The AHEAD Model
Hospital Global Budgets
Initial Review of CMS Methodology

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

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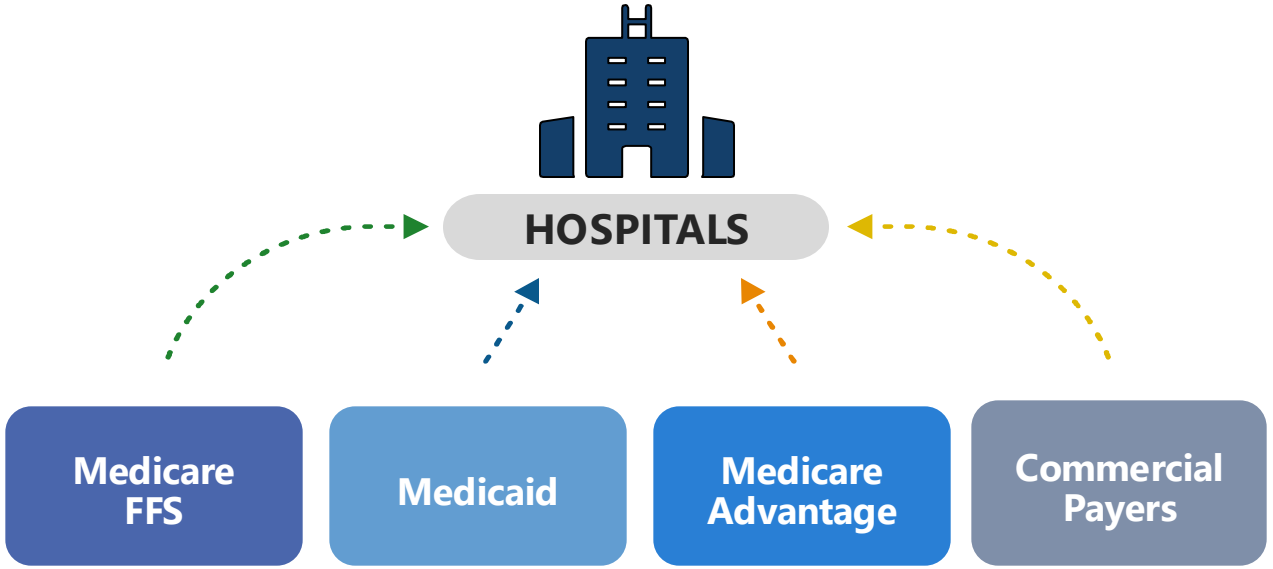
Progress Together

Discussion Series – Initial Topics

- December 19, 2023 – AHEAD Model Components and Key Focus on Governance
- January 11, 2024, 2:00 p.m. EST – Considerations for Hospital Global Budgets
- January 18, 2024, 2:00 p.m. EST – Considerations for Primary Care AHEAD
- February 22, 2024, 2:00 p.m. EST- Initial Assessment of Medicare Hospital Global Budget Methods
- Additional sessions TBD

AHEAD Hospital Global Budget Participation Requirements



Medicare FFS

- **CMS sets the methodology** for all except for states with existing rate setting authority and experience (MD, VT)
- Lead agency to recruit hospitals. Targets are:
  - 10% of Medicare FFS spending for the state/region by PY1
  - 30% of Medicare FFS spending for the state/region by PY4.

Medicaid

- The state Medicaid agency will be responsible for developing their Medicaid-specific hospital global budget methodology. States can have separate models for FFS and MCOs
- Any Medicaid methodology will need to be approved through normal regulatory processes and CMS approval.
- Mandatory participation by PY1

Commercial Payers
Medicare Advantage

- Participating states will develop a methodology with high-level alignment principles outlined by CMS.
- At least one commercial payer must participate in global budgets by PY2.

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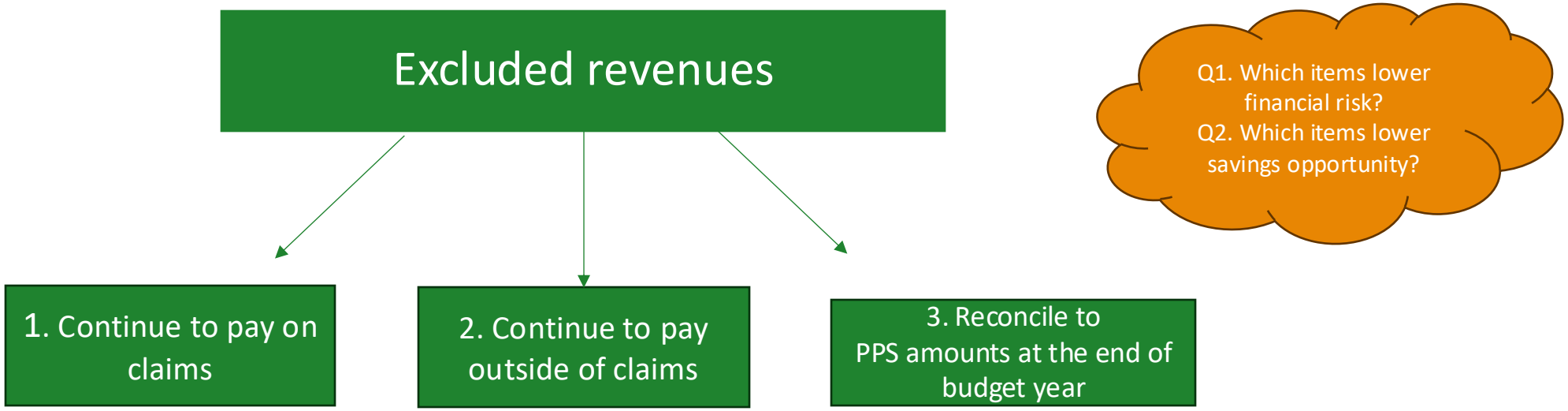
Source: CMS Notice of Funding Opportunity

Hospital Global Budget Exclusions



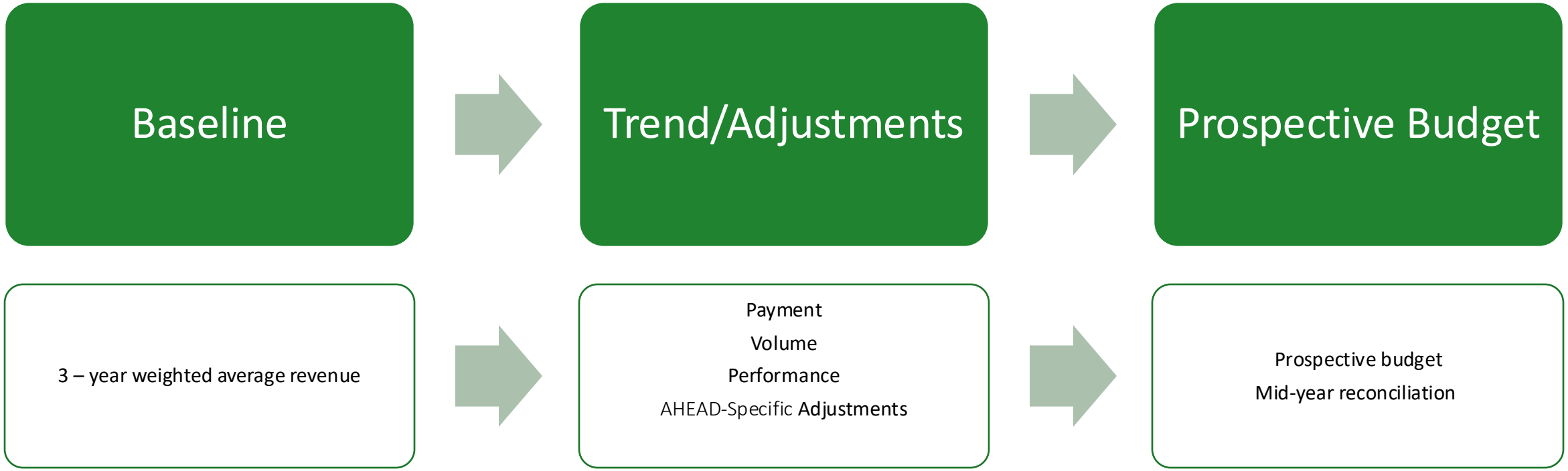
Q1. Which items lower financial risk?
Q2. Which items lower savings opportunity?

- Distinct part units (psych beds, rehab units etc.)
- CAH Method II billing for professional services
- New technology adjustment payments (NTAP)
- Outpatient claims with reasonable cost payments (drugs, biologicals, blood products, brachytherapy etc.)
- Medicare secondary payer

- Bad Debt
- Direct Graduate Medical Education
- Nurse and Allied Health Education
- Organ acquisition cost

- Outlier payments
- Low volume payments
- Set BY 3 as floors
  - Indirect medical education (IME)
  - Disproportionate share (DSH)
  - Uncompensated Care (UCC)
  - CAH total reveneu

Global Budget Adjustment Cycle



Budget Adjustments

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 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

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).

Which of these adjustments is more significant?

Source: AHEAD Model Hospital Global Budgets Webinar, February 14, 2024.

Why Global Budgets?

Business model under FFS

- Higher price
- Do more
- Close-down unprofitable services

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Price

Provide inflationary adjustment.

Volume

Restructure:

1. Changes due to beneficiary enrollment (hospital cannot do anything about this)
2. New service lines/closures (expectation to align with population health and equity goals and improving access)
3. Market shifts (competition between hospitals.

R

Total revenue to providers/ Cost to purchases/payers

Prospective, fixed.
Prospective and not tied to units or rates. Instead pay for

1. Transformation and social risk
2. Better clinical outcomes
3. Patient experience
4. Etc.

Business model under Global Budget

- Do less or manage the growth
- Improve performance on outcomes measured in payment

Annual Adjustments

Adjustment type	HGB List	Compared to current payment methods (FFS, Cost-based CAH reimbursement)
Payment	• Inflation • Wage index, low volume, etc.	Similar
	• IME, DSH, UCC	Initially might be better than FFS. Overtime, BY3 amounts might be lower as FFS formulas include updates.
	• BY3 as floor for CAHs	Higher/lower depending on individual hospital trend. Most likely become lower over time if floor is not updated.
Quality	• All CMS quality programs	Similar
Other	• Sequestration	Similar

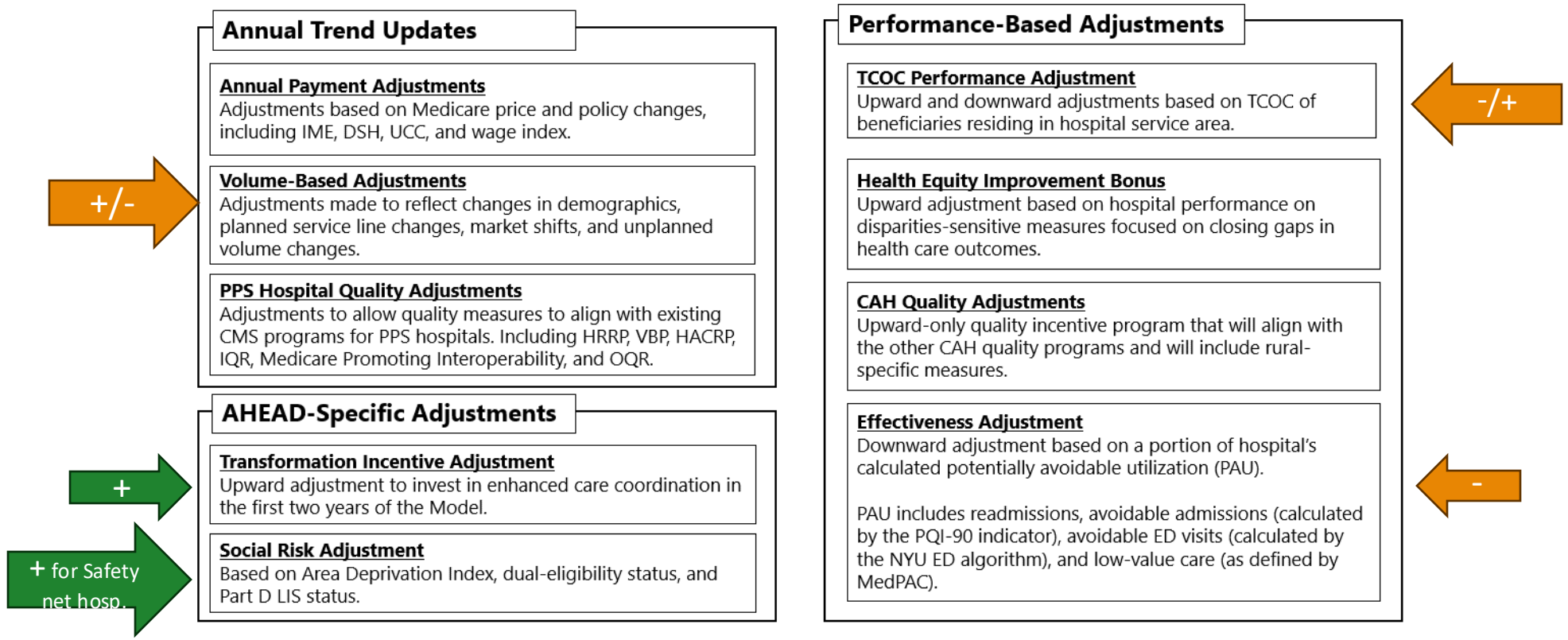
Volume Adjustments

Volume Adjustments	Details of adjustment	Potential concerns from hospitals	State considerations for Medicaid method
Demographic/ Membership Shifts	Prospective: Population growth 65+ adjusted for age Correction: Medicare FFS beneficiary growth adjusted for HCC.	Demographic adjustment may provide increase in payment, but final "correction" will likely reduce the payment due to declines in Medicare enrollment if beneficiaries enroll into Medicare Advantage.	Medicaid churn may introduce additional considerations for accounting for membership shifts.
Market Shift Adjustment (MSA)	Algorithm is used by MD and PA. Track changes in volume by service lines and make proportional allocations. Pay 50% of average "cost".	Unknown until the end of the period. 50% payment rate may not be sufficient to cover costs for some hospitals. Hospitals might be reluctant to join the model or decide to exit early if the market shift algorithm does not cover their volume increases and 50% rate is insufficient.	Volume shift algorithm may not work in small geographies. Medicaid payment rates do not cover the cost. 50% of additional payment may not be desirable.
Service Line Adjustment (SLA)	• New services: 2-year reconciliation to claim-based payment amounts. Mid-year reconciliations to account for data lags. • Contraction/elimination: PPS hospital retains up to 50% of historical payment, CAH may retain 100% of payment • Must be pre-planned and approved by State and CMS. Must align with State Health Equity plan.	Restricts service line changes to approved changes. Mid-year reconciliations works against predictability. Pays only 50% for upside, cannot keep all revenue lost except for CAHs. Hospitals may find this too much regulation on their operational decisions.	Administrative burden on states to track, approve, and reconcile service line changes for participating hospitals. Type of services are important for applying payment adjustments (closure of labor & delivery)
Unplanned Volume Change Adjustment (UVA)	• Additional adjustment for volume changes +/- 5 percent volume change after all other adjustments. • Declines: remove full amount for PPS, retain 50% for CAHs. • Increases: receive 50% of the revenue provided hospital achieved total cost benchmark.	5 percent variance in volume is a risk corridor after all other volume adjustments. Lower's the risk of the model. Incentivize to report all the service line changes as SLA.	Hospitals with low volume may experience large swings and volume shift.

AHEAD-Specific and Performance Adjustments

Adjustment	Summary	Adjustment type	Amount	First Measurement Year	First Payment year
Transformation incentive	Provided only during the first two years of the model. Amount will depend on all annual trend updates have been completed. Must be repaid if hospital exists Model before PY6.	Upward	1%	Performance year (PY) 1 budget amount	PY 1
Social risk adjustment	Measured using ADI and a combination of dual-eligibility and Part D Low-Income Status (LIS).	Upward	Up to 2%	Not specified	PY1
CAH quality adjustment	Will begin as pay-for-reporting and advance to pay-for-performance.	Upward	Up to 2%	PY1 (pay-to-report) PY3 (pay-to-perform)	PY3 (pay-to-report) PY5 (pay to perform)
Health equity improvement bonus	Based on improvement on historic performance over a fixed-base period for readmissions and PQI-92 in the High Adversity cohort.	Upward	Up to 0.5%	PY2	PY4
Total cost of care (TCOC performance adjustment)	Establishes a TCOC benchmark for beneficiaries within hospital's geographic service area compared to a national comparison group.	Begin as upward-only	Up to +/- 2%	PY2	PY4
Effectiveness adjustment	Based on the individual hospital's percentage of PAU charges compared to the statewide average PAU charges. PAU include readmissions, PQI-90, avoidable ED, Low-value care measures.	Downward	Increases over time, up to –2%	Gap year	PY2

Major Drivers of Financial Impact



Appendix Introductions

About NASHP

The National Academy for State Health Policy (NASHP) is a nonpartisan organization committed to developing and advancing state health policy innovations and solutions.

NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

- To improve the health and well-being of all people across every state.
- To be of, by, and for all state by providing nonpartisan support for the development of policies that promote and sustain healthy people and communities, advance high quality and affordable health care, and address health equity.

How NASHP Accomplishes Our Mission

- **Advance innovation** by supporting states in the development of new policies and programs.
- **Surface and support the implementation and spread of best practices** by engaging states to inform data driven policy making at the state and federal level.
- **Ensure states have the information, data, and tools** to successfully design and implement policy.
- **Encourage sustainable cross sector solutions** by strengthening partnerships across state agencies, executive and legislative branches, and the private sector.
- **Elevate the state perspective** for a broad group of stakeholders, partners, and the public.

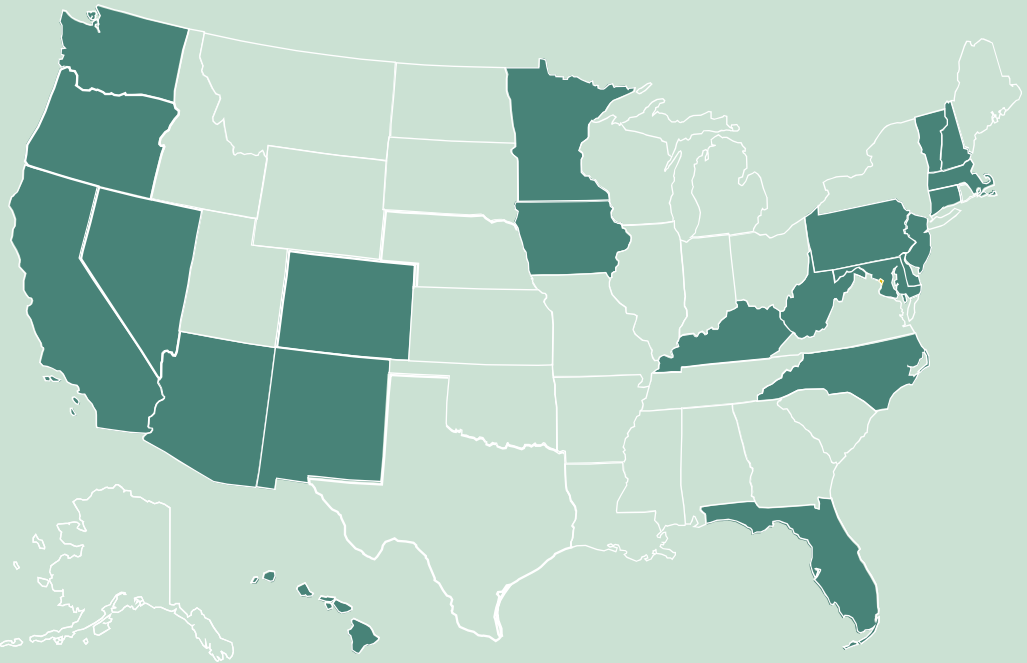
About Mathematica | Focus Area Health

Our Health team **collaborates with clients to improve the health and well-being of our most vulnerable populations** through transformation to an equitable, data-driven, value-based health care system.

Our Mission

Improve public well-being by bringing the highest standards of quality, objectivity, and excellence to bear on the provision of information collection and analysis.

State Health Footprint I Project Highlights



- Pennsylvania Rural Health Model
- Vermont All-Payer Model
- Maryland Total Cost Model and Evaluation
- California and New Jersey Total Cost and Primary Care Benchmarks
- NASHP Hospital Cost Tool
- Medicaid 1115 waiver and Primary Care Model evaluations
- National/State Medicaid, Medicare and Commercial claims analytics

Dr. Sule Gerovich

(Shooleh Gherovich),Pronounce: She/Her

- Over 15 years of experience in health services research and policy
- Expertise in health care payment policy, quality and performance measurement
- Hospital global budget implementation in three states: PA, MD, VT
- Strategic assessment of CMS models, including CMS Community Health Access and Rural Transformation (CHART) Model for Washington State
- Total cost benchmarking and all-payer claims analytics: CA, MA, MN, VT, MD and NASHP Hospital cost tool

- Senior Fellow at Mathematica
  Ph.D., Johns Hopkins University School of Public Health