HIGHMARK WHOLECARE

DECEMBER 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

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Medicare Assured Members Individual Care Plans Through NaviNet

Highmark Wholecare sends our Medicare Assured providers a copy of every Medicare Assured members' Care Plan through the Highmark Wholecare provider portal (NaviNet) that is based on the member's individual goals identified while completing their annual Health Risk Assessment (HRA). The Plan has sent a copy of each member's care plan to the member as well. Please be sure to review and discuss the care plan with your Highmark Wholecare patients so we can work together to help our members reach their health care goals. Providers also have the ability to review quarterly materials that are sent to members that address common chronic conditions. They can also be found by accessing the Highmark Wholecare provider portal.

Highmark Wholecare Care Gap Management Application

At Highmark Wholecare, we value the important role practitioners play in serving our members. Our Care Gap Management Application (CGMA) has supported Highmark Wholecare's mission to improve the health and wellness of the individuals and the communities we serve by offering providers access to important care gap information throughout the year.

Although 2022 is rapidly coming to a close, there is still time to impact your care gap closure rates. To that end, we have extended the deadline for CGMA submissions. You will be able to submit 2022 care gap and service event information to the CGMA until 11:59 p.m. EST on **January 13, 2023.**

If you have any questions, please contact your Clinical Transformation Consultant directly or email us at: ProviderEngagementTeam@HighmarkWholecare.com.

Second Opinions

Highmark Wholecare ensures member access to second opinions. Second opinions may be requested by Highmark Wholecare, the member or the PCP. Highmark Wholecare will provide for a second opinion from a qualified health practitioner or provider within the network, or arrange for the member to obtain a second opinion out of network at no cost to the member. The second opinion must not be in the same practice as the attending practitioner. Second opinions are obtained by in-network practitioner or providers. However, out-of-network referrals may be authorized at no cost to the member when no in-network practitioner or provider is accessible or able to meet the member's needs.

UM Criteria & Guidelines

Highmark Wholecare ensures that utilization management criteria are available to practitioners and providers who make a request via telephone, email, fax or letter. Medical policies are available to practitioners and providers on the Highmark Wholecare website. Additionally, information about how to request this information is included on all denial notices. As a reminder, the Utilization Management telephone number is 1-800-392-1147 (TTY 711).

2022 Annual Provider Accessibility Audit/ Provider Obligations

Highmark Wholecare used a NCQA certified vendor to conduct an annual, telephonic accessibility audit of over 1,400 Medicaid and Medicare primary care, medical specialists, and behavioral health specialists (Medicare only) in 2022. The purpose of the audit was to determine if participating practice sites are adhering to established access standards related to the timeliness of members to receive care; including wait time for appointments and after-hour access to care. Standards related to missed appointments and the members average time spent in the office waiting room and exam room before seeing a practitioner were also included in the audit.

The audit results identified that primary care practice sites continue to meet after-hours access for both Medicaid and Medicare. For Medicaid, pediatric practice sites continue to provide timely access for urgent care and met the average office wait time standard in 2022. Oncology practice sites met the missed appointment and average office wait time standards in 2022. Improvement is needed for all other access standards.

Highmark Wholecare used the audit results to identify initiatives to improve access. One of those initiatives is continuous education of our provider network through promotion of the accessibility standards in our provider manuals, provider newsletters, through provider webinars, and publishing the accessibility standards on our provider website at https://highmarkwholecare.com/Provider/Provider-Resources/Accessibility-to-Care-Standards.

The next annual accessibility audit will be launched in the second quarter of 2023. Please review the accessibility standards with your office staff that schedule member appointments, including off-site central scheduling and call center staff, to ensure that your practice site meets the standards.

In addition, to keep you informed of other Provider Obligations related to member access, we have provided excerpts from your contract below:

Provider Services

Provider shall provide to Members those Covered Services that are within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this agreement. Such Covered Services shall be delivered in a prompt manner, consistent with professional, clinical and ethical standards and in the same manner as provided to Provider's other patients. Provider shall accept Members as new patients on the same basis as Provider is accepting non-Members as patients.

Provider shall make Covered Services available and accessible to Members on a 24 hour-per-day, 7 day-per-week, including, without limitation, telephone access to Provider. Provider shall provide Emergency Services without requiring prior authorization of any kind. Provider is not required to provide non-Covered Services as more specifically described in Program rules and regulations.

If Provider is a Primary Care Physician, Provider may, upon sixty (60) calendar days prior written notice to MCO, request that Provider's practice site not be required to accept additional Members. MCO will respond to Provider's request within (30) calendar days of MCO's receipt of Provider's request.

December is National Stress-Free Family Holidays Month.

Managing Holiday Stressors can be difficult, especially with the pressures of the holidays combined with already existing mental illness.

Here are some tips you can share with your patients for lessening the burden of stress this season:

- **Be kind to yourself.** All you can do is your best and your best is good enough. It's impossible to please everyone.
- **It is okay to feel the way you feel**. It is healthy to acknowledge your feelings and work through them, rather than suppressing them. Stay connected to your positive supports throughout the holiday season.
- **Come up with a plan.** Spread out your errands, so you don't become overwhelmed with too many tasks at once.
- **Make a budget.** It's important not to go overboard. Do your best to stick to a budget while still leaving a small amount extra for wiggle room.
- **Focus on gratitude when you become overwhelmed.** Studies suggest that people who practice gratitude are more optimistic, pleased with their lives, and connected to others.
- **Seek professional help if you need it.** Despite your best efforts, you may find yourself feeling persistently sad or anxious. If these feelings last for a while, talk to your doctor or a mental health professional.

For more information on mental health supports and treatment please visit SAHMSA at SAMHSA's National Helpline | SAMHSA or call the national helpline at 1-800-662-HELP (4537).

Mark your calendar!

Learning and Earning with Highmark Wholecare Free Professional Education CME/CEU Webinars

Topic	Date/Time	Key Speaker
Neonatal Abstinence Syndrome: Where We Started and Where We Are Now	Wednesday, January 4, noon–1 p.m.	**David Turkewitz, MD** Medical Director, Newborn Nurseries Allegheny Health Network
Registration link for January webinar: https://bit.ly/LearningEarningFREECME_NeonatalAbstinenceSyndrome		
Co-Occurring Disorders: Which Came First, the Chicken or the Egg?	Wednesday, February 1, noon–1 p.m.	**Shannen Lyons, MSW, LCSW, CAADC** Addiction Specialist Highmark Wholecare
Registration link for February webinar: https://bit.ly/LearningandEarningWebinar_Co-occurringDisorders		

Who qualifies for CME?

Webinars are free and open to all interested. CME/CEU credits are available for physicians, midlevel practitioners, nurses, psychologists and social workers.

Each webinar is eligible for one (1) CME/CEU credit. To receive credit, you must create a free account at CME.AHN.org. After creating your account, you will need to register for the webinars you wish to attend, using the instructions above. You only need to create the account one time to be eligible to receive CME credit for attendance at all live Learning and Earning webinar activities as well as accessing your transcripts. Instructions for claiming CME/CEU credit will be provided at each live webinar.

You must also create a free account at CME.AHN.org to access your transcript.

QUESTIONS?

Questions? Contact the Highmark Wholecare Provider Engagement Team at: **ProviderEngagementTeam@HighmarkWholecare.com**

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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Allegheny General Hospital and Highmark Wholecare. Allegheny General Hospital is accredited by the ACCME to provide continuing medical education for physicians. Allegheny General Hospital designates this live webinar activity for a maximum of 1.0 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Allegheny General Hospital is approved by the American Psychological Association to offer continuing education for psychologists. Allegheny General Hospital maintains responsibility for the program and its content. Social workers may claim credits for attending educational courses and programs delivered by pre-approved providers, such as the American Psychological Association. Approved for 1.0 APA credits.

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the policy of Allegheny Health Network, 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, honorarium, 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).

Fraud, Waste and Abuse Reminder Corrective Action Plans

Corrective Action Plans

Providers are required to complete a Corrective Action Plan (CAP) to address discrepancies identified from Fraud Waste and Abuse (FWA) reviews. The CAP should describe the plan of action to resolve the identified problem to ensure that appropriate services are provided, compliance with regulations and standards, and deficiencies are eliminated. The plan should address the root cause of the identified problem and show how it will be avoided in the future. Providers are required to submit a CAP within 30 days of notification. More information may be found in the Highmark Wholecare Provider Manual.

Corrective Actions may include:

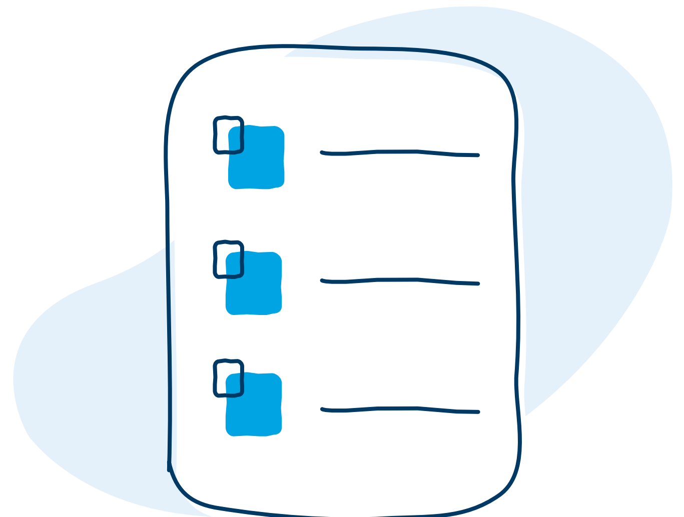
- Education
- Prepay Review
- Refunds
- Extrapolation of findings
- Self-Audits
- Payment Suspension
- Termination

References

https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/CAP-Guidelines.aspx

https://oig.hhs.gov/compliance/

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-self-audit.pdf



Emergency Medicine and Opioid Use Disorder Series

Informed Consent

In August, we announced that we would be providing information monthly to our Emergency Medicine providers regarding treating Opioid Use Disorder (OUD) in the Emergency Department, specifically regarding Medications for Opioid Use Disorder (MOUD).

Emergency Department (ED) adoption of evidence-based practices for patients with substance use disorder is essential to addressing the nation's substance use and overdose epidemic. Those that are reluctant to adopt these practices miss a key opportunity to improve health outcomes, save lives, and reduce racial disparities.[1] Approximately one of every 80 ED visits are opioid-related, costing around $5 billion per year.[2]

So far, we have discussed screening and diagnosis, including severity (mild, moderate, severe). We know that some individuals presenting to the ED may be explicitly seeking treatment for OUD or may present with a complication of opioid misuse like withdrawal, overdose, or infection. When the presentation is not entirely clear that OUD may be a concern, we can identify opportunities for intervention through the implementation of quick, evidence-based, universal screening tools, and we can further assess those who screen positive to diagnose OUD.

Treatment with buprenorphine should be considered for those with moderate to severe OUD. While naltrexone and methadone are also FDA-approved for treating OUD, they are not started as easily within the ED setting. Still, some knowledge of these modalities is necessary because a patient-centered approach requires informed consent. This discussion should review treatment options based on available research, the results and risks the patient can expect from each therapy, and the potential outcomes of declining all treatment.

Recalling adult learning styles can help providers to not only tailor informed consent to best meet the unique needs of their patients but also to develop a streamlined handout, form, and/or electronic health record process that can work for most patients while also fitting it into the already-busy workflows for clinicians.

Previous parts of this series can be found at https://highmarkwholecare.com/Provider/Provider-Newsletters or by outreaching to our team for PDF copies. A member of our team can be reached via email at BHI2@HighmarkWholecare.com. We also encourage you to outreach to us if you are interested in one-on-one collaboration and technical assistance regarding launching or strengthening addictions services in these settings.

References

1. Yeboah-Sampong, S., Weber, E., & Friedman, S. (2021). Emergency: Hospitals are violating federal law by denying required care for substance use disorders in emergency departments [PDF]. Legal Action Center. Retrieved July 11, 2022 from https://www.lac.org/assets/files/LAC-Report-Final-7.19.21.pdf

2. Langabeer, J. R., Stotts, A. L., Bobrow, B. J., Wang, H. E., Chambers, K. A., Yatsco, A. J., Cardenas-Turanzas, M., & Champagne-Langabeer, T. (2021). Prevalence and charges of opioid-related visits to U. S. emergency departments. Drug and Alcohol Dependence, 221, 108568. https://doi.org/10.1016/j.drugalcdep.2021.108568

3. Substance Abuse and Mental Health Services Administration. (2021). Use of Medication-Assisted Treatment in Emergency Departments [PDF]. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-5.pdf

Please help us improve the Highmark Wholecare member experience by completing the Cultural Competency Data Form.

By providing your race, ethnicity, language and cultural competency training data, you allow Highmark Wholecare to better connect members to the appropriate practitioners, deliver more effective provider-patient communication and improve a patient's health, wellness and safety. The information requested is strictly voluntary and the information you provide will not be used for any adverse contracting, credentialing actions or discriminatory purposes.

The Cultural Competency Data e-form is located on the Highmark Wholecare website in the Cultural Toolkit Resource Guide at the link below:

https://www.HighmarkWholecare.com/provider/provider-resources/cultural-toolkit

You can also download a copy of the Cultural Competency Data e-Form from the link below:

https://www.HighmarkWholecare.com/Portals/8/provider_forms/CulturalCompetencyDataForm.pdf

Important Update Regarding Maximum Out of Pocket (MOOP)

Beginning January 1, 2023, per the CY 2023 Medicare Advantage Final Rule, Medicare Advantage Plans must calculate Maximum Out-of-Pocket based on the accrual of all cost-sharing in the plan benefit, regardless of whether that costsharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid.

MOOP is a cost-sharing limit that once reached, triggers a Medicare Advantage plan to pay 100% of the allowed costs for covered Part A and Part B services. MOOP is accumulated as claims for Part A and Part B services are received, and finalized by, a health plan.

Historically, MOOP accumulations have primarily been tracked for Highmark Wholecare Medicare Assured Ruby members, as only actual member out of pocket costs were required to be tracked. In order to be compliant with the CY2023 MA Final Rule, we will begin tracking MOOP accumulations for Highmark Wholecare Medicare Assured Diamond members, as well.

As a reminder, our dually eligible Medicare Assured members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency or Community HealthChoices Plan (CHC) is liable for the cost-sharing. Providers further agree that upon payment from Highmark Wholecare Medicare Assured, providers will accept the plan payment as payment in full or bill the appropriate State source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance, and copayments is prohibited by Federal law.

Navigating Grief During the Holiday Season

This season is scattered with holidays that traditionally include gathering with family and friends, and navigating the holiday season is especially challenging for your patients who are experiencing grief and loss. The swell of grief brought upon by memories and traditions of the loved ones we have lost can feel so immense and isolating. How can we be expected to enjoy what is supposed to be “the most wonderful time of the year”?

Highmark Caring Place, A Center for Grieving Children, Adolescents and Their Families, shares the following tips that may help your patients from individuals who have shared their experiences of coping with grief through the holiday season.

- Realize that the anticipation of the holidays is often as difficult as — or even more difficult than — the holidays themselves.
- Remember your limits. Grieving takes energy. You may find that you have even less energy now than at other times of the year. Be gentle with yourself and your children and allow yourself to take whatever time for yourself you need.
- Seek out supportive people. Find those people who accept your feelings, who understand that the holidays can be more difficult and who allow you to express your feelings — happy and sad. Ask for support.
- Don't get caught in unreasonable expectations. Losses and separations of all kinds make this a difficult season. For many people, whether grieving or not, the holidays produce more stress and pain than joy. In light of this, there is no reason for guilt, no reason for wondering, "Am I ruining the holidays?" You don't need to provide the perfect holiday — for yourself, for your children or for others.
- Take time beforehand to plan out your activities. Focus on your needs and the needs of your children. Decide with your family what traditions you would like to continue and what traditions you're going to need to let go of this year. Having a plan — while knowing you can change at any point — can help you from being caught off guard. In your grief, you are in the process of changing traditions and rituals and discovering new meaning for the holidays. Allow your children to be a part of this process.
- Embrace your memories. Memories are one of the best legacies that exist after someone dies. Sharing and hearing your memories and your children's memories and crying and laughing together keeps the person who died a part of these special days.
- Talk about your grief and about the person who has died. Share your feelings and your memories with people you trust. Say the person's name and invite others to do the same.
- Remember that different people grieve differently — even within the same family. Allow everyone in the family to express their desires for the holidays. If some family members can't bear to even see holiday decorations and other members would like to make things as much like the "old days" as possible, try to see how much each person's wishes can be accommodated. If a fully decked-out family room would be unbearable for some, what about smaller decorations? Or even paper ornaments made by children and kept in their rooms? If going to a traditional religious service is out of the question for a parent, perhaps another caring adult could take children if the children still want to go. In many cases, the choices don't have to be all or nothing. Be respectful of each other's grief and hopes.

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- Allow children and adolescents space to grieve in their own way. Be prepared for any type of reaction from children. Be patient with anger or meanness but also be careful of a child trying to "be strong" for you. They need to grieve as well. Give kids space when they need it, alone or with the support and security of friends.
- Seek comfort in your faith. If your faith is important to you, being in the presence of a familiar, supportive community may nourish you.
- Remember that your grief is important and unique. Be patient with yourself, love yourself and don't let anyone take your grief away. And know that there are times, despite your best efforts, that nothing will seem to work. So, remember — be gentle with yourself and with your children.

For a list of 64 more tips that may help to cope with grief during the holidays, visit https://whatsyourgrief.com/64-tips-grief-at-the-holidays/

Those local to Pittsburgh, Warrendale, Erie, or Harrisburg may also be interested in the information and services provided by Highmark Caring Place. To learn more, visit their website at https://www.highmarkcaringplace.com/

Source: https://www.highmarkcaringplace.com/cp2/grief/griefHolidays.shtml

Highmark Wholecare Lifestyle Management Programs

Balancing Lifestyle for Maximum Health and Wellness

Program	Asthma	Cardiac	COPD	Diabetes	Hypertension	Healthy Weight Management	MOM Matters* (Maternal Outreach and Management)
Eligibility	Any member with a diagnosis of asthma	Any adult member with the following diagnosis: AMI, atrial fibrillation, CHF, heart failure diagnosis, IVD, MI or stroke	Any adult member with a diagnosis of COPD	Any adult member with a diagnosis of Type 1 or Type 2 diabetes	Any adult member with a diagnosis of hypertension	Any member with a diagnosis of overweight or obesity	All pregnant or postpartum females
Contact for Referrals	**Medicaid: 1-800-392-1147** **Medicare Assured: 1-800-685-5209**						
Description	• The programs provide patient education for medication, diet and lab testing adherence, as well as other tools to reduce inpatient and emergency room utilization • The programs emphasize prevention and exacerbation of complications by using evidence-based guidelines and member empowerment strategies • The programs support the physician's plan of care and supports the provider-member relationship						**This program offers care coordination and SDoH resources to reduce low birth weight, pre-term deliveries and NICU**

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<table>
<tr><th>Program</th><th>Asthma</th><th>Cardiac</th><th>COPD</th><th>Diabetes</th><th>Hypertension</th><th>Healthy Weight Management</th><th>MOM Matters* (Maternal Outreach and Management)</th></tr>
<tr><td>Enrollment</td><td colspan="6">• Members are identified through claims, member self-referral, or Highmark Wholecare utilization management
• Provider referrals are also welcome</td><td>Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women for proactive interventions</td></tr>
<tr><td>Coordination of Care</td><td colspan="7">• Case managers assist you and your patients with coordination of care for specialists visits
• Home health, behavioral health, DME and community referral needs are coordinated through the Highmark Wholecare Case Management department</td></tr>
<tr><td>Provider Benefits and Support</td><td colspan="7">• The management of members in programs aimed at:
- Decreasing inpatient and ED utilization
- Increasing appropriate lab testing and medication adherence
• Encouraging adherence to obtain flu and pneumonia immunizations as well as other preventative testing and procedures</td></tr>
</table>

Medicare Parts A and B Cost Sharing

All members enrolled in Highmark Wholecare Medicare Assured Diamond and Highmark Wholecare Medicare Assured Ruby℠ also have Medicaid (Medical Assistance) or receive some assistance from the State.

Some members will be eligible for Medicaid coverage to pay for cost sharing (deductibles, copayments, and coinsurance). They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility.

As a reminder, our dually eligible Medicare Assured members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

Providers further agree that upon payment from Highmark Wholecare's Medicare Assured Plans, providers will accept the plan payment as payment in full; or bill the appropriate State source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance, and copayments is prohibited by Federal law.

Our organization and its practitioner network are also 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.

Highmark Wholecare Medicaid and Medicare Assured plan members have certain rights and responsibilities as members of our plans. To detail those rights and responsibilities in full, we maintain a Member Rights and Responsibilities statement which is reviewed and revised annually.

The Member Rights and Responsibilities statement can be located in either the Member Handbook for Medicaid members, or the Evidence of Coverage for Medicare Assured members. The Member Rights and Responsibilities Statement is also available for review online at HighmarkWholecare.com

Providers are also encouraged to contact us if you have questions about this Provider Update or need additional member specific information.

Our Provider Services Department can be reached at one of the following numbers,

Monday – Friday, 8 a.m.– 4:30 p.m.:

Medicare Assured
1-800-685-5209 (TTY 711)

Medicaid
1-800-392-1147 (TTY 711)

Notice of Practice/Practitioner Changes

Medicaid and Medicare

One of the many benefits available to Highmark Wholecare members is improved access to medical care through Highmark Wholecare's contracted provider network. Highmark Wholecare strives to provide the most accurate and up-to-date information in our provider directory to allow our members unhindered access to network providers.

To ensure our members have up-to-date and accurate information about Highmark Wholecare's network providers, it is imperative that providers notify Highmark Wholecare of any of the following:

- Address changes;
- Phone & fax number changes;
- Changes of hours of operation;
- Primary Care Practice (PCP) panel status changes (Open, Closed & Existing Only);
- Practitioner participation status (additions & terminations) and;
- Mergers and acquisitions.

Providers who experience such changes must provide Highmark Wholecare a written notice at least 60 days in advance of the change by completing the Highmark Wholecare Practice/ Provider Change Request Form, or practices/ practitioners may submit notice on your practice letterhead.

Please submit change requests via fax or mail.

Fax: 1-855-451-6680

Mail: Highmark Wholecare
Provider Information Management
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

As a friendly reminder for Federally Qualified Health Centers and Rural Health Clinics, please report any of the changes listed on this page using the Roster Template which is located on the Highmark Wholecare website under: Provider-Provider Resources- FQHC/RHC Resources.

As a reminder, the PA Department of Human Services (DHS) requires all providers to have current NPI information. It is critical that providers revalidate their information on a regular basis. If providers do not enroll/revalidate their information with DHS, no payments will be made.

Encounters Submissions

In order to effectively and efficiently manage a member's health services, encounter submissions must be comprehensive and accurately coded. As a reminder, all Highmark Wholecare providers are contractually required to submit encounters for all member visits regardless of expected payment.

Risk Adjustment Gap Closure Program Update

Highmark Wholecare joins you in our continued commitment to ensure optimal continuity of care and annual monitoring and documentation of members' chronic conditions. To that end, we're excited to announce that beginning in 2023 we will be transitioning to a new Unconfirmed Diagnosis Code (UDC) program in partnership with a new vendor.

We're currently going through the implementation process of this new solution that we expect to complete in the fourth quarter of this year. As we roll out the program, we'll be providing detailed materials and training to help educate and prepare your teams. As always, our goal of the program is to put diagnosis information in front of your clinicians as they are seeing the patient so they can evaluate the patient for their current conditions, noting that there may be new conditions that need to be addressed in addition to the historical conditions that may or may not continue to exist.

This solution will replace our current program with Inovalon that will be discontinued at the end of this year. You'll have until December 31, 2022 to submit any SOAP notes as part of that program through ePASS®.

We appreciate your cooperation and partnership and look forward to working with you as we make this change for 2023. Please contact your designated Clinical Transformation Consultant with any questions or email us at ProviderEngagementTeam@HighmarkWholecare.com.

More to come soon.

Medical Necessity Determinations

At Highmark Wholecare, medical necessity determinations in the authorization process are accomplished through the application of the Pennsylvania Department of Health and Human Services' definition of medical necessity. A service, item, procedure, or level of care compensable under the Medical Assistance Program that is necessary for the proper treatment or management of an illness, injury or disability is one that: and if it meets any one of the following standards:

- Will, or is reasonably expected to, prevent onset of an illness, condition, injury or disability.
- Will, or reasonably expected to reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Licensed health care providers who are qualified and trained must make medical necessity determinations. If unable to approve, the Utilization Care Manager refers an authorization request to the Highmark Wholecare Medical Director for a medical necessity determination.

Medicaid Reinstatement of Pennsylvania for Shift Care

Medicaid Reinstatement of Prior Authorization Requirements for Shift Care Services for Highmark Wholecare Members Under 21 Years of Age

Pursuant to the PA Department of Human Services Medical Assistance Bulletin 05-22-02, 16-22-01, effective November 1, 2022, Highmark Wholecare has started to conduct medical necessity reviews for shift care services as authorizations are scheduled to expire. Members have received a letter notifying them of the date in which their authorization for current services will expire. No action is required by providers at this time. Highmark Wholecare will reach out approximately 30 days prior to the expiration of an authorization to advise what information is needed.

Below are some reminders regarding Letters of Medical Necessity (LOMN):

- LOMNs should outline the service requested, the setting, quantity, and duration of the service or item requested.
- LOMNs may outline the member's overall condition and needs as well as any recent or expected changes to the member's overall condition.
  - Explain why the service or item is medically necessary.
    - How the service or item may prevent onset of an illness, condition, or disability.
    - How the service or item may reduce or ameliorate the physical, mental, or developmental effects of the illness, injury, or disability.
    - How the service will assist the member to achieve or maintain maximum functional capacity in performing activities of daily living.
    - The member's functional capacity and the functional capacities that are appropriate for members of the same age.
- Members receiving pediatric shift care services should have a new LOMN annually.

If you should have any questions, please contact Highmark Wholecare's Special Needs Unit at 1-800-392-1147.

Model of Care

As a Special Needs Plan (SNP), Highmark Wholecare is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC) Plan.

In accordance with CMS guidelines, Highmark Wholecare's SNP MOC Plan 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 MOC has goals and objectives for targeted populations, a specialized provider network, utilizes nationally-recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of beneficiaries, and adds services for the most vulnerable beneficiaries including, but not limited to those beneficiaries who are frail, disabled, or near the end-of-life.

The SNP MOC includes 4 main sections: Description of the SNP population, Care Coordination, SNP Provider Network, and MOC Quality Measurement and Performance. This training will focus on the SNP Provider Network section and what Highmark Wholecare expects from its providers.

Provider Network - The SNP Provider Network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP Provider Networks.

There are 3 sections in this MOC section:

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

Within the above elements, Highmark Wholecare's expectations of providers are explained in detail. The below is a summary of our provider network composition and responsibilities.

1. Highmark Wholecare expects all network practicing providers to utilize established clinical practice guidelines when providing care to members to ensure the right care is being provided at the right time, as well as to reduce interpractitioner variation in diagnosis and treatment.
2. We encourage providers to follow the adopted clinical practice guidelines, but allow the practitioners to execute treatment plans based on a member's medical needs and wishes. When appropriate, behavioral health guidelines are followed using government clinical criteria.
3. During a care transition, it is expected that the transferring facility will provide, within one business day, discharge summary and care plan information to the receiving facility or if returning home, to the PCP and member.

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4. We expect all network practicing providers to receive MOC training annually. If there is a trend of contiued non-attestation, those providers found to be non-compliant with the MOC may be targeted for potential clinical interventions. For those non-compliant providers, individual results such as, but not limited to, utilization patterns, hospital admissions, readmissions and HEDIS performance outcomes may be reviewed.
5. We conduct medical record reviews annually. Reviews are conducted on PCPs, Speciality Care Practitioners, Behavioral Health Practitioners and ancillary providers. Results from the review are communicated to providers and include opportunities for improvement and education.
6. We provide multiple ways for providers to receive information about updates. Provider manuals and newsletters are located on the provider portal and website. Newsletters are updated quarterly and provide information regarding any new clinical programs or updates that would affect the provider's communication with their direct pod or ICT. Provider manuals are updated annually, and reviewed during annual trainings. Current manuals are always available on the provider section of our website.
7. Our provider directories are continuously updated regarding taking new members, how long waiting lists are to see specialists, and other barriers that may affect the member.

Common MOC Terms and Definitions:

Members may ask you about the following information that is routinely discussed with their case manager.

- **Health Risk Assessment (HRA) Survey:** We use the HRA to provide each Medicare member a means to assess their health status and interest in making changes to improve their health promoting behaviors. The HRA is also used by the case managers to provide an initial assessment of risk that can generate automatic referrals for complex case management and then at least annually with continuous enrollment. Newly enrolled members identified for the Centers for Medicare and Medicaid Services (CMS) monthly enrollment file are requested to complete an initial HRA within 90 days of their effective date of enrollment as required by CMS MOC standards. Each member with a year of continuous enrollment is requested to complete a reassessment HRA within 12 months of the last documented HRA or the member's enrollment date, if there is no completed HRA.
- **Individualized Care Plan (ICP):** Highmark Wholecare's goal is to have Care Plans be as individualized as possible to include:
  - Services specifically tailored to the member's needs, including but not limited to specific interventions designed to meet needs as identified by the member or caregiver in the HRA
  - Member personal health care preferences
  - Member self-management goals and objectives, determined via participation with the member and/or caregiver
    - Identification of:
      - Goals and measurable objectives
      - Whether they have been "met" or "not met"
      - Appropriate alternative actions if "not met"

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- **Interdisciplinary Care Team (ICT):** Member care routinely demands a combination of efforts from physicians of various disciplines, registered nurses and licensed social workers, as well as other pertinent skilled health care professionals and paraprofessionals. Comprehensive patient care planning involves coordination, collaboration, and communication between this ICT and the member.

As a provider, you are an important part of the member's ICT. The ICT team members come together to conduct a clinical analysis of the member's identified level of risk, needs, and barriers to care. Once an Individualized Care Plan (ICP) is developed, it is then reviewed with the member. The member's agreement to work in partnership with his/her care manager, towards achievement of established goals, is obtained.

The ICT analyzes, modifies, updates, and discusses new ICP information with the member and providers, as appropriate.

Highmark Wholecare's Provider Portal should be utilized frequently for any communication regarding members, their individual ICP or ICT. Additionally, please watch for the Provider Dashboard, which is sent to providers on a quarterly basis. This dashboard identifies members' current care gaps and chronic disease conditions.

Other Important Information About Our MOC

We recognize that a member's care needs are varied and are subject to change. Policies and procedures have been put in place to allow members to review the level of care management needed for their particular circumstance.

Members may be referred for Care Management in a variety of ways, including referral by Provider, Highmark Wholecare employee, or self-referral by member.

Providers: 1-800-685-5209

Member Self Referral: 1-800-685-5209

Highmark Wholecare employees may refer via the established internal process.

Oversight of the Model of Care Plan is managed by the Quality Improvement and Accreditation department. Specific questions with regard to the MOC should be addressed with your Highmark Wholecare Provider Representative.

Action Required:

Please go to https://www.HighmarkWholecare.com/provider/moc-response to submit an attestation indicating that you have completed and comprehend this Model of Care training.

Important Phone Numbers

Provider Services

Monday – Friday, 8 a.m.– 4:30 p.m.

Medicare: 1-800-685-5209/TTY 711
Medicaid: 1-800-392-1147/TTY 711

Member Programs Services

Monday - Friday, 8:30 a.m.- 4:30 p.m.

- Care Management
- Maternity/MOM Matters®
- Asthma/ Cardiac/COPD/Diabetes
- Preventive Health Services/EPSDT/Outreach

Medicare: 1-800-685-5209/TTY 711
Medicaid: 1-800-392-1147/TTY 711

ALC (Transportation Services)

Monday – Friday, 8 a.m.– 5 p.m.
Saturday 9 a.m.– 1 p.m.

1-877-797-0339/TTY 711

For Medicare Assured member only

Fraud and Abuse and Compliance Hotline

1-844-718-6400

Voicemail during off hours: The call will be returned the next business day. Please do not leave multiple voicemail messages or call for the same authorization request on the same day.

Hours of Operation:

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

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 14 counties in northeastern Pennsylvania, 12 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Inovalon is a separate company that provides quality programs, analytics, information technology and medical record retrieval support for Highmark Wholecare.

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

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare").