The AHEAD Model Hospital Global Budgets

NATIONAL ACADEMY FOR STATE HEALTH POLICY

Discussion Series – Initial Topics

- December 19, 2023 – AHEAD Model Components and Key Focus on Governance
- January 11, 2024, 2:00 p.m. EST – Considerations for Hospital Global Budgets
- January 18, 2024, 2:00 p.m. EST – Considerations for Primary Care AHEAD
- Additional sessions TBD

AGENDA

- AHEAD Hospital Global Budget Requirements
- Global Budget Key Concepts and Considerations for States

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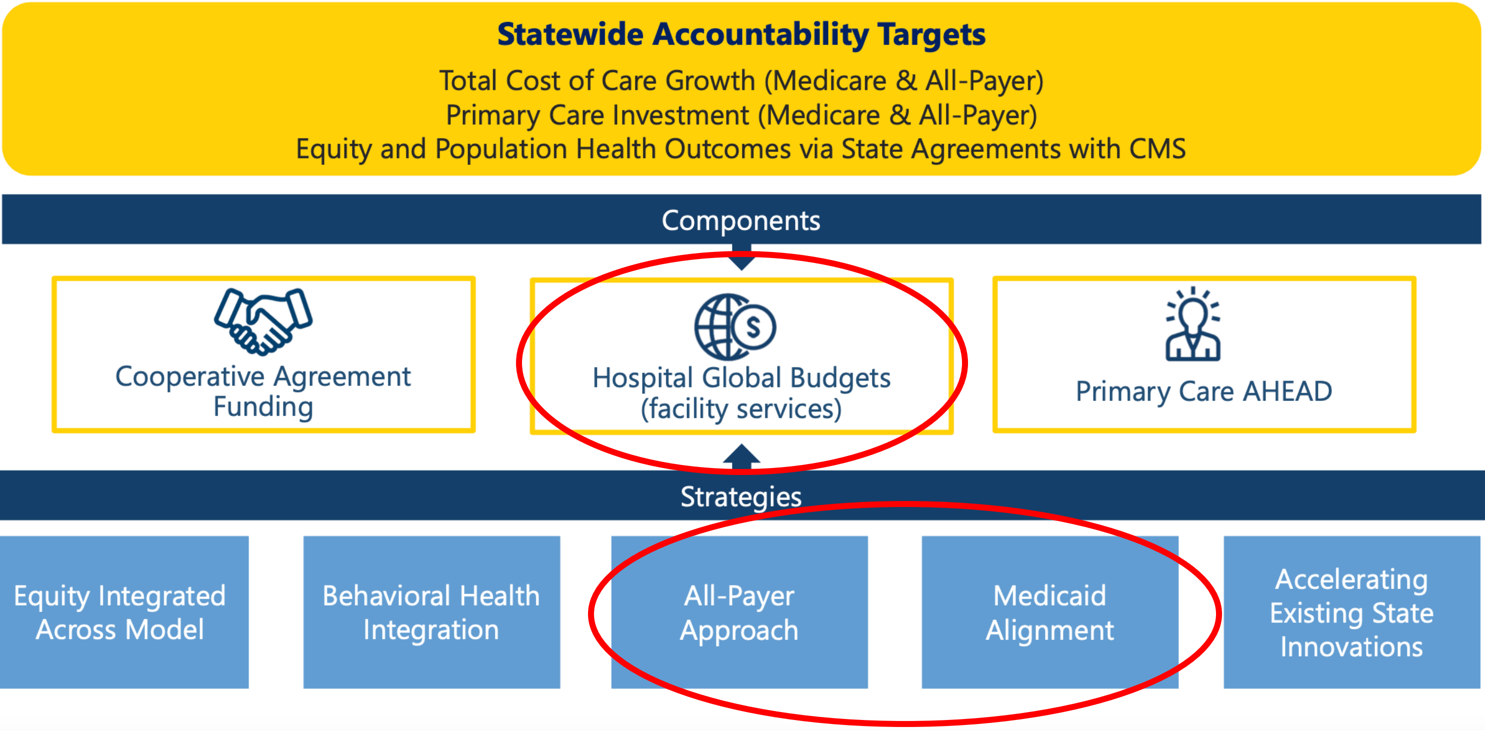
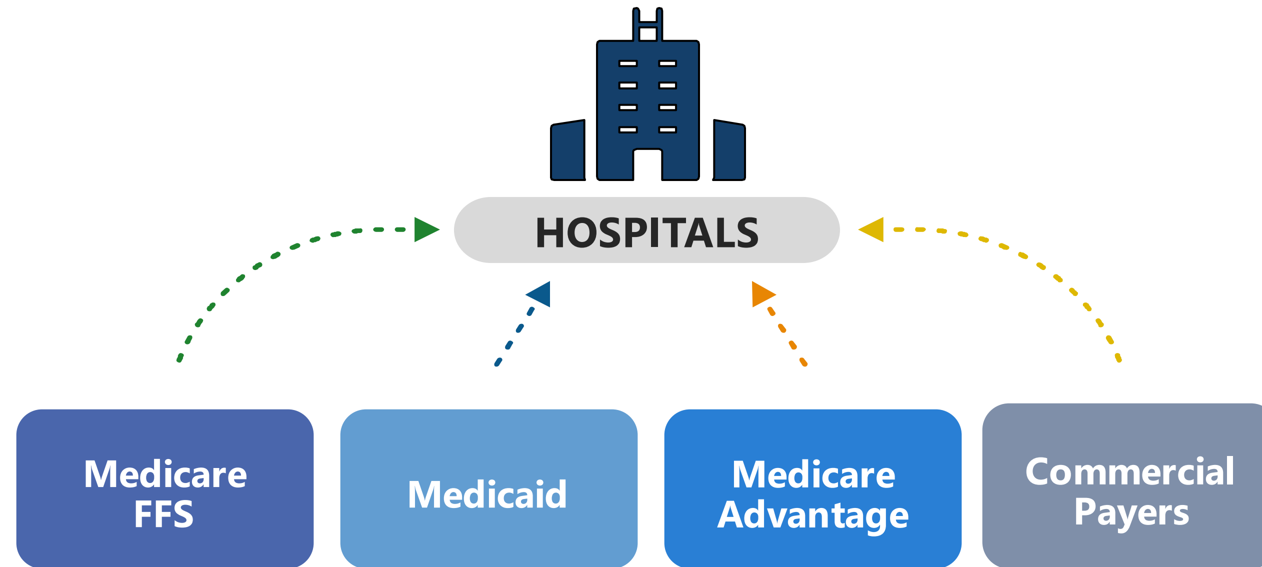
AHEAD Hospital Global Budget Requirements

AHEAD Model Components



Source: CMMI Presentation on AHEAD Model, September 18, 2023

AHEAD Hospital Global Budget Participation Requirements



Medicare FFS

- CMS sets the methodology for all except for states with existing rate setting authority and experience (MD, VT)
- Lead agency to recruit hospitals. Targets are:
  - 10% of Medicare FFS spending for the state/region by PY1
  - 30% of Medicare FFS spending for the state/region by PY4.

Medicaid

- The state Medicaid agency will be responsible for developing their Medicaid-specific hospital global budget methodology. States can have separate models for FFS and MCOs
- Any Medicaid methodology will need to be approved through normal regulatory processes and CMS approval.
- Mandatory participation by PY1

Commercial Payers

Medicare Advantage

- Participating states will develop a methodology with high-level alignment principles outlined by CMS.
- At least one commercial payer must participate in global budgets by PY2.

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Source: CMS Notice of Funding Opportunity

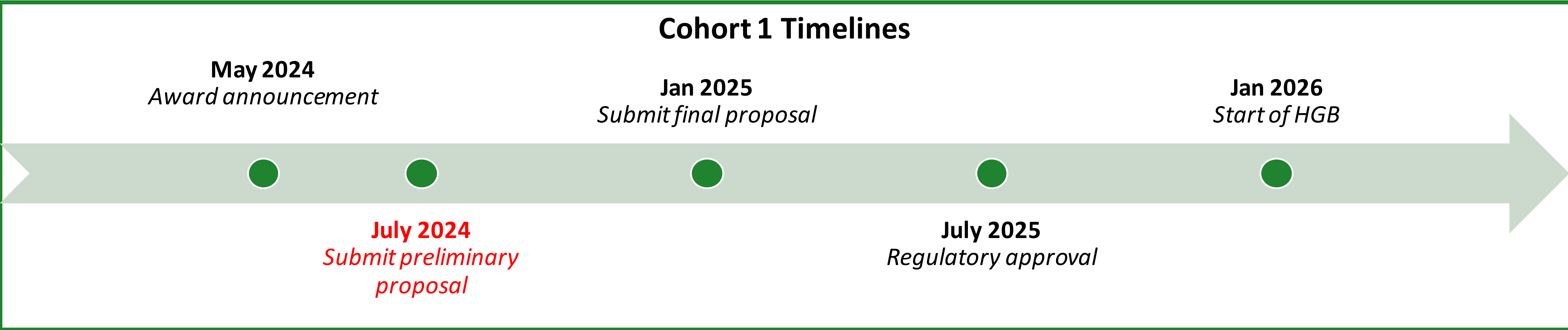
Medicaid Hospital Global Budget General Requirements

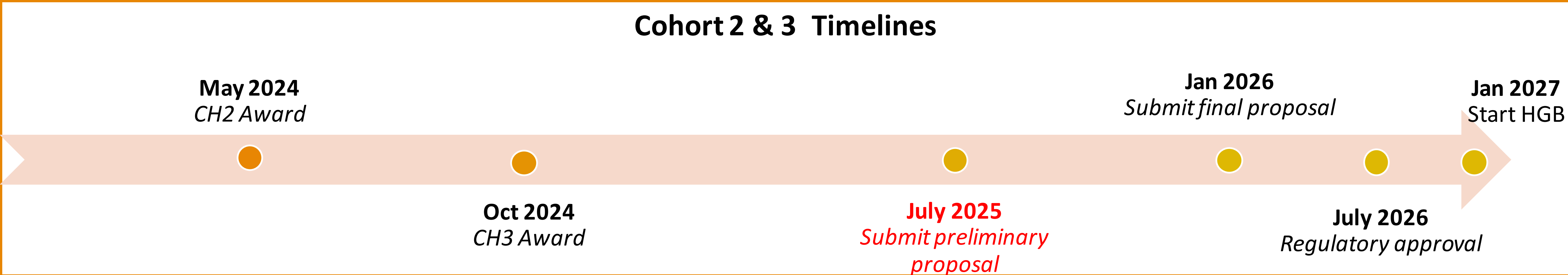
- Must be implemented prior to or no later than the end of PY 1 (may start earlier to align with provider/MCO contractual timelines)
- States must finalize Medicaid global budget methodology and share with hospitals in accordance with Model Milestones timeline

If PY1 start not met: $500,000 will be restricted in budget period 3 until Medicaid HGB is implemented.
If not start of PY2, CMS will take steps up to and including termination.

- The methodology considers incentives to recruit and retain hospitals early into the global budget methodology.
- CMS encourages hospital global budget methodologies to be public to foster transparency and accountability.
- Early and substantive engagement with managed care plans on proposed changes, with risk analysis for MCOs conducted during the Pre-Implementation Period.

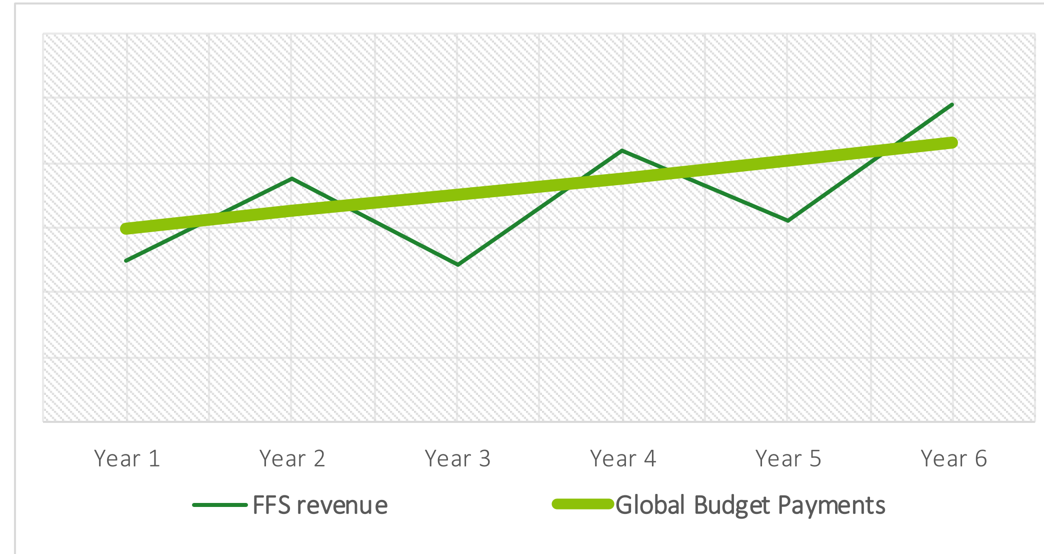
Milestone Requirements for Medicaid Hospital Budgets





Global Budget Key Concepts and Considerations

Hospital Global Budget Business Model



Fee-for-Service Payment

Units/Cases × Price Per Unit or Case

- Incentives: Higher payment rates and utilization rates, focus on high margin services

Global Payment

Revenue Base + Updates

- Incentives: Focus on availability in lower cost settings, improve population health, reduce operational cost and avoidable hospital utilization

Why Global Budgets?

Hospitals

- Mission alignment and leadership
- Predictable revenue
- Operational flexibilities, potential waivers from regulatory requirements
- Transformation incentives ($ and technical assistance)
- Primary care AHEAD if they own primary care practices

States/Payers

- Control the growth of hospital cost (40% of total health care $)
- Transforming health care delivery with largest institution's support
- Stabilize safety-net hospitals including rural providers
- Predictable spending
- Operational flexibilities- Denials, pre-authorization, etc.

Patients

- Coordinated care
- Primary care and prevention
- Focus on social drivers of health
- Better quality and access with strong safety net providers
- Benefit enhancements

Concerns with Hospital Global Budgets

- Hospital prices are too high, we will lock in historical inefficiencies
- Hospitals may stop offering certain services
- How do we keep hospitals accountable for improving care?
- Hospitals cannot control other factors outside of their walls
  - Physicians are mostly incentivized to perform more procedures/more volume
  - Post-acute care is not available
  - Primary care workforce is not sufficient
  - Social and economic factors

AHEAD Medicaid Hospital Global Budget- Eligibility Requirements

- **Hospitals**
  - Short-term acute care hospital, and critical access hospital participation at minimum.
    - CAHs cannot settle back to Medicaid costs
    - Rural emergency hospitals are also eligible to participate
  - **The State Medicaid Agency (SMA) may propose including additional types of hospitals (e.g., psychiatric hospitals, or children's hospitals).**
  - Long Term Care Hospitals (LTCH) and federally-owned government facilities are not included in the Medicaid global budget.
- **Services**
  - Hospital global budgets will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum.
    - **The SMA may propose including or excluding hospital inpatient and outpatient services that differ from the services included in the Medicare global budgets (e.g., hospital- based dental services).**
- **Populations**
  - CMS will negotiate with the state on which populations may be excluded from HGBs

Hospital recruitment

Is it a good opportunity?

Do they trust CMS/State?

1. You don't need all hospitals to participate!!
   - How many hospitals will meet 10-30% Medicare revenue target?
2. How significant is Medicare FFS and Medicaid revenue for hospitals?
   - Payer-mix of hospitals (NASHP tool)
3. What is the opportunity to reduce hospital utilization?
   - Avoidable utilization (Mathematica tool)
4. Are hospitals already in alternative payment models?
   - Eligibility may vary for CMS participation
5. Special considerations for system-owned, CAHs and other safety net hospitals

Medicaid Global Budget Methods

How to design the HGB for Medicaid?

What is the impact on the overall Medicaid budget?

1. CMS's alignment criteria and timelines
2. Participation of MCOs
3. Mechanisms to implement: State plan, 1115 waiver, state directed payment
4. Legislative process

Commercial payer participation

What is the level of commercial payer participation to create an incentive for hospital to join?

1. What is the opportunity for commercial payers under this model?
2. How would the new model change negotiation between payers and hospitals?
3. Do the payers have existing alternative payment models?
4. How would the state engage national vs. local carriers?

AHEAD Medicaid Hospital Global Budget- Considerations for Methods

- Maintain competition for high quality and patient choice
  - Adjust for market shifts if patients go from Hospital A to another place
  - Provide additional revenue/cut budgets if hospital opens/closes services
- Fixed-revenue incentivizes to do less
  - Require/monitor/increase incentives for delivery reform
  - Effective monitoring of quality and outcomes such as transfers, wait times
- Key questions for methods
  - Geographic attribution: Who will be counted from Medicaid enrollees to adjust budgets for membership changes or for other performance measures?
  - MCO alignment: How will MCOs participate and what will remain as a contractual negotiation between plans and hospitals?

Global Budget Alignment Criteria for Medicaid Considerations for Payment Options

- Fixed-payment – Stop claim payments and pay a check
  - Payment frequency- monthly
  - Infrastructure to stop claim-based payments
  - Regulatory barriers to stop claim-based payments
  - Impact on MCO rate development
  - Updates for service line changes (if reconciliation is needed)
- Virtual budget - Continue to pay claims and true up the end of the period
  - May need additional up-front payments/mid-year supplemental payments if claim payments are lower
  - Payment mechanism for settlement amounts (especially if hospital needs to pay-back)
  - Time lags and cost accounting

Next Time - Preview

- Considerations for Primary Care AHEAD, January 18, 2024

- If you have any questions you would like to discuss during the next calls please email them to vveltri@nashp.org
- Please take 5-10 minutes to answer a few questions that would help plan future support for states on this topic: Call Series Survey

Appendix 1
NOFO Requirements

Hospital recruitment plan (required)

- Provide detailed plan for recruitment of hospitals to participate in hospital global budgets (e.g., regulatory levers and strategies the state will use to meet hospital recruitment requirements).
- Applicants should summarize communications (e.g., conversations, outreach, etc.) with hospitals to-date, including the number of hospitals they aim to recruit, and hospital experience with hospital global budgets or other value-based payment models in their state or designated sub-state region, if applicable.
- Applicants should provide a timeline for hospital recruitment, including specific recruitment goals, strategy for engaging rural hospitals and safety net hospitals, and contingency plan if recruitment goals are not met during pre-implementation.
- Any Letters of Intent (LOIs) from hospitals should be included in the an appendix (LOIs are not included in the appendix page limit).
- At least one LOI from a hospital is **required** for the application. An LOI from a hospital is not binding; however, it will help CMS understand how applicants are engaging with hospitals and health systems).

Medicaid Model

- The proposed pathway that offers the most streamlined regulatory approach in the context of the applicant's Medicaid program structure.
- An outline of applicant's managed care vs. fee-for-service Medicaid populations and considerations for implementation via managed care organization, if applicable.
- The steps required of the SMA and legislature/other state entities to construct a state plan amendment or managed care contract change.
- The anticipated timeline for each step, such that the first global budget payment can be implemented beginning in PY1 for required Medicaid alignment to AHEAD Medicare FFS hospital global budgets.
- Describe plan for engagement with interested parties (e.g., what stakeholder groups need to be engaged on the global budget methodology development for Medicaid and commercial payers), including a brief, high-level description of when and how the state will engage these groups throughout the Pre-Implementation period.

Commercial payer (required)

- Describe commercial payer participation in state health care reform and population health improvement efforts, if applicable.
- Describe commercial payer efforts to implement value-based payment and advanced primary care models, if applicable.
- Describe commercial payer efforts to address affordability and control cost growth, if applicable.
- Describe state legislative or regulatory authority the state intends to utilize under the Model to facilitate commercial payer participation in hospital global budgets and an aligned primary care program, and to hold commercial payers accountable for TCOC growth (for example, reference-based pricing; premium rate review; D-SNP contracting; all-payer rate setting; hospital budget authority).
- Describe if and how the applicant intends to include Marketplace QHPs and state employee health plans in hospital global budget payments. Describe approach to hold commercial payers accountable for TCOC growth.

Global Budget Alignment Criteria for Medicaid- Baseline and Annual Updates

Global Budget Construction	AHEAD Medicaid Hospital Budget Alignment	Purpose of the method	Considerations
Baseline revenue	Suggested: 2- 3 year weighted base years	Provide solid revenue base as a start	• COVID-19 pandemic • Data validation and availability Membership changes (unwinding) • MCO contracts especially new plans
Demographics and inflation	Required: Risk adjustment, inflation, population growth Include medical and social risk adjustment	Annual adjustments for factors impacting cost of care	• Annual increase in Medicaid rates • Determine geographic areas hospitals serve • Monthly membership changes vs. annual fixed amounts • Risk adjustment methods • Social risk measure and adjustment

Global Budget Alignment Criteria for Medicaid: Additional Adjustments

Global Budget Construction	AHEAD Medicaid Hospital Budget Alignment	Purpose of the method	Considerations
Changes in services	Market shifts, New/closed services offered by hospitals	Maintain competition and avoid unintended consequences (close services, or no new services that are needed by the community)	• Predictability vs. changes in the market • Complicated vs. fair adjustment • Prospective vs. reconciliation with actual trend • Avoid backdoor FFS incentives
Performance	Quality Disparities-sensitive quality measures	Pay for outcomes not volume Improve health equity	• Measure alignment • Medicare FFS methodology also has total cost of care, effectiveness adjustments
"Supplemental" Payments: UPL, UCC, IME, DSH, DSRIP	CMS will establish guardrails and requirements for each type of supplemental payment and their inclusion.	Minimize impacting other payment policies Maintain level of funding	• Complicated included/excluded revenue accounting

Appendix 2
Introductions

About NASHP

The National Academy for State Health Policy (NASHP) is a nonpartisan organization committed to developing and advancing state health policy innovations and solutions.

NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.

- To improve the health and well-being of all people across every state.
- To be of, by, and for all state by providing nonpartisan support for the development of policies that promote and sustain healthy people and communities, advance high quality and affordable health care, and address health equity.

How NASHP Accomplishes Our Mission

- **Advance innovation** by supporting states in the development of new policies and programs.
- **Surface and support the implementation and spread of best practices** by engaging states to inform data driven policy making at the state and federal level.
- **Ensure states have the information, data, and tools** to successfully design and implement policy.
- **Encourage sustainable cross sector solutions** by strengthening partnerships across state agencies, executive and legislative branches, and the private sector.
- **Elevate the state perspective** for a broad group of stakeholders, partners, and the public.

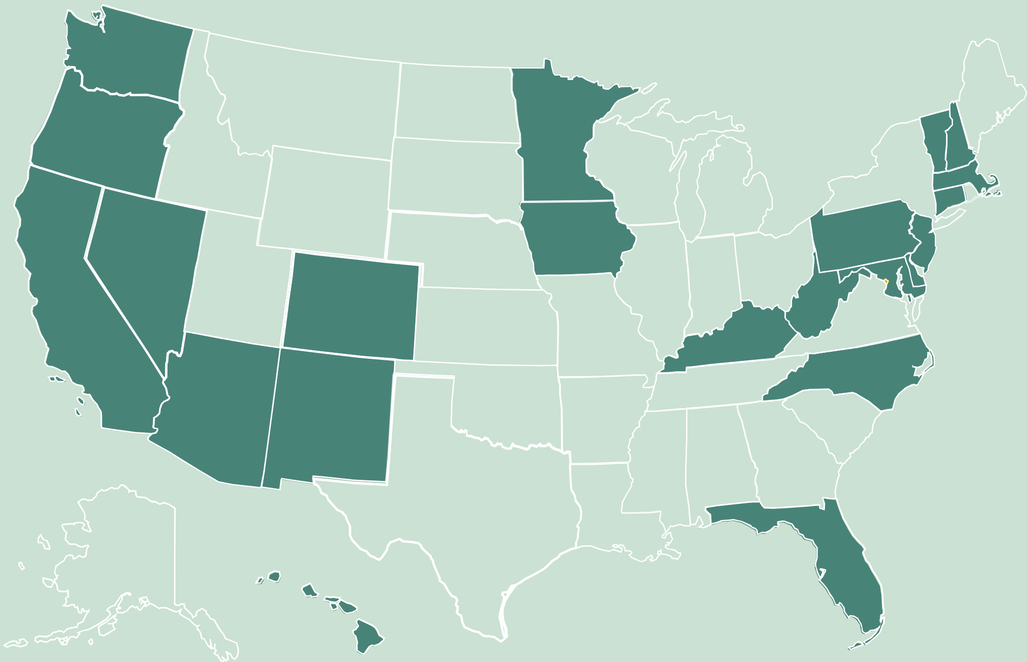
About Mathematica | Focus Area Health

Our Health team **collaborates with clients to improve the health and well-being of our most vulnerable populations** through transformation to an equitable, data-driven, value-based health care system.

Our Mission

Improve public well-being by bringing the highest standards of quality, objectivity, and excellence to bear on the provision of information collection and analysis.

State Health Footprint I Project Highlights



- Pennsylvania Rural Health Model
- Vermont All-Payer Model
- Maryland Total Cost Model and Evaluation
- California and New Jersey Total Cost and Primary Care Benchmarks
- NASHP Hospital Cost Tool
- Medicaid 1115 waiver and Primary Care Model evaluations
- National/State Medicaid, Medicare and Commercial claims analytics

Dr. Sule Gerovich

(Shooleh Gherovich),Pronounce: She/Her

- Over 15 years of experience in health services research and policy
- Expertise in health care payment policy, quality and performance measurement
- Hospital global budget implementation in three states: PA, MD, VT
- Strategic assessment of CMS models, including CMS Community Health Access and Rural Transformation (CHART) Model for Washington State
- Total cost benchmarking and all-payer claims analytics: CA, MA, MN, VT, MD and NASHP Hospital cost tool
- Senior Fellow at Mathematica
  Ph.D., Johns Hopkins University School of Public Health