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

March 23, 2023

Agenda

- Program Updates
- 2023 Beneficiary Notification
- Voluntary Alignment
- Care Management/Benefit Enhancement Education

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Program Updates

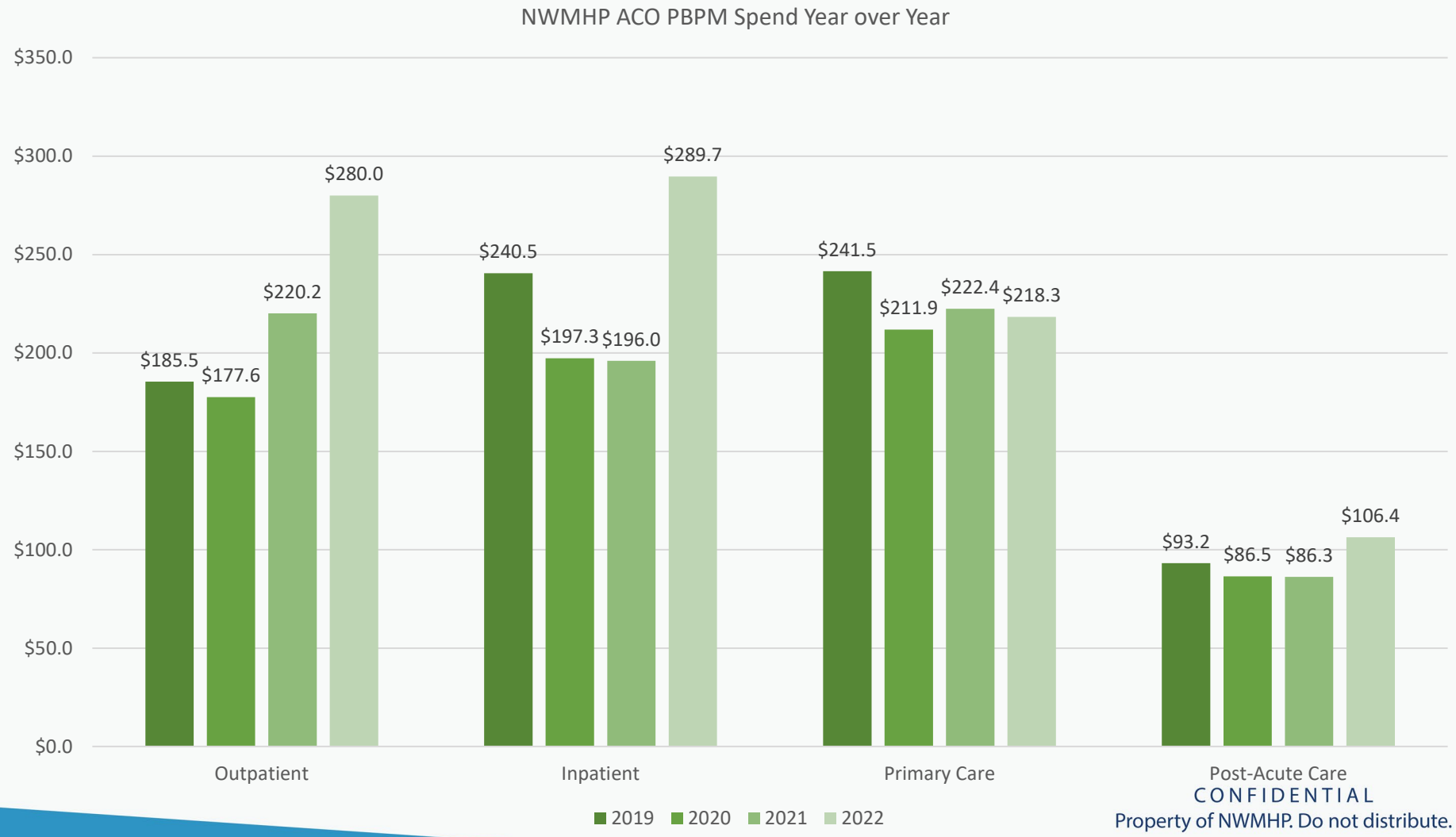
NWMHP ACO Spend YoY

2022 ACO beneficiaries = 24,336

2021 ACO beneficiaries = 27,377

2020 ACO beneficiaries = 15,120

2019 ACO beneficiaries = 13,305



Innovaccer

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

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.		

- Each organization must designate a "Point of Contact" to sign off on each request form and be responsible for notifying PSW of user terminations.

Upcoming all ACO Innovaccer training: April 5th at 10-11am

Box.com – Data Report Delivery

- Secure file transfer platform
- Used to deliver reports such as attribution and scorecards

Box.com pushed a security update requiring multi-factor authentication. Users must complete this. Please use the email sent to you from Box.

2023 Attribution Lists

- 2023 Attribution lists are now available in Box.com.

- For questions/access issues, contact Sherri King – SherriK@pswipa.com

Important notes:

1. Attribution lists are updated quarterly in Box.com but monthly in Innovaccer
2. The CMS alignment window for 2023 is 7/1/2020 – 6/30/2022
3. Several providers saw a reduction in alignment that may have been caused by low utilization during the alignment period

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2023 ACO REACH Voluntary Alignment

2023 ACO REACH Voluntary Alignment (VA)

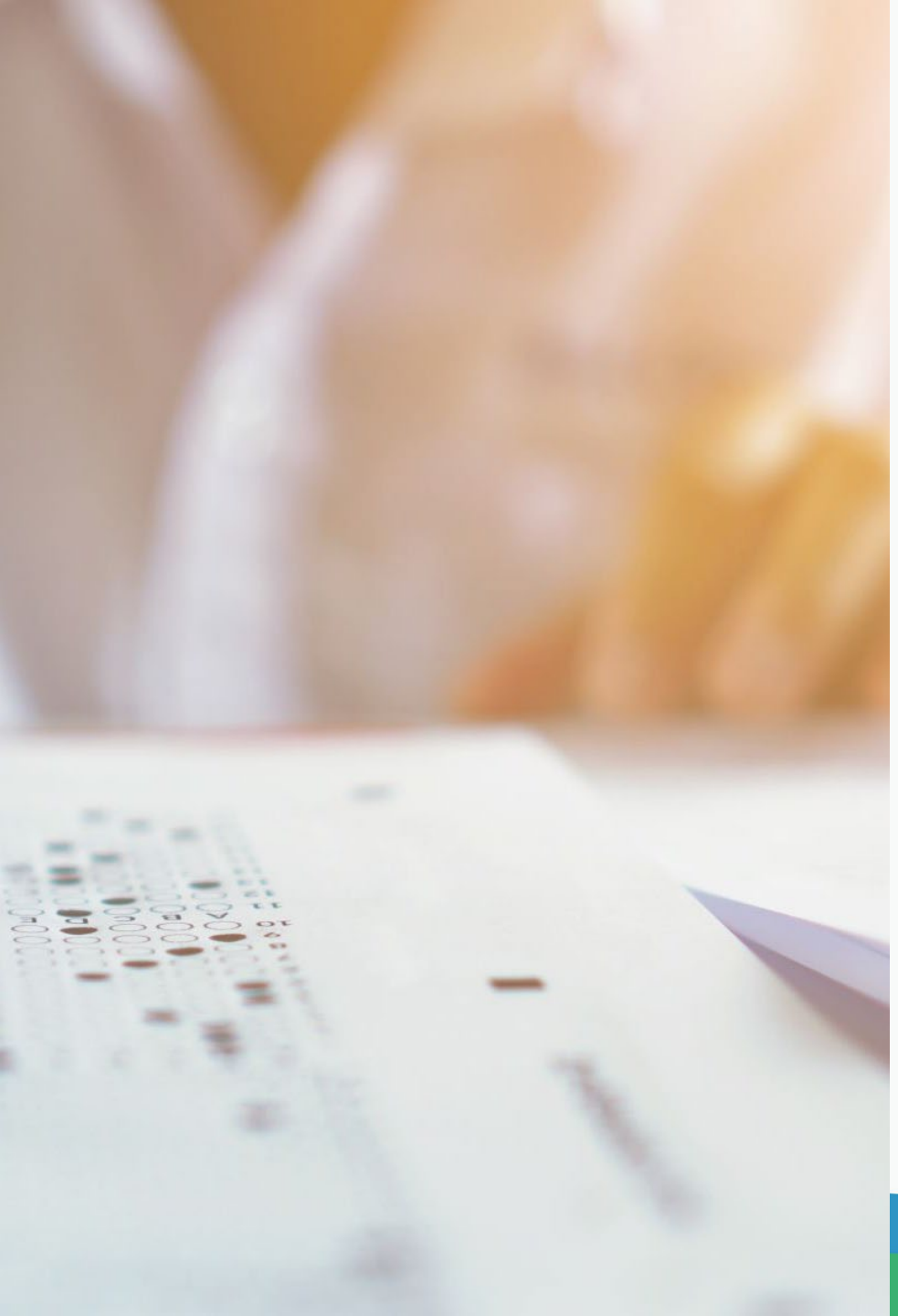
- Voluntary alignment is the process that lets Medicare fee-for-service (FFS) beneficiaries select, or “voluntarily align” with, a primary clinician
- A beneficiary may align to a Participant Provider through Medicare.gov Voluntary Alignment (MVA) or,
- A beneficiary may align to a Participant Provider through a Signed-Attestation Based Voluntary Alignment (SVA)
- Providers may not begin offering SVA forms to beneficiaries until CMS has approved of the NWMHP 2023 form

Precedence in Voluntary Alignment

- The most recent valid voluntary alignment attestation (either MVA or SVA) will take precedence over ACO REACH claims-based alignment
- MVA or SVA designation is considered valid if it was made no earlier than 24 months before the start of that performance year, or
- If the Participant Provider has submitted a claim for a Primary Care Qualified Evaluation and Management (PQEM) service furnished to the beneficiary in the 24 months before the start of the performance year.

❖ For PY2023, the following initiatives will take precedence over ACO REACH for beneficiary alignment (if applicable): The Kidney Care Choices Model or the Medicare Shared Savings Program.

❖ For example, SVA Attestations for ACOs in the ACO REACH Model will not take alignment precedence over claims-based alignment for ACOs in the Shared Savings Program that select Prospective Assignment



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ACO REACH 2023 VA Plan

- NW Momentum Health Partners (NWMHP) ACO intends to utilize the Signed-Attestation Based Voluntary Alignment Form as a method for beneficiaries to voluntarily align to an ACO Participant Provider
- The ACO would like the Signed-Attestation Based Voluntary Alignment form to be available in Participant Provider offices
- This Signed-Attestation Based Voluntary Alignment form **must be handed separately** and kept separate from all check-in forms at the provider office
- The beneficiary will then be instructed to mail the form to NWMHP or fax a completed form to NWMHP. A beneficiary may also complete the form and ask the Participant Provider to fax completed forms to NWMHP

Sample SVA Attestations

- Participant Providers may refer individuals to NWMHP for more information or to request a Voluntary Alignment Form.
- These forms will be available for NWMHP to mail, fax or email the forms at beneficiary request
- NWMHP intends to post any informational resources about Voluntary Alignment and offer beneficiaries the ability to download the Signed-Attestation Based Voluntary Alignment Form online at https://www.nwmomentumhealthaco.com/ACO-Voluntary-Alignment/
(website page not available until approved by CMS)

Screenshot of Voluntary Alignment Form

1. CONFIRM ✔

By signing below I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is [$PROVNAME AND/OR $MEDICALGROUP].

[$BENENAME]

_____ Signature

_____ Print Name

___/ _/_____ Date

____-___-_____ Medicare Beneficiary Identifier (MBI)

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call [$ACONAME] at [$ACONUMBER] to request a new form.

2. RETURN ✉

Return this form in the envelope that we provided.

[ACO may include additional instructions for returning this form to the ACO]

Tips for Complying with VA Requirements

- **DO NOT** complete a Voluntary Alignment Form or designate a clinician on Medicare.gov on behalf of the Beneficiary (May offer technical assistance)
- **DO NOT** directly or indirectly coerce or otherwise influence a Beneficiary's decision to complete a Voluntary Alignment Form or Medicare.gov designation
- **DO NOT** Include the Voluntary Alignment Form and instructions with any other materials or forms for beneficiaries to sign

- **DO** ensure Beneficiaries know that they can still go to any health care provider who accepts Medicare, even after they have voluntarily aligned
- **DO** make the official CMS Voluntary Alignment Beneficiary Fact Sheet accessible to all beneficiaries in your ACO
- **DO** let beneficiaries know the Practice partners with NWMHP in providing care

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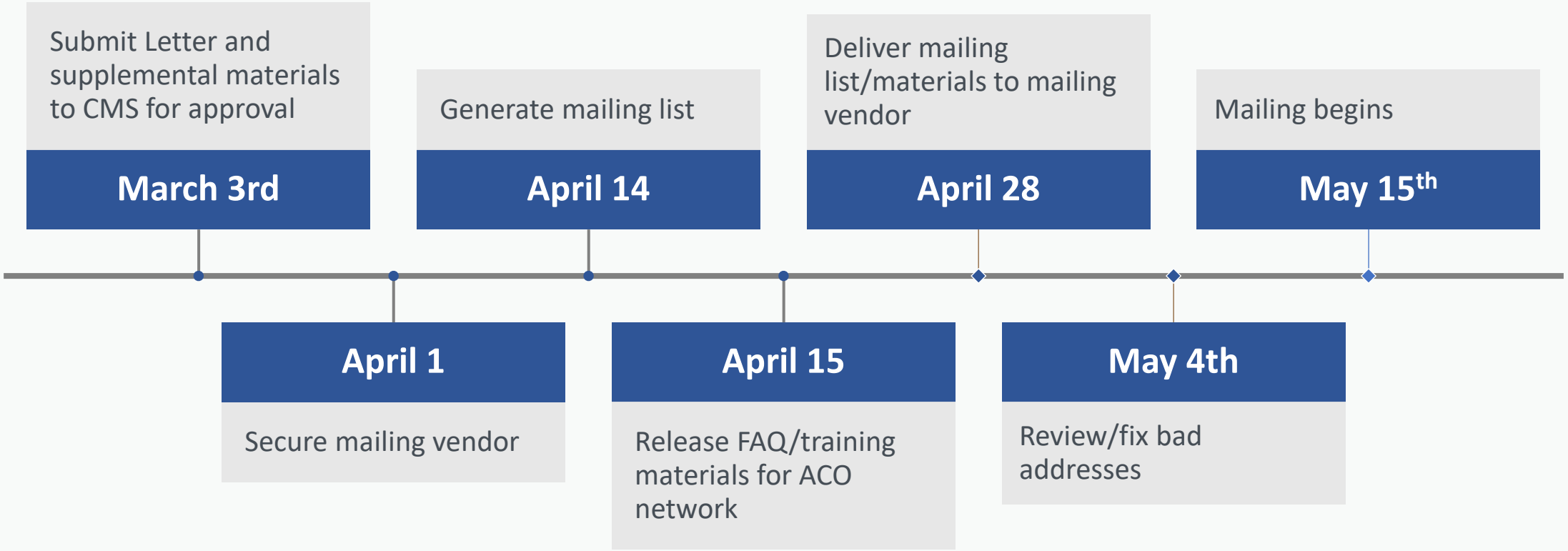
2023 ACO REACH Beneficiary Notification

2023 ACO REACH Beneficiary Notification

- **Annual CMS required notification letter (template)**
- **Purpose**
  - Informs beneficiary their provider is participating in ACO REACH
  - 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

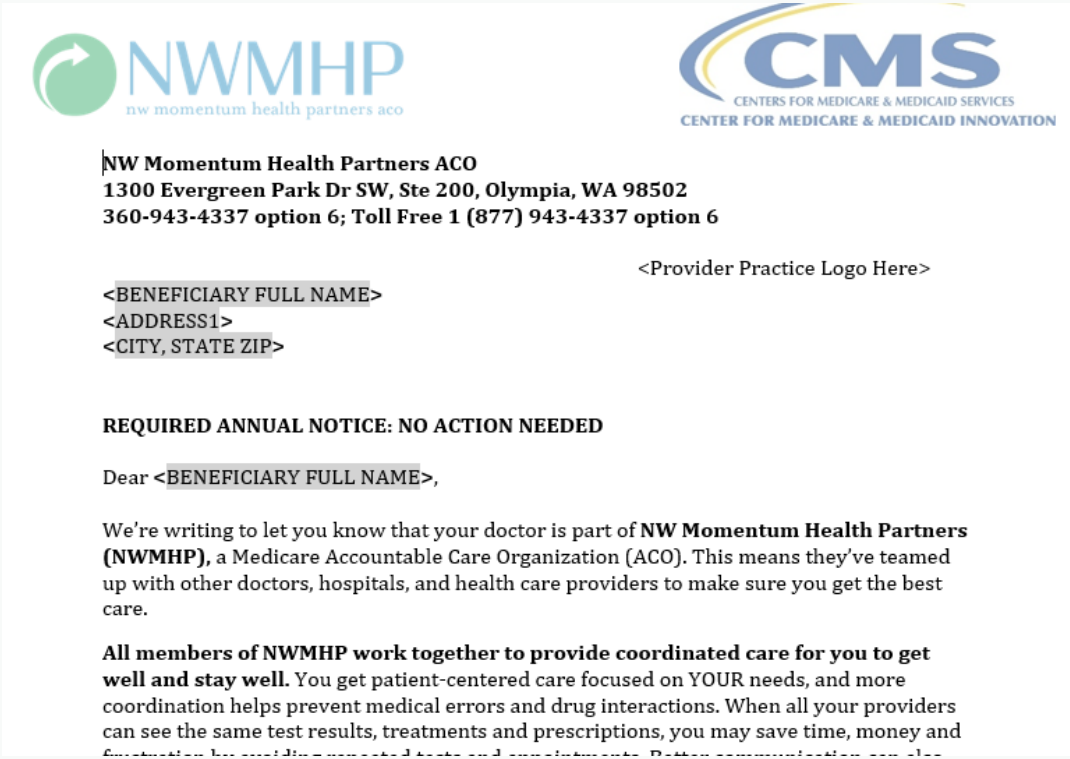
2023 ACO REACH Beneficiary Notification Timeline



2023 ACO REACH Beneficiary Notification Letter

Changes to the letter for 2023:

1. CMS made language changes to their portion of the letter
2. Tightened language on benefits
3. CMS has added a QR code that links to the Medicare.gov “About ACOs” section



NW Momentum Health Partners ACO
1300 Evergreen Park Dr SW, Ste 200, Olympia, WA 98502
360-943-4337 option 6; Toll Free 1 (877) 943-4337 option 6

<Provider Practice Logo Here>

<BENEFICIARY FULL NAME>
<ADDRESS1>
<CITY, STATE ZIP>

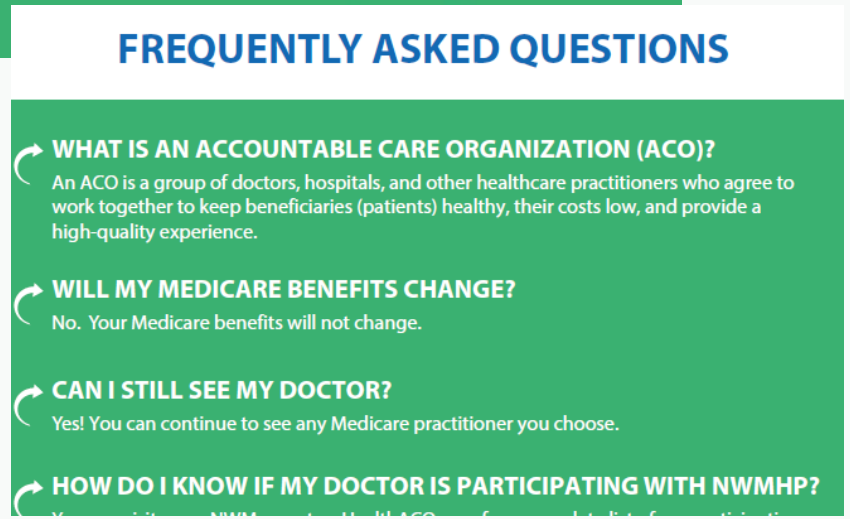
REQUIRED ANNUAL NOTICE: NO ACTION NEEDED

Dear <BENEFICIARY FULL NAME>,

We’re writing to let you know that your doctor is part of **NW Momentum Health Partners (NWMHP),** a Medicare Accountable Care Organization (ACO). This means they’ve teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.

All members of NWMHP work together to provide coordinated care for you to get well and stay well. You get patient-centered care focused on YOUR needs, and more coordination helps prevent medical errors and drug interactions. When all your providers can see the same test results, treatments and prescriptions, you may save time, money and

Materials with the notification



Materials were shared with NWMHP Beneficiary Board Members to review the language and provide feedback

Once materials are approved by CMS, they will be shared with ACO network providers

2023 ACO REACH Beneficiary Notification

Partner/ Provider Responsibilities

What should you do to prepare?

- Review and share the FAQ with providers and staff
- Prepare staff for to answer beneficiary questions
- Educate beneficiaries on why your facility chose to participate in ACO REACH 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

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Care Management Overview

CM Programs, SDoH, & Benefit Enhancements

Transitional Care Management

ED Discharge Outreach

- Focused on High Risk & High Utilizers
- Access to care, understanding red flags & DC paperwork, equipment, medications received
- SDoH screening
- Mail resource list & CM information flyer

Inpatient Discharge Outreach

- Following discharge from inpatient or post-acute stays
- 4-week program, with at least 2 outreach calls required to meet goals
- Customized to client's need, can be education or resource focused
- Determine if Care Management program (general, complex, or RPM) recommended

Post-Acute Outreach

- Routine engagement with SNF, Swing Bed, and/or IRF during admission for progress and barriers to discharge
- Handoff back to Care Management team to initiate IP Discharge Outreach upon return home
- Engages with home health agencies in preferred provider network

Care Management Programs

General Care Management

- Addresses needs when individual may not meet complex care management qualifications, or if not willing to address complex medical needs by enrolling in CCM

Complex Care Management (CCM)

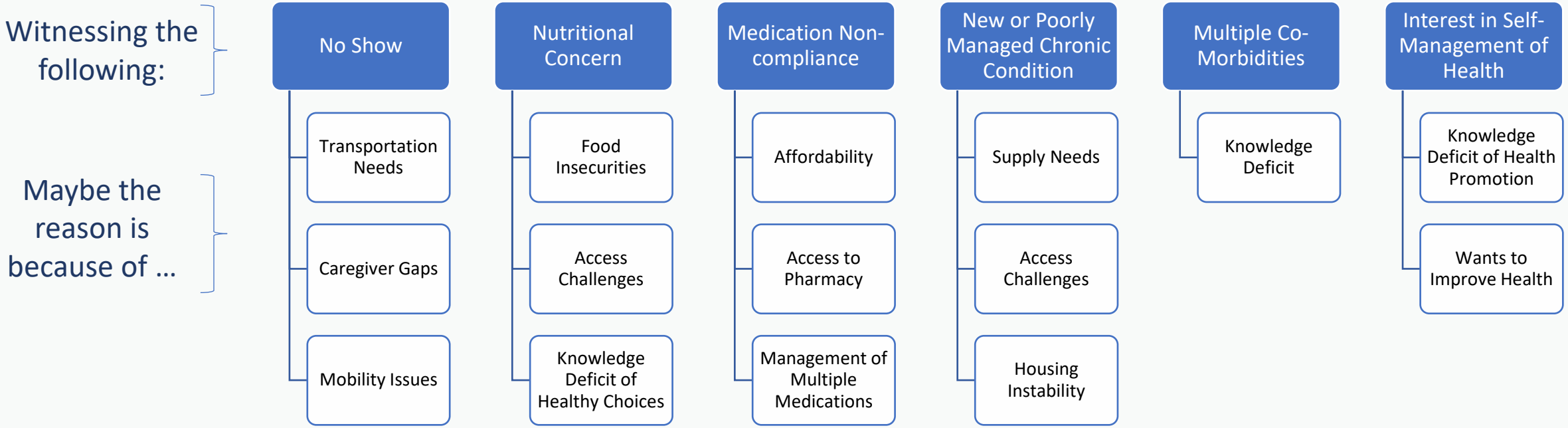
- ≥ 90-day program
- Designed for beneficiaries with chronic conditions, specialty care needs, multiple medications, abnormal findings, and/or high-risk

Remote Patient Monitoring (RPM)

- Cardiac or Pulmonary condition
- Focused on self-management of condition
- Capable of using device, or have assistance
- Monthly results shared with PCP

Participants may qualify for Chronic Disease Reward Program – up to $75 gift cards after participating!

When a beneficiary presents with the following…is there more than meets the eye?



Referrals to Care Management can help to support needs of beneficiaries

Identifying Appropriate Referrals

- Awareness of aligned Medicare beneficiaries
  - Can clinic team help identify ACO beneficiaries?
- High-Risk/High-Utilizers – list sent weekly to TRC partners
  - Option to engage in interdisciplinary high-risk meeting on Wednesdays
  - Interdisciplinary team to review barriers to engagement, complicated cases
- Knowing service options & when to engage Care Management
  - Care Management informational flyers
- Provider involvement helpful in successful engagement of individual
- SDoH screening
  - Consider food, stable housing, utilities, medication payment, transportation, emotional/physical safety

    For Providers in area serviced by DispatchHealth, certain visits will include a SDoH assessment

https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Partnering together

- NWMHP may request additional support, or call with concerns
- Enrollment in Care Management services will fax enrollment & care plans

Common Needs	Requested Outcome
NWMHP may call with concerns or questions for continuity of care	Communicate reciprocally
Appointment availability	Scheduler awareness of NWMHP ACO, or route to find available options
Medical Records – helpful for CM intake to have information on PMH or current needs	Currently medical records request, explore read-only access to EMR if applicable
Review high-utilizer list	Engage beneficiaries in office and ask about NWMHP outreach, validate who we are

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Social Determinants of Health (SDoH)

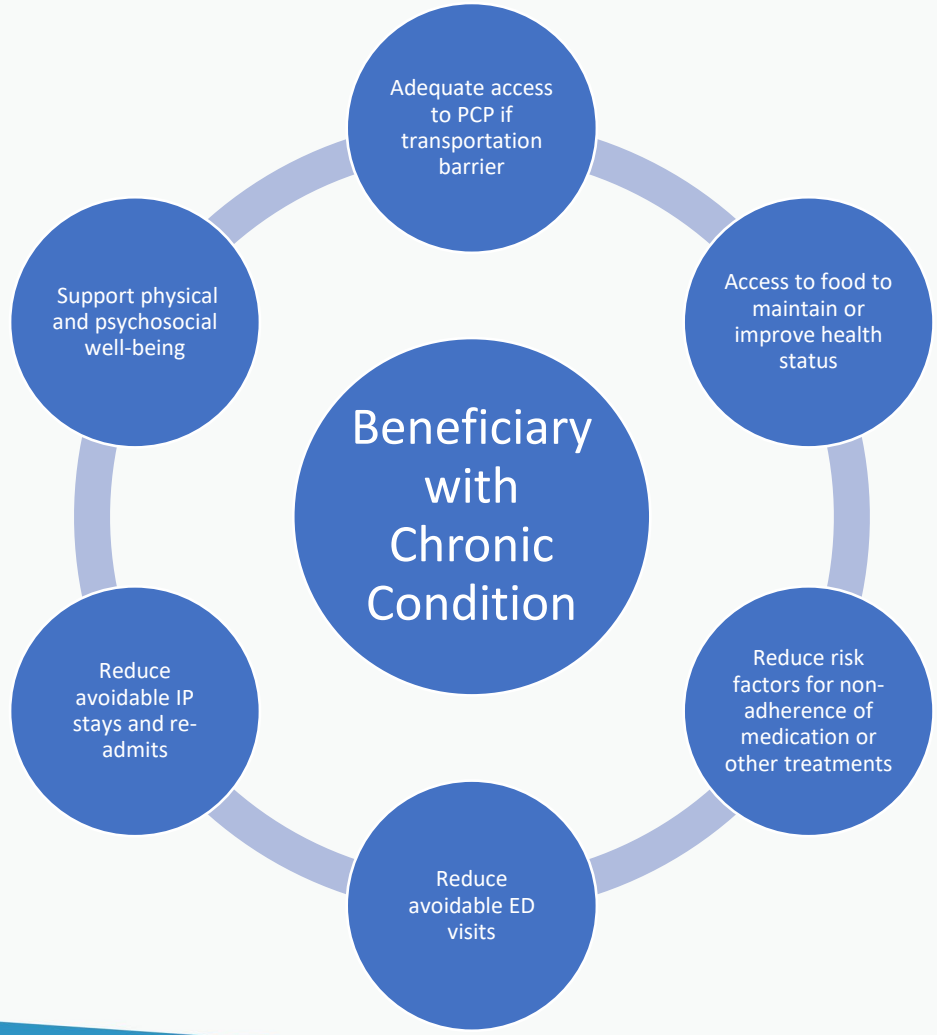
Social Determinants of Health (SDoH)

- *Social determinants of health are non-medical factors that account for up to 55 percent of an individual's health outcomes, according to the World Health Organization.*
- Social determinants of health have a major impact on people's health, well-being, and quality of life

- 5 domains
  - Economic Stability
  - Education Access & Quality
  - Health Care Access & Quality
  - Neighborhood & Built Environment
  - Social and Community Context

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

SDoH In-Kind Benefits



Qualifications for SDoH In-Kind Benefits

1. Beneficiary is aligned with NWMHP ACO population at time of service
2. Participating in Transitional Care Management (EDTC or IDO), Care Management (GCM, CCM, RPM, COPD), Social Services, or Post-Acute Care programs
3. Evaluation of available resources should be completed, and access community resources first
   - Includes evaluation of need and evidence to support how the utilization of benefit meets one or more of the clinical goals associated with a chronic health condition
   - Beneficiaries with Medicaid or other state/federal programs may not qualify
4. Must have a clinical goal associated with the use of the service:
   - Adherence to a treatment plan
   - Adherence to a drug regime
   - Adherence to follow a care plan
   - Management of a chronic disease

SDoH Program Overview

- Beneficiaries may qualify for the following services:
  - Restrictions apply to amount and time period for utilization

SDoH Service	Purpose of Benefit
Transportation	Supports need to access healthcare when transportation is an access barrier
Groceries/Food	Supports nutritional needs for at-risk clients with identified food insecurities while a longer-term solution to meet the needs is implemented
Non-Covered DME or Supplies	Supports medical equipment or supplies needed for health & well-being that are not covered under Medicare

Intent is to be a bridge to support the beneficiary while other community services are being set up for long-term support

SDOH Referral Process

- Send secure email to CareTeam@NWMHPACO.com with the following information:
  - Beneficiary Name and Date of Birth
  - Current phone number
  - SDoH need
  - Goal associated with the use (care plan)

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Remote Patient Monitoring

Remote Patient Monitoring (RPM)

Eligibility Requirements:

- Has a cardiac or pulmonary condition
- Ability to participate in self-management of their chronic disease
- Ability to understand and participate in medication management
- Physically and cognitively capable to participate in using the monitoring devices
- Clients with Stage IV and End Stage Renal Disease are reviewed with a Medical Director prior to enrollment into the program.

Goals of the Program:

1. Client will demonstrate knowledge and skill to obtain and record their vital signs daily.
2. Client will verbalize knowledge of what their vital signs mean in relationship to their overall health and wellbeing.
3. Client will identify the parameters of when they should seek medical attention in relation to their vital sign results.
4. Client will identify five ways their signs and symptoms of their condition may result in change in their vital signs such as increased edema in their ankles with increase in weight.
5. The client will identify when they should inform their practitioner of changes in condition and when to seek urgent care versus immediate care.

RPM Referral Process

- Send secure email to CareTeam@NWMHPACO.com with the following information:
  - Beneficiary Name and Date of Birth
  - Current phone number
  - Condition requesting RPM program
  - Clinical note & medication list from recent office visit, if available

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Chronic Disease Management Gift Cards

Chronic Disease Management Gift Cards

- Qualifying Diagnosis
  - Chronic Respiratory Condition
  - Chronic Cardiac Condition
  - Diabetes
  - Depression, or other mental health disorder
  - CKD

- Enrolled in Chronic Disease Management Program (GCM, CCM, RPM) – each of the following achievements earns the beneficiary a $25 gift card:
  - 60-day enrollment & meet participation engagement requirements in care plan
  - Achieve a care plan goal
  - Achieve a second care plan goal

Care plan goals must be focused on the above qualifying diagnoses. It is not enough that they have a diagnoses – the work done for Chronic Disease Management must be related to that condition.

Gift Card Process

- Gift Card Request Form
  - Can be provided at time of completion of 60-day enrollment & goals, or as the achievements are being made
- Documentation in beneficiary record
- Approved gift card list
  - Partners may submit recommendations to NWMHP Compliance for new gift card ideas
  - Exclude businesses that sell tobacco products or alcohol
- Email completed form to careteam@nwmhpaco.com
  - Beneficiary Name and Date of Birth
  - Current phone number
  - Confirmed current address
  - Completed request form

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Post-Acute Benefit Enhancements

Skilled Nursing Facility 3-Day Waiver

Waiver definition:

Eliminates the requirement of a 3-day inpatient stay before admission to a SNF

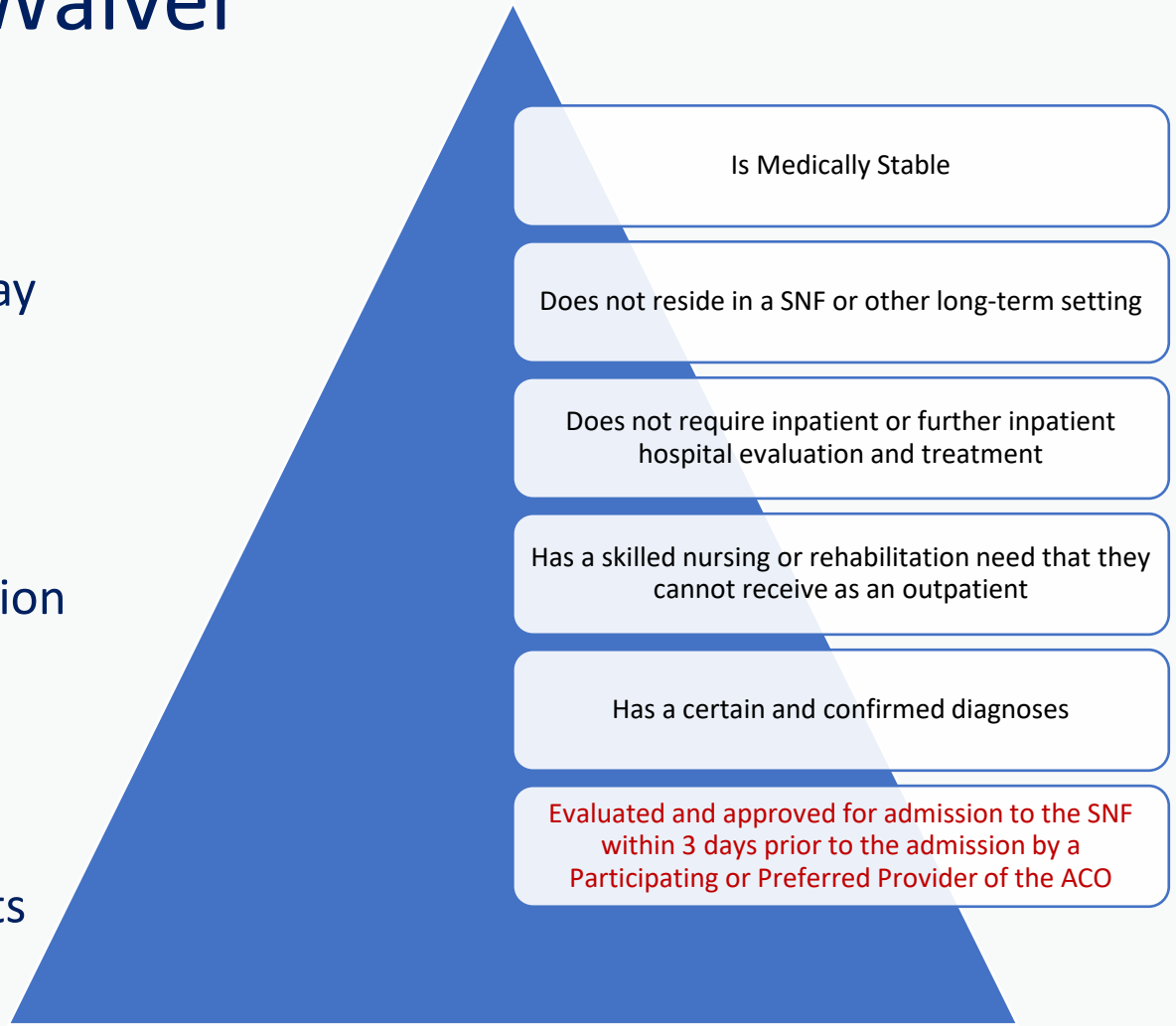
What does the waiver allow?

Allows for direct admit to SNF without hospitalization or if hospitalized, before 3 midnights

What are the requirements?

Must meet standard SNF level of care requirements

<u>*Not for custodial or Long-Term Care needs</u>



Home Health Homebound Waiver

Waiver definition:

Eliminates the requirement of homebound status requirements for qualifying beneficiaries when using select home health agencies

What does the waiver allow?

Home health services for qualifying beneficiaries who are not homebound but will benefit from home health services

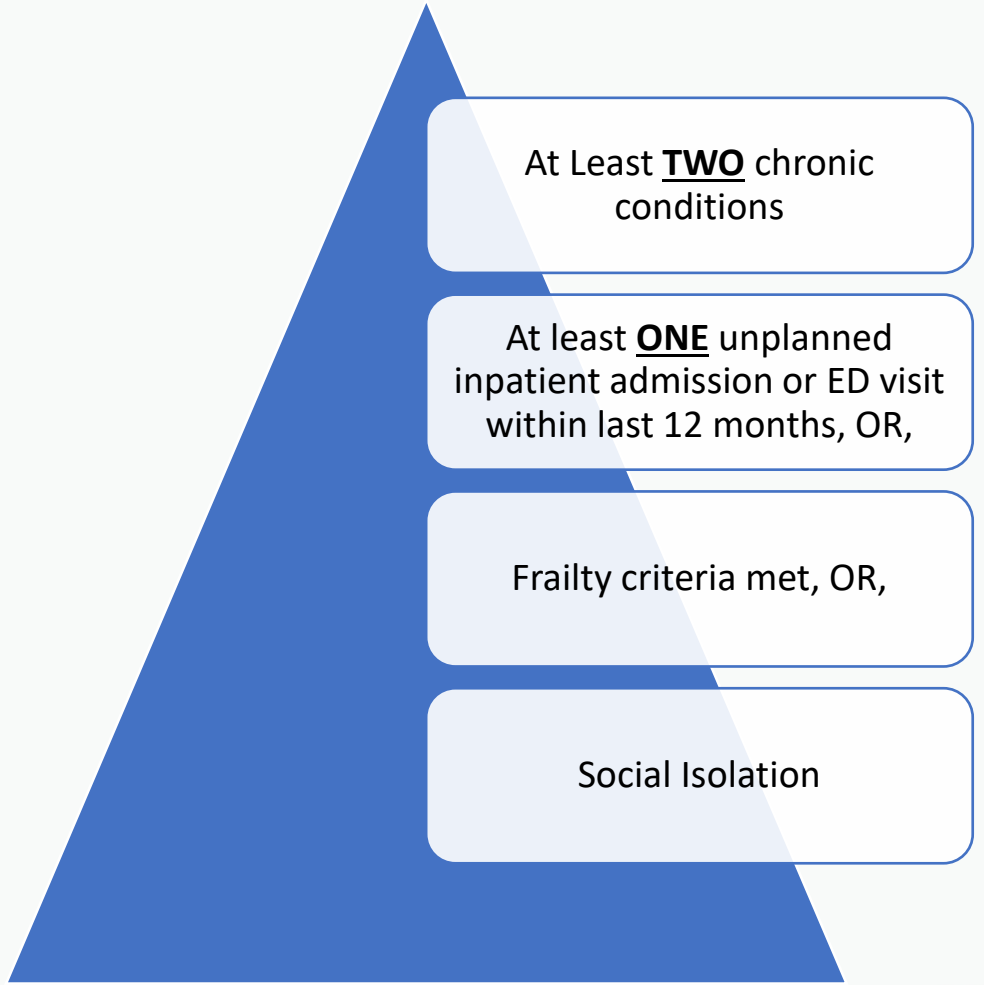
What are the requirements?

Must have at least 2 qualifying co-morbitities, and meet qualification of prior unplanned inpatient/ED visit in preceding 12 months or frailty/social isolation

Home Health Homebound Waiver

Eligibility must include one of the following conditions:

1. Renal Failure
2. COPD
3. Depression, or other mental health disorder
4. Diabetes
5. CHF



Post-Acute Waivers - Considerations

- Eligibility for waiver should be considered prior to engaging beneficiary in discussion
  - Can discuss with Director of Post-Acute Network to brainstorm options & eligibility, or submit waiver request to initiate process
- Questions to ask consider when assessing if waiver is appropriate
  - What is occurring that is concerning (lack of caregiver, mobility challenges, safety)
  - What is client's baseline versus current
  - Is this an acute change, will it improve/resolve with a SNF or Home Health admission?
  - What could resolve the concerns in home (equipment, set-up changes, caregiver, etc)
  - What services are current being utilized, or is there access through additional services at county or state level to accommodate needs
- Has client had a 3-day qualifying inpatient stay within past 30-days?
  - If so, can use prior qualifying stay to access Medicare Part A SNF benefits = no waiver needed
- Is client homebound?
  - If so, can utilize normal referral process to Home Health Agency = no waiver needed

Post-Acute Waivers - Process

- Client needs to have assessment by provider
  - SNF waiver requires assessment within 3-days of SNF admission by ACO provider
- Provider completes forms (available on NWMHP Portal):
  - ACO Waiver Eligibility – this form also goes to SNF or HHA
  - Waiver Notification Form (different for SNF & Home Health) – for NWMHP use only
- Email or Fax forms to NWMHP
  - Response from NWMHP expected within 2-4 business hours Monday-Friday (8a-4p)
  - Post-Acute team may be able to assist with calling SNFs, but will need clinical assessment notes
  - Requesting location responsible for submitting admission paperwork to facility
    - 3-days from assessment for SNF waiver
- For SNF waiver, provider needs to complete admitting documents directly for SNF

Thank you!

Transportation

- Benefit supports client when transportation is an access barrier
- Non-emergent care needs:
  - Appointments with primary or specialty providers
  - Obtaining prescriptions or treatments ordered by provider
  - Outpatient services
  - Participation in community preventative care clinics (ie: free vaccine clinic)
  - Evaluation by Urgent Care for non-emergent changes in health status or non-substantial injury
- Limited to certain number of events and total amount
- **Criteria for Utilization:**
  - Client does not have access through Medicaid or community-based services
  - Does not have active driver's license or family support unable to transport
  - Has active driver's license, but unable to drive due to acute or chronic health condition (ie: eye surgery, ankle fracture, etc)
  - Financial need affecting ability to pay for transportation services and does not qualify for Medicaid (may be in process of application)

Groceries/Food

Criteria for utilization:

A. Chronic health condition in which nutritional intervention is needed to support overall health status

B. Must demonstrate need related to one or more of the following:

   i. At risk for alteration in nutritional status due to impaired ability to obtain adequate groceries from local supermarket, low activity tolerance, or limitations due to transportation.

   ii. At risk for ability to prepare meals in home due to limited mobility; poor activity tolerance; impaired cognition; or assessed risk factors affecting ability to home cook meals.

   iii. Weakness following an inpatient stay either at an acute or post-acute care facility within the last 30 days

   iv. Financial need contributing to food insecurities with the potential to affect overall health and well-being

-AND-

C. Demonstrate evidence of interventions aimed to address food insecurities following the use of services will address the needs above

Groceries/Food - Criteria

Additional Qualification Requirements:

- Food items should be based on therapeutic diet
- Need & criteria should be evaluated bi-weekly at a minimum

Disqualifications:

- **Already enrolled in Meals on Wheels, or state food program (including EBT, food stamps, SNAP)**
  - Clients receiving state services may qualify for supplemental nutrition based on clinical evaluation demonstrating need.
  - For example:
    - Clients may receive nutritional support specific to health-related problem such as protein shakes to help with wound healing in addition to or separate from the prior benefits offered.
    - Maximum benefit for this type of nutritional supplement is $80.00 provided over a 30-day period.
    - To qualify there must be a clinical evaluation to demonstrate the need of the supplement being provided.

Non-Covered DME or Supplies

- Aids with purchase of non-covered medical equipment or supplies to manage a chronic condition and support improved health outcomes
  - Items can not be covered by Medicare

- **Criteria for Utilization:**
  A. Must have a chronic health condition and meet at least one of the following tied to their chronic condition:
     i. At risk for alteration in health status due to impaired ability to obtain non-covered medical equipment
     ii. Lack of resources to support adherence to recommendations
     iii. Non-covered item supports the ability to achieve a care plan goal identified