

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

September 22, 2026

Margaret Drew, CMS/CMMI:

Hi everyone, thank you for joining us this afternoon. We're going to give folks a few minutes to trickle in and get started a little after 3:00.

Hi, everyone. Thank you for joining us this afternoon. We are still seeing some folks trickling in, so we are going to go ahead and wait a couple of minutes. We will get started a couple of minutes after 3:00.

Okay, it looks like we're hitting critical mass, so I'm going to go ahead and get us started. Good afternoon, everyone, and thank you for joining us for the AHEAD Hospital Global Budgets, Strategic Considerations, and Medicare Fee-for-Service Methodology Updates webinar. Next slide, please.

Before we get started, I have a few housekeeping items to cover. This event is being recorded and closed captioning is available. Please see the instructions on your screen to toggle on closed captioning if desired. Thank you to all of you who submitted questions ahead of the event through the registration form or the public comment form.

To submit additional questions or comments, please use the Q&A box at the top of your screen. Due to our limited time together today, questions submitted through the Q&A box may not be answered live but will be answered in future materials and events.

Additionally, we will share a short survey at the end of the event, and we kindly ask that you please complete it. Your feedback and ideas are important to us and help us to ensure that we provide accurate information that supports your understanding of and participation in the AHEAD Model. We greatly appreciate your input.

Finally, the recording and presentation slides from today's webinar will be posted on the AHEAD Model website and will be available within one week of today's event. Next slide, please.

We'll begin with a welcome and brief introductions from our presenters, followed by an overview of today's agenda. With that, let's start by introducing our presenters.

Today's conversation will be led by members of the CMS Innovation Center's AHEAD Model team. We are joined by Abid Khan, Director of the Division of Multi-Payer Models for the AHEAD Model, who will share some opening remarks on the model and the important role and opportunities that Hospital Global Budgets create for hospitals, communities, and broader goals of participating states.

We're also joined by the AHEAD Hospital Global Budget co-leads, myself, Maggie Drew, Alexa Paiva, and Jaafar Salim. Our team leads global budget design, implementation, and the methodology updates that we'll discuss later in today's session. In addition to these roles, we also serve as state leads and support other areas of the model.

With that, I'll turn it over to Abid for some opening remarks.

Abid Khan, CMS/CMMI:

Good afternoon, everybody. I'm very pleased to welcome you all to this session. I'll keep this short because we have a lot of great content for you ahead. I appreciate you taking the time to join us on your busy schedules. As many of you know, AHEAD is the Innovation Center's flagship state-based model.

It is essentially many models in one. It includes Hospital Global Budgets, a Geographic ACO, advanced primary care, regulatory reform, and more. But I would say Hospital Global Budgets are probably the most transformational element in the sense that they represent not an incremental, but a

foundational shift in practice. And while the NOFO (the Notice of Funding Opportunity) that all the states responded to and state and participation agreements provide a broad framework for how the global budgets are structured, the financial specifications are truly where the details and reality of both the financial and the quality model for AHEAD are laid out. And so, we believe in harnessing collective wisdom, in addition to over 100 FTEs of staff and contractors that will be engaged over the next 10 years in making this model a success. We have had significant input from states and from stakeholders, including many hospitals, for our specifications. We encourage you to read, understand, and also provide feedback and comments on the specifications because we really want them to be transformational. They will be much improved from our incorporation of the feedback that we've already received and look forward to receiving from you. And I think the first step in that is gaining a good understanding of how the Hospital Global Budgets work, and that's what this session is all about. So, I will pass it back to my co-presenters and thank you again for being here.

Margaret Drew, CMS/CMMI:

Thank you, Abid. Next slide, please.

Today's webinar is an opportunity to reconnect on the AHEAD Model, dive into Hospital Global Budgets, and take a deeper look at some of the enhancements made to the methodology in response to stakeholder feedback. We recognize that a lot has happened since we last connected on Hospital Global Budgets under AHEAD in April 2025, over a year ago.

At that time, we introduced version 3.0 of the methodology and shared some details on how the Hospital Global Budget is calculated. Since then, we acknowledge that the AHEAD Model has changed with the introduction of new model components such as Geo AHEAD, the ACO-like component of the model that has added new pathways for hospitals to participate.

On the Hospital Global Budgets front, we released versions 3.1 and 3.2 of the specifications this summer.

Today, we'll begin with a discussion of why hospitals should consider AHEAD and Hospital Global Budgets, including a walkthrough of some of the pathways available for hospital participation. We'll then take a closer look at what Hospital Global Budgets offer hospitals and hear directly from a Maryland hospital with first-hand experience. From there, we'll dive into the mechanics of the Medicare Fee-for-Service Hospital Global Budget methodology, including some key recent updates that have been made. We'll close by sharing some additional resources and outlining what to expect next.

Next slide, please.

We'll begin by discussing the AHEAD Model, how it's pivotal now, and the various pathways available for hospital participation.

Our healthcare system faces significant challenges, rising costs, lagging population health outcomes, fragmented care delivery, and growing financial pressures and uncertainty. Many of you experience these challenges firsthand and work every day to navigate them within your organizations.

At the same time, these are challenges that extend beyond the walls of any single hospital or practice or payer. They are complex and systemic issues that require a coordinated response. And the AHEAD Model was built on recognition that meaningful transformation happens when stakeholders across the healthcare ecosystem work towards a shared vision and aligned incentives.

The AHEAD Model provides a state-based opportunity to move from fragmented efforts to a more coordinated approach to healthcare transformation. By aligning hospitals, primary care practices, ACOs, and payers around shared total cost of care and population health goals, the AHEAD model aims to bend the cost curve, improve health outcomes, strengthen care coordination and integration, and support a more sustainable and competitive health care system.

At its core, AHEAD is about creating the conditions for providers to not only focus on delivering care today, but also to build the healthcare system that communities will need tomorrow. I will now talk more about the components of the AHEAD Model to bring this vision to life. Next slide, please.

The AHEAD Model is a comprehensive and flexible framework for system-wide transformation. It starts with a common vision, but we recognize that every state has different needs, priorities, and healthcare landscapes and adapt it [the model] accordingly across our states.

Through system enablers such as the total cost of care accountability and targets, the population health accountability plans and investments, choice and competition policies, and waivers and regulatory flexibility, states tailor the model to their unique context and build on innovations already underway to advance AHEAD goals.

To translate these goals into action, AHEAD engages key players across the healthcare system, each with a distinct but interconnected role to play in the aligned payment models. Primary care practices participate through PC AHEAD, helping to strengthen prevention, care coordination, and whole-person care. Hospitals can participate through HGB AHEAD, where global budgets provide greater financial stability and flexibility while creating incentives to improve outcomes and reduce utilization. Geographic accountable care organizations participate through Geo AHEAD, bringing additional tools for care management, care coordination, and accountability for population health and total cost of care, while engaging additional primary care practices and hospitals, and model goals.

Together, we look at states to provide the strategy and policy foundation while providers and organizations work towards shared goals for better health outcomes, more sustainable care delivery, and slower cost growth. The remainder of today's discussion will really focus on the roles that hospitals play within this broader vision and the opportunities available through HGB AHEAD. Next slide, please.

While HGB AHEAD is the primary pathway for hospital participation in AHEAD, hospitals may also have opportunities to participate in Geo AHEAD and through their affiliated primary care practices in PC AHEAD. We wanted to take a little bit of time to walk through different avenues for hospital participation.

Hospitals themselves may be able to participate in Geo AHEAD in several ways: As a Geo Entity, where a hospital serves as the accountable care organization for a Geographic region, hospitals would participate in a competitive bidding process and, if selected, assume responsibility for total cost of care and quality while having the opportunity to earn shared savings. Hospitals may alternately enter into financial arrangements with Geo Entities as a Geo Participant, if they provide primary care services, or as a Geo Affiliate. Under these arrangements, hospitals may have opportunity for shared savings as well as access to additional supports and beneficiary enhancements.

For hospitals participating in HGB AHEAD, affiliated primary care practices can also participate in PC AHEAD or Geo AHEAD. Under PC AHEAD, hospital-affiliated practices select a PCP [primary care provider] pathway and receive the financial benefits associated with that pathway, such as capitated payments, and the Enhanced Primary Care Payment, or EPCP.

Under Geo AHEAD, practices may be able to contract with Geo Entities as a Geo Affiliate or Geo Participant. These arrangements can provide opportunities for shared savings, additional supports and beneficiary enhancements, and for Geo Participants, access to EPCP and capitated payments.

We wanted to highlight these options so hospitals understand that while HGB AHEAD may be their primary participation pathway, additional opportunities are available and may be worth exploring.

Next slide, please.

We wanted to talk a bit about the timing for the AHEAD Model from a hospital perspective. AHEAD runs from 2028 through 2035 and provides hospitals with multiple participation pathways, but there are important decisions and enrollment windows to be aware of before the model begins for cohorts two and three states.

Across HGB AHEAD, PC AHEAD, and Geo AHEAD, participation agreements are expected to be signed starting in 2027, with model participation beginning in 2028.

For HGB AHEAD, Medicare Fee-for-Service global budgets will begin in 2028, with Medicaid and commercial global budgets layered in over time.

For Geo AHEAD, there are two distinct contract periods over the course of the model. Geo Entities are selected at the start of each contract period through a competitive process. Once a contract period begins, new Geo Entities cannot enter until the next contract period, although hospitals and practices may still have opportunities to participate by contracting with an existing Geo Entity.

For HGB AHEAD and PC AHEAD, hospitals will have the opportunity to join annually.

The years between now and 2028 are an important runway for hospitals to evaluate participation options, prepare operationally, and position themselves for available incentives, including bonuses for early participation. Practically, that means learning more about the AHEAD Model, engaging with your state AHEAD team and hospital association, reviewing available resources, and using the calculator tools on the AHEAD Model website that can help you understand the potential impacts for your organization. We also encourage you to begin socializing these opportunities internally with key decision makers, so your organization is prepared when participation decisions need to be made. Next slide, please.

With hospital participation pathways and timing in mind, we wanted to take a closer look at how Hospital Global Budgets work and the benefit that they offer to hospitals. Next slide, please.

As a reminder, a Hospital Global Budget, or HGB, is a prospectively set annual budget that provides hospitals with predictable payments throughout the year rather than relying on Fee-for-Service reimbursement. While the methodology is important, and we will get there, we wanted to take a bit of time at the top to discuss the value of HGBs for hospitals. From our conversations with hospitals that have experience operating under a global budget, we consistently heard several key benefits.

First, Hospital Global Budgets provide predictable prospective payments, giving hospitals greater certainty on annual revenue, allowing leaders to focus less on month-to-month fluctuations and more on strategic planning.

HGBs also change the relationship that hospitals have with volume. HGBs decouple financials from volume alone and allow hospitals to focus more on delivering the right care in the right setting rather than maximizing service volume.

HGBs provide protection against unexpected events and financial shocks, helping hospitals maintain stability when faced with market-wide factors outside of their control.

We also heard that HGBs create opportunity to create, to generate and reinvest savings. As we heard from Maryland hospitals, strong use of data, performance management, and care redesign can create resources that support continued transformation.

HGBs create opportunities to invest in long-term transformation, including workforce, technology, care coordination, community partnerships, and population health initiatives. As you think about HGBs and AHEAD participation, we encourage you to consider the question on the right side of the slide. How would knowing your budget before the year begins and receiving predictable payments throughout the year, change your ability to invest in your workforce, infrastructure, and population health goals? Next slide, please.

The other point we wanted to emphasize up front is that Hospital Global Budgets represent a mindset shift. The global budget itself is not the transformation, but it's what makes the transformation possible.

As hospitals evaluate participation, we want you to consider what participation in an HGB makes possible for your hospital and community over multiple years. The hospitals that have seen success under a global budget are not successful because they have a global budget, but because of what they did with it. They used that foundation to redesign care, invest in new capabilities, strengthen partnerships, and pursue long-term goals that would have been difficult in a purely volume-driven environment. You will hear shortly from a Maryland hospital who had this experience.

HGB AHEAD isn't a quick fix, and it's not just a payment change. We see global budgets as a way to not just automatically improve quality, transform care delivery, or strengthen community health, but to create the conditions to allow those changes to happen. We really want hospitals to consider what

their organization could accomplish by taking advantage of the various levers available under the HGB model. You'll learn more about some of those levers as we get into the methodology later today.

And with that, I will pass it off to our next presenter, Alexa.

Alexa Paiva, CMS/CMMI:

Great. Thank you so much, Maggie. Next slide, please.

So, while the AHEAD Model includes 3 distinct types of Hospital Global Budgets, those being Medicare, Medicaid, and commercial payer HGBs, today we're planning to focus largely on CMS designed Medicare Fee-for-Service Hospital Global Budgets. So, the CMS methodology, which is sort of detailed in the yellow box at the bottom of the slide, has four parts. We start with the hospital's baseline, which establishes the starting point for Performance Year 1. And then we apply a set of three different adjustments: The first adjustment accounts for shifts in volume and capacity, the second maintains parity with Fee-for-Service, including relevant payment and demographic changes, and then the third applies AHEAD-specific adjustments and incentives. And when you take these four components together, you end up with the hospital's final, annual HGB. And on the next slide, I'll go into more detail about each part of this calculation.

Thank you. So, like I said, this slide goes over each of those four components in a little bit more detail, starting from the left in blue with the baseline. This establishes the hospital's starting HGB amount. So, for PY1 (Performance Year 1), CMS calculates the baseline using a weighted average of three historical base years of Medicare inpatient and outpatient revenue.

It's worth highlighting that in version 3.2, CMS updated the baseline time frames. We extended the gap period from 6 months to 1 year, which means that the baseline years are now full calendar years and they end one year prior to Performance Year one. Those 3 baseline years are weighted at 10%, 30%, and 60%, with the most recent baseline year receiving the greatest weight.

A couple of additional notes on the baseline calculation. So before developing the baseline, CMS excludes or carves out certain inpatient services and outpatient drugs from the HGB calculation. More on that to come. We'll get into that in a little bit more detail in some subsequent slides.

I'll say that for PY1 only, we use a logistic regression to adjust the weighted baseline and better estimate what Medicare Fee-for-Service payments would have been in the absence of HGB payments. And we call this process baseline optimization. Again, that's for PY1 only.

So, moving to the next column in yellow, this category is the volume-based adjustment category. And these adjustments are designed to account for changes in hospital capacity and utilization over time. So, we have numerous different adjustments. The market shift adjustment accounts for changes in a hospital's share of services within its market area.

The outlier adjustment helps account for unusually high-cost cases. And the SLA [Service Line Adjustment] allows hospitals to receive prospective funding when adding needed capacity or services, as well as provides legacy revenue when hospitals reduce capacity or shift care to lower cost settings that generate Medicare savings.

The third column from the left in orange represents adjustments for parity with Fee-for-Service. The goal of this category is pretty straightforward. Hospitals that participate in HGBs should continue to receive key price and policy updates that they would have received under Medicare Fee-for-Service.

So, the annual payment adjustment incorporates changes such as base rate updates, wage index changes, and other Medicare payment policy changes. And then the demographic adjustment accounts for changes in the size and the acuity of the Medicare population that the hospital serves.

Together, these adjustments help ensure that the HGB remains aligned with what Medicare revenue would have looked like under Fee-for-Service. And then finally in purple, we have the AHEAD-specific adjustments, which are, as the name would imply, you know, unique to the AHEAD Model. The TIA, the Transformation Incentive Adjustment, provides additional funding in early years of participation to support care transformation and model implementation. The social risk adjustment

provides additional funding for hospitals serving higher risk populations. The total cost of care adjustment evaluates overall spending performance. The Effectiveness Adjustment [EA] focuses on reducing potentially avoidable utilization. And the community improvement bonus rewards performance on two community health focused quality measures. And when you take these four components together, we're transforming historical Medicare revenue into a prospective annual Hospital Global Budget that reflects changes in hospital capacity, reflects Fee-for-Service payment updates, reflects changes to your population's needs, as well as reflects the hospital's performance under the AHEAD Model.

And one note that I'll make before we move on to the next slide. Critical access hospitals have a payment floor that is equal to 101% of payments. So, there are some additional protections in our methodology for Critical Access Hospitals specifically.

If we can move to the next slide, please. Great.

So, I've given you a sort of high-level overview of the Medicare Fee-for-Service HGB methodology. And now we want to bring that to life for you. So, on this slide, we're showing the journey of a hospital as it participates in a Medicare Fee-for-Service Hospital Global Budget. And each bubble, if you will, on the left, exemplifies a different strategic decision that a hospital might make and how the HGB methodology is designed to really support those decisions. I think the key takeaway here is that, you know, there isn't a single pathway to success under an HGB. Hospitals can succeed by expanding needed services, they can succeed by investing in prevention or reducing potentially avoidable utilization or even shifting care to more appropriate settings. And that's because ultimately the HGB methodology is designed to better align financial incentives with delivering high value care. So, let's spend a little time here and sort of walk through some of the strategic decisions that this example hospital is making and see how that would play out under Fee-for-Service compared to under HGBs. So, starting with this first row, let's say that the hospital decides to shift orthopedic procedures to an ambulatory surgery center [ASC]. Under Fee-for-Service, you know, moving services to a lower cost setting generally reduces hospital system revenue because Medicare pays a lower rate in the ASC setting. But under an HGB, the hospital might retain a portion of the savings generated through that shift, reducing the financial penalty for, you know, doing what is probably the right thing for the patient, right?

Moving to this next example, let's now imagine that the hospital identifies a need to invest in post-acute care coordination and actually succeeds in reducing avoidable readmissions. You know, under Fee-for-Service, where you're really linked to volume, fewer admissions means less revenue. But under an HGB, the hospital can benefit from the operational savings that are associated with that reduced utilization because volume and revenue have been decoupled. So, we're really reducing the impact of volume loss on revenue for the hospital. And actually, the HGB offers a positive adjustment potential for reducing readmissions and lowering market area total cost of care.

Moving on to the next row, perhaps the hospital strategy team decides that they should invest in prevention and community health. And maybe that looks like expanding mammography screening programs. Under Fee-for-Service, if you are preventing future illness, you're really reducing future hospital utilization, which means you're reducing future hospital revenue. But under a global budget, hospitals have greater flexibility to make those investments because their revenue is less dependent on volume.

And then lastly here, you know, maybe the data show that there's a need for oncology infusion services in the hospital's market area. So, it opens up a new outpatient infusion center. Under traditional Fee-for-Service, yes, increased utilization generates increased revenue for the hospital. But under the HGB, you know, we are able to recognize this new capacity through the mechanism of the Service Line Adjustment and could provide prospective funding to support expansion and improve patient access to those services. So, I think stepping back and taking all of this together, these examples really demonstrate a shift.

So, the HGB methodology is designed to, I think, reduce the financial tension between what's right for patients, what's best for the community, and what's best for the hospital. So instead of relying on

volume growth for a hospital to succeed, hospitals now have multiple pathways to create value, to improve outcomes, to expand patient access and to invest in long-term care transformation.

Next slide, please. Great.

So now that we've covered the fundamentals of Hospital Global Budgets, I think we wanted to offer you all the opportunity to hear from someone who is living in this work every single day. So, as I'm sure many of you know, Maryland has been using Hospital Global Budgets for more than a decade, making the state the nation's longest running and most established example of the HGB approach. And to really help, I think, bring the experience of HGBs to life, we are pleased to be joined by Dr. Joshi and Mr. Repak, who lead Meritus Health, which is a community-based academic health system serving Western Maryland. Meritus brings its unique perspective on what it means to offer within an HGB environment while advancing strategic priorities for patients and for their communities.

Thank you both so much for being here. Awesome. So nice to see you. Thank you both so much for joining us today. I think we'd love to, we have about 10 minutes to chat, and we'd love to start by hearing about your experience with Hospital Global Budgets and what they've meant for Meritus. So, you know, I know that Meritus has, we know that Meritus has operated under an HGB for more than 15 years. Looking back across those years, what has been the biggest benefit of participating in an HGB to your hospital, to your health system?

Maulik S. Joshi, Meritus Health:

Well, thank you very much. Good afternoon, I'm Maulik, and I'll turn it over to Josh, but we do appreciate the opportunity to share and learn from everybody as well. And I think Maggie said it well in the previous slides about this being an enabler for change. And so, I'll let Josh talk about that specific to this and then some of the later questions.

Joshua A. Repac, Meritus Health:

Yes, being under the global budget for the last 15 years as a sole community provider has provided stability to our organization to allow us to focus beyond the four walls of the hospital. We have reduced unnecessary utilization, but we have continued to grow volume that is necessary in our community, so patients don't have to travel down the road. So, we've seen volumes grow pretty much exponentially year over year. And the global budgets, there is a funding mechanism for it. But on the other side, when we reduce volumes, we're able to retain that revenue if it's unnecessary utilization. So overall, what I would say is the global budgets have allowed us to focus beyond the four walls of the hospital to really take the community needs into focus and where's the most appropriate setting to deliver those services.

Alexa Paiva, CMS/CMMI:

Yeah, that's excellent. And I think, you know, it's possible that some hospitals here are global budget and their first inclination is that you have to reduce services or you have to limit growth. And it sounds like that hasn't been Meritus's experience. So, wondering if you could elaborate on sort of what you've been able to do under HGB's, why or how have you been able to grow? If you could just speak to that a little bit more, that would be wonderful.

Joshua A. Repac, Meritus Health:

Yeah, absolutely. So Meritus, over a most recent six-year period, our physician practices, our physician providers have grown from 100 to over 250 providers. We have more aligned with our community physicians and improved their referral network within our community to make sure services are available here. So, we've added additional service lines that weren't previously offered, again, so that patients don't have to travel down the road and we deem this a lower total cost of care setting. But again, global budget isn't a means of strategy. It is a mechanism. It's a finance mechanism for us to be able to meet the community needs.

Maulik S. Joshi, Meritus Health:

And our view is to grow because it meets the needs of the community. So, we view growth as an important part in terms of community needs. And it may mean that there's a delay in the revenue. But again, money always follows the patient. And so, we do see it happening. It just might be a little bit more delay versus another payment model, so to speak. But you have to grow to meet the needs of the communities that have people that have needs. And so, it's important to us through all settings of care.

Alexa Paiva, CMS/CMMI:

And are there, you know, are there certain areas of growth, certain areas of investment that you've been able to make that would have been more difficult or more challenging under a traditional Fee-for-Service payment?

Joshua A. Repac, Meritus Health:

Absolutely. The global budgets have provided stability. You know what revenue you're going to have year over year. COVID was a perfect example where our institution did see a volume drop temporarily, but we didn't see that revenue cut. As a sole community provider, we need to plan more long term. And that's what the global budgets have allowed us to do, to not think year over year, but to plan for the next 5 to 10 years. We, under a global budget, just started a medical school three years ago. And so, it allowed us to take what we have generated from an operating margin perspective and investments and go upstream further to satisfy the needs of the community and provide additional access.

Maulik S. Joshi, Meritus Health:

Josh, do you want to just mention our crisis stabilization beds and some of that as ways of how we've been able to invest considering the global budget?

Joshua A. Repac, Meritus Health:

Yeah, absolutely. So as Malik mentioned, we have crisis stabilization beds. We have six beds that are embedded in our hospital. These are for patients that are transitioning to seek treatment. So, they come in through the ED. They can be directly admitted to this unit through our urgent care walk-in.

But they're looking for placement in either outpatient substance abuse or outpatient setting for recovery: for 30-, 60-day recovery. This was a service that was a community need. It wasn't a revenue generator but embedding it in the hospital allowed us to use the resources of 24/7 nursing coverage, security, et cetera. So, we leveraged the infrastructure of the hospital, but it wasn't to generate a larger profit. It was to reduce ED utilization. It was to reduce readmissions to the hospital and to continue to improve the health of our community.

Maulik S. Joshi, Meritus Health:

I think it's fair to say that in a pure Fee-for-Service world, this would be a service that's hard to sustain. And for us, it allowed us to think differently. They're not acute mental health beds. They're not med-surge beds. It's a setting of care for someone in transition. And often hospitals and health systems are the place where they go for that. If not there, elsewhere, which might be more tenuous for them. So, I think, again, the global budget lets us think about this type of care and allows it to actualize it without having such a financial strain on it.

Alexa Paiva, CMS/CMMI:

That's wonderful and thank you so much for sharing that work. I personally find it very energizing, so wonderful.

I know that we have a lot of hospitals on the webinar today, and hopefully many of them are deciding whether the AHEAD HGBs are right for them. Do you have any advice that you would offer to these hospitals as they contemplate participation?

Joshua A. Repac, Meritus Health:

I would say again, this is, it's a reimbursement change, but it doesn't change what the role of the hospital is in the community. It might change where the services are offered and how you address the needs of the community because you're not focused on growing admissions or ED visits. You're trying to meet the needs of the community in the lowest total cost of care setting. So, some of that is backfilling with more high acuity services that weren't previously offered. And that opens up capacity by reducing that utilization that isn't needed.

Maulik S. Joshi, Meritus Health:

I think, as you know, finance payment is a means, it's not an end. And so, this gives us the enabler to do the things we want to for our community. Everybody does that. You know, every model has flaws, has challenges, but I'll be honest, we're in on this. We're all in on this model and it feels good to take care of people and not to get paid more by having more people come to the ED or be admitted. We're here to take people and impact their health and get paid by managing cost but still growing and still meeting community need.

Joshua A. Repac, Meritus Health:

I'd say that is one aspect that has really changed over our last 6 or 7 years. It's that expense management side. We're talking about the reimbursement side. There are timing differences in reimbursement, especially if you're growing volumes. So, expense side of it is how you sustain operations for reducing those expenses. It's much more critical under a fixed revenue system if you're in a growth mode.

Alexa Paiva, CMS/CMMI:

Thank you both. And maybe one last question before we wrap. For those hospitals who do think that they're going to participate in AHEAD HGBs, you know, what lessons can you share about how to get the most value?

Joshua A. Repac, Meritus Health:

So again, I think it's meeting the community needs. That's what the value is driven by. We keep going back to the same thing, but it's looking at the community needs assessment. It's partnering with your community providers to see what services they're referring outside the community to address. And it's not a one-size-fits-all. Everybody is addressing it different ways.

Alexa Paiva, CMS/CMMI:

Okay.

Joshua A. Repac, Meritus Health:

But it's what works for your community and for your hospital. For us, it is, we just had our inpatient rehab unit closure this year. We evaluated what the need was for the community. We had to expand med surge beds because of more patients that are staying local. So, we adjusted, we looked at what resources were available, what were the acuity of the patients. We saw that the need was being met outside the four walls of the hospital. It was not a good use of our GBR [Global Budget Revenue] dollars, and so we pivoted. But again, the model allows us to do that. We wouldn't have previously.

Maulik S. Joshi, Meritus Health:

I think it was said in an earlier slide as well. It's about investment, right? This won't happen overnight. And so, the stability of the model allows organizations to invest in the right areas that some things work, some things don't work, but this stability of the model allows us to test those models. And I think it's great. I think, again, it's directionally in the right way towards meeting needs, meeting growing needs of communities as well, and being effective in managing your costs.

Alexa Paiva, CMS/CMMI:

Thank you both so much for the time today and for sharing your experience. I, you know, thank you and thank you very much for the partnership. Really, really appreciate this. And yeah, thank you. Looking forward to many more years of partnership to come.

Maulik S. Joshi, Meritus Health:

Thank you.

Joshua A. Repac, Meritus Health:

Thank you.

Alexa Paiva, CMS/CMMI:

Just give us a moment while we get the slides back on screen. Awesome.

Now that we've walked through overall Medicare Fee-for-Service methodology, we've looked at a few examples of how hospitals might experience HGBs. We've heard how hospitals experience HGBs. We want to shift our focus and really hone in on the updates that CMS has made to the methodology since our last HGB-focused webinar.

Next slide, please.

So, the last time we discussed HGB methodology in detail, we were really, we were focusing on version 3.0, but since then, CMS has released versions 3.1 and 3.2 of the HGB specifications, incorporating feedback from states, hospitals, associations, and other stakeholders. So, the next section of our presentation is going to focus on the areas where we've made meaningful refinements or added new detail to the methodology. And we have three major updates that we are sharing with you all today. So first, carve outs. Carve outs are a policy to identify certain high-cost services and drugs that will be excluded from the HGB and that will continue to be reimbursed through Medicare Fee-for-Service payment methodologies. The second update that we'll share today is Service Line Adjustments. So, we have significantly expanded the methodology, operational guidance, et cetera. around hospital capacity, excuse me, around changes to hospital capacity, as in expansions, reductions, shifts in site of care. And then the third major update that we'll share with you today is around the Effectiveness Adjustment. We have refined how hospital performance on PAU, or potentially avoidable utilization, how that will be measured and then translated into an adjustment to your HGB.

So, let's go to the next slide. We'll start with carveouts. Thank you so much.

So, carve outs are intended to protect patient access to high cost, highly specialized services and drugs by excluding those services and drugs from the Medicare Fee-for-Service HGB and instead reimbursing them under original Medicare Fee-for-Service payment methodologies. So, this means that rather than including every single Medicare service or Medicare covered drug within the HGB, there is a limited set of services and drugs that will be carved out. And those are ones that CMS excludes because they may create significant financial risk or uncertainty if they were fully incorporated into the HGB. So, we have two different coding frameworks that we're using to identify carveouts. On the left, on the inpatient side, we're using diagnosis-related groups, or DRGs. And we use specific DRG codes to identify inpatient services that will be carved out. On the right side, for outpatient drugs, we use Healthcare Common Procedure Coding System, or HCPCS, codes to identify outpatient drugs that will be carved out of the HGB. I do want to note that on the outpatient side, the

policy is only applicable to drugs identified through HCPCS codes. So, we are not carving out outpatient services themselves. Those will generally remain within the HGB.

Next slide, please.

And on this slide, we will walk through the specific criteria that CMS uses to determine which DRGs and HCPCS codes are included in the carve out list. So, on the left, we're showing the DRG-based criteria for inpatient carve outs. This methodology really focuses on highly specialized services such as transplants, open heart procedures, trauma and burn cases, and then other highly specialized services that meet our certain, you know, utilization and payment thresholds. I'll note that there we're also carving out New Technology Add-On Payments Those are also excluded from the HGB. On the outpatient side, we have a HCPCS code-based criteria to identify certain high-cost drugs that we think are appropriate for exclusion from the HGB. Our methodology considers where the drug is predominantly furnished, as well as the spending associated with the patients receiving the drug.

This is, you know, the criteria that you see outlined on this slide are really only one part of the process. After we perform our quantitative analysis and we come up with an initial list, CMS then plans to conduct a clinical review to evaluate whether additional services or drugs should be added to the carve out list or whether, you know, there are things that should be removed from the carve out list, right? But that clinical review is really intended to ensure that the final list appropriately reflects evolving clinical practice, access considerations, as well as program and model goals. It's worth saying that, you know, utilization changes, technologies evolve, treatment approaches change over time. So, the carve out list is not static. We will evaluate the methodology and the resulting carve out list annually, allowing for updates to occur as new therapies emerge and as care delivery evolves. I do also want to sort of add a caveat here. The carve out methodology that's presented on this slide does remain under review. We intend to consider stakeholder feedback received through the public comment process. So, we're showing here the current proposal that's reflected in the 3.2 specifications, but it's possible that we'll make some refinements to the methodology before it is complete and finalized for PY1.

Next slide, please.

And so, this slide here just walks through a pretty quick example of carveouts. So, in this scenario, an ASC is offering a new oncology therapy. It's clinically important, but it's really expensive and demand is growing for this treatment. Without a carve out policy, the hospital would need to absorb the cost of that growth within a fixed global budget, which could potentially create uncertainty around future expansion of that service. But, under the carve out policy, the drug remains outside of the HGB. It continues to be reimbursed through Medicare Fee-for-Service. So as utilization increases, you know, reimbursement is going to continue outside of the HGB through the existing payment system. I think the high-level takeaway across this policy in general is that, you know, carve outs are intended to preserve access to certain high-cost therapies, as well as reduce financial barriers to hospitals offering these services.

With that, I will turn it over to my colleague, Jaafar Salim, and he will go through the next major methodology update, which are Service Line Adjustments.

Jaafar Salim, CMS/CMMI:

Thanks, Alexa. Next slide, please.

Alright, so as Alexa mentioned, in the Service Line Adjustments, we've expanded our methodology and operational guidance. And so, the last time we touched on this, the Service Line Adjustment was introduced in version 3.0 of the methodology. However, based on stakeholder feedback, CMS added substantial additional detail and operational guidance in version 3.1 and 3.2. As a result, we wanted to spend some additional time walking through how this policy works and the types of changes it is intended to support. At a high level, the Service Line Adjustment, or sometimes referred to as SLA, is designed to ensure that the Hospital Global Budget can adapt as hospitals respond to changing community need, adjust capacity, and redesign how care is delivered over time.

The methodology addresses two different situations, as we see here. The first is when a hospital is adding capacity or services. The second is when a hospital is reducing capacity or shifting services to lower cost settings. Focusing in on the left side, for service line additions, CMS provides prospective funding. The purpose of prospective funding is to support hospitals that are expanding capacity before utilization data or claims experience. Rather than waiting for future claims to demonstrate demand, CMS can prospectively add funding to the Hospital Global Budget or HGB to support the expansion. Examples of changes that we could think about what may qualify for prospective funding include adding capacity for a specific service line, increasing hospital-wide capacity, adding a hospital-based service that was previously unavailable, expanding a service line that experienced meaningful growth, or shifting capacity between hospitals within the same market area.

Shifting our focus to the right side, for service line reductions, CMS provides what is referred to as legacy revenue, which represents a portion of the Medicare savings generated by the change. The intent is to reduce financial barriers to make clinically appropriate and cost-effective changes in care delivery. Some examples that we could think through are, you know, changes that may qualify for legacy revenue, include right-sizing capacity based on market need, improving efficiency, eliminating services with sustained low demand, consolidating duplicative services or shifting care to lower cost settings such as ambulatory surgery centers. The key distinction is that service line additions may receive prospective funding to support growth and expansion, while service line reductions may receive legacy revenue or a share of savings to support care redesign, transformation activities, and the transition to new models of care. Over the next couple of slides, we'll walk through the Service Line Adjustment process, funding methodology, and a few illustrative examples.

Next slide, please. Thank you.

So, the previous slide described the changes that may qualify for a Service Line Adjustment. This slide walks through the process hospitals follow to receive one. The first thing to note is that these Service Line Adjustments are initiated by the hospital. CMS does not, sorry, we do not automatically identify expansions, reductions, or capacity changes. Hospitals will submit, firstly, a request due September 1st annually prior to the Performance Year. This Service Line Adjustment will take effect, describing the proposed change, the rationale supporting the change, the projected Medicare revenue impact, and any supporting regulatory or state documentation. This process also applies to certain changes that occurred during the baseline years. Hospitals may identify significant service line increases or decreases that occurred during the base years through the baseline survey process, so CMS can appropriately account for those changes when estimating the hospital's starting HGB amount. Once a request is submitted, CMS first will review for eligibility. The eligibility review is relatively straightforward and focuses on two main questions. Is the proposed change a substantive and durable change in hospital capacity? And secondly, does it meet the required Medicare revenue threshold? If the request is determined to be eligible, CMS will then conduct an approval review. During this review, we will evaluate factors such as community need, beneficiary access, operational feasibility, and financial sustainability. For approved requests, we will determine the funding amount. Service line additions may receive prospective funding, while service line, as mentioned before, service line reductions may receive legacy revenue, representing a portion of the associated Medicare savings. An important note to mention is that these funding amounts are initially based on projections and estimates. To ensure payments ultimately reflect actual experience, approved Service Line Adjustments are reconciled after two years. In other words, hospitals receive funding prospectively, but CMS will later compare projected results to actual results and adjust as necessary. The main callout and main takeaway from this slide is that hospitals play an active role in this process. They identify the change, submit the request, and provide the information needed for us at CMS to determine eligibility, approval, and eventual funding.

Next slide, please.

All right, so this example illustrates how the Service Line Adjustment can support hospitals when they move care to a lower cost setting. In this scenario, a hospital decides to transition knee arthroscopy procedures from the hospital setting to an ambulatory surgery center. For many patients, this can be a lower cost and clinically appropriate site of care.

Under traditional, sorry, traditional Medicare Fee-for-Service, the outcome is different. Or, sorry, the decision creates a challenge for hospitals. Medicare benefits because the service is delivered at a lower cost. But the hospital typically experiences a reduction in revenue. Under HGB, the outcome is different. Through the Service Line Adjustment methodology, the hospital may receive legacy revenue, which represents a portion of the Medicare savings generated by the change. The result is now a shared benefit. So, Medicare will retain a portion of the savings associated with moving care to a lower cost setting, while the hospital will retain a portion of those savings to support transformation activities and ongoing operations. This illustrates one of the core goals of the Hospital Global Budget model, reducing the financial barriers that can exist when hospitals make changes that improve efficiency and lower costs. Again, the main takeaway here is that, under an HGB, hospitals are not necessarily financially disadvantaged from making the right operational or clinical decisions. Instead, both CMS and the hospital can benefit from the savings generated through those changes.

Next slide, please. Thank you.

All right, so on the previous slide, we discussed the concept of legacy revenue. This slide shows how CMS determines the amount of legacy revenue hospitals may retain following an approved service line reduction. The basic approach is that hospitals retain a percentage of the Medicare savings generated by the reduction. That percentage differs based on hospital type and decreases over time for most hospitals. Looking at the table, for non-Critical Access Hospitals, a portion of the savings is designated for population health aligned activities, while another portion may be used at the hospital's discretion. During the first few years following a service line reduction, hospitals retain a larger share of savings. The population health aligned activities portion then gradually steps down over time, while the discretionary portion remains constant. The intent is to provide hospitals with transition funding and incentives to make investments that support care redesign, population health, and broader transformation activities.

Critical access hospitals are treated differently. Recognizing their unique financial and access challenges, Critical Access Hospitals retain 100% of savings to CMS. The main takeaway here is not any single percentage in the table, rather the methodology is designed so that when a hospital makes a clinically appropriate change that generates Medicare savings, it can then return or retain a portion of those savings to support the transition and continue investment in the community.

Next slide, please. Thank you. So, the final methodology that we'll talk through is the Effectiveness Adjustment. Next slide.

So, before we get into the updates made in version 3.1 and 3.2, it's important to note that the Effectiveness Adjustment is not new. It was included in earlier versions of the methodology, including version 3.0. What we're going to discuss over the next few slides are refinements we have made to how the adjustment is calculated. At a high level, the EA, Effectiveness Adjustment, is intended to encourage hospitals to implement interventions that reduce potentially avoidable utilizations, or PAU, where PAU is defined by avoidable admissions, avoidable readmissions, and unnecessary emergency department utilization. The Effectiveness Adjustment is a downward-only adjustment, with a maximum adjustment of negative 2%. Hospitals with stronger performance on potentially avoidable utilization, or PAU, avoid some or all of that reduction, while hospitals with lower performance may be subject to a larger adjustment. The adjustment is also phased over time. So, for acute care hospitals, the EA begins in Performance Year 2 and gradually increases to a maximum adjustment of 2%. For safety net hospitals, the adjustment begins later in Performance Year 3 and phases in more gradually to provide additional time to build the care coordination and population health capabilities needed to manage potentially avoidable utilization. Under this methodology, hospitals are compared based on their performance on measures related to PAU. Acute care hospitals are compared against other acute care hospitals in their state, while safety-net hospitals are compared against other safety-net hospitals in their state, with additional adjustments to account for differences in social risk.

Next slide, please. Thank you.

So, the first refinement we made to the Effectiveness Adjustment relates to how PAU or potentially avoidable utilization is measured. So, under prior methodology, CMS used non-risk adjusted

measures when calculating hospital performance. Based on stakeholder feedback, version 3.2 updates the methodology to use risk-adjusted measure scores, which we then normalize using these scores when determining the PAU scores, which yields hospital rankings. At a high level, the goal of this change is to improve comparability across hospitals by accounting for differences in the population they serve.

Next slide, please. Thank you.

And I know we're close to time, so I'll get through these. So, the second refinement CMS made to the EA relates to how hospitals are grouped in performance bands. So, under prior methodology, hospitals were grouped in four relatively broad percentile bands. While that approach was straightforward, it meant that hospitals could make meaningful improvements in potentially avoidable utilization without seeing a corresponding change in their Effectiveness Adjustment. In version 3.2, what we've done is we've increased the number of performance bands from four to nine, creating more gradual progression between performance levels. So, as you'll see in this table, hospitals in the top performing group, those at or below the 20th percentile, received no Effectiveness Adjustment. Beginning at the 20th percentile, the adjustment increases in smaller increments across each performance band until reaching the maximum adjustment.

Next slide, please.

Realizing that we are at time, thank you. We wanted to get through some opportunities for continued engagement, additional resources, and future conversations about the AHEAD Model.

Next slide, please.

So today we've discussed how hospitals can participate in the AHEAD Model, what a Hospital Global Budget is, heard perspectives from a Maryland hospital operating under an HGB, and walked through the Medicare Fee-for-Service HGB methodology, including the updates we made in 3.1 and 3.2. Throughout that discussion, a common theme has emerged: participation in a Medicare HGB does not mean leaving Medicare Fee-for-Service principles entirely behind. Instead, the model is designed to preserve many of the features hospitals value under Fee-for-Service while creating additional opportunities to support transformation and population health.

Next slide, please.

So, before we dive into next steps, just wanted to highlight an opportunity for stakeholders. As we've discussed, we've made updates to the methodology and have opened the latest version for public comment. Well, we welcome all and any feedback from all current and prospective AHEAD states, hospitals, and any other interested stakeholders on the CMS-designed Medicare Fee-for-Service HGB financial spec methodology version 3.2 and the Maryland addendum. Just to note, public comment period will remain open through October 30th, 2026. And please submit your comments and questions through the form linked on this slide. Last note there, the PY 2028, oh sorry, Medicare Fee-for-Service global budget specs for cohorts one to three are expected to be finalized in early 2027.

Next slide, please.

And we'll just do a quick skim overview of this slide. We wanted to highlight the resources available on the AHEAD Model website's participant resources page. And we encourage you all to use the materials as we continue to explore the model and consider what participation could mean for you or your hospital. To make navigation easier, the resources are organized around the questions hospitals are most commonly trying to answer.

Next slide, please.

And with that, final steps. First, as we discussed, submit comments to the global HGB version 3.2 financial methodology by October 30th. Secondly, try to review available resources and stay tuned for new resources. Build familiarity with the methodology using the HGB calculator tool, discuss HGBs with organization leaders and decision makers, and lastly, connect with your state's AHEAD team to ask questions and learn more.

Next slide.

All right, and with that, thank you all for your time. We appreciate your time and look forward to supporting you as you explore participation in AHEAD. To help us provide the most useful and responsive support possible, we invite you to complete our post-event survey using the QR code on screen. A survey link will also be shared via e-mail following today's event.

If you have any questions, feel free to reach out to us at the AHEAD e-mail as shown here. And then thank you, and we look forward to staying connected. Thanks, everyone.