AHEAD CMS-Designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) Methodology Overview Version 3.0 Webinar

April 8, 2025

Maria Abrica-Gomez, CMS:

Good afternoon, everyone, welcome to the AHEAD Medicare Fee-for-Service Hospital Global Budget Methodology Version 3.0 Webinar.

I see a lot of folks joining in. Thank you for being here. We're thrilled that some of you decided to join us again after previously joining us in the past Version 1 and 2 methodology overview webinars and are equally thrilled that some of you are joining us, perhaps, for the first time to hear the latest and greatest on the updated methodology.

With that we're going to get started.

Before we get started, we wanted to cover a few housekeeping items. First and foremost, today's webinar is being recorded, you will find closed captioning available at the bottom of your screen. If at any point during the webinar you have any questions or comments, please submit them using the Q&A box on the bottom of your screen. We will answer as many questions as we're able to during our time together.

Lastly, please complete a survey at the end of the webinar, as your feedback will help us understand how we did and what we can do better next time.

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By way of introduction, my name is Maria Abrica-Gomez, and I am a Senior Policy Advisor for the AHEAD Model. I'll be one of your presenters today. Also presenting today is Abid Khan, a Senior Policy Advisor for the AHEAD Model, and Mattan Alalouf, a Health Insurance Specialist for the AHEAD Model.

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In today's webinar we plan to provide a quick overview of the AHEAD Model, walk you through the Version 3.0 methodology, including enhancements made from previous Versions, and leave some time for Q&A at the end.

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So, with that, let's dive right in into the AHEAD Model overview. Next slide, please.

At a high level, the AHEAD Model is a voluntary Model. It's a voluntary State-led total cost of care model that seeks to drive healthcare transformation within a state or sub-state region. The Model is designed to be a flexible framework for participating States to take on accountability for total cost of care, increased primary care investment, and population health improvements.

As part of the model, States will utilize a set of tools to meet the set targets over the course of the eight or nine Performance Years. This includes cooperative agreement funding from CMS to invest

in infrastructure and primary care, Hospital Global Budgets for hospitals, which is the focus of this webinar, and Primary Care AHEAD for primary care practices.

These components are designed to rebalance healthcare spending across the system, encourage collaboration to improve prevention and community-based care and create an ecosystem where states, payers, and providers align, including in payments.

More information about the model can be found at the CMMI AHEAD website.

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Participation in the AHEAD Model is voluntary for eligible hospitals interested in the CMS Medicare Fee-for-Service Hospital Global Budget.

Most hospitals are eligible to participate, as you can see here on the slide. This includes Acute Care Hospitals, Critical Access Hospitals, and several other special designation hospitals.

Most specialty care hospitals are not eligible to participate, and this includes cancer, children, and psychiatric treatment facilities.

The good news is that eligible hospitals interested in participating in the CMS Medicare Fee-for-Service Hospital Global Budgets can do so by simply signing a Participation Agreement with CMS. So, no application is required.

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This slide highlights some of the upcoming milestones that we wanted to briefly cover. The first is for Medicare Fee-for-Service Hospital Global Budgets, CMS does revise and finalize the payment methodology with the latest Version being the subject of today's webinar. We anticipate making the revised methodology publicly available in the coming weeks.

Next month CMS also plans to release the complementary Medicare Fee-for-Service Hospital Global Budget Calculator Tool, which essentially is a plug and play calculator that allows the end user to enter hospital specific data values in certain fields to demonstrate how the payment is calculated.

Prior to the first Performance Year, CMS also provides hospitals with a number of Medicare Fee-for-Service Hospital Global Budget calculations, and this includes simulations estimating what Hospital Global Budget payments would have been for prior years, using historic data and estimated payments for the first Performance Year 1.

In the coming months we also anticipate hosting additional live sessions for the AHEAD states and hospitals to demo the Calculator Tool and continue to answer methodology questions.

As a reminder, just want to highlight this again, hospitals interested in participating in the CMS Medicare Fee-for-Service Hospital Global Budgets will need to sign a Participation Agreement with CMS the October prior to the first Performance Year.

Next slide, please.

Before we dive into the Medicare Fee-for-Service Hospital Global Budget Methodology, we wanted to revisit what a Hospital Global Budget is and the value proposition of it.

At a high level, a Hospital Global Budget is a prospective annual budget for hospital inpatient and outpatient facility services based on historical revenue. There are key benefits to Hospital Global Budgets as an alternative to Fee-for-Service, including providing participating hospitals with increased payment, predictability, and sustainability as this predetermined budget helps hospitals better predict costs focus on long-term strategies.

Strong financial incentives that give hospitals more upside, potential relative to Fee-for-Service or cost-based reimbursement, and the opportunity to reinvest revenue from reduced avoidable utilization.

Ultimately, Hospital Global Budgets create a win-win-win scenario for patients, hospitals, and payers by aligning financial and clinical incentives without disruption to hospital capacity.

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This slide summarizes four key steps taken to calculate the CMS Medicare Fee-for-Service Hospital Global Budget payments which CMS pays in lieu of traditional Fee-for-Service claims or cost-based reimbursement on a bi-weekly basis.

The first step is the Baseline Calculation to determine the starting point before adjustments are applied.

The second step is the Volume-Based Adjustments to account for changes in revenue due to shifts in patient volume, service lines, and to manage risk around outliers.

The third is Annual Adjustments that apply similar Pricing and Demographic Adjustments to Fee-for-Service.

And finally, the fourth step is the AHEAD-Specific Adjustments which provide upfront investment revenue, account for social risk, and reward quality improvements and reductions in avoidable costs.

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This table summarizes each type of adjustment applied to Medicare Fee-for-Service Hospital Global Budget baselines within each calculation step over the course of the Model performance period.

The takeaway is that in any given Performance Year, participating hospitals can expect more upside than they do downside adjustments. By design, the payment methodology offers more financial rewards than it does penalties, and provides additional flexibilities to Safety Net Hospitals, including Critical Access Hospitals. We will highlight these flexibilities throughout the presentation.

Now to walk you through the initial steps of the calculation methodology, I'll pass it over to my colleague Abid Khan.

Thank you.

Abid Khan, CMS:

Good afternoon, everyone.

Maria Abrica-Gomez, CMS:

Hi Abid. We can hear you. Would you mind turning on your video as well?

Abid Khan, CMS:

I cannot. I have a message saying the host has stopped it and needs to activate it.

Maria Abrica-Gomez, CMS:

Oh, okay. No. Problem.

Abid Khan, CMS:

All right. In the meantime, I will get going.

I'm going to start by diving into more detail on the construction of an AHEAD Hospital Global Budget which I'll be referring to as an HGB from here on out, because it's less of a mouthful.

Please note that you can find more detailed information on all of these calculations on the model website and in the Financial Specifications. The presentation also contains an appendix at the end of the slides, which includes more information on the enhancements we've made for Version 3. So be on the lookout for these materials to be posted on the website over the next few weeks.

Now let's take a look at the Baseline Calculation. Next slide, please.

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So, to calculate the HGB, you need a starting point. For Performance Year 1, the starting point is based on three years of prior data, and this includes all inpatient and outpatient paid amounts regardless of beneficiary residence starting three and a half years before Performance Year 1, which I'm going to use interchangeably with PY, and running up to six months before the start of PY 1. This is intended to allow for four months of claims run out, and then some additional time for calculation and implementation of payments.

The most recent year, as you can see in this figure over here, is weighted more heavily at 60%, goes down to 30% for the year before that, and 10% the year prior to that. This way the HGB reflects current trends, which are most likely to be the best predictions for the budget, and it also adjusts for fluctuations in prior years as opposed to a single-year Baseline.

I just want to point out if you look at the bottom right corner of the slide, and you'll see this popping up throughout the presentation, there is a yellow triangle icon with the circle around it, and this indicates an enhancement to Version 3 Methodology based on stakeholder feedback, which we really value, and we actually use to fine tune the Methodology because this is a partnership. So, wherever you see that if you're familiar with the Version 2 Methodology, this is an update.

Also in Version 3, we made another enhancement so that in addition to the three years of baseline data, we also apply an additional adjustment using an advanced logistic regression model that predicts if the projected baseline for a given hospital is likely to be overestimated or underestimated

and corrects for that at the State and the individual hospital level to maximize the accuracy and reliability of the predictions.

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Just as a note to that, for Critical Access Hospitals, the methodology is a little bit different, and of course the baseline is based on 101% of Fee-for-Service and then they're projected forward as Hospital Global Budgets.

Now, we're going to move on to the Volume-Based Adjustments which account for changes in revenue based on shifts in either patient volume, changes in service lines, or to manage risk around high-cost encounters or encounters that use high degree of resources. So, outliers.

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First up we have the Market Shift Adjustment, or the MSA. This begins in Performance Year 2, and accounts for year-over-year shifts in volume and complexity of care between eligible hospitals. Note that it is not limited to participating hospitals, but any eligible hospital.

So, if volume moves from an Acute Care Hospital A that's operating under traditional Fee-for-Service to a neighboring hospital B, which is under an AHEAD Hospital Global Budget, this shift will still account for additional volume and will cause the HGB at Hospital B to grow in the subsequent years.

As a hospital's relative volume and complexity grows, its HGB grows.

So, the MSA takes place, basically in three steps. The first step for each participating hospital is to define the hospital specific market area. The next step is to calculate the relative shift in Fee-for-Service payments and case weights which helped fully account for complexity of care for that hospital in its market area. As you can see in the blue, green sort of aquamarine box, the Fee-for-Service payments and case weights are equally weighted in the calculation, so they're half and half and they tend to run together regardless. But this process provides additional safeguards. They're calculated based on no pay claims and total Fee-for-Service equivalents for eligible hospitals in the geographic area.

Now, looking at the two yellow enhancement triangles, here are some Version 3 improvements. The market area is calculated at the zip code level instead of the county level, so, this increases accuracy. The MSA is also adjusted using the State Growth Benchmark, so that's how much the combined spending in the area grows from year to year, and an 80% funding factor. So, 80% of the total spend is proportionally allocated to participant hospitals based on MSA calculations. The goal is to balance appropriate allocation with payment stability, protecting hospitals from oversized year-to-year fluctuations.

Another enhancement is that for small hospitals, and this is defined by those with less than 2% market share in the AHEAD region, either statewide or a substate region, CMS will apply a 0% floor to the MSA. This means they only see upward adjustments protecting them from any downward adjustments relative to their market shift because of their small size and year on year fluctuations.

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Next, we have the Service Line Adjustment or the SLA. The aim here is to make prospective adjustments to the HGB that reflect known future changes in hospital service lines. So, it adjusts funding to better align payments with operational and service line changes. All SLAs require CMS approval.

Note that this requires that participant hospitals proactively share their intent to modify a service line and get approval from their State.

A service line addition increases the hospital's HGB. And if a service line reduction is approved, the hospital can then retain a portion of the revenue that was removed from the HGB.

As you can see in some of the details on the slide, the amount is half of the revenue associated with that volume. So, for an Acute Care Hospital, 50% of that revenue can be reinvested as long as it is reinvested towards population health activities that align with Model goals. Now, there's an exception for Critical Access Hospitals in the Model. In the case of a service line reduction from a Critical Access Hospital, it may request to reinvest up to 100% of that revenue into Model aligned population health goals.

These shifts really enable hospitals to generate reinvestment revenue based on the difference between historical revenue and current costs from lower utilization in response to the reduced demand during Performance Years.

The estimated SLA amount is reconciled to Fee-for-Service for two years and then projected forward as an HGB for the rest of the performance. So, this is important, regardless of the estimate of the service line shift, no pay claims will be used to assess exactly the amount of increase or decrease in services, and after two years, we gather there has been sufficient data collected to project accurately through the future.

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And finally, we have the Outlier Adjustment, which, as you can see from the yellow triangle, is a newly added adjustment to mitigate the financial risk associated with encounters that are unusually expensive and resource intensive. We've removed outlier components from the Annual Payment Adjustment, the APA, and made it a separate adjustment to increase accuracy and transparency.

We now calculate the amounts based on claims instead of estimates, essentially adjusting HGBs by the change in share Fee-for-Service outliers. So, what proportion of no pay claims would have been outliers, and how much has that shifted from the baseline share? We adjust the HGB by that amount starting in Performance Year 3. This is because we use data from the early PYs to estimate this adjustment. So that's why it begins in PY3.

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Next, we're going to move on to Pricing and Demographic Adjustments which ensure parity with Fee-for-Service.

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The Annual Payment Adjustment, or APA. The aim here is to ensure that the HGB reflects changes in Fee-for-Service prices and policies ranging from operating and capital base rates to Fee-for-Service payment factors and patient population complexity. Generally, we anticipate the APA will

be a positive adjustment up to about 2% annually, as you can see from that circle and arrow on the top right of the slide, or however much CMS changes the IPPS and OPPS prices in the future.

The APA differs from other adjustments in the Global Budget that account for acuity and volume. It instead reflects the specific Fee-for-Service payment factors, such as wage indexes for each participant hospital and adjust baseline and Performance Year amounts accordingly. It denotes the percentage change in a weighted average of Medicare pricing factors specific to each hospital.

So, at the bottom of the slide against the white background, you can see a number of these factors listed, including market basket, DSH, IME, and Uncompensated Care. CMS quality programs, and more. The point is to match what would be calculated for a prospective payment system for a single DRG leading to better parity with Medicare Fee-for-Service.

I also want to emphasize that within the prospective payment system, hospital quality adjustments are included to align with existing CMS programs for PPS hospitals. However, we address this differently for CAHs. Critical Access Hospital quality adjustments are considered AHEAD-specific. So, we're going to be sharing more information about those adjustments later in this presentation. But just leave sort of the quality component out of the APA when it comes to those Critical Access Hospitals. So, when we refer to the quality programs, that PPS hospitals only.

Finally, to ensure payments won't be lower under Fee-for-Service, including settlements performed by the max, CMS applies a floor to the disproportionate share hospital and uncompensated care factors. So, there's an additional safeguard there. Generally, we anticipate the APA will be a positive adjustment of about 2%.

I also want to call out hospital quality programs as part of the APA. Non-CAH participating hospitals will continue to participate and perform in these quality programs.

And now we will move on to the next slide and the Demographic Adjustment.

The Demographic Adjustment, or the DA, is designed to adjust HGBs for changes in both the size and medical risk using HCC scores of the population attributed to each participating hospital. And it's calculated every year. So, this accounts for changes in service utilization, the number of patients and the risk profile of the population over time.

Keep in mind that the Demographic Adjustment accounts for more medically complex population as the population ages for new beneficiaries that qualify for Medicare coverage, for existing beneficiaries whose care becomes more medically complex over time, and also for the proportion of beneficiaries enrolled in Medicare Advantage and how that changes over time. Basically, if the acuity or size of a prospective payment system hospital's patient population increases, the Demographic Adjustment increases the hospital's HGB.

Next slide, please. And with that I will turn it over to my colleague, Mattan Alalouf.

Mattan Alalouf, CMS:

Thank you, Abid, and hello, everyone.

Next, we will cover the AHEAD-Specific Adjustments which update the baseline amount to reward hospitals that participate in the Model early to account for baseline difference in social risk of population served, and to reward improvements in quality and reductions in avoidable cost.

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The first of the AHEAD-Specific Adjustments is the Transformation Incentive Adjustment. This is an automatic 1% increase to the Hospital Global Budget that takes place in the first two performance periods, after all of the other adjustments, including the ones that Abid discussed and some of the ones that will come next have been calculated.

There's two key incentives to emphasize or goals of the Transformation Incentive Adjustment. The first is to support hospitals as they make the transition from a Fee-for-Service system to a Global Budget system, to have the opportunity to use those resources to invest in the care transformation that's necessary to be successful under a Global Budgets framework. And the second is to encourage hospitals to participate in the model early. So just to emphasize that again, the Transformation Incentive Adjustment is available in the first two Performance Years of the Model for each State rather than the first two years that a hospital is participating in the model. And so, we hope that encourages hospitals to get in as the AHEAD Model starts.

We'll also flag here that the TIA does not need to be repaid to CMS for hospitals that exit the Model unless they exit before the sixth year.

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So, the next AHEAD-Specific Adjustment is another upside only adjustment. It's the Social Risk Adjustment which is intended to provide additional support to hospitals that care for beneficiaries with the highest social risk among hospitals in AHEAD states. So, it can be up to two percentage points. It depends on the social risk of the market area that the hospital serves and social risk here, and this phrase will come up again throughout some of the subsequent slides, is defined through the beneficiary Social Risk Score. You can see the formula on the slide here. That is a combination of the Community Deprivation Index, a low-income marker that's a combination of dual eligibility status for beneficiaries that live in the hospitals market area and a Part D low-income status for beneficiaries in that same area.

The Social Risk Adjustment is scaled depending on where the hospital falls in that Social Risk Score against other hospitals in the State. So, you can see the formula there on the right-hand side. For hospitals in the top 10% of Social Risk Score in the State, they get a 2% increase for their Global Budgets. Hospitals that serve relatively lower social risk beneficiaries compared to other hospitals in the State don't see any adjustment to their Global Budgets as part of the social risk adjustment at all.

The Social Risk Scores, we expect that hospitals are going to be taking initiatives and activities in their communities that might support patients and potentially reduce their social risk, ideally reduce their social risk over the course of the Model. But we don't want to disincentivize that sort of activity and so the Social Risk Score that's used in the determination of the Social Risk Adjustment is not allowed to go any lower than the value that it takes in the first Performance Year of the Model.

And the Social Risk Scores are going to be calculated by CMMI, and they'll be provided to hospitals to provide information about what this adjustment will look like for each hospital ahead of the Performance Year.

The Social Risk Score has a couple of refinements compared to the Version, 2.0 of the Specs. The key ones are moving from the Area Deprivation Index to the Community Deprivation Index that you see here on the slides. And that's to de-emphasize the role of housing costs just in the sense that we can avoid situations where beneficiaries who otherwise are high social risk might look lower social risk because they live in an area with high housing costs.

And then the other enhancement is this move to comparing hospitals against the Social Risk Score only of hospitals in the same AHEAD state. We want to ensure that we're targeting and improving experiences for the highest social risk beneficiaries in each state that AHEAD operates in,

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So, the third, oh, thank you. So, the third adjustment here is the Community Improvement Bonus. This is also an upside only adjustment, similar to the Social Risk Adjustment, and it is paired with the existing quality payments that Abid touched on that are currently part of the Fee-for-Service methodology and maintained in AHEAD through the APA. Those target maintaining levels of quality for the beneficiaries that a hospital serves, the Community Improvement Bonus pairs with those by incentivizing hospitals to generate improvements in quality measures. And so, the key quality measures that make up the Community Improvement Bonus are the Hybrid Hospital-Wide Readmission Rate and the Prevention Quality Indicator Rate for PQI-90.

Hospitals will be evaluated on their improvement relative to baseline in each of those indicators, and that improvement will be multiplied by a Social Risk Score multiplier. So that's using that same Social Risk Score formula that we saw earlier a couple of slides ago, hospitals with higher social risk, as you can see in the panel on the right-hand side of this slide, will have even more incentives and have even more opportunities to receive increases to their Global Budgets as a result of improving performance on these indicators.

The Community Improvement Bonus has also had a couple of enhancements, including using all beneficiaries who are admitted to hospitals to calculate these indicators to improve sample size and move over from the PQI- 92 measure to the PQI-90 measure.

We want to emphasize for both the Community Improvement Bonus and the Social Risk Adjustment that these upside opportunities, these adjustments to the Hospital Global Budgets don't necessarily have an analog in the Fee-for-Service system. These are adjustments that are specific to Hospital Global Budgets.

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The Effectiveness Adjustment is in place to incentivize hospitals to implement interventions that can reduce expenditures and utilization associated with unnecessary or avoidable care which we'll be calling throughout this slide potentially avoidable utilization or PAU.

Hospitals that have relatively lower PAU compared to other hospitals in the State have the opportunity to experience a smaller downward adjustment from the Effectiveness Adjustment. So, the Effectiveness Adjustment over the lifetime of the Model can take a maximum value of a 2% reduction to Hospital Global Budgets. But any hospital in the 20th percentile or below of the PAU measure doesn't receive any adjustment to their Global Budgets from this at all.

The Effectiveness Adjustment doesn't kick in right at the beginning of the Model, as hospitals have time to adapt to the Global Budget environment. It starts in the second Performance Year for Acute

Care Hospitals, and then, a year later for Safety Net Hospitals and CAHs and the magnitude of the maximum potential adjustment starts lower than that 2% and only rises to that 2% over the course of the Model.

So, we want to emphasize that hospitals that are successfully able to use the Hospital Global Budget framework to target and reduce potentially avoidable utilization benefit both from the reduction in that Effectiveness Adjustment, but also just from the structure of the way that Hospital Global Budgets work are able to retain and reinvest the revenue from care that would have been potentially avoidable and reinvest that into other population health services.

The Effectiveness Adjustment looks pretty similar to the way it looked in the Version 2.0 of the Specs, but we have updated the definition of potentially avoidable utilization that we use to determine where a hospital falls by removing Low Value Care Measure and the NYU Avoidable ED Measure from the PAU definition and adding in NCQA's Emergency Department Utilization Measure. In addition, in the latest Version of the Specs, the PAU is adjusted by the Social Risk Score again, the same formula that we saw on the Social Risk Adjustment before determining where hospitals fall among all hospitals in the State.

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The next adjustment is the first one of the AHEAD-Specific Adjustments that could go either up or down. That's the Total Cost of Care, or TCOC, Performance Adjustment. So, this is intended to provide hospitals, not just with the incentive that is naturally occurring through Global Budgets to manage population health outcomes and costs for care that's happening inside the hospital, but also to manage those health outcomes and costs for patients in their entire experience, in their total cost of care.

The maximum value of this adjustment is 2% in either direction. And the way that it's determined is that CMS will calculate a baseline value of total cost of care benchmark that would be provided to each hospital, based on the beneficiaries that live in their market area, and total cost of care will be evaluated over the performance here, and the final level of actual total cost of care that's experienced would be compared to that benchmark to determine whether a hospital has an upward or downward adjustment to their Global Budgets and how much that adjustment is. The benchmark that we provide is static, but we expect natural fluctuations in total cost of care for the beneficiaries that are served by each hospital. And so, one of the enhancements that we've made between Version 2.0 and Version 3.0 of the specification is to allow for performance corridor, where no adjustments are made for deviations between the benchmark and actual total cost of care of up to 2%.

Hospitals' baselines, which are determined at the beginning of the performance period, are grown forward at a trend factor. This is also an enhancement from Version 3.0 that matches the trend factor that we use for setting state total cost of care targets, and the goal in this enhancement is really to make sure that states and hospitals are moving toward the same goals, because we expect the States and the hospitals to be partners in all aspects of the AHEAD Model. We want to avoid situations where they're targeting different outcomes for the patients that they serve.

The Total Cost of Care Adjustment has a delayed start, as we hope and expect that hospitals will be able to take the first few years of the Model to adapt to the incentives and the structure of Hospital Global Budget payments and hopefully build out some of those relationships with community-based organizer or community-based organizations, primary care practices and other providers in the area to sort of have that relationship that allows hospitals to manage total cost of care.

So, the first year that the Total Cost of Care Adjustment kicks in is in the fourth Performance Year, and in that year it's an upside only adjustment so that hospitals have the opportunity to experience how the Total Cost of Care Adjustment plays out without having to worry about that downside risk in the first year.

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The Total Cost of Care Adjustment is one of the more technical adjustments in the Global Budgets methodology so we just want to take an opportunity here to give an example of what this might look like in practice. So, let's suppose that we're already in one of the Performance Years where the Total Cost of Care Adjustment applies and to do the calculations, we need to know both where we're starting and where we're going. So, in the first performance here, the baseline year relative to the Performance Year we're going into, the per beneficiary per month total cost of care for this hospital that CMS had provided as a target was $1,000. Then the state growth rate that's also used to determine what the State's total cost of care target will be statewide is 4%. So, if we apply that to the baseline, then the target during the current Performance Year is $1,040. When the year happens, we evaluate what actual per beneficiary per month total cost of care was for beneficiaries served by this example hospital, and it turns out to be $1,015, and so to determine what the Total Cost of Care Performance Adjustment will be, we calculate, the percentage difference between the target of $1,040 and the experience of $1,015. We can see the calculations on the right-hand side. So, without going into too many details and just reading those off the screen that translates to outperforming the total cost of care target by 2.5%. And we had flagged that 2% deviations from total cost of care are allowed in that performance corridor. But this 2.5% is outside of that 2% range and that means that the total cost of care adjustment will apply in this example.

So, you can see the formula that's used to translate the total cost of care performance to the Performance Adjustment, and the resulting adjustment is an increase to the Hospital Global Budget for this example of 0.5% to essentially reward the hospital for achieving lower total cost of care than CMS would have predicted using the combination of the baseline and that state growth target.

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The last of the AHEAD-Specific Adjustment is the CAH Quality Adjustment, and this is again paired with what we see as key goals of the Model to integrate quality into every aspect of the methodology. The Annual Performance Adjustment that Abid talked about earlier in the presentation means that the quality programs that already exist under Fee-for-Service continue to apply to those PPS hospitals. We want to make sure that CAHs also have the opportunity to receive adjustments and particularly upside only adjustments for quality performance. And so, we've designed this using rural relevant quality measures to do so specifically for CAHs.

So, the way that the CAH Quality Adjustment works is it starts out as paper reporting in the first 4 Performance Years of the Model, and then slowly transitions over to paper performance.

The CAHs will be required to receive that upward adjustment to report at least one measure from the key measure domains listed the 3 key measure domains listed on the slide here. So those are healthcare quality and utilization, patient safety, and patient experience.

The performance for these metrics would be typically based on National CAH Benchmarks where possible, and in some cases on call historic performance improvement.

We see on the table in the bottom of this slide what the timeline looks like for shifting for pay for reporting to pay for performance for an example that's operating in a cohort one state. So the opportunity to earn that 2% upward adjustment for reporting only kicks in immediately at the beginning of the performance period in 2026 in this example, and continues to be only pay for reporting through 2029, at which point the adjustment doesn't just switch to being pay for performance, but pay for performance incentives slowly fade in while the pay for reporting incentives fade out, and only in the last year of the model is the CAH Quality Adjustment tied only to performance.

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And please excuse me, that concludes our review of the Hospital Global Budget Methodology. As we mentioned, CMS will post the slides on the AHEAD website for reference. There are appendix slides that we won't have a chance to review today, but those provide additional in-depth information on the methodology changes from Version 2 to Version 3, and we encourage you to review those appendix slides as well as you take a look back through the slides when we have a chance to post them on the website

Before we switch over to the question-and-answer portion of the webinar, we want to thank everyone for attending today. CMS welcomes feedback and input to continue to enhance the financial methodology. Please submit any suggestions or questions to the AHEAD Model team. You can email them to us at AHEAD@CMS.hhs.gov.

Next slide, please.

So now we're going to turn over to questions and answers. We have a few prepared questions that we'll be going through before we move over to some of the questions that you've been submitting in the chat. But please continue to use the Q&A function in Zoom to share your questions.

We're working to queue up those questions and getting answers ready for you. Also keep sending those in, and we are going to turn over now to our frequently asked questions and get to as many of your questions as we can.

Next slide, please.

The first of the frequently asked questions that we want to present here are what strategies can hospitals use to support success under the Model?

So, success under the Model looks like reducing hospital utilization where possible, by proactively managing population health and hopefully getting upstream to translate to less care that needs to take place in the hospital but also shifting care to lower acuity settings. So, for those patients who are already at the stage where they need hospital care. For example, hospitals can move ED care to urgent care centers, enhance hospital to post-acute care discharge planning, and ideally reduce inpatient length of stay.

We have sort of alluded to this throughout the adjustments. But ideally, all of these sorts of activities will require collaboration across healthcare systems and community program developing partnerships with other physicians in the community, social service providers and community-based organizations. And we understand, of course, that every hospital strategy will depend on that hospital's environment and the population that you serve.

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Another question that we've received frequently is Version 3.0 of the Fee-for-Service Hospital Global Budget Specifications considered final, or do we still expect more changes?

So at the moment, we don't expect more enhancements to the Fee-for-Service Global Budget Specifications, but we do plan to continue making updates to the methodology. And so, as we said a couple of slides ago, please continue to send your questions to us at that AHEAD@CMS.hhs.gov website, we want to continue to learn what's working for you, what you think will work so that we can continue to update the Global Budget Specifications as necessary throughout the model.

And next slide, please, and I will hand, for some of the remaining frequently asked questions, the mic back to Abid. Thank you.

Abid Khan, CMS:

Thank you, Mattan.

So, can hospitals concurrently participate in HGBs and other CMMI Models?

Yes, overlaps are permitted in specific cases and intended to work synergistically to improve health costs and quality outcomes. So, between the Shared Savings Program, the TEAM Model, and AHEAD, there is a specific interaction where there can be overlap. But we would like to refer you to the AHEAD Model overlaps policy fact sheet located on the AHEAD Model webpage, and that will be revised as needed with more upcoming models and overlaps.

Next question, please.

Will participating hospitals receive HGB from multiple payers?

Yes, participating hospitals can expect to receive HGBs for Medicare Fee-for-Service and for Medicaid as required under the AHEAD Model. Participating hospitals may also receive HGBs from commercial payers that voluntarily participate in AHEAD. This could include revenue from state employee health plans, basic health plans, qualified health plans and Medicare Advantage plans, including D-SNPs among others.

So, Medicare Fee-for-Service HGBs are required right from the beginning in Performance Year 1. Medicaid HGBs are required, beginning PY2, and then each State is required to have at least one commercial payer operating in the state or substate region participating in HGBs by the start of PY2. Now that one payer may have broader or more limited reach, so a given hospital may in PY2 only have Medicare and Medicaid Hospital Global Budgets, or it may have a wider variety of payers. We encourage States to try and advance payment alignment with Hospital Global Budgets. We found from previous models, such as the Pennsylvania Rural Health Model, that it is really important to get that alignment in the path to transformation.

Next slide, please.

How does the AHEAD Model define safety net hospitals?

So, safety net hospitals under AHEAD include short-term hospitals that serve above a baseline threshold of dual eligibles for Medicare and Medicaid, or Part D low-income subsidy, the LIS.

Critical Access Hospitals are all under that definition of Safety Net for AHEAD and short-term hospitals with Medicare DSH payment percent exceeding the 75th percentile threshold for all congruent facilities that build Medicare within their State.

A hospital identified as Safety Net in the base year retains its Safety Net Hospital status for the duration of the Model. So, if any of these criteria fluctuate, for example, if the DSH patient percentage does not exceed the 75th percentile threshold in the second year, but it was qualified in the first year, or the baseline period, that does not remove its Safety Net Hospital status. It retains that status and the benefits that are conferred with that status. This gives the hospitals more time to gain experience with the AHEAD Model, for example, the Effectiveness Adjustment for safety net hospitals begins a little bit later in Performance Year 3, one year later than acute care hospitals

Next slide, please.

All right. In closing, I'm going to pass it back to Maria.

Maria Abrica-Gomez, CMS:

Thank you all for joining and for just hearing us out in just sharing the updated methodology. We do see some questions and a lot of engagement in the Q&A. So, we wanted to turn live to answer some of these questions and Mattan, do you want to take the first one?

Mattan Alalouf, CMS:

Sure. Thank you, Maria.

So, the first question that we want to answer from the Q&A pod; is an organization able to participate in either the Hospital Global Budget or the Primary Care AHEAD program, or would they have to participate in both?

Participants can choose either, however, participation in both is highly encouraged. Health system owned practices may only participate in Primary Care AHEAD if the health systems hospitals are participating in the Hospital Global Budgets in the same Performance Year.

Maria Abrica-Gomez, CMS:

Thank you, Mattan.

For the second question. There is a question in the in the Q&A that states; does the simulator referenced earlier do a multi-year simulation, that is show how the adjustments would impact the hospital over time based on actual Fee-for-Service volume, PAU performance, etc.?

First, I wanted to distinguish two things, one of the milestones that we referenced was the Calculator Tool, and that one, as mentioned, is a plug and play tool that allows you to input your own hospital data. And so that maybe you may choose to do that and play around with it for one year, the second year, the third year. Again, this is intended to show you how the calculation flows. And separately there is the simulation tool, which is what we referenced as the essentially calculations that that follow the methodology for historical years. And right now, we're the simulation is provided for a historical year. But we can take that in as input and consider if and consider if multiple years would be helpful.

Thank you for the question.

Abid Khan, CMS:

I can jump in with the next question.

It looks like the HGB only accounts for Medicaid Fee-for-Service payments, right? So, hospitals will have to maintain current billing protocols for Medicare Advantage, commercial, Medicaid, etc.

So, I spoke to this a little bit during the FAQ Q&A. CMS will calculate only the Medicare Fee-for-Service Global Budget and then the State Medicaid Agency will develop a Medicaid Hospital Global Budget that will be offered to hospitals, and at least one commercial payer must offer an HGB within the State or substate region. But CMS does encourage all payers to offer HGBs to maximize the opportunity for care transformation.

And while I'm here I did want to correct something. So, I'm going to pull up another question regarding the CAH budget. Did you mean to say 101% of cost for CAHs not 101% of Fee-for-Service?

Yes, for cost settlements made through cost reports to reconcile to 101% of costs are incorporated into our historical Medicare Fee-for-Service revenue to make sure that the HGBs fully account for Medicare revenue that's replaced by the Hospital Global Budgets. So, thank you.

Mattan Alalouf, CMS:

Thanks, Abid.

So, the next question that we want to answer is the Market Shift Adjustment only at the zip code level? So, if the hospital that increased utilization is in a different market area is that accounted for?

For this we want to clarify that the Market Shift Adjustment is calculated across all of the set of zip codes that correspond to the geographic area served by the hospital. So, it's a variety of zip codes that represent where the hospital has a substantial number of patients. It's not a single zip code.

Maria Abrica-Gomez, CMS:

The next question is, if a hospital is planning to expand this give me one second, let me just make sure I'm getting the right one. If a hospital is planning to expand its service line, how will the Hospital Global Budget adjust for this?

We did mention that the Service Line Adjustments allow for hospitals to receive prospective payments for expanding service offerings. And so, part of the adjustment process is hospitals that want to see reflected in adjustments submit to us, and the State a request for an adjustment prior to the Performance Year. And so, we'll work with each of the hospitals to apply the adjustments if approved.

Mattan Alalouf, CMS:

Next question I will take.

Maria Abrica-Gomez, CMS:

Mattan, you want to take the next question. Thank you.

Mattan Alalouf, CMS:

What happens if a hospital sees a utilization shift and doesn't have enough in its current funds to account for that utilization shift? Do they have to wait a year before getting an adjustment?

In this case, hospitals can request an exogenous factor adjustment for large, unexpected events. So that's outside of the typical adjustment that we see in the details of the methodology that we described today.

Maria Abrica-Gomez, CMS:

And Abid, there is a question about the Demographic Adjustment if you don't mind answering that one.

Abid Khan, CMS:

Absolutely. The Demographic Adjustment is looking retrospectively and adjusted prospectively. The Demographic Adjustment uses historical data to apply a prospective adjustment to HGBs. Yes, so it is sort of using the data available to look forward and make adjustments to HGBs.

Maria Abrica-Gomez, CMS:

Thank you.

And the next question, let me just make sure this one is for you, Mattan.

Mattan Alalouf, CMS:

Would you mind reading the question out for me, Maria?

Maria Abrica-Gomez, CMS:

I can definitely do that. The question is, what happens if a hospital sees the utilization shift and doesn't have enough in its current funds to account for that utilization shift? Do they have to wait a year before getting an adjustment?

Mattan Alalouf, CMS:

Oh, yep. That's so similar to the question that we were talking about a couple of questions ago that would also result in the exogenous factor that the hospital could request for a change that's sort of outside of all of the adjustments we've described today.

Maria Abrica-Gomez, CMS:

Great. Thank you.

The next question is, will CMS consider service line adjustments that are less than 50%, 100%?

Just a quick response here. Yes, CMMI will consider service line request on a case-by-case basis.

Abid Khan, CMS:

I've seen a couple of questions pertaining to service line. I just wanted to add a little bit of detail there on how the Service Line Adjustments can be made. So, the initial step is that the hospital

proactively notifies CMS of the request to add or expand a specific service line, including forecasting financial impact of the added service line, so supplying impacted DRGs, HCPCs, or revenue codes and then CMS reviews and the request and determines whether to adjust the HGB in consultation with the State. So, there's a submission of data, an assessment of financial impact, and a determination by CMS and then, in consultation with the State, whether to grant the request, and if that is done, then, in addition to the sort of projected impact that affects HGB, there's reconciliation to Fee-for-Service expenses. So, we do see the actual no pay claims running for two years and then settle on a pattern of expenses. So that's how that operates.

Sorry back to you.

Maria Abrica-Gomez, CMS:

Oh, no, this is all good. There are also a couple of questions on the calculator or hospital calculator, and I wanted to just address a few of those. The first question is, will the hospital calculator be adjustable to apply to Medicaid?

The Calculator Tool is specific to the CMS Medicare Fee-for-Service Global Budget. And it follows the methodology that we just reviewed. So, Medicaid Hospital Global Budgets will be designed and implemented by States and that is in progress. And so, the State itself, you know, once the methodology is determined, is who will determine the tools available made available to the respective hospitals.

Mattan Alalouf, CMS:

I see a question here about the timing of the adjustments. So, we have one question, how often are these adjustments done? Are any of them retroactive to account for changes that actually happened, or any adjustments to future payments?

These adjustments are perspective to avoid reconciliation, with the exception of applying the CAH floor and a one-time adjustment to account for the timing of IPPS payment updates. The Global Budget is calculated annually to provide payment stability and allow time for hospitals to budget.

Abid Khan, CMS:

I just wanted to make a clarification as we've gotten a couple of questions, I think in reference to Slide 36 saying, the Medicaid Hospital Global Budget needs to be in place by PY2. So, by that we mean during PY1 before PY2, it would be put in place. So, it's not during PY2.

And regarding some of the questions on prospective adjustments using retrospective data. One of the considerations we're trying to balance is we've seen in past models, there being significant reconciliations and the predictability of Hospital Global Budgets being one of the benefits we don't want to compromise that. So, we're over here there's an effort to strike a balance between accuracy and also not allowing hospitals to plan and use the funds that they expect to receive.

Maria Abrica-Gomez, CMS:

Thank you, Abid. There are additional questions on the Calculator Tool. One of them is, will a hospital be able to determine its social risk adjustment in the soon to be released calculator?

Again, that Calculator Tool is intended to be educational, essentially to show you how the methodology is being applied, and how the calculations are being done, and this includes the

formulas within them. And so, for Social Risk Adjustment, this is a plug and play tool, so you can select, or we have some ranges in which you can select what that may look like for your specific hospital.

There is also about one about how are Service Line Adjustments estimates calculated. Is there a tool calculator?

I just wanted to quickly say that the Calculator Tool, which is again a plug and play, does allow you to enter baseline information. There are instances where we may not have, you know, the most updated information, so that tool allows you to enter your most recent baseline. And so, some of the things that we may not have captured from historical claims you can enter there, and there are opportunities later to resolve some of those differences with CMS.

Mattan Alalouf, CMS:

I see another question here about the Social Risk Adjustment and the floor on the CDI that we touched on briefly during the slide. So, the question here in the Social Risk Adjustment is the Social Risk Score subject to the floor on the CDI or the CDI?

And so, for this I just want to sort of restate that national CDI is fixed or allowed to go higher, based on the Performance Year 1 calculation to account for positive influence. So, to reframe that or rephrase that, if the activities that hospitals take, mean that the CDI of the population that they serve improves, the CDI can't go any lower than it was in the first Performance Year. We don't want to disincentivize any of those activities

Abid Khan, CMS:

I'm seeing a question referring to professional fees of hospital employed clinicians, are they included in the HGB and if not, why not?

Professional fees are excluded in all cases. The HGB for most Acute Care Hospitals, excluding CAHs and other special designation hospitals, is based on IPPS/OPPS, which is substantially different from the relative value scale used to pay for professional services, and for that reason it is limited to the prospective payment systems.

Maria Abrica-Gomez, CMS:

Abid, there's also a question about Outlier Adjustments that maybe you can quickly address. I can read you the question.

Abid Khan, CMS:

Yeah, could you read the question, and I'll answer it?

Maria Abrica-Gomez, CMS:

Yes, are there any outlier adjustments or exclusions in the total cost of care calculation?

Abid Khan, CMS:

The TCOC Adjustment includes all claims-based payments made by Medicare as well as non-claims-based payments such as shared savings payments. So that is it.

I am also seeing that we have less than a minute remaining. So, we want to take this opportunity to thank our participants for both your engagement and questions, we will continue to answer any questions that come in to us.

Please take the survey following the webinar, so we can learn how to improve and communicate better moving forward. For more information about hospital eligibility, please refer to the Model CMS-Designed HGB Methodology on the AHEAD Model webpage, and you can look at additional resources on that page or also email your comments and feedback to AHEAD@CMS.hhs.gov with the subject line AHEAD Hospital Global Budget methodology, and we will reach back out to you as soon as possible with answers. Thank you so much for your participation today.

Maria Abrica-Gomez, CMS:

Thank you for joining.