Total Cost of Care (TCOC) Subgroup #5

OCTOBER 25, 2022 MEETING SUMMARY

Meeting Agenda

1. Feedback heard from this TCOC subgroup so far
2. Discuss potential TCOC approaches to address the following key issues and features of Vermont:
   - Delivery system stability
   - Financial and regulatory barriers
3. Next steps

Reminder: Purpose of TCOC Subgroup

Vermont seeks to develop a list of concrete "asks" on TCOC to share with CMS to inform the design of the new state model.

- The State aims to provide as many different options/straw models as possible for CMS to consider while they design the TCOC component of the new state model.
- The goal of the TCOC subgroup is to identify any options/straw models that lack support and should *not* be raised with CMS during negotiations.
- The primary focus of this subgroup is on traditional Medicare per capita spending targets, which is within CMMI's authority and control.
- AHS and GMCB seek to collect feedback from subgroup members on TCOC to inform conversations with CMS.
- TCOC subgroup meetings will serve as a mechanism for AHS and GMCB to solicit input and gauge providers' reactions to potential straw models.

1. Feedback Heard from this TCOC Subgroup So Far

Recap of Feedback on Already Large Proportion of Payments within Vermont's Health Care System are Fixed

Option 1: Take out payments under global budgets and other forms of prospective payment from both Medicare and All-Payer per capita spending targets and measure only per capita spending that is not covered by these forms of payment (i.e., the remaining spend that is FFS).

Option 2: Still factor in global payments into per capita per spending targets, but weight them lighter in the methodology than remaining FFS payments.

Option 3: If there were bonuses/penalties tied to hitting target (unclear from CMS description), narrow risk corridor. For example, if 50% of the payments are fixed and 50% can vary, then it is twice as hard for any 1% increase or decrease in spending, since only half of the budget has to do all of the "work" to generate the savings.

General Feedback:

- The subgroup agreed that is it important to consider the range of services that remain in FFS and what incentives are set up with the application of spending targets to that set of services. One subgroup member noted that if the subset of services left in FFS correlate with preventative care it could have unintended consequences to apply downward pressure on spend.
- One subgroup member made the point that the proposed introduction of global budgets will mean that the global budget spend is based on care in Vermont whereas statewide spend targets will continue to be based on care to Vermonters, as today.

Recap of Feedback on Older and Aging State

Option 1: Request that Vermont is not asked to bend the curve in all-payer per capita spending.

Option 2: Request "credit" for achievements by having the ability to invest savings in health-related initiatives.

Option 3: Request "credit" for achievements by applying discounts to and/or risk adjusting PBPY actual spending.

General Feedback:

- The subgroup agreed that risk adjustment of spend targets makes sense. It will likely be harder to accomplish for All-Payer than Medicare but possible (e.g., Hopkins Grouper in APCD).
- If the design of the spending targets is a fixed starting point with a trend, it is more important to have risk adjustment; whereas if the spend targets are re-set each year, the age of the population is more naturally taken into account.
- Subgroup members raised that exogenous factors related to constraints on the delivery system can push up total cost of care being measured in the spend targets.

Recap of Feedback on Rural State

Option 1: Request to sustain or increase dollars in Blueprint and SASH programs "outside" of TCOC.

Option 2: Request "credit" for achievements by having the ability to invest savings in health-related initiatives.

Option 3: Request "credit" for achievements by applying discounts to PBPY actual spending.

General Feedback:

- The subgroup agreed that for CAHs, the exclusion of the cost-based reimbursement in total spend targets should continue.
- One subgroup member said that generally, we would want more, not less, care diverted to CAHs since they are local to rural communities. As raised in previous parts of the discussion, care should be taken that the spend targets do not unintentionally constrain appropriate and preventive care.

Subgroup Member Discussion on Recap of Topics

- One subgroup member raised the idea of potentially having a TCOC “floor” for services outside of the hospital global budget to incentivize shifting care to more community-based settings.
- Another subgroup member indicated concerns around the All-payer TCOC target since there is cost shifting to commercial payers. The Medicare TCOC target feels more manageable.

2. Continued Discussion of Vermont's Key Issues and Features informing TCOC

Today's Topics

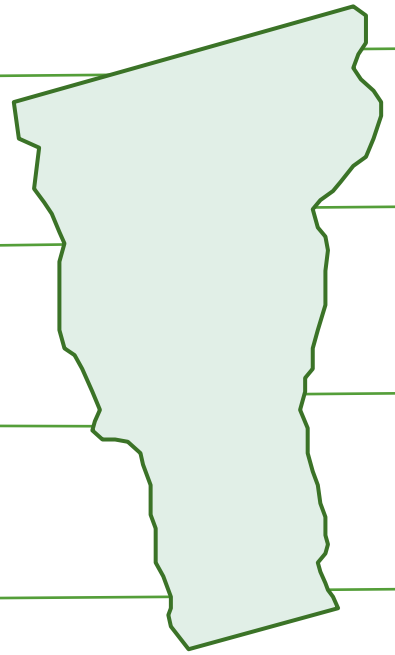
The main workgroup and this TCOC subgroup have identified the following features in Vermont that must be accounted for in a new model

1. Low spend state for Medicare

2. Significant patient movement across state lines

3. Evolving Medicare Advantage landscape

4. Already large proportion of fixed payment models



5. Older and aging state

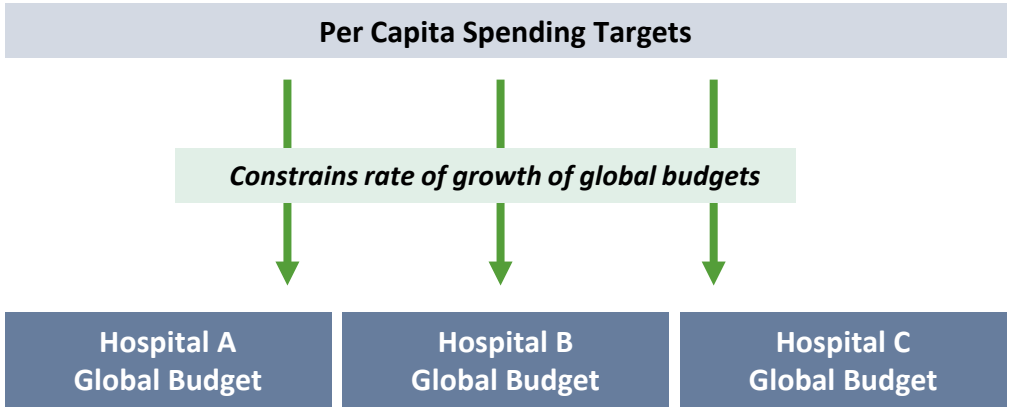
6. Rural/Critical Access Hospitals

7. Paramount need for delivery system stability

8. Financial and regulatory barriers

Note: Some of these issues/features are not unique to Vermont (e.g., rural state), but are particularly salient to our State.

#7: Paramount Need for Delivery System Stability (1 of 2)



Operating Margins of Vermont Hospitals

Operating Margin (%)	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022 Proj.
Brattleboro	(3.1%)	(2.4%)	0.8%	0.6%	(1.7%)	(3.5%)
Central VT	(0.9%)	(3.8%)	(2.1%)	(0.6%)	(1.0%)	(5.0%)
Copley	(0.6%)	(3.3%)	(3.2%)	(3.9%)	5.1%	(2.0%)
Gifford	(1.6%)	(10.7%)	(0.8%)	2.5%	8.8%	8.2%
Grace Cottage	(6.9%)	(2.9%)	(6.7%)	1.1%	8.0%	(3.1%)
Mt. Ascutney	2.7%	1.9%	(0.1%)	0.9%	9.1%	1.0%
North Country	(2.3%)	(2.3%)	1.9%	3.7%	4.6%	(1.2%)
Northeastern VT	1.9%	1.7%	1.8%	1.3%	2.9%	(1.4%)
Northwestern	(1.2%)	(3.4%)	(8.0%)	(0.9%)	4.7%	(1.0%)
Porter	2.7%	1.8%	5.2%	4.1%	7.7%	3.1%
Rutland	1.6%	0.5%	0.4%	0.2%	2.2%	(3.8%)
Southwestern VT	3.7%	4.6%	3.3%	2.8%	4.5%	(0.5%)
Springfield	(7.1%)	(12.8%)	(18.4%)	(11.2%)	1.2%	0.5%
University of VT	5.2%	3.4%	2.2%	(0.3%)	2.3%	(2.5%)
TOTAL	2.7%	1.1%	0.7%	0.1%	2.8%	(2.1%)
MEDIAN	(0.7%)	(2.3%)	0.2%	0.8%	4.5%	(1.3%)

Current State

- The issue of provider stability should primarily be addressed through the global budget design, rather than the spend target design. However, the two are intertwined.
- Both all-payer and Medicare per capita spending targets constrains the rate of growth of global budgets.
- A recurring theme from stakeholders is that per capita spending targets and global budgets need to account for the impact of COVID, inflation, and workforce shortages on provider stability. To note, some providers noted that their financial positions have been eroding prior to COVID.
- Data shows that systemwide margins declined 2.8 percentage points from FY19 to FY22. For Days Cash on Hand (DCOH), from FY18 to FY22, CAHS improved by 20% (127 to 153) and PPS decreased by 19% (176 to 143).

#7: Paramount Need for Delivery System Stability (2 of 2)

Options for Consideration

1. **Ensure that Vermont has adequate investment through the Medicare program by:**
   - Requiring Vermont to keep absolute PBPY Traditional Medicare costs below the national average or hold the % by which Vermont is below national PBPY steady, but no obligation to further bend the cost curve.
   - Allowing Vermont to capture back a portion of gap between Vermont's per capita Medicare spend and national per capita Medicare spend for reinvestment in health system.
   - Requesting higher rates in Traditional Medicare as part of the global budget (similar to Maryland) to offset pressure on commercial rates (low likelihood but high impact).
2. **Maintain Medicare funding for successful programming included in current All-Payer ACO Model (Blueprint/SASH)**
3. **Ensure that the methodology for distributing any new statewide Medicare investments within Vermont enables targeting of funds to providers facing the most challenging economic conditions.**
4. **Ensure that moving to a more fixed payment methodology for hospital stability via global budgets does not hurt Vermont's performance on total spend targets, by:**
   - Taking out payments under global budgets and other forms of prospective payment from both Medicare and All-Payer per capita spending targets and measure only per capita spending that is not covered by these forms of payment (i.e., the remaining spend that is FFS).
   - Still factoring in global payments into per capita per spending targets, but weight them lighter in the methodology than remaining FFS payments.
   - If there were bonuses/penalties tied to hitting target (unclear from CMS description), narrowing risk corridor.

Already discussed in context of low spend state

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Subgroup Member Discussion on Need for Delivery System Stability

- The subgroup raised whether TCOC targets are appropriate given that the State's health care system is experiencing financial pressures.
  - Vermont acknowledged the subgroup's position and noted that CMS will likely continue requiring TCOC targets as part of the future model. However, the State indicated they can highlight options (e.g., adjustments, exclusions) to mitigate the potential consequences of TCOC targets applying downward pressure on the health care system.
- Another subgroup member noted that TCOC targets can encourage care to shift to other settings, however, it will take time for these changes to occur due to workforce shortages.

#8: Financial and Regulatory Barriers (1 of 3)

This group has already discussed the continued or expanded need for financial and regulatory flexibilities that ensure people can get the right care at the right place at the right time, reducing overall health care spending and lessening pressure on per capita spending targets.

Potential Additional Flexibilities	Detail/Discussion
1. Physician self-referral law and Federal anti-kickback statutes	Waived in current APM for purposes of shared savings distribution.
2. Patient Engagement Incentives	Certain provisions are waived in current APM for the purposes of patient engagement in the ACO.
3. Telehealth Flexibilities	Current APM has waivers of originating site requirements and waiver of interactive telecommunications system requirement with respect to teledermatology and teleophthalmology services.
4. Waiver of physician "incident to" requirements for the purposes of care management	Current APM has waiver that increases the availability of in-home care to beneficiaries determined by the ACO to be at risk of hospitalization to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions.
5. SNF 3 Day Rule	Current APM waives requirement for a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended-care service for eligible beneficiaries.
6. Other SNF flexibilities: Physician delegation of Tasks; Personal physician visits; telehealth flexibilities	Waived in current APM for access to appropriate care as well as health and safety of SNF residents.

= Flexibility granted during PHE that has expired or will expire at the end of the PHE. The State may consider requesting these flexibilities to be renewed.

#8: Financial and Regulatory Barriers (2 of 3)

Potential Additions for Feedback

Potential Additional Flexibilities	Detail/Discussion
1. Expanded Medicare reimbursement for Licensed Alcohol and Drug Counselors, Licensed Clinical Mental Health Counselors, Licensed Psychologists, Licensed Psychiatric Nurses, and Licensed Marriage and Family Counselors	Current Medicare restriction of credentialing to only LICSWs and PhD Psychologists limits access to care for Medicare beneficiaries.
2. Flexibility to provide skilled nursing services to select individuals who do not meet Medicare criteria for skilled home health but for whom additional nursing services could prevent ED visits or hospitalizations	Would allow alignment with Vermont Medicaid flexibility, allowing visits for individuals who do not meet the "homebound" criteria and some aide visits for individuals who do not have a "skilled" need.
3. Hospice (potential waiver)	Would expand palliative services offered through the Medicare home health benefit; would allow alignment with the Medicaid children's benefit, which includes holistic hospice services (care planning, pain management, goal setting for treatment, spiritual counseling, bereavement and grief counseling for family) without regard to a doctor determining an individual has 6 months to live and without requiring individuals to give up on curative treatment to receive the other benefits.
4. Temporary Nurse Aide (potential waiver)	Would make permanent the waiver that allowed (during PHE) SNFs to use non-licensed aides following adequate training.

= Flexibility granted during PHE that has expired or will expire at the end of the PHE. The State may consider requesting these flexibilities to be renewed.

#8: Financial and Regulatory Barriers (3 of 3)

Potential Additions for Feedback (cont'd)

Potential Additional Flexibilities	Detail/Discussion
5. Allow SNFs to bill Medicare directly for physician services provided by locum physicians	If the SNF (rather than the physician/practice) had the ability to bill, they could engage in flat fee contracts with the physician/practice and recoup Medicare dollars to cover the costs.
6. Expanded Telehealth Flexibilities	E.g., (from CHART model) – allowing Medicare providers to engage with non-established patients by telehealth. **Other?**
7. Waiver of certain Medicare Hospital and/or CAH Conditions of Participation (CoPs)	As already allowed in CHART model, Waivers of Medicare CoPs could allow Participant Hospitals to make certain changes to their facility structure and maintain their hospital or CAH status for the purpose of Medicare enrollment and certification, Medicare hospital quality reporting, and in order to receive payments under the capitated payment arrangement.
8. 96 Hour Certification Rule	As already allowed in CHART model, this would waive the condition of payment for inpatient CAH services that a physician must certify that a patient is expected to be discharged or transferred to another hospital within 96 hours.

Subgroup Member Discussion on Financial and Regulatory Barriers

- The subgroup noted that flexibilities around telehealth and SNFs are extremely valuable.
- Several members noted that the waiver of physician “incident to” requirements for the purposes of care management is difficult to implement due to issues around billing and contracting.
- The group agreed that these Medicare waivers are very helpful and would appreciate the opportunity to discuss these in greater detail.

3. Next Steps

Next Steps

- The TCOC subgroup meetings have concluded. We appreciate your feedback on the per capita spending targets. This will inform our negotiations with CMMI.
- The subgroup is welcome to rejoin the Health Care Reform workgroup. Meeting dates and topics are pending but will be communicated via email.
- Please reach out to Ena Backus (Ena.Backus@vermont.gov) and Wendy Trafton (Wendy.Trafton@vermont.gov) with any questions.