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

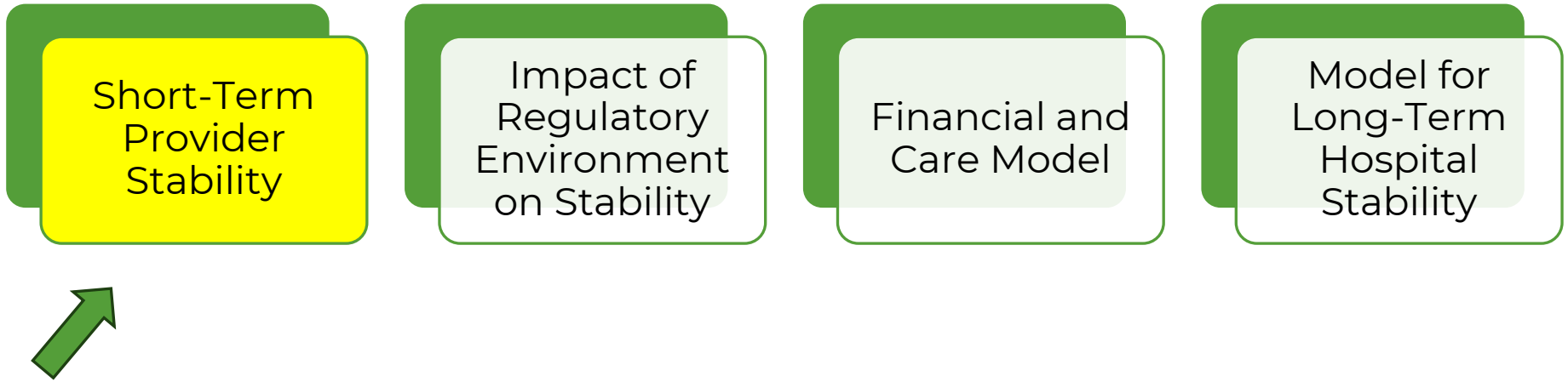
AUGUST 31, 2023

Meeting Agenda (Continued from 8/3/23 Meeting)

1. Welcome, Introductions, and Review of Agenda
2. Reminder - Subgroup Overview and Meeting Purpose
3. Reminder – Meeting notes from 6/30/23, 8/3/23, and 8/17/23
4. Discussion on Status of Current Activities (continued)
5. Discussion:
   - ❑ Identification of Barriers and Potential Refinements
   - ❑ Continuation of Current Activities and Identification of New Activities
   - ❑ Assessing Progress
6. 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 (1 of 2)

- 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.
- Solutions were based on the following foundational principals of system reform to ensure long-term strategic alignment:
  - Invest in strategies focused on high-value care that align with our long-term health care reform goals and objectives.
  - Work to balance cost with needed care for Vermonters, and to align revenue with access to necessary care.
  - Be predictable and flexible, measure outcomes, and adapt strategies if not achieving agreed-upon goals.
  - Maintain or improve quality of care and access, including making it possible for patients to receive care in the most appropriate setting possible, which may mean evolving how and where care is provided.
  - Strengthen primary care, mental health, post-acute and long-term care.

System Stabilization: Short-Term Provider Stability Subgroup (2 of 2)

- Recommendations were made across four categories and focused on actions which could be taken during the next 18 months with the understanding that there is a pressing need for substantive action within the next 6 months:
  - 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 *(completed at 6/30 meeting)*
- ❑ Identify barriers to addressing incomplete activities *(began on 8/3)*
- ❑ Define potential refinements or "course corrections" on activities based on implementation experience *(began on 8/3)*
- ❑ Should we continue to pursue previously-identified activities that haven't been completed? *(began on 8/3)*
- ❑ Are there additional activities that we should pursue? *(began on 8/3)*
- ❑ How can we assess progress on short-term stability?

Goal is to complete work by September 1.

Summary of Input from June 30th Short-Term Provider Stability Subgroup

- **Workforce**:
  - Use of temporary labor: need to grow the **workforce pipeline**; anticipate that this will be ongoing issue.
  - Mental Health: Work in collaboration with DMH has been very helpful. Still in crisis mode; programs closing, workforce challenges. Need to improve **Medicare coverage for Master's level clinicians** to support expansion of elder care.
- **Addressing complex care needs**:
  - Work with Brattleboro Retreat has been beneficial; hopeful about iCare work that DAIL is leading.
  - SNF and home health capacity; options for people who are too complex for home health.
- **Provider-specific challenges**
  - Challenges for **hospitals** are a result of system challenges; important to **advocate for all parts of the system**.
  - Challenges for **Skilled Nursing Facilities (SNF)** include caring for people with **complex needs, SNF medical directors. SNF rate methodology** discussions underway. Need to look at Extraordinary Financial Relief (EFR is time-limited).
  - Challenges for **home health:**
    - **Federal issues:** Medicare rates and clawback; migration to Medicare Advantage Plans and proposed CMS Medicaid rules.
    - **State issues:** Medicaid rates; conflict free case management implementation; workforce.

Summary of Input from August 3rd Meeting

- **Post-Acute Care/Home Health:** Jill: *Federal:* Substantial permanent cut to standard PPS Medicare rate, while still wrestling with claw back of 3-4 years of payments. Need help on that issue. No real policy solutions for Medicare Advantage plans (inability to negotiate rates). May be bigger issue than Medicare cuts. *State:* Grateful for elimination of provider tax. Need skilled rate of at least 100% of Medicare and LTC rate. Vermont discharges to home health are high compared to other states; can share some data on that.
- **Mental Health/DAs:** Rachel and Simone: When we look at DA data on workforce challenges and factors driving people away, pay is one of them and administrative burden is another (e.g., assessments have 300-400 questions; do we use all that data?). Working with AHS departments to determine what is meaningful. Alison: DMH engaged in improvement plan on how to collect and input information. Working with SAMHSA and looking at VA; they have done work on how to improve data entry, use clinical informatics and technology. Can we learn from the VA? Resources:
  - Recoding America (macmillan.com)
  - https://freakonomics.com/podcast/marina-nitze-if-you-googled-business-efficiency-consultant-i-was-the-only-result/

Training on access to critical needs to provide safe place for discharges and significant increase in capacity for inpatient beds have been positive developments. Statewide mobile crisis will likely roll out in January. Goal is regional 2-person teams that can deploy 24/7. Staffing challenges will likely lead to phased rollout. Rachel: System flow and where people go in more rural counties that don't have built out mobile teams is an issue. CSAC working with local hospital to refine the model. Transports to hospital by law enforcement another issue.

Summary of Input from August 3rd Meeting (cont'd)

Long-Term Care: Helen: Rate setting discussion is important as financial stability issues will continue. Potential for additional payments based on assessments. VHCA is aware of models from other states and can share. LNA shortage is a challenge. Recruiting cohort of SNFs as Centers of Excellence is a great goal but may not fit into short-term window. iCare addresses one area. Monica: In terms of iCare, sale of the building is moving rapidly. CON may not be needed as it is a transfer of ownership. Current projected first resident admission to iCare: 11/14/23. Regarding Centers of Excellence specific to psychiatric supports, this work was started by DMH and DAIL. Alison: DAIL and DMH met with SNF nursing staff to discuss care for patients with anti-psychotic medications and to clarify potential support from DAs. Helen: Great to work with the DAs; don't always need DA staff for 1:1 management. May need different staffing. Vermont appears to be above the national norm in level of patients in SNFs using those medications.

Hospitals: Devon: Excited to have iCare come online; still have a lot of subacute individuals in hospital beds. Need to keep strengthening SNF capacity. May need to reconsider DSH payments or other things to shore up finances. Is there interest in looking at other entities that responded to RFP if we need more capacity than iCare (e.g., for SNF Centers of Excellence)? Will check on local crisis response processes with hospitals, DAs, and SNFs to avoid using ED. Mental health wait times appear to be going down in EDs.

Summary of Input from August 17th Meeting (cont'd)

- Emma Harrigan (VAHHS) presented data on bed occupancy by individuals waiting in Emergency Departments for mental health placement. There are operational challenges to collecting this data, which is primarily provided by ED doctors and nurses.
  - The group noted that adult trends are downward (improving) and most are waiting for voluntary inpatient care. Most youth who are waiting are seeking a different level of care (such as residential treatment). It was noted that there is interest in understanding the barriers to get individuals to the services/settings where they want to go.

- DAIL provided several system flow-related updates:
  - The goal is to have Icare operational by the end of this year.
  - VHCA is performing an assessment of facilities, such as Assisted Living Residences and Residential Care Homes, that have capacity which will enable discussions about opportunities for expanding this system. That report is due at the end of September.
  - Activities underway as a result of Executive Order No. 02-23 (Housing Directives) could also impact system flow.

- Medicare Advantage (MA) issues (e.g., denials, prior authorization processes) were also noted as problematic, particularly as MA market penetration increases. It was noted that state-level influence may be limited; options could include elevating concerns to the Congressional delegation.

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)

15 of 22 completed

Discussion - Remaining Tasks

- **Regulation:**
  - ❑ Escalate package of stability measures to CMS and Federal Delegation (AHS)
- **System Flow:**
  - ❑ 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)

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?

Potential New Activities from August 3rd and August 17th Meetings

- **8/3**
  - Reduce DA administrative burden (joint effort between DAs and AHS Departments)
  - Explore efficiencies identified in VA system to see if applicable
  - Focus on gradual dose reduction and staffing support for SNF patients on psychiatric medications
  - PUCK-type models: Updates, data, sharing of best practices, sustainability
  - Interface between rate setting and SNF Centers of Excellence (e.g., for psychiatric supports); examples from other states (may not be Short-Term activity)
- **8/17**
  - Escalate to the Congressional delegation issues impacting providers serving Vermonters in Medicare Advantage plans
  - Identify additional transition barriers for individuals waiting in the Emergency Department for mental health placement
  - Review learnings from VHCA facility capacity assessments and Housing Directives activities to determine if additional system flow-related recommendations are needed

Other ideas for new activities?

Next Steps

- Next Meeting: TBD
- Action items from previous activities and meetings (in addition to exploring new activities):
  - Escalate stability measures to CMS and/or congressional delegation (e.g., home health rate cuts and Medicare Advantage concerns; other)?
  - SNF rate-setting process
- Assessing progress on short-term provider stability