



States AHEAD Model:

Implications of CMMI's Newest Model for ACOs



November 2023

Speakers



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Aledade

AHEAD Model – Background



States Advancing All-Payer Health Equity Approaches and Development Model

“States Advancing AHEAD” or “AHEAD” Model



CMS’s goal

Collaborate with states through total cost of care, multi-payer alignment to curb cost growth, improve population health, and advance health equity



Scheduled to operate from 2024 through 2034



Eligible applicants are state agencies

States assume responsibility for health providers
Maximum of \$12 million awarded to each participating state



Builds off other state-based models

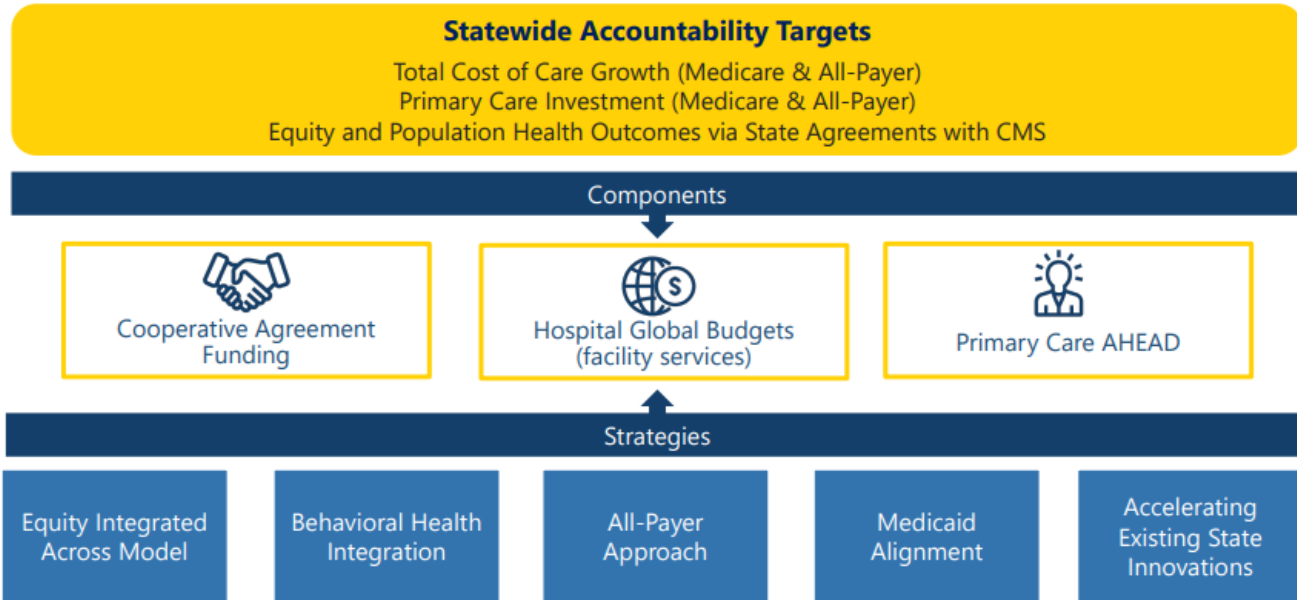
[Vermont All-Payer Accountable Care Organization Model](#)
[Maryland Total Cost of Care Model](#)
[Pennsylvania Rural Health Model](#)

AHEAD Model – Background



AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



Stakeholder Roles



States

- Establish governance
- Set growth targets
- Increase primary care payments
- Implement health equity plan

Hospitals

- Participation cannot be forced
- At least 10% of Medicare FFS must be paid under global budget at the start; Increases to 30% by the 4th year

Primary Care Practices

- Can participate in both Medicaid efforts and enhanced Medicare FFS payments

Payers

- Participate in hospital global budgets and primary care enhanced payments

Hospital Global Budgets



CMMI recognizes this is a very different business model than FFS

- Upside option for CAHs on quality
- CMS will provide global budget for Medicare
- Medicaid and commercial/MA will develop and deliver their own budgets

Hope to have full hospital budgeting methodology by early 2024

Enhanced Primary Care Payments



Primary Care AHEAD

- An average PBPM of \$17 for attributed beneficiaries, paid quarterly
- 5% at risk for quality performance, moving up to 10% later in the model
- Options for risk and capitation in future years
- Enhanced payments can be used for infrastructure and staffing
 - i.e. care coordinators, behavioral health staff, community health workers, health-related social needs

Other requirements

- Must participate in Medicaid PCMH
- Must meet state care transformation requirements
- No minimum beneficiary number for participation
- FQHCs and RHCs also eligible

Timeline



- CMS plans to release a Notice of Funding Opportunity in late Fall
- Subsequent application period in Spring 2024
- CMS expects to award cooperative agreements to up to eight states across the two application periods

| | | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2034 |
|-----------------|----------|------|-----------------------------|-----------------------------|------|------|------|------|------|------|------|------|------|
| Model Year | | | MY1 | MY2 | MY3 | MY4 | MY5 | MY6 | MY7 | MY8 | MY9 | MY10 | MY11 |
| 1st NOFO Period | Cohort 1 | NOFO | Pre-Implementation (18 mos) | | PY1 | PY2 | PY3 | PY4 | PY5 | PY6 | PY7 | PY8 | PY9 |
| | Cohort 2 | | Pre-Implementation (30 mos) | | | PY1 | PY2 | PY3 | PY4 | PY5 | PY6 | PY7 | PY8 |
| 2nd NOFO Period | Cohort 3 | | NOFO | Pre-Implementation (24 mos) | | PY1 | PY2 | PY3 | PY4 | PY5 | PY6 | PY7 | PY8 |

Hospital Global Budgets



Karen Marie Joswick, MHA, CHICIO, FHIMSS, CPHIMS



- **President, Benevolence Health**
- +20yrs Healthcare, +10yrs in Accountable Care, Pop Health, Quality, Analytics
- Former First Responder, Clinical Researcher, Compliance & Privacy Officer
- VBC Portfolio (Adult and Pediatrics) + 2B expense, over 500k lives, with +50M in new VBC Revenue over 4 years, contracting, start-up & innovation
- **Board of Directors, NAACOS**
- **Faculty, Jefferson University & CCBC**
- Mom x 5 & Daughter, navigator of the health delivery system



Payment Model Spectrum

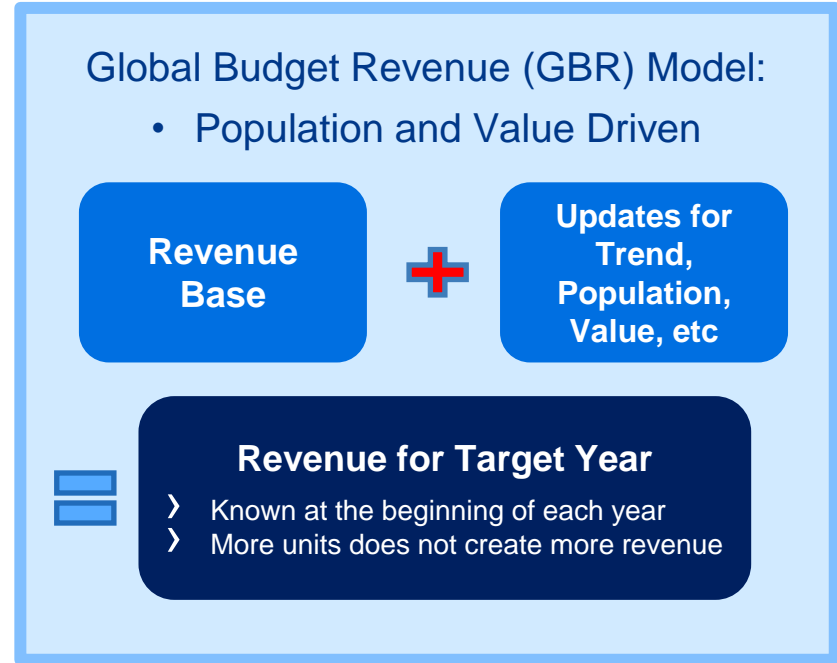
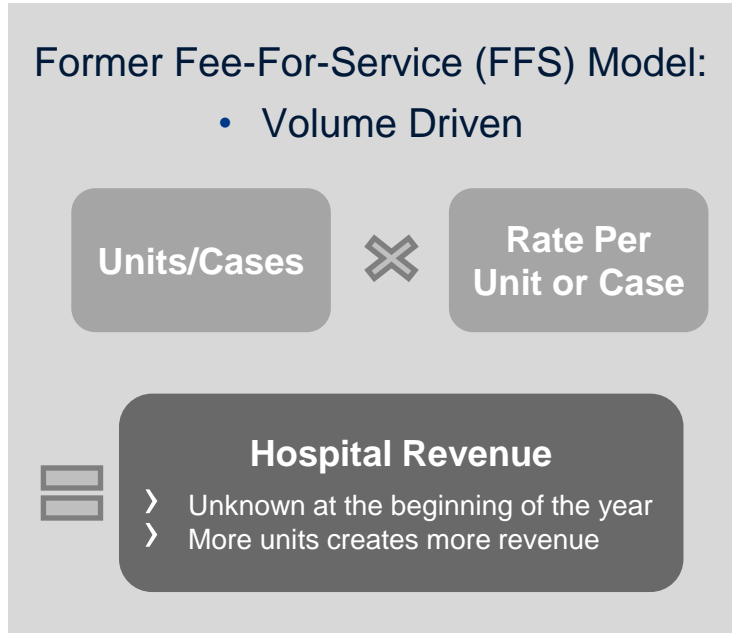


| Method | | Description | Examples |
|--|----------------------------|--|--|
| Full accountability | Global Budget | Payment is provided based on historical services | Maryland Model |
| | Full capitation | Payment is provided on a PMPM basis regardless of services used | |
| | Partial capitation | Certain services reimbursed on a PMPM, with the remainder as FFS | Vermont / PA Models Primary Care Models |
| | Bundled payments | Payment covers all aspects of care for a single episode | |
| Shared accountability | Upside and downside | Providers and payers share accountability for total cost of care (e.g., ACOs) | MSSP ACO/ ACO REACH |
| Limited accountability (upside only) | Shared savings | Providers receive share of payer savings from reducing total cost of care (e.g., PCMH) | Most hospitals |
| | Upside-only | | |
| | Pay for performance | Payment bonus is provided based on quality, efficiency, etc. KPIs | |

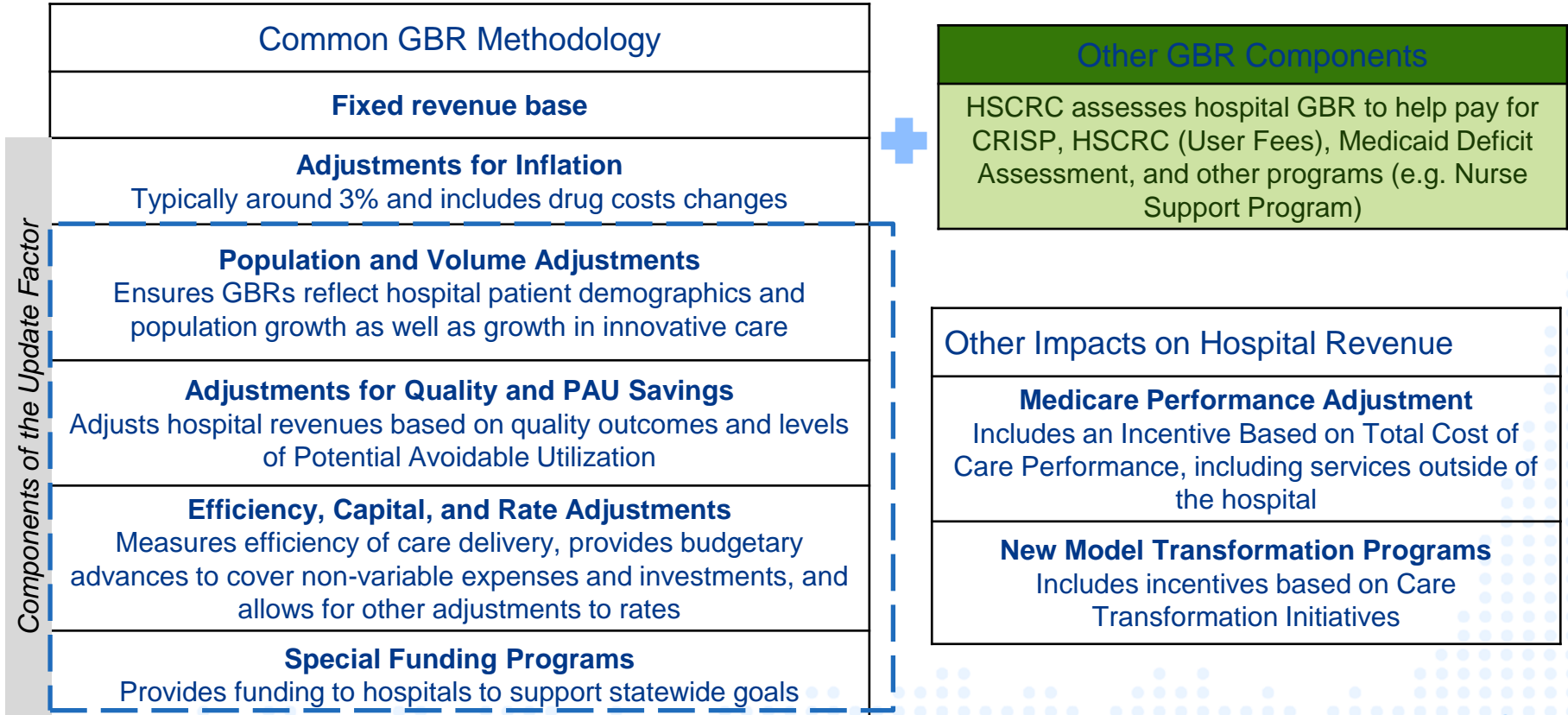


What is a Global Budget?

Rather than let volumes control revenue, HSCRC sets an annual revenue target (GBR) that each hospital must meet.



SAMPLE - Key Components of the Global Budget Revenue (GBR)



Global Budget Opportunities



- Overall Cost to system decreases
 - Prospective, predictable payments, based on historical Revenue instead of through a fee-for-service model in value-based care models
 - Waste is removed from the healthcare system with the alignment of incentives to new care models
 - Outside investments and reinvestment of savings offer resources to support population health initiatives and innovation
 - Re-investment can improve outcomes to drive future success in the AHEAD MODEL and generate increased savings, improved health, and address health disparities

Sources of Savings – Similar to ACOs



Maximizing Care Continuum Partners

Coordinating with primary care doctors to help manage chronic conditions

Leveraging cost-effective sites of care

Avoidance of medical complications and exacerbations

Reduction of avoidable utilization

Global Budget Considerations



Health Systems/Providers

- Market Shift Movement
- Internal Benchmarking/
Fixed vs. Variable Costs
- Uncompensated Care
- Current Pop Health Models
/ Maturity

Broader Ecosystem



Budget Methodology



Multi-Payer Incentives



Innovation & Care Model Incentives



Data Infrastructure / HIE



Waivers



- Thank you!
- Karen@benevolencehealthadvisors.com

Enhanced Primary Care



Maryland Primary Care Program (MDPCP) and All-Payer Health Equity Approaches and Development (AHEAD) Models



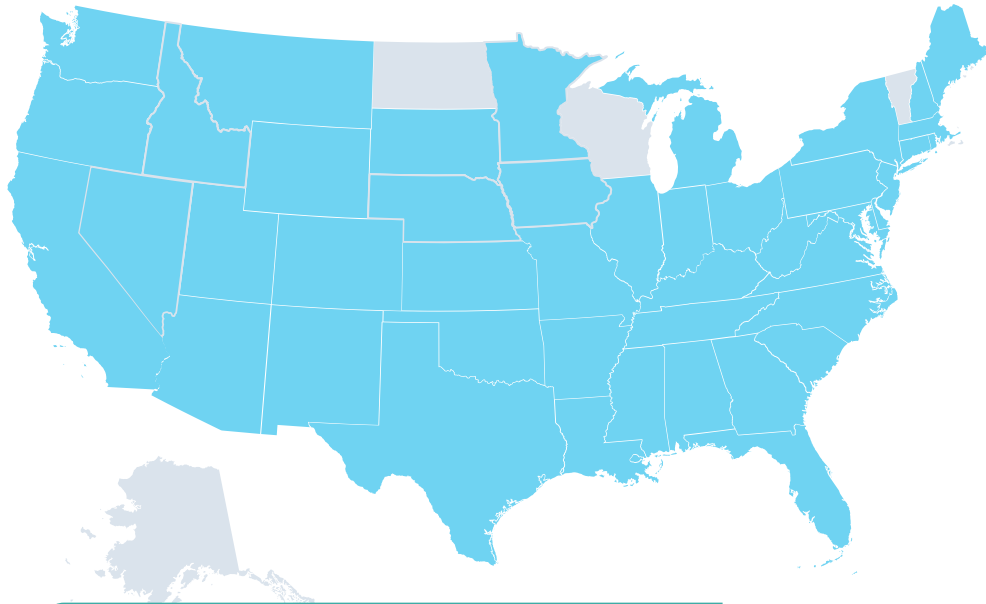
Tyler Blanchard

Market President, Delaware,
Maryland, DC

- Leads 3 MSSP ACOs and an MDPCP CTO, including a team of 17 clinical and workflow transformation experts
- Serves on the Maryland Primary Care Workgroup and the Delaware Primary Care Reform Collaborative
- MBA candidate, Fall 2023
- Has 4 boys, ages 8 to 8 months



Aledade is the largest and fastest growing independent value based primary care network



45 States

16,300+ Clinicians

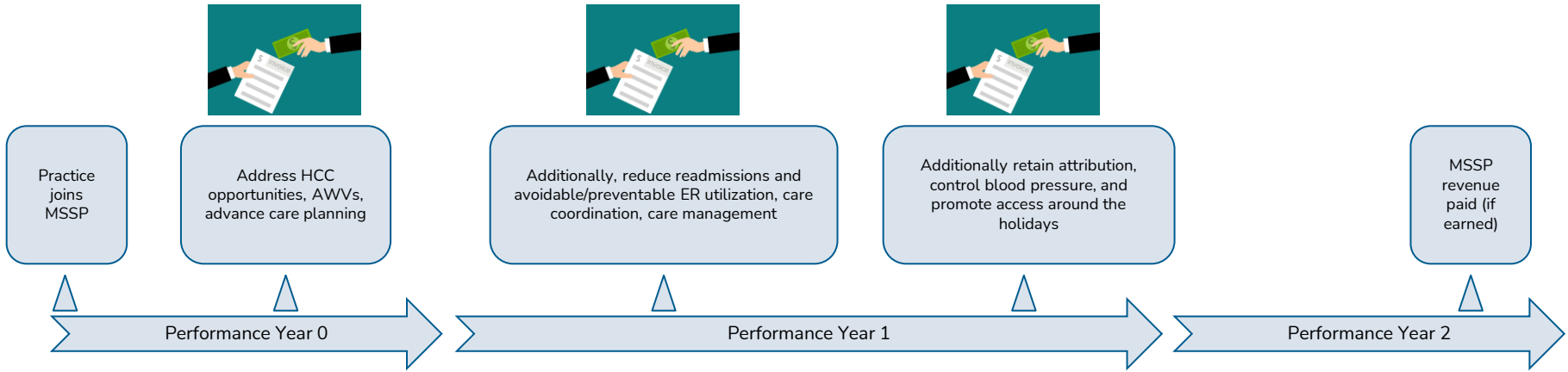
2M+ Patients

1,500+ Practices & CHCs

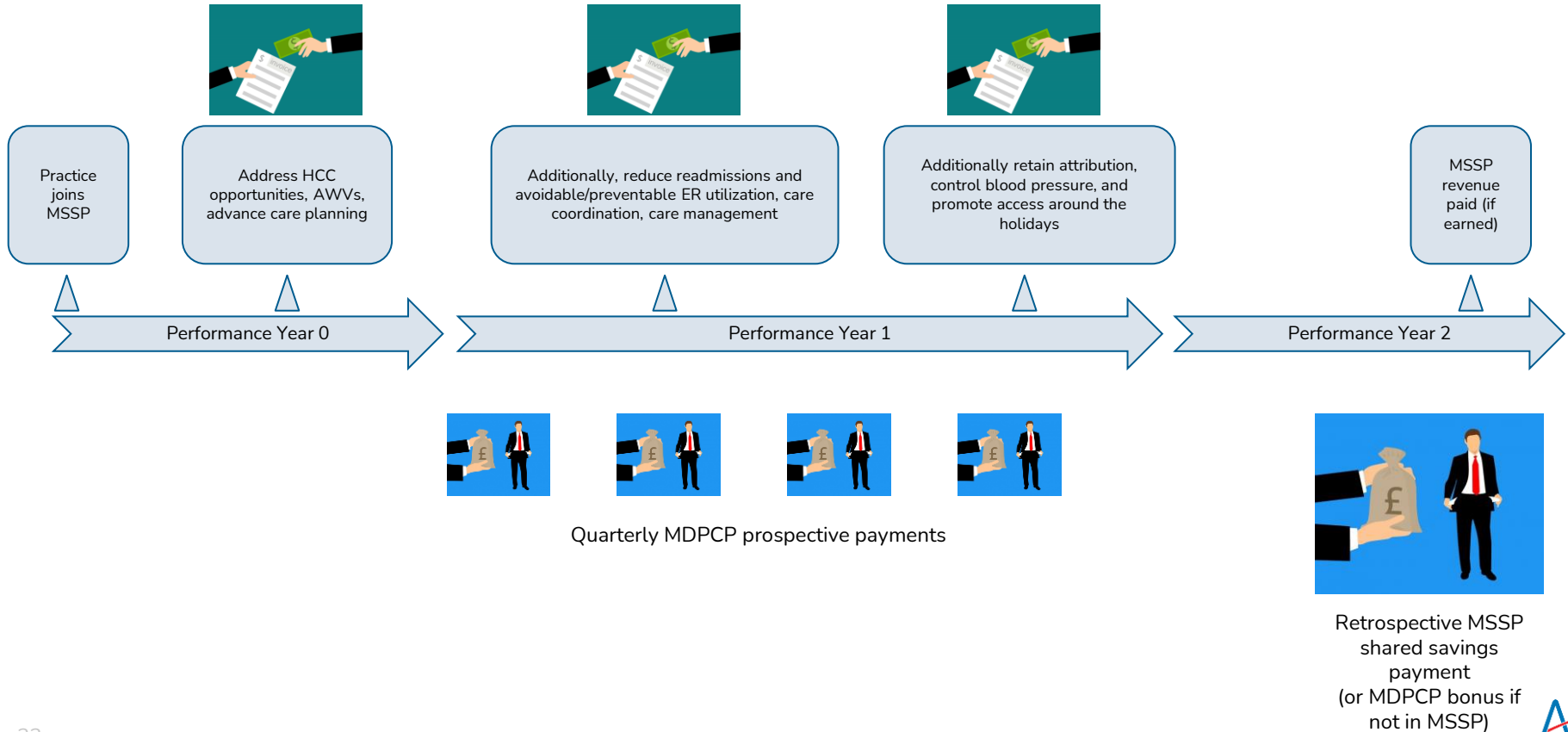
\$20B+ Medical Spend Under Management

The Aledade Class of 2023, alone, would be the **3rd largest MSSP ACO** in the U.S.

MSSP Challenge: Revenue, if earned, comes well after expenses are incurred



MDPCP enables a cash flow positive MSSP experience for Primary Care Providers



MDPCP is the “primary care component” of the Maryland Total Cost of Care Model

MODEL OVERVIEW

The MD TCOC Model is part of an evolving Maryland Model that began in 2014 with the Maryland All-Payer Model (MDAPM), which introduced all-payer global budgets for hospitals in the state. With the start of the MD TCOC period in 2019, the state took on increasing responsibility for cost and quality—committing to \$2 billion in Medicare savings over 8 years and meeting population health goals. The state and CMS also broadened incentives and supports to engage a wide range of providers in care transformation.

Model components



Hospital global budgets across all payers



Incentives to hospitals to reduce total cost of care



Incentives to improve the efficiency and quality of episodes spanning hospital and non-hospital care



Waivers allowing hospitals to align incentives with other providers



Primary care practice transformation through Maryland Primary Care Program (MDPCP)



Funding to hospitals and partners to reduce incidence of diabetes and overdose deaths

MDPCP is one program within the MD TCOC Model

PARTICIPANTS



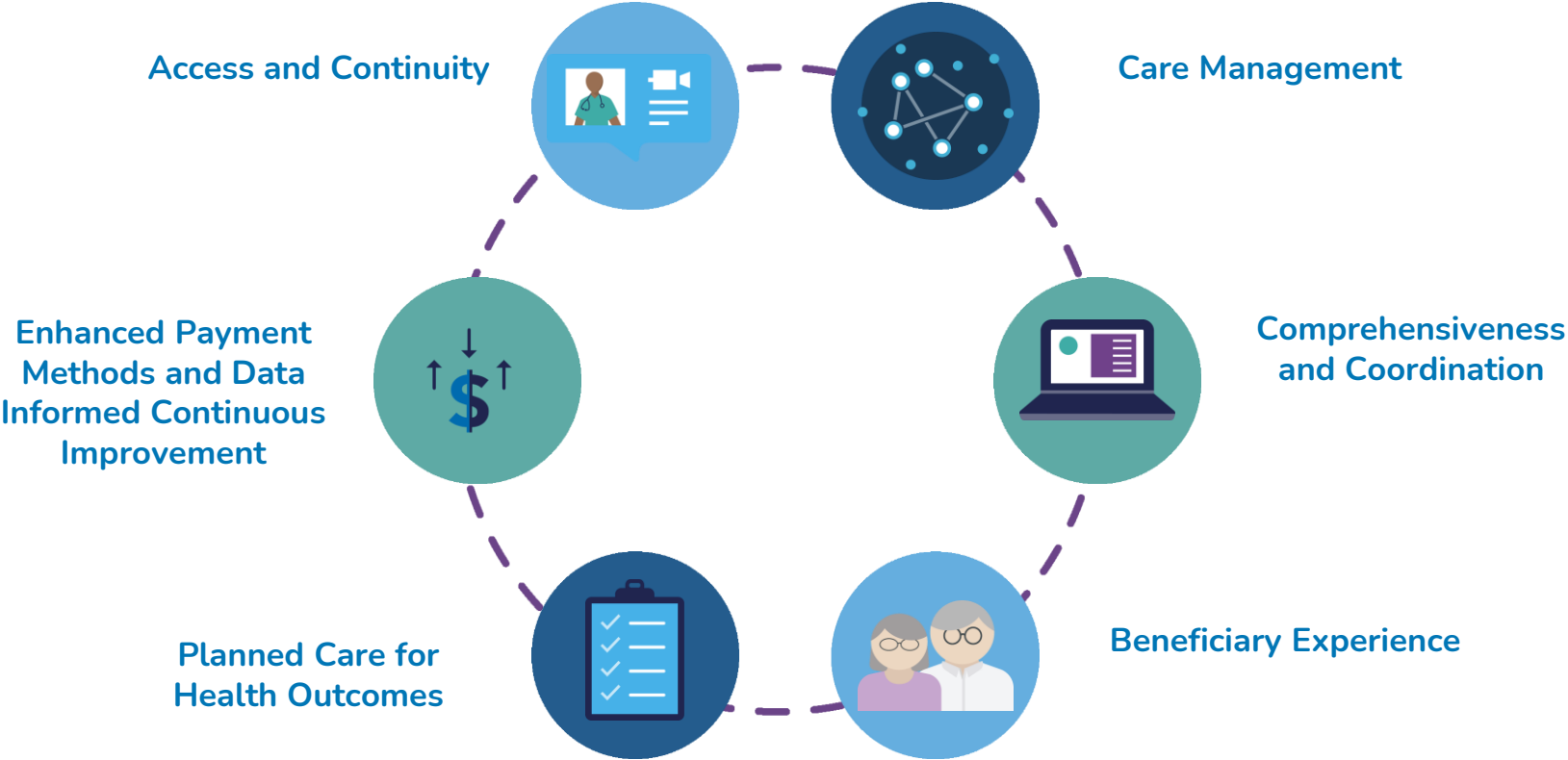
- Almost all hospitals in Maryland received quality-adjusted global budgets (52 hospitals).
- 85% participated in an episode incentive program.



- In 2021, 524 primary care practices participated in MDPCP, over a quarter (27%) of all primary care practices in the state.



MDPCP Participant Requirements



MDPCP Care Transformation Organizations (CTOs)

Practices may choose to partner with a CTO like Aledade to access embedded and shared clinical resources to help meet the program requirements in exchange for a portion of MDPCP revenue

Patient-facing partnerships:



Manager,
Care
Management
**Shantel
Matthews**



Community Health Worker
Program
Jennifer Joynes



Clinical
Pharmacist
**Emily
Duncheskie,
PharmD**



RN Care
Manager
**Anna- Maria
Howard**



RN Care
Manager
Erin Wennberg



RN Care Manager
**Jenna Hastings-
Stasulli**

mindoula*

SylvanHealth



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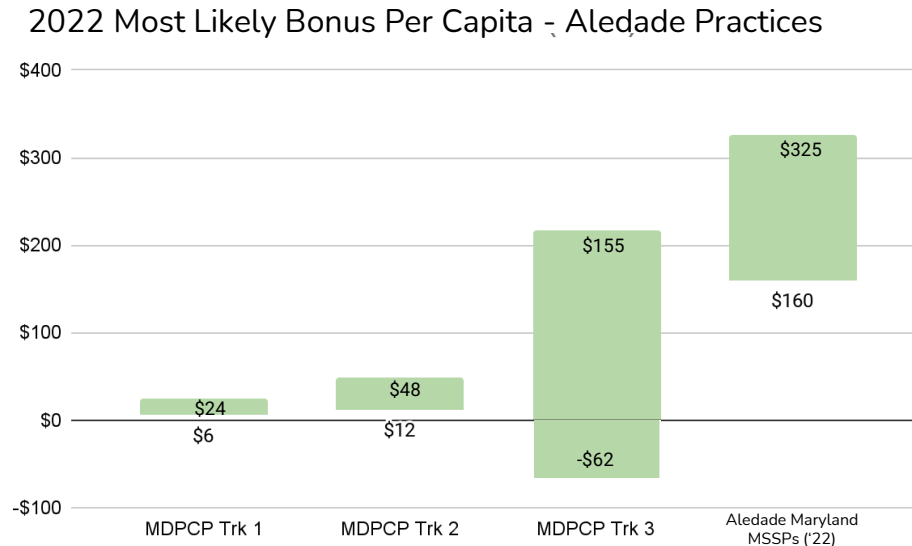
Blood Pressure CareKit



MDPCP bonus vs MSSP bonus

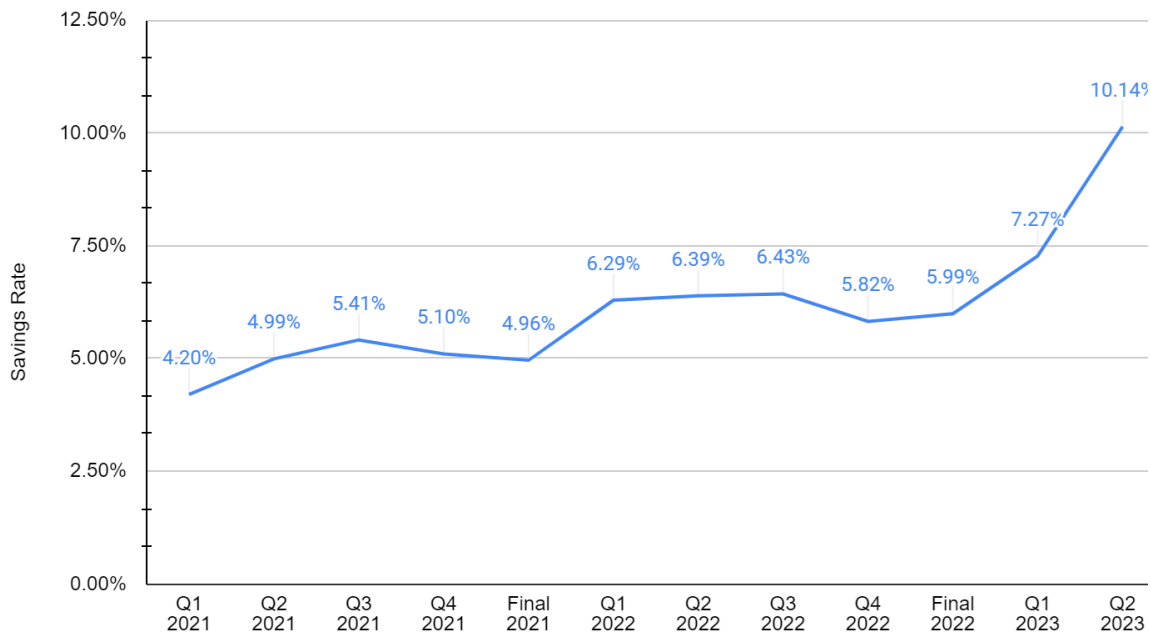
MDPCP bonus is PBIP or PBA, MSSP bonus is shared savings

- MDPCP Care Management fees, HEART payments, and capitation rates are not impacted by MSSP participation
- MDPCP PBIP (Tracks 1-2) or PBA (Track 3) bonuses are replaced by Shared Savings
- Be aware that MDPCP and ACO REACH are not compatible programs



Following 2-yr MSSP hiatus, MDPCP has contributed to strong MSSP performance

Maryland ACO Savings Rate



MDPCP Notable Considerations

AHEAD model details aren't fully public yet, but these MDPCP considerations may be present:



MDPCP CMF payments add to the total cost of care, potentially reducing shared savings in PY1 by 1% or more, unless the regional benchmark incorporates widespread participation



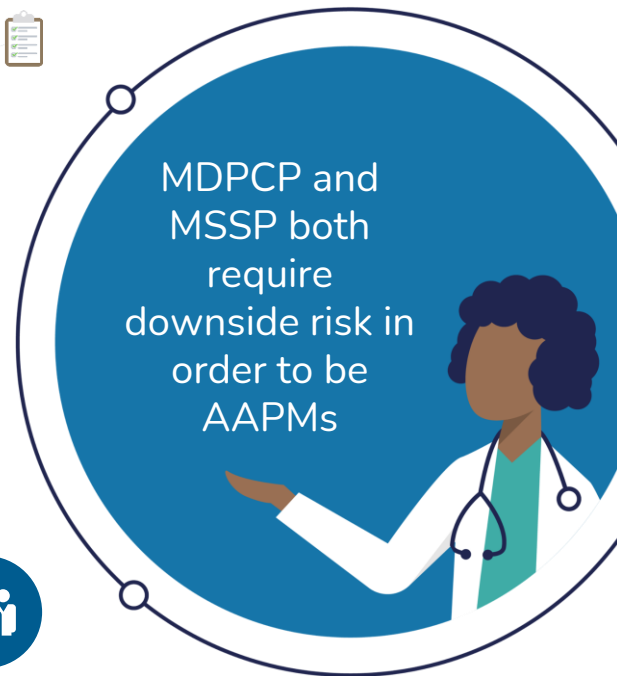
MDPCP partially capitates the primary care provider fee schedule

Like AHEAD, MDPCP purports to be multi-payer, but largely has not garnered participation outside of Medicare



Dual participating practices must report quality in both programs separately (but only MSSP quality impacts payment)

MSSP and MDPCP attribution methodologies differ slightly





Thank You

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Questions?



Reach out with questions to
advocacy@naacos.com

Upcoming Events



**Webinar: NAACOS
Meeting of ACO Members**

November 15, 2023

2:00 – 3:00 PM ET

[Register here!](#)



**NAACOS Winter Boot
Camps:**

February 8-9, 2023

Marriott Orlando Airport Lakeside, FL

[Sign up here!](#)

Thank you!



*Please email advocacy@naacos.com with additional feedback
or questions.*