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

Center for Medicare and Medicaid Innovation
October 2, 2:00 – 3:00pm ET

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Housekeeping and Logistics

This event is being recorded.

Closed captioning is available on the bottom of the screen.

Additional options for audio listening:

Dial-in: +1 833-568-8864

Webinar ID: 161 739 9453

Please submit comments in response to the event via the Q&A box on the bottom of your screen.

Please complete the short survey at the end of the event.

Today's Facilitators

Kashay Webb
Health Insurance Specialist, AHEAD Model
CMS Innovation Center

Christina Crider
Deputy Division Director
Division of Multi-Payer Models
CMS Innovation Center

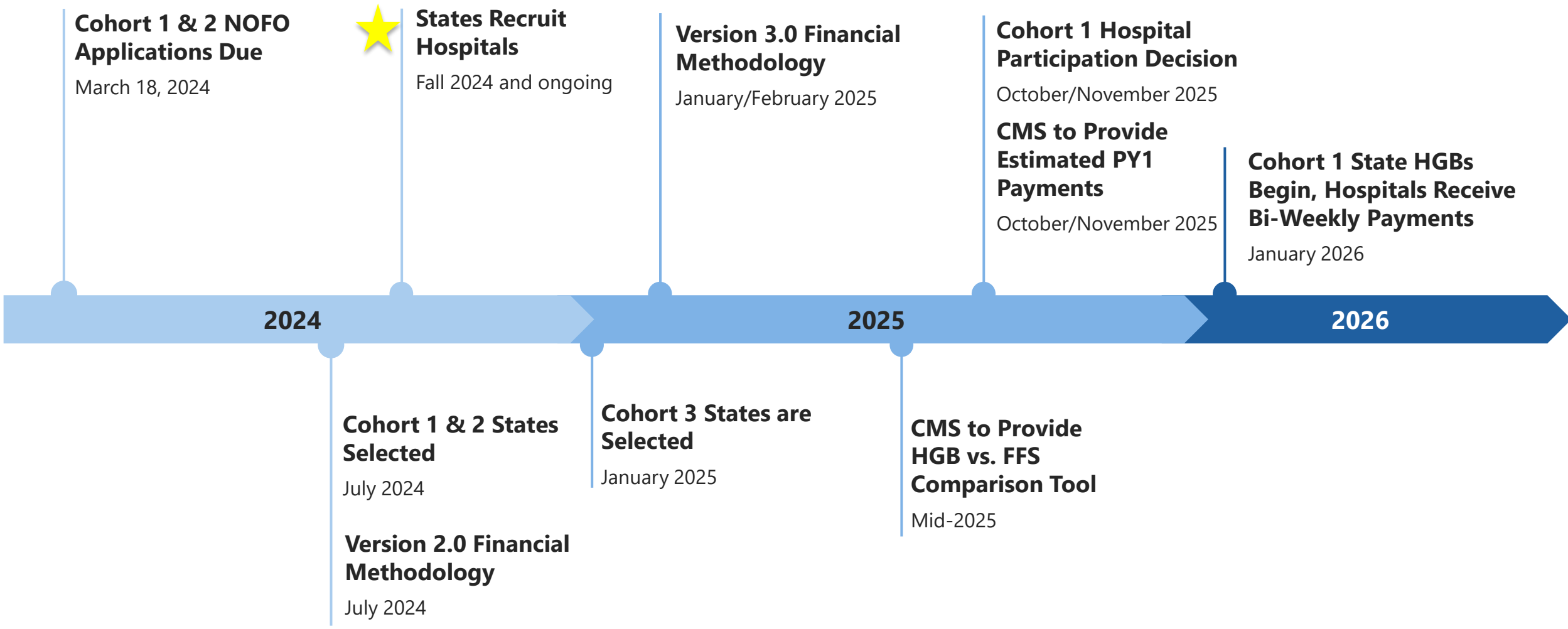
Agenda

This office hour provides participants the opportunity to have their questions answered about the AHEAD Model's CMS-Designed Medicare FFS Hospital Global Budget (HBG) Methodology.

1. Timeline Review
2. AHEAD Model Previously Submitted Questions
3. Live Q&A

Timeline Review

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.*

Previously Submitted Questions

Previously Submitted Question (1 of 13)

Q Will CMS normalize Skilled Nursing Facility (SNF) and swing bed spending to avoid provider referrals based on local swing beds?

A

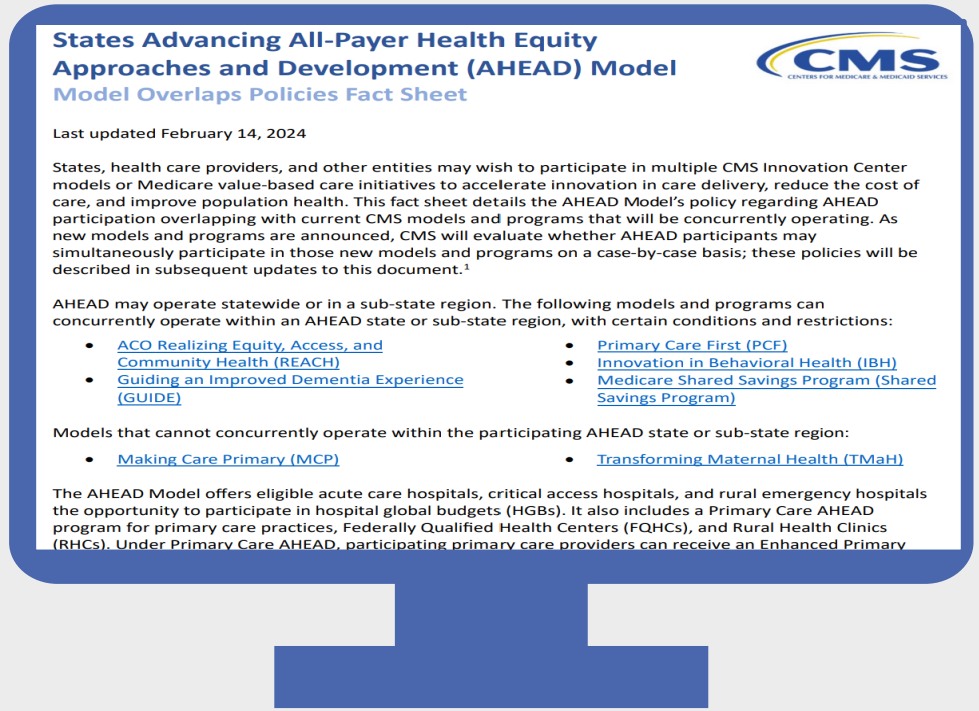
SNF beds are not part of HGBs and will be excluded from both the baseline and performance years. Swing beds are included for Critical Access Hospitals (CAHs) only. For more information, please refer to Section 2.1 of the AHEAD Model CMS-Designed HGB Methodology.

Previously Submitted Question (2 of 13)

Q How closely aligned is the AHEAD Model to existing payment models?

A

The AHEAD Model builds upon lessons learned from the state-based models: Vermont All-Payer Accountable Care Organization (VT ACO) Model, Maryland Total Cost of Care Model (MD TCOC), and Pennsylvania Rural Health Model (PARHM) with additional focus on advancing health equity by reducing disparities in health outcomes. Overlaps are permitted in specific cases and intended to work synergistically to improve health care cost and quality outcomes, specifically between Medicare Shared Savings Program, Transforming Episode Accountability Model (TEAM), and AHEAD. A hospital participating in both a HGB and an episode-based payment model, like TEAM, could benefit from both models' unique cost savings opportunities. HGBs encourage improvements in population health, while episodes help providers to focus on making improvements for a narrower pool of patients associated with costlier clinical conditions or procedures. Please refer to the AHEAD Overlaps Fact Sheet for more information. CMS will add additional information as new models are announced.



States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

Model Overlaps Policies Fact Sheet

Last updated February 14, 2024

States, health care providers, and other entities may wish to participate in multiple CMS Innovation Center models or Medicare value-based care initiatives to accelerate innovation in care delivery, reduce the cost of care, and improve population health. This fact sheet details the AHEAD Model's policy regarding AHEAD participation overlapping with current CMS models and programs that will be concurrently operating. As new models and programs are announced, CMS will evaluate whether AHEAD participants may simultaneously participate in those new models and programs on a case-by-case basis; these policies will be described in subsequent updates to this document.[1]

AHEAD may operate statewide or in a sub-state region. The following models and programs can concurrently operate within an AHEAD state or sub-state region, with certain conditions and restrictions:

- ACO Realizing Equity, Access, and Community Health (REACH)
- Guiding an Improved Dementia Experience (GUIDE)
- Primary Care First (PCF)
- Innovation in Behavioral Health (IBH)
- Medicare Shared Savings Program (Shared Savings Program)

Models that cannot concurrently operate within the participating AHEAD state or sub-state region:

- Making Care Primary (MCP)
- Transforming Maternal Health (TMaH)

The AHEAD Model offers eligible acute care hospitals, critical access hospitals, and rural emergency hospitals the opportunity to participate in hospital global budgets (HGBs). It also includes a Primary Care AHEAD program for primary care practices, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs). Under Primary Care AHEAD, participating primary care providers can receive an Enhanced Primary

Image for reference purposes.
Use the link in the box to the left to review further.

Previously Submitted Question (3 of 13)

Q How can an organization maximize savings to reinvest in enhancing the health of its resident population?

A

The AHEAD HGB methodology includes an upward Transformation Incentive Adjustment (TIA) in the first 2 model years to support enhanced care management. Hospitals may also see increases in their HGB for improved quality, including health equity-related measures. Hospitals will have the option to capture and reinvest funds from reduced, potentially avoidable, utilization or a planned service line change, etc. in population health and health equity. As previously mentioned, the model builds on the learnings from the HGB Models in Maryland (MD) and Pennsylvania (PA), where CMS created incentives for hospitals and other health care providers to coordinate with each other to provide patient-centered care. For more information, please refer to the Hospital Global Budget Fact Sheet and the AHEAD Model CMS-Designed HGB Methodology.

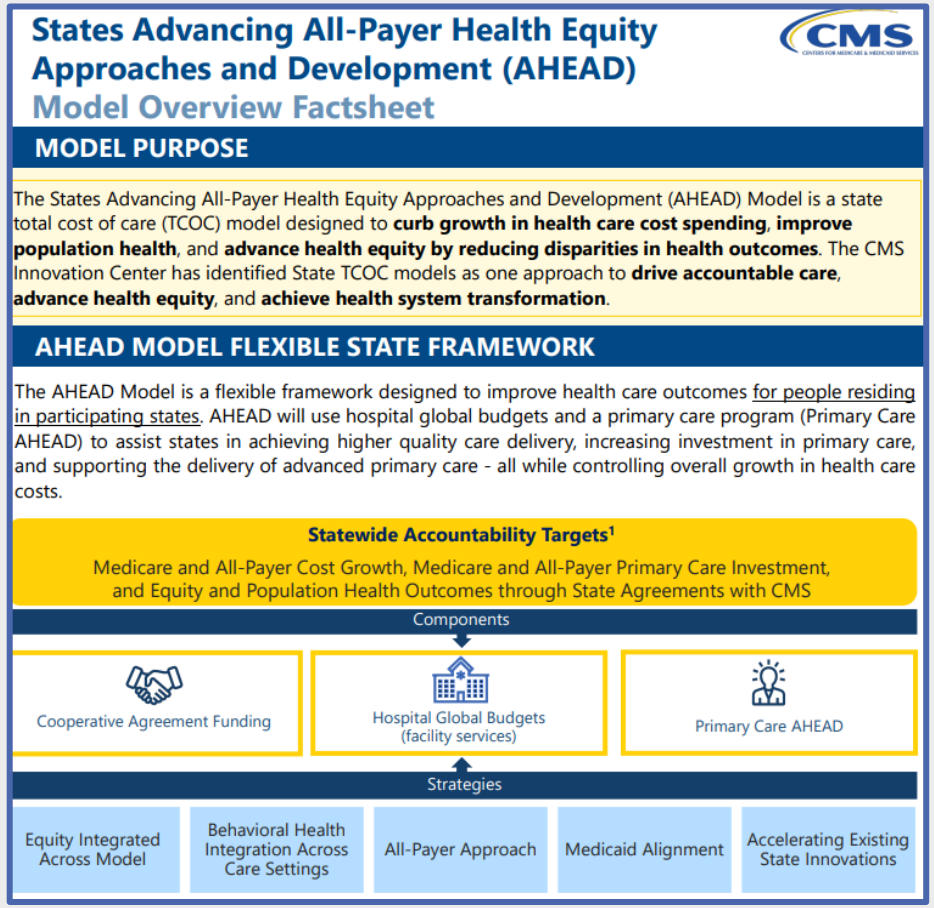


Image for reference purposes.
Use the link in the box to the left to review further.

Previously Submitted Question (4 of 13)

Q How will CMS calculate HGBs for hospitals with shared CMS Certification numbers (CCNs)? Will CMS consider site-specific HGBs?

A

Yes, CMS will calculate site-specific HGBs so long as sites can be identified by a National Provider Identifier (NPI). Site-specific HGBs will include the same calculations as other global budgets, except the Annual Price Adjustment will use the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) factors specific to the hospital's CCN.

Previously Submitted Question (5 of 13)

Q How are dual-eligible populations accounted for in HGBs?

A

Medicare Claims for dual-eligible beneficiaries are included in all HGB calculations, including the Baseline, Quality, and Performance Adjustments, because Medicare is the primary payer for those with both Medicare and Medicaid coverage. Medicare Secondary Payer (MSP) beneficiaries are excluded because Medicare does not pay the full amount on the claim. States are encouraged to leverage D-SNP plans to offer aligned HGBs in Medicare Advantage to participating hospitals.

Previously Submitted Question (6 of 13)

Q In the Attribution Method, how are members assigned to a hospital? Is it based on claims data, location, or other factors? Additionally, can CMMI provide input on managing extensive overlapping geographies, and what are the potential advantages and disadvantages of using attribution by person versus by geography?

A Beneficiaries are not attributed to hospitals in the HGB. Instead, HGBs are based on each hospital's historical Medicare FFS revenue. Adjustments, such as those for Demographic, Social Risk, and Total Cost of Care (TCOC) allocate medical risk, social risk, and spending to hospitals based on the share of revenue or beneficiaries from each geography served. This approach recognizes that hospital geographic areas overlap and are proportional to the services provided by the hospital. Please refer to Section 2.3.4 of the AHEAD Model CMS-Designed HGB Methodology for more information.

Previously Submitted Question (7 of 13)

Q What is the process for negotiating TCOC targets? What are the expectations for low-cost states (i.e., budget neutrality)?

A

The AHEAD Model includes both statewide TCOC targets, for which the state is accountable, and the hospital TCOC Performance Adjustment. CMS will negotiate the statewide targets with each state and include the final target in each state's State Agreement. Savings expectations for low-cost states are budget neutrality. For hospitals TCOC targets, the current CMS-Designed HGB Methodology uses a case matched group of beneficiaries, which is a different approach than for statewide targets. CMMI is considering aligning with the statewide target methodology in the State Agreement.

Previously Submitted Question (8 of 13)

Q Will I know my HGB amount before I sign any contract?

A

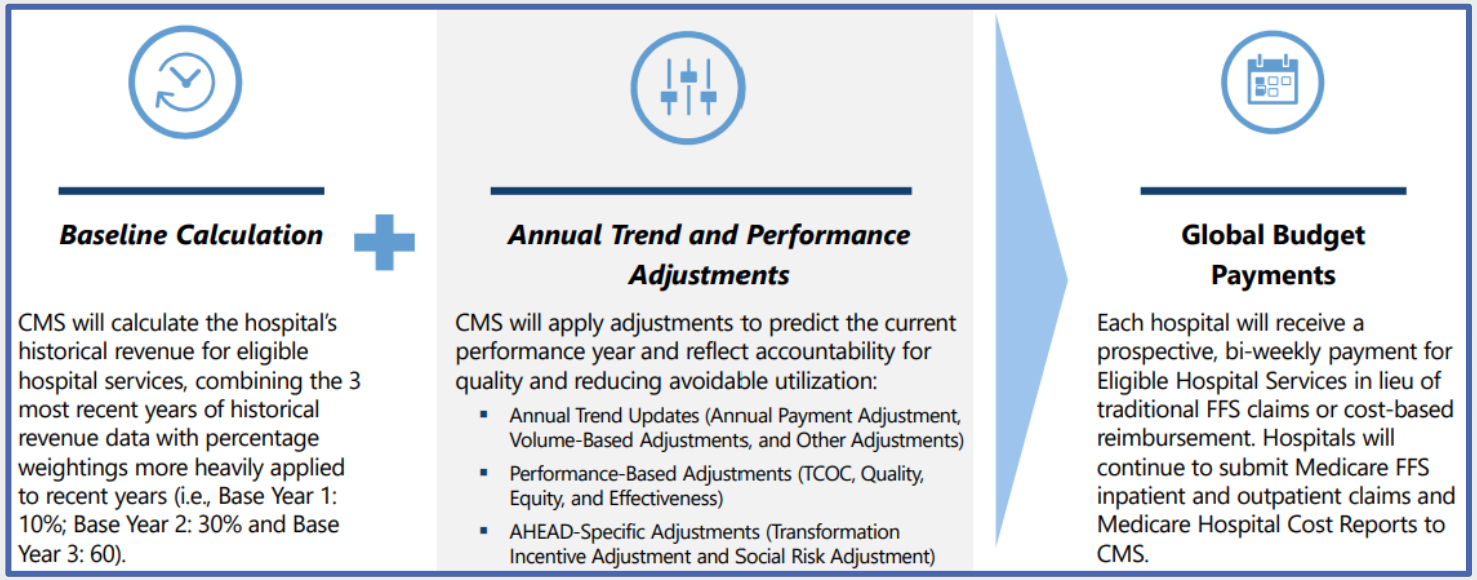


Image for resource reference. Please use the link in the box below to review further.

Hospitals will know the actual amount of their HGB before signing a Participation Agreement. CMS will also provide an Estimator Tool in mid-2025 that will help hospitals understand how the methodology works and provide comparison to Medicare FFS payments. For more information on how CMS will calculate a hospitals HGB, please refer to Section 2 of the AHEAD Model CMS-Designed HGB Methodology.

Previously Submitted Question (9 of 13)

Q Will CMS change the methodology during the course of the model? If it does, am I able to drop out?

A

CMS is always open to stakeholder feedback to improve the Model. If updates are made to the methodology, CMS will inform participants in advance of a performance year, allowing hospitals to decide whether to stay. However, hospitals must abide by the terms and conditions of the Participation Agreement for that performance year.

Previously Submitted Question (10 of 13)

Q Cancer drugs are excluded, but other Part B drugs that can be quite variable are included. How will CMS account for a new drug that causes significantly higher than expected costs?

A

Typically, individual Part B drugs, other than those for cancer, represent a very small percentage of a HGB revenue and based on analysis, are less than 1% of HGBs. In the event of the introduction of a new abnormally expensive drug, CMS may apply an Exogenous Factor Adjustment.

Previously Submitted Question (11 of 13)

Q There are a lot of hospitals in our hospital service area. How can we be held accountable for the cost of all the beneficiaries in our hospital service area? Does it matter if those hospitals are participating or not?

A

TCOC performance is allocated to hospitals based on the share of services they provide to each geographic area, inclusive of participating and non-participating hospitals in the AHEAD model. The TCOC adjustment incentivizes hospitals to proactively consider the health of their communities and partner with community-based providers.

Previously Submitted Question (12 of 13)

Q How will CMS set the HGB baseline?

A

To construct the CMS-designed HGB for Participant Hospitals, CMS will first calculate a Participant Hospital's HGB baseline by combining the hospital's historical revenue from Medicare FFS payments using the three most recent years prior to joining the AHEAD Model. CMS will weight historical revenue, weighting the most recent years more heavily (i.e., Base Year (BY) 1: 10%; BY 2: 30% and BY 3: 60%). Historical revenue paid by CMS outside the FFS framework (e.g., non-claims-based payments, beneficiary out-of-pocket payments) are excluded from the HGBs and will continue to be paid separately. Please see Section 2.1 in the AHEAD HGB Specifications for more information.

CMS will include the baseline inpatient and outpatient paid amounts for which Medicare is the primary payer for the relevant BYs. Professional services rendered in a hospital setting are not included in the CMS-designed HGB and will continue to be paid FFS. For a list of detailed payments excluded from HGBs see Appendix D in the AHEAD Model CMS-Designed HGB Methodology. CMS is evaluating potential ways to improve the baseline calculation in Version 3.0.

Previously Submitted Question (13 of 13)

Q How will CMS adjust for changes in volume over time?

A

The Market Shift Adjustment accounts for changes in volume over time. CMS is considering revisions to this adjustment for Version 3.0 and would welcome stakeholder input. For more details, see Section 2.2.3 of the AHEAD Model CMS-Designed HGB Methodology.

Live Q&A

Live Q&A Session

Open Q&A

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

Closing

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 Office Hour so we can learn how to improve our events.

Do you still 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***

Additional Resources

For more information regarding the AHEAD Model, please review the following resources:

- The Version 2.0 Financial Specifications for the CMS-designed HGB Methodology
- The CMS-Designed Medicare FFS Hospital Global Budget (HGB) Methodology Version 2.0 Webinar Slides, Recording, and Transcript, which outline the updates made to the methodology from Version 1.0 to 2.0
- The AHEAD Model's Hospital Global Budget Fact Sheet, which includes information about the AHEAD CMS-Designed Medicare FFS HGB
- Frequently asked questions specific to CMS-Designated Medicare FFS HGB

Thank You!