Policy Title: Beneficiary Enhancements, Beneficiary Engagement Incentives, & Beneficiary Termination			
Department Responsible: THN Assistant Director of ACO Operations & THN Marketing	**Policy Number:** BE-001	**THN's Effective Date:** January 1, 2022	**Next Review/Revision Date:** September 30, 2023
Title of Person Responsible: THN Assistant Director of ACO Operations	**THN Approval Council:** THN Compliance Committee	**Date Approved:** August 25, 2022	**Date Approved by THN Board of Managers:** August 29, 2022

I. **Purpose.** The purpose of BE-001 is to provide guidance for (1) the use of Benefit Enhancements and Beneficiary Engagement Incentives selected by Triad HealthCare Network (THN), (2) requirements for termination of Benefit Enhancements or Beneficiary Engagement Incentives, and (3) procedures to ensure that THN's practices are consistent with its stated policies.

II. **Policy.** THN may select as described in Section 8.01 of the Agreement to provide one or more Benefit Enhancements and Beneficiary Engagement Incentives for a Performance Year. Appendices A-H shall apply to the Agreement for a given Performance Year only if THN selected to provide the relevant Benefit Enhancement or Beneficiary Engagement Incentive for that Performance Year as described in Section 8.01 of the Participation Agreement and that selection was not rejected by CMS pursuant to Sections 8.02 or 10.01.E of the Participation Agreement.

III. **Procedure.**

A. Benefit Enhancements and Beneficiary Engagement Incentives:

1. THN shall submit to CMS, in a form and manner and by a date specified by CMS, a plan for implementing each Benefit Enhancement and each Beneficiary Engagement Incentive selected by THN as described in Section 8.01 of the Agreement, the first time that the Benefit Enhancement or Beneficiary Engagement Incentive is selected by THN, in advance of any Performance Year during which a material amendment to a Benefit Enhancement or Beneficiary Engagement Incentive previously selected will take effect, and at such other times specified by CMS. An Implementation Plan shall be consistent with the applicable requirements set forth in Appendices A-H and shall be deemed approved within 30 days after submission unless rejected in writing by CMS.
2. If THN selects to provide one or more of the Benefit Enhancements for a Performance Year, THN's DC Participant Providers and

Preferred Providers, as indicated on the relevant DC Participant Provider List and Preferred Provider List under Article IV of the Agreement, may submit claims for services furnished pursuant to such Benefit Enhancement(s) as described in Article X of the Agreement during the Performance Year for which THN selected to provide the Benefit Enhancement.

3. CMS may require THN to report data on the use of Benefit Enhancements and Beneficiary Engagement Incentives to CMS. Such data shall be reported in a form and in a manner and by a date specified by CMS.
4. If CMS determines that THN's proposed implementation of one or more Benefit Enhancements or Beneficiary Engagement Incentives is inconsistent with the terms of the Agreement or likely to result in program abuse or integrity concerns, CMS may reject THN's selection to provide one or more Benefit Enhancements or Beneficiary Engagement Incentives or may require THN to submit a new Implementation Plan. If CMS rejects THN's selection of a Benefit Enhancement or Beneficiary Engagement Incentive, THN shall not implement the Benefit Enhancement or Beneficiary Engagement Incentive for the following Performance Year.

A. Requirements for Termination of Benefit Enhancements or Beneficiary Engagement Incentives:
   1. THN must obtain CMS consent before voluntarily terminating a Benefit Enhancement or Beneficiary Engagement Incentive effective during a Performance Year. THN shall provide at least 30 Days advance written notice of such termination to CMS. If CMS consents to such termination, the effective date of such termination will be the date specified in the notice of termination or such other date specified by CMS.
   2. If during a Performance Year a Benefit Enhancement or Beneficiary Engagement Incentive will cease to be in effect with respect to THN or any DC Participant Provider or Preferred Provider pursuant to Section 17.01 of the Agreement, the effective date of such termination will be the date specified by CMS in the notice to THN.
   3. CMS shall cease coverage of claims for a terminated Benefit Enhancement 90 Days after the effective date of such termination, unless otherwise specified in Appendices A-H.
   4. If a Benefit Enhancement or Beneficiary Engagement Incentive will be Terminated or otherwise cease to be in effect during a Performance Year pursuant to Section 10.10.A or Article XVII of the Agreement, THN shall provide written notice to its DC Participant Providers, Preferred Providers, and DC Beneficiaries and Originally

Aligned Beneficiaries who are currently receiving items and services or other remuneration pursuant to a Benefit Enhancement or Beneficiary Engagement Incentive, within 30 Days after the effective date of termination or cessation of the Benefit Enhancement or Beneficiary Engagement Incentive. In the Case of a Benefit Enhancement, 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. In the case of a Beneficiary Engagement Incentive, such notification shall state that following a date specified by CMS, Beneficiary Engagement Incentives must no longer be provided to the Beneficiary. Any notice to Beneficiaries is subject to review and approval by CMS under Section 5.04 of the Agreement as Marketing Materials.

5. If THN selected to offer a Benefit Enhancement or a Beneficiary Engagement Incentive for a Performance Year and does not select to offer the Benefit Enhancement or Beneficiary Engagement Incentive for the next Performance Year, THN shall notify all its DC Participant Providers, Preferred Providers, Beneficiaries and Originally Aligned Beneficiaries who are currently receiving services pursuant to a Benefit Enhancement or incentives pursuant to a Beneficiary Engagement Incentive, that the Benefit Enhancement or Beneficiary Engagement Incentive will not be offered during the next Performance Year. Such notices must be furnished no later that 30 Days prior to the start of the next Performance Year.

Appendix A: Telehealth

About the Waiver

- This waiver:
  - ✓ Eliminates the rural geographic component of originating site requirements,
  - ✓ Allows the originating site to include a beneficiary's home, and
  - ✓ Permits the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology provided that certain requirements are met.
- An aligned beneficiary will be eligible for the Telehealth Expansion Waiver if the beneficiary is located at their home or one of the CMS defined telehealth originating sites.
- Asynchronous ("store and forward") telehealth ophthalmology and dermatology services includes transmission of recorded health history through a secure electronic communications system to a practitioner who uses the information to evaluate the case or render a service outside of a real-time interaction.
- This waiver will apply to both new and existing beneficiaries aligned to a DCE.
  - Distant site practitioners will bill these new services using Innovation Center specific asynchronous telehealth codes.
  - Distant site practitioner must be a DC Participant Provider or Preferred Provider who has elected to use this benefit enhancement, and beneficiaries must be aligned to a DCE that has selected this benefit enhancement.

Appendix B: Post-Discharge Home Visits

About the Waiver

- Physicians or Advanced Practice Providers (APPs) can currently provide certain post-discharge services in patient homes.
  - This is ***not*** a home health (or homebound) service.
- Under existing regulations, this service must be provided under direct physician supervision (i.e., physician/APP is present at the time the service is provided to the patient).
- Under the Post-Discharge Home Visits Benefit Enhancement, the service may be provided ***under general supervision*** – physician (or other practitioner) may contract with auxiliary personnel to provide this service and the service is billed by the physician's (or other practitioner's) office.
  - Provides flexibility during this critical time post-discharge for patients.
- Auxiliary personnel (as that term is defined under 42 CFR 410.26(a)(1) under the *general* – instead of direct – supervision of a DC Participant Provider or Preferred Provider (i.e., physician or other practitioner) may furnish "incident to" services at an aligned beneficiary's home.
- Up to a total of nine post-discharge visits may be furnished within 90 days following discharge from an inpatient facility (e.g., hospital, CAH, SNF, IRF).

- DCEs are required to abide by their state's laws regarding the provision of incident to services.

Appendix C: Care Management Home Visits

About the Waiver

- Care Management Home Visits are home visits that can be provided by auxiliary personnel (as that term is defined under 42 CFR 410.26(a)(1)) under the general supervision of a DC Participant Provider or Preferred Provider who has initiated a care treatment plan for an aligned beneficiary.
- This benefit enhancement provides flexibility in billing for home visits provided to beneficiaries to prevent possible hospitalization.
    - Eliminates requirement that these services be furnished under direct supervision.
- Beneficiaries who are eligible or currently in a home health episode are not eligible for Care Management Home Visits; it is not a home health service.
- A beneficiary will be eligible to receive up to 12 Care Management Home Visits within a performance year.
- Care Management Home Visit services are considered "incident to" services currently allowable through Medicare.
    - DC Participant Providers and Preferred Providers should follow the Medicare documentation rules surrounding "incident to" services.

Appendix D: 3-Day SNF Rule Waiver

About the Waiver

- Beneficiaries must meet the clinical criteria for admission (i.e., beneficiary must be medically stable with a confirmed diagnosis and have an identified skilled nursing or rehabilitation need).
- The SNF must have an overall quality rating of three or more stars in 7 out of the past 12 months under the CMS 5-Star Quality Rating System.
    - Star ratings are reviewed at the time the Proposed DC Participant Provider list or Preferred Provider list is submitted. SNF must be listed on the Proposed DC Participant Provider list or Preferred Provider List with the SNF benefit enhancement indicated.
    - ***During the COVID-19 public health emergency, this requirement is not being enforced.***
- The beneficiary is eligible for the waiver if:
    - They are not residing in a SNF or long-term care facility at the time of SNF admission under this waiver.
        - For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities.
    - They are medically stable and have confirmed diagnoses.

  - They have a skilled nursing or rehabilitation need identified by a physician or other practitioner that cannot be provided on an outpatient basis.
- Direct admission v. following hospital stay:
  - For direct admission:
    - The beneficiary has an evaluation within 3 days prior to SNF admission by a physician or another practitioner licensed to perform the evaluation, or
    - The beneficiary does not require inpatient hospital evaluation or treatment.
  - For admission following fewer than 3 days of inpatient hospitalization, the beneficiary does not require further inpatient hospital evaluation or treatment.

Appendix E: Cost-Sharing Support for Part B Services

About the Waiver

- The DC Participant Providers and Preferred Providers can reduce or eliminate beneficiary cost sharing amounts (in whole or in part) for categories of aligned beneficiaries and for categories of Part B services identified by the DCE.
- DCEs will make payments to those DC Participant Providers and Preferred Providers to cover some or all of the amount of beneficiary cost sharing not collected.
- The goal of offering this cost sharing support is to reduce financial barriers so that certain beneficiaries may obtain needed care and better comply with treatment plans, thereby improving their own health outcomes.
- Eligible Services may include any Part B service identified in the DCE's Implementation Plan, which must not include durable medical equipment or prescription drugs.
- Eligible Beneficiaries may include, without limitation, one or more of the following:
  - Aligned Beneficiaries without Medicare supplemental insurance (i.e., Medigap),
  - Aligned Beneficiaries experiencing high health care costs, and/or
  - Aligned Beneficiaries who require certain Part B services, the receipt of which could reduce the individual's overall health care costs.
- The Cost Sharing Support must advance one or more of the following clinical goals:
  - Adherence to a treatment regime,
  - Adherence to a drug regime,
  - Adherence to a follow-up care plan, or
  - Management of a chronic disease or condition.
- The DCE must have an agreement with each DC Participant Provider and Preferred Provider who has agreed to provide Cost Sharing Support for Part B Services and must specify the following:

- Categories of eligible beneficiaries and eligible services where they may provide Cost Sharing Support,
- Requirement that the DC Participant Provider or Preferred Provider provide Cost Sharing Support in accordance with the DCE's Implementation Plan, and
- Amount and frequency with which DCE will reimburse DC Participant Provider or Preferred Provider for the cost sharing amounts not collected.

Appendix F: Chronic Disease Management Reward

About the Waiver

- DCEs can provide gift cards (annual limit of $75) to eligible beneficiaries to incentivize participation in a chronic disease management program.
- To participate, an eligible beneficiary must have a clinically diagnosed chronic disease targeted by a qualifying Chronic Disease Management Program in the DCE's Implementation Plan.
- A gift card may be provided under the Chronic Disease Management Reward Program benefit enhancement only if:
  - The beneficiary was an eligible beneficiary at the time they were enrolled in, or began participating in, the Chronic Disease Management Program.
  - The beneficiary satisfied all criteria for obtaining the gift card, as set forth in the DCE's Implementation Plan.
  - The gift card is provided to the beneficiary directly by the DCE.
  - The cost of the gift card is funded entirely by the DCE.
  - The gift card is programmed to prevent the purchase of tobacco and/or alcohol products.
  - The gift card cannot be offered in the form of cash or monetary discounts or rebates, including reduced cost-sharing or reduced premiums and cannot be redeemable for cash.
- A Chronic Disease Management Program is a program described in the DCE's Implementation Plan that focuses on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources for individuals with the chronic diseases targeted by the program.
  - For example, a Chronic Disease Management Program may include:
    - Utilizing services or preventive screening benefits,
    - Adhering to prescribed treatment regimens,
    - Attending education or self-care management lessons, or
    - Meeting nutritional goals.
      - Note: A survey alone does not constitute a Chronic Disease Management Program.

Appendix G: Homebound Requirement Waiver for Home Health

About the Waiver

- A beneficiary must be confined to the home ("homebound") as defined in § 1814(a) and § 1835(a) for Medicare to cover and pay for home health services.
    - This requirement can limit access to home health services, as it focuses on a beneficiary's mobility limitations rather than the underlying health conditions or comorbidities often present in this population.
- This waiver:
    - Permits Medicare reimbursement of home health services for beneficiaries with certain clinical risk factors that are not homebound.
    - Enhance patients' ability to return to, remain in, and receive care in their home.
    - Providing access to home health services is expected to reduce hospital readmissions, improve patient outcomes, and reduce costs for this population.
    - This additional flexibility also would aid DCEs in developing alternative payment arrangements with home health agencies, promoting innovation.
- Beneficiaries are eligible for this waiver if they:
    - Otherwise qualify for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home and
    - Have a combination of clinical risks, which will be determined by CMS later.
        - ***Note: Beneficiaries that are receiving services under the post-discharge visits or care management home visits benefit enhancements would not be eligible to receive covered home health services under this benefit.***
- DCEs would identify home health providers that are DC Participant Providers or Preferred Providers to provide these services to eligible aligned beneficiaries. All other requirements regarding Medicare coverage and payment for home health services would continue to apply. enhancement.

Appendix H: Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit

About the Waiver

- Under current Medicare rules, when electing hospice, beneficiaries must waive Medicare coverage for services that are considered curative in favor of receiving services that are more palliative in nature.
    - However, studies have shown that offering both palliative and curative care in hospice can result in better pain and symptom management, care coordination, and shared decision making as well as timelier incorporation of patient-centered goals into the plan of care.
    - In addition, the stark decision required between curative and hospice care negatively impacts a beneficiary's access and ease of transition to hospice.

- Under the proposed waiver of the requirements in Section 1812 and 42 CFR Section 418.24(d)(2), DCEs would work with hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services.
    - Services would be related to a hospice enrollee's terminal condition and associated conditions that align with the enrollee's wishes and are appropriate to provide on a transitional basis. This waiver is expected to ease the transition of care and enhance beneficiary choice for beneficiaries, providing a tool for DCEs to improve the quality of care.
    - This benefit enhancement would only be available to DCEs participating in the Global option of Direct Contracting. Additional information regarding the Global option can be found in the Direct Contracting Request for Application.
- To be eligible, the concurrent care services that the DCE elects to make available must be specified in the beneficiary's plan of care and provided by designated DC Participant Providers or Preferred Providers.
    - These expenditures would be included as part of the total cost of care for the relevant performance year for the purposes of the Model financial calculations.
- Medicare would continue existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is under hospice election, except with respect to those hospice and non-hospice organizations identified by the DCE.
    - The Medicare FFS claims submitted by these organizations will be paid by Medicare if they are otherwise appropriate for payment absent the restriction for paying claims for a beneficiary that has elected hospice.

Date	Reviewed	Revised	Notes
January 1, 2022			Originally Published
August 2022	X		No changes