VERMONT
GREEN MOUNTAIN CARE BOARD

AHEAD Model Update

February 21, 2024

Agenda

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1. Review of Executive Session
2. AHEAD Model Background & Overview
3. AHEAD Model Timelines
4. Primary Care AHEAD
5. Board Questions
6. Public Comment
7. *Potential Executive Session*

Executive Session

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Grounds for Holding an Executive Session

- The GMCB may hold an executive session to consider "contracts" after making a specific finding that premature general public knowledge would clearly place the GMCB or a person involved at a substantial disadvantage. *See* 1 V.S.A. § 313(a)(1).

Motion/Scope

- A motion to go into executive session must be made during the open part of the meeting and must indicate the nature of the business of the executive session. No other matter may be considered in the executive session except the matter included in the motion. 1 V.S.A. § 313(a).
- No formal or binding action shall be taken in an executive session (except relating to securing real estate options). 1 V.S.A. § 313(a).

Vote

- An affirmative vote of 2/3 of members present is required to go into executive session. 1 V.S.A. § 313(a).

Attendance

- Attendance in an executive session shall be limited to members of the public body, and in the discretion of the body, its staff, clerical assistants and legal counsel, and persons who are subjects of the discussion or whose information is needed. 1 V.S.A. § 313(b).

Health Care Reform Update: The AHEAD Model

Green Mountain Care Board Meeting

February 21, 2024

Pat Jones, Interim Director of Health Care Reform, Agency of Human Services

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Today's Topics

1. Background and Overview

2. AHEAD Model Timelines

3. Primary Care AHEAD

Background and Overview

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Why Consider Health Care Reform?

Health Care Reform seeks to use public policy to address challenges in our health care system. Challenges and related goals Include:

- Ensuring affordability
- Improving access to care and insurance coverage
- Optimizing quality and experience of care
- Improving the health of the entire population
- Improving equity and reducing disparities in health and health care
- Identifying and addressing social determinants of health
- Ensuring adequate workforce across all care settings
- Reducing complexity (including misalignment across public and private payers)
- Creating a sustainable health care system

Payment reform is one component of health care reform. It is a means to an end: the goal is for payment changes to encourage and support care delivery transformation that leads to **better health outcomes and population health.**

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Why Consider New Federal Model?

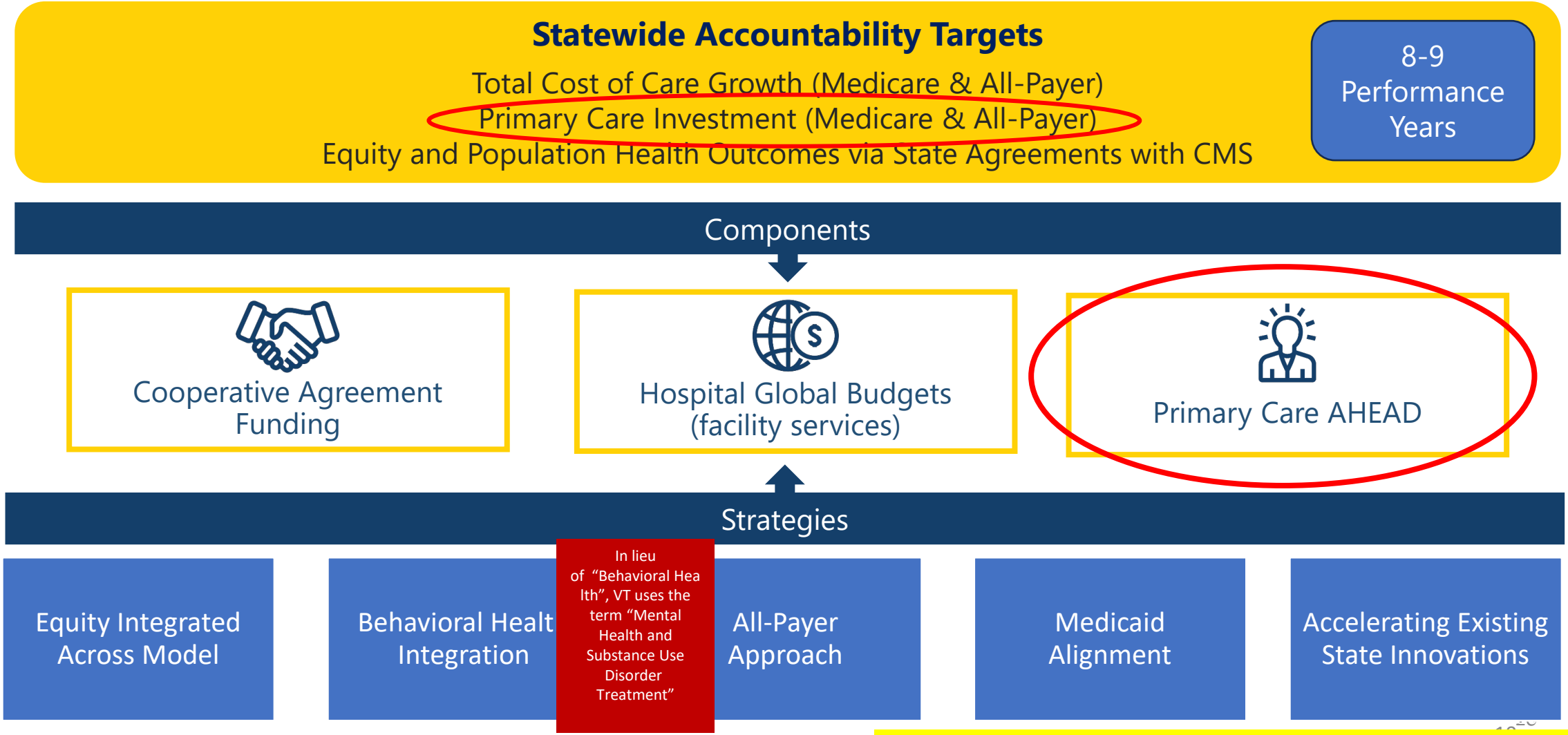
- Current Vermont model is arrangement between Vermont and the Centers for Medicare and Medicaid Services (CMS) that **allows Medicare**, Medicaid, and commercial insurers **to pay for health care differently** and establishes state-level accountability to **reduce cost growth, improve the health of Vermonters, and maintain or improve quality**
- Model shifts from paying for each service (fee-for-service) to **predictable, prospective payments** that are linked to quality (value-based)
- Relies on accountable care organization (OneCare Vermont) to develop voluntary network of providers that agree to be **accountable for care, cost, and quality**
- Original performance period was **2018-2022** (5 Performance Years)
- Currently in second year of a **two-year extension period**
  - Currently set to end on 12/31/2024; CMS interested in extending through 12/31/2025 to provide bridge to potential future federal-state model

AHEAD Announcement

- **September 5th:** Center for Medicare & Medicaid Innovation (CMMI) announced new model – "States Advancing All-Payer Health Equity Approaches and Development" (AHEAD)
- **November 16th:** CMMI released Notice of Funding Opportunity (NOFO) for AHEAD Model, inviting states or sub-state regions to apply for the model. Focus is on state capacity to implement AHEAD and how states would use up to $12 million in "Cooperative Agreement Funding" to support the Model.
- **Link to website:** https://www.cms.gov/priorities/innovation/innovation-models/ahead
- Applications for Cohort 1 and Cohort 2 states are due on **March 18, 2024.**
- Competitive process; CMMI will select only 8 states or sub-state regions.
- **NOTE:** Application is the **first step in potential state participation** – it is the start, not the end.

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Benefits of Continuing to Include Medicare in Vermont Health Care Reform

Ability to influence Medicare reimbursement for Vermont providers

Continued recognition of Vermont's status as a long-time low-cost state for Medicare

Helps ensure that baseline financial calculations recognize Vermont's past reforms that have saved money for Medicare

Access to up to $12M in AHEAD Cooperative Agreement funds to support health care reform efforts over 5.5 years

>$9M annually for Medicare's portion of Blueprint (payments to primary care practices recognized as Patient-Centered Medical Homes, Community Health Teams, and Support and Services at Home program)

Increased Medicare investments in primary care (could approach $17M annually if all Vermont primary care practices participate)

Medicare transformation funding for hospitals that participate during early years; equity and quality funding (if hospitals show improvement; CAHs only need to report for quality payment in initial years)

Greater alignment in priorities, payment models, quality measures and reporting, which sends a stronger signal to all health care system partners

Waivers of Medicare regulations (e.g., 3-day stay Skilled Nursing Facility waiver) **and ability to propose new waivers**

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AHEAD Model Timelines

Key Dates for Cohort 1 States

March 18, 2024

Applications Due from States

May/June 2024

Anticipated Notice of Award to Selected States

July 1, 2024 – December 31, 2025

18-month Pre-Implementation Period

January 1, 2026

Start of 9-year Performance Period

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Operational Milestones

The NOFO includes operational milestones for the pre-implementation and implementation period related to model components that will be a requirement by the Cooperative Agreement, and to the extent applicable, will also be included in the State Agreement for the remainder of the Model.*

Operational Milestones

State Agreement Negotiation and Signature by State Leadership and CMS — *June 30, 2025*

Final Milestone: Execution of State Agreement **6 months prior to PY1**

Creation and Implementation of All-Payer TCOC and Primary Care Investment Targets — *Oct. 1, 2025*

Final Milestone 1: Creation of Targets (Or Process to Determine Target) via State Executive Order, Statute, or Regulatory Change **90 days before PY1**

Final Milestone 2: Finalization of Targets in an Amended State Agreement **90 days before PY2** — *Oct. 1, 2026*

Successful Recruitment of Hospitals to Participate in Medicare FFS Hospital Global Budgets — *Oct. 1, 2025*

Final Milestone 1: Hospitals Agree to Participate such that 10% of Medicare FFS Net Patient Revenue (NPR) Would Be Under Medicare FFS HGBs **by PY1**

Final Milestone 2: See Above, 30% of Medicare FFS NPR in an HGB **for PY3 for each subsequent PY** — *Oct. 1, 2028*

Implementation of Medicaid Primary Care APM — *Jan. 1, 2026*

Final Milestone: Implementation of Medicaid Primary Care APM with Participation from Primary Care Practices **by the beginning of PY1**

Implementation of Medicaid Hospital Global Budgets — *Dec. 31, 2026*

Final Milestone: Implementation of Medicaid Hospital Global Budgets **by the end of PY1**

Commercial Payer Alignment with Hospital Global Budgets — *Jan. 1, 2027*

Final Milestone: At Least One Commercial Payer Participating in Hospital Global Budgets **by the start of PY2**

Source: CMS Presentation from November 16 AHEAD Notice of Funding Opportunity Webinar *(dates added)*

AHEAD Timeline #1: Model Development, Announcement, Application, and Selection

CMMI = Federal Center for Medicare & Medicaid Innovation, a component of CMS

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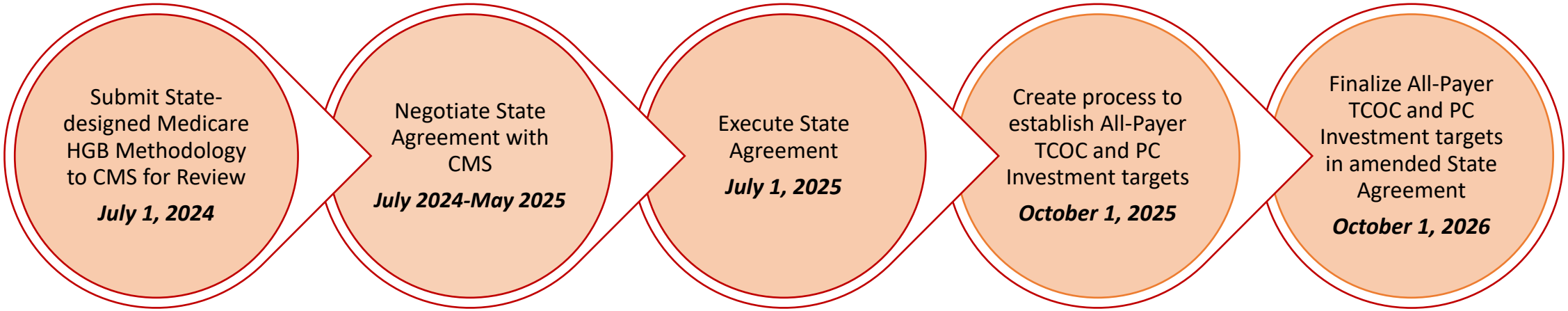
AHEAD Timeline #2: Negotiations, Execution of State Agreement, and Setting Statewide Targets



TCOC = Total Cost of Care
PC = Primary Care

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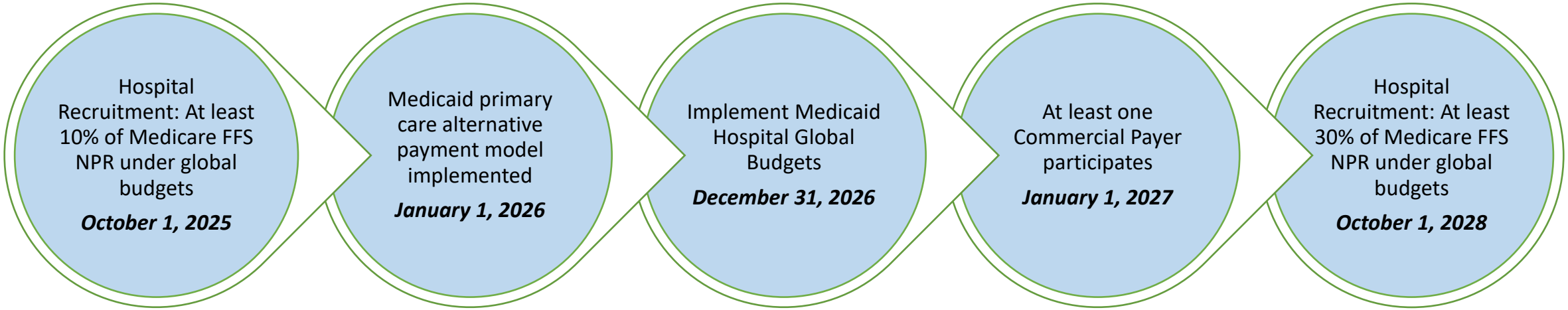
AHEAD Timeline #3: Key Implementation Milestones



FFS = Fee-for-Service
NPR = Net Patient Revenue for hospital inpatient and outpatient services

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Primary Care AHEAD

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What is Primary Care AHEAD?

A voluntary, **beneficiary-focused** advanced primary care program designed to align Medicare with state-led primary care efforts. It has an overarching, flexible framework of **care transformation priorities** that will complement statewide Medicaid primary care priorities. Primary Care AHEAD is intended to increase overall capacity for **care coordination** and connection to **community resources**, improve quality, offer whole **person-centered care**, and **minimize provider burden**.

What are the Program Components & Goals?

Program Goals

- **Increase Primary Care Investment**
- **Align Payers**
- **Support Advanced Primary Care**
- **Broaden Beneficiary Reach through FQHC*, RHC*, and Small Practice Participation**

**Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)*

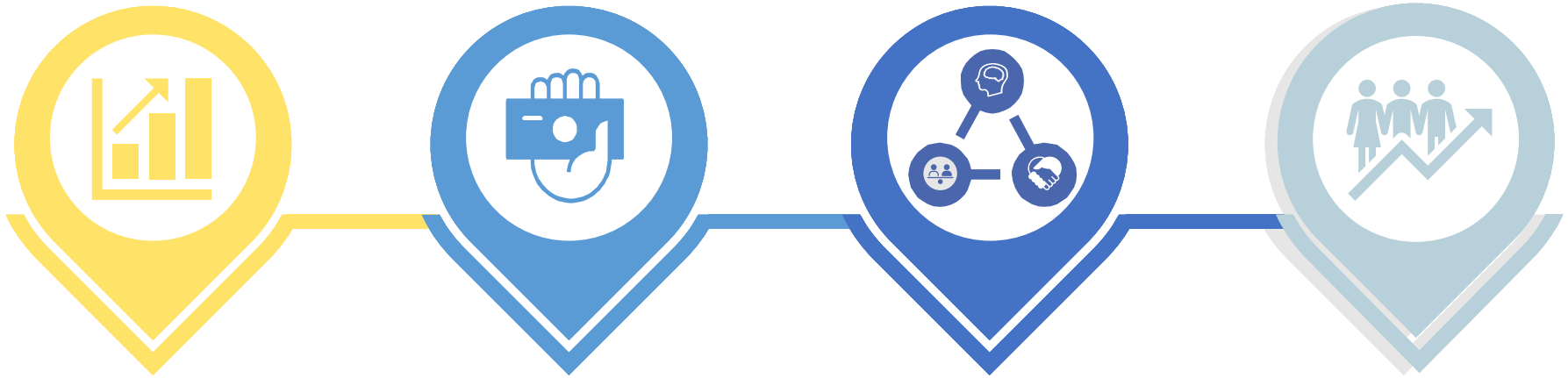
Program Components

- **Care Transformation Activities**
- **Enhanced Payment**
- **Learning Collaboratives & Supports**
- **Data & Technical Assistance**

Source: Primary Care AHEAD Fact Sheet from CMS AHEAD Website

Primary Care AHEAD Goals

Primary Care AHEAD is flexible to align with each state's Medicaid primary care goals and will bring Medicare to the table for increased investment and care transformation initiatives.



Increase Primary Care Investment

Increase primary care investment statewide as a percent of the total cost of care

Align Payers

Bring Medicare to the table for state-led primary care transformation, with a focus on Medicaid alignment

Support Advanced Primary Care

Advance behavioral health integration, care coordination, and HRSN-related activities for primary care delivery

Broaden Participation

Facilitate successful participation by small practices, Federally Qualified Health Centers, and Rural Health Clinics

CMMI has committed to introducing primary care tracks with additional risk/capitation in the future. Any future Primary Care AHEAD tracks will align with these program goals.

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Increasing Primary Care Investment

Excerpts from CMS AHEAD Website:

- "The AHEAD Model is designed to increase Medicare FFS [fee-for-service] investment in primary care and align primary care transformation with existing innovations in state Medicaid programs."

- "There is flexibility for states to construct their own primary care definitions for spending measurement for All-Payer Primary Care Investment targets."

AHEAD Application Requirements: Statewide Accountability

Key Elements in AHEAD NOFO: Statewide Accountability
Describe strategy to **measure** statewide total cost of care (TCOC) and **primary care investment** across payers over time, including current TCOC and primary care spend on an all-payer basis.
Describe current or planned efforts to include all-payer TCOC and **primary care investment targets** in state executive order, statute, and/or regulation, and any mechanisms for enforcement of such targets.
Describe applicant's **ability to obtain** TCOC and **primary care spending information** for each year from commercial payers and Medicaid.
Describe anticipated **policy levers to increase primary care spending** by commercial payers and Medicaid.
Describe regulatory and policy levers the applicant intends to use to achieve or enforce TCOC cost growth targets across payers.
Identify **known gaps** in the state's TCOC and **primary care spending reporting**.

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Primary Care AHEAD: Enhanced Primary Care Payment

Primary Care AHEAD participants will receive an Enhanced Primary Care Payment (EPCP) to facilitate Medicare FFS investment in advanced primary care and enhanced care management.

Payment

- Participating practices will receive **an average $17 PBPM* for attributed beneficiaries**, paid quarterly.
- A small portion of this payment (initially 5%, scaled up to 10%) is **at risk for quality performance**.

Requirements

- Participating practices must participate in the state's Medicaid Patient-Centered Medical Homes or other primary care alternative payment model.
- Practices must meet specific Care Transformation Requirements, which will be aligned across Medicaid and Medicare.

Potential Uses

Practices may use the EPCP to invest in infrastructure and staffing to perform advanced primary care (e.g., care coordinators, behavioral health staff, or community health workers).

**A state may earn a higher (max $21) or lower (floor $15) PBPM based on hospital recruitment or state TCOC performance.*

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

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Eligibility Criteria – Primary Care Practices

Primary care practices may participate voluntarily in the Primary Care AHEAD program to receive a Medicare Enhanced Primary Care Payment and support corresponding care transformation.

Primary Care Practices

Primary Care Practices

- Primary care practices, FQHCs, and RHCs that are located within a participant state or sub-state region and are participating in the state's Medicaid Primary Care Alternative Payment Model (APM).
  - The state's Medicaid Primary Care APM could support a Patient-Centered Medical Home program, health home, or similar care coordination program.
- Hospital-owned practices will only be eligible to participate in Primary Care AHEAD if the affiliated hospital is participating in AHEAD hospital global budgets for that performance year with an exception for FQHCs/RHCs.

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

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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.

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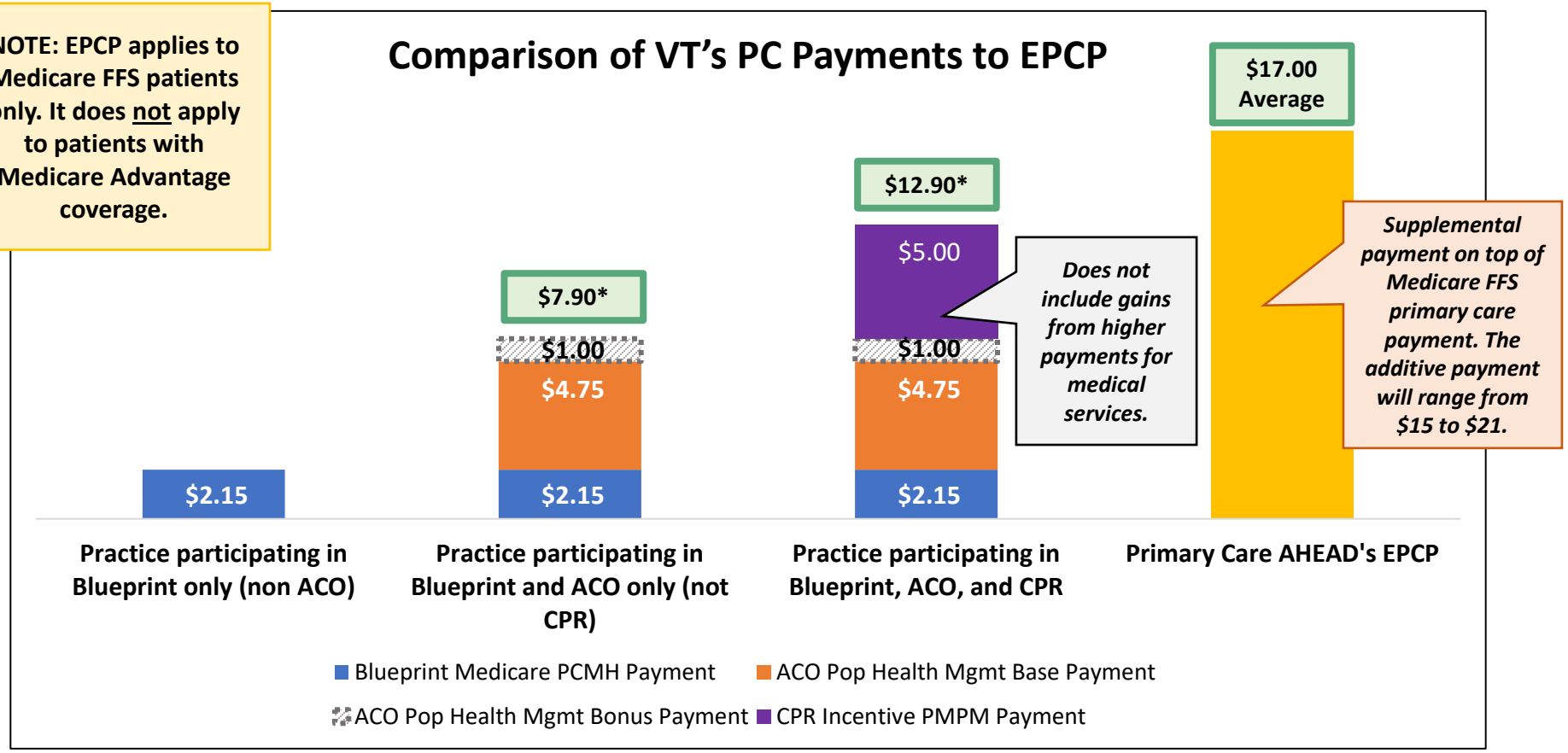
How do Vermont's Current Primary Care Payments Compare to Primary Care AHEAD's EPCP? (DRAFT)

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.

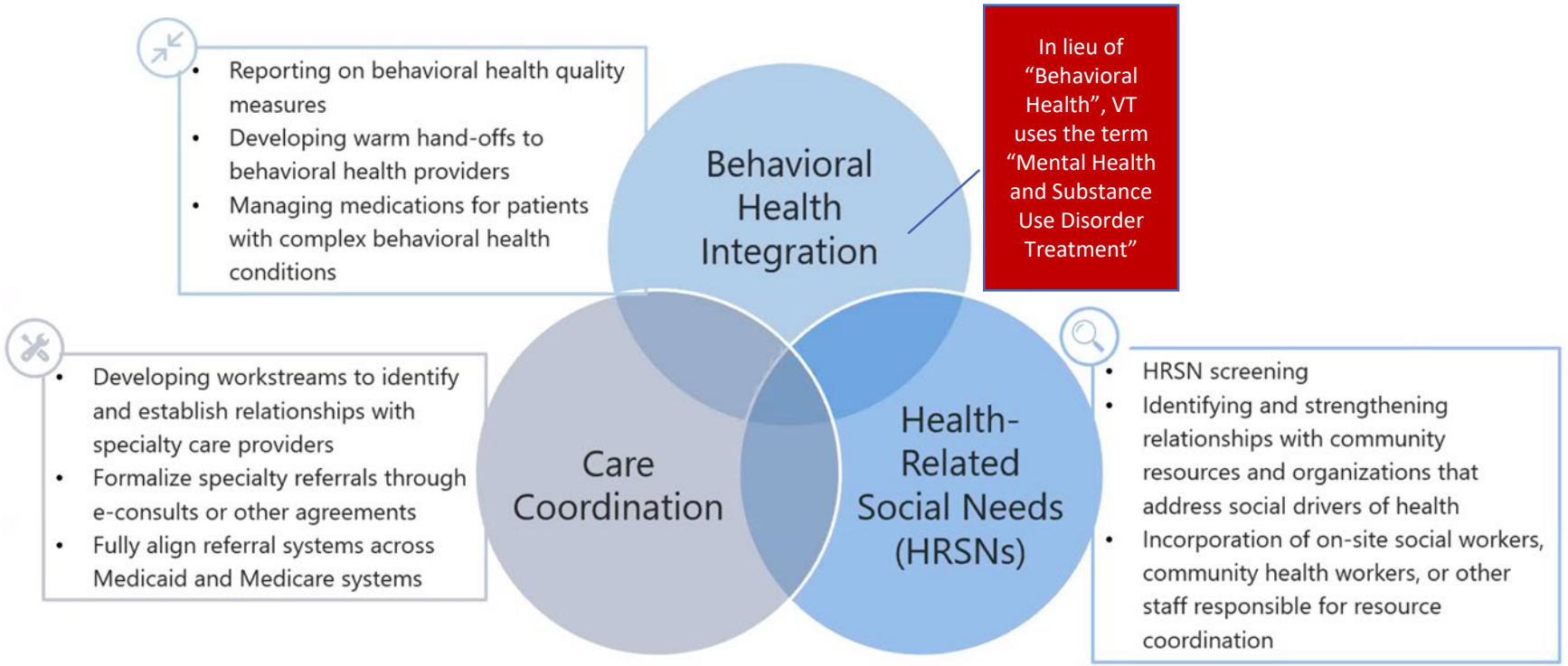
NOTE: EPCP applies to Medicare FFS patients only. It does not apply to patients with Medicare Advantage coverage.



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

Primary Care AHEAD: Care Transformation Requirements

Primary Care AHEAD will include care transformation requirements for person-centered care. They are intended to align with the state's existing Medicaid care transformation efforts.



Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

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Vermont Blueprint for Health: Core Components

Patient-Centered Medical Homes

- Patient-Centered Medical Homes are primary care practices that have been assessed and recognized by the National Committee for Quality Assurance (NCQA) as meeting high quality standards for primary care, largely through enhanced levels of preventive care and care coordination.

Community Health Teams (CHTs)

- CHTs are multi-disciplinary teams developed at the regional level to address unmet health care needs. CHT staff include nurses, care coordinators, social workers, counselors, health educators, registered dietitians, nutrition specialists, health coaches, and community health workers. Staff may be located centrally within each region as a shared resource, particularly for patients of smaller practices, or embedded in practices with sufficient patient volumes and needs. The purpose is to support patient access and enhanced levels of preventive services and coordinated care.

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Vermont Blueprint for Health: Extended Services

Hub and Spoke Services for Opioid Use Disorder (OUD)

- For OUD treatment, Medicaid funds:

✓Intensive, specialized, and highly supervised treatment in Opioid Treatment Programs ("Hubs") managed by the Vermont Department of Health.

✓Community Office-Based Opioid Treatment services ("Spokes"), commonly administered by primary care providers and supported by the Blueprint for Health.

Pregnancy Intention Initiative (PII)

- Medicaid funds the PII program to support primary care and preventive services for people of childbearing age, including access to Long-Acting Reversible Contraception for people who choose it, enhanced health and psychosocial screening, follow-up through brief in-office intervention, and referral to health and community services.

Support and Services at Home (SASH)

- Medicare funds the SASH program in Vermont to provide wellness nurses and care managers to serve elderly and disabled Medicare beneficiaries in congregate housing or nearby communities.

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Blueprint for Health Expansion Pilot

- Vermont Medicaid is expanding funding for Blueprint for Health Community Health Teams to implement a **two-year pilot program** designed to improve access to mental health and substance use disorder services and address social determinants of health through increased integration with primary care.
  - Vermont experiencing increased deaths from drug overdose and suicide; concerning levels and acuity of mental health and substance use disorders.
  - Need to identify and address social determinants of health, particularly housing instability.
  - Objective of pilot is to ensure that additional supports and services are provided across entire population served by primary care practices participating in Blueprint for Health (majority of primary care practices in Vermont).

AHEAD Quality Strategy

From NOFO: "The overall Model quality strategy includes three sets of quality measures, each with a health equity focus:

1. Statewide measures
2. Primary Care measures
3. Hospital quality programs"

CMS has outlined four domains with corresponding goals and measures.

Domain Area	Goals
Prevention & Wellness	• Increase equitable access to preventive services
Population Health	• Improve chronic conditions by focusing on health care transformation efforts at the community level • Achieve high-quality, whole-person, equitable care across different population groups
Mental Health & Substance Use Disorder	• Improve outcomes in alignment with unique needs of state initiatives
Health Care Quality & Utilization	• Reduce avoidable admissions and readmissions • Improve patient experience and delivery of whole-person care

AHEAD Primary Care Measure Set

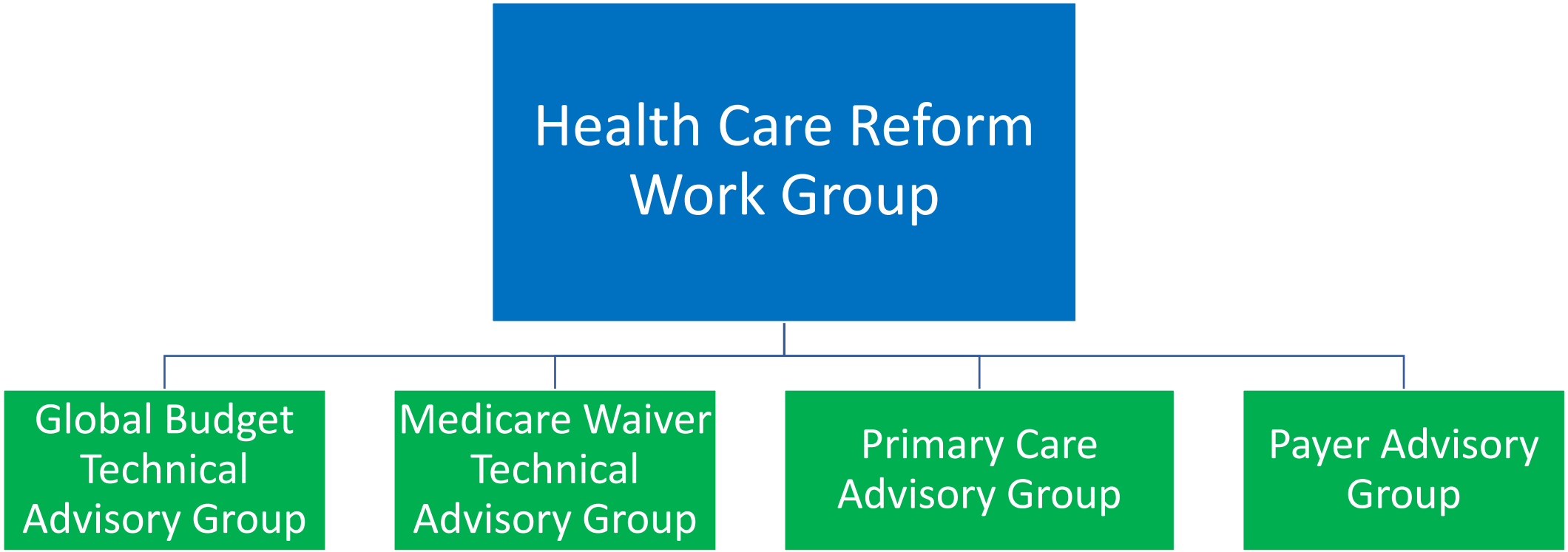
CMS will require 5 measures for primary care practices participating in AHEAD. “Should an award recipient wish to propose an alternative measure to align with other ongoing state efforts, CMS will consider potential measure replacements, so long as the alternative measure aligns to a domain below or to Model goals broadly.”

Domain	Measure
Prevention & Wellness (choose at least one)	Colorectal Cancer Screening
	Breast Cancer Screening: Mammography
Chronic Conditions (choose at least one)	Controlling High Blood Pressure
	Hemoglobin A1c Poor Control (>9%) for Patients with Diabetes
Mental Health & Substance Use Disorder (measure required)	Screening for Depression and Follow-Up Plan
Health Care Utilization (both measures required)	Emergency Department Utilization
	Acute Hospital Utilization

Application Requirements: Vision for Primary Care Transformation and Practice Recruitment

Key Elements in AHEAD NOFO: Primary Care
Describe current **Medicaid initiatives** underway in primary care, especially related to MH/SUD integration, health-related social needs, care management, and specialty care coordination.
Describe tool(s) that will be leveraged to **increase Medicaid investment** in primary care (i.e., state directed payments for certain primary care services, rate increases and enhanced reimbursement for primary care services, additional tools to rebalance funding across the delivery system).
Describe tools for **increasing access** to primary care services; existing **Medicaid Primary Care alternative payment model** (APM), including current participation of FQHCs and RHCs; and how Primary Care AHEAD might align with these existing efforts in the state.
Provide a detailed **plan for recruitment** of primary care practices for participation in Primary Care AHEAD (e.g., how the applicant will identify practices participating in state Medicaid primary care value-based payment arrangements and conduct recruitment outreach to those providers).
Include description of the **types of practices** currently participating **in the state's Medicaid Primary Care APM**, including identification of gaps in current participation and plans to address those gaps under Primary Care AHEAD.

Current Advisory Group Structure



Previous Subgroups from Summer and Fall 2022 provided foundation and key principles for this deeper work:

Short-Term Provider Stability, Global Budget, and Total Cost of Care Subgroups

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Forums for Discussions on Primary Care

Green Mountain Care Board Primary Care Advisory Group (PCAG)

- June 21, 2023: Health Care Reform Update
- November 15, 2023: Presented on the AHEAD Model and discussion of PCAG Priorities
- January 17, 2024: Update on AHEAD Model

AHS Primary Care Work Group

- Membership includes primary care providers, association leaders, GMCB staff, OneCare representative
- Seven meetings since October 2023; at least two more scheduled

Health Care Association Coalition

- Membership includes American Academy of Pediatrics-VT, Bi-State Primary Care Association, HealthFirst, VT Association of Adult Day Services, VT Association of Hospitals and Health Systems, VT Care Partners, VT Dental Society, VT Health Care Association, VT Medical Society, VNAs of VT
- Attended several weekly meetings to discuss the AHEAD Model

Other Meeting Requests

- Examples: Vermont Medical Society Board, HealthFirst Leadership, Bi-State Primary Care Association Board

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Question posed to AHS Primary Care Workgroup and GMCB Primary Care Advisory Group:

What would great primary care look like for your patients?

Summary from AHS Primary Care Workgroup

Workgroup members provided the following feedback:

- 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

Summary from GMCB Primary Care Advisory Group

Advisory Group members provided the following feedback:

- Adequate time to listen to patients and talk about options; time with patients is the “currency of primary care.”
- Reduced paperwork; it should not take more time to document in EHR than the actual visit.
- Availability: patients can see their provider when they want to.
- Primary care is close to home.
- Everyone in the state has a primary care provider and has been seen in the past year.
- Care is affordable.
- Patient panel sizes are reasonable (suggested 1200 per provider) and account for complexity of many patients.
- There is support for preventive care and team-based care, and for addressing housing, food insecurity, and other social determinants of health.
- Physicians and nurses are supported in working at the top of their license.
- There is flexibility and creativity in how care can be delivered (e.g., home visits, telehealth, team-based care).
- Capitated payment and other value-based payments; comprehensive payment reform (CPR) program or something similar.
- Adequate resources outside of the office: mental health care, home health services, rehabilitation services, etc.
- Primary care is prioritized in training; encourages people to go into primary care.
- Care is redirected from specialists to primary care when appropriate.

Questions/Discussion

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