VERMONT
GREEN MOUNTAIN CARE BOARD

Vermont Hospital Global Budget Design

An Ongoing Discussion…

May 6th, 2024

Agenda

1. Public Discussion
    1. (Continue) Digging into AHEAD & Hospital Global Payment Design
    2. Public Comment
2. Executive Session
    1. Discuss Negotiation Strategy

Board Negotiation Goals: Vermont-Specific Medicare Global Budget Specification

Board Meeting Topics	Target Date
Overview of Draft GB Methodology v.1	January 17th
Negotiation Strategy: (1) Medicare TCOC (2) VT Medicare GB Specification: Base & Base Adj.	April 1st
Review Board Feedback/Questions from April 1st meeting & Negotiation Strategy: (3) Step Back Big Picture – AHEAD & Hospital GB	April 17th
Review Board Feedback/Questions from April 17th meeting & Negotiation Strategy: (4) VT Medicare GB Specification: Annual/Performance Adj.	April 29th
Review Board Feedback/Questions from April 29th meeting & Negotiation Strategy: (5) VT Medicare GB Specification: Annual/Performance Adj.	May 1st
Review Board Questions from May 1st meeting & Negotiation Strategy: **(6) VT Medicare GB Specification: Annual/Performance Adj.; CAH-specific considerations & Delivery System Reform/Hospital Transformation Funding**	**May 6th**
Provider Panel on AHEAD/HGP	May 15th
Mathematica delivers near final Methods paper to Board for review and to post for public comment (*approximate*)	May 20th
Expert Panel on Value Based Care/Payment & Delivery System Reform	May 22nd
Special Public Comment Period on Hospital Global Payment Methodology	May 21st - May 28th
Board Discussion & Vote on Hospital Global Payment Methodology	May 29th
Board Discussion & Vote on Hospital Global Payment Methodology (Alternative)	June 5th

AHEAD Timeline: Key Components

	Deadline Type	Board Vote Required	Due Date
Vermont-specific Medicare Global Payment Specification	**CMMI**	**Yes (June 1)**	**July 1, 2024**
Continue Act 167 Development of Commercial Hospital Global Payment	GMCB/AHS	N/A	Late Summer/Fall 2024
Medicaid Global Payment Implementation (Target Date)	DVHA	No	January 1, 2025
Hospital Budget Guidance Incorporates Global Payments	GMCB	Yes	March 31, 2025
Execution of State Agreement (AHEAD)	CMMI	Yes	June 30, 2025
Implementation of Medicare Primary Care Payments & Medicare Hospital Global Payments (Medicare: 10% of NPR in Y1; 30% in Y3)	CMMI	N/A (State Agreement)	January 1, 2026
All Payer TCOC & Primary Care Spend Targets Incorporated into the State Agreement	CMMI	Yes	October 1, 2026
Commercial Hospital Global Payment Methodology (At least one commercial Payer program)	CMMI	Yes	January 1, 2027 (or sooner)

What is the Board voting on by when?

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***.

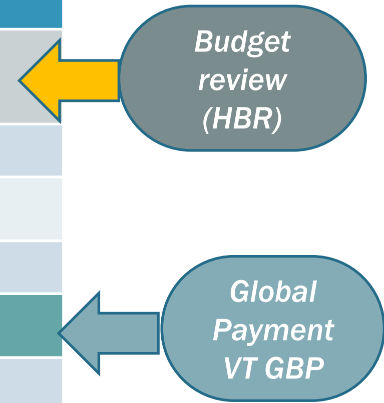
The methodology is NOT a done deal as submitted, as it is subject to negotiation.

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

DIGGING INTO AHEAD & MEDICARE HOSPITAL GLOBAL PAYMENT DESIGN

Potential NPR included in Global Budget Payment

	2022 Estimates	
	Revenue	Proportion of Total Net Payer Revenue and FPP
Total Net Payer Revenue & Fixed Prospective Payment	**$3,017,752,722**	**100%**
Physician revenue[a]	$473,387,653	16%
Other payer exclusions[b]	$324,832,007	11%
Patient portion[c]	$234,949,283	8%
Global Payment Revenue	**$1,984,583,779**	**66%**
Medicare – FFS[d]	$429,357,739	14%
Medicaid – FPP[e]	$102,349,994	3%
Medicaid – GB[e]	$141,789,856	5%
Private and Medicare Advantage- Potential[e]	$1,311,086,190	43%



Source: GMCB, Adaptive Platform, Payer Revenue Sheet and Income Statement, FY 2022. VHCURES (for commercial patient portion estimates, using 2021 amounts). National Medicare FFS claims database for Medicare FFS included revenue. Data are preliminary and were not validated with hospitals.

[a] Physician revenue of hospitals will be considered in the phase II of methods development.
[b] Other payer exclusions: revenue from workers compensation, uninsured and self-pay, non-VT Medicaid, and uncategorized (DSH) amounts in Adaptive financial reports.
[c] Patient Portion amounts use 2021 VHCURES beneficiary portion estimates applied to Adaptive data.
[d] Medicare FFS revenue comes from national Medicare FFS claims database. Included revenue is estimated using definitions from the AHEAD model.
[e] Medicaid and commercial amounts come from Adaptive, and these numbers include revenue for SNF/clinic/rehab and swing beds, as Adaptive does not appear to split out these service lines for net revenue amounts.

Overall Summary – FY* 2023

Preliminary analysis of CMS exclusions/reconciliations to FFS amounts, suggests that about 65% of Medicare hospital facility payments would be under global payment. The largest exclusion is patient and secondary payer payments, which are excluded already excluded from CMS payments.

Please note that we are not able to calculate some of the excluded categories for CAH hospitals.

Hospital Type	Total Medicare FFS Facility Payments (Hospital Revenue)	Percent of Revenue Included in GB based on CMS method	Excluded from Global Payment				
			% Patient and secondary payer payments	% DSH/UCC/IME	% Other subunits	% Outliers	% OP Carve-outs
PPS	509,914,342	63%	12%	6%	1%	4%	13%
Critical Access Hospital	181,321,505	68%	30%	0%	2%	na	na
Vermont Total	**691,235,847**	**65%**	**17%**	**5%**	**1%**	**na**	**na**

Data source: National Medicare FFS claims database.
Total Medicare FFS facility payments includes Medicare facility claims revenue across all units of the hospital (IP, OP, Swing, Subunits) as well as patient payments.
Included revenue is a preliminary estimate, does not include exclusion for NTAP payments and CAH method II billing. CAH's exclusions cannot be calculated do to lack of claim indicators.
**OP Carve-out payments are estimated for AIPB attributed claims. This estimation is based off the percent of excluded revenue out of total revenue from claims payments (excluding AIPB). This percent is then applied to the AIPB amount.
***Other subunits include acute rehab or acute psych units.

*FY=Federal/Hospital fiscal year

Trends in Excluded Revenue

Exclusion of three additional services would reduce the risk to Vermont hospitals for high-cost cases (IP Outliers) or increase utilization in (rehab, psych, and outpatient oncology and infusion services).

- 2023 growth rates shown below indicate these services grow either at the same rate or higher in IPPS hospitals.
- CAH hospitals experienced significant decline in payments for subunits.

Hospital Type*	FY2022 Included Revenue	23-22 Growth rate	IP Outlier Payments in 2022	2022-2023 Growth Rate	OP Carve-Out Payments in 2022	2022-2023 Growth Rate	Other subunit payments in 2022	2022-2023 Growth Rate
PPS	303,979,417	7.0%	19,739,259	7%	60,179,455	8%	4,057,837	12%
Critical Access Hospital	125,378,322	-1.5%	-	na	-	na	4,004,242	-18%
Vermont Total	**429,357,739**	4.7%	**19,739,259**		**60,179,455**		**8,062,079**	

Data source: National Medicare FFS claims database.
For IP Outlier and OP Carve-outs, only PPS hospitals were included.
OP Carve -out payments are estimated for AIPB attributed claims. This estimation is based off the percent of excluded revenue out of total revenue from claims payments (excluding AIPB). This percent is then applied to the AIPB amount.
Other subunits include acute rehab or acute psych units.

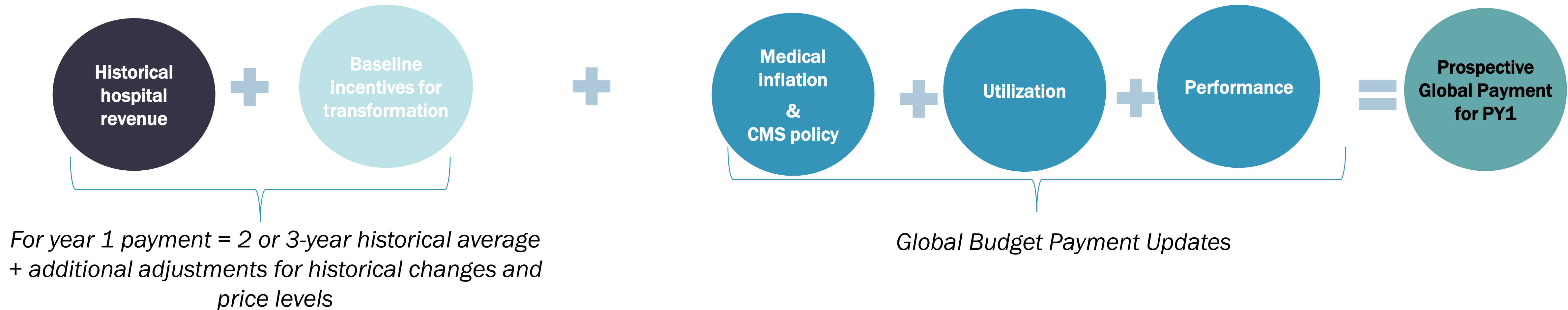
Calculating Global Budget Payments – Baseline Payments

The goal of the Global Payment Model is to provide predictable, stable revenue to hospitals

Baseline payments trended forward for prospectively calculated annual payment amounts

No retrospective settlement (true-up)

Align with CMS methods where there are no major concerns. State designed methodology needs approval from CMS.



Vermont Medicare Hospital Global Payment Components: Annual Updates

Annual Payment Updates	Description (Draft methods)	Purpose
Inflation*, CMS Medicare policy	Standard adjustments in current CMS policies.	Provide annual updates similar to Medicare's general trend.
Utilization updates*	+/- adjustments to account for enrollment, market shifts, new/expanded/closed services.	Rebalance incentives towards improving access to high-quality, population health focused care.
Social risk adjustment*	Up to + 2% additional funding based on social risk factor of a hospital.	Provide additional funding to hospitals who are taking care of patients with the highest social-economic barriers
CAH adjustments*	Reimbursement floor using latest cost report at the point of model entry and monitor future budgets.	Move CAHs away from cost-based settlement, while providing financial stability/sustainability.

*Required in state designed methodology per CMS.

Social Risk Adjustment

Purpose: Provide additional funding to hospitals who are taking care of patients with the highest social-economic barriers.

Adjustment type		CMS HGB	VT GPP
Social risk adjustment	Social risk score	Beneficiary-level national and state Area Deprivation Index (ADI), dual-eligibility status, and Part D low-income subsidy status	Use Social Vulnerability Index (SVI) instead of ADI and Medicaid enrollees in the scores Calculate scores based on statewide averages (i.e., exclude national distribution)
	Calculation	Calculate hospital scores by summing weighted social risk scores across the hospital's geographic area	Simplify the social risk calculation and align with health equity bonus methodology by using social risk score of the patients seen by the hospital to calculate hospital's social risk scores.
	Adjustment	Hospitals with scores above the state's average will be eligible for an adjustment scaled up to 2% of the global payment every year. Scores will be recalculated annually.	Provide additional funding to all hospitals based on their social risk score up to 2% of the global payment every year. Recalculate the scores in every 2-3 years.

Board members to weigh in during proposed executive session to discuss negotiation strategy.

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.

   Measures at the census-block level.

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.

   Measures at the census-track level.

SVI and ADI scores vary

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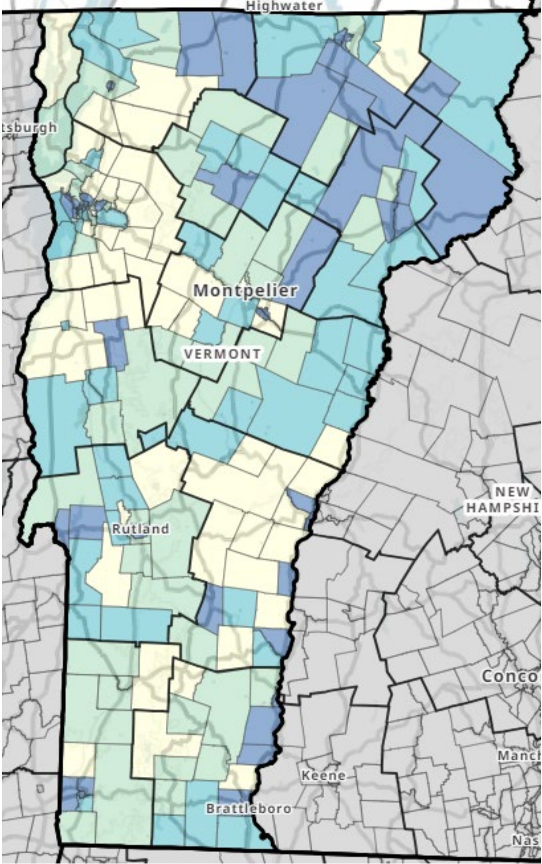
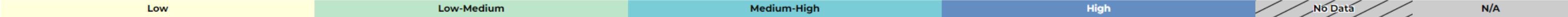
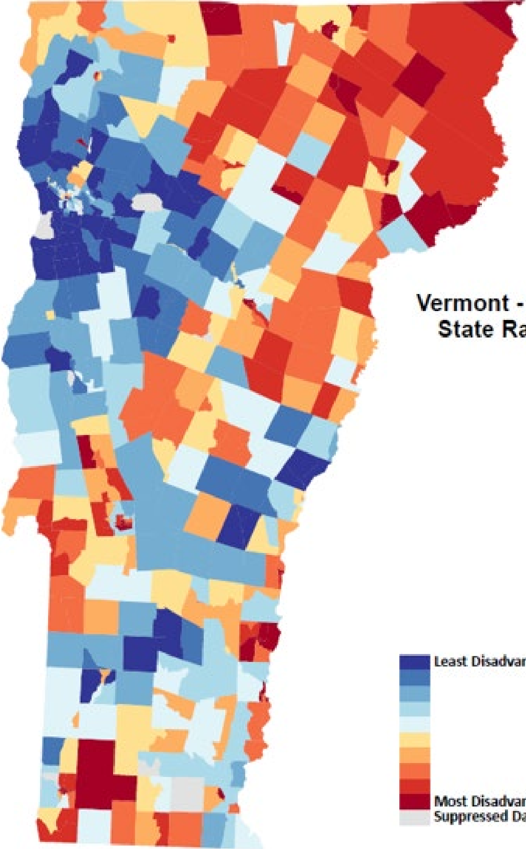
SVI by Census Tract, 2020

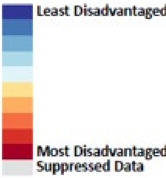


Level of Vulnerability



ADI by Census block group, 2020





PERFORMANCE ADJUSTMENTS (NEW MATERIAL)

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Vermont Medicare Hospital Global Payment Components: Performance Adjustments

Performance Adjustments	Description (CMS methods)**	Purpose
Quality*	+/- adjustments on inpatient revenues	Maintain payments for hospital-level quality performance (based on CMS national quality programs or similar measures). *FUTURE WORK: DEVELOP ALL-PAYER APPROACH.*
Health equity improvement bonus*	Up to +2% funding for improvement in high-adversity populations.	Rewards hospitals for improving care for the most disadvantaged populations relative to other groups while improving overall care for all.
Total cost of care (TCOC) performance adjustment*	Up to +/-2% for TCOC savings compared to benchmarks.	Protects against shifting hospital costs to community providers without overall savings. Accountability provides additional CMS funding for practices who are linked to the model (MIPS).**
Effectiveness Adjustment	-.5% to 2% based on hospital's potentially avoidable utilization (PAU).	To incentivize a reduction in unnecessary hospital utilization.**

*Required in state designed methodology per CMS.
** Vermont methodology is still under development.

Performance Adjustments: Quality

CMS methods apply existing programs to PPS hospitals. Critical Access Hospitals will have new reporting requirements and payment adjustments,

Adjustment Method	Critical Access Hospitals (CAH)s	Acute Care Hospitals
Measures / programs	Align with other quality programs and include rural-specific measures Sample quality measures: CMS Hybrid Hospital-Wide Readmission Emergency Transfer Communication Measure Outpatient ED Arrival to Discharge OPI-01 Safe Use of Opioids – Concurrent Prescribing National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection VTE-1 Venous Thromboembolism Prophylaxis Sepsis Bundle Severe Obstetrics Complications HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems	Hospital Value-Based Purchasing (VBP) Program Hospital Readmission Reduction Program (HRRP) Hospital-Acquired Condition (HAC) Reduction Program Hospital Inpatient Quality Reporting (IQR) Program Hospital Outpatient Quality Reporting (OQR) Program
Adjustment	**Upside-only** PY3-4: 2% adjustment for pay-for-reporting using PY1-2 data PY5: .5% for pay-for-performance using PY3 data PY6: 1% for pay-for-performance using PY4 data PY7: 1.5% for pay-for-performance using PY5 data PY8: 2% for pay-for-performance using PY6 data	**Upside and downside** PY1 Hospital Global Budget will be adjusted to remove a quarter of the impact of all Quality Adjustments in PY1 (i.e., removing October – December 2025 for a PY2026)

Board members to weigh in during proposed executive session to discuss negotiation strategy.

Performance Adjustments: Health Equity Improvement Bonus

HEIB	CMS	Vermont
Measures to calculate Outcome Diversity Index (ODI)	Beneficiary-level national and state Area Deprivation Index (ADI), dual-eligibility status, and Part D low-income subsidy status in hospital's HSA	Use Social Vulnerability Index (SVI) instead of ADI and Medicaid enrollees in the scores Calculate scores based on statewide averages (i.e., exclude national distribution)
Performance measures	CMS Hybrid Hospital-Wide Readmission (Hybrid eHWR) Prevention Quality Indicators (PQI)-92 Chronic Conditions Composite	Align
Calculation	Identify High Adversity Cohort using the hospital's 75th percentile of ODI scores Calculate overall improvement in performance measures at the hospital If the hospital had an overall improvement the performance measures, calculate improvement among the High Adversity Cohort Scale the High Adversity improvement for each measure to global payment impact with a maximum reward of 0.25% of global payments per performance measure	Align
Adjustment	Up to 0.5% per year (0.25% per performance measure)	Align

Board members to weigh in during proposed executive session to discuss negotiation strategy.

Performance Adjustments: Total Cost of Care (TCOC)

	CMS HGB	VT GPP prior discussions / considerations
Performance	Part A and B spending, risk adjusted by HCC. Determine a growth target based on comparison benchmarks.	Consider corridors (e.g. make an adjustment only if TCOC exceeds the benchmark by 1%)
Attribution	Residents living in zip codes selected by the hospital as Primary Service Area Any unclaimed zip code is attributed based on hospital's share and/or 30-minute travel time.	Hospital service area (HSA), except small hospitals use sub-level HSA assignment (methods for sub-level to come next year) Market share of hospitals is small in some HSAs (See next slide)
Benchmark	Comparable national counties.	VT counties may not be as comparable to national counties; if CMS selects benchmark counties, it may be difficult to foresee the implications.
Excluded payments	Enhanced Primary Care Payments (EPCP) Transformation Incentive Adjustment	Social Risk Adjustment (SRA), Vermont Transformation Incentive **Blueprint, SASH, CHT payments**
Financial Impact	Maximum +/- 2 percent.	Align
Measurement start date	PY 2 (CY2027) Payment adjustment will be in PY4 due to data lags.	Align
Adjustment	PPS: upwards only in PY4 payment, upwards/downwards for all other PYs CAH and SNH: upwards only in PY4, PY5, upwards/downwards for all other PYs	Align

TCOC: Considerations for Geographic Attribution

Hospital Service Area	Highest Proportion VT Hospital*	Percent of Hospital Payments for Residents of HSA	Percent of Total Medicare Payments for Residents of HSA	Total Insurance Payments for VT residents w/ AIPBP
Barre	Central Vermont Medical Center	58%	42%	$ 118,491,439
Bennington	Southwestern Vermont Medical Center	49%	34%	$ 83,962,698
Brattleboro	Brattleboro Memorial Hospital	32%	23%	$ 61,072,330
Burlington	University of Vermont Medical Center	84%	57%	$ 228,571,247
Middlebury	Porter Medical Center	40%	28%	$ 48,989,909
Morrisville	Copley Hospital	49%	35%	$ 42,478,142
Newport	North Country Hospital	29%	24%	$ 50,053,966
Randolph	Gifford Medical Center	31%	24%	$ 28,574,010
Rutland	Rutland Regional Medical Center	59%	40%	$ 130,609,876
Springfield	Springfield Hospital	20%	15%	$ 58,308,485
St. Albans**	Northwestern Medical Center	42%	28%	$ 69,876,480
St. Johnsbury	Northeastern Vermont Regional Hospital	43%	34%	$ 54,828,393
White River Jct	Mt. Ascutney Hospital and Health Center	5%	4%	$ 102,699,239
Unknown	N/A			$ 11,893,132

**Grace Cottage Hospital does not have significant market share in any of HSAs*. UVMC has 45 percent of the total payments for St. Albans as the highest proportion.

Data Source: VHCURES, FY 2022. Data are limited to residents with a Vermont mailing address in VHCURES. No other exclusions are applied. Total Medicare Payments for VT hospitals include other providers associated with hospital.

Performance Adjustments: Effectiveness

VT could consider developing this adjustment at the all-payer level in the future

Description (CMS methods)	VT Method Considerations
A maximum downward adjustment of -0.5% (PPS-PY2, CAH-PY3) to 2% (PPS-PY5+, CAH-PY6+) based on hospital's potentially avoidable utilization (PAU). PAU includes: 1. Readmissions 2. Avoidable admissions (calculated by the PQI-90 indicator) 3. Avoidable ED visits (calculated by the NYU ED algorithm) 4. Low-value care (as defined by MedPAC)	Developing an all-payer adjustment in future years (PY3 or later). Focus on access issues for effectiveness measures. Develop an all-payer measure framework for effectiveness/efficiency/commercial price/productivity adjustment.

Board members to weigh in during proposed executive session to discuss negotiation strategy.

Effectiveness:
Avoidable Utilization & Overuse of Care

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 of overuse are defined as health care services that medical professional societies have concluded provide little to no benefit to patients

Effectiveness: 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)
  - *If we apply Vermont PAU percent to Total Medicare FFS Payment including AIPBP, the estimated total PAU is $60 mil in 2022.*

	Total Medicare FFS Payments (w/o AIPBP)
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.

	Proportion of Hospital Payments for PAU
VT Hospital Median Rate	11%
National Hospital Average	12%
Lowest VT Hospital Rate	8%
Highest VT Hospital Rate	24%

Provider State	Proportion of Total Payments for PAU	
NJ	15.0%	Highest percentage
MA	12.8%	
RI	11.8%	
MD	11.6%	
VT	11.3%	
NH	10.0%	
ME	9.0%	
MT	7.3%	Lowest percentage
National	**12.10%**	

Source for PAU measures: Mathematica's Hospital Potentially Avoidable Utilization (PAU) Dashboard and VHCURES analysis. 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.

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IN SUMMARY...

Summary of Vermont Medicare Hospital Global Budget Methodology

Adjustments	Required in state-designed methodology[a]	VT draft methodology	Adjustment Type	Amount
Transformation incentive	X	X	Upward	1%
Vermont delivery reform investment		X	Upward	CMS negotiation
Annual Updates				
Inflation updates	X	X	Upward	about 3%
Beneficiary updates	X	X	Upward/downward	estimated to be -1% (varies by hospital)
Medicare policy	X	X	Upward/downward	Varies by hospital
Service line adjustments	X	X	Upward/downward	Varies by hospital
Social risk adjustment	X	X	Upward	Up to 2%
Performance Adjustments				
Quality	X	X	Upward/downward	CMS amounts
CAH quality adjustment	X	TBD	Upward	Up to 2%
Health equity improvement bonus	X	X	Upward	Up to 0.5%
Total cost of care (TCOC) performance adjustment	X	X	Begin as upward-only in PY2 measurement	Up to +/- 2%
Effectiveness adjustment		TBD		

[a] State-designed methodology does not have to use the same methods as the AHEAD model, but it must meet the intent of the adjustment.

Mitigating concerns with Hospital Global Payments (1 of 3)

Global payment is a method to change the way hospitals receive their revenue. The goal is to remove financial barriers to invest in population health as these investments will ultimately reduce hospital's revenue due to reductions in utilization. However, more than 10 years of experience in alternative payment models showed us that removing financial barriers is not enough. Delivery reform strategies with infrastructure support, technical assistance, and additional policy levers are needed to achieve the goals of better health care system.

Concerns raised	Potential solutions under Vermont Global Payment Program
Hospital prices are too high	Commercial global payment methodology could be designed to consider higher prices in the commercial sector. GMCB would continue to regulate overall NPR growth with the hospital budget review process.
Using historical revenue as a base locks-in inefficiencies	Payments may be adjusted in future years based on efficiency and performance to improve cost-efficiency. Service line adjustments that removes only marginal cost would incentives to remove inefficient services. New measures would be needed to define efficiency if hospital is incentivized to improve population health, improve access and reduce avoidable utilization.

Mitigating concerns with Hospital Global Payments (2 of 3)

Concerns raised	Potential solutions under Vermont Global Payment Program
Under fixed-revenue model, hospital may stop offering high-cost services/patients. Under fixed-revenue model, hospitals do not have financial incentive to offer new services.	High intensity and high-cost services are excluded from the global payment if Vermont aligns with CMS methodology. Payments will be adjusted for changes in services offered (+/-) based on agreed upon methodologies and alignment with community need. Upfront prospective payment may provide additional investment to improve access for low-margin services. Monitoring metrics will include transfers, wait times and other metrics to monitor the performance and unintended consequences. Oversight could be added to monitor changes in services offered (reductions, closures, expansions, additions).

Mitigating concerns with Hospital Global Payments (3 of 3)

Concerns raised	Potential considerations (Global Payment would have limited influence on these factors)
Hospitals cannot control external factors	
• Volume incentives for non-employed clinicians remain	Add physician revenue to global payment in future years. Measure physician productivity in addition to RVUs.
• Post-acute care resources are limited	Provide additional transformation funding for partnerships.
• Primacy care/health care workforce is not sufficient	Measure/provide additional incentives to spend more on targeted areas (e.g. primary care, mental health and substance abuse).
• Social and economic factors impact health more than health care	Provide additional funding based on social and economic conditions of hospital's patients. *(draft methods include additional funding for hospitals)*

Framework for Evaluation and Measurement

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Federal-State Accountability Targets

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

Hospital-Level Payment Model Measures

- Quality performance adjustment based on CMS national quality programs or similar categories of quality measures
- Health equity improvement bonus for performance on selected health equity-focused measures
- TCOC performance adjustment for a defined population

Primary Care Measures

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

Broader Monitoring and Evaluation

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

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

AHEAD: Implementation of Key Components

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

Next Steps

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- ❑ Any other Board feedback on what you heard today & any thoughts on our previous topics by 5/7.
- ❑ Full draft of Vermont Medicare Hospital Global Payment Methods Paper expected 5/20.
- ❑ Outline of future Analytic Work to support AHEAD/Vermont Medicare Hospital Global Payment negotiations and evaluation – potential deliverables, timeline, & feasibility (under development)

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BOARD QUESTIONS & PUBLIC COMMENT?

What is the Board voting on by when?

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***.

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.*