HIGHMARK

TruePerformance | Post-Acute Care

True Performance Skilled Nursing Facility Episodic Value-Based Bundled Payment Program

Program Year 2022

PROGRAM MANUAL

Release: August 2022

For Program Year this Program Manual supersedes the Program Manual with a Release Date of April 2022.

This Program Manual is applicable to the following health plans: Highmark Inc. . Each such health plan is referred to herein as "Highmark".

Proprietary and Confidential

Form No: (SW)MANVBR-SNF-PE-20220809-15

TABLE OF CONTENTS

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 skilled nursing facility 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 Skilled Nursing Facility ("SNF") Episodic Value-Based Bundled Payment Program ("Program"), between Highmark and a contracting entity ("Contracting Entity") that is a skilled nursing facility or an entity that owns, employs or contracts with multiple skilled nursing facilities.

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 SNFs.

The Program will serve as an enhanced value-based reimbursement program for Highmark's skilled nursing facility provider network. 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

Performance Measurement

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. To ensure a focus on positive patient outcomes, Participants will be required to meet or exceed quality and cost and utilization metrics. Performance measures of the Program include the following:

Quality Measures

- Risk Adjusted 30-day Readmission Rate
- Risk Adjusted 30-day Outpatient Emergency Department Utilization

Cost and Utilization Measure

- Risk Adjusted 60-day Measured Cost of Care

The intent of the Program is to allow Participants the autonomy to provide care and manage member episodes resulting in innovative care techniques, better quality and reduced cost and utilization.

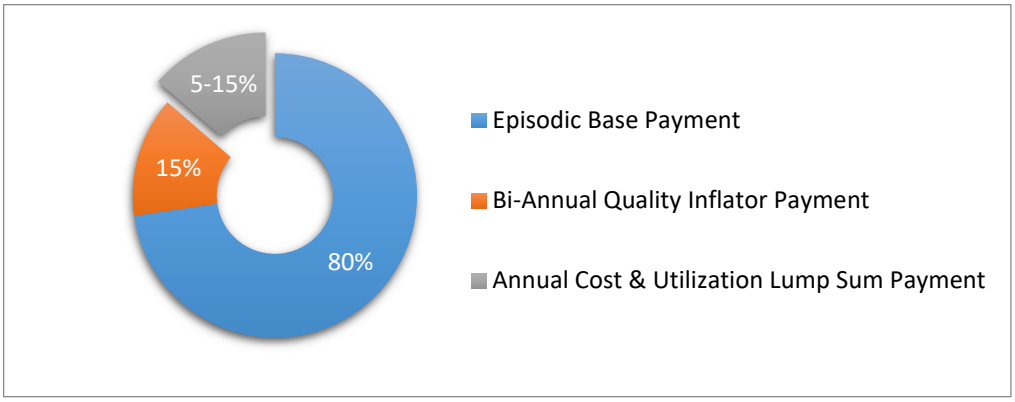
Program Overview, *continued*

This methodology also seeks to reward Participants with an incentive to earn higher reimbursement (up to 110%) based on quality outcomes.

The Program Reimbursement structure and earning potential is represented in Figure 1.

Program Components

Figure 1:
SNF Episodic Value-Based Bundled Payment Program Reimbursement Structure



The Program includes the following components:

1. **Episodic Base Payment (80%)**
2. **Bi-Annual Quality Inflator Payment (15%)**
3. **Annual Cost & Utilization Lump Sum Payment (5-15%)**

Episodic Base Payment

Participants will be issued an Episodic Base Payment per 30-day SNF Episode. Participants will receive 80% of their Episodic Base Payment set forth in the Agreement when the SNF claim is billed to Highmark. The Episodic Base Payment is member level risk adjusted according to low, medium, or high member risk. The proprietary risk model considers the following factors:

- Diagnosis codes indicated on SNF authorization request
- Recent authorization history
- Claims history
- Member age and demographic profile
- Other proprietary data points

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

Program Overview, *continued*

Bi-Annual Quality Inflator Payment

The next component of Program Reimbursement that Participants will be eligible to earn is the Bi-Annual Quality Inflator Payment if the Quality Threshold is passed. This component of Program Reimbursement accounts for 15% of the member level risk adjusted Episodic Base Payment set forth in the Agreement and is reimbursed when the SNF claim is billed to Highmark, in addition to the Episodic Base Payment, totaling 95% of Program Reimbursement.

Annual Cost & Utilization Lump Sum Payment

The final component of Program Reimbursement that Participants may be eligible to earn is the Annual Cost & Utilization Lump Sum Payment which potentially adds an additional 5-15% to the overall Program Reimbursement. Both quality measures must be passed to be eligible for the Annual Cost & Utilization Lump Sum Payment. This component of the Program Reimbursement will be issued in the form of a lump sum payment at the end of the Performance Period.

Program Participation and Eligibility

Eligible Program Participants include SNFs who are credentialed with Highmark and are contracted within Highmark's provider network under an applicable Underlying Provider Agreement at Highmark's sole discretion.

Eligible Program Participants must be covered under a True Performance SNF Episodic Value-Based Bundled Payment Program Participation Agreement and Limited Addendum (the "Agreement").

SNF's within the Highmark Pennsylvania provider network must meet the minimum annual volume of 50 or more SNF Episodes for Highmark Medicare Advantage members during the calendar year prior to the Performance Period. In addition to Participants having 50 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.

Participant Additions and Removals

In accordance with the Agreement, additional SNF providers acquired by the Contracting Entity may be added to the Agreement as a Participant. The Contracting Entity must complete and submit the Facility/Ancillary Change Form located on the Provider Resource Center under Forms and return to Highmark for processing and other health plan operational needs beyond Program reporting or reimbursement.

A few example scenarios of Participant additions and removals 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.

Program Overview, *continued*

Participant Additions and Removals *Continued*

- If a SNF is being acquired by or merged with another participating corporate entity, the acquired SNF would not be a part of the Program until 1/1 of the following year under the new ownership assuming the minimum volume thresholds are met.

- If a contracted SNF purchases a new facility during the Performance Period, the new facility would not be added under the Agreement until the next calendar year when the Performance Period resets.

- An acquired entity, in the Program already, would be measured and paid out based on its provider composition prior to the change of ownership.

- If a SNF is terminated or closed, the data of that location(s) would be included up to and including the termination and/or closure date. If applicable, payment may be made to the Contracting Entity for up to and including the termination and/or closure.

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 Medicare Advantage product. Federal Employee Program (FEP) members are excluded. Medigap members are excluded. BlueCard Home (Highmark members) claims are excluded. BlueCard Host (other Blue Plans members) claims are excluded in all Markets.

Program Reporting and Claim Submission

Program reporting, 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 Program Administrative Requirements.

Program Overview, *continued*

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); and
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.

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 Overview, *continued*

Clinical and Professional Judgement

Notwithstanding anything contained in the Agreement or this Program Manual to the contrary, Participant shall at all times exercise clinical and professional judgment in the best interests of the Program Member. Without limiting the foregoing, Participant shall at all times make referrals based on the Participant's 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.

Utilization Management

Participants are required to submit all prior authorization requests through naviHealth via NaviNet, phone or fax to avoid a claim rejection. Each authorized 30-day SNF Episode of care that does not overlap a prior 30-day SNF Episode of care, will receive a member level risk adjusted Episodic Base Payment. The risk adjustment is determined from current and historical clinical data points.

Admission Survey

Effective for SNF Episodes beginning on or after July 1, 2022, Participants are required to complete and submit an Admission Survey in the Helion Portal. The Admission Survey is a survey designed to collect information on many items related to a skilled nursing facility recipient's demographic information, clinical status, and service needs. The Admission Survey must be submitted by day 5 of the admission to the SNF and received prior to claim submission. The SNF claim will reject if it is submitted to Highmark before the Admission Survey is completed.

Participants who receive a denial for prior authorization after care has started can submit a retrospective appeal review. If the original determination is overturned and authorization is approved, the Participant should complete the Admission Survey in the Helion Portal in order for the episode to be properly risk adjusted. If the provider has already submitted a claim for the episode and received a rejection, the provider should resubmit the claim following completion of the Admission Survey.

Recertification Survey

If a member is not ready for discharge on day 30, the Participant will submit an authorization request for the next SNF Episode via naviHealth. Effective for SNF Episodes beginning on or after July 1, 2022, Participants are required to complete and submit a Recertification Survey within 3 days of recertification through the Helion Portal. The Recertification Survey is a survey designed to collect information on many items related to a skilled nursing facility recipient's demographic information, clinical status, and service needs.

In the event the Helion Portal is unavailable, an exception can be made for the SNF Participant if the Admission Survey or Recertification Survey is not submitted timely as prescribed above.

Program Definitions

Definitions

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

"Annual Cost and Utilization Lump Sum Payment" shall mean the final payment that Participants may be eligible to receive annually if they earn the Bi-annual Quality Inflator Payment and also meet a specific percentile for performance in the cost and utilization measures. This value-based reimbursement accounts for potentially 5-15% of the Episodic Base Payment and will be issued in the form of a lump sum payment at the end of the Performance Period.

"Bi-Annual Quality Inflator Payment" shall mean the reimbursement that Participants may be eligible to receive if they pass the quality measures. This reimbursement accounts for 15% of the member level risk adjusted Episodic Base Payment that can be earned and is applied to the claim submitted for the member's episode of care. It is evaluated bi-annually on a rolling 12-month time period.

"Episodic Base Payment" shall mean the reimbursement that Participants will receive per 30-day SNF Episode when its claim is submitted. Participants will receive 80% of their Episodic Base Payment set forth in the Agreement. The Episodic Base Payment will be member level risk adjusted according to low, medium, or high member risk. If the SNF Episode extends beyond the initial 30 days of care, this would qualify as a new SNF Episode, and the Participant would receive an Episodic Base Payment for the new SNF Episode. In situations where the subsequent episode is less than or equal to 4 days, the Participant would receive a per diem Inlier Payment for the subsequent SNF Episode. While in an established 30-day SNF Episode, if the member is discharged and then subsequently returns to the same SNF that the member originated in, the subsequent readmission to the SNF would be considered a continuation of the original SNF Episode and a new Episodic Base Payment would not be received until day 31, should a concurrent SNF Episode be established.

"Inlier Payment" shall mean the non-risk adjusted per diem payment set forth in the Agreement for a SNF length of stay that is equal to or less than four (4) days.

"Market" shall mean Participants that had 50 or more total Highmark Medicare Advantage SNF Episodes during Calendar Year 2022, located within the Highmark, Inc. service area which includes designated areas of PA.

"Program Reimbursement" shall mean the reimbursement associated with successful results at the end of the Performance Period. Highmark, in its sole discretion, reserves the right to adjust the amount of reimbursement annually.

Definitions *Continued*

"**Quality Threshold**" shall mean the minimum performance on quality metrics necessary to earn a specific type of reimbursement in the Program.

"Risk Adjusted 60-day Measured Cost of Care (MCOC)" 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: Inpatient Medical, Inpatient Surgical, Inpatient Rehabilitation, Skilled Nursing Facility, Outpatient Emergency Room and Observation (including Professional claims), Outpatient Physical Therapy (PT). Occupational Therapy (OT). Speech Therapy (ST), Professional Inpatient Medical Visits, Professional Inpatient Surgery, Professional Office Visits, Professional Chiropractor, Urgent Care Visits, Preventive Physical Exams, Home Health, and Ambulance. Helion reserves the right to amend this list at any time.

"Risk Adjusted 30-day Outpatient Emergency Department ("OP ED") Rate per 100" shall mean the count of Outpatient ED events for members within 30 days of the SNF 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 SNF being scored corresponds to the overall risk pool of the SNF population for that time period. To compare SNF performance, riskier populations will have a factor applied that will adjust the rate down, while healthier populations will have a factor applied to adjust the rate up.

"Risk Adjusted 30-day Readmission Rate"/ "Readmission Rate" shall mean the readmission rate for inpatient stays ending within 1 day of a SNF episode start date and is a numerator/denominator value reported as a percentage. Denominator events include acute inpatient stays of 2 days or greater, excluding Long Term Acute Care Hospital (LTACH), Inpatient Rehabilitation Hospital (IRF), Psychiatric, Maternity, Birth and Perinatal. Numerator events include 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. The Readmission Rate is risk-adjusted to account for how the risk of the member population of the SNF being scored corresponds to the overall risk pool of the SNF population for that time period. To compare SNF performance, riskier populations will have a factor applied that will adjust the rate down, while healthier populations will have a factor applied to adjust the rate up.

"**SNF Episode**" shall mean the managed care provided by a Participant during a set time period. An episode begins with the first SNF admit day in the reporting dataset. It is specific to the member and SNF owner and spans a total of 30 days. The first covered SNF day that is not captured by a prior 30-day episode will begin a new episode. The process repeats until all SNF covered days are grouped into an episode. In situations where a member is transferred

to another SNF belonging to the same owner, the episode will be attributed to the first admitting SNF.

Performance Measurement - Quality

Quality Measures

The structure of this Program interlaces the Bi-Annual Quality Inflator Payment as well as the Annual Cost and Utilization Payment with value-based measures to drive high-value care and emphasize positive health outcomes.

A Bi-Annual Quality Inflator of 15% of the Episodic Base Payment will be applied to the claim in addition to the Episodic Base Payment if the Participant passes the Quality Threshold inclusive of two performance measures:

1) **Risk Adjusted 30-day Readmission Rate**
   This metric focuses on reducing 30-Day readmissions for the Medicare Advantage populations. Highmark will compare the Participants Risk Adjusted 30-Day Readmission Rate during the Performance Period to the benchmark Risk Adjusted 30-Day Readmission Rate during the Performance Period.

   The Readmission Rate is risk adjusted to account for how the risk of the member population of the SNF being scored corresponds to the overall risk pool of the SNF population for that time period. To compare SNF performance, riskier populations will have a factor applied that will adjust the rate down, while healthier populations will have a factor applied to adjust the rate up.

2) **Risk Adjusted 30-day Outpatient Emergency Department ("OP ED") Utilization - per 100 episodes**
   This metric focuses on the count of OP ED events for Program Members within 30 days of the SNF Episode start date, measured from the start of care of the SNF Episode up to and including the OP ED event. OP ED events occurring on the same day that the SNF Episode started will be excluded. The OP ED Utilization metric is then standardized to 'per 100' episodes.

Risk Adjustment

The OP ED Utilization metric is risk adjusted using Cotiviti, Inc. ("Cotiviti") risk scores to account for how the risk of the Program Members population of the Participant scored corresponds to the overall risk pool of the Participant population, for that time period. For the purpose of comparing Participant 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. 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 Medicare Advantage.

Performance Measurement – Quality, continued

Risk Adjustment *Continued*

The risk-adjustment calculation steps are listed below:

- 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.
- The scored 30-day OP ED measure is the risk adjusted amount, listed in the equation below, for example.

The Market for the OP ED Utilization measures is identified by the Medicare Advantage product. 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 OP ED Utilization measure. The formula is:

Risk-Adjusted 30-day OP ED Utilization =
Actual OP ED Utilization / Risk Score Normalized by Market Average Risk Score

Quality Measure Benchmarks

Participants must meet a minimum level of performance better than or equal to the benchmark target on **both measures** to pass the Quality Threshold. The Quality Measure Benchmarks in Table 1 will be set prospectively based on historical performance (CY 2021) and will be updated annually.

Table 1: Quality Measure Benchmarks

Quality Measure	Benchmark Percentile*
Risk-Adjusted 30-day Readmission Rate	22%
Risk-Adjusted 30-day OP ED Utilization	17.0

- If the Risk Adjusted 30-day Readmission Rate is less than or equal to the benchmark of 22%, the measure is passed.
- If the Risk Adjusted 30-day OP ED Utilization measure is less than or equal to the benchmark of 17.0, the measure is passed.

**The benchmarks will be determined based on the percentile above during the Performance Period.*

If **both** Quality Measures are passed, the Participant receives the Bi-Annual Quality Inflator Payment in addition to the Episodic Base Payment for each SNF Episode See the examples below which illustrate Quality Measure scenarios.

Performance Measurement – Quality, continued

Quality Measure Benchmarks *Continued*

Example 1

Quality Measure	Benchmark Percentile*	Participants Rate Achieved	Score
Risk Adjusted 30-day Readmission Rate	22%	21%	Pass
Risk Adjusted 30-day OP ED Utilization	17.0	14.0	Pass

In this example, the Participant **passed** the Quality Threshold by passing both quality measures.

Example 2

Quality Measure	Benchmark Percentile*	Participants Rate Achieved	Score
Risk Adjusted 30-day Readmission Rate	22%	18%	Pass
Risk Adjusted 30-day OP ED Utilization	17.0	19.0	Fail

In this example, the Participant **did not pass** the Quality Threshold since it passed one of the quality measures but failed the other.

**The benchmarks will be determined based on the percentile above during the Performance Period.*

Quality Payment

A Bi-Annual Quality Inflator Payment of 15% of the member level risk adjusted Episodic Base Payment will be applied to the claim in addition to 80% of the Episodic Base Payment if the Participant passes the Quality Threshold, totaling 95% Program Reimbursement. See the example below which illustrate a Quality Payment Calculation scenario.

Quality Payment Calculation Example

Adjusted Episodic Base Payment*	15% Quality Payment	Total Adjusted Episodic Base Payment*
$4,800	$900 (15% of $6,000)	$5,700

**member level risk adjusted*

Performance Measurement – Quality, continued

Quality Payment *Continued*

The Quality Threshold needs to be passed to be eligible for the Annual Cost and Utilization Lump Sum Payment. Quality will be based off the entire Performance Period. This will be assessed prior to the Cost and Utilization Metric being reviewed and the time needed for claims runout. For example, if the Quality Threshold is passed in the first half of the year but not in the second half of the year, the Participant is still eligible to earn the Annual Cost and Utilization Lump Sum Payment if Quality is met for the entire Performance Period.

Example	Jan-Jun 2022 Quality Passed	Jul-Dec 2022 Quality Passed	Full Year 2022 Quality Passed	Eligible for Cost and Utilization Payment
A	Yes	No	Yes	Yes
B	No	Yes	Yes	Yes
C	Yes	No	No	No

For the initial Program Year, Participants will be considered to have passed the quality measures while baselines are established. For the next Program Year, the Quality Inflator Payment will no longer be automatic, and the Participants will need to pass the Quality Threshold to earn the Bi-Annual Quality Inflator Payment.

Performance Measurement - Cost and Utilization

Cost and Utilization Measure

The final Program Reimbursement component that Participants may earn is the Annual Cost and Utilization Lump Sum Payment. This component includes the potential to earn an additional 5, 10 or 15% to the overall Program Reimbursement structure previously illustrated in Figure 1. To be eligible for the Annual Cost and Utilization Lump Sum Payment, the Participant must pass the Quality Threshold.

This Cost and Utilization measure will evaluate the ability of the Participant to promote member well-being and safety while helping to control costs. It is made up of the following metric:

- **Risk-Adjusted 60-day Measured Cost of Care (MCOC)**

MCOC is a cost measure based on a 60-day episode of care beginning at the initiation of a skilled nursing admission that occurs during the Performance Period. The 60-day MCOC is risk adjusted to account for how the risk of the member population of the skilled nursing provider being scored corresponds to the overall risk pool of the skilled nursing population, for that time period. For the purpose of comparing SNF 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 SNF Episode and all medical costs incurred during the 60-day episode are identified through Highmark claims. It is limited to medical cost categories which Highmark has identified as being actionable under post-acute care.

The MCOC metric has a min, mid, and max performance level with respective percentiles. The Participant's performance level corresponds to the amount of Annual Cost and Utilization Lump Sum Payment that will be earned, varying from 5, 10 or 15% of the Episodic Base Payment (see Table 2).

If a Participant earns an additional Annual Cost and Utilization Lump Sum Payment, it is applied at the end of the Performance Year and paid as a Lump Sum based on MCOC performance. The Participant's MCOC performance level will be determined by comparing the Participant's performance during the Performance Period to the Market's benchmark performance for the Performance Period.

The same Cotiviti risk adjustment process applies that was outlined in the OP ED quality measure section. The risk adjusted 60-day MCOC calculation is as follows:

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

Table 2 shows the corresponding MCOC percentiles and performance level associated with each.

Performance Measurement - Cost and Utilization

Cost and Utilization Measure *Continued*

Table 2: Measured Cost of Care Summary

Performance Level	Cost and Utilization Performance Percentile	MCOC Thresholds*	Payment
None	0-49th percentile	$15,501+	0%
Min	50-59th percentile	$14,801-$15,500	5%
Mid	60-84th percentile	$12,401-$14,800	10%
Max	85th and greater percentile	$0-$12,400	15%

The examples below illustrate the Payment tier earned based on MCOC performance:

- Participant A has a MCOC which equals $14,200 and earned the Mid performance level. In this example, the Participant will receive a 10% payment, which is applied to their Episodic Base Payment.

- Participant B has a MCOC which equals $15,250 and earned the Min performance level. In this example, the Participant will receive a 5% payment, which is applied to their Episodic Base Payment.

- Participant C has a MCOC which equals $21,450. In this example, the Participant is not eligible for any Cost and Utilization Lump Sum Payment.

**MCOC Thresholds are included for illustrative purposes*

Engagement

Engagement	There are a variety of communication mechanisms through which Highmark can share data including, but not limited to, NaviNet®, the Helion 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 access the Helion Portal which enables Participants to submit the Admission Survey and Recertification Survey, as well as access reporting via the Helion Provider Dashboard.