Benefit Enhancements Technology Implementation

NW Momentum Health Partners ACO
Lewiston, ID
March 21, 2019

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Objectives

- Review benefit enhancement implementation status
  - Direct SNF admission
  - Post-discharge home visits
  - Care management home visits
  - Chronic disease reward program
- Review technology implementation status
  - Innovaccer
  - Post-Acute Analytics

Drivers for Success

Driver	Provider Role/Responsibility
➢ Beneficiary Engagement	▪ Provide beneficiaries with information on Next Gen ACO and the benefit to them for care coordination ▪ Promote CMS Benefit Enhancement usage with high-risk patients ▪ Team-Based Binder ▪ Refer to care management services
➢ Provider Timely Access to Care ➢ ER Prevention	▪ Reserve same day appointments ▪ Encourage calling after hours ▪ Promote Urgent Care ▪ Utilize direct admissions to preferred network of skilled nursing facilities ▪ Refer to ACO hospital partner
➢ Practice Engagement	▪ Provider PSW access to EHR system ▪ Communicate concerns and opportunities

NGACO Benefit Enhancements for 2019

BENEFIT ENHANCEMENT	GENERAL INFORMATION	IMPLEMENTATION PLAN
3-Day SNF Waiver	Eliminates the requirement of a 3 mid-night inpatient stay before admission to SNF	Ready for implementation
Care Management Home Visit	Allows providers to initiate two care management in home visits in a 90 day period that are not home bound, to supplement provider visits to support improved health outcomes following a provider appointment.	April – May 2019
Post-Discharge Home Visit	Allows for 9 home visits in a 90 day period following an inpatient stay by licensed or certified personnel under the supervision of a provider.	April – May 2019
Telehealth	Supports beneficiaries by allowing them to originate a synchronous telehealth encounter in their home with their provider.	TBD
Cost Sharing for Part B Services	Aim is to offer cost sharing support to reduce financial barriers for beneficiaries, to support adherence with treatment plans and improve health outcomes.	June - July 2019 – will require agreements with providers and process for reporting between providers and NWMHP
Chronic Disease Management Reward Program	Allows NGACOs to provide gift cards up to $75 annually to incentivize participation in chronic disease management program.	April – May 2019

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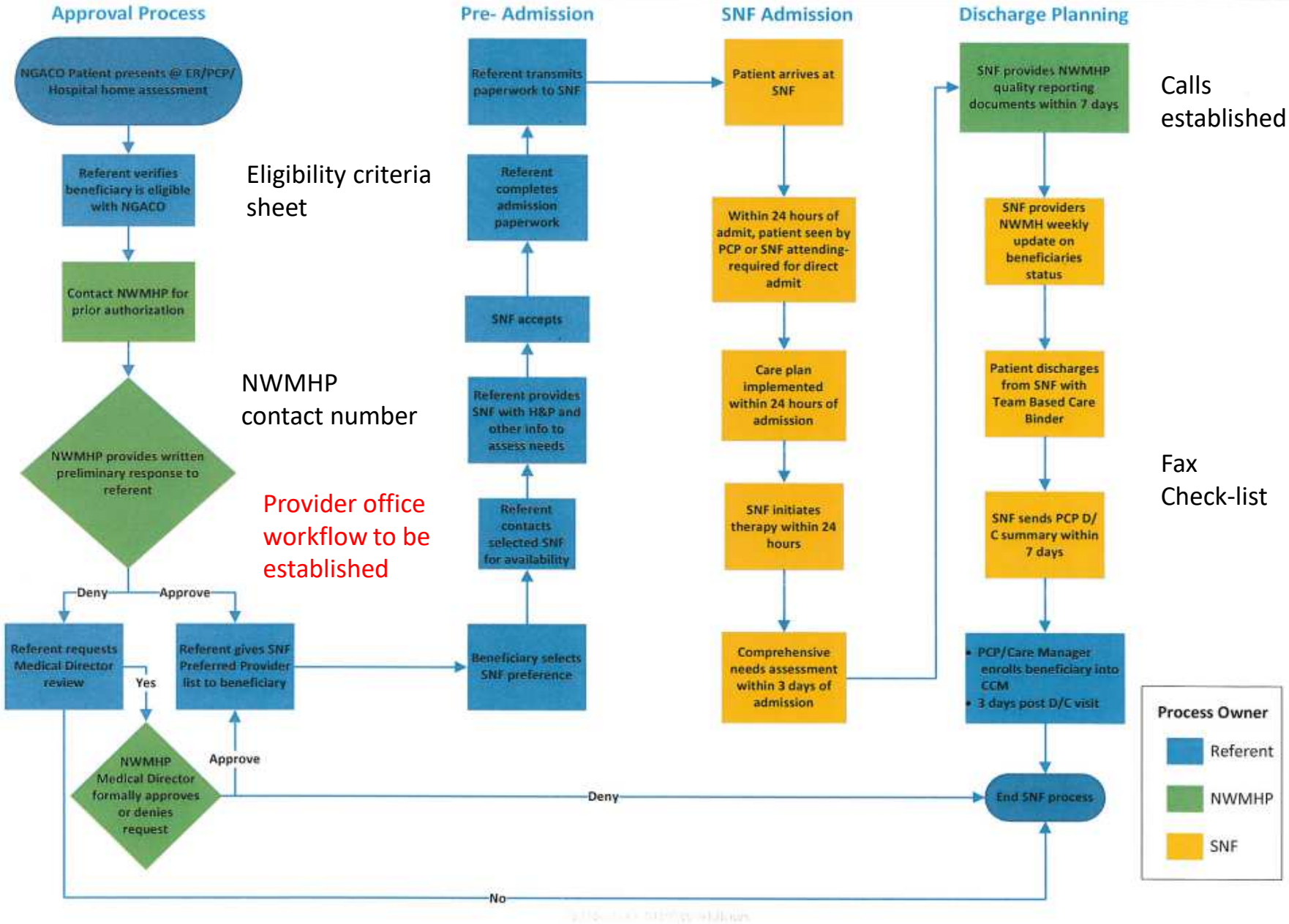

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CM1 CherylM, 3/18/2019

NGACO Benefits Enhancement: Direct SNF Admission

Referral Process		
Information for providers to contact NWMHP for prior approval	NWMHP	Completed
Written communication for documentation of approval status	NWMHP	In Development
Provider education on eligibility and approval process	CMG/SJRMC	April 2019
Informational flyers for Urgent Care and ER	CMG/SJRMC	May 2019
Pre-Admission Process		
Preferred SNF providers list for beneficiaries	NWMHP	Completed
Fax form for SNF providers	NWMHP	Completed
Physician order form (SNF physician to see patient in 24 hours)	CMG/SJRMC	April 2019
Admission Process		
SNF checklist to identify requirements for documentation	NWMHP	Completed
Fax cover sheet to provide required documents to NWMHP	NWMHP	Completed
Discharge Process		
Discharge summary to provider	CMG/SJRMC	April 2019
Team-based binder	CMG/SJRMC	Completed
Enrollment into care management services (TCM)	CMG/SJRMC	April 2019
Post-discharge survey to beneficiary	NWMHP	Process in Place
Other		
JOC Meeting schedule and agenda	CMG/SJRMC	April 2019
Development of score cards and metrics to demonstrate SNF performance	CMG/SJRMC NWMHP	April 2019

Next Steps: Benefit Enhancements

Care Management Home Visits

- Builds on the Post Discharge Home Visit Waiver to allow for hospital avoidance
- Allows for up to 2 CM Home Visits within 90 days of a provider visit
- Requires a provider initiated care plan

Post-Discharge Home Visits

- Allows for up to 9 visits post-discharge in 90 days
- Is supervised and billed out by provider
- Requires a provider initiated care plan

Chronic Disease Management Reward Program

- Permits use of gift card incentives for participation in disease management
- $75 annual limit
- Aligned beneficiaries with a specific disease or chronic condition
- Funded and distributed by the NGACO

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Care Management Home Visits - Eligibility

- Beneficiary is aligned with the ACO
- Beneficiary has an identified care management need
- Beneficiary's provider is an attributed provider within the ACO
- Care management provided within 90 days of seeing participating or preferred provider

Care Management Home Visits

- Completed needs assessment and developed care plan.
  - Review of medical history information
  - Need for or follow-up on pending diagnostic tests and treatments.
- Development of a communication plan between clinician and primary care provider
- Care provider under general supervision of physician will provide education to the beneficiary, family, guardian, and/or caregiver
- Care provider will:
  - Establish or re-establish referrals
  - Arrange for needed community resources
  - Assist in scheduling required follow-up with community providers and services.
- Medication reconciliation and support of treatment regimen and adherence.

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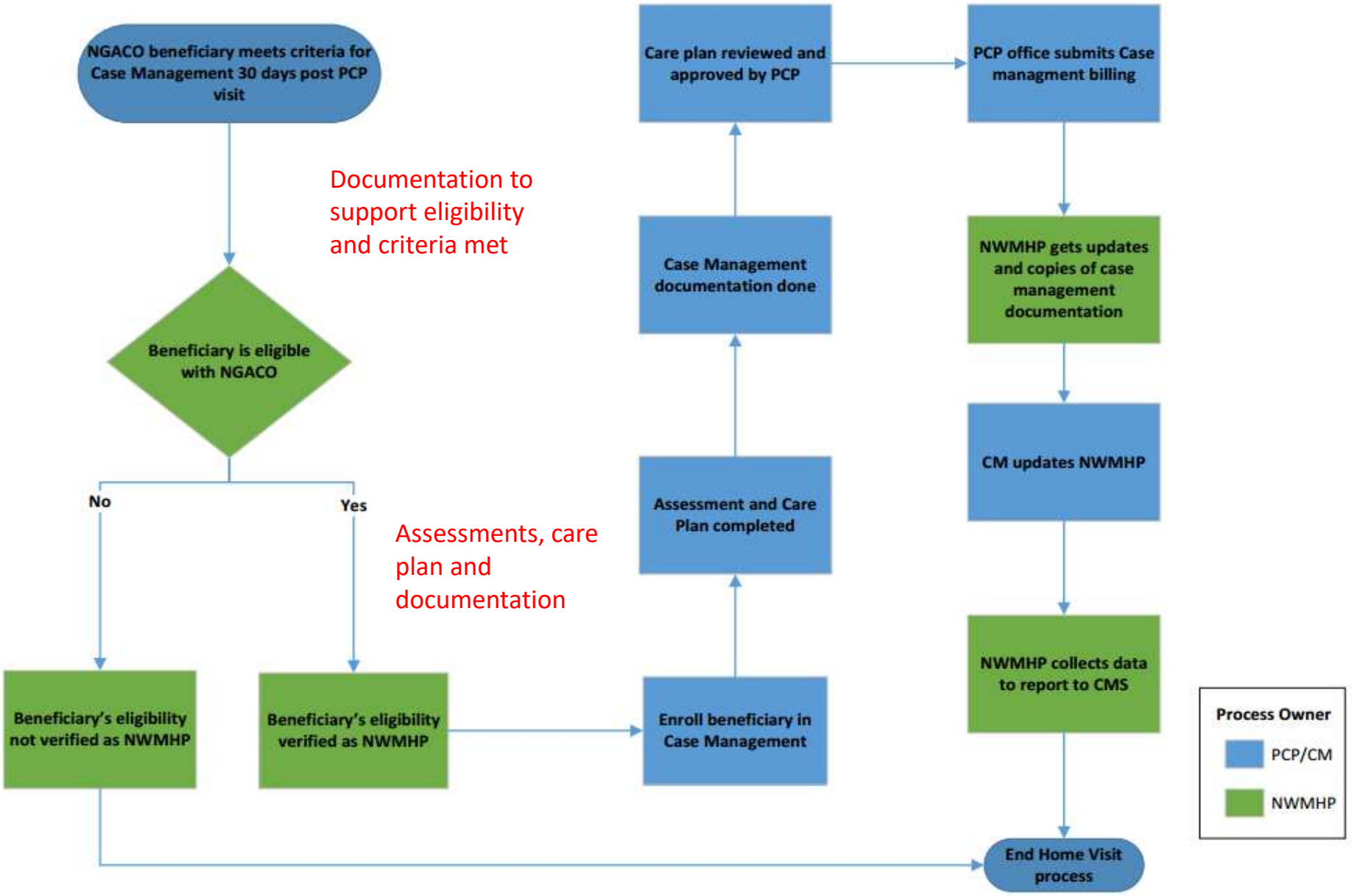
Case Management Workflow



NGACO Benefits Enhancement: Care Management Home Visits

Enrollment– Eligibility Review		
Information for providers to contact NWMHP for prior approval	NWMHP	April 2019
Provider education on eligibility and approval process	CMG/SJRMC	April 2019
Process Steps – Documentation Requirements		
Documentation Process for home visits and care plan	CMG/SJRMC NWMHP	April 2019
Billing process and coding details	NWMHP	April 2019
Process for data collection for CMS reporting • **Decision timing to utilize waiver** • **Provider type responsible for supervision of home visits** • **Provider type performing home visit** • **Care and services provided** • **Assessments completed** • **Patient identified needs communicated to primary provider**	CMG/SJRMC	April 2019
Communication Materials		
Beneficiary educational flyer	NWMHP	April 2019
Provider billing and utilization informational flyer	NWMHP	April 2019

Post-Discharge Home Visit - Eligibility

- Beneficiary has discharged from an inpatient qualifying stay
- Beneficiary does not qualify for home health services
- Services will be provided within the beneficiary's home or place of residence during the period after discharge from an inpatient facility.
- Beneficiary is aligned with the NG ACO

Post-Discharge Home Visit - Criteria

- Multiple chronic co-morbidities
- Evidence of social risk factors
- Psychiatric, Cognition, or Substance abuse concerns
- New diagnosis and/or medication change
- Abrupt change in functional status
- Recovering from major surgery (or minor surgery with complications)
- History of frequent hospital admissions or re-admissions
- Implemented within 30 days of inpatient discharge

Post-Discharge Home Visit

- Qualified home visit providers include:
  - MD or DO
  - NP or PA
  - RN
  - Therapist
  - Pharmacist
  - Care coordinator
  - Care manager
  - Social worker
  - Home health aide
  - Paramedic or EMT
  - Community health worker (CHW)

Post-Discharge Home Visit

- Care and Services Provided
  - Medication management/reconciliation
  - Skin and wound care
  - Medication administration
  - Nutrition care
  - Maintenance of an appliance
  - Respiratory therapy
  - Physical or occupation therapy
  - Caregiver education or training
  - Palliative consultation
  - Other (provide explanation)

Assessment Type	Objective	*Example Information Collected*
Functional	Evaluate individuals' ability to manage tasks and activities necessary or desirable in daily life (e.g., ADLs, IADLs) to determine assistance needed	*Health conditions and functional needs*
Environmental	Collect information on individuals' home environments to assess and mitigate safety risks	*Fall risk and home hazard assessment, use of personal precautions, fire and disaster risk and preparedness, and crime risk*
Social services	Collect information on the existence of and need for social supports in individuals' lives	*Instrumental support, informational support, and emotional support*
Community engagement	Measures individuals' level of engagement in their communities to determine level of isolation and mitigate negative impacts on physical and mental health	*Whether respondents feel like they belong, can be independent, and have productive activities to do in their communities*
Caregiver and family support	Examines financial, physical, emotional, and social needs and strengths of caregivers and family supports to prevent caregiver burnout	*Caregiving context, caregiver well-being, and skills/abilities/knowledge to provide recipient with needed care*
Financial status	Collects information on individuals' financial situation and capacity to afford necessary services or qualify for subsidized services	*Information necessary to qualify for a range of benefits and/or devise lower-cost treatment plans for individuals struggling financially*
Transportation	Gathers information about individuals' difficulty accessing or affording transportation to understand the impacts of transportation issues on medical care	*Whether individuals have had to go without health care because of distance or transportation, whether transportation expenses hamper access to medical care, and whether individuals have caregiver supports to facilitate access to medical care*
Cognitive function	Determines individuals' cognitive abilities to recognize early the presence of an impairment in cognitive functioning, and to monitor individuals' cognitive response to various treatments	*Current cognitive function; onset, duration, impact of potential cognitive impairment*
Behavioral health	Determines whether an individual is functioning well on a psychological, social, or developmental level to aid identification and diagnosis of mental health conditions such as depression or anxiety, substance use issues, and suicidal ideation	*Mood and affect, speech and thought process, thought content, and cognition, and other symptoms of behavioral health conditions*
Nutrition	Gathers information on individuals' food and nutrient intake, lifestyle, and medical history to evaluate nutritional status	*Anthropometric data (e.g., height, weight), biochemical data (e.g., blood, urine), clinical data, and dietary data*

Post-Discharge Home Visit

- Identified care need to support need for home visits
  - Barriers to transportation/mobility
  - Home modification required
  - Social service support needs
  - Insufficient caregiver support
  - Limited community engagement
  - Therapy need
  - Home health care need
  - Behavioral health
  - Memory and cognition
  - Patient need was identified not communicated to PCP
  - Other need identified (provide explanation)

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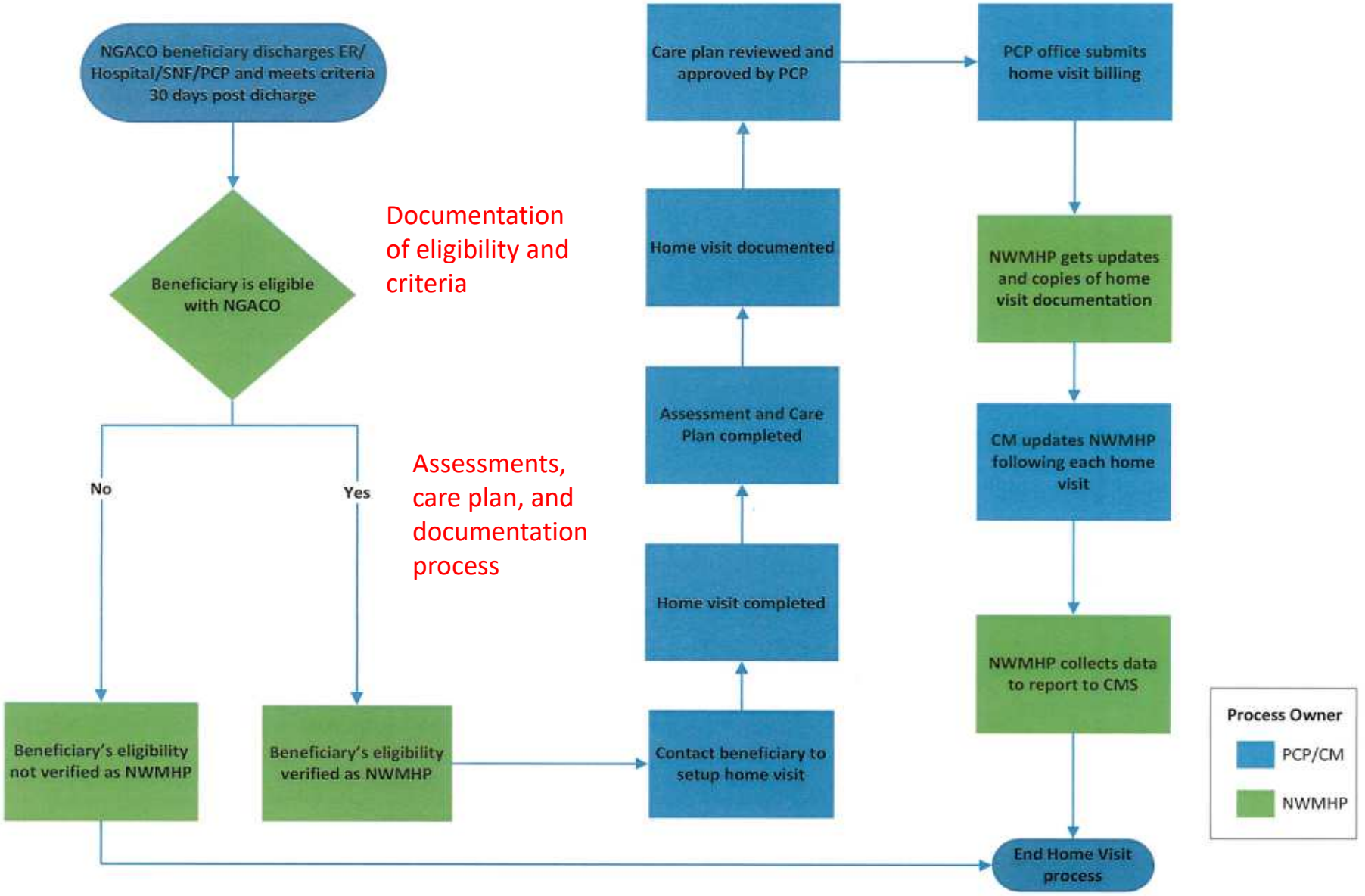
Home Visit Workflow



NGACO Benefits Enhancement: Post-Discharge Home Visit

Discharge Status – Eligibility Review		
Information for providers to contact NWMHP for prior approval	NWMHP	April 2019
Provider education on eligibility and approval process	CMG/SJRMC	April 2019
Process Steps – Documentation Requirements		
Documentation Process for home visits and care plan	CMG/SJRMC NWMHP	April 2019
Billing process and coding details	NWMHP	April 2019
Process for data collection for CMS reporting • **Patient discharging facility** • **Decision timing to utilize waiver** • **Provider type responsible for supervision of waiver-based home visits** • **Provider type performing home visit** • **Care and services provided** • **Assessments completed** • **Patient identified needs communicated to primary provider** • **Reason why total visits were not completed as indicated** • **Reason why patients who were eligible to receive a visit did not receive a visit.**	CMG/SJRMC NWMHP	April 2019

Chronic Disease Management Reward Program

- Enroll in the care management program for four months
- Participate in care management program contact minimum requirements as follows:
  - Weekly for the first four weeks
  - Biweekly for the following four weeks
  - Monthly for the remaining two months
- Participate in two home visits:
  - One at the onset of the care management program
  - One within the remaining four month period.
- Demonstrate utilization of the Team-Based Binder
- Established an Advance Care Plan such as a POLST/POST, living will or other recognized document that establishes the beneficiary's health care preferences.

NGACO Benefits Enhancement: Chronic Disease Management Reward Benefit

Eligibility Review		
Information for providers to contact NWMHP for prior approval	NWMHP	April 2019
Provider education on eligibility and approval process	CMG/SJRMC	April 2019
Process Steps – Documentation Requirements		
Documentation to demonstrate met criteria • **Evidence of enrollment in CM for minimum of 4 months** • **Evidence of contacts to meet requirements** • **Evidence of home visits** • **Evidence of Team-Based Binder utilization** • **Evidence of participation in Advance Care Planning**	CMG/SJRMC NWMHP	April 2019
Gift Card process • **Available selection** • **Process for presenting gift card** • **Documentation of beneficiary receiving gift card(s)**	NWMHP	April 2019
Process for data collection for CMS reporting	NWMHP	April 2019
Communication Materials		
Beneficiary educational flyer	NWMHP	April 2019
Provider billing and utilization informational flyer	NWMHP	April 2019

Technology Implementation

- Innovaccer
  - Executive leadership demo held March 13, 2019
  - Care management module training held March 19, 2019
  - CMG working with team to establish connection
  - SJRMC started process to establish connection

- Post-Acute Analytics
  - SNF training held March 13, 2019
  - NGACO population being added for monitoring
  - Pending schedule for SNF connection

Innovaccer

- Care management tool
  - Transitional Care
  - Care Management
- Reports outcomes related care management services
- Tracking of utilization of benefit enhancements

Post-Acute Analytics

- Manage post-acute performance
  - Cost of care
  - Length of stay
  - Re-hospitalizations
- Supports communication between providers
  - Address social determinants
  - Identify community resources
  - Utilize benefit enhancements

Questions?

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