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Potential Medicare Waivers under Maryland Total Cost of Care Agreement

Overview and Purpose

Maryland's Total Cost of Care (TCOC) Model includes certain Medicare waivers to give providers the tools they need to be successful. For example, in order to implement the State's all-payer hospital rate-setting, we have obtained waivers from Medicare's Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) (Appendix G of the Maryland TCOC Model State Agreement). In order to implement the hospital-convened Care Redesign Programs (CRP), additional federal waivers specific to CRP were issued by the federal government.

As Maryland stakeholders consider what new types of health care payment and delivery innovation should be considered in the state, additional flexibility in the form of federal Medicare waivers may be desired. Those waivers could function under the existing TCOC Model programs — for the example, under the all-payer hospital-rate setting system, CRP, or the Maryland Primary Care Program (MDPCP). Or they could be part of a New Model Program, convened by non-hospital providers — including the current episode-based structure currently under development, the Enhanced Episode Program (EEP).

This document summarizes some waivers that could be considered as part of a new approach, based on existing waivers in national models. In order for CMS to approve a waiver, the State will need to demonstrate a use case for the waiver in the context of the TCOC Model. This document offers possible use cases for illustrative purposes, but the State will rely on stakeholders to articulate what use cases are most appropriate. It should be noted, however, that if a particular approach has been approved by the State through its SIG process, then approved by CMS, it will likely take another 12 months for CMS to effectuate the change with the MAC.

There are three types of waivers the State can request from CMS:

1. Payment policy waivers that are available to providers in the Next Gen ACO and BCPI-A Models;
2. Fraud and abuse waivers that are provided in the Next Gen ACO Model to encourage beneficiary alignment with an ACO; and
3. Other unique payment policy waivers that the State has designed in order to expand access to care and reduce the TCOC in the State.

SIG members should come prepared to discuss the utility of potential waivers that could be requested to advance the goals of the TCOC Model. SIG members should also be prepared to discuss principles for the application of a new waiver — as previously discussed, that it would

improve care quality, help with TCOC, and that waivers with the potential to increase costs will need to be attached to programs that include downside risk based on the TCOC.

Payment Waivers Currently in BPCI-A and Next Gen

Note: The federal government is proposing additional changes to its policies around Medicare payment for telehealth, which may reduce the need for telehealth waivers. However, it is not clear where these proposed policy changes will land.

Telehealth Waiver. Eliminates the requirement that the originating site of a telehealth service be located in a rural area and for the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology.

Waiver Legal Details:
CMS will waive the geographic area requirement in Sections 1834(m)(4)(C)(i)(I)—(III) of the Act, which allows Medicare payment for telehealth services where the site at which the eligible telehealth professional is located is one of eight healthcare settings specified in Section 1834(m)(4)(C)(ii), regardless of whether the site is located in a geographic area that satisfies the requirements of Sections 1834(m)(4)(C)(i)(I)—(III).

Further, with respect to with respect to covered teledermatology and teleophthalmology, CMS will waive:

1. The requirement in Section 1834(m)(4)(C)(i) of the Act regarding the location of the originating site and the requirements of 42 C.F.R. § 410.78(b)(4) that covered services use asynchronous store and forward technologies; and
2. The requirement under Section 1834(m)(1) of the Act and 42 C.F.R. § 410.78(b) that telehealth services be furnished via an "interactive telecommunication system," as that term is defined under 42 C.F.R. § 410.78(a)(3).

Waiver Operational Requirements:

- Eligible Providers: The State would likely need to submit a list of Medicare practitioners who may utilize the waiver.
- Eligible Beneficiaries: The State would likely need to submit a list of Medicare FFS Beneficiaries for whom this waiver would apply.

Potential Use Case:
This waiver could be applied statewide for mental health providers. Integrating mental health services into a primary care practices can reduce unnecessary costs and utilization. However, shortages of mental health providers has created a barrier to integration, a barrier that could grow due to the MDPCP requirements to collocate behavioral health. In order to increase access to collocated mental health services, the State could allow any mental health provider to provide services via telehealth.

Telehealth Benefit Extension. Adds the beneficiary's home as an "originating site" for the provision of telehealth services in order to allow beneficiaries to receive services in their home.

Waiver Legal Details:
CMS will waive the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be "furnished at an originating site."

Waiver Operational Requirements:

- Eligible Providers: The State would likely need to submit a list of Medicare practitioners for whom this waiver would apply.
- Eligible Beneficiaries: The State would likely need to submit a list of Medicare beneficiaries for whom this waiver would apply.
- Restrictions: The telehealth services covered by the waiver must include one of the follow Healthcare Common Procedure Coding System (HCPCS) codes G9481 – G9489.

Potential Use Case:
Beneficiaries with chronic diseases that require frequent check-ups with their doctor (diabetes or COPD) but also do not have reliable transportation services face a severe access problem. Therefore, the State could propose to allow certain providers to provide telehealth services originating in the home of an attributed beneficiary who has diabetes or COPD and receive payment for those services.

Post-Discharge Home Visit Waiver. Allows for a physician to contract with licensed clinicians (i.e., auxiliary personnel) to provide a home visit to a patient at the patient's home under the general supervision of a CRP or EEP Preferred Provider following discharge from an inpatient facility, which includes hospitals, critical access hospitals, skilled nursing facilities, and inpatient rehabilitation facilities.

Waiver Legal Details:
CMS will waive the requirement in 42 C.F.R. § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) (i.e., "incident to" services) be furnished under the direct supervision of the physician (or other practitioner) so long as the services are provided in the beneficiary's home, by auxiliary personnel as defined in 42 C.F.R. § 410.26(a)(1), and to a beneficiary who is not eligible for home health care under 42 C.F.R. § 409.42.

Waiver Operational Requirements:

- Eligible Providers: The State would likely need to submit a list of Medicare practitioners for whom this waiver would apply.
- Eligible Beneficiaries: The State would likely need to submit a list of applicable DRGs. The waiver would apply to any beneficiary discharged from a provider on the list submitted by the State with one of the DRGs on the list.
- Restrictions: Post-discharge home visit service waiver claims must contain one of the following HCPCS codes: 99324 - 99328, 99334 – 99337, 99339 – 99350.

Potential Use Case:
This waiver could be applied to ECIP. Home-based transitional care management can help to reduce the probability of a readmission to the hospital but currently those services can only be performed under the direct supervision of a physician (meaning that they are in the same building and immediately accessible). Requiring a physician to accompany the care team to the beneficiary's home is a barrier to necessary home-based follow-up care.

Skilled Nursing Facility 3-Day Rule Waiver. Allows an aligned beneficiary to be eligible for Medicare covered SNF services when admitted to a SNF without a three-day qualifying inpatient hospital or previous SNF stay, including beneficiaries who are in the hospital for fewer than three days or admitted directly from a physician's office.

Waiver Legal Details:
CMS waives the requirement in Section 1861(i) of the Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services.

Waiver Operational Requirements:

- Eligible Providers: The State would need to submit a list of Medicare providers for whom this waiver would apply.
- Eligible Beneficiary: The State would submit a list of DRGs *and* a list of beneficiaries. The waiver would apply to any beneficiaries who is discharged from a Provider on the State's list with a DRG on the State's list *or* any beneficiary on the State's list regardless of any discharge.
- Restrictions: Only SNFs that have maintained an overall rating of three or more stars under the CMS 5-Star Nursing Home Quality Rating System during the previous 12 months may bill under the waiver. CMS will maintain the list of eligible SNFs.

Potential Use Case:
This waiver could be applied to the Expanded Episode Program. Currently, beneficiaries cannot be admitted to a SNF without a preceding hospital admission. Consequently, if recovery from surgery requires a SNF stay then that surgery must be performed at a hospital even if the surgery itself could be performed at an outpatient setting. This requires episodes to be performing at a higher cost setting of care. Therefore, the State could propose that the waiver apply to any provider that is in EEP. This waiver could also apply to ECIP if the inpatient hospital costs are included in the episode costs.

Fraud and Abuse Waivers

Beneficiary Incentives. Participating providers may provide certain in-kind items or services to beneficiaries during an episode of care. The item or service must be reasonably connected to a beneficiary's medical care and either be preventive or advance a clinical goal. Incentives may include items of technology that allow a beneficiary to receive telehealth visits.

Waiver Legal Details:
The Secretary will waive section 1115A(d)(l) of the Act, section 1128A(a)(5) of the Act (relating to the Beneficiary Inducements Civil Monetary Penalty (CMP)) and sections

1128B(b)(l) and (2) of the Act (relating to the Federal anti-kickback statute) are waived with regard to in-kind items and services.

Waiver Operations Details:

- The waiver would allow the participant (a CRP Hospital, an EEP Episode Convener, or an MDPCP Practice) to provide preventive care items and services that do one of the following:
    - Are preventive care items or services, or
    - 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 Participant shall maintain contemporaneous records of the in-kind items and services furnished to beneficiaries and make those records available to CMS upon request. Such records must include the following
    - The nature and value of the in-kind item or service;
    - The identity of the individual or entity that furnished the in-kind item or service;
    - The identity of the beneficiary who received the in-kind item or service; and
    - The date the in-kind item or service was furnished.

Potential Use Case:
This waiver could allow participants in the MDPCP program to provide technological assistance for medication adherence programs. MDPCP practices are required to conduct medication reconciliation but beneficiaries may need assistance in order to comply with medication adherence programs. Examples of the assistance that could be provided to beneficiaries include assistive devices, such as pill splitters or smart pill bottles, or computer or mobile device applications to reinforce medication regimens.

Beneficiary Coordinated Care Reward. Rewards beneficiaries for receiving their Annual Wellness Visit from a participant.

Waiver Legal Details:
Pursuant to 1115A(d)(l) of the Act, section 1128A(a)(5) of the Act (relating to civil monetary penalties for beneficiary inducements), and sections 1128B(b)(l) and (2) of the Act (relating to the Federal anti-kickback statute) are waived with regard to a $25 cash payment made by the participant to beneficiaries that receive an annual wellness visit with the provider.

Waiver Operations Details:

- The waiver will allow the participant (a CRP Hospital, an EEP Episode Convener, or a MDPCP Practice) to provide a $25 check to beneficiaries that receive an Annual Wellness Visit from the Participant.
- The Participant shall maintain contemporaneous records cash payment furnished to beneficiaries and make those records available to CMS upon request. Such records must include the following

- The identity of the individual or entity that furnished the payment;
- The identity of the beneficiary who received the payment; and
- The date the in-kind item or service was furnished.

Potential Use Case:
In order to meet the Medicare Savings Targets, the State is encouraging policies that enroll entire Medicare population in the State in an active care management program. The Annual Wellness Visit is a critical component of care management programs and provides a Medicare beneficiary the opportunity to discuss family and medical history, preventive care, medications, and the other doctors that are regularly involved in providing medical care to the beneficiary. This visit can help provide better care and care coordination. In order to incentivize uptake of the Annual Wellness Visit, beneficiaries enrolled in one of the Medicare care management programs under the TCOC Model could receive an incentive payment — and that Incentive Payment could be made by the providers themselves in order to incentivize a longitudinal relationship between the provider and their beneficiaries.

Other Innovative Medicare Payment Waivers

The State has already requested that CMS allow nurse practitioners to order home health services. Under State law, nurse practitioners are already allowed to order home health services and currently do so for Medicaid beneficiaries. However, Medicare requires that beneficiaries be under the care of a physician – not a nurse practitioner – in order to receive home health services. **According to CMS, this waiver is likely to go into effect in Maryland in January 2020. This would apply to Maryland nurse practitioners who write orders for home health in Maryland.**

Another potential waiver is to allow EMS providers to transport patients to a setting of care other than a hospital. HSCRC staff had previously described this as a potential innovative waiver not currently available in CMMI programs. However, on February 14, 2019, CMS announced a new program for EMS providers that would likely include such waivers. Hopefully additional information will be available by the time of the SIG meeting on February 25, 2019.