Comparative Analysis: Vermont's Hospital Global Payment Program and CMS's AHEAD Methodology

TECHNICAL ADVISORY GROUP

02/29/2024

Agenda

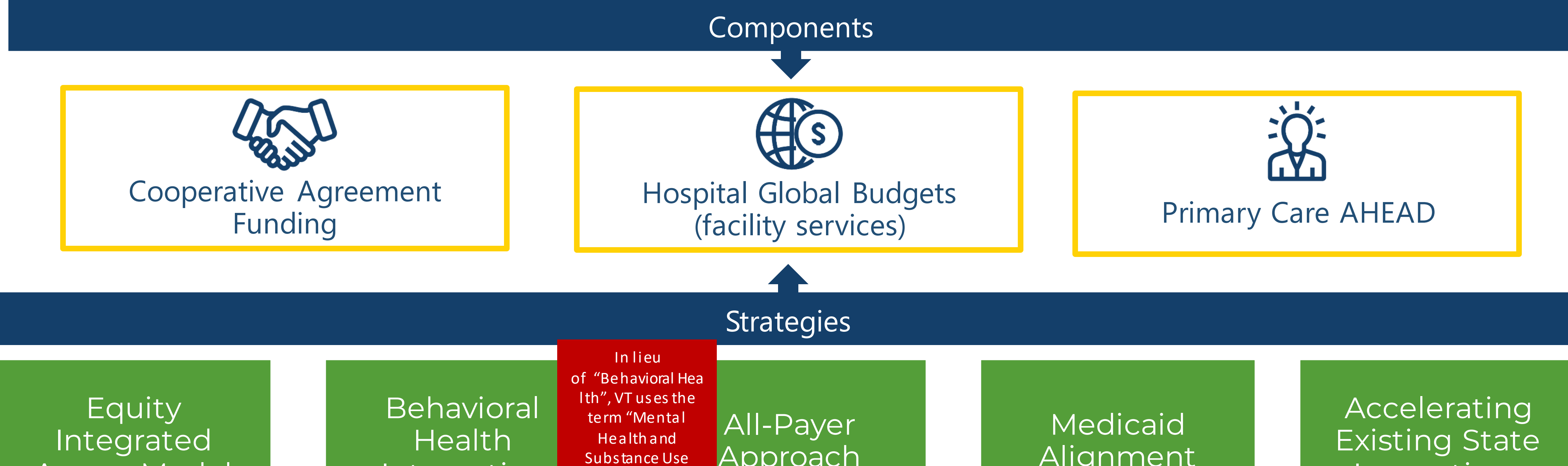
1. AHEAD Model Recap and Update on Vermont Application

2. Comparative Analysis: CMS' AHEAD Methodology vs. Vermont's Hospital Global Payment Methodology

3. Initial Considerations for VT Medicare FFS Methodology Version 2

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.



Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

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	NOFO	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.

Source: CMS Presentation from September 26 AHEAD Model Overview Webinar

Benefits of Continuing to Include Medicare in VT Health Care Reform: Opportunities in AHEAD

Ability to influence Medicare reimbursement for Vermont providers

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

Access to up to $12M in AHEAD Cooperative Agreement funds to support health care reform efforts over 5.5 years

>$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)

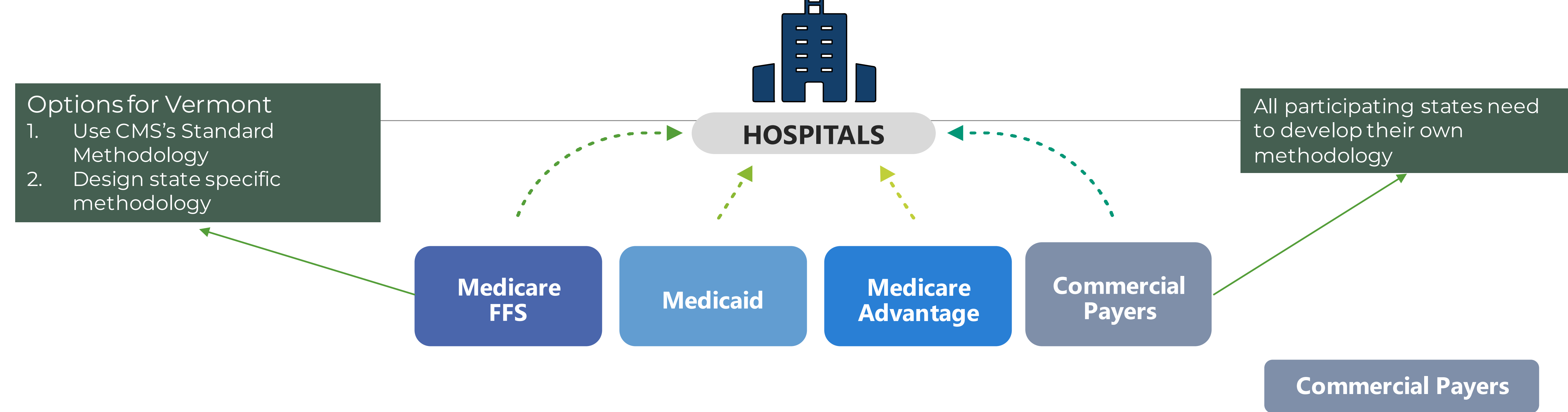
Increased Medicare investments in primary care (average $17 per Medicare FFS member per month)

Medicare transformation funding for hospitals that participate during early years; equity and quality funding (if hospitals show improvement; CAHs only need to report for quality payment in initial years)

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

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

AHEAD Hospital Global Budget Participation Requirements



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.
- 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.

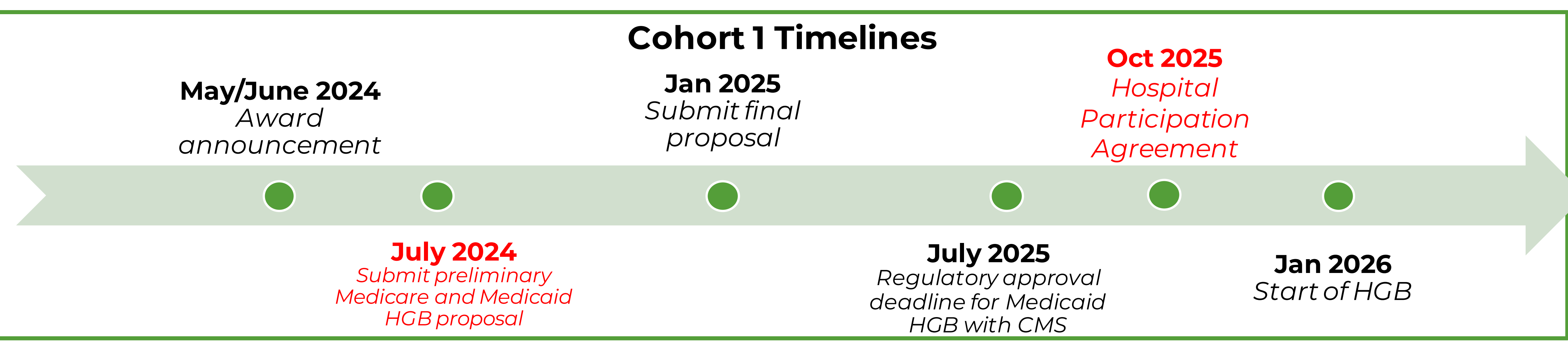
Source: CMS Notice of Funding Opportunity

Global Budgets: What is Required in the NOFO Application?

- **Hospital Recruitment**
  - Provide detailed plan for recruitment of hospitals to participate in hospital global budgets, including regulatory levers and strategies will use to achieve goals.
- **Hospital global budget methodology development**
  - Description of statewide hospital rate/budget setting authority (i.e., statute) and of state's prior experience in population-based payments or global budgets.
  - If the state has rate/budget setting authority, indicate whether state intends to develop state-specific methodology or use the CMS-designed methodology.
- **Letter of Intent from at least one hospital**
  - An LOI from a hospital is not binding; however, it will help CMS understand how applicants are engaging with hospitals and health systems

Milestone Requirements for Hospital Global Budgets (HGB) for Cohort 1

- If Vermont chooses 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.



State Designed Global Budgets: CMS Alignment Principles - Eligibility and Recruitment

1. Hospital global budgets will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum.
2. Available to short-term acute care hospitals and critical access hospitals (CAHs), at a minimum.
3. 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. Consider incentives to recruit and retain hospitals early into the Model.

State Designed Global Budgets: CMS Alignment Criteria-Payment Adjustments (cont.)

5. Adjusted for both medical and social risk for either the beneficiaries the hospital serves or the hospital's geographic service area.

6. Adjusted for hospital-level quality performance.
   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. 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.

7. Adjusted for performance on disparities-sensitive quality measures for improving health equity.

State Designed Global Budgets: CMS Alignment Principles-Payment Adjustments (cont.)

8. Hold hospitals accountable for Medicare FFS TCOC (also, related to principle #3)
9. Account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization.
10. Account for annual changes, such as inflation.
11. Modifications to account for the unique circumstances of critical access hospitals (as CMS's methodology does)

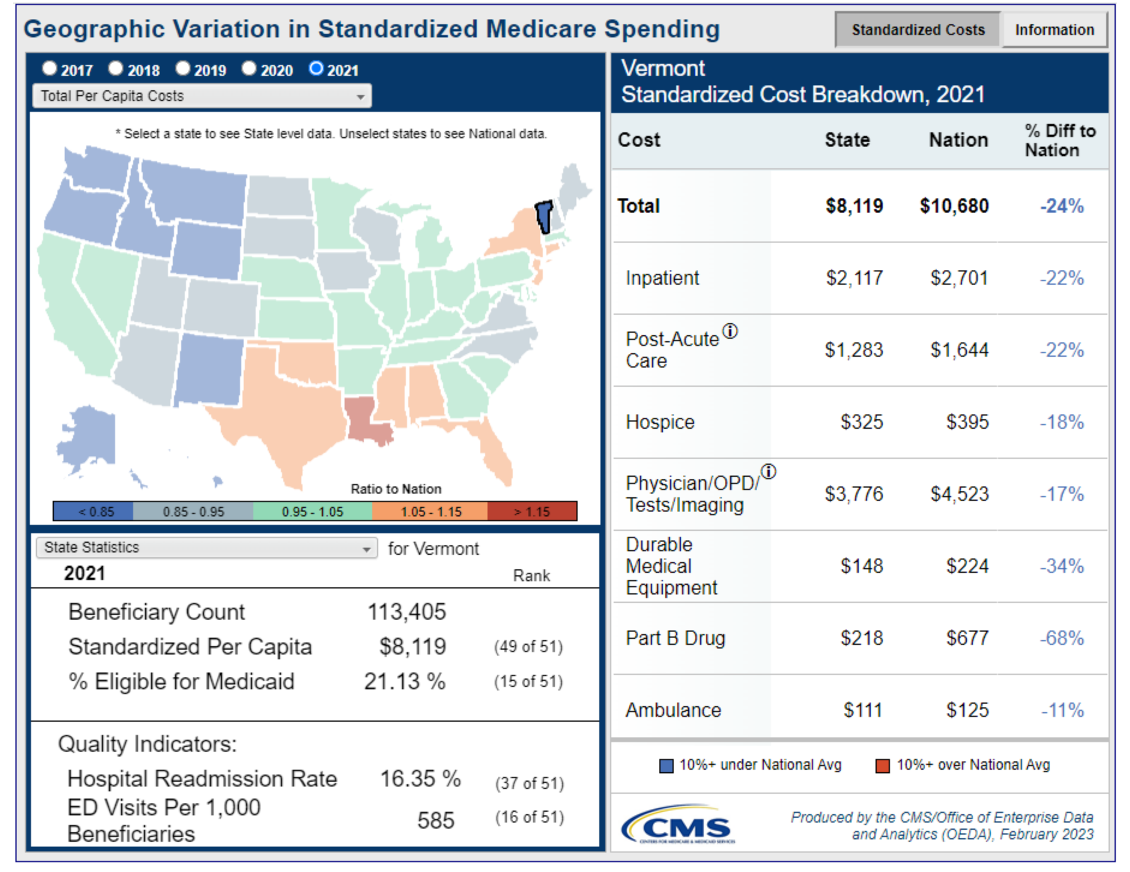
AHEAD: Participation in Multiple CMS Programs

- Hospitals may simultaneously participate in AHEAD and Shared Savings Program ACOs.
- Hospitals may not participate in ACO REACH and AHEAD, but providers practicing at AHEAD Participant Hospitals may participate in ACO REACH.
- CMS will make model-by-model determinations as to whether hospitals can participate in both episode-based CMS models and AHEAD.

Continued recognition of Vermont's status as a long-time low-cost state for Medicare and current models produced significant cost savings.

2021 Medicare Spending	United States	Vermont	Difference from National Average
Medicare Part A and/or Part B Program Payments Per Traditional Medicare Enrollee	$ 11,080	$9,206	**-17%**

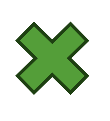
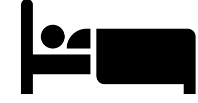
Compound growth rates			
Per Traditional Medicare Enrollee	United States	Vermont	Difference from National Average
2013-2017	1.5%	1.7%	**0.2%**
2018-2021	2.9%	2.7%	**-0.2%**

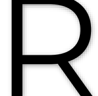


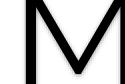
Source: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county

Draft Comparative Analysis: Vermont Medicare FFS Global Payment Model and CMS AHEAD Model Methodology

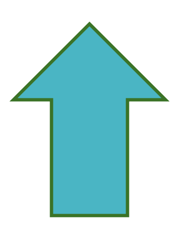
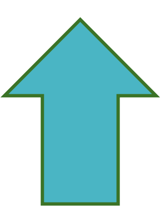
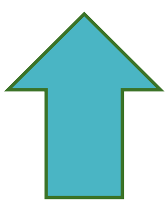
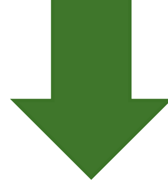
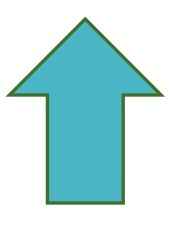
Hospital Business Model under Fee-for-service Payment

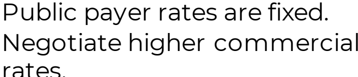




Rates	Units	Total revenue to providers/ Cost to purchases/payers	Operating Costs	Margins

Public payer rates are fixed. Negotiate higher commercial rates.



Increase utilization (especially those with higher payment/lower cost).

Right care at the right time at the right place.

More revenue is better for providers.

Lower is better to make health care more affordable.

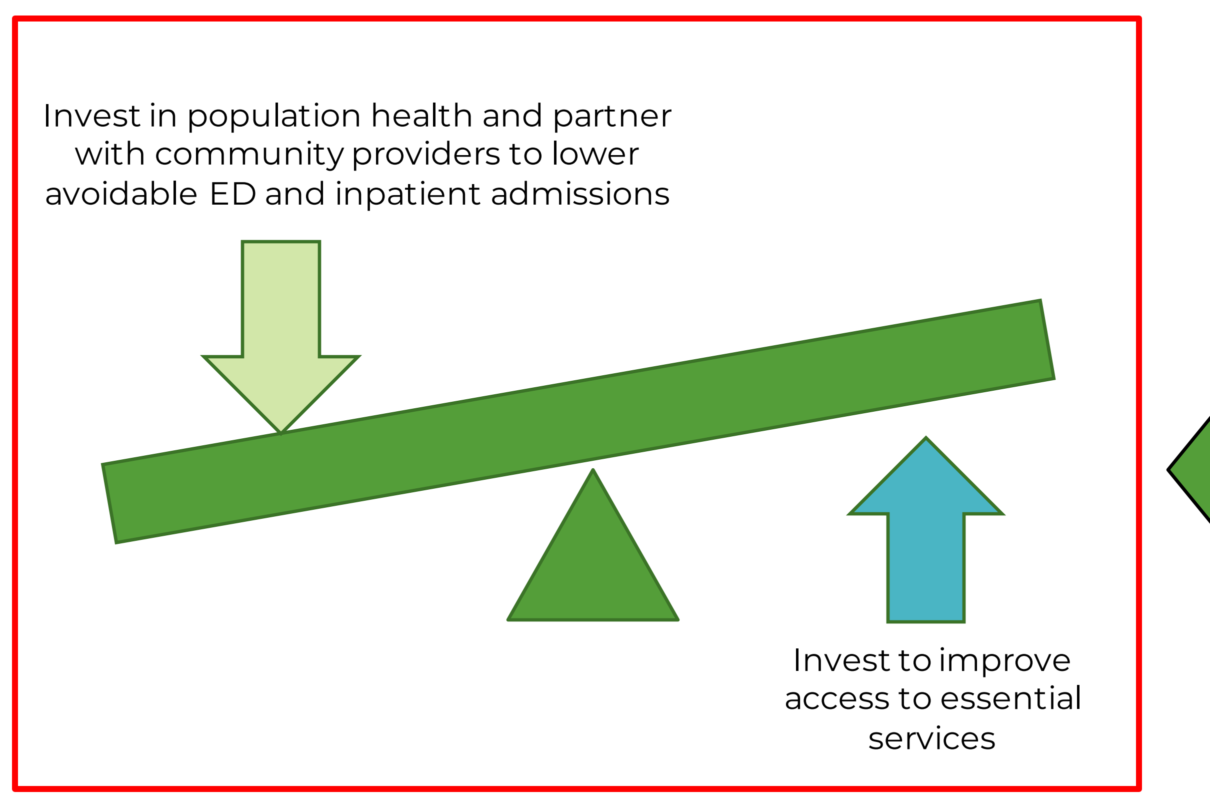
Reduce costs, especially if revenue is not sufficient. Fixed cost: not much hospital can do in the short-run. (50-30%)

Lowering costs is the only way to make health care more affordable.

Higher margins are always better.

Need reasonable margins to maintain and invest.

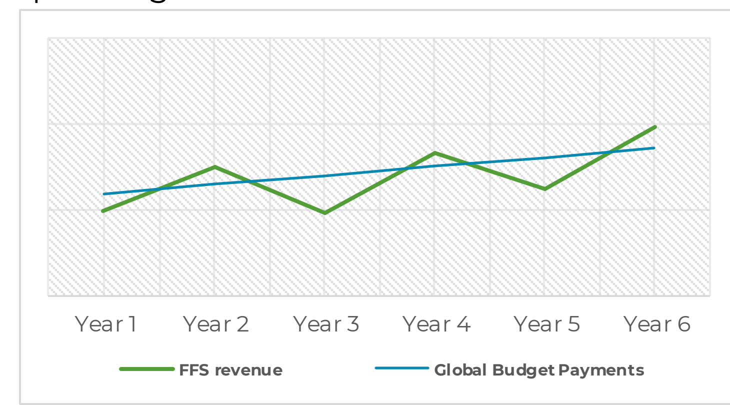
Turning hospital business model to invest in strategies to improve right care at the right time and right place



Right care at the right time at the right place.

R

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

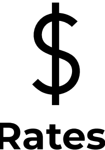


Transformation Support

- Multi-payer care delivery programs (Blueprint, SASH etc.)
- Operational flexibilities
- Data systems and infrastructure
- Aligned performance measures

VT Global Payment Program

What are the main problems and how can global payment program address them?



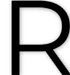
Rates

Medicare FFS rate increases **is same or better than FFS**

Units

Reorient:

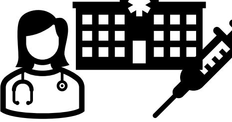
1. Changes due to beneficiary enrollment (hospital cannot do anything about this)
2. New service lines/closures (expectation to align with population health and equity goals and improving access)
3. Market shifts (competition between hospitals).



Total revenue to providers/ Cost to purchases/payers

Prospective and not tied to units or rates. Instead pay for

1. Transformation and social risk
2. Better clinical outcomes
3. Patient experience, wait times
4. Etc.



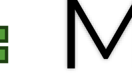
Operating Costs

Manage the cost withing a fixed revenue and focus on efficiency.

Reducing utilization would save costs (variable costs).

Monitor changes for two types:

1. Quality care: low-value care, avoidable ED visits
2. Unintended consequence: transfers,



M

Margins

Potentially Avoidable Utilization Definitions and Measures

- **Potentially Avoidable Utilization (PAU) is defined as hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community-based care. Measures commonly used are:**
  - Unplanned readmissions for any cause within 30 days of the discharge date for the patient
  - Ambulatory Care Sensitive Inpatient Hospitalizations (PQI)
  - Avoidable Emergency Department Visits
  - Low-value/over-use measures

- **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.**
- **Payments for PAUs can be considered as potential opportunity for hospitals to reduce and keep the savings under a fixed revenue model.**
- **Percent payment measure is a reflection of hospital's services (more outpatient services reduces the percent PAU), and access to other services in the area not a measure of hospital's performance.**

See appendix for detailed definitions.

Payments for avoidable utilization for Vermont providers are lower than the national average.

Provider State	Potentially Avoidable Utilization (PAU) Payments	Total Payments	Proportion of Total Payments for PAU
NJ	$793,603,854	$5,304,836,053	15.0%
FL	$1,458,407,193	$10,134,758,050	14.4%
TX	$1,432,336,087	$10,105,243,225	14.2%
NY	$1,684,124,520	$12,105,581,721	13.9%
CT	$297,744,222	$2,172,517,878	13.7%
NV	$168,680,434	$1,248,812,902	13.5%
DE	$103,662,646	$799,857,628	13.0%
IL	$968,296,901	$7,474,523,262	13.0%
MS	$232,014,969	$1,802,494,482	12.9%
MA	$791,394,253	$6,189,850,185	12.8%
MI	$635,549,135	$4,996,474,686	12.7%
AL	$270,799,717	$2,132,393,958	12.7%
GA	$552,230,211	$4,383,687,011	12.6%
LA	$262,390,419	$2,085,915,252	12.6%
CA	$2,242,494,255	$18,154,799,303	12.4%
WV	$152,252,704	$1,251,405,329	12.2%
TN	$417,334,887	$3,473,931,889	12.0%
SC	$334,000,770	$2,794,271,937	12.0%
IN	$457,094,579	$3,824,304,338	12.0%
NC	$637,125,142	$5,332,451,682	12.0%
VA	$551,661,889	$4,633,826,597	11.9%
PA	$935,457,192	$7,864,618,640	11.9%
KY	$296,333,324	$2,502,258,385	11.8%
WY	$49,931,329	$423,674,364	11.8%
RI	$54,512,088	$463,203,567	11.8%
HI	$61,044,015	$524,514,876	11.6%
MD	$632,226,895	$5,436,306,440	11.6%
OH	$700,803,052	$6,033,569,443	11.6%
AR	$202,909,507	$1,761,639,953	11.5%

Provider State	Potentially Avoidable Utilization (PAU) Payments	Total Payments	Proportion of Total Payments for PAU
VT	$35,961,609	$317,655,505	11.3%
OK	$252,836,576	$2,262,310,346	11.2%
MO	$413,630,821	$3,734,891,398	11.1%
DC	$92,694,609	$842,371,365	11.0%
NM	$91,420,782	$837,906,992	10.9%
AZ	$307,243,858	$2,987,312,824	10.3%
AK	$56,544,763	$554,710,570	10.2%
NH	$116,631,576	$1,163,309,139	10.0%
KS	$190,125,837	$1,934,702,611	9.8%
WA	$373,613,325	$3,802,721,145	9.8%
WI	$323,076,800	$3,300,739,328	9.8%
OR	$201,276,753	$2,060,862,524	9.8%
MN	$325,083,303	$3,402,138,066	9.6%
NE	$130,987,320	$1,419,261,753	9.2%
IA	$195,996,469	$2,174,498,723	9.0%
ME	$75,429,180	$838,153,737	9.0%
ND	$75,078,158	$855,419,432	8.8%
UT	$98,047,606	$1,185,029,754	8.3%
CO	$192,273,860	$2,325,110,938	8.3%
SD	$74,558,178	$944,439,436	7.9%
ID	$63,495,303	$851,993,079	7.5%
MT	$66,730,692	$913,842,297	7.3%
National	**$21,129,153,567**	**$174,121,103,998**	**12.1%**

Source: Mathematica's Hospital Potentially Avoidable Utilization (PAU) Dashboard, Medicare FFS FY2022 includes only readmissions, PQIs and ED. Compiles data from public and administrative sources. The data are limited to short-term acute hospitals and Critical Access Hospitals and does not include AIPB payments for Vermont.

Highest opportunity for improvement exists with PQI rates but they are also the most challenging

- Denominator: Hospitals with more outpatient services will have lower percent PAU
- Accountability: It is not an indication of hospital's direct performance but a combination of hospital services and issues related to access to other services.
- Medicare FFS population has the highest estimates of avoidable utilization (mostly due to the higher disease burden)

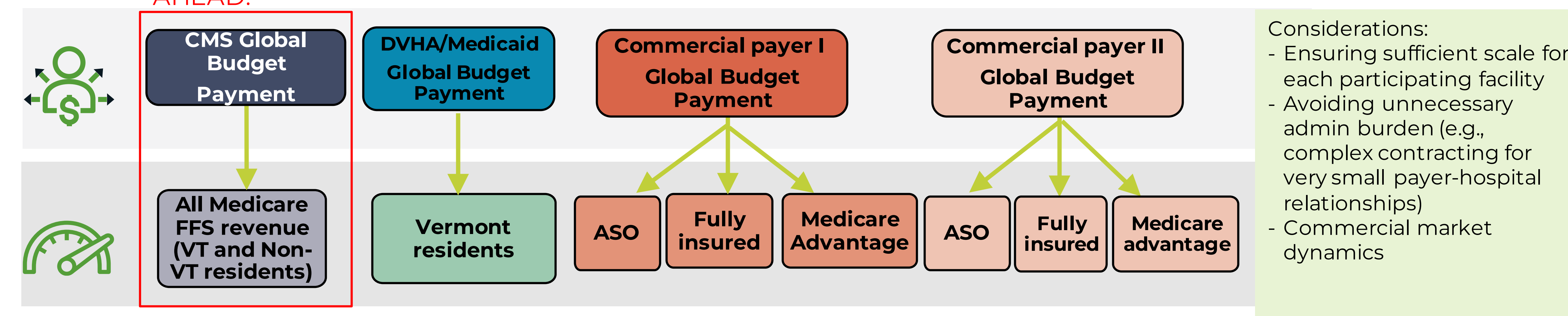
	Total Payments
PAU Total Payments to VT Hospitals	$36 mil.
Readmission to the same hospital	$15 mil.
Prevention quality indicators (PQI)	$17.5 mil.
Avoidable ED	$3 mil.
Selected over-use measures	$1.5 mil.

Medicare FFS Distribution of Potentially Avoidable Utilization (PAU)	**VT Hospital Median Rate**	**Lowest VT Hospital Rate**	**Highest VT Hospital Rate**
Total PAU/Total Inpatient and Outpatient Hospital Payments	**11%**	**8%**	**24%**
Payments for PQI/Total Inpatient Payments	17%	5%	23%
Payments for Readmission/Total Inpatient Payments	10%	5%	14%
Payments for Avoidable ED/Total Emergency Department Payments	27%	21%	32%

Source for PAU measures: Mathematica's Hospital Potentially Avoidable Utilization (PAU) Dashboard. Compiles data from public and administrative sources. The data are limited to short-term acute hospitals and Critical Access Hospitals.. Over-use measures are based on 2021 VHCURES analysis, includes both insurance and patient paid amounts for Medicare beneficiaries. PAU estimates for VT residents in this analysis is $46 mil.

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



Calculating Global Budget Payments Draft Medicare FFS Vermont Global Payment Model

Step 1. Determine baseline payments

Historical claim-based payments and additional non-claims payments and additional baseline incentives

Step 2. Apply annual updates

Inflation, membership, policy and performance

Step 3. Calculate Year-1 payments

Bi-weekly fixed payments; 26 payments per year

Step 4. Mid-year payment adjustment if needed

Exogenous factors, major disruptions in service/financial flows

Step 5. Trend forward to Year-2

Apply annual updates for year 1 payment amounts
Apply additional adjustments

- 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.

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

VT GPP vs. CMS AHEAD Model Comparison: Inclusions and exclusions

Baseline revenue	Vermont Global Payment Draft	CMS AHEAD Model
Inclusion	All facility-based claims from hospitals for inpatient, outpatient and emergency department services.	All facility-based billing except for • Distinct units (psych beds, rehab beds) • CAH method II billing for professional claims
Special cases	Tertiary care (include in the GPP, reconcile in future years)	Outlier payments (include in HGP, reconcile in future years)
Add-on payments	Continue to use current funding formulas.	Baseline Year 3 will serve as a floor for additional payments: DSH, IME, UCC, DSH
Carve-outs	No carve-outs.	New technology payments, outpatient payments based on reasonable cost (e.g., drugs, biologicals) and fee-schedule (labs, imaging)

Baseline Incentives

CMS AHEAD Model

- **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.
- **Social Risk Adjustment** : Up to 2% adjustment based on hospital's score on Area Deprivation Index (ADI), Part D Low-income subsidy and Dual eligibility status

Potential additional adjustments for Vermont

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

- Health equity investment, access investments, hospital

Baseline revenue	VT vs. CMS method comparison	Purpose
Historical revenue base	Similar	Provide a reasonable starting point.
Transformation incentive adjustment	Similar	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	Significant differences	Provide additional revenue to hospitals serving most disadvantaged populations. Available as annual adjustments in CMS methodology.
Access-related investment	**VT specific**	**Provide up-front investments on target areas to improve access.**
Sustainability investment	**VT specific**	**For hospitals with negative margin in the baseline period, avoid "baking in" losses in subsequent years.**
Exception-based factors	**Similar**	**Hospitals may request exception-based adjustments on a case-by-case basis.**

Considerations for Baseline Incentives

Q1. Size of investment funds

- Expected state-wide Medicare FFS spending trend
- Exclusion of baseline incentives from total cost spending measures

Q2. Variation between hospitals

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

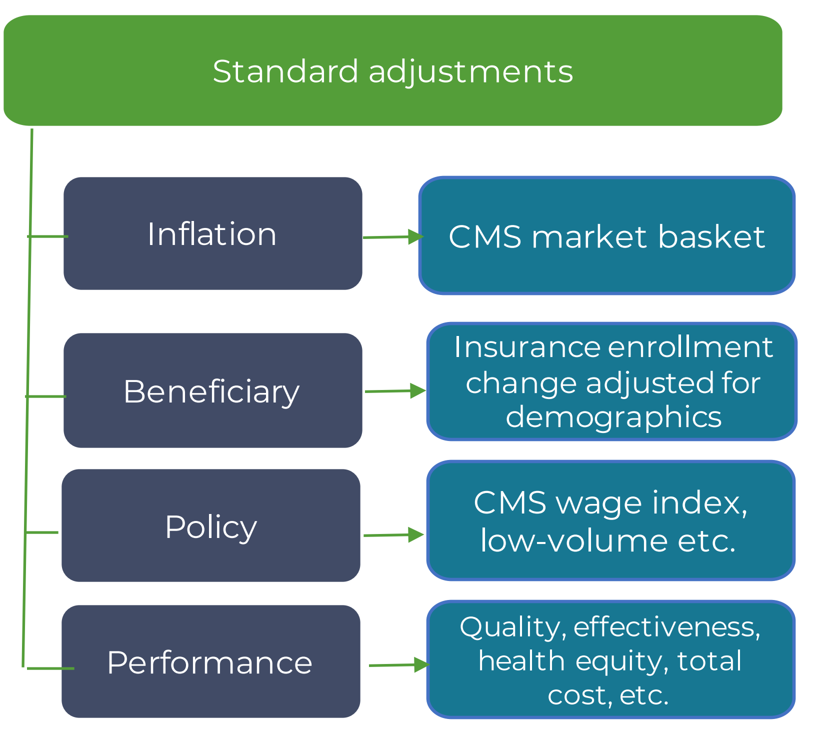
Q3. Time period for additional funding

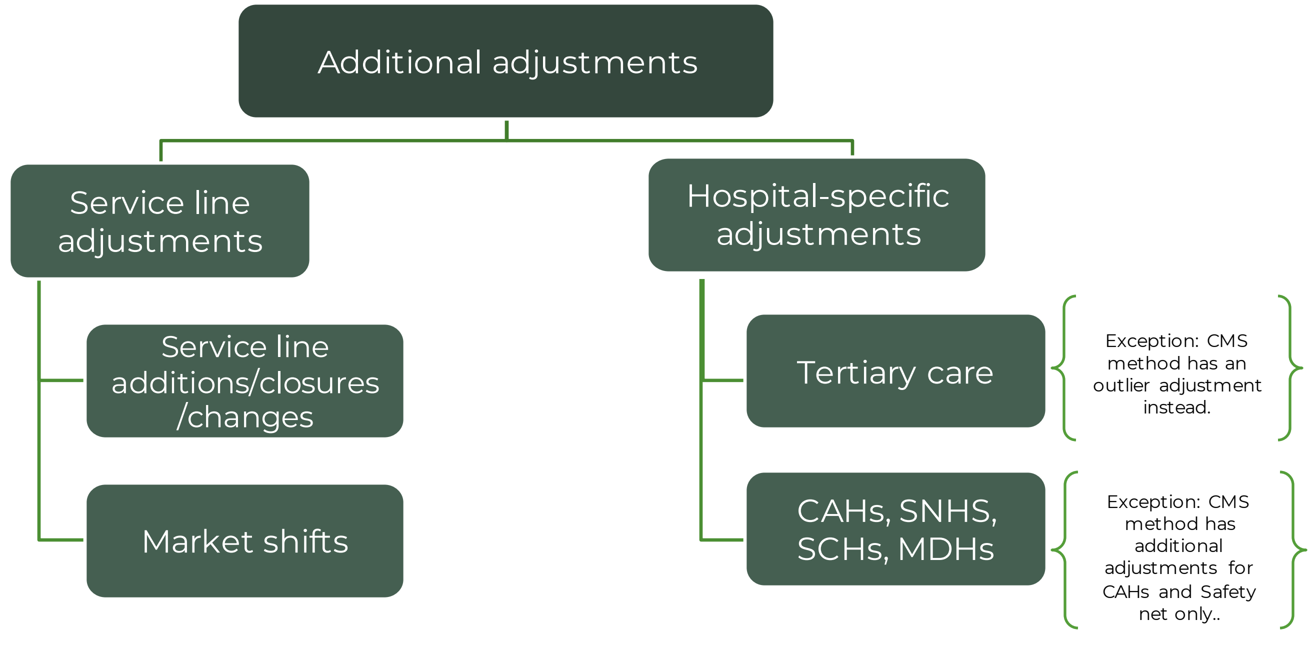
- Incentivize to join the model early
- Multi-year funding

Q4. Accountability

- Transformation plans
- Improving access

VT Medicare GPP and CMS HGB are conceptually aligned, except for considerations for hospital-specific adjustments





CMS methodology differs substantially in a few areas from VT GPP's draft.

VT draft methods is mostly aligned. More discussion is needed.

Annual Trend Updates

Annual Payment Adjustments
Adjustments based on Medicare price and policy changes, including IME, DSH, UCC, and wage index.

Volume-Based Adjustments
Adjustments made to reflect changes in demographics, planned service line changes, market shifts, and unplanned volume changes.

PPS Hospital Quality Adjustments
Adjustments to allow quality measures to align with existing CMS programs for PPS hospitals. Including HRRP, VBP, HACRP, IQR, Medicare Promoting Interoperability, and OQR.

AHEAD-Specific Adjustments

Transformation Incentive Adjustment
Upward adjustment to invest in enhanced care coordination in the first two years of the Model.

Social Risk Adjustment
Based on Area Deprivation Index, dual-eligibility status, and Part D LIS status.

Performance-Based Adjustments

TCOC Performance Adjustment
Upward and downward adjustments based on TCOC of beneficiaries residing in hospital service area.

Health Equity Improvement Bonus
Upward adjustment based on hospital performance on disparities-sensitive measures focused on closing gaps in health care outcomes.

CAH Quality Adjustments
Upward-only quality incentive program that will align with the other CAH quality programs and will include rural-specific measures.

Effectiveness Adjustment
Downward adjustment based on a portion of hospital's calculated potentially avoidable utilization (PAU).

PAU includes readmissions, avoidable admissions (calculated by the PQI-90 indicator), avoidable ED visits (calculated by the NYU ED algorithm), and low-value care (as defined by MedPAC).

Source: CMS Technical Specifications, v1.

Global Budget Methodology Adjustments Timelines

Adjustments	Required in state-designed methodology	VT draft methodology	Adjustment Type	CMS's Amount
Transformation incentive		X	Upward	1%
Social risk adjustment	X		Upward	Up to 2%
Health equity investment		X	Upward	
Access-related investment		X	Upward	
Sustainability investment		X	Upward	
Exception-based factors		X	Upward	
Annual Updates				
Inflation updates	X	X	Upward	
Beneficiary updates	X	X	Upward/ downward	
Medicare policy and quality	X	X	Upward/downward	
Service line adjustments	X	X	Upward/downward	
Performance Adjustments				
CAH quality adjustment	X		Upward	Up to 2%
Health equity improvement bonus		X	Upward	Up to 0.5%
Total cost of care (TCOC) performance adjustment	X	X	Begin as upward-only	Up to +/- 2%
Effectiveness adjustment			Downward	Increases over time, up to –2%

Initial assessment and feedback on CMS's methodology

What are some considerations in assessing CMS's methodology and alignment for VT GPP?

- **Hospital Global Budget Design Goals Recommended by TAG in April:**

1. Create financial predictability and sustainability for hospitals to have the workforce and capital investment resources needed to meet the needs of the communities they serve.
2. Create a payment model that supports delivery of the right care, in the right place, and at the right time. This includes financial flexibility, means for collaboration between hospitals and community providers, budgetary mechanisms, and reporting that supports hospitals in moving resources from delivery of avoidable or unnecessary acute care to high-quality care in other community-based settings, with the long-term aims of improving the health of Vermonters; preventing illness; expanding affordable access to primary, mental health, and home health care; and reducing the need for low-value or preventable services.
3. Support and incentivize increased efficiency in administration and clinical care by reducing – and when possible, eliminating – unnecessary costs and effort associated with administrative processes, which can be barriers to high-quality clinical care and provider well-being. A multi-payer global budget payment model will not eliminate administrative effort or processes, and some administrative processes are necessary for provision of high-quality care and may be required for ongoing health system monitoring.
4. Establish hospital spending levels that achieve a balance between consumer affordability, access to care, and system sustainability that maximizes the benefits to individuals and communities served by Vermont's health care systems.
5. Improve health care quality, equity, and outcomes for individuals served by Vermont's health care system in accordance with an improvement and accountability framework that prioritizes patient and community needs – both directly through the global budget model and in coordination with other State and provider efforts to improve Vermont's health care system – while containing cost growth and reducing unnecessary costs wherever possible.
6. Maximize available government funding.

Global Budgets and Payments CMS AHEAD Specific Adjustment

Adjustment type	CMS HGB	VT GPP
Transformation incentive	1 % of established global budget for first two years.	Prior discussion: Baseline investments are necessary to increase resources for transformation. Potential alignment: Align with CMS, simplify the calculation
Social risk adjustment	Annual adjustment: based on Area Deprivation Index (ADI), dual-eligibility status, and Part D low-income subsidy status. Calculate hospital scores as weighted average of national and state distributions.	Prior discussion: Included as a baseline incentive, considered measures other than ADI. Potential alignment: Make this an annual adjustment (stays in the budget until the end) Use Social Vulnerability Index (SVI) instead of ADI and Medicaid enrollees in the scores. Calculate scores based on state-wide averages (not include National distribution)

SVI measure includes more domains compared to ADI

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		

1. **Area Deprivation Index (ADI)**: The index was originally developed using data from the 1990 census, updated with 2020 data.
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.

Global Budgets and Payments
Annual adjustments

Adjustment type	CMS HGB	VT GPP Draft Methods
Inflation	• IPPS market basket minus productivity (0.2 – 0.7) • OPPS market basket minus productivity (0.2 – 0.7)	PPS market basket
Membership/ demographic changes	Prospective: Population growth 65+ adjusted for age Correction: Medicare FFS beneficiary growth adjusted for HCC*	Medicare beneficiary change adjusted for age, gender, ESRD
PPS payment changes	Apply annul adjustments as specified by CMS. Create floors for IME, DSH, UCC No additional adjustment for MDH	Apply annual adjustments as specified by CMS Apply policy adjustments for Medicare Dependent Hospitals (MDH) Potential alignment: adapt floors and update floors with inflation adjustment every year
PPS Hospital quality Adjustments	Apply annual adjustments similar to current policies.	Apply annual adjustments similar to current policies, move to an all-payer approach over time
CAH specific adjustments	BY 3 is a floor for HGB	Potential alignment: consider BY3 as the floor, update it with inflation adjustment every year.

CMS Methodology- Service line adjustments

Adjustment type	VT GPP prior discussions	CMS HGB
Market Shift Adjustment (MSA)	• Limited need for MSA given geography • Identify main service lines • Track transfers	• Determine increases and declines for all service lines • Make an adjustment at 50 % of the “FFS payment” to the hospital
Service line change (SLA)	• Align with the GMCB’s review process • Consider temporary changes different from permanent changes	New services: 2-year reconciliation to claim-based payment amounts. Mid-year reconciliations to account for data lags. Contraction/elimination: PPS hospital retains 50% of historical payment, CAH may retain 100% of payment Must be approved my CMS and align with State Health Equity plan.
Unplanned Volume Change Adjustment (UVA)	Develop alternative measures instead of relying on volume estimates.	Additional adjustment for volume changes +/- 5 percent volume change after taking into account the demographic shift adjustments, MSAs, or SLAs. • Declines: remove full amount for PPS, retain 50% for CAHs. • Increases: Receive 50 % of the revenue provided hospital achieved total cost benchmark.

VT Global Budget Payment Potential Alignment with CMS Methods

- **Complexity is inevitable but overengineering is a temptation we should resist.**
- **Initial draft recommendations for TAG discussion**
  - Baseline : Align with CMS but simplify baseline adjustments for PPS policies.
  - Annual updates:
    - Simplify CMS's approach for payment adjustments.
    - Use BY3 factors as floors, align with CMS methodology
  - Service line changes:
    - Use 3 % variance to apply service line adjustments.
    - Set thresholds for prospective service line adjustments (e.g., $100K or 0.5% of Total GB)
    - Make service line specific evaluations for market shifts (CMS runs a general algorithm for all service lines).

Please note that state designed methodology needs approval from CMS.

VT Global Budget Payment Potential Alignment with CMS Methods

- **Initial draft recommendations for TAG discussion:**
  - Use CAH/Safety Net specifical considerations from CMS methods and add Medicare Dependent Hospital to the same category.
  - Transformation incentive: Make 1 % transformation funding constant
    - (PY2= PY1 global payment*1% * Inflation adjustments) rather than recalculation in PY2 in the CMS method.
  - Social risk adjustment: Instead of recalculating every year, calculate the score using BY3, and provide financial incentive in the baseline revenue).
    - Social risk scores do not change significantly over time.
    - Add a review/recalculation in PY5.

Please note that state designed methodology needs approval from CMS.

CMS Methodology- Performance Adjustments

Adjustment type	CMS HGB
Total cost of Care Adjustment	• Participant Hospitals will be rewarded or penalized for exceeding or limiting, respectively, a TCOC benchmark for beneficiaries within their geographic service area. • Starts with measuring in PY2 as an upward adjustment up to 2 percent reward applied in PY4 budget. • Downward adjustment will start in measurement year PY3, with up to 2 percent reduction. • The TCOC Performance Adjustment will include nonclaims-based payments, which includes, but is not limited to, capitated payments and Accountable Care Organization (ACO) shared savings or losses.
Health Equity Bonus	Participant hospital may receive an annual upward adjustment based on hospital performance on select disparities-sensitive quality measures.
CAH quality adjustments	Upside reward will begin as a pay-to-report in PY3 and progress to a pay-to-perform in PY5. Up to 2 % additional payment moving from pay-to-report to performance.
Effectiveness Adjustment	Downward adjustment based on hospitals revenue in potentially avoidable utilization (PAU).

CMS Methodology: Total cost of Care Adjustment

Adjustment type	VT GPP prior discussions	CMS HGB
Geography	• Use Hospital Service Area (HSA) • Consider how to account for small market share of hospitals in each HSA.	• Hospital lists a zip codes as Primary Service Area • Any unclaimed zip code is attributed based on hospital's share and/or 30 minute travel time.
TCOC benchmark	Not discussed.	• Matching algorithm to select comparable national counties.
Performance	Part A and Part B spending only.	• Part A and B spending, risk adjusted by HCC. • Determine a growth target based on comparison benchmarks.
Financial impact	Consider making adjustments only when VT cannot meet state-wide target (minimum AHEAD requirement).	• Maximum +/- 2 percent.

CMS Methodology: Health Equity Bonus

Adjustment type	CMS HGB
Measures	• Hybrid Hospital Wide Readmission measure, Inpatient stays only • Prevention Quality Indicators (PQI)-92 Chronic Conditions Composite (including inpatient and observation stays)
Definition	• A hospital's 75th percentile of Outcome Diversity Index (ODI) • ODI by measuring ADI at a state and national level, and Part D LIS and Medicaid dual-eligibility. HEIB will use the same calculation as the AHEAD Social Risk Adjustment in Section 3.2.3.1
Performance	• Annual improvement in patients with high adversity (ODI)
Financial impact	• Up to 0.5% upside reward is split between two measures.

CMS Methodology-Effectiveness Adjustment

Adjustment type	CMS HGB
Adjustment	• Downward adjustment based on the individual hospital's percentage of PAU charges compared to the statewide average PAU charges . • CAHs and SNHs will begin one year later than Acute Care Hospitals.
Measures	• Hybrid Hospital Wide Readmission measure • AHRQ PQI-90 • Avoidable ED visits (calculated by the New York University Emergency Department algorithm (NYU EDA)) , • Low-value care (as defined by MedPAC)
Performance	• Annual improvement in patients with high adversity (ODI)
Financial impact	• Starts with 0.5 % , increases by 0.25 every year up to 2% by PY5. • CAHs and SNHs amounts are one-year lagged.

Additional Adjustments in VT GPP

Adjustment type	Initial considerations
Efficiency adjustment	Develop an efficiency measure to determine operational efficiency of hospitals and apply adjustment for all-payors.
Tertiary care adjustment	Carve-out of most complicated services. (Include in the prospective payments and reconcile to FFS amounts for the future years). CMS has an outlier carve-outs instead.

Appendix

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