Health Care Reform Update

Green Mountain Care Board Primary Care Advisory Group

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Why Consider New Federal Model and Why Now?

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 gets a lot of attention; it is just one component of health care reform. It is also 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.**

Current Vermont All-Payer Model Agreement

- **Signatories:** Governor, AHS Secretary, GMCB Chair
- Arrangement between Vermont and the federal government that **allows Medicare**, Medicaid, and commercial insurers **to pay for health care differently** and establishes state-level accountability for cost, population health, and quality
- The model shifts from paying for each service (fee-for-service) to **predictable, prospective payments** that are linked to quality (value-based)
- Changing payment is intended to **reduce health care cost growth, maintain or improve quality, and improve the health of Vermonters**
- Relies on an accountable care organization (OneCare Vermont) to develop a voluntary network of providers that agree to be **accountable for care, cost, and quality** for their attributed patients.
- Original performance period was **2018-2022** (5 Performance Years)
- Currently in first year of a **two-year extension period**
  - Extension suggested by the Center for Medicare & Medicaid Innovation (CMMI); signatories approved in November 2022 to act as a bridge to a future federal-state model (which was then expected for 2025)
  - Currently set to end on 12/31/2024

Benefits of Continuing to Include Medicare in Vermont Health Care Reform

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

Ability to influence Medicare reimbursement for Vermont providers

>$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)

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

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

4

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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 Application and Implementation Timeline

		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Model Year			MY1	MY2	MY3	MY4	MY5	MY6	MY7	MY8	MY9	MY10	MY11
1st NOFO Period	Cohort 1	NOFO	Pre- Implementation (18 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9
	Cohort 2		Pre-Implementation (30 mos)			PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
2nd NOFO Period	Cohort 3		NOFO	Pre-Implementation (24 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8

Source: CMS AHEAD Model Website

Cohort 1 is for states that would participate in 18-month pre-implementation period, tentatively 7/2024 – 12/2025, with a 1/2026 first performance year.

There will be 9 performance years for Cohort 1 states; the model runs through 2034.

Key Dates for Cohort 1 States

March 18, 2024

Applications Due from States

May 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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Discussion:
What would great primary care look like for your patients?

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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.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

8-9 Performance Years

Components

- Cooperative Agreement Funding
- Hospital Global Budgets (facility services)
- Primary Care AHEAD

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

In lieu of "Behavioral Health", VT uses the term "Mental Health and Substance Use Disorder Treatment"

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

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

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

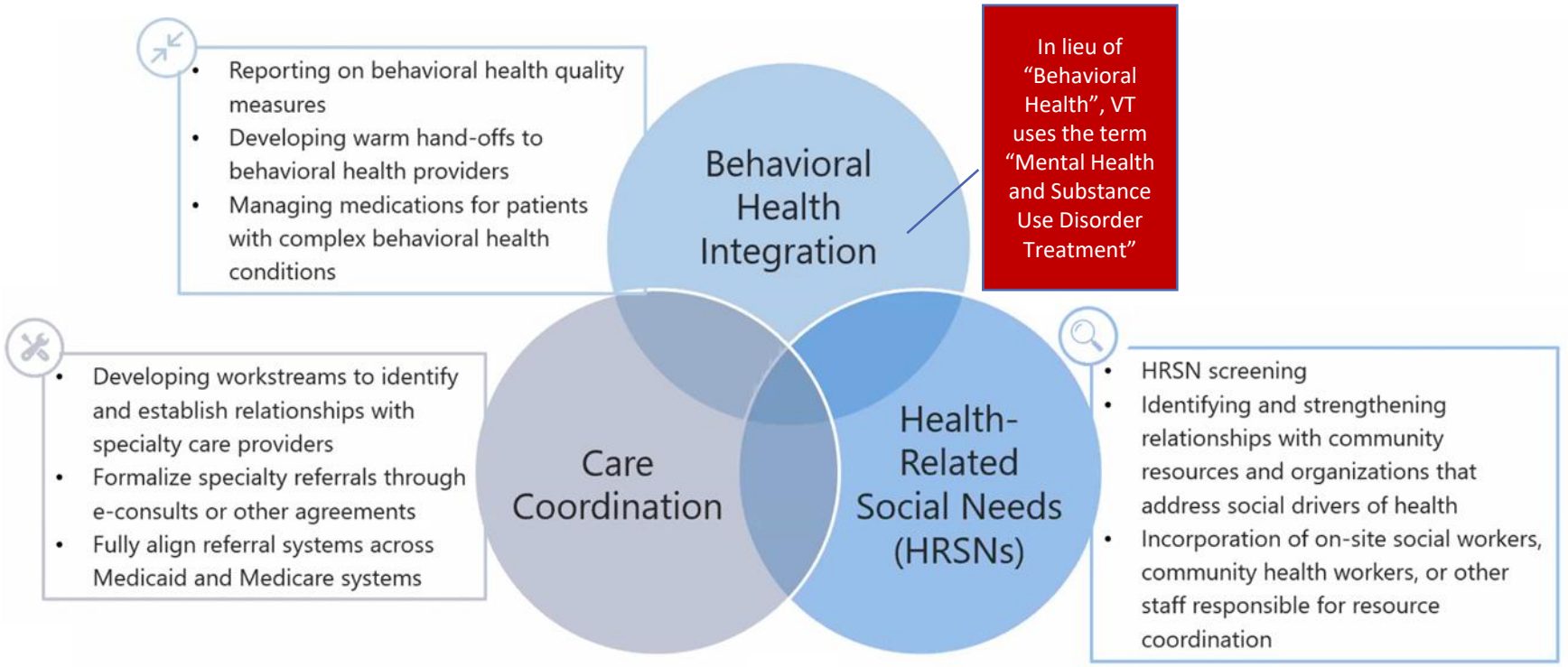
Practices may use the EPCP to invest in infrastructure and staffing to perform advanced primary care (e.g., care coordinators, behavioral health staff, or community health workers).

**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

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.



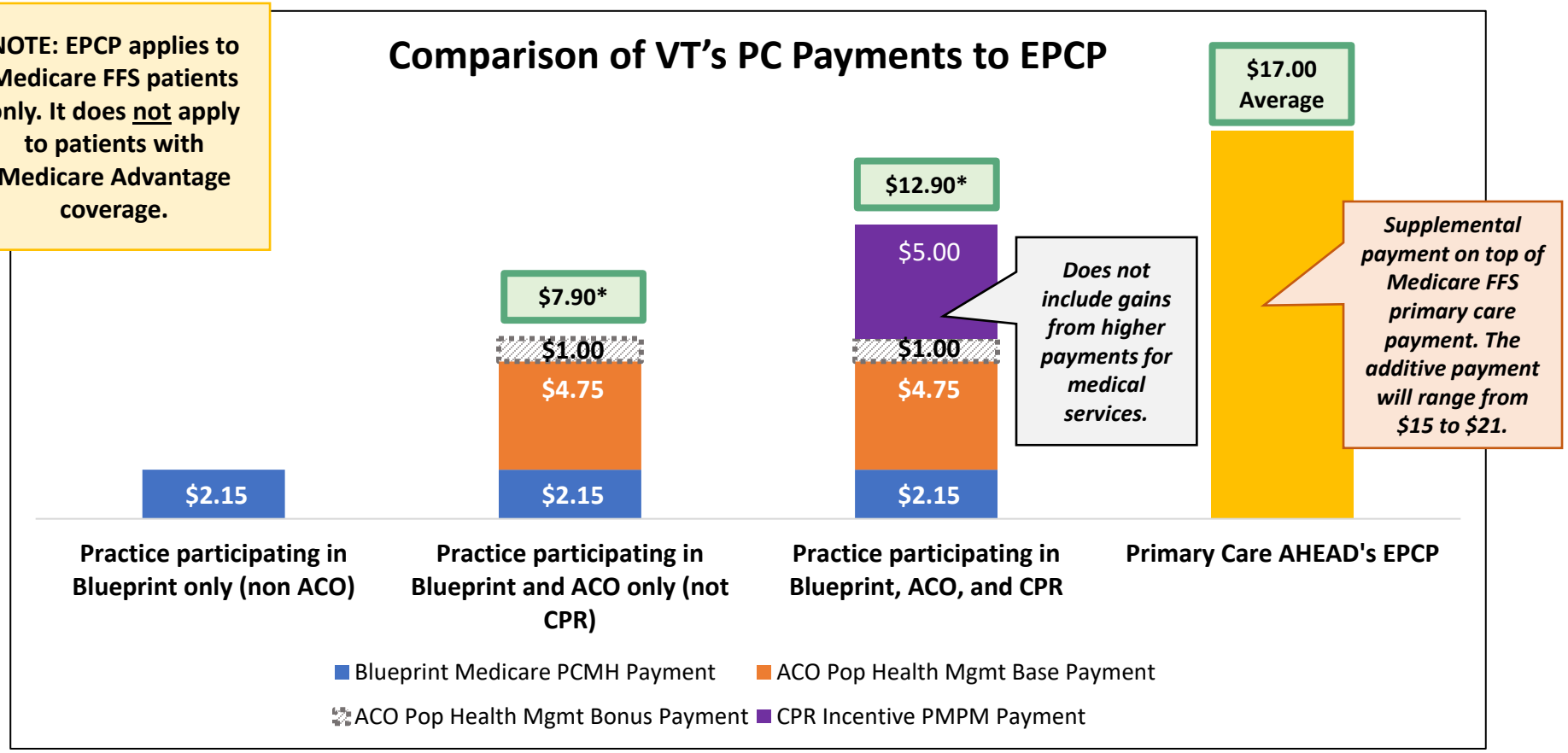
Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

12

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

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

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



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

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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14

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.

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

Framework for Evaluation and Measurement

Federal-State Accountability Targets

- Statewide quality and equity targets
- Limited number of measures (6)
- Statewide Medicare and all-payer Total Cost of Care (TCOC) and Primary Care Investment targets
- Hospital and payer participation targets
- State may have some flexibility for certain elements, but limited

Hospital-Level Payment Model Measures

- Quality performance adjustment based on CMS national quality programs or similar categories of quality measures
- Health equity improvement bonus for performance on selected health equity-focused measures
- TCOC performance adjustment for a defined population
- Effectiveness adjustment to support reductions in unnecessary utilization

Primary Care Measures

- Limited number of measures (5)
- Performance will be used to adjust Enhanced Primary Care Payments for primary care practices' Medicare patients
- States may have some flexibility in measure selection, but limited

Broader Monitoring and Evaluation

- Not required by federal-state Agreement
- Measure whether changes are occurring
- Spot unintended consequences, including adverse incentives & results
- Domains: care delivery (e.g., access, transitions in care); intermediate outcomes (e.g., primary care visits, wait times, follow-up care); long-term outcomes (e.g., patient satisfaction, readmissions, health disparities)

Ensuring alignment across these components will help to align incentives and limit administrative burden.

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17

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

Questions/Discussion

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