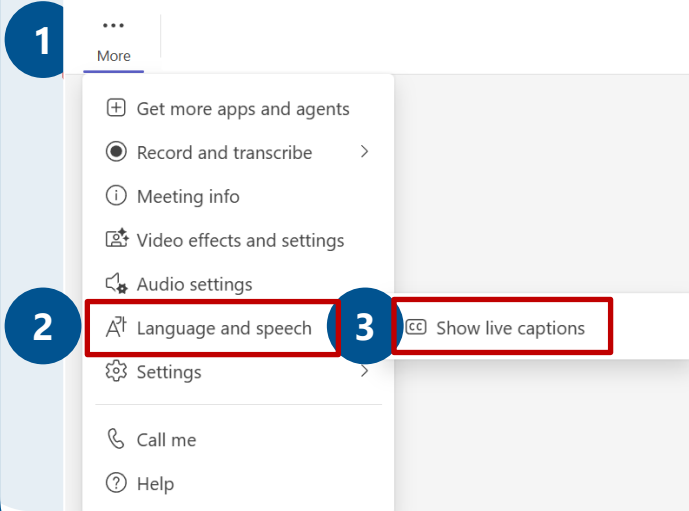


AHEAD Hospital Global Budgets: Strategic Considerations & Medicare Fee-for-Service Methodology Updates

Webinar

September 22, 2026

Closed captioning is available. Please navigate to "More", then "Language and speech", then select "Show live captions".



Please submit questions and comments via the Q&A box at the top of your screen.

Questions will inform future materials and events.

Please complete the short survey that will be sent via email and available via QR code at the conclusion of today's event to provide feedback.

Welcome

Today's Presenters & Opening Remarks



Abid Khan

Director of the Division of Multi-Payer Models , AHEAD Model, CMS Innovation Center

Maggie Drew

Connecticut State Lead and HGB Co-Lead, AHEAD Model, CMS Innovation Center

Alexa Paiva

Rhode Island State Lead and HGB Co-Lead, AHEAD Model, CMS Innovation Center

Jaafar Salim

Finance and HGB Co-Lead, AHEAD Model, CMS Innovation Center

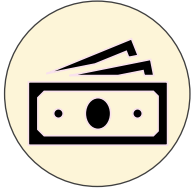
This session is an opportunity for States and hospitals to reconnect on AHEAD Hospital Global Budgets, including recent methodology updates, and learn about opportunities for further engagement.

- 1 | Why AHEAD and Pathways for Participation**
- 2 | AHEAD Hospital Global Budgets in Focus**
- 3 | CMS-Designed Medicare FFS Hospital Global Budgets AHEAD Methodology Updates**
- 4 | Resources, Next Steps, and Closing**

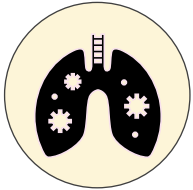
Why AHEAD and Pathways for Participation

AHEAD was created to help address the current challenges hospitals are facing

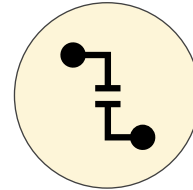
Health System Challenges



Rising healthcare costs
Costs outpacing revenue



Poor population health
Spend rising while results lag



Fragmented care delivery
Complexity drains value



Financial pressures
Instability threatens access



AHEAD Model

Fully aligned state-based total cost of care (TCOC) model that:

- Curbs costs
- Improves population health
- Streamlines care delivery
- Strengthens financial sustainability & market competition

AHEAD Model: A System-Wide Model to Bend Cost, Improve Health, and Strengthen Care Delivery

The AHEAD Model tests a system-wide approach that aligns statewide spending targets and provider accountability to curb total cost of care (TCOC) growth and improve population health.

System Enablers

**TCOC
Accountability**

**Population
Health
Investment**

**Performance-
Based
Financing**

**Multi-Payer
Alignment**

**Market Choice
& Competition**

**Waivers &
Regulatory
Flexibility**

Aligned Payment Models



Primary Care AHEAD (PC AHEAD)

Elevating Everyday Care

- **Enhanced primary care payments**
- Upstream prevention & behavioral health integration
- Medicaid alignment required

Medicare FFS / Medicaid



Hospital Global Budget (HGB) AHEAD

Rooted in Community Care

- **Predictable, stable revenue**
- Upside opportunity from improved care, efficiencies, and outcomes
- Population health reinvestment

Medicare FFS / Medicaid / Commercial



Geo AHEAD

Partners in Patient Health

- **Geographic Accountable Care Organization (ACO)**
- Expanded shared savings opportunity through increased geographic accountability
- Enhances care management & care coordination
- Medicaid alignment optional

Medicare FFS

How Hospitals Can Participate in AHEAD

Hospitals can engage in AHEAD through multiple pathways - HGB AHEAD, Geo AHEAD, and hospital-affiliated primary care practice participation in PC AHEAD.

HGB AHEAD



Hospitals can participate in **HGB AHEAD**

PC AHEAD



Hospital-affiliated primary care practices* can choose a **PC AHEAD Pathway**

Geo AHEAD



Hospitals can bid to participate as a **Geo Entity**

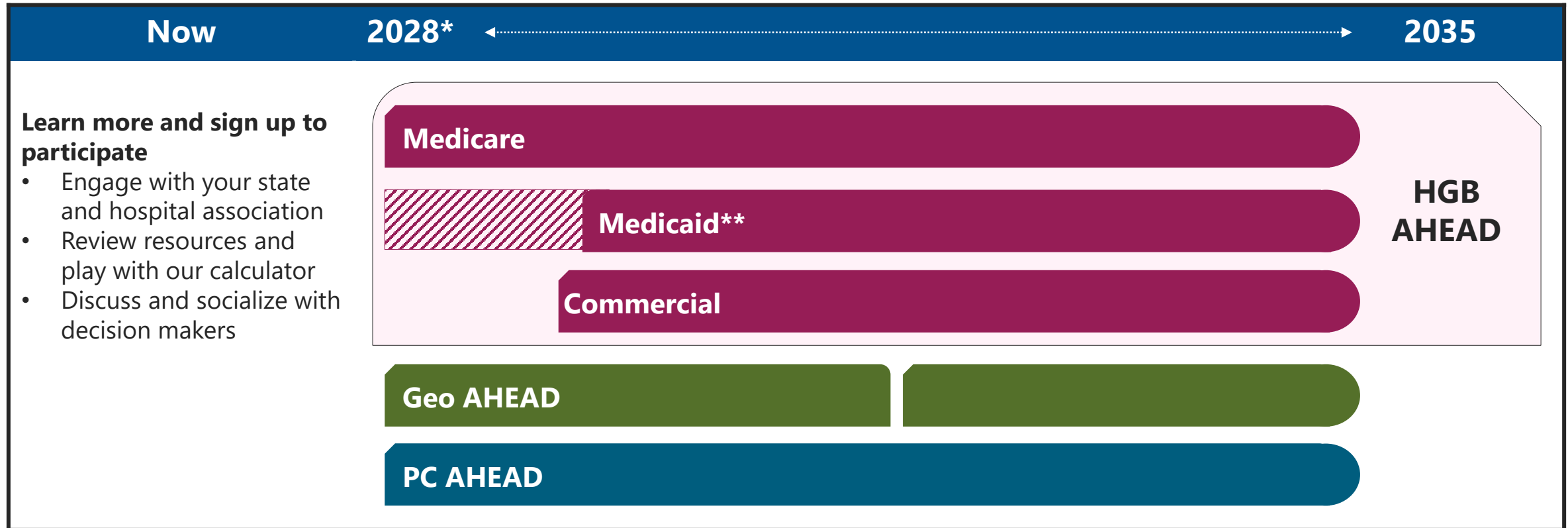
Hospitals can enter financial arrangements with Geo Entities as **Geo Participants or Geo Affiliates**

Hospital-affiliated primary care practices* enter financial arrangements with Geo Entities as **Geo Participants or Geo Affiliates**

*Hospital-affiliated primary care practices can only be PC AHEAD providers or Geo Participants if their parent hospital joins HGB AHEAD.

Hospital Participation Pathways in AHEAD Will Run Through 2035

AHEAD allows hospitals options to determine *when and how* they participate. It also offers an onramp for preparation and engagement with bonuses for those that join early and phased in approaches.



*Start dates are subject to change based on state negotiations. Check in with your state for updates.

**States are expected to implement Medicaid HGBs by January 1, 2029. CMS may provide flexibility when extenuating circumstances affect a state's ability to meet this timeline.

This slide applies to states in Cohorts 2 and 3.

AHEAD Hospital Global Budgets in Focus

The AHEAD Strategy for Hospitals: Hospital Global Budgets (HGBs)

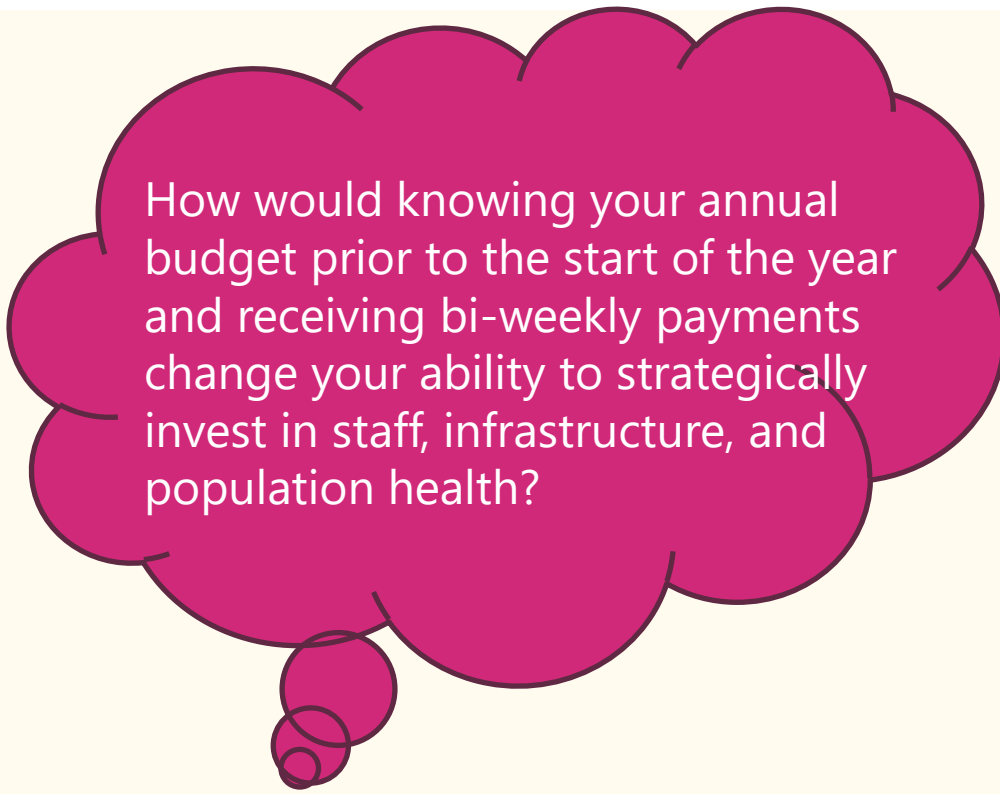
WHAT IS AN HGB?



A prospectively set annual budget for a specific patient population or program. Under AHEAD, the CMS-Designed Medicare HGB amount is calculated using historical FFS inpatient and outpatient revenue data with adjustments for changes in prices, volume, social risk, and performance.

The Value of HGBs:

- Predictable Payments.
- Changes Relationship with Volume.
- Protection from Shocks.
- Bankable Savings.
- Opportunities for Strategic Investments.



How would knowing your annual budget prior to the start of the year and receiving bi-weekly payments change your ability to strategically invest in staff, infrastructure, and population health?

Hospital Global Budgets in Context

A global budget is not itself the transformation. It's what makes the transformation possible.

What It Is

- ✓ Stability to enable change over the long term
- ✓ Three aligned payment models to amplify wins across the ecosystem
- ✓ Collaborations between CMS, the State, payers, and providers to enhance feasibility
- ✓ A model that builds on prior learning & success

What It's Not

- ✗ A quick fix
- ✗ An isolated solution to one part of the system
- ✗ A hands-off program
- ✗ An untested idea
- ✗ A payment change on its own

The tool

A predictable global budget

The work

9 years of transformation

The goal

Healthier population, sustainable cost

State-Led. Provider-Enabled. Patient-Focused. Outcome-Driven.

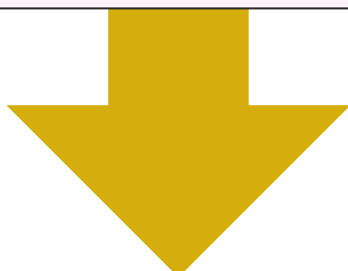
The Medicare FFS Hospital Global Budget Methodology



Medicare FFS HGB

Medicaid HGB

**Commercial Payers
HGB (including MA)**



Baseline



Volume Shifts

FFS Parity

**AHEAD-specific
incentives**

Annual HGB



CMS-Designed Medicare FFS HGB AHEAD – Methodology Overview

HGB AHEAD provides an annual budget that accounts for historic FFS revenue *and* offers additional financial incentives.

Baseline

Weighted average of three base years (BYs) of historical Medicare revenue.*

BY1 · Starts 4 years prior · 10%

BY2 · Starts 3 years prior · 30%

BY3 · Starts 2 years prior · 60%

Baseline Carveouts

CMS excludes certain inpatient services and outpatient drugs from the HGB.

Volume-based Adjustments

Trend baseline annually to account for market shifts and outliers.

Market Shift Adjustment (MSA)

Based on proportional change; phases in starting Performance Year 2 (PY2)

Service Line Adjustment (SLA)

Adjusts for capacity changes; prospective

Outlier Adjustments

Bidirectional adjustment, phases in from PY3

Adjustments for Parity with FFS

Adjust for annual pricing changes and changes in size/acuity of population.

Annual Payment Adjustment (APA)

Market basket, Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), Uncompensated Care (UCC), wage index, Prospective Payment System (PPS) quality

Demographic Adjustment (DA)

Bidirectional adjustment

AHEAD-specific Adjustments

Quality, TCOC, and other adjustments specific to the AHEAD model.

Transformation Incentive Adjustment (TIA)

Upward adjustment first two PY only

Social Risk Adjustment (SRA)

Upward adjustment

Performance-based adjustments

TCOC performance, Effectiveness Adjustment (EA), hospital Community Improvement Bonus (CIB)

Final HGB

What the hospital is paid each pay period.

Final budget paid

Prospective bi-weekly payments to hospitals

*The baseline gap period is 0-1 years. HGB AHEAD payments for PY2 and onward are based on prior HGB payments.



Journey of Hospitals in Medicare FFS vs. Medicare HGB AHEAD



Example Hospital

In response to community need, the hospital shifts orthopedic surgeries to an Ambulatory Surgery Center (ASC)

The hospital invests in post-acute care to improve quality, reduce avoidable readmissions, and reduce TCOC

The hospital expands community mammography screening to improve early detection of breast cancer

The hospital adds an outpatient oncology infusion center, responding to community need.

Under FFS

Revenue declines



Hospital revenue reduced; CMS pays a lower rate to ASC.

Reduced readmissions may reduce revenue



Declining readmissions reduce volume and FFS revenue

Prevention reduces future revenue



Earlier detection may reduce future inpatient utilization and FFS revenue.

Hospital revenue increases



Increased volume leads to higher revenue as claims are generated.

HGB AHEAD

Revenue decline mitigated, margin improves



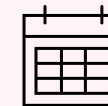
Hospital retains significant share of savings to CMS, reducing revenue impact.

Hospital earns "reinvestment revenue", margin improves



Mitigated revenue impact, potential quality bonus, and potential positive TCOC adjustment.

Revenue certainty supports investment, margin improves



Knowing revenue in advance allows hospital to fund screening programs without relying on service volume.

Prospective funding supports expansion



Hospital receives a CMS approved Service Line addition, providing prospective revenue.

Resources for Understanding What AHEAD Means for Your Organization (Slide 1 of 2)

Model Overview

What is the AHEAD Model?	AHEAD Model Overview Fact Sheet & Infographic - high-level summary of the model Overlaps Fact Sheet - clarifies what is and isn't allowed when participating in multiple models 2026 Model Updates Webinar - foundational overview of the AHEAD model, including Geo AHEAD Frequently Asked Questions (FAQs)	What is PC AHEAD?	Primary Care Pathways Infographic - options for primary care providers to participate in AHEAD PC AHEAD Fact Sheet - inclusive of all pathways PC AHEAD Specs & At-A-Glance - basic and advanced pathways only; more pathways available in 2028
		What is Geo AHEAD?	Geo Fact Sheet - high-level overview of Geo AHEAD Geo Specs Preview - Geo Entity & Bidding Process, Geo Beneficiary Attribution, Geo Shared Savings & Capitation Geo Technical Specifications: Version 1

HGB AHEAD-Specific

What are HGBs and the Medicare FFS HGB Methodology?	HGB Financial Methodology v3.2 - latest version of the technical specification HGB Specs v3.2 At-A-Glance - summary of the v3.2 specs (coming soon) HGB Specs v3.0 Webinar - foundational webinar on the methodology, with transcript and recording	How does the Medicare FFS HGB Methodology work in practice?	For Acute Care Hospitals Medicare FFS HGB Calculator Tool - demonstration video, excel tool & At-A-Glance instructions For Critical Access Hospitals Medicare FFS HGB Calculator Tool - demonstration video, calculator tool & At-A-Glance
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Find these and other AHEAD resources on the [AHEAD Model Website Participant Resources](#) page.

Perspective on Hospital Global Budgets from Maryland: Meritus Health



Maulik S. Joshi, DrPH

- *President and CEO, Meritus Health*
- *President and Professor, Meritus School of Osteopathic Medicine*



Josh Repac, CPA, MBA

- *Chief Financial Officer, Meritus Health*

CMS-Designed Medicare FFS HGB AHEAD Methodology Updates

Methodology Versions 3.1 and 3.2 Updates Summary – Carveouts

-  **1** | **Carveouts**
-  **2** | Service Line Adjustments
-  **3** | Effectiveness Adjustment



Certain high-cost, specialized services and drugs are “carved out” of the HGB to protect access to and investment in high-cost, high-acuity drugs and services.

Inpatient Services identified using DRG Codes

- Diagnosis-Related Group (DRG) codes are used to categorize and pay for Medicare inpatient hospital stays.
- DRG codes indicate the patient's condition, procedures performed and expected resource needs.

Outpatient Drugs identified using HCPCS Codes

- Healthcare Common Procedure Coding System (HCPCS) codes are used to identify and pay for Medicare outpatient services and drugs.
- Only HCPCS-coded drugs (not outpatient services) are carved out of the AHEAD FFS HGB.



Carved out services and drugs will be excluded from the inpatient and outpatient budget amount in PY1 and future performance years and reimbursed under original Medicare FFS methodologies.



CMS will use the below methodology to determine the list of inpatient services and outpatient drugs that will be carved out of the Medicare FFS HGB annually.

Inpatient Service Exclusions (DRG Codes)

- **Pre-MDC DRGs (MDC 00):** Resource-intensive inpatient cases (e.g., lung transplant)
- **Open Heart DRGs**
- **Trauma and Burn DRGs** with a Case Mix Index (CMI) greater than 2.5
- **Other Highly Specialized DRGs:** DRGs that meet all the following criteria:
 - $\geq 40\%$ of national Medicare FFS payments for the DRG are attributable to AMCs
 - Case Mix Index (CMI) > 2.5
 - Impact Score* $> 0.015\%$
- Any additional DRG codes following clinical review

Outpatient Drug Exclusions (HCPCS Codes)

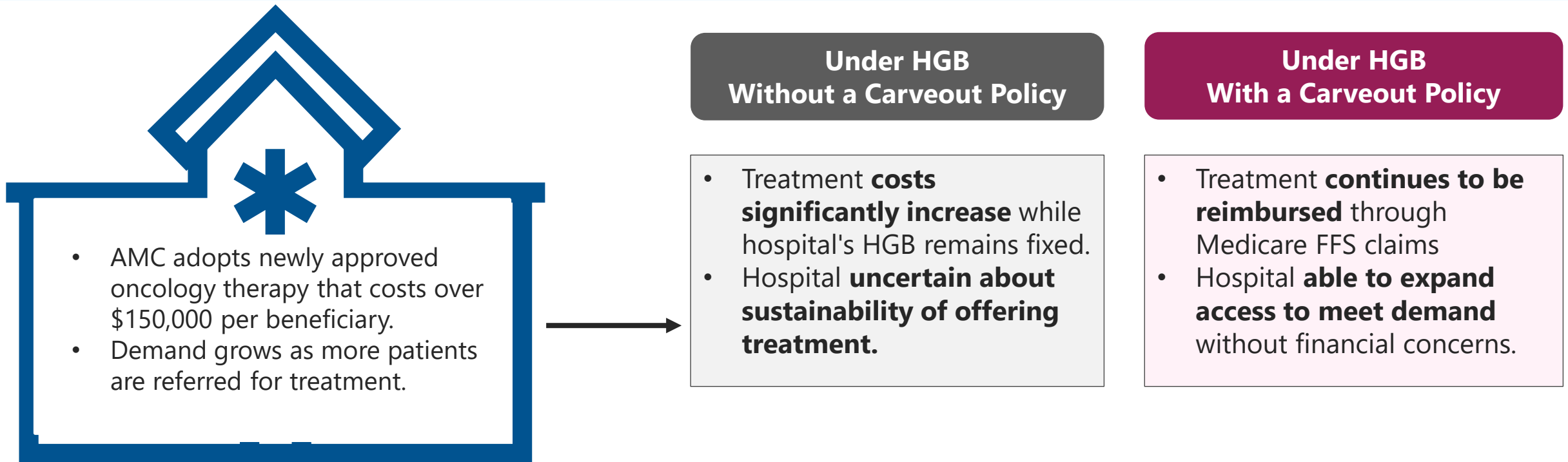
- **Outpatient Percentage:** $\geq 80\%$ of Medicare FFS payments for the drug are attributable to the outpatient hospital setting (vs. office and outpatient hospital settings combined).
- **Annual FFS Cost Per Bene:** $\geq \$100,000$ in annual Medicare FFS spending per beneficiary receiving the drug.
- Any generics, biosimilars, or substitutes
- Any additional HCPCS codes following clinical review

*The Impact Score measures the potential financial impact of a DRG across hospitals by comparing actual DRG payments to expected DRG payments and aggregating variation across hospitals and baseline years.

Version 3.2 Update – Carveouts: Example



With carveouts, hospitals can pursue innovation and specialty growth while maintaining financial predictability under the HGB. Patients benefit from timely access to emerging therapies.



Example AMC Expanding Access to Innovative Cancer Treatment

Methodology Versions 3.1 and 3.2 Updates Summary – Service Line Adjustments

- ① 1 | Carveouts
- ② 2 | **Service Line Adjustments**
- ③ 3 | Effectiveness Adjustment

Version 3.1 Update – Service Line Adjustment: Overview



The Service Line Adjustment (SLA) prospectively adjusts HGBs to reflect planned structural changes, driven by documented population access needs. These may include changes in physical infrastructure or staffing levels that alter hospital service capacity.

Service Line Additions: Hospitals Receive Prospective Funding

New Capacity	Adding capacity for a specific service
	Hospital-wide capacity increase
	Service Line increase in Base Year(s)
	Adding hospital-based services previously unavailable
Capacity Shift	Hospital system shifts service between two market area hospitals
	Hospital closures

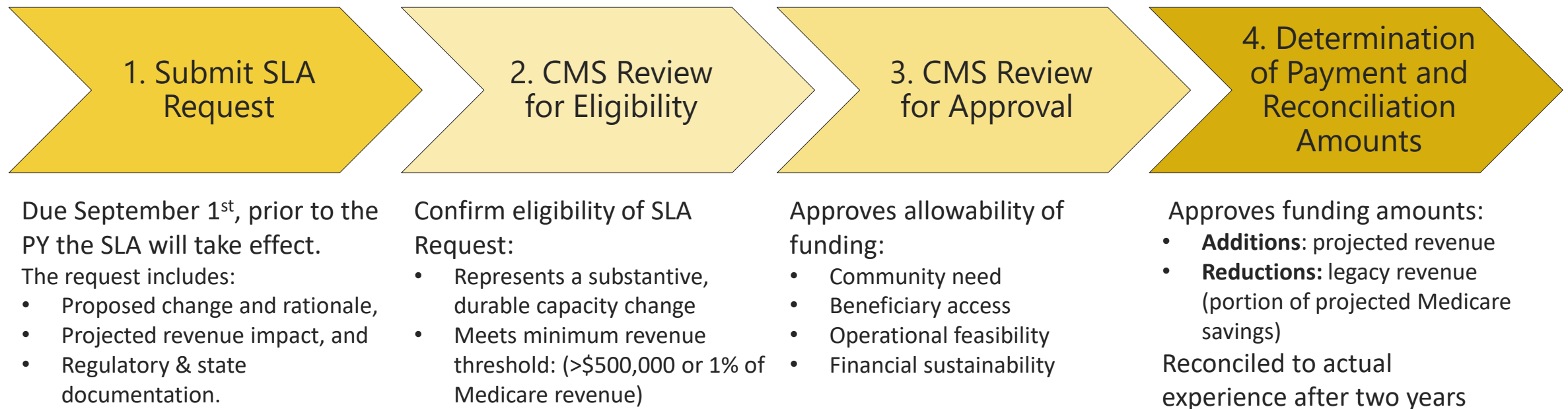
Service Line Reductions: Hospitals Receive a Portion of Medicare FFS Savings

Rightsizing	Rightsizing based on market need
	Efficiency gains
	Elimination of service due to sustained low demand
	Shifting services to lower cost ASC setting
Shift to Lower Cost Setting	Shifting services to Home Health (HH) or a Skilled Nursing Facility (SNF)

Version 3.1 Update – Service Line Adjustment: Process



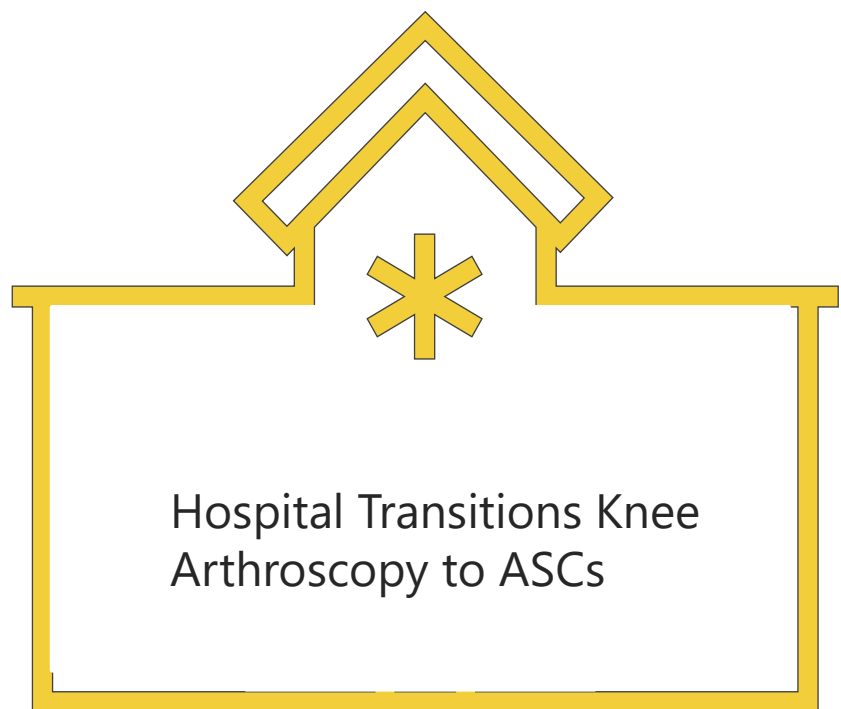
CMS reviews SLA requests through a four-step process to determine whether a proposed change is eligible for prospective funding (Additions) or legacy revenue (Reductions).



Version 3.1 Update – Service Line Adjustment: Example

With the service line adjustment, HGBs cushion the financial impact of capacity reductions. Hospitals can safely move a meaningful share of care to lower-cost settings and retain a share of the savings to Medicare.

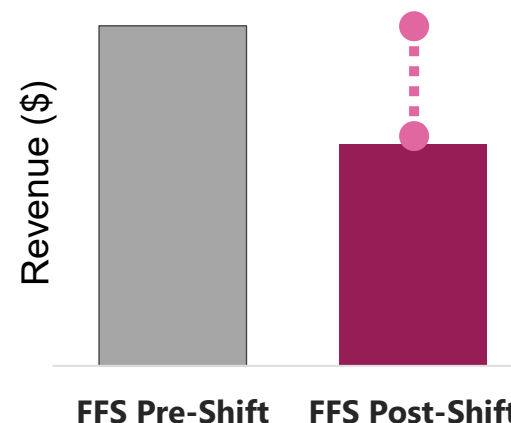
Example Hospital Engaging in a Service Line Reduction



Under FFS

Hospital: Revenue loss due to the lower per-unit reimbursement rate

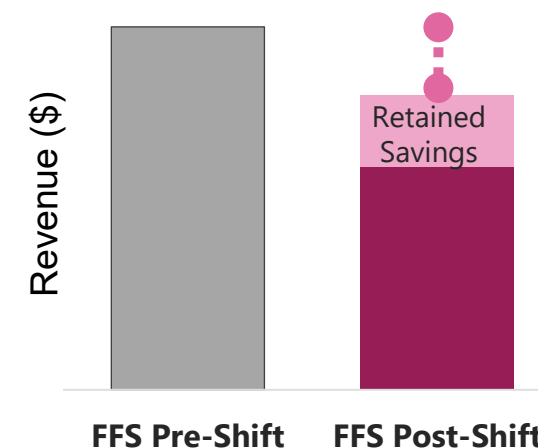
CMS: Retains saving due to lower Medicare payments for the same care



Under HGB

Hospital: Retains portion of savings to Medicare (Legacy Revenue)

CMS: Retains portion of the savings





CMS uses a schedule to determine the legacy revenue for service reductions. The schedule steps down the amount over time for most hospitals and designates a portion to be dedicated to population health aligned (PHAP) activities. CAHs maintain full funding over time.

Service Line Reduction Legacy Revenue Retention Schedule

Legacy Revenue is based on the savings amount to CMS due to the reduction in capacity or shift to a lower cost setting

Year During /After Reduction	All Hospitals (Non-CAH)		CAH	
	Population Health Aligned (PHAP)	Discretionary	Population Health Aligned (PHAP)	Discretionary
1	50%	20%	50%	50%
2	40%	20%	50%	50%
3	30%	20%	50%	50%
4+	0%	20%	50%	50%

Methodology Versions 3.1 and 3.2 Updates Summary – Effectiveness Adjustment

- ① 1 | Carveouts
- ② 2 | Service Line Adjustments
- ③ 3 | **Effectiveness Adjustment**



The **Effectiveness Adjustment (EA)** is designed to incentivize Participant Hospitals to implement interventions that reduce unnecessary or avoidable care.

EA Methodology

- Hospitals are ranked based on their Potentially Avoidable Utilization (PAU) performance relative to other hospitals in the AHEAD region, with adjustments for Social Risk Score (SRS).
- Hospitals at or below the 20th percentile receive no downward adjustment; hospitals above the 20th percentile receive an adjustment based on their percentile band.
- Adjustment amounts increase gradually over time as hospitals gain experience reducing PAU and building partnerships to support care coordination and population health.

Based on stakeholder input, we've enhanced how we calculate this adjustment to improve how PAU is measured and hospitals are ranked.



PAU Measure Scores

Prior Methodology

Uses non-risk adjusted measures.

Version 3.2 Methodology

Use risk adjusted measure scores
normalized with z-scores

PAU measure scores are used to estimate each hospital's level of Potentially Avoidable Utilization (PAU) and determine its ranking relative to other hospitals in the AHEAD region.
PAU includes unplanned readmissions, avoidable admissions, and emergency department utilization.

Version 3.2 Update – Effectiveness Adjustment: Percentile Range Bands



Version 3.2 increases the number of percentile bands from 4 to 9, more accurately reflecting differences in hospital PAU performance.

Percentile Range Bands

Prior Methodology

Include only 4 bands. 0-20th percentile, 20-49 percentile, 50-79 percentile, and 80-100 percentile.

Version 3.2 Methodology

Includes 9 bands. Shifts to decile bands starting at 20th percentile.

PAU Percentile Bands	
Hospital Percentile	EA Adjustment (PY7+)
0-20	0.00%
20-30	-0.25%
30-40	-0.50%
40-50	-0.75%
50-60	-1.00%
60-70	-1.25%
70-80	-1.50%
80-90	-1.75%
90-100	-2.00%

Resources, Next Steps, and Closing

Benefits of Medicare FFS HGBs

Medicare FFS HGBs offer hospitals a predictable revenue base you can plan and invest against, backed by defined protections with CMS and the State as partners.

What you gain with a Medicare FFS HGB



- ✓ More stable, predictable annual revenue.
- ✓ Regular, prospective payments that smooth cash flow.
- ✓ Incentives to provide right care in right setting, not less.
- ✓ Upside for market area efficiency gains.
- ✓ Adjustment for social risk of population served.
- ✓ Potential to retain revenue that would otherwise be lost from eliminating unnecessary utilization like readmissions.

What you keep from Medicare FFS



- ✓ Annual Medicare FFS price and policy changes.
- ✓ Incentives to provide high-cost services and drugs.
- ✓ Protection against market wide revenue declines.
- ✓ Growth opportunity from increasing market area share of services.
- ✓ Growth opportunity from adding needed capacity.



How might your hospital benefit from a global budget? Consider how you might partner with other community hospitals, primary care practices, etc.

Public Comment Period Closing October 30, 2026

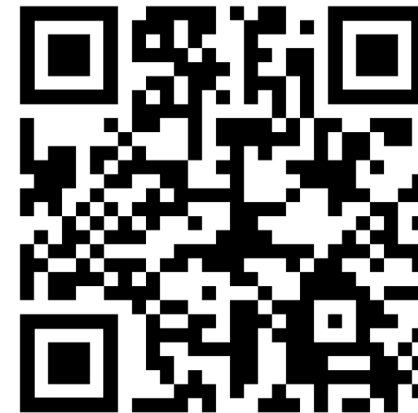
CMS is welcoming feedback from all current and prospective AHEAD States, hospitals, and any other interested stakeholders on the CMS-Designed Medicare FFS HGB Financial Specifications Methodology v3.2 and Maryland Addendum.

Scan the relevant QR code below to submit your comments and questions.

**CMS-Designed Medicare FFS
Financial Specifications
Methodology v3.2 Form**



Maryland Addendum Form



The public comment period will remain open through **October 30, 2026.**

Resources for Understanding What AHEAD Means for Your Organization (Slide 2 of 2)

Model Overview

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Find these and other AHEAD resources on the [AHEAD Model Website Participant Resources](#) page.

Next Steps



**Submit comments on the HGB v3.2
Financial Methodology due
10/30/26.**



**Review available resources
and stay tuned for new
resources**



**Build familiarity with the
Financial Methodology using the
HGB calculator tool**



**Discuss AHEAD with leaders and
decision makers at your
organization**



**Connect with your state's AHEAD
team to learn more**

Thank You and Post-Event Survey



Thank you for your time and interest in AHEAD Hospital Global Budgets.

Please take the survey that will be disseminated via email following this webinar or scan the QR code to provide feedback and suggestions for future events.



Do you have questions? View additional resources on the [AHEAD Model Website Participant Resources](#) page or email your comments and feedback to AHEAD@cms.hhs.gov.

Thank You!

Appendix

All Hospitals

- Payment stability from annual changes in UCC and DSH rates
- Select high-cost claims excluded from baseline calculations to reduce financial uncertainty

Critical Access Hospitals (CAHs)

- Protects CAHs with a payment floor
- Limited downside risk during early years of participation
- Opportunity for additional upside through quality reporting

Safety Net Hospitals (SNHs)

- Reduced early financial risk exposure
- More time to build capabilities before downside risk
- Quality assessed relative to peers

Small Hospitals*

- Protected against downside market shift impacts

**Hospitals that comprise less than 2% of state or sub-state revenue*

Version 3.1 Update – Service Line Adjustment: Impact



Hospitals receive prospective funding to expand needed services or a portion of the savings to CMS (legacy revenue) to support care redesign and transitions to lower-cost settings.

Service Line Additions

- CMS provides upfront funding while utilization data is unavailable
- Estimated Medicare FFS revenue associated with the capacity expansion is added to the HGB for the first two years
- Funding supports expansion of needed services and capacity
- Payments are reconciled to actual experience after two years

Service Line Reductions

- CMS provides legacy revenue when Medicare savings generated
- Estimated legacy revenue associated with reduction is added to the HGB for 4+ years
- A portion of the funding must support population health investments [aligned with the Population Health Accountability Plan (PHAP)]
- Payments are reconciled to actual experience after two years