Medicaid Hospital Quality and Global Budgets

Changing How We Pay for Care

Med-QUEST Division, DHS

Ranjani Starr, PhD, MPH

Interim Deputy Director, Med-QUEST Division

Today’s Presentation

Quality P4P program

Quality P4P aligned incentives with Hospital Global Budgets

Initial Lookback Model (2019-2024) – Medicaid and Medicare

Next Steps

Medicaid Payments to Private Hospitals (2018-2025)

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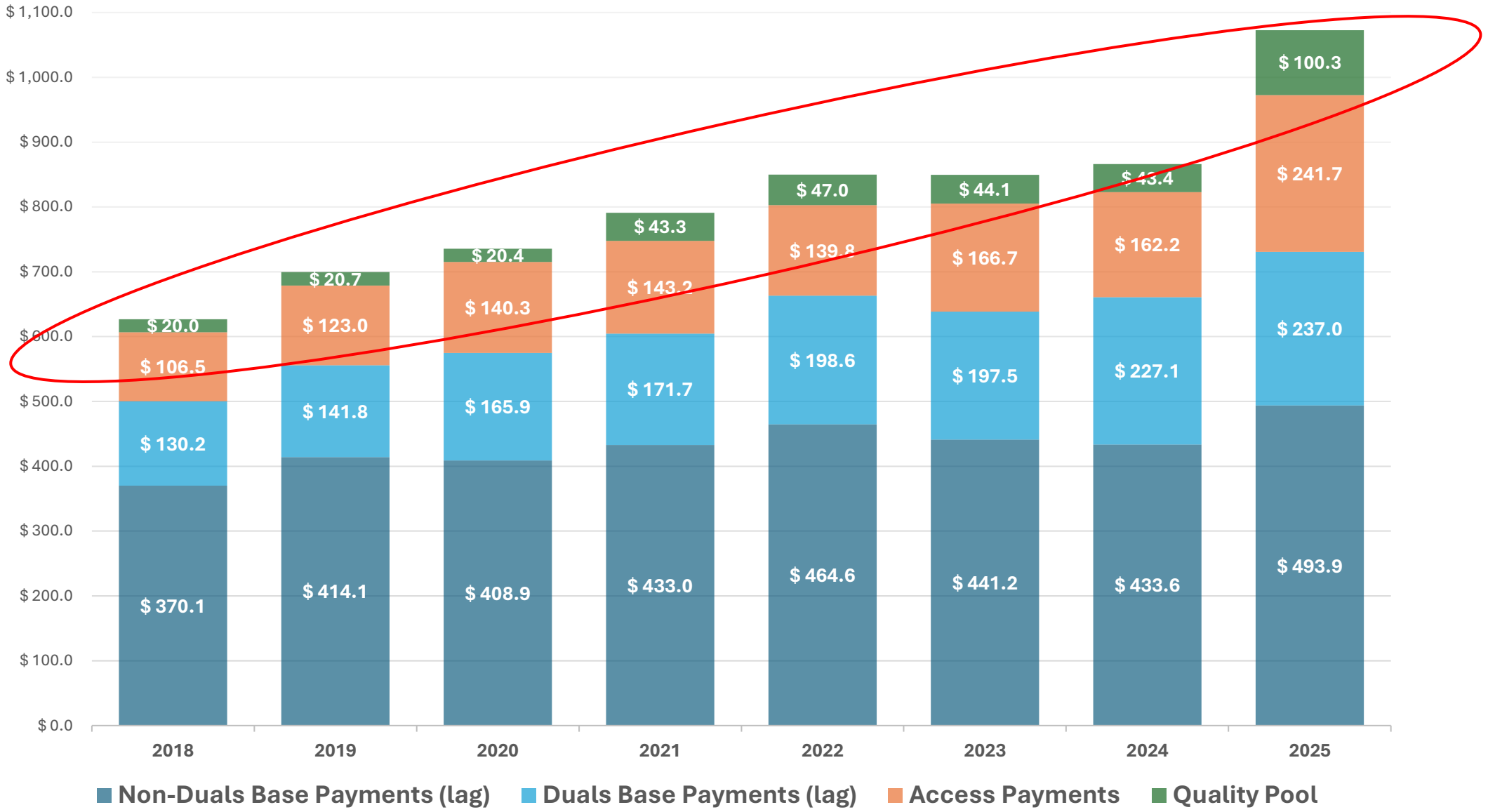

Current Model (2025 Approximates)

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68.1%

Inpatient/Outpatient Utilization ($731M)

+

22.6%

Access Payments ($242M)

+

9.3%

Quality Pay for Performance ($100M)

=

Total Payments ($1.1B)

The Med-QUEST Hospital Quality Program

Important source of hospital Medicaid revenue

2025 P4P Pool

$100,290,002

$20,058,000 (20%)

Reducing re-admissions

$20,058,000 (20%)

Decreasing ED visits among high frequency users

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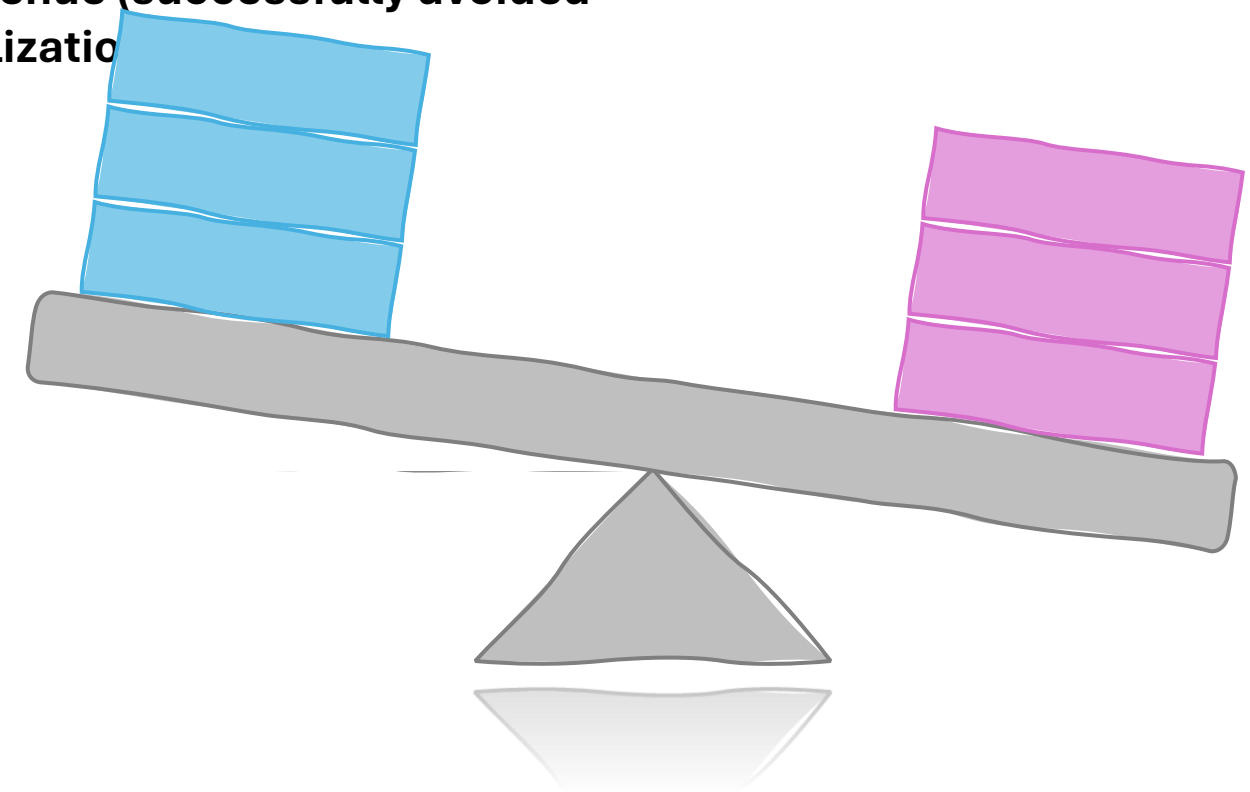
Cost to the hospital (EHR changes), or reductions in paid revenue (successfully avoided utilizatio

P4P Earnings



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Reducing Re-Admissions

$20,058,000 (20%)

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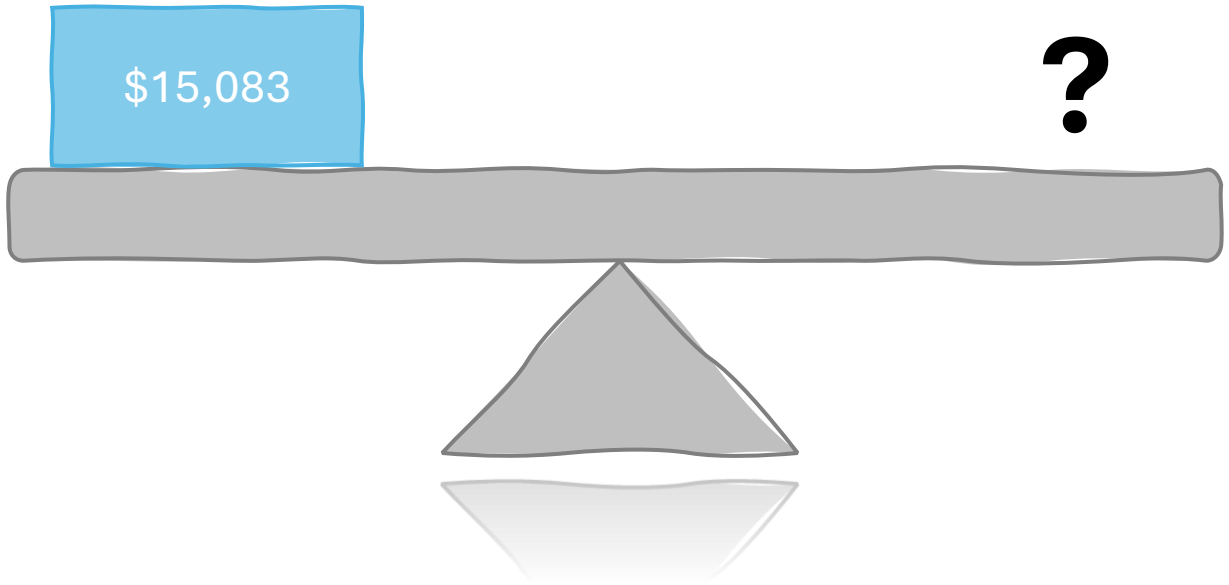
Avg revenue per re-admission

Earning per re-admission avoided



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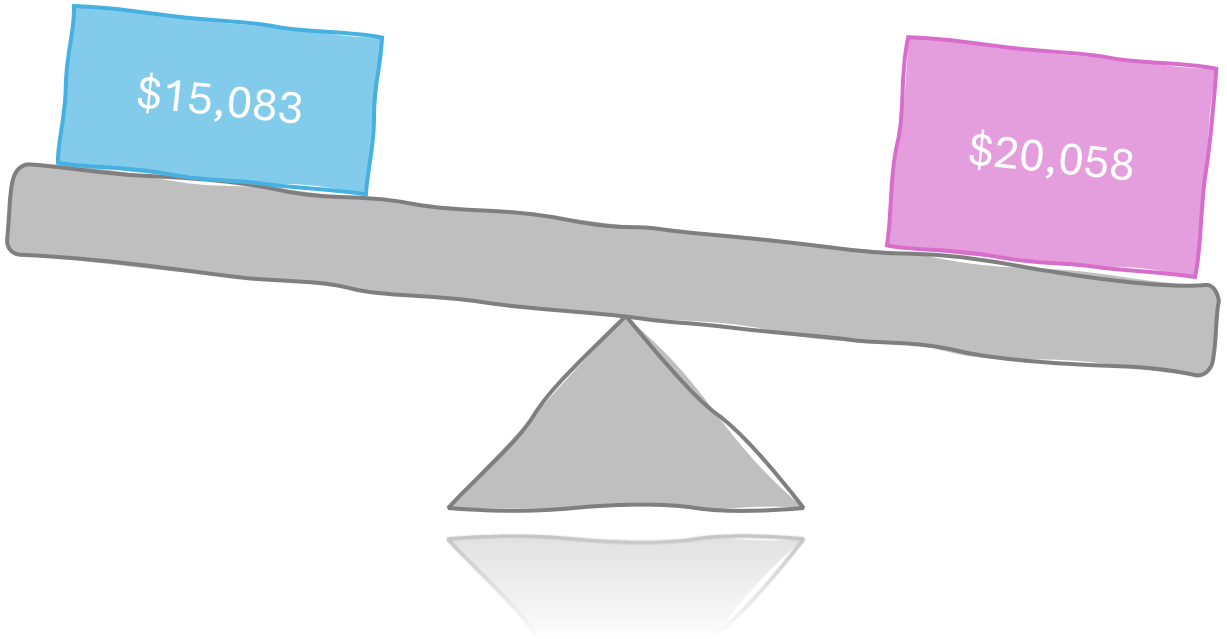
Avg revenue per re-admission

Earning per re-admission avoided



$4,975 net revenue per re-admission avoided

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Avoiding ER Visits Among High ER Utilizers

$20,058,000 (20%)

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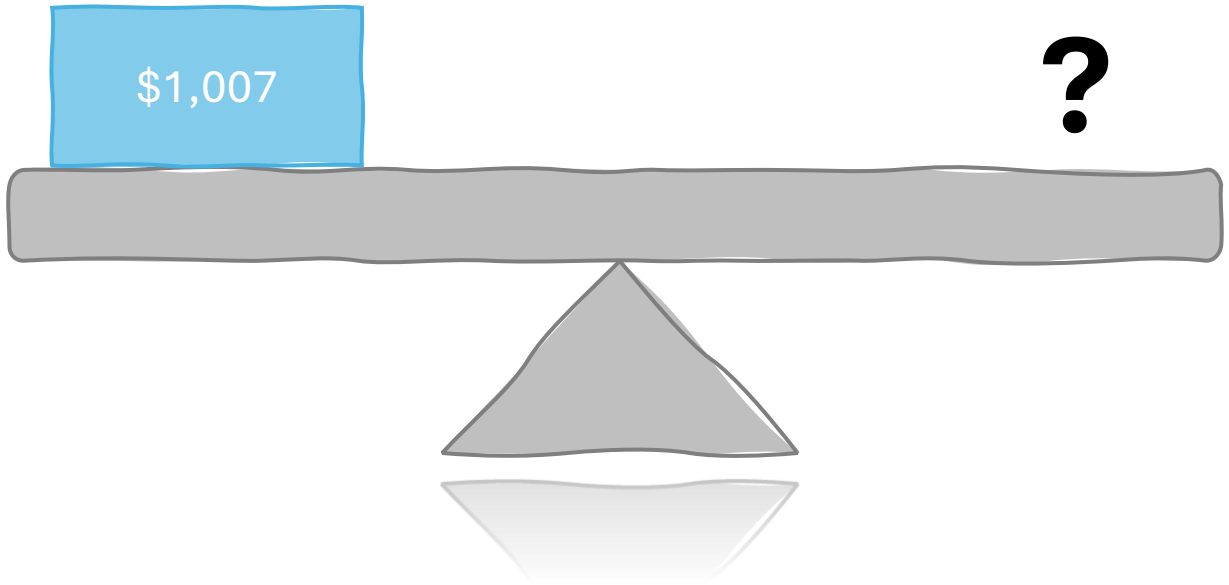
Average revenue per ER Visit among High ER Utilizers

Earning per ER visit avoided



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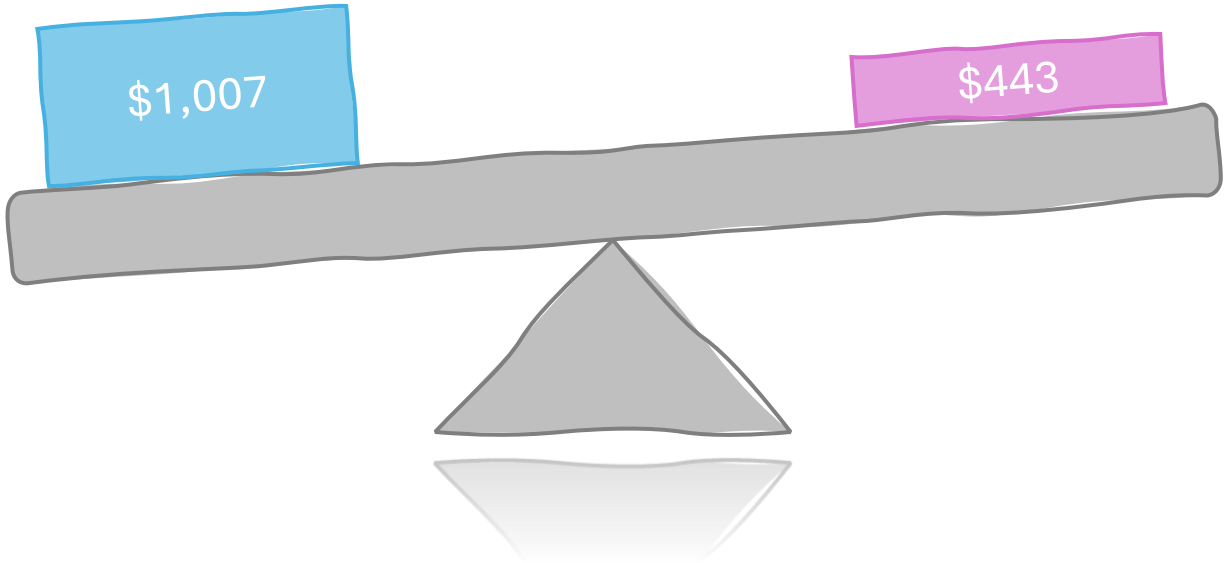
Average revenue per ER Visit among High ER Utilizers

Earning per ER visit avoided



$564 net loss in revenue per high utilizer ER visit avoided

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Taken together

- Since the net goal is balance, we're probably allocating too many dollars to avoiding re-admissions, and too few dollars to reducing ER visits among high ER utilizers.

- Aside from the tweaks, the money is there to drive improvement.

Key Takeaways #1

- The MQD quality program has grown significantly and includes a number of initiatives.
- “Quality” is a serious source of hospital revenue.
- Investing in quality is rewarding now, but essential to succeeding in a future Hospital Global Budget model.

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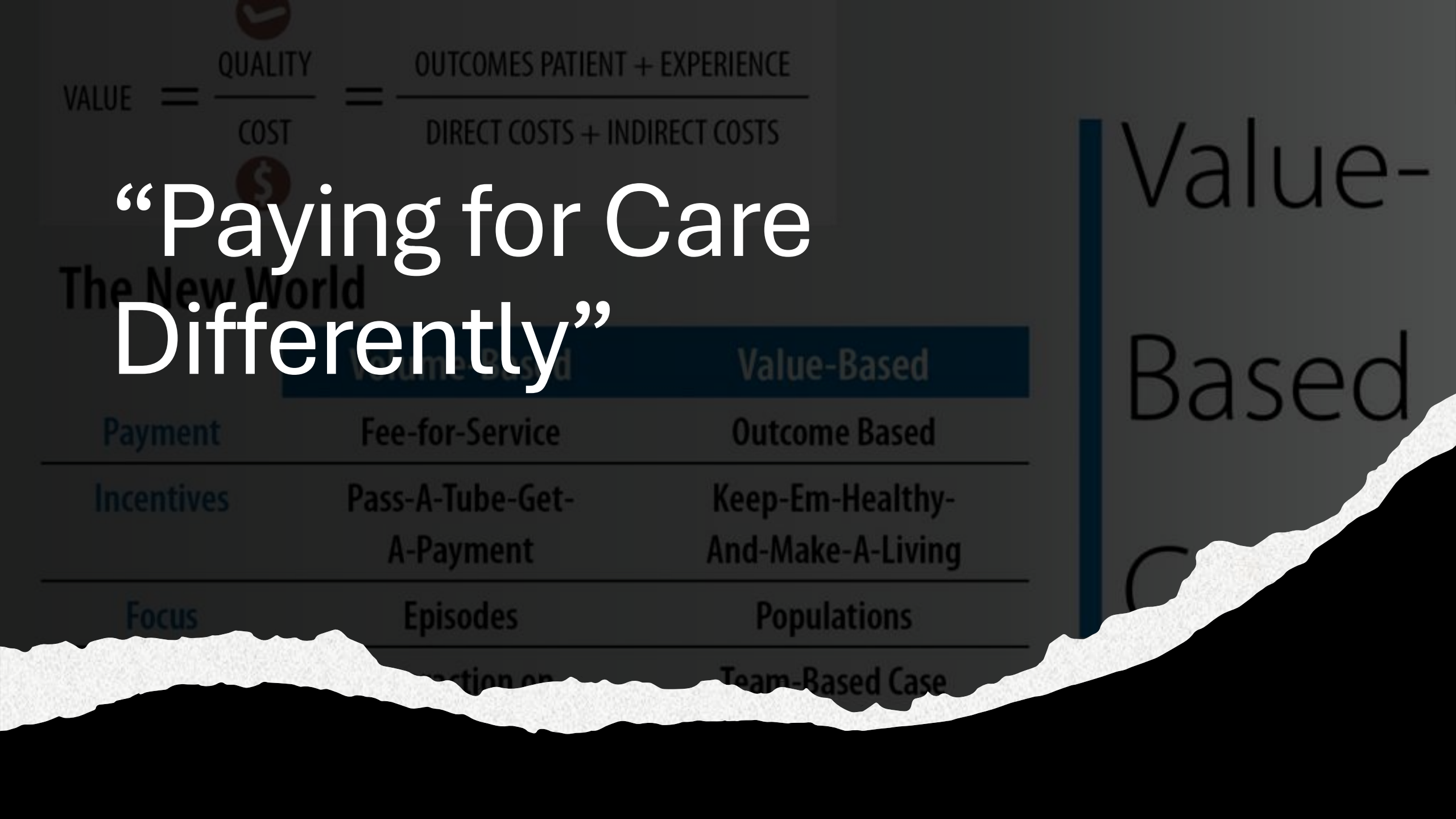
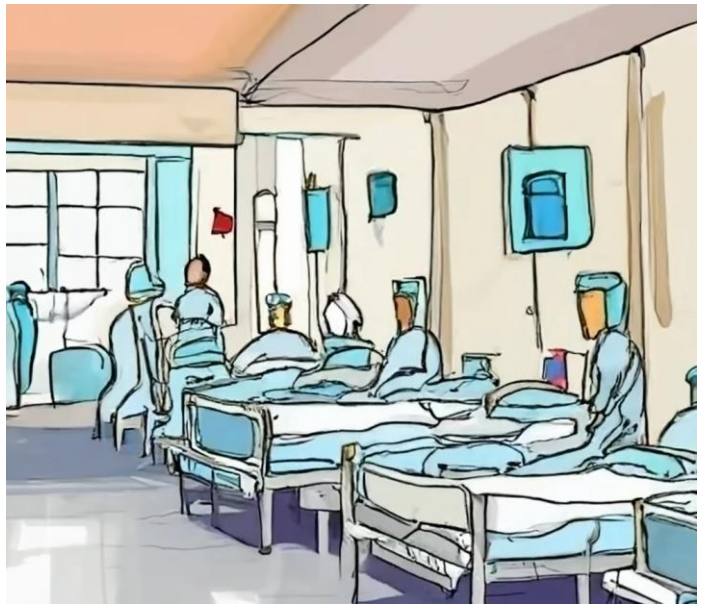
What are “Hospital Global Budgets”?



“Paying for Care Differently”

Current Model → Future Model



The current model continues to reward volume.

Phase I: Quality as a major revenue stream

Phase II: Hospital Global Budgets and aligned incentives

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Medicaid Hospital Global Budgets

Structure and relationship to the Quality Program

Current Model (2025 Approximates)

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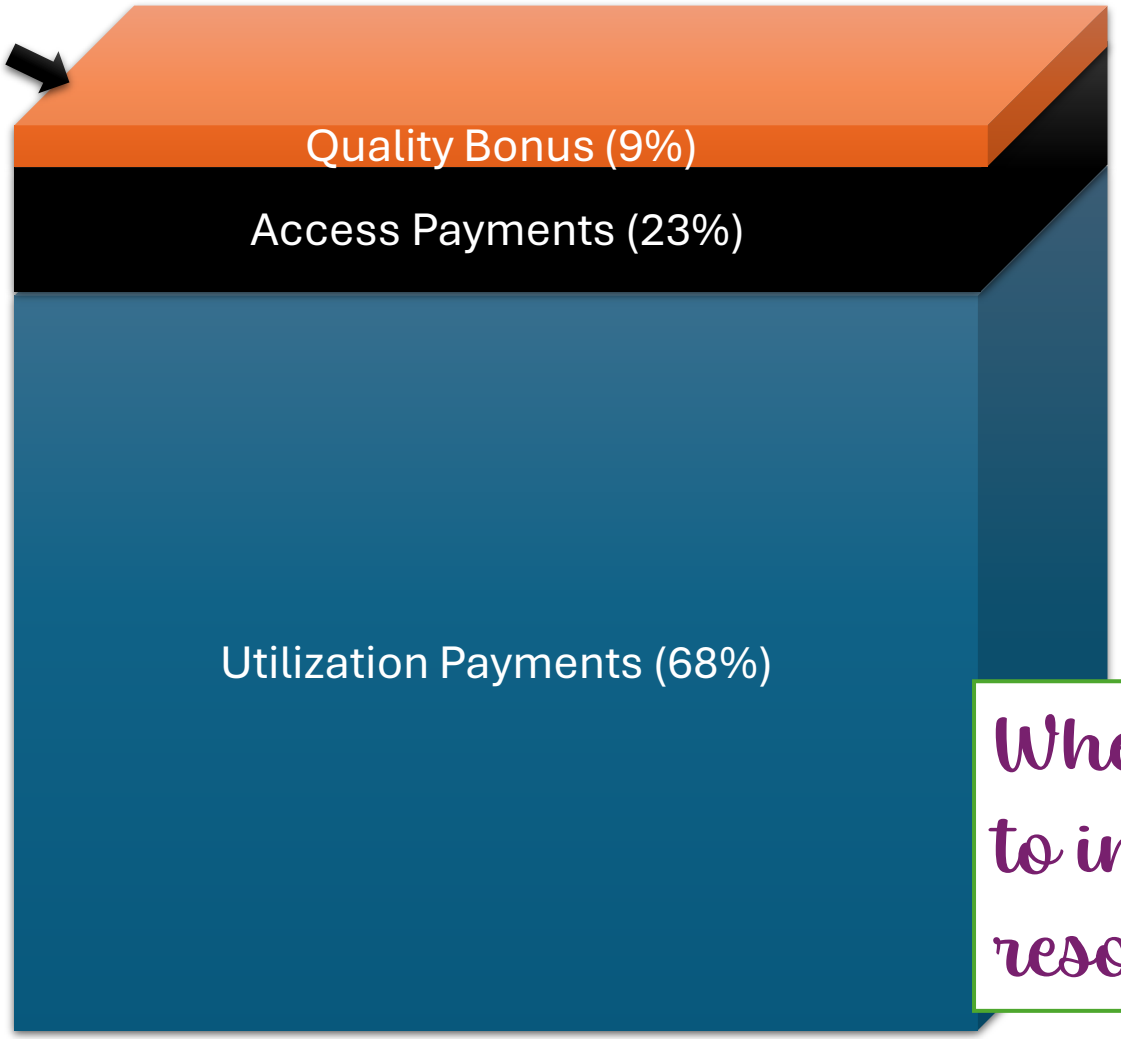
Does increasing payout here…



Result in a decrease in payout here?

Where does it "pay off" to invest my time and resources?

Hospital Global Budget Aligned Initiatives

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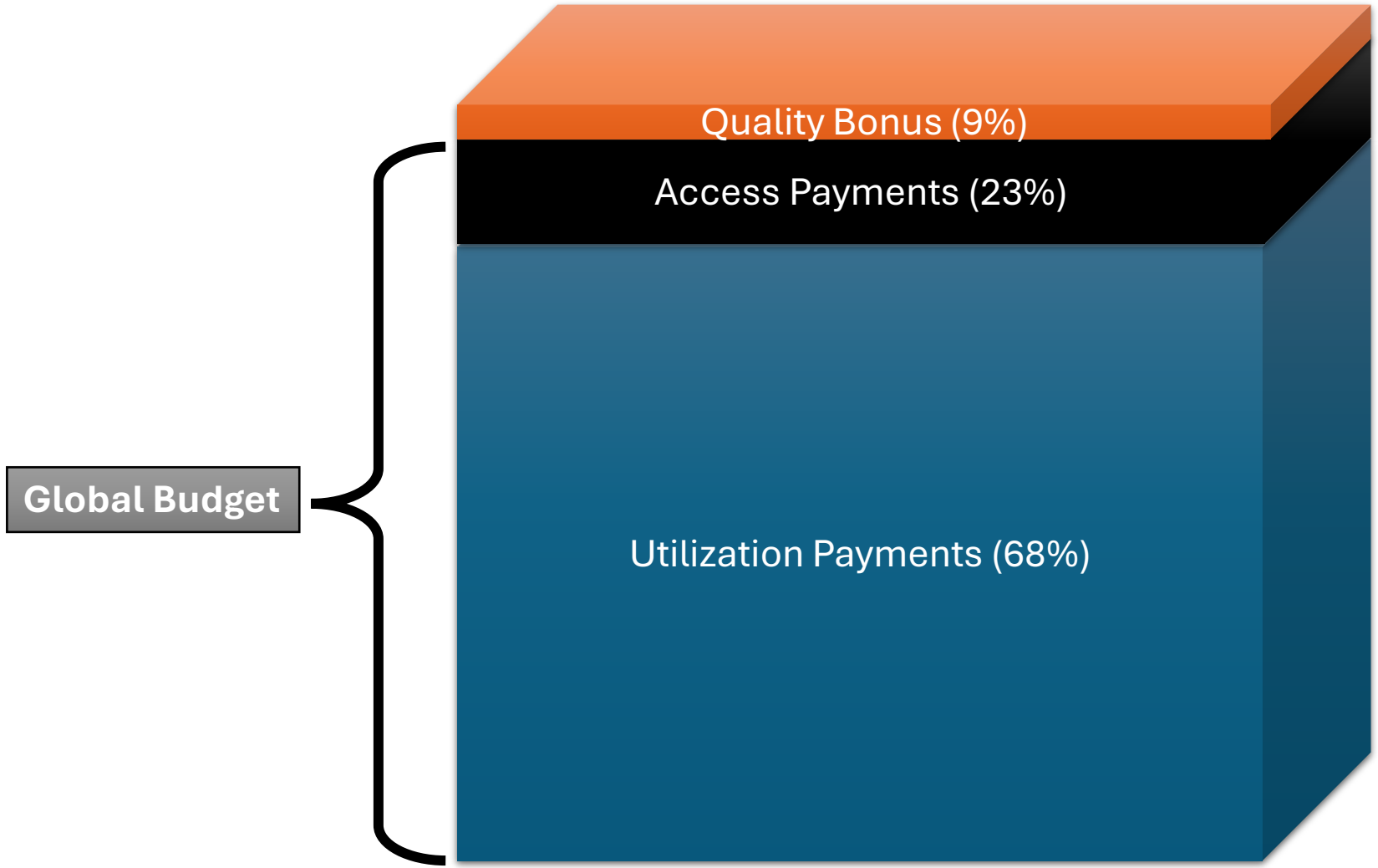

Hospital Global Budget Aligned Initiatives

Med-QUEST Division, DHS

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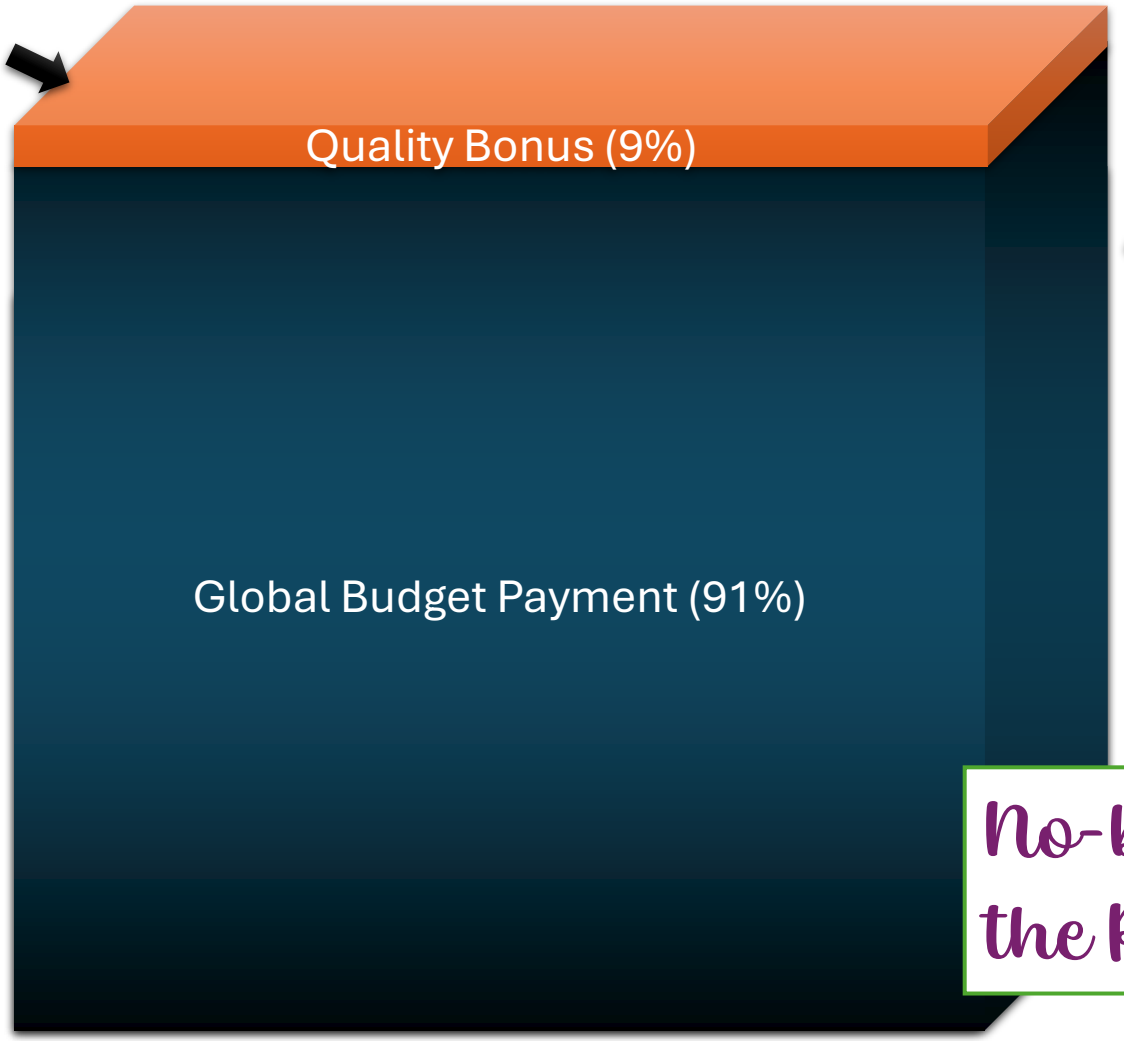

Does not decrease payouts here

+ decreases costs/expenses that were previously cutting into profit margin

No-brainer to invest in the P4P program.

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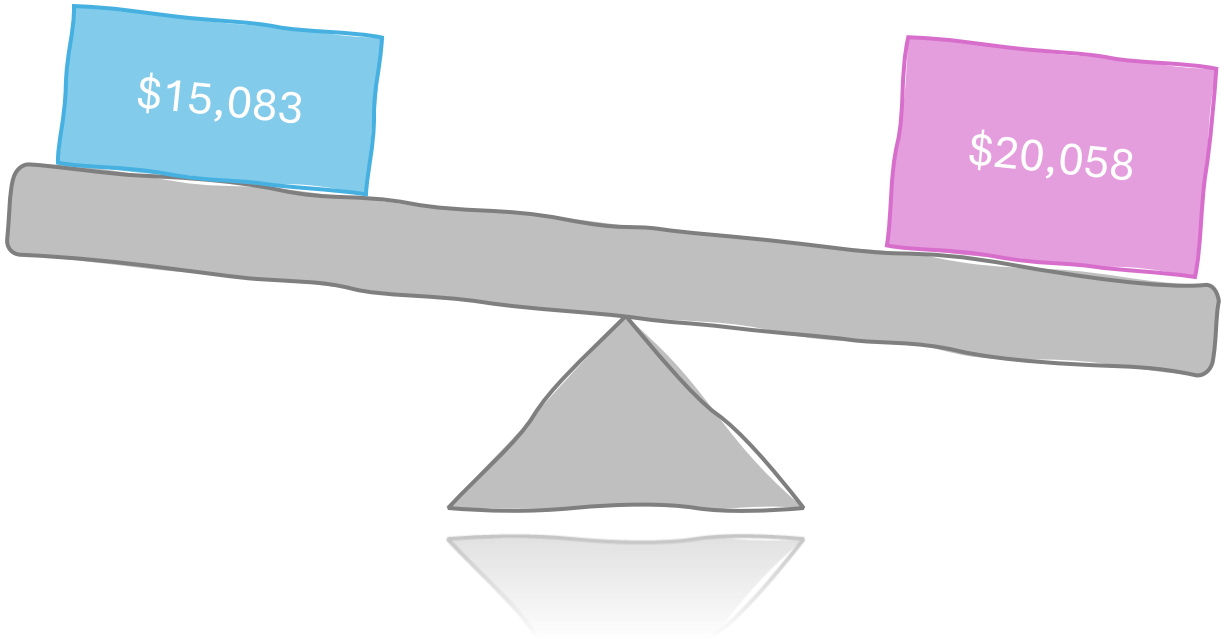
Avg revenue per re-admission

Earning per re-admission avoided



$4,975 net revenue per re-admission avoided

Hospital Global Budget

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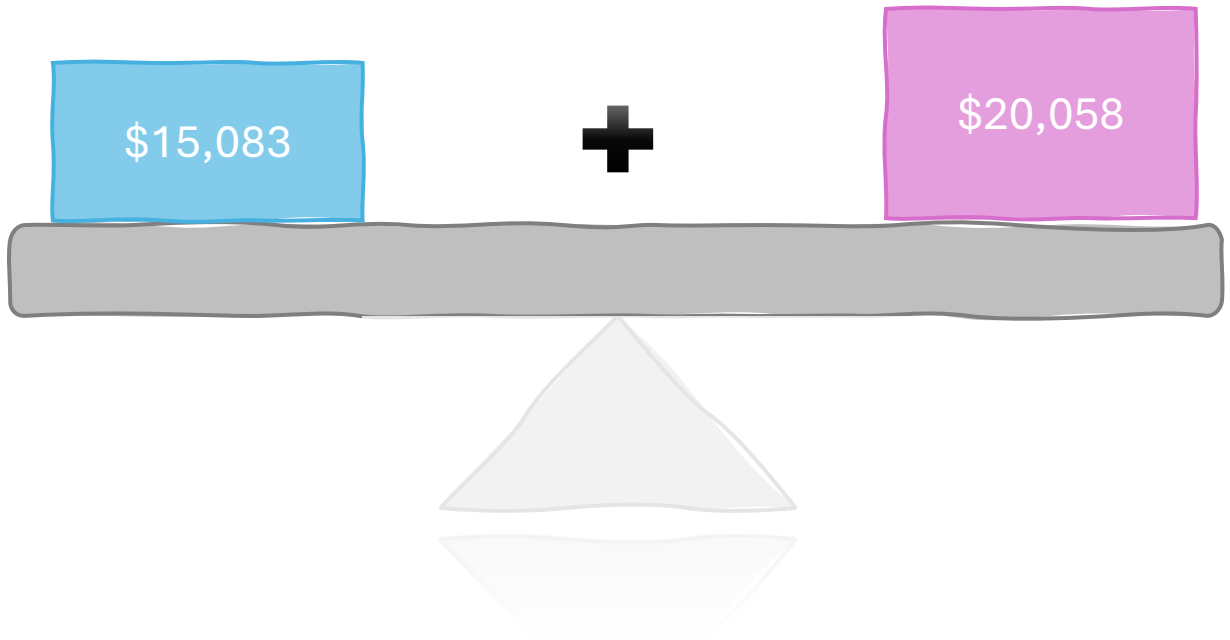
Budget per re-admission built into the HGB PMPM

Earning per re-admission avoided



7x higher return!

$35,141 net revenue per re-admission avoided

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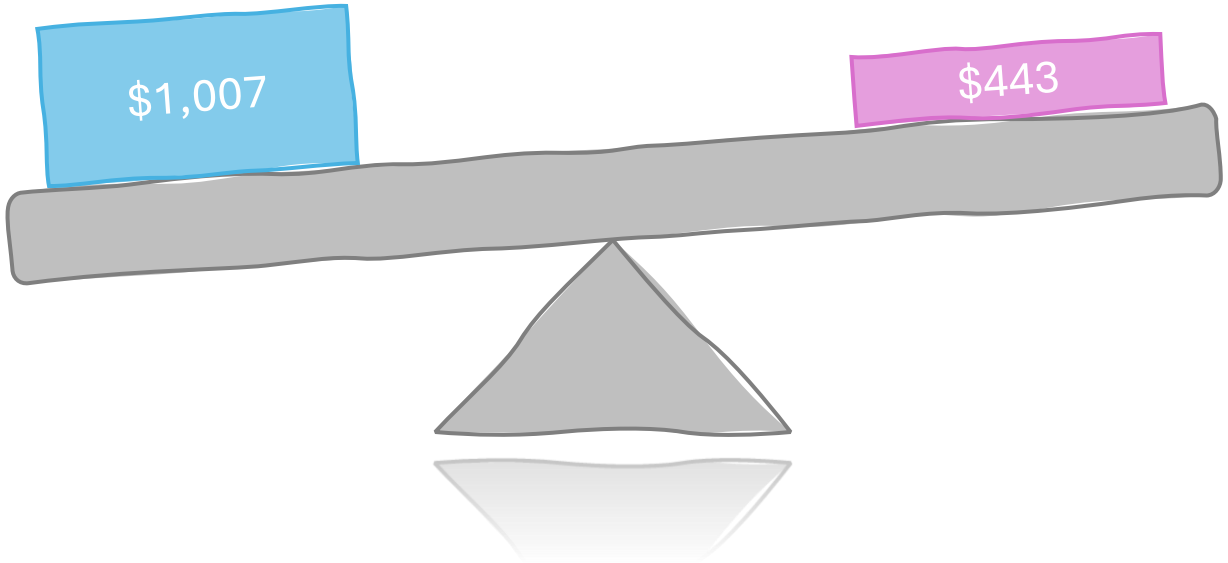
Average revenue per ER Visit among High ER Utilizers

Earning per ER visit avoided



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Hospital Global Budget

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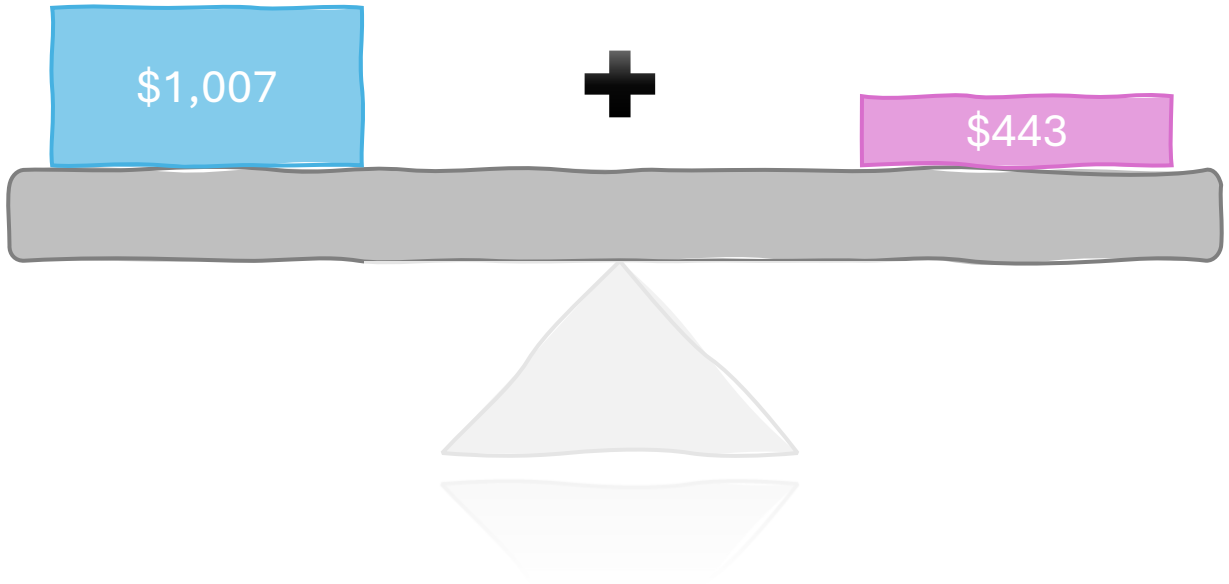
Earning per ER visit avoided



Reversal from net loss to 1.5x gain

$1,450 net revenue per high utilizer ER visit avoided

Key Takeaways #2

- MQD is strongly exploring Medicaid HGBs.
- The intent is to create clear alignment between Medicaid HGBs and the existing Medicaid P4P program to create a win-win definition of “successfully paying for care differently.”

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Medicaid Global Budget Scenarios & AHEAD Implications

MQD & Milliman

Initial lookback analysis

Lookback Analysis

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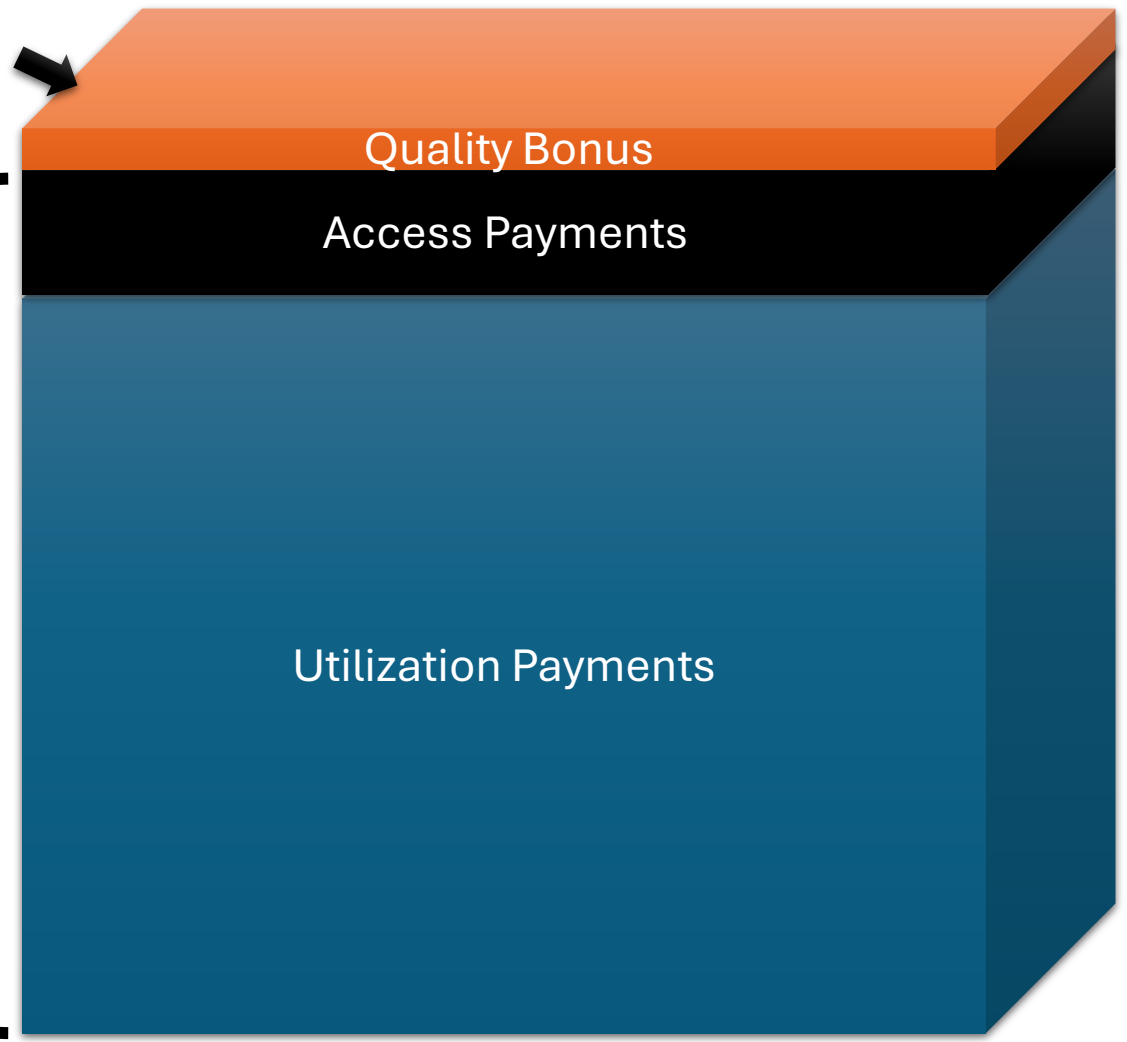
Does increasing payout here…



Does not decrease payouts here

+ decreases costs/expenses that were previously cutting into profit margin

Global Budget

This Analysis

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Initial Lookback Simulation

Historic data from 2017 used as the baseline year.

Used to mock a HGB model from 2019-2024. Comparison to actual revenue.

Separate Medicaid, Medicare, and combined.

Model Adjustments

Applied

- Annual Payment Adjustment (APA)
- Demographic Adjustment (DA)
- Market Shift Adjustment (MSA)
- Medicare-only FFS AHEAD Adjustments (social risk adjustment SRA), effectiveness adjustment (EA), community improvement bonus (CIB), TCOC performance adjustment, Transformation Incentive Adjustment (TIA), CAH quality adjustment)
- Medicare-only Sequestration

Not Applied

- Outlier Adjustment
- Service Line Adjustment (SLA)

Additional adjustments (like HRSN, race-ethnicity, ESL, etc.) are possible as data becomes available.

Model Features

"Market shift floors" to support smaller hospitals on Oahu and all Neighbor Island hospitals.	• Does not penalize smaller hospitals that lose patient volumes due to market shift. • These protective floors increased the HGB by $57M.
Model Trend (expected year-over-year % increase in rates)	• Currently, we backed into the modeled 3.6% trend. • The requested trend from CMS will be higher.
"Business as usual!" Without any change in care delivery.	• Improving quality will reduce hospital costs. • Reductions in avoidable utilization will improve net revenue.
No Phase In Period (Part HGB/Part FFS)	• MQD has a proposal to stabilize hospital revenue under AHEAD despite HR1. Full HGB provides the "greatest up-front revenue." • Simpler administration for everyone.

Medicaid Lookback (2019-2024)

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3.6% Trend

Statewide, revenue improved by 4.6%. 6 of 13 neighbor island hospitals, and 11 out of 20 hospitals (statewide) achieved net increases.

Medicare Lookback (2019-2024)

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2.5-3.0% Trend

Statewide, revenue improved by 13.0%. All neighbor island hospitals, and 18 out of 19 hospitals (in total) achieved net increases.

Medicare & Medicaid Lookback (2019-2024)

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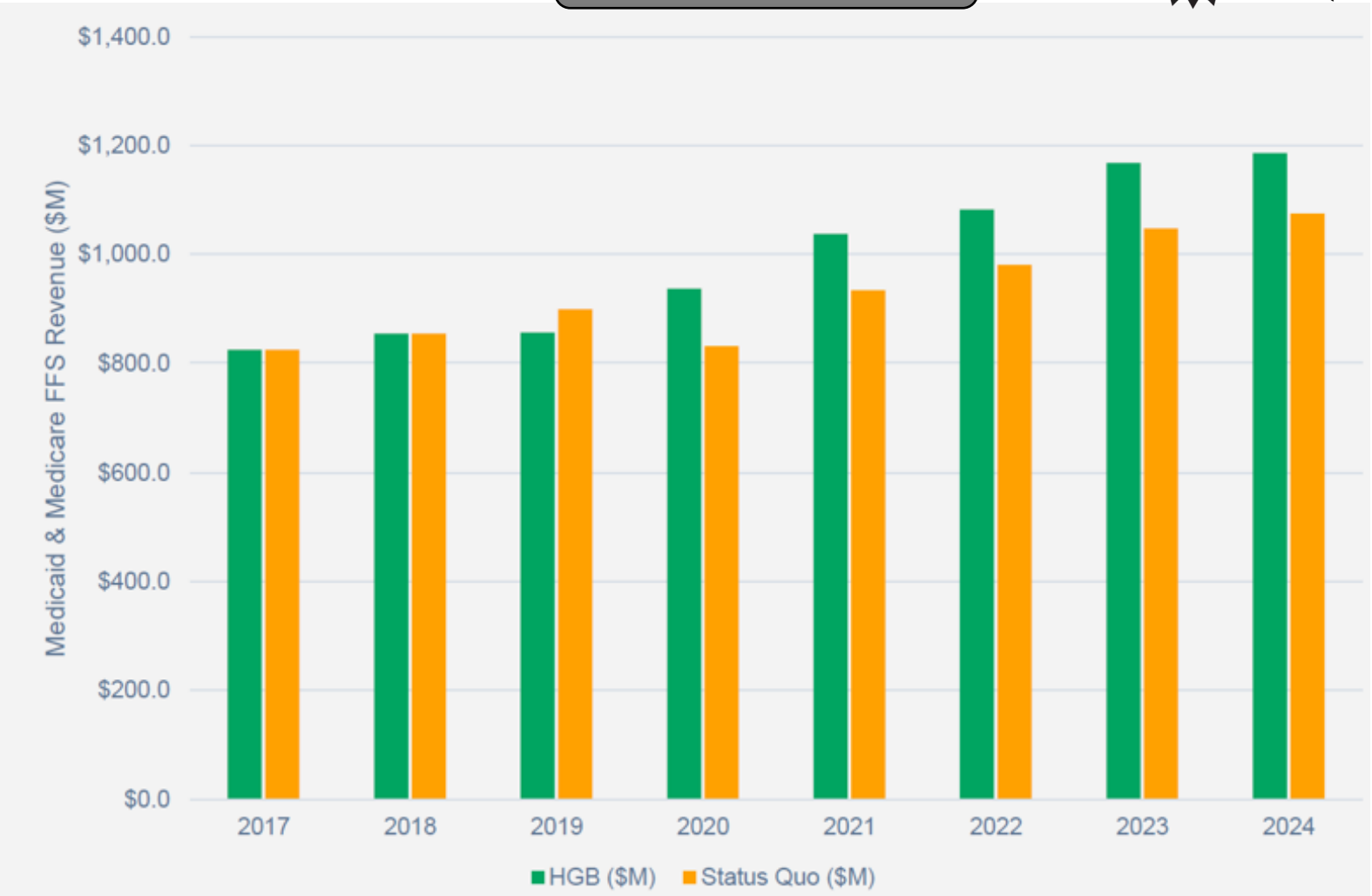
Blended Trend



Statewide, revenue improved by 8.5%. 15 out of 20 hospitals achieved net increases. Operating margin increased by 1.9% (2019-2024) [2.2% between 2023-2024].

Swing Factors

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Expected Change	FFS Model	HGB Model
Increase		
Decrease		
Not Sure (?)/No Impact		

Key Takeaways #3

Most hospitals fared better! 20 out of 21 hospitals had a ++ outcome in aggregate.

Net operating margin doubled

The market shift floors added $57M of revenue into the HGB.

HGBs are good to start during a “high trend” period. We are in a high trend period now! ☺

Quality improvements can improve all these outcomes significantly.

MQD has a “revenue stabilizing” proposal to CMS to mitigate impacts of HR1 for AHEAD hospitals

In Conclusion, Next Steps, Timelines

#1: MQD leaning towards making Medicaid HGB Participation Mandatory

Hospital-owned practices depend on parent participation.

Mandatory hospital participation reinforces PCP coordination.

- MQD is also leaning towards mandatory primary care APM. Joint participation aligns incentives to maximize outcomes.

Mandatory participation ensures a level playing field.

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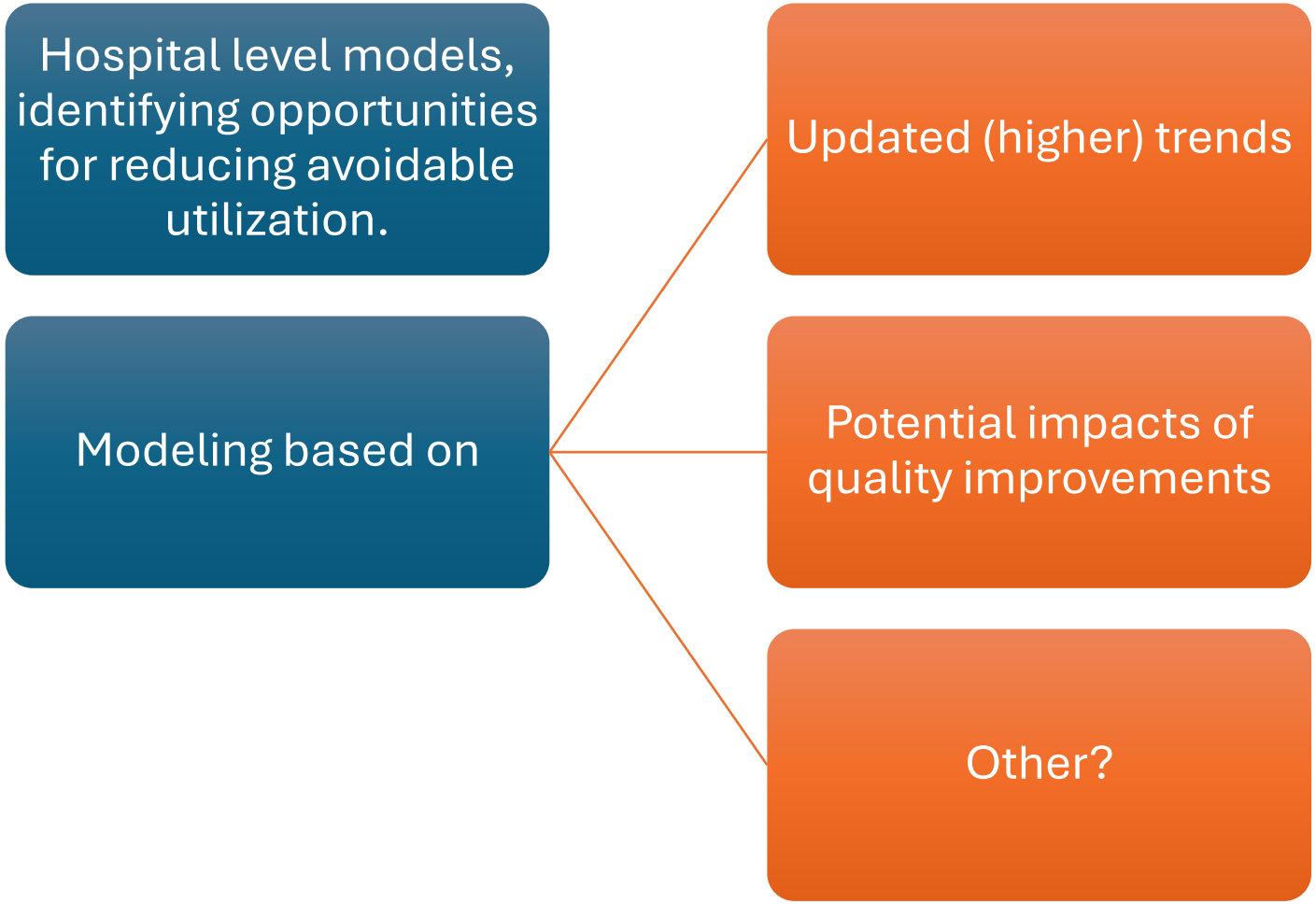
#2: We are interested in understanding what additional modeling would be of help?



Next Steps

Milestone	Target Date	Description
Methodology Draft	Q1 2026	Initial Medicaid HGB specification
Feedback and Revisions	Q1-Q2 2026	Obtain stakeholder feedback and make revisions
Final Approval	Q3-Q4 2026	Obtain CMCS and CMMI approval
Hospital Engagement	Q3-Q4 2026	Educate hospitals on final program design and participation requirements
Baseline Data Collection	Q1 2027	Gather calendar year (CY) 2024-2026 hospital revenue data
Baseline Calculation	Q2 2027	Calculate hospital-specific baselines and provide to hospitals
Participation Elections	Q2-Q3 2027	Hospitals final negotiations (Medicaid) and elections to participate (Medicare, Commercial)
MCO Contract Modifications	Q3-Q4 2027	Negotiate and execute managed care plan contract amendments
Performance Period Start	January 1, 2028	Begin Medicaid global budget payments to participating hospitals (non-risk)

AHEAD HGB (& PC) Timeline

Activity	2024-2026	2027	2028	2029	2030	2031-2035
AHEAD Model Period	Pre-Implementation		Performance Period			
Hospital Global Budgets (HGB)			**Medicaid HGB** Non-Risk Year Starts	**Medicaid** HGB with Risk Starts 1/1/29		
				Commercial HGB (at least one payer) Starts 1/1/29		
			Medicare FFS HGBs Starts 1/1/28			
Primary Care AHEAD			**Medicaid** Advance Primary Care Program Starts 1/1/28			
			Medicare and Commercial Primary Care AHEAD Starts 1/1/28			

Questions?

The Math

$15,083

- Analysis by Milliman based on CY2024 (All Hospitals, Duals and Non-Duals).
- “All cause 30-day readmissions” (2,403 statewide)
- Total revenue spent on all-cause 30-day readmissions in the year ($36.2M)
- Average per admit rate ($36.2M/2400) = $15,083

$20,058

- Analysis by MQD based on CY2025 P4P pool ($20,058,000 for ↓ readmissions)
- Assuming 2,403 represents the max O:E ratio (1.25) qualifying for a P4P payout
- Calculate the number of readmissions that would need to be avoided to qualify for each 0.01 O:E decrease (~20)
- Apply CY2025 P4P methodology of a 2% payout ($401,160) for each 0.01 decrease.
- Average earning per re-admission avoided ($401,160/20) = $20,058

The Math

$1,007

- Analysis by Milliman based on CY2024 (All Hospitals, Duals and Non-Duals).
- “ER Visits for Individuals w/ 4+ED Visits a Year” (41,820 statewide)
- Total revenue spent on ER Visits for Individuals w/ 4+ED Visits in a Year ($42.1M)
- Average per ER Visit rate ($42.1M/41,820) = $1,007

$443

- Analysis by MQD based on CY2025 P4P pool ($20,058,000 for ↓ ER Visits among High ER Utilizers)
- High utilizer visits (41,820) are 22.7% of all ER visits (184,556)
- Calculate the number of visits that would need to be avoided to qualify for each 1% decrease in ER visits (~2,262)
- Apply CY2025 P4P methodology of a 5% payout ($1,002,900) for each 1% decrease.
- Average earning per high utilizer ER visit avoided ($1,002,900/2,262) = $443