Implementation Plan for Chronic Disease Management Reward Benefit Engagement Incentive

General Overview

NW Momentum Health Partners (NWMHP) is committed to reducing Medicare expenditures while improving the quality of patient care. NWMHP's goal is to support beneficiaries with self-management of chronic disease conditions and reduce the risk of injury and illness while supporting independent living and promoting efficient use of health care resources using CMS approved incentive programs. The Chronic Disease Management Program is aimed to promote improved health outcomes. Implementation of the Chronic Disease Management Reward Beneficiary Engagement Incentive ("Chronic Disease Management Reward Benefit") will include the provision of gift cards. This benefit enhancement will be provided to eligible beneficiaries under certain conditions with safeguards as established by CMS for the purpose of incentivizing participation in NWMHP's Chronic Disease Care Management Program. Furthermore, the goal is to include early identification of changes in health status and work with health care provider(s) to reduce potentially avoidable emergency department use or inpatient acute care stays. NWMHP's Chronic Disease Care Management Program will focus on supporting health care needs for newly diagnosed beneficiaries, provide education related to risks and benefits for informed decision-making regarding adherence to provider recommendations, and establish beneficiaries' health care goals.

SECTION 1: GENERAL OPERATIONS INFORMATION

1.1 Understanding and Definition of Beneficiary Eligibility

The Chronic Disease Management Reward Benefit is available to beneficiaries who are aligned to the NWMHP Direct Contracting Entity ("DCE"). Beneficiaries must be aligned at the time of enrollment into qualifying programs and remain aligned during the qualification period to achieve the reward.

The Chronic Disease Management Reward Benefit is available to aligned beneficiaries who participate in Care Management programs which are provided for 60 days or greater. Care Management programs include, but are not limited to, General Care Management, Complex Care Management, Chronic Disease Care Management or Behavioral Health Care Management. Beneficiaries may also participate in the Care Management Home Visit benefit or the Post-Discharge Home Visit benefit to qualify for the Chronic Disease Management Reward Benefit. Eligibility is based on identified support needs for self-management of chronic disease conditions: Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes Mellitus Type II (DM), Chronic Renal Disease, and Depression or other mental health diagnoses. These primary conditions identified will be further stratified by focusing on newly diagnosed beneficiaries within the prior 3-month period or poorly managed chronic conditions. Newly diagnosed conditions will be identified through Primary Care Provider ("PCP") referrals for all 5 diagnoses.

DC Participant and DC Preferred Providers ("DC Providers") have access to information regarding alignment through the population health tool that is updated monthly. DC Providers are

knowledgeable on the process for verifying beneficiary alignment prior to discussing or offering any benefits to the beneficiary.

An eligible beneficiary will be required to complete specific requirements for each of the 3 available $25.00 gift cards of their choosing. Beneficiaries will be required to be enrolled in a Care Management Program to support self-management of chronic disease. If identified to be eligible for the Chronic Disease Management Program, the beneficiary will need to meet the following criteria to obtain the first gift card and continue to be eligible for the remaining two gift cards.

1. Enroll in the Care Management Program for a minimum of 60 days
2. Participate in the Care Management Program requirements to maintain minimum contact as established between the Nurse Care Manager and the beneficiary.

The remaining two gift cards may be achieved at the time of the completion of the 2-month period. Beneficiaries will receive the remaining two gift cards for achieving self-care goals focused on managing their identified chronic disease. Goals will be established based on the beneficiary's preferences and their PCP's input into recommendations to promote health and well-being. Goals may include, but are not limited to:

- Completion of a diabetic education to address knowledge deficits.
- Reduce their HgA1c to below 9. Interventions to reduce the HgA1c will be supported by the PCP's recommendations.
- Smoking Cessation
- Medication adherence
- Self-care management and identification of early warning signs with provider notifications should changes occur.

Care plan goals will be shared with the PCP, the Nurse Case Manager and the beneficiary to demonstrate collaborative approach to meet the beneficiary's personal goals. If the beneficiary's goals are not in alignment with the PCP's recommendations to improve health outcomes the goal will not meet the requirements of success.

Beneficiaries participating in the Chronic Disease Management Program may be eligible for more than one waiver benefit such as the Cost-Sharing Support Benefit Enhancement, Post-discharge Home Visit Benefit Enhancement or Care Management Home Visit Benefit Enhancements. Beneficiaries that meet the criteria for more than one benefit enhancement will not be excluded and may have access to all benefit enhancements where criteria are met. The goal of NWMHP is to assist the beneficiary with chronic disease conditions that may need additional supportive care and provide services to help the beneficiary understand their disease. The Chronic Disease Management Program will support beneficiaries' learning of self-care management and identifying of early changes for improved treatment regimens, offer education to reduce risk of injury or illness, and promote adherence to DC Provider recommendations.

1.2 System for Managing and Tracking Utilization of the Benefit

Beneficiaries eligible for the Chronic Disease Management Program will be tracked through the population health tool. Tracking elements will include the identity of the eligible beneficiary , acceptance or declination of enrollment into the program, and successful completion of criteria to achieve the gift card reward, including date and the amount of the gift card(s) given. The beneficiaries care management profile will also include the chronic disease identified to allow for evaluation of outcomes based on engagement and trends of emergency room and inpatient care needs related to chronic diseases chosen for program. The Care Management program will track care plans with goals and interventions to demonstrate qualifications met or not met to receive the

gift card(s) and distribution of the gift card(s) to the beneficiaries. Information will be documented on a tracking form for DC Providers who do not use the population health tool for care management documentation. The tracking form includes all pertinent information demonstrating qualifications and distribution of gift cards to ensure compliance with the DCE's Participation Agreement. DC Providers are required to submit forms on a monthly basis to review the beneficiaries who have been enrolled into a qualifying program and allow for monitoring-through-completion to ensure qualified beneficiaries receive gift cards per the Implementation Plan's guidelines.

1.3 Number of Beneficiaries Expected to Utilize the Benefit

NWMHP is experienced in implementing and utilizing the Chronic Disease Management Reward program under its historical model participation and has provided over 20 gift cards to 9 beneficiaries during its most recent performance year.. It is anticipated that the utilization of the benefit will increase under Direct Contracting, with the addition of chronic diseases conditions used to qualify beneficiaries and the reduction of the enrollment period from 90 days to 60 days. NWMHP expects to issue over 50 gift cards for up to 30 beneficiaries in our first performance year. Additionally, NWMHP believes that continued utilization of the benefit will increase year-over-year as the DC Providers work to offer care management services to the more of the DCE's beneficiary population. Limitation to the utilization of the benefit is contingent on beneficiary agreement to enroll in Care Management and the DC Providers' ability to provide the Care Management services.

SECTION 2: MANAGEMENT APPROACH

2.1 Technical Assistance

Education and technical assistance are provided for DC Providers regarding the availability and workflows for utilization of the Chronic Disease Management Reward Benefit.

Education to DC Providers includes, but is not limited to, webinars, written workflows, documents to support compliance for utilization, and provider-facing collateral with frequently asked questions. Technical assistance on how to complete forms and use tools to verify eligibility is also provided during webinars and upon request by DC Providers as needed.

Ongoing technical assistance, particularly around the critical component of reporting, is made available to DC Providers as indicated. DC Providers are supplied NWMHP staff member contact information to include phone, e-mail and fax to request further support and technical assistance.

2.2 Infrastructure for Implementing the Beneficiary Engagement Incentive

NWMHP has created workflows, forms, collateral and guidelines for the implementation of the Chronic Disease Management Reward Benefit. A list of gift cards and workflows related to purchasing and provisioning of gift cards to beneficiaries has been established to include the capability to distribute by certified mail delivery, as needed.

DC Providers have been offered education by the Chief Nursing Officer ("CNO") on the Chronic Disease Management Reward Benefit program to include workflows, documentation, and record submission. Care Management has received education, and the population health tool has been updated to include documentation of Care Management services to track and evaluate program efficacy. The Compliance Department has reviewed the implementation guidelines and is

responsible for oversight of the auditing and monitoring of the benefit utilization. NWMHP will establish an annual budget to allow for the utilization of the benefit based upon the population eligible in addition to the expected utilization of the Chronic Disease Management Reward Benefit.

2.3 Integration into Operational Processes

Newly diagnosed beneficiaries will be referred the Chronic Disease Management Reward Benefit program by their DC Provider. PCPs may notify the Care Management team of qualified patients in a manner that is conducive for their workflow process. A care manager will contact the beneficiary to notify them of their qualification and referral by the PCP. All beneficiaries who are unable to be reached following a referral or identified qualification of eligibility will receive a flyer in the mail notifying them of their eligibility if they should choose to enroll. All engagement and referral sources will be recorded in the Care Management platform used by NWMHP for those that meet criteria for the Chronic Disease Management Reward Benefit.

NWMHP has a current process to identify utilization of the Chronic Disease Management Reward Benefit and will be able to continue to use that process for evaluation of those that meet criteria for the program. Beneficiaries with the identified chronic diseases that meet the utilization criteria are identified with the daily review for Transitional Care Services and referrals to Care Management Services. A review of claims data will allow the team to ensure that beneficiaries who may have qualified but were overlooked are offered the opportunity to participate. Beneficiaries will be identified through the DC Provider referral process, beneficiary engagement, risk stratification, or through medical record reviews and subsequently offered the opportunity to participate.

All beneficiaries that are identified as eligible for the Chronic Disease Management Reward Benefit program will be contacted a minimum of three times to be offered the opportunity to participate in the program. Beneficiaries will be educated on the program and their right to decline. Those that choose to participate in the program will be enrolled in care management services and be assigned to a Nurse Care Manager to oversee the development of their care plan and communication with their DC Provider.

Upon acceptance into the program, an interaction will be scheduled with the beneficiary to review their needs through an assessment or screening process. A care plan will be established with the beneficiary and shared with the beneficiary's DC Provider for review and signature by both parties. At the time of enrollment, the Nurse Care Manager will discuss the gift cards available the criteria for achievement with the beneficiary and allow them to choose which three goals they would like to work towards achieving. Upon successful completion of meeting the criteria to achieve a gift card, the Nurse Care Manager will record the information in the beneficiary's care management record and confirm with the beneficiary which gift card they would like to receive to ensure the beneficiary still wants their original choice. The gift card may be delivered to the beneficiary by certified mail, or in person as agreed upon between the Nurse Care Manager and the beneficiary. The recommendation and goal for the delivery of the gift card will be to deliver in person, however, it is not expected to be prudent in all circumstances. Available gift cards will be identified on a document that the beneficiary will be able to select recognizable choices as first, second, and third. Gift cards will be purchased upon confirmation the beneficiary has achieved the established care plan goals.

2.4 Designated Implementation and Management Staff

The Chief Nursing Officer (CNO) is responsible for the implementation of the Chronic Disease Management Reward Beneficiary Engagement Incentive program. The CNO will provide oversight and guidance to identification of eligibility for the program, educational programs for both beneficiaries and DC Providers, and evaluation of implementation efficacy. The CNO will be responsible to report outcomes to the DCE's Medical Directors Committee Meetings and Physician Advisory Council (PAC) bi-annually at minimum, following the implementation of the benefit enhancement.

The Care Management Team will implement the Chronic Disease Management Reward Benefit to include the benefit enhancement gift cards. The Care Management Team will be trained on the guidelines of the established program prior to implementation. Training will focus on eligibility and criteria for successful outcomes in order for beneficiaries to receive gift cards. The Care Management Team will enroll beneficiaries into one of the eligible Care Management Programs and evaluate qualifications based on participation in the program, duration of participation, and development and achievement of goals. Team members will work with beneficiaries to identify potential health coaching needs related to chronic disease management and to develop care plan goals and interventions established with the beneficiary. The Nurse Care Manager assigned to the beneficiary will provide education of the Chronic Disease Management Reward Benefit and the criteria to receive up to $75.00 in gift cards upon successful completion of agreed upon goals. The Nurse Care Manager may refer the beneficiary to receive additional support to include community support services or refer to the Care Navigator within the Care Management Team to assist with social determinants of health affecting the beneficiary's ability to perform self-management of their chronic disease(s).

2.5 Development of Standard Operating Procedures

NWMHP has established written guidelines for DC Providers to support implementation and management of the program. Guidelines include definitions for eligibility and requirements under the Chronic Disease Management Reward Benefit. The guidelines are provided to each DC Provider Group and will be available on the DCE's provider portal for easy accessibility.

Requirements are included in the guidelines for receiving gift cards, types of gift cards available and distribution recommendations. Beneficiaries qualify to receive up to three gift cards annually, in $25.00 increments for each gift card, upon successful completion of Chronic Disease Management goals. Beneficiaries may demonstrate successful completion of their three established goals at the same time to be awarded a total of $75.00 in gift cards. Gift cards will be provided based upon the beneficiary's choices between local services or businesses that support the continued health goals of the beneficiary. Gift cards will not be issued as Visa, Master Card or other similar type, and the card will be programmable to prevent the purchasing of tobacco products or alcohol. Locations where tobacco or alcohol items are sold will require a restriction of use to prevent the gift card from being accepted to make those purchases.

Gift cards are funded entirely by the DCE and will be available for aligned/qualified beneficiaries only. Individuals who are eligible for the program must be aligned beneficiaries upon enrollment and throughout the program including at the time the achievement criteria are met. Beneficiaries will be made aware of the criteria for eligibility at the time of enrollment. If they should choose to disenroll from the program, change providers to a non-participating or non-preferred provider out of the network, or expire they will be no longer be eligible for participation and will not receive a gift card. A list of available gift cards will be created and provided to beneficiaries upon enrollment into a Chronic Disease Management Program.

2.6 System Access

NWMHP is committed to protecting the privacy and security of beneficiary data and communications, as it is with respect to all aspects of its operations and services to beneficiaries. As a threshold matter, all data and communications are governed by appropriate reciprocal agreements between NWMHP and its DC Providers to ensure the privacy and security of data and the necessary implementation of all appropriate administrative, technical and physical safeguards. These contractual obligations require use and disclosure of information in accordance with all applicable federal and state regulations, including CMS Data subject to the Data Use Agreement. The importance of diligence in data protection is a point of emphasis in communications to all providers.

NWMHP ensures that communications by and between beneficiaries, family and social supports, and PCPs respect the privacy concerns of beneficiaries. DC Providers are provided access to the population health tool which provides access to the beneficiaries aligned to the Direct Contracting Model. Access to the population health tool requires an application process that is reviewed by Compliance and managed by a Systems Support Analyst to ensure end users are set up appropriately with roles and data access privileges.

NWMHP secure messaging when providing copies of clinical records between the care management team and the primary care provider to include care plans and documentation of services provided. DC Providers have access to documentation through the population health tool.

SECTION 3: PATIENT ENGAGEMENT

3.1 Availability of the Beneficiary Engagement Incentive and Beneficiary Education

Information regarding the Chronic Disease Management Reward Benefit may be provided to beneficiaries through CMS approved collateral and at the point of care with DC Providers. Beneficiaries will receive additional education when identified as eligible to enroll in care management services. The Care Management Department uses mail to deliver information to eligible beneficiaries with information on how to enroll and participate in services to qualify for the benefit. Nurse Care Managers provide education with telephonic interactions and offerings to enroll in services.

DC Providers are supplied information regarding the benefit and workflows with details regarding what the provider can and expect with enrollment among their patients. DC Providers will be educated on the workflow process related to referring newly diagnosed beneficiaries that would benefit from the program.

DC Providers will be kept informed of their beneficiaries' participation in the program through a shared copy of the care plan which will require their review and signature. DC Providers will be notified of the beneficiary's progress and achievements of goals routinely throughout participation in program. DC Providers will also be encouraged to outreach to the Care Management Team to obtain more information or ask questions.

3.2 Verifying up-to-date Beneficiary Alignment

Throughout the course of model participation, CMS will provide regular beneficiary alignment data to NWMHP. Data files received from CMS will be uploaded to the NWMHP population

health tool affording Providers the most current beneficiary eligibility information for utilization of the Chronic Disease Management Reward Waiver throughout the performance year.

3.3 Handling Beneficiary Complaints

Beneficiaries are provided information on how to contact NWMHP in the annual beneficiary notification letter. Additionally, DC Providers can offer this information at point of service. NWMHP staff, its Participant Providers and Preferred Providers are educated on how to identify a complaint and the appropriate process of escalation and reporting, whether received verbally or in writing. Beneficiary complaints are forwarded to the Compliance Department for intake and investigation. Complaints are reviewed within 5 business days to determine the best course of action, with additional evaluation completed by the Chief Nursing Officer, Medical Director or other subject matter experts as needed. If immediate health and safety concerns are brought forward, the reviews are completed within 1 business day. The Compliance Department will report the number of beneficiary complaints and any identified trends to executive leadership and the Board on a regular basis. Beneficiary complaints of a health and safety concern may be referred to the Chief Nursing Officer, the Medical Director and/or the Physicians Advisory Council for review and potential clinical action.

SECTION 4: COMPLIANCE APPROACH

4.1. Tracking and Monitoring Services Provided

The Care Management Department documents and tracks utilization of the Chronic Disease Management Reward Benefit. The Compliance Department will audit the process regularly and

document to ensure compliance with protocols for implementation of the program. The CNO will monitor outcomes and appropriate utilization of the waiver as part of the quality program. Education will be provided to DC Providers based on findings from the quality review process. The Compliance department will ensure compliance with the requirements of the Participation Agreement and Chronic Disease Management Reward Benefit guidance through auditing, monitoring, and claims analysis. Any identified corrections or updates to the Chronic Disease Management Program will be agreed upon by the DCE's Medical Directors Committee and the Physicians Advisory Council.

The CNO and Compliance Officer are responsible for overseeing compliance to the program and reporting on implementation and outcomes to the DCE's Medical Director as well as the DCE's Physician Advisory Council no less than quarterly. The Chief Medical Officer will be responsible for reporting to the DCE's Physicians Advisory Council and Board of Directors if evaluation of the implementation of the waiver identifies any compliance concerns. The DCE's Physicians Advisory Council will be responsible to approve clinical interventions or to provide feedback to Compliance on how to address compliance issues.

4.2 Management of up-to-date Agreements

DC Provider Agreements and records are managed and maintained by the Compliance Department in conjunction with the DCE's Provider Network Coordinator. Mid-year, ad-hoc inclusions and terms will be evaluated by Compliance and the Provider Network Coordinator to ensure accuracy of DC Provider rosters and confirm fully executed Participant Agreements are in place.

4.3 Claims Analysis

The Chronic Disease Management Reward Beneficiary Engagement Incentive program does not use claims for reporting or tracking services however is able to use claims analysis to identify

potential candidates for the program. The Care Management Department uses claims analysis to identify potential eligible beneficiaries to perform outreach to offer services. Claims analysis includes a review of those beneficiaries with the qualifying diagnosis for participation, risk score, historical utilization of acute care, and trends related to provider engagement and services received. Beneficiaries who are identified as high-risk and meet the qualifications for enrollment into Complex Care Management, Chronic Disease Care Management, or Behavioral Health Management programs will be provided outreach to offer those services throughout the calendar year.

4.4 Outcomes Analysis

Outcomes of utilization of the Chronic Disease Management Reward Benefit will include a review of acute care utilization trends, beneficiary engagement with their PCP, and overall health outcomes. Beneficiaries that were offered and engaged in the program will have their outcomes (numerator) compared to the total of those who were eligible for services (denominator). In addition to general goals for outcome analysis, beneficiaries will be surveyed to identify their perception of the program and evaluated based on a Likert scale. Use of the survey will allow for NWMHP to review the program and recognize opportunities to improve participation from the beneficiaries' perspective. Outcomes from both analytics and surveys will be reported to the Board of Directors and Physician Advisory Council at least once per calendar year.

4.5 Long-term Records Retention and Maintenance

NWMHP shall maintain and provide access to records and data related to the Chronic Disease Management Reward Benefit to include costs, quality performance reporting, and utilization. Beneficiaries enrolling into the Chronic Disease Management Program will be monitored

through documentation in a care management platform. The platform will allow for documentation of the requirements established within standard protocols and to document when a beneficiary has been awarded a gift card for successful completion of agreed upon goals. Data recorded in the platform will be accessible through data extraction and reporting. Nurse Care Managers assigned to beneficiaries will be trained on documentation requirements and criteria for success to ensure appropriate documentation is met. Additionally, NWMHP shall maintain and require all DC Providers, individuals and entities performing functions or services related to DCE Activities to maintain such records and/or other evidence for a period of 10 years from the expiration or termination of the Participant Agreement.