States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Medicare FFS Hospital Global Budget Overview Version 2.0 Webinar

Center for Medicare and Medicaid Innovation
July 24, 2024

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Today's Presenters

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Agenda

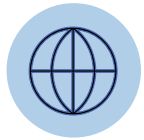
This webinar provides an update on the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology. The following topics will be discussed:

1. AHEAD Model Overview
2. AHEAD Model Timeline
3. AHEAD HGB Version 2.0 Updates
4. Medicare FFS Hospital Global Budget (HGB) Financial Methodology
5. HGB Calculation & Adjustments

AHEAD Model Overview

AHEAD Model Overview

The AHEAD Model aims to rebalance health care spending across the system, with hospitals working with primary care and community-based providers to reduce potentially avoidable utilization.



States

- Investment to support statewide infrastructure for improving patient outcomes and reducing cost.
- Build upon existing efforts across your state to improve health equity.
- Engage multiple payers and providers in the transformation of the health care system in your state.

Hospitals

- Investment to support transformation in early years of the model.
- Improved financial stability & predictability.
- Ability to share in savings from more efficient care delivery and reducing avoidable utilization.
- Opportunity to earn upside dollars for improving health equity and quality.

Patients

- Enhance coordinated, team-based, whole-person primary care
- Support improved care management, behavioral health integration, and a focus on health-related social needs.
- Focus on improved quality of care, efficiency of care, and health outcomes.

WHAT IS A HOSPITAL GLOBAL BUDGET?

A fixed, prospectively set amount of annual revenue to a hospital for selected Medicare Part A and outpatient facility services covered under Part B. Under AHEAD, Hospital Global Budget amounts will be paid by Medicare to participating hospitals in the form of prospective, bi-weekly payments in place of traditional Medicare FFS claims. Professional services rendered in a hospital setting are excluded.

Case for Hospital Global Budgets

The AHEAD Model builds upon existing work of the Innovation Center and integrates lessons learned from each of the state-based models and seeks to implement them synchronously across multiple states.

Fee for Service Payment

Unit/Cost × Price Per Unit or Case

Incentives

- Revenue growth based on volume change and continued market share growth
- Focus on growing high-margin services
- Variable hospital revenue over time

Hospital Global Budget Payment

Revenue Base + Updates

Incentives

- Reduce unnecessary hospital utilization
- Perform better on quality and effectiveness
- Payment stability from bi-weekly global budget payments
- Reduce operational cost through efficiency

Eligible Hospitals in AHEAD

Participation in the AHEAD Model by hospital and critical access hospital (CAH) is voluntary and will be subject to state-level coordination and oversight.

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

Hospitals that voluntarily agree to participate under a HGB will sign Hospital Participation Agreements with CMS that enumerate their participation requirements and expectations. For more information regarding AHEAD hospital eligibility, please refer to the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology, available on the AHEAD Model webpage.

Medicare FFS Hospital Global Budget (HGB) Version 2.0 Updates

AHEAD's Hospital Global Budget Methodology Updates At-A-Glance

Version 2.0 includes changes that improve specificity, clarity, transparency, and predictability in the financial methodology. There are nine key revisions:

1. **Updated the Baseline Period for HGB:** The HGB Baseline is shifted forward by 6 months and includes a completion factor that improves accuracy of the global budgets.

2. **Revised the Part B Drugs Carveout:** The Part B carveout now only excludes cancer drugs that represent a significant and highly variable portion of hospital spending, reducing risk for hospitals. This change balances the risk to hospitals with the goal that the global budget be inclusive of most hospital spending.

3. **Annual Payment Adjustment (APA) Higher of UCC/DSH:** To provide additional payment stability, the methodology uses the higher of Uncompensated Care (UCC) and Disproportionate Share Hospital (DSH) payment factors from the IPPS Final Rule when calculating the change in CMS prices as part of the APA.

4. **Annual Payment Adjustment (APA) IPPS Timing Update:** CMS HGBs will account for updated IPPS prices (e.g., wage indexes, base rates) applicable during Q4 of the PY, ensuring hospitals are paid appropriately.

This symbol signifies methodology revisions between Version 1.0 and Version 2.0. Italicized text also indicates revisions.

This symbol signifies methodology revisions that are planned to be made for Version 3.0.

AHEAD's Hospital Global Budget Methodology Updates At-A-Glance

5 **Demographic Adjustment:** Adjustments to demographic changes no longer apply retrospectively after the PY.

6 **Total Cost of Care (TCOC), and Social Risk Adjustments (SRA):** The TCOC and SRA now use the same geographic definitions as the Market Shift Adjustment, helping to align the methodology.

7 **Market Shift Adjustment Out-of-Area Geography:** Added a 120-mile distance threshold to exclude long distance outliers such as snowbirds from the calculation, improving accuracy.

8 **Standardized Area Deprivation Index (ADI):** CMS is using a standardized ADI to reduce rural-urban differences due to prices, improving equity.

9 **Payment Floor for CAHs:** The payment floor ensures that HGB payments for CAHs are no lower than current Medicare FFS reimbursement at 101% of costs (before sequestration). The floor is calculated such that if the HGB payments for the performance year are less than what would have been paid by Medicare FFS had the CAH not participated in the HGB, CMS will make an additional payment to the CAH equal to the difference.

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This symbol signifies methodology revisions that are planned to be made for Version 3.0.

Medicare FFS HGB Financial Methodology

Version 2.0 of the AHEAD Model's CMS-Designed Medicare FFS HGB Methodology

Baseline Calculation

CMS will calculate the hospital's historical revenue for eligible hospital services, combining the 3 most recent years of historical revenue data with percentage weightings more heavily applied to recent years (i.e., Base Year 1: 10%; Base Year 2: 30% and Base Year 3: 60).

Annual Trend and Performance Adjustments

CMS will apply adjustments to predict the current performance year and reflect accountability for quality and reducing avoidable utilization:

- Annual Trend Updates (Annual Payment Adjustment, Volume-Based Adjustments, and Other Adjustments)
- Performance-Based Adjustments (TCOC, Quality, Equity, and Effectiveness)
- AHEAD-Specific Adjustments (Transformation Incentive Adjustment and Social Risk Adjustment)

Global Budget Payments

Each hospital will receive a prospective, bi-weekly payment for Eligible Hospital Services in lieu of traditional FFS claims or cost-based reimbursement. Hospitals will continue to submit Medicare FFS inpatient and outpatient claims and Medicare Hospital Cost Reports to CMS.

The full AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology Version 2.0, including additional details on the hospital global budget and sample calculations, is available on the AHEAD Model website.

Version 2.0 of the AHEAD Model's CMS-Designed Medicare FFS HGB Methodology

Annual Trend Updates

Annual Payment Adjustments
Adjustments based on Medicare price and policy changes, including IME, DSH, UCC, and wage index.

Volume-Based Adjustments
Adjustments made to reflect changes in demographics, planned service line changes, market shifts, and material unplanned volume changes.

PPS Hospital Quality Adjustments
Adjustments to allow quality measures to align with existing CMS programs for PPS hospitals. Including HRRP, VBP, HACRP, IQR, Medicare Promoting Interoperability, and OQR.

AHEAD-Specific Adjustments

Transformation Incentive Adjustment
Upward adjustment to invest in enhanced care coordination in the first two years of the Model.

Social Risk Adjustment
Based on Area Deprivation Index, dual-eligibility status, and Part D LIS status.

Performance-Based Adjustments

Total Cost of Care (TCOC) Performance Adjustment
Upward and downward adjustments based on TCOC of beneficiaries residing in hospital service area.

Health Equity Improvement Bonus
Upward adjustment based on hospital performance on disparities-sensitive measures focused on closing gaps in health care outcomes.

CAH Quality Adjustments
Upward-only quality incentive program that will align with the other CAH quality programs and will include rural-specific measures.

Effectiveness Adjustment
Downward adjustment based on a portion of hospital's calculated potentially avoidable utilization (PAU).

PAU includes readmissions, avoidable admissions (calculated by the PQI-90 indicator), avoidable ED visits (calculated by the NYU ED algorithm), and low-value care (as defined by MedPAC).

Hospital Global Budget Baseline Calculation

Hospital Global Budget Baseline Calculation

Historical Revenue Calculation

CMS will calculate the hospital's historical revenue for eligible hospital services, combining 3 years (Baseline Years (BY)), *beginning 3.5 years before the first Performance Year (PY),* of historical data with percentage weightings more heavily applied to recent years. The baseline will include all Medicare FFS revenue, regardless of beneficiary residence. There is a Gap Period to allow for sufficient claims run-out, as noted below.

Year	Description	Dates of Service Included	Percentage Weighting
BY 1	Hospital PY1 minus 3.5 years	2022 Q3 – 2023 Q2	10%
BY 2	Hospital PY1 minus 2.5 years	2023 Q3 – 2024 Q2	30%
BY 3	Hospital PY1 minus 1.5 years	2024 Q3 – 2025 Q2*	60%
Gap Period	Hospital PY1 minus 6 months	2025-Q3 through 2025 Q4	-

**CMS will apply a completion factor to account for any claims that have been incurred but not yet paid by CMS in BY3.*

Hospital Global Budget Inclusions and Exclusions

Included Payments

- All FFS payments for services paid under the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) will be included in the baseline.
- Eligible services in the baseline include inpatient hospitalizations covered under Part A and certain outpatient services covered under Part B that are billed on facility claims (Bill Types, 11X, 12X, 13X, 14X, 85X, or 18X).
- Generally, Medicare hospital payment policy factors under IPPS and OPPS are including in the HGB (i.e., wage indexes, DSH).

Inclusive of all Part B drugs except antineoplastics or cancer drugs.

Excluded Payments

- Payments made outside the Medicare FFS claims payment mechanisms (e.g., non-claims-based payments, such as shared savings).
- Payments made to specialty hospitals and distinct part units (e.g. rehab units inside acute care hospitals).
- Inpatient services paid separately from the Medicare Severity Diagnosis Related Groups (MS-DRG) including new technology and organ acquisition costs.
- New Technology Add-On Payments.
- Antineoplastics or cancer drugs.
- IME payments for Medicare Advantage Plans

See Appendix D of Version 2.0 of the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology for more information regarding on the payment exclusions and carve-outs.

Hospital Global Budget Baseline Calculation — Example

Moore Health

Hospital Snapshot:
- Acute Care Hospital (ACH), serving predominately urban and suburban patients
- 300 Beds
- Participating in a state within AHEAD Model Cohort 1 (January 1, 2026 start)

AHEAD Baseline:
- Moore Health's HGB baseline revenue:
  - *2022 Q3 – 2023 Q2 revenue* (10% weight)
  - *2023 Q3 – 2024 Q2 revenue* (30% weight)
  - *2024 Q3 – 2025 Q2 revenue* (60% weight).
- All Medicare FFS payments for services paid under the IPPS and OPPS will be included in the baseline.
- Calculated HGB Baseline: $350M Revenue

Boone Valley Hospital

Hospital Snapshot:
- Critical Access Hospital (CAH), serving predominately rural patients
- 25 Beds
- Participating in a state within AHEAD Model Cohort 2 (January 1, 2027 start)

AHEAD Baseline:
- Boone Valley Hospital's HGB baseline revenue:
  - *2023 Q3 – 2024 Q2 revenue* (10% weight)
  - *2024 Q3 – 2025 Q2 revenue* (30% weight)
  - *2025 Q3 – 2026 Q1 revenue* (60% weight)
- Medicare payments and cost report settlements, including swing beds, that reflect total payments will be included in HGB baseline.
- Calculated HGB Baseline: $35M Revenue

Note: Baseline will include all Medicare FFS revenue, regardless of beneficiary residence.

See Section 2.1 of Version 2.0 of the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology for more information regarding the HGB baseline calculation.

Hospital Global Budget
Annual Trend Updates

Annual Trend Updates

Annual Trend Updates

CMS will calculate the HGB using **historical hospital revenues** that are **prospectively updated** to reflect appropriate price and policy changes and provide sufficient revenue for patient care. Trend updates are applied on an **annual basis** to each participant hospital's **HGB baseline** to develop the global budget payment amount for the **upcoming Performance Year**. These updates fall into the following three categories:

Annual Payment Adjustments

- Updates baseline revenue based on price and policy changes, including Medicare market basket and changes in IME, DSH, UCC, quality, and wage index.
- Updates are based on provider-specific changes in base IPPS (DRG base rates) and OPPS (Ambulatory Payment Classification base rates).

Volume-Based Adjustments

- Updates to reflect changes in demographics, planned service line changes, market shifts, and material unplanned volume changes.

Additional Adjustments

- Updates to account for additional policy (e.g., sequestration), programmatic, and exogenous factors (e.g., COVID-19).

Annual Payment Adjustments

Annual Payment Adjustments update baseline revenue based on price and policy changes, including Medicare market basket and changes in IME, DSH, UCC, quality, and wage index. Updates are based on provider-specific changes in base IPPS (DRG base rates) and OPPS (Ambulatory Payment Classification base rates).

Annual Payment Adjustments, No Floor

Market Basket
Used to update Inpatient National Standardized Amounts

Medicare Promoting Interoperability Program
Accounts for any change in hospital's Medicare Promoting Interoperability Program performance

Hospital Quality Programs*
Accounts for any change in performance in a PPS hospital's CMS quality program performance

Outlier
Accounts for changes in outlier payments

Low Volume
Accounts for any change in a hospital's Low Volume Adjustment

Indirect Medical Education
Accounts for any change in the IME for a hospital

Annual Payment Adjustments with "Higher of"

The highest previous DSH/UCC values are used in the APA calculations. The floor will provide stability and predictability of payment for the vulnerable populations.

Disproportionate Share Hospital (DSH)
Accounts for any change in a hospital's Medicare DSH adjustment

Uncompensated Care
Accounts for changes in Uncompensated Care adjustments

*This includes the Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting, Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Condition Reduction Program.

Volume-Based Adjustments

Demographic Adjustment

- Based on historic trends in population size, age, and medical risk for a participant hospital's geographic service area.
- *Revisions for Version 2.0 include no longer applying a retrospective adjustment after the PY.*

Market Shift Adjustment

- Shifts in volume between hospitals that reflect patient choice and movement on an annual basis. *Revisions for Version 2.0 added a 120-mile distance threshold to exclude long distance outliers such as snowbirds from the calculation, improving accuracy.*
- This adjustment is meant to provide additional funding for the variable cost of the new volume without providing additional incentives for unnecessary volume growth.

Service Line Adjustments

- Pre-planned changes to existing service lines that are pre-approved by the AHEAD state.
- These changes can be to add, expand, eliminate, or contract specific services lines or services within a service line.
- New service line additions will be reconciled back to FFS volumes for two PYs and then incorporated fully into the HGB.
- By disclosing the intent to modify or eliminate a service line and gaining approval, hospital participants may retain, at CMS' discretion, a portion of the associated revenue to invest in care management and population health activities.

Unplanned Volume Changes

- Service line additions, expansions, eliminations, or contractions greater than 5% that are not disclosed and pre-approved.
- Due to the AHEAD participant not disclosing and receiving approval in advance, they are ineligible to:
  - Retain a portion of the HGB associated with that volume in the case of a contraction or elimination for reinvestment in care management and population health activities.
  - Receive partial funding for excess service line volume in the case of an addition or expansion, beyond the Market Shift Adj.

Demographic Adjustment Calculation Example

Moore Health

- Moore Health serves beneficiaries across 3 counties.
- Below shows CMS would calculate Moore Health's PY1 Demographic Adjustment across those 3 counties.

Inputs	County 1	County 2	County 3	Total
Sum of HCC Scores from Y2	72.5	68.5	70	-
Total Revenue in Y1	$110k	$40k	$160K	$310k
Sum of HCC Scores from Y1	74.5	62.5	77.4	-

Equations	County 1 Calculations	County 2 Calculations	County 3 Calculations	Total
Y1 Share of FFS Claims	$\frac{\$110k}{\$310k} = \mathbf{35.48\%}$	$\frac{\$40k}{\$310k} = \mathbf{12.90\%}$	$\frac{\$160k}{\$310k} = \mathbf{51.61\%}$	-
Total Change in HCC from Y1 to Y2	$\frac{(74.5 - 72.5)}{72.5} = \mathbf{2.76\%}$	$\frac{(62.5 - 68.5)}{68.5} = \mathbf{-8.76\%}$	$\frac{(77.5 - 70)}{70} = \mathbf{10.71\%}$	-
County Adjustment	$35.48\% \times 2.76\% = \mathbf{0.98\%}$	$12.90\% \times -8.76\% = \mathbf{-1.13\%}$	$51.61\% \times 10.71\% = \mathbf{5.53\%}$	$0.98\% + -1.13\% + 5.53\% = \mathbf{5.58\%}$

Hospital Global Budget
AHEAD-Specific Adjustments

AHEAD-Specific Adjustments

Transformation Incentive Adjustment (TIA)

- CMS will include a **1% upward** TIA to a participant hospital's global budget in the first two Performance Years (PY) of the applicable cohort **after all other adjustments have been completed.**
- The TIA is intended to **incentivize early hospital participation** and **provide additional revenue in care management and transformation activities** that will **generate medium- and long-term savings** under the Model or other resources needed to **succeed under a hospital global budget.**
- The TIA will **only need to be repaid** if the hospital exits the Model before the sixth performance year.

Social Risk Adjustment (SRA)

- The AHEAD Model will apply an **upward adjustment** to hospital global budgets to account for **hospital-to-hospital differences in social risk for their beneficiary population.**
- The SRA is intended to **provide additional resources for hospitals that are treating higher adversity patient populations.**
- *Standardization of the original Area Deprivation Index (ADI) to account for varying housing prices.*
- Linear scaling is then used to apply the SRA to participating hospitals. The SRA can be **up to 2% of a participating hospital's global budget.**

Social Risk Adjustment Example

To calculate the SRA for each participant hospital's eligible beneficiaries, CMS will use the steps below to calculate a score ranging from 1 to 150 points:

1. Assign a ***standardized* National ADI** as a percentile with a **range of 1 to 100** for each beneficiary and multiple by 0.20.
2. Assign a ***standardized* State ADI** for each beneficiary and multiply by 0.80. points for State ADI. This will **range from 1 to 80**.
3. Assign **Low-Income Marker (LIM)** of "1" or "0" and multiply by 50. Points for LIM will **range from 0 to 50**.
4. Add points from steps 1-3 to **calculate a total possible SRA score for each beneficiary**. The maximum possible score for each beneficiary is 150 points.
5. Aggregate scores across the **MSA geography** and **calculate the median**.
6. **Compute hospital-level scores** using weights based on the defined geographic area proportionate to hospital payments, then multiply by the defined geographic score.
7. Participant hospitals with **SRA scores above the median** score for the **entire AHEAD state** will be eligible to **receive an upward HGB adjustment of up to 2%**.

Annual Trend Updates — ACH Example

Moore Health

- Moore Health is preparing for the second PY as part of the AHEAD Model.
- The hospital's global budget from the current Performance Year (PY1) is used as a starting point for annual HGB adjustments.
- Market basket (inflation) updates, based on CMS rules, will be updated each calendar year based on the October rule for IPPS and the January OPPS rule.

Adjustment	Adjustment Amount
PY1 HGB w/ Annual Payment and Demographic Adjustments	**$350,000,000**
Market Shift Adjustment	$350,000
Planned Service Line Changes	N/A
Unplanned Volume Changes	$87,500
HGB Adjusted for Volume	**$350,437,500**
Annual Payment Adjustment (3.0%)	$10,512,075
Demographic Adjustment (2.0%)	$7,008,050
HGB w/ Annual Payment & Demographic Adjustments	**$367,957,625**
Social Risk Adjustment (Max +2.0%; Moore Health receives +1.75%)	$6,438,646
Transformation Incentive Adjustment (PY1 and PY2 only) (Moore Health receives +1.0%)	$3,679,226
HGB Following Annual Performance Adjustments	**$378,075,497**

Annual Trend Updates — CAH Example

Boone Valley Hospital

- Boone Valley Health is preparing for the second PY as part of the AHEAD Model.
- The CMS market basket will serve as the basis to price level to PY1 dollars for CAHs.
- CAHs will be able to request up to the entire revenue associated with the reduced or eliminated service line to be retained if it is used to specifically target care management and population health activities that are aligned to the state and hospital's health equity plan.

Adjustment	Adjustment Amount
PY1 HGB w/ Annual Payment and Demographic Adjustments	**$35,000,000**
Market Shift Adjustment	35,000
Planned Service Line Changes	3,500
Unplanned Volume Changes	8,750
HGB Adjusted for Volume	**35,047,250**
Annual Payment Adjustment (3.0%)	1,051,418
Demographic Adjustment (2.0%)	700,945
HGB w/ Annual Payment & Demographic Adjustments	**36,799,613**
Social Risk Adjustment (Max +2.0%; Boone Valley receives +1.75%)	643,993
Transformation Incentive Adjustment (PY1 and PY2 only) (Boone Valley receives +1.0%)	367,996
HGB Following Annual Performance Adjustments	**$37,811,602**

In this example, if $37,811,602 is less than 101% of CAH costs (what would have been paid by Medicare FFS had the CAH not participated in AHEAD), CMS will make an additional payment to the CAH equal to the difference.

Hospital Global Budget Performance-Based Adjustments

CAH Quality Adjustment

Critical Access Hospitals

- As CAHs are not required to participate in CMS national hospital quality programs, CAHs participating in the AHEAD Model will participate in an **upside-only quality incentive program** that will **align with the other quality programs** and will **include rural-specific measures**.
- The CAH Quality Adjustment will start with pay-for-reporting before transitioning to pay-for-performance.
- CAH performance will be based on national CAH benchmarks where possible, as well as CAH historic performance for improvement.
- **Key Measure Domains:** Healthcare Quality and Utilization, Patient Safety, and Patient Experience (e.g., HCAHPS)

Example Year (Cohort 1)	2026	2027	2028	2029	2030	2031	2032	2033
	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Pay-to-Report	Start Reporting	Continue to Report	2%	2%	1.5%	1%	0.5%	0%
Pay-to-Perform	-	-	-	-	0.5%	1%	1.5%	2%

Health Equity Improvement Bonus

Hospitals participating in the AHEAD Model can earn **up to 0.5% in additional revenue** through the Health Equity Improvement Bonus (HEIB), which is based on hospital performance on select disparities-sensitive measures.

Timing

- Hospitals will receive a HEIB reward for improvement between the base period and performance period among beneficiaries in the highest Social Risk Score group (75th percentile) across readmissions and PQI-92 performance.
- HEIB measurement will begin in the PY2, adjustment begins in PY4.

Measurement

- Measures will be disparity-risk-stratified with an Social Risk Score using a method similar to ACO REACH by measuring ADI at a state and national level (using an 80:20 weighting), and Part D LIS and Medicaid Dual Eligibility.

Payment

- The 0.5% upside reward is split between a maximum 0.25% reward for improvement in readmissions in the high adversity cohort, and a maximum 0.25% for improvement in PQI-92 in the high adversity cohort.
- Performance on readmissions and PQI-92 are calculated and scaled separately, and hospitals must have overall improvement in readmissions for all patients to qualify for that reward, similarly, overall improvement in PQI-92 to qualify for that reward.

Effectiveness Adjustment

- The Effectiveness Adjustment (EA) incentivizes hospitals to **implement interventions that reduce unnecessary or avoidable care,** including developing transitional care programs, promoting better integration with primary providers to co-manage patients with chronic disease, and engaging with community-based organizations focused on addressing the social drivers of health.
- HGBs will receive a downward adjustment based on the individual hospital's percentage of PAU costs compared to other hospitals in the AHEAD state.
- If an ACH, CAH, or SNH is in 20th percentile or below (the best performance), they will not receive a downward adjustment.
- The EA **increases gradually over time** as hospitals gain additional experience with implementing processes to control PAU and form partnerships. The EA for **ACHs will start in PY2.**
- CAHs and SNH will be evaluated separately from ACHs. For **CAHs and SNHs, the EA will begin in PY3**.

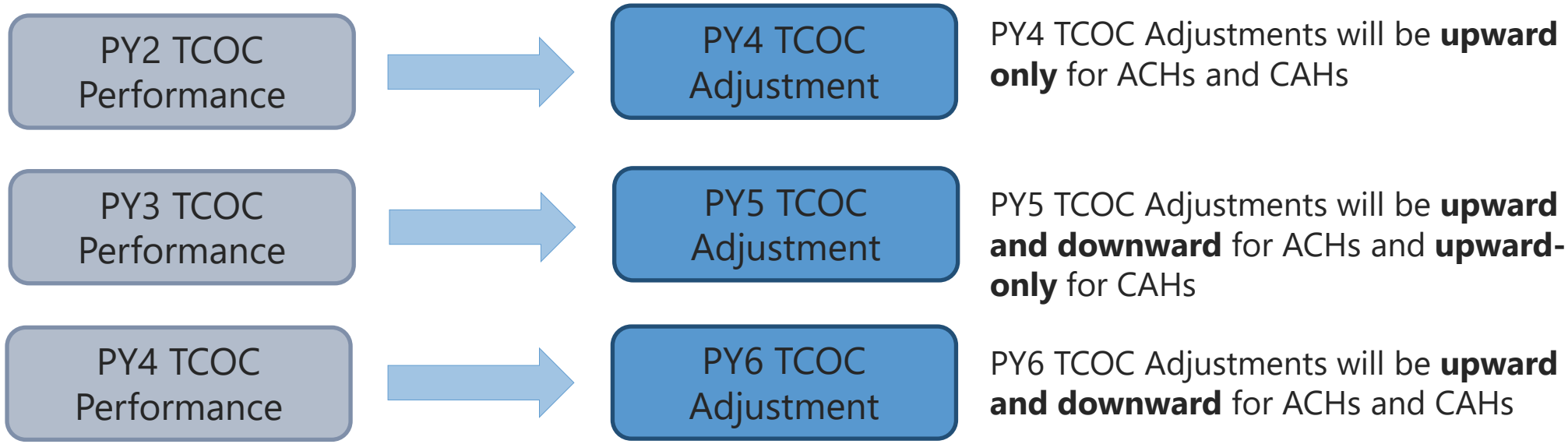
Potentially Avoidable Utilization (PAU):
- Avoidable ED Visits (NYU ED Algorithm)
- Avoidable Admissions (PQI-90)
- Readmissions
- Low-Value Care (MedPAC)

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

Total Cost of Care (TCOC) Performance Adjustment

The TCOC Performance Adjustment provides an incentive for hospitals to manage population health outcomes and costs for beneficiaries within their geographic service area.

- Participant hospital's performance will be measured by comparing beneficiary costs within their geographic service area to a comparable benchmark.
- The TCOC Performance Adjustment will be capped at +/- 2% of a participant hospital's HGB and will be phased in during the Performance Period, as described below.



Subsequent TCOC adjustments will follow same two-year delay

Hospital Global Budget Performance-Based Adjustments — CAH Example

Boone Valley Hospital

- Boone Valley Health is preparing for PY4 as part of the AHEAD Model.
- Following annual trend updates made to the HGB, performance-based adjustments are then applied.
- CAHs and SNHs have different timing and application of performance-based adjustments to hospital global budgets:
  - Effectiveness Adjustments start in PY3 and are in place for PY4.
  - The CAH Quality Program is Pay-to-Report until becoming Pay-to-Perform in PY5; Boone Valley submits reports on all measures.
  - TCOC Performance Adjustments are upside-only until PY4.

Adjustment	Adjustment Amount
PY4 HGB after Annual Trend Updates	**$36,799,613**
Effectiveness Adjustment (Max -0.75%; Boone Valley receives -0.50%)	(183,998)
CAH Quality Adjustment (Max +2.0%; Boone Valley receives + 2.0%)	735,992
HEIB (Max +0.5%; Boone Valley receives +0.25%)	91,999
TCOC Performance Adjustment (Max +/- 2.0%; Boone Valley receives +1.0%)	367,996
HGB with Annual and Performance Adjustments (PY4)	**$37,811,602**

Hospital Global Budget Adjustments — PY2 Summary Example

Moore Health

Adjustment	Basis
PY1 HGB w/ Annual Payment and Demographic Adjustments	
Market Shift Adjustment	Gap Period – BY3
Planned Service Line Changes for PY2	TBD
Unplanned Volume Changes	Gap Period – BY3
HGB Adjusted for Volume	
Annual Payment Adjustments	PY2 / PY1
Demographic Adjustments	PY2 / PY1
HGB with Annual Payment and Demographic Adjustments	
Social Risk Adjustment	≤2.0% Based on PY1
HGB after Annual Trend Updates	
Effectiveness Adjustment	≤.25% Based on Performance
Health Equity Improvement Bonus	NA (Starts PY4)
TCOC Performance Adjustments	NA (Starts PY4)
Transformation Incentive Adjustment	1.0%
HGB with Annual and Performance Adjustments	
Sequestration	-2.0%
Final PY2 HGB	
Mid-Year Reconciliation	PY1 Service Line & Util.

Boone Valley Hospital

Adjustment	Basis
PY1 HGB w/ Annual Payment and Demographic Adjustments	
Market Shift Adjustment	Gap Period – BY3
Planned Service Line Changes for PY2	TBD
Unplanned Volume Changes	Gap Period – BY3
HGB Adjusted for Volume	
Annual Price Adjustments	PY2 / PY1
Demographic Adjustments	PY2 / PY1
HGB with Annual Payment and Demographic Adjustments	
Social Risk Adjustment	≤2.0% Based on PY1
HGB after Annual Trend Updates	
Effectiveness Adjustment	NA (Starts PY3)
CAH Quality Adjustment	
Health Equity Improvement Bonus	NA (Starts PY4)
TCOC Performance Adjustments	NA (Starts PY4)
Transformation Incentive Adjustment	1.0%
HGB with Annual and Performance Adjustments	
Sequestration	-2.0%
Final PY2 HGB	
Mid-Year Reconciliation	PY1 Service Line & Util.

Question and Answer Session

Question & Answer Session

Open Q&A

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

Frequently Asked Questions (1 of 5)

Question #1

How will HGBs incentivize and/or support Primary Care and community-based organizations (CBOs) to achieve value?
The AHEAD Model incentivizes hospitals, PCPs, FQHCs, and CBOs to work together to achieve value through several channels. First, HGBs allow hospitals to focus on keeping their communities healthy. When hospitals prevent unnecessary and low-value care and improve population health, they are able to retain additional revenue. In addition, the model requires participating states and hospitals to create health equity plans that include approaches to coordinating with CBOs and working with providers to eliminate health disparities and address health-related social needs.

Frequently Asked Questions (2 of 5)

Question #2

How will the HGB methodology handle outlier claims?
Outlier claims are accounted for in HGB payments. Outlier payments are additional payments that Medicare provides to hospitals for beneficiaries who incur unusually high costs. The baseline includes outlier claims and is trended forward to account for future incurred costs.

Frequently Asked Questions (3 of 5)

Question #3

How does AHEAD impact ACOs?
ACOs are not direct participants in the AHEAD Model. At a high level, hospital participants in AHEAD HGBs are required to submit no pay claims as part of the model. In cases of overlap or when an attributed beneficiary is admitted to a participating hospital, both Medicare Shared Savings Program and ACO REACH will use those zero-pay claims to determine the amount that otherwise would have been paid. Those claim amounts will be used both for benchmarking and to determine performance year expenditures for the purpose of ACO performance year reconciliation. For more information on overlap rules with ACOs and other models, please see the AHEAD Model Overlaps Policies Fact Sheet.

Frequently Asked Questions (4 of 5)

Question #4

Will portions of the applications from awarded states be released to inform other state applicants' methodologies?
Some states may make their application, or portions of their application, public. More information regarding Medicaid HGB and Medicaid PC methodologies will be provided as they are developed and finalized. For all other matters, please consult the Notice Of Funding Opportunity (NOFO) which details program requirements.

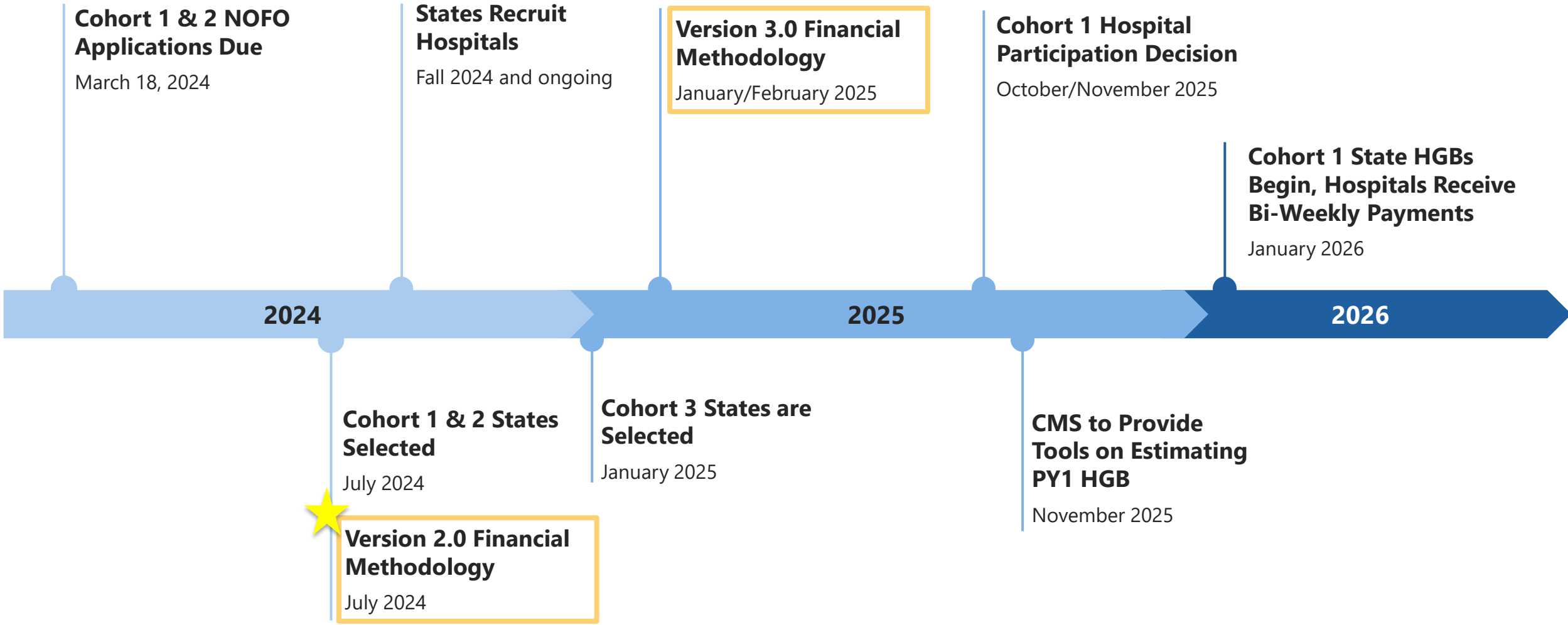
Frequently Asked Questions (5 of 5)

Question #5

What information or tool is CMS planning to provide for estimating Medicare HGBs?
CMS plans to provide an HGB estimator tool prior to the date by which hospitals are required to make participation decisions. The estimator tool will align with the most recent financial specification document at that time of release.

Closing

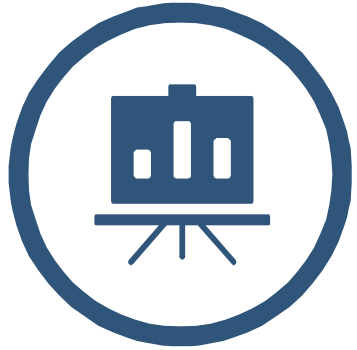
AHEAD Model Hospital Global Budget Timeline*



**Specific dates will be released later and are subject to change. Hospitals may join in any year during the AHEAD Performance Period.*

Audience Poll #1

Please respond to the live poll using the Zoom platform.



What about the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology Version 2.0 do you want to learn more about?

a. Baseline construction, including eligible hospitals and services
b. Annual and performance-based adjustments
c. Timing of adjustments and payments
d. Eligibility requirements
e. How PC AHEAD and HGBs will work together
f. Data collection and reporting
g. Other (please specify in the Q&A)

Audience Poll #2

Please respond to the live poll using the Zoom platform.

Following this presentation, I understand changes to the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology Version 2.0 sufficiently to make a business decision to participate or to explain the methodology to participants

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Thank You

Thank you for your time and interest in the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget Methodology!

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

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

Thank You!