Q1 2026

Provider Newsletter

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

FEATURED ARTICLES:

Table of Contents

When you see this icon, click it to return to this content list.

Contact Us

Highmark Health Options and Highmark Health Options Duals (HMO SNP) Provider Services is the first line of communication for providers' questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling the following numbers:

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

Upcoming HHOPE Incentive Program Webinars and CGMA Launch

The 2026 Highmark Health Options Practitioner Excellence (HHOPE) Program launched on March 2. Learn more about opting in, program details, and the new Care Gap Management Application (CGMA).

We appreciate the vital role practitioners play in improving the health and well-being of our members and communities. The HHOPE Program supports this mission by providing access to integrated, superior health care.

HHOPE Program Opt-In & Details

To opt-in and confirm your participation, please contact your Clinical Transformation Consultant directly or email **DePET@Highmark.com**.

Providers will be enrolled in chosen programs based on specialty and eligibility criteria, as outlined in the HHOPE Program Guide available on our website.

2026 HHOPE Overview Webinar Series

The HHOPE provider team is hosting multiple hour-long webinars to provide an overview of the 2026 HHOPE Program. If you missed our March sessions, you have four more opportunities to join:

1. Use the links below for the session(s) you would like to attend and click "Register."
   - **Tuesday, April 7 at 11 a.m.**
   - **Wednesday, April 15 at 12 p.m.**
   - **Wednesday, June 10 at 11 a.m.**
   - **Tuesday, Sept. 1 at 12 p.m.**
2. On the registration form, enter your information and then click "Register." Once the host approves your request, you will receive a confirmation email with instructions on how to join the event.

If you have questions, feel free to reach out to our Clinical Transformation Consultant directly team directly at **DePET@Highmark.com**.

Continues on the next page

2026 Highmark Health Options Care Gap Management Application (CGMA) & Provider Reporting Launch

The Care Gap Management Application (CGMA) launches on April 1, offering providers access to critical care gap information. This application streamlines the flow of member care gap data, supporting our mission to improve health and wellness. The D-SNP launch date will be announced separately.

The CGMA is a powerful, user-friendly web application designed to help providers by:

- Viewing member care gaps.
- Submitting evidence for care gap closure.
- Tracking progress towards closing member care gaps.
- Accessing your Highmark Health Options health member roster.
- Viewing HHOPE Performance and Opportunity Reporting.
- Performing bulk evidence submissions for a member.
- Generating bulk member-level gap PDF reports.
- Generating multi-provider gap reports.
- Enhancing measure due dates (now available for applicable measures like W30, OMW).
- Displaying a measure badge with remaining days to act for event-based measures.

Complete the 2026 Model of Care Training for D-SNP

Provider Training Requirement: If you have not already done so, please complete the Model of Care training before December 31, 2026.

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

The SNP MOC is divided into four sections:

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

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

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

1. Specialized Expertise
2. Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols (CTPs)
3. Annual Model of Care Training for the Provider Network

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

Action Required:

Review the Model of Care Provider Training found on the **Provider Resource Center**. Once you have completed this training, please submit an **attestation** indicating that you have completed and comprehend the Model of Care training.

Interactive Care Management Programs

Highmark Health Options and Highmark Health Options Duals (HMO SNP) offer Interactive Care Management Programs at no cost to eligible members to support their health. Programs address varying levels of clinical complexity, chronic disease burden, and preventive needs across the continuum of care. Services are implemented in accordance with applicable evidence-based clinical guidelines.

Providers can access care plans through the Provider Portal to support coordinated care.

Program Highlights

- **Complex Case Management:** Individualized, person-centered support for members with high-acuity medical, behavioral health, substance use conditions, as well as those experiencing significant social determinants of health/health-related social needs.
- **Disease Management:** Targeted support for cardiovascular, metabolic, respiratory, gastrointestinal, and renal conditions, with focus areas evolving based on population health analysis and emerging clinical priorities.
- **Maternity, Maternal-Fetal, and Pediatric:** Education, risk screening, care coordination, and monitoring for pregnant, high-risk maternal-fetal, postpartum, and pediatric populations.
- **Preventive Health:** Outreach supporting recommended screenings, immunizations, laboratory monitoring, and risk reduction strategies, including pre-diabetes and recommended cancer screenings to promote early detection and prevention.
- **Health Promotion:** Education and lifestyle strategies supporting healthy aging, brain health, nutrition, physical activity, and overall wellness.

Continues on the next page

Member Identification and Participation

Members may be identified through systematic population health analytics, clinical review, health assessments, claims data, or direct member or provider referral. Participation is voluntary; members may enroll, decline, or opt out at any time unless otherwise specified by program requirements.

Partnering With You

Care Management clinicians collaborate with treating providers to reinforce the plan of care, support medication adherence, coordinate specialty referrals, address care gaps, and connect members to community-based resources.

Access to Care Management Plans

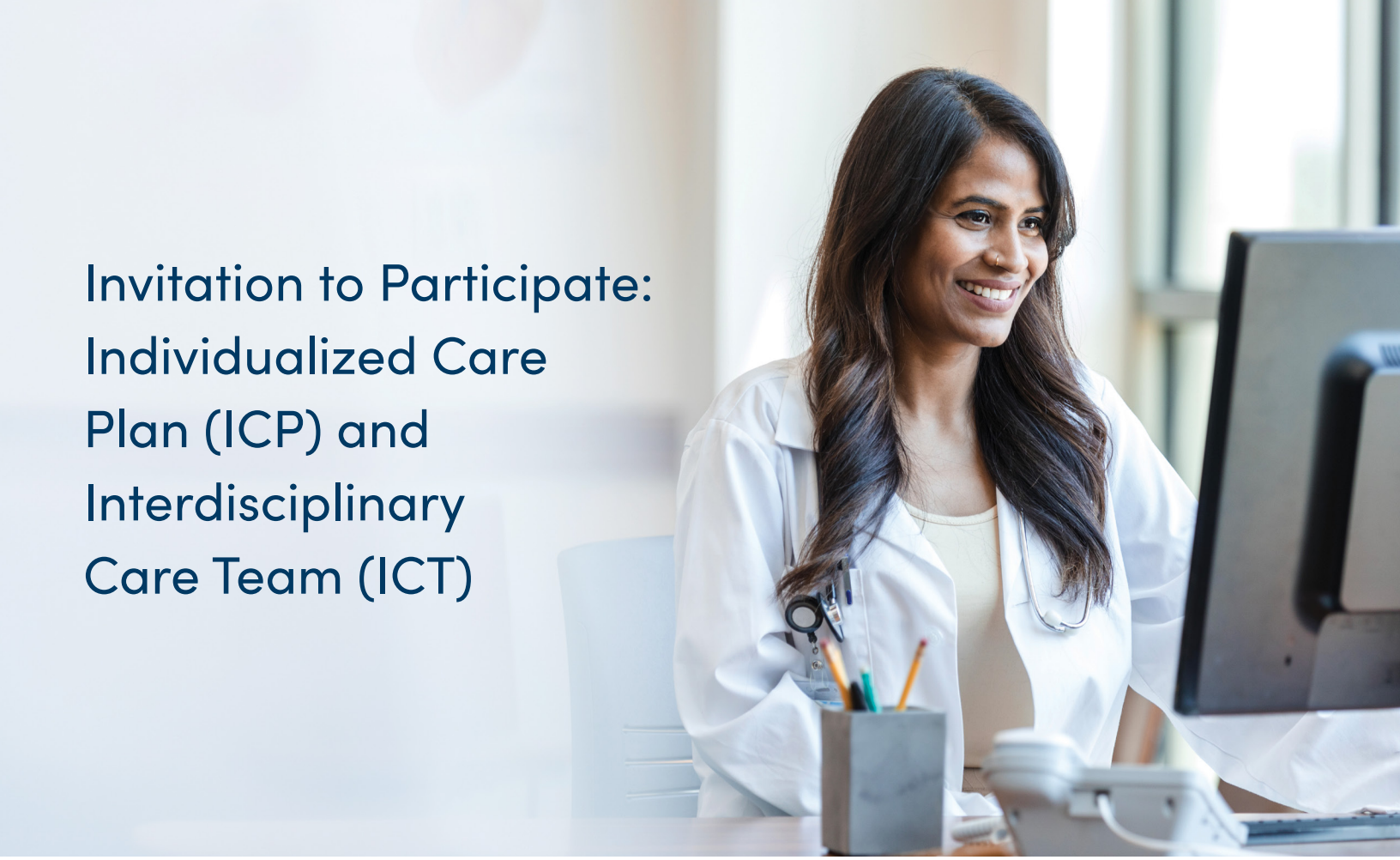
Care Management plans for participating members are made available to practitioners through established communication channels, including the Provider Portal, to support timely engagement, coordination, member management, and continuity of care.

Referrals and Assistance

For referrals, questions, or assistance with Provider Portal access, please contact Highmark Health Options Provider Services at **1-844-325-6251 (TTY: 711)** or Highmark Health Options Duals Provider Services at **1-855-401-8251 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

We value your partnership and remain committed to coordinated, high-quality, member-centered care.

Invitation to Participate: Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT)



As a valued member of the Interdisciplinary Care Team (ICT), you are the first step to the success of our members' care. Each Medicare D-SNP member has an Individualized Care Plan (ICP), which they have access to on the member portal or by mail upon request. You have access to the ICPs for your panel, available on the provider portal. We encourage you to review the member's care plan with them during their next visit.

We also invite you to participate in ICT meetings regarding your patients. The purpose of ICT meetings is to focus on our members and their specific needs to help achieve their overall health care goals. Each ICT meeting results in an updated Individualized Care Plan, so your input is critically important.

Please call the Case Management Department to schedule an ICT meeting for any of your Highmark patients at **1-855-401-8251 (TTY: 711)**.

Cotiviti Claims Pattern Review (CPR)

Highmark is enhancing its existing claim editing program to broaden the overall accuracy and integrity of our claims processing.

To enhance the accuracy and timeliness of claims processing, Cotiviti Claims Pattern Review (CPR) will be implemented. CPR will enable efficient Payment Policy Management and review of claims while utilizing real-time analytics. CPR will have the ability to pause claims processing and enable Cotiviti CPR experts to review claims for proper validation prior to payment. As part of this process, registered nurses with coding certifications will review claim data in conjunction with patient claim history to validate appropriate claims processing.

Information regarding Cotiviti CPR can be found in the Highmark Health Options Medicaid and the Highmark Health Options Duals (HMO SNP) Medicare D-SNP Provider Manuals, located on the **Provider Resource Center**.

Prescriber Notice: Diagnosis Code Requirement for Certain Medications

As part of ongoing efforts to ensure compliance with regulatory requirements, Highmark has identified a billing documentation gap related to certain high-cost and potentially abused maintenance medications.

During Medicaid drug claim reviews, auditors require documentation of a corresponding diagnosis that aligns with the FDA-approved indication for the prescribed medication.

To ensure compliance and maintain the integrity of clinical records, providers must include the corresponding ICD-10 diagnosis code with all billed medical encounters involving prescribed maintenance medications on an annual basis, at a minimum.

This requirement is especially important for the following therapeutic drug classes, which are flagged for review:

- Stimulants (e.g., Adderall, Ritalin)
- Inflammatory Conditions (e.g., Entyvio, Cosentyx, Taltz, Humira, Rinvoq)
- Bowel Conditions (e.g., Trulance, Pentasa, Linzess, Sulfasalazine)
- Movement Disorders (e.g., Austedo, Ingrezza, Tetrabenazine)

Accurate and complete documentation, including diagnosis codes, not only supports appropriate clinical review and regulatory compliance, but also facilitates timely claims processing and continuity of care.

Fraud, Waste and Abuse Audits and Medical Record Request Standards

The Financial Investigations and Provider Review (FIPR) Team is responsible for conducting audits regarding Fraud, Waste and Abuse (FWA). If selected for an audit, you will receive a letter from the primary investigator, or delegates that have been contracted by the Plan, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond.

If Highmark requests medical records, you must provide copies of the records at no cost to the Plan. This includes notifying any third party who may maintain medical records of this stipulation. In addition, you must provide access to any medical, financial, or administrative records related to the services provided to our members within 30 calendar days of our request or sooner. All required documentation must be submitted at the time of the original medical record request. Additional documentation will not be accepted after the review is complete.

Failure to provide requested medical records within the specified timeframe will result in claims being denied.

We require medical records to comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. For more information on medical record requests and standards, please refer to the Medicaid and Medicare Provider Manuals, located on the **Provider Resource Center.**

Accessibility Standards: Timeliness of Access to Care

Highmark Health Options Delaware maintains standards and processes for ongoing monitoring of access to health care.

To help ensure our members receive services in a timely manner, practice sites are contractually required to follow these standards. Please take a few minutes to review the accessibility standards and share with your office staff that schedule member appointments, including off-site central scheduling and call center staff.

The accessibility standards and additional resource information related to accessibility are available on our **provider website**.

Participating Providers Should Not Balance Bill Patients

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

As a reminder, reference the following language from page 19 of the Highmark Health Options Provider Manual Billing Responsibilities section.

Billing patients for covered services

Under no circumstance may a provider bill; charge, collect a deposit from, seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

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

Cotiviti is a separate company that administers pre-pay claim editing, retrospective data mining activities, readmissions, and chart reviews for Highmark Health Options.

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

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

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

MON-26-0028 (03/30/2026)