Vermont Health Care Reform Work Group: Primary Care Workgroup

January 26, 2024

VERMONT
AGENCY OF HUMAN SERVICES

Today's Agenda

- Primary Care Investment Targets Under the AHEAD Model
- Revisit Primary Care AHEAD Quality Requirements and Reporting
- 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 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 preexisting priorities and reporting structure.
  - **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.

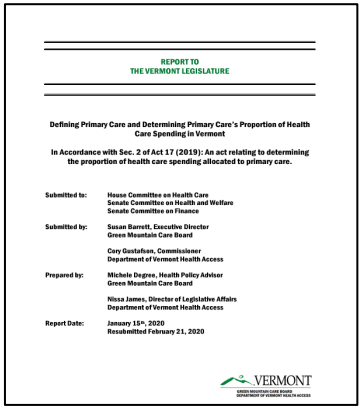
Refer to pages 22-24 and 104-105 in the AHEAD NOFO for more detailed information about Primary Care AHEAD.

Source: AHEAD Notice of Funding Opportunity

AHEAD Model Primary Care Investment Targets

Vermont's Experience to Date Measuring Primary Care Investment

Vermont has done significant work to define and report on primary care spend. However, there is currently no required minimum target.



REPORT TO
THE VERMONT LEGISLATURE

Defining Primary Care and Determining Primary Care's Proportion of Health Care Spending in Vermont

In Accordance with Sec. 2 of Act 17 (2019): An act relating to determining the proportion of health care spending allocated to primary care.

Submitted to: House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

Submitted by: Susan Barrett, Executive Director
Green Mountain Care Board

Cory Gustafson, Commissioner
Department of Vermont Health Access

Prepared by: Michele Degree, Health Policy Advisor
Green Mountain Care Board

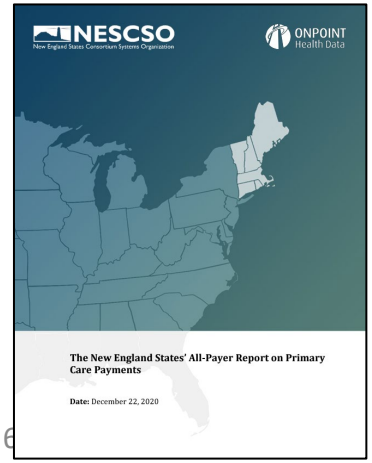
Nissa James, Director of Legislative Affairs
Department of Vermont Health Access

Report Date: January 15th, 2020
Resubmitted February 21, 2020

VERMONT

Defining Primary Care and Determining Primary Care's Proportion of Health Care Spending in Vermont Report to Legislature (2020)

Pursuant to Act 17 of 2019, The Green Mountain Care Board (GMCB) and Department of Vermont Health Access (DVHA) worked with stakeholders to develop a definition of primary care. The 2020 report concluded that total primary care spend (including both claims based and non claims based spend) was around **10%** of all spending in 2018.



NESCSO
New England States Consortium Systems Organization

ONPOINT
Health Data

The New England States' All-Payer Report on Primary Care Payments

Date: December 22, 2020

The New England States' All-Payer Report on Primary Care Payments (2020)

Vermont engaged in a multi-state effort (CT, ME, MA, NH, RI, VT) to develop a standardized methodology to measure primary care payments as a percentage of total health care expenditures. The methodology was used to calculate states' primary care spending.

Primary Care Investment Targets under AHEAD

States participating in AHEAD will be held accountable for both Medicare fee-for-service (FFS) and all-payer primary care investment targets.

Medicare FFS Primary Care Investment Target
(p. 15 of NOFO)

- Participating states/regions will be responsible for meeting the following targets for their Medicare FFS beneficiaries:
  - Annual improvement targets throughout the implementation period
  - A final primary care investment target by the end of the implementation period
- CMS will set a standard definition of primary care for the purpose of measuring Medicare FFS primary care spending *(definition available at "AHEAD Primary Care Investment Methodology" document)*.
- CMS will set the targets on a state-by-state basis during the pre-implementation period.

All-Payer Primary Care Investment Target
(pp. 15-16 of NOFO)

- There are 2 alternatives for how All-Payer Primary Care Investment Targets can be set up and operationalized prior to 2026:
  - If the state "has an existing all-payer primary care investment target, the state may use their current definition of primary care for measurement, subject to CMS approval"; **OR**
  - The target can be "set by CMS on a state-by-state basis and align existing state efforts on all-payer primary care investment"

CMS anticipates that a participant's final primary care target will be between 6-7% of Medicare TCOC, depending on current Medicare primary care spend in the state or sub-state region.

Source: AHEAD Notice of Funding Opportunity

Discussion Questions

- What are your thoughts and reactions to the way CMS is setting up minimum primary care spend targets under AHEAD (Medicare FFS and All-Payer)?
- Do you have questions about how primary care investment is measured in Vermont today?
- What challenges do you think increased investment would address?

Summary of Workgroup Member Input

- Workgroup members had questions around how primary care is defined for both the Medicare FFS and All-Payer primary care investment targets.
  - GMCB clarified that the definition of Medicare primary care spend will likely differ across CMS and Vermont. CMS' definition of primary care for the Medicare FFS target is narrower compared to Vermont's definition of primary care under the All-Payer target. Vermont considers Blueprint payments and non-claims payments, among others, to fall under primary care.
- Workgroup members wondered how Medicare was going to increase its investment in primary care to ensure states participating in the AHEAD model can achieve their targets. AHS indicated that CMS will be providing a $17 average Medicare Enhanced Primary Care Payment (EPCP). Another important factor to increase primary care spend would be increased utilization of primary care. However, the detail of the increase CMS will be expecting from Vermont is unknown at this time.
- Workgroup members preferred that the State have flexibility to define its All-Payer primary care investment target, rather than having it set by CMS.
  - AHS clarified that an investment target does not need to be set prior to the submission of the NOFO in March 2024, rather, the State needs to articulate the process for setting a target (e.g., executive order, statute).

Revisiting Primary Care AHEAD Quality Requirements

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)

Electronic Clinical Quality Measure Overview

- eCQMs are measures specified in a standard electronic format that use data electronically extracted from electronic health records (EHRs) and/or health information technology (IT) systems.
- eCQMs allow for all-population, all-payer measurement.
- Providers must use certified electronic health record technology (CEHRT) to successfully capture and report eCQM data. CERHT criteria can be found at 45 CFR 170.315(c)(1) – (c)(3).
- eCQMs can be collected by an aggregator, such as a statewide HIE.
- Currently under the VTAPM, OneCare does **not** report on eCQMs. The ACO has a unique pathway where it collects data across participating providers and sends the data in a template to an external vendor who calculates the score for Medicare.

CMS' Value Proposition for eCQMs:

- Use clinical data to assess treatment outcomes
- Reduce burden of manual abstraction and reporting
- Foster goal of access to real-time data for point of care quality improvement and clinical decision support

Providers may use eCQMs to identify opportunities for clinical quality improvement.

Sources: Electronic Clinical Quality Measures Basics; Certified EHR Technology; Get Started with eCQMs

eCQM Reporting in Similar CMS Alternative Payment Models

Since its inception in 2013, CMS has increasingly required providers to report eCQMs. New CMMI models launching (e.g., Making Care Primary) generally require eCQMs. Importantly, MSSP ACOs must report eCQMs starting in 2025.

	Making Care Primary (similar to Primary Care AHEAD)	Medicare Shared Savings Program
Required eCQMs To Be Reported	• Controlling high blood pressure* • Hemoglobin A1c* • Colorectal cancer screening* • Screening for depression and follow-up plan* • Depression remission at 12 months	• Controlling high blood pressure* • Hemoglobin A1c* • Screening for depression and follow-up plan*
Data Must Be Reported At The…	MCP organization level (TIN/NPI), not the individual clinician level	ACO level (based on patient level data across all participant TINs and CCNs)
Other Information	• First reporting period is expected to occur from 1/1/26 to 2/28/26 for PY 2025.	• Starting in 2025, all MSSP ACOs must report eCQMs for all patients and payers across all practices.

*Also required Under Primary Care AHEAD

Sources: Electronic Clinical Quality Measures Basics; Certified EHR Technology; Making Care Primary Request for Applications; Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP)

Discussion Questions

- What are your general reactions to the Primary Care AHEAD quality measures?
- What types of quality data for these Primary Care AHEAD quality measures are you reporting today and how? What successes or challenges have you experienced in collecting these data?
- eCQMs:
  - Are most practices now using CEHRT?
  - What are this group's concerns about getting started with eCQM reporting?
  - What additional supports would be helpful in your practice's data collection and quality reporting efforts?

Summary of Workgroup Member Input

- One workgroup member asked if there is alignment around eCQM reporting for both CMS's AHEAD model and Health Resources and Services Administration's (HRSA's) Uniform Data System (UDS) reporting. AHS indicated it would follow up with CMS.
- Several primary care providers in the workgroup indicated that they are already doing eCQM reporting today. They are able to report data at the practice-level. Participation in the ACO also allows for aggregate reporting.
- One workgroup member wondered if there were additional costs associated with eCQM reporting. One primary care provider indicated that if providers have a certified electronic health record (EHR), they are likely to be able to do eCQM reporting. There may be workflow adjustments that may be needed.

Next Steps

Next Steps

- Is the Work Group interested in continuing to meet? If so, we will add a couple of February and March dates. Fridays at noon seem to work pretty well for Work Group members.
- 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.		