Vermont Medicaid and Exchange Advisory Committee Meeting Agenda

1.	10:00	**Call to Order**	Mary Kate Mohlman & Sharon Henault, Co-Chairs
2.	10:05	**Roll Call** **Establish Quorum** **Approve Previous Minutes**	Zack Goss, Director of Customer Communication (Department of Vermont Health Access, "DVHA")
3.	10:10	**AHEAD Model Funding Opportunity**	Pat Jones, Interim Director of Health Care Reform Wendy Trafton, Deputy Director of Health Care Reform
4.	10:40	**Committee Role**	Mary Kate Mohlman & Sharon Henault, Co-Chairs
5.	10:55	**Medicaid Renewal Status Update**	Adaline Strumolo, Acting Commissioner (DVHA)
6.	11:10	**Commissioner's Office Update**	Adaline Strumolo, Acting Commissioner (DVHA)
7.	11:20	**Public Comment**	Mary Kate Mohlman & Sharon Henault, Co-Chairs
8.	11:25	**Final Committee Discussion**	Mary Kate Mohlman & Sharon Henault, Co-Chairs
9.	11:30	**Adjourn**	Mary Kate Mohlman & Sharon Henault, Co-Chairs

January 22, 2024
10:00-11:30 am

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AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Roll Call, Quorum, December 11, 2023 Meeting Minutes

Zack Goss, Director of Customer Communication (DVHA)

Health Care Reform Update: Overview of New Federal AHEAD Model

Pat Jones, Interim Director of Health Care Reform
Wendy Trafton, Deputy Director of Health Care Reform
Vermont Agency of Human Services

Medicaid and Exchange Advisory Committee

January 22, 2024

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Why Consider New Federal Model and Why Now?

Health Care Reform seeks to use public policy to address **challenges in our health care system**. Challenges include:

- Affordability
- Access (to care and insurance coverage)
- Quality, including how people experience care
- Health of the entire population
- Disparities/inequities in health and health care
- Difficulty meeting health-related social needs like food, housing, and transportation
- Trouble finding workers across all care settings
- Complexity
- Concerns about how to sustain health care in the future
- Other?

Payment reform is just one component of health care reform; it is a means to an end. The goal is for payment changes to support changes in how care is delivered, leading to **better health outcomes and population health.**

Current Vermont 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.

Vermont's Feedback on Future Model

AHS and GMCB met regularly with the CMS Innovation Center's new model leaders 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**

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

- **September 5:** CMS Center for Medicare & Medicaid Innovation (CMMI) announced new model – "States Advancing All-Payer Health Equity Approaches and Development" (AHEAD)
- **November 16:** CMMI released the Notice of Funding Opportunity (NOFO) (application guidelines) for the AHEAD Model
- Vermont has decided to apply to the model as an early ("Cohort 1") participant.
- Application is due to CMS on **March 18, 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

Timeline:

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

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

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

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<tr><th colspan="2"></th><th>2023</th><th>2024</th><th>2025</th><th>2026</th><th>2027</th><th>2028</th><th>2029</th><th>2030</th><th>2031</th><th>2032</th><th>2033</th><th>2034</th></tr>
<tr><td colspan="2">Model Year</td><td></td><td>MY1</td><td>MY2</td><td>MY3</td><td>MY4</td><td>MY5</td><td>MY6</td><td>MY7</td><td>MY8</td><td>MY9</td><td>MY10</td><td>MY11</td></tr>
<tr><td rowspan="2">1st NOFO Period</td><td>Cohort 1</td><td rowspan="2">NOFO</td><td colspan="2">Pre- Implementation (18 mos)</td><td>PY1</td><td>PY2</td><td>PY3</td><td>PY4</td><td>PY5</td><td>PY6</td><td>PY7</td><td>PY8</td><td>PY9</td></tr>
<tr><td>Cohort 2</td><td colspan="3">Pre-Implementation (30 mos)</td><td>PY1</td><td>PY2</td><td>PY3</td><td>PY4</td><td>PY5</td><td>PY6</td><td>PY7</td><td>PY8</td></tr>
<tr><td>2nd NOFO Period</td><td>Cohort 3</td><td></td><td>NOFO</td><td colspan="2">Pre-Implementation (24 mos)</td><td>PY1</td><td>PY2</td><td>PY3</td><td>PY4</td><td>PY5</td><td>PY6</td><td>PY7</td><td>PY8</td></tr>
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Key Dates for Cohort 1 States

March 18, 2024

Applications Due from States

May 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

Goals and Approaches in the AHEAD Model

From CMS/CMMI's 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)*

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."

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

What do we mean by Health Equity?

CMS defines health equity as:

"The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

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

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 the hospital changes needed to join the model;
- Controlling growth in hospital spending at an affordable level; and
- Chance to learn from others 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.

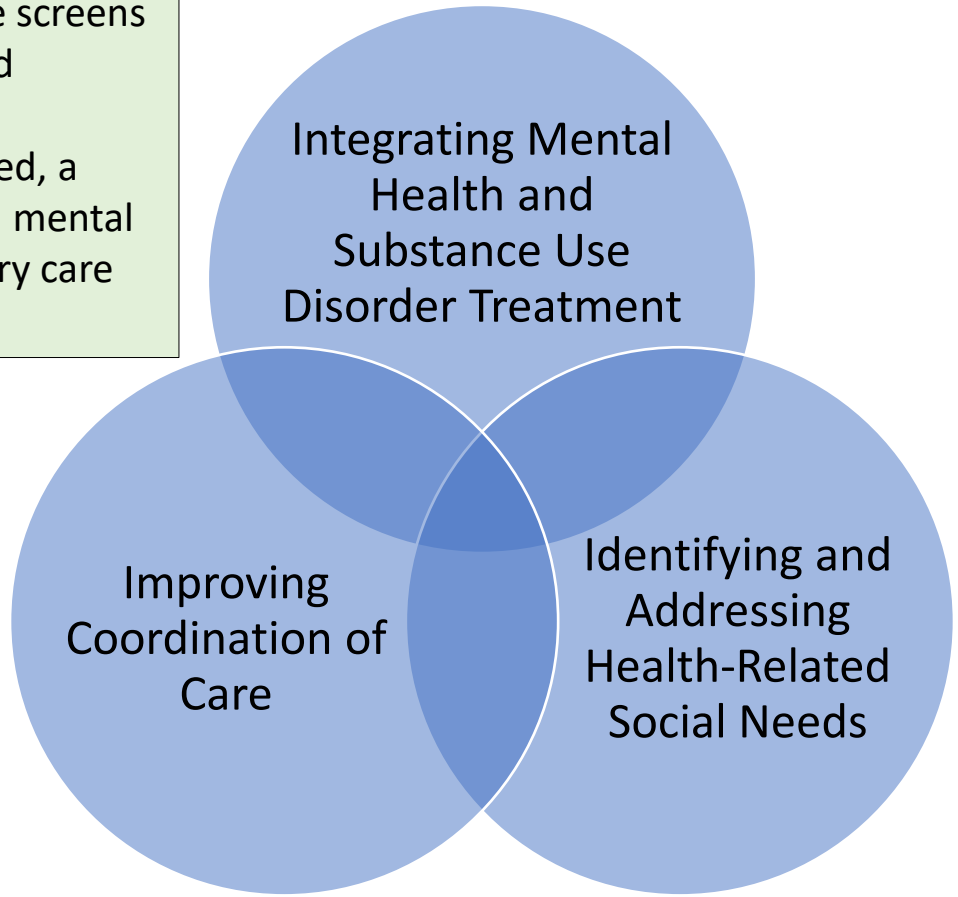
How would AHEAD help Primary Care?

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).
- **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.
- **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.

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 things like food security, housing, and transportation. A community health worker in the practice and strong ties with community organizations help connect people to services.

What is meant by “Medicaid Alignment”

While the AHEAD Model revolves around changes to Medicare payment, there is a strong focus on aligning with state Medicaid programs in these areas:

State Medicaid Agencies are essential and required partners in AHEAD

Medicaid would offer aligned hospital global payments program in first year

Medicare would align with Medicaid primary care programs (e.g., Blueprint)

Medicaid would participate in cost, primary care investment, and quality targets

Questions and Discussion

Committee Role

Mary Kate Mohlman & Sharon Henault , Co-Chairs

Discussion

Medicaid Renewal Status Update

Adaline Strumolo, Acting Commissioner (DVHA)

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Medicaid Renewal Dashboards – Discussion

https://dvha.vermont.gov/unwinding/renewal-dashboard

Commissioner's Office Update

Adaline Strumolo, Acting Commissioner (DVHA)

Public Comment & Final Committee Discussion

Adjourn

Mary Kate Mohlman & Sharon Henault , Co-Chairs