AHEAD Model: CMS-Designed Medicare Fee-For-Service Hospital Global Budget Methodology Version 3.1 At-A-Glance

Overview

Purpose

This At-A-Glance document provides an overview of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Centers for Medicare & Medicaid Services (CMS)-Designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) Methodology Version 3.1 (v3.1). It is intended to help hospital leadership and other stakeholders understand what an HGB is, how HGBs are constructed, and the implications of each component for their organization. Methodological elements unique to Critical Access Hospitals (CAHs) are highlighted on **page 6**. For more detailed information, refer to the CMS-Designed Medicare FFS HGB Methodology v3.1 Specifications available on the AHEAD Model website.

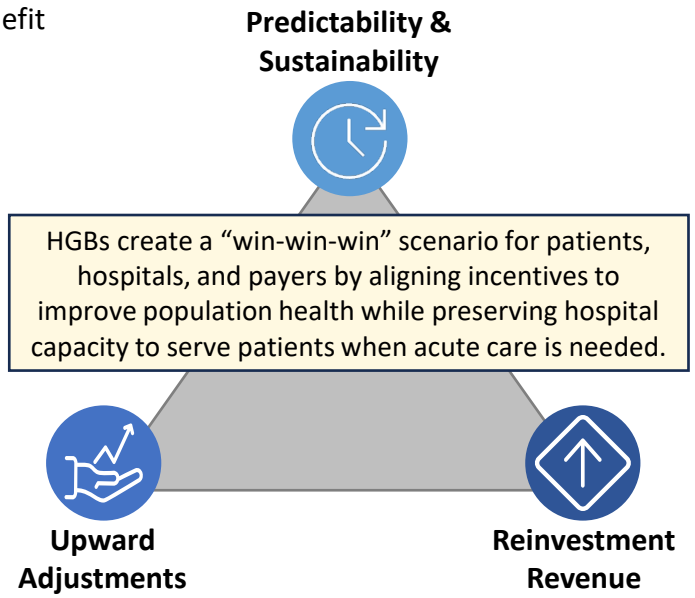
What is a Hospital Global Budget?

An HGB is a fixed annual payment that covers specified inpatient and outpatient facility services, paid at regular intervals and updated over time. It replaces traditional claims for participating hospitals that voluntarily enter into agreements with payers. Under the AHEAD Model, Hospitals will receive HGBs under Medicare, Medicaid, and some commercial payers. This resource focuses on CMS-Designed Medicare FFS HGBs.

Benefits of Hospital Global Budgets

By participating in HGBs and shifting away from FFS, hospitals benefit financially from:

- Stable, predictable funding,
- The opportunity to earn upward annual adjustments to their HGB revenue,
- The potential to reinvest revenue from reduced Potentially Avoidable Utilization (PAU) and shifts to non-hospital settings,
- The ability to shift focus to population health management, and
- The opportunity to implement innovative strategies to enhance patient care quality and boost clinician engagement.



Construction of CMS-Designed Medicare Fee-For-Service Hospital Global Budgets

Below are the key components of CMS-Designed Medicare FFS HGBs. CMS calculates HGBs using historical baseline revenue, adjusted annually to reflect changes in prices, volume, social risk, and medical risk. There are also additional adjustments tied to performance on quality and cost measures. The following pages describe how each component is calculated and the implications for hospitals.

Baseline Calculation + **Volume-Based Adjustments** + **Reflect FFS: Pricing & Demographic Adjustments** + **AHEAD-Specific Adjustments** = **Hospital Global Budget Payments**

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Step 1: Hospital Global Budget Baseline Calculation

The first step in constructing an HGB is the baseline calculation, which serves as the foundation for payments to participating hospitals. To establish the Performance Year (PY) 1 baseline, CMS uses historical FFS payments from three baseline years (BYs), each spanning July 1 to June 30, with more recent years weighted more heavily. CMS carves out highly specialized Diagnosis-Related Groups (DRGs) and high-cost outpatient drugs [identified by Healthcare Common Procedure Coding System (HCPCS) code] to support hospitals in delivering high-cost, complex care. These claims will be paid as regular FFS claims during the PYs. Beginning in PY2, the prior year's HGB amount (excluding AHEAD-Specific adjustments) serves as the baseline for subsequent years. The baseline is designed to fully reflect the historical revenue that the HGB replaces.

Exhibit 1: Example PY1 Baseline Calculation

A hospital's PY1 (2028) Medicare HGB baseline is calculated by combining the weighted revenue from the prior three years, with weights of 10%, 30%, and 60%, respectively, to account for variation over time.

BY1 Revenue (July 2024 - June 2025)		BY2 Revenue (July 2025 - June 2026)		BY3 Revenue (July 2026 - June 2027)
$320M x 10% = $32M	+	$330M x 30% = $99M	+	$365M x 60% = $219M

PY1 (2028) Medicare HGB Baseline Calculation
$350M = $32M+ $99M+ $219M

Step 2: Volume-Based Adjustments

CMS then applies Volume-Based Adjustments to support payment predictability and create incentives for growth in reinvestment revenue or savings. These adjustments account for changes in a hospital's market share relative to peers, shifts in service offerings, and variation in outlier payments to help maintain payment stability.

Market Shift Adjustment (MSA): Accounts for year-over-year changes in patient volume and complexity across hospitals within a defined market area. Hospitals that gain relative market share receive a positive adjustment to help cover the incremental costs of shifting volume. To promote stability, small hospitals—defined as those with less than 2% market share in the AHEAD region—are protected from downward adjustments due to year-over-year fluctuations and volatility. The MSA is applied annually beginning in PY2.

Service Line Adjustment (SLA): Prospectively accounts for planned structural changes to infrastructure or permanent staffing levels, including the addition, expansion, reduction, or elimination of specific service lines. It supports hospitals in adapting their care delivery while supporting the service transition and enabling reinvestment in priority areas. When a hospital adds or expands a service line, its HGB increases based on projected revenue, reconciled with actual experience over time. When a hospital reduces or eliminates a service line, including shifts to lower-cost settings, the hospital retains a portion of the associated savings (or legacy revenue) to reinvest in population health and related priorities for a defined period. The SLA is applied annually beginning in PY1. See **page 7** for more details.

Outlier Adjustment: To promote payment stability, the HGB includes an adjustment for changes in a hospital's share of outlier payments over time. This adjustment helps protect hospitals from fluctuations in the frequency or intensity of high-cost cases between the baseline and performance years. To account for claims runout, particularly for complex cases, the outlier adjustment is applied annually beginning in PY3.

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Step 3: Pricing & Demographic Adjustments to Reflect FFS Revenue

CMS then applies Pricing and Demographic Adjustments. The Annual Payment Adjustment (APA) updates the HGB to reflect changes in policy and prices, while the Demographic Adjustment accounts for shifts in the medical complexity of the patient population.

Annual Payment Adjustment (APA): Updates the HGB to reflect changes in Medicare FFS prices from one year to the next. The adjustment accounts for inpatient and outpatient pricing separately.

The ***Inpatient APA*** reflects changes in Inpatient Prospective Payment System (IPPS) payment factors, including updates to the base rate, geographic adjustments (e.g., wage index), and policy and quality-related adjustments [e.g., Indirect Medical Education (IME), Uncompensated Care (UCC), and the Hospital Readmissions Reduction Program (HRRP)]. To help create payment stability, two years of UCC and Disproportionate Share Hospital (DSH) data are reviewed and the higher value is utilized.

The ***Outpatient APA*** reflects changes in hospital-specific Ambulatory Payment Classification (APC) payment amounts. Similar to the Inpatient APA, it incorporates geographic adjustments (e.g., wage index) as well as updates for policy changes and price updates.

Exhibit 2: APA Calculations

Demographic Adjustment (DA): Accounts for year-over-year changes in the size, age, Medicare status, and medical complexity of a hospital's patient population. It uses Hierarchical Condition Category (HCC) scores to adjust for the demographic and clinical risk of beneficiaries in the counties served by the hospital, weighted by each county's share of hospital revenue.

Step 4: AHEAD-Specific Adjustments

CMS then applies AHEAD-Specific Adjustments, including both Annual and Performance-Based updates. These adjustments refine the HGB to support care transformation, strengthen management, and promote high-quality care.

Annual Adjustments

The annual AHEAD-Specific adjustments include the Transformation Incentive Adjustment (TIA) and the Social Risk Adjustment (SRA). These adjustments represent targeted investments to support participating hospitals' success under the model, while providing added flexibility to deliver whole-person care and focus on population health.

Transformation Incentive Adjustment (TIA): Participating hospitals receive an **automatic upward 1%** adjustment during the first two PYs of the AHEAD Model. This adjustment incentivizes early participation and provides additional resources to support care management and transformation activities.

Social Risk Adjustment (SRA): Provides an upward adjustment of up to 2% for hospitals serving higher-adversity patient populations. It is based on a hospital's Social Risk Score (SRS), which is calculated using the Community Deprivation Index (CDI) and measures of low-income status, including dual eligibility and the Part D Low-Income Subsidy (LIS). Hospitals are ranked relative to others in the AHEAD state or sub-state region, and those above the 40th percentile receive an adjustment.

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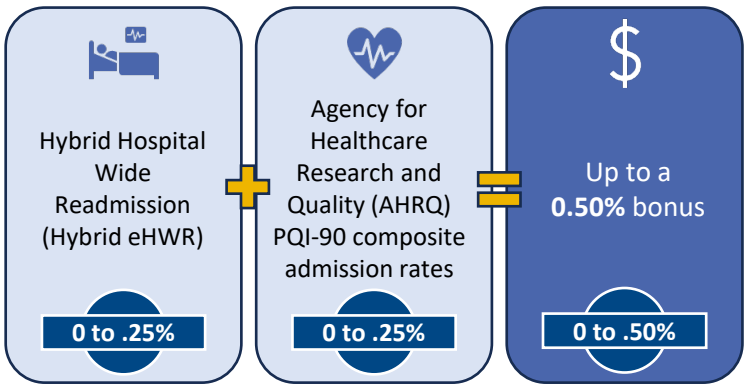
Step 4: AHEAD-Specific Adjustments (continued)

Performance-Based Adjustments

The Performance-Based Adjustments are updates made to the Participant Hospital's HGB based on performance. These adjustments are not factored into the PY1 HGB but are included in subsequent years.

Hospital Community Improvement Bonus (CIB): Adjustment of up to 0.5% for performance on two quality measures that incentivize a focus on population health: Hybrid Hospital Wide Readmissions (Hybrid eHWR), which measures the observed-to-expected readmissions rate and Prevention Quality Indicators (PQI)-90, which measure composite admission rates for select conditions. Each measure is calculated, scaled, and rewarded independently and each result in an up to 0.25% adjustment (**Exhibit 3**).

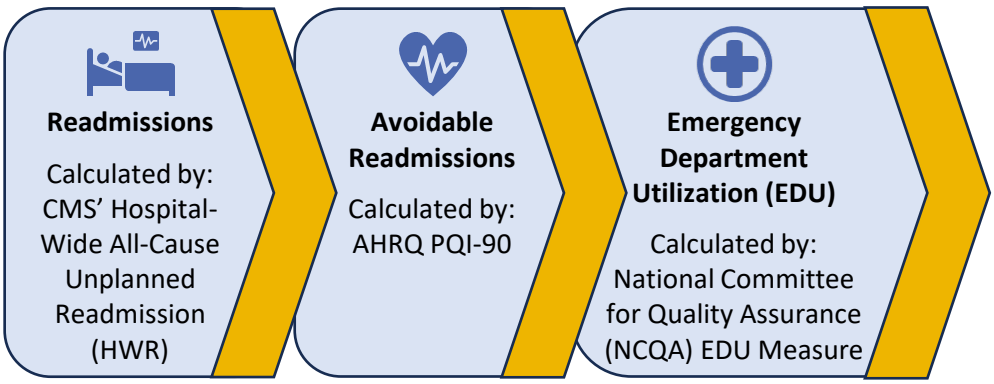
Exhibit 3



Effectiveness Adjustment (EA): Adjustment of between 0% to -2% based on a hospital's Medicare FFS avoidable utilization (see **Exhibit 4** for measures) performance (adjusted by the hospital's SRS to account for differences in population risk) relative to all other eligible hospitals in the state or sub-state region.

The EA incentivizes interventions that reduce unnecessary or avoidable care, such as transitional care programs and stronger integration with primary care providers. Hospitals that improve performance relative to peers can reinvest HGB funding in clinical and social services, supporting continued success under AHEAD.

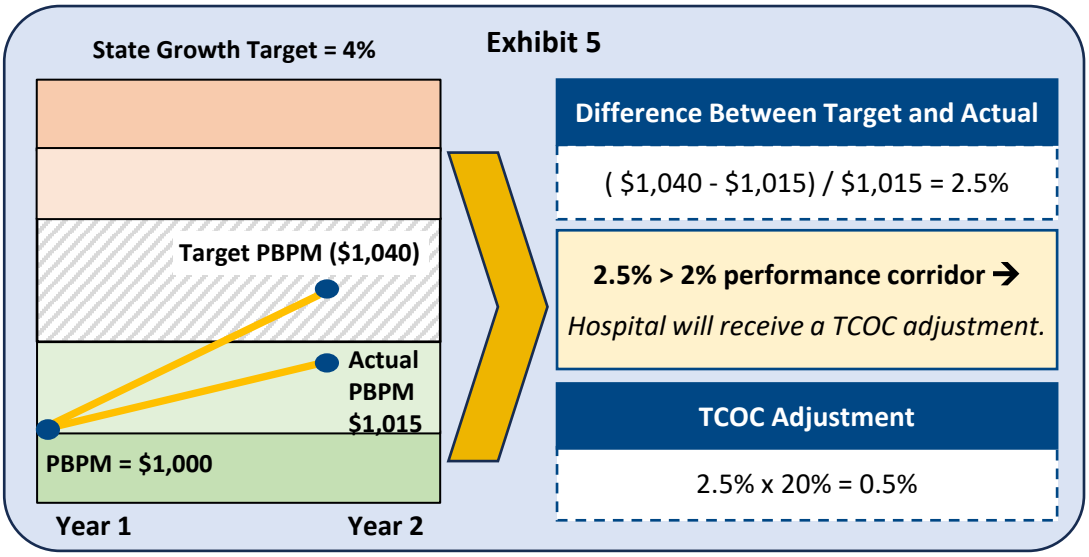
Exhibit 4



Total Cost of Care (TCOC) Adjustment: Adjustment of up to ±2% that incentivizes hospitals to reduce TCOC for Medicare FFS beneficiaries within their market area through population health management.The adjustment is based on the difference between actual and target TCOC, with higher payments for hospitals that reduce costs.

The target TCOC is based on historical spending trended forward using a state-specific growth benchmark. If the difference between actual and target TCOC exceeds ±2%, hospitals receive an adjustment equal to 20% of the difference (see example in **Exhibit 5**).

Exhibit 5



Hospital Global Budget Adjustments in Focus

Exhibit 6 shows the upside, downside, and bilateral HGB adjustment components by PY. The upward green arrows are pure upside opportunities. The yellow arrows can go up or down, meaning they flex with real-world changes. These adjustments give hospitals the chance to earn more when progress is made. The red downward arrows can reduce a hospital's HGB but are intended to encourage reducing avoidable utilization.

Exhibit 6

HGB Adjustment Component	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Annual Payment Adjustment	↑	↑	↑	↑	↑	↑	↑	↑
Demographic Adjustment	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
Service Line Adjustment	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
Market Shift Adjustment		↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
Outlier Adjustment			↑↓	↑↓	↑↓	↑↓	↑↓	↑↓
Transformation Incentive Adjustment	↑	↑						
Social Risk Adjustment	↑	↑	↑	↑	↑	↑	↑	↑
Total Cost of Care Performance Adjustment [1]				↑	↑↓	↑↓	↑↓	↑↓
Community Improvement Bonus				↑	↑	↑	↑	↑
Critical Access Hospital Quality Adjustments[2]			↑	↑	↑	↑	↑	↑
Effectiveness Adjustment [3]		↓	↓	↓	↓	↓	↓	↓

↑	Pure upside opportunity (increase only)
↑↓	Adjustments that flex with real-world changes (can increase or decrease)
↓	Downward adjustments to incentivize reducing avoidable utilization (decrease only)

[1] For Prospective Payment System (PPS) hospitals, TCOC is upward only in PY4, and bidirectional thereafter; for Safety Net Hospitals (SNHs) and CAHs, TCOC is upward only PY4 – PY5 and bidirectional thereafter.

[2] This CAH Quality Adjustment begins as a pay-for-reporting reward in PY3 and progresses to a pay-for-performance reward by PY8. This adjustment is only applicable to CAHs.

[3] For PPS hospitals, EA is downward only starting in PY2; for SNHs and CAHs EA is downward only starting in PY3.

Step 5: Determining the Hospital Global Budget Payment for PY1

CMS will calculate the PY1 HGB Payment amount by combining the elements described in **pages 1-5.** **Exhibit 7** below walks through how all steps and components combine to determine the final payment.

Exhibit 7

[A] HGB Baseline Amount	$350,000,000
[B] Market Shift Adjustment (MSA)	N/A for PY1
[C] Service Line Adjustments (SLA)	$35,000
[D] Outlier Adjustment	N/A for PY1
[E] HGB Amount Adjusted for Volume (A+B+C+D)	$350,035,000
[F] Annual Payment Adjustment (APA)	3%
[G] Demographic Adjustment (DA)	2%
[H] HGB with APA and DA (E*(1+F)*(1+G))	$367,746,771

[I] Social Risk Adjustment (SRA)	0.5%
[J] Transformation Incentive Adjustment (TIA)	1% for PY1&2
[K] HGB after Annual AHEAD-Specific Adjustments (H*(1+I)*(1+J))	$373,281,360
[L] Effectiveness Adjustment (EA)	N/A for PY1
[M] Community Improvement Bonus (CIB)	N/A for PY1
[N] Total Cost of Care Adjustment (TCOC)	N/A for PY1
[O] Final HGB Payment (K*(1+L)*(1+M)*(1+N))	$373,281,360

Special Protections in the CMS-Designed Medicare Fee-For-Service Hospital Global Budget Methodology for Critical Access Hospitals & Safety Net Hospitals

There are several key methodological differences in how the AHEAD Model calculates HGBs for CAHs and SNHs. These provisions are designed to support financial stability, phase in risk more gradually, and account for structural differences across hospital types.

- **Payment Floor (CAH):**
  - Ensures that CAH HGB payments are no lower than 101 percent of Medicare FFS costs (pre-sequestration).
- **Quality Incentive Program (CAH):**
  - Beginning in PY3, CAHs are eligible for an upside-only quality adjustment, which transitions from pay-for-reporting to pay-for-performance on a defined set of measures.
- **Service Line Adjustment (CAH):**
  - CAHs may retain up to 100 percent of revenue associated with reduced or eliminated service lines, subject to SLA approval.
- **TCOC Adjustment (CAH & SNH):**
  - The TCOC adjustment is upside-only in PY4 and PY5 and becomes bi-directional in PY6, reflecting a one-year delay compared to Acute Care Hospitals (ACHs).
- **Effectiveness Adjustment (CAH & SNH):**
  - The effectiveness adjustment begins in PY3, one year later than for ACHs.

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Service Line Adjustments in Focus

Under HGBs, hospitals are encouraged to formally request Service Line Adjustments (SLAs) when implementing durable, hospital-initiated changes in service capacity. Hospitals may request two types of SLA adjustments, described below.

Definitions	Additions	Reductions
	New or expanded service lines may qualify for prospective payments based on projected Medicare FFS revenue for two PYs (subject to reconciliation to actual utilization). Approval requires evidence of unmet market need.	Eliminated or materially reduced service lines may qualify for payments allowing hospitals to re-purpose funds to meet population health or other delivery system transformation needs. Approval requires demonstration that beneficiary access will not be adversely affected.
Payments	• Paid through bi-weekly HGB payments for 2 PYs. • Based on projected Medicare FFS volume × Medicare payment rates. • Reconciled to actual utilization using no-pay claims. • After reconciliation, actual revenue is incorporated into the baseline.	• Paid outside the HGB as a share of estimated savings. • Phases down over time and funding that can be used for population health investments and discretionary costs (e.g., workforce transition, closure costs). • Reconciled after two years based on actual savings. • Payment stops immediately for the removed/reduced service.

Proposed changes must demonstrate a substantive, multi-year shift in increased or decreased capacity—not temporary operational variation or demand-driven fluctuations. They also must be clearly defined using applicable billing codes (e.g., DRGs, HCPCS, revenue codes).

Service Line Adjustment Reporting and Approval Process

To receive an SLA, hospitals must proactively report planned service line changes and complete a streamlined CMS application and approval process. Requests must be submitted in advance, no later than September 1 prior to the PY, to be eligible for prospective payments or legacy revenue.

1 Submit SLA Request

- Hospital submits request with rationale, projected revenue impact, and documentation.
- Requests must be submitted by September 1 prior to PY.

2 CMS Eligibility Review

CMS screens requests for:

- Durable, structural change in capacity
- Minimum revenue threshold (≥1% of Medicare revenue or ≥$500K).

3 CMS Approval Review

CMS evaluates requests for:

- Access and market need or preservation of access.
- Alignment with Population Health Accountability Plan (PHAP), State input, regulatory approvals, and market conditions.

4 Payment Determination and Reconciliation

- CMS establishes payments and incorporates into HGB.
- Payments reconciled to actual FFS utilization after two years.
- Approved changes are incorporated into future HGB calculations
- Criteria for reconciling payments differs for SLA additions and SLA reductions.

Additional AHEAD Hospital Global Budget Resources

- Financial Specifications for the CMS-Designed Medicare FFS HGB Methodology See Version 3.1 for the latest version of the specifications.
- AHEAD CMS-Designed Medicare FFS HGB Methodology Overview v3.0 Webinar Recording, Slides, and Transcript detailing HGB components, including each adjustment.
- CMS-Designed Medicare FFS HGB Calculator Tools Excel-based tools that allow hospitals to enter values for baseline and other adjustments to understand how the methodology works. *(Contact State, if you have not received your tool)*