

Health Care Reform Work Group

AUGUST 25, 2022 MEETING SUMMARY

Meeting Agenda

1. Subgroup on System Stabilization meeting results
2. CMMI's seven priorities for its new multi-state all-payer model
3. Draft principles to guide health care reform planning
4. Plans for next meeting

Reminder: Work Streams

Short-Term
Provider
Stability

Impact of
Regulatory
Environment
on Stability

Financial and
Care Model

Model for
Long-Term
Hospital
Stability

focus of the recent
Subgroup meetings

1. Subgroup on System Stabilization Meeting Results

The Subgroup met six times between July 15th and August 21st. Using the input generated by this work group as a launching point, it focused on short-term actions (i.e., to be taken within 6-18 months) that will improve system stability.

In the end, the Subgroup made recommendations across four categories:

- Workforce
- Regulation
- System Flow
- Revenue

Subgroup Recommendations: Workforce

1. Use available needs-based dollars remaining in the Workforce Recruitment and Retention Program (\$15-26M) in one or more of the following ways: differential pay, retention bonuses, quarterly premium pay bonuses, payments for onboarding new RNs, preceptor payments and financial support for staff to train and move up to LNA, LPN and RN status (the latter if allowed by ARPA). Avoid creating an incentive for “sign-on bonus jumping.” (August 2022)
2. Continue to implement recommendations of the Workforce Development Committee related to the critical workforce shortages in the health care sector. (Ongoing 2022)

Subgroup Recommendations: Regulation

1. Federal: Escalate to CMS and the federal delegation a package of measures to address stability including, Medicare rates for home health, nursing home medical director and primary care providers oversight and current APM limits requests. Include acknowledgement of the Medicaid “wins” in the 1115 waiver as an example of a successful partnership. (August 2022)
2. Federal: Provide public comment on the proposed Medicare rate adjustments for home health. (August 2022)
3. State: Implement a short-term rational method for targeting services to the highest need individuals within the Choices for Care program. (August 2022)

Subgroup Recommendations: System Flow (1 of 3)

1. Develop the capacity to provide care for high-acuity sub-acute patients:
 - a) Procure through an RFP, for Medicaid specialized units in long term care (LTC) and residential facilities, include an enhanced rate and special worker training to support patients with high acuity mental health, substance use and developmental disability needs. (August 2022)
 - b) Explore feasibility of caring for high acuity patients in hospital-owned long-term care facilities (Woodridge, Helen Porter and UVMHN) including enhanced rates, increased staffing requirements, and streamlined admissions processes. (August 2022)
 - c) Recruit a cohort of SNFs to become centers of excellence for serving patients with developmental disabilities, mental health and substance use treatment needs. (Fall, 2022)
2. Convene conversations between Designated Agencies, Skilled Nursing Facilities (SNFs), and hospitals to develop processes for crisis response at a local level to avoid Emergency Department utilization. (August 2022)

Subgroup Recommendations: System Flow (2 of 3)

3. Create statewide approach to SNF Medical Director requirements through the engagement and implementation of a shared capacity and utilization potentially through OneCare. (On-going)
4. Clarify a consistent interpretation and application of the statewide use-of-force policy between the Department of Public Safety and DAs to help law enforcement and DA crisis teams safely and effectively respond to individuals in crisis. Also clarify a consistent interpretation and application of the statewide use-of-force policy in emergency departments between the Department of Public Safety and hospitals.
5. Consider a new collaborative care model that offers telehealth “curbside consultations” for long-term care facilities, and train staff in SNFs in de-escalation techniques.

Subgroup Recommendations: System Flow (3 of 3)

6. Explore opportunities for obtaining SMART medical clearance in primary care, urgent care and possibly other settings, and for hospitals to accept such patients.
7. Clearly define emergency mental health services within each community and define needed rate adjustments or additional/new programs through an RFP to fill gaps.
8. Create a forum between hospitals and designated agencies to open opportunities for increased mental health resource sharing.
9. Invest in psychiatric/mental health urgent care by exploring capital investment opportunities and escalating federal regulatory issues of collocating on hospital property.

Subgroup Recommendations: Revenue (1 of 2)

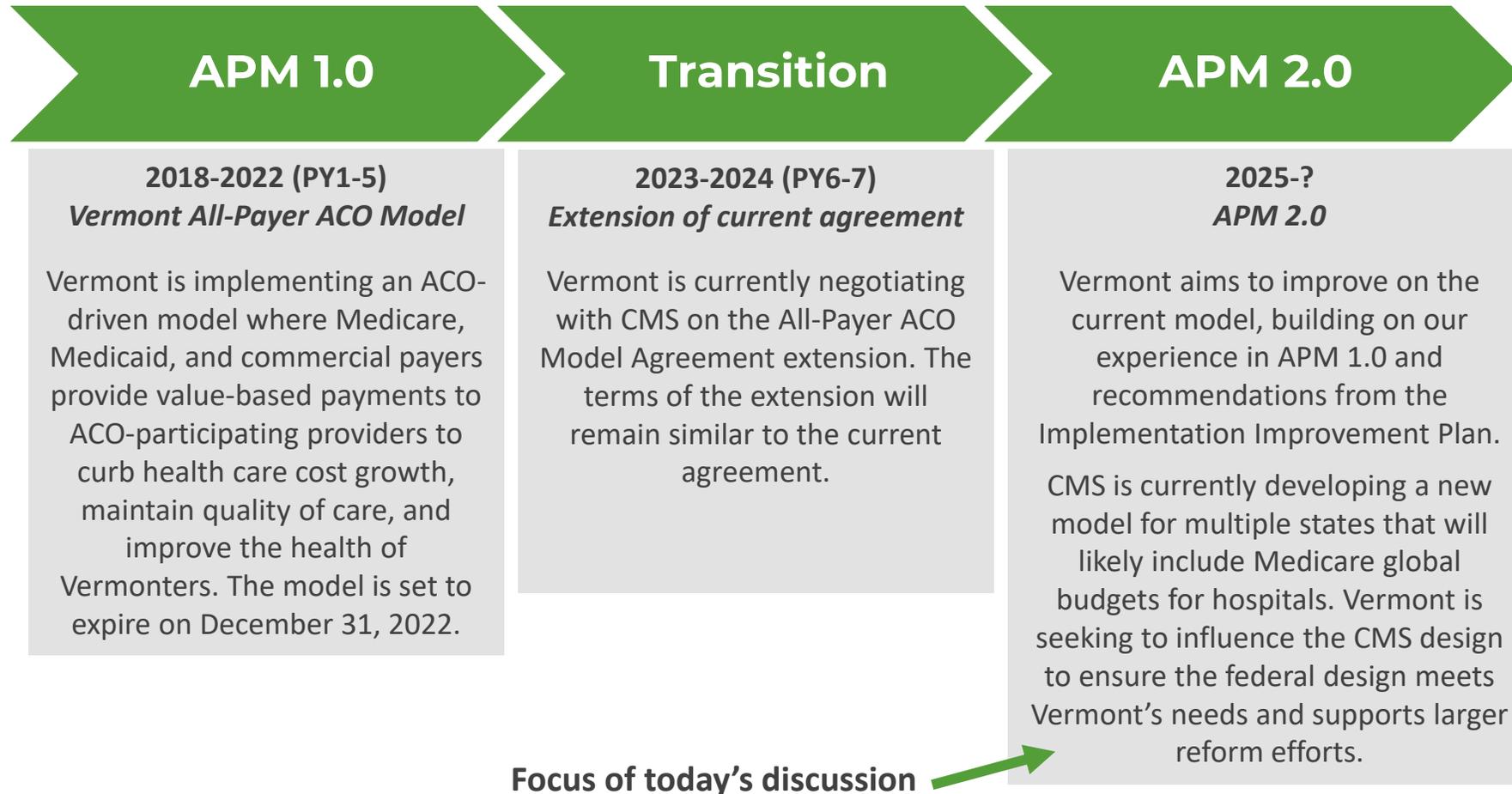
1. Update rate methodologies and potentially rules to address inflationary costs, including staffing, within cost-based rate methodologies for Skilled Nursing Facilities, Private Non-Medical Institutions, and other residential care providers through the Division of Rate Setting at the Department of Vermont Health Access (DVHA). (Fall, 2022 – Anticipated Budget Item)
2. Conduct rate studies to evaluate Choices for Care rates to determine the sustainability of the program. (Fall, 2022 – Anticipated Budget Item)
3. Provide a one-time increased Disproportionate Share Hospital (DSH) payment to hospitals. (September 2022)
4. Increase to the maximum federal allowance, GME payment to UVMHN utilizing enhance intergovernmental transfers from the University of Vermont. (September 2022)

Subgroup Recommendations: Revenue (2 of 2)

5. Study the trend in revenues from the provider tax including the impact of the pandemic compared to the trend in provider rate increases. Determine if there is an opportunity for short-term one-time relief. Forecast long-term provider tax revenue. (Fall, 2022 – Anticipated Budget Item)
6. Explore inpatient psychiatric rates.

2. CMMI's Seven Priorities for its New Multi-State All-Payer Model

Working with CMS on APM Evolution



CMS Innovation Center's Design Criteria

CMS has indicated that development of the successor to Vermont's current All-Payer ACO will be informed by a cohort of states' experiences (MD, PA, WA, OR, VT, RI). 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. Include goals for 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.

The slides that follow present CMS' perspective so far on each concept. In future sessions, we will take a deeper dive into each concept and the Work Group will be asked to help hone Vermont-focused priorities corresponding to each concept.

#1. Include Global Budgets for Hospitals

CMS has indicated that it is looking to scale the national footprint of hospital global budgets, including through its proposed new state model that is intended to launch in 2025.



CMS Perspective

- The rationale for hospital global budgets is that they decouple hospitals from volume incentives, particularly for specialty and elective procedures that may be at low demand, and instead allow hospitals more flexibility to add service lines that are not traditional profit centers but support community population health needs.
- Global budgets already exist in Maryland for all hospitals, and in Pennsylvania for rural hospitals. Other states are beginning to pilot global budgets under the CMS “CHART” model.
- Revenue destabilization since COVID 19 has increased CMS’ interest in scaling hospital global budgets nationally.



Considerations

- Vermont (AHS, GMCB and the legislature via Act 167) have agreed to explore with stakeholders a transition to global budgets, particularly as a means to provide more predictable funding to hospitals.
- Vermont is interested in building on its current model to be more inclusive than hospital-only.
- Vermont will want to influence CMS approaches, particularly to ensure they are appropriate for a statewide rural health system.
- Vermont will join a multi-state collaborative to partner with other states in shaping CMS’ approach.

#2. Include Total Cost of Care (TCOC) Target/Approach

CMS has indicated an interest in combining the global budget approach with measurement of TCOC across all health spending.



CMS Perspective

- When combined with hospital global budgets, TCOC assesses spending both inside and outside the global budget.
- CMS will continue to measure Medicare total cost of care under the new model, as under the ACO model today, and will continue to tie provider incentives to TCOC.
- CMS will expect participating states and payers to also continue to measure TCOC.



Considerations

- Vermont's current model includes statewide TCOC targets.
- Vermont sees that a TCOC overlay on top of global budgets can incentivize providers to strive for optimal utilization statewide.
- Vermont is interested in also developing a concept of shared incentives across alternative payment models (e.g., Mental Health and Primary Care) to incent specific goals like coordination.

#3. All-Payer Participation

CMMI will require state participants to engage Medicaid and as much participation across all other payers as possible.



CMS Perspective

- CMS will continue to be responsible for Medicare Parts A/B alternative payments under the new state model.
- CMS will expect states participating in the new model to engage multiple payers in:
 - Aligned payments
 - Aligned quality measures
 - Aligned data sharing approaches



Considerations

- Vermont model currently includes participants from all three major payer categories.
- Vermont will seek to include **all** payers (Medicaid, Medicare, commercial) within APM 2.0 at the outset, to the greatest extent possible.

#4. Minimum Investment in Primary Care

CMS has indicated that the new state model will prioritize primary care investment goals and improvement.



CMS Perspective

- CMS' new state model may offer Medicare PMPM payments to participating practices.
- CMS may contemplate minimum investment requirements.
- CMS will likely expect states participating in the new model to engage multiple payers in:
 - Aligned payments to primary care medical homes
 - Aligned quality measures for PCPs
 - Aligned data sharing approaches with PCPs



Considerations

- ◆ Vermont has a strong existing foundation for investing in and supporting primary care through the Blueprint for Health which is an aligned all-payer model.

#5. Include Safety Net Providers from the Start

CMS is emphasizing inclusion of Medicaid-focused providers, and/or those that have not traditionally been participants in APMs.



CMS Perspective

- CMS is focused on ensuring that policies across the agency support safety net providers (e.g., [Equity Strategy](#)).
- CMS recognizes that safety net providers are currently underrepresented in APM participation nationally relative to other providers, contributing to further underinvestment.
 - FQHCs
 - Critical Access Hospitals



Considerations

- ◆ FQHCs and CAHs are current participants in Vermont's statewide All-Payer Model.
- ◆ There is variation in CAH participation by ACO payer program type.
- ◆ Vermont is exploring a safety net provider model for mental health and substance use disorder treatment providers (Certified Community Behavioral Health Centers).

#6. Address the Social Determinants of Health

CMS has indicated support for states' efforts to invest in mental health and substance use disorder services and to intervene on SDOH as part of ongoing health care reform.



CMS Perspective

- CMS is committed to payment models that provide flexibility and incentives for provider organizations to address SDOH.
- Based on current CMMI efforts, this could include options for reinvestment of shared savings, learning collaboratives, or potentially support for organizations that serve to link health care delivery with social services organizations, as is currently being tested in the Accountable Health Communities model.



Considerations

- Vermont's existing Complex Care Model is a strength that can be built on to address Mental Health, Substance Use Disorder, and Social Determinants of Health.
- Vermont is interested in continuing efforts to incorporate SDOH data into risk models to drive global budget formation, TCOC targets and other financial aspects of the model.
- Vermont can leverage public-private partnership to strengthen approaches to MH, SUD and SDOH.

#7. Address Health Equity

CMS is looking to incorporate equity into the design of each of its CMMI models.



CMS Perspective

- CMS is likely to incorporate into the model:
 - Use of “health equity plans”
 - Equity-focused weightings in quality measurement
 - Increased collection of sociodemographic data as part of model
 - Equity-focused measurements as part of independent evaluation

(See [Equity Strategy](#), 2022).



Considerations

- Vermont is currently engaged in improving collection and reporting of health equity data and metrics.
- Pandemic has further highlighted need to address rural inequity.
- Per Act 167 Vermont will engage with BIPOC, disability, MH, SUD and LGBTQ+ communities to inform model development and approach to CMS.

Work Group Reactions to CMMI's Seven Priorities

The Work Group offered these suggestions after learning of CMMI's Seven Priorities:

1. Identify Vermont's current strengths and weaknesses relative to these priorities.
2. Explicitly consider the role of ACOs, safety net providers, home health, and hospice care within this new model.
3. Communicate and collaborate with CMS on fitting a model tailored to Vermont's needs, that considers:
 - Vermont's rurality;
 - Vermont's status as a low-cost Medicare state, and
 - Vermont's lack of provider market competition.
4. Determine the range of services to be included within "Total Cost of Care."
5. Consider equity, in part, in terms of differences associated with rurality.
6. Consider how safety net providers can participate in financial models when they are unable to assume risk.
7. Prioritize stability.

Timeline and Next Steps

Over the next several weeks, the Health Care Reform Work Group will discuss Vermont's vision for APM 2.0 and how it fits with CMMI's priorities. Meeting topics may change depending on Work Group discussions.

Topic (<i>subject to change</i>)	Date
Global Budgets (Pt. 1)	Late August
Global Budgets (Pt. 2), APM 2.0 Principles	Early September
Total Cost of Care, All-Payer Participation	Mid September
Minimum Investment in Primary Care	Late September
Safety Net Providers	Late September
Social Determinants of Health, Health Equity	Early October
TBD	Mid-October and beyond

3. Draft Principles to Guide Health Care Reform Planning

1. Finance reform and delivery system reform are in service of outcomes.
2. Cost containment is multifaceted, and at minimum needs to address quality, efficiency, price, and input costs.
3. Any future model should utilize a public-private partnership and governance model.
4. All-payer participation is critical.
5. Combine mandatory and voluntary approaches to provider participation.
6. Focus on all care delivered in Vermont rather than care delivered to Vermonters, i.e., not an attribution-based focus.
7. Key components to support reform are delivery system changes, data analytics, and practice transformation/innovation.
8. Support care integration across the continuum through payment innovation, data, support for transformation/innovation, and regulation.
9. Advance a Learning Health System with intentional and practice-focused support for transformation.

Wrap-up and Next Meeting

The next Work Group meeting is scheduled for Tuesday **August 30th** from 9-10:30am.

Work Group members should review the draft principles and submit written comment to Chris (cromero@bailit-health.com) by **September 1st**. We'll continue discussion of the principles during the following Work Group meeting on **September 6th**.