CONNECTICUT | AHEAD

States Advancing All-Payer Health Equity Approaches and Development Model

October 24, 2024

Stakeholder Webinar: Hospitals

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Topics

- AHEAD overview
- Health Equity
- Hospital Global Budgets
- Primary Care AHEAD
- CT AHEAD Timeline
- Questions

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Person-centered care

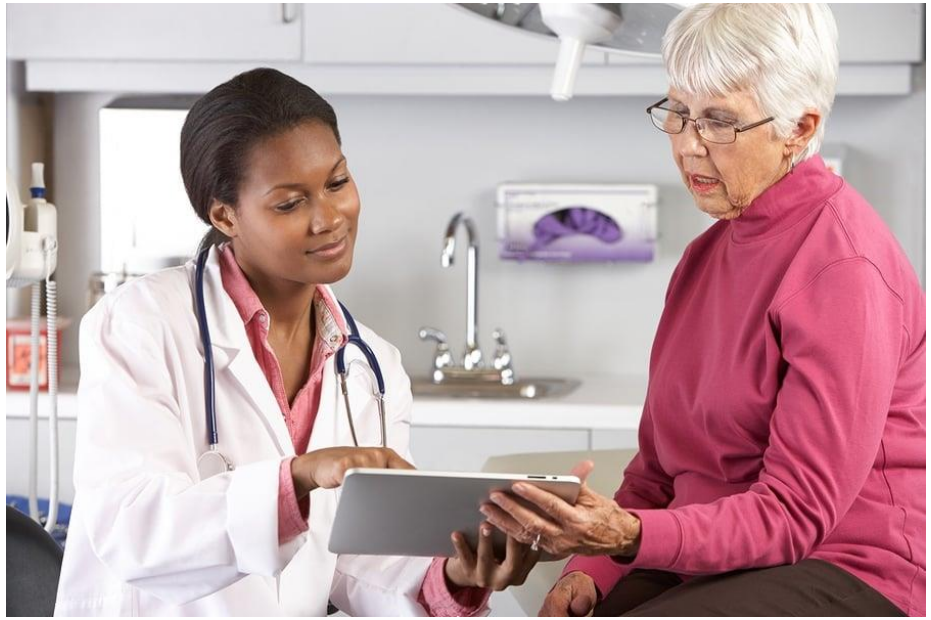
with providers who listen, take time to get to the root cause of behavioral, emotional and physical health concerns

Quality

across the healthcare system

Coordination

of services, systems, payers



People's Desire in Health care

Source: United States of Care

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- Partnerships
- Focus on affordability
- Quality-focused Outcomes-based
- Multi-payer approach
- Grounded in health equity

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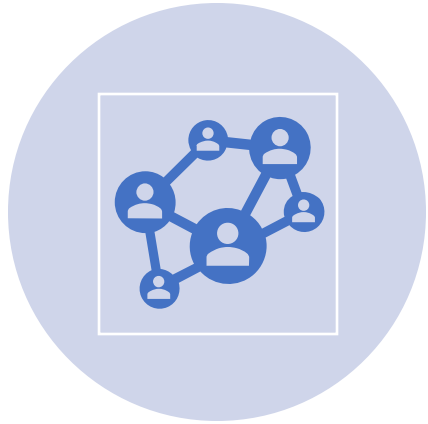
HEALTHCARE BENCHMARKS (COST, QUALITY AND EQUITY)

STATE PRIMARY CARE INVESTMENT TARGETS



PERSON CENTER/INTEGRATED AND COORDINATED CARE

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Model Components

HOSPITAL GLOBAL BUDGETS PAYMENT MODEL

PRIMARY CARE AHEAD TRANSFORMATION

HEALTH EQUITY

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Advancing Health Equity

- **Develop State Health Equity Plan & Quality Targets** for participating states, which will inform statewide equity strategies and support quality improvement.
- **Enhance Partnerships between State, Providers, and the Community** to meet model goals.
- **Increase Safety Net Provider Recruitment** among hospitals and primary care providers in the AHEAD Model to reach vulnerable populations.
- **Use Social Risk Adjustment** of provider payments to increase resources available to care for vulnerable populations.
- **Utilize Health Related Social Needs Screening Among Hospitals and Primary Care Providers** to identify unmet needs and connect patients to community resources.

AHEAD components

Source: CMS AHEAD Model Overview Webinar

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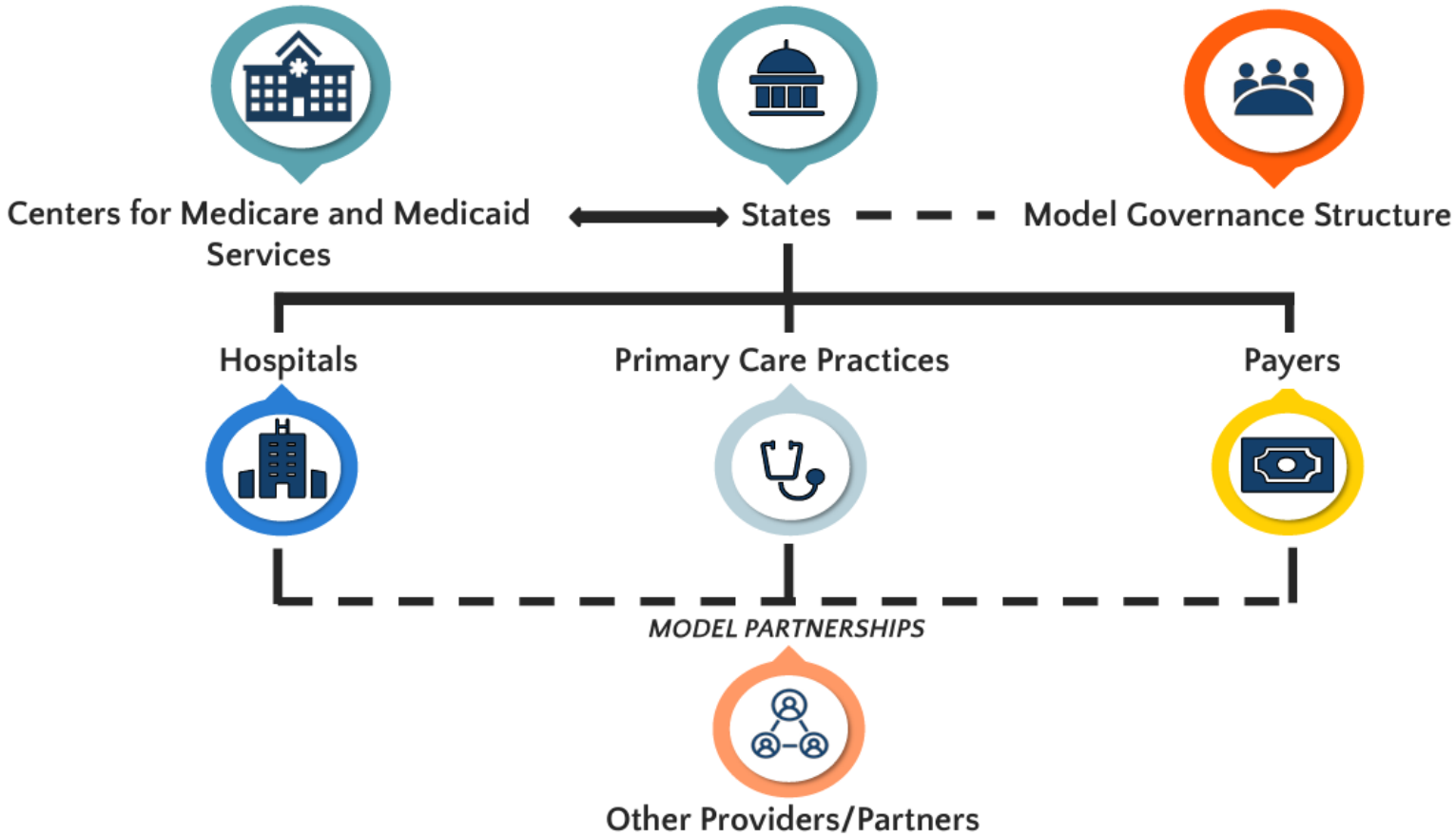

Partnerships

Source: CMS AHEAD Model Overview Webinar

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Federal (CMS/CMMI)

- Support the implementation of Medicare FFS Global Budget
- Support states and partners in developing and implementing model components through funding, technical assistance and learning collaboratives
- Monitor progress and model activities including unintended consequences through existing hospital reporting measures.

State

- Establish Model Governance
- Implement Statewide Health Equity Plan
- Set all-payer cost growth targets
- Increase primary care investment
- Design Medicaid & Commercial Global Budgets and primary care transformation
- Facilitate multi-payer alignment and engage with State Employee Health Plans and Marketplace Plans

Hospital

- Can participate in global budgets, transform care, and improve population health
- Pursue opportunities for quality improvement and identify efficiencies
- Create hospital health equity plans to close disparity gaps and improve health outcomes

Primary Care Practices

- Can participate in Medicaid transformation efforts and Primary Care AHEAD for Medicare FFS
- Meet care transformation requirements for person-centered care
- Pursue opportunities for quality improvement and improved care coordination

Payers

- Contribute to all-payer cost growth target and Primary Care Investment Targets
- Participate as an aligned payer in global budgets and primary care transformation

Community Organizations

- Participate in Statewide and hospital Health Equity Plans
- Opportunity to partner with hospitals and primary care practices on HRSNs referrals and care coordination
- Elevate and facilitate consumers voices in planning

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What suggests the AHEAD model can be effective?

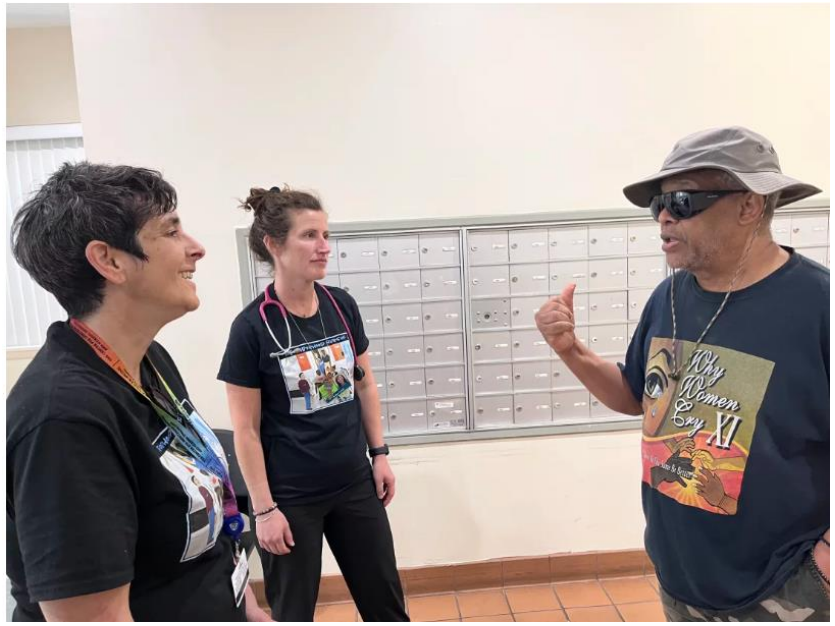
- AHEAD builds on the demonstrated success of existing models in other states
  - Vermont All-Payer Accountability Care Organization (VT-ACO)
  - Maryland Total Cost of Care (MD TCOC)
  - Pennsylvania Rural Health (PARHM)
- These states have *expanded access to primary care, behavioral health services and care for underserved populations*

In Baltimore, nurses go door-to-door to bring primary care to the whole neighborhood

JUNE 11, 2024 · 5:00 AM ET

FROM TRADEOFFS

By Leslie Walker, Dan Gorenstein



https://www.npr.org/sections/shots-health-news/2024/06/11/nx-s1-4997717/nurses-primary-care-community-baltimore-costa-rica

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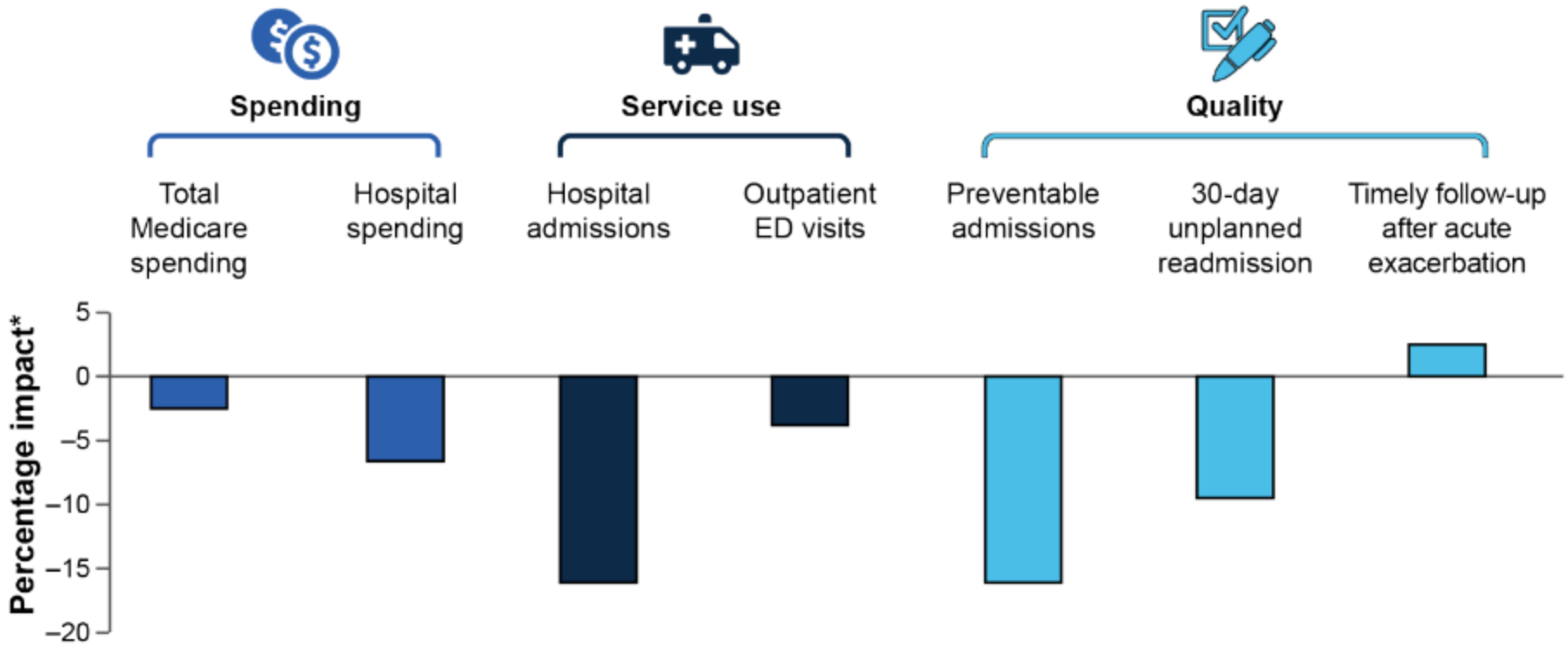
Maryland TCOC model Findings



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Fee-for-Service Payment

Units/Cases X Price per Unit or Case

Strategies for success:

- Negotiate higher rates with commercial payers
- Grow volumes, especially in high margin services
- Reduce/curtail low margin services

Global Payment (Budget)

Revenue Base + Updates

Strategies for success:

- Align expenses with available budget (predetermined revenue)
- Shift services to less costly settings
- Reduce avoidable hospitalizations and ED visits

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Ineligible

- Cancer Hospitals
- LTCHS/SNFs
- Psychiatric Hospitals
- Rehabilitation Hospitals
- Veteran's Hospitals

Eligible

- **Acute care hospitals**
- **Children's hospitals *(not eligible for Medicare FFS GB)***

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Hospital Global Budgets by Payer

Medicare FFS

- CMS-designed Medicare FFS Global Budget Methodology

Medicaid

- State (DSS) develops Medicaid methodology

Commercial

Medicare Advantage

- State (OHS) develops methodology
- Payer participation voluntary; CT must recruit at least one commercial payer by 2028 (PY2)
- Participation ties larger portion of hospital revenue to global budget

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Alignment Across Payers

- Same general incentives
- Include inpatient, outpatient and ED at a minimum
- Prospective and regular payments (bi-weekly or monthly)
- For baseline - use 2-3 years of historical data to calculate global budget, weighing the most recent years more heavily
- Must account for inflation, population growth, and demographic changes
- Must be adjusted for medical and social risks and performance on quality measures

States Have Flexibility

- May apply different covered services, member populations, unique revenue sources and payment streams
- If existing value-based care strategies in place, should maintain
- May exclude certain patient populations from global budgets calculations
- May propose including other types of hospitals (i.e. children's hospital)
- May propose certain service line inclusion/exclusions from Medicare FFS

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Medicare Fee-for-Service Global Budgets

Baseline Calculation

CMS will calculate the hospital's historical revenue for eligible hospital services, combining the 3 most recent years of historical revenue data with percentage weightings more heavily applied to recent years (i.e., Base Year 1: 10%; Base Year 2: 30% and Base Year 3: 60).

Annual Trend and Performance Adjustments

CMS will apply adjustments to predict the current performance year and reflect accountability for quality and reducing avoidable utilization:

- Annual Trend Updates (Annual Payment Adjustment, Volume-Based Adjustments, and Other Adjustments)
- Performance-Based Adjustments (TCOC, Quality, Equity, and Effectiveness)
- AHEAD-Specific Adjustments (Transformation Incentive Adjustment and Social Risk Adjustment)

Global Budget Payments

Each hospital will receive a prospective, bi-weekly payment for Eligible Hospital Services in lieu of traditional FFS claims or cost-based reimbursement. Hospitals will continue to submit Medicare FFS inpatient and outpatient claims and Medicare Hospital Cost Reports to CMS.

Key Opportunities for Hospital to Consider

Health equity & transformation

- Potential additional 3% revenue (social risk adjustment/quality bonus)
- Additional 1% revenue for the first two years
- Technical assistance for delivery reform

Enhanced payments for primary care physicians owned by hospitals

- $17 per beneficiary per month (PBPM, up to $21 PMPM
- Adjusted for beneficiary social and medical risk
- Technical assistance for care management and coordination

How do we know that cost-control efforts won't hurt care or access to care?

CMS and CT are committed to closely monitor for unintended consequences and risks to beneficiaries that may arise including, but not limited to:

- Changes in the provision of appropriate services
- Worsened performance on population health outcomes, access, and quality measures and targets
- Exacerbation of inequities
- Care stinting
- Limiting beneficiary choice

Participating hospitals are still required to take part in CMS quality assurance and reporting measures:

- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Inpatient Quality Reporting Program (IQR)
- Hospital Outpatient Quality Reporting Program (OQR)
- Hospital Value-Based Purchasing Program (VBP)

Primary Care **AHEAD**

- **Voluntary** participation provides prospective, flexible and enhanced payments intended to increase the capacity to deliver advanced primary care services
- Fund transformation in care coordination, behavioral health integration and health-related social needs interventions

FQHC

PCMH/PCMH+

PHYSICIAN PRACTICES

Primary Care **AHEAD**

Increase Primary Care Investment

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

Align Payers

State-led primary care transformation:

Medicare aligns with Medicaid PC priorities

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

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Today – 2026
- Pre-implementation
- Stakeholder engagement
- Global Budget Technical Design
- Statewide Health Equity Planning

2027 PY 1
- 10% Medicare FFS under global budget
- Primary Care AHEAD launch

2028 PY 2
- At least one commercial payer participating

2029 PY 3
- Continued hospital onboarding & payer engagement

2030 PY 4
- 30% Medicare FFS under global budget

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We want to hear from you! Please share feedback, questions, thoughts with us.

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