Value-Based Care at Highmark:

Creating a remarkable health experience, freeing people to be their best.

HIGHMARK IS AN INNOVATOR IN VALUE-BASED CARE DELIVERY AND REIMBURSEMENT METHODS THAT POSITION PHYSICIANS TO PROVIDE HIGH-QUALITY AND HIGH-VALUE CARE TO OUR MEMBERS.

The work done within our network demonstrates Highmark's commitment to advance the Institute for Healthcare Improvement's quadruple aim:

Our value-based care (VBC) strategy emphasizes shared accountability for patient outcomes and expenses with our network providers. We align incentives to ensure everyone is working toward common care and cost goals. By influencing all provider types and care settings, we believe we can truly improve health outcomes and costs, as well as the patient and provider experience. We collaborate with our physicians and hospitals to provide the information they need to thrive in VBC, including insightful tools, custom reporting, and personalized field-based support dedicated to value-based programs.

We have successfully designed and implemented various new value-based initiatives for physicians and hospitals in the past few years and continuously expand and improve upon existing programs. The following pages give you a closer look at the difference we and our providers are making in preventive and skilled care. Their success reduces costs and, most importantly, keeps patients free to do the things they love and to be their best.

WHY VALUE-BASED CARE?

AT HIGHMARK, OUR MISSION IS TO CREATE A REMARKABLE HEALTH EXPERIENCE, FREEING PEOPLE TO BE THEIR BEST.

A Message from Dr. Tony Farah, Executive Vice President and Chief Medical & Clinical Transformation Officer

Our VBC programs are a major part of that mission. From continuously enhancing existing programs to introducing new ones that address emerging health challenges, our No. 1 priority is to give physicians and hospitals the tools, data, and resources they need to deliver the best, highest-quality care possible to over 2 million Highmark members under their care.

We emphasize supporting people's health rather than treating them after something goes wrong.

We reward providers who excel at keeping patients healthy and helping members with chronic conditions like asthma and diabetes stay in control and avoid emergency care or hospital stays.

We've been innovators in value-based strategies for more nearly 30 years — starting with a quality improvement program for physicians in 1993. In 2002, we became one of the very first health plans to offer a pay-for-value hospital program.

Today, we continue to put more than a quarter century of knowledge to work to develop cutting-edge VBC approaches for our members and providers.

Our History With Value-Based Care

1993	First physician quality program
2002	First hospital pay-for-performance program
2012	Expanded to networkwide Patient-Centered Medical Home (PCMH) model
2013	Introduced Accountability Care Organization (ACO) model
2017	Launched new foundational physician program — True Performance
2018 to Present	Introduced and broadened specialty care programs

To help physicians make more informed care decisions, our data experts share long-term historical member care information that shows what health issues they've had and treatment options that worked and didn't work. Our chronic care teams help providers monitor our members who have chronic conditions to ensure they complete scheduled screenings and adhere to medications. Our dedicated support staff team with providers on proven practice strategies that lead to high-quality outcomes and lower cost.

On the following pages, you'll see examples of the success of our primary care, specialist, facility, and skilled care value-based programs. These achievements are the result of the hard work and dedication of our providers and our value-based staff and support teams.

While we're proud of these accomplishments, we are firmly focused on the future. We are committed to delivering a remarkable health experience for our members. One in which they get the right care, at the right time, and in the right place.

MAKING A DIFFERENCE: MORE EFFECTIVE, MEANINGFUL VBC

HELPING PEOPLE STAY HEALTHY AND REACH THEIR FULL POTENTIAL REQUIRES TRUE COMMITMENT AND ATTENTION TO DETAIL.

A Message from Jason Renne, Senior Vice President, Provider Partnerships and Contracting

That's why at Highmark we go beyond the traditional techniques of VBC program development with a comprehensive, six-pillared approach that delivers simple, more effective primary and pediatric care, specialty care, hospital care, post-acute care, and home health programs with meaningful results.

Pillar 1: Methodology Development

Our systematic enterprise-wide strategy ensures our programs meet all regulatory requirements and address a wide variety of patient needs rather than just specific conditions or interventions. It also builds in the flexibility needed to best serve our commercial adult and pediatric members, as well as those in Medicare Advantage and Medicaid programs. And, whenever appropriate, it aligns all provider payment methods across all lines of business.

Pillar 2: Analytics

Highmark's people, process, technology, and data structures set us apart. We have a robust and diverse set of resources to support our programs and deliver continuous improvement and evolution. Our strong analytical capabilities, combined with partnerships with other technical innovators, enable providers to optimize their performance in Highmark's programs.

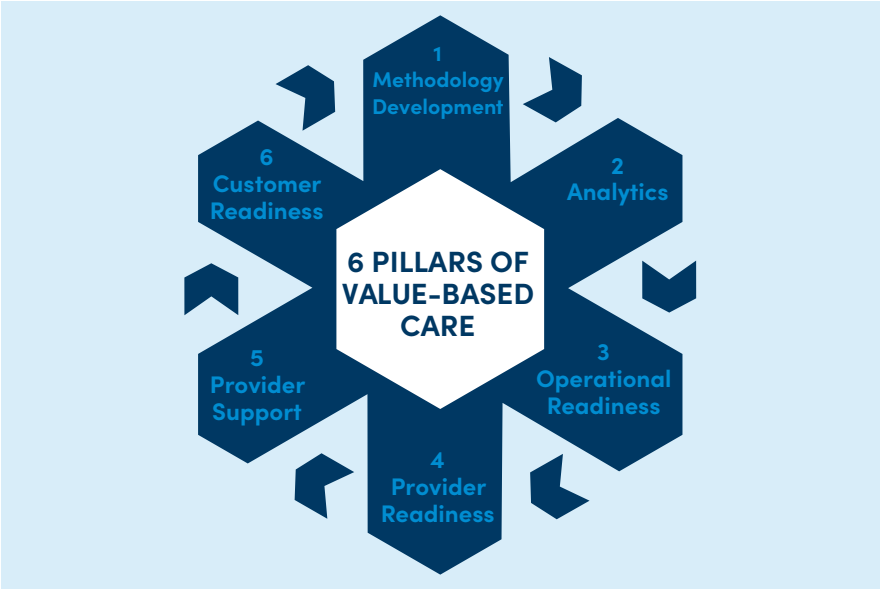
Pillar 3: Operational Readiness

Our forward-looking readiness model considers workforce, capabilities, and technology to give the business more flexibility to administer VBC strategies.

Pillar 4: Provider Readiness

We assess provider readiness annually based on their culture, capabilities, and capital position to maximize their potential for success within our new and existing programs. Aligning provider capabilities with the right Highmark VBC program enhances not only their performance but ultimately the health of our members. We offer a variety of program types and incentive structures to best suit each provider's readiness, from the entry-level True Performance Lite program all the way to advanced risk share opportunities

Pillar 5: Provider Support



We share responsibility for patient outcomes with our network providers and support them through our Clinical Transformation Consultants (CTCs) who work directly with providers toward common care and cost goals. CTCs live in the same communities as the providers they support and understand the unique local health care systems, members' needs, and challenges.

Together, these VBC experts and providers use chart reviews, Highmark's best-in-class reporting packages, health care analytics, and self-service tools to create focused, attainable action plans and goals that improve the quality of care our members receive. This includes our curated health solutions (CHS) that offer data-based, personalized, clinician-prescribed, fully integrated solutions for promoting and preserving a person's whole health — physical, mental, social. Our CHS team works with providers to give members access to personalized, alternative preventive services that can reduce reliance on emergency room treatment, keep them healthier, and reduce costs. The Onduo Well360 Diabetes Management program —

an at-home type 2 diabetes management solution — is just one example. It offers patients simplified glucose monitoring and support for managing medications, diet, and activity. It even provides access to a personal health coach, diabetes educators, and virtual visits with doctors, as needed. CHS also has or is developing programs to address hypertension, heart failure, kidney disease, and plans to offer virtual primary care, behavioral health, and physical therapy solutions.

Pillar 6: Customer/Client Readiness

Of course, a VBC program has no value if our customers can't benefit from it. That's why we develop our programs and solutions to address the needs of all of our customers. And we work in tandem with our product and benefits team to consider regulatory requirements, verify that benefit structures align with the program incentives, and ensure that our programs truly provide value to our clients.

This is especially important as increasing numbers of employers now offer their own customized insurance plans. As an administrator for these plans, Highmark actively seeks ways to better communicate and demonstrate the value of our VBC programs to clients as we reimburse physicians for non-traditional services that meet the unique needs of our clients' employees and their families. Furthering that mission, Highmark details the efficiency of our programs down to the client level. With this enhanced transparency, clients are able to make a direct connection to the cost-saving benefits of Highmark's VBC.

MAKING A DIFFERENCE: THE IMPACT OF VALUE-BASED CARE

A Message from Kayvin Robertson, Vice President, Provider Contracting and Relations

Driving Improved Performance

Maximizing our members' health is at the heart of all our VBC programs. That's why we go beyond traditional VBC programs and reimbursement approaches with age-appropriate, localized strategies that prevent higher-cost care, such as emergency department usage and hospital admissions.

We've carefully chosen nationally sourced clinical quality metrics that focus on prevention, screening, and wellness; address our members' most common medical conditions; and give physicians and hospitals the greatest opportunity to positively impact their health

HELPING PEOPLE STAY HEALTHY AND REACH THEIR FULL POTENTIAL IS WHAT DRIVES US AT HIGHMARK.

We also look beyond our members' clinical needs to address social determinants that can impact how members access care services and how well they manage their health. For example, our CHS team will pilot a mobile integrated health program in coordination with Allegheny Health Network to assist members in better managing their chronic conditions. These innovative approaches ensure we address local health care challenges and opportunities for all pediatric, adult, and senior patients and support and encourage providers to achieve the best possible outcomes.

Our emphasis on local care solutions is shared by the Blue Cross and Blue Shield Association and is a major difference to the one-size-fits-all approach of our national competitors. Even within our own service areas, we work with providers on care innovations that best meet our local members' health care needs.

To make certain our programs' performance measurements are fair and match our local focus, metrics are set based off the experience in our markets so that providers are compared to their peers rather than national outcomes for pediatric, adult, and senior care. To further ensure fairness, physicians in our programs are compared to one another for cost analysis, benchmarks, risk adjustment, and total cost of care based on the panel of patients they see. So rather than just comparing primary care to primary care, we evaluate pediatric to pediatric, adult to adult, and so on.

We understand there are certain nuances for each patient segment and each provider type. Our programs account for those differences with specific views for each segment and provider type to drive performance.

Our focus is more than just primary care. To further emphasize VBC members receive in facilities, our legacy hospital program is being restructured and will be launched as True Performance Hospital. The new program will have even more influence on inpatient and outpatient

spend and will focus on lowering costs per episode below a set target price. It will incorporate more nationally recognized outcome, safety, and appropriateness metrics and best practices that address local care challenges. It will reward hospitals that improve quality and control costs and utilization as compared to their peers.

In addition, we have a growing list of programs that address specialist care, maternity, skilled nursing, site of care, and substance use disorders.

Most importantly, we are moving beyond traditional bonus programs and driving change through risk-reward arrangements and components. Perhaps the most high-profile example of this is our PCP Value-Based Fee Schedule Adjustments initiative, which ties a positive or negative adjustment to PCP standard fee schedule claims reimbursement to select VBC performance. We are the only commercial payer in the U.S. with an initiative of this kind.

Keeping It Simple, Sharing Timely Data

We've carefully chosen nationally sourced clinical quality metrics that address our local health care population and focus on prevention, screening, and wellness to address our members' most common medical conditions. This method gives physicians and hospitals the greatest opportunity to positively impact their health.

We regularly provide timely, actionable data for our providers. We are preparing to introduce an intuitive, easy-to-use, and interactive platform for monthly and quarterly True Performance reports that will enhance providers' abilities to identify and close care gaps and drive performance.

This platform gives providers high-level financial and quality performance data through dynamic, navigable reports with multiple ways to view, filter, search, and export information.

Innovation Through Collaboration

Highmark understands that transforming health care can't happen without the support and knowledge of the local and regional health care community. In recent years, we've launched extensive pediatric and adult primary care and inpatient value-based innovations and collaborations with strategic providers to deliver improved outcomes for our customers. These include:

- Using an Integrated Delivery and Financing System (IDFS) approach, advanced VBC programs are developed in collaboration with Allegheny Health Network. These programs deeply integrate AHN's clinically integrated network (CIN), specialists, and hospitals to drive quality and costs through deeper connections and program designs. This includes work on many innovations within various service lines to support a very meaningful risk arrangement that has been in place since 2021. This arrangement allows for advanced population health payments and advanced care models for the nearly 195,000 Highmark members the CIN serves.

In 2020, the CIN reduced PMPM costs by an average of nearly 2% and Emergency Department utilization by nearly 10% for adults, 32% for pediatric patients, and 15% for seniors.

- A commercial pediatrics program with a major health system that provides additional incentives for decreasing total cost of care for children with chronic conditions and keeps new specialist visits in the local system to provide the most cost-effective care.
- An incentive-based hospital reimbursement model focused on controlling key episodic costs and achieving quality metrics.
- An advanced VBC gain share program for managing total cost of care against a PMPM target compared to market and achieving quality metrics.

These collaborations have also enabled several joint clinical and quality teams to include clinical management and enhanced data sharing and reporting and to facilitate the management of the programs and the populations served. As these collaborations mature, we are working with these providers on risk-based reimbursement models that include clinically appropriate downside risk tied to performance.

Taken together, all these components demonstrate our comprehensive, ambitious, value-based approach to helping our providers achieve exceptional performance and giving our members a remarkable health experience.

The next few pages provide specific examples* of the impact our VBC programs have had on quality and cost-savings for our members.

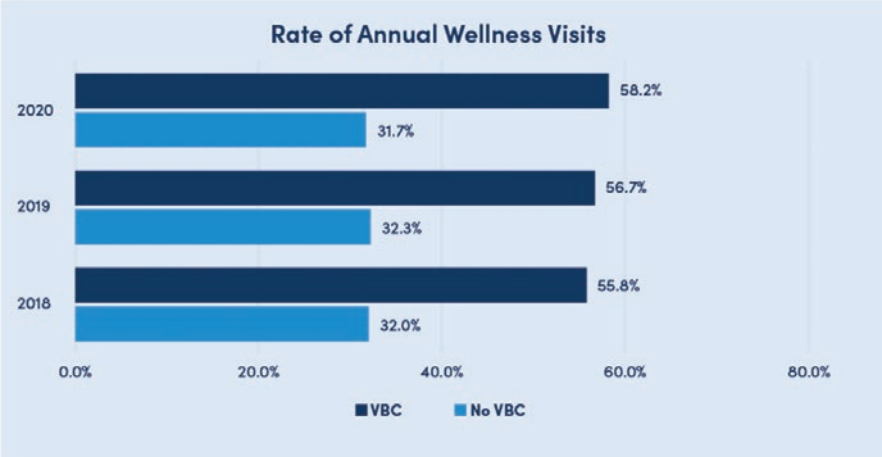
*VBC PROGRAM RESULTS ARE BASED ON 2020 YEAR-END DATA AND WILL BE UPDATED ACCORDINGLY WHEN CY2021 DATA IS AVAILABLE.

COORDINATION OF CARE RESULTING IN MEASURABLE IMPROVEMENTS

Across all lines of business, physicians in VBC programs are making an impact. PCPs are focused on preventive care such as annual wellness visits and cancer screenings.

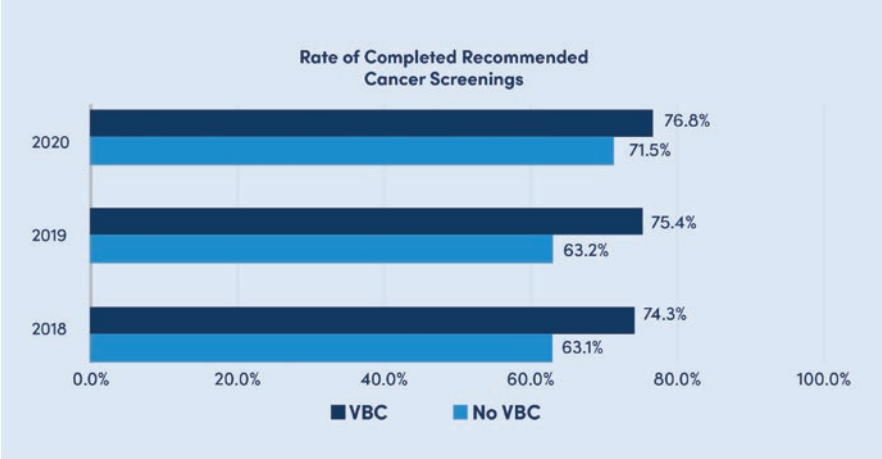
Annual wellness visits help our members succeed in their health and life journey. Not only do annual wellness visits provide physicians with an update on a member's overall health, but they may also identify health problems early.

In three years, nearly 164,000 additional annual wellness visits associated with providers participating in a VBC program have been recorded.



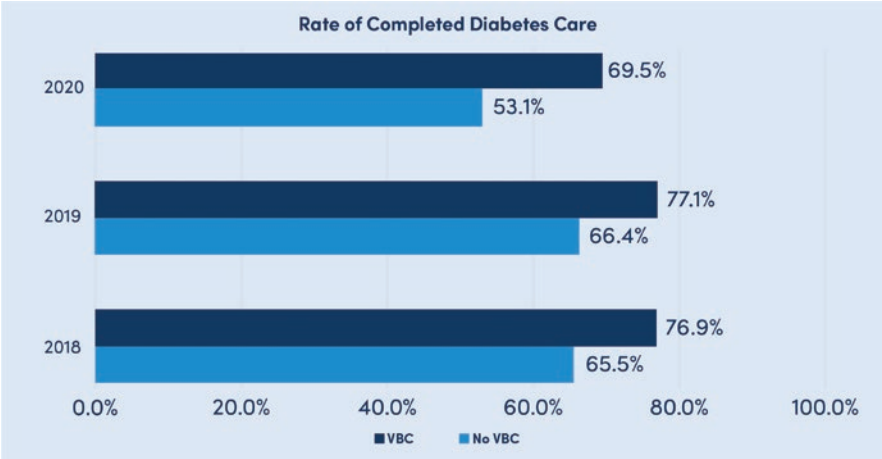
Cancer screenings also help our members succeed in their overall health. Screenings may find cancer in earlier stages, which then increases the chances of successful treatment.

In three years, more than 154,000 additional cancer screenings were completed by providers participating in a VBC program.



The data shown measures the rate of completion for breast cancer and colorectal cancer screenings.

Chronic diseases such as heart disease, cancer, and diabetes are leading causes of death in the United States. Members with chronic conditions require extra care and coordination with their physician to help monitor progression of the disease and medication adherence.



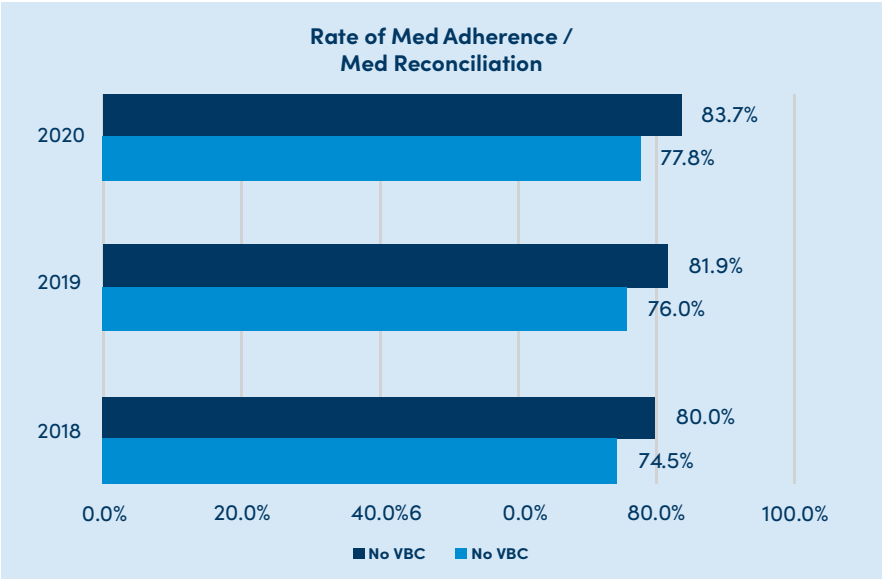
The above data measures the rate of completion for diabetes care screenings for nephropathy and retinal eye exams performed.

Diabetes care measures are in place to help monitor the health of members with this disease, evaluate their compliance with recommended care, and to prevent diabetes-related complications from occurring.

In three years, nearly 83,000 additional diabetes care gaps were closed by providers participating in a VBC program.

Taking medications as prescribed is another important aspect of caring for members with chronic disease as adherence often improves health outcomes. Medication reconciliation is just as important to help prevent further complications.

In three years, medication use monitoring and planning showed improved medication adherence for more than 97,000 members associated with participation in a VBC program.



Data includes appropriate statin therapy use, medication adherence for statin use/ diabetes medication, compliance in medication therapy management, and medication reconciliation post-discharge.

A COMPREHENSIVE, TRANSFORMATIVE APPROACH TO QUALITY, HEALTH, AND VALUE

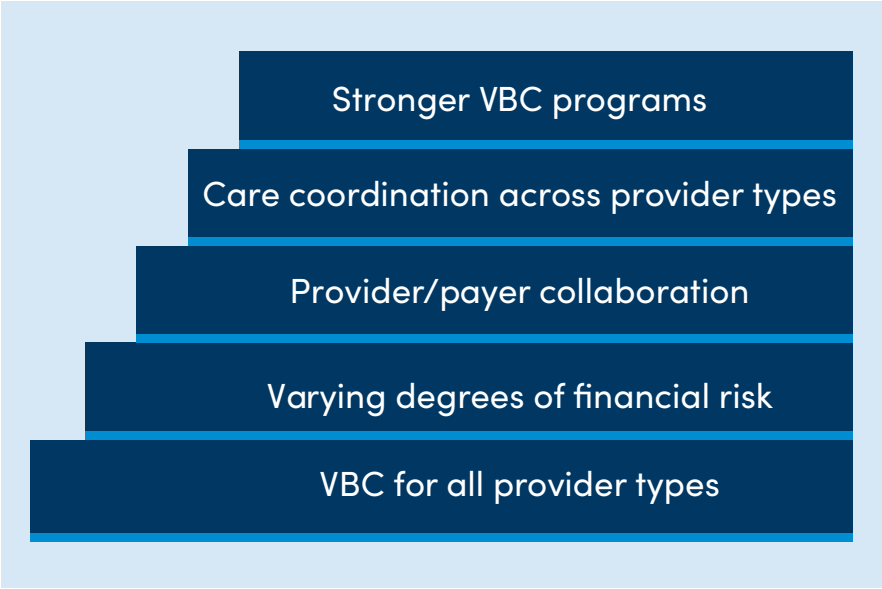
The health care challenges our members face are diverse and constantly changing. That's why we take a comprehensive approach to VBC, with programs that span primary care, specialty care, hospital and ancillary facilities, and post-acute care.

It's also why we continuously enhance our existing programs and challenge providers to innovate in managing our members' health. Part of this process is moving providers from our base programs into more advanced models that encourage greater provider/payer collaboration and build stronger programs with increased potential for cost reduction and quality improvement.

Our VBC programs also are cornerstones to Highmark's Living Health strategy. Living Health blends the relationship between patient and provider through the use of technology, actionable data, and local strategic collaborations with providers.

Strategic collaborations and affiliations allow Highmark to invest in new, transformative primary care, hospital, post-acute, and specialty care capabilities — which translates to better outcomes, lower costs, and greater access for our members. The strategy also involves incentivizing providers as aggressively as possible to deliver high-quality care at a more affordable price point. Likewise, we decrease reimbursement for unnecessary and lower-quality care.

Across the Highmark enterprise, our connected suite of VBC solutions and providers minimizes overlap and duplicative costs for our members, and streamlines data sharing and clinical recommendations. For example, Helion, Highmark's home and community care organization, has more than 400 home health and skilled nursing providers engaged in VBC arrangements. Helion continues to increase its pay-for-value influence in post-acute care while it empowers providers to deliver increasing value.



Highmark-specific clinical programs — including but not limited to care management, utilization management, transition of care, and our Well360 program suite — further demonstrate the linkage between quality outcomes, cost, and value.

2.4 million members eligible for care under VBC program

84% managed by at least one VBC program

41% managed by multiple VBC programs

Our full suite of VBC programs rewards providers for driving patient outcomes and placing patient care at the center of reimbursement. We're excited and proud of the success these programs have had so far.

Approximately 81% of Highmark medical spend is associated with providers participating in a VBC program.

Approximately $1.86 billion in potentially avoided costs to date*

Primary Care	**$1.81 billion**
Hospital/Facilities	**$33.9 million**
Specialty Care	**$2.3 million**
Post-Acute Care	**$12.1 million**

* Through June 30, 2021

CY2020 Plan Spend by LAN APM Category

Highmark		[1]Blue System	[2]Other Payers
19.2%	Fee-for-Servive: No Link to Quality & Value	52.21%	39.3%
18.3%	Fee-for-Servive: Link to Quality & Value	15.01%	19.8%
50.3%	APMs Built on Fee-for-Service Architecture	30.43%	34.2%
12.2%	Population-Based Payment	2.35%	6.7%

[1]CY2020 Blue System Healthcare Payments by APM Category
[2]Health Care Payment Learning & Action Network. Measuring Progress: *Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage and Traditional Medicare Programs.* December 15, 2021

PRIMARY CARE

Many patients begin their interactions with the health care system under the care of a primary care physician (PCP). We believe that PCPs are critical to transforming care and influencing better outcomes and better patient experiences for our members. With nearly 2 million attributed Highmark members and 85% of eligible PCPs, True Performance, our foundational program for PCPs, is one of the largest risk- and value-based reimbursement programs of its kind in the country.

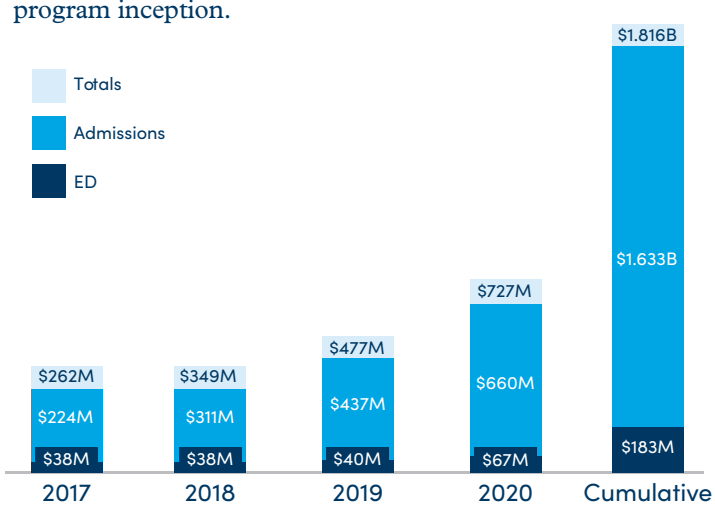
TOTALS:

- **430+** contracted entities
- **2,000+** practices
- **10,000+** PCPs
- Nearly **1.9 million** attributed members
- Almost **42%** in advanced arrangement

Since it started in 2017, PCPs in the program have helped to potentially avoid nearly $1.9 billion in health care costs due to lower rates of emergency care and hospital stays.

Additional costs-avoided trends are as follows:

- **Emergency Department (ED) Utilization** costs avoided have remained consistent over the four-year history of the program.
- **Savings from costs avoided** related to **Inpatient Admissions** has **increased** by an average of approximately **70% each year** since program inception.



We also have advanced shared savings and shared risk arrangements that encourage provider/payer collaboration and boost potential quality improvement and cost savings.

HOSPITAL/FACILITIES

The Quality Blue Hospital Pay for Value (P4V) program helps hospitals align care with industry standards and best practices to better manage the care our members receive and improve outcomes. Hospitals in the program focus on key health care quality and patient safety issues that align with national measures and standards, reduce inpatient hospital waste, and lower the cost of select episodes based off comparison to market. And, beginning in 2023, our new True Performance Hospital program will expand the number of quality metrics and introduce advanced cost and utilization metrics for inpatient and outpatient episodes, including outpatient surgery. The new program will place even greater emphasis on improving quality and cost performance.

In the past five years, hospitals in the program have amassed approximately $34 million in potentially avoided costs related to emergency care, hospital admissions, and care episodes.

TOTALS:

140+ contracted entities

Nearly **30,000** licensed beds served

88% eligible hospitals contracted in program

Nearly **3.2%** decrease in costs realized for 10 episodes in 2020

Additional avoided-cost trends are as follows:

- Nearly **1,000** potentially averted readmissions generated an estimated cost savings of **$13 million** since CY 2016.
- With the average ED encounter cost of approximately **$1,122**, Highmark estimates avoided costs of approximately **$1.7 million** due to fewer return ED visits since CY 2016.
- More than **2,500** additional consultations provided for complex patients since CY 2016.

POST-ACUTE CARE

Helion, Highmark Health's home and community services affiliate, offers programs that enhance care and value for both skilled nursing and home health. The **Skilled Nursing Facility (SNF) P4V** program is focused on reducing readmissions to hospitals, transfers to hospitals for emergency care, and care episode costs — while improving outcomes and the care experience for our members.

Helion's **Home Health P4V** program, introduced in 2020, creates new solutions to improve care and delivery and enable home and community care providers to deliver increasing value and to help patients achieve better outcomes and avoid unnecessary hospitalization and emergency department visits.

In two years, these programs have achieved about $12.1 million in avoided costs, based on lower readmission rates.

TOTALS:

300+ participating facilities and

100+ agencies across PA regions

Almost **75%** of facilities in an advanced arrangement

More than **52,000** episodes managed across programs

SPECIALTY CARE

While PCPs play a major role in patient care and their health care decisions, specialists also have a big impact on care outcomes and costs, especially for our members with chronic or serious conditions.

Approximately 20% of overall spend for our members is on specialty care services.

That's why we have established an integrated solution aimed to drive the value-based journey for specialists, allowing providers to succeed across quality and cost performance.

Introduced in 2018, our **Bundled Payment Program** rewards specialists who improve care coordination, provide continuity, and reduce variability and duplication in care delivery for select medical/surgical procedures. The current program includes nearly 50 provider groups and impacts approximately 25,000 episodes and $86 million in annual spend — representing a high percentage of the care our members receive and addressing significant variance in cost across our service areas.

- Program currently includes **22 procedures.**
- Avoided costs totaled **$1.6 million** in 2020.
- Program has realized **$2.3 million** in potentially avoided costs since CY2018.

Our **Specialist Performance Initiative** shares cost profiles with specialists and PCPs to inform them about how well specialists deliver value, with the goal of reducing the overall cost of care.

Specialty Care Focus Areas

- Behavioral Health
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- General Surgery
- Nephrology
- Neurology
- OB-GYN
- Ophthalmology
- Orthopaedics
- Psychology
- Pulmonology
- Rheumatology
- Urology

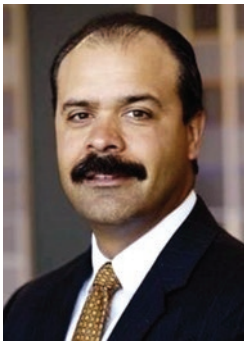
Our site of care program encourages providers and facilities to shift the volume of procedures performed in a hospital facility to a quality and cost-effective **ambulatory surgery center (ASC)**, when appropriate.

Our **maternity program** features upside-only incentives and focuses on the maternity episode, delivery, and the time period immediately following delivery.

Our first **behavioral health program** aims to improve outcomes and reduce substance use disorder-related readmissions and emergency care utilization through high-quality care, inclusive of well-planned discharge planning.

THE FUTURE OF VBC: A LARGER STAKE FOR PROVIDERS IN HEALTH CARE OUTCOMES

A Message from James Benedict, Executive Vice President, Living Health Partnerships



As you've seen on the previous pages, Highmark's value-based care programs have had great success so far as we continuously work to enhance health outcomes, reduce costs, and create the best health care experience for our members and providers. But we know there is more to do.

We are committed to finding new and advanced ways to continue to help our members — and our providers — reach their full potential through shared accountability and effective health management.

One of the biggest ways we're doing that is by giving physicians and hospitals in our value-based programs a larger stake in health care outcomes through shared savings and shared risk reimbursement opportunities. We'll continue to drive providers to achieve even higher levels of performance by offering greater rewards for delivering high-quality and high-value health outcomes.

Our high-performing providers who are ready to take on more financial risk have been moving to our advanced programs that feature these types of payment arrangements. And we expect larger numbers of them to transition to risk-based incentives in the coming years as they become more experienced with our value-based programs.

Greater Reward for High-Quality, High-Value Care

In July 2021, our PCP Value-Based Fee Schedule Adjustment began tying standard fee schedule reimbursement to measures of high-value care, for PCPs in our value-based programs in Pennsylvania and West Virginia, reducing costs for patients, and improving health outcomes.

These providers will now earn more than the standard fee schedule when they pass performance targets, and less when they don't.

We will continue to anticipate the changing health care landscape so that our VBC programs and participating physicians are best prepared for tomorrow's challenges. We want our members to be assured they're receiving the best, highest-quality, and most cost-effective care possible.

We are excited about our future and are confident that we — and our members — can reach our full potential.

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