Vermont Medicare FFS Global Payment Methods Update

TECHNICAL ADVISORY GROUP

MAY 28, 2024

Agenda

1. Welcome and Review of Agenda
2. Status of Vermont-Specific Medicare FFS Hospital Global Payments Design
3. Application, Pre-Implementation, and Implementation Timelines
4. Review of Proposed Methods

AHEAD Application: Cohort 1 Timeline

March 18, 2024

Applications Due from States

June 2024

Anticipated Notice of Award to Selected States

July 1, 2024 – Dec. 31, 2025

18-month Pre-Implementation Period

January 1, 2026

Start of 9-year Performance Period

Key Model Milestones – Pre-Implementation for Cohort 1

18 months prior to start of Performance Year (PY) 1 (July 2024)
- State-designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) methodology to be submitted to CMS
- Medicaid primary care (PC) Alternative Payment Model (APM) and Medicaid HGB "regulatory change processes" proposals to be submitted to CMS

6 months after award date (November 2024)
- Establish Model Governance Structure

12 months prior to start of PY1 (January 2025)
- Medicaid HGB methodology to be submitted to CMS

Negotiations would begin when state is selected. Prior to execution of State Agreement, Vermont is not committed to participating in AHEAD.

6 months prior to start of PY1 (July 2025)
- **Execution of State Agreement**
- Obtain letters of interest from hospitals interested in participating in Medicare FFS HGBs
- CMS approval of Medicaid HGB methodology
- Draft Executive Order to create TCOC/PC spend targets (or process to set targets)

3 months prior to start of PY1 (October 2025)
- Demonstration of readiness for Medicaid HGB implementation and Medicaid primary care APM
- CMS checks that at least **10%** of Medicare FFS Net Patient Revenue is under Medicare FFS HGBs as reflected in hospitals' participation agreements
- Finalize Executive Order to create TCOC/PC spend targets (or process)

End of Pre-Implementation Period (December 2025)
- Finalize Statewide Health Equity Plan

Key Model Milestones – Implementation for Cohort 1

Performance Year 1

Beginning of PY1 (January 2026)

- Implementation of Medicare Primary Care AHEAD and expectation that Medicaid Primary Care APM goes live
- Implementation of Medicare HGBs

90 days prior to start of PY2 (October 2026)

- Final All-Payer TCOC and Primary Care Investment targets to be memorialized in amended state agreement
- At least one commercial payer indicates participation in the HGB model

By end of PY1 (December 2026)

- Implementation of Medicaid HGBs

Performance Year 2

Beginning of PY2 (January 2027)

- Measurement of All-Payer TCOC and Primary Care Investment Target begins
- Expectation that HGBs go live for Medicaid and at least one commercial payer
- Potential implementation of Medicare primary care capitated track under Primary Care AHEAD (CMS is currently evaluating this option)

Performance Year 3 and Beyond

90 days prior to start of PY4 (October 2028)

- CMS checks that at least **30%** of Medicare FFS Net Patient Revenue is under Medicare FFS HGBs as reflected in hospitals' participation agreements

Vermont-Designed Medicare FFS Hospital Global Payments (*Version 1*)

Submission of State-Designed Method for Medicare FFS Hospital Global Payments

Submission of a Vermont-specific Medicare Global Budget Specification, consistent with the Draft Methods Paper, by July 1, 2024.

The methodology is NOT a done deal as submitted, as it is subject to negotiation.

If Vermont is selected for AHEAD and decides to move forward, state signatory approval and execution of state-level agreement with CMS must occur by July 1, 2025.

Review of Proposed Methods: Medicare FFS Hospital Global Payments

Discuss main changes from Straw Model that was developed in the Fall with TAG's input (highlighted in the next slides)

Vermont modifications and future considerations are proposed in the Methods Paper and subject to change based on feedback from Vermont stakeholders and CMS negotiations.

Eligibility and Baseline

Method	Description from AHEAD	Proposed VT-specific methods	Future considerations for VT methods	Rationale
Eligible facilities	Hospitals eligible to participate in HGBs under the AHEAD Model include Acute Care Hospitals, CAHs, and REHs (pending state-enabling legislation) located within a Participating State or Sub-State region.	None	Include specialty hospitals	Global payments must be available to short-term acute care hospitals and critical access hospitals (CAHs), at a minimum.
Included/excluded services	HBG settings generally include Medicare Part A and outpatient facility services covered under Part B furnished by Participant Hospitals. Rehab, psych licensed beds, outpatient drugs, outliers are excluded. Professional services rendered in a hospital setting are excluded.	VT passthrough payments excluded; CMS AHEAD exclusions are applied, VT reserves the right to adjust inclusion/exclusion criteria	Include professional services and other services (e.g., clinics, RHC, and SNFs)	Data is not reliable to include physician services at the moment for Medicare. Exclusions will protect access to care for high-cost services.
Baseline calculation	The 3-year time period used to develop HGBs, based on Eligible Hospital Services. Given the need for Claims Run-Out, there will be a 1-year Gap Year between the Baseline and the Participant Hospital's first PY.	AHEAD: weighted three-year base years VT: higher of weighted three-year base years vs last base year	None at this time	Averaging over years protects against setting baseline in an abnormal year. Using higher of the two will reduce disincentive to participate if a hospital has higher baseline YR3 revenue.

Exceptions and Sequestration

Method	Description from AHEAD	Proposed VT-specific methods	Rationale
Exception-based factors	Participant Hospitals may request exception-based or exogenous factor (e.g., a pandemic or recession) adjustments to HGBs, including for service line changes. These adjustments would need to be approved by CMS.	The state will work to determine a process and threshold for the consideration of an adjustment. The state will also consider on a case-by-case basis whether to apply adjustments for changes in federal policy, including, but not limited to, payment rate changes. Any exception-based adjustments will be at the sole discretion of the state and will require approval by CMS.	We cannot predict all future circumstances, and some hospitals may have very unique circumstances that are not covered in regular adjustments.
Sequestration	AHEAD HGBs account for sequestration as an overall reduction in Medicare FFS payments made to hospitals. CMS will remove sequestration applied to Medicare FFS payments when calculating the HGB for each BY, which serves as the basis of PY1 HGB. After a hospital's HGB is calculated for each Performance Year, CMS will apply sequestration prior to making bi-weekly payments to hospitals consistent with current law.	None	Sequestration is required as part of The Budget Control Act of 2011.

Baseline Incentives

Method	Description from AHEAD	Proposed VT-specific methods	Future considerations for VT methods	Rationale
Transformation incentive	An upward 1% adjustment applied to each Participant Hospital's HGB in the first two Performance Years of the Applicable Cohort to facilitate investment by hospitals in care management and transformation activities. The TIA will need to be repaid if a Participant Hospital exits the Model before the sixth Performance Year for its respective Cohort.	None	Assess if 1% adjustment is adequate for transformation	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.
Vermont health delivery reform investment	Not provided in CMS	Distribute pool to participating hospitals for a number of years and require that hospitals report on their plans and progress.	Continue to work on developing a process for applications and reviews.	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 additional funding pool to improve access to care and invest in population health.

Annual Updates

Method	Description from AHEAD	AHEAD methods and Proposed VT-specific methods	Future considerations for VT methods	Rationale
Inflation updates	Based on IPPS Hospital Market Basket data minus/less productivity.	AHEAD: IPPS hospital market base minus productivity for PPS VT: IPPS hospital market basket only for all participating hospitals	Incorporate other measures of inflation that reflects Vermont's experiences. state will consider adding a productivity adjustment through an all-payer adjustment rather than through the inflation update in the Medicare GPP	All-payer approach to productivity is better suited for Vermont given GMCB's regulatory role.
AHEAD: Demographic changes **VT: Beneficiary updates**	Adjustment to HGBs on an annual basis to reflect changes in the status of the population. Based on a geographic area's historic trends in population size, aging, and medical risk.	AHEAD: Use age, HCC, and population growth. Correct the calculation based on observed beneficiary trends VT: Use age, sex, ESRD and beneficiary change	Incorporate HCC adjustment	Demographic adjustments capture more than 60 percent of variation in hospital cost. HCC measures are based on total costs and CMS is currently transitioning the methods, which creates additional uncertainty for the prospective budgets.
Social risk adjustment	An upward adjustment up to 2% of HGBs based on a combination of the Area Deprivation Index (ADI) and proportion of Medicare-Medicaid dually eligible and/or Part D Low-Income Status (LIS) beneficiaries in the Participant Hospital's service area.	AHEAD: Measures social risk using ADI, dual-eligible, and LIS at the beneficiary level. Hospital scores are a weighted average of the geography. Annual calculation VT: Calculate social risk at the beneficiary level using SVI, dual-eligible. Limit calculation to patients seen by the hospital. Recalculate score every 3-5 years	Vermont will continue to monitor appropriate social risk measures	SVI is chosen based on feedback from stakeholder meetings. ADI is based on very small geographies, which may have higher measurement error in census. Mathematica's preliminary data analysis showed SVI scores did not change significantly in the past two years.
Medicare policy updates	Change in PPS claim-based adjustments, including IME, DSH, UCC, outlier payments	None	None at this time	Participating hospitals will not lose these adjustments and may benefit from favorable changes.

Quality and Performance

Method	Description from AHEAD	Proposed VT-specific methods	Future considerations for VT methods	Rationale
Quality adjustment	Quality adjustments to HGBs allow quality measures to align with existing CMS programs for PPS hospitals. Participant Hospitals will continue to report to these programs under the AHEAD Model.	Simplify calculations while maintaining the scores and amounts from CMS policy	Assess alignment across payers and explore modifications to the quality adjustment.	Need more time to develop an all-payer quality adjustment
CAH quality adjustment	CAHs will have a up to 2% upside-only Quality Adjustment. Ahead is designed to incentivize performance on specific rural-relevant quality measures.	None	Assess feasibility of additional measures, changes	Required. Vermont CAHs are reporting most of these measures.
Health equity improvement bonus	HGBs may receive an annual upward adjustment up to 0.5% of the HGB based on hospital performance on select disparities-sensitive quality measures. Identify high adversity cohort using ADI, dual-eligible, and LIS.	Identify high adversity cohort using an alternative measure such as SVI and dual-eligible	Vermont will continue to monitor appropriate ways to identify high adversity cohorts Small cell sizes may require calculating multi-year results	Adjustment for performance on disparities-sensitive quality measures for improving health equity

Quality and Performance (cont'd)

Method	Description from AHEAD	Proposed VT-specific methods	Future considerations for VT methods	Rationale
Total cost of care (TCOC)	An upward or downward adjustment to the HGB based on hospital performance relative to a TCOC target for the hospital's attributed population.	Use Hospital Service Areas for geographic attribution. Establish an adjustment factor to reflect market share in the HSA. Apply corridors to measure performance. Exclusions from TCOC calculations: SRA (AHEAD not clear), TIA, EPCP, blueprint passthrough	Reconsider 2% max in future years	Required
Effectiveness adjustment	Adjustment to HGBs based on a portion of a Participant Hospital's calculated Potentially Avoidable Utilization (PAU). AHEAD: maximum downward adjustment of -.5% (PPS-PY2, CAH-PY3) to 2% (PPS-PY5+, CAH-PY6+).	Make no adjustment.	Develop effectiveness at the facility level. Focus on access issues before implementing a form of all-payer effectiveness/efficiency/productivity adjustment	Reducing potentially avoidable utilization would require availability of resources outside of hospitals in Vermont.

Service Line Changes

Method	Description from AHEAD	Proposed VT-specific methods	Future considerations for VT methods	Rationale
Service line adjustments (SLA)	Services added, expanded, eliminated, or contracted by a hospital during a specific Performance Year would be added or removed from the global budget for the next Performance Year, depending on approval of the change by CMS and/or the State Model Governance Structure. Participating Hospitals may be able to retain some revenue if it is used to meet population health goals.	Apply $ or % threshold for service line revenue adjustment. Assess standardized service line definitions to expedite the review and approval process. Assess whether 50% reduction is appropriate for reductions in revenue for closures.	Consider how this intersects with Vermont Act 167 hospital transformation work Align with CON and HBR processes with input from stakeholders	Ensure access, improve sustainability of hospitals and support transformation, streamline and reduce administrative burden.
Market shift adjustments (MSA)	Adjustments to HGBs based on material shifts in volume for specific services between hospitals in such a way that covers hospitals' variable costs. AHEAD: 50% funding factor. All service lines qualify for an adjustment.	Due to small cell sizes and limited shifts, VT will not apply this adjustment. Instead make adjustments if transfers increase compared to historical period. Also, conduct market shift review at service line level every 3 years to assess whether rebasing is needed.	Continue to monitor and develop monitoring process to detect major changes	Account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization.

Service Line Changes (cont'd)

Method	Description from AHEAD	Proposed VT-specific methods	Future considerations for VT methods	Rationale
Unplanned volume change review	Change in the volume of services that is not captured by the MSA or SLA. This adjustment is intended to protect against over- or under-payment beyond a materiality threshold of 5 percent volume change not addressed through the demographic shift adjustments, MSAs, or SLAs. AHEAD: Volume increase >5%: 50% above threshold added to global payment Volume decrease >5%: additional revenue removed from global payment (50% for CAHs)	Start with monitoring and ad-hoc adjustments based on review. Expand 50% of kept revenue for CAHs to MDHs	Assess if 5 percent threshold is adequate to limit number of hospitals to be reviewed.	Monitor and make adjustments for changes that are not captured in prospective service line adjustments.

Other Adjustments

Method	Description from AHEAD	Proposed VT-specific methods	Rationale
Critical Access Hospitals (CAHs), Safety Net Hospitals (SNH) and Medicare Dependent Hospitals (MDH)	Reimbursement floor using latest cost report *at the point of model entry* and monitor future budgets for CAHs	If global payments fall below a % of the latest cost report at the point of model entry + inflationary, then the budget will be rebased using the latest cost report for CAHs and MDHs VT reserves the right to tailor additional methods for these hospitals given the populations that they serve	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.
Commercial Reliance Shift	AHEAD is Medicare only methodology	Future facility-level efficiency measures may include assessment of commercial prices.	Improve payer equity and commercial affordability of health care while maintaining hospital sustainability.

Additional Resources

TAG Meeting Materials

Board Meeting Materials

- May 15th
- May 6th
- May 1st
- April 29th
- April 17th

CMS AHEAD

AHEAD Global Payment Methodology

Appendix

CMS's Hospital Global Budget Alignment Principles for State-Designed Methodologies

AHEAD MODEL REQUIREMENTS

CMS's Hospital Global Budget Alignment Principles for State-Designed Methodologies

1. The state-designed methodology must **establish annual global budgets for hospital participants** that transition hospitals away from existing volume-based reimbursement and incentivize a reduction in unnecessary hospital utilization. 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 Year.
    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**.

CMS's Hospital Global Budget Alignment Principles for State-Designed Methodologies (cont'd)

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.

CMS's Hospital Global Budget Alignment Principles for State-Designed Methodologies (cont'd)

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. If the state chooses to select its own quality measures for these purposes, hospital performance on those measures must achieve or surpass the measured results in terms of patient outcomes and cost savings as the CMS national hospital quality 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.

AHEAD NOFO p.96 - 97

CMS's Hospital Global Budget Alignment Principles for State-Designed Methodologies (cont'd)

7. The methodology must **hold hospitals accountable for TCOC of a defined beneficiary population via 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.