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Vermont Medicare Hospital Global Payment Update

An Ongoing Discussion…

May 22nd, 2024

Agenda

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1. Review methods paper on Vermont Medicare Hospital Global Payment Design (*Version 1*)
2. Reframing the vote?

Board Negotiation Goals: Vermont-Specific Medicare Global Budget Specification

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Board Meeting Topics	Target Date
Discuss Draft Vermont Medicare HGB Methodology & Negotiation Strategy & Solicit Board Feedback	Jan – May 2024
1. Vermont Medicare Hospital Global Payment & AHEAD Update 3. Provider Panel on AHEAD/HGP	May 15th
Near final Methods paper delivered to Board for review and to post for public comment (*approximate*)	May 20th
1. Expert Panel on Value Based Care/Payment & Delivery System Reform	May 22nd
2. Review of Methods paper for submission to CMMI	
Special Public Comment Period on Hospital Global Payment Methodology	May 21st - May 28th
Board Discussion & Potential Vote on Medicare Hospital Global Payment Methodology	May 29th
Board Discussion & Potential Vote on Medicare Hospital Global Payment Methodology (Alternative)	June 5th
Develop Specification based on Vermont Medicare Hospital Global Payment Methodology	June 5th – July 1st
Submission of a Vermont-specific Medicare Hospital Global Payment Specification	July 1st
Potential Negotiations (Requires CMMI acceptance of VT application submitted March 2024)	July 1st, 2024 – June 30th, 2025

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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

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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**.

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

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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.

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

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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.

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

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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.

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VERMONT-DESIGNED MEDICARE HOSPITAL GLOBAL PAYMENT (*VERSION 1*)

Methods paper given Board and Public feedback to date.

Eligibility and Baseline

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Method	Description from AHEAD	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. Selected services may be excluded for specific policy considerations. Professional services rendered in a hospital setting are excluded.	VT passthrough payments excluded; 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

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Method	Description from AHEAD	VT-specific methods	Future considerations for VT 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.	None at this time	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	None at this time	Sequestration is required as part of The Budget Control Act of 2011.

Baseline Incentives

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Method	Description from AHEAD	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	None at this time	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	TBD	Distribute pool to participating hospitals for a number of years and require that hospitals report on their plans and progress	None at this time	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

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Method	Description from AHEAD	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

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Method	Description from AHEAD	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. Including HRRP, VBP, HACRP, IQR, Medicare Promoting Interoperability, and OQR. Participant Hospitals will continue to report to these programs under the AHEAD Model.	Simplify calculations while maintaining the scores and amounts from CMS policy	Develop an all-payer hospital 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 designed under AHEAD that will incentivize performance on specific rural-relevant quality measures.	None	Assess feasibility of additional measures, changes	Required
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.	AHEAD: identify high adversity cohort using ADI, dual-eligible, and LIS VT: 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
Total cost of care (TCOC performance adjustment)	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 bumpers after removing tertiary care (30%?) Exclusions from TCOC calculations: SRA (AHEAD not clear), TIA, EPCP, blueprint passthrough	Reconsider 2% max in future years	Required
Effectiveness/Efficiency 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+).	Need time to develop effectiveness on an all-payer level. Focus on access issues before implementing a form of all-payer effectiveness/efficiency/productivity adjustment	Incentivize a reduction in unnecessary hospital utilization (does not specify specific methodology, so it can be accomplished through global payments)

Service Line Changes

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Method	Description from AHEAD	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.	AHEAD: no threshold for adjustment. Adjustment applies for two years. VT: Apply $ or % threshold for service line revenue adjustment. Assess standardized service line definitions. VT to assess whether 50% reduction is appropriate using cost report data	Consider how this intersects with Vermont Act 167 hospital transformation work	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. VT: Due to small cell sizes and limited shifts, VT will not apply this adjustment. However, will 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.
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) VT: Start with monitoring and ad-hoc adjustments based on review. Expand 50% CAH decreases to MDHs	Asses if 5 percent threshold is adequate to limit number of hospitals to be reviewed.	Account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization.

Other adjustments

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Method	Description from AHEAD	VT-specific methods	Rationale
Critical Access Hospitals (CAHs), Safety Net Hospitals (SNH) and Medicare Dependent Hospitals (MDH)	These hospitals have different cost structures that may require additional adjustments in the budget	AHEAD: reimbursement floor using latest cost report *at the point of model entry* and monitor future budgets for CAHs VT: 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	Efficiency measure will include assessment of commercial prices. Commercial global payment methods may include additional adjustments.	Improve affordability of health care while maintaining hospital sustainability and increasing public funding.

AHEAD: Implementation of Key Components

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Key Component	Locus of Implementation	Board Vote Required	Due Date
Hospital Global Payment: Vermont-specific Medicare Global Payment Specification	Begin negotiations with CMMI on Payment Method	Yes (June 1)	July 1, 2024
Hospital Global Payment: Medicaid Global Payment Implementation (Target Date)	DVHA Rate Setting Authority (VSA)	No	January 1, 2025
Execution of State Agreement (AHEAD) • Process for est. All Payer TCOC & Primary Care Spend Targets • Medicare TCOC Statewide "Savings" Targets • General terms (e.g. State or CMS withdrawal from agreement; corrective action triggers)	Contract between SOV & CMS	Yes	June 30, 2025
Execution of State Agreement (AHEAD) • All Payer TCOC & Primary Care Spend Targets Incorporated into the State Agreement	Contract between SOV & CMS	Yes	October 1, 2026
Hospital Global Payment: Commercial Hospital Global Payment Methodology (At least one commercial Payer program)	GMCB Rate Setting Authority (VSA)	Yes	January 1, 2027 (or sooner)
Hospital Budget Review: Update HBR Process for Global Payment Implementation as Necessary	GMCB Hospital Budget Authority (VSA) & Rule 3.000	Yes	TBD

What is the Board voting on by when?

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Submission of a Vermont-specific Medicare Global Budget Specification, consistent with the methods paper; ***Board vote by June 1, 2024,*** *for* ***submission by July 1, 2024****.*

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

Board votes on participation in the AHEAD model by ***June 30, 2025****.*

What is the Board voting on by when? An Alternative Approach

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Challenge: Given the draft nature of the Vermont Medicare hospital global payment methodology, as well as the AHEAD negotiation timeline and associated uncertainties, it is difficult for the Board to judge this methodology on its own merit and whether and under what conditions it would benefit Vermont as compared to an alternative.

Possible Solution: The Board could establish principles for negotiating a Vermont-specific Medicare Hospital Global Payment, within the broader context of State health care reform strategies and regulation, delegating to [TITLE] the submission of a DRAFT (non-binding) Vermont-specific Medicare Hospital Global Payment methodology/specification, consistent with those principles.

What is the Board voting on by when? Proposed Vote Language

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Delegate to [TITLE] the submission of a DRAFT (non-binding) Vermont-specific Medicare Global Payment Methodology and Specification, consistent with the following principles:

- Vermont is a **low-cost Medicare state** with a long history of health care reform which has resulted in **substantial savings to Medicare.** Accordingly, Because of this, additional large savings may be difficult to achieve in the short-term and Vermont's achievements should be recognized and accounted for.
- Many Vermont communities struggle with **access to essential services** and long wait times. Future efforts to improve healthcare in Vermont must support maintaining or preferably improving access to essential services.
- A hospital global payment program is more likely to be successful in promoting delivery system transformation using an **all-payer/multi-payer approach**.
- Vermont's hospitals, local insurance companies, and community providers are financially fragile, as demonstrated by worsening margins, and the global payment program should support **innovation and sustainability of Vermont's healthcare system**.
- Payment methodologies should be **transparent and data-driven**, and support Vermonters' access to high-quality affordable health care, consistent with **Act 167 of 2022 1(b)(1)**.
- Any Vermont-specific Medicare methodology should seek to **reduce Vermont's high commercial insurance costs**.

Question to Board Members

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What are your thoughts on voting on the Medicare Hospital Global Payment?

1. Do you want a **vote on the final product** (and which product – methods paper or specification) or **delegate to staff to complete and submit consistent with principles**?
2. If delegate to staff, do you have any **feedback on the proposed principles**?

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).

Motion for Executive Session

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Suggested motion language:

- Motion #1: *I move we find that premature general public knowledge regarding negotiation of Medicare total cost of care target and the hospital global budget proposals would clearly place the Board at a substantial disadvantage in future negotiations of contracts with CMS that includes those items.*

- Motion #2: *I move that we enter into executive session to consider negotiation of Medicare total cost of care target and the hospital global budget proposals under the provisions of 1 V.S.A. § 313(a)(1)(A) of the Vermont Statutes. Attendance at the executive session will be the Board members, Board staff working on the agreement with CMS, Board contractors from Mathematica working with the Board on the agreement, and the State's Director of Health Care Reform and other staff from the Agency of Human Services working on the agreement.*