**States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Overview Webinar**

**9/18/2023**

**>> Emily Moore, CMS:** Good afternoon, and thank you for joining us. I'm excited to have you join today's webinar that will provide an overview of the State's Advancing All-Payer Health Equity Approaches and Development Model, also known as the AHEAD Model.

There are 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'll be selecting questions for future events and FAQs. You can also reach out to our help desk at AHEAD@cms.hhs.gov.

We'd also 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.

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Before we dive into the content let me give you a brief overview of what you can expect. We will begin with a welcome from John Blum and other CMS leadership to open the webinar.

Next the model team myself. Hi! I'm Emily Moore, the Model lead for this model. I will provide a basic overview of the AHEAD Model goals. Following that, we will share more information on the Model Statewide Targets, the Primary Care AHEAD Program, our use of the Hospital Global Budgets, Model Strategies, and then, finally, the application timeline and process to receive the Cooperative Agreement funding for this model. You will then turn to a Q&A session where our team will answer your questions submitted in the chat 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 information to share today and are excited to get going.

Now, I'm going to pass the mic to John Blum to formally welcome you to today's event.

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>> **John Blum, CMS:** Well, thank you, Emily. And first and foremost, thank the nearly 700 people that have joined us today, so far. It's a really phenomenal showing to see how many people are so excited for this new model.

I want to also thank Liz Fowler and her team for putting together this very thoughtful work and new model concept.

The team here is tremendously excited for us to think about this next phase for - really a fundamental change, for how CMS thinks, and for how CMS operates going forward. And 2 points just to raise here for this call, then I'll turn it over to Liz.

First is, as CMS thinks about our programs, and we think about the populations that we serve, that most people through time will touch many different CMS programs.

And folks know on this phone call that most people change programs, they change payers, they change delivery systems. So, any one model that is just tied to Medicare, that is just tied to Medicaid, that is just tied to private insurance, will never achieve the full potential for true transformation.

So, our team has worked really hard in the last couple of years to really think about what it means for us to work in much closer partnership with states, much closer partnership with private payers, with much closer partnership with healthcare delivery systems. So, one way to think about this new model is - that really represents how CMS wants to think, how CMS wants to work, going forward. To think much more systematically, think much more holistically, for how we think about care transition. So that's point number one.

And point number 2 that we think about often here, is how much disruption there was during the past several years while our country suffered during the COVID pandemic. And what I think we will discover, we look back and really detail what happened, is that those systems, those care systems that had more surety to their finances, that had more predictability, were those that were much faster to adjust and to adapt to the new realities that came from COVID.

The one thing that we want to do going forward here at CMS is that we support better that we had in the past those healthcare delivery systems that want to think about transformation- not only to create better business models, not only to create better healthcare outcomes, but to really think about how we have much more resilient healthcare systems going forward. So, another way for us to think about this new model is that it's going to help support local healthcare transformations to better plan, to better finance, and to better work together, to think about how we avoid what happened to our country during the past 3 and a half years or so.

So, those 2 points is what I think about. There is surely going to be questions about the financial model. There is surely going to be questions about, does this deal work for different parts of the country, different healthcare systems?

And while those questions are very valid. Those questions are very important. What I hope we talk more about than just the overall financial deal is, will it help support true health care, transformation, delivery change that will affect people changing programs, changing healthcare delivery systems through time, and will it really help us build much more resilient healthcare systems for the future? So, we can have better planning, better predictability, better financial structures that will really help healthcare systems change and adapt to whatever circumstance they will face in the future.

So, couldn't be more excited to be here. Really want to congratulate the CMS team that has put so much work, so much energy, so much conversation to take us this far. And now comes the really hard part to build participation, stand the model up, and celebrate the results that we'll see during the next 5, 10 years.

So, with that, we'll turn it over to Liz and thank you everyone for joining us today.

>> **Liz Fowler, CMS:** Thank you so much, John, for joining us this afternoon, and for your leadership at CMS as our Principal Deputy Administrator, and also for your support of this new model.

Briefly, I'd like to share a bit about the CMS Innovation Center on our Strategy Refresh. As this model closely ties to our strategic priorities.

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Some of you may be familiar with the statutory authority that created the Innovation Center. In short, our purpose is to test innovative payment and service delivery models. And since our inception in 2010, we've implemented over 50 alternative payment models and demonstrations that test innovative strategies aiming to improve the quality of care and lower costs.

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In the fall of 2021, we released a white paper on our renewed vision to build a health system that achieves equitable outcomes through high quality, affordable, person-centered care.

To realize this vision, we laid out 5 strategic objectives. I'll just go through them briefly. The first is, drive accountable care that promotes delivery of whole person integrated care. We set a goal for every Medicare beneficiary and the vast majority of Medicaid beneficiaries to be in an accountable care relationship by 2030, where a provider through an ACO, or advanced primary care practice, is responsible for total cost of care and quality.

Second, advance health equity. We committed to embedding equity into all aspects of our models from design through evaluation, including a focus on engaging safety net and rural providers that care for underserved populations. It also includes data collection, including social drivers of health.

Third, support innovation that enables the delivery of person-centered, integrated care. Model participants, providers, organizations, they need tools, data, resources, and flexibilities to deliver care that is consistent with people's goals and preferences.

Affordability. Our statute directs us to focus on program savings, and of course we remain committed to that goal. But we also want to address affordability for the people that we serve.

And finally, partner to achieve health system transformation. Medicare/CMS can't do this alone. We need to collaborate with other payers, including states, commercial insurers, and employers.

The development of the AHEAD Model is directly related to our strategic vision, and our hope is that you can see how this model aligns with each of these priorities.

AHEAD is a multi-state model that aims to curb rising health care cost growth, improve population, health and health outcomes, and address health disparities.

As John mentioned, the model proposes a significant restructure of the health system spending across all payers in a state or region with increased investments in the types of care better correlated with

improved population health and health equity, which are offset by reductions in spending and utilization in other areas to constrain total cost of care growth.

We've been developing AHEAD for several years now, and we're so excited to finally be at this point.

AHEAD is a very ambitious model in its design and it combines elements and lessons learned from multiple previous CMMI models, including the Vermont All-payer ACO model, the Maryland Total Cost of Care Model, and the Pennsylvania Rural Healthcare Model.

We're excited to offer a multi-state model that will increase impact and scope of these approaches and strategies, and ultimately the number of people who can benefit through better, more person-centered care that improves quality and health outcomes.

AHEAD's total cost of care approach offers an opportunity to expand accountable care through statewide accountability for quality and costs through Hospital Global Budgets and primary care efforts. The model also features, as I mentioned, multi pay alignment with a specific focus on alignment with Medicaid on statewide targets and provider alternative payment models. And worth noting that while the model aims to directionally align payers across states or a region, it's designed to be flexible enough to meet states where they are and support ongoing transformation efforts.

The team is going to share more detail, and so, I'm getting ready to hand it over to them. But it's very ambitious, as you'll learn, and will require real strong partnerships between CMS and states, as well as providers, payers, and community organizations.

We welcome all of you also to be part of this transformation journey. We believe this will be key to advancing our vision of whole health system transformation and transformation sustainability.

And speaking of Federal partners, I'm now going to turn it over to Dan Tsai, who leads the Center for Medicaid and CHIP Services to share more about Medicaid alignment in this model, Dan.

**>> Dan Tsai, CMS:** Thanks, Liz, and thanks, Jon. I'll just say a few pieces briefly before turning it back over to the team.

I think you've heard from Liz, from Jon, from the Administrator, how committed we are to trying to make all the efforts of CMMI and the Innovation Center inclusive and focus also on the safety net, and the individuals that we cover and provide care for within the Medicare and CHIP programs— kids and a whole range of others. And that is a firm commitment. It's also really difficult. And that's part of what we have been working through in earnest with the AHEAD Model.

There are few things that I just wanted to note that are really important from a Medicaid standpoint, and where the states are.

One, the whole discussion around moving away from fragmented care to something that is much more person-centered, to something that really advances population health, we want that as equally and fervently for our Medicated enrollees. And we don't want Medicaid to be excluded or left behind when we think about delivery system models. So, finding a way to really align Medicaid alongside other payer models here is a really, really important piece.

And that also includes thinking about, to the extent of all this – for any of this to really succeed, I think we firmly believe you need a very strong state localized approach here. Around the buyers, models, the

intersections with how things are designed, and that's also nowhere more true than thinking about how a state and a Medicaid agency addresses kids, for example.

So, we're really excited that part of the focus here of states, really, partnering is to think about the entire delivery system context, state level and what State Medicaid Agency and state officials can really help drive. So, a lot of that thinking is embedded into the AHEAD Model piece, as well as our emphasis and the importance of primary care alike.

The last thing I just wanted to note, when it comes to total cost of care and what the budgets are, and bending the cost curve, all of that is true also for Medicaid when we think about avoidable hospitalizations and things of that sort.

We also want to be clear that we, as an Administration, have been really trying to emphasize sufficient and equitable reimbursement and rates for Medicaid that really helps ensure a network of providers that's more a parity.

So, to the extent states are making investments in underlying rates to ensure access, those are the types of things that will be adjusted and accounted for in the total cost of care and global budget pieces. Really, so that you know, there's an incentive, there's not a penalty for states really investing more in Medicaid rates.

So those are a few pieces, I think we're quite excited to partner together, and we know a lot of states have great interest and appreciate it to Liz and team for all the work on this.

So, I think with that, I'm passing it over to the team. Thanks, thanks, everybody.

**>> Emily Moore, CMS:** Thank you, Dan. Appreciate your words as well as those from Jon Blum and Liz Fowler. We appreciate our leadership support and excitement about this model.

Good afternoon again. My name is Emily Moore, and I will be taking you through our model overview on behalf of our dedicated model team here at the Innovation Center.

As you heard in the model overview, slides and recordings will be shared in advance. And so, I just want to re-articulate that because I know we're about to jump into many details. We also have a fact sheet other resources available on the model website, and we'll be continuing to add to this over the coming months. So please take a look at that, and also subscribe to our listserv if you're interested in more information.

I want to go to the next slide and share that we want to make sure that today's webinar is an engaging one. And so, we will have multiple opportunities for you to provide us feedback and insight. So here is just one first poll question to get a sense of who from the over 800 folks on this line, who do you represent? Take a moment and vote, that'd be great.

Alright. Well, thank you. We'll turn to the next polling question.

For the next polling question, we are using a more interactive platform that will allow you to participate using your phone or computer browser. Your responses to the poll will be anonymous. Please join our PollEverywhere activity by scanning the QR code on your screen with your phone or mobile device. The link to the poll has been included in the chat. So, you can easily participate using your computer browser if you prefer that method. I'll give you a few moments to join before moving on.

Fabulous. It's great to see the green dots continue to pop up on the screen and have such a diverse representation from where folks are joining today, we'll let folks continue, but this is awesome.

Thank you so much, everyone for participating. It's exciting to see where everyone is joining us from today. Thanks again for taking the time out of what I'm sure is a busy day on a Monday to be here for this event.

Next slide, please.

As you heard from our CMS Leadership, we are excited to have announced the State's Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model. I will be referring to it as the AHEAD Model for brevity moving forward, but just wanted to share again the full model title.

At the highest level, the CMS goal in the AHEAD Model is a partner with states to improve population, health, advance, health equity, and curb healthcare cost growth.

CMS will work with states to implement different model components to achieve these goals. We recognize that these goals are broad and ambitious but, are hopeful that the longer pre-implementation and performance period will allow CMS and states to achieve meaningful transformation and to see its impact.

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As you heard from our Center Director Liz Fowler, about the Innovation Center Strategic Refresh, it has had a direct impact on the design of this model. The CMMI Strategic Refresh specifically identifies state total cost of care identified state total cost of care models as a path to increase the number of Medicare fee-for-service and Medicaid beneficiaries and accountable care relationships to support advancing health equity and promoting health system partnerships for transformation.

The Innovation Center has integrated lessons learned from many of our single state models, mainly Maryland, Vermont, and Pennsylvania into the AHEAD Model. By doing so, we can test these concepts in other states and increase impact of these interventions to additional beneficiaries.

State total cost of care models hold participating states accountable for quality and population health outcomes, while concerning costs of healthcare services delivered in a state or a specific sub-state region across all healthcare payers, including Medicare, Medicaid and private insurers and plans.

States are often described as the laboratories of democracy, but in the context of the AHEAD Model, we believe that they are uniquely positioned to advance accountable care, population health, and health equity.

We recognize that many states are already pursuing transformation efforts or building coalitions to address the needs of their residents. States can also align policies across programs, and for payers and providers within their state lines.

States also have established stakeholder relationships with local communities and organizations that are essential, particularly when considering population health and health equity connections.

Through a clear framework that can be adopted to the unique state context, the Innovation Center can support states in implementing state total cost of care models.

Next slide, please.

I'll now take you through that flexible framework under the AHEAD Model which can be used in multiple states.

On the last slide, I spoke about the how state total cost of care state total cost of care models include accountability. You'll see that represented in this top yellow box. Under AHEAD, states will be asked to meet targets for Medicare fee-for-service, and across all payers. Namely for total cost of care, primary care investment and statewide equity and population health outcomes

Underneath, you'll see the different components to help states meet these targets. The first is Cooperative Agreement funding for participating states to help implement the model. The second are Hospital Global Budgets for facility services that provide that stable perspective payments to help incentivize care management and population health activities.

The third component is Primary Care AHEAD, the primary care program for Medicare fee-for-service that will help CMS meet our goals around primary care investment and provide funding for enhanced care management activities and person-centered care.

You'll hear later on in this presentation about the design of this program, this intended deadline with Medicaid primary care transformation.

On the bottom, you can see the cross-cutting strategies are in this model. Health equity, multi-payer alignment, a focus on Medicaid alignment, and as well as behavioral health integration have been considered throughout this model.

And finally, as you've heard earlier, we are hoping to accelerate existing state innovations.

These model components work to meet the model goals of curbing healthcare cost growth, improving population health and advancing health equity by reducing disparities in health outcomes.

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We recognize that the AHEAD Model is ambitious and will require significant commitments from states to participate.

That said, we believe that there are several key benefits to participating in this model.

The first being, an opportunity to address the challenges facing this healthcare system, which we know states are focused on as well.

The second is funding to support states in implementing this model, and health transformation. Up to $12 million will be available for up to 8 states.

The third is increased investment into primary care and alignment with Medicaid primary care efforts.

The fourth is multi- payer alignment with Medicare Fee-for-Service and Medicaid at the table, alongside commercial payers who share model goals.

Finally, optional waivers will be offered in this model for providers to test new flexibility, to provide care and care transformation. Collectively these benefits provide participating states the ability to address health equity, improve population health, and align payers to achieve more sustainable cost growth.

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All 50 states, territories, and Washington, D.C., Collectively known as states, will be eligible to apply to participate in AHEAD. States may apply to participate at the state level or designate a sub-state region subject to CMS approval.

Of note, states or sub-state regions that are participating in another CMMI model, Making Care Primary are ineligible to apply to avoid model overlap. A sufficient number of Medicare fee-for-service beneficiaries must reside in the state or sub-state region in order to set accurate growth targets.

CMS is determined that this minimum number be 10,000 beneficiaries. Base will be selected through a competitive application process. More information will be included in the Notice of Funding Opportunity released later this fall.

Next slide, please.
In addition to states, there are a number of eligible participants and partners in this model, including Hospitals, Primary Care Practice, Payers, and other partners.

As Liz mentioned, partnerships are essential for health transformation, so there'll be a number of other stakeholders who will be great partners in implementing this model. For example, this may include home health agencies partnering with participating hospitals who are in global budget to help support care transitions after discharge.

So, we certainly have included this for pictorial representation of the different stakeholders but know that we it's only just a high-level diagram. In addition, there'll be a model governance structure with cross sector representation to guide model implementation. And you can see that to the right of the state diagram.

Next slide, please.

So, this slide can provide a quick snapshot of different activities and responsibilities under the AHEAD Model.

For states, participation includes establishing a model governance structure and developing a state health equity plan, collaborating with providers, payers, and the communities to achieve statewide accountable targets on cost growth, primary care investment, and statewide equity and quality targets.

States also participate as an aligned payer for the Medicaid agency for global budgets and primary care transformation. In addition, states will engage payers on multi-payer alignment, including participation potentially, including participation from state employee health plans and marketplace plans.

From a hospital perspective, participation will include participation in our Hospital Global Budget, transforming care, and improving population health and identifying efficiencies. In addition, hospitals will pursue opportunities for quality improvements and create hospital health equity plans to reduce disparities in care and outcomes in their community and within their hospital.

For primary care practices, participation will include participation in Medicaid transformation efforts and the Medicare Fee-for-Service Primary Care AHEAD Program. In that program there will be care transformation requirements for person centered care. Medicaid and Medicare Fee-for-Service are required payers in the AHEAD Model, but commercial payers, including Medicare Advantage, employer sponsored plans, and others, can participate as aligned payers, and in the global budgets on the primary care transformation. Payers will also be included in measuring the All-Payer cost growth and the primary care investment targets.

Note, of course, the model governance structure also will play a role which we'll describe later in the slides.

Next slide.

During this section I will now share more information about the statewide targets within the AHEAD Model.

The purpose of statewide targets is to identify the shared goals of the model between CMS and participating states, help set state expectations and galvanize collective action within the state to achieve these targets.

Here you can see how our statewide targets align with our 3 model goals.

These statewide targets will be reflected in a State Agreement which will be executed with CMS in advance of the performance year, Performance Year (PY) One.

The four statewide targets include Medicare Fee-for-Service, Total Cost of Care Targets, All-Payer Total Cost of Care Targets, Medicare Fee-for-Service and All-Payer Primary Care Investment Targets, and Statewide Quality and Equity Measures and Targets.

In the subsequent slides, we will discuss each target in detail.

Next slide, please.

AHEAD's quality population health strategy builds on the lessons learned from past CMMI models and other statewide initiatives.

States will select measures that align with state health equity plans and quality improvement efforts over the course of the model. States can select from a core set of measures provided by CMS, with opportunities for additional measures. CMS will request stratified reporting based on data availability and measure feasibility.

The five core domains to set these statewide quality and equity targets are below. These include Population Health, Prevention & Wellness, Chronic Conditions, Behavioral Health and Healthcare Quality and Utilization.

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AHEAD was developed in response to affordability and cost growth containment efforts underway in states across the nation. The Medicare Fee-for-Service Total Cost of Care Target is the final value to which CMS will compare participant states' annual spending for each performance year during the model for all Medicare part A and part B residents in the participating state or sub-state region.

These targets constrain overall expenditure increases and aim to identify strategies to address the unique context of past investments and transformations as well as the state's historic expenditures.

The targets incorporate risk adjustment for changes to the participant state's population over time. In addition, they will include a prospective trend factor with a retrospective guardrail that includes a savings component to generate savings to CMS over the course of the model.

So here you can see that figure in which we think about bending the cost curve, and that you can see the difference between the state growth absent the model, and state growth under the model.

Next slide, please.

Increasing the primary care investment is a significant component of the AHEAD model. The Primary Care Investment Target for Medicare Fee-for-Service provides flexible, state-specific annual improvement targets to incentivize progression and build on existing State goals.

The primary care AHEAD program will aim to increase Medicare Fee-for-Service Primary Care investment. The Medicare Fee-for-Service Primary Care Investment Targets are determined by CMMI based on estimates of current spending and feasibility.

Each state's investment target is measured as a percentage of the total cost of care, with a focus on improvement year by year for each participating state.

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As you've heard, AHEAD focuses on multi-payer alignment and improvements for all residents in a state regardless of insurance coverage. States will work with CMS to set All-Payer Primary Care investments, and All-Payer Total Cost of Care Targets for the model, which being - will be included in the State Agreement.

Both All-Payer Primary Care Investment Targets, and All-Payer Total Cost of Care Targets will require codification by Executive Order or legislation, and to build on existing State progress for all-payer efforts. These targets can also be informed by a Medicare methodology if a state does not have a current methodology.

Multiple states have already created these targets given their interest in curbing healthcare costs and increasing investment in primary care. For more research, please see the Peterson-Milbank Program for Sustainable Healthcare Costs which has tracked many of these efforts.

Next slide.

Primary Care is widely recognized as the foundation of an equitable, efficient, and high-quality health system. The Innovation Center emphasizes the importance of high quality, primary care in the Strategic Refresh as well as in the AHEAD Model.

We'll now turn to describing the Primary Care AHEAD Program.

Please go to the next slide.

Primary Care AHEAD is designed to align Medicare Fee-for-Service with state-led, primary care efforts with an overarching framework of participant accountability and care transformation. Through this

approach the model will facilitate the development of higher quality, primary care in participating states.

The Primary Care AHEAD Program aims to achieve the following goals.

First, increase the investment of primary care as a proportion of the total cost of care for Medicare Fee-for-Service and on an all-payer basis, serving as a tool for states to meet the statewide targets.

Second, aligning Medicare's Primary Care Strategy with state efforts already underway by State Medicaid Agencies.

Third, supporting advanced primary care through behavioral health integration, care coordination and health related social needs related activities for primary care.

Finally, the model aims to broaden participation of target populations most in need of improved access to high quality, primary care by ensuring that health centers, such as Federally Qualified Health Centers and the lookalikes, as well as Rural Health Clinics, can receive these types of enhanced primary care payments. We're really excited to have FQHCs and RHCs in this model.

Next slide.

Participation in the Primary Care AHEAD Program is voluntary. Participating Primary Care Practices must maintain participation in a State Medicaid primary care alternative payment methodology for the duration of their participation in Primary Care AHEAD. At minimum, the participating practice must be engaged in some form of enhanced care management or accountable care relationship with Medicaid beneficiaries.

Primary Care Practices, FQHCs, and RHCs, collectively we're going to call them Practices, that are located within a participant State or sub state region and are also in the State Medicaid Primary Care APM, are eligible to participate in Primary Care AHEAD.

CMS may consider exceptions to this criterion for FQHCs and RHCs if there is no such Medicaid program available to them.

States will submit Medicaid primary care APM participant lists to CMS prior to performance year one, and on ongoing basis.

I recognize that some states on this call may not have a Medicaid Primary Care APM. They may still be able to apply to AHEAD so long as they have that in place by the first Performance Year.

Practices that participate in Making Care Primary, Primary Care First, or another capitated primary care model, or as well as an additional model with no overlaps policy with AHEAD will be ineligible to participate. More information on those overlaps will be available in the NOFO.

Primary Care AHEAD participation will be at the organizational level. Participating primary care practices will enter into a participation agreement with CMS.

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Primary Care AHEAD consists of a voluntary, practice-focused advanced primary care program that includes a Medicare Enhanced Primary Care Payment, also known as the EPCP.

It includes corresponding care transformation requirements for participating Primary Care Practices. EPCP is a quarterly, prospective per-beneficiary payment similar to a care management fee.

In addition to executing care coordination activities, practices can use EPCP if they are Primary Care Practices, FQHCs and RHCs, and are in that State or sub-State region, and they participate in the Medicaid Patient Center Medical Home, or other APMs.

Packages may use the EPCP to invest in the infrastructure and staffing needs to perform advanced primary care and care management, such as hiring behavioral health staff or community health workers.

You'll see here that we have shared that the average PBPM for each attributed beneficiary will be around $17, and a small portion of this payment, initially, 5% will be at risk for quality performance.

States may earn a higher PBPM based on hospital recruitment or state performance on the total cost of care targets with it, scaling up to 21 PBPM. The PBPM may also be lower depending on the State's performance and hospital recruitment, and also on their state targets. However, the floor will be $15 PBPM.

In addition, before we move to the next slide, I'd like to share that we are also considering a capitated track being available in later years of the model.

Next slide, please.

Primary Care AHEAD is designed to support advanced primary care and the care transformation requirements have been informed by research and CMMI's other primary care models.

You'll see here several examples of our care transformation domains that focus on behavioral health integration, care coordination and addressing health related social needs. These activities may range from reporting on specific behavioral health quality measures and developing warm handoffs to behavioral health providers, to folks formalizing specialty referrals through e-consults or other agreements to screen health related social needs and referring beneficiaries to resources in their community.

Next slide, please.

Now, I will focus on the Hospital Global Budgets in the AHEAD Model.

Next slide.

The AHEAD Model aims to rebalance health care spending across the system, leveraging Hospital Global Budgets and Primary Care Investment Targets to shift health care spending and utilization from acute care settings to primary care and community-based settings.

Global Budgets provide hospitals with a predetermined, fixed annual global budget for specific patients, population, or program. Global Budgets are calculated based on a review of Medicare and Medicaid payments from previous years, with calculated updates to reflect inflation, changes in population served and the services provided.

We have an explainer and a definition of Global Budgets on our website and encourage you to look at that if you have the chance.

Participant Global Budgets provide hospitals with several benefits, including the ability to reduce potentially avoidable utilization, earning upside dollars for improving equity and quality, receiving technical assistance, and contributing to the population health of their community. In addition, Global Budgets increase the financial stability and predictability of revenue, which allows hospitals to receive care transformation investment, and also utilize waivers to support transformation.

We hope that these incentives will allow for hospitals and feel comfortable with transitioning to a Global Budget, given these benefits.

Next slide, please.

I will now turn to thinking about the eligibility criteria for hospitals. Acute Care Hospitals and Critical Access Hospitals (CAHs) will be eligible to participate in the Medicare Hospital Global Budgets under the model. Medicaid agencies may allow other types of hospitals to participate.

In model states that enact enabling legislation during the performance period, eligible facilities will also include Rural Emergency Hospitals (REHs), and new Medicare provider types offering outpatient observation and emergency services, as well as ancillary services, such as diagnostic, therapeutic, and laboratory services, as well as school nursing.

Participant hospitals must be a Medicare enrolled facility in good standing with CMS to participate and located in the participating state or sub-state region.

Hospital and CAH participation in AHEAD is voluntary. States will have the primary responsibility for recruiting participant hospitals.

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The terminology around Global Budgets can sometimes be confusing. Each participant payer determines a Hospital Global Budget for that payer patient population for an upcoming year.

At the outset of the performance year, the Global Budgets will include hospital facility services.

And so, you can see in this diagram where Medicare Fee-for-Service will pay our Global Budget to hospitals. Medicaid agencies will work on paying that either through their programs as well as potentially Medicare Advantage and commercial payers as part of their programs.

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To determine methodology for Medicare Fee-for-Service, CMS will offer flexibility to states with statewide rate setting, Hospital Global Budget authority, and experience in value-based care. These states may develop their own Hospital Global Budget methodology.

CMS will review and approve any State design methodology and provide alignment expectations for fidelity to the model.

States without these authorities will use a CMS- designed Medicare Fee-for-Service Global Budget Methodology. This methodology will consider lessons learned from past Global Budget Models.

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As you've heard, Medicaid alignment is a critical component of the AHEAD Model.

States will be required to implement an aligned Medicaid Hospital Global Budget payment by Performance Year 1. The State Medicaid Agency will be responsible for developing their Medicaid specific Hospital Global Budget methodology. CMMI and CMCS will review the provide technical assistance on this methodology with additional information to be provided in the Notice of Funding Opportunity (NOFO).

Of note, any Medicaid methodology will need to be approved through the normal regulatory processes. Acceptance into AHEAD does not guarantee approval of any of these regulatory changes necessary.

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Commercial payer participation in AHEAD's Hospital Global Budgets encourage and will help achieve the All-Payer Total Cost of Care Targets. Furthermore, robust commercial payer participation will maximize hospital participation as the Global Budgets will cover a greater portion of a hospital's overall net patient revenue.

Participating states can develop a commercial Global Budget methodology.

At least one payer beyond Medicare Fee-for-Service and Medicaid must participate in the hospital budgets by Performance Year 2. This may include State Employee Health Plans or marketplace plans, or as well as Medicare Advantage and commercial and employer sponsored coverage.

Next slide, please.

In this slide, we'll provide a very high-level overview of the CMS design Medicare Fee-for-Service Hospital Global Budget methodology.

CMS recognizes that this methodology will be of great interest to states and hospitals as they consider participation in the AHEAD Model.

More information will be available in the Notice of Funding Opportunity, and once states are selected into this model.

At the highest level, Hospital Global Budgets are based on each facility's historic net patient revenue, or "built bottom up." This historic baseline is then adjusted to be commensurate with its given performance year with demographic shifts, inflation, and other trends.

Once that baseline is determined, CMS will apply several adjustments. The Transformation Incentive Adjustment will provide an upward adjustment for hospitals to invest in enhanced care coordination in the first 2 years in the model.

Next will be Quality Adjustments. CMS will adjust the Hospital Global Budget for Acute Care Hospitals, or PPS Hospitals, based on their performance in CMS's hospital quality programs. In addition, there will be an upside option for Critical Access Hospitals under the AHEAD Model to support their movement to value-based care and participation in quality pay for performance activities.

The third is the Health Equity Improvement Bonus, which is an upward adjustment based on the hospital's performance on disparity sensitive measures, focused on closing the gaps in healthcare outcomes.

In addition, there will be Clinical and Social Risk Adjustments based on likely what we're thinking at the Hierarchical Condition Category (HCC) Codes, as well as Area Deprivation Index and Part D Low-Income Subsidy status, adjusting for clinical and social risk. This is intended to help provide providers for serving high needs for vulnerable communities with the resources needed to improve care outcomes.

In addition, there will be a total cost of care Performance Adjustment, which will be an upward and/ or, downward adjustment based on its total cost of care beneficiaries residing in the hospital service areas.

Finally, there'll be a Practice Adjustment which will include a downward adjustment based on a proportion of a hospital's calculated avoidable utilization.

Global Budgets will be set prospectively on an annual basis. For the CMS designed Medicare Fee-for-Service Service Global Budget, participating hospitals will receive their Global Budget in the form of prospective bi-weekly payments for Medicare Fee-for-Service. These Global Budgets will be in place of fee-for-service claims, and for cause in replacement of cost-based reimbursement.

Next slide please.

We will now share more about other components and strategies in the AHEAD Model.

Next slide.

The model will focus extensively on advancing health equity in several ways, including requiring all States participating in the AHEAD Model to develop a statewide and cross sector model governance structure and a Statewide Health Equity Plan. We're going to call those the Statewide HEPs.

These plans will outline cross-sector and community driven strategies for improving population health and reducing identified disparities across the state and within a specific geography for sub- state region.

The statewide Health Equity Plan should also line with the Statewide Quality and Equity Measures and Targets described early in this presentation. Those are again, Behavioral Health Domains, Prevention, Population Health, Healthcare Utilization and Quality, among others.

Hospitals will also be asked to develop Hospital Health Equity Plans.

In addition to the Health Equity Plans and cross sector partnership, health equity is often considered in AHEAD's inclusion and adaptations to its methodology for Safety Net Providers to encourage their participation.

We are also thinking closely about the use of social risk adjustment to increase resources available for those who care for vulnerable populations, and a focus on screening and referrals for health-related social needs both by Hospitals and Primary Care Providers.

So, as you saw in our Strategic Refresh, we are advancing health equity by integrating into all parts of the model. And so, these are just a few components that we've considered health equity.

Next slide, please.

Each participating state will establish and multi-sector model governance structure. This body must have a formal role in model implementation. States may build on pre-existing work groups or boards to meet this requirement. In terms of the governance representation, you can see this here on the left. The

required elements must include patients and or advocacy organizations for the community voice to be present.

In addition, community-based organizations, payers, including commercial Medicaid managed care, Medicare Advantage, and other types of payers, are included. As well as provider organizations, namely, hospitals, primary care, FQHCs and behavioral health, local tribal communities where applicable, State Medicaid Agencies and state and Tribal territorial Public Health Agencies.

So, you can see that this is a diverse group in which we have states, providers, payers, community organizations, and patients all the same table to support model implementation.

States may also choose to have additional types of members of this governance structure, including State Cost Commissions, Divisions of Insurance, and other relevant state agencies and additional partners.

In terms of the governance role, this is a bit flexible, and states will have the opportunity to think critically about how they would like to use this governance structure. In terms of what is required, the governance structure will be required to develop statewide Health Equity Plans and provide input on the selection of those equity and quality targets. Review and support a possible Health Equity Plan as well as input into the Cooperative Agreement investment.

States may also choose to use this government structure to support reviewing state designed Medicare Global Budget Methodology, reviewing the Medicaid Commercial Global Budget methodology as well as other activities.

Next slide, please.

I mentioned the inclusion of behavioral health at the outset of my remarks but want to call into focus several ways we have integrated behavioral health, no pun intended, into our model strategy and components.

We've included behavioral health as one domain in the statewide quality measures and equity as well as in the statewide health equity plans.

In addition, we have behavioral health considered as one of the care transformation, requirement domains for Primary Care AHEAD.

There are other opportunities with the waivers and Cooperative Agreement funding to utilize the model components to support improvement in behavioral health access quality and outcomes.

This may also be another area which states can build on existing innovations and efforts under the AHEAD Model.

Next slide.

Multi-payer alignment is critical to achieving success under the All-Payer Total Cost of Care Targets, the All-Payer Primary Care Investment Targets, and improving outcomes for all state residents, which is our ultimate goal.

This model provides a venue to support multi-payer alignment, and states are encouraged to consider the levers available to them and to encourage payer alignment and participation where feasible.

As noted, states must recruit at least one commercial payer to participate by PY 2, and ideally more over the course of the model.

Next slide, please.

So, you heard from Dan Tsai about the importance of Medicaid alignment in this model.

And so, we have called into focus here the different ways that you've heard from us about the importance of Medicaid alignment and how it works both on the State participation, Global Budgets, Primary Care and Statewide Targets.

Participant states will be required in their application to have the Medicaid Agency either part of the applicant for the Cooperative Agreement, or as a sub-recipient to make sure that they can have support necessary to implement this model.

In addition, states will, and the reason for that is that states will need to develop a Global Budget methodology to participate as an aligned payer by PY 1.

States may use state directed payments or 1115 for Hospital Global Budget implementations and updates the managed care organization contracting requirements to achieve Global Budget alignment.

In addition, for Primary Care, Medicare fee-for-service aligns to the ongoing Medicaid Primary Care transformation or will, if the state decides to participate in this model.

Participants participating in Primary Care AHEAD must participate in Medicaid Primary Care APMs in the same year.

States may also adapt, might choose to adapt our Medicare characterization requirements and quality measures to the Medicaid priority, so long as that they are aligned.

In addition, Medicaid will participate in the All-Payer Total Cost of Care Targets, the Primary Care Investment Targets, and the Quality Targets.

I want to draw your attention to the fact that while Medicaid contributes to these targets there'll be considerations of Medicaid's unique population and a greater focus on improving population health, increasing access, and reducing avoidable utilization.

In addition, this includes what Dan Tsai was mentioning in terms of increases to rate as Medicaid agents are thinking through adequate provider reimbursement.

Next slide.

To engage providers across the care continuum and patient-centered care, the model is considering voluntary waivers for certain optional Medicare payment requirements to help test the model.

These benefit enhancements may include a 3-day Inpatient Stay Requirement Waiver for Skilled Nursing Facility Admission, waivers to the Critical Access Hospital 96-Hour Certification, Nurse Practitioner and Physician Assistant Service Waivers, Home Health Homebound Waiver, Care Management Home Visit Payments, Telehealth Waivers, and as well as Waivers for Concurrent Care for Hospice Beneficiaries.

Next slide, please.

In this next session of the webinar, I'd like to walk you through the model application Cooperative Agreement timeline.

Next slide.

The AHEAD Model anticipates awarding up to 8 Cooperative Agreements, or CoAgs to state agencies providing approximately up to $12 million dollars per state brought to the initial 6 years of the model, including the pre-implementation period.

Cooperative Agreements are intended to support state start startup costs associated with the model, such as recruiting primary care providers and hospitals to participate in the alternative payment models, setting statewide total cost of care targets for negotiation with CMS, as well as meeting the Primary Care Investment Targets, developing statewide Health Equity Plans, and reviewing hospital Health Equity Plans, as well as developing commercial and Medicaid Global Budget methodologies and, supporting multi-payer alignment on primary care and population health activities.

We recognize that states will have a number of expectations during this model, and this Cooperative Agreement can help them hire staff to implement the model, as well as think about sustainability strategies for the future.

Interested states may prepare to apply to the AHEAD Model considering the timeline listed. The first Notice of Funding Opportunity, the NOFO period, will be released in the fall of 2023, with a 90-day period before applications are due in early spring of 2024.

A second period for applications will be open in the spring of 2024 with a 60-day period before applications are due later this summer.

Specific dates for applications will be released at a later time, but I want to stop on this slide and sort of note that the end, the intent of having two application periods is for states to understand how ready they are to apply to the model, and also think through what types of pre-implementation period they'd like.

Next slide, please

Again, to accommodate different levels of readiness among potentially interested states, CMS will open two application periods and the opportunities for states to select their model timeline.

Okay, so this this table can be a bit complicated, so I'll walk you through it. So, states, apply into the first NOFO period, may select either a one-and-a-half year pre-implementation period followed by 9 performance years, or a 2-and-a-half year pre-implementation period, followed by 8 performance years.

So, you can see that application in in 2023 ends in early 2024, and the pre-implementation period would likely start in July first of 2024, and then the performance year for Cohort One would start in 2026, and then the implementation period for Cohort. 2 would start in 2027.

States applying to the second NOFO will have 2-year pre-implementation period, followed by 8 Performance Years. So, you can see that application period will be in 2024, and then the pre-implementation period will start in 2025, and then have 2025 to 2026 as the pre-implementation period.

With Cohort, 3 joining Cohort 2 and starting the implementation period in 2027. They will also have 8 Performance Years.

The model will end for all Cohorts at the end of the year 2034, with an optional 2-year transition period that allows states other transition hospitals and providers back to fee-for-service or another model.

So, this is the longest model that CMMI has put out there given the ambitious nature and goals for this model. So, we're encouraged by the opportunity to have 8 to 9 Performance Years as well as pre-implementation time to make sure States are ready to embark on this transformation journey.

Next slide, please.

We will now move into the Q&A section of this webinar, and so I'll give you a moment to take a breath, and for me to take a breath and to get a sip of water as we dive into the questions.

Alright, before we dive in, I want to share that we will release an updated FAQ based on the questions in this webinar. If we do not get to your question, we'll be sure to answer that in the FAQ.

Next, we would like to take some time to understand more about what elements of the AHEAD Model align with your priorities, initiatives, and activities within your state.

Please join our poll activity in your Zoom chat window. I'll give you all a few moments to join before moving on.

Alright. Webinar host, can we see the answers to this question.

Alright, it looks like we have a strong showing of 77% alignment. I'm excited to see more and dig into those long answer responses. Thank you.

Alright.

Now, feel free to share any questions through the Q&A Pod to the right of your screen.

As a reminder due to the high volume, we might not be able to get to every question, but we'll take a note of each question and try to ensure either the future materials and FAQs to help address any common themes. You may also submit questions to the AHEAD Model help desk at AHEAD@cms.hhs.gov

Alright, our first question is, how does the AHEAD Model differ from other primary care models?

Well, the AHEAD Model builds on the lessons learned from existing state-based models, including Maryland, Vermont, and Pennsylvania, but we also recognize that there are a number of similarities across our CMS Innovation Center on primary care.

We have followed quite closely the NASEM report on primary care that was released, I think 2 years ago, maybe more, but thinking about what is primary care and whole-person care. And so, we have a number of shared themes throughout both the CMS's Primary Care AHEAD Program in the AHEAD Model as well as Making Care Primary and other work, so that is intentional in terms of the similarities. There are a number of differences that this infographic on the next slide can show you and is available on our CMS website.

Move to the next slide, please.

Alright, of the questions we're getting in our presentation, a lot is around Making Care Primary. And, as I mentioned the state or sub-state regions participating in Making Care Primary will be ineligible in this model to participate in this model. I recognize that might be disappointing, but that is the current policy.

Alright, we'll look at these other questions.

The next question I'll take, is there upfront risk to hospitals? What are the specific risks to hospitals?

And so, I want to just share that we have been thinking really hard about how to develop the CMS designed Hospital Global Budget methodology to understand a hospital's value proposition for participating in this model. We've been thinking through the upfront transformation incentive adjustment which is intended to support for hospitals taking on the risk of joining global budgets as it provides them an upfront incentive for the first 2 performance years to allow for their transition. For them to think about investing in the types of care transformation activities necessary, to work with their CFO and accounting teams, help working to help implement the model, and of course, we recognize that hospitals need to manage their budgets and their resources effectively to deliver high value care. So, that is one of the things in terms of the upfront joining the model that we've been thinking through.

Alright.

Thank you.

Next question is whether the PBPM and the Primary Care AHEAD Program is Medicare only?

And yes, it is Medicare only. And if you go back to this slide on the Primary Care AHEAD Program.

I think it is. Let me go back.

Oh, yes, it is again, Medicare fee-for-service only will be a base amount of $17 PBPM. The Medicaid Agency may consider whether to increase their current model PBPM, but at this point that that $17 is for Medicare fee-for- service only.

Thank you.

Alright. Next question is, what is that $12 million fund?

And again, this is going to the Cooperative Agreement funding, and this is intended to be flexible, so long as that funds are being used in in concordance with the model's goals as well as HHS Federal Grant Regulations. In general, we expect that states will be using that those dollars to support hiring staff to implement the model, thinking through developing their Medicaid and commercial Hospital Global Budget methodology to support primary care transformation, and to also support the model governance structure.

States may also choose to use it, those dollars, to invest in statewide health information exchanges and other types of IT necessary to support the model implementation.

Alright. The next question is recruitment of hospitals: How will CMS be supporting states in recruiting hospitals?

Thanks, that's an excellent question and something we have given a lot of thought. In addition, we'll be working with states and providing them technical assistance both through CMMI and our learning contractors to help states work with hospitals to recruit them and also help them understand what are Hospital Global Budgets.

In addition, we'll be working with states and providing them technical assistance both through CMMI and our learning contractors to help states work with hospitals to recruit them and also help them understand what are Hospital Global Budgets. We recognize that Hospital Global Budgets are a new concept for many and will require both understanding, the overarching purpose and the value proposition as well as getting into the details.

And so, we will be working on both resources that provide that technical nature of what is, what are the financial specifications, as well as how does this work from a medical and clinical perspective. So that is certainly something we are looking to provide resources on. And we'll be working closely with states during their pre-implementation period.

Alright. The next question is on the role of the State Medicaid Agency in the managed care states. So, we believe that, regardless of whether a State Medicaid Agency has either managed care or fee-for-service that they'll be key partners in this model. A State Medicaid Agency will need to be working with the managed care organizations if they're in managed care to help implement the Hospital Global Budget. Again, the state will be developing the methodology for their Medicaid program, and that includes considerations of managed care.

Alright.

The next question I received is, can you describe more about the stakeholder engagement to develop the model?

And that's one of the reasons why I'm really glad that you're asking this question. And that's as I mentioned, is one that reasons why we have taken a number of months and sometimes years, to develop a model. We have engaged with a number of stakeholders to develop this model, including state agencies, current states that are participating in our single state, total cost of care models as well as new states and other states during this model. We have been looking at the states that have some of those All-Payer Targets that I mentioned, particularly to help them understand how they came to have those, and sort of what are what are their interests in improving population health.

We also did a roadshow, or sort of an early listening sessions, around hospitals and providers for Hospital Global Budgets. We also held a listening session for beneficiaries and community organizations to help us think through some of our health equity considerations. So, stakeholder engagement was really critical developing this model.

Alright. Next question was- is, how does the model include children?

And that's a great question. And one of the reasons that Medicaid alignment so important, given the - that they cover many children in this country. And so, Medicaid Hospital Global Budgets will include children and, as well as the primary any Medicaid Primary Care Program may also consider children health issues. And so, that's a great question.

Alright.

Next question is, how does how do commercial payers fit in? And I think I've spoken a bit a bit about this, but happy to share again. Multi-payer alignment is really critical to this model, and we recognize that not all states may have rate setting authority. That said, we think that there is a lot of opportunity for multi-payer alignment, given shared goals for improving quality and reducing costs.

So, commercial payers will be an important stakeholder for states to work with closely, including, both through the model governance structure as well as through their own state partnerships, to participate in health transformation. We also expect that states will be recruiting commercial payers to participate in the Hospital Global Budget and align as possible to the primary care work. So, certainly that is something that states may be doing

Alright. My next question is, around what flexibility do states have in measure selection? So again, for the statewide quality and equity measures and targets, states will be selecting from a set of core measures on those domains I shared earlier, and if I can get them off the top of my head they're: behavioral health, prevention, population health, healthcare quality and access. I might be missing another one, but generally, states will be selecting from these, which often that have been intentionally selected to align with a core set of measures that many states are reporting on for Medicaid for their Medicaid program for the both the adult and child core measure steps, and so these should not be new measures for many states. In addition to these core measures that states will be looking through, states may also choose to add additional measures that they are particularly interested in, and these might also capture more around health-related social needs or other types of population health measures.

Alright.

What happens after 2034? Will traditional fee-for-Service Medicare outside of the AHEAD Model no longer exist?

So, if I had a crystal ball, I would love to know what 2034 will look like, for many different reasons. But you know, I think one of the things with this longer model horizon is that we want to make sure that states can embark on this ambitious model and allow for that long runway for improving population health and health equity. That said, you know, we will see and what how the Medicare program will evolve over time, and so, whatever the model transitions to will either be sort of the norm at that time or to a new model. Potentially expansion, if the model is successful.

Oh. alright!

I have got a couple of questions around FQHC and RHC Participation. So, FQHCs and RHCs will be participating in the Primary Care AHEAD Program and will be eligible to receive that same care management fee or Enhanced Primary Care Payment that other partners will be eligible to receive as well. We recognize that FQHCs and RHCs may need a special consideration in terms of reporting quality measures and CMS will be working closely with states and those providers in helping to meet the model requirements. I'm really excited to have rural health clinics participate in this model. We think that is important as a real, important safety net provider to participate, and you know for what it's worth, the current Primary Care AHEAD Program track is really, is an upside program, so that you know, this will be helping them, helping to invest more dollars into primary care which we're really excited about.

Alright.

Okay, I've gotten a question about what percentage of the budget, I think this is for the Cooperative Agreement, is allowed for grant staff, ie., Project director, Contract Specialist, Accountants, etc.?

That's a great question. And I we won't be able to address that, and similar types of grant questions on this webinar. But more information on that will be available on Notice of Funding Opportunity. We do recognize that standing up this model will require state staff resources, and it is expected that the Cooperative Agreement can be used for that purpose. And so, for all of you all, we're really excited that the once a NOFO is released we'll be providing more information about the specific grant requirements, including the budgets. The budget process, which is our partners in the Office of Acquisition Grants Management, will help provide those answers.

Alright.

Next question, does this eliminate cost reports?

And that's an excellent question. As you heard, Hospital Global Budget methodology for the CMS designed methodology will have cause not be based on, tied to cost-based reimbursement. So, the question then becomes, does this is eliminate the cost report. And the answer is, no. We do believe that that reporting is essential for us to better understand activities within the Critical Access Hospital, but there may be modifications to cost reports to allow for documentation of model participation.

So, the answer is, yes, but it might be a bit different.

And then I should add, that there is also likely to be technical assistance for any changes to cost reporting structure. And that's been something we've been working through in some of our other models as well.

Alright. The next is, are additional dollars going into Hospital Global Budgets?

And I think this is a bit challenging to say, based on the outset. But you did hear from me about the transformation incentive adjustment which will be the upfront adjustment for the first 2 years of participation for global budget. This again will be offset potentially over the course of the model, as hospitals think about reinvesting and reducing avoidable utilization. But it's sort of hard to say in terms of whether an ultimate number on this front.

Alright. The next question is, how will AHEAD impact hospice?

Can we go back to the waiver slide.

I think that's an important one. Slide 45.

Yeah, this one. Thank you. So, you'll see that one of our goals here is that we will be waiving the requirements to offer concurrent care for hospice beneficiaries. So, this is a waiver that will forego the requirement to forego curative care as a condition of being electing into hospice benefit, thereby allowing them to receive care with respect to terminal illness, and so we believe that this can allow for improved coordination and for beneficiaries to receive hospice services earlier in in in their care journey.

I also want to point out that we also have a number of other home-related waivers here, with the Home Health Homebound Waiver, which expands the beneficiary and provider eligibility for certain home health services to improve access to care for underserved beneficiaries. As well as the care management

home visits to allow for payment for certain home visits that are furnished to eligible beneficiaries. So, we're excited about those opportunities to expand access to these types of services.

Alright. Okay, thank you for these great questions. The next question is, will CMS require hospital participation? And the quick answer to that is no, and you know we will be working with states to recruit hospitals to participate in this model.

Alright. The next question is for Emily, please share more about the behavioral health integration strategy in this model.

So, I am happy to do so. I will be. Let's go back to the behavioral health slide. I may have gone through it a bit quickly, but generally we've been thinking through behavioral health as a key issue, especially if we're thinking about population health outcomes. And so, we wanted to make sure that we had flexibility to allow states to given, how differently sometimes behavioral health infrastructure is organized within states to think about what their state specifically needs. And so that is in part why we did not have a specific behavioral health provider intervention, but rather thinking through how we could integrate behavioral health into this model.

So, as you heard, we'll have a behavioral health as a focus of our statewide health equity plans and our quality measures and targets. And so, one of the core measures that are required. You know the panel of measures in the core measure set, will include 2 to 3 behavioral health measures that a state can select to focus on as part of their statewide quality measures and targets.

In addition, Primary Care AHEAD includes a focus on behavioral health integration which is tied as requirements for their care transformation requirements. And then we have a number of flexibilities available on waivers. I know that there's a lot of exciting and emerging literature around telehealth for behavioral health, increasing behavioral health access some hub and spoke models. And so those are certainly under consideration here, as well as the cooperative agreement funding. So, for example, if a state identifies behavioral health as a you know, and specific activities in their statewide health equity plan, cooperative agreement dollars can be used as initial startup funds for those types of activities.

So again, it's an intended to be a flexible strategy, and sort of integrate into a number of our key components.

Alright. Thanks.

The next question is around, say more about the future of primary care capitation.

So, what you see here for our Primary Care AHEAD Program is that it is intended to be on top of fee-for-service with an enhanced primary care management fee. We will be zeroing out certain part fee care management services, but instead providing a higher level of investment with our enhanced primary care payments. I mentioned earlier that CMS will be designing a primary care capitation track in the future, and that is certainly something we are thinking closely about and would be working with states to implement. We know that many states have interest in primary care capitation. We've seen some movement in the state landscape around partial or full capitation, and recognize that many in the community think that primary care capitation is one of the future directions of transformation. And so again, we are, we will be continuing our focus on primary care investment and Medicaid alignment with

any type of primary care capitation program. And we'll be working closely with states to develop those tracks as a model. But again it, they would have a similar level of investment.

Alright. The next question we received is, if hospitals do not participate, do states still get the dollars from AHEAD for the model?

So that is an excellent question. Obviously a very nuanced one. We do believe hospital participation is an essential element of this model, and, as I mentioned, will be working with States to help recruit hospitals to share more about the value proposition, and the methodology as they consider participation. But ultimately, if hospitals do not participate states, would likely be unable to move into the implementation period for the model, so that we would probably terminate their participation. This is definitely an outcome that we are looking to avoid as well, and will be partners along that journey. But it is an essential component of the model, and so we will meet hospital participation for continuing for the entire duration of the model.

Alright, the next question is, will AHEAD also include Indian Health Services?

And we can certainly provide more information about that in the in the FAQ to make sure we get our answers correctly on this one. But we do want to make sure that we can increase primary care investment. And so, we'll be thinking closely about this one. Thanks for that question.

Alright. The next one is what factors should states consider when deciding which Cohort to apply to?

This is an excellent one, because I recognize that phase one to make sure you have the right timeline, the right level pre-implementation ready. So, I think if I was a state I would, or a state leader, I should say I would consider what elements of the head model do I already have? Do you have past history and these types of value-based care arrangements generally? Second would be, do I have experience in setting all payer public health or primary care investment targets?

Again, there is that right requirement for having it be codified, an executive order or legislation, and so I would hope they kind of get a sense of like. What is the feel around that has your State already been thinking about investments in primary care? For example. I would also think through you know, payer and provider interest in the model. That's certainly something that we'll think is helpful for a State and have a sense of what this model is, and we'll be sharing more about different model components for that education both prior to the NOFO application and during the NOFO period opening. But I would say, if you're starting with, you know, fewer elements already in place, you might want to consider applying to Cohort 2 which apply allows you for the greatest amount of pre implementation time, which allows for the most funded time to help think through that work. And you know, partner with CMS on that pay limitation period. If you're a state that is excited rearing to go and feels like, Hey, I've got 90% of this work figured out. Maybe the first Cohort is for you. Certainly, there is the opportunity to transition to the second Cohort. If you need more time, but I definitely would want to make sure that you feel ready. To implement in 18 months, because that it's a pretty quick time.

And then, if you are you know. Not sure if you're you know December is a pretty busy month for you all, and you're still thinking about engaging with different stakeholders in the field to determine whether there's enough interest. Cohort 3, and the second application period might be right for you, so allows you to sort of see what the NOFO is when it's released, participate in the webinars, and then sort of work on your application earlier in 2024.

So, we do think that that is a great option, because it allows filter that 2 years of pre-implementation put a bit more time to get together an application. Of course, states may be able to apply to both. If you're not selected to the first NOFO, you may apply to the second but again, a number of decisions to be made. CMS is open to connecting with different states. If there is interest in this model. We will not be able to take individual State calls during the application period opening. But prior to, we are very interested in hearing from states about if there's interest and learning more about the model.

Alright.

Next question, do hospitals and primary care practices need to wait for the State to apply first?

Well, that's a that's a great question. So, you know, if the state does not apply the global budget and Primary Care AHEAD will not be available in your state. And that's sort of the simple truth of it.

But we really encourage you that if you are a hospital or primary care practice that is excited about this model, please connect with your State Agency and leadership to let them know of your interest. I think that's certainly helpful for states as they're thinking about whether to apply. State leaders helpful to also share that this is an opportunity. We are certainly trying to publicize this model as much as possible, and share more about this opportunity, but hearing from providers in their community will be really helpful for them to choose to apply. So, definitely encourage your State to apply if you are so interested.

Alright. The next question is, will states still need to get approval from CMS for Medicaid waivers? And yes, the answer is, Yes, they will. The regulatory processes will exist as normal, for you know, things like 1115 Waivers, State directed payments, etc. So really encourage you to be connecting with our your CMCS Colleagues about your interest in this model, as well as how this model might work for you, given your specific Medicaid structure.

Alright. Next question is, how is post-acute care and long-term services and supports included in this model?

And so, for post-acute care we've actually seen, this is a great place for partnership with hospitals as part of Hospital Global Budgets. We've seen in Maryland, the benefits of how hospital can create partnerships with skilled nursing or home health agencies to help manage the discharge and transition planning back to home or to another facility. This is important, particularly around thinking about improving care outcomes care management and reducing potentially avoidable util utilization, including readmissions. And so, our goal is that the waivers including this model, can support the some of those partnerships, and we'll be also investigating fraud and abuse waivers for hospitals and other providers to partner together on that work.

Alright. The next question is, will specialists be part of this model?

And so that is a bit of a complicated question. But I'm happy to give that answer. And so, we think that specialists are a key component with any healthcare system. And obviously our number of the providers that are practicing at a hospital. And so, specialists who are practicing at a hospital can sort of should be informed about the Hospital Global Budgets, about the model, and sort of engage in that care transformation activities. In addition, primary care, and specials will want partner as part of the Primary Care AHEAD Program help with that care management as well. So, we see them as a critical care partner and engage in terms of the role.

Alright.

Next question, worries about how this model governance structure will work.

And so, we started the webinar by talking about the unique relationships and partnerships that states have with the community providers and payers. And we believe that this model governance structure will help cement some of those relationships informed an opportunity for input into the model, development of that state health equity plan, and the like. We are really thinking about the model government structure as a way to provide advisory support, input on model decisions, and partnering with the state as I mentioned, that should include about robust participation from hospitals, primary care providers, community partners, patients, and the state agencies themselves. So that diverse representation is needed for those really truly cross sector partnerships.

Alright.

Thinking through, I think we are almost at the end of our time together. And so, I think we've been able to capture many of these questions.

So, we will certainly take note of this chat, and think through how we can better answer these questions, support states on considering whether apply, and help share the word about this really exciting model.

So, with that I will take us home and share more about our next steps here.

Alright.

Let's transition to the next slide

For our last polling question, we would like to know what additional information would be helpful to states, considering to apply?

We'll give you a moment to do that.

While we're doing that. I'd like to share a bit more about our next steps and upcoming events. We are partnering with a number of great organizations to support additional partner events in the coming weeks. So, some of the topics we queued up for the next few sessions are state efforts to increase primary care investment and addressing rising costs, as well as more information about Hospital Global Budgets and Primary Care APM. So please stay tuned.

Alright, let's see if someone is pulling question responses.

Well, thank you so much for this, and we appreciate you sharing more here. It looks like we have a number of different topics to dive into in more detail. So, thank you.

Thank you again. For your participation in today's webinar. We will be connecting more with you all through the AHEAD listserv and mailbox. Please stay tuned to our upcoming events and to learn more about the AHEAD Model.

And so, we encourage you to visit our AHEAD Model webpage, to find out more information and submit additional questions for input as well as signing up for the AHEAD listserv.

And we can conclude the webinar on the next slide.

Thank you. All have a wonderful afternoon.