VERMONT ACADEMY OF FAMILY PHYSICIANS

Vermont Medical Society

Vermont Chapter
INCORPORATED IN VERMONT
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

To : Secretary Jenney Samuelson, Agency of Human Services
Chair Owen Foster and Members of the Green Mountain Care Board
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: January 3, 2025
RE: Feedback regarding AHEAD Model

The Vermont Medical Society, Vermont Academy of Family Physicians and American Academy of Pediatrics-Vermont Chapter submit these comments regarding joining the Centers for Medicare and Medicaid Services (CMS) AHEAD Model. We would like to thank AHS, the AHS Director of Health Care Reform, and the Green Mountain Care Board for soliciting and including physician feedback in developing plans for payment reform.

Our organizations submitted joint comments in May 2024 regarding the Model. We reiterate many of the comments made at that time and will summarize our major points below. While we do have additional information regarding some details of the model – strongly suggestive that the Model may help support primary care in the State – other details of the Model remain to be determined and will impact the success and benefits of the Model for primary care and our entire health care system.

Cohort 1 vs Cohort 2

We understand that AHS and the GMCB are weighing whether to join the Model in Cohort 1 (Model will begin January 2026) or Cohort 2 (Model will begin January 2027). **From a primary care perspective, our organizations have substantial concern that waiting to join Cohort 2 could prove particularly disruptive for primary care practices**. As well known to AHS and the GMCB, practices will face a cliff in losing the financial and programmatic support of OneCare Vermont and federal Blueprint for Health payments on January 1, 2026. Losing these payments over the course of 2026, with no plan for how to backfill financial support for the year, threatens to substantially destabilize practices, especially independent practices depending on OneCare's Comprehensive Payment Reform program. Practices will be focused on financial survival, making them even less prepared to analyze the impacts and have the capacity to join the AHEAD Primary Care Model in 2027 for Cohort 2. **We urge AHS and the GMCB to closely analyze the impact on primary care of waiting to join until Cohort 2, and put in place one-time financial support to hold practices harmless in 2026 should other factors determine that the State should or must wait until Cohort 2.**

Primary Care Payments & Benefits

As documented in the draft state agreement and term sheet, CMS will make a $15-21 per-Fee for Service Medicare-beneficiary-per-month payment (PBPM) available to practices participating in the Model.[1] The

[1] See slides 8-12 of the following presentation to the Primary Care Advisory Group comparing this monthly payment to Vermont's existing Blueprint and ACO payments: https://humanservices.vermont.gov/sites/ahsnew/files/documents/Primary%20Care%20Workgroup%20%235%20Sli

average payment will be $17 PBPM, which promises an increased investment by Medicare in primary care. AHS estimates this could provide approximately $11 million in payments to Vermont practices in 2026.[2] As a part of the Model, CMS is also agreeing to continue Blueprint Community Health Team and Supports and Services at Home (SASH) payments – an estimated $10.9 million of payments in 2026.

Finally, if Vermont can hold to the current Medicare cost trend estimated in the agreement, CMS would contribute up to $138.9 million in additional Medicare funding in 2026 (with a similar formula for payments in future years of the model), which would go into an "EAST fund" to provide resources to stabilize health care providers, address access issues, and increase availability of services across the continuum of care (e.g., mental health, substance use disorder (SUD), primary care, home health, long-term care, and specialty care initiatives). This is one of the few opportunities for major Medicare investment in the continuum of care, and is especially important in light of decreasing Medicare fee for service fee schedules for many providers, including primary care professional services.[3]

Our organizations welcome these new federal funding streams for primary care practices and the health care system as a whole. They deserve close analysis by AHS and the GMCB and will likely strengthen our primary care system.

At the same time, we reiterate from May several concerns with the Model design for Vermont's primary care practices, many of which have been participating in Vermont payment reform programs for years. These suggest points for ongoing negotiations with CMS or ways the State can mitigate destabilizing losses from our ACO.

- Primary care practices should not be subject to additional administrative burden for, by example, subjecting them all to the Medicare's Merit-based Incentive Payment System (MIPS). Vermont should continue to prioritize in negotiations with CMS obtaining a MIPS exception for participating in AHEAD. Absent securing this exception, AHS should support all possible State-based paths forward for a MIPS exception, such as supporting the creation of a Medicare Shared Savings Program ACO[4] or developing a state-based Advanced Payment Model.
- Vermont should also prioritize in negotiations with CMS a predictable, stable PBPM payment that does not vary based on statewide hospital and total cost of care targets nor should the payment be included in a TCOC measure starting in Year 4. Absent securing this in negotiations with CMS, AHS should plan for mitigating year to year fluctuations in this payment to primary care practices, such as guaranteeing that the payment will not decrease from the level set in Performance Year 1 (2026), which might require backfilling funding through state mechanisms such as Medicaid or Blueprint payments. If private payers participate in the model, a consistent PBPM payment should be set.
- $17 PBPM is greater than most payments currently available to primary care, however this will only be linked to FFS Medicare patients, so the impact on each practice will be different –

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des_12.15.23_Summary_Final.pdf

[2] https://ljfo.vermont.gov/assets/Meetings/Health-Reform-Oversight-Committee/2024-12-06/Vermonts-Health-Care-Reform-Efforts-AHS.pdf (note that this is inclusive of current CMS patient centered medical home payments – so is not all new money to practices- and is partially offset by losses in ACO payments for practices currently participating in OneCare).

[3] The 2025 Medicare professional fee schedule includes a 2.83% cut - Medicare payment rates have fallen by 33 percent (PDF) over the past two decades, when adjusted for the costs of running a practice.

[4] https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/about; see also the presentation to the Primary Care Advisory Group, explaining how an MSP ACO could operate concurrently with the AHEAD Model.
https://humanservices.vermont.gov/sites/ahsnew/files/documents/Primary%20Care%20Workgroup%20%235%20Slides_12.15.23_Summary_Final.pdf

especially pediatric practices, which face losing all ACO payments while gaining very few dollars linked to Medicare payment. Independent practices participating in OneCare's capitated Comprehensive Primary Care (CPR) program, stand to lose 105% FFS rates for "non core" services as well as a steady, predictable income stream. All primary care practices, particularly independent and pediatric practices currently participating in Vermont's existing ACO payment reform activities must be held harmless – if not additionally supported – with the transition to the AHEAD Model. Absent CMS agreeing to a capitated payment model for primary care beginning in 2026, AHS must consider what it can do directly to assist with the transition to a new payment model for these practices, including but not limited to developing Medicaid capitated primary care payments, matching the Medicare PBPM payment with Medicaid, addressing what primary care payments look like from commercial payers and increasing Blueprint Patient Centered Medical Home Payments, as recommended by the Act 51 of 2023 report completed by the Blueprint for Health regarding PMPM payments to patient centered medical homes.[5]

- AHS should address in negotiations with CMS how CMS will assist in securing participation in the Model by Medicare Advantage plans.
- With the likely loss of an ACO, our organization request technical assistance for primary care practices by AHS in completing the fiscal analyses, contracting, quality/data and other administrative requirements necessary for successful participation in the AHEAD Model
- CMMI should partner with participating states to advocate internally to CMS to ensure adequate Medicare fee schedules for the health care system. The impact of one model increasing payment while another is cut undermines any progress.
- Access to Medicare data is also a concern for participating practices, and AHS should address in negotiations with CMS the ability for primary care practices to obtain and review for accuracy any Medicare patient data used for attribution, quality or performance metrics.
- AHS should continue to convene the Primary Care Advisory Group to both share developing information regarding the Model and solicit input regarding implementation – and should also seek far more than the minimum indicated in the State's application of 1 primary care clinician participating on the Model Governance Body.

Primary Care Spend Target

The AHEAD Model will require participating states to establish and meet an all-payer primary care investment target. Our organizations support the general direction of the AHEAD Model and application in setting a primary care spend target.

Our organizations reiterate our comments from May that:

- The Model Governance Body - which is charged with informing the primary care spending target – include robust participation from primary care clinicians and organizations. AHS continue to convene a Primary Care Subgroup and seek their input on primary care spend methodologies and targets.

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[5] See https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/Blueprint_Act51_Report_on_PCMH_Payments_final.pdf. The report concludes that to sustain the program, the legislature could create parity between Medicaid and commercial insurers by (1) Increasing the commercial insurer PCMH payment to $4.65 through a two-year increase of $0.83 in FY2025 and $0.82 in FY2026; and (2) With input from the Department of Financial Regulation, implementing legislative clarification of contributions by third-party administrators of self-funded plans and a renewed focus on engaging all commercial insurers in all Blueprint initiatives. We request that the Committee move forward with these recommendations in H. 151, consistent with a multifaceted approach to supporting primary care in Vermont.

- AHS, the GMCB and the legislature further clarify and define the roles and lines of responsibility and communication between AHS and the GMCB when it comes to health care reform generally and primary care innovation specifically. This should include which entity/entities will lead, support or collaborate on setting a primary care spend target and methodology; what entity will negotiate with payers (Medicaid, Medicare, commercial) to set contract terms, targets, and funding; how these decisions will be incorporated into the GMCB's current insurance and hospital rate regulation systems; and clarifying the role of the Model Governance Body in setting the primary care target. The lead entity should be required to consult with primary care clinicians and professional associations in developing the target and methodologies.

Hospital Global Budget/ Sustainability

Many of our members work at, and all rely on the ability to make referrals to, a stable and accessible hospital system that includes specialty, tertiary and emergency care. As stated in May, our organizations urge that a global budget be reviewed for whether it meets the Hospital Global Budget Technical Advisory Group (TAG) goals[6] that a hospital global budget:

- Create financial predictability and sustainability for hospitals to have the workforce and capital investment resources needed to meet the needs of the communities they serve;
- Create a payment model that supports delivery of the right care, in the right place, and at the right time;
- Support and incentivize increased efficiency in administration and clinical care by reducing – and when possible, eliminating – unnecessary costs and effort associated with administrative processes.

As discussed in the AHEAD application, Vermont already has a history of being a low-cost Medicare state and achieving savings in the Medicare program without seeing those savings reinvested in the State's health care system. Ongoing downward budgetary pressures can continue to exacerbate Vermont's access issues. Not only is there challenge accessing primary care, but a well documented concern in the state is the wait time for certain specialty services, with patients experiencing the longest waits for services such as dermatology, neurology, psychiatry and endocrinology.[7] We emphasize the importance of Vermont achieving a sustainable global budget and capturing savings to support the ability to hire and retain both primary care and specialty clinicians in order to support the workforce needed to prevent higher cost admissions, address wait times and more.

Thank you for considering our feedback as Vermont considers whether to join the AHEAD Model. We look forward to continued partnership on these issues and please reach out any time to discuss further.

[6] https://gmcboard.vermont.gov/sites/gmcb/files/documents/TAG%20Meeting%2015%2020240229-1.pdf (see slide 31).
[7] https://dfr.vermont.gov/sites/finreg/files/doc_library/vermont-wait-times-report-021822.pdf