# 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

December 14, 2023

# Agenda

- Landscape/Policy Updates
- Program Updates
- New Upcoming Model – GUIDE
- Care Management

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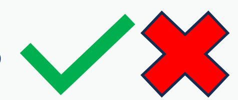
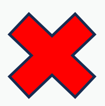
# Landscape/Policy Updates

# 2024 MPFS Final Rule

- MSSP ACOs have Medicare CQM option as an alternative to eCQM or MIPS CQM required for PY 2025
- Proposal for Advanced APM providers to need to report Promoting Interoperability category pushed to 2025 
- QP determinations will remain at the APM entity level
- Decrease in Medicare conversion factor from $33.89 to $32.74 for 2024, a 3.4% decrease 
- Advocacy continues to extend the AAPM bonus for providers

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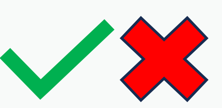
# MIPS – Promoting Interoperability

- Currently REACH & MSSP ACOs attest annually that at least 75% of eligible clinicians in the ACO are using 2015 Edition Cures Update CEHRT

- Removes 75% CEHRT attestation beginning 2025
  - Beginning 2025, Advanced APMs must require the use of 2015 Cures Update CEHRT for **all** participants
  - **Postponed 1 year**

- Requires all MIPS eligible, QP, and partial QP clinicians participating in an ACO to report MIPS Promoting Interoperability measures beginning 2025
  - Can be reported at the group level or at the APM entity level
  - **Postponed 1 year**



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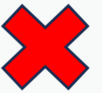
# MIPS – Promoting Interoperability

- Currently the required performance period for PI is 90 continuous days within the calendar year

- Increased performance period to 180 continuous days within the calendar year
  - We do not get our first snapshot of MIPS eligible clinicians until July of the performance year, so 180-day performance period poses a barrier with identifying which groups need to prepare to report PI in 2025; We would need to prepare all groups with this new requirement
  - Will impact the ACO once we need to report PI beginning PY 2025



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# QP Determinations

- QP determinations are currently made at the APM Entity level
- Finalized QP determinations will remain at the APM entity level
- 2024 QP thresholds increase:
  - Medicare payments:
    - QP threshold increasing from 50% to 75%
    - Partial QP threshold increasing from 40% to 50%
  - Medicare patients:
    - QP threshold increasing from 35% to 50%
    - Partial QP threshold increasing from 25% to 35%

NWMHP was at 56% payment and 72% patient for PY 2023

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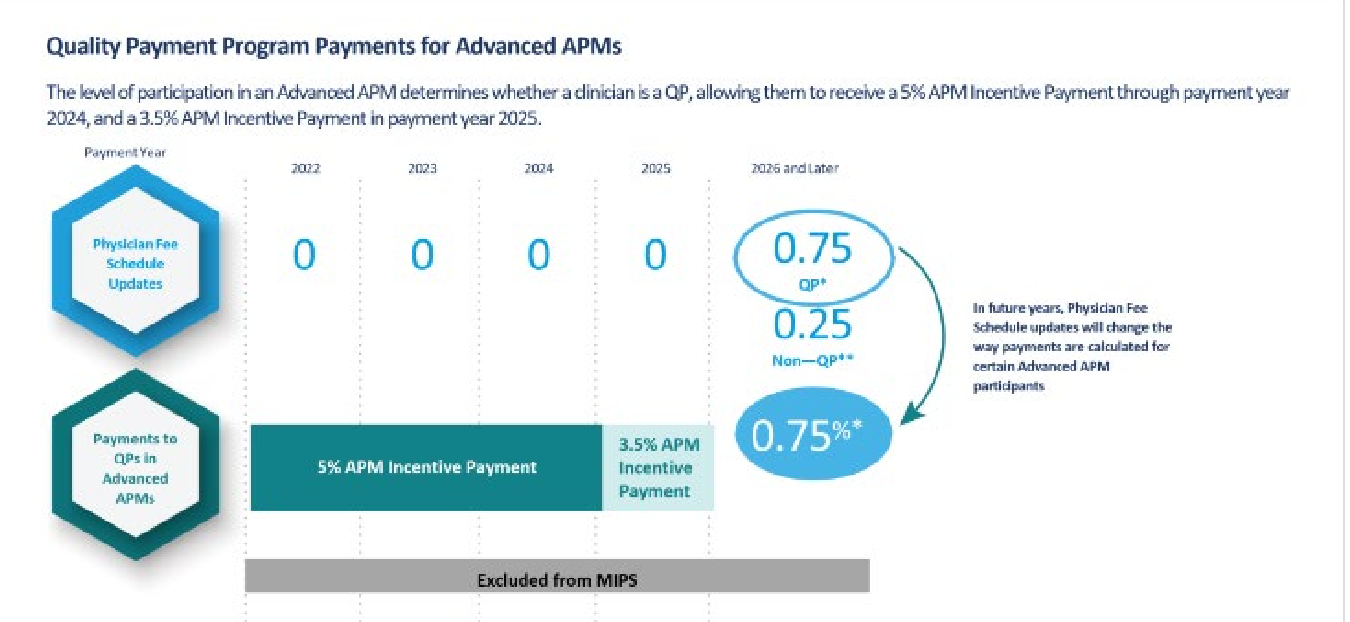
# QP Determinations

- In PY 2023, QPs receive a 3.5% incentive payment (paid in 2025)
- In PY 2024, QPs will receive a 0.75% conversion factor to Medicare PFS payment rates
- Partial QPs can choose not to report MIPS and will not receive a MIPS payment adjustment or can choose to report MIPS and will receive a MIPS payment adjustment based on their score

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# Risk Adjustment

- Cap on regional service area risk score growth
  - Symmetrical and Independent of 3% cap on ACOs risk score growth
  - Disincentivizes coding intensity for ACOs with high market share in region

- Introduction of V28 Model for MSSP will be phased in over 3 years similar to MA

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# Program Updates – 2023

# Provider Network Management

Per CMS guidelines provider additions and terminations must be updated monthly. The ACO REACH **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 out
    - Forms to be 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 Bianca Faulkner at **Communications@NWMHPACO.com**

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# 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) – ACO REACH only
- Electronic via Medicare.gov – MSSP or ACO REACH

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# Sample Paper VA Form

- 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.
- Template forms can be found on the Partner Portal or by contacting Bianca Faulkner at Communications@NWMHPACO.com

**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]

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# 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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# 2024 Preparations

# 2024 Meeting Schedule

## January
**1st:** PY2024 Performance Year Begins

## February
**13th:** NWMHP Board Meeting

**15th:** TRC Partner Check-In

## March
**21st:** All ACOs Town Hall

## April
**25th:** TRC Partner Check-In

## May
**16th:** Legacy Risk Pool Meeting

**22nd:** NWMHP Board Meeting

## June
**13th:** TRC Partner Check-In

## July
**25th:** TRC Partner Check-In

## August
**8th:** All ACOs Town Hall

**14th:** NWMHP Board Meeting

## September
**19th:** TRC Partner Check-In

## October
**24th:** Legacy Risk Pool Meeting

## November
**6th:** NWMHP Board Meeting

**21st:** TRC Partner Check-In

## December

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# State of the State – Capitation

## The Federal Level:

- CMS is aiming to have all Medicare beneficiaries in a care relationship with accountability for quality and total cost of care by 2030. A new Medicare payment model has been released; Making Care Primary (MCP) where Providers choose a full or partial prospective payment model.

## The State Level:

- The Washington Health Care Authority, along with the state's health insurers, third-party administrators (TPAs), and primary care provider community, have been working since 2019 to develop a new approach to delivering and paying for primary care. This effort is designed to encourage moving away from fee-for-service primary care to focus on whole-person.

Washington State Health Care Authority

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# 2025 REACH Prospective-Based Payments

CMS has increased the fee reduction that each REACH Participant Provider must take each year. By 2025, the mandatory fee reduction will be 100%.

NWMHP is developing a prospective-based payment model for ACO REACH providers when this 100% reduction takes place.

**Goals of prospective-based payment model**

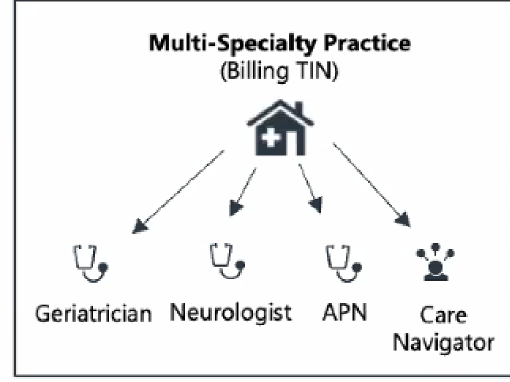
1. Provide steady revenue to REACH practices
2. Allow for the potential for higher reimbursement that FFS
3. Create clear incentives that drive shared savings

# New GUIDE Model

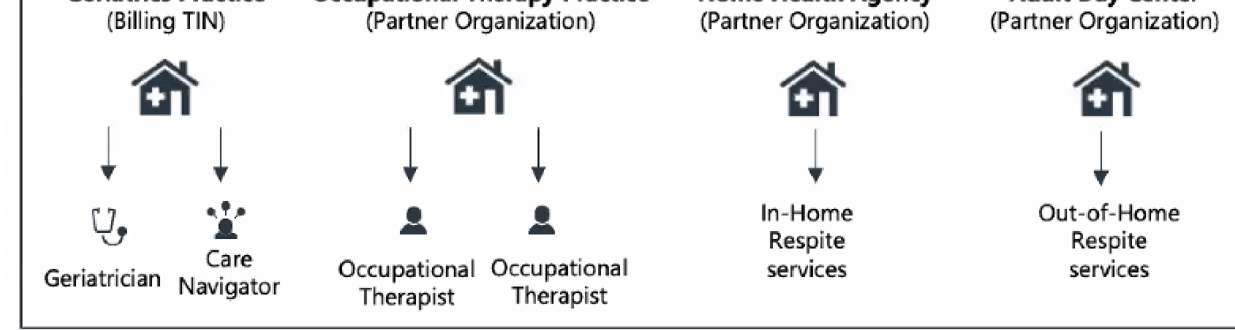
# Model Participants

GUIDE participants will be Medicare Part B enrolled providers/suppliers, excluding durable medical equipment (DME) and laboratory suppliers, who are eligible to bill for Medicare Physician Fee Schedule service and agree to meet the care delivery requirements of the model. If the GUIDE participant can't meet the GUIDE care delivery requirements alone, they have the ability to contract with "Partner Organizations," which are other Medicare providers/suppliers, to meet the care delivery requirements

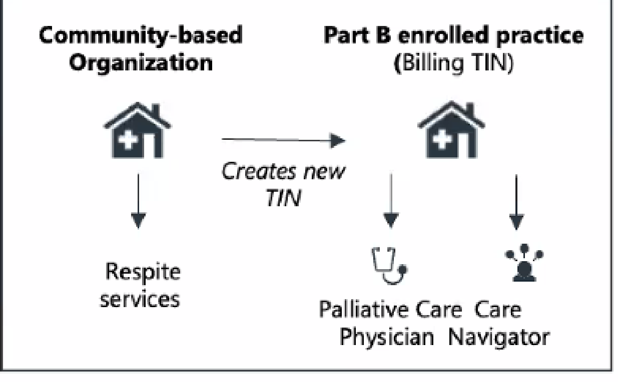
## Example Dementia Care Program provider and supplier arrangements:




*A single Medicare provider with multiple suppliers forms a GUIDE DCP*




*Several Medicare providers and multiple suppliers form a DCP*




*Medicare-enrolled provider establishes a new Part B enrolled TIN to form a GUIDE DCP*

GUIDE is an 8-year voluntary model offered in all states, D.C., and the U.S. territories.

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# GUIDE Care Delivery

### COMPREHENSIVE ASSESSMENT
Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

### REFERRAL & SUPPORT COORDINATION
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

**Interdisciplinary Care Team**

### CARE PLAN
Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

### CAREGIVER SUPPORT
Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

### 24/7 ACCESS
Beneficiaries and caregivers can call a member of their care team or a third-party representative using a 24/7 helpline.

### MEDICATION MANAGEMENT
Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

### ONGOING MONITORING & SUPPORT
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.

### CARE COORDINATION & TRANSITION
Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate care with the specialist.

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# GUIDE Beneficiary Alignment

The GUIDE model is designed for community-dwelling Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid. Eligibility criteria for model beneficiaries are outlined below:

**GUIDE Beneficiary Eligibility Criteria**

**Dementia Diagnosis**
Beneficiary has dementia confirmed by attestation from clinician practicing within a participating GUIDE dementia care program

**Enrolled in Medicare Parts A & B**
Beneficiary must have Medicare as their primary payer and not enrolled in Medicare Advantage, including Special Needs Plans (SNPs)

**Not Residing in Long-Term Nursing Home**

**Not Enrolled in Medicare Hospice**
Services overlap significantly with the services that will be provided under the GUIDE model

**Not Enrolled in PACE**
Services overlap significantly with the services that will be provided under the GUIDE model

**Voluntary Alignment Process**

The GUIDE model will use a voluntary alignment process for aligning beneficiaries to model participants. Participants must inform beneficiaries about the model and the services that they can receive through the model, and document that a beneficiary (or their legal representative if applicable) consents.

**Beneficiaries can be dually aligned in GUIDE and ACO models (MSSP or REACH)**

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# GUIDE Beneficiary Communications

- Provider Networks: GUIDE participants will develop provider networks with primary care providers, neurologists, etc. Organizations from those networks may recommend beneficiaries who already have dementia diagnosis as well as suspected.
- CMS data sharing based on claims: Following a request by the GUIDE Participant, CMS will use claims data from a three-year historical look-back period that falls within the five years prior to the start date of the Model Performance Period.
- Beneficiary Outreach Letter: CMS will send targeted outreach letters to eligible beneficiaries with dementia diagnosis codes in their claim's history.

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# Next Steps

1. Determine number of aligned beneficiaries in MSSP or REACH that may be eligible for GUIDE.

2. Create financial analysis – impact of GUIDE payments on ACO expenditures.
   - Also, any financial opportunity.

3. Confirm services and pricing offered by potential GUIDE partners.

4. Present final recommendations on GUIDE and/or Partners to ACO Board.

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# Care Management

# Refresher on Program Offerings – 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

*ADT events prompt outreach automatically – no provider referrals necessary!*

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# Refresher on Program Offerings – Other Care Management

**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

*Referrals generate from:*

- *Transitional Care Programs*
- *High Risk & High Utilizer Reviews*
- ***Providers**, Clinics, Hospitals, SNFs*
- *Self-Referral*
- *Targeted Outreach*

Send referrals to: CareTeam@NWMHPACO.com or call 360-943-4337, option 4

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# 2023 Engagement Updates
# January – October Outreach

**6,966 Beneficiaries Outreached**

| Care Management Program | Group | Individuals Outreached | Low Risk *Received Eligibility Letter starting Aug* |
|---|---|---|---|
| **Emergency Dept Transitional Care** | Legacy | 1,186 | 628 |
| | TRC | 2,775 | 1,784 |
| **Inpatient Discharge Outreach** | Legacy | 658 | 146 |
| | TRC | 883 | 165 |
| **Care Management** | Legacy | 74 | *Not Applicable* |
| | TRC | 140 | *Not Applicable* |
| **Post-Acute Outreach** | Legacy/TRC | 695 | *Not Applicable* |

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# Focus Areas on the Horizon

- COPD
  - Top reason for avoidable ED visits, accounting for $221k in ED spend
- Tied to Health Equity Plan (ACO REACH)
- Rural areas participating have some of highest prevalence rates in WA state
  - 2 out of top 5 WA counties in ACO (Grays Harbor & Lewis)
    - 10% of Grays Harbor County aligned beneficiaries are identified as tobacco users
  - 5 out of top 15 WA counties in ACO (Lewis, Mason & Klickitat)

NEW Care Management offering:

**COPD Prevention & Management Program**

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*Data sources: The model-based estimates were generated using data from BRFSS 2021 and ACS 2017-2021, and 2021 Census county population estimates.*
*National Center of Chronic Disease Prevention and Health Promotion, Division of Population Health. Reviewed 11/29/23* https://www.cdc.gov/copd/data-and-statistics/county-estimates.html

# COPD Outreach – July 2023

- Prior to COPD Program Development – July 2023
  - Focused on potentially newly diagnosed COPD, or identified as very high or rising risk in population health tool
- 85% of identified beneficiaries also were overdue for AWV
- Many had other chronic conditions: Diabetes, CHF, CKD
- Cold calls to offer services:

**81** beneficiaries – all mailed CM info
**63%** answered calls
**5** Enrolled in CM services
**2** Assisted with other needs

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# COPD Outreach – December 2023

- COPD Program Developed
- Focus on populations who will remain in ACO REACH in 2024
  - Montesano Internal Medicine
  - 135 Beneficiaries
- Customized eligibility letter mailed 12/4/23
- Telephonic follow-up beginning 12/13/23

Will continue outreach efforts in 2024 & welcome referrals!

Available to ACO REACH & MSSP aligned beneficiaries

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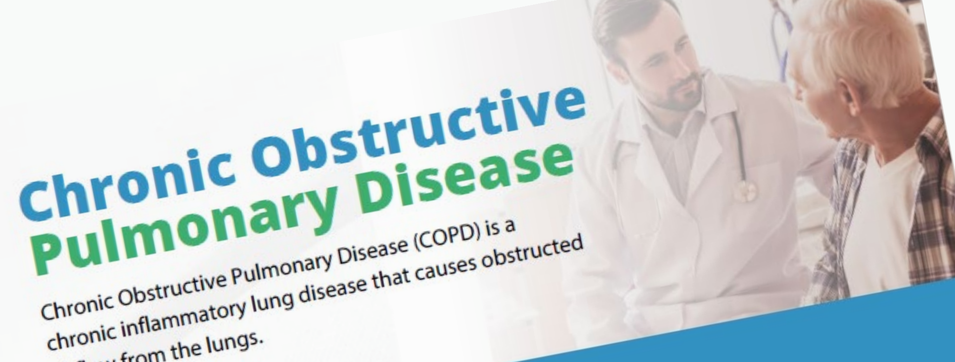

# Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs.

## Symptoms:

- Breathing Difficulty
- Chronic cough
- Mucus (sputum) production
- Wheezing or chest tightness
- Fatigue or tiredness
- Anxiety

## Causes:

- Air pollution
- Smoking
- Heart problems

**Treatment:** Although COPD is a progressive disease that gets worse over time, COPD is treatable. With proper management, most people with COPD can achieve good symptom control and quality of life.

- Lifestyle changes such as diet and exercise
- Oxygen therapy
- Medication (oral or inhaled medicine)

**When to see a doctor:** Talk to your doctor if your symptoms are not improving with treatment or getting worse, or if you notice symptoms of an infection.

**NW Momentum Health Partners (NWMHP) ACO can help you manage your COPD. Enrolling into our COPD Prevention and Management Program provides help to reduce the risk of your COPD becoming worse. Through one-on-one support and help you connect with your provider, NWMHP can assist you in managing your health.**

**The COPD Prevention and Management Program is available and free to eligible Medicare beneficiaries of participating providers. Visit us at https://nwmomentumhealthaco.com/participating-physicians/ to find out if your healthcare provider participates.**

## WA State has many resources available to those looking to quit using tobacco

Since 2000, the Washington State Quitline has helped tens of thousands of Washington residents quit smoking. You can get free, confidential, one-on-one counseling from a smoking cessation coach, and you may be eligible for free medication to help you quit smoking, vaping, or using tobacco. Register at:

- Call 1-800-QUIT-NOW (1-800-784-8669);
- Visit the website: quitline.com
- Text "READY" to 200-400.

## Other options for those looking to quit using tobacco

**Talking to your health care provider about using prescription pill medications such as:**

- Varenicline OR Bupropion

**Using Nicotine Replacement Therapy**

- Over-the-counter forms: nicotine patch, gum, lozenge
- Prescription: inhaler, nasal spray

**Combining Medications**

- Use a long-acting form of nicotine replacement therapy (nicotine patch) along with a short-acting form (such as nicotine gum or lozenges). Compared to using a form of nicotine replacement therapy, this combination can further increase your chance of quitting smoking.

Source: Quitting Tobacco — Grays Harbor County Public Health (healthygh.org)
Washington State Quitline | Washington State Department of Health

+1-877-943-4337, ext 4

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# Thank you!