Health Care Reform Work Group

December 11, 2023

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Today's Agenda (and future meetings if needed)

1. Overview of 2025 Medicare Waiver Opportunities
2. Continue discussion of AHEAD Model Notice of Funding Opportunity (NOFO):
   - Summary of feedback from November 27 meeting discussion on Statewide and Provider-Level Accountability Targets
   - Hospital Global Payments *(Slides 20-26)*
   - Primary Care AHEAD *(Slides 27-34)*
   - Model Governance Structure and Health Equity *(Slides 35-38)*
   - Cooperative Agreement Funding *(Slides 39-41)*
   - Medicaid and Commercial Payer Alignment *(Slides 42-44)*
   - Statewide Data/Health Information Technology Infrastructure *(Slides 45-47)*

Meeting Goals

- Summarize key information from the Center for Medicare & Medicaid Innovation (CMMI):
  - Medicare Waivers for 2025
  - NOFO for the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
- Continue to obtain input and address questions about the AHEAD Model
- Identify immediate next steps, including continued engagement

Additional Medicare Waiver Flexibilities Could be Available in a 2025 Extension Period, Depending on Provider Interest

Waiver Name	Description
Home Health Homebound Waiver (as it exists in ACO Reach)	▪ Waive the requirements that a beneficiary must be confined to the home or in an institution that is not a hospital, SNF, or nursing facility to qualify for Medicare coverage of home health services. ▪ Waive the requirement that the certification for home health services include a certification that such services are or were required because the individual is or was confined to their home.
Concurrent Care for Hospice Beneficiaries Waiver (as it exists in ACO Reach)	▪ Waive the requirement to forgo curative care as a condition of electing the hospice benefit thereby allowing a beneficiary to receive such care with respect to their terminal illness (“Concurrent Care”).
96 Hour Certification Rule (as it was contemplated under CHART)	▪ Waive the requirement that a physician must certify patients will be reasonably discharged or transferred to another hospital within 96 hours.
Expanded Telehealth Benefit Enhancement (Currently extended through the end of CY24)	▪ Waive the requirement that telehealth services must be furnished at an originating site and waive the originating site facility fee. ▪ Allow the use of audio-only equipment (waive ‘interactive telecommunication system requirement) to furnish services described by the codes for audio-only telephone evaluation and management services, and mental health and substance user disorder counseling and educational services. ▪ Allow CMS to expand the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services.

Summary of November 27 Meeting: Statewide and Provider-Level Accountability Targets

The following information was presented at the November 27 meeting:

- An overview of the AHEAD model *(Slides 7 and 8)*
- The model timeline, including NOFO release date and deadline for states to apply *(Slide 9)*
- Information on Statewide and Provider-Level Accountability Targets, including required elements inn a NOFO response *(Slides 10-19)*

Work Group member questions and feedback:

- Clarify what is meant by "states will be subject to reporting requirements….where feasible" and Medicare Fee-for-Service (FFS). *Clarified that Medicare FFS refers to traditional Medicare members vs. Medicare Advantage members.*
- There may not be direct changes in provider payments based on statewide results, but there may be an impact on payment levels if statewide targets aren't met.
- Have more discussion on statewide quality measures and how they are used – are they solely to comply with model requirements or are they replacing other measures (e.g., Blueprint, OneCare, etc.). What entity will collect data and communicate results to providers?

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Summary of November 27 Meeting (cont'd)

Work Group member questions and feedback (cont'd):

- Discussions about opportunities/adjusting for avoidable utilization (effectiveness) must consider what needs to happen across the ecosystem to ensure capacity for long-term care, home health, and mental health and substance use disorder treatment. Evaluating whether the model works requires looking at the entire delivery system.
- Do we include broader care delivery needs in the base before making adjustments, or does addressing system capacity happen in parallel? Important to know what we want to negotiate. What is the State role on access to care (e.g., access in rural communities)?
- Does Vermont want to anchor its financial accountability model on what CMMI proposes or do we want to propose a state-designed methodology?
- Important to also focus on system sustainability, although not explicitly outlined in federal goals.

Overview and Goals of AHEAD

From NOFO: "The AHEAD Model is a voluntary, state-based alternative payment and service delivery model designed to ***curb health care cost growth, improve population health, and advance health equity by reducing disparities in health outcomes***. The AHEAD Model will test a flexible framework that includes statewide or sub-state accountability targets for all-payer and Medicare fee-for-service cost growth, primary care investment, and equity and population health outcomes. The Model will include specific components to help each award recipient to achieve these goals, including an initial investment via the Cooperative Agreement award to support planning and implementation activities, Medicare fee-for-service and Medicaid hospital global budgets for participating hospitals, and a primary care program for participating primary care practices." *(Emphasis added)*

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

8-9 Performance Years

Components

- Cooperative Agreement Funding
- Hospital Global Budgets (facility services)
- Primary Care AHEAD

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

In lieu of "Behavioral Health", VT uses the term "Mental Health and Substance Use Disorder Treatment"

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

AHEAD Model Information and Timeline

https://innovation.cms.gov/innovation-models/ahead

Timeline:

Notice of Funding Opportunity Publication: ***November 16, 2023***

Letter of Intent (LOI) to Apply Due Date (encouraged but not required): ***February 5, 2024***

Deadline for State Applications for Cohorts 1 and 2: ***March 18, 2024***

		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Model Year			MY1	MY2	MY3	MY4	MY5	MY6	MY7	MY8	MY9	MY10	MY11
1st NOFO Period	Cohort 1	NOFO	Pre- Implementation (18 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9
	Cohort 2		Pre-Implementation (30 mos)			PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
2nd NOFO Period	Cohort 3		NOFO	Pre-Implementation (24 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8

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Key Components of AHEAD Model

- Statewide and Provider-Level Accountability Targets
- Hospital Global Payments
- Primary Care AHEAD
- Cooperative Agreement Funding
- Model Governance Structure
- Health Equity
- Medicaid and Commercial Payer Alignment
- Statewide Data/Health IT Infrastructure

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Framework for Evaluation and Measurement

Federal-State Agreement: Accountability Targets

- Statewide quality and equity targets
- Limited number of measures (6)
- Statewide all-payer TCOC and primary care investment targets
- Hospital and payer participation targets
- State flexibility for some elements, but limited

Hospital-Level Payment Model Measures

- Quality performance adjustment based on CMS national quality programs or similar categories of quality measures
- Health equity improvement bonus for performance on select health equity-focused measures.
- Total Cost of Care performance adjustment for a defined population
- Effectiveness adjustment to incentivize reduction in unnecessary utilization

Primary Care Measures

- Limited number of measures; CMS will require 5 measures
- Performance will be used to adjust Enhanced Primary Care Payments
- States may have some flexibility in measure selection

Ensuring alignment across these components will help to align incentives and limit administrative burden.

AHEAD Quality Strategy

From NOFO:

"The overall Model quality strategy includes three sets of quality measures, each with a health equity focus:

1. Statewide measures
2. Primary Care measures
3. Hospital quality programs"

Four domains with corresponding goals:

Domain Area	Goals
Prevention & Wellness	Increase equitable access to preventive services
Population Health	Improve chronic conditions by focusing on health care transformation efforts at the community level Achieve high-quality, whole-person, equitable care across different population groups.
Mental Health & Substance Use Disorder	Improve outcomes in alignment with unique needs of state initiatives.
Health Care Quality & Utilization	Reduce avoidable admissions and readmissions Improve patient experience and delivery of whole-person care

NOFO Requirements: Statewide Accountability Targets for Quality and Equity (1 of 2)

States are accountable for performance and improvement on a set of **at least six population-level measures.**

States will be subject to **reporting requirements**, including **baseline and at least annual updates** for each selected measure on a Medicare FFS and all-payer basis where feasible.

Each reported measure must be **stratified by data** including race, ethnicity, dual status, and geography where statistically feasible, with additional factors relevant to equity recommended.

States will be required to **monitor performance on addressing disparities** identified at baseline over the course of the Model.

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Statewide Accountability Targets (2 of 2)

Core Statewide Measures

Domain	Measure
Pop. Health	CDC Health-Related Quality of Life-4 (Healthy Days Core Module)
Prevention & Wellness	Colorectal Cancer Screening
	Breast Cancer Screening: Mammography
Chronic Conditions	Controlling High Blood Pressure
	Hemoglobin A1c Control for Patients with Diabetes
Behavioral Health	Use of Pharmacotherapy for Opioid Use
	Antidepressant Medication Management
	Follow-Up After Hospitalization for Mental Illness
	Follow-up after ED Visit for Substance Use
Quality/Utilization	Plan All-Cause Unplanned Readmission

Statewide Optional Measures

Domain	Measure
Maternal Health Outcomes	Live Births Weighing Less than 2500 grams
	Prenatal and Postpartum Care: Postpartum Care
Prevention Measures	Adult Immunization Status
	Prevalence of Obesity
	Medical Assistance with Smoking and Tobacco Use Cessation
	ED Visits for Alcohol and Substance Use Disorders
Social Drivers of Health	Food Insecurity
	Housing Insecurity

NOFO Application Requirements: Statewide Accountability Targets

Applicants must:

- Describe strategy to measure statewide total cost of care (TCOC) and primary care investment across payers over time, including current TCOC and primary care spend on an all-payer basis.
- Describe current or planned efforts to include all-payer TCOC and primary care investment targets in state executive order, statute, and/or regulation, and any mechanisms for enforcement of such targets.
- Describe applicant's ability to obtain TCOC and primary care spending information for each year from commercial payers and Medicaid.
- Describe anticipated policy levers to increase primary care spending by commercial payers and Medicaid.
- Describe regulatory and policy levers the applicant intends to use to achieve or enforce TCOC cost growth targets across payers.
- Identify known gaps in the state or sub-state region's TCOC and primary care spending reporting.

NOFO Requirements: Hospital Payment Model Measures for Quality

PPS Hospitals	Critical Access Hospitals
Participating PPS hospitals will be **accountable for performance in the following national hospital programs** via budget adjustments: • Hospital Inpatient Quality Reporting, • Hospital Outpatient Quality Reporting • Hospital Value-Based Purchasing Program • Hospital Readmissions Reduction Program • Hospital-Acquired Condition Reduction Program • Medicare Promoting Interoperability Program. State-designed methodologies may base the quality adjustment on similar categories of quality measures, **but hospital performance must achieve or surpass the measured results** in terms of patient outcomes and cost savings as the CMS national hospital quality programs.	Participating **CAHs will receive upside-only quality adjustment** based on scoring in a CAH specific quality program, which will begin as pay-for-reporting and advance to pay-for-performance. NOFO provides a CAH measure set, which aligns with existing measures used to assess rural health care quality.

NOFO Requirements: Additional Adjustments for Hospital Performance

PPS Hospitals	Critical Access Hospitals

• Health equity improvement bonus for performance on health equity-focused measures beginning in PY2
  • Degree of adjustment is based on performance
  • Selected measures must include sufficient data to identify disparities and changes in such disparities.
• TCOC performance adjustment
  • Begins as upward only for PY4, then upward and downward starting PY5
  • CMS methodology includes geographic assignment, but state-designed methodology may utilize a different approach to assign beneficiaries to hospitals for these purposes
• Effectiveness adjustment based on portion of potentially avoidable utilization for downward adjustments
  • State-designed methodology must incentivize reduction in unnecessary utilization
	• Health equity improvement bonus (same as for PPS hospitals).
	• TCOC performance adjustment will begin as upward-only for PY4 and PY5, and change to upward and downward starting in PY6
	• Effectiveness adjustment will begin being applied one PY later (adjustments starting in PY3)

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NOFO Requirements: Primary Care Measure Set

CMS will require 5 measures. “Should an award recipient wish to propose an alternative measure to align with other ongoing state efforts, CMS will consider potential measure replacements, so long as the alternative measure aligns to a domain below or to Model goals broadly.”

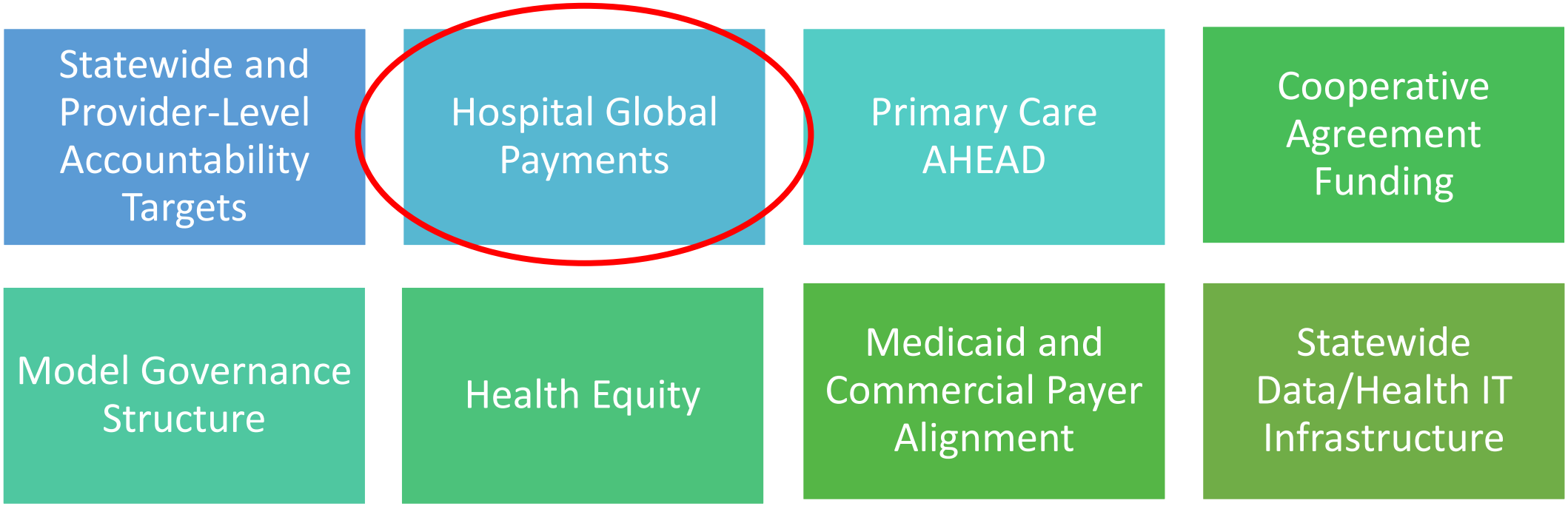
Domain	Measure
Prevention & Wellness (choose at least one)	Colorectal Cancer Screening
	Breast Cancer Screening: Mammography
Chronic Conditions (choose at least one)	Controlling High Blood Pressure
	Hemoglobin A1c Poor Control (>9%) for Patients with Diabetes
Mental Health & Substance Use Disorder (measure required)	Screening for Depression and Follow-Up Plan
Health Care Utilization (both measures required)	Emergency Department Utilization
	Acute Hospital Utilization

Statewide and Provider-Level Accountability Targets

Immediate Next Steps:

- Summarize current data collection, reporting, and accountability regarding TCOC and primary care spending, and identify known gaps in reporting
- Summarize potential policy and regulatory levers to increase primary care spending and meet TCOC growth targets
- Outline timeline for establishing statewide and provider-level quality measures/programs, and corresponding engagement strategy (including current work groups)
- Other?

Key Components of AHEAD Model



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What is a Hospital Global Budget under AHEAD?

AHEAD HOSPITAL GLOBAL BUDGET

In the AHEAD Model, hospital global budgets are built "bottom up" from past net patient revenue within the facility (inpatient and outpatient), including hospital outpatient departments.

This historic baseline will be fixed for the duration of the model with annual adjustments for inflation, demographic changes, and service line changes for each Performance Year.

The AHEAD Model aims to support hospitals in transforming care delivery and shifting utilization to primary care and community-based settings, where appropriate, through the incentives and flexibilities of hospital global budgets.

Incentives for Hospital Participation

- Initial investment to support hospital transformation in early years of the model
- Increased hospital financial stability and predictability when revenue is decoupled from FFS
- Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery
- Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community
- Potential use of waivers to support care delivery transformation and engage non-hospital providers in transformation
- Opportunity to participate in learning opportunities to facilitate success under global budgets

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Hospital Global Payments in AHEAD: Highlights

CMS AHEAD Hospital Global Budget Methodology

Hospital global budgets will be prospective, predetermined amounts for inpatient and outpatient hospital services, based on historical spend with annual updates for population changes and inflation.

Payments will be adjusted for social risk and quality, with bonus for health equity improvement. Transformation Incentive Adjustment in first two performance years to support investments in enhanced care coordination.

Adjustments for total cost of care (for traditional Medicare members in the hospital service area) and for effectiveness (related to avoidable utilization).

"Participating states with statewide rate setting or hospital global budget authority and experience in value-based care can develop their own hospital global budget methodology. CMS will provide alignment expectations for state-designed methodologies…and will need to review and approve…"

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CMMI Criteria for State-Proposed Methodology

The state-designed hospital global payment program must:

- Establish annual global payments for hospitals that move away from volume-based reimbursement and incentivize a reduction in unnecessary hospital utilization.
- Include facility services in hospital inpatient, outpatient, and emergency departments, at minimum.
- Allow participation from short-term acute care hospitals and critical access hospitals (CAHs), at a minimum.
- Include a Total Cost of Care performance adjustment, quality adjustments tied to the CMS hospital quality programs or similar metrics proposed by the state, and equity adjustments.
- Provide incentives to recruit and retain hospitals early into the model, such as an upward adjustment, similar to CMS's Transformation Incentive Adjustment (1% increase in Y1 & Y2).
- Adjust for both medical and social risk.
- Account for population growth, demographic changes, and other factors influencing the cost of hospital care.
- Account for changes in service lines, inflation, and other typical annual shifts.
- The state may propose risk mitigation or other modifications for CAHs, but payments may not be fully reconciled back to costs or FFS.

NOFO Application Requirements: Hospital Global Payment Methodology Development

Applicants must:

- Indicate whether the state intends to develop a state-specific Medicare FFS hospital global budget methodology (subject to CMS approval) or use the CMS-designed methodology.
- Describe capacity to develop Medicaid hospital global budget methodology in accordance with the timeline and requirements set forth in the NOFO (e.g., implement prior to or during PY1)
- [Relating to Medicaid methodology] Include a proposed approach for developing methodology and engaging hospitals on the methodology prior to the start of PY1. Include the applicant's proposed regulatory pathway for the change in payment methodology. The proposed timeline should include:
  - The proposed pathway that offers the most streamlined regulatory approach in the context of the applicant's Medicaid program structure
  - Necessary steps and associated timelines
  - Description of plan for engagement with interested parties.

NOFO Application Requirements: Hospital Recruitment Plan

Applicants must:

- Provide detailed plan for recruitment of hospitals to participate in hospital global budgets (e.g., regulatory levers and strategies the state will use to meet hospital recruitment requirements).
- Summarize communications (e.g., conversations, outreach, etc.) with hospitals to-date, including the number of hospitals they aim to recruit, and hospital experience with hospital global budgets or other value-based payment models in their state or designated sub-state region, if applicable.
- Provide a timeline for hospital recruitment, including specific recruitment goals, strategy for engaging rural hospitals and safety net hospitals, and contingency plan if recruitment goals are not met during pre-implementation.
- At least one LOI from a hospital is **required** for the application. An LOI from a hospital is not binding.

Hospital Global Payments

Immediate Next Steps:

- Continue engagement with Hospital Global Budget Technical Advisory Group to develop potential state-designed methodology
- Continue developing straw model for hospital review and consideration
- Decide whether to propose state-designed methodology
- Summarize progress on Medicaid global payments program
- Other?

Summary of Work Group Input

- Work group members asked when CMS would release their Medicare hospital global payment methodology, and whether VT could start with the CMS version and then move to a VT-specific methodology. There is concern about CMS' ability to implement state-designed methodologies, given historical experience. AHS and GMCB indicated that they think VT could start with CMS methodology and then transition to VT-designed. It appears that the state-designed methodology requires the state to run numbers and provide them to Medicare. CMS would review and approve the methodology and suppress FFS claims. It is important to consider what should vary from Medicare and what shouldn't. State has heard consensus about including professional services in the future; area of risk because it is very different from CMS methodology. Timing for submitting the state-specific methodology is expected to be June 30, 2024 for Cohort 1 states; CMS needs 18 months for review, approval and system changes..

- A work group member asked what Vermont needs for sustainability and care transformation. How do we negotiate for what we really need re: Long-Term Care, Mental Health and Substance Use Disorder treatment, and Emergency Medical Services? Appendix 7 in NOFO indicates that Critical Access Hospitals (CAH) would have to give up cost-based reimbursement. CAHs have cost structures that can change dramatically and because of that they currently have a cost-based true-up settlement. GMCB and AHS observed that there are hospital incentive payments in AHEAD. There are potential pros and cons; if true-up indicated that CAHs had to repay funds under cost-based reimbursement, those participating in AHEAD would not have to do so.

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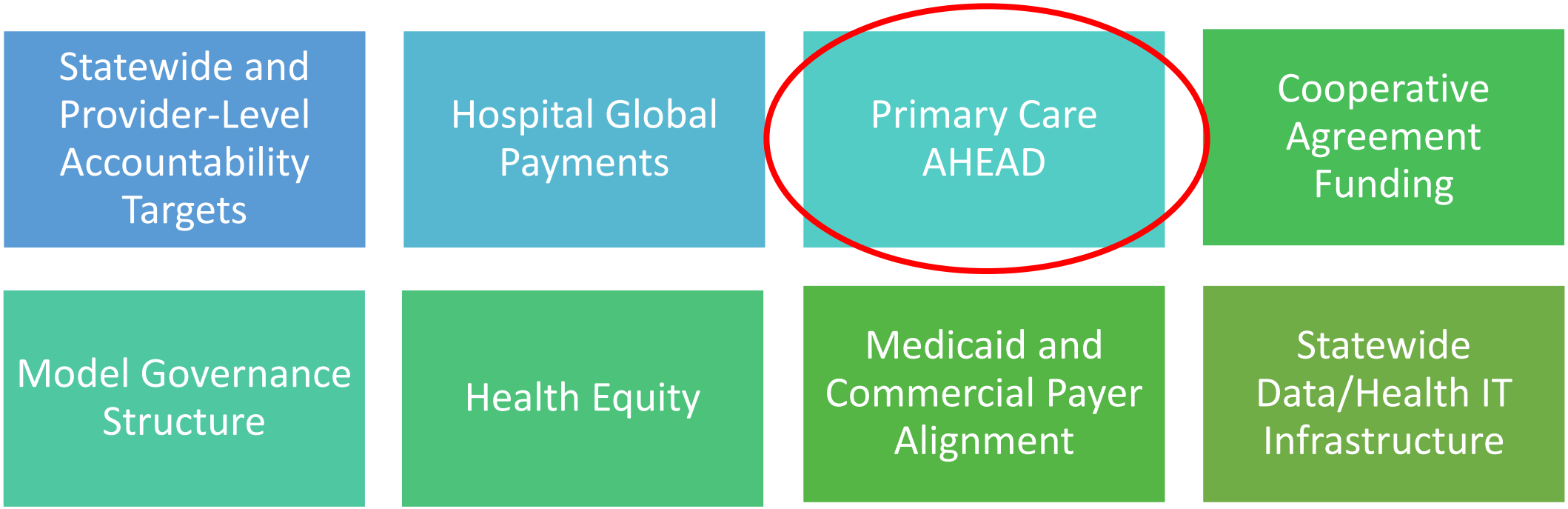
Summary of Work Group Input (cont'd)

- A work group member asked if VT uses a state-designed methodology, what other deviations would there be? The first bullet on Slide 22 gives a lot of pause. Prospective payment model from Medicare may fall short. The NOFO lacks specificity for CAH and Medicare dependent hospitals.
- A work group member suggested that VT run 2 models – what NOFO says and what VT's needs are – and assess how closely they align. This is a 10-year model; there is a very tight timeline for the state to evaluate and decide. How do we evaluate if this is good for Vermonters? GMCB responded that its contractor can compare CMS methodology when it is provided with the VT-designed straw model developed with Hospital Global Budget Technical Advisory Group and being modeled for VT hospitals. Then these can be modeled against FFS. Can't currently add more layers to the modeling given time and resources but could consider for later if resources allow.
- A work group member asked whether the state needs hospitals to show support for the model for the March application deadline or by June 30? AHS clarified that a non-binding letter of intent is needed from at least one hospital for the March application. The member replied that it will be hard to submit a letter of intent unless hospitals understand more about the details and see numbers. They believe in health care reform but also have a fiduciary responsibility.

Key Components of AHEAD Model



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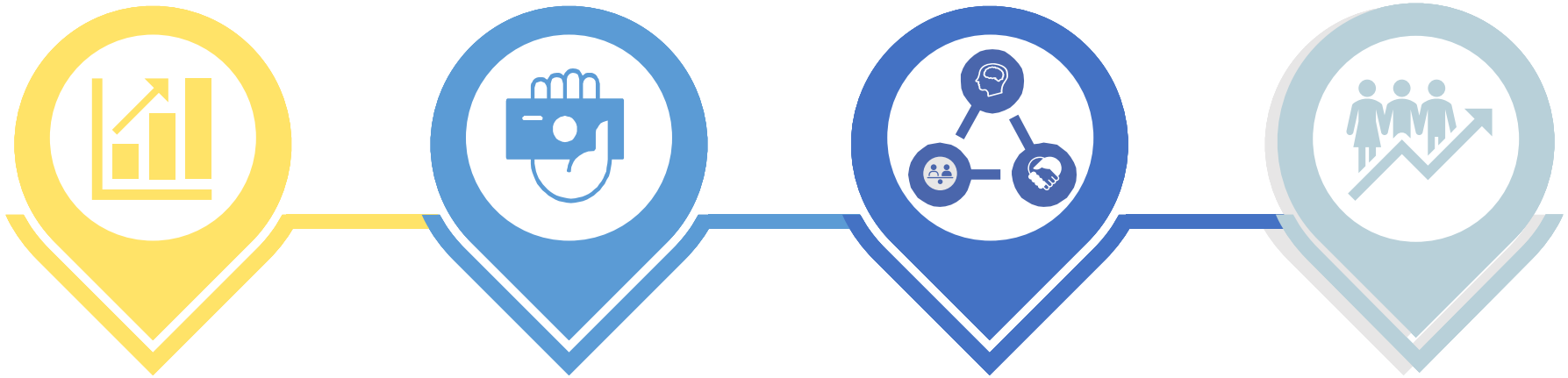
Primary Care AHEAD Goals

Primary Care AHEAD is flexible to align with each state's Medicaid primary care goals and will bring Medicare to the table for increased investment and care transformation initiatives.



Increase Primary Care Investment

Increase primary care investment statewide as a percent of the total cost of care

Align Payers

Bring Medicare to the table for state-led primary care transformation, with a focus on Medicaid alignment

Support Advanced Primary Care

Advance behavioral health integration, care coordination, and HRSN-related activities for primary care delivery

Broaden Participation

Facilitate successful participation by small practices, Federally Qualified Health Centers, and Rural Health Clinics

CMMI has committed to introducing primary care tracks with additional risk/capitation in the future. Any future Primary Care AHEAD tracks will align with these program goals.

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Eligibility Criteria – Primary Care Practices

Primary care practices may participate voluntarily in the Primary Care AHEAD program to receive a Medicare Enhanced Primary Care Payment and support corresponding care transformation.

Primary Care Practices

Primary Care Practices

- Primary care practices, FQHCs, and RHCs that are located within a participant state or sub-state region and are participating in the state's Medicaid Primary Care Alternative Payment Model (APM).
  - The state's Medicaid Primary Care APM could support a Patient-Centered Medical Home program, health home, or similar care coordination program.
- Hospital-owned practices will only be eligible to participate in Primary Care AHEAD if the affiliated hospital is participating in AHEAD hospital global budgets for that performance year with an exception for FQHCs/RHCs.

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Primary Care AHEAD: Enhanced Primary Care Payment

Primary Care AHEAD participants will receive an Enhanced Primary Care Payment (EPCP) to facilitate Medicare FFS investment in advanced primary care and enhanced care management.

Payment

- Participating practices will receive **an average $17 PBPM* for attributed beneficiaries**, paid quarterly.
- A small portion of this payment (initially 5%, scaled up to 10%) is **at risk for quality performance**.

Requirements

- Participating practices must participate in the state's Medicaid Patient-Centered Medical Homes or other primary care alternative payment model.
- Practices must meet specific Care Transformation Requirements, which will be aligned across Medicaid and Medicare.

Potential Uses

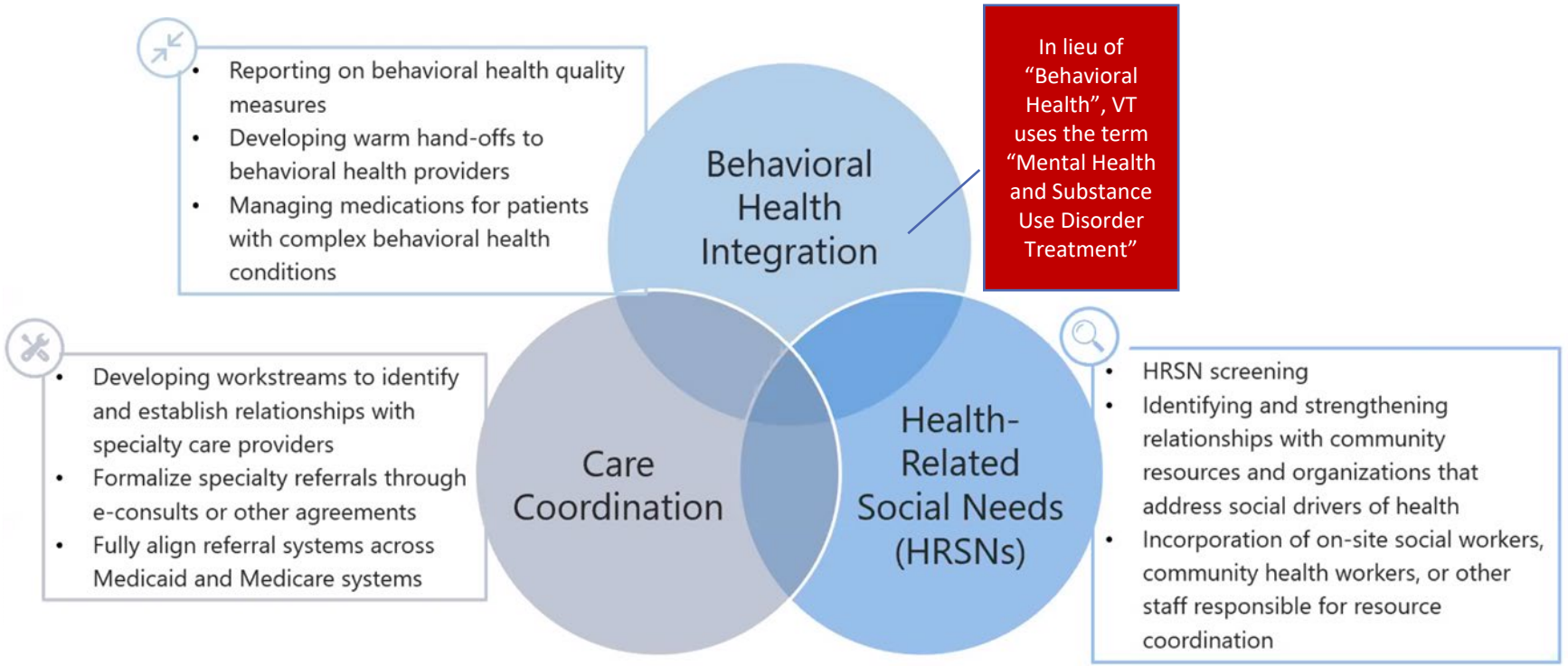
Practices may use the EPCP to invest in infrastructure and staffing to perform advanced primary care (e.g., care coordinators, behavioral health staff, or community health workers).

**A state may earn a higher (max $21) or lower (floor $15) PBPM based on hospital recruitment or state TCOC performance.*

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Primary Care AHEAD: Care Transformation Requirements

Primary Care AHEAD will include care transformation requirements for person-centered care. They are intended to align with the state's existing Medicaid care transformation efforts.



Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

NOFO Application Requirements: Vision for Primary Care Transformation

Applicants must:

- Describe current Medicaid initiatives underway in primary care, especially related to MH/SUD integration, health-related social needs, care management, and specialty care coordination.
- Describe tool(s) that will be leveraged to increase investment in primary care in the Medicaid space.
- Describe tools for increasing access to primary care services; existing Medicaid Primary Care APMs, including current participation of FQHCs and RHCs; and how Primary Care AHEAD might align with these existing efforts in the state.

NOFO Application Requirements: Primary Care Practice Recruitment Plan

Applicants must:

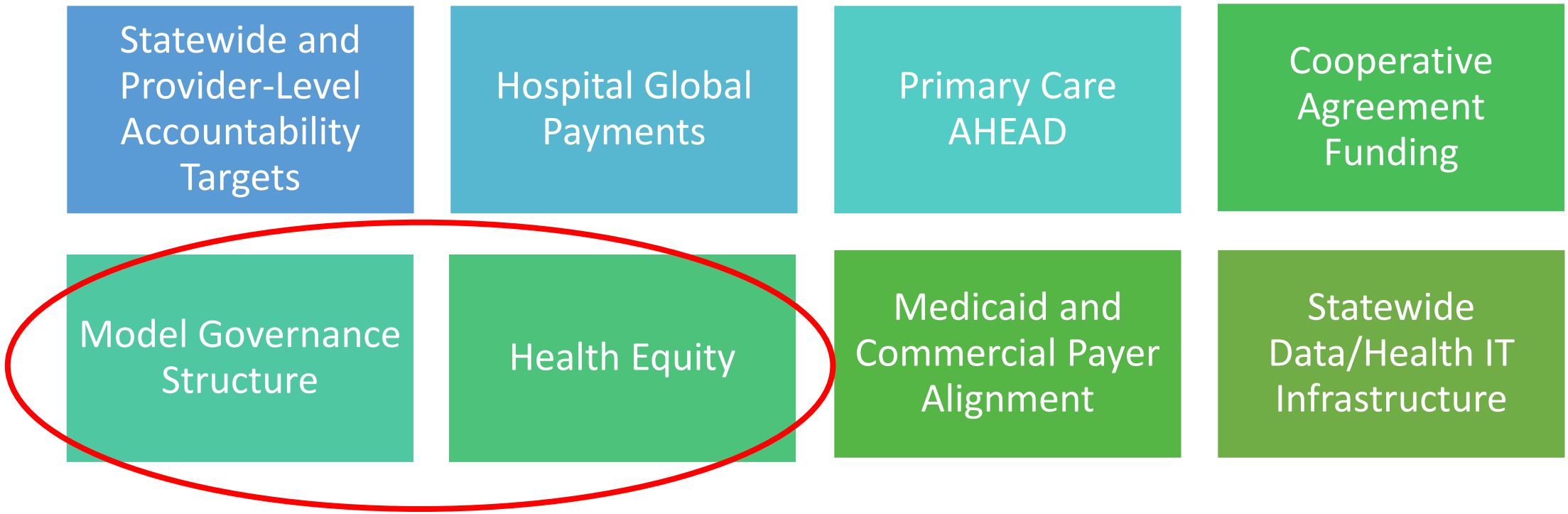
- Provide a detailed plan for recruitment of primary care practices for participation in Primary Care AHEAD (e.g., how the applicant will identify practices participating in state Medicaid primary care value-based payment arrangements and conduct recruitment outreach to those providers).
- Include description of the types of practices currently participating in the state's Medicaid Primary Care APM, including identification of gaps in current participation and plans to address those gaps under Primary Care AHEAD.

Primary Care AHEAD

Immediate Next Steps:

- Continue engagement with Primary Care Work Group on components of Primary Care AHEAD
- Create crosswalk of Blueprint for Health program with AHEAD requirements, including elements of the program that address health-related social needs, mental health and substance use disorder treatment integration, care management, and specialty care coordination
- Other?

Key Components of AHEAD Model



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Model Governance Structure

Each participating state will establish a multi-sector model governance structure. This body must have a **formal role** in model implementation, which could be advisory. States can build on pre-existing workgroups or boards to meet this requirement.

Governance Representation

Required:

- Patients and/or advocacy organizations
- Community-based organizations
- Payers (including commercial, Medicaid managed care, and Medicare Advantage)
- Provider organizations, including hospitals, primary care, FQHCs, and behavioral health
- Local tribal communities (where applicable)
- State Medicaid Agencies
- State and Territorial Public Health Agencies

Optional: State cost commissions, divisions of insurance, other relevant state agencies, and additional partners

Governance Role

Required:

- Develop Statewide Health Equity Plan and provide input on State Quality and Equity Targets
- Review and support of hospital health equity plans
- Input on Cooperative Agreement investment

Optional:

- Review state-designed Medicare FFS HGB methodology
- Review of Medicaid and commercial HGB methodologies
- Support activities to achieve other statewide targets

Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

NOFO Application Requirements: Health Equity and Model Governance Structure (1 of 2)

NOFO lays out key strategies and activities to advance Health Equity through AHEAD. Applicants must detail:

- Existing health equity initiatives and activities (e.g., State Health Improvement Plan, Community Health Needs Assessments)
- Existing activities aimed at reducing health disparities and identifying and addressing Health Related Social Needs (HRSN) (e.g., collection of demographic and HRSN data)
- Plan for health equity-related program requirements, including Cooperative Agreement funding, for:
  - Statewide Health Equity Plan
  - Hospital Health Equity Plan
  - Enhanced Demographic Data Collection
  - HRSN Screening and Referral
  - Model Governance Structure
- Plan for identifying appropriate participants for and the role and responsibilities of the Model Governance Structure

Health Equity and Model Governance Structure (2 of 2)

Immediate Next Steps:

- Coordinate with current activities and experts such as:
  - Health Equity Advisory Commission
  - Vermont Department of Health (related to the State Health Assessment/State Health Improvement Community Engagement Process)
  - GMCB Act 167 Community Engagement to Support Hospital Transformation
  - AHS Health Information Technology Team and GMCB Data Team
  - Blueprint for Health
- Design Model Governance Structure in alignment with AHEAD model requirements.
- Determine expertise and representation, including populations experiencing health inequities, needed to:
  - Support health equity activities (e.g., develop Statewide Health Equity Plan, review hospital Health Equity Plans, provide input on statewide population health and quality measures and equity targets, provide input on the use of Cooperative Agreement funding), and
  - Ensure model is informed by diverse perspectives.

Key Components of AHEAD Model

Statewide and Provider-Level Accountability Targets	Hospital Global Payments	Primary Care AHEAD	Cooperative Agreement Funding
Model Governance Structure	Health Equity	Medicaid and Commercial Payer Alignment	Statewide Data/Health IT Infrastructure

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Cooperative Agreement Funding (1 of 2)

Funding is ~$2M per year over the first five Budget Periods (note: $4M is available for the first 18-month period)

Per the NOFO, Cooperative Agreement funding is intended to support the state's implementation of the model, such as:

- Recruiting primary care providers and hospitals to participate
- Setting statewide TCOC cost growth targets and primary care investment targets
- Building mental health/substance use disorder infrastructure and capacity
- Supporting Medicaid and commercial payer alignment across the model

CMS examples of use of funds include:

- State agency staff to implement the Model
- New technology related to HIT
- Integration of community services referrals
- Bolstering health information exchange and creation of provider dashboards
- Supporting population health activities
- Implementing health-related social needs screening and referral processes
- Development of Medicaid and/or commercial hospital global budget methodology
- All other aspects that align with building a population health agenda

Cooperative Agreement Funding (2 of 2)

Immediate Next Steps:

- Define time-limited and one-time investments that will support the state's implementation of the model and attainment of AHEAD model goals
- Define sustainability plan for those activities funded under the Cooperative Agreement

Key Components of AHEAD Model

Statewide and Provider-Level Accountability Targets	Hospital Global Payments	Primary Care AHEAD	Cooperative Agreement Funding
Model Governance Structure	Health Equity	Medicaid and Commercial Payer Alignment	Statewide Data/Health IT Infrastructure

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NOFO Application Requirements: Commercial Payer Alignment

Applicants must:

- Describe commercial payer participation in state health care reform and population health improvement efforts, if applicable.
- Describe commercial payer efforts to implement value-based payment and advanced primary care models, if applicable.
- Describe commercial payer efforts to address affordability and control cost growth, if applicable.
- Describe state legislative or regulatory authority the state intends to utilize under the Model to facilitate commercial payer participation in hospital global budgets and an aligned primary care program, and to hold commercial payers accountable for TCOC growth.
- Describe if and how the applicant intends to include Marketplace QHPs and state employee health plans in hospital global budget payments.
- Describe approach to hold commercial payers accountable for TCOC growth.

Medicaid and Commercial Payer Alignment

Immediate Next Steps:

- Coordinate with Department of Vermont Health Access to assess current alignment with CMS requirements and identify gaps
- Describe current state of commercial payer alignment
- Reconvene commercial insurer group to discuss potential alignment
- Other?

Key Components of AHEAD Model

Statewide and Provider-Level Accountability Targets	Hospital Global Payments	Primary Care AHEAD	Cooperative Agreement Funding
Model Governance Structure	Health Equity	Medicaid and Commercial Payer Alignment	Statewide Data/Health IT Infrastructure

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NOFO Application Requirements: Statewide Data/Health IT Infrastructure

Applicants must:

- Describe the current and/or planned future capacity of data/health IT infrastructure.
- Describe existing data infrastructure action plans and governance.
- Describe staff capacity, data analytic capabilities and experience supporting value-based payment and quality reporting.
- Describe ability to leverage health IT to meet Model requirements, including data alignment, sharing, flow, and linking capacity across potential partners and participants.
- Describe current health oversight agency status and/or ability to become a health oversight agency for the purposes of data sharing prior to the start of PY1.

Statewide Data/Health IT Infrastructure

Immediate Next Steps:

- Coordinate with AHS Health Information Technology Team and GMCB Analytics Team to describe current state
- Assess current capacity to stratify accountability measures by race, ethnicity, dual status, and geography
- Other?