Health Care Reform Work Group

SEPTEMBER 25, 2023

Meeting Agenda

1. Welcome, Introductions, and Review of Agenda
2. CMMI AHEAD Model
   - Announcement and Website
   - Highlights
   - Timeline
   - Primary Components and Eligible Participants
   - Hospital Global Budgets
   - Primary Care AHEAD
   - Medicare Waivers
   - Model Governance
3. Next Steps

AHEAD Announcement & Website

Sept. 5: Center for Medicare & Medicaid Innovation (CMMI) announced new model – States Advancing All-Payer Health Equity Approaches and Development (AHEAD)

Link to website: https://www.cms.gov/priorities/innovation/innovation-models/ahead

Website includes:

- Overview
- Highlights
- Model Purpose
- 3 Primary Components and 3 Eligible Categories of Participants
- Model Governance Structure
- Statewide Health Equity Plan
- FAQ, Fact Sheet, Press Release, Model Comparison

September 18 Webinar: Video and slides will be posted

AHEAD Highlights
(language from CMMI website; emphasis added)

- The AHEAD Model is designed to address the following in each participating state:
  - **Improve overall population health** of a specific state or region.
  - **Advance health equity** by reducing disparities in health outcome.
  - Curb the growth of **health care costs**.

- The AHEAD Model **holds states accountable** for state-specific Medicare and all-payer **cost growth** and **primary care investment targets**, and for **population health and health equity outcomes.**

- People living and receiving care in states participating in the AHEAD Model may benefit from model components like hospital global budgets and the Primary Care AHEAD programs. These model components can **enhance coordinated, team-based, whole-person primary care**, which can lead to improved care management, …[mental health and substance use disorder treatment] integration, and a focus on health-related social needs.

- The Model will focus extensively on **advancing health equity** in several ways, including requiring all states participating in AHEAD to develop a statewide and cross-sector **model governance structure and statewide health equity plan**…These plans will outline cross-sector and community-driven strategies for improving population health and reducing identified disparities across the state or within a specific geography.

Summary of Workgroup Member Input

- One workgroup member requested additional detail around primary care investment targets under the AHEAD model. AHS noted that CMS indicated they would work with states on how to measure primary care investment.
- Another workgroup member noted how CMS defines baseline and targets under the AHEAD model will be important. AHS has reiterated its status as a low-cost Medicare spend state during discussions with CMMI.
- One workgroup member noted that some components of the AHEAD model, such as its focus on the integration of MH/SUD, social determinants of health, and health-related social needs, align with Vermont's existing initiatives, such as Blueprint and Certified Community Behavioral Health Clinics.
- Several workgroup members had questions around model participation and potential start dates. AHS noted that CMMI will not mandate participation from hospitals and primary care practices. AHS also indicated that if Vermont were to participate in AHEAD, it would consider a 2026 start date.

Focus and Timing of AHEAD *(updated)*

CMMI has provided additional clarification on focus/timing of AHEAD:

- CMMI offering only **multi-state models** rather than state-specific models; AHEAD is multi-state
- CMMI previously outlined **seven priorities** central to AHEAD; announcement reinforced those
- CMMI will release **Notice of Funding Opportunity** (NOFO) in late November or early December
- **Applications from states**, outlining their proposals, will be due in early 2024
- Earliest implementation of Medicare provisions of AHEAD is **January 2026**
- CMMI and Vermont are negotiating **what 2025 will look like**, with goal of providing smooth transition to new Medicare/multi-payer model in 2026

AHEAD Timeline

		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

Cohort 1 is for states that would participate in 18-month pre-implementation period, tentatively 7/2024 – 12/2025, with a 1/2026 first performance year.

There will be 9 performance years for Cohort 1 states; the model runs through 2034.

CMMI's previous signals about new model

"To accelerate and support these efforts, the Innovation Center is exploring a state-based model to improve population-level health outcomes and advance health equity by testing total cost-of-care approaches to shift health care spending and utilization from acute care to primary care. The future state-based, total cost of care models under consideration by the Innovation Center will amplify Medicaid-led advanced primary care efforts by aligning Medicare FFS and other payers to these efforts."
- CMS Blog, The CMS Innovation Center's Strategy to Support High-quality Primary Care

CMMI previously signaled that it would produce a design spanning multiple states to address 7 priorities:

Payment Design

1. Include global budgets for hospitals.
2. Include Total Cost of Care target/approach.
3. Be all-payer.
4. Include goals for minimum investment in primary care.

Core Principles

5. Include safety net providers from the start.
6. Address mental health, substance use disorder, and social determinants of health.
7. Address health equity.

Through the advisory group structure and other methods, AHS and GMCB are gathering input on a variety of topics to inform feedback to CMMI on a new multi-payer, multi-state model.

Primary Components and Eligible Participants

Three Primary Components

- Hospital Global Budgets
- Primary Care AHEAD
- Cooperative Agreement Funding

Three Primary Categories of Participants

- States
- Hospitals *(including Critical Access Hospitals)*
- Primary Care Practices *(including Federally-Qualified Health Centers and Rural Health Clinics)*

Five Strategies

- Equity integrated across model
- Mental health/substance use disorder integration
- All-payer approach
- Medicaid alignment
- Accelerating existing state innovations

Summary of Workgroup Member Input

- Several workgroup members had questions around the cooperative agreement funding, specifically around potential uses of the funding and availability of funds.
  - AHS indicated it would work with stakeholders and the model's governance body to decide on permissible uses of funding.
  - AHS also noted that CMMI indicated the cooperative agreement funding will be available during the pre-implementation period.
- One workgroup member asked if skilled nursing facilities could participate in CMMI's other value-based payment models if the State participated in the AHEAD model. AHS indicated it would need to follow up with CMS.

Hospital Global Budgets

Hospital Global Budgets will be available to Acute Care and Critical Access Hospitals; CMS will not require hospitals to participate

Medicaid Hospital Global Budget methodology must meet CMS alignment principles, will be reviewed by CMMI and CMCS, and must be approved through normal regulatory processes

CMMI and CMCS will provide technical assistance on Medicaid methodology

"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..."

Hospital Global Budget Value Proposition

“The AHEAD model aims to rebalance health care spending across the system, shifting utilization from acute care settings to primary care and community-based settings.”

INCENTIVES FOR HOSPITAL PARTICIPATION

- Initial investment to support transformation in early years of the model
- Increased financial stability and predictability
- 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 improved population health in their community
- Potential use of waivers to support care delivery transformation
- Opportunity to participate in system learning opportunities when moving to a population-based payment

Source: AHEAD Model Overview Webinar

Primary Care AHEAD

Primary care is foundational to the AHEAD model. **Goals are to:**

- Strengthen primary care (including enhanced payments and investment targets).
- Include FQHCs, RHCs, and smaller practices.
- Improve care coordination.
- Increase screening and referrals to community resources (e.g., housing, transportation)
- Establish accountability for quality; enhance demographic data collection with screening for health-related social needs.

Program elements include:

- Enhanced primary care payments for participating practices will average $17 per beneficiary per month (PBPM), with a floor of $15 and a maximum of $21 PBPM.
- Payments adjusted for social risk.
- Small amount at risk for quality performance (~5% to start).
- Payments can be used for infrastructure and staffing (e.g., care coordinators, community health workers, mental health and SUD staff) to support advanced primary care.
- Requirement to participate in Medicaid transformation efforts (e.g., Patient-Centered Medical Homes).

Summary of Workgroup Member Input

- Two workgroup members had questions around provider participation in the AHEAD model, specifically around whether providers can participate if the State does not participate in the model and around eligibility for Primary Care AHEAD.
  - AHS indicated that providers' participation in AHEAD is contingent upon the State of Vermont participating in the model.
  - CMMI has announced that independent primary care practices, federally qualified health centers, and rural health clinics within an AHEAD-participating state are eligible for Primary Care AHEAD. AHS is unsure if direct care practices are eligible.
- Two workgroup members indicated that the model is focused on hospitals and primary care practices. However, they noted that home health agencies, skilled nursing facilities, and other community-based organizations play an important role in hospital discharges and throughout the continuum of care.
  - AHS acknowledged this and indicated that one of CMMI's goals of the model is to rebalance health care spending across the system. The State will work with stakeholders to identify ways to support these organizations.

	Program	Payment by Payer
ACO-Participating Primary Care Practices	**Comprehensive Payment Reform (CPR) Program** *(ACO participating practices only)*	**Fixed, prospective PMPM for standard ("core") primary care services calculated to meet target primary care spend rate.** **Above-market payment for other ("non-core") services delivered in primary care setting:** • 105% of FFS **Incentive PMPM payment to encourage participation:** • $5 PMPM
	Population Health Payments *(All primary care practices)*	• All-Payer* (2023): $4.75 PMPM per attributed life • PHM Bonus Payment (2023): Up to $1.00 PMPM for achieving target performance in specified measures ** Entire Medicare share is covered by hospital dues.*
All Blueprint Primary Care Practices (FQHC, Hospital-Owned, Independent Primary Care)	**Blueprint Patient-Centered Medical Home (PCMH) Payments**	**Base PCMH** • Commercial: $3.00 • Medicaid: $4.65 • Medicare: $2.15 **Utilization *(measured at practice level)*** • Commercial/Medicaid: $0.00 - $0.25 • Medicare: $0.00 **Quality *(measured at community/HSA level)*** • Commercial/Medicaid: $0.00 - $0.25 • Medicare: $0.00
Community Health Teams	**Core CHT Staffing in all Blueprint Health Service Areas**	**Base Core CHT Staffing** • Commercial: $2.77 • Medicaid: $2.77 • Medicare: $2.68 + $0.31 for risk-bearing providers in Medicare ACO

Primary Care AHEAD – EPCP Payment

Traditional Medicare will pay practices an average of $17 PMPM Enhanced Primary Care Payment (EPCP) fee + FFS primary care payment

Will be risk-adjusted, including social risk adjustment to increase resources for vulnerable populations

CMMI plans to introduce primary care tracks with additional risk/capitation options starting in ~ 2027

Additional Medicaid investments support the Hub and Spoke and Pregnancy Intention Initiatives, Enhanced CHT Pilot, and Support and Services at Home (SASH) infrastructure.

Anticipated Waivers for Medicare Benefit Enhancements

Waiver	Description	Available under current model?
3-Day Inpatient Stay Requirement for Skilled Nursing Facility (SNF) Admission	Waive the requirement for a 3-day inpatient stay prior to SNF admission to allow admission to SNF from the community or following inpatient stays of less than 3 days	Yes
CAH 96-Hour Certification	Waive the requirement that CAH physicians certify that patients will be reasonably discharged or transferred to another hospital within 96 hours	No
Nurse Practitioner and Physician Assistant Services Waivers	Waive certain requirements to expand services and actions Nurse Practitioners and Physician Assistants may perform	No
Home Health Homebound Waiver	Expand beneficiary and provider eligibility for certain home health services to improve access to care for underserved beneficiaries and regions	No
Concurrent Care for Hospice Beneficiaries	Waive the requirement to forgo curative care as a condition of electing the hospice benefit thereby allowing them to receive such care with respect to their terminal illness	No
Cost Sharing Support	Allow hospitals to waive cost sharing for all or certain services for beneficiaries	No
Telehealth	Originating site, audio-only, expand type of practitioners	Unsure*
Care Management Home Visit	Allow for payment for certain home visits that are furnished to eligible beneficiaries by auxiliary personnel under the general supervision of a physician or other practitioner proactively and in advance of potential hospitalization	Yes

*More information needed; may align with current flexibilities in the APM and those afforded by the 2023 Consolidated Appropriations Act.

Medicare Waiver Discussion

What types of technical assistance would increase uptake of these waivers to improve care delivery?

Are there other types of supports that would promote adoption and ongoing use of these waivers?

Model Governance Structure

- The model includes a state-level, **multi-sector model governance structure:**
  - Can be formal advisory role that supports model implementation
- **Representation** must include:
  - Patients and/or advocacy organizations
  - Community-based organizations
  - Local tribal communities (where applicable)
  - Payers
  - Provider organizations (e.g., hospitals, primary care, FQHCs, MH/SUD)
  - State Medicaid Agency
  - State and territorial public health agencies (e.g., VDH)

  Other partners may be included
- **Role** includes:
  - State Health Equity Plan development and input on State Quality and Equity Targets
  - Hospital health equity plan review
  - Cooperative Agreement investments

  Other activities may be included

Questions and Discussion

Upcoming Meetings

- October Meeting: October 23rd from 1 PM – 2 PM

  (Tentative agenda: Continued discussion of AHEAD; Updates on Act 167 Community Engagement and Hospital Global Budget Technical Advisory Group)

- November Meeting: November 27th from 1 PM – 2 PM