Highmark Inc.

2020 RISK SCORE ACCURACY (RSA)

PROGRAM MANUAL

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SECTION 1: OVERVIEW

The goal of Highmark Inc.'s **("Highmark")** RSA Program **("Program")** is to help ensure that quality health care is provided to Highmark Medicare Advantage and Inter-Plan Medicare Advantage members (as further detailed in Section 7: *Inter-Plan Medicare Advantage Care Management and Provider Engagement)* **("Program Members")** with complex chronic health conditions by assisting provider practices consisting of Primary Care Physicians **("PCPs")** and selected Specialties Physicians **(herein collectively identified as "Participants")** to accurately identify, treat, document and report appropriate ICD-10-CM and Hierarchical Condition Category **("HCC")** diagnosis codes to Highmark.

In order to support this, analytics are used to identify persistent (previously reported) and/or suspected diagnosis condition(s) of Program Members, and Participants are asked to address these diagnosis condition(s) during office visits using an Electronic Medical Record **("EMR")**-based or desktop-based, system-generated form **("RSA Tool")**. Participants must respond to the RSA Tool, document the condition in the Member's medical record, and submit any confirmed condition(s) via claim as indicated in the instructions and Program training materials. Evaluating each Program Member for the diagnosis condition(s) listed on the RSA Tool helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each Program Member to the Centers for Medicare and Medicaid Services **("CMS")**.

The Program will be made available to Participants that have Program Members with diagnosis condition(s) that need to be evaluated during the current year. Participants will have the potential to receive compensation **("Program Compensation")** by taking steps toward providing quality health care through assessment of the Program Members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this Program. It is important that every office visit with the Program Member be precisely documented in the medical record to provide a complete picture of the Program Member's health for purposes of appropriate treatment and follow-up care. The information presented in the RSA Tool is derived from diagnosis codes reported in previous years by multiple sources, including PCPs, Specialists, and clinical data, facilities, chart reviews and other sources. The RSA Tool will only appear for a Program Member who has not been evaluated for the specific diagnosis condition(s) listed on the RSA Tool in the current year.

The Program is intended to assist with support for the accuracy of the diagnoses codes reported to Highmark and not intended to influence clinical and coding judgment.

SECTION 2: PROGRAM PROCESS

Participants agree to review each Program Member's diagnosis condition(s) to determine if the condition(s) exists. If the condition currently exists, Participants must ensure that each diagnosis code is monitored, evaluated, assessed and/or treated **("MEAT")** in the current calendar year. Participants may demonstrate these actions by confirming the diagnoses directly in the EMR via the RSA Tool and submitting a claim or by disagreeing using the RSA Tool and removing any erroneous diagnosis from the Program Member's medical record as needed. **Participants may <u>not</u> schedule an office visit with the Program Member for the sole purpose of completing any or all of these actions.** Program Compensation will be paid on a quarterly basis as further detailed in Section 6: *Program Compensation.*

Highmark may terminate this Program or a Participant from this Program at its sole discretion at any time.

The following details out the Program process:

1. Program Members are assigned to a Participant based on the Highmark attribution process.

2. Attributed Members without designated PCPs in the EMR, or who are in hospice or are institutionalized will not be in scope for the Program.

3. At the start of the Program, Participants will receive a baseline report at the member level that will include a list of all attributed Program Members, their corresponding "Estimated Risk Adjustment Factor" **("RAF")** scores (*see below for further detail on how this is calculated*) and/or the total number of gaps depending on RSA Tool capabilities. Also listed on this report will be diagnosis codes, diagnosis conditions and related information for all attributed Program Members with unconfirmed diagnosis condition(s). This is defined by Highmark at the start of the Program.

    a. "Estimated RAF Score" will be calculated based on the sum total of the known RAF values or total number of gaps for all potential diagnoses in scope for the Program that are 1) Reported in a previous year but not yet reported in the current year; *and/or* 2) Derived from other data in the Program Member's medical record. *and/or* 3) Derived from other external data such as prior year claims.

4. At the time of a Program Member visit, the RSA Tool will be available to notify the Participant if the Program Member has any unconfirmed diagnosis condition(s).

5. If the Participant agrees with the diagnosis condition(s) listed, the Participant may confirm the condition in the RSA Tool and submit the condition through a claim and document appropriately in the medical record.

6. If the Participant does not agree with a diagnosis condition(s) listed in the RSA Tool, the Participant will be prompted to remove the condition(s) from the Program Member's medical record and/or will have the ability to deny the condition in the RSA Tool. If the medical record or RSA Tool is updated accurately, the erroneous diagnosis condition will not appear again for that Program Member in the current calendar year.

7. The Participant also will have the option to dismiss and not respond to the RSA Tool. If this occurs, the diagnosis condition will remain "unaddressed" and Participant will be prompted again the next time the Program Member is seen.

8. The Participant also will have the option to address existing diagnosis conditions outside of the RSA Tool through the submission of a claim associated with that diagnosis, using standard EMR functionality.

9. Participants will receive an established Program Compensation amount based on suspect and/or persistent conditions addressed in the RSA tool, on a quarterly basis as further detailed in Section 6: *Program Compensation.*

10. Other provider programs, such as the Quality Improvement Specialist program, may also identify and present suspected diagnosis conditions through the RSA Tool presented in the RSA Program.

11. Cost performance will not be measured in the Program; however, it is anticipated that accurately reporting Program Member diagnoses condition(s) and ensuring that each diagnosis condition is monitored, evaluated, assessed and/or treated annually will help improve the quality of care and may reduce future cost of care.

SECTION 3: PARTICIPATION

As a condition of participation, all Participants will have in effect all contractual documents as may be required by Highmark, in its sole discretion, including, without limitation, a Blue Shield Participation Agreement, Medicare and/or Medicare Advantage Provider Agreement. All Participants also must allow access to Highmark patient medical records for coder review and chart retrieval.

Participants will not be permitted to participate in both the RSA Program and the Unconfirmed Diagnosis Code ("UDC") Program concurrently.

SECTION 4: PROGRAM MEMBERS AND IMPACT

The Program will not impact any Program Member's benefit design regardless of Participant involvement in the Program. Highmark and/or the Participant, as applicable, agree that individuals participating in Highmark's Medicare Advantage plans (including, but not limited to, HMO and PPO), Commercial ACA products (Offered ON Exchange and OFF Exchange) and/or Inter-Plan Medicare Advantage members (as further detailed in Section 7: *Inter-Plan Medicare Advantage Care Management and Provider Engagement)*, are covered as Program Members pursuant to the Program. Highmark may require other Program criteria that will be set forth in an appropriate agreement or Program administrative requirements, as applicable.

SECTION 5: DATA AND REPORTING

To monitor progress, Participants will receive progress reporting that will indicate the Participant's performance in the Program. The "as of" date will be included on the report.

SECTION 6: PROGRAM COMPENSATION

Participants will be compensated based on the level of effort spent addressing each condition for their Program Member population, for the purposes of the Program, over the course of the calendar year. Participants must be capable of receiving and responding to suspected condition data from Highmark; Participants unable to meet this requirement will be reimbursed at 50% of rate stated. Participants will be compensated at the same rate for activity conducted by their respective clinicians.

Program Compensation is driven by:

- **Evaluation of suspect conditions**: Compensates activity related to the preparation of and evaluation and documentation of suspect conditions that would not otherwise be required but for the Program. Acknowledging that the level of effort to evaluate a suspect condition is consistent regardless of how condition is dispositioned, payment is uniform.
    - o Suspected conditions confirmed or resolved/never existed will be compensated at $100 per condition
- **Evaluation of persistent conditions**: Compensates activity related to the preparation of, and evaluation and documentation of persistent conditions that would not otherwise be required but for the Program. Given that confirmation, documentation, review and monitoring for treated persistent conditions requires more activity, higher compensation is rewarded for treated persistent conditions. Addressing and denying persistent conditions is also compensated, but the lesser activity is compensated at a lesser rate.
    - o Persistent conditions confirmed will be compensated at $100 per condition
    - o Persistent conditions resolved/never existed will be compensated at $25 per condition

Example of how compensation will be measured when addressing each condition type:

Suspect Conditions		***Compensation***
Condition 1	Yes	$100
Condition 2	No	$100
Condition 3	No Response	$0
		$200

Persistent Conditions		***Compensation***
Condition 1	Yes	$100
Condition 2	No	$25
Condition 3	No Response	$0
		$125

Participants will receive disbursements for participation in this Program at the entity level. This disbursement will be separate from other disbursements. Disbursements will be issued on a quarterly basis based on prior quarter performance. Quarterly payments will be paid out in the month following quarter end. (Timing of payments may be subject to delay depending on volume and operational processing times).

Highmark reserves the right to adjust compensation for activity related to the Program based on documentation of conditions addressed, the ability of Participants to receive and respond to suspect/persistent condition data, and based on the needs and requirements to conform to any applicable regulations impacting the Program.

Medical record documentation for Program Members will be audited by Highmark or its designee on a periodic basis to validate that confirmed diagnosis codes are substantiated in the documentation captured in the EMR for the visit. If the diagnosis condition is not substantiated in the Medical Record, the condition will be represented. It should be noted that Highmark reserves the right to limit compensation in whole or in part if it is found that CMS and Highmark documentation requirements are not satisfied.

Total compensation for Participants who do not receive and respond to suspect condition data from Highmark will be reduced by 50%.

SECTION 7: INTER-PLAN MEDICARE ADVANTAGE CARE MANAGEMENT AND PROVIDER ENGAGEMENT

The purpose of the Inter-Plan Medicare Advantage Care Management and Provider Engagement Program is to improve care management and data sharing strategies for the Medicare Advantage Member population for out of area ("**OOA**") Blue Shield ("**BS**") plans whose members are hosted by Highmark.

The 2020 RSA Program is structured to support and improve the coordination of care on BS Medicare Advantage Members within the Highmark provider network ("Hosted Members"). Highmark will be including Hosted Members from other Blues Plans who live in Highmark BS service area. For additional information please refer to the Inter-Plan Medicare Advantage Care Management and Provider Engagement Program Manual which can be found on NaviNet and the Provider Resource Center under Value Based Reimbursement Programs/Medicare Advantage Stars.