COPE HEALTH SOLUTIONS

New York State 1115 Medicaid Waiver, AHEAD Global Budget Program Position Paper

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Introduction

On September 5, 2023, CMS announced a new, voluntary state total cost of care model called the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. This new payment model directly aligns with CMS' strategic direction to drive delivery system transformation through the shift to value-based care. One of the main components of the AHEAD model is the introduction of a hospital Global Budget. Under this model, a hospital's revenue for inpatient and outpatient facility services and specific lines of business are pre-determined and fixed for the year, based on historical payments and adjusted to account for annual changes. The State of New York applied for AHEAD and was accepted in the third cohort for the downstate region consisting of five counties: Bronx, Kings, Queens, Richmond, and Westchester.

In conjunction with AHEAD, NYS must develop a Medicaid Hospital Global Budget methodology as a requirement for the New York State (NYS) 1115 Waiver which was approved on January 9, 2024.[1] This methodology is expected to be directly linked to and aligned with the AHEAD model and similarly aims to enhance financial sustainability.

In Downstate New York, particularly in the Bronx, Brooklyn, but also in parts of Manhattan, Staten Island, Queens, Long Island and the lower Hudson Valley, there are significant challenges to care coordination and access to high quality ambulatory care and non-medical supportive services. These challenges impact various populations, including those with Medicaid Managed Care (MMC), Medicare Advantage (MA), Medicare Advantage Plus (MAP), traditional Medicare fee for service and subsidized Exchange coverage. Many Medicaid beneficiaries lack access to urgent care centers, private medical groups, due to financial constraints including transportation, food and other non-medical needs.

The fragmented health care landscape and misaligned financial incentives drive hospitals to continue to focus primarily on hospitalization and high-cost ambulatory procedures in hospital licensed outpatient units as a primary revenue driver. Hospitals have not been adequately and consistently incentivized to focus on building large scale primary care networks with adjacent and coordinated ancillary services and aligned high performing specialists vs replacements and upgrades to high cost hospital inpatient and nearby hospital licensed outpatient services. Limited access to high quality lower cost care in the surrounding communities may be driving the use of higher cost care options, negatively impacting quality and care coordination.

The continued focus on high-cost care modalities has been exacerbated by fee-for-service reimbursement environments within the NYS Medicaid program that have artificially suppressed reimbursement levels for high-cost institutional services while positioning the state to close gaps between reimbursement and cost for those institutions through large, supplemental, support payments on the hand. Decades of "economic interference" have inhibited the same market forces that have driven change in care delivery in other markets across the US. This has created an unsustainable cycle of excessive utilization, inappropriate site of service selection, and financial dependency to meet the basic healthcare needs of underserved communities in NYS.

With the confluence of the 1115 Waiver Amendment and AHEAD, NYS, particularly with relation to safety net hospitals in the Downstate region, has a unique opportunity to facilitate a more coordinated approach to care, the "right care at the right time in the right place," by better aligning financial incentives. By melding existing data-driven, value-based payment (VBP)

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contracted, clinically integrated networks with hospitals and health systems under Global Budget, NYS can align incentives and facilitate the design, implementation and efficient operation of clinically integrated networks, both hospital and community physician controlled, with community needs.

Hospital Global Budget will be implemented in downstate New York for twelve designated hospitals for Medicaid starting in 2027, AHEAD is optional. In this region, there is a unique opportunity to leverage existing clinical integration concepts and operating models with health-related social needs (HRSN) driven strategies and operations, to improve health for Downstate New Yorkers. The transformation will allow health systems to transition from their current high cost, institutional/ procedural focus, to a large-scale primary care focused, ancillary and specialty supported network approach that will make access to high quality, lower cost care easier.

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Downstate NY Faces Uncertainty on the Optimal Approach to Implement Global Budgets

While it may seem with Medicaid Global Budgets that New York State, through the stroke of a pen, has solved for a significant challenge in balancing its budget, the devil is in the details of how a Medicaid Global Budget program will be implemented, with or without some hospitals choosing to also engage with AHEAD. To date, there is no publicly available information on how Medicaid Global Budgets in New York will work. In fact, the program intended to serve as the model, AHEAD, is itself, still incomplete. CMMI has released the AHEAD Medicare FFS hospital Global Budget methodology, both as a V1.0 in February 2024 and a V2.0 in July 2024. A V3.0 is expected in Q1 2025.

With few concrete details for the administration of a program decided, it is still worth exploring the economic realities, and the subsequent challenges they create, that are inherent when fixing in place the total cost of a large sector of the healthcare delivery system in NYS. The challenge NYS faces is that solving complications stemming from this methodology may create a conflicting complication for other stakeholders in the delivery system. For the purpose of this discussion, and while we wait for more concrete details from both NYS and CMS, we will simply highlight some of the more pressing issues that a Global Budget reimbursement model presents to the current healthcare delivery environment and through the lens of three key stakeholders.

Hospitals

Setting the Global Budget Baseline

The Global Budget program's application is directed towards safety net hospitals who have been poorly leveraged in their negotiations with Medicaid MCOs since their inception. The economic reality of unit price negotiation has suppressed rates to levels well below published fee schedules for these facilities. These low rates are of course offset by relatively high rates at facilities that have the leverage. The playing field is not level from facility to facility.

Fixing the total reimbursement to a facility without restating that reimbursement leveraging a standardized methodology and putting that facility at risk for volume increases only exacerbates the financial reality for these safety net facilities. Ensuring an equitable rate calculation is used in establishing the baseline "Global Budget" is a minimum standard that should be leveraged before asking that facility to mitigate demand for services at their facility.

The intended goal for this program is to incentivize a contraction of services which should in turn result in the ability for a participating facility to reduce cost. The cost structure of a hospital is such that a significant portion of their cost is fixed, and reductions in cost can only be achieved when the contraction of utilization is meaningfully significant. If the starting point represents an even larger gap between operating cost and revenue, there will be little chance for success under this program.

Capital Considerations

In order to successfully manage the transition from fee for service revenue to Global Budget and value-based care revenue, most providers will need to incur some level of capital investment. The level of capital investment will vary significantly from hospital to hospital depending on their own unique circumstances.

In planning for capital needs hospitals will need to consider existing primary and specialty care and ancillary services in their service areas, how they can partner with existing community IPAs/CINs/ACOs to grow access points and panel sizes, and where the hospital will want to grow new bricks and mortar primary care, specialty care and ancillary sites (typically a hub and spoke approach of primary care sites around "super-centers" with urgent care, specialty and ancillary services including surgical and procedural capabilities) in tandem with robust value based care enablement population health management functions that can support primary, specialty and even hospital care at home as well as care in the community – coordinated with community based organizations that can support HRSNs.

In addition to the cost of the transformations noted above, there is an implication for a hospital's existing debt structure. Most hospital bonds are secured by a gross revenue pledge. The implementation of a Global Budget substantially changes the nature of the gross revenue pledge. The hospital's main revenue streams are changing – something that was never contemplated at the time bonds were issued -and existing capital structures may need to be re-assessed.

Network Development and Referral Management

The Global Budget construct currently has no native attribution model, exposing a hospital to a seemingly infinite population of physicians and an unidentified patient population. This construct contrasts with successful value based care models that assign or attributed "members" to primary care physicians and often through them to specialists, hospitals and other key services.

AHEAD attempts to account for this through a geographic constraint, however setting an exclusion for geographic outliers of 120 miles does little to mitigate these concerns. AHEAD also allows for participating hospitals to participate in MSSP ACOs in parallel with AHEAD for traditional fee for service Medicare, which will not have an impact on Medicaid Global Budget

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Health Plans

Service and Member Mix Change

If Global Budget payments are accomplished through payments made by health plans without change to the premium structure that they work within, payors are at significant risk for fluctuations in both member and service mix over time. This is especially the case when the population of membership is relatively small, and the methodology is not all inclusive of the population of providers in a market. By virtue of the fact that participation in this program seems likely to only encompass safety net facilities, how will health plans account for shifts in utilization towards facilities that remain in a fee for service environment?

A perverse incentive is created in this situation. It is in the best interest of a health plan to maximize utilization at a Global Budget hospital, while it is in the best interest of the Global Budget hospital to move utilization to another entity. How this push/pull plays out remains to be seen, however it will be important to track not only what mechanisms are employed at the front end of the process, but also during discharge planning. In situations where a patient is to be discharged to a sub-acute site of service such as a skilled nursing facility or inpatient rehab, the financial incentive to allow for increased length of stay in an acute facility exists.

Along similar lines, health plans with large volumes of membership utilizing services from a participating hospital are at risk for losing that membership to a competitor plan while retaining the cost. This is especially true without a mechanism for shifting responsibility for the historic cost. Moreover, due to the nature of the hospital business, the likelihood of a single patient driving similar costs year to year is low, so simply tying historic cost to a specific member that moves between plans is not a valid approach, and such a methodology would likely be met with resistance from the plans.

VBP with Small Membership

As a condition of participation, facilities participating in the Global Budget program are being asked to develop infrastructure for participation and performance in Value-Based Programs, consistent with the state's VBP roadmap. While this is a noble pursuit, and discussed extensively here, there will likely be an expectation that all plans allow for participation in their VBP programs. The challenge occurs when the volume of attributed lives for a newly developed CIN, in a given program, is too small to participate in that program. Moreover, Health plans employ different thresholds for participation for similar programs. Will the state mandate that participation be allowed? If so will the state set criteria under which such participation is mandated? Or will plans simply be required to offer alternative VBP models for cases where attributed membership falls below a threshold?

Calculating Out of Pocket and Benefit Utilization for Encounters at a Global Budget Facility

The AHEAD model requires that state participation include the participation of at least one Commercial Health Plan. While much less of an issue when speaking to Medicaid implications, in both the commercial and Medicare Advantage space, the challenge of calculating benefit utilization comes into play. If a member seeks care in a Global Budget facility, calculation of deductible, co-insurance, and benefit maximums need to be accounted for.

Payments to hospitals under a Global Budget model eliminate direct claim cost calculations. In the case of Traditional Medicare, claim cost can be imputed based on the published CMS fee schedule, but as you move into Medicare Advantage, and most notably the commercial health plan space, an imputed rate creates significant concern with respect to impact to individual member benefits.

It's also worth noting the challenges that can arise in situations where members have both primary and secondary coverage. Will the rules for coordination of benefits and subrogation need to be rewritten to account for utilization occurring in a Global Budget facility?

Community IPAs/CINs/ACOs

Implementation of Medicaid Global Budget, and potentially AHEAD, presents a challenge to the performance of existing community IPAs/CINs/ACOs operating in Total Cost of Care VBP models. Fixing cost for institutional care even if only in part, creates a perverse incentive, not dissimilar to those in place today relative to reimbursement rates for Emergency Department and Outpatient Hospital services in today's Medicaid FFS environment. A fixed payment to hospitals under a Global Budget model would remove the incentive to reduce utilization and/or to shift site of service. It would also reduce the opportunity for cost reduction, potentially inhibiting greater proliferation of CIN infrastructure, by reducing the upside opportunity to these entities. If the Global Budget model were to be implemented market wide, this would have the benefit of capping upside exposure to trend escalation, however, when only a portion of the market is subject to Global Budget, the potential for escalated cost and utilization at non-Global Budget hospitals coupled with the fixed nature of cost at Global Budget facilities would represent a significant risk to total cost models of VBP exposed to this environment.

There are however, opportunities to mitigate these concerns. Total Cost value based programs could carve out payments under Global Budget from the calculation of performance year cost, substituting them for an imputed cost for services that are actually performed. Some level of analysis of claims for services performed will be necessary for year-to-year adjustments under the AHEAD methodology, it stands to reason that this may not create an overwhelmingly burdensome methodology. This would serve to maintain the incentives for CINs to seek opportunities to reduce utilization in an acute care environment and promote the use of higher value sites of service.

The physician CINs taking global risk could be required to partner with health systems/hospitals enrolled in Medicaid Global Budget, and potentially AHEAD, for institutional care for all members who are deemed to be "institutionally attributed" based on hospital and hospital ancillary utilization and potentially geography. In this model parties, physician CINs and health system/hospital IPAs are incentivized to coordinate care and social services and to ensure care and social support services are easily accessible and referred to in order to reduce avoidable high-cost hospital inpatient, emergency department, ancillary, diagnostic and specialty services. This model has been successfully implemented in California with significant reductions in high-cost utilization, it is called "dual risk" there.

Other Considerations

The Global Budget model that NYS and CMMI implement must align and complement existing risk arrangements, including other CMMI programs. CMMI and NYS should consider mandating that hospitals participate in another selected VBP program as a condition to entering Global Budget. This requirement can and should span across lines of business. In addition, NYS should consider tying the annual incentive adjustments included within the hospital Global Budget methodology to participation in these other risk arrangements.

For hospitals, especially the safety nets, a requirement to participate in other CMMI risk arrangements would spur the exact transformation that the 1115 Waiver necessitates to succeed under Global Budget. In fact, the 1115 Waiver requires that they create a "custom roadmap" to transform in order to earn the Waiver's investment dollars.

This transformation is predicated on building a high-performing ambulatory network that creates a contractual relationship between the facility and the physician. There are many ways to achieve this, namely through creating IPAs/CINs and exploring opportunities through different lines of business, including D-SNP, MAP, Exchange, and MSSP. These opportunities would sit outside the Global Budget but align strategically by offering shared savings potential through achieving the same goals: improving quality and lowering total cost of care for the covered attributed population.

Strategies for Success for Global Budget Hospitals

Hospitals are required to submit a "custom roadmap" to NYS by March 31, 2025. This is an opportunity to both re-envision existing hospital, ancillary and ambulatory facilities and any existing employed or contracted physician network into a true clinically integrated network. Transforming from geographically concentrated hospital and high-cost specialty and ancillary focused services to a more disseminated network anchored in primary and home based care with easily accessible high performing specialists and community ancillary services is a heavy lift.

One of the most significant barriers to hospitals adopting value-based payments has been managing the significant loss of fee-for-service revenue while making the transition. Global budgets could present a unique opportunity to manage this transition as hospital payments will be fixed for several years. In order to effectively take advantage of this opportunity there are a number of strategies hospitals should adopt:

- **Begin planning now:** The Global Budget program in New York will not begin until 2027 – giving participating hospitals time to plan for the transition to a new payment system. NYS has provided guidelines for an operational gap assessment and roadmap. Hospitals should perform the gap assessment and begin to address deficiencies today to be ready for implementation in 2027.
- **Develop a financial model**: A detailed financial model to understand the specific components that will be used to calculate the baseline will aid in understanding the specific services to target for migrating to an ambulatory or other setting.
- **Develop an organized network of primary care and specialty physicians – commit to a primary care focused growth and performance strategy:** The Global Budget model is specifically intended to drive hospitals towards value-based care. Hospitals must organize their employed and voluntary physicians through an IPA and ACO to successfully transform to a value-based care entity. Further, the IPA and ACO must be supported with robust data, care management protocols, and a funds flow model. Significant capital and management focus must be deployed to grow access for high quality primary care, specialty care and ancillary services across the communities served by the hospital. This strategy and the goals for membership to be empaneled by line of business, should be the key influencer of service line, physician recruitment and facility development planning.
- **Develop a strategy for success in the Medicare Shared Savings Program and other value-based agreements:** The AHEAD model specifically allows for participation in the Medicare Shared Savings Program or ACO REACH while also participating in Global Budget. Likewise, hospitals will have the ability to participate in Medicaid value-based agreements while participating the Medicaid Global Budget program. Hospitals should take the opportunity to build attribution in both Medicare and Medicaid value-based agreements while planning for the implementation of Global Budget.
- **Improve Quality:** One of the most important keys to success in value-based care is a robust quality program. Hospitals should take the opportunity to focus on both inpatient and outpatient quality improvement while developing their value-based care infrastructure.
- **Perform a community needs assessment:** The service areas surrounding the safety net hospitals is often lacking in necessary components of a high functioning healthcare delivery system. Many of these services have been filled leveraging Hospital Based outpatient and acute care services, often times when care has been delayed to the point that a patient is in "crisis". It is critical that facility leadership understand the opportunities for establishing free standing modalities of care that can serve the community well in advance of their need for an inpatient confinement or an emergency room visit. This may include placement of primary care and specialty physician offices, or the establishment of freestanding diagnostic facilities.
- **Consider modifying your strategic plan:** Hospital strategic plans, are often acute care-centric. If your strategic plan does not include a robust plan for transition away from hospital-based services towards a primary care focused network with expansive ancillary facility and ambulatory services and a wrap-around care model powered by a high performing population health management services organization (MSO), now is the time to address this transition.
- **Establish relationships with existing community based CINs:** EEngaging the totality of your medical staff in a CIN that you operate is a rare occurrence. Community based CINs are thriving in NY today, and partnership is a great way to accelerate your own VBP capabilities. Building VBP competency takes time and is a worthwhile use of resources, however leveraging partnerships will not only allow you to establish a greater level of control over the population utilizing your facility, but will also provide

you with examples of successful tactics to employ within your own CIN. Leverage financial modeling, membership growth, quality and utilization goals to design revenue share through aligned value-based payment agreements between the hospital or hospital CIN, community CIN and health plan(s).

- **Partner with local Social Care Network (SCN) to align shared goals and strategies:** Managing Health Related Social Needs is fundamental to success in managing the total cost of care for Medicaid populations. As part of the waiver, every geographic region of NYS now has a designated SCN that will manage a network of CBOs and other HRSN service providers and will be responsible for establishing community priorities for funding and for providing shared data and IT platforms for screening, service navigation and care management. Global budget hospitals should build strong relationships with these SCNs as soon as possible to ensure alignment in workflows, platforms and funding priorities for the hospital's geographic area, at the least ensuring access to make and track referrals for HRSN services required by hospital and community partner CINs.

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Appendix A: AHEAD Medicare FFS Hospital Global Budget Methodology and Administration

CMS released Version 2.0 of its methodology for calculating the Medicare FFS hospital Global Budget on July 24 after it released Version 1.0 in February 2024. Version 3.0 is expected in Q1 2025. The Global Budget baseline will be calculated using historical revenue and will be adjusted annually based on changes in market dynamics and performance. Certain adjustments incentivize early participation and strong performance that will impact a hospital's Global Budget in the future performance years of the model. Hospitals will be paid via prospective, bi-weekly payments.

The AHEAD model includes developing a baseline of historical claims data inclusive of all services covered under the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). The table below highlights the typical types of payments and their inclusion/exclusion in the baseline Global Budget calculation:

Medicare FFS Payment Baseline Inclusion

Included	Excluded
FFS payments under IPPS and OPPS	Medicare Bad Debt
Inpatient Part A hospitalizations	Direct Graduate Medical Education (DGME)
Certain outpatient Part B services billed on facility claims	New Technology Adjustment Payments (NTAP)
Indirect Medical Education (IME)	Medicare Secondary Payer (MSP)
	Drugs and supplies paid through separate APC
	Professional services rendered in hospital set-ting

The baseline budget is developed from a weighted average of historical paid claims from the three most recent years preceding the first year a hospital joins AHEAD (minus one gap year). The table below represents the baseline calculation for hospitals in states entering Cohort 3 of AHEAD, whose first performance year (PY) is 2027.

YEAR	DESCRIPTION	% WEIGHT
Base Year 1	Q3 2023 – Q2 2024	10%
Base Year 2	Q3 2024 – Q2 2025	30%
Base Year 3	Q3 2025 – Q2 2026	60%

CMS built a gap period (Q3 – Q4 2026 between the last base year and the first PY because of data lags, as claims data are collected during the gap period.

The baseline hospital Global Budgets are updated on an annual basis under four types of adjustments:

1. Annual payment adjustment: updates to baseline data to reflect appropriate price and policy changes
2. Volume based adjustment: Updates to baseline data to reflect changes in demographics, market shifts, and unplanned volume changes
3. AHEAD specific adjustments: Social Risk Adjustment (SRA) and Transformation Incentive Adjustment (TIA)
4. Performance Based Adjustments: State Medicare fee for service Total Cost of Care (TCOC) performance, Critical Access Hospital Quality, Hospital Health Equity Improvement Bonus and Effectiveness

Type	ADJUSTMENT COMPONENTS	KEY CONSIDERATIONS
Annual Payment Adjustment	Disproportionate Share	Aim to avoid penalizing hospitals for reducing avoidable utilization. BY3 will serve as the floor
	Indirect Medical Education	
	Uncompensated Care	
Volume Based Adjustments	Market Shift Adjustments	Meant to provide additional funding for market shifts
	Service Line Adjustments	Pre-planned changes to existing service lines. New service line additions must be pre-approved and will be reconciled back to FFS volumes for two PYs and then incorporated into budget
	Unplanned Volume Change Adjustments	Hospitals not receiving approval for service line changes are ineligible to either retain portion of Global Budget or receive additional funding unless variance exceeds 5%
AHEAD Specific Adjustments	Transformation Incentive Adjustment (TIA)	1% upward TIA for hospitals that join in first two PYs of applicable cohort (must pay back if exit model before PY6)
	Social Risk Adjustment (SRA)	Up to 2% starting PY1 to account for social risk difference of hospital's bene-ficiary populations
Performance Based Adjustments	State Medicare FFS TCOC Performance	Upside only up to 2% starting PY4 based on region performance (+/-2% starting PY6)
	CAH Quality	Upside only starting PY3 as pay to re-port
	Hospital Health Equity Improvement Bonus	Up to 0.5% based on performance to certain measures starting PY 4
	Effectiveness Adjustment	Downward adjustment starting PY3 based on ability to reduce unnecessary or avoidable care