Vermont Health Care Reform Work Group: Primary Care Workgroup

January 12, 2024

VERMONT
AGENCY OF HUMAN SERVICES

Today's Agenda

- Discussion on Vision for Primary Care
- Interaction Between MSSP and AHEAD
- Primary Care AHEAD Quality Requirements
- Discussion on Primary Care AHEAD Quality Requirements

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 will be 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

Discussion on Vision for Primary Care

Summary of Workgroup Member Input

- AHS asked workgroup members about their vision of exemplary primary care. Workgroup members noted the following:
  - Moving from reactionary crisis management to proactive wraparound wellness care
  - Team-based care that includes robust support staff (e.g., nursing, mental health, social services) to address patients' health-related social needs
  - Reduced administrative burden
  - Ability to recruit more primary care providers and ensure they're properly supported to meet patients' needs
  - Transitioning to a panel paradigm so providers are looking at their total patient panel and deploying resources in a way that ensures patients have access to the care they need
  - Increased engagement with the community and conducting outreach to populations that may not be seeking primary care
  - Eliminating barriers (e.g., administrative, regulatory) that prevent practices and providers from providing the best care to their patients

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 component of Vermont All-Payer Model (VTAPM):

- 9 out of 14 hospital (including 3 Critical Access 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 Affordable Care Act (Section 3022) and is the largest Medicare Alternative Payment Model 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 (i.e., traditional Medicare) beneficiary population. *For more information on the MSSP tracks, see slide 26.*
- Medicare beneficiaries may voluntarily align themselves to an ACO at any time during the year; they designate a provider 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 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

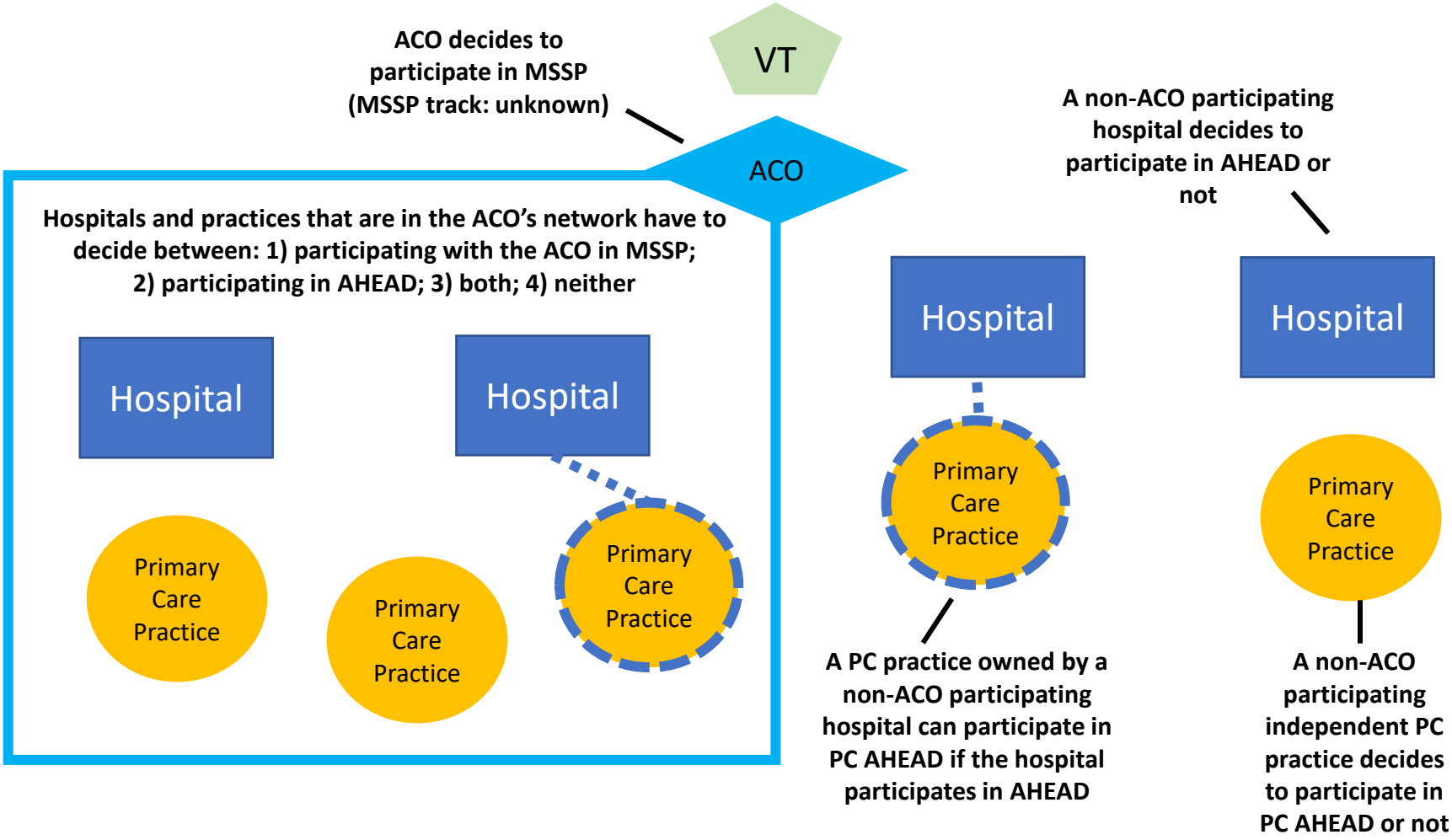
Note: Provider/hospital participants cannot simultaneously participate in MSSP and the current VTAPM. Vermont providers' participation in MSSP is limited, if any.

ACO in MSSP + State in AHEAD

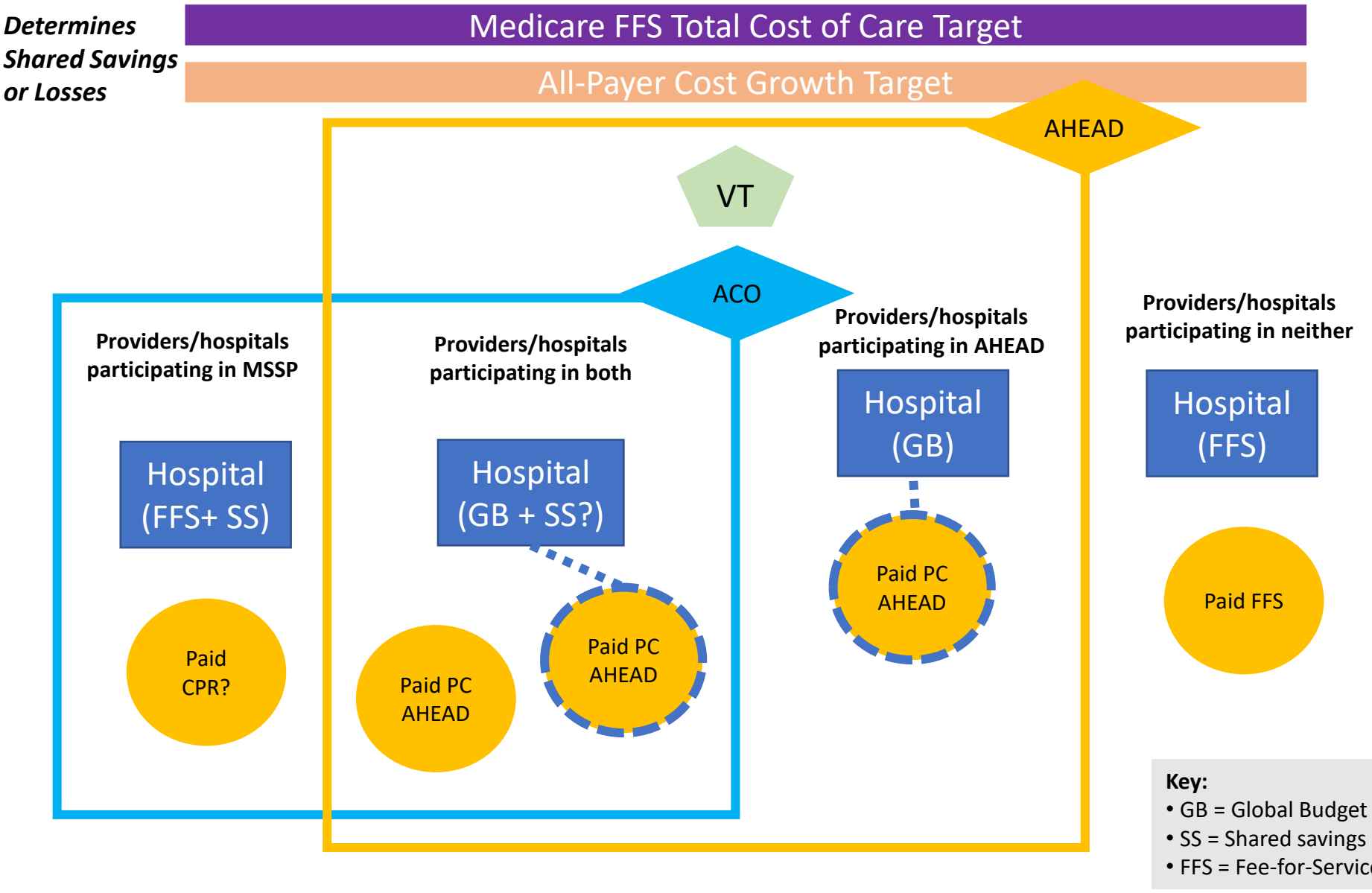
Determines Shared Savings or Losses

Medicare FFS Total Cost of Care Target

All-Payer Cost Growth Target



Potentially Creates Overlapping Groups



Key Considerations

- MSSP and AHEAD could create two competing dynamics in VT:

An ACO's ability to influence total cost of care within its network could be limited if some hospitals and/or PC practices participate in AHEAD/PC AHEAD while others participate in MSSP due to fixed hospital GBs.

Hospitals comprise a major portion of spending. ACO-participating hospitals choosing to participate in AHEAD would each receive hospital global budgets, which are fixed costs, also limiting ACO ability to gain shared savings.

- **Questions for today's group:**
  - At this early stage for AHEAD and in the formation of potential new MSSP ACOs, it is difficult for Vermont provider organizations to weigh the pros/cons around the best option (i.e., Primary Care AHEAD, MSSP, or both).
    - How is your organization thinking about this issue at this time?
    - What would be compelling about opting into MSSP vs. AHEAD vs. both?

Summary of Workgroup Member Input

- One workgroup member indicated there may be a synergistic relationship between hospitals that have hospital global budgets and community providers in an ACO arrangement with shared savings and losses. Both hospitals and community providers do not have an incentive to drive up health care expenditures.
- Another workgroup member wondered if practices could receive both the Medicare Enhanced Primary Care Payment (EPCP) under Primary Care AHEAD and continue to receive capitated payments under the Comprehensive Payment Reform (CPR) program – if OneCare participates in MSSP. AHS indicated that CMS has said that Medicare cannot provide capitated payments at least for the first performance year (2026) but may be possible in the later years of the model—CMS has indicated in the NOFO that is it evaluating an option for a Medicare primary care capitated track potentially for implementation beginning in 2027.

Summary of Workgroup Member Input

- Workgroup members discussed potential considerations around primary care practices' decisions to participate in MSSP v. AHEAD v. both:
  - Ability to participate in a capitated payment program for primary care
  - Relief from administrative burden (e.g., exempt from MIPS reporting)
  - Ability to coordinate with providers across the care continuum
  - Connection to a Vermont-based entity that can provide support around quality reporting, data, attribution, contracting, etc.
    - AHS noted that CMS indicated openness to have an organization that performs these functions under the AHEAD model.

Primary Care AHEAD Quality Requirements

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Quality and Population Health Strategy Goals Under AHEAD

CMS has indicated that the quality and population health strategy under AHEAD is an important lever for "driving alignment across payers and advancing health equity." It is focused on:

Prevention and Wellness

Improve equitable access to preventive services

Population Health

Improve chronic conditions through community-level health care transformation efforts

Ensure various populations have access to high-quality, whole-person care

Mental Health and Substance Use Disorder (MH/SUD)

Improve MH/SUD outcomes in alignment with state initiatives (e.g., reducing opioid use disorder)

Health Care Quality and Utilization

Reduce avoidable admissions and readmissions

Improve patient experience and delivery of whole-person care

Source: AHEAD Notice of Funding Opportunity

Primary Care AHEAD Quality Measures

Participating primary care practices will be accountable, through the EPCP, for performance on a set of five measures outlined below. To start, 5% of the EPCP will be tied to a practice's performance. By PY8, it will increase to 10%.

Domain	Measure	Data Source	Payer and Program Alignment	Currently Collected by VT Providers?
Mental Health and Substance Use Disorder (30%) *Measure is required*	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	eCQM	• Medicaid Adult Core Set • Commercial • Making Care Primary • CPC • HRSA Uniform Data System	✓ *(Medicaid ACO, Medicare ACO)*
Prevention and Wellness (15%) *Must select at least 1 measure in this domain*	Colorectal Cancer Screening	eCQM	• Medicaid Adult Core Set • Commercial • Making Care Primary • CPC+ and CPC • HRSA Uniform Data System	✓ *(Medicare ACO)*
	Breast Cancer Screening: Mammography	eCQM	• Medicaid Adult Core Set • Medicare • Marketplace • Commercial • CPC+ and CPC • HRSA Unform Data System	✓ *(VT Medicaid Adult Core Set)*

Source: AHEAD Notice of Funding Opportunity; Adult Core Set of Health Care Quality Measures for VT Medicaid; Vermont Medicaid Next Generation ACO Program 2021 Performance; Vermont All-Payer ACO Model Annual Health Outcomes and Quality of Care Report Performance Year 4 (2021)

Primary Care AHEAD Quality Measures

Domain	Measure	Data Source	Payer and Program Alignment	Currently Collected by VT Providers?
Chronic Conditions (15%) *Must select at least 1 measure in this domain*	Controlling High Blood Pressure	eCQM	• Medicaid Adult Core Set • Medicare • Marketplace • Commercial • Making Care Primary • Primary Care First • CPC+ and CPC • HRSA Unform Data System	✓ *(VT Medicaid Adult Core Set, Medicaid ACO, Medicare ACO)*
	Diabetes: Hemoglobin A1c Poor Control (>9%)	eCQM	• Medicaid Adult Core Set • Medicare • Marketplace • Making Care Primary • Primary Care First • CPC+ and CPC • HRSA Unform Data System	✓ *(VT Medicaid Adult Core Set, Medicaid ACO, Medicare ACO)*
Health Care and Utilization (40%) *Both measures are required*	Emergency Department Utilization	Claims	• Commercial • Making Care Primary • CPC+	? *(Monitored by ACO and Reported to Providers?)*
	Acute Hospital Utilization	Claims	• Commercial • Primary Care First • CPC+	? *(Monitored by ACO and Reported to Providers?)*

States may propose alternative measures to CMS to align with existing state efforts. The measure must fall under one of four domains (MH/SUD treatment, prevention and wellness, chronic conditions, health care and utilization) or align with the model's broader goals.

Source: AHEAD Notice of Funding Opportunity; Adult Core Set of Health Care Quality Measures for VT Medicaid; Vermont Medicaid Next Generation ACO Program 2021 Performance; Vermont All-Payer ACO Model Annual Health Outcomes and Quality of Care Report Performance Year 4 (2021)

Discussion Questions

- What are your thoughts and reactions to the Primary Care AHEAD quality measures?
- What types of quality data for these measures are you reporting today and how? What successes or challenges have you experienced in collecting these data?
- Are there alternative measures that the State should consider proposing to CMS?
- What additional supports would be helpful in your practice's data collection and quality reporting efforts?

Next Steps

Next Steps

- The next Primary Care Workgroup meeting is currently scheduled for January 26 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

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

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.		