Implementation Plan for Chronic Disease Management Reward Benefit Engagement Incentive

General Overview

NW Momentum Health Partners (NWMHP) is committed to reducing Medicare expenditures while improving the quality of patient care. NWMHP's goal is to support beneficiaries with self-management of chronic disease conditions and reduce the risk of injury and illness while supporting independent living and promoting efficient use of health care resources using incentives. The NWMHP Care Management Program focuses on Chronic Disease Management and is aimed at promoting improved health outcomes. Implementation of the Chronic Disease Management Reward Beneficiary Engagement Incentive ("Chronic Disease Management Reward Benefit") will include the provision of up to $75.00 in gift cards per performance year. This process will be under certain conditions with safeguards as established by CMS to eligible beneficiaries for the purpose of incentivizing participation in a qualifying Care Management Program with NWMHP. Furthermore, the goal is to include early identification of changes in health status and work with health care provider(s) to reduce potentially avoidable emergency department use or inpatient acute care stays. The NWMHP Care Management Program will support health management educational needs for beneficiaries, provide education related to informed decision-making regarding provider recommendations, and work with beneficiaries to define their health care goals.

SECTION 1: GENERAL OPERATIONS INFORMATION

1.1 Understanding and Definition of Beneficiary Eligibility

The Chronic Disease Management Reward Benefit is available to beneficiaries who are aligned to the NWMHP ACO REACH Model. Beneficiaries must be aligned at the time of enrollment into qualifying programs and remain aligned during the qualification period to achieve the benefit.

The Chronic Disease Management Reward Benefit is available to beneficiaries who are eligible and participate in Care Management programs which are provided for 60 days or greater. Care Management programs include, but are not limited to, Complex Care Management, Chronic Disease Care Management or Behavioral Health Care Management. Beneficiaries may also participate in the Care Management Home Visit or Post-Discharge Home Visit benefit enhancement to qualify for the Chronic Disease Management Reward Benefit. Eligibility is based on support needed for self-management of conditions associated with chronic heart or pulmonary disease, Diabetes Mellitus Type II (DM), Chronic Renal Disease, and Depression or other mental health diagnoses. These primary conditions identified will be further targeted by focusing on newly diagnosed beneficiaries within the prior three-month period or poorly managed chronic conditions. Newly diagnosed conditions will be identified through primary care provider referrals for all three diagnoses.

Participant and Preferred Providers have access to information regarding alignment through the population health tool that is updated monthly. Providers are knowledgeable on the process for identifying beneficiaries for alignment prior to accessing any benefits provided to the beneficiary.

The eligible beneficiary will be required to complete specific requirements for each of the three (3) available $25.00 gift cards of their choosing, totaling no more than $75.00 per performance year. Beneficiaries will be required to be enrolled in a Care Management Program to support self-management of chronic disease. Once identified to be eligible for the Care Management Program, the beneficiary will need to meet the following criteria to obtain the first gift card and to be eligible for the remaining two gift cards.

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

The remaining two gift cards may be achieved any time after the meeting the 60-day requirement. Beneficiaries will receive the remaining two gift cards for achieving self-care goals focused on managing their identified chronic disease. Goals will be established based on the beneficiary's preferences and their provider's input into recommendations to promote health and well-being. Goals may include, but are not limited to:

- Completion of a diabetic education course preapproved by their provider and care manager to meet their education needs.
- Reduce their HgA1c to below 9. Interventions to reduce the HgA1c will be supported by the primary care provider's recommendations.
- Smoking Cessation
- Medication adherence
- Identification of early warning signs within the yellow zone with provider notifications of changes.

Care plan goals will be shared with the primary care provider, the case manager, and the beneficiary to demonstrate a collaborative approach to meet the beneficiary's personal goals. If the beneficiary's goals are not in alignment with the provider's recommendations to improve health outcomes the goal will not meet the requirements of success.

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

1.2 System for Managing and Tracking Utilization of the Benefit

Beneficiaries eligible for the Chronic Disease Management Reward Benefit will be tracked through the population health tool to include the identity of the beneficiaries eligible, acceptance or declination of enrollment into the program, and successful completion of criteria to achieve the gift card reward, including the amount of the gift card(s) given. The beneficiaries care management profile will also include the chronic disease identified to allow for evaluation of outcomes based on engagement and trends of emergency room and inpatient care needs related to chronic diseases chosen for program. The care management program will track care plans with

goals and interventions to demonstrate qualifications met or not met to receive the gift card(s) and distribution of the gift card(s) to the beneficiaries. Information from the care management program will be submitted quarterly for CMS reporting. Information reported to CMS will be used for Quality Improvement review and reporting to the Clinical Quality Improvement Committee. Additionally, utilization and outcomes will also be reported to the Board of Directors no less than annually.

Information will also be followed on a tracking form for Participant and Preferred Providers who do not use the population health tool for care management documentation. The tracking form includes all pertinent information demonstrating qualifications and distribution of gift cards to ensure compliance to the program. Participant and Preferred Providers are required to submit forms monthly to review the beneficiaries who have been enrolled into a qualifying program and allow for monitoring-through-completion to ensure qualified beneficiaries receive gift cards per the benefit guidelines.

1.3 Number of Beneficiaries Expected to Utilize the Benefit

NWMHP anticipates that the utilization of the benefit will increase with the expansion of the chronic diseases included for eligibility. It is anticipated during 2023 over 50 gift cards for up to 30 beneficiaries will be distributed and a continued utilization of the benefit will increase year-to-year as the network expands care management services to the population. Limitation to the utilization of the benefit is based on the beneficiary agreement to enroll in Care Management and the network ability to provide the Care Management services.

SECTION 2: MANAGEMENT APPROACH

2.1 Technical Assistance

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

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

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

2.2 Infrastructure for Implementing the Beneficiary Engagement Incentive

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

Network providers have been offered education by the Chief Nursing Officer ("CNO") on the Chronic Disease Management Reward Benefit program to include workflows, documentation, and record submission. The Care Management team has received education, and the population health tool has been updated to include documentation of Care Management services to track and evaluate

program efficacy. The Compliance Department has reviewed the implementation guidelines and is responsible for oversight of the auditing and reporting to CMS as indicated. NWMHP has created a budget for 2023 to allow for the utilization of the benefit based upon the population eligible in addition to the expected utilization of the Chronic Disease Management Reward Benefit.

2.3 Integration into Operational Processes

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

NWMHP currently has a process to identify utilization of the Chronic Disease Management Reward Benefit and will be able to continue to use the process for evaluation of those that meet criteria for the program. Beneficiaries with the identified chronic diseases that meet the utilization criteria are identified with the daily review for Transitional Care Services and referrals to Care Management services. A review of claims data will allow the team to ensure that beneficiaries who may have qualified but were overlooked are offered the opportunity to participate.

Beneficiaries will be identified through the provider referral process, member engagement, risk stratification, or through record reviews and subsequently offered the opportunity to participate.

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

Upon acceptance into the program by the beneficiary, an interaction will be scheduled to review the beneficiary's needs through an assessment or screening process. A care plan will be established with the beneficiary and shared with the beneficiary's provider for review and signed by both parties.

At the time of enrollment, the care manager will discuss with the beneficiary the gift cards available including the criteria for achievement and allow the beneficiary to choose which three goals they would like to work towards achieving. Upon successful completion of meeting the criteria to achieve a gift card, the Nurse Care Manager will record the information in the beneficiary's care management record and confirm with the beneficiary which gift card they would like to receive to ensure the beneficiary still wants their original choice. The gift card may be delivered to the beneficiary by certified mail, or in person as agreed upon between the care manager and the beneficiary. The recommendation and goal for the delivery of the gift card will be to deliver in person, however it is not expected to occur for all instances. Gift cards that are available will be identified on a document that the beneficiary will be able to select recognizable

choices as first, second, and third. Gift cards will be purchased upon confirmation the beneficiary has achieved the established care plan goals.

2.4 Designated Implementation and Management Staff

The Chief Nursing Officer (CNO) is responsible for the implementation of the Chronic Disease Management Reward Benefit program. The CNO will provide oversight and guidance to identification of eligibility for the program, educational programs for both beneficiaries and providers, and evaluation of implementation efficacy. The CNO will be responsible to report outcomes to the Clinical Quality Improvement Committee at a minimum bi-annually following the implementation of the benefit enhancement.

The Care Management Team will implement the Chronic Disease Management Reward Benefit program to include the benefit enhancement gift cards. The Care Management Team will be trained on the guidelines of the established program prior to implementation to include eligibility, and criteria for successful outcomes to receive gift cards. The Care Management Team will enroll beneficiaries into one of the eligible Care Management Programs and evaluate qualifications based on participation in the program, duration of participation, and development and achievement of goals. Team members will work with beneficiaries to identify potential health coaching needs related to chronic disease management and to develop care plan goals and interventions established with the beneficiary. The Nurse Care Manager assigned to the beneficiary will provide education of the Chronic Disease Management Reward Benefit and the criteria to receive three (3) $25.00 gift cards (not to exceed$75.00 in a performance year) upon successful completion of agreed upon goals. The Nurse Care Manager may refer the beneficiary to receive additional support to include community support services or refer to the Care Navigator within the Care Management Team to

assist with social determinants of health affecting the beneficiary's ability to perform self-management of their chronic disease(s).

2.5 Development of Standard Operating Procedures

NWMHP has established written guidelines for Participant and Preferred Providers to support implementation and management of the program. Guidelines include definitions for eligibility and requirements under the Chronic Disease Management Reward Beneficiary Engagement Incentive. The guidelines are provided to each Participant and Preferred Provider Group and will be available on the provider portal for 2023 for easy access.

Included in the guidelines are requirements for receiving gift cards, types of gift cards available and distribution recommendations. Beneficiaries qualify to receive up to three (3) gift cards per performance year, in $25.00 increments for each gift card, upon successful completion of Chronic Disease Management goals. Beneficiaries may demonstrate successful completion of their three established goals at the same time to be awarded a total of $75.00 in gift cards. Gift cards will be provided based upon the beneficiary's choices between local services or businesses that support the continued health goals of the beneficiary. Gift cards will not be issued as Visa, Master Card or other similar type, and the card will be programmable to prevent the purchasing of tobacco products or alcohol. Locations where tobacco or alcohol items are sold will require a restriction of use to prevent the gift card from being accepted to make those purchases.

Gift cards are funded entirely by NWMHP and will be available for aligned beneficiaries only. Individuals who are eligible for the program must be aligned beneficiaries upon enrollment and throughout the program including at the time the achievement criteria are met. Beneficiaries will be made aware of the criteria for eligibility at the time of enrollment. If they should choose to

disenroll from the program, change providers to a non-participating or non-preferred provider out of the network, or expire they will be no longer be eligible for participation and will not receive a gift card. A list of available gift cards will be created and provided to beneficiaries upon enrollment into a Chronic Disease Management Program.

2.6 System Access

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

NWMHP ensures that communications by and between beneficiaries, family and social supports, and primary care providers respect the privacy concerns of beneficiaries. Participant and Preferred Providers are provided access to the population health tool which provides access to the beneficiaries aligned to the ACO REACH Model. Access to the population health tool requires an application process that is reviewed by and managed by Compliance to ensure HIPAA (Health Insurance Portability and Accountability Act) regulations are followed.

NWMHP follows HIPAA regulations when providing copies of clinical records between the care management team and the primary care provider to include care plans and documentation of

services provided. Participant and Preferred Providers have access to documentation through the population health tool.

SECTION 3: PATIENT ENGAGEMENT

3.1 Availability of the Beneficiary Engagement Incentive and Beneficiary Education

Information regarding the beneficiary engagement incentive benefit may be provided to beneficiaries through flyers and office visit education opportunities. Beneficiaries will receive education when identified as eligible to enroll in care management services. The Care Management Department uses mail to deliver information to eligible beneficiaries with information on how to enroll and participate in services to qualify for the benefit. Nurse Care Managers provide education with telephonic interactions and offerings to enroll in services.

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

Providers will be kept informed of their patients' participation in the program to include a copy of the care plan to review and sign. Providers will be notified of the patient's progress and achievements of goals routinely throughout participation in program. Providers will also be encouraged to outreach to the Care Management Team to obtain more information or ask questions.

3.2 Verifying up-to-date Beneficiary Alignment

Throughout the course of the model performance period CMS will provide beneficiary alignment data to NWMHP. Data files received from CMS will be uploaded to the NWMHP population health tool, at which time the Participant and Preferred Providers will have access to verify beneficiary eligibility for the Chronic Disease Management Reward Benefit 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, Participant and Preferred Providers can offer this information at point of service. NWMHP staff, its Participant Providers and Preferred Providers are educated on how to identify a complaint and the appropriate process of escalation and reporting, whether received verbally or in writing. Beneficiary complaints are forwarded to the Compliance Department for intake and investigation. Complaints are reviewed within 5 business days to determine the best course of action, with additional evaluation completed by the Chief Nursing Officer, Medical Director or other subject matter experts as needed. If immediate health and safety concerns are brought forward, the reviews are completed within 1 business day. The Compliance Department will report the number of beneficiary complaints and any identified trends to executive leadership and the Board on a regular basis. Beneficiary complaints of a health and safety concern may be referred to the Chief Nursing Officer, the Medical Director and/or the Clinical Quality Improvement Committee for review and potential clinical action.

SECTION 4: COMPLIANCE APPROACH

4.1. Tracking and Monitoring Services Provided

The Care Management Department documents and tracks utilization of the Chronic Disease Management Reward Benefit. The Compliance Department will audit the process and document regularly to ensure compliance with protocols for implementation of the program. The Chief Nursing Officer will monitor outcomes and appropriate utilization of the waiver as part of the quality program. Education will be provided to Participant and Preferred Providers based on findings from the quality review process. The Compliance Officer will ensure compliance with the requirements of the Participation Agreement and Chronic Disease Management Reward Benefit guidance through auditing, monitoring, and claims analysis. Any identified corrections or updates to the Chronic Disease Management Program will be agreed upon by the Clinical Quality Improvement Committee.

The Chief Nursing Officer and Compliance Officer are responsible for overseeing compliance to the program and reporting to the Medical Directors as well as the Clinical Quality Improvement Committee no less than quarterly on implementation and outcomes. The Chief Medical Officer will be responsible for reporting to the Clinical Quality Improvement Committee and the Board of Directors if evaluation of the implementation of the waiver identifies any compliance concerns. The Clinical Quality Improvement Committee will be responsible to approve interventions to address compliance issues.

4.2 Management of up-to-date Agreements

Provider Agreements and records are managed and maintained by the Compliance Department in conjunction with the Provider Network Coordinator. Mid-year, ad-hoc inclusions and terms will

be evaluated by Compliance and the Provider Network Coordinator to ensure accuracy of Participant and Preferred Provider rosters and confirm fully executed Participant Agreements are in place.

4.3 Claims Analysis

The Chronic Disease Management Reward Benefit program does not use claims for reporting or tracking services, however the Care Management department is able to use claims analysis to identify potential candidates for the program and perform outreach to offer services. . Claims analysis includes a review of those beneficiaries with the qualifying diagnosis for participation, risk score, historical utilization of acute care, and trends related to provider engagement and services received.

Beneficiaries who are identified as high-risk and meet the qualifications for enrollment into, Complex Care Management, Chronic Disease Care Management, or Behavioral Health Management programs will be provided outreach to offer those services throughout the performance year.

4.4 Outcomes Analysis

Outcomes of utilization of the Chronic Disease Management Reward Benefit will include a review of acute care utilization trends, beneficiary engagement with their primary care provider, and overall health outcomes. Beneficiaries that were offered and engaged in the program will have their outcomes (numerator) compared to the total of those who were eligible for services (denominator). In addition to general goals for outcome analysis, beneficiaries will be surveyed to identify their perception of the program and evaluated based on a Likert scale. Use of the survey

will allow for NWMHP to review the program and recognize opportunities to improve participation from the beneficiaries' perspective. Outcomes from both analytics and surveys will be reported to the Board of Directors and Clinical Quality Improvement Committee at least once per calendar year.

4.5 Long-term Records Retention and Maintenance

NWMHP shall maintain and provide access to records and data related to the Chronic Disease Management Reward Benefit to include costs, quality performance reporting, and utilization. Beneficiaries enrolling into the Chronic Disease Management Program will be monitored through documentation in a care management platform. The platform will allow for documentation of the requirements established within standard protocols, and to document when a beneficiary has been awarded each gift card for successful completion of agreed upon goals. Data recorded in the platform will be accessible through data extraction and reporting. Care Managers assigned to beneficiaries will be trained on documentation requirements and criteria for success to ensure appropriate documentation is met.

Additionally, NWMHP shall maintain and require all ACO Providers, individuals and entities performing functions or services related to ACO activities to maintain such records and/or other evidence for a period of 10 years from the expiration or termination of the Participant Agreement.