Spotlight on Primary Care in the AHEAD Model
May 9, 2024

>>Nora Lewis, CMS: All right. It is one o'clock so I think we're going to go ahead and get started, I know folks are still creeping in here on the webinar. If you could advance to the next slide, that would be great.

So, I just want to welcome everyone, good afternoon. We have about an hour in front of us to spotlight the Primary Care Strategy in the States Advancing All-Payer Health Equity Approaches and Development Model or the AHEAD Model.

My name is Nora Lewis I am the Primary Care and Medicaid Alignment Workstream Lead for the AHEAD Model here at the CMS Innovation Center in the Division of Multi-Payer Models. Our division also houses the Maryland Total Cost of Care Model and the Vermont All-Payer Accountable Care Organization (ACO) Model. It's going to be my pleasure today to take everyone through most of this webinar. I'm also joined on the line by various colleagues, including Laura Snyder, our Co-Model Lead, Kate Sapra, our Division Director, and other members of the AHEAD team.

Thanks so much to everyone for joining today. This is a really essential webinar, since we'll be delivering some key messaging around the Primary Care AHEAD program and how it fits into the AHEAD Model goals. I also want to thank the partner organizations and the primary care community who have provided a lot of expertise and feedback on this really important topic.

So, we're going to cover a few things today. I'll dive first into an overview of the AHEAD Model. I'll also go over our goals for primary care investment in the context of AHEAD and highlight some partnerships for delivery system and population health reform. We'll also provide some specifics around the Primary Care AHEAD program, our Enhanced Primary Care Payment, and some of the mechanics around those payment mechanisms and support that primary care practices can expect to receive in participating in Primary Care AHEAD, as well as the impact that we think this will have on the delivery of advanced primary care in AHEAD states and regions.

We'll also have some time for frequently asked questions and a Q&A at the end. So feel free to keep track of your questions. Please use the Q&A function to enter them as the webinar goes on, and we'll try to address as many of them as we can at the end of the webinar here. All right next slide, please.

So, the AHEAD Model. This slide gives a brief overview of the model components. But I'd really encourage folks to take a look at the AHEAD Model website for more comprehensive information about the various model components. The AHEAD Model is designed to be a flexible framework for up to eight states to take on accountability for total cost of care, increased primary care investment, and equity, and population health improvement for all beneficiaries in the state.

States will use a few key tools to meet these targets over the course of the 10-year model, including up to 12 million dollars in Cooperative Agreement funding, and our two Alternative Payment Models (APMs) for participating hospitals and participating primary care practices. So those are our hospital global budgets and the Primary Care AHEAD program. We have several strategies integrated, integrated across all of these model components. So that includes a comprehensive health equity focus, behavioral health integration strategies, multi-payer alignment, and Medicaid participation. And I'd really like to

highlight today the goal of existing, accelerating existing state innovations, not just in the primary care space, but across really, all components of the model.

Our presentation today will focus on the role of the Primary Care AHEAD program and primary care investment targets in accomplishing model goals. We believe that strengthening the primary care system should be a vital policy focus in the AHEAD Model. Our primary care program and investment targets are part of a suite of interventions included in the AHEAD Model to ensure that primary care practices can deliver whole-person and advanced primary care in their communities, and therefore contribute to the overall goals of the model. Next slide, please.

So, I'd like to speak a bit first to the primary care investment strategy in the AHEAD Model. We recognize that primary care is a chronically underfunded public good. The Medicare fee-for-service Primary Care Investment Targets will bring Medicare to the table to build on the really great work that states and primary care leaders have been doing to measure and increase primary care spending, while simultaneously curbing the growth of total cost of care. Some states already have complementary cost growth targets and primary care investment targets in place because they're working towards a set of goals aligned with the AHEAD Model.

Again, AHEAD is a 10-year model. We know that it takes time to see savings and impact on population health from increased investments in primary care. We are not expecting primary care providers to bend the cost growth curve by themselves, but they will play a very important role in the overall rebalancing of the health care system spend that we want to see in AHEAD states and regions. The model works to create efficiencies and accountability structures for hospitals, for payers and for states, in addition to primary care practices. Next slide please.

So, a few more specifics about our primary care investment strategy in AHEAD. As I outlined on the model overview slide, AHEAD includes both All-payer and Medicare fee-for-service Primary Care Investment Targets. Our overall strategy here aims to establish state capabilities for defining and measuring primary care spending and then go above and beyond that by targeting those primary care investments to the communities and to the beneficiaries that need them the most. We really want states to use their unique levers to increase investments in primary care across all payers. We will then bring Medicare fee-for-service to the table for these existing innovations via the Primary Care AHEAD program. We'll be utilizing CMS data to track Medicare fee-for-service investment in participating states and providing a framework for a standardized approach to defining primary care for spending measurements.

The AHEAD definition of primary care, for spending measurement is available on the AHEAD Model website, and it builds on the structure of existing definitions and state legislation and best practices distilled by organizations such as the Milbank Memorial Fund, Primary Care Development Corporation, Primary Care Collaborative and many others who are leading the national work in this space. So, I would encourage folks that are interested to check out that definition on the AHEAD Model website. Next slide, please.

We'd also like to speak a bit more to the role that primary care providers will play in this model. Primary care providers are key partners in accomplishing the goals that states will be pursuing under the AHEAD Model, but they won't be working alone. Primary Care AHEAD is a part of a new generation of primary care models coming out of the Innovation Center, but it's not a standalone program. It really is designed

to fit into the suite of interventions and partnerships required in the AHEAD Model to maximize delivery system reform and population health improvement. Next slide, please.

So, some notes on who does what in this model. AHEAD is a really complex framework, and it will depend on a range of actors working together to ensure success in AHEAD states and regions. States, of course, are very active participants in the model. They'll be collaborating with providers, payers, and local communities to achieve their statewide accountability targets. They'll be engaging model governance structures for feedback on model activities and they'll be developing a state health equity plan to guide their equity focus throughout the entire performance period.

State Medicaid agencies will participate as an aligned payer in hospital global budgets and the primary care transformation pieces. Other state agencies will also be engaging additional payers on payer alignment, including soliciting participation from state employee health plans and marketplace plans. Participating hospitals will be operating under hospital global budget arrangements and we'll be aiming to transform care and improve population health under those arrangements. They'll be pursuing opportunities for quality improvement, and they'll be creating hospital specific health equity plans to reduce disparities in care and to improve outcomes in the hospital and within the community.

Our participating primary care practices will likewise be executing Care Transformation Requirements for person-centered care in both Medicaid and Medicare via the Primary Care AHEAD program. They'll also be pursuing opportunities for quality improvement and improved care coordination to deliver high quality primary care to their beneficiaries. They'll also have an opportunity to contract with aligned payers in addition to Medicare and Medicaid to maximize impact for care transformation across payers.

Commercial payers will be contributing to the All-Payer Total Cost of Care Targets and the All-Payer Primary Care Investment Targets at the state level. They will also participate as an aligned payer in the hospital global budgets, and they'll have the opportunity to participate in primary care transformation efforts as well. Next slide, please.

I'd like to call out a key partnership here, which is between hospitals and primary care practices. So, the model works to create shared incentives across hospitals and primary care practices in AHEAD states and regions. We're really working here to bring these two types of providers together under the umbrella of shared goals for population health and quality improvement. Hospitals and primary care practices both benefit from keeping people healthy and out of the hospital for ambulatory sensitive care.

AHEAD will improve health care delivery in participating states by helping providers deliver care in the right setting and at the right time. So, for this to happen, hospitals and primary care practices need to be well resourced and equipped to serve their communities. We will be providing technical assistance (TA) and learning systems to support both hospitals and primary care practices in bolstering this coordination. We also recognize that system owned or affiliated primary care practices may have different needs than independent primary care practices to maximize specialty coordination. So, the TA will be targeted to these different types of existing relationships between primary care practices and hospitals.

I want to call out a few specific features of our APMs that will be encouraging these productive relationships between hospitals and primary care practices. On the Primary Care AHEAD side, we have

some incentives built into the program for hospital coordination. Examples of this include our Designated Specialty Care Integration Requirements that can be executed using our Enhanced Primary Care Payment dollars.

There are also eligibility requirements for primary care practices based on hospital ownership and participation in hospital global budgets to tie these two APMs together. We also have inclusion of emergency department utilization and avoidable hospital utilization in our quality measure set. So, we have quality components here that incentivize those partnerships between primary care practices and between hospitals.

On the hospital global budget side, we have some key features of hospital global budgets that encourage primary care partnerships. Hospital global budgets decouple volume from income and allow them to focus on efficiencies, improving health outcomes within the community, sharing resources with primary care practices without risk to the bottom line. Hospitals are able to retain revenue for potentially avoidable utilization under hospital global budget arrangements and are encouraged to reduce this utilization via mechanisms like the total cost of care adjustment.

The methodology for hospital global budgets also incentivizes partnerships with community-based organizations to support population health with a focus on advancing health equity. Many of these will be the same community-based organizations that primary care practices will be partnering, partnering with. So, there will be continuity between these community-based organizations, primary care practices and hospitals in a specific locality or community.

Finally, we're providing some waiver flexibilities to better allow hospitals to partner with primary care practices. So again, while there will be a lot of partnerships across the entire state to accomplish AHEAD Model goals, we really want to call out that hospitals and primary care practices will be working very closely together to improve population health in their communities. All right, next slide, please.

So, we're going to shift gears a little now, and dive into our Primary Care AHEAD program. I'll spend some time outlining some of our key goals of the program which are illustrated here on this slide. Of course, we're going to be increasing primary care investment. The goal here is not just to increase primary care investment statewide as a percentage of the total cost of care, but also to tie that statewide accountability and those reform goals for primary care investment directly to provider level supports and enhanced payments.

In addition to increasing primary care investment, we also want to align payers. So streamlining requirements in the broader delivery system so that providers are working towards the same goals across payers and really able to focus on patient outcomes. All of this will support the provision of advanced primary care services.

So, a goal here again, is really building on state innovations and existing partnerships to move primary care services in AHEAD states towards that National Academics of Sciences, Engineering, and Medicine (NASEM) definition of advanced primary care. States are really uniquely positioned to build infrastructure and partnerships necessary to support this advanced primary care. We have a focus in Primary Care AHEAD around behavioral health integration, care coordination and health-related social needs activities. But again, we are building on state innovations in all of these spaces.

Another key goal of the model is to broaden participation. So, in order to reach the populations that are most in need of enhanced service coordination and increased investment, to move that needle on population health and health equity improvement, we're really working to facilitate successful participation by small practices, by Federally Qualified Health Centers and by Rural Health Clinics. I also want to call out here that we will be working to introduce primary care options with partial and full capitation for primary care services in the future. Any future Primary Care AHEAD tracks would align with these program goals that we're articulating here on this slide. All right next slide, please.

So this slide walks us through some of the payment mechanics of our Enhanced Primary Care Payment. We're really aware that practices will be asking, what is the bottom line financially, when they're contemplating joining Primary Care AHEAD. So here it is, at a high-level. And I also want to call out that we will be providing financial literacy tools to help practices understand how their specific math will work out in terms of risk adjustment, in terms of quality performance, and in terms of overall enhancement to their revenue that they can expect under the Primary Care AHEAD program.

So the EPCP or the Enhanced Primary Care Payments, replaces and enhances a subset of Part B care coordination and behavioral health integration codes for participating practices. Likewise, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will instead have their Chronic Care Management (CCM) and BHI G-codes replaced and enhanced by the Enhanced Primary Care Payment.

So you can see here in the graphic, primary care practices will be billing the vast majority of their primary care services like normal fee-for-service. That's their base primary care revenue. There is a small zeroed-out subset of Part B care management and behavioral health integration codes. On average, we estimate this to be about $2.45 per beneficiary per month and on top of that we have our enhanced primary care payment. So, this is an average of $17 per beneficiary per month. It is adjusted for the social and medical risk of attributed beneficiaries. And there is a potential quality performance adjustment of 5 to 10% of that Enhanced Primary Care Payment, 5% at the beginning of the model and then we'll be scaled up to 10% by the end of the performance period. I'll also highlight that the first year is pay-for-performance only.

So one key message here that I'm hoping folks will take away is that we really are expecting primary care practices to be coming out with enhanced revenue for primary care services and for enhanced care coordination activities under this model and that, we'll be providing resources for practices to be able to understand exactly what that means for them financially, and in terms of the type of care that they'll be able to deliver under the AHEAD Model. All right next slide, please.

So, a key thing to go over here in terms of primary care innovation and AHEAD is the role of the state Medicaid agency. State Medicaid agencies need to be the primary recipient or the subrecipient of AEHAD Cooperative Agreement funding. This is because they really are so integral in driving care transformation, and in standing up key elements of the model. So, we really want to ensure that they have sufficient resources to do that.

State Medicaid agencies will be responsible for identifying opportunities and partnerships to strengthen primary care. So, a few examples of this might include fostering collaboration with Medicare, with commercial payers and other state insurance bodies to align payers for primary care transformation activities. It might also include reducing administrative burden for practices in the context of their unique state Medicaid program. And it will include measuring primary care spending in Medicaid, and

using data to identify populations and providers most in need of increased investment. Another key requirement here for state Medicaid agencies is that they must operate a Medicaid Primary Care APM or Patient-Centered Medical Home by the start of Performance Year 1.

So this program is really essential because it will serve as the basis for practice eligibility and as the basis for alignment for care transformation activities in the Primary Care AHEAD program. So, Medicare fee-for-service will be following suit via the Enhanced Primary Care Payment to allow practices to tailor those EPCP dollars to the activities in their Medicaid APM. So what follows here, is that it is the state's responsibility to encourage broad participation in the Medicaid in primary care APM or PCMH program, as well as in Primary Care AHEAD. States have to recruit primary care practices for participation in Primary Care AHEAD and provide CMS with a list of eligible practices on an annual basis. Next slide, please.

So, to speak a little more to eligibility requirements. At a very high level, primary care practices, FQHCs and RHCs that are located within an AHEAD state or sub-state region and are participating in that Medicaid APM are eligible to participate in AHEAD. There is no minimum beneficiary count, given some of our goals around including small practices in this program.

An important caveat here, is that hospital-owned practices will only be eligible to participate in Primary Care AHEAD if the affiliated hospital is participating in Medicare fee-for-service hospital global budgets for that performance year. We included this requirement to maximize incentives for hospitals to join hospital global budgets and to balance savings in primary care outlays in the kind of context of this total cost of care model. FQHCs and RHCs are exempt from this requirement to help minimize barriers to safety net provider participation in the primary care transformation efforts. Next slide, please.

All right, so spending some time on a really important topic, which is the role of FQHCs and RHCs in Primary Care AHEAD. And we heard a lot of feedback from the primary care community that FQHC and RHC participation in new primary care models is really essential to comprehensive primary care system transformation. So, we designed Primary Care AHEAD to facilitate that success of FQHCs and RHCs in serving their communities. It's the first Center for Medicare and Medicaid Innovation (CMMI) model to include Rural Health Clinics. And it also builds on lessons learned and successes from MDPCP, which was the first CMMI model to include FQHCs. Also want to call out here that any future capitated tracks would do the same to the greatest extent possible.

We have a couple of reasons for doing this. One, is to really broaden our reach to rural and urban underserved communities. Another, is to build on innovations that FQHCs and RHCs are leading in Medicaid. So in many communities, we know that FQHCs and RHCs are really at the forefront of health-related social needs coordination, enhanced care coordination, and other components of advanced primary care. So we'd really like to learn from them and spotlight them in this program.

We also want to increase FQHC and RHC capacity for participation in multi-payer, value-based payment arrangements. And we're going to do that by providing risk-adjustment, targeted primary care investments that can be tailored to the needs of the communities that providers are serving. Our bullets here call out some program features that are going to be really important for FQHC and RHC success. So importantly, FQHCs and RHCs will not have their underlying Provider Payment System (PPS) rates or AIR rates change to receive the EPCP. It is just those care management and behavioral health integration G-codes that will be zeroed out.

We also give flexibilities, as I called out on the last slide, for hospital-owned FQHC and RHC eligibility for participation and Primary Care AHEAD. We'll also be providing extra technical assistance and reporting flexibilities for quality performance assessment for FQs and RHCs. All right, next slide please.

Okay, so zooming out a little bit more, in terms of how Primary Care AHEAD is designed for the success of primary care teams. The current iteration of the program is designed to minimize administrative burden on primary care teams and make participation feasible for that wide range of practice types that I've been calling out. Primary Care AHEAD again builds on successes and lessons learned from the Maryland Primary Care Program and past primary care models such as Comprehensive Primary Care (CPC+) and Primary Care First (PCF).

We have flexible care transformation requirements that align with state-specific Medicaid primary care programs. We also have minimal reporting requirements for care attestation. So that's an annual attestation form that practices will fill out to indicate to us how they're using EPCP dollars. The quality component is also very targeted, and it's based on just four quality measures that can be changed to align with the existing Medicaid APM. And a really important distinction between Primary Care AHEAD and ACO-based primary care models, is that our Enhanced Primary Care Payment dollars flow directly to primary care practices.

One other key feature of the EPCP, is that it's prospective. So a lot of folks on the phone might be very aware of the benefit of prospective dollars in the primary care space. But I really want to underscore that this is all part of an effort to move care coordination dollars out of the fee-for-service system and provide teams with the flexibility that they need to invest in work streams, technology, and staff to ensure success. We also include waivers for Nurse Practitioners and Physician's Assistants to help practices build robust primary care teams and combat the workforce shortage issues, which we know are a real challenge to primary care practices right now. Next slide, please.

So this is a key slide, because it emphasizes a range of ways that a practice might use EPCP dollars to transform care within our general avenues of care coordination, behavioral health integration, and health-related social needs services. So we have some examples of allowable uses for the EPCP on the left hand side here. It might include quality reporting and performance assessment tools. They might be able to invest in tools and workstream development for specialty coordination. It can be used to hire staff to build out a comprehensive primary care team, or for targeted case management for chronic conditions in beneficiaries.

A couple of specific sample activities here and again within each of these avenues. It can be tailored to the state Medicaid APM as well as the specific needs that the practice sees in its community. We have health-related social needs interventions which might include identifying and strengthening relationships with community-based organizations, or potentially incorporation of an on-site social worker, a community health worker, or another member of the primary care team who's specifically focused on addressing the social needs of their beneficiaries. A health-related social needs screening is required, but we're also really expecting concrete follow-up and not just identification of the health-related social needs of the patient population.

Within the care coordination and specialty integration section, we expect practices to be the developing workstreams to identify and establish relationships with specialty care providers. They can also formalize specialty referrals through e-consults or other agreements. Behavioral health integration on

the primary care side is, of course, another key component of our care transformation vision here. So, practices will be reporting on behavioral health quality measures. They'll be developing integrated teams for behavioral health coordination. And they might be managing medications for patients with complex behavioral health conditions.

So I would like folks to just take away here, that there's flexibility. But there's also a lot of options in terms of how practices will be using those EPCP dollars to provide advanced primary care services to their patients. Next slide, please.

So all of these care transformation activities under Primary Care AHEAD should improve the patient experience of care. Beneficiaries, as I said, will receive screenings for their social needs, but they'll also receive concrete follow-up for those needs to actually address them. They'll receive investments for their care that are more proportional to their individual level of social and medical risk.

We also believe that better funded primary care teams have the space and time to build trust and longitudinal relationships with patients. So a patient attributed to a Primary Care AHEAD practice should have better coordination across appointments and across provider types as well. Next slide, please.

So I spent a lot of time today on our Enhanced Primary Care Payment, and on the current iteration of the Primary Care AHEAD program, and what we think it can do for primary care teams and patients. So the current version of Primary Care AHEAD delivers that streamline care management investment. But we know that AHEAD states might be interested in moving more towards prospective or capitated primary care payments over the course of this 10-year model.

So, the AHEAD team has committed to designing additional tracts of Primary Care AHEAD that will include partial and potentially full primary care capitated payments. The design of these tracks will incorporate the aims that we're highlighting here on the slide, and we'll continue to draw on stakeholder feedback about models like MDPCP, Making Care Primary, Primary Care Flex and other past primary care models. So, calling out here, we'll be focusing continually on increased primary care investment on Medicaid-led innovations and care transformation, on maximizing safety net provider participation to the extent possible, and on providing financial literacy tools, as these methodologies become more complex across tracks. Next slide, please.

Okay. I just delivered a lot of information to everyone listening. And I've been talking at you for a good 30 minutes. So I'd like to call out just some key takeaways that I'd like everyone to walk away with today.

The first is that we're providing a lot of flexibility in this primary care program to allow participating practices and states to achieve their goals. State Medicaid agencies, as I've said, will drive recruitment and the vision for care transformation in the primary care space in their state. And CMS will continue to work with states to maximize that multi-payer alignment for quality and for care transformation in the primary care space.

We also have a really strong emphasis on partnerships. So primary care teams will operate in partnership with other model participants and with CMS. Specifically, hospitals and primary care APMs are designed to complement each other, one another in this model and to increase coordination across the entire delivery system in participating AHEAD states and regions.

To do these things, we're providing a number of supports. So generally, AHEAD helps primary care practices provide whole-person care with that advanced funding via the Enhanced Primary Care Payment. And CMS, states, and external partners will continue to develop financial literacy, data sharing, and care transformation tools over the course of the pre-implementation period and the performance period for the model.

In terms of payment design, we've designed the Primary Care AHEAD program to minimize administrative burden and complexity for primary care providers. The EPCP provides that upfront, streamlined funding for care coordination that primary care practices need as a first step towards the delivery of advanced primary care services. Next slide, please.

In addition to these key takeaways, just some individual things that actors listening in on this webinar should think about getting started on, if you're interested in the AHEAD Model. So states that are interested in AHEAD, if you don't have a Patient Center Medical Home program or a primary care APM, start assessing where there are gaps in your primary care delivery system. Work on getting stakeholder input to construct that Medicaid PCMH program or APM. And if you have one in place, start assessing barriers to participation in that APM for primary care practices, as well as what your priorities are for care transformation over the next ten years.

If you're a hospital, start engaging with your state agencies, work on strengthening your relationships with primary care practices in your community and start identifying areas for population health improvement as well. If you are a primary care practice, or a stakeholder in primary care, encourage health system participation in the model, encourage commercial participation in the model, and raise your voice to influence that Medicaid PCMH design. That's going to be really important to have the voice of providers at the table, as we set that foundation on the Medicaid side. If you're a payer, start assessing your ability to align with key components of the Primary Care AHEAD program.

And in terms of our ongoing commitment here at CMS and the Innovation Center, we are committed to continuing to create more specific resources for practices to assess CMS primary care model options as well as more information around what Primary Care AHEAD might mean for an individual practice. We'll also continue to engage with our stakeholder community which has just been so active and supportive over the course of the model's design. Next slide, please.

All right, great. So we have a couple of FAQs that I'm going to go over before we dive into an open Q&A, which we'll have plenty of time for. First thing, we got, we've gotten a lot of questions around is the overlap between MSSP and Primary Care AHEAD, as well as other primary care models. So we have a couple of resources we will pop in the chat, they're also linked on these slides, which will be available soon on the AHEAD Model website.

Just want to take a step back and recognize that there are a lot of primary care innovations and models coming out of the Innovation Center right now. So, we have various resources on the CMMI website to help stakeholders understand these complexities. That includes, so there’s specifically a blog on the Center's overall vision for primary care transformation, as well as a really useful infographic that compares Primary Care AHEAD with the Making Care Primary program as well as Primary Care Flex.

I want to speak specifically to a couple of overlaps, policies that we have here around Primary Care AHEAD. So quick, but important, reminder that Making Care Primary cannot function in AHEAD states or region. So there is no state overlap between Making Care Primary and the AHEAD Model.

However, the MSSP program may operate in AHEAD states and regions. We heard feedback that providers often do not wish to leave their MSSP arrangements to participate in new opportunities like Primary Care AHEAD, so we're allowing MSSP and Primary Care AHEAD overlaps at the practice level. However, ACO PC Flex is an exception to that, so providers may not participate in ACO PC Flex and Primary Care AHEAD. But ACO PC Flex may be operating in AHEAD states or sub-state regions, and any Medicare primary care investments made in Primary Care Flex will count towards AHEAD statewide primary care investment targets. And we're aware of some of the choice fatigue that practices and ACOs might be facing with all these options, so we'll continue to work with our partners in the primary care community to provide more resources on financial literacy and these overlaps policies as well.

Alright, and just to speak to timeline a little bit here, we are in the midst of our state selection for the AHEAD Model. So up to eight states will be awarded Cooperative Agreement funding. We're right in the middle of stages three and four here, so we've received one round of applications. Another round of applications to the Notice of Funding Opportunity will open later in the year, and we'll be awarding Cohort 1 and 2 in June of 2024, and Cohort 3 in October of 2024. So by October of 2024, we'll know which states are participating in the model. Next slide, please.

And once we know which states are in the model, we have a couple of cohorts here. We have three. They vary in terms of the amount of pre-implementation time we get, so we included a pretty long pre-implementation period for this model across the board because of how complex it is. Cohort 1 will start its performance period in 2026, after a pre-implementation period of 18 months. Cohorts 2 and 3 will start in 2027 with respective pre-implementation periods of 30 months and 24 months. And then all states will be ending their performance periods at the end of 2034.

Okay, I've been talking for quite a while. I'm going to turn it over to our Model Co-Lead, Laura Snyder, to help me facilitate some of the Q&A that you all might have. Thanks so much for listening to me so far.

>>Laura Snyder, CMS: Thanks so much, Nora. That was a ton of information. Drink some water, catch your breath.

So, as Nora mentioned, my name is Laura Snyder. I'm Co-Lead of the AHEAD Model. We are so pleased to see so much engagement in this webinar and interest in the Primary Care AHEAD component of the AHEAD Model. So thank you for joining.

Wanted to thank everyone who sent their questions in advance, and we will start with addressing those, as we typically do in webinars and office hours sessions. But we've also been seeing lots of questions come in throughout the presentation. If you didn't already submit, please do so in the Q&A. And we will have our AHEAD team members continue to sort through those, and we'll provide responses live, where feasible.

One thing I wanted to clarify before we got into the question and answer portion, was on slide 10 about the Enhanced Primary Care Payment and the 5 to 10% adjustment that is based on each practice's performance on quality measures. Just wanted to correct one very important word. The first year is pay-for-reporting only with later years pay-for-performance. So, in other words, practices will receive full

credit, you know the full 5%, in that first year just for reporting on the quality measures. And then in later years, that would transition to assessing the actual performance based on the data.

>>Nora Lewis, CMS: Thanks, that's really important clarification.

>>Laura Snyder, CMS: Sure. Thank you to Adam on the team for catching that. So all right, we will go ahead and move into the Q&A portion. And one of the first questions that we received was asking about whether there will be work groups and collaboratives forming and sharing successes, lessons learned, and case study examples? Nora, did you want to respond to that question, or would you like me to?

>>Nora Lewis, CMS: Yeah, I can take it, and then, you know, feel free to add anything you'd like to add some color too, Laura. I think, the short answer to that question is, yes, absolutely we have been working with our external partners who have been developing resources for states that are interested in AHEAD. We also have both technical assistance and our shared learning system for the model. So the shared learning system will be facilitating that exact type of collaborative, lessons learned work. Not only, you know, within one AHEAD state, but also across models and across AHEAD states in general. So we have quite a bit of learning collaborative support, not just around primary care transformation, but around all components of the model. But, Laura feel free to add, if I missed anything there.

>>Laura Snyder, CMS: No, I think that was great. Thanks, Nora. We also received a question about how we will measure performance at the practice level if we are using Tax Identification Number (TIN) level attribution without any minimum beneficiary count?

>>Nora Lewis, CMS: Yeah, I can take that one. So because we're using TIN level practice participation definition, we actually expect that most primary care practices, as defined at the TIN level, will have enough beneficiaries to accurately evaluate their performance on quality. But for those very, very small and independent practices, we're exploring options to make sure that we can accurately assess their quality component. Again, the key here is really that we want to invest as much as possible in these practices, so we're exploring options for those specific situations and really welcome feedback on how we can approach this issue. We'll be sharing more information on the performance assessment specifics in the Primary Care AHEAD payment methodologies which will be coming out later this year.

>>Laura Snyder, CMS: Perfect. Next question is, exactly how will states be addressed, directed to address and demonstrably increase minimum primary care spending in the AHEAD Model?

>>Nora Lewis, CMS: Okay, I love this one. I think I spoke to this a little bit earlier in the webinar. There's a little bit of a difference between the Medicare fee-for-service and the All-Payer Primary Care Investment Targets, in that we're a little more specific on the Medicare side. Right? So we're providing this Enhanced Primary Care Payment. The goal there is really for state Medicaid agencies and AHEAD states to maximize participation in that program in order to maximize their Medicare fee-for-service primary care investment. And the way that we're sort of targeting that investment is through some of the features that I highlighted, including the social risk adjustment components, as well as the types of practices that we're trying to make sure can participate in this program.

On the all-payer primary care investment side, it's going to be a little state-specific. As I mentioned, some states already have legislation passed around all-payer primary care investment goals. But one thing that we're going to be really encouraging is that base level, as I said, of spending measurement ability, defining primary care abilities. So we're providing that definition of primary care which really

dictates how you're thinking about what primary care is in your state and therefore, you know exactly what you're investing in.

So I would really encourage folks to take a look at that AHEAD definition of primary care, for spending measurement. And then also think about what kind of data a state Medicaid agency or commercial governing body might need to make sure that it's measuring primary care investment across payers. And then we would take a look at where that lack of investment is, and work with the state to make sure that they're targeting increased investments, either through rate increase on the Medicaid side, through that Medicaid APM, or through other levers in the commercial space as well. I hope that's helpful. Feel free to ask a follow-up question if, if that's not specific enough.

>>Laura Snyder, CMS: Great thanks so much, Nora. We also received the question, what efforts are being made to enroll and include small independent practices in Primary Care AHEAD?

>>Nora Lewis, CMS: Yeah, I mean, I think the first thing that we're doing is eliminating a minimum beneficiary count, which is going to open the door to a lot of those really small practices to participate in the program. We really think that webinars like this one help communicate important information about the model to those small practices. And we're going to be relying on our primary care partner organizations as well as local organizations in AHEAD states to be helping these small practices understand, again, the financial impact of Primary Care AHEAD and the impact that the program might have on their ability to provide advanced primary care. So it really is going to be a team effort between CMS, between our external partners, between the state Medicaid agency that's responsible for recruiting all practices, including small ones. And then leaning on that learning system that I mentioned before, to facilitate that peer-to-peer learning across small and independent primary care practices who are participating in the program.

>>Laura Snyder, CMS: Thanks again, Nora. Can you explain how Primary Care AHEAD will impact Medicare fee-for-service rates and Medicaid reimbursement rates for states?

>>Nora Lewis, CMS: Yes, so on the Medicare fee-for-service side, just to reiterate here, the Enhanced Primary Care Payment is an enhanced Medicare investment, so it doesn't impact Medicare fee-for-service rates outside of that subset of care management and behavioral health integration codes that will be zeroed out for participating practices. We also don't have any explicit requirements on the Medicaid side for how a state Medicaid agency is increasing its primary care investment. That might include a rate increase for certain primary care services, it might include a Per Patient Per Month (PMPM) payment made through the Patient-Centered Medical Home mechanism, so we're flexible on the Medicaid side. I wouldn't anticipate any specific changes to the Medicaid primary care fee-for-service rates or managed care capitation rates. But again, we do expect state Medicaid agencies to be somehow increasing their primary care investment.

>>Laura Snyder, CMS: Great. We had several questions come in about whether the primary, Enhanced Primary Care Payments and any potential future capitated payments would be risk-adjusted and made in addition to fee-for-service payments for covered services? So just thought we could revisit, you know, some of the details on the EPCP and any potential future capitated payments.

>>Nora Lewis, CMS: Yeah, definitely. I'm going to provide a pretty high-level answer here, is that we are really focused on both medical and social risk adjustment for the EPCP, so it will be adjusted for the

medical and social risk scores of the attributed beneficiary population for participating practices. We are planning to do the same thing for the capitated tracks, although we'll have to release more information specifically about that when we have it. And we'll also be releasing more information in our payment specs for the Primary Care AHEAD program around exactly how the EPCP is adjusted for social and medical risk. So keep and keep an eye out for those this year, as well.

>>Laura Snyder, CMS: We received a question that has to have come from someone from the state of Maryland asking about whether the construct of Maryland Primary Care pro, the Maryland Primary Care Programs' Care Transformation Organizations, or CTOs, will carry forward to AHEAD?

>>Nora Lewis, CMS: Yeah, so this is a Maryland specific issue. Should Maryland enter the AHEAD Model, the state may propose to continue their CTOs under the model, and we would work directly with the state in that situation.

>>Laura Snyder, CMS: Thanks, Nora. We have a question about community health workers, and how payments to community health workers could be made or how can they be included in the Primary Care AHEAD program?

>>Nora Lewis, CMS: Yeah. So on the Medicare side, we designed the Enhanced Primary Care Payment to really focus on that hiring of staff to build out comprehensive primary care teams, so that might very well include a community health worker on the Medicare side. So those EPCP dollars are very much intended to support that kind of work from community health workers. On the Medicaid side, there's a lot of flexibility, and I think recent attention around Medicaid, trying to ensure that community health workers can be reimbursed for Medicaid services that they're providing. So it is absolutely an option for states to be targeting their increased primary care investments on the Medicaid side towards community health worker reimbursement.

>>Laura Snyder, CMS: Here's more of a Medicaid question for you, right up your alley. So how does the AHEAD Model and perhaps specifically, the Primary Care AHEAD program interact with 1115 waivers?

>>Nora Lewis, CMS: Yeah. So, as I said, at the top of the hour, we have two APMs in AHEAD, both of which require Medicaid participation. So I'll just briefly say, if a state needs an 1115 waiver for the Medicaid hospital global budgets, they will work with Center for Medicare and Medicaid Services (CMCS) to get that federal authority. And I would reference our Notice of Funding Opportunity for more information about what that process would look like and what the requirements are around a Medicaid hospital global budget.

On the primary care side, there's no requirement that a state pass an 1115 waiver amendment or renewal in order to enact the Medicaid primary care APM. They might want to, if it's part of a package of a broader 1115 waiver change that they're working on with CMCS. But there are a lot of other federal authority routes that a state could use to strengthen its Medicaid primary care system. It could be a state plan amendment, it could be managed care contracting authority via state directed payments. So again, we're not very prescriptive on the primary care Medicaid transformation side in terms of federal authorities. But, it is certainly a possibility that a state might have some intersection with its overall goals around population health and, and primary care investment, and an 1115 demonstration.

>>Laura Snyder, CMS: Great, thank you. We have an interesting question about the role that philanthropic foundations could play in supporting states that are participating in the AHEAD Model.

>>Nora Lewis, CMS: Yeah, I can I can do my best on this one. I think that philanthropic organizations have a little bit more experience, specifically on the ground in the communities that these primary care practices might be serving. So, I could see them playing, you know, a really useful role in engaging communities and strengthening those community partnerships that we're expecting to see between primary care practices and community-based organizations, and other entities within a service area, as well as with hospitals. So I think just that local perspective that they can share, as well as potentially resources to help strengthen that delivery system or those partnerships, could certainly be a great opportunity for them to be partnering, not just with providers in their community, but also potentially with the state Medicaid agency and other state entities that are participating in the model. But feel free to add to that or anyone else on the team as well.

>>Alex Brown, CMS: I think that was well said Nora. I think another way that the philanthropic foundations, could, you know, contribute and participate under AHEAD, would also be potentially in the model governance structure at the state level. Because other, under the AHEAD Model, the model governance structure the state will select diverse participants, and they could play a role at that to have that perspective at the state and also the local level. But I think your response was well said.

>>Laura Snyder, CMS: Great, thank you both. I know we're coming up, we have five minutes left. We'll try to get a few more questions in. Are concierge model primary care practices eligible to participate? And Nora, if you want to kick this one back, please let me know.

>>Nora Lewis, CMS: Yeah, I might kick this one back.

>>Laura Snyder, CMS: Sure. So we don't directly exclude participation by concierge primary care practices, but they must participate in the state's Medicaid PCMH to be eligible for participation in Primary Care AHEAD.

Next we had questions asking more specifically for the lists of the Part B codes for primary care practices, and also the codes that FQHCs and RHCs, their G-codes that will be replaced and enhanced. Just wanting more information on where those codes can be accessed or if they're not available now where, when prospective participants could expect them?

>>Nora Lewis, CMS: Yeah. So I believe we have that list of codes in the appendix of the Notice of Funding Opportunity. If they are not in there, they will be in the payment specs which are coming out later this year. But we can, we can follow-up on that one.

>>Laura Snyder, CMS: Great. There are a couple of questions related to the primary care investment target. Attendees were curious how that is calculated, whether the target is regional or statewide, and if CMMI has a target level of PC investment in mind?

>>Nora Lewis, CMS: Yep, yeah, I see all these in the chat. So these are statewide primary care investment targets. If the state is participating as a sub-state region, we would be holding them accountable for increasing primary care investment to that extent in that particular region. I hope that answers the question about statewide versus regional.

An important clarification here is that we will have a target level of primary care investment in mind for Medicare fee-for-service. We will be setting Medicare fee-for-service primary care investment targets for each participating state. And that'll be based on our definition of primary care, and then the existing

level of definition, the existing level of primary care spend that the state has when they're coming into the model, and what we think is attainable, based on the increased investments that we're offering in the Enhanced Primary Care Payment.

On the all-payer side, it's more flexible. Again, we want to build on the work that a lot of states have already done. So if they have investment targets already in place, we will accept those, and we'll be working thing with states that don't have them in place already to reach an appropriate target for all-payer primary care investment.

>>Laura Snyder, CMS: Great, thanks so much Nora. This was an item that you touched on in the FAQs portion of the presentation. But, can organizations participate in both AHEAD, and the ACO Flex shared savings model?

>>Nora Lewis, CMS: No. No, ACOs doing Primary Care Flex will not be eligible for their practices to participate in the Primary Care AHEAD program.

Although I do want to call out another, what I think is an important question, and I might turn this over to the model team to answer which is: Will practices be able to participate in both AHEAD and MSSP? Yes, except for Primary Care Flex. And, if so, are there any impacts to the AHEAD quality performance adjustments when a practice also participates in MSSP? I'm going to, I'm going to turn it over to the model team here to answer this one because I think it's important for practices that want to participate in both.

>>Adam Kellerman, CMS: Thanks, Nora, this is Adam. I can take a stab at this. I do think that the, to the specific question about how quality performance would be assessed, we will be releasing more information on how the quality score will be calculated for all Primary Care AHEAD practices, but also including those that are in ACO models, including MSSP in the financial specifications or the payment methodology that Nora mentioned earlier. So more to come on that later this year.

>>Nora Lewis, CMS: Thanks, Adam.

And I know we only have a minute left, so I'll just take a minute to thank everyone who's attended this hour with us. We know that was a lot of information. Please take a look at our AHEAD website. There's a lot more information, there are a lot more resources there, including our definition of primary care, our Overlaps Fact Sheet, and some of the other links that we sent out, as well as any upcoming events we might be having for the model.

Laura, anything else you would add here before folks hop off?

>>Laura Snyder, CMS: Yeah, just briefly. Any questions, there were so many questions that were coming in. It's just great to see. Please look out for the webinar materials that we publish in the next week or so. Because they may contain answers to the questions that we couldn't get to live. And if you don't see that we've addressed any questions there, feel free to send your questions to the AHEAD inbox, which is AHEAD@CMS.HHS.gov.

>>Nora Lewis, CMS: Alright. Thank you so much everyone, for attending. Really appreciate your time.