spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

States Advancing AHEAD Update

OVERVIEW

On November 16th, the Centers for Medicare and Medicaid Services (CMS) released the Notice of Funding Opportunity (NOFO) for states interested in participating in the States Advancing AHEAD model, an all-payer total cost of care (TCOC) delivery model that will establish global budgets for hospitals in a region. AHEAD consists of three components, all intended to apply on a multi-payer basis (Medicare, Medicaid, and private):

- A regional total cost of care growth commitment between the State and CMS;
- Prospectively set hospital global budgets; and
- Enhanced primary care payments.

Under the NOFO, states interested in the model may apply for cooperative agreement funding of $12 million over approximately six years to help develop infrastructure to implement AHEAD in their state or sub-state region. States who receive funding will then develop a State Agreement outlining their commitments with CMS to implement the model, which must be executed by six months prior to the start of Performance Year (PY) 1. States interested in the first two cohorts must apply by March 18, 2024; states interested in participating in the third cohort must apply by August 12, 2024.

The full NOFO is available here. SPG's earlier summary and major takeaways from the model are available here. Below is a summary of important new information from the NOFO. Please contact SPG for more details.

GOVERNANCE STRUCTURE

States participating in AHEAD must establish a governance structure that includes a wide variety of stakeholders in the AHEAD region, including:

- The State Medicaid and/or Health agency;
- Other relevant state agencies (e.g., Insurance Departments);
- Community-based organizations, including those serving underserved communities;
- Patients underserved communities (and associated advocacy groups);
- Health care payers, including commercial payers;
- Clinicians and provider organizations, including those from underserved communities; and
- Other groups whose policies influence population health.

States can choose an existing entity or designate a new entity to serve as the governance body. Although states remain ultimately responsible for AHEAD targets, the governing body will serve various functions, including:

- Providing input into the selection of statewide (or region-wide) quality and equity targets;

60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- Developing the statewide (or region-wide) Health Equity Plan;
- Helping to review hospital-specific health equity plans;
- Providing input on the use of cooperative agreement funding; and
- Ensuring that AHEAD implementation is informed by diverse community perspectives. This may include input into the establishment of cost growth and primary care investment targets.

STATE ACCOUNTABILITY TARGETS

Cost Growth Targets

CMS and participating states will work together to set all-payer and Medicare fee-for-service (FFS) cost growth targets. The exact targets (both in terms of total cost growth and expected savings) will depend on state-specific factors. States will have until 90 days before the start of PY2 (i.e., September 2026 or 2027) to fully define the all-payer growth target and calculation methodology.

CMS may require remediation if the state fails to meet the all-payer growth target, including the adjustment of enhanced Primary Care AHEAD payments. Similarly, if participants fail to meet the Medicare FFS targets, CMS will offer an opportunity for remediation, after which it may adjust Medicare FFS hospital budgets. CMS will consider holding states harmless for Medicaid cost growth if that growth is due to increased access to care, additional uptake/reimbursement for preventive services, or other AHEAD-aligned reasons.

Primary Care Investment Targets

AHEAD states will set targets to increase investments in primary care, both on an all-payer and Medicare FFS basis. In Medicare FFS, CMS will seek to set a final primary care target for the end of the model in 2034 of between 6-7% of total Medicare FFS cost of care. A February 2023 report by the Milbank Memorial Fund and the Physicians Foundation found that Medicare primary care spending generally varied from 3.8% to 4.6% from 2015 to 2019.[1] However, CMS will produce its own data for the purposes of the AHEAD program, based on a standardized definition of primary care.

States will be responsible for developing their own all-payer primary care investment metrics and targets. Targets must be established by 90 days before the start of PY 1 (i.e., September 2025 or 2026), and the full methodology must be formalized by the state by 90 days prior to the start of PY 2 (i.e., September 2026 or 2027).

The methodology must include collection of primary care spending from Medicaid and commercial payers and should include both claims-based and non-claims-based payments for primary care. States

[1] https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf

60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

may use their own definitions of "primary care", subject to approval by CMS. If a state does not have its own existing definition of "primary care," it may use the standardized CMS AHEAD definition.

GLOBAL BUDGET METHODOLOGY

Medicare FFS

Under AHEAD, CMS will provide participating hospitals with prospective, bi-weekly payments that represent their Medicare FFS revenue. At least 10% of the region's Medicare FFS hospital net patient revenue must be included in PY 1, increasing to 30% by PY 4. Hospitals will continue to submit FFS inpatient and outpatient claims and cost reports as they normally would. Beneficiary cost-sharing will be unchanged.

CMS will develop a detailed Medicare FFS methodology for global budget setting, which will be standardized across hospitals. States with experience and existing hospital rate-setting or budget-setting authority may also seek to design a state-specific Medicare FFS methodology, subject to the approval of CMS. Participating states may seek to develop tailored methodologies as the AHEAD model progresses, which should be submitted 18 months in advance of the PY in which they would take effect.

States must have a process defined in the AHEAD State Agreement to handle hospital requests for adjustments to their global budgets, based on service line changes (e.g., upward adjustment for additions or retaining revenue if a service is removed). CMS will consider such requests on a case-by-case basis.

To facilitate planning, CMS has provided a high-level overview of the standard AHEAD methodology for Medicare FFS, as follows:

- **Historical revenue**: CMS will calculate a weighted average of the hospital's historical Medicare inpatient and outpatient revenue over the three most recent years available.
    - Beneficiary cost-sharing, new technology adjustments, and pass-through adjustments—including bad debt, Medicare graduate medical education (GME), nursing and allied health education (NAHE), and organ acquisition—will be removed from the baseline.
    - Payment adjustments based on hospital quality performance will also be removed, as they will be accounted for later in the global payment amount. These include:
        - Rhe Hospital-Acquired Condition Reduction Program (HACRP);
        - The Hospital Readmissions Reduction Program (HRRP);
        - The Hospital Inpatient Quality Reporting Program (IQR);
        - The Outpatient Quality Reporting Program (OQR); and
        - The Hospital Value-Based Purchasing Program (VBP).
    - For hospitals participating in 2027, the weighted average will be composed of the following:
        - **2023**: 10% weight
        - **2024**: 30% weight

    - **2025**: 60% weight
- **Baseline adjustments**: Global budgets will be adjusted to account for a variety of supplemental payments, including:
  - Medicare Disproportionate Share Hospital (DSH) payments**;**
  - Indirect Medical Education (IME);
  - Low Volume Adjustments;
  - Outlier Adjustments;
  - Uncompensated Care (UCC) payments;
  - Wage Index updates; and
  - Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) adjustments.
- **Adjustments based on population and service changes**: Global budgets will be subject to a number of adjustments to reflect population and service changes, including:
  - **Risk adjustment**: CMS will adjust global budgets based on medical and social risk. Methodologies will be determined later, but may include HCC-based risk adjustment, Area Deprivation Index (ADI) social risk adjustment, dual status, and Low Income Subsidy (LIS) participation.
  - **Demographic shifts**: Global budgets will be adjusted based on the changes in the demographics of the hospital's service area, such as population size, age, and volume.
  - **Inflation**: Budgets will be trended forward using a Medicare FFS inflation factor**.**
  - **Market shifts**: Budgets will be adjusted for "material shifts in volume for specific services between hospitals."
  - **Service line changes**: Budgets may be adjusted to account for service line additions, expansions, eliminations, or contractions.
- **Adjustments based on performance**:
  - **Quality adjustment**: In each performance year, CMS will adjust each hospital's budgets to approximate quality adjustments applied in Medicare FFS, including the HACRP, HRRP, IQR, OQR, and VBP programs mentioned above.
  - **Health Equity Improvement Bonus**: Starting in PY 2, CMS will offer an upward adjustment to the budget in a future performance year based on selected quality measures focused on promoting equity. It is likely that PY 2 performance will result in an adjustment in PY 4 or later, to allow for data collection and evaluation time.
  - **TCOC Performance Adjustment**: Starting in PY 2, CMS will offer an adjustment based on the TCOC of beneficiaries in the hospital's service area. Adjustments will begin in PY 4, based on PY 2 performance, as upward-only. Starting in PY 5, the adjustments will be both upward and downward.
  - **Effectiveness Adjustment**: Starting in PY 2, CMS will make downward adjustments to global budgets based on hospitals' calculated potentially avoidable utilization (PAU). The PAU metrics may include readmissions, avoidable admissions, low-value care, and other indicators.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- **Transformation Incentive Adjustment**: CMS will provide a 1% upward adjustment during PY 1 and PY 2 to facilitate hospital investment in transformation. Hospitals that exit the model prior to PY 6 will be required to repay this amount.

Hospitals may request further adjustments in exceptional circumstances, and CMS reserves the right to make further adjustments based on federal policy changes as needed.

Medicaid Global Budgets

State Medicaid programs will need to develop a framework for Medicaid authority to pay hospital global budgets, as well as a methodology for calculating the budget, subject to CMS approval.

Medicaid budgets should "provide the same general incentives" as the Medicare FFS global budgets, but are likely to differ based on different covered services, revenue sources, and so on. Payments may either be provided as true prospective payments as in Medicare FFS, or as a "virtual global budget," in which payments would be made under existing contract arrangements with a defined reconciliation process to result in the hospital receiving its calculated global budget.

At a minimum, Medicaid global budgets must meet the following requirements:

- Budgets must include hospital inpatient and outpatient services.
  - States may propose to include or exclude certain specific service lines (which may differ from Medicare FFS global budgets), subject to approval by CMS. For example, this could pertain to Medicaid FFS populations or services that are not covered by Medicare (e.g., dental services).
- Budgets should use several years of historical data and account for inflation, population growth, demographic changes, and other factors.
  - Budgets must be adjusted for both medical and social risk.
- Budgets must be adjusted for quality performance, based on the outcomes of a specific attributed patient population. CMS suggests using existing hospital quality performance programs. Adjustments should include "disparities-sensitive quality measures."
- Medicaid supplemental payments, including Upper Payment Limit (UPL) payments, Medicaid UCC, Medicaid IME, Medicaid DSH, and Delivery System Reform Incentive Payments (DSRIP), may be included in the methodology where relevant. CMS will establish policies around their inclusion and work with states to finalize details on these payments.
- The budget updating process must account for service line and unplanned volume shifts.

CMS encourages states to engage substantively with Medicaid managed care organizations (MCOs) early on to determine how to modify model contracts and capitation rates. Global budgets may be (but are not required to be) allocated to MCOs based on volume.

Medicaid global budgets for participating hospitals may be implemented at any point prior to or during PY 1, but must be in place by the end of that year. In particular, if the state's Medicaid rates are usually

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

finalized in Q3 or Q4, CMS encourages states to begin the implementation at that point before the start of PY 1. The exact timeline will be developed by the State, taking into account the necessary authorities, community engagement, MCO contracting processes, and so on.

PRIMARY CARE AHEAD

Under AHEAD, CMS will offer an aligned, multi-payer enhanced primary care option called Primary Care AHEAD, which will include:

- A Medicare FFS Enhanced Primary Care Payment (EPCP) to fund advanced primary care investment;
- Care transformation requirements, including integration of behavioral health, care management and specialty coordination, and addressing health-related social needs; and
- A state-specific aligned Medicaid primary care alternative payment model (APM) option.

For states that are implementing primary care capitation in their Medicaid programs as an APM, CMS is evaluating whether to include a capitated option for Medicare in Primary Care AHEAD as well, beginning in 2027.

Eligibility

Primary care practices, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) may participate in Primary Care AHEAD if they:

- Are located within an AHEAD state or sub-state region;
- Participate in the state's aligned Medicaid primary care APM; and
- Are eligible to bill Medicare.

Practices will be identified at the TIN level, except for system-owned practices, which will also include the NPI for identification. Hospital-owned practices may only participate if the hospital is participating in a global budget (except FQHCs and RHCs).

Payment

The Medicare EPCP is expected to average $17 per beneficiary per month, adjusted for beneficiary medical and social risk. Based on state performance in AHEAD (hospital participation and Medicare FFS TCOC), this amount may range between $15 and $21. EPCP will be paid on a quarterly basis. A small portion of the EPCP, starting at 5% and increasing to 10% by PY 8, will be tied to performance on select quality measures.

Payment will be made to each practice for their attributed Medicare FFS beneficiaries. Attribution will be determined on a quarterly basis, based on where the beneficiary is expected to receive the plurality of their primary care services in that quarter.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Participating practices will not be paid for existing Medicare FFS care management services, as they would be duplicative of the EPCP payment.

COMMERCIAL PAYERS

States participating in AHEAD will be expected to use their authority to hold commercial payers accountable for TCOC growth, as commercial spending will be incorporated into the all-payer cost growth measurements.

In each state, at least one commercial payer operating in the state or sub-state region must participate in hospital global budgets by the start of PY 2. Commercial payers are defined to include:

- State employee health plans;
- Basic Health Plans (the Essential Plan in New York);
- Qualified Health Plans (Marketplace plans); and
- Medicare Advantage Plans.

OTHER REQUIREMENTS

Sub-State Regions

States seeking to implement AHEAD in a sub-state region must provide a justification for their selection, including detailed information on the region's population health outcomes and spending. At least 50% of the Medicare FFS TCOC for beneficiaries residing in the region must be delivered within that region.

States may expand the sub-state region during the Pre-Implementation Period, subject to CMS approval.

State Timelines

Participating states must meet the following milestones:

- 18 months prior to PY 1: Submit a plan for Medicaid authority to implement hospital global budgets
- 12 months prior to PY 1: Submit a detailed methodology for Medicaid hospital global budgets
- 6 months prior to PY 1: Execute the State Agreement
- 90 days prior to PY 1:
  - Execute Participation Agreements with hospitals, such that at least 10% of the state or substate region's Medicare FFS hospital net patient revenue (NPR) is included in a global budget
  - Memorialize the state's commitment to an all-payer TCOC growth target in law, executive order, or regulation
- Start of PY 1: Implement a Medicaid Primary Care APM

SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- 90 days prior to PY 2: Establish all-payer TCOC goals and primary care investment targets in law, executive order, or regulation
- Start of PY 2:
  - Implement Medicaid hospital global budgets
  - Ensure participation of at least one commercial payer
- 90 days prior to PY 4: At least 30% of the Medicare FFS hospital NPR in the AHEAD region must be included in a hospital global budget.