The Town Hall will begin shortly……

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.

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NWMHP ACO Town Hall

January 26, 2023

Agenda

- 2023 Operations Ramp-Up
- Quality Measures Deep-Dive
- Alignment vs. Attribution
- 2023 Good to Know

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2023 Operations Ramp-Up

New Approach to Town Halls

Based on network feedback, Town Halls will look slightly different in 2023. Town Halls will now be 1-hour meetings with more focused agendas.

The Town Hall invites have been sent. There will be **6 Town Halls in 2023**:

1. January 26th, 2023, at 7:30-8:30am
2. March 23rd, 2023, at 7:30-8:30am
3. May 25th, 2023, at 7:30-8:30am
4. August 24th, 2023, at 7:30-8:30am
5. October 19th, 2023, at 7:30-8:30am
6. December 14th, 2023, at 7:30-8:30am

If you haven't already….

INNOVACCER USER ACCESS REQUEST

Request Type	☐ New User	☐ Modify User	**Date:** Click or tap here to enter text.
Requestor Information			
Requestor Name	Click or tap here to enter text.	**Work Phone**	Click or tap here to enter text.
Job Title	Click or tap here to enter text.	**Email Address**	Click or tap here to enter text.
Manager Name	Click or tap here to enter text.	**Manager Job Title**	Click or tap here to enter text.
Manager Email Address	Click or tap here to enter text.	**Manager Phone Number**	Click or tap here to enter text.
Practice/Facility Name	Click or tap here to enter text.	**Requested LOB**	☐ ACO ☐ MA
Requestor's Population (Counties) – Choose one	☐ Columbia ☐ Grays Harbor ☐ Klickitat ☐ Lewis ☐ Mason ☐ Pacific ☐ Pend-Oreille ☐ Thurston ☐ All ☐ Other _____		
Reason for Access – Choose one	☐ Beneficiary Eligibility Only ☐ Dashboard/Analytics ☐ Care Management ☐ Dashboard/Analytics & Care Management		
Job Duties/Description:	Click or tap here to enter text.		

Innovaccer requests forms can be sent to InnovaccerSupport@pswipa.com

Innovaccer questions can also be submitted to the Innovaccer support team

Box.com requests forms can be sent to Communications@NWMHPACO.com

Reminder – up to 3 users per organization

BOX.COM USER ACCESS REQUEST

Request Type	☐ New User	☐ Reinstate User	**Date:** Click or tap here to enter text.
Requestor Information			
Requestor Name	Click or tap here to enter text.	**Work Phone**	Click or tap here to enter text.
Job Title	Click or tap here to enter text.	**Email Address**	Click or tap here to enter text.
Manager Name	Click or tap here to enter text.	**Manager Job Title**	Click or tap here to enter text.
Manager Email Address	Click or tap here to enter text.	**Manager Phone Number**	Click or tap here to enter text.
Practice/Facility Name	Click or tap here to enter text.		

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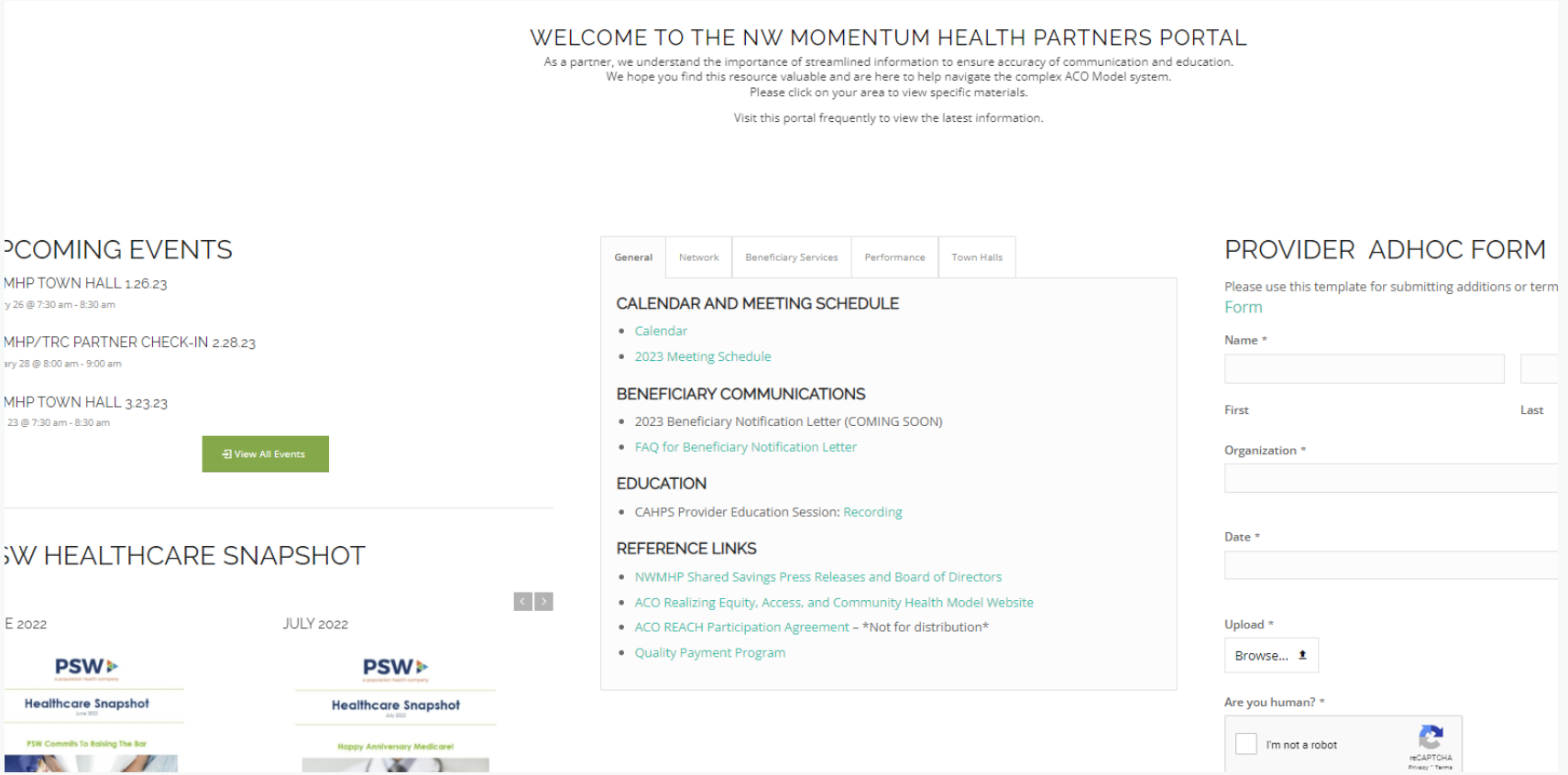
NWMHP Partner Portal – New features

- Updated 2023 calendar and flyers
- Healthcare Snapshot archive
- Archive of all Town Hall presentations
- Provider Adhoc submission



Register now at **https://www.nwmomentumhealthaco.com/partner/**

Fee Reduction Payment Schedule

Payments will be processed on these dates. If the payment is processed on this date, it may not be paid the same day, but would be paid the next business day.

- February 8th, 2023
- March 8th, 2023
- April 12th, 2023
- May 10th, 2023
- June 14th, 2023
- July 12th, 2023
- August 9th, 2023
- September 13th, 2023
- October 11th, 2023
- November 8th, 2023
- December 13th, 2023
- January 10th, 2024

- Final Payment – Tentatively February 14th, 2024

Annual Beneficiary Notification

Annual CMS required notification letter (template provided by CMS)

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

- NWMHP manages mailing per CMS guidelines for entire ACO
  - Provide call support and answer questions/concerns
  - Copies will be provided to partners prior to mailing
  - Provide a FAQ that partners can use to address questions

- Schedule
  - Scheduled to be distributed at the end of April/early May

Annual Beneficiary Notification

Partner/Provider Responsibilities:

What should you do to prepare?

- Review and share the FAQ with providers and staff – FAQ will be provided before the mailing is sent
- Prepare staff for to answer beneficiary questions
- Educate beneficiaries on why your facility chose to participate in the ACO and what it means to them
- Reach out to NWMHP with any questions or concerns

Why is this important?

- Many beneficiaries are unaware of the services they can receive through the ACO
- Helps the beneficiary understand that your organization elected to participate in this program to help coordinate their care and increase quality outcomes
- Allows beneficiaries to hear from their trusted Primary Care Provider on who NWMHP is and the services we offer

ACO REACH
Nurse Practitioner Benefit Enhancement

1. **Hospice Care Certification**:

- Provide **initial** certification that a patient needs hospice care and is terminally ill.

2. **Certification of Need for Diabetic Shoes:**

- NP's practicing "incident to" the physician supervising the beneficiary's diabetic condition to certify the need for diabetic shoes.

3. **Certification of Cardiac Rehabilitation Care Plan:**

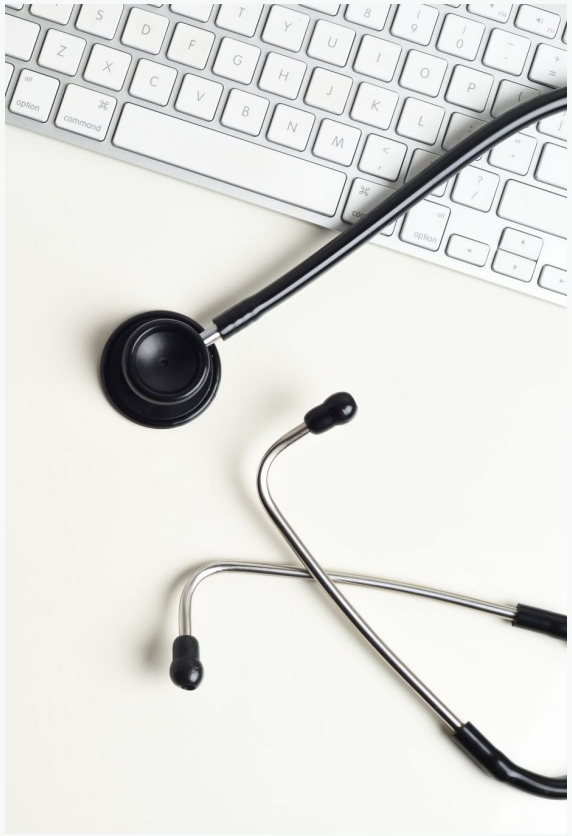
- Establish, review, and sign a written care plan for an aligned beneficiary to receive cardiac rehabilitation.

4. **Certification of Plan of Care for Home Infusion Therapy:**

- Establish, review, sign, and date a home infusion therapy plan of care prescribing the type, amount, and duration of infusion services to be furnished to a beneficiary.

5. **Referral for Medical Nutrition Therapy:**

- Refer beneficiaries with diabetes or renal disease to dieticians or nutrition professionals for medical nutritional therapy.



Effective July 1, 2023, PAs added to Benefit Enhancement!

- Beginning July 1, 2023, PAs will be able to utilize the NP benefit in ACO REACH.
- Prior authorization from NWMHP (NPs & PAs) is required to ensure that the benefit utilization meets the requirements established by CMS.
- Technical assistance on how to obtain prior authorization, complete forms and use tools to verify eligibility is also provided during webinars and upon request by Participant and Preferred Providers.

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ACO REACH Quality Measures

ACO REACH Quality Measures

ACO REACH Quality Metrics consist of 3 claims-based measures and the CAHPS survey. These are the same quality measures from GPDC.

Claims-Based Measures

1. Risk-Standardized All-Condition Readmission
2. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
3. Timely Follow-Up After Acute Exacerbation of Chronic Conditions

CAHPS

The CAHPS program is a survey administered by CMS to assess patients' experiences with healthcare.

These surveys focus on aspects of quality, from the perspective of the beneficiary, such as the communication skills of physicians and office staff, and the ease of access to healthcare services.

Quality Measures vs. Performance Measures

Performance Measures	Quality Measures
1. Per Beneficiary Per Month spend 2. Annual Wellness Visit Rate 3. Inpatient Admissions per 1,000 4. Inpatient Readmission Rate 5. Emergency Department Visits per 1,000	1. Risk Standardized, All-Condition Readmissions (ACR) 2. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC) 3. Timely Follow-Up (TFU) After Acute Exacerbations of Chronic Conditions 4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Performance Measures are continuously measured in Innovaccer and are the measures that NWMHP believes will generate Shared Savings. Utilization benchmarks are provided for these measures yearly.	Quality measures are used by CMS to determine the ACO's Quality Score at the end of the Performance Year. The measures are claims-based or captured through a survey by a 3rd party administrator.
Performance Measures will be scored at the Risk Pool level and are used to determine the Performance Score in each Risk Pool's Funds Flow Risk Arrangement.	In 2023, the ACO's Quality Score can impact 2% of the ACO's final benchmark. This affects the entire ACO's Shared Savings.

Risk-Standardized All-Condition Readmission (ACR)

1. Risk-adjusted percentage of hospitalizations by REACH ACO aligned beneficiaries that result in an unplanned readmission to a hospital within 30 days following discharge from the index hospital.

2. ACR is an outcome measure calculated using 12 consecutive months of Medicare Fee-for-Service (FFS) claims data. The measure is a risk-standardized readmission rate (RSRR) that adjusts for stay-level factors and clinical and demographic characteristics.

3. Lower RSRRs indicate better performance.

4. **Numerator**: Risk-adjusted unplanned readmissions at a non-Federal, short-stay acute-care or critical access hospital within 30 days of discharge from the index admission included in the denominator.

5. **Denominator**: All eligible hospitalizations for REACH ACO-assigned beneficiaries aged 65 or older at non-Federal, short-stay acute-care or critical access hospitals.

All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)

1. Rate of risk-standardized, acute, unplanned hospital admissions per 100 person-years among beneficiaries aged 66 years and older, who have multiple chronic conditions (MCCs), and are aligned to the REACH ACO.

2. An outcome measure calculated using 12 consecutive months of Medicare FFS claims data. The measure is a risk-standardized acute admission rate (RSAAR) adjusted for age, chronic disease categories, and other clinical/frailty risk factors present at the start of the measurement period as well as social risk factors.

3. Lower RSAARs indicate better performance.

4. **Numerator**: The number of acute unplanned admissions per 100 person-years at risk of admission during the measurement period. This measure **does not include the following** types of admissions in the outcome because they do not reflect the quality of care provided:

Planned hospital admissions	Admissions that occur directly from a SNF or acute rehab facility
Admissions that occur after the patient has entered hospice	Admissions within a 10-day "buffer period" after discharge from a hospital, SNF, or acute rehab facility
Admissions related to complications from procedures or surgeries	Admissions related to accidents or injuries
Admissions that occur prior to the first visit with the aligned REACH ACO	

5. **Denominator**: The cohort is Medicare FFS beneficiaries aged 66 years and older assigned to the REACH ACO during the measurement period with diagnoses that fall into two or more of nine chronic disease groups:

Acute myocardial infarction (AMI)	Alzheimer's disease and related disorders or senile dementia	Atrial fibrillation
Chronic kidney disease (CKD)	Chronic obstructive pulmonary disease (COPD) and asthma	Depression
Diabetes	Heart Failure	Stroke and transient ischemic attack (TIA)

Timely Follow-Up (TFU) After Acute Exacerbations of Chronic Conditions

1. Follow-up for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions of interest which can be attributed to providers participating in ACO REACH.

2. Results of the measure are aggregated on an ACO level. The Center for Outcomes Research and Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, NQF #3455.

3. **Numerator**: The sum of the ACO-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays—including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals) for acute exacerbations of hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes where follow-up was received within the timeframe recommended by clinical practice guidelines, as detailed below:
   - Hypertension: Follow-up within 14 days of the date of discharge for high-acuity patients, 30 days for medium-acuity patients.
   - Asthma: Follow-up within 14 days of the date of discharge
   - Heart Failure (HF): Follow-up within 14 days of the date of discharge
   - Coronary Artery Disease (CAD): Follow-up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
   - Chronic Obstructive Pulmonary Disease (COPD): Follow-up within 30 days of the date of discharge
   - Diabetes: Follow-up within 14 days of the date of discharge for high-acuity patients

4. **Denominator**: The denominator is the sum of the ACO-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for any of the six conditions listed (hypertension, asthma, HF, CAD, COPD, or diabetes).

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- Survey administered to measure the patient and caregiver experience
- For REACH ACOs, a random sample of 860 aligned beneficiaries will be surveyed
- NWMHP ACO is not informed on who these beneficiaries are or who their providers are
- NWMHP ACO must use a 3rd party administrator to survey the beneficiaries

2023 CAHPS Timeline

Beneficiary Data Collection by Survey Vendors	
Beneficiary sample downloaded by survey vendors	08/21/23
Teaser postcard mailed	09/11/23
Vendor Help Desk opens	09/12/23
1st questionnaire mailed	09/18/23
Reminder/Thank you postcard mailed	09/25/23
Non-response follow-up (2nd) questionnaire mailed	10/16/23
Telephone (CATI) non-response follow-up	11/13/23 – 12/08/23
Last day to receive questionnaires by mail	12/08/23
REACH ACOs can remove Waiting Room FAQs	12/08/23

CAHPS – Helpful Tips

- Patients are more accepting of appointment delays if they understand the cause of the delay. When the provider is behind:
  - Office staff should keep the patients up to date and attempt to explain the cause for the delay.
  - Consider allowing the patients to leave for a short time and return at the new expected time.
  - Office staff should acknowledge the delay when talking with the patient.

- Ask patients to schedule their routine check-ups and follow-up appointments in advance.
  - Advise patients on the best days or times to schedule appointments.

- Ask patients how the provider/office staff could help improve their healthcare experience.

- Before a patient's visit, review the reason for the visit and determine if a follow up is needed on any health issues or concerns from a previous visit.
  - The survey will ask how often the provider has information about the patient's care.
  - Use history and medical information to provide personalized health advice based on each patient's risk factors.

CAHPS Do/Don't

Do	Don't
Express support for the survey.	Ask patients if they would like to be included in the survey.
Answer questions based on the Waiting Room FAQs.	Influence patients' answers on the survey.
Confirm the legitimacy of the survey and the survey vendor.	Attempt to determine which patients were sampled.
Confirm that participation is voluntary.	Solicit positive feedback from patients in the survey.
Assure patients that the REACH ACO has no way of knowing who responds to the survey. Patient names are never reported, only responses.	Imply that the REACH ACO or its providers will be rewarded for positive feedback.
Confirm that their participation will not affect the care they receive.	Offer incentives of any kind for participating in the survey.
Confirm that their participation will not affect their Medicare benefits or other health care benefits.	Provide a copy of the questionnaire to patients.

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Poll

Would you/your providers attend a PSW hosted Educational Session on CAHPS?

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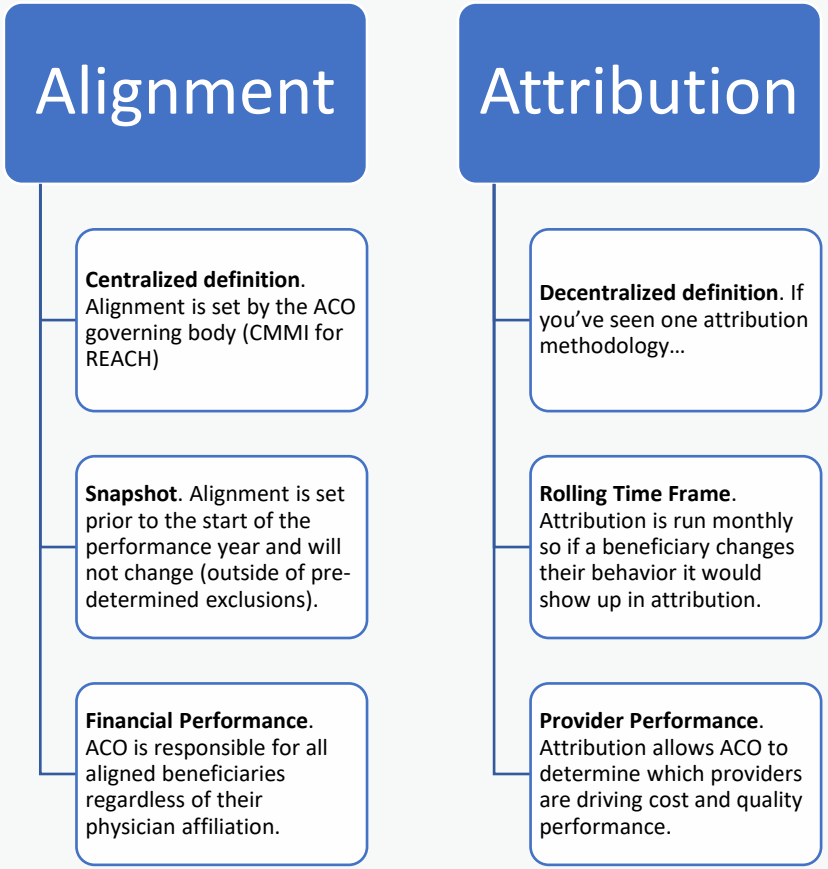
Alignment vs. Attribution

Alignment vs Attribution: Comparison



- 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

CMMI Alignment Methodology

To be Claims-Based Aligned, a Beneficiary must be alignment eligible during the "Alignment Period" – for PY2023 is 7/1/2020 – 6/30/2022.

Claims-Based Alignment of a Beneficiary is determined by comparing:

1. PQEM Services that the Beneficiary received from Participant Providers in the ACO; and
2. PQEM Services that the Beneficiary received from each provider/supplier that is not a Participant Provider and is a Medicare-enrolled billing TIN.

*Primary Care Qualified Evaluation & Management (PQEM) Services are Primary Care Services furnished by a Primary Care Provider or select Non-Primary Care Provider.

CMS will align a Beneficiary to the ACO based on Claims-Based Alignment if CMS determines that:

1. The Beneficiary is a Claims-Based Alignment eligible Beneficiary;
2. The Beneficiary received the plurality of their PQEM Services during the Alignment Period from the ACO's Participant Providers; and
3. The Beneficiary is not already aligned or assigned to a participant in another Innovation Center model, the Medicare Shared Savings Program, or another Medicare shared savings initiative that takes precedence for purposes of Beneficiary alignment.

NWMHP Attribution Methodology

NWMHP utilizes historical claims from the Alignment Period to determine attribution, following these steps:

1. Determine the provider that provided the majority of services to the beneficiary within the Alignment Period.
2. Determine if this provider is a Participant Provider.
3. If so, is the provider considered a Primary Care Provider?
    1. If so, and this PCP provided the majority of services in past 12 months, they are attributed.
    2. If not, is the majority of services provided by a Participant PCP in the past 24 months? If yes, they are attributed.
4. If neither of the two above, NWMHP determines if the Participant provider that provided the majority of services is a SPC Participant Provider.
    1. If so, and this SPC provided the majority of services in past 12 months, they are attributed.
    2. If not, is the majority of services provided by a Participant SPC in the past 24 months? If yes, they are attributed.
5. For the remaining unattributed, the methodology relies on the CMS alignment file to help designate the attributed provider.

Why is this important?

1. **Timing**
    1. Claims-based alignment is set by CMS once a year (not including Voluntary Alignment). The number of aligned beneficiaries will decrease during the year.
    2. Attribution is run monthly and will be updated based on roster changes and beneficiary behavior

2. **Performance**
    1. Alignment will dictate the ACO's overall performance
    2. Attribution is used for provider-level performance monitoring during the year

3. **Limiting beneficiary confusion**
    1. A beneficiary may be aligned to the ACO through a provider that they do not typically see
    2. Attribution attempts to account for this difference and help ensure that the beneficiary's "routine" provider is listed on the notification letter

What about providers added during the year?

Providers added mid-year are **not eligible** for claims-based alignment

However,

1. A beneficiary may voluntarily align to a provider during the year and be aligned the next available quarter
2. A beneficiary may be re-attributed during the year if a provider leaves the ACO and claims support the beneficiary being re-attributed

Voluntary Alignment

What is Voluntary Alignment?

- The process by which a Beneficiary may voluntarily align with the ACO by designating a Participant Provider as their main doctor, main provider, and/or the main place they receive care

ACO REACH – Prospective Plus Voluntary Alignment

- Beneficiary alignment is performed prospectively prior to the start of a Performance Year
- Prospective Plus alignment is performed prior to the start of the second through fourth calendar quarters of a Performance Year
  – adding beneficiaries throughout the Performance Year

How do beneficiaries align?

- Paper Based Form (Mail, email, Fax)
- Electronic via Medicare.gov

Data Reporting

- Quarterly Performance Data Reports: **Attribution**
- Innovaccer: **Attribution**
- NWMHP Funds Flow: **Alignment**
  - Why do we use Alignment for funds flow? Since alignment is used by CMS to determine financial performance, we use alignment for the funds flow algorithm.

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2023 Good to Know

2023 Calendar of Meetings

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January	February	March	April
26th: Town Hall Meeting	**15th:** ACO Board Meeting **28th:** TRC Partner Check-In	**23rd:** Town Hall Meeting	**20th:** TRC Partner Check-In
May	**June**	**July**	**August**
17th: ACO Board Meeting **25th:** Town Hall Meeting	**22nd:** Executive JOC Meeting	**20th:** TRC Partner Check-In	**16th:** ACO Board Meeting **24th:** Town Hall Meeting
September	**October**	**November**	**December**
14th: TRC Partner Check-In	**19th:** Town Hall Meeting	**15th:** ACO Board Meeting **30th:** Executive JOC Meeting	**14th:** Town Hall Meeting

WHO CAN ATTEND:
ACO Board Meeting = Board Only
Executive JOC Meetings = Regional Partner Representatives Only
Town Hall Meetings/Trainings = Open to all network participants/staff

What to Expect?

February - March:

- Finalize SNF network for new partners
- Attribution file available via Box.com
- Participant Providers will receive the 2023 Paper-Based Voluntary Alignment Form

April:

- Innovaccer data to begin to be populated in early April

May:

- Updated Attribution file
- Q1 Quarterly Data Reports

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Poll

Would you or someone from your organization benefit from an Innovaccer training?

ACO REACH: Getting Started

- What steps can be taken today?
  - Identify Medicare FFS patients
  - Schedule Annual Wellness Visits
  - Establish workflows
  - Communicate about the ACO once attribution is available

- Resources – located on Partner Portal
  - About Care Management flyer *available now*
  - Care Management Referral Form *available now*
  - 2023 Informational AWV flyers *coming soon*

Questions?

Thank you!