PROVIDER NEWS

HIGHMARK

A newsletter for Highmark Blue Shield providers in central Pennsylvania, the Lehigh Valley, northeastern Pennsylvania, and southeastern Pennsylvania

Issue 1, 2020

Highmark Teams with Civica Rx and the Blue Cross Blue Shield Association to Lower Outpatient Generic Drug Costs

Highmark is a founding member of a new subsidiary of Civica Rx designed to ensure that Highmark insurance members continue to have access to affordable generic prescription drugs in outpatient settings. This new subsidiary of Civica Rx, a non-profit generic drug manufacturer, will create value for consumers by producing select high-cost generic medications at a more affordable price.
Highmark, along with 17 other Blue Cross Blue Shield organizations across the U.S. and the Federal Employee Program, created the subsidiary of Civica Rx in response to an increasing number of shortages and price increases for outpatient generic medications.

“Over the past few years, overall drug prices have continued to rise. Generic drugs, which have historically offered a more cost-effective option for consumers, have also been impacted by these market dynamics,” says Sarah Marchè, senior VP of pharmacy services for Highmark. “Decreased market competition in generic drug manufacturing has placed a greater financial burden on our health care system and created a barrier to better health for our members. We are proud to be a founding

member of this new non-profit Civica Rx subsidiary, which will help ensure a steady supply of outpatient generic drugs and lower costs for our members."
The new Civica Rx subsidiary will produce select outpatient generic drugs and make them available in the market by early 2022, helping maintain accessibility and affordability for members who need them.

Civica Rx was founded in 2018 by three philanthropies and a variety of health systems from across the U.S., with the initial goal of stabilizing the supply and cost of generic drugs in hospital settings. Allegheny Health Network was a founding member of Civica Rx's hospital-focused initiative.

Read the press release for more information.

The Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield plans.

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2019 HEDIS Audit Results

The Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used set of performance measures in the managed care industry. Developed by the National Committee for Quality Assurance (NCQA®), HEDIS is part of a larger process that complements the NCQA accreditation program and establishes accountability in health care.

In areas of most concern to your patients, HEDIS helps compare how managed care plans perform.

HEDIS data are collected annually for members of Highmark's various products. The HEDIS measures span many areas of care delivery and service:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health plan descriptive information

Using this subset of HEDIS measures, the performance of services that Highmark members received in measurement year (MY) 2018 for the HEDIS reporting year (RY) 2019 is compared to the 2019 national averages. And for additional comparison, MY 2018 results are included.

You can review these results on the Provider Resource Center under **EDUCATION/MANUALS > HEDIS >HEDIS Results.**

Important Note: The source of the National Average data contained in this publication is from Quality Compass® 2019 and is used with the permission of NCQA®. Quality Compass 2018 includes certain CAHPS® data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

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Important Reminder: Include Rendering Provider Information on All Claims

Highmark has seen an increase in claims submitted with missing or incorrect rendering provider information. We want to remind you that all claims must contain the correct rendering/servicing provider information, including:

- National Provider Identifier (NPI)
- Provider Taxonomy Code correlating to the contracted specialty when **more than one** rendering/performing provider's NPI is associated with a Highmark-assigned provider number to enable accurate application of the provider's contractual business arrangements with Highmark

Failing to provide the correct rendering provider information can result in your claims being delayed or denied unnecessarily.

You can verify your practice information or make changes via the Provider File Management functionality on NaviNet. This function can be used to update the practice information such as contact information, practitioners affiliated with a location, office hours, age range the practice serves, etc. For more information, see the *Highmark Provider Manual,* Section 3.3, *Reporting Changes in Your Practice*.

Please note that any claim – **including $0 CPTII codes entered via NaviNet 1500** – submitted on or after May 1, 2019 **that did not list a performing provider will be evaluated for the E6343 rejection.** Please ensure that you have addressed/corrected any E6343 rejected claims with the necessary rendering (for billable claims)/attributed (for CPTII codes only) provider information.

How to Enter Rendering/Attributed Provider on NaviNet 1500 Claim Submissions

When submitting NaviNet 1500 claim submissions, providers must select the provider who performed the service, or a physician within the attributed practice, when applicable.

As shown below, under **Rendering/Servicing Provider,** click the arrow to open the drop down menu which displays all providers within the billing provider number. You will need to select the rendering/attributed provider for any CPTII codes submitted.

NOTE: If the rendering provider is not listed in the drop down, providers may submit the CPTII code based on a provider within the attributed practice.

If you need additional information about submitting claims – including $0 claims with CPTII codes via NaviNet 1500 claim submissions, see the *Highmark Provider Manual*, Section 6.4, *Professional (1500/837P) Reporting Tips*, or contact your Provider Account Liaison.

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Is Your Prescribing Authority Information Up-To-Date?

Highmark has seen an increase in prescriptions being rejected at the point of sale due to providers having incorrect/outdated prescribing authority on file in the National Plan and Provider Enumeration System (NPPES) for the prescriptions they write. This is especially true of controlled prescription drugs due to tighter regulations on prescribing authority for these drugs.

Please take a moment to review your NPPES data, make any necessary updates, and certify its accuracy to ensure your patients don't experience unnecessary delays and rejections on otherwise valid prescriptions.

Review, Certify, and Update Your Data in NPPES

To review your data in NPPES:

- Go to https://npiregistry.cms.hhs.gov/ and enter your NPI in the **NPI field**.
- Click on your **NPI number** to access your data record.
- Review your data for accuracy, and scroll to the bottom to the **Taxonomies** section to review your prescribing authority information, including your taxonomy code for your provider type.
- CMS provides a list of accepted taxonomy codes based on provider type. NOTE: If your taxonomy code is not one of the accepted codes for your provider type, prescriptions will be rejected at the point of sale.

To update and certify your data in NPPES:

- Go to https://nppes.cms.hhs.gov/NPPES/Welcome.do and log in using your user ID and password.

- Update your information as needed. This includes ALL address locations for where you practice and your taxonomy code for your provider type.
- Finalize any changes and follow the instructions to certify your information.

For More Information

Review the NPPES FAQ for additional information, including information on recovering/resetting your user ID and/or password, and changing your taxonomy code. Also, visit https://nppes.cms.hhs.gov/.

The Centers for Medicare and Medicaid Services (CMS), as well as various states, require that providers have the appropriate prescribing authority for any prescriptions they write. Prescribing authority is based on providers' data in the NPPES.

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Notifications for Providers

Several times annually, Highmark notifies providers of important policies and guidelines. The following notification is for your information and reference.

PA Medicare Advantage Medical Policy S-218: Endovascular Repair of Aortic and/or Iliac Aneurysms

The PA Medicare Advantage Medical Policy S-218 Billing and Coding: Endovascular Repair of Aortic and/or Iliac Aneurysms Version 002 did not publish on the expected issue date of August 12, 2019. The issue date has been updated and is reflected in version 002 of this policy. There is no change to version 003.

Update to Highmark Reimbursement Policy Bulletin RP-054, Ambulance Services

Highmark Reimbursement Policy Bulletin RP-054, Ambulance Services, has been updated. Please see the Policy Update History Information section at the end of the policy, which identifies the changes that have been made within the policy for the February 2020 revision.

To access Highmark Reimbursement Policy Bulletins on the Provider Resource Center, select CLAIMS, PAYMENT & REIMBURSEMENT, and then click on Reimbursement Policy.

Preventive Health Guidelines Available Online

Highmark and participating network physicians annually review and update the Preventive Health Guidelines, which are distributed to the practitioner community as a reference tool to encourage and assist you in planning your patients' care.

To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit highmarkblueshield.com and click **Provider Resource Center** under **Helpful Links**. (NaviNet® users, simply click on **Resource Center** from the Plan Central page.) Next, go to **Education/Manuals**, and then select **Preventive Health Guidelines**.

The Preventive Health Guidelines include:

- Adult (under and over 65)
- Pediatrics
- Prenatal/perinatal

Please ask your clinical support staff to bookmark this web page as a handy reference tool to help plan your patients' care. To obtain a paper copy of the guidelines, write to:
Highmark
Director, Accreditation and Compliance
Fifth Avenue Place
120 Fifth Avenue, Suite P4425
Pittsburgh, PA 15222

Appropriate Utilization Decision Making

Highmark makes utilization review decisions based only on the necessity and appropriateness of care and service and the existence of coverage. In addition, Highmark does not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor does it provide any financial incentives to utilization review decision-makers to encourage denials of coverage.

Request for Criteria

Highmark uses resources such as nationally recognized clinical review criteria, medical policy, and Medicare guidelines in determining whether a requested procedure, therapy, medication, or piece of equipment meets the requirements of medical necessity and appropriateness. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

If a PCP or specialist requests a service that a clinician in Utilization Management is unable to approve based on criteria/guidelines, the clinician will refer the request to a Highmark Physician Reviewer. A Highmark Physician Reviewer may contact the PCP or specialist to discuss the request or to obtain additional clinical information.

A decision is made after all of the clinical information has been reviewed.

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making medical/surgical decisions by calling Highmark at **1-800-421-4744.** To request a copy of the criteria/guidelines used in making behavioral health decisions, call **1-800-258-9808.**

Patient Notification of Approvals, Denials

All network providers are expected to notify their patients who are Highmark members of both approval and denial-of-coverage decisions as soon as possible upon their office receiving notification of the decision from Highmark or a delegated entity of Highmark.

Member Rights and Responsibilities

Our members have certain rights and responsibilities that are a vital part of membership with a managed care or PPO plan. These rights and responsibilities are included in the member handbooks and are reviewed annually in the member newsletter. We also make them available online for our network providers to help you maintain awareness and support your relationship with your patients who are Highmark members.

(On the Provider Resource Center, click on **Education/Manuals**. You'll find the Member Rights and Responsibilities in Chapter 1, Unit 5, of the ***Highmark Provider Manual***.) A paper copy of the Member Rights and Responsibilities is available upon request.

Case Management Referral

You can now submit automated referrals for Clinical Care and Wellness (CC&W) case management programs via NaviNet. This feature will help to:

- Ensure that patients with chronic conditions and complex medical needs are connected with the right clinical support for their needs.
- Simplify and expedite the overall case management referral process
- Reduce administrative burden

To access this feature:

- Log into NaviNet and and access Plan Central.
- Click the **Case Management Referral and Inquiry** link under **Workflows for this Plan** to go to the **Clinical Care & Wellness** page.
- Click the **Create New Referral** button under **Submit New Referral to CC&W**
- Follow the steps to create and submit the referral.

We also want to remind you that the Highmark Member Clinical Programs and Services catalog (complete with useful information and helpful resources) is available to further your understanding of the full range of programs and services available to Highmark members in all service areas for all lines of business.

We encourage you to review this catalog to help you identify members who can benefit from the programs and services we offer.

To access the Highmark Member Clinical Programs and Services catalog on the Provider Resource Center:

- Click **EDUCATION/MANUALS**
- Click **Clinical Programs and Services for Highmark Members**
- Click the link to the Catalog Reference Guide

Peer-to-Peer Conversations: Availability of Physicians, Behavioral Health Practitioners, and Pharmacist Reviewers*

Highmark provides you with an opportunity to discuss utilization review denial decisions with a clinical peer reviewer following notification of a denial determination. Clinical peer reviewers are licensed and board-certified physicians, licensed behavioral health care practitioners, and licensed pharmacists, and they are available to discuss review determinations during normal business hours.

Your call will be connected directly to the peer reviewer involved in the initial review determination, if he or she is available. If the original peer reviewer isn't available when you call, another clinical peer will be made available to discuss the denial determination within one business day of your request. To request a peer-to-peer conversation, you may call the appropriate number listed in the chart below.

***IMPORTANT NOTE: The peer-to-peer review process is no longer available for Medicare Advantage members. See Chapter 5, Units 3 and 5, of the *Highmark Provider Manual* for details.**

PRACTITIONER/ ORDERING PROVIDER	UM ISSUE	TELEPHONE NUMBER
Practitioners	Med/Surg UM decisions	**1-866-634-6468**
Behavioral health providers	Behavioral health	**1-866-634-6468**
Pharmacists	Pharmacy services	Telephone number identified on determination letter

Practitioners	Advanced radiology imaging	Telephone number identified on determination letter
Practitioners	Radiation Therapy	Telephone number identified on determination letter
Practitioners	Physical Medicine	Telephone number identified on determination letter

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Provider Accessibility Expectations

To stay healthy, our members must be able to see their physicians when needed. To support this goal, Highmark's expectations for accessibility of primary care physicians (PCPs), medical specialists, obstetricians, and behavioral health providers are outlined below.

The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.
Physicians are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

PCP and Medical Specialist Accessibility Expectations	
Patient's Need:	**Performance Standard:**
Emergency/life-threatening care • Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)	Immediate response
Urgent-care appointments • An urgently needed service is a medical condition that requires	Office visit within 1 day (24 hours)

rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)	
Regular and routine care appointments • Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain) • Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)	**Pennsylvania and West Virginia:** • Within 2-7 days (Non-urgent) • Within 30 days (Routine wellness) **Delaware:** Office visit within 3 weeks of member request
After-hours care • Access to practitioners after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours)
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes

Maternity Care Accessibility Expectations (Obstetrics)	
Patient's Need:	**Performance Standard:**
Maternity Emergency	Immediate response

Maternity 1st Trimester	Within 3 weeks of first request
Maternity 2nd Trimester	Within 7 calendar days of first request
Maternity 3rd Trimester	Within 3 calendar days of first request
Maternity High Risk	Within 3 days of identification of high risk

Behavioral Health Provider Accessibility Expectations	
Patient's Need:	**Performance Standard:**
Care for a life-threatening emergency • Immediate intervention is required to prevent death or serious harm to patient or others	Immediate response
Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	Care within 6 hours
Urgent care • Timely evaluation is needed to prevent deterioration of patient condition	Office visit within 48 hours
Routine office visit • Patient's condition is considered to be stable	**Pennsylvania and West Virginia:** Office visit within 10 business days **Delaware:** Office visit within 7 calendar days

After-hours care • Access to providers after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the provider or answering machine message telling caller how to reach the provider after hours)
In-office waiting times • Providers are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes


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Quarterly Formulary Updates Available Online

We regularly update our prescription drug formularies and related pharmaceutical management procedures. To keep our network physicians apprised of these changes, we provide quarterly formulary updates in the form of Special *e*Bulletins.

These Special *e*Bulletins are available online. Additionally, notices are placed on the Provider Resource Center's (PRC) **Hot Topics** page to alert physicians when new quarterly formulary update Special *e*Bulletins are available.

Providers who don't have internet access or don't yet have NaviNet® may request paper copies of the formulary updates by calling our Pharmacy area toll-free at **1-800-600-2227.**

Pharmaceutical Management Procedures

To learn more about how to use pharmaceutical management procedures — including providing information for exception requests; the process for generic substitutions; and explanations of limits/quotas, therapeutic interchange, and step-therapy protocols — please refer to the **Pharmacy Program/Formularies** page, which is accessible from the main menu on the Provider Resource Center (PRC).

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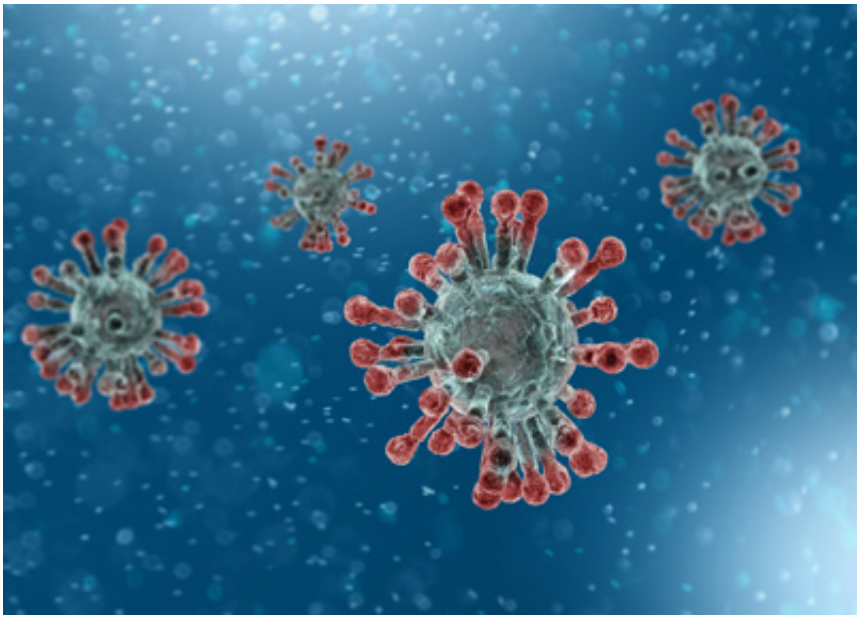
Review and Share CDC Guidance on 2019 Novel Coronavirus Outbreak



Cases of 2019 Novel Coronavirus infection began recently in Wuhan, China, and additional cases are being identified in a growing number of countries, particularly in Asia.

The Centers for Disease Control (CDC) is advising health care providers to be alert for patients with respiratory symptoms and a history of recent travel to Asia, particularly Wuhan, China. Symptoms associated with this infection include fever, cough, and trouble breathing.

The CDC is closely monitoring the outbreak of this disease and has made guidance on 2019 Novel Coronavirus infection available on its website.

We encourage you to review this guidance and share it with your staff.

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Maternity Case Management Programs: Supporting Expectant Mothers

Having the right support and resources during pregnancy can mean better outcomes and care quality for both mothers and babies.

That's why Highmark has created maternity case management programs to ensure the best possible outcomes for moms and babies, particularly for high-risk pregnancies. In addition, the Blue Cross and Blue Shield Association (BCBSA) created the Baby Blueprints® maternity program to give expectant mothers and their health care providers the support and resources they need.

We encourage you to discuss these programs with your patients and, when appropriate, refer them to these programs.

High Risk Pregnancy Program

The High Risk Pregnancy program addresses the risks and needs of women planning a pregnancy who have a history of high-risk pregnancy, or who may be at higher risk for complications secondary to fertility planning and treatments, or other comorbidities such as asthma, diabetes, depression, or chronic pain. Assessment covers the prenatal period and the initial postpartum period to allow for collection of outcome data regarding the impact for both mother and baby. Case management will be provided to the mother and baby through discharge to home.

Maternal Opioid & Mental Health Support (MOMS) Program

The MOMS program helps pregnant women gain access to quality care in a stigma-free environment to help reduce the negative outcomes associated with untreated mental health and opioid use disorders during pregnancy, such as Neonatal Abstinence Syndrome (NAS). Social Determinants of Health needs are addressed and women are assisted in obtaining evidence-based treatments and community resources. Support is provided throughout pregnancy and into the postpartum period to promote health and recovery for both the mom and the infant.

Baby Blueprints Maternity Program

The Baby Blueprints program provides tools, education, information, and ongoing, personalized support from health coaches throughout all stages of their maternity experience to encourage pregnant women to take a more proactive role in their health, and help support positive outcomes for both moms and babies.

How to Refer Your Patients

If you feel that any expectant mothers you care for can benefit from any of these programs, you can refer them to these programs as follows:

By Phone

- MOMS Program: Call **(833) 834-6865** to connect immediately to a Behavioral Health Specialist (BHS)
- Baby Blueprints: Expectant mothers simply call toll-free at **1-866-918-5267** to enroll over the phone. They will then receive a confirmation mailing with helpful pregnancy tips.

By NaviNet®

- Log into NaviNet and access Plan Central
- Click the **Case Management Referral and Inquiry** link under **Workflows for this Plan** to go to the **Clinical Care & Wellness (CC&W) page**
- Click the **Create New Referral** button under **Submit New Referral to CC&W**
- Follow the steps to create and submit the referral

By Fax

- Download the Clinical Services Referral Form on the Provider Resource

Center
- Complete the form and fax to **1-888-344-3455**

Baby Blueprints is a registered trademark of the Blue Cross and Blue Shield Association.

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Reducing Wait Times and Improving the Patient Experience for Specialist Visits

The average wait time to see a specialist in the US is more than 24 days, according to a survey by Merrit Hawkins mentioned in an article in *Becker's Hospital Review*. Long wait times are patients' number one dissatisfaction about specialist visits.

Long Waits + Difficulty Scheduling Appointments and Connecting to Providers = Poor Patient Experience and Outcomes

Long waits, along with difficulty scheduling appointments and connecting to providers, can mean:

- **Delayed care, or sometimes care not received at all.** As patient wait times increase, patients are more likely to cancel appointments, or fail to show up altogether. The number one reason patients cancel or fail to show up is poor patient access.
- **Poor patient satisfaction ratings.** The Consumer Assessment of Healthcare Providers and Systems (CAHPS)® survey and other patient satisfaction surveys ask patients how long they have to wait to talk to providers, how long they have to wait between calling a specialist's office and speaking to someone, whether they experienced difficulty doing so, and if so, the reason for the difficulty, such as inconvenient appointment times.
- **Provider and staff dissatisfaction and burnout**. Providers and staff feel overwhelmed and frustrated when patients fail to keep appointments, as well as stressed when dealing with patient complaints about appointment delays.

What You Can Do

While not all factors are within your control, there are some ways specialist practices can reduce wait times and help their patients have a better overall experience. These include:

- **Online direct scheduling:** The easier it is for patients to make appointments, the more likely they are to keep them. Online direct scheduling allows patients to see which options are available and choose the best ones for their needs.
- **Appointment type organization:** Appointment types vary depending on patients' needs, from initial consultations and pre-op consultations to post-op and follow-up visits. Allowing for different types of appointments in terms of length of time, etc. can allow more efficient scheduling.
- **Virtual visits:** Specialists and primary care providers of all types have come to embrace virtual visits as a way to give their patients more options for greater access to the care they need.
- **Onsite technology:** Computer kiosks and tablets in providers' waiting areas for patient check in/registration, appointment scheduling, etc. can reduce time for patient intake before visits.
- **Patient portals/mobile apps:** These allow patients to communicate with providers securely and conveniently, and some even offer real time chats.

We encourage you and your staff to:

- Review your practice's patient satisfaction data and discuss what's working well and what can be improved
- Discuss whether any of the options above, as well as other technologies, could work for your practice
- Ask your patients about which options they'd like to see in your practice

Learn More

The Agency for Healthcare Research and Quality (AHRQ) has resources for improving patients' experiences with primary and specialty care.

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About This Newsletter

Provider News is a newsletter for health care providers who participate in our networks. It contains valuable news, information, tips and reminders about our products and services.

- *Classic Blue*
- *Direct Blue*
- *EPO Blue*
- Freedom Blue PPO
- *PPO Blue*
- *PPO Plus*
- *Advance Blue*
- *Simply Blue*
- *Community Blue*

Do you need help navigating the *Provider News* layout? View a **tutorial** that will show you how to access the stories, information and other links in the newsletter layout.

Important note: For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the monthly publication ***Medical Policy Update***.

Note: This publication may contain certain administrative requirements, policies, procedures or other similar requirements of Highmark (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.

Comments/Suggestions Welcome

Bryce Walat, Editor

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments or ideas for articles in future issues, please write to the editor at **Bryce.Walat@highmark.com**.

Contact Us

Providers with internet access will find helpful information online at highmarkblueshield.com. NaviNet® users should use NaviNet for all routine inquiries. But if you need to contact us, below are the telephone numbers exclusively for providers.

HIGHMARK
1-866-731-8080

Convenient self-service prompts available.

1-866-588-6967 — Freedom Blue℠ PPO Provider Service Center

1-866-675-8635 — Freedom Blue PFFS Provider Service Center

1-866-634-6468 — Requests for Medical Management and Policy peer-to-peer conversations

1-800-992-0246 — EDI Operations (electronic billing)

1-800-600-2227 — Option 2 — Pharmacy (prescription authorizations)

Legal Information

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Shield serves the 21 counties of central Pennsylvania and the Lehigh Valley as a full-service health plan. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Highmark Senior Health Company and Highmark Benefits Group are service marks of Highmark Inc. NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance plans. Highmark Health is the parent company of Highmark Inc.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

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