A Newsletter for
Highmark Health Options
Providers and Clinicians

PROVIDER UPDATE

HIGHMARK® Delaware HEALTH OPTIONS

INSIDE THIS ISSUE

DECEMBER 2017

PROVIDER UPDATE

HIGHMARK. Delaware HEALTH OPTIONS

Table of Contents

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••• CLINICAL

COORDINATING CARE BETWEEN PHYSICAL AND BEHAVIORAL HEALTH

The Importance of Collaboration and Coordination in Physical and Behavioral Health Care

Mental health is essential to everyone's overall health and well-being. More than 68 percent of adults with a mental illness have also been diagnosed with at least one chronic medical condition. Conversely 29 percent of adults with chronic medical conditions have also been diagnosed with a mental health disorder. The pathways causing comorbidity are complex and bidirectional.

Chronic physical health conditions can lead to mental health conditions. Some physical health conditions and medications may cause symptoms related to mental illness. Thyroid disorders, diabetes, Parkinson's disease, multiple sclerosis, strokes, tumors and some viral infections may cause symptoms of depression. Medications can also cause symptoms of depression. This includes some medications used to treat blood pressure and arthritis as well as hormone therapy may. Corticosteroid use can be associated with symptoms of psychosis and mania. A diagnosis of a serious or terminal illness, a serious accident, chronic physical pain, abuse of any type, as well as alcohol or drug use can result in depression. Patients will often seek medical attention for symptoms including headaches, fatigue, pain or gastrointestinal problems. However, these somatic symptoms often overlap with symptoms of depression and anxiety making an appropriate diagnosis challenging.

Mental health disorders can also place a person at risk for certain medical conditions. For example antipsychotics used to treat bipolar disorder and schizophrenia can cause metabolic disorders resulting in the development of diabetes. Individuals with mental and substance use disorders are also less likely than individuals in the general population to receive preventive services such as immunizations, cancer screenings, and smoking cessation counseling placing them at greater risk for developing more serious health conditions and related complications due to the lack of early detection. In addition individuals with mental illness also may have poor interpersonal skills which negatively affects their ability to collaborate with their medical providers.

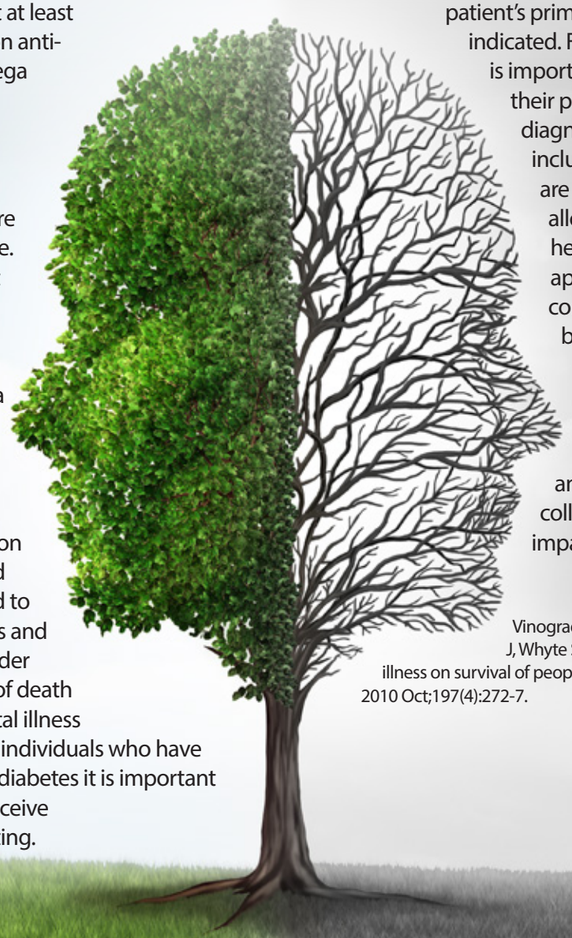
As a result it is important that we address the needs of all of our members from the perspective of positively impacting the mind and body as when one begins to fail there is a greater likelihood that the other will become impacted. This can be supported by care collaboration and coordination by having members sign consents to release information between physical and behavioral health providers.

Druss, B.G., & Reisinger Walker, E. (2011, February). The Synthesis Project. *Mental disorders and medical comorbidity.* Retrieved May 09, 2017, from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1

THE IMPORTANCE OF DIABETES SCREENING FOR INDIVIDUALS WITH SCHIZOPHRENIA OR BIPOLAR DISORDER

Diabetes screening is important for anyone with schizophrenia or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen people with schizophrenia for diabetes annually. Members 18 to 64 years of age with schizophrenia or bipolar disorder and who are dispensed an antipsychotic medication should have a diabetes screening test at least once a year. Second generation anti-psychotics such as Abilify, Invega and Seroquel can cause side effects such as weight gain, increased blood sugar levels and increased triglycerides. These risk factors combined are known as metabolic syndrome. This is a serious condition that can lead to heart disease, diabetes and stroke. As a result diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed an antipsychotic medication is recommended. Routine diabetes screening may lead to earlier identification and treatment of diabetes and reduced complications related to diabetes. People with diabetes and schizophrenia or bipolar disorder have a 50 percent higher risk of death than diabetics without a mental illness (Vinogradova et al., 2010). For individuals who have already been diagnosed with diabetes it is important that they be encouraged to receive on-going routine diabetic testing.

The known physical health risk for complication as a result of treatment for behavioral health related diagnosis promotes the need for physical health- behavioral health coordination and collaboration. For behavioral health providers it is important that they ensure patients being prescribed anti-psychotics receive the recommended testing and necessary follow up with the patient's primary care provider if indicated. For primary care providers it is important that they are aware of their patient's behavioral health diagnosis and treatment plan including any medications that are being prescribed. This will allow for needed physical health intervention and appropriate care planning considerations. Physical and behavioral health providers are encouraged to obtain member consent to share health information and care plans with one another to promote care collaboration and positively impact member health.



Vinogradova Y, Coupland C, Hippisley-Cox J, Whyte S, Penny C. Effects of severe mental illness on survival of people with diabetes. Br J Psychiatry. 2010 Oct;197(4):272-7.

IMPROVING THE OFFICE VISIT EXPERIENCE THROUGH EFFECTIVE COMMUNICATION

Effective patient-provider communication is critical because it can help the patient feel that they have a stronger relationship with their provider, understand health information given to them, feel empowered to help make their own health care decisions, and have better health outcomes.[1,2] Ineffective patient-provider communication can lead to poor patient health outcomes and patients choosing to leave their provider. One study found that approximately 20% of patients who leave their providers do so because of poor patient-provider communication, relationships, and interactions.[3]

"Even though a clinician explains a diagnosis, test result, or treatment option to a patient, if the person walks away and does not understand the explanation, it has not been an effective communication"[1]

At Highmark Health Options, we want to ensure patients and providers have the best experience during an office visit. While we educate our members to ensure they come prepared to their doctor's visit, we also want to take this opportunity to suggest some strategies that providers can use to more effectively communicate with their patients. Some items providers may want to consider when holding discussions with their patients are:

- ***Avoid using complicated medical terms.*** If you do need to use medical terms, be sure to explain it in a simple and easy to understand manner. Many patients have minimal health care knowledge.
- ***Take your time and speak slowly.*** It may take patients longer to process medical information, especially if the subject is new to them.
- ***Use the teach-back method.*** Often when patients are asked, "Do you understand?" they respond with, "Yes" even though they actually don't understand. Ask your patient to repeat what they have learned back to you.
- ***Provide additional resources.*** Some patients have trouble understanding verbal instructions. Offer them visuals such as brochures or internet resources they can review at home and at their own pace. If applicable, you may even want to provide a demonstration.
- ***Listen to your patient.*** Part of effective communication is hearing and attentively listening to what your patient has to say.
- ***Always be respectful.*** All patients have different educational and cultural backgrounds.
- ***Encourage your patient to play an active role in decisions about their health care.*** Discuss both the benefits and disadvantages of tests, medications, or treatments. Ask the member what they think is the best option for them when it comes to these tests, medications, or treatments.

[1] Retrieved from https://www.ahrq.gov on October 25, 2017
[2] Ha JF, Longnecker N. Doctor-Patient Communication: A Review. *The Ochsner Journal*. 2010;10(1):38-43.
[3] Safran DG, Montgomery JE, Chang H, et al. Switching doctors: predictors of voluntary disenrollment from a primary physician's practice. *J Fam Pract* 2001;50(2):130-6.

NEW IN 2018: CHIROPRACTIC CARE

Effective, Jan. 1, 2018, patients will be eligible to receive a maximum of one manual manipulation per member per day and a maximum of 20 manual manipulations per member per calendar year. This includes:

- One X-ray or PART exam per member per year to diagnose spinal subluxation
- One PART exam per member per year to determine progress; PART exams may be conducted more frequently if determined medically necessary by the Contractor
- X-rays may be used to determine progress if determined medically necessary by the Contractor
- Includes manipulation and adjunctive therapy associated with the treatment of neck, back, pelvic/sacral pain, extra-spinal pain and/or dysfunction and for chiropractic supportive care
- Does not include treatment for any condition not related to a diagnosis of subluxation or neck, back, pelvic/sacral or extra-spinal pain and/or dysfunction

PHARMACEUTICAL PREFERENCES AND RESTRICTIONS

Highmark Health Options follows the preferred drug list (PDL) of Delaware's Division of Medicaid & Medical Assistance, DMMA.

There are additional non-PDL medications (e.g., OTCs) included as covered for our members as well. The complete list can be found at https://highmarkhealthoptions.com/providers/drugcoverage. Prescribers can browse the Drug Formulary alphabetically, OR search by either the brand or generic name of a medication. Prescribers can also search within the therapeutic class of a medication to find a preferred medication.

The Highmark Health Options Drug Formulary is updated on a regular basis. Formulary changes reflect the evaluations and decisions made by the DMMA Pharmaceutical and Therapeutics (P&T) Committee and by the Highmark Health Options P&T Committee.

The most current version of the Drug Formulary and Formulary Updates can be accessed on the website listed above.

Some of the medications require prior authorization, have a quantity limit, must be dispensed by a specialty pharmacy or require step therapy. These medications are marked with a symbol under the Notes & Restrictions column.

Prior Authorization: A medication benefit that is approved once established criteria are met. The criteria are medication specific and may be based on FDA and manufacturer guidelines, medical literature, national compendia, safety, appropriate use and benefit design. A prior authorization may be established to address appropriate utilization due to patient safety concerns, limited indications and potential for misuse/abuse.

Step Therapy: A process which allows for utilizing the safest and most cost effective medication first, before moving to another more costly treatment if necessary. This process allows for a preferred agent to be tried first unless documentation supports therapeutic failures or contraindications of preferred agents in the same therapeutic class.

Quantity Limits: Quantity limits of medications include once daily medications and the maximum limit recommended by the Food and Drug Administration (FDA) approved dosing and medical literature. Quantity limits are put in place to ensure members do not receive a quantity greater than the recommended limit (monthly or yearly FDA recommendations).

Generic Substitution: Highmark Health Options will follow DMMA's generic substitution policy regarding mandatory generic substitution. If a generic equivalent product is available, the generic will be covered and the brand name product will be non-formulary, except in the event that DMMA or Highmark Health Options considers a brand name product preferred over its generic equivalent. The PDL and Supplemental Formulary will identify the situations where a brand product is preferred over its generic equivalent(s).

Therapeutic Interchange: Only when indicated by a licensed practitioner's prescription are pharmacies permitted to switch a member from a non-formulary medication to a formulary medication (therapeutic interchange). Highmark Health Options does not provide any financial or other incentive to a pharmacist to encouraging the practitioner to change his/her prescription order.

Members and practitioners have the right to request an exception for a non-formulary medication.

A prescriber may request a prior authorization for a medication by completing and submitting the Highmark Health Options Medicaid Drug Exception Form.

2017 HEDIS AUDIT RESULTS

Every year, NCQA-accredited health plans conduct a HEDIS® (Healthcare Effectiveness Data and Information Set) audit to measure performance against industry benchmarks. The audit uses a wide variety of indicators covering effectiveness of care, medication management, utilization management, preventative screenings, and more. The final results are analyzed annually, trended over time, and compared to other health plans nationwide.

The 2017 HEDIS audit resulted in several rates surpassing the NCQA 75th percentile. Some of these measures include:

- Adults' Access to Preventative/Ambulatory Health Services
- Chlamydia Screening in Women
- Identification of Alcohol and Other Drug Services

The audit also showed in several measures performing below expectations, thereby resulting in opportunities for improvement. Some of these measures include:

- Comprehensive Diabetes Care
- Postpartum Care
- Cervical Cancer Screenings

Highmark Health Options, after reviewing the final results, has developed several initiatives to positively impact the rates of various measures. In addition to targeted member outreach and internal collaboration, Highmark Health Options has hired additional staff, enhanced provider education, and has put several new processes in place in the Member Services department. We are hopeful that these changes will not only improve HEDIS rates, but also make a positive impact on our customers and their experience as members of Highmark Health Options.

UNDERSTANDING CAHPS

Every year, a sample of members are asked to complete a member satisfaction survey. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks members a variety of questions related to their experience with Highmark Health Options and their providers. Three separate CAHPS surveys are completed annually to assess member satisfaction for the adult, child, and CHIP populations. Survey questions are combined to form the following categories:

- Getting Needed Care
- Getting Care Quickly
- Customer Service
- How Well Doctors Communicate
- Coordination of Care
- Shared Decision-Making
- Health Promotion and Education

Members are then asked to rate their health care, health plan, personal doctor, and specialist on a scale from one to ten. The responses allow us to focus resources on underperforming areas and make improvements where needed. The 2018 CAHPS survey will be mailed to members in the 1st quarter of 2018.

ALL PROVIDER TYPES

NOTIFIABLE DISEASES AND CONDITIONS

The State of Delaware requires providers to report certain diseases, infections, conditions and outbreaks such as, but not limited to, chicken pox, lead poisoning, Lyme disease, and mumps[1]. A full listing of notifiable diseases can be found at http://dhss.delaware.gov/dph/dpc/rptdisease.html , along with how to report and identify rapidly reportable conditions that require immediate contact to the Delaware Division of Public Health.

[1] Delaware Administrative Code, 16 DE Admin Code 4202 Control of Communicable and Other Disease Conditions, Section 2.0

QI/UM WORK PLAN

The Highmark Health Options' Quality Improvement/Utilization Management (QI/UM) Program's purpose is to assure quality, safety, appropriateness, timeliness, availability, and accessibility of care and services provided to Highmark Health Options members. The comprehensive evaluation and assessment of clinical, demographic, and community data in conjunction with current scientific evidence is paramount to meet the identified needs.

The goal of the QI/UM Program is to ensure the provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality health plan services. The QI/UM Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Highmark Health Options health care provider network and the effectiveness and efficiency of systems and processes that support the health care delivery system. The QI/UM Program is assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI/UM Program objectives.

As a participating provider, Highmark Health Options asks that you cooperate with Quality Improvement activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various Quality Improvement initiatives and programs, and allowing the plan to use and share your performance data.

Implementation and evaluation of the QI/UM Program is embedded into Highmark Health Options daily operations. The QI/UM Program has available and uses appropriate internal information, systems, practitioners, and community resources to monitor and evaluate use of health care services, the continuous improvement process, and to assure implementation of positive change.

The scope of the Program includes the following, but not all:

- Enrollment
- Members' Rights and Responsibilities
- Network Accessibility and Availability, including those related to Special Needs
- Network Credentialing/Recredentialing
- Medical Record Standards
- Claims Administration
- Clinical Outcomes
- Patient Safety
- Preventive Health, Disease Management, Long-Term Services and Support (LTSS)
- Continuous Quality Improvement using Total Quality Management Principles

To request a copy of the complete Quality Improvement Program, Work Plan, or Annual Evaluation, please contact Highmark Health Options Provider Services Department at 1-844-325-6251.

WHAT HIGHMARK HEALTH OPTIONS DOES WITH MEMBER INFORMATION

Highmark Health Options protects medical and non-public personal information obtained from its members as required according to the HIPAA Privacy and Security Rules (45 CFR, Parts 160 and 164). This protection extends to verbal, written, and electronic communications. While member information must be made available to healthcare professionals in order to enable proper care, timely payment and reimbursement, our employees are trained to follow strict guidelines to authenticate callers prior to the release of information and to avoid disclosing more information than what is needed to accomplish a particular task. We want our providers to be aware that the HIPAA guidelines also permit healthcare providers to use or give out member medical information in some instances without the need for a written authorization from the member. Some of these instances may include:

- To contact members about new or changed benefits
- To avoid a serious and likely threat to health or safety
- For public health activities (such as reporting disease outbreaks)
- For government healthcare oversight activities (such as fraud investigations)
- For judicial and administrative proceedings (such as in response to a court order)

Under HIPAA guidelines, Highmark Health Options may collect non-public information about its members. An example of this is contact information provided on an enrollment application. Highmark Health Options does not permit the release of non-public information unless required or permitted by law, or if granted permission to do so. Additionally, in January 2013, the Department of Health and Human Services (HHS) released the new Omnibus Rule, which amended a wide range of privacy, security, and breach notification requirements under HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act. The effective date of changes was September 23, 2013. To learn more about how Highmark Health Options uses or discloses member information, please visit us online at www.highmarkhealthoptions.com to view the "Notice of Privacy Practices." To request a paper copy of the notice, please contact our Member Services department at 1-844-325-6251.

OFFICE STAFF

SECOND OPINIONS

Highmark Health Options ensures member access to second opinions. Second opinions may be requested by Highmark Health Options, the member, or the PCP. Highmark Health Options will provide for a second opinion from a qualified health care provider within the network or arrange for the member to obtain one outside the network, at no cost to the member. The second opinion specialist must not be in the same practice as the attending physician and must be a participating provider. Out of network referrals may be authorized when no participating provider is accessible to the member or when no participating provider can meet the member's needs.

PEER REVIEW INFORMATION

Highmark Health Options offers providers the opportunity for peer reviews whenever a medical necessity decision is made to deny or reduce a service. The Utilization Management Nurse phones the ordering or attending physician's office to review the details of the request and the physician's decision. The nurse will provide the Highmark Health Option's physician name and a phone number so that you have the opportunity to discuss the decision, including the reason you believe the service is medically necessary. When calling the Highmark Health Options physician, please have the following information readily available to ensure a timely discussion with the appropriate physician:

- Name of the Highmark Health Options physician to whom you were directed to speak
- Member information, including the Highmark Health Options identification number and/or authorization number

2017 PROVIDER SATISFACTION SURVEY RESULTS

Earlier this year, Highmark Health Options conducted its first survey of provider satisfaction with our services, including contracting and claims processes, as well as their satisfaction with the adequacy, effectiveness, and quality of the network. Specialties in the survey sample included primary care physicians (PCPs), specialty care providers, and behavioral health providers.

Overall, providers gave us favorable scores for recommending the Plan to other physician practices. Additionally, providers offered positive scores for overall satisfaction with Highmark Health Options, and, behavioral health providers gave good scores for our Plan compared to all other contracted plans. Survey results also assisted in targeting areas needing improvement such the prescription drug formulary and quality of the provider orientation process. If you would like a Summary of the survey results, please call Provider Services at 1-844-325-6251. You can also view the Summary on the Provider Portal.

Highmark Health Options continually strives to meet and exceed the needs of our provider network. We are actively working to address your recommendations and areas for improvement. Look for future updates about our progress to be communicated in this newsletter.

OFFICE STAFF

PATIENT WAIT TIME AFFECTS MEMBER SATISFACTION

When patients wait long periods of time to get an appointment, wait in the waiting room, or for test results, patient satisfaction goes down, no show rates increase, and patients become less likely to comply with doctors' orders. As a result, patient care suffers and healthcare professionals waste time with rework and redundancy.

Tips For Reducing Wait Time

There are several approaches to help reduce wait time for scheduling appointments. Here are a few recommended changes from the Institute of Healthcare Improvement Organization to consider:

1. Measure supply and demand over a long period of time in order to anticipate future highs and lows.
2. Reduce and eliminate backlog by first measuring the backlog, and then creating and using a deliberate backlog reduction plan.
3. Use alternatives to one-on-one visits.
4. Telephone consults
5. Reduce future work (in many cases, eliminating the need for extra appointments) by doing as much for the patients while they are the office for a given visit.
   a. Look for any patient who is also on the schedule for a future date and address future needs during the first visit.
   b. Use a preventive care checklist to anticipate patients' future needs and take care of them during today's visit whenever possible.

Visit IHI.org for more information on reducing wait times for appointments.

ENVIRONMENTAL ASSESSMENT STANDARDS FOR HIGHMARK HEALTH OPTIONS OFFICE SITES

Highmark Health Options has established specific guidelines for evaluating both the external and internal aspects of a practitioner's office. An Environmental Assessment (EA) is conducted based on member complaints and monitoring for subsequent deficiencies. In addition, for our participating Medicaid practices an EA is conducted as part of the initial credentialing process for all primary care practitioners and dental practitioner office sites.

The standards reviewed address the following areas:

- Physical Accessibility
- Physical Appearance
- Adequacy of waiting and examining room space
- Availability of Appointments
- Adequacy of treatment record keeping

The following performance standards have been established:

- 80% compliance for all site visit standards
- 80% compliance for medical record keeping standards

Any office found to have deficiencies will be required to develop an action plan and bring the office into compliance within 90 days.

A Provider Relations Representative will re-review the physician office to assure ongoing compliance with the standards has been obtained. Highmark Health Options reviews member complaints on a monthly basis to determine if there are issues with the practice site regarding EA standards. If deficiencies are noted the Provider Relations Representative will schedule another site visit to bring the office back into compliance. The same process is followed when a Quality Improvement Nurse notifies Provider Relations of an office deficiency.

If you have any questions regarding the EA Standards or site visit process, please contact your Provider Relations Representative. A copy of the Highmark Health Options EA Standards is also available on the Highmark Health Options website at https://highmarkhealthoptions.com/sites/default/files/Medicaid_provider_manual.pdf; section 5.4 of the current Provider Manual.

HOURS OF OPERATION

Please remember – Highmark Health Options has a requirement that our Provider's hours of operations for their Medicaid patients are expected to be no less than what your practice offers to commercial members. Please reference your provider contract and Highmark Health Options procedure manual regarding provider availability and accessibility.

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Highmark Health Options utilization management (UM) decisions are based only on the appropriateness of care and services and the member's existence of coverage. Highmark Health Options does not specifically reward practitioners or other individuals for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Highmark Health Options monitors for both over-and under-utilization of care to prevent inappropriate decision making, identify causes, and indicate inadequate coordination of care or inappropriate use of services, possibly resulting in the development of a corrective action. Highmark Health Options is particularly concerned about under-utilization and monitors utilization activities to assure members receive all appropriate and necessary care.

NEW FRAUD SCHEME

Fraud affects all of us and it is a major concern for Highmark Health Options. Fraud impacts the health and welfare of our members and increases health care costs. That's why Highmark Health Options takes a proactive approach in detecting and investigating potential health care fraud, waste and abuse. Our Payment Integrity Department is tasked with investigating all cases of health care fraud, but your help is needed. A few examples of fraud are:

- A member using another person's health insurance card
- A provider billing for services or items that a patient did not receive
- Altering receipts, claims, or prescriptions

If you suspect fraud, waste, or abuse relating to a provider, member, or employee, you should report the issue to Highmark Health Options by calling our Fraud Hotline at 1-844-325-6256. Your call will be kept confidential and you can remain anonymous when reporting if you chose. You can also view more information about fraud, waste, and abuse on our website at www.highmarkhealthoptions.com under *Fraud and Abuse* at the bottom of the home page.

COMPLIANCE WITH HIGHMARK HEALTH OPTIONS POLICIES

Highmark Health Options has policies in place to make sure that the care and services our members get are what they need. As a valued partner, both practitioners and providers need to know what these policies are as well.

Examples of some policies may be:

- Time limits for having copies made of a member's medical record
- Protecting member privacy
- Responsibilty of Specialists to provide written correspondence to the Primary Care Practitioner for continuity and coordination of care.

There are some special services that need to be authorized by Highmark Health Options before the service is provided. The Highmark Health Options member must seek authorization for the services listed below:

- Non-emergency Ambulance Services, except for trips for dialysis
- Chiropractic Treatment
- Durable Medical Equipment, (such as wheelchairs) Orthotic and Prosthetic Devices and Medical Supplies (more than $500)
- Scheduled Hospital Admissions
- Hospital Admissions for Acute Medical, Rehabilitation, Behavioral Health, Substance Abuse or Long Term Acute Care
- Home Health Visits
- Home Infusion
- Outpatient CT Scans, MRI/MRA, Nuclear Cardiology Tests and Pet Scans
- Non-Participating Providers
- Certain Outpatient Services/Surgery
- Outpatient Neuropsychiatric and Psychiatric Testing
- Electroconvulsive (ECT) Therapy
- Outpatient Rehabilitation Services (Occupational, Cardiac, Physical, Speech and Language Therapy)
- Skilled Nursing Facility Care

If a Highmark Health Options member has a legitimate medical emergency requiring immediate medical attention in order to prevent death, loss of a limb or function of a limb, they should go to the nearest emergency room (ER). Some possible examples of an emergency are uncontrollable bleeding, chest pain or sudden confusion and slurred speech. In these situations, the member does not need to get approval from their PCP. As soon as possible, they should tell you about their emergency. If the member is not sure if they have a medical emergency, the member should call you to help determine if their care can best be handled in your office or the ER. All PCPs and Specialists are required to have coverage in the evenings and on weekends. This may be through an answering service or an on-call doctor.

If you have any questions about Highmark Health Options policies, please call the Provider Services Department at 1-844-325-6251.

PROVIDER RELATIONS CONTACTS

Below is a listing of the various contacts within Highmark Health Options provider networks.

Provider Relations:

Paula Victoria
Manager, Provider Relations, LTSS
PVictoria@Highmarkhealthoptions.com
302-502-4083

Andrea Thompson - New Castle County
Provider Account Liaison
**includes servicing of LTSS Providers*
AThompson@Highmarkhealthoptions.com
302-502-4024

Chandra Freeman - Kent County and City of Newark
Provider Account Liaison
**includes servicing of LTSS Providers*
CFreeman@Highmarkhealthoptions.com
302-502-4067

Tracy Sprague - Sussex County
Provider Account Liaison
**includes servicing of LTSS Providers*
TSprague@Highmarkhealthoptions.com
302-502-4120

Chanel Bailey
Senior Provider Contracting Executive
CWalker-Bailey@Highmarkhealthoptions.com
302-502-4154

Elsa Honma
Provider Contract Analyst, LTSS
EHonoma@Highmarkhealthoptions.com
302-317-5967

Melanie Anderson
Director, Provider Networks
MAnderson@Highmarkhealthoptions.com
302-317-5967

Ancillary Strategy:

Katrina Tillman
Provider Contract Analyst – Behavioral Health
KTillman@Gatewayhealthplan.com
302-528-4871

Laura Gudenburr
Provider Contract Analyst – Free Standing PT/OT/ST; Free Standing Radiology; Urgent Care; Ambulatory Surgery Center; Walk-In Clinics
LGudenburr@Gatewayhealthplan.com
412-420-6465

Rick Madey
Provider Contract Analyst – DME
RMadey@Gatewayhealthplan.com
412-918-8554

Julia Donohue
Provider Contract Analyst – Dialysis; Lab and Audiology
JDonohue@Gatewayhealthplan.com
412-420-6467

HIGHMARK Delaware
HEALTH OPTIONS

HIGHMARK HEALTH OPTIONS CONTACT INFORMATION

Our website, www.highmarkhealthoptions.com, provides up-to-date information.

IMPORTANT ADDRESSES	
OFFICE LOCATION	Highmark Health Options 800 Delaware Avenue Wilmington, DE 19801
MEMBER CORRESPONDENCE	Highmark Health Options – Member Mail P.O. Box 22188 Pittsburgh, PA 15222-0188
PROVIDER CORRESPONDENCE	Highmark Health Options – Provider Mail P.O. Box 22188 Pittsburgh, PA 15222-0188

TELEPHONE NUMBERS AND HOURS OF AVAILABILITY		
DEPARTMENT	**CONTACT NUMBER**	**HOURS**
Provider Services	1-844-325-6251	Mon. – Fri., 8 a.m. to 5 p.m.
Member Services	1-844-325-6251	Mon. – Fri., 8 a.m. to 8 p.m.
Member Services (DSHP Plus)	1-855-401-8251	Mon. – Fri., 8 a.m. to 8 p.m.
Authorizations	1-844-325-6251	Mon. – Fri., 8 a.m. to 5 p.m. (24/7 secure voicemail for inpatient admissions notification)
Care Management/Long Term Services and Support (LTSS)	1-844-325-6251	Mon. – Fri., 8 a.m. to 5 p.m. (after hours support accessible through the Nurse Advice Line)
Member Eligibility Check (IVR)	1-844-325-6161	24/7
Behavioral Health	1-844-325-6251	Mon. – Fri., 8 a.m. to 5 p.m.

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