HIGHMARK HEALTH OPTIONS

Quarterly Update for Providers

Spring 2023

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Use these strategies to identify patients' health-related social needs.

Learn about the new Free Market Health Specialty Pharmacy Management Program.

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Contact us.

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

Write for the brand Narcan when prescribing naloxone.

When prescribing naloxone for a Highmark Health Options member, write for the brand Narcan.

Brand Narcan is listed as the preferred agent on the 2023 Preferred Drug List (PDL) for the State as well as at the managed care organizations (MCOs).

Highmark Health Options follows the Delaware State PDL, which has been established by Division of Medicaid and Medical Assistance (DMMA). This PDL is a comprehensive list of medications that have been carefully selected based on their safety, efficacy, and cost-effectiveness, and are preferred for coverage by the MCOs in the state.

If you need help processing a claim, call Provider Services at 844-325-6251.

Provider satisfaction survey results are in.

Ninety-seven percent of Highmark Health Options (HHO) providers surveyed would recommend HHO to other physician practices.

The provider satisfaction survey measures provider satisfaction with HHO. Information obtained from the survey allows HHO to measure how well we are meeting providers' expectation and needs.

HHO's goal is for all measures to rank in the 75th percentile and above.

Measures	Provider Percentile	Hospital/Ancillary Percentile
Would Recommend	97th	100th
Overall Satisfaction	91st	87th
Network/Coordination of Care	89th	76th
Finance Issues	88th	78th
Health Plan Call Center Service Staff	88th	68th
Utilization & Quality Management	87th	63rd
All Other Plans	86th	85th
Provider Relations	72nd	85th
Pharmacy	61st	97th

Note: To determine the percentile, measure summary rates are compared to the 2021 SPH Medicaid Book of Business which is made up of 86 Medicaid plans.

Earn prizes by participating in Risk Revenue's new competition.

Here are the PGC program competition winners.

Last August, Highmark Health Options launched a competition between Risk Adjustment program participants to reward providers for improving their addressed rate for risk gaps. Practice groups were grouped in tiers by total membership.

Family Medicine at Greenhill: Winner for practices with up to 1,000 total members.

Family Medicine at Greenhill increased their gaps-addressed rate by 12.4%. Their practice received HHO stainless steel water bottles for their accomplishment and participation.

Total Care Physicians: Winner for practices with up to 2,000 members.

Total Care Physicians increased their gaps-addressed rate by 16.9%. Their practice received HHO stainless steel water bottles for their accomplishment and participation.

Beacon Pediatrics: Winner for overall highest gap-addressed rate.

Beacon Pediatrics increased their overall gaps-addressed rate by 34.6%. Their practice received a celebratory plaque and lunch on HHO for their accomplishment and participation.

Prospective Gap Closure (PGC) Program for 2023

This year's PGC Program is underway. As a reminder, providers will receive rewards for their participation and excellent work addressing risk gaps. The provider with the highest gap-addressed rate in their respective tier will receive a reward:

- Biannual winners will receive HHO branded rewards after each measuring period.
- The year-end grand prize is rewarded to the provider with the highest gap-addressed rate among all tiers. The grand prize winner receives a catered lunch and commemorative plaque to celebrate their win.

Tracey Howard, office manager for Beacon Pediatrics, stated she appreciated the lunch provided to staff. She went on to say, "The portal is super user friendly and is a great check and balance to make sure we are addressing gaps in care which leads to better management of our patient's health."

To participate in or learn more about the competition, reach out to Bryan Boyd at bryan.boyd@highmark.com.

Xylazine is linked to more overdose deaths.

Xylazine, a sedative and analgesic approved for veterinary use in animals, is increasingly found in fentanyl, heroin, and other street drugs and is linked to a growing number of overdose deaths. Xylazine is not approved for use in humans and is not an opioid.

The FDA recommends the following:

"Health care professionals should consider potential xylazine exposure when patients presenting with an overdose do not respond to naloxone. In these situations, health care professionals should provide supportive measures and consider screening for xylazine using appropriate tests. Additionally, health care professionals who see patients with severe, necrotic skin ulcerations should consider repeated xylazine exposure as part of the differential diagnosis. Finally, health care professionals caring for patients with OUD should monitor patients for withdrawal symptoms not managed by traditional OUD treatments, as this may indicate xylazine withdrawal."

Some facts about xylazine:

- It can be difficult to distinguish opioid overdose from xylazine exposure.
- Xylazine is not currently known to be reversed by naloxone.
- Xylazine is not detected by routine immunoassay toxicology screenings.
- Repeated exposure to xylazine may lead to severe necrotic skin alterations, at the injection site and in other parts of the body.
- Withdrawal symptoms can be severe.
- Users may refer to xylazine as "tranq," "tranq dope," and "zombie drug."

The FDA provides more information at hho.fyi/xylazine.

If you have questions, call Provider Services at 844-325-6251, Monday–Friday, 8 a.m.–5 p.m. If your patients have questions, they can contact Member Services at 844-325-6251 or call their Case Manager or Care Coordinator.

Collaborate with the Case Management team to provide care.

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

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

Create healthier outcomes with cervical cancer screenings.

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

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

Cervical screening recommendations include:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
- Women who have had hysterectomies with cervical removal for reasons other than precancerous lesions: No screening needed.

The American Cancer Society's estimates for cervical cancer in the United States for 2023 that about 13,960 new cases of invasive cervical cancer will be diagnosed and about 4,310 women will die from cervical cancer.

Cervical pre-cancers are diagnosed far more often than invasive cervical cancer. It is still important to encourage patients to have their regular Pap screenings. This helps to determine if they have cervical cancer, the stage of cervical cancer, and to initiate the most appropriate treatment options for healthier outcomes.

References: American Cancer Society. Cancer Facts & Figures 2023

Use these strategies to increase AMR performance.

The Asthma Medication Ratio (AMR) assesses patients ages 5–64 with both:

- Persistent asthma.
- A ratio of controller medications to total asthma medications of 0.50 or greater.

The goal of this measure is to increase compliance with asthma controller medications. Appropriate medication management for patients with asthma can help reduce:

- Asthma-related hospitalizations.
- Emergency room visits.
- The need for dangerous acute asthma exacerbations and rescue medications.

If a patient has an AMR less than 0.50, it is interpreted that they are filling more rescue medications than controller medications. This would require a follow-up to optimize their asthma regimen.

The following strategies can help providers increase AMR performance:

- Assess barriers (e.g., cultural, financial, social support, health beliefs, access to care, language).
- Calculate the AMR monthly.
- Evaluate and track disease activity to adjust medication regimen as needed.
- Provide asthma education and self-management for AMR < 0.50, such as accountability on the possibility of nonadherence to controller medication and triggers leading to frequent use of rescue medication.
- Reconcile medications (e.g., assess for effectiveness, number of prescription refills).
- Refer chronic case management.
- Review the patient's knowledge about medication and symptom exacerbation.

Colorectal cancer screening and early detection are important.

Regular screenings can help prevent many colorectal cancers. Screenings can find precancerous polyps so that they can be removed before they turn into cancer. The best screening test available for colorectal cancer is a colonoscopy. It is the only screening test that can detect many colorectal cancers.

When performing a colonoscopy:

- Ensure patients have received instructions on what to eat and how to empty their bowels.
- Examine the lining of the entire colon to check for polyps or tumors. Remove any found polyps.

Recommend patients start having colonoscopies at age 45, regardless of gender. Patients with an increased risk of colorectal cancer may have a screening earlier.

Colorectal cancer is caused by an uncontrolled division of abnormal cells in the colon or rectum. It is the third most common cancer in the United States, and it occurs most often in people age 50 and older. Screening is important because colorectal cancer is highly treatable when found early.

Colorectal risk factors

- Age
  - Colorectal cancer is more common in people age 50 and older.
- Personal and family history
  - Patients at an increased risk of colorectal cancer include those who:
    - Have a parent, sibling, or child with colorectal cancer, especially if the family member was diagnosed before age 60.
    - Have had colorectal cancer are higher risk of recurrence.

- Race
  - Black and African American individuals are at higher risk. The reasons for this are not fully understood.
  - Jewish people of eastern European descent are at higher risk. About 6% have DNA changes that increase their risk of colorectal cancer.
- Inflammatory bowel disease (IBD)
- IBD, which includes ulcerative colitis and Crohn's disease, puts patients at a higher risk of developing colorectal cancer
- Lifestyle
  - Being overweight, having an inactive lifestyle, eating a diet high in red meat and processed meat, smoking and drinking alcohol can increase the risk of colorectal cancer.

Review provider medical record standards.

Highmark Health Options has adopted and maintains medical record standards that contracted providers must follow. This is to ensure the quality and completeness of medical records for our members. These standards help verify that providers:

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

Every year, Highmark Health Options will randomly select 72 providers for medical record audit. Passing audit requires that a minimum of 80% of standards to be met. In recent years, all providers have been passing medical record audit.

NEW Medical Record Standard for 2023

Providers must document within the medical record the member's consent for all telehealth/virtual visits. To review the complete list of medical record standards, providers can visit the HHO website.

Do not balance bill Highmark Health Options members.

Highmark Health Options continues to receive numerous complaints from members who have been inappropriately balance billed for services rendered by a participating provider. Providers can reference the below language from page 19 of the Highmark Health Options Provider Manual Billing Responsibilities section:

- **Billing patients for covered services:** Under no circumstance may a provider bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

If you have questions about balance billing, contact your Provider Account Liaison or Provider Services at 844-325-6251, Monday–Friday, 8 a.m.–5 p.m.

Providers must meet the requirements of the 21st Century Cares Act.

All Delaware network providers must be enrolled in the **Delaware Medical Assistance Program (DMAP)**.

This applies to all Highmark Health Options (HHO) network providers who furnish, order, refer, or prescribe items or services to Delaware Medicaid members.

Providers should have received a notice from DMAP to attest or complete a new Provider Enrollment Application. Failure to timely fulfill this requirement will result in termination and/or nonpayment of claims.

Providers can contact Gainwell Provider Services with questions about DMAP enrollment applications on the provider portal. Call 1-800-888-3371 Option 0 then Option 4 or email DelawarePret@GainwellTechnologies.com.

Reminder: Providers should not send any correspondence that has protected health information (PHI) to this mailbox.

Use these strategies to identify patients' health-related social needs.

Health-related social needs (HRSN), previously referred to as social determinants of health, are environmental conditions that can affect a person's health, well-being, and quality of life. Prioritizing early identification and mitigation of HRSN can help improve a patient's quality of life and well-being.

HRSN embraces a prevention framework to recognize and address a person's social, economic, and environmental needs that have been previously overlooked. HRSN encompasses:

- Education (e.g., English as a Second Language [ESL], General Education Development [GED], or other education programs affecting HRSN).
- Employment and income.
- Family and social supports (e.g., prenatal support services, childcare, social isolation, respite services, or caregiver support).
- Food insecurity.
- Housing instability and quality (e.g., homelessness, poor housing quality, or inability to pay mortgage or rent).
- Interpersonal violence (e.g., domestic partner violence, elder abuse, or child maltreatment).
- Transportation needs beyond medical transportation.
- Utility needs (e.g., difficulty paying utility bills).

Providers can use certain strategies to address HRSN. The following strategies were developed by the National Academies' Committee on Integrating Social Needs Care into the Delivery of Healthcare to Improve the Nation's Health.

- **Awareness:** Identify social risks specific to the patient and their population.
- **Adjustment:** Adjust clinical care to meet patients' needs, such as providing a language line, educational literature in an easy-to-understand format, and off-hour visits or telehealth services.
- **Assistance:** Connect patients with local community and government resources for short-term and long-term assistance.
- **Alignment:** Assess the patient's social care assets in the community. This is a great way to collaborate with the patient's LTSS Case Managers or Care Coordination who are available to provide continuous support and resources to patients.
- **Advocacy:** Form alliances with local social care organizations to advocate for policies that promote resources and address health-related social needs.

Respond to medical requests to avoid corrective action.

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

These standards help verify that providers:

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

HHO has record standards developed for:

- PCPs and specialists
- Behavioral health providers

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

For telehealth and online visits, providers must document the member's consent in the member's medical records.

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

Learn about the new specialty pharmacy program with Free Market Health.

Coming in Q3 2023, Highmark Health Options (HHO) is implementing a new specialty pharmacy program for select specialty drugs. The list of specialty drugs included in the program will be shared once finalized.

This program:

- Facilitates a seamless match between specialty pharmacies and authorized specialty drug referrals based on member care needs and cost.
- Enables fair access to specialty drug referrals for accredited, in-network specialty pharmacy providers.

Under the new program, providers and their HHO patients may notice that new specialty pharmacies are dispensing their medication(s). Specialty medications may require additional monitoring and care. The specialty pharmacy will coordinate with the prescriber office to obtain the prescription.

Learn more about Free Market Health at hho.fyi/fmh.

Providers with any questions about this program can contact Pharmacy Services at 844-325-6251.

Note changes to the prior authorization list.

The following prior authorization codes have changes.

Update	Prior Authorization Category	Code
Deletion	MP-1190- External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices, and Audiological Testing	92550, 92553, 92555, 92556, 92557, 92558, 92700, 92562, 92563, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92640, 92650, 92651, 92562, V5008
Deletion	MP-1007 Colorectal Cancer Screening	45378
Addition	MSK	L8679, L8680
Deletion	MP-1002 Pharmacogenetic Testing	81479, 84999, 87999
Addition, General (Policy Name Change)	MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon	91113
Deletion	MP-1158 Treatment of Prostate	55899, 53899
Addition	MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections	20600, 20604, 20605, 20606, 20610, 20611, 20550, 20551, 20552, 20553, 76942, 76882
Addition	RP-1120 Chiropractic Benefits and Services Policy	98940, 98941, 98942, 98943, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215 (Auth required after initial E&M service) 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220 (Auth required after initial set of X-rays)
Addition	RP-1005 Facility Based Behavioral Health Services	0114, 0124, 0912, 0913
Addition	2nd Quarter DME Codes	A4341, A4342, A4560, A6590, A6591, A7049, E0677, E0711, E1905, K1035, L8678

Update	Prior Authorization Category	Code
Deletion	MP-1190- External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices, and Audiological Testing	92550, 92553, 92555, 92556, 92557, 92558, 92700, 92562, 92563, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92640, 92650, 92651, 92562, V5008
Deletion	MP-1007 Colorectal Cancer Screening	45378
Addition	MSK	L8679, L8680
Deletion	MP-1002 Pharmacogenetic Testing	81479, 84999, 87999

To review the complete prior authorization list, scan the QR code or visit hho.fyi/pal-tool.

Call Provider Services at 844-325-6251, Monday–Friday, 8 a.m.–5 p.m., or talk to your Provider Account Liaison with any questions about these changes.

Return medical records requests for quality-of-care grievances.

Per the DMMA contract, providers are required to send Highmark Health Options (HHO) copies of medical records when requested. Providers are required to maintain and share, as appropriate, complete and accurate medical records in accordance with HHO's policies and in accordance with professional standards.

When request medical records are submitted HHO, providers receive a thorough and accurate review from the Medical Director pertaining to the grievance. If HHO does not receive the medical records, the case is sent to the Medical Director without the records for review, and a determination is made based on the member's grievance. Providers who do not send in records are at risk of not being able to have a thorough review.

For more information about the quality-of-care grievance process, call Provider Services at 844-325-6251.

Accurately measure blood pressure every time.

Did you know incorrect patient preparation and positioning can cause unreliable and often higher blood pressure readings? The following table shows some common preparation mistakes that can cause higher and inaccurate blood pressure measurement:

When the patient has:	Blood pressure can change by an estimated*:
Crossed legs	2-8 mm Hg
Cuff over clothing	5-50 mm Hg
Cuff too small	2-10 mm Hg
Full bladder	10 mm Hg
Talking or active listening	10 mm Hg
Unsupported arm	10 mm Hg
Unsupported back/feet	6.5 mm Hg

*These values are not cumulative.

Accurate blood pressure measurement is important because it can help diagnose and treat hypertension in patients. To obtain the most accurate blood pressure measurement for each patient, providers should:

- Ask the patient if they need to use the restroom and allow them to do so prior to taking the measurement.
- Ensure the patient is properly positioned:
  - Seated in a chair with the back supported
  - Feet are flat on the ground or supported by a foot stool
  - Legs are uncrossed
- Not allow the patient to talk or use their phone during the procedure.
  - Clinical staff and any family present should not talk during the procedure.
- Place the blood pressure cuff mid-arm, just above the elbow. Support the arm so the arm and cuff are at the level of the patient's heart.
- Use a validated, automated device to measure blood pressure.
- Use the correct cuff size for the patient's arm.

Providers can partner with Highmark Health Options for wellness programs and linkage to services.

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

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

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

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

Community resources and programs are available to help patients stay well and manage their conditions. HHO staff can provide patients with ongoing disease education and management with our Lifestyle Management/Wellness Programs. More Lifestyle Management/Wellness Program information is available on our website.

Providers have an important role in the Care Management Program.

The Highmark Health Options Care Management team can partner with providers to decrease the number of times a patient goes to the emergency department, help a patient avoid going back to the hospital, and support a personal plan of care for a patient.

HHO has nonclinical and clinical staff available to:

- Address patient's physical and/or behavioral health issues.
- Link patients to applicable services, such as local community resources, and self-management tools.
- Remind patients to go to their annual physicals and help them make appointments.
- Review medications with patients.

Call Care Management at 844-325-6251 with any questions about the Care Management Program.

The PCP Portfolio Report promotes quality and safety of care.

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

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

Provider feedback is incorporated into these reports.

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

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

Provider network contacts.

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Review Statement of Members' Rights and Responsibilities.

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

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

Check out this useful information.

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

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

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

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

Check out these tools.

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

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

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

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