VERMONT
GREEN MOUNTAIN CARE BOARD

Vermont Hospital Global Budget Methodology

April 1, 2024

Agenda

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1. AHEAD Model Timelines
   - Key Components
   - Vermont-Specific Medicare Global Budget Specification
2. Review of Executive Session
3. Board Questions
4. Public Comment
5. *Executive Session*

Overall Timeline: Key Components

	Deadline Type	Board Vote Required	Due Date
Vermont-specific Medicare Global Budget Specification	CMMI	Yes	July 1, 2024
Continue Development of Commercial GB methodology	GMCB/ AHS	Yes	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) • *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)*	CMMI	Yes	June 30, 2025
Implementation of Medicare Primary Care Payments & Medicare Hospital Global Budgets (Medicare: 10% of NPR in Y1; 30% in Y3)	CMMI	N/A (Incl. in 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 Budget Methodology (At least one commercial Payer program)	CMMI	Yes	January 1, 2027 (or sooner)

Board Decision Timeline: Vermont-Specific Medicare Global Budget Specification

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Board Meeting Topics	Target Date
Overview of Draft GB Methodology v.1	January 17th
Negotiation Strategy on Key Decisions: **(1) Medicare TCOC** **(2) VT Medicare GB Specification: Base & Base Adj.**	**April 1st**
Review Board Questions from April 1st meeting (Exec. Session) & Negotiation Strategy on Key Decisions: (3) VT Medicare GB Specification: Performance Adjustments	April 17th
Board Discussion of Key Decisions	May 1st
Review Draft GB Methodology v.2 & Board Discussion of Key Decisions	May 15th
Board Discussion & Vote on Board Position on Key Decisions	June 1st

Medicare NOFO: TCOC Expenditure Target

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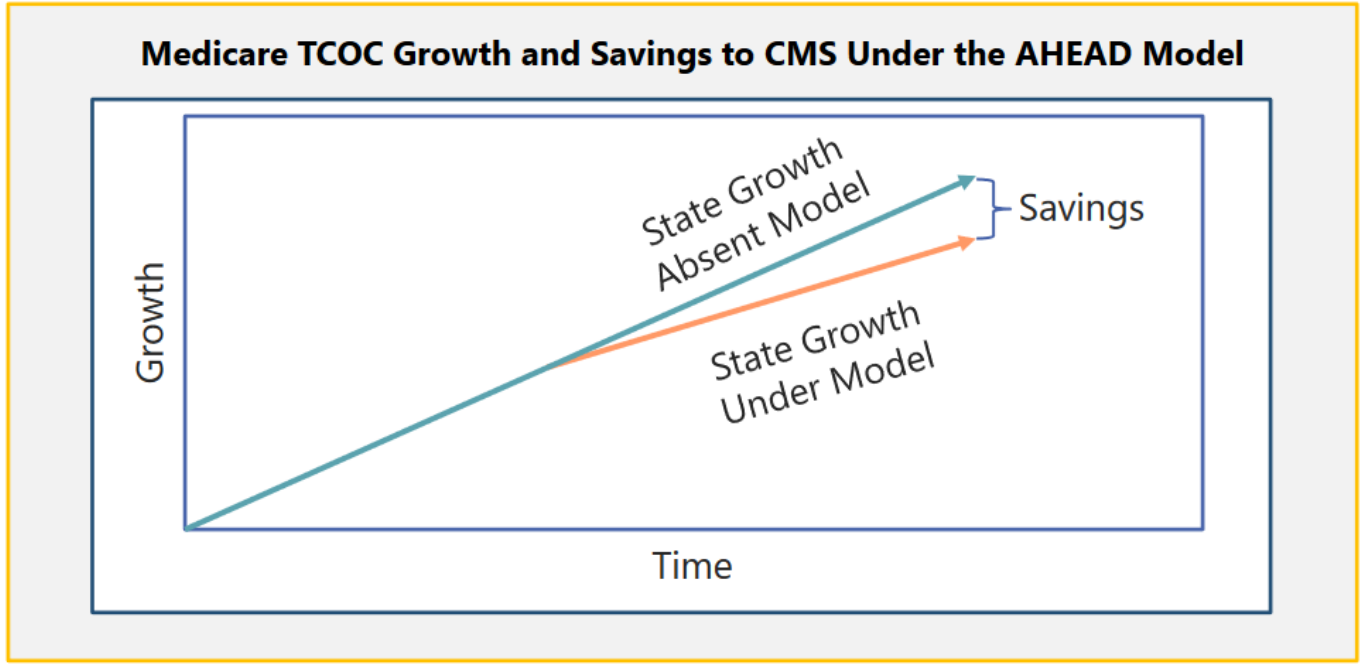
Medicare FFS TCOC Targets

The AHEAD Model was developed in alignment with affordability and cost growth containment efforts underway in states across the nation. Participating states or sub-state regions will be held accountable for a Medicare FFS cost growth target representing expenditures for Medicare Part A and B residents in the participating state or sub-state region during the Model's Performance Period.



Source: States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Overview Webinar (cms.gov)

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.*

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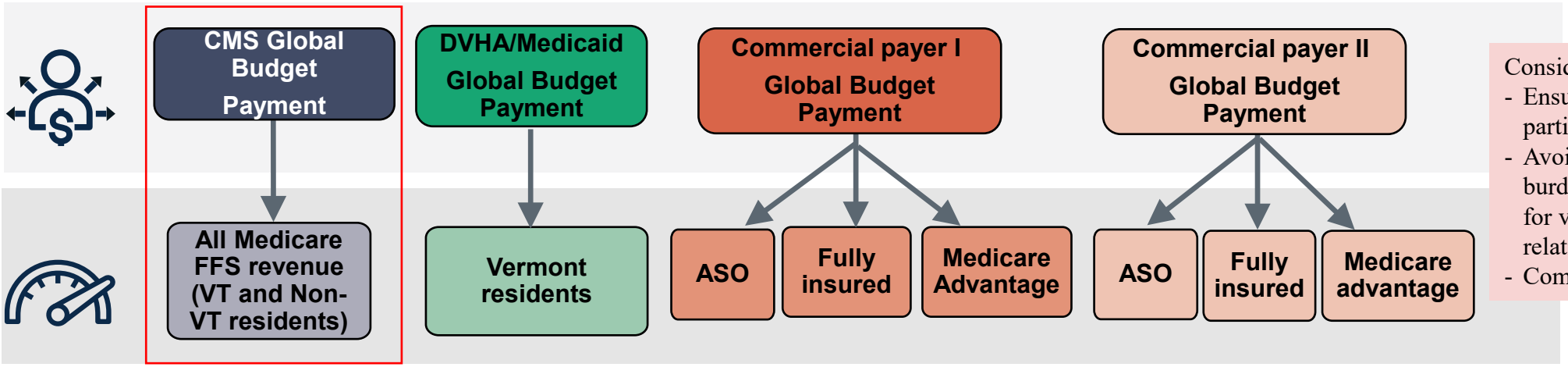
APPENDIX – MEDICARE GLOBAL BUDGET REVIEW

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**

Priority for discussion is here to prepare for AHEAD.



Considerations:
- Ensuring sufficient scale for each participating facility
- Avoiding unnecessary admin burden (e.g., complex contracting for very small payer-hospital relationships)
- Commercial market dynamics

Source: January 17th GMCB Board Meeting Presentation

Source: January 17th GMCB Board Meeting Presentation

Scope of Hospital Global Budget Payment

Included Services

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

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%

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)

Source: Global Budget TAG Meeting #15

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**: An annual additional funding up to 2% of HGB for hospitals serving high-adversity populations. The additional funding will remain in the budget until the end of the program. High-adversity scores are based on Area Deprivation Index (ADI), and dual eligibility and Part-D Low-Income Subsidy Status. Scores will be calculated using national and state distributions on an annual basis.
- **Potential additional adjustments for Vermont**
  - Access related
  - Sustainability

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

Baseline Incentives	VT vs. CMS method comparison	Purpose
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).
Social risk adjustment	Similar	Provide additional funding to address health equity.
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.**

Source: Global Budget TAG Meeting #15

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)

Source: Global Budget TAG Meeting #15

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

Source: Global Budget TAG Meeting #15