HIGHMARK HEALTH OPTIONS

Quarterly Update for Providers

Spring 2022

In this newsletter:

Breast Cancer Coalition transportation services are available to assist providers.

Check out the updated Cultural Competency Training.

Accurately measure blood pressure every time.

The PCP Portfolio Report promotes quality and safety of care.

... and more.

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Contact us.

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

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 biannually.
- 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.

Breast Cancer Coalition transportation services are available to assist providers.

The Delaware Breast Cancer Coalition (DBCC) can help providers assist patients with transportation needs. The DBCC works with organizations to increase breast cancer screenings in Delaware.

Providers who identify patients with transportation barriers or health-related social needs challenges can refer them to DBCC. The DBCC can help get patients to and from their breast screening appointments with their DBCC bus or Lyft.

Encourage patients to contact the DBCC and help them get to their appointments:

Delaware Breast Cancer Coalition Inc.

100 W. 10th Street, Suite 209
Wilmington, DE 19801

Phone: 1-302-778-1102

Mobile: 1-302-778-1102

Fax: 1-302-778-1104

Toll-Free: 1-866-312-DBCC

Email: dbcc@debreastcancer.org

debreastcancer.org

Verify practice information in the Provider Directory.

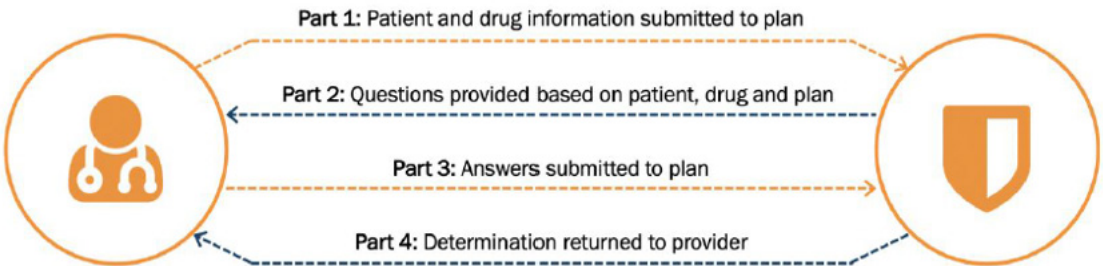
Providers are encouraged to verify that their practice information is accurate in the Provider Directory. It is important to keep this information up to date because members use the directory to search for in-network providers. Providers who find that their practice information is incorrect should fill out and submit a Provider Update form. Using this form, providers can:

- Update a practitioner or group name, address, phone number, email, website address, and specialty.
- Remove a practitioner from a group.

This form has been created for in-network provider use in order to comply with the No Surprises Act that was signed into law in December 2020. Changes to these elements will not be accepted via any other electronic form.

Use the electronic prior authorizations (ePA) process.

Providers can use the CoverMyMeds portal to generate prior authorization requests. An enhanced submission process was implemented on Dec. 7, 2021 and works as follows:



When using CoverMyMeds, providers should:

- Answer all questions in their entirety and as accurately as possible. Inaccurate or incomplete information may delay the decision process.
- Fully submit the ePA request. Authorizations left in a pending status will automatically close out after five days.

As a reminder, while providers may receive a decision in as little as one hour after submission of a complete ePA, the decision can take up to 24 hours. Be mindful of this when discussing treatment initiation with patients.

Electronic submission of prior authorizations is not mandatory. Providers can still submit requests via fax, phone, or portal.

Highmark Health Options will share expansions to this program as they become available. As of publication of this newsletter, requests for the following medications and classes can be submitted via ePA:

ADHD agent (preferred and nonpreferred)
Analgesics, narcotic long-acting (preferred and nopreferred)
Analgesics, narcotic short-acting (preferred and nonpreferred)
Antibiotics, GI
Antipsychotics
Antipsychotics < 18
Anxiolytics
Carisoprodol
Cytokine and CAM antagonists, oral/SQ
Enbrel
Freestyle Libre
Humira
Immunomodulators, atopic dermatitis
Lidocaine patch
Lyrica/pregabalin
Skeletal muscle relaxants (preferred and nonpreferred)
Xifaxan

Providers with any questions about this process can contact CoverMyMeds Support at 1-866-452-5017 or use the chat feature on the CoverMyMeds website.

PDL prior authorization requirements.

Highmark Health Options may require prior authorization for certain medications, even though they may be listed on the PDL or Supplemental Formulary. The **prior authorization form** can be found on the website.

Providers should complete the prior authorization form as soon as possible when notified that one is required. This helps prevent delays in patient care. Providers should schedule patients at least one week prior to the date their prescription ends to prevent a lapse in availability of medicine.

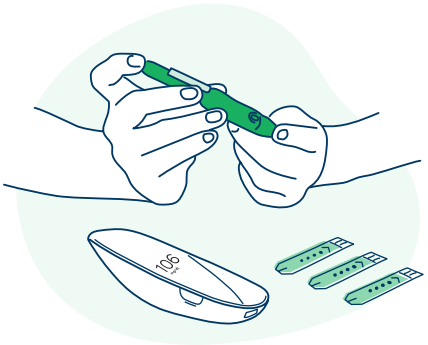
Once the form is completed, providers should:

- Fax the form to **1-855-476-4158**.
- Allow 24 hours for processing.

Pharmacy support is available 24/7. Providers can call Pharmacy Services at **1-844-325-6251**, Monday–Friday, 8 a.m.–7 p.m.

After regular business hours and on weekends, providers can leave a message. Representatives will respond to messages after hours.

Order annual A1c and LDL level tests for patients with diabetes.



Annual A1c and LDL tests are important for patients with diabetes, especially patients with schizophrenia and diabetes. These patients are at risk for diabetes and increased lipid levels because of their anti-psychotic medications. A yearly A1c and LDL test will help manage their A1c levels and close care gaps.

Normal levels for patients with diabetes are:

- Good A1c: 6
- Good LDL: Under 110

However, these numbers could vary depending on a patient's medical conditions and risk factors. Walk patients through their treatment plan so they can target the proper A1c and LDL levels.

Providers can also help patients by:

- Coordinating and collaborating with the behavioral health provider or medical provider, if applicable.
- Educating the patients about their A1c and LDL levels and what the numbers mean to help them manage their diabetes.

Here are the PGC program competition winners.

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

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

Just Kids Pediatrics: Winner for practices with up to 1,000 total members.

Just Kids Pediatrics increased their gap-addressed rate from 0% to 23.3%. Their practice received HHO stainless steel water bottles for their accomplishment and participation.

La Red Health Center: Winner for practices with up to 2000 members.

La Red Health Center increased their gaps-addressed rate from 2.5% to 11.6%. Their practice received HHO stainless steel water bottles for their accomplishment and participation.

We will be starting another competition in the 3rd quarter this year. If you'd like to participate in or learn more about the competition, please reach out to Bryan Boyd at bryan.boyd@highmark.com.

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

Beacon Pediatrics increased their overall gaps-addressed rate from 3.9% to 33.5%. Their practice received a celebratory plaque and lunch on HHO for their accomplishment and participation.

Tracey Howard, office manager for Beacon Pediatrics, stated she appreciated the lunch provided to staff. She went on to say, "I feel like the program is super easy. It helps keep us accountable with documenting the chronic illnesses of our patients. It also makes sure we are following up on those chronic diagnoses throughout their visits and creating a care plan."

LTSS dual-eligible Medicaid patients require PASSR and PAE submissions.

Pre-Admission Screening and Resident Review (PASRR) is a federal requirement that helps ensure patients are not inappropriately placed in nursing homes for long-term care. Nursing facilities that admit LTSS dual-eligible Medicaid patients with Medicare as the primary payer must ensure a PASRR is completed prior to admission. In addition, nursing facilities are required to submit a preadmission evaluation (PAE) form to Highmark Health Options (HHO). The purpose of this document is to ensure payment should the member exhaust their short-term rehab benefit.

PASRR requires that facilities:

- Evaluate all patients for serious mental illness and intellectual disability.
- Offer all patients the most appropriate setting for their needs (e.g., in the community, a nursing facility, or acute care).
- Provide all patients the services they need in those settings.

HHO is not able to remit payment for services provided prior to the PASRR completion date. It is the nursing facility's responsibility to ensure that a PASRR is completed prior to admission. Providers need to submit signed documents to HHO to their assigned Case Manager who acts as a single point of contact. HHO is required to submit PAEs to the Delaware Division of Medicaid and Medical Assistance (DMMA) for payment and care, and to let them know where the patient is.

Providers with questions about this requirement can contact Provider Services at 1-844-325-6251.

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

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

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

Providers should work with Case Managers to provide the care patients need.

Check the provider updates and notices.

Providers should regularly check the Highmark Health Options website for updates and notices. The website provides news and updates from us, as well as the latest breaking stories from the health care industry. The HHO website offers providers tools to stay informed.

Collaboration makes discharge planning more successful.

Discharge planning is vital to patients' health success. Preventing readmissions should be viewed as part of a patient's care journey. Balancing patient visits and discharge planning can be difficult at times. Here are tips to make discharge planning more successful:

- Assess patients post-discharge.
- Collaborate with LTSS Case Managers and Care Coordinators. Case Managers are required to:
  - Ensure patient needs are met, such as durable medical equipment is delivered, home environment is safe, medication is available, and follow-up visits are scheduled and attended.
  - Follow up after discharge with patients and their support system to ensure a safe discharge has occurred.
  - Partner with the multidisciplinary team and facility staff upon admission and follow up weekly for patient status.
  - Review patient clinical information.
- Coordinate with facility staff and providers for patient discharge needs.
- Include patient, family, and caregivers or guardians in the discharge plan.
- Obtain recommendations for the care plan.
- Return calls from Case Managers and hospital social workers for assistance.
- Share and exchange relevant clinical information.

Respond in time to medical record requests.

Providers are required to respond to all medical record requests in a timely manner. Each request should be reviewed thoroughly. In addition, providers must submit all documentation requested. If additional clarification is needed, providers can contact the individual who sent the request.

Include the following information with the medical records:

- Member identifying information, e.g., photo ID, member card.
- Consent to treat.
- Privacy practices disclosure.
- Release of Information for payment.
- Notes and documentation for service dates.

Providers can contact Payment Integrity at 1-844-325-6251 to request an extension if they need more time to gather information for the submission.

Submit medical records by mail to:

Highmark Health Options
120 Fifth Avenue
FAPHM-052C
Pittsburgh, PA 15222

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' expectations and needs.

Survey Results	Provider Percentile	Hospital/Ancillary Percentile
Would Recommend (%Yes)	97th	97th
All Other Plans (Comparative Rating) (%Well or Somewhat above average)	97th	99th
Overall Satisfaction (%Completely or Somewhat Satisfied)	95th	99th
Finance Issues (%Well or Somewhat above average)	90th	100th
Utilization and Quality Management (%Well or Somewhat above average)	82nd	96th
Network/Coordination of Care (%Well or Somewhat above average)	88th	100th
Pharmacy (%Well or Somewhat above average)	69th	97th
Health Plan Call Center Service Staff (%Well or Somewhat above average)	87th	93rd
Provider Relations (%Well or Somewhat above average)	75th	98th

Note: 2021 Summary Rate is in comparison to 2020 SPH Medicaid Book of Business which includes 86 Medicaid plans nationwide.

Interpretation and translation services for patients.

Per the Highmark Health Options (HHO) contract, providers are required to address, arrange, and coordinate interpreter services for patients. Reasonable steps should be taken to provide meaningful access to services, including translator services for patients with limited English proficiency. HHO offers the Member Handbook and other materials in large print, in Braille, or on cassette tape at no cost to members. Providers may obtain copies of documents that explain legal requirements for translation services by contacting Provider Services at **1-844-325-6251**.

Check out the updated Cultural Competency Training.

Highmark Health Options (HHO) has developed a new Cultural Competency Training program. This program covers community characteristics, cultural values, beliefs, and behaviors using a storytelling approach. HHO is committed to building a trusted network of providers so we may connect our members with truly personal health care. Provider Relations is available to answer providers' questions about the new **Cultural Competency Training program** at 1-844-325-6251, Monday–Friday, 8 a.m.–5 p.m.

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

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

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

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

Early detection of Alzheimer's in patients.

Health care providers play a critical role in identifying and addressing cognitive health and cognitive impairment in patients. Research suggests that only about half of the people who would meet the criteria for Alzheimer's disease or related dementias have been diagnosed by a physician. According to Healthy People 2030, only 59.7% of those diagnosed with Alzheimer's or their caregivers have been told of their diagnosis. Individuals who are diagnosed with dementia yet are unaware of their diagnosis are at a much higher risk of accidental injury. They are 2.5 times more likely to prepare hot meals, 1.5 times more likely to drive, and more than twice as likely to manage their own medications.

Early detection and diagnosis allow:

- Access to information, services, and support.
- Better health outcomes by managing co-occurring conditions.
- Opportunity for advance planning for health, care, financial, housing, and legal concerns.
- Treatment options for patients and families.

Other benefits are:

- Establishment of a support system and opportunity for the patient to express wishes about care team composition.
- Discussions to address driving and safety concerns.
- Informed care coordination across treatment teams.
- The option to participate in clinical trials.

For more information, view the Alzheimer's Association's 2022 Alzheimer's Disease Facts and Figures Report.

Diabetes Corner

Help patients understand their numbers.

Providers can help patients manage their diabetes by regularly monitoring their blood glucose. Providers should also administer an A1c test at least twice a year; however, some patients may need more frequent testing based on certain risk factors, such as family history, age, or ethnicity.

The A1c goal for most patients with diabetes is 7% or less, but personal goals for patients may vary depending on their particular risk factors or medical conditions. Before administering an A1c test, providers should talk with patients about any factors that could falsely increase or decrease their A1c results. These factors could include:

- Blood loss or transfusion
- Certain medicines, such as opioids or some HIV medications
- Kidney failure, liver disease, or anemia
- Pregnancy

Providers should:

- Encourage patients to take regular blood glucose tests at home.
- Make sure they understand what their target blood glucose range is, what the numbers mean, and how often they should check their blood glucose.
- Discuss any changes they may need to make to their treatment plan.
- Working closely with patients can help them to manage their diabetes.

Encourage patients to quit vaping or smoking.

Seventy percent of smokers want to quit, but only 20% will attempt it, either on their own or by asking for help. Providers can help patients begin to live a vape- and tobacco-free life by starting the conversation and educating patients about tobacco cessation using the 5A's strategy.

The 5A's are:

- **Ask** about and document tobacco use status at every visit.
- **Advise** in a clear, personalized manner that tobacco users stop smoking.
- **Assess** willingness to quit at this time. Or ask former tobacco users how recently they stopped and what challenges they may still have trouble dealing with.
- **Assist** by prescribing NRT, when applicable.
- **Arrange** follow-up, including counseling.

Refer patients age 13 and older to the Delaware Quitline at **1-866-409-1858**. Find more information on how to help patients quit smoking on the CDC website.

Accurately measure blood pressure every time.

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:
  - In a chair with the back supported.
  - With feet flat on the ground or supported by a foot stool.
  - With uncrossed legs.
- Not allow the patient to talk or use their phone during the procedure.
- Not allow the clinical staff and any family present to 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 help prevent domestic violence.

Providers can play a role in preventing and ending domestic violence. The Delaware Coalition Against Domestic Violence (DCADV) has information and resources available to help providers talk to patients about domestic violence. Patients can also use this site and contact trained advocates who can help them create confidential, personalized safety plans.

Domestic violence is a pattern of abusive behaviors used by one partner in an intimate relationship to control the other. It can include physical, psychological, verbal, sexual, and financial abuse. It is estimated that 1 in 4 women will be a victim of domestic violence in her lifetime.

DCADV is a statewide, nonprofit coalition of agencies and individuals working to stop domestic violence in Delaware. They can be contacted at:

100 West 10th St., Suite 903
Wilmington, DE 19801

Phone: **1-302-658-2958**

National Hotline: **1-800-799-7233**

dcadvadmin@dcadv.org

dcadv.org

In addition, local 24-hour hotlines and shelters are available at:

- New Castle County: **1-302-762-6110** (bilingual)
- Kent and Sussex Counties: **1-302-422-8058/1-302-745-9874** (bilingual)

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, child care, 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.

There are the 5A's to address health-related social needs:

- **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.

The PCP Portfolio Report promotes quality and safety of care.

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

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

Provider feedback is incorporated into these reports.

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

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

Provider network contacts.

Provider Services

Desiree Charest
Hospitals, ASCs, ACOs, FQHCs, and walk-ins
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Melanie Anderson
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Melanie.Anderson@highmark.com
1-302-502-4072

Provider Complaints (not claims related)

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

Statement of Members' Rights and Responsibilities.

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

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

Check out this useful information.

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

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

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

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

Check out these tools.

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

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

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