Highmark Response

Highmark contracts with the federal government to offer Medicare Advantage plans annually. Medicare Advantage is a federally designed program, governed at the federal level. The Centers for Medicare and Medicaid Services (CMS) oversees the Medicare Advantage program and administers the rules, regulations, and oversight mechanisms to which the program must adhere.

CMS funds Medicare Advantage plans through a per capita reimbursement from CMS and Stars/quality bonus payments. CMS adjusts the per capita reimbursement based upon each member's relative risk, so that a Medicare Advantage plan receives a higher reimbursement for sicker members since it costs more to cover their care. The quality bonus payment is made to plans that receive a rating of 4 Stars or higher in the annual Stars/quality ratings. In addition to revenue from CMS, Medicare Advantage plans are also funded through member premiums and cost sharing. CMS regularly reviews and audits Medicare Advantage plans adherence to these rules and regulations to ensure Medicare beneficiaries are receiving appropriate benefits and care, as well as ensuring these federal funds are used properly.

Highmark takes this responsibility very seriously. As required by CMS, Highmark regularly participates in these annual oversight and audit activities. To comply with these rules and regulations, and to ensure Highmark Medicare Advantage plans are executed in alignment with CMS's intent, Highmark engages in robust Stars quality and risk adjustment activities, and continually refines and improves those programs to ensure compliance with regulations and better outcomes for our members. Outlined below are further examples of our robust Stars quality and risk adjustment programs.

Highmark's Medicare Advantage plans are among the best in the industry when it comes to quality, as demonstrated through CMS's annual Star rating. Each year, CMS rates MA plans' overall quality on a scale of 1 Star (poor) to 5 Stars (excellent). These ratings take into account how well health plans score in five categories that include: keeping members healthy and up-to-date on preventive care measures; managing chronic health conditions; member experience; handling problems and complaints; and customer service.

The Star rating allows Medicare beneficiaries to compare the quality of Medicare Advantage plans so they can make an informed decision when choosing a plan. Our ratings continue to be very strong, with most plans achieving a 5-Star Rating – the highest score possible. According to CMS, of the 507 Medicare Advantage plans receiving a Star rating for 2023, only 57 plans nationwide achieved the 5 Star designation. Highmark alone had four plans that achieved 5 Stars. We also invest the quality bonus payments into our products in the form of lower premiums and enhanced benefits, which help defray out-of-pocket costs for members. But since the measurement period predates the launch of the DE Medicare product, our DE plan is officially designated "too new to score" for 2023. However, again, our overall approach to quality and results across our entire footprint demonstrate we are among the top performers.

Highmark maintains an enterprise-wide approach to Stars/quality, understanding that Star ratings are a representation of the entire member experience, from clinical care to operations and satisfaction. Our approach to quality is rooted in our philosophy of clinician-led care. As an insurance carrier, Highmark has the unique perspective of maintaining visibility into a member's entire health journey. Members may seek care across a spectrum of clinicians and facilities, but Highmark remains the common link. Therefore, we deploy robust primary care engagement and incentive programs to ensure primary care

providers have line of sight into Highmark members' conditions, as well as progress against universally recognized quality metrics, as defined by the National Committee for Quality Assurance (NCQA), the Pharmacy Quality Alliance (PQA) and CMS. This includes preventative care, such as cancer screenings, chronic care management, such as diabetic testing and blood pressure monitoring, and adherence to prescription drugs, among other things. Continuous attention to these items leads to a better experience for members and a constant focus on driving health outcomes. This aligns to CMS's intent of the program.

Not only does Highmark provide comprehensive data, reporting and tools to support providers, we also provide financial support to ensure our providers have the resources to pursue these outcomes. Highmark recognizes that providers need support to conduct patient outreach, prepare charts, conduct follow-up activities, all in pursuit to meeting quality standards. This empowers providers to continue driving toward better health outcomes.

Similar to our approach to Stars/quality, Highmark's risk adjustment programs are aligned with CMS's intent that all members receive the level of care appropriate to meet their unique health needs. It is important to Highmark that our members' conditions are evaluated and captured accurately. This supplies CMS with the information needed to adjust the per capita reimbursement to align with the anticipated cost of care.

Appropriate risk coding allows for a more thorough view into members' conditions, which gives providers extra assurance they are delivering appropriate care based on comprehensive and accurate data. We have also worked with providers to reduce administrative burden through direct data flows, which decrease the reliance on manual medical record retrieval. This allows providers to spend more time on patient care.

Several years ago, as part of Office of Inspector General's (OIG) oversight activities of the Department of Health and Human Services (HHS) programs, including Medicare Advantage, OIG began conducting routine risk adjustment validation audits. Most large payors were selected for one of these audits, including Highmark, with more audits anticipated to be published. Highmark holds multiple contracts with CMS through different legal entities. The one contract that was subject to this OIG audit was held with Highmark Senior Health Co. This audit focused on diagnoses that were at higher risk for being miscoded and billed by providers from 2014-2015 which does not apply to Delaware.

It is important to note that Highmark disagreed with OIG's findings and recommendations on several grounds. Specifically, OIG's audit narrowly targeted records with high likelihood of provider coding errors, however OIG did not include instances of under-reported codes by providers, which understated the acuity of the population. In Highmark's response, Highmark's review and analysis demonstrated that had OIG targeted both under and over coding records for this audit, the results would be materially different. Highmark employs vigorous and diligent compliance and monitoring programs, and OIG did not make any specific recommendations for improvement in its report.

Highmark was referenced in this one chart in the New York Times article because Highmark is considered among the nation's leading Medicare Advantage carriers because of the number of Medicare members we service across Pennsylvania, Delaware, West Virginia and Western and Northeastern New York, but we are one of many plans who underwent an OIG audit. There are many other plans who are

not listed in the New York Times article who also went through the OIG audit process, and OIG has published similar reports and recommendations on varying audit scopes for other plans.