pharmacy Benefit Manager (PBM).



GET STARTED

account.covermymeds.com

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Medication Information for Providers

Go to hho.fyi/meds for:

- Finding medications requiring prior authorizations.
- Downloading the General Drug Exception Form (Prior Auth Form).
- Faxing the prior auth forms.
- Searching prior auth criteria by type.
- Using the drug formulary database.

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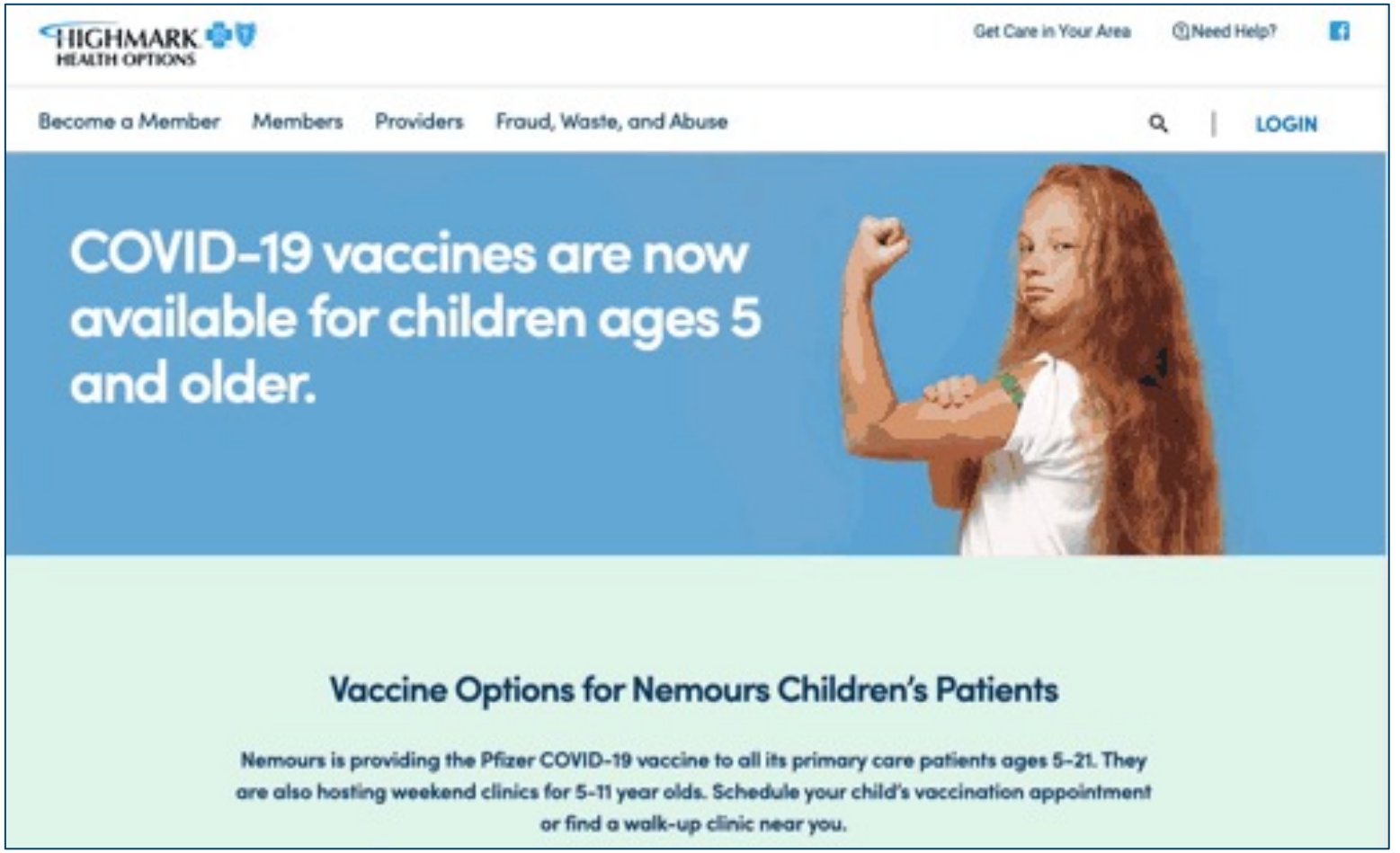
Navigating the Webpage



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Fax Completed Forms

- Fax 1-855-476-4158.
- Fax number is also located on each of the prior auth forms.
- Processing time for prior auth form is 24 hours.

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Formulary Standards

- Highmark Health Options formulary follows the Delaware Health and Social Services (DHSS) Preferred Drug List (PDL).
- Review the complete Delaware Medicaid PDL at hho.fyi/2021-pdl.

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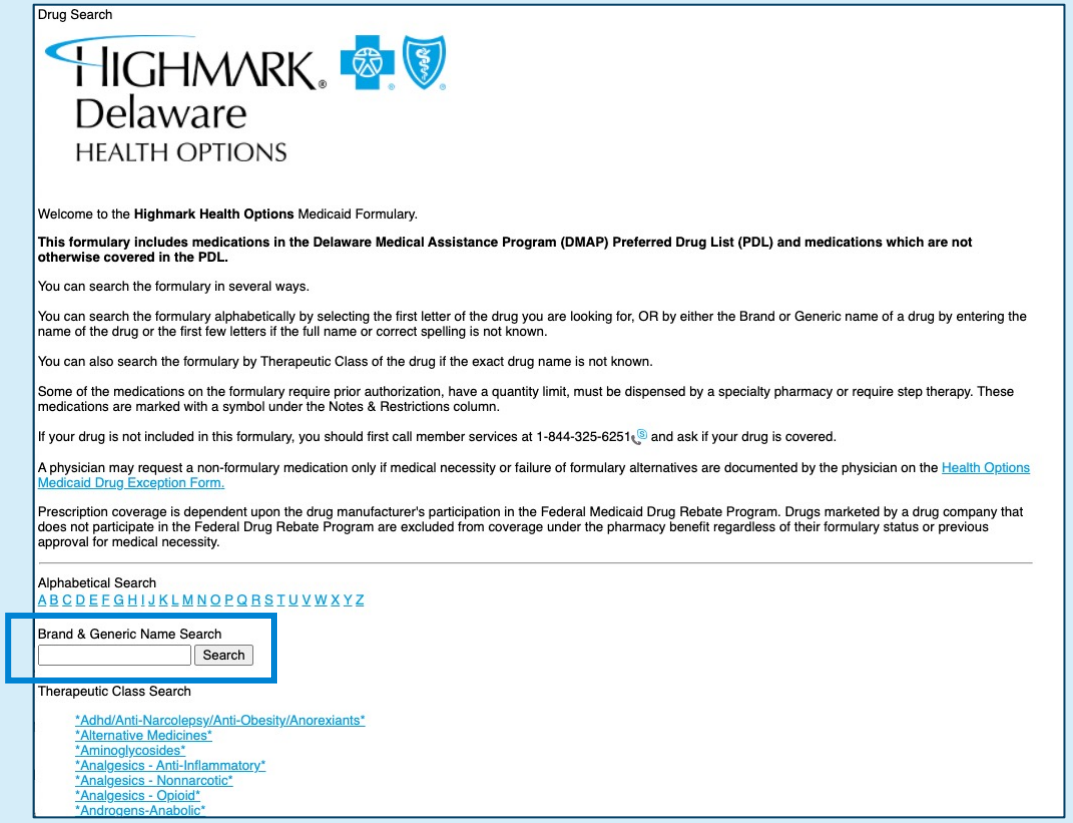
Searching the Drug Formulary

- Alphabetically by selecting the first letter of the drug you are looking for
- By brand or generic name using the first few letters if the name.
- By therapeutic class of the drug if the exact drug name is not known.



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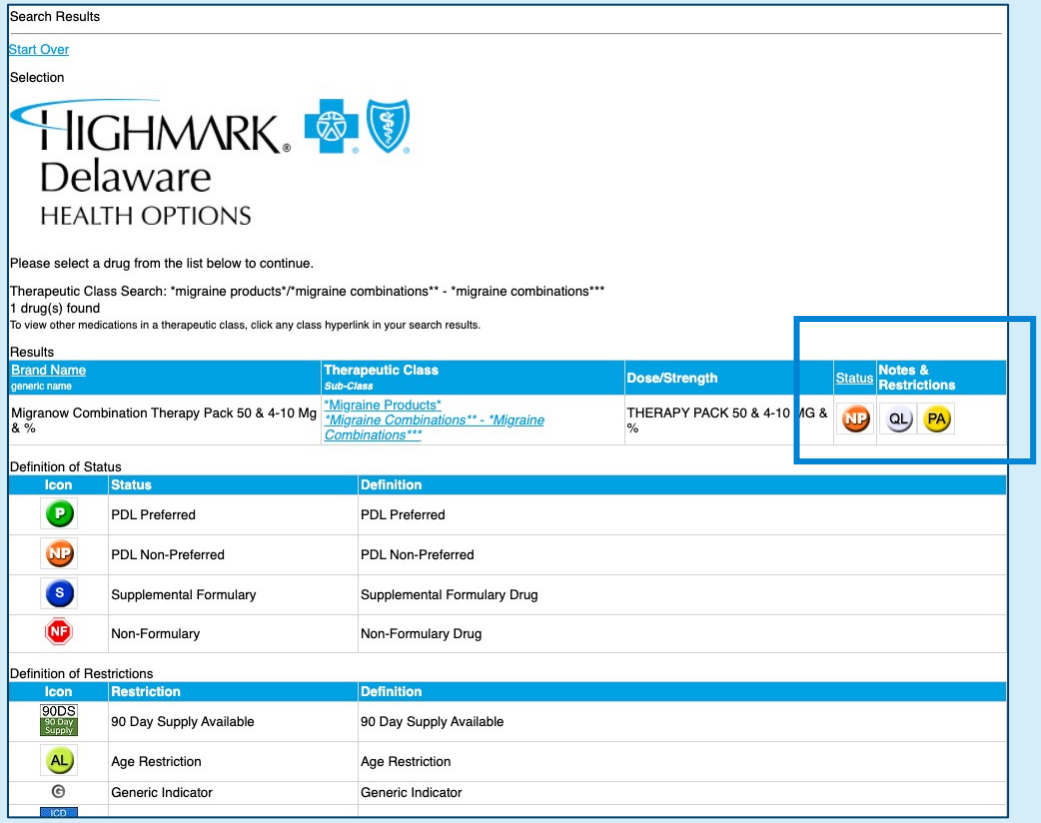
Searching the Drug Formulary

Some of the medications:

- Require prior auths.
- Have a quantity limit.
- Must be dispensed by a specialty pharmacy.
- Require step therapy.

These medications are marked with a symbol in Notes & Restrictions.



Search Results

Start Over

Selection

HIGHMARK. Delaware HEALTH OPTIONS

Please select a drug from the list below to continue.

Therapeutic Class Search: *migraine products*/*migraine combinations** - *migraine combinations***
1 drug(s) found
To view other medications in a therapeutic class, click any class hyperlink in your search results.

Results

Brand Name / generic name	Therapeutic Class / Sub-Class	Dose/Strength	Status	Notes & Restrictions
Migranow Combination Therapy Pack 50 & 4-10 Mg & %	*Migraine Products* *Migraine Combinations** - *Migraine Combinations***	THERAPY PACK 50 & 4-10 MG & %	NP	QL PA

Definition of Status

Icon	Status	Definition
P	PDL Preferred	PDL Preferred
NP	PDL Non-Preferred	PDL Non-Preferred
S	Supplemental Formulary	Supplemental Formulary Drug
NF	Non-Formulary	Non-Formulary Drug

Definition of Restrictions

Icon	Restriction	Definition
90DS 90 Day Supply	90 Day Supply Available	90 Day Supply Available
AL	Age Restriction	Age Restriction
G	Generic Indicator	Generic Indicator

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Contact Pharmacy Services

Get pharmacy support 24/7.

- Call Pharmacy Services at 1-844-325-6251, Monday – Friday, 8 a.m. – 7 p.m.
- For help outside of regular business hours, leave a message at 1-844-325-6251, Monday – Friday, 7 p.m. – 8 a.m. and on weekends.

Representatives will respond to your message after hours.

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Quality Improvement

HIGHMARK HEALTH OPTIONS

Section 1

Critical Incidents

HIGHMARK HEALTH OPTIONS

Critical Incidents Defined

Critical incidents are defined by the **Division of Medicaid and Medical Assistance** (DMMA). They include:

- Unexpected death of a member, including deaths occurring suddenly or in any suspicious or unusual manner, when the deceased was not attended by a physician.
- Suspected physical, mental, or sexual mistreatment; abuse; or neglect of a member.
- Suspected theft or financial exploitation of a member.
- Severe injury sustained by a member.
- Inappropriate or unprofessional conduct by a provider involving a member.

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We’re in this together.

Putting our members and their safety first is a responsibility we all share.

We must ensure that critical incidents are:

- **Identified**
- **Reported**
- **Managed appropriately**

This is a vital step in our mission.

Thank you for participating.

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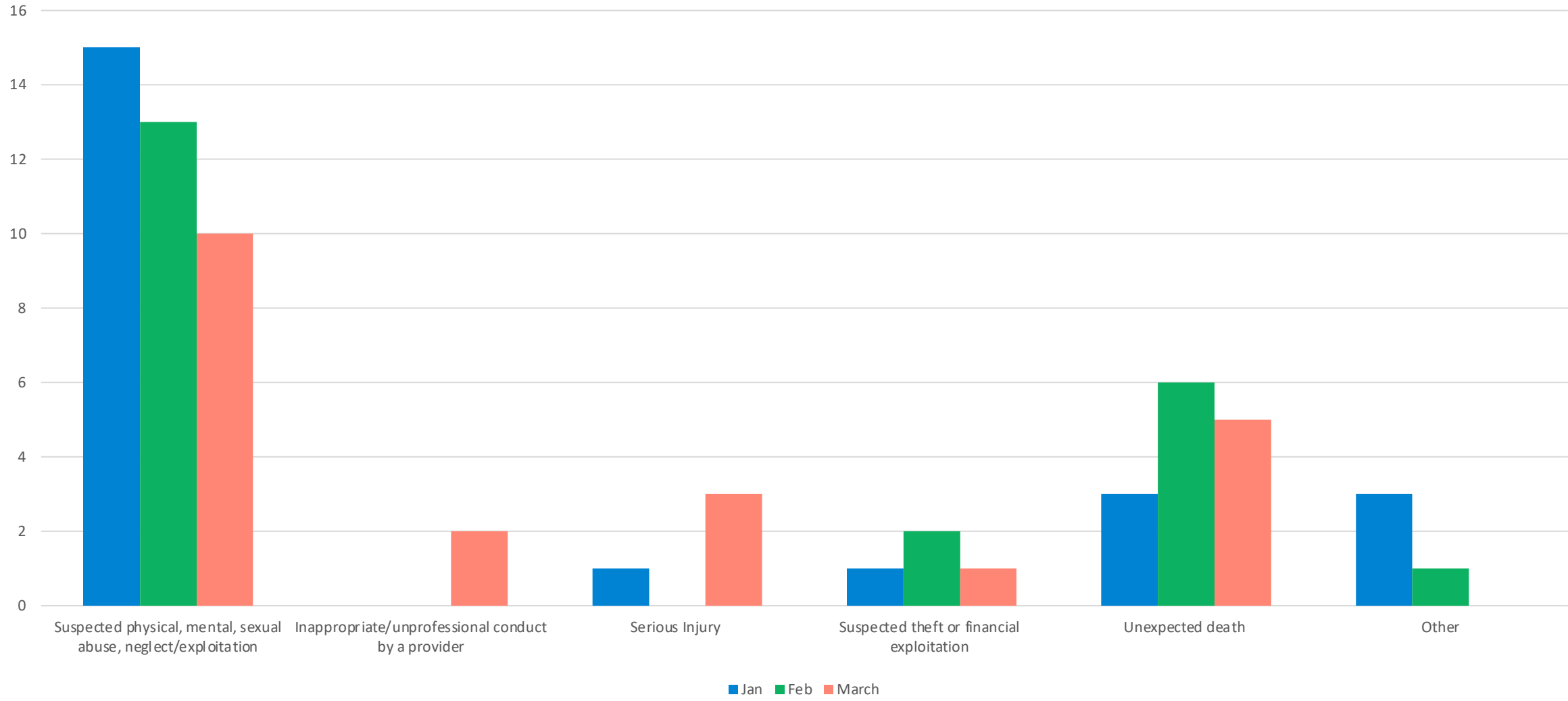
Q1 2021 Critical Incidents



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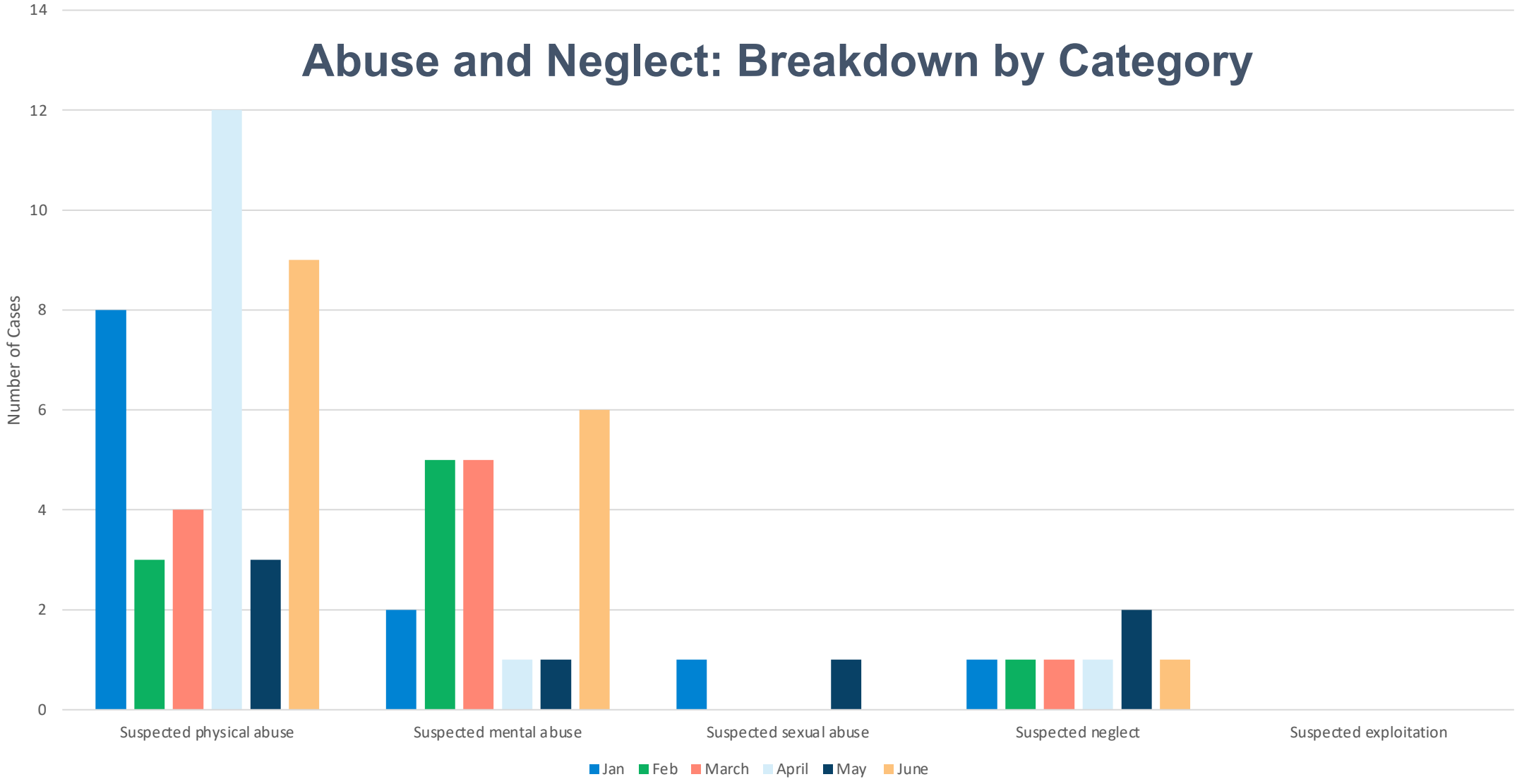
Abuse and Neglect: Breakdown by Category



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Identification and Notification

Report critical incidents the same business day they occur to:

Adult Protective Services (APS)
1-302-424-7310

For suspected abuse, neglect, disruptive behavior, or exploitation.

Delaware Health and Social Services (DHSS) Long-Term Care Office of the State Ombudsman (OSO)
1-800-223-9074

For long-term care facility residents who have a complaint about their rights.

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Identification and Notification

Division of Health Care Quality (DHCQ)

1-877-453-0012

For members in a long-term care or pediatric nursing facility.

Office of Health Facilities Licensing and Certification (OHFLC)

1-302-292-3930 or
1-800-942-7373

For members in an acute care or outpatient health care facility.

Division of Family Services (DFS)

1-800-292-9582

DFS receives, investigates, and responds to critical incidents of abuse or neglect involving children living in the community.

Note: This phone number is also the 24-hour Child Abuse and Neglect Reporting Hotline.

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Scenario 1

A toddler presents with multiple different-shaped bruises in a variety of stages of healing on his legs.

Mom states he is very active and climbs everything.

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What should you do?

- Recognize that **this is not a critical incident** because:
  - The child is an active toddler who climbs a lot.
  - There is no swelling or crepitus in the legs.
  - Activity can cause a variety of bruises on the legs.
- Follow up with regular visits.

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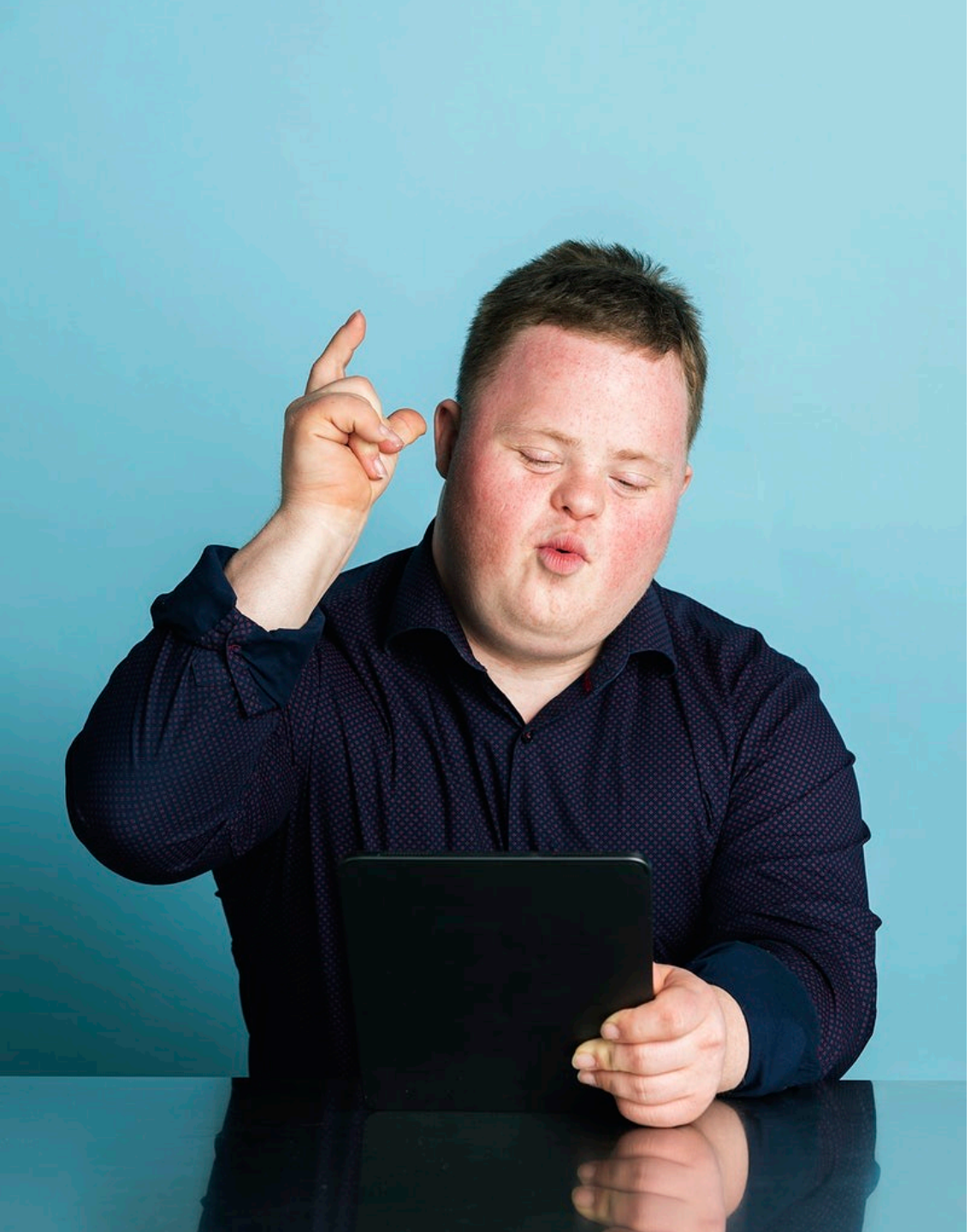

Scenario 2

The 30-year-old sister of a 16-year-old male with Down syndrome has taken her brother out of his group home to care for at her home after their mother has died. She brings him in for his checkup and the staff or provider finds:

- The sister does not have knowledge of the member's medications, whether the member had adequate medications, or when the medications were last filled.
- The sister does not seem to know the member's medical appointment dates.
- The sister seems to be a poor historian regarding the member and his care.

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What should you do?

- Recognize that **the reported situation is a critical incident** – suspected neglect of a member.
- Notify DFS at **1-800-292-9582**.
- Report to Highmark Health Options at **1-844-325-6251**.

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Scenario 3

A 70-year-old female LTSS member slips and falls on ice-covered steps when visiting a friend across the street. The member fractures her hip.

The member calls Member Services soon after she returns home from the hospital.

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What should you do?

- Recognize that **this is not a critical incident** because member was:
  - Visiting a friend.
  - Not receiving care from a provider at the time.
- Report to Highmark Health Options at **1-844-325-6251**.

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Section 2

Quality of Care (QOC) Investigations

HIGHMARK HEALTH OPTIONS

Who performs QOC investigations?

- QOC team includes QOC RNs and medical directors.
- Collabs with grievance analysts, providers, and medical directors to ensure that investigations and determinations are performed in a timely manner.
- Do your part: provide medical records promptly.

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Resolution of QOC Investigations

Harm Scores

- Death
- Severe Permanent Harm
- Permanent Harm
- Temporary Harm
- Additional Treatment
- Emotional Distress or Inconvenience
- No Harm

Corrective Action Plans

- Are usually sent out when harm scores reach 1-3.
- Must be responded to within 10 business days.

Provisional Harm Letters

- Sent when medical records are not received promptly.
- Any harm level can be assigned.

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Who can report a critical incident or QOC?

Anyone!

- Members and family members
- Office staff
- Providers
- State or federal agencies
- Fraud, Waste, and Abuse

Report by calling **1-844-325-6251**.

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What are Performance Improvement Projects (PIPs)?

- Purpose: achieve significant improvement sustained over time in clinical or nonclinical areas through ongoing measurements and interventions.
- PIPs use continuous improvement methodology to achieve significant improvement in health outcomes and member satisfaction; sustained over time.
- PIPs are designed to change behavior of Members, Providers, and HHO and/or health care system
- PIPs are expected to have a favorable effect on member health outcomes and member satisfaction.
- See also: Federal regulation, Title 42 C.F.R. §§ 438.330 and 457.1240(b).

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Provider Collaboration

- Identify those members that are high/overutilizers of the ED.
- Identify those members that are newly enrolled with the Provider and/or HHO and are determined to have healthcare/SDOH needs.
- Identify those members that are 18 months of age and missing a lead screening.
- Identify those members that are age 18-64, have Schizophrenia + Diabetes and are missing annual LDL-c and/or HbA1c.

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Section 3

Updates and Reminders

HIGHMARK HEALTH OPTIONS

Clinical Practice Guidelines

- Maintained to assist providers in optimizing patient care through evidenced-based care options.
- CPGs are located on the Highmark Health Options website.
- All CPGs were updated in 2021.
- Some CPGs include:
  - Preventive Care (Child and Adult)
  - Diabetes
  - Routine & High-Risk Prenatal Care
  - Major Depression
  - HIV/AIDS
  - Asthma

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HEDIS

HEDIS = Healthcare Effectiveness Data Information Set

- Measures health care performance.
- Provides information on health care quality.
- Helps HHO strive to deliver highest quality health care.
- Helps identify gaps in key preventive care.
- Helps HHO assess and understand where more resources and effort are needed.

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HEDIS

- Rates determined by claims data/data sharing -plus- medical record reviews.
- Data capture is a key component to HEDIS success.

A big **THANK YOU** to all providers!

Earlier this year HHO finished a successful HEDIS season thanks to your partnership in fulfilling our medical record requests and providing us remote access to your EMR. Your data was key!

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MY2020 HEDIS Rates

Despite 2020 obstacles, you provided important preventive care to your patients, our members:

- Nearly two-thirds of women are up-to-date with their Cervical Cancer Screening (CCS).
- Over half of diabetic members have HbA1c controlled (<8%) in 2020.
- Over 90% of women who delivered a baby had timely prenatal care.
- Over three-quarters of children had a lead screening by age 2.

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Quality Performance Measures

The following healthcare measures are our priority measures:

- HbA1c < 8%
- Controlling High Blood Pressure
- Breast Cancer Screening
- Cervical Cancer Screening
- 30-Day Hospital Readmission
- Timely Prenatal Visits
- Asthma Medication Ratio

Provider partnership allows for optimal patient health outcomes. Identify your patient care gaps and outreach.

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Improve Your Health Care Measures

- Provide appropriate care within the designated timeframes.
- Know gaps in care prior to patient visit.
- Document clearly and completely ALL the care provided.
- Code accurately.
- Understand HEDIS measures including documentation requirements and parameters.
- Make most of telehealth visits. Prior to telehealth visit, remind patients to take their blood pressure prior to visit, along with temperature, weight, pulse.

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Remote EMR Access

HHO + Provider Partnership

- Quality measurement: reporting and improvement
- Point of care
- Risk score accuracy
- Value-based contract

CONTACT
Clinical Quality Improvement
Su-Linn Zywiol, *Strategy Program Manager*
(302) 317-5939
su-linn.zywiol@highmark.com

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Remote EMR Access and Data Sharing

- Frees providers from manual intervention of providing medical records.
- Monitors patient journey, disease landscape, and effectiveness of therapeutic strategies.
- Identifies gaps in care and unmet member needs.
- Provides info to create programs for member outreach and education.
- Provides info to identify how HHO and providers can help each other.

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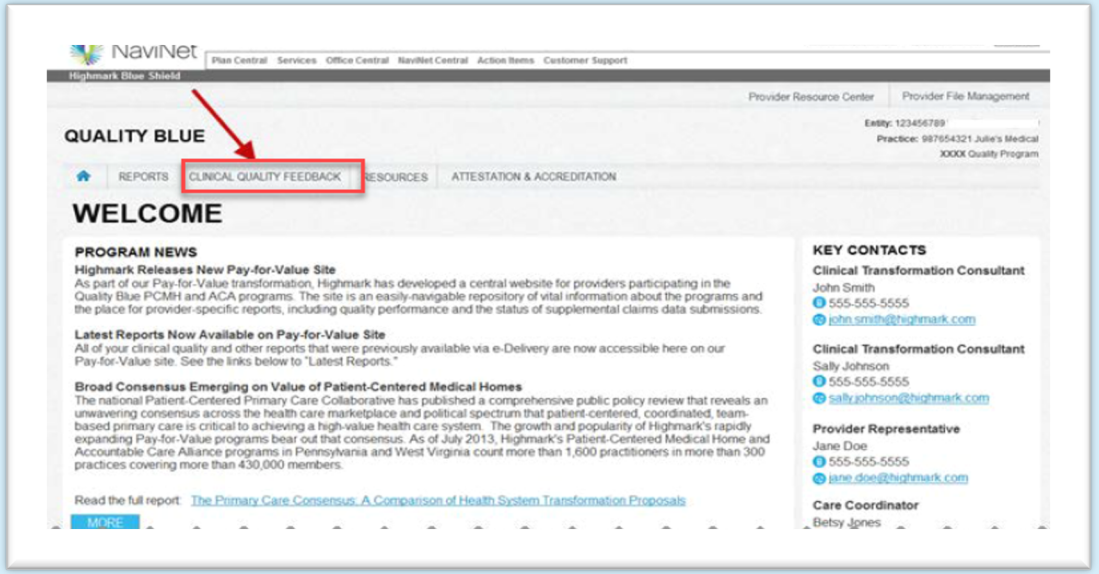
Clinical Quality Feedback (CQF) Loop

- Providers can access CQF through Navinet to submit additional clinical data documentation to supplement what does not appear in Highmark claim data.
- Quality measures include: BCS, CCS, CDC, and more.
- Review the Clinical Quality Feedback Loop



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2021 CQF Loop Updates

- **QN76** Controlling Blood Pressure
  - Providers can submit for HHO members' through CQF.
  - Review CBP Update
- **QN72** Prenatal and Postpartum Care: Timeliness of Prenatal Care
  - Added to list of services in CQF under service "Prenatal Care Visit."

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Current Clinical Initiatives

To help our diabetic members:

- HbA1c Home Kits were mailed to diabetic members in October.
- Providers will receive report of A1c result from our vendor, Home Access.

To help our members get breast cancer screenings:

- DE Breast Cancer Coalition outreaches our members with care gaps.
- Mammogram health campaign state-wide going on now!
  - Bus ads and posters and flyers throughout state.

To help our members reduce their chance of hospital readmission within 30 days of discharge:

- Transition of Care Model implementation currently underway.
- Eye-catching ‘Welcome Home’ card with pertinent discharge information; currently meeting with hospital partners to implement.

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Our Current Clinical Initiatives

To help our asthmatic pediatric members:

- Current and ongoing collaboration with targeted providers with patients identified as filling their rescue medications more often than their asthma controller medications.

To help our hypertensive members:

- Recommend Ivira hypertensive monitoring program. Member will get free cuff and monitoring consultations; Ivira 302-274-0020.
- Member education provided; preparing for virtual visits (report BP to provider).

To help our members with cervical cancer screening care gap:

- Targeted member phone outreach; linking with an OB/GYN if they do not have one. Appointment assistance.

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Provider Medical Record Audit

Medical record standards ensure high quality records.

- Required to ensure quality and completeness of medical records for our members.
- Medical record standards maintained/used to conduct reviews each year on a sample of our providers. Every visit should address:
  - Medical history
  - Medication list & allergies
  - Tobacco/alcohol/drug assessment
  - Plan of action/treatment
  - Follow-up visit
  - Confidentiality statements
  - Signature (electronic) and date

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Utilization Management

HIGHMARK HEALTH OPTIONS

Utilization Management Defined

Utilization Management (UM) is a system for reviewing the appropriate and efficient allocation of Health Care Services that are provided, or proposed to be provided, to a member.

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Contacting UM

- Frontline UM staff are available by phone at 1-844-325-6251, Monday – Friday, 8 a.m. – 5 p.m.
  - Manages the call center, incoming faxes, build the authorization shells
  - Provides an automatic approval authorization without a clinical review in accordance with established guidelines.

	Fax
Home Health Visits (Post Acute &/or ongoing)	855-451-6667
Abortion/Sterilization	855-412-7996
Inpatient (Acute & Post-Acute) & NICU	855-451-6670
Durable Medical Equipment (DME)	855-451-6663
Maternity & PAR Elective Surgery	855-451-6671
Outpatient Therapy	855-451-6664
Hospice and Out of Network (OON) Elective Surgeries &/or Procedures	855-451-6665
Behavioral Health	855-412-7997
Private Duty Nursing	855-445-4239

REMINDER: When sending a fax to the Utilization management department, please send a **separate** FAX for each member instead of submitting one fax packet that includes multiple members.

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New Authorization Format

- The current system generated Authorization # is a Case-8 digit numeric ID created during authorization entry.

Current Authorization Format
Case-12345678

- The new system generated Authorization # will be a 9-digit alphanumeric ID created during authorization entry

New Authorization Format
1013WC8H8

- 1013 = The date the authorization was created
- W = The day of the week (Wednesday)
- C8H8 is system generated

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Behavioral Health

- Highmark Health Options partners with providers, community-based stakeholders, appropriate State-based case management services, and the member to develop care plans that support the member's behavioral wellness.
- The behavioral health UM staff conduct medical necessity reviews for various levels of care that encompass substance recovery care and behavioral health treatment within the least restrictive environment.

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Behavioral Health

- Levels of care managed by the team include:
  - Psychiatric: Institutions for Mental Disease (IMD) and Partial Hospital Program (PHP).
  - Substance Abuse Detoxification.
  - Drug and alcohol services (treatment provided in a residential setting, intensive outpatient programs, inpatient withdrawal management).

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Behavioral Health

- Other behavioral health services include but not limited to:
  - Applied Behavioral Analysis (ABA) therapy.
  - Neuropsychological testing.
  - Transcranial Magnetic Stimulation (TMS).
- Offer provider education and training on InterQual and ASAM criteria:
  - Quarterly ASAM trainings at all SUD facilities.
  - Quarterly IMD/SUD facility meetings.

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Inpatient Services

- The UM team conducts medical necessity reviews for members across several levels of care including:
  - Acute care setting.
  - Skilled Nursing Facility (SNF) for short-term rehabilitation.
    - Covered up to 30 calendar days per year.
  - Acute Rehabilitation.
  - Long Term Acute Care (LTAC).

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Outpatient Services

- The UM Team conducts medical necessity reviews for services including but not limited to:
  - Home Healthcare (Skilled nursing visits, Home Health Aides, PT, OT, ST, SW)
  - Hospice
  - Durable Medical Equipment (DME)
  - Outpatient Therapies (PT, OT, and ST)
  - Chiropractic services
  - Cardiac and Pulmonary Rehabilitation
  - Elective Surgeries
  - Genetic testing
  - Transplants
  - Non-participating provider requests (e.g., office visits, specialists, surgeries etc.)
  - Vision exceptions
  - Dental (bony, impacted wisdom teeth extractions are covered under the member's Highmark Health Options medical benefit)

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Home Health Care

- Home Health is encouraged for members when they're being discharged from an acute or post-acute care facility to decrease risk of readmission and increase compliance with treatment. Your patients – our members – do not need to be homebound to qualify for services.

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Home Health Care

What home services can we provide?

- Highmark Health Options can authorize up to 10 visits per discipline at time of discharge from an in-patient stay:
  - Does your patient need a medication reconciliation?
  - Do they need medication/disease process education?
  - Are you concerned with their home safety environment?

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Durable Medical Equipment (DME)

- DME items that are a covered benefit under $500 do not require a prior authorization.
- Examples include, but are not limited to nebulizers, walkers, cane, or crutches.
- Prior authorization is required for items including, but not limited to continuous glucose monitoring (CGM), prosthetics, orthotics, wound VACs, ventilator, power wheelchairs, hospital beds, support surfaces, customized items, speech generating devices, etc.

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Private Duty Nursing

- Private Duty Nursing (PDN) is a covered benefit.
- Members must meet criteria to qualify for PDN/Home Health Aid (HHA) services.
- Requirements include a letter of medical necessity for PDN/HHA services.

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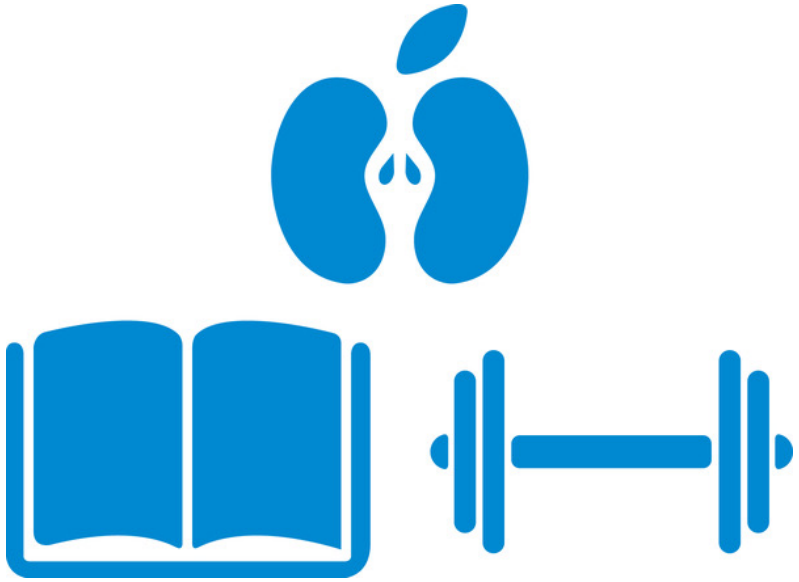
YMCA
Diabetes Prevention Program

HIGHMARK HEALTH OPTIONS

the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY
REDEFINE YOUR HEALTH
TRANSFORM YOUR LIFE
YMCA'S DIABETES PREVENTION PROGRAM

DIABETES PREVENTION PROGRAM



Prevention includes:

- Modest weight loss.
- 30 minutes of physical activity at least 5 days a week.
- Know you numbers- get your blood sugar checked.

EVIDENCE-BASED LIFESTYLE CHANGE PROGRAM

- Reduced the incidence of Type 2 Diabetes by 58% for those 60 years of age and under

- Reduced the number of type 2 Diabetes by 70% in individuals over age 60

1. The Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med. 2002 Feb 7;346(6);393-403

IS PREVENTION WORKING?

[a] Population estimates for 2018 were derived from rates for 2017–2018 applied to July 1, 2018 US resident population estimates from the US Census Bureau (See Detailed Methods).

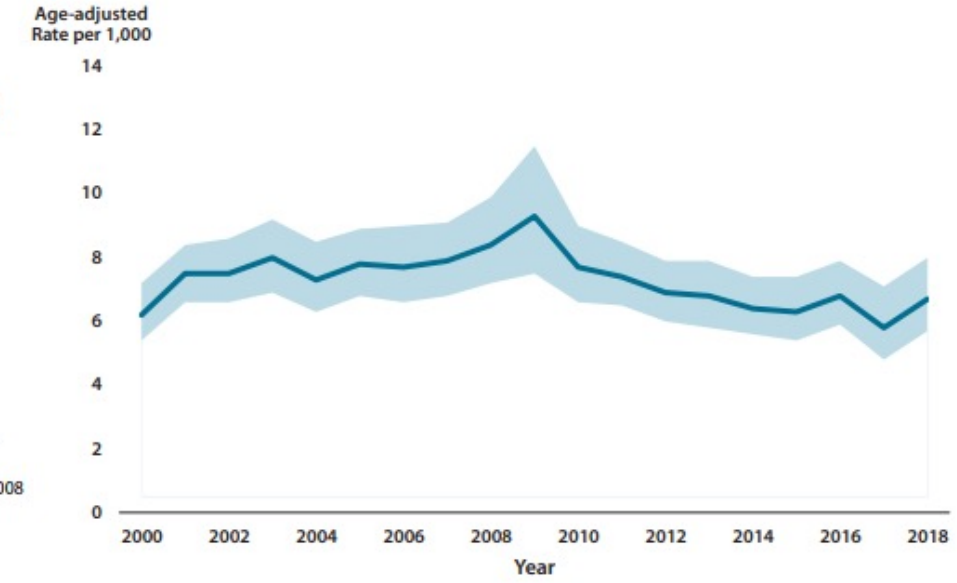
[b] Rates were calculated using 2018 data only.

Data sources: 2017–2018 National Health Interview Survey and 2018 US Census Bureau data.

Trends in Incidence Among Adults

- Among adults aged 18 years or older, the age-adjusted incidence of diagnosed diabetes was similar in 2000 (6.2 per 1,000 adults) and 2018 (6.7 per 1,000 adults). A significant decreasing trend in incidence was detected from 2008 (8.4 per 1,000 adults) through 2018. (Figure 4).

Figure 4. Trends in age-adjusted incidence of diagnosed diabetes among adults aged 18 years or older, United States, 2000–2018



Notes: Data shown are estimated incidence rates (solid blue line) and 95% confidence intervals (shaded). Joinpoint identified in 2008 (See Detailed Methods).

Data source: 2000–2018 National Health Interview Survey.

QUALIFICATIONS

To qualify for the YMCA's Diabetes Prevention Program, participants must meet the following criteria:

- 18 years of age or older
- Not pregnant
- Overweight (BMI ≥ 25; BMI ≥ 23 for Asian individuals)
- Not diagnosed with Type 1 or Type 2 diabetes or ESRD (End Stage Renal Disease)

And have ONE of the following:

- Diagnosed within the last year with prediabetes via a qualifying blood test value*
- Previous diagnosis of gestational diabetes
- Qualifying Risk Score as determined by the risk assessment

DIAGNOSED WITH PREDIABETES

within the last year via qualifying blood values

- A1C: 5.7-6.4%
- Fasting Glucose: 100-125 mg/dL
  - (Medicare beneficiaries 110-125 mg/dL)
- 2-hour plasma Glucose: 140-199 mg/dL
- Prediabetes determined by clinical diagnosis of gestational diabetes (GDM) during previous pregnancy

YMCA'S DIABETES PREVENTION PROGRAM

In a classroom setting, a trained lifestyle coach helps members change their lifestyle by encouraging healthy eating, physical activity, and other behavior modifications over the course of 25 one-hour group sessions

Program Structure:

25 sessions over 12 months

- 16 weekly sessions
- 3 bi-weekly sessions
- 6 monthly

Sessions focus on

- Healthy Eating
- Physical Activity
- Behavior Modification

Primary Goals

- Reduce body weight by 7%
- Participation in 150 minutes of Physical Activity per week

ADDED BENEFITS

- – Up to 4 FREE months of family membership at the YMCA of Delaware (State of the art fitness equipment, youth and adult fitness center, group exercise classes, saunas, swimming pools, babysitting), and an

- – Additional 8 months at 50% off membership fees (with session attendance).

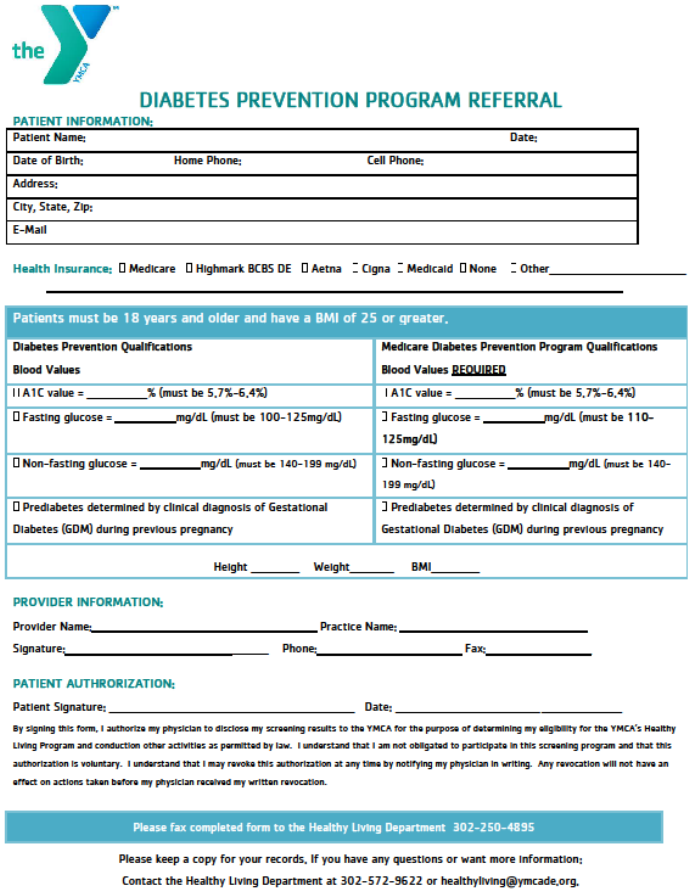
- SAVINGS of up to $850!

INCENTIVES FOR HEALTH CARE PROVIDERS

- Practice with the highest overall referrals will earn a free lunch for the entire practice staff.
- Opportunity for 3 practices to do an in-depth referral project. Practice will receive additional support from the YMCA of Delaware, Quality Insights, and the AMA.

SCREEN, TEST, EDUCATE, & REFER

1. Screen patients for prediabetes risk factors
2. Test glucose values
3. Educate about prediabetes and risk of type 2 diabetes
4. Refer to the YMCA's Diabetes Prevention Program
   - Online referral form
   - Faxed referral form
   - EHR direct message (will require setup)



the YMCA

DIABETES PREVENTION PROGRAM REFERRAL

PATIENT INFORMATION:

Patient Name:		Date:
Date of Birth:	Home Phone:	Cell Phone:
Address:		
City, State, Zip:		
E-Mail		

Health Insurance: ☐ Medicare ☐ Highmark BCBS DE ☐ Aetna ☐ Cigna ☐ Medicaid ☐ None ☐ Other_____

Patients must be 18 years and older and have a BMI of 25 or greater.

Diabetes Prevention Qualifications Blood Values	Medicare Diabetes Prevention Program Qualifications Blood Values REQUIRED
☐ A1C value = _____% (must be 5.7%–6.4%)	☐ A1C value = _____% (must be 5.7%–6.4%)
☐ Fasting glucose = _____mg/dL (must be 100–125mg/dL)	☐ Fasting glucose = _____mg/dL (must be 110–125mg/dL)
☐ Non-fasting glucose = _____mg/dL (must be 140–199 mg/dL)	☐ Non-fasting glucose = _____mg/dL (must be 140–199 mg/dL)
☐ Prediabetes determined by clinical diagnosis of Gestational Diabetes (GDM) during previous pregnancy	☐ Prediabetes determined by clinical diagnosis of Gestational Diabetes (GDM) during previous pregnancy

Height _____ Weight_____ BMI_____

PROVIDER INFORMATION:

Provider Name:_____ Practice Name: _____

Signature:_____ Phone:_____ Fax:_____

PATIENT AUTHRORIZATION:

Patient Signature: _____ Date: _____

By signing this form, I authorize my physician to disclose my screening results to the YMCA for the purpose of determining my eligibility for the YMCA's Healthy Living Program and conduction other activities as permitted by law. I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

Please fax completed form to the Healthy Living Department 302-250-4895

Please keep a copy for your records, If you have any questions or want more information:
Contact the Healthy Living Department at 302-572-9622 or healthyliving@ymcade.org.

CONTACT INFORMATION

Kat Luebke
Community Health Integration Program Director

kluebke@ymcade.org
Office: 302-472-6769
Fax: 302-250-4895

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

HIGHMARK HEALTH OPTIONS

What is EPSDT?

- The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
- EPSDT ensures that children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services.

Early
Periodic
Screening
Diagnostic
Treatment

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EPSDT Requirements

- An EPSDT visit is considered complete when all age-appropriate screenings are completed, including immunizations, according to the American Academy of Pediatrics Bright Futures Periodicity schedule and then billed properly to the MCO.

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EPSDT Program

- Federal requirements mandate that all State Medicaid plans ensure that their members are provided “health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered.”

Vision	Hearing	Dental	Medical	Behavioral	Other
YV	YH	YD	YM	YB	YO

- HHO is committed to ensuring our members receive a comprehensive evaluation for any issues identified, followed by the appropriate treatment in a timely manner. In order to accomplish this, we require the coding of any referrals made during a visit be placed on the claim.

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EPSDT Program

- Our highly trained and skilled care coordination staff will outreach to members that you refer to see a specialist if there is not a claim on file within 90 days of the date of your referral.
- We will help with locating an in-network specialist, coordinating transportation, and any other potential issue the member may be experiencing.

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EPSDT Team

Provider Education

- EPSDT coordinator tracks and monitors trends in EPSDT dashboard (Tableau with information from claims PCP attribution).
- EPSDT guidelines: Bright Futures Periodicity Schedule.
- EPSDT coding.

Member Outreach

- Resource coordinators outreach to members with care gaps.
- Assist with transportation and community resources.

Kim York, LCSW, CCM
Supervisor, Clinical Quality Management
EPSDT Coordinator
302-317-5944

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Delaware Health Advisory #463

- A recent review of Delaware childhood blood lead testing data reveals 54% drop in the first six months of 2020 compared to 2019.
- 63% drop in the first six months of 2021 compared to 2019.
- Testing required at ages 12 and 24 months.

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Section 3

Contacting Provider Services

Provider Services

Provider Services is the first line of communication for provider questions and inquiries. Provider Services can be reached through multiple methods:

- 1-844-325-6251, Monday through Friday, 8 a.m. – 5 p.m.
- hho-depsresearch2@highmark.com

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Provider Relations

Desiree Charest
Provider Account Liaison
Serving Sussex County, City of Milford
Desiree.Charest@highmark.com
302-217-7991

Christina Hales
Provider Account Liaison
Serving New Castle County
Christina.Hales@highmark.com
302-421-2542

Samantha Jenkins-Witt
Provider Account Liaison
Serving All Counties and Ambulatory Surgery Centers
Samantha.JenkinsWitt@highmark.com
302-535-3221

Terri Krysiak
Provider Contract Analyst
PR Representative, Behavioral Health
Terri.Krysiak@highmark.com
302-502-4054

Michael Stewart
Provider Account Liaison
Serving All Counties and Ancillary Strategy
Michael.S.Stewart@highmark.com
302-416-7677

Paula Victoria
Manager, Provider Relations
Paula.Victoria@highmark.com
302-502-4083

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Provider Contracting

Melanie Anderson
Director, Provider Networks
Melanie.Anderson@highmark.com
302-502-4072

Paula Brimmage
Sr. Provider Contract Analyst
Paula.Brimmage@highmark.com
302-433-7709

Kim Hammond
Sr. Provider Contract Analyst
Kim.Hammond@highmark.com
302-421-2098

Kia Knox
Provider Contracting Consultant
Kia.Knox@highmark.com
302-502-4041

Terri Krysiak
Provider Contract Analyst
PR Representative, Behavioral Health
Terri.Krysiak@highmark.com
302-502-4054

Provider Complaints (Excludes claims)
HHO-ProviderComplaints@highmark.com
844-228-1364
Fax: 844-221-1569

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More Helpful Resources

- Highmark Health Options – highmarkhealthoptions.com
- Highmark Provider Resource Center – hdebcbs.highmarkprc.com
- Community Support – hmhealthoptions.findhelp.com
- Prior Authorizations for Cardiology and Radiology – evicore.com
- Member Advocates – 1-855-430-9852, hho-dememberadvocate@highmark.com

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Section 4

Open Forum

HIGHMARK HEALTH OPTIONS