Home Health Pay for Value (P4V) Program

Program Year 2020

PROGRAM MANUAL

Release: July 29, 2021

This Program Manual is applicable to Highmark Inc. 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 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 Home Health Pay for Value (P4V) Program ("Program"), between Highmark and a contracting entity ("Contracting Entity") that is a home health provider or an entity that owns, employs or contracts with multiple home health providers.

The Program will serve as a foundational value based reimbursement program for Highmark's home health 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 home health providers. To ensure a focus on positive patient outcomes, the Participants will be required to pass the Quality Gate (described herein) prior to being assessed for an additional earning opportunity. The Quality Gate is reached by meeting the following two (2) Program Quality Measures (described herein):

1) 7-Day Follow Up Rate and
2) Timely Initiation of Care.

If the Participant passes the Quality Gate, 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:

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PROGRAM OVERVIEW, Continued

Introduction, continued

1) Total Cost of Care (TCC),
2) All-Cause Unplanned Readmissions, 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 DEFINITIONS

Program Definitions

All terms not defined herein shall have the meaning ascribed to such term in the Home Health Pay for Value (P4V) Program Participation Agreement and Limited Addendum.

"**All-Cause Unplanned Readmission**" shall mean the number of acute inpatient stays (which meets the HEDIS criteria) with a discharge date during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days divided by the expected number of readmissions.

All-Cause Unplanned Readmission = (Observed/Expected), where

- **Observed** = All-Cause Unplanned Readmissions during the Performance Period.
- **Expected** = Expected number of readmissions during the Performance Period based on HEDIS Plan All-Cause Unplanned Readmission logic.

"**Emergency Department Utilization**" or "**ED Utilization**" shall mean the percentage of Program Members receiving home health care who are then admitted to the Emergency Department (ED) during the Home Health Episode.

"**Home Health Episode**" shall mean the time period beginning at the initiation of home health care up to day 60. The Start of Care (SOC) (also referred to as the Admission Date) is the first date of service reported on the initial home health claim submitted to Highmark. The source of admission to home health care may include a Hospital, Long Term Acute Care Facility, Inpatient Rehabilitation Facility or a Skilled Nursing Facility. It may also include a physician directed referral from a community based setting. A home health episode shall also extend to any subsequent 60 day episode(s) of care provided to members who continue to meet home health eligibility criteria defined by CMS, also known as a recertification.

"Index Admission" shall mean a Medicare Advantage or Commercial member home health admission following an initial acute inpatient stay that meets the HEDIS criteria for inclusion in the denominator of the All-Cause Unplanned Readmission rate calculation. Only Index Admissions that occur on or between January 1st and December 1st of the calendar year are included in the denominator of the All-Cause Unplanned Readmission rate calculation.

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PROGRAM DEFINTIONS, Continued

Program Definitions, continued

"Market" shall mean Participants that had 10 or more total Highmark home health Medicare Advantage, and/or Commercial, or a combination of both admissions during calendar year 2019, located within the Highmark, Inc. service area which includes designated areas of PA.

"**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.

"**Total Cost of Care (TCC)**" shall mean all medical costs (excluding pharmacy, but including Part B drugs for Medicare Advantage members) incurred by a Highmark Program Member receiving home health care from the SOC up to and including 60 days. The TCC is reported as the average total medical costs incurred during a 60 day episode per member during the course of their home health care.

TRANSPARENCY

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

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.

PROGRAM PARTICIPATION

Program Eligibility

Eligible Program Participants include home health providers who are credentialed with Highmark and are contracted within Highmark's provider network on a fee-for-service reimbursement methodology under an applicable Underlying Provider Agreement.

In addition, to be eligible for the Program, home health providers within Highmark's Pennsylvania home health network must meet the minimum volume of annual home health admission requirements of 10 or more Highmark home health admissions for Highmark Medicare Advantage and/or Commercial members during the calendar year prior to the Performance Period. Retrospective home health admission volume will be evaluated annually to determine eligibility to participate in the Program.

In order to participate in the Program, eligible home health providers must be covered under a Home Health Pay for Value (P4V) Program Participation Agreement and Limited Addendum (the "Agreement").

Participant Additions and Removals

In accordance with the Agreement, additional home health providers acquired by the Contracting Entity may be added to the Agreement as a Participant. Due to the 6-month period structure of the Program and in order to enable accurate reporting and reimbursement, adding Participants to a Contracting Entity must be implemented with an effective date no later than January 1, 2020 of the Program year. Such Participants must have a single Blue Shield identification number in order to be included as an additional Participant. Additions to a Contracting Entity's Participant structure that occur with an effective date later than January 1, 2020 will be reflected in the next year's Program performance. Additionally, Participant additions occurring in the first quarter of the year must be communicated to Highmark prior to March 1, 2020 to be effective in the current Program year. Any Participant additions communicated to Highmark after March 1, 2020 will be applied for the next Program year.

There is no deadline for removing Participants from a Contracting Entity. Participants can be removed from a Contracting Entity throughout the Program Year. All Participant removals, regardless of reason, should be communicated to Highmark in a timely fashion.

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Participant Additions and Removals, continued

A few example scenarios of Participant additions are listed below. This listing is not meant to be an all-inclusive listing of changes that may impact a Contracting Entity's composition of Participants. The examples do not reflect all of Highmark's rights for such changes and other legal and contractual rights may be relevant:

- In January 2020 Entity A opens a new Participant. Entity A notifies Highmark of the Participant addition prior to March 1, 2020. Therefore, the Participant is added to Entity A for the 2021 Program year.

- In March 2020 Entity B purchases a new Participant. The newly purchased Participant will not be added to the Program for Entity B until Program year 2021. Highmark should be notified of the change in a timely manner for other health plan operational needs beyond Program reporting or reimbursement.

- Entity C sells a Participant in November 2020. This Participant will be removed from Entity C upon timely notification to Highmark.

Program Members

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 Commercial or Medicare Advantage, if applicable, products. Medigap members are excluded for Medicare Advantage. Highmark shall designate for the purposes of the Program those Commercial members who are covered under products offered or administered by Highmark. Commercial products do not include Federal Employees Program ("FEP") members or Blue Distinction Total Care ("BDTC") members. Blue Card Home (Highmark members) claims are included, but Blue Card Host (other Blue Plans members) claims are excluded in all Market areas.

Program Reporting and Claims Submission

Claims data utilized in Program reporting is generated from all Highmark network Program Participants. Participants are responsible for submitting timely and accurate claims to Highmark in accordance with industry standard billing practices and Highmark requirements.

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Program Reporting and Claims Submission, continued

Errors may result in rejection, inaccurate claim payments or denials, usually because required information is missing, invalid, incomplete, or inconsistent with standard billing practices. To assure claims are captured for the final Program reporting and scoring purposes, all claims and claims corrections must be received by Highmark no later than one month following the end of the Performance Period. This is necessary to allow time for claims to be processed before the final run-out period has concluded.

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 diagnosis, 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
- Resumption of Care
- Recertification
- 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 home health recipient's demographic information, clinical status, functional status, and service needs. To be considered timely with submissions, Participants are required to submit their OASIS no later than 30 days from the date of the assessment completion. This is applicable to the following OASIS documents:

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Program Reporting and Claims Submission, continued

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

Participants are required to have 90% timely submission. If Participants do not meet that threshold, there is a risk of the claims payment rate increase being withheld.

Participants should submit their OASIS Assessments through the Home Health Utilization Management ("HHUM") portal.

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 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 acknowledge 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.

PROGRAM PERFORMANCE PERIOD

Program Performance Period	The Program utilizes a 12-month period for measurement beginning January 1, 2020 to December 31, 2020. The effective date of the Performance Period for the 2020 Program will be the 12-month period which begins January 1, 2020 and concludes December 31, 2020. Data measurement will begin January 1, 2021 to allow sufficient time for data collection and claims run-out in order to provide comprehensive and complete results.

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. Based on the results of performance on metrics across these categories, Participants may be eligible to earn a claims payment rate increase.

Performance for the Performance Period will be assessed by reviewing the results for the Quality Measures and the Cost and Utilization Measures on a Participant level with a start of care date no earlier than January 1, 2020. If the Quality Gate is passed, each Participant will have the opportunity to earn a 2%-6% claims payment increase which will become effective July 1st of the following year. Cost and Utilization Measures will be evaluated to determine the Participant's earning potential.

QUALITY MEASURES

Quality Gate

Participants are required to achieve at minimum, a targeted threshold performance for two (2) Quality Measures in order to reach the Quality Gate. Performance for the Quality Measures will be evaluated based on submitted claims data to Highmark. There is no payment incentive applied to the performance measurement of the Quality Measures. However, the Participant must meet the Quality Measure thresholds to pass the Quality Gate during the Performance Period in order to be eligible for the Cost and Utilization Measures performance and scoring. The two Quality Measures include:

- **7-Day PCP and/or Specialist Follow Up**:
  - Highmark's Quality Measure which measures the percentage of Home Health Episodes of care in which a follow up appointment with a primary care provider and/or specialist is completed within seven (7) days of the inpatient discharge from a hospital, long term acute care facility, inpatient rehabilitation facility or a skilled nursing facility. An eligible primary care provider performing a visit that qualifies for the 7 day follow up rate includes primary care physicians (PCPs), certified registered nurse practitioners (CRNPs), and physician assistants (PAs) who are credentialed with Highmark as a PCP, CRNP PCP, or PA PCP, as applicable. Eligible specialties include: internal medicine, family practice, general practice, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine). Updates to eligible specialties will be made annually or as necessary.

- **Timely Initiation of Care:**
  - Highmark's Quality Measure which measures the rate of Program Members who are prescribed home care and receive their visit within 48 hours of the inpatient discharge from a hospital, long term acute care facility, inpatient rehabilitation facility or a skilled nursing facility.

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QUALITY MEASURES, Continued

Thresholds

The following thresholds must be achieved for each Quality Measure during the Performance Period in order to pass the Quality Gate.

Table 1: Quality Measure Thresholds

Quality Measure	Threshold	Measurement Period
7-Day Follow Up	≥40%	Jan 2020 – Dec 2020
Timely Initiation of Care	≥65%	Jan 2020 – Dec 2020

COST AND UTILIZATION MEASURES

Cost and Utilization Measures

If the Quality Gate requirements are passed, the Participant will be evaluated on the Cost and Utilization Measures to determine if the Participant will receive an increase in reimbursement. If the Participant passes the Quality Gate but fails to reach the minimal Cost and Utilization Measures performance requirements, the Participant becomes ineligible for the claims payment rate increase.

The Cost and Utilization Measures include Total Cost of Care (TCC), All-Cause Unplanned Readmissions, and Emergency Department Utilization. These Cost and Utilization Measures promote member well-being and safety, while helping to control costs.

Total Cost of Care (TCC)

TCC is a cost metric based on a 60 day episode of care beginning at the initiation of a home health admission that occurs during the Performance Period, on or between January 1st and December 31st 2020. The home health admission and all medical costs incurred during the 60 day episode are identified through Highmark claims. All claims for health care services from any provider type are included in the TCC with the exception of pharmacy claims. Drug costs will be excluded from the metric for all Program Members; however, Part B drugs are considered medical expenditures for Medicare Advantage and will be included in the TCC. Costs for inpatient, outpatient and professional services as well as labs and diagnostics are included.

Points are awarded for the TCC measure by comparing each Participant's performance during the Performance Period to the Market's benchmark performance for the historical CY 2019 time period. As shown in the Table 2 below, the Participant will be awarded a different amount of points based on their level of performance. If the Participant's performance is less than the 40th percentile relative to Market, no points will be awarded for this Cost and Utilization Measure. The benchmarks will be set prospectively based on historical performance and will be shared with Participants.

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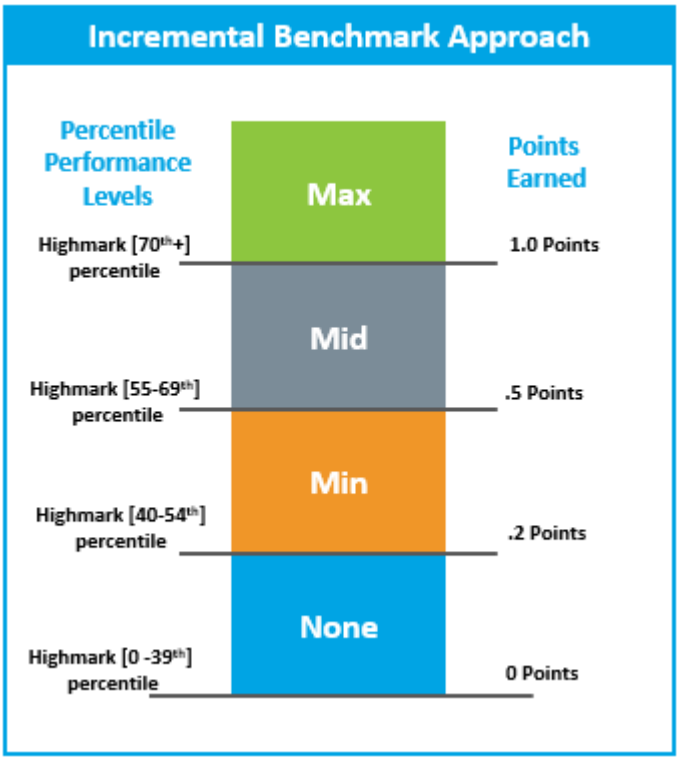
Total Cost of Care (TCC), continued

Table 2: Total Cost of Care Percentiles

Performance Level	Benchmark Percentiles	Points Awarded
Max	70th and greater percentile	1.0
Mid	55-69th percentile	0.5
Min	40-54th percentile	0.2
None	0-39th percentile	0

Below is a depiction of the incremental benchmark approach for the Cost and Utilization Measure.

Figure 1: Incremental Benchmark Approach



The TCC benchmark and results will be risk-adjusted by Cotiviti, Inc. ("Cotiviti"). (Highmark reserves the right to use an updated version of the Cotiviti software when available or to change software it uses to determine risk scores.) Cotiviti utilizes concurrent risk score models for different patient populations, such as Commercial and Medicare Advantage.

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COST AND UTILIZATION MEASURES, Continued

Total Cost of Care (TCC), continued

The risk-adjustment calculation steps are listed below:

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

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

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

The market for the TCC measure is identified by the product (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 TCC measure).

The risk adjusted 60-Day TCC calculation is:

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

All-Cause Unplanned Readmissions

The All-Cause Unplanned Readmission metric focuses on reducing all-cause unplanned 30 day readmissions for the Medicare Advantage and Commercial populations. Participants will be evaluated on the number of All-Cause Unplanned Readmissions of Program Members during their Performance Period as compared to the Baseline Period (which will be set using historical market data from CY 2019. The Participant's individual performance will be compared to the benchmark set to determine the performance level. The All-Cause Unplanned Readmission metric is derived from the NCQA HEDIS® Plan All-Cause Unplanned Readmissions (PCR) specification. The inclusion and exclusion criteria remain the same as in the NCQA measure. The same version of the HEDIS® definition will be used in calculating the readmission ratio during the Baseline and Performance Periods. Expected and Observed readmission rates from the Baseline Period and Performance Period will be risk-adjusted.

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All-Cause Unplanned Readmissions, continued

Points are then awarded for the All-Cause Unplanned Readmission measure by comparing each Participant's readmission ratio performance for the Performance Period to the Market's benchmark performance using the historical CY 2019 time period. As shown in the Table 3 below, the Participant will be awarded a different amount of points based on their performance level. If the Participant is measured at less than the 40th percentile relative to Market, no points will be awarded for this Cost and Utilization Measure. The benchmarks will be set prospectively based on historical performance and will be updated annually.

Table 3: All-Cause Unplanned Readmission Percentiles

Performance Level	Benchmark Percentile	Points Awarded
Max	70th and greater percentile	1.0
Mid	55- 69th percentile	0.5
Min	40-54th percentile	0.2
None	0-39th percentile	0

Emergency Department Utilization

The ED Utilization metric is included in the Program because of its importance of utilizing the most cost-effective treatment location, but more importantly, supporting the ambulatory management of Program Members. This Cost and Utilization Measures metric represents the percentage of Program Members receiving home health care who are then admitted to the Emergency Department (ED) during the Home Health Episode. Historical claims data from CY 2019 is being used to determine the ED Utilization threshold.

Points are awarded for the Emergency Department Utilization measure by comparing each Participant's performance for the Program Year to the Market's benchmark performance for the historical CY 2019 time period. As shown in the Table 4 below, the Participant will be awarded a different amount of points based on their performance level. If the Participant is measured at less than the 40th percentile relative to Market, no points will be awarded for this measure. The benchmarks will be set prospectively based on historical performance and will be updated annually.

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Emergency Department Utilization, continued

Table 4: ED Utilization Percentiles

Performance Level	Benchmark Percentile	Points Awarded
Max	70th and greater percentile	1.0
Mid	55-69th percentile	0.5
Min	40-54th percentile	0.2
None	0-39th percentile	0

COST AND UTILIZATION MEASURES, SCORING, AND CLAIMS PAYMENT RATE INCREASE

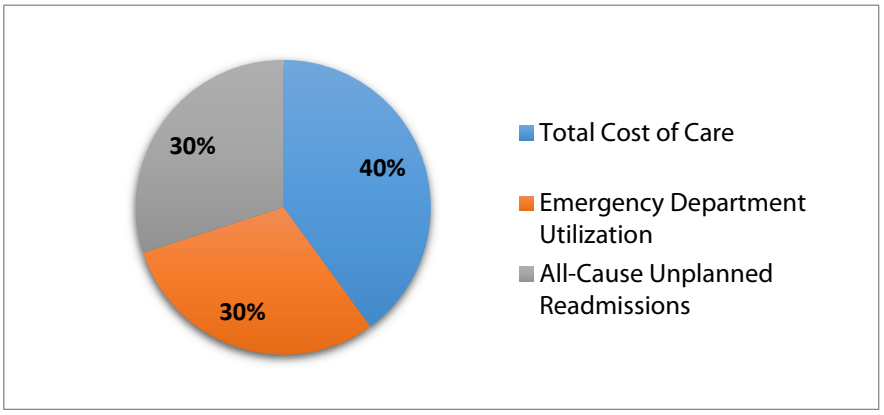
Cost and Utilization Claims Payment Rate Increase

Each Participant will have the ability to earn additional reimbursement if the Participant meets enough of the performance thresholds for the Cost and Utilization Measures as described in the prior section.

Participants that meet the Cost and Utilization Measures performance requirements will receive a 2%-6% percent claims payment rate increase to the Participant's claim payment rates set forth in the Participant's Underlying Provider Agreement which are associated with Participant's role as a home health provider. Any other payment rates in the Underlying Provider Agreement that are not applicable to home health shall remain in full force and effect and will not be altered by the claims payment rate increase. Payout occurs the fiscal year following the measurement year, meaning the claims payment rate increase will become effective July 1st of the calendar year (CY) following the measurement year. For the 2020 Performance Period (January 1, 2020 through December 31, 2020), adjustments will be applied July 1, 2021 through June 30, 2022.

As illustrated in Figure 2, below, 40% of the available payment increase for the Cost and Utilization Measures is based on Total Cost of Care performance. The other portion is equally distributed between the ED Utilization and All-Cause Unplanned Readmissions metrics, both representing 30% of the overall Cost and Utilization Measures. Final scoring is based on the 40/30/30 weighting of the three Cost and Utilization Measure components.

Figure 2: Cost and Utilization Claims Payment Increase Weighting



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Cost and Utilization Claims Payment Rate Increase, continued

The Overall Cost and Utilization Score is calculated as follows:

(TCC Points*TCC Weight) + (Readmits Points*Readmits Weight) + (ED Points*ED Weight) = Overall Cost and Utilization Score

Table 5 shows the relation between each Cost and Utilization Measure and the points associated with each threshold.

Table 5: Cost and Utilization Measure Thresholds

Performance Level	Points Awarded	TCC Threshold	All Cause Unplanned Readmission Threshold	ED Utilization Threshold
Max	1.0	≤ $8,700	≤0.37	≤7.40%
Mid	0.5	$8,701 - $9,500	0.38-0.50	7.50% - 8.90%
Min	0.2	$9,501 - $10,200	0.51-0.61	9.00% - 10.70%
None	0	>$10,200	>0.61	>10.70%

The example below illustrates the scoring calculation:

Participant 1 has a Total Cost of Care which equals $9,000. They also have an All-Cause Unplanned Readmission ratio of 0.35, and an ED Utilization rate of 8.20%. The Illustration below lists the Points Awarded which are based on the Performance of the Participant.

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Cost and Utilization Claims Payment Rate Increase, continued

Example Illustration:

Cost and Utilization Measure	Performance Met	Performance Level	Points Awarded
TCC	$9,000	Mid	.5
All-Cause Unplanned Readmissions	0.35	Max	1.0
ED Utilization	8.20%	Mid	.5

Example Cost and Utilization Score Percentiles:

Cost and Utilization Percentile	Cost and Utilization Score	Claims Payment Increase
0-49th percentile	<20%	0%
50-59th percentile	20-34%	2%
60-84thpercentile	35-44%	3%
85th and greater percentile	≥45%	6%

Shown below, we have populated the scoring calculation with the scores that Participant 1 earned:

Overall Cost and Utilization Score **= (.5*40%)** + **(1.0*30%)** + **(0.5*30%)**

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

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Cost and Utilization Claims Payment Rate Increase, continued

In this example, the Participant's Overall Cost and Utilization Score was greater than 45% for the 85th Percentile (as shown in the Example Cost and Utilization Score Percentiles Table above); therefore, this Participant would be eligible for the maximum claims payment rate increase to be applied to their base rate. See Table 6 for the illustration of percentiles and their relation to the claims payment rate increase.

Table 6: Cost and Utilization Percentiles, Scoring Cut-off Points, and Payment Percentages

Percentiles	Claims Payment Rate Increase
0-49th percentile	0%
50-59th percentile	2%
60-84thpercentile	3%
85th and greater percentile	6%

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Cost and Utilization Claims Payment Rate Increase, continued

See the additional examples below which illustrate different scenarios and are not reflective of an actual Program Participant's achievements.

Example 2: Minimum Increase Earned

Quality Metrics	Benchmarks	Participant's Rate Achieved	Score
7-Day Follow Up	40%	45%	Pass
Timely Initiation of Care	65%	72%	Pass
Cost & Utilization Metrics	**Participant's Rate Achieved**	**Performance Level**	**Points Awarded**
60 Day Total Cost of Care	$10,100	Min	0.2
All-Cause Readmissions	0.40	Mid	0.5
ED Utilization	11.0%	None	0

Shown below is the populated scoring calculation with the points that this Participant earned in this example:

Overall Cost and Utilization Score = (0.2*40%) + (0.5*30%) + (0*30%)
Overall Cost and Utilization Score = 8% + 15% + 0% = **23%**

The Participant passed the Quality Gate and was able to earn points for two of the three Cost and Utilization Measures. The Participant has an Overall Cost and Utilization Score of 23%. In this example, the Participant will be eligible for a 2% claims payment increase, as a result of performing within the 50-59th percentile.

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Cost and Utilization Claims Payment Rate Increase, continued

Example 3: Maximum Increase Earned

Quality Metrics	Benchmarks	Participant's Rate Achieved	Score
7-Day Follow Up	40%	45%	Pass
Timely Initiation of Care	65%	70%	Pass
Cost & Utilization Metrics	**Participant's Rate Achieved**	**Performance Level**	**Points Awarded**
60 Day Total Cost of Care	$8,900	Mid	0.5
All-Cause Readmissions	0.42	Mid	0.5
ED Utilization	8.20%	Mid	0.5

Shown below is the populated scoring calculation with the points that this Participant earned in this example:

Overall Cost and Utilization Score = (0.5*40%) + (0.5*30%) + (0.5*30%)
Overall Cost and Utilization Score = 20% + 15% + 15% = **50%**

In this example, the Participant passed the Quality Gate and met the mid performance levels of the Cost and Utilization Measures. In this example, the Participant's Overall Cost and Utilization Score is 50%. The Participant would be eligible for the maximum 6% percent claims payment rate increase, associated with the 85th and greater percentile.

Example 4: No Increase Earned

Quality Metrics	Benchmarks	Participant's Rate Achieved	Score
7-Day Follow Up	40%	25%	Fail
Timely Initiation of Care	65%	20%	Fail
Cost & Utilization Metrics	**Participant's Rate Achieved**	**Performance Level**	**Points Awarded**
60 Day Total Cost of Care	**Not Eligible**	**Not Eligible**	**N/A**
All-Cause Readmissions	**Not Eligible**	**Not Eligible**	**N/A**
ED Utilization	**Not Eligible**	**Not Eligible**	**N/A**

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COST AND UTILIZATION MEASURES, SCORING, AND CLAIMS PAYMENT RATE INCREASE, Continued

Cost and Utilization Claims Payment Rate Increase, continued	In this final example, the Participant failed the two metrics included in the Quality Measures and therefore, did not pass the Quality Gate. As such, the Participant would not be eligible to be assessed for the Cost and Utilization Measures. As a result, the Participant would not be eligible for any claims payment rate increase.
COVID-19	Highmark is reviewing Program performance to assess the impact of the 2020 COVID-19 pandemic on Contracting Entity and Participant performance and resulting Program reimbursement. The performance results used to score certain Program components may be adjusted to compensate Contracting Entity and/or Participants for performance results that were negatively impacted by the 2020 COVID-19 pandemic. Highmark will notify Contracting Entity and/or Participants, as appropriate, of the Program components that are eligible for a performance adjustment to ensure awareness, documentation, and mutual agreement.

ENGAGEMENT

Home Health Utilization Management Provider Dashboard

There are a variety of communication mechanisms through which Highmark can share data including, but not limited to, NaviNet®, the Home Health Utilization Management ("HHUM") Portal, and the e-Delivery system. Note: The e-Delivery 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 HHUM Portal, which enables Participants to submit authorization requests and OASIS assessments, as well as access reporting via the HHUM Provider Dashboard.