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CMMI Hospital & Primary Care Pilot Mimics Maryland Model

Dementia & Multi-Payer Clinic Models Quietly Announced This Summer

Relevant Companies

On September 5, 2023, CMMI released a new voluntary, state-based total cost of care hospital and primary care pilot program (here) that mimics existing models in VT, MD, and PA. This is the third model released by CMS in the past few months, on top of a dementia and a multi-payer clinic model.

Our Take & Next Up

Three new care delivery models announced by CMMI don't appear to move the VBC needle, last about a decade each, and may even cost money over time. Two primary care pilots (AHEAD and Making Care Primary) involve rural clinics and embrace multi-payer models instead of Medicare only patients. The dementia model is a bolt-on to existing programs like ACO Reach or MSSP and provides dollars to providers such as home health agencies. Recall CMMI's strategic goal to have all Medicare FFS beneficiaries and a majority of Medicaid beneficiaries in a patient centric model, with better quality and lower total cost of care by 2030. The three new models are ones with longer duration – 8 to 11 years -- and seek to loop in all payers over time (Medicare, Medicaid, Commercial) while advancing primary care with a focus on safety-net, rural providers, and health equity.

We do not see how the new models move the ball forward more quickly to the 2030 goal, but they provide positive messaging by the administration in a quiet summer period. ICYMI, ACO REACH tweaks were also quietly made in August (Capitol Street memo here) to assuage participants around RTA and provide clarity on v28 applicability; we await the 2026+ landscape, as REACH sunsets in a few short years.

Key Points

AHEAD: PRIMARY CARE & HOSPITAL (STATE-BASED) MODEL

States Advancing All-payer Health Equity Approaches and Development (AHEAD) Model (here) released September 5, provides a max of $12 M per state (8 participating states) for 6 years. CMMI will support states via (1) increased investment in primary care, (2) financial stability for hospitals, and (3) beneficiary connection to community resources.

AHEAD will operate for a total of 11 years (2024 through 2034). Cohorts 1 and 2 pre-implementation period will begin in July 2024, with Cohort 1's first year beginning in Jan 2026 and continuing through 2034. Cohort 2's first performance year begins Jan 27 and continues through 2034. Cohort 3 pre-implementation period will begin in Jan 2025 with the first year beginning in Jan 2027 through 2034.

This is a Total Cost of Care (TCOC) approach. A participating state assumes responsibility for managing health care quality and costs across all payers, including Medicare, Medicaid, and private coverage.

States will assume both upside and downside risk. States will be accountable for state-specific Medicare and all-payer cost growth and primary care investment targets. Each state will be required to generate savings relative to a counterfactual (e.g., the state's projected Medicare TCOC growth absent the model).

We don't envision many applicants for this program, but time will tell. CMS will support participating states through various components including states, hospitals, and primary care.

- **States can apply either for the entire state or a specified sub-state region**. States will be held accountable for targets that align with goals for Medicare FFS and all payers.
- **Hospitals will receive an annual Medicare FFS global budget that will be set prospectively.** They will be required to cover inpatient and outpatient services as well as will be required to meet performance measures for quality and health equity.
- **Primary care practices (including FQHCs, RHCs, and safety net providers) in a participating state have the option to participate in Primary Care AHEAD.** Primary Care practices will be required to engage in state-led Medicaid efforts and the aligned Medicare Primary Care AHEAD program and will receive a care management fee to meet requirements. Practices will be responsible for reaching performance goals on model quality measures.

Quality measures will be used to drive alignment across payers and advance health equity across participating states, payers, and providers.

GUIDE: NEW DEMENTIA MODEL

Guiding an Improved Dementia Experience (GUIDE) Model was released July 31 (here) and tests an alternative payment for those who deliver supportive services to dementia patients. This model involves an Interdisciplinary Care Team that will have a care navigator and a clinician with dementia proficiency. It ultimately hopes to delay long-term nursing home care.

GUIDE is not a shared savings or total cost of care model. It is a condition-specific longitudinal care model designed to be compatible with other CMS accountable care models and programs.

The model will last 8 years and will launch on July 1, 2024 for established programs and July 1, 2025 for new program participants.

Medicare Part B enrolled providers (e.g., home-based care providers) in all states are eligible and ineligible providers can partner with Medicare Part B providers. Providers must be able to bill for Medicare Physician Fee Schedule services. Providers in the established program track will need to have experience providing dementia care, but providers in the new program track require no experience to incorporate safety-net providers.

The model includes three payment types to providers.

- The Dementia Care Management Payment (DCMP) DCMP is a per-beneficiary per-month (PBPM) payment that ranges from $150-$390 in the first 6 months and $65-$215 following the first 6 months depending on complexity and caregiver status. The DCMP can increase/decrease based on a performance-based adjustment and a health equity adjustment.
- Payment for Respite Services Annual cap of $2500 per beneficiary per year, and participants have flexibility in the types of respite services they provide.
- Lump-sum Payments Up-front payments for certain safety net providers in the new program track to set up infrastructure.

Participants' Performance-based Adjustment will be calculated across four domains (1) care coordination and management (2) beneficiary quality of life (3) caregiver support and (4) utilization.

MCP: ANOTHER PRIMARY CARE MODEL

Making Care Primary (MCP) Model was released on June 8 (here) and is a State-based Medicaid & Medicare clinic and practice model that targets rural and smaller providers.

Current ACO REACH Participant Providers and Grandfathered Tribal FQHCs are not eligible for MCP. Organizations will not be able to concurrently participate in the Medicare Shared Savings Program (MSSP) and MCP after the first 6 months of the model.

The model will launch on July 1, 2024 and last 10 years (8 states). CMS will test the new model in 8 states including CO, MA, MN, NJ, NM, NY, NC, and WA. CMS will work with the participating states to address issues specific to their communities including care management for chronically ill, behavioral health, and access for rural residents.

VBC-inexperienced providers are targeted. The pilot will support physicians and clinics with varying levels of experience with VBC, including FQHCs and physician practices with limited experience in VBC. Indian Health Service facilities and Tribal clinics may also participate.

CMS is working with state Medicaid agencies in the 8 states to engage in care transformation across public programs, with plans to engage private payers in the coming months. The multi-payer alignment strategy allows CMS to build on existing state innovations and for all patients served by participating primary care clinicians to benefit from improvements in care delivery, financial investments in primary care, and learning tools and supports under the model.

The model includes a 3-track approach based on participants' experience level with VBC and alternative payment models. Participants in all 3 tracks will receive enhanced payments.

- Participants in Track 1 focus on building infrastructure to support care transformation.
- Participants in Track 2 and 3 includes certain advanced payments that will offer more opportunities for bonus payments based on participant performance.

ACO REACH: INCREMENTAL POSITIVES FOR PARTICPANTS

As a reminder, on August 14, CMS released an update to the ACO REACH Model for performance year 2024 & will shortly notify on what happens post 2026 (Capitol Street memo here). ACO Reach ends in 2026 and we will hear from CMMI shortly on where the program is headed and what components are likely to be extended.

The new v28 MA model, finalized by CMS on March 31, will be phased-in for ACO REACH with CMS providing incremental predictability into other measures such as RTA, health equity measures and beneficiary alignments.

Other policies meant to improve accuracy and predictability to ACO REACH include:

- RTA Adjustment
- Beneficiary Alignment
- Beneficiary Alignment Fluctuations
- Refinement to Eligibility Criteria for Alignment to a High Needs Population ACO
- Provisional Settlement
- Financial Guarantee
- Health Equity Benchmark Adjustment (HEBA)

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