Hospital Global Budget Technical Advisory Group

DECEMBER 5, 2023
MEETING #14

Meeting Agenda

1. AHEAD Model Notice of Funding Opportunity
2. TAG Meeting #11 follow-up: Medicare FFS straw model
3. State monitoring and evaluation framework

Recap of October 31st Meeting

October 31st Meeting Recap (1 of 3)

Additional feedback on **needed hospital supports**:

- Assistance for reducing avoidable utilization and ER visits
- Sufficient payment/revenue for community providers and hospital-employed provider to ensure upstream access.

Budget payment implementation roles for the State and payers/hospitals:

- Support for starting with a centralized approach for all State roles since it eliminates the potential for confusion and helps with consistency, which could be revisited over time based on resources and needed flexibilities
- Support for a more collaborative approach with shared roles
- Support for having an independent party perform the analytic work once the methodology is determined
- Several members shared questions/concerns for how payment implementation will be funded and the level of needed resources, and cited the importance of a good data validation process regardless of the roles

October 31st Meeting Recap (2 of 3)

Roles and frequency of payment distribution:

- Support from several members for having payers directly pay hospitals to reduce unnecessary layers of administration and eliminate the resources required if there was a fiscal agent
- Suggestion for a blended approach where Medicaid and larger carriers like BCBSVT could pay directly but some smaller carriers could be part of pooling.
- Acknowledgement by some members that having a separate entity collect and redistribute payments could be helpful for smaller payers.
- Support for monthly payments at a minimum and ideally biweekly

Mid-year adjustments

- Support from one member allowing hospitals to make such requests, provided that it's a data-driven process with collaboration from both sides
- Caution from one member that mid-year adjustments will mean dipping into reserves since funds are set well in advance, which may require additional planning such as through rate changes

October 31st Meeting Recap (3 of 3)

Capital Improvement expenditures

- Several members supported a hybrid approach for funding capital improvements, including both ad hoc budget adjustments and funding through traditional means (including ensuring adequate operating margins) since this would allow for greater flexibility for hospitals that have greater pent-up need.

Meeting Objectives

1. Discuss AHEAD Model Notice of Funding Opportunity release
2. Discuss Meeting #11 follow-up items pertaining to the straw model:
   a) Trends in excluded hospital revenue
   b) Trends in proportion of hospital revenue by HSA
3. Develop a conceptual framework and goals for state monitoring and evaluation for the global budget payment model, including how the model should be monitored for unintended consequences

AHEAD Model Notice of Funding Opportunity Release

AHEAD Model Notice of Funding Opportunity (1 of 2)

- The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Notice of Funding Opportunity (NOFO) was released on November 16, 2023.
- The AHEAD Model will operate for 11 years (2024-2034).
- Applicants must select one of three Cohorts to participate in based on their stage of readiness to implement the Model.
  - Applications for Cohorts 1 and 2 are due March 18, 2024
  - Anticipated issuance notice(s) of awards for Cohorts 1 and 2 on May 24, 2024
  - Cohort 1 Pre-Implementation Period begins July 1, 2024; Implementation Period begins January 1, 2026

AHEAD Model Notice of Funding Opportunity (2 of 2)

- Hospital Global Budgets
  - CMS will develop and maintain a Medicare FFS hospital global budget methodology, which will be standardized across Participant Hospitals. A high-level overview of the methodology is in the NOFO.
  - CMS will allow award recipients with statewide hospital rate setting authority or hospital budget setting authority and prior experience with population-based payments or global budgets to develop a state-designed Medicare FFS global budget methodology, subject to CMS approval.
  - Any state-designed methodology must align with CMS methodology on general principles, which will be detailed in the financial specifications of the CMS methodology. The NOFO contains a high-level overview of these principles.
  - The state-designed methodology must be submitted for CMS approval at least 18 months in advance of the performance year for which it would be effective.
- During the next TAG meeting in January, we will review further details of the NOFO and compare the Medicare FFS Straw Model with the CMS methodology and Alignment Principles.

AHEAD Model NOFO: https://www.grants.gov/search-results-detail/349644

TAG Meeting #11 Follow-Up: Medicare FFS Straw Model

Scope of Hospital Global Budget Payment, Medicare Methodology

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 • Patient portion	Exclude • Disproportionate Share Payments • Graduate Medical Education • Revenue streams billed under the pharmacy benefit (e.g., retail pharmacy) • Other non-Net Patient Revenue

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%**

Straw Model Maximizes Participation to Show Potential Impact, All Payer

	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%

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

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

Hospital Charges by HSA, 2020 – 2022, Medicare

	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River Jct	Grand Total
Central Vermont														
2020	**86%**	0%	0%	**2%**	0%	**4%**	0%	**4%**	0%	0%	0%	**1%**	**2%**	100%
2021	**88%**	0%	0%	**2%**	0%	**3%**	0%	**3%**	**1%**	0%	0%	**1%**	**1%**	100%
2022	**89%**	0%	0%	**1%**	0%	**8%**	0%	**1%**	0%	0%	0%	**1%**	0%	100%
Copley														
2020	**8%**	0%	0%	**25%**	**1%**	**55%**	**5%**	0%	0%	0%	**4%**	**1%**	0%	100%
2021	**9%**	0%	0%	**27%**	0%	**54%**	**4%**	0%	0%	0%	**4%**	**1%**	0%	100%
2022	**2%**	0%	0%	**18%**	0%	**59%**	**6%**	0%	0%	0%	**7%**	**9%**	0%	100%
Gifford														
2020	**16%**	0%	0%	**1%**	0%	0%	0%	**66%**	**1%**	**1%**	0%	0%	**14%**	100%
2021	**16%**	0%	0%	0%	0%	0%	0%	**67%**	**1%**	**1%**	0%	0%	**14%**	100%
2022	**7%**	0%	0%	0%	0%	0%	0%	**61%**	0%	**2%**	0%	0%	**30%**	100%
Grace Cottage														
2020	0%	**6%**	**73%**	0%	0%	0%	0%	0%	**1%**	**19%**	0%	0%	0%	100%
2021	0%	**5%**	**73%**	0%	0%	0%	0%	0%	**1%**	**21%**	0%	0%	0%	100%
2022	0%	**5%**	**81%**	0%	0%	0%	0%	0%	0%	**14%**	0%	0%	0%	100%
Mt. Ascutney														
2020	**1%**	0%	0%	0%	0%	0%	0%	**1%**	**1%**	**23%**	0%	0%	**73%**	100%
2021	**1%**	0%	**1%**	0%	0%	0%	0%	**1%**	**1%**	**25%**	0%	0%	**72%**	100%
2022	0%	0%	**1%**	0%	0%	0%	0%	0%	0%	**21%**	0%	0%	**78%**	100%
Springfield														
2020	0%	0%	**4%**	0%	0%	0%	0%	0%	**1%**	**91%**	0%	0%	**2%**	100%
2021	0%	**2%**	**3%**	0%	0%	0%	0%	0%	**1%**	**90%**	0%	0%	**3%**	100%
2022	0%	**1%**	**1%**	0%	0%	0%	0%	0%	0%	**96%**	0%	0%	**1%**	100%
UVMMC														
2020	**8%**	0%	0%	**64%**	**7%**	**4%**	**2%**	0%	**4%**	0%	**10%**	**1%**	0%	100%
2021	**8%**	0%	0%	**65%**	**7%**	**4%**	**1%**	0%	**4%**	0%	**10%**	**1%**	0%	100%
2022	**6%**	0%	0%	**63%**	**11%**	**3%**	**2%**	**1%**	**4%**	0%	**9%**	0%	0%	100%

Source: VHCURES
Changes greater than 5 percentage points are highlighted in red
Note that the table only shows the hospitals with more significant changes for visual purposes. The NH Upper Valley Region and NY Capital District HSAs were also removed for visual purposes due to all charges amounting to 0% or less than 0.5%

State Monitoring and Evaluation Framework

Overall Framework for Evaluation, Monitoring, Measurement

Federal-State Agreement: Accountability Targets

- 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

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 select health equity-focused measures.
- Total Cost of Care performance adjustment for a defined population
- Effectiveness adjustment to incentivize reduction in unnecessary utilization

Broader Monitoring & Evaluation Framework

- 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.

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NOFO Requirements: Accountability Targets (1 of 2)

- States are accountable for performance and improvement on a set of **at least six population-level measures**:
  - at least one measure from each of the five core domains
  - at least one additional measure from at least one of the optional domains
- States will be subject to **reporting requirements**, including **baseline and at least annual updates** for each selected measure on a Medicare FFS and all-payer basis where feasible.
- Each reported measure must be **stratified by data** including race, ethnicity, dual status, and geography where statistically feasible, with additional factors relevant to equity recommended
- States will be required to **monitor performance on addressing disparities** identified at baseline over the course of the Model.

NOFO Requirements: Accountability Targets (2 of 2)

Core Statewide Measures

Domain	Measure
Pop. Health	CDC HRQOL– 4 Healthy Days Core Module
Prevention & Wellness	Colorectal Cancer Screening
	Breast Cancer Screening: Mammography
Chronic Conditions	Controlling High Blood Pressure
	Hemoglobin A1c Control for Patients with Diabetes
Behavioral Health	Use of Pharmacotherapy for Opioid Use
	Antidepressant Medication Management
	Follow-Up After Hospitalization for MI
	Follow-up after ED Visit for Substance Use
HC Quality & Util	Plan All-Cause Unplanned Readmission

Statewide Optional Measures

Domain	Measure
Maternal Health Outcomes	Live Births Weighing Less than 2500 grams
	Prenatal and Postpartum Care: Postpartum Care
Prevention Measures	Adult Immunization Status
	Prevalence of Obesity
	Medical Assistance with Smoking and Tobacco Use Cessation
	ED Visits for Alcohol and SUDs
Social Drivers of Health	Food Insecurity
	Housing Insecurity

Quality Measurement and Improvement in the VT APM

- Current quality focus: Vermont has made progress in aligning measures across payers and programs (see Appendix B in this GMCB Report)
- Overarching goals in VT All-Payer ACO Model:
  - Increase Access to Primary Care
  - Reduce Deaths from Suicide and Drug Overdose
  - Reduce Prevalence and Morbidity of Chronic Disease (Diabetes, Hypertension, COPD)
- These goals largely align with CMMI's quality and population health strategy domains, with some variation.
- *Do these goals still resonate? Are there other important areas of focus?*

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NOFO Requirements: Hospital Payment Model Measures for Quality

PPS Hospitals	Critical Access Hospitals
Participating PPS hospitals will be **accountable for performance in the following national hospital programs** via budget adjustments: • Hospital Inpatient Quality Reporting, • Hospital Outpatient Quality Reporting • Hospital Value-Based Purchasing Program • Hospital Readmissions Reduction Program • Hospital-Acquired Condition Reduction Program • Medicare Promoting Interoperability Program. *State-designed methodologies may base the quality adjustment on similar categories of quality measures, **but hospital performance must achieve or surpass the measured results** in terms of patient outcomes and cost savings as the CMS national hospital quality programs.	Participating **CAHs will receive upside-only quality adjustment** based on scoring in a CAH specific quality program, which will begin as pay-for-reporting and advance to pay-for-performance. NOFO provides a CAH measure set, which aligns with existing measures used to assess rural health care quality (see Appendix)

NOFO Requirements: Additional Adjustments for Hospital Performance

PPS Hospitals	Critical Access Hospitals

• *Health equity improvement bonus* for performance on health equity-focused measures beginning in PY2
  • Degree of adjustment is based on performance
  • Selected measures must include sufficient data to identify disparities and changes in such disparities.
• *TCOC performance adjustment*
  • Begins as upward only for PY4, then upward and downward starting PY5
  • CMS methodology includes geographic assignment, but state-designed methodology may utilize a different approach to assign beneficiaries to hospitals for these purposes
• *Effectiveness adjustment* based on a portion of potentially avoidable util. for downward adjustments
  • State-designed methodology must incentivize reduction in unnecessary utilization
	• *Health equity improvement bonus* (same as for PPS hospitals).
	• *TCOC performance adjustment* will begin as upward-only for PY4 and PY5, and change to upward and downward starting in PY6
	• *Effectiveness adjustment* will begin being applied one PY later (adjustments starting in PY3)

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Context: Monitoring and Evaluation Lessons from VT APM

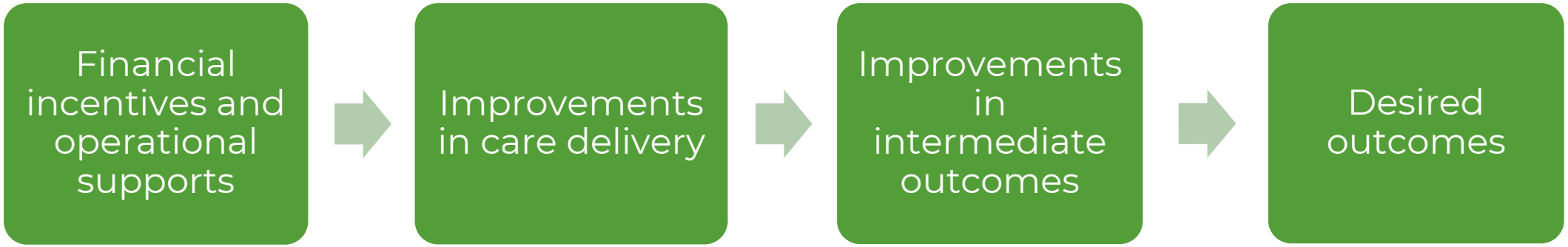
1) Prioritize key measures
2) Understand and set achievable benchmarks
3) Create a process to refine/retire/add measures over time
4) Link up monitoring with actions
5) Consider data lags and balance efforts for monitoring (e.g., quarterly vs. annual)

Do you agree with these lessons?

What additional lessons can we carry forward to state-level monitoring and evaluation for the AHEAD model?

Logic Model for Hospital Global Budget Payments

- This framework shows how the global budget payment model is expected to improve health care outcomes and reduce costs.
- Monitoring will be required throughout the life of the model to track process improvements, changes in early or leading indicators, and expected changes in final outcomes.
- Over the following slides, we will solicit your feedback on these logic model components to help inform priority domains for state-level monitoring.



Improvements in Care Delivery

- Improve care standards and quality
- Provide better access to services
- Improve care transitions
- Expand care coordination with providers in the community
- Screen for social determinants of health and link patients to services

What additional care delivery improvements should be monitored?

Improvements in Intermediate Outcomes

- Increase in primary care visits and resources
- Increase in follow-up visits after hospital use
- Increase in telehealth/alternative methods of care delivery
- Optimize service delivery based on community needs
- Reduction in wait times

What additional intermediate outcomes should be monitored?

Desired Long-Term Outcomes

Quality
- Fewer hospital readmissions
- Improved patient satisfaction
- Population health
- Lower mortality
- Lower incidence of target conditions

Equity
- Reduction in health disparities

Utilization
- Fewer low-value services
- Fewer avoidable ED and inpatient admissions

Spending
- Lower rate of growth of total health spending
- Hospital financial stability
- Cost efficiency
- Stable margins

What additional desired outcomes should be monitored? What are the most important categories or domains to monitor based on the desired outcomes?

Context: Potential for Unintended Consequences (1 of 2)

- Currently in VT, many are concerned about access to inpatient and outpatient hospital services, which must be considered in the context of incentives under the hospital global budget model.
- Under the model, hospitals have the financial incentive during a performance year to improve care delivery and reduce preventable or wasteful utilization.
- Hospitals can also respond to financial incentives through other mechanisms, including:
  - reducing the length of inpatient stays,
  - shifting care from inpatient settings to post-acute or outpatient settings or other hospitals,
  - reducing the number of high-risk or high-cost admissions, and
  - reducing the number of patients admitted to the hospital from the emergency room.

Context: Potential for Unintended Consequences (2 of 2)

- In some cases, these changes might be desirable, e.g., if more patients receive care in the most cost-effective and clinically appropriate setting without compromises in care quality.
- In other cases, such changes could be clinically inappropriate and result in unintended adverse consequences for patients, such as worse quality of care or increased mortality. For example:
  - Shifting care from the hospital to the community setting for patients who would benefit from a longer length of stay could lead to post-discharge complications.
  - Unnecessary transfers to other hospitals not participating in the global budget model could increase the burden on such hospitals and create stress on the health care system.

Potential Domains and Indicators

Potential domains and indicators for monitoring unintended consequences include:

1) Lack of improvement in or reduction in access to care
   - Changes in wait times and same- or next-day transfers to post-acute care or to an AMC
   - Reduction in availability of essential service
2) Adverse effects in care quality and population health
   - Deterioration in beneficiary experience of care
   - Increased mortality within 30 days of hospital discharge
3) Reduction in high-risk/high-cost admissions

Discussion (1 of 2)

- Are there additional unintended consequences that could result from the model where monitoring may be needed?
- What additional domains should be monitored for unintended consequences?
- In addition to monitoring changes over time, should the model link undesirable changes in specific indicators to adjustments in the global budget methodology so that there is an in-built disincentive to increase margins by stinting on care?

Discussion (2 of 2)

- *Goals of monitoring and evaluation*: Given what we know that CMMI will require, are there other areas that should be considered for broader state level monitoring and evaluation?
- *Centering equity in the monitoring plan*: What populations do you think are experiencing health care disparities?
  - What issues or challenges could occur when measure results are stratified by factors leading to disparities in health, e.g., race/ethnicity, disability status, rural/urban location, SVI/ADI?
  - How could those issues be addressed?

Wrap-up and Meeting Schedule

The next Hospital Global Budget Technical Advisory Group meeting will be in January (date and time TBD).

- Topic: Model Description Review and CMMI Comparison

Appendix

CAH Measure Set for HGBs

Domain	Measure	Steward	Data Source	CMS Program Alignment
Health Care Quality and Utilization	Hybrid Hospital-Wide All-Cause Unplanned Readmission Measure	CMS	Claims and Electronic Health Data	HIQR
Health Care Quality and Utilization	Emergency Transfer Communication Measure	Univ. of MN	Claims, Elec. Health Data, Paper Medical Records	N/A (Medicare Beneficiary QIP)
Health Care Associated Infections	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure	CDC	Elec. Health Data, Other, Paper Medical Records	HACRP
Health Care Associated Infections	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	CDC	Elec. Health Data, Other, Paper Medical Records	HACRP
Patient Experience	Hospital Consumer Assessment of Healthcare Providers and Systems	CMS	Instrument- Based Data	HIQR; HVBP
Patient Safety	Safe Use of Opioids – Concurrent Prescribing	CMS	Electronic Health Data (eCQM)	HIQR; Promoting Interoperability
Patient Safety	Venous Thromboembolism Prophylaxis	JC	Electronic Health Data (eCQM)	HIQR; Promoting Interoperability