CMS-Designed Medicare FFS Hospital Global Budget Version 2.0 Webinar

July 24, 2024

Chris Crider, CMS:

Good afternoon or good morning. Welcome to the AHEAD Model Hospital Global Budget Webinar.

Before we get started, I wanted to share a few housekeeping items. As you just heard, today's event is being recorded. Captioning is available on the bottom of the screen. Please submit any questions or comments via the Q&A box on the bottom of your screen. We will answer as many questions as we're able to in the time available. Please complete the short survey at the end of the event as well. We greatly appreciate it. The slides have already been posted to the AHEAD Model website for those of you interested in having a copy of the slides and we will also post a transcript of the webinar shortly following the conclusion of our webinar today.

Our presenters today include Kashay Webb, the health insurance specialists with the AHEAD Model team here at the CMS Innovation Center, and I am Chris Crider, the deputy director for CMMI's Division of Multi-Payer Models.

Our webinar today will provide an update on the AHEAD Model Medicare Fee-For-Service Hospital Global Budget Methodology, which we originally released back in February. The methodology document, as I mentioned, is available on our AHEAD Model webpage.

We will cover the following topics today.

An overview of the AHEAD Model and timeline, an overview of the updates that we've made to the methodology, we'll walk through the methodology and demonstrate how the global budgets and adjustments are calculated, and we will close with audience question and answer.

A quick note before we start. Under the AHEAD Model, participating states that have all payer rate setting authority or hospital budget authority may develop their own Medicare hospital global budget methodology subject to CMS' approval.

States that don't have this authority will use the CMS designed methodology. Our webinar today and the specifications on our website focus on this CMS designed methodology only. This is the methodology we anticipate most participating states will use.

Okay, so first we will start today with a basic overview of the Model and of hospital global budgets in general. You may be familiar with the AHEAD Model while others may be hearing about it for the first time. So, I will start with a review of some of the foundational elements of the model.

The AHEAD Model is designed to support collaboration between hospitals, primary care providers, and community-based providers to improve population health and health equity while slowing the overall growth in healthcare costs.

The Model builds off lessons learned from previous CMMI models, including those currently operating in Maryland, Vermont, and Pennsylvania. These models have all been successful in supporting hospitals and other providers to perform better on quality and effectiveness metrics. They've given providers flexibility to deliver additional services to patients. For example, to address health-related social needs and they've reduced operational costs for the hospitals and providers.

The AHEAD Model aims to improve predictability and accuracy of provider payments while also incorporating new policy objectives, including the elimination of health disparities, increasing overall investment in primary care spending, and to integrate coordination across communities.

Global budgets are an important tool within this AHEAD framework, and they provide hospitals with incentives and flexibility to improve quality, population health, and equity and reward hospitals for gains in efficiency. Hospitals that choose to participate in the Model will receive a global budget from Medicare fee-for-service, from Medicaid, and from participating commercial payers.

Based on our experience in these prior models, we know that hospital global budgets work best when in partnership with primary care to improve the management of new or worsening health condition and to reduce avoidable inpatient and emergency department visits.

Under traditional fee-for-service payment, hospitals are paid based on their volume of services. But, hospital global budgets, in contrast, provide hospitals with a fixed predictable payment. Payment amounts are based on hospital historic revenue and adjusted to grow over time based on changes in the population size and other demographics as well as updates to prices and other Medicare policies. In addition, the global budgets can provide additional incentives and payment incentives based on the quality of services provided.

The predictable nature of global budgets enables hospitals to make longer-term investments in care delivery innovations, insulates hospitals from fluctuations and fee-for-service volumes, and allows hospitals to have routine savings from reduced avoidable utilization.

In the AHEAD Model, participation in hospital global budgets by hospitals is voluntary. Most hospitals are eligible to participate, including acute care hospitals, critical access hospitals, and several specialty designation hospitals, such as sole community hospitals and tribal hospitals. However, most types of specialty hospitals, such as cancer, children, and psychiatric facilities, are not eligible to participate in the Medicare fee-for-service global budget. However, states may choose to include these additional specialty hospital types, like these in their Medicaid hospital global budgets.

More information and details on eligibility can be found in the financial specifications document which is on our website.

In the next part of our webinar, my colleague, Kashay Webb, will walk through the hospital global budget financial calculation, including development of the baseline and how we will factor in adjustments to determine the prospective global budget payment amount for each performance year.

She'll draw attention to the updates that we've made in version 2.0, updating the specifications that we released back in February. These changes are identified on the slides with a triangle. She will also call out where CMS is considering further refinement. These potential changes are indicated with an arrow symbol and represent what we are currently considering for version 3.0, which we anticipate releasing early in 2025. Although this presentation doesn't focus much on the versions 3.0, the larger financial specifications that are on the website do provide greater detail on the types of changes that we are currently working on.

The updates to this 2.0 version that we are presenting today are based both on our own internal analyses, but also largely on stakeholder feedback. Our goal with these revisions has been, and will continue to be, to increase transparency and predictability for hospitals of the payment amounts.

And so, I really want to extend my sincere thanks to all of you who have submitted questions, comments, and feedback on the version 1.0. The stakeholder feedback we've received to date has been so incredibly helpful and I invite you all to continue the conversation here on the webinar today, as well as over the next several months, as we continue to iterate on the specifications. Again, we welcome questions in the Q&A box, as well as to the AHEAD Model email inbox, and we will continue to consider all feedback that we receive as we update the specifications.

And with that, I will hand the mic over to my colleague Kashay.

Kashay Webb, CMS:

Thank you, Chris. As we just mentioned, there are several updates to version 2.0 of the hospital global budget methodology.

First, we've updated the baseline period, shifting it forward six months and we added a completion factor to improve the accuracy of global budget calculations.

For the second update, it's critical to include as much of the total spend as possible in a hospital global budget. However, some Part B drugs are extremely variable and high cost. Previously, we excluded all Part B drugs for that reason, but now we found a way to include most Part B drugs, carving out only some cancer drugs as they tend to have the most variability. This update increases revenue under the hospital global budget while still excluding the highest cost, most variable drugs. And this ensures that hospitals have the resources to treat patients appropriately.

The next update is to the APA. We adjusted the annual payment adjustment for uncompensated care and disproportionate share hospital payments, ensuring that UCC/DSH payments are not lower than any previous year starting the Model. And this provides more stability to safety net hospitals caring for vulnerable populations.

Another APA update involves IPPS timing. Hospital global budgets will now account for updates to IPPS prices such as wage indexes and UCC/DSH amounts applicable during Quarter 4 of the performance year. And this ensures hospitals receive all of the same adjustments as they would under fee-for-service.

We also made a change to the demographic adjustment to simplify the calculation and remove the retrospective adjustment. This change will improve predictability for hospitals and increase confidence in payment amounts. CMMI also created uniformity in the geographic definitions for the TCOC adjustment and SRA, which are now the same.

Next, the market shift out-of-area adjustment now excludes long distance outliers. The reason being to allow hospitals to be accountable for patients within their locus of control.

Additionally, we updated the ADI to reduce rural urban differences that are due to housing prices, improving its accuracy and measuring underserved populations.

And lastly, we set a payment floor for critical access hospitals to give them the opportunity to participate in this type of model without concern that it'll negatively impact already tight margins.

Now we'll move into reviewing the overall hospital global budget methodology. This will be a review of material for some. But as we go, I'll continue to call out areas that have changed since version 2.0, and I do want to highlight again that more information about these calculations can be found on the AHEAD Model website and in version 2 of the financial specifications.

At a high level, the hospital global budget calculation has three stages. First, is the historic revenue calculation, referred to as the baseline. In the AHEAD Model, we use three base years, with the most recent year weighted more heavily.

The second stage is the annual trend and performance adjustments, which update the baseline to performance year dollars. There are several adjustments here, including annual payment, performance, and AHEAD-specific adjustments, each with its own methodology.

We'll get into more detail on these adjustments in the upcoming slides. And, as I mentioned, more detail is available in the financial specifications.

And lastly, we'll estimate the upcoming annual hospital global budget and deliver global budget payments to participating hospitals.

Once CMS sets the annual hospital global budget, we'll divide it into 26 bi-weekly payments to reflect the 52 calendar weeks in the year.

Before we dive into the baseline calculation, I'd like to preview the different types of adjustments made to the baseline that we'll cover in the upcoming slides.

They fall into three broad categories: annual trend updates, AHEAD-specific adjustments, and performance-based adjustments.

Annual trend updates are based on Medicare price and policy changes, volume changes, and quality measures. The AHEAD-specific adjustments include an upward transformation incentive adjustment to invest in care coordination and a social risk adjustment that takes into account the cost of caring for a safety net population.

And lastly, there are performance-based adjustments that are based on quality or cost metrics.

I will note here that the arrow symbols on the right, not to be confused with the triangle, represent planed revisions for version 3 of the financial specifications and you can find details about those plan revisions also in version 2 of the financial specifications on the Model website.

Next, we'll break down how the baseline will be calculated.

To calculate the baseline, CMMI is using three baseline years weighted at different percentages. The most recent year is weighted 60%, followed by 30% and 10%, respectively. The dates of service for each baseline year for cohort one are noted in the third column. And this assumes a cohort one performance year of 2026. As previously noted, we've shifted the baseline forward six months, now starting 3.5 years before the first performance year. And instead of a full gap year, there is now a gap period of two quarters before the performance year starts. And that change will allow us to use more recent data for the baseline as claims are about 99% complete six months after the end of the year.

CMMI will also apply a completion factor to estimate the remaining 1%, which is small compared to changes in a hospital's business over six months.

This next slide details the services included and excluded from the historical revenue calculation. Payments in a participating hospitals baseline includes all fee-for-service payments for services paid through the inpatient perspective payment system and outpatient perspective payment system.

Inpatient hospitalizations covered by Medicare Part A and specific outpatient services covered under Medicare Part B are included as well.

The AHEAD Model will also include hospital payment adjustments linked to volume changes under IPPS and OPPS, such as indirect medical education in the hospital global budgets.

Since all fee-for-service payments are included in the hospital global budget baseline, payments generally made outside of this framework will be excluded and continue to be paid separately and under existing processes.

Similarly, inpatient services that are not paid through the MSDRG, such as organ acquisition costs, will be paid normally as well.

Specific to critical access hospitals, or CAHs, professional outpatient services paid under CAH method 2 are excluded from hospital global budget baselines. And on this slide, you can see a triangle next to Part B drugs under included payments. In the previous version, we excluded all Part B drugs, but now, to be more inclusive, we've added Part B drugs back into the hospital global budget calculation except for cancer drugs due to their extremely high cost and variability.

To show how these calculations would look in a real-life scenario throughout this presentation, we'll use two fictitious hospitals as examples of how AHEAD hospital global budgets are constructed and updated over time.

First, on the left, we have Moore Health, an acute care hospital in an urban setting serving mostly urban and suburban patients. Moore Health has 300 beds and has decided to start receiving hospital global budgets on January 1, 2026, as a part of cohort one.

Moore Health hospital global budget payments will be constructed using 10% weight to its 2022 revenue, 30% weight to its 2023 revenue, and 60% weight to its 2024 revenue, and will include all Medicare fee-for-service payments paid to the hospital through IPPS and OPPS. After baseline calculations, Moore Health will have a 350-million-dollar revenue basis for its hospital global budget.

On the right, we have Boone Valley Hospital, a critical access hospital in a rural area serving mostly rural patients. Boone Valley Hospital has only 25 beds and has chosen to start receiving hospital global budget payments on January 1, 2027, as a part of a state in cohort 2. In this scenario, Boone Valley Hospital’s hospital global budget will include a 10% weight to 2023 revenue, 30% weight to 2024, and 60% weight to 2025, resulting in a 35-million-dollar hospital global budget baseline. Under the AHEAD Model, CAHs will have Medicare fee-for-service payments and cost report settlements, including swing beds that reflect total payments included in that baseline. And services built under CAH method 2, again, are excluded from the baseline and will continue to be paid through current processes.

After the baseline, we move into the second stage, annual trend and performance adjustments. First, we'll start with annual trend.

CMMI will apply an annual trend update to the baseline to make it applicable to the performance year.

The annual trend update takes the baseline or the previous year's partially adjusted hospital global budget and prospectively updates it to reflect price and policy changes for the upcoming year. And these updates are essential for ensuring that the AHEAD Model's hospital global budgets function as not only a sustainable payment stream for financing hospital services, but also to support quality and improvement activities.

They also remove the financial incentive to increase utilization that can be seen under a fee-for-service system. The annual trend updates include annual payment adjustments and volume-based adjustments, with some adjustments additionally to account for not only policy and programmatic changes, but also exogenous factors like the COVID-19 pandemic.

On this slide, note that the annual payment adjustments and volume-based adjustments have been revised from version 1 to version 2, which we'll now discuss.

The APA is applied annually to each participant hospital's baseline global budget for performance year 1 and to the previous year's hospital global budget for each subsequent performance year to determine the global budget payment for the upcoming year.

Some of these adjustments can be both positive and negative, while others can only increase over time. Adjustments with no floor or inflation, outliers, low volume, indirect medical education, and other programmatic changes can move up or down with each performance year.

I want to call out hospital quality programs as an annual payment adjustment. Non-critical access hospitals will continue to participate in CMS quality programs, which are listed in the box in the lower right of the slide. However, critical access hospital quality adjustments are considered performance-based adjustments under the Model, which we'll discuss later.

A change noted on the right from version 1 is the higher of approach for disproportionate share and uncompensated care payments. These are initially set using baseline year 3. This means that CMMI will use the highest DSH/UCC values from baseline year 3 or subsequent performance years in the APA calculations. And this floor will ensure that safety net hospitals have the resources to treat the most vulnerable populations.

After the annual payment adjustments, CMMI will make volume-based adjustments to update baseline data for changes in demographics, market shifts, service line adjustments, and unplanned volume changes.

When calculating these adjustments, we consider Medicare payments for all eligible hospital services to all eligible hospitals in a state or sub-state region participating in the AHEAD Model, regardless of individual hospital participation.

The demographic adjustment updates hospital global budgets for changes in the size and medical risk of the population served by each participating hospital. And it accounts for changes in use of services and the number and risk profile with population changes that we may see over time. In

version 2.0, CMMI removed a retrospective adjustment to the DA to simplify and improve predictability of hospital global budget payment amounts.

The market shift adjustment accounts for revenue changes when patient volume shifts between hospitals within a market and service line. It provides revenue to hospitals to cover costs associated with patient volume shifts from one hospital to another. And this includes shifts between participating and non-participating hospitals in the same healthcare market. In the version 2.0 update, CMMI has added a 120-mile distance threshold to ensure that we're truly measuring market shifts and not another phenomenon, such as snowbirds.

Moving on down to service line adjustments. These reflect the addition expansion or elimination of service lines or specific services within a service line in a participating hospital and a participating hospital may receive perspective funding for proposed service line additions. Hospitals that notify and gain approval from the AHEAD state for the service line modifications can retain a portion of the revenue removed from the hospital global budget to invest in population health activities that align with Model goals.

CAHs participating in the Model, like Boone Valley Hospital in our example earlier, will be able to request to retain up to the entire revenue associated with the service line reduction or elimination.

And finally, we have unplanned volume changes, which are intended to address service line changes with more than a 5% volume change, and that's measured using case mix adjusted discharges for inpatient services and case mix adjusted visits for outpatient services. These unplanned volume changes are ones that are not disclosed and pre-approved or accounted for in the market shift or demographic adjustments.

Participating hospitals that do not disclose or gain approval for these changes cannot retain a portion of the associated hospital global budget revenue for reinvestment in population health activities. However, participating hospitals may receive partial funding for service line additions or expansions, but CMS will not provide any retroactive funding.

Next slide. So, let's return to our example hospital Moore Health to demonstrate how the demographic adjustment calculation would work.

The DA uses hierarchical condition category scores to adjust hospital global budgets for the demographic and clinical risk of beneficiaries in the county served by the hospital, weighted by the share of revenue the hospital gets from each county.

The county risk profile of beneficiaries changes slowly over time, contributing to payment stability. In this example, you can see how patients from three counties are weighted to calculate the overall demographic adjustment for the hospital global budget payment amount.

We'll now move into discussing the AHEAD-specific adjustments.

The AHEAD-specific adjustments include the transformation incentive adjustment as well as the social risk adjustment. Both of these adjustments are investments from CMS to support participating hospitals success under the Model while adding additional flexibility for hospitals to treat patients holistically and focus on population health and alignment with AHEAD Model goals.

The TIA is a 1% upward adjustment to each participating hospital global budget in the first two performance years of the applicable cohort after all annual trend updates have been applied. The social risk adjustment is also an upward adjustment to hospital global budgets to account for hospital-to-hospital differences and social risk for the beneficiary population.

Like the TIA, the SRA provides additional resources specifically for hospitals treating higher adversity patient populations.

The social risk adjustment is measured using the area deprivation index or ADI scores and a combination of dual eligibility status and Part D low-income status. A change from version 1 to version 2 is the standard standardization of the ADI to better account for housing price variations. CMMI received stakeholder input that original ADI calculations did not fully measure high deprivation in urban areas with high housing prices, like Manhattan for example. This update to the ADI ensures that the methodology accounts for those hospitals caring for populations in high need urban areas.

The social risk adjustment also uses a linear scaling approach and can be up to 2% of the hospital's global budget.

Now we will walk through an example of how the social risk adjustment will work. First, we assign the standardized ADI score, which ranges from 1 to 100. This score is weighted at 20%, so we multiply it by 0.2. Next, we assign the standardized state ADI score, which has an 80% weight, so we multiply it by 0.8.

Then we assign a low-income marker or LIM. If the beneficiary is either dual eligible, full or partially dual, or deemed eligible for Part D LIS at any point in a rolling 12-month period immediately preceding this calculation it can be 1.0 or 0.0.

Next in step 4, we add points from steps 1 through 3 and calculate a social risk adjustment score for each beneficiary, with a maximum possible score of 150.

Then we'll aggregate those scores at the geographic level, calculate a mean, and compute hospital levels across those scores using weights based on geographic area and proportion of hospital payments.

Then we'll multiply that by the defined geographic score. In conclusion, participating hospitals with social risk scores above the median for the state will be eligible to receive that upward adjustment up to 2%.

To see how the previous adjustments work, we'll return to Moore Health, our acute care hospital, preparing for its second performance year in the AHEAD Model. PY 1 is going to be used as the starting point for annual hospital global budget adjustments. We'll start with the volume-based adjustments.

Moore Health did not end up removing a service line, so no change there. However, there are increases for market shift and unplanned volume changes.

Next, we have annual payment adjustments and demographic adjustments which also show increases. I do want to note the market basket adjustment for inflation, this follows CMS rules and will be updated annually in October for IPPS and in January for OPPS.

Then for AHEAD specific adjustments, the social risk adjustment has a max of 2%, but Moore Health is only going to receive 1.75%. But Moore health will receive the full 1% transformation incentive adjustment for PY 1 and PY 2 only.

So here you can see how the hospital global budget is adjusted following the annual trend updates.

Moving to our CAH example, Boone Valley Hospital, they are preparing for their second year in the AHEAD Model.

We start by applying volume-based adjustments. Boone Valley Hospital had a service line adjustment at $3,500. After adjusting for volume, we'll apply the annual payment adjustments and demographic adjustments, which both increase the budget.

Next, the social risk adjustment is applied with a maximum of 2%. Boone Valley is receiving 1.75% and will also receive the full 1% transformation incentive adjustment.

And note that for CAHs service line adjustments, if a service line is reduced or eliminated, CAHs can request the entire revenue associated with that change to be used for care management and population health activities aligned with the state and hospitals health equity plan.

Lastly, a change from version 1 that we've updated here is that we've set a floor for the hospital global budget at 101% of CAH cost or what Medicare fee-for-service would have paid.

If Boone Value's 37.8 million dollars is less than 101% of CAHs costs during the performance year, CMS will provide additional funding to cover the difference.

Next up, we'll move to performance-based adjustments. This section will detail how a hospital global budget will be adjusted based on the hospital's performance in the AHEAD Model. And I do want to note that quality adjustments for acute care hospitals will be included in the annual payment adjustments, but CAH quality adjustments will be treated as performance-based adjustments.

CAHs participating in the AHEAD Model will be subject to an upside-only incentive program that aligns with other quality programs and includes rural specific measures. The program will start as pay-for-reporting and shift to pay-for-performance in later years of the Model.

CAH performance will be compared to national CAH benchmarks where possible and will also include CAH historical performance for improvement.

As you can see in this example, a CAH participating in cohort 1 will start reporting quality data in 2026. The quality program will remain pay-for-reporting until 2030, then transition to pay-for-performance. And the performance weight increases from 0.5% in 2030 to 2% in 2033.

Also, note the arrow at the top of this slide that indicates this is an area where you can expect further iteration in the next version of the financial specifications. Stakeholder feedback is welcome on this adjustment, specifically around CAH quality measures, and you can share your feedback with us by emailing AHEAD@CMS.hhs.gov.

Another performance-based adjustment that we're excited to talk to you about today is the health equity improvement bonus, or HEIB. Hospitals participating in the AHEAD Model can earn up to 0.5% of additional revenue from this bonus, which is based on their performance on specific disparity sensitive measures. And this bonus supports CMMI's mission to focus resources and incentives on reducing health disparities.

Hospitals will receive the reward for improvement between the base period and performance period among beneficiaries in the highest outcome diversity index group, or 75th percentile, across readmissions and PQI-92.

The social risk score, which uses ADI and includes Part D and dual eligibility status, will be used for the bonus. And the HEIB will use the same calculation as the social risk adjustment that we covered earlier. The ADI is based on the census block group that the beneficiary resided in on their first day of eligibility with the performance year and applies to all beneficiaries with an inpatient admission or observation stay of greater than 23 hours at each hospital.

The HEIB measurement will begin in performance year 2 with adjustments starting in performance year 4. It's a similar method to that used in ACO REACH. The AHEAD Model is building on lessons from ACO REACH, adapting it to the state-based Model with a blended state and national ADI.

And then finally for payment, it will be up to a 0.5% upward reward split equally between PQI-92 performance and readmissions and the high diversity cohort. Performance on each measure will be calculated and scaled separately. As you can see on this slide, there is a symbol noting that the HEIB has an anticipated revision for version 3. CMS will continue to consider how to increase conceptual alignment of measures across hospital global budget adjustments and the disparity risk stratifications included in the HEIB. So, we welcome and encourage stakeholder feedback on this.

Next up, the AHEAD Models effectiveness adjustment, or EA, which is also a performance-based adjustment. The EA encourages hospitals to reduce potentially avoidable utilization, which includes unnecessary readmissions, avoidable admissions, avoidable ED visits, and low value care. This is an opportunity for hospitals to keep revenue earned from their efforts to reduce unnecessary or avoidable care.

The EA is calculated by taking a hospital's PAU as a percent of total payments and scales the results compared to statewide averages of PAU charges. Hospitals in the 20th percentile or lower, in this case lower is better, will not receive a downward adjustment.

The EA will start for acute care hospitals in the second performance year and gradually increases as hospitals improve their PAU control. An effective process to reduce PAU may include working with primary care providers, post-acute care providers, and community-based organizations. The EA will be phased in later for safety net hospitals and critical access hospitals and they will be evaluated separately from acute care hospitals.

Note the arrow at the top of this slide. CMMI is still refining this adjustment in terms of the measures included in the adjustment and welcomes stakeholder feedback on those quality measures.

Next, we'll walk through the total cost of care performance adjustment. This adjustment provides an incentive for hospitals to manage both population health outcomes and costs for beneficiaries in their geographic service area in addition to costs within their hospitals. And this entails working with providers and community-based organizations across the healthcare delivery system to manage population health of their communities.

With the TCOC adjustment, participating hospitals will be measured by comparing beneficiary costs within their geographic service area to a comparable benchmark. And this adjustment will include non-claim-based payments, including, but not limited to, capitated payments and ACO shared savings or losses.

The TCOC performance adjustment will be capped at plus or minus 2% of the hospital global budget and will be phased in overtime with a 2-year delay. So, that means the total cost of care performance in PY 2 will be the basis for the PY 4 adjustment.

The adjustment starts as upward only, but starting in PY 5, based on PY 3 performance, it can go up or down for acute care hospitals. In performance year 6, CAHs also see either an upward or downward adjustment. And here again, I want to note the arrow at the top of this slide. CMMI has anticipated a revision for version 3. We're assessing methods for refining the benchmark to ensure that it provides an appropriate counter factual for spending in absence of the AHEAD Model.

To see the performance-based adjustments in action, we'll go back to our CAH, Boone Valley, as it prepares for its 4th performance here in the AHEAD Model.

You start with the hospital global budget from the previous year and apply annual trend updates. Next, we apply a performance-based adjustment. The effectiveness adjustment is a maximum of 8.75% downward adjustment. This is the same for acute care hospitals and critical access hospitals.

Boone Valley will see a negative 0.5% adjustment. And the CAH quality adjustment is a possible increase of 2%. Boone Valley achieved this and will receive the full 2%. And because this is performance year 4, the CAH quality program is still pay for reporting and will become pay for performance in performance year 5.

For the HEIB, Boone Valley is going to receive 0.25% out of a possible max of 0.5%. And Boone Valley will be receiving a 1% total cost of care performance adjustment out of a possible 2%. Because this is the performance year 4, again, the TCOC adjustment is based on PY 2 performance and is upside-only.

Lastly, I want to emphasize the CAH floor. As noted earlier, if 37.8 million dollars turns out to be less than 101% of Boone Valley's costs for performance year 4, CMS will make up the difference.

I want to leave you all with this summary example of how all these different types of adjustments are applied to hospital global budgets, for PY 2 specifically. We look at Moore Health, the acute care hospital, and Boone Valley Hospital, the critical access hospital on the same slide.

For PY 2, both hospitals start with the PY 1 global budget payment amounts. After annual payment and demographic adjustments, volume-based adjustments will be applied. Then the rest of the annual trend adjustments with social risk adjustments. And then, after that performance-based adjustments, remember, CAHs receive a CAH quality adjustment while acute care hospitals include the quality adjustments in their annual payment adjustments. And then finally, we apply sequestration and any midyear reconciliation based on service line changes and utilization.

That concludes our deep dive into version 2.0 of the hospital global budget financial methodology. I will hand it back to Chris to go over a few operational considerations before we open it up for questions.

Chris Crider, CMS:

Thank you, Kashay.

Kashay Webb, CMS:

Nope, we are moving to questions. Thank you, Chris.

Chris Crider, CMS:

Thank you, Kashay. So, thank you to everyone who submitted questions in advance of the webinar. I don't see any open questions in the Q&A box at this time. Thank you to the AHEAD Model team who's been diligently monitoring the box and responding to questions throughout the presentation. Please do feel free to put more questions into the box but Kashay and I will walk through now and respond to the questions that we received in advance of the webinar. So again, thank you to those of you who have submitted.

Question one. How will hospital global budgets incentivize and/ or support primary care and community-based organizations to achieve value?

The AHEAD Model incentivizes these participating providers to work together to achieve value via a number of channels. First, the global budgets allow hospitals to focus on keeping communities healthy by offering these fixed perspective predictable payments. When hospitals are able to prevent unnecessary and low value care and improve the health of the population surrounding them, they are able to retain additional revenue by having these fixed payments, even as volumes may decrease with reduced avoidable utilization.

In addition, the Model requires participating states and hospitals to each create health equity plans that include approaches to coordinate with the community-based organizations and work with providers in order to eliminate disparities and help and to address health related social needs.

Kashay Webb, CMS:

Next question is how will the hospital global budget methodology handle outlier claims?

Outlier claims are accounted for in hospital global budget 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.

Chris Crider, CMS:

How does AHEAD impact ACOs?

So, ACOs are not direct participants in the AHEAD Model. At a high level, participants in AHEAD hospital global budget will continue to submit claims to CMS, so these will be no pay claims and they will be processed but not paid and, so, in cases where there are overlaps between attributed beneficiaries of an ACO who has been admitted to a participating AHEAD hospital, both the Medicare shared savings program and ACO REACH will look at these zero pay claims to determine the amount that otherwise would have been paid. Those claim amounts can be used both in benchmarking as well as to determine the performance year expenditures for the purposes of calculating shared savings and reconciliation to the ACO models.

For more information on our overlaps policies and a little bit more detail on how the various costs will be factored into these other models, you can see the AHEAD Model overlaps sheet on our website.

Kashay Webb, CMS:

The next question, will portions of the applications from awarded states be released to inform other states applicants' methodologies?

Some states may make their application or portions of their application public. More information regarding Medicaid hospital global budgets and Medicaid PC methodologies will be provided as they are developed and finalized. For all other matters, please consult the Notice of Funding Opportunity, or NOFO, which details program requirements.

Chris Crider, CMS:

What information or tool is CMS planning to provide for estimating Medicare hospital global budgets?

And this is such a great question and something we are very excited about. We do plan to provide a hospital global budget estimator tool for states and hospitals to use prior to the date by which hospitals will need to make their participation decision for the first performance year. This tool will align with the most recent financial specification document at the time of release. So, as we mentioned, we do anticipate at least one additional update to the specifications early into 2025. If there is another update prior to the start of the first performance year, the tool will align with that methodology.

And so, with that, I think we do have some open Q&A in the chat, and Kashay, I'll turn it to you to take the first.

Kashay Webb, CMS:

Thank you, Chris. I am looking through all of the questions now.

Chris Crider, CMS:

I can start with the first if that's easier. I will start with your question, Mehul. Thank you.

Will CMS be monitoring under service or stinting? If so, are they reflected in some way in the hospital global budget methodology?

Yes, that is definitely a part of our monitoring plan for under service. But there is no specific adjustment in the methodology. So, we will work with hospitals and with states as the monitoring occurs to provide any real time updates for concerns that we see in the data and to implement any actions needed in response to that monitoring.

Kashay Webb, CMS:

I see a question in the chat from Jonathan Williams, is the global hospital budget meant to cover all payers or all patients or only Medicare fee-for-service?

Only Medicare fee-for-service.

Chris Crider, CMS:

And then a question from Geoffrey Battista. Does that market shift adjustment out-of-area state logic apply to both the baseline and the adjustments?

The market shift adjustment applies only to adjustments, it does not apply to the baseline.

Kashay Webb, CMS:

The question from Ben Winick, for the Medicaid global budget, where most of the patient revenues are paid through MCOs and not fee-for-service, would those total cost of care payments be classified as directed payments? And should Medicaid payments be determined by looking at Medicaid expenses or only the base year Medicaid revenues?

CMS does intend to pay the state directed payments. It will be a pathway for Medicaid Managed Care, and you can also see the Medicaid alignment principles in the NOFO for more details on Medicaid.

Chris Crider, CMS:

I have lost track of which questions have been answered. In the chat I see a question from Deidre. If hospitals are able to retain revenue from discontinued services, how do we prevent low margin services from being discontinued? Will there be monitoring of retained revenue?

Sorry, I'm just taking a minute to digest that question. So, I think you are referring to the planned service line adjustments. And so, I think, in terms of your question of preventing low margin services or services that, so I guess I'll rephrase that and say that, for the planed service line, in order for the hospital to retain the revenue, it needs to be aligned with the state's health equity plan and it needs to be approved.

And so, I think in terms of how that is monitored, it will be a part of our monitoring. And it will be a part of both the state and the hospitals health equity plans.

Kashay Webb, CMS:

I see another question around quality adjustments. Can you please provide more reasoning as to why hospital quality adjustments are included in the payment adjustments for acute care versus performance for cause?

This is to align with IPPS pricing, which incorporates quality adjustments into prices in fee-for-service. CAH payments in fee-for-service do not include similar quality adjustments in pricing.

Chris Crider, CMS:

All right, we have a question. Can states decide to amend the CMS designed methodology for Medicare payments or do states only have control over changes to the Medicaid methodology?

So, for states who do not have hospital rate setting or budget setting authority, they will use the CMS designed methodology and states are not able to amend that methodology. They only have control over the Medicaid methodology. And I'll just put another plug in, this is why we are providing these types of forums for folks to continue to provide feedback and input into specifications and why CMS takes it so very seriously. And we will continue to do so throughout the implementation period of the Model.

In states that have been accepted to the Model, such as Maryland and Vermont, will all acute care hospitals be required or mandated to participate in ACO AHEAD?

So, I'm not entirely sure I understand the question, but I will re-emphasize that participation among hospitals, including in Maryland and Vermont, is completely voluntary as it has been in the current Maryland and Vermont models, it will remain voluntary hospital participation under the AHEAD Model. The AHEAD Model is not an ACO model, although we do allow for overlaps with ACOs following the policy that we referenced earlier.

I do believe we have covered most, if not all, of the questions that have come in, both in advance of the webinar, as well as through the Q&A box. If any more comes up in the next minute or so we can certainly take those. But while we're waiting to see if there are additional questions that come in, just wanted to walk you all through a high-level timeline of where we are in the Model life cycle.

The star on the screen represents where we are today, in July, with the release of our 2.0 methodology and noting that we've accepted applications for our first 2 cohorts, who submitted applications in March and the first participants into the AHEAD Model are Maryland and Vermont in cohort 1 and Connecticut and Hawaii in cohort 2. The final cohort of states will submit their applications next month and will be awarded by January of 2025.

We are still collecting stakeholder feedback and working on additional revisions to our forthcoming 3.0 version hospital global budget specifications, and we will provide this in early 2025. We expect state efforts to recruit hospitals for participation in the Model to start soon, especially in cohort 1 and 2, sorry, the cohort 1 and 2 states, if it has not already begun. And we hope this presentation can help inform these efforts.

If there are no more questions in the chat, which I don't see at this time, I just want to thank you all for your participation on the webinar today. Your interest in the AHEAD Model and your

ongoing contributions through both the Q&A here, as well as to the AHEAD inbox, to share your input on these methodologies.

We, again, really do appreciate all of the conversation that has been happening around these and the engagement.

And I want to just emphasize again, you know, this webinar today has focused on hospitals and on hospital global budgets but I do want to re-emphasize the importance of this as a state-based population health model that really aims, in addition to improving population health and health equity, to strengthen partnerships between hospitals, primary care providers, community-based organizations, and others in the community to really have this transformative impact on population health and health equity. It really is a model that will require partnership across multiple sectors and multiple actors. So, thank you all for your participation today and I look forward to continuing to engage with you.

With that we will launch our poll and appreciate folks responding to the poll. What about the AHEAD Model CMS designed Medicare fee-for-service hospital global budget methodology in the version 2.0 that was just released are you interested in learning more about? You could please select your answer.

Again, we take all feedback we receive really seriously and look forward to being able to respond to the areas in which you indicate interest.

Thank you all again and I hope you have a wonderful day.

And we have a second poll question for folks. Poll number two, if you could please respond.

Following the presentation, I understand changes to the AHEAD Model CMS designs hospital global budget methodology sufficiently to make a decision to participate or explain the methodology to potential participants.

Alright, thank you folks for responding to the poll. Thank you again for your time and interest in the AHEAD CMS designed hospital global budget methodology. In addition to the two poll questions, we also have a survey to provide feedback on the webinar. We encourage you to please take the survey that Eli has posted into the chat. Thank you all again and we look forward to seeing you at the next event.