TruePerformance | Post-Acute Care

True Performance Home Health Episodic Bundled Value Based Payment Program

Program Year 2024

PROGRAM MANUAL

Release: October 30, 2023

This Program Manual is applicable to Highmark Inc., which is referred to herein as "Highmark".

Proprietary and Confidential

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Program Overview

Introduction

Highmark continues the evolution of our efforts to reinforce and improve quality, enrich our member experience, and reduce the overall cost of care by supporting Home Health (HH) providers with the flexibility to implement innovative care delivery models focused on health outcomes and quality, as well as reduce the operational burden of administrative requirements that do not add value. Highmark is instituting a HH Episodic Value-Based Program ("Program"), between Highmark and a contracting entity ("Contracting Entity") that is a HH provider or an entity that owns, employs or contracts with multiple HH providers.

The Program will serve as an enhanced value-based reimbursement program for Highmark's HH provider networks. The Program offers the potential for significant value-based reimbursement by rewarding Participants for managing their Highmark member patient population toward high-value (both quality and efficiency) outcomes of care.

The Program continues to advance the Institute for Healthcare Improvement's (IHI) "Triple Aim" of health care improvement:

- Improving the experience of care,
- Improving the health of the population, and
- Reducing per capita cost of health care.

As Highmark continues the journey to transform the way providers are reimbursed for delivering health care, the Program has been developed to provide additional opportunities for HH providers. Participants will be guaranteed a member-level, risk-adjusted, Episodic Base Payment, when an initial claim is submitted for the episode of care. To ensure a focus on positive patient outcomes, the Participants will then be required to meet or exceed quality and cost and utilization metrics. An Annual Quality Inflator will be applied to the Episodic Base Payment if the Participant meets or exceeds the requirements of the following two (2) Program quality measures (described herein):

1) 7-Day Primary Care Physician (PCP) and/or Specialist Follow Up
2) Timely Initiation of Care

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Program Overview, Continued

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If the Participant passes the quality measures, the Program cost and utilization measures (described herein) will be scored to determine if additional reimbursement is achieved. The three (3) cost and utilization measures include:

1) Measured Cost of Care (MCOC),
2) Risk Adjusted 30 Day Readmission Rate and
3) Emergency Department (ED) Utilization.

Highmark continues working to improve the health of its members by providing resource support and data sharing, encouraging care coordination across all aspects of care delivery, and incorporating value-based goals and objectives.

Program Participation

The Program will be available to a subset of providers within Highmark's Pennsylvania HH network. Eligible Program Participants include HH providers who are credentialed with Highmark and are contracted under an applicable Underlying Provider Agreement or other HH providers at Highmark's sole discretion.

In addition, to be eligible for the Program, HH providers within Highmark's Pennsylvania HH network must meet the minimum volume of annual HH episode requirements of 20 or more Highmark HH episodes for Highmark Medicare Advantage members during the calendar year prior to the Performance Period. Retrospective HH admission volume will be evaluated annually to determine eligibility to participate in the Program. In addition to Participants having an average over three calendar years of 20 or more episodes prior to the Performance Period, they also need to meet the episode requirement during the current Performance Period to be considered eligible for participation in the Program. Low-volume providers are excluded from earning any value-based reimbursement incentives.

Low-volume providers are providers that have an average of 20 or less Highmark Medicare Advantage episodes for the prior three calendar years. Assuming the provider has submitted all required documentation through the prior authorization process, low-volume providers will receive 100% of the risk adjusted base payment. These providers will not be eligible for any of the additional incentive bonuses. This also applies to providers who have undergone a change of ownership during the Performance Period.

To participate in the Program, eligible HH providers must be covered under a True Performance HH Episodic Value Based Program Participation Agreement and Limited Addendum (the "Agreement").

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Program Members

PROGRAM OVERVIEW, continued

Participants will be evaluated for this Program using Program Members' claims data. This includes Program Members 18 years or older with primary coverage under Highmark Medicare Advantage, if applicable, products. Medigap, and Federal Employee Program members are excluded for Medicare Advantage.

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Program Reporting and Claims Submission

Program reporting and performance assessments and subsequent value- based reimbursements, if eligible, are based upon the submitted claims of the Participant. Claims submitted to Highmark are required to include accurate and complete coding with documentation to support the claim appropriately captured in the Program Member's medical record. Participants are required to submit the Program Member's principal diagnoses, as well as all complications and comorbid diagnoses with each claim. Highmark reserves the right to audit any and all claims or data submitted. Audit findings that identify failure to submit accurate and comprehensive information constitutes a failure to meet participation criteria requirements and may result in adverse Program reimbursement impacts including, but not limited to, financial recoveries of Program reimbursement and termination of Program participation pursuant to the Agreement and the Administrative Requirements.

Participants are required to complete an Outcome and Assessment Information Set ("OASIS") on all Program Members at any applicable point of the following intervals per each episode of care:

- Start of Care ("SOC")
- Resumption of Care ("ROC")
- Recertification ("REC")
- Transfer to Inpatient Facility
- Death at Home
- Discharge from Agency

The OASIS is a comprehensive assessment designed to collect information on many items related to a HH recipient's demographic information, clinical status, functional status, and service needs. To be considered timely with submissions, Participants are required to submit an OASIS assessment no later than 14 days from the date of the assessment completion. This is applicable to the following OASIS documents:

- Transfer to Inpatient Facility
- Death at Home
- Discharge from Agency

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Program Reporting and Claims Submission continued

If Participants fail to submit their SOC/REC/ROC OASIS within 14 days, proper, risk-adjusted payment cannot be determined and will be denied until the OASIS and authorization submission process occurs through the Helion Arc (formerly Home Health Utilization Management ("HHUM") Portal).

Each authorized 60-day episode of care that does not overlap a prior 60-day episode of care, will receive a risk adjusted episodic base payment. The risk adjustment is determined by a combination of data points received through the Helion Arc during the prior authorization process that determines the complexity of the case.

If a claim is submitted to Highmark for an authorized episode of care, but the authorization was not submitted through the Helion Arc, the claim will reject as a risk adjustment is unable to be calculated. In order to avoid a claim rejection, the provider should submit all prior authorization requests through the Helion Arc. However, if a prior authorization request is submitted through another channel, i.e., phone, fax or customer service and prior authorization is approved, the provider should upload the corresponding the corresponding SOC/REC/ROC OASIS Assessment to the Helion Arc at least 2 days or 48 hours prior to submitting any associated claims for that episode.

Providers receiving a denial for prior authorization and appeal after care has started, a retrospective review will be completed. If the original determination is overturned and authorization is approved, the provider should also upload any corresponding OASIS to the Helion Arc in order for the episode to be properly risk adjusted. If the provider has already submitted a claim for this episode and it was rejected, the provider should resubmit the claim once at least 2 days or 48 hours after uploading the corresponding OASIS Assessment(s).

The SOC/REC/ROC OASIS, as applicable, must be submitted and received prior to claim submission. Participants are required to have 90% timely submission for OASIS completion. If Participants do not meet that threshold, there may be is a risk of the claims payment rate increase being withheld.

Episodes that appear on the scorecard for performance evaluation may be different or not perfectly aligned to payment being made on claims.

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Transparency

Contracting Entity acknowledges and on behalf of its Participants acknowledges that Contracting Entity and Participants will cooperate with Highmark's quality improvement and transparency programs and initiatives, which include, but are not limited to, programs developed to satisfy the compliance requirements of the National Committee for Quality Assurance (NCQA), other accreditation entities and any applicable regulatory body (collectively, "Quality Initiatives"). In connection with Quality Initiatives, Highmark may:

(a) Utilize, publish, disclose, and display any information and data related directly or indirectly to the Contracting Entity/Participant's delivery of health care services, such as, but not limited to, performance or practice data, information relating to Contracting Entity/Participant's costs, charges, payment rates and quality, utilization, outcome and other data ("Participant Data");
(b) Disclose Participant Data to Highmark's contracted vendors and agents to assist in the review, analysis and reporting of the Participant Data;
(c) Report the Participant Data to other providers to assist such providers in the management of care costs, quality outcomes and other efficiencies;
(d) Report the Participant Data to members and customers (including third parties who supply information and analysis services to group customers);
(e) Support Contracting Entity/Participant's participation in certain benefit value levels (such as network tiers).

Contracting Entity acknowledges and on behalf of its Participants acknowledges and agrees that any Participant Data is proprietary to Highmark, a highly confidential trade secret of Highmark and is entitled to protection as such. In the event that Contracting Entity/Participant receives any Participant Data (which may be Contracting Entity/Participant's own Participant Data or the Participant Data of a provider other than Contracting Entity/Participant), Contracting Entity/Participant agrees to maintain the Participant Data as confidential and to use it for the purpose or purposes for which the Participant Data was provided by Highmark or its contractor or agent and agrees to not publish or publicly share the Participant Data, except as expressly permitted by Highmark in writing.

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Transparency, continued

Without limiting the foregoing, any provisions in the Contracting Entity/Participant's Underlying Provider Agreement or Administrative Requirements that address the confidentiality of information and data, such as the Participant Data, shall remain in full force and effect and such provisions shall govern the Participant Data in addition to this Transparency section.

Clinical and Professional Judgement

Notwithstanding anything contained in the Agreement or this Program Manual to the contrary, Participants shall at all time exercise clinical and professional judgment in the best interests of the Program Member. Without limiting the foregoing, Participants shall at all times make referrals based on the Participants' best clinical and professional judgment and in the best interests of the Program Member. Furthermore, nothing contained herein shall operate to limit or restrict the Program Member from choosing the provider of service of the Program Member's choice.

Furthermore, Contracting Entity agrees on its own behalf and on behalf of its Participants, that Participants shall not withhold any and all necessary care to Program Members based on participation in the Program. Contracting Entity acknowledges and on behalf of its Participants acknowledges that nothing in the Program is intended to encourage the reduction or limitation of medically necessary services furnished to any particular patient or prohibit, restrict or otherwise adversely impact Contracting Entity and each Participant from advocating for and/or providing medically necessary and appropriate care. Participants shall continue to provide care in accordance with their independent medical judgment.

Social Determinants of Health

To improve performance in this Program, Participants are encouraged to utilize available quarterly and monthly Program Member outcome reports via the Helion Arc, work with their assigned Helion Network Performance Manager to conduct root cause analysis, and to focus on the complete care needs of the Highmark Medicare Advantage Program Members including assessing each person for social determinant of health (SDOH) needs. Contact your Helion Network Performance Manager for available resources provided by Highmark.

Program Definitions

Definitions

All terms not defined herein shall have the meaning ascribed to such term in the HH Episodic Value-Based Program Participation Agreement and Limited Addendum.

"Annual Cost and Utilization Bonus Factor Adjustment" shall mean the increased factor applied to claims that the HH provider will be eligible to receive annually if the quality inflator thresholds are met or exceeded for the Performance Period in addition to scoring with a specific percentile for additional quality measures. This value-based reimbursement accounts for a potential increase of 2-5% to the Episodic Base Payment. The bonus factor adjustment will be paid at the claims level. It will begin on July 1st of the following year after the Performance Period and will run through June 30th of the next year.

"Annual Quality Inflator" shall mean the increased factor that the HH provider will be eligible to receive, if they pass the quality measures. Participants can earn the quality inflator increase, annually if the quality measures were passed. The inflator accounts for 5% of the risk adjusted base payment that can be earned and is evaluated annually.

"**Emergency Department Utilization**" or "**ED Utilization**" shall mean the count of Outpatient ED events for members within 30 days of the HH episode start date, measured from the beginning of the episode up to and including the ED event. ED events on the same day that the episode began, and those that resulted in an Inpatient admission, are excluded. This is the count standardized to a 'per 100' episodes, risk-adjusted to account for how the risk of the member population of the Home Health Agency (HHA) being scored corresponds to the overall risk pool of the HHA population, for that time period.

"Episodic Base Payment" shall mean the member level risk adjusted base payment the HH provider will receive upon claim submission at the end of the 60-day member episode. In order to receive this payment, a valid claim must be received. If the episode extends beyond the initial 60 days of care and the member is recertified, this would qualify as a new payment episode. Note: for the payment to be risk adjusted, the provider must submit all required documentation through the prior authorization process.

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"Excluded or Unbundled Services" shall mean the procedures and/or services the Participant provides to the member that are reimbursed separately from the episodic bundle. The Participant should refer to their Underlying Provider Agreement for the applicable fee schedule.

"**Home Health Episode"** shall mean, an episode that is specific to a Member and the HHA delivering the care. An episode begins with the first HH visit and can last up to 60 days. The rolling 60-day episode period begins with the earliest HH visit in the reporting dataset and starts again with the first HH visit following the 60-day episode. An episode may begin within the community or when a member is discharged from an institutional setting (Inpatient Hospital including Rehab, Skilled Nursing Facility SNF, or Inpatient Psychiatric). If the HH episode start date follows the institutional discharge date, and is within 14 days of it, then it will be an institutional episode; otherwise, it will be deemed a community episode for reporting purposes only.

"Low Visit Episodes (LVEs)" shall mean any Highmark Medicare Advantage episode that is less than or equal to four (4) visits.

"Low Volume Provider" shall mean any HH provider that has an annual average of 20 or less Highmark Medicare Advantage episodes for the prior three calendar years.

"Market" shall mean Participants that had 20 or more total Highmark HH Medicare Advantage episodes during calendar year 2024, located within the Highmark, Inc. service area which includes designated areas of PA.

"Measured Cost of Care" The 60-day Measured Cost of Care metric is a subset of a member's Total Cost of Care and is measured from the start of the episode to day 60. It is limited to medical cost categories which Highmark has identified as being actionable under post-acute care. These categories are classified using the Milliman Health Cost Grouper and are as follows: IP Medical, IP Surgical, IP Rehabilitation, Skilled Nursing Facility, OP Emergency Room and Observation (including Professional claims), OP PT/OT/ST, Professional IP Medical Visits, Professional IP Surgery, Professional Office Visits, Professional PT, Professional Chiropractor, Urgent Care Visits, Preventive Physical Exams, Home Health, and Ambulance. Helion reserves the right to amend this list at any time.

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"Overlapping Payment Episode" shall mean an episode of HH services for a member that overlaps another HH episode for the same member by the same Participant. An episode is considered to be an overlap when a new episode begins within a previously established 60-day episode of care.

"Program" shall mean Highmark's True Performance Home Health Episodic Bundled Payment Value Based Program, as further described in the Agreement.

"**Quality Gate**" shall mean the established minimum performance on two (2) quality measures required to be considered to earn the claims payment rate increase associated with the Cost and Utilization Measures component of this Program.

"Risk Adjusted 30 Day Readmissions" This measure is a numerator/denominator value reported as a percentage and represents the readmission rate for Inpatient stays ending within 14 days of (prior to) a HH episode start date. Denominator events include acute inpatient stays of 2 days or greater, excluding Long-Term Care Hospital (LTACH), Inpatient Rehabilitation Facility (IRF), Psychiatric, Maternity, Birth and Perinatal. Numerator events are the sum of distinct acute inpatient stays of 2 days or greater, occurring within 30 days of a denominator event, excluding LTACH, IRF, Psychiatric, Maternity, Birth, Perinatal, Transplants (based on Diagnosis Related Group (DRG)), chemotherapy related admissions (based upon the primary diagnosis code on the claim), Elective admissions, and Trauma admissions.

This will be risk-adjusted to account for how the risk of the member population of the HHA being scored corresponds to the overall risk pool of the HHA population, for that time period. For the purpose of comparing HHA performance, riskier populations will have a factor applied that will adjust the rate down, while healthier populations may have a factor applied to adjust the rate up.

"**Total Cost of Care (TCOC)**" shall mean the 60-Day TCOC averaged across all episodes. The Total Cost of Care is the total allowed amount of medical claims (excluding Part D/routine prescription drugs) submitted to Highmark, by any health care provider, whose service date was within 60 days of the HH episode start date.

Program Components

Program Components

The intent of this program is to allow Participants the autonomy to provide care and incentivize Participants to manage member episodes resulting in innovative care techniques, better quality, reduce cost and utilization. This methodology also seeks to reward Participants with an incentive to earn higher reimbursement based on quality outcomes.

Participants will receive a one-time risk adjusted payment for each non-overlapping 60-day episode of care. Risk adjustment is based on a multitude of data points collected by Highmark throughout the member journey. These data points are gathered through claims, prior authorization and other clinical data components.

Overlapping Payment Episodes

If a member is active in a 60-day episode of HH care and is discharged from HH earlier than the 60th day, then subsequently returns to the same HH Participant with a new start of care that falls within the prior 60-day episode this will be classified as an overlapping episode. The Participant will be reimbursed for the first 60-day episode in full and the subsequent, overlapping episode will be paid a prorated amount based upon the number of days overlapped.

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Program Components, continued

Program Components

Example:

Episode #	Risk Adjustment Amount	Start of Care	Start of Episode	Discharge Date	End of Episode	Total Payment
1	$1,948	1/1/2024	1/1/2024	1/20/2024	3/1/2024	$1,948
2	$2,100	2/4/2024	2/4/2024	4/5/2024	4/4/2024	$1,210.02

In the example above, the member was admitted to HH with a start of care date of January 1, 2024 and end of episode date of March 1, 2024. This represents the full 60-day episode from the start of episode date. The provider would receive risk adjusted payment of $1,948 for this episode. The patient was discharged from HH on January 20, 2024 and was readmitted to HH with a new start of care on February 4, 2024. Since there is an overlapping episode the second episode would be prorated by 57.62% since that is the number of days overlapped. The prorated amount is derived from the second episode based on the member's acuity. In this example, the second episode would be paid $1,210.02, which is risk adjusted.

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Program Components, continued

Services Reimbursed

Services provided by the Participant during the established 60-day episode of care will be reimbursed under the episodic bundle. These services include:

Revenue Code	Service	Medicare Advantage
0421	Physical Therapy	Included in Episodic Bundle
0424	Physical Therapy Evaluation	Included in Episodic Bundle
0431	Occupational Therapy	Included in Episodic Bundle
0434	Occupational Therapy Evaluation	Included in Episodic Bundle
0441	Speech Therapy	Included in Episodic Bundle
0444	Speech Therapy Evaluation	Included in Episodic Bundle
0551	Skilled Nursing	Included in Episodic Bundle
0559	Enterostomal Therapy	Included in Episodic Bundle
0561	Medical Social Services	Included in Episodic Bundle
0571	Home Health Aide	Included in Episodic Bundle
0583	Skilled Nursing Evaluation	Included in Episodic Bundle
0919	Psych Nursing/Social Services	Included in Episodic Bundle
0942	Nutritional/Dietary	Included in Episodic Bundle
0780	Telemedicine	Included in Episodic Bundle
0270	Medical/Surgical Supplies and Devices	Included in Episodic Bundle

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Program Components, continued

Excluded or Unbundled Services	Certain procedures and/or services are considered excluded from the episodic bundle. Claims for these services will be reimbursed separately under the Participants fee for service fee schedule located in the Underlying Provider Agreement. All excluded unbundled services should be submitted with Type of Bill 341 to ensure proper payment.
Low Visit Episodes (LVEs)	Participants will be reimbursed for Low Visit Episode's at the full 60-day payment rate. Each Participant will be evaluated throughout the Performance Period calendar year and again at the conclusion of the Performance Period calendar year following claims runout. A LVE will be considered an episode with four or fewer visits. The first evaluation will be the LVE percentage compared to the overall average of participating providers in the episodic program. If the participants LVE percentage is greater than or equal to than the overall average plus 500 basis points (BPS) then the participant will automatically be subject to review. For example, if the overall average LVE percentage is 12% and then any participant with a LVE of greater than 17% would be subject for a review. The second evaluation will be based upon how a providers LVE percentage compares to their own prior year LVE percentage. If the participants LVE is above the overall average and has gone up year over year, then that participant will be subject to a review. For example, if the overall average LVE percentage is 12% and a participant had a 14% LVE percentage in the current year and a 10% LVE in the prior year, then the provider would be subject to review.

Quality Measures

Quality Measure Descriptions

The structure of this program interlaces the Annual Quality Inflator as well as the Annual Cost and Utilization Bonus Factor Adjustment with value-based measures to drive high-value care and emphasize positive health outcomes. The quality measures associated with the potential to earn a Annual Quality Inflator are based on passing the quality measures described listed below. The thresholds are updated annually and will be communicated during the program year. These thresholds are set using historical claims data and require prior years claims runout to occur before being established.

- **7-Day PCP and/or Specialist Follow Up**:
  - The percentage of inpatient and Skilled Nursing Facility (SNF) discharges, ending up in the care of the HHA, that are followed-up by a Highmark credentialed primary care provider or specialist within 7 days. The measurement begins the day after discharge (hospital, SNF, Long Term Acute Cate, Inpatient Rehabilitation Facility). The follow-up visit is defined by claims with a provider specialty whose Health Cost Guideline (Milliman HCG) belongs to one of the following: Professional Office/Home Visits – by a PCP or Specialist, Professional Preventive Physical Exams, Transitional Care Management Services within 7 days, Telehealth, or Professional Medical Visits within a Nursing Facility. Re/Certification codes (alone) are excluded.
  - Visits on the same day as the inpatient or SNF discharge are not included in this measure. If the member is transferred to a SNF or other inpatient setting, this will be deemed a transfer and would be out of scope for this measure.
- **Timely Initiation of Care:**
  - Institutional episodes are measured for initiation of care, beginning with the inpatient facility discharge, up until the day of the earliest HH visit. Some additional visit types will be considered in this measurement in place of hospital discharge if they occur between the hospital discharge and the earliest HH visit. Additional visit types include Emergency Department, Observation, Outpatient Surgery, and PCP/Specialist visits. This measure is reported on an average basis and does not include community episodes.
  - This measure is defined as the percentage of discharges to home that have an initiation of care of ≤2 days.

Cost and Utilization Measures

Cost and Utilization Measure Descriptions

The cost and utilization component measures (listed below) of the Program will evaluate the ability of the Participant to promote member well-being and safety, while helping to control costs. The Participant's performance will determine their Annual Cost and Utilization Bonus Factor Adjustment. The cost and utilization component measures determine the Annual Cost and Utilization Bonus Factor Adjustment and is made up of the following measures:

Measured Cost of Care (MCOC)

MCOC is a cost measure based on a 60-day episode of care beginning at the initiation of a HH episode that occurs during the Performance Period, on or between Jan. 1st and December 31st, 2024. The 60-Day MCOC is risk-adjusted to account for how the risk of the member population of the HH provider being scored corresponds to the overall risk pool of the HH population, for that time period. For the purpose of comparing HH provider performance, riskier populations will have a factor applied that will adjust the cost down, while healthier populations may have a factor applied to adjust the cost up. The HH episode and all medical costs incurred during the 60-day episode are identified through Highmark claims. It is limited to medical cost categories which Helion has identified as being actionable under post-acute care. These categories are classified using the Milliman Health Cost Grouper and are as follows: IP Medical, IP Surgical, IP Rehabilitation, Skilled Nursing Facility, OP Emergency Room and Observation (including Professional claims), OP PT/OT/ST, Professional IP Medical Visits, Professional IP Surgery, Professional Office Visits, Professional PT, Professional Chiropractor, Urgent Care Visits, Preventive Physical Exams, Home Health, and Ambulance. Helion reserves the right to amend this list at any time.

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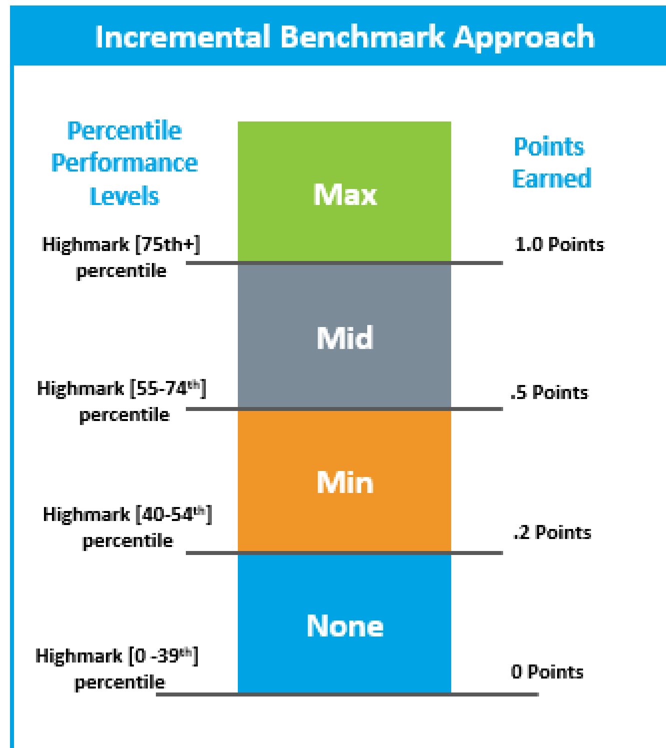
Cost and Utilization Measure Descriptions, continued

Below is a depiction of the incremental benchmark approach for the cost and utilization measures.

Figure 1: Incremental Benchmark Approach



The MCOC benchmark and results will be risk-adjusted. Highmark reserves the right to change software it uses to determine risk scores.

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Cost and Utilization Measure Descriptions, continued

The risk-adjustment calculation steps are listed below:

1. Market average risk scores are calculated and separated by Commercial and Medicare Advantage lines of business for reporting purposes.

2. The normalized risk score is the observed concurrent risk score divided by the market average risk score.

3. The scored 60-Day MCOC is the risk-adjusted amount, listed in the equation below.

The market for the MCOC measure is identified by the lines of business, (Commercial and Medicare Advantage) as well as the episode type (whether orthopedic vs non-orthopedic). The normalization accounts for the different episode mix (product type) within each Participant, so that they are all measured on the same scale relative to the market for the MCOC measure).

The risk adjusted 60-Day MCC calculation is:

Risk Adjusted 60-Day MCOC =
Actual MCOC / Risk Score Normalized by Market Average Risk Score

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Cost and Utilization Measure Descriptions, continued

Risk Adjusted 30 Day Readmissions

This measure is a numerator/denominator value reported as a percentage and represents the readmission rate for Inpatient stays ending within 14 days of (prior to) a HH episode start date. Denominator events include acute inpatient stays of 2 days or greater, excluding LTACH, IRF, Psychiatric, Maternity, Birth and Perinatal. Numerator events are the sum of distinct acute inpatient stays of 2 days or greater, occurring within 30 days of a denominator event, excluding LTACH, IRF, Psychiatric, Maternity, Birth, Perinatal, Transplants (based on DRG), chemotherapy related admissions (based upon the primary diagnosis code on the claim), Elective admissions, and Trauma admissions.

This will be risk-adjusted to account for how the risk of the member population of the HH Admissions being scored corresponds to the overall risk pool of the HH Admissions population, for that time period. For the purpose of comparing HH episode performance, riskier populations will have a factor applied that will adjust the rate down, while healthier populations may have a factor applied to adjust the rate up.

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Cost and Utilization Measure Descriptions, continued

Emergency Department (ED) Utilization

The ED Utilization measure is included in the Program because of its importance in utilizing the most cost-effective treatment location, but more importantly, supporting the ambulatory management of Program Members. This Cost and Utilization Measures measure represents the 30-day OP ED measure, standardized to a 'per 100' episodes, risk-adjusted to account for how the risk of the member population of the HH provider being scored corresponds to the overall risk pool of the HH population, for that time period. For the purpose of comparing HH provider performance, riskier populations will have a factor applied that will adjust the rate down, while healthier populations may have a factor applied to adjust the rate up. This represents the percentage of Program Members receiving HH care who are then admitted to the Emergency Department (ED) during the HH Episode. Performance Period claims data is being used to determine the ED Utilization threshold.

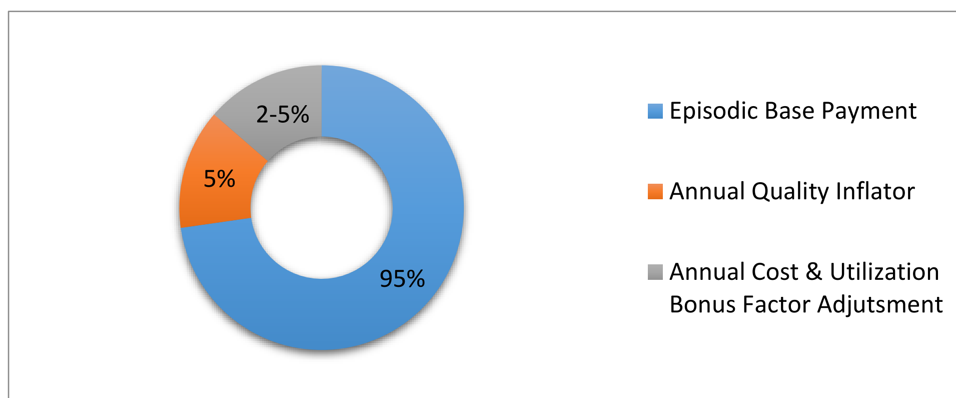
Performance Measurement

Performance Measurement Overview

Performance measurement is a critical component of the Program and serves to quantify improvement in the quality of care, assure receipt of standards of care, and prevent adverse or unintended consequences such as denial of needed care, or discrimination against the treatment of more medically complex or difficult-to-treat members. In addition to the Episodic Base Payment, providers may be eligible to receive two additional reimbursement tiers through the Program that can increase their earning potential. The additional reimbursement is earned based on performance for the metrics across the Annual Quality Inflator and Annual Cost and Utilization Bonus Factor Adjustment components. Providers may be eligible to earn up to two additional reimbursement tiers through the Program, which increases the earning potential up to 105% of the episodic base payment amount. This earning potential is represented in Figure 2 below.

1. **Episodic Base Payment (95%)**
2. **Annual Quality Inflator (5%)**
3. **Annual Cost and Utilization Payment (2-5%)**

Figure 2: Highmark Home Health Bundled Episodic Value Based Program Reimbursement Structure



For each component beyond the Episodic Base Payment, various Program measures will be evaluated to determine the provider's earning potential.

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Performance Measurement Evaluation

Performance evaluation for cost and utilization metrics are based on Market performance during the Performance Period and will have two groups based on volume. A high-volume provider will be defined as provider(s) with greater than or equal to 100 episodes, while a low volume provider will be defined as provider(s) with less than 100 episodes. A provider's assigned group for the Performance Period will be communicated through the first available Quarterly Quality Scorecard during the performance year. **Table 1 illustrates the volume categories below.**

Table1 : Volume Categories

Category	Number of Episodes
High Volume	>= 100 Episodes
Low Volume	<100 Episodes

Performance within these volume groups will also be evaluated based on tiers.

Episodic Base Payment

Episodic Base Payment

The Episodic Base Payment is issued per HH Episode. This payment is considered a member level risk adjusted base rate. Participants will receive 95% of their episodic base payment when an initial claim that meets the episodic criteria is submitted. Providers will need to submit the HH claim with all visit detail at the end of the episode and bill to Highmark. The Episodic Base Payment is not impacted by the quality or cost and utilization measures.

Annual Quality Inflator

Annual Quality Inflator

The next component of reimbursement that participating providers will be eligible to earn is the Annual Quality Inflator which is worth 5% in addition to the Episodic Base Payment.

All quality measures (7-Day Follow Up, Timely Initiation of Care) must be met in order to earn this payment. The quality measures are equally weighted.

All quality measures need to be met in the Performance Period in order for a Participant to be eligible for the Annual Cost and Utilization Bonus Factor Adjustment. Quality will be assessed prior to the cost and utilization measures being reviewed. Three months of claims runout will be accounted for when the cost and utilization measures are reviewed.

Please see the example shown below which illustrates how the Quality Inflator can be earned in addition to the Risk Adjusted Episodic Base Payment. In this example, the Participant has treated and serviced Program Members for 6 episodes of care. The Participant's episodic rate will vary per episode, based on the complexity score. Complexity scores determine payment adjustments based on the clinical characteristics and care needs of each member. In this example, the Risk Adjusted Episodic Base Payment is 95% of the episodic rate for each 60 -day episode.

Example of Episodic Base Payment Calculation:

Quarter 1 Risk Adjusted Episodic Base Payment	95% Guaranteed
$2,000 (Episode 1)	$1,900.00 (95% of $2,000)
$2,110 (Episode 2)	$2,004.50 (95% of $2,110)
$2,005 (Episode 3)	$1,904.75 (95% of $2,005)
$1,960 (Episode 4)	$1,862.00 (95% of $1,960)
$2,200 (Episode 5)	$2,090.00 (95% of $2,200)
$1,999 (Episode 6)	$1,899.05 (95% of $1,999)
Total Risk Adjusted Episodic Base Payment =	**$11,660.30 (for 6 episodes of care)**

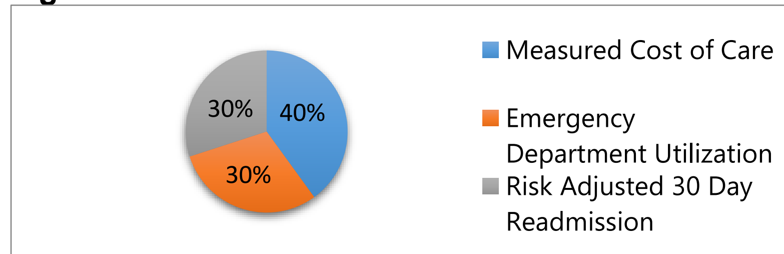
If all quality measures are met, the Participant will then be eligible for 5% of reimbursement in addition to the 95% Risk Adjusted Episodic Base Payment. The additional 5% would be applied to each episode.

Annual Cost and Utilization Bonus Factor Adjustment

Annual Cost and Utilization Bonus Factor Adjustment

The final payment increase component that participating providers can earn is the Annual Cost and Utilization Bonus Factor Adjustment. This component potentially adds an additional 2-5% of reimbursement to the overall reimbursement structure, which was illustrated in Figure 2. As depicted below, 40% of the Annual Cost and Utilization Bonus Factor Adjustment is based on Measured Cost of Care per episode performance. The other remaining 60% portion is equally distributed between the ED Utilization and Risk Adjusted 30 Day Readmissions metrics. Performance for the ED Utilization metric represents 30%, and the Risk Adjusted 30 Day Readmissions metric represents 30% of the overall cost and utilization measures component.

Figure 3: Annual Cost and Utilization Readmissions



For each metric, there is a min, mid, and max level that will be set at the 40th, 55th, and 70th percentiles, and assigned 0.2, 0.5, and 1.0 points, respectively. Final scoring would be a weighted average of the three metrics based on the 40/30/30 weighting of the components. Based on final composite scores, an additional 2% Bonus Factor Adjustment would be awarded to those in the 50th-59th percentile, an additional 3% would be awarded to those in the 60th–84th percentile, and those in the 85th percentile or better would receive the additional 5% Bonus Factor Adjustment.

Table 1: Cost and Utilization Measures and Associated Weights

Measure	Weight
Measured Cost Per Episode	40%
ED Utilization	30%
Risk Adjusted 30 Day Readmissions	30%

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Annual Cost and Utilization Bonus Factor Adjustment, Continued

Annual Cost and Utilization Bonus Factor Adjustment, continued

The Annual Cost and Utilization Bonus Factor Adjustment is calculated as:

(MCOC Score*MCOC Weight) + (Risk Adjusted 30 Day Readmissions Admit Score*Risk Adjusted 30 Day Readmissions Admit Weight) + (ED Score*ED Weight)

The following Table shows the relation between each cost and utilization measure and the points associated with each threshold.

Table 2: Cost and Utilization Measure Threshold Examples

Performance Level	Points	MCOC Threshold	Risk Adjusted 30 Day Readmissions Threshold	ED Utilization Threshold
Max	1.0	$0 - $5,900	0%-7.0%	≤7.5/100
Mid	0.5	$5,901-$6,300	7.1%-9.0%	7.51/100 - 9.0/100
Min	0.2	$6,301-$6,900	9.1%-11.0%	9.1/100 - 10.30/100
None	0	$6,901 +	11.1 +%	≥10.31/100

Participant 1 has a Measured Cost of Care which equals $6,200. Participant 1 also have a Risk Adjusted 30 Day Readmissions rate of 0.06, and an ED Utilization rate of 8/100. The illustration below lists the Points Awarded which are based on the Performance of the Participant. Table 3 below illustrates a scoring example of cost and utilization.

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Annual Cost and Utilization Bonus Factor Adjustment, continued

Table 3: Cost & Utilization Scoring Example:

Cost and Utilization Measure	% of payment	Performance Met	Performance Level	Points Awarded
MCOC	40%	$6,200	Mid	.5
Risk Adjusted 30 Day Readmissions	30%	0.06	Max	1.0
ED Utilization	30%	8/100	Mid	.5

Participant 1's scores are calculated as:

Overall Cost and Utilization Score **= (0.5 * 40%) + (1.0 * 30%) + (0.5 * 30%)**

Overall Cost and Utilization Score **= 20% + 30% + 15% = 65%**

Table 4: Cost and Utilization Percentile Example:

Cost and Utilization Percentile	Cost and Utilization Score	Claims Payment Increase
0-49th percentile	0% - <20%	0%
50-59th percentile	20% - <35%	2%
60-84th percentile	35% - <45%	3%
85th and greater percentile	45% - 100%	5%

In this example, Participant 1's Overall Cost and Utilization Score was greater than 45% and achieved greater than the 85th Percentile; therefore, Participant 1 would be eligible for the maximum Cost and Utilization Bonus Factor Adjustment of 5%. See Table 5 for the illustration of percentiles and their relation to the Cost and Utilization Bonus Factor Adjustment.

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Annual Cost and Utilization Bonus Factor Adjustment, Continued

Annual Cost and Utilization Bonus Factor Adjustment, continued

Table 5: Cost and Utilization Percentiles, Scoring Thresholds, and Payment Percentages

Cost and Utilization Percentile	Cost and Utilization Percentile Score*	Cost & Utilization Bonus Factor Adjustment
0-49th	0% - <20%	0%
50-59th	20% - <35%	2%
60-84th	35% - <45%	3%
85th and greater	45% - 100%	5%

**The Cost and Utilization Percentile Score will vary based upon the Performance Period.*

Engagement

Reporting

There are a variety of communication mechanisms through which Highmark can share data including, but not limited to the Online Provider Portal, the Helion Arc, and the MFT: Managed File Transfer system. Note: The MFT system is an internet accessible tool which provides the ability to securely exchange files between Highmark and the Participant.

Data sharing may require the execution of specific business agreements that will allow for appropriate information exchange and for the use of, or access to, any/all Highmark communication mechanisms. Participants will continue to have access to the Helion Arc, which enables Participants to submit authorization requests and OASIS assessments, as well as access reporting via the Helion Provider Dashboard.

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