Vermont Health Care Reform Work Group: Primary Care Workgroup

July 18, 2024

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Today's Agenda

- AHEAD Updates; Recap of MIPS Exemption/AAPM Proposal to CMS
- Primary Care AHEAD Participation Considerations
- Medicare Codes and Intersection with Primary Care AHEAD
- All-Payer Primary Care Investment Target
- Next Steps

AHEAD Updates

Key Dates

- **November 16, 2023:** CMS announced the first of two Notice of Funding Opportunities (NOFO) for the AHEAD model.
- **March 18, 2024:** Applications for Cohort 1 and 2 participants are due. Vermont has decided to apply to the model as a Cohort 1 participant.
- ★ **July 2, 2024:** CMS issued notices of award. VT was selected as a Cohort 1 participant.
- **Later in 2024:** During the May 9 webinar, CMS indicated they will release additional Primary Care AHEAD payment specifications (exact timing TBD).
- **July 1, 2024 to December 31, 2025:** Pre-Implementation Period (18 months)
- **January 1, 2026 to December 31, 2034:** Model Implementation Period (up to 9 years)

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Considering a MIPS Exemption/AAPM Proposal to CMS

Update on MIPS Exemption/AAPM Status

In preparation for AHEAD discussions with CMS, Vermont is considering potential approaches for primary care practices (PCPs) to retain MIPS exemption/AAPM bonus that they currently have under VTAPM.

Under this proposal, it is possible that PCPs could receive a MIPS exemption/AAPM bonus if they **both** participate in Primary Care AHEAD (and therefore the Blueprint) **and** have a "care relationship" with a participating hospital. **This proposal has not yet been vetted with CMS.**

Potential Scenarios (simplified):

Scenario	Implication for MIPS
1) AHEAD participating practice is owned by or affiliated with an AHEAD participating hospital	MIPS-exempt; AAPM bonus to clinicians
2) AHEAD participating practice is independent, but has a "care relationship" with an AHEAD participating hospital – **see next slide**	MIPS-exempt; AAPM bonus to clinicians
3) AHEAD participating practice is an FQHC	N/A – FQHCs do not report MIPS
4) Practice is owned by or affiliated with an AHEAD participating hospital, but chooses not to participate in Primary Care AHEAD	No exemption/bonus – must participate in PC AHEAD
5) Practice is owned by a VT hospital that decides not to participate in AHEAD	No exemption/bonus – owned practices are ineligible to participate in PC AHEAD if the hospital owner does not participate in AHEAD

Potential Options for Defining PCP/Hospital "Care Relationship"

It is advantageous for VT's requirements/threshold around care relationships between AHEAD-participating hospitals and PC AHEAD-participating PCPs to be as inclusive as possible.

Potential options for what constitutes a "care relationship" (not mutually exclusive)

1. ***PCP ownership or status.*** PCPs owned by or affiliated with AHEAD-participating hospitals.
2. ***Admitting privileges.*** A participating PCP must have employed at least one clinician with admitting privileges to an AHEAD-participating hospital.
3. ***Geographical proximity (same or nearby HSA).*** PCPs providing care to patients who received care at a hospital within the same or nearby HSA.
4. ***Telehealth.*** PCPs and hospitals with shared telehealth platform or e-consult service and telehealth relationships serving some small or minimum number of Medicare FFS beneficiaries. Establishing a care relationship would not depend on the geographical proximity between a hospital and a PCP.
5. ***Possible data integration/care coordination criteria:***
   a) Shared EHR
   b) ADT notifications passing between hospital and PCP
   c) Other based on shared VHIE use?
   d) Courtesy medical staff (i.e., staff who do not use the hospital as their primary hospital but who, because of their association with active staff members and/or place of practice, may on occasion use the hospital to accommodate patients and colleagues)
   e) Joint care planning between a PCP and hospital
   f) PCP participation in Blueprint practice improvement activities
   g) Typical pattern of referrals for specialty services

Under all options, the PCP would need to participate in PC AHEAD <u>and</u> the relationship would need to be with at least one hospital participating in AHEAD.

** This slide has been updated to reflect feedback from the workgroup on June 21 and July 18. Updates are in green text.*

Summary of Workgroup Member Input

- One workgroup member indicated that it would be helpful to define care relationships with hospitals at the primary care organization (i.e., tax identification number [TIN]) level, rather than at the individual practice level.
- Another workgroup member shared that Blueprint-participating primary care practices are recognized as patient centered medical homes (PCMHs) under National Committee for Quality Assurance (NCQA) standards. To be recognized as a PCMH, one of the criteria is to establish and maintain a connection with a hospital. They suggested adding this as an option for defining the PCP and hospital "care relationship." Vermont will look into this specific PCMH requirement.
- One workgroup member indicated it would be helpful to broaden Option 5 to include PCPs' typical patterns of referrals for specialty services.

Primary Care AHEAD Participation Considerations

Primary Care AHEAD Participation

As discussed previously, CMS has outlined eligibility criteria for Primary Care AHEAD.

- The following provider organization types are eligible to participate in Primary Care AHEAD:
  - Primary care practices
  - Federally qualified health centers (FQHCs)
  - Rural health clinics (RHCs)
- Practices must participate in the state's Medicaid Primary Care APM (i.e., Blueprint) and be eligible to bill to Medicare.
- Eligible practices will be identified at the Tax Identification Number (TIN) level, except system-owned practices, which will be identified by NPI in addition to TIN.
- **Practices owned by a hospital or health system can only participate in Primary Care AHEAD if that hospital is participating in AHEAD hospital global budgets.**
  - Hospital or health-system affiliated FQHCs and RHCs are exempted from this requirement.

Source: AHEAD Notice of Funding Opportunity

Vermont's Primary Care AHEAD Recruitment Goals

Vermont plans to take a phased approach to Primary Care AHEAD recruitment, with the goal of increasing participation as the model progresses.

- Primary Care AHEAD is scheduled to go live 1/1/26.
- Vermont's recruitment goals are:
  - All employed practices for participating hospitals;
  - Five new FQHC and RHC sites per year for Performance Years 1 to 4; and
  - At least half (approximately 65 practices) of Blueprint-participating practices throughout the duration of the model.
- The State also acknowledges that there are some information gaps that need to be filled before practices decide to participate or not. CMS has committed to technical assistance.

Vermont is committed to working with practices to ensure they have the information they need to make an informed decision around participation in Primary Care AHEAD.

Discussion

- What information do you need to decide to participate in Primary Care AHEAD?
- What are some key factors that will inform your decision?
  - Payment amount
  - Availability of primary care capitated payments
  - Advanced Alternative Payment Model (AAPM) status / exemption from MIPS reporting
  - Level of administrative burden
  - Other?
- **Should VT request CMS conduct a webinar with primary care practices in states that have been accepted into the model?**

Summary of Workgroup Member Input

- The workgroup discussed considerations around their decision to participate in Primary Care AHEAD:
  - ***Financial impact on PCPs.*** The group recognizes that the average $17 Medicare Enhanced Primary Care Payment (EPCP) is greater than Blueprint PMPM payments today. However, the financial impact of losing population health payments with the conclusion of the Vermont All-Payer ACO Model (VTAPM) and zeroing out of the chronic care management codes remains unclear.
  - ***Other payers.*** The group also understands Medicare's contribution to support advanced primary care, however, there are questions around what Medicaid and commercial investments in primary care will look like in the future.
  - ***EPCP.*** Members raised the fluctuation of EPCP due to performance as one concern. Additionally, they wondered how CMS would attribute the average $17 PMPM to patients.
  - ***Future State.*** The group also mentioned the uncertainty around the future of the ACO and indicated there may potentially be opportunities for PCPs in the Medicare Shared Savings Program.
- The workgroup indicated it would be helpful to attend a webinar with CMS in the future when there is new information available (e.g., overlaps with existing programs, additional information on payments, etc.). The workgroup is tracking the information CMS has released to date.
- Vermont confirmed that CMS is considering a primary care capitation model for participating practices in 2027. There would be no capitated payments available in 2026.

Medicare Codes and Intersection with Primary Care AHEAD

Primary Care AHEAD Care Management Codes

Under Primary Care AHEAD, CMS will "zero out" (i.e., no longer pay) Medicare care management codes for participating PCPs to avoid duplicative payments with the average $17 Medicare EPCP.

Service	HCPCS Codes
CCM Services	99490, 99491, 99437, G0511
Complex chronic care coordination services	99487, 99489
Prolonged non-face-to-face evaluation and management (E&M) services	99358, 99359
Assessment/care planning for patients requiring CCM services	G0506
Non-complex CCM clinical staff time	99439
CCM services for a single high-risk disease (Principal Care Management or PCM)	99424-7
Remote Physiologic Monitoring Treatment Management Services (RPM), Development and management of a plan of treatment based upon patient physiologic data	99457-8
Behavioral Health Integration Services, timed, per month	99484, 99492-4, G2214, G0512 and G0511 (FQHCs and RHCs)
Interprofessional Consultation	99446-9, 99451-2
CCM Services	99490, 99491, 99437, G0511

New Medicare Physician Fee Schedule 2024 Health Equity Services

The 2024 Physician Fee Schedule Final Rule includes new services and billing codes to promote health equity. Providers can receive additional reimbursement for offering these services.

- The four new services are:

1. **Caregiver Training Services.** New coding available when practitioners train and involve one or more caregivers to help patients carry out a treatment plan for certain diseases or illnesses.
2. **Social Determinants of Health (SDOH) Risk Assessment.** New G code to pay for administering a standardized, evidence-based SDOH assessment (5-15 minutes), no more than once every 6 months. Must be furnished by the practitioner on the same day they furnish an E/M visit.
3. **Community Health Integration (CHI).** New services codes for CHI services (e.g., person-centered planning, health system navigation, facilitating access to community-based resources) that auxiliary personnel, including community health workers, may perform incidental to the professional services of a physician or other billing practitioner, under general supervision.
4. **Principal Illness Navigation (PIN).** For individuals with a serious high-risk condition, illness, or disease. New service codes for PIN services (e.g., patient and family communication, service coordination and systems navigation) that auxiliary personnel may perform incidental to the professional services of a physician or other billing practitioner under general supervision.

More information can be found in the MLN: Health Equity Services in the 2024 Physician Fee Schedule Final Rule

Discussion

Care Management Codes

- Does your practice use the care management codes today? It appears that there may be minimal Medicare billing of these codes among Blueprint practices.
- Do you have concerns about not being paid separately by Medicare for these codes under Primary Care AHEAD?
- Are there additional questions about this issue that Vermont should elevate to CMS?

Health Equity Codes

- Are you aware of these codes being used or trialed in Vermont?
  - *Note: We do not yet know if CMS will provide separate payment for these codes under Primary Care AHEAD.*

All-Payer Primary Care Investment Target

Recap of 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.

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.

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

- There are two 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"
- **There may be more room for states to negotiate with CMS on this target compared to the Medicare FFS primary care investment target.**

Source: AHEAD Notice of Funding Opportunity

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Setting Up the All-Payer Primary Care Investment Target

Vermont outlined its proposed high-level approach to setting the all-payer target in its application to CMS.

- Vermont's Governor plans to codify the process and authorities for establishing the all-payer primary care investment target via Executive Order.
- Vermont plans to use the definition included in the New England States Consortium Systems Organization (NESCSO) report as the definition of primary care, with a minor modification to include primary care delivered by naturopaths.
  - ***Primary care provider:*** general practice, family medicine, pediatrics, internal medicine, nurse provider, physician assistant, OB/GYN, naturopaths
  - ***Primary care services:*** office visits, preventive visits, visit codes used by public payers, consultation services, selected preventive services, telehealth services, immunization services, chronic care management services, advanced care planning, prolonged services, and home visits.
    - Services that may be performed by OB/GYNs or, in some cases, by primary care providers included contraception insertion and removal, newborn care services, selected gynecological services, delivery, antepartum, and postpartum care services.

Source: AHEAD Notice of Funding Opportunity

Discussion

- What would be important elements in a process to establish the All-Payer Primary Care Investment Target?
- Do you have any questions about the definition?
- Is there anything else that we would want CMS to know or consider regarding all-payer primary care investment in Vermont?

Next Steps

Next Steps

- The next Primary Care Workgroup meeting has not been scheduled. What is the group's preference going forward?
- 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!

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