Health Care Reform Update and Discussion: AHEAD Model and PCAG Priorities

Green Mountain Care Board Primary Care Advisory Group
November 15, 2023

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Agenda

1. AHEAD Model (Model Summary, Timeline, Key Elements)
2. Brief Overview of Hospital Global Budgets
3. Primary Care AHEAD
4. PCAG Feedback from Prior Meeting
5. Opportunities for Input

Center for Medicare and Medicaid Innovation (CMMI) AHEAD Model

OVERVIEW, TIMELINE, HOSPITAL GLOBAL BUDGETS, PRIMARY CARE AHEAD, MODEL GOVERNANCE STRUCTURE

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

AHEAD Model Information and Timeline

https://innovation.cms.gov/innovation-models/ahead

Anticipated Timeline:

Notice of Funding Opportunity Publication: Expected by November 16, 2023

Deadline for State Applications for Cohorts 1 and 2: February-March 2024

<table>
<tr><th colspan="2"></th><th>2023</th><th>2024</th><th>2025</th><th>2026</th><th>2027</th><th>2028</th><th>2029</th><th>2030</th><th>2031</th><th>2032</th><th>2033</th><th>2034</th></tr>
<tr><td colspan="2">Model Year</td><td></td><td>MY1</td><td>MY2</td><td>MY3</td><td>MY4</td><td>MY5</td><td>MY6</td><td>MY7</td><td>MY8</td><td>MY9</td><td>MY10</td><td>MY11</td></tr>
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Hospital Global Budgets in AHEAD: Key Elements

CMS AHEAD Hospital Global Budget Methodology

Hospital global budgets will be prospective, predetermined amounts for inpatient and outpatient hospital services, based on historical spend with annual updates for population changes and inflation.

Payments will be adjusted for social risk and quality, with bonus for health equity improvement. Transformation Incentive Adjustment in first two performance years to support investments in enhanced care coordination.

Adjustments for total cost of care (for traditional Medicare members in the hospital service area) and for effectiveness (related to avoidable utilization).

"Participating states with statewide rate setting or hospital global budget authority and experience in value-based care can develop their own hospital global budget methodology. CMS will provide alignment expectations for state-designed methodologies…and will need to review and approve…"

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What is a Hospital Global Budget under AHEAD?

AHEAD HOSPITAL GLOBAL BUDGET

In the AHEAD Model, hospital global budgets are built "bottom up" from past net patient revenue within the facility (inpatient and outpatient), including hospital outpatient departments.

This historic baseline will be fixed for the duration of the model with annual adjustments for inflation, demographic changes, and service line changes for each Performance Year.

The AHEAD Model aims to support hospitals in transforming care delivery and shifting utilization to primary care and community-based settings, where appropriate, through the incentives and flexibilities of hospital global budgets.

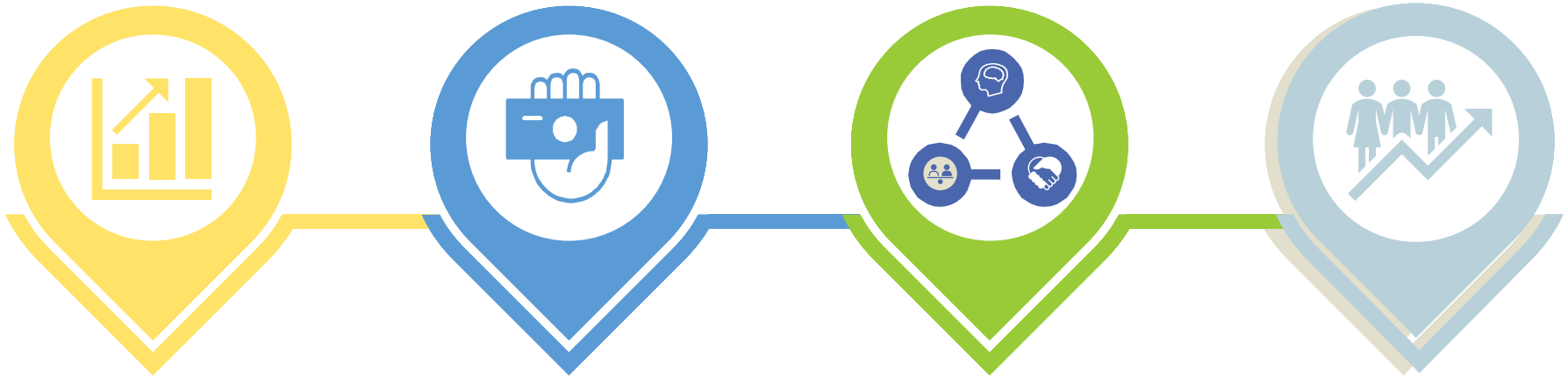
Incentives for Hospital Participation

- Initial investment to support hospital transformation in early years of the model
- Increased hospital financial stability and predictability when revenue is decoupled from FFS
- Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery
- Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community
- Potential use of waivers to support care delivery transformation and engage non-hospital providers in transformation
- Opportunity to participate in learning opportunities to facilitate success under global budgets

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

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

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

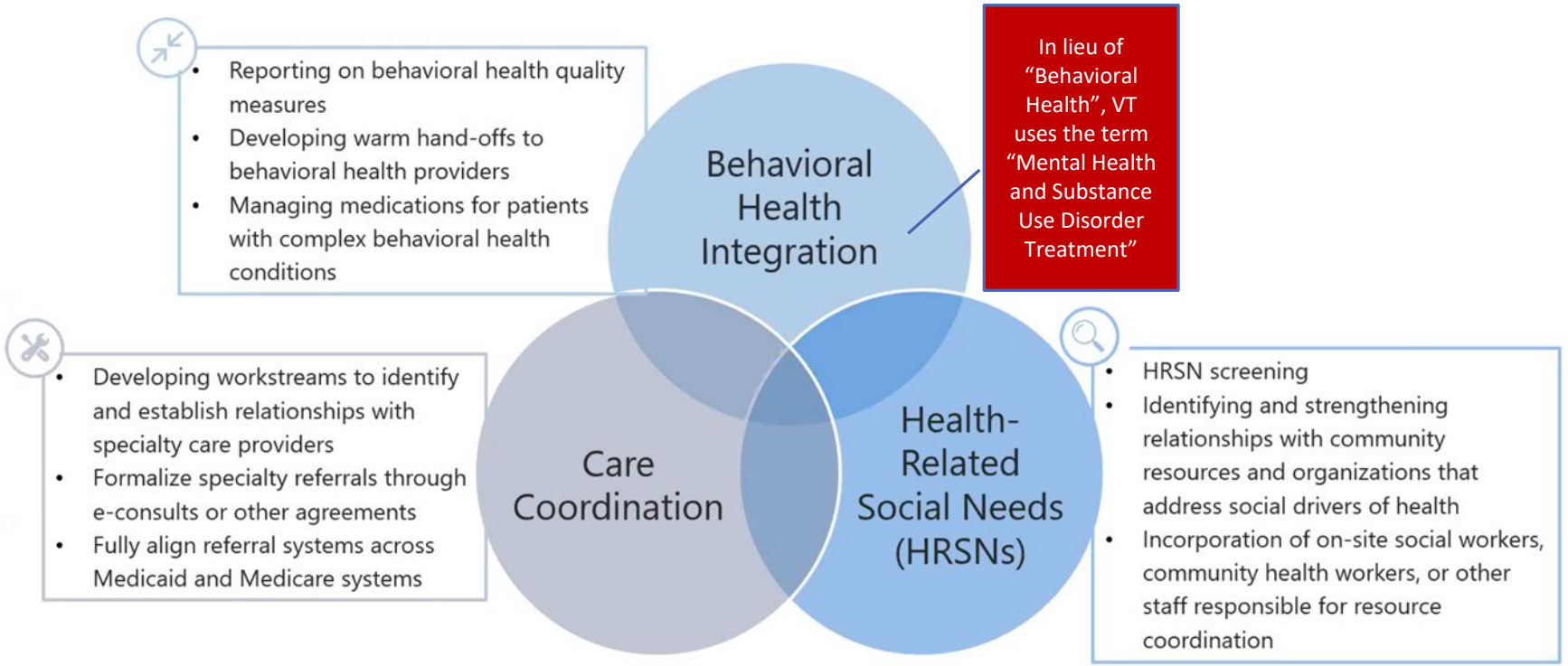
Practices may use the EPCP to invest in infrastructure and staffing to perform advanced primary care (e.g., care coordinators, behavioral health staff, or community health workers).

**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

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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Model Governance Structure

Each participating state will establish a multi-sector model governance structure. This body must have a **formal role** in model implementation, which could be advisory. States can build on pre-existing workgroups or boards to meet this requirement.

Governance Representation

Required:

- Patients and/or advocacy organizations
- Community-based organizations
- Payers (including commercial, Medicaid managed care, and Medicare Advantage)
- Provider organizations, including hospitals, primary care, FQHCs, and behavioral health
- Local tribal communities (where applicable)
- State Medicaid Agencies
- State and Territorial Public Health Agencies

Optional: State cost commissions, divisions of insurance, other relevant state agencies, and additional partners

Governance Role

Required:

- Develop Statewide Health Equity Plan and provide input on State Quality and Equity Targets
- Review and support of hospital health equity plans
- Input on Cooperative Agreement investment

Optional:

- Review state-designed Medicare FFS HGB methodology
- Review of Medicaid and commercial HGB methodologies
- Support activities to achieve other statewide targets

Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

Discussion:
PCAG Feedback in September 19 Memo

PRIORITIES, ASSISTANCE FOR PAYMENT TRANSITION, PAYER PARTICIPATION, ENGAGING SPECIALISTS, TRANSITIONS OF CARE, PROVIDING FEEDBACK, ENGAGEMENT IN HEALTH CARE REFORM, IMPACT

PCAG Primary Care Priorities

- How to incentivize primary care in the transition to value based care?
- Maximum investment in primary care vs CMS 'minimum investment' – *increase primary care spend*.
- An overarching goal for the APM should be to increase the number of Vermonters who *have a PCP and have seen them in the last year.*
- Full reimbursement for educational debt in return for commitment to practice in Vermont
- Improve primary care practice environment; address onerous administrative burden on PCPs that has only grown over the decades.
- Lack of standardization across OneCare, NCQA, Cigna, Blue Cross, MVP, United, etc. takes time and resources away from care for patients. This is a heavier burden on primary care offices than specialty or inpatient care.
- Loss of PCPs means practices move toward discharging patients; patients look for other PCP options – where can they go?
- Equitable reimbursement across provider type and site for same care.

Assistance for Transition from Fee-for-Service to Value-Based Care

- PCAG is looking for actionable assistance that is clinician based:
  - Outlines
  - Processes
  - Goals

- ACO providers agree to be accountable:
  - Who defines that accountability?
  - What held accountable for and to?
  - How measured?

Payer Participation in All-Payer Models

- Specify who is affected by this in Vermont:
  - Large group
  - Small group
  - Individual
  - Employer based self-insured

Note: In AHEAD Model, CMMI will require at least one commercial plan to be in the model by Performance Year 2.

Engaging Specialists

- PCAG would like to engage specialists, with some basic tenets:
  - Return patients to primary care as soon as medically reasonable
  - Send consult notes to primary care providers for every visit
  - Provide concise consult notes that contain a treatment and follow up plan
  - Be available by phone to facilitate treatment before/between specialist appointments
  - Consider clear PCP request and specialist response for consult, vs. referral for ongoing care.
- We acknowledge some patients need ongoing specialty care, and some PCPs may not wish to manage certain medications.

Transitions of Care

- Medication reconciliation – outpatient->inpatient/specialist->rehab->outpatient/home – is a known safety issue.
- Medication lists need to be current. Medication lists need to match discharge summary content.
- Two changes could have enormous impact:
  - Assure that discharge summaries are *useful*. We often receive ‘data dumps’, two recent examples – 86 pages, 163 pages
  - Consider putting priority elements of discharge plan at the beginning of the note. Consider involving Care Management/Coordination RN.
- Hospitalists consider reach out directly to the PCP, or their covering colleague, on a complex patient/discharge, as they would do in transferring inpatients between units.

Providing Feedback

- It is unclear where and how to provide requested feedback on the AHS and GMCB websites, separate from public comment.
- If we provide feedback, how is it posted or catalogued?
- Can we see others' feedback?
- Should we expand request for feedback to PCPs beyond PCAG? If so, how?

Engagement in Health Care Reform

- Health Care Reform Work Group currently includes employers and healthcare entities, and advocacy group representing physicians.
- Encourage representation from all providers (MD/DO, APRN, PA) and other clinicians in primary care (RN, CHT, MH, dental, SW, etc.)

Impact

- PCAG members have not always felt input leads to change.
- How do we know if it is being applied and integrated, whether theoretical or day to day practice?
- How can PCAG have the most impact, given the multiplicity of stakeholders at all levels contributing to potential meaningful healthcare reform?