Methods for Vermont Hospital Global Payment Program (v1)

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Mathematica® Inc.

0 Versioning

The methodology for the Vermont Hospital Global Payment Program is a living document and updates will be tracked using a versioning system. This document includes details on each of the component payer programs, including Medicare, Medicaid, and Commercial payers.

Version	Date	Changes
V1	5/20/2024	• Initial version

1 Glossary of terms

Alternative payment model (APM). Payment approach with incentives to provide high-quality, coordinated care.

Baseline incentives. Medicare global payments' additional incentives for hospitals, during the first few performance years, to encourage early participation in the model and to support health care delivery reform in Vermont. The Vermont-specific incentive must be approved by the Centers for Medicare and Medicaid Services (CMS).

Baseline payments. Included payments during the baseline period and baseline incentives.

Baseline period, also called base years (BYs). Historical time period for which the base for global payment is constructed.

Commercial payers. Insured, self-funded (state regulated), self-funded (other), Medicare Advantage (Part C), and Medicare Supplement. Final definition is to be determined.

Exception-based factors. Participating hospitals may request exception-based adjustments on a case-by-case basis, subject to CMS and state approval.

FFS equivalent amounts. Refer to what would have been paid under fee-for-service (FFS).

Global Payment Program (GPP). Vermont Global Payment Program (VT GPP) is the term for the all-payer, facility-level hospital global payment approach. **Medicare FFS GPP** refers to the Medicare fee-for-service global payment program, **Medicaid GPP** refers to the Medicaid global payment program, and **Commercial GPP** refers to the commercial global payment program.

Global payments. A prospective, predetermined fixed amount of hospital facility revenue that is prospectively predetermined—for a hospital's inpatient and outpatient services—to beneficiaries for the upcoming year.

Global payment updates. Ongoing adjustments to the global payment, which may include updates for performance, policy, beneficiary changes, inflation, service line changes, and hospital-specific adjustments, among other updates. Global payment updates may vary by payer; please refer to each payer's specific section for information on the applicable global payment updates.

Hospital budget review (HBR). The GMCB process to review and establish budgets for Vermont's 14 community hospitals. Aspects of the GMCB hospital budget review process resemble a global budget.

Hospital service area (HSA). Uses Vermont Department of Health (VDH) data to map zip codes to the given hospital service areas.

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Implementation Period. The period after pre-implementation through the end of the AHEAD Model (December 31, 2034).

Market basket. Change in price, over time, of the goods and services used to provide health care to reflect input price inflation for medical services.

Market segment. Whether the claim was considered as paid by Medicare Advantage or commercial plans.

Mid-year updates. Ad hoc, one-time payments for extreme circumstances (for example, major influenza outbreak). The adjustment does not flow to future global payments. If a longer-term adjustment is needed, it would be considered under ongoing adjustments.

Payer. Actual payer who paid for the claim.

Performance year (PY). Refer to the Implementation Period.

Provider. Hospital that filed the claim.

States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD Model). Voluntary state total cost of care model from the Centers for Medicare & Medicaid Services.

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2 Overview of the Global Payment Program

Background and development of the model

The Vermont Global Payment Program (VT GPP) is a state-designed alternative payment model (APM) for Vermont hospitals. The multi-payer model is one of three components of the Centers for Medicare & Medicaid Services (CMS) Innovation Center's States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Vermont hospitals that participate will be paid through a global payment—a fixed amount of revenue that is prospectively predetermined—to provide hospital inpatient and outpatient services to patients for the following calendar year. Vermont will design the methodology to maximize payer participation as hospital global payments work best when a significant portion of revenue is included under global payment, so that hospitals can undertake major transformations to redesign care patterns regardless of the payer.

Objectives and goals of the model

The VT GPP aims to provide Vermont hospitals with a predictable and stable cash flow, not subject to year-to-year volume fluctuations, and align incentives to pave the way for population health investments to improve access to health care and reduce avoidable hospital utilization. Through an agreement with Vermont, the CMS Innovation Center sets expectations for recruiting hospitals and payers to participate in the model, calculating facility-level global payments, and monitoring quality. The state of Vermont would design a Vermont-specific Medicare fee-for-service (FFS) global payment program that complies with the requirements of the AHEAD model, and meets the state's needs regarding hospital transformation and health care affordability and quality. Commercial and Medicaid payment designs are currently under development. The state reserves the right to revise the methodology to ensure alignment with the state's health care reform and regulatory goals.

Key aspects and design features

There are three key aspects of the VT GPP: (1) hospital eligibility, (2) payer participation, and (3) prospective budget design.

Hospital eligibility

Critical access and short-term acute care hospitals in Vermont are eligible to voluntarily participate in the VT GPP. The state can include additional types of hospitals (for example, psychiatric hospitals or children's hospitals) in the Medicaid or commercial GPP, or both.

Payer participation

Hospitals will have separate global payments from each payer and will be encouraged to participate with all payers in the VT GPP. The Green Mountain Care Board (GMCB, or the Board) has rate setting authority and will oversee the Medicare and Commercial GPPs. The State of

Commercial participation is in development and will consider magnitude of included revenue for each participating hospital, administrative burden of contracting, and commercial market dynamics, among other factors.

Vermont's Department of Vermont Health Access (DVHA) develops the methodology for the Medicaid GPP and determines these payment amounts consistent with the state budget. At least one commercial payer must participate in the VT GPP at the start of performance year 2 (PY2, which begins January 1, 2027). Commercial payers may include state employee health plans, Basic Health Plans, Qualified Health Plans, and Medicare Advantage plans (including Dual Eligible Special Needs Plans). The final definition for commercial payers is to be determined. Global payments will be calculated for each payer with market-level adjustments and methodologies that will be aligned as much as possible across different payers. The commercial GPP is under development and will be aligned with Medicare, but the methodology will be adjusted to address issues specific to the commercial population and markets in Vermont (for example, affordability).

Prospective budget design

The Medicare FFS global payments are based on historical revenues (see section 5.1 for included revenue) and are adjusted for inflation, beneficiary changes, policy, performance, service line changes, and hospital-specific changes. Hospitals may also receive baseline incentives for investments in care transformation and health care delivery reform. The transformation incentive is offered to hospitals in the initial years of participation to encourage early participation and to facilitate investment in activities that will generate medium- and long-term cost savings. The Vermont health care delivery reform investment provides participating hospitals with upfront funding to improve access to care and invest in health care delivery reform. Lastly, hospitals may request a mid-year adjustment to payments on an ad hoc basis to account for major exogenous factors.

3 Timelines

3.1 Hospital budget review

The hospital budget review (HBR) process is intended to slow health care spending growth and to control, to the extent possible, a disproportionate reliance on commercial payers to ensure the financial solvency of a hospital. The Board annually reviews and establishes Vermont's hospital budgets for the hospital fiscal year (FY) that begins on October 1. Historically, the Board has set a cap on net patient revenue (NPR) and fixed prospective payment (FPP) growth. The Board has also regulated NPR and FPP by limiting changes in gross charges, except for FY 2024, when it began capping price growth consistently across commercial payers. In conjunction with capping price growth, the Board has required hospitals to reduce their expenses to achieve budgeted margins. The Board has also reviewed other hospital budget and performance trends

including growth in operating expenses, hospital productivity, quality and challenges associated with access to care, among other factors.[1] This process includes submitting budgets approved by local hospital boards and discussing budget requests at hearings. Table 1 shows the HBR timeline.

Table 1. Current timeline of hospital budget review

Deadline	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Hospitals submit prior year actual results to GMCB	31											
Hospital budget guidance			31									
Review for prior year hospital budget enforcement			X	X								
Hospitals submit budgets and accompanying documents							1					
Hospital budget hearings								X				
GMCB establishes hospital budgets									15			
Hospital FY begins, budget orders sent to hospitals										1		
Hospitals file approved budgets											1	

Note: The numbers in the table represent calendar dates and the X represent a period within the month.
FY = fiscal year; GMCB = Green Mountain Care Board; GPP = Global Payment Program; HBR = hospital budget review.

In addition to establishing budgets, the Board is responsible for enforcing hospital budgets. The Board may review the financial performance of hospitals that exceed the growth limits ordered in their budgets and may take enforcement action if performance differs substantially. The enforcement action timeline is at the end of the first quarter (Q1) and into Q2 (Table 1).

3.2 Global payment

Medicare, Medicaid,[2] and commercial budget payments will be set on a calendar year basis. The timeline for the VT GPP must align with other programs including the HBR. Alignment of Medicaid policy with Medicare policies for the VT GPP is to be determined. While the global payments across payers may account for approximately 66 percent of net patient revenue, assuming full participation rates in the commercial market including Medicare Advantage, there is still significant revenue that will be outside of global payment (see Table 14 in Appendix 9.2). A portion of the excluded revenues are the patient portion of the payment which would likely be lower if hospitals can reduce avoidable hospitalization visits. Table 2 shows the HBR and VT GPP timelines. The hospital budget guidance and submission and CMS's release of the hospital inpatient prospective payment systems (IPPS) final rule need to be jointly considered. The global payment calculations rely on information from the CMS-issued IPPS final rule, which updates IPPS hospital payment policies. This information is released annually by August 1; however, the Board has been operating on a set deadline of July 1 for the hospital budget submission to permit enough time to review and approve budget requests ahead of the hospital's fiscal year. One approach to avoid delays in the HBR process is for the Board to publish guidance using

[1] The GMCB has been evolving its hospital budget review process to focus more on hospital and system-level efficiency, in simultaneous pursuit of commercial insurance affordability, hospital solvency, and increasing access to high quality essential services for all Vermonters.
[2] DVHA will assess the timeline for Medicaid given that Medicaid uses a state fiscal year which begins in July.

proposed IPPS amounts in April. Budget hearings may consider major changes in the final IPPS rule and final amounts could be used to calculate final budgets before orders are released.

Table 2. Current timeline of hospital budget review and proposed timeline for the global payment program processes

Key
HBR
GPP

Deadline	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Hospitals submit prior year actual results to GMCB	31											
Cost report deadline		X										
Hospital budget guidance			31									
Review for prior year hospital budget enforcement			X	X								
IPPS proposed rule published				X								
Claims with 90-day runout for baseline					X							
Hospitals submit budgets and accompanying documents							1					
Hospital budget hearings								X				
IPPS final rule published								X				
Hospital budget payment determination									X			
GMCB establishes hospital budgets									15			
Hospital FY begins, budget orders sent to hospitals										1		
Hospitals file approved budgets											1	
Hospital budget payment begins	1											

Note: The numbers in the table represent calendar dates and the X represent a period within the month.
FY = fiscal year; GMCB = Green Mountain Care Board; GPP = Global Payment Program; HBR = hospital budget review; IPPS = inpatient prospective payment system.

Another strategy to align the HBR and VT GPP timelines is to shift the HBR from a fiscal year to calendar year basis; however, this would require a statutory change.

4 Global Payment Cycles and Adjustments

The prospective global payments for the first performance year (PY) are calculated using revenue from the historical baseline for each hospital and payer, as described in section 5.2 for the Medicare GPP. The adjustments, which can vary by payer, are applied to the historical baseline revenue and this amount is trended forward as the baseline for the first PY. Next, a set of global payment updates, or adjustments, are applied to the baseline to determine the PY1 global payment amount (Figure 1). Examples include inflation, policy and performance adjustments, and beneficiary updates. Adjustments account for changes in the market that hospitals may not be able to control like changes in the patient population. Performance adjustments are used to drive certain quality and equity improvements.

Figure 1**.** Performance year 1 global payment formula

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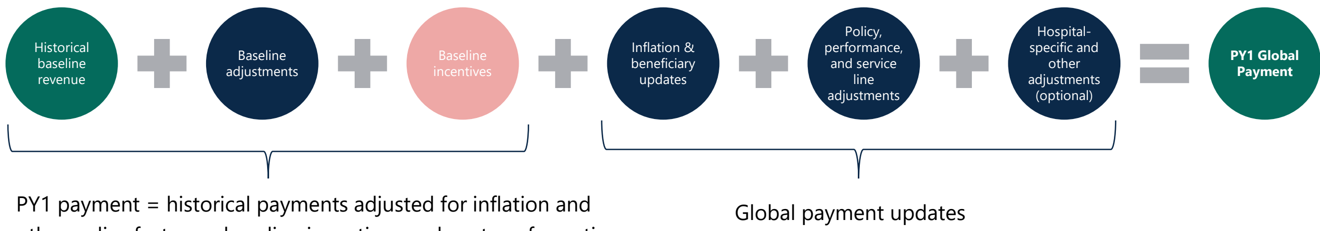

The starting VT GPP for PY2 is the prospectively set PY1 global payment. All adjustments to the global payment will be made prospectively. In other words, there will be no reconciliation payments to hospitals at the end of the budget period. Similar to the PY1 cycle, updates include inflation, beneficiary, and other policy and performance changes. Performance adjustments will be added in future years as hospitals implement transformation plans and are held accountable for total cost of care (TCOC) growth and reducing health disparities under this new model. Table 3 shows when adjustments are implemented in the Medicare FFS GPP. The details in Table 3, such as the type of adjustment and phased-in adjustments, may be refined as the state finalizes its Medicare model proposal.

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Table 3. Implementation timeline for Medicare FFS GPP adjustments

Adjustment	Adjustment type	Adjustmen t origin	Percentage	Payment adjustment period	First measurement period	Details
Exception-based factors	Upward	AHEAD	Varies by hospital	PY1–PY9	n.a.	Adjustment is on a case-by-case basis.
Baseline incentives						
Transformation incentive	Upward	AHEAD, required[a]	1%	PY1–PY2	n.a.	To incentivize early hospital participation and to facilitate activities that will generate medium- and long-term savings. Adjustment percentage applied to all eligible hospitals.
Vermont health care delivery reform investment	Upward	Vermont	TBD	PY1–PY3	n.a.	To provide upfront funding to improve access to care and delivery reform.
Global payment updates						
Inflation updates	Upward	AHEAD, required	Approximat ely 3%	PY1–PY9	n.a.	Updated annually to reflect changes in input cost of hospital inpatient and outpatient services.
Beneficiary updates	Upward/ downward	Vermont, required	Varies by hospital	PY1–PY9	n.a.	Updated annually to account for beneficiary changes in age, gender, ESRD, and count of members and for migration of members to a hospital.
Social risk adjustment	Upward	AHEAD, required	Up to 2%	PY1–PY9	BY3 Updated every 3 years	To account for hospital-to-hospital differences in social risk of the beneficiary population. Adjustment percentage depends on hospital's health equity score. AHEAD uses Area Deprivation Index (ADI) for measuring social risk. Vermont will use the Social Vulnerability Index (SVI).
Medicare policy updates	Upward/downward	AHEAD, required	Varies by hospital	PY1–PY9	n.a.	Updated annually for significant changes in other IPPS and OPPS claim-based adjustments.
Wage index	Upward/downward	AHEAD, required	Varies by hospital	PY1–PY9	n.a.	Updated annually based on CMS wage index as published in the IPPS impact files.

Adjustment	Adjustment type	Adjustment origin	Percentage	Payment adjustment period	First measurement period	Details
Low volume	Upward/downward	AHEAD, required	Varies by hospital	PY1–PY9	n.a.	Updated annually based on the number of inpatient discharges in a formula published in the IPPS rules.
Quality adjustment	Upward/downward	AHEAD, required	CMS amounts	PY1–PY9	n.a.	Based on the participant hospital's performance on CMS national hospital quality programs for PPS hospitals. [b]
Health equity improvement bonus	Upward	AHEAD, required	Up to .5% in extra revenue	PY4–PY9	PY2 improvement compared with BY3	Eligibility is dependent on performance on CMS Hybrid Hospital-Wide Readmission and Prevention Quality Indicators 92 Chronic Conditions Composite measures.[b]
Total cost of care (TCOC performance adjustment)	Begin as upward only; then upward/downward	AHEAD, required	+/- 2%	PPS hospitals: PY4 (upward only), PY5-PY9 CAHs: PY4 and PY5 (upward only), PY6-PY9	PPS hospitals and CAHs: PY2[b]	Holds participating hospitals accountable for TCOC growth within their hospital service area (HSA) or sub-level HSA for small hospitals; adjustments made based on a hospital's TCOC growth compared to a benchmark (the Vermont Medicare statewide savings target).
Effectiveness/efficiency	Upward/downward	Vermont	TBD	TBD	TBD	Vermont will consider a facility-level adjustment to assess efficiency/effectiveness of hospital operations.
Service line adjustments	Upward/ downward	AHEAD, required	Varies by hospital	Optional	n.a.	Potential adjustment for prospective changes in service lines, market shifts/transfers, and unplanned volume.
Hospital-specific adjustments	Upward	Vermont	Varies by hospital	Optional	n.a.	Special adjustments for hospitals with different payment policies.

Source: AHEAD Model NOFO.

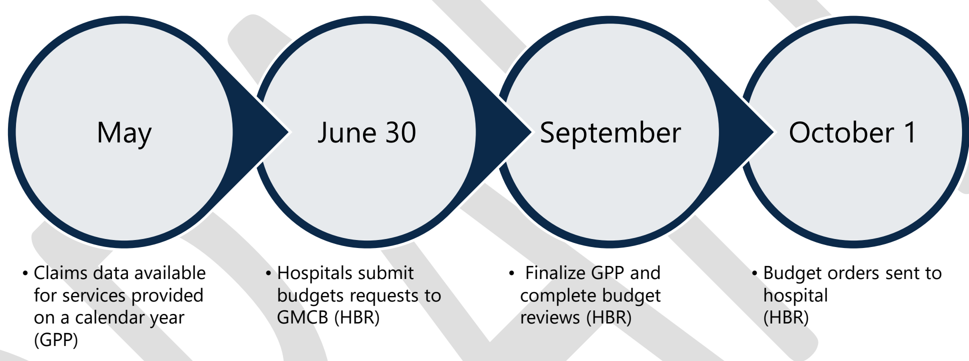
[a] The AHEAD Model requires that state-designed Medicare FFS methodology includes incentives to recruit and retain hospitals early into the model and to support hospital investments in the global budget infrastructure.

[b] Details as defined by CMS in the AHEAD Model NOFO; may be subject to change if the state adopts alternate approach.

AHEAD = All-Payer Health Equity Approaches and Development; BY = base year; CAH = critical access hospital; CMS = Centers for Medicare & Medicaid Services; ESRD = end-stage renal disease; FFS = fee-for-service; GPP = global payment program; HSA = hospital service area; IPPS = inpatient prospective payment system; n.a. = not applicable; NOFO = Notice of Funding Opportunity; OPPS = outpatient prospective payment system; PPS = prospective payment system; PY = performance year; TBD = to be determined; TCOC = total cost of care.

To implement performance adjustments, time is needed between the measurement year and implementation year to ensure that there is adequate data runout for the measurement year and to analyze performance for the basis of adjustment. The state can choose the performance period for the global budget cycle adjustments and whether adjustments should occur on a calendar year or fiscal year basis. The simplest approach is to employ a calendar year where performance is measured for the calendar year and adjustments are implemented on a calendar year cycle. This would allow for approximately a month to calculate adjustments using claims data with 90-day runout to prepare for hospitals' submission of budgets to the hospital budget review process in June (Figure 2). While this approach would allow for the adjustments to be implemented on the same calendar year basis as the overall global payment timeline, there will be a lag between the measurement and implementation periods. Table 3 details how performance adjustments could be implemented into the Medicare GPP and the measurement and analysis time necessary to implement the adjustments for the first two performance years.

Figure 2**.** Key dates for global payment performance adjustments



GMCB = Green Mountain Care Board; GPP = Global Payment Program; HBR = hospital budget review.

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5 Medicare Fee-for-Service Payment Model Design

5.1 Revenue inclusions and exclusions

The Medicare GPP includes Medicare FFS payments (traditional Medicare) to a hospital when CMS is the primary payer. This payment covers acute hospital inpatient facility services under Medicare Part A and hospital outpatient department (HOPD) facility payments under Medicare Part B. This includes room and board, procedures, treatments, and ancillary services (for example, diagnostic tests, pharmaceuticals, and emergency room services) when a member is admitted to a hospital, such as a medical/surgical unit, behavioral health unit, and rehabilitation/swing bed. Both acute hospital inpatient facility services and HOPD facility services claim types are defined in Uniform Billing-04 (UB-04) hospital claims with a CMS Certification Number (CCN).

Potential inclusions of hospital-owned services in future phases of the Medicare FFS GPP include:

- Professional services
- Other services (for example, clinics, rural health clinics, and skilled nursing facilities)

Through an arrangement between the state and the federal government, there are established Medicare pass-through payments that will be paid to the state through Medicare FFS GPP payments. Table 4 lists all payment types, the name of the payment, and whether it is included or excluded in the Medicare FFS GPP revenue. The state reserves the right to include or exclude additional services at any point of the model.

Table 4**.** Payment inclusions and exclusions in the Medicare GPP

Payment type	Payment	Include in the monthly fixed GPP?	Rationale for exclusion or reconciling to actual FFS payment
Claim-based	Medicare secondary payment	No	If a beneficiary has Medicare and other health insurance (like from a group health plan, retiree coverage, or Medicaid), “coordination of benefits” rules determine who pays first. The “primary payer” pays what it owes on the beneficiary’s bills first, and then sends the rest to the “secondary payer” (supplemental payer) to pay. These payments are small amounts and may fluctuate over time, creating additional risk and administrative burden for providers under global payment.
	Distinct part unit payment	No	These claims are submitted with a modified certificate number and subject to different payment rules. They include rehabilitation and psychiatric beds.
	CMS quality adjustments	Yes	n.a.

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Payment type	Payment	Include in the monthly fixed GPP?	Rationale for exclusion or reconciling to actual FFS payment
	Indirect medical education (IME)	Yes[a]	BY3 will serve as the floor to avoid penalizing hospitals for reducing avoidable utilization.
	Disproportionate share hospital (DSH)	Yes[a]	BY3 will serve as the floor to avoid penalizing hospitals for reducing avoidable utilization.
	Uncompensated care (UCC)	Yes[a]	BY3 will serve as the floor to avoid penalizing hospitals for reducing avoidable utilization.
	Low-volume hospital (LVH)	Yes	n.a.
	New technology add-on payments (NTAP)	No	NTAPs are available for a limited time and are, by definition, specific to certain services and are paid separately from the GPP. They are excluded to maintain access to these technologies.
	Inpatient outlier payments	Yes[b]	An adjustment to update the global payments based on changes in outlier payments and to protect the hospital from large financial losses due to unusually expensive cases. They are excluded to maintain access for complicated high-cost patients.
	Hospital outpatient services not paid under OPPS[c]	No	Drugs and supplies that are historically paid either at reasonable cost or through a separate ambulatory payment classifications payment are excluded from global payments and would continue to be paid through the normal claims process. These services have different cost trends compared to OPPS update factors and excluded to maintain access to these services.
	CAH Method II Billing	No	These amounts for the professional services will continue to be paid under established methodologies.
	All-Inclusive Population-Based Payment (AIPBP)	Yes	CMS's payments for attributed beneficiaries under the Vermont All-Payer ACO Model is through the AIPBP. AIPBP is reconciled at the end of the performance period to actual FFS equivalents. Baseline payments under the Medicare GPP will include FFS equivalents for AIPBP.
Non-claim-based	Bad debt	No	In Medicare FFS, the Medicare Administrative Contractor (MAC) makes pass-through payments outside of the FFS claims processing systems. These payments will continue to be paid under established methodologies.
Non-claim-based	Organ acquisition costs	No	In Medicare FFS, the MAC makes pass-through payments outside of the FFS claims processing systems. These payments will continue to be paid under established methodologies.
Non-claim-based	Direct graduate medical education (DGME)	No	In Medicare FFS, the MAC makes pass-through payments outside of the FFS claims processing systems. These payments will continue to be paid under established methodologies.

Pay-ment type	Payment	Include in the monthly fixed GPP?	Rationale for exclusion or reconciling to actual FFS payment
	Nurse and allied health education (NAHE)	No	In Medicare FFS, the MAC makes pass-through payments outside of the FFS claims processing systems. These payments will continue to be paid under established methodologies.

[a] Reconciled to actual FFS amounts if budget year amount is lower
[b] Reconciled to actual FFS amounts
[c] These services include corneal tissue acquisition, certain Certified Registered Nurse Anesthetist services and Hepatitis B vaccines, pass-through drugs and biologicals, pass-through device categories, non-pass-through drugs and non-implantable biologicals, influenza vaccine, pneumococcal pneumonia vaccine, blood and blood products, and brachytherapy sources.
ACO = Accountable Care Organization; AIPBP = All-Inclusive Population-Based Payment; BY = base year; CAH = critical access hospital; CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; GPP = global payment program; MAC = Medicare Administrative Contractor; n.a. = not applicable; OPPS = outpatient prospective payment system.

5.1.1 Vermont add-on pass-through payments

CMS contributes to Vermont's specific programs, known as the Blueprint for Health Program, which includes the Blueprint Community Health Team (CHT) payments, Support and Services at Home (SASH) payments, and Blueprint Patient-Centered Medical Home (PCMH) payments for primary care practices (see Table 5 for a description of the payments).

Table 5. Vermont add-on pass-through payments

Payment	Description
Blueprint Community Health Team (CHT)	These capitated payments to support community health team staff, applied to the medical home population, will continue to be paid on a per-payer claims-attributed patient per month basis, dependent on approvals by the GMCB of prepaid Medicare shared savings investments in Blueprint CHTs.
Support and Services at Home (SASH)	This payment is based on a pre-existing program and will continue to be funded separately.
Blueprint Patient-Centered Medical Home (PCMH)	These capitated payments made to primary care practices, contingent on their NCQA PCMH recognition, applied to the medical home population, will continue to be paid annually on the latest available all-payer claims database (VHCURES) Medicare patient attribution counts approved by the GMCB.

Source: Vermont Blueprint for Health Manual. July 1, 2022. https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/Blueprint%20Manual%20July%202022_Updated.pdf.
GMCB = Green Mountain Care Board; NCQA = National Committee for Quality Assurance; VHCURES = Vermont Health Care Uniform Reporting and Evaluation System.

5.2 Baseline payment calculations

The global payment for the first PY is based on historical fee-for-service revenue. The first step to calculate the historical revenue is to isolate the revenue included in the Medicare FFS GPP

during a given time period. The historical revenue from each baseline period will be trended forward to the PY and adjusted for all other Medicare policy changes to determine the baseline revenue for each facility. Prospective adjustments are applied to the baseline revenue to set the global payment for the first PY (see section 5.4). After determining the global payment for the first PY, future global payments will be based on the previous year's global payment.

Baseline period

For the three most recent fiscal years, the state will calculate a weighted average of the historical revenues. Percentage weights (Table 6) will be applied to the historical revenue to calculate the revenue for the baseline period. More recent years are weighted more heavily in the model.

An illustrative example of how this weighting might be applied to the historical revenue is in Table 6. Included payments, adjusted for inflation and policies, from each base year are multiplied by the percentage weights and all three years are added together to form the baseline. A weighted approach could be advantageous because it does not rely on one year of data for baseline calculations. Relying on one year may introduce risk if a hospital has outlier revenue in the year chosen for the baseline. In the example in Table 7, $114,000,000 would be used as the baseline.

Table 6. Example proposed baseline calculation

Year	Weight	Included payments[a]	Weighted included payments	Weighted average	BY3	Baseline
Formula	*A*	*B*	*C=A*B*	*D=sum(C)*	*E*	*F=max(D,E)*
BY1	10%	$105,000,000	$10,500,000	$112,500,000	$114,000,000	$114,000,000
BY2	30%	$112,000,000	$33,600,000			
BY3	60%	$114,000,000	$68,400,000			

[a] Payments will be adjusted for inflation and policies.
BY = base year.

5.2.1 Exception-based factors

Participant hospitals may request exception-based or exogenous factor (e.g., a pandemic or recession) adjustments to the Medicare GPP, including for service line changes. These adjustments would need to be approved by CMS.

The state will monitor the gap year for major changes. For example, if the calculated baseline revenue for a hospital is much lower than the hospital's revenue in the gap year, the state may consider reflecting the major change in future global payments. Since there is no reconciliation, the adjustment would be implemented in PY2, as the PY1 budgets will have already been established.

5.3 Baseline incentive

During the first few performance years, the state proposes to include additional investments to promote health care delivery reform in Vermont. These baseline adjustments include a transformation incentive and Vermont health care delivery reform investment.

The magnitude of baseline incentives will depend on the impact on the statewide Medicare FFS and all-payer total cost of care targets.

5.3.1 Transformation incentive

To facilitate investment in infrastructure and capacity development, an upward adjustment of at least 1 percent of the Medicare global payment will be applied to all hospitals in the model for the first two years of implementation. The state will assess whether the adjustment is sufficient based on the hospitals' cost of implementing the Medicare GPP.

5.3.2 Vermont health care delivery reform investment

Many Vermont communities struggle with access to essential services and long wait times. This creates a need to provide upfront funding to improve access to care and delivery reform as hospitals move away from fee-for-service incentives and focus on improving population health and reducing avoidable utilization. The Vermont health care delivery reform investment provides additional funds to support hospitals in implementing their delivery reform goals. Given that Vermont is a low-cost Medicare state with a long history of health care reform which has resulted in substantial savings to Medicare, Vermont will create an additional funding pool to improve access to care and invest in population health.

Hospitals that participate in the VT GPP will be eligible to receive additional funding from the pool through their global payments. By creating a pool, Vermont will have more predictable funding for investment . The pooling option may also create more flexibility, funding, and the ability to link delivery reform activities to strategic plans.

The size of the available investment will depend on an annual trend factor established for Medicare TCOC, the negotiated savings target, and expected state performance in Medicare TCOC based on current trends. The portion of the pool that is distributed to each hospital will be determined by the needs demonstrated in the hospital-submitted projects, described in greater detail below. The state will also consider whether it would like to cap the delivery reform investment available to eligible hospitals each year. The state may set aside a portion of the pool for strategic planning purposes such as providing funding or technical assistance for hospitals to prepare their strategic plans and project applications.

Eligible hospitals will propose delivery reform projects in their transformation plans for approval and receipt of the delivery reform investment; the state will establish a process and scoring criteria for reviewing the transformation plans. Considerations for the scoring criteria include,

but are not limited to, community partnerships, implementation of Act 167 recommendations,[3] and affordability impacts.

The funding for delivery reform will be available for several years with the option for renewal. Eligible hospitals who join the model after the first performance year may be eligible for investment pool funding; however, they may have a reduced chance of receiving the investment funding as the available funding may diminish over time. The state will establish an initial period for the investment pool, such as three years, with the possibility for additional flexibility in the investment period based on hospital-submitted projects and available funding.

The state will establish a process to evaluate each hospital's use of the delivery reform investments and reporting process. Considerations for the evaluation process include, but are not limited to, implementation period, available monitoring and accountability measures, and flexibility in measures that could differ by hospital.

5.4 Global payment updates

5.4.1 Inflation updates

Each year global budget revenue will be updated to reflect changes in the input costs of hospital inpatient and outpatient services. Baseline or prior year global payment revenue data will be updated using the Medicare IPPS Hospital Market Basket from the final rule.[4] In future years, the state will assess alignment across payers and potential modifications to the inflation updates under the Medicare GPP.[5]

See section 5.4.3.1 for updates for critical access hospitals (CAHs) and Medicare dependent hospitals (MDHs).

5.4.2 Beneficiary updates

Hospital global payments will be adjusted based on Medicare FFS enrollment changes in a geographic area. To account for changes in medical risk, Medicare FFS beneficiary counts will be adjusted for age, sex, and end-stage renal disease (ESRD) factors. The state will not use the CMS hierarchical condition category (HCC) scores because of how sensitive clinical risk measures are

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[3] In 2022, the legislature passed Act 167 (of 2022) which called for health care delivery reform in the state of Vermont. A central part of this legislation is a listening tour to hear directly from Vermonters about current experiences with the health care system and what they would like to see in the future. The information gleaned in these meetings will be used to inform recommendations to support hospitals in identifying short-, medium-, and long-term actions to keep them sustainable.

[4] The state is considering using the market baskets from the IPPS proposed rule to align the timelines with the hospital budget review process. Vermont will continue to assess whether there are other measures of inflation that will better reflect the state's experiences.

[5] According to the Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology (version 1.0), the AHEAD Model reduces the inflation updates through a producitivity adjustment for PPS hospitals.

to utilization and updates to the HCC model.[6] The current age, sex, and ESRD factors should account for much of the variation in costs associated with changes in medical complexity (see Appendix 9.2). The state will monitor changes in CMS-HCC scores every three years and will consider including it as an adjustment to beneficiary counts if there are major changes in the scores over time. Vermont's risk adjustment method will serve the needs of the state while aligning with CMS's principle that hospital global payments are adjusted for medical risk. The state may also consider other risk adjustment methods, such as the Johns Hopkins ACG System, to align with other payers (see Appendix 9.2).

The demographic weights will be reviewed and updated every three years and the beneficiary updates will be recalculated annually due to significant changes in Medicare FFS enrollment and paid amount distributions within hospital service areas (HSAs) from year to year. Table 7 shows an example of a hospital's adjusted beneficiary change across HSAs.

Table 7. Illustrative example of beneficiary update calculation

HSA	Adjusted BY beneficiary counts	Adjusted PY beneficiary counts	Adjusted beneficiary change	Hospital A revenue	Hospital A revenue distribution	Hospital A membership change
Formula	*A*	*B*	*C=B/A-1*	*D*	*E=D/sum(D)*	*F=C*E*
HSA A	1000	940	-6%	$1,000,000	33%	-2.0%
HSA B	1000	930	-7%	$1,000,000	33%	-2.3%
HSA C	1000	940	-6%	$1,000,000	33%	-2.0%
Total				$3,000,000		-6.3%

BY = base year; HSA = hospital service area; PY = performance year.

5.4.3 Social risk adjustment

The social risk adjustment (SRA) is aimed at addressing health care disparities by providing hospitals with an upward adjustment of up to 2 percent to the hospital's global payment that is commensurate with the level of adversity of their patient population. This adjustment would account for hospital-to-hospital differences in social risk of the patient population.

The adjustment will be prorated based on the state social determinant of health (SDOH) score of the hospital's HSA. The SDOH score will be determined using the Social Vulnerability Index (SVI)[7]

[6] CMS uses hierarchical condition category (HCC) risk adjustment models to estimate future health care costs for Medicare Advantage patients based on health status and demographic factors. The CMS-HCC model V28 will be phased in over a three-year period, with a blend of 33 percent from the V28 model and 67 percent from the V24 model for 2023 dates of service. V28 will be used at 67 percent for 2024 dates of service and fully phased in at 100 percent for 2025 dates of service. V24 will be used at 33 percent for 2024 dates of service and fully phased out for 2025 dates of service.

[7] While the Area Deprivation Index (ADI) was constructed for policy and health care program applications, SVI may be a better area-level SDOH index for Vermont given the need for detailed address information for ADI. There are benefits and advantages to each index but the recent findings about how ADI is

and dual-eligibility status for beneficiaries in each HSA. The proportion of hospital payments in each HSA will be used as weights to determine the hospital-level SDOH score. See Table 8 through Table 10 for an illustrative example of the three steps to calculate hospital-level social risk adjustment. Vermont has not experienced substantial year-over-year changes in SVI scores so the state will recalculate the SDOH scores every three years.

Table 8. Illustrative example of SDOH scores by hospital service area (step 1)

Hospital service area	SDOH score
HSA A	150
HSA B	140
HSA C	100

HSA = hospital service area; SDOH = social determinant of health.

Table 9. Illustrative example of weighted SDOH scores, by hospital (step 2)

Hospital	Hospital A	Hospital B	Hospital C
Proportion of hospital payments at each HSA			
HSA A	90%	5%	50%
HSA B	10%	35%	30%
HSA C	0%	60%	20%
Weighted SDOH scores (Proportion of hospital payments*SDOH score in Table 8)			
HSA A	135	7.5	75
HSA B	14	49	42
HSA C	0	60	20
Total	149	116.5	137

HSA = hospital service area; SDOH = social determinant of health.

Table 10. Illustrative example social risk adjustment, by hospital (step 3)

Calculation step	Formula	Hospital A	Hospital B	Hospital C
Hospital budget	A	$1,000,000	$1,000,000	$1,000,000
Hospital's SDOH score	B	149	116.5	137
State mean SDOH score	C	130	130	130
95th percentile SDOH score	E	149	149	149
Hospital above / (below) state mean	F=B/C-1	15%	-10%	5%
Scaling factor	G=1-(E-B)/(E-C)	1.00	0.25	0.37
Max adjustment	H	2%	2%	2%

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calculating its scores and how this leads to misclassification of neighborhoods makes it difficult to use this index given it may lead to under-resourcing hospitals. For more information on SVI, see https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Calculation step	Formula	Hospital A	Hospital B	Hospital C
Hospital percent adjustment	I=G*H	2.00%	0.50%	0.74%
Hospital adjustment amount	J=I*A	$20,000	$5,000	$7,368

SDOH = social determinant of health.

5.4.4 Policy

Annual adjustments to the global payments will include Medicare policy changes, the wage index adjustment, and the low volume adjustment.

5.4.4.1 Medicare policy updates

Global payments may be adjusted annually for significant changes in other PPS claim-based adjustments including:

- Medicare outlier payments
- indirect medical education (IME)
- disproportionate share hospital (DSH)
- uncompensated care (UCC) payment

The methodology for these adjustments is under development by the state.

5.4.4.2 Wage index

Medicare FFS payment amounts include a prospective wage index adjustment that adjusts payments for hospital area-level differences in wage levels by a prespecified factor that reflects the relative hospital wage level in the hospital's geographic area compared to the national average hospital wage level. Wage index hospital geographic areas are defined by core-based statistical areas (CBSAs) established by the Office of Management and Budget and include any wage index reclassification. Wage indexes are updated annually, based on information derived from hospitals' Medicare Cost Reports, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documents. The wage index for participating hospitals' CBSAs will be applied to the labor portion of their global payment amount and will be updated annually based on CMS's updated wage index as published in the IPPS impact files.

5.4.4.3 Low volume

Medicare FFS payment amounts include a low-volume adjustment, used to compensate hospitals for fixed costs that cannot be recovered under the IPPS when total discharges are low. The low-volume adjustment is based on a percentage coefficient and is updated annually based on the number of inpatient discharges in a formula published in the IPPS rules. Only PPS hospitals that apply for and are eligible to receive a low-volume adjustment will receive a low-volume add-on payment in their Medicare global payment. The low-volume adjustment is excluded in the baseline payment and will be updated annually to eligible participating hospitals' global payments, in accordance with published IPPS rules.

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5.4.1 Performance

Annual adjustments to the global payments will reflect hospital performance in quality, health equity, and total cost of care.

5.4.1.1 Quality adjustment

Starting in PY1, an adjustment will be applied to the global payment for PPS hospitals based on the participant hospital's performance in CMS national hospital quality programs. The methodology will approximate the revenue at risk under the quality programs and apply the scoring on these programs to the hospital global payments. Adjustment factors are applied to inpatient acute care payment amounts, excluding capital payment amounts and low-volume payment amounts. First year baseline budget, broken out by labor and non-labor portion of paid amounts of inpatient claims and outpatient paid amount, will be used to calculate these adjustments in subsequent years.

Currently CMS has six programs for PPS hospitals. The CMS national hospital quality programs include:

Hospital Value-Based Purchasing (VBP) Program. The year-on-year change in value-based incentive payment adjustment factor is used to adjust the labor and non-labor portion of paid amounts of inpatient claims. CMS publishes the relevant factors to be used for a given year (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html).

Hospital Readmission Reduction Program (HRRP). The year-on-year change in readmissions adjustment factor is used to adjust the labor and non-labor portion of paid amounts of inpatient claims. CMS publishes the relevant factors to be used for a given year (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html).

Hospital-Acquired Condition (HAC) Reduction Program. The year-on-year change in HAC score (total HAC score greater than the 75th percentile of all total HAC scores will be subject to a 1 percent payment reduction) is used to adjust the labor and non-labor portion of paid amounts of inpatient claims. CMS publishes the relevant factors to be used for a given year. No payment reductions will be applied when CMS does not calculate these scores (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html).

Hospital Inpatient Quality Reporting (IQR) Program. The year-on-year change in market basket, as published by the CMS Office of the Actuary, is used to adjust the labor, non-labor, and capital portion of paid amounts of inpatient claims (https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program).

Hospital Outpatient Quality Reporting (OQR) Program. The year-on-year change in market basket, as published by the CMS Office of the Actuary, is used to adjust the labor and non-labor portion of paid amounts of outpatient claims (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html).

Medicare Promoting Interoperability Program. To be considered a meaningful user and avoid a downward payment adjustment, eligible hospitals and CAHs attesting to the Medicare Promoting Interoperability Program will be required to use certified electronic health record technology (CEHRT) that has been updated to meet 2015 Edition Cures Update criteria (https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs).

CAHs are not required to participate in the CMS national hospital quality programs. In AHEAD, CAHs will participate in an upside-only quality incentive program that will align with the other quality programs and will include rural-specific measures. See section 5.4.3.1 for CAH quality adjustments.

5.4.1.2 Health equity improvement bonus

The Medicare FFS GPP includes an adjustment for performance on disparities-sensitive quality measures among a high adversity cohort. The upside-only adjustment reflects hospital performance on select quality measures that focus on promoting health equity (see Table 11 for a proposed list of measures). At a minimum, measures must include sufficient data to identify disparities and changes in those disparities over time and align with overall model goals.

Table 11. Proposed measures for the health equity improvement bonus

Measures	Purpose	Source
Social determinant of health (SDOH) score	Identify the high adversity cohort	Social Vulnerability Index, dual eligibility status
Hybrid Hospital-Wide All-Cause Unplanned Readmissions (Hybrid HWR)	Measure hospital performance in readmissions	Claims and electronic health data
Prevention Quality Indicators-92 Chronic Conditions Composite (PQI-92)	Measure hospital performance in chronic conditions	Claims and administrative data (non-claims)

Note: Vermont will consider using multi-year data and/or additional measures for outpatient care given the smaller size of inpatient care for some hospitals.

The methodology to adjust for performance in disparities-sensitive quality measures will align with the AHEAD model and the state's health equity plan. For the Hybrid HWR and PQI-92 measures, a stratified measurement approach will be used to assess improvement among the high adversity cohort. The Medicare FFS GPP will provide a variable upward adjustment depending on the magnitude of improvement. Hospitals could receive up to 0.5% of their global payment for performance on two health equity-focused measures, with a maximum of 0.25% for each measure.

The upward adjustment will be applied to the fourth performance year to allow time for data collection. The state will refine the time periods to align with data availability for the final measures.

5.4.1.3 Total cost of care

The total cost of care (TCOC) performance adjustment holds participating hospitals accountable for TCOC growth within their hospital service area (HSA) or sub-level HSA for small hospitals. TCOC includes Part A and Part B services paid by Medicare. The baseline incentives and Vermont pass-through payments that are excluded from the all-payer total cost of care statewide expenditure performance calculations for savings requirements will also be excluded from the hospital TCOC adjustment. The TCOC hospital performance adjustment will exclude the Social Risk Adjustment (SRA), Transformation Incentive Adjustment (TIA), Enhanced Primary Care Payments (EPCP), and other payments supporting care delivery transformation.

In order to determine if TCOC adjustments will apply to a hospital, the state will utilize the statewide Medicare FFS TCOC target as the adjustment's benchmark. If a hospital's TCOC performance is below the target (benchmark), the state will assess if the proportion of primary care and preventive services is increasing relative to hospital and specialty care services. If this proportion is increasing, then the Medicare GPP will receive an upward adjustment in a subsequent performance year. However, if TCOC performance is above the benchmark, then the Medicare GPP may receive a downward adjustment in a subsequent performance year. The state may also utilize and determine corridors (also known as bumpers) in which an adjustment is made if the performance is a certain amount outside of the benchmark (for example, if TCOC growth is 1 percent higher or lower than the benchmark, then an adjustment is made). This adjustment will be implemented in PY4 and will have a maximum upward/downward adjustment of plus or minus 2 percent of the Medicare GPP. Table 12 below demonstrates a calculation for determining a TCOC adjustment. Please note that this calculation does not yet consider potential corridors.

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Table 12. TCOC adjustment example calculation for acute care

	BY3					**PY2**				
Provider name	**Provider type**	**Total payments**	**Member months**	**TCOC PMPM**	**TCOC**	**Total payments**	**Member months**	**TCOC PMPM**	**TCOC**	**Change in TCOC**
		A	B	A/B	A/(B/12)	C	D	C/D	C/(D/12)	E
Hospital A	IPPS	$27,000,000	30,000	$900.00	$10,800.00	$29,000,000	32,000	$906.25	$10,875.00	0.7%

Provider name	**PY2 after annual adjustment**	**Actual growth**	**TCOC growth target**	**At risk%**	**TCOC adjustment %**	**TCOC adjustment (upside only)**
	F	G	H	I	J = ((G-H)/H)*I	K = F * J

Hospital A	$22,000,000	0.7%	4.2%	+/-2% (for first implementation year, upside-only)	1.7% (results in -1.7%, but use the positive for calculation)	$374,000

BY = base year; IPPS = inpatient prospective payment system; PMPM = per member per month; PY = performance year; TCOC = total cost of care.

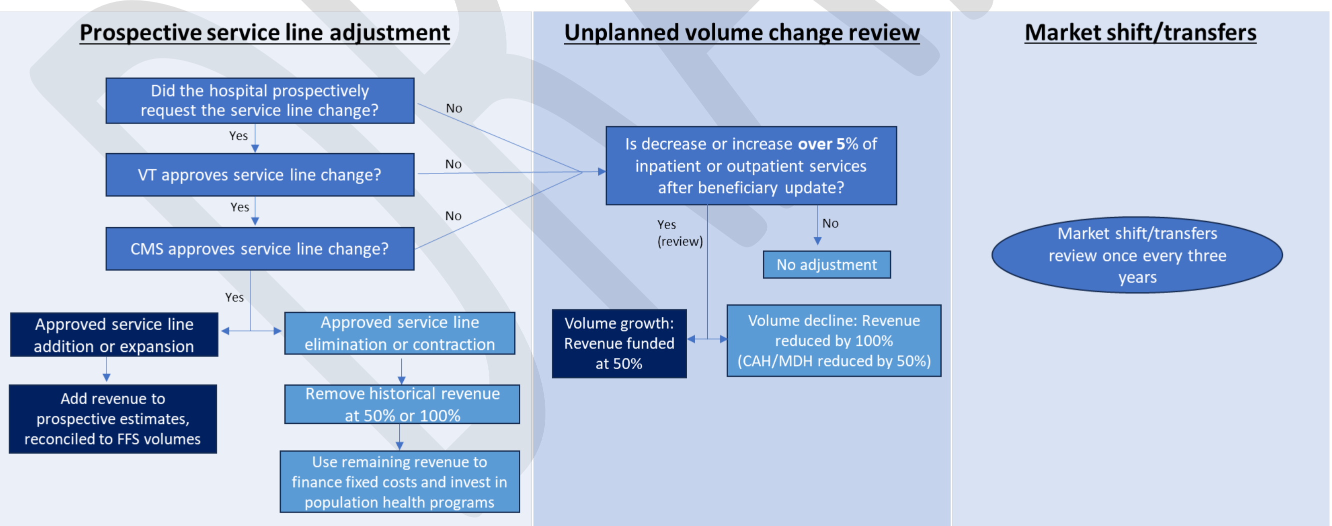
5.4.1.4 Effectiveness and efficiency

Vermont will consider an adjustment at a facility level to assess hospitals on the effectiveness and efficiency of their hospital operations, and may consider measures of utilization, commercial rate growth, staffing and productivity, among others. Hospitals might receive bonuses or reductions in global payments based on their organizational efficiency. The methodology for an adjustment such as this will also be determined and described in a future version of the Medicare GPP. The state will carefully consider the methodology of applying the adjustment to global payments to prevent unintended consequences related to access to care.

5.4.2 Service line adjustments

The Medicare GPP is subject to adjustments for changes in service line utilization. Hospitals that prospectively report service line changes could receive the full addition or expansion or keep a portion of their historical revenue for service line closures. Hospitals with substantial service line changes that are not pre-approved will undergo an unplanned volume change review. Figure shows the process for determining the adjustments for volume change.

Figure 3. Flow chart for proposed service line adjustments



CAH = critical access hospital; CMS = Centers for Medicare & Medicaid; FFS = fee-for-service; MDH = Medicare-dependent hospital; VT = Vermont.

5.4.2.1 Prospective service line adjustment

Major changes to service lines after the baseline years will be incorporated into the budget calculations separately as appropriate. Changes to services lines include openings, expansions,

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temporary changes, and closures of existing service lines. These changes must meet a materiality threshold (dollar amount or percentage of Medicare GPP) to qualify for a prospective service line adjustment.

Service line changes will be captured in the hospital's budget materials that are submitted to GMCB as a part of the hospital budget review process. These materials will include information about plans to open, expand, reduce, or close specific service lines. Additionally, hospitals will provide information on whether they have experienced a temporary service line change (for example, due to a provider vacancy).

5.4.2.1.1 Increase access

Service line additions or expansions requested by hospitals should be changes intended to increase access to services that are currently nonexistent or impeded by travel and distance constraints (unmet need-related). Global payment adjustments for service lines expanding or opening during performance years will be estimated and added to the global payment prospectively. Hospitals will develop their estimates based on the methodology set forth in the Medicare FFS GPP policy and will be validated by comparing the estimates with historical utilization and other relevant information. GMCB will monitor actual changes in revenue from service lines opening or expanding and adjust future global budget amounts when the hospital submits their actual budget results in January of the following year (see section 3.1 for the hospital budget review process timeline for more detail).

There will be two pathways for state approval of prospective service line openings and expansions that meet a certain threshold:[8]

- **Preapproved service lines.** Planned service line additions or expansions requested by hospitals should be intended to increase access to services for community members. As a result, Vermont will publish a list of preapproved service lines that are volume- and location-specific.[9] The preapproved list is subject to change over the course of the GPP. Hospitals that fit the preapproval criteria will receive an expedited review.
- **Full review.** Hospitals that propose service line adjustments outside of the preapproved list must undergo a full review. Under the full review, hospitals will provide information about specific definitions of relevant service lines through diagnosis-related group (DRG) codes, Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes or other medical codes. Hospitals will additionally provide rationale for planned service line changes, including budget estimates for each service

[8] The threshold (dollar amount or percentage of global payments) for prospective service line adjustments is to be determined by the state.

[9] Options for determining whether a service line expansion increases access within the community include defining primary service lines, leveraging Act 167 community engagement recommendations, using the hospital's most recent Community Health Needs Assessment, or a combination of these options.

line as part of the narrative budget submission and any temporary changes in their services.

The adjustments will be based on the Medicare payment rate of the service line multiplied by a specified percentage as determined and approved by the state. Reconciliation of prospective service line changes will occur in the next PY and the remaining biweekly payments will be adjusted to account for the difference in the forecasted and actual service line changes. For service line contractions, a condition of approval is for a hospital to review their composition of services for any opportunities that warrant contraction.

5.4.2.1.2 Temporary changes

A hospital can receive a nonpermanent adjustment to its global payment for temporary changes to its service lines. An example of a temporary service line change includes a provider leaving the participating hospital, when the hospital has not yet filled the vacancy. The state will monitor actual changes in revenue at the service line level from the prior performance year and apply a nonpermanent adjustment to the next year's global payment amounts.

5.4.2.1.3 Closures

Hospital budgets will be adjusted if the hospital plans to close a service line and the resulting loss in revenue meets or surpasses a materiality threshold to be determined and approved by the state. Hospitals that close service lines will submit plans during the hospital budget review process. The state will review and approve submitted plans. If anticipated costs and revenues decline at or above the specified materiality threshold, the state will apply a prospective adjustment. Hospital estimates will be validated by comparing the estimates with historical utilization and cost data using FFS claims. Prospective budget adjustments will be based on the Medicare payment rate of the closed service line multiplied by a specified percentage, to be determined and approved by the state. GMCB will monitor actual changes in revenue from service line closures and adjust future global budget amounts.

5.4.2.2 Market shift or transfers

Due to limited market shifts in the state and to ensure there are sufficient data to identify a shift, Vermont will conduct market shift reviews every three years to assess whether global payment adjustments based on shifts of patients from one hospital to another are needed. The state will review transfer rates and volume from participating and nonparticipating hospitals and adjust the global payments if there is a disproportionate increase in transfers. The state will monitor same- and next-day inpatient and emergency department (ED) transfers by (1) establishing the baseline level of transfers, (2) regular (for example, quarterly or semi-annual) monitoring of levels of transfers, and (3) adjustments to hospital global budgets based on the increase in transfer cases combined with a standard transfer cost (calculated using a pre-established formula).

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5.4.2.3 *Unplanned volume change review*

Hospitals that experience changes in volume that are not disclosed and preapproved or captured in the market shift or transfers or beneficiary update adjustments will be subject to an unplanned volume change review. Hospitals with greater than a 5 percent increase or decrease in inpatient and outpatient volume combined will trigger a review and the state could increase or decrease the Medicare GPP (see Table 13 for potential adjustments by hospital type). In the case where over 40 percent of participating hospitals require a review, the state will assess the sufficiency of the Medicare GPP adjustments or increasing the threshold for review.

Table 13. Potential adjustment for hospitals that experience substantial unplanned volume change, by hospital type

Threshold	PPS hospitals	CAHs/MDHs
>5% increase	Add 50% of revenue above 5% threshold	Add 50% of revenue above 5% threshold
>5% decrease	Remove all revenue beyond 5% threshold	Remove 50% of revenue beyond 5% threshold

Note: MedPAC used a conservative approach to estimate hospitals' fixed costs and found that about 20% of hospital costs are fixed (excluding managerial or clinical labor costs). Among smaller hospitals, about 50% of costs are fixed over a one-year period due to low occupancy rates and difficulty reducing staff and equipment costs when volume decrease. Vermont may conduct an analysis on hospital fixed costs in the state and revise the percentages.
CAH = critical access hospital; MDH = Medicare-dependent hospital; MedPAC = Medicare Payment Advisory Commission; PPS = prospective payment system.

5.4.3 Hospital-specific adjustments

Special adjustments are applied to the global payments on an as-needed basis to ensure sufficiency of global payments. This includes adjustments for other facilities (for example, CAHs and MDHs), and other case-by-case circumstances.

5.4.3.1 *Critical access hospitals and Medicare-dependent hospitals*

The Medicare GPP for CAHs and MDHs will be rebased using the latest cost report if global payments fall below a percentage of the latest cost report at the point of model entry after inflationary updates.

Given Vermont's ongoing work on hospital transformation, the state will delay design of the adjustment for CAHs and MDHs until the state has formulated its approach to hospital transformation. Vermont reserves the right to tailor additional methods for these hospitals given the populations that they serve.

5.4.4 Other

The state will also consider, on a case-by-case basis, whether to apply adjustments to hospital global payments for changes in policy and extraordinary circumstances including, but not limited to, payment rate changes and major changes in inflation.

Participant hospitals may request exception-based or exogenous factor (e.g., a pandemic or recession) adjustments to the Medicare GPP, including for service line changes. These

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adjustments would need to be approved by CMS.[10] The state will work to determine a process and threshold for the consideration of an adjustment. Any exception-based adjustments will be at the sole discretion of the state.

5.5 Mid-year updates[11]

In rare cases, hospitals may request updates to their budgets in the middle of a performance year. Vermont is proposing mid-year budget updates that will be a one-time payment outside of the global payment for major disruptions in service volume or financial flows caused by exogenous factors. Approval of participating hospital's requests for an additional mid-year budget payment will be approved at the sole discretion of the state. These one-time payments will not carry over into the next performance year's global payment.

6 Medicaid Payment Model Design

The State of Vermont's Department of Vermont Health Access is developing the methodology for Medicaid.

7 Commercial Payer Payment Model Design (TBD)

The GMCB is developing a methodology for Commercial payers using its rate setting authority.

8 Transformation Plans (TBD)

The State will establish a process for reviewing and approving transformation plans, and will serve as an input to the GMCB's hospital budget review.

9 Appendix

9.1 Definitions

9.1.1 Hospital service area

The VT GPP uses hospital service area as the geography (see Figure).

[10] The roles of CMS and the state will be finalized during the pre-implementation period.
[11] Mid-year update is a Vermont-specific methodology and is not included in the AHEAD Model.

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Figure 4. Map of Vermont's hospital service areas

Source: Vermont Department of Health, Public Health GIS.
https://experience.arcgis.com/experience/fd469cf0213a441592d54edd832fc98d/page/Page/

9.2 Global payment revenue

Table 14 shows potential excluded revenue and included global payment revenue, by payer, using FY 2022 revenue. Approximately 66 percent of net patient revenue would be included in the global payments, assuming full participation in the commercial market.

Table 14. Estimated revenue included and excluded from the global payment program, 2022

	Revenue	Proportion of total net patient revenue and FPP
Total net patient revenue and FPP	**$3,017,752,722**	**100%**
Physician revenue[a]	$473,387,653	16%
Other payer exclusions[b]	$324,832,007	11%
Patient portion[c]	$234,949,283	8%
Global payment revenue	**$1,984,583,779**	**66%**
Medicare – FFS[d]	$429,357,739	14%
Medicaid – FPP[e]	$102,349,994	3%
Medicaid – GB[e]	$141,789,856	5%
Private and Medicare Advantage – Potential[e]	$1,311,086,190	43%

Source: GMCB, Adaptive Platform, Payer Revenue Sheet and Income Statement, FY 2022. VHCURES (for commercial patient portion estimates, using 2021 amounts). National Medicare FFS claims database for Medicare FFS included revenue. Data are preliminary and were not validated with hospitals.

FFS = fee-for-service; FPP = fixed prospective payment

[a] Physician revenue of hospitals will be considered in a future phase of the methods development.

[b] Other payer exclusions: revenue from workers compensation, uninsured and self-pay, non-VT Medicaid, and uncategorized (DSH) amounts in Adaptive financial reports.

[c] Patient portion amounts use 2021 VHCURES beneficiary portion estimates applied to Adaptive data.

[d] Medicare FFS revenue comes from national Medicare FFS claims database. Included revenue is estimated using definitions from the AHEAD Model.

[e] Medicaid and commercial amounts come from Adaptive, and these numbers include revenue for SNF/clinic/rehab and swing beds, as Adaptive does not appear to split out these service lines for net revenue amounts.

9.3 Methodology to select weights for beneficiary updates

Vermont used a regression-based approach to identify the weights for the beneficiary update. To align with the revenues that will be included in the anticipated global payment, we used Medicare insurer-paid hospital costs from FFS claims[12] on a per member per month (PMPM) basis as the dependent variable.

While dual eligible status is strongly associated with higher per member per month costs, especially for patients with ESRD (Table 15), the beneficiary updates adjustment does not account for changes in dual eligibility because the number of dual eligibles does not

[12] The analysis included all Medicare payments from FFS claims and excludes AIPBP. The Medicare GPP will exclude certain services and include the FFS-equivalents under AIPBP.

substantially change over time. Table 16 shows that the percent of members that are dual eligible slightly declined from 2021 to 2022 but this trend might be influenced by the differential effects on mortality among the frail elderly during the pandemic. In addition, a report from the Vermont Legislative Joint Fiscal Office found that enrollment among dual eligibles did not substantially change from the continuous Medicaid enrollment provision in the federal Consolidated Appropriations Act, 2023. The report also noted that resuming normal eligibility and enrollment operations and completing Medicaid redeterminations will have a minimal impact on dual eligibles because their eligibility is not tied to employment status.[13] Table 15 shows that there is a minimal impact in the change in average demographic factor when adding dual eligibility status. It is important to continue to monitor the changes in dual eligible enrollment if Vermont does not include dual eligibility in the Medicare FFS GPP's membership adjustment.

Table **15**. Regression results for demographic factors in the membership adjustment

	Baseline: Age and Sex Only	Approach 1: ESRD and Dual	Approach 2: ESRD Only
Intercept	$285	$197	$263
ESRD	Not Included	$3,073	$3,232
Dual	Not Included	$197	Not Included
Age 65-74	-$146	-$94	-$138
Age 75-84	-$73	Not Significant	-$47
ESRD and Dual	Not Included	$439	Not Included
Male and Age 65-74	Not Significant	$38	$35
Male and Age 75-84	$74	$74	$69
Male and Age 85+	Not Significant	$127	$82
Dual and Under 65	Not Included	-$80	Not Included
Regression Statistics	R-Squared: 0.2143 Adjusted R-Squared: 0.2014 F Statistic: 16.70 (<0.0001)	R-Squared: 0.6358 Adjusted R-Squared: 0.6288 F Statistic: 90.61 (<0.0001)	R-Squared: 0.5885 Adjusted R-Squared: 0.5813 F Statistic: 82.61 (<0.0001)

Table **16**. Change in percent dual eligible by HSA, FY2021-2022

HSA	2021	2022	2021 to 2022 change
Vermont	**22.1%**	**21.4%**	**-0.8%**
Barre	22.4%	21.7%	-0.8%
Bennington	22.7%	21.9%	-0.8%
Brattleboro	22.5%	21.5%	-0.9%
Burlington	18.6%	18.0%	-0.6%
Middlebury	17.8%	17.3%	-0.4%
Morrisville	0.2%	0.2%	0.0%

[13] Vermont Legislative Joint Fiscal Office. "Impacts of the Temporary Medicaid Continuous Enrollment in Vermont, 2020-2023." November 2023. https://ljfo.vermont.gov/assets/Publications/Issue-Briefs/de33fe7dc4/GENERAL-372409-v2-2023_Temporary_Continuous_Enrollment-v6.pdf.

HSA	2021	2022	2021 to 2022 change
Newport	32.8%	32.0%	-0.9%
Randolph	20.9%	19.4%	-1.5%
Rutland	25.2%	24.0%	-1.2%
Springfield	23.6%	22.9%	-0.8%
St. Albans	25.1%	24.8%	-0.3%
St. Johnsbury	25.0%	23.8%	-1.2%
White River Jct	16.9%	16.4%	-0.5%

Table **17**. Change in regression-based average demographic factor by HSA, FY2021-2022

HSA	Change with dual status	Change without dual status	Difference
Vermont	**-0.2%**	**0.1%**	**0.3%**
Barre	0.0%	0.3%	0.3%
Bennington	0.3%	0.5%	0.2%
Brattleboro	0.3%	0.6%	0.3%
Burlington	0.0%	0.2%	0.2%
Middlebury	-0.3%	-0.3%	0.0%
Morrisville	0.7%	1.1%	0.4%
Newport	-0.5%	0.0%	0.5%
Randolph	-1.1%	-0.2%	0.9%
Rutland	0.1%	0.7%	0.6%
Springfield	-1.4%	-1.2%	0.2%
St Albans	-0.3%	-0.5%	-0.2%
St Johnsbury	-0.6%	-0.1%	0.5%
White River Jct	-0.8%	-0.9%	-0.1%

Note: Factors included in both regression-based approaches are age, gender, and ESRD status.

Global budgets are based on historical revenue, which incorporates utilization and service intensity of hospitals. The beneficiary update adjustment will proportionally distribute changes in member counts to each hospital so it is not an attribution model where risk adjustment of individual enrollees may be important. Overall, the health risk of a population living in certain geographies should not change drastically on an annual basis. Medicare Advantage penetration may be the only issue to have significant impact on the medical risk profile of Medicare fee-for-service beneficiaries, yet preliminary analysis of CMS-HCC scores in Vermont did not show an increase in risk scores. Vermont will monitor the impact of Medicare Advantage on the program to assess whether using age, gender, and ESRD factors is sufficient for capturing changes in the population's health status.

Since clinical risk scores are derived from diagnoses or other codes on claims, changes in utilization can drive risk scores higher or lower due to the volume of claims rather than a change in patient complexity. Table 18, below shows declining risk scores in Vermont's Medicare

population, by county, between 2020 and 2021. These declines may demonstrate the sensitivity of clinical risk measures to utilization, as a decrease in utilization due to the coronavirus pandemic may have impacted risk scores. Risk scores in the Medicare population may have decreased at a lower rate due to overall patient acuity as compared to the all-payer population.

Table 18. Prospective average CMS-HCC score and Medicare FFS beneficiary count by Vermont County

County	CMS-HCC score 2019	CMS-HCC score 2020	CMS-HCC score 2021	CMS-HCC score change from 2019 to 2020	CMS-HCC score change from 2020 to 2021	Medicare FFS beneficiary count 2020	Medicare FFS beneficiary count 2021	Medicare FFS beneficiary count change from 2020 to 2021
Addison	.87	.91	.87	4%	-4%	6,571	6,303	-4%
Bennington	.97	.99	.95	2%	-4%	8,015	7,634	-5%
Caledonia	.90	.92	.89	2%	-3%	6,247	6,057	-3%
Chittenden	.93	.93	.88	0%	-5%	23,537	21,921	-7%
Essex	.91	.92	.88	0%	-4%	1,508	1,385	-8%
Franklin	.97	.98	.92	1%	-6%	8,203	7,856	-4%
Grand Isle	.85	.87	.80	2%	-7%	1,558	1,458	-6%
Lamoille	.88	.90	.84	2%	-6%	4,445	4,226	-5%
Orange	.90	.91	.87	1%	-4%	6,015	5,818	-3%
Orleans	.92	.90	.87	-2%	-3%	6,106	5,818	-5%
Rutland	.98	.97	.93	0%	-5%	13,490	12,783	-5%
Washington	.92	.92	.88	0%	-4%	11,707	11,293	-4%
Windham	.91	.92	.87	1%	-4%	9,435	9,095	-4%
Windsor	.91	.91	.89	-1%	-2%	12,151	11,758	-3%

Note: The beneficiaries included in this table are those enrolled in Medicare FFS, who do not have ESRD and who were not in hospice.

Sources: HCC scores are from https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ffs-data-2015-2021; Member FFS beneficiary counts are from the Medicare Geographic Variation file.

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