Update on Potential Future Federal Model: States Advancing All-Payer Health Equity Approaches and Development (AHEAD)

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Green Mountain Care Board

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Brief Background: Current Vermont All-Payer Model and Evolution of Federal Model

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Current Vermont All-Payer Model Agreement

- **Signatories:** Governor, AHS Secretary, GMCB Chair
- Arrangement between Vermont and the federal government that **allows Medicare**, Medicaid, and commercial insurers **to pay for health care differently** and establishes state-level accountability for cost, population health, and quality
- The model shifts from paying for each service (fee-for-service) to **predictable, prospective payments** that are linked to quality (value-based)
- Changing payment is intended to **reduce health care cost growth, maintain or improve quality, and improve the health of Vermonters**
- Relies on an accountable care organization (OneCare Vermont) to develop a voluntary network of providers that agree to be **accountable for care, cost, and quality** for their attributed patients.
- Original performance period was **2018-2022** (5 Performance Years)
- Currently in first year of a **two-year extension period**
  - Extension suggested by the Center for Medicare & Medicaid Innovation (CMMI); signatories approved in November 2022 to act as a bridge to a future federal-state model (which was then expected for 2025)
  - Currently set to end on 12/31/2024

Benefits of Continuing to Include Medicare in Vermont Health Care Reform

Continued recognition of Vermont's status as a long-time low-cost state for Medicare

Helps ensure that baseline financial calculations recognize Vermont's past reforms that have saved money for Medicare

Ability to influence Medicare reimbursement for Vermont providers

>$9M annually for Medicare's portion of Blueprint (payments to primary care practices recognized as Patient-Centered Medical Homes, Community Health Teams, and Support and Services at Home program)

Waivers of Medicare regulations (e.g., 3-day stay Skilled Nursing Facility waiver) **and ability to propose new waivers**

Greater alignment in priorities, payment models, quality measures and reporting, which sends a stronger signal to all health care system partners

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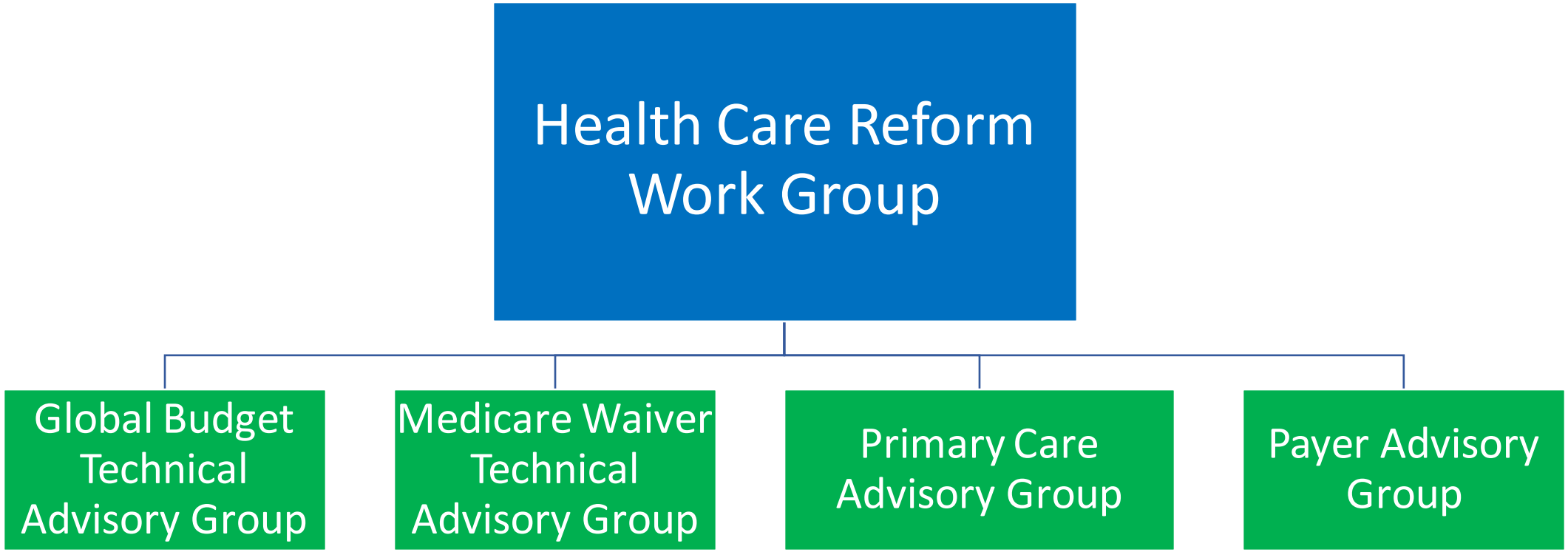
Vermont's Feedback to CMMI on Future Model

AHS and GMCB met regularly with CMMI's new model leads during the past year. **Based on feedback from Vermont providers and other partners**, the state continuously reinforced the importance of the following elements in a future model:

- **Support for rural provider stability and sustainability** (workforce and inflation are important concerns)
- **Increase in predictability of payments**
- **Ensuring the right amount of revenue** (recognition that Vermont is a low-cost state for Medicare)
- **Support for investments in preventive and community care**
- **Making sure payment models and quality measures are aligned across payers as much as possible**
- **Allowing Vermont to move forward on important health care reform efforts**

Current Advisory Group Structure



Previous Subgroups from Summer and Fall 2022 provided foundation and key principles for this deeper work:

Short-Term Provider Stability, Global Budget, and Total Cost of Care Subgroups

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Engagement Plan

Summer 2022 – Work focused on short-term stability (workforce, regulation, systems flow, revenue)

Fall 2022 – Work began to establish a framework to inform discussions on a potential future federal model

February 2023 – Work groups formed for technical discussions on design of global budget model and Medicare waivers that might be beneficial to Vermont; payer and primary care work groups added later

Throughout 2023 – Discussions at existing AHS and GMCB forums (e.g., DAIL Advisory Board, Mental Health Integration Council, Primary Care Advisory Group)

Throughout 2023 – Mechanisms for public input on GMCB and AHS websites, regular updates at GMCB public board meetings, numerous meetings with provider groups

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The AHEAD Model

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New Model: "States Advancing All-Payer Health Equity Approaches and Development" (AHEAD)

- The Center for Medicare & Medicaid Innovation (CMMI) is now offering only models that more than one state can join, rather than state-specific models.
- More details on the model were released by CMMI in the form of a 127-page **Notice of Funding Opportunity** (NOFO) on November 16, 2023.
- Applications from states for the first two cohorts, outlining their proposals, are due on March 18, 2024.
- The earliest implementation date of the Medicare payment provisions of this model, for states selected for the first cohort, is January 1, 2026.
- This timing means that the current model will need to be further extended or Vermont will revert to fee-for-service payments for Medicare.
- As a result, CMMI and Vermont are negotiating what 2025 will look like, with the goal of providing a smooth transition to a new Medicare/multi-payer model in 2026.
- CMMI has indicated that it can offer an additional one-year extension of the current model for calendar year 2025.

AHEAD Model Information and Timeline

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

Timeline:

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

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

Deadline for States to Submit Applications for Cohorts 1 and 2: ***March 18, 2024***

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

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Goals of AHEAD Model

From Centers for Medicare & Medicaid Services (CMS) Notice of Funding Opportunity (NOFO):

"The AHEAD Model is a voluntary, state-based alternative payment and service delivery model designed to ***curb health care cost growth, improve population health, and advance health equity by reducing disparities in health outcomes***." *(Emphasis added)*

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AHEAD Model At-A-Glance

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

Statewide Accountability Targets

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

8-9 Performance Years

Components

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

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
- In lieu of "Behavioral Health", VT uses the term "Mental Health and Substance Use Disorder Treatment"
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Act 167 Elements Included in AHEAD Model

- ✓Total cost of care targets
- ✓Global payment models (including hospital global budgets)
- ✓Strategies and investments to strengthen access to:
  - ✓Primary Care
  - ✓Mental Health and Substance Use Disorder Treatment Services
- ✓Strategies and investments to address health inequities and social determinants of health

Home- and community-based services, subacute services, long-term services and supports: *"The AHEAD Model aims to support hospitals in transforming care delivery and shifting utilization to primary care and community-based settings, where appropriate, through the incentives and flexibilities of hospital global budgets."*

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AHEAD Application Requirements Outlined in NOFO

Project Narrative must include descriptions of:

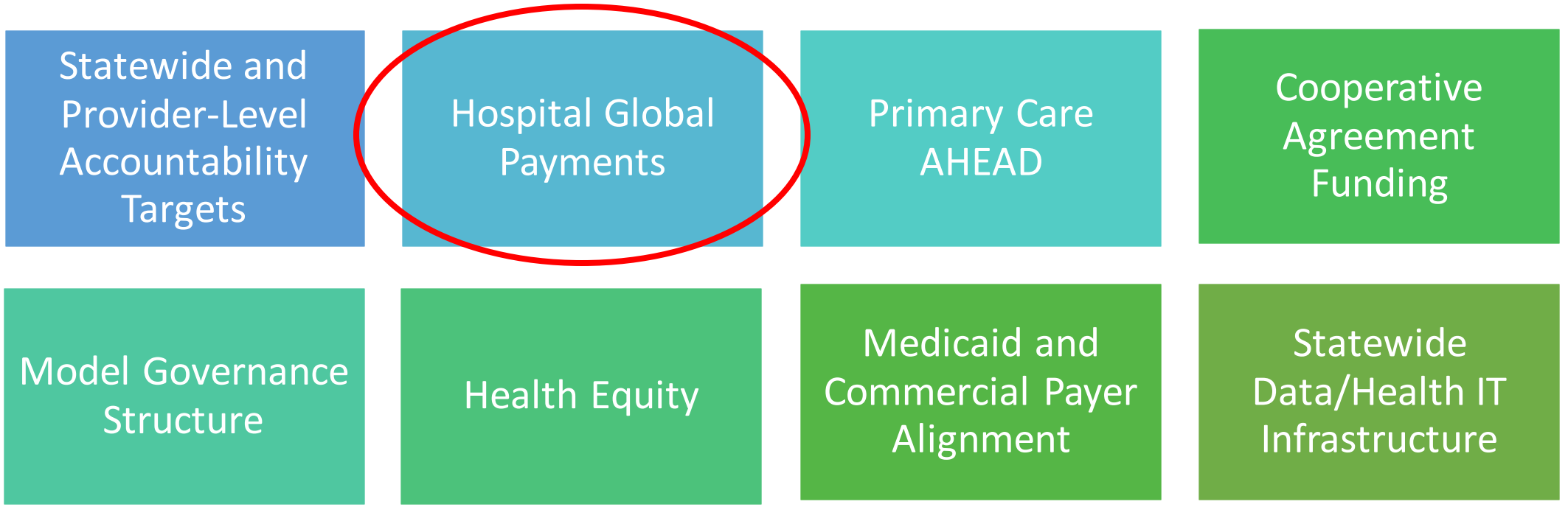
- Organizational capacity
- Proposed region (e.g., state or sub-state region)
- Statewide Accountability Targets (e.g., strategy to measure statewide total cost of care and primary care investments)
- Hospital recruitment plan
- Hospital global budget methodology development
- Vision for primary care transformation
- Primary care recruitment plan
- State data/health information technology infrastructure
- Current and planned health equity activities
- Proposed Model Governance Structure
- Commercial payer alignment

Budget Narrative must include descriptions of:

- Activities funded with Cooperative Agreement funds, and
- Sustainability plan

Appendices (e.g., letters of support, non-binding Letter of Intent from at least one hospital)

Key Components of AHEAD Model



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What is a Hospital Global Budget under AHEAD?

AHEAD HOSPITAL GLOBAL BUDGET

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

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

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

Incentives for Hospital Participation

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

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Hospital Global Payments in AHEAD: Highlights

CMS AHEAD Hospital Global Budget Methodology

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

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

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

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

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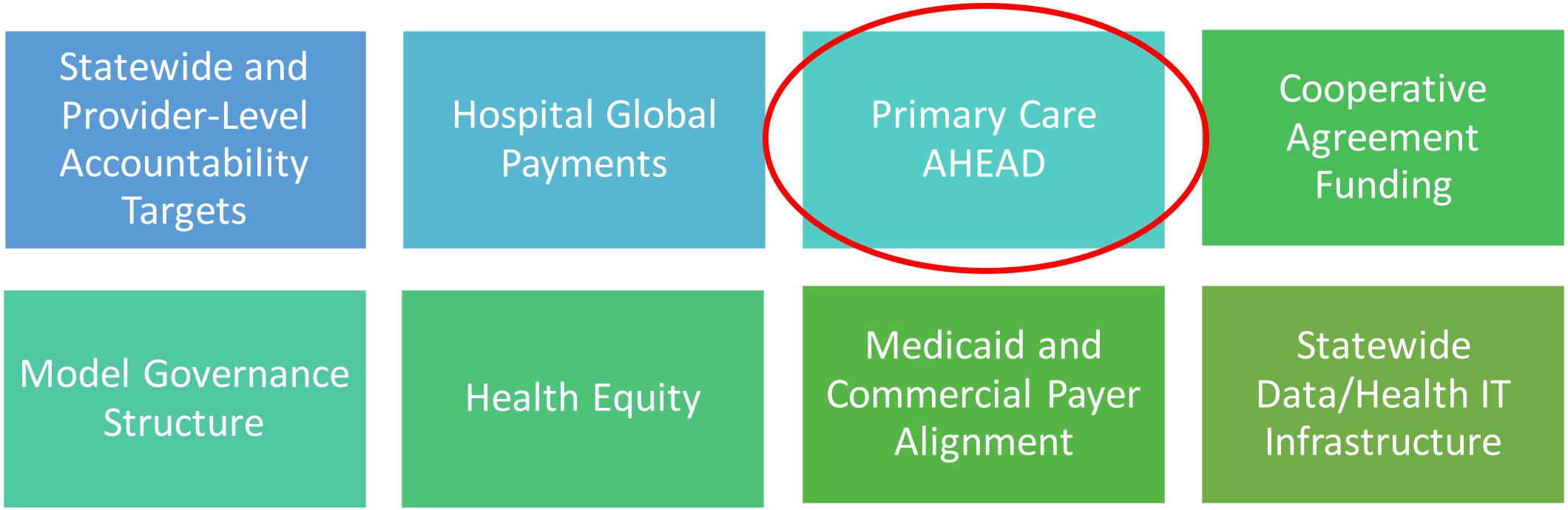
CMMI Criteria for State-Designed Methodology

The state-designed hospital global payment program must:

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

Key Components of AHEAD Model



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Primary Care AHEAD Goals

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

Increase Primary Care Investment

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

Align Payers

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

Support Advanced Primary Care

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

Broaden Participation

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

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

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Primary Care AHEAD: Enhanced Primary Care Payment

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

Payment

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

Requirements

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

Potential Uses

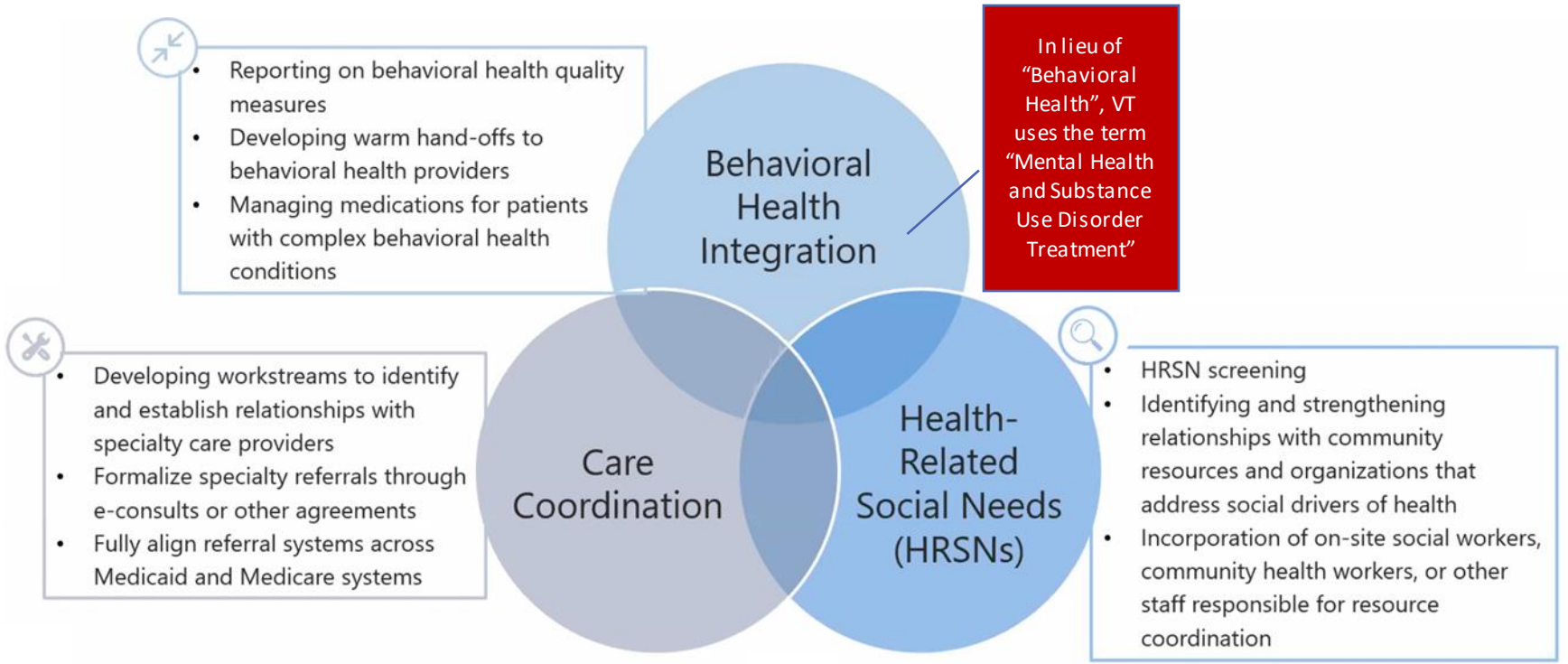
Practices may use the EPCP to invest in infrastructure and staffing to perform advanced primary care (e.g., care coordinators, behavioral health staff, or community health workers).

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

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Primary Care AHEAD: Care Transformation Requirements

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



Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

Key Components of AHEAD Model

Statewide and Provider-Level Accountability Targets

Hospital Global Payments

Primary Care AHEAD

Cooperative Agreement Funding

Model Governance Structure

Health Equity

Medicaid and Commercial Payer Alignment

Statewide Data/Health IT Infrastructure

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Framework for Evaluation and Measurement

Federal-State Agreement: Accountability Targets

- Statewide quality and equity targets
- Limited number of measures (6)
- Statewide Medicare and all-payer Total Cost of Care (TCOC) and Primary Care Investment targets
- Hospital and payer participation targets
- State may have some flexibility for certain elements, but limited

Hospital-Level Payment Model Measures

- Quality performance adjustment based on CMS national quality programs or similar categories of quality measures
- Health equity improvement bonus for performance on selected health equity-focused measures
- TCOC performance adjustment for a defined population
- Effectiveness adjustment to support reductions in unnecessary utilization

Primary Care Measures

- Limited number of measures (5)
- Performance will be used to adjust Enhanced Primary Care Payments for primary care practices' Medicare patients
- States may have some flexibility in measure selection, but limited

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

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AHEAD Quality Strategy

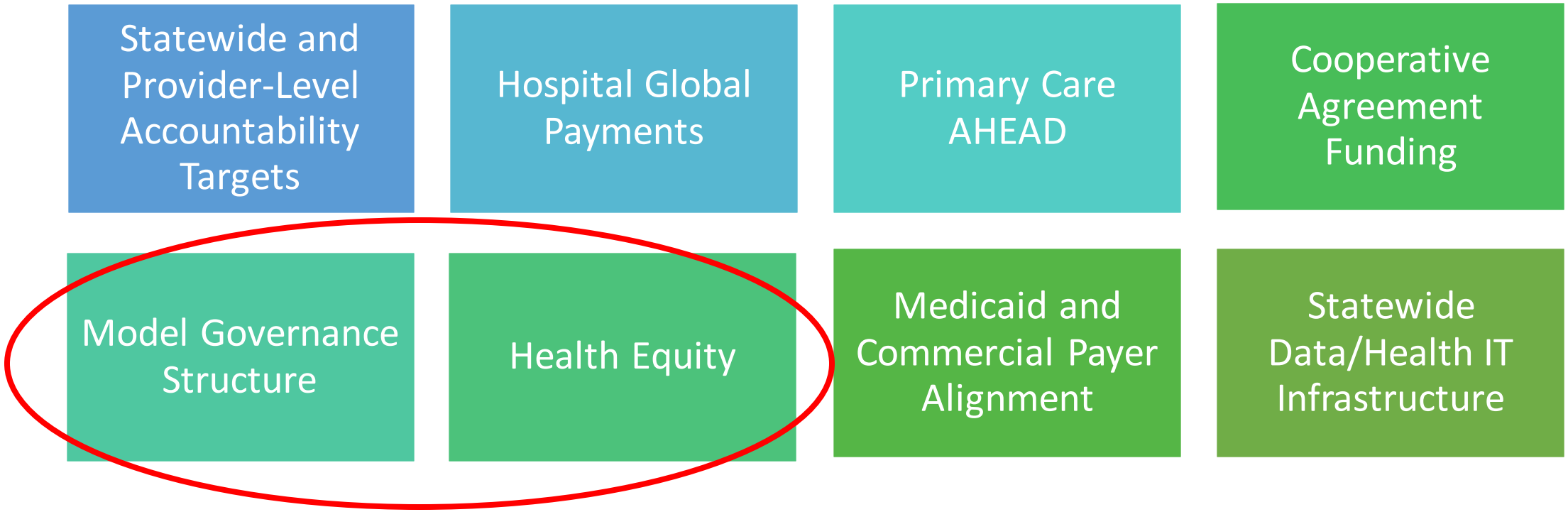
From NOFO: "The overall Model quality strategy includes three sets of quality measures, each with a health equity focus:

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

CMS has outlined four domains with corresponding goals and measures (see Appendix for measure detail):

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

Key Components of AHEAD Model



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Model Governance Structure

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

Governance Representation

Required:

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

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

Governance Role

Required:

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

Optional:

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

Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

Health Equity

The AHEAD Model includes key strategies and activities to advance health equity across multiple sectors

- Model Governance Structure will plan for and assist with model implementation with a primary focus on advancing health equity
- Program requirements include:

Statewide Health Equity Plan	Hospital Equity Plan	Enhanced Demographic Data Collection	Health Related Social Needs Screening and Referral
• Identify health disparities and population health focus areas • Set measurable goals • Plan to advance goals • Use of award funding • Stakeholder involvement	• Observed disparities • Approaches and resources to advance equitable outcomes • Annual updates to be reviewed by the Model Governance Structure	• Participating hospitals and primary care practices must collect and report standardized self-reported patient demographic data • Monitor impacts on disparities	• Participating hospitals and primary care practices must screen and make referrals for health-related social needs related to housing, food, and transportation

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Health Equity and Model Governance Structure Approach

The State has an opportunity to leverage and build upon current efforts

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

Key Components of AHEAD Model

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

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Cooperative Agreement Funding

Funding is ~$12M disbursed as $2M per year over the first five Budget Periods (note: $4M is available for the first 18-month period)

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

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

CMS examples of use of funds include:

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

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The Role of Medicare Waivers in Care Delivery Transformation

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What is a Hospital Global Budget under AHEAD?

AHEAD HOSPITAL GLOBAL BUDGET

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- Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community
- Potential use of waivers to support care delivery transformation and engage non-hospital providers in transformation
- Opportunity to participate in learning opportunities to facilitate success under global budgets

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

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Medicare Waivers (1 of 2)

CMS has indicated waivers necessary for the purposes of carrying out the testing of the AHEAD Model will be available. Additional documentation is forthcoming.

- AHS convened a Medicare Waiver Technical Advisory Group to propose modifications to current waivers available under the Vermont All-Payer ACO Model and new waivers that could support care delivery reform (See next slide for examples)
- Stakeholders described operational challenges that limit Medicare waiver uptake as currently implemented by the federal government
  - Billing and contracting (e.g., some waivers require physicians to contract with and bill home health providers)
  - Attribution-based eligibility
- AHS is advocating for opportunities to improve waiver implementation over the course of the AHEAD model

Medicare Waivers (2 of 2)

Examples of Medicare waivers that support advancement of care delivery reform goals include:

Connecting Vermonters to the right care, at the right place, at the right time	• Post-Discharge Home Visit Waiver (available under current VT All-Payer Model) • Skilled Nursing Facility 3-Day Rule Waiver (available under current VT All-Payer Model)
Expand access to services at home	• Care Management Home Visit Waiver (available under current VT All-Payer Model • Home Health Homebound Waiver (available under CMS ACO REACH Model)
Improve care delivery at the end of life	• Concurrent Care for Hospice Beneficiaries Waiver (available under CMS ACO REACH Model)

Enhance access to care, especially in rural areas, through optimal use of technology	• Expanded Telehealth Benefit Enhancement (available under PHE and currently extended)
	  • Waive requirement that telehealth services must be furnished at an originating site
	  • Allow use of audio-only equipment for evaluation and management services and mental health/substance use disorder counseling and educational services
	  • Expand the types of health care professionals who can furnish telehealth services

Appendix

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

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

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

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

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

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Statewide Accountability Targets for Quality and Equity (2 of 2)

Core Statewide Measures

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

Statewide Optional Measures

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

Hospital Quality Measures Impacting Payment Under the AHEAD Model

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

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Additional Adjustments for Hospital Performance

PPS Hospitals	Critical Access Hospitals

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

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AHEAD Primary Care Measure Set

CMS will require 5 measures for primary care practices participating in AHEAD. "Should an award recipient wish to propose an alternative measure to align with other ongoing state efforts, CMS will consider potential measure replacements, so long as the alternative measure aligns to a domain below or to Model goals broadly."

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

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Global Payment Model Development and Global Budget Technical Advisory Group (TAG) Updates

December 13, 2023

Michele Degree, Health Policy Project Director, GMCB

Act 167 Sections 1 and 2

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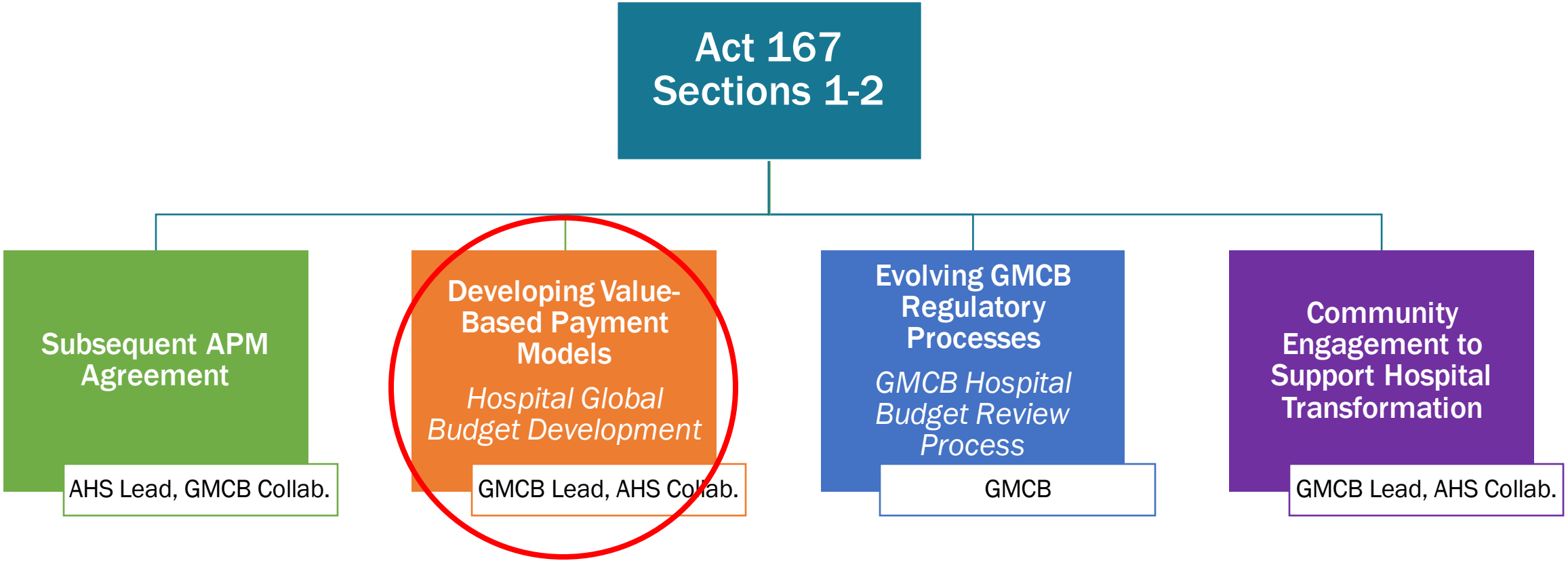

Global Budget TAG
Purpose and Meeting Structure

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Members: Representatives of hospitals, payers, unions, advocates; members invited based on technical expertise

Charge: Make recommendations for conceptual and technical specifications for a multi-payer Vermont hospital global budget program by the time CMMI introduces a future multi-state model.

- Anticipate federal limits and guardrails for any state-developed methodology to ensure alignment with federal principles
- Goal is a multi-payer model with broad commercial and Medicaid participation; "straw model" focused on Medicare to support CMMI negotiations, identifying areas where Medicaid and commercial may need to vary

Meetings: Approximately every 3 weeks for 2 hours from January 2023 – February 2024. All materials posted publicly.

Global Budget TAG
Analysis and Discussion Topics

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Scope:

- ☑ Defining services included in hospital global budget payments
- ☑ Defining populations included in hospital global budget payments
- ☑ Commercial payer participation
- ☑ Provider participation

Calculating global payments:

- ☑ Calculating baseline budget
- ☑ Defining potential budget adjustments (annual, periodic, and ad hoc) and adjustment methodologies

Transformation, administration, evaluation:

- ☑ Strategies to support care transformation and quality
- ☑ Program administration
- ☑ Evaluation and monitoring

Global Budget TAG
Progress and Future Plans

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- Continue to build out Medicare FFS straw model
  - GB TAG recommendations are the key starting point; straw model factors in operational feasibility and data availability, as well as alignment with state goals
  - Expect Medicare AHEAD global hospital payment specifications in January 2024
- Hospital-specific, Medicare Excel models in development for early 2024
- February TAG meeting to review and compare Medicare models
- Continue work on commercial straw model (Date TBD)

TAG materials are publicly available on the GMCB website

Board Process

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- AHS leading AHEAD application process
- Continuation of monthly AHS/GMCB staff presentations through March
  - Public board presentations will address concept areas and application approach, may include subject matter experts in specific areas of focus
  - No board vote required on AHEAD application
  - Vermont NOFO Application submitted by March 18, 2024

- Should the State enter into negotiations on a future agreement, staff will present on future decision points & State flexibilities