Health Care Reform Work Group

APRIL 24, 2023

Meeting Agenda

1. Welcome, Introductions, and Review of Agenda
2. Carryover from March 26 Meeting: Short-Term Stability Updates - Revenue
3. Status of CMMI Engagement
4. Global Budget Technical Advisory Group Progress Report
5. Medicare Waiver Advisory Group Progress Report
6. Other Stakeholder Engagement Activities
7. Next Steps

Short-Term Stability Updates

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)

Revenue (1 of 3)

- **Update rate methodologies and rules to address inflationary costs (DVHA)**
  - Coordinating rule change for PNMI methodologies to reflect annual inflationary adjustments effective 7/1/23
  - Calculating SNF cost rebase and inflation effective 7/1/23

- **Conduct rate studies to evaluate Choices for Care rates to determine program sustainability (DVHA).**
  - Rate studies were completed and submitted to the legislature

- **Increase GME payment to UVMHN to maximum federal allowance (DVHA)**
  - Received Global Commitment (GC) spending authority through BAA to increase annual GME amount for SFY23 (~$21M)
  - Additional payment will be issued by June 30, 2023

Revenue (2 of 3)

- **Explore in-patient psychiatric rates (DVHA)**
  - The Brattleboro Retreat Alternative Payment Model provides monthly prospective payments with augmented per diem rate for inpatient services, with financial reconciliation and performance measurement framework. The goal is for the Brattleboro Retreat to increase total bed capacity, regardless of payer, to 100 beds by June 30, 2023
  - DVHA will continue to review and monitor inpatient rates

Revenue (3 of 3)

- **Updates related to stability activities (included in January report)**
  - The following are included in the Governor's FY24 budget request:
    - Funding for statewide expansion of mobile crisis ($3.15M gross - unchanged in House)
    - Funding for alternatives to emergency department mental health crisis care ($1.59M gross – unchanged in House)
    - Increase to GME payment to UVMHN (unchanged in House)
    - Increase of $3M gross for HH rates, $17.79M gross for NH rebasing and inflation factor (House changed downward to equal a 15% rate increase, per the 2/15 rate report. NH rebasing and inflation factor is unchanged.)
    - Increase of $2.32M gross for PNMI to include an inflationary factor in rates (unchanged in House)
    - One-time $10M for provider stability (COVID contingency fund) and one-time funding for 2-year Blueprint for Health/Hub and Spoke pilot expansion to integrate mental health and primary care ($20.9M gross over 2 years – changed to 1 year in House)

Discussion: Is there a need to revisit Short-Term Stability?

- *A number of actions were previously identified.*
- *Progress has been made on many of them, and work continues.*
- *Does the group have observations about the current state of system stability?*
- *Is there value in coming together again to review current state and identify new actions to support short-term stability?*

Summary of Work Group Member Input

- Provider representatives provided input on the current state of health care system stability and the impact of short-term stability efforts to date.
- Themes included ongoing challenges with workforce, federal issues, administrative burden, need to support community services to improve population health, inflation, contract staff/traveler costs, low or negative operating margins and other aspects of financial sustainability, flat reimbursement, patients in acute hospital beds who should be receiving care at SNFs or MH facilities, increasing acuity and hospital lengths of stay, role of primary care, need for access to data.
- There was agreement that some of the efforts have had an impact (e.g., premium pay and tuition support can help with staff retention).
- Work group members agreed that it would help to convene the Short-Term Stability Subgroup again.

Status of CMMI Engagement

Discussions are getting more detailed as we get closer to CMMI's anticipated release of Notice of Funding Opportunity in Summer or early Fall of 2023.

- Upcoming topics include:
  - ✓Core components of AHEAD Model
  - ✓Opportunities for flexibility under AHEAD Model

- Vermont would like to begin to present high-level input from Global Budget Technical Advisory Group and Medicare Waiver Technical Advisory Group

Global Budget TAG Progress Report

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Currently Participating Organizations

Co-Chairs: Robin Lunge, GMCB and Pat Jones, AHS

- BlueCross BlueShield of Vermont
- Cigna
- Department of Vermont Health Access
- Gifford Medical Center
- GMCB General Advisory Committee
- Mt. Ascutney Hospital
- MVP Health Care
- Northwestern Medical Center
- Office of Health Care Advocate
- OneCare Vermont
- Rutland Regional Medical Center
- University of Vermont Health Network
- Vermont Department of Financial Regulation
- Vermont-National Education Association

Technical Advisory Group Purpose and Meeting Structure

Technical Advisory Group charge: Make recommendations for conceptual and technical specifications for a Vermont hospital global budget program by the time CMMI introduces its new APM program.

Technical Advisory Group deliverable: Specifications outlining a Vermont hospital global budget design and implementation approach.

Technical Advisory Group meeting period: January-November

Meeting cadence: 120-minute meetings, approximately every three weeks.

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Hospital Global Budget Design Decision Topics

1) Defining Population, Services and Providers for Inclusion

2) Methodology for Determining Baseline Budgets

3) Budget Adjustments (e.g., financial performance, demographics, inflation, utilization, quality, equity, risk mitigation, exogenous factors)

4) Terms of Payer Participation and Payment Mechanism

5) Terms of Hospital Participation

6) Strategies to Support Care Transformation and Quality of Care

7) Implications for Commercial Plan Administration

8) Budget Calculation and Payment Administration

9) Monitoring and Evaluation

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Summary of Hospital Global Budget Recommendations to Date

The global budget should **include consideration of the following services**:

- **All hospital inpatient and outpatient services**, with the possible exception of infrequent and high-cost hospital services, which the group will revisit.
- Both **employed and non-employed professional services** billed under the hospital's taxpayer identification number (TIN), but *not* non-employed professionals not billed under the hospital's TIN.
- At least **some hospital-owned facility-based services**, with phased inclusion of additional services over time.
- **Corporate parent-owned entities on a case-by-case basis**, based on whether those services can be appropriately allocated to a specific hospital based on geography or other factors.

Summary of Hospital Global Budget Recommendations to Date

The global budget should **include the following populations**:

- **Only VT Medicaid members** (i.e., not members of other state Medicaid programs).
- **All Medicare FFS beneficiaries** (VT residents and non-VT residents), acknowledging the importance of understanding the percentage of non-resident Medicare charges from non-border states, as those beneficiaries are more likely to receive primary care out-of-state.
- **Commercial self-insured, fully-insured, and Medicare Advantage**, including both VT and non-VT residents with commercial insurance.

Summary of Hospital Global Budget Recommendations to Date

Calculating baseline budgets

- The primary data source for determining baseline budgets should be **actual revenue**, provided that baseline budget adjustments will take into consideration the financial experiences of the hospitals.
- Assuming 2025 as the first performance year, an **average of 2022 adjusted data and 2023 data** should be used to establish baseline budget expenditures. If later than 2025, the most recent year with complete data should be used.

Areas for Further Discussion

- The group will **revisit the different approaches for constructing baseline budgets** with more detailed models for: one primary hospital budget across all payers & markets vs. hospitals & payers establishing individual payer budgets.
- The State will review all non-patient service hospital revenue (operating & non-operating) and **develop recommendations regarding commercial payer and Medicaid revenues for budget inclusion**.
- For future discussion of payer participation, the group will consider the implications of **whether the hospital and payer have an existing contractual relationship**, and the **appropriate revenue thresholds** for including commercial payers based on a percentage of a hospital's budget.
- Discussion of inclusion of **Blueprint Community Health Team** services and funding in global budgets, recognizing the need for additional transparency and tracking of how funds are used if included.

Summary of Work Group Member Input

- How can we incentivize high-value care rather than low-value care? *Could be handled in adjustments to global budgets.*
- Goal is participation from Medicare, Medicaid, and commercial payers. Will participation be mandatory or voluntary? *Likely to look at a range of options. Rate setting rule or statute could support mandatory participation.*
- What about non-hospital providers?
- When will value-based payment become real? Trying to resist utilization increases, but pressure is to go back to more traditional approach supported by fee-for-service.
- Discussion ended with this item due to time constraints; Medicare waiver discussion will carry over to May 22 meeting.

Medicare Waiver TAG Progress Report

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Medicare Waivers Technical Advisory Group's Charge

The group's primary goal is to identify the key "asks" on Medicare waivers to share with CMS to inform the design of the AHEAD model.

- CMMI is considering the types of waivers it could make available to states under the AHEAD model and welcomes Vermont's feedback.
- CMMI asked the State to indicate the most important "asks."
  - Include a clear policy rationale for updating existing waivers available under the VTAPM and/or requesting new waivers under the AHEAD model.
  - Members have already provided some compelling examples.
- Vermont aims to understand:
  - Problems that new or revised waivers could help address (e.g., discontinuity of care with transitions)
  - On-the-ground experiences (successes, challenges) with implementing current waivers under the Vermont All-Payer ACO Model
  - New waivers that are of interest to stakeholders

Theory of Change for Medicare Waivers

- Medicare waivers are a means to an end, not the end itself.
- Logic should be:
  - What are the care delivery models we want to see implemented in Vermont?
  - How do those care delivery models advance outcomes?
  - **What waivers do we <u>need</u> to implement the models?**
- Successful implementation of similar flexibilities by Medicaid and other payers is relevant and is likely to be of interest to CMMI.

Potential Framework for Discussion with CMMI

Medicare waivers can help ensure Vermonters receive the right care in the right place at the right time.

- Vermont's priorities are to:
  a. Improve quality and beneficiary experience associated with transitions between care settings
  b. Improve access to services at home
  c. Improve delivery of care at the end of life
  d. Enhance access to care, especially in rural areas, through optimal use of technology
  e. Expand access to care within long term care by optimizing staffing and organizational structures

A: Improve Transitions Between Care Settings

- **Patients transitioning from one care setting to another are vulnerable to poor outcomes.**
  - Continuity of care between settings leads to lower costs, higher patient and provider satisfaction, and reduced hospitalizations and emergency department use.
- The following Medicare waivers with operational changes may help facilitate seamless transitions between care settings:
  - Care management home visits (current APM)
  - Post-discharge home visits (current APM)
  - SNF 3-day rule waiver (current APM)
  - Expansion of Home Health benefit (would be new – see next slide)
- Consider how Medicare waivers could support health-related social needs that prevent timely transitions to lower-acuity and community settings.

High-Level Feedback

- **Administrative challenges** have limited use of the current home visits waivers (care management and post discharge). For example, the post-discharge home visit waiver requires HHAs to maintain individual contracts with physicians to receive reimbursement for services. Physicians may not have an infrastructure to bill for services and it is challenging for discharge planners to know all contractual relationships.
- **Expanding the eligibility criteria** for certain waivers beyond attribution may improve uptake and implementation. For example, expanding the 3-day SNF rule waiver beyond attributed lives would reduce administrative burden. Vermont is interested in discussing with CMMI how waivers will apply within a hospital global budget design, which will not include ACO style attribution.

B: Expand Access to Services at Home

- **Home health care enables individuals to maintain their independence, receive care in a safe, comfortable, and convenient environment, and manage total cost of care.**
- To increase alignment with Vermont's Medicaid approach, the State is interested in discussing a **new** expansion of the Medicare Home Health benefit that would allow visits for those who do not meet "homebound" criteria and aide support for individuals who do not have a need for skilled services.

High-Level Feedback

- Vermont is interested in learning more about CMMI's implementation of the **Home Health Homebound Waiver under ACO REACH**.
- **Removing the "in need of skilled services" requirement** (in addition to the flexibilities available in ACO REACH) would allow more individuals to receive other non-skilled home health services (e.g., medical social services, home health aide, DME and supplies).

C: Improve Care Delivery at the End of Life

- **Vermont is on the lower end of Medicare hospice utilization, ranking #38 out of 50 states in 2020.**
- Vermont would like to provide access to holistic hospice services for Medicare beneficiaries without them having to forgo curative care. This would align with Vermont Medicaid's approach for children and authority for adults available within the state's Medicaid 1115 waiver.

High-Level Feedback

- Vermont is interested in learning more about CMMI's implementation of **concurrent curative and hospice care under ACO REACH**.

D: Enhance Access to Care Through Optimal Use of Technology

- Telehealth enhances access to care. Various modalities of telemedicine (e.g., asynchronous e-consults, remote patient monitoring, virtual check-ins) enable individuals to receive care for a variety of acute and chronic conditions.
- **Telehealth is especially valuable since Vermont is a rural state, where nearly two-thirds of residents live in rural areas.**
- Priorities for Vermont (to be refined in further discussion with stakeholders) include:
  - Use of telehealth for SNF residents (see next slide)
  - Physical and Occupational Therapy
  - Remote Patient Monitoring
  - Removing geographic restrictions (urban-rural) and location restrictions (i.e. home)
  - Removing platform-based restrictions (i.e. audio-only)

High-Level Feedback

- **Vermont is interested in improving the current APM telehealth waivers to reduce administrative burden and expand use beyond attributed members.**

E: Expand Access to Care within Skilled Nursing Facilities

- **According to SNF stakeholders in Vermont,** an unprecedented disruption to the health care workforce is interrupting facilities' ability to meet demands for patient placement, provide high quality care, and contain costs within the health care system.
- SNFs' capacity and access to care would be improved through:
  - Options to use virtual (vs. direct) observation in admissions assessments
  - Flexibility to build Primary Care Teams Led by APPs and coordinated across licensure types
  - Flexibility to meet Health Related Social Needs, such as nutrition support, to facilitate transitions from SNF to Lower-Acuity Care Settings (including home) (see slide 10)
  - Expanded grace period for licensure of entry level nursing workforce, building the local nursing pipeline

High-Level Feedback

- **Waivers around staffing and roles/responsibilities help mitigate the impacts of workforce shortages.** The workgroup expressed interest in maintaining these flexibilities and noted those available during the PHE were helpful. It was also noted that SNF eligibility should not be based on star ratings.

Other Stakeholder Engagement Activities

- **Department of Disabilities, Aging and Independent Living Advisory Board**
  - 16-member Board composed of advocates, service providers, persons with a disability, VT Legal Aid
  - February 9: Health Care Reform presented on All-Payer Model Extension and next steps
  - April 13: Health Care Reform Update Provided
- **Mental Health Integration Council**
  - Chaired by VDH Commissioner Levine and DMH Deputy Commissioner Krompf
  - 27-member Council composed of people who have received services and delivered peer services; family members; state officials; and representatives from the Office of Health Care Advocate, the Mental Health Care Ombudsman, various providers, and payers.
  - Health Care Reform participates in this group and will provide update at future meeting.
- **Meeting individually with Payers and preparing for Payer Advisory Group**

Next Steps: Upcoming Meetings

- **Medicare Waiver Technical Advisory Group**
  - TBD

- **Hospital Global Budget Technical Advisory Group**
  - 5/9 and 5/23 from 10 AM – 12 PM

- **Health Care Reform Work Group**
  - Monthly
  - Next Meeting = 5/22 from 1 PM – 2 PM