



Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Updates Recorded Webinar Transcript

[Introduction 0:00]

Hello and welcome to the Achieving Healthcare Efficiency through Accountable Design Model Updates recorded webinar. In this video, we will highlight the recent updates to the AHEAD Model that went into effect in September of 2025.

The recorded webinar will review the AHEAD Model and recent updates. It will cover changes to the timeline, Geo AHEAD, and Primary Care pathways, as well as the hospital global budgets, which have not changed much. It will also cover the new choice and competition and Population Health Accountability Plan requirements. Today's presenters include myself, Ryan Marie Smith, Health Insurance Specialist, and several other members of the CMMI AHEAD Model team.

We will start with a quick refresher on the AHEAD Model and then walk through the key updates introduced in September of 2025. These changes were designed to strengthen the model and help states advance their healthcare goals.

While this webinar is to discuss the updates to the AHEAD Model, the primary goals of the model have not changed. The commitment to care transformation and partnership with states remains bedrock, and we will be working to provide new tools to guide stakeholders in this momentous care transformation journey.

This transformation journey is not just about policy changes. It is about fundamentally re-imaging how states healthcare ecosystems deliver care to improve outcomes while making healthcare more accessible, affordable, and sustainable.

The AHEAD Model is a collaborative effort between the CMS Innovation Center and participating states. Our goal is to empower states to lead reforms that transform population health, but the state alone cannot accomplish this without strong participation from you, the stakeholders - primary care providers, hospitals, community partners, commercial payers, and now geographic risk-bearing entities. We aim to create unity across payers and systems, promoting accountability and collaboration to achieve shared goals.

States participating in AHEAD will benefit from a flexible framework that allows them to both leverage existing innovations and test new ones. Building on the lessons learned from other state-based models in our history, AHEAD expands the tools available to states to improve the quality of care for their residents and decreased costs to Medicare.

Accountability for the total cost of care and agreed on quality targets is the basis of the AHEAD Model and will be central to the success of this strategy. Each alternative payment approach in the model aligns with the core strategy.

There are several other key strategies that will also help drive change under the model. First, benefit enhancements, cooperative funding, and legislative waivers will give participants the support and flexibility they need to meet payment and quality goals.

Second, alignment between Medicare, Medicaid, and commercial payers in each state will reduce administrative burden for providers and extend the model's reach and benefit to a broader patient population through state authority.

Third, AHEAD states will drive progress towards the model's goals by implementing new policies that foster choice and competition, increasing choices for patients.



The AHEAD Model will carry out these strategies through three alternative payment approaches, each of which is tailored to specific care delivery settings. Primary Care AHEAD is a patient-focused advanced primary care program designed to align Medicare with the state-led primary care efforts.

Hospital global budgets provide hospitals opportunities to retain global budget savings with a focus on reducing avoidable utilization and improving outcomes in ways aligned to community needs. And third, Geo AHEAD is a geographic-based accountable care organization that will enhance care management and care coordination for unattributed beneficiaries and support providers and hospitals in transformation efforts.

Ultimately, through the combination of these features, the model will encourage better health outcomes across populations, increase patient choice and encourage stronger competition and patient engagement.

This and the following two slides provide a high-level overview of the major changes to the AHEAD Model effective fall of 2025. After we share this overview, we will spend some time discussing each change in more detail. But before we discuss these changes, throughout the presentation, we will refer to AHEAD cohorts and want to do a quick review of which states are included in each cohort. At the bottom of this slide you will see Cohort 1 includes Maryland, Cohort 2 includes Connecticut, Hawaii and Vermont and Cohort 3 includes New York and Rhode Island.

Turning to the updates, we can start with the timeline. Cohort 1 maintained the start date of January 1, 2026, allowing the state to keep progressing on activities already underway, while the end date will shift one year later to December 31, 2035.

For Cohort 2 and 3 states, the model performance dates shift back one year to January 2028 through December 2035, providing additional time for planning and securing legislative authorities. If interest exists, there will be an opportunity for up to two additional states to participate in the model.

The model now includes a new Geo AHEAD program, a geographically based accountable care organization (ACO) program which expands accountable care to all original Medicare beneficiaries and provides additional supports for participating providers. There are also three new Primary Care AHEAD pathways with varying level of risk and reward that provide practices flexibility and choice in how they participate.

Under AHEAD, states will now implement or expand upon existing choice and competition policies that will aid in achieving model aims with at least one policy promoting consumer choice and one promoting market competition.

States and hospitals will develop population health accountability plans to identify priorities and strategies for improving population health outcomes in their States and communities. Reporting requirements are streamlined to reduce reporting burden. And additionally, states will share payer's and hospital's performance on a state-owned website to foster patient choice and engagement.

Now let us discuss the updated model timelines in detail. This slide shows the model timeline for Cohort 1, or Maryland. Those in Maryland already know that Maryland officially began AHEAD Model implementation at the beginning of January of 2026.

Maryland will continue using the existing Maryland Medicare Hospital Global Budget methodology for the first two years, 2026 and 2027, while under the AHEAD Model. Then, in 2028, Maryland will transition to the AHEAD Hospital Global Budget methodologies starting with Medicare and then Medicaid and commercial payers. For primary care providers (PCPs), those currently in Maryland Primary Care Program (MDPCP) can continue under that methodology. Those not in MDPCP can participate in Primary Care AHEAD through one pathway in 2026 and the option of two pathways in 2027.

In 2028, MDPCP will officially end, and Maryland PCPs will have the opportunity to join Primary Care AHEAD with the option of four pathways that we will discuss more on these later.



Geo AHEAD will begin in 2028 and the state will identify choice and competition policies to pursue by January 1, 2029. The model will run through the end of 2035 in Maryland.

On this slide, we see the updated model timeline for Cohorts 2 and 3, or Connecticut, Hawaii, New York, Rhode Island, and Vermont.

Cohort 2 and 3 states will begin AHEAD on January 1, 2028, with Medicare fee-for-service, hospital global budgets, Primary Care AHEAD for Medicare fee-for-service, and the Medicaid Advanced Primary Care Program and Geo AHEAD all beginning on that date.

By 2029, Cohort 2 and 3 states will implement their state-designed AHEAD Medicaid Hospital Global Budget methodology, and starting in 2029, at least one payer in each state will implement a commercial hospital global budget methodology.

States will identify choice and competition policies to pursue by January 1, 2029.

[Geo AHEAD 9:43]

I'm Matan Alalouf, and now that we've shared the updated timeline, let's get into the detail of the new model component Geo AHEAD.

Geo AHEAD introduces a new accountable care organization, or ACO program. This program offers new pathways for providers to engage in AHEAD and uses novel approaches to expand accountable care to all Medicare fee-for-service beneficiaries. Geo AHEAD is a geographically based, two-sided ACO program available in participating AHEAD states.

Risk-bearing organizations called Geo Entities take on total cost of care accountability and support state efforts to expand access to value-based care, improve care coordination and quality, and promote patient choice and competition in a geographic area. Beneficiaries are aligned to Geo Entities in three ways - based on choice, claims, or their geography. The geographic attribution method maximizes engagement of eligible original Medicare beneficiaries in accountable care and supports states in achieving AHEAD's transformation goals and total cost of care and quality targets.

Let's take a closer look at how Geo AHEAD helps close the gap for original Medicare beneficiaries who aren't yet in accountable care relationships. Geo AHEAD works alongside other AHEAD components and existing hospital and primary care programs, with a goal of keeping original Medicare beneficiaries from falling through the cracks.

Over the past several years, Medicare has made significant progress in engaging beneficiaries in accountable care. Through the Medicare Shared Savings Program, SSP, about 41% of beneficiaries are in accountable care relationships, getting us to mile marker 41.

Other ACO models, like ACO Reach and ACO Primary Care Flex, added another 11% of beneficiaries into accountable care, bringing us to mile marker 52. But we're not yet at 100%. We still have 48% of original Medicare beneficiaries without accountable care, or we can call this "The Last Mile." Geo AHEAD is designed to close that gap, powering "The Last Mile" and moving toward all original Medicare beneficiaries engaging in accountable care. While these numbers are based on national averages and states vary greatly, the vision remains the same - AHEAD will ensure that every original Medicare beneficiary has access to accountable, coordinated care.

Geo AHEAD is designed to ensure beneficiaries have access to coordinated care through Geo Entities. These entities engage directly with providers and beneficiaries, aligning incentives and building infrastructure needed to enhance care coordination and improve quality within a defined geographic region.

Through these efforts, Geo Entities contribute to and reinforce state's total cost of care and quality targets. AHEAD expands the types of organizations that are eligible to serve as Geo Entities. These may include provider-led groups, health plans, hospitals, technology and digital health companies, or other risk-bearing organizations that meet state requirements or qualify for an exemption. Geo Entities



will be accountable for total cost of care and quality outcomes for attributed original Medicare populations in a specific state or substate region.

A key innovation of Geo AHEAD is the introduction of competitive bidding into the Geo Entity application process. CMS will establish a total cost of care benchmark for each AHEAD state, sub-state regions and sub-state division. Geo Entity applicants will submit competitive bids offering a percentage discount off this benchmark.

In addition to cost accountability, Geo Entities are responsible for improving performance on eight quality measures. These measures align with state, Primary Care AHEAD, and global budget measures and focus on reducing unnecessary utilization, promoting prevention, improving behavioral health, and enhancing patient experience. Performance in these areas will determine eligibility for shared savings.

Geo AHEAD offers multiple participation pathways for primary care providers, hospitals, and specialty and community-based care providers. Participants will contract with the Geo Entity negotiating their financial arrangements with the potential to receive shared savings. The following slides will explore these participation options in more detail but first let's talk more about the selection process for Geo Entities.

Geo AHEAD will consist of two four-year contract periods. The first will run from January 1, 2028, through December 31, 2031, and the second will run from January 1, 2032, to December 31, 2035. To select Geo Entities, CMS will issue competitive requests for applications or RFAs, and eligible Geo Entities will bid to participate in an AHEAD state or substate region or a substate division. Substate divisions are used only in Geo AHEAD to define geographic service areas for the Geo Entities. In collaboration with the state, CMS will define substate divisions or geographic areas, with at least 20,000 attribution-eligible beneficiaries. Only provider-led Geo Entities can bid for individual substate divisions.

As discussed on the previous slide, Geo AHEAD will use a competitive bidding process. CMS will establish a Geo total cost of care benchmark associated with the original Medicare attribution-eligible beneficiaries in each AHEAD state or sub-state region or sub-state division. Bidding entities will bid on the percentage discount relative to the CMS defined total cost of care benchmark that they can offer. A Geo Entity shared savings payments will be based on achieving the discount included in their bid.

To support bid development, CMS will provide prospective Geo Entities summary level, historical data on attribution eligible beneficiaries within a geographic area that includes utilization and spending, risk scores and measures, and quality measures, in addition to a benchmark workbook. CMS will not provide any beneficiary level data.

CMS will evaluate bids based on three factors. First, the magnitude of the bid discount. Second, the organization's capacity to educate and deliver beneficiaries and providers with benefits, payments, and care transformation supports. And third, their strength and depth of partnerships with community-based organizations.

Prospective Geo Entities can apply for one or more states or sub-state regions, although applications will be considered and awarded separately.

CMS will select a minimum of three Geo Entities in Connecticut, Maryland, and New York, and a minimum of two Geo Entities in Hawaii, Rhode Island, and Vermont. If CMS is unable to select the minimum required number of Geo Entities, or if any sub-state division is not covered by the minimum required number of Geo Entities, Geo AHEAD will not operate in that state for the first contract period.

Now let's talk about the two different types of Geo Entities. In Geo AHEAD, there are statewide Geo Entities and sub-state Geo Entities. Each have different requirements. Statewide Geo Entities are technology and digital health companies, health plans and hospitals, provider-led organizations, or



other risk-bearing entities. They must bid on the entire state or substate region, and they'll be responsible for any attributed beneficiaries from any areas within the state or substate region.

On the other hand, substate Geo Entities can only be provider-led Geo Entities, which means they're owned, managed, and controlled by a majority of providers, more than 51%, and that the providers practice in the area covered by the Geo.

Health systems may be sub-state Geo Entities, provided that their TIN is associated with a hospital or other provider type. They can bid on one or more divisions within the head state or sub-state region, though if they meet the definition in the full state, they can bid on the entire state - we expect that will be rare.

Substate Geo Entities will be responsible for any attributed beneficiaries from the specific divisions they cover. CMS encourages substate Geos to apply and will set aside one award in each substate division for a substate Geo Entity.

At the bottom of the slide, we illustrate how statewide and substate Geos may overlap in a state. The rectangle you see represents a state with 180,000 beneficiaries. It has statewide Geo Entity One represented in orange covering the whole state. And statewide Geo Entity Two represented in blue stripes also covering the whole state. In total it has two statewide Geo Entities. Additionally, it has one substate Geo Entity represented in blue covering a substate division. In that substate division, the three Geo Entities overlap.

Now let's talk about how providers participate in Geo AHEAD. Geo AHEAD has multiple ways for providers to participate with the potential of shared savings and other financial benefits dependent on their specific financial arrangements with the Geo Entity or Entities.

When talking about Geo AHEAD, providers include primary care providers, hospitals and specialty care or community-based providers. It also provides pathways for Primary Care AHEAD practices and hospital global budget hospitals to participate, aligning the state healthcare ecosystem around shared goals - coordinated care, improved patient outcomes and sustainable cost management, and elevating the impact of Primary Care AHEAD and hospital global budgets. These providers can participate as Geo participants or Geo affiliates, which we'll briefly discuss shortly.

Geo participants are Medicare enrolled providers who participate with only one Geo Entity in a way that generates alignment and do not participate in other ACO models in a way that generates alignment, like ACO Reach, or in Primary Care AHEAD. They contribute to claims-based attribution and are accountable for financial and performance risk.

They will receive primary care capitated payments in lieu of payments for select primary care, Medicare fee-for-service claims and enhanced primary care payments, or EPCP, for care management passed through the Geo Entity. Geo participants must use CEHRT and can qualify for Advanced Alternative Payment Model (APM) status. They must also participate in the state's Medicaid Advanced Primary Care Program if they are a PCP.

It is also worth noting some unique considerations. Geo participants at the National Provider Identifier, or NPI level, may participate in multiple ACO programs, Primary Care AHEAD, or Geo Entities provided they bill under separate taxpayer identification numbers, or TINs. For hospitals and hospital-owned practices, hospitals may be Geo participants if primary care is billed under the hospital TIN. Hospital-owned practices can only be Geo participants if their parent hospital participates in AHEAD Hospital Global Budgets.

Geo affiliates, on the other hand, have more flexibility. They are Medicare enrolled providers who can participate with one or multiple Geo Entities. Geo affiliates are allowed to simultaneously participate in other ACO models and Primary Care AHEAD, and they are not required to be enrolled in the state's Medicaid Advanced Primary Care Program, unless they are also participating in Primary Care AHEAD. However, they do support Geo Entity goals and are eligible to share in savings through a negotiated financial arrangement with the Geo Entity.



In addition to Geo participants and Geo affiliates, there are Geo partners. These are non-Medicare enrolled providers and organizations that contract with one or multiple Geo Entities to provide supportive services such as care coordination or beneficiary education. Like Geo participants and affiliates, they also have the potential to receive shared savings through their contracts with Geo Entities.

This slide shows the relationship between CMS, Geo Entities, and providers in AHEAD. As discussed, CMS will select at least two or three Geo Entities in each state or sub-state region to promote competition and ensure overlapping coverage of the entire region. Finances will flow from CMS to the Geo Entities, through to the providers.

CMS will form contractual relationships with the Geo Entities, and in turn, the Geo Entities will form contractual relationships with Geo participants and Geo affiliates, each with individually negotiated financial arrangements.

Geo participants can form financial relationships with only one Geo Entity. For example, note how Geo participants in the light blue boxes participate with either Geo Entity A or Geo Entity B, but not both.

The Geo Entity pays participants primary care capitated payments in lieu of Medicare fee for service payments for select primary care services, enhanced primary care payments for care management, and they're eligible for shared savings payments. Meanwhile, participants contribute to voluntary, claims based and geographic beneficiary attribution.

Geo affiliates, on the other hand, can form financial arrangements with multiple Geo Entities. For example, the Geo affiliate shown in the light green box in the center has a relationship with both Geo Entity A and Geo Entity B. While Geo affiliates are eligible for shared savings payments based on their financial arrangement with the Geo Entity, they do not receive other forms of payments that participants receive. For attribution, provider beneficiary relationships with Geo affiliates inform geographic attribution, helping to ensure that a beneficiary's usual source of care with Geo affiliates is prioritized. Now let's take a closer look at the different ways beneficiaries are attributed to providers, as this is a unique aspect of Geo AHEAD.

Under Geo AHEAD, all eligible original Medicare beneficiaries in a participating AHEAD state or substate region not currently attributed to the Medicare Shared Savings Program or other ACO models will be aligned to a Geo Entity. Beneficiaries will be attributed annually prior to the start of the performance year and potentially at additional times.

Voluntary alignment and attribution eligibility will be assessed quarterly, and beneficiaries who lose eligibility will be removed from attribution on a quarterly basis.

Beneficiary attribution under Geo AHEAD will occur sequentially through three mechanisms. Geo AHEAD will first attribute original Medicare beneficiaries not already aligned to SSP or other ACO models through voluntary alignment. Beneficiaries may choose to align by selecting a provider who is a Geo participant. This is a foundational element of Geo AHEAD and Geo Entities and their participants are encouraged to conduct outreach to beneficiaries and advocacy organizations to raise awareness and promote voluntary participation.

From the remaining pool of unaligned beneficiaries, attribution will occur using claims-based methods, aligning beneficiaries to Geo participants from whom they have received services. Any eligible beneficiaries still unaligned will be attributed to a Geo Entity based on geographic attribution. This method will also consider where beneficiaries have a usual source of care.

And to circle back to our earlier discussion, this is how Geo AHEAD aligns the remaining 48% of original Medicare beneficiaries to close the gap and bring 100% of original Medicare beneficiaries into accountable care relationships.

[Primary Care AHEAD 24:02]



My name is Pooja Seth and I'm the primary care lead. Now let's take a deeper dive into Primary Care AHEAD or PC AHEAD and learn about the new pathways.

Primary Care AHEAD, or PC AHEAD, has been a foundational component of AHEAD since its inception, and its core design elements remain unchanged. It is designed to strengthen primary care through targeted investments and strategies: through flexible payment pathways, allowing participants to choose options that match their readiness and priorities; alignment between Medicare and Medicaid components for broader transformation; incentives to transform care delivery in key areas of behavioral health integration, specialty care coordination and health promotion; opportunities for practices to quality and benefit from advanced APM status; and claims based attribution that recognizes established patient relationships and rewarded improvements.

Primary Care AHEAD is a voluntary advanced primary care program designed to support a wide range of participants, including primary care practices, or PCPs, community health centers, or CHCs - such as federally qualified health centers, health-centered look-alikes and rural health clinics. Participants can choose from four distinct Primary Care AHEAD pathways with the flexibility to choose pathways annually. The four Primary Care AHEAD pathways are Basic, Advanced Fee-for-Service, Advanced Hybrid, Advanced Capitated. We'll share details about each pathway in later slides.

Primary Care AHEAD participants can join any of these four Primary Care AHEAD pathways. They may alternatively participate in Advanced Geo Pathway, which is similar to the Primary Care Advanced Capitated pathway, but through Geo AHEAD. However, participants cannot participate in both Primary Care AHEAD and Geo. They must select one of the five pathways available. These five pathway options will be available to Primary Care AHEAD participants in Cohort 1, 2 and 3 states starting in 2028. We'll take a closer look at the four Primary Care AHEAD pathways in the next few slides.

Before 2028, only Cohort 1 will start implementing Primary Care AHEAD, and there are a few key details to keep in mind. From 2026 through 2028, Primary Care AHEAD is limited to Maryland practices that are not in the Maryland Primary Care Program, or MDPCP.

For those practices that choose Primary Care AHEAD - in 2026, everyone starts in the basic pathway. In 2027, practices can choose to stay in the Basic pathway or move to the Advanced Fee-for-Service pathway. By 2028, if MDPCP ends, all practices in Maryland will have the opportunity to select any of the five pathways - four Primary Care AHEAD and one Geo AHEAD pathway.

All participants in Primary Care AHEAD across the four tracks will receive an enhanced primary care payment, or an EPCP, for care management. Plus, they will receive payments for Medicare services in the form of Medicare fee-for-service and/or capitated payments.

EPCPs are prospective quarterly per-beneficiary-per-month payments to be used for activities such as integrating behavioral health, strengthening specialty care coordination, and promoting overall health and wellness. The average base EPCP amounts will vary from \$17 to \$21 per beneficiary per month with adjustments that we'll talk more about shortly. Based on the pathway chosen, participants will receive payment for Medicare services using different approaches.

For the Basic and Advanced Fee-for-Service pathways, participants will continue to receive Medicare fee for service payments as usual. Providers will receive payments for each visit, test, or procedure delivered to a beneficiary according to the Medicare Physician Fee Schedule.

For the Advanced Hybrid and Advanced Capitated pathways, participants will receive capitated payments in lieu of some or all of their Medicare fee-for-service payments. Capitated payments provide participants with a fixed monthly amount for each patient attributed to the participant under the model.

This will be an important consideration in participants selecting the path right for them. Now let's dive a little deeper into each of these components.



The EPCP is calculated at the patient level based on state participant and patient level factors. It's not tied to the number of visits, but rather the needs and context of the patient and practice or community health center. The calculation starts with a state specific base EPCP amount, which is adjusted for three factors.

The Medical Risk Adjustment or MRA, which is an adjustment for patients' medical complexity. This utilizes the Hierarchical Condition Category, or HCC, so sicker patients result in bigger payments.

The Population Adjustment, or PA, which adjusts based on patient population factors such as age, income, and community resources using the Community Deprivation Index, or CDI, Low Income Subsidy, or LIS, and Medicare/Medicaid dual eligibility.

And the Quality Based Adjustment, or QBA. This adjustment works a little differently than the other two. The QBA is a flat 5 to 15% built into the EPCP - the percent varies by the pathway. Participants receive this amount as part of their prospective EPCP payment. However, to earn credit for this amount, the Primary Care AHEAD participant is required to demonstrate meeting or improving on their quality targets. For example, a practice in the Basic track will get a base EPCP of \$17 that has a 5% QBA built in, accounting for \$0.85 of the base EPCP. This \$0.85 is earned if quality targets are met for all measures.

Primary Care AHEAD participants are evaluated against quality targets at the end of each performance year. Those meeting at least one target per measure retain their full EPCP. Participants may be able to retain partial QBA from the EPCP, relative to the number of quality measures they meet.

In response to a question we received, the list of duplicative overlapping services in the Primary Care AHEAD financial specifications for Maryland forms the basis of what will be included for other states, but this is subject to change and likely to change.

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

The capitated payment will be a fixed payment per attributed beneficiary, and the amount will be steady regardless of the number of services delivered. The base rate for each participant is set by CMS using participant-specific historic data at the time a provider enters the pathway. Rates are then adjusted on an annual basis to account for factors such as payment adjustments, updates to the Physician Fee Schedule, and changes in care settings. The capitated payment covers services delivered by participants, representing more than 80% of participants' revenue under Medicare, and are sensitive to fee-for-service variation.

Now that we've talked about the different payment components, we want to show the differences in Primary Care AHEAD pathways. As noted earlier, Primary Care AHEAD includes four participation pathways with the flexibility for participants to transition between them plus an option to participate through Geo AHEAD.

Overall, the pathways move from minimal financial risk and reward to higher financial risk and reward, allowing choice and flexibility.

The first pathway is the Basic pathway. This option combines fee-for-service payments with the EPCP. In the first year, 5% of EPCP payments are at risk for a quality adjustment or QBA, and this amount gradually increases to 10% over time. This pathway carries the lowest level of risk for participants while offering upfront support and encouraging improvements in quality and patient outcomes. The Basic pathway is a Merit-based Incentive Payment System, or MIPS, whereas other Primary Care AHEAD pathways have a higher risk and are Advanced APMs.

The second pathway is the Advanced Fee-for-Service pathway, which follows a similar methodology to the Basic pathway, but with slightly increased risk. Under this option, participants receive



Advanced APM status and accordingly, approximately 15% of the EPCP is at risk for the QBA. This pathway incentivizes participants to maintain high quality care with large incentives for improvements in quality and patient outcomes.

The third pathway is the Advanced Hybrid pathway, which combines the EPCP with a bent of 50% fee-for-service payments and 50% capitated payments. While this pathway requires participants to assume greater financial risk, it also offers enhanced flexibility in care delivery and stronger incentives for advancing patient care transformation.

Finally, the fourth pathway is the Advanced Capitation pathway, which includes the EPCP and 100% capitated payments. This option represents the higher financial risk for participants, while at the same time delivering maximum flexibility and strong incentives to drive comprehensive of patient care transformation.

The Geo AHEAD Advanced Capitation pathway is designed to align with the Primary Care AHEAD Advanced Capitation pathway. This encompasses the EPCP, 100% capitated payments, plus, unlike in Primary Care AHEAD, participating in Geo offers the potential for shared savings. This pathway offers PCPs the potential for the largest financial benefits alongside other supports provided by Geo Entities.

The enhanced funding in Primary Care AHEAD is designed to support primary care transformation, improve care quality, and reduce potentially avoidable utilization and allow PCPs to achieve care delivery goals. Participants will be required to meet a set of care transformation requirements, or CTRS, to increase investment and incentivize care delivery transformation in three categories aligned to the CTR's: behavioral health integration, specialty care coordination, and health promotion activities.

Within each CTR there are example activities PCPs can perform to meet their CTRS. These activities include promoting screening and referrals, building team-based care, supporting quality improvement, and leveraging health IT.

Primary Care AHEAD participants will submit the Care Transformation Attestation form confirming investment in activities across the CTR's.

Now let's talk about beneficiary attribution and how beneficiaries are attributed to Primary Care AHEAD participants. Beneficiary attribution ensures Medicare fee-for-service beneficiaries are accurately assigned to a single participant where they receive their primary care services, or PCS's.

Attribution is important because it's used to calculate enhanced primary care payments, or EPCPs, measure Primary Care AHEAD participant performance, and transition participants from fee-for-service only payments to managing care for attributed beneficiaries.

A few key things to know about attribution. It's perspective – so beneficiaries are attributed to a participant before each quarter begins using an attribution algorithm. Participants receive quarterly attribution reports showing which beneficiaries are attributed and the associated payments. Attribution is generally stable. While a few beneficiaries may come or go each quarter, most participants will see consistent attribution and therefore stable EPCP payments.

The attribution process starts by identifying all Medicare fee-for-service beneficiaries with a PCS claim and in a two year look back period.

For each beneficiary with a claim, the algorithm then identifies that patient's most common and recent provider of PCS services by looking for the tax identification number, or TIN, that appears most frequently and the most recent National Provider Identifier, or NPI, in the beneficiary's PCS claims. If these both align with the same AHEAD participant, the beneficiary is attributed to that AHEAD participant.



If the beneficiary does not meet these criteria, the algorithm then looks for claims for key PCS services that are indicative of a meaningful care relationship. Beneficiaries are attributed to an AHEAD participant if the most recent key service claim submitted was from such a participant.

If a beneficiary does not have a key service claim with an AHEAD participant, the algorithm then determines if an AHEAD participant delivered the most or majority of the beneficiary's PC services. If so, the beneficiary is attributed to that AHEAD participant.

If the beneficiary does not meet any of these criteria, the beneficiary is not attributed to AHEAD and is not included in the AHEAD payment calculations.

This algorithm ensures that the attribution is based on real care patterns and helps capture beneficiaries who have a consistent relationship with an AHEAD participant.

Of course, there are nuances to the methodology. To review the details, please see the Primary Care AHEAD Financial Methodology Specifications document, which will be made available on the AHEAD Model website.

In addition to the mechanics of Primary Care AHEAD payment methodology, a critical component is payer alignment. Multi-payer alignment supports long-term model sustainability, flexible primary care transformation tailored to each state's needs, and reduced burden on practices that are consistent, streamlined approaches - regardless of payer.

States will use the pre-implementation period to fully meet the AHEAD Model primary care criteria by the start of performance year one, building from existing programs and infrastructure. All Primary Care AHEAD participants will be required to join their state's Medicaid Advanced Primary Care Program.

AHEAD bridges Medicaid primary care and Medicare fee-for-service primary care through aligned strategies, including care transformation requirements, or CTR's, payment design and models, and quality-based adjustment domains.

[Hospital Global Budgets 39:59]

My name is Katja Morgan, and next we will talk about hospital global budgets, which largely remain unchanged.

A hospital global budget is a fixed prospective set amount of annual revenue for hospital inpatient and outpatient facility services. These budgets cover what would be paid for under fee-for-service, plus additional benefits through the adjustments.

CMS will now calculate the hospital global budget payment amounts for all participant hospitals using the CMS-designated methodology as states will no longer be able to develop and implement a state specific Medicare fee-for-service hospital global budget methodology.

Through successes in prior CMMI models and other state initiatives, we have learned that hospital global budgets not only help hospitals to achieve all-payer and Medicare fee-for-service cost growth targets, they provide hospitals with a stable and predictable source of funding, global budget savings, and upward adjustments that allow them to invest in quality, innovation and population health, focus on reducing potentially avoidable utilization, collaborating with providers for a more coordinated beneficiary experience, and drive improved community health outcomes.

Ultimately, hospital global budgets create a win-win-win scenario for patients, hospitals and payers by aligning incentives for promoting population health while maintaining the ability of hospitals to address acute care needs, when needed.

Under AHEAD, there are three distinct hospital global budgets - one for each payer type - represented by blue for Medicare, green for Medicaid, and orange for commercial payers.



On this slide, you'll see Cohort 1's timeline above Cohorts 2 and 3. Cohort 1 will continue using the existing Maryland Hospital Global Budget methodology and transition to the respective AHEAD Hospital Global Budget methodology with the other AHEAD cohorts.

Let's start with Medicare, shown in blue. CMS develops and maintains the Medicare fee-for-service hospital global budget for all states. Each participating hospital will receive an annual Medicare hospital global budget based on historic revenue with adjustments for demographics, prices, social risk, and performance on quality and cost. CMS sets this amount in the fall before the performance year and pays hospitals prospectively in 26 biweekly installments. Hospitals will still submit claims as usual, but those claims will be zeroed out for payment. All states will begin using the AHEAD Medicare Hospital Global Budget in 2028.

Next is Medicaid, shown in green. Every state must implement a Medicaid hospital global budget under AHEAD by 2029, which means all states will start using this methodology in 2028. CMS will provide guidance and alignment criteria, and states will share more details with hospitals as they develop their methodologies. Including Medicaid is critical for payer alignment and system-wide transformation.

Finally, commercial payers shown in orange. By 2029, each state must have at least one commercial payer participating in hospital global budgets under AHEAD. CMS will issue guidance as commercial payers join and additional details will follow.

As you heard earlier when we were discussing Geo AHEAD, hospitals can participate in both Geo AHEAD and Hospital Global Budget AHEAD. Engaging in both amplifies benefits to both hospitals and Geo Entities. We want to spend some time showing you how this works.

When Geo Entities and hospitals participate in AHEAD - through Geo AHEAD and Hospital Global Budget AHEAD respectively - each gains the benefits from controlling costs, which they each retain in the form of savings. What's less obvious is that when hospitals engage in both hospital global budget and Geo AHEAD, a synergistic effect occurs. This dual participation amplifies the benefits for both the hospitals and the Geo Entity due to their overlapping attributed beneficiaries.

Let's walk through an example to see how this works. On the left, we have an example state, the rectangle. Hospital Z is located in the state and participating in Hospital Global Budget AHEAD. Geo Entity A is operating in the state and covers the area where Hospital Z is located. Hospital Z and Geo Entity A will implement strategies independently and maximize results.

Let's start with Hospital Z. Under HCB AHEAD, Hospital Z implements strategies that reduce hospital costs overall - for example, by reducing avoidable utilization or readmissions that results in retaining savings under HCBs. Geo Entity A is also benefiting since this strategy results in reduced hospital costs for Geo Entity A attributed beneficiaries.

On the right, we see there are now three dollar symbols under Hospital Z to signify the success under HCB AHEAD. We also see one dollar symbol under Geo Entity A indicating the resulting financial benefit for Geo Entity A.

Next, we see that Geo Entity A's strategies reduce unnecessary costs for Geo Entity A attributed beneficiaries across the state - perhaps they reduced admissions driven by upstream factors. Geo Entity A strategies reduce costs for Geo Entity A attributed beneficiaries seen at Hospital Z and therefore benefit Hospital Z as well. As a result, Geo Entity A earns three dollar symbols for their efforts and Hospital Z benefits as well, though not as much, earning an additional dollar symbol.

Now Hospital Z and Geo Entity A partner to develop collaborative strategies, perhaps care coordination efforts that further optimize patient care and reduce costs. This results in cost saving and improved outcomes only possible because they work together. As a result, they each gained two additional dollar symbols.



And this is why we say that overlapping efforts create a win-win and collaboration amplified the benefits of Geo AHEAD and Hospital Global Budget AHEAD.

[Choice and Competition 46:05]

Now we will discuss the new choice and competition requirements.

States are now required to implement at least two policies that promote choice and foster competition as part of AHEAD. The purpose of these policies are to empower consumers by ensuring beneficiaries have access to a broader range of providers and care delivery options, to drive market efficiency through competition among providers and payers that can lead to improved quality, innovation, and lower costs by reducing monopolistic practices and encouraging value-based care, and to support total cost of care goals for states looking to better manage healthcare spending and meet the financial targets required under the AHEAD Model, as well as improve access to care and encouraging innovation.

States will need to select at least two policies, one to promote choice and one to promote competition, allowing states to tailor reforms to their local context and priorities. These can be new policies or an enhancement of an existing policy, and these will likely require state actions such as legislation, regulation, executive order, or other interpretive guidance to fulfill implementation requirements.

States will identify policies to pursue by the end of 2028, must take action to enable implementation of the policy by the end of 2029, and begin implementation by the end of 2030.

On this slide, we have the four policy options states will choose from to promote choice. They include: implement Medicaid site neutrality by aligning payment rates for the same outpatient services across different care settings, for example, hospital outpatient departments versus physician offices to support clinically appropriate care, access and choice; expand access to telehealth services by enabling new care modalities like audio only, asynchronous or remote patient monitoring and joining interstate licensure compacts to improve care coordination, access and choice, especially for postpartum and chronic disease management; advanced prescription drug price transparency by requiring reporting from key supply chain entities like manufacturers and PBM's, and publicly sharing pricing data to help consumers and payers make informed, cost-conscious decisions; or increase provider mobility and patient access by banning non-compete clauses for licensed health professionals to ensure clinicians can freely practice across settings and regions without contractual restrictions.

As a reminder, this is a requirement at the state level, not the hospital, PCP or Geo Entity level. Each state is required to select and take action to implement at least one policy from these options. Based on the state selection, outreach to impacted stakeholders may occur later in the process, and stakeholders will receive sufficient notice before any changes take effect.

On this slide, we have the four policy options state may choose from to foster competition. They include: change scope of practice restrictions to allow non-physician providers, like nurse practitioners or physician assistants, to practice to the full extent of their training, improving access and workforce efficiency; repealing Certificate of Need requirements for non-hospital settings to reduce regulatory barriers and encourage competition and innovation in healthcare delivery; revise network adequacy provisions to improve access by modernizing standards like time, distance, and provider ratios and ensuring accurate provider directories across Medicaid and commercial markets in support of expanded access and choice; or expand contracting flexibilities by repealing any willing provider laws, enabling health plans to build high-value networks and better manage costs and quality.

Again, this is a requirement at the state level, not the hospital, PCP, or Geo Entity level. Each state is required to select and take action to implement at least one policy to foster competition from the options listed. These policies are chosen by the state. Based on the state selection, outreach to impacted stakeholders may occur later in the process, and stakeholders will receive sufficient notice before any changes take effect.



[Population Health Accountability Plans 50:18]

We will now move on to the Population Health Accountability Plans.

The Population Health Accountability Plan, or PHAP, is a strategic plan required of states and hospitals under the model that outlines measurable goals and evidence-based strategies to improve population health and prevention against statewide quality targets. States will identify priority health areas using existing plans like State Health Improvement Plans, or SHIPs, or Community Health Needs Assessments, or CHNAs. Each PHAP must include clear, measurable goals related to prevention, chronic illness, behavioral health, healthcare utilization, and patient reported outcomes.

Plans must outline actionable, evidence-based strategies to achieve each goal, ensuring alignment with best practices. States are encouraged to use tools such as Medicaid waivers, regulatory authority, and funding mechanisms to support implementation.

A communication strategy is required to ensure stakeholders are informed and involved in achieving statewide goals. And states must submit annual updates to CMS detailing progress on outcomes, strategies developed, and improvements in population health.

This slide notes the details of the statewide PHAP and the hospital PHAP. In terms of the statewide PHAP, the statewide PHAP is developed by the state to guide population health improvement across the entire state or sub-state region. It is created with input from the state's model governance structure, or MGS, or another designated governing body. The statewide PHAP will set targets for and track progress on at least six population health measures using all peer data. The statewide PHAP will be submitted to CMS with annual updates, including statewide progress on the targets and summarized information on the hospital PHAPs.

In terms of the hospital PHAP - the hospital PHAP is developed to support and align with the statewide PHAP, focusing on hospital-specific strategies, and will be led by a designated hospital leader or committee with regular engagement from hospital leadership. Hospital PHAPs will be designed to meet expectations at the federal, state, and local level, and should be designed to align with hospital needs based on data, for example, from community health needs assessments. The PHAP will be submitted to the state and MGS, who will provide updates on the hospital PHAPs for CMS monitoring.

States will select at least six population health level metrics that reflect the health priorities and goals outlined in their PHAP. States must report baseline and annual updates for each measure using both Medicare fee-for-service and all payer data where feasible. Measures must be stratified by payer, dual status, and geography where statistically feasible to assess improvements across different population segments. The selected measures help guide data collection, stakeholder collaboration, and deployment of strategies throughout the model performance period.

[Resources & Closing 53:13]

Thank you to my CMMI colleagues for presenting the AHEAD Model updates. Now, don't jump off just yet, we are going to walk through the AHEAD resources and materials. On this slide, we are highlighting key resources that stakeholders can expect under AHEAD.

For hospitals - early in 2026, we will provide simulated hospital global budgets. These estimates show what each eligible hospital's hospital global budget would have been in prior years before performance year one.

For primary care providers - in August of 2025, we released the Primary Care AHEAD Payment Specifications, a technical document covering participation requirements, beneficiary attribution, and EPCP calculations. An at-a-glance overview will follow in early 2026, and details on capitation will come later in 2026. Also, in early 2026, we will share a pathway infographic that visually outlines the different ways PCPs can participate in AHEAD.



For states - we will provide a Population Health Accountability Plan template in early 2026 to guide states in developing their plans.

For Geo AHEAD - throughout 2026, we will release written materials and webinars with more information on attribution, participation, and benefits. In summer of 2026, we will publish Geo AHEAD Technical Specification Version 1.0.

We encourage you to regularly check the AHEAD Model website for updates and additional resources. Existing model resources are being revised to reflect changes, and new materials are under development. They will be posted as they are available.

We truly appreciate you taking the time to listen to this recorded webinar. We hope you have found it useful and informative. If you have any remaining questions or comments, please submit those to AHEAD@cms.hhs.gov with the subject line AHEAD Model Updates.

This concludes the recording. Thank you so much for listening and we really appreciate your partnership.