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GREEN MOUNTAIN CARE BOARD

AHEAD & Vermont Medicare Hospital Global Payment Update

An Ongoing Discussion…

May 15th, 2024

Agenda

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1. Vermont Medicare Hospital Global Payment Design (GMCB)
2. AHEAD Update (AHS/Director Health Care Reform)

Board Negotiation Goals: Vermont-Specific Medicare Global Budget Specification

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Board Meeting Topics	Target Date
Discuss Draft Vermont Medicare HGB Methodology & Negotiation Strategy & Solicit Board Feedback	Jan – May 2024
1. Vermont Medicare Hospital Global Payment (GMCB) & AHEAD Update (AHS/Dir HCR) **2. Provider Panel on AHEAD/HGP**	May 15th
Near final Methods paper delivered to Board for review and to post for public comment (*approximate*)	May 20th
1. Expert Panel on Value Based Care/Payment & Delivery System Reform 2. Review of Methods paper for submission to CMMI	May 22nd
Special Public Comment Period on Hospital Global Payment Methodology	May 21st - May 28th
Board Discussion & Potential Vote on Medicare Hospital Global Payment Methodology	May 29th
Board Discussion & Potential Vote on Medicare Hospital Global Payment Methodology (Alternative)	June 5th
Develop Specification based on Vermont Medicare Hospital Global Payment Methodology	June 5th – July 1st
Submission of a Vermont-specific Medicare Hospital Global Payment Specification	July 1st
Potential Negotiations (Requires CMMI acceptance of VT application submitted March 2024)	July 1st, 2024 – June 30th, 2025

Summary of Vermont Medicare Hospital Global Budget Methodology

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Adjustments	Required in state-designed methodology[a]	VT draft methodology	Adjustment Type	Amount
Transformation incentive	X	X	Upward	1%
Vermont delivery reform investment		X	Upward	CMS negotiation
Annual Updates				
Inflation updates	X	X	Upward	about 3%
Beneficiary updates	X	X	Upward/downward	estimated to be -1% (varies by hospital)
Medicare policy	X	X	Upward/downward	Varies by hospital
Service line adjustments	X	X	Upward/downward	Varies by hospital
Social risk adjustment	X	X	Upward	Up to 2%
Performance Adjustments				
Quality	X	X	Upward/downward	CMS amounts
CAH quality adjustment	X	TBD	Upward	Up to 2%
Health equity improvement bonus	X	X	Upward	Up to 0.5%
Total cost of care (TCOC) performance adjustment	X	X	Begin as upward-only in PY2 measurement	Up to +/- 2%
Effectiveness adjustment		TBD		

[a] State-designed methodology does not have to use the same methods as the AHEAD model, but it must meet the intent of the adjustment.

What is the Board voting on by when?

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*Submission of a Vermont-specific Medicare Global Budget Specification, consistent with the methods paper; **Board vote by June 1, 2024** for **submission by July 1, 2024**.*

The methodology is NOT a done deal as submitted, as it is subject to negotiation.

*Board votes on participation in the AHEAD model by **June 30, 2025**.*

What is the Board voting on by when? An Alternative Approach

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Challenge: Given the draft nature of the Vermont Medicare hospital global payment methodology, as well as the AHEAD negotiation timeline and associated uncertainties, it is difficult for the Board to judge this methodology on its own merit and whether and under what conditions it would benefit Vermont as compared to an alternative.

Possible Solution: The Board could establish principles for negotiating a Vermont-specific Medicare Hospital Global Payment, within the broader context of State health care reform strategies and regulation, delegating to [TITLE] the submission of a DRAFT (non-binding) Vermont-specific Medicare Hospital Global Payment methodology/specification, consistent with those principles.

What is the Board voting on by when? Proposed Vote Language

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Delegate to [TITLE] the submission of a DRAFT (non-binding) Vermont-specific Medicare Global Payment Methodology and Specification, consistent with the following principles:

- Vermont is a **low-cost Medicare state** with a long history of health care reform which has resulted in **substantial savings to Medicare**. Accordingly, Because of this, additional large savings may be difficult to achieve in the short-term and Vermont's achievements should be recognized and accounted for.
- Many Vermont communities struggle with **access to essential services** and long wait times. Future efforts to improve healthcare in Vermont must support maintaining or preferably improving access to essential services.
- A hospital global payment program is more likely to be successful in promoting delivery system transformation using an **all-payer/multi-payer approach**.
- Vermont's hospitals, local insurance companies, and community providers are financially fragile, as demonstrated by worsening margins, and the global payment program should support **innovation and sustainability of Vermont's healthcare system**.
- Payment methodologies should be **transparent and data-driven**, and support Vermonters' access to high-quality affordable health care, consistent with **Act 167 of 2022 1(b)(1)**.
- Any Vermont-specific Medicare methodology should seek to **reduce Vermont's high commercial insurance costs**.

Next Steps

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Question to Board Members: What are your thoughts on voting on the Medicare Hospital Global Payment? Do you want a vote on the final product or delegate and establish priniples? Do you have any initial feedback on principles?

We will revisit this topic on May 22nd when we review the updated draft methods paper.

AHEAD Model Update

Green Mountain Care Board Meeting

May 15, 2024

Pat Jones, Interim Director of Health Care Reform, Agency of Human Services

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Agenda

1. Timelines

2. Potential Areas of Negotiation

3. System Transformation

Key Dates for Cohort 1 States

March 18, 2024

Applications Due from States

June 2024

Anticipated Notice of Award to Selected States

July 1, 2024 – December 31, 2025

18-month Pre-Implementation Period

January 1, 2026

Start of 9-year Performance Period

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Key Model Milestones – Pre-Implementation for Cohort 1

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

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

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

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

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

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

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

Key Model Milestones – Implementation for Cohort 1

Performance Year 1

Beginning of PY1 (January 2026)

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

90 days prior to start of PY2 (October 2026)

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

By end of PY1 (December 2026)

- Implementation of Medicaid HGBs

Performance Year 2

Beginning of PY2 (January 2027)

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

Performance Year 3 and Beyond

90 days prior to start of PY4 (October 2028)

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

Potential Areas of Negotiation

Category	Topic	Estimated Timing
Statewide Accountability	Medicare Total Cost of Care Targets	Early (2024)
	All-Payer Total Cost of Care Targets	Later (later 2025)
	Medicare Primary Care Investment Targets	Early/Medium
	All-Payer Primary Care Investment Targets	Later
	Statewide Population Health and Equity Targets	Medium (early 2025)
Hospital Global Budgets	VT-Specific Medicare FFS Hospital Global Budget Methodology	Early
	Medicaid Hospital Global Budget Methodology	Medium
	Blueprint and Support and Services at Home (SASH) Payments	Early
Primary Care AHEAD	Primary Care Capitation Payment Model	CMS Determines
	Quality Measures and Electronic Clinical Quality Measure (eCQM) Reporting	Early/Medium
	Merit-Based Incentive Payments (MIPS) Reporting	Early
	Intersection of Medicare Payment Model and Primary Care Investment	Early
	Payment Model Risk Adjustment	Early
Medicare Waivers	Waiving Regulations to Support Model Goals and Improve Care Delivery	Early/Medium
Technical Assistance	Request Technical Assistance on Interface of Multiple Federal Models	Early

Supporting the System in Care Transformation: Medicaid, Medicare, and All-Payer Approaches

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Vermont's Current Health Care Reform Focus

Stability of our health care system following the pandemic

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

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Stability: VT Medicaid focus on broader system of care

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

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

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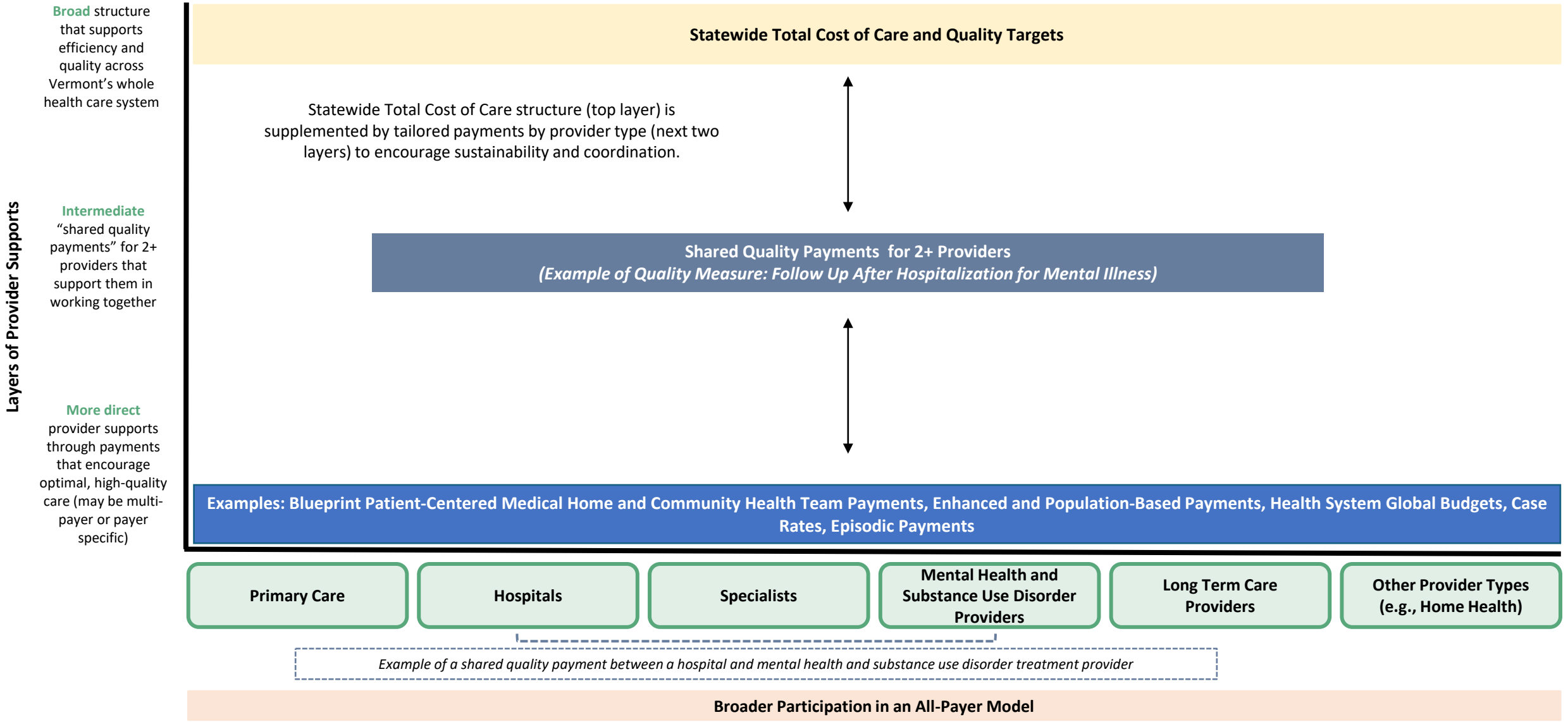
Vermont's Vision for a Statewide Approach



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

Example: Vermont Blueprint for Health Extended Services

Hub and Spoke Services for Opioid Use Disorder (OUD)

- For OUD treatment, Medicaid funds:

✓Intensive, specialized, and highly supervised treatment in Opioid Treatment Programs ("Hubs") managed by the Vermont Department of Health.

✓Community Office-Based Opioid Treatment services ("Spokes"), commonly administered by primary care providers and supported by the Blueprint for Health.

Pregnancy Intention Initiative (PII)

- Medicaid funds the PII program to support primary care and preventive services for people of childbearing age, including access to Long-Acting Reversible Contraception for people who choose it, enhanced health and psychosocial screening, follow-up through brief in-office intervention, and referral to health and community services.

Support and Services at Home (SASH)

- Medicare funds the SASH program in Vermont to provide wellness nurses and care managers to serve elderly and disabled Medicare beneficiaries in congregate housing or nearby communities.

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Blueprint for Health Pilot Program

- Vermont Medicaid is expanding funding for Blueprint for Health Community Health Teams to implement a **two-year pilot program** designed to improve access to mental health and substance use disorder services and address social determinants of health through increased integration with primary care.
  - Vermont experiencing increased deaths from drug overdose and suicide; concerning levels and acuity of mental health and substance use disorders.
  - Need to identify and address social determinants of health (e.g., housing instability).
  - Objective of pilot is to ensure that additional supports and services are provided across entire population served by primary care practices participating in Blueprint for Health (majority of primary care practices in Vermont).

Federal Approaches to Support Broader System of Care

Medicare models don't always include specific broader system investments but do often:

- Encourage cross-organization partnerships
- Highlight potential to shift funding to preventive and community-based care
- Offer waivers of certain Medicare regulations that could support care delivery transformation
- Advance multi-payer approaches

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CMS Description of AHEAD Model

From CMS/CMMI materials about AHEAD:

"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."

"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."

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Role of Hospital Global Budgets in Transformation

CMS sees hospital global budgets in AHEAD as an important tool to control costs and improve quality. Here are some of the benefits:

- Steady, predictable financing for hospital services;
- Flexibility in how to provide services to best meet community needs;
- Support to improve equity and quality of care, and health of the whole population;
- Ability to share in savings from reducing avoidable use of services and delivering care more efficiently;
- Added funding from CMS in the early years of the model to support hospital changes needed to join the model;
- Controlling growth in hospital spending at an affordable level; and
- Chance to learn from other hospitals that join AHEAD.

Having a role in designing Medicare, Medicaid, and Commercial hospital global budget methods would give Vermont a chance to address other state goals.

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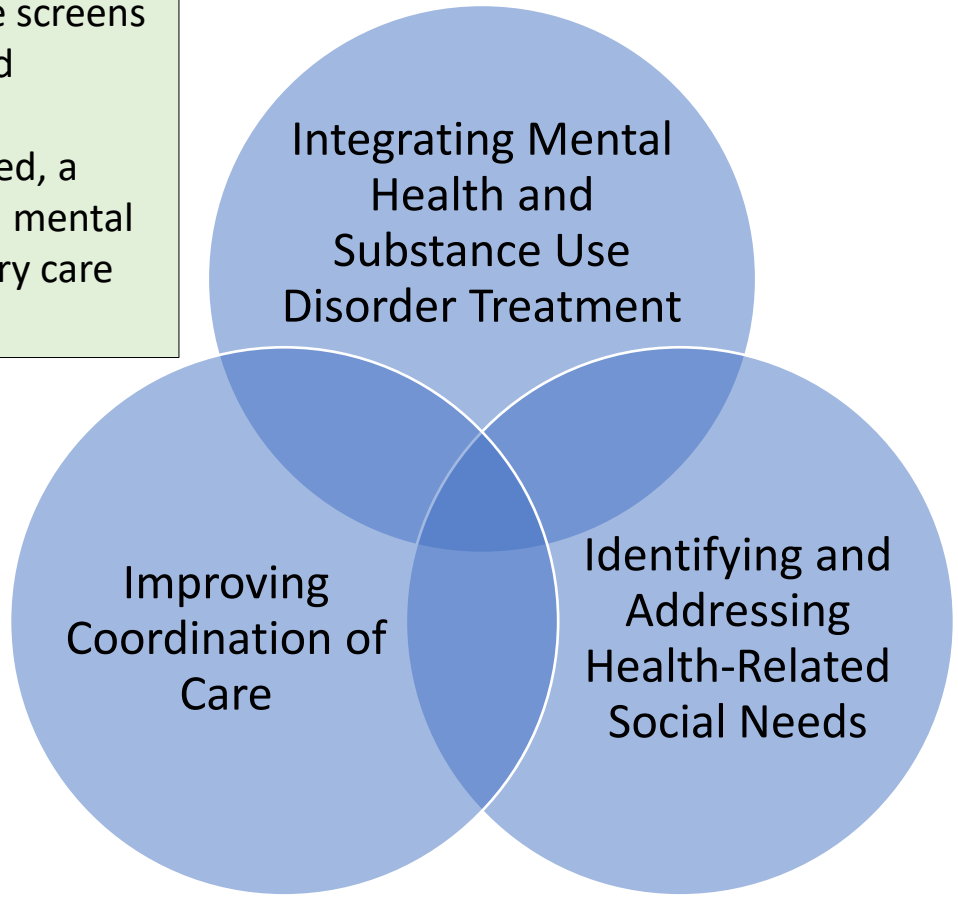
What Does CMS Mean by "Care Transformation" in Primary Care AHEAD?

Example: Primary care office screens people for mental health and substance use conditions. If additional services are needed, a "warm hand-off" occurs to a mental health provider in the primary care office or in the community.



Example: Primary care office has relationships with specialty care providers and referral processes to ensure that people get the specialty care they need.

Example: Primary care office asks people about food security, housing, and transportation. A community health worker in the practice and strong ties with community organizations help connect people to services.

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Medicare Waivers: Flexibilities Expected to be Available in 2025 Extension Period (and maybe beyond)

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

Health Equity: Central to the AHEAD Model

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
- Prioritize recruitment of safety net providers; adjust payments for social risk to increase resources available to care for vulnerable populations
- Program requirements include:

Statewide Health Equity Plan	Hospital Equity Plans	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

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.

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

Summary: AHEAD Model in Context of Broader Health Care Reform

- AHEAD would be **one component of** Vermont's health care reform portfolio; as part of a multi-faceted approach, could offer opportunity to address some challenges.
- AHEAD (like Vermont's current All-Payer Model) allows **Medicare** to join Medicaid and commercial insurers in **paying for health care differently** than fee-for-service.
- Emphasis on **primary care and hospital** payments and **care transformation**.
- **Health equity** central to the model.
- **Continues Medicare support** for Vermont's Blueprint for Health and Support and Services at Home (SASH).
- Offers waivers of Medicare regulations that provide **flexibility** in how services are delivered to Medicare beneficiaries.
- States accountable for meeting targets related to **total cost of care, primary care investment, and equity and population health outcomes.**

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