The AHEAD Model
Primary Care AHEAD

NATIONAL ACADEMY
FOR STATE HEALTH POLICY

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

Mathematica Progress Together

AHEAD Primary Care AHEAD Requirements

AHEAD Model Components

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

Components

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

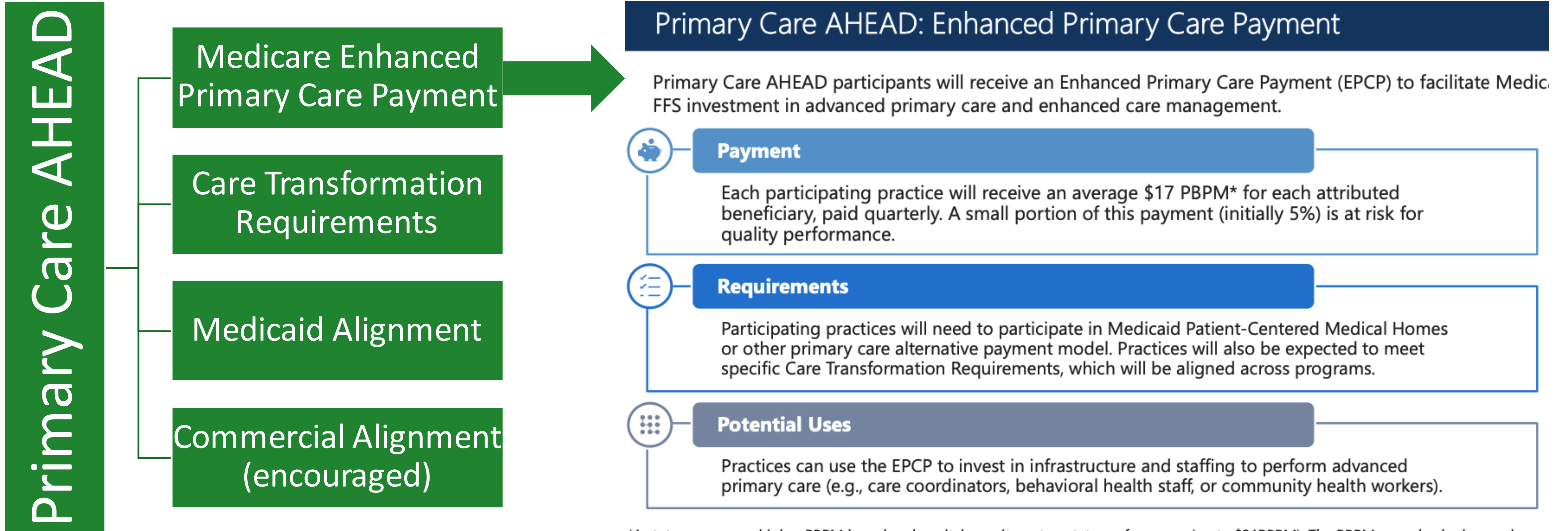
Source: CMMI Presentation on AHEAD Model, September 18, 2023

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.

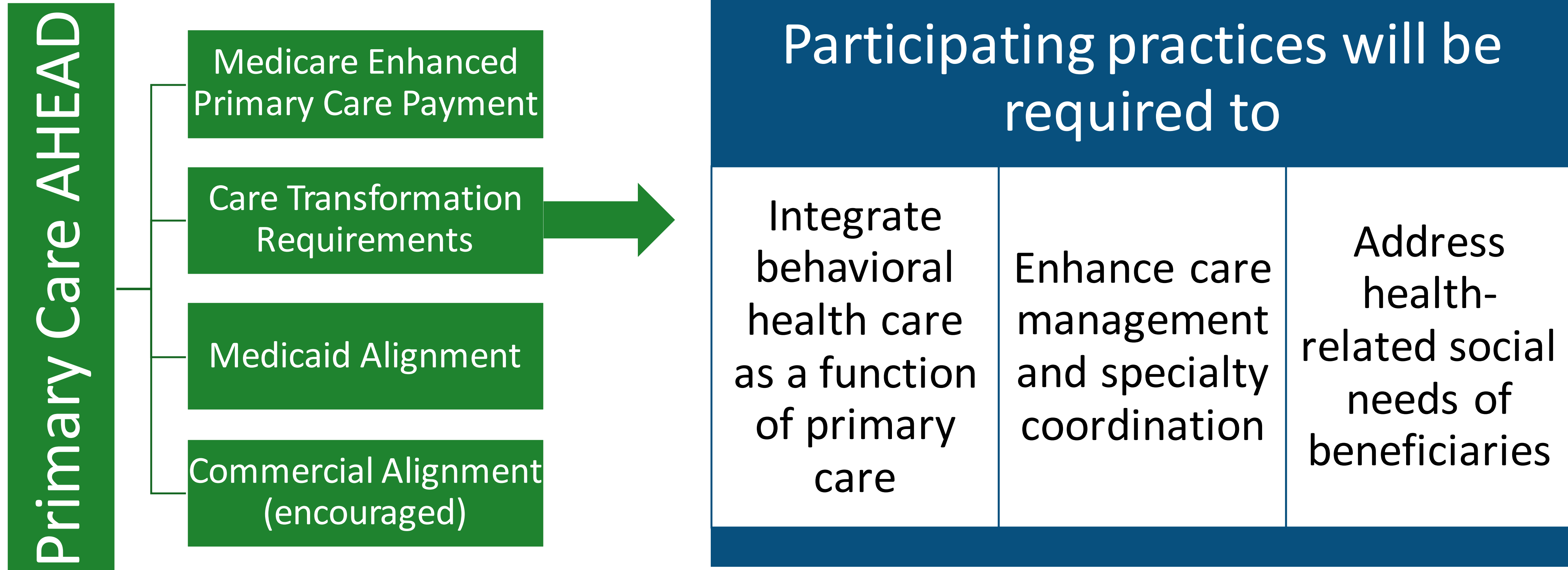
Sources: CMS Notice of Funding Opportunity, Appendix IX, and Frequently Asked Questions

Primary Care AHEAD Sub-components



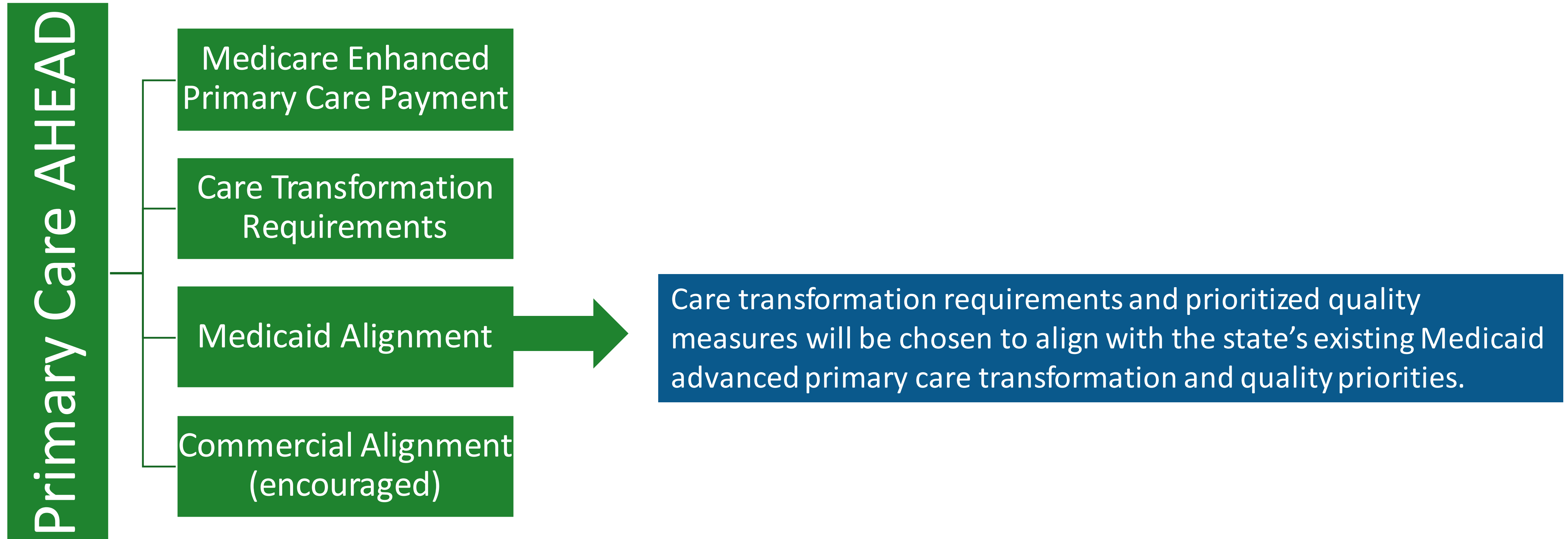
Sources: CMMI Presentation on AHEAD Model, September 18, 2023, and CMS Notice of Funding Opportunity, Appendix IX

Primary Care AHEAD Sub-components



Source: CMS [Notice of Funding Opportunity]

Primary Care AHEAD Sub-components



Source: CMS Notice of Funding Opportunity

Primary Care AHEAD Requirements

Item	Requirement
Medicaid participation	Required by PY1
Commercial payer participation	Encouraged commercial and Medicare Advantage alignment – TA to be provided
Practice eligibility	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) Practices can only be in Primary Care AHEAD if they are in a state-based PCMH or state-based APM for that same PY Practices can be in Medicare Shared Savings Program (MSSP) or ACO REACH and Primary Care AHEAD)*
Agreements	All practices must sign participation agreements with CMS in advance of the first PY they plan to participate

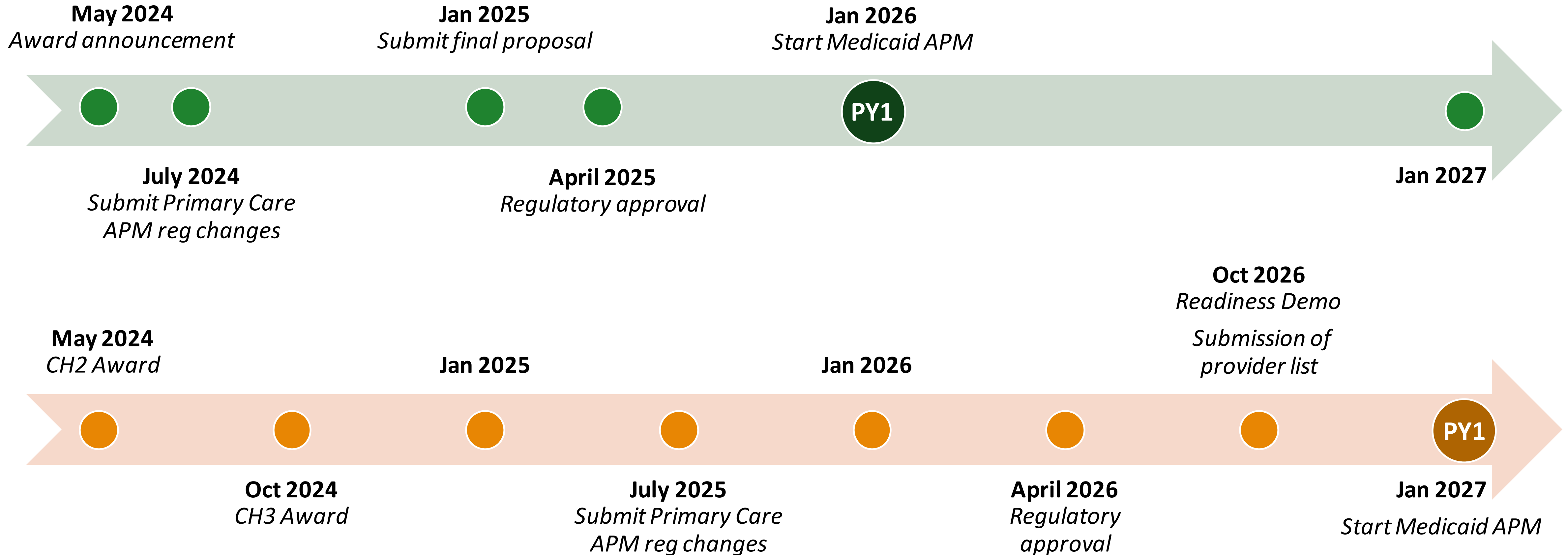
- Sources: CMS Notice of Funding Opportunity, Appendix IX, and Frequently Asked Questions

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

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

Assessment of program

Vision for Primary Care Transformation

Size of practices in current model

Optional Partners? Other providers /community organizations to assist

Recruitment

Does your Medicaid program have an existing Primary Care APM?

Recruitment of FQHCs/RHCs, large and small practices – must be part of process from beginning

Regulatory pathway proposal for update to current model or for new model

Other

Any gaps in existing Medicaid model? Primary care specialty types aligned with CMS?

Alignment of current state practice agreements with CMS expectations of practice agreements

Are practices part of commercial APMs? Surveys may be useful

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?

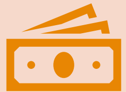
What support/mechanism is there for outside support with HRSNs for Medicare FFS and Medicaid beneficiaries?

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

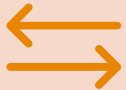
What chassis will the state use for its Medicaid APM?

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

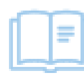
Broaden Beneficiary Reach through FQHC*, RHC*, and Small Practice Participation

Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)

Program Components

Care Transformation Activities

Enhanced Payment


Learning Collaboratives & Supports

Data & Technical Assistance

https://www.cms.gov/files/document/ahead-primarycare-fs.pdf

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

	Medicare FFS definition	Notes for consideration
Primary care providers	Working definition 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	There is flexibility for states to construct their own primary care definitions for spending measurement for All-Payer Primary Care Investment Targets.
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

About NASHP

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.

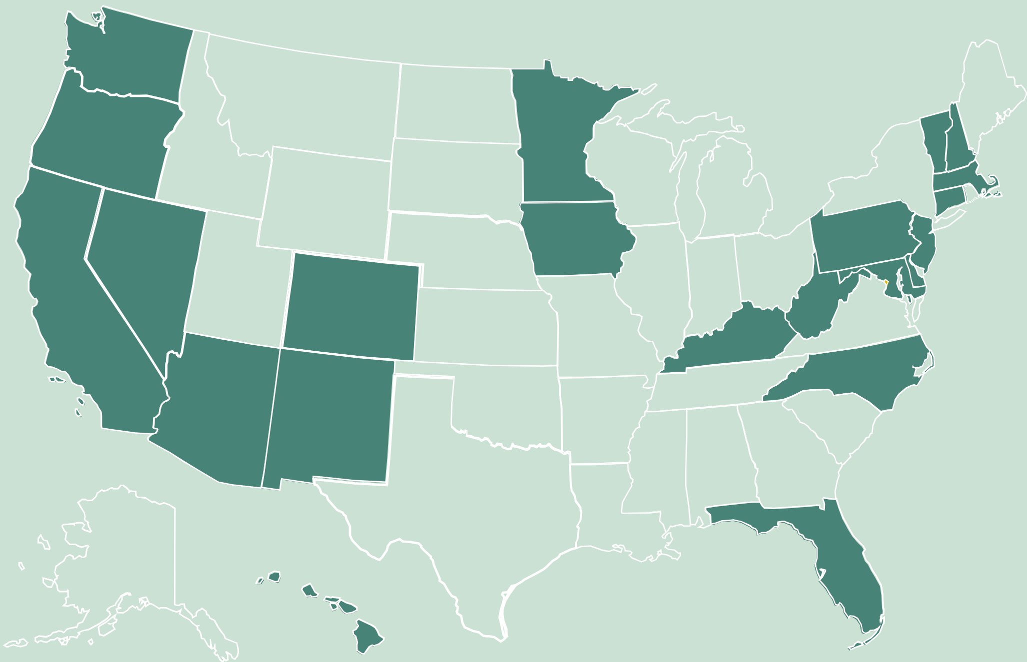
About Mathematica | Focus Area Health

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.

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.

State Health Footprint I 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

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