Health Care Reform Work Group

SEPTEMBER 13, 2022 MEETING SUMMARY

Recap of Last Meeting's Discussion re: Our Short-Term Focus

- CMMI will be releasing a new multi-state All-Payer Model in late 2023.
- CMS controls Medicare dollars, so CMS participation is necessary to achieve all-payer (or at least most payer) reach.
- CMS has stated that its new model will allow for some customization, but perhaps less room to negotiate than Vermont's current APM.
- CMS has listed 7 priorities for the next model, and the model is under active development at CMS.
- **Our collective task is to develop feedback and "asks" for CMS on these 7 priorities *in the next few months* so that the new model advances Vermont's goals.**

Reminder of 7 CMS Priorities:

1. Include global budgets for hospitals.
2. Include TCOC target/approach.
3. Be All-Payer.
4. Minimum Investment in Primary Care
5. Include safety net providers from the start.
6. Address mental health, substance use disorder, and social determinants of health.
7. Address health equity.

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Meeting Agenda

1. Identifying the highest priority problems to be solved in Vermont's All-Payer Model (APM) 2.0
2. Cataloguing the technical design issues for further work to inform CMMI in next 2-3 months:
    a) Health System Global Budgets
    b) Total Cost of Care
3. Next Steps and Next Meeting

1. Identifying the “Problems to be Solved” by New APM

Identifying the Problems to Address Through Vermont's All-Payer Model

What are the top 1-3 problems that the new All-Payer Model needs to solve?
CMS's new model needs to be a "good deal" in terms of addressing the problems Vermont seeks to solve.

As the group noted in the last discussion, the picture in 2022 differs from the picture in 2015. Some may not be as relevant to CMS conversations.

1. Provider stability
2. Rural sustainability
3. Cost containment
4. Access to primary care
5. Improving the pipeline through transitions of care (e.g., making progress on SNF bottlenecks)
6. Progress on MH/SUD quality and outcomes
7. Affordability for Vermonters
8. Improving experience of care for Vermonters

Identifying the Problems to Address Through Vermont's All-Payer Model: *Work Group Member Feedback*

- Strong member agreement that prioritization should be placed in the next two years and during the next phase of the All-Payer Model upon:
  - #1 provider stability;
  - #2 rural sustainability, and
  - #5 improving the pipeline through transitions of care.
- Regarding payment, member agreement on prioritizing predictability, aligning incentives/rewards and ensuring an adequate Medicaid growth rate.
- In general, members felt the serious challenge of the present affects consideration of planning for the longer term.

Translating Priorities to a High Level "Vermont Design Wishlist" for CMMI

Medicare APM Structure

- ✓ Increase predictability of revenue for hospitals
- ✓ Consider expanding global budget design beyond facility fees into professional services *(subject to details of design)*
- ✓ Provide more direct mechanisms to promote collaboration across provider types ("shared incentives")
- ✓ Keep or increase Medicare funding available for primary care population-based payments

Tailoring to Vermont's Delivery System

- ✓ Account for Vermont's longstanding culture of medical conservativism – baseline utilization is lower than other states
- ✓ Build on existing DVHA VMNG model for Medicaid population
- ✓ Design for largely rural environment – current workforce and inflation pressures on costs are especially acute
- ✓ Design for aging population
- ✓ Consider border issues – can APM be based on care to Vermonters rather than care in Vermont?

Other Possible Asks

- ✓ Keep SNF three-day waiver
- ✓ Telehealth flexibility for SNFs
- ✓ Increase funds flow for practice transformation and learning
- ✓ Help Vermont structure incentives or mandates for other payers to participate, including MA plans?
- ✓ Allow for Medicare reimbursement for MH/SUD providers (e.g., licensed alcohol and drug counselors, psychologists, etc.)
- ✓ Consider how APM 2.0 will align with other Medicare value-based payment models

Translating Priorities to a High Level "Vermont Design Wishlist" for CMMI: *Work Group Member Suggested Additions*

- Members suggested the following:
  - Medicare telehealth availability and flexibility for all provider types
  - Medicare flexibility for the homebound requirement for home health
  - Revenue predictability for skilled home health

2. Setting up Key Technical Design Issues for Deeper Work in the Next 2-3 Months

Recap of Context: CMS Innovation Center's 7 Design Criteria

CMMI is signaling it will produce a design to span multiple states from 2025 that will address seven priorities.

1. **Include global budgets for hospitals.**
2. **Include TCOC target/approach.**
3. **Be All-Payer.**
4. **Minimum Investment in Primary Care**
5. **Include safety net providers from the start.**
6. **Address mental health, substance use disorder and social determinants of health.**
7. **Address health equity.**

★ ***Today: revisit both concepts and begin setting up the range of technical issues to be tackled***

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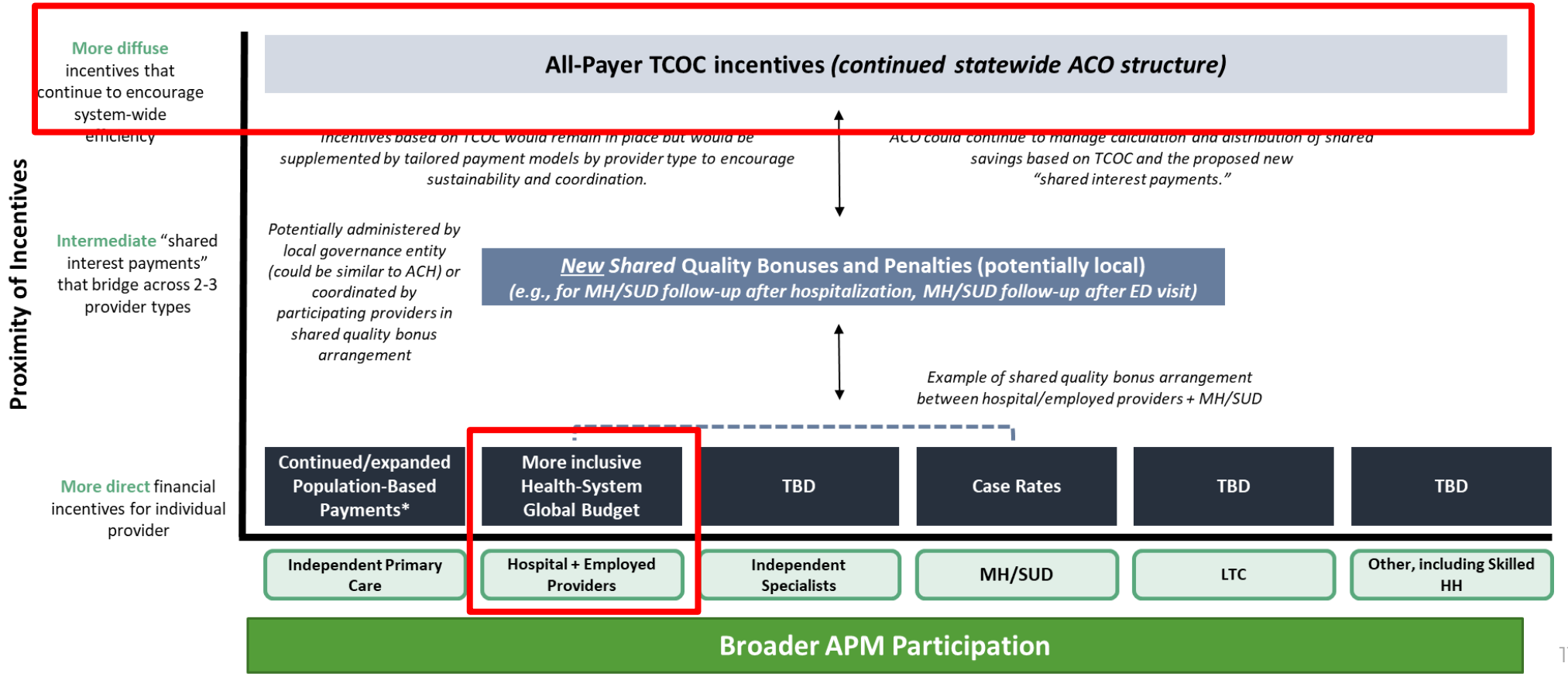
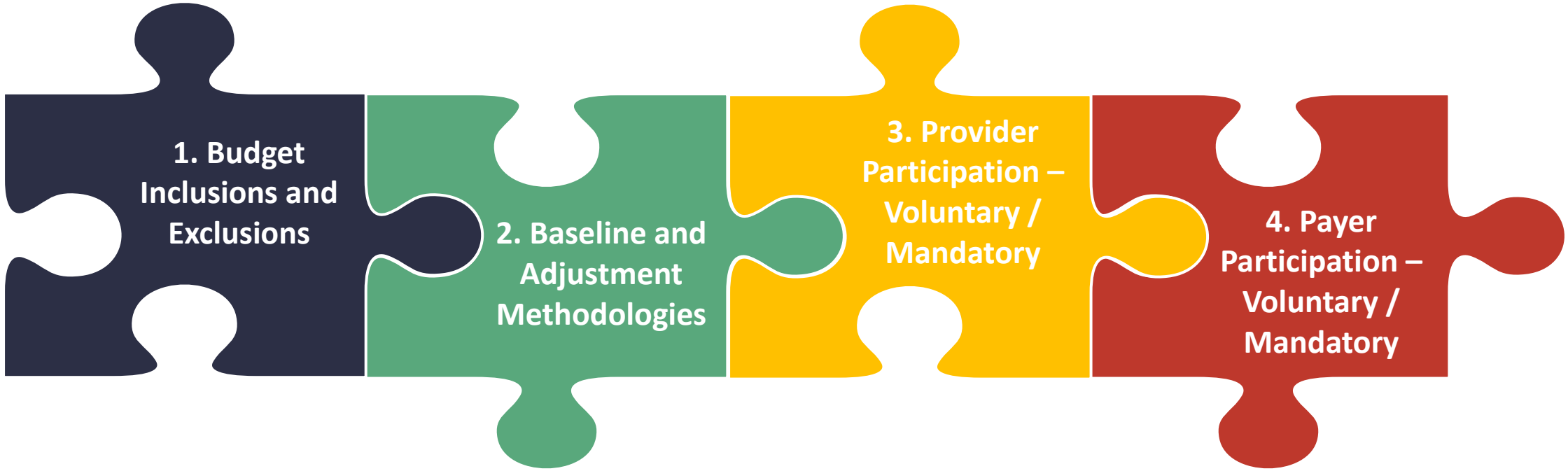
“Portfolio” Approach Introduced In Prior Two Meetings

There is much devil in the detail. High priorities for discussion with CMS are Vermont’s desired parameters of the health system global budget and the TCOC design.



2a. Health System Global Budget Design Issues

Preliminary Health System Global Budget Design Issues



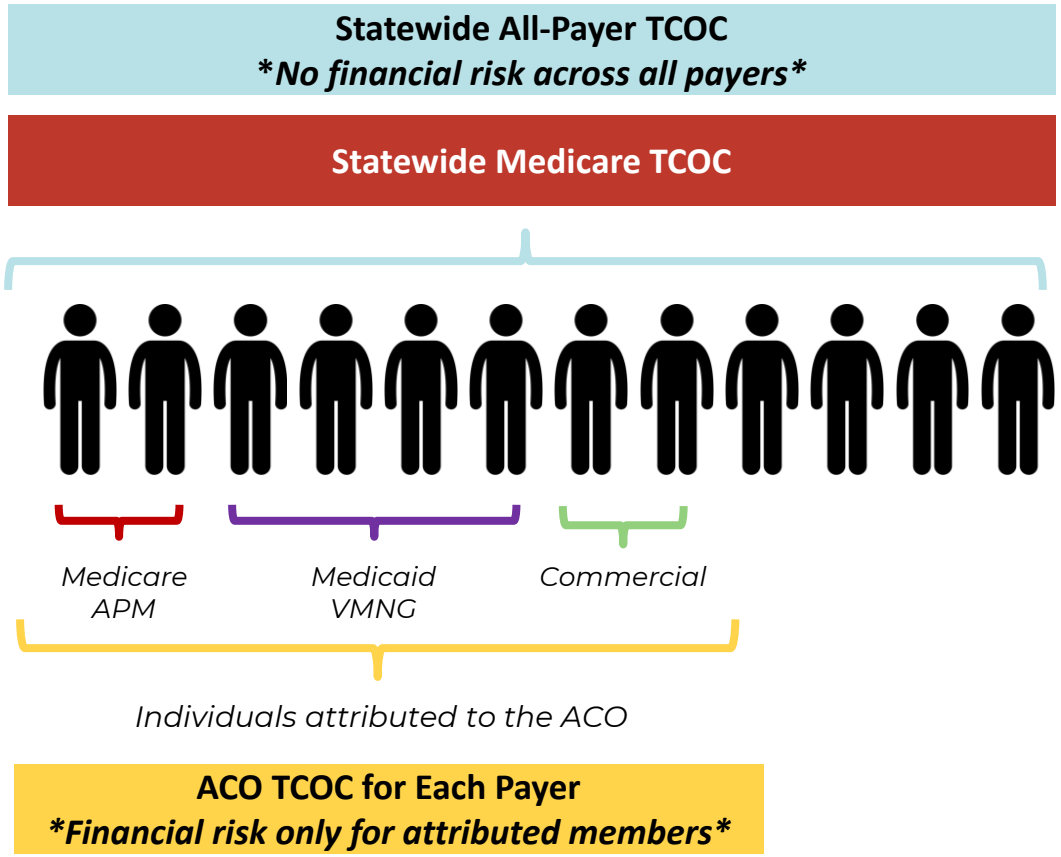
Preliminary Health System Global Budget Design Issues

- AHS and the GMCB clarified that a new subgroup will be jointly convened by AHS and the GMCB to address both how to influence CMMI's global budget design requirements, and to address Act 167 requirements.
- Work will consider not only incentives for hospitals but how those should align with incentives for other provider types too.
- The Work Group suggested including in the subgroup all of those who would be affected by the global budget and bringing back updates on the work to the full Work Group on a periodic basis, and not only when complete.

2b. Total Cost of Care Design Issues

Current State of Vermont's Total Cost of Care Model

Under the current model, two layers of incentives (statewide and ACO) operate simultaneously. There are two TCOC incentives operating at the state level (All-Payer TCOC, Medicare TCOC). Within the ACO layer, there are different TCOC incentives by payer.



- CMS has not indicated what it means by "TCOC", but we assume that there would be shared savings/losses associated with it (like under ACO contracts).
- What services should be in/out of TCOC?
- How should CMS take into account that Vermont is a low spend state for Medicare beneficiaries?
- How should CMS adjust benchmarks and trend rates to account for exogenous factors (e.g., pandemic, high inflation)?
- How should quality factor into benchmark or shared savings/losses?

Total Cost of Care Model

- AHS will convene a new subgroup for this topic, adding subject matter experts to interested Work Group member volunteers.
- Work Group members raised questions for future subgroup consideration, including but not limited to:
  - Should the State and its providers assume risk for care delivered outside of Vermont?
  - Should we focus on achieving shared savings or achieving a sustainable rate of growth?
  - How do we solve for the “wrong pocket” problem?
  - How do we align global budgets and the TCOC model?

Proposed Timeline and Next Steps

Meeting topics may change depending on work group discussions.

Topic *(subject to change)*	**Date**
All-Payer Participation, Primary Care Investment Targets	Mid-September
Safety Net Providers	Late September
Social Determinants of Health, Health Equity	Early September
TBD	Mid-October and beyond