Health Care Reform Work Group

MAY 20, 2024

Meeting Agenda

1. Welcome and Introductions; Agenda Review (1:00 – 1:05)
2. Updates on 2025 All-Payer Model Extension and AHEAD Application (1:05 – 1:20)
3. Broader Health Care Reform Progress and Priorities (1:20 – 1:50)
4. Closing Discussion and Next Steps (1:50 – 2:00)

AHEAD Application Submitted

March 18, 2024

Applications Due from States

June 2024

Anticipated Notice of Award to Selected States

July 1, 2024 – Dec. 31, 2025

18-month Pre-Implementation Period

January 1, 2026

Start of 9-year Performance Period

Key Model Milestones – Pre-Implementation for Cohort 1

18 months prior to start of Performance Year (PY) 1 (July 2024)
- State-designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) methodology to be submitted to CMS
- Medicaid primary care (PC) Alternative Payment Model (APM) and Medicaid HGB "regulatory change processes" proposals to be submitted to CMS

6 months after award date (November 2024)
- Establish Model Governance Structure

12 months prior to start of PY1 (January 2025)
- Medicaid HGB methodology to be submitted to CMS

Negotiations would begin when state is selected. Prior to execution of State Agreement, Vermont is not committed to participating in AHEAD.

6 months prior to start of PY1 (July 2025)
- **Execution of State Agreement**
- Obtain letters of interest from hospitals interested in participating in Medicare FFS HGBs
- CMS approval of Medicaid HGB methodology
- Draft Executive Order to create TCOC/PC spend targets (or process to set targets)

3 months prior to start of PY1 (October 2025)
- Demonstration of readiness for Medicaid HGB implementation and Medicaid primary care APM
- CMS checks that at least **10%** of Medicare FFS Net Patient Revenue is under Medicare FFS HGBs as reflected in hospitals' participation agreements
- Finalize Executive Order to create TCOC/PC spend targets (or process)

End of Pre-Implementation Period (December 2025)
- Finalize Statewide Health Equity Plan

Key Model Milestones – Implementation for Cohort 1

Performance Year 1

Beginning of PY1 (January 2026)

- Implementation of Medicare Primary Care AHEAD and expectation that Medicaid Primary Care APM goes live
- Implementation of Medicare HGBs

90 days prior to start of PY2 (October 2026)

- Final All-Payer TCOC and Primary Care Investment targets to be memorialized in amended state agreement
- At least one commercial payer indicates participation in the HGB model

By end of PY1 (December 2026)

- Implementation of Medicaid HGBs

Performance Year 2

Beginning of PY2 (January 2027)

- Measurement of All-Payer TCOC and Primary Care Investment Target begins
- Expectation that HGBs go live for Medicaid and at least one commercial payer
- Potential implementation of Medicare primary care capitated track under Primary Care AHEAD (CMS is currently evaluating this option)

Performance Year 3 and Beyond

90 days prior to start of PY4 (October 2028)

- CMS checks that at least **30%** of Medicare FFS Net Patient Revenue is under Medicare FFS HGBs as reflected in hospitals' participation agreements

Potential Areas of Negotiation

Category	Topic
Statewide Accountability	Medicare Total Cost of Care Targets*
	All-Payer Total Cost of Care Targets
	Medicare Primary Care Investment Targets*
	All-Payer Primary Care Investment Targets
	Statewide Population Health and Equity Targets
Hospital Global Budgets	VT-Specific Medicare FFS Hospital Global Budget Methodology*
	Medicaid Hospital Global Budget Methodology
	Blueprint and Support and Services at Home (SASH) Payments*
Primary Care AHEAD	Primary Care Capitation Payment Model
	Quality Measures and Electronic Clinical Quality Measure (eCQM) Reporting*
	Merit-Based Incentive Payments (MIPS) Reporting*
	Intersection of Medicare Payment Model and Primary Care Investment*
	Payment Model Risk Adjustment*
Medicare Waivers	Waiving Regulations to Support Model Goals and Improve Care Delivery*
Technical Assistance	Request Technical Assistance on Interface of Multiple Federal Models*

* = Earlier work

Themes from Provider Panel from May 15 GMCB Meeting

Overarching:

- AHEAD is complex and challenging to understand.
- Concerns about loss of CPR program for independent primary care; ACO support with data sharing, quality measurement, attribution estimates, financial modeling; need glidepath between models.
- Workforce challenges and increases in expenses need to be addressed; they impact access.
- Should strive towards all-payer, all-hospital and value-based care models.
- Adequate clinician involvement in model governance is essential.
- Need to better understand alternatives and comparisons between options including impact on affordability, access to care, and provider stability.
- Consider “Cons” as well as “Pros” - need to monitor impacts over time to ensure reforms are working for Vermonters.
- Care delivery and payment reform across the system is essential.

Themes from Provider Panel at May 15 GMCB Meeting (cont'd)

Primary Care AHEAD:

- Sustaining primary care is critical.
  - Continue capitation models, Blueprint, SASH, Medicare waivers.
  - Concerns about how Primary Care AHEAD payments may impact primary care providers differently based on how they are currently paid and patient mix.
  - Administrative burden needs to be reduced; concerns about Vermont losing current MIPS reporting exemption.

Hospital Global Budgets:

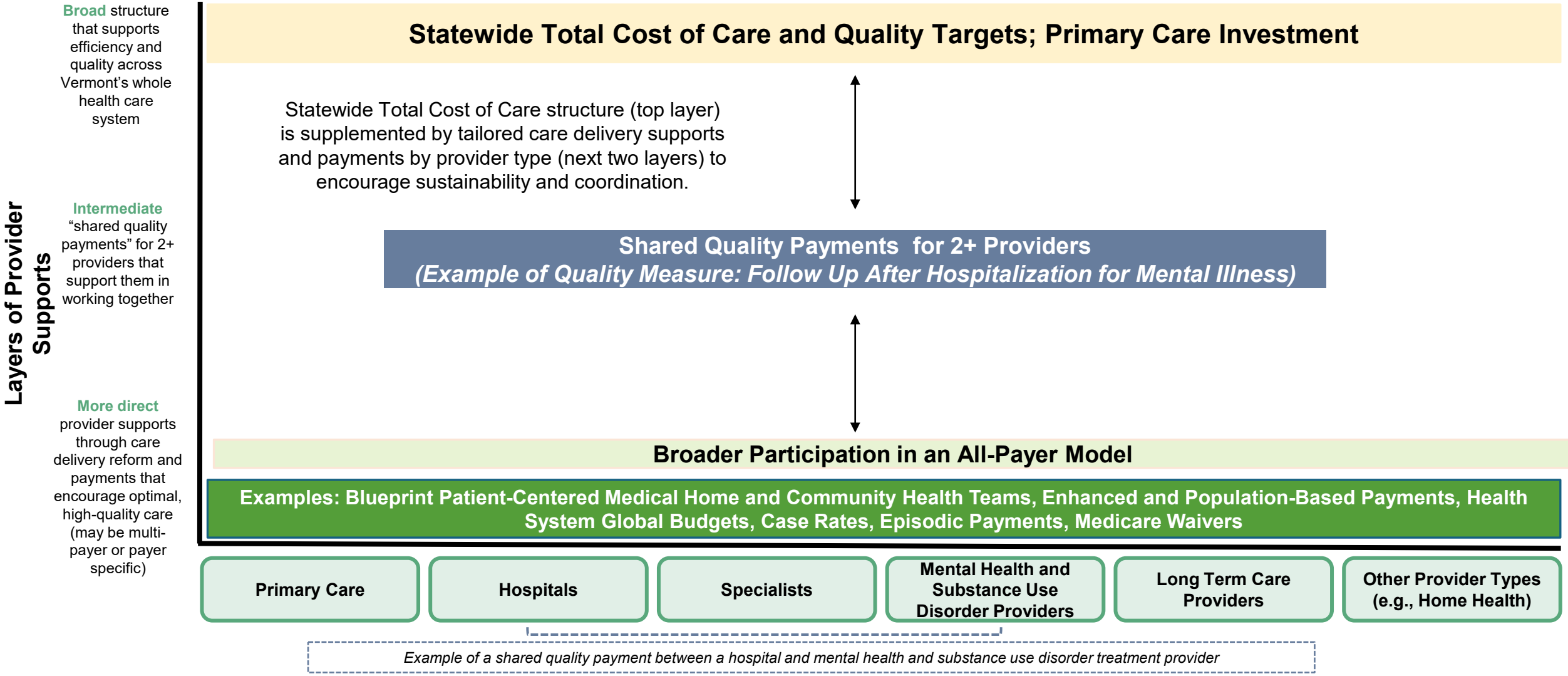
- Need to ensure global payment methodology allows for continued investment across the system and increased access to care.
- Providers need access to comprehensive data to be successful.
- Focus on affordability and access vs. overutilization; Vermont's rate of potentially avoidable utilization is relatively low.

Vermont's Current Health Care Reform Focus

Stability of our health care system following the pandemic

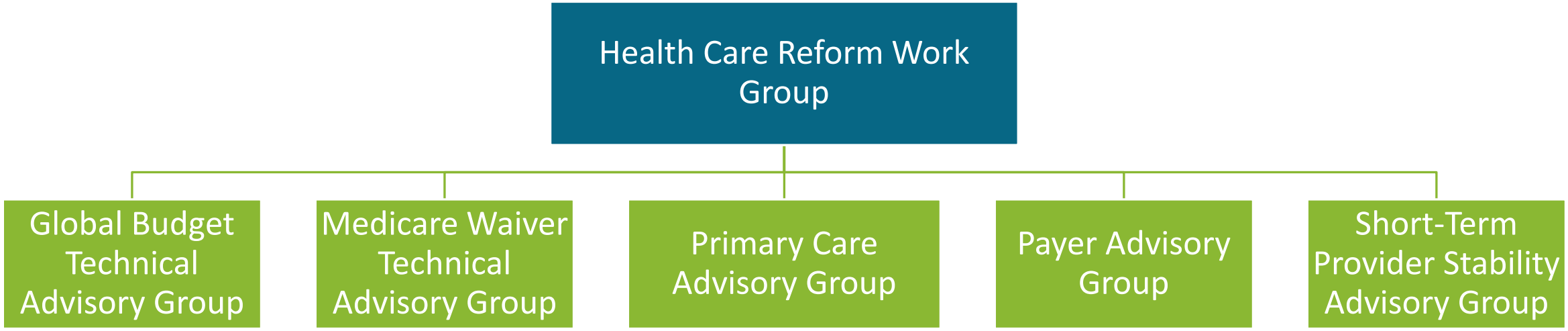
Vision and direction, including focus on aligned and comprehensive reforms and preparing for potential future multi-payer model

Vermont's Vision for a Statewide Approach

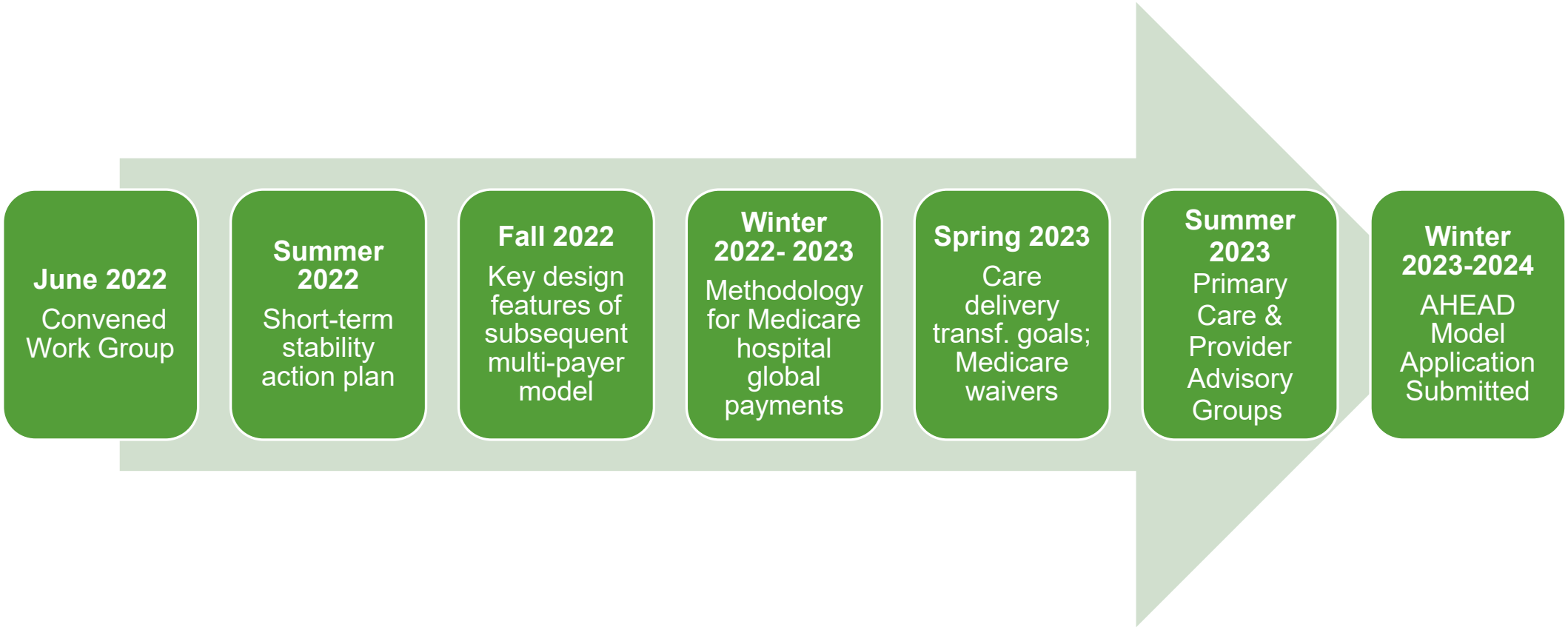


Population-Based Payment: A provider or provider organization is accountable for the health of a group of patients in exchange for a set payment. This gives providers flexibility to coordinate and manage care for their patients. They accept risk for costs of care that exceed the set payment amount.
Health System Global Budget: A global budget is a budget that is established ahead of time for a fixed period (typically one year) for a specified set of services (e.g., inpatient and outpatient hospital services) for a set population.
Case Rate: A provider receives a flat rate for a patient's treatment for a specific period of time.

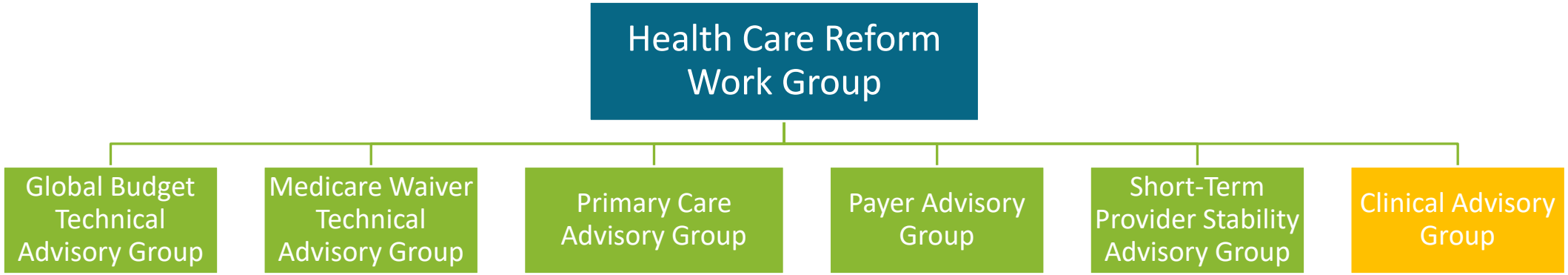
Health Care Reform Work Group



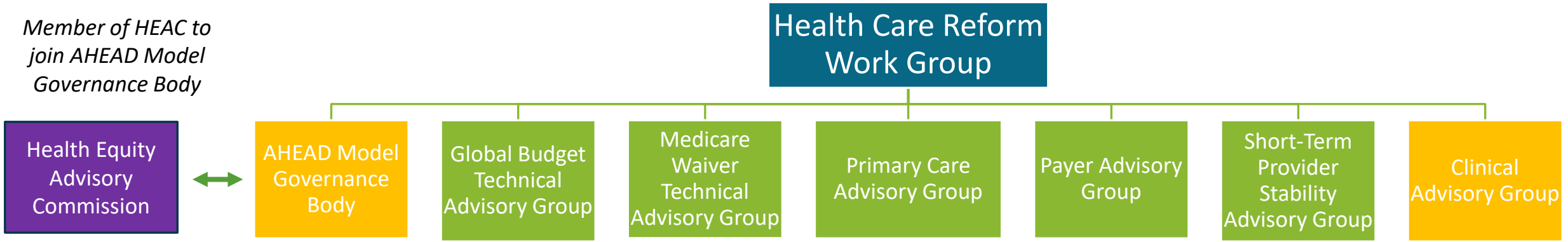
Focus to Date



Proposed Future Addition



Structure if AHEAD Moves Forward



Accomplishments and Forthcoming Activities

Address provider stability in the short-term

- Identified 22 discrete actions focused on workforce, regulation, system flow, revenue.
- Majority completed; continued efforts needed in system flow area.

Inform design of future financial and care delivery models

- Provided feedback to CMMI on potential future model and AHEAD topics.
- Proposed and secured additional Medicare waivers to support improved care delivery.
- Designed VT-specific Medicare hospital global payment methodology.
- Informed Blueprint enhanced integration pilot.

Inform activities that support long-term sustainability

- Forthcoming discussion on qualitative and quantitative findings from Act 167 community engagement to support hospital and other care transformation workstream.

Stability: Focus on broader system of care

- Over **$164 million in base rate increases** across health system over last two fiscal years across the provider continuum
- Additional **targeted investments** in critical areas from 2022-2025. Examples:
  - ✓ 988 suicide prevention lifeline, mental health mobile crisis, youth inpatient and residential mental health
  - ✓ Blueprint funding to expand mental health services and screening for health-related social needs in primary care
  - ✓ Specialized skilled nursing beds for people with complex needs
  - ✓ Provider tax relief for home health agencies

- **Workforce initiatives** to partner with employers on recruitment and retention, grow nursing workforce, and create Health Care Workforce Data Center
- Grants for providers of **home and community-based services** to address critical investments in infrastructure, enhance workforce, drive care model innovation, strengthen provider processes

Medicare Waiver TAG: Flexibilities Expected to be Available in 2025 Extension Period

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.

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Global Budget TAG: Progress and Future Plans

- **Members:** Representatives of hospitals, payers, unions, advocates
- **Meetings**: 15 two-hour meetings since January 2023
- Continue to build out Vermont-designed **Medicare straw model**
  - GB TAG recommendations are key starting point
  - CMS released their version of the Medicare AHEAD hospital global payment specifications on February 14: Ahead Model Fin Specifications (cms.gov)
- February 29 meeting reviewed and compared CMS and Vermont Medicare hospital global budget models
- Engage in work on commercial straw model

TAG materials are publicly available on the GMCB website

Primary Care Work Group

Work Group consists of the following members:

- Practicing primary care providers, administrators from organizations delivering primary care, leaders from associations representing primary care providers (including OneCare), state government staff and advisors from Manatt
- Since October 2023, 9 meetings have been held. Topics have included:

Overview of AHEAD; Detailed Review of Primary Care AHEAD

Medicaid Alignment (crosswalk between AHEAD care transformation guidance and VT programs)

Mental Health and Substance Use Disorder Integration Under AHEAD

Comparison of AHEAD Enhanced Primary Care Payments and VT Primary Care Payments

Health Equity Approaches and Quality Requirements in AHEAD

Interaction between AHEAD and Medicare Shared Savings Program

Primary Care Investment Targets

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Payer Advisory Group

Members: Representatives from Blue Cross Blue Shield, Cigna Healthcare, MVP Health Care, and Vermont Medicaid

Meetings: Four meetings held in Spring and Summer of 2023; reconvened in April 2024

Topics:

Areas of Interest and Potential Alignment in:

- Care Transformation
- Payment Models
- Quality Measures
- Evaluation

April meeting focused on hospital global budget design elements and potential variation between Commercial and Medicare methodologies.

Proposed Clinical Advisory Group

- Membership would include experts to advise on clinical vision and priorities to support care transformation, informed by qualitative and quantitative assessment of Vermont's health care system.

- Focus on overarching clinical goals, including:
  - ❑ Vermonters can access the care they need, where they need it, and when they need it
  - ❑ Improved population health
  - ❑ Optimal experience of care
  - ❑ Improved coordination among providers

- Would address primary care, long-term care, and mental health and substance use disorder care, as well as hospital care.

Closing Discussion and Next Steps

- Work Group (and sub-group) principles, focus, and actions to date:
  - How are we doing on achieving our goals?
  - What are other high priority gaps that need to be addressed?

- Next Steps