Q3 2025

Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals (HMO SNP) | DELAWARE

HIGHMARK

HIGHMARK HEALTH OPTIONS

FEATURED ARTICLES:

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Contact Us

Highmark Health Options and Highmark Health Options Duals 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 the following numbers:

HHO Provider Services: **1-844-325-6251** HHO Duals Provider Services: **1-855-401-8251**

Key D-SNP Changes in Delaware for 2026: What Providers Need to Know

Significant changes are coming to Dual Eligible Special Needs Plans (D-SNPs) in Delaware for 2026, impacting your dual-eligible (Medicare and Medicaid) patients including two new D-SNP offerings, changes in coverage options, and benefits.

New D-SNPs from Highmark Health Options

Highmark Health Options is offering two D-SNP options in Delaware for 2026:

- Highmark Health Options Duals Select (Partial D-SNP) NEW for 2026
- Highmark Health Options Duals (Full D-SNP)

Both plans include Special Supplemental Benefits for the Chronically Ill (SSBCI), offering valuable wellness rewards to eligible members.

Delaware D-SNP Landscape Shifts in 2026

Market Exits:

- **What's Changing:** Aetna, Cigna, and UnitedHealthcare will no longer offer D-SNP in Delaware in 2026.
  - **Patient Impact:** Patients with these plans must select new coverage during the Medicare Annual Enrollment Period (October 15–December 7) to maintain D-SNP benefits. Failure to do so will result in enrollment in Original Medicare and loss of D-SNP benefits.

Highmark remains committed to serving Delaware's Medicaid and Dual Special Needs members. If you are contracted with Highmark Health Options for Medicaid but are not contracted for D-SNP and would like to be, please reach out to **HHOContracting@highmark.com**.

Mandatory Alignment of D-SNP and Medicaid Coverage:

- **What's Changing:** Starting in 2026, dual-eligible individuals enrolling in a D-SNP must receive their D-SNP (Medicare) and Medicaid benefits from the same health plan company. **Split coverage is no longer permitted.**

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- **Patient Impacts:**
  - Patients currently enrolled in a D-SNP with the same company as their Medicaid plan and making no changes during annual enrollment: No coverage changes occur.
  - Patients enrolled in a D-SNP and Medicaid plan through **separate** plans: Medicaid coverage will be changed to the health plan providing the D-SNP. Highmark Medicaid members who lose D-SNP coverage in 2026 and do not enroll in a new D-SNP plan will retain Highmark Medicaid benefits (upon renewal) and receive Original Medicare. **Please note: patients who default to Original Medicare may lose some of their benefits received under their D-SNP plan.**
  - Patients enrolling in a new D-SNP for 2026: Medicaid coverage will change to the same health plan as the new D-SNP.

Note: Patients enrolled in other Medicare Advantage Plans or Original Medicare will not experience changes to their Medicare unless they enroll in a D-SNP in the future.

Patients enrolled in Highmark Health Options (HHO) D-SNP and HHO Medicaid will receive a single member ID card.

Updates to Extra Benefits (SSBCI):

- **What's Changing: The Centers for Medicare and Medicaid Services (CMS) is eliminating Value-Based Insurance Design (VBID) for 2026** but is taking important steps to address Social Determinants of Health (SDoH) through Special Supplemental Benefits for Chronically Ill (SSBCI). SSBCI benefits can include flex card values, dental services, home-based palliative care, and home delivered meals.
  - **Patient Impact:** To ensure continuity of benefits, patients are encouraged to stay with their current plan or understand the impact of switching. Switching plans may delay access to these extra benefits, while staying in the same plan could allow pre-qualification for SSBCI benefits.
- **NEW for 2026:** To ensure your D-SNP patients receive SSBCI benefits, providers must attest to the patient's eligibility. This can be done by submitting an attestation form for new Highmark D-SNP patients, or, for existing D-SNP patients, by documenting proper diagnosis codes in the patient's chart for qualifying conditions.

How You Can Support Your Patients

- **Annual Enrollment:** Remind patients about the Medicare Annual Enrollment Period (October 15–December 7).
- **Discuss Implications:** Encourage patients to consider how these changes impact their care and benefits.
- **Highmark Resources:** Direct patients to Highmark Health Options for more information and support.

We appreciate your partnership in providing the best possible care to our members.

Mark Your Calendar for an Upcoming Provider Webinar

Navigating Telehealth: Best Practices for Virtual Care
Nov. 11, 2025 from 12 to 1 p.m. EST

Speakers from Financial Investigations and Provider Review (FIPR)

- Anne Lacienski, CPMA; Manager
- Cynthia Scott, CPC; Senior Investigator
- Jayme Patterson, CPC; Senior Investigator
- Sherry Roedersheimer, COC, CPC, CPMA; Lead Investigator

Objectives

- Identify what constitutes Telehealth.
- Illustrate Telehealth functionality and modality.
- Outline various types of Telehealth equipment.
- Identify common areas of potential Fraud, Waste, and Abuse within Telehealth.

Who Qualifies for CME?

Webinars are free and open to all interested. CME/CEU credits are available for:

- Physicians
- Midlevel practitioners
- Nurses

Earn CME/CEU Credit

This webinar is eligible for one CME/CEU credit. To receive credit and access your transcript, create a free account at **CME.AHN.org**. You only need to enroll once to be eligible to receive CME/CEU credit for attendance at live webinar activities. Instructions for claiming CME/CEU credit will be provided during the live webinar.

Registration

Click here to register for the event.

After registering, you will receive a confirmation email containing information about joining the webinar. If you have any questions, please contact your designated Provider Account Liaison or Lead Provider Relations Representative.

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Accreditation Statement:

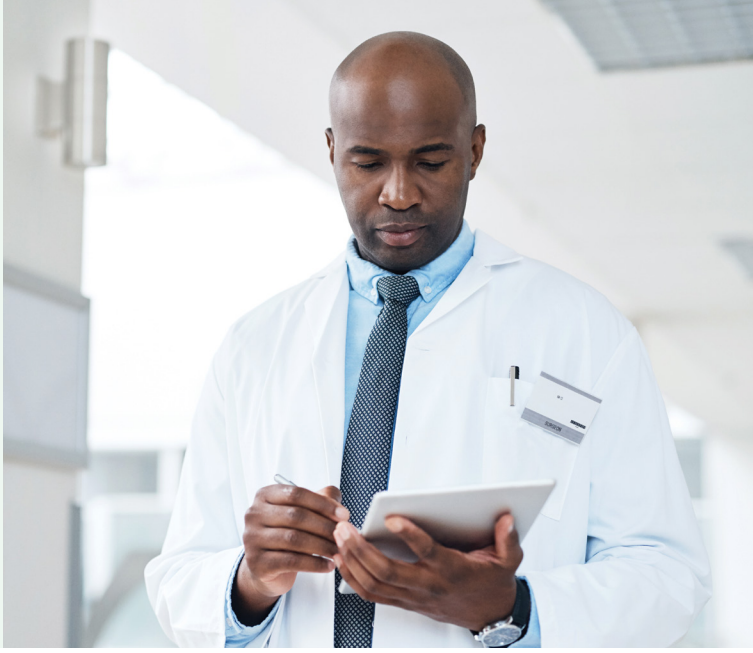
Allegheny General Hospital is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Allegheny General Hospital designates this live activity for a maximum of 1.0
AMA PRA Category 1 Credit™

Disclosure Statement:

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the policy of Allegheny General Hospital, presenters must disclose all relevant financial relationships, which in the context of their presentation(s), could be perceived as a real or apparent conflict of interest, (e.g., ownership of stock, honoraria or consulting fees). Any identifiable conflicts will be resolved prior to the activity. Any such relationships will be disclosed to the learner prior to the presentation(s). Highmark Presenters have no relevant financial relationships with commercial interests to disclose.

GLP-1 Maintenance Dosing: A Key to Effective Treatment



Verify that patients currently prescribed Wegovy or Zepbound have reached and are adhering to the appropriate maintenance dosage.

GLP-1 medications such as Wegovy (semaglutide) and Zepbound (tirzepatide) are FDA-approved for weight loss and other conditions. These GLP-1 medications should be titrated monthly up to an appropriate maintenance dose. Studies demonstrating the effectiveness of these drugs at maintenance doses are well-established. However, for patients who are not achieving or maintaining a maintenance dose, alternative treatment options should be considered.

Approved maintenance doses include:

- **Wegovy (semaglutide):** 1.7 mg, 2.4 mg
- **Zepbound (tirzepatide):** 5 mg, 10 mg, 15 mg

Highmark Health Options has conducted an analysis of drug claims for recipients receiving more than two consecutive fills of low "titration" doses of Wegovy or Zepbound below the maintenance dose.

The doses defined as low "titration" doses for this review are:

- **Wegovy (semaglutide):** 0.25 mg, 0.5 mg, 1 mg
- **Zepbound (tirzepatide):** 2.5 mg

Our analysis of Highmark Health Options pharmacy claims data indicates that one out of every eight patients is consistently filling prescriptions for a titration dose of Wegovy or Zepbound below the maintenance dose.

Ensure you regularly review patient dosages of Wegovy and Zepbound. To assist with this review, Highmark Health Options may be sending you specific information regarding your patients who appear to be on a low dose of these medications. We understand that drug therapy must be individualized based on each patient's unique needs and overall clinical situation.

Primary Care Provider (PCP) Portfolio Report

Highmark Health Options is committed to partnering with you to improve the quality of care for our members. The July PCP Portfolio Report is now available on NaviNet.

Key Report Information

- **Purpose:** To share data and facilitate conversations that drive improvements in member care.
- **Content:** Includes actionable data on key claim utilization, preventative care services, pharmacy data, quality of care, and quality of service.
- **Distribution:** Quarterly (April, July, October, and January) to Medicaid PCP practices with panel sizes of 50 or more members.
- **Benefits:** Provides network-wide performance data and highlights opportunities for collaborative improvements in patient care and outcomes.

Accessing the Report

Log in to NaviNet to view and download your July PCP Portfolio Report.

Questions?

Contact your Highmark Health Options Clinical Transformation Consultant at **DePET@Highmark.com** for more information about the PCP Portfolio Report or the NaviNet portal.

Please share this information with all providers in your practice.

Staying Informed and Connected: Attend Our Monthly Provider Forums

As valued partners in delivering quality healthcare to our Highmark Health Options and Highmark Health Options Duals members, we invite you to our monthly provider forums. These forums are designed to keep you informed and connected.

Why Attend?

- **Early Access to Information:** Get the latest on upcoming initiatives and process changes before they launch.
- **One-Stop Shop for Updates:** Hear directly from our Claims, Quality Improvement, Case Management, LTSS, and other key departments in a single, convenient session.
- **Your Questions Answered Live:** Participate in real-time Q&A sessions with Highmark subject matter experts.

Easy Access via Zoom

Join our monthly updates from anywhere via Zoom.

Registration is Simple

Look for the monthly invitation to register for these Zoom meetings directly in your inbox. Register in advance to ensure you don't miss out.

Missing Your Invite?

If you're not receiving the monthly invitations, please contact your Provider Account Liaison to be added to the distribution list.

We value your partnership and look forward to connecting with you at our next provider forum!

Disease Reporting Requirements for D-SNP Providers

As a reminder, Highmark Health Options Duals providers must report certain diseases, infections, or conditions as determined by Delaware Code Title 16, Health and Safety § 1012 REPORTING OF DISEASES, INFECTIONS AND CONDITIONS. The Reportable Conditions Policy explains this contractual requirement as well as the methods by which providers will be notified of its necessity.

If you are looking for additional information or to obtain a copy of the Reportable Conditions policy, please contact Highmark Health Options Duals Provider Services Department at **1-855-401-8251**. Additionally, these regulations, including the complete list of reportable conditions and timeframes for reporting, can be found **here**.

2025 Model of Care Training Summary

Provider Training Requirement: If you have not already done so, please complete the Model of Care training before Dec. 31, 2025.

As a Special Needs Plan (SNP), Highmark Medicare Dual-eligible Special Needs Population (D-SNP) members are required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC). In accordance with CMS guidelines, Highmark's SNP MOC is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals. Our network providers are expected to complete and attest to MOC training on an annual basis.

The SNP MOC is divided into four sections:

1. Description of the SNP population
2. Care Coordination
3. SNP Provider Network
4. Quality Measurement & Performance

The annual provider training focuses on the SNP Provider Network section and outlines what Highmark expects from our providers in maintaining an effective MOC.

The MOC ensures that the SNP Provider Network is comprehensive and able to care for the unique and specific needs of the population by implementing the following elements throughout the SNP provider network:

1. Specialized Expertise
2. Use of Clinical Practice Guidelines
3. Care Transition Protocols
4. Annual Model of Care Training

The training also includes common MOC terms and definitions as well as Highmark's contact information.

Action Required: If you have not already done so, please complete the MOC training before Dec. 31, 2025.

Review the Model of Care Provider Training found on our **website here**. Once you have completed this training, please submit an attestation indicating that you have completed and comprehend the Model of Care training by **clicking here**.

Wellness Programs for Your Patients

Highmark Health Options has partnered with the YMCA of Delaware to offer wellness programs designed to help your eligible Highmark Health Options and Highmark Health Options Duals (HMO SNP) patients reach their health goals:

- **Lifelong Essentials for Activity and Nutrition (LEAN):** This is a 12-week weight loss program for adults ages 18 and older that focuses on developing sustainable, healthy habits. The program includes weekly 90-minute sessions with learning discussions, personal check-ins, and small-group training.
- **Diabetes Prevention Program (DPP):** A year-long program for adults ages 18 and older who are at risk for type 2 diabetes. Participants work with a trained coach in a supportive group setting to learn healthy habits. **According to the CDC**, the DPP can reduce the risk of developing type 2 diabetes by up to 58%. The program includes 25 sessions (both in-person and online options), covering nutrition, physical activity, and stress management techniques.

Referral Information

You can refer your interested patients through the **YMCA patient referral form** or by calling Highmark Health Options Provider Service at **1-844-325-6251 (Medicaid)** or **1-855-401-8251 (Medicare D-SNP)**. Additionally, you can contact the YMCA directly at **302-572-9622** to refer patients or send any questions on referrals or the programs to **communityhealth@ymcade.org**.

Substance Use Disorder Resources for Your Patients

According to **Delaware Health Social Services**, there have been over 284 suspected overdose deaths in Delaware for 2024.

Highmark provides substance use disorder (SUD) assistance for your Highmark Health Options patients through programs such as Care Coordination and Case Management.

If your patients are struggling with SUD, please encourage them to contact Member Services at **1-844-325-6251** or visit the **Addiction Resource Center page** on our HHO Member Website.

Additional SUD resources can be found at **HELP**.

Ensuring Clear Communication with Members: Language Access Resources

Highmark Health Options (HHO) is committed to helping you provide the best possible care to our members. This includes ensuring effective communication, regardless of language.

Language Identification Card

To assist members in communicating their language needs, HHO offers a free, easy-to-use language card. Members can:

- Print the card.
- Save a digital version on their phone.
- Request a printed copy from Member Services.

This card allows members to easily identify their preferred language during office visits and when receiving services.

Click here to request a language card.

Your Role in Providing Interpreter Services

As an HHO provider, your contract requires you to arrange and coordinate interpreter services for patients. This ensures meaningful access to care for those with limited English proficiency. HHO can assist you in locating interpreter resources upon request.

Additional Resources Available:

- **Alternative Formats:** The Member Handbook and other important information are available in large print, Braille, and multiple language translations at no cost to the member. Please instruct patients to call Member Services at **1-844-325-6251** to request these formats.
- **Cultural Competency Training:** Enhance your understanding of diverse cultural needs with our **Cultural Competency Toolkit**.
- **Multilingual Signage:** Download multilingual signs that allow patients to indicate their language needs quickly and easily by pointing. Access the **HHO Provider Language Access Guide for Interpretation Services** or scan the QR code.

By utilizing these resources, you can help us ensure all members receive the clear and effective communication they deserve.

The Importance of Vaccines

As we transition from a pandemic to an endemic phase of COVID-19, it's vital to stress the importance of vaccination against both COVID-19 and influenza. Please encourage your patients to get both their COVID-19 and flu vaccines during the same visit for maximum protection against respiratory illnesses.

Vaccination Timeline Guidance

Influenza Vaccine:

- **Optimal Timing:** September and October are generally the best months to get vaccinated against the flu.
- **Timing Considerations:** Vaccination too early (i.e., July or August) may lead to reduced protection later in the flu season, especially for older adults. However, it is still preferable to getting no vaccine at all.
- **Vaccination Throughout the Season:** Vaccination should continue to be offered as long as flu viruses are circulating.

COVID-19 Vaccine:

- **Stay Up-to-Date:** Encourage patients to stay up-to-date with recommended COVID-19 vaccines, including boosters, as per CDC and Advisory Committee on Immunization Practices (ACIP) guidance.
- **New Formulations:** Be aware of any new vaccine formulations targeting current variants and provide patients with the latest information.
- **Ongoing Boosters:** Recommendations for booster doses may change. Please advise patients to stay informed and consult with you for the most current advice.

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Key talking points when discussing vaccinations:

- **Co-administration:** COVID-19 and flu vaccines can safely be administered at the same time, streamlining the vaccination process for patients. Please refer to the **CDC Recommendations Update**.
- **Endemic status:** While COVID-19 is now considered endemic, the virus continues to circulate, and vaccination remains a primary defense against severe illness, hospitalization, and long-term complications.
- **Flu season:** Remind patients that the flu can be a serious illness, especially for vulnerable populations. Vaccination is the most effective way to prevent the flu and its complications.

By staying informed about these updated guidelines and emphasizing the importance of timely vaccination, you can play a vital role in improving the health and well-being of your patients and our members.

Please refer to the CDC COVID-19 and Flu Recommendations Update.

Highmark Health Options Provider Satisfaction Survey Results

The 2024 provider satisfaction survey results are in, and 94.1% of Highmark Health Options (HHO) ancillary and hospital providers would recommend HHO to other practices. We use your feedback to improve our services and strive for performance measures at or above the 75th percentile.

Measures	Provider Percentile
Network/Coordination of Care	89th
Provider Relations	87th
Finance Issues	85th
Utilization & Quality Management	84th
All Other Plans	82nd
Health Plan Call Center Service Staff	76th

Measures	Ancillary/Hospital Provider Percentile
Provider Relations	91st
Would Recommend	87th
Utilization & Quality Management	85th
Finance Issues	84th
Health Plan Call Center Service Staff	80th
Pharmacy	76th

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Note: Percentiles are based on the 2023 Press Ganey Medicaid Book of Business (108 Medicaid plans).

Participate in the 2025 Survey

In October, you may receive our 2025 provider satisfaction survey. We encourage you to complete it with input from your billing and clinical staff, especially regarding authorizations, claims, and clinical matters. As a thank you, the first 200 respondents will be entered to win one of ten $150 Visa gift cards.

Thank you for your continued partnership in improving the health of our members.

Highmark Health Options Quality Improvement Program

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

The goal of the QI/UM Program is to ensure the excellent provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other health care services and quality health plan services for our members. The QI/UM Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the HHO provider network, as well as 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, identify opportunities that meet the QI/UM Program objectives, and develop a work plan.

As a participating provider, HHO asks that you cooperate with QI activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various QI 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 HHO 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, continuous improvement processes and implementation of positive change.

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The scope of the Program includes, but is not limited to:

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

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

Accessibility Standards

Highmark Health Options (HHO) Delaware maintains standards and processes for ongoing monitoring of access to health care. To help ensure our members receive services in a timely manner, practice sites are contractually required to follow these standards.

Please take a few minutes to **review the accessibility standards** and share with your office staff that schedule member appointments, including off-site central scheduling and call center staff.

These standards and additional resource information related to accessibility are available on our HHO provider website.

Member Rights and Responsibilities

Highmark Health Options Medicaid and Medicare Duals members have certain rights and responsibilities as members of Highmark. To detail those rights and responsibilities in full, Highmark maintains a Member Rights and Responsibilities statement, which is reviewed and revised annually.

Highmark and its provider network do not and are prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.

Members have the right to:

- Receive information from Highmark in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.).
- Be treated with fairness and respect at all times.
- Receive timely access to covered services and drugs.
- Have personal health information kept private and confidential.
- Receive information from Highmark about the Plan, its network of providers, covered services, and rights.
- Have Highmark support their right to make decisions about their care.
- Issue a complaint or ask Highmark to reconsider decisions the Plan has made by filing an appeal.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Receive a written explanation in the event a medical service or Part D drug is not covered, or if their coverage is restricted in some way.
- Receive a copy of their medical records free of charge upon request. Know their treatment options and risks in a way they can understand.
- Participate in decisions about their health care, including the right to refuse any recommended treatment.
- Be given instructions about what is to be done if they are not able to make decisions for themselves. This includes maintaining an advance directive, such as a living will or a power of attorney for health care.
- Contact the Department of Health and Human Services' Office for Civil Rights if they believe their rights have not been respected due to their race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.

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- To request and/or participate in a scheduled Interdisciplinary Care Team (ICT) meeting which may include your assigned Highmark Case Manager, your PCP, caregiver, and any other pertinent personnel directly included in your care.
- To access and have direct input into your individualized care plan (ICP). Your care plan is available on your portal page or can be mailed to you upon request.

Members are responsible for:

- Getting familiar with their covered services and the rules they must follow to get these covered services.
- Informing Highmark if they have any other health insurance coverage or prescription drug coverage in addition to our plan.
- Telling their doctor and other health care providers that they are enrolled in our plan.
- Helping their doctors and other providers care for them by providing needed information, asking questions, and following through on their care.
- Respecting the rights of other patients and acting in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- Paying Medicare premiums and any applicable copayments or late enrollment penalties.
- Notifying Highmark if they move, regardless of whether it is outside or inside of Highmark's service area.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

*If a minor becomes emancipated, or legally freed from control by his or her parents (over the age of 16), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

The Member Rights and Responsibilities Statement can be found in the Medicaid Member Handbook, the Evidence of Coverage, or on our website at Medicaid Member Resources and Medicare Member Resources.

For more information, please call Provider Services at:

- Medicaid: **1-844-325-6251**
- Medicare Duals: **1-855-401-8251**

Participating Providers Should Not Balance Bill Patients

Highmark Health Options (HHO) continues to receive numerous complaints about participating providers who have inappropriately balance billed HHO patients for services.

As a reminder, 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.

Contact Provider Services at **1-844-325-6251** to learn more about balance billing.

NaviNet® is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Health Options such as routine eligibility, benefits and claims status inquiries.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield. Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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