

Achieving Healthcare Efficiency through Accountable Design (AHEAD)

Model Updates Recorded Webinar

Center for Medicare and Medicaid Innovation
January 2026

Agenda

This recorded webinar provides an overview of updates to the AHEAD Model, effective September 2025, covering the following topics:

- 1 | AHEAD Model Overview & Updates
- 2 | Geo AHEAD
- 3 | Primary Care AHEAD
- 4 | Hospital Global Budgets (HGBs)
- 5 | Choice and Competition
- 6 | Population Health Accountability Plans
- 7 | Resources & Closing



Key Model Updates

- Shifts in Timelines
- Geo AHEAD
- Additional Primary Care AHEAD (PC AHEAD) Pathways
- Choice and Competition

Today's Presenters



Ryan Marie Smith

Health Insurance Specialist, AHEAD Model, CMS Innovation Center

Mattan Alalouf

Health Insurance Specialist, AHEAD Model, CMS Innovation Center

Pooja Seth

Health Insurance Specialist, AHEAD Model, CMS Innovation Center

Katarina Morgan

Health Insurance Specialist, AHEAD Model, CMS Innovation Center

AHEAD Model Overview & Updates

CMMI & State Partnership: Advancing Local Strategies to Help Solve National Healthcare Challenges



Empowers States to Lead Bold Reforms that Transform Population Health

Emphasis on choice and competition

Novel approaches that build on state's current programs and prior experiences

Flexible paths for participation



Unifies Across Payers and Systems

Incentives that promote accountability and collaboration across all healthcare entities

Alignment and reinforcement towards shared goals (e.g., expanding accountable care delivery, value driven health outcomes)



Emphasizes Value, Fiscal Responsibility, and Sustainability

Opportunities for financial win-wins across stakeholders

The AHEAD Model is a Comprehensive System-Wide Approach

The AHEAD Model equips states, providers, hospitals, and geographic risk-bearing entities with tools and resources to drive transformation -- enabling proactive, personalized care, improving population health, and curbing cost growth.

Key Strategies

**Total Cost of Care
Accountability &
Quality Targets**

**Benefit
Enhancements**

**Cooperative
Funding**

**Multi-payer
Alignment**

**Choice &
Competition**

**Waivers &
Legislative
Authority**

Alternative Payment Approaches

Primary Care AHEAD (PC AHEAD)

Elevating Everyday Care

- Enhanced and advanced payment pathways
- Invests in upstream prevention, specialty care, and behavioral health integration
- Required Medicaid alignment

Hospital Global Budgets (HGB) AHEAD

Rooted in Community Care

- Predictable revenue
- Global budget savings opportunity
- Rewards population health management
- Required Medicaid alignment

Geo AHEAD

Partners in Patient Health

- Geographic ACO
- Shared savings opportunity
- Enhances care management and care coordination
- Optional Medicaid alignment

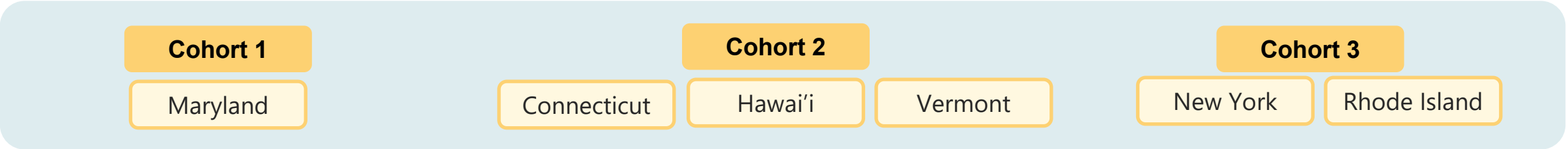


Care Delivery Transformation that Drives Better Health, More Choice, Stronger Competition

State-Led. Provider-Driven. Patient-Focused.

What's New? 1 - 3

	Update	Objective(s)/Benefits
 Timeline	Cohort 1 will maintain the original performance start date and the end date will shift back one year. (January 1, 2026 - December 31, 2035). In all Cohort 2/3 states, the model performance dates shift back one year (January 1, 2028 - December 31, 2035).	• Allows Cohort 1 to maintain momentum and continue progressing on activities without delay. • Provides Cohort 2/3 states additional time for planning and securing legislative authorities
 Opportunity for Additional States to Join AHEAD	Opportunity for two additional states to participate in the model starting in 2028 and/or 2029.	• More opportunities for innovation and transformation



What's New? 2 - 3

	Update	Objective(s)/Benefits
 Addition of Geo AHEAD	New geographically-based accountable care organization (ACO) program incorporating novel geographic alignment mechanisms and competitive bids against a discounted benchmark (January 1, 2028 – December 31, 2035).	- Expands accountable care to all eligible, Original Medicare beneficiaries using attribution approaches that balance patient choice with geographic coverage - Introduces competitive bidding on CMS-determined benchmark to drive cost savings, quality and innovation - Establishes regional accountability for quality and TCOC aligned to state targets - Adds new pathways for providers to participate in AHEAD, offering additional supports and shared savings
 New PC AHEAD Pathways	Addition of three new pathways with varying level of risk and reward , including two capitated payment pathways. Cohort 1: New pathways will be added annually (Jan 2026/Basic; Jan 2027/Advanced-Hybrid). Cohort 2/3: All pathways will begin January 1, 2028.	- Provides practices flexibility and choice in how they participate (through PC AHEAD and/or Geo AHEAD) - Supports movement towards hybrid payment models - PCPs have options (not requirements) to advance pathways

Cohort 1

Maryland

Cohort 2

Connecticut

Hawai'i

Vermont

Cohort 3

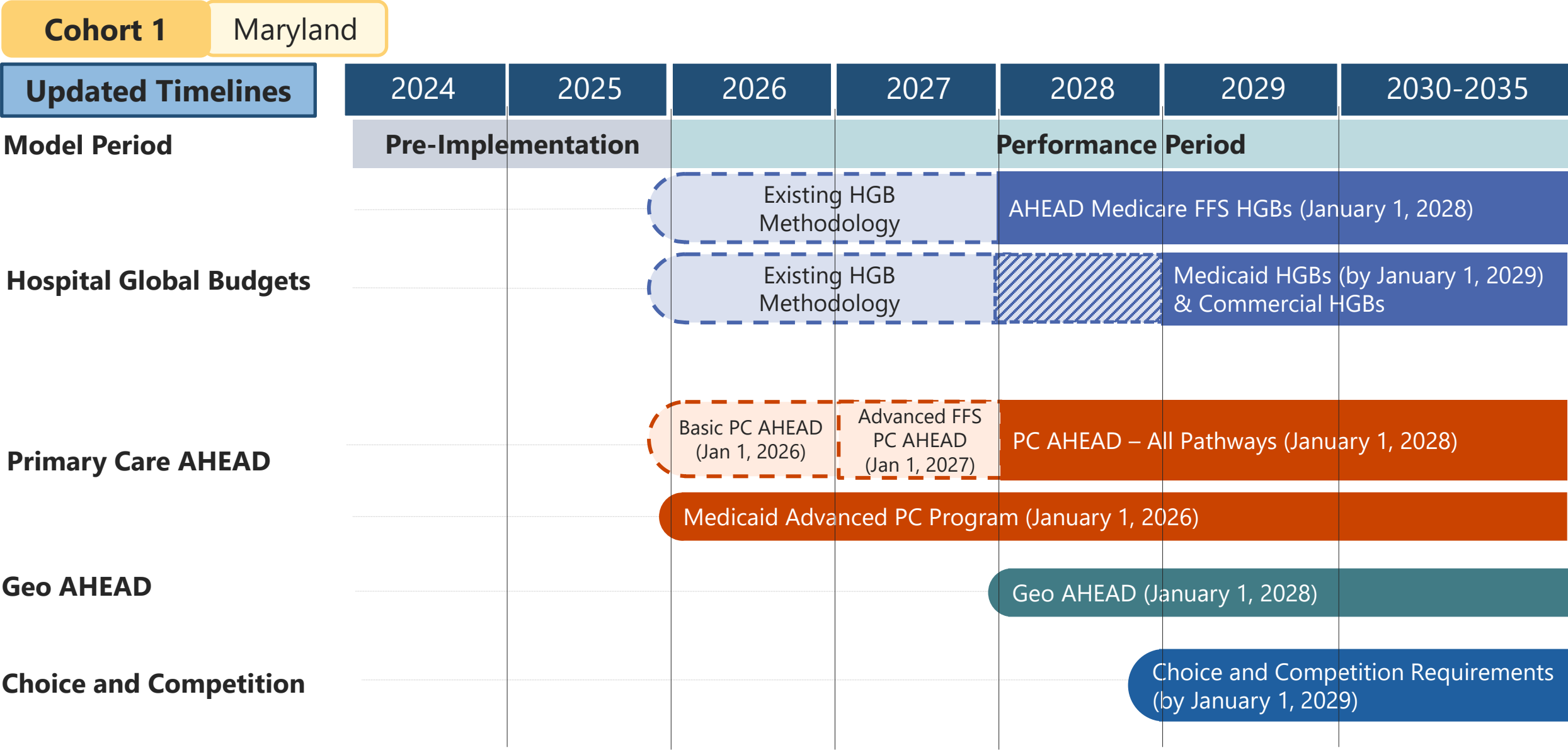
New York

Rhode Island

What's New? 3 - 3

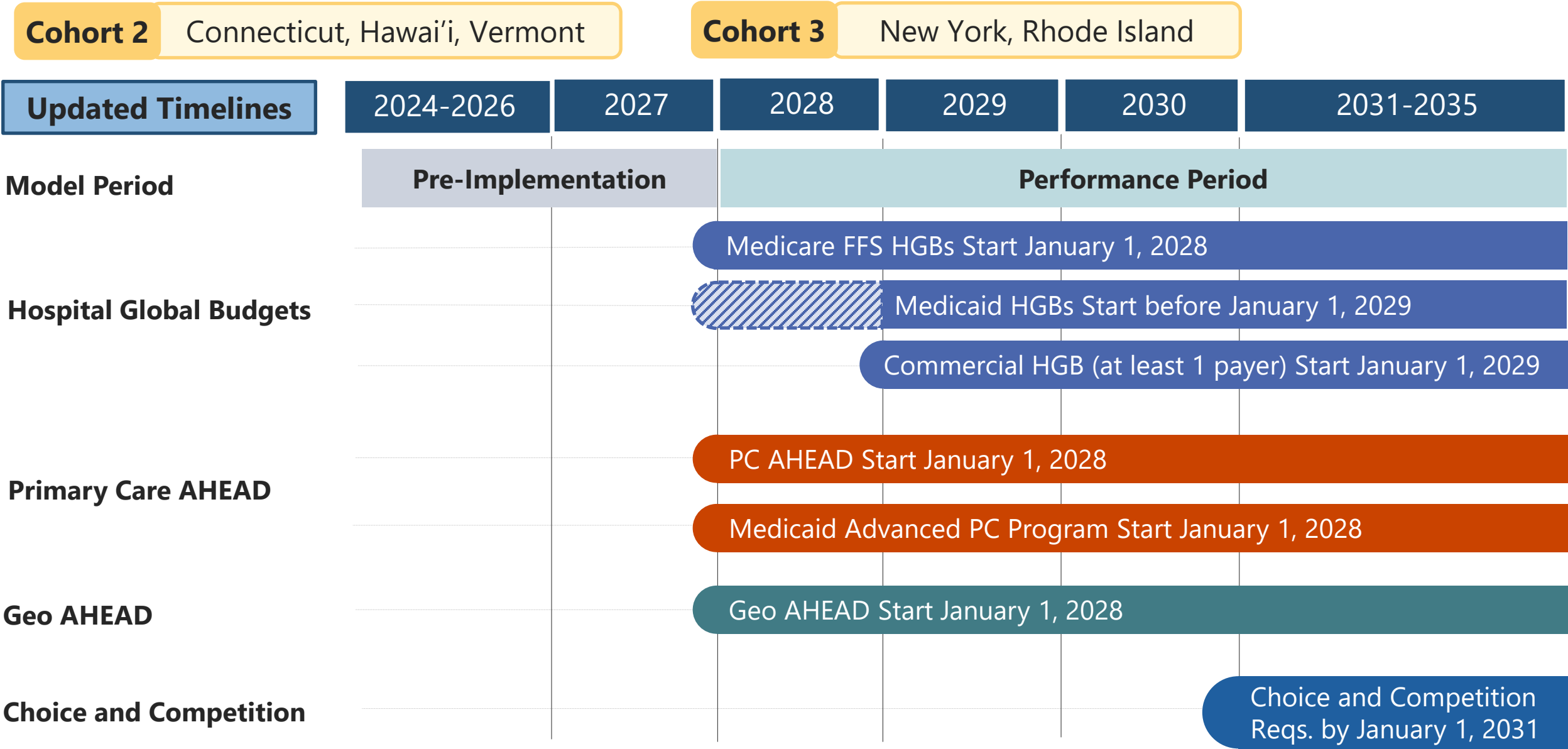
	Update	Objective(s)/Benefits
 Choice & Competition	States will implement or enhance policies that increase consumer choice and market competition.	• Supports states in meeting cost and quality targets required under AHEAD.
 Population Health Accountability Plans (PHAP)	State and hospital accountability plans to increase support of population health improvement.	• Emphasizes quality measures and improved health outcomes for all. • Sets state-driven priorities to align payers and participating providers.
 Reporting Requirements	States are no longer required to report quality metrics by race/ethnicity. Hospitals and providers no longer required to submit demographic data. States must make public each payer's and hospital's performance on a state-owned website.	• Streamlines reporting requirements and reduces reporting burden (in alignment with Executive Order 14173). • Promotes consumer choice through easy access to hospital cost and quality data.

Updated Model Timeline – Cohort 1



MD will launch the AHEAD Medicaid HGB methodology during this period.

Updated Model Timeline – Cohort 2 and 3



States expected to launch AHEAD Medicaid HGB methodology during this period.

Geo AHEAD



Geographically-based accountable care organization (ACO) program where risk-bearing entities support total cost of care (TCOC) accountability and enhance the state's efforts to expand beneficiary access to value-based care, promote prevention and care coordination, improve quality, and encourage choice and competition.

Provides additional tools to support states in enhancing accountable care and achieving TCOC targets and quality goals:

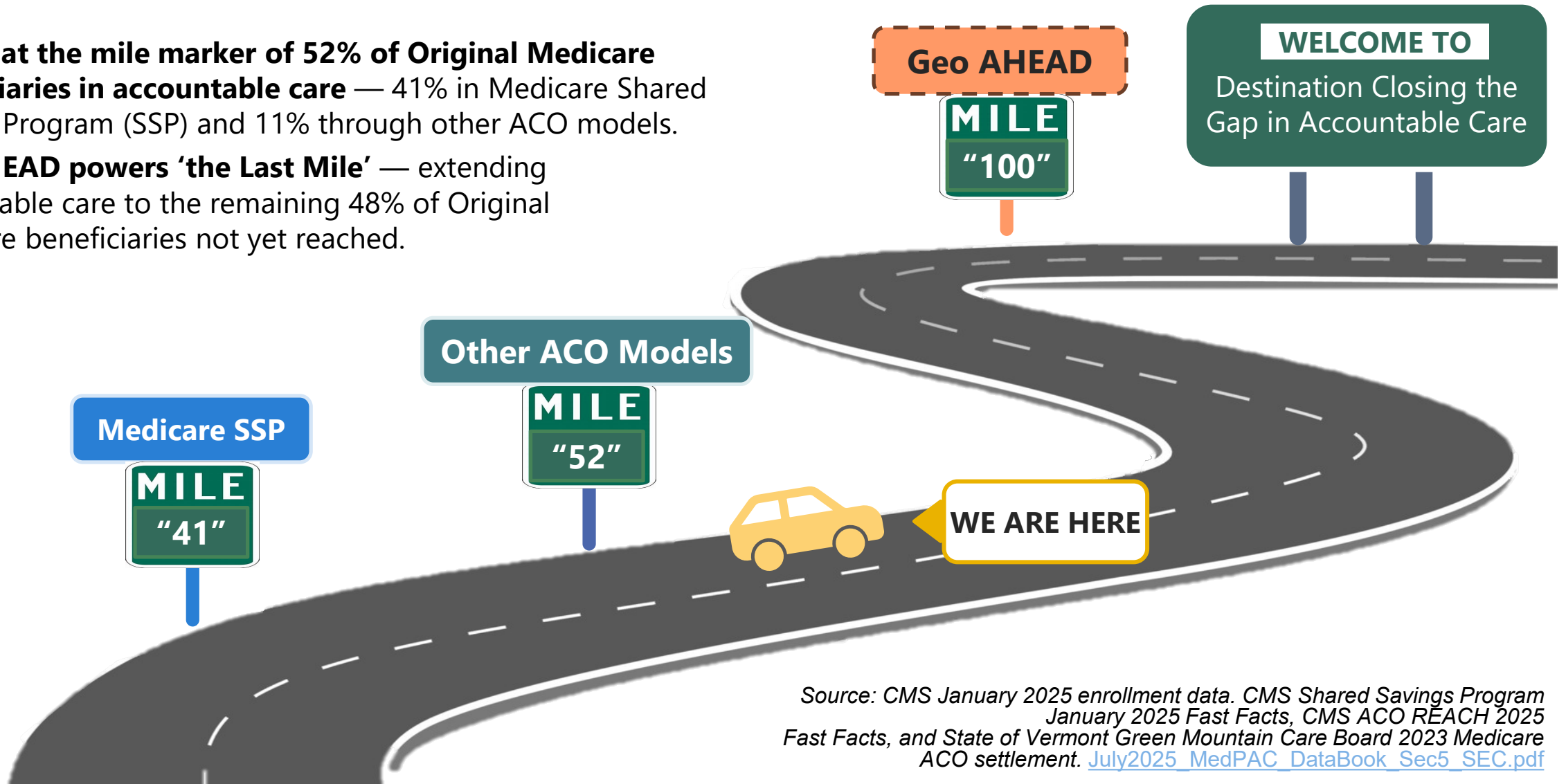
- Expands accountable care to all eligible Original Medicare beneficiaries using attribution approaches that balance patient choice with geographic coverage
- Introduces competitive bidding for Geo Entities to drive cost savings, improve quality, and foster innovation
- Establishes regional accountability for quality and TCOC aligned to state targets
- Adds new pathways for providers and hospitals to engage in AHEAD and benefit from shared savings

Geo AHEAD: 'The Last Mile' to Accountable Care

Geo AHEAD leverages geographic attribution mechanisms to connect eligible Original Medicare beneficiaries to systems of care that improve patient outcomes and reduce TCOC.

We are at the mile marker of 52% of Original Medicare beneficiaries in accountable care — 41% in Medicare Shared Savings Program (SSP) and 11% through other ACO models.

Geo AHEAD powers 'the Last Mile' — extending accountable care to the remaining 48% of Original Medicare beneficiaries not yet reached.



Source: CMS January 2025 enrollment data. CMS Shared Savings Program January 2025 Fast Facts, CMS ACO REACH 2025 Fast Facts, and State of Vermont Green Mountain Care Board 2023 Medicare ACO settlement. [July2025_MedPAC_DataBook_Sec5_SEC.pdf](#)

Geo AHEAD: Approach and Key Players

Geo Entities (i.e., provider-led groups, technology and digital health companies, health plans, hospitals, and other risk-bearing entities) **are accountable for attributed beneficiaries within the state/sub-state region, including geographically aligned beneficiaries.**

TCOC Accountability

Take on TCOC risk for a defined eligible Original Medicare population

- Competitively bid on a CMS-defined TCOC Benchmark to offer a discounted rate with options for financial benefits

Quality

Responsible for improvement in eight quality measures

- Focus on reducing unnecessary utilization, promote prevention, improve behavioral health, and enhance patient experience
- Eligible for shared savings, if quality standards met
- Scaled quality improvement score applied to savings/losses
- Aligned with Primary Care (PC) AHEAD and Hospital Global Budget (HGB) measures

Who Can Participate & What Are Their Roles?



Primary Care Providers



Hospitals



Specialty & Community Care

Contract with Geo Entities as
-Geo Participants
-Geo Affiliates



Beneficiaries

Aligned with Geo Entity
-Voluntary
-Claims-based
-Geographic

Geo AHEAD: Selection and Operations

CMS will issue competitive Requests for Applications (RFA) and eligible Geo Entities will bid to participate in an AHEAD state (or substate regions).

Geo Entity Bidding Process

- **CMS will release RFAs** for two 4-year contract periods: 2028 to 2031 and 2032 to 2035
- **CMS will provide Geo Entities with state-specific data** to inform their competitive bids:
 - Geo total cost of care (TCOC) Benchmark established by CMS for attribution-eligible Original Medicare beneficiaries
 - Summary-level, historical data on attribution-eligible beneficiaries

CMS Selection Process

- **CMS will evaluate bids** based on:
 - Magnitude of bid discount
 - Capacity to educate and deliver beneficiaries and providers with benefits, payments, and care transformation and coordination supports
 - Strength and depth of partnerships with community-based organizations
- **CMS will select** a minimum of:
 - **Two Geo Entities in states with < 200,000** attribution-eligible beneficiaries or
 - **Three Geo Entities in states with $\geq$ 200,000** attribution-eligible beneficiaries



Geo Entities will operate statewide or within a substate division. CMS will consult with States to create substate divisions. Geo AHEAD will only operate in states (or substate regions) where CMS identifies the minimum required number of Geo Entities.

Geo AHEAD: Two Types of Geo Entities

Statewide Geo Entities

- **Can be any type of risk-bearing entity**, including technology and digital health companies, health plans, hospitals, provider-led, or other risk-bearing entities
- **Bid on entire state or substate region (e.g., downstate NY)**
- Accept attributed beneficiaries from all regions within the state or substate region

Substate Geo Entities

- **Can only be a provider-led entity** (e.g., owned, managed, and controlled by a provider majority, >51%), and providers must practice in the area covered by Geo Entity
- **Bid on one or more substate divisions (or entire state/substate region)**
- Accept attributed beneficiaries from all areas covered by Geo Entity
- CMS will set aside one award in each substate division for a Substate Geo Entity

Example of How Geo Entities Cover a State

- U.S. State A has 180,000 attribution-eligible beneficiaries
- Two Statewide Geo Entities bid on the entire state
- One Substate Geo Entity bid on a substate division in the state

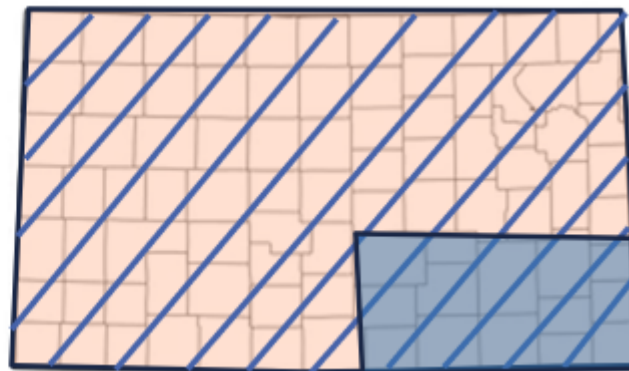
Statewide
Geo Entity 1



Statewide Geo
Entity 2



Substate
Geo Entity 1



Geo AHEAD: Two Ways for Providers to Participate

Geo Participants

Medicare-enrolled provider/supplier

1

Align with only one Geo Entity



Cannot concurrently participate in Primary Care (PC) AHEAD or Accountable Care Organization (ACO) models (e.g., *Medicare Shared Savings Program*),



Contribute to claims-based attribution



Receive capitation payments in lieu of Medicare FFS payments for select PC services plus an Enhanced Primary Care Payment (EPCP) for care management



Accountable for financial and performance risk with potential for shared savings/losses

- Must participate in state's Medicaid Advanced PC Program
- Must use CEHRT, which qualifies as an Advanced Alternative Payment Model (AAPM)
- Eligible for benefit enhancements
- Hospital owned practices can only be Geo Participants if their parent hospital participates in HGB AHEAD.

Geo Entity Alignment

Overlaps

Claims-based Attribution

Payment Methodology

Accountability

Geo Affiliates

Medicare-enrolled provider/supplier

≥ 1

Align with one or more Geo Entities



Able to concurrently participate in PC AHEAD and/or ACO Models



Do not contribute to claims-based attribution



Receive Medicare FFS payments as usual for select Medicare PC services

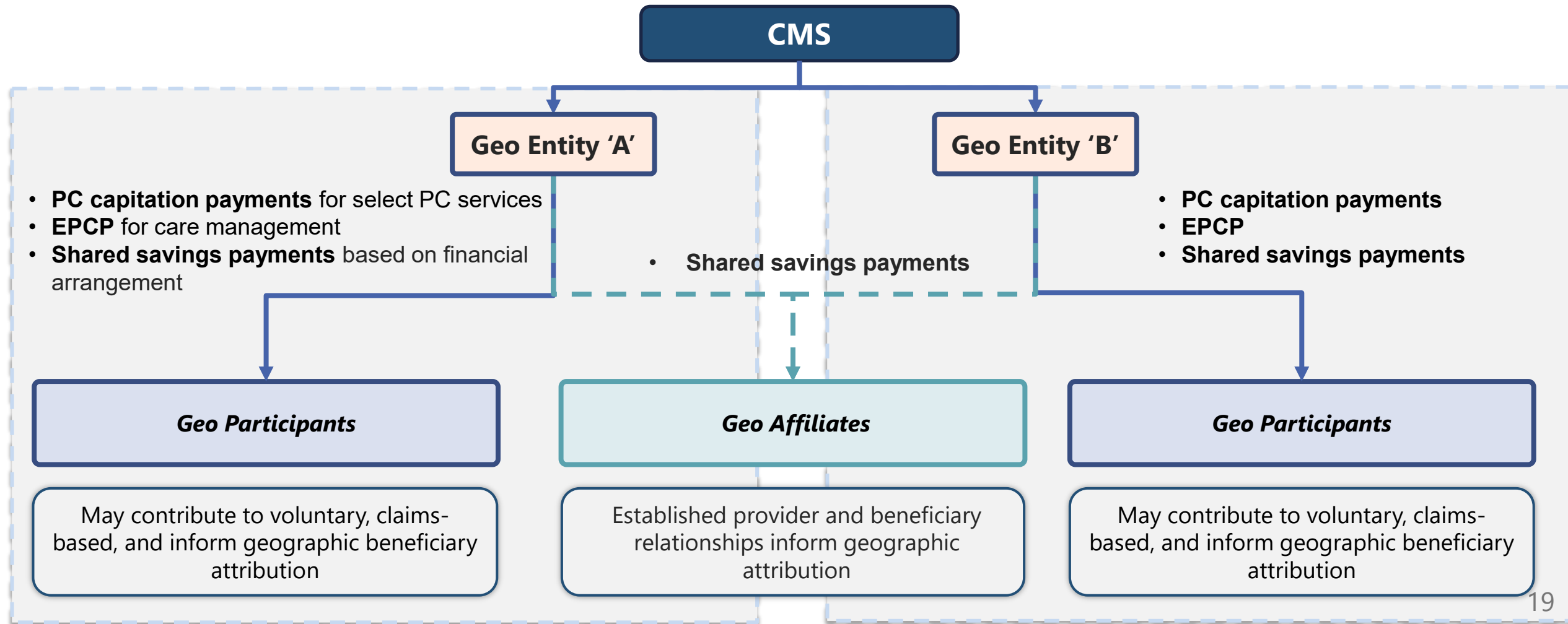


Support Geo Entity goals (e.g., quality) with potential for shared savings/losses as defined in the financial arrangement

- No requirement to be in Medicaid Advanced PC Program
- Eligible for benefit enhancements
- No required reporting, unless specified in financial arrangements with Geo Entity

Geo AHEAD: Examples of Relationships Between Geo Entities and Providers

- Geo Entities form financial relationships with both Geo Participants and Geo Affiliates and specify payment amounts and terms in their contracts.
- Geo Participants can form a financial relationship with only **one** Geo Entity, whereas Geo Affiliates can form financial relationships with **multiple** Geo Entities.



Geo AHEAD: Beneficiary Attribution

- Beneficiaries will be attributed annually prior to the start of the performance year and potentially at additional times.
- Voluntary attribution will occur on a quarterly basis, and beneficiaries who lose attribution eligibility will be dropped on a quarterly basis.

Under Geo AHEAD all eligible Original Medicare Beneficiaries that are not currently attributed to Medicare Shared Savings Program (SSP) or other accountable care organization (ACO) models will be attributed to a Geo Entity

Attribution to Geo Entities will take place in the following order:

- 1. Voluntary Attribution:**
Beneficiaries choose to align with a Geo Participant
- 2. Claims-based Attribution:**
Beneficiaries aligned based on claims with a Geo Participant
- 3. Geographic Attribution:**
Any remaining non-aligned beneficiaries in a geographic area assigned to a Geo Participant

SSP & Other
ACO
Beneficiaries

Non-
MSSP/Other
ACO
Beneficiaries

Voluntary
Attribution

Other
Beneficiaries

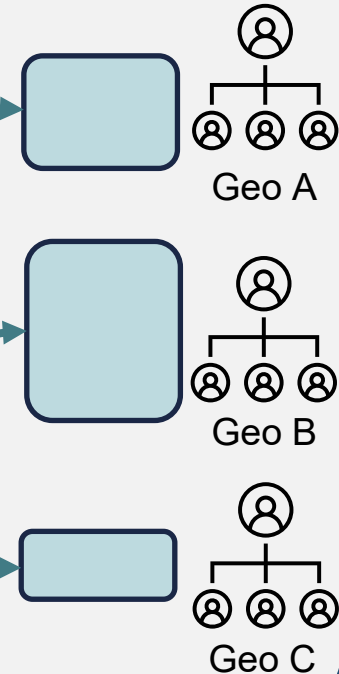
Prioritize
beneficiary
choice with
voluntary
attribution to
a Geo Entity

Encourage
existing care
relationships
with claims-
based
attribution

Claims-
based
Attribution

Geographic
Attribution

Attribute all
remaining
beneficiaries to
a Geo Entity



Primary Care AHEAD

Primary Care (PC) AHEAD: Key Design Elements



Payment Model

Participants choose from four quality-adjusted pathways and receive Enhanced Primary Care Payments (EPCPs), which provide funding to drive meaningful care transformation



Medicaid Alignment

To be eligible for PC AHEAD, participants must be in the state's Medicaid advanced PC program



Care Delivery Model

Participants focus on behavioral health integration, specialty care coordination, and health promotion activities with financial benefits for measurable improvements



Advanced Alternative Payment Model (APM) Opportunities

Participants in more advanced pathways qualify for Advanced APM status, making them eligible for additional incentives under Medicare's Quality Payment Program



Claims-based Attribution

Medicare fee-for-service (FFS) beneficiaries are prospectively attributed to participants based on historic claims data and established relationships

Primary Care (PC) AHEAD: Pathways in AHEAD



- PC AHEAD is a voluntary advanced primary care program offering four pathways for participation.
- Participation is open to Primary Care Practices (PCPs) and Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs), Health Center Look-Alikes, and Rural Health Clinics (RHCs).

PC AHEAD Pathways (All Cohorts): Jan 2028 – Dec 2035

- ☐ **Basic**
- ☐ **Advanced – Fee-for-Service (FFS)**
- ☐ **Advanced – Hybrid**
- ☐ **Advanced – Capitated**
- ☐ **Advanced – Geo (Geo AHEAD Pathway)**

Participants can choose any of the PC AHEAD pathways or the Geo AHEAD pathway.
They may switch pathways annually beginning in 2029 and retain the same base payment rates.

Primary Care (PC) AHEAD: Pathways in AHEAD – Cohort 1



- Maryland practices not in the Maryland Primary Care Program (MDPCP) can participate in PC AHEAD.
- In 2026, practices had the option of joining the Basic pathway.
- In 2027, the Advanced FFS Pathway will be added as another option.
- In 2028, if MDPCP ends, all practices will have the opportunity to transition to any of the pathways.

PC AHEAD Pathways (Cohort 1 – Maryland): Jan 2026 – Dec 2027

- ☒ **Basic** (*began January 2026*)
- ☒ **Advanced – Fee-for-Service (FFS)** (*beginning January 2027*)
- ☐ **Advanced – Hybrid** (*not available until January 2028*)
- ☐ **Advanced – Capitated** (*not available until January 2028*)
- ☐ **Advanced – Geo (Geo AHEAD Pathway)** (*not available until January 2028*)

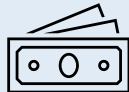
**Maryland practices already participating in MDPCP can choose to continue in MDPCP or join PC AHEAD.
Practices not already participating in MDPCP can only join PC AHEAD.**

Primary Care (PC) AHEAD: Core Payment Methodology Components

All PC AHEAD participants receive an Enhanced Primary Care Payment (EPCP) plus, depending on the pathway selected, some or all of Medicare fee-for-service (FFS) payments may be replaced with capitated payments.

EPCP Amount

All participants receive a prospective, quarterly per beneficiary per month payment.



Averaging \$17-21 per beneficiary in all states



Payment for Medicare Services

Depending on the PC AHEAD Pathway selected, participants will also:

Continue to receive Medicare FFS payments

Claims paid according to the Medicare Physician Fee Schedule (PFS).

and/or

Receive capitated payments in lieu of some/all of Medicare FFS

Fixed capitated monthly payment regardless of services provided based on historic revenue.

Primary Care (PC) AHEAD: Enhanced Primary Care Payment (EPCP) Payment Components

The EPCP Amount is calculated per patient, taking state, participant, and patient-level factors into consideration.

Calculating the EPCP Amount

Applies to:

- All Pathways

Base EPCP

Each state has a base EPCP amount that is adjusted for beneficiary and participant level factors.



Adjustments

Medical Risk Adjustment (MRA)

EPCP is adjusted based on the clinical complexity of the participant's patients.

Population Adjustment (PA)

EPCP is adjusted based on population factors of the participant's patients.

Quality Based Adjustment (QBA)

5-15% of the EPCP is adjusted based on the participant's performance, tied to quality measures.



Earning QBA Credit: While the QBA is incorporated in the prospective EPCP amount, participants must show they are meeting their quality targets for each measure to earn QBA credit.

Primary Care (PC) AHEAD: Capitated Payment Considerations

While participants in the Basic and Advanced-FFS pathways will continue to receive Medicare FFS payments, those in the Advanced-Hybrid and Advanced-Capitated pathways will receive capitated payments in lieu of some or all of their Medicare FFS payments.

Capitated Payments

Fixed quarterly capitated payment per attributed patient in lieu of some/all of Medicare FFS Payments.

Applies to Pathways:

- Advanced-Hybrid
- Advanced-Capitated

Base Rate



Base rates set by CMS upon entry into a capitated payment pathway based on participant-specific historic data

Annual Rate Adjustments



Based on:

- Merit-Based Incentive Payment System (MIPS) payment factors
- Physician Fee Schedule (PFS) updates
- Care setting changes (facility vs. non-facility)

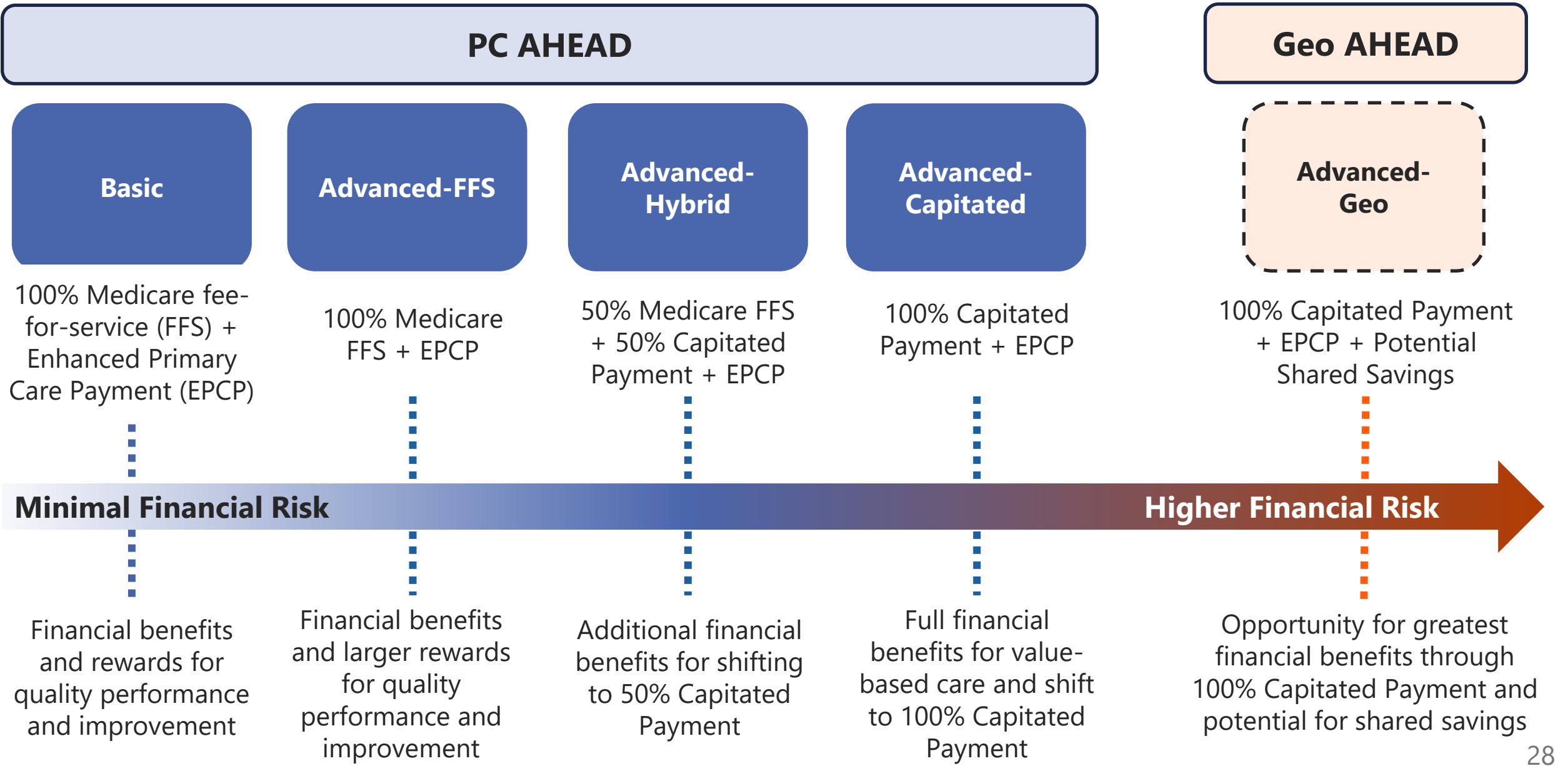
Services Covered



Includes:

- Services delivered by PCPs
- Over 80% of Medicare revenue
- Sensitive to FFS variation

Primary Care (PC) AHEAD: Participant Pathways



Primary Care (PC) AHEAD: Care Transformation Requirements (CTRs)

To support PC AHEAD goals, participants will be required to meet a set of CTRs designed to facilitate increased statewide investment in primary care, grouped into three categories:

Behavioral Health Integration

- A routine **universal screening** process for behavioral health to establish collaborative care (e.g., PHQ-9).
- **Facilitate referrals**/warm hand offs to specialty behavioral health services (e.g., certified community behavioral health clinics).
- Increasing **access to consultations** (e.g., psychiatric consultations or behavioral health).
- Developing **crisis protocols** for high-risk patients.
- Hiring **in-house behavioral health providers**.



Specialty Care Coordination

- Establishing a screening process to **identify patients for care management** services.
- Increasing **access to consultations** (e.g., care management services or specialty services).
- **Creating an integrated care team** matched to the needs of the identified patient (e.g., through use of e-consult codes or video-conferencing technology such as Project ECHO).
- Establishing a **closed-loop referral system** and coordination process for integrated care team.



Health Promotion Activity

- Routine **screening for social support services** (e.g., transportation, nutrition support, housing services, etc.).
- Developing plan for **increased referrals** to community organizations/social support services.
- Developing a process for **creating an integrated care team** (e.g., community health workers) to identify and connect patients needing social support services.



Primary Care (PC) AHEAD: Beneficiary Attribution



Beneficiaries are attributed to PC AHEAD participants based on where they receive Primary Care Services (PCSs).

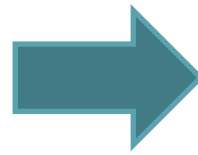
Prospective Attribution

- Beneficiaries are prospectively attributed to one PC practice or community health center quarterly using an algorithm.
- While patient panels may change slightly over time, the number of Medicare fee-for-service (FFS) patients attributed to a PC AHEAD participant is generally similar quarter to quarter.

Attribution Algorithm

Medicare FFS Beneficiaries with a PCS Claim

Any Medicare FFS beneficiary
with a PCS claim in the 2-year
lookback period



Attribution Algorithm

The Attribution Algorithm uses claims data to identify patients' affiliation through one of three methods:

Seen Most
Commonly &
Recently

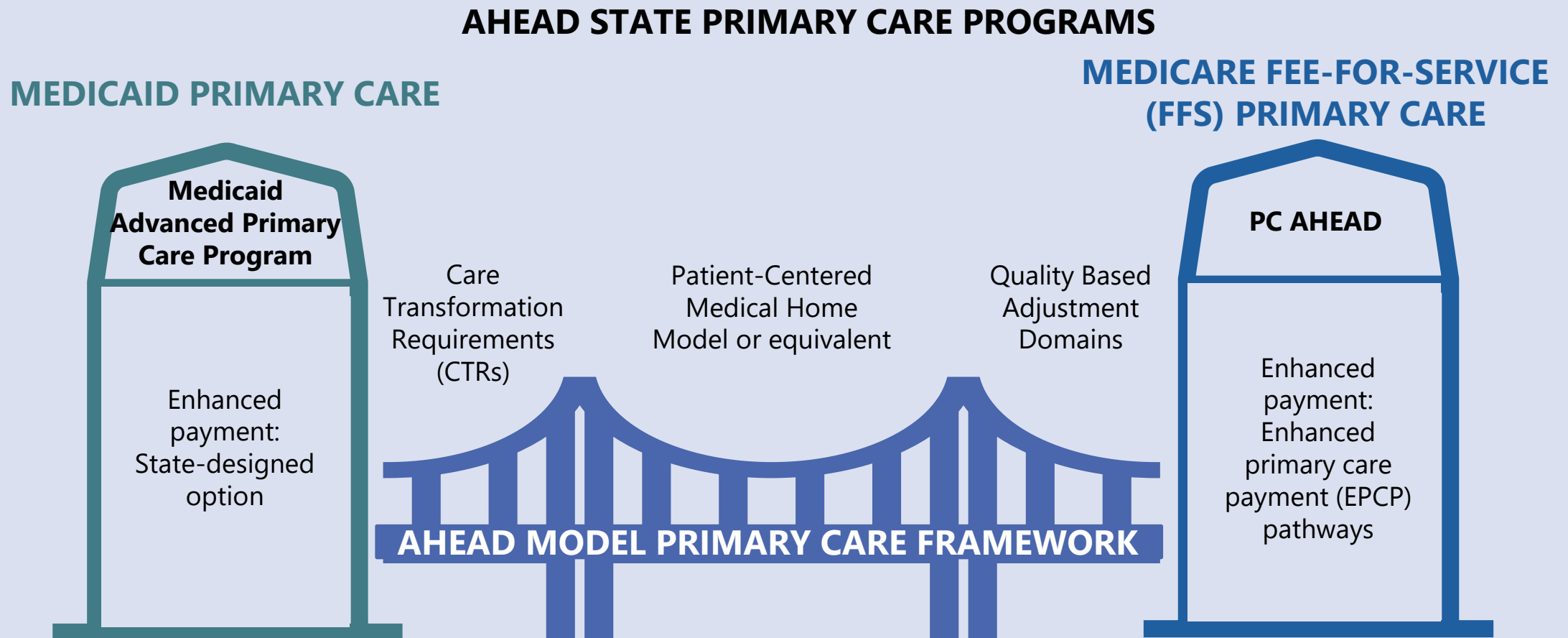
Seen for Key
Services*

Seen for
Majority of PC
Services

* Key Services include: Welcome to Medicare, Annual Wellness, Chronic Care Management, Initial Preventive Physical Examination [IPPE]

Primary Care (PC) AHEAD: Promotes Multi-Payer Alignment

- All AHEAD States will operate a Medicaid Advanced Primary Care Program.
- All Primary Care Practices (PCPs) participating in PC AHEAD will be required to participate in these programs.



Hospital Global Budgets (HGB)

Hospital Global Budget (HGB) AHEAD



The AHEAD Model aims to rebalance health care spending across the system, ensuring that patients receive high-quality care, in the right setting, with a focus on prevention.

WHAT IS A HOSPITAL GLOBAL BUDGET?

- A **prospectively set annual budget** for hospital inpatient and outpatient facility services. Under the AHEAD model, HGBs are calculated based on historic Fee-For-Service (FFS) revenue data with adjustments to account for changes in prices, volume, social risk, and performance on quality and cost measures.
- CMS will use the CMS-designed methodology to calculate the HGB payment amounts for all AHEAD Hospitals. States can no longer use state-specific Medicare FFS HGB methodology.

Predictability & Stability

- ✓ Fixed budget
- ✓ Mitigates volume shift impacts
- ✓ Reflects Medicare pricing updates
- ✓ Safeguards small and safety net hospitals

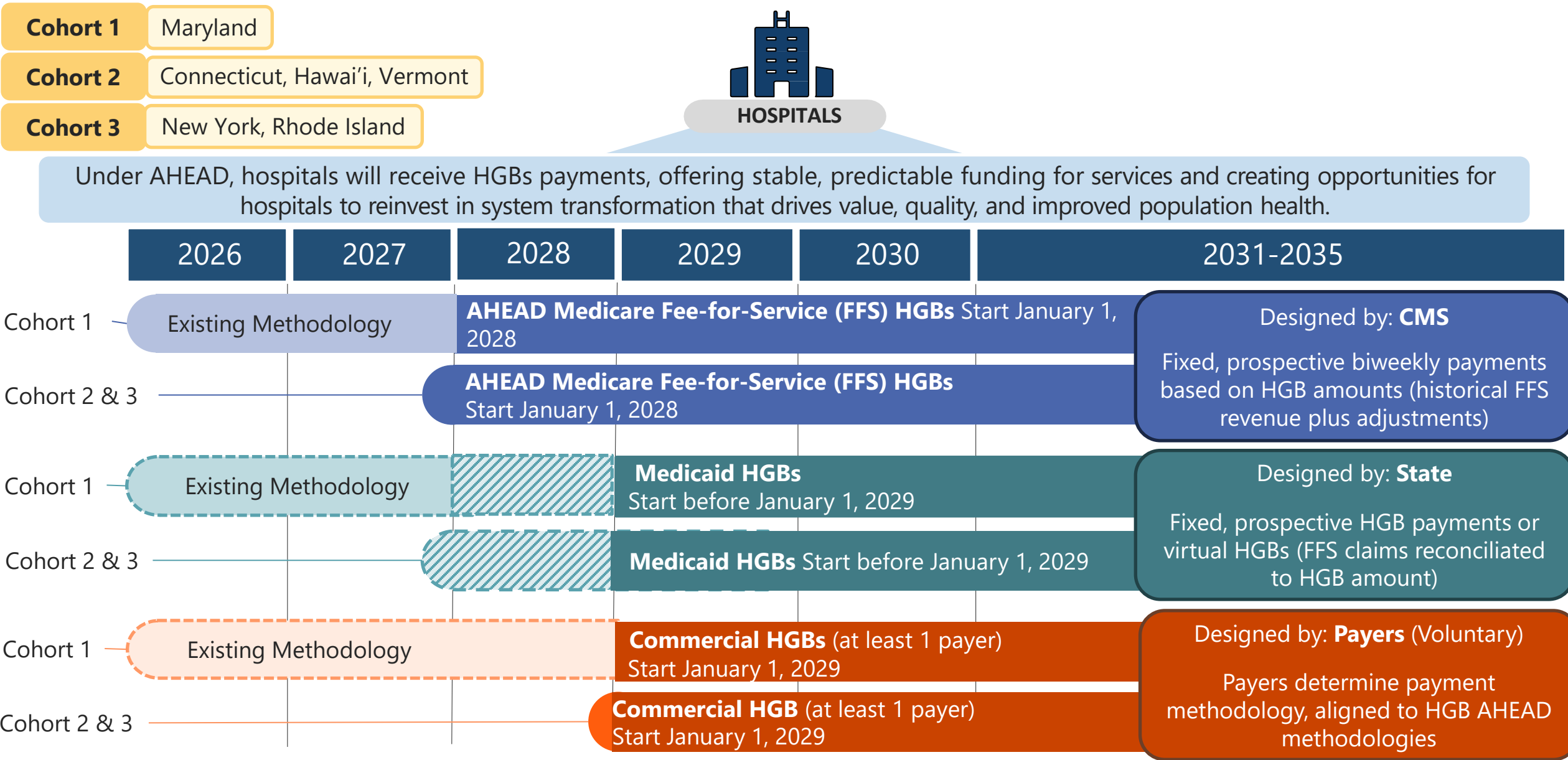
Global Budget Savings

- ✓ Reinvest savings from reduced avoidable utilization and site of care shifts
- ✓ Support strategic population health priorities

Upward Adjustments

- ✓ Upward annual adjustments (e.g., Improvement Bonuses) not available in FFS
- ✓ Initial investment to support transformation in early years

How do Hospital Global Budgets (HGBs) work across Payers in AHEAD?

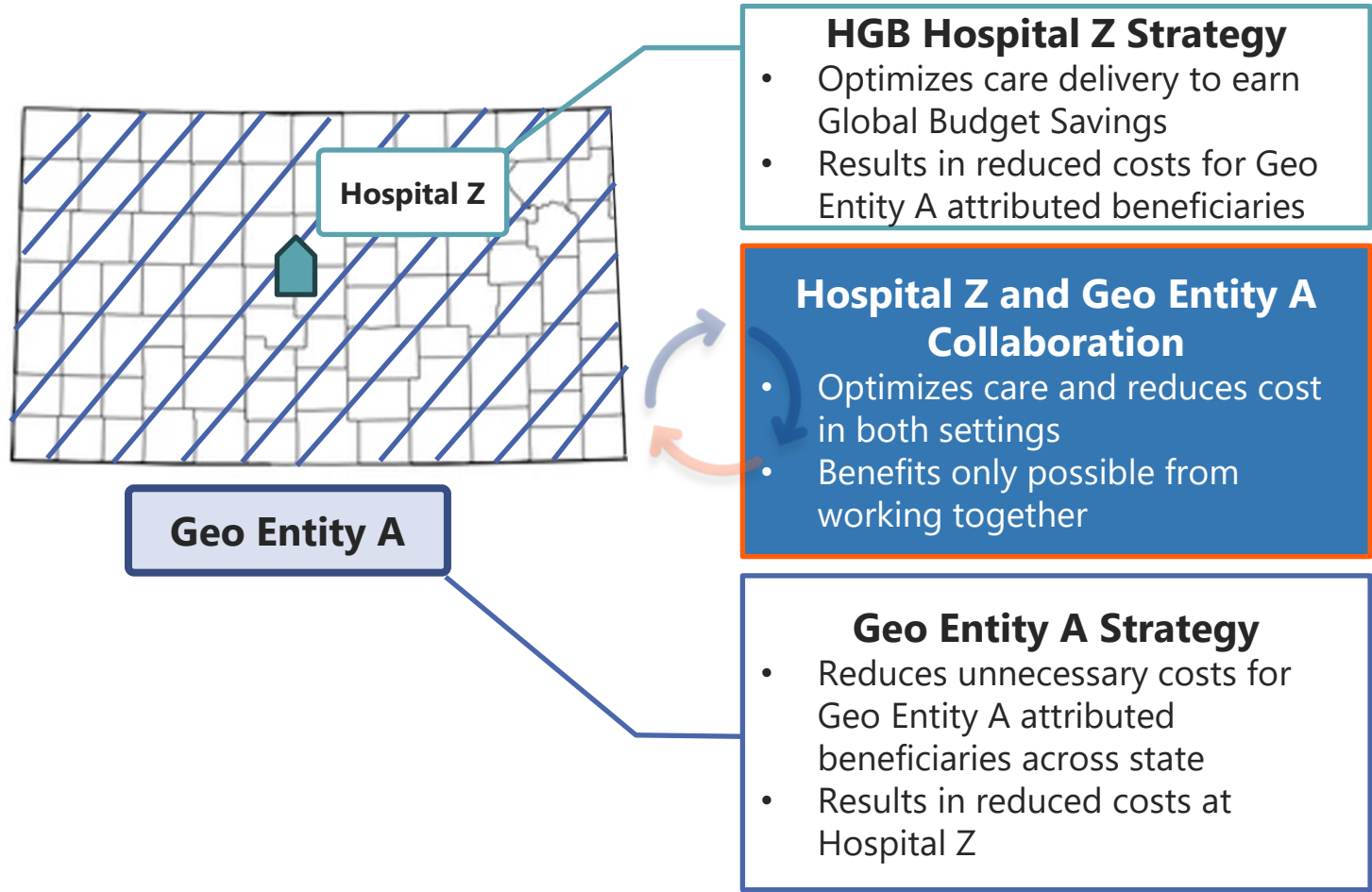


 States expected to launch AHEAD Medicaid HGB methodology during this period.

Geo AHEAD: Win-Win for Hospital Global Budget (HGB) Hospitals and Geo Entities

By working together to improve outcomes and reduce costs, HGB hospitals and Geo Entities in the same geographic region can amplify the benefits and shared savings.

Example of Shared Savings for Geo Entities and HGB Hospitals



Overlapping Efforts Create a Win-Win

Hospital Z Savings

Three teal dollar signs + one blue dollar sign + two orange dollar signs

Geo Entity A Savings

One teal dollar sign + three blue dollar signs + two orange dollar signs

Collaboration Amplifies the Win-Win

Choice & Competition

Choice and Competition



States will be required to implement at least two policies – **one promoting *choice* and another fostering *competition***– to drive progress towards AHEAD total cost of care (TCOC) targets and improve the functioning of Medicaid and commercial health insurance markets.

Requirements

- **Select at least two policies to implement**- one to promote *choice* and one to promote *competition* -- from the options provided by CMS (see next slide)
- Each may represent a **new policy or an enhancement** to an existing policy
- Policies would require state action on or after the start date of the first budget period
- Each policy may require enacting legislation, regulation, executive order, or other interpretive guidance
- States will submit Annual Progress Reports to CMS on implementation

Implementation Timeline

Policies to pursue selected by
end of 2028

State action must be in place
by end of 2029

State action must begin implementation
by end of 2030.

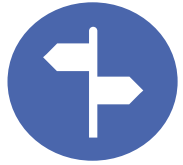
2028

2029

2030

Future Years

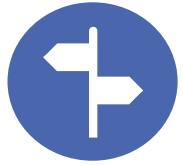
Choice and Competition: Promoting Choice



States will choose one from the following options to **promote choice**.

	Implement Medicaid site neutrality	Improve access to new and/or additional modes of care delivery via telehealth	Advance prescription drug price transparency	Free up provider movement by banning non-compete clauses
Implementation	Reform Medicaid FFS payment systems to align payment rates across health care settings through legislation, and/or State Plan Amendments	Allow more alternatives to in-person services under Medicaid and commercial health insurance by enacting legislation or regulations	Require key drug supply chain entities report on and make drug revenue/pricing information public	Ban non-compete clauses for all physicians, advanced practice clinicians, and other licensed health-related professionals
Benefits	Expanded access to and choice in settings	Expanded access to and choice in providers	More informed drug purchase decisions	Expanded access and choice in providers

Choice and Competition: Fostering Competition



States will choose one from the following options to **foster competition**.

	Change scope-of-practice restrictions to maximize workforce contributions	Repeal Certificate of Need (CON) requirements to allow for more competition	Revise network adequacy provisions to enhance accessibility	Expand contracting flexibilities by repealing any-willing provider laws
Implementation	Change scope-of-practice statutes to allow specific non-physician providers to practice independently	Simplify the CON process for hospitals and repeal CON for non-hospital facilities and services	Revise network adequacy standards in commercial health insurance and Medicaid in alignment with federal requirements	Repeal any-willing provider laws for commercial payers and Medicaid managed care
Benefits	Expanded access to providers and reduced costs	Expanded access to and choice in care facilities	Expanded access to and choice in providers	Expanded access to providers and use of higher-value providers

Population Health Accountability Plans

Population Health Accountability Plan (PHAP)



The model now uses Statewide and Hospital PHAPs to support accountability of population health improvement.

WHAT IS A PHAP?



A tool through which states and hospitals will identify population health priorities, track progress against statewide quality targets and memorialize strategic planning. The PHAPs build on existing efforts for addressing current health priorities to address population health needs at the state and hospital level.

PHAP's Key Components

Identify
Population
Health Focus
Areas

Set Measurable
Quality Targets
for
Improvement

Identify
Accountable
Individuals at
State and
Hospital Levels

Engage
Stakeholders

Monitor and
Report on
Progress

Population Health Accountability Plan (PHAP) Cont.

Statewide PHAP

Purpose: Identifies state population health priorities to target for improvement through AHEAD

Measures: States will identify and track progress on at least six population-level metrics against state quality targets

Reports: Baseline and annual data updates submitted to CMS

Data: Multi-payer data stratified by payer, dual status, and geography

Template: States may adapt an existing template to include the required core elements

Hospital PHAP

Purpose: Aligns with Statewide PHAP to improve preventive health and quality outcomes among hospital beneficiaries

Measures: Hospitals will choose two measures of focus in alignment with statewide quality targets in the Statewide PHAP

Reports: Annual reports to states; states include Hospital PHAP in submission to CMS

Data: Hospital level data on key quality metrics

Template: Hospitals may adapt an existing template to include the required core elements

Statewide Population Health Measures

States will use the population health needs and goals defined in their statewide Population Health Accountability Plan (PHAP) to inform the selection of their specific measures.

	Measure Domain	Measure Name
Required Measures (choose five, at least one from each domain)	Population Health	General Health Status
	Prevention & Wellness	Colorectal Cancer Screening
		Breast Cancer Screening: Mammography
	Chronic Conditions	Controlling High Blood Pressure
		Hemoglobin A1c Poor Control/Control for Patients with Diabetes
	Behavioral Health	Use of Pharmacotherapy for Opioid Use Disorder
		Follow-Up After Hospitalization for Mental Illness*
		Follow-Up After Emergency Department Visit for Substance Use*
	Health Care Quality and Utilization	Plan All-Cause Unplanned Readmission
Required Supplemental Measures (choose at least one)	Maternal Health	Live Births Weighing Less than 2500 grams
		Prenatal and Postpartum Care*
	Prevention Measures	Adult Immunization Status^
		Prevalence of Obesity
		ED Visits for Alcohol and Substance Use Disorders Adverse Events
	Upstream Drivers of Health	Food Insecurity
		Housing Instability

* = states will need to report two rates for this measure.

^ = states will need to report five rates for this measure.

Resources & Closing

AHEAD Model Technical Resources:



- **Hospitals:**
 - **Simulated Hospital Global Budgets (HGBs):** (Early 2026)



- **Primary Care Providers:**
 - **PC AHEAD Payment Specifications & At-A-Glance:** (August 2025/Early 2026).
 - **Primary Care Providers Pathway Infographic:** (Early 2026)



- **States:**
 - **Population Health Accountability Plan Template:** (Early 2026)



- **Geo AHEAD:**
 - **Resources Previewing the Requirements:** (2026)
 - **Geo AHEAD Technical Specifications, Version 1.0.** (Summer 2026)



- **All:**
 - **Model Website with Linked Resources**



Thank you for your time and interest in the AHEAD Model's Updates!

Do you have questions? View additional resources on the [AHEAD Model webpage](#) or email your comments and feedback to AHEAD@cms.hhs.gov with subject line ***"AHEAD Model Updates."***

Thank You!
