The AHEAD Model
Primary Care AHEAD
Discussion Series – Initial Topics

• December 19, 2023 – AHEAD Model Components and Key Focus on Governance
• January 11, 2024, 2:00 p.m. EST – Considerations for Hospital Global Budgets
• January 18, 2024, 2:00 p.m. EST – Considerations for Primary Care AHEAD
• Additional sessions TBD
AGENDA

• Primary Care AHEAD Requirements

• Key Concepts and Considerations for States
AHEAD
Primary Care
AHEAD
Requirements
AHEAD Model Components

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

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

Source: CMMI Presentation on AHEAD Model, September 18, 2023
Primary Care AHEAD Goals

• Increase investment in primary care as a proportion of TCOC for Medicare FFS and across all-payers.

• Align Medicare’s primary care strategy with efforts already underway in state Medicaid programs, including enhanced care management, behavioral health integration, and referrals for health-related social needs (HRSNs).

• Target populations most in need of improved access to high-quality primary care by ensuring that FQHCs and RHCs can receive enhanced primary care payments and adjusting payments for medical and social risk of the patients they serve.

• Encourage more providers to build increased capacity to deliver advanced primary care.

Sources: CMS Notice of Funding Opportunity, Appendix IX, and Frequently Asked Questions
Primary Care AHEAD Sub-components

- Medicare Enhanced Primary Care Payment
- Care Transformation Requirements
- Medicaid Alignment
- Commercial Alignment (encouraged)

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

Each participating practice will receive an average $17 PBPM* for each attributed beneficiary, paid quarterly. A small portion of this payment (initially 5%) is at risk for quality performance.

Requirements

Participating practices will need to participate in Medicaid Patient-Centered Medical Homes or other primary care alternative payment models. Practices will also be expected to meet specific Care Transformation Requirements, which will be aligned across programs.

Potential Uses

Practices can 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 PBPM based on hospital recruitment or state performance (up to $21PBPM). The PBPM may also be lowered depending on state performance on hospital recruitment targets and/or state performance on targets (floor $15PBPM).

Sources: CMMI Presentation on AHEAD Model, September 18, 2023, and CMS Notice of Funding Opportunity, Appendix IX
Participating practices will be required to:

- Integrate behavioral health care as a function of primary care
- Enhance care management and specialty coordination
- Address health-related social needs of beneficiaries

Source: CMS Notice of Funding Opportunity
Care transformation requirements and prioritized quality measures will be chosen to align with the state’s existing Medicaid advanced primary care transformation and quality priorities.

Source: CMS Notice of Funding Opportunity
## Primary Care AHEAD Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>Requirement</th>
</tr>
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<tbody>
<tr>
<td>Medicaid participation</td>
<td>Required by PY1</td>
</tr>
<tr>
<td>Commercial payer participation</td>
<td>Encouraged commercial and Medicare Advantage alignment – TA to be provided</td>
</tr>
<tr>
<td>Practice eligibility</td>
<td>Hospital-owned practices that want to participate must participate in AHEAD hospital global budget for that performance year (N/A for hospital-owned FQHC/RHC)</td>
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<td>Practices can only be in Primary Care AHEAD if they are in a state-based PCMH or state-based APM for that same PY</td>
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<td>Practices can be in Medicare Shared Savings Program (MSSP) or ACO REACH and Primary Care AHEAD)*</td>
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<tr>
<td>Agreements</td>
<td>All practices must sign participation agreements with CMS in advance of the first PY they plan to participate</td>
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*Practices in Primary Care First, Making Care Primary ineligible

Sources: CMS Notice of Funding Opportunity, Appendix IX, and Frequently Asked Questions
Primary Care AHEAD Transformation Requirements

• BH Integration - quality measures, warm handoffs, med management for patients with complex BH conditions
  • CMS considering waivers of Medicare payment rules for BH integration
  • BH measures required
• Care coordination – relationships with specialty providers, e-consults or other formal referral arrangements, align referrals across Medicaid and Medicare
• HRSNs - screening, strengthen community-based or relationships re drivers, incorporation of CHWs or related staff for coordination
• Specific primary care measures in NOFO, though states can propose alternatives if aligned with state and Model goals.
Milestones

May 2024
Award announcement

Jan 2025
Submit final proposal

Jan 2026
Start Medicaid APM

July 2024
Submit Primary Care APM reg changes

April 2025
Regulatory approval

PY1

Jan 2027

Oct 2026
Readiness Demo
Submission of provider list

Jan 2027
Start Medicaid APM

May 2024
CH2 Award

Oct 2024
CH3 Award

July 2025
Submit Primary Care APM reg changes

April 2026
Regulatory approval

PY1

If Medicaid Primary Care APM is not implemented by PY2, CMS will take steps up to and including termination of the Cooperative Agreement and State Agreement to address this performance miss. Remediation required if not in place by PY1.
Primary Care AHEAD - Key Concepts and Considerations
## Key Concepts – Items to evaluate now

<table>
<thead>
<tr>
<th>Assessment of program</th>
<th>Recruitment</th>
<th>Other</th>
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<tbody>
<tr>
<td>Vision for Primary Care Transformation</td>
<td>Does your Medicaid program have an existing Primary Care APM?</td>
<td>Any gaps in existing Medicaid model? Primary care specialty types aligned with CMS?</td>
</tr>
<tr>
<td>Size of practices in current model</td>
<td>Recruitment of FQHCs/RHCs, large and small practices – must be part of process from beginning</td>
<td>Alignment of current state practice agreements with CMS expectations of practice agreements</td>
</tr>
<tr>
<td>Optional Partners? Other providers /community organizations to assist</td>
<td>Regulatory pathway proposal for update to current model or for new model</td>
<td>Are practices part of commercial APMs? Surveys may be useful</td>
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CMS Practice Agreements

• Participant practices required to advance care transformation activities throughout the model duration

• Activities tailored to:
  • State and community context
  • Specific needs of attributed Medicare FFS and Medicaid lives
  • Existing state transformation efforts
  • All will be part of the practice participation agreement

• CMS committed to new tracks with additional risk/capitation in the future. Details to come and may change the recruitment plans for future.
Key considerations - Now and during pre-implementation re recruitment

Recruitment ability may depend on Medicaid care management fees/other non-claims support in addition to Medicare EPCP

What support will the state offer practices to participate and on an ongoing basis?

Is the state considering altering any quality measures for BH, care management, or HRSNs from the current NOFO measures (or potential CMS modifications/expansion of measures)? (Appendix NOFO)

Does the state have the infrastructure to support practice for quality reporting to ensure practices can improve performance?

What supports or barriers are there for BH integration?

What support/mechanism is there for outside support with HRSNs for Medicare FFS and Medicaid beneficiaries?

State's plan for risk arrangements up to and including capitation now or in the future

What chassis will the state use for its Medicaid APM?
Additional Considerations

- Alignment with Primary Care Investment Targets
- Alignment with Hospital Global Budgets
- Looking forward to payment changes – e.g., capitation
Summary of Key Considerations

- Does Medicaid program have an existing Primary Care APM?
- MSSP can work with Primary Care AHEAD – details to follow from CMMI
- Gaps in existing model
- Small practices, FQHCs, RHCs?
- Practice Recruitment - CMS agreements
- Chassis for reform – 1115 waiver, SPA, other waiver, MCO contracts*
- BH Integration
- Health Related Social Needs
- Quality measures – infrastructure for collection and reporting?
New Primary Care AHEAD Fact Sheet

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Primary Care AHEAD Factsheet

What is Primary Care AHEAD?
A voluntary, **beneficiary-focused** advanced primary care program designed to align Medicare with state-led primary care efforts. It has an overarching, flexible framework of **care transformation priorities** that will complement statewide Medicaid primary care priorities. Primary Care AHEAD is intended to increase overall capacity for **care coordination** and connection to **community resources**, improve quality, offer whole **person-centered care**, and minimize **provider burden**.

What are the Program Components & Goals?

**Program Goals**
- Increase Primary Care Investment
- Align Payers
- Support Advanced Primary Care
- Broaden Beneficiary Reach through FQHC*, RHC*, and Small Practice Participation

**Program Components**
- Care Transformation Activities
- Enhanced Payment
- Learning Collaboratives & Supports
- Data & Technical Assistance

*Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)
Appendix 1 – Quality Measure NOFO Requirements
Primary Care AHEAD Quality Measures (and weightings)

• Behavioral Health (30%)- Required - Preventive Care and Screening: Screening for Depression and Follow-Up Plan

• Prevention and Wellness (15%)
  • Choice of colorectal cancer screening (COL-AD) or breast cancer screening: mammography (BCS-AD)

• Chronic Conditions (15%)
  • Choice of controlling HBP (CBP-AD) or Diabetes: Hemoglobin A1c Poor Control (>9%)

• Health Care Utilization (40%)
  • ED Utilization (EDU) AND
  • Acute Care Hospitalization (AHU)

• Source: NOFO Appendix X – includes citations to measure sources and uses
Appendix 2 – Definitions
## Definitions

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<tr>
<th>Primary care providers</th>
<th>Medicare FFS definition</th>
<th>Notes for consideration</th>
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<tr>
<td><strong>Working definition</strong> for investment measurement includes: general practice, family practice, internal medicine, OBGYN, hospice and palliative care, psychiatry, geriatric psychiatry, pediatric medicine, geriatric medicine, certified nurse midwife, nurse practitioner, addiction medicine, preventive medicine, neuropsychiatry, certified clinical nurse specialist, physician assistant</td>
<td>There is flexibility for states to construct their own primary care definitions for spending measurement for All-Payer Primary Care Investment Targets.</td>
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| Beneficiary attribution | CMS will attribute Medicare FFS beneficiaries to Participating Primary Care Practices prior to the start of each quarter during a given Performance Year. | There is no minimum beneficiary attribution requirement for participation in Primary Care AHEAD. |
Appendix 3
The National Academy for State Health Policy (NASHP) is a nonpartisan organization committed to developing and advancing state health policy innovations and solutions.

NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.

To improve the health and well-being of all people across every state.

To be of, by, and for all state by providing nonpartisan support for the development of policies that promote and sustain healthy people and communities, advance high quality and affordable health care, and address health equity.
How NASHP Accomplishes Our Mission

• **Advance innovation** by supporting states in the development of new policies and programs.

• **Surface and support the implementation and spread of best practices** by engaging states to inform data driven policy making at the state and federal level.

• **Ensure states have the information, data, and tools** to successfully design and implement policy.

• **Encourage sustainable cross sector solutions** by strengthening partnerships across state agencies, executive and legislative branches, and the private sector.

• **Elevate the state perspective** for a broad group of stakeholders, partners, and the public.
About Mathematica | Focus Area Health

Our Health team **collaborates with clients to improve the health and well-being of our most vulnerable populations** through transformation to an equitable, data-driven, value-based health care system.

**State Health Footprint | Project Highlights**

- Pennsylvania Rural Health Model
- Vermont All-Payer Model
- Maryland Total Cost Model and Evaluation
- California and New Jersey Total Cost and Primary Care Benchmarks
- NASHP Hospital Cost Tool
- Medicaid 1115 waiver and Primary Care Model evaluations
- National/State Medicaid, Medicare and Commercial claims analytics

**Our Mission**

*Improve public well-being* by bringing the highest standards of quality, objectivity, and excellence to bear on the provision of information collection and analysis.
Dr. Sule Gerovich
(Shooleh Gherovich), Pronounce: She/Her

• Over 15 years of experience in health services research and policy
• Expertise in health care payment policy, quality and performance measurement
• Hospital global budget implementation in three states: PA, MD, VT
• Strategic assessment of CMS models, including CMS Community Health Access and Rural Transformation (CHART) Model for Washington State
• Total cost benchmarking and all-payer claims analytics: CA, MA, MN, VT, MD and NASHP Hospital cost tool
• Senior Fellow at Mathematica
  Ph.D., Johns Hopkins University School of Public Health