SKILLED NURSING FACILITY

PAY-FOR-VALUE

Program Year 2020

ADMINISTRATIVE REQUIREMENTS

Release: July 2020

Update: 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

Program Overview	Highmark Inc. ("Highmark") is instituting a Pay for Value program ("Program") between Highmark and a contracting entity ("Contracting Entity") that is a skilled nursing facility ("SNF") or a corporate entity ("Corporate Entity") that owns multiple Skilled Nursing Facilities. The goal of the Program is to improve clinical outcomes and quality, and to reduce All-Cause Readmission rates by incentivizing Participants to improve the quality and efficiency of care.

TRANSPARENCY

Transparency

Participants acknowledge and will cooperate with Highmark's quality improvement and transparency programs and initiatives, which include, but are not limited to, programs developed to support Highmark member and provider initiatives and, 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 use the Provider Data, as defined below, for such purposes, including, but not limited to, as follows:

(a) Utilize, publish, disclose, and display any information and data related directly or indirectly to a Participant's delivery of health care services, such as, but not limited to, performance or practice data, information relating to a Participant's costs, charges, payment rates and quality, utilization, outcome and other data ("Provider Data");

(b) Disclose the Provider Data to Highmark's contracted vendors and agents to assist in the review, analysis and reporting of the Provider Data;

(c) Report the Provider Data to other providers to assist such providers in the management of care costs, quality outcomes and other efficiencies;

(d) Report the Provider Data to Members and customers (including third parties who supply information and analysis services to group customers); and

(e) Use the Provider Data to support a Participant's participation in certain benefit value levels (such as network tiers).

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Transparency (Continued)

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

Without limiting the foregoing, any provisions in a Participant's participating agreement or Administrative Requirements that address the confidentiality of information and data, such as the Provider Data, shall remain in full force and effect and such provisions shall govern the Provider Data in addition to this Transparency Section.

DEFINITIONS

All terms not defined herein shall have the meaning ascribed to such term in the Agreement (defined below).

Definitions

"Agreement" shall mean the Highmark Inc. Skilled Nursing Facility Pay for Value Program Participation Agreement.

"**Index Admissions**" shall mean a Medicare Advantage or Commercial member SNF admission following an initial acute inpatient stay that meets the HEDIS criteria for inclusion in the denominator of the All-Cause 30-Day 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 30-Day Readmission rate calculation.

"**Total Admissions"** shall mean the total number of Highmark Medicare Advantage and Commercial members admitted to the SNF for any reason and from any setting between January 1st and December 31st of the Baseline or Performance Period. This number is not factored into the Market Risk-adjusted Readmission Rate but is used to determine eligibility to participate in the program and to calculate the amount of payment earned by the contracting entity.

"**Market**" shall mean the Highmark, Inc. service area which includes designated areas of PA, WV and DE.

PERFORMANCE MEASUREMENT

Effective Date and Program Performance Period

The Contracting Entity and each Participant who has executed an Underlying Provider Agreement shall execute a Skilled Nursing Facility Pay-for-Value Program Participation Agreement. The Performance Period for the calendar year ("CY") 2020 Program begins January 1, 2020 and concludes December 31, 2020. Data measurement will begin January 1, 2020 (unless otherwise noted) to allow sufficient time for data collection and claims run-out in order to provide comprehensive and complete results. A final three month run-out period will be used on Program components to identify all claims that should be included for performance measurement and scoring purposes. To assure claims can be captured for final CY 2020 Program reporting and scoring purposes, all claims and claims corrections must be received by Highmark no later than January 31, 2021 in order to be processed before the final run-out period has concluded. Claims submitted after that time cannot be guaranteed to be completely processed for year-end resulting. Following year-end processing of data, Participants will not be able to submit additional corrections related to underlying claims data used to calculate the performance results. For purposes of clarification, claims s*ubmitted by* Participants will be used for Program Member attribution.

ELIGIBILITY

Eligibility	Highmark is implementing the Program to improve clinical outcomes and All-Cause Readmission rates for SNF providers located in the Commonwealth of Pennsylvania. Individually participating SNFs with 10 or more total Highmark Medicare Advantage and Commercial admissions during the calendar year prior to the Performance Period and Corporate Entities with 10 or more total admissions in aggregate are eligible to participate in the Program. Highmark will reevaluate Participants' eligibility on an annual basis.

PERFORMANCE MEASUREMENT

Performance Analysis

Highmark will compare the Contracting Entity's MR Readmission Rate during the Baseline Period to the Contracting Entity's MR Readmission Rate during the Performance Period. If the Contracting Entity achieved either a reduction in the MR Readmission Rate during the Performance Period (Performance Improvement), or a MR Readmission Rate equal to or less than an established benchmark (Superior Performance), a payment will be earned according to a tiered reimbursement structure as displayed in Table 2 Reimbursement Tier. The benchmark for Superior Performance shall be set as the value of the MR Readmission Rate at the projected 90th percentile of the MR Readmission Rates for all eligible SNFs ("Benchmark") based on historical claims data.

The All-Cause Readmission metric focuses on reducing all-cause unplanned 30 day readmissions for the Medicare Advantage and Commercial populations. SNFs will be evaluated on their Performance Period as compared to the Baseline Period. Program evaluation is based on historical performance. The quality metric to be used for measurement is derived from NCQA HEDIS® Plan All-Cause Readmissions (PCR) inclusion and exclusion criteria. The same version of the HEDIS® definition will be used in calculating MR Readmission Rates during the Baseline and Performance Periods. Readmissions to both the facility where the Index Admission occurred and other facilities will be assessed. Expected and Observed readmission rates from the Baseline Period and Performance Period will be risk-adjusted by a Market Expected Readmission Rate for their respective period (Market Expected Rate) using the following calculation:

*MR Readmission Rate = (Observed/Expected) * (Market Expected Rate)*

Performance Scoring and Reimbursement

The Contracting Entity's performance in the Program will be evaluated to determine if it meets one of the following criteria:

1. Performance Improvement
    - *A reduction in the MR Readmission Rate during the Performance Period from the MR Readmission Rate during the Baseline Period greater than or equal to 2%.*

2. Superior Performance
    - *MR Readmission Rate during the Performance Period less than or equal to an established Benchmark*

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Performance Scoring and Reimbursement (Continued)

Performance Improvement and Superior Performance are mutually exclusive in terms of reimbursement. Should Contracting Entity meet both criteria, Superior Performance shall take precedence. Participants that are owned by a Corporate Entity will have their performance aggregated to the Corporate Entity level. Corporate Entity's MR Readmission Rate for the Baseline Period and for the Performance Period will be based on an aggregate of the MR Readmission Rates of Corporate Entity's owned facilities and reported as an aggregate rate. For corporate entities that experience ownership changes during the Performance Period, Highmark will not recalibrate the Corporate Baseline Readmission Rate to remove facilities that have been sold or add facilities that have been purchased. The aggregate Baseline Readmission Rate will be determined by a Corporate Entity's owned facilities as of December 31st of the baseline year. The Performance Period Readmission Rate and scoring will be determined by the Corporate Entity's owned facilities as of December 31st of the performance year. The following example is an illustration of the methodology used to calculate an aggregate rate for the Performance Period:

Table 1 MR Readmission Rate

Facilities owned by Corporate Entity	Actual Readmissions	Expected Readmissions
Facility A	5	4.6
Facility B	8	9.4
Facility C	15	17.3
Market Expected Readmission Rate	16.30%	

*Entity Level Risk Adjusted Readmission Rate = (Entity A Actual Readmissions + Entity B Actual Readmissions + Entity C Actual Readmissions) / (Entity A Expected Readmissions + Entity B Expected Readmissions + Entity C Expected Readmissions) * Market Expected Readmission Rate*

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PERFORMANCE MEASUREMENT, Continued

Performance Scoring and Reimbursement (Continued)

*Entity Level Risk Adjusted Readmission Rate = (5+8+15) / (4.6+9.4+17.3) * 16.30%= 14.58%*

Performance Summary Results and Payment Calculations are rounded to the nearest whole number for reporting and scoring.

Therefore, 14.58 is rounded to 15%.

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Performance Scoring and Reimbursement (Continued)

Table 2 Reimbursement Tier

Performance Improvement (Tiers 1 and 2)
• 2% up to but not including 6% reduction: $25.00 per Medicare Advantage and Commercial Program Member admission • Greater than or equal to 6% reduction: $40.00 per Medicare Advantage and Commercial Program Member admission
Superior Performance (Tier 3)
• Less than or equal to Benchmark (7%): $50.00 per Medicare Advantage and Commercial Program Member admission

Total payout will be calculated as follows:
Total Payout = (Payment Amount) * (Total # of Medicare Advantage and Commercial Program Member admissions during the Performance Period)

Payment will be made to Contracting Entity by June 30, 2021. Corporate Entities will receive the lump sum amount of payment earned by all SNFs which Corporate Entity owned at the end of the Performance Period.

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Performance Scoring and Reimbursement (Continued)

The following scenarios are illustrative and do not reflect or predict actual Entity performance.

Scenario 1:
MR Readmission Rate during the Baseline Period equals 8%
MR Readmission Rate during the Performance Period equals 6%
Total Number of Medicare Advantage and Commercial Program Member admissions during Performance Period equals 50

Payment Amount would equal $50 per admission since Contracting Entity and/or Participant qualifies for Superior Performance payment by achieving a MR Readmission Rate less than the Benchmark during the Performance Period.

Total Payout = ($50) * (50) = $2,500

Scenario 2:
MR Readmission Rate during the Baseline Period equals 18%
MR Readmission Rate during the Performance Period equals 15%
Total number of Medicare Advantage and Commercial Program Member admissions during Performance Period equals 100

Payment Amount would equal $25 per admission since Contracting Entity and/or Participant qualified for Performance Improvement by achieving a 3% MR Readmission Rate reduction during the Performance Period which is greater than 2% but less than 6%.

Total Payout = ($25) * (100) = $2,500

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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.

REPORT FREQUENCY AND DELIVERY

Report Frequency and Delivery

- Highmark shall provide monthly reports with Program Member level data to Contracting Entities and/or Participants. Reports will indicate MR Readmission Rate during the Baseline Period and Benchmark for Superior Performance. Contracting Entity agrees, or shall cause its Participants to agree, to review and discuss these reports as requested by Highmark.
- Contracting Entities will receive a Program performance analysis with interim results within 30 days of the last day of the Performance Period, and a final performance evaluation with payout results within 60 days of the three month claims run-out period following the Performance Period.
- Reports will be delivered via *e*Delivery, a service allowing for the electronic delivery and retrieval of reports and other agreed-upon data. Each Contracting Entity must execute an *e*Delivery Agreement in order to obtain access to reports through *e*Delivery.

POLICIES AND REQUIREMENTS

Requirements of Participants

Highmark and Contracting Entity agree, Contracting Entity agrees on behalf of the Participants, to the following as part of the Program: Contracting Entity and its Participants shall not withhold any and all necessary care to Program Members based on its participation in the Program. Contracting Entity and each Participant 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. Contracting Entity and its Participants shall continue to provide care in accordance with their independent medical judgment.

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.

Highmark Services

Highmark may provide one or more of the following services to support the Contracting Entity:

- Periodic access to clinical education opportunities.
- Resources and assistance to provide guidance, review, and education to achieve quality outcomes, including reducing unplanned transitions of care and streamlining patient-centered care and developing standardized practice guidelines or suggestions.
- Monitoring of the Contracted Entity and/or Participant performance throughout the Performance Period.

Sharing of dashboard reports on a regular cadence in an effort to provide insight for further process improvement. More frequent patient-level detail reports may be provided for directional insight between formal reporting periods. Because monthly reports will not have full claims run-out (3 months), they will be informational only.

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Provider Policies and Procedures

In addition to CMS required provider policies (i.e. QAPI, 72 hour SNF admission patient meeting), it is recommended that Contracting Entity adopt policies and procedures for the following (but is not required to do so for the Program):

- Utilization of best practices when facilitating non-emergent ambulance transports to and from a SNF. Contracting Entity and/or Participant agree to share all SNF transport data for Program Members with Highmark upon request.

- Cooperating with vendors and consultants who have been engaged by Highmark to provide items or services including but not limited to NaviHealth, Inc., Aspire Health, Inc. and Quartet Health, Inc. to allow onsite visits for evaluation, coordination, and process improvement.

- Cooperating with Highmark Member Vendor program, including, but not limited to Stars gap closure and revenue management activities to permit onsite visits for evaluation, coordination, and process improvement.

- Committing to maintain, or work towards achieving, a nursing care model with 3.4 hours per patient day or above (for direct patient care only).

- Where available, facilitating process improvements for Program Members' Medicare Advantage Stars and HEDIS® gap closures as published by the current year CMS Part C&D Star rating Technical Notes and the Healthcare Effectiveness Data and Information Set Technical Specifications.

- Facilitating effective transition of care processes internally and across the care continuum, including the Transition of Care Registered Nurse (or designee), who has primary responsibility to oversee the process, and Primary Care Physician.

- Performing medication reconciliation within 24 hours of arrival and at the time of discharge.

- Confirming whether the transition of care appointment has been scheduled, and if not, assisting with scheduling the appointment.

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Provider Policies and Procedures (Continued)

- Initiating home health evaluations within seven (7) days of SNF admission for patients with Durable Medical Equipment (DME) needs, DME installation needs, limited home support, or as otherwise deemed necessary by SNF staff.

- Standardizing quality and increasing effectiveness by utilizing quality programs including but not limited to The National POLST Paradigm and Interventions to Reduce Acute Care Transfers (INTERACT).

- Maintaining a list of state and federal survey results, including all survey results with "F" level and other deficiencies.

- Utilization of a post-discharge follow-up process which includes a patient satisfaction metric.

- Compliance with Notice of Medicare Non-Coverage (NOMNC).

- Utilization of NaviNet submission for authorizations.

Highmark reserves the right to audit Contracting Entity and/or Participant's policies and procedures for compliance with the above recommendations.

The Contracting Entity's implementation of the recommendations may contribute to a favorable outcome under the Program but Highmark does not forecast such an outcome due to multiple factors that may impact the performance of the Contracting Entity.