States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Medicare FFS Hospital Global Budget Overview Webinar
February 14, 2024

>>Shaina Haque, SEA: Good afternoon, everyone, and thank you for joining today's Hospital Global Budgets Webinar for the State's Advancing All-Payer Health Equity Approaches and Development Model, or AHEAD model.

There are a few housekeeping items to discuss before we get started. During today's presentation all participants will be in listen-only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed on the bottom of the meeting room window. Given time constraints, we may not get to every question, but we will collect questions for future events and FAQs. We will also have a few minutes at the end of today's event for a Q&A session, where our team will answer questions submitted by audience members. You can also reach out to our help desk at AHEAD@cms.hhs.gov.

We also would like you to know that today's presentation is being recorded. If you have any objections, please hang up at this time. The slide deck, a recording of today's presentation, and a transcript will be made available on the AHEAD model website in the coming days. At this time, I will pass it over to Emily Moore from the AHEAD team at CMMI to walk through the agenda for today.

>>Emily Moore, CMS: Thank you, Shaina. Good afternoon, everyone. It's great to be here with you, learning about everyone's favorite topic, hospital global budgets. So if you could go to the next slide, please.

Today you'll be hearing from myself, I'm Emily Moore, Co-Model Lead for the AHEAD Model as well as my colleague, Eli Boone, who'll be walking you through most of the actual technical details of our methodology. So you'll be hearing from us today, and we're excited to be with you. Next slide, please.

So I'll just give you a rundown of how we are going to approach this webinar. And certainly, this is not the only time that we have to chat about global budgets. We are very open to continuing the conversation in upcoming office hours as well. But today we'll start with an AHEAD Model overview. Then walk you through next on key concepts and policies before Eli will walk you through the hospital global budget payment construct in more detail. We'll then end with a bit of operational considerations, before transitioning to a Q&A session at the end. So, as it was mentioned at the top of the webinar, please do include those Q&A questions. And if we don't get to it, we'll be sure to follow-up or consider it for future events. Next slide, please.

So before we get started, I would love to get a better sense of the over 262 folks on this webinar. So, if you wouldn't mind sharing with us, what type of organization you represent, that'd be incredibly helpful to us. I'll give you a moment.

Alright if folks could wrap that up. Okay, great. Great, it looks like we have a strong representation from hospitals and health systems on the call, welcome. And it's great to see some other folks represented as well, thank you for joining. Let's move on.

Alright, I'll take you next to our overview of our model framework. Many of you will be familiar with the States Advancing All-Payer Health Equity Approaches and Development Model, or the AHEAD Model. But I want to take a moment here as we talk about where hospital budgets fall in our model. You'll see that with our state total-cost-of-care models, states taking on accountability for quality, improving health equity and curbing cost growth. And you'll see that we have a number of components as part of the model designed to support states and providers to partner on these goals. You'll, we have talked about the Notice of Funding Opportunity that's currently available for the Cooperative Agreement funding, and then the hospital global budgets and our Primary Care AHEAD program, in different webinars we've provided an overview of them.

Today will be focusing on hospital global budgets. But I do want to sort of call attention to the fact that this really is going to be a partnership from many different types of providers, stakeholders, government and payers to really make these state accountability targets successful. And so hospitals do not bear the only burden on achieving these targets, and so it is going to be a partnership. Hospitals themselves don't have specific state targets that we'll talk more about sort of how they'll be held accountable for quality and costs in alignment with these state targets, but they are, it's intended to connect together. So that's just a bit about where hospitable budgets fall in our model framework. Next slide, please.

So next we'll go through some key concepts and policies. Next slide.

So we have shared this slide before. But just to ground us before we get into the technical details, I want to talk more about what is a hospital global budget. And you'll see our definition here that we've shared in both past materials and on our webinars. But really, a global budget is a fixed prospective set amount of annual revenue for a hospital for selected Part A and Part B facility services. Under our hospitable budgets for AHEAD, and our CMS design methodologies, these we paid to participating hospitals in prospective bi-weekly payments, and these will be in place of traditional Medicare fee-for-service claims.

So in terms of incentives for hospital participation, we'll be talking through a number of these as we get into the methodology. But I want to call attention to these first six. We have thought really carefully about how to increase participation in this model, as hospital participation is voluntary. So we have provided initial investment to support early transformation for the early years of the model. We also believe that in an era of unpredictability, that the increased financial stability and predictability of the global budgets will be a big benefit for participating hospitals. In addition, hospitals have the opportunity to share in the savings from reduced potential, avoidable utilization, and more care delivery. So we are breaking those ties to fee-for-service volumes and allowing hospitals to retain revenue for those reduced avoidable utilization.

Next, we will also include the opportunity to earn upside for health equity and quality improvement. Participating hospitals will also have the potential use of waivers. And I'm going to anticipate this question here. We do not have a list of final waivers. But we have integrated some of that on our overview webinar, and you can get a sense of that there. Finally, we do believe that there is a great opportunity to participate in our learning system and learn from other peers who are working through this global budget and care transformation efforts. So those are some of the value propositions that we see for participating in global budgets. Next slide.

So in terms of what we are focusing on today. We, you hear a hospital global budget, and often folks are saying, is that for all payers, or is that just for Medicare fee-for-service? And so today we'll be focusing on the Medicare fee-for-service hospital global budget. And we've talked about this as well, but states with statewide hospital rate setting or hospital budget authority with experience in value-based care can design their own methodology under the AHEAD Model.

So what we're going to be presenting today is the methodology that'll be used in all other states. So that is what we are calling the CMS design methodology. And I'm sure we've got a number of these questions already. But your question, there's probably going to be a question about, are these methodologies and the financial specifications that will be posted final. And right now, this is just version 1.0. Our goal was to submit these and post them right before the webinar but due to some of our challenges with our 508ing process, they will be coming very soon. And we are working really hard to get them up there because we understand the demand for it.

So once they are up there, you'll be able to sort of dive deep into the, I think it's 190-page document, of our version 1.0. And so we welcome your feedback. And as we continue to iterate on this, these financial specifications. So thank you again for your patience, and we'll be posting those shortly. Because we do not have those financial specifications, I do want to share a health policy, Valentine given. It is Valentine's day, and I do not want folks to go without some health policy love. So thank you for your patience and hope. You get a quick chuckle from that.

Alright, in terms of hospital global budgets, as I mentioned, we'll, we're focused on Medicare fee-for-service today. But under the AHEAD Model, we do have a strong focus on multi-payer alignment. And so this is again the Medicare fee-for-service methodology, but states have the opportunity to design the Medicaid, Medicare Advantage, and commercial payer methodology. We shared more about this information in our Notice of Funding Opportunity, and you'll see those references here. But again, CMS will be partnering with states on that process. Next slide.

In terms of providers that are eligible to participate in Medicare hospital global budgets, we have three major categories: Acute Care Hospitals, Critical Access Hospitals and Rural Emergency Hospitals. For each of these hospitals, they will be embarking on hospital budgets if they choose to participate in the global budget. There are many different types of acute care hospitals. This list here is not exhaustive, but intended to be descriptive. And you, I welcome you to let us know if there are any other types of hospitals, acute care hospitals that we may have missed.

In addition, I want to make a quick note about Critical Access Hospitals before we dive in further. Right now, Critical Access Hospitals are reconciled back to 101% of reasonable costs as part of their cost reporting process. Under the AHEAD for global budgets, they will be doing something new, they will no longer be reconciled back to 101% of reasonable costs. We'll talk more about the specific considerations for CAHs and safety net hospitals in a bit.

Finally, we do recognize that there is a new designation, the Rural Emergency Hospital Designation. And this is a really unique and new provider category. We are planning to allow for their participation, but we'll need to be working through this a bit more as the financial details evolve for those hospitals. So certainly, is something we're aware of and planning for participation, but at this juncture do not have more details, although we would consider some of the same adaptations to methodology, as we are doing for Critical Access Hospitals and safety net hospitals. Next slide.

As I mentioned, we are really thinking carefully, given our focus on health equity and supporting care and for underserved populations. Whether there are specific adaptations to the methodology that are needed to ensure so robust participation from Critical Access Hospitals and safety net hospitals. So you'll, probably, the first question that you would want to ask as well is around, what is the definition of safety net hospitals? This is something we are continuing to refine. But for now you'll see our current working definition on this slide.

For Critical Access Hospitals and safety net hospitals, we have a number of different considerations in our methodology. One key theme is our phased-in risk approach, so a number of our adjustments that either have upset and downside risk will be phased in over time. The second is the CAH quality adjustment, which I think is really exciting. And so we're providing an upside up to 2% quality adjustment for those hospitals that move from pay-for-reporting to pay-for-performance. And then we are also ensuring a CAH minimum floor for the hospital global budget, baseline that'll be greater than the latest cost report. So we believe that these will be help to support greater CAH and safety net hospital participation. Next slide.

With that, I think I'll be turning it over to Eli to take you through. Actually, no, I am on this, apologies. I will be taking you through a quick highlight of the global budget methodology before Eli will then take it to you even further. So next slide, please.

So a global budget sort of has three different stages that you see here. First, is our historic revenue calculation, that is when we create a hospital global budget baseline. Next, is when we create and update the baseline for the upcoming performance year. There are a number of adjustments here, annual trend performance and AHEAD specific adjustments, and there are methodologies for each of these. So once we do those machinations on the baseline, we then estimate the upcoming annual hospital global budget.

From there, we take it into the global budget payments. So for example, we'll set the annual global budgets. And then these biweekly payments we'll determine by dividing the annual by 26, because there are 52 weeks in the year. So we will be posting these methodology specifications shortly. We were hoping that they would be available for this webinar. But then, thanks again for your patience. Next slide.

So, as I mentioned, we have a number of incentives, and we thought about the value proposition. So you'll see that here, the number of adjustments at a glance, that we'll be going taking you through. So we have annual trend updates, which include Annual Payment Adjustments for IPPS and OPPS factors, Volume-Based Adjustments, and our PPS Quality Adjustments. In addition, we have our specific AHEAD adjustments for our Transformation Incentive Adjustment, and that Upfront Investment Care Transformation, and our Social Risk Adjustment as well.

In addition, we have our performance-based adjustments that adjust hospital global budgets based on performance on quality or cost metrics. And so we'll you'll see that with our Total Cost of Care Performance Adjustment, Health Equity Improvement Bonus, our CAH Quality Adjustment Program, and our Effectiveness Adjustment. So Eli, is there anything else that you'd like to call attention to on this slide?

>> Eli Boone, CMS: Not yet, Emily. I think you did a great job. I'm excited to dig more into it with folks. So I can take it from here.

>>Emily Moore, CMS: Thanks.

>>Eli Boone, CMS: Okay. So thanks again, Emily, great job covering that introduction, and everybody thanks for joining us, on Valentine's Day no less. So we have a lot of exciting ground to cover, so I'm going to get us started right away.

As Emily mentioned, the first step in constructing a participating hospital's global budget is to calculate the baseline, so we'll start there. In calculating the baseline, it starts with looking at the hospital's historic revenue for all eligible services over the previous three, over a previous three-year period, excuse me. So historic revenue for each year will be weighted differently, with more recent revenue, weighted more heavily than older revenue. And this will include all Medicare fee-for-service revenue, regardless of where a beneficiary resides.

So we have an example for you here on the screen in the blue table. So, if a hospital joins the AHEAD Model in Cohort 1, which would start January 1st 2026, CMS is going to weight 2022 revenue, called Base Year 1, at 10%. Base Year 2 revenue, coming from 2023, will be weighted at 30%, and then Base Year 3 revenue from 2024 will be weighted at 60%. And some of you may notice that 2024 is not the most recent year before the hospital begins participation in 2026, and you're totally correct. Given the need for sufficient claims run out, the AHEAD Model includes a one-year gap year, is what how we're calling it, between the baseline and the participant hospital's first performance year. So 2024 data is weighted as Base Year 3 in this example, with 2025 data being the gap year.

And now that we know which, or what, historical revenue will be used as the basis of the hospital global budgets, we need to understand what services are going to be included. So payments in a participating hospital's baseline will include all fee-for-service payments, as I mentioned, for services paid through the Inpatient Perspective Payment System, or IPPS and the Outpatient Prospective Payment System, or OPPS. Inpatient hospitalizations covered under Medicare Part A and specific outpatient services covered under Medicare Part B will be included as well. And the AHEAD Model will also include hospital payment adjustments linked to volume changes under IPPS and OPPS, like indirect medical education, as well. We're going to get more into volume-based adjustments shortly. So just hold on one second.

And when it comes to excluded payments, since all fee-for-service payments are included in the hospital global budget, baseline payments that are generally made outside of this framework will continue to be paid separately and under existing processes. And similarly, inpatient services that are not paid through the MS-DRG, things like organ acquisition costs, will be paid normally as well. And items or services that are currently paid at reasonable cost, through separate APC payments, like specific drugs or supplies, are excluded from the hospital global budget as well, and will continue to be paid as is. And specific to Critical Access Hospitals, or CAHs, professional outpatient services paid under CAH Method II are excluded from hospital global budget baselines as well.

And we want to make this presentation applicable and kind of fun for all of the hospitals and health system participating folks that are joining us today, and others tuning as well. So throughout this presentation, we're going to use two fictitious hospitals as examples of how the AHEAD hospital global budget is constructed, and then updated over time.

So first, we have Moore Health, an acute care hospital in an urban setting that serves predominantly urban and suburban patients. Moore Health has 300 beds and has decided to start receiving hospital

global budgets on January 1st 2026 as part of a state in Cohort 1. So Moore Health's hospital global budget payments will be constructed using 10% weight to its 2022 revenue, 30% weight to its 2023 revenue, excuse me, and 60% weight to 2024 revenue, and will include all Medicare fee-for-service payments paid to the hospital through IPPS and OPPS. So Moore Health will have a $350, or 350 million dollar revenue as the basis for their hospital global budget after calculation.

And we also have Boone Valley Hospital, a CAH or Critical Access Hospital, in a rural region largely serving rural patients. Boone Valley Hospital has only 25 beds and has chosen to start receiving hospital global budget payments on January 1st 2027 as part of a state in Cohort Number 2. Now, Boone Valley Hospital's global budget will include a 10% weight to 2023 revenue, 30% weight to 2024, and 60% weight to 2025. And under the AHEAD Model, CAHs will have Medicare fee-for-service payments and cost report settlements, including swing beds, that reflect total payments included in that baseline. And as I mentioned, services billed under CAH Method II are excluded from that baseline and will continue to be paid through current processes.

So the AHEAD model, as Emily mentioned, will also provide a minimum reimbursement, or floor, to ensure hospital global budgets, hospital global budget baselines for CAHs cover the latest cost reporting when they begin participation in the model. So Boone Valley Hospital will see that as well. And CMS is going to continue to monitor and analyze sufficiency in that floor. In addition to working with our other federal partners to ensure that costs can continue to cover their ratios of fixed cost to variable costs we're using cost report data to help inform these analyses.

And I know I'm moving fast, but we have a lot more ground to cover. But now that we've explained how a hospital global budget baseline is set, we're going to look at the different types of updates and adjustments applied to participating hospitals' global budgets. And that starts with the annual trend updates. And these annual trend updates take the baseline, or the previous year's hospital global budget that's been partially adjusted, and prospectively updates it to reflect price and policy changes for the upcoming performance year. And these annual trend updates are essential to ensuring the AHEAD Model's Hospital global budgets function as not only a sustainable payment stream for financing hospital services, but also to support quality improvement activities, while also removing the financial incentives to increase utilization that we see under a fee-for-service system. These annual trend updates take the form of not only annual payment adjustments, but also volume-based adjustments, with some additional adjustments to account for not only policy and programmatic changes, but also exogenous factors like the COVID-19 pandemic, which we'll dive into now.

So, starting with the Annual Payment Adjustment, it is applied annually to each participating hospital's baseline global budget for PY 1 or to the previous performance years hospital global budget for each subsequent performance year to develop the hospital global budget payment amount for the upcoming performance year. And we'll have an example to help explain that a little bit later. I know those timelines can get confusing and due to these adjustments being so interrelated, they have to be constructed together to avoid the overlap in accounting for volume changes.

And it's helpful to think of these annual payment adjustments as having two different types, one with no floor and those with a floor. So inflationary, outlier, low volume, and other programmatic adjustments do not have a floor. And I do want to pay a little some special attention to the hospital quality programs here. Non-CAH participating hospitals will continue to participate in CMS quality programs. You can see them in the light gray box on the bottom right corner of this slide. CAH quality

adjustments, however, are going to be considered performance-based adjustments under the model. And we'll share more about that adjustment later in this presentation.

Otherwise there are annual payment adjustments that include a floor. These include disproportionate share or DSH payments made to hospitals, as well as uncompensated care and indirect medical education payments. This floor will be set at the Base Year 3. And the intent here is that this floor is to avoid penalizing participating hospitals for reducing avoidable utilization among low income patients.

So, moving to volume-based adjustments is the next part of our annual trend updates.

Volume-based adjustments update baseline data to reflect changes in demographics, market shifts, unplanned volume changes and service line adjustments. And it's important to note that, calculating these adjustments, consider Medicare payments for all eligible hospital services to all eligible hospitals in a state or sub state region that's participating in the AHEAD Model, regardless of whether an individual hospital is participating or not.

So, the Demographic Adjustment, this is designed to adjust hospital global budgets for changes in both the size and medical risk of the population served by each participating hospital. And this is to account for the change in use of services but also the number and risk profile of population changes that we may see over time.

And the Market Shift Adjustment is intended to reflect appropriate revenue changes when patient volume is realigned or shipped between hospitals in a given market and service line. Within a market, the MSA provides revenue to hospitals to cover costs associated with a shift of patient volume from one hospital to another. And this adjustment is intended to monitor and account for patient movement between participating hospitals and nonparticipating hospitals within the same health system.

Moving to service line changes, these changes can add, expand, eliminate, or contract specific service lines or services within a service line in a participating hospital. And a participating hospital may receive prospective funding for that proposed service line addition, I'll explain this in a second. And hospitals that share their intent to modify a service line and gain approval from the participating AHEAD state can retain a portion of that revenue associated with the volume that has been removed from the hospital global budget and invest that in population health activities that align with model goals. And CAH's participating in the model like, Boone Valley Hospital, will be able to request retention of up to the entire revenue associated with a service line reduction or elimination.

And finally, we have unplanned volume changes. These are meant to address service line changes that are greater than 5% volume change, which is measured using a case mix adjusted discharge for inpatient services, and a case mix adjusted visit for outpatient services, that are not disclosed and preapproved or accounted for in the market shift or demographic adjustments. In participating hospitals that fail to disclose or gain approval for these changes are going to be ineligible to retain a portion of the associated hospital global budget revenue for reinvestment in population health activities. However, participating hospitals may receive partial funding for service line additions or expansions, but CMS will not provide any retroactive funding.

I'll walk through an example of an approved, an approved service line addition for a new gastroenterology service, including inpatient and outpatient services in PY 1 that Moore Health is

considering. As you can see prior to the first performance year, Moore Health has its gastroenterology service line approved by the state and submits a forecasted revenue to CMS for review and perspective addition into the hospital global budget for 1 million dollars, annually forecasted. So that'll be included in the hospital global budgets, and biweekly payments through midyear PY 2, or the second performance year.

Mid-second performance year, CMS is going to be able to reconcile utilization in that first performance year and adjust the remaining biweekly payments to Moore Health accordingly, for the remainder of PY 2. So, in this example we see there's only $750,000 in revenue or in utilization, excuse me, instead of the forecast, 1 million, so Moore Health will return $250,000 back to CMS. And that 1 million dollars inclusion for the new gastroenterology service line continues into the third performance year until PY 2 claims can be reconciled by CMS in another midyear reconciliation taking place in that PY 3.

So, this time Moore Health completed 1.1 million dollars in utilization, so it's going to receive an additional $100,000 during that PY 2 reconciliation. And furthermore, CMS is going to add an additional $100,000 to the PY 3 hospital global budget service line adjustment to make Moore Health whole. So, Moore Health will receive an additional 200,000 over the remaining biweekly payments in PY 3. And it is important to note that starting in that Market Shift Adjustment will be factored into any Service Line Adjustments as well. And then PY 4, and every performance year thereafter, Moore Health hospital global budget will be 1.1 million for this added gastroenterology service line. And while that won't be subject to reconciliation, moving forward, it will be subject to the Market Shift Adjustment.

So, moving into AHEAD-Specific Adjustments. We know that robust hospital participation is important for realizing care transformation and sustainable savings under the model. So, the model includes updates to baseline revenue to account and support care transformation and management activities and to adjust for hospital to hospital differences and social risk of the beneficiary population.

So, these AHEAD specific adjustments are twofold. First, the Transformation Incentive, Transformation, Incentive Adjustment excuse me, and then the Social Risk Adjustment. And both of these adjustments are investments from CMS to support participating hospitals success under the model, while adding additional flexibility for hospitals to treat patients holistically and focus on population health in line with the AHEAD Model goals. Now, the Transformation Incentive Adjustment, or TIA, which we recognize is sometimes used for treating strokes, but this is separate, will be a 1% upward adjustment to each participating hospital's global budget, in the first two performance years of the applicable cohort, after annual trend updates have been completed.

And then the Social Risk Adjustment, which is an upward adjustment to hospital global budgets to account for hospital to hospital differences in social risk for the beneficiary population. And that Social Risk Adjustment, similar to the Transformation Incentive Adjustment, is to provide additional resources for hospitals, but to treat higher diversity patient populations. And we see the Social Risk Adjustment is measured using the Area Deprivation Index or ADI scores and a combination of dual eligibility status and Part D low income status. And ADI is going to be based on the census block group that the beneficiary resided in on their first day of eligibility and is applied to all eligible beneficiaries geographically attributed to the participant hospital. And in the Social Risk Adjustment we use linear scaling to apply that Social Risk Adjustment to participating hospitals and can be up to 2% of our participating hospitals global budget.

One quick thing on the Transformation Incentive Adjustment I didn't mention. Hospitals that participate in the AHEAD Model don't need to repay this unless they exit the model before Performance Year 6. So, if they keep with the model they are welcome to keep that money after PY 6.

And so here I want to walk us through an example of how the Social Risk Adjustment will work, and there's six, maybe seven steps depending on what the calculation shows us. First, we assign a National ADI, that's Area Deprivation Index. It'll be on a range of one to 100, and we're weighting that at 20%, so we'll multiply it by 0.20. Next, we assign a State ADI, and that has an 80 percent weight as a state-based model, so it'll be multiplied by 0.80. And then we assign a Low-Income Marker, or LIM. And the beneficiary's LIM is going to be 1.0, if that beneficiary is either dual eligible, either full or partially dual, or deemed eligible for Part D LIS at any point in a rolling 12-month of period immediately preceding this calculation, so it can be 1.0 or 0.

Next, in step 4, we add points from steps one through three, and calculate a Social Risk Adjustment score for each beneficiary with a maximum possible score of 150. Then we'll aggregate those scores at a geographic level and calculate a mean, compute a hospital level across scores using weights based on the geographic area and proportion of hospital payments, and then multiply that by the defined geographic score. And participating hospitals with Social Risk Adjustment scores above the mean or median we're still deciding on which to use, will for the, compared to the entire AHEAD state, excuse me, will be eligible to receive that upward adjustment, up to 2%.

Okay, so that's a lot for annual trend updates but we have a couple of examples here. So, Moore Health, our acute care hospital, is preparing for its second performance year as part of the AHEAD Model. We can see the hospitals global budget from the current performance, here, PY 1 is going to be used as the starting point for annual hospital global budget adjustments. So, we start with those volume-based adjustments. It looks like Moore Health did not end up adding that gastroenterology service line, so no change there. But they do see an increase for market shift and unplanned volume changes. And then we have Annual Payment Adjustments and Demographic Adjustments, two increases as well. And then following through with the AHEAD specific adjustments, we see the Social Risk Adjustment that has a max of 2%, but Moore Health is only going to receive 1.7% and a Transformation Incentive Adjustment for again, PY 1 and PY 2 only, Moore Health will receive that full 1%. So, you can see, how the hospital global budget is adjusted following those annual trend updates.

And one quick note on a Market Basket Adjustment, or inflation, that's going to be based on CMS rules and will be updated each calendar year in October for IPPS based on that rule, and then in January for the OPPS rule.

And moving to our CAH example, we see Boone Valley Health is also preparing for the second performance year, as part of the AHEAD Model. Those volume-based adjustments are applied. We see that Boone Valley Hospital did have a Service Line Adjustment at $3,500. So, after the hospital global budget is adjusted for volume, we'll apply those Annual Payment Adjustments and Demographic Adjustments, both increases to that budget. And then a max of 2% for that Social Risk Adjustment, but Boone Valley is only receiving 1.75%, but will receive the full 1% from the Transformation Incentive Adjustment.

And then again, a note on CAH Service Line Adjustments or changes. If those are reduced or eliminated, CAH's can request the entire revenue associated with that reduction or elimination as part

of Service Line Adjustments. Specifically, if they use it to target care management and population health activities in alignment with the state and hospital's health equity plan.

Okay, so moving forward to Performance-Based Adjustments. The following section is going to detail how a participating hospital's global budget will be adjusted based on their performance. And I want to note again, quality adjustments for acute care hospitals participating in the model will be applied to the Annual Payment Adjustments, but CAH quality adjustments are going to be considered performance-based adjustments.

So you can see here on the screen, since CAHs are not required to participate in CMS National Quality Programs, National Hospital Quality Programs, excuse me, the AHEAD Model is going to introduce an upside-only quality incentive program that will align with other quality programs and include rural specific measures. And this is going to start as pay-for-reporting before transitioning to pay-for-performance later in the in the model. And CAH performance will be compared against national CAH benchmarks where possible, including, and include CAH historic performance for improvement as well.

And there's no way to include all of the measures that are included in this, so I do encourage you to check out the financial specifications file when it's on the AHEAD Model website, again, we'll let you know when it's there, if you subscribe to our listserv. But you can see at this example for a CAH participating in Cohort 1, they're going to prepare for reporting in PY 1 that's 2026, and then start reporting that data in PY 2, through PY 4, and then in PY 5 forward, they'll move to pay-to-perform. And that will start as a point 5% adjustment and then increase to 2% over time.

Another Performance-Based Adjustment that we're excited to talk with you all today is the Health Equity Improvement Bonus, or HEIB. And hospitals participating in the AHEAD Model can earn up to 0.5% of additional revenue from this HEIB bonus, which is going to be based on hospital performance, on select disparity sensitive measures. In this timing of the HEIB will be, hospitals will receive the reward for improvement between the base period and performance period among beneficiaries in the highest outcome Diversity Index Group, or the 75th percentile across readmissions and PQI-92.

And that ODI, that Outcome Diversity Index, is measured using ADI at state and national level, including that Part D and dual eligibility status. And the HEIB will use the same calculation as the Social Risk Adjustment that we covered earlier. And the ADI is based on the census block group that the beneficiary resided in on their first day of eligibility, and is applied to all eligible beneficiaries within an inpatient admission or observation stay of greater than 23 hours at each hospital. And so, the HEIB measurement will begin in PY 2 with adjustments starting in PY 4. And like I said, those measures will be disparity risk stratified using the ODI. It's a method similar to ACO REACH, and the AHEAD Model is very much building on the lessons from that model and adjusting to work with the state-based model, using that blended state and national ADI approach.

And then payment, as I mentioned, will be up to a 0.5% upward reward split between PQI-92 and readmissions in the high diversity cohort, equally so, 0.25% for each. And performance on readmission and is going to be calculated and scaled separately. And hospitals must have overall improvement in readmissions and for all patients to qualify for that reward, similarly overall improvement in PQI-92 as well.

And so the AHEAD Model's Effectiveness Adjustment is also a performance-based adjustment, and it incentivizes hospitals to use interventions that reduce Potentially Avoidable Utilization, or PAU. And

this represents a great opportunity for hospitals to keep revenue, to do their hard work, reducing that PAU. And that EA, or Effectiveness Adjustment will be calculated by taking a hospital's PAU, which includes readmissions, avoidable admissions, avoidable ED visits and low-value care, you can see those defined in the in one of the orange boxes in the bottom of your screen, as a percent of total payments and scaling the results compared to statewide averages of PAU charges. And hospitals that perform in the top 20th percentile or below, these are the highest performers, will not receive a downward effectiveness, adjustment.

And that EA is going to increase gradually over time after first being applied to critical, or acute care hospitals, excuse me, in the second performance year. And then, as hospitals gain additional experience with implementing processes to control PAU, and form partnerships with not only primary care providers, but post-acute care providers and community-based organizations, they can address social drivers of health, it's going to increase over time. Special considerations will be made for CAHs and safety net hospitals in the form of not only delaying the application of the Effectiveness Adjustment, but evaluating them separately from acute care hospitals as well.

And I want to give an example of how that Effectiveness Adjustment will change over time. And to be clear, this is illustrative and version 1.0 of our financial specifications file. So, if this resonates with you and you feel like providing feedback, please do write us at our AHEAD email address that's on our AHEAD website. But you can see, for acute care hospitals that max downward adjustment will start at 0.5% and then increase slowly over time, being 2% by PY 5, with a PY 7 adjustment and then hold stable at that level. And similarly for CAHs or safety net hospitals, it'll start at 0, remember, there's a delay for these provider types, but then increase over time as well before reaching a 2% possible adjustment in PY 8, based on PY 6, performance data.

Okay, we're nearly through. We're doing great so next, I want to talk about the Total Cost of Care Performance Adjustment. So, this provides an incentive for hospitals to manage population health outcomes and costs for beneficiaries in their geographic service area. So, participating hospitals will be measured by comparing beneficiary costs within their geographic service area to a comparable benchmark. And that adjustment will include non-claims-based payments including, but not limiting to, capitated payments and ACO shared savings or losses. And that Total Cost of Care Performance Adjustment will be capped at plus or minus 2% of our participating hospitals global budget and will be phased in during the performance period as described below.

So, you can see a participating hospital's PY 2 Total Cost of Care Performance will be applied in PY 4. And during that PY 4, it's going to be upward only for not only account acute care hospitals, excuse me, but also Critical Access Hospitals as well. PY 3 Total Cost of Care Performance will be used two years later in PY 5, and will be both an upward and downward adjustment for acute care hospitals and upward only for CAHs. PY 4's Total Cost of Care Performance will be applied in PY 6, and be both upward and downward for acute care, hospitals and CAHs. And then subsequent Total Cost of Care adjustments will follow that same two-year delay.

Okay, and to provide an example of these performance-based adjustments, you see Moore Health here is preparing for their fourth performance year as part of the AHEAD Model. So we can take their previous hospital global budget, including annual trend updates, and then we'll build off of that. You can see performance-based adjustments are applied. The effectiveness adjustment, that has a max 2% change, again subject to change, Moore Health is going to receive a -1.5% adjustment, and then the health equity improvement bonus with a max of 0.5% across those two measures, Moore Health is

going to receive an increase of 0.25%. And then that total cost of care performance adjustment of a +/- 2%, Moore Health is receiving a +1.0%. So you can see how their hospital global budget changes over time due to these performance-based adjustments.

Moving to our Critical Access Hospital, Boone Valley Hospital, they're also preparing for their fourth performance year as part of the AHEAD Model. So same thing, you take that hospital global budget from the previous year, that accounts for annual trend updates, and then apply your performance-based adjustments. The change here is that CAHs will have cost quality adjustments included under their performance-based adjustments. But the effectiveness adjustment, again a maximum of a - 2% downward adjustment, Boone Valley is going to receive a negative -1.25%. That CAH quality adjustment, a possible increase of 2%, Boone Valley made that goal and is going to receive the full 2%. And then, similarly, to Moore Health HEIB, Boone Valley is going to receive 0.25% out of a possible 0.5% and a 1% total custom care performance adjustment out of a possible +/- 2%.

So, I do want to just call out some specifics to CAHs and Safety Net Hospitals, as far as these timings go. You can see the effectiveness adjustment will start in PY 3 and is in place for PY 4, and the CAH Quality Program is going to be pay-to-report until becoming pay-to-perform in PY 5, which is why you see that +2% in the Boone Valley Hospital example here. And Boone Valley will submit reports for on all measurements, and that's how they attain that that 2% bump, and then the Total Cost of Care Performance Adjustment, as I mentioned, will be upside-only in until PY 4. So in this example, this is the last year Boone Valley can receive upside-only as part of that adjustment.

Okay, that was a ton of information really quickly, and so I want to leave you with this summary example of how all of these different types of adjustments are applied to hospital global budgets for PY 2 specifically. And I have both Moore Health, our acute care hospital, and Boone Valley Hospital, our CAH, on the same screen. So you see, for PY 2 both hospital global budgets will start with that PY 1 hospital global budgets, after Annual and Demographic Adjustments, Volume-Based Adjustments will be applied, then Annual Payment and Demographic Adjustments, then the rest of the Annual Trend Adjustments with Social Risk Adjustments. And then, after that, we'll move into our Performance-Based Adjustments.

And the difference between acute care hospitals and CAHs, are that CAHs will have that CAH Quality Adjustment, whereas acute care hospitals will have Quality Adjustments included in Annual Payment Adjustments. And then, finally, once we have our hospital global budget with annual, all annual and performance-based adjustments, we'll apply sequestration and then do any sort of midyear reconciliation based on service line changes and utilization.

So, with that, I'm going to turn it back over to Emily Moore to round us out. But thanks so much for attending today and bearing with us.

>>Emily Moore, CMS: Thank you, Eli. Alright, appreciate you walking us through each of those adjustments. I'll now take you through some of our operational considerations, as you start to think about how this could work in practice. Next slide, please.

So you'll see here we have tried to outline the timeline for the hospital global budgets. And right now it's still February, February 14th, in fact, and the first applications for Cohort 1 and 2 are due on March 18th. The states will be selected in May or June, and then the Pre-Implementation will start in July. During this Pre-Implementation process, CMS will work with states to recruit and share information,

recruit hospitals and share information about hospital global budgets. And so this is just the first of many conversations like this, in which we'll provide an overview of the methodology in more bite size pieces, and describe the value proposition for hospital participation. We'll be also working to provide tools and estimating the performance year one hospital global budget, so hospitals can start to work with their own data as they consider participation.

I do also want to talk more about, what does that participation decision look like, and, sort of, how is it effectuated. Generally, CMS will be working with states to get a sense of which hospitals are interested and start to calculate global budgets for them. That is not, you know, just saying you're interested is not going to be a formal yes, until a hospital signs a participation agreement with CMS. This will need to happen in the fall in advance of an upcoming performance year. Our performance years start on the calendar year, so January 2026, would be the first performance year for cohort one with the first performance year for Cohort 2 and 3 starting in January 2027.

So, you'll see that for Cohorts 2 and 3, states will be continuing to work on recruitment, as well as Cohort 1 states. Hospitals can join at any year in the AHEAD performance period. So again, we have a focus on early recruitment given its importance, but certainly we'll be providing support throughout. And so I just did want to just take a moment to talk about that, in terms of sort of how the process will work. Next slide, please.

So, you, you heard from Eli in terms of how do we construct the hospital budgets and the bi-weekly payments. And so I do want to also talk more about claims, the claims processing, and how the global budget payments are effectuated. So participant hospitals will continue to bill submit claims and Medicare hospital cost reports. Those expectations will remain the same. CMS uses these claims for quality monitoring purposes, global budget calculations, and to calculate expenditures and purposes of shared savings programs or other payment models. So that is still a really critical piece of information for CMS as well.

For claims processing, participant hospitals will not be paid via the standard Medicare fee-for-service system, for facility services covered under the global budget. So if they're included in the global budget, facility service will not be paid fee-for-service, so essentially we'll not be double paying that. The professional services on a claim, the patient contributions, will still be the same however. Participant hospitals will then receive, instead, this fixed global budget in the form of prospective bi-weekly payments, and this will be in the place of claims. These bi-weekly payments start when the hospital performance year starts. So again, if the hospital is to start in January 2026, those bi-weekly payments would start in January. Next slide, please.

So, as I alluded to in the timeline, we will be working with states to help hospitals fully understand hospital global budgets during the Pre-Implementation Period and the early performance years. In the interim, hospitals can help take steps now to support their readiness by familiar, familiarizing themselves on the overall concept and submitting questions. So thank you to those who have submitted questions already, and again, happy to continue the conversation.

As I mentioned, during the Pre-Implementation Period, we'll be developing technical assistance resources to support hospital decision-making. Hospitals will then indicate interest in receiving a Participation Agreement just to see what it looks like, and the methodology as well, and the method estimate. I know we are presenting version 1.0 today, but I do have a commitment that the final methodology would be a prerequisite for any hospital having to sign on the dotted line. So that is

certainly something that would be in place. Estimate we'll also, we probably, we'll have an early estimate, as hospitals need some time to decide. But right before that signature in the fall we'll be updating that with the final IPPS, OPPS rules prior to signing a Participation Agreement.

During the performance period, we will actively monitor participant hospitals or their financial performance metrics. You saw a number of the measures we're using, but that is not the only measure we'll be using and monitor our models. In addition, we'll be developing a dashboard with key metrics for hospital decision making that will align with these financial performance metrics. In addition, participant hospitals can participate in technical assistance and learning activities. Next slide.

So I do want to take a moment to talk about overlaps with other CMS programs and CMMI models. I know this has also been a hot topic of conversation and questions that we've received. It is going to be a package of the financial specs and an overlaps fact sheet. But this is generally the key information on ACO overlaps. For ACO REACH, overlaps are not permitted with ACO REACH participants and preferred providers receiving Total Care Capitation (TCC), Primary Care Capitation (PCC), or the Advanced Payment Option (APO) payments. An updated policy here is that overlaps are committed with ACO REACH preferred providers not receiving TCC, PCC, or APO. And then, as we've discussed, prior hospital-based professionals can participate in ACO REACH. Again, they are not included in the global budgets, so their claims are not affected by the global budgets. But again, they can participate in ACO REACH and received capitated payments.

For Medicare Shared Savings, the policy generally follows the same, in which there are allowed overlaps from both hospital providers and hospital-based professionals. In terms of the accountability for hospital spending for ACO REACH and Shared Savings Programs, they will be accountable for benefit ACO-aligned beneficiaries' hospital spending. They will be using the no-pay claims to support financial settlement for determining the shared savings or losses. And so that, I hope, provides a bit more clarity. The overlap fact sheet will have a fun flow diagram of these payments that, I hope, is illustrative and helpful. And thank you for those questions.

In addition and since we've chatted recently, we have the updated two new models from the State and Population Health Group that we're really excited about; the Transforming Maternal Health Model as well as Innovation and Behavioral Health. So more of this will be in the forthcoming overlaps fact sheet, but generally for TMaH, state or geographic overlap, sorry to be more specific, geographic overlap with TMaH is not possible. So, therefore, overlaps are not permissible between hospital global budgets and anything in the maternal health model. I will say that maternal health is certainly a focus for us in AHEAD, and so there will be opportunities to think about how to improve maternal health in our hospital global budgets and our technical assistance activities. For IBH, we will allow geographic overlap with the IBH Model, but overlap is not permitted for, from a provider perspective.

So, we think, so that is just an update there. I'll now move us to our question and answer sessions. But before so before we do that, we'll go to a poll. So next slide, please.

So, we are curious about what part of the AHEAD Model methodology would you most like to learn more about? Thank you. All right. Thank you.

Let's move on to the next set of questions. And so again, many of you already doing this, thank you. Please submit your questions in the Q&A pod. We are working to queue them up.

Let's go to our first prepared question. How can I encourage my state to apply? So, you know, I do want to call attention that hospitals and health systems can consult applicable state agencies to encourage and inform them about their application. At least one Letter of Interest from a hospital required as part of the state application. So again, those deadlines for cohort one and two are in March 18th, but I will note that these Letters of Interest are non-binding.

Thank you. Alright. Let's look at the questions. Chris, could you hand me the next question?

>>Chris Crider, CMS: Sure, thanks, Emily. Do you want to take Emily Brower's question from the chat, making a clarification about SSP overlaps?

>>Emily Moore, CMS: Sure. Do I read this correctly, that savings paid to hospitals under AHEAD will be charged the MSSP ACO? No, that is not true. So, we'll be using the value of the no-pay claims will be used for the MSSP ACO financial settlement. Adam Kellerman, is there any other update you'd make to that update? I know you've been working on that. I see Adam still on mute.

>>Adam Kellermann, CMS: Sorry, Emily, can you hear me?

>>Emily Moore, CMS: Yes.

>>Adam Kellermann CMS: Okay, yes, I don't, I don't think that I have anything to add, but that everything that you said is correct.

>>Emily Moore, CMS: Thank you.

>>Chris Crider, CMS: Thanks, Adam and Emily. Emily, here have been a number of questions about the value proposition for hospitals to participate, but also the risks for hospitals to participate in in global budgets. Can you speak to that, please?

>>Emily Moore, CMS: Sure. So, I appreciate the question about, you know, what happens if the hospital overspends, or the like. And so, I do want to talk more about this.

Hospital global budgets are capitated payment arrangements. And so you know, the global budget revenue is intended to cover the fee-for-service delivered off, pay the services that are included in the hospital global budgets. You know the volume shifts that we've noted, the market shift adjustment, the On-Plan volume changes, the service line additions, are intended to support, you know, changes of volume that we feel make sense. But you know beyond those, there is no additional payment if hospital exceeds its hospital global budget.

That said, we do recognize that there are sometimes shifts that are outside of hospitals' control, whether it's, for example, the hospital next door closing, or an exogenous factor such as COVID-19. So that is something that we do about updates for exogenous factors. But again, there needs to be supporting evidence. So yes, it is a capitated payment arrangement, in terms of that being a form of downside risk. But again, our goal is to make sure that they are calculated appropriately, so that way hospitals can continue to provide the needed services. Thanks, Chris.

>>Chris Crider, CMS: Thank you, Emily. We have a couple of questions about hospital participation. How will hospitals be chosen? And also is hospital participation mandatory?

>>Emily Moore, CMS: Thanks, Chris. So, hospital participation is voluntary under the AHEAD Model. And so again, this is a business decision for hospitals to participate. That is why CMS wants to work with States to recruit hospitals and provide the necessary information. So, hospitals, hospital leaders, their boards, their health systems, can make the appropriate decision for their specific hospital. So again, it is voluntary. Alright. What other questions should we cover? I think we are at time.

>>Chris Crider, CMS: I think we only have one minute left. I want to know there's a number of follow up questions about overlaps, just reiterating that we do intend to post some more details on our overlaps policy shortly. Hopefully, these will answer many of the questions. We can also work to address the specific questions in the chat here, in a public posting and upcoming.

>>Emily Moore, CMS: Thanks, Chris. Let's move on to our closing. Again, thank you. Time has flown, and we are excited to continue the conversation on our future office hours, and we'll be considering additional events. Please do answer this last poll question. We welcome your honest feedback, as well as responding to the closeout survey, if you have a chance. So, I'll let you get to the poll.

Alright, let's continue on and just to say thank you for joining. It has been a pleasure to help give you a quick overview of the hospital budget methodology. As noted we'll be working to post these ASAP. We we'll make sure to follow up on that, and with a notification, once they are posted.

And thank you again for joining. Have a great day and a happy Valentine's day.

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