AHEAD Model: CMS-Designed Medicare Hospital Global Budget Version 3.0 Methodology At-A-Glance

Overview

Purpose

This At-A-Glance document provides an overview of the Centers for Medicare & Medicaid Services (CMS)-Designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) Version 3.0 Methodology. Hospital leadership and other interested parties can use this document to understand what a HGB is, how it is constructed, and the implications of each component for their context. Unique methodological elements specific to Critical Access Hospitals (CAHs) are also provided on page 5. For more detailed information, see the CMS-Designed Medicare FFS HGB Version 3.0 Methodology Specifications on the AHEAD Model website.

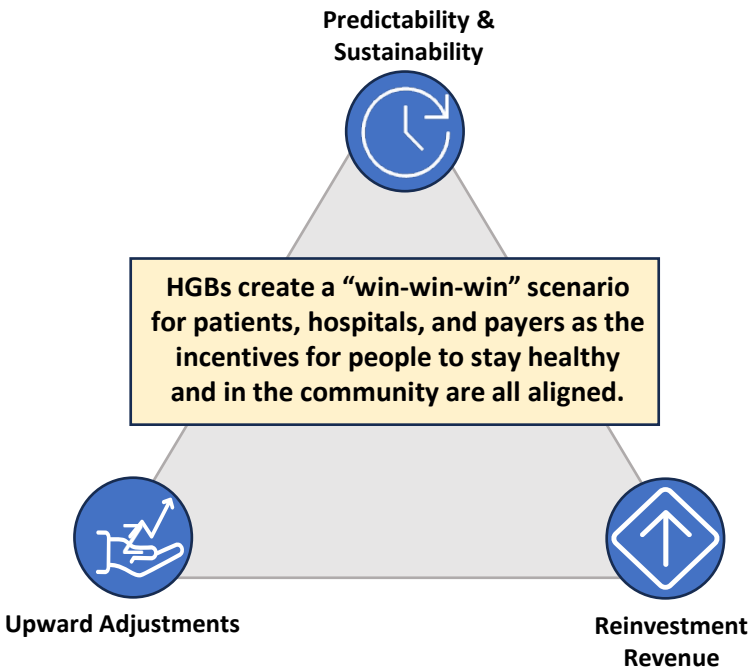
What is a Hospital Global Budget?

A HGB is a prospectively set fixed annual payment for Medicare FFS inpatient and outpatient facility services that is payable bi-weekly from Medicare and grows over time, replacing FFS claims for AHEAD-eligible Hospitals that voluntarily sign Hospital Participation Agreements with CMS. Under the AHEAD model, HGBs are calculated based on historical FFS revenue data with adjustments to account for year-to-year changes in prices, volume, social risk, and medical risk. Additional adjustments are made to reflect performance on quality and cost measures.

Benefits of Hospital Global Budgets

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

- Stable, predictable funding,
- Payment levels comparable to FFS, plus 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.
- Ability to shift focus to population health management, and
- Opportunity to implement innovative strategies to enhance patient care quality and boost clinician engagement.



Construction of a Hospital Global Budget

Below are the key components of HGB under AHEAD. The following pages describe how each component is calculated and the implications for hospitals.

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Step 1: Hospital Global Budget Baseline Calculation

The first step in constructing a HGB is the HGB Baseline Calculation. The baseline serves as the foundation for the HGB payment for Participating Hospitals. To calculate the HGB Baseline for Performance Year (PY1), CMS uses historical Medicare FFS payments from three baseline years (BYs). Each BY is a 12-month period starting July 1 and ending June 30. CMS weights historical revenue, with the most recent years weighted more heavily (see example below). Beginning in PY2, the previous year's HGB amount (excluding AHEAD specific adjustments) serves as the baseline amount for each consecutive PY. All factors used in Medicare FFS claim payments are incorporated to ensure the HGB Baseline Amount fully accounts for Medicare FFS revenue that is replaced by the HGB.

Example PY1 Baseline Calculation

As shown to the right, a Cohort 1 hospital's PY1 (2026) HGB Baseline Calculation is constructed by adding the weighted revenue of the prior three years—weighted by 10%, 30%, and 60%, respectively to account for variation over time.

BY1 Revenue (July 2022 - June 2023)	+	BY2 Revenue (July 2023 - June 2024)	+	BY3 Revenue (July 2024 - June 2025)
$320M x 10%= $32M		$330M x 30%= $99M		$365M x 60%= $219M

PY1 (2026) HGB Baseline Calculation
$350M= $32M+ $99M+ $219M

Step 2: Volume-Based Adjustments

After the HGB Baseline Calculation, CMS applies Volume-Based Adjustments, which facilitate predictable HGB payments and provide incentives for growth in reinvestment revenue or savings. These adjustments account for shifts in a hospital's market share relative to other hospitals and changes in hospital service offerings. In addition, shifts in outlier payments are accounted for to ensure payment stability.

Market Shift Adjustment (MSA): Adjusts for proportional year-over-year changes in patient volume and complexity between hospitals within a Hospital-Specific Market Area. Participant Hospitals that gain proportional market share receive a positive MSA. The MSA is designed to cover the incremental cost of the volume shift between hospitals. CMS applies a 0% floor to small hospitals (hospitals with less than 2% market share in the state or sub-state region) shielding them from any downward adjustments due to year-over-year fluctuations. The MSA begins in PY2.

Service Line Adjustment (SLA): Adjusts for service line modifications, including additions, expansions, reductions, or eliminations of specific service lines. A Participant Hospital adding or expanding a service line will receive an upward adjustment to their HGB for the next PY to account for the forecasted revenue associated with the SLA. In the inverse scenario, when a Participant Hospital notifies CMS of its plan to contract or eliminate a service line, the Participant Hospital may request to reinvest a percentage of the revenue (up to 50%) associated with the reduced service line in the following PY. Reinvested funds must be used for population health and care coordination activities, consistent with the Hospital Community Health Plan. The SLA begins in PY1.

Outlier Adjustment: To foster payments stability, the HGB accounts for the change in share of a Participant Hospital's outlier payments year-to-year. This adjustment protects Participant Hospitals against changes in the frequency or intensity of outlier cases between the baseline and/or PYs. To allow for nine months of claims runout, which may be needed for complex claims, the outlier adjustment is first applied in PY3.

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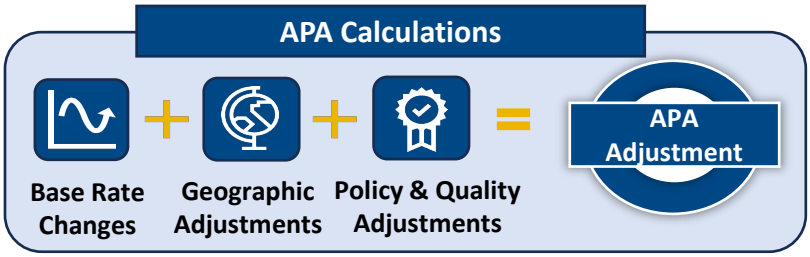
Step 3: Pricing & Demographic Adjustments to Reflect FFS Revenue

After application of the Volume Based Adjustments, CMS applies Pricing and Demographic Adjustments. The Pricing (Annual Payment Adjustment [APA]) and Demographic Adjustment update the HGB Baseline Amount to reflect changes in Medicare FFS policy and prices and shifts in the medical complexity of the patient population.

Annual Payment Adjustment (APA): Adjusts for changes in Medicare FFS prices between BYs or from one PY to the next. The calculation adjusts for changes in Inpatient and Outpatient prices separately. The ***Inpatient APA*** is based on changes in hospital-specific Inpatient Prospective Payment System (IPPS) payment factors This reflects changes to the IPPS base rate, location specific adjustments (e.g., wage index), and policy/quality adjustments (e.g., Indirect Medical Education (IME), Uncompensated Care (UCC), Hospital Readmissions Reduction Program (HRRP)).

The ***Outpatient APA*** is based on changes to the hospital-specific Ambulatory Payment Classifications (APC) payment amounts. Like the Inpatient APA, the Outpatient APA incorporates geographic area differences in hospital wages (e.g., Wage Index) and updates for policy shifts and price changes.



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

Step 4: AHEAD-Specific Adjustments

After the Pricing and Demographic Adjustments, CMS applies the AHEAD-Specific Adjustments, including both annual adjustments and performance-based adjustments. These adjustments update the Baseline Amount to support care transformation and management activities and to promote quality.

Annual Adjustments

The Annual AHEAD-Specific Adjustments include the Transformation Incentive Adjustment (TIA) and the Social Risk Adjustment (SRA). Both adjustments are investments from CMS to support Participating Hospitals' success under the model, while adding flexibility for hospitals to treat patients holistically and focus on population health.

Transformation Incentive Adjustment (TIA): Automatic upward 1% adjustment for hospitals that join AHEAD in the first two PYs. The adjustment incentivizes early participation and provides additional revenue for care management and transformation activities.

Social Risk Adjustment (SRA): Upwards adjustment of up to 2% for Participant Hospitals treating higher adversity patient populations. The SRA is based on a hospital's Social Risk Score (SRS). Hospitals receive a percentile ranking relative to other state or sub-state region hospitals and those that falls above the 40th percentile, received a SRA. A hospital's SRS is calculated using the Community Deprivation Index (CDI) and a combination of dual-eligibility and Part D Low Income Subsidy (LIS) referred to as the Low-Income Marker.

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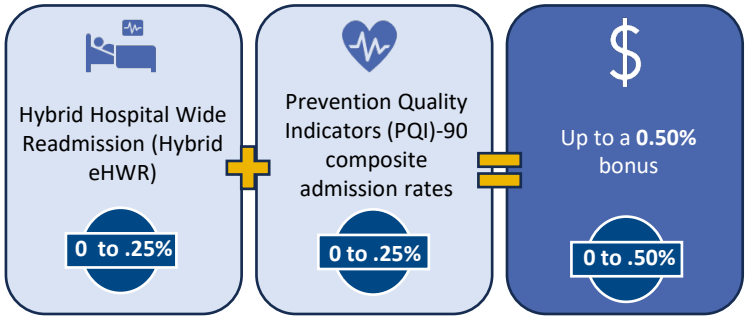
Performance-Based Adjustments

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.

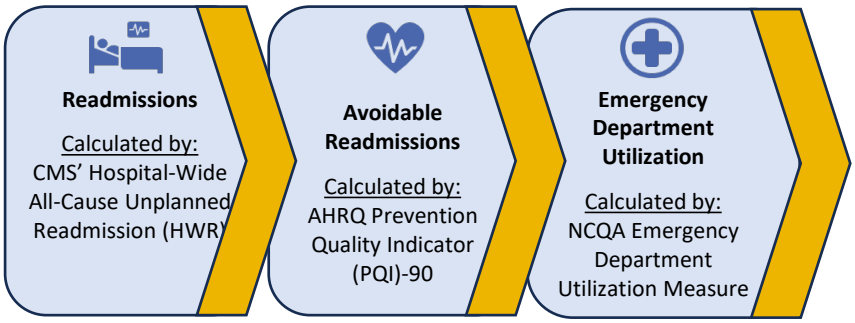
Hospital Community Improvement Bonus (CIB) Adjustment of up to 0.5% for hospital performance on two quality measures that incentivize hospital focus on population health: Hybrid Hospital Wide Readmissions (Hybrid eHWR), which measures the observed over expected rate of readmissions and Prevention Quality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

Exhibit 3



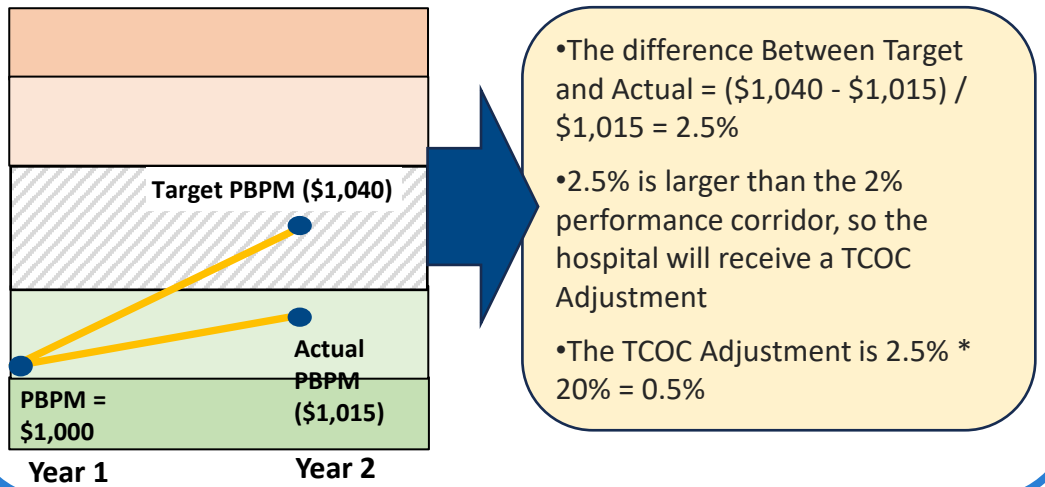
Effectiveness Adjustment (EA): Adjustment of between 0% to -2% based on a Participant Hospital's Medicare FFS avoidable utilization (**Exhibit 4 details the measures considered)** performance (adjusted by the hospitals SRS to account for differences in population risk) relative to all other eligible hospitals in the state. The EA is designed to incentivize Participant Hospitals to implement interventions that reduce unnecessary or avoidable care. The EA encourages hospitals to develop strategies such as transitional care programs and better integration with primary care providers. Hospitals that effectively reduce PAU relative to other hospitals in the state reinvest HGB funding in clinical and social services that continue to promote the hospital's success under the model.

Exhibit 4



Total Cost of Care (TCOC) Adjustment: Adjustment based on performance in reducing the TCOC within the Participant Hospital's market area through population health management. The TCOC adjustment provides additional incentives for managing TCOC incurred by Medicare FFS beneficiaries. Beginning in PY4, CMS will adjust HGB payments **by up to 2%** based on hospital TCOC versus a target TCOC, with the intention of rewarding hospitals that are reducing TCOC. The target TCOC is based on historical cost data trended forward using a customized state growth benchmark. The percentage difference between the Actual and the Targeted TCOC determines the adjustment amount. Participant Hospitals with a difference greater than +/- 2% will receive an adjustment of 20% of the difference. **Exhibit 5** provides an example of a positive TCOC adjustment.

Exhibit 5



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Step 5: Identifying the HGB Payment for PY1

CMS will calculate the PY1 HGB Payment amount by combining the elements described in pages 1-4. The **example** below walks through how each steps and component combines.

[A] HGB Baseline Amount	$350,000,000
[B] Market Shift Adjustment	N/A for PY1
[C] Service Line Adjustments	$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

Critical Access Hospitals (CAHs) & Safety Net Hospitals (SNHs)

There are methodological differences in the HGB calculation for Critical Access Hospitals (CAHs) and Safety Net Hospitals (SNHs) that participate in AHEAD:

- **Payment Floor:** The AHEAD Model includes a payment floor to ensure HGB payments for CAHs are no lower than current Medicare FFS reimbursement at 101 percent of costs (before sequestration).
- **CAH Quality Incentive Program:** CAHs can participate beginning in PY3. This adjustment is only applicable to CAHs, is upside-only, and begins as pay-for-reporting and advances to pay-for-performance on a select set of measures.
- **Service Line Adjustment:** CAHs may request retention of the entire revenue associated with a reduced or eliminated service.
- **TCOC Adjustment**: For CAHs and SNHs ,the TCOC Adjustment is upside only in PY4 and PY5, then becomes bi-directional in PY6, one year later than for Acute Care Hospitals (ACHs).
- **Effectiveness Adjustment**: For CAHs and SNHs, begins in PY3, one year later than for ACHs.

Additional AHEAD HGB Resources

- AHEAD Medicare HGB v.3 Specifications Webinar (Recording, Slides, and Transcript) Provides details of the business case for HGBs in AHEAD and how HGBs are calculated. (CMS AHEAD Website*)
- AHEAD Medicare HGB Financial Specifications Version 3.0 of the specifications. (Provided to Participating States by the POs and will be made public on the CMS AHEAD Website*)
- AHEAD Medicare HGB Calculators/Estimator Tool Excel based tool that allows hospitals to enter values for baseline and other adjustments to understand how the methodology works. (Provided to Participating States by CMS POs*)

*Location where resource will be made available, if not already available.