Policy Title: FWA Compliance: Benefit Enhancements and Beneficiary Engagement Incentives			
Department Responsible: THN ACO Operations	**Policy Number:** FWA-002	**THN's Effective Date:**	**Next Review/Revision Date:** September 30, 2023
Title of Person Responsible: THN Assistant Director ACO Operations	**THN Approval Council:** THN Operations Committee	**Date Approved:** **June 8, 2023**	

I. **Purpose.** The purpose of FWA-002 is to detail Triad Healthcare Network's (THN) policy and processes to ensure compliance with ACO REACH PA requirements related to the provision of certain payment rule waivers, also known as Benefit Enhancements or Beneficiary Engagement Incentives.

II. **Policy.** It is the policy of THN to abide by all rules and regulations set forth by the Centers for Medicare and Medicaid Services (CMS) in regard to the Benefit Enhancements and Beneficiary Engagement Incentives available to THN under the ACO REACH Model.

III. **Procedures.**

A. THN shall take all necessary steps to ensure compliance with the rules of any and all applicable Benefit Enhancements and/or Beneficiary Engagement Incentives it opts to employ.

1. The available Benefit Enhancements are the

a. 3-Day SNF Rule Waiver

b. Telehealth

c. Post-Discharge Home Visits,

d. Care Management Home Visits

e. Home Health Homebound Waiver

f. Concurrent Care for Beneficiaries that Elect Medicare Hospice

g. Nurse Practitioner and Physician Assistant Services Benefit Enhancement

2. The available Beneficiary Engagement Incentives are

1. Part B Cost-Sharing Support
2. Chronic Disease Management Reward

B. **Election of Benefit Enhancements and/or Beneficiary Engagement Incentives:** If THN wishes to offer any Benefit Enhancement and/or Beneficiary Engagement Incentives during a Performance Year it must timely submit to CMS:

   1. its selection of the Benefit Enhancement and/or Beneficiary Engagement Incentive (including a list of any Participants and Preferred Providers who have agreed to participate); and
   2. an Implementation Plan meeting all requirements specified in the appropriate Appendix for the selected Benefit Enhancement and/or Beneficiary Engagement Incentive.

C. **Beneficiary Eligibility:** In order to be eligible to receive services under these Benefit Enhancements and Beneficiary Engagement Incentives, the Beneficiary must be aligned to THN at the time or be an Originally Aligned Beneficiary excluded from alignment to THN within the 90 days prior.

   1. This Grace Period does not apply to the Beneficiary Engagement Incentives.
   2. For Benefit Enhancements, this Grace Period does not apply when the Beneficiary is excluded from alignment for any of the following reasons:

      a. Transition to Medicare Advantage or other Medicare managed care plan;
      b. Medicare is no longer the primary payer;
      c. Loss of Medicare coverage for Part A, when the furnished service would have been reimbursed under Medicare Part A; or
      d. Loss of Medicare coverage for Part B, when the furnished service would have been reimbursed under Medicare Part B.

D. Services furnished under these Benefit Enhancements must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria.

E. **3-Day SNF Rule Waiver:** waives the requirement in §1861(i) of the Social Security Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services (SNF Services) furnished under the terms and conditions set forth in Appendix I of the ACO REACH PA.

1. THN shall maintain and provide to its Participants and Preferred Providers an accurate and complete list of Eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF or Swing-Bed Hospital eligibility. This list shall also be furnished to a Beneficiary, upon request.
2. THN must provide written notification to CMS within 10 days of any changes to its list of Eligible SNFs. Within 10 days following the removal of any Eligible SNF from the list, THN must also provide written notification to the SNF or Swing-Bed Hospital that is has been removed from the list and that it no longer qualifies to use this Benefit Enhancement.
3. THN shall provide a copy of the ACO REACH PA Appendix I to each Eligible SNF to which Beneficiaries are referred by Participants and Preferred Providers.
4. In order to be eligible to submit claims for services furnished to Beneficiaries pursuant to the 3-Day SNF Rule Waiver Benefit Enhancement, an entity must be
    a. a Participant or Preferred Provider;
    b. a SNF or a hospital or critical access hospital that has swing-bed approval for Medicare post-hospital extended care services ("Swing-Bed Hospital");
    c. designated on the Participant List or Preferred Provider List, submitted in accordance with OP-004, as participating in the 3-Day SNF Rule Waiver Benefit Enhancement; and
    d. approved by CMS.
        i. Approval will be, in part, based upon the SNF's scoring posted on the Nursing Home Compare Website. SNFs with fewer than 6 reported months on the Nursing Home Compare Website are ineligible to participate.
5. In order to be eligible to receive services under this Benefit Enhancement the Beneficiary must:

a. Not be residing in a SNF or long-term care facility at the time of admission.

   i. For purposes of this Benefit Enhancement, independent living facilities and assisted living facilities are not deemed long-term care facilities.

b. Be Medically stable;

c. Have confirmed diagnoses;

d. Not require inpatient hospital evaluation or treatment; and

e. Have a skilled nursing or rehabilitation need that is identified by the evaluating physician or other practitioner and cannot be provided as an outpatient; and

f. In the case of a direct admission, have been evaluated by a physician or other practitioner licensed to perform the evaluation within three days prior to admission

6. THN Compliance will conduct periodic reviews to ensure that admission of Eligible Beneficiaries to Eligible SNFs under this waiver are medically appropriate and consistent with the terms of the waiver.

F. **Telehealth Benefit Enhancement:** Waives certain provisions of §1834(m) of the Social Security Act and 42 CFR. §410.78, 414.65 and 410.78(b) with respect to telehealth services furnished in accordance with the requirements of the Telehealth Benefit Enhancement.

1. In order to be eligible to bill for telehealth services furnished to Beneficiaries pursuant to the Telehealth Benefit Enhancement, an individual or entity must be:

   a. a Participant or Preferred Provider who is a physician or other practitioner listed at 42 CFR §410.78(b)(2);

   b. authorized under relevant Medicare rules and applicable state law to bill for telehealth services;

   c. designated on the Participant List or Preferred Provider List as participating in the Telehealth Benefit Enhancement; and

   d. approved by CMS.

2. In order to be eligible to bill for teledermatology or teleophthalmology furnished using asynchronous store and forward

technologies, as that term is defined under 42 CFR §410.78(a)(1), pursuant to the Telehealth Benefit Enhancement an individual must be

a. approved to bill for telehealth services pursuant to paragraph 1. above;

b. a physician; and

c. enrolled in Medicare with a Medicare physician specialty of dermatologist or ophthalmologist.

3. In order to be eligible to receive services under this Benefit Enhancement the Beneficiary must

   a. Be located at an originating site that is either:

      i. one of the sites listed in section 1834(m)(4)(c)(ii) of the Act; or

      ii. In the case of the "Originating Site" portion of this Benefit Enhancement, the Beneficiary's home, or place of residence.

4. Claims for telehealth services furnished under this paragraph will be denied unless submitted using one of the HCPCS codes G9481-G9489.

5. Claims for asynchronous teledermatology and teleopthalmology services furnished under the terms of the waiver will be denied unless submitted using one of the HCPCS codes G9868-G9870.

6. THN shall ensure that Participants and Preferred Providers do not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when he or she knows or should know those services are Medically Necessary.

7. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Participant or Preferred Provider shall not submit a claim for such telehealth services.

8. Regardless of whether THN selects to provide the Telehealth Benefit Enhancement for a Performance Year, payment to

Participants for telehealth services furnished pursuant to section 1899(1) of the Act is governed by the terms and conditions of Appendix K of the ACO REACH PA. Payment is available for otherwise covered telehealth services furnished to Beneficiaries, without regard for geographic requirements if the telehealth service is furnished by a Participant.

G. **Post-Discharge Home Visits:** increases the availability to Beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility (SNF) by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits as long as certain requirements are met.

1. The services must be furnished to a Beneficiary who either does not qualify for Medicare coverage of home health services under 42 CFR §409.42 or who qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 §60.4.
2. The services must be furnished in the Beneficiary's home after the Beneficiary has been discharged from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or SNF.
3. The individual performing services under this Benefit Enhancement must be "auxiliary personnel" as defined at 42 CFR §410.32(b)(3)(i), of a Participant or Preferred Provider participating in the Post-Discharge Home Visits Benefit Enhancement.
4. The claims for services under this Benefit Enhancement must be submitted by the supervising Participant or Preferred Provider.
5. The services furnished under this Benefit Enhancement may not be furnished more than nine times: one time in the first ninety (90) days following discharge.
    a. If the Beneficiary is readmitted within ninety (90) days of the initial discharge, the Beneficiary may receive only the nine services connected to the initial discharge.
6. The services may only be furnished to a Beneficiary who is not receiving services under the Care Management Home Visits or

Home Health Homebound Waiver Benefit Enhancements.

7. The claims for services furnished under the terms of this Benefit Enhancement must be submitted using one of the HCPCS codes G2001-GG2009, or G2013- G2015.

8. In order to be eligible to submit claims for services furnished to Beneficiaries pursuant to this Benefit Enhancement, the supervising physician or other practitioner must be:

    a. a Participant or Preferred Provider who is a physician or other non-physician practitioner listed at 42 CFR §410.78(b)(2);

    b. eligible under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual;

    c. designated on the Participant List or Preferred Provider List as participating in the Post-Discharge Home Visit Benefit Enhancement; and approved by CMS.

9. THN shall ensure, through its contract with each Participant and Preferred Provider who will be participating in the Post-Discharge Home Visit Benefit Enhancement, that the Participant or Preferred Provider shall require all auxiliary personnel to comply with the terms of the ACO REACH PA and the policies of THN.

10. THN shall ensure that services furnished under this Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.

H. **Care Management Home Visits:** increases the availability of in-home care to Beneficiaries determined by THN to be at risk of hospitalization and for whom a Participant or Preferred Provider has initiated a care treatment plan by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions.

    1. In order to be eligible to submit claims services furnished pursuant to this Benefit Enhancement, the supervising physician or other practitioner must be:

        a. a Professional or Preferred Provider who is a physician or other non- physician practitioner listed at 42 CFR §410.78(b)(2);

b. eligible under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual;

c. designated on the Participant List or Preferred Provider List, as participating in the Care Management Home Visits Benefit Enhancement; and

d. approved by CMS.

2. The individual performing services under this Benefit Enhancement must be "auxiliary personnel" as defined at 42 CFR Section 410.26(a)(1).

3. Services provided under this benefit enhancement must be furnished to a Beneficiary who is determined to be at risk of hospitalization, for whom a Participant or Preferred Provider has initiated a care treatment plan, and either does not qualify for Medicare coverage of home health services under 42 CFR Section 409.42 or qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 §60.4.

4. The services are furnished in the Beneficiary's home by "auxiliary personnel", as defined in 42 CFR §410.26(a)(1), under the general supervision of a Participant or Preferred Provider.

5. The services must be furnished to a Beneficiary who is not receiving services under the Post-Discharge Home Visits or Home Health Homebound Waiver Benefit Enhancements.

6. Claims for such services must be submitted by the supervising Participant or Preferred Provider.

7. Claims for services provided may not be furnished more than 20 times within the Performance Year.

   a. No additional care management home visits services may be furnished to the Beneficiary until the completion of the Performance Year, after which time additional care management home visits are furnished to the Beneficiary only in accordance with the terms of this benefit enhancement.

8. THN shall ensure, through its contract with each Participant and Preferred Provider who will be participating in the Care Management Home Visits Benefit Enhancement, that the

Participant or Preferred Provider shall require all auxiliary personnel to comply with the terms of the ACO REACH PA and the policies of THN.

9. THN shall ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

l. **Home Health Homebound Waiver Benefit Enhancement:** waives the requirements that a beneficiary must be confined to the home or in an institution that is not a hospital, SNF, or nursing facility to qualify for Medicare coverage of home health services; and that the certification for home health services include a certification that such services are or were required because the individual is or was confined to the home.

1. In order to be eligible to submit claims for services furnished to Beneficiaries pursuant to the Home Health Homebound Waiver Benefit Enhancement, the individual or entity must be

   a. A home health agency that is a Participant or Preferred Provider;

   b. Designated on the Participant or Preferred Provider List as participating in the Home Health Homebound Waiver Benefit Enhancement; and

   c. Approved by CMS.

2. Services must be furnished to a Beneficiary who

   a. is not currently receiving services under the Post Discharge Home Visits or the Care Management Home Visits Benefit Enhancement;

   b. otherwise qualifies for home health services under 42 CFR §409.92 except that the Beneficiary is not confined to the home;

   c. has one or more chronic conditions and at least one of the following:

      i. Inpatient service utilization, defined as at least one unplanned inpatient admission or emergency department visit within the last 12 months.

      ii. Frailty, defined as a score that meets or exceeds the threshold established by CMS on a frailty

scale specified by CMS.

iii. Social isolation, defined as the absence or weakness of a social network or resources provided by other persons or institutions.

3. THN uses the Home Health Homebound Waiver Form provided by CMS to document these criteria. A copy of this completed and certified form is maintained in the Beneficiary's medical records.

4. THN shall ensure Participants and Preferred Providers do not furnish home health services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive home health services in lieu of in person services when the provider knows or should know in person services are medically necessary.

J. **Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancements:** waives the requirement in Section 1812 of the Act to forgo curative care as a condition of electing the hospice benefit and instead receive care with respect to their terminal illness furnished under the terms and conditions of this Benefit Enhancement.

1. In order to utilize this Benefit Enhancement, THN must select Global as its Risk Sharing Option.

2. In order to be eligible to submit claims for services furnished to Beneficiaries pursuant to this Benefit Enhancement, an individual must be

   a. A Participant or Preferred Provider who is a provider or supplier as defined at 2 CFR §400.202;

   b. Designated on the Participant or Preferred Provider List as participating in the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement; and

   c. Approved by CMS.

3. THN maintains and provides to its Participants and Preferred Providers an accurate and complete list of Eligible Concurrent Care Providers and shall furnish updated lists as necessary to reflect any changes in eligibility. THN also furnishes these lists to any Beneficiary, upon request.

4. THN provides a copy of the ACO REACH PA and any applicable Appendices to all Participants and Preferred Providers

5. THN shall ensure Participants and Preferred Providers provide services under the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit only when a beneficiary has elected Medicare hospice care as described in 42 CFR §418.24.
6. THN shall ensure that Participant Providers and Preferred Providers only furnish Medically Necessary concurrent care services.

K. **Nurse Practitioner and Physician Assistant Services Benefit Enhancement:** Allows an eligible Nurse Practitioner or Physician Assistant to complete the following actions in place of an attending physician:

A. Certify that a Beneficiary is terminally ill for hospice care;
B. Certify a Beneficiary's need for extra-depth shoes with inserts or custom molded shoes with inserts under a comprehensive plan of care related to the Beneficiary's diabetic condition (diabetic shoes);
C. Establish, review, and sign an individualized cardiac rehabilitation care plan;
D. Establish a plan of care for home infusion therapy;
E. Make a referral for medical nutrition therapy services;

1. In order for an individual to certify, establish a plan of care for, or provide a referral for any of the services identified under this Benefit Enhancement, and detailed in Appendix T of the ACO REACH Model PA, the individual must be:
    a. A Participant or Preferred Provider THN identified on the Participant or Preferred Provider list as participating in the Benefit Enhancement;
    b. A nurse practitioner (as described in 42 CFR §410.75(b)) or a physician assistant (as described in 42 CFR §410.74(a)); and
    c. Approved by CMS.
2. THN shall ensure that Participants and Preferred Providers only certify, establish a plan of care for, or provide a referral for Medically Necessary services under the Benefit Enhancement and that certification of, establishment of a plan of care for, or referral of services pursuant to the Benefit Enhancement is not used to

prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

3. THN shall ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

L. **Part B Cost-Sharing Support Beneficiary Engagement Incentive:** Allows THN to enter into Cost-Sharing Support Arrangements with Participants and Preferred Providers, pursuant to which the Participants and Preferred Providers reduce or eliminate cost sharing for those categories of Part B services and Beneficiaries identified by THN.

1. THN has a written arrangement with each Participant and Preferred Provider who has agreed to participate in this Beneficiary engagement Incentive.
2. Not all Participants and Preferred Providers within THN, or within any ACO related TIN, must agree to participate in this Beneficiary Engagement Incentive.
    a. THN does not condition the Participant or Preferred Provider's participation in the ACO on their participation in this Beneficiary Engagement Incentive.
3. THN finances all payments made to Participants and Preferred Providers under the Cost-Sharing Support Arrangement entirely out of its own funds.
4. The Cost-Sharing Support must be provided in accordance with THN's Implementation Plan and the application Cost-Sharing Support Arrangement and advance one or more of the following clinical goals:
    a. Adherence to a treatment regime;
    b. Adherence to a drug regime;
    c. Adherence to a follow-up care plan; or
    d. Management of a chronic disease or condition.
5. THN maintains copies of the written Cost-Sharing Support Arrangements as well as records that document the following:

a. The identity of the Beneficiary for whom Cost-Sharing Support has been provided;

b. The nature and date of the Part B services for which Cost-sharing Support was provided;

c. The dollar amount of the Cost-Sharing Support; and

d. The Participant or Preferred Provider who furnished the service for which Cost-Sharing Support was provided.

M. **Chronic Disease Management Reward Beneficiary Engagement Incentive:** allows THN to provide a gift card reward for the purpose of incentivizing participation in a qualifying Chronic Disease Management Program.

1. Rewards are furnished only to Beneficiaries who have a chronic disease, as identified by a clinical diagnosis that is targeted by a qualifying Chronic Disease Management Program identified in THN's Implementation Plan submitted to CMS.
2. In order to receive a gift card, Beneficiaries must
    a. be eligible at the time he or she is enrolled in, or otherwise begins participating in, the Chronic Disease Management Program; and
    b. satisfy all criteria for obtaining a gift card as set forth in THN's Implementation Plan.
3. The gift card is:
    a. provided to the Beneficiary directly by THN;
    b. funded entirely by THN;
    c. programmed to prevent the purchase of tobacco and alcohol products;
    d. not offered in the form of cash or monetary discounts or rebates, including reduced cost-sharing or reduced premiums; and
    e. not redeemable for cash or transferable to another individual.
4. The aggregate value of any and all gift cards provided by THN to the Beneficiary during a Performance Year does not exceed $75.

5. THN maintains records that document the following:

    a. The identity of each Beneficiary who received a gift card reward;

    b. The Chronic Disease Management Program(s) in which the Beneficiary's participation is being rewarded;

    c. The nature and date(s) of the activities or other conduct engaged in by the Beneficiary to qualify for the gift card reward; and

    d. The nature and amount of each gift card received by the Beneficiary.

N. **Responsibility for Denied Claims:** In the event that CMS denies a claim under one of the Benefit Enhancements:

    1. CMS may, in some limited circumstances make payment but recoup the payment from the ACO, payable as Other Monies Owed for the Performance Year. In most cases, CMS will make no payment.

    2. THN shall ensure that the individual or entity that provided the Services does not charge the Beneficiary for the expenses incurred for such services;

    3. THN shall ensure that the individual or entity that provided the Services returns to the Beneficiary any monies collected from the Beneficiary; and

    4. THN shall indemnify and hold the Beneficiary harmless for payment of any such services provided to the Beneficiary.

O. **Access to Up-to-Date Beneficiary Rosters:** Compliance with ACO REACH PA requirements related to Benefit Enhancements and Beneficiary Engagement Incentives cannot be ensured if Participants and Preferred Providers do not have access to the most up-to-date information regarding Beneficiary alignment to THN. Without this information, the Participant or Preferred Provider may inadvertently refer an ineligible Beneficiary or file an inappropriate claim. As a result, THN has established appropriate procedures to ensure that Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to THN.

P. If THN wishes to make a change to the Implementation Plan approved by CMS for any of the above listed Benefit Enhancements or Beneficiary Engagement Incentives, a revised Implementation Plan must be submitted to CMS for review and approval.

Q. THN maintains records related to provision of any of the above listed Benefit Enhancements and Beneficiary Engagement Incentives in accordance with the Record Retention Policy.

R. **Requirements for Termination of Benefit Enhancements or Beneficiary Engagement Incentives**: THN must obtain CMS consent before voluntarily terminating any Benefit Enhancement or Beneficiary Engagement Incentive effective during a Performance Year.

1. **Termination within the Performance Year.** THN must obtain CMS consent before voluntarily terminating any Benefit Enhancement or Beneficiary Engagement Incentive effective during a Performance Year. THN shall provide at least 30 days advanced written notice of such termination to CMS. If CMS consents to such termination, the effective date will be the date specified in the notice of termination unless another date is specified by CMS.

    a. Within 30 days after the effective date of termination, THN shall send notice in writing to its Participants, Preferred Providers and affected Beneficiaries.

        I. For all Benefit Enhancements such notification shall state that following a date that is 90 days after the effective date of termination, services furnished under the Benefit Enhancement will no longer be covered by Medicare and the Beneficiary may be responsible for the payment of such services.

        II. For all Beneficiary Engagement Incentives, such notification shall state that following a date specified by CMS, Beneficiary Engagement Incentives must no longer be provided to the Beneficiary.

        III. Any notice to Beneficiaries is subject to review and approval in accordance with **OP-002.**

2. **Termination Between Performance Years.** If THN elects to discontinue a Benefit Enhancement or Beneficiary Engagement Incentive for a subsequent Performance Year, THN shall notify all Participants, Preferred Providers and affected Beneficiaries at least 30 days prior to the start of the next Performance Year.

S. **Reporting:** THN is required to report data on the use of Benefit Enhancements and Beneficiary Engagement Incentives to CMS, in a form and manner and by a date specified to CMS.

Date	Reviewed	Revised	Notes
April 2023			New REACH policy