

Hawai`i Medicaid Hospital Global Budget Strawman Discussion

For discussion purposes only

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April Hospital Global Budget (HGB) Discussion Recap

Area	Discussion
Hybrid HGB approach	Under the hybrid methodology, utilization-based payments to hospitals will continue but at reduced levels (offset by increases to fixed payments and quality). The Medicaid HGB will be determined on a prospective basis.
Funding pools	Decrease utilization pool, with increases to the fixed and quality pools as the basis for the Medicaid HGB (demonstrated on next two slides).
Hospital eligibility	Acute care hospitals and CAHs are eligible for AHEAD. Children's hospitals are not eligible for Medicare FFS AHEAD, but may be eligible for Medicaid AHEAD HGB.
Hospital risk mitigation	<ul style="list-style-type: none"> • Phase-in transition from utilization-based to "fixed" revenue streams • Corridors around hospital global budget • Outlier adjustment
Rewarding quality	The HGB incorporates the Medicaid Hospital Quality P4P program and is tied to Hawai'i's Med-QUEST Quality Strategy. In general, the quality adjusted proportion of hospital Medicaid revenue is expected to increase.
Medicaid fee schedules	Under the 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).

Funding Streams: Components of Medicaid HGB (Review)

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.

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%	

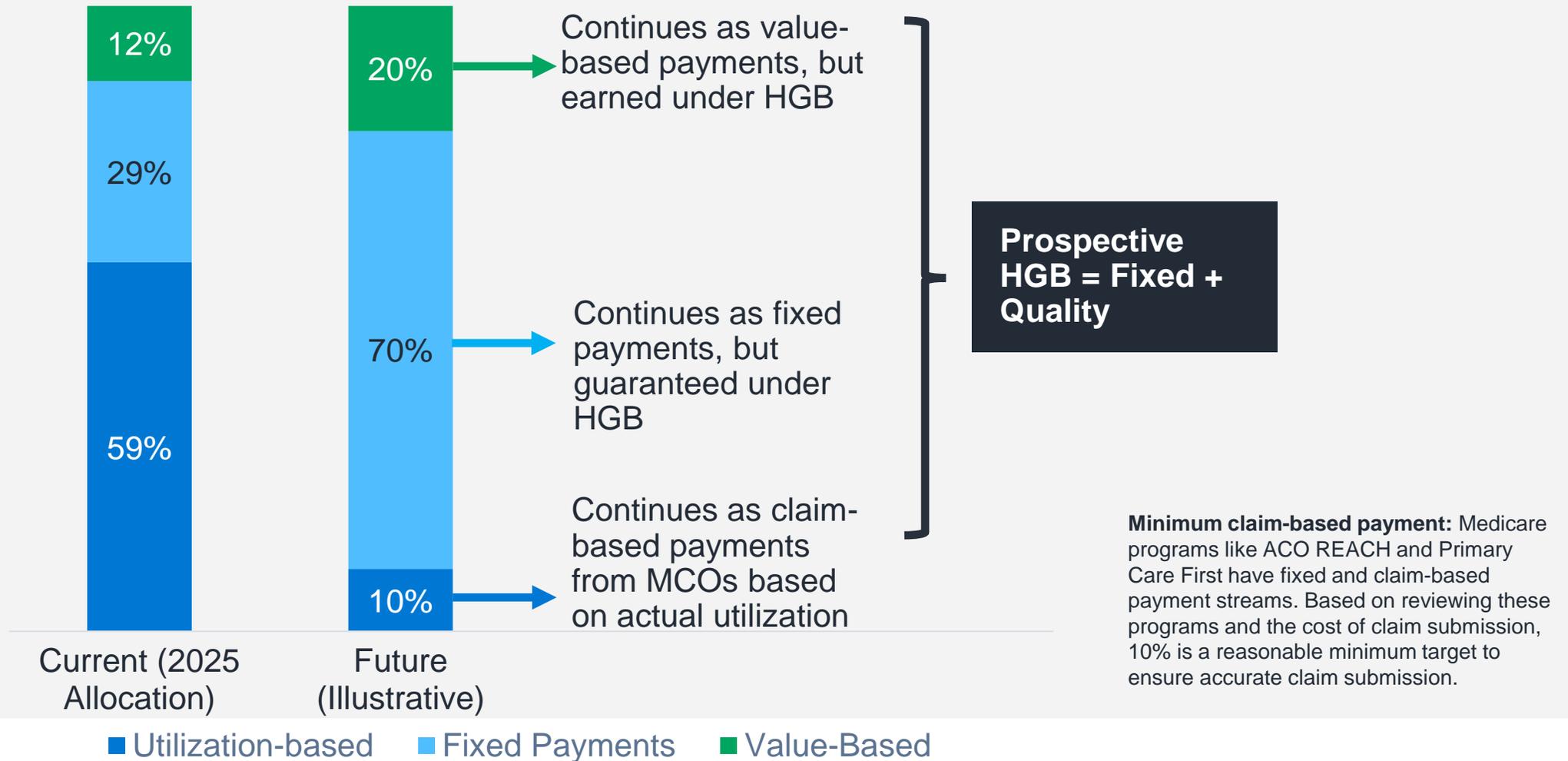
Note: (1) Excludes Medicaid FFS members. SFY 2023 values are shown and are not trended forward.

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)

Medicaid Hospital Global Budget Funding Components Illustration

Example for Private Hospitals – *Future funding portions are illustrative*



Phase-in of HGB / phase-out of utilization-based payments

Example for Private Hospitals

Scenario 1: Phase-out utilization-based payments by PY5

HGB Component	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Utilization-based payments	50%	40%	30%	20%	10%	10%	10%	10%
HGB (Fixed + Quality)	50%	60%	70%	80%	90%	90%	90%	90%

Scenario 2: Phase-out utilization-based payments by PY3

HGB Component	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Utilization-based payments	43%	27%	10%	10%	10%	10%	10%	10%
HGB (Fixed + Quality)	57%	73%	90%	90%	90%	90%	90%	90%

Utilization reduction illustration

Illustrative of impact of reducing utilization under existing payment model versus HGB (amounts in \$M)

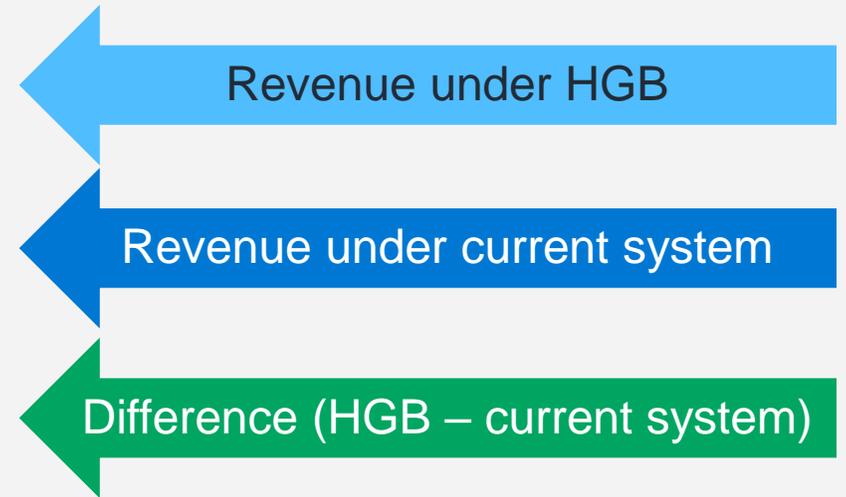
HGB baseline illustration: Revenue increases by 3% per year

	PY1 2027	PY2 2028	PY3 2029	PY4 2030	PY5 2031	PY6 2032	PY7 2033	PY8 2034
Utilization-based payments	\$145.7	\$92.4	\$35.7	\$36.7	\$37.9	\$39.0	\$40.2	\$41.4
Hospital global budget	\$190.6	\$254.0	\$321.1	\$330.7	\$340.7	\$350.9	\$361.4	\$372.2
Total	\$336.3	\$346.4	\$356.8	\$367.5	\$378.5	\$389.9	\$401.6	\$413.6



Illustrative scenario: PY4 utilization is 10% lower than expected

Utilization-based payments	\$145.7	\$92.4	\$35.7	\$33.1
Hospital global budget	\$190.6	\$254.0	\$321.1	\$330.7
Total	\$336.3	\$346.4	\$356.8	\$363.8
Utilization-based payments	\$195.7	\$201.6	\$207.6	\$192.5
Access + quality	\$140.6	\$144.8	\$149.2	\$153.6
Total	\$336.3	\$346.4	\$356.8	\$346.1
Utilization-based payments	(\$50.0)	(\$109.2)	(\$171.9)	(\$159.4)
HGB / Access + Quality	\$50.0	\$109.2	\$171.9	\$177.1
Total	\$0.0	\$0.0	\$0.0	\$17.7



Notes:

- 1) Baseline assumes 3% annual payment growth under HGB. E.g., due to population growth, payment rate increases, or other factors.
- 2) In this illustration, utilization is 10% lower than expect (e.g., drops by approximately 7% from PY3 to PY4).

Medicare FFS HGB vs. Medicaid Hospital Quality P4P Program Design

	Quality in Medicare FFS HGB	Medicaid Hospital Quality P4P	
		Current State (2025)	Future State
Methodology for assigning dollars to quality	Percent adjustment to a hospitals budget	Funding pool calculated as 20% of base payments for private hospitals and 5% of base payments for HHSC.	May change
Non-federal share	NA	Hospital sustainability fee for private hospitals	May change
Infrastructure payments vs. outcome-based payments	Structure payments PY1 & PY2 P4R for Rurals Hospitals only	40% at risk quantitative measures 60% required reporting	≥ 40% at risk quantitative measures ≤ 60% required reporting
Payment timing	Through prospective payment	Periodic lump sum payments reconciled to achievement after measurement period if needed	May change
Unearned funds	Unearned dollars are forfeited	Unearned dollars are redistributed to all hospitals based on achievement	May change

Source: AHEAD_CMS Medicare FFS HGB technical specifications 3.0; [QI-2512 FFS 25-06 Hospital Quality Pay for Performance Guidance for Measurement Year 2025 \(part 1\) - signed.pdf](#)

Service Line Adjustment and Market Shift Adjustment

CMS Requirements

- Hospital global budgets must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization.
- Must clearly define this process for the Medicaid global budget, including identifying these or other circumstances under which this process would occur.
- Consider how the AHEAD Medicare FFS global budgets account for market shift and service line changes.
- Coordinate timing with Medicaid rate changes as they relate to AHEAD Medicaid global budget implementation and market shifts and service line changes.

Service Line Adjustment

Purpose	Adjust prospective HGBs to account for anticipated revenue changes from pre-planned service line changes, including additions, eliminations, expansions, or contractions
Medicare FFS approach	<ul style="list-style-type: none">• Participant Hospital must notify CMS. DRGs, HCPCS, or revenue codes affected are provided to CMS for analysis. Approved prospective adjustment is applied to future budgets, with reconciliation adjustments applied to future periods.• Hospitals retain 50% (100% for CAHs) of revenue associated with eliminated services to invest in population health activities.• For service additions, reconciliations are performed for first two Performance Years.
Potential Medicaid approach	Mirror the Medicare FFS approach, but potentially adjust the percent of revenue retained for service line reductions.

Market Shift Adjustment (MSA)

<p>Purpose</p>	<p>Account for upward and downward changes in revenue when patient volume and complexity realigns or shifts between Eligible Hospitals within a hospital market area.</p>
<p>Medicare FFS approach</p>	<ul style="list-style-type: none"> • Based on hospital-specific market area, defined by zip codes where the hospital has significant market share. • MSA is based on hospital’s change in market share and is applied prospectively. • MSA is calculated separately for inpatient and outpatient services. • Hospitals that gain market share receive a positive MSA, while losses in market share can result in a negative MSA. • \$0 MSA floor for small (<2% market share) hospitals. • The MSA is dampened by an 80% factor to reflect incremental costs.
<p>Potential Medicaid approach</p>	<ul style="list-style-type: none"> • Modify Medicare FFS approach by using an island-based hospital service area. Honolulu hospitals have a statewide service area (i.e., are affected by market shifts for all islands). • Implement floors for small hospitals and hospitals outside of Honolulu. • Add provisions for extreme and uncontrollable circumstance.

MSA: Island of Hawai`i Medicaid Inpatient Illustration

Hospital	2022 IP for Hawai`i Residents (\$M) [1]	2023 IP for Hawai`i Residents (\$M) [1]	IP Shift Percentage	MSA IP for Island of Hawai`i (\$M)	MSA IP after Floor [2] (\$M)
Hilo Medical Center	\$15.1	\$12.5	-0.8%	\$ (0.3)	\$ 0
Kapiolani Medical Center	\$14.4	\$12.2	<0.1%	<\$ 0.1	\$ 0
Kona Comm. Hospital	\$6.2	\$4.3	-2.2%	\$ (0.8)	\$ 0
North Hawaii Comm. Hospital	\$2.9	\$4.3	4.1%	\$ 1.6	\$ 1.6
The Queen's Medical Center	\$12.4	\$9.3	-2.8%	\$ (1.0)	\$ (1.0)
All Other	\$2.3	\$2.6	1.6%	\$ 0.6	\$ 0.6
Market Area Included Total	\$53.5	\$45.2		\$ 0	\$ 1.2

For this Island of Hawai`i illustration, North Hawaii Community Hospital receives the largest positive inpatient MSA adjustment since it saw the largest relative increase in the use of its inpatient services by the island residents from 2022 to 2023.

[1] This illustration uses inpatient utilization-based payments only and does not include other funding sources. The actual MSA adjustment would affect all components of the HGB (e.g., the fixed and quality pools).

[2] \$0 floor applied to island hospitals.

MSA: Island of Hawai`i Medicaid Outpatient Illustration

Hospital	2022 OP for Hawai`i Residents (\$M) [1]	2023 OP for Hawai`i Residents (\$M) [1]	OP Shift Percentage	MSA OP for Island of Hawai`i (\$M)	MSA OP after Floor [2] (\$M)
Hilo Medical Center	\$ 14.1	\$ 18.3	4.1%	\$ 1.3	\$ 1.3
Kapiolani Medical Center	\$ 1.8	\$ 1.6	-1.2%	\$ (0.4)	\$ (0.4)
Kona Comm. Hospital	\$ 6.5	\$ 7.1	-1.5%	\$ (0.5)	\$ 0
North Hawaii Comm. Hospital	\$ 4.5	\$ 4.9	-0.8%	\$ (0.3)	\$ 0
The Queen's Medical Center	\$ 2.1	\$ 2.4	<0.1%	<\$ 0.1	\$ 0
All Other	\$ 3.3	\$ 3.7	-0.6%	\$ (0.2)	\$ 0.1
Market Area Included Total	\$ 32.3	\$ 38.1		\$0	\$ 1.0

For this Island of Hawai`i illustration, Hilo Medical Center receives the largest positive outpatient MSA adjustment since it saw the largest relative increase in the use of its outpatient services by the island residents from 2022 to 2023.

[1] This illustration uses inpatient utilization-based payments only and does not include other funding sources. The actual MSA adjustment would affect all components of the HGB (e.g., the fixed and quality pools would be included in the "Dollars Available to Shift").

[2] \$0 floor applied to island hospitals.

Market Shift Adjustment (MSA) Recap

Purpose: Account for upward and downward changes in revenue when patient volume and complexity realigns or shifts between Eligible Hospitals within a hospital market area.

Approach Component	Medicare FFS	Medicaid (Proposed)	Medicaid Discussion
Hospital market	Zip codes that contribute significant revenue to hospital	Island (and state for large hospitals)	Apply floors for small hospitals and hospitals outside of Honolulu
Volume Measurement	50/50 weighted measure of (i) “hospital payments” and (ii) DRG weights and OP service weights	Changes in “utilization-based payments” (requires both IP and OP service weights)	Requires a standard set of outpatient weights (in addition to existing inpatient APR-DRG weights)
Calculation Approach	Hospital-level change in share of volume and payments for the hospital market	Hospital-level change in share of market area level	Propose using the 80% dampening factor to mirror Medicare FFS. MSA will apply to all HGB components.

Note: “Utilization-based payments” indicates payments under fee-for-service payment schedules. These amounts would be used to measure Medicaid market share for the MSA calculations.



Appendix

Medicare FFS HGB Quality Adjustments – Acute Care Hospitals

Adjustment Category	Description	PY1 2027	PY2 2028	PY3 2029	PY4 2030	PY5 2031	PY6 2032	PY7 2033	PY8 2034
Transformation Incentive Adjustment	Additional payments to invest in enhanced care coordination and transformation	▲ 1%	▲ 1%						
Total Magnitude of Infrastructure/P4R Payments		1%	1%	0%	0%	0%	0%	0%	0%

Performance Based Adjustments

Adjustment Category	Description	PY1 2027	PY2 2028	PY3 2029	PY4 2030	PY5 2031	PY6 2032	PY7 2033	PY8 2034
Effectiveness Adjustment	Downside risk based on Potentially Avoidable Utilization (Readmissions, Avoidable Admissions PQI 90 and ED Visits)		▼ 0.5%	▼ 0.75%	▼ 1%	▼ 1.25%	▼ 1.5%	▼ 2%	▼ 2%
Total Cost of Care Performance Adjustment	Two-sided risk based on TCOC of beneficiaries residing in hospital market area				▲ 2%	▼ 2% - ▲ 2%	▼ 2% - ▲ 2%	▼ 2% - ▲ 2%	▼ 2% - ▲ 2%
Community Improvement Bonus	Upside risk based on hospital performance on disparity sensitive measures (Readmissions and Avoidable Admissions PQI 90, adjusted for social risk)				▲ 0.5%	▲ 0.5%	▲ 0.5%	▲ 0.5%	▲ 0.5%
Total Magnitude of Performance Based Adjustments		0%	0.50%	0.75%	3.5%	5.75%	6.0%	6.5%	6.5%

Note: Medicare FFS HGB for Acute Care Hospitals **also receive** an adjustment for existing CMS national quality programs incorporated into FFS (Inpatient Quality Reporting, Outpatient Quality Reporting, Hospital Readmissions Reduction Program, Hospital-Acquired Condition Reduction Program, and Hospital Value-Based Purchasing)

Source: AHEAD_CMS Medicare FFS HGB technical specifications 3.0

Medicare FFS HGB Quality Adjustments – Critical Access Hospitals

Adjustment Category	Description	PY1 2027	PY2 2028	PY3 2029	PY4 2030	PY5 2031	PY6 2032	PY7 2033	PY8 2034
Transformation Incentive Adjustment	Additional payments to invest in enhanced care coordination and transformation	▲ 1%	▲ 1%						
Critical Access Hospital Quality Adjustment – P4R	Pay for Reporting on select Medicare FFS quality measures			▲ 2%	▲ 2%	▲ 1.5%	▲ 1%	▲ 0.5%	
Total Magnitude of Infrastructure/P4R Payments		1.0%	1.0%	2.0%	2.0%	1.5%	1.0%	0.5%	0%

Performance Based Adjustments

Adjustment Category	Description	PY1 2027	PY2 2028	PY3 2029	PY4 2030	PY5 2031	PY6 2032	PY7 2033	PY8 2034
Critical Access Hospital Quality Adjustment – P4P	Pay for Performance on select Medicare FFS quality measures					▲ 0.5%	▲ 1%	▲ 1.5%	▲ 2%
Effectiveness Adjustment	Downside risk based on Potentially Avoidable Utilization costs (Readmissions , Avoidable Admissions PQI 90 and ED Visits)			▼ 0.5%	▼ .75%	▼ 1%	▼ 1.25%	▼ 1.5%	▼ 2%
Total Cost of Care (TCOC) Performance Adjustment	Two-sided risk based on TCOC of beneficiaries residing in hospital market area				▲ 2%	▲ 2%	▼ 2% - ▲ 2%	▼ 2% - ▲ 2%	▼ 2% - ▲ 2%
Community Improvement Bonus	Upside risk based on hospital performance on disparity sensitive measures (Readmissions and Avoidable Admissions PQI 90 , adjusted for social risk)				▲ 0.5%	▲ 0.5%	▲ 0.5%	▲ 0.5%	▲ 0.5%
Total Magnitude of Quantitative Risk Based Adjustments		0%	0%	0.5%	3.25%	4.0%	6.75%	7.5%	8.5%

Source: AHEAD_CMS Medicare FFS HGB technical specifications 3.0

Market Shift Adjustment (MSA)

Statewide hospital market share

Under Medicare FFS HGB, the market shift adjustment is floored at \$0 for hospitals whose statewide market share is less than 2% (in year 2 of the MSA calculation).

The figure on the right shows the fiscal year 2023 statewide market share by hospital under Medicaid and Medicare FFS. Values below 2% are highlighted.

Hospital	% of Medicaid	% of Medicare FFS
The Queen's Medical Center	27.1%	35.3%
Kapiolani Medical Center for Women & Children	22.7%	n/a
Hilo Medical Center	6.7%	7.8%
Straub Medical Center	6.6%	12.9%
Maui Memorial Medical Center	5.7%	7.9%
Pali Momi Medical Center	5.2%	8.6%
Kaiser Permanente Moanalua Medical Center	4.5%	1.9%
Adventist Health Castle	4.0%	5.7%
Kona Community Hospital	3.1%	2.7%
Wilcox Medical Center	2.9%	4.0%
Samuel Mahelona Memorial Hospital	2.0%	0.2%
Kuakini Medical Center	1.7%	4.8%
Hale Ho'ola Hamakua	1.6%	0.4%
Kauai Veterans Memorial Hospital	1.6%	1.3%
Queen's North Hawaii Community Hospital, Inc.	1.2%	2.5%
Ka'u Hospital	1.0%	1.4%
Kula Hospital	0.8%	0.3%
Molokai General Hospital	0.7%	0.5%
Kohala Hospital	0.7%	0.8%
Kahuku Medical Center	0.2%	0.9%
Lanai Community Hospital	0.0%	0.0%

MSA Proposed Approach Detail

Dampening of the dollars available to shift

- In the Medicare FFS HGB model (v3.0), the MSA adjustments are scaled down by an 80% factor (e.g., to reflect hospital marginal costs). We propose mirroring the Medicare FFS approach for Medicaid, but the 80% factor could be adjusted to increase stability (lower than 80%) or reward higher volumes (higher than 80%).

Service volumes and payments affected by the MSA

- For the illustrations shown we used historical MCO payments in 2022 and 2023.
- A standard volume measure may need to be used instead of relying on MCO payment amounts. Therefore, a standard outpatient schedule will likely be needed.
- The MSA is applied to the HGB. The impact of the MSA will grow as utilization-based payments are phased out, since the MSA will apply to a larger HGB.

MSA adjustment timing

	BY1	BY2	BY3	Gap	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Market Share Adjustment (MSA)	N/A	N/A	N/A	N/A	N/A	BY3 to Gap	Gap to PY 1	PY1 to PY2	PY2 to PY3	PY3 to PY4	PY4 to PY5	PY5 to PY6

MSA Calculation Detail

Market areas reflect the beneficiary island of residence. The MSA amount is driven by the shift in proportional use of hospital services by island residents.

The MSA is calculated separately for inpatient and outpatient. Below is the formula for inpatient and outpatient:

$$IP\ MSA = \left(\frac{IP\ Hospital\ Payments_{Y2}}{IP\ Market\ Payments_{Y2}} - \frac{IP\ Hospital\ Payments_{Y1}}{IP\ Market\ Payment_{Y1}} \right) * IP\ HGB\ Dollars\ Available\ to\ Shift$$

$$OP\ MSA = \left(\frac{OP\ Hospital\ Payments_{Y2}}{OP\ Market\ Payments_{Y2}} - \frac{OP\ Hospital\ Payments_{Y1}}{OP\ Market\ Payment_{Y1}} \right) * OP\ HGB\ Dollars\ Available\ to\ Shift$$

All participating hospitals in the market area contribute to “HGB Dollars Available to Shift”. The “HGB Dollars Available to Shift” are the inpatient or outpatient “Market Payments” for year 2 trended to the budget year and adjusted by the “funding factor” (e.g., 80%).

The Medicare FFS HGB includes MSA floors for small hospitals as discussed on the prior slide.

Limitations

This analysis and its contents were prepared solely for the internal business use of internal use of Med-QUEST and are subject to the terms of Milliman's contract with Med-QUEST. This document is intended to support discussion during meetings with MQD .The contents of this document are not intended to represent a professional opinion or interpretation on any matters.

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).

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