Health Care Reform in Vermont and Overview of New Federal Model

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Goals of Health Care Reform

Health Care Reform seeks to address challenges in our health care system. Goals include:

- Reducing cost growth to ensure that health insurance and health care are affordable
- Improving access to care by making sure that Vermonters can get care when and where it is needed
- Improving quality and experience of care for Vermonters
- Improving the health of the entire population
- Ensuring health equity so that all Vermonters are healthy and well
- Supporting providers in caring for Vermonters

Approaches to Transforming Health Care

Health care reform requires a multi-faceted approach

- No single approach or initiative can meet all our goals

Components of health care reform

- Payment reform is intended to support changes in how care is delivered
- Care delivery transformation leads to better health outcomes and population health

Recent History of Vermont Health Care Reform

- **2005:** VT first approved for federal 1115 Global Commitment Waiver for Medicaid, providing flexibility to expand insurance coverage, implement innovative care models, accelerate payment models, and strengthen care coordination and population health management to encompass the full spectrum of health-related services and supports
- **2007:** VT expanded insurance coverage through Catamount Health, affordable individual health insurance for qualified Vermonters without access to employer insurance
- **2008:** Medicaid pilots VT Blueprint for Health care delivery reform model establishing integrated health and human services and advanced primary care; commercial insurers joined in 2010; Medicare in 2011
- **2011:** Act 48 establishes Green Mountain Care Board and calls for a publicly financed health care system to provide coverage for all Vermont residents
- **2013:** Vermont Health Connect launched in response to the federal Affordable Care Act to provide eligible Vermonters with health insurance and premium assistance
- **2016:** Current Vermont All-Payer Model Agreement signed between state leaders and the federal Centers for Medicare & Medicaid Services

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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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VT Medicaid's 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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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

Vermont's Current All-Payer Model

- Vermont's current All-Payer Model: Agreement with federal government that **allows Medicare**, Medicaid, and commercial insurers **to pay for health care differently.**
- Holds State accountable for **reducing cost growth, improving quality, and improving the health of Vermonters**.
- Shifts from payment for each service ("fee-for-service") to **predictable payments** linked to quality ("value-based").
- Relies on accountable care organization (OneCare Vermont) to support providers that agree **to take responsibility for the quality and cost of care** for their patients.
- Currently ends on 12/31/2024; federal Centers for Medicare & Medicaid Services (CMS) working with State to extend through 2025.
- Looking to the future: CMS is now offering only **models that can operate in multiple states**, rather than individual state-specific models like Vermont's.

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

- **August 2022:** Vermont began engaging stakeholders to inform potential future all-payer model agreement.
- **September 5, 2023:** CMS Center for Medicare & Medicaid Innovation (CMMI) announced new model – "States Advancing All-Payer Health Equity Approaches and Development." (AHEAD)
- **November 16, 2023:** CMMI released the Notice of Funding Opportunity (NOFO) (application guidelines) for the AHEAD Model.
- Vermont decided to apply to the model as an early ("Cohort 1") participant.
- Application submitted to CMS on **March 15, 2024**.

NOTE: Application is the **first step in potential state participation** – it is the start, not the end. Joining the model depends on being selected and on negotiations with CMS on the terms of a new State Agreement.

AHEAD Model Timeline for Cohort 1 States

- **March 18, 2024:** Applications for the first group of state participants were due; Vermont applied
- **June 2024:** CMS announces which states were selected
- **July 1, 2024 to December 31, 2025:** Selected states work on designing the model and defining the terms of an agreement with the federal government. An agreement would need to be signed by July 1, 2025
- **January 1, 2026 to December 31, 2034:** Selected states launch the program for up to 9 years

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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
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

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

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

How Would AHEAD Help Primary Care?

Primary Care AHEAD has four important components:

- **Medicare Enhanced Primary Care Payment.** Primary care practices will get a new payment from CMS for their traditional Medicare patients ($15-21 per person per month; average of $17).
- **Care Transformation.** CMS wants primary care practices to use those payments to improve coordination of services and quality of care for their patients.
- **Alignment with Medicaid Primary Care Programs.** CMS wants to align with states' Medicaid primary care programs and quality priorities. Vermont's Blueprint for Health program is a good example of such a program. Importantly, AHEAD would continue Medicare support for the Blueprint and Support and Services at Home (SASH).
- **Increased Investment in Primary Care.** In AHEAD, states will have to show that the percentage of health care spending devoted to primary care is increasing, both for traditional Medicare and across all payers.

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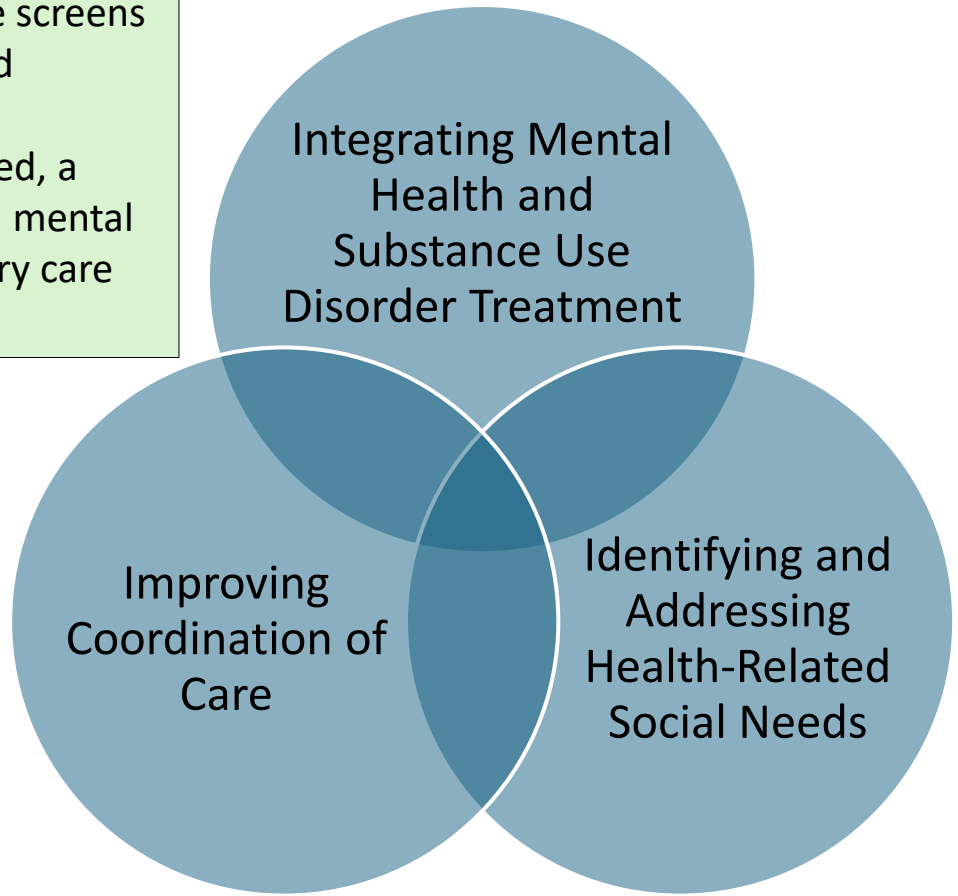
What Does CMS Mean by "Care Transformation" in Primary Care AHEAD?

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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What are Hospital Global Budgets?

Hospital global budgets are **fixed annual payments** to hospitals, determined in advance based on past payments, with adjustments for factors like inflation, changes in people served, and changes in services provided.

Hospitals that decide to join AHEAD will receive separate global payments for each payer that joins. To start, the payments will cover hospital inpatient and outpatient services.

Medicare	Medicaid	Commercial
Because of the way it regulates health care, Vermont could either: *Design its own hospital global budget method (with guidance and approval from CMS) *Use the CMS hospital global budget method	*DVHA would be responsible for designing a Medicaid hospital global budget method that meets CMS criteria *It would have to be put in place by the end of the first year of the model	*Commercial payers include Blue Cross Blue Shield and MVP qualified health plans, Cigna plans, health insurance from employers, and Medicare Advantage plans *The State would design a commercial hospital budget method using principles outlined by CMS

Why Hospital Global Budgets?

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 like rural provider sustainability.

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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

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

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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.

Continuing to Include Medicare in VT Health Care Reform: Potential Benefits of AHEAD

Ability to influence Medicare reimbursement for Vermont providers

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

Access to up to $12M in AHEAD Cooperative Agreement funds to support health care reform efforts over 5.5 years

>$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)

Increased Medicare investments in primary care (average $17 per Medicare FFS member per month)

Medicare transformation funding for hospitals that participate during early years; equity and quality funding (if hospitals show improvement; CAHs only need to report for quality payment in initial years)

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

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

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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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Additional Resources

AHEAD Websites

- Vermont AHS - https://humanservices.vermont.gov/ahead-model
- CMS Overview - https://www.cms.gov/priorities/innovation/innovation-models/ahead

CMS Primary Care Strategy

- CMS Supporting Primary Care Infographic - https://www.cms.gov/files/document/primary-care-infographic.pdf
- CMS Strategy to Support High-quality Primary Care - https://www.cms.gov/blog/cms-innovation-centers-strategy-support-high-quality-primary-care

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