

Hawai`i Hospital Global Budgets Brainstorming Session

Medicaid Hospital Global Budget

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Agenda

Medicaid Hospital Global Budget

- Key design principals
- Current Medicaid hospital funding streams
- Prospective, virtual, and hybrid approaches
- Utilization-based payments
- Alignment of value-based / quality measures
- Required adjustments

AHEAD Participation and Transformation Activities

- Participation incentives
- Coordination between Hospitals and Physician Groups

Additional Information

Discussion Goals

Align on Medicaid Hospital Global Budget design principles and success criteria.

Understand how the Medicaid Hospital Global Budget builds on existing programs, initiatives, and infrastructure.

Discuss how the Medicaid Hospital Global Budget approach aligns with existing programs and the Medicare FFS Hospital Global Budget.

Gather any feasibility concerns and 'wish list' items.

Medicaid Hospital Global Budget



Medicaid Hospital Global Budget: Key design principles

MQD has flexibility in designing the AHEAD Medicaid Hospital Global Budget

- MQD proposes to build upon its existing Medicaid hospital value-based purchasing initiatives and funding streams to establish the Medicaid Hospital Global Budget (HGB)
- MQD current has **three main Medicaid hospital funding streams**:
 1. Utilization-based payments (i.e., DRG)
 2. Fixed payments (i.e., Access pool)
 3. Value-based payments (i.e., P4P Quality pool)

Key decision point: the budgeting of these funding streams when determining the Medicaid HGB

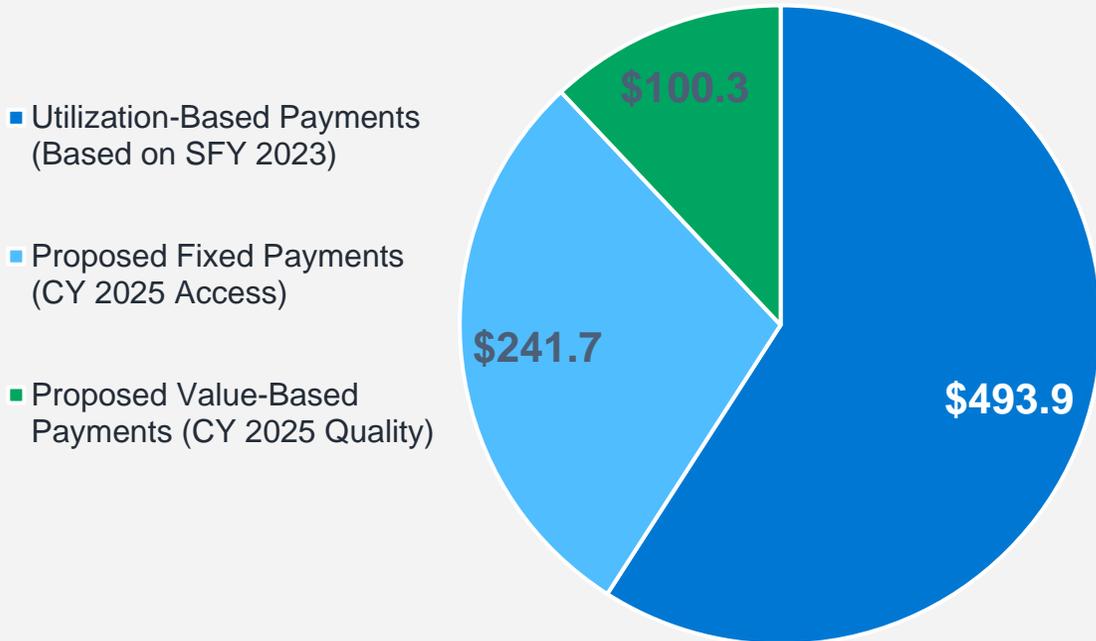
- MQD must apply a **“Prospective”, “Virtual”, or hybrid HGB methodology** (based on CMS’ terminology).
 1. *Prospective*: Bi-weekly payments fully inclusive of legacy Utilization/Fixed/Value-based components (without interim utilization-based payments)
 2. *Virtual*: MCOs make utilization-based payments (paid claims) and conduct periodic reconciliation (to “true up” claim payments against prospectively set global budgets)
 3. *Hybrid*: combination of interim utilization-based payments and bi-weekly payments (need to determine approach for funding adjustments when a performance year is over/under target)

Key decision points: the Medicaid HGB methodology; the proportion of utilization, fixed, and value-based funding

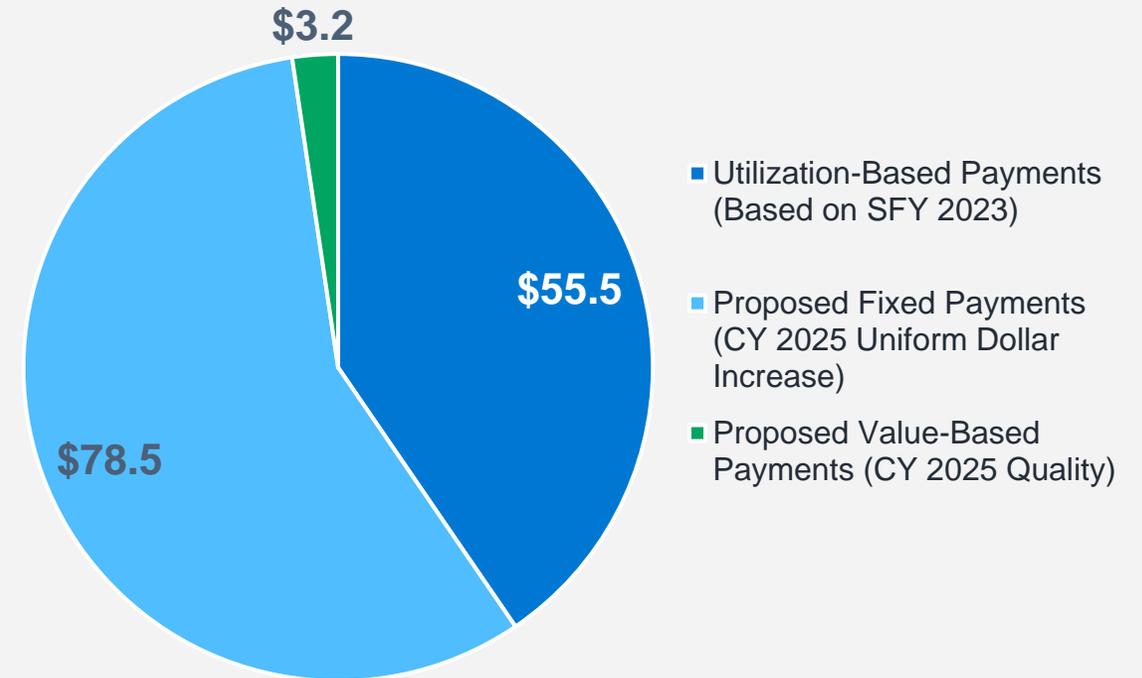
Key design principles: Current Medicaid hospital funding streams

In 2025, utilization-based payments and fixed payments are projected to be the largest funding streams, and value-based payments are the smallest. Projections include both inpatient and outpatient hospital payments.

Private Hospital Funding Streams (\$853.8M Total)



HHSC Public Hospital Funding Streams (\$137.2M Total)



Notes: Medicaid Managed Care Base Payments excludes Medicaid FFS members. SFY 2023 values are shown and are not trended forward. Excludes Medicare/Medicaid Dually Enrolled. Excludes DSH. 2025 DSH payments are estimated to be \$22.9M. DSH payments are limited based on a cost ceiling, so may be reduced as the State moves towards an ACR ceiling.

Source: MQD CY 2025 Hospital State Directed Payment Preprint Total Payment Rate Demonstration (dated 4/11/2025)

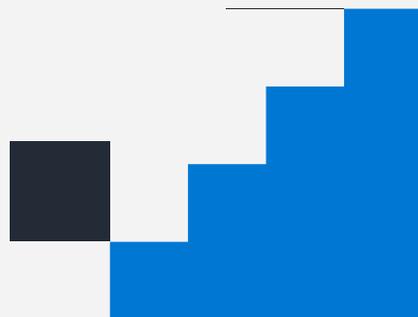
Funding Streams: Private Hospital Fixed and Value-Based Payments

Funding streams over time

MQD’s proposed private Hospital Access payments for 2025 are greater than the 2024 Access and Quality Pool payments combined.

For MQD’s proposed 2025 Quality Pool, the portion tied to administrative activities is greater than the total 2024 Quality Pool.

*Future payment increases limited to average commercial rates (ACR) per CMS requirements.



*Quality Pool Payments 2022 – 2024 had some dollars at risk for quantitative measures, variable by hospital. For example, a private hospital with OB had 6% of the hospitals 2024 quality pool at risk based on performance on a measure related to ED utilization (20% of pool with a measure specific floor of 70%)

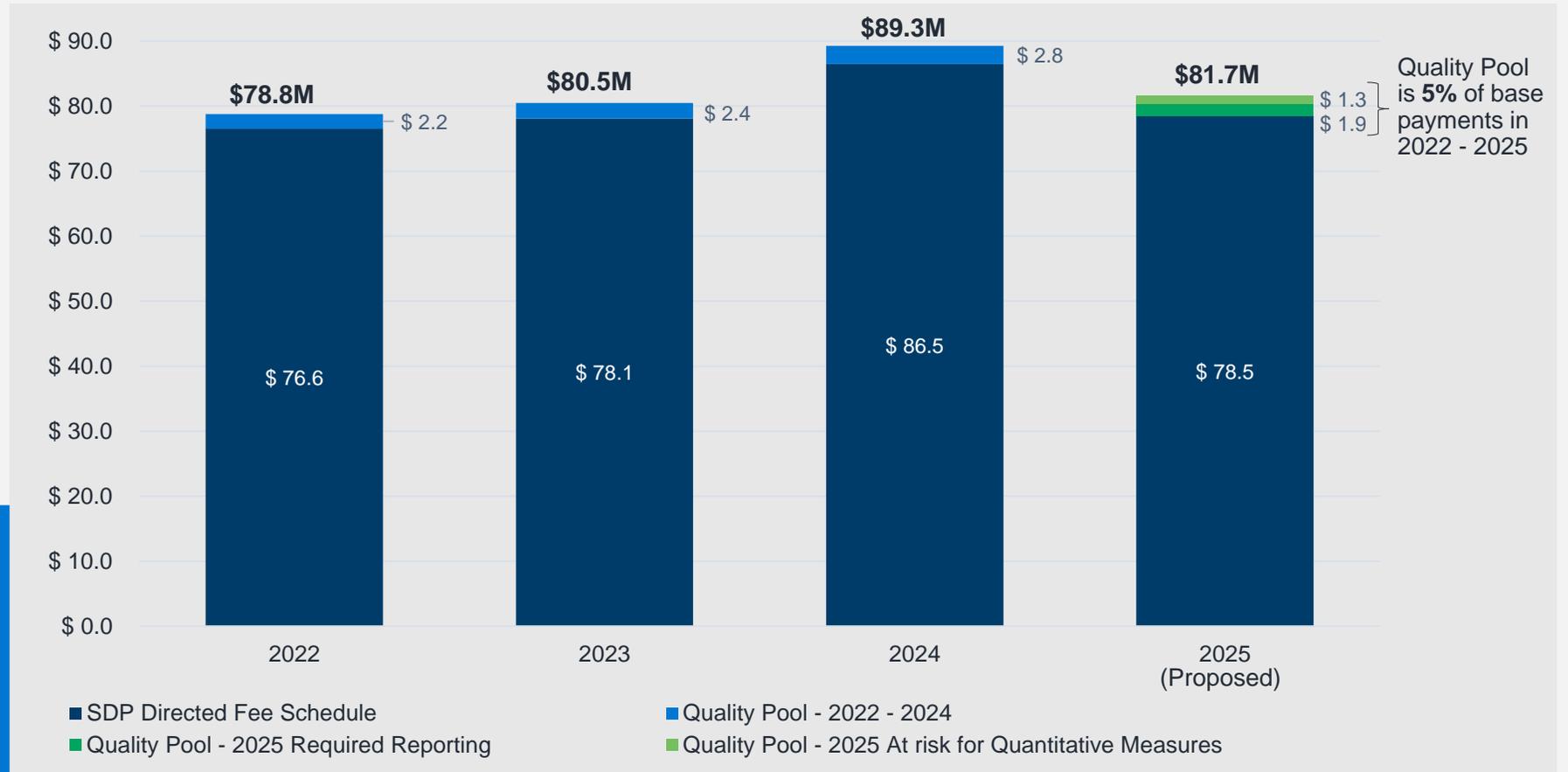
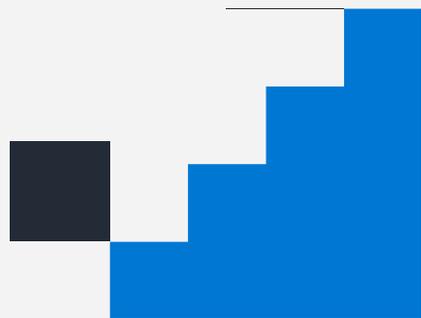
Funding Streams: HHSC Hospital Fixed and Valued-Based Payments

Funding streams over time

HHSC Directed Payments and P4P payments have remained generally consistent over time, peaking in 2024

MQD's proposed HHSC Directed Payment pool will decrease in 2025 due to lower utilization

*Future payment increases limited to average commercial rates (ACR) per CMS requirements



Source: MQD §438.6(c) state directed payment "preprint" applications each contract year, and HHSC hospital P4P models received from MQD.

Funding Streams: Components of Medicaid HGB

MQD’s priority is to increase value-based payments above CY 2025 levels for hospitals that participate in the AHEAD Medicaid HGB. Under AHEAD, fixed payments will increase while utilization-based payments decrease.

What level, if any, of utilization-based payments best supports hospital participation in the AHEAD Medicaid HGB?

Hospital Class	Medicaid Hospital Funding Stream	Estimated Current Payments (\$M)	Current Allocation %	Illustrative 2027 Allocation % Changes
Private	Utilization-based payments (SFY 2023 base payments) ¹	\$493.9	59.1%	Decrease
	Fixed payments (CY 2025 Access)	\$241.7	28.9%	Increase
	Valued-based payments (CY 2025 Quality)	\$100.3	12.0%	Increase
	Total	\$835.8	100.0%	
HHSC Public	Utilization-based payments (SFY 2023 base payments) ¹	\$55.5	40.5%	Decrease
	Fixed payments (CY 2025 uniform dollar increase)	\$78.5	57.2%	Increase
	Valued-based payments (CY 2025 Quality)	\$3.2	2.3%	Increase
	Total	\$137.2	100.0%	

Note: (1) Excludes Medicaid FFS members. SFY 2023 values are shown and are not trended forward.

2025 DSH payments are estimated to be \$22.9M. DSH payments are limited based on a cost ceiling, so may be reduced as the State moves towards an ACR ceiling.

Source: Milliman analysis for the State of Hawai'i Med-QUEST Division: CY 2025 Hospital State Directed Payment Analyses, Preprint Total Payment Rate Demonstration (dated 4/10/2025)

Key design principles: Prospective, Virtual, and Hybrid approaches

Prospective Medicaid HGB:

- Hospitals receive biweekly lumpsum payments inclusive of all legacy funding streams (without interim utilization-based payments)
- Hospitals continue to bill for \$0 paid clams so that utilization can be measured
- *Pro: Simplified approach with fully guaranteed funding stream, providing maximum incentive to reduce total cost of care*
- *Con: Providers at greater risk for increases in utilization and/or service intensity*

Virtual Medicaid HGB:

- Hospitals continue to bill and receive utilization-based payments (payment levels TBD); annual total payments would be reconciled to the target Medicaid HGB.
- *Pro: Initial cash flow is based on utilization and/or service intensity*
- *Con: More complex approach with providers*

Hybrid Medicaid HGB: Incorporates both Prospective HGB and utilization-based payments, but without reconciliation of utilization-based payments that occur under the Virtual HGB.

Key design principles: Prospective, Virtual, and Hybrid approaches (Cont.)

- The **Medicare FFS AHEAD HGB (prospective)** generally makes budget adjustments prospectively with approximately a two-year delay from the measurement period to the performance year for adjustments like the Market Shift Adjustment, Outlier Adjustment, Effectiveness Adjustment, Community Improvement Bonus, and the Total Cost of Care Adjustment.
- Under the **Maryland model (virtual without retrospective settlement)** budget adjustments, and adjustments for when revenue is above or below the budget target, are typically applied to the next budget cycle rather than processed as one-time settlements (this process also has a delay).
- **MQD would prefer to not do retrospective settlements**, consistent with the current Medicaid Access and Quality payments (and consistent with Medicare FFS AHEAD), subject to CMS approval of a hybrid budget methodology.
 - Similar to other HGB methodologies, funding adjustments can be applied to future performance years, including when the current performance year is over/under target.
 - MQD is considering a hybrid approach to maintain some utilization-based payments.

Which approach would best support hospital participation in the AHEAD Medicaid HGB?

Medicaid HGB Methodology: Utilization-based payment

Current Medicaid inpatient DRG methodology includes policy adjusters to enhance payment:

- Neonatal: 1.55 factor
- Well-newborn: 1.15 factor
- Maternity: 1.15 factor
- Psychiatric and alcohol and drug abuse: 1.15 factor
- Trauma services (based on DRG): 1.15 factor
- All other pediatric services (age 20 and under): 1.15 factor

Under a Medicaid HGB utilization will continue to need to be measured to capture resource use and support year to year budget adjustments (e.g., market shift)

- Inpatient: APR-DRG based system with required fee schedule policy adjusters
- Outpatient: Medicare-like methodology negotiated by MCOs and hospitals

Are there adjustments to current utilization-based payment methodologies to best support accurate measurement of resource use for the purposes of the Medicaid HGB?

Are there specific hospital services that should remain as utilization-based payments?

Key design principles: Considerations for Alignment of Value-Based / Quality Measures

- *What data infrastructure can be used to support quality improvement, population health, advance health equity, and limit cost growth across payers?*
- *What areas of VBP alignment are most important across payers? E.g., administrative, clinical, financial/value-based payment?*

Activities rewarded by Medicare FFS HGB (Medicare FFS population)

- Quality reporting and performance: Existing IQR/OQR and AHEAD's Critical Access Hospital Quality Adjustment (2%)
- Reducing potentially avoidable utilization:
 - Community Improvement Bonus (0.5%)
 - Effectiveness Adjustment (-0.5% initially, up to -2.0%)
- Limiting trends in Medicare FFS per capita cost for the hospital's service area: Total Cost of Care Performance Adjustment (+/- 2%):

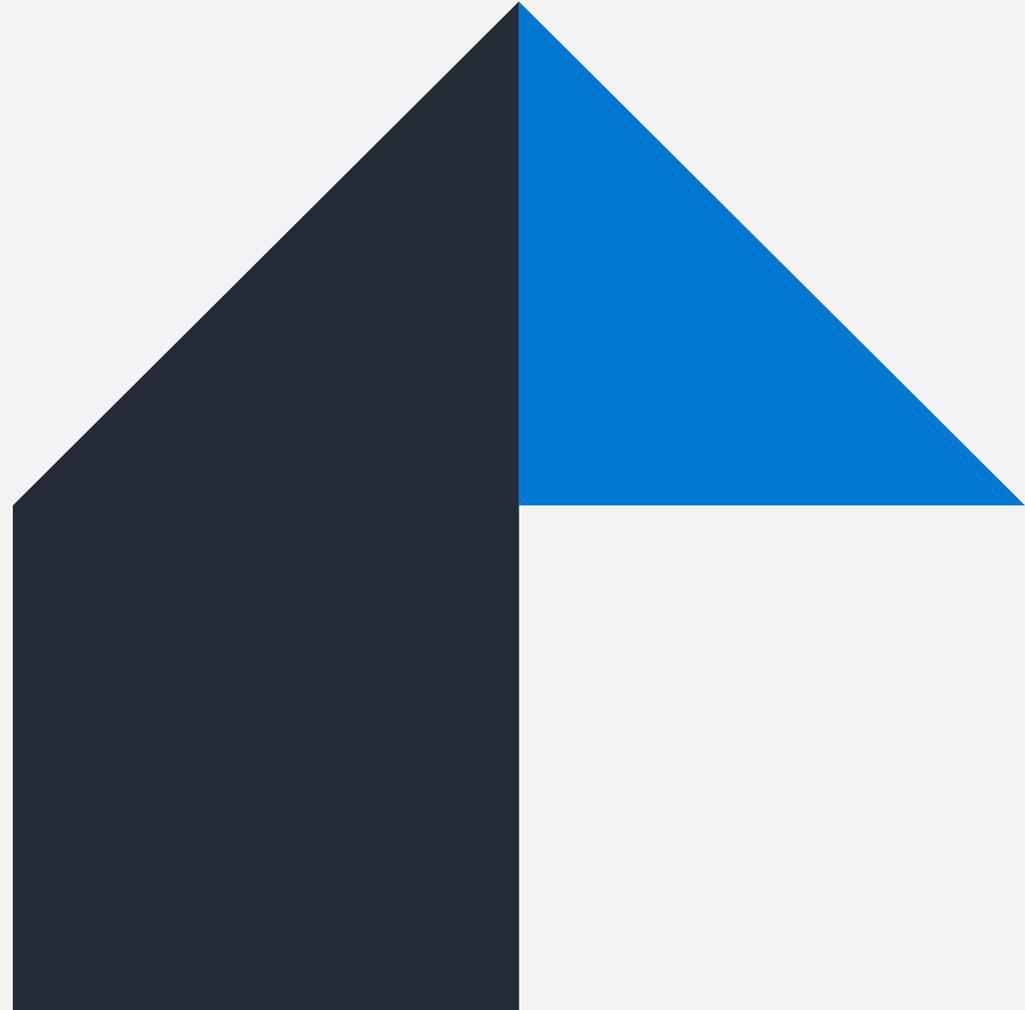
Source: Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology Version 3.0

Medicaid HGB Methodology: Required Adjustments

What should MQD consider in the budget adjustment process?

Required Adjustment	Medicaid Discussion	Medicare FFS HGB Example(s)
Inflation	Overall funding changes; Medicaid rate setting	Annual Payment Adjustment (APA)
Population growth, Demographic changes	Change in Medicaid population by age band, gender, and eligibility group for hospital's service area.	Demographic Adjustment (DA)
Medical and social risk	Must adjust for medical and social risk for <u>either</u> the beneficiaries the hospital serves or the attributed geographic region.	Demographic Adjustment (DA) and Social Risk Adjustment (SRA)
Other factors influencing the cost of care		Outlier Adjustment, Logistic Regression
Service line changes	Must account for changes in service line. Must be consistent with Medicare FFS HGB.	Service Line Adjustment (SLA)
Unplanned volume shifts	Market shifts within an island or ZIP code.	Market Shift Adjustment (MSA)
Included services or populations	Must include inpatient and outpatient hospital services. Must identify the Medicaid beneficiary groups to include and exclude.	Carve-outs for specific services (e.g., cancer drugs) and funding streams (e.g., organ acquisition)
Quality	Budget must be adjusted for hospital performance on quality measures. Must reflect attributed patient population and use disparities-sensitive quality measures.	Community Improvement Bonus, Effectiveness Adjustment (non-CAH), Total Cost of Care Performance Adjustment
Critical access hospitals (CAH)	The state may not reconcile Medicaid global budget payments to CAHs back to Medicaid costs.	CAH Quality Adjustment, CAH Payment Floor

AHEAD Participation Incentives and Coordination



Hospital Participation in the AHEAD HGB

Medicare FFS Upside: Includes the Transformation Incentive Adjustment (TIA), a 1% adjustment applied to Medicare FFS HGB after annual updates for PY1 and PY2 of the program, plus other adjustments many of which provide additional upside (see next slide).

- Maximum Upside PY1: 3%
- Maximum Upside PY2: 3%
- Maximum Upside PY3: 2% (Non-CAH), 4% (CAH)
- Maximum Upside PY4+: 4.5% (Non-CAH), 6.5% (CAH)

Medicaid Upside:

- Incorporate higher value-based payments (with quality metrics aligned with AHEAD), not to exceed ACR
- Decrease of Utilization payment components and increase to Fixed and Value-Based payment components to incentivize decreases in utilization

What level of expected revenue upside is required to make participating the Medicare FFS HGB attractive?

Source: Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology Version 3.0

Hospital Participation in the AHEAD HGB: Medicare FFS upside

Sources of upside (and downside) by performance year

HGB Adjustment Component	Direction	PY1 (2027)		PY2 (2028)		PY3 (2029)		PY4 (2030)		PY5 (2031)		PY6 (2032)		PY7 (2033)		PY8 (2034)	
		Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
Transformation Incentive Adjustment	Upside	1.0%	1.0%	1.0%	1.0%												
Social Risk Adjustment ¹	Upside	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%
TCoC Performance Adjustment ²	Bi-directional							0.0%	2.0%	-2.0%	2.0%	-2.0%	2.0%	-2.0%	2.0%	-2.0%	2.0%
Community Improvement Bonus	Upside							0.0%	0.5%	0.0%	0.5%	0.0%	0.5%	0.0%	0.5%	0.0%	0.5%
Effectiveness Adjustment (non-CAH)	Downside			0.0%	-0.5%	0.0%	-0.75%	0.0%	-1.0%	0.0%	-1.25%	0.0%	-1.5%	0.0%	-2.0%	0.0%	-2.0%
CAH Quality Adjustment ³	Upside					0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%
Effectiveness Adjustment (CAH)	Downside					0.0%	-0.5%	0.0%	-0.75%	0.0%	-1.0%	0.0%	-1.25%	0.0%	-1.5%	0.0%	-2.0%
CAH Payment Floor		<i>HGB payments for CAHs have a cost-based floor applied</i>															

Notes:

1: Social risk adjustment is based on Community Deprivation Index (CDI) and a combination of dual-eligibility and Part D Low Income Subsidy (LIS)

2: Total Cost of Care (TCoC) Performance Adjustment for non-CAH, acute care hospitals can drop up to - 2.0% in PY5- PY8.; For CAHs it can drop only PY6-PY8

3: For CAHs, from PY5-PY8 the 2% payments are split between reporting and pay-for-performance

Source: Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology Version 3.0

Coordination between Hospitals and Physician Groups

AHEAD participation requirements

1. Hospitals that participate in the Medicare FFS HGB also must participate in the Medicaid HGB.
2. Hospitals are expected to coordinate with physicians that utilize the hospital.
3. Primary care practices that are affiliated with a participant hospital are only eligible for Primary Care AHEAD if the hospital participates in the HGB.

What coordination should occur between hospitals and physician groups for:

- Transformation activities
- Managing the total cost of care

Are the care coordination incentives for hospitals and physician groups sufficient?

Additional Information



Medicaid Hospital Global Budget Approaches

Prospective payment: *Under this option, Participant Hospitals would no longer receive payments for fee-for-service claims and managed care plan rates as outlined in current fee schedules and contracts and/or provider participation agreements. Instead, Participant Hospitals will receive a fixed payment amount as calculated in the state's global budget methodology at regular, specified intervals (e.g., biweekly, monthly) over the course of the year. Following each performance year, the state completes a review process as outlined in their financial specifications to adjust future payments for performance, quality, market shifts, and other factors.*

Virtual global budget: *Under this option, states/MCOs continue to pay fee-for-service claims for care furnished to enrollees under current arrangements and conduct periodic reconciliation to global budget amounts (e.g., monthly, quarterly, annually). There would be a defined reconciliation process to true up the claims payments against the prospectively set global budgets.*

Consideration: Any retrospective settlements may require a recoupment of Federal matching dollars by CMS.

The next four slides discuss the detailed Medicaid Hospital Global Budget.

Source: AHEAD NOFO Final 11.15.2023, Pages 98, 99

Medicaid Hospital Global Budget requirements

Area	Requirements
Approach	<p>Prospective or virtual</p> <ul style="list-style-type: none"> • A prospective global budget payment is delivered to hospitals on a regular, periodic basis (e.g., biweekly, monthly), • A virtual budget uses current FFS/MCO payments to hospitals and reconciles payments to the global budget, or • A hybrid budget (<i>subject to CMS approval</i>) implements a Medicaid HGB while keeping some FFS/MCO utilization-based payments.
Start year	PY1 (can start later than Jan 1 to align with Medicaid rate setting)
Scope of services	Will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum.
Incentives / recruitment	The methodology considers incentives to recruit and retain hospitals early into the global budget methodology.

Source: AHEAD NOFO Final 11.15.2023, Page 100

Medicaid Hospital Global Budget requirements

Area	Requirements
Transparency	CMS encourages hospital global budget methodologies to be public to foster transparency and accountability.
Eligible hospitals	Minimum: short-term acute care hospitals and critical access hospitals. Can propose including additional types (e.g., children’s, psychiatric)
Start year	PY1 (can start later than Jan 1 to align with Medicaid rate setting)
Critical access hospitals (CAH)	The Medicaid methodology may include accommodations for CAH participation, however after the end of a PY, the state may not reconcile Medicaid global budget payments to CAHs back to Medicaid costs.
Eligible Hospital Services	Must include inpatient and outpatient hospital services. Service line inclusions/exclusions (e.g., the Service Line Adjustment) are generally expect to be consistent between Medicare FFS and Medicaid.
Baseline	CMS suggests using 2-3 years of historical data to calculate Medicaid hospital global budgets, weighting the more recent years more heavily

Source: AHEAD NOFO Final 11.15.2023, Pages 101

Medicaid Hospital Global Budget requirements

Area	Requirements
Adjustments	<ul style="list-style-type: none"> • Required: inflation, population growth, demographic changes, and other factors influencing the cost of care. • Hospital global budgets must be adjusted for both medical and social risk for either the beneficiaries the hospital serves or the attributed geographic region.
Market shift and service line changes	<ul style="list-style-type: none"> • Hospital global budgets must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization. • Process must be clearly defined and should be coordinated with Medicare FFS. • Timing should be coordinated with Medicaid rate setting.
Included Medicaid beneficiary groups	<p>SMA must identify the Medicaid beneficiary groups to include and exclude. Justification must be provided.</p>

Source: AHEAD NOFO Final 11.15.2023, Pages 101, 102

Medicaid Hospital Global Budget requirements

Area	Requirements
Quality	<ul style="list-style-type: none"> • Budget must be adjusted for hospital performance on quality measures. • Quality performance adjustments must be based on the quality outcomes of an attributed patient population. • CMS suggests relying on state-specific hospital reporting and hospital quality performance programs currently in place for the Medicaid programs. • For budget adjustments, must use disparities-sensitive quality measures aimed at improving health equity.
“Supplemental” Payments: UPL, UCC, IME, DSH, DSRIP	<p>CMS will establish guardrails and requirements for each type of supplemental payment and their inclusion in the Medicaid Global Budget methodology where relevant. State will work with CMS to finalize the details.</p>

Source: AHEAD NOFO Final 11.15.2023, Pages 101, 102

Hospital and physician group participation requirements

Medicaid HGB participation: Hospitals that participate in the Medicare HGB under the AHEAD Model are also required to participate in the Medicaid HGB. States participating in the AHEAD Model must offer HGBs to Eligible Hospitals via their state Medicaid agencies, as part of the Model's focus on multi-payer alignment (Source: AHEAD_CMS Medicare FFS HGB technical specifications 3.0_Pre-508, page 87).

A State Medicaid Agency may propose including additional types of hospitals (e.g., psychiatric hospitals, or children's hospitals).
(Source: AHEAD NOFO Final 11.15.2023, Page 101)

Hospital engagement with physicians: Hospitals must actively engage with professional services providers who furnish care to hospital patients. This includes primary care physicians and other healthcare professionals providing services within the hospital setting. The goal is to ensure a seamless integration of care delivery across different providers to improve patient outcomes and reduce unnecessary utilization (Source: AHEAD_CMS Medicare FFS HGB technical specifications 3.0_Pre-508, Page 7).

Primary Care AHEAD and AHEAD HGB: For physician practices affiliated with a hospital, the primary care AHEAD participation requirements are as follows:

1. Hospital Participation in AHEAD: The affiliated hospital must be participating in the AHEAD hospital global budgets for that performance year (PY). This ensures alignment of incentives across the system and robust recruitment of both hospitals and practices.
2. Medicaid Primary Care APM Participation: The primary care practice must also participate in a state-based Medicaid patient-centered medical home (PCMH) or other state-based Medicaid advanced primary care program ("Medicaid Primary Care APM") for the same PY. This alignment is essential for the practice to be eligible for Primary Care AHEAD.

These requirements ensure that physician practices affiliated with hospitals are integrated into the broader goals of the AHEAD Model, aligning with both hospital global budgets and state Medicaid initiatives to enhance primary care services and improve health outcomes. (Source: AHEAD NOFO Final 11.15.2023, Page 24)

Limitations

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The models rely on data and information as input to the models. We have relied upon certain data and information provided by MQD for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete.

Milliman has developed certain models to estimate the values included in this analysis. The intent of the model is to compare Hawai'i Medicaid managed care payments to estimated payments under average commercial rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

Milliman is not advocating for, recommending, or endorsing any particular program design. Implementation of any state directed payments subject to approval by CMS through a preprint. Implementation of an AHEAD Medicaid hospital global budget is subject to approval by CMS. All final decisions regarding the design, modeling methodologies, parameters, and assumptions, and other aspects of the state directed payment are the responsibility of Med-QUEST.

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