

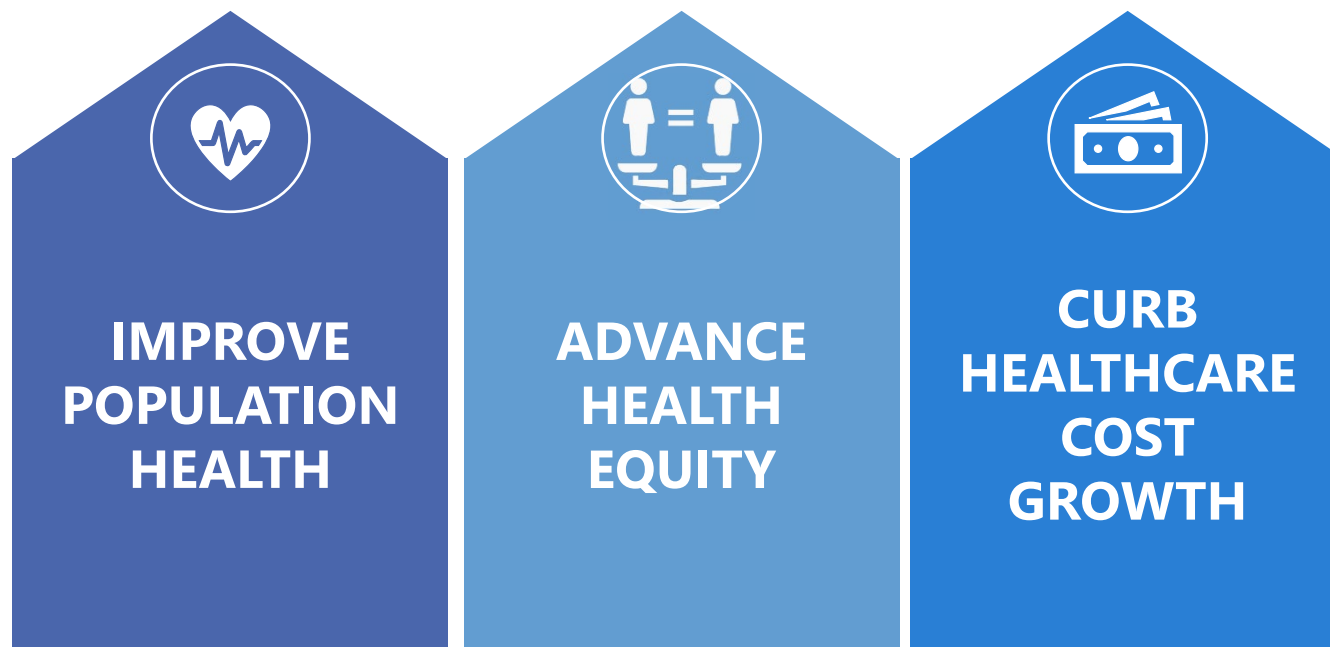
# States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

Presentation for NAIC

Center for Medicare and Medicaid Innovation

# States Advancing All-Payer Health Equity Approaches and Development

CMS's goal in the AHEAD Model is to collaborate with states to improve population health; advance health equity by reducing disparities in health outcomes; and curb health care cost growth.



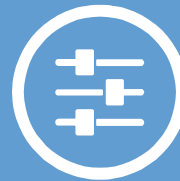
CMS will support participating states through various AHEAD Model components that aim to increase investment in primary care, provide financial stability for hospitals, and support beneficiary connections to community resources.

# Promise of State-Based Total Cost of Care Models

**States are uniquely positioned to advance accountable care, population health, and health equity:**



Build on and incorporate transformation efforts within a state



Align policies and programs across payers and providers



Leverage stakeholder relationships and community knowledge

**Through a multi-state model concept with a clear framework that can be adapted to the unique state context, the Innovation Center can support states in improving population health and constraining cost growth**

# 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



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

# Benefits of State Participation in the AHEAD Model

States will benefit from a variety of tools as part of participation in the AHEAD Model:

- 1 | Levers to **improve population health, address health equity, and curb rising cost growth**
- 2 | Funding to support opportunities to **support Model planning and implementation activities**
- 3 | Alignment with Medicaid and increased investment in **advanced primary care**
- 4 | **Multi-payer alignment** to drive change more effectively
- 5 | Optional waivers under the model to provide **flexibilities to providers**



Improve Population Health



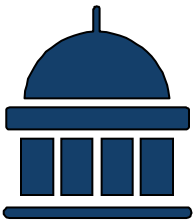
Advance Health Equity



Curb Health Care Cost Growth

# AHEAD Model Eligibility Criteria for States

## States

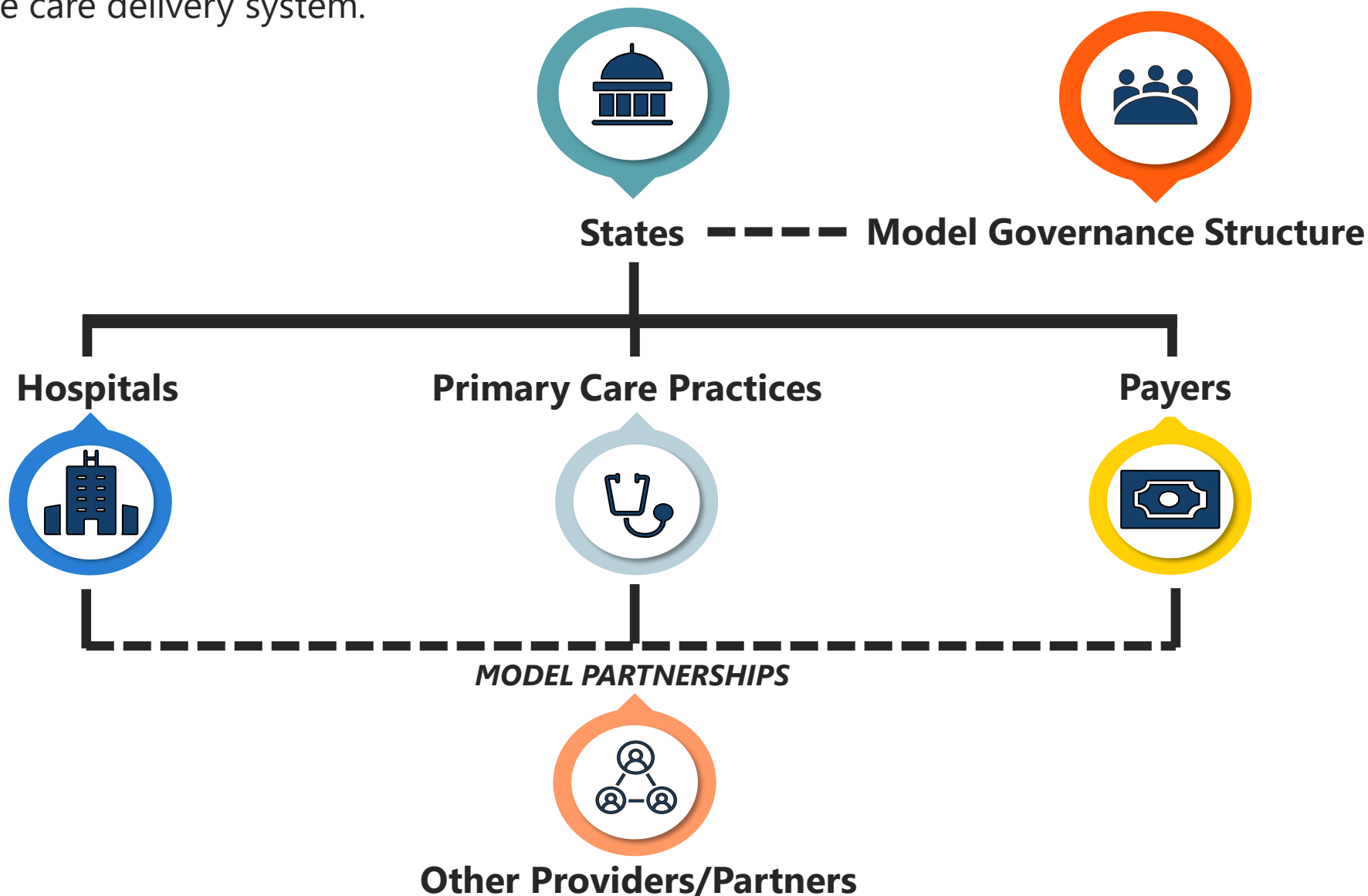


- US states, territories, and Washington, DC (“states”) are eligible to apply to participate in AHEAD. Making Care Primary states or sub-state regions are ineligible.
- States should engage multiple state agencies to support AHEAD goals and activities.
  - States can choose which state agency should apply to the Notice of Funding Opportunity (NOFO) (e.g., state Medicaid agency, public health agency, insurance agency) to receive Cooperative Agreement funding from CMS.
  - State Medicaid agencies must be the recipient or sub-recipient of the funding.
- States may apply to participate at the state level or designate a sub-state region, subject to CMS approval. At least 10,000 Medicare Fee for Service (FFS) beneficiaries with Part A and B must reside in the applicant state or sub-state region.
- A maximum of eight states or sub-state regions will be selected for participation.

**Additional information about the participation requirements will be available in the NOFO released later this Fall.**

# AHEAD Model Stakeholders

The AHEAD Model will give participating states additional tools and incentives to align care transformation activities across the care delivery system.



# Stakeholder Roles



## States

- Establish model governance
- Set all-payer cost growth targets
- Increase primary care investment
- Implement statewide health equity plan
- Design Medicaid hospital global budgets and primary care transformation
- Facilitate multi-payer alignment and can engage State Employee Health Plans and Marketplace Plans



## Hospitals

- Can participate in hospital global budgets, transform care, and improve population health
- Pursue opportunities for quality improvement (e.g., CMS hospital quality programs and other metrics) and identify other efficiencies
- Create hospital health equity plans to reduce disparities in care and outcomes within the hospital and community



## 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 the All-Payer Cost Growth Target and All-Payer Primary Care Investment Targets
- Participate as an aligned payer in hospital global budgets and primary care transformation

**The Model Governance Structure and other partners also play a key role in model implementation.**



# Multi-Payer Alignment

The AHEAD Model will strive to achieve the highest possible level of multi-payer alignment across components.



## Payers

- Medicare Advantage and commercial payer participation is voluntary, but strongly encouraged.
  - Note: States must recruit at least one commercial payer to participate in HGBs by PY2.
- AHEAD will require Medicaid participation across all Model components to further Model goals around improving health equity.
- States will be accountable for commercial payer spend through the all-payer TCOC growth targets and primary care investment targets.

# Medicaid Alignment

State Medicaid agencies play a critical role in the AHEAD Model, including participation as an aligned payer in hospital global budgets and primary care.



## STATE PARTICIPATION

**State Medicaid Agencies are essential and required partners in model participation**

- Any state health agencies with the ability to accept award funding (e.g., State Medicaid Agencies, Public Health Agencies, Insurance Agency, etc.) may apply to the NOFO by itself or as a joint applicant with another state agency.
- If a group other than the State Medicaid Agency is a recipient of the CoAg, there will be dedicated funding for state Medicaid implementation.



## GLOBAL BUDGETS

**Medicaid would be an aligned payer by PY1**

- Goal is that Medicaid FFS and managed care would be an aligned payer for HGBs by PY1.
- States might use state directed payments or 1115 waiver for HGB implementation and updates to Managed Care Organization contracting requirements.



## PRIMARY CARE

**Medicare FFS would align with ongoing Medicaid primary care transformation**

- Practices participating in Primary Care AHEAD must participate in Medicaid primary care APM in the same year.
- States may adapt core Medicare Care Transformation Requirements and quality measures to Medicaid priorities.



## STATEWIDE TARGETS

**Medicaid would participate in all-payer TCOC, primary care investment, and quality targets**

- Medicaid contributes to all-payer targets; however, there will be considerations of Medicaid's unique population and a greater focus on improving population health, increasing access, and reducing avoidable utilization.

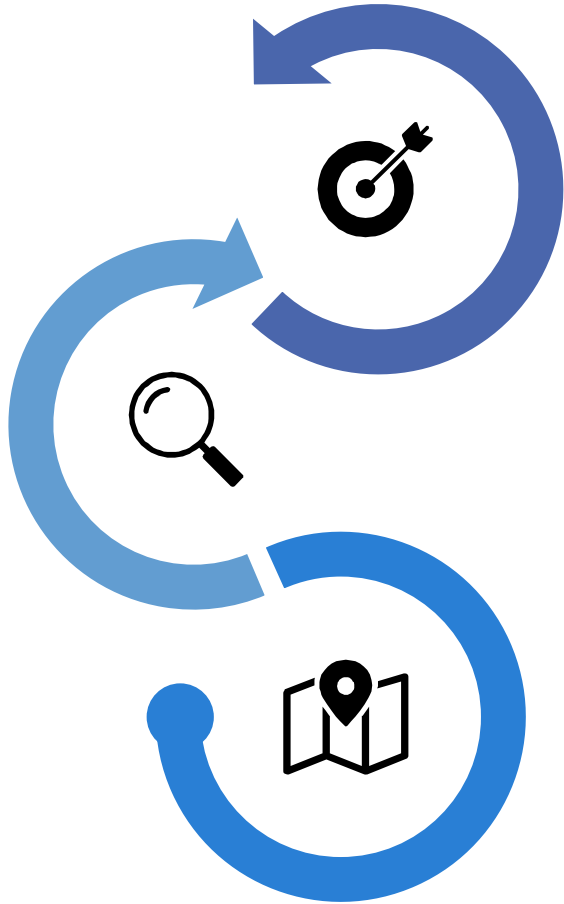
# Opportunities for Insurance Commissioners

## ***How do I get involved? What can I do to support the Model?***

- Consider serving as a partner in model application
- Participation in model governance structure
- Collaboration with other state agencies on engaging with commercial and other payers in state on model goals
- Use state regulatory levers to help achieve and as needed, enforce, all-payer targets as feasible
- Educate state legislators and other decisionmakers on the model and existing state cost control efforts
- Support measurement of all-payer targets in the model
- Other ideas – welcome your input!

# Statewide Targets At-A-Glance

Participating states take on accountability for quality, costs, and outcomes for a defined sub-state region or statewide. These targets are memorialized in the State Agreement between the state and CMS.



Improve Population Health



Advance Health Equity

- **Medicare FFS Primary Care Investment Target**
- **All-Payer Primary Care Investment Target**
- **Statewide Quality and Equity Targets (Medicare FFS and All-Payer)**



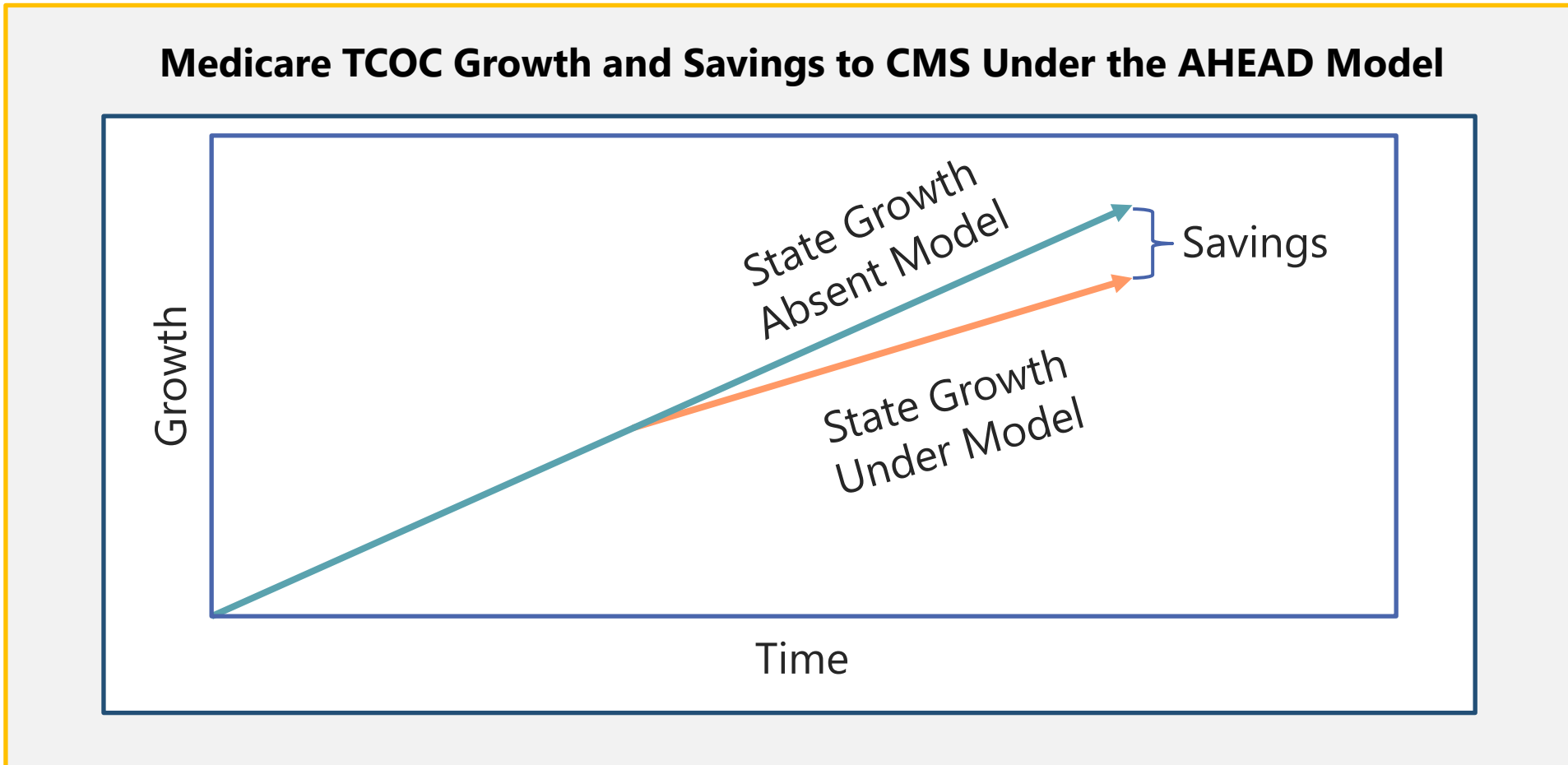
Curb Health Care Cost Growth

- **Medicare FFS Total Cost of Care Targets**
- **All-Payer Cost Growth Targets**

**Targets are measured for residents within the defined region.**

# Medicare FFS TCOC Targets

AHEAD was developed in alignment with affordability and cost growth containment efforts underway in states across the nation, and the Medicare TCOC target holds states accountable for “bending the cost curve” for Medicare Part A and Part B expenditures of resident beneficiaries. By holding states accountable for cost growth, CMS hopes to support states in achieving a more affordable cost trajectory and increased long-term sustainability. CMS will work collaboratively with each state during the pre-implementation period to set state-specific Medicare FFS TCOC growth targets.





### **All-Payer Cost Growth Targets**

Each state will be accountable for meeting a target for all-payer TCOC growth, comprising Medicare, Medicaid, and commercial payers, on an annual basis.

**Key Goal: Build on and expand existing state innovations and cross-state learnings.**

States and conveners have made significant progress in the national space on cost growth target setting in recent years. Some states may enter the model with prior cost growth targets; others may enact new targets in order to participate in the model.

Award recipients beginning Model participation without all-payer cost growth targets will be encouraged to leverage the experience of early adopters and build on methodologies used in other existing state cost growth benchmarking programs. The Peterson-Milbank Program for Sustainable Healthcare Costs has been tracking these efforts and has additional resources for states.

# All-Payer Cost Growth Targets: Requirements

## Memorialization

- All-payer cost growth targets (or, at minimum, the process to determine such a target) must be memorialized in state Executive Order, statute, or regulatory change 90 days before the start of PY1.
- The specific all-payer cost growth target and calculation methodology must be determined, at minimum, 90 days before the start of PY2.

## Duration

- Targets must subsequently be sustained throughout the duration of the AHEAD performance period.

## Execution

- If the state misses its TCOC target, CMS will request a corrective action plan for the state, which may include public reporting on commercial cost growth in aggregate and by payer, among other actions to be taken by the state

## Data Reporting

- Data collection and reporting on all-payer cost growth must be shared with CMS and coordinated with data collection for the primary care investment target

# Assessing Readiness for All-Payer Cost Growth Constraint in AHEAD Applications



Having an existing cost growth target is not a requirement to be an AHEAD model participant, but applicants should consider the feasibility of enacting legislation in accordance with the model milestones timeline.



Legislation or executive order that provides authority to establish targets must be enacted by the start of PY1; targets must be set by the start of PY2.



States should demonstrate readiness and political will to establish the necessary governing bodies and execute the requirements described above as part of their NOFO application.



Technical assistance and learning supports will be available for states that are new to cost growth benchmarking.



# Primary Care Investment Targets



## Medicare FFS Primary Care Investment Targets

- ✓ Methodologies and benchmarks determined by CMS, based on current state spending
- ✓ Annual targets are state-specific, improvement-focused
- ✓ CMS and state will determine performance annually on specified target based on available data
- ✓ State to recruit participants for Primary Care AHEAD and pursue activities to support primary care

## All-Payer Primary Care Investment Targets

- ✓ Methodologies and benchmarks determined by states and reviewed by CMS (may build on existing legislation and targets, if applicable)
- ✓ Require All-Payer Primary Care Investment Target memorialized in Executive Order or legislation by the first performance year
- ✓ Must continue for the duration of the AHEAD performance period
- ✓ May use state-specific definition of primary care; states without existing targets are encouraged to use AHEAD Medicare FFS definition of primary care

# AHEAD Primary Care Definition Approach: Medicare FFS Targets

## Structure

- Consists of specified list of HCPCS codes and non-claims-based-payments (NCPBs). HCPCS codes are selected via a cross-analysis of definitions used in existing state legislation and other primary care investment reports.

## Non-claims-based payment inclusion

- More primary care payments are coming through NCBPs. Given this, CMS will be including NCBPs in the calculation for Medicare FFS and providing states with a NCBP reporting template for all payers.

## “Narrow vs. broad” approach

- Use “meet in the middle” approach by filtering for specialty type “and” HCPCS codes type (rather than “or”), but keeps both definitions relatively broad (i.e., including some OBGYN and BH services). This allows targets/benchmarking to be based on a singular definition.

## State flexibility

- States may add additional services to their definition and/or NCBP reporting template, with justification and pending CMS approval. Targets will remain the same regardless of additions to the primary care definition.



## State Responsibilities for Measurement of Primary Care Spending

- States are required to collect primary care investment spending information from commercial payers and Medicare Advantage plans
- State Medicaid Agencies must also report on primary care investment spending information
- Reports for commercial and Medicaid payers must use CMS-supplied NCBP reporting template
- The agency that is the recipient of the Cooperative Agreement funding award will be responsible for aggregating this spending information by payer and reporting it to CMS for combination with the Medicare FFS primary care spending data
- CMS will work with states to ensure that primary care spending data is reported in a way that coordinates with the State Health Equity Plan (HEP) and engages the state's governance structure

# All-Payer and Medicare Primary Care Investment Targets Comparison

## Goals for All-Payer Primary Care Investment Targets

Build on existing state and national progress in the primary care investment space

Include flexibility for states to adopt policies to their unique context

Leverage state tools for increasing payer accountability to increase primary care investment

## Shared Goals

Increase primary care investment to strengthen the primary care system in participating states and regions

Encourage thoughtful, targeted, equity-focused investment tactics across payers

Build capacity for defining and measuring primary care spending

## Goals for Medicare FFS Primary Care Investment Targets

Bring Medicare FFS to the table for primary care investment efforts via Primary Care AHEAD Program

Utilize CMS data to track Medicare FFS primary care investment in participating states

Provide a standardized approach for defining primary care

# Model Next Steps

# Model Timeline

## Model Timeline with Pre-Implementation and Performance Years

|   | 2023      | 2024                    | 2025                        | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2034 |     |
|---|-----------|-------------------------|-----------------------------|------|------|------|------|------|------|------|------|------|-----|
| Model Year (MY)                         |           | MY1                     | MY2                         | MY3  | MY4  | MY5  | MY6  | MY7  | MY8  | MY9  | MY10 | MY11 |     |
| 1 <sup>st</sup> NOFO Application Period | Cohort 1* | NOFO Application Period | Pre-Implementation (18 mos) |      | PY1  | PY2  | PY3  | PY4  | PY5  | PY6  | PY7  | PY8  | PY9 |
|   | Cohort 2  |                         | Pre-Implementation (30 mos) |      |      | PY1  | PY2  | PY3  | PY4  | PY5  | PY6  | PY7  | PY8 |
| 2 <sup>nd</sup> NOFO Application Period | Cohort 3  | NOFO Application Period | Pre-Implementation (24 mos) |      | PY1  | PY2  | PY3  | PY4  | PY5  | PY6  | PY7  | PY8  |     |

\*States in Cohort 1 may choose to move to Cohort 2 during the Pre-Implementation Period, with CMS approval.

# Application Submission Process

HHS strongly recommends that you do not wait until the application due date to begin the application submission process.



## Application Materials

- All application materials are available at <http://www.grants.gov>



## Registration Process

- You may start the registration process by visiting <http://www.grants.gov>

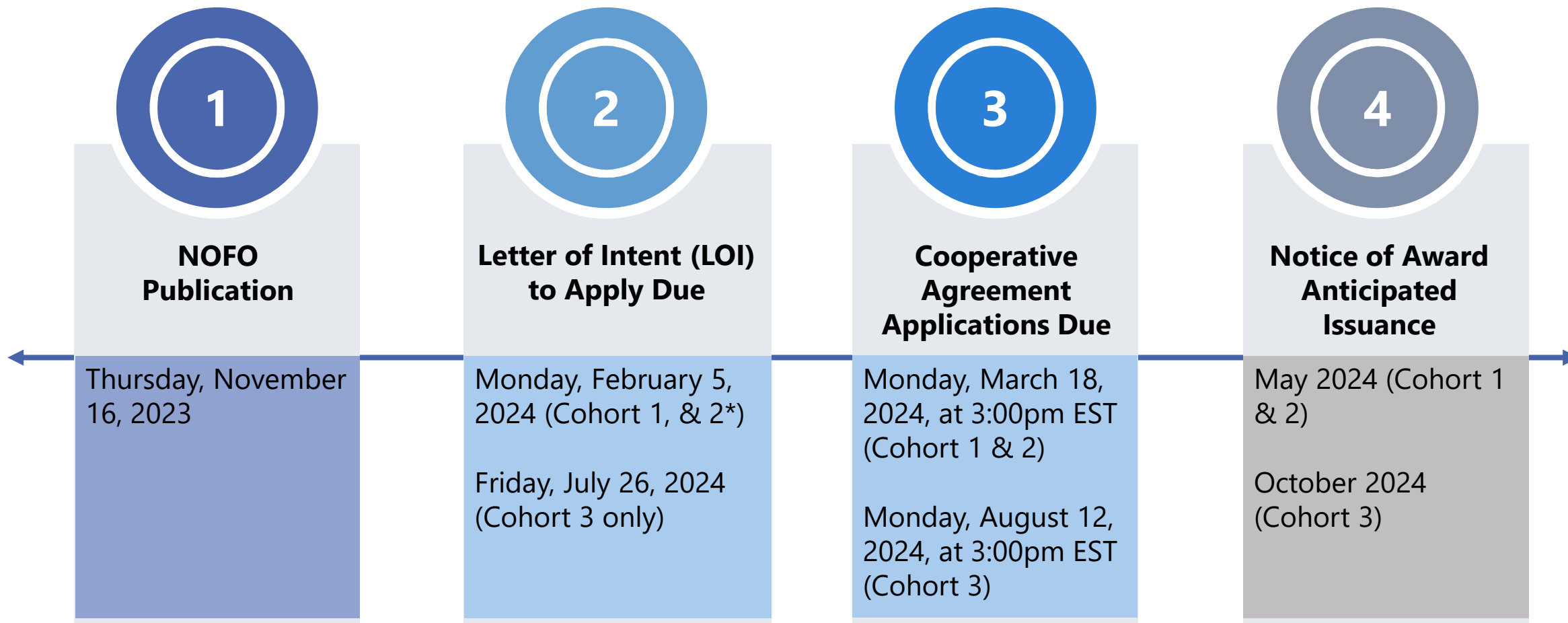


## Application Due Dates

- Optional Letter of Intent (LOI) for Cohort 1 and 2 during the first NOFO application period are due February 5, 2024
- Submit applications to <http://www.grants.gov> for Cohort 1 and 2 by the deadline date of March 18, 2024

# Application Timeline

HHS strongly recommends that you do not wait until the application due date to begin the application submission process.



Potential applicants can submit their Letters of Intent by email at: [AHEAD@cms.hhs.gov](mailto:AHEAD@cms.hhs.gov)

*\*Potential applicants considering Cohort 3 may submit their LOI before February 5, 2024, and do not have to wait until the July 26, 2024,*





**Thank you in advance for your review and feedback on our model! We appreciate your time and interest!**

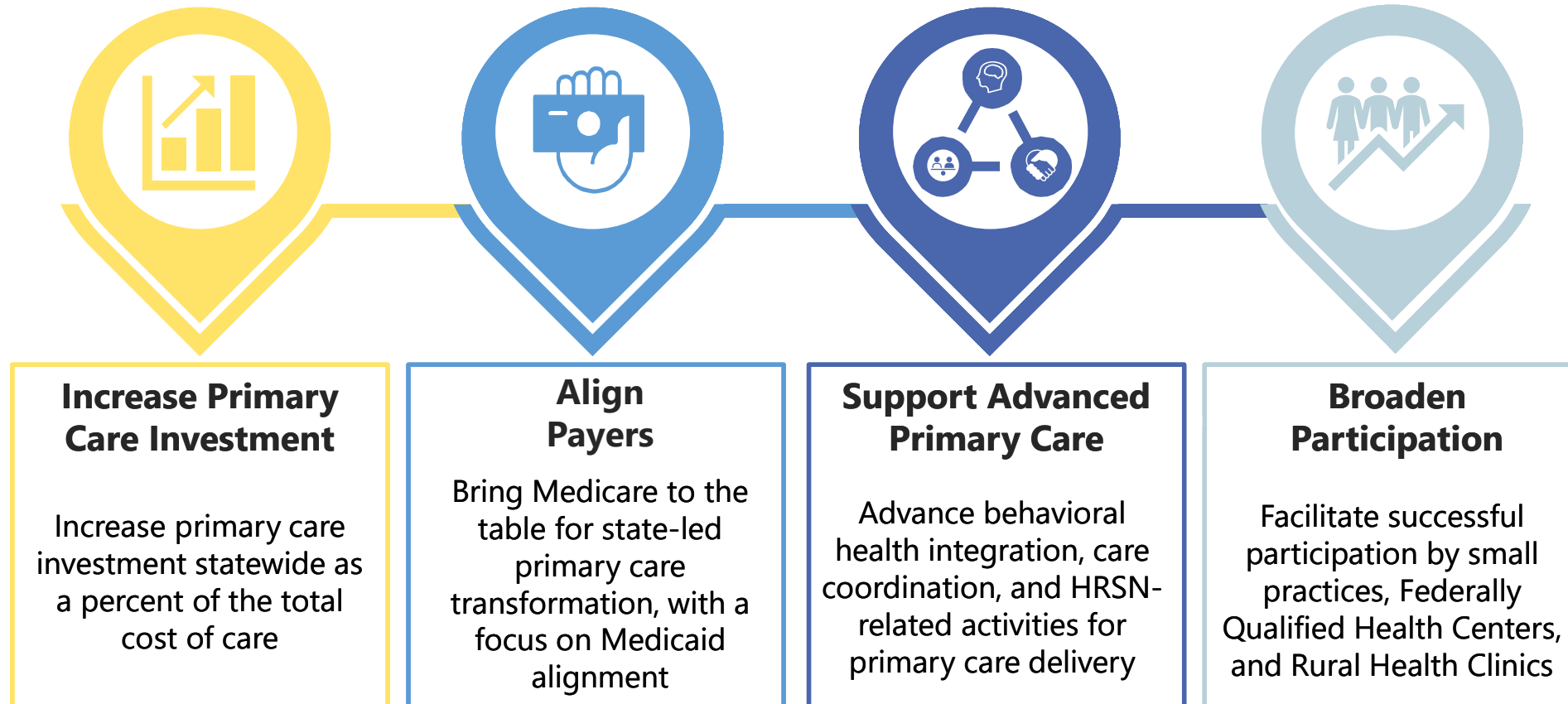
Do you have questions? Email your comments and feedback to [AHEAD@cms.hhs.gov](mailto:AHEAD@cms.hhs.gov).

# Appendix

# Primary Care AHEAD

# Primary Care AHEAD Goals

Primary Care AHEAD is flexible to align with each state's Medicaid primary care goals and will bring Medicare to the table for increased investment and care transformation initiatives.



CMMI has committed to introducing primary care tracks with additional risk/capitation in the future. Any future Primary Care AHEAD tracks will align with these program goals.

# Eligibility Criteria – Primary Care Practices

Primary care practices may participate voluntarily in the Primary Care AHEAD program to receive a Medicare Enhanced Primary Care Payment and support corresponding care transformation.



## Primary Care Practices



### Primary Care Practices\*

- Primary care practices, FQHCs, and RHCs that are located within a participant state or sub-state region and are participating in the state's Medicaid Primary Care Alternative Payment Model (APM).
  - The state's Medicaid Primary Care APM could support a Patient-Centered Medical Home program, health home, or similar care coordination program.
- Primary Care AHEAD participation will be at the organizational level.
  - Non-FQHCs/RHCs are defined as a single Medicare-enrolled billing TIN.

\*Hospital-owned practices will only be eligible to participate in Primary Care AHEAD if the affiliated hospital is participating in AHEAD hospital global budgets for that performance year.

# 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 model. 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).

# Hospital Global Budgets

# Hospital Global Budget Value Proposition

The AHEAD Model aims to rebalance health care spending across the system, shifting utilization from acute care settings to primary care and community-based settings.

## WHAT IS A HOSPITAL GLOBAL BUDGET?

When hospitals receive a pre-determined, fixed annual budget. These budgets are for a specific patient population or program, such as Medicare FFS beneficiaries. As it is used by the CMS Innovation Center, global budgets are calculated based on a review of Medicare and Medicaid payments in previous years, with adjustments to account for inflation and changes in populations served and services provided.

[\(CMMI Total Cost of Care and Hospital Global Budgets, 2023\)](#)

## Incentives for Hospital Participation



Initial investment to support transformation in early years of the model



Increased financial stability and predictability



Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery



Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community



Potential use of waivers to support care delivery transformation

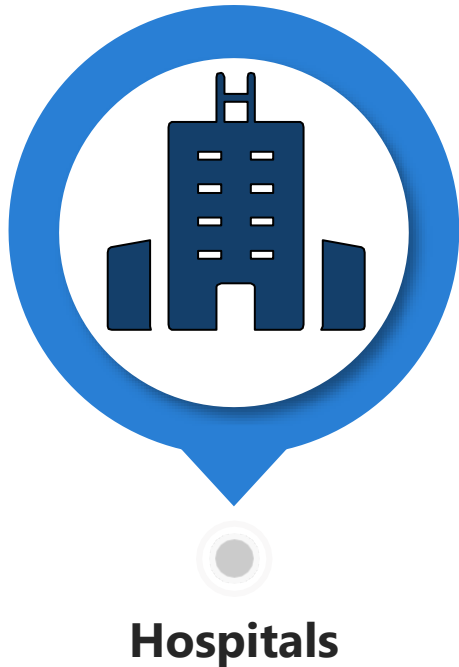


Opportunity to participate in system learning opportunities when moving to a population-based payment



# Eligibility Criteria – Hospitals

Acute care hospitals and critical access hospitals (CAHs) will be eligible to participate in Medicare hospital global budgets under the Model.

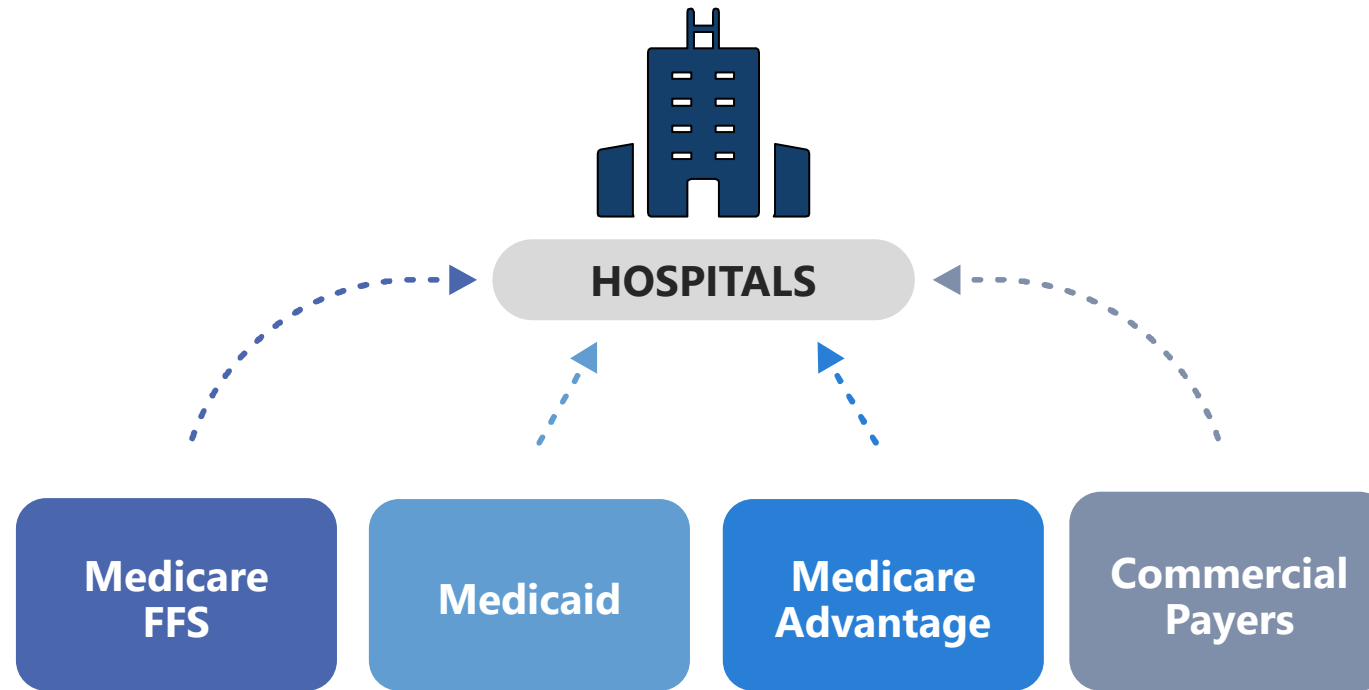


## Hospitals

- CMS will not require hospital participation.
- Hospital Participants (e.g., acute care hospitals and CAHs) must be a Medicare-enrolled facility in good standing with CMS and located in the participating state or sub-state region.
- In participating states that enact enabling legislation during the performance period, eligible facilities will also include Rural Emergency Hospitals (REH).

# Hospital Global Budgets






Hospital global budgets will be the primary mechanism for achieving all-payer and Medicare FFS TCOC Targets, improving hospital quality, and helping to curb cost growth.



**Each participating payer provides a global budget to the participating hospital for facility services.  
This global budget is determined prospectively.**

# Health Equity Strategy

The AHEAD Model aims to advance health equity in alignment with the CMS Framework for Health Equity. The AHEAD Model Health Equity Strategy is inclusive of the following elements:

-  **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.