HIGHMARK WHOLECARE

SEPTEMBER 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

IN THIS ISSUE

Fraud, Waste and Abuse Reminder

Responding to Medical Record Requests:

Highmark Wholecare's Fraud, Waste and Abuse (FWA) Department regularly performs medical record reviews. Providers shall provide prompt access to Member medical records at no charge to Highmark Wholecare, whether such records are stored manually or electronically.

- This includes notifying any third party who may maintain medical records of this stipulation as well as the time constraints
- Provider shall provide copies of all requested medical records within fifteen (15) days of a request, or as otherwise noted

These requests are made to review compliance with regulatory requirements for routine and targeted audits. Failure to submit required records may result in an administrative denial by Highmark Wholecare and recoupment of the original payment. Your timely cooperation is appreciated.

References:
http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.51.html&d=reduce

https://highmarkwholecare.com/Portals/8/MedicaidManual.pdf?ver=j56QZ72MYV3-c9SwDogeXQ%3d%3d

September is National Recovery Month!

National Recovery Month is observed every September to honor the emergence of a strong and proud recovery community and the dedication of service providers and community members across the nation who make recovery from substance use disorders possible in all its forms.

What is Recovery?

SAMHSA (Substance Abuse and Mental Health Services Administration) defines recovery as: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Recovery is a unique, individualized process; it looks different for everyone. Recovery pathways are highly personalized, building on the strengths, talents, coping abilities, and resources of each individual.

Some types of recovery pathways include, but are not limited to:

- **Mutual Aid** (Five types)
  - **Twelve-Step Fellowship** (Alcoholics Anonymous, Narcotics Anonymous, etc.)
  - **Non-Secular** (Celebrate Recovery, Recovery Dharma, Wellbriety Movement, etc.)
  - **Secular** (SMART Recovery, LifeRing Secular Recovery, etc.)
  - **Physical Activity Mutual Aid** (Nonformal with examples such as Recovery Yoga)
  - **All-Recovery Mutual Aid** (No formal framework, open to all pathways)
- **Harm Reduction** (Syringe services programs, Narcan, nicotine replacement patches)
- **Medications to support recovery** (Methadone, Vivitrol/ReVia, Buprenorphine, Antabuse)
- **Peer-based recovery supports** (Certified Recovery Specialists, Certified Peer Specialists)
- **Ongoing professional/clinical support** (Certified Addiction Counselor, Licensed Social Worker)
- **Natural Recovery** (Remission and recovery happens naturally over time)

Highmark Wholecare is working to support the recovery community through education, awareness, and our anti-stigma campaign. Please consider taking our anti-stigma pledge at https://www.surveymonkey.com/r/AntiStigmaPledge

For more information on substance use and recovery please visit: https://www.samhsa.gov/find-help/recovery#recovery-support

Mark your calendar!

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

Topic	Date/Time	Key Speaker
Opioid Overdose Reversal: Naloxone (NARCAN®)	Wednesday, October 5 noon–1 p.m.	**Rachel Shuster, BSN, RN, CARN, CAAP** Addiction Specialist Highmark Wholecare
Registration link for October webinar: https://bit.ly/LearningEarningFREECME_OpioidOverdoseReversal		
Rural Appalachia: Disparities and Barriers to Behavioral Health Services	Wednesday, November 2 noon–1 p.m.	**Shannen Lyons, MSW, LCSW, CAADC** Addiction Specialist Highmark Wholecare
Registration link for November webinar: https://bit.ly/LearningEarningFREECME_RuralAppalachiaDisparitiesandBarrierstoBHServices		

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).

Emergency Medicine and Opioid Use Disorder Series

ICYMI: Webinar by IRETA and Marla Oros, RN, MS, FAAN

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 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]

In case you missed it, the Institute for Research, Education, & Training in Addictions (IRETA) recently hosted a timely webinar presented by Marla Oros, RN, MS, FAAN, entitled **"Emergency Departments: A Front Door to Address the Opioid Epidemic."**

The presentation addressed how to identify:

1. Why the Emergency Department is a critical setting to systematically integrate screening and interventions for opioid use disorder
2. Key considerations for Emergency Departments in linking patients with opioid use disorder to care
3. The steps to adopt a comprehensive model to improve the treatment gap

The webinar was recorded and is available to view on IRETA's website at https://ireta.org/resources/emergency-departments-a-front-door-to-address-the-opioid-epidemic/

Marla Oros can be contacted via email at moros@groupmosaic.com. We also encourage you to reach out to our Behavioral Health team should you be interested in one-on-one collaboration and technical assistance regarding launching or strengthening addictions services in these settings. A member of our team can be reached via email at BHI2@HighmarkWholecare.com.

2022 Annual Accessibility Audit

The annual provider accessibility audit was conducted July through August of 2022 by SPH Analytics, Highmark Wholecare's audit vendor. Practice sites were contacted by phone to determine if the site is adhering to Highmark Wholecare's Accessibility Standards related to members' timely access to primary care, specialty care, and behavioral health care services (including: wait time to schedule an appointment, access to care after-hours, and the average time spent in the waiting room and exam room before a member is seen for their scheduled routine care appointment).

In the next few months, all practice sites that participated in the audit will receive a letter indicating their audit results. The audit results will be mailed to your practice sites physical location and will be addressed to the attention of Corporate Compliance/Office Administrator.

Your site will receive either a "congrats" letter indicating that you passed the audit OR a letter indicating that you failed the audit and need to complete specific actions identified in the letter within 45 days (a report card detailing your audit results will be included).

Actions include:

- Submission of a corrective action plan (CAP) for each failed standard
- Completion of staff training and practice self-assessment (Attestation from your corporate compliance or Office Administrator confirming completion is required)

To ensure your practice is in compliance with your physician agreement, please complete all actions and submit documentation timely directly to the fax line listed in your letter.

The audit results and corrective action plan documentation submitted by your practice site will be used to identify access barriers and develop initiatives to improve access to care.

The Accessibility to Care Standards, Practice Self-Assessment Tool, and other access resource information is available on our website at https://highmarkwholecare.com/Provider/Provider-Resources/Accessibility-to-Care-Standards.

Thank you for you participation in the audit and continued support to ensure that Highmark Wholecare members have timely access to primary care, specialty care, and behavioral healthcare services!

Highmark Home and Community Services' Enhanced Community Care Management (ECCM) program

There is a new program beginning in September that offers specialized care coordination and supportive care for Highmark Wholecare members.

Highmark Wholecare has partnered with HM Home and Community Services' Enhanced Community Care Management (ECCM) program for both Medicare and Medicaid members that helps them manage their health, obtain access to valuable health, and work with a care team to achieve their best health.

You are receiving this notification because you may have patients in your practice that could benefit from the ECCM program. ECCM provides an extra layer of support for your patient to help them live their best life while maintaining their independence in the community. This ECCM program is a free, non-billable service. Initial implementation will be focused in Central PA. HM Home and Community Services will be reaching out to eligible members' primary care physicians (PCP) and other physicians to gather information and collaborate on opportunities to best support those members.

What is ECCM?

- Supportive and palliative care for high risk populations, providing care coordination and specialty medical expertise that collaborates closely with the PCP and focuses on leading patients to live their best lives.
- ECCM's interdisciplinary care team includes physicians, advanced practice providers, registered nurses and licensed social workers, and care coordinators. It provides team-driven care directed by whole-person centered outcomes, such as self-management of patient's chronic conditions, improved quality of life, symptom burden alleviation, emotional well-being improvement, increased communication, stronger continuity of care and decreased care giver burden.
- ECCM care is provided both virtually and in the community.
- The ECCM team ensures it is meeting patients where they are and matching them with the appropriate resources based on the patients' changing needs.
- The ECCM model is flexible, reducing disruption for the patient, family, and caregiver by providing care during the most complex parts of the care continuum. ECCM is the extra set of eyes and hands in the home to monitor patients more closely when they need it the most.

For questions or information regarding this program contact Highmark Wholecare provider services at: Medicaid 1-800-392-1147, Medicare Assured 1-800-685-5209.

Tobacco Cessation Counseling

Smoking cessation lowers the risk of cancer and other serious health problems. Counseling, behavior therapy, medicines, and nicotine-containing products, may be used to help a person quit smoking. As a Tobacco Cessation Counselor, you can help your patients, quit smoking through an effective 30 second intervention, while also billing for tobacco related services. Counseling is critical to the success of tobacco dependence treatment. Both individual and group counseling can be effective to support cessation in patients.

In order to bill (procedure code S9075) for tobacco cessation services, provided to fee-for-service (FFS) Medical Assistance (MA) recipients, a provider must:

- Be pre-approved by the Department of Health (DOH) as a Tobacco Cessation Services Program (TCP).
- Be a licensed health care provider such as a physician, dentist, psychologist, certified registered nurse practitioner, or an independent medical/surgical clinic, general hospital, rehabilitation hospital, pharmacy, home health agency, rural health clinic/federally qualified health center, outpatient drug, and alcohol facility, outpatient psychiatric clinic, or family planning clinic.
- Enroll in the MA program, either under the provider's existing provider type or as a provider type 37 (tobacco cessation provider).

Become a Tobacco Cessation Provider by enrolling today!

The Bureau of Fee-For-Service Programs (BFFSP) follows the processes of the Department of Human Services to enroll certified providers in Department of Health (DOH) Tobacco Cessation Program (TCP). https://www.dhs.pa.gov/providers/Billing-Info/Pages/Billing-Info-Tobacco-Cessation.aspx

For Providers to enroll and get paid for TCP services in PROMISe: Provider must be pre-approved registered by the Department of Health (DOH). https://www.health.pa.gov/topics/programs/tobacco/pages/registry.aspx

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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Program	Asthma	Cardiac	COPD	Diabetes	Hypertension	Healthy Weight Management	MOM Matters* (Maternal Outreach and Management)
Enrollment	• Members are identified through claims, member self-referral, or Highmark Wholecare utilization management • Provider referrals are also welcome						**Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women for proactive interventions**
Coordination of Care	• 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						
Provider Benefits and Support	• 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						

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.

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

Coding Corner

Diagnosis Billing Guidelines for Ground Ambulance Services

Highmark Wholecare follows guidance from the Centers for Medicare and Medicaid Services (CMS) and the Pennsylvania Department of Human Services (PA DHS) in regards to reimbursement for Ground Ambulance Services.

Providers should report the most appropriate ICD-10-CM code that adequately describes the patient's medical condition at the time of transport as the primary diagnosis. Additionally, all ambulance transports require dual diagnosis codes (e.g., primary and secondary code) as described in Highmark Wholecare's Medical Policies on Ground Ambulance Services:

- Highmark Wholecare Medicaid, Ambulance Services – Ground, MP-072-MD-PA Ambulance - Ground (highmarkwholecare.com)
- Highmark Wholecare Medicare Assured, Ambulance Services – Ground, MP-074-MC-PA Ambulance - Ground (highmarkwholecare.com)

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Highmark Wholecare's Ground Ambulance Services Policies list 3 groups of required ICD-10-CM codes:

- **Group 1** – A list of diagnosis codes that may be used as a primary diagnosis for transport to acute care, or for the transport on to another facility for specialty or other care.
- **Group 2** – A list of diagnosis codes that are to be used for post treatment transfer (e.g., transfer to home, nursing facility, SNF, IRF, IPP).
- **Group 3** – The following list of secondary diagnosis codes that are required on all ground ambulance services:

Group 3 ICD-10 Code	Description
Z74.01	Bed confinement status
Z74.3*	Need for continuous supervision
Z78.1*	Physical restraint status
Z99.89*	Dependence on other enabling machines and devices

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*** Note:** Use code Z74.3 to denote cardiac/hemodynamic monitoring required en route.

*** Note:** Use code Z78.1 to denote patient safety: danger to self and others – monitoring other and unspecified reactive psychosis.

*** Note:** Use code Z99.89 to denote the need for continuous IV fluid(s), "active airway management," or the need for multiple machines/devices.

Assignment of Group 1 and Group 2 diagnoses should correspond with the required ground ambulance two-alpha character origin and destination code modifier. The first position alpha character represents the origin, with the second position alpha character representing the destination. The Centers for Medicare and Medicaid Services (CMS) maintains the list of valid codes.

Origin and destination alpha characters and their descriptions are as follows:

- **D** – Diagnostic or therapeutic site other than P or H when these are used as origin codes
- **E** – Residential, domiciliary, custodial facility (other than 1819 facility)
- **G** – Hospital based ESRD facility
- **H** – Hospital
- **I** – Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- **J** – Freestanding ESRD facility
- **N** – Skilled nursing facility
- **P** – Physician's office
- **R** – Residence
- **S** – Scene of accident or acute event
- **X** – Intermediate stop at physician's office on way to hospital (This is a destination code only)

Additional information may be found at the following sources:

- Centers for Medicare and Medicaid Services, Local Coverage Determination, Ambulance Services (Ground Ambulance), L35162 https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=35162&ver=71
- Centers for Medicare and Medicaid Services, Local Coverage Article, Billing and Coding: Ambulance Services (Ground Ambulance), A54574 https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=54574&ver=46
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 15 – Ambulance https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf
- Pennsylvania Department of Human Services, CMS-1500 Claim Form Completion for PROMISe™ Ambulance Providers: https://www.dhs.pa.gov/providers/PROMISe_Guides/Documents/CMS%201500%20Billing%20Guide%20for%20PROMISe%20Ambulance%20Providers.pdf

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 heath 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, Regulatory and Accreditation departments. 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.

CAHPS Satisfaction Scores Are In!

Medicaid

Earlier this year, a satisfaction poll was mailed to our Medicaid members. It was called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Highmark Wholecare members were chosen at random to take the survey. They were asked to tell us about their health care experience. We use these results to serve our members better.

Our adult members report being most happy with their ability to get care whenever they need it. They were also satisfied with their personal doctor. Adult members also felt satisfied with Highmark Wholecare overall.

Surveys were also sent to the parents or guardians of members under 18 years of age. We wanted to learn how parents and guardians felt about their child's health care in our health plan. This group thought their child's personal doctors did a good job. They also felt satisfied with the care their child had received overall. These members also felt satisfied with Highmark Wholecare overall. We are proud of these results. But we know we can do better. One area that we can do better is helping members get care more quickly.

Highmark Wholecare works with members and doctors to give a great health care experience. We listen to what you say. We hope you will let us know when we do something well. We hope that you will let us know when we need to do better. Improving the health care experience for our members is a team effort! Please call Member Services at 1-800-392-1147 for more information about Highmark Wholecare' s 2022 CAHPS results. TTY users call 711.

Highmark Wholecare Medicaid 2021 CAHPS Survey Results

CAHPS Survey Measures – Adult Results	2020 (Surveyed in 2021)	2021 (Surveyed in 2022)
Rating of Health Plan	82.1	78.6
Rating of Health Care	82.4	78.1
Rating of Personal Doctor	81.8	83.9
Rating of Specialist	84.2	76.9
Customer Service	89.3	83.6
Getting Needed Care	89.3	83.5
Getting Care Quickly	84.7	83.1
How Well Doctors Communicate	93.3	91.8

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CAHPS Survey Measures – Child Results	2020 (Surveyed in 2021)	2021 (Surveyed in 2022)
Rating of Health Plan	91.2	83.7
Rating of Health Care	86.5	92.3
Rating of Personal Doctor	90.9	89.5
Rating of Specialist	85.9	88.5
Customer Service	93.4	81.5
Getting Needed Care	87.2	83.4
Getting Care Quickly	94.3	88.2
How Well Doctors Communicate	n/a	94.7

Medicare

Earlier this year, a satisfaction poll was mailed to our Medicare members. It was called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Highmark Wholecare members were chosen at random to take the survey. They were asked to tell us about their health care experience.

	2020 (Surveyed in 2021)	2021 (Surveyed in 2022)
Getting Needed Care	82.3	80.2
Getting Appointments & Care Quickly	78	76.7
Health Plan Customer Service	90.7	89.5
Care Coordination	85.4	84.3
Rating of Health Plan	90.8	89.8
Rating of Health Care	85.4	83.7
Getting Needed Rx Drugs	91.3	89.1
Rating of Drug Plan	91.8	89.3
Flu Vaccine	69.6%	69.5%

Our members report being most happy with our health plan, our customer service our drug plan, and their ability to get needed prescription drugs. Our members were least happy with getting appointments and care quickly and getting needed care suggestions to improve your patient's experience.

continued >

Getting Needed Care

Questions

In the last 6 months…

- How often did you get an appointment to see a specialist as soon as you needed?
- How often was it easy to get the care, tests or treatment you needed?

Recommendations

- Review authorization and referral processes to eliminate patient obstacles to access care.
- Follow up with patients to see that referrals to specialists are successful and help your patient if having any problems.
- Collaborate with your patient in to ensure they have an input about their care for topics such as tests, referrals, and treatment options.

Pro Tips

- Help patients make appointments with specialists before the patient leaves your office.
- Ask patients if they have had any delays in getting care

Getting Appointments And Care Quickly

Questions

In the last 6 months…

- When you needed care right away, how often did you get care as soon as you needed?
- How often did you get an appointment for a check-up or routine care as soon as you needed?
- How often did you see the person you came to see within 15 minutes of your appointment time?

Recommendations

- Section off some dedicated time slots each day to accommodate urgent visits.
- Provide patients with addresses and phone numbers of urgent care options. Consider getting cards printed with this info.
- Talk to patients about after-hours call processes and provide a telephone number.
- Talk to patients about scheduling routine visits in advance and offer to schedule before they leave your office.
- Make sure patients are supported by staff and long wait times are explained.

Pro Tips

- Explain any delays for scheduling appointments or available appointment times.
- Offer an appointment with a nurse or physician assistant to accommodate issues.
- Offer to add the patient to a wait list and call the patient if earlier appointment slots open up.

continued >

Care Coordination Questions

In the last 6 months…

- When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- When your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow-up to give you those results?
- When your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- How often did you and your personal doctor talk about all the prescription medicines you were taking?
- Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- How often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Recommendations

- Prepare relevant material and medical history, including appointments with specialists, as available during office visits.
- Develop a process for patients to effortlessly and securely get test results.
- Call patients about test results quickly and inform them if no calls are made for normal results.
- Review patient medications during each visit.
- Follow-up quickly with patients after inpatient stays.
- Provide further support to patients with numerous needs to coordinate and monitor delivery of health services.

Annual Flu Vaccine

Question

- Have you had a flu shot since July 1 of the prior year?

Recommendations

- Recommend a flu shot to all eligible patients and offer to administer during scheduled appointment.
- Talk to patients about why they don't want to get the vaccine and address misconceptions.
- Use local and national public health resources, posters, etc. in office to educate patients.
- Order vaccine as soon as available and have a communications plan to inform patients that it is available.
- Plan flu clinics where patients can get the vaccine without a scheduled office visit.

Pro Tips

- Visit www.cdc.gov/flu/professionals/vaccination/prepare-practice-tools.htm for more tips on how to talk to your patients about the flu vaccine and make a strong recommendation.

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Doctors Who Communicate Well

Questions

In the last 6 months…

- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor show respect for what you had to say?
- How often did your personal doctor spend enough time with you?

Recommendations

- Educate and train staff to be able to handle sensitive situations.
- Treat patients with empathy and respect. Make eye contact, listen carefully, and express understanding.
- Use visual aids and simple language to give patients information in a way they can easily understand.
- Ask the patient to repeat in their own words what you had explained to ensure the patient understands.
- Establish cultural sensitivity and use interpreter services if needed.
- Involve patients in coming up with plans, goals, and decisions for treatment.

Pro Tips

- Remaining seated during a visit provides enhanced patient perception of care
- Visit www.cdc.gov/healthliteracy/developmaterials/understandaudience/index.html for cultural competency and health literacy tools and resources

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.

Good Measures is a separate company that administers the Diabetes Prevention Program for Highmark Wholecare.

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").