MEDICARE ADVANTAGE

SUPPLEMENTAL REQUIREMENTS

A supplemental document to Highmark's Medicare Acute Care Provider Agreement

***For providers in Pennsylvania and West Virginia**

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MEDICARE ADVANTAGE SUPPLEMENTAL REQUIREMENTS

TABLE OF CONTENTS

TOPIC	SEE PAGE
INTRODUCTION	3
DEFINITIONS	4
DISPUTE RESOLUTION	5
CODING DISPUTES	7
USE OF INFORMATION AND DATA	9
NETWORK ACCESS	10
CMS STARS	11
RISK ADJUSTMENT	12
QUALITY IMPROVEMENT	14
HIPAA / PRIVACY	16

INTRODUCTION

Purpose

The **Medicare Advantage Supplemental Requirements** contain an integrated set of policies, procedures and requirements that are applicable to participating facilities and are meant to supplement the **Highmark Medicare Acute Care Provider Agreement** ("**Agreement**").

What Region Am I?

Overview

Highmark developed these Medicare Advantage Supplemental Requirements in order to expand upon specific criteria within the Agreement including, but not limited to, the following:

- Applicable Definitions
- Dispute Resolution
- Coding Disputes
- Use of Provider Information and Data
- Network Provider Access
- CMS Stars Rating
- Risk Adjustment
- Quality
- HIPAA / Privacy

IMPORTANT!

Medicare Advantage Supplemental Requirements are binding upon providers and may be supplemented or superseded, in whole or in part, by other Highmark guidance and/or requirements furnished or otherwise made available to Providers, provided supplements do not conflict with the applicable federal and state laws and regulations.

Highmark complies with all state and federal laws, including those laws related to Medicare and our Medicare Advantage products. In cases where Highmark Medical Policy, and/or the Medicare Advantage Supplemental Requirements conflict with the Centers for Medicare & Medicaid Services (**CMS**) laws, regulations, or directives, the CMS laws, regulations, and/or directives shall apply.

Conflicts

In the event of a conflict between the requirements of the Medicare Advantage Supplemental Requirements and the Agreement, the following order of control should apply: (a) First, the Agreement; (b) Second, the Medicare Advantage Supplemental Requirements.

DEFINITIONS

Inpatient Services: ***defined***

Inpatient Services shall mean all services normally covered in the federal Medicare DRG payment or other payment designated by CMS for acute medical and surgical hospital care including, but not limited to, Emergency Services that do result in an admission within twenty-four (24) hours of the delivery of the Emergency Services, Observation Services that do result in an admission within forty-eight (48) hours of the delivery of the Observation Services, emergency room care that does result in an admission within twenty-four (24) hours of the delivery of the emergency room care, pre-admission testing performed within seventy-two (72) hours of an admission, diagnostic testing performed during an inpatient stay, nursing care, room and board, durable medical equipment, ancillary services, inpatient drugs, meals and special diets, use of operating room and related facilities, use of intensive care and cardiac units and related services.

Outpatient Services: ***defined***

Outpatient Services shall mean all outpatient medical and surgical emergency room and ancillary services including, but not limited to, ambulatory surgery and all ancillary services pursuant to ambulatory surgery, outpatient laboratory, radiology and diagnostic procedures, Emergency Services that do not result in an admission within twenty-four (24) hours of the delivery of the Emergency Services, Observation Services that do not result in an admission within forty-eight (48) hours of the delivery of the Observation Services, emergency room care that does not result in an admission within twenty-four (24) hours of the delivery of the emergency room care and other outpatient services covered under the Member's Evidence of Coverage. Outpatient Services do not include pre-admission testing performed within seventy-two (72) hours of an admission.

DISPUTE RESOLUTION

Dispute Resolution Process: *defined*

This **dispute resolution process** is intended to apply to all disputes between Highmark and Provider arising under the Agreement between Highmark and Provider. This includes, without limitation, billing and payment disputes, medical policy disputes, audit issues, torts, contract issues, unfair trade practices and antitrust allegations, and all other disputes which could otherwise be brought in a state or federal court action. Highmark and Provider each acknowledge and agree that any disputes between them:

(a) be filed as individual arbitrations and
(b) will not be combined or consolidated with disputes of third parties against Highmark or Provider.

Highmark and Provider each expressly waives its right to join or otherwise participate in any class action arbitration against the other party. This process does not apply to disputes involving a Member grievance or complaint, which shall be handled in accordance with other applicable procedures. Further, all coding disputes shall be subject to the terms and conditions set forth on page seven (7), under "Coding Disputes", and not the terms and conditions of this section.

Negotiation

Should Provider seek an interpretation of a specific provision of Agreement, or question an administrative decision made by Highmark, a Provider representative will first discuss the matter with a Member of the Provider Relations and/or Provider Contracting department. If the matter is not resolved, Provider's representative will request that a Highmark senior management representative arrange an informal meeting of representatives of Provider and Highmark. Such meeting will be held within forty-five (45) days of the date the request is received by the appropriate Highmark management representative. Prior to such meeting, any party may present a written explanation of its position with regard to the matter.

Mediation

If negotiation is unsuccessful any party may make a request for non-binding mediation by filing such request in writing with the other parties, such mediation to occur only upon mutual agreement of all parties using a single mediator.

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DISPUTE RESOLUTION, Continued

Arbitration

If mediation is unsuccessful, any party may make a request for arbitration by filing such request in writing with the other parties. Arbitration will be conducted under the auspices and rules of the American Arbitration Association Healthcare Payor Provider Rules, or its successor rules, before a mutually agreed-upon panel of three (3) arbitrators. In the event the parties are unable to agree upon the panel of three 3 arbitrators within thirty (30) days of the request for arbitration, each party shall select an arbitrator within thirty (30) days and with two (2) selected arbitrators selecting the third arbitrator within thirty (30) days of the appointment of the latest selection of either of such two (2) arbitrators . In the event a party fails to select an arbitrator within the above time period, such party shall have waived its right to select an arbitrator.

Arbitration Process

The arbitrators shall convene a hearing on the dispute in Pittsburgh, Pennsylvania. Further, the parties may mutually agree upon an alternative location. The award of the arbitrators shall be final and binding and shall contain no right of appeal by the parties. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof, and any such judgment so entered shall be entered as a confidential judgment under seal. The costs and expenses of arbitration, including the fees of the arbitrators but excluding attorney's fees and expenses, shall be paid in such proportion as is determined by the arbitrators as part of the award or, if no such determination, equally by the parties. Except as otherwise provided herein, the arbitrators shall have broad discretion with respect to any dispute to award any and all types of compensation or damages as well as to render any and all legal and equitable relief which a court of competent jurisdiction could have ordered if the dispute had not been arbitrated hereunder and had been determined by such court.

CODING DISPUTES

Overview

This section is intended to provide a means whereby Highmark and the Provider will resolve any Coding Audit Dispute related to any claim for services submitted to Highmark, including those arising under the Agreement.

Coding Audit Disputes: *Defined*

For purposes hereof, the term **"Coding Audit Dispute**" shall mean a dispute that arises as a result of one or more claims coding audits as conducted by Highmark and/or its designated agent and that further

(a) result in a disagreement between Highmark and Provider as to the appropriate code(s) assigned to a particular diagnosis and/or service rendered or supplied by Provider to a Member and

(B) has not been resolved by the parties through informal means.

Whenever a Coding Audit Dispute arises, which cannot be resolved through discussions between the parties, Provider will receive a letter from Highmark or its designee on which the Provider must state its intention to either accept or appeal Highmark's or its designee's decision. Provider shall comply with all written requests for Provider's intention to accept or appeal a coding decision within the time period as set forth in any written correspondence from Highmark or its designee. If Provider fails to respond to the written request to the Provider to state its intention to accept or appeal a coding decision by Highmark or its designee within the time period as set forth in the letter then the parties agree that Provider shall be deemed to have accepts the decision made by Highmark or its designee. If the Provider chooses to appeal Highmark's or its designee's coding decision, Provider shall indicate its choice to appeal and have the Coding Audit Dispute thereafter submitted to a **Certified Review Entity** (hereinafter, "CRE") to perform a review and conclusively resolve the dispute.

Certified Review Entity (CRE)

Highmark shall give Provider a written list of two (2) or more such CREs from which the Provider may choose one CRE. Provider shall designate which of the CRE it has selected in writing to Highmark within ten (10) business days of its receipt of the list of potential CREs from Highmark. If the Provider fails to select a CRE within ten (10) business days, Highmark shall have the sole discretion to choose the CRE or utilize another resolution process that may be available under the terms of the Provider Agreement or otherwise. The CRE shall be independent (other than with respect to any contract with Highmark to provide CRE services). The parties agree that the resolution process set forth in herein shall be the sole means for resolving Coding Audit Disputes.

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CODING DISPUTES, Continued

CRE:
Process

Within ten (10) days of receiving Provider's formal written request for the use of a CRE to resolve a Coding Audit Dispute and Provider's formal written choice of a CRE, Highmark shall forward to the CRE the entire file pertaining to the Coding Audit Dispute and provide notice of such action to Provider. Within ten (10) days of Provider's receipt of the notice that the file has been forwarded to the CRE, the Provider may supply additional information to the CRE for consideration and shall simultaneously provide copies of the information to Highmark. Highmark shall have ten (10) days after receipt of Provider's additional information to provide any further information or comment it deems relevant to the dispute to the CRE for consideration and shall simultaneously provide copies of the information to the Provider. This is not intended to restrict the Provider or Highmark from providing the CRE with additional information for consideration with respect to information submitted by the other party hereto. Copies of such additional information shall be provided simultaneously to the other party hereto.

CRE:
Decision

The CRE shall review and issue its decision within ten (10) days of receipt of the last information submitted. The decision shall be in writing and shall include:

- A list of the information considered in reaching the decision; and
- The basis and clinical rationale for the decision; and
- A brief statement of the decision.

These Coding Audit Dispute provisions shall apply to individual disputes between the Provider and Highmark and that the arbitrator(s) shall have no power or authority to certify or otherwise determine a class action or otherwise combine any individual dispute with other disputes between the parties or between a party hereto and one or more third parties without the prior written consent of all affected parties hereto.

Binding Decision Final!

The decision by the CRE shall be final and binding on, and non-appealable by, Highmark and Provider. Further, Highmark and Provider waives its right to commence litigation as to the Coding Audit Dispute in a court of law as well as appeal the determination by the CRE of a coding audit dispute to a court of law.

Fees and Costs

When the CRE's decision is fully in favor of one party, the other party shall pay the entire fees and costs associated with the CRE's review and decision. If the CRE's decision is partly in favor of each party, the parties shall share equally the cost of the review. If required by the CRE, Highmark and Provider shall make escrow deposits to cover the costs of review by the CRE.

USE OF INFORMATION AND DATA

Use of Information

Provider agrees that now and hereafter Highmark may utilize, publish, disclose and display information relating to Provider and/or to this Agreement to entities, including, but not limited to, current and potential group customers and their agents or designees , the Blue Cross and Blue Shield Association and its related companies, participating providers , and current and potential Members, using those formats and media (including, without limitation, marketing materials, other publications, directories and internet) that are most appropriate under the specific circumstances and as in accordance with the Agreement and administrative requirements. The displayed Provider information includes, but is not limited to:

- Provider's name, address and telephone number;
- Description of Provider's services;
- Descriptive and educational information, including the results of customer satisfaction surveys concerning Provider and its services, facilities and staff;
- Information relating to Provider's costs, charges, payment rates and/or amounts for services hereunder,
- Patient pay amounts (including coinsurance amounts),
- Quality, utilization, and data relating to Provider's delivery of health care;
- Any data, information and conclusions generated in connection with a Highmark designed program, report and/or study regarding Provider and/or other Participating Providers.

Other Purposes

Highmark, in accordance with applicable Laws, may use and/or include data generated by Provider for studies and reports (including reports to its group customers) on a group-specific or aggregate basis. Highmark may also disclose the terms of the Agreement or provide a third party with a copy of the Agreement (including all Exhibits) where a disclosure of terms is required for an audit.

NETWORK ACCESS

Network Access Requirements

Provider agrees to the following network access requirements:

- Treat all persons covered by a network access arrangement, as defined in the Provider Agreement, as if a Member under Highmark's Medicare Advantage Program(s) (as determined by Highmark and no matter where the person resides) and shall provide services to such person at the payment rates set forth in the Agreement and any applicable exhibits.
- Render services in accordance with all requirements of the Evidence of Coverage governing such person and subject to the terms and conditions of the Agreement and all exhibits, except if Highmark specifically advises Provider in writing of a provision or provisions of the Agreement and/or any exhibit which shall be inapplicable to such persons.
- That its name, address and telephone number a description of its facilities and Provider Services may be listed in a directory or marketing materials produced in connection with a network access arrangement.
- Cooperate with Highmark's administration of a network access arrangement and shall comply with any reporting or data collection requirement of Highmark with respect to services received by persons covered under a Network Access Arrangement.

Note: Highmark may add or delete network access arrangements by providing prior written notice, including electronically, to Provider.

Provider Directories

Providers agree to the following with respect to Provider directories:

- Provider agrees that Highmark may list its name, address and telephone number and a description of its facilities and services in Highmark's marketing materials and its roster and/or directory of participating Providers that is given to Members and prospective Members or as available on internet web-sites.
- Highmark agrees that Provider, in its public communications and marketing materials, may refer to Highmark as a payor with which Provider participates. Such material is subject to Highmark's written approval to ensure compliance with Highmark, CMS and/or Blue Cross Blue Shield Association standards.

CMS STARS

STARS: ***Objective***

The **STARS** objective is to help our Members maintain and improve their health outcomes and effectively manage chronic conditions. Further, CMS is directly connecting reimbursement for Medicare services to patient outcomes such that to continue to offer competitive reimbursement rates to our in-network Providers, Highmark seeks to increase Provider awareness related to the CMS STARS measurements.

CMS is working with Highmark to improve the quality and cost effectiveness of services provided to patients. The Medicare STARS rating program measures how well plans perform based on a cross section of quality metrics including clinical, pharmacy, member satisfaction with their plan (as well as Providers), health outcomes and plan operations

STARS: ***Provider Compliance***

- Provider agrees to adhere to Highmark standards relative to any CMS quality rating program. Should Provider fail to comply with such standards Highmark, in its sole discretion, may take remedial actions, including without limitation:
    - Require hospital to undertake appropriate training.
    - Require access to medical records (electronic, paper, or otherwise).
    - Terminate the Provider from the network.
- Provider must provide all discharge data, without limitation, date of service, discharge instructions, and all diagnoses and treatments, to a Highmark case manager within twenty-four (24) hours of discharge. In the event Provider is unable to meet this twenty-four (24) hour standard as a result of its inability to operationalize, **Provider will notify Highmark immediately and agrees to comply with this standard no later than one year from the effective day of the Provider's Agreement.**
- Provider will participate in Highmark's electronic medical record and/or data exchange initiatives ("Data Exchange Programs"), which shall support and/or facilitate the availability and exchange of claims-based information and clinical information for the treatment and ongoing case management of Members within one hundred eighty (180) days of any such initiative being offered to the Provider by Highmark. Further, Provider agrees to provide any necessary data required for Data Exchange Program participation within ninety (90) days upon Highmark's request.

In the event Provider has entered into an exclusive Data Exchange Program arrangement with any third party, Provider will notify Highmark immediately and agrees to discontinue such exclusive arrangement as soon as contractually possible. In the event Provider is unable to meet this standard as a result of its inability to operationalize, **Provider will notify Highmark immediately and agrees to comply with this standard no later than one year from the effective day of the Provider's Agreement.**

RISK ADJUSTMENT

Risk Adjustment: *Objective*

The objective of **Risk Adjustment** is to deliver complete and accurate documentation to evaluate and ensure quality of care, patient safety, efficacy, and data integrity. CMS requires that all applicable diagnosis codes be reported to the highest level of specificity and such coding must be substantiated by the medical record. As such, medical records must align with reported diagnosis codes. There are several elements that must be present in the medical record. **M.E.A.T.** is an acronym used to describe four factors that help Providers to establish the presence of a diagnosis during an encounter in proper documentation. M.E.A.T. is an acronym for:

- Monitoring– signs, symptoms, disease progression, disease regression
- Evaluating– test results, medication effectiveness, response to treatment
- Assessing/Addressing– ordering tests, discussion, review records, counseling
- Treating– medications, therapies, other modalities

Providers shall establish the presence of a diagnosis during an encounter in proper documentation that will render a diagnosis eligible for submission to CMS for the purpose of risk adjustment.

Risk Adjustment: *Requirements*

Provider agrees to render and fully and accurately document Provider services in a manner consistent with professional recognized standards of health care and documentation including without limitation, to follow Highmark's procedures approved by CMS to identify Members with complex or serious medical conditions by:

(a) monitoring conditions;
(b) evaluating the conditions;
(c) assessing those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and
(d) treating the condition, including establish and implement a treatment plan appropriate to those conditions with an adequate number of direct access visits to specialists to accommodate the treatment plan.

Any and all medical record documentation, including without limitation, diagnosis and treatment plans, must be accurate and align with the diagnosis code reported to Highmark. In the event diagnosis code and corresponding medical records do not align, Provider must immediately correct and submit to Highmark either the diagnosis code and/or the medical record, as applicable. Should Provider fail to make necessary corrections timely and/or consistently submit inaccurate data, including errors in coding, Highmark, in its sole discretion, may take remedial actions, including without limitation:

- Require hospital to undertake appropriate training.
- Reject claims.
- Collect overpayments.
- Terminate the Provider from the network.

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RISK ADJUSTMENT, Continued

Risk Adjustment: ***Additional Requirements***

The Provider, and/or its subcontractors, as applicable, agrees to obtain any and all Member authorizations and/or consents, as may be required, in advance, in order to comply with state and federal laws and the terms of the Provider Agreement, including without limitation, any terms related to Highmark's quality initiatives.

To the extent applicable, Provider shall:

- Assist in the development and implementation of the treatment plans.
- Cooperate with conducting a comprehensive health assessment of all Members.
- Inform Members of follow-up care and/or provide Members with training in self-care.
- Monitor, evaluate, assess, and treat Members.

To the extent applicable, Provider shall use its best efforts to ensure all professional Providers affiliated with the hospital:

- Perform an annual wellness visit and/or complete a comprehensive risk assessment.
- Have contact with their patients as may be required to properly care for the patient in accordance with the requisite prescribed standards of care.
- Correct claims immediately upon discovery of error or notification by Highmark.
- To accurately record the patient's medical information in accordance with CMS and Highmark standards.

QUALITY IMPROVEMENT

Overview

Provider shall comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider services for Members.

Provider Requirements

As required or appropriate, Provider shall participate in and cooperate with Highmark's efforts to develop quality improvement, cost containment, or coordination of health services as well as to develop, compile and report performance standards, statistics and other information for dissemination to Members and the general public regarding operation costs, utilization patterns, availability and accessibility of services, and satisfaction with Highmark and Provider services.

Provider Involvement

Highmark shall consult with certain participating Providers and other health care professionals regarding its medical policies, quality assurance program, risk adjustment and medical management programs and ensure that practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in the particular field and applicable Medicare requirements; and
- Consider the needs of the enrolled population; and
- Are developed in consultation with participating Providers; and
- Are reviewed and updated periodically; and
- Are communicated to Participating Providers and, as appropriate, to Members.

Electronic Communication

Provider shall, and encourage its affiliated physicians, to utilize technology and communicate electronically to its fullest extent, including without limitation, the Provider portal, NaviNet®, for all:

1. Utilization management requests,
2. Data exchange program or initiative for all claims data, and
3. Authorizations.

Further, Provider shall integrate electronic health records into the day-to-day operations in a meaningful way to support optimal patient care, performance measurement, patient education, and enhanced communication.

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QUALITY IMPROVEMENT, Continued

On-Site Access

Provider shall permit onsite Highmark clinical staff on site to facilitate appropriate discharge planning, disease management and/or case management as may be required. The parties will work collaboratively to identify and resolve any privacy and confidentiality issues. Further, Highmark clinical staff, as applicable, shall have access to medical records, electronic and other formats as may be required.

Quality Criteria

Provider shall participate in, cooperate and comply with, and abide by decisions of Highmark with respect to Highmark's credentialing requirements; medical policies and medical management programs, procedures or activities; peer review; quality improvement and performance improvement programs, procedures and activities; utilization management or review; risk adjustment, CMS quality rating programs and other programs, procedures and activities deemed appropriate by Highmark for assuring quality care, cost effectiveness of care, and patient satisfaction.

Independent Quality Review

Provider shall comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider services for Members. As required or appropriate, the Provider will participate in and cooperate with Highmark's efforts to develop quality improvement, cost containment, or coordination of health services as well as to develop, compile and report performance standards, statistics and other information for dissemination to Members and the general public regarding operation costs, utilization patterns, availability and accessibility of services, and satisfaction with Highmark and Provider services.

HIPAA / PRIVACY

Medical Records and Protected Health Information

Medical Records and all Protected Health Information **(PHI)** are subject to various statutory and regulatory privacy standards, including, without limitation the regulations of state Insurance Departments implementing the provisions of Title V of the Gramm-Leach-Bliley Act, the Health Insurance Portability and Accountability Act (**HIPAA**), the HIPAA Privacy and Security Rules, and other applicable statutory and regulatory privacy standards required by federal and state programs. Both Highmark and Provider agree to abide by all applicable Laws regarding confidentiality and disclosure and shall treat all such records and information in accordance with those standards, and shall use or disclose Protected Health Information only for the purposes stated in the Agreement or to comply with judicial process or any applicable Law.

Provider further agrees that Provider will adopt or has adopted such policies and procedures, will execute or has executed such written agreements, and will provide or has provided such further assurances, as required to make Provider's activities under the Agreement compliant with any regulations of the United States Department of Health and Human Services adopted pursuant to HIPAA, including, without limitation, the following:

Business Associate Agreements	45 C.F.R. §164.504(e); and
Information Safeguards	45 C.F.R. §164.530(c); and
Standard Transactions	45 C.F.R. Part 162; and
Data Security	45 C.F.R. Part 164. Subpart C

If the regulations adopted pursuant to HIPAA are modified in any way that affects the terms and conditions of the Provider's Agreement with Highmark or any additional relevant exhibits, administrative requirements, or Provider's obligations thereunder, Provider and Highmark agree to adopt such policies and procedures, execute such written agreements, as applicable, and provide such further assurances as may be required to make Provider's and Highmark's activities under the Agreement compliant on or before the final compliance date of any such modifications.

The parties agree that all communications between Provider and Highmark that are required to meet the Standards for Electronic Transactions, as set forth and defined in 45 C.F.R. Part 162 of the HIPAA Privacy Rule, shall do so. For any other communications between Highmark and Provider, Provider shall use such forms, tape formats or electronic formats as Highmark may approve.

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HIPAA / PRIVACY, Continued

PHI and Member Consent

The parties acknowledge and agree that the HIPAA Privacy Rule permits Provider to provide Protected Health Information to Highmark for purposes of Treatment, Payment and Health Care Operations (each as defined by the HIPAA Privacy Rule) without a consent or authorization, except for psychotherapy notes.

The definition of Health Care Operations includes, but is not limited to:

- Quality assessment and improvement activities,
- Activities related to improving health or reducing health care costs,
- Case management and care coordination,
- Credentialing of Providers, and
- Evaluating Provider performance.

Provider agrees to provide information or authorize other Providers to provide information, including Protected Health Information, to Highmark for purposes of Treatment, Payment and Health Care Operations activities in accordance with the requirements of HIPAA and other applicable federal or state requirements without the authorization or consent of Member who is the subject of the Protected Member Information, unless such consent is otherwise required by state or federal Law, including, but not limited to, applicable state laws regarding disclosure of inpatient mental health records, involuntary outpatient mental health records, HIV-related information, and information regarding drug or alcohol abuse or dependence. In those instances where a Member's consent is required, Provider will obtain such consent.

NaviNet® is a registered trademark of NaviNet, Inc., which is a separate company that provides a secure, web-based portal between Providers and health care insurance companies.