The Town Hall will begin shortly…

Thank you for joining us today

Due to the number of attendees, please mute yourself unless you plan to speak.

To ask a question at anytime during the presentation, please use the chat to submit your question.

NW Momentum Health Partners ACO

Town Hall

5/5/22

Agenda

Policy/Advocacy and CMMI Updates

GPDC 2022 Program Updates

Data & Reporting

Care Management

Open Forum

PSW Healthcare Snapshot

Monthly download on Value-Based Care

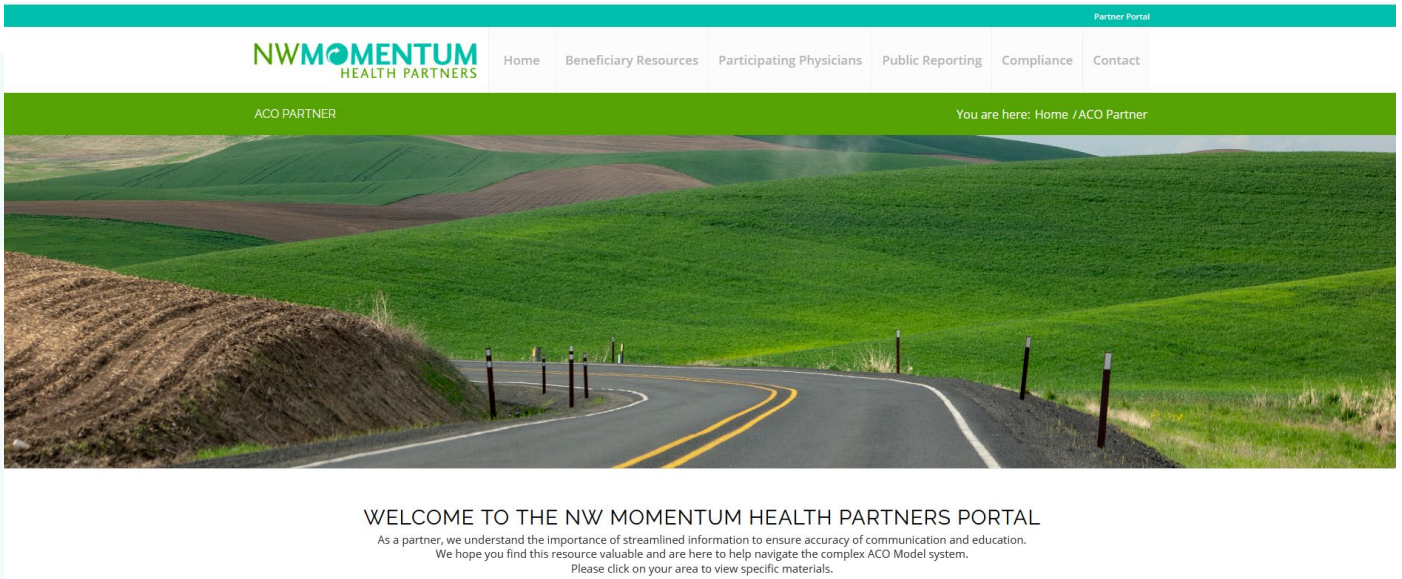
These monthly snapshots will give you and your providers a look into the world of Value-Based Care

For more information, questions, or to have someone added to the Healthcare Snapshot mailing list, please contact Communications@pswipa.com

NWMHP Partner Portal

https://www.nwmomentumhealthaco.com/

- Secure Private Portal – Updated to reflect Direct Contracting
- View up-to-date information
- Access numerous resources
- Calendar of 2022 Meetings



Provider Network Management

The Direct Contracting **Participation Agreement states that terminations must be submitted 30-days prior to a provider leaving**.

A reminder email will be sent monthly to submit these adds and terms

- The email will contain a form to be filled and returned by the 5th of the month
- Email will ask for providers that **have been added in the previous 30 days** and providers who **will be terminated in the next 30 days**.

Failure to meet the requirements may result in remedial action, up to and including, termination of the ACO's agreement with CMS.

For any questions regarding the process of submitting changes to your provider roster:

Contact Angie Valderrama at **ProviderNetwork@pswipa.com**

Policy/Advocacy and CMMI Updates

Policy/Advocacy

NAACOS Conference

April 27th – 29th

Several PSW staff attended the NAACOS Conference in Baltimore, MD

PSW presentations:

1. **Melanie Matthews**
   - Direct Contracting and ACO REACH: Expected Policy Changes for 2023

2. **Cheryl Moses**
   - Building an ACO Post-Acute Network: Effective Strategies for Contracting, Network Utilization, and Performance Monitoring
   - Conundrums in Care: Innovative Post-Acute Strategies

3. **Tamra Ruymann**
   - Road to Risk Meeting Series: Leveraging Data to Assess Your Provider Network

Federal Landscape/Policy Priorities

GPDC/REACH

1. Affordable Care Act (ACA) celebrates its 10-year anniversary

2. Value Act Hill Letter – in response to ACO advocacy
    1. 41 lawmakers wrote a letter to the Secretary of Health and Human Services calling for more incentives for value-based care
    2. "Adoption of value-based payments has played a critical role in slowing health care spending while improving pending over the last decade."

3. Continued advocacy around the benefits of value-based care models
    1. Letters to political representatives
    2. Meetings with CMMI
    3. Patient Stories
    4. Advocacy Groups (APG, VBCC, NAACOS, HCTTF)

4. Greater detail on REACH changes
    1. Health Equity Plan requirement
    2. Health Equity Benchmark Adjustment (Based on Area Deprivation Index)

Policy Updates

Public Health Emergency (PHE)

- The COVID-19 PHE is due to expire July 15, 2022.
- HHS promises to give states 60 days notice before letting the PHE expire.
- Telehealth flexibilities are set to expire 151 days after expiration of the PHE. Without Congress action, telehealth policies revert to pre-PHE policies.
- CMS will waive shared losses for MSSP ACOs by the percentage of months in the performance year affected by the PHE (If the PHE ends in July, CMS will waive 7/12^{ths} (58.33%) of an MSSP ACO's losses).
- During PHE effected months, CMS will remove COVID-19 treatment episodes from PY expenditures

ACO REACH

GPDC Transitions to ACO REACH

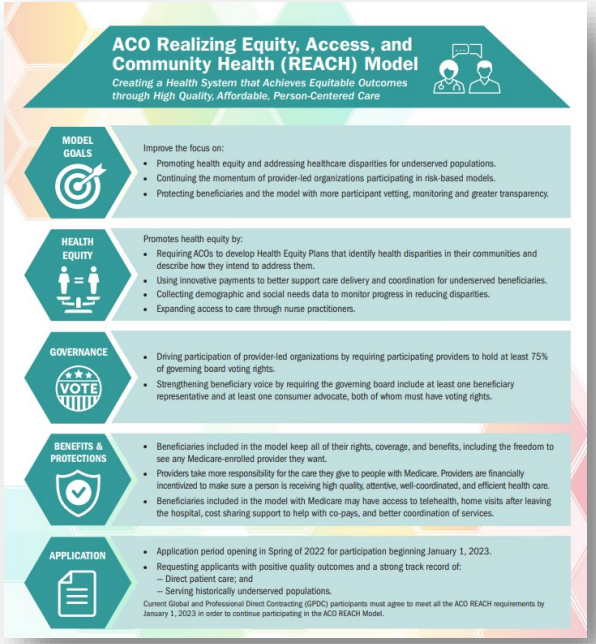
Why the change?

- In January 2022, members of Congress called for termination of the Global Professional Direct Contracting (GPDC) Model.
- NAACOS and ACO Coalition members recommended revision vs termination of the GPDC Model.
- Beginning in 2023, ACO Realizing Equity, Access and Community Health (REACH) addresses the changes to the GPDC Model with a focus on serving underserved communities.
- ACO REACH Model includes 5 new policies to promote Health Equity

ACO Reach Model – Starting 2023

Starting January 1, 2023, the Direct Contracting Model will become the ACO Realizing Equity, Access, and Community Health (REACH) Model.

Current DCEs can transition into REACH by meeting the required changes and having a strong compliance record.



https://www.naacos.com/aco-reach-model

ACO REACH

Model Changes starting PY2023

Changes include:

- Health Equity Plan – ACOs must develop a health equity planned targeted at underserved beneficiaries.
- Health Equity Benchmark Adjustment – ACO benchmarks will be adjusted based on the number of underserved beneficiaries within their ACO population.
- Collection of Data – ACOs must collect and submit data to CMS on beneficiary demographic and social needs data.
- Quality Withhold – ACO REACH will reduced the 5% Quality Withhold from Direct Contracting to 2%.
- New Benefit Enhancement – Nurse Practitioner Services Benefit Enhancement: Nurse Practitioners will be able to assume certain responsibilities or furnish certain services without physician supervision such as certifying the need for diabetic shoes or hospice care.

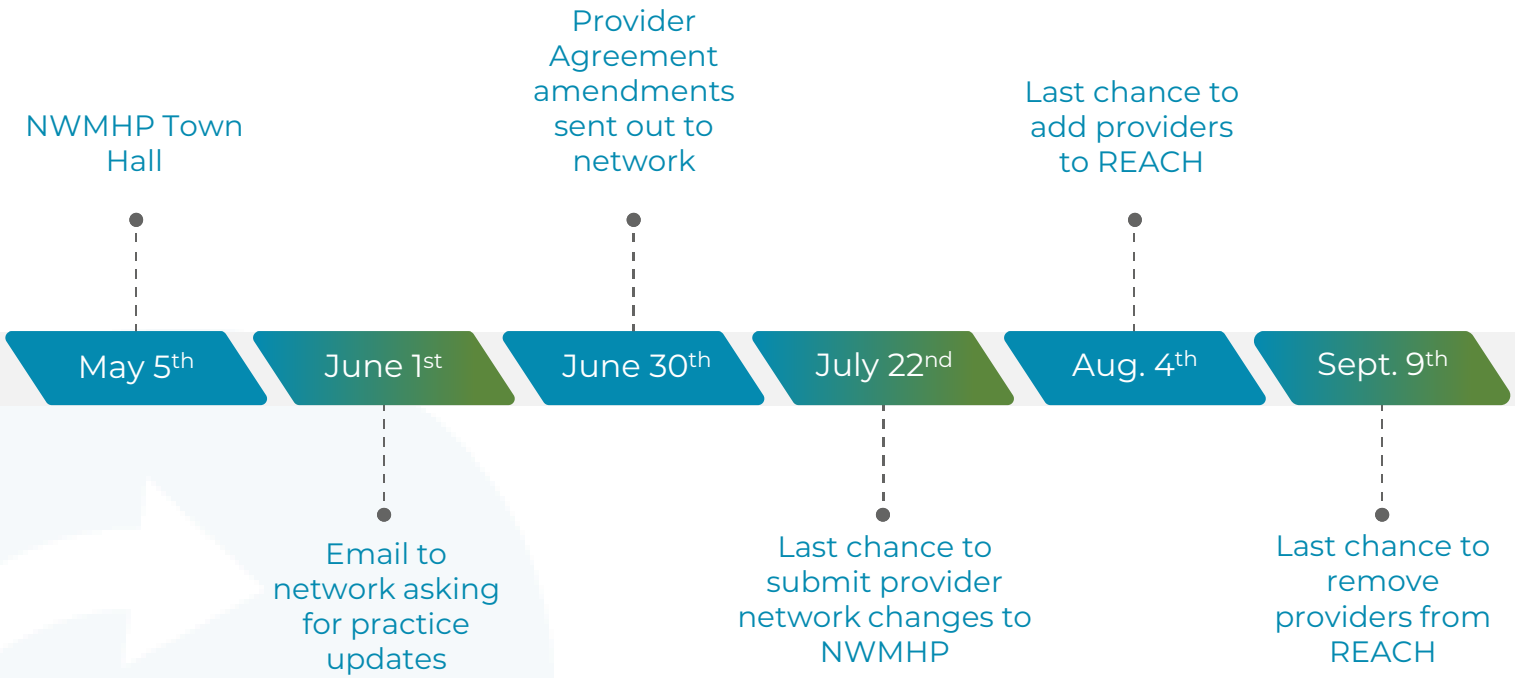
ACO REACH

What will not change?

- NWMHP still participates in the Professional risk track and utilize Primary Care Capitation.
- The network will still consist of Participant Providers and Preferred Providers.
- The current Benefit Enhancements will still be available.
- Quality Measures will still consist of claims-based measures and CAHPS.
- Voluntary alignment can still be conducted through the Performance Year.
- ACO REACH will still be an Advanced Alternative Payment Model (AAPM)
- Benchmarking years will still be 2017 (10%), 2018 (30%), and 2019 (60%).

2023 Timeline

Transitioning to ACO REACH



Health Equity

ACO REACH Focus on Health Equity

Beginning 2023, key new policies will be introduced promoting Health Equity

Health Equity Plan Requirement

Health Equity Benchmark Adjustment

Health Equity Data Collection Requirement

Nurse Practitioner Services Benefit Enhancement

Equity - "the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American individuals, Asian Americans and Pacific Islanders and other individuals of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals; individuals with disabilities; individuals who live in rural areas; and individuals otherwise adversely affected by persistent poverty or inequality."

Health Equity Plan

Purpose: For each ACO to identify underserved communities **within its aligned beneficiary population** and implement initiatives to measure and reduce health disparities for such populations over the course of the model.

- A Health Equity Plan will be submitted in advance of **each** PY (and other times as indicated by CMS).
- CMS will provide a list of components in advance that the ACO shall include in the Plan.
- The requirements regarding the content and use of the Equity Plan shall be outlined in the MPP Participation Agreement. ACO's must use the template language provided by CMS.

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Health Equity Plan

The Innovation Center will provide ACO's with a template based on the Disparities Impact (DI) Statement to:

- Identify health disparities
- Define health equity goals
- Establish a health equity strategy
- Establish a plan for implementing the health equity strategy and monitoring and evaluating progress in efforts to achieve health equity for the underserved communities.

****Underserved community refers to populations sharing a particular characteristic, as well as geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the definition of "equity."**

Health Equity Benchmark Adjustment

Beginning 2023, CMS will apply an adjustment to increase the benchmark for ACOs serving a higher proportion of underserved beneficiaries.

Calculated using a composite measure incorporating **Area Deprivation Index (ADI)** and **Dual Medicaid/ Medicare status**.

The Area Deprivation Index is measured as a percentile (continuous variable). Medicaid Status is a binary metric.

CMS will calculate the measure by starting with the Area Deprivation Index for a given beneficiary's census block group of residence (scored from 0-99 based on percentile relative to the nation) and applying a 25-point increase to the score for dually eligible beneficiaries.

For example, a dually eligible beneficiary residing in a census block group with an Area Deprivation Index in the 75th percentile would receive a score of 75 + 25, for a total of 100.

Health Equity Data Collection Requirement

CMS will require all ACOs to collect and report beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries

In addition, CMS is requiring ACOs to collect and report this information to determine whether quality is improving for all beneficiaries aligned to the ACO, including underserved sub-populations.

Health Equity Data Collection Requirement

In PY 2023, completing the requirement to collect and report beneficiary reported demographic information will result in a **bonus** to the ACO's quality score. For PY 2023, there will be **no downward adjustment for failure to report** this information. In PY 2024 and beyond, CMS **may a downward adjustment** to the ACO's quality score if not completed.

NOTE: Beneficiary submission of demographic information is **voluntary**. **ACOs that document a beneficiary's choice not to disclose demographic data (eg "prefer not to say") on a survey will receive credit for reporting the data.**

Nurse Practitioner Services Benefit Enhancement

New!! Beginning PY 2023

- **Hospice Care Certification**
- **Certification of Need for Diabetic Shoes**
- **Establish, review and sign a written Plan of Care for Cardiac Rehabilitation**
- **Certification of Plan of Care for Home Infusion Therapy**
- **Referrals for Medical Nutrition Therapy**

Questions?

How May We Help?

GPDC 2022 Program Updates

Primary Care Capitation

DC Capitation Process

Payment Schedule

February 28th, 2022	August 10th, 2022
March 9th, 2022 – March 11th, 2022	September 14th, 2022
April 13th, 2022	October 12th, 2022
May 11th, 2022	November 9th, 2022
June 8th, 2022	December 14th, 2022
July 13th, 2022	January 11th, 2023

Payment report/Remittance Advice are sent with the payment.

Reports are delivered via Box.com.

For questions regarding access to Box.com, please contact Jake Woods or Sherri King

JacobW@pswipa.com or SherriK@pswipa.com

DC Capitation Process

Remittance Advice

The Remittance Advice (RA) will be changing for the May payment to new pdf. An excel version will still be supplied with the monthly payments.

The monthly pdf RA will be generated with the following:

1. Organization LBN and TIN
2. Provider Name or CCN for RHCs
3. Claim From Date and Claim Thru Date
4. Adjustment Amount and Code (Credit vs. Debit)
5. Reimbursement Amount (5% Reduction amount)
6. Total Claim Billed Amount (5% Reduction + 95% amount paid to provider by CMS)
7. Payment Date
8. Patient MBI
9. Patient Name

Beneficiary Notification

Annual Beneficiary Notification Mailing

For NW Momentum Health Partners Direct Contracting beneficiaries

Purpose

- Informs beneficiary their provider is participating in the DCE
- Assures beneficiary that this does not change their Medicare rights
- Provides information on availability of value-added services
  - Beneficiary enhancements
  - Care Management Services

Annual Beneficiary Notification Mailing

For NW Momentum Health Partners Direct Contracting beneficiaries

Timeline

- Mailing was sent in two stages
  - Stage 1 – Legacy Risk Pool (**April 15th**)
  - Stage 2 – TRC Risk Pool (**April 29th**)

PSW Staff/Provider Preparations

- Template letter has been distributed and posted on Partner Portal
- FAQ/Scripting document has been created and shared with providers

Has your organization received questions from beneficiaries?

Voluntary Alignment

Voluntary Alignment Planning

Why is this important?

- Retain beneficiaries that may not be captured through claims
- Increase number of aligned beneficiaries within a performance year
- Ensures the beneficiary continues to be eligible to receive the DCE services (Benefit Enhancements, SDoH, etc.)

Methods of VA

- Paper-Based VA / NWMHP Website
- Medicare.gov / Marketing Materials
- Marketing Events

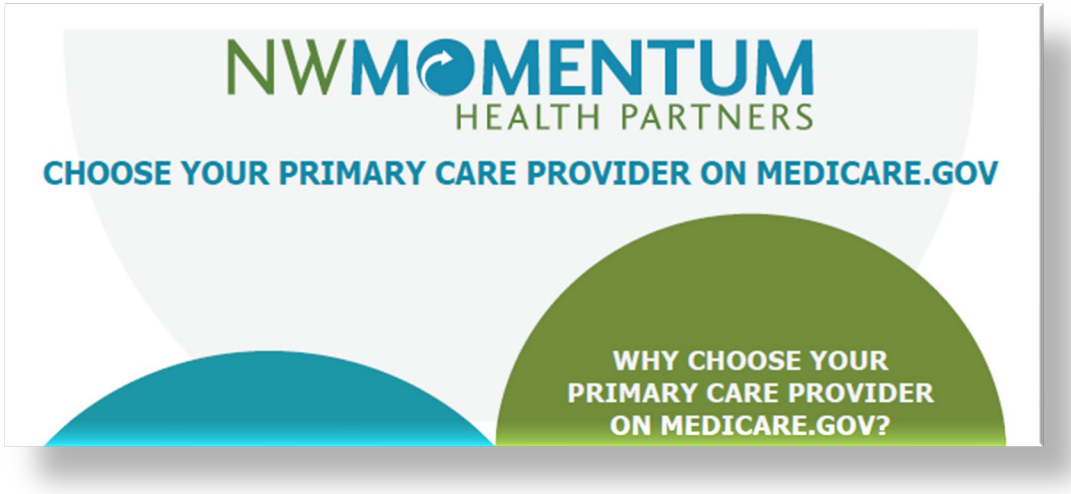
Voluntary Alignment

NWMHP has created a branded version of an Electronic Voluntary Alignment Flyer.

A copy of this flyer was mailed with the Beneficiary Notification and is available on the Partner Portal.

Please print this flyer and post it in your clinics for beneficiaries to see.

<u>This flyer cannot be modified in any way. This is a CMS provided flyer.</u>



Voluntary Alignment

Where are we now?

Q2 2022

- NWMHP Branded EVA flyer has been emailed out and is ready to be posted in practices.
- Branded EVA flyer was included in the Beneficiary Notification.
- Paper-Based Voluntary Alignment Form has been approved by CMS and will be sent to the network.

Compliance – Voluntary Alignment

Educating Beneficiaries – Do's

- Beneficiaries can register for Medicare.gov to select their primary practitioner (EVA)
- Provider should inform the Beneficiary of the steps to select a practitioner on Medicare.gov
- Beneficiaries can complete a paper-based voluntary alignment (PVA) and submit this form to their primary practitioner
- Voluntary Alignment does not affect the Beneficiaries' Medicare benefits or restrict their options to seek health care from any practitioner
- Inform the Beneficiaries that they may contact NWMHP directly with any questions related to Voluntary Alignment

Educating Beneficiaries – Don'ts

- Do not complete the EVA/PVA form or select a practitioner on Medicare.gov on behalf of the Beneficiary
- Coercion, withholding services, and/or influencing the Beneficiary to complete EVA/PVA is strictly prohibited
- Gifts/Renumeration to complete EVA/PVA is strictly prohibited
- PVA Form must NOT be included with any other forms requiring signature from the Beneficiary

Note: All CMS approved collateral related to Voluntary Alignment is posted on the NWMHP Provider Portal. Partners may not edit these final version documents.

DC Marketing Materials

The Direct Contracting Model requires that all beneficiary facing descriptive and marketing materials must be approved by NWMHP Compliance and submitted to CMMI for approval.

CMS templated materials such as the EVA flyer and Beneficiary Notification are provided by CMS and are not able to be modified in any way.

NWMHP provides many beneficiary facing materials throughout the Performance Year. All materials will be available for download on the NWMHP Partner Portal.

If you have any suggestions for materials to be created, please reach out to Jake Woods JacobW@pswipa.com

Data & Reporting

May Data & Reports

Quarterly Data Reporting (QPD)

QPD Reports are still scheduled to be delivered in Box.com by the end of May:

1. Patient Evaluation Forms (PEF)
2. GAP Reports – AWVs
3. High Utilizer Risk Report (HURR)
4. Updated Attribution

An update on the May Monthly Performance Reports is expected to be available by the end of next week.

Alignment vs. Attribution

FILE	DEFINITION	AVAILABLE
Alignment File	Provided by CMS and is the prospective list of beneficiaries aligned to NWMHP	January-February
Attribution File	NWMHP proprietary process, using the CMS alignment file and historical claims data to determine the attributed primary care provider or specialist for each beneficiary.	February-March

- NWMHP cannot remove beneficiaries; must be done by CMS through exclusion files
- Beneficiary alignment is reduced monthly based on CMS exclusions
- Beneficiary alignment can increase quarterly through Voluntary Alignment

NWMHP is developing an Attribution FAQ document that will get posted to the Partner Portal

May QPD

How to use these reports?

Patient Evaluation Form (PEF)

1. Describes suspected HCCs that have not been reviewed in the current Performance Year for beneficiaries based on previous year information.

GAP Reports

1. This report only displays attributed beneficiaries without an annual AWV, not full membership. The report also lists the most recent AWV date for each beneficiary where one is due.

High Utilizer Risk Report (HURR)

1. Allows you to identify high utilizers for: High cost of care, most readmits, most ER visits.

2022 Reports

PEF and GAP Reports

Member Name:
Member ID:
Gender: **Date of Birth:**
Unreviewed Risk: **Total Risk:** 2.85

Primary Care Provider:
PCP Vendor:
PCP Vendor Tax ID:

Patient Evaluation Form

We know you're taking good care of your patients--proper documentation and coding is necessary to ensure appropriate reimbursement

This information is based on Medicare FFS claims for dates of service covering 1-1-2019 to present. Please review each suspected condition (at least once annually) in a face-to-face visit with the patient, document the visit in the medical record, and submit appropriate code(s) for all confirmed conditions on the claim

Still Needs Review this Year?	Suspected Condition	Most Recent Diagnosis	Additional Information
Yes	**HCC#:** 108 **Risk:** 0.29 **Name:** Vascular Disease	**ICD Code:** I82621 **Date Billed:** 8/7/2019 **Description:** Acute embolism and thrombosis of deep veins of right upper extremity	**HCC Captured by PCP Vendor?** No **Confidence Level:** Medium-Low
Yes	**HCC#:** 99 **Risk:** 0.23 **Name:** Intracranial Hemorrhage	**ICD Code:** I609 **Date Billed:** 11/19/2019 **Description:** Nontraumatic subarachnoid hemorrhage, unspecified	**HCC Captured by PCP Vendor?** Yes **Confidence Level:** Medium-Low

GAP Report

Northwest Momentum Health Partners

Claims processed between January 1, 2021 and March 31, 2021

MBI	First Name	Last Name	Date of Birth	Member Address	City, State, Zip	RAF
H123456	Donald	Duck	6/21/1942	401 Ada Street	Seattle, WA	2.6
H32456	Micky	Mouse	1/31/1955	620 4th Ave SW	Chicago, IL	5.1
M932653	Minnie	Mouse	2/23/1945	940 S Miller Street	Spokane, WA	1.7

2022 Reports

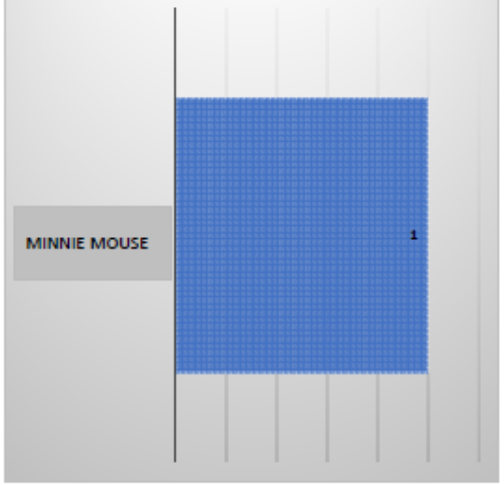
High Utilization & Risk Report (HURR)

DISNEY FAMILY PRACTICE
ERIC, PRINCE

2020-04-01 Thru 2021-03-31

Total ER Visits 1

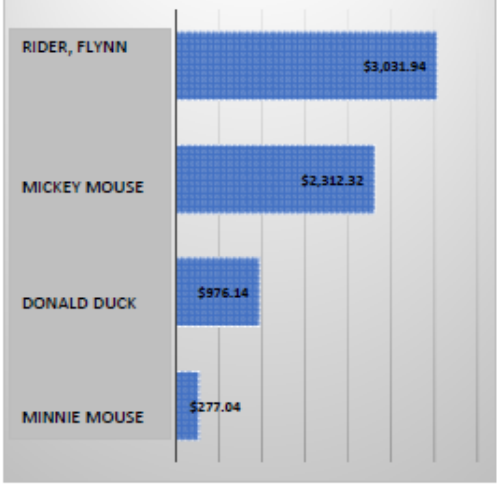
ER Visits per Patient[1]



Attributed Members[3]: 8

Total Spending $6,597.44

Spending per Patient[1]

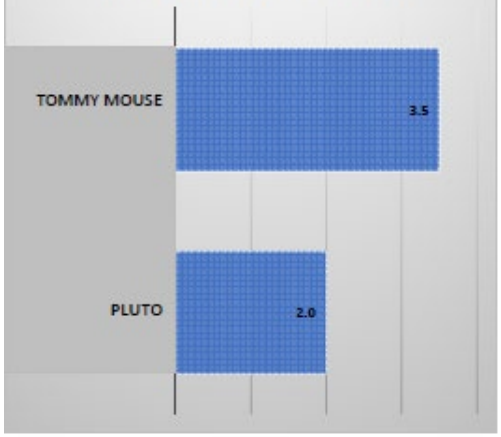


Total IP Readmits 0

IP Readmits Per Patient[1]

Average Risk Score 1.0

Patients Most Likely to Benefit from Chronic Case Management (Risk Score)[2]

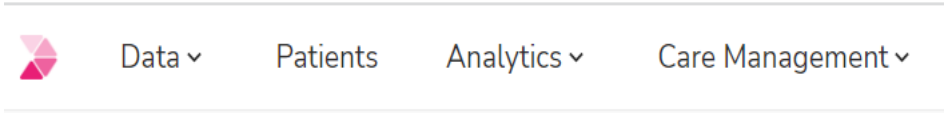


Initiative Spotlight

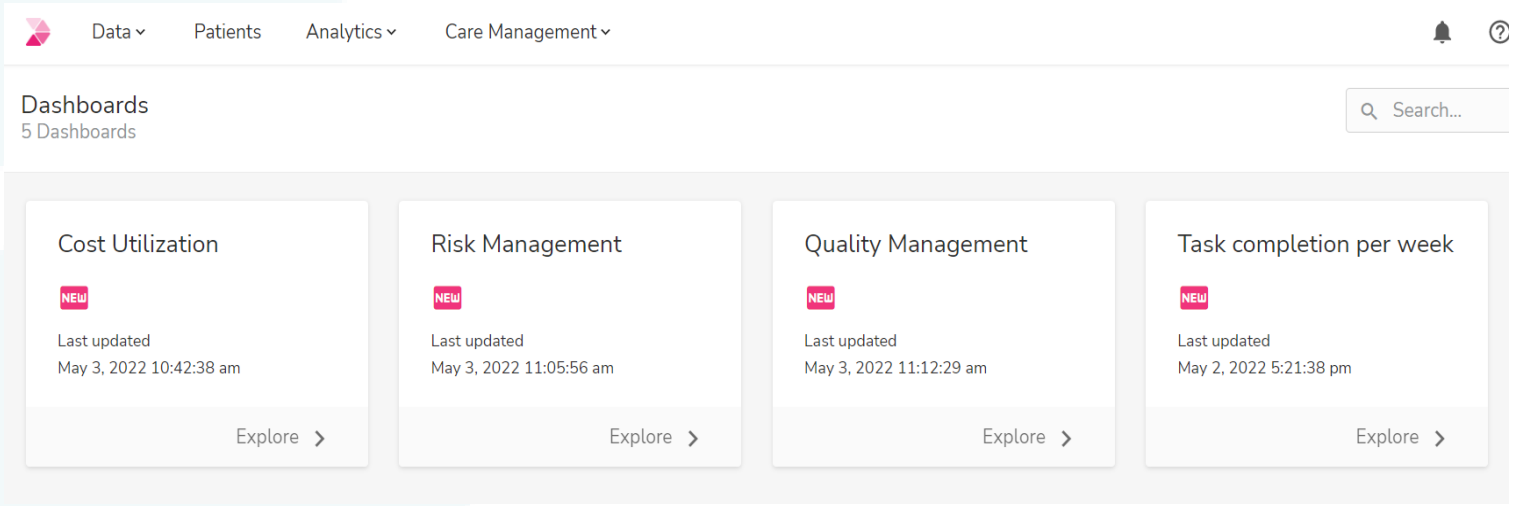
Population Health Management with Innovaccer

Very High-Risk Beneficiaries over age 80 with no PCP visits in past year

1. Log in to Innovaccer with your Username and Password.
2. Click the Analytics tab to open the dashboard.



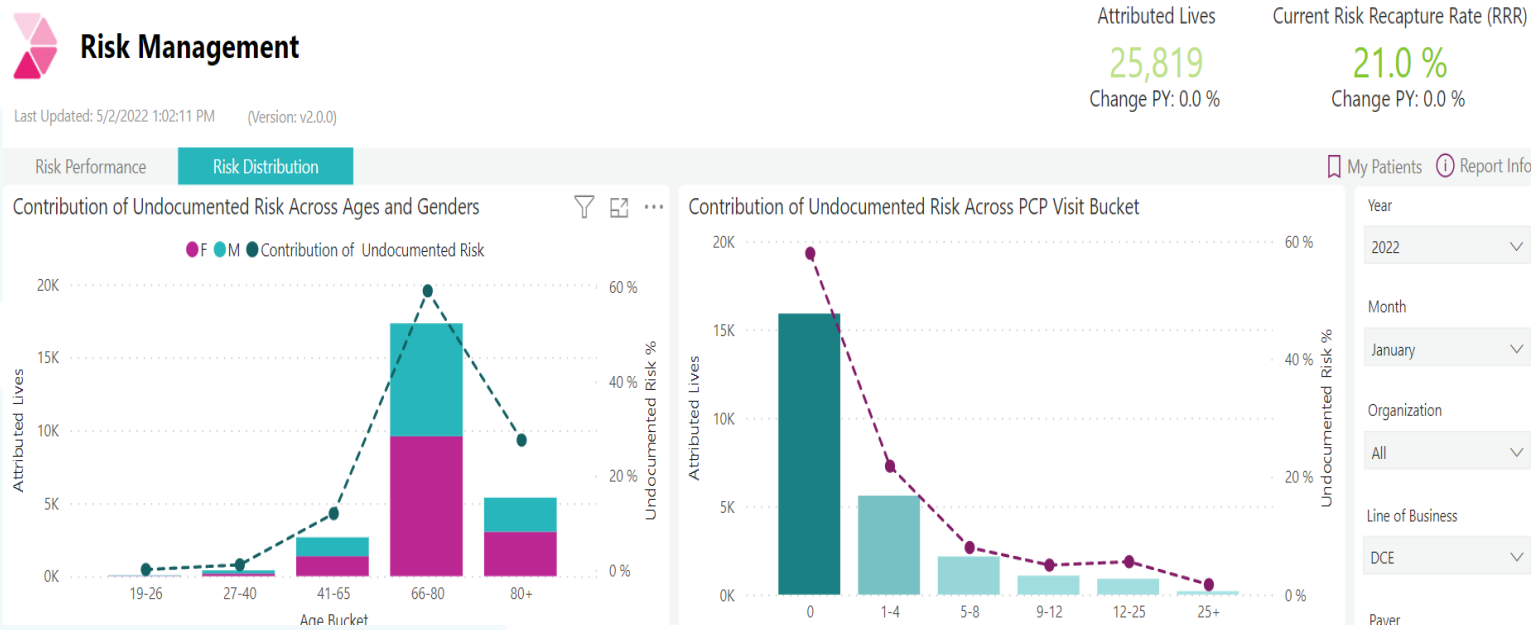
3. From the dashboard, Explore the risk management tab.



Population Health Management with Innovaccer

Very High-Risk Beneficiaries over age 80 with no PCP visits in past year

- Risk Management tab will open to the page below.
- Choose Risk Distribution Tab.
- Apply filters for Year, Month, Organization, etc. (far right column). Ability to filter to NPI level.
- Note number of attributed lives (25,819)

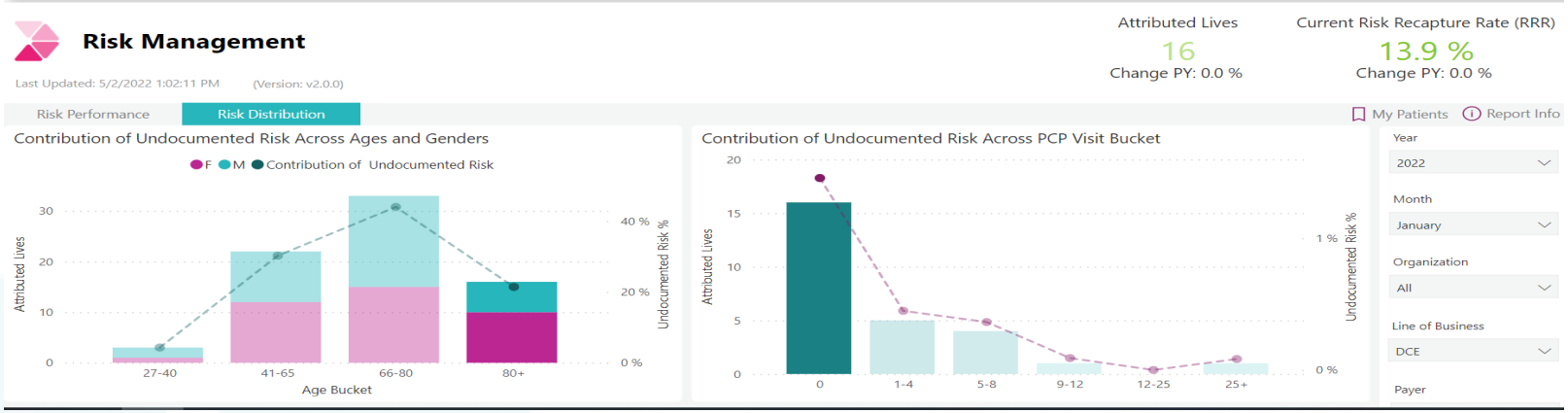


Population Health Management with Innovaccer

Very High-Risk Beneficiaries over age 80 with no PCP visits in past year

Filter Age and Gender (***Ctrl click "80+"***)

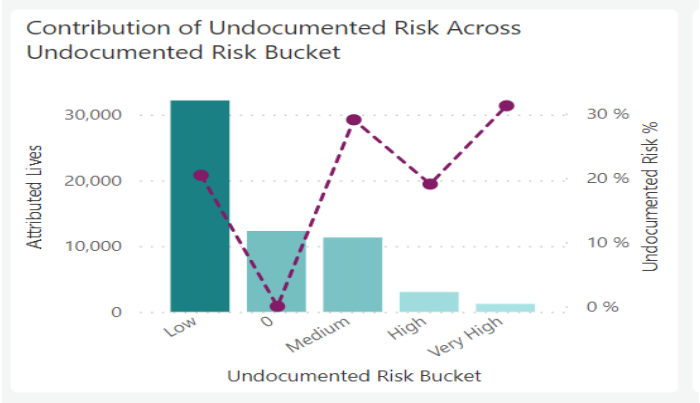
Filter Undocumented Risk Across PCP visit for number of years (***Ctrl click "0"***)



Filter Contribution of undocumented risk Across Undocumented Risk Bucket (***Ctrl click "Very High"***)

Note number of Attributed Lives (16)

Ability to list the 16 beneficiaries for follow up



From Data to Outreach

Data

- Identify smaller list of patients for outreach

Outreach

- How do we work to help these patients?

Risk Management Outreach

Identified Population – Created by utilizing the Risk Management Dashboard

Initial outreach by a Non-Licensed Care Navigator

Intake and enrollment into Care Management Services with a Registered Nurse Care Manager

Risk Management Outreach

Initial outreach by a Non-Licensed Care Navigator

A well-informed Non-Licensed Care Navigator (NLCN) will conduct the initial outreach to the patient with knowledge of the identified risk.

The client will be informed of the services that we offer and how we can assist.

After services have been explained the NLCN will set the patient up for an appointment for Intake with the Registered Nurse Care Manager.

Risk Management Outreach

Intake and Enrollment into Care Management with a Registered Nurse Care Manager

Outreach

- A Nurse Care Manager will outreach to the patient at the specified time of appointment.

Intake Assessment

- An in-depth intake assessment will be performed with the patient.

Care Plans

- After the intake assessment, goals and a care plan will be established based off the patients preferences and needs.

Enrollment into Care Management

- The care plan and enrollment letter will be sent to both the attributed PCP and the patient. The PCP is welcome to add input to current goals identified.

Goals

- The care plan will identify the outreach frequency, whether that is weekly, bi-weekly, or monthly. And the goals and interventions that the Nurse Care Manager and patient created together for the patient to work on.

Care Management

Care Management Services

- Care Coordination
  - Provider engagement
- Complex Care Management
  - Disease management education
- Remote Patient Monitoring
  - Improving self-care
- Social Determinants of Health Program
- Transitional Care Management
- Post-Acute Care Management

Team consists of licensed nurses, care navigators and post-acute coordinators

NWMOMENTUM HEALTH PARTNERS

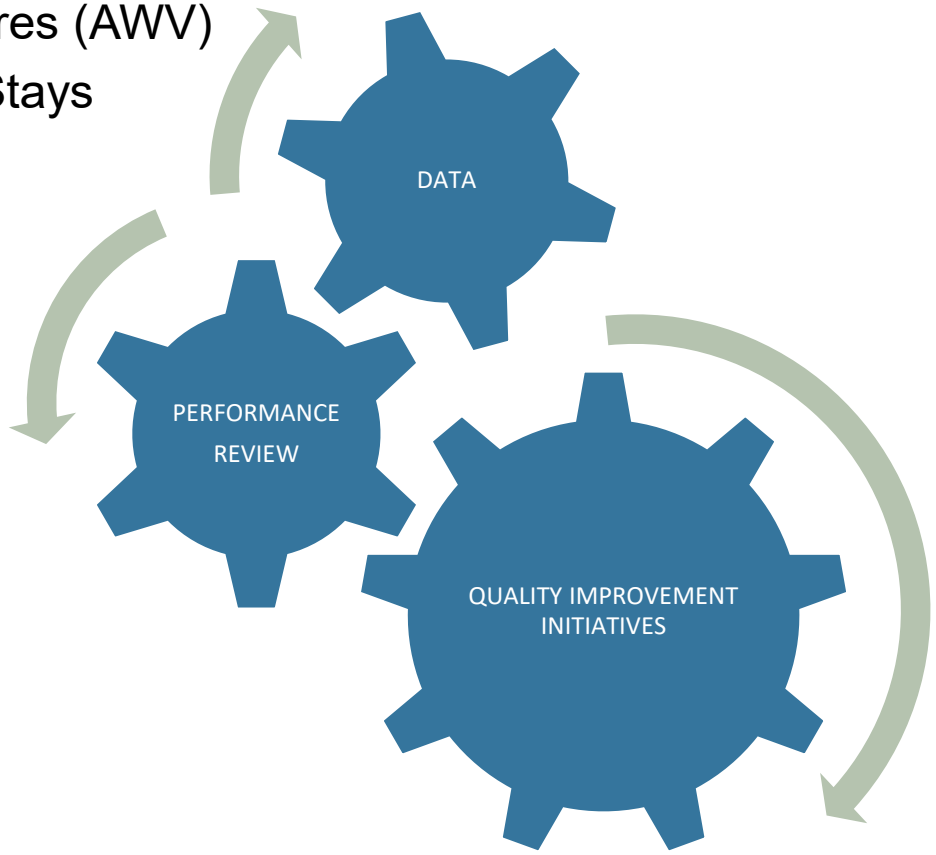
Goals of Care Management

Reduce overall costs of healthcare

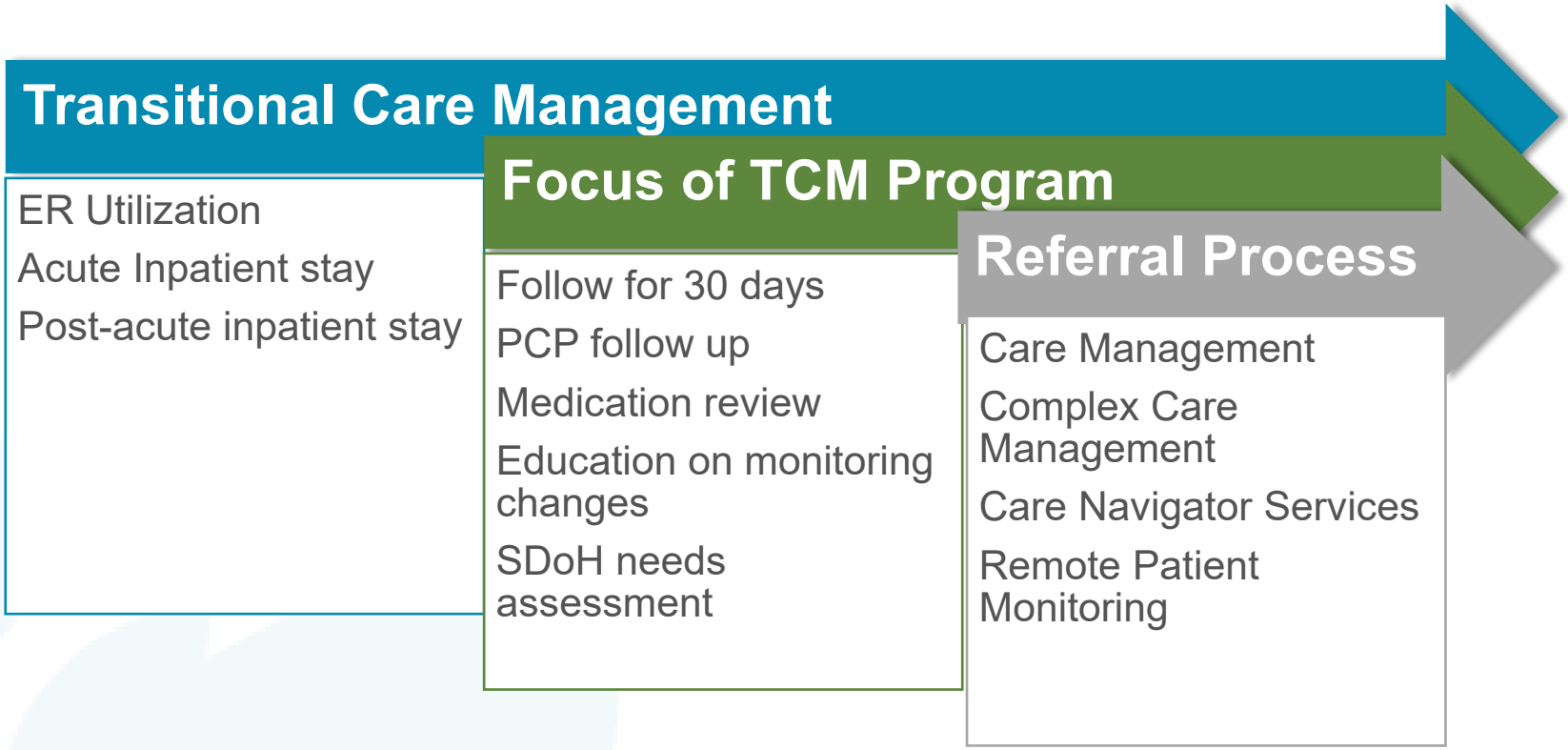
1. Emphasize prevention
2. Support shared decision making
3. Reduce unnecessary duplicative diagnostics
4. Reduce emergency room utilization
5. Reduce avoidable inpatient stays
6. Improve population self-care for chronic disease management
7. Utilize community programs for SDoH needs

Key Performance Indicators

1. **Member Engagement**
   - i. Preventative Health Measures (AWV)
   - ii. TCM for ED and Inpatient Stays
   - iii. Care Management (CCM)
2. **Provider Engagement**
   - i. Care Collaboration
   - ii. Setting Appointments
   - iii. Care Planning
3. **Data Analytics**
   - i. Trends and Opportunities
   - ii. High Risk Evaluation
   - iii. Performance Outcomes
   - iv. Quality Outcomes



Transitional Care Management



SDoH Needs Assessment

- Evaluate needs with each engagement
- Identify qualifications for ACO benefits
- Referrals to community resources

Questions?

New Resources on the Partner Portal

Available now!

- NWMHP Branded Electronic Voluntary Alignment Flyer
- 2022 About Care Management Services
- NWMHP Care Management Referral Form
- Coding Counts Resources
  - Do's & Don'ts
  - Pitfalls

NWMOMENTUM
HEALTH PARTNERS

Thank you!

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www.nwmomentumhealthaco.com