Hawai`i Medicaid Hospital Global Budget

AHEAD Steering Committee Update

Draft for internal discussion purposes

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Medicaid Hospital Global Budget

Hospital Global Budget

Background and purpose

- Hospital Global Budgets (HGBs) provide a **steady, predictable revenue source**, and incentivize hospitals to contain or reduce potentially avoidable utilization **without harming revenues**
- AHEAD model includes HGB for both Medicare FFS and Medicaid; while Medicare FFS HGB methodology has been established by CMS, MQD has some flexibility in establishing the Medicaid HGB approach (subject to federal approval)
- MQD has a number of policy decisions and considerations that must be finalized within the framework of CMS requirements

Recent meetings with hospitals

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Recent meetings with hospitals

- Hilo Benioff Medical Center
- Kona Community Hospital
- Queen’s North Hawai`i Community Hospital
- The Queen’s Medical Center

Decisions made to date

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Medicaid HGB: Decisions made to date

Program Components

Category	Item	Preliminary Decision
Eligibility	**Eligible Beneficiary Groups**	• Managed care population
	Eligible Providers	• Regular acute, CAH, and large children's hospitals
Quality	**Quality Program**	• Build on current Medicaid Hospital Quality P4P Program

Medicaid HGB: Decisions made to date (cont.)

Adjustments

Category	Item	Preliminary Decision
Adjustments	**Timing of Adjustments**	• Adjustments made prospectively
	Demographic Adjustment	• Use existing Medicaid standard for MCO rate setting
	Annual Payment Adjustment	• Follow Medicare unit price trend
	Outlier Adjustment	• Utilize APR-DRG outlier methodology • No outpatient outlier
	Market Shift Adjustment	• Modify Medicare FFS approach with either a. Island-based service area b. Island subregion based on service area • Implement floors for small hospitals (like Medicare FFS) and neighbor hospitals
Tracking	**IP Fee Schedule for Tracking**	• Utilize IP APR-DRG weights with policy adjustments
	OP Fee Schedule for Tracking	• Use National Medicare OP fee schedule for resource tracking

H.R.1

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H.R. 1 Federal Budget Reconciliation Bill

State Directed Payment (SDP) phase down illustration

- SDP annual phase down begins for rating periods on or after **January 1, 2028**, based on "the total amount of such payment" reduced by **10 percentage points each year** until the "total payment rate" is equal to the **target Medicare rate** (100% for Hawai`i)
- Simplified phase-down example assuming no utilization or rate increases:

Average Rate Per Unit Type	CY 2027 – 0% reduction	CY 2028 – 10% reduction	CY 2029 – 20% reduction	CY 2030 – 30% reduction	CY 2031 – 40% reduction	CY 2032 – 50% reduction
Medicaid Base Payments	$6,000	$6,000	$6,000	$6,000	$6,000	$6,000
Medicaid SDP	**$4,000**	**$3,600**	**$3,200**	**$2,800**	**$2,400**	**$2,000**
Total Medicaid Rate	$10,000	$9,600	$9,200	$8,800	$8,400	$8,000
100% Medicare Target	**$8,000**	**$8,000**	**$8,000**	**$8,000**	**$8,000**	**$8,000**

- Actual phase-down process yet to be operationalized by CMS, and may be a **moving target** affected by **changes to rates and Medicaid utilization**
- MQD has not made policy decisions about how and where to reduce total directed payments down to the Medicare target

H.R. 1 bill entitled "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14.", SEC. 71116. State directed payments, July 4, 2025.

Open decisions

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Example Baseline Period Selection

Utilizing a three-year baseline period is the standard across Medicare TCOC programs including Medicare FFS AHEAD. However, utilizing a one-year baseline can more accurately capture recent trends

Three-year Baseline

2023	2024	2025
10%	30%	60%

Pros:

- Helps smooth out anomalies that can drive high or low revenue in a single year. I.e., the budget is less affected by outlier events.
- Promotes fairness and statistical credibility in budget process.

Cons:

- Increases budget for hospitals with a downward trend in utilization from 2023 to 2025.

One-year Baseline

2025
100%

Pros:

- Higher weight on most recent experience.
- Easier to interpret benchmark.

Cons:

- Does not mitigate year to year variation, which may lead to penalizing some small hospitals (e.g., small hospitals where 2025 was a “down year”).

Note: Under a three-year baseline, 2023 and 2024 are trended to 2025 levels when creating the “blended baseline budget”. The baseline budget is then trended to each performance year.

Financial protections: Shadow Budget for 2027

As an opportunity to showcase a global budget, a “Shadow Budget” can be enacted for 2027 as a no-risk test run for the state and potential hospital participants

State calculated budget values using the Medicaid HGB methodology

State disseminates monthly payment to each hospital based on the calculated budget

State performs a reconciliation to determine methodology accuracy

2027

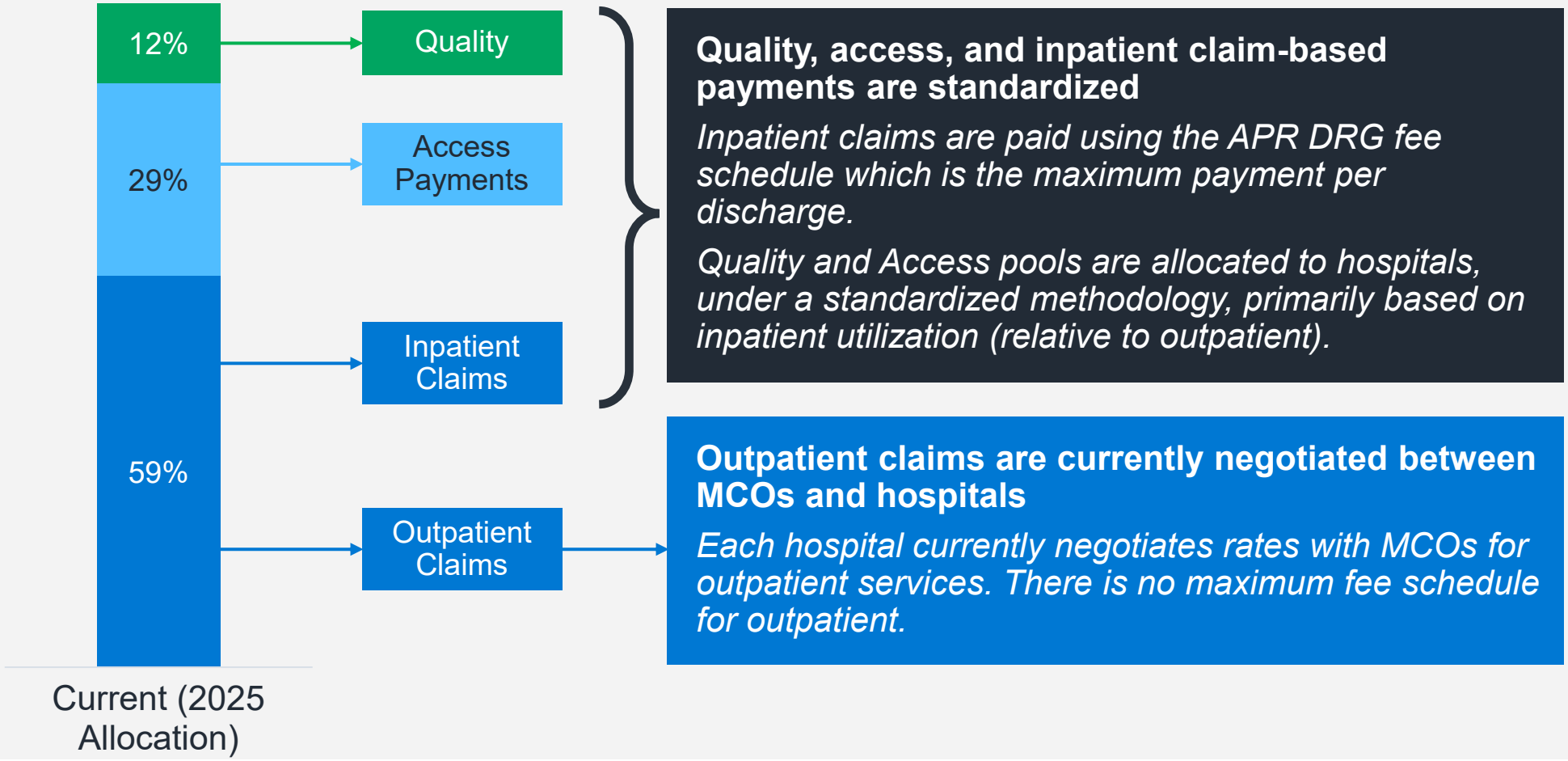
2028

If the state underpaid hospitals under the hospital global budget, *the state will make hospitals whole*

If the state overpaid hospitals under the hospital global budget, *the hospital will return excess funds to the state*

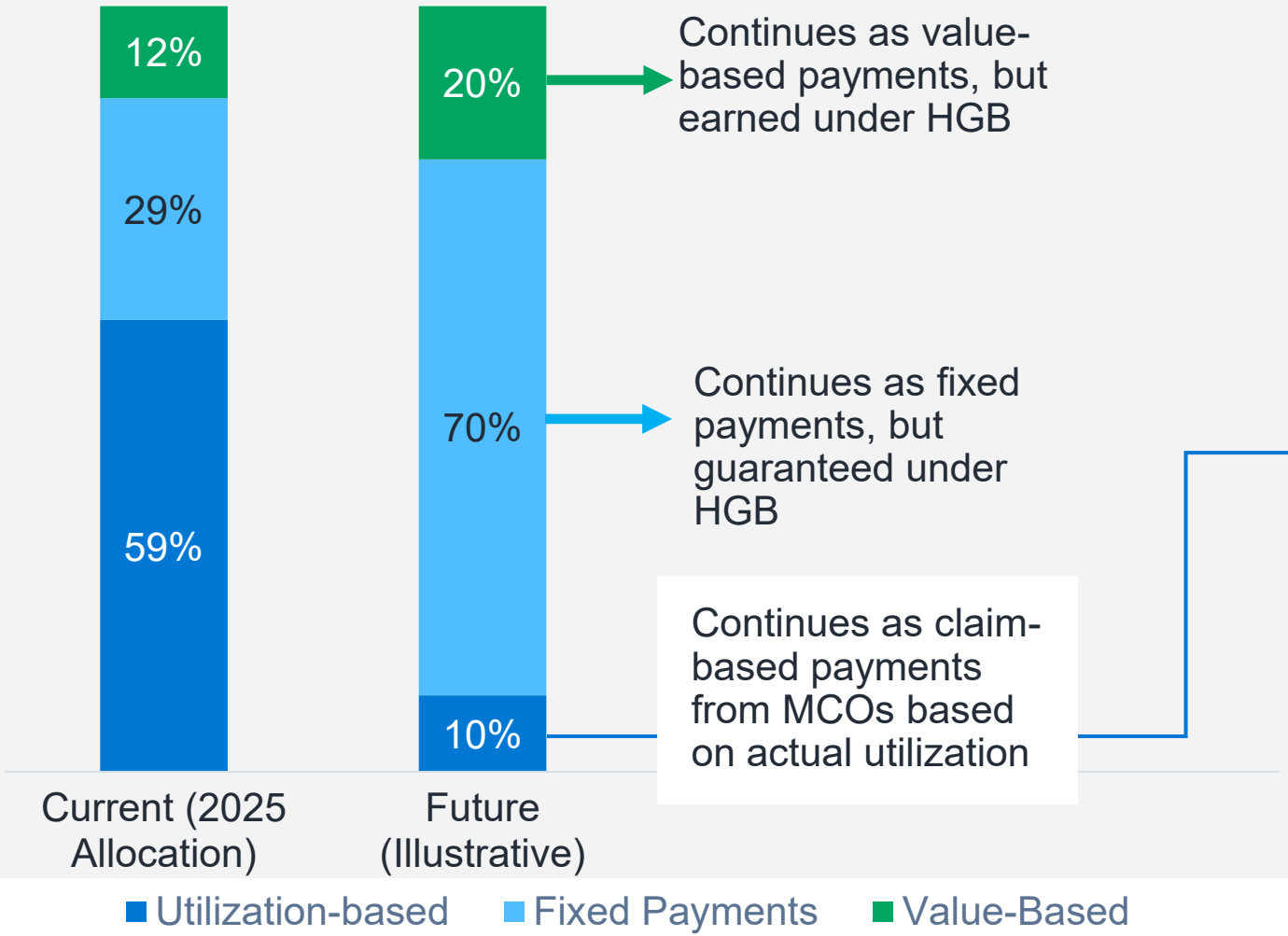
Negotiated rates within the hospital global budget baseline

Under the current Medicaid reimbursement model for hospitals, only a portion of the total payments are negotiated.
Illustration for Private Hospitals



Financial protections: Phase-out of utilization-based payments

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



Example continued claims-based payments:

Under the current approach, a $1,000 payment to a hospital would mean an original payment of ~$1,695

$$\frac{\$1{,}000}{59\%} = \$1{,}695$$

Under the illustrative approach, the hospital would receive 10% once fully phased-in

$$\$1{,}695 \times 10\% = \$169.50$$

The other 90% of that claim payment would be made prospective as fixed payments and value-based payments

Financial protections: Phase-out of utilization-based payments (cont.)

The phase-out of utilization-based payments can be gradual across several time horizons. Below an example phase-out schedule by PY5 and PY3 is shown below

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%

MCO Utilization Management Activities

With participation in the HGB, there are some MCO management activities that may no longer be necessary.

Utilization Management Activities

- Prior authorizations
- Concurrent reviews
- Retrospective utilization review

Network Management

- Narrow network management
- Tiered network management

Claims-based Cost Control

- Claim denials and edits
- Payment negotiations

Care management

- Case management
- Post-discharge follow-ups

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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Additional information for reference

Medicare FFS hospital global budget

Sources of upside and downside by performance year: non-CAH example

	PY1 (2027)		PY2 (2028)		PY3 (2029)		PY4 (2030)		PY5 (2031)		PY6 (2032)		PY7 (2033)		PY8 (2034)	
HGB Adjustment Component	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**
Transformation Incentive Adjustment	1.00%	1.00%	1.00%	1.00%												
Social Risk Adjustment[1]	0.00%	2.00%	0.00%	2.00%	0.00%	2.00%	0.00%	2.00%	0.00%	2.00%	0.00%	2.00%	0.00%	2.00%	0.00%	2.00%
TCoC Performance Adjustment[2]							0.00%	2.00%	-2.00%	2.00%	-2.00%	2.00%	-2.00%	2.00%	-2.00%	2.00%
Community Improvement Bonus							0.00%	0.50%	0.00%	0.50%	0.00%	0.50%	0.00%	0.50%	0.00%	0.50%
Effectiveness Adjustment[3]			-0.50%	0.00%	-0.75%	0.00%	-1.00%	0.00%	-1.25%	0.00%	-1.50%	0.00%	-2.00%	0.00%	-2.00%	0.00%
Total	**1.00%**	**3.00%**	**0.50%**	**3.00%**	**-0.75%**	**2.00%**	**-1.00%**	**4.50%**	**-3.25%**	**4.50%**	**-3.50%**	**4.50%**	**-4.00%**	**4.50%**	**-4.00%**	**4.50%**

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: Effectiveness Adjustment can result in downside adjustment.

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

CMS requirements for Medicaid HGB

Requirements for the Medicaid HGB are similar to the Medicare FFS HGB in many ways, but the program can be tailored to the nuances of the Medicaid population

Requirements	Principles*
General	• States will establish annual Medicaid global budgets for Participant Hospitals that transition hospitals away from existing volume-based reimbursement and incentivize a reduction in unnecessary Medicaid hospital utilization. • Hospital global budgets will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum. • A prospective global budget payment is delivered to hospitals on a regular, periodic basis (e.g., biweekly, monthly), or implemented as a virtual budget (continue current FFS/MCO payments to hospitals and reconcile payments to the global budget).
Eligible Hospitals	• The Medicaid global budget will allow for all short-term acute care hospital and critical access hospital participation at minimum. • A SMA may propose including additional types of hospitals (e.g., psychiatric hospitals, or children's hospitals). • For critical access hospitals, the Medicaid methodology may include accommodations for their participation, however after the end of a PY, the state may not reconcile Medicaid global budget payments to CAHs back to Medicaid costs.
Baseline Setting and Adjustments	• The methodology must account for inflation, population growth, demographic changes, and other factors influencing the cost of hospital care. • In addition, hospital global budgets must be adjusted for both medical and social risk for either the beneficiaries the hospital serves or the attributed geographic region
Quality	• Hospital global budgets must be adjusted for performance on quality measures. • Quality performance adjustments must be based on the quality outcomes of an attributed patient population. • Hospital global budgets must be adjusted for performance using disparities-sensitive quality measures aimed at improving health equity. At minimum, the selected measures must provide sufficient data to identify disparities and improvements in health equity, and the measures must align with the overall model goals
Market and Service Line Shifts	• Hospital global budgets must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization.

* Principles as defined in the NOFO. There are additional application requirements not listed above

Medicare Inpatient and Outpatient Prospective Payment System

CMS leverages a standard fee schedules for processing inpatient and outpatient claims for Medicare. The Medicare FFS HGB uses both the Medicare payments and the relative weights to measure hospital volume.

The **Inpatient** fee schedule will be measured using the DRG weights with corresponding adjustments

MS DRG Weight	×	Base Rate	×	Adjustments
There are DRGs for each major inpatient admission type with adjustments for visits that have complications		*The Base Rate includes labor and non-labor adjustments that are updated annually*		*Adjustments are made for local conditions such as wage index, DSH, IME, hospital type (e.g., SCH), outlier*

The **Outpatient** Fee schedule calculates in a similar fashion as the Inpatient DRG schedule

APC Weight	×	National Payment Rate	×	Adjustments
Ambulatory Payment Classifications group outpatient services to those with similar cost and complexity		*The National Payment rate for 2025 is $89.169 for reporting hospitals*		*Adjustments are made for local conditions such as wage index and hospital type (e.g., SCH), outlier*

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 at or 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%