CONNECTICUT

AHEAD

States Advancing All-Payer Health Equity Approaches and Development Model

Agenda

- AHEAD Overview
- Global Budgets
- Primary Care AHEAD
- CT AHEAD timeline
- Questions & Discussion

What is the AHEAD Model?

All-Payer Health Equity Approaches and Development Model

CMS, 11-year, Innovation Model

- 6 states are participating (MD, VT, HI, CT, RI, NY sub-region)
- Model offers:
  - **Global Budgets:** a new multi-payer payment model that can provide hospital financial stability
  - **Advanced Primary Care:** through federal investments and strategies to strengthen prevention and coordinated care
  - **Health Equity Framework:** through statewide planning and goal development to close disparity gaps, address social needs and link people to community resources

Provider participation in the model is voluntary

CT will be accountable for meeting certain cost and quality benchmarks

What are the key opportunities the model offers?

- For hospitals: The model offers **predictable, stable, annually updated financing from multiple payers**. This could be a particularly good option for rural and smaller safety-net hospitals that can't rely on large patient volumes and a diverse payer-mix to stay afloat.
- The model offers hospitals **flexibility** to invest in **care coordination, community health, and address social needs** to keep people healthy and to avoid unnecessary hospitalizations.
- The model offers much needed investments directly in primary care practices. Participating practices receive an enhanced monthly payment for their Medicare* members to **coordinate care, and to address behavioral health and social care needs.**
- For the state: The federal partnership brings extensive **evaluation, monitoring, and learnings from other states** to support our efforts to improve care and contain healthcare costs.

*Medicare fee-for-service members

Who is eligible to participate in this voluntary model?

- **Hospitals can participate in Global Budgets**
  - Acute care hospitals
  - Children's hospitals (limited to Medicaid and commercial insurance)
- **Primary Care practices**
  - Independent practices
  - System-owned practices (as long as their affiliate hospital is under a global budget)
  - FQHCs
- **Commercial payers (required to have at least one)**

Hospital Global Budgets

Hospital Global Budgets vs. FFS and Capitation

Payment Models	**Fee-for-Service (FFS)** Paid per service	**Global Budgets** Fixed annual budget based on projected needs	**Traditional Capitation** Fixed per-patient payment, regardless of services used
What are the incentives?	Higher service volume = higher revenue	Stable funding encourages shift to less costly settings, focus on preventive care, strategies to reduce avoidable utilization and improve coordinated care. Not volume-based revenue	It can encourage preventive and coordinated care
What is the impact to the patient?	More services available but may lead to unnecessary overuse, fragmented care. Not necessarily tied to quality	Promotes preventive care, reduces unnecessary procedures or avoidable ED visits or readmissions, and supports community health interventions. Must be monitored for quality and potential service gaps.	Focus on preventive care but may lead to limitations or withholding of care
Effectiveness in controlling costs?	Low - costs rise with service volume regardless of need	Moderate/high - hospitals must manage resources effectively but have predictable funding to shift services to align with community needs instead of unnecessary high-cost services	Moderate—costs are predictable but require careful patient management or risk of under-provision

Hospital Global Budgets by Payer

Medicare FFS

- CMS-designed Medicare FFS Global Budget Methodology

Medicaid

- State (DSS) develops Medicaid methodology

Commercial

Medicare Advantage

- State (OHS) develops methodology
- Payer participation voluntary; CT must recruit at least one commercial payer by 2028 (PY2)
- Participation ties larger portion of hospital revenue to global budget

CMS Methodology for Global Budgets

Baseline Calculation

CMS will calculate the hospital's historical revenue for eligible hospital services, combining the 3 most recent years of historical revenue data with percentage weightings more heavily applied to recent years (i.e., Base Year 1: 10%; Base Year 2: 30% and Base Year 3: 60).

Annual Trend and Performance Adjustments

CMS will apply adjustments to predict the current performance year and reflect accountability for quality and reducing avoidable utilization:

- Annual Trend Updates (Annual Payment Adjustment, Volume-Based Adjustments, and Other Adjustments)
- Performance-Based Adjustments (TCOC, Quality, Equity, and Effectiveness)
- AHEAD-Specific Adjustments (Transformation Incentive Adjustment and Social Risk Adjustment)

Global Budget Payments

Each hospital will receive a prospective, bi-weekly payment for Eligible Hospital Services in lieu of traditional FFS claims or cost-based reimbursement. Hospitals will continue to submit Medicare FFS inpatient and outpatient claims and Medicare Hospital Cost Reports to CMS.

What suggests Global Budgets can be effective?

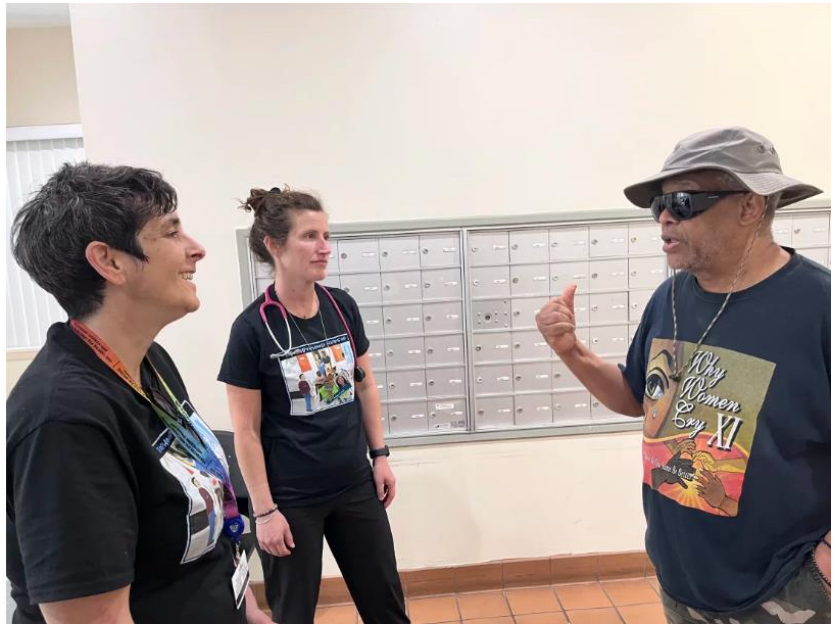
- AHEAD builds on the demonstrated success of existing models in other states
  - Vermont All-Payer Accountability Care Organization (VT-ACO)
  - Maryland Total Cost of Care (MD TCOC)
  - Pennsylvania Rural Health (PARHM)
- These states have *expanded access to primary care, behavioral health services and care for underserved populations*

In Baltimore, nurses go door-to-door to bring primary care to the whole neighborhood

JUNE 11, 2024 · 5:00 AM ET

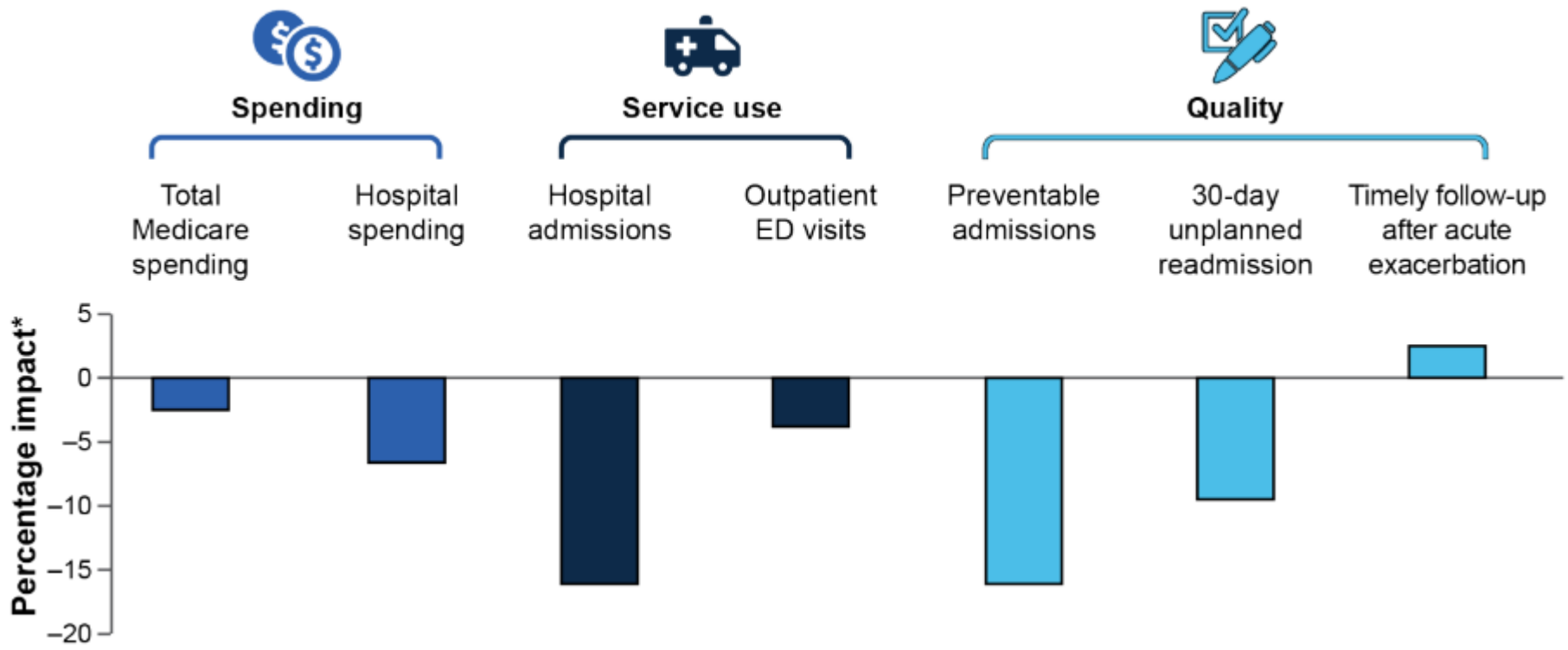
FROM TRADEOFFS

By Leslie Walker, Dan Gorenstein



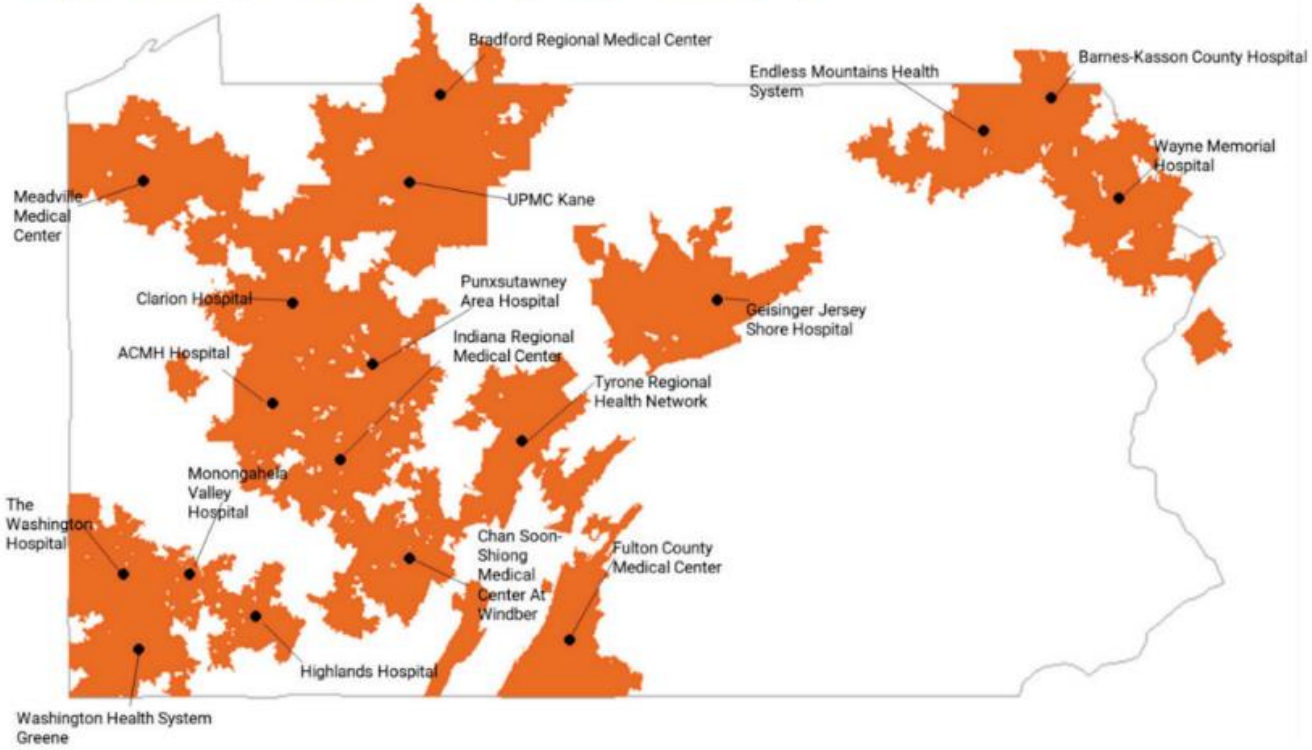
https://www.npr.org/sections/shots-health-news/2024/06/11/nx-s1-4997717/nurses-primary-care-community-baltimore-costa-rica

Maryland TCOC model Findings



Pennsylvania Experience

Exhibit 1.2. The market areas for participating hospitals are located in Western, Northern, and Northeastern Pennsylvania and also include ZIP codes in New York and New Jersey.



SOURCE: Medicare FFS Claims (CY 2013-CY 2017)

KEY TAKEAWAYS

- Provided fiscal stability to 18 rural hospitals, helped them keep their doors open through the pandemic.
- Enhanced cross-sector collaborations, particularly around addressing substance use disorder
- Fixed bi-weekly payments provided fiscal stability
- Upfront engagement from payers, philanthropy, and state and local governments was helpful
- LESSONS LEARNED: Payment reconciliation process resulted in uncertainties.

Sources: Fourth Annual Report – Findings at a Glance, Fourth Annual Report

Primary Care AHEAD

- Global Budgets are an important but not the only mechanism to achieve desired outcomes
- AHEAD also comes with extensive investments in primary care and primary care transformation support
- Under AHEAD, hospital global budgets and primary care investments will work in tandem to support a healthier population.

Primary Care **AHEAD** Program Components

CARE TRANSFORMATION ACTIVITIES

ENHANCED PAYMENT

LEARNING COLLABORATIVES & SUPPORTS

DATA & TECHNICAL ASSISTANCE

How Does AHEAD Benefit Primary Care?

- Participating primary care practices (including FQHCs) can get **a prospective $17 per member per month enhanced payment** for their Medicare patients.
- For example, a provider with 500 patients could receive between $8,500 monthly or $102,000 annually (can be used to pay for a community health worker, dietician, care coordinator)
- **Participating practices would be expected to use the enhanced payments to improve care coordination, behavioral health and address social needs**
- Hospital owned primary care practices can participate ONLY if their parent hospital is participating in the hospital global budget program.

Source: Spotlight on Primary Care in the AHEAD Model

AHEAD Advisory Committee

- A 21-member Advisory Committee under the Health Care Cabinet
- Members represent consumers, payers, hospitals & health systems, primary care providers, clinicians, community-based organizations, service providers, population health/health equity leaders.
- Roles
  - Guide model planning activities
  - Support stakeholder engagement
  - Advise and make recommendations on health equity and quality goals
  - Offer expertise and guidance on strategies to monitor model's impact on patient experience, quality, and cost control

CONNECTICUT Health Strategy

DEPARTMENT OF SOCIAL SERVICES

Connecticut AHEAD

Today – 2026

- Pre-implementation
- Stakeholder engagement
- Global Budget Technical Design
- Statewide Health Equity Planning

2027 PY 1

- 10% Medicare FFS under global budget
- Primary Care AHEAD launch

2028 PY 2

- At least one commercial payer participating

2029 PY 3

- Continued hospital onboarding & payer engagement

2030 PY 4

- 30% Medicare FFS under global budget

For more information:

Connecticut AHEAD website for FAQs, webinar recordings, advisory committee meetings and other online resources

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