

AHEAD Medicare FFS Hospital Global Budget Summary of Changes from v2.0 to v3.0

Prepared for the Hawai'i Med-QUEST Division (MQD) for the purpose of understanding the high-level impact of the recent changes to the AHEAD Medicare FFS Hospital Global Budget (HGB). This document is intended for discussion purposes only.

In preparing our analysis, we relied upon the accuracy of data and information from CMS. We have not audited this information, although we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

As described by CMS in the “AHEAD Model, Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology, Version 3.0” (dated 4/1/2025) version 3.0 of the financial specifications contains updates intended to improve the predictability of HGB payments and reduce risk for participant hospitals. Outlined below are the twelve (12) key changes highlighted by CMS in version 3.0 from version 2.0. Our commentary is below CMS’s description of each change with discussion of the high-level impact in brackets and color coded as follows:

- **[Increase: discuss detail]**
- **[Decrease: discuss detail]**
- **[Varies: discuss detail]**

1. **Baseline Calculation:** To better account for the time needed to calculate HGBs, the baseline calculation has been clarified to use four months of Claims Runout rather than six months. Additionally, the baseline amounts are optimized using logistic regression to be comparable to what Medicare FFS payments to the Participant Hospital would have been in the absence of HGB payments during the first PY.

Baseline runout period decrease from 6 months to 4 months. **[Varies: CMS will use fewer months of claims runout and a higher completion factor, which may or may not be favorable to specific hospitals depending on claim payment speed. In general, we expect the impact to be small, since a calendar year of Medicare hospital claims is typically 99% complete after four months¹.]**

Logistic regression baseline adjustment to correct for over or under predicting hospital costs at the state (or sub-state region) level. For PY1 only (PY2+ will be based on PY1 trended forward) a baseline adjustment factor (BAF) will be applied. **[Varies: Depends on the hospital-specific adjustment factor and state-level scaling factor.]**

¹ Based on our experience working with Medicare FFS claims data. The Medicare Shared Savings Program (MSSP) uses three months’ runout and a completion adjustment of 1.013.

2. **Disproportionate Share Hospital (DSH), Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Payments:** To ensure Participant Hospitals are compensated for costs related to DSH, IME, DGME, and N&AH for Medicare Advantage beneficiaries, CMS now applies a floor to these payments so that they are not lower than what would have been paid under Medicare rules applicable during each PY, including settlements performed by the Medicare Administrative Contractor (MAC).

[Affects non-CAH hospitals only. Increase: because this is a payment floor, this change will increase or not affect the HGB for hospitals receiving these Medicare FFS payments. Exhibit 1 shows the historical level of DSH and IME by hospital relative to all Medicare FFS inpatient payments.]

3. **Annual Payment Adjustment (APA):** The APA is now separated into two components so that the uncompensated care payment adjustment, which is unrelated to case mix is no longer adjusted by the Participant Hospital's case mix. This allows for better parity with Medicare FFS.

Below is the inpatient APA formula by for v2.0 and v3.0 of the HGB specification:

v2.0

$$(Eq. 2) \text{ AHEAD Case Adjusted Rate (CAR)} = \frac{\frac{\text{Estimated Medicare Payments}}{\text{Case Mix Index}}}{\text{Total Number Medicare Discharges}}$$

v3.0

$$(Eq. 2) \text{ AHEAD Case Adjusted Rate (CAR)} = \frac{\frac{(\text{Est Medicare Payments} + \text{Policy \& Qual Adj})}{\text{Case Mix Index}}}{\text{Medicare Discharges}} + \frac{\text{UCC Oper. Adj}}{\text{Medicare Discharges}}$$

[Affects non-CAH hospitals only. Varies: Because the Uncompensated Care (UCC) is a per discharge payment and is not DRG-weight adjusted, separating the UCC from the other DRG weight adjusted Medicare IPPS payment components will better capture Medicare inpatient unit price trends (i.e., improve the inpatient APA).]

4. **Outlier Adjustment:** The Outlier Adjustment is a new adjustment that uses actual outlier payment amounts from No-Pay Claims to calculate the change in the share of a Participant Hospital's outlier payments year-to-year. Previously, adjustment for outliers was included in the APA using estimated amounts sourced from the Inpatient Prospective Payment System (IPPS) Impact File.

[Affects non-CAH hospitals only. Varies: Hospital-specific impact will depend on the actual outlier payments compared to the estimated outlier payments under v2.0.

Inpatient outlier amounts can vary by significantly hospital (see Exhibit 1 below) and were approximately 4.4% of total IPPS payments in FY2023², and outpatient outlier amounts are typically less than 1% of the total Medicare allowed for outpatient.

This change will also increase the importance of hospitals submitting accurate “no-pay claims”.]

- 5. Market Shift Adjustment (MSA):** The MSA is adjusted to better account for shifts between hospital markets. First, the geographic area is now based on zip code instead of county. Zip-codes are identified by the contribution to the Participant Hospital’s total Medicare FFS Payments or the Participant Hospital’s rank within the zip based on Medicare FFS payments relative to other hospitals that also serve the zip. This results in smaller geographic areas that better reflect the market area served by a Participant Hospital. Second, the MSA is now calculated using the Participant Hospital’s year-over-year change in the share of FFS payments and case weights within its geographic market area. To protect small hospitals from high year-over-year variation, CMS applied a floor limiting reductions in HGB payments from the MSA for Participant Hospitals defined as small hospitals in the methodology. Finally, the MSA no longer includes the lesser of rule or the Unplanned Volume Adjustment. These changes combine to provide higher face validity by better aligning the MSA with changes in volume.

An MSA small hospital³ floor will be implemented. The floor will be set at 0%, ensuring no eligible hospital receives a downward adjustment from the MSA. Eligible small providers are any hospitals whose Year 2 FFS payments represent 2% or less of the AHEAD state’s or sub-state region’s total Year 2 FFS payments. [Floor affects small hospitals only. Increase: Small hospitals can no longer have a negative MSA, so payments can only increase relative to v2.0 methodology. Further, the Unplanned Volume Adjustment could be positive or negative under v2.0 so its removal shouldn’t bias payments in either direction.]

- 6. Average Sales Price (ASP)/Average Wholesale Price (AWP) Drugs Weighting:** For purposes of including ASP/AWP drugs in the MSA, CMS now creates a scale factor that converts ASP/AWP prices to Ambulatory Payment Classifications (APC) weights. The scale factor represents the average payment made by CMS in dollars per unit of APC weight for outpatient services paid via APC.

² Based MedPAR data for federal fiscal year 2023 for all Hawai’i hospitals.

³ Under the AHEAD Model, a small hospital is defined as a hospital that accounts for less than two percent of an AHEAD state’s or sub-state region’s total Medicare payments. This threshold is assessed and applied annually to each performance year (AHEAD_CMS Medicare FFS HGB technical specifications 3.0_Pre-508, Page 43).

Calculates an “APC weight” for outpatient drugs paid based on ASP⁴ or AWP⁵ and includes the drugs in the Market Shift Adjustment (MSA) calculations. [Varies: incorporating drugs into MSA calculation, this could increase or decrease a hospital’s global budget.]

- 7. Social Risk Adjustment (SRA):** The SRA now utilizes the CMS-developed Community Deprivation Index (CDI) in lieu of the Area Deprivation Index (ADI) to align more closely to other validated health measures. The scaling for the SRA is now based on the percentile of the Participant Hospital’s Social Risk Score (SRS) relative to hospitals within each AHEAD state or sub-state region rather than the state median. This allows for a less concentrated distribution of SRA rewards. In addition, the CDI value used to calculate a hospital’s SRS cannot be lower than the CDI used in the SRA for Performance Year 1 (PY1), to avoid penalizing hospitals that positively influence social health needs of local areas.

Refinements to the SRA calculation. [Varies: HGB payment will depend on both the difference between ADI and CDI, and a hospital’s Social Risk Score (SRS) relative to other hospitals in the AHEAD state or sub-state region (instead of relative to state median SRS). The implementation of a floor for the CDI (the CDI of a hospital that participate in PY1) will increase the impact of the SRA on its own (not taking into account the impact of changing between ADI and CDI).]

- 8. Total Cost of Care (TCOC) Adjustment:** The TCOC Adjustment has been revised to use risk corridors and a trend factor that better aligns with statewide TCOC targets. Instead of using the case-matched trend described in Version 2.0, risk adjusted attributed Per Beneficiary Per Month (PBPM) TCOC for each Participant Hospital is trended forward using the same annual growth factor as used in AHEAD State TCOC calculations to set the Participant Hospital’s Target PBPM TCOC. A performance corridor of +/- two percent is then applied to protect providers that have small changes in their TCOC from natural fluctuations and only rewards or penalizes providers that have outperformed or underperformed their target by a meaningful amount.

[Varies: The impact of these updates to the TCOC adjustment will vary by hospital, but is expected to dampen the effect of the TCOC adjustment on the HGBs across the state.]

- 9. Effectiveness Adjustment:** The New York University Emergency Department measure is replaced with NCQA’s Emergency Department Utilization measure. The Low Value Care measure is also removed. The effectiveness adjustment was also updated to adjust Participant Hospital’s overall PAU percent by their SRS.

⁴ Average Sales Price (ASP)

⁵ Average Wholesale Price (AWP)

[Varies: Changing to NCQA’s Emergency Department Utilization will affect hospital’s Effectiveness Adjustment (EA). The EA begins in PY2 and is a maximum downward adjustment of 0.5%.]

10. Community Improvement Bonus (CIB): The CIB is revised to replace the PQI-92 measure with PQI-90 and to update the readmissions measure to use the Hybrid eHWR measure. The CIB is also modified to calculate performance improvement for all beneficiaries in each measure as opposed to only the high acuity cohort. The high acuity cohort was replaced due to small data sizes that resulted in high variability in HGB calculations. The targets are also revised for each measure and performance year. Finally, the CIB now multiplies the improvement score for each measure by the Participant Hospital’s SRS percentile.

[Varies: Using all beneficiaries to calculate performance measures should dampen year-over-year changes in performance improvement.]

11. Critical Access Hospital (CAH) Quality Incentive Program: The Safe Use of Opioids measure was moved from the Quality and Utilization domain to the Patient Safety Domain because it more closely aligns with the other Patient Safety measures. The pay-for-reporting threshold was increased from at least one measure in two domains to at least one measure in all three domains.

[Impacts CAHs only. Varies: Increases quality reporting requirements for CAHs.]

12. Site Specific HGBs: Hospitals may elect to participate in HGBs at either the CMS Certification Number (CCN) or Organizational National Provider Identifier (ONPI) level. If a hospital participates at the ONPI level, the baseline and all other adjustments except the Annual Payment Adjustment (APA) are calculated specific to the ONPI. This allows hospitals within systems to gain experience with HGBs.

Baseline budget and overall participation keyed to an ONPI instead of CCN. [Varies: Impact is hospital specific and depends on how providers bill under ONPIs. Below is an example of the ONPIs associated with The Queen’s Medical Center (CCN 120001). If hospitals use this new flexibility to participate under select ONPIs, it may hinder the State’s ability to meet AHEAD’s participation requirements.]

| ONPI | Description | Primary Taxonomy |
|------------|--|--|
| 1669871844 | SATOMI FUJII MD LLC | 282N00000X - General Acute Care Hospital |
| 1861637860 | THE QUEEN'S MEDICAL CENTER | 282N00000X - General Acute Care Hospital |
| 1184612764 | THE QUEENS MEDICAL CENTER | 282N00000X - General Acute Care Hospital |
| 1518741487 | THE QUEEN'S MEDICAL CENTER - OUTPATIENT PHARMACY | 3336C0002X - Pharmacy - Clinic Pharmacy |
| 1811369408 | THE QUEENS MEDICAL CENTER | 282N00000X - General Acute Care Hospital |
| 1881931780 | RYAN RAO, LLC | 282N00000X - General Acute Care Hospital |

| | | |
|------------|---------------------------|--|
| 1013143940 | QUEENS MEDICAL CENTER | 283Q00000X - Psychiatric Hospital |
| 1225384654 | THE QUEENS MEDICAL CENTER | 3336I0012X - Pharmacy - Institutional Pharmacy |
| 1134414923 | GRACE LIU, MD, LLC | 282N00000X - General Acute Care Hospital |
| 1275789216 | THE QUEENS MEDICAL CENTER | 261QD00000X - Clinic/Center - Dental |
| 1487693586 | RYAN RAO, LLC | 282N00000X - General Acute Care Hospital |

]

Exhibit 1: FY 2023 (10/2022-9/2023) Medicare FFS Inpatient Payments by Hospital (source: MedPAR; does not reflect final settlements with CMS)

| <i>CCN</i> | <i>Name</i> | <i>Total Allowed</i> | <i>Outlier Amount</i> | <i>DSH</i> | <i>IME</i> | <i>Uncompensated Care Payment</i> |
|------------|---|----------------------|-----------------------|------------|------------|-----------------------------------|
| 120002 | Maui Memorial Medical Center | \$36,059,835 | 3.6% | 1.5% | 0.0% | 3.8% |
| 121303 | Molokai General Hospital | \$505,482 | 0.0% | 0.0% | 0.0% | 0.0% |
| 121308 | Kula Hospital | \$15,044 | 0.0% | 0.0% | 0.0% | 0.0% |
| 121305 | Lanai Community Hospital | \$2,324 | 0.0% | 0.0% | 0.0% | 0.0% |
| 120005 | Hilo Medical Center | \$33,160,091 | 6.1% | 1.8% | 2.4% | 0.3% |
| 120014 | Wilcox Medical Center | \$14,823,464 | 1.3% | 1.8% | 0.0% | 3.1% |
| 120019 | Kona Community Hospital | \$12,237,001 | 12.3% | 1.3% | 0.0% | 3.0% |
| 120028 | North Hawaii Community Hospital, Inc | \$7,037,885 | 0.2% | 1.9% | 0.0% | 4.6% |
| 121300 | Kauai Veterans Memorial Hospital | \$1,920,847 | 0.0% | 0.0% | 0.0% | 0.0% |
| 121302 | Kohala Hospital | \$22,431 | 0.0% | 0.0% | 0.0% | 0.0% |
| 120001 | The Queen's Medical Center | \$136,249,394 | 4.6% | 3.9% | 5.9% | 2.3% |
| 120022 | Straub Medical Center | \$46,853,529 | 5.6% | 2.5% | 2.2% | 1.9% |
| 120026 | Pali Momi Medical Center | \$31,598,172 | 1.6% | 2.1% | 4.1% | 1.4% |
| 120007 | Kuakini Medical Center | \$17,697,695 | 3.4% | 1.7% | 3.9% | 0.7% |
| 120006 | Adventist Health Castle | \$22,669,594 | 1.3% | 4.9% | 0.0% | 1.0% |
| 123025 | Rehabilitation Hospital of The Pacific | \$10,121,829 | 0.8% | 6.7% | 0.0% | 0.0% |
| 120011 | Kaiser Foundation Hospital | \$8,961,195 | 13.8% | 1.2% | 1.0% | 6.4% |
| 120004 | Wahiawa General Hospital | \$2,745,112 | 1.0% | 2.1% | 0.8% | 4.5% |
| 123300 | Kapiolani Medical Center for Women & Children | \$419,228 | 0.0% | 0.0% | 0.0% | 0.0% |
| 121304 | Kahuku Medical Center | \$17,880 | 0.0% | 0.0% | 0.0% | 0.0% |