VERMONT
GREEN MOUNTAIN CARE BOARD

AHEAD Model & Global Payment Development

January 17, 2024

Agenda

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1. Introduction
2. Review of Executive Session
3. Status Update: AHEAD Model & NOFO
4. Status Update: DRAFT Vermont Medicare FFS Global Payment Model
5. Board Questions
6. Public Comment
7. *Potential Executive Session*

Executive Session

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Grounds for Holding an Executive Session

- The GMCB may hold an executive session to consider "contracts" after making a specific finding that premature general public knowledge would clearly place the GMCB or a person involved at a substantial disadvantage. *See* 1 V.S.A. § 313(a)(1).

Motion/Scope

- A motion to go into executive session must be made during the open part of the meeting and must indicate the nature of the business of the executive session. No other matter may be considered in the executive session except the matter included in the motion. 1 V.S.A. § 313(a).
- No formal or binding action shall be taken in an executive session (except relating to securing real estate options). 1 V.S.A. § 313(a).

Vote

- An affirmative vote of 2/3 of members present is required to go into executive session. 1 V.S.A. § 313(a).

Attendance

- Attendance in an executive session shall be limited to members of the public body, and in the discretion of the body, its staff, clerical assistants and legal counsel, and persons who are subjects of the discussion or whose information is needed. 1 V.S.A. § 313(b).

AHEAD Model Update:
Timelines and Areas of Flexibility

Pat Jones, Interim Director of Health Care Reform, Agency of Human Services

January 17, 2024

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Act 167 Sections 1 and 2

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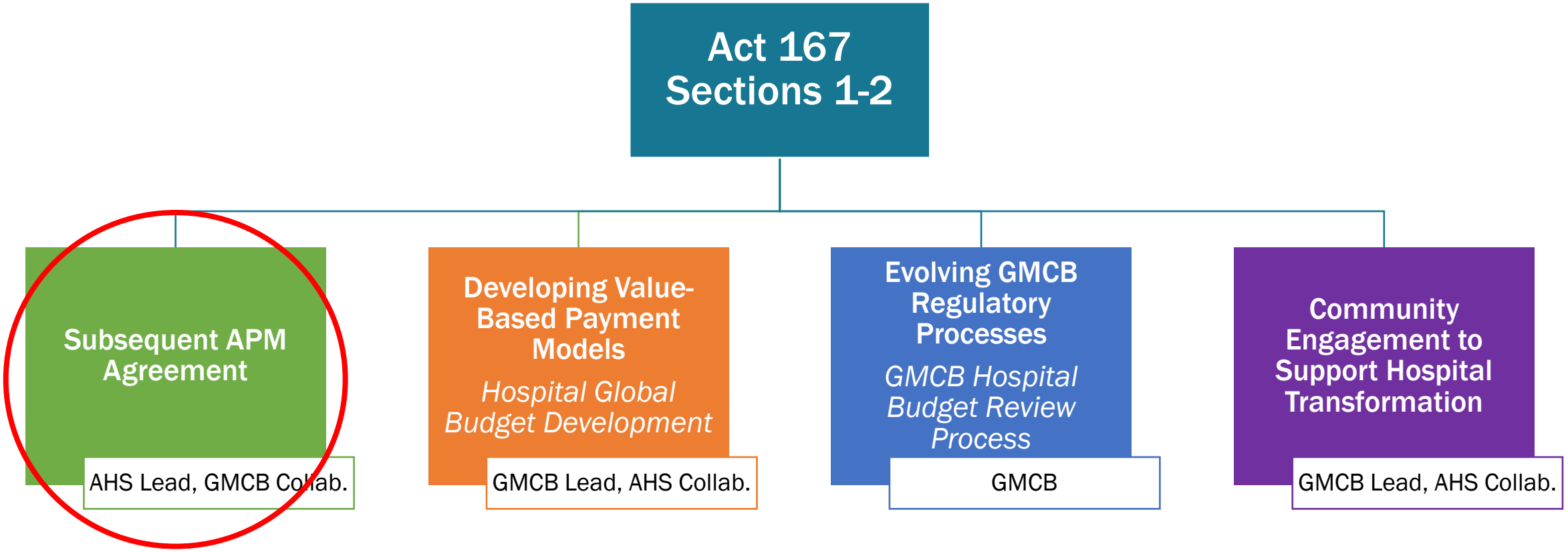

Why Consider New Federal Model and Why Now?

Health Care Reform seeks to use public policy to address challenges in our health care system. Challenges and related goals Include:

- Ensuring affordability
- Improving access to care and insurance coverage
- Optimizing quality and experience of care
- Improving the health of the entire population
- Improving equity and reducing disparities in health and health care
- Identifying and addressing social determinants of health
- Ensuring adequate workforce across all care settings
- Reducing complexity (including misalignment across public and private payers)
- Creating a sustainable health care system

Payment reform gets a lot of attention; it is just one component of health care reform. It is also a means to an end: the goal is for payment changes to encourage and support care delivery transformation that leads to **better health outcomes and population health.**

Current Vermont All-Payer Model Agreement

- **Signatories:** Governor, AHS Secretary, GMCB Chair
- Arrangement between Vermont and the federal government that **allows Medicare**, Medicaid, and commercial insurers **to pay for health care differently** and establishes state-level accountability for cost, population health, and quality
- The model shifts from paying for each service (fee-for-service) to **predictable, prospective payments** that are linked to quality (value-based)
- Changing payment is intended to **reduce health care cost growth, maintain or improve quality, and improve the health of Vermonters**
- Relies on an accountable care organization (OneCare Vermont) to develop a voluntary network of providers that agree to be **accountable for care, cost, and quality** for their attributed patients.
- Original performance period was **2018-2022** (5 Performance Years)
- Currently in first year of a **two-year extension period**
  - Extension suggested by the Center for Medicare & Medicaid Innovation (CMMI); signatories approved in November 2022 to act as a bridge to a future federal-state model (which was then expected for 2025)
  - Currently set to end on 12/31/2024

Benefits of Continuing to Include Medicare in Vermont Health Care Reform

Continued recognition of Vermont's status as a long-time low-cost state for Medicare

Helps ensure that baseline financial calculations recognize Vermont's past reforms that have saved money for Medicare

Ability to influence Medicare reimbursement for Vermont providers

>$9M annually for Medicare's portion of Blueprint (payments to primary care practices recognized as Patient-Centered Medical Homes, Community Health Teams, and Support and Services at Home program)

Waivers of Medicare regulations (e.g., 3-day stay Skilled Nursing Facility waiver) **and ability to propose new waivers**

Greater alignment in priorities, payment models, quality measures and reporting, which sends a stronger signal to all health care system partners

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AHEAD Announcement

- **September 5th:** Center for Medicare & Medicaid Innovation (CMMI) announced new model – "States Advancing All-Payer Health Equity Approaches and Development" (AHEAD)
- **November 16th:** CMMI released Notice of Funding Opportunity (NOFO) for AHEAD Model, inviting states or sub-state regions to apply for the model. Focus is on state capacity to implement AHEAD and how states would use up to $12 million in "Cooperative Agreement Funding" to support the Model.
- **Link to website:** https://www.cms.gov/priorities/innovation/innovation-models/ahead
- Applications for Cohort 1 and Cohort 2 states are due on **March 18, 2024.**
- Competitive process; CMMI will select only 8 states or sub-state regions.
- **NOTE:** Application is the **first step in potential state participation** – it is the start, not the end.

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

8-9 Performance Years

Components

- Cooperative Agreement Funding
- Hospital Global Budgets (facility services)
- Primary Care AHEAD

Strategies

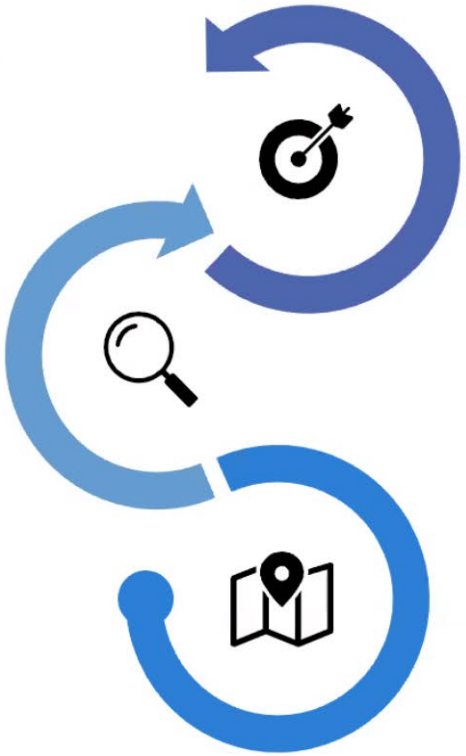
- Equity Integrated Across Model
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

In lieu of "Behavioral Health", VT uses the term "Mental Health and Substance Use Disorder Treatment"

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Statewide Targets At-A-Glance

Participating states take on accountability for quality, costs, and outcomes for a defined sub-state region or statewide. These targets are memorialized in the State Agreement between the state and CMS.



Targets are measured for residents within the defined region.

Improve Population Health

Advance Health Equity

- Medicare FFS Primary Care Investment Target
- All-Payer Primary Care Investment Target
- Statewide Quality and Equity Targets (Medicare FFS and All-Payer)

Curb Health Care Cost Growth

- Medicare FFS Total Cost of Care Targets
- All-Payer Cost Growth Targets

Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

AHEAD Model Timelines

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AHEAD Application and Implementation Timeline

		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Model Year			MY1	MY2	MY3	MY4	MY5	MY6	MY7	MY8	MY9	MY10	MY11
1st NOFO Period	Cohort 1	NOFO	Pre- Implementation (18 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9
	Cohort 2		Pre-Implementation (30 mos)			PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
2nd NOFO Period	Cohort 3		NOFO	Pre-Implementation (24 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8

Source: CMS AHEAD Model Website

Cohort 1 is for states that would participate in 18-month pre-implementation period, tentatively 7/2024 – 12/2025, with a 1/2026 first performance year.

There will be 9 performance years for Cohort 1 states; the model runs through 2034.

Key Dates for Cohort 1 States

March 18, 2024

Applications Due from States

May 2024

Anticipated Notice of Award to Selected States

July 1, 2024 – December 31, 2025

18-month Pre-Implementation Period

January 1, 2026

Start of 9-year Performance Period

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Operational Milestones

The NOFO includes operational milestones for the pre-implementation and implementation period related to model components that will be a requirement by the Cooperative Agreement, and to the extent applicable, will also be included in the State Agreement for the remainder of the Model.*

Operational Milestones

State Agreement Negotiation and Signature by State Leadership and CMS — *June 30, 2025*

Final Milestone: Execution of State Agreement **6 months prior to PY1**

Creation and Implementation of All-Payer TCOC and Primary Care Investment Targets — *Oct. 1, 2025*

Final Milestone 1: Creation of Targets (Or Process to Determine Target) via State Executive Order, Statute, or Regulatory Change **90 days before PY1**

Final Milestone 2: Finalization of Targets in an Amended State Agreement **90 days before PY2** — *Oct. 1, 2026*

Successful Recruitment of Hospitals to Participate in Medicare FFS Hospital Global Budgets — *Oct. 1, 2025*

Final Milestone 1: Hospitals Agree to Participate such that 10% of Medicare FFS Net Patient Revenue (NPR) Would Be Under Medicare FFS HGBs **by PY1**

Final Milestone 2: See Above, 30% of Medicare FFS NPR in an HGB **for PY3 for each subsequent PY** — *Oct. 1, 2028*

Implementation of Medicaid Primary Care APM

Final Milestone: Implementation of Medicaid Primary Care APM with Participation from Primary Care Practices **by the beginning of PY1** — *Jan. 1, 2026*

Implementation of Medicaid Hospital Global Budgets

Final Milestone: Implementation of Medicaid Hospital Global Budgets **by the end of PY1** — *Dec. 31, 2026*

Commercial Payer Alignment with Hospital Global Budgets

Final Milestone: At Least One Commercial Payer Participating in Hospital Global Budgets **by the start of PY2** — *Jan. 1, 2027*

Source: CMS Presentation from November 16 AHEAD Notice of Funding Opportunity Webinar

AHEAD Model Application Requirements and Expected Areas of Flexibility in Potential Future State Agreement

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Application Requirements: Statewide Accountability

Key Elements in AHEAD NOFO: Statewide Accountability
Describe strategy to measure statewide total cost of care (TCOC) and primary care investment across payers over time, including current TCOC and primary care spend on an all-payer basis.
Describe current or planned efforts to include all-payer TCOC and primary care investment targets in state executive order, statute, and/or regulation, and any mechanisms for enforcement of such targets.
Describe applicant's ability to obtain TCOC and primary care spending information for each year from commercial payers and Medicaid.
Describe anticipated policy levers to increase primary care spending by commercial payers and Medicaid.
Describe regulatory and policy levers the applicant intends to use to achieve or enforce TCOC cost growth targets across payers.
Identify known gaps in the state's TCOC and primary care spending reporting.

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Statewide Accountability: Potential State Flexibility for Discussion/Negotiation with CMS

Flexibility in Statewide Accountability	Deadline for Cohort 1
Medicare Fee-for-Service (Medicare FFS; i.e., "Traditional Medicare"): • Calculation of TCOC (e.g., selection and weighting of baseline years, and savings component), • Calculation of Primary Care Investment (e.g., non-claims payments) • Quality and Equity Targets	May 1, 2025 (to include in State Agreement)
Process and authorities for setting All-Payer TCOC and Primary Care Investment targets (via Executive Order, statute, or regulatory change)	September 30, 2025
Methodologies and targets for All-Payer TCOC and Primary Care Investment	September 30, 2026

Application Requirements: Hospital Global Payments

Key Elements in AHEAD NOFO: Hospital Global Payments
Description of statewide hospital rate setting authority or hospital budget setting authority.
Description of state's prior experience in population-based payments or global budgets.
Indicate whether state intends to develop a state-specific Medicare FFS hospital global budget methodology (subject to CMS approval) or use CMS-designed methodology.
Description of state's capacity to develop and implement Medicaid hospital global budget methodology by end of Performance Year 1. Includes proposed timeline of activities, approach for developing methodology and engaging hospitals, and regulatory pathway.
Non-binding Letters of Intent from hospitals (at least one is required) to help CMS understand how state is engaging with hospitals and health systems.
Detailed hospital recruitment plan: regulatory levers and strategies to meet recruitment requirements, communications with hospitals to date, number of hospitals state aims to recruit, hospital experience with global budgets or other value-based payment models, timeline for hospital recruitment (including specific recruitment goals), strategy for engaging rural hospitals and safety net hospitals, contingency plan if goals not met.

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Hospital Global Payments: Potential State Flexibility for Discussion/Negotiation with CMS

Flexibility in Hospital Global Payments	Deadline for Cohort 1
State-designed Medicare Fee-for-Service methodology, aligned with CMS methodology on general principles	July 1, 2024
Process for review of individual hospital requests for adjustments in their global budgets pertaining to service line changes	May 1, 2025 (to include in State Agreement)
Detailed Medicaid hospital global payment methodology	June 30, 2025
Implementation of Medicaid hospital global payment methodology	During 2026

Application Requirements: Vision for Primary Care Transformation and Practice Recruitment

Key Elements in AHEAD NOFO: Primary Care
Describe current Medicaid initiatives underway in primary care, especially related to MH/SUD integration, health-related social needs, care management, and specialty care coordination.
Describe tool(s) that will be leveraged to increase Medicaid investment in primary care (i.e., state directed payments for certain primary care services, rate increases and enhanced reimbursement for primary care services, additional tools to rebalance funding across the delivery system).
Describe tools for increasing access to primary care services; existing Medicaid Primary Care alternative payment model (APM), including current participation of FQHCs and RHCs; and how Primary Care AHEAD might align with these existing efforts in the state.
Provide a detailed plan for recruitment of primary care practices for participation in Primary Care AHEAD (e.g., how the applicant will identify practices participating in state Medicaid primary care value-based payment arrangements and conduct recruitment outreach to those providers).
Include description of the types of practices currently participating in the state's Medicaid Primary Care APM, including identification of gaps in current participation and plans to address those gaps under Primary Care AHEAD.

Primary Care AHEAD: Potential State Flexibility for Discussion/Negotiation with CMS

Flexibility in Primary Care AHEAD	Deadline for Cohort 1
CMS will require 5 measures for primary care practices participating in AHEAD and has outlined recommended measures. "Should an award recipient wish to propose an alternative measure to align with other ongoing state efforts, CMS will consider potential measure replacements, so long as the alternative measure aligns to a domain below or to Model goals broadly."	In State Agreement or Provider Agreements?
Possible opportunity to discuss method of risk adjustment of Enhanced Primary Care Payments	In State Agreement?

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Application Requirements: Model Governance and Health Equity

Key Elements in AHEAD NOFO: Model Governance & Health Equity
Describe existing governance structures that can be leveraged to create the AHEAD Model Governance Structure.
Describe how the state will identify appropriate participants and the anticipated role and responsibilities of the governance structure, including a preliminary list of individuals and/or organizations that could be included.
Detailed summary of state engagement in existing health equity initiatives and activities (e.g., State Health Improvement Plan, Community Health Needs Assessments).
Describe how state health equity activities could be leveraged to support performance on statewide measures.
Describe existing activities aimed at reducing health disparities and identifying and addressing health-related social needs (HRSN) (e.g., state support for collection of demographic and HRSN data).

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Model Governance & Health Equity: Potential State Flexibility for Discussion/Negotiation with CMS

Flexibility in Model Governance & Health Equity	Deadline for Cohort 1
Establish Model Governance Structure	~November 1, 2024
Establish Statewide Health Equity Plan	December 31, 2025

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Application Requirements: Commercial Payer Alignment

Key Elements in AHEAD NOFO: Commercial Payer Alignment
Describe commercial payer participation in care delivery reform, value-based payment, population health improvement, and affordability activities in the state, if applicable.
Describe commercial payer efforts to implement value-based payment and advanced primary care models, if applicable.
Describe commercial payer efforts to address affordability and control cost growth, if applicable.
Describe state legislative or regulatory authority the state intends to utilize under the Model to facilitate commercial payer participation in hospital global budgets and an aligned primary care program.
Describe if and how the state intends to include Marketplace Qualified Health Plans and state employee health plans in hospital global budget payments.
Describe approach to hold commercial payers accountable for TCOC growth.

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Commercial Payer Alignment: Potential State Flexibility for Discussion/Negotiation with CMS

Flexibility in Commercial Payer Alignment	Deadline for Cohort 1
Timing of Commercial Payer Participation in hospital global budgets	January 1, 2027
Commercial hospital global budget methodology	Q4 2025? (to allow time for implementation)

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Application Requirements: Data/Health Information Technology (HIT) Infrastructure

Key Elements in AHEAD NOFO: Data/Health Information Technology
Describe the current and/or planned future capacity of data/HIT infrastructure.
Describe existing data infrastructure action plans and governance.
Describe staff capacity, data analytic capabilities and experience supporting value-based payment and quality reporting.
Describe ability to leverage HIT to meet Model requirements, including data alignment, sharing, flow, and linking capacity across potential partners and participants.
Describe current health oversight agency status and/or ability to become a health oversight agency for the purposes of data sharing prior to the start of Performance Year 1.

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Cooperative Agreement Funding: Intended Uses

Recruiting primary care providers and hospitals to participate

Setting total cost of care cost growth and primary care investment targets

Building mental health and substance use disorder infrastructure and capacity

Supporting Medicaid and commercial payer alignment across the model

From NOFO:

- "Cooperative Agreement funds are intended to support the award recipient's Model implementation broadly.."
- Detailed budget and narrative required, and requested funding must be reasonable.
- "Detailed Sustainability Plan: Strategy for sustaining the Model after Cooperative Agreement funding ends…"

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How Cooperative Agreement Funds Can Be Used

AHEAD NOFO includes examples of how funds can be used:

- State agency staff to implement the Model
- New technology (e.g., implementing, acquiring, or upgrading health information technology)
- Integration of community services referrals
- Supporting demographic data collection
- Bolstering health information exchange and creation of provider dashboards
- Supporting population health activities
- Implementing health-related social needs screening and referral processes
- Development of Medicaid and/or commercial hospital global budget methodology
- All other aspects that align with building a population health agenda

AHEAD Quality Strategy

From NOFO: "The overall Model quality strategy includes three sets of quality measures, each with a health equity focus:

1. Statewide measures
2. Primary Care measures
3. Hospital quality programs"

CMS has outlined four domains with corresponding goals and measures.

Domain Area	Goals
Prevention & Wellness	• Increase equitable access to preventive services
Population Health	• Improve chronic conditions by focusing on health care transformation efforts at the community level • Achieve high-quality, whole-person, equitable care across different population groups
Mental Health & Substance Use Disorder	• Improve outcomes in alignment with unique needs of state initiatives
Health Care Quality & Utilization	• Reduce avoidable admissions and readmissions • Improve patient experience and delivery of whole-person care

Framework for Evaluation and Measurement

Federal-State Accountability Targets

- Statewide quality and equity targets
- Limited number of measures (6)
- Statewide Medicare and all-payer Total Cost of Care (TCOC) and Primary Care Investment targets
- Hospital and payer participation targets
- State may have some flexibility for certain elements, but limited

Hospital-Level Payment Model Measures

- Quality performance adjustment based on CMS national quality programs or similar categories of quality measures
- Health equity improvement bonus for performance on selected health equity-focused measures
- TCOC performance adjustment for a defined population
- Effectiveness adjustment to support reductions in unnecessary utilization

Primary Care Measures

- Limited number of measures (5)
- Performance will be used to adjust Enhanced Primary Care Payments for primary care practices' Medicare patients
- States may have some flexibility in measure selection, but limited

Broader Monitoring and Evaluation

- Not required by federal-state Agreement
- Measure whether changes are occurring
- Spot unintended consequences, including adverse incentives & results
- Domains: care delivery (e.g., access, transitions in care); intermediate outcomes (e.g., primary care visits, wait times, follow-up care); long-term outcomes (e.g., patient satisfaction, readmissions, health disparities)

Ensuring alignment across these components will help to align incentives and limit administrative burden.

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GMCB Board Presentation

Status update on Vermont Hospital Global Payment Program -Methods

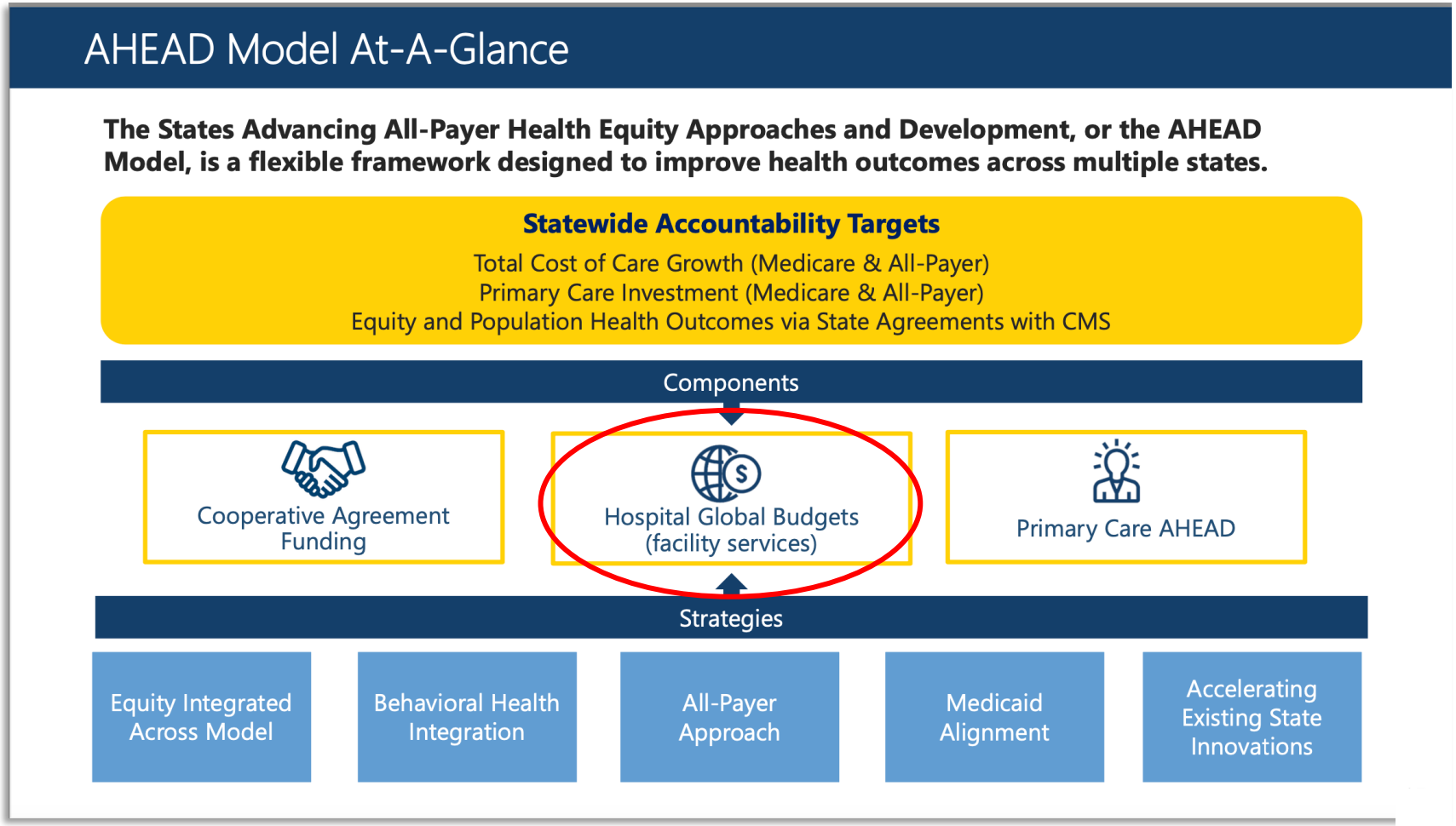
Sule (Shoolay) Gerovich, PhD

Pronounces: she/her

Senior Fellow, Mathematica

01/17/2024

AHEAD Model Components

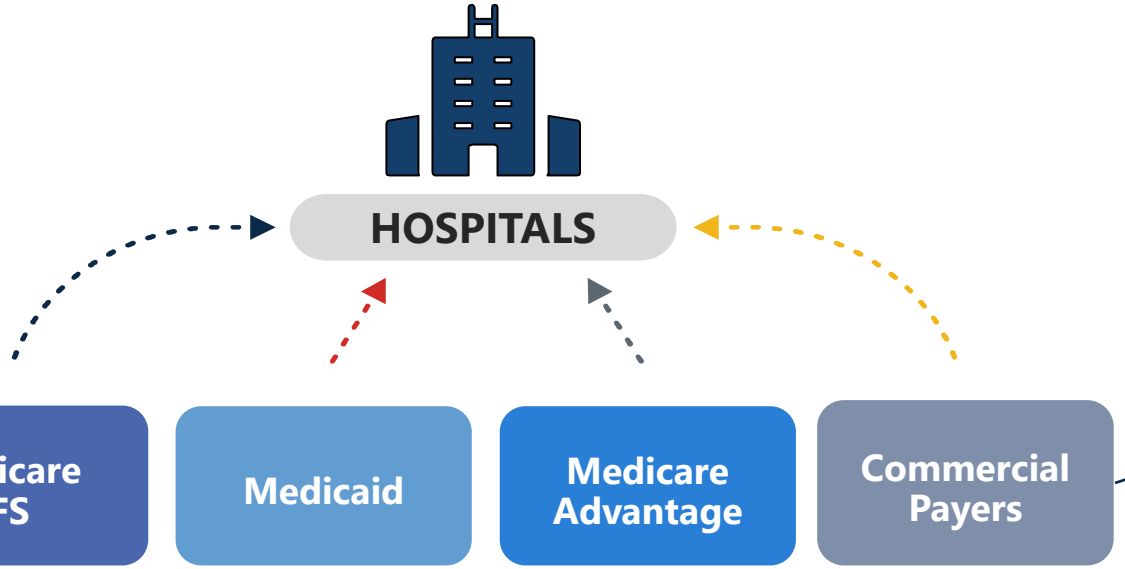


Source: CMMI Presentation on AHEAD Model, September 18, 2023

Mathematica
Progress Together

AHEAD Hospital Global Budget Participation Requirements

Options for Vermont
1. Use CMS's Standard Methodology
2. Develop Vermont version



Options for Vermont
1. All participating state needs to develop its own methodology

Medicare FFS

- **CMS sets the methodology for all except for states with existing rate setting authority and experience and choose to do their own methodology**
- Lead agency to recruit hospitals. Targets are:
  - 10% of Medicare FFS spending for the state/region by PY1
  - 30% of Medicare FFS spending for the state/region by PY4.

Medicaid

- The state Medicaid agency will be responsible for developing their Medicaid-specific hospital global budget methodology. States can have separate models for FFS and MCOs
- Any Medicaid methodology will need to be approved through normal regulatory processes and CMS approval.
- Mandatory participation by PY1

Commercial Payers
Medicare Advantage

- Participating states will develop a methodology with high-level alignment principles outlined by CMS.
- At least one commercial payer must participate in global budgets by PY2.

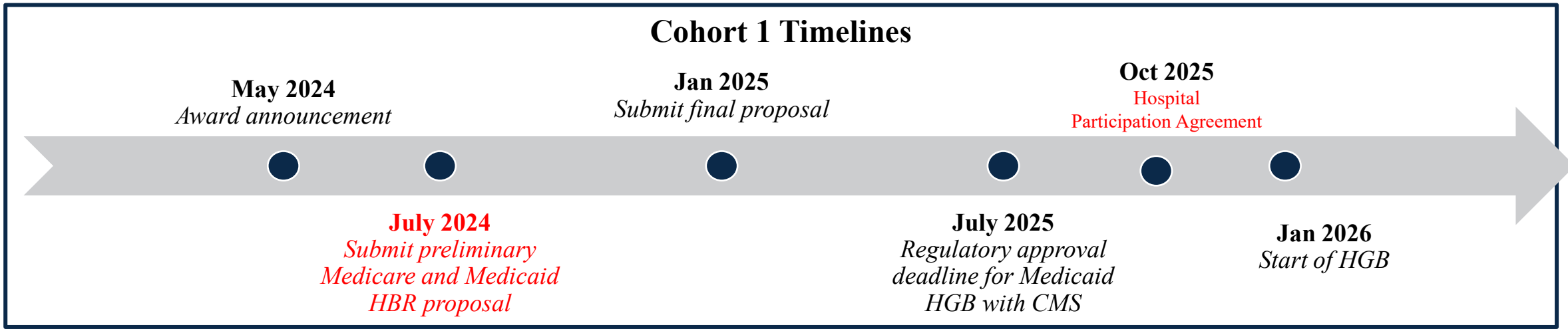
Mathematica
Progress Together

Source: CMS Notice of Funding Opportunity

Milestone Requirements for Hospital Global Budgets

If Vermont choses to develop its own Medicare FFS methodology, draft methodology will be due in July 2024 based on the current NOFO timelines.

First year of implementation is January 2026.



General Considerations to Establish Global Budget Payment Model

FFS Payment Model

Hospitals revenue:

- ACO: Attributed patients FFP amounts as pre-payment but reconciled back to FFS for Medicare
- Medicaid Fixed Payments for most members, FFS for others
- Commercial: FFS

- **Incentives**: Higher payment and utilization rates, focus on high margin services

Global Payment Model

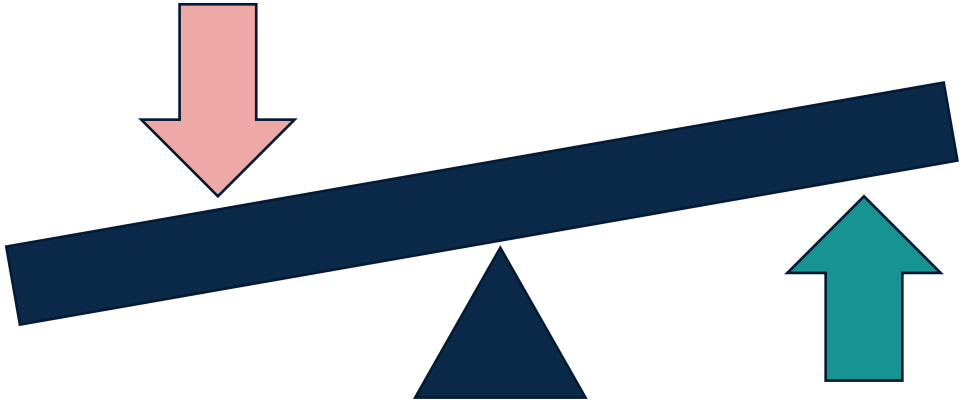
Hospital revenue (included in GBP):

- Revenue will be set based on historical revenue base + Inflationary adjustment+ enrollment changes
- No reconciliation back to FFS
- Updated payments based on population health and access improvements

- **Incentives:** Focus on availability in lower cost settings, improve population health, reduce operational cost

Delivery Transformation Goals

Invest in population health and partner with community providers to lower avoidable ED and inpatient admissions



Invest to improve access to essential services

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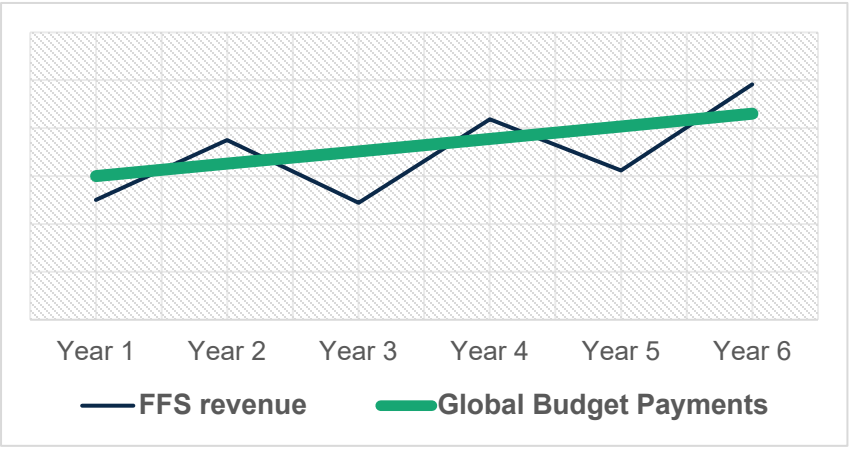
Predictable and sustainable revenue while slowing long-term rate of growth in health spending



Transformation Support

- Operational flexibilities
- Data systems and infrastructure
- Performance measures

Draft Vermont Medicare FFS Global Payment Model

Vermont Technical Advisory Group-(TAG)
Background

Charge: Make recommendations for conceptual and technical specifications for a multi-payer Vermont hospital global budget program by the time CMMI introduces a future multi-state model.

Anticipate federal limits and guardrails for any state-developed methodology to ensure alignment with federal principles

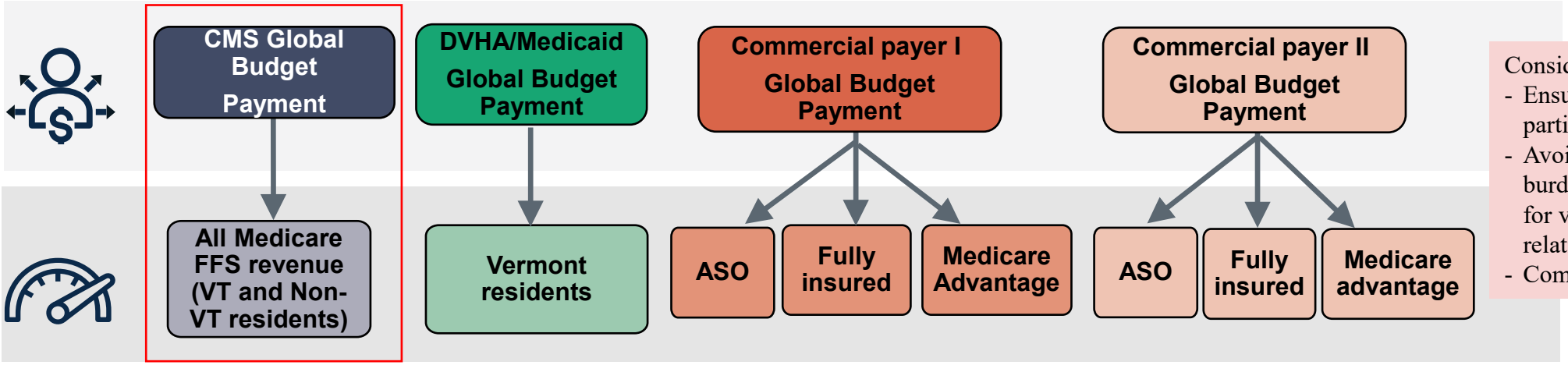
Meeting Period: January 2023-February 2024

Meeting cadence: 120-minute meetings, approximately every three weeks.

Global budget payment determinations

- **Global budgets will be calculated for each payer with market-level adjustments**
- **Methodologies will be aligned as much as possible across different payers**

Priority for discussion is here to prepare for AHEAD.



Considerations:
- Ensuring sufficient scale for each participating facility
- Avoiding unnecessary admin burden (e.g., complex contracting for very small payer-hospital relationships)
- Commercial market dynamics

Scope of Hospital Global Budget Payment

Included Services

Work is ongoing to include professional services, CMS AHEAD model does not include this revenue

Hospital Operating Revenue Classification	
1.Net Patient Revenue and ACO Fixed Prospective Payments (include in straw model)	**2. Other Operating Revenue (exclude from straw model, *no change in payment*)**
Include Phase I: Facility payments for • Hospital inpatient • Hospital swing bed • Hospital outpatient departments including outpatient drugs Phase II: • Payments for professional services	Exclude • Disproportionate Share Payments • Graduate Medical Education • Revenue streams billed under the pharmacy benefit (e.g., retail pharmacy) • Other non-Net Patient Revenue
Exclude • Patient portion	

Year	All-payer total operating revenue	Other operating revenue (excluded)	Percent of operating revenue excluded from the model
2020	$2,884 M	$457 M	16%
2021	$3,183 M	$435 M	14%
2022	$3,457 M	$439 M	13%

Potential NPR included in Global Budget Payment

	2020 Estimates		2021 Estimates		2022 Estimates	
	Revenue	Proportion of Total Net Payer Revenue and FPP	Revenue	Proportion of Total Net Payer Revenue and FPP	Revenue	Proportion of Total Net Payer Revenue and FPP
Total Net Payer Revenue & Fixed Prospective Payment	**$2,427,521,973**	**100%**	**$2,747,813,202**	**100%**	**$3,017,752,722**	**100%**
Physician revenue	$412,229,973	17%	$456,274,910	17%	$473,387,653	16%
Other payer exclusions*	$211,149,233	9%	$246,415,239	9%	$236,851,214	8%
Patient portion	$184,617,940	8%	$210,483,247	8%	$234,949,283	8%
Global Payment Revenue	**$1,619,524,827**	**67%**	**$1,834,639,806**	**67%**	**$2,072,564,573**	**69%**
Medicare - FFS	$621,495,416	26%	$692,605,621	25%	$781,638,318	26%
Medicaid - FPP	$68,131,187	3%	$97,853,235	4%	$102,349,994	3%
Medicaid- GB	$106,399,803	4%	$123,050,065	4%	$141,789,856	5%
Commercial - Potential	$812,791,846	33%	$906,341,863	33%	$1,033,524,133	34%

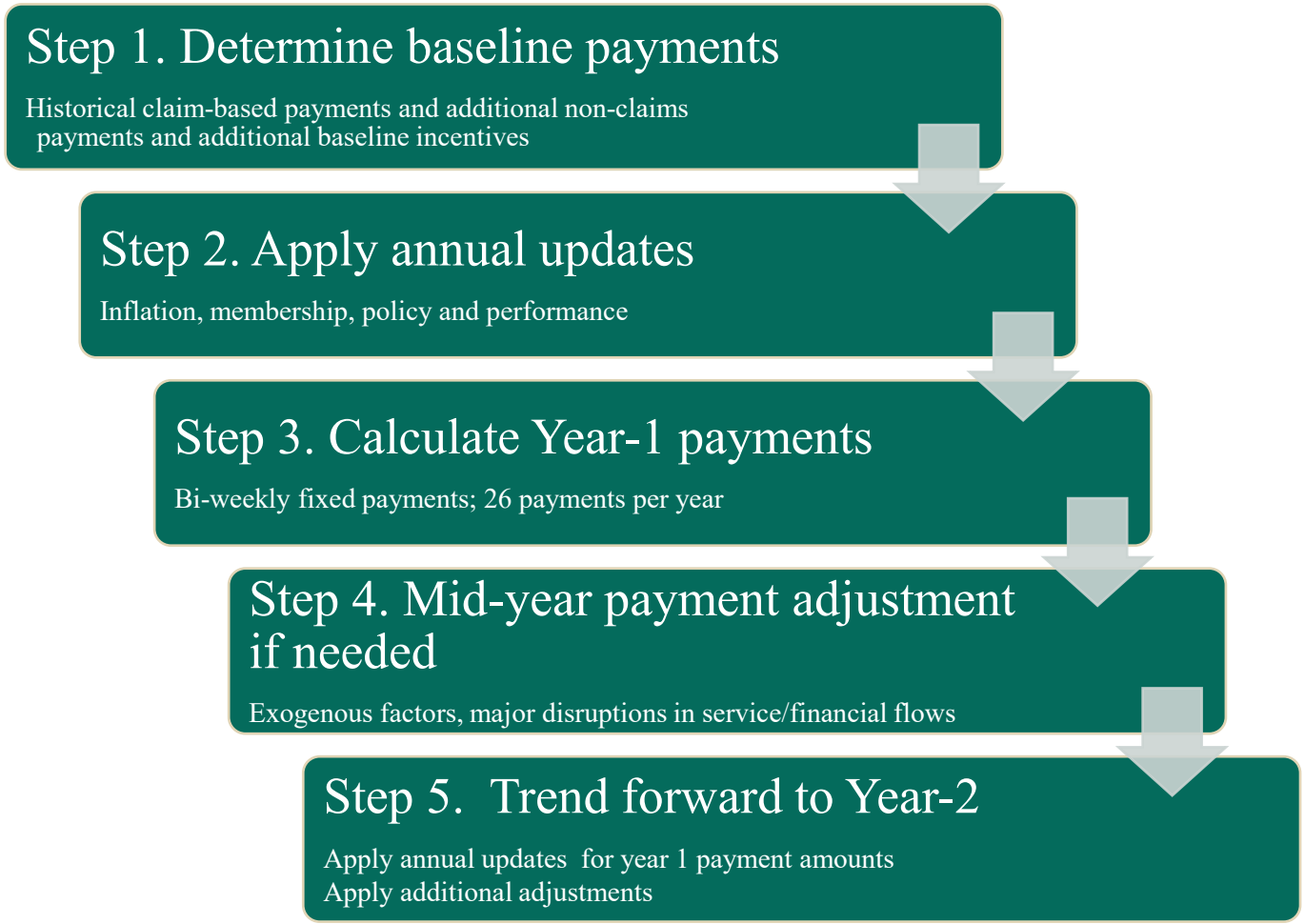
Budget review

Global Payment

*Other payer exclusions: revenue from workers compensation, uninsured and self-pay, Non-VT Medicaid, and uncategorized amounts in Adaptive financial reports.

Source: GMCB, Adaptive Platform, Payer Revenue Sheet and Income Statement, FY. Data is not validated with hospitals. VHCURES (for commercial patient portion estimates, using 2021 amounts)

Calculating Global Budget Payments
Draft Medicare FFS Vermont Global Payment Model



- Draft Vermont Medicare FFS global payment model describes main concepts in each step in global budget payment
- Many details still need to be determined (e.g., methodology for specific adjustments)
- Vermont model focuses on Medicare FFS to support response to CMMI's AHEAD Model application
  - Commercial straw model will need to reflect unique considerations for commercial payers. Plan to seek alignment as much as possible/where appropriate

Step 1: Determine Historical Revenue and Baseline Incentives

- **Include all CMS payments to Vermont hospitals for hospital inpatient and outpatient services that is paid on the claim**
  - Excludes Part D payments (retail pharmacy benefits administered by Part D plans)
  - Excludes beneficiary co-pays / coinsurance
  - Excludes payments made outside of claims
- **Average two-three years of historical revenue**
  - For Cohort 1 starters, first year global payment= CY 2026
    - Baseline revenue: FY 2022, FY 2023 and FY 2024

Align with AHEAD: 3-year average with Yr1=10%, Yr2=30%, Yr3=60% weights

*FFY=Federal/Hospital fiscal year

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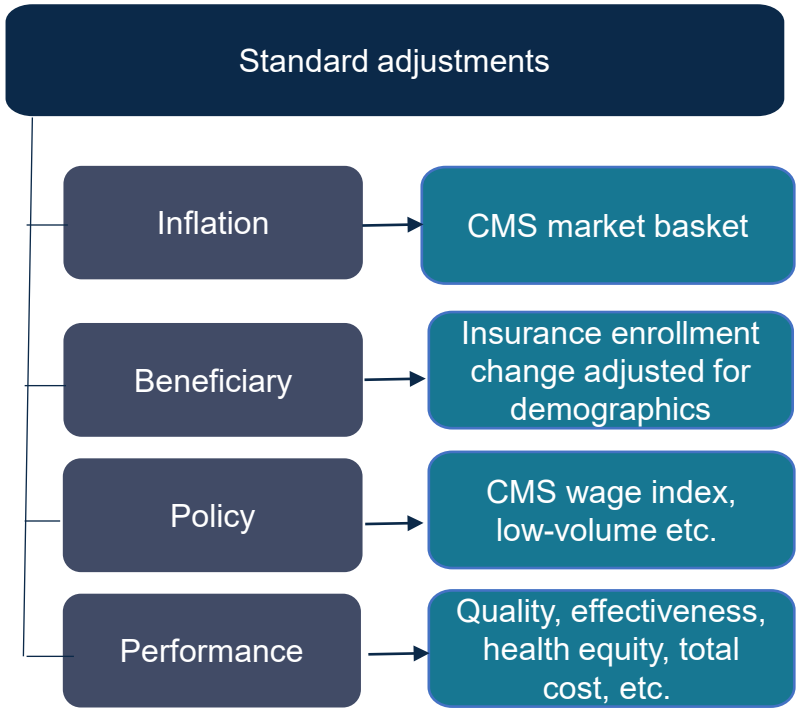
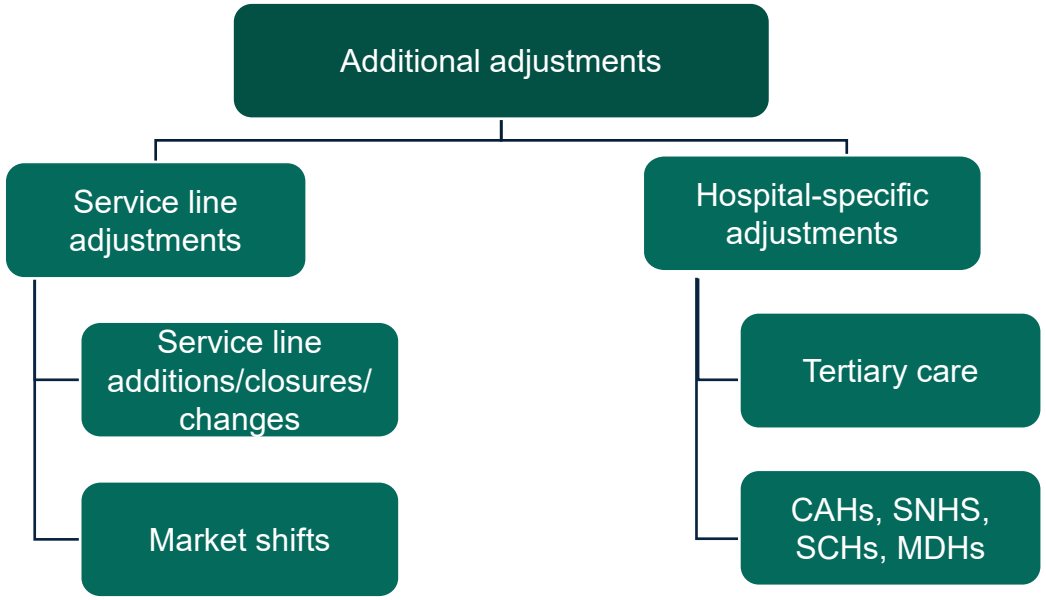
Step 2: Global budget payment updates





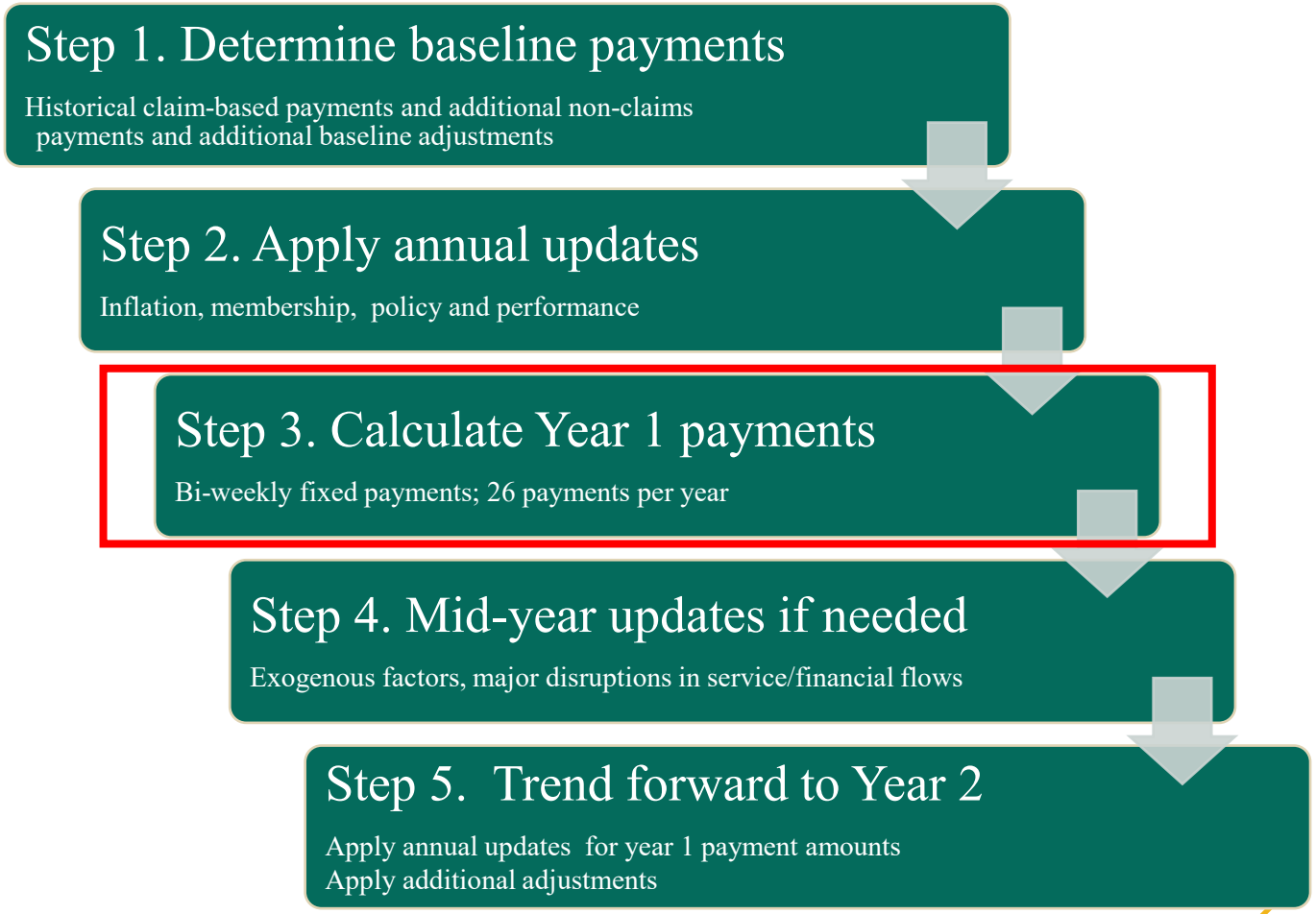
Considerations: Incorporate factors for cost increases, measure membership and performance based on changes in hospital service areas adjusted for demographics

Consider additional adjustments in prospective budgets:

1) If changes in utilization are beyond a selected threshold
2) Negative margins beyond a certain threshold could trigger ad hoc adjustment for financial risk, informed by a hospital's financial position

Step 3: Payment method

- CMS will stop claim payments for included claims and issue fixed payments every 2 weeks.
- Global payments: Year 1 prospective global budget payment/26

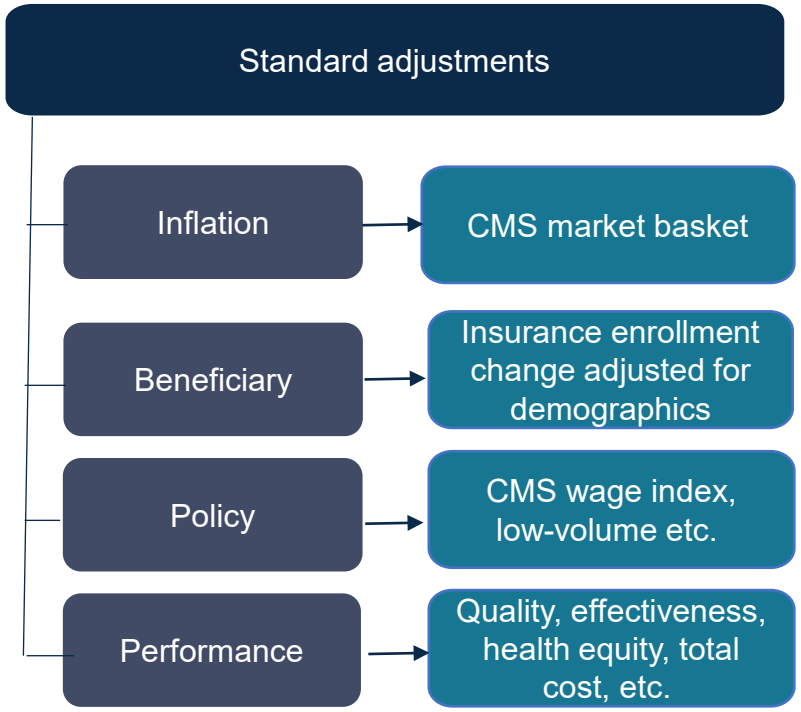


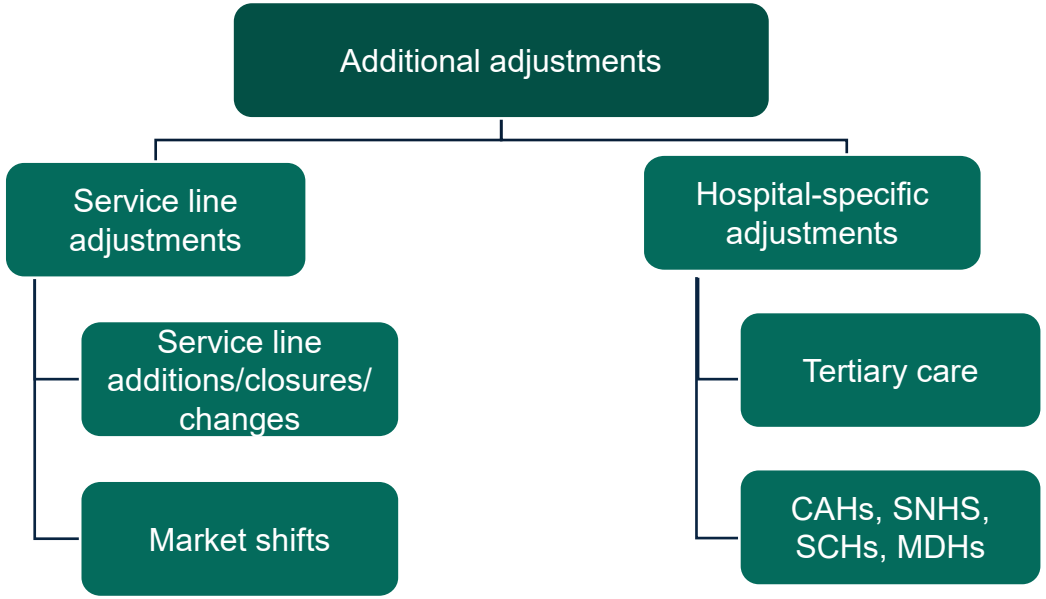
Step 4: Mid-year updates (ad-hoc)

- Hospitals could request mid-year adjustments for certain conditions (e.g., exogenous factors, major disruptions in services, financial flows, etc.)
- Align timing of GMCB hospital budget process and global budget processes

Step 5: Trend forward
Apply global budget updates

- **No retrospective settlements; all updates and additional adjustments will impact the global budget payment for the next budget year**





Considerations for Baseline Revenue and Incentives

Determine Historical Revenue

- Validate payment amounts and clarify how the payments currently made outside of the claims will be calculated
- Finalize how Vermont payments for Blueprint, CHT and SASH will be made
- Make adjustments to incorporate policy and service line changes happened in the base years

CMS Medicare FFS Payment Types

Medicare FFS claim types

- **Included**
  - Part A (inpatient)
  - Part B (outpatient)
- **Excluded**
  - Part D (drugs)

CMS claim payments for Part A and B

- **Included**
  - DRG, APC and RVU payments
  - CMS quality adjustments
  - Indirect Medical Education (IME)
  - Disproportionate Share Hospital (DSH)
  - Uncompensated Care (UCC)

Vermont non-claim-based payments

- **Included**
  - All-inclusive per beneficiary payments (AIPBP)
  - Advance Shared Savings (Blueprint, CHT, SASH funding)

Payments made outside of patient claims

- **Excluded**
  - Bad debt (BD)
  - Organ acquisition (OA)
  - Direct graduate medical education (DGME)
  - Nurse and allied health education (NAHE)

*FFY=Federal/Hospital fiscal year

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Baseline Incentives

Transformation support

- **CMS NOFO:** Transformation Incentive Adjustment: An upward adjustment of 1% of the Medicare baseline global budget will be applied to the hospital global budgets for PY1 and PY2. If a hospital exits the model prior to the state's PY6, the hospital will be required to repay the Transformation Incentive Adjustment

Potential additional adjustments for Vermont

- Health equity investment, access investments, hospital sustainability

Ability to invest additional resources will depend on state-wide savings requirements negotiated with CMS

Baseline revenue	Purpose
Historical revenue base	Provide a reasonable starting point without changing rate dynamics.
Transformation incentive adjustment	To facilitate investment in the infrastructure and capacity development needed for enhanced care management services. **Incentivize early participation (available only first two-years).**
Health equity investment	Provide additional revenue to hospitals serving most disadvantaged populations.
Access-related investment	Provide up-front investments on target areas to improve access.
Sustainability investment	For hospitals with negative margin in the baseline period, avoid "baking in" losses in subsequent years.
Exception-based factors	Hospitals may request exception-based adjustments on a case-by-case basis.

Considerations for Baseline Incentives

/ Size of investment funds

- Expected state-wide Medicare FFS spending trend
- Exclusion of transformation funds from total cost spending measures

/ Variation between hospitals

- Health equity
- Act 167 community engagement and needs
- Financial stability
- Cost efficiency

/ Time period for additional funding

- Incentivize to join the model early
- Multi-year funding

/ Accountability

- Transformation plans
- Improving access

Adjustments for Social Risk – Health Equity

Goal: Provide additional funding to invest in reducing health disparities

Determine a set amount at the state level and distribute the funding based on social risk scores of the patients for whom hospitals are providing care.

Measure selection: CMMI uses "Area Deprivation Index," which combines many factors. NOFO did not indicate which measure will be used.

Prior TAG comments: Members had previously expressed support for the concept of adjustment for social risk but acknowledged it may be premature to incorporate a budget adjustment at this time due to limitations in existing research and tools.

Considerations for Adjustments

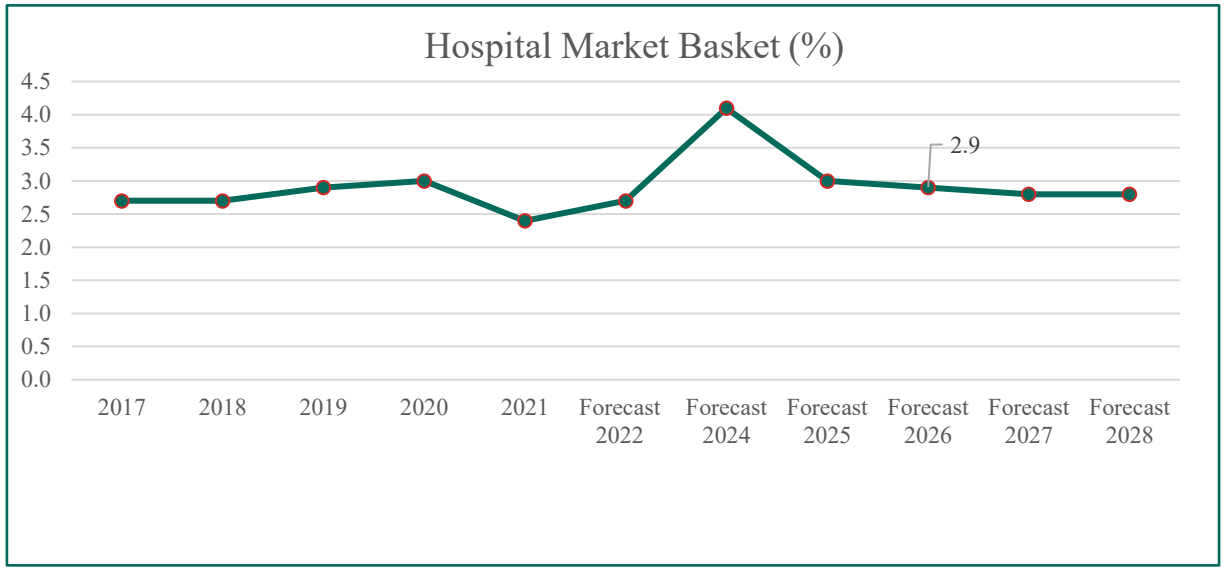
Calculating Global Budgets and Payments
Prospective adjustments

- On an annual basis, provide adequate updates to cover inflation and changes in membership and demographics, government payer policy, and planned service line changes

Adjustment type	Purpose and Incentives
Inflation trends	Purpose: Account for hospitals' cost increases on an average basis. Use CMS's inflation factor for Medicare and Commercial, combined with additional adjustment for high-inflationary services. Potential Incentives: Contain costs to an average level. Reduce services with higher inflation factors
Membership/ demographic changes	Purpose: Account for population and demographic changes for each payer and each hospital Potential Incentives: Focus on managing population in dominant hospital service areas
Policy changes	Purpose: Account for changes in payer policy (e.g., changes in underlying IPPS Medicare payment amounts) Potential Incentives: Continue to receive additional payments from CMS, make hospitals no-worse off from regular CMS adjustments (wage adjustment, low-volume adjustment, etc.)
Quality and performance	Purpose: Pay for outcomes and direct resources to population health and improving access.

Inflation Adjustment

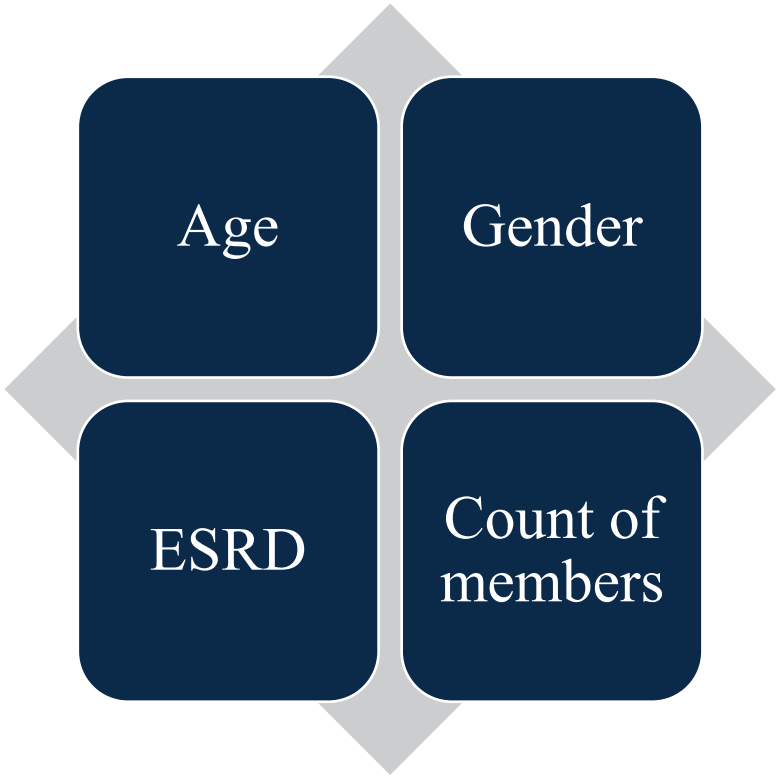
- **NOFO does not specify what Medicare is planning to use.**
- **CMS Hospital Market Basket**
  - updates inpatient hospital operating, outpatient PPS payments for Medicare FFS
- **Critical Access Hospitals (CAH) and Medicare Dependent Hospital (MDH) adjustments may be different**



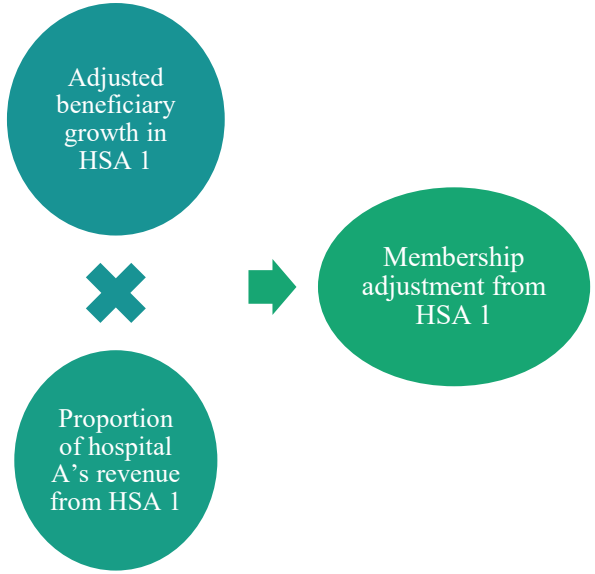
Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata. Latest update: reflects the 2022Q4 forecast with historical data through 2022Q3

Beneficiary Adjustment

1. Calculate Adjusted beneficiary growth for each Health Service Area



2. Distribute adjusted beneficiary growth to hospital



	HSA-1	HSA-2	HSA-3	HSA-4	Total
Beneficiary changes adjusted for demographics	10%	6%	-10%	5%	
Hospital A's revenue from HSA residents	80%	10%	6%	4%	
Hospital's beneficiary change	**8.00%**	**0.60%**	**-0.60%**	**0.20%**	**8.20%**

Policy and Performance Adjustments

- **CMS policy adjustments: Medicare Disproportionate Share Hospitals (DSH), Indirect Medical Education (IME), Low Volume Adjustment, Outlier Adjustment, Uncompensated Care (UCC), Wage Index updates, and for Sole Community Hospitals (SCH) or Medicare Dependent Hospitals (MDH).**
- **Quality: Start with CMS quality programs, move towards All-Payer Quality Program implementation**
- **Performance: Total cost of care accountability, improvements in health disparities, efficiency etc.**
  - **Adjustments may start at later budget years**

AHEAD CMMI Model Global Budget Adjustments and Timelines

Adjustment	Adjustment Type (CMMI)	PY1 Budget Payment	PY2 Budget Payment	PY3 Budget Payment	PY4-PY9 Budget Payment
Baseline adjustments					
Transformation incentive adjustment	Upward	x	x		
Payment updates					
Beneficiary	Upward/downward	x	x	x	x
Inflation	Upward	x	x	x	x
Policy (wage index, low-volume etc.)	Upward/downward	x	x	x	x
Performance					
Quality adjustment	Upward/downward	x	x	x	x
CAH quality adjustment	Upward	x	x	x	x
Health equity improvement bonus	Upward				x (based on PY2)
TCOC performance adjustment	Begin as upward-only then upward/downward				x (based on PY2 performance)
Effectiveness adjustment	Downward		x	x (CAHs, SNHs)	x

Rationale for TCOC Accountability

- Provides financial accountability for services outside of global budget payments, and protects against shifting hospital costs to community providers
- Incentivizes improvements in population health
- Results in APM incentive payment & exclusions from MIPS
- Required by AHEAD model

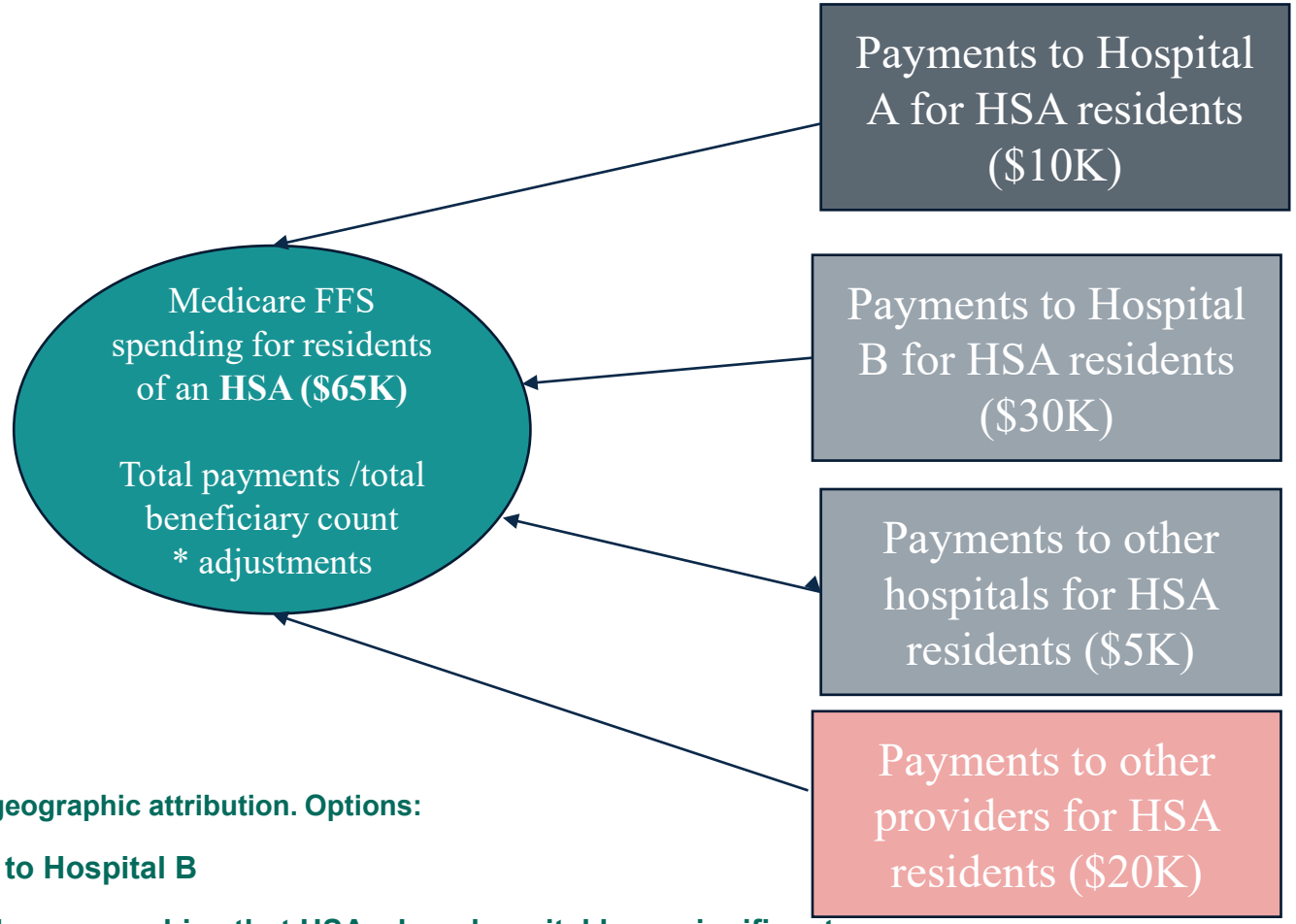
- Hospitals would be held accountable for costs they cannot fully control
- Could add further complexity to the model
- Some hospitals have very small market share to have a significant impact on total cost of care

CMS NOFO:

- **Hospital global budgets must be designed in such a way that enables the state to both meet its annual Medicare FFS TCOC targets and achieve savings by the conclusion of the Performance Years.**
  - **The methodology must include a process by which hospital global budgets can be adjusted in the event the state misses the statewide Medicare FFS TCOC target(s) and is on a Corrective Action Plan. (pg90)**
- **TCOC includes claims and non-claim-based payments for Medicare Part A and B beneficiaries residing in the state (regardless of where care was received), including payments made for participation in shared savings programs and other CMMI models**
- **Will exclude Medicare enhanced primary care payments (EPCP) and the transformation incentive adjustment from TCOC performance expenditure calculations. EPCP will subsequently be part of the all-payer TCOC expenditure performance calculations beginning in PY4.**

Total Cost of Care Accountability Attribution

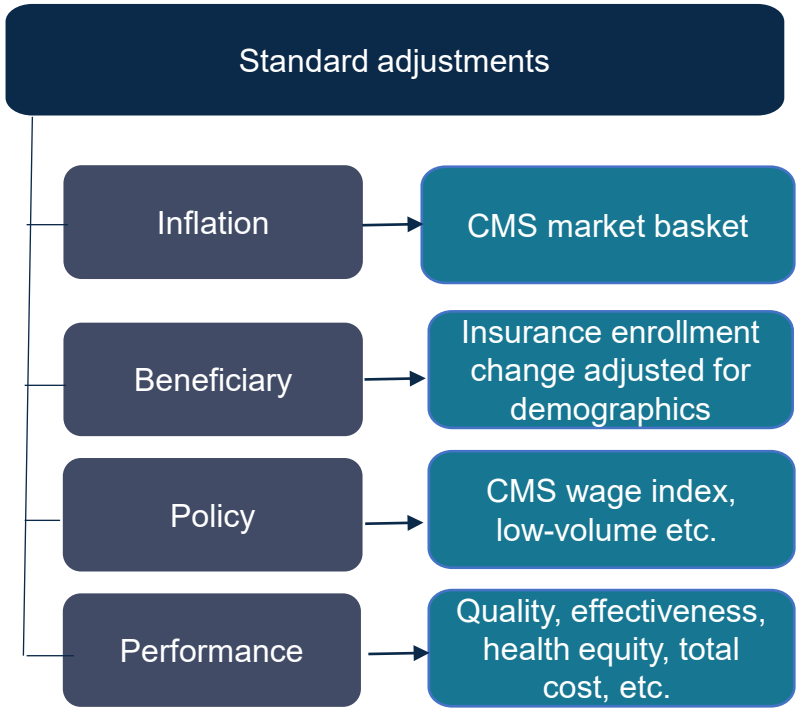
- TCOC includes claims and non-claim-based payments for Medicare Part A and B beneficiaries residing Vermont Health Service Area (HSA) with certain exclusions
- TCOC performance: Total payments per beneficiary in PY1/total payments per beneficiary in baseline year
- Benchmark: Tied to state-wide Medicare savings target adjusted for medical and social risk
- Adjustment: Make an adjustment only if state does not meet savings target

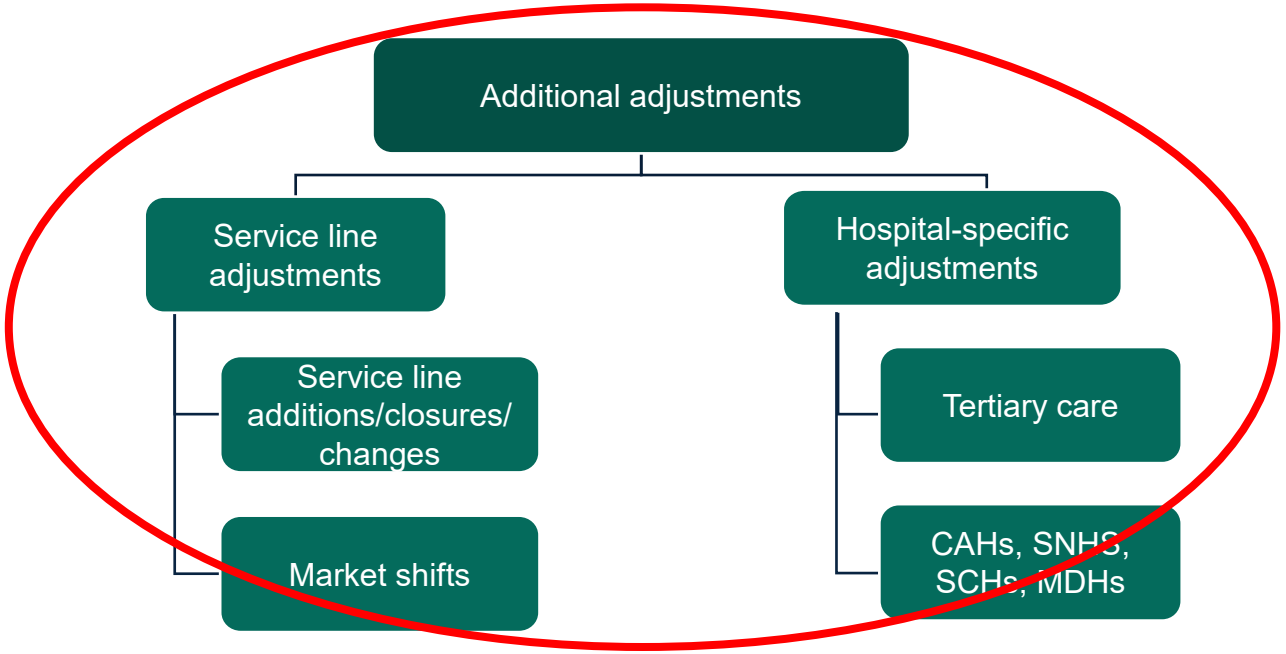


- Attribution: CMS requires geographic attribution. Options:
  - Assign HSA to Hospital B
  - Define smaller geographies that HSA where hospital have significant market share
  - Calculate pro-rated impact to (Hospital B receive only 46 % of the adjustment ($30/$65)

Additional Global Budget Payment Adjustments

- **<u>No retrospective settlements</u>; all updates and additional adjustments will impact the global budget payment for the next budget year**





Consider additional adjustments in prospective budgets:

1) If changes in utilization are beyond a selected threshold
2) Negative margins beyond a certain threshold could trigger ad hoc adjustment for financial risk, informed by a hospital's financial position

Service Line Changes, Under Development

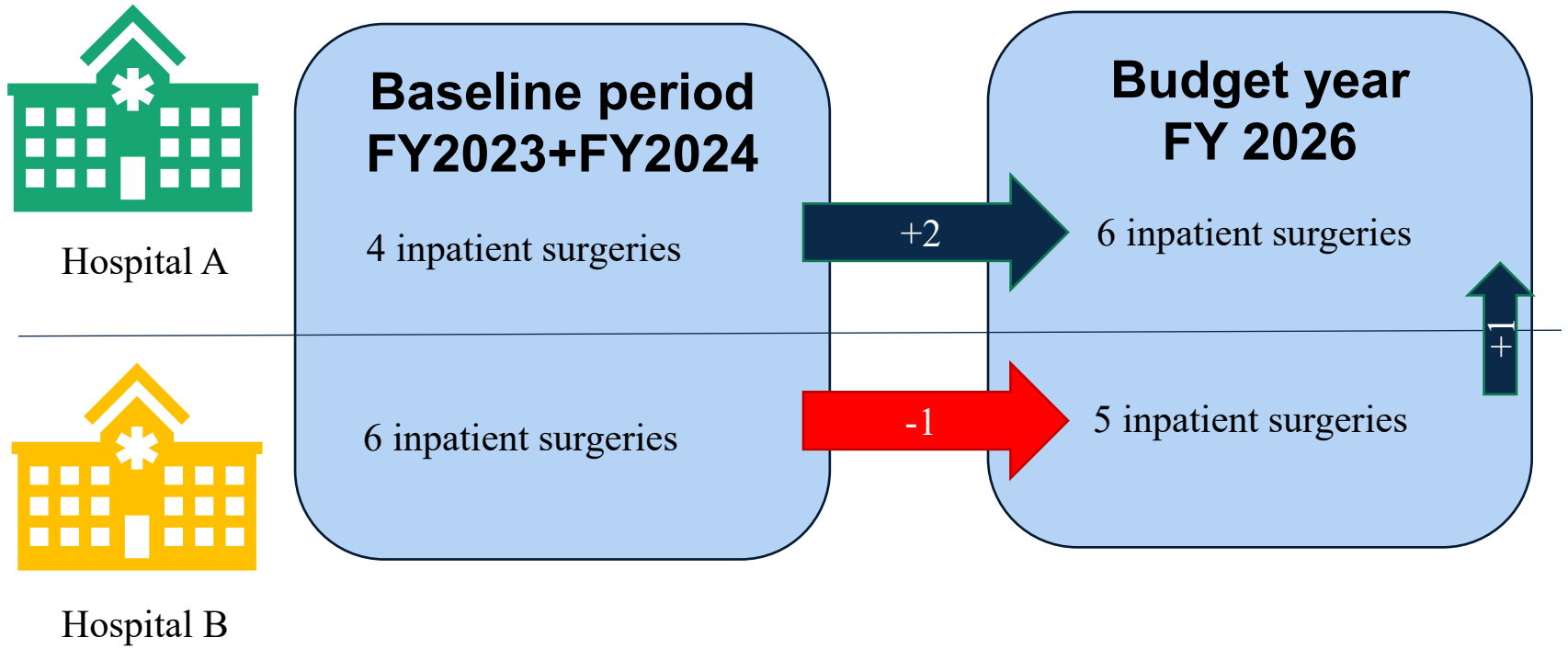
- **Purpose: Ensure hospitals receive adequate additional revenue for new service lines and reduce payments if they are no longer providing services**

- **Discussion questions:**
  1. To ensure materiality of the service line changes, should there be a threshold for service line changes?
  2. What should be used to calculate magnitude of service line adjustments? Should we use FFS equivalents or variable cost to calculate the global payment adjustment?
  3. Should there be a process to review/reconcile projected vs. actual utilization

Four Scenarios:
1. New or expanded services to improve access to care
2. Closures/reductions
3. Temporary changes (e.g. new hires to replace retired physician)
4. Gain/loss of market share

Assessing Market Shift

1. Determine the service lines with significant changes from baseline
2. Assess if utilization increased/decreased at other providers
3. Adjust prospective budget for the utilization shifted to other providers



Tertiary Care

- **Purpose: Adjust for changes in utilization in very high-cost services provided at only a few facilities**
- CMS methodology does not have this adjustment, instead
  - They may be excluding outlier payments from the global budget
  - There is also undefined “Exception-Based Factors” and “other adjustments”
- Working definition, more refinement needed for final specifications
  - Selected tertiary service lines are the highest average weighted service lines
  - For hematology and neonatology service lines, highest DRG weights

Table 1. Tertiary care service lines

Inpatient Service Lines	Average Weight
Transplant Surgery	**8.97**
Ventilator Support	**8.52**
Cardiothoracic surgery	**5.45**
Hematology*	**4.92**
Burns and trauma	**4.74**
Neurological surgery	**3.68**
Invasive cardiology	**3.48**
Neonatology*	**3.17**
*DRGs selected from these service lines	
CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL IMMUNOTHERAPY	37.45
EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.67
PREMATURITY W MAJOR PROBLEMS	3.87
FULL TERM NEONATE W MAJOR PROBLEMS	3.97

Critical Access and Medicare Dependent Hospitals- CMS NOFO

CMS does not plan to reconcile CAH global budgets back to costs at the end of each Performance Year.

- The CAH Quality Adjustment program, a 2% upside-only adjustment for pay-for-reporting before moving to pay-for-performance in later years of the Model
- The effectiveness adjustment will begin being applied to CAH and SNH hospital global budgets one performance year later than it will be applied to acute care hospitals (adjustments starting in PY3 of the applicable Cohort).
- The TCOC performance adjustment applied to CAH and SNH hospital global budgets will begin as upward-only (for PY2 and PY3 performance); upward and downward adjustments to hospital global budgets (starting PY4 performance).

AHEAD will provide a reimbursement "floor" to ensure CAH hospital global budget baselines cover the latest cost reporting at the point of Model entry.

For future performance years, CMS will continue to **monitor sufficiency of hospital global budgets** based on finalized cost reports and additional data sources, ensuring that CAHs and SNHs can continue to cover their ratios of fixed costs (defined as capital and non-labor) to variable costs (defined as labor).

Note: Definition of Safety-Net Hospital is TBD.

Additional Considerations from CMS' AHEAD Methodology

CMS AHEAD Methodology: Health Equity Improvement Bonus

- **Beginning in PY2 of the model, hospitals will receive an upward adjustment for performance on certain quality measures**
  - The measures focus on promoting health equity – hospitals' performance on the measures will determine an upward adjustment applied to a future performance year to allow time for data collection
- **The methodology to adjust for performance in quality measures will align with the AHEAD Model and the state's health equity plan**
  - Details on the measures and calculations will be refined after CMS releases the technical specifications for Medicare FFS

Source: CMS Notice of Funding Opportunity

CMS AHEAD Methodology: Effectiveness Adjustment

- A portion of Participant Hospitals' calculated potentially avoidable utilization (PAU) will serve as the basis for downward adjustments applied to the hospital global budget.
- Starts in PY2 for PPS hospitals
- CAHs and safety net hospitals will be one year delayed (PY3)

Source: CMS Notice of Funding Opportunity

AHEAD NOFO includes the following measures as a “basis of downward adjustment

- **PAU measures**
  - -All-Cause Unplanned Readmissions
  - -Ambulatory Care Sensitive Inpatient Admissions (PQIs)
  - -Avoidable Emergency Department Visits
- **Overuse measure examples**
  - -Prostate-specific antigen testing for men ages 75 and over
  - -Cervical cancer screening for women ages 65 and over
  - -Colorectal cancer screening for adults ages 85 and over
  - -Parathyroid hormone (PTH) measurement for patients with stage 1–3 chronic kidney disease
  - -Total or free T3 level testing for patients with hypothyroidism
  - -Preoperative stress testing
  - -Stress testing for stable coronary disease
  - -Percutaneous coronary intervention (PCI) with balloon angioplasty or stent placement for stable coronary disease
  - -Laminectomy or spinal fusion
  - -Arthroscopic surgery for knee osteoarthritis
- **All measures are based on claims-analysis and specific algorithms developed by various national organizations***

*Please see appendix slides for measurement details.

Overall Framework for Evaluation, Monitoring, Measurement

Federal-State Agreement: Accountability Targets	Hospital-Level Payment Model Measures	Broader Monitoring & Evaluation Framework
• Statewide quality and equity targets • Limited number of measures (6) • Statewide all-payer and Medicare TCOC and primary care investment targets • Hospital and payer participation targets • Limited state flexibility • Consideration: Maximize state autonomy, establish improvement targets that are achievable	• Quality performance adjustment based on CMS national quality programs or similar categories of quality measures • Health equity improvement bonus for performance on select health equity-focused measures. • Total Cost of Care performance adjustment for a defined population • Effectiveness adjustment to incentivize reduction in unnecessary utilization	• Not required by federal-state Agreement • Broader set • Measure changes that may or may not occur (e.g., changes in transfers) – magnitude and likelihood • Assess whether changes are occurring (quantitative and qualitative) • Spotting unintended consequences, including adverse incentives and results

Ensuring alignment across these components will help to align incentives and limit administrative burden.

Appendix

Example of social risk measures

SDOH DOMAIN(S)	Dimension(s)	Area Deprivation Index	Social Vulnerability Index (SVI)
ECONOMIC WELLBEING	Income & poverty levels	✓	✓
ECONOMIC WELLBEING	Educational attainment	✓	✓
ECONOMIC WELLBEING	Employment & occupation	✓	✓
ECONOMIC WELLBEING	Family & household composition	✓	✓
ECONOMIC WELLBEING	Housing availability & affordability	✓	✓
ECONOMIC WELLBEING	Cost of living & other	✓	✓
ECONOMIC WELLBEING	Geographic or social mobility		
ECONOMIC WELLBEING	Public assistance rate		
EDUCATION ACCESS & QUALITY	Education access		
EDUCATION ACCESS & QUALITY	Teacher Workforce		
EDUCATION ACCESS & QUALITY	Academic achievement		
BUILT ENVIRONMENT	Housing type/safety/quality	✓	✓
BUILT ENVIRONMENT	Transportation	✓	✓
BUILT ENVIRONMENT	Food access & quality		
BUILT ENVIRONMENT	Physical activity access		
BUILT ENVIRONMENT	Community resources & services		
PHYSICAL & CHEMICAL ENVIRONMENT	Water pollution, air pollution		
PHYSICAL & CHEMICAL ENVIRONMENT	Toxic waste sites		
PHYSICAL & CHEMICAL ENVIRONMENT	Heat, climate change		
SOCIAL & COMMUNITY CONTEXT	Social capital, cohesion & support		
SOCIAL & COMMUNITY CONTEXT	Community empowerment		
SOCIAL & COMMUNITY CONTEXT	Attitudes & social norms		
SOCIAL & COMMUNITY CONTEXT	Safety		
SOCIAL & COMMUNITY CONTEXT	Other social & community context		
HEALTHCARE ACCESS & QUALITY	Health insurance		✓
HEALTHCARE ACCESS & QUALITY	Healthcare utilization		
HEALTHCARE ACCESS & QUALITY	Availability of healthcare centers		
HEALTHCARE ACCESS & QUALITY	Availability of providers		
SOCIAL DEMOGRAPHICS	Racial & ethnic composition		✓
SOCIAL DEMOGRAPHICS	Language		✓
SOCIAL DEMOGRAPHICS	Age distribution		✓
SOCIAL DEMOGRAPHICS	Sex distribution		
SOCIAL DEMOGRAPHICS	Disability status		✓
OPPRESSION & MARGINALIZATION	Racial residential segregation		
OPPRESSION & MARGINALIZATION	Place-based inequities		
OPPRESSION & MARGINALIZATION	Discriminatory policies & practices		
OPPRESSION & MARGINALIZATION	Cultural attitudes, stigma		

Area based measures: Place of patient's residence

1. **Area Deprivation Index (ADI)**: The index was originally developed using data from the 1990 census, updated with 2020 data. Example use: CMMI payment adjustments.
2. **Social Vulnerability Index (SVI)**: The index is largely intended to assess needs before, during, and after an emergency event such as severe weather, floods, disease outbreaks, or chemical exposure. Example use is for the CDC to distribute emergency funds.

Health-related social risk: Medicare's Inpatient Quality Reporting (IQR) program mandated reporting starts in 2024.

- food insecurity
- housing instability
- transportation needs
- utility difficulties
- interpersonal safety

All-Cause Unplanned Readmission

- **Measures number of unplanned readmissions for any cause within 30 days of the discharge date for the patient**
  - Excludes readmissions for pregnancy and perinatal care, patients in hospice care, and nonacute inpatient stays
  - Excludes planned readmissions (maintenance chemotherapy, rehab, etc.)
- **NCQA developed measure used in Medicaid Adult and Health Core Set, Marketplace Quality Rating System, and Medicare Part C Star Rating**
  - Assess quality of care for providers as well as plans
- **Hospital global budget savings occur from readmissions averted regardless of the index hospitalization**

Ambulatory Care Sensitive Inpatient Hospitalizations

- **Developed by the Agency for Healthcare Research and Quality's (ARHQ)**
- **Prevention Quality Indicators (PQI 90)**
  - Acute conditions (PQI 91)
  - Chronic conditions (PQI 92)
- **The PQIs provide a good starting point for assessing the quality of health services in a region**
- **They can identify gaps in primary care access or outpatient services in a community and highlight potential health care quality problem areas that might need further investigation**
- **Greater access to care is reflected by lower hospitalization rates**

- **Includes admissions for one of the following conditions:**
  - Diabetes short-term complications
  - Diabetes long-term complications
  - Chronic obstructive pulmonary disease (COPD) or asthma in older adults
  - Hypertension
  - Heart failure
  - Angina without procedure
  - Uncontrolled diabetes
  - Asthma in younger adults
  - Lower extremity amputation among patients with diabetes

Avoidable Emergency Department Visits

- **No standard national definition**
- **Commonly used New York University Billings ED Algorithm**
  - ED visits with a primary diagnosis that falls into one of the algorithm's avoidable categories:
  - Non-emergent: Cases where immediate medical care was not required within 12 hours
  - Emergent/primary care treatable: Cases where treatment was required within 12 hours, but adequate care could have been provided in a primary care setting
  - Emergent- ED care needed – preventable/avoidable: Cases where ED care was required at the time presented, but could have been prevented if the patient had access to effective ambulatory care

Overuse Measures

/ No standard definition

- Choosing Wisely campaign
- Low-value of care measures

/ MEDPAC definition*

- **Services with little or no clinical benefit**
  - When risk of harm from a service outweighs its potential benefits
- **Potential to harm patients**
  - Direct: Risks from low-value service itself
  - Indirect: Service may lead to cascade of additional tests and procedures that contain risks but provide little or no benefit
- **Increases health care spending**

MEDPAC Definition	Broader version	Narrower version
Categories that account for most volume	• Imaging • Cancer screening	• Imaging • Diagnostic and preventive testing
Categories that account for most spending	• Cardiovascular tests/procedures • Other surgical procedures	• Other surgical procedures • Imaging

*Source: /https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/medicare-coverage-and-use-of-low-value-care_public.pdf

CMS AHEAD: Medicare FFS Hospital Budget Alignment Criteria- Summary

1. **Hospital global budgets will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum.**
2. **The state must make hospital global budgets available to short-term acute care hospitals and critical access hospitals (CAHs), at a minimum.**
3. **Hospital global budgets must be designed in such a way that enables the state to both meet its annual Medicare FFS TCOC targets and achieve savings by the conclusion of the Performance Years. a. The methodology must include a process by which hospital global budgets can be adjusted in the event the state misses the statewide Medicare FFS TCOC target(s) and is on a Corrective Action Plan.**
4. **The methodology must consider incentives to recruit and retain hospitals early into the Model, and to facilitate hospital investment in the infrastructure needed to be successful under a hospital global budget construct (e.g., an upward adjustment to hospital global budgets for the first two Performance Years, similar to CMS's Transformation Incentive Adjustment).**
5. **Hospital global budgets must be adjusted for both medical and social risk for either the beneficiaries the hospital serves or the hospital's geographic service area. The methodology must account for population growth, demographic changes, and other factors influencing the cost of hospital care.**
6. **The methodology must include a mechanism by which hospital global budgets are adjusted for hospital-level quality performance (similar to CMS's Quality Adjustment described above). This quality adjustment must be based on performance on either the CMS national hospital quality programs themselves or on similar categories of quality measures to those used for these programs.** a. Hospital global budgets must be adjusted for performance on disparities-sensitive quality measures for improving health equity. At minimum, the selected measures must include sufficient data to identify disparities and changes in those disparities, and the selected measures must align with overall model goals.

Source: CMS Notice of Funding Opportunity

CMS AHEAD: Medicare FFS Hospital Budget Alignment Criteria- Summary cont.

7. **The methodology must hold hospitals accountable for TCOC of a defined beneficiary population via a performance adjustment (e.g., CMS's TCOC Performance Adjustment) or some other mechanism. The CMS-designed methodology will include geographic assignment, but a state-designed methodology may utilize a different approach to assign beneficiaries to hospitals for these purposes.**
8. **Hospital global budgets should account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization.**
9. **The methodology must account for annual changes, such as inflation.**
10. **While the methodology may include modifications to account for the unique circumstances of critical access hospitals (as CMS's methodology does), the hospital global budgets for CAHs may not be reconciled back to costs.**

Source: CMS Notice of Funding Opportunity