AUGUST 20, 2026

The AHEAD Model

Overview and Considerations

Georgia Hospital Association Center for Rural Health

Agenda

TODAY'S DISCUSSION

01 BRG Overview and Background

02 AHEAD Model

03 Hospital Global Budgets in Maryland and Pennsylvania

04 Lessons Learned and Next Steps

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Patrick Dooley bio

RELEVANT RECENT CLIENT ENGAGEMENTS

- Johns Hopkins Health System
- The Brooklyn Hospital Center
- Ascension Health
- Delaware Healthcare Association
- Maryland Hospital Association

EDUCATION

- MA, Johns Hopkins University
- BA, University of Maryland

INDUSTRY EXPERIENCE

- State Legislature
- Executive Branch Agencies
- Health System

SERVICE AREA EXPERTISE

- Alternative Payment Models
- Value-Based Care
- Strategic Planning
- Regulatory Advisory

Patrick Dooley, Managing Director

Patrick Dooley is a managing director with BRG's Healthcare practice.

He brings over twenty years of healthcare experience, including leadership roles in legislative and executive governmental agencies and the largest health system in the State of Maryland.

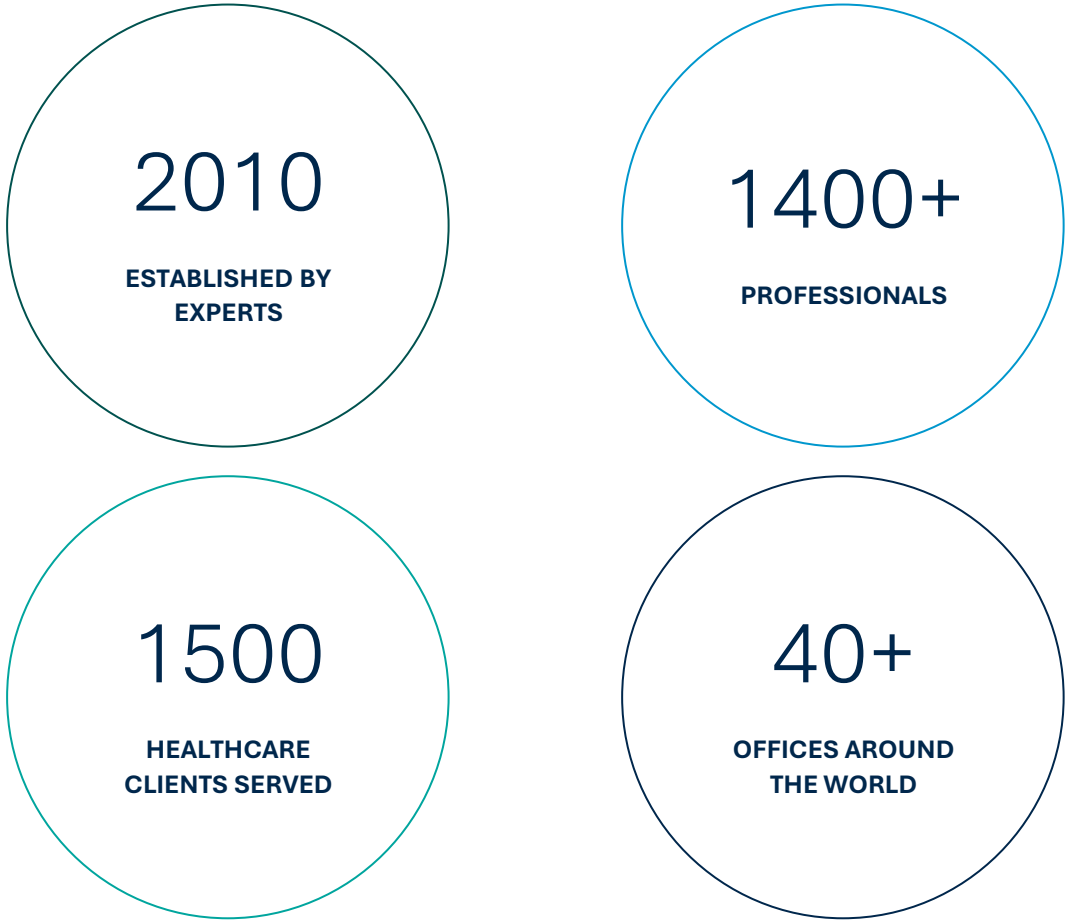
During his time in state government, Mr. Dooley worked on a range of issues including Medicaid expansion, behavioral health, and provider licensing and regulation. He worked extensively with other executive branch agencies, legislative leaders, and stakeholders across the spectrum, combining legislative and communications expertise to implement public policy initiatives effectively.

As a population health-focused executive with the University of Maryland Medical System, Mr. Dooley led the development of a clinically integrated network of providers, contracting with governmental and private payers on innovative payment models like accountable care organizations. He also worked directly with the hospitals throughout the medical system to implement programs to better manage high-risk patients across the care continuum.

1 BRG Overview and Background

BRG Overview

Berkeley Research Group, LLC (BRG) is a global consulting firm that helps leading organizations advance in three key areas: disputes and investigations, corporate finance, and performance improvement and advisory.



BRG's Integrated Capabilities

CORPORATE FINANCE

Multidisciplinary solutions to realize value achievement throughout the business change continuum.

ECONOMICS & DAMAGES

Clear, compelling testimony, and economic analysis in complex disputes.

HEALTHCARE

Multidisciplinary services to deliver innovative, independent, and data-driven solutions.

GLOBAL INVESTIGATIONS & STRATEGIC INTELLIGENCE

Relevant and timely information required to make fully informed business and legal decisions.

PERFORMANCE IMPROVEMENT & ADVISORY

Evidence-based, theory- informed, and insight- driven strategic advice with a dynamic capability framework.

2 AHEAD MODEL

AHEAD Model Participation and Implementation Timeline

1 LAUNCH & MODEL DESIGN

- The CMS Innovation Center announced in 2023 that it was creating a new model, the States Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, to voluntarily enroll hospitals in hospital global budgets for Medicare, with the expectation being that participating states use regulatory authority to align Medicaid and Commercial payers
- Medicaid and at least one Commercial payer are expected to participate in each state
- Model name subsequently changed to Achieving Healthcare Efficiency through Accountable Design (AHEAD)

2 STATE PARTICIPATION

- Six states applied and were approved for the AHEAD program (MD, VT, RI, CT, NY, HI) during the first Notice of Funding Opportunity (NOFO)
- VT could not come to terms with CMMI and has now dropped from the program

3 TIMING & EXPANSION

- Implementation has been delayed a year, with Cohorts 2 and 3 now starting January 1, 2028
- An additional NOFO is expected to be released in late August or early September with the goal of enrolling 2-3 additional states
- Potential states include AK, DE, MA, NJ, and GA

AHEAD Model – Problem, Solution, Outcomes, and Strategy

1 PROBLEM

Rising health care costs, uneven investment in primary care, and inconsistent quality of care at the state level contribute to poor patient outcomes.

2 SOLUTION

Investing in primary care, hospital global budgets, geographic ACO entities, with multi-payer alignment and shared cost and quality targets can stabilize funding, expand primary care services, and improve population health.

3 OUTCOMES

AHEAD's goal is to improve the overall health of a state's population and support a sustainable health care budget.

4 STRATEGY

AHEAD gives participating states, geographic ACO entities, primary care providers, and hospitals tools to better manage and lower Medicare and Medicaid costs thus protecting taxpayers and tools to improve quality of care and population health outcomes. Aspects of AHEAD model design also advance the strategic pillars of choice and competition and prevention.

Source: https://www.cms.gov/priorities/innovation/innovation-models/ahead

AHEAD Model Overview

AHEAD rebalances health care spending across the system by providing hospitals with a Hospital Global Budget (HGB), encouraging collaboration with primary care and community-based providers to provide financial stability and flexibility, and improving community health and coordination.

1. STATEWIDE ACCOUNTABILITY TARGETS

1. Total Cost of Care (TCOC) Growth (Medicare & All-Payer)
2. Primary Care Investment (Medicare & All-Payer)
3. Population Health Outcomes via State Agreements with CMS

8-9 Performance Years

2. MODEL COMPONENTS

1. Cooperative Agreement Funding
2. **HGBs (facility services)**
3. Primary Care AHEAD
4. GEO AHEAD

3. ENABLING STRATEGIES

1. Community Health Improvement
2. Behavioral Health Integration
3. All-Payer Approach
4. Medicaid Alignment
5. Accelerating Existing State Innovations

 Source: AHEAD CMS-Designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) Methodology Overview - April 8, 2025

Building Hospital Global Budgets Under AHEAD

HGBs provide an annual budget that accounts for historic Fee-for-Service (FFS) revenue and offers additional financial incentives.

HGB BUILDING BLOCKS

1 Baseline Calculation

- Starting point for determining Performance Year 1 payment for a Participant Hospital.

+

2 Volume-Based Adjustments

- Market Shift Adjustment
- Service Line Adjustment
- Outlier Adjustment

+

3 Adjustments for Parity with FFS

- Annual Payment Adjustment
- Demographic Adjustment

+

4 AHEAD-Specific Adjustments

- Annual Adjustments
- Transformation Incentive Adjustment
- Social Risk Adjustment
- Performance-Based Adjustments

PAYMENT

5 Global Budget Payments

- Bi-weekly payments in lieu of traditional FFS claims or cost-based reimbursement.

 Source: AHEAD CMS-Designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) Methodology Overview - April 8, 2025

3 Hospital Global Budgets in Maryland and Pennsylvania

Maryland Total Cost of Care Model – Overview

1	**Model evolution**	CMMI developed the All-Payer Model (2014-2018) and Total Cost of Care Model (2019-2025) with the State of Maryland to enroll hospitals in global budgets for all payers
2	**All-payer foundation**	The Models built upon the existing rate regulated, all-payer model that has been in place in Maryland since the 1970s whereby a gubernatorially-appointed commission (Health Services Cost Review Commission) sets hospital rates for all hospitals in the state
3	**Performance expectations**	In addition to significant cost savings targets, the Model agreements also required reductions in readmissions and hospital acquired infections
4	**Aligned delivery reforms**	The hospital global budgets were coupled with other value-based programs, including a bundled payment program for episodic clinical care and an advanced primary care program similar to other CMMI models

Maryland Total Cost of Care Model – Assessment

1 MEASURED IMPACT

During the Maryland TCOC period, the model reduced:

- **Medicare fee-for-service spending by 2.1%**
- **Hospital admissions by 16.2%**
- **Disparities in several quality measures**

2 HOSPITAL CONCERNS

Despite the success on these measures, hospitals have raised concerns regarding:

- Suppressed margins
- Inability to recapitalize aging facilities
- Outmigration of certain clinical services to neighboring states
- Conflicting and complicated methodologies
- Lag in payments for volume changes

3 NEXT PHASE

Maryland officially started participation in the AHEAD Model in 2026 with all Maryland hospitals participating, including the Academic Medical Centers

Pennsylvania Rural Health Model – Overview

MODEL PURPOSE

CMMI developed the Pennsylvania Rural Health Model (PARHM) with the Commonwealth of Pennsylvania to maintain access to essential health care services in rural communities.

SIX-YEAR GOALS

The model aimed to achieve the following goals in rural Pennsylvania over six performance years (2019-2024)

- **Improve population health outcomes**
- **Increase access to high-quality care**
- **Strengthen the financial viability of rural acute care hospitals**
- **Reduce the growth of hospital expenditures across payers**

IMPLEMENTATION

Participation

18 hospitals participated, including both Critical Access Hospitals (CAH) and Prospective Payment System (PPS) hospitals

Transformation plan

Each hospital was required to develop a Hospital Transformation Plan, including goals and milestones, as part of participation

Pennsylvania Rural Health Model – Assessment

1	**Payment performance**	Overall, average global budget payments to PPS hospitals consistently exceeded the FFS value of services rendered.
2	**Predictability challenge**	Hospitals and commercial payers reported that the global budget's reconciliation process did not eliminate year-to-year financial unpredictability.
3	**Transformation barriers and response**	While participating hospitals appreciated the stable cash flow, they cited lack of allocated funds and concern about potential paybacks resulting from future reconciliations as barriers to investing in care transformation. Participating hospitals made incremental changes to improve the quality of care and population health.
4	**MODEL OUTCOME**	**The model has ended and was not renewed.**

4 Lessons Learned and Next Steps

Lessons Learned from Current Hospital Global Budget Participants

OPERATING MODEL

1. **Culture change**
   Don't underestimate the culture change needed to pivot from fee for service to global budgets, from the executive team to front line clinical staff

2. **Accountability shift**
   Global budgets aggressively move hospitals into greater accountability for total cost of care like an insurer but without any of the tools (benefit design, utilization management, network management)

3. **Investment horizon**
   Be mindful of the amount of investment needed to redesign the care delivery model from volume to value, and the time that it will take to achieve results

4. **Operating discipline**
   Set operational metrics early and hold people (investments) accountable for achieving them – or shut them down and pivot

CAPABILITIES & ECONOMICS

5. **Capability requirements**
   The skills to run a hospital are not necessarily the same ones necessary to build out an ambulatory infrastructure that manages patients across the continuum – new talent or capabilities may be needed

6. **State accountability**
   Hold the state accountable to maintain their role as a social services provider, and not look to the hospitals to fill that role simply because the payment model has changed

7. **Cost structure**
   Expense reduction is critical as volumes decrease – maintaining the existing cost structure will limit the ability to drive margin and reinvestment

Next Steps to Access Participation and Likelihood of Success

Financial Assessment

1. How will the global budget work for my hospital compared to fee for service?
2. If revenue is now capped, does my hospital have other revenue streams to supplement or potentially grow total revenue over time?
3. What additional investments might be needed?
4. What is the opportunity for expense reduction?

Operational Assessment

1. Are current programs structured to manage patients holistically or episodically?
2. What ambulatory infrastructure is in place (owned, affiliated or partnered) to manage patients across the care continuum and what may be needed?
3. Does the hospital have the subject matter expertise currently (internal or external) to assess participation and understand how to operate under a global budget?

Thank you.

INTELLIGENCE THAT WORKS

BRG