HIGHMARK PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY NETWORK

FREQUENTLY ASKED QUESTIONS

Q: What metrics were used to evaluate the participating physical, occupational and speech therapists?

A: Highmark used metrics that have been tracked as part of our Physical Medicine Utilization Management program and reported to Highmark participating providers for the past several years. Scorecards are sent semi-annually to participating providers to notify them of their results. Highmark used the following metrics to score the participating physical therapists. **Note:** The weight assigned to each metric is shown within parentheses.

Physical, Occupational, Speech Therapy metrics (weighting percent indicated within parentheses)

- Average visits per patient (Category 1) ≤ 8 **(5%)**
- Average visits per patient (Category 2) ≤ 14 **(5%)**
- Average physical medicine procedures or units per visit ≤ 4 **(15%)**
- Total care registration and authorization requests ≥ 20 **(0%)**
- Care authorizations obtained via NaviNet ≥ 90% **(25%)**
- Authorization request approval rate ≥ 94% **(25%)**
- Requested visit approval rate ≥ 94% **(25%)**

Q: Which products use this High Performing Network?

A: The High Performing Network for Physical, Occupational and Speech Therapy providers will apply to commercial ACA my Direct Blue products and Medicare Advantage Community Blue. The participating physical therapists chosen for the new network will be considered in-network providers for these products.

For commercial tiered products, participating providers selected for the Physical, Occupational, Speech Therapy Network will be placed in the highest benefit tier. Participating providers not selected will be placed in a lower benefit tier. In order for members with commercial tiered benefits to have the lowest cost share, they must receive services from providers in the top benefit tier.

Q: Are my Highmark patients aware of the implementation of this Network?

A: Highmark members in affected products who have claim records indicating that they recently received services from participating providers who will be moving from top tier to low tier as of Jan. 1, 2022, will be notified via mail.

Q: What if there are no top tier providers available in my patient's location?

A: Highmark has carefully evaluated its network composition to ensure that members in all counties in Pennsylvania have the appropriate amount of access at the highest benefit level.

Q: What region does this apply to?

A: Highmark's service areas in Pennsylvania.

Q: How often are tiering and network selection determinations made? Can I appeal the decisions for 1/1/22?

A: Tiering and network selection determinations are made annually and are based on the most current performance data. Highmark cannot make dramatic changes to its provider networks more than once a year due to regulatory constraints. There is no appeals process for the tiering/network decisions made for 1/1/22.

Q: Can you provide examples of how Total Authorization Approval Rate and Requested Visit Approval Rate are calculated?

A: Example of calculation for Total Authorization Approval Rate and the Requested Visits Approval Rate:

- 10 authorization requests requesting 10 visits each are submitted
- 9 of the 10 authorization requests are fully approved.
- For one authorization request, 6 of 10 visits are approved.

Total Authorization Approval Rate = Authorization Request Approvals / Authorization Requests
= 9/10
= 90%

Requested Visits Approval Rate = Visits Approved / Visits Requested
= 96/100
= 96%

The prescreening process compares the data to the decision support pathway and returns what is recommended by the guidelines. It then presents the provider with a choice.

Example: If a provider requests 8 visits and the prescreening system states that the guidelines show 6 visits, the provider can agree to change his/her request to align with those guidelines (i.e., request 6 and have all 6 approved). So, these are considered approvals.

Q: What is the difference between the Pathways Program and the tiering/network decisions made by Highmark?

A: Tivity administers the Pathways program and notifies providers whether or not they have achieved "Qualifying Status" for the upcoming year. Although the metrics used are the same, Highmark weights the metrics to determine an overall score for providers and makes decisions on not just the metric scores but also by value and member access/experience.
In addition, the time periods used for evaluation is different for the two programs. The Pathways determination for 1/1/22 was based on the metrics from 6/1/20-5/31/21 while the Highmark tiering/network decisions for 1/1/22 were based on 6/1/19-5/31/20.

Q: How do I improve my performance to change my status for the next calendar year?

A: Highmark suggests that all participating providers focus on improving their performance for the metrics listed above.

Q: What are the differences between Category 1 and Category 2?

A: Category 1: Conditions comprised of less complex diagnoses/conditions, such as mild/moderate strains and sprains.

Category 2: Conditions comprised of more complex diagnoses/conditions that typically require extensive rehabilitation, such as congenital development disorders and progressive diseases.

Q: Will providers be notified of their 1/1/22 tiering/network status?

A: Only providers whose status is changing for 1/1/22 will be notified of their new tiering/network status. Providers whose status remains the same will not receive notification from Highmark.

Q: Where can I submit questions?

A: Please send you questions through email to AncillaryProviderContractAdministration@Highmark.com

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