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

Center for Medicare and Medicaid Innovation
February 14, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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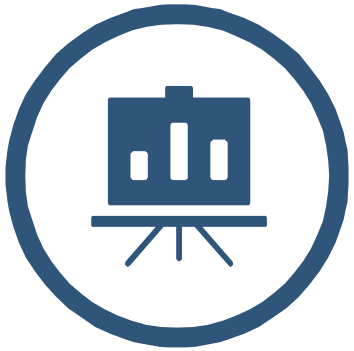
Agenda

This webinar provides an overview of the AHEAD Model's Medicare FFS Hospital Global Budget methodology. The following topics will be discussed:

1. AHEAD Model Overview
2. Key Concepts and Policies
3. HGB Payment Construct
   - Baseline Calculation
   - Annual Trend Updates
   - AHEAD-Specific Adjustments
   - Performance-Based Adjustments
4. Operational Considerations
5. Questions and Answer Session
6. Closing and Resources

Audience Poll #1

Please respond to the live poll using the Zoom platform.



Please select what type of organization you represent.
a. State Medicaid Agency b. State Public Health Agency c. Other State Government Role d. Hospital or Health System e. Critical Access Hospital (CAH) or Other Safety Net Hospital (SNH) f. Primary Care Provider g. Other Type of Provider h. Community Organization i. Patient or Consumer Advocate

AHEAD Model Overview

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

Components

Cooperative Agreement Funding

Hospital Global Budgets (facility services)

Primary Care AHEAD

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

Key Concepts and Policies

Hospital Global Budget Value Proposition

The AHEAD Model aims to rebalance health care spending across the system, with hospitals working with primary care and community-based providers to reduce potentially avoidable utilization.

WHAT IS A HOSPITAL GLOBAL BUDGET?

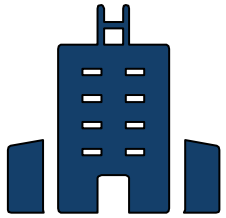
A fixed, prospectively set amount of annual revenue to a hospital for selected Medicare Part A and outpatient facility services covered under Part B. Under AHEAD, Hospital Global Budget amounts will be paid by Medicare to participating hospitals in the form of prospective, bi-weekly payments in place of traditional Medicare FFS claims. Professional services rendered in a hospital setting are excluded.

Incentives for Hospital Participation

- Initial investment to support transformation in early years of the model
- Increased financial stability and predictability
- Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery
- Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community
- Potential use of waivers to support care delivery transformation
- Opportunity to participate in system learning opportunities when moving to a population-based payment

Medicare FFS Hospital Global Budgets

Hospitals who choose to participate in the AHEAD Model will receive a Medicare FFS Hospital Global Budget.



HOSPITALS

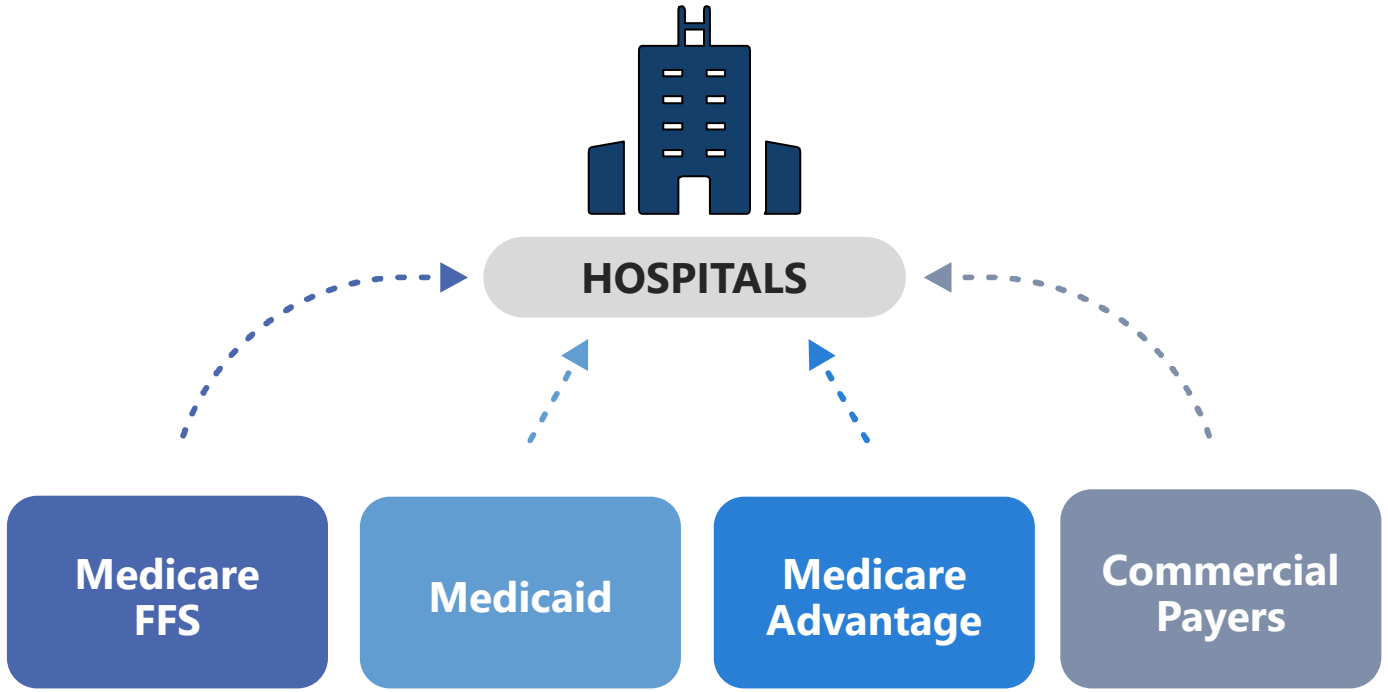
Medicare FFS

- **This webinar will focus on the CMS-designed methodology.** States without the authorities outlined below will use a CMS-designed Medicare FFS global budget methodology.
- Participating states with statewide hospital rate setting or hospital budget authority and experience in value-based care can develop their own hospital global budget methodology. CMS provided alignment expectations for state-designed methodologies in the NOFO and will review and approve in advance of a given Performance Year.

Q: Is this methodology and the financial specifications "final"?
A: This represents Version 1.0 and CMS will continue to iterate based on feedback and additional analyses to refine the methodology. Releasing these specifications now is intended to be informational as states are considering applying to AHEAD.

Hospital Global Budgets

Hospital global budgets (HGB) will be the primary mechanism for achieving all-payer and Medicare FFS TCOC Targets, improving hospital quality, and helping to curb cost growth. Each participating payer provides a prospective HGB to the participating hospital for facility services.



As a reminder, AHEAD States design the Medicaid, MA, and commercial payer methodology. CMCS and CMMI are committed to continued close partnership to assist states in the process of obtaining relevant authorities and designing Medicaid HGBs during Pre-Implementation Period. See NOFO, Appendices X and Appendix VIII for more information.

Provider Types Eligible to Participate in Medicare HGBs

Acute Care Hospitals

- Broadly, many different types of PPS hospitals are eligible, including Medicare-Dependent Hospitals; Rural Referral Center Program Hospitals; Sole Community Hospitals; Tribal Hospitals; and Indian Health Service Hospitals.

Critical Access Hospitals

- CAHs are eligible to participate and if they choose to participate in AHEAD, they will no longer be reconciled back to 101% of reasonable costs as part of their cost reporting.

Rural Emergency Hospitals

- Medicare FFS payments that reflect unique payment methodologies for REH will be used to construct the baseline. Participating Hospitals that convert to REH during Model Performance Years will have the HGB reconstructed on a case-by-case basis. CMS will continue to develop a REH-specific HGB methodology for inclusions of additional considerations.

Consideration for Safety Net Providers

Based on lessons from past models, CMMI has included several considerations in the methodology to incentivize and support CAHs and other safety net hospitals (SNHs) given their unique characteristics.

SNHs, including CAHs, are short-term hospitals that serve above a baseline threshold of beneficiaries with dual eligibility or Part D Low-Income Subsidy (LIS). Facilities are identified as a SNH when their patient-mix of beneficiaries with dual eligibility or Part D LIS exceeds the 75th percentile threshold for all congruent facilities who bill Medicare.

CMS will consider additions and refinements to this definition prior to PY1.

Model Participation Incentives for CAHs and SNHs

Risk-Based Phase-In Approach

- The Effectiveness Adjustment for CAHs and SNHs will begin in PY3.
- The TCOC Performance Adjustment will be phased in over the Model with upside-only risk for PY2-3.
- The magnitude of these adjustments will also be phased in over time.

CAH Quality Adjustment

- To encourage CAHs to participate in CMS hospital quality programs, the Model will provide an initial 2% upside-only risk adjustment for pay-for reporting.
- In later years, Model will move to pay-for performance maintaining upside-only risk.

CAH Minimum Baseline

- CMS will provide a reimbursement "floor" to ensure HGB baselines for CAHs cover the latest cost reporting when they begin participation.
- CMS will continue to monitor the sufficiency of HGBs for CAHs over the Model.

Hospital Global Budget Payment Construct

AHEAD Medicare FFS Hospital Global Budget Methodology

Historical Revenue Calculation

CMS will calculate the hospital's historical revenue for eligible hospital services, combining 3 years of historical data with percentage weightings more heavily applied to recent years.

Annual Trend, Performance, and AHEAD-Specific Adjustments

CMS will apply adjustments to predict the current performance year and reflect accountability for quality and reducing avoidable utilization:

- Annual Trend Updates (Annual Payment Adjustment, Volume-Based Adjustments, and Other Adjustments)
- Performance-Based Adjustments (TCOC, Quality, Equity, and Effectiveness)
- AHEAD-Specific Adjustments (Transformation Incentive Adjustment and Social Risk Adjustment)

Global Budget Payments

Each participating hospital will receive a fixed global budget in the form of prospective, bi-weekly payments for Medicare FFS in place of FFS reimbursement and, for CAHs, of cost-based reimbursement.

The full CMS-designed Medicare FFS hospital global budget methodology, including additional details on the hospital global budget and sample calculations, is available on the AHEAD Model website.

AHEAD Medicare FFS Hospital Global Budget Methodology

Annual Trend Updates

Annual Payment Adjustments
Adjustments based on Medicare price and policy changes, including IME, DSH, UCC, and wage index.

Volume-Based Adjustments
Adjustments made to reflect changes in demographics, planned service line changes, market shifts, and material unplanned volume changes.

PPS Hospital Quality Adjustments
Adjustments to allow quality measures to align with existing CMS programs for PPS hospitals. Including HRRP, VBP, HACRP, IQR, Medicare Promoting Interoperability, and OQR.

AHEAD-Specific Adjustments

Transformation Incentive Adjustment
Upward adjustment to invest in enhanced care coordination in the first two years of the Model.

Social Risk Adjustment
Based on Area Deprivation Index, dual-eligibility status, and Part D LIS status.

Performance-Based Adjustments

Total Cost of Care (TCOC) Performance Adjustment
Upward and downward adjustments based on TCOC of beneficiaries residing in hospital service area.

Health Equity Improvement Bonus
Upward adjustment based on hospital performance on disparities-sensitive measures focused on closing gaps in health care outcomes.

CAH Quality Adjustments
Upward-only quality incentive program that will align with the other CAH quality programs and will include rural-specific measures.

Effectiveness Adjustment
Downward adjustment based on a portion of hospital's calculated potentially avoidable utilization (PAU).

PAU includes readmissions, avoidable admissions (calculated by the PQI-90 indicator), avoidable ED visits (calculated by the NYU ED algorithm), and low-value care (as defined by MedPAC).

Hospital Global Budget Baseline Calculation

Hospital Global Budget Baseline Calculation

Historical Revenue Calculation

CMS will calculate the hospital's historical revenue for eligible hospital services, combining 3 years of historical data with percentage weightings more heavily applied to recent years. The baseline will include all Medicare FFS revenue, regardless of beneficiary residence. There is a Gap Year to allow for sufficient claims run-out, as noted below.

Year	Example if 2026 was PY1 (Cohort 1)	Description	Percentage Weighting
Base Year 1	2022	First Hospital Performance Year minus 4 years	10%
Base Year 2	2023	First Hospital Performance Year minus 3 years	30%
Base Year 3	2024	First Hospital Performance Year minus 2 years	60%
Gap Year	2025	Used for some HGB adjustments, but not baseline	0%

Additional examples are included in Appendix I of the Financial Specifications.

Hospital Global Budget Inclusions and Exclusions

Included Payments

- All FFS payments for services paid under the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) will be included in the baseline.
- Eligible services in the baseline include inpatient hospitalizations covered under Part A and certain outpatient services covered under Part B that are billed on facility claims (Bill Types, 11X, 12X, 13X, 14X, 85X, or 18X).
- Generally, Medicare hospital payment adjustments that are linked to fluctuations in volume under the IPPS and OPPS are included in the HGB (i.e. IME, DSH).

Excluded Payments

- Payments that are generally made outside the FFS framework continue to be paid separately under existing methodologies and are not included (e.g., bad debt, Direct Graduate Medical Education).
- Inpatient services, which are currently paid separately from the MS-DRG payment (e.g., organ acquisition costs) will be paid as normal.
- Drugs and supplies that are historically paid either at reasonable cost or through a separate APC payment are excluded from HGB and would continue to be paid as normal.
- Professional outpatient services billed under CAH Method II Billing will be excluded and will continue to be paid as normal.

See Section 3.1.2 of the Financial Specifications for more detail on the payment exclusions and carve-outs.

Hospital Global Budget Baseline Calculation — Example

Moore Health

Hospital Snapshot:
- Acute Care Hospital (ACH), serving predominately urban and suburban patients
- 300 Beds
- Participating in a state within AHEAD Model Cohort 1 (January 1, 2026 start)

AHEAD Baseline:
- Moore Health's HGB baseline will include 2022 revenue (10% weight); 2023 revenue (30% weight); and 2024 revenue (60% weight).
- All Medicare FFS payments for services paid under the IPPS and OPPS will be included in the baseline.
- Calculated HGB Baseline: $350M Revenue

Boone Valley Hospital

Hospital Snapshot:
- Critical Access Hospital (CAH), serving predominately rural patients
- 25 Beds
- Participating in a state within AHEAD Model Cohort 2 (January 1, 2027 start)

AHEAD Baseline:
- Boone Valley Hospital's HGB baseline will include a 2023 revenue (10% weight), 2024 revenue (30% weight), and 2025 revenue (60% weight)
- Medicare payments and cost report settlements <u>including swing beds</u> that reflect total payments will be included in HGB baseline
- Calculated HGB Baseline: $35M Revenue

Note: Baseline will include all Medicare FFS revenue, regardless of beneficiary residence.

Hospital Global Budget
Annual Trend Updates

Annual Trend Updates

Annual Trend Updates

CMS will calculate HGB using **historic hospital revenues** that are **prospectively updated** to reflect appropriate price and policy changes and provide sufficient revenue for patient care. Trend updates are applied on an **annual basis** to each Participant Hospital's **HGB baseline** to develop the global budget payment amount for the **upcoming Performance Year**. These updates fall into the following three categories:

Annual Payment Adjustments

Updates baseline revenue based on price and policy changes, including Medicare market basket and changes in IME, DSH, UCC, quality, and wage index.

Updates are based on provider-specific changes in base IPPS (DRG base rates) and OPPS (Ambulatory Payment Classification base rates).

Volume-Based Adjustments

Updates to reflect changes in demographics, planned service line changes, market shifts, and material unplanned volume changes.

Additional Adjustments

Updates to account for additional policy (e.g., sequestration), programmatic, and exogenous factors (e.g., COVID-19).

Annual Payment Adjustments

Annual Payment Adjustments update baseline revenue based on price and policy changes, including Medicare market basket and changes in IME, DSH, UCC, quality, and wage index. Updates are based on provider-specific changes in base IPPS (DRG base rates) and OPPS (Ambulatory Payment Classification base rates).

Annual Payment Adjustments, No Floor

Market Basket (Inflation)
Accounts for CMS Market Basket Data less productivity

Medicare Promoting Interoperability Program
Accounts for any change in hospital's Medicare Promoting Interoperability Program performance.

Hospital Quality Programs*
Accounts for any change in performance in a PPS hospital's CMS quality program performance

Outlier
Accounts for changes in outlier payments

Low Volume
Accounts for any change in a hospital's the Low Volume Adjustment

Annual Payment Adjustments with Floor

Base Year 3 will serve as the floor to avoid penalizing Participant Hospitals for reducing potentially avoidable utilization.

Disproportionate Share Hospital (DSH)
Accounts for any change in a hospital's Medicare DSH adjustment

Uncompensated Care
Accounts for changes in Uncompensated Care adjustments

Indirect Medical Education
Accounts for any change in the IME for a hospital

*This includes the Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting, Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Condition Reduction Program.

Volume-Based Adjustments

Demographic Adjustment

- Based on historic trends in population size, age, and medical risk for a Participant Hospital's geographic service area.

Market Shift Adjustment

- Shifts in volume between hospitals that reflect patient choice and movement on an annual basis
- This adjustment is meant to provide additional funding for the variable cost of the new volume without providing additional incentives for unnecessary volume growth

Service Line Adjustments

- Pre-planned changes to existing service lines that are pre-approved by the AHEAD State
- These changes can be to add, expand, eliminate, or contract specific services lines or services within a service line
- New service line additions will be reconciled back to FFS volumes for two PYs and then incorporated fully into the HGB
- By disclosing the intent to modify or eliminate a service line and gaining approval, Hospital Participants may retain, at CMS discretion, a portion of the associated revenue to invest in care management and population health activities

Unplanned Volume Changes

- Service line additions, expansions, eliminations, or contractions greater than 5% that are not disclosed and pre-approved
- Due to the AHEAD Participant not disclosing and receiving approval in advance, they are ineligible to:
  - Retain a portion of the HGB associated with that volume in the case of a contraction or elimination for reinvestment in care management and population health activities
  - Receive additional funding for that service line in the case of an addition or expansion, beyond the Market Shift Adjustment

Service Line Adjustment Addition Example

Moore Health

Time	Step for Moore Health's Gastroenterology Service Line Addition (SLA) for PY1
Before PY1	The SLA is **approved by the AHEAD State**. Moore Health submits Annual Forecasted Revenue (~$1M) to CMS for review.
PY1	CMS **prospectively adds $1M to the HGB for PY1**; which is then included in the bi-weekly payments.
PY2	There is insufficient time for claims run-out from PY1 to update SLA amount to set initial PY2 HGB. **CMS continues the $1M in PY2 HGB** for this SLA.
Mid-PY2	CMS performs reconciliation of PY1 by adjusting the remaining bi-weekly payments for PY2: • In PY1, the **utilization of the SLA was $750,000**, compared to the $1M added to the PY1 HGB prospectively. • Therefore, **Moore Health must return $250,000** to CMS.
PY3	CMS continues the $1M in initial PY3 HGB for SLA (still waiting on PY2 claims run-out).
Mid-PY3	CMS performs reconciliation for PY2 and updates to PY3 SLA amount. Determining reconciliation amount: • In PY2, **utilization was $1,100,000**, compared to the $1M added to the PY1 HGB prospectively. • Therefore, the **Moore Health will receive an additional $100,000** for PY2 reconciliation. • Since the Service Line Addition for PY3 should be not reconciled, but based at the PY2 observed amount, CMS needs to **add an additional $100,000** to make the Participant Hospital whole for the PY3 HGB SLA. • Therefore, the **Moore Health receives a combined $200,000** spread over remaining bi-weekly payments. • Note: This SLA is subject to the MSA starting in PY3.
PY4+	Moore Health has $1,100,000 in its HGB representing this SLA and is not subject to reconciliation, however it is subject to the MSA.

Hospital Global Budget
AHEAD-Specific Adjustments

AHEAD-Specific Adjustments

Transformation Incentive Adjustment (TIA)

- CMS will include a **1% upward** TIA to participating hospital's global budget in the first two Performance Years of the applicable cohort after all other adjustments have been completed.
- The TIA is intended to incentivize early hospital participation and provide additional revenue in care management and transformation activities that will generate medium- and long-term savings under the Model or other resources needed to succeed under a hospital global budget.
- The TIA will only need to be repaid if the hospital exits the Model before the sixth performance year.

Social Risk Adjustment (SRA)

- The AHEAD Model will apply an upward adjustment to hospital global budgets to account for hospital-to-hospital differences in social risk for their beneficiary population.
- The SRA is intended to provide additional resources for hospitals that are treating higher adversity patient populations.
- The SRA is measured using Area Deprivation Index (ADI) scores and combination of Dual-eligibility and Part D Low-Income Status.
- Linear scaling is then used to apply the SRA to participating hospitals. The SRA can be up to 2% of a participating hospital's global budget.

Social Risk Adjustment Example

To calculate the SRA for each Participant Hospital's eligible beneficiaries, CMS will use the steps below to calculate a score ranging from 1 to 150 points:

1. Assign a **National ADI** as a percentile with a **range of 1 to 100** for each beneficiary and multiple by 0.20.
2. Assign a **State ADI** for each beneficiary and multiply by 0.80. Points for State ADI will **range from 1 to 80**.
3. Assign **Low-Income Marker (LIM)** of "1" or "0" and multiply by 50. Points for LIM will **range from 0 to 50**.
4. Add points from steps 1-3 to **calculate a total possible SRA score for each beneficiary**. The maximum possible score for each beneficiary is 150 points.
5. Aggregate scores at the **beneficiary-defined geographic area** and **calculate the mean score**.
6. **Compute hospital-level scores** using weights based on the defined geographic area proportional of hospital payments, then multiply by the defined geographic score.
7. Participant Hospitals with **SRA scores above the mean or median** score for the **entire AHEAD State** will be eligible to **receive an upward HGB adjustment of up to 2%**.

Annual Trend Updates — ACH Example

Moore Health

- Moore Health is preparing for the second Performance Year as part of the AHEAD Model.
- The hospital's global budget from the current Performance Year (PY1) is used as a starting point for annual HGB adjustments.
- Market basket (inflation) updates, based on CMS rules, will be updated each calendar year based on the October rule for IPPS and the January OPPS rule.

Adjustment	Adjustment Amount
PY1 HGB w/ Annual Payment and Demographic Adjustments	**$350,000,000**
Market Shift Adjustment	350,000
Planned Service Line Changes	NA
Unplanned Volume Changes	87,500
HGB Adjusted for Volume	**350,437,500**
Annual Payment Adjustment (3.0%)	10,512,075
Demographic Adjustment (2.0%)	7,008,050
HGB w/ Annual Payment & Demographic Adjustments	**367,957,625**
Social Risk Adjustment (Max +2.0%; Moore Health receives +1.75%)	6,438,646
Transformation Incentive Adjustment (PY1 and PY2 only) (Moore Health receives +1.0%)	3,679,226
HGB Following Annual Trend Updates	**$378,075,497**

Annual Trend Updates — CAH Example

Boone Valley Hospital

- Boone Valley Health is preparing for the second Performance Year as part of the AHEAD Model
- The CMS market basket will serve as the basis to price level to Performance Year 1 dollars for CAHs
- CAHs will be able to request up to the entire revenue associated with the reduced or eliminated service line to be retained if it is used to specifically target care management and population health activities that are aligned to the state and hospital's health equity plan

Adjustment	Adjustment Amount
PY1 HGB w/ Annual Payment and Demographic Adjustments	**$35,000,000**
Market Shift Adjustment	35,000
Planned Service Line Changes	3,500
Unplanned Volume Changes	8,750
HGB Adjusted for Volume	**35,047,250**
Annual Payment Adjustment (3.0%)	1,051,418
Demographic Adjustment (2.0%)	700,945
HGB w/ Annual Payment & Demographic Adjustments	**36,799,613**
Social Risk Adjustment (Max +2.0%; Boone Valley receives +1.75%)	643,993
Transformation Incentive Adjustment (PY1 and PY2 only) (Boone Valley receives +1.0%)	367,996
HGB Following Annual Trend Updates	**$37,811,602**

Hospital Global Budget Performance-Based Adjustments

CAH Quality Adjustment

Critical Access Hospitals

- As CAHs are not required to participate in CMS national hospital quality programs, CAHs participating in the AHEAD Model will participate in an **upside-only quality incentive program** that will **align with the other quality programs** and will **include rural-specific measures**.
- The CAH Quality Adjustment will start with pay-for-reporting before transitioning to pay-for-performance.
- CAH performance will be based on national CAH benchmarks where possible, as well as CAH historic performance for improvement.
- **Key Measure Domains:** Healthcare Quality and Utilization, Patient Safety, and Patient Experience (e.g., HCAHPS)

Example Year (Cohort 1)	2026	2027	2028	2029	2030	2031	2032	2033
	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Pay-to-Report	Start Reporting	Continue to Report	2%	2%	1.5%	1%	0.5%	0%
Pay-to-Perform					0.5%	1%	1.5%	2%

Health Equity Improvement Bonus

Hospitals participating in the AHEAD Model can earn **up to .5% in additional revenue** through the Health Equity Improvement Bonus (HEIB), which based on hospital performance on select disparities-sensitive measures.

Timing

- Hospitals will receive a HEIB reward for improvement between the base period and performance period among beneficiaries in the highest Outcome Diversity Index (ODI) group (75th percentile) across readmissions and PQI-92 performance.
- HEIB measurement will begin in the PY2, adjustment begins in PY4.

Measurement

- Measures will be disparity-risk-stratified with an ODI using a method similar to ACO REACH by measuring ADI at a state and national level (using an 80:20 weighting), and Part D LIS and Medicaid Dual Eligibility.

Payment

- The 0.5% upside reward is split between a maximum 0.25% reward for improvement in readmissions in the high adversity cohort, and a maximum 0.25% for improvement in PQI-92 in the high adversity cohort.
- Performance on readmissions and PQI-92 are calculated and scaled separately, and hospitals must have overall improvement in readmissions for all patients to qualify for that reward, similarly, overall improvement in PQI-92 to qualify for that reward.

Effectiveness Adjustment

- The Effectiveness Adjustment (EA) incentivizes hospitals to implement interventions that reduce unnecessary or avoidable care, including developing transitional care programs, promoting better integration with primary providers to co-manage patients with chronic disease, and engaging with community-based organizations focused on addressing the social drivers of health.
- HGBs will receive a downward adjustment based on the individual hospital's percentage of PAU costs compared to other hospitals in the AHEAD State.
- If an ACH, CAH, or SNH is in 20th percentile or below (the best performance), they will not receive a downward adjustment.
- The EA increases gradually over time as hospitals gain additional experience with implementing processes to control PAU and form partnerships. The EA for ACHs will start in PY2.
- CAHs and SNH will be evaluated separately from ACHs. For CAHs and SNHs, the EA will begin in PY3.

Potentially Avoidable Utilization (PAU):
- Avoidable ED Visits (NYU ED Algorithm)
- Avoidable Admissions (PQI-90)
- Readmissions
- Low-Value Care (MedPAC)

Remember: Reducing PAU is an opportunity – Participant Hospitals get to retain revenue from reduced PAU beyond the EA. CMS will provide data and best practices to support Participant Hospitals.

Hospital Global Budget Effectiveness Adjustment — Example

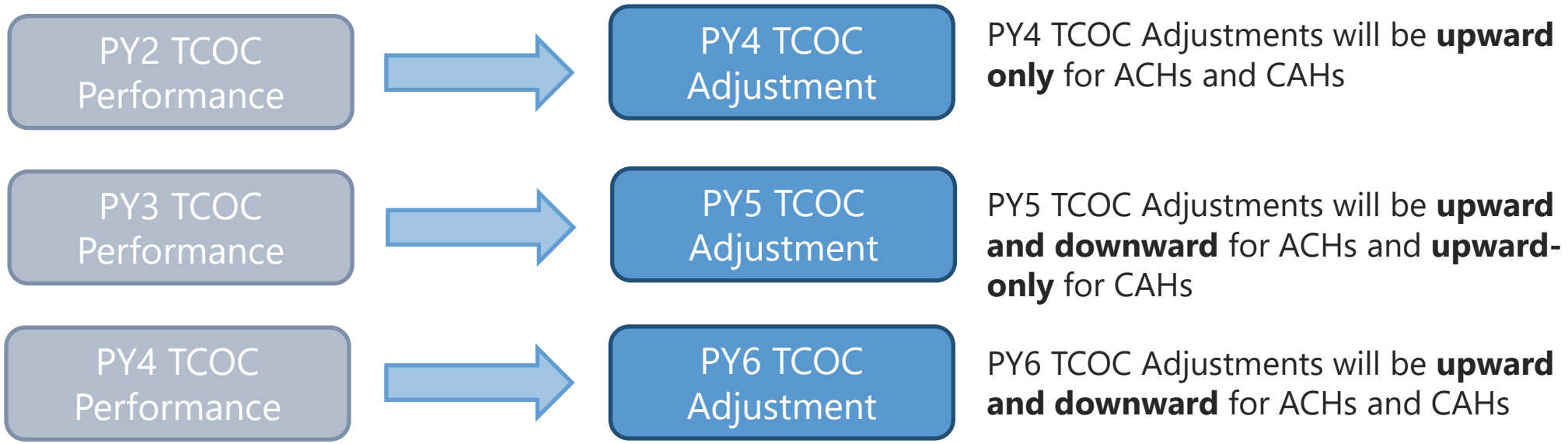
Performance Period	Payment Adjustment Start	Moore Health ACH Max Downward Adjustment	Boone Valley Hospital CAH/SNH Max Downward Adjustment
Gap Year	**PY2**	-.5	0
PY1	PY3	-.75	-.5
PY2	PY4	-1.0	-.75
PY3	PY5	-1.25	-1.0
PY4	PY6	-1.5	-1.25
PY5	PY7	-2.0	-1.5
PY6	PY8	-2.0	-2.0
PY7	PY9 (or Transition Period Year)	-2.0	-2.0

This phased-in EA and specific % amounts are illustrative and subject to change.

Total Cost of Care (TCOC) Performance Adjustment

The TCOC Performance Adjustment provides an incentive for hospitals to manage population health outcomes and costs for beneficiaries within their geographic service area.

- Participant Hospital's performance will be measured by comparing beneficiary costs within their geographic service area to comparable benchmark.
- The TCOC Performance Adjustment will be capped at +/-2% of a Participant Hospital's HGB and will be phased in during the Performance Period, as described below.



Subsequent TCOC adjustments will follow same two-year delay

Hospital Global Budget Performance-Based Adjustments — ACH Example

Moore Health

- Moore Health is preparing for the PY4 as part of the AHEAD Model
- Following annual trend updates made to the hospital global budget, performance-based adjustments are then applied.

Adjustment	Adjustment Amount
PY4 HGB after Annual Trend Updates	**$367,957,625**
Effectiveness Adjustment (Max -1.0%; Moore Health receives -0.75%)	(2,759,682)
HEIB (Max +0.5%; Moore Health receives +0.25%)	919,894
TCOC Performance Adjustment (Max +/- 2.0%; Moore Health receives +1.0%)	3,679,576
HGB with Annual and Performance Adjustments (PY4)	**$369,797,413**

Hospital Global Budget Performance-Based Adjustments — CAH Example

Boone Valley Hospital

- Boone Valley Health is preparing for PY4 as part of the AHEAD Model
- Following annual trend updates made to the HGB, performance-based adjustments are then applied.
- CAHs and SNHs have different timing and application of performance-based adjustments to hospital global budgets:
  - Effectiveness Adjustments start in PY3 and is in place for PY4
  - The CAH Quality Program is Pay-to-Report until becoming Pay-to-Perform in PY5; Boone Valley submits reports on all measures.
  - TCOC Performance Adjustments are upside-only until PY4

Adjustment	Adjustment Amount
PY4 HGB after Annual Trend Updates	**$36,799,613**
Effectiveness Adjustment (Max -0.75%; Boone Valley receives -0.50%)	(183,998)
CAH Quality Adjustment (Max +2.0%; Boone Valley receives + 2.0%)	735,992
HEIB (Max +0.5%; Boone Valley receives +0.25%)	91,999
TCOC Performance Adjustment (Max +/- 2.0%; Boone Valley receives +1.0%)	367,996
HGB with Annual and Performance Adjustments (PY4)	**$37,811,602**

Hospital Global Budget Adjustments — PY2 Summary Example

Moore Health

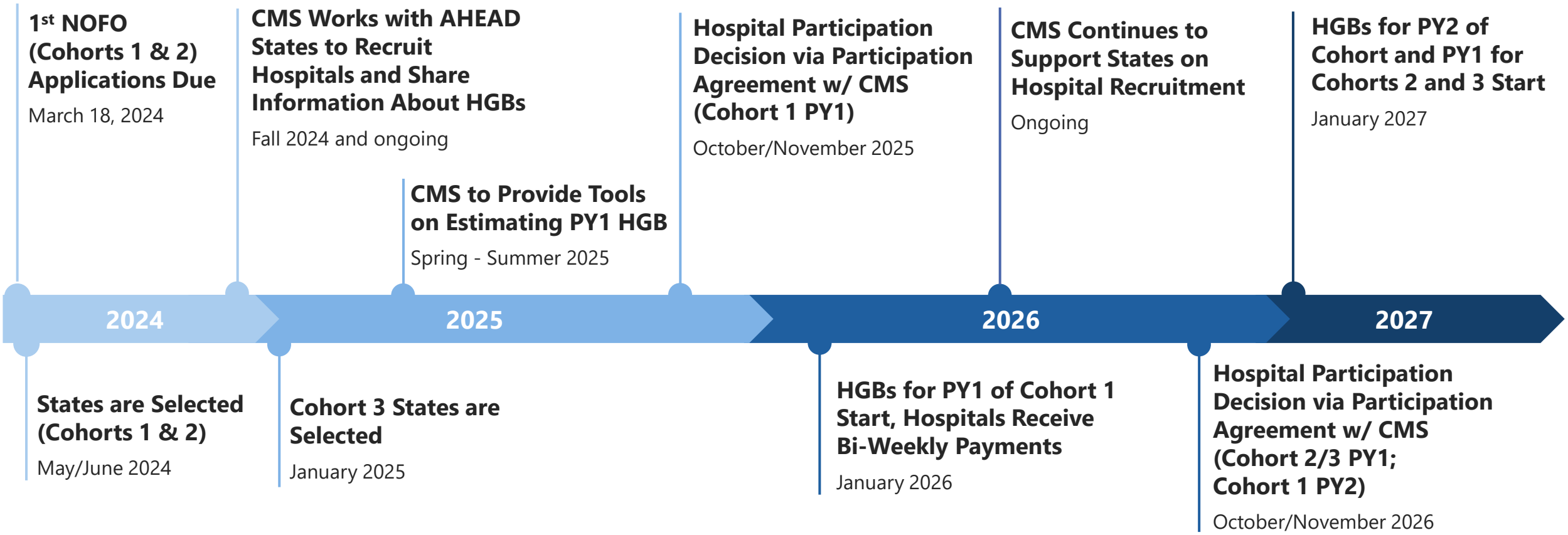
Adjustment	Basis
PY1 HGB w/ Annual Payment and Demographic Adjustments	
Market Shift Adjustment	Gap Year – BY3
Planned Service Line Changes for PY2	TBD
Unplanned Volume Changes	Gap Year – BY3
HGB Adjusted for Volume	
Annual Payment Adjustments	PY2 / PY1
Demographic Adjustments	PY2 / PY1
HGB with Annual Payment and Demographic Adjustments	
Social Risk Adjustment	≤2.0% Based on PY1
HGB after Annual Trend Updates	
Effectiveness Adjustment	≤1% Based on Performance
Health Equity Improvement Bonus	NA (Starts PY4)
TCOC Performance Adjustments	NA (Starts PY4)
Transformation Incentive Adjustment	1.0%
HGB with Annual and Performance Adjustments	
Sequestration	-2.0%
Final PY2 HGB	
Mid-Year Reconciliation	PY1 Service Line & Util.

Boone Valley Hospital

Adjustment	Basis
PY1 HGB w/ Annual Payment and Demographic Adjustments	
Market Shift Adjustment	Gap Year – BY3
Planned Service Line Changes for PY2	TBD
Unplanned Volume Changes	Gap Year – BY3
HGB Adjusted for Volume	
Annual Payment Adjustments	PY2 / PY1
Demographic Adjustments	PY2 / PY1
HGB with Annual Payment and Demographic Adjustments	
Social Risk Adjustment	≤2.0% Based on PY1
HGB after Annual Trend Updates	
Effectiveness Adjustment	NA (Starts PY3)
CAH Quality Adjustment	
Health Equity Improvement Bonus	NA (Starts PY4)
TCOC Performance Adjustments	NA (Starts PY4)
Transformation Incentive Adjustment	1.0%
HGB with Annual and Performance Adjustments	
Sequestration	-2.0%
Final PY2 HGB	
Mid-Year Reconciliation	PY1 Service Line & Util.

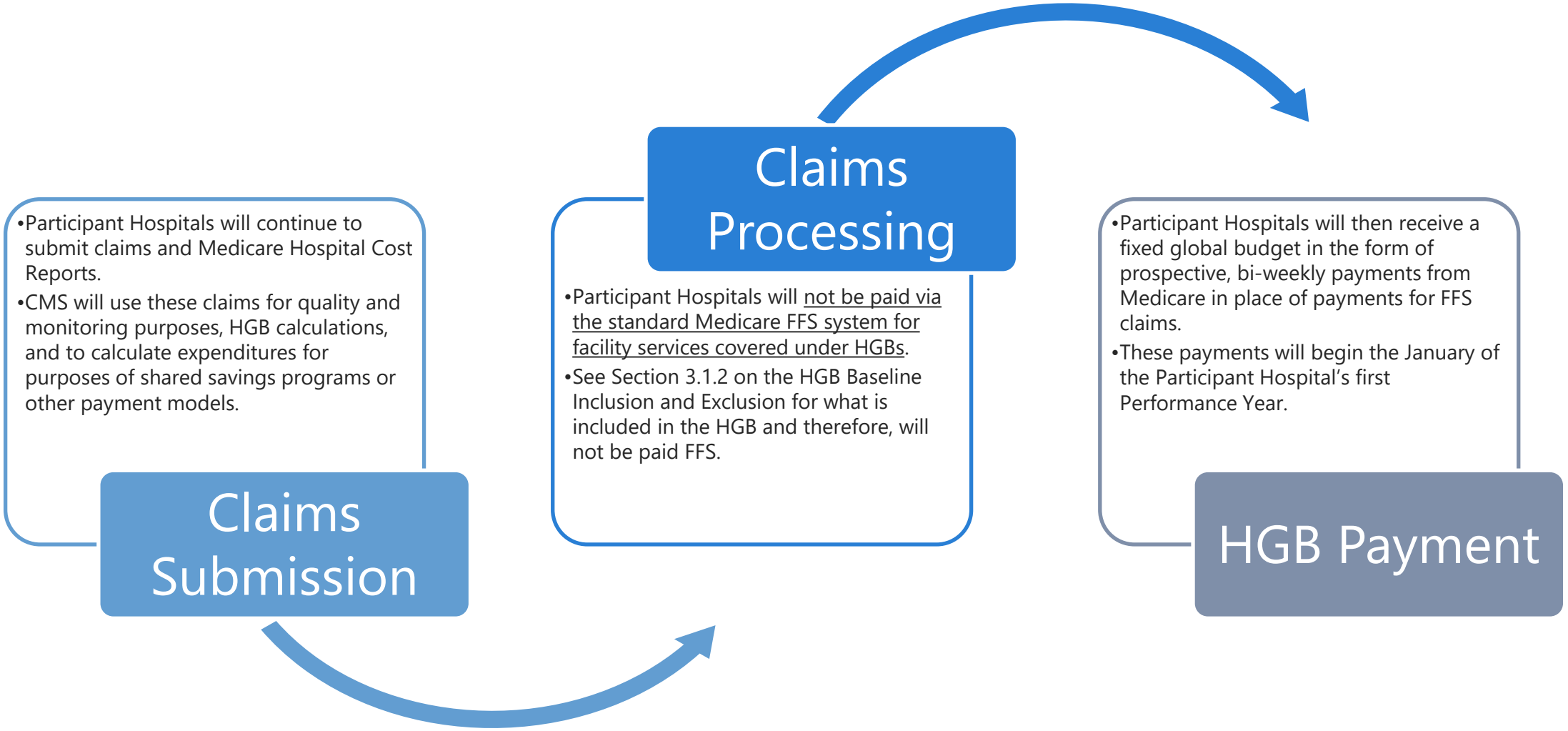
Operational Considerations

AHEAD Model Hospital Global Budget Timeline*



**Specific dates will be released later and are subject to change. Hospitals may join in any year during the AHEAD Performance Period.*

Payment Operations for Hospital Global Budgets



Beneficiary cost-sharing will remain as normal
(i.e., beneficiaries will pay cost-sharing based on the value of what would have been paid in FFS).

Considering Participation in the AHEAD Model

- CMS, through the AHEAD Model, will partner with States to help hospitals to fully understand HGBs during the Pre-Implementation Period and for early Performance Years.

- In the interim, hospitals can begin to take steps now to support their readiness for participation in the AHEAD Model by familiarizing themselves on the overall concept and submitting questions to CMS/state.

- During the Pre-Implementation Period:
  - CMS will be developing technical assistance resources to support hospital decision-making.
  - Hospitals will indicate interest in receiving a Participation Agreement and Hospital Global Budget estimate.
  - Interested hospitals will have the final CMS-designed Medicare FFS Hospital Global Budget Methodology prior to signing a Hospital Participation Agreement.
  - This estimate will be updated with final IPPS and OPPS rules prior to signing a Participation Agreement, further increasing transparency while reducing risk.

- During the Performance Period:
  - CMS will actively monitor Participant Hospitals' financial and performance metrics during the model.
  - CMS will be sharing a dashboard with key metrics for hospital decision-making.
  - Participant Hospitals can participate in technical assistance and learning activities to support transformation and knowledge sharing.

Overlaps with Other CMS Programs & CMMI Models

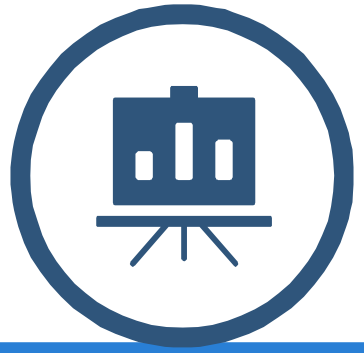
Model/Program	Overlaps Policy	
ACO Realizing Equity, Access, and Community Health (ACO REACH)	**Hospital Providers**: • Overlaps are not permitted with ACO REACH Participants and Preferred Providers receiving Total Care Capitation (TCC), Primary Care Capitation (PCC), and/or Advanced Payment Option (APO) payments • Overlaps are permitted with ACO REACH Preferred Providers not receiving TCC, PCC, and/or APO payments **Hospital-Based Professionals**: overlaps permitted; professionals practicing at AHEAD hospitals can participate in ACO REACH and receive capitated payments for professional services from REACH.	**Accountability for Hospital Spending**: ACO REACH and Shared Savings Program ACOs will be accountable for hospital spending on ACO-aligned beneficiaries at financial settlement for the purposes of determining shared savings/losses using the value of the no-pay claims. This includes costs incurred at hospitals participating in AHEAD hospital global budgets, whether those hospitals are ACO REACH/Shared Savings Program participants or not. The costs for services rendered at hospitals participating in AHEAD HGBs for attributed ACO beneficiaries will be determined using no-pay claims.
Medicare Shared Savings Program (Shared Savings Program)	**Hospital Providers**: overlaps permitted; hospitals may simultaneously participate in AHEAD hospital global budgets and Shared Savings Program ACOs. **Hospital-Based Professionals**: overlaps permitted; professionals practicing at hospitals participating in AHEAD hospital global budgets may simultaneously participate in Shared Savings Program ACOs.	
Transforming Maternal Health (TMaH)	Overlaps not permitted; hospitals may not simultaneously participate in AHEAD HGBs and TMaH's APM.	
Innovation in Behavioral Health (IBH)	Overlaps not permitted; hospitals, including CAHs, may not simultaneously participate in AHEAD HGBs and IBH.	

Additional information on these overlaps policies and others is available in the forthcoming AHEAD Overlaps Policies Fact Sheet.

Question and Answer Session

Audience Poll #2

Please respond to the live poll using the Zoom platform.



What about the AHEAD Model's hospital global budget methodology do you want to learn more about?

a. Baseline construction, including eligible hospitals and services
b. Annual and performance-based adjustments
c. Timing of adjustments and payments
d. Considerations for CAHs and Safety Net Providers
e. Overlaps with other CMS and CMMI payment models
f. Data collection and reporting
g. Other (please specify in the Q&A)

Question & Answer Session

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.
Specific questions about your organization can be submitted to AHEAD@cms.hhs.gov.

Frequently Asked Questions

How can I encourage my state to apply?
Hospitals and health systems can consult with applicable state agencies to encourage and inform state application to participate in the AHEAD Model. These groups may also submit a Letter of Intent (LOI) to participate in the model as part of the state application. At least one LOI from a hospital is required as part of state application to participate in the AHEAD Model. LOIs from hospitals are non-binding; however, they will help CMS understand how applicants are engaging with hospitals and health systems.

Frequently Asked Questions

How will the AHEAD HGB fund infrastructure to address health equity?
The CMS-designed Medicare FFS hospital global budget methodology includes a Transformation Incentive Adjustment, which is an upward adjustment in the first two years of the model intended to support enhanced care management for Medicare beneficiaries, including screenings and referrals for health-related social needs and coordinating with other providers and community-based organizations on care management. Hospitals participating in the AHEAD Model's Medicare hospital global budget will have the option to capture and reinvest funds in population health and health equity. For example, a hospital could propose reinvesting funds from reduced potentially avoidable utilization or a planned service line change to address population health or health equity-related goals. Additional details can be found in the Notice of Funding Opportunity.* Hospitals will continue to be able to use community benefit dollars to support population health and addressing health disparities.

**See Notice of Funding Opportunity: Section A4.5 for more information.*

Frequently Asked Questions

How can a hospital reasonably see margin under the AHEAD HGB?
Participating hospitals will benefit from stable and predictable funding through the AHEAD Model's hospital global budgets. Hospitals may also see increases in their hospital global budgets for improved quality, including health equity-related measures. Participation in the AHEAD Model gives hospitals the opportunity to use benefit enhancements available under the model to support care redesign efforts. Participating hospitals may also realize savings generated from reductions in avoidable utilization coupled with gains in care delivery efficiency. Hospitals that chose to participation in the AHEAD Model will also benefit from technical assistance and learning resources that are intended to aid care transformation activities.

Frequently Asked Questions

What types of hospitals can participate in the AHEAD Model?
Acute Care Hospitals (including but not limited to Academic Medical Centers, Medicare Dependent Hospitals, Regional Referral Centers, Rural Referral Centers, or Sole Community Hospitals) and Critical Access Hospitals are eligible to participate in the AHEAD Model. Rural Emergency Hospitals in participating states that have enacted enabling legislation during the model implementation period may also participate in the model. Cancer Hospitals, Children's Hospitals, Long Term Care Facilities, Psychiatric Hospitals, Rehabilitation Hospitals, Transplant Hospitals or Veteran's Hospitals are not eligible to participate in the model's Medicare FFS hospital global budgets.

Frequently Asked Questions

When will a hospital get to review the methodology?
CMS plans to share a draft methodology for the CMS-designed Medicare FFS methodology in early 2024 and will host webinars to help orient interest hospitals to the methodology. A final CMS-designed Medicare FFS methodology will be available during the Pre-Implementation Phase as states work to recruit hospitals to participate in hospital global budgets. CMS anticipates providing technical assistance to hospitals during this process and allowing for sufficient time for hospitals to make an informed decision on their participation prior to signing any Participation Agreement.

Closing Resources

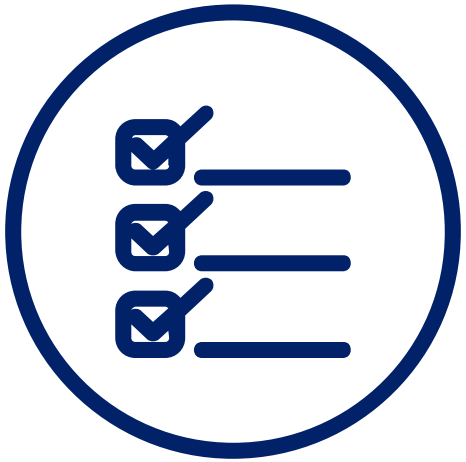
Audience Poll #3

Please respond to the live poll using the Zoom platform.

Following this presentation, I understand the AHEAD Model's Medicare HGB methodology sufficiently to make a business decision to participate or to explain the methodology to participants

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

Please Complete Our Survey



We appreciate your input!

Please click the link posted in the chat to take our survey.

We would love to learn how to make our events better.

Thank You

Thank you in advance for your review and feedback on the CMS-designed Medicare FFS Hospital Global Budget methodology! We appreciate your time and interest!

Please take the survey following this webinar so we can learn how to make our events better.

Do you have questions? Email your comments and feedback to AHEAD@cms.hhs.gov with subject line ***AHEAD Hospital Global Budget Methodology***

THANK YOU!

Appendix

What is Medicaid's Role in AHEAD Hospital Global Budgets?

This presentation focuses on the CMS-designed Medicare FFS hospital global budget methodology. However, the AHEAD Model includes a requirement for participating states to design and implement a Medicaid hospital global budget. Medicare, Medicaid, and commercial payer hospital global budgets are critical to achieving the goals of the AHEAD Model.

Medicaid Hospital Global Budgets

Medicaid participation in hospital global budgets is required by the end of Performance Year 1. States, in consultation with CMS, will propose their own methodologies for Medicaid hospital global budgets. This methodology must fit a set of CMS-specified criteria and guardrails to ensure that it reflects the model's goals and uses existing Medicaid authorities.

- These criteria are designed to allow for some flexibilities for Medicaid Agencies to propose a methodology that is appropriate for their state and provider contexts.
- CMCS and CMMI are committed to continued close partnership to assist states in the process of obtaining relevant authorities and designing Medicaid global budget methodologies during the pre-implementation period.