

# Health Care Reform Work Group

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SEPTEMBER 6, 2022 MEETING SUMMARY

# Meeting Agenda

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1. Global budgets discussion (Part 2)
2. Work Group feedback on draft principles for health care reform planning
3. Next steps and next meeting

# 1. Global Budgets Discussion (Pt. 2)

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

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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. ]★ *Continued focus of today's discussion***
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.

# Updates from Discussion with CMMI Leadership on 8/30

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Since CMMI is in the early stages of model design, Vermont has a clear opportunity to influence CMMI's design of the new state model.

- CMMI is particularly interested in Vermont's input on global budgets, total cost of care measurement, primary care, and governance/regulatory structures.
- CMMI aims to build a multi-state model that is flexible enough to account for states' unique characteristics.
- CMMI is exploring primary care investment targets and increasing primary care transformation (e.g., expanded primary care access and service offerings through evening/weekend hours and integrated mental health).
- Tentative timeline:
  - CMMI to release RFP for new state model in late 2023
  - CMMI to select model participants in 2024
  - States to implement model in 2025

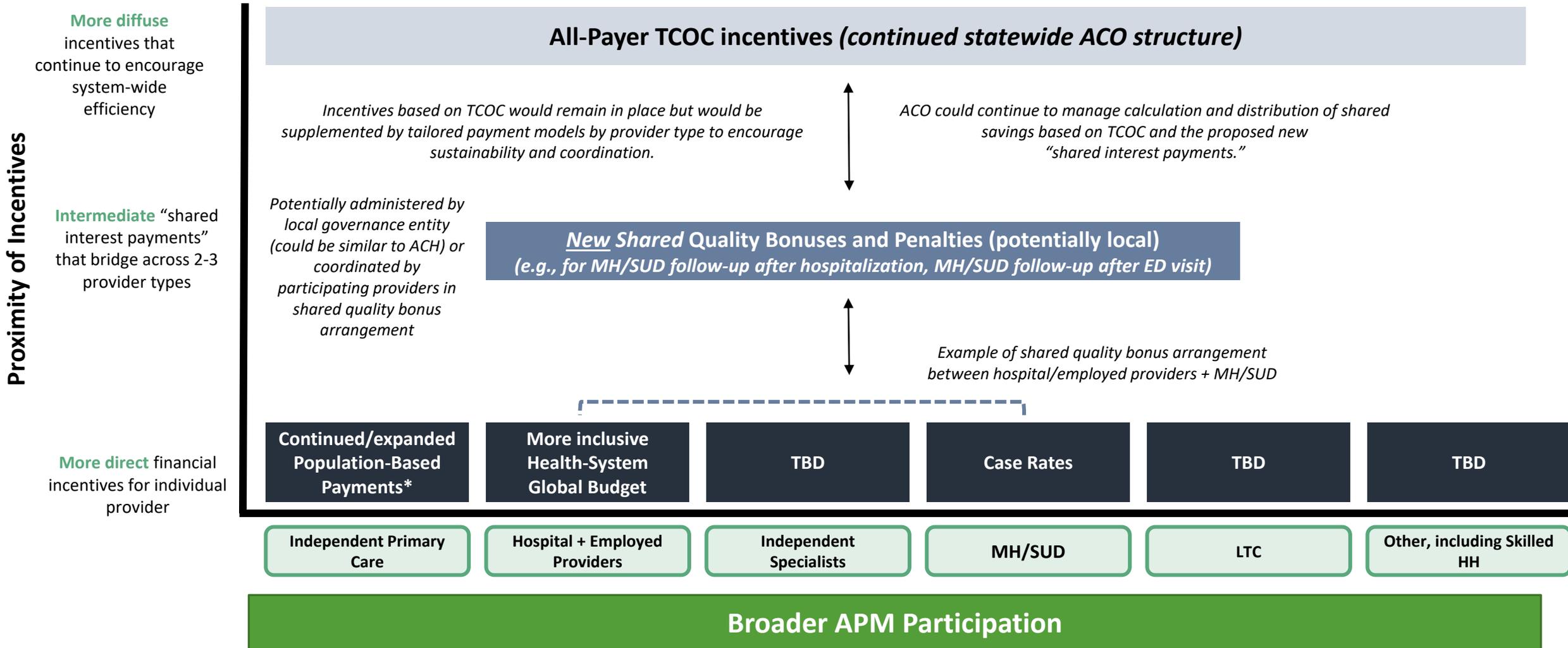
# Further Discussion of Future State Straw Models (continuing from 8/30)

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Both straw models build from the current state. In **both** straw models:

- Model would remain multi-payer.
- More provider types would be covered by an Alternative Payment Model than today.
- Alternative Payment Models for different provider types would evolve from current state.
- Hospital revenues would be more stable than today:
  - Medicare payments to hospitals would be more fixed than today's AIPBP, which is reconciled to FFS.
  - Medicaid approach would evolve into new model.
- Primary care practices would continue to receive substantial population-based payments across all payers.
- Total cost of care incentives would continue to apply across provider types.
- Quality incentives would continue to apply across provider types.

# “Portfolio” Approach: Statewide, Multiple APMs with Extended APM Participation

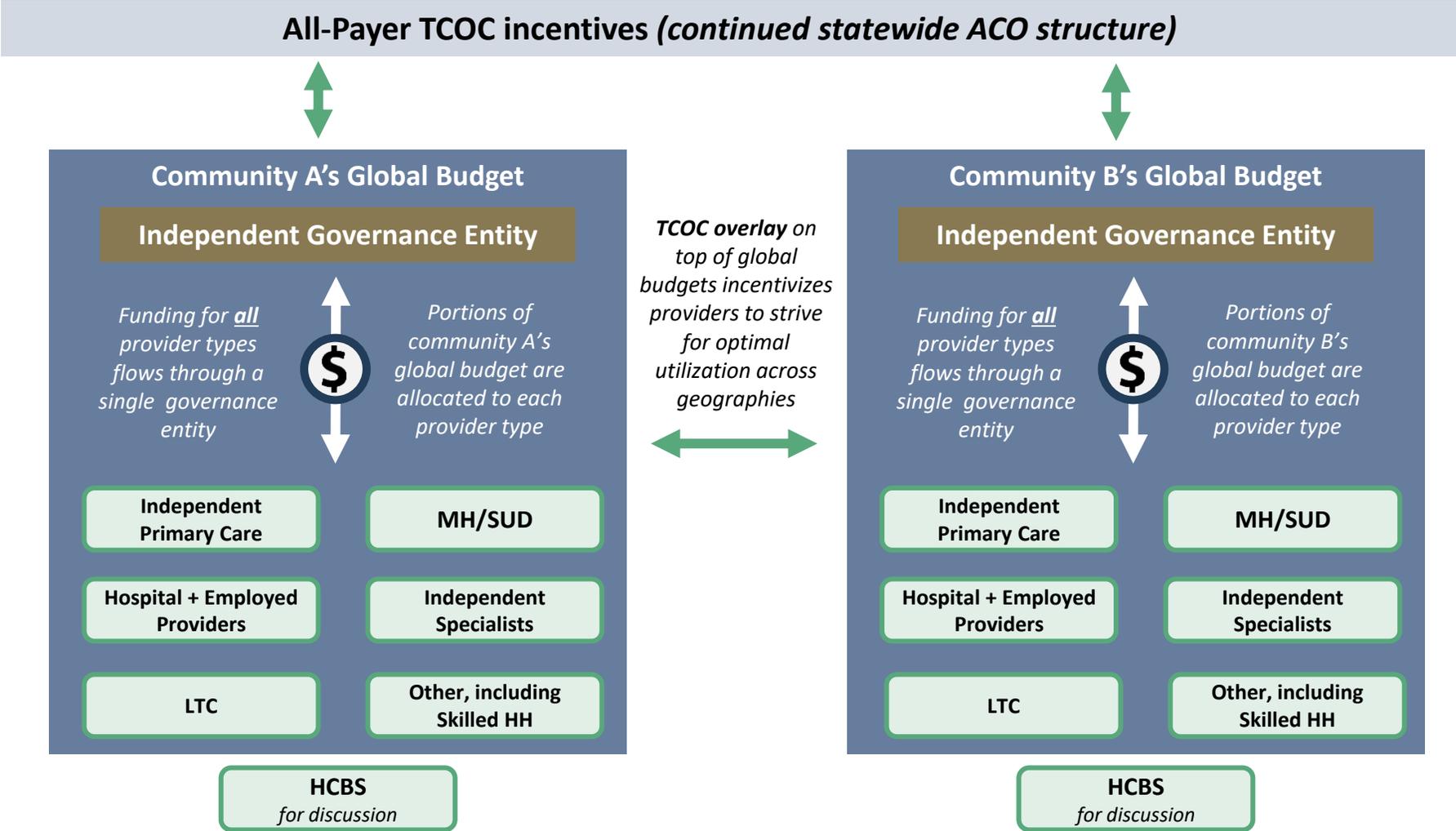


# Portfolio Approach

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- This model would build on existing efforts, representing a more iterative approach than moving immediately to community-based global budgets.
- Some key evolutions from current model:
  - Design would be more inclusive of currently non-participating provider types.
  - Shared interest payments (middle layer) strengthen incentives for cross-provider collaboration within a community.
  - Goal is to “dial up” payment incentives inherent in each provider-level Alternative Payment Model.
  - Includes a community-based global budget component (building off a pilot global budget model under Medicaid in 2023).
  - Allow providers to request reinvestment from one category of funding to another under an advanced governance structure.
- The portfolio approach would need to incorporate an element that addresses the impact of tertiary care on the total cost of care for a community.

# “True” Community-Based Global Budget Approach: **Organized APM by Region**



# Work Group Member Reactions to Straw Models

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- Members asked:
  - What problems are we trying to solve, what are our strategies for doing so, and what is our vision for the future health care system?
  - Are we focused on health care system sustainability, innovation or cost containment?
  - Is AHS proposing that we maintain our vision from the All-Payer Model, but develop new methods for overcoming operational challenges?
    - *AHS confirmed this to be the case.*
- Members questioned how shared incentives at a regional or a local level might work, noting OneCare's pivot away from HSA-based risk due to population changes from year to year, problems with small population numbers, and the financial impact of out-of-state care.
- The group agreed that bringing meaningful and aligned performance incentives down to the provider level is a continuing challenge, and part of the answer is use of a limited, generally stable set of aligned measures.
- Members generally did not weigh in on whether the “portfolio approach” or “true community-based global budget” was preferred, but two members did voice support for the portfolio approach.

## 2. Work Group Feedback on Draft Principles for Health Care Reform Planning

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# Draft Principles to Guide Health Care Reform Planning Shared During August 25<sup>th</sup> Meeting

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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.

# Work Group Member Feedback on Draft Principles to Guide Health Care Reform

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- Seven Work Group member organizations provided feedback on the draft principles:
  - BlueCross BlueShield of Vermont
  - HealthFirst
  - MVP Health Care
  - Vermont Association of Hospitals and Health Systems
  - Vermont Care Partners
  - Vermont Medical Society
  - VNAs of Vermont
- Comments were submitted in response to all nine draft principles. Commenters also proposed additional principles.
- We will review general comments first, then comments on the draft principles, and finally proposed additional principles.

# Work Group Member Feedback: General Comments on the Draft Principles

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- We should define a *vision* before discussing principles.
- We should develop *goals* before discussing principles, perhaps starting with those in Section 2 of Act 167.
- Let's not spend time on principles; Vermont already has the robust set of Act 48 health reform principles that have been adopted by the legislature, apply to the Administration and GMCB, and had broad stakeholder input.
- Adopt a broader framing of the principles to be inclusive and reflective of all Vermonters' health care needs and experiences...Individual Vermonters should be at the center in these discussions.
- The principles are more approaches and tactics than “principles.” Also, several draft “principles” are very hard to agree to as a “truth” because the details matter.

# Work Group Member Feedback: Selected Comments on Individual Principles (1 of 9)

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## **#1 “Finance reform and delivery system reform are in service of outcomes.”**

- What are the outcomes we are seeking?
  - These question was raised by multiple respondents.
  - Commenters had multiple suggestions of what they should be.
- One respondent was confused by “finance reform” and thought we should be talking about “payment reform” instead.
- Another respondent voiced strong support for this principle.

# Work Group Member Feedback: Selected Comments on Individual Principles (2 of 9)

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## **#2 “Cost containment is multifaceted, and at minimum needs to address quality, efficiency, price, and input costs.”**

- Two respondents felt that “price” should be removed.
- One respondent voiced strong support for this principle.
- One respondent suggested “contain cost growth at a level below what would be otherwise expected...” as an alternative (in part).
- One respondent felt this principle inferred that cost containment was the primary objective of reform and disagreed if that was the intention.
- One respondent felt this was a statement rather than a principle.

# Work Group Member Feedback: Selected Comments on Individual Principles (3 of 9)

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## **#3 “Any future model should utilize a public-private partnership and governance model.”**

- Two of the five organizations commenting on this principle expressed a desire to understand what was intended by “public-private partnership and governance model.”
- A third organization suggested a wording change to indicate that the All-Payer Model would *continue* to use a public-private partnership and governance model.

# Work Group Member Feedback: Selected Comments on Individual Principles (4 of 9)

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## **#4 “All-payer participation is critical.”**

- All commenting respondents supported this draft principle.
- One suggested future participation of commercial payers in addition to BCBSVT and MVP.
- Another suggested adding to the end of this draft principle “and will help drive provider participation” and eliminating principle #5.

# Work Group Member Feedback: Selected Comments on Individual Principles (5 of 9)

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## **#5 “Combine mandatory and voluntary approaches to provider participation.”**

- One commenter said its organization would not support mandatory participation in a model without yet knowing what that model is, if it is sustainable for all types of providers, and what types of providers would be required to participate.
- Another suggested eliminating principle #5 and amending principle #4.

# Work Group Member Feedback: Selected Comments on Individual Principles (6 of 9)

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## **#6 “Focus on all care delivered in Vermont rather than care delivered to Vermonters, i.e., not an attribution-based focus.”**

This draft principle generated a range of reactions across four respondents, including the following:

- “What is the stated benefit from shifting from the focus away from attribution?”
- “This will ensure that the payment of care will not track with the reform outcomes.”
- “Agree.”
- “Remove...This principle incentivizes exporting care out of state and would need further discussion for [our organization] to reach agreement.”

# Work Group Member Feedback: Selected Comments on Individual Principles (7 of 9)

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## **#7 “Key components to support reform are delivery system changes, data analytics, and practice transformation/ innovation.”**

- One respondent noted that delivery system changes may not be possible in the current workforce environment, and there is probable need for a workforce principle.
- Another respondent recommended adding “regulatory alignment and simplification” as additional key components.
- A third respondent voiced strong support for this principle.

# Work Group Member Feedback: Selected Comments on Individual Principles (8 of 9)

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## **#8 “Support care integration across the continuum through payment innovation, data, support for transformation/ innovation, and regulation.”**

Respondents suggested a number of edits to this principle:

- Add “sufficient and sustainable reimbursement.”
  - Another commented “Payment innovation cannot solve inadequate payment - adequate reimbursement needs to be included.”
- Add “appropriate” before “regulation.”
- Remove “/innovation.”
  - Another commented “...the focus has been too much on implementing “new” ideas and too little on examining existing structures...”
- Remove “through payment innovation, data, support for transformation/ innovation, and regulation.”

# Work Group Member Feedback: Selected Comments on Individual Principles (9 of 9)

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## **#9 “Advance a Learning Health System with intentional and practice-focused support for transformation.”**

- One respondent expressed a lack of understanding of this draft principle.
- Another respondent suggested adding “broad” before “Learning Health System.”

# Work Group Member Feedback: Suggestions for 10 Additional Principles (1 of 2)

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1. “The model is designed to achieve consistency in provider requirements such as data collection and quality measures and to reduce provider administrative burden.”
2. “The model should provide for more predictable, stable revenue streams to providers and should encourage collaboration across provider types.”
3. “All-payer participation and all-payer cost growth at a reasonable rate are critical.”
4. “Incorporate successes and lessons learned from the current All-Payer Model.”

# Work Group Member Feedback: Suggestions for 10 Additional Principles (2 of 2)

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5. “Build on and support existing service delivery structures before building new ones.”
6. “Align payment incentives between providers.”
7. “Consider existing value-based payment models before developing/applying new ones.”
8. “Don’t use “reform” as a solution to inadequate payment.”
9. “Reforms should recognize areas of the system where utilization should increase.”
10. “Build interventions to prevent hospitalizations and ED visits weighing heavily on the experience and advice of providers whose primary work is to do just that.”

# Next Steps and Next Meeting

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**Meeting topics may change depending on workgroup discussions.**

<b>Topic (<i>subject to change</i>)</b>	<b>Date</b>
Total Cost of Care, All-Payer Participation	9/13
Primary Care Investment Targets	9/20
Safety Net Providers	9/27 ( <i>in person in Waterbury</i> )
Social Determinants of Health, Health Equity	10/4
TBD	Mid-October and beyond

# Work Group Member Reactions to the Work Group Meeting Timeline

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- A member asked about the timeline for providing feedback to CMMI.
- AHS explained that CMMI will need to finalize its new multi-state all-payer model design within 4-5 months. Work Group members were invited to submit ideas other than the two proposed straw models
- AHS may modify the planned meeting agendas based on feedback provided during the meeting. In addition, AHS may create a focused subgroup to help support progress in a tight timeframe.