**Implementation Plan for the Post Discharge Home Visits Benefit Enhancement**

## *General Overview*

Hospital re-admission is a costly occurrence for Medicare and produces poor outcomes for beneficiaries. Many elderly individuals experience a decline in cognitive or physical functioning after recovery from the acute event which led to hospital admission. According to the Journal of American Medicine, about one-third of patients over 70 years old and more than half of patients over 85 years old leave the hospital more disabled than when they arrived. Seniors are leaving hospitals unable to

care for themselves after discharge and needing assistance with daily activities such as bathing, dressing or walking but find themselves without community or familial support. Ideally these issues would be discovered prior to discharge, but often the extent of these challenges is not realized until the individual arrives home. Likewise, discharge instructions reviewed in the hospital may not always be understood when at home.

The federal government has estimated that nearly 20 percent of Medicare beneficiaries return to the hospital within 30 days, costing more than $26 billion annually. CMS has tied reimbursement and quality scores for facilities to 30-day re-admission rates making the prevention of re-admissions a unique area for collaboration between multiple areas of the healthcare system. Innovative approaches to transitional care management implemented in other health care systems have shown success. North Carolina Healthcare Quality Alliance website (http://www.ncquality.org/) sites research showing a well targeted post discharge home visit program can reduce 30-day re-admission rates by as much as half compared to the post-discharge

telephone call. The greatest impact was seen among medically complex patients such as those with 3 or more chronic co-morbidities.

## SECTION 1: GENERAL OPERATIONS INFORMATION

### 1.1 Understanding and Definition of Beneficiary Eligibility

Beneficiary eligibility is dependent upon beneficiary alignment with the NWMHP Direct Contracting Entity ("DCE") and have been identified as potential candidates for the Post-Discharge Home Visits Benefit Enhancement ("PDHV Benefit") services. Beneficiaries are required to meet the following criteria in addition to verifying alignment.

- Beneficiary has discharged from an inpatient qualifying stay.
- Beneficiary does not qualify for home health services under 42 C.F.R. 409.42.
- Services will be provided within the beneficiary's home or place of residence during the period after discharge from an inpatient facility.
- Beneficiary has identified care management needs that are administered in accordance with all other Medicare coverage and payment criteria including the provisions of 42 C.F.R. 410.26(b).
- The Beneficiaries DC Provider has implemented the benefit enhancement.

### 1.2 System for Managing and Tracking BE Services

NWMHP has developed documentation tools for tracking reporting requirements as established by CMS. Each beneficiary that is enrolled into the PDHV Benefit will have a record kept that describes the key components for reporting to include but not limited to date of visits, person and licensure performing the home visit, purpose of the home visit, assessment type completed,

beneficiary needs, reason for discontinuation of home visits and summary of inpatient information. The document also identifies the beneficiary, date of discharge from acute care facility and guidelines of the services which includes providing no more than nine visits in the 90-day period. Nurse Care Managers are responsible to report and document all post-discharge home visits and submitting completed documents to NWMHP for review. The information will be used for quarterly reporting to CMS of waiver utilization and for quality assurance purposes.

### 1.3 Number of Beneficiaries Expected to Utilize the Benefit Enhancement

Beneficiaries eligible for the benefit will be dependent on those providers that are able to support the program. It is anticipated that the volume for 2022 will be low with approximately 50 beneficiaries being eligible. It is expected that there will be an increasing volume as DC Provider groups are able to set up internal workflows and implement strategies to support benefit utilization. It is the goal of implementing the program to increase participation by combining the Cost Sharing Support Benefit to reduce beneficiary burden. Beneficiaries who participate in the program will also be eligible for the Chronic Disease Management Reward benefit if they participate the full 90 days as outlined in the implementation plan. Limitation of the waiver utilization will be based on DC Provider participation. It is expected that as more DC Providers become educated and supported in development of office workflows that the utilization of the waiver will increase throughout the first performance year and beyond.

## SECTION 2: MANAGEMENT APPROACH

### 2.1 Provision of Technical Assistance to Participants

NWMHP has provided individualized support regarding the requirements of the program, coding and reporting for the utilization of the PDHV Benefit. NWMHP has long-standing collaborative

relationships with its Primary Care Providers ("PCPs") and maintains knowledgeable staff available to assist with the transitions of care and answer questions and remediate concerns. NWMHP also produces regular educational events and communications for their network including face-to-face learning groups, quarterly newsletters and educational flyers and pamphlets. The DCE's Medical Directors engage DC Providers as needed to discuss individual beneficiary complex care needs and opportunities for additional services to support health and wellbeing to include the use of the PDHV Benefit as applicable.

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 given staff member contact information to include phone, e-mail and fax to request further providing technical assistance

**2.2 Infrastructure for Implementing the Benefit Enhancement**

Beneficiaries are eligible to receive services by auxiliary personnel under the general supervision of a physician, as opposed to direct supervision, in a beneficiary's home in the 30-day period following discharge from an inpatient setting. Beneficiaries will receive services by a clinician licensed to perform the supervising provider-ordered services under applicable state law and CMS standards.

The benefit enhancement allows up to nine PDHV Benefit over a 90-day period. Further if a beneficiary is discharged and then readmitted within 90 days the beneficiary would qualify for visits that had occurred prior to readmission, and nine visits following the second discharge. The beneficiary would not qualify for any "remaining" visits of the nine allowed from the first discharge. (for example, if the beneficiary received two visits prior to readmission, following the

second discharge the beneficiary will qualify for nine visits, and not an accumulated sixteen visits.) A subsequent discharge resets the benefit for the subsequent discharge 90-day period.

The criteria for participation in the PDHV Benefit are as follows. Beneficiaries must have a least one of the below listed criteria:

- Multiple chronic co-morbidities – one or more as cause for admission
- Evidence of social risk factors (transportation, lack of support at home)
- Psychiatric, Cognition, or Substance abuse concerns
- New diagnosis and/or medication change of significance likely to require additional education
- Abrupt change in functional status relative to pre-admission level of function
- Recovering from major surgery (or minor surgery with complications)
- History of frequent hospital admissions or re-admissions
- Within 30 days of Inpatient discharge

NWMHP will disseminate standard protocols to PCPs, Hospitals and Skilled Nursing Facilities via face-to-face meetings, written materials and on the DCE's provider portal. Additionally, NWMHP will have trained staff available to answer beneficiary or DC Provider questions by phone.

**2.3 Integration into Operational Processes**

NWMHP will work with a select group of DC Providers with interest and ability to implement the PDHV Benefit. The operational processes will include developing a coordinated transitional care management program structured to reach the most at risk patients throughout the network. DC Providers implementing the benefit enhancement have access to admission, discharge, and transfer data to identify qualifying beneficiaries. The Care Management staff will be able to

review eligibility and document PDHV Benefit utilization in the population health tool provided.

NWMHP will support DC Providers to incorporate the PDHV Benefit into existing care management programs.

NWMHP will ensure DC Providers utilize appropriate billing rules and codes during each performance year by providing education and coding resources.

Effective April 1, 2019 the applicable HCPCS used to bill PDHV services will be G2001 - G2009 and G2013 – G2015. Following any future update to billing codes provided by CMS, NWMHP will provide additional education on new billing codes to ensure appropriate coding. NWMHP will validate with CMS use of existing codes through announcement of new codes to be used prior to implementation of the waiver.

Through the process of the Transitional Care Management (TCM) program, the Care Management Team members will screen to identify potential candidates for the PDHV Benefit. Referrals for the PDHV Benefit will be reviewed with PCPs to identify beneficiaries and to work with DC Providers to develop care planning needs for visits. The Care Manager will provide direction and collaborate care between the DC Provider and the beneficiary to meet the following requirements:

- Identify patient needs through assessment and development of a care plan.
- A review of discharge information and review need for or follow-up on pending diagnostic tests and treatments.
- Development of a communication plan between auxiliary personnel and PCP as well as a communication plan with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems.

- Auxiliary personnel under general supervision will provide education to the beneficiary, family, guardian, and/or caregiver; and establish or re-establish referrals and arrange for needed community resources as well as assist in scheduling required follow-up with community providers and services.
- Medication reconciliation and support of treatment regimen and adherence.
- Support from Nurse Care Managers, Care Navigators and Social work team as needed

Care Manager assigned to beneficiary for implementation of the PDHV Benefit will ensure the DC Provider has agreed with care plan and is informed of visit outcomes to support supervision of the program. NWMHP will develop tools to meet DC Provider needs related to communication of visits and beneficiary's response to interventions and achievement of health care goals established by the beneficiary and provider. Goals will be based on preferences and priority of the beneficiary and information will be communicated to the DC Provider to include the established care plan.

**2.4 Designated Implementation and Management Staff**

The Chief Nursing Officer (CNO) is responsible for the developing and oversight of benefit enhancement program. This position reports directly to the DCE ACO Executive, works with the DCE's Chief Medical Officer and Medical Directors for activities related to the delivery of medical care and clinical services such as cost management, utilization review, quality assurance and medical protocol development.

The DC Providers are responsible for determining staff members responsible for coordinating home visits, billing of services, and meeting reporting requirements. The CNO will work with each DC Provider Group to assist with workflows, documentation requirements, and other requirements for provision of the benefit.

The NWMHP Care Management Department supports a collaborative process with DC Providers to implement, coordinate, monitor and evaluate the options and services essential to meet the health care needs of the beneficiary. The Care Management Team works with community partners and healthcare providers to enhance communication, collaboration and integration across the continuum of care to support the DC Providers.

**2.5 Development of Standard Operating Procedures**

NWMHP has created a manual for utilization guidelines of the waiver. The operating procedures and guidelines are provided to DC Providers for reference and is available on the NWMHP portal. The Standard Operating Procedures (SOP) were developed based on measures to support communication across the care continuum to reduce risk of adverse outcomes to the beneficiary and to support transitional care needs. The SOP includes information regarding process steps to ensure implementation meets regulatory requirements under the waiver. Processes include communication between the DC Providers and the Care Management Team. The SOP is reviewed and approved by the DCE's Executive Leadership Team and Physician Advisory Council.

**2.6 System Access**

NWMHP is committed to protecting the privacy and security of beneficiary data and communications pursuant to the PDHV Benefit, 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 law rules, 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, PCPs, and hospitalists respect the privacy concerns of beneficiaries by thoughtful inclusion of necessary parties to develop and implement fully integrated Care Management. As successful implementation of the PDHV Benefit may require timely and effective communication between multiple parties, NWMHP, as the coordinator of the process, can direct the communications within the framework of established policies and procedures that safeguard patient privacy.

DC Providers are issued access to the population health tool which grants access to the NWMHP aligned beneficiaries. Access to the population health tool requires an application process that is reviewed by the Compliance Department and managed by the Systems Support Analyst to ensure end users are set up appropriately with roles and data access privileges.

## SECTION 3: PATIENT ENGAGEMENT

### 3.1 Availability of the Benefit Enhancement and Beneficiary Education

Beneficiaries will be made aware of the program once they have been identified as a potential candidate for the PDHV Benefit. Beneficiaries will be identified by their PCP, the discharging hospital or skilled nursing facility or the CM department. Once eligibility has been confirmed, beneficiaries will be contacted by telephone, offered the PDHV Benefit and counseled about the benefits of transitional care.

NWMHP will conduct an internal review of the program on a quarterly basis and will solicit feedback from all stakeholders (beneficiaries, DC Providers and facilities). NWMHP will host committee meetings no less than annually with the DC Providers performing the PDHV Benefit. NWMHP may consider the development of collateral for eligible beneficiaries provide further information available to DC Providers as allowed under the rules of the waiver. NWMHP may also consider communicating details of the available benefit enhancements to beneficiaries through the NWMHP web site as preapproved by CMS. Beneficiaries will be educated on the benefit enhancements available and informed of their rights to decline services offered or end services at any time during their participation. DC Providers who have established the PDHV Benefit for their beneficiaries will be apprised when services have been declined or discontinued.

**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 Post-Discharge Home Visit 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 care. NWMHP staff, its DC Providers and its affiliates are educated on how to identify a beneficiary 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 DCE's CNO, 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 the DCE's Executive Leadership Team and the Board of Directors on a regular basis. Beneficiary complaints of a health and safety concern may be referred to the DCE's CNO, the Medical Director and/or the DCE's Physicians Advisory Council for review and potential clinical action

## SECTION 4: COMPLIANCE APPROACH

### 4.1 Tracking and Monitoring Services Provided

The Compliance Department is responsible for overseeing auditing and monitoring of documentation, reporting, timely submission of data, adherence to the standards set forth in the DCE Participation Agreement this Implementation Plan and reporting to the DCE's Physicians Advisory Council and Board of Directors as applicable.

### 4.2 Management of up-to-date Provider Agreements

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 the Compliance Department 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

Claims data files for aligned beneficiaries will be provided to NWMHP by CMS throughout the performance year. NWMHP's Compliance Department will review claims data using the

designated CPT code set for the PDHV Benefit against the utilization logs for accuracy of tracking claims on a regular basis throughout the performance year. Additionally, claims data will be evaluated for indicators of misuse and quality standards to verify adherence to the implementation plan.

### 4.4 Outcomes Analysis

Information received regarding beneficiaries that have participated in the program will be reviewed through the quality assurance processes. The quality outcome report will include date of discharge to home and number of visits provided during the 90-day period to those that participated in the PDHV Benefit. Results of the report will be shared with DC Providers as well as with the DCE's Physicians Advisory Council. Information will include beneficiary outcomes such as ER utilization or Re-hospitalizations for beneficiaries that have participated in the PDHV Benefit.

NWMHP also uses a population health tool to document home visits and development of care plans. The population health tool information will be used to monitor the outcomes of the home visits as well as to ensure compliance with documentation requirements, including tracking the number of visits performed for each beneficiary.

### 4.5 Long-term Records Retention and Maintenance

NWMHP shall maintain and provide access to records and data related to utilization of the PDHV Benefit, costs, quality performance reporting and financial arrangements. 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.