Medicare Waivers Technical Advisory Group

FEBRUARY 14, 2023 MEETING SUMMARY

Meeting Agenda

1. Overview of Medicare Waivers Technical Advisory Group
2. Level set on current and potential Medicare waivers
3. Deeper dive on waivers related to services at home
    a. Home Health Expansions and Flexibilities
    b. Care Management Home Visits
    c. Post Discharge Home Visits
4. Next Steps

1. Overview of Medicare Waivers Technical Advisory Group

Context

- Vermont negotiated with the Center for Medicare and Medicaid Innovation (CMMI) to extend the current Vermont All-Payer ACO Model through 2023, with a guarantee of an option to extend through 2024.
- The State is currently in discussions with CMMI regarding the development of a new multi-payer model that would go live in 2025.
- CMMI indicated this model (called “AHEAD”) will likely be a multi-state model.

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

2. Level Set on Current and Potential Medicare Waivers

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

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

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
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 care delivery waivers. Work on the participation/fraud and abuse waivers is pending based on global budget design discussions (separate workgroup).

★ ***Focus of today's discussion***

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 as Part of APMs

Medicare waivers are offered as part of Alternative Payment Models in order to help participating organizations succeed under the model test. *Examples:*

A waiver for care management home visits enables an individual with multiple chronic conditions, such as congestive heart failure and fibromyalgia, to receive in-home care (e.g., medication reconciliation, assessment of social needs, patient coaching) to avoid ED utilization or hospitalization.

Telehealth waivers allow an individual living in a rural area with limited transportation options to access necessary care through e-visits and consultations. This increases access to care—the patient can regularly meet with their providers to manage their care and prevent their health conditions from worsening.

A 3-day SNF rule waiver allows a patient with a fall-related injury to access services such as skilled nursing care, assistance with ADLs and physical therapy, without having to meet the three-day inpatient requirement. The patient can receive the right care at the right time and avoid unnecessary hospital utilization.

3. Deeper Dive on Waivers Allowing Services at Home

Home Health Expansions and Flexibilities

Feedback Received to Date:

- Vermont should request flexibility to provide skilled nursing services to select individuals who don't meet Medicare criteria for home health but for whom services could prevent ED visits or hospitalizations
  - Vermont Medicaid is currently more flexible than Medicare. It allows visits for individuals who do not meet the homebound criteria and permits aide visits for individuals who do not have a skilled need
  - OneCare's Longitudinal Care Pilot program has had a positive impact – preliminary data suggest it reduces ED visits and hospitalizations for individuals served

Comparison Point: Home Health Homebound Waiver Under CMMI's ACO REACH Model

This waiver under ACO REACH allows expansion of Home Health for Medicare beneficiaries with multiple chronic conditions who are at risk of unplanned inpatient admissions.

Eligibility

- Otherwise qualify for home health services under 42 CFR § 409.42 ***except*** that the beneficiary is not required to be confined to the home; ***and***
- Have at least 2 chronic conditions as defined by CMS (i.e., condition that requires ongoing assessment and treatment that is documented in the beneficiary's plan of care); ***and***
- Have 1 of 3 indicators: inpatient service utilization, frailty, and/or social isolation; ***and***
- Not be receiving services under the Post-Discharge Home Visits Benefit Enhancement or the Care Management Home Visits Benefit Enhancement

Personnel

- ACO to identify home health providers that are Participant Providers or Preferred Providers who would offer these services to eligible beneficiaries

Implementation

- CMS will provide the ACO with a "Home Health Homebound Waiver" form template to document these eligibility criteria
- ACO shall ensure that a completed and certified form is maintained in the beneficiary's medical records

Source(s): pp. 73-74 of ACO REACH Request for Applications

Home Health Expansions and Flexibilities Discussion

Discussion Questions:

- What are the group's reactions to the ACO REACH flexibilities? Should Vermont consider advancing a request for the same or similar flexibilities?
  - How should the eligible group of Medicare beneficiaries be defined?
  - How should personnel be defined who are able to serve Medicare beneficiaries at home (The ACO has discretion under the REACH model)?
- What are the lessons learned so far from implementation of the OneCare Longitudinal Care program?
- What other features should be considered in order to align with Medicaid to the maximum extent possible?

Summary of Workgroup Member Input

- One workgroup member noted that the Home Health Homebound Waiver under CMMI's ACO REACH model generally looks good but had a concern with the requirement around the need for skilled services.
  - There is interest in continuing OneCare's Longitudinal Care Pilot Program; however, this waiver might not provide the flexibility needed to operate this program because some participants do not otherwise qualify for home health services since they may not have a demonstrated need for skilled services. This program serves people who need a lower level of service such as medication management, safety assessments, and telemonitoring.
- The workgroup member also noted that allowing direct payments from CMS to home health providers for the provision of services under this waiver is important and would improve uptake and implementation.
- The workgroup member indicated no immediate concerns with the documentation requirements under ACO REACH'S Home Health Homebound Waiver but noted the need for more detail about the "Home Health Homebound Waiver" form template to make an assessment.

Post Discharge Home Visits

The post discharge home visit waiver is identical under the VTAPM and ACO REACH.

Topic	VTAPM and ACO REACH
Eligibility Criteria	• Does not qualify for Medicare coverage of home health services under 42 CFR § 409.42 ***or*** does qualify for Medicare coverage of home health services on the sole basis of living in a medically underserved area; ***and*** • Discharged from the acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or SNF
Personnel	• Furnished by auxiliary personnel under general supervision of ACO-participating provider (42 CFR § 410.26)
Service Delivery	• No more than 9 times in the first 90 days following discharge • The 9 home visit services do not accumulate across multiple discharges; if the beneficiary is readmitted within 90 days of the initial discharge and before receiving nine home visits, the beneficiary may receive only nine home visits in connection with the subsequent discharge. The beneficiary cannot receive the remainder of the nine home visits associated with the initial discharge.

Feedback Received to Date

- Difficult to operationalize under current model due to billing. CMMI requires billing to "be a contract between a physician and home health agency." Payment could not be received directly.

Discussion Questions

- What have been the specific challenges implementing this waiver under the current APM?
- Is this waiver or a version thereof important, if the Home Health benefit is also expanded? Or does it serve a distinct purpose?

Source(s): Appendix F of VTAPM 2019 Participation Agreement; pp. 72-73 of ACO REACH Request for Applications

Summary of Workgroup Member Input

- One workgroup member indicated that even if the Home Health Homebound waiver was available under the AHEAD model, there is still a need for the Post Discharge Home Visits waiver. The former covers discharges from home health while the latter addresses transitions from the hospital to home.
- The workgroup member noted that this waiver was not implemented due to challenges around contracting and billing. There may need to be refinements to eligibility criteria and/or service delivery, but the workgroup member was unsure since the waiver has not been implemented under the current VTAPM.

Care Management Home Visits

There are slight differences between the care management home visit waiver under the current VTAPM and the newer ACO REACH.

Topic	VTAPM	ACO REACH
Eligibility Criteria	• Determined to be at risk of hospitalization; ***and*** • Has a care treatment plan initiated by the ACO-participating provider; ***and*** • Not eligible for the Post Discharge Home Visits Benefit Enhancement; ***and*** • Does not qualify for Medicare coverage of home health services under 42 CFR § 409.42 ***or*** does qualify for Medicare coverage of home health services on the sole basis of living in a medically underserved area	• Determined to be at risk of hospitalization; ***and*** • Has a care treatment plan initiated by the ACO-participating provider; ***and*** • Not currently utilizing the Post-Discharge Home Visits Benefit Enhancement **or the Home Health Homebound Waiver Benefit Enhancement**; ***and*** • Does not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area)
Personnel	• Furnished by auxiliary personnel under general supervision of ACO-participating provider (42 CFR § 410.26)	• Furnished by auxiliary personnel under general supervision of ACO-participating provider (42 CFR § 410.26)
Service Delivery	• No more than 2 times within 90 days of the beneficiary seeing the ACO-participating provider who initiated the care management plan • Beneficiary may receive 1 additional care management home visit within 90-day period if they first have an in-office visit with the ACO-participating provider	• **May receive up to 20 care management home visits within a calendar year**

Discussion Questions

- What have been the specific challenges implementing this waiver under the current APM?
- Is this waiver or a version thereof important, if the Home Health benefit is also expanded? Or does it serve a distinct purpose?

Source(s): Appendix G of VTAPM 2019 Participation Agreement; p. 73 of ACO REACH Request for Applications

Summary of Workgroup Member Input

- The workgroup had questions around the criterion "does qualify for Medicare coverage of home health services on the sole basis of living in a medically underserved area." AHS clarified that an individual may receive care management home visits if the reason they qualify is if they live in a remote area (rather than qualifying due to their medical condition).

4. Next Steps

Next Steps

- AHS is in the process of identifying dates and times for upcoming Medicare Waivers Technical Advisory Group meetings.
- Future meetings will cover the following topics:
  - SNF
  - Hospice
  - Telehealth
  - MH/SUD personnel
  - Wrap up