Vermont Health Care Reform Work Group: Primary Care Subgroup

December 15, 2023

Updated December 19, 2023

VERMONT
AGENCY OF HUMAN SERVICES

Today's Agenda

- Crosswalk of Current VT Primary Care Payments to Primary Care AHEAD Payments
- Interaction Between MSSP and AHEAD
- Discussion

Purpose of this Group

- On November 16, CMS announced the first of two Notice of Funding Opportunities (NOFO) for the AHEAD model.
- Vermont has decided to apply to the model as a Cohort 1 participant, while recognizing that participation in the model depends on negotiations with CMS on the terms of the State Agreement.
- The NOFO response is due to CMS on March 18, 2024.

AHS is convening this group to obtain Vermont primary care providers' feedback on Primary Care AHEAD, so that the State can prepare for the NOFO and application period due in March.

Key Components of Primary Care AHEAD

- Primary Care AHEAD is comprised of three program sub-components:
  - **Medicare Enhanced Primary Care Payment (EPCP).** This payment is intended to fund advanced care management and mental health/substance use disorder (MH/SUD) treatment integration activities.
  - **Care Transformation Requirements.** Participants will be required to meet requirements around enhanced care management, MH/SUD integration, and addressing health-related social needs (HRSNs). Required activities will be based on the state's priorities.
  - **Medicaid Alignment.** States will be able to align their care transformation requirements and Primary Care AHEAD quality measures with states' existing Medicaid advanced primary care transformation and quality priorities.

Refer to pages 22-24 and 104-105 in the AHEAD NOFO for more detailed information about Primary Care AHEAD.

Source: AHEAD Notice of Funding Opportunity

Primary Care AHEAD Participation

CMS outlined several benefits of primary care providers' participation in Primary Care AHEAD.

- Participating primary care providers will receive a "prospective, flexible, enhanced" investment ($15-$21 PMPM) that is intended to:
  - Increase provider capacity to deliver advanced primary care services;
  - Fund care transformation activities around care coordination, MH/SUD treatment, and HRSN interventions that are tailored to a state's Medicaid APM (e.g., PCMH program); and
  - Provide opportunities for practices to hire staff, increase quality reporting and performance capacities, and strengthen coordination with specialty providers and community-based organizations to provide team-based, whole person care

Comparing AHEAD to CMS' Primary Care Models

CMS noted the AHEAD model differs from CMS' other primary care models in three ways:

1. Establishes a specific goal of increasing statewide investment in primary care
2. Combines hospital global budgets with advanced primary care
3. Offers a flexible framework that allows for alignment with a state's existing Medicaid primary care activities

Source: AHEAD Model Frequently Asked Questions

Crosswalk of Current VT Primary Care Payments to Primary Care AHEAD's EPCP

Primary Care AHEAD's EPCP

Eligibility	• Primary care practices, FQHCs, and RHCs that are: 1) located within a recipient state who are participating in the State's Medicaid Primary Care APM; 2) participate in the State's Medicaid Primary Care APM; and 3) eligible to bill Medicare may receive EPCPs.
Payment	• The average EPCP payment will be $17 PBPM. This amount will be adjusted for beneficiary social and medical risk. The EPCP floor is $15 and the ceiling is $21. • The payment will also be adjusted upward or downward based on the state's performance on hospital participation goals and state Medicare FFS TCOC cost growth targets. • Practices will not receive payment for certain Medicare case management codes since they will be duplicative of the care transformation activities paid for by the EPCP.
Payment Adjustments	• Social and medical risk scores will be calculated on a quarterly basis and adjusted for inflation annually. • CMS is considering using CMS Hierarchical Condition Category (CMS-HCC), Area Deprivation Index (ADI), and Low-Income Subsidy (LIS) data to adjust scores.
Beneficiary Attribution	• CMS will attribute Medicare FFS beneficiaries to participating practices prior to the start of each quarter. Attribution will be assessed quarterly and is based on where beneficiaries are expected to receive a plurality of their primary care services in the upcoming quarter.
Quality	• A portion of the EPCP (5% at the beginning of the model, eventually scaled up to 10% by PY 8) will be tied to a practice's performance on select quality measures.

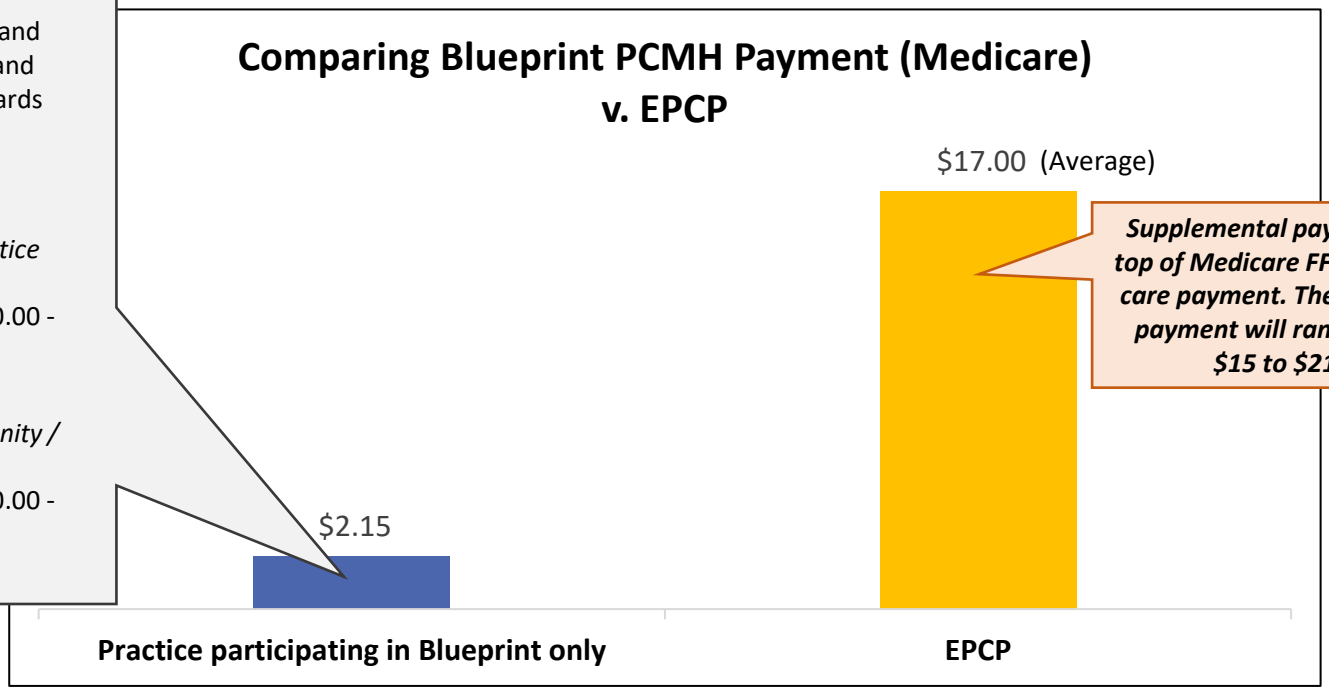
Source: AHEAD Notice of Funding Opportunity

Primary Care AHEAD v. Blueprint Payments

The EPCP significantly exceeds Medicare's share of the Blueprint PCMH payment.

All Blueprint Primary Care Practices (FQHCs, Hospital-owned, Independent)

- Base payment to implement and maintain enhanced services and rigorous PCMH quality standards
  - 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**



NOTE: EPCP applies to Medicare FFS patients only. It does not apply to patients with Medicare Advantage coverage.

Source: Vermont's Blueprint for Health Program: An Overview

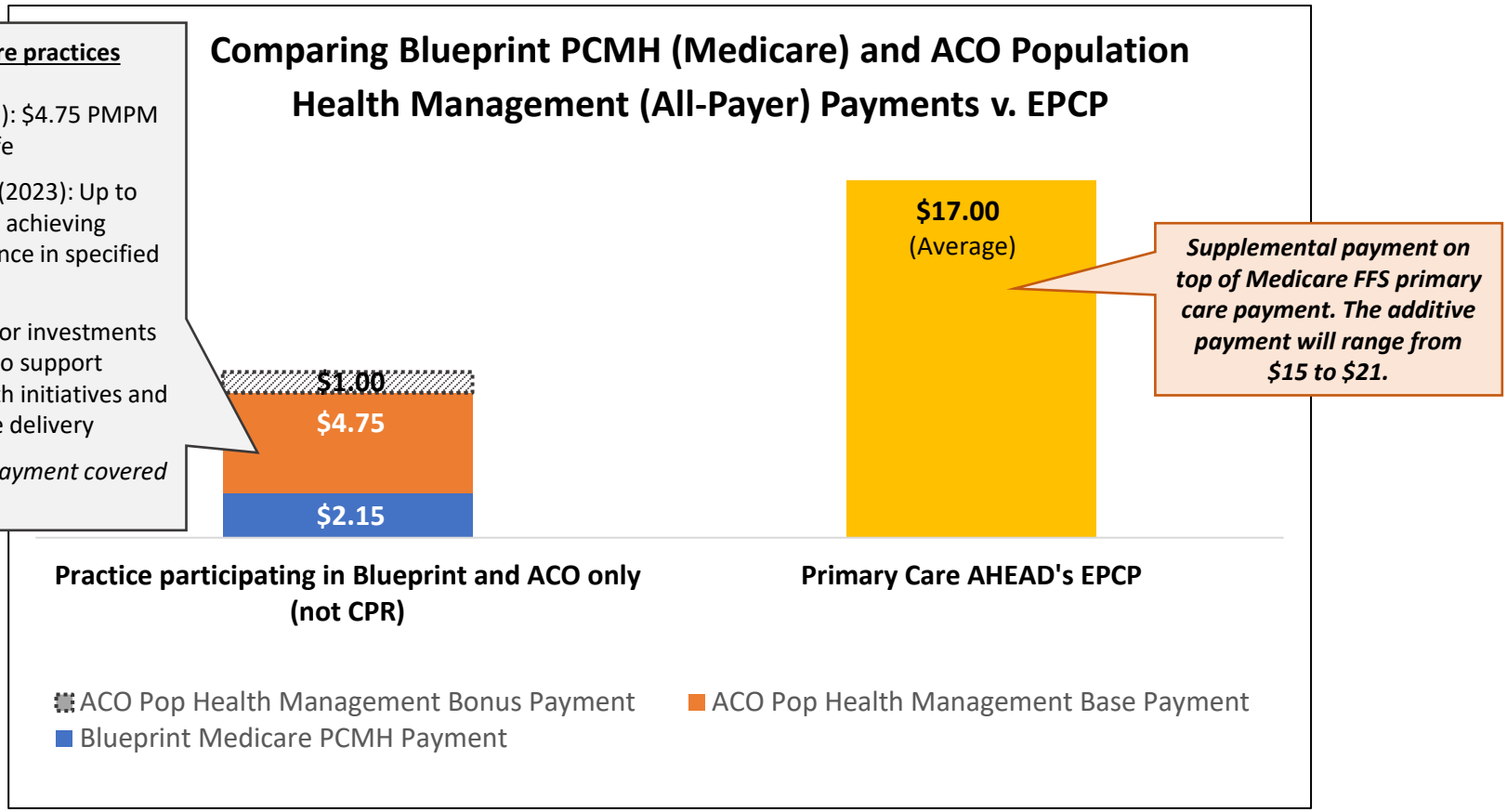
Primary Care AHEAD v. ACO Population Health Management Payments

The EPCP, which is Medicare only, is nearly triple the All-Payer ACO Population Health Management payment. When accounting for both the Blueprint Medicare PCMH Payment and All-Payer ACO Population Health Management payment, it is nearly double.

All ACO primary care practices

- All-Payer* (2023): $4.75 PMPM per attributed life
- Bonus Payment (2023): Up to $1.00 PMPM for achieving target performance in specified measures
- PMPM funding for investments in primary care to support population health initiatives and high-quality care delivery

** Entire Medicare payment covered by hospital funds.*



NOTE: EPCP applies to Medicare FFS patients only. It does not apply to patients with Medicare Advantage coverage.

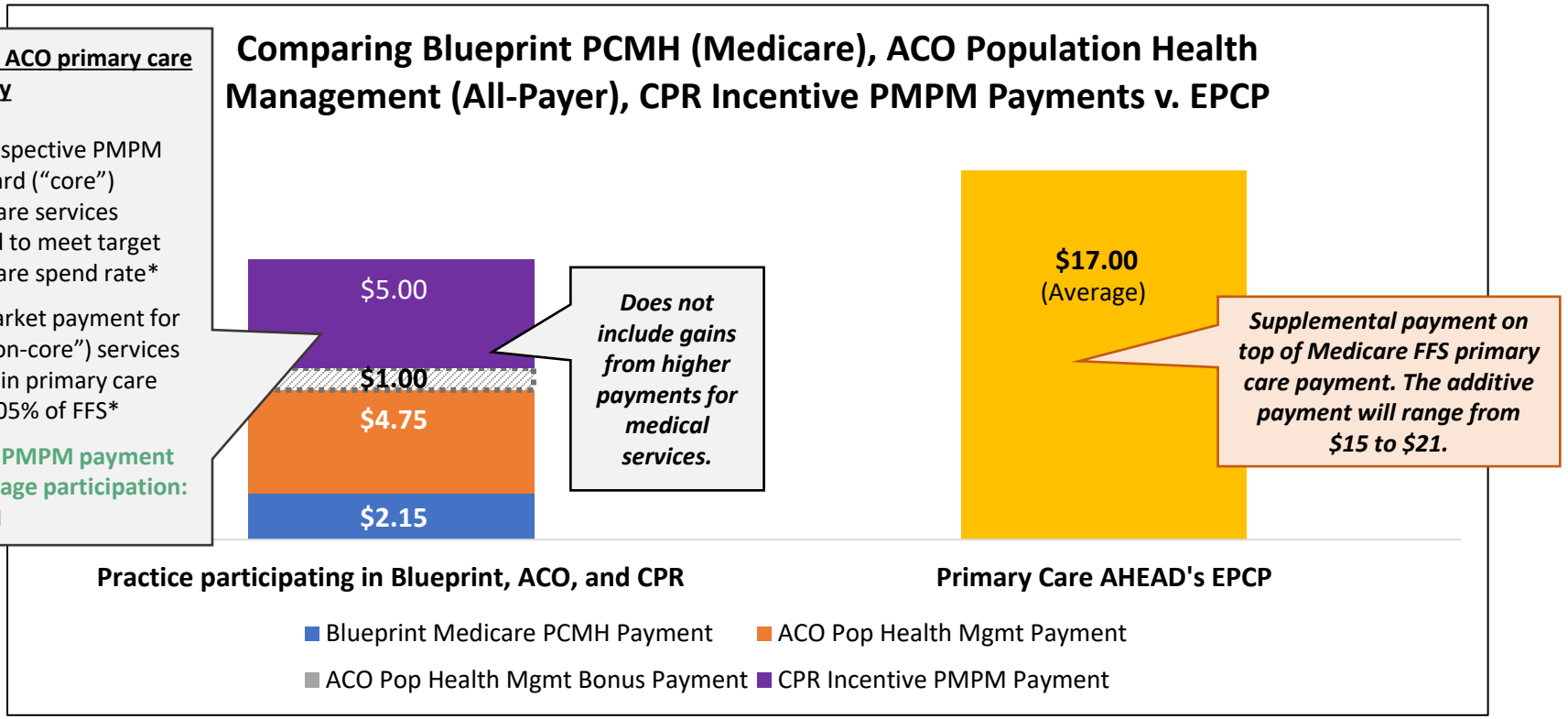
Primary Care AHEAD v. CPR Program Payments

EPCPs are for enhanced care management activities and not underlying medical services. Although CPR program payments and EPCPs are intended for differing activities, the EPCP is significantly greater than the Incentive PMPM portion of the CPR payment.

To note, the Primary Care AHEAD model would be a step backward for CPR participating practices regarding reimbursement for medical services since they would receive standard FFS payments, rather than a capitated payment that is greater than FFS.

Participating ACO primary care 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**



NOTE: EPCP applies to Medicare FFS patients only. It does not apply to patients with Medicare Advantage coverage.

Primary Care AHEAD v. CHT and SASH Payments

CMS has noted they are willing to continue Medicare payments to support CHT and SASH. However, more information is needed from CMS on how they will continue this funding.

Community Health Teams (CHTs)

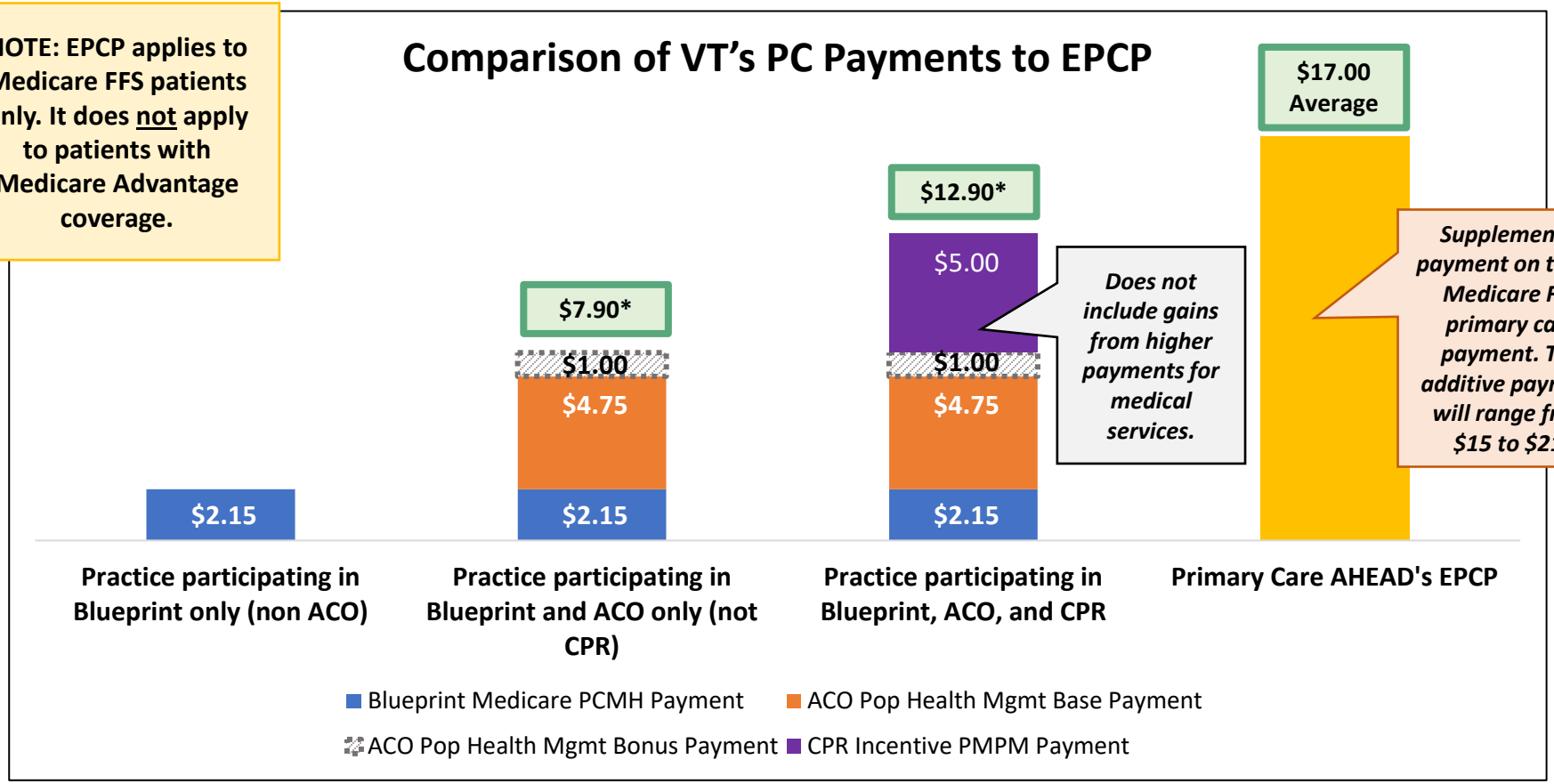
Program	Payment by Payer
CHT Staffing in All Blueprint Health Service Areas	**Base Core CHT Staffing** • Commercial: $2.77 • Medicaid: $2.77 • Medicare: $ 2.68 + $0.31 for risk-bearing providers in Medicare ACO

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

How do Vermont's Primary Care Payments Compare to Primary Care AHEAD's EPCP?

While the activities supported by Vermont's current primary care payments and EPCP are slightly different, this high-level analysis shows that under various participation scenarios (Blueprint only, Blueprint/ACO, Blueprint/ACO/CPR) the average $17 EPCP is greater than the sum of Vermont's current Medicare payments.

NOTE: EPCP applies to Medicare FFS patients only. It does not apply to patients with Medicare Advantage coverage.



** This total is likely lower since the ACO Population Health Management Payment is All-Payer and not only Medicare.*

Summary of Workgroup Member Input

- Workgroup members wondered if Primary Care AHEAD's EPCP applied to patients with Medicare Advantage. AHS reiterated that the EPCP applies to Medicare FFS patients only.
- Workgroup members wondered if Blueprint payments would continue under the AHEAD Model. CMS has indicated that if Vermont were to participate in the model, the EPCP would cover Medicare's portion of the Blueprint PCMH. CMS has noted they would also continue to provide Medicare payments for CHT and SASH, which is a positive development for the State. However, more information is needed from CMS on the specific mechanics around how the CHT and SASH payments would be distributed.
- The workgroup indicated that the ACO's Comprehensive Payment Reform (CPR) program under VTAPM has been important to independent primary care practices and wondered if and how it could continue under the future model. AHS agrees this is an open question. Today, Medicare does not put any dollars into CPR directly and would not put in any dollars in the future. It is unclear what the ACO's role and funding streams may look like and whether it would be able to continue CPR.

Interaction Between MSSP and AHEAD

MSSP and AHEAD Interaction

CMS has announced that primary care practices may simultaneously participate in Medicare Shared Savings Program (MSSP) and Primary Care AHEAD.

Since CMS is allowing model overlaps, starting in 2026, there may be a scenario where the State decides to participate in AHEAD while select Vermont providers participate in MSSP.

NOTE: CMS has not yet clarified how MSSP and AHEAD will interact on the ground. The subsequent slides are intended to highlight several initial considerations for Vermont's providers.

Reminder of Composition of Current Medicare VTAPM:

- 9 (including 3 CAHS) out of 14 hospitals
- 82 out of 113 providers (e.g., primary care practices, rehabilitation facilities, home health agencies, etc.) are in the VTAPM

Source: OneCare Participants

Overview of MSSP

- MSSP is a nationwide program authorized by the ACA (s. 3022) and is the largest Medicare APM run by CMS. In 2023, there were 456 MSSP ACOs serving 10.9 million Medicare beneficiaries.
- ACOs participate in 1 of 6 tracks and are held accountable for the quality, cost, and experience of care of an assigned Medicare FFS beneficiary population. *For more information on the MSSP tracks, see slide 27.*
- Medicare beneficiaries may voluntarily align themselves to an ACO at any time during the year; they designate a provider or supplier who they believe to be responsible for coordinating their overall care.
- CMS and participating ACOs share savings and losses:
  - ***Shared Savings.*** CMS distributes any shared savings an ACO achieves directly to the ACO and does not prescribe how the savings must be distributed. ACOs are required to provide a description in their application of how they will use the shared savings to meet the goals of MSSP.
  - ***Shared Losses.*** ACOs must develop a method for repaying losses to the Medicare program, such as indicating funds that may be recouped from Medicare payments to its providers, reinsurance, etc.

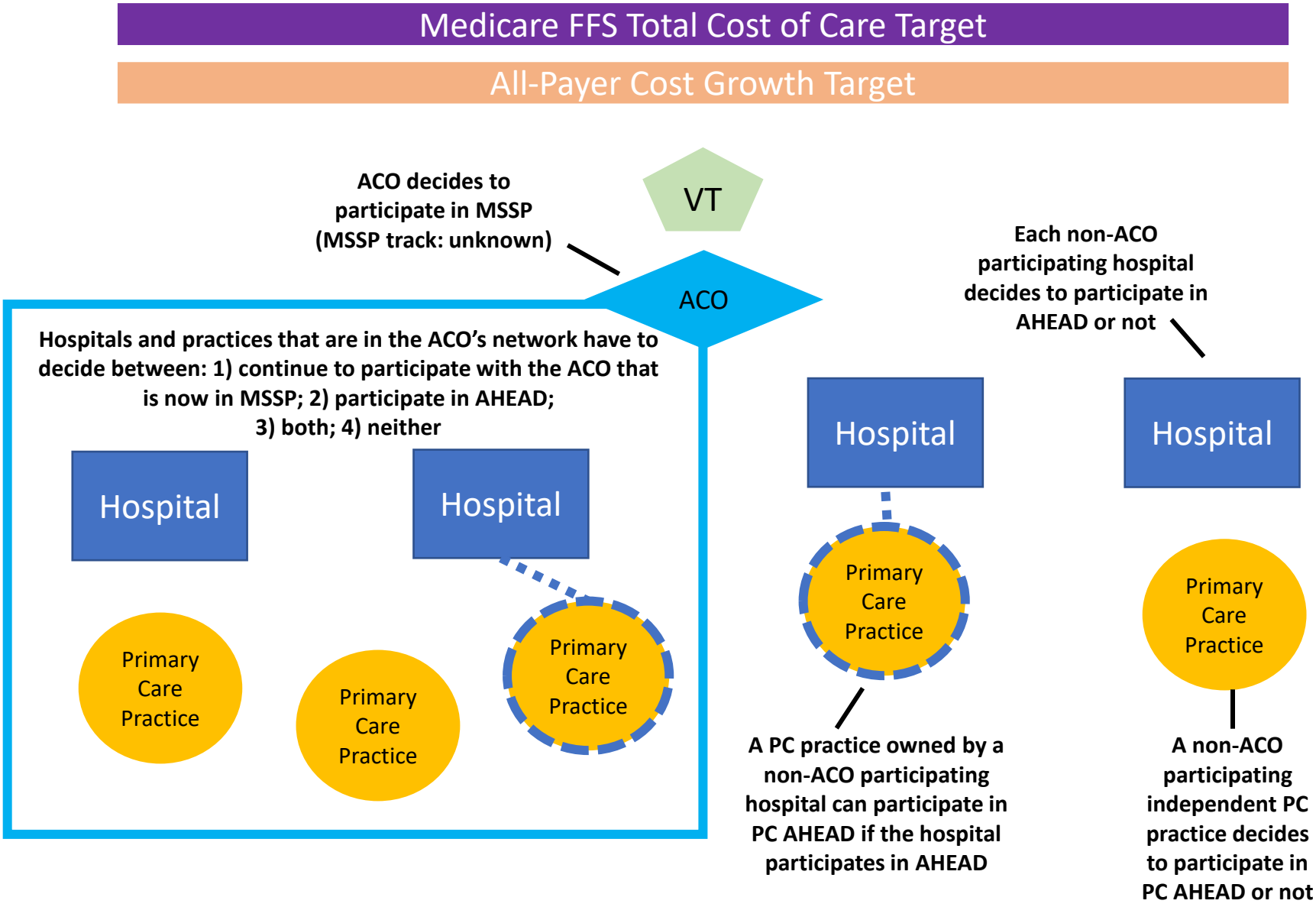
Eligibility

The following Medicare providers and suppliers are eligible to participate in the model:

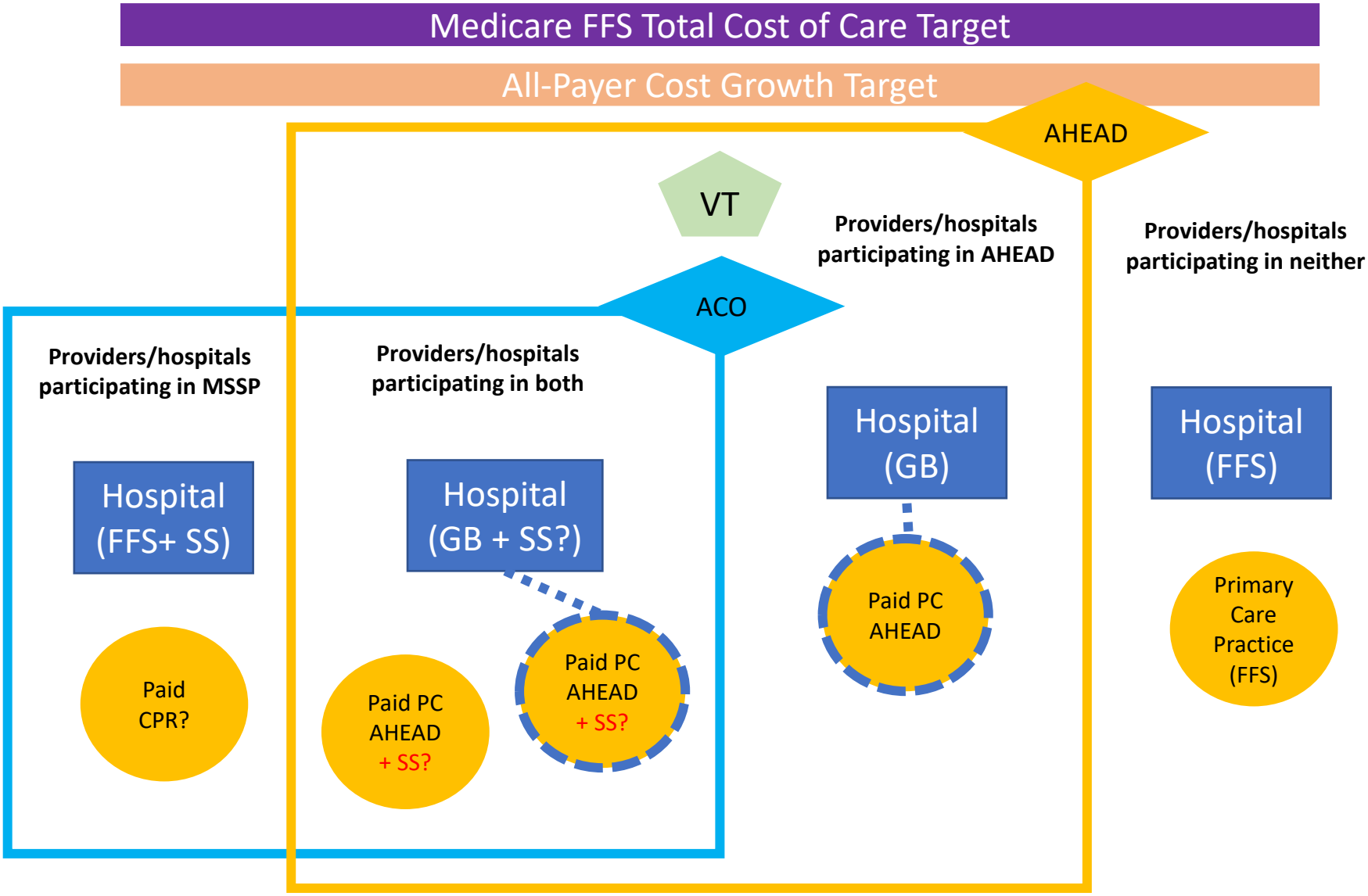
- Professionals in group practice arrangements
- Networks of individual practices
- Partnerships between hospitals and professionals
- Hospitals employing professionals
- CAHs
- FQHCs
- RHCs
- Teaching hospitals

Note: Provider/hospital participants cannot simultaneously participate in MSSP and the current VTAPM. Vermont providers' participation in MSSP is limited, if any.

ACO in MSSP + State in AHEAD

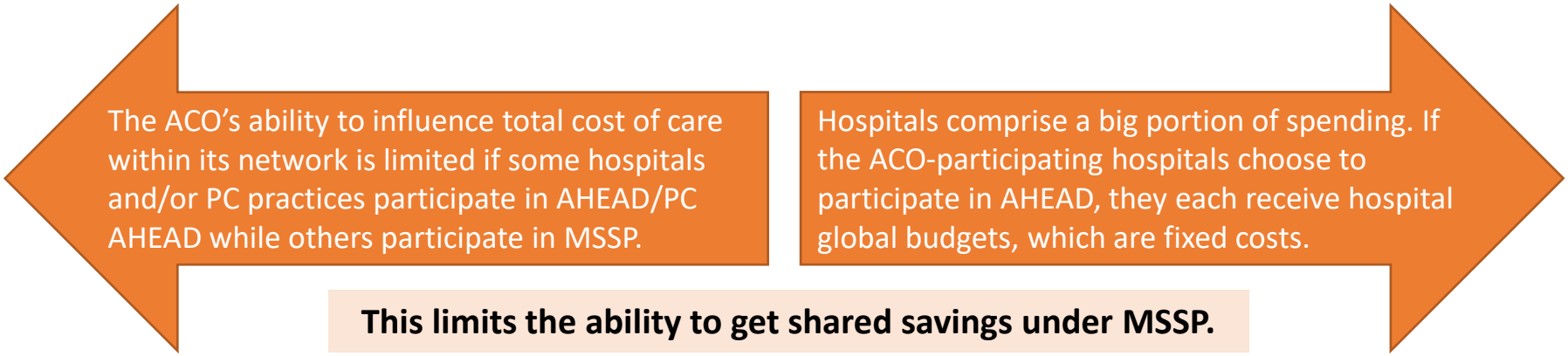


Potentially Creates Overlapping Groups



Key Considerations

- One key area of uncertainty is how this scenario would generate savings since there are two competing dynamics:



- Other considerations include:
  - Difficult for providers, including primary care practices and hospitals, to weigh the pros/cons around the best option (i.e., Primary Care AHEAD, MSSP, or both) for their organization.
  - Uncertainties around how to align Medicare incentives with Medicaid.

Next Steps

Next Steps

- The next Primary Care Workgroup meeting is currently scheduled for December 27 at 12 PM.
- Please send any questions or comments to Pat Jones (pat.jones@vermont.gov) and Wendy Trafton (wendy.trafton@vermont.gov).

Thank you for your participation!

Appendix

Recap: Federal Models are Evolving

- Vermont has been in discussion with the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS), regarding the development of a new multi-payer model to replace and build on the current Vermont All-Payer ACO Model (VTAPM).
- CMS intends that this model, called "AHEAD", will be an option for multiple states with a unified design.
- On September 5, CMS formally announced AHEAD.
- On November 16, CMS released details about the model in a document called a "Notice of Funding Opportunity" (NOFO).
- States have 120 days after the release of the NOFO to apply. CMS will select states from the applicants. The first cohort of states will go live in January 2026.
- Currently, CMS and Vermont are negotiating whether to extend the VTAPM for 2025, with the goal of providing a smooth transition to a potential new model in 2026.

Recap: High-Level Overview of AHEAD Model

Overarching Goals

To improve population health, advance health equity, and curb health care cost growth.

Three Primary Components *(see Appendix for more details)*

- 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

Description of AHEAD's Primary Components

- **Hospital Global Budgets.** Hospitals in participating states will have the option to be paid via a global budget – a fixed amount of revenue – to provide inpatient and outpatient services to Medicare fee-for-service beneficiaries for the upcoming year.
- **Primary Care AHEAD.** Primary care practices in participating states will have the option to participate in a primary care model that includes Medicare per beneficiary per month payments with a quality component, and which could transition to a more prospective method for paying practices.
- **Cooperative Agreement Funding.** CMS will provide each participating state up to $12 million in cooperative agreement funding to support planning activities during the pre-implementation period and initial performance years of the model.

Focus of this group

Comparing Current VT Primary Care Payments to Payments Under Primary Care AHEAD (DRAFT)

	Program	Payment by Payer
ACO-Participating Primary Care Practices	**Comprehensive Payment Reform (CPR) Program** *(Participating ACO 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 ACO primary care practices)*	• All-Payer* (2023): $4.75 PMPM per attributed life • Bonus Payment (2023): Up to $1.00 PMPM for achieving target performance in specified measures ** Entire Medicare payment covered by hospital funds.*
All Blueprint Primary Care Practices (FQHC, Hospital-Owned, Independent)	**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.

Crosswalk Between Primary Care AHEAD and Vermont's Existing Programs

Vermont is in a strong position to show that its Medicaid primary care initiatives align with AHEAD.

Primary Care AHEAD Guidance	Existing Vermont Medicaid Initiatives
• **Medicaid Alignment:** Practices must "participate in the Medicaid primary care APM" to participate in PC AHEAD (e.g., Patient Centered Medical Home)	• Recognition as Patient Centered Medical Homes under Blueprint
• **HRSN Care Transformation:** Practices must screen for health-related social needs	• Relevant NCQA PCMH requirements • Blueprint community health teams (CHTs) screen for HRSNs • Blueprint Expansion seeks to expand CHTs' capacity to provide HRSN screenings
• **HRSN Care Transformation:** Practices must incorporate on-site social workers, community health workers (CHWs), or other staff responsible for resource coordination	• Blueprint Expansion is focused on increasing CHT capacity to navigate and coordinate services • Blueprint Expansion funding can be used to embed licensed or unlicensed mental health counselors, social workers, CHWs, family specialists or psychologists.
• **HRSN Care Transformation:** Practices must identify and strengthen relationships with community resources and organizations that address social drivers of health (SDOH)	• Blueprint practices work with CHTs to refer patients to community resources and organizations that fit their needs

Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

Current MSSP Tracks

For comparison: In PY3, OneCare was contracted at a 5% risk corridor in a two-sided arrangement under the VTAPM.

	BASIC			ENHANCED *Two-sided*
	A & B *Upside only*	**C & D** *Two-sided*	**E** *Two-sided*	
# of ACOs (2023) *N = 456*	151 (33%)	19 (4%)	125 (28%)	161 (35%)
Time Limits Before Moving into Higher Risk? (2023)	7 years total – a new and/or inexperienced ACO may remain at Level A for all PYs of its first BASIC track agreement period (5 years) and then 2 additional years under Levels A or B during its subsequent agreement period	Must move from C to D after 1 year	None – can participate indefinitely under Level E; maximum level of risk/reward under BASIC track	None – highest level of risk/reward under MSSP; participation in the ENHANCED Track is optional
QPP A-APM Status (2023)	No (MIPS)	No (MIPS)	Yes	Yes
Min Savings Rate / Min Loss Rate (2024)	• ***MSR:*** 1st dollar savings at a rate of 40%; capped at 10% of benchmark • MLR: N/A	• ***MSR (Tracks C & D):*** 1st dollar savings at a rate of 50%; capped at 10% of benchmark • ***MLR (Track C):*** 1st dollar losses at a rate of 30%; not to exceed 2% of ACO participant revenue; capped at 1% of updated benchmark • ***MLR (Track D):*** 1st dollar losses at a rate of 30%; not to exceed 4% of ACO participant revenue; capped at 2% of updated benchmark	• ***MSR:*** 1st dollar savings at a rate of 50%; capped at 10% of benchmark • ***MLR:*** 1st dollar losses at a rate of 30%; not to exceed 8% of ACO participant revenue; capped at 4% of updated benchmark	• ***MSR:*** 1st savings at a rate of 75%; capped at 20% of updated benchmark • ***MLR:*** 1st dollar losses at a rate determined by ACO's health equity quality performance score; shared loss rate ranges from 40-75%; not to exceed 15% of updated benchmark
Quality (2023)	ACOs have the option to report on 10 CMS Web Interface measures, 3 electronic clinical quality measures (eCQMs), or 3 Merit-based Incentive Payment System (MIPS) clinical quality measures.			
Waivers (2023)	--	The following waivers are available in MSSP for ACOs participating in Tracks C-E and the ENHANCED Track: 3-day SNF, expanded telehealth services, & can establish beneficiary incentive programs.		