CMS-Designed Medicare FFS Hospital Global Budget Version 2.0 Office Hour

October 2, 2024

Kashay Webb, CMS:

Okay, we are going to go ahead and get started. Next slide, please, Amanda.

Thank you everyone for joining this session this afternoon. We want to start off with a few housekeeping items before we jump in. First, this event is being recorded and it'll be made available for viewing following the webinar. Closed captioning is available at the bottom of your screen, and for those of you who need additional audio options, we've included dial in information on this slide for you to do so.

This is an office hour session, so we encourage you to engage and feel free to ask questions throughout. You can submit your questions and comments in the Q&A box located at the bottom of your screen, and we'll keep an eye out for questions throughout this session.

And lastly, at the end of today's event, we kindly ask that you take a moment to complete a short survey. Your feedback is important to us, and it helps us to improve future sessions. Thank you again for your attention to these items.

Today's office hour will be led by both myself, Kashay Webb; I'm a health insurance specialist at the CMS Innovation Center working on the AHEAD Model along with Chris Crider, the Deputy Division Director of the Division of Multi-Payer Models at the Innovation Center.

So, to start with our agenda for today, this office hour is designed to provide an open forum for you to get your questions answered about the AHEAD Model CMS-Designed Medicare Fee-for-Service Hospital Global Budget methodology.

We'll begin with a timeline review, walking through key milestones and updates related to the global budget methodology, then we'll address previously submitted questions we've received ahead of today's session, and finally, we'll open the floor for a live Q&A where you can ask any additional questions in real time. And our goal today is to ensure that everyone leaves this session with a clearer understanding of the methodology.

So, we'll first begin by reviewing a timeline to better understand where we are and where we're going in the future.

This timeline gives a big picture view of where we are in the Model's process. The yellow star indicates our current stage. Applications for cohorts 1 and 2 were accepted in March, and in July we announced the four States participating: Vermont, Maryland, Connecticut, and Hawai'i. The final cohort of States will be announced in January of 2025.

Currently, we're still gathering feedback from stakeholders and working on additional revisions. The final version of the financial methodology will be available in early 2025, and we expect States to begin recruiting hospitals for participation in the Model soon, if they haven't already started, and we hope that this session will guide and help support those efforts.

Now we will move into some of the questions that were submitted in advance. Again, if you have any questions you'd like to submit now, you can start to use the Q&A function in Zoom to share it with us.

So, first question, will CMS normalize Skilled Nursing Facility and swing bed spending to avoid provider referrals based on local swing beds?

Our answer to that is that Skilled Nursing Facility beds are not included in the hospital global budgets and will be excluded from both the baseline and performance years. However, swing beds are included for critical access hospitals only and if you would like more details on this, we recommend referring to Section 2.0 of the AHEAD Model CMS-Designed Hospital Global Budget methodology.

I will turn it over to Chris for the next question.

Chris Crider, CMS:

Thank you, Kashay.

So, the next question we received was how closely aligned is the AHEAD Model to existing payment Models? And I think our assumption was that this specifically meant existing CMMI Models, and we developed the AHEAD Model to build upon lessons from our previous State-based Models in Vermont, Maryland, and Pennsylvania and really wanted to maximize the opportunity for providers on the ground to participate in the AHEAD Model, as well as other CMMI Models if applicable, and so overlaps are permitted with the intention of working synergistically across the goals of both programs to improve healthcare cost and quality outcomes.

And I think two examples that folks have submitted the most questions about are related to the Medicare Shared Savings Program and the newly announced Transforming Episode Accountability Model or the TEAM Model with AHEAD.

So, we just wanted to call out our vision for how these Models can all overlap with aligned goals. A hospital participating in both a global budget and an episode-based payment Model like TEAM could benefit from both Models unique cost savings opportunities. The goal of hospital global budgets is really to encourage improvements in population health, while episodes really focus on helping providers make improvements for a more narrow pool of patients associated with costly or clinical conditions or procedures.

So, overlaps are permitted between these two Models. For a fuller list of the overlaps that are permitted, we encourage you to visit the AHEAD website where we have the Overlaps Fact Sheet which has been updated as new Models have been announced since we first released the Fact Sheet. And, if my colleagues can maybe put the link to the AHEAD website in the chat. Both these slides are already posted to the website along as the references and the resources that we call out in our responses here.

So, I'll hand it over to Kashay for the next question.

Kashay Webb, CMS:

Thank you, Chris.

The next question is how can an organization maximize savings to reinvest in enhancing the health of its resident population? We first want to call attention here to the Upward Transformation Incentive Adjustment that will be available for the first two Model years, and it is intended to support enhanced care management. So that's one area. Also, hospitals may see increases in their hospital global budgets for improving quality of care with a focus on health equity.

We'd also like to point out that hospitals under the AHEAD Model and hospital global budgets can capture and reinvest savings from reducing avoidable hospital use or modifying their services and using those funds to improve population health and promote health equity.

Like Chris mentioned in the previous slide, the AHEAD Model does build on insights from other hospital global budget Models in Maryland and Pennsylvania, where hospitals and providers have collaborated to provide more coordinated, patient-centered care.

One notable example of this is hospitals in Maryland have reinvested savings from the Total Cost of Care Model into mobile crisis care, and that initiative is expected to significantly reduce the number of emergency department visits and inpatient admissions for individuals who are in need of behavioral health services. So just wanted to point out an example in action here. And of course, we recommend reviewing the hospital global budget Fact Sheet and the methodology for further details.

Turn it back to you, Chris.

Chris Crider, CMS:

How will CMS calculate hospital global budgets with shared CMS Certification numbers? Will CMS consider site specific global budgets?

Yes, we will calculate site specific global budgets as long as sites can be identified by their NPI. Site-specific global budgets will include the same calculations as other global budgets, except that the Annual Price Adjustment will use the IPPS and OPPS factors specific to that hospital's CCN.

Next slide and back over to Kashay.

Kashay Webb, CMS:

Next question is on dual eligible populations. How are dual eligible populations accounted for in hospital global budgets?

Medicare claims for dual eligible bennies will be included in hospital global budget calculations, and the reason being is that Medicare is the primary payer for individuals who have both Medicare and Medicaid coverage. But Medicare secondary payer bennies are excluded from these calculations since Medicare doesn't cover the full claim amount. We encourage States to leverage D-SNP plans to offer aligned hospital global budgets and Medicare Advantage for participating hospitals.

Next slide.

Chris Crider, CMS:

In the attribution method, how are members assigned to a hospital? Is it based on claims data, location, or other factors? Additionally, can CMMI provide input on managing extensive overlapping geographies? And what are the potential advantages and disadvantages of using attribution by person versus geography?

Beneficiaries are not attributed to hospitals under the Medicare hospital global budget. Instead, the Medicare global budgets are based on each hospital's historic revenue and adjustments, such as those for Demographic, Social Risk, and the Total Cost of Care Adjustments allocate the medical, social risk, and the spending to hospitals based on their share of revenue or beneficiaries from the geography served. This approach recognizes that hospital geographic areas often overlap and are proportional to the services provided by the hospital. And for more information you can see section 2.3.4 of the methodology on the website.

Next slide. Please.

Kashay Webb, CMS:

Next question is what is the process for negotiating TCOC targets? What are the expectations for low-cost states?

So, to answer the first question, the AHEAD Model includes statewide Total Cost of Care targets for which the State is accountable, but also, there is a hospital Total Cost of Care Performance Adjustment. So, CMS will negotiate the statewide targets with each State and include the final targets in each State's State Agreement. For low-cost States, the savings expectations are set to achieve budget neutrality. And, as for hospital TCOC targets, the current CMS design hospital global budget methodology uses a case match group of beneficiaries, and that differs from the approach used for statewide targets. So that's the current situation. But CMMI is considering

aligning the hospital targets with the statewide target methodology that's outlined in the State Agreement. So more to come on that soon

Next slide.

Chris Crider, CMS:

Will I know my global budget amount before I sign a contract?

Yes, hospitals will know the actual amount of their hospital global budget payment for the upcoming performance year before they are asked to sign a Participation Agreement to enter into the Model. We'll also provide an estimator tool in mid-2025 that will help hospitals understand how the methodology works and provide comparison to Medicare fee for services using their own data. For more information on how we will calculate global budgets, please see the hospital global budget methodology. And I think, just to add, you know, the estimator tool is expected mid-2025. The Participation Agreements need to be signed more toward the end of 2025. So, there'll be a couple of months there with the estimator tool, and then, with the final budget number before the Agreements need to be signed.

Next slide, please.

Kashay Webb, CMS:

Speaking of Participation Agreements, will CMS change the methodology during the course of the Model? If it does, am I able to drop out?

We would say here CMS is always open to stakeholder feedback to enhance the Model, and we consistently seek this feedback at several points in order to improve the Model. If there are ever any updates to the methodology, CMS will notify participants before the start of the performance year, and that gives hospitals the opportunity to decide whether or not to continue participating. But, just want to note that hospitals must adhere to the terms and conditions of the Participation Agreement Chris just mentioned for that performance year.

Next slide.

Chris Crider, CMS:

Cancer drugs are excluded, but other Part B drugs that can be quite variable are included. How will CMS account for a new drug that causes significantly higher than expected cost?

What we have seen in our Modeling is that the individual Part B drugs, apart from the cancer drugs, represent a very small percentage of global budget revenue and based on our analyses are less than one percent of the total global budget. But we do recognize that the technology is constantly changing, and there is a lot of uncertainty related to some of these new drugs and new technologies. So, in the event that there is the introduction of a new expensive drug, CMS may

apply an Exogenous Factor Adjustment and hospitals may request an adjustment based on an exogenous factor related to drug costs, or to other exogenous factors.

Next slide, please.

Kashay Webb, CMS:

Next question. There are a lot of hospitals in our hospital service area. How can we be held accountable for the cost of all the beneficiaries in our hospital service area? Does it matter if those hospitals are participating or not?

And our response here, just to remind how the TCOC Adjustment works, the TCOC performance is allocated to hospitals based on the proportion of services they provide in each geographic area, and that includes both participating and non-participating hospitals in the AHEAD Model, and the TCOC Adjustment incentivizes hospitals to proactively consider the health of their communities and to collaborate with community-based providers whenever possible.

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Chris Crider, CMS:

How will CMS set the hospital global budget baseline?

To construct the CMS-designed hospital global budget for participant hospitals, CMS will first calculate a participant hospital's hospital global budget baseline by combining the hospital's historical revenue from Medicare fee for service payments using the three most recent years prior to joining the AHEAD Model. So, if you start in Performance Year 1, or if a hospital chooses to start in performance year 3, it will always be that hospital's most recent year, and then we will weigh the historical revenue with the more recent years more heavily weighted. So, the most distant baseline year would be 10%, with the second baseline year at 30%, and the most recent at 60%. And the historical revenue paid by CMS outside of the fee for service framework, including non-claims-based payments, out of pocket payments are excluded from the global budget and will be paid separately to hospitals through whatever means they're paid. Currently, we will include in the baseline inpatient and outpatient paid amounts for which Medicare is the primary payer for that baseline year. Professional services that are rendered in a hospital setting are not included in the global budget, and again, will continue to be paid fee for services outside of the global budget.

The global budget specifications on the website include a detailed list of payments, both included and excluded from the global budget baseline and then annual payments.

We are evaluating potential ways to improve the baseline in version 3.0. So, we'll share updates as we have them, and of course, always welcome your feedback on this point in in the chat now, or through emails to the AHEAD mailbox.

Next slide. Please.

Kashay Webb, CMS:

Last question of our previously submitted questions, how will CMS adjust for changes in volume over time?

Changes in volume over time would be accounted for through the Market Shift Adjustment which you can see more details about in Section 2.2.3 of the hospital global budget methodology. But we do want to make a plug here that CMS is considering revisions to this adjustment for version 3.0, and we definitely welcome stakeholder input here.

Chris Crider, CMS:

All right. Thanks, Kashay. I don't know if we want to take the slides down at this point and go to the questions that have been coming in through the chat. I will take the first one.

The question is, can CMMI please explain how they will adjust global budgets for differences in prices or policy for payments that are made between October and the end of the performance year? In the specifications document CMS indicates they will adjust global budgets to account for the portion of the performance year that is subject to the next fiscal year's payment adjustment. How does CMMI propose to do this?

So, if you look at page 28 of the specs, we detail the approach here. The update will be used to calculate the next performance year's hospital global budget and to calculate an adjustment to the current performance year's global budget to account for updated prices applicable between October and January of the current performance year. So, what this amounts to is a one-time payment at the beginning of the next performance year to account for the updated prices.

Kashay Webb, CMS:

The next question we have in the chat. In the annual trend Update CMS accounts for uncompensated care payments when calculating estimated Medicare payments. Estimated Medicare payments are then divided by case mix to calculate the case adjusted rate. However, uncompensated care payments are not adjusted for case mix like other IPPS payment adjustments. Should uncompensated care payments be included after adjusting for case mix?

We think this is a wonderful question, and we will take this into consideration as we're making revisions to the methodology.

Chris Crider, CMS:

Next question. Currently, CMS is basing outlier payments on the Outlier Adjustment factor published in the IPPS impact file. Our understanding is that this outlier factor is meant to be multiplied by base operating payments which are not adjusted for DSH, IME, or UCC, to derive annual estimated outlier payments. However, in the annual trend update, CMS multiplies the outlier factor by base operating payments and these other adjustments. These other adjustments

are relevant claim level. But is it appropriate to include them when estimating annual payments using the Outlier Adjustment factor from the IPPS impact file?

So again, this is another example of an excellent question that we appreciate you raising, and we'll take it into consideration as we continue to refine [inaudible].

Kashay Webb, CMS:

The next question we have in the chat is, can the annual payment update factor be negative?

It's possible for it to be negative. But we do just want to note that CMMI intends to apply a floor for DSH and UCC. And any decreases in prices would also apply to non-participating hospitals in IPPS.

Chris Crider, CMS:

All right.

Kashay, can I ask you to take the next question as I am trying to work on my audio? Thank you.

Kashay Webb, CMS:

Absolutely. The next question is when calculating the Demographic Adjustment, will CMMI use the initial or midyear Model software ICD-10 mappings to calculate the HCC score?

So here I would say that CMMI will evaluate changes to the HCC Model on an ongoing basis.

Chris Crider, CMS:

All right. Thank you, Kashay. I think I am back. The next question, does CMS plan to risk adjust the measure of readmissions used in the Effectiveness Adjustment?

So, as we currently outline in the specifications, the Risk Adjustment would not be applied to the effectiveness adjustment.

Kashay Webb, CMS:

And we have a similar question, does CMS plan to risk adjust the AHRQ patient quality indicators used in the Effectiveness Adjustment?

And, as described in the specifications, Risk Adjustment would not be applied to the EA.

Chris Crider, CMS:

Thank you. I am going to repeat the question that got cut out earlier and the answer just so we can ensure everyone heard it.

So, the question was about outlier payments and the Outlier Adjustment published in the IPPS impact file. It is this, this individual's understanding that the outlier factor is meant to be

multiplied by base operating payments which are not adjusted based on DSH, IME, or UCC to derive annual estimated outlier payments, however, in the annual trend update, CMS is multiplying the outlier factor by base operating payments and these other adjustments. And these other adjustments are relevant for the outlier calculation at the claim level. But the question here is whether or not it's appropriate to include them when estimating annual payments using the Outlier Adjustment factor from the IPPS impact file.

And so, we will certainly take this into consideration as we make our 3.0 updates. I think this is an excellent question, and a great example of how much we appreciate and rely on this partnership, and the feedback we get from all of you. So, thank you again for your very thorough read of the specifications and participation in this forum.

Kashay Webb, CMS:

Next question is around antineoplastic drugs. The question is CMMI intends to exclude antineoplastic drugs from the global budget baseline amounts and has indicated in prior communications that they will identify these drugs in the claim record based on the NDC on the claim and the therapeutic class of that NDC. My understanding is that NDCs do not directly map to therapeutic classes. Can CMMI please provide a detailed description of their methodology for identifying antineoplastic drugs? Will CMMI map to RxNorm concept unique identifier and then to therapeutic class? Lastly, has CMMI considered publishing a list of excluded NDCs as was done in prior Models that required identification of chemotherapy drugs?

So, we are mapping NDCs using a reference table provided by Metaspan that identifies specific therapeutic drug classifications, using the first and second subsets of the 14-character general product identifier or GPI and CMMI is investigating releasing the Metaspan crosswalk that would crosswalk those drugs.

Chris Crider, CMS:

The next question we have from the chat: are outpatient new technology APCs excluded from the global budget as opposed to new technology add-on payments in the IPPS?

Yes, new technology payments are excluded, and this is outlined in Appendix D of the financial specifications.

Kashay Webb, CMS:

Next question, is there a timeframe for when cohort 3 hospitals need to make a participation decision?

Hospitals in AHEAD States will need to sign participation agreements with CMS no later than October 1st of the year prior to the first performance year. So that would be the timeframe.

Chris Crider, CMS:

But hospitals may join the Model in any performance year. We do need a minimum of 10% of the Medicare net patient revenue in the Model for the first performance year. But hospitals have the option to sign a PA by October 1st in advance of every performance year.

The Transformation Incentive Adjustment is only available to hospitals who join in the first two years.

Kashay Webb, CMS:

We did have a question of if the questions and answers will be posted.

Yes, we will post an FAQ following the webinar that you can view on the AHEAD Model website.

Chris Crider, CMS:

We do not have any additional questions in the chat at this time.

I think we are happy to stay on. If folks have additional questions or if folks want to drop off, I think that that is fine too, happy to take follow up on anything, but if folks want to ponder the information that has already been shared but we're happy to hang out for a bit longer to see if anything else comes in

And as we're waiting to see if there are additional questions again, just want to take the opportunity to thank folks for your interest in the AHEAD Model and for your partnership as we continue to refine our hospital global budget methodology and specifications. We really do value your input and your time and your expertise on this and are really helpful to build a methodology that is transparent and fair, and supports the goals of the Model, and that will work for hospitals in our participating States to really transform care delivery and have a positive impact on the healthcare of the state and on individual beneficiaries.

I do see an additional question in the chat about outlining additional changes being considered for 3.0. That has been outlined on the previous hospital global budget webinar and in the hospital global budget specifications. I think we can send you a link to the slides from our last hospital global budget webinar which very succinctly summarizes what those changes are that we're considering at this time. And I don't think there's a hard and fast deadline. We do anticipate releasing the next iteration of the specifications in early 2025. So, I would say, probably by the end of the year in order for us to realistically consider or incorporate them into that next iteration.

Alright, feel free to continue to add questions into the chat. But if we could go to the next slide, please, before folks sign out. Just want to again thank you for your time. We do have a survey that we would really appreciate if folks can take the time to respond to so that we can work to continually improve our events and provide you all with the information you need to make a decision about participating in the Model.

So, thank you all. And again, we'll hang out here for another couple of minutes if additional questions come in.

I see the numbers dropping off quickly. So, I think if we get back down below maybe 50 participants then we can safely assume that most folks are jumping off and no more questions are coming in.

We do have links to additional resources that are on our website that have been referred to throughout the presentation listed on the slide here and again all of the hyperlinks are included on the slides which are on the website as well. So really, all you need is that link that we put in the chat to the AHEAD Model web page earlier on the presentation.

Alright. I think it's safe to assume that we have addressed all questions that folks have at this point in time, but of course, always welcome additional comments and questions, either via the survey or to our AHEAD inbox ahead@cms.hhs.gov. Thanks again everyone for your time and wish you a wonderful rest of your Wednesday.

Have a great day bye, bye.