Medicare Waivers Technical Advisory Group Meeting #3

APRIL 11, 2023 MEETING SUMMARY

Meeting Agenda

1. Recap of task at hand and current/potential Medicare waivers
2. Recap of discussion during 3/30 Medicare Waivers TAG meeting
3. Deeper Dive on Telehealth Waivers
    a. Telehealth Expansion Benefit Enhancement – Waiver of Originating Site Requirements, Waiver of Interactive Telecommunications System Requirement
    b. Use of Telehealth in SNFs for Physician Visits
4. Update on MH/SUD Flexibility
5. Next Steps

1. Recap Task at Hand and Current/Potential Medicare Waivers

Medicare Waivers Technical Advisory Group's Charge

The group's primary goal is to identify the key "asks" on Medicare waivers to share with CMS to inform the design of the AHEAD model.

- CMMI is considering the types of waivers it could make available to states under the AHEAD model and welcomes Vermont's feedback.
- CMMI asked the State to indicate the most important "asks."
  - Include a clear policy rationale for updating existing waivers available under the VTAPM and/or requesting new waivers under the AHEAD model.
  - Members have already provided some compelling examples.
- Vermont aims to understand:
  - Problems that new or revised waivers could help address (e.g., discontinuity of care with transitions)
  - On-the-ground experiences (successes, challenges) with implementing current waivers under the Vermont All-Payer ACO Model
  - New waivers that are of interest to stakeholders

Theory of Change for Medicare Waivers

- Medicare waivers are a means to an end, not the end itself.
- Logic should be:
  - What are the care delivery models we want to see implemented in Vermont?
  - How do those care delivery models advance outcomes?
  - **What waivers do we <u>need</u> to implement the models?**
- Successful implementation of similar flexibilities by Medicaid and other payers is relevant and is likely to be of interest to CMMI.

Medicare Waivers Under Consideration

Category	Existing Under Current VTAPM	Potential New Waivers

Participation/ Fraud and Abuse	• Participation Waiver
	• Shared Savings Distribution Waiver
	• Physician Self-Referral Law Waiver
	• Waiver for Patient Engagement Incentives
	• AIPBP Payment Arrangement Waiver
		• Waivers found in CHART model:
		  ○ Waiver of Certain Medicare Hospital and/or CAH Conditions of Participation (CoPs)
		  ○ 96-hour Certification Rule

Services at Home	• Care Management Home Visits • Post-discharge Home Visits	• Home health expansion/flexibilities

SNF	• 3-day SNF Rule Payment	• Allow SNFs to bill Medicare directly for physician services provided by locum physicians.
		• For beneficiaries in SNFs,
		  ○ Physician delegation of tasks to a physician assistant, nurse practitioner
		  ○ Personal physician visits not already exempted by 483.30(c)(4)
		• Temporary nurse aide waiver
		• Telehealth (as above)

Hospice		• Allow expanded palliative care benefit for adults

Telehealth	• Telehealth Expansion Benefit Enhancement
	  ○ Waivers of Originating Site Requirements
	  ○ Waiver of Interactive Telecommunications System (teledermatology and teleophthalmology services)
		• Allow use of telehealth in SNFs for physician services

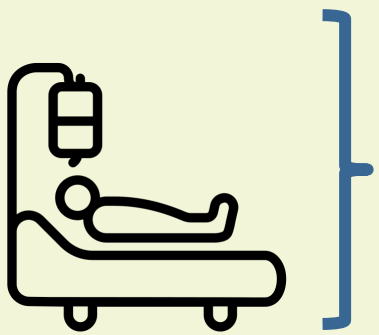
MH/SUD Access		• Allow for Medicare reimbursement for Licensed Alcohol and Drug Counselors, Licensed Clinical Mental Health Counselors, Licensed Psychologists, Licensed Psychiatric Nurses, and Licensed Marriage and Family Counselors

This workgroup will be primarily focused on <u>care delivery</u> waivers. Work on the participation/fraud and abuse waivers is pending based on global budget design discussions (separate workgroup).

Discussed during previous meetings.

★ ***Focus of today's discussion***

Medicare Waivers Within the Context of the Care Continuum



An individual is admitted to a hospital and requires an inpatient stay.

The individual is discharged to a skilled nursing facility.

- 3-day SNF Rule
- Allowing SNFs to bill Medicare directly for physician services provided by locum physicians
- Physician delegation of tasks in SNFs
- Personal physician visits
- Temporary nurse aides
- Use of telehealth in SNFs for physician services

The individual is discharged to the home and may require home care.

- Post Discharge Home Visits
- Care Management Home Visits
- Home health expansion/flexibilities

The individual requires care from their primary care provider and other specialists.

- Telehealth waiver of originating site requirements
- Telehealth waiver of interactive telecommunications system

2. Recap of Discussion During 3/30 Medicare Waivers TAG Meeting

Recap from 3/30: SNF PHE Flexibilities

Current State. The following waivers were in effect during the COVID-19 public health emergency. However, they have since been terminated:

- **Physician Delegation of Tasks in SNFs:** CMS waived the requirement in § 483.30(e)(4) 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 who meets the applicable definition in § 42 CFR 491.2 or, in the case of a clinical nurse specialist, is licensed as such by the state and is acting within the scope of practice laws as defined by state law. ***Terminated on 5/7/22.***
- **Physician Visits:** CMS waived the requirement at § 483.30(c)(3) 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. ***Terminated on 5/7/22.***
- **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 NFs to hire staff; the temporary waiver helped these facilities provide adequate levels of staffing for the duration of the COVID-19 pandemic. ***Terminated on 6/6/22.***

Feedback Received

- Need more information about what is possible and where there are models in other states; desire to maintain as many PHE flexibilities as possible
- Workforce shortages will impact providers' abilities to implement these waivers; waivers rely on health care providers working in the field; should consider where telehealth could be used for delegation
- State licensure regulations may impact use of the training and certification of nurse aides flexibility

Recap from 3/30: SNF Flexibility Around Billing

Stakeholder Feedback Received to Date:

- To expand SNFs' abilities to attract solo physicians and use locums, SNFs should have the flexibility to bill Medicare directly for those physician services. Currently the physician, physician practice, hospital, or FQHC must do the billing.
  - Physicians do not want the administrative burdens associated with billing.
  - In situations where some SNFs are contracting with a vendor for locums, nobody can bill for the physician services.
    - The vendor cannot because it is not Medicaid/Medicare certified.
    - SNFs are Medicaid/Medicare certified but do not technically provide the service. They are responsible for ensuring it is provided. Therefore, they can't bill.
  - If the SNF had the flexibility to bill, they could engage in flat fee contracts with physicians for services, and recoup Medicare dollars to cover the costs.

Feedback Received

- High administrative costs of setting up SNFs' billing systems to enable this billing functionality is a potential barrier to implementation

Recap from 3/30: 3-day SNF Rule Waiver

Eligibility Under VTAPM *(but criteria is similar across other CMMI models)*

An **eligible SNF** is a SNF or Swing-Bed Hospital that is an Initiative Participant or Preferred Provider that has:

- Entered into a written agreement with the ACO to provide SNF services in accordance with the SNF 3-Day Rule Waiver Benefit Enhancement; ***and***
- Been identified by the ACO as having agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement; ***and***
- Been approved by CMS to participate under the 3-Day SNF Rule Waiver Benefit Enhancement following a review of the qualifications of the SNF or Swing Bed Hospital to accept admissions without a prior inpatient hospital stay and admissions after an inpatient stay of fewer than 3 days
  - Must have an overall rating of 3+ stars under the CMS 5-Star Quality Rating system in 7 of the previous 12 months as reported on the Nursing Home Compare website*

A **beneficiary** is eligible to receive services under this waiver if they are:

- An initiative beneficiary at the time of admission to an Eligible SNF under this waiver or within the grace period
- Not residing in a SNF or LTC Facility at the time of admission to an Eligible SNF under this waiver (independent living facilities and assisted living facilities shall not be deemed LTC facilities)

A **direct SNF admission** will be covered if, at the time of admission, the beneficiary is:

- Is medically stable
- Has confirmed diagnoses
- Has been evaluated by a physician or other practitioner licensed to perform the evaluation within 3 days prior to admission to the eligible SNF
- Does not require inpatient hospital evaluation or treatment; ***and***
- Has a skilled nursing or rehabilitation need that is identified by the evaluating physician or other practitioner and cannot be provided as an outpatient

A **SNF or Swing Bed Hospital Admission** will be covered for a beneficiary who is discharged to an Eligible SNF after fewer than 3 days of the inpatient hospitalization only if, at the time of admission, the beneficiary is:

- Is medically stable;
- Has confirmed diagnoses
- Does not require further inpatient hospital evaluation of treatment; and
- Has a skilled nursing or rehabilitation need that has been identified by a physician or other practitioner during the inpatient hospitalization and that cannot be provided on an outpatient basis

Feedback Received

- Interest in discussing with CMS
- Several components of the waiver that can be improved
  - Expand waiver beyond ACO-attributed lives to reduce administrative burden around implementation
  - Consider alternate ways to determine eligibility for waiver around quality (shift away from SNF star ratings to another measure that reflects quality in real time)
  - Consider other settings for transfer to a SNF, such as home or the ED

Recap from 3/30: Hospice Waiver

Detail on Medicare Hospice Waiver in ACO REACH

Personnel

- ACO to identify hospice and non-hospice providers and suppliers to participate under this benefit enhancement. These providers must be Participant Providers or Preferred Providers.

Implementation

- CMS will require ACOs to include the following information in their implementation plans:
  - Description of how the identified Participant Providers and Preferred providers will have the appropriate staff capacity and necessary infrastructure to carry out proposed care coordination activities; ***and***
  - Explanation of how the ACO will ensure, working with participating hospices and non-hospice providers and suppliers, that an appropriate plan of care will be developed for all beneficiaries receiving concurrent care and that these beneficiaries will be fully informed of what care or services would or would not be included in their care plan, what clinician or organization would be providing which services, how care coordination would be achieved, and whether there are any limitations; ***and***
  - Explanation of how the ACO will ensure that the beneficiary or his/her representative is fully aware of the care plan and informed of the beneficiary's right to revoke the hospice election at any time consistent with current law
- Medicare will retain its existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is under hospice election, except with respect to services furnished by those hospice and non-hospice providers and suppliers identified by the ACO as participating in this benefit enhancement
- Medicare FFS claims submitted by these organizations will be paid by Medicare if they are otherwise appropriate for payment absent the restrictions on paying claims for a beneficiary that has elected hospice

Feedback Received

- Group generally agreed with the intent of this waiver (i.e., enabling individuals to receive hospice care and curative care simultaneously)

3. Deeper Dive on Telehealth Waivers

Discussion: Improvements in Access to Care

Framing Question:

How can telehealth flexibilities improve access to care for Vermonters?

#1: Telehealth Expansion Benefit Enhancement

There are two waivers that fall under the Telehealth Expansion Benefit Enhancement:

- **Waiver of Originating Site Requirements (Section 1834(m)(4)(C):** CMS waives the requirement that beneficiaries be located in a rural area and at specific settings (e.g., physician office, rural health clinic) to receive telehealth services. This expands access to telehealth services. For example, through this waiver, a beneficiary's place of residence is eligible to serve as an originating site (i.e., the site where a Medicare beneficiary receives medical services through a telecommunications system).
- **Waiver of Interactive Telecommunications System Requirement (Section 1834(m)(1):** CMS waives the requirement that telehealth services are furnished via an interactive telecommunication system. If a model participant elects this waiver, beneficiaries can receive select teledermatology and teleophthalmology services using asynchronous store and forward technologies (i.e., technologies that allow a patient's medical information to be transmitted to a health care provider, enabling the provider to review the information without the patient present). For example, providers can be reimbursed for receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluations.

Based on a review of CMMI's recent models, most have one or both waivers. The criteria is similar across all models.

Model	Waiver of Originating Site Requirements	Waiver of Interactive Telecommunications System Requirement
MSSP	✗	✗
CHART	✓	✗
PARHM	✓	✓
ACO REACH	✓	✓
VTAPM	✓	✓

Sources: ACO REACH Model Frequently Asked Questions (2022); CHART Model NOFO (2021); Telehealth Expansion Benefit Enhancement Under PARHM – Implementation (2020); Vermont Medicare ACO Initiative Participation Agreement

#1: Telehealth Expansion Benefit Enhancement Under the VTAPM

Detail regarding both waivers under the Telehealth Expansion Benefit Enhancement in the VTAPM are below.

Topic	VTAPM
Eligible Beneficiaries	▪ The beneficiary must be: – An initiative beneficiary at the time the telehealth services are furnished or within the grace period (services furnished within 90 days following the date of ACO alignment exclusion); ***and*** – Located at an originating site that is listed in Section 1834(m)(4)(C)(ii) OR the beneficiary's home or place of residence
Eligible Providers	▪ Eligible Telehealth Provider: meets requirements under Section XI.C.2 ▪ Eligible Asynchronous Telehealth Provider: meets requirements under Section XI.C.4
Implementation	▪ The ACO must submit the following to CMS: – Election of the benefit enhancement – Implementation plan – List of preferred providers that have agreed to participate in the benefit enhancement ▪ Claims for telehealth services furnished for which the originating site is a beneficiary's home or place of residence must be submitted using one of the HCPCS codes G9481-G9489 ▪ Claims for asynchronous teledermatology and teleophthalmology services furnished will be denied unless submitted using one of the HCPCS codes G9868-G9870

Discussion

- What have been the successes and/or challenges with implementing these waivers under the VTAPM?

Source: Vermont Medicare ACO Initiative Participation Agreement

#2: Use of Telehealth in SNFs for Physician Visits

Physician Visits in SNFs (42 CFR §483.30): 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. ***Terminated on 5/7/22.***

Feedback Received to Date:

- This flexibility was valuable during the pandemic.
- This waiver is important to reinstate due to the ongoing workforce shortages in Vermont.

Discussion

- What have been the successes and/or challenges with implementing these waivers during the PHE?
- How has care delivery been impacted as a result of this waiver being terminated?

Source: Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19; Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers

Summary of Workgroup Member Input

- One workgroup member indicated confusion around the definition of “supervision” (i.e., whether a physician has to be onsite or not). They noted that supervision should be done remotely.
- The workgroup member also noted that regulatory rounds, ability to perform more frequent rounding for high-risk patients, and physician assessments are some potential uses of telehealth during SNF physician visits.

Discussion – Other Telehealth Flexibilities

- Are there other telehealth flexibilities that should potentially be advanced with CMS?
- How do these flexibilities impact care delivery?

Source: Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19; Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers

Summary of Workgroup Member Input

- One workgroup member highlighted several challenges with telehealth for FQHCs.
  - Under the Waiver of Interactive Telecommunications System Requirement, FQHCs are recognized as originating sites, rather than distant site providers. This has led to operational challenges.
  - FQHCs can only provide mental health services via telehealth, restricting their ability to provide other types of care.
- Another workgroup member indicated the desire for CMS to recognize physical therapy and occupational therapy as eligible telehealth services.
- Several workgroup members noted the need for Medicare reimbursement for services provided via telehealth:
  - Diabetes prevention programs (and possibly other self management programs)
  - Remote patient monitoring

4. Update on MH/SUD Flexibility

MH/SUD Flexibility

Vermont's Request

Vermont seeks Medicare reimbursement for the provider types below to expand access to MH/SUD care. The Medicare restriction of credentialing only LICSWs and PhD psychologists limits access to care for Medicare beneficiaries.

- Licensed Alcohol and Drug Counselors
- Licensed Clinical Mental Health Counselors
- Licensed Psychologists
- Licensed Psychiatric Nurses
- Licensed Marriage and Family Counselors

Updates

There has been some recent progress at the federal level through the Consolidated Appropriations Act 2023 (pp. 1444-5) and 2023 Physician Fee Schedule. A few components of the State's request have been granted.

- Licensed Alcohol and Drug Counselors
- ✓ **Licensed Clinical Mental Health Counselors**
- Licensed Psychologists
- Licensed Psychiatric Nurses
- ✓ **Licensed Marriage and Family Counselors**

5. Next Steps

Next Steps

- AHS expects to discuss Medicare waivers with CMMI in late Spring or early Summer.
- The next Medicare Waivers Technical Advisory Group meeting will be on **Tuesday, April 18** from **9:00 – 10:00 am**. We will review the waivers discussed to date.