Vermont's Health Care Reform Efforts

Secretary Jenney Samuelson,
Vermont Agency of Human Services

Health Reform Oversight Committee
December 6, 2024

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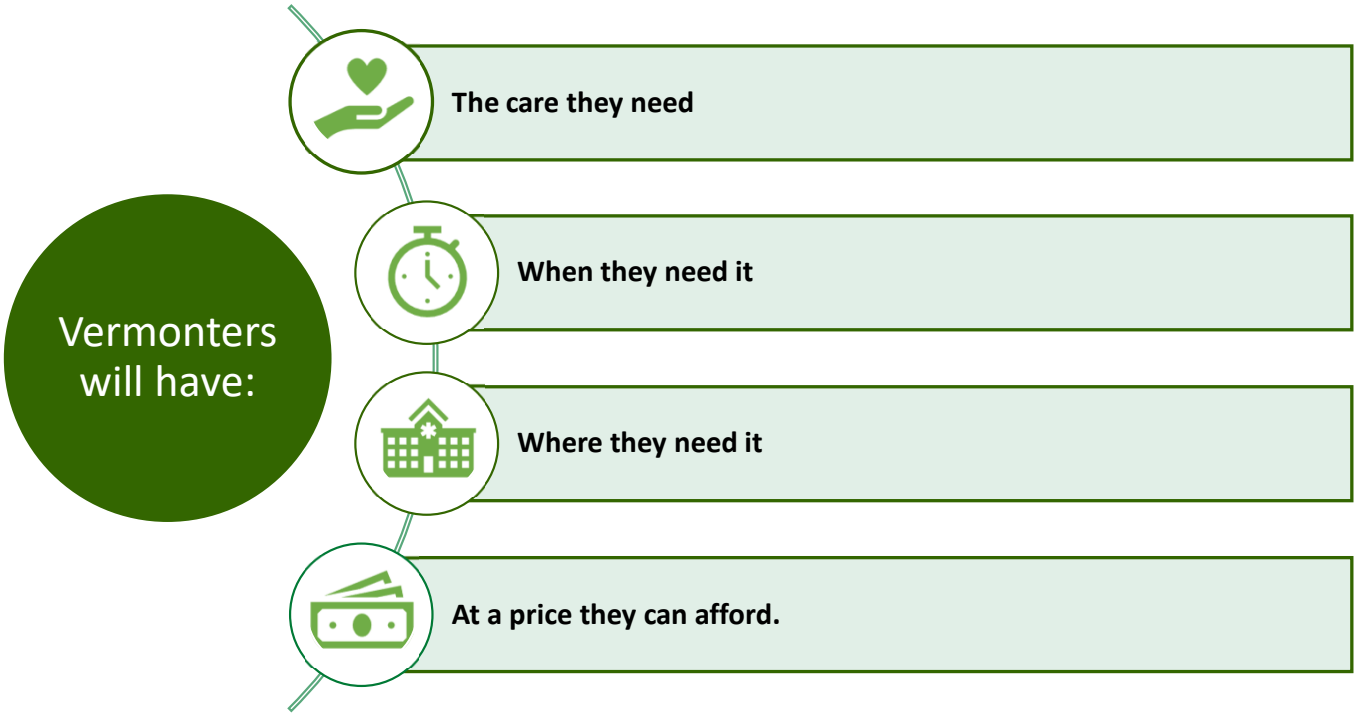
Health Care Reform Vision



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Context for Reform: VT's Current Health Care System

- Vermont's health care system faces challenges in affordability, sustainability, access, and equity
  - Health insurance premiums and out-of-pocket maximums have risen dramatically in the past 5-10 years
  - More than half of the state's hospitals are operating at a loss
  - Vermont's health insurers are facing financial sustainability issues
  - Vermonters are experiencing long wait times for primary and specialty care
  - Gaps in community-based care results in increased use of hospitals
  - Low-income populations in rural areas face significant health-related social needs barriers to receiving care (e.g., housing, transportation)
- Demographics - Simultaneously, Vermont's population is aging while the working age population declines

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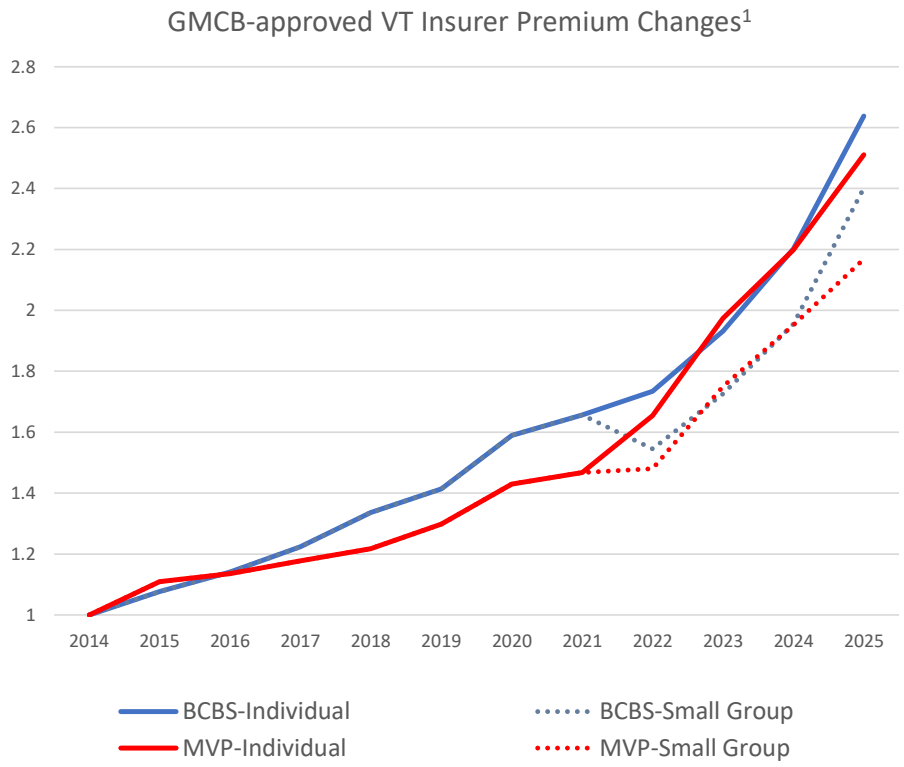
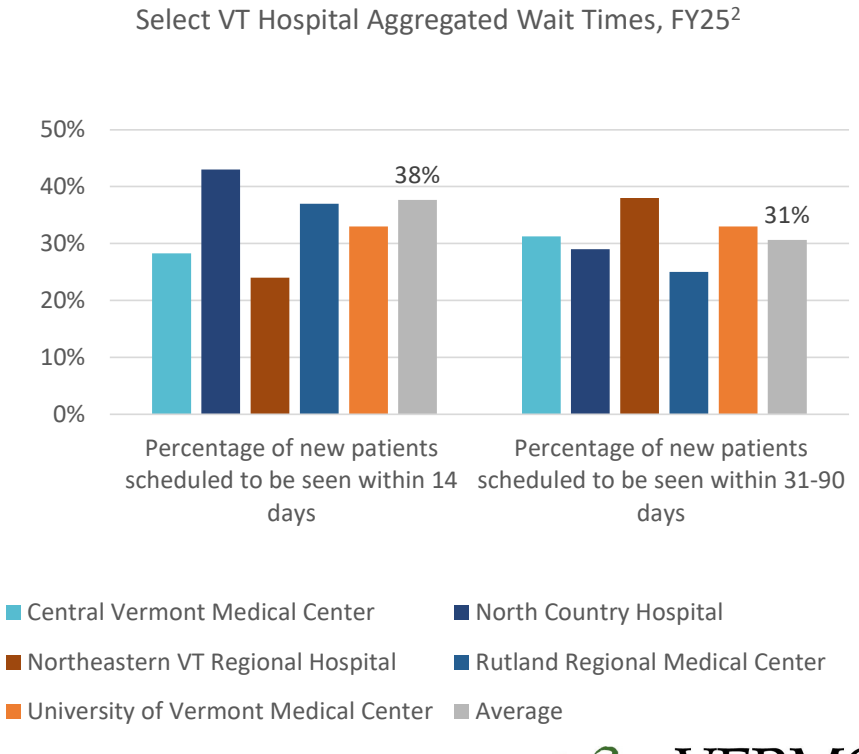
VT's Current Health Care System: Insurance Premiums & Wait Times





[1] Green Mountain Care Board, rate changes over time.; [2] Green Mountain Care Board, analysis of hospital global budget submissions

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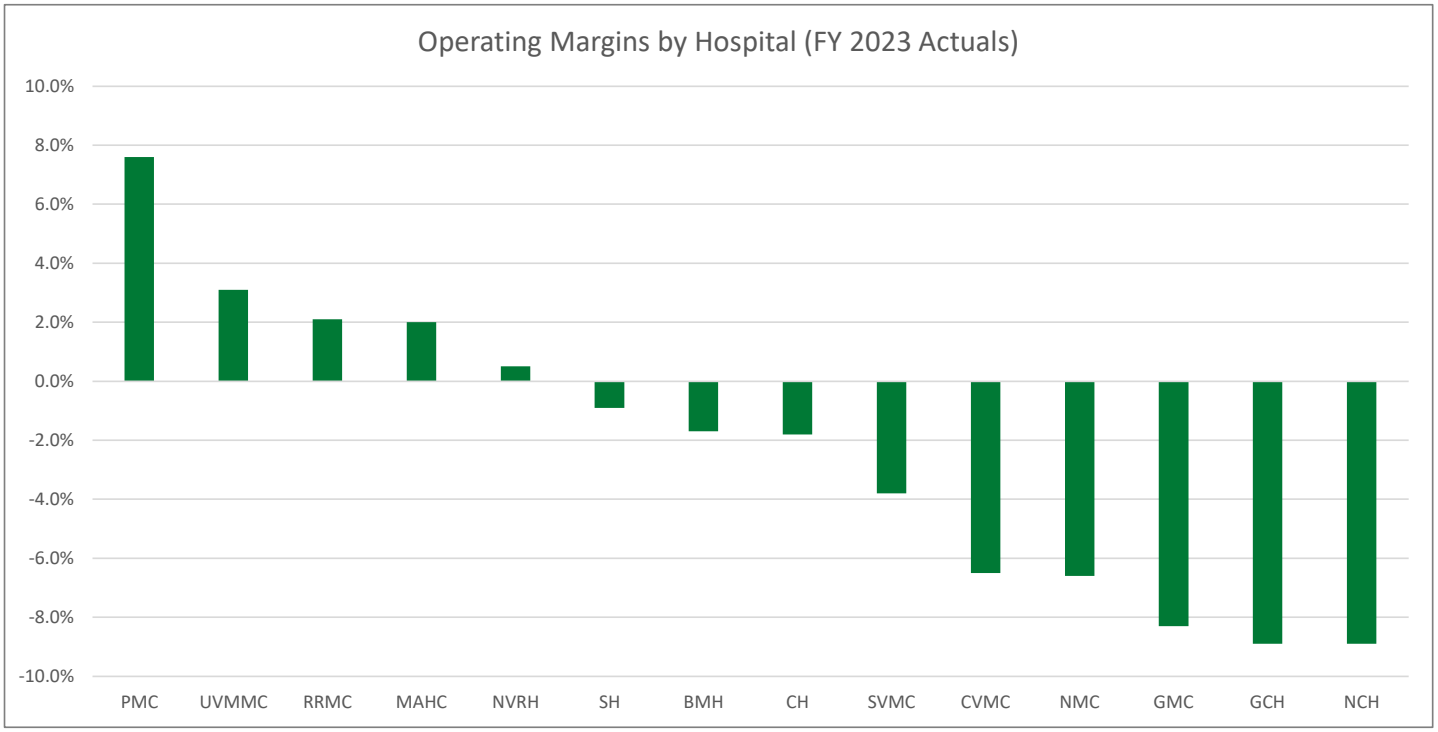
VT's Current Health Care System: Hospital Operating Margins



Source: Green Mountain Care Board

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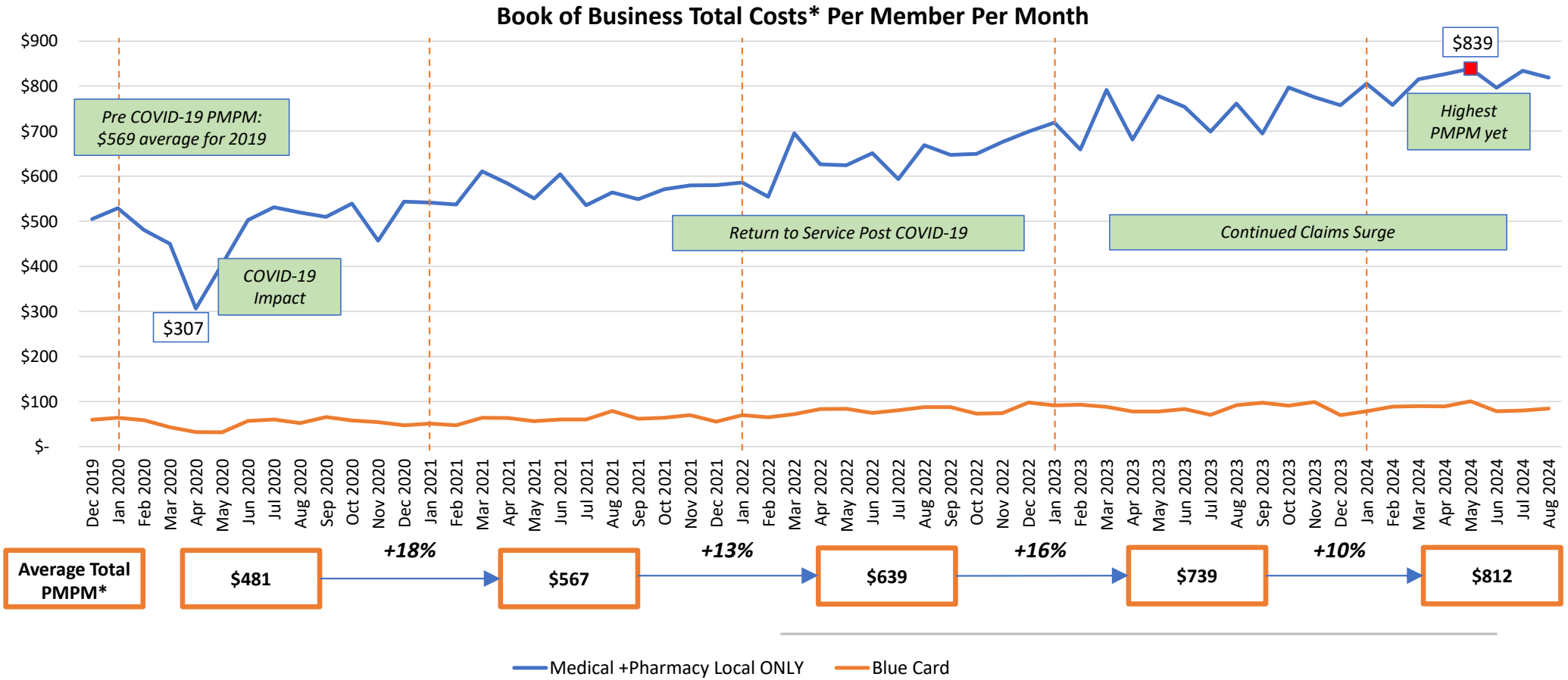
Average annual per member per month medical and pharmacy costs have increased from $481 to $812 since 2020 for local claims only, excluding Medicare primary and FEP. Blue Card claims trend does not exhibit the same escalation.



Blue Card claims represent 12% of total medical claims in 2024 year to date.

**EXCLUDES BLUE CARD, FEP, MEDICARE PRIMARY*
INCURRED CLAIMS BASIS
CURRENT PERIOD = INCURRED CLAIMS JAN-AUG 2024, PAID THROUGH OCT 2024

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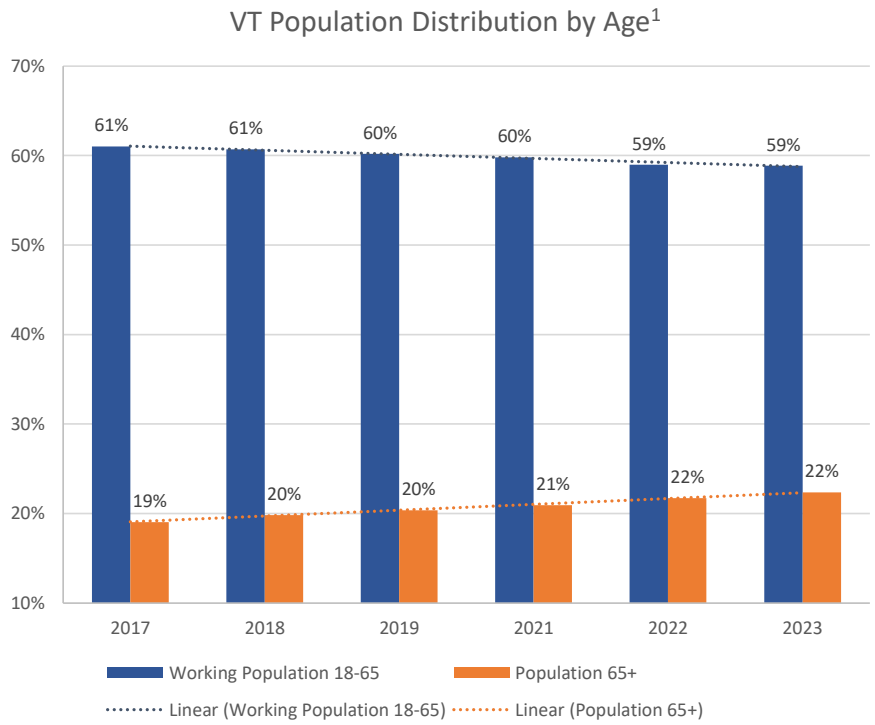
VT's Current Health Care System: Aging Demographics and Health-related Social Needs



14% of Vermonters spend half or more of their income on housing[2]

14% of Vermonters lack access to broadband[2]

9% of Vermonters are food insecure[2]

[1] KFF estimates based on the 2008-2023 American Community Survey, 1-Year Estimates. The American Community Survey did not release the 1-year estimates for 2020 due to significant disruptions to data collection brought on by the coronavirus pandemic..; [2] County Health Rankings data, 2024

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Act 167 Updates

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Act 167

Actions
Sections 1 to 3

Propose Federal Model for Multi-Payer Payment Model	Design Hospital Global Budget	Stakeholder Engagement: Hospital System Transformation	*Added Later via Act 51:* Hospital System Transformation Planning and Projects

Act 167 also included sections on Health Information Exchange (HIE), Blueprint, options to support those with moderate needs, GMCB reporting, Medicaid primary care reimbursement, and prior authorization reporting.

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Act 167: Federal Multi-Payer Payment Model

Actions
Sections 1 to 3

- Propose Federal Model for Multi-Payer Payment Model
- Design Hospital Global Budget
- Stakeholder Engagement: Hospital System Transformation
- *Added Later via Act 51:* Hospital System Transformation Planning and Projects

Federal Model Requirements

- Total Cost of Care Target
- Global Payment Model/Hospital Global Budget
- Strategies & Investments in Continuum of Care
- Reduce Health Inequities & Invest in SDOH
- Future for ACO

Act 167 also included sections on Health Information Exchange (HIE), Blueprint, options to support those with moderate needs, GMCB reporting, Medicaid primary care reimbursement, and prior authorization reporting.

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Act 167 and Alternative Payment Models

Act 167 directed AHS and GMCB to collaborate on a new alternative payment model agreement, specifically involving hospital global budgets.

Progress:

- Assessed model options including ACO Reach, Making Care Primary, and provider type specific payment models, etc.
- Preliminary assessment of Reference Based Pricing and returning to fee-for-service
- Work informed by the Health Care Reform Workgroup, public comments gathered by AHS and GMCB, and public feedback during GMCB meetings

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Act 167 and Alternative Payment Models (cont'd)

Findings:

- No one model accomplishes all the goals laid out in Act 167 or addresses all the challenges the health care system faces, need to pair models
- Federal models that could be paired that most closely match requirements outlined in Act 167:
  - All-payer Health Equity Approaches and Development (AHEAD)
  - CCBHC known in Vermont as Certified Community-Based integrated Health Centers (mental health and substance use)
  - Potential to provide payment incentives for shared measures between models for consistent priorities across providers
- All models contain inherent risk
  - Resources to Implement model
  - Impacts on commercial rates and affordability
  - Impact on access and quality of services
  - Sustainability of health care providers

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Other Act 167 Payment and Delivery Models

Consistent with Act 167, AHS has taken action to stabilize the health care system and identify payments and delivery system approaches for hospital and community-based providers with an initial focus on reducing boarders in emergency room and hospital inpatient boarders. Examples include:

- **Mental Health** - 988, mobile crisis, mental health urgent care, Brattleboro retreat stabilization, CCBHC, expanding hospital level youth mental health beds, adding psychiatric residential treatment beds in Vermont for youth, enhanced transport to Brattleboro Retreat, post pandemic extraordinary financial relief (EFR) for providers
- **Skilled Nursing Facilities** (SNF) – Stabilize SNF through EFR and rate methodology updates, creation of a high acuity skilled nursing facility
- **Substance Use Disorde**r – Rate increases to residential, support co-occurring treatment at hubs, creation of "hublets" in treatment desserts, contingency management, completing gaps analysis
- **Home Health** – Financial support to Home Health by sunsetting the provider tax
- **Hospitals** – Post pandemic hospital stabilization with added Medicaid Disproportionate Share Hospital (DSH) payment
- **Primary care** – Blueprint expansion: universal screening for health-related social needs (HRSN), mental health, and substance use disorder. Embedding mental health resources into primary care

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Act 167 and Elements Included In AHEAD

Act 167		AHEAD
A.	Total Cost of Care Target	✓ Total cost of care targets
B.	Global Payment Models (specifically hospital global budgets)	✓ Multi-Payer hospital global budgets
C.	Strategies and Investments in: i. primary care; ii. home- and community-based services; iii. subacute services; iv. long-term care services; and v. mental health and substance use disorder treatment services;	✓ Specific targets, strategies and investments for primary care ✓ Investment opportunities in the broader continuum of care, with targets to be identified by the State in: i. Mental health and substance use treatment services ii. Home health and skilled nursing iii. Specialty providers
D.	Strategies and investments to address health inequities and social determinants of health; and	✓ Strategies and investments to address health inequities and social determinants of health
E.	The role, if any, of accountable care organizations in Vermont's multi-payer alternative payment models going forward.	• Does not involve an ACO

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Act 167 also included sections on Health Information Exchange (HIE), Blueprint, options to support those with moderate needs, GMCB reporting, Medicaid primary care reimbursement, and prior authorization reporting.

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Act 167: Stakeholder Engagement

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Goals of Hospital System Transformation

- Reduce Inefficiencies
- Lower Costs
- Improve Health Outcomes
- Reduce Health Inequities
- Increase Access to Essential Services

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Act 167 and Care Transformation Activities

- Act 51 directed AHS to lead transformation activities following the completion of the GMCB-led report on hospital sustainability. These planned activities include:
  - Continuation and enhancement of provider stabilization and long-term sustainability efforts
  - Emergency Medical Services (EMS) Planning and Report
  - Hospital Care Transformation Plans and Technical Assistance for Hospitals and Primary Care Practices
  - A potential Equity, Access and Statewide Transformation (EAST) Fund under the AHEAD Model that would ensure Medicare support for care transformation initiatives

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Additional Ongoing Care Transformation Activities

- Assessing the impact, feasibility and financial cost of the Oliver Wyman report recommendations
- Engaging outside resources
  - Partnering with the Health Resources and Services Administration (HRSA) to assess Critical Access Status vs. Rural Emergency Hospital
  - Engaging Milbank and the National Academy for State Health Policy (NASHP) to assess nesting of payments models (e.g., AHEAD, reference-based pricing)
  - Convening providers on service line changes

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Additional Support for Health Care Transformation

- AHS is supporting transformation work at individual hospitals, primary care practices, and community-based service providers with the goals of improving quality, preserving access and reducing cost growth.
- Examples of technical assistance activities for both hospitals and primary care practices include:
  - Developing analytic dashboards to track quality and financial data
  - Reducing health inequities
  - Understanding and moving towards capitated payment models
  - Collecting and using demographic and health-related social needs data
- Hospital transformation plans will include short-, medium- and long-term actions to support financial sustainability, ensure that people receive care at the most appropriate level and in the appropriate setting, and ensure that care is well-coordinated.

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Examples: Hospital Initiatives After Act 167 Report

- Gifford Medical Center
  - Participating in UVM and Dartmouth transfer center including accepting additional transfers from Dartmouth Hitchcock Medical Center
  - Undertaking an initiative to increase efficiency of providers
  - Participating in conversation about regional goals for OB/GYN
  - Closed two under-utilized services lines:
    - Urogynocology
    - Chiropractic Services

- Rutland Regional Medical Center:
  - Considering options for dialysis (inpatient, outpatient, and home)
  - Reconceptualizing existing Intensive Care Unit to support the complex care delivery associated with inpatient dialysis
  - Addressing limitations in healthcare infrastructure (e.g., lack of long-term care supports, housing, transportation, etc.) that create inefficiencies and inappropriate use of hospital services

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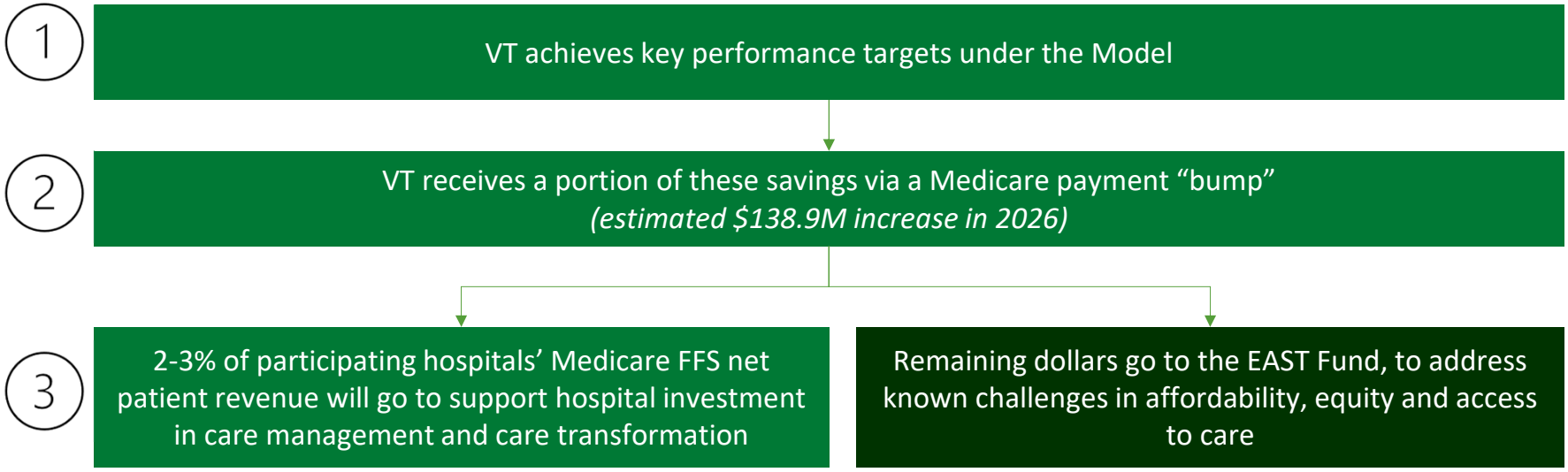
Support for Care Transformation in AHEAD

- The proposed Equity, Access and Statewide Transformation (EAST) Fund under the AHEAD Model in Vermont would provide resources to stabilize health care providers, address access issues, and increase availability of services across the continuum of care (e.g., mental health, substance use disorder (SUD), primary care, home health, long-term care, and specialty care initiatives).



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Legislative Recommendations from the Oliver Wyman Report

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VERMONT LEGISLATORS AND AGENCIES NEED TO START ON TRANSFORMATION PRIORITIES IN 2025 TO ALLOW FOR ORDERLY SYSTEM TRANSFORMATION TO COMPLETE BY 2028

Priority policy changes for Vermont legislators to approve in 2025

1. Remove barriers to building affordable housing for VT residents and newcomers to the State
2. Approve funding for EMS transformation
3. Expand broadband coverage to rural areas (e.g. Star Link)
4. Review existing AHS agency structure and program list to identify overlaps and opportunities for efficiency
5. Develop state regulations and provision details for Rural Emergency Hospital and free-standing birthing centers
6. Expand professional licensure and practice scope for nurses, EMT and pharmacists

Form the critical **infrastructure and regulatory foundations** for implementation of health system transformation

Priority transformation programs for AHS to initiate in 2025

1. Regionalize of specialty care services across hospitals
2. EMS professionalization and regionalization
3. Improved care coordination and management for heavy utilizers (e.g., elderly, mental health, and neuro-divergent and foster care)
4. Dual eligible targeting, care planning and coordination
5. State-wide electronic medical record coordination and optimization

Devise **realistic operational details and implementation plan** for transformation initiatives

Priority regulatory changes for GMCB to apply starting 2025

1. Permit no further increases in commercial subsidization for hospital financial shortfalls
2. Refrain from licensing any further hospital-based outpatient department unit
3. Simplify and shorten CON process
4. Encourage free-standing diagnostic, ASC, birthing centers
5. Begin movement to reference-based pricing ideally at 200% of Medicare or less for PPS hospitals
6. Require all hospitals to use the same accounting agency and method to construct hospital financials and budget submissions

Align system incentives and guardrails to desired transformation goals

Source: Oliver Wyman Report

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Oliver Wyman Legislative Priorities for 2025

Priority policy changes for Vermont legislators to approve in 2025	AHS Context
1 Remove barriers to building affordable housing for VT residents and newcomers to the State	**Opportunity** – Examining permit/appeals processes, funding tools (ACCD)
2 Approve funding for EMS transformation	**In progress** – Evaluate after VDH EMS report is released
3 Expand broadband coverage to rural areas (e.g. Star Link)	**In progress –** Expansion of cell coverage and telehealth to rural areas (DPS)
4 Review existing AHS agency structure and program list to identify overlaps and opportunities for efficiency	**In progress** – Conducting analysis in accordance with Act 119
5 Develop state regulations and provision details for Rural Emergency Hospital and free-standing birthing centers	**Anticipated** – Ongoing conversations with HRSA
6 Expand professional licensure and practice scope for nurses, EMT and pharmacists	**Opportunity –** Explore with Office of Professional Regulation (OPR)

Form the critical **infrastructure and regulatory foundations** for implementation of health system transformation

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Oliver Wyman's Recommendations in the Context of AHS's Broader Health Care Reform Initiatives

Concurrent Multi-Dimensional Approach Across All Departments

Mental health	Substance use disorder	Hospital Transformation	Primary Care & Blueprint
Long Term Care	Health-related social needs (e.g., housing, EMS, transportation)	Health care workforce	Health information exchange

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Future of Payment Reform Discussion (AHEAD)

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Lessons Learned from Current All-Payer Model

What did work:

- Increased support for providers, including independent primary care practices
- Sustained Medicare support for Blueprint and Support and Services at Home (SASH)
- Some funds redistributed to community-based providers
- Public and private sectors coalesced around key quality and financial goals

What didn't work:

- Lack of a multi-payer approach
- Multiple activities that changed over time ("all flowers bloom") may have hindered focus on core business
- Lack of clarity in vision may also have hindered focus and accountability
- Mostly provider-driven; could have benefited from stronger public-private partnership
- "Attribution Based" model rather than all Vermonters
- Concern that it diverted needed energy and resources from other innovations

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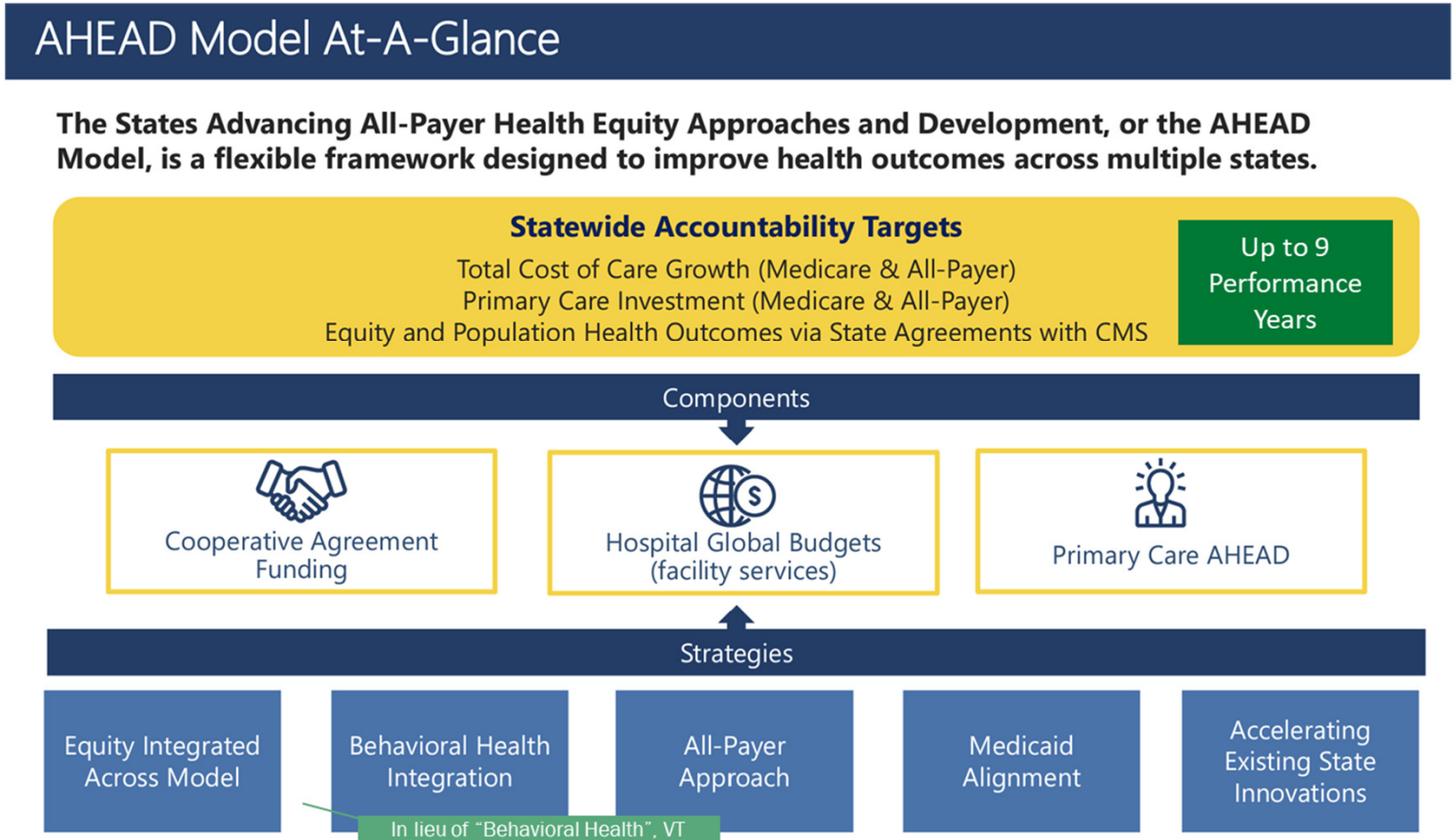
AHEAD: "States Advancing All-Payer Health Equity Approaches and Development"

The AHEAD model is a **partnership** between States and the Centers for Medicare & Medicaid Services (CMS) to implement a combination of hospital global budgets and support for primary care.



Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

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Multi-payer Hospital Global Budgets

- Medicare and Medicaid participation in year 1
- Hospital participation is scaled up over time. The rate Medicare participation is currently under negotiations. For example:
  - 1 - 10% one medium size hospital
  - year 2 - 50% one medium size hospital and UVM Medical Center
  - year 3 - 80% UVM Medical Center and all the medium size hospitals
  - year 5 - 85% UVM Medical Center, the medium size hospitals, and a critical access hospital
- Commercial Insurer – one commercial plan by year 2
- Note risk from of our last model – never got to scale for all providers with all payers which reduces the effectiveness of the model
- Flexibility to change services with the hospital global budget
- Changes to service lines would need to be approved by GMCB and Medicare

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Estimated Funding Available to VT Through AHEAD

Total Cost of Care - Increased Medicare Funding: if we hold to the current Medicare cost trend estimated $138.9M additional Medicare funding in 2026 trended forward each year of participation with the flexibility to make key investments.

Enhanced Primary Care Payments: ~$11M in 2026

Support for Blueprint for Health and Support and Services at Home: ~$10.9M in 2026

Incentive for early hospital participation in global budgets: Upward adjustment of 2-3%

Funding to the State to Support Model Implementation: $12 million over 5.5 years

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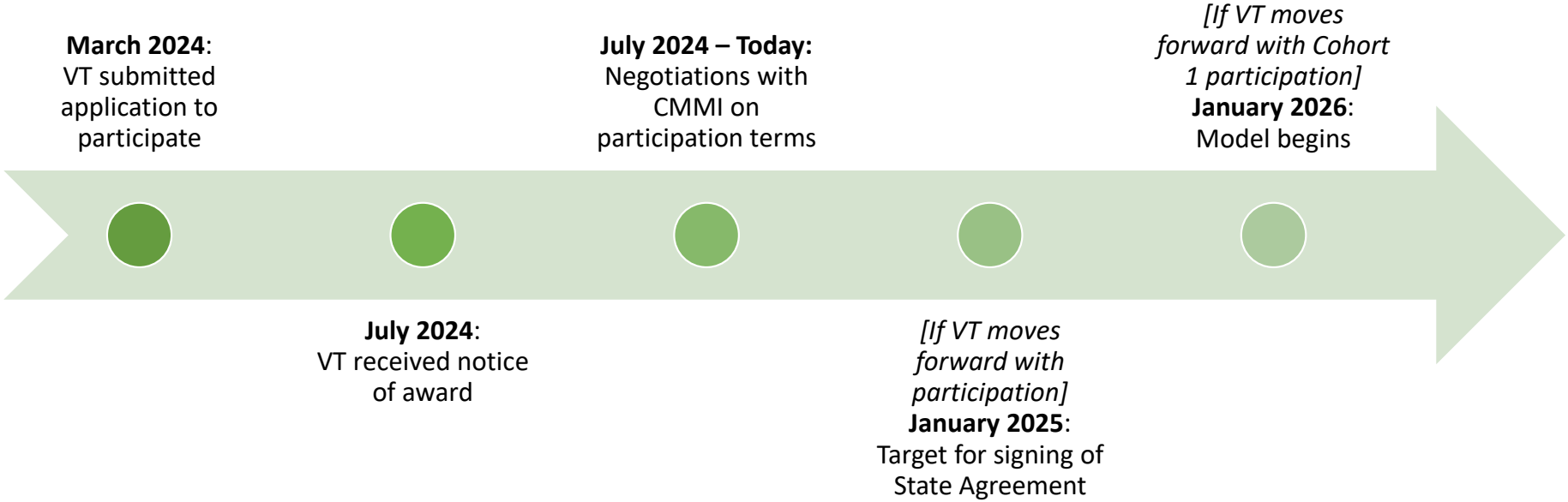
AHEAD Opportunities and Broader Health Care Reform

- Additional Opportunities and Responsibilities - The Model could offer opportunity to address system challenges and continue current Medicare Investments.
  - **Healthcare transformation and health equity** central to the model. Consistent with the work on Act 167 the State and each hospital will need to develop and demonstrate progress on a health care transformation plan, a component of which will focus on addressing health inequities.
  - **Continues Medicare support** for Vermont's Blueprint for Health and Support and Services at Home (SASH).
  - Keep current waivers and offers additional waivers of Medicare regulations that provide **flexibility** in how services are delivered to Medicare beneficiaries.
- AHEAD would be **one component** of Vermont's health care reform portfolio as part of a multi-faceted approach.
- Based on priorities identified in Healthcare Reform AHEAD will be paired with other models (e.g. CCBHC) and broader stability and reform activities. State will work to align the models through shared quality measures, payments that drive alignment (shared interest payments), and transformation activities.

Update on AHEAD Participation Process



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Questions / Potential Risks of AHEAD

- Adequate Funding: AHEAD would impose limits on Medicare spending (total costs and hospital budgets) at a time when we have access challenges and high commercial rates
- Access: Capitated hospital budgets could incent hospitals to reduce access to care to meet budget targets
- Impacts Across Payers: Aligning commercial hospital global budgets with Medicare and Medicaid could be challenging and without alignment, scale, and sufficient funding could impact commercial rates
- Provider Stability: In theory, provide predictability and flexibility for hospitals to transform, but it could be overly burdensome to make it a reality
- Resources:
  - Significant state responsibilities - additional state resources (GMCB and AHS) will be needed to implement hospital global budgets and other elements of the model. Cooperative Agreement funding would cover some, but not all the resources needed
  - Impacts to providers

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If desired, Vermont can Terminate Participation in the AHEAD Model

- The State may terminate the Agreement at any time during the Pre-Implementation Period (before the Model is live) for any reason with 30 days advanced notice to CMS
- The State may terminate the Agreement at any time during the Implementation Period for any reason with 180 days advanced notice to CMS
- If CMS terminates the Model, there is a 12–24-month transition period following the termination or expiration of the model to allow for an orderly wind-down of the model

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AHEAD and Reference-based Pricing

- Reference-based pricing (RBP) is a methodology where provider payments are capped at a certain percentage of Medicare (e.g., Oliver Wyman recommended not to exceed 200% of what Medicare pays for the same service)
- Tool that could be incorporated into Vermont's approach to commercial rates within the global budgets under AHEAD
- Could also be implemented outside of the AHEAD model as a method of controlling commercial costs within Vermont's health care system and aligning costs to Medicare
- If the percent of Medicare is set too low, could pose further sustainability challenges for providers

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If Vermont Does Not Participate in AHEAD, Provider Payments Will Revert to Fee-for-Service (FFS)

- Providers will be subject to Medicare's Merit-based Incentive Payment System (MIPS) quality payment program
- Vermont will remain in a FFS model for Medicare which could drive up utilization and revenues, but not necessarily for high-priority services
- Providers could potentially participate in other CMS National Models, like:
  - ACO REACH (with out-of-state ACO)
  - Medicare Shared Savings Program (ACO model)
- Vermont primary care practices would lose existing Medicare support for the Blueprint for Health, and housing organizations would lose Medicare funding for the Support and Services at Home (SASH) program
- Vermont may lose access to current Medicare Waivers garnered under the All-Payer Model

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Board Questions and Further Discussion

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Next Steps for AHEAD

- Continued negotiation with CMS regarding the terms of the State Agreement *(December 2024)*
- Public posting of the draft State Agreement *(December 2024)*
- Decision whether to participate in Cohort 1 or Cohort 2 *(December 2024)*
- Finalize State Agreement *(anticipated January 2025)*
- Green Mountain Care Board vote and, if approved, signature *(anticipated January 2025)*
- Signature from the Agency of Human Services and Governor *(anticipated January 2025)*
- Signature from CMS *(anticipated January 2025)*

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