Health Care Reform Work Group

July 24, 2023

Meeting Agenda

1. Welcome, Introductions, and Review of Agenda
2. Review CMMI Focus, Timing, and Priorities
3. Health Care Reform Work Group Focus: Four Areas of Work
4. Initiatives in Two Areas of Work: Financial and Care Model, Short-Term Provider Stability
5. Prioritizing Medicare Waivers
6. Short-Term Stability: Subgroup Update; Status of Current Activities
7. Next Steps

Focus and Timing of Future All-Payer Model

The Center for Medicare & Medicaid Innovation (CMMI) has provided clarification on the focus and timing of the next model:

- CMMI is moving in the direction of offering only **multi-state models** rather than state-specific models.
- CMMI has outlined **seven priorities** that will be central to this model (see next slide).
- More details on the model are expected to be released by CMMI in the Fall.
- Applications from states, outlining their proposals, will likely be due in early 2024.
- CMMI has informed Vermont that full implementation of the Medicare payment provisions of this model **will occur in 2026**, not in 2025 as previously anticipated.
- As a result, CMMI and Vermont are negotiating **what 2025 will look like**, with the goal of providing a smooth transition to a new Medicare/multi-payer model in 2026.
- At the same time, CMMI and Vermont are continuing to discuss a potential 2026 model.

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Summary of Workgroup Member Input

- Given the AHEAD model will launch in CY 2026, workgroup members had questions around plans for CY 2025. Vermont indicated it is in active discussions with CMMI and reiterated its commitment to ensure a smooth transition to a new model in CY 2026 for participating stakeholders. Vermont clarified that CMMI will not be standing up a new model in CY 2025.
- Workgroup members noted these recent developments around model timing will impact planning.

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What do we know about the new payment model under development by CMMI?

"To accelerate and support these efforts, the Innovation Center is exploring a state-based model to improve population-level health outcomes and advance health equity by testing total cost-of-care approaches to shift health care spending and utilization from acute care to primary care. The future state-based, total cost of care models under consideration by the Innovation Center will amplify Medicaid-led advanced primary care efforts by aligning Medicare FFS and other payers to these efforts."
- CMS Blog, [The CMS Innovation Center's Strategy to Support High-quality Primary Care]

CMMI is signaling that it will produce a design spanning multiple states that will address 7 priorities:

Payment Design

1. Include global budgets for hospitals.
2. Include Total Cost of Care target/approach.
3. Be all-payer.
4. Include goals for minimum investment in primary care.

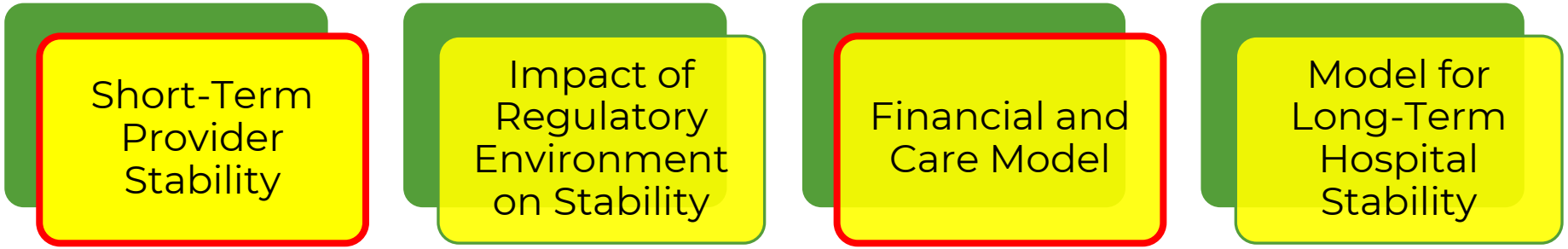
Core Principles

5. Include safety net providers from the start.
6. Address mental health, substance use disorder, and social determinants of health.
7. Address health equity.

Through an advisory group structure and other methods, AHS and GMCB are gathering input on a variety of topics to inform feedback to CMMI on a new multi-payer, multi-state model.

The Health Care Reform Work Group was initiated in June 2022

Four Areas of Work:

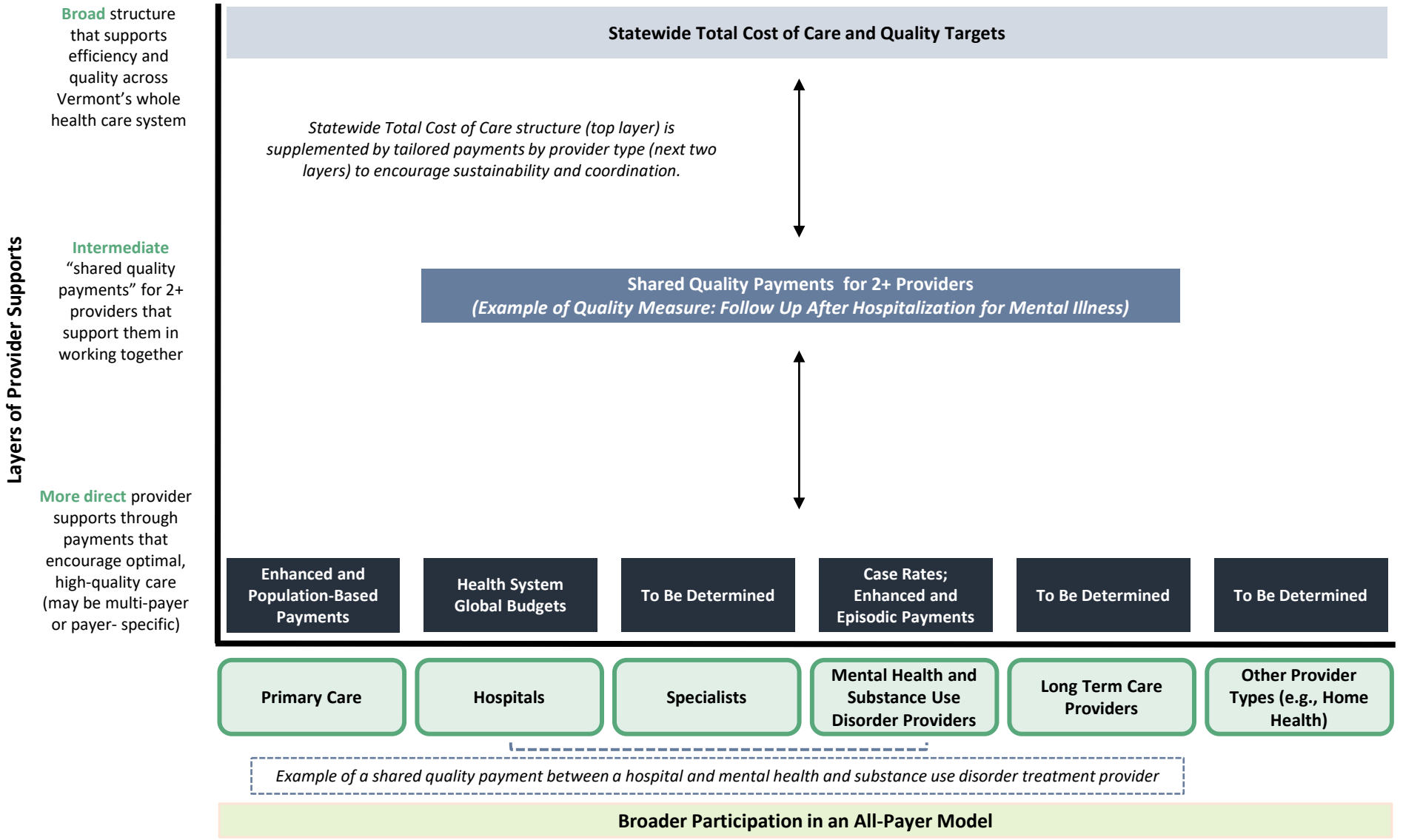


Today's discussion:
Financial and Care Model; Short-Term Provider Stability

Financial and Care Model: Current and Planned Initiatives

1. Vision for Statewide Approach (“Portfolio Model”)
2. Global Budget Technical Advisory Group
3. Blueprint for Health Expansion
4. Medicaid Payment Reform
5. Medicare Waivers
6. Shared Interest Measures

Vermont's Vision for a Statewide Approach



Population-Based Payment: A provider or provider organization is accountable for the health of a group of patients in exchange for a set payment. This gives providers flexibility to coordinate and manage care for their patients. They accept risk for costs of care that exceed the set payment amount.
Health System Global Budget: A global budget is a budget that is established ahead for a fixed period of time (typically one year) for a specified set of services (e.g., inpatient and outpatient hospital services) for a set population.
Case Rate: A provider receives a flat rate for a patient's treatment for a specific period of time.

Summary of Workgroup Member Input

- Related to the bottom layer of Vermont's vision for a statewide approach to health care reform, one workgroup member indicated that Medicare home health has a value-based model (Prospective Payment System (PPS)) but Vermont Medicaid pays on a fee-for-service basis.
- Another workgroup member noted that OneCare's Comprehensive Payment Reform (CPR) program provides payer-blended payments to independent primary care practices and that the model is more advanced than shared quality payments. Vermont has reiterated the importance of the CPR program and the importance of not going backwards in health care reforms to CMMI and will continue to do so.

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Global Budget TAG
Payment Design Topics Covered To Date

1) Services included in hospital global budget payments
2) Populations included in hospital global budget payments
3) Calculating baseline global budget payments
4) Annual, periodic, and ad hoc global budget payment adjustments

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Global Budget TAG
Progress and Future Plans

- Currently working to develop a straw model based on TAG recommendations to-date
- Looking ahead: TAG will react to straw model this summer, and see a more developed model with actual Vermont data in fall
- In the meantime, continuing to tackle key issues: strategies to support care transformation, terms of payer participation, terms of hospital participation, budget calculation and payment operations, and monitoring and evaluation

The Appendix includes a summary of input to date from Global Budget TAG meeting participants for topics that have been covered.

TAG materials are publicly available on the GMCB website

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Update on Medicare Waivers

- The Health Care Reform Work Group previously reviewed potential waiver requests and highlighted areas of greatest interest.
- The State is discussing with CMMI current problems that new or revised waivers could help address.
- We continue to welcome feedback on the most important "asks" for both the current model and a future model.
- Waivers under consideration can be found in Appendix 3.

Blueprint for Health Expansion Pilot

Vermont Medicaid is expanding funding for Blueprint for Health Community Health Teams (CHTs) to implement a **two-year pilot program** designed to improve access to mental health and substance use disorder services and address social determinants of health through increased integration with primary care.

- Vermont experiencing increased deaths from drug overdose and suicide; concerning levels and acuity of mental health and substance use disorders.
- Need to identify and address social determinants of health, particularly housing instability.
- Objective of pilot is to ensure that additional supports and services are provided across entire population served by primary care practices participating in Blueprint for Health (majority of primary care practices in Vermont).

Blueprint for Health Expansion (cont'd)

- Pilot program will expand CHT staffing to support primary care practices in providing the following services across the entire population:
  - Systematic identification of needs, through universal screening for mental health, substance use disorder, and social determinants of health,
  - Brief intervention within the practices when there are positive screening results, and
  - Navigation to additional specialty and other community-based services when warranted.

Blueprint CHT Expansion Pilot Supports

Supports provided to Blueprint Patient-Centered Medical Home primary care practices and regional Blueprint Program Managers during the pilot include:

- Embedded or centralized CHT Staff
- Quality improvement facilitation to assist with implementation, continuous quality improvement, and pilot evaluation
- Trainings to increase knowledge and skill in mental health and substance use care
- Guidance documents summarizing best-practices, tools, and templates

Home Page | Blueprint for Health (vermont.gov)

Medicaid Payment Reform

	PLANNING	DESIGN	IMPLEMENTATION	EVALUATION	Program Launch & Model Description
Vermont Medicaid Next Generation ACO Program (DVHA)				★	• Program launch in 2017 • Monthly prospective population-based payments with financial reconciliation • Includes value-based incentive fund
Mental Health Payment Reform (DMH)			★		• Program launch in 2019 • Monthly per person case rate; varies by agency • Caseload reconciliation • Encounter data submission • Value-based payment component
Residential SUD Program Payment Reform (DSU)			★		• Program launch in 2019 • Episodic payment per residential stay • Payments vary by SUD diagnosis
Applied Behavior Analysis Payment Reform (DVHA)				★	• Program launch in 2019 • Monthly bundled payments by tiers based on level of service, with financial reconciliation • Value-based payment component
Developmental Disability Services Payment Reform (DAIL)		★			• Interim payment methodology implemented • Encounter data submission • Standardized assessment implemented
Children's Integrated Services Payment Reform (DCF)			★		• Program launch in 2020 • Per person per month bundled payment • Encounter data submission • Value-based payment under development
High-Technology Nursing (VDH and DAIL)			★		• Program launch in 2022 • Hybrid model: prospective monthly payment + reduced FFS payments; financial reconciliation • Value-based payment component
Brattleboro Retreat Alternative Payment Model (AHS, DMH, DVHA)			★		• Program launch in 2021 • Monthly prospective payments for inpatient services • Financial reconciliation • Robust performance measurement framework

Shared Interest Measures

Examples of shared interest measures:

- Readmissions
- Follow-up after hospitalization for mental illness
- Follow-up after emergency department visit for mental illness
- Follow-up after emergency department visit for substance use disorder
- Prevention quality indicators (potentially avoidable hospitalizations for ambulatory care-sensitive conditions)

A number of these measures are in current quality frameworks in Vermont and provide opportunities to encourage coordination among providers in important clinical areas.

Summary of Workgroup Member Input

- One workgroup member noted hospice utilization and length of stay would be another important measure for the State to consider. Hospice utilization has a well-documented impact on total cost of care and would be an optimal area for collaboration between providers.
- Another workgroup member asked about next steps for collecting stakeholders' feedback on shared interest measures. Vermont indicated CMMI will provide more information on their areas of focus in the future and that states will likely have flexibility to select measures that fall within CMMI's priority domains. Vermont will request stakeholder input. The State remains focused on aligning measures across programs to reduce administrative burden.

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System Stabilization: Short-Term Provider Stability Subgroup

- Stabilizing the system was identified as a critical short-term priority.
- Subgroup met six times between July 15th and August 21st of 2022 to focus on short-term actions (i.e., within 6-18 months) that will improve system stability.
- Recommendations were made across four categories:
  - Workforce
  - Regulation
  - System Flow
  - Revenue
- 22 discrete actions were identified; progress has occurred on many of them.
- System Flow category has the most open items.

Mid-point Reconvening (July-August 2023): Questions for Subgroup

- What are your observations about progress to date, with particular focus on System Flow, but also for Workforce, Regulation, and Revenue categories?
- Is current progress what you would have expected at the midpoint of this action plan?
- What are the known barriers to addressing incomplete activities?
- Are there potential refinements or “course corrections” on activities based on implementation experience?
- Should we continue to pursue previously-identified activities that haven’t been completed?
- Are there additional activities that we should pursue?
- How can we assess progress on short-term stability?

Summary of Input from June 30th Short-Term Provider Stability Subgroup

- Challenges for hospitals are a result of system challenges; important to advocate for all parts of the system.
- Challenges for Skilled Nursing Facilities (SNF) include caring for people with complex needs, SNF medical directors. SNF rate methodology discussions underway. Need to look at Extraordinary Financial Relief (EFR is time-limited).
- Use of temporary labor: need to grow the pipeline; anticipate that this will be ongoing issue.
- Addressing complex care needs: work with Brattleboro Retreat has been beneficial; hopeful about iCare work that DAIL is leading.
- Need to determine how to build more SNF and home health capacity. Big issue is options for people who are too complex for home health.
- Mental Health: Work in collaboration with DMH has been very helpful. Still in crisis mode; programs closing, workforce challenges. Need to improve Medicare coverage for Master's level clinicians to support expansion of elder care.

Appendices:

1. Global Budget Technical Advisory Group: Summary of Feedback
2. Status of Short-Term Provider Stability Activities
3. Medicare Waivers

Appendix 1:

Global Budget Technical Advisory Group: *Summary of Feedback*

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Global Budget TAG Input to Date

1. Services Included in Hospital Global Budget Payments

- All hospital inpatient and outpatient services, with the possible exception of infrequent and high-cost hospital services, a question which the Technical Advisory Group will revisit.
- Both employed and non-employed professional services billed under the hospital's taxpayer identification number (TIN), but not non-employed professionals not billed under the hospital's TIN.
- At least some hospital-owned facility-based services, with phased inclusion of additional services over time.
- Corporate parent-owned entities on a case-by-case basis, based on whether those services can be appropriately allocated to a specific hospital based on geography or other factors.

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Global Budget TAG Input to Date

2. Populations Included in Hospital Global Budget Payments

- Vermont Medicaid members and not members of other state Medicaid programs.
- All Medicare FFS beneficiaries (VT residents and non-VT residents receiving care at Vermont hospitals), acknowledging the importance of understanding the percentage of non-resident Medicare charges from non-border states, as those beneficiaries are more likely to receive primary care out-of-state.
- As many commercially insured people as possible, including both VT and non-VT residents receiving care at Vermont hospitals.

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Global Budget TAG Input to Date

3. Calculating Baseline Budget Payments

- Use net patient revenue from Medicaid, Medicare, and participating commercial payers as the primary data source for determining baseline budget payments
- Calculate at the facility level (not the system-level)
- One-time adjustments to the baseline budget should take into account:
  - Hospital financial condition, including hospital operating margins
  - Inflation trends
  - Demographic changes
  - Policy changes (e.g., changes in Medicare and Medicaid payment)

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Global Budget TAG Input to Date
4. Annual & Ad Hoc Adjustments

- Make annual adjustments to the global budget payments for the following:
  - Inflation trends – balancing hospital cost inflation lens with affordability lens
  - Demographic changes – methodology TBD
  - NOTE: Future meetings will include discussion about adjustments for efficiency, potentially avoidable utilization, high-value care, etc.
- Make annual and potentially mid-year adjustments for changes in utilization. Two potential approaches (mixed TAG feedback) – stay tuned!
- Include two-sided accountability for total cost of care (TCOC)
- Consider adjustments to mitigate provider financial risk in extreme circumstances
  - Monitoring for (1) changes in utilization beyond a selected threshold or (2) negative margins beyond a certain threshold could trigger ad hoc adjustment for financial risk, informed by a hospital's financial position

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Appendix 2:
Status of Short-Term Provider Stability Activities (as of June 30, 2023)

Short-Term Provider Stability: All Tasks – 22 Total

- **Workforce:**
  - ✓ Spend remaining Workforce Recruitment and Retention Program Funds (AHS)
  - ❑ Implement Workforce Development Committee recommendations regarding shortages (AHS)
- **Regulation:**
  - ❑ Escalate package of stability measures to CMS and Federal Delegation (AHS)
  - ✓ Provide public comments on Medicare rate adjustments (AHS)
  - ✓ Implement short-term method to target Choices for Care services to highest need individuals (DAIL)
- **System Flow:**
  - ✓ Procure Medicaid specialized units in LTC and residential facilities (DAIL)
  - ✓ Explore caring for high-acuity patients in hospital-owned LTCs (DVHA/DAIL)
  - ❑ Recruit a cohort of SNFs to becomes centers of excellence (DAIL/DMH)
  - ❑ Discuss local crisis response processes with hospitals, DAs, and SNFs to avoid using the Emergency Department (DMH)
  - ❑ Create a statewide approach to SNF medical director requirements (DAIL)
  - ❑ Clarify a consistent interpretation of Use-Of-Force policy between DPS, DAs, and hospitals (DPS)
  - ❑ Consider a collaborative care model using telehealth “curbside consultations;” train SNF staffs on de-escalation
  - ❑ Explore obtaining SMART medical clearance; have hospitals accept such patients (DMH)
  - ❑ Define community emergency mental health services and identify gaps (DMH)
  - ✓ Mental health resource sharing conversations between hospitals and DAs (DMH)
  - ✓ Invest in psychiatric/mental health urgent care (AHS)
- **Revenue:**
  - ✓ Update rate methodologies and rules to address inflationary costs (DVHA)
  - ✓ Conduct rate studies to evaluate Choices for Care rates to determine program sustainability (DVHA)
  - ✓ Provide a one-time increased DSH payment (DVHA)
  - ✓ Increase GME payment to UVMHN to maximum federal allowance (DVHA)
  - ✓ Study provider tax trends; determine opportunity for short-term one-time relief (AHS)
  - ✓ Explore in-patient psychiatric rates (DVHA)

13 of 22 completed

Workforce

- **Implement Workforce Development Committee recommendations regarding shortages (AHS)**
  - The Nurse Preceptor Incentive Grants Program application period closed on May 31st and grant awards are in process.
  - The Round 1 application period for the Nursing Apprenticeship and Pipeline Grant Program closed on July 21st. A second funding round will open in January 2024.

Regulation

- **Escalate package of stability measures to CMS and Federal Delegation (AHS)**
  - AHS and GMCB seek to engage the Center for Medicare and Medicaid Innovation (CMMI) in discussions to modify existing Medicare waivers and implement new Medicare waivers under current or future demonstration models.
  - Requests will be informed by the Medicare Waiver Technical Advisory Group.

Status of Short-Term Stability Subgroup Actions on System Flow

Actions from prior work that have been completed:

- ✓ Procure Medicaid specialized units in LTC and residential facilities (DAIL)
- ✓ Mental health resource sharing conversations between hospitals and DAs (DMH)
- ✓ Invest in psychiatric/mental health urgent care (AHS)
- ✓ Explore caring for high-acuity patients in hospital-owned LTCs (DVHA/DAIL)

Actions from prior work still in process:

- ❑ Recruit a cohort of SNFs to becomes centers of excellence (DAIL/DMH)
- ❑ Discuss local crisis response processes with hospitals, DAs, and SNFs to avoid using the ED (DMH)
- ❑ Create a statewide approach to SNF medical director requirements (DAIL)
- ❑ Clarify a consistent interpretation of Use-Of-Force policy between DPS, DAs, and hospitals (DPS)
- ❑ Consider a collaborative care model using telehealth “curbside consultations;” train SNF staffs on de-escalation
- ❑ Explore obtaining SMART medical clearance; have hospitals accept such patients (DMH)
- ❑ Define community emergency mental health services and identify gaps (DMH)

System Flow (1 of 3)

- ❑ **Recruit a cohort of SNFs to becomes centers of excellence (DAIL/DMH)**
  - DAIL contracted with a provider to serve post-acute patients requiring complex care.
  - DMH explored options in the Northeast Kingdom.
  - Additionally, DAIL and DMH are engaging with community partners on client-specific placement options.

- ❑ **Discuss local crisis response processes with hospitals, DAs, and SNFs to avoid using the Emergency Department (DMH)**
  - DMH attends a monthly meeting with DAIL and Office of the Public Guardian (OPG) to discuss complex cases, and DAIL utilizes ad hoc consultation with DMH when urgent complex cases arise outside of the monthly standing meeting.

System Flow (2 of 3)

- ❑ **Create a statewide approach to SNF MD requirements using shared capacity**
  - OneCare-led activity
  - Considering contractor approach to physician employment related services, including being the Medical Group to serve as the employer for physicians/APPS and bill payers for reimbursable services.
  - Stakeholder identified concern with pathway to paying ongoing Medicare Director salaries.

- ❑ **Clarify a consistent interpretation of Use-of-Force policy between DPS, DAs, and hospitals (DPS)**
  - DPS and Vermont Care Partners met with leadership from the Vermont Criminal Justice Council (VCJC), which oversees law enforcement training.
  - DPS/VCP and VCJC are continuing to meet at this time to discuss possibility of training update and/or clarification memo from VCJC related to Use of Force policy. No known current issues related to Emergency Departments and the Use of Force policy.

- ❑ **Consider a collaborative care model using telehealth "curbside consultations;" train SNF staffs on de-escalation (External)**
  - Not considered a priority activity to address short-term stability issues at this time.

System Flow (3 of 3)

- ❑ **Explore obtaining SMART medical clearance; have hospitals accept such patients (DMH)**
  - Project on hold. Medical directors at hospitals unsure they would accept a PCP's Level of Care determination rather than a psychiatrist. Likely would require either psychiatric consultation or additional training for PCPs.
  - Prioritizing this next step for providers lost steam due to low numbers of individuals who are successfully referred within PCP office hours. Due to limited bed availability patients often wait over 24 hours. Limiting the impact of a PCP SMART clearance to avoid the ED.

- ❑ **Define community emergency mental health services and identify gaps (DMH)**
  - Emergency Services have been defined distinctly from two new emergency response models: 1. Mobile Crisis Response 2. CAHOOTS.
  - The Mobile Crisis program has been identified as a gap in the emergency services system and the services have been defined through a new Mobile Crisis Response manual posted on the DMH website. HCRS has been selected as the contractor for a statewide community-based mobile crisis service and a draft contract is under review with feedback from HCRS due 6/21.
  - CAHOOTS has been renamed Burlington CARES; a contract was signed on June 15th and the Burlington Police Department is preparing to post for positions in the coming weeks.

Revenue (1 of 2)

- **Update rate methodologies and potentially rules to address inflationary costs, including staffing, within cost-based rate methodologies for Skilled Nursing Facilities, Private Non-Medical Institutions, and other residential care providers (DVHA)**
  - Private Non-Medical Institution (PNMI) Rate Setting Rule changes have been adopted, effective 7/1/23, to include annual inflationary updates.
  - Rates for all PNMI programs will be updated 7/1/23 incorporating inflationary increases.
  - Nursing home rates will also be updated 7/1/23, rebasing to 2021 costs and incorporating the most recent inflationary factors. Budget approval ensured appropriations for both increases.

Revenue (2 of 2)

- **Updates related to stability activities (included in previous reports)**
  - The following were included in the Governor's FY24 budget request and passed by the legislature:
    - Funding for statewide expansion of mobile crisis ($3.35M gross – As Passed)
    - Funding for alternatives to emergency department mental health crisis care ($1.59M gross – As Passed)
    - Increase to GME payment to UVMHN (As Passed)
    - Increase of $3M gross for HH rates, $17.79M gross for NH rebasing and inflation factor
      - As Passed budget includes downward adjustment to equal a 15% rate increase for Personal Care, Homemaker, and Respite care
      - As Passed includes Home Health Agency specialized rate increase to 90% of LUPA
      - As Passed includes NH rebasing and inflation factor adjustments as proposed in Gov. Rec.
    - Increase of $2.32M gross for PNMI to include an inflationary factor in rates (As Passed)
    - One-time $10M for provider stability (As Passed) and one-time funding for 2-year Blueprint for Health/Hub and Spoke pilot expansion to integrate mental health and primary care (As Passed)

Appendix 3:
Medicare Waivers
(slides from June 26, 2023 Meeting)

For Reference – Previously Discussed Requests and Current Waivers (1 of 4)

Waiver Description	Source	New Waiver, Modification Request, or No Change
Post Discharge Home Visit Waiver: This waiver increases the availability of in-home care after discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility. The supervision level for "incident to" services is changed from "direct" to "general" supervision to allow personnel under a physician's general supervision to make home visits under certain conditions.	Current All Payer Model	**Modification Request:** Vermont requests to modify administrative requirements associated with implementing this waiver, specifically around billing and contracting. Under the current structure, which Vermont proposes that CMS eliminate, physicians need to bill for services performed by home health providers, leading to lags in payment and administrative complexity. Under this proposal, home health agencies would be able to bill Medicare directly.
Skilled Nursing Facility (SNF) 3-day Rule Waiver: This waiver eliminates the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended-care service for eligible beneficiaries. Patients can be admitted to a skilled nursing facility without a 3-day stay at a hospital.	Current All Payer Model	**Modification Request:** Vermont seeks to expand the eligibility criteria for this waiver beyond ACO-attributed lives to any Medicare FFS life.
Care Management Home Visit Waiver: This waiver increases access to in-home care for beneficiaries that are at risk of hospitalization and for whom a provider has initiated a care treatment plan. The supervision level for "incident to" services is changed from "direct" to "general" supervision to allow personnel under a physician's general supervision to make care management visits under certain conditions.	Current All Payer Model	**Modification Request:** Similar to the post discharge home visit waiver request above, Vermont proposes to streamline the administrative requirements around billing and contracting associated with implementing this waiver.
Home Health Homebound Waiver: This waiver allows ACOs to receive reimbursement for the provision of home health services for select beneficiaries with certain clinical risk factors who are not homebound.	Available under ACO REACH	**New Waiver:** The State is interested in potentially adding this waiver to Vermont's All-Payer ACO Model. It is currently available under ACO REACH. The State would like to propose a change to the ACO REACH eligibility criteria by eliminating the requirement around the need for skilled services *("Otherwise qualify for home health services under 42 CFR § 409.42 except that the beneficiary is not required to be confined to the home").*

For Reference – Previously Discussed Requests and Current Waivers (2 of 4)

Waiver Description	Source	New Waiver, Modification Request, or No Change
Medicare Hospice Waiver: This waiver allows beneficiaries to receive palliative and curative care simultaneously. ACOs may work with hospice and non-hospice providers to define and provide a set of concurrent care services.	Available under ACO Reach	**New Waiver**
Mental Health and Substance Use Disorder (MH/SUD) Provider Flexibility: The State seeks reimbursement for select MH/SUD providers (licensed alcohol and drug counselors, licensed psychologists, and licensed psychiatric nurses) to expand access MH/SUD treatment.	Previous All Payer Model Request	**New Waiver**
Participation Waiver: Section 1877(a) of the Act (physician self-referral law) and sections 1128B(b)(1) and (2) of the Act (Federal anti-kickback statute) are waived with respect to any arrangement between the ACO, one or more of its Initiative Participants, or a combination thereof, provided certain conditions are met.	Current All Payer Model	**No Change**
Shared Savings Distribution Waiver: Section 1877(a) of the Act (physician self-referral law) and sections 1128B(b)(1) and (2) of the Act (Federal anti-kickback statute) are waived with respect to distributions or use of Shared Savings earned by the ACO, provided certain conditions are met.	Current All Payer Model	**No Change**
AIPBP Payment Arrangement Waiver: Section 1877(a) of the Act (physician self-referral law) and sections 1128B(b)(l) and (2) of the Act (Federal anti-kickback statute) are waived with respect to an AIPBP Payment Arrangement, provided certain conditions are met.	Current All Payer Model	**No Change**

For Reference – Previously Discussed Requests and Current Waivers (3 of 4)

Waiver Description	Source	New Waiver, Modification Request, or No Change
Compliance With the Physician Self-referral Law Waiver: Sections 1128B(b)(l) and (2) of the Act (Federal anti-kickback statute) are waived with respect to any financial relationship between or among the ACO and its Initiative Participants or Preferred Providers that implicates the physician self-referral law, provided certain conditions are met.	Current All Payer Model	**No Change**
Waiver for Patient Engagement Incentives: Section 1128A(a)(5) of the Act (civil monetary penalties for beneficiary inducements) and sections 1128B(b)(l) and (2) of the Act (Federal anti-kickback statute) are waived with respect to items or services provided by the ACO or its Initiative Participants to Beneficiaries provided certain conditions are met.	Current All Payer Model	**No Change**
Telehealth Expansion Benefit Enhancement a. Waiver of Originating Site Requirements: This waiver expands allowable originating sites to include a beneficiary's place of residence for select synchronous and asynchronous telehealth services. b. Waiver of Interactive Telecommunications System Requirement: This waiver enables providers to bill for certain ophthalmology and dermatology services furnished through asynchronous technologies.	Current All Payer Model	**No Change**

For Reference – Previously Discussed Requests and Current Waivers (4 of 4)

Waiver Description	Source	New Waiver, Modification Request, or No Change
Telehealth in SNFs for Physician Visits: CMS waived the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.	Available during COVID PHE	**New Waiver (Reinstate PHE Flexibility)**
(1) Physician Delegation of Tasks in SNFs CMS waived the requirement that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver has given physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist. ***(2) Physician Visits*** CMS waived the requirement that all required physician visits (not already exempted in §483.30(c)(4) and (f)) must be made by the physician personally. This permits physicians to delegate any required physician visit to a nurse practitioner, physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the state and performing within the state's scope of practice laws.	Available during COVID PHE	**New Waiver (Reinstate PHE Flexibility):**
Training and Certification of Nurse Aides CMS waived the requirements at §483.35(d), except for §483.35(d)(1)(i)). To ensure the health and safety of nursing home residents, CMS did not waive §483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services. CMS temporarily waived these requirements so they do not present barriers for SNFs and nursing facilities to hire staff.	Available during COVID PHE	**New Waiver (Reinstate PHE Flexibility):** Vermont requests to extend the allowable grace period between being trained as a licensed nursing assistant to receiving final certifications from 4 months to 24 months. Proposed language for consideration: *Nursing assistants may practice for a grace period of 24 months without receiving final certification in a state-recognized exam. They may not use the title 'licensed' or 'certified' during this time but may perform tasks within a licensed nursing assistant scope of practice.*

Potential New Waiver Requests – Telehealth and other PHE Waivers (1 of 2)

Waiver Description	Source	New Waiver, Modification Request, or No Change
Telehealth Coverage for MH/SUD Services: CMS expanded Medicare's coverage of MH/SUD telehealth services (i.e., services "for purposes of diagnosis, evaluation, or treatment" of a SUD or co-occurring mental health condition) during the PHE and recently made them permanent. Flexibilities include: a. Eligible Originating Sites: Patients may receive telehealth visits in any part of the country and from any location, including their own home. Previously, patients could receive telehealth services only if they were in a rural area and physically located at an eligible provider originating site. b. Audio-Only Services: CMS authorizes coverage for MH/SUD counseling services when delivered telephonically (i.e., without synchronous video). Prior to the pandemic, audio-only coverage was limited. c. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): These entities may bill for MH/SUD telehealth services. Previously, FQHCs and RHCs could not bill for telehealth services.	Available during COVID-19 PHE, extended to 12/31/24	**New Waiver (Reinstate PHE Flexibility)**
Audio-Only Telehealth for Certain Services: CMS waived the requirement that requires use of interactive telecommunications systems to furnish telehealth services (i.e., use of video technology) for certain services. This waiver allows use of audio-only equipment for select audio-only telephone evaluation and management services and MH/SUD counseling and educational services.	Available during COVID-19 PHE, extended to 12/31/24	**New Waiver (Reinstate PHE Flexibility)**

Potential New Waiver Requests – Telehealth and other PHE Waivers (2 of 2)

Waiver Description	Source	New Waiver, Modification Request, or No Change
3-day Rule for Swing Bed Services: Currently, Medicare beneficiaries must have a medically necessary 3-day (consecutively) inpatient hospital stay prior to receiving swing bed services.	Available during COVID-19 PHE, extended to 12/31/24	**New Waiver (Reinstate PHE Flexibility)**
Verbal Orders: CMS waived the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to provide additional flexibility related to verbal orders where read-back verification is required but authentication may occur later than 48 hours. This will allow more efficient treatment of patients in surge situations. Specifically, the following requirements were waived: §482.23(c)(3)(i) — If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently.	Available during COVID-19 PHE, extended to 12/31/24	**New Waiver (Reinstate PHE Flexibility)**

Potential New Waiver Requests – Waivers Available Under Other Models

Waiver Description	Source	New Waiver, Modification Request, or No Change
Waiver of Certain Medicare Hospital and/or Critical Access Hospital (CAH) Conditions of Participation (CoPs): This waiver allows Participant Hospitals to make certain changes to their facility structure and maintain their hospital or CAH status for the purpose of Medicare enrollment and certification, Medicare hospital quality reporting, and in order to receive payments under the capitated payment arrangement.	Available under CHART	**New Waiver**
96 Hour Certification Rule: Currently, for CAHs to receive payment under Medicare Part A, physicians must certify that patients will be reasonably discharged or transferred to another hospital within 96 hours. This would waive the condition of payment.	Available under CHART	**New Waiver**
Nurse Practitioner Services: This waiver enables nurse practitioners to certify the need for hospice care; certify the need for diabetic shoes; order and supervise cardiac rehabilitation; establish, review, sign, and date home infusion therapy plans of care; and make referrals for medical nutrition therapy.	Available under ACO Reach	**New Waiver**
Acute Hospital Care at Home Waiver: This waiver enables hospitals to provide at-home, acute, hospital-level treatment to select patients whose care can be delivered via telemedicine. This care is provided concurrently with home visits by nursing and other appropriate personnel and supportive services. This is an institutional-level waiver that waives CMS' 24-hour on-site nursing requirement for hospitals participating in Medicare (i.e., "hospital must have an organized nursing service that provides 24-hour nursing services…that must be furnished or supervised by a registered nurse").	Available during COVID-19 PHE	**New Waiver**