WELCOME!

Highmark Delaware Health Options

Highmark Health Options is an independent licensee of the Blue Cross and Blue Shield Association

HIGHMARK. Delaware HEALTH OPTIONS

Introductions

- Melanie Anderson - Director, Provider Networks
- Paula Victoria - Manager, Provider Relation LTSS
- Tracy Sprague - Provider Account Liaison
- Chandra Freeman – Provider Account Liaison
- Desiree Charest – Provider Account Liaison
- Nikki Cleary - Provider Account Liaison
- Felicia Herron – Provider Account Liaison
- Andrea Thompson - Provider Contract Analyst
- Elsa Honma - Provider Contract Analyst, LTSS
- Kia Knox – Senior Provider Contract Analyst
- Alastair Crosbie - Senior Fraud Consultant
- Nicholas Duko - Manager, LTSS Case Management
- Angela Fournarakis - Manager, LTSS Case Management
- Catella Visser - Manager, LTSS Case Management
- Carolyn Stahl - Manager, Care Coordination
- Jill Haer - Manager, Care Coordination
- Donna Tuohey - Quality Improvement
- Yvette Wright - Quality Improvement
- Carrie Nocentino - Quality Improvement
- Iyana Johnson – Clinical Transformation Consultant
- Deepthi Harkar - Clinical Transformation Consultant
- Su-Linn Zywiol - Clinical Transformation Consultant
- Renee Licwinko – Pharmacy Product Director

About Highmark Health Options

- Highmark Health Options is a wholly owned not for profit subsidiary of Highmark Blue Cross and Blue Shield of Delaware.

- Highmark Health Options serves enrollees in the following programs:
  - Diamond State Health Plan
  - Diamond State Health Plan Plus
  - Diamond State Health Plan Plus/LTSS

- Highmark Health Options' headquarters is located in Wilmington, Delaware

- We have over 200 employees deployed throughout the state supporting our members and providers.

Added Benefit and Services Provided

Value added benefits available to Highmark Health Options adult members include:

Added Benefit

- GED Completion Program

Services

- Weight scales for members living with heart failure under care coordination
- Assistance with obtaining a free cell phone
- Texting messaging programs

Agenda

- EHS Processing Platform
- NaviNet
- Membership and Eligibility
- Claims and Processing
- Provider Services and Provider Relations
- Fraud, Waste and Abuse
- LTSS
- Care Coordination
- Quality Program
- Risk Adjustment
- Pharmacy

EHS Transition

Challenges

- Highmark Health Options has experienced some challenges with our migration to EHS in January.
- We are working with our providers on an individual basis to work through these systems issues.
- Please contact Provider Services or your Provider Account Liaison with any questions or concerns with the system migration.

EHS Processing Platform

- On January 1, Health Options transitioned to the EHS processing platform.
- There are a few changes required to assure claims are processed efficiently:
  - If your National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty should be submitted along with the NPI.
  - The billing provider 5 digit plus 4 zip code is required on all claims.
  - Non specific CPT codes will require a description added to the claim form.
- If you have any questions about these changes, please call us at 1-844-325-6251 to speak directly with a Provider Services representative.

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NaviNet®

Highmark Health Options strongly encourages all providers to enroll in Navinet, which is a free technology resource for providers that can be accessed 24 hours a day, 7 days a week.

There are numerous benefits to joining Navinet.

- **Highmark Delaware Branded NaviNet** - Your single access point for both Highmark Delaware commercial members **AND** Highmark Delaware Health Options Medicaid members.
- **Eligibility and Benefits –** Verify member eligibility. Should the member not have their ID card with the Unique Member ID - Medicaid ID searches are supported as are name/exact DOB.
- **EOB/Remittance Inquiry** - Access EOBs/Remittances
- **Authorizations** – Submit and review authorizations. When submitting authorizations for Medicaid members you will need to choose the Highmark Health Options categories and services. Pharmacy authorizations cannot be requested or accessed through Navinet.
- **Claim Status Inquiry** - Find additional detail on your claim.
- **Provider File Management** - Real time updates for your offices e.g. update addresses, phone numbers, NPI, and add or delete providers.
- **Enhanced Provider Features** – Appeals/claim disputes can be requested, view LTSS authorizations, access NIA RadMD portal and access secure messaging.

NaviNet
Where healthcare comes together.

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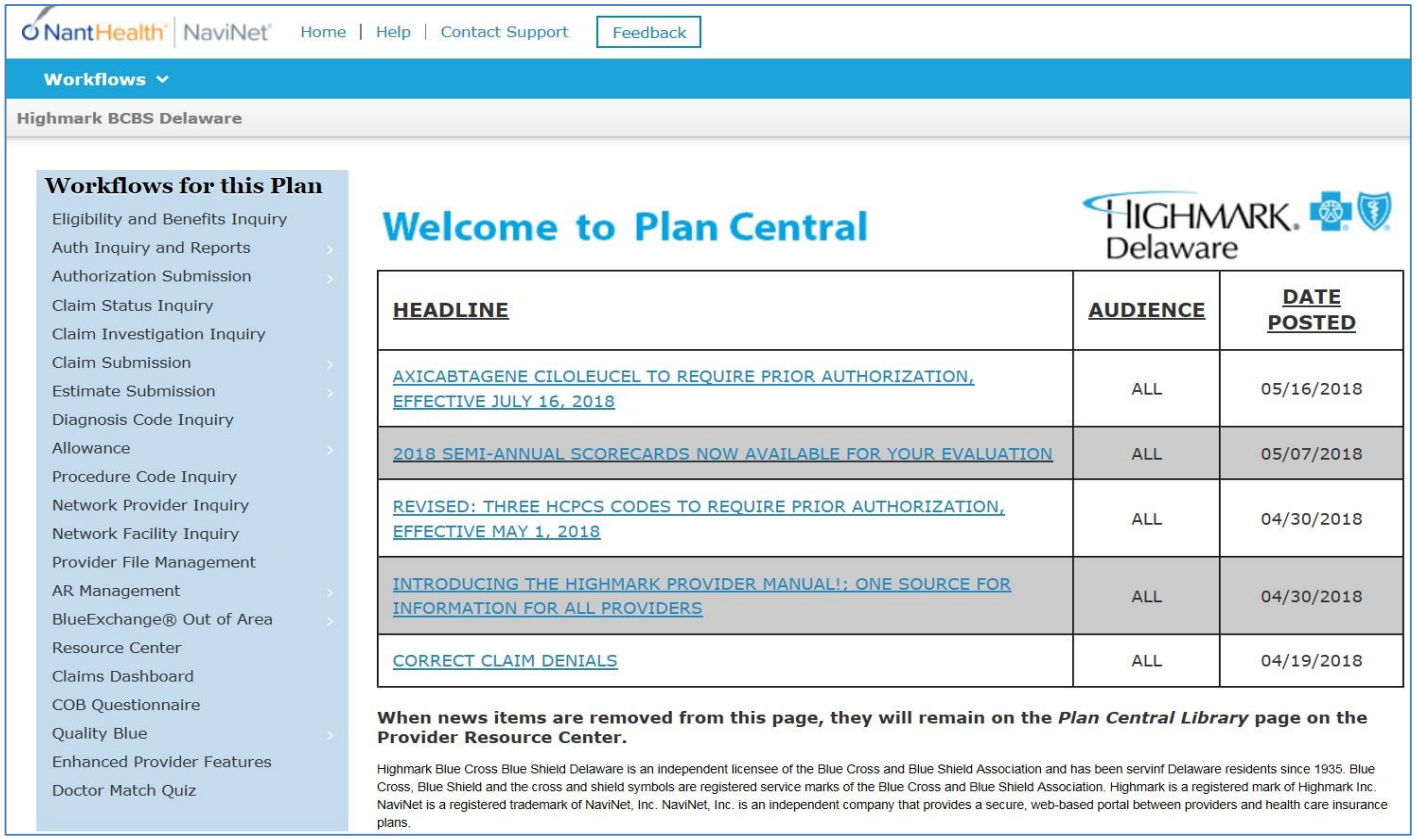
NaviNet®

Navinet Home Page



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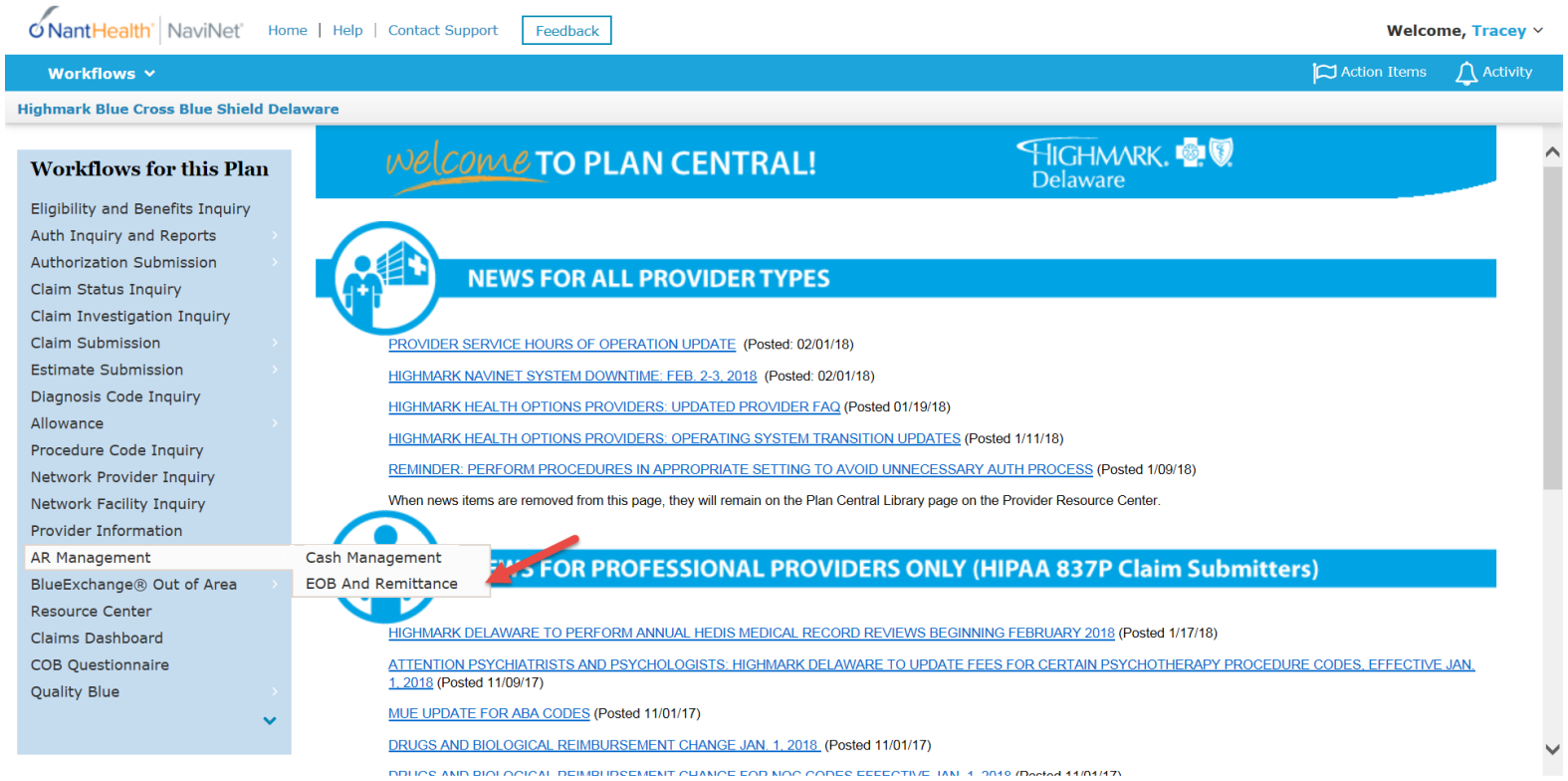
EOB and Remittance on NaviNet®



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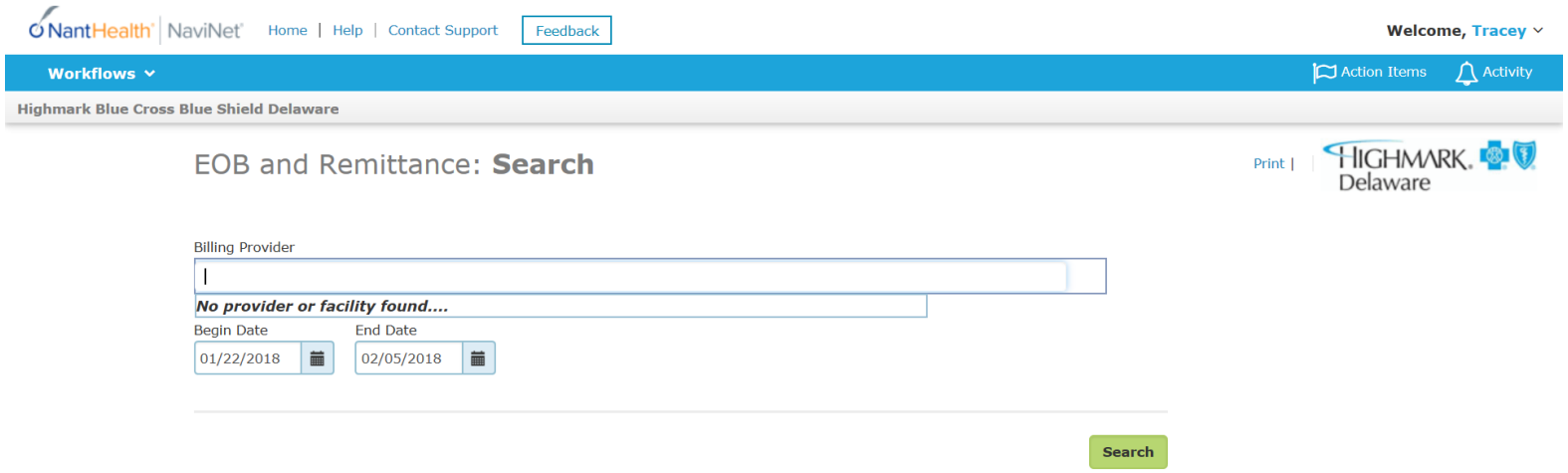

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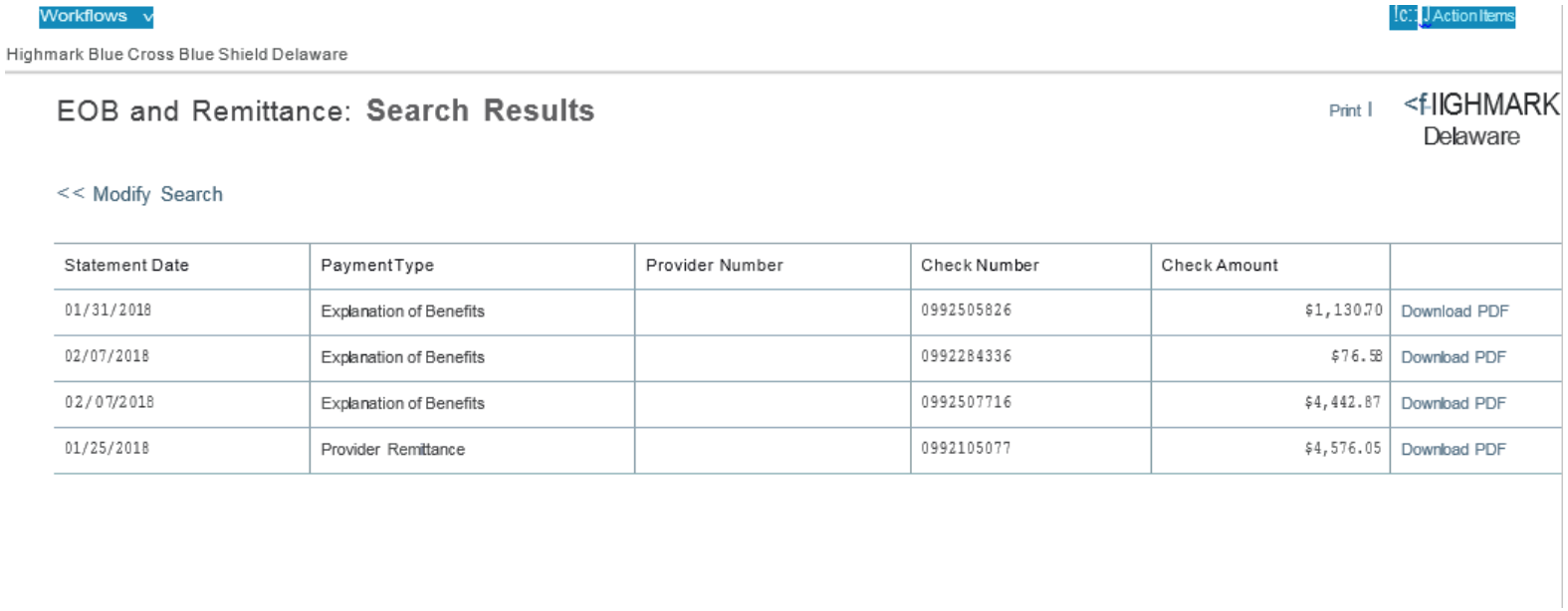
EOB and Remittance on NaviNet®



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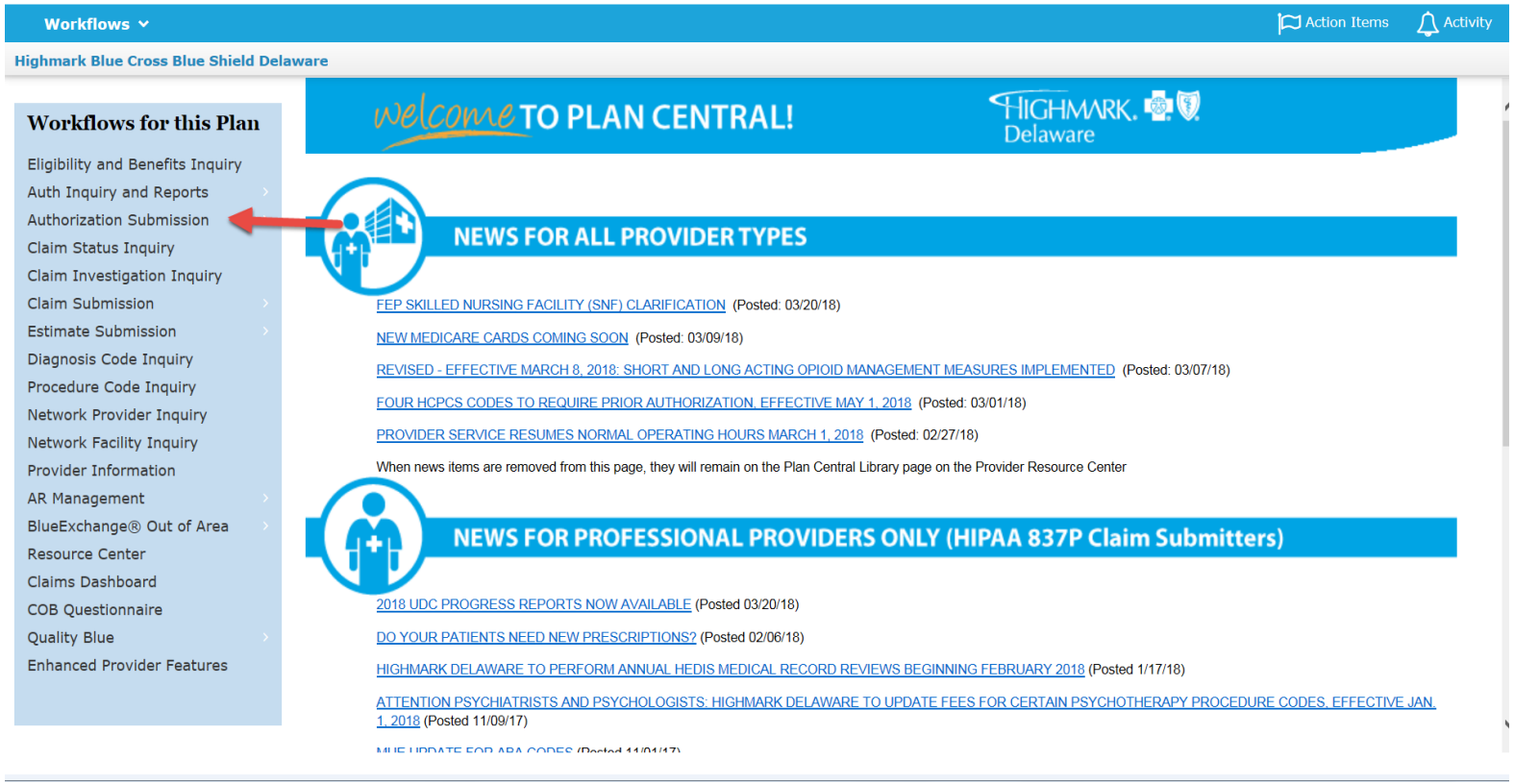
AUTHORIZATIONS IN NAVINET



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AUTHORIZATIONS IN NAVINET

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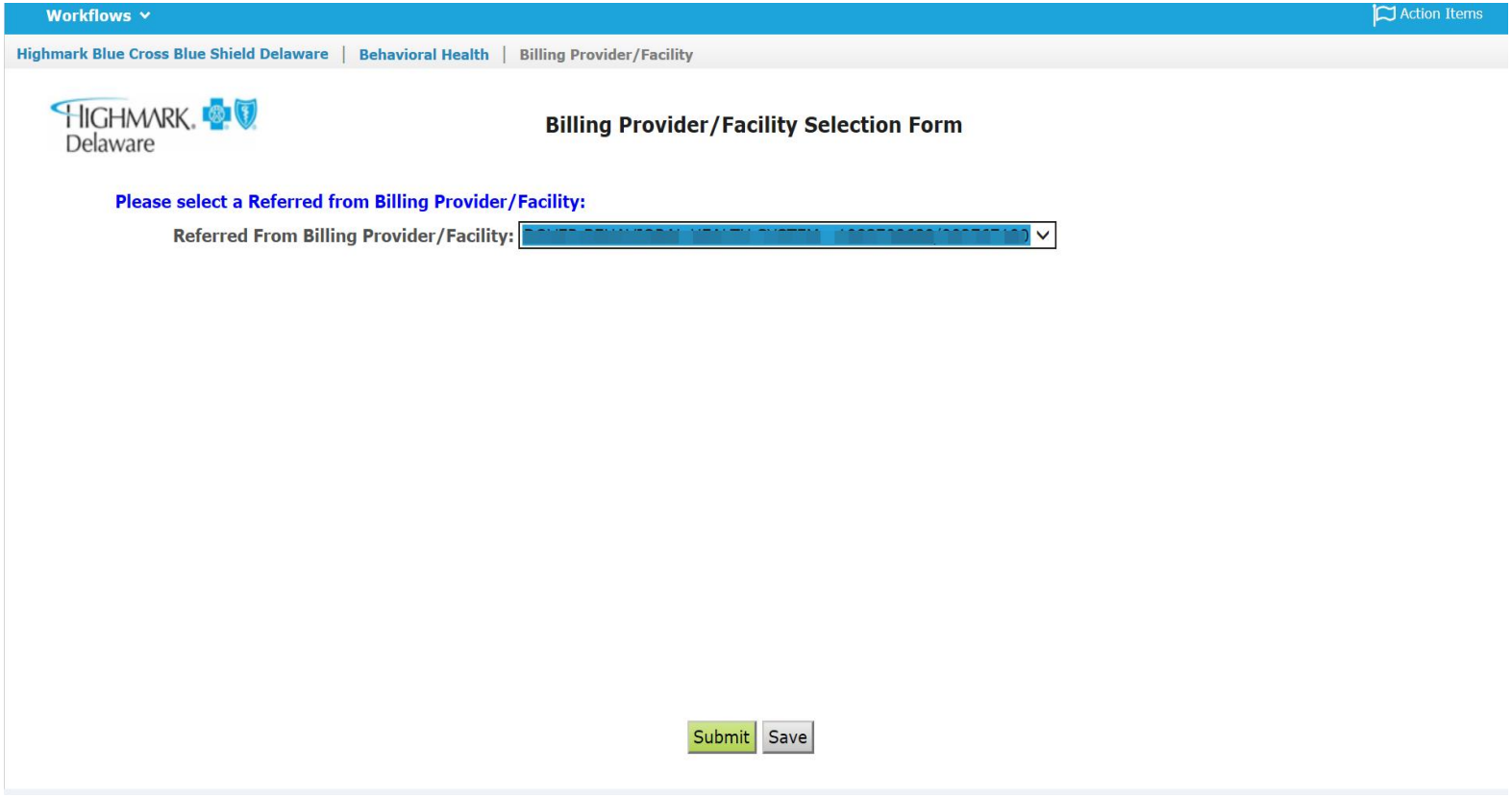

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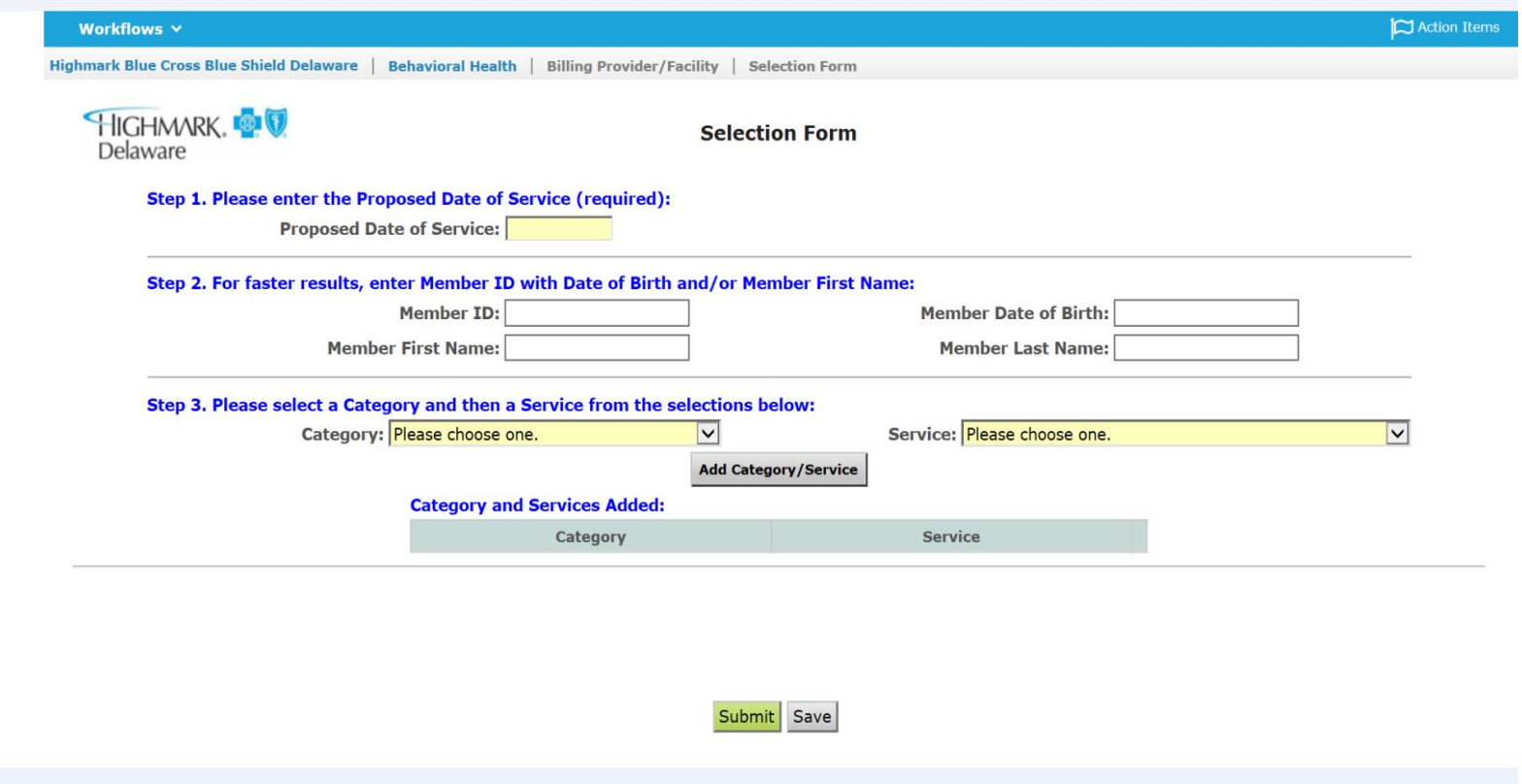
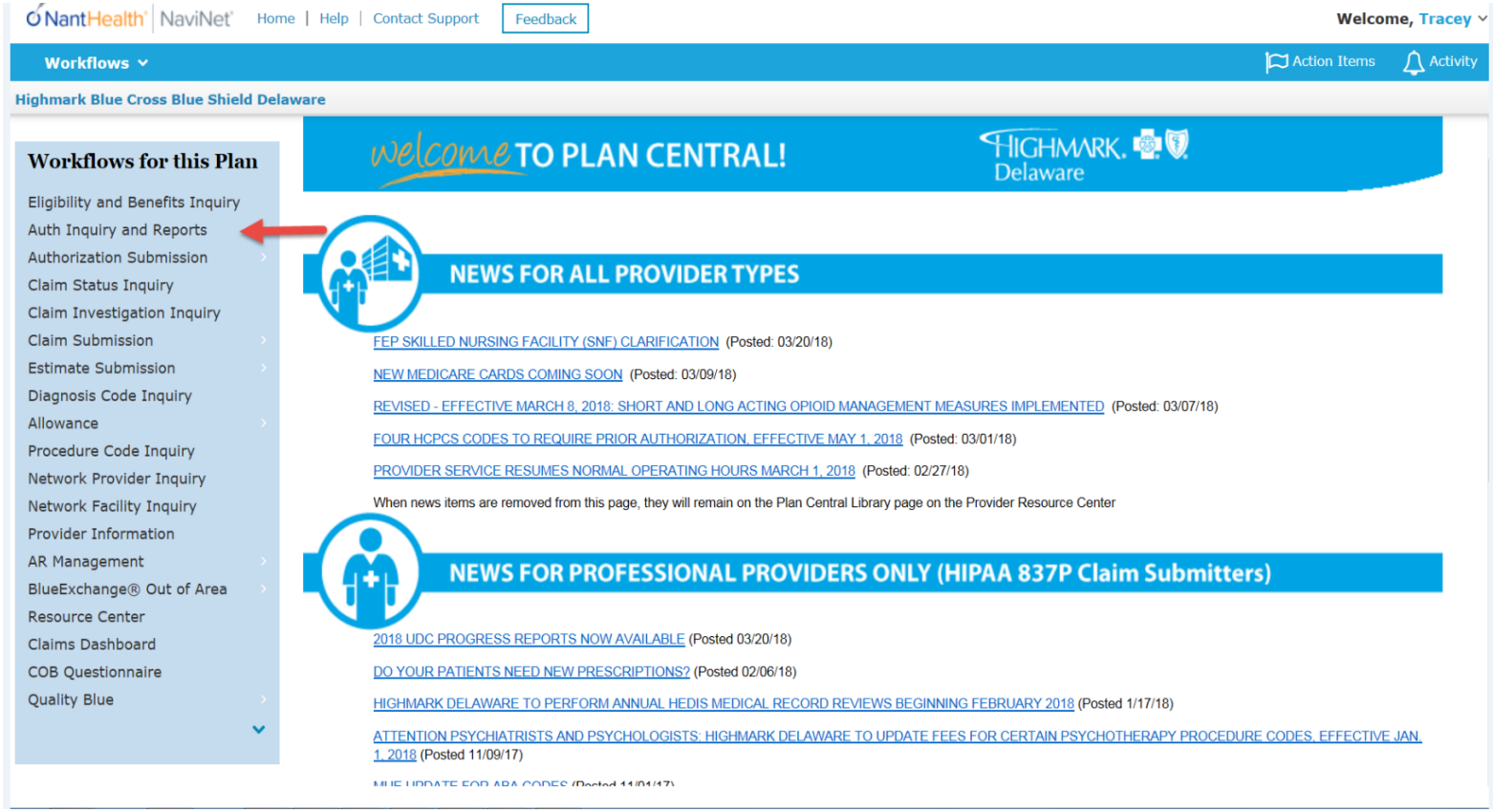


Authorization Inquiry and Reports



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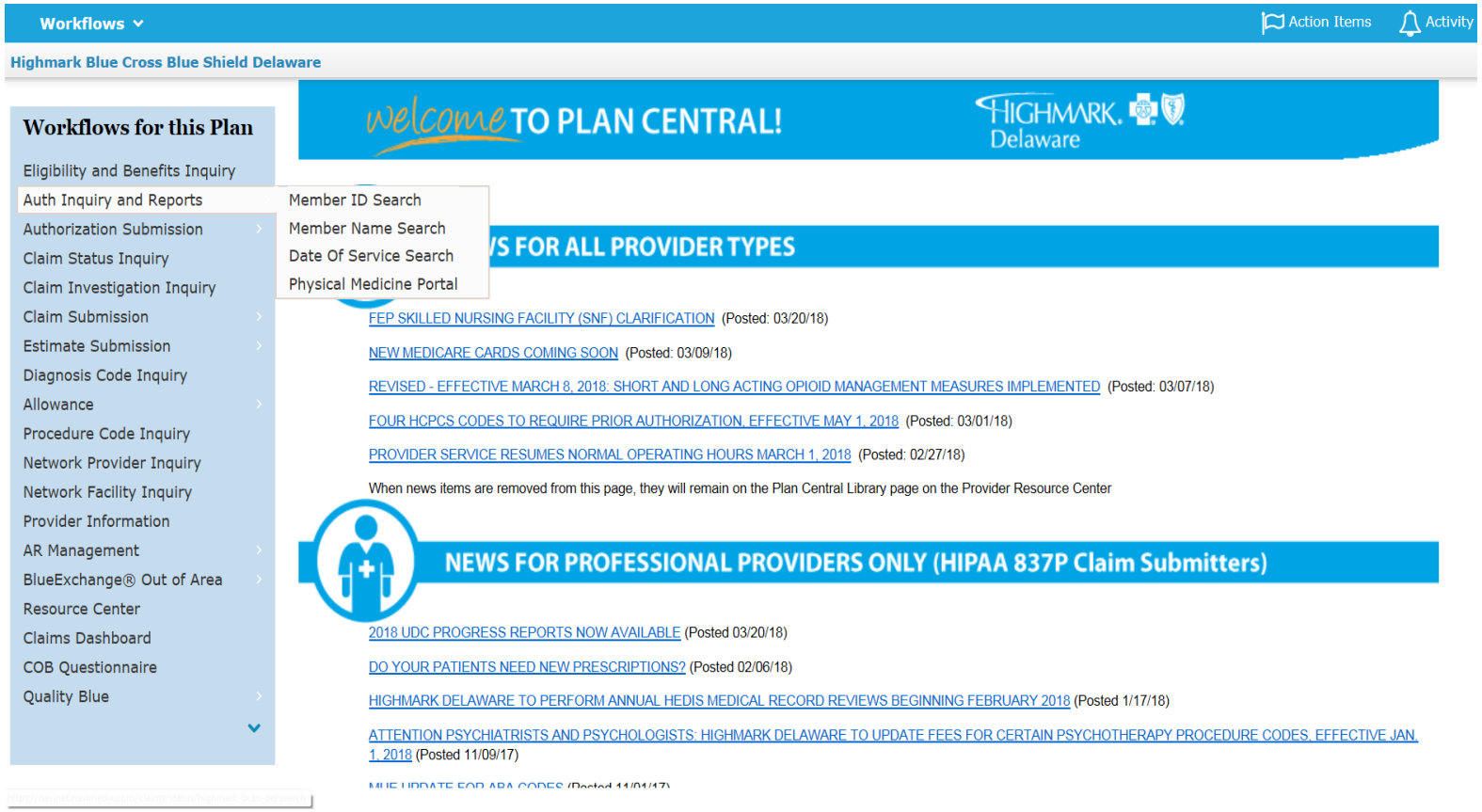

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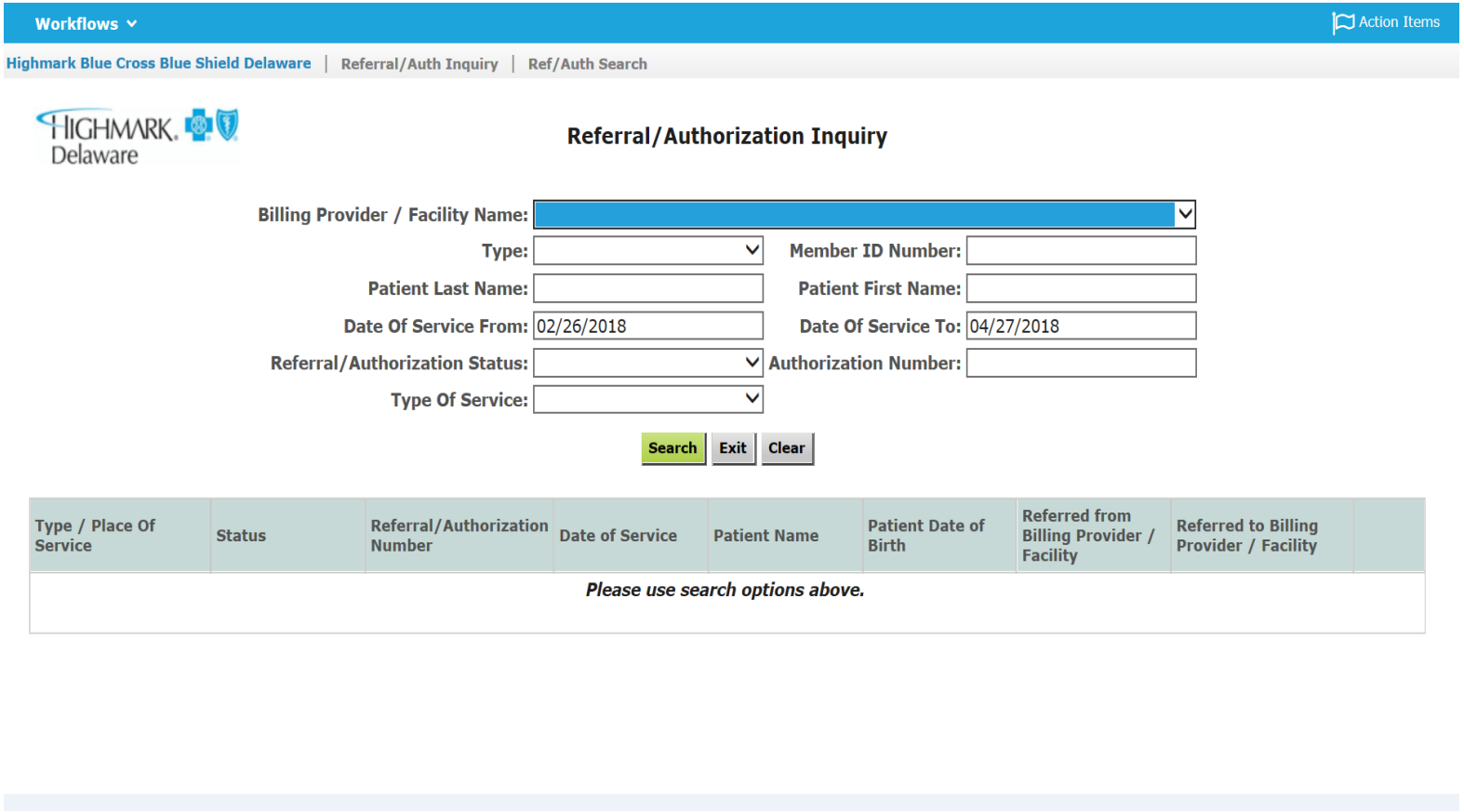

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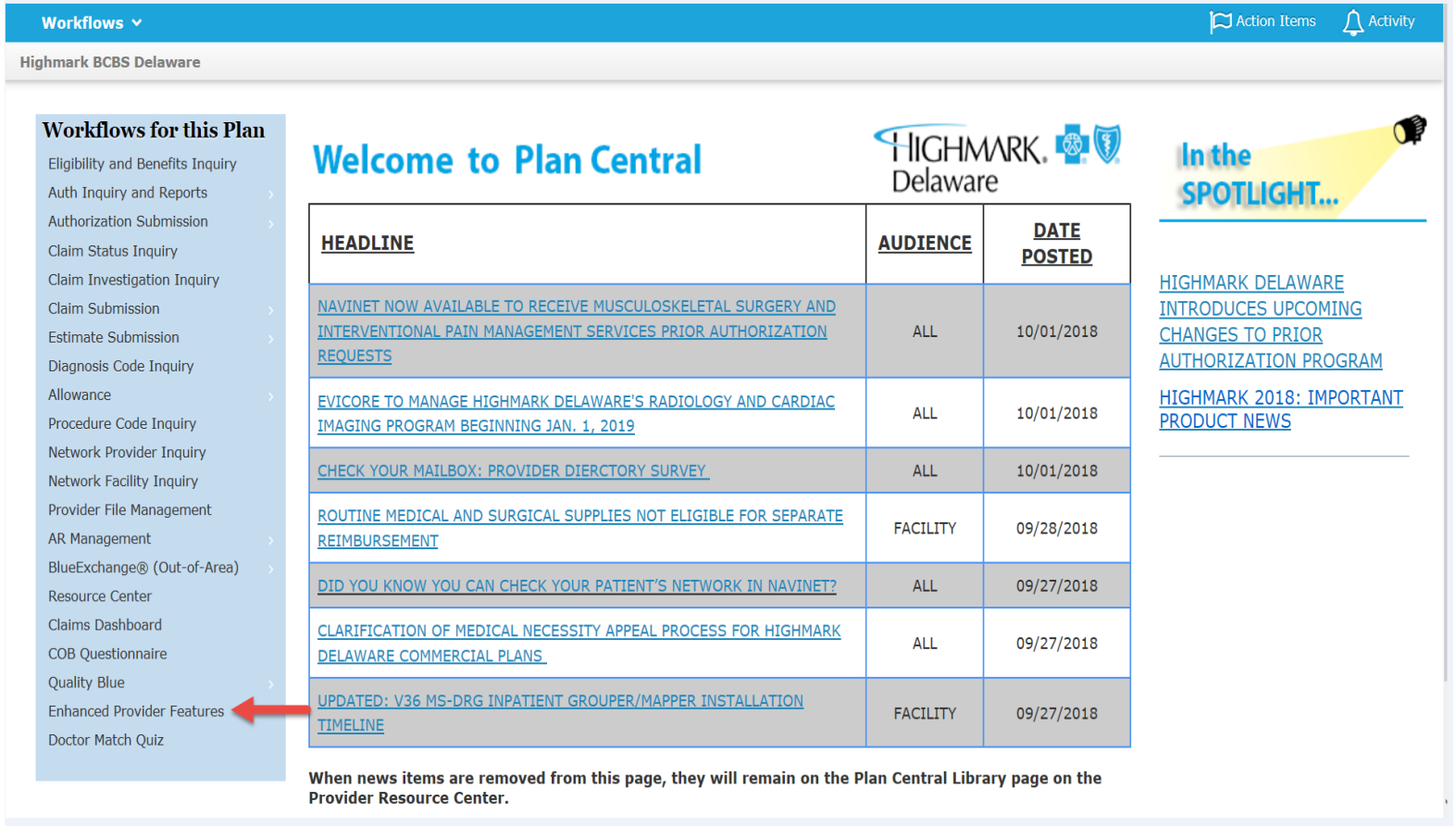
Enhanced Provider Features



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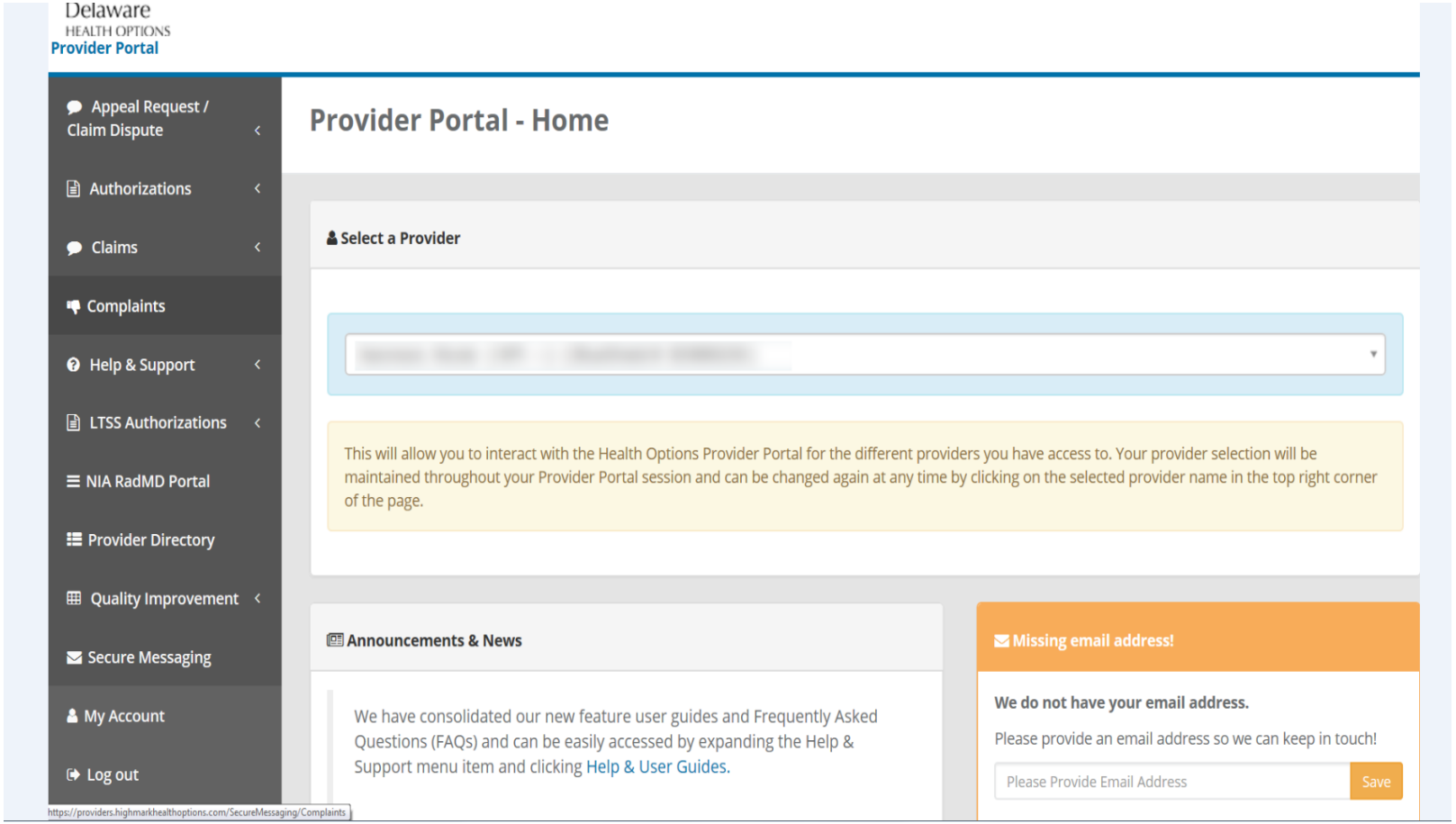
Enhanced Provider Features



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Membership

Membership as of October 2018:

159,523

Eligibility

- You can verify member eligibility by:
  - Accessing NaviNet *Eligibility and Benefits Inquiry* transaction
  - The Highmark Health Options DIVA (IVR) system by calling 1-844-325-6161
  - Providers can also use DMES system
  - A member's Highmark Health Options ID card

Claims and Processing

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Claims Submission

- Paper claim submissions (on original CMS-1500 or UB-04 red ink claim forms) are accepted at a centralized mailroom:

  Highmark Delaware Health Options - Claims Department
  P.O. Box 890402
  Camp Hill, PA 17089-0402

- Electronic Claims Submission (preferred method) electronic data interchange (EDI) claims to Emdeon or Relay (either directly or through your clearinghouse/vendor)
- Payor IDs:
  - **Emdeon**: 47181 Professional and Institutional
  - **Relay Health**: 7148 Professional, 7693 Institutional

Claims Overview - Requirements

- Claims must be submitted for all services rendered.
- All claims including EPSDT claims must be received within 120 days of the date of service or 60 days from the date of remittance from a primary payer.
- Corrected claims or requests for review are considered if information is received within the 180-day follow-up period from the date on the Health Options remittance advice.
- Tax ID, National Provider Identifier (NPI), and Taxonomy are required.
- All drug-specific claim information reported using the 837P and 837I electronic format **MUST** be reported with a HCPCS code (such as a J-code) **AND** an 11 digit NDC code. Claims submitted without both the appropriate HCPCS code and NDC will be rejected.

Claims Inquiries

- Immediate answers to most inquiries can be found by using NaviNet.
- For more complex issues, Provider Service Representatives are available:

  Phone: 1-844-325-6251

  Hours of Operation: Mon. – Fri. 8 a.m. to 5 p.m.
- Have the following information available:
  - Patient's name and Member ID
  - Type of service and date of service, if available
  - Claim number, if applicable
  - Provider's name, NPI, Tax ID or Plan provider number

Claims Review

- Claim inquiries for administrative payment disputes/medical review should be faxed to:
  - Administrative Payment Disputes: 1-844-207-0334
  - Clinical Appeals: 1-855-501-3904
  - Navinet under the Enhanced Provider Feature

- Corrected claims or requests for review are considered if information is received within the 180-day follow-up period from the date on the Health Options remittance advice.

Important Information About Your Remittance

- The Health Care Remittance Advice (paper remit) coincides with the check or electronic payment for the referenced claims.

- Electronic Funds Transfer, also known as an ACH Direct deposit, provides an easy method of depositing funds automatically to your bank account. For more information please visit **www.highmarkhealthoptions.com**.

- The Provider Remittance provides detailed payment data based on the information provided to us.

- If all or part of the claim has been denied, consult the Claim Adjustment Reason Code (CARC) and or the Remittance Advice Remark Code (RARC). To find the text of the CARC or RARC code, go to Washington Publishing Company at **www.wpc-edi.com/reference**.

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Administrative Claim Disputes

Provider disputes are requests that are not regarding medical necessity rather are administrative in nature such as, but not limited to, disputes regarding the amount paid, appeals of denials regarding lack of modifiers, refunded claim payments due to incorrect payments or coordination of benefit issues.

You may fax these requests to **1- 844-207-0334** or through the Enhanced Provider Features tab in Navinet.

Clinical Appeals

Clinical provider appeals are cases that are denied due to lack of prior authorization or denied based on medical necessity.

You may fax these requests along with all supporting documentation to **1-855-501-3904** or mail to:

Highmark Delaware Health Options

Attn: Clinical Provider Appeals

P.O. Box 22278

Pittsburgh, PA 15222

Appeals must be filed within 60 days from the date of the Explanation of Payment.

Provider Complaints

- Health Options has created a Provider Complaint system for participating and non-participating providers to raise issues with Health Options' policies, procedures and administrative functions.

- Providers can call 1-844-228-1364 to discuss their issue with a Provider Representative.

- In addition to calling, providers have the option of sending a written complaint within 45 days regarding any policy, procedure or administrative function using one of the following methods:
  - NaviNet Provider Complaint Messaging Center
  - Highmark Health Options Provider Complaint Form – available on the Highmark Health Options website, www.highmarkhealthoptions.com , under Provider Forms & Reference Materials. Completed forms may be e-mailed to ProviderComplaints@HighmarkHealthOptions.com . Fax completed form to 1-844-221-1569.

- Complaints will be investigated and the details of the findings and disposition will be communicated back in writing to the provider within 30 days of receipt. If additional time is needed to resolve, Health Options will provide status updates to the provider as applicable.

Member Appeals and Grievances

- Our members have a right to appoint a representative to act on their behalf

- Members may also ask for help with their grievance or appeal by contacting a Member Advocate at 855-430-9852.

Member Appeals and Grievances (cont.)

- A grievance must be filed within 90 days of the date of the occurrence.

- Members may send or attach any additional documents to support their grievance to the *Member Grievance Form*. Members can contact us at:

Highmark Delaware Health Options
Appeals and Grievances
P.O. Box 22278
Pittsburgh, PA 15222-0188
Phone: 1-844-325-6251
Fax: 1-844-325-3435

Provider Services

Provider Service Center

- 1-844-325-6251
- Representatives are available Monday through Friday 8am-5pm
- First point of contact for Plan related inquiries

Provider Relations

Dedicated Provider Account Liaison assigned to facilities and provider offices. They are able to assist with:

- Initial and ongoing education and training
- High level or global issues and trends
- Plan policies and procedures

Cultural Competency

Health Options understands that in order to best improve the quality of life of our members, we must be cognizant of their cultural and linguistic differences. For this reason we have made a commitment to address racial and ethnic disparities. A collaborative and trusting patient-provider relationship is the key to reducing the gaps in health care access and outcomes.

Health Options has assembled a list of resources and web-based tools to assist you and your office staff in providing care that is sensitive to the cultural and linguistic differences of your patients.

Visit the Highmark Health Options website to access the Cultural Competency Toolkit.

- https://www.highmarkhealthoptions.com/providers/forms

Provider Responsibilities

- The primary care practitioner is responsible for the coordination of a member's health care needs and access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care services. Although members may obtain health care services without a PCP referral, Highmark Health Options strongly encourages members to work through their PCP to access any health care service.

- Highmark Health Options also strongly encourages PCPs to play an active role in coordinating the health care services needed by their patients, including working with specialty providers and other practitioners to meet the patients' health care needs.

- Communication between the PCP, specialists, and member are key to providing high quality, cost effective care for our members.

Access and Availability Standards

Health Plan members are expected to receive an appointment with a qualified primary care/specialty practitioner based on the following standards:

TYPE OF CARE	TIME FRAME REQUIREMENT
PCPs & Specialists	
Emergency Services	Immediately 24 hours a day, 7 days a week
Routine appointment (including EPSDTs)	Within three weeks
Emergency condition appointment	Same day
Urgent Care	Within two calendar days
Maternity Care Providers	
Initial appointment in first trimester	Within three weeks
Initial appointment in second trimester	Within seven calendar days
Initial appointment in third trimester	Within three calendar days
Initial appointment for high risk pregnancy	Within three calendar days
Behavioral Health Providers	
Care for a non-life-threatening emergency	Within 6 hours
Potential suicidal individual	Within 1 hour or call Mobile Crisis Intervention Team or call police
Urgent care	Within 48 hours
Initial visit for routine care	Within 7 business days
Follow-up routine care	Within 3 weeks

Medical Records Requests

The member, or a member's representative, including head of household, legal guardian, or durable power of attorney, shall have access to view and/or receive copies of the medical record upon request. There is no charge for the copied medical record if the record is sent to another practitioner or provided directly to the member. The request must allow reasonable notice and follow the specific procedures of the practitioner or provider.

Resources

- Highmark Health Options Website
  www.highmarkhealthoptions.com
- Provider Manual
- NaviNet
- Monthly Provider Newsletters
- Online Provider Directory
- Reference Material

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Contact Information

Health Options Toll Free Contact Information	
Member Services	844-325-6251
Provider Services	844-325-6251
Pharmacy Provider Services	844-325-6251
Utilization Management	844-325-6251
Care Management	844-325-6251
Fraud and Abuse	844-325-6256
Behavioral Health	844-325-6251
Shared Health	844-325-6258
Health Options DSHP Member Advocate	855-430-9852
Health Options DSHP Plus Member Advocate	855-430-9853
Highmark Delaware Provider Services	302-421-8703
24 Hour Nurse Line	855-445-4241

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QUESTIONS

Fraud, Waste and Abuse

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Fraud, Waste and Abuse

Payment Integrity – Special Investigation Unit

Working Together To Combat Fraud, Waste and Abuse

Fraud and Abuse Definitions:

Fraud: Any *intentional* deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself, herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste: Involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to inappropriate act or omission by player with control over, or access to, government resources.

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result either in an unnecessary cost to the Federally funded programs or in reimbursement for services that are not medically necessary or provider practices that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the federally funded programs.

Fraud and Abuse Hotline -1-844-325-6256
Source **www.highmarkhealthoptions.com/fraud**

Fraud, Waste and Abuse

Examples of actions that may constitute fraud include:

• Knowingly billing for services not furnished or supplies not provided, including billing for appointments that the patient failed to keep;
• Billing for non-existent prescriptions; and
• Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of actions that may constitute waste include:

• Conducting excessive office visits or writing excessive prescriptions;
• Prescribing more medications than necessary for the treatment of a specific condition; and
• Ordering excessive laboratory tests.

Examples of actions that may constitute abuse include:

• Billing for unnecessary medical services;
• Billing for brand name drugs when generics are dispensed;
• Charging excessively for services or supplies; and
• Misusing codes on a claim, such as upcoding or unbundling codes

Source **www.cms.gov**

Fraud, Waste and Abuse

How Do You Prevent Fraud, Waste and Abuse?

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

Source **www.cms.gov**

QUESTIONS

Health Options
Provider Forum DSHP Plus LTSS

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Agenda

- What is DSHP Plus LTSS?
- Case Manager Role in Nursing Facilities
- Nursing Facility Authorization Process
- Nursing Facility Transition (NFT) Program
- Late and Missed Visit Reporting
- How to Identify and Report a Critical Incident
- Provider Portal - NaviNet

What is DSHP Plus LTSS?

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What is DSHP Plus LTSS?

History of LTSS

- Implemented in the State of Delaware April 1st, 2012
  - 2 participating MCO's at go-live: DPCI and UHC
  - Currently managed by Highmark Health Options and AmeriHealth Caritas
- Prior to MCO's managing the program, the State of Delaware managed the benefit.
  - Fragmented with multiple access points and no coordination
  - Limited options and choices
  - Heavily institutional
- Impact of Switch to Managed Care
  - Shift in benefits management
  - Shift in provider coordination
  - Shift in case management

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What is DSHP Plus LTSS?

- Long Term Services and Supports
  - A case management department within a managed care organization that manages the enhanced benefits package for DSHP Plus members.
    - 100% Case Management of Members
    - Coordination of Care
    - Transitions of Care
  - Goals
    - Maximize Independence
    - Keep member in the least restrictive and most appropriate and cost effective environment while honoring their choices
    - Delay or prevent the need for institutional placement when possible
- 4 Ways of Receiving Services in Delaware
  - Consumer of Health Options
  - Consumer of AmeriHealth Caritas
  - Consumer of St. Francis Life Care Program (PACE) (no NF benefit)
  - Fee for Service Medicaid where the ADRC will set up short-term services, usually while waiting for LTSS application to be approved.

What is DSHP Plus LTSS?
Who We Are (as of August 2018)

- A Multidisciplinary Department
  - Director, RN, CCM
    - 4 Managers, RN and LCSW (CCM)
      - 3 Full-Time LTSS Clerks
        - » 1 Temp Clerk
      - 8 Full-Time Supervisors, RN, BSW/MSW/MS, LCSW (CCM)
        - » 82 Full-Time Case Managers, a mixture of licensed and unlicensed staff with behavioral health, social work, case management, nursing and healthcare backgrounds (RN, LPCMH, LCSW)
        - » 6 Temp Case Managers
  - Full-Time LTSS Medical Director
  - Full-Time LTSS Member Advocate
  - LTSS Support Center
    - Manager, Supervisor, Member Associates, and Business Analyst
    - Available 8am-6pm, EST

What is DSHP Plus LTSS?

Where Are Our Members

- Home and Community Based Settings (HCBS)
  - Assisted Living Facilities
  - Private Residences, apartment buildings, group homes, etc.
- Nursing Facilities
  - ECC and Voorhees for pediatric members up to age 21
- All Across the State of Delaware
  - Case Managers live in all 3 counties

What is DSHP Plus LTSS?

What Services Are Provided

- Adult Day Care
- Day Habilitation
- Attendant Care (includes ADL and iADL assistance)
- Self-Directed Attendant Care (SDAC)
- Specialized Medical Equipment (SME)
- Minor Home Modifications
- Personal Emergency Response System (PERS)
- Home Delivered Meals (HDM)
- Respite – Inpatient and In-Home
- Cognitive Services
- Nutritional Supplements (AIDS Waiver – AW)
- Assisted Living Facility
- Nursing Facility – Custodial Care
  - Bedhold Days (medical and therapeutic)
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
- Nursing Facility Transition Program (NFT) (Formally MFP Program)
  - $2500 allowance to help with transitions
- All services are authorized for 90 days at a time
- All services require prior authorization
  - All services must be authorized by the case manager

What is DSHP Plus LTSS?

Who Are Our Providers

- Attendant Care Agencies
- FEA/FMS Agencies
- Emergency Response Companies
- Meal Providers
- Day Programs
- Nursing and Assisted Living Facilities

What is DSHP Plus LTSS?

What Exactly Do We Do

- HCBS Members are seen in the home every 90 days (including ALF).
  - Members get a monthly assessment by phone.
- NF Members are seen in the facility every 180 days.
  - Case managers attend quarterly facility care plan meetings.
  - Assess all members for ability to transition to the community.
    - Refer to NFT.
    - Case Manager Directed Discharge.

  All members will be seen more frequently if needed
- Case Managers complete a comprehensive needs assessment.
  - Create an emergency plan and a disaster plan.
  - Create a service plan including authorized LTSS services and all other services (other payors and community resources).
  - Create a back-up plan for authorized services.
  - Create a care plan with member-centric goals.
- Quarterly Coordination with PCP, Specialists, and Community Resources.
- Assist with transitions of care.
- Member Advocate.
- All other duties as assigned.

What is DSHP Plus LTSS?

Collaboration

- Our case managers work with the member to create a member-centric care plan that includes:
  - Their wishes and goals
  - Input and recommendations from you, our providers!

- Case managers will reach out to PCPs, behavioral health providers, and specialists for input on the care plan.
  - You don't have to wait for us to call you; we'd love to hear from you!

Regardless of setting, in the community or in a facility, our case managers will reach out for input from the interdisciplinary team.

What is DSHP Plus LTSS?

How to Make a Referral

- Call the Central Intake Unit (CIU)
  - 866-940-8963
- Visit the Aging and Disability Resource Center (ADRC)
  - www.delawareadrc.com
  - A Preadmission Evaluation packet (PAE) will be completed which includes a financial review.
    - Applicants must have 1 ADL deficiency to qualify for HCBS level of care (LOC).
    - Applicants must have 2 ADL deficiencies to qualify for NF LOC.
      - A Pre-Admission Screening and Resident Review (PASRR) must be completed prior to any nursing facility admission.
  - For continued participation in the program, the LTSS RN case managers complete an annual redetermination and the PCP completes a MAP A or an H&P. The state completes the annual financial redetermination with the member. Members that no longer meet LOC will be referred to the state for final determination and may be disenrolled.

What is DSHP Plus LTSS?

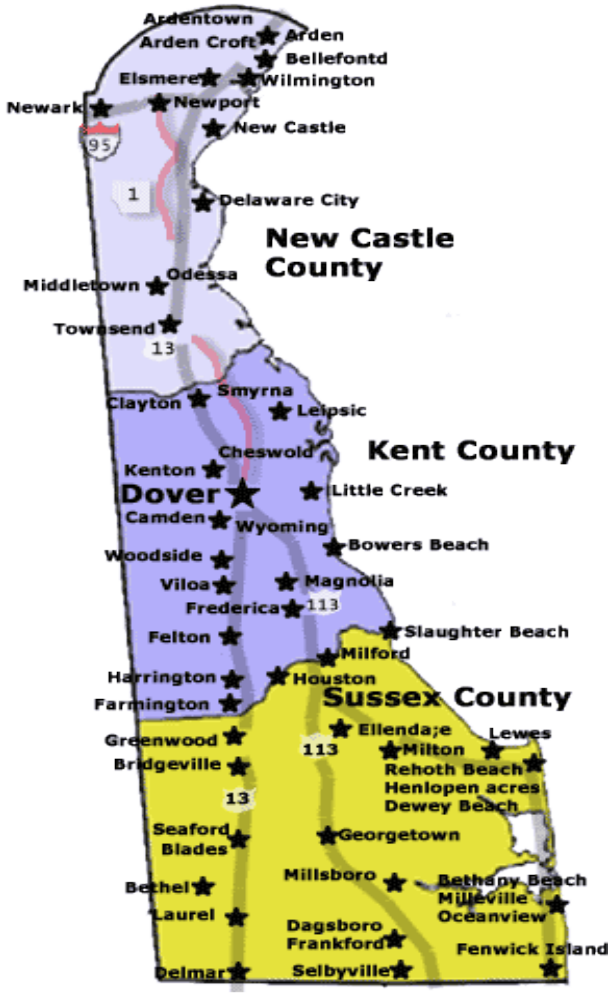
LTSS Membership by County

As of August, 2018

New Castle
- NF 1086
- HCBS 1939

Kent
- NF 250
- HCBS 669

Sussex
- NF 444
- HCBS 821



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Case Manager Role in Nursing Facilities

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Case Manager Role in Nursing Facilities

- Case Manager (CM) is single point of contact
- CM serves as Member Advocate
- The LTSS CM conducts a face to face visit every 6 months.
- CM attends care conferences
- CM evaluates for transition back to community (NFT program or independently)
- Assesses member for any assistance needed for activities of daily living/or chore services (ADL/IADL) and Behavioral Needs
- Develops plan of care (POC) for services with member and/or representative
- Member selects preferred providers for their care
- Case Manager support available 24/7
- Goal: Maintain the member in the most appropriate and least restrictive environment according to the members preferences.

Case Manager Role in Nursing Facilities

How you can help us:

- Please send us the dates for care plan meetings
- Notify us of any known transitions as soon as you are made aware
- Notify us of any Health Options admissions and discharges
- Help our case manager obtain access to the electronic medical record

For any needs, please contact your facility case manager or email us at LTSSNF@highmarkhealthoptions.com

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Nursing Facility Authorization Process

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Nursing Facility Authorization Process

- Required for bed holds
- Therapy PT/OT/ST
- Contact LTSS clerks at:
  - Tracy 302-317-5937
  - Lynn 302-502-4117
  - Donna 302-502-4036

Nursing Facility Transition (NFT) Program

(Formally Money Follows the Person (MFP) Program)

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Nursing Facility Transition (NFT) Program

One of the LTSS goals is to ensure that the member is in the least restrictive and preferred environment. Thus the CM will ask appropriate members what is their preferred environment.

Where do they wish to live?

An explanation of the Nursing Facility Transition Program and the Nursing Home Diversion program is provided to the member and family.

Anyone can make a referral on a member's behalf – please contact the Health Options single point of contact or the facility social worker.

Nursing Facility Transition (NFT) Program

- **Eligible Members**
  - ✓ LTSS with a 90 day stay in a qualified facility

- **Assistance** with locating a place to live, arranging for medical, rehabilitative, home health or other services needed in the community.

- **Assistance** for the person to develop their own plan of care

- **Funding** for Supplemental NFT Transition Services

Nursing Facility Transition (NFT) Program

FUNDING FOR:

- **Initial household setup expenses** (e.g. security and utility deposits, basic necessities etc.)
- **Counseling for basic living skills** such as budgeting, nutrition and transit travel, etc.
- **Education and Training on Community Services and Medical Care** such as informational workshops about services that can be accessed in the community.
- **Assistive Technology** that provides necessary assistive devices for individuals to function within the community.
- **Personal Assistance Services** provides assistance with any instrumental daily living activities. (e.g. grooming, meal preparation and recreation, etc.)
- **Home Accessibility Modifications** can provide necessary accessibility needs in the home such as ramps or bathroom access.
- **Respite Care** offers short term care assistance when your regular care provider is not available.
- **Home Delivered Meals**

Late and Missed Visit Reporting

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Late and Missed Visit Reporting

- State contract requires us to track and trend missed visits for home care.
- Fax missed visits to: 844-207-0328 when unable to cover shift (members name, MCI#, date and # of hours)
- No need to report member cancellations

How to Identify and Report a Critical Incident

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How to Identify and Report a Critical Incident

Definitions

- **Abuse or Neglect** means the infliction of physical pain, injury or mental anguish, or the deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services which are necessary to maintain that person's health or welfare.

- **Exploitation** means the improper use by a caretaker of funds which have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult.

- **Sexual Abuse** occurs when an adult is forced, tricked, threatened or otherwise coerced by a person into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against such adult's will. Sexual abuse occurs when an adult is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person.

How to Identify and Report a Critical Incident

Types of Critical Incidents

The types of abuse, neglect and exploitation include:

- Death of a member
- Suspected of Abuse or neglect
- Financial exploitation
- Unprofessional conduct
- Physical abuse with injury
- Falls with injury
- Neglect with mistreatment
- Significant injury unknown
- Unable to locate the member
- Entrapment
- Restraint – inclusions
- Medication theft
- Unsafe conditions
- Quality of care issues

How to Identify and Report a Critical Incident

Legal Requirement to Report

If there is suspicion that an adult has suffered abuse, neglect or exploitation,

- Is required to report to Division of Medicaid and Medical Assistance (DMMA) at 1-877-453-0012 or fax 1-877-264-8516
- The report must be made immediately and always ***within 8 hours of discovery by phone and fax***
- APS 1-800-223-9074
- Office of Health Facilities Licensing & Certification – for cases in an Acute, Outpatient, Hospital or Hospice setting. 1-800-942-7373
- Contact DHSS LTC Office of the State Ombudsman Community Services Program at 302-577-1406 for cases in a facility regarding a member's rights

Any person having reasonable cause to suspect that a child has suffered abuse, neglect or exploitation must be reported or cause the report to be made to Delaware Family Services at: 1-800-292-9582

How to Identify and Report a Critical Incident

Provider Responsibility

- Providers should notify CM within one business day of a critical incident
- Call the Assigned Case Manager
- Call LTSS Member Services 1-855-401-8251
- Call the LTSS Support Center 1-844-325-6258

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QUESTIONS

Health Options
Care Coordination

Health Options
Highmark Blue Cross Blue Shield Delaware

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Agenda

- Overview Care Coordination Department
- Model of Care
  - **Pediatric POD**
  - **BH POD**
  - **PROMISE POD**
  - **Maternity/EPSDT POD**
  - **Chronic Conditions POD**
  - **Integrated/Special Needs POD**
  - **Opioid POD**
- Collaboration with Providers
- Utilization Management
- Important Contact Information

The Right Care at the Right Time

All Member	Level 1	Level 2
Appointment Assistance and Linkage to Services	Resource Coordination (Non-Clinical)	Clinical Care Coordination
Member Services	Resource Coordinator (telephonic and field based)	Clinical Care Coordinator (telephonic and field based)
Member Services now refer to Care Coordination as follow up to New Member outreach calls	Appointment Assistance	Member Outreach and Assessment
Resource Coordinator (telephonic and field based)	Linkage to Covered and Non-Covered Medically Necessary Services	Care Plan Development
Appointment Assistance	Access to Wellness	Discharge Planning
Linkage to Covered and Non-Covered Medically Necessary Services	Care Gap Reminders	Internal/External Specialized Resources
Access to Wellness	Vaccine (FLU/Pneumonia)	Treatment Options
Care Gap Reminders	Advanced Health Directives	Transitions Between Levels of Care
Vaccine (FLU/Pneumonia)	Discharge Planning	Care Team Collaboration
Advanced Health Directives	High Utilization Low Acuity ER visits	Medication Reconciliation
		Palliative/Hospice integration

Care Management Structure

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New Opioid Management Program

Program Name	Opioid Management Program- Behavioral Health Care Coordination
Plan Name	Highmark Health Options
Program Description	Highmark Health Options of Delaware has implemented a number of strategies to safely prescribe opioids and prevent opioid addiction in their Medicaid population. Delaware's Opioid Epidemic is representative of the national epidemic of opioid use and abuse. Opioids can be highly addictive and their use and abuse is a growing issue in the United States. While the US has about five percent of the world's population, it consumes about 80 percent of the global supply of prescription opioids. Delaware has been hit hard by the opioid epidemic. According to the NSC (National Security Council) in 2014, Delaware had the 8th highest heroin fatality rate in the US. Delaware's drug overdose rate, across all categories of drugs, has increased. In 2016 emergency responders used Naloxone on 2,334 occasions. The Highmark Health Options Opioid Management Program entails an initial review by Pharmacy Services and referral to the Care Coordination department process (Opioid POD). This program will be phased in. Phase one will be for members currently on doses of opioids that exceed 90 Morphine milligram equivalents (MMEQ) per day will be targeted to receive a letter of the program and upcoming limitations to opioids. Their prescribers will also receive notice that provides informational links to CDC website tools for prescribing. Phase two will consist of limiting short acting opioid prescriptions to a 7 day supply for children and a 14 day supply for adults age 18 or older. Members that are exceeding 90 MMEQ will be given a conditional approval with instructions to the prescriber to work with the member to taper the daily dose. Pharmacy claims will be monitored 3 months after the conditional approval to check for tapering. Members not tapering will be referred to care coordination and motivational interventions. The program conducts a full clinical case review including Pharmacy recommendations, and case summary creation that is then presented to the work group (Pharmacy Director, BH Medical Director, Manager BH UM, and Supervisor Opioid POD). All case reviews and decisions are documented in EHS system.

SPOC Outreach & Engagement Strategies

85

Care Coordination

- Proactive outreach to members with high-risk chronic or catastrophic conditions on an ongoing basis.
  - Coordination of Care
  - Educate Members
  - Address potential barriers to care and adherence to treatment plans
  - Coordinate community resources
  - Collaborate with providers to optimize patient outcomes
  - Maintain health and prevent complications/comorbidities
  - Transition of Care Management

Care Coordination

- An integrated and collaborative approach to supporting member access to the right level of care, at the right time
- Oversees coordination of behavioral/physical health services including services to address mental health, drug and alcohol concerns as well as managing medical needs
- Supports member access to care and self management

Goal of Care Coordination

- Supporting members experiencing behavioral/physical health concerns attain/maintain autonomy and self reliance through:
  - Timely access to quality care within the least restrictive setting; and
  - Appropriate care coordination support based upon the member's unique needs, rendered in a member-centric and culturally competent manner.

Care Coordinators Staff

- Care Coordinators are experienced nurses and social workers who are responsible for:
  - Telephonic outreach and engaging members (face to face based on the member's unique need)
  - Communication with providers and community stakeholders
  - Coordinate care between Behavioral Health and Physical Health

Coordination and Collaboration with Providers

- Care Coordinators support providers with oversight and input to the member's care plan.
  - Navigate health care system
  - Member focused coaching
  - Coordination of Care
  - Medication Reconciliation
  - Transitions of Care
  - Identify barriers
  - Discharge Coordination

Behavioral Health Program: Utilization Review

- All requests for behavioral health services (mental health or drug and alcohol) through non-participating providers requires prior authorization
- All Behavioral Health Authorizations are completed by staff located in Delaware
- For services being rendered by a participating provider, the following levels of care require prior authorization:
  - Behavioral Health In-patient
  - Residential Treatment Facility
  - Partial Hospitalization
  - Intensive Out-patient
  - Electroconvulsive Therapy (ECT)
  - Psychological Testing
  - Home Care Services

EPSDT Provider Report

- Introducing EPSDT Provider Dashboard available via NaviNet.
- Primary Care, Pediatricians and FQHC will receive a notification quarterly, watch for notification **EPSDT Report**

Subject: APR17 EPSDT Report

We are pleased to share this new offering with you. Attached below is your most recent EPSDT report. It includes Highmark Health Options members that have identified your practice as their Primary Care Provider. Highmark Health Options is committed to collaborating with you to provide information to ensure our members receive all the mandated benefits outlined within the EPSDT program. This report will be generated quarterly and can assist you in identifying the current status of all your patients in regards to their EPSDT preventative health screenings. It reflects member information and compliance statistics generated from submitted claims. We want to work together to close any potential gaps in care. Please feel free to outreach your Provider Relations Representative if you have further questions regarding this report.

Thank you,

Highmark Health Options

Attached files: 1

EPSDT Provider Report – Summary Page

EPSDT Panel Summary

Member Summary

Total EPSDT Eligible Members	Foster Care Members	Compliant Members	Non Compliant Members	% Compliant
3,072	57	90	2,982	3%

Billing Summary

Expected EPSDT Visits	Completed EPSDT Visits	Correctly Billed (per EPSDT specs)	Billing Discrepancies	Billed without EP Modifier	Billed with different Diagnosis	Billed without EP Modifier and different Diagnosis
3,072	960	0	955	900	0	55

*Total visits are not linked to unique members, but can reflect multiple visits per member as identified via claims submission
*Optional Screenings (risk assessment to be performed with appropriate action to follow, if positive) at any age bracket currently DO NOT contribute to overall compliance (marked as Completed or Not Completed)
*Screenings that span multiple age brackets currently DO NOT contibute to overall compliance status (marked as Completed or Not Completed)
*Screenings not applicable to a member at their current age are marked as N/A

*For a member to be compliant with EPSDT Guidelines, they must get all recommended age appropriate screenings per the BrightFutures/APP Periodicity Schedule
and a claim with one of the following procedure codes must be submitted:
99381, 99382, 99383, 99384, or 99385 (for New Patients)
99391, 99392, 99393, 99394, or 99395 (for Existing Patients)
99460 or 99463 (for Newborns)

*Correctly billed EPSDT Claims must have (on the line with 99381-5/99391-5/99460 or 99463 CPT Code) -
1. Modifier: EP
2. Primary Diagnosis Code: Z00.121 or Z00.129 or Z76.2 or Z76.1 (V20.2 or V20.1 or V20.0)

EPSDT Provider Report – Member Detail

- Partial view of the Provider Report

EPSDT Eligible Members Details

FAMILY HLTHCARE/PCP has 2 members in foster care

Member #	First Name	Last Name	Foster Care	Measuremen	Vision	Hearing	Developmental Screen	Autism	Developmental Surveillanc	Behavioral Assmnt	DrugUse Assmnt
	COREY J		YES	Missing	N/A	N/A	N/A	N/A	Missing	Missing	Missing
	RAYMOND		YES	Missing	N/A	N/A	Missing	Missing	N/A	Missing	Missing
	ANTHONY		NO	Missing	Missing	N/A	N/A	N/A	Missing	Missing	Missing
	JAMILETTE		NO	Completed	Completed	Completed	N/A	N/A	Completed	Completed	Completed

Home Health Care

- Home Health is encouraged for Members when they're being discharged from an Acute or Post-Acute care facility to decrease risk of readmission and increase compliance with treatment
- Your Patients (*our mutual Members*) do NOT need to be homebound
- What home services can we provide? Highmark Health Options can Authorize up to 10 visits per discipline at time of discharge from an in-patient stay
  - Does your Patient need a medication reconciliation?
  - Do they need medication/disease process education?
  - Are you concerned with their home safety environment?

Hospice Authorization

- Hospice is utilized to support Members and their families in the last stages of life
- The Member must be Hospice certified by Hospice Provider
- The Member and family must agree to Hospice care
- Highmark Health Options can authorize up to 30 days for home Hospice

Care Coordination Leadership Team

Diana Rappa-Kesser RN, MSN, CCP, CCM
Vice President Care Management
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Jill Haer, LPCMH, NCC CCM Behavioral Health/Behavioral Health Utilization Management
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Highmark Health Options
Utilization Management Program

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What is the Highmark Health Options Utilization Management Program?

- An integrated and collaborative approach that supports Member access to the right level of care, at the right time
- Oversees coordination of Utilization Management services including services to address medical and mental/behavioral health
- Identifies and supports Members who would benefit from care coordination

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Goals of the Utilization Management Program

- The UM Staff are licensed clinicians who support Members experiencing medical and/or behavioral health concerns attain/maintain autonomy/self-reliance through:
  - Timely access to quality care within the least restrictive setting
  - Supporting Members with concurrent physical health and behavioral health considerations by coordinating with the Highmark Health Options Medical and Behavioral Health Care Coordinator as needed driven by each Member's unique need
  - Providing appropriate care coordination based upon the Member's needs, rendered in aMember-centric and culturally competent manner

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Coordination and Collaboration: Health Care Providers

- Utilization Management Staff are able to:
  - Support Providers with Member transition between Health Providers
  - Assist Providers with discharge coordination when Member discharge entails transfer to a less restrictive level of care, with ultimate goal of getting member to home setting as applicable/able

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Appeal Process

- **How/Where to submit an appeal?**
  - All appeals are required to be submitted in writing.
    - When submitting a written request for an appeal, the Provider is required to submit any and all supporting documentation including, but not limited to, a copy of the Denial Letter, the reason for the Appeal, and the member's medical record containing all pertinent information regarding the services rendered by the Provider.
    - Address for submission: PO Box 22278, Pittsburgh, PA 15222
    - Fax for submission: 855-501-3904
- **Appeal Submission timeframes:**
  - All appeals are to be received by Highmark Health Options within the timeframes noted below.
  - Appeals received outside of designated timeframes will be administratively dismissed.
- **Appeals for denied Authorizations**
  - When an authorization is denied, Provider must submit an appeal based on the denied authorization timeframes as indicated in denial letter received from utilization management. The time frame for submission of appeal does not restart when a claim is submitted and denied.
  - **Timeframe to submit appeal for denied authorization:**
    - Ninety **(90)** days

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Peer to Peer Process

- Peer to Peer Process:
  - Utilization Management (UM) Staff will offer Peer to Peer and provide the Peer to Peer Phone # 844-278-8451
  - The Provider Representative and/or Provider MD can call the Peer to Peer phone line to schedule with UM Clerk
  - The UM clerk will assign to the appropriate Highmark Health Options Medical Director for call back

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Utilization Management Phone Contacts

- **Carolyn M. Stahl** RN, BSN CCM**,** Director Care Coordination
  (302) 317-5927 (office)
  E-mail: cstahl@highmarkhealthoptions.com
- **Donna Moses-Pendleton**, RN, MSN UM Manager/Inpatient Services
  (302) 217-7924
- **Dawn Behulak**, RN, BSN, BC, UM Supervisor/Inpatient Services
  (302) 502-4047
- **Lynn Phillips**,LSW, CCM UM Supervisor/Durable Medical Equipment/Outpatient Services/Home Care
  (412) 918-8669
- **Highmark Health Options Provider Services**
  Phone #1-844-325-6251

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Provider Key Fax Numbers

Home Health Visits (Post Acute &/or ongoing)	855-451-6667
Abortion/Sterilization	855-412-7996
Inpatient (Acute & Post-Acute) & NICU	855-451-6670
Durable Medical Equipment (DME)	855-451-6663
Maternity & PAR Elective Surgery	855-888-8252
Outpatient Therapy	855-451-6664
Hospice and Out of Network (OON) Elective Surgeries &/or Procedures	855-451-6665

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Highmark Health Options
Quality Program Updates

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Member Rights and Responsibilities

What are Member Rights and Responsibilities?

Examples of Member Rights:

- See your medical records as allowed by law
- All facts from your doctor of any information about your medical condition, treatment plan or ability to look at and offer corrections to your own medical records.
- Be told about other treatment choices or plans for care in a way the fits your condition
- Be treated with respect, dignity and the right to privacy all the time
- Choose your PCP from the PCPs in our Provider Directory that are taking new patients
- Make an Advance Directive (also called a living will).
- File a complaint or an appeal about Highmark Health Options, any care you get or if your language needs are not met.

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Member Rights and Responsibilities

Examples of Member Responsibilities:

- Learn as much as you can about your health issue and work with your doctor to set up treatment goals you agree on with your doctor
- Make and keep medical appointments and tell your doctor at least 24 hours in advance when you cannot make it.
- Always show your member Highmark Health Options ID card and Delaware Medicaid card when you get health care services.
- Use the emergency room only in cases of an emergency or as your doctor tells you.
- If you owe a co pay to your pharmacies, pay at the time the services are received
- Treat all Highmark Health Options staff and doctors with respect and courtesy.
- Tell the DHSS Change Report Center and us when you change your address, family status or other health care coverage.

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Member Rights & Responsibilities

Why are they important?

- Encourages a mutually respectful relationship with members
- Part of the commitment to service excellence by the Plan and its Network
- Required reading for all staff, providers, and sub-contractors serving members
- Annual notification complies with:
  - United States Code of Federal Regulations (CFR)
  - Delaware Division of Medicaid and Medical Assistance (DMMA)
  - National Committee for Quality Assurance (NCQA)

What do you need to do?

- Ask your staff to read the Member Rights & Responsibilities Statement found at:

https://www.highmarkhealthoptions.com/rights

What is a Quality of Care or Quality of Service Concern?

Situations where:

- there is potential that the quality of the health care services provided to a member did not increase the likelihood of desired health outcomes;
- care is not consistent with current professional knowledge; or
- the member's health or life may have been placed in jeopardy due to the action or lack of action taken by a practitioner.
- Examples include:
  - Unsafe discharges from a facility
  - Equipment failure resulting in negative outcome
  - Medication Errors
  - Delay in diagnosis
  - Delay in treatment

Who can report a Quality of Care or Quality of Service Concern?

- Anyone
- External examples include Providers, Practitioners, Office Staff, State or Federal Agencies, Fraud Waste & Abuse

Quality of Care and Quality of Service Concerns

What We Do

- Conduct a medical record review, review findings, and resolution.
- Refer suspected or actual QOC findings to a Medical Director for possible actions:
  - Provider Response
  - Education
  - Corrective Action Plan
  - Peer Review
- Notify other areas as needed:
  - Credentialing
  - Fraud and Abuse
  - DMMA
- Track and trend QOC concerns.
- Identify process improvement opportunities.
- Report confirmed findings and trends to the QI/UM Committee and the Board of Directors.

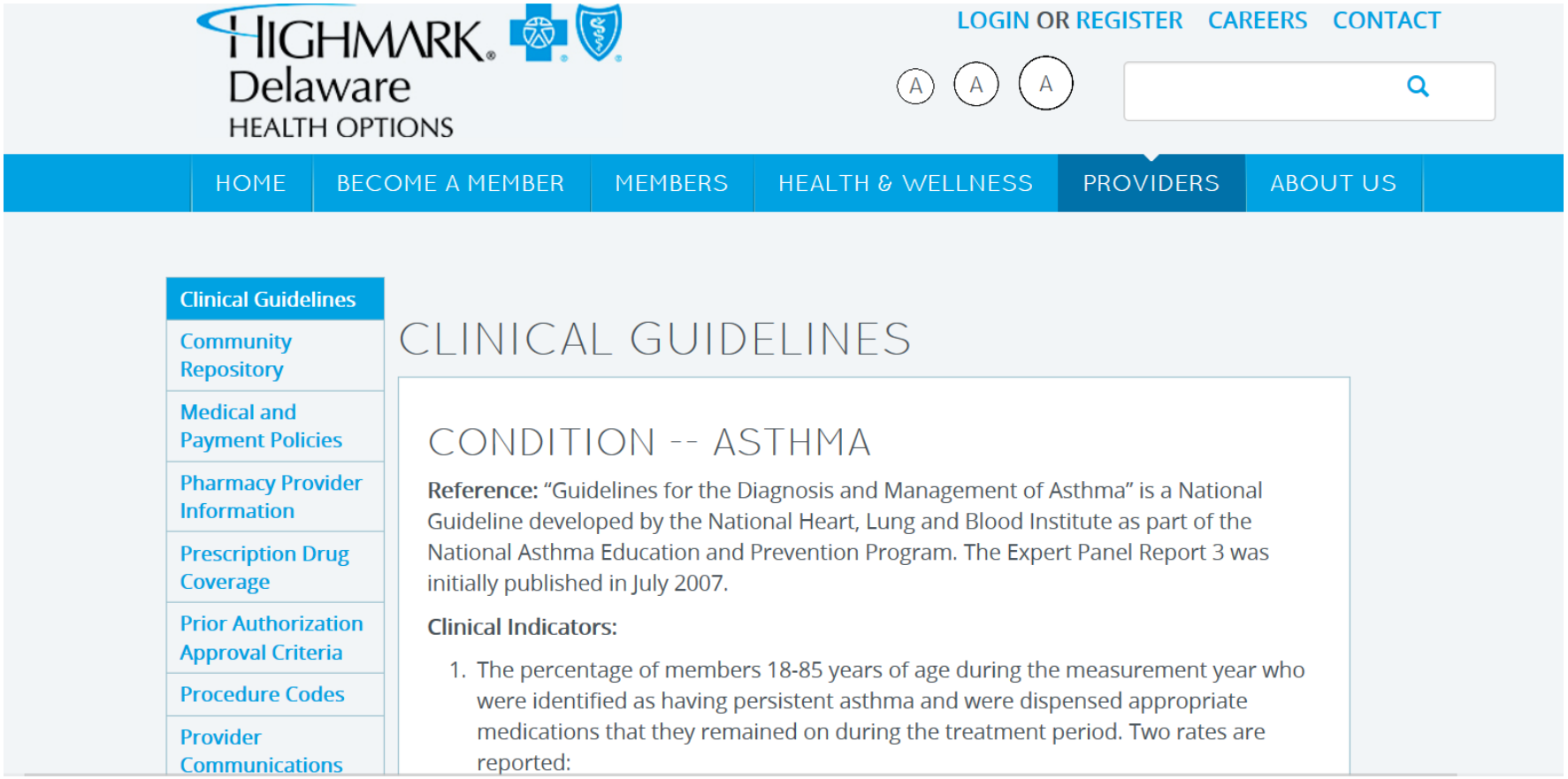
Quality of Care and Quality of Service Concerns

How Do You Notify Quality Improvement of a Potential Quality of Care Issue?

- Email: quality_of_care@highmarkhealthoptions.com
- Telephone Provider Services at 844-325-6251

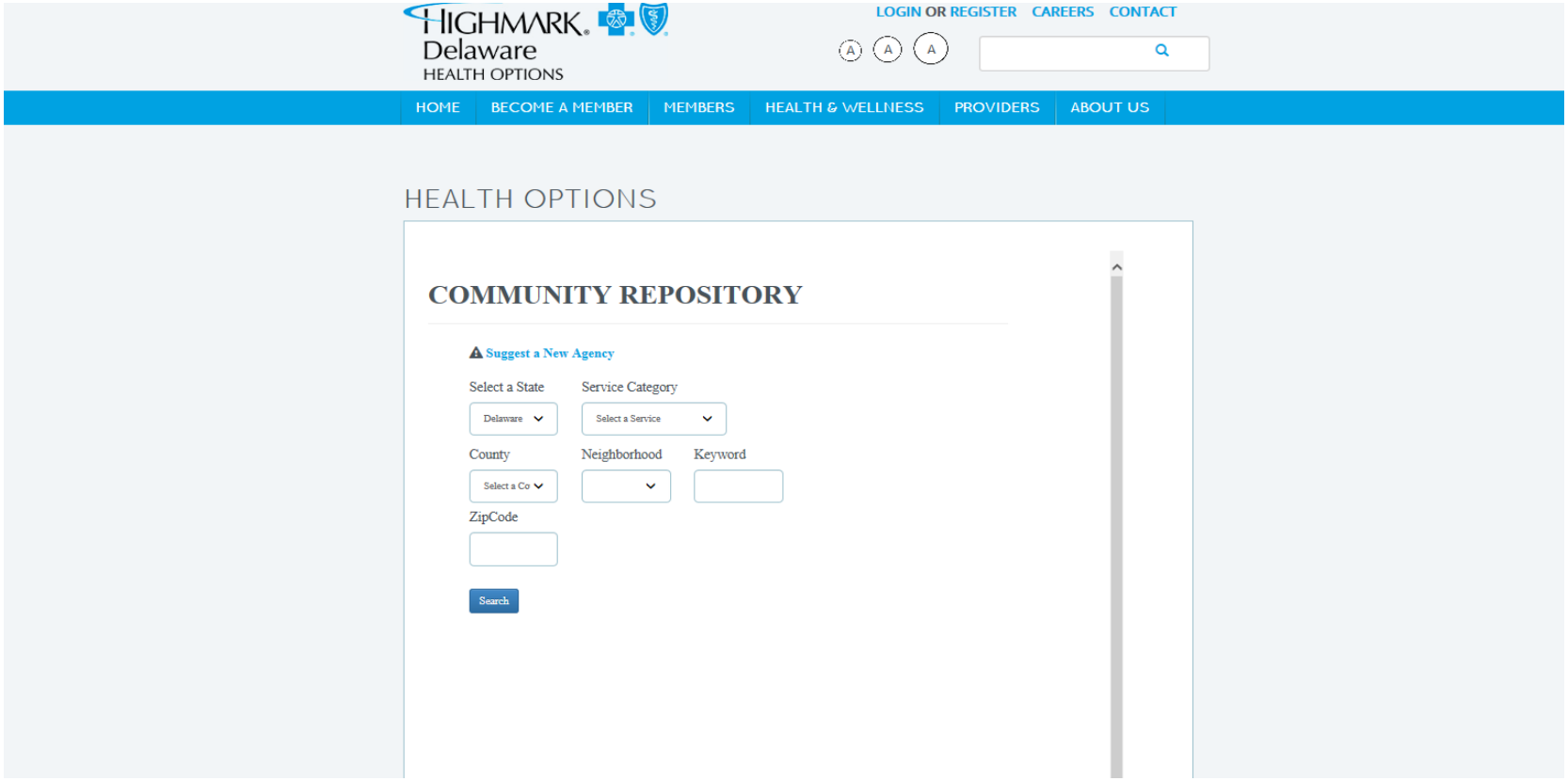
Clinical Practice Guidelines

- Available at https://www.highmarkhealthoptions.com/providers/guidelines



Community Resource Connection (formerly Community Repository)

- Available at https://www.highmarkhealthoptions.com/providers/communityrepository



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Community Resource Connection (formerly Community Repository)

- There are currently 134 Delaware agencies represented in the Community Resource Connection.

- Some of the 33 resource categories include:
  - Prescription Assistance
  - Behavioral Health
  - Crisis Support
  - Exercise and Nutrition
  - Financial Assistance
  - Cancer Education
  - Maternity Services
  - Housing
  - Senior Services
  - Transportation

Importance of Daily Oral Health Care

- Daily oral health care is an important component of general health and well-being. Those with disabilities may have a greater challenge in maintaining oral health due to functional limitations. **Because of this, special focus on oral health care is given to LTSS members. As a health plan, we are mandated to do a Performance Improvement Project on oral care for LTSS population.**

- Poor Oral Health Care Can Lead to:
  - Caries, Abscesses, and Periodontal Disease
  - Cardiovascular Disease
  - Dementia
  - Respiratory Infections
  - Diabetes (increased risk and control difficulty)
  - Cancer
  - Kidney Disease
  - Rheumatoid Arthritis
  - **Overall Decreased Quality of Life for our Members**

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Importance of Daily Oral Health Care

The best way to prevent serious health issues caused by bad oral health is to practice good oral hygiene.

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Importance of Daily Oral Health Care

Highmark Health Options Partners with LTSS Providers to Deliver Best Oral Health Care to Members

- Skilled Nursing Facility Providers
  - Use a standardized assessment tool
  - Establish a schedule to assess
  - Personalize the oral care plan for each resident/member
  - Document oral health care as an interventions on service plan, and allow CMs access to service plan
  - Document oral health care being conducted (at least daily brushing/denture care)
  - Provide SNF staff with oral health care training
  - Manage compliance of oral health program

- Community-Based Providers
  - Assessment of member's needs for proper oral care (special utensils, supervision, hands-on)
  - Document oral health care as an intervention on plan of care
  - Document oral health care being conducted (at least daily brushing/denture care)
  - Suggest a central, easy to find location for plan of care
  - LTSS CMs will be looking for oral health intervention on plan of care during quarterly home visits
  - Reach out to LTSS CMs if any oral health issues noticed; partner for best care

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Importance of Daily Oral Health Care

Dental Coverage is Provided to Medicaid Members up to age 21

Assistance for Adult Members?

- FQHCs (sliding fee scale)
- Recommend member contact their CM to learn about other possible resources (mobile dental clinics, other community dental offerings)

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HEDIS

- Annual Healthcare Effectiveness Data and Information Set rates drive:
  - Internal initiatives to improve rates
  - Outreach to members:
    - Health Education
    - Coordination of Care
    - Case Management
  - Collaboration with providers
    - Closure of Care Gaps
    - Exchanging information
    - Working together to achieve goals

- Ultimate goal: Improve the health care of our members!

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Example: Body Mass Index (BMI)

- Adult members over 20 years of age are compliant if they have both of the following:
  - At least one outpatient visit in the measurement year or year prior
  - BMI coded on claim

- Adult members 18 and 19 years of age are compliant if they have both of the following:
  - At least one outpatient visit in the measurement year or year prior
  - BMI *Percentile* coded on claim

Quality Performance Measures (QPMs)

- 7 Total Measures Mandated by DMMA for Improvement
- The QPMs contain 6 HEDIS measures:
  - Adult BMI Assessment (ABA)
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Comprehensive Diabetes Care (CDC) – HbA1c Control <8%
  - Medication Management for People with Asthma (MMA)
    - 5-11 year olds
    - 12-18 year olds
  - Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care
  - 30-day Hospital Readmission

Health Options
Risk Adjustment Programs
&
Role of the Clinical Transformation Consultant

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Health Options – Risk Adjustment Programs

- **Purpose**: Ensure that Health Options providers address their members' chronic Dx conditions each year
  - Dx conditions may by confirmed, denied, or corrected through two separate programs
- **Programs**:
  - ***Retrospective Program***: Pre-populated Risk Gap Closure Forms are sent to providers via Risk Gap Closure Module in NaviNet
    - ✓ Providers confirm or deny risk adjusted chronic conditions
    - ✓ If a Dx Condition(s) is properly substantiated, but was not previously reported, a Provider will submit a **Corrected Claim** with the new ICD-10 code
    - ✓ Health Options will incentivize Providers:
      - ✓ **$150** per Corrected Claim (one per member-form) submitted via Risk Gap Closure Module on the Provider Portal/NaviNet
      - ✓ **$125** per Corrected Claim submitted via any other method
      - ✓ **$10** for completed attestations only via provider portal
      - ✓ **$5** for completed attestations only via any other method

Health Options – Risk Adjustment Programs

- ***Prospective Program***: Providers receive a pre-populated form (SOAP Note) for each targeted member that contains risk adjusted chronic conditions; outreach to members by our third party, Inovalon
  - ✓ SOAP Notes are distributed by mail
  - ✓ Each pre-populated chronic condition on the SOAP Note must be addressed during a face-to-face encounter
  - ✓ SOAP Notes are completed
    - ❑ Using paper form and returned by fax or mail
    - ❑ Completed electronically using **ePASS**
  - ✓ Health Options incentivizes providers:
    - ✓ **$125** per electronic SOAP Note submission
    - ✓ **$75** per paper submission

Health Options – Clinical Transformation Consultant

- Role: CTCs work directly with network providers to champion provider practice transformation in support of HHO endorsed strategic care delivery models.
  - ***Risk Revenue Programs***
    - Close risk gaps, which encourages providers to address all chronic conditions with their members each year
    - Helps HHO to accurately report our members' risk scores to the State
    - Helps to keep member premiums low with proper State/Federal compensation based on accurately submitted risk adjusted conditions information
  - ***Quality Programs***
    - Improves members' quality of care
    - As a joint initiative between Risk Revenue and Quality, the CTCs will work toward improving the rates for the following HEDIS measures by educating providers about the importance of these measures and appropriate billing for services.
      - **ABA** – Adult BMI Assessment
        - Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
      - **CDC: HbA1c**
        - Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing.

QUESTIONS

***You may contact your CTC directly or by email*:**
DEproviderengagement@highmarkhealthoptions.com

HIGHMARK. Delaware HEALTH OPTIONS

Pharmacy

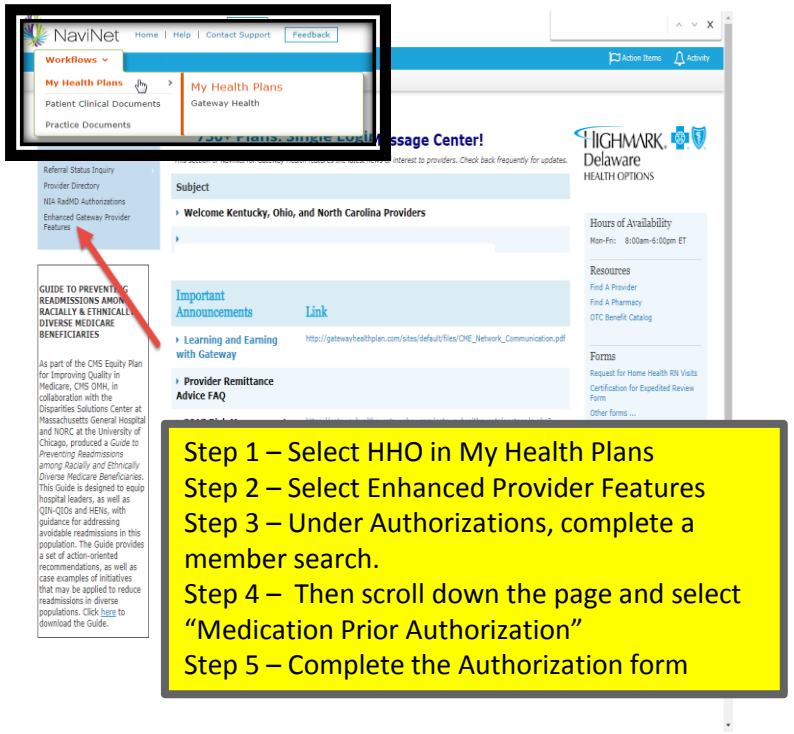
- Network includes national chains and many local, independent pharmacies
- Highmark Health Options follows the Delaware Health and Social Services Preferred Drug List (PDL)
  - Some of the medications on the formulary require prior authorization, have a quantity limit, must be dispensed by a specialty pharmacy or require step therapy. These medications are marked with a symbol under the Notes & Restrictions column when you find the medication in the drug formulary online.
  - Prior authorization criteria that is approved by DMMA is posted to the Provider tab on the website
- Pharmacy Department: 1-844-325-6251
- Opioid Management Program
  - Pharmacy implemented phase one of the program October 1st: the high dose opioid edit.
    - Members that have a cumulative dose above 90 morphine milligram equivalents per day will require prior authorization.
    - This program will include a Care Coordination POD to help members.
  - Phase two of the program will be introduced November 5th and will limit the day supplies to 7 day for members under the age of 21 and 14 day for members over the age of 21.

HIGHMARK. Delaware HEALTH OPTIONS

MEDICATION LISTS REQUIRING MEDICAL PRIOR AUTHORIZATION HAS ADDITIONS

- The prior authorization* process will apply to all Highmark Health Options members.
- NaviNet is the most efficient means to request authorization for using autofill functionality.
- If you have trouble completing an authorization or have an issue with accessing NaviNet, contact your Provider Account Liaison.

Highmark Health Options Page within NaviNet



Step 1 – Select HHO in My Health Plans
Step 2 – Select Enhanced Provider Features
Step 3 – Under Authorizations, complete a member search.
Step 4 – Then scroll down the page and select "Medication Prior Authorization"
Step 5 – Complete the Authorization form

HCPCS codes requiring Authorization on or After 3/5/18

J1300	J1561	J1745	J9355
J1322	J1566	J9042	J3490
J1459	J1568	J9228	J3590
J1556	J1569	J9271	J9999
J1557	J1572	J9299	
J1561	J1599	J9305	

Outpatient services only.

Highmark Delaware HEALTH OPTIONS

QUESTIONS