Highmark Inc.

2021 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 and chart reviews are used to identify persistent (previously reported) and/or suspected diagnosis condition(s) of Program Members that are displayed in an Electronic Medical Record **("EMR")**-based or desktop-based, system-generated form **("RSA Tool")**. Participants are asked to address these diagnosis condition(s) during eligible patient encounters with their healthcare provider that Centers for Medicare and Medicaid Services **("CMS")** determines to be appropriate for this activity **("CMS-eligible provider visit")**. 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 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 CMS-eligible provider visit as a part of this Program. It is important that every CMS-eligible provider 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, 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 in the RSA Tool in the current year during CMS-eligible provider visits.

The Program is intended to assist with support for the accuracy of the diagnosis 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 agreeing to 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 a provider 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 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 and their corresponding number of diagnosis conditions with diagnosis codes and other related information.
4. At the time of a CMS-eligible provider 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 respond to the condition in the RSA Tool by agreeing 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 disagree with 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 open and the Participant will be prompted again the next time the Program Member is seen for a CMS-eligible provider visit.
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. However; Program Compensation will only be paid if the RSA Tool is utilized.
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.

By participating in this voluntary program, Participants agree to the terms and conditions of the Program.

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) 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, the Participants will receive reports that will indicate the Participant's cumulative performance in the Program based on assessed gaps through a specific date in time **("RSA Risk Adjustment Compensation Report")**. In addition, there will be reporting available related to members with open diagnosis gaps through a specific date in time **("RSA Risk Adjustment Members Open Diagnosis Gaps")**, to assist further with care coordination for Program Members. The "as of" date will be included on the Summary page of the reports. Participants with access to the Quality Blue User Interface via NaviNet will be able to view these reports through the interface every other week or monthly depending on the RSA Tool being utilized. There may be some exceptions where reports are emailed securely.

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 when there is evidence the RSA Tool was utilized. 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 the 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.
    - Suspected conditions agreed to or disagreed with 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 disagreeing with persistent conditions is also compensated, but the lesser activity is compensated at a lesser rate.
    - Persistent conditions agreed to will be compensated at $100 per condition
    - Persistent conditions disagreed with will be compensated at $25 per condition

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

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

Persistent Conditions		***Compensation***
Condition 1	Agree	$100
Condition 2	Disagree	$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 approximately 45 days after the prior 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 re-presented. 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.

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 2021 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.