Vermont: AHEAD NOFO Application
PROJECT NARRATIVE

Section I. Organizational Capacity of Applicant Organization

Vermont is a national leader in health care delivery and payment reform. Uniquely, Vermont has partnered continuously with CMS on multi-payer delivery system reform ever since entering the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration in 2010. Vermont's Agency of Human Services (AHS), responsible for a broad portfolio of health and human services programs, has a strong track record of implementing complex multi-year reforms statewide, which include the following key initiatives:

Blueprint for Health: Vermont's longstanding advanced primary care and integrated health services program, the Blueprint for Health ("Blueprint"), has been in place on a multi-payer basis since 2010, forming a foundation for primary and preventative care across the state. More detail on the Blueprint is given in Section VI below.

Vermont All-Payer Accountable Care Organization (ACO) Model (VTAPM): The VTAPM is Vermont's current Alternative Payment Model (APM) with CMS which will sunset no later than 2025. The VTAPM was first implemented in 2017 to improve quality and outcomes statewide by shifting payment incentives from volume to value for Vermonters attributed to traditional Medicare, Vermont Medicaid, and commercial insurers. 10 hospitals (including their employed practices), 21 independent primary care practices, 6 FQHC organizations, and 5 naturopathic practices currently participate in the Vermont Medicare ACO Initiative Program under the VTAPM. Prior to the VTAPM, Vermont's participation in and support from CMS' State Innovation Model (SIM) helped prepare for the VTAPM.

Payment Reform in Medicaid: Vermont's Medicaid program serves nearly 209,000 individuals (one-third of all Vermonters). AHS has designated the Department of Vermont Health Access

(DVHA) to administer Vermont's Medicaid program and operate as a public managed care model. In addition to its participation in the Blueprint and the VTAPM, DVHA has several payment reform initiatives underway for services such as developmental disabilities, children's and adult mental health (MH), and substance use disorder (SUD). Importantly for AHEAD, DVHA has also begun implementation of hospital global payments. More detail on Medicaid payment reform is given in Sections V and VI.

Entity Performing Cooperative Agreement Activities and Key Personnel

Building on the track record described above, Vermont's AHS is ready to implement AHEAD, working in partnership with the Green Mountain Care Board (GMCB) and the Vermont Department of Health (VDH) within state government. Respective roles, responsibilities, and key personnel are as follows:

***Agency of Human Services*:** AHS governs all health and human services of the state government and is the State Medicaid Agency (SMA). AHS will take overall responsibility for performing the activities within the AHEAD Cooperative Agreement, including being a signatory on the State Agreement; participating in Model Governance; aiding in hospital and primary care practice recruitment for AHEAD; and operating the Medicaid APM.[1] AHS has approximately 71 employees at the AHS Central Office. Key AHS personnel are: (1) **Jenney Samuelson,** Vermont's Secretary and leader of AHS, who will have management authority over AHEAD; (2) **Monica Ogelby**, Medicaid Director within AHS, who will be a signatory to the State Agreement with CMS; (3) **Pat Jones,** Interim Director of Health Care Reform, who will supervise the AHEAD

[1] To note, Vermont did not include a letter of support from the SMA indicating capacity since AHS is the SMA and is serving as the applicant on behalf of the State of Vermont.

Project Director; (4) **Wendy Trafton**, Deputy Director of Health Care Reform, who leads Medicare waivers and supports health equity work; (5) **Dr. John Saroyan**, Executive Director of Blueprint, who leads advanced primary care and integration of health and human services; and (6) **Judith Morse**, Financial Manager, who is Vermont's Authorized Organizational Representative (AOR). Additional key AHS personnel include: (1) **Lynne Cleveland Vitzthum**, Health Care Workforce Director; (2) **Heriberto Troche**, Health Care Workforce Data Center Manager; (3) **Frances Hodgins,** Administrative Services Director leading the Home and Community-Based Services (HCBS) Spending Plan; and (4) Health Services Researcher, currently vacant and under recruitment, who will support data collection and reporting for AHEAD.

Department of Vermont Health Access: DVHA, Vermont's public managed care entity that administers the Medicaid program, is organized under AHS and reports to the Secretary. The Commissioner position within DVHA is currently vacant. **Amy Coonradt** (Director of Operations, ACO Programs) and **Alicia Cooper** (Director of Managed Care Operations) are responsible for the operation of APMs within Vermont Medicaid.

Green Mountain Care Board: The GMCB, established in 2011, is an independent state government entity with responsibility for (1) advancing innovation in health care payment and delivery; (2) serving as a transparent source of information and analysis on health system performance; and (3) regulating major areas of Vermont's health care system. The GMCB is responsible for review of hospital budgets and health insurance rates, certificate of need assessments for capital improvements and new services, and ACO budget review and certification in Vermont as part of an overall charge of managing cost growth while ensuring high quality of care. Under AHEAD, GMCB will be responsible for establishing Medicare global

budgets and regulating the hospital global budgets as described in Section V, and tracking and measuring health system performance relative to total cost of care (TCOC) and primary care spend targets. The GMCB has 5 members who have knowledge of or expertise in health policy, health care delivery, or health care financing, and openness to alternative approaches to health care, as defined by 18 V.S.A. § 9392. The GMCB has approximately 31 state employees, including Board members. The GMCB Executive Director is **Susan Barrett**.

Supporting Contractors: Vermont is experienced in procuring and working with contractors to implement APMs and delivery system reform initiatives. Current AHS contractors include Health Management Associates (attribution, data analysis, actuarial services) and Manatt (project management, policy development, stakeholder engagement). GMCB retains Mathematica Policy Research (data analysis, modeling, reporting) and Bailit Health (hospital global budget technical assistance [TA], stakeholder engagement). If Vermont proceeds with AHEAD, it expects to procure contracted assistance as described in the Budget Narrative.

Section II. Description of Region

Vermont intends to implement the AHEAD model statewide. The State has a population of about 645,000 residents and nearly two thirds live in rural areas, which may impact access to health care.[2] Currently, 94% of the population is White; however, the number of Vermonters of color has doubled in the last 15 years.[3,4] Vermont is older than the US as a whole, with nearly 22% of Vermonters older than age 65, compared to the nationwide average of 17%.[3]

[2] Overview of the State - Vermont - 2021
[3] United States Census Bureau Quick Facts Vermont
[4] Vermont Statewide Health Needs 2023

Delivery System: Vermont's delivery system is comprised of: **14 non-profit hospitals**, including 8 critical access hospitals (CAHs), 5 rural hospitals, and 1 academic medical center; **11 FQHCs** with approximately 48 sites across the state; **10 rural health clinics (RHCs);** approximately **160-170 primary care practices** owned by individuals, groups, and hospitals; **11 designated agencies** and **7 specialized services agencies** that provide comprehensive MH and developmental disability services; **20 SUD preferred providers** with approximately 30 locations; and a strong network of **long-term services and supports providers**, including approximately 37 nursing home facilities, 10 home health agencies, 17 assisted living residences, 100 residential care homes, 10 hospice organizations, 11 adult day providers, and 5 Area Agencies on Aging. Vermonters also travel out-of-state to receive care. For example, many receive tertiary care at Dartmouth Hitchcock Medical Center in New Hampshire.

***Payer Mix*:** Approximately 97% of Vermonters have health insurance (as of 2021, private insurance 49%; Medicaid 24%; Medicare [including Medicare Advantage] 21%; military 3%; and uninsured 3%), making it a state with one of the highest rates of coverage.[5] Vermont does not have contracted Medicaid managed care plans.

***Health Care Delivery System Redesign in Vermont*:** Most hospitals and primary care providers, as well as many long-term services and supports providers and other partners, currently participate in the VTAPM and Blueprint. Overall, the Vermont health care community is reform minded, informed on policy, and engaged with state government on planning. During 2022 and 2023, AHS conducted extensive engagement with the delivery system to inform discussions with CMS about the planned transition from the VTAPM to AHEAD, through a Health Care

[5] Vermont's Health Care System Overview: Payers & Players

Reform Workgroup, Primary Care Workgroup, Payer Workgroup and Hospital Global Budget Technical Advisory Group (TAG), among others.[6] Through these channels, AHS has been as transparent as possible with Vermont stakeholders about the trajectory of the VTAPM and the potential for multi-payer hospital global budgets. More information on recruitment is in Section VII below.

Section III. Statewide Accountability Targets

Vermont has extensive experience measuring and reporting TCOC and Primary Care Investment. Under the AHEAD Model, the state is prepared to refine its measurement, codify targets, and use existing levers and authorities to pursue the targets.

Current and Planned Measurement of TCOC and Primary Care Spending

Vermont's current state and future plans are as follows:

***TCOC Spend Measurement and Data Collection Mechanisms*:** Under the State's current VTAPM Agreement, GMCB has measured Medicare and all-payer TCOC and reported results to the Center for Medicare and Medicaid Innovation (CMMI) annually since 2018. GMCB has the authority to require collection and reporting of data to calculate the TCOC from insurers, providers and other state government agencies under 18 V.S.A. 9410, subject to the limitations of *Gobeille v. Liberty Mutual Ins. Co.*, 746 F. 3d 497 (2016), and would continue this work together with AHS under AHEAD. The methods currently used to calculate all-payer TCOC are described in Appendix B of the most recent Annual TCOC Report. Under the current VTAPM, TCOC is defined as including Medicare Part A- and B-equivalent services. Pursuant to Section 10.d of the VTAPM Agreement, Medicaid claims payments and Medicaid all-inclusive

[6] Health Care Reform Workgroup and Subgroups

population-based payments (AIPBPs) are adjusted to exclude some Medicaid price increases from TCOC calculations. These exclusions of cost growth attributable to increases in Medicaid reimbursement rates are intended to help ensure greater access for Medicaid beneficiaries.

Vermont's primary data source for calculating TCOC is the state's all-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), of which GMCB is the steward. If selected to participate in AHEAD, Vermont would leverage its experience in including non-Fee-for-Service (FFS) payment types in TCOC calculations, by collecting non-claims data from a variety of sources. Under the current VTAPM Agreement, Medicare and Medicaid pay participating Vermont hospitals that elect to receive AIPBP via non-claims payments. To capture non-claims spending, including Patient Centered Medical Home (PCMH) and Community Health Team (CHT) payments, capitation and population-based payments, and any shared savings/loss payments, AHS and GMCB collect data from Blueprint, Medicaid, and commercial payers.

Primary Care Spend Measurement and Data Collection Mechanisms: GMCB and AHS also have experience calculating Primary Care Investment using both a state-specific definition codified by Vermont's legislature and the New England States Consortium Systems Organization (NESCSO) definition, which would be leveraged to calculate Primary Care Investment under AHEAD. In 2020, GMCB and AHS' Department of Vermont Health Access submitted a report to Vermont's General Assembly that calculated primary care spending (all-payer and by payer type) as a proportion of health care spending. That report found 10.2% of health care spending was allocated to primary care, though investment varied by payer (Medicare: 6.5%; Medicaid: 24.3%; commercial: 9.2%). Vermont also contributed to a 2020 NESCSO report on primary care

spending across New England states, and has performed internal analyses on claims-based primary care spending in conjunction with TCOC analyses under the VTAPM. For the purposes of the AHEAD model, Vermont plans to use the NESCSO report definition of primary care with broad inclusivity of primary care services, with a minor modification to include primary care delivered by naturopaths. Similar to the data collection used to support calculation of TCOC, GMCB has the authority under 18 V.S.A. 9410 to collect data for the purpose of calculating Primary Care Investment.

Gaps, Challenges, and Mitigation: Challenges for calculating TCOC and Primary Care Investment to date have included lack of complete commercial claims data in VHCURES due to self-funded plans' exemption from state regulation under the Employee Retirement Income Security Act of 1974 (ERISA) leading to some plans electing not to submit data; lack of complete non-claims payment data from all commercial payers; and challenges allocating non-claims payments that support a range of primary care and non-primary care activities.

A large – and growing – portion of Vermont's commercially insured market is self-funded. Vermont's most recent APM Scale Targets and Alignment Report shows that an estimated 154,600 Vermonters (24% of Vermont's total population) are members of self-funded plans, exempted from state requirements due to ERISA, while just under 95,000 (14% of all Vermonters) are members of fully-insured plans. Data is submitted to VHCURES on behalf of 93,400 members of self-funded plans. Vermont has no data about the remaining estimated 61,200 individuals. Self-funded plans' willingness to submit data to all-payer claims databases (APCDs) is a national challenge, but one where Vermont would be interested in obtaining TA, including tools or strategies to encourage voluntary participation.

If selected for AHEAD Model participation, GMCB will work closely with payers, including Third Party Administrators and Pharmacy Benefit Managers, during the Pre-Implementation period to address challenges related to non-claims payment data collection, incorporating lessons learned from current reporting on TCOC. GMCB will work with payers to come to a common understanding on needed data elements and how they will be used/reported, and engage with submitters' technical staff to develop the proper submission formats, definitions, and specifications. This will include working with commercial payers to adopt the CMS-provided standard reporting template for non-claims payments (per Notice of Funding Opportunity [NOFO] Section A4.2). If use of this template is required by CMS, GMCB can compel mandated submitters to utilize it for reporting; if the template is optional, GMCB will work with its data collection vendor on the best means for submission, potentially leveraging national work by the APCD Common Data Layout Workgroup related to non-claims data collection. For non-claims payments that support both primary care and non-primary care activities, Vermont and payers will develop analytic assumptions to support allocating portions of these payments to primary care with a higher degree of confidence.

Plan for Memorializing TCOC and Primary Care Investment Targets

Vermont's Governor intends to codify the process for establishing all-payer TCOC and Primary Care Investment targets via Executive Order, as allowed for in the NOFO (Section A4.2, pages 14-15).

Regulatory and Policy Levers to Increase Medicaid and Commercial Primary Care Spending

Vermont would leverage current statutory, policy, and regulatory levers to increase primary care investment as described below.

Blueprint: The Blueprint has provided increased monetary and programmatic support for primary care and integrated services since its inception via per member per month (PMPM) payments and quality incentives to practices (PCMH payments); CHTs supported by all participating payers; practice improvement and transformation support; and new MH, SUD, and health related social needs (HRSN) expansion programs described further in Section VI. Medicare joined in 2011 via the MAPCP Demonstration and continues to contribute via Advanced Shared Savings provided to Vermont Medicare ACO Initiative participants under the VTAPM. Vermont's self-funded state employee health plan participates as well. Commercial participation is required by 18 V.S.A. § 706 and through state managed care regulations promulgated by the Department of Financial Regulation (DFR). Medicaid's Blueprint payments have increased over time, while Medicare and commercial payment amounts have remained largely static. In 2023, the Vermont legislature required a report on increasing commercial payer investments. Under the AHEAD Model, Vermont would explore using the Blueprint as a mechanism for increased primary care spending via higher payment amounts, the addition of new expansion programs that fall within the scope of primary care transformation, and/or increases to Medicare and commercial contributions to be in line with Medicaid.

Regulatory Authorities: GMCB's rate review authority (8 V.S.A. §4062, 18 V.S.A. §9375), which covers the individual, small group, and large group markets, includes specific authority to consider affordability in GMCB's decisions to approve, reject, or modify health plan rate requests. While not currently implemented, this authority (along with the authority to set payment reform methodologies under 18 V.S.A. 9375(b)(1)(A)) could support the development of "Affordability Standards" like those promulgated in other states to implement primary care

spend requirements for carriers. Primary care investment that includes payer-specific analysis could also provide public transparency and increase motivation for payers to increase their spending on primary care.

Regulatory and Policy Levers to Enforce TCOC Cost Growth Targets

GMCB's authority related to hospital budget review and rate review have been and will continue to be Vermont's key regulatory levers to achieve TCOC growth targets. GMCB's hospital budget review has successfully contained growth in hospital spending, from 7.2% from 2003-2012 to 4.9% since 2012, by capping growth in net patient revenue and limiting hospital charge increases. Under the current hospital regulatory model, enforcement for spending beyond GMCB's established cap often occurs through subsequent year adjustments to charges. GMCB is currently working to enhance its hospital regulatory framework. In health insurance premium rate review, GMCB considers carrier assumptions about negotiated provider prices as a component of overall rate requests. GMCB has frequently required carriers to use lower price assumptions in its final rate decisions. These powerful regulatory tools will be even more critical in helping to set multi-payer hospital global payments if Vermont participates in AHEAD. In addition, Vermont's state-developed hospital global budget methodology will encourage providers to consider spending and resource allocation across the entire continuum of care via performance adjustments based on TCOC growth in each hospital's Health Service Area (HSA).

NORC's evaluation of the VTAPM has found that the model's TCOC targets – which require Vermont to hold TCOC growth to between 3.5 and 4.3% – have brought health system partners together, providing a common goal for health care cost containment efforts. Over the first four performance years, the VTAPM reduced gross spending by $686.40 Per Beneficiary

Per Year, or 6.2% for ACO-attributed Medicare beneficiaries. Across the four performance years included in the evaluation, there was a $129.4 million decline in net Medicare spending.[7] Vermont anticipates that an Executive Order outlining authorities, processes, and methodologies for the State to set targets for all-payer TCOC and Primary Care Investment will have a similar effect. In addition to the savings identified in the recent evaluation, past federal evaluations have found cost savings from the Blueprint and Support and Services at Home (SASH) programs. Those savings have not been reinvested in the health care system. The providers creating those savings are now too financially fragile to increase investments in MH, SUD, and long-term services and supports. If the savings are not captured, Vermont enters AHEAD at a significant disadvantage that impacts the state's ability to redirect funding to lower-cost community settings. Vermont will continue these programs, with the expectation that this would continue to limit TCOC growth due to increases in care provided in lower-cost settings and increased Primary Care Investment.

Anticipated Challenges in Meeting TCOC and Primary Care Investment Targets

Vermont has extremely low Medicare spending compared to other states and may be challenged to reduce Medicare TCOC growth. The COVID-19 pandemic exacerbated sustainability challenges for Vermont health care providers. Vermont's focus on Medicare cost containment, overall payer mix, limited health care workforce, and other factors have likely contributed to thin or negative provider margins. In seeking to contain cost growth, Vermont must target its efforts so that access, quality of care, and equity for Vermonters do not suffer, and must ensure that there are sufficient resources to care for the state's rapidly aging

[7] Evaluation of the Vermont All-Payer Accountable Care Organization Model Third Evaluation Report

population. This is an area of major concern for the state, as well as Vermont providers and consumer advocates, as evidenced by questions asked during CMMI information sessions with Vermont stakeholders and AHEAD Office Hours. Understanding CMMI's plans to address TCOC growth in light of Vermont's low Medicare spending is likely to be a major factor in state-federal negotiations should Vermont be accepted for AHEAD, and in providers' willingness to voluntarily participate.

Vermont must also address pre-existing access to care challenges causing significant wait times for some services. Like many other states, Vermont is currently experiencing challenges related to patient flow through the health care system, particularly related to availability of post-acute care and MH/SUD treatment. Vermont also has longstanding access challenges related to some subspecialty services in the most rural areas. Addressing these underlying issues is likely to require investment and/or provider payment changes.

While Vermont believes it is well positioned to achieve Medicare and All-Payer Primary Care Investment targets, the current low proportion of Medicare primary care spending compared to other payer types may present a challenge. In addition, the State may receive pushback from commercial insurers related to any requested increases in primary care spending. Vermont is interested in federal TA on these issues.

Section IV. Hospital Recruitment Plan

In 2022, the Vermont legislature passed Act 167, which directed GMCB, in collaboration with AHS, to develop value-based payments for hospitals, including exploring global payments, and ensure opportunities for stakeholder engagement throughout the proposal's development.

Summary of Conversations with Hospitals and Strategy for Further Recruitment

As required by Act 167, GMCB and AHS have engaged directly with hospitals to provide education related to, and solicit feedback on, participation in hospital global budgets through multiple forums and meetings over the past 14 months. These include (1) Hospital Global Budget TAG meetings (co-led by GMCB and AHS), with staff updates to the Health Care Reform Work Group (led by AHS) and to the GMCB; (2) Vermont Association of Hospitals and Health Systems (VAHHS) Board and Financial Leaders Group meetings; and (3) individual meetings with hospital and health system leaders. Vermont is encouraged by non-binding letters of intent from the University of Health Vermont Health Network (representing 3 Vermont hospitals) and Rutland Regional Medical Center, found in the Appendix.

Hospital Global Budget Technical Advisory Group: In January 2023, AHS and GMCB jointly convened the Hospital Global Budget TAG with the charge of recommending conceptual and technical specifications for Vermont hospital global budgets, pursuant to Act 167. Hospital Global Budget TAG members include representatives from 7 hospitals, including CAHs, and Prospective Payment System (PPS) and Academic Medical Center (AMC) hospitals. TAG members also include Medicaid, commercial payer, ACO, individual provider, union, and health care advocate representatives. AHS and GMCB selected TAG membership based on technical expertise and knowledge of current provider payment models.

The TAG has provided an opportunity for members to understand various design components of hospital global budgets, how global budgets are implemented, and how they are expected to change hospitals' current payment and care delivery systems. Presentations offered concrete examples from other states' hospital global budget models (e.g., Maryland's

TCOC Model and the Pennsylvania Rural Health Model) to help inform recommendations for a Vermont model. Hospitals have also learned about benefits that global budgets can offer, such as predictable, stable revenue and greater flexibility to modify hospital service offerings to improve population health and meet community needs. The TAG has allowed participants to voice questions and concerns about model development and implementation, and engage with experts experienced in global budget design and implementation.

Through the TAG meetings, AHS and GMCB have solicited feedback on numerous hospital global budget design and implementation components, including covered services and provider types, initial and ongoing budget adjustments, monitoring and evaluation, supports that hospitals anticipate needing to transition to global budgets, and mitigating against potential risks and unintended consequences. For topics specific to global budget methodology (e.g., budget adjustments), the State solicited feedback on components of an all-payer hospital global budget model and the state-designed Medicare FFS methodology. If selected, the future state-designed Medicare FFS methodology that Vermont plans to submit in July 2024 will reflect relevant TAG feedback, as well as additional input to be solicited in the months ahead.

The Hospital Global Budget TAG materials are all posted publicly on the GMCB website. In addition to providing updates on the TAG's work via the targeted hospital engagement described below, the TAG co-chairs provided regular briefings on the TAG's work to the Health Care Reform Workgroup (described further in Section X) during 2023. The TAG co-chair and staff also provided monthly public updates on the TAG's progress during GMCB meetings to solicit public input, including from hospitals.

Throughout the course of the Hospital Global Budget TAG process, hospital representatives demonstrated interest in understanding how global budget payments would work, how global budget payments differ from payments under the current VTAPM, and how the hospital global budget payment model could evolve over time.

Vermont Association of Hospitals and Health Systems (VAHHS): AHS and GMCB have engaged in several meetings with the VAHHS Board; these discussions updated VAHHS Board members on the AHEAD model and development of a state-specific global payment methodology for hospitals, and obtained their input on the proposed model. The State also met with the VAHHS Financial Leaders Group 7 times from November 2023 through mid-March 2024. The group, convened specifically to discuss and provide feedback on hospital global budget development, includes representatives from 8 hospitals. The Office of the Health Care Advocate (HCA) also attended some of these meetings. The meetings provided an opportunity for VAHHS Financial Leaders Group members to ask questions and provide input about hospital global payments for Medicaid and a state-designed Medicare FFS model, suggest modeling that would be useful for hospitals in advance of participation, and share feedback regarding what would make participation in global payments appealing or unappealing for hospitals.

Financial modeling and individual hospital meetings: Based on feedback from hospitals about the type of modeling that would be most useful, GMCB is conducting hospital-specific financial modeling to provide each hospital with information regarding the anticipated financial impact of a state-designed Medicare FFS methodology. This ongoing modeling includes estimated base net patient revenue (NPR), quantifiable adjustments for each hospital where possible, a directional indication of whether other hospital-specific or across-the-board adjustments would

likely trend up or down, and a comparison to projected FFS revenue. GMCB and AHS staff shared modeling assumptions with all hospitals and provided a walk-through of key potential differences between the Medicare model and Vermont's draft proposal at the February 2024 Hospital Global Budget TAG meeting and during two separate meetings in early March that were open to all hospitals. As discussed below, the State plans to continue to update the modeling and engage with hospitals during the Pre-Implementation period, including providing one-on-one meetings with hospitals to explain the model.

Hospital Readiness Based on Experience with Medicaid Global Budget Payments: As described in further detail in Section V, under the Medicaid ACO initiative of the current VTAPM, all eligible Vermont hospitals receive fixed prospective payments (FPPs) that are not reconciled with FFS payments. The existing robust hospital participation with Medicaid under a global budget model provides evidence of hospital preparation and readiness to engage in global budget payments on a broader scale. In addition, hospitals may be motivated to participate in global budgets with multiple payers in order to have greater uniformity of payment methodologies across payers.

Anticipated Percent of Hospital Services and TCOC to be Under an AHEAD Global Budget: At a minimum, Vermont anticipates meeting the AHEAD model milestone requirements that 10% of Medicare FFS NPR will be under Medicare FFS hospital global budgets by Performance Year 1, and at least 30% of Medicare FFS NPR will be under Medicare FFS hospital global budgets beginning in Performance Year 4 and for each subsequent performance year. Vermont will also meet the AHEAD requirements for Medicaid to implement hospital global budgets by the end of

Performance Year 1, and for at least one commercial payer to participate in hospital global budgets by the start of Performance Year 2.

GMCB engaged in an analysis, as shown in the table below, to determine the estimated percentage of Medicare FFS NPR that would be included under a global budget for each Vermont hospital to provide context for the participation requirement.

Table 1. Medicare FFS NPR[8]

Hospital	Included Medicare FFS NPR and FPP (excluding physician)[9]	% Share of Statewide Included Medicare FFS NPR and FPP[10]
Brattleboro	$27,804,363	3.6%
Central Vermont	$71,135,949	9.1%
Copley	$30,086,857	3.8%
Gifford	$18,620,414	2.4%
Grace Cottage	$8,990,284	1.2%
Mt. Ascutney	$21,661,416	2.8%
North Country	$24,670,672	3.2%
Northeastern	$24,028,697	3.1%
Northwestern	$26,161,467	3.3%
Porter	$36,761,069	4.7%
Rutland	$89,048,355	11.4%
Southwestern	$53,787,699	6.9%
Springfield	$10,839,216	1.4%
UVMMC	$338,041,861	43.2%
Total	**$781,638,318**	**100%**

Proposed Timeline for Hospital Recruitment

The State plans to continue engaging with hospitals during the Pre-Implementation period to provide hospitals with information to make an informed decision regarding

[8] Sources: GMCB, Adaptive Platform, Payer Revenue Sheet and Income Statement, FY 2022. Data has not been validated with hospitals.
[9] This represents the Medicare global budget payment included revenue. It includes hospital net patient revenue (NPR) and fixed prospective payment (FPP) revenue for Medicare residents and non-residents. Excluded revenue contains physician revenue and the beneficiary portion estimates.
[10] Takes included Medicare FFS NPR and FPP revenue for each hospital and divides by the included Medicare FFS NPR and FPP revenue for all hospitals.

participation in AHEAD, and to ensure that Vermont meets the minimum hospital participation requirements. A high-level timeline and a more detailed description of activities is below.

Table 2. Timeline for Hospital Engagement

Activity	2024		2025			
	Q3	Q4	Q1	Q2	Q3	Q4
GMCB and AHS continue to share information, updates, and financial modeling of the state-proposed methodology through: • VAHHS Financial Leaders meetings • One-on-one and group meetings with hospitals • Hospital Global Budget TAG meetings • Health Care Reform Work Group meetings • Public meetings	X	X	X	X		
AHS engages with hospitals to understand concerns and lead recruitment efforts through: • Working with VAHHS to meet with hospital CEOs and CFOs • One-on-one meetings with hospitals	X	X	X	X		
Medicaid solicits feedback from hospitals on development of a Medicaid hospital global budget methodology through: • Hospital Global Budget TAG meetings • Health Care Reform Work Group meetings • One-on-one and group meetings with hospitals	X	X	X	X		
GMCB aligns state hospital budget review methodology to reflect transition to hospital global budget payments		X	X	X	X	X
Hospitals express commitments to global budgets				X	X	
State identification of potential and committed hospital participants' TA needs	X	X	X	X	X	X

During the Pre-Implementation period, the State will focus on ensuring that hospitals understand the incentives under the AHEAD model, including (1) financial incentives, such as stable and predictable funding and upward adjustments to support care transformation and improve health equity, and CAH-specific policies for service line changes and other methodology components, and (2) non-financial incentives, such as TA and learning resources

to aid transformation activities. To help with hospital recruitment and address hospitals' concerns described below, Vermont is exploring providing additional financial incentives that will be detailed in the proposed Medicare FFS state-designed methodology. Pending CMMI approval of the state-designed methodology, AHS will focus on these incentives during hospital meetings to encourage participation.

GMCB's role as the regulator will be to provide information, updates, and modeling of the state-proposed Medicare FFS payment methodology in a transparent manner to hospitals, other key stakeholders, and the public, in conjunction with AHS, during the Pre-Implementation period. Pending CMS approval of Vermont's state-designed Medicare FFS global budget methodology, GMCB plans to update the hospital-specific financial modeling. The timing of updating the modeling is dependent on discussions with and approval from CMMI. GMCB and AHS will subsequently engage with hospitals through VAHHS Financial Leaders meetings and one-on-one meetings with hospital and health system leaders to explain the revised modeling, along with continued updates to the state-proposed methodology. GMCB and AHS will also continue to engage the Global Budget TAG on policy decisions and updates regarding the state-proposed methodology, and will provide updates on the methodology to a broader group of stakeholders via the Health Care Reform Work Group and public meetings. In addition, GMCB will work to align its state hospital budget review methodology, where needed and appropriate, to reflect a move from FFS to hospital global payments for at least some hospitals.

Vermont Medicaid (DVHA) will solicit feedback from hospitals and other stakeholders through Global Budget TAG and Health Care Reform Work Group meetings and meetings with hospitals to inform development of the Medicaid hospital global budget methodology.

Following submission of the methodology, Medicaid will continue to engage with hospitals and others on refinements prior to final CMS approval.

During the second half of 2025, the State will work with hospitals that intend to participate to ensure that these hospitals receive needed TA and other supports to successfully transition to global budget payments. During this time period, the State will also continue engaging with hospitals that have elected not to participate in Performance Year 1 but have expressed interest in participating beginning in Performance Year 2 or later.

Policy and Regulatory Levers to Incentivize Hospital Participation

Vermont is currently considering a voluntary approach to hospital participation in AHEAD and will use both CMS-defined and Vermont-specific policy levers to incentivize participation, as discussed below. The State's Hospital Global Budget TAG generated two other options for hospital participation, both of which would use GMCB's provider rate-setting authority pursuant to 18 V.S.A. § 9376, which authorizes GMCB to implement rate-setting for different groups of health care professionals (see Section V). The first option is a phase-in approach whereby hospitals voluntarily join at the start of the model. As the model progresses, the State would move to provider rate-setting by a certain date. Under the second option, if it appears that a voluntary or phased-in approach could result in the State not meeting the AHEAD milestones for participation, the State would pursue required hospital participation through provider rate-setting.

Prior to exerting regulatory levers, Vermont plans to incentivize early hospital participation in AHEAD through educating hospitals about the existing financial and non-financial incentives under the model, as described above. In addition, the State will educate

hospitals on state-specific financial incentives, pending CMMI approval of the state-designed methodology, to help inform hospitals' decisions to join the AHEAD model.

Recruitment Goals, Potential Challenges, and Contingency Plan

Vermont intends to meet the AHEAD model milestone requirements for the minimum percentage of Medicare FFS NPR that will be under Medicare FFS hospital global budgets, as well as the requirements for Medicaid and commercial payers to participate in hospital global budgets. Vermont's recruitment goals will focus on ensuring that these milestones are met. If the State is unable to obtain sufficient hospital participation to meet the requirements, the GMCB may invoke its provider rate-setting authority as a contingency plan.

Vermont anticipates several hospital recruitment challenges. As raised in Section III, Vermont has low Medicare spending compared to other states, and hospitals may have reservations about joining AHEAD if they are expected to further reduce Medicare TCOC growth. The COVID-19 pandemic exacerbated sustainability challenges for Vermont health care providers and hospitals. Vermont hospitals have experienced thin or negative margins in recent years. In FY22, aggregate Vermont hospital operating margins were -1.8%, with PPS median hospital operating margins of -3.8% and CAH median hospital operating margins of 1.0%, which represented marked declines from 2021. In FY23, aggregate operating margins were 0.78%, with PPS median hospital margins of -2.7% and CAH median hospital operating margins of -1.6%. Furthermore, CAHs have concerns about moving away from cost-based reimbursement.

In addition to being financially fragile, Vermont hospitals have access issues, including long wait times for certain specialty care, as documented in a 2022 interagency State report and information that GMCB collects through the hospital budget review process. Like many

other states, Vermont is experiencing challenges with patient flow through the health care system, particularly related to availability of post-acute care and MH/SUD services. Vermont Medicaid has taken steps to address these challenges, such as enhancing MH crisis services; implementing an alternative payment model for inpatient MH services delivered by the Brattleboro Retreat to ensure predictable cash flow; increasing rates for certain home health agency services; and proposing updates to skilled nursing facility rate methodologies. However, further work is needed to address access and patient flow challenges for Medicare and commercially insured populations. As noted in Section III, Vermont hospitals' financial status and previous savings limit the ability to invest in additional capacity to address access challenges. As a result, hospitals may hesitate to participate in AHEAD without a guarantee of additional state-specific financial incentives under hospital global budgets, which will be detailed in the proposed state-designed methodology.

Section V. Hospital Global Budget Methodology Development

A. State-Designed Medicare FFS Methodology

The State of Vermont intends to develop a state-specific Medicare FFS hospital global budget methodology. The State has oversight authority through the existing hospital budget review process, and could implement the state-specific Medicare FFS hospital global budget methodology for those that participate using provider rate-setting authority.

Statewide Hospital Budget Setting Authority: Under 18 V.S.A. § 9375 (Duties), GMCB is required to review and establish hospital budgets pursuant to 18 V.S.A. § 9456. Under this statute**,** GMCB is directed to conduct reviews of each hospital's proposed budget and establish an annual budget under which each hospital must operate. Pursuant to 18 V.S.A. § 9451

(Definitions), GMCB's hospital budget review authority applies to all state-licensed hospitals, except the Vermont Psychiatric Care Hospital that is operated by the State of Vermont. The hospital budget review statute is implemented via GMCB Rule 3.000. As defined in Hospital Budget Guidance, GMCB currently makes annual decisions for each hospital's budget that establish: (1) allowable growth in NPR and FPP, and (2) caps for the average gross charge increase for all services across all payers. GMCB has significant flexibility within the existing statutory authority, which could be leveraged to support hospital financial regulation under a state-designed hospital global budget.

Statewide Provider Rate-Setting Authority: Under 18 V.S.A. § 9375 (Duties), GMCB is authorized to implement methodologies for achieving payment reform and containing costs, which may include global payments or global budgets. In addition, 18 V.S.A. § 9376 (Payment amounts; methods) authorizes GMCB to set reasonable rates for health care professionals, among other entities providing health services or supplies. The statute specifies that GMCB, in its discretion, may implement rate-setting for different groups of health care professionals over time. This authority could be used in 2 different ways. First, the GMCB could use rate-setting to ensure that there is a consistent global budget payment methodology for hospitals voluntarily participating. Second, if it appears that voluntary participation will be insufficient to meet the AHEAD participation milestones, the GMCB could use this authority, in combination with the hospital budget review process, to require participation. The GMCB has not exercised the rate-setting authority to date and will need to enact rules to implement a payment methodology.

State Experience in Hospital Population-based Payments:

The VTAPM supports risk-sharing arrangements and population-based payments that flow through OneCare Vermont, the sole all-payer ACO operating in the state, to participating hospitals. For ACO-attributed Medicare beneficiaries, hospitals can elect AIPBPs, which include expected FFS claims in prospective monthly payments for each attributed beneficiary, with reconciliation to Medicare FFS at the end of the year. For the Medicaid ACO initiative, hospitals receive FPPs which are not reconciled with FFS payments. For the commercial ACO initiative, participating commercial payers reimburse through FFS payments. In the VTAPM Performance Year 7 (2024), 8 of the 14 eligible Vermont hospitals participate in all 3 payer initiatives. 14 hospitals participate in the Medicaid ACO initiative (13 of 14 eligible Vermont hospitals and 1 New Hampshire hospital) and 10 hospitals participate in the Medicare ACO initiative (9 Vermont hospitals and 1 New Hampshire hospital).

B. Medicaid Hospital Global Budget Methodology

As mentioned above, Vermont Medicaid is already engaged in a risk-sharing arrangement and makes population-based, fixed, unreconciled payments to hospitals through the VTAPM. This arrangement, which includes prospective attribution and TCOC accountability for attributed Medicaid members, grew from 4 participating Vermont Health Service Areas (HSAs) in 2017 to 14 participating HSAs (all HSAs in Vermont) in 2019 through 2024. Each HSA's hospital is the risk-bearing entity for that community, and each hospital is paid by OneCare (the ACO) an unreconciled fixed prospective payment for hospital services for Medicaid members who either seek care in or reside in that HSA's catchment area. In 2024, Medicaid leveraged its existing relationship with OneCare to evolve the Vermont Medicaid Next Generation ACO

model to offer a voluntary payment model that would convert remaining FFS revenue for unattributed Medicaid members for TCOC services for ACO-participating hospitals and independent primary care practices into prospective payments. This complementary offering begins to break the link between attribution and prospective payments, and tests global budget-like arrangements to prepare participating entities for Medicaid's potential future participation in the AHEAD model. Medicaid already has valuable experience developing global budget-style payment arrangements, as well as developing and implementing a financial, utilization, and quality monitoring framework for this complementary model, and is thus well placed for future, more advanced global budget payment arrangements under AHEAD.

Vermont Medicaid, through its current ACO arrangement, also has experience developing attribution methodologies based on past utilization patterns and geographic area of residence, and could easily leverage these methodologies for assessing hospital quality performance and TCOC accountability under a global budget model.

Proposed Authority for Medicaid Hospital Global Budget Payments: To implement Medicaid hospital global budgets, Vermont would leverage the State Directed Payment (SDP) mechanism under 42 CFR §438.6(c) or an amendment to its current 1115 Global Commitment to Health Demonstration Waiver. If CMS's rules governing SDP do not allow for an unreconciled global budget, the State would seek to amend its 1115 Demonstration Waiver. The State does not anticipate using a State Plan Amendment to authorize these payments because the State's current 1115 Demonstration Waiver permits the State to make payments using methodologies or payment levels that differ from what is in the State Plan.

Process for Developing and Implementing Medicaid Hospital Global Budget Methodology:

Upon notification of selection in Spring 2024, Vermont Medicaid would begin work with its contracted actuaries on developing a Medicaid hospital global budget methodology. Vermont Medicaid would leverage existing forums and groups described above to engage with hospitals, as well as the Medicaid and Exchange Advisory Committee (MEAC) to solicit consumer input on Medicaid's participation in the AHEAD model. Vermont Medicaid would incorporate stakeholder input in a refined hospital global budget methodology, which it would submit to CMS for approval by January 1, 2025. Simultaneously, Vermont Medicaid would engage with CMS and leverage TA to determine the best pathway for regulatory approval. The timeline for approval and authority for implementing hospital global budgets differs between the SDP and 1115 waiver processes, but Vermont anticipates having time during the Pre-Implementation period to secure approval for implementing hospital global budgets on January 1, 2026. See Table 3 below for a more detailed timeline.

Table 3. Vermont Medicaid Timeline for Hospital Global Budget Implementation

Milestone	Deadline
Anticipated Notice of Award	May-June 2024
Vermont Medicaid engages with CMCS TA to determine which regulatory pathway would be most appropriate for Medicaid hospital global budgets in Vermont and submits initial proposal to CMS	June- July 2024
Vermont Medicaid and its contracted actuaries begin design and development of Medicaid hospital global budget methodology, solicit feedback from stakeholders (via Hospital Global Budget TAG, VAHHS, Vermont Medical Society, and MEAC)	June-September 2024
Vermont Medicaid and its contracted actuaries incorporate stakeholder feedback, refine Medicaid hospital global budget methodology	October-December 2024
Vermont Medicaid submits detailed Medicaid hospital global budget methodology to CMS	January 2025
Vermont Medicaid works with hospitals intending to participate to ensure they receive needed TA and other supports	July – December 2025

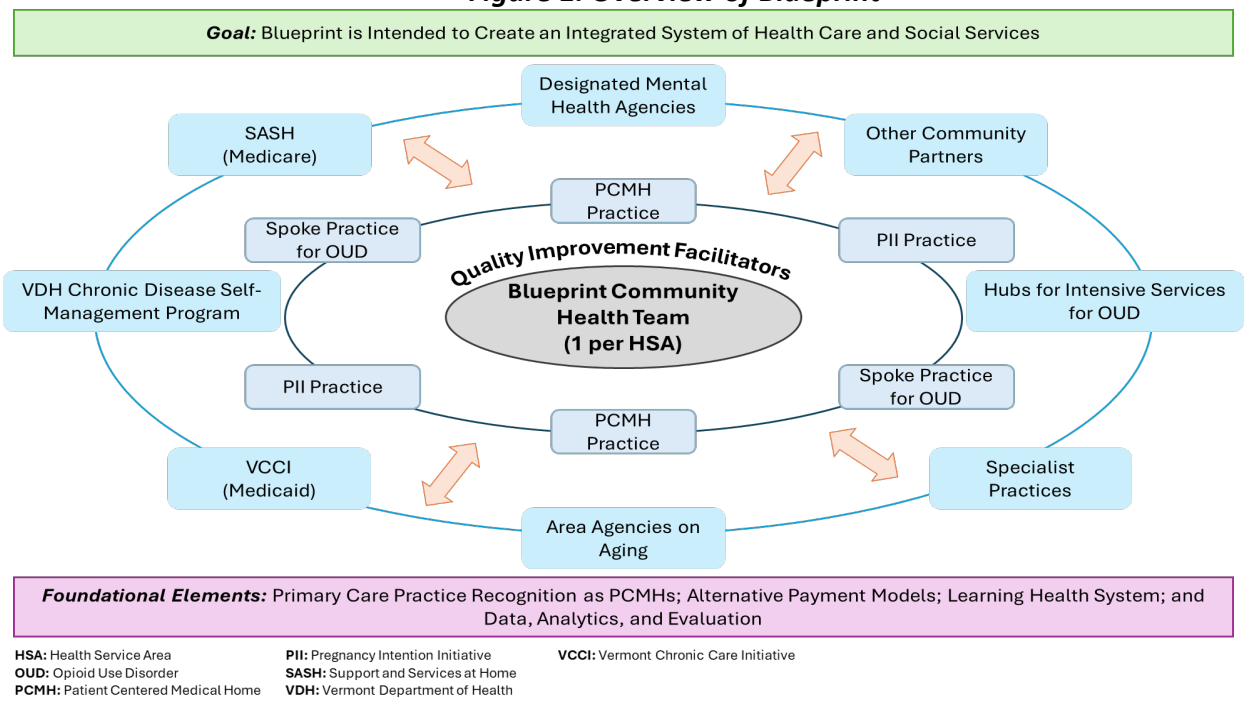
Eligible and interested hospitals confirm participation in Medicaid hospital global payment model	No later than October 1, 2025
Vermont Medicaid receives approval for implementing hospital global budget payment model from CMCS (SDP or waiver)	November 1, 2025
Vermont issues GC public notice 30 days prior to implementation of Medicaid hospital global budget methodology	December 2025
Vermont Medicaid begins implementation of Medicaid hospital global budget methodology	January 2026

Section VI. Vision for Primary Care Transformation

Current Primary Care Transformation Initiatives and Goals Under Medicaid Primary Care APM

Blueprint: Through participation in AHEAD, Vermont will build upon its longstanding Medicaid and multi-payer primary care transformation approach, the Blueprint. Blueprint will remain in place and (as explained below) is currently expanding on a pilot basis to increase screening for HRSN and further integrate MH/SUD services. Vermont's vision is that Primary Care AHEAD will align closely with Blueprint and further enhance Blueprint's ability to serve Vermonters in a payer-agnostic fashion.

Figure 1. Overview of Blueprint



HSA: Health Service Area
OUD: Opioid Use Disorder
PCMH: Patient Centered Medical Home
PII: Pregnancy Intention Initiative
SASH: Support and Services at Home
VDH: Vermont Department of Health
VCCI: Vermont Chronic Care Initiative

The Blueprint has been in place since 2008, when Medicaid launched it as a pilot program. It is designed, administered, and supported by a centralized team at AHS. Blueprint is Vermont's Medicaid APM for primary care, yet is also broader than Medicaid: the expectation is that Blueprint services are available to individuals who need them, regardless of insurance coverage. Commercial insurers are statutorily mandated to participate in the Blueprint: Blue Cross Blue Shield of Vermont (BCBSVT), MVP Health Care, and Cigna Healthcare have done so since 2010. Medicare FFS's continuous participation in Blueprint began in 2011 when Vermont was selected for CMS' MAPCP Demonstration, and Vermont looks forward to continuing to work with Medicare FFS under Primary Care AHEAD.

Most of the state's primary care practices (130 out of 160-170 total) participate in Blueprint, including all hospital-owned practices, all 48 FQHC practice sites, all 10 RHCs, and most independent practices.[11] In 2022, 330,000+ Vermonters visited Blueprint-participating primary care practices, making up over 75% of Vermonters with medical claims submitted to Vermont's all-payer claims database. Core elements of the Blueprint program include:

***Patient-Centered Medical Homes (PCMHs)*:** All Blueprint practices are required to obtain and maintain PCMH recognition from the National Committee for Quality Assurance (NCQA). Since most primary care practices currently participate in Blueprint, Vermont expects that all practices opting into Primary Care AHEAD will be Blueprint PCMH practices. Medicaid and all other participating payers provide PCMHs with PMPM payments for their attributed members to support advanced primary care, using a PMPM structure aligned with Primary Care AHEAD's

[11] The practices that do not participate are small independent practices, many of which are naturopathic practices (which are identified as primary care in Vermont) or direct pay practices that do not take insurance.

Enhanced Primary Care Payment (EPCP) in key areas. As of 2024, the Medicaid base PMPM is $4.65, paid monthly. Patients are attributed to a PCMH if they had a majority of their primary care visits at the PCMH within the prior 2 years. PCMHs can earn additional payments of up to $0.50 PMPM from Medicaid and commercial payers based on their performance on quality and utilization indicators.[12]

Community Health Teams (CHTs): Blueprint has long encompassed a care coordination/care management structure called CHTs. The CHT structure, financially supported by Medicaid and all Blueprint participating payers, sets Vermont apart from typical Medicaid PCMH programs by providing additional support aligned with all three of CMS' priorities for Primary Care AHEAD (integrating MH/SUD treatment; improving coordination of care; and identifying and addressing HRSN). There is one CHT in each of the state's 13 HSAs. Their role is to augment services provided by PCMHs for patients with complex health and social needs. While the composition varies by HSA, CHTs often include community health workers, nurse care coordinators, social workers, health educators, panel managers, dieticians, and MH/SUD clinicians. CHT payments are provided by all participating payers to a central administrative entity in each HSA, which distributes the funds for hiring CHT staff.

***Additional Blueprint Components Funded by Medicaid*:** Over the years, the CHT structure has served as a springboard for innovative care transformation in Vermont. At this time, these interventions are funded by Medicaid only. Each aligns closely with the goals of Primary Care AHEAD as noted in parentheses.

[12] Indicators include Child and Adolescent Well-Care Visits, Developmental Screening in the First Three Years of Life, Hemoglobin A1c Poor Control, Controlling High Blood Pressure, and Total Resource Utilization Index.

- ***Opioid Use Disorder Treatment (SUD integration):*** In conjunction with VDH, the Blueprint co-directs the nationally recognized Hub and Spoke program that provides treatment for individuals with opioid use disorder, including coordination with specialty care. Opioid treatment programs ("hubs") offer higher intensity services, such as daily medication and therapeutic support. VDH administers 8 hubs throughout the state. The 85 participating PCMH and specialty care practice sites (as of 2023) that serve as Spokes provide office-based opioid treatment services, including medication, screening, and care management. Payments to spokes are determined by the number of patients with MH/SUD conditions that are served. On average, Medicaid pays $196,500 per 100 individuals served to hire nurses and MH/SUD clinicians.
- ***Pregnancy Intention Initiative (MH/SUD, Specialty Care Integration, HRSN)****:* PCMH or specialty practices that agree to participate in this program are provided with staffing resources to enhance discussion of pregnancy intention, screening and brief interventions and treatment for HRSN and MH/SUD, and same day access to contraceptive care. Medicaid pays $78,000 for each Pregnancy Intention Initiative counselor to serve 1,200 patients, and pays each participating practice $1.25 PMPM to cover operational costs.
- ***Blueprint Expansion (MH/SUD, Specialty Care Integration, HRSN):*** In recognition of increased and concerning levels of acuity and mortality in MH/SUD and the need to address HRSN, this newest Blueprint initiative is a two-year pilot that began in July 2023, with the objectives of: (1) enhancing systematic identification of needs by screening for HRSN, MH, and SUD across the entire PCMH population; (2) providing additional

capacity for brief intervention within PCMHs; (3) providing ongoing treatment for low-acuity MH/SUD; and (4) supporting navigation to specialty and other community providers when needed. Most Blueprint practices (115) have elected to participate in the pilot. CHT staffing is increased to support PCMHs[13] to address MH, SUD, and HRSN; quality improvement facilitation is offered to assist with implementation; trainings are provided to increase knowledge and skill in MH/SUD care; and guidance documents are developed to summarize best practices, tools, and templates.

Support and Services at Home (SASH). The Blueprint works closely with SASH, which was implemented statewide in 2011 as part of the MAPCP. SASH is a unique wellness initiative that provides services and support to Medicare recipients living independently. Participants are part of a panel of up to 100 people based on where they live or, in some cases, their Medicare plan. Each panel has a care coordinator and wellness nurse who work together to provide prevention services, respond to HRSN, and develop a healthy living plan for each participant based on their self-defined goals. Since 2018, Medicare payments for SASH flow through OneCare (the ACO participating in the VTAPM). A 2019 federal HHS evaluation of SASH found that it had a favorable impact on Medicare expenditures; helped mitigate growth of Medicaid long-term institutional care spend; and helped participants avoid evictions.

Vermont tracks the success of Blueprint within the state and through independent evaluations. Vermont prioritizes tracking and reporting on: (1) quality performance (statewide and risk-adjusted by HSA); (2) measures of access to care and primary care utilization; and (3)

[13] Approved staffing types for the Blueprint Expansion pilot are Mental Health Counselors, Social Workers, Community Health Workers, Family Specialists, and Psychologists.

claims across the broader delivery system, including emergency department and MH/SUD utilization. Vermont also tracks and reports on the work of the CHTs, including staff roles and patients served by CHTs. Results can be found in an annual report to the Legislature. Blueprint has been independently evaluated multiple times since its inception, including as part of the MAPCP Demonstration. The evaluations suggest that the combination of PCMHs and CHTs offers benefits, including slower growth of Medicare expenditures, over PCMH payments alone.

Current VTAPM Programs: In addition to Blueprint, OneCare operates two payment models for its primary care network**.** All primary care practices participating in the ACO receive population health payments, PMPM payments funded by multiple payers including Medicaid. Hospital dues to OneCare subsidize the Medicare population health payments and a portion of the commercial payments. In addition, ACO-participating independent primary care practices have the option of participating in the Comprehensive Payment Reform (CPR) model, a payer-blended fixed payment model that replaces and supplements FFS payments with a single fixed monthly payment from OneCare. As of 2024, 19 independent practices are participating in CPR. OneCare's population health and CPR payments are separate from and in addition to Blueprint payments. While the future of ACO population health and CPR payments is uncertain with the expiration of the VTAPM, Vermont aims to continue offering prospective payments to primary care practices that are ready for them, and is encouraged by CMS' commitment to evolve Primary Care AHEAD towards a more prospective Medicare payment model in future years.

Plan for Aligning Medicare EPCP with Current Medicaid Care Delivery Requirements

Practices participating in the Blueprint are required to perform activities that align closely with CMS' care transformation goals for Primary Care AHEAD. Each Blueprint CHT

screens individuals for HRSN and works with Blueprint practices to connect patients to community resources and organizations that address identified needs. As described above, the Blueprint Expansion pilot provides Medicaid funding to expand CHT staffing to screen for HRSN (e.g., transportation, housing, food security), and to provide brief interventions and assist with navigation to services for patients with complex needs. The Primary Care AHEAD EPCP would support practices in serving additional Vermonters in alignment with the Blueprint.

Vermont has experience with establishing practice- and HSA-level accountability to ensure that Blueprint's care delivery requirements are advanced. First, each practice participating in the Blueprint must achieve and sustain recognition as a PCMH from the NCQA. Second, under the Blueprint Expansion pilot, to receive funds or accept staffing, participating practices must (1) incorporate CHT staff into patient care teams as needed; (2) engage with a Quality Improvement Facilitator to implement pilot goals and strategies and conduct continuous quality improvement activities; (3) screen for HRSN; (4) participate in educational opportunities offered by Blueprint related to MH/SUD treatment in primary care settings; and (5) submit information about staffing, CHT care, and quality improvement.

Vermont understands and appreciates that for Primary Care AHEAD, CMS will look to leverage existing or planned care delivery reporting mechanisms rather than create new ones at the federal level. Vermont is confident that existing requirements (particularly under the Blueprint Expansion pilot) can be used or built upon for this purpose.

Tools to Increase Primary Care Investment in Medicaid and Access to Primary Care Services

Vermont already uses a number of mechanisms to ensure strong investment in primary care, and will continue to pursue and enhance these tools for the duration of the AHEAD model. Tools include the following:

Regular Review and Updates to Medicaid Rates: Vermont Medicaid reviews reimbursement rates annually and mirrors the methodology employed by Medicare for its Physician Fee Schedule for professional services. In recent years, Vermont Medicaid has reimbursed primary care services at 100% of Medicare rates, which is unusual across state Medicaid programs nationally. With the support of the Governor and the Legislature, Vermont most recently increased rates to pay 110% of the 2023 Medicare rates for primary care services.

Potential Expansion of Mandatory Multi-payer Participation in Blueprint: As explained above, the Blueprint has unique statutory authority in 18 V.S.A. §706 to require participation from commercial insurers in its initiatives. Act 51 of 2023 required that Vermont evaluate the potential to support Blueprint through the health care claims tax. Vermont has been exploring the claims tax and other options (including additional legislation) to enhance multi-payer contributions to improve Blueprint sustainability.

Minimum Primary Care Spending Targets: As described in Section III, Vermont has not yet engaged in minimum target setting; however, Vermont has completed significant work defining and quantifying primary care spending across all payers, culminating in a 2020 Report to the Legislature, and is prepared to adopt minimum spending targets.

Exploration of FQHC/RHC Medicaid Alternative Payment Methodology:[14] In response to Act 51 of 2023, AHS developed a methodology that could be used to calculate Medicaid reimbursement to FQHCs and RHCs as an alternative to the federally-mandated Prospective Payment System. This alternative methodology was designed to address a gap between actual costs and the prospective encounter rates set by the federal Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) framework. If such an alternative were available, FQHCs and RHCs would have an annual opportunity to opt into the alternative payment methodology for Medicaid.

Workforce Initiatives: Vermont participates in federal and state funded initiatives to provide loan repayment for multiple levels of primary care providers, including MDs, DOs, APRNs, PAs, DDS, DMDs, and Primary Care RNs. In addition, Vermont has funded programs to provide preceptor payments for clinical educators, as well as pipeline and apprenticeship programs for nurses and nursing assistants at all educational levels to address the nursing workforce shortage. Vermont's J-1 visa waiver program's first priority for approving applications is primary care sub-specialties; and Vermont's Area Health Education Center system supports education programming to increase the primary care provider workforce and supports loan repayment programs as well as community health worker training and certification.

Planned Medicaid Primary Care APM Implementation by Launch of AHEAD PY 1

As described above, Vermont's Medicaid APM is the Blueprint. Vermont seeks to further build upon Blueprint's successes by (1) exploring expansion of multi-payer support; and (2)

[14] in the context of FQHC reimbursement, "alternative payment methodology" denotes an alternative to the PPS, rather than an alternative to FFS.

continuing to test enhanced MH, SUD, and HRSN interventions through the recently-launched expansion pilot. Vermont does not require any new Medicaid authorities to continue Blueprint implementation as the basis for AHEAD.

Current Participation of FQHCs and RHCs in Existing Medicaid Primary Care APM

There is robust FQHC and RHC participation in Vermont's Medicaid Primary Care APM; as mentioned above, all of the state's FQHCs and RHCs participate in the Blueprint. They have shown interest in participating in other health care payment reform efforts, including moving towards more prospective payment methodologies for their services over time. AHS recently advanced proposals to enhance Medicaid reimbursement of FQHCs and RHCs. Vermont will assess financial and care delivery impacts, develop risk adjustment methodology, and encourage FQHC and RHC participation in Primary Care AHEAD as described in Section VII.

Section VII. Primary Care Practice Recruitment Plan

Strategy for Recruitment

Summary of State Experience and Participation in Current Medicaid APM: As described in Section VI and below, Blueprint has a high participation rate across the primary care sector in Vermont. Because it administers the Blueprint, AHS can easily identify practices participating in the current Medicaid APM through its Blueprint provider portal. Primary care participation in the Medicaid component of the VTAPM is also high. Current practice counts for Blueprint and the Medicaid VTAPM through OneCare are shown in the following table.

Table 4. Primary Care Practice Participation in Blueprint and OneCare Medicaid Program

Blueprint Patient Center Medical Home		OneCare Medicaid Primary Care Practices	
by Practice Type	**Count**	**by Practice Type**	**Count**
FQHC-Owned	48	FQHC-Owned	39
Hospital-Owned	42	Hospital-Owned	40

Independent	40	Independent	35
Grand Total	**130**	**Grand Total**	**114**

Interest from Primary Care Practices to Date: AHS has conducted several Primary Care Workgroup sessions to discuss Primary Care AHEAD with leaders in the field, including primary care clinicians and representatives of Blueprint practices, the Vermont Medical Society, HealthFirst (an independent practice association), Bi-State Primary Care Association (the FQHC/RHC association), and OneCare. Vermont practices appear interested in continuing to partner with CMS and Medicare FFS on primary care transformation; are supportive of CMS' intention to align with existing Medicaid care delivery requirements; and are pleased to see AHEAD's emphasis on primary care investment. Issues that have arisen in discussing AHEAD with primary care leaders include: **(1) Desire for Forward Motion on Progress Made Under VTAPM:** As mentioned, OneCare's CPR model is a prospective, payer-blended methodology offered under the VTAPM. Independent practices that participate in CPR with OneCare appreciate the prospective nature of this payment. All practices have appreciated OneCare's population health payments. It is unclear what options will continue to be available for practices to participate with OneCare after the VTAPM ends. Practices with experience accepting prospective payments from OneCare and Medicare have indicated a preference to remain in a prospective arrangement similar to CPR rather than revert to FFS. **(2) Quality Reporting:** The VTAPM did not include electronic clinical quality measure (eCQM) reporting; thus, the transition to AHEAD will necessitate a change in quality reporting for most practices. While most practices in Vermont have Certified Electronic Health Record Technology (CEHRT), providers have indicated that they will need a period of adjustment and TA. **(3) Quality Payment Program (QPP)/Merit-Based Incentive Payment System (MIPS):** Since Vermont

practices participating in the VTAPM have been considered Advanced APM participants, practices in Vermont are concerned that AHEAD participation will result in a change in status with new administrative requirements. **(4) Primary Care Target Setting:** Primary care providers in Vermont are supportive of AHEAD's emphasis on increased primary care spend as a percentage of total spending. Providers have raised questions about CMS' methodology for calculating Medicare FFS primary care spend, particularly the gap between CMS' stated intention to reach 6-7% of all spending and the current Medicare FFS spend of around 3.8% as most recently calculated by CMS. Vermont providers have asked about the extent to which the EPCP will bridge the gap and whether increased primary care utilization for Medicare FFS beneficiaries is specifically expected.

Proposed Timeline of Primary Care Recruitment Activities: Pre-implementation recruitment planning for Primary Care AHEAD will occur from now until the end of the Pre-Implementation period (December 2025), with AHS leading Vermont's efforts to recruit practices into Primary Care AHEAD. Blueprint program managers in each HSA are also available to conduct practice outreach, answer questions, and support participation. A high-level timeline is in Table 5.

Table 5. Proposed Primary Care Recruitment Activities Timeline

Activity	2024				2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Development of educational materials	X	X	X	X				
Educational Sessions about Primary Care AHEAD for Blueprint practices and CHTs	X	X	X	X				
Presentations for: • Primary care related professional associations • GMCB's Primary Care Advisory Group	X	X	X	X	X	X	X	X

• AHS' Primary Care Workgroup • Other meetings (e.g., individual primary care organizations, HSA convenings)								
Identification of potential primary care practice participants' TA needs		X	X	X	X	X	X	X

AHS will engage with stakeholders in a variety of ways. Since practices will continue to participate in the Blueprint Medicaid APM, messaging will focus on signing up for Primary Care AHEAD to receive Medicare FFS's support in advancing primary care. Pre-implementation recruitment planning will include: **(1) Development of educational materials about Primary Care AHEAD:** Based on information provided by CMS about Primary Care AHEAD, AHS has begun developing materials explaining the Primary Care AHEAD model. Material will focus on: how AHEAD will build on the Blueprint structure, including existing care delivery requirements; the Medicare FFS Primary Care AHEAD payment model as described by CMS; and quality reporting expectations. **(2) Educational sessions about Primary Care AHEAD** for Blueprint state staff, program managers and CHT leaders from each HSA, quality improvement facilitators, and other field staff, with the goal of encouraging participation in Primary Care AHEAD. The State convenes these leaders monthly and more often if needed. **(3) Presentations to primary care-related professional associations** (current and ongoing throughout application and Pre-Implementation period). **(4) Presentations to Primary Care Practices Through AHS' Primary Care Workgroup and GMCB's Primary Care Advisory Group** to share information and solicit feedback, with emphasis on organizations representing and consisting of FQHCs and RHCs. **(5) Coordination with OneCare Vermont** to determine potential interaction between Primary Care AHEAD and CPR for independent primary care practices, depending on OneCare's decisions on continuing the program after the conclusion of the VTAPM. All of these activities will include

identification of TA to support primary care practices with analysis of impact and implementation of Primary Care AHEAD.

Recruitment Goals: Vermont plans to take a phased approach to Primary Care AHEAD recruitment, with the goal of increasing participation as the model progresses. Vermont's recruitment goals are: (1) all employed practices for participating hospitals; (2) 5 new FQHC and RHC sites per year for Performance Years 1 – 4; and (3) at least half (approximately 65 practices) of Blueprint-participating practices throughout the duration of the model.

Potential Challenges and Barriers to Recruitment: More than 40 practices in Vermont are hospital-owned. If hospitals choose not to participate in AHEAD, then their owned practices will not be able to participate in Primary Care AHEAD. Additionally, If OneCare were to decide to participate in MSSP, ACO-participating primary care practices may choose that option which could impact participation in Primary Care AHEAD.

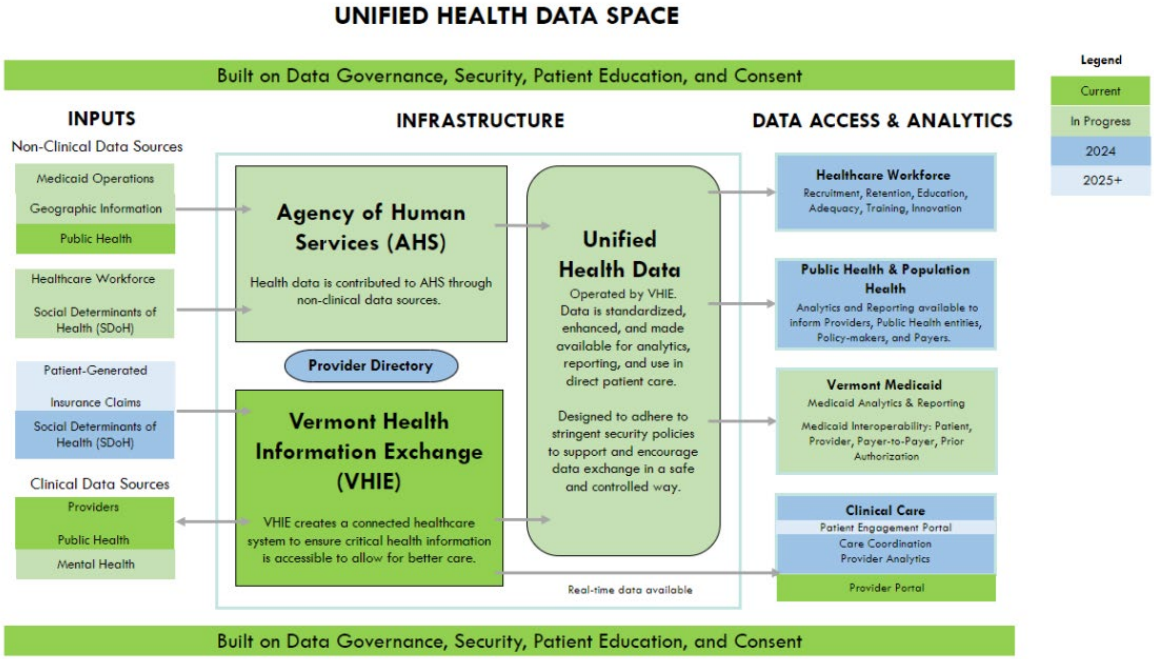
Alignment Between Primary Care AHEAD and Medicaid Primary Care APM: Vermont seeks to align Primary Care AHEAD and the Blueprint Medicaid APM by targeting recruitment efforts to practices currently participating in Blueprint. The AHEAD Model's transformation goals are closely aligned with Blueprint transformation goals. Vermont anticipates that this alignment will support successful recruitment of practices that participate in Blueprint to Primary Care AHEAD.

Section VIII. State Data / Health IT Infrastructure

Vermont's **Unified Health Data Space (UHDS)** is a collaborative initiative, led by AHS, to streamline data services required to improve health care in Vermont. UHDS draws together health care stakeholders for improvement supported by data: at the point of care (providers); quality and population health (payers, providers); policy (AHS, GMCB); and for patients directly.

UHDS is intentionally designed to support value-based payment and value-based care in Vermont. Figure 2 illustrates the relationship between various key functions of the UHDS.

Figure 2. Vermont's Unified Health Data Space



The four goals of the UHDS are to (1) create one health record for every person; (2) improve health outcomes; (3) improve healthcare operations; and (4) use data to inform investment and policy decisions. The UHDS infrastructure also provides data that supports the success of current care delivery and payment models in Vermont (e.g., Blueprint, VTAPM). By integrating data from various sources, the VHIE supports the UHDS's objective of providing actionable and meaningful insights for patient care. Vermont is one of the states that has an APCD. It is used to calculate TCOC, primary care spend, hospital global budgets, and quality measures. The APCD collects claims data (medical, pharmacy, dental) and eligibility data from public and private payers, which allows for in-depth analysis of health care delivery, costs, and quality, informing efforts to enhance affordability, access, and health outcomes.

Vermont continues to enhance and update the UHDS to include significant new functionalities planned for 2024, 2025, and beyond, as described below. Today, Vermont has a notably high level of engagement in UHDS, with all of Vermont's hospitals, the majority of primary care practices, and all designated MH/SUD community partners participating. 98% of Vermonters consent to their data being included.

Vermont Health Information Exchange (VHIE): Vermont is a national leader in Health Information Exchange implementation, with its VHIE being one of the first in the country to achieve CMS Certification in 2022. The VHIE is a key component of the UHDS infrastructure, which collectively acts as the statewide engine to collect, normalize, and exchange health data and enable the transformation of that data into actionable and meaningful insights for patient care. One key benefit of this certification is that VHIE is eligible for federal Medicaid funding through the Medicaid Management Information System (MMIS). VHIE provides data to OneCare and Blueprint in support of the current APM calculations. The VHIE consists of core modular and interoperable HIE technology infrastructure, aligned with the Office of the National Coordinator for Health Information Technology (ONC) standards. Aligned functionalities include: (1) A cutting-edge **Master Person Index (MPI),** ensuring 98% person matching and reducing the risk of costly errors. This supports care delivery by enabling care coordination, such as when a patient moves between providers, they are assured they are treating the same person and avoiding false positives; (2) **Advanced terminology services** standardizing 'local' codes and promoting interoperability. This supports care delivery by enforcing interoperability through the process of translating local codes into a standard that is uniformly used across all providers for diagnoses and treatments, eliminating risks of

misdiagnoses and incorrectly treating patients; (3) A powerful **integration engine** allowing for efficient integration of different data sources, making the sending of the data from the source (providers) efficient and secure; (4) A **Fast Healthcare Interoperability Resources (FHIR) Data Repository** on Release #4 (R4), ensuring compliance with the 21st Century Cures Act and enforcing interoperability rules as related to defining healthcare "resources" such as patients, providers, diagnoses; and (5) A **relational database** mapping FHIR into a relational model for efficient reporting and analysis allowing providers to obtain insights from the collected data by efficiently producing user friendly extracts, reports, and dashboards.

Action Plan: The 2023-2027 HIE Strategic Plan (a form of "action plan") last updated in December 2023, outlines the state's roadmap for further strengthening the existing UHDS foundation. Over the next three years, the following functions will be added to the UHDS as laid out in the Strategic Plan: **(1) Improvements to Population Health Capacity:** The UHDS is set up to provide data to address the unique needs of individuals with complex medical and social needs. UHDS is also working with VDH to integrate immunization and other registries, as well as ambulatory data that is otherwise not reflected in primary care records, such as rescue squads. **(2) Advanced Analytics Platform:** The state is committed to developing a comprehensive analytics layer to enhance data usability and support value-based care efforts. Scoping and requirements gathering for an advanced analytics platform will begin in 2024. **(3) Care Coordination and Referral Platform:** This platform will be a centralized hub that connects hospitals, healthcare providers, care managers, community partners, and patients, fostering efficient communication and collaboration. **(4) HRSN Focus:** Vermont has multiple HRSN projects underway. AHS is working to ingest New to Medicaid (NTM) and General Assessment

(GA) surveys conducted by the Vermont Chronic Care Initiative (VCCI) into the UHDS. AHS is also developing a unified approach for Blueprint providers to use a standard HRSN questionnaire developed by CMS, as part of the Blueprint Expansion described in Section VI. Both projects aim to collect HRSN data to use for care coordination, risk stratification, and population health reporting. These functionalities will strengthen practices participating in Blueprint and Primary Care AHEAD in screening, tracking, and managing HRSN. This focus is reflected within the HIE Data Governance Council and informs the state's data-driven initiatives.

(5) Medicaid: Medicaid is building the foundation for the data warehouse and analytics solution that will be utilized for claims and public health data, and population health reporting. The UHDS will also support Medicaid through its ingestion of VCCI HRSN data (described above) to be used for risk stratification, care coordination, and population health reporting. Finally, the UHDS will support Medicaid in its interoperability requirements for the 21st Century Cures Act.

Governance

The UHDS has a dedicated Data Governance Council, which was established in 2023. The Council holds monthly meetings that are chaired by AHS and includes voting members from Vermont Legal Aid, VDH, VITL, BCBSVT, VAHHS, and the Howard Center (a designated community MH agency). The Council has dedicated domain teams for 42 CFR Part 2 and HRSN to better address the complex nature of these data types and ensure compliance with state and federal requirements. Vermont is committed to transparency by holding open Council meetings and incorporating public feedback into its work.

Staffing to Support Statewide Data Infrastructure

Vermont possesses the necessary staffing capacity and organizational capability to successfully implement and manage the AHEAD Model. The state is committed to continuous optimization, learning, and improvement to ensure the highest level of effectiveness. AHS' agency-wide data team draws experts from various departments with diverse skillsets. More detailed information on the staffing structure of the team is available in the Appendix.

Health Oversight Agency (HOA)

AHS and GMCB both intend to comply with the CMS requirements for health oversight agencies. As described above, both agencies use Medicare data for different functions. AHS is designated as an HOA and aims to incorporate Medicare claims data into the UHDS through a data use agreement, to merge claims and clinical data for analytics to support care transformation. GMCB has a current data use agreement with CMS for Medicare data through VHCURES and is currently designated as an HOA, with a focus on measurement and reporting.

Section IX. Current and Planned Health Equity Activities

State Strategies to Improve Health Equity

Vermont has extensive experience designing and implementing population health activities to improve health equity. Vermont's rurality and workforce shortages can create access barriers, exacerbating other known inequities.

Outreach, Stakeholder Engagement, and Data Collection/Analysis: Vermont has multiple structures in place to identify and make progress on equity. **(1) The Vermont Health Equity Advisory Commission (HEAC),** which is advisory to VDH and the Legislature, is tasked with promoting health equity and eradicating health disparities among Vermonters, including those who are Black, Indigenous, and Persons of Color (BIPOC), those who are LGBTQ+, and

individuals with disabilities. As described further in Section X, the HEAC includes significant representation from Vermonters from groups subject to health disparities. Part of the HEAC's role is to advise on the development of a new Office of Health Equity. The HEAC is also charged with creating a common terminology around health equity to be used by the State of Vermont and recommending how data should be collected and grouped. The HEAC developed initial recommendations on analyses and research that must be completed to establish proposed definitions. **(2) SHA/SHIP:** VDH undertakes a State Health Assessment (SHA) and State Health Improvement Plan (SHIP) on a five-year cycle. In the 2018 – 2023 SHA/SHIP cycle, Vermont took intentional steps to incorporate a health equity lens throughout planning and development. The State engaged with a range of diverse organizations with backgrounds in agriculture and rural issues, racial justice, immigrant issues, disability rights, veterans' affairs, aging, and youth leaders in these efforts. The 2018 SHA identified and quantified health inequities among Vermonters of Color; LGBTQ+ Vermonters; Vermonters with Disabilities; and Vermonters with Lower Incomes. Based on the findings from the 2018 SHA, VDH worked with a broad set of stakeholders to develop a set of State Health Improvement Strategies in the SHIP. At the time of this application, VDH is in the process of updating the SHA which will guide SHIP implementation in 2025. To ensure the health needs addressed in the plan are grounded in the lived experience of all Vermonters including the groups identified above, the Department has partnered with a Vermont-based contractor to complete an environmental scan to inform the SHA. Starting in December 2024, a Steering Committee will identify the top 3-5 priorities and, within these priorities, goals for improvement; strategies to achieve the goals; and indicators to track progress. **(3) Hospital CHNAs and Act 167**: Two sources of insight into hospitals'

awareness and attention to health equity issues are hospital Community Health Needs Assessments (CHNAs) and results from community outreach outlined in Act 167. In recent years, Vermont's community hospitals have become increasingly attentive towards issues of health equity, which is reflected in insights gained through both processes. The most noted concerns from CHNAs align with those identified by the SHA. Certain hospitals have been particularly proactive in addressing these issues. For instance, Brattleboro Memorial Hospital engaged their county's NAACP Health Justice Community, which coordinated a large data-collection effort to address disparities in COVID-19-related harm for people of color. The University of Vermont Medical Center acknowledged that the population of Burlington is diversifying and has made efforts to improve accessibility of (and trust in) their services to non-white people, non-English speaking people, immigrants, and LGBTQ+ people. Central Vermont Medical Center identified that local Asian residents reported alarming rates of uninsurance in their county, and that local LGBTQ+ residents reported abnormally high rates of food insecurity and mental illness. The Vermont Legislature, through Act 167 of 2022, directed GMCB to collaborate with AHS to develop and facilitate a "data-informed, patient-focused, community-inclusive engagement process" for Vermont's hospitals to improve population health outcomes, reduce health inequities, lower costs, and increase access to essential services. To achieve this goal, GMCB is working with a contractor to analyze existing Vermont data and facilitate 30+ community and provider meetings across the state, as well as 13 interviews with community members identifying or representing Vermonters from diverse populations, with recommendations expected in mid-2024. **(4) Health Equity Community Needs Assessments**: In 2023, the Vermont Program for Quality in Health Care (VPQHC), a non-profit designated by the

Vermont Legislature to focus on quality analysis and improvement across the health care continuum, facilitated focus groups with individuals from communities experiencing health inequities in each HSA, focusing on participants' access to hospital care and cultural and linguistically appropriate care. VPQHC is developing individualized reports for each hospital on focus group findings, strengths, and recommendations for improvement. These reports will be distributed to each site by May 2024.

Planning and Implementation of Care Delivery Activities to Address Health Inequity

Vermont's programs and initiatives focused on care delivery and population health improvement are intentionally focused on improving health equity, including the specific disparities identified above. Each of these existing activities can be leveraged to support performance on AHEAD's statewide quality measures and execute against the Statewide Health Equity Plan (HEP) that Vermont will produce for AHEAD. Vermont is energized by the opportunity under AHEAD to reduce health inequities. Key care delivery activities and programs include: **(1) Blueprint and Blueprint Expansion Pilot**. The Blueprint annually publishes Community Health Profile Data by each Blueprint hospital service area community, with the purpose of using such data to evaluate Blueprint effectiveness and plan improvements to the program. Blueprint's CHT approach is strongly oriented to improving equity by addressing HRSN, as described in Section IV. Blueprint's existing measures are also closely aligned with the Medicare measures listed in Appendix X of the NOFO. **(2) Medicaid programming under the 1115 Global Commitment Waiver.** Vermont has offered several initiatives to advance new care models and efforts to advance health equity through its Global Commitment to Health Section 1115 Demonstration (first approved in 2005), including a Supportive Housing Assistance Pilot**;**

alternatives to MH crisis care (e.g., Psychiatric Urgent Care for Kids); intensive housing case management; and cultural and linguistic competence training for designated and specialized services agencies that provide developmental services. **(3) Certified Community Behavioral Health Clinics (CCBHCs).** Vermont received a CCBHC planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2023 and is in the process of planning further implementation. CCBHCs are required to provide robust care coordination services, including connecting individuals to social services, housing, educational systems, and employment opportunities. **(4) Vermont Chronic Care Initiative (VCCI).** Through this complex care management initiative, individuals enrolled in Medicaid (including dually eligible members) with complex needs receive holistic, intensive, and short-term case management services. VCCI case managers and outreach coordinators screen members to identify and prioritize their medical needs and HRSN. **(5) Health Equity Grant Funding.** VDH was awarded a Centers for Disease Control and Prevention (CDC) COVID-19 Health Equity grant to address the persistent and disproportionate impact of COVID-19 on populations at higher risk of health disparities. The Department established an Office of Health Equity Integration with the mission of reimagining and rebuilding public health systems that have historically prevented individuals and communities in Vermont from living their healthiest lives. They issued grants to a range of organizations to implement various HRSN interventions.[15] **(6) Health Care Quality Funding.** VDH provided funding to VPQHC to advance health equity. Funding was used to provide 18 health equity trainings to health care workers. It also supports hospital quality initiatives, including (1) assessing the current state of hospitals' health equity activities; (2) identifying and

[15] A full list of projects funded by CDC's COVID-19 Health Equity Grant can be found here.

providing TA for hospitals and their health equity quality improvement projects; (3) cohort-level trainings on systems-level strategies for advancing health equity in hospitals; and (4) the Health Equity Community Needs Assessment described above.

State-Level Requirements and Investments to Identify and Address HRSN

Over the past nearly two decades, Vermont has made significant investments in interventions designed to address HRSN, through: **(1) HRSN Grant Funding.** AHS is currently in the process of developing a $500,000 program that will provide grant funding or incentive payments to eligible HCBS providers and PCMHs that coordinate with HCBS providers to select, implement, and/or integrate HRSN screening tools or available HRSN data into their intake and assessment processes. AHS will provide TA to eligible applicants seeking funding for HRSN screening tools and assistance in use and exchange of HRSN data. **(2) HIE Initiatives.** As described in Section VIII, the VHIE Strategic Plan is highly focused on HRSN data integration. Vermont's Medicaid Data Aggregation and Access Program (MDAAP) supports HCBS providers and MH/SUD treatment providers to purchase data systems and connect to the VHIE. The program has 5 distinct tracks; incentive payments are tied to achieving specified milestones within each track. As of March 2024, nearly all the Designated Agencies (community MH providers whose clients are 51-100% Medicaid) have completed milestones within the program to update their HIT infrastructure. **(3) VHCURES.** VHCURES is Vermont's APCD. As of February 2023, Vermont added fields in VHCURES to report race and ethnicity data. Incorporating data on race and ethnicity is essential to identifying health inequities across communities, providing insights for interventions and program development, and assessing progress toward health equity. Data on race and ethnicity, along with other demographic data in VHCURES, facilitates more actionable

analyses. **(4) VTAPM.** OneCare, Vermont's contracted statewide ACO, is working to improve the capacity of providers to address their patients' HRSN. For example, since October of 2023, OneCare has convened 3 working sessions with providers from across the state and health care continuum, as well as payers and AHS representatives, to explore the feasibility of using an aligned HRSN screening tool across the health system while also continuing to meet requirements and regulations around HRSN screening. The goal of this work is to align processes for collecting HRSN data that can be electronically transmitted to and governed by the state's HIE.

AHEAD Model Components to Meet Health Equity Objectives and Program Requirements

Vermont intends to use a portion of the Cooperative Agreement funding for activities to meet the model's health equity objectives and program requirements. First, funding will be allocated to the AHEAD Model Governance Structure. As described in Section X, funding will be used to hire 2 full time employees to manage program administration, coordinate activities, and implement the structure. Funding will be available for stipends, meeting accommodations, and accessible meeting locations to ensure individuals representing communities experiencing health disparities are able to actively participate. Contractor resources will be used to develop materials for the model governance meetings to ensure content is clear and members are meaningfully engaged and to support development of the Statewide HEP. Additional funding will be used to support health system capacity-building equity initiatives informed by the Model Governance Structure that align with the Statewide HEP. Some Cooperative Agreement funding will be used to provide TA to hospitals and primary care providers to support them with meeting program requirements (e.g., quality and health equity reporting).

Section X. Proposed Model Governance Structure

AHEAD is a complex model with multiple implementation components including hospital global budget implementation, primary care model implementation, and TCOC and primary care spending target attainment. To inform model implementation and ensure participants are progressing towards shared goals, Vermont proposes creating an AHEAD model governance body as a critical subgroup of the AHS Health Care Reform Workgroup, which focuses on comprehensive health care reform. The key responsibilities of the AHEAD model governance body ("AMGB") will be to review and advise on overall progress of model implementation; provide input into selection of AHEAD statewide measures and targets as described in the NOFO; develop and provide progress reports on the AHEAD Statewide HEP; review Hospital HEPs; provide input into allocation of AHEAD Cooperative Agreement funds; and inform the Health Care Reform Workgroup about progress on AHEAD. AHS anticipates reviewing the membership of the Health Care Reform Workgroup to ensure broad representation.

Planned Model Governance Structure and Composition

The AMGB will be convened by the AHS Director of Health Care Reform, Medicaid Director, and VDH Commissioner (or designee). These conveners would be assisted by the proposed new AHS AHEAD Project Director; would approve the final list of individuals nominated for the AMGB; and would provide input on and approval of an annual workplan. AHS proposes that at least one-third of group participants identify as representing populations experiencing health inequities in Vermont under the SHA/SHIP (see Section IX above). If selected for AHEAD, Vermont would move to convene this group as quickly as possible, no later than 6 months after the CMS AHEAD award is made.

In addition to the conveners and assisting staff member, other key state government participants on the AMGB will be: Representative of GMCB; Representative of Department of Financial Regulation; and a Representative of Office of Rural Health. The AMGB will be comprised of an additional 12-17 participants external to state government, which AHS proposes will include at least 2 representatives of participating provider organizations, including at least one participating in hospital global budgets and at least one clinician participating in Primary Care AHEAD; at least 1 representative from commercial/Medicare Advantage payers; 1 non-governmental representative from the HEAC, which will remain separate from the AMGB but will closely communicate with it on equity issues; and representatives from groups with known disparities in Vermont, such as underserved communities; BIPOC Vermonters; individuals with disabilities, Indigenous Vermonters; LGBTQ+ Vermonters; unstably housed Vermont residents; and older Vermonters.

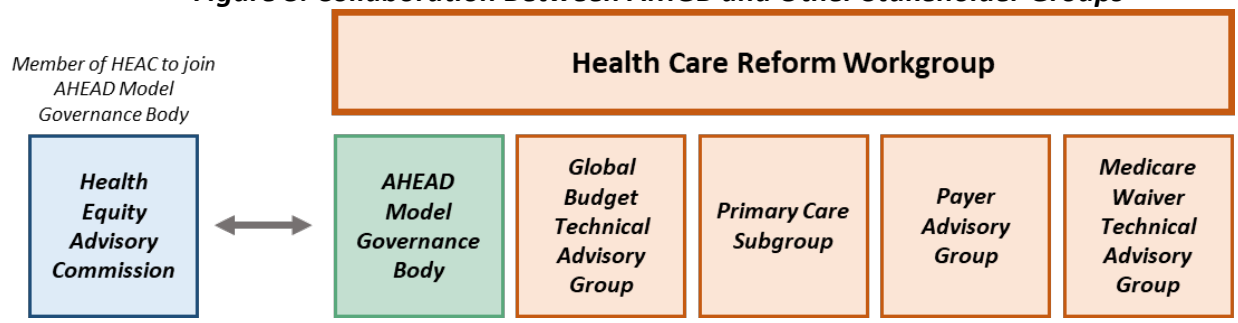
Individuals external to state government will be selected by AHS through a nomination and application process. Co-chairs will be selected among the participants to assist in agenda development and meeting facilitation. AHS recognizes that rigorous outreach and communication will be required to ensure that a balanced and representative group is recruited for the AMGB. To accomplish this, AHS plans to partner with the HEAC to develop informational materials (e.g., one-pagers about AHEAD and the AMGB) and host an informational webinar and office hours to describe the role and application process. As part of the application, applicants will be asked to describe their relevant experience, skills, and interest in participating; their affiliations; and the geography in which they live and work. They will be asked to submit a letter of reference to support their candidacy. AHS will review applicants to

identify where a single individual may represent multiple categories (e.g., an individual may be a BIPOC Vermonter and a primary care practitioner) and will ensure geographic diversity.

Collaboration and Intersections with Existing Stakeholder Groups

Vermont's experience overseeing the VTAPM and continuously improving payment and care delivery to advance the state's health care reform goals will strongly inform preparation for AHEAD. To achieve the goals of AHEAD, Vermont recognizes the need to offer a balance of (1) opportunities for deep stakeholder input on technical topics (e.g., hospital global budget methodology); (2) continued focus on advancing health equity; and (3) transparency about all aspects of the model. Vermont's vision for AHEAD governance is that the AMGB will complement Vermont's existing groups that specialize in the different model aspects, and continuously engage with the overarching Health Care Reform Workgroup.

Figure 3. Collaboration Between AMGB and Other Stakeholder Groups



As shown in the diagram, the existing groups are: **(1)** **Health Care Reform Workgroup and Subgroups:** As described in Section IV, the Health Care Reform Workgroup has been in operation since 2022. AHS has actively engaged both the main Workgroup and its subgroups to solicit feedback to inform preliminary planning on the AHEAD model, particularly around the issues of TCOC; Medicare waivers; hospital global budgets; and primary care.[16] **(2)** **The HEAC**,

[16] See the Legislative Reports webpage for more information on the various workgroups and meeting topics.

described in Section IX above. Additionally, GMCB has led the Global Budget TAG in collaboration with AHS. GMCB has existing advisory structures, including a General Advisory Group and a Primary Care Advisory Group, that advise GMCB on activities within the Board's scope of work, including regulatory activities anticipated under AHEAD. These structures will remain in place under AHEAD.

AHEAD Resources to Support Creation of Model Governance Structure

AHS intends to allocate Cooperative Agreement funding resources to support the AMGB through: **(1) AHS Staffing.** As mentioned above, the planned new AHS FTE (i.e., the Project Director) will focus on supporting the group and general stakeholder engagement and communications. **(2) Participant Supports.** AHS will provide funding for special accommodations (e.g., interpreters, closed captioning, etc.) and offer optional relevant trainings to ensure robust participation from members with disabilities and other individuals from communities experiencing health inequities. Stipends will be provided for pre-meeting preparation and meeting participation for members from communities experiencing health inequities who are not otherwise being paid for participating on the AMGB by other community-based or advocacy organizations. **(3) Community Meeting Space.** AHS will use Cooperative Agreement funding to support occasional in-person meetings in accessible locations. This would enable the group to strengthen relationships and obtain additional input from the public. **(4) Targeted Cooperative Agreement Funding.** The group will be able to direct funding through competitive grants or contracts to ensure the State is advancing the goals described in the AHEAD Statewide HEP.

Role in AHEAD Model Planning and Implementation

The AMGB will meet on a monthly basis. Meetings will be open to the public, and CMMI attendance will be welcome. Vermont anticipates that the group will meet more frequently at times, such as when the AHEAD Statewide HEP is under development. The group will: **(1) Review and advise on the overall progress of model implementation:** As data becomes available, the group will review key indicators of success under AHEAD (e.g., AHEAD statewide quality measures). Prior to implementation, Vermont expects the group to review progress on hospital and primary care practice recruitment. **(2) Provide input into the selection of statewide measures and targets required under the AHEAD Model:** The key measures and targets to be set by Vermont include statewide all-payer cost targets; statewide primary care spending targets; and statewide quality, population health, and equity measures and targets. **(3) Contribute to equity activities:** The AMGB will contribute to AHS' development and annual review of the AHEAD Statewide HEP; review Hospitals' HEPs; and provide input into allocation of AHEAD Cooperative Agreement funds for equity activities.

Section XI. Commercial Payer Alignment

Commercial Payer Participation in State Care Delivery Reform, Value-Based Payment, Population Health Improvement, and Affordability Activities to Date

Vermont has a strong history of participation by commercial payers in health care delivery system reform, supported by value-based payment. AHS and GMCB have engaged with commercial payers through the Health Care Reform Workgroup and its Payer Advisory Workgroup to solicit their feedback on current and existing models, including around payment and quality. Most recently, the State has engaged with commercial payers individually and through the Hospital Global Budget TAG to solicit input on hospital global budget design, asking

commercial payers to share issues or concerns unique to the commercial market that could influence design of a commercial global budget methodology during the Pre-Implementation period. Payers have expressed a range of views on participation, but overall, remain interested and engaged in the discussion.

Commercial payers have been closely involved in Vermont's current care delivery and payment models, as follows: **(1) Blueprint:** As described in Section VI, the Blueprint has been implemented on an all-payer basis since 2010. Today, BCBSVT, Cigna Healthcare, and MVP Health Care, which together represent 98.9% of the fully insured major medical market members in 2020, participate in the Blueprint. The State continues to explore whether there are ways to increase participation among smaller insurers and self-insured plans, and to create parity between Medicaid and commercial insurers. **(2) VTAPM:** Currently, one of the major commercial payers in the state, MVP Health Care, participates in the VTAPM, having joined in 2020. The University of Vermont Medical Center, a self-insured plan, joined the model in 2019 with the full UVM Health Network joining in 2023. BCBSVT participated in the model from 2018 to 2022 through its qualified health plan on the Vermont health insurance marketplace, large group fully insured products, and a subset of self-insured plans. In 2023, BCBSVT withdrew from the model citing OneCare's approach to health care data management and analytics.[17] BCBSVT has since developed a new prospective primary care product known as "Enhanced Community Primary Care," which will be introduced in 2024.

[17] Blue Cross Will Pause Relationship with OneCare Vermont in 2023

Commercial Payers' Commitment to TCOC and Affordability Activities

BCBSVT, Vermont's largest commercial payer, has indicated that it aims to promote cost control and affordability through integrated care management across medical, pharmacy, and MH/SUD. Additionally, it implements comprehensive financial controls; end-to-end fraud, waste and abuse programming; wellness and member engagement strategies; payment reform initiatives; and partnerships with providers who are committed to closing gaps in care that improve quality outcomes and lower the cost of care.

State Legislative or Regulatory Levers to Facilitate Commercial Payer Alignment with AHEAD and Hold Commercial Payers Accountable for TCOC Growth

For commercial payer participation in TCOC and primary care reporting and accountability to targets, Vermont's approach is described in Section III above. As noted, GMCB has the authority to require collection and reporting of data on TCOC and primary care spending from commercial insurers under 18 V.S.A. 9410, subject to the limitations of *Gobeille v. Liberty Mutual Ins. Co.,* 746 F. 3d 497 (2016). For commercial payer participation in hospital global budgets, GMCB could maximize participation by setting a commercial global payment methodology through its provider rate-setting authority. As described in Section III, Vermont is considering several options for engaging commercial payers in hospital global budgets. The following three options were generated by the State's Hospital Global Budget TAG in the fall of 2023. The first is a fully voluntary approach. The second is a phase-in approach whereby commercial payers voluntarily join at the start of the model. As the model progresses, the State would move to rate-setting by a certain date. The third would be to set a methodology through the GMCB provider rate-setting authority at the outset.

For primary care, commercial payer participation in Blueprint is already required for fully insured commercial insurer business, as described above. As described in Section VI, care delivery requirements under Blueprint are closely aligned with Primary Care AHEAD, including through MH integration; integration of HRSN and primary care/specialty care coordination.

To hold commercial payers accountable for TCOC growth, GMCB's authority related to rate review and hospital budget review will be used to promote commercial payers' accountability. Under its authority for rate review, GMCB currently assesses insurers' proposed premium medical trend assumptions for alignment with hospital budget decisions and may modify the premium if there is not alignment between the medical trend and the decisions. For more information, refer to Section III. As part of the hospital budget review process, GMCB reviews and establishes hospital budgets under which each hospital must operate. Refer to Section V, subsection A for more information.

Marketplace QHPs, BHPs, and/or State Employee Health Plans Participation

The above discussion of commercial insurer involvement and authority applies to Vermont Health Connect's qualified health plans. While there are "off-exchange" health plans in Vermont's individual and small group markets, the plan designs and premiums are regulated uniformly across the markets as a whole with only small differences between on and off-exchange plans. Vermont anticipates uniformly applying data collection and commercial insurance requirements across the markets without regard to whether the plan is offered through Vermont Health Connect. As noted in the NOFO, participation of any of these plans, one or more self-insured plans, or the state employee health plan would be sufficient to meet the commercial insurer participation milestone by the second performance year.