Notice of Funding Opportunity Webinar for the States Advancing All-Payer Health Equity Approaches and Development Model
November 16, 2023

>>Arbre'ya Lewis, SEA: Good afternoon, everyone. Thank you for joining today's Notice of Funding Opportunity Webinar for the States Advancing All-Payer Health Equity Approaches and Development Model, also known as the AHEAD Model.

There are a few housekeeping items to discuss before we get started. During today's presentation, all participants will be in listen-only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window. Given time constraints, we may not get to every question, but we will collect questions for future events and FAQs. You can also reach out to our help desk at AHEAD@cms.hhs.gov. We also would like you to know that today's presentation is being recorded. If you have any objections, please hang up at this time. This slide deck, a recording of today's presentation and a transcript will be made available on the AHEAD Model website in the coming days. Next slide, please.

Before we dive into content, let me give you a brief overview of the agenda for today's webinar. First, the model team will dive into the AHEAD Model's background. Following that, we will provide an overview of the model's Notice of Funding Opportunity, or NOFO. Next, the Office of Acquisition and Grants Management, OAGM, will join us to walk us through federal award information as is related to the AHEAD Model. Then the OAGM will share more information about the AHEAD Model's application process, federal award administration, and finally, post award milestone requirements. We will have a few minutes at the end of today's event for a Q&A session where our team will answer questions submitted by audience members. As a reminder, you can submit questions using the Q&A function at the bottom right hand corner of your screen.

Again, thank you for joining us today. As you can tell, we have a lot of great information to share. Now, I'm going to pass the mic to Laura, the AHEAD Model's new Co-Lead to formally welcome you to today's event. Next slide, please.

>> Laura Snyder, CMS: Good afternoon. I'm excited to welcome you to this webinar on the Notice of Funding Opportunity for the AHEAD Model. Thank you again for joining us today and for your interest in this model. Next slide, please.

First I'll walk you through the speakers joining us for today's webinar. Today's speakers include me, Laura Snyder, and my fellow AHEAD Model Co-Lead, Emily Moore. Joining us today also, from the Office of Acquisitions and Grants Management, we have Grants Management Officer Jamie Atwood. I also want to say thank you to the entire AHEAD team and our CMS colleagues for their work on this webinar. Next slide, please.

As you heard in the opening remarks, slides and the recording from today's presentation will be posted to the AHEAD Model website in the next few days. We also have a factsheet and other resources available there, and we will continue to add to those resources on the AHEAD Model website over the coming months. Please do not hesitate to share any questions during this presentation, or to let us know if we're going too quickly. We can get a little excited sharing all the work we've been doing on this model. Before we dive into the Notice of Funding Opportunity details, I will provide you all with a

brief refresh of the model background. I promise to keep it brief, since many of you have likely joined our recent more in-depth webinars on the AHEAD Model. Next slide, please.

So at the highest level, CMS's goal in the AHEAD Model is to partner with states to improve population health, advance health equity, and curb the growth of health care costs. So under AHEAD, states will be asked to meet a few different targets under both Medicare fee-for-service and across All-Payers. Namely, for each state, there will be a total cost of care target, one for Medicare and one for All-Payers, a primary care investment target, again, one for Medicare and one for All-Payers, and statewide equity and population health outcome targets.

Now, at the bottom of this slide you'll see the components of the model that will help states meet those targets. The first is the Cooperative Agreement funding for participating states to help implement the model. The second is hospital global budgets for facility services only, not professional services, that provide stable prospective payments to hospitals. The third component is Primary Care AHEAD, the primary care program for Medicare fee-for-service that will help states meet the Medicare fee-for-service primary care investment targets. The program will provide funding for enhanced care management activities and person-centered care, and it is intended to align with each state's Medicaid primary care transformation.

Now cutting across the model are a number of strategies that inform the model's design. Namely, we are really focused on advancing health equity and have integrated it across the model. We will also see a focus on behavioral health integration. This model, of course, also brings in multi-payer alignment, with Medicaid alignment being a key element. Finally, we are hoping to build on and accelerate existing state innovations. So these model targets, components and strategies all work together to meet the model goals stated earlier of curbing health care cost growth, improving population health, and advancing health equity by reducing disparities in health outcomes. Next slide, please.

On the next slide I will share a brief overview of the AHEAD Model Notice of Funding Opportunity. Next slide, please.

So the NOFO is the mechanism by which CMS, through its Innovation Center seeks applications for the AHEAD Model. The Notice of Funding Opportunity is intended to articulate the specific requirements of the AHEAD Model and help applicants understand how to apply. So this NOFO includes three main components; the application process, the model overview, and award information and implementation. We will walk you through these components in detail. Again, if you have any questions, please utilize the Zoom Q&A feature, and we will do our best to answer them during the Q&A session.

So a little more information about each of those components. We'll start with the application process. Within that, you'll find information related to the application and submission, the application review processes, federal awards as they pertain to this particular model construct and your CMS contacts. The second section on model overview will provide detail on the model components, model eligibility, the payment methodology, model requirements, and importantly, the model timeline. And finally, the Notice of Funding Opportunity will provide detailed information related to federal award information and implementation. So that will cover award recipient information, the funding that will be available, and the model performance period. Next slide, please.

In the next slide, we'll discuss the various eligibility requirements for the AHEAD Model. Next slide, please.

All 50 US states, Washington DC, And US territories, which collectively we refer to as “states” will be eligible to apply to participate for the AHEAD Model. States may apply to participate at the state level or designate a sub-state region, subject to CMS approval. A sufficient number of Medicare fee-for-service beneficiaries must reside in the state or sub-state region in order for us to set accurate growth targets. CMS has determined this minimum number to be 10,000 fee-for-service beneficiaries. Those not eligible to participate in the AHEAD Model are states participating state-wide in the Making Care Primary Model. If Making Care Primary operates only in a particular region of a state, however, the state may apply to participate in AHEAD in a different sub-state region, as long as there is no geographic or provider overlap. Eligible applicants for the AHEAD Model are state agencies that have the authority to accept the Cooperative Agreement award funding, such as state medicaid agencies, state public health agencies, or state insurance agencies. Next slide, please, and I will hand it over to Jamie.

>>Jamie Atwood, CMS: Thank you. Hi, everyone. As you heard earlier, my name is Jamie Atwood from the Office of Acquisition and Grants Management. Today I'm going to walk you through the federal award information contained within the model, and later we'll dive into the application process and federal award administration processes. Next slide, please.

So, for the AHEAD program, the type of award issued will be a Cooperative Agreement. And this differs from a grant in that it requires substantial involvement between the federal awarding agency and the non-federal entity in carrying out the activity contemplated by the federal award. CMS anticipates awarding up to eight Cooperative Agreement awards of up to $12 million dollars each, pending the availability of funds. The amount of the award will depend upon the total budget proposed by the applicant in response to the NOFO, whether those costs are allowable and reasonable, and also the state's need for the funding, as demonstrated in the application submitted. The total available funds will have up to $96 million to support states, subject to the availability of funds. And, as previously stated by Laura, the State Medicaid Agency or other state agency, such as a state public health agency, or state insurance agency with the authority and capacity to accept the award, can be the recipient of this Cooperate Agreement award. Next slide, please.

The AHEAD Model will operate from 2024 through 2034 and includes two distinct periods, the Pre-Implementation Period and the Implementation Period. The model also uses another term to define the time period funded by this Cooperative Agreement, which is the Cooperative Agreement Period of Performance, which spans the Pre-Implementation Period, and includes some years in the Implementation Period. The anticipated Period of Performance for Cohorts 1, 2, and 3 are shown on this slide. To accommodate the different levels of readiness among potentially interested states, CMS will allow for states to choose their model timeline based on the level of readiness. States applying to the first NOFO period may select either a one-and-a-half-year Pre-Implementation Period, followed by nine performance years, or a two-and-a-half-year Pre-Implementation Period followed by eight performance years. States applying for the second deadline, for Cohort 3 will have a 2-year Pre-Implementation Period, followed by eight performance years. The model will end for all cohorts at the end of the year 2034. Next slide, please.

So all award recipients will receive an initial Cooperative Agreement award reflected as Budget Period 1 on the Notice of Award, followed by subsequent awards through a non-competing continuation

application process reflected as Budget Periods 2 through 5, or 2 through 6 on each respective Notice of Award. And please also note that Budget Period 1 begins at the start of the Pre-Implementation Period. You can review these tables in the NOFO as well. Next slide, please.

So now I'm going to be discussing the AHEAD application process. Next slide, please.

So this slide walks you through information you'll need for the application materials, the registration process and application due dates. All the application materials and registration information can be found at grants.gov. You can also see here for the application due dates. For a Letter of Intent for Cohort 1 and 2, for the first application, deadline is due February 5th, 2024. You want to submit applications to grants.gov for Cohort 1 and 2 by the deadline date of March 18th 2024. Next slide, please.

This slide here outlines important dates for applicants to be aware of. The first is the NOFO publication date, today. The Letter of Intent to apply due date, which is Monday, February 5th 2024 for Cohorts 1 and 2 and Friday July 26th 2024 for Cohort 3. The Cooperative Agreement applications are due Monday, March 18th 2024 at 3 PM Eastern Standard Time for Cohorts 1 and 2 and August 12th, 2024 for Cohort 3. The Notice of Award anticipated issuance date is around May 2024 for Cohort 1 and 2 and October 2024 for Cohort 3. Potential applicants can submit their Letters of Intent by email at the following email address AHEAD@CMS.HHS.gov. Next slide, please.

So the Authorized Organizational Representative must be the individual who submits the application on behalf of the organization. This individual must register with grants.gov to obtain a username and a password. In the chart below, you can see that there's several admission submission requirements that must be met in order for an agency to apply. You must have a valid EIN or TIN number, a Unique Entity Identifier. You must be registered in the system for award management. And please note that this is an annual registration process. So please make sure that your account is active when you apply. You must also have a login.gov account. The signature of the individual who submits the application will populate throughout the application. That individual must match the Authorized Organization Representative named on the SF424. Next slide, please.

So this slide here references the NOFO sections that you should be familiar with when submitting your application. Sections D and Appendix 2 walk you through instructions on how to submit a complete application. Specifically, Section D2 walks you through the font size, the formatting, the page limitations required forms and documents. And then Section E1 gives you the application review criteria and explains how the applications will be assessed. Next slide, please.

All applications must include the following standard forms. A project abstract summary. This is a one-page abstract that gives you a succinct description of the proposed project and includes the goals, the total budget, description of how the funds will be used, proposed geographic service area. The standard 424 Application for Federal Assistance, which is the form I previously mentioned. This is the form you use to apply for federal grants. It gives us identifying information about your agency, such as your UEI and your EIN. And again, that Authorize Organization Representative signs page 3 of this form. The SF424A is your budget information for non-construction. This is where you're outlining the total funds that you will need by budget period for the entire project, but also each year, and then by budget category. Please also note that our just instructions of how to apply and the appendix walk you through how to submit two separate 424A forms, because this project will be up to six years for Cohort 3, and up to five-and-a-half for Cohorts 1 and 2, you will submit two different SF424A forms so that we

can capture the exact amount that you're requesting by year for the full time period. So please make sure that you review those directions and comply. Next slide, please.

The SF-LLL is your disclosure of lobbying activities. This is a required form. Even if your agency does not lobby, you must fill out the form. You can insert non-applicable on the form in the appropriate areas, and you still need the AOR name, contact, information and signature. The Project Performance Site Location is also a required form, and lets us know where the model activities will take place. Next slide, please.

So the project narrative is a maximum of 60 pages, and this is the majority of where you will communicate the requirements of the application to CMS. Please refer to Section A4 program requirements and also D2 for everything that needs to be included in the project narrative. You also need to look at E1 criteria of how that project narrative will be assessed and evaluated by CMS. In the project narrative, you're going to detail your proposed goals, your objectives, your milestones, again following the instructions and content requirements that we've set out in the NOFO.

The budget narrative complements the standard 424A. This is a narrative that breaks down all the costs, you know, describes those costs more clearly, or itemizes those costs, consistent with the SF424A. So you want to include a clear description of the proposed set of services covered with the award funds. The maximum here is 15 pages. There's also a sample budget narrative in the NOFO.

The Business Assessment of Applicant Organization is something we're required to do by HHS Grant Regulation 45Cfr75. So, for Cooperative Agreements we must evaluate the risk posed by an applicant before we issue this award. So we're looking at financial stability, the quality of management systems, internal controls. So please make sure that you fill out the Business Assessment Applicant Organization. This is required for all applicants. Next slide, please.

The Negotiated Indirect Cost Rate Agreement is required if your agency has indirect costs and you're requesting indirect costs. This should be an up-to-date rate agreement. Please include that with your application. In the appendices here, you can see it's a maximum of 35 pages. This will detail in the NOFO which appendices are required and which are optional, which you can see on the screen here as well. So you want to make sure that you clearly follow that. Please also note that some of this information is requested in the project narrative, and it's also mentioned the appendices, and so the NOFO will tell you where you need to include that and if it's okay to put it all in the appendices. Please make sure you follow the directions, and it's at least included somewhere if it's a required document. And again, that's limited to 35 pages. Next slide, please.

If successful, applicants will receive a Notice of Award signed and dated by the Grants Management Officer. And this is the legal document authorizing the award, issued to the applicant and allows you to draw down funds. It's going to be issued through our grants management system, Grant Solutions. Any communication between CMS and the applicant prior to issuance of the Notice of Award is not an authorization to begin performance of a project. If unsuccessful, CMS will notify you within 30 days of the award date. Next slide, please.

So now I will be discussing federal award administration Next slide, please.

This gives you just a high-level overview of the process. So not going into too much depth here. But when the NOFO is published, this is the announcement process, and so you'll have the requisite time

period to put your application together and submit. Once that comes in at number 3, this application evaluation, if your application is eligible, then it will proceed to a merit review process. And after that, once we finish our internal evaluation of that application, there'll be a negotiation process where we may outline questions and concerns that will have to be resolved prior to issuing any award. If selected, you'll receive an award, there will be post award monitoring, and then close out. So again, this is the life cycle that will be followed for the awards. This just gives you a high-level overview. Next slide, please.

So, the sources cited below address regulatory and policy requirements which apply to federal grant Cooperative Agreement awards. This is the HHS grant regulation, 45 CFR Subpart 75 -Uniform Administrative Requirements Cost Principles and Audit Requirements for HHS Awards. You have the HHS Grants Policy Statement. And then there's SAM.gov that I referenced earlier. That includes information on your agency, exclusions for your agency if they're applicable, responsibility and qualification information which was previously FAPIIS, and then reps and starts, which is financial assistance. So please make sure that your agency is up to date with SAM.gov registration prior to submitting an application to CMS via grants.gov. Next slide, please.

Okay, and I'm going to turn it now over to Emily to cover post award milestone requirements.

>>Emily Moore, CMS: Thank you, Jamie. Next slide, please.

The NOFO describes program components, for example the creation of state targets, implementation of hospital global budgets, advanced primary care programs, multi-payer alignment and health equity. In addition, the NOFO includes operational milestones for the Pre-Implementation and Implementation Period related to these model components that will be required by the Cooperative Agreement, and to the extent applicable, will also be included in the State Agreement for the remainder of the model. These milestones are shared to provide applicants with an understanding of the model expectations, however, these may be subject to change by CMS and will be finalized in the Cooperative Agreement terms and conditions.

These milestones include, first, State Agreement negotiation and signature. The final milestone, execution of the State Agreement, will be due six month prior to Performance Year 1. The second is the creation and implementation of the All-Payer total cost of care and primary care investment target. The final milestone will be the creation of these All-Payer total cost of care and primary care investment targets or process to determine such a target via executive order, statute, or regulatory change, at minimum of 90 days prior to Performance Year 1. Finalization of the all-payer targets will be memorialized in an amended State Agreement at minimum 90 days prior to Performance Year 2.

The next milestone is recruitment of hospitals to participate in Medicare fee for-service hospital global budgets. This milestone is met by the execution of Hospital Participation Agreements between CMS and hospitals. More specifically, the final execution of Hospital Participation Agreements for hospitals, such that 10% of Medicare fee-for-service Net Patient Revenue, or NPR, would be under Medicare fee-for-service hospital global budgets for Performance Year 1. The agreements are signed 90 days in advance of Performance Year 1 and on a similar cadence moving forward. For Performance Year 3 and beyond the milestone is 30% of hospital net patient revenue.

The next milestone is implementation of a Medicaid primary care alternative payment model, or APM. The final milestone for this is the implementation of Medicaid primary care APM, with participation of primary care practices by Performance Year 1.

The next milestone is implementation of the Medicaid hospital global budgets. The final milestone for this will be implementing Medicaid hospital global budgets by the end of Performance Year 1.

And the final milestone is alignment of at least one commercial payer with hospital global budgets by Performance Year 2. This will be noted by the milestone. Specifically, participation with at least one commercial payer in hospital global budgets, by that time frame. More information on these milestones can be included in the NOFO and the appendix on this screen. Now we will move to the Q&A section of the webinar. Next slide please.

Before we dive into the Q&A, we would now like to take some time to further engage with you all. Please respond to the live poll using the Zoom platform. Our question for you is: Which NOFO application do you intend to apply to? I will give another minute or so to respond before we show the results.

Apologies, we're working on getting the poll set up for you all. Please stay with us. Alright, let's move on and come back to this. I'm sure you all might want to hear more about your questions before maybe answering that question. So, it might be a silver lining there.

Please feel free to share any questions we have in the Q&A pod on the right of your screen. We recognize that many of you have submitted during the presentation and thank you for that. We are trying to answer them or will answer them live. As reminder, due to the high volume of attendance, we may not be able to get to every question. We will take note of each question and try to ensure that future materials help to address common themes. You're also welcome to submit additional questions for the AHEAD Model help desk at AHEAD@cms.hhs.gov. Next slide, please.

Alright, this is a frequently asked question, so we'll dive in here. So how are state selected to participate in the AHEAD Model? As you know, we just released our Notice of Funding Opportunity. We're super excited about that. And you must apply, any state that is interested in participating must apply during the NOFO period. You'll hear, heard that there are two NOFO periods. And there is a competitive application process which does include a merit review of all applications. The merit review panel will score applications using the detailed rubric which is available in the NOFO. So interested states can submit a letter, an optional letter of interest, intent to express their interest in implying These are due at least 45 days before the NOFO applications are due. Hope that one helps. Alright, next one. Next slide, please.

Alright. There's another frequently asked question. How can Cooperative Agreement funding be used? As you heard, states selected to participate in the model, receive up to 12 million dollars in Cooperative Agreement funding. The parameters around how these funds can be used are included in the NOFO. Generally, funding is intended to support model planning and implementation activities, which include but are not limited to these on the slide. So thinking about primary care, statewide total cost of care growth targets, building behavioral health infrastructure capacity, hiring new staff to support the model, and helping with data collection, and the like. So, encourage you to think through how you might use those funds in the application. As a reminder, CMS reviews all budget narratives submitted in the applications to ensure alignment with HHS grant guidelines on the use of federal

funds, more information on the prohibited use of federal funds is included in the NOFO. Next slide, please.

Thanks. Another great question that we've received is: What are CMS's expectations for participating states to demonstrate funding sustainability? This author likely knows that the Cooperative Agreement is only available for the initial years of the model, for the first six years for Cohort 3 and the first 5 and a half years for Cohort 1 and 2. So the NOFO does ask for a detailed sustainability plan as part of the budget narrative in your applications. CMS recommends that states consider strategies to sustain funding and model activities throughout the Implementation Period. So this is an opportunity for states to think ahead about how do they implement the model after the Cooperative Agreement ends. Next slide, please.

Alright, so this relates to the Primary Care AHEAD program. So how do I know whether my Medicaid program has an APM that qualifies, what information should I include in the application about my current or proposed program? So more information on this is in the NOFO, which is likely going to be a refrain for us in the Q&A section of this webinar. However, briefly, the primary care APM can be a Patient-Center Medical Home or another program that focuses on enhanced care coordination services, including behavioral health integration and health-related social needs interventions. It should focus on the delivery of whole-person, team-based primary care services. CMS does plan to allow for some variation between these state and Medicaid primary care APMs and PCMH programs and has designed Primary Care AHEAD to be tailored to the specific care transformation priorities of the state. So, more information on the application recommendations are in the NOFO, but you see a few of them here in terms of describing the current efforts. Next slide, please.

Thanks. The next question relates to the Medicaid hospital global budgets. What level of detail is needed to describe the state regulatory changes, federal flexibilities, or waiver authorities required to implement hospital global budgets for Medicaid? Applicants will need to describe the state's capacity to develop and implement Medicaid global budgets by the end of the Performance Year 1. This would include the proposed authority or mechanism for making payments and considerations of the state's unique Medicaid context. Please see the NOFO for more information, and we have an entire appendix dedicated to this topic and the associated model milestones.

Alright. Well now turn to some of the questions we've received live and in the model registration.

Alright. One of the questions we just received: Our organization hopes to learn about the technical definition of primary care spending that will be used by AHEAD participants. Now this relates to the state Medicare fee-for-service primary care investment targets and the All-Payer primary care investment targets that are included as a component of the model. So first, thank you for this question. Additional technical specifications on the primary care spending definition will be released in the coming weeks on the AHEAD website. So while the NOFO does describe the expectations around primary care targets, it does not include sort of the very exact codes, specialty type etc. So we will be making that available in the coming weeks.

Alright, we also got another question about Advanced APM status question for MIPS, which is the Merit Incentive Payment. Alright, no more acronym quizzes for me today. Alright, getting into it. So, CMS is still determining AAPM status for AHEAD Model components. It is not anticipated that the current Primary Care AHEAD program will be an Advanced APM, although CMS is planning for additional tracks, which may qualify in the future. So hope that answers that question.

Alright, next up, ACO overlaps. So let's dive in here. We've gotten questions about the Medicare Shared Savings Program overlaps for both our hospital global budgets and the Primary Care AHEAD program. And so, it is our intent that SSP ACO providers can participate in Primary Care AHEAD and hospital global budgets. So we will allow for overlap there and more detail in those overlaps be available in the coming weeks.

Next up, ACO REACH overlaps. So here's a little bit more detail on this. Primary Care AHEAD providers can participate in ACO REACH. Professionals at hospitals can participate in ACO REACH. However, we do not anticipate that hospital facilities will be able to participate in both hospital global budgets and ACO REACH. Of note, ACO REACH in the AHEAD hospital budgets will only overlap for 2026 as the ACO REACH Model currently runs through December 2026. Of course, there may be changes there. I don't know, I'm not on that team, but just wanted to sort of flag that timeline for you all.

Alright, next up. What is the role of an ACO? How will data be shared? I have concerns that AHEAD is not a provider-led program. Thanks for that question. We do believe that states have unique opportunities to take charge of population health in their state, and that's in part what our model is premised on. We believe that in collaboration with providers, states can work together on care transformation and quality improvement. That said, the AHEAD Model is not an ACO model. ACOs are not direct participants in the model. However, the AHEAD team believes that ACOs can be an important and optional tool to achieving the state targets within AHEAD, and therefore seek to allow overlaps as much as possible. CMS will share data with participating AHEAD states, hospitals, and primary care providers. And states can work with other entities on quality improvement and data sharing within data privacy laws and protections. The model government structure will include provider representation as well. So thanks for that question.

Alright. What is the, alright, next one. How do you define safety net providers, small practices, independent providers, etc.? So you heard, likely, on our overview webinar that we're committed to increasing safety net provider participation in CMMI models and in the AHEAD Model specifically. The definition for hospitals will be available in the hospital methodology guidelines that will be released in early 2024. The NOFO does include an overview of our methodology, but for those policy wonks or finance analysts, it might not have as much information as you may want. We will be sharing more information in early 2024 and the definition will be included in that methodology. So we do anticipate that Critical Access Hospitals, FQHCs and RHCs would be definitely be included, although again, it is a hospital global budget methodology, so cost would be the only one apply applicable for that.

Right, alright. This next question is about how will primary care providers participate and how will AHEAD interact with other models, REACH, GUIDE, MSSP, and bundled payment. So, I've already addressed both REACH and SSP. But for GUIDE and bundle payments, let's talk about it. So, primary care providers can still serve as partners in coordinating care with specialists and others under the bundled payment programs. CMS is optimistic that overlap with the GUIDE model will be permitted, but we are currently finalizing our policy. So stay tuned for more.

Alright, next up. What exactly would need to be addressed by state legislation or executive order for participation? So more information on that is in the NOFO. But just to give you a quick preview, each award recipient will be accountable for meeting a target for an All-Payer total cost of care growth, and then All-Payer primary care investment target, which both comprise of Medicare, Medicaid,

commercial payers on an annual basis. For all award recipients, All-Payer cost growth and primary care investment targets must be memorialized in state executive order, statute, or regulatory change, 90 days before the start of PY 1. So that deadline is a bit new and is included in the NOFO. And these targets must be sustained throughout the duration of the Implementation Period. Okay, so you might be nervous about 90 days before the start of PY 1 sounds incredibly soon, especially for those that are, they're considering Cohort 1. As a result, we are allowing states to find the actual specific numeric target before the start of PY 2, so 90 days before PY 2, which is what you heard described in our operational milestones. So these state targets are memorialized after the signing of that State Agreement. We will then amend the city agreement to include that number. So hope that gives a bit more context in terms of how the phasing of that milestone is.

Alright, next question. How can vendors get involved to impact the outcomes of the AHEAD Model? So, you know, we have vendors at CMS to help us implement the model. But beyond that, there, you can reach out to state partners to see if you can provide support with state activities or with providers. So that is something that CMS is not involved with and, you know, encourages those who are interested in the model engaging with those in your state.

Alright. What information is still coming? For example, the global budget methodology. So, you just heard me share that we will be sharing more about the methodology in early 2024. The overview is provided in the current NOFO. We do ask that if you have more questions about the methodologies that you'd like to hear, let us know and we can make sure to try to include that in any type of methodology document.

Alright. One registrant asked for an update on which states would be participating, if possible. So, we don't know. The application is open and I'm excited to see the range of state applications that we might receive. So if you are interested in whether your state is applying, we encourage you to get in touch with your state agency and policy makers at this juncture.

Alright, another question that we received. What elements of the AHEAD Model will support pediatric practices with low Medicare patients, and which elements include state flexibility? Great question. So Primary Care AHEAD is the payment program for Medicare fee-for-service. But, as you heard, we are looking to align Primary Care AHEAD with the states Advanced Primary Care APM. So, Primary Care AHEAD does accommodate small Medicare practices. We do not have a minimum beneficiary count. In addition, this practice, a pediatric focus practice, can still participate in a Medicaid APM depending on your state program. So, I think that might be state specific.

Alright, next question. How will the model work for AMCs? How will CMMI ensure that hospitals under AHEAD don't gain the system and drive care to another hospital. Like other hospitals, academic medical centers are eligible to participate in the AHEAD Models Medicare hospital global budgets. Any participating hospital must be a Medicare enrolled facility in good standing with CMS located in a participating state or sub-state region. I'm assuming that an academic medical center in this question does qualify for that but let's continue. CMMI designed the AHEAD methodology for Medicare fee-for-services global budgets to account for the unique care delivered by academic medical centers, including consideration for high cost drugs and novel therapies. The end model includes multiple processes to ensure that hospitals and health systems are not driving care elsewhere to take advantage of model payment and policies. This is in part both in the methodology design and will be through our monitoring program. So for example, the CMS designed Medicare hospital global budget methodology includes the market shift adjustment to capture revenue shifts between market hospitals

and markets and service lines. This adjustment accounts for patients that might seek care elsewhere and supports hospitals through unplanned volume changes. Additionally, hospitals will continue to submit Medicare fee-for-service inpatient and outpatient claims and Medicare hospital cost reports to CMS, as they normally would. And will we use that for monitoring quality measurement purposes and to calculate expenditures for the purposes of shared savings programs or other payment models as well as performance metrics. CNS may recoup any overpayments for the Medicare fee-for-service portion of the global budgets that CMS may make for the any reasons by adjusting future payments. So, hope that helps, and more information can be in the methodology.

Alright. What ways can funds be available for health-related social needs? I'm assuming that the author is thinking through our model's focus on health equity. So I think you heard earlier in their questions, funds available in the Corporate Agreement can be used if they are in line with the model goals and activities. The NOFO includes information like what funds cannot be used for, I should say. But applicants still need to describe and provide justification for the use of funds in their budget narrative. Funds can be used for addressing health equity and health-related social needs if they meet this criteria.

Alright, for statewide quality and equity targets, the slides from an early presentation reference states selecting from a core set of measures. What are these measures? Great question. These measures are in the NOFO, but let me talk to you a bit more about them. So the NOFO includes the proposed core measure set and ideas for optional measures. These measures are still subject to change, however, the current set should give applicants a sense of the types of quality measures and domains that will be included in the model. So take a look, let us know. And if there are any questions about the measures, we can certainly answer more of them.

Alright. On the primary care investment targets, how do you intend to express that, as a percentage of the total cost of care, a dollar, or rate of growth amount? The target anticipated for be for Medicare fee-for-service, Medicaid, and all commercial payers or are the requirements to ensure investment focuses on populations historic access barriers. Another great question. We expect that this will be expressed as a percentage of total cost of care for the Medicare fee-for-service target. States will also be asked to have an all-payer target like I spoke of earlier. However, states have more flexibility in all-payer targets and how are they expressed.

Alright. Regarding Medicaid integration into Primary Care AHEAD, how do you intend payments to practices to invest in infrastructure for care coordination, behavioral health, and community health workers to interact? Do they overlap, replace, or enhance the payments that Medicaid and MCOs receive to provide similar services? Alright, you can tell somebody's really digging into their details here. That's great. So the Enhanced Primary Care Payment is a Medicare payment, Medicare fee-for-service payment, I should be more specific, and does not replace or mitigate Medicaid patients, payments for similar services either under managed care or fee-for-service context. State Medicaid agencies are expected to invest in and deliver care transformation activities and enhance primary care investments to maximize primary care alignment with Primary Care AHEAD program. So again, our goal is that the payments that Medicaid might make to support and enhance care coordination can be aligned with payments that Medicare makes in terms of care transformation as well. So they do not replace each other but should be working together for the overall goals of taking care of your patients.

Alright. Next question. Is there an allocation of seats for each cohort? Alright, the total anticipated number of awards across all three cohorts is eight. That's our special number. However, CMS will make awards of up to five applicants for Cohorts 1 and 2 and reserve a minimum of three award blocks for Cohort 3. If less than five awards are made for Cohorts 1 and 2, then the number of awards in Cohort 3 will increase to allow us to get to our magic number of the total of eight awards. The number of awards issued for each of the cohorts is not guaranteed, and will also depend upon the number and the quality of applications. So I hope that gives more context to that.

Alright. I think I have another one. What are the examples of the required and optional activities to support behavioral health integration? Alright, the NOFO describes opportunities to describe behavioral health integration activates within states and Medicaid primary care APM, but does not specific, does not specify requirements. More information on care integration requirements for Primary Care AHEAD will be available during the Pre-Implementation stage of the model and CMS and is considering additional provider information being available in early 2024.

Alright, great question. Alright, 12 million dollars seems low. Am I missing something? Alright, I want to clarify first that this does not cover provider payments. So our primary care investments through the Primary Care AHEAD program, which is $17 PBPM is not included in that 12 million dollars. So that might help alleviate some concerns there. But I want to speak to the, another question in terms of, will this be enough to do all the activities for the state, work with partners and the like? And I think our perspective is that the Cooperative Agreement dollars are intended to help with startup funds, implementation during the early years of the model. But it's not intended to replace all of the funds that a state might need for the model duration. However, it should be, our hope is that it should set them off on a great direction and again this speaks to our inclusion of a sustainability plan for after the Cooperative Agreement. So hope that both clarifies and provides more context on the funding amounts.

Alright, how flexible can states be in setting health reform goals, for example, on mental health and SUD? That's a great question. So states, you know, our model goals are really around improving health quality, addressing health disparities, and addressing the cost of care to allow for better care for patients and consumers. So generally, we include a number of focuses in our state quality measures, but really will allow states to focus on the types of goals that are most salient for their state context. So for example, states will be developing state health equity plans, they can include goals related to population health, quality costs in those to support quality improvement and address health equity. So states have a lot of flexibility on these areas. And again, that's one of the goals of this model is to provide a framework that states can use, but allows states to really customize their activities to their unique population. So I hope that helps.

Right. When will we provide more detail on ACO overlaps? That is a very active area of policy work. We have team members working on that a lot and so we're hoping within the next few weeks, but if not, at latest by early 2024. Hope that helps.

Alright, next question. How will CMMI utilize beneficiary and provider perspectives for the selection of specific PROMs in the AHEAD Model? And then, will states have the ability to select their own PROMs beyond CAHPS. So, what you have here in the NOFO is our statewide quality measures, our suggested primary care measures, as well as measures for our hospital, Critical Access Hospital quality program. And so in that statewide quality measure set, we do include a measure around healthy days, but states can select additional PROMs that they might like to report as part of their optional measures. So hope

that answers that question. And then on the provider level, you know, Medicare is working, has the ability to adjust some of the quality measures and the Primary Care AHEAD program to align with what Medicaid may do in the Primary Care AHEAD program. So, states may consider a PROM measure there as well.

Alright. How does the AHEAD Model build on the AHC model? Well, we have certainly come a long way since the Accountable Health Communities model happened. You know, it's, social determines of health, health-related social needs are certainly more part of our conversation, both at the policy and provider stage. And so I do believe that model created a culture shift that we're really learning from and taking a lot of the lessons learned from. You'll see that in our care transformation requirements for Primary Care AHEAD, we have included addressing health-related social needs as one of the main care transformation requirement domains. And we've thought through how hospitals, and included expectations that hospitals also use some type of social needs screening tool as well. So I think just having, thinking more about screening referral as part of the care delivery process is it one of the main contributions of the Accountable Health Communities model. In addition, the AHC model also talks about, or sort of considered community collaboration to make sure that the resource for available to actually not only to identify social needs, but also works forward to, you know, community-based organizations, other social services that are available. So, you know, states can build on some of those lessons and think through what might be needed to support providers and community organizations in their statewide health equity improvement, their statewide health equity plan. So definitely a lot of great lessons learned and we, I'm continuing to be excited about the research that comes out the AHC model and incorporating it into our policymaking.

Great. So another question that we have is around a requirement that, for primary care practices, if they are system-owned, their hospital must also participate in global budgets. So that is intended for us to make sure that we think through primary care investment and hospital global budgets together. However, we do have an exception for Rural Health Clinics and Federally Qualified Health Centers given their safety net provider status, from that requirement. So, if a system-owned Rural Health Clinic is interested in participating in the Primary Care AHEAD program, but their hospital is not, they can still participate. So we did make special consideration of that.

Alright, another one. Is hospital participation mandatory? So, it is not mandatory. That is the bottom line up front. But we are hopeful that states will actively recruit hospitals in either statewide or in their sub-state region. You'll see in the Notice of Funding Opportunity, we have specific targets for states in terms of hospital participation. We are expecting that states to recruit hospitals such that 10% of their hospital net patient revenue is under a global budget for Performance Year 3, and that target is 30% for performance, 10% for PY 1, 30% for PY 3, my apologies. So again, while it is not mandatory, we encourage that states consider opportunity to meet that robust participation.

Alright. Is there a sense of how social service and behavioral health providers may benefit from telehealth under the model to address health provider shortages? Yeah, that's a great question. So this, the AHEAD Model will include telehealth waivers so that partners of participating providers can use telehealth leavers. We recognize that after the pandemic, a number of flexibilities have been offered to providers, but to the extent that there are still potential restrictions on telehealth access or service use, that is an opportunity for us under the model. So we do think that this is a helpful tool to address for health provider shortages, but states can also take additional opportunities to address them while recognizing that it is a really challenging need.

Alright, when will the capitated program be developed? So that is a great question. We do not anticipate that this will be available for 2026. We are working towards, potentially, 2027, which for Cohort 2 and 3 will be the first year of implementation. So we do anticipate that'll be available in the early years of the model, but are still working through those details. So, more to come and we will be certainly learning from lessons learned from other capitated or partially capitated primary care tracks.

Alright, do we have to exit SSP if the state joins AHEAD? No, you do not have to exit SSP. Certainly, you know, as I, as you heard me share earlier, practices participating, primary care practices and hospitals participating in SSP can still participate in SSP under the AHEAD Model as well participating in the AHEAD Model program components, the Primary Care AHEAD preprogram and the hospital global budget. Hope that answers that.

Alright, let's see if any other questions. How will the Medicare budget model adjust for the growth of the Medicare Advantage penetration? That was a great question. So from, so we do anticipate that the Medicare fee-for-service total cost of care targets will need to consider the shift that we might be seeing in some markets towards Medicare Advantage. So we will we will be considering opportunities in that negotiation to talk about that, and it will also be based on the attributed beneficiaries. So I do think our methodology can accommodate that, but it is certainly something that is on our mind.

So we are at the five-minute mark. A lot happens when you're having fun in policy. So, let's try to capture that poll before we close. So, hoped that helped answer your questions. We certainly can continue the conversation. But just thank you for your interest.

Alright, let's try this again. To which NOFO application do you intend to apply? So we'll just pull it up. Alright, thirty more seconds. We should have some Jeopardy music in the background or something for our next webinar. Okay, let's move on. Thank you for those who responded. We certainly are interested in interest. Next slide, please.

Alright, so thank you again for joining our webinar. Please feel free to continue the questions and send them coming through the AHEAD@cms.hhs.gov mailbox. We welcome your questions and look, will certainly consider themes and questions for future updates for FAQs. I also encourage you to consider staying in touch with us on the AHEAD webpage for more information and model announcements and future AHEAD events. We will be having office hours in the coming months during the application period. So stay tuned for that.

We, as I mentioned, encourage you to reach out to us at AHEAD@cms.hhs.gov. But in the meantime, I will leave you with 127 pages of great policy reading. And so we look forward to hearing more from you all as you have a chance to read and get up to speed on our model policy.

Again, thank you for your interest in joining today and we look forward to continuing the conversation. I've often been told to plug the CMS Twitter or X at CMS@Innovate. And so, you know, if we want to stay more in touch with CMMI, we do have our CMMI listserv as well.

So, thank you. This concludes our webinar. I hope you have a great rest of your day.

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