Overview

Purpose

This At-A-Glance document provides an overview of the Primary Care Achieving Healthcare Efficiency through Accountable Design (PC AHEAD) Model Payment Specifications, Version 2.0 that describes the PC AHEAD Basic Pathway. Primary care practices (PCPs), Community Health Centers (CHCs), and other interested parties can use this document to understand the financial components of PC AHEAD and how beneficiaries are attributed to participants. More detailed information is located in the PC AHEAD Payment Specifications, Version 2.0 on the AHEAD Model website.

Goals of PC AHEAD

PC AHEAD is a cornerstone of the AHEAD Model, designed to transform primary care by promoting evidence-based preventive services, empowering patients to reach their health goals, and driving efficiency, choice, and cost containment. At its core, PC AHEAD advances six strategic goals that shape the future of care delivery:

Improve preventive care delivery and outcomes.	Increase access to high-quality and timely primary care services.	Improve care coordination across the continuum.
Create alignment between Medicare and state-based primary care initiatives.	Integrate behavioral health screening, treatment, and coordination within primary care.	Incentivize providers to adopt advanced payment models that ensure predictable revenue and accountability for outcomes and cost management.

Benefits of Participating in PC AHEAD

PC AHEAD is designed to strengthen primary care by expanding capacity for care coordination, connecting patients to community resources, improving quality, delivering whole-person, patient-centered care, and reducing provider burden. Through this approach, PC AHEAD offers:

Enhanced primary care investments to support high-value services, practice transformation activities, patient-centered care, and practice sustainability.

Flexibility to deliver and get paid for care outside traditional visits, including telehealth, care coordination, patient outreach, and team-based care.

Reduced provider burden through multi-payer alignment, streamlining quality and reporting measurement.

Build value-based care experience and progression to position your practice for the future.

PC AHEAD Care Transformation Requirements (CTR)

To support PC AHEAD goals, participants will be required to meet a set of Care Transformation Requirements (CTRs) designed to facilitate increased statewide investment in primary care. CTRs will build over time, with additional expectations that reflect growing experience and capacity. CMS will provide example activities to meet the CTRs:

Behavioral Health Integration: supports implementation of universal behavioral health screenings and improved access to services.

Example activities include routine universal screening process for behavioral health to establish collaborative care (e.g., PHQ-9), developing crisis protocol for high-risk patients, and hiring in-house behavioral health providers.

Specialty Care Coordination: focuses on building integrated care teams and establishing referral processes, including warm handoffs.

Example activities include establishing a screening process to identify patients who could benefit from care management services, increasing access to consultations, and establishing a closed-loop referral system and coordination process for integrated care team.
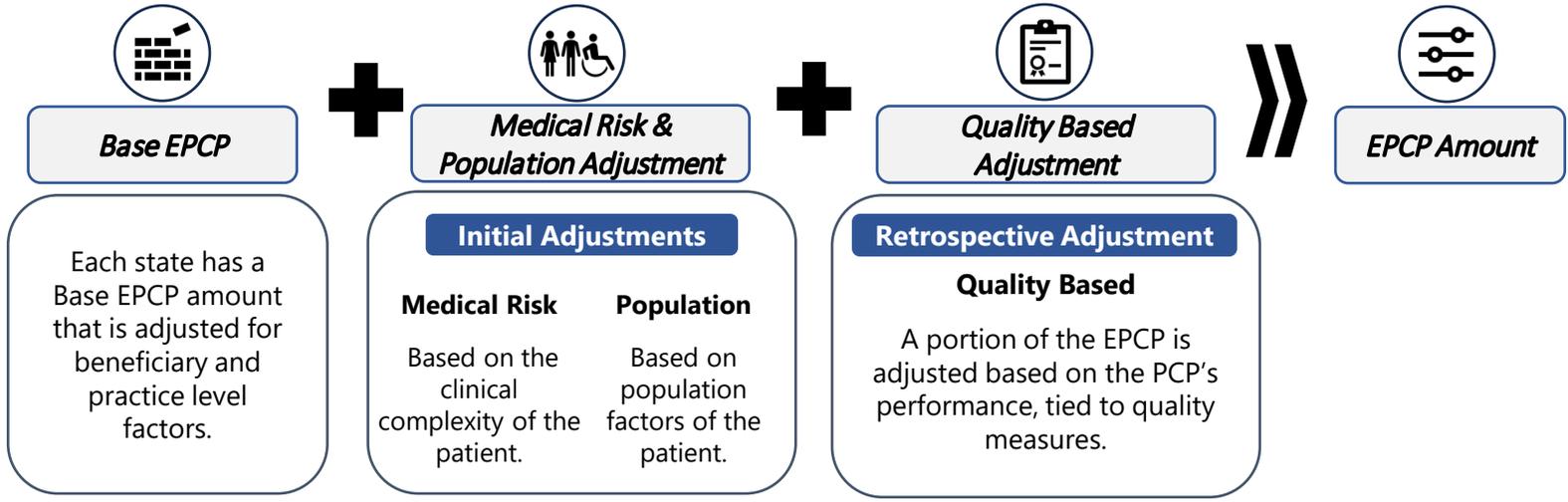
Health Promotion Activity: promotes screening for upstream drivers of health and lifestyle activities and connecting patients to local resources.

Example activities include establishing a screening process for social support services, developing a plan for increased referrals to community organizations/social support services, and developing a process for creating an integrated care team to identify and connect patients needing social support services.

What is an Enhanced Primary Care Payment (EPCP)?

Enhanced Primary Care Payments (EPCP) are risk-adjusted, non-visit-based payments determined by beneficiary medical and population risk, with a portion tied to performance on quality and utilization metrics. Each state has a Base EPCP amount that is adjusted for beneficiary and practice level factors. PC AHEAD Participants will receive a prospective EPCP at the beginning of each quarter for each Medicare attributed beneficiary. The EPCP will be paid in addition to traditional fee-for-service (FFS) codes, except for certain care management codes that are considered duplicative of the EPCP and are not billable while the participant receives EPCPs.

Order of Operations for Calculating the EPCP

Below are the key order of operations for calculating the EPCP. To see sample beneficiary EPCP calculations, visit Section 4.6 of the PC AHEAD Payment Specifications, Version 2.0.

Base EPCP

Each state has a Base EPCP amount that is adjusted for beneficiary and practice level factors.

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Medical Risk & Population Adjustment

Initial Adjustments

Medical Risk

Based on the clinical complexity of the patient.

Population

Based on population factors of the patient.

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Quality Based Adjustment

Retrospective Adjustment

Quality Based

A portion of the EPCP is adjusted based on the PCP's performance, tied to quality measures.

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EPCP Amount

Payment Composition Overview

Step 1: Base Enhanced Primary Care Payment (EPCP)

The Base EPCP is a statewide average based on the State's planned investments, performance on hospital participation goals, and, in later years, performance on state Medicare FFS TCOC cost growth targets under the State Agreement. The Base EPCP will be adjusted for inflation starting in Year 2 using the Medicare Economic Index (MEI).

Step 2: Medical Risk and Population Adjustments

CMS applies the Medical Risk Adjustment (MRA) and the Population Adjustment (PA).

Medical Risk Adjustment (MRA): An adjustment to the Base EPCP, excluding the QBA portion of the EPCP, applied based on an AHEAD Beneficiary's medical risk score (e.g., the sicker the patient, the greater the payment). Beneficiaries are assigned to one of five medical "risk tiers" prior to each quarter. Each tier is assigned a specific per beneficiary per month (PBPM) EPCP rate.

Population Adjustment (PA): An adjustment to the Base EPCP, excluding the QBA portion of the EPCP, based on an AHEAD Beneficiary's Low-Income Subsidy (LIS) eligibility, dual enrollment in Medicaid, and Community Deprivation Index (CDI) score (top 20th percentile) (e.g., the higher the needs of the patient, the greater the payment).

Step 3: Quality Based Adjustment (QBA)

The QBA is a portion of the EPCP at-risk for performance based on a set of utilization and quality measures (see boxes below). Following each PY, CMS evaluates the PC AHEAD Participant's performance to determine whether it met the targets for each measure and to calculate the QBA. Based on the evaluation, practices may be able to earn the full QBA amount, or practices may be required to repay some or all the QBA. For participants in the Basic Pathway in PY 1, 5% of the statewide base EPCP is at risk.

The model applies both achievement and improvement targets for the QBA. Practices that meet the high-performance benchmark (available starting PY1), improvement target (available starting PY2), or longitudinal continuous improvement target (available starting PY3) for all quality measures retain their full QBA.

The **utilization component contributes 40%** to the total QBA score.
- Acute Hospital Utilization (AHU) (20%)
- Emergency Department Utilization (EDU) (20%)

The **quality component contributes 60%** to the total QBA score.
- Behavioral Health electronic clinical quality measure (eCQM) (20%)
- Prevention and Wellness eCQM (20%)
- Chronic Conditions eCQM (20%)

Final Calculation: Enhanced Primary Care Payment (EPCP) Amount
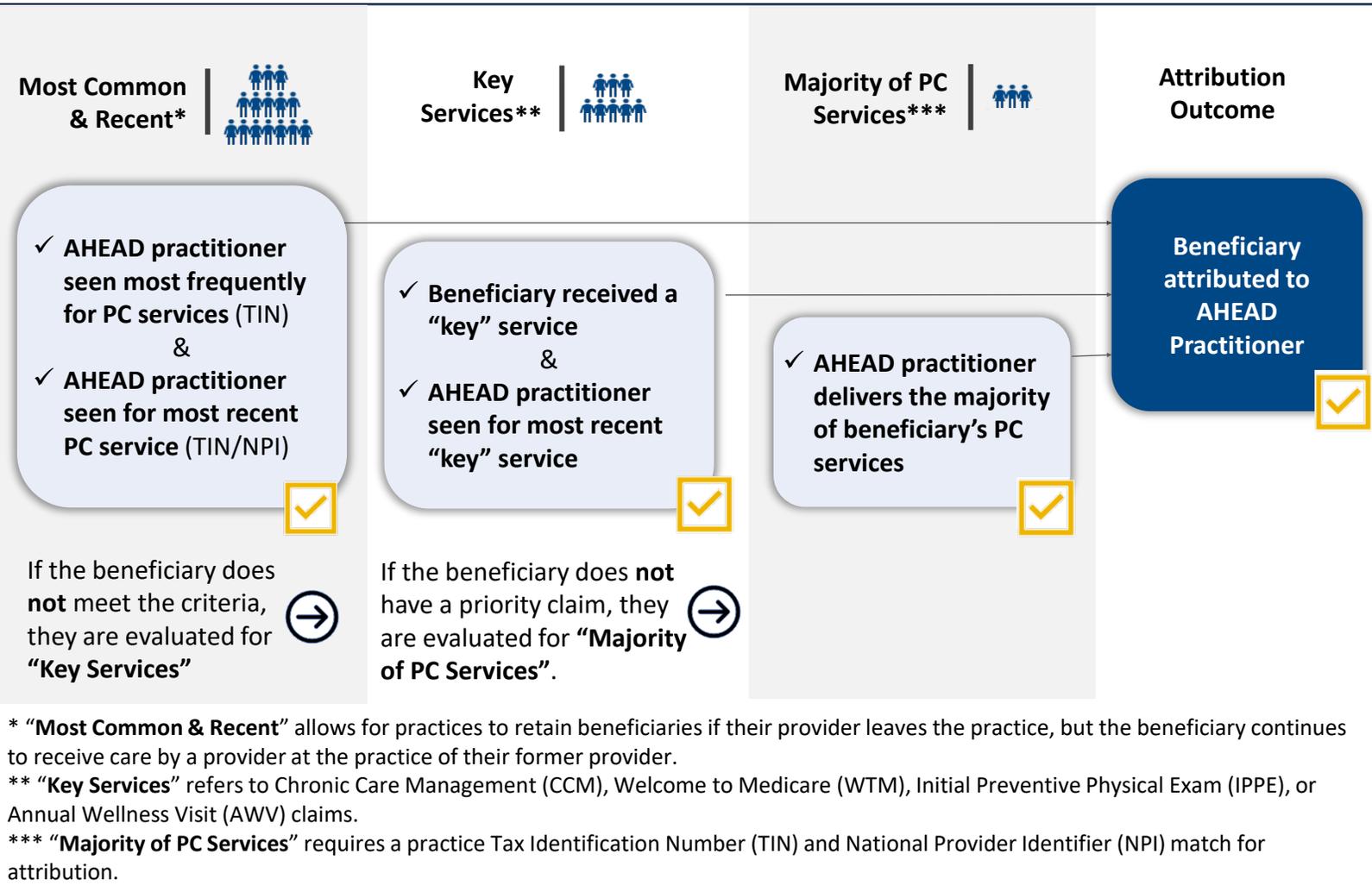
Following all adjustments to the Base EPCP, the EPCP Amount is calculated, which is the amount paid to the participant.

For more information on the AHEAD Model and additional payment resources, please visit the AHEAD Model website.

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Overview of Beneficiary Attribution

CMS uses two years of primary care claims data to attribute beneficiaries to the participant with whom they have an established relationship. PC AHEAD Participants will receive a unique list of beneficiaries attributed to them prior to the start of each quarter. While patient panels may change slightly over time (e.g., taking on new patients), in other models similar to AHEAD, the experience has been that the number of Medicare FFS patients attributed to a participant is generally consistent quarter to quarter.

The attribution algorithm uses three methods to determine if a beneficiary can be attributed to a PC AHEAD Participant:

Most Common & Recent*

- ✓ AHEAD practitioner seen most frequently for PC services (TIN) &
- ✓ AHEAD practitioner seen for most recent PC service (TIN/NPI) ☑

If the beneficiary does **not** meet the criteria, they are evaluated for "Key Services" →

Key Services**

- ✓ Beneficiary received a "key" service &
- ✓ AHEAD practitioner seen for most recent "key" service ☑

If the beneficiary does **not** have a priority claim, they are evaluated for **"Majority of PC Services"**. →

Majority of PC Services***

- ✓ AHEAD practitioner delivers the majority of beneficiary's PC services ☑

Attribution Outcome

Beneficiary attributed to AHEAD Practitioner ☑

* "**Most Common & Recent**" allows for practices to retain beneficiaries if their provider leaves the practice, but the beneficiary continues to receive care by a provider at the practice of their former provider.

** "**Key Services**" refers to Chronic Care Management (CCM), Welcome to Medicare (WTM), Initial Preventive Physical Exam (IPPE), or Annual Wellness Visit (AWV) claims.

*** "**Majority of PC Services**" requires a practice Tax Identification Number (TIN) and National Provider Identifier (NPI) match for attribution.

For more information on the PC AHEAD beneficiary attribution process and PCS claims, see Chapter 3 of the PC AHEAD Payment Specifications, Version 2.0.

Additional PC AHEAD Resources

- **AHEAD Model Website**: Provides AHEAD Model overview resources as well as PC AHEAD specific resources.
- **PC AHEAD Payment Specifications, Version 2.0**: Provides details on participation requirements, beneficiary attribution, and the calculation of the EPCP.