Health Care Reform Work Group: Short-Term Provider Stability Subgroup

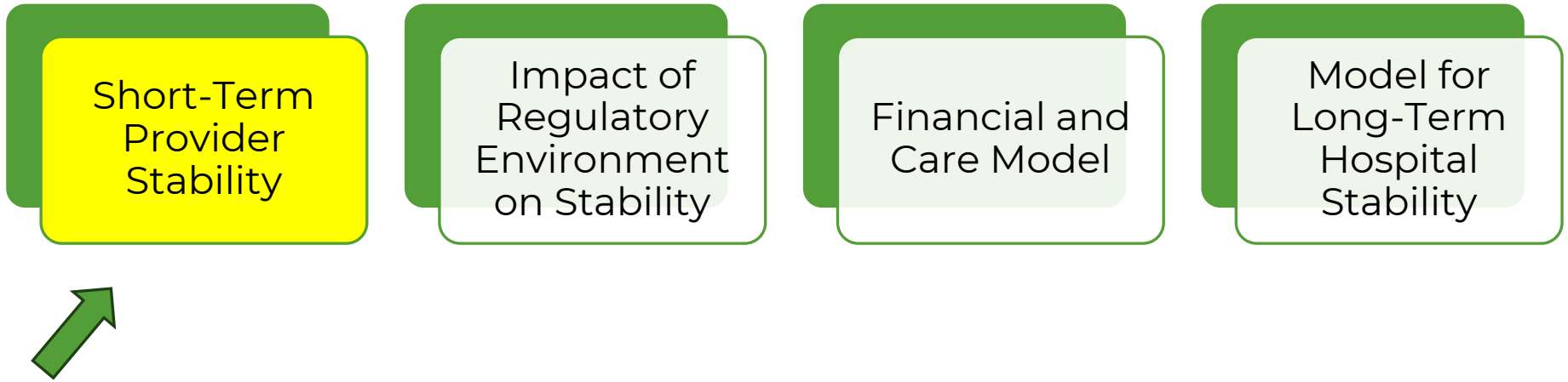
JUNE 30, 2023

Meeting Agenda

1. Welcome, Introductions, and Review of Agenda
2. Subgroup Overview and Meeting Purpose
3. Status of Current Activities
4. Discussion:
   - ❑ Identification of Barriers and Potential Refinements
   - ❑ Continuation of Current Activities and Identification of New Activities
   - ❑ Assessing Progress
5. Next Steps

Subgroup Overview and Meeting Purpose

The Health Care Reform Work Group was initiated in June 2022 with Four Areas of Work



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

Midpoint Reconvening of the Subgroup

Reconvening Subgroup to see if action plan is still on track:

- Review progress at the activity level
- Identify barriers to addressing incomplete activities
- Define 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?

Goal is to complete work by September 1.

Status of Current Activities

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 5/31 and grant awards are in process.
  - AHS is accepting applications for the Nursing Apprenticeship and Pipeline Grant Program through July 14th for Round 1. 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)

Discussion

Questions

- 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?

Next Steps

Appendix

VNAs of Vermont Sustainability Concerns

Federal issues:

- Proposed 7.85% cut to base skilled Medicare rate slated for January 1.
- Expected “clawback” plan for base rate back to 2020 (implementation period unclear).
  - It will be the equivalent of the 7.85% cut x 4 (rate went into effect January 1, 2020) and will be devastating.
- Migration to Medicare Advantage (MA) Plans. MA plans appear not to have any reimbursement requirements and may implement fee schedules for Home Health Agencies (HHAs) well below Medicare rates.
- Long-term care: Proposed CMS Medicaid rules would require that 80% of personal care payments go to wages and benefits.
  - Concerned that mileage reimbursement does not “count” as a benefit.
  - Doesn’t align with federal and state mandates with costs – supervision, Electronic Visit Verification, scheduling, etc.
- Federal intervention in traveler costs – High contract rates and potential tax advantages.

VNAs of Vermont Sustainability Concerns (cont'd)

State issues:

- Skilled Medicaid rates (90% of Medicare LUPA; other providers are at 100% or more).
- Implementation of Choices for Care rate study – needs to be fully funded for HHA services.
- Impact of conflict free case management on clients – harm mitigation/ transition planning.
  - Activities to come into compliance with this federal Medicaid requirement are under discussion in a separate workgroup.
- Workforce crisis/competition with other employers.
- "Local" travelers.