AHEAD Model Notice of Funding Opportunity Support Office Hour Session – Transcript

February 26, 2024

>>Julia Marcus, CMS: Okay, good afternoon, everyone. Thank you for joining the States Advancing All-Payer Health Equity Approaches and Development or AHEAD Model Notice about Funding Opportunity (NOFO) office hours. We have scheduled these office hours to answer questions you have about the NOFO, the application, process and requirements for application and participation in the AHEAD Model. We are unable to answer any unrelated questions about the AHEAD Model at this time. As usual, the format for our time today will be fairly casual. We will have most of the AHEAD Model team on the line, as well as our colleagues, from the Office of Acquisition and Grants Management, to answer your questions. If you'd like to ask a question, we do ask that you either use the Q&A function, not the chat feature in Zoom to ask your questions. This is a change from the last office hours where we used the chat. We are really going try and put things in the Q &A so we can keep track of everything. You are also more than welcome to raise your hand, unmute yourself, let us know where you're calling from, and ask your question. I'm just going through my notes here to make sure I hit everything. We will stay on the line for the full hour. We've got quite a few folks still joining. We will be on the lines until four o'clock in Eastern time to answer questions.

However, we are asking that if you have questions about our recently released policy documents, which went up on our website since we last spoke, this includes our official overlaps policy with other CMMI models as well as the Hospital Global Budget financial specs document. If you have questions on these two documents in particular, if you can try and ask those at the top of our call today, particularly around the Hospital Global Budget financial methodology, that would be super helpful. We have a lot of folks on our team on the line who are ready to help answer those questions, and I want to make sure they are able to thoroughly review your questions and provide answers within the hour. If you could ask those in the Q&A feature in writing towards the top. We'll do our best to get to all of those.

Also, one last housekeeping item, we are recording today's office hours for folks who are unable to attend. If you have any objections, please hang up at this time. The recording of the office hours as well as a transcript and an FAQ, as appropriate, will be posted on the AHEAD Model website in the coming weeks.

And then, Kathy, if you wouldn't mind just flipping the next slide quickly. I just want to highlight our resources slide which has been updated since our last office hours. This does have those recent resources that I just mentioned: the financial specifications for the CMS-designed Medicare Fee-for-Service Hospital Global Budget methodology, the recording of that webinar, which we hosted on Valentine's Day, as well as the transcripts and the slides. And we also included the link to that model Overlaps policy fact sheet. These are all live on our website right now. We wanted you to have these, and again our AHEAD inbox, which is just AHEAD@cms.hhs.gov.

With all the housekeeping out of the way, we're happy to start fielding questions for folks. So again, if you'd like to either raise your hand, or if you want to put your question in the Q&A. We will do our best to get to all of them in the next hour.

I see a note that my audio is hard to hear. Give me one second, and I will fix it, but feel free to put your questions in the Q&A while I do that,

Melvin, I see your question about pre-submitted questions. We're going to get someone on our end to pull those up from the AHEAD Model inbox and we will also answer those. Of course, we really appreciate you submitting those in advance, it makes our lives a lot easier because we can make sure we really get you all the information. So we'll pull those up and run through those live.

I see the questions coming in through the chat. So we are just working on responses and will get back to you in a moment.

Hey, Jack, I always appreciate you joining me on video here.

So, I'm going to go ahead with the first question that I can answer as we get some of these other ones. And again, Melvin, we pull up all the pre-submitted questions.

This question is, “what is an appropriate level of possible participation?” Actually, that was not the one I meant to answer. I'm going to go with “What are the specific requirements of the content of the letter intent from a hospital supporting the AHEAD Model?” So, we did not put any parameters on the letter of support from a hospital, though we do have some requirements about actually having those or trying to get those when you submit your application. So, I think we're leaving it relatively open-ended. If we didn't include anything in the NOFO, saying that “this is what the letter has to entail” then it doesn't need to include anything specific beyond saying, you know, we talk to X organization about this model, we're interested in participating, et cetera. So, I just did a quick search of the NOFO. We actually don't put any parameters on that. So, I’m going to go ahead and say we're leaving it relatively open, ended. But you can submit, those letters of support. So, I hope that answered your question. If the state wants to put something around those themselves, they’re more than welcome to, but we are not requiring any things specific in the letters of support from hospitals.

Again, we are just doing our best to get through all the questions in the Q&A, but if you have other questions please feel free to keep submitting them so that we can answer them during our time today. And I apologize that I'm not the expert on all these things, and I can't answer them off the top of my head. But we have a lot of people on our team who've been working on these things. So, I want to make sure the right people are answering all of your questions.

>>Jack Lewin, MD: I put mine on the chat this time, Julia, so I could. But I can ask them verbally if you want?

>>Julia Marcus, CMS: Um, let me see. OK, I see a couple in here as well. Try and put them in the Q&A just to keep track of everything that would be a little bit easier. But, I see your questions. So let me try and pull everything from the chat. Lindsay, I also see your questions and we will work on getting your response in just a moment, Jack.

>>Jack Lewin, MD: Okay, sure, no worries.

>>Julia Marcus, CMS: As we continue working through those, I do see a question that I think would be best answered by our colleagues over at the Office of Acquisition and Grants Management. So, Jamie, this one is for you “For the lobbying form SFLLL, our state agency does not allow lobbying. Should we put “NA” in the required name street and city field?”

>>Jamie Atwood, CMS: So, if you do not participate in lobbying, you would put, I don't know if it's ten a and ten b, which you would put “NA” in those fields, you would still have to complete the form and contact information, the signature of the AOR, all that still happens on the form. You would just put NA in the appropriate fields. If your agency does lobby, you would have to fill out those fields, and then there'll be a supplemental form that you'll have to fill out when you apply. Regarding a certification of lobbying form. So, we would add to that, if that's the case. But if it's not applicable, just put the NA in the appropriate fields, and you'll still need to sign it and submit it. Without that form, your application would be ineligible. So, it is a required form.

>>**Jack Lewin MD**: Yeah. And there's some questions about lobbying. We obviously have to all work with the Legislature. And you know, we're submitting testimony to bills and all that sort of stuff, and to some of this extent you can say we're lobbying for increased budget and for new programs, and so forth, but as a state agency, you don’t have to register as a lobbyist.

>>Jamie Atwood, CMS: Yeah, I mean, let me just pull up this form here, so I can speak about this. Let me see, I’m going pull up the actual directions in here. But this is something that basically if it does apply, we have to have it on file. So, we don't really have a choice on that. And I get what you're saying like, maybe lobbying on some activities, but not others. So, it's one of those things where, if lobbying is done, then you fill out the form it gives you.

>>Jack Lewin, MD: Yeah, okay, because we don't have any registered lobbyists on our staff here.

>>Jamie Atwood, CMS: Okay. Well, then, it probably does not apply because you put the name and address of the lobbying registrant. So that doesn't apply to you for fields 10a and 10b of the form.

>>Jack Lewin, MD: Thank you.

>>Jamie Atwood, CMS: Sure.

>>Joy Soares: Uh, this is Joy from Hawaii. Can I ask a follow up question on that?

>>Julia Marcus, CMS: Sure.

>>Joy Soares: I don't see where the NA is or doesn't apply to you on the form.

>>Jamie Atwood, CMS: It’s not a drop down. So, you just basically can type it in. Because if you're typing in a name, you type in a name, if not, you can just put NA on the form like it's not like a drop down thing. You're literally typing into the form.

>>Joy Soares: Okay, so we type NA in.

>>Jamie Atwood, CMS: yeah, in ten A and ten B.

>>Joy Soares: Okay, in all of the required fields?

>>Jamie Atwood, CMS: No. Let me see.

>>Joy Soares: because there's the street that's required.

>>Jamie Atwood, CMS: Yeah, so you're still going to fill out, for example, like you would still um. If it's possible for me to share my screen, Julia, I can show them what I'm looking at. If that's not possible. I'll just talk,

>>Julia Marcus, CMS: Kathy, can Jamie share her screen so she can show them the form? Because it sounds like a couple of folks have this question.

Jamie, you should be able to now. But let me know if it doesn't work.

>>Jamie Atwood, CMS: All right. So, you're still going fill it out here. So, this one's a cooperative agreement you see here, initial awards. You're still putting the name of your agency and your address. Um, so all these things are kind of being filled out, and you follow the directions you're just putting NA for ten A and ten B. Then the signature here is still your AOR and the contact information. So really the only thing that you're not putting information in is ten A and ten B. You're putting your NA in, but you still have to fill out the form, because you're basically saying for your organization, that this doesn't apply to you, so, you can't just leave everything blank.

>>Joy Soares: And then for the number Six "Federal Department Agency". Do we put CMS, CMMI?

>>Jamie Atwood, CMS: Yes, CMS.

>>Joy Soares: Okay.

>>Jamie Atwood, CMS: Any other questions from anyone on this form.

>>Jack Lewin, MD: Thanks, that's helpful.

>>Jamie Atwood, CMS: Sure.

>>Julia Marcus, CMS: And then, Kathy, if you wouldn't mind pulling up the resources slide, just so people have it. Thank you.

I did answer the question regarding graduate medical education in the Q&A. If you have follow up questions on how graduate medical education is incorporated in the Hospital Global Budget, please let us know.

I also see a question regarding the appropriate. The question is, "what is an appropriate level of possible participation in a State? For example, Missouri has about 110 hospitals and 25 critical access hospitals." So, this is directly pulled from the Notice of Funding Opportunity. You do have to have an execution of a hospital participation agreement such that at least 35% of net-patient revenue would be under Medicare fee for service hospital global budgets by performance year three, and for each subsequent performance year. You also need to have ten percent of net-patient revenue by performance year one. I know It's a little complicated, so I'm going to write it out in the Q&A as well. If you have all questions on the specific numbers, please let us know. But that should answer your question.

Um, also some really good, including the pre-submitted questions, questions about the financial specs that were recently released. So please know I see your questions. We're working on responding. So, if you can just hang tight for a few more minutes we will try and get to all of them. But again, for anyone who just joined, please continue to either put your questions in the Q&A, instead of the chat. And then you are also more than welcome to raise your hand, come off mute, and ask your question live. We're

doing our best to get to everything. As you can imagine, with some of the more technical questions, we just want to get more than one set of eyes on before we reply. So, just give us a couple moments, and we'll try and get to everything.

I see another question, that I can answer quickly in the chat, as we work on those financial spec related questions. The question is “So, only 11 states will participate across the three cohorts, are there plans for another round of applications in 2025?” There are no plans for another round of applications in 2025, right now. We are only planning to have the three cohorts. Cohorts 1 and 2, whose applications are due on March 18, and then Cohort 3 for this model. So that, you know, follows everything that we've outlined in the NOFO to date, which includes the up to twelve million dollars for each recipient in cooperative agreement award funding (we will only award up to eight cooperative agreement awards). So, I hope that your questions, but if you have anything that you'd like to collaborate on in the future, please feel free to let us know.

Again, we are working on getting through all the questions in the Q&A, which includes many of the questions about the financial specs that we recently released. So, we are working on responses for all of these. As you can imagine, it is probably much easier to understand those responses in writing, so we are going to respond to everything with the answer um option in the Q&A. And then, if you have additional questions, feel free to let us know, and we can talk through it live.

>>Nora Lewis, CMS: Julia. I can take a couple that are coming in on the advanced primary care side.

>>Julia Marcus, CMS: Sure. Thanks, Nora.

>>Nora Lewis, CMS: Okay. So, what I’m going to take is, “can a hospital system participate in APC”— which, I’m assuming means advanced primary care or the Primary Care AHEAD program. Please correct me if I’m interpreting that wrong— “if one to two of its hospitals are in a hospital local budget?” That is dependent on the criteria that we develop for system owned practices. Uh. But it is very likely that only primary care practices in the service area of the hospital participating in the Hospital Global Budget would be eligible. So, we're going to be taking a close look at those hospital systems and sort of parsing them up geographically. Um, but we will be providing more guidance as we develop that criteria for primary care practice eligibility for Primary Care AHEAD for system-owned practices.

We also had another question, I believe, from the same person about FQHCs. Which says “Do FQHCs have to be in prospect of payments in APC, or is transition possible?” Um, I think I would love a little more clarity on that question on exactly what you mean. I think, you know, either a FQHC would be opted into Primary Care AHEAD, or not opted into Primary Care AHEAD. Um, we will be providing, you know, a certain level of technical assistance for FQHCs to participate in the program. But if you could elaborate a little more on what you mean by “is transition possible?” That would be very helpful.

>>Jack Lewin, MD: Well, you know, I can. I'm asking. I ask these questions. So, um, if the FQCHs come in, you know they love their perspective Fee-for-Service payments. Right? So, is what's the, uh, what’s the. I mean, we would figure this out. Is there a way for them to move from that to new payment models over time. Or does that have to be immediate?

>>Nora Lewis, CMS: Are you asking specifically about the Medicare Fee-for-Service payment in Primary Care AHEAD?

>>Jack Lewin, MD: Yes.

>>Nora Lewis, CMS: OK. Um, thanks, Jack. That's really helpful. Yes, so um, and we'd be happy to provide a little more information on this. But the payment that's actually affected for FQHCs is really a limited set of one or two g-codes that they bill for care management and behavioral health integration. We are not touching the underlying PPS rates. Um in the current integration of Primary Care AHEAD.

>>Jack Lewin, MD: Yeah, okay, All right. That's helpful. Thank you.

>>Nora Lewis, CMS: Sure.

>>Jack Lewin, MD: And you know, I guess we'd like to drill down at some other time when in terms of what that the upside of that might be for them.

>>Nora Lewis, CMS: Yeah, definitely, I know it'll come down to numbers um for a lot of these FQHCs. And I think it'll depend a little bit on how much they're already utilizing their sort of care Management g-codes and the CCM programs. So, yes, we will definitely be providing some more guidance on that and happy to discuss more.

>>Jack Lewin, MD: Yeah, I guess so. The other subsequent question then, is, if they were willing to move to a different payment model immediately, could they participate with the entire seventeen dollars per member per month approach, Um, if they want you to do Medicare participation without their typical PPS reimbursement? And or is there some way for them to participate in enhance that for all, for all their primary care activity.

>>Nora Lewis, CMS: Yeah. So, I think what uh you might be potentially referring to is that we are working on developing a capitated track of Primary Care AHEAD. We don't speak to that much in the NOFO, so I'm not going to speak to it much here, but I will say more information forthcoming. One of our goals is to get FQHCs in that.

>>Jack Lewin, MD: Okay. Okay, thanks.

>>Nora Lewis, CMS: Yup:

>>Jack Lewin, MD: Then back to the one that you answered earlier, which is, we have hospital systems that have doctors who, you know, a medical group participants deployed, but also some contracting. But the contracting doctors can participate. But the employed doctors who work for the hospital systems oftentimes support hospitals across the state in a variety of ways, and have, you know. So it's a complicated process in terms of "Are they eligible?". If the hospital is only participating with, let's say, starting with some of their neighbor island or rural hospitals, but not the mothership right away, and the doctors participate.

>>Nora Lewis, CMS: Yeah. So, what I'll say, I mean, I think we need to, maybe take that one back. But What I will say is that we are defining practice participation in Primary Care AHEAD at the TIN level and not at the NPI level. So, individual practitioners can't opt into the program. It has to be their entire TIN. So, that might be a little limiting in terms of what you're describing for an individual practitioner that's employed by a hospital. Does that make sense?

>>Jack Lewin, MD: Yeah. Well, no, I'm thinking about for the employed doctors who you know there's medical groups that are employed. If the if the hospital, um, the total system isn't in, but some of the facilities are, how would we determine which of the doctors would become eligible?

>>Nora Lewis, CMS: Yeah, so that that'll be geographic. It'll likely be based on the service area that the specific hospital within the system is in um. But we are developing that criteria right now. So, we don't have a full final answer or a methodology on that right now.

>>Jack Lewin, MD: Yeah, yeah. Because there's some crossover between, you know, practices in terms of stuff. Okay, Thank you

>>Nora Lewis, CMS: Yeah, thank you. That's a great flag. I appreciate it.

>>Julia Marcus, CMS: Again, still working on a lot of the technical questions. But we did get a few questions about the application. So again, while we have Jamie from our Office of Acquisition and Grants management, I want to get her take on me so. A couple of questions for you, Jamie. The first is, "What should the applicant identifier be on the SF424 question number four?" which is a very specific question, if you're able to answer that.

>>Jamie Atwood, CMS: Ah, let me let me actually pull up the 424 in front of me, so I can make sure I get the right answer.

>>Julia Marcus, CMS: I think everyone's trying to take advantage of having you live on the call today, so we appreciate it.

>>Jamie Atwood, CMS: That's good. Okay, so, I think for this one we, we don't care about that one. I'm going to check some of ours. Um: We yeah, let me pull up some of the other ones I can give you an exact answer.

>>Julia Marcus, CMS: No problem. Thanks, Jamie.

>>Jamie Atwood, CMS: Okay, yeah, that's not one of the numbers that we actually care about. Let me pull this back up here. So, if you look at the actual 424, the numbers and the fields that matter to us are under eight. So eight is the legal name, and then there's EIN, um, and then there's a UEI, so as long as you're registered in the system for award management. So, if you're all state agencies. I'm sure that's already, you know, the case. So, you would have to fill out the EIN, and then your UEI. Those are the identifiers that we care about, and that's under field eight A, B, C.

So, is there any more follow up on that? I can pull up, you know a blank 424, if you have any other questions. But yeah, the applicant identifier, we don't expect anything in that one or 5A or 5B. So, it's, um eight is the numbers where I referenced.

>>Julia Marcus, CMS: Okay, Jamie, we've got a couple of other questions for you. If there are any other questions. I think that came from Joyce. If you have any other questions on the 424, please let us know. Another person, asks Jamie, "Is the cost of the grants of factor in selection?" So, I think they mean is their budget narrative a factor when we review application.

>>Jamie Atwood, CMS: If you look in the NOFO, the budget narrative is part of the scoring, I believe, but also yes, we are looking at your application for a couple of different things. One is we want to make sure you've identified allowable costs, and the Budget narrative is where you're going to go into a lot of detail

about the activities that you're proposing and the costs associated with them that allows us to do our review. So, let's say, for example, from my perspective, I'll be looking at it in terms of are these allowable costs? Do they line up with the cost principles in the reg, you know, grants regulation? But also your project officers, programmatically, they are going to be looking at it, to say that this supports the goals and objectives of the project. Let's say they look at the Budget Narrative, and what you have in there doesn't seem to support that, right? Yes, it would be a factor in the selection process. Now, it's not guaranteed that you would have negotiations. It depends on how you know far your application gets in the process. But, during the negotiations process, sometimes we can talk through some of those questions and concerns that we have. But, yes, your budget's very crucial, because we're looking at whether the costs are allowable, whether they're reasonable, whether they're necessary, they support the project, they are part of, like, you know, the scoring of the application in terms of Merit Review. So, I would definitely say that "Yes", it's important what you have in the Budget Narrative, so if that doesn't answer your question. Just go ahead and expand upon it in the chat, and we'll follow up.

I think there's another question, Julia.

>>Julia Marcus, CMS: There is one more question for you. It is a very specific question about the Budget Narrative and the required reporting information for contract and consultant approval. Some of the information requested is TBD. So, they're not able to provide the name of a contractor, the method of selection, period of performance, etc. They could generally describe what that looks like in their state and provide a general scope of work of the areas where they know the contracts are consulted. Does that work in the Budget Narrative?

>>Jamie Atwood, CMS: Yes, look at the NOFO. I think we say in there that it's perfectly reasonable to provide estimated information. Because for most entities, including states, like you can't guarantee funding in advance of getting an award from us, so you can't go out and contact ABC Contractors or sub recipients or consultants, and then get a detailed contract and sign that, right? Because you don't even have an award from us yet. So, we perfectly recognize that a lot of things are going to be kind of "to be determined", even if you have an idea of who you want to work with. Some of those contracts are going to require you, you know, to go out and competitively bid things like that too, so it's fine to put together a "to be determined", like, you don't have the name of the contractor yet, but fill out as much as you can as far as the scope of the work anticipated, the estimated costs and activities for that. Once if you get the award, you'll have to circle back with us once those things are identified. Because, if you look at those list of questions for a contract or a consultant, we have to have those on record for all of them. So, you would give us the information you have at the time you're applying. If you get the award, then you'd follow back up once you've actually solidified that contract or that consultant. But you do have to detail out because you can't just give us the cost without any kind of scope backing that up. So, you're going to say, "Okay, these are the activities and costs", and then, you know, it's to be determined as far as who we're going to work with, how we're going to select them, you know period of performance. Now I will say, a period of performance like you have to be very careful that it's not beyond the year that you're in, or the budget period that you're in right. So, when you get an award for some of the cohorts, it's greater than twelve months. So, normally in a budget period, you have twelve months to be careful of that, too, is that you're allocating, based off um the time that you have like, if it's a budget period of twelve months. That's what the time period is. But, yes, "to be determined" is fine, and we see that all the time.

>>Julia Marcus, CMS: Thanks, Jamie.

>>Jamie Atwood, CMS: Sure.

>>Julia Marcus, CMS: Again, we are still working through the questions in the Q&A.

Jamie, we've got one more question for you. I have got on the hot seat. But just while you're at it for the Congressional District questions 16A and 16B. “Our Medicaid agencies, the application and provide services statewide. For 16A, do we list all the congressional districts in our state?”

>>Jamie Atwood, CMS: No. I think there when you actually fill out the 424, because right now, um, of course, I’m not applying online, but I think there's one where you can pick where it has, like, all. It's not, it's not just a particular district. But, um, I'll double check on that. If it did, it would have to. If it did have a district, it would be obviously the place of where your agency is located, but I think there's also a possibly to do like an all one for the State. So, but, there are drop-down options. I just can't show you all those, because I’m not applying. But I’ll double check on that.

>>Julia Marcus, CMS: Thanks, Jamie. Again, we are working through a lot of different questions related to the financial specs that we're recently released. We've got twenty more minutes. We're going to make our way through as many as possible. We'll also follow up with everything in writing. So, we did have a couple of questions that were submitted in the chat. Um, I think the first one I’m. I'm going to tap Kate Sapra, who is our Division Director to answer some of these live, if she doesn't mind. So, we've got some questions: “Can services, um OB participate in a hospital global budget if the rest of the facility does not?” and “Can other acute facilities participate? Psychiatric, VA, long-term care, ICF, SNF etc.?”

>>Kate Sapra, CMS: Thanks, Julia, my turn to be on the hot seat. Usually I get to be behind the scenes. So, thanks for these questions. So, for the hospital global budgets, it is for all inpatient and outpatient hospital services. So, we're not able to simply offer one service line of prospective global payment. So, that's the long answer to a short answer which is “no”. Um on number four, the question about which hospitals can participate. So, we outline all of that in the financial specs for the Medicare Fee-for-Service. However, Medicaid could include other hospital types. So, for example, children's hospitals were not including those in Medicare, but Medicaid could. Thanks, Julia.

>>Julia Marcus, CMS: Thank you, Kate.

>>Jamie Atwood, CMS: Hey Julia.

>>Julia Marcus, CMS: Again, if you submitted your questions via the Q&A, which I did ask you to do, we are providing a lot of the responses to the more technical questions in writing so that you have those. If you review our responses and still have questions, please feel free to let us know and we can try and clarify that. Just for other folks on the phone, we have answered questions about quality, we have answered questions about graduate medical education, um, we also clarified that these are resources will be made available, things like that.

We did get one question which I have a clarifying question on the question is: “Why are ACO aligned beneficiaries included in historical revenue calculations and excluded when calculating total cost of care targets?’ I would like to know if you're talking about the statewide total cost of care targets or the total cost of care performance adjustment in the Hospital global budget. If you wouldn't mind clarifying, we're happy to answer that question, I'm just not sure which one you're referring to in your question.

We did ultimately another question which says “The State Budget Methodology seemed to suggest that if States Don't hit their target, CMS could recoup some of it through the hospital payments. Will you clarify and elaborate?” I'm going to tap Kate again to see if she wants to answer this one live.

>>Kate Sapra, CMS: Thanks, Julia. This is an important thing to clarify. If a state is not meeting, it's Medicare fee for service or all payer total cost of care targets, CMS will work collaboratively with the State to ensure that in future performance years the State will need those targets, and there are a range of options available. That could include CMS requiring the State to submit and implement a corrective action plan. It could include changes to the enhanced primary care payment amount, and it could include changes to the CMS Designed Medicare Fee for Service Hospital, global budget payment amount.

And again, this is to ensure that the State is meeting the total cost of care targets, you know, as we know, in the NOFO, If the state we're not meeting the all-payer total cost of care growth, target. Then, as part of a corrective action plan CMS may require, for example, public reporting on commercial cost, growth in aggregate and by payer.

If we look at all payer cost growth, and we see that it is Medicaid that's driving the cost growth, and it's because, for example, they expanded Medicaid, or they expand the types of eligible population, CMS will hold the state harmless for that. So, it really is collaborative, and all of this will be specified in the State agreement as well.

There will be a lot of detail afford it to States in the State agreement, and it really is designed to be collaborative and ensure that future performance years have success. It is not about going back and recouping those money.

Thanks, Julia.

>>Julia Marcus, CMS: Thanks, Kate, still working through quite a few of these questions here. Again, we got to a lot, and it just occurred to me that not everyone can see the Q and A. So, if you didn't ask the question, you cannot see the answer. A lot of these are questions about the financial specs. But another one that I think is important to highlight is the question, how is CMS defining the defined geographic service area for hospitals. I’m going to run through this response quickly, because I think other people also ask the same question.

First, hospitals will be assigned costs and beneficiaries based on a defined geographic service area listed in the hospital's primary service areas just typically defined as sixty percent. Costs and beneficiaries in the defined geographic areas claimed by more than one hospital, will be allocated according to the Hospital's share of Medicare fee for service inpatient and outpatient discharge claims among hospitals, claiming that zip code. Next, defined geographic service areas not claimed by any hospital are assigned to hospitals with plurality of Medicare fee for service claims in that defined geographic service area. If it does not exceed a 30-minute drive time, from the hospitals TSA, which is the primary service area. Finally, the defined geographic service area is still unassigned will be attributed to the nearest possible based on drive time.

So hopefully that helps. You can see why we're answering a lot of this in writing. The recording, this transcript, and FAQ will all be posted on our website. We're going to work to get that out ASAP. So hopefully, it's up there in the next week or so. So that you can see all this in writing because we

acknowledge that some of these questions are very technical in nature. To me, reading the response isn't necessarily helpful. But again, keep the questions coming. We're working on these.

We did also get some questions about commercial payers. So just FYI because we're responding to some of these in writing. Again, commercial payers can use. CMS is Medicare Hospital, global budget methodology, or they can design, and use an alternative. The commercial payers are responsible for the design and administration of their hospital global budget.

We got some clarifying questions on that. I just wanted to share that information aloud as well.

Quick question about academic medical centers. How are academic medical centers, defined? Academic medical centers, colloquially known as AMC's, are affiliated with medical schools, and confirmed medical degrees. Most AMCs are also teaching hospitals but not all teaching hospitals are AMCs.

And again, as you can tell, as I look at my other screens, here we are working to answer the remaining questions, most of which are about the financial specs. So just give us a couple more moments. Again, we are going to respond to everything in writing, so any of the questions that came into the inbox, we will get you a written response as well. The recording, the transcript, and an FAQ, as appropriate will all be posted on our website. We know that you know, when they come in fast, and there's a lot of technical questions, it's hard to follow them all. We'll make sure that those go out to everyone on our website, and if you're not already on the AHEAD Model listserv, for example I know there was some confusion about the link for today. If you would like to be on the AHEAD model listserv and you are not, please let me know and we can add you so you can get all our updates by email as well.

Okay, a couple of questions in here. I'm going to answer quickly. We can add you to the list of today. If you are not on it, so feel free to just send me your email address. I'll make sure I get you added to that. How soon will written answers be available? If they were submitted to our inbox, we try to get them out every week. If you have not yet submitted them, or they came in through this Q &A, hopefully in the next week or so. But I don't' want to commit to anything. I see some emails coming in to get you added. So again, if you are not on the listserv and you want to be added, I'm happy to get you added to that. We also have a clarifier from Jamie about the SF424. Jamie, do you want to answer that live?

>>Jamie Atwood, CMS: Sure, that's fine. I basically I copy and pasted it in the chat for Julia. So, you guys cannot see. But there are directions for completing the SF424. So, when you're in grants.gov hopefully, you'll see those. Or you can Google them online if you go to the grants.gov website. That form has directions, and it says in there if all congressional districts in a state are affected, enter all for the district number, e.g., Maryland all for all congressional districts. So, you do have that option. If its only partial, you would enter the actual districts that are affected. So, these directions are available for the 424 online.

>>Julia Marcus, CMS: And just FYI which Jamie just ran through, those directions all available online, as she mentioned. I just popped what she said in the chat, not the Q&A. So, if you have questions on that. Again, I copy and pasted what she just said so you have that available.

I know we've only got five minutes. We're doing our best to get through all these questions so hopefully, we can get to a couple more.

Julia Marcus: And again, if we don't get these questions live, it all saves when we close out. So again, we're going to work on getting questions in writing. And if you submitted questions to the AHEAD inbox, we did not get to all of them. I know there were many, and I apologize, we didn't get to everything today. We'll follow up with you in writing to get those ASAP. We are working on a couple of remaining questions. So just give me a moment. In the 3 minutes we're going to try and pack a lot in.

>>Laura Snyder, CMS: Hi. This is Laura Snyder. I'm, the head model co-leads the first time you're hearing from me today. But we wanted to speak to some questions that we're getting about what specific support and facilitation CMS will provide to help with calculations and implementation for non-Medicare fee for service hospital global budgets. And so, the short answer is that we can assist States with understanding how they can help other payers align with our concepts, if that's the direct you choose to go. But Medicare/CMS, is not going to be making the calculations or handling the implementation directly. So, in other words, each payer would be handling those elements.

>>Julia Marcus, CMS: Okay, in the last 60 seconds here, we're getting to a couple additional ones in the chat. But again, we will post the recording, the transcript, an FAQ on the website in the coming days/weeks. We are going to work on getting a done ASAP. If you have any questions that came to the AHEAD model inbox that we did not get to, we will follow up with you in writing. You are also more than welcome to email us at the ahead of model inbox, which is just ahead@cms.hhs.gov. So on the screen, I'm throwing it the chat, so you have it there. Do you have any additional questions that you have not yet submitted? You can send those over via email and we will get to you. You can also email us to get added to the listserv. Then you won't miss out on any of our notifications when things go live on our webize, links for webinars, things like that.

So, with that I would like to thank you all for joining and asking a lot of really great questions. I apologize that we didn't get to everything live today, but we will follow up with you so we can get everyone responses. You can always reach us at our inbox, and we work on getting responses out asap.

But otherwise, I hope you have a great day and a great rest of your week, and as you continue working on those applications which are due on March 18th, which is coming up, please let us know if you have any questions. And with that we are going to go out and close out.

>>Jack Lewin, MD: Thanks very much.

>>Julia Marcus, CMS: Thanks, Jack. All right, Thanks, everyone. We will follow up with all the questions we didn't get to inviting. So, thank you, and have a great afternoon.

AHEAD Model Notice of Funding Opportunity Support Office Hour Session – Q&A

Q: What is an appropriate level of hospital participation in a state? E.g., Missouri has ~110 hospitals and 25 Critical Access hospitals.

A: Execution of hospital Participation Agreement for hospitals such that at least 30% of Medicare FFS NPR would be under Medicare FFS hospital global budgets by PY3 and for each subsequent PY. 10% NPR by PY1. Does that help?

Q: I have seen nothing on Graduate Medical Education (GME) and AHEAD. How will GME be addressed in AHEAD?

A: Regarding Graduate Medical Education in the hospital global budget (HGB), it happens in two phases. Direct Medical Education is handled outside the global budget and will continue in the usual manner. Indirect Medical Education is paid in the FFS setting as an add on to DRG payments, so it will be set as part of the baseline budget at historical levels. Note that the GME is a baseline that is designed not to go below a floor as future volumes change over the life of the HGB.

Q: We are interested in better understanding how Medicaid state agencies can best align with Quality requirements for the hospital global budget. In the NOFO you list many existing hospital quality programs hospitals may participate in some or all of these. Outside of the CAH hospital quality adjustment can you provide more clarity on the required adjustment based on quality performance data?

A: Acute care hospital quality adjustments as part of the CMS-designed Medicare FFS HGBs allow quality measures to align with existing CMS programs for PPS hospitals. These programs include Hospital Readmission Reduction Program (HRRP), Value-Based Purchasing (VBP), Hospital Acquired Condition Reduction Program (HACRP), Medical Inpatient Quality Reporting (IQR), Medicare Promoting Interoperability, and Medical Hospital Outpatient Quality Reporting (OQR). Non-CAH participating hospitals will continue to report to these programs under the AHEAD Model. There are no other AHEAD-specific Quality incentive programs other than the Health Equity Improvement Bonus.

Q: Re HBG methodology: Why are ACO-aligned beneficiaries included in historical revenue calculations and excluded when calculating total cost of care targets?

A: Thanks so much for attending the NOFO office hours webinar. We are so sorry we weren't able to respond to your question about ACO-aligned beneficiaries and the HGB TCOC Performance Adjustment.

You asked why ACO-aligned beneficiaries are included in historical revenue calculations but excluded when calculating total cost of care adjustment for hospitals. Per pg. 96 of the Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology, "the TCOC Performance Adjustment will include non claims-based payments, which includes, but is not limited to, capitated payments and Accountable Care Organization (ACO) shared savings or losses."

We hope this helps answer your question, but please let us know if you found any of the language in our materials confusing. We would appreciate it if you could point us to the material(s) that gave you the impression that ACO-aligned beneficiaries would be excluded from the HGB TCOC Performance Adjustment calculation.

Q: Re HBG methodology: How is CMS defining the defined geographic service area for hospitals?

A: First, hospitals will be assigned costs and beneficiaries based on a defined geographic area listed in the hospital's Primary Service Areas (PSAs) (typically defined at 60%). Costs and beneficiaries in defined geographic
areas claimed by more than one hospital will be allocated according to the hospital's share of Medicare FFS inpatient and outpatient discharge claims among hospitals claiming that ZIP code.

Next, defined geographic areas not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS claims in that defined geographic area, if it does not exceed 30 minutes' drive time from the hospital's PSA.

Finally, defined geographic areas still unassigned will be attributed to the nearest hospital based on drive-time.

Q: The state budget methodology seemed to suggest that if states don't hit their targets, CMS could recoup some it through the hospital cap payments. Will you clarify/elaborate?

A: If a state misses their Medicare FFS or all-payer TCOC targets, CMS will work with the state to ensure that the state will meet these targets in future performance years. This could include requiring the state to submit and implement a corrective action plan, CMS implementing changes to the hospital global budget calculation, and/or changes to the EPCP amount. This will be outlined in the State Agreement.

Q: Hospital leaders interested in the model are concerned about the market shift adjustment. Using the example from CMS, it seems as if one hospital reduces volumes through better population health, they could see a decrease in the cap payment through a market shift adjustment if other hospitals don't similarly reduce volumes. Will you elaborate on this decision to include all hospitals and not just AHEAD participants?

A: For reductions in utilization for potentially avoidable utilization (PAU), they should not be captured in the market shift measure. That measure compares hospitals gaining volume within a geographic area with hospital losing volume within the same area. Market shift is restricted to net exchanges between those hospitals. For hospitals reducing volume that is not picked up in other facilities, there is no transfer of revenue because it is not a shift from one hospital to another. Market shift capture volumes lost in one facility but picked up in another in the same geographic area.

Q: Regarding Potentially Avoidable Utilization (PAU) measures, are these measures prescribed by CMS or can states select analogous measures that they feel are more suitable to measure PAU?

A: For the CMS-designed Medicare FFS HGB, CMS is continuing to explore how a state definition of PAU may be included in the PAU calculation and Effectiveness Adjustment. For state-designed HGB methodologies, CMS would consider an alternative definition of PAU.

Q: How are the Academic Medical Centers defined?

A: Academic medical centers (AMCs) are affiliated with medical schools and confer medical degrees. Most AMCs are also teaching hospitals, but not all teaching hospitals are AMCs.

Q: Will there be public use files (PUFs) for block group level claim counts and other relevant statistics (like low income status, etc.) by hospital?

A: I'm not certain what you mean by "block group level claim counts", so please let me know if you can clarify. We will provide participating hospitals with hospital specific data, however, the hospital "dashboards" have not yet been built, so I can't say what specifically will be included, but we welcome input on what would be most useful!

Q: Dos a hospital network treated as one unit or as separate facilities?

A: Hospitals will be defined based on hospital provider number

Q: Re HBG methodology: Why are ACO-aligned beneficiaries included in historical revenue calculations and excluded when calculating total cost of care adjustment for hospitals?

A: The CMS-designed Medicare FFS hospital global budget takes a participating hospital's historical revenue from IPPS and OPPS payments, including those for ACO-aligned beneficiaries, with sufficient complete claims to create the most accurate baseline possible. Historical revenue paid by CMS outside the FFS framework will continue to be paid separately from Hospital Global Budgets. The total cost of care (TCOC) Performance Adjustment as part of the CMS-designed Medicare FFS hospital global budget methodology will be based on a benchmark that includes beneficiaries within the geographic service area. The TCOC Performance Adjustment will include non-claims-based payments, which include, but is not limited to, ACO shared savings or losses.

Q: Is there a role for Medicare Advantage participation in the hospital global budget?

A: Yes, the AHEAD Model allows for participation by Medicare Advantage plans (including Dual Eligible Special Needs Plans). States must recruit at least one commercial payer operating in the state or sub-state region to participate in hospital global budgets by the start of the second Performance Year as required in each award recipient's State Agreement and the Cooperative Agreement Terms and Conditions. Participation by one or Medicare Advantage plans counts towards this requirement. In addition, the state will set targets for all-payer cost growth and primary care investment target that will include Medicare Advantage plans. The state may also choose to convene payers, including Medicare Advantage plans, to support multi-payer alignment on primary care transformation and other population health activities.