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

Disclaimer: *The content in this resource does not reflect updates to the AHEAD Model, effective as of August 2025. These updates include model timeline changes, the addition of a geographic-based component (Geo AHEAD) that overlays hospital global budgets, and a requirement to implement state-level choice and competition policies that may impact hospitals. For the most up-to-date information about the AHEAD model and these updates, please see the AHEAD Model Webpage.*

Center for Medicare and Medicaid Innovation
April 8, 2025

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Today's Presenters

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Agenda

This webinar provides a high-level overview of the AHEAD Model's Centers for Medicare & Medicaid Services (CMS)-Designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) Methodology, including enhancements from Version 2.0 to 3.0, and highlights how HGBs benefit eligible hospitals in AHEAD. The following topics will be discussed:

1. AHEAD Model Overview & Timeline
2. Medicare FFS HGB Financial Methodology Details & Key Changes in Version 3.0
3. Question and Answer Session

AHEAD Model Overview

AHEAD Model Overview

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

Statewide Accountability Targets
Total Cost of Care (TCOC) Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Population Health Outcomes via State Agreements with CMS

8-9 Performance Years

Components

Cooperative Agreement Funding

HGBs (facility services)

Primary Care AHEAD

Strategies

- Community Health Improvement
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

Eligible Hospitals in AHEAD

Participation in the AHEAD Model is voluntary and will be subject to state-level coordination and oversight.

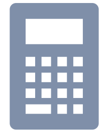
Eligible Hospital Types	Ineligible Hospital Types
• Acute Care Hospitals (ACHs) • Critical Access Hospitals (CAHs) • Medicare-Dependent Hospitals • Rural Emergency Hospitals • Rural Referral Center Programs • Sole Community Hospitals • Tribal Hospitals • Indian Health Service Hospitals	• Cancer Hospitals • Children's Hospitals • Long-Term Care Facilities • Psychiatric Hospitals (free standing and distinct part units) • Rehabilitation Hospitals (free standing and distinct part units) • Transplant Hospitals • Veterans' Hospitals

Hospitals that **voluntarily** agree to participate under a Hospital Global Budget (HGB) will sign Hospital Participation Agreements with CMS that enumerate their participation requirements and expectations.

AHEAD Model Upcoming Milestones

Financial Specifications:

- **CMS Medicare FFS HGB Financial Specifications**: Document detailing and summarizing Version 3.0 of the methodology, including baseline and adjustments. (April 2025)



Calculations:

- **CMS Medicare FFS HGB Calculator Tool:** A plug and play, automated calculation tool that allows hospitals to enter values for baseline and other adjustments to enhance understanding of the Version 3.0 methodology. (May 2025)
- **Simulated CMS Medicare FFS HGBs**: HGB estimates simulating for each eligible hospitals what their HGB would have been in years prior to AHEAD Performance Year 1 (PY1). (Prior to PY1)
- **Estimated CMS Medicare FFS HGBs**: Initial, prospective HGB payment calculation estimates for PY1. (Prior to PY1)
- **Final CMS Medicare FFS HGBs:** Final, prospective HGB payment calculations for PY1. (November prior to PY1)

Technical Assistance:

- **Live Sessions:** To answer questions on the CMS Medicare FFS HGB methodology & calculation tool. (Spring 2025)

Hospital Participation Agreements: Legal agreements with CMS that enumerate participation requirements and expectations. (October prior to PY1)

Hospital Global Budgets (HBGs)

WHAT IS AN HGB?

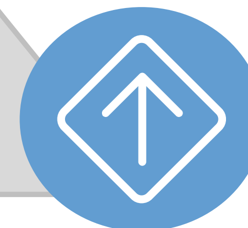
A **prospectively set annual budget** for hospital inpatient and outpatient facility services. Under the AHEAD model, HGBs are calculated based on historical Fee-For-Service (FFS) revenue data with adjustments incorporated to account for changes in prices, volume, social risk, and performance on quality and cost measures.

BENEFITS OF HGBs

Predictability & Sustainability

HGBs create a "win-win-win" scenario for patients, hospitals, and payers by aligning incentives to improve population health while preserving hospital capacity to serve patients when acute care is needed.

Upward Adjustments



Reinvestment Revenue

Understanding the Calculation of Hospital Global Budgets (HGBs)

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

Baseline Calculation

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

Volume-Based Adjustments

- Market Shift Adjustment
- Service Line Adjustment
- Outlier Adjustment

Adjustments for Parity with FFS

- Annual Payment Adjustment
- Demographic Adjustment

AHEAD-Specific Adjustments

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

Global Budget Payments

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

AHEAD HGB Components – Upside, Downside, or Bidirectional HGB Adjustment Components by Applicable Performance Year (PY)

Step 1: Baseline Calculation

Step	HGB Adjustment Component	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Step 2: Volume-Based Adjustments	Service Line Adjustment	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
	Market Shift Adjustment		↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
	Outlier Adjustment			↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
Step 3: Annual Pricing & Demographic Adjustments for Parity with FFS	Annual Payment Adjustment, *including PPS Hospital Quality Adjustment*	↑	↑	↑	↑	↑	↑	↑	↑
	Demographic Adjustment	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
Step 4: AHEAD-Specific Adjustments	Transformation Incentive Adjustment	↑	↑						
	Social Risk Adjustment	↑	↑	↑	↑	↑	↑	↑	↑
	Total Cost of Care Performance Adjustment*				↑	↑↓	↑↓	↑↓	↑↓
	Community Improvement Bonus				↑	↑	↑	↑	↑
	Critical Access Hospital Quality Adjustments			↑	↑	↑	↑	↑	↑
	Effectiveness Adjustment**		↓	↓	↓	↓	↓	↓	↓

*For Prospective Payment System hospitals, Total Cost of Care Performance is upward only in PY4, and bidirectional thereafter; for SNHs and CAHs Total Cost of Care Performance is upward only PY4 – PY5 and bidirectional thereafter.

**For Prospective Payment System hospitals, Effectiveness Adjustment is downward only starting in PY2; for SNHs and CAHs Effectiveness Adjustment is downward only starting in PY3.

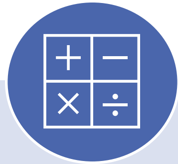
Medicare Fee-For-Service (FFS) Hospital Global Budget (HGB) Financial Methodology Details & Key Changes in Version 3.0

Financial Methodology: Baseline Calculation

Hospital Global Budget (HGB) Baseline Calculation

Purpose

The starting point for determining Performance Year (PY) 1 HGB payments. HGB payments for PY2 and onward are based on prior HGB payments.



Methodology

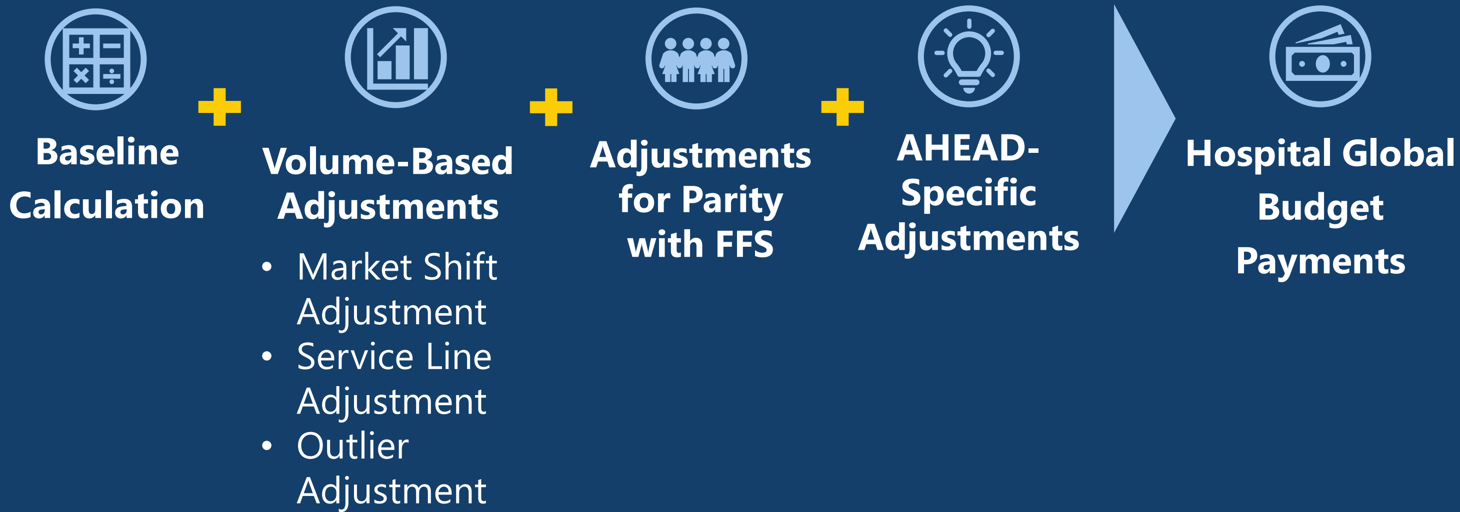
- Combine three Baseline Years (BYs), beginning 3.5 years before the first PY, of historical data.
- Apply weighting more heavily to recent years.
- Include all Medicare Fee-For-Service (FFS) revenue (inpatient/outpatient), regardless of beneficiary residence.
- Apply Baseline Adjustment Factor using logistic regression to adjust by the probability that the weighted baseline is above or below PY1 FFS, to enhance baseline accuracy.

	BY 1	BY 2	BY 3
Timing	3.5 years prior to PY1	2.5 years prior to PY1	1.5 years prior to PY1
Weight	10%	30%	60%

Remember: For CAHs, settlements made through cost reports to reconcile to 101 percent of costs are incorporated in historical Medicare FFS revenue and a HGB payment floor applies.

Version 3.0 Refinement

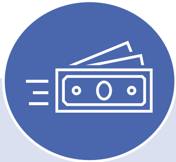
Financial Methodology: Volume-Based Adjustments



Market Shift Adjustment (MSA)

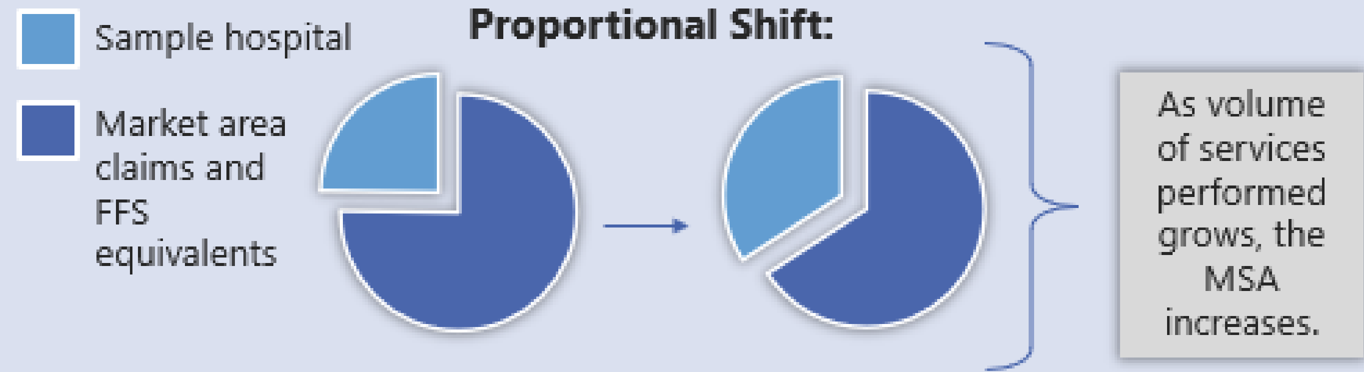
Purpose

Accounts for bidirectional volume shifts between Eligible Hospitals in a Hospital-Specific Market Area and overlapping market areas, beginning in PY2, except for "small hospitals."



Methodology

- Calculates MSA based on the proportional shift in FFS payments and weights for the hospital within its market area (defined at the *zip code level*).
- Scale of the MSA is impacted by an MSA Shift Allowance that is calculated based on no-pay claims and total FFS equivalents for hospitals in the in the geographic area.
- Applies a 0% floor to small hospitals (<2% of state or substate total Medicare payments) to protect against unpredictable downward volume shift, ensuring upward only MSA adjustment.



Hospital MSA Amount = Proportional Shift × MSA Shift Allowance

Where,

Proportional Shift = *(FFS Payments Proportional Shift * 50%)* + *(FFS Weights Proportional Shift * 50%)*

$$\text{MSA Shift Allowance} = \sum_{j=1}^{j=n} s_j * State\ Growth\ Benchmark * Funding\ Factor$$

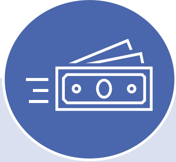
Remember: *The MSA Shift Allowance is adjusted by the *State Growth Benchmark* and a *Funding Factor*, an 80% multiplier recognizing costs for moving volume from one location to another.

Version 3.0 Refinement

Service Line Adjustment (SLA)

Purpose

Prospectively adjusts Hospital Global Budgets (HGBs) to account for pre-planned service line additions, expansions, reductions, or eliminations.



Methodology

- For service line additions or expansions, the estimated SLA amount is added to prospective HGB, then reconciled back to Fee-for-Service (FFS) for two Performance Years (PYs) or subject to the Market Shift Adjustment methodology thereafter.
- For Acute Care Hospitals, CMS may reduce prospective HGBs by the full estimated SLA amount associated with service line reductions or eliminations, *OR* 50% of it (if approved for up to 50% retention).
- For Critical Access Hospitals, CMS may reduce prospective HGBs by the full estimated SLA amount associated with service line reductions or eliminations, *OR* 0% of it (if approved for up to 100% retention).
- SLAs must be pre-approved by CMS for hospitals to observe benefit of FFS true-up or revenue retention.

Remember: Volume-based adjustments facilitate predictable HGB payments, remove the volume-based incentives of FFS, and enable hospitals to generate reinvestment revenue reflecting the difference between fixed historical revenue and costs from lower utilization in response to reduced demand during the PYs.

Outlier Adjustment (New)

Purpose

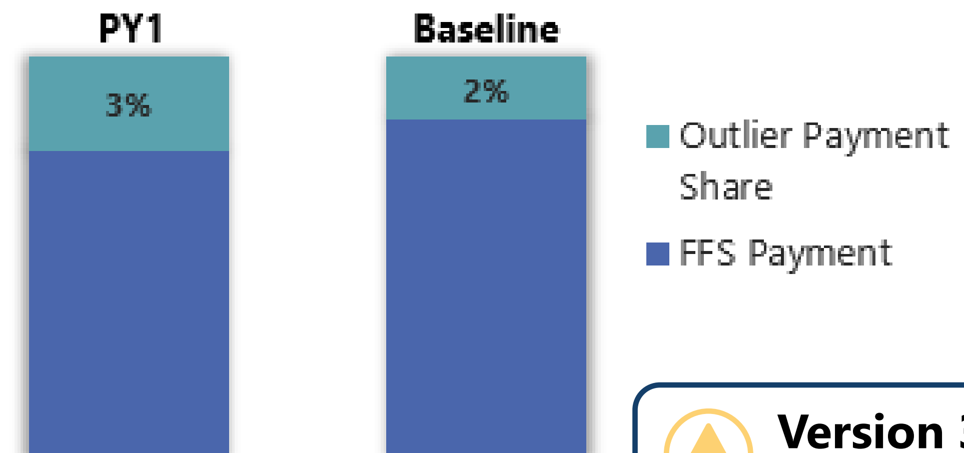
To mitigate the financial risk associated with encounters that are unusually expensive and resource intensive.

Methodology

- Removes outlier components from Annual Payment Adjustment (APA).
- Calculates outlier amounts based on claims instead of estimates.
- Adjusts Hospital Global Budgets (HGBs) by the change in the share of FFS outliers included in HGBs.
- Calculates Outlier Adjustment in November of Performance Year (PY) 2 and first applied in PY3.

Example: Adjustment for PY3 =

[PY1 share of outlier payments from no-pay claims − Baseline share of outlier payments from FFS claims] x HGB



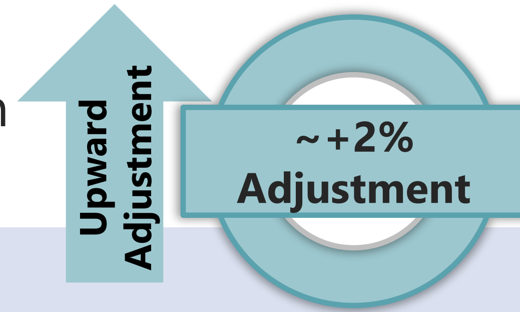
Financial Methodology: Annual Pricing & Demographic Adjustments for Parity with Fee-For-Service (FFS)

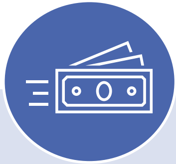
- Annual Payment Adjustment
- Demographic Adjustment

Annual Payment Adjustment (APA)

Purpose

To adjust the Hospital Global Budget (HGB) Baseline to account for changes in Medicare Fee-For-Service (FFS) prices and policy changes.





Methodology

- Accounts for price and policy changes only.
- Reflects the specific FFS payment factors (e.g., wage indexes) for each Participant Hospital.
- Denotes the percentage change in a weighted average of Medicare pricing factors specific to each hospital.
- Includes Prospective Payment System (PPS) Hospital Quality adjustments to align quality measures to existing CMS programs for PPS hospitals.

Annual Payment Adjustments (APA): Factors Included

Market Basket

Medicare Promoting Interoperability Program

Low Volume

Uncompensated Care (UCC)

PPS Hospital Quality Programs

Indirect Medical Education

Disproportionate Share Hospital (DSH)

Remember: CMS provides an APA to reflect appropriate price and policy changes and provide sufficient revenue for patient care.

Demographic Adjustment

Purpose

To adjust the HGB for changes in the status of the population (population size, age, Medicare status, medical risk, etc.) served by the hospitals in a specific geographic region.

Methodology

- Uses Hierarchical Condition Category (HCC) scores to adjust HGBs for the demographic and clinical risk of beneficiaries in the counties served by the hospital.
- HCC scores incorporate data on beneficiary health condition(s) using the ICD-10 codes and demographic factors.

Remember: The Demographic Adjustment accounts for a more medically complex population as the population ages, new beneficiaries qualify for Medicare coverage, and existing beneficiaries' care becomes more medically complex.

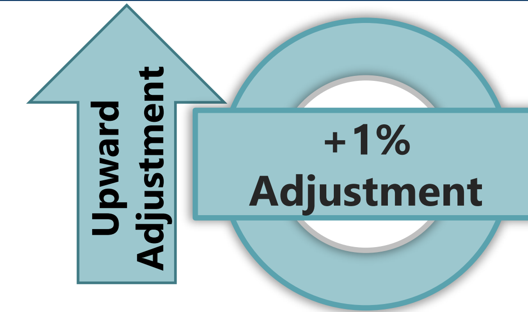
Financial Methodology: AHEAD-Specific Adjustments

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

Transformation Incentive Adjustment (TIA)

Purpose

To incentivize early hospital participation and provide additional revenue in care management and transformation activities that will generate medium- and long-term savings.



Methodology

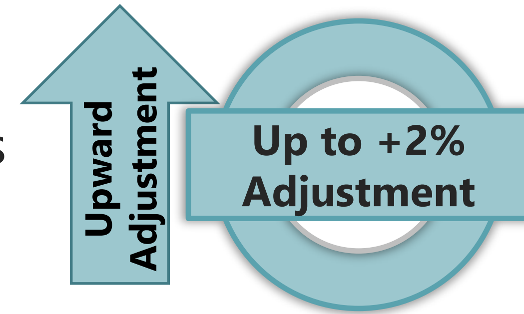
- 1% increase to a participant hospital's global budget in the first two Performance Years (PYs) after all other adjustments have been completed.
- TIA only needs to be repaid if the hospital exits the Model before the sixth PY.

Remember: Joining the model early is an opportunity to receive additional funding for population health and transformation activities.

Social Risk Adjustment (SRA)

Purpose

To adjust HGBs to account for beneficiary population social risk differences among hospitals within the state or sub-state region.



Methodology

Beneficiary Social Risk Score (SRS) =

National Community Deprivation Index (CDI) + Low Income Marker (LIM)

LIM is defined by Dual Eligibility and Part-D Low-Income Status

- Using geocoding, FFS Beneficiaries are assigned to a census block group area.
- The SRS for a Participant Hospital is calculated based on each census block group's proportion of hospital payments multiplied by the census block group's average SRS.
- The hospital SRA is calculated based its SRS relative to other hospitals in the state.

SRS Percentile Lookup Table to Determine the SRA Percentage

SRS Within State Percentile	SRA %
0-39%	0.0%
40-49%	0.2%
50-59%	0.4%
60-69%	0.7%
70-79%	1.1%
80-89%	1.6%
90-100%	2.0%

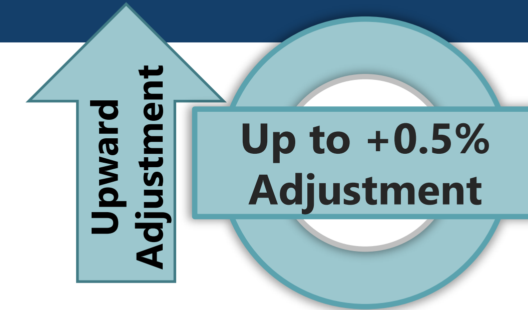
Remember: AHEAD provides an upside-only benefit to hospitals that treat greater adverse populations.

Version 3.0 Refinement

Community Improvement Bonus (CIB)

Purpose

To provide hospitals with the opportunity to earn up to 0.5% in additional revenue based on hospital performance on select population health measures.



Methodology

Hybrid Hospital-Wide Readmission (eHWR) Improvement Rate =
Percent Change in eHWR x Social Risk Score (SRS) Multiplier

Prevention Quality Indicator (PQI)-90 (PQI-90) Improvement Rate =
Percent Change in PQI-90 x SRS Multiplier

- Measures improvement between the base period and performance period among all beneficiaries admitted to the hospital that meet the inclusion criteria for each measure.
- Adjusts improvement scores by a SRS multiplier (ranging from 1.0-2.0) that is based on the SRS percentile of that hospital in its state.
- The hospital CIB is determined based on its Improvement Rate in each measure relative to measure specific targets.

SRS Multiplier by SRS Percentile Categories

SRS Within State Percentile	SRS Multiplier
0-9%	1
10-19%	1
20-29%	1
30-39%	1.1
40-49%	1.2
50-59%	1.3
60-69%	1.4
70-79%	1.6
80-89%	1.8
90-100%	2

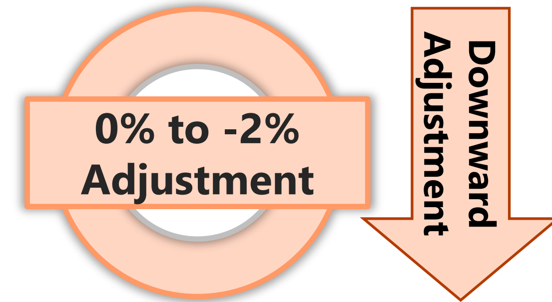
Remember: The CIB incentivizes hospitals to close patient gaps and improve health outcomes by monitoring a hospitals performance on select population health measures.

Version 3.0 Refinement

Effectiveness Adjustment (EA)

Purpose

To incentivize hospitals to implement interventions that reduce expenditures associated with unnecessary or avoidable care.



Methodology

- Based on the individual hospital's percentage of Potentially Avoidable Utilization (PAU) costs compared to other hospitals in the state, adjusted by hospitals' Social Risk Score (SRS)
- Hospitals in the 20th percentile or below will not receive a downward adjustment.
- Increases gradually over time as hospitals gain additional experience implementing processes to control PAU and form partnerships.
- For ACHs, starts in Performance Year (PY) 2; For SNHs and CAHs, starts in PY3.

Updated Measures

Removed: Low-Value Care and New York University Avoidable Emergency Department Algorithm Measures

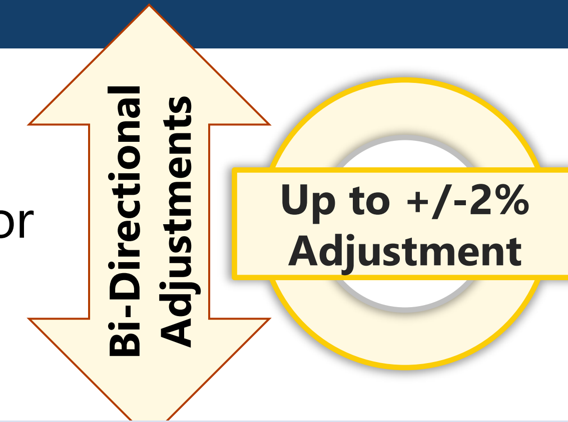
Added: National Committee for Quality Assurance (NCQA)'s Emergency Department Utilization Measure

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

Version 3.0 Refinement

Total Cost of Care (TCOC) Performance Adjustment

Purpose
To incentivize hospitals to manage population health outcomes and costs for beneficiaries within their geographic service area.



Methodology

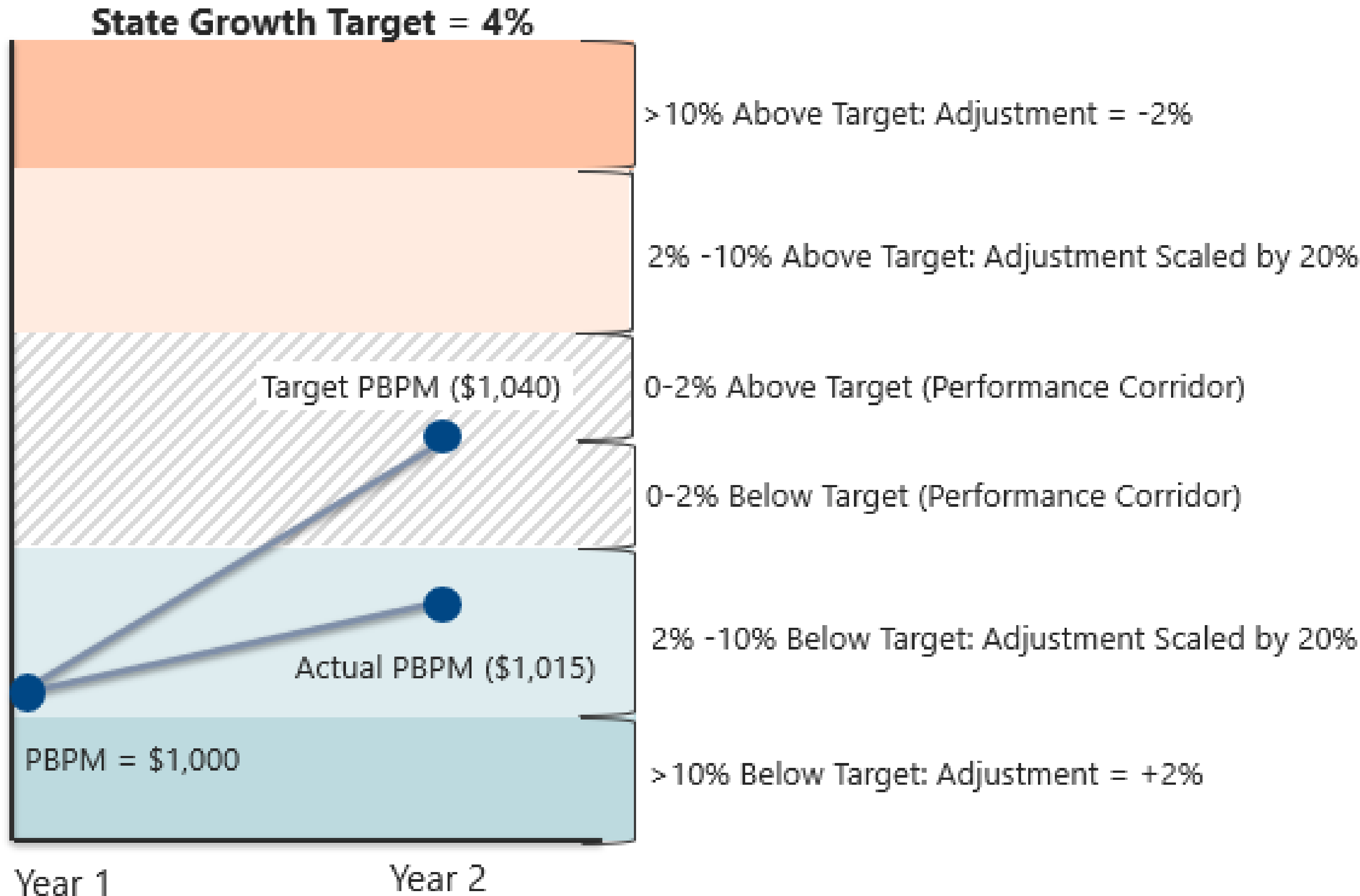
- Adjustment for TCOC more than 2% above or below the TCOC benchmarks.
- Hospital's risk adjusted per beneficiary per month (PBPM) TCOC is trended forward using the State Growth Benchmark to set the Participant Hospital's Target PBPM TCOC.
- TCOC adjustment begins in Performance Year (PY) 4.

Remember: The TCOC Adjustment will begin as upward only, allowing hospitals time to work across the health care delivery system and manage population health.

Version 3.0 Refinement

Total Cost of Care (TCOC) Performance Adjustment – Sample Calculation

Example TCOC Adjustment Calculation

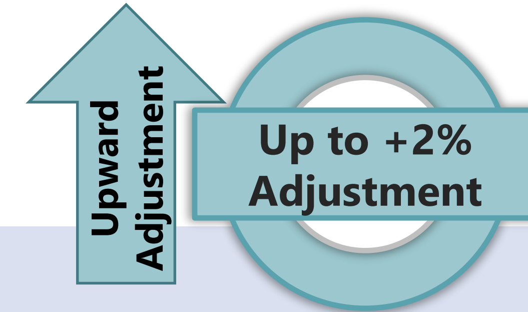


- The difference Between Target and Actual = ($1,040 - $1,015) / $1,015 = 2.5%
- 2.5% is larger than the 2% performance corridor, so the hospital will receive a TCOC Adjustment
- The TCOC Adjustment is 2.5% * 20% = 0.5%

Critical Access Hospital (CAH) Quality Adjustment

Purpose

To incentivize performance on specific rural-relevant quality measures.



Methodology

- Allows CAHs to starts 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., Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS])

Example Year (Cohort 1)	2026 (PY1)	2027 (PY2)	2028 (PY3)	2029 (PY4)	2030 (PY5)	2031 (PY6)	2032 (PY 7)	2033 (PY 8)
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%

Remember: CAHs participating in the AHEAD Model will participate in an upside-only quality incentive program that will align with the other quality programs, will include rural-specific measures, and will require reporting on at least one measure in each key domain.

Connecting with the AHEAD Team

Share your thoughts and recommendations!

The AHEAD Model Financial Specifications for the HGB Methodology was updated to Version 3.0 in response to feedback from key audiences to improve predictability of HGB payments to reduce risk for interested Participant Hospitals.

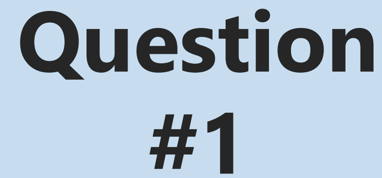
CMS welcomes feedback and input to continue enhancements to the methodology. Suggestions or other questions about the AHEAD Model can be submitted to AHEAD@cms.hhs.gov.

Question and Answer Session

Question & Answer (Q&A) Session

Open Q&A

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

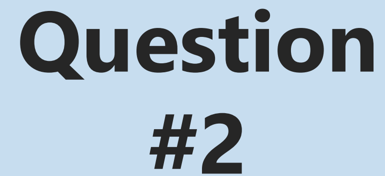


Q: What are strategies hospitals can use to support their success under the model (e.g., improve population health, contain costs)?

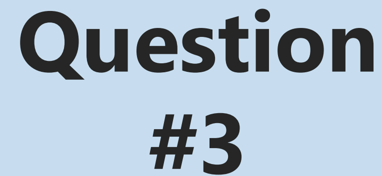
Hospitals can employ strategies such as:

1. Proactive care management and population health initiatives. This may include investing in preventative care and disease management, enhancing discharge planning, or connecting frequent ED users to primary care or behavioral health
2. Shift care to lower-acuity settings where appropriate. For example, hospitals may move ED care to urgent care centers, enhance hospital to post-acute care discharge planning to reduce inpatient length of stay, and move some surgeries to non-hospital settings (e.g., dialysis clinics, outpatient clinics, ambulatory surgical centers)
3. Collaboration across health systems and community programs. Develop partnerships with physicians and social service providers

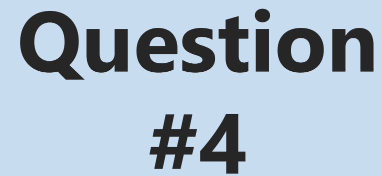
Each hospital's strategy will depend on the unique hospital environment and population served.



Is Version 3.0 of the CMS-Designed Medicare Fee-For-Service (FFS) Hospital Global Budget (HGB) Financial Specifications considered final or will changes still be made?
No major enhancements are anticipated for the CMS-Designated Medicare FFS HGB Financial Specifications. As needed, CMS will release specification updates, which would be disseminated prior to the start of the effective Performance Year.



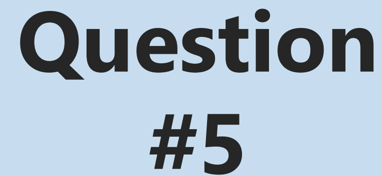
Q: Can hospitals concurrently participate in Hospital Global Budgets (HGBs) and other CMMI models?
Overlaps are permitted in specific cases and intended to work synergistically to improve health care cost and quality outcomes, specifically between Medicare Shared Savings Program, Transforming Episode Accountability Model (TEAM), and AHEAD. The AHEAD Model Overlaps Policy Fact Sheet, located on the AHEAD Model webpage, will be revised as needed.



Q: Will participating hospitals receive Hospital Global Budgets from multiple payers?

Yes. Participating hospitals may expect to receive HGBs for Medicare FFS and Medicaid, as required under the AHEAD Model. Participating hospitals *may* also receive HGBs from commercial payers that voluntarily participate in AHEAD, which may include revenue from state employee health plans, Basic Health Plans, Qualified Health Plans, and Medicare Advantage plans (including Dual Eligible Special Needs Plans), among others.

Medicare FFS HGBs are required beginning in Performance Year (PY) 1. Medicaid HGBs are required beginning in PY2. Each state is required to have at least one commercial payer operating in the state or sub-state region participate in HGBs by the start of PY2.



Q: How does the AHEAD Model define Safety Net Hospitals?

Safety Net Hospitals include:

1. Short-term hospitals that serve above a baseline threshold of beneficiaries with dual eligibility for Medicare and Medicaid or Part D Low-Income Subsidy (LIS).
2. Critical Access Hospitals.
3. Short-term hospitals with Medicare DSH Patient Percent (DPP) exceeding the 75th percentile threshold for all congruent facilities who bill Medicare within their state.

A hospital identified as a Safety Net Hospital in the base year will retain its Safety Net Hospital status for the model's duration.

The methodology accounts for the unique context of Safety Net Hospitals and delays the application of some adjustments to give these hospitals more time to gain experience with the AHEAD model. For example, the Effectiveness Adjustment for Safety Net Hospitals begins in Performance Year 3, one year later than Acute Care Hospitals.

Closing

Thank You

Thank you for your time and interest in the AHEAD Model's CMS-Designed Medicare Fee-For-Service (FFS) Hospital Global Budget (HGB) Methodology!

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

For more information regarding AHEAD hospital eligibility, please refer to the AHEAD Model's CMS-Designed Medicare FFS HGB Methodology, available on the AHEAD Model webpage.

Do you have questions? View additional resources on the AHEAD Model webpage or email your comments and feedback to AHEAD@cms.hhs.gov with subject line ***"AHEAD Hospital Global Budget Methodology."***

Thank You!

Appendix: Additional Detail on Adjustment Enhancements

Hospital Global Budget (HGB) Baseline Calculation Enhancements

Baseline Enhancement #1

Summary: For PY1 only, CMS adjusts the weighted baseline to ensure it appropriate represents what Medicare FFS payments would have been in the absence of HGB payments.

Benefit: Hospitals receive a baseline amount that closely resembles Fee-For-Service (FFS) payments.

Baseline Enhancement #2

Summary: Participant Hospitals can specify and receive site specific HGBs if unique Organizational National Provider Identifiers (NPIs) are available.

Benefit: Hospital systems can receive HGBs that reflect the specific communities served by unique hospital locations.

*CMS will use historical claims data and an advanced logistic regression methodology to estimate the difference between the 60/30/10 baseline and projected PY1 claims. Adjustments are then made to adjust the weighted baseline.

Market Shift Adjustment (MSA) Enhancements (1 of 2)

MSA Enhancement – Geography

Summary: Utilizes hospital specific market areas, developed at the *zip-code* level, for calculating the shift in volume between hospitals.

Benefit: Aligns with how hospitals think about the areas they serve. More granular approach provides additional accuracy.

Hospital Market Service Area is identified by:

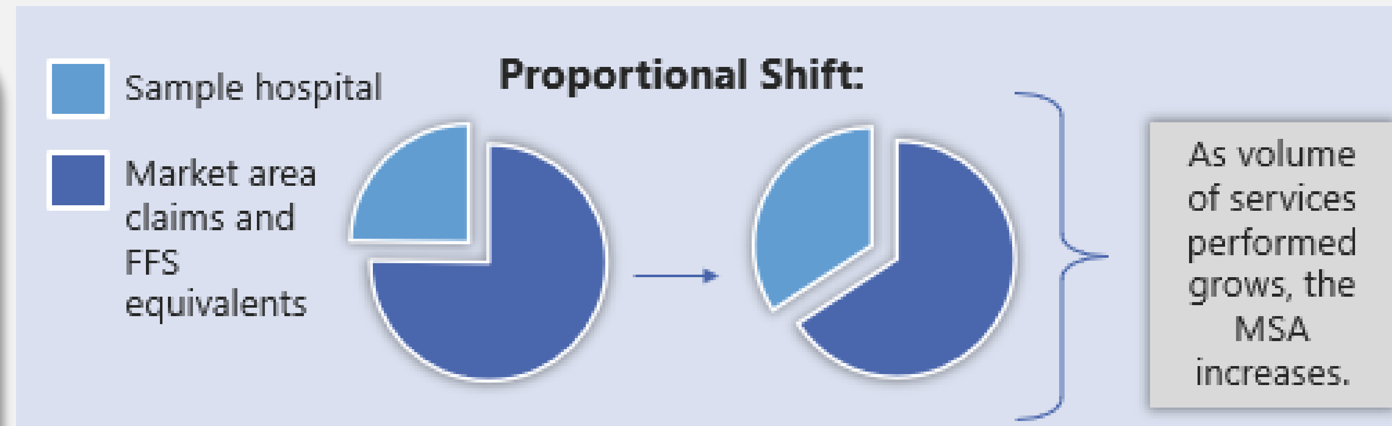
1. Sum hospital revenue by beneficiary zip-code within 120 miles of the hospital.
2. Select zip codes:
   - That contribute at least 0.75% of the hospital's total revenue; OR
   - Where the hospital is the first or second hospital ranked by revenue for the zip code; OR
   - That contribute to the 75% cumulative Fee-For-Service (FFS) revenue of a hospital.
3. Select all hospitals in the zip codes selected in Step #3. This is the hospital market area.

Market Shift Adjustment (MSA) Enhancements (2 of 2)

MSA Enhancement – Updated Calculation

Summary: Calculates MSA based on the ***proportional shift in Fee-For-Service (FFS) payments and weights*** for the hospital within its market area. The scale of the MSA is impacted by an ***MSA Shift Allowance*** that is calculated based on no-pay claims and total FFS equivalents for hospitals in the in the geographic area.*

Benefit: Acknowledges that a hospital's share of volume (as measured by weights and dollars) within a market area can shrink or grow over time. In addition, recognizes that a market area can shrink or grow over time.



MSA Calculation:

Proportional Shift = [FFS Payments Proportional Shift x 50%] + [FFS Weights Proportional Shift x 50%]

***The MSA Shift Allowance is reduced by a "Funding Factor" to maintain additional payment stability.**

Social Risk Adjustment (SRA) Enhancements

SRA Enhancement – Community Development Index (CDI)

Summary: Uses CDI*, which standardizes data from the American Community Survey. Beneficiaries are now geocoded to the census tract and block group level.

Benefit: Reduces influence of housing prices that can mask differences. Geocoding enhances accuracy of attribution of benes.

*The CDI value for a hospital will not be lower than that determined for PY1, to account for the possibility that a hospital may positively influence the community deprivation of local areas, and to not penalize them for doing so.

SRA Enhancement – State Percentile Approach

Summary: Shifts to a within state percentile approach. Reference a lookup table to determine the specific adjustment amount. (***See below)***

Benefit: Results in adjustments that are more proportional to social risk.

SRS Within State Percentile	SRA %
0-39%	0.0%
40-49%	0.2%
50-59%	0.4%
60-69%	0.7%
70-79%	1.1%
80-89%	1.6%
90-100%	2.0%

Community Improvement Bonus (CIB) Enhancements (1 of 2)

Updated Measures and Reporting Threshold

Summary: The CIB now includes Prevention Quality Indicator (PQI)-90 instead of PQI-92. Successful pay-for-reporting shifted from at least one measure in two domains to at least one measure in all three domains.

Benefit: Aligns measures across HGB programs and increases sample size and reliability. Ensures that CAHs are reporting measures in all domains.

Updated Measured Population

Summary: The CIB now measures improvement for all admitted patients that meet the measure inclusion criteria.

Benefit: Increases the sample sizes for the measures and the reliability of the improvement estimates.

Community Improvement Bonus (CIB) Enhancements (2 of 2)

Added Social Risk Score (SRS) Multiplier

Summary: Added a step to multiply improvement rates by hospitals SRS percentile in their state.

Benefit: Incentivizes greater rewards for hospitals caring for the most socially at-risk beneficiaries if they narrow gaps in performance over time.

Revised CIB Targets

Summary: Shifted to calculating results for all beneficiaries that leads to more reliable estimates that vary less year-to-year.

Benefit: Updated targets will maintain the original intent of the CIB and the feasibility to obtain rewards with the revised quality measures.

Effectiveness Adjustment (EA) Enhancements

Updated Measures

Summary: Removed the Low-Value Care and New York University (NYU) Emergency Department (ED) Algorithm measures. Added the National Committee for Quality Assurance (NCQA)'s Emergency Department Utilization (EDU) measure.

Benefit: The EDU measure is used in multiple CMS programs and is a validated measure of preventable ED utilization.

Added Social Risk Score (SRS) Adjustment

Summary: The final PAU score is now adjusted for hospital's SRS.

Benefit: Adjusting for SRS accounts for the impact of differences in population mix on PAU. Hospitals with higher SRS will have higher expected PAU values.

Total Cost of Care (TCOC) Performance Adjustment Enhancement

TCOC Enhancement #1

Summary: Uses a +/- 2% performance corridor to determine which Participant Hospitals receive a TCOC Adjustment.

Benefit: Protects providers that have small changes in their TCOC from natural fluctuations and only rewards or penalizes providers that have outperformed or underperformed their target by a meaningful amount.

TCOC Enhancement #2

Summary: Per Beneficiary Per Month (PBPM) TCOC for each Participant Hospital is trended forward using the State Growth Benchmark (e.g., AHEAD statewide TCOC targets) to set the Participant Hospital's Target PBPM TCOC.

Benefit: Adjusts so state-specific growth rate better aligns with statewide TCOC targets.