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Vermont Hospital Global Budget Design

An Ongoing Discussion…

May 1st, 2024

Agenda

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1. Picking up Where we left off…(Continue) Digging into AHEAD & Hospital Global Payment Design
    1. Describe Vermont-specific Medicare Hospital Global Payment Annual Updates & Performance Adjustments
    2. Solicit Board Feedback on Design to Date
2. Public Comment
3. *Executive Session (if necessary)*

Board Negotiation Goals: 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: (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 17th/29th meeting & Negotiation Strategy: (4) VT Medicare GB Specification: Annual/Performance Adj.	**May 1st**
Review Board Questions from April 17th meeting & Negotiation Strategy: (5) CAH-specific considerations & Delivery System Reform/Hospital Transformation Funding	May 6st
Staff – Board Member Meetings to solicit feedback	Week of April 29th
Review Board Questions & Negotiation Strategy: Hold for outstanding items	May 6th
Staff – Board Member Meetings to solicit feedback	Week of May 6th
Review Draft GB Methodology v.2 & Board Discussion of Key Decisions	May 15th
Board Discussion & Vote on Board Position on Key Decisions	June 1st

AHEAD Timeline: Key Components

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	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?

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

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

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

REMINDER: What is GMCB's role in AHEAD Model & Payment Reform?

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Per Act 167 Section 1 of 2022 GMCB shall…

- …**develop all-payer value-based payments,** including **hospital global payments** (in collaboration with AHS)
- …determine **how** best to **incorporate** value-based payments, including global payments **into the Board's regulatory processes**
- …identify potential opportunities to use **regulatory processes** to improve hospitals' **financial health**
- … **recommend a methodology** for determining the **allowable rate of growth** in Vermont hospital budgets
- …**consider the appropriate role of global budgets for Vermont hospitals**

Relevant authorities

- Hospital Budget Regulation (18 V.S.A. § 9456(d)(1))
- Regulation of Provider Payment (18 V.S.A. § 9376(b)(1)) - *not currently implemented*
- Oversight of Payment Reform (18 V.S.A. 9375(b)(1))

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DIGGING INTO AHEAD & MEDICARE HOSPITAL GLOBAL PAYMENT DESIGN

Input

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- Technical advisory group (TAG)
- Hospital meetings
- VAHHS meetings
- Payer meetings
- Office of the Health Care Advocate

Hospital Global Payment Business Model

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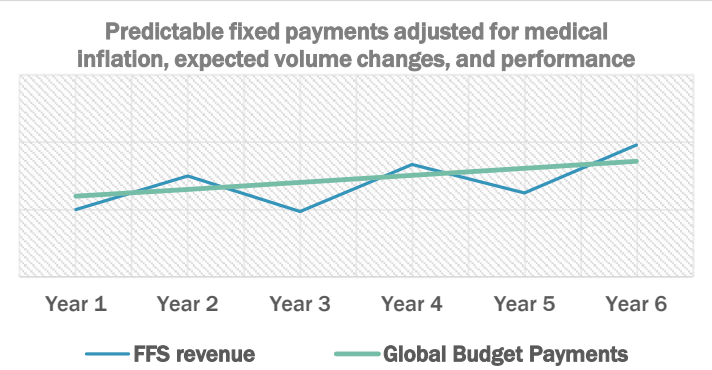

Fee-for-Service Payment

Units/Cases × **Price Per Unit or Case**

Incentives

- Higher commercial payment rates
- Increase utilization across profitable services/patients
- Focus on growing high-margin services

Global Payment

Revenue Base + **Updates**

Incentives

- Reduce hospital utilization
- Increase market share
- Perform better on quality and effectiveness
- Provide additional services without claim-payments (e.g. pop health)
- Reduce operational cost

Global budget payment determinations

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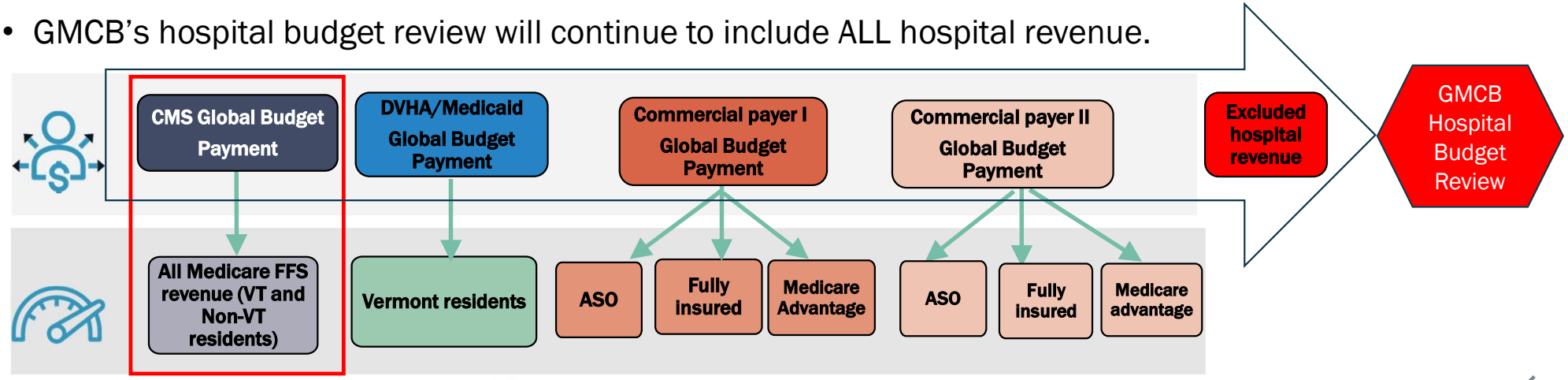
- Global budgets will be calculated for each payer with market-level adjustments.
- Phase I focused on Medicare FFS budget (i.e. Traditional Medicare insurance)
- Methodologies will be aligned as much as possible across different payers while recognizing different goals.
  - e.g. Medicare methods may focus more on avoidable utilization while commercial methods may need to focus on reducing high-commercial rates.
- GMCB's hospital budget review will continue to include ALL hospital revenue.



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Potential NPR included in Global Budget Payment

	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%

Budget review (HBR)

Global Payment VT GBP

*Physician revenue of hospitals will be in the phase II of methods development.
**Other payer exclusions: revenue from workers compensation, uninsured and self-pay, Non-VT Medicaid, and uncategorized amounts in Adaptive financial reports.
*** Medicare FFS revenue potential to include in global payment is lower in the claim-based analysis.

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

Why Global Payment?

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Hospitals

- Mission alignment and leadership
- Predictable revenue
- Funding of fixed-costs
- Operational flexibilities, potential waivers from regulatory requirements
- Transformation incentives ($ and technical assistance)
- Upfront funding for service line changes

States/Payers

- Control the growth of hospital cost (40% of total health care $)
- Transforming health care delivery leveraging largest sector in health care
- Stabilize safety-net hospitals including rural providers with declining volumes
- Predictable spending
- Operational flexibilities- Denials, pre-authorization, etc.

Patients

- Coordinated care
- Primary care and prevention
- Focus on social drivers of health
- Better quality and access with strong safety net providers
- Benefit enhancements

Concerns with Global Payment

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- Hospital prices are too high, global budget does not address the price.
- Using historical revenue as a base locks-in inefficiencies
- Under fixed-revenue model, hospital may stop offering high-cost services or create barriers for high-cost patients.
- Expanding services would require policy decisions on determining financing mechanism
- Administrative burden would increase on providers

- Hospitals have limited impact on health care
  - Volume incentives for non-employed clinicians remain
  - Post-acute care resources are limited
  - Primacy care/health care workforce is not sufficient
  - Social and economic factors impact health more than health care

Delivery Transformation Goals

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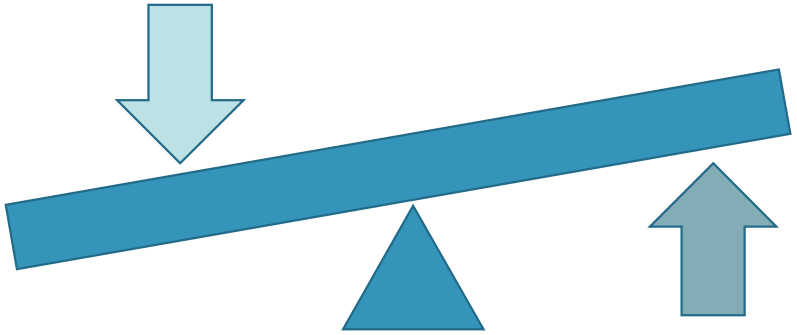
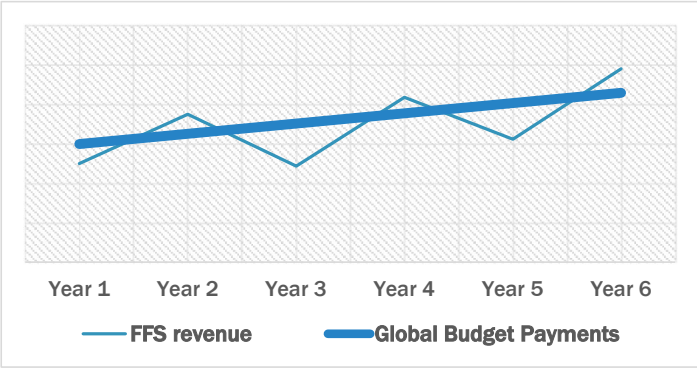
Invest in population health and partner with community providers to lower avoidable ED and inpatient admissions



Invest to improve access to essential services

$

Predictable and sustainable revenue while slowing long-term rate of growth in health spending, Funding for fixed cost of hospital care.



Transformation Support
- Operational flexibilities
- Data systems and infrastructure
- Performance measures

Considering an Effectiveness Adjustment: Vermont has better health status, lower utilization rates (except for ED, Hospital Outpatient & RHC)

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	Vermont	National	VT Difference
Average Age Medicare Beneficiary	72	72	0%
Percent White Beneficiary	94%	80%	17%
Percent of Beneficiaries with Dual Eligibility	21%	17%	23%
Average HCC score (health status)	**0.82**	**1**	**-18%**
Medicare Advantage Participation Rate	22%	48%	-54%
Utilization covered events per 1,000 benes			
Inpatient stays	177	220	-20%
ED visits	**585**	**559**	**5%**
E&M, Procedures, Clinic	22,198	24,749	-10%
Hospital Outpatient	**8,221**	**4,638**	**77%**
Ambulatory Surgical Center	39	181	-78%
E&M	9030	13704	-34%
Procedures	3306	5724	-42%
FQHC & Rural Health Clinic (RHC)	**1602**	**502**	**219%**
Skilled Nursing Facility	46	55	-16%
Home Health	263	277	-5%
Hospice	25	31	-19%
Tests	3116	8968	-65%
Imaging	2496	3752	-33%
DME	1206	1503	-20%
Ambulance events	299	325	-8%

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

Medicare Spending per Beneficiary by Service Type, 2021

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Standardized Medicare Payments for beneficiaries age 65+	VT	RI	NE	National	ME	MA
Total Payment	$ 8,006	$ 10,059	$ 10,381	$ 10,478	$ 9,063	$ 10,502
Inpatient	$ 2,019	$ 2,538	$ 2,370	$ 2,563	$ 2,056	$ 2,769
Inpatient payment per user	$ 16,989	$ 16,995	$ 17,341	$ 18,238	$ 16,721	$ 17,626
Outpatient	$ 2,227	$ 2,017	$ 2,498	$ 1,912	$ 2,518	$ 2,308
Outpatient payment per user	$ 2,627	$ 2,708	$ 3,557	$ 2,876	$ 3,058	$ 2,866
Ambulatory Surgery Center	$ 32	$ 116	$ 163	$ 149	$ 60	$ 77
Skilled Nursing Care	$ 804	$ 913	$ 1,110	$ 821	$ 691	$ 883
Rehabilitation hospitals	$ 68	$ 129	$ 139	$ 264	$ 176	$ 224
Long term care hospitals	$ -	$ -	$ 96	$ 81	$ -	$ 74
Home Health	$ 477	$ 626	$ 286	$ 518	$ 431	$ 639
Hospice	$ 362	$ 444	$ 325	$ 431	$ 523	$ 380
Office visits	$ 632	$ 1,092	$ 796	$ 1,088	$ 700	$ 1,156
Procedure	$ 374	$ 703	$ 639	$ 706	$ 443	$ 591
Tests	$ 115	$ 304	$ 206	$ 339	$ 172	$ 249
Imaging	$ 93	$ 230	$ 182	$ 237	$ 116	$ 201
Durable medical equipment	$ 132	$ 157	$ 233	$ 208	$ 164	$ 166
FQHC/Rural health clinic	$ 223	$ 22	$ 174	$ 61	$ 182	$ 24
Part-B Drugs	$ 212	$ 350	$ 816	$ 680	$ 514	$ 358

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

Calculating Global Budget Payments
Baseline Payments

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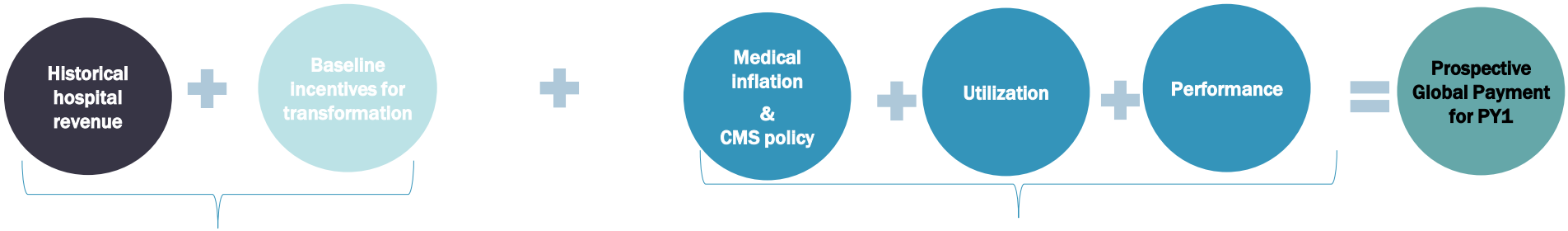
The goal of the Global Payment Model is to provide predictable, stable revenue to hospitals

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.



For year 1 payment = 2 or 3-year historical average + additional adjustments for historical changes and price levels

Global Budget Payment Updates

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SERVICE INCLUSIONS/ EXCLUSIONS (NEW CONTENT)

Hospital Global Budget Payment Exclusions

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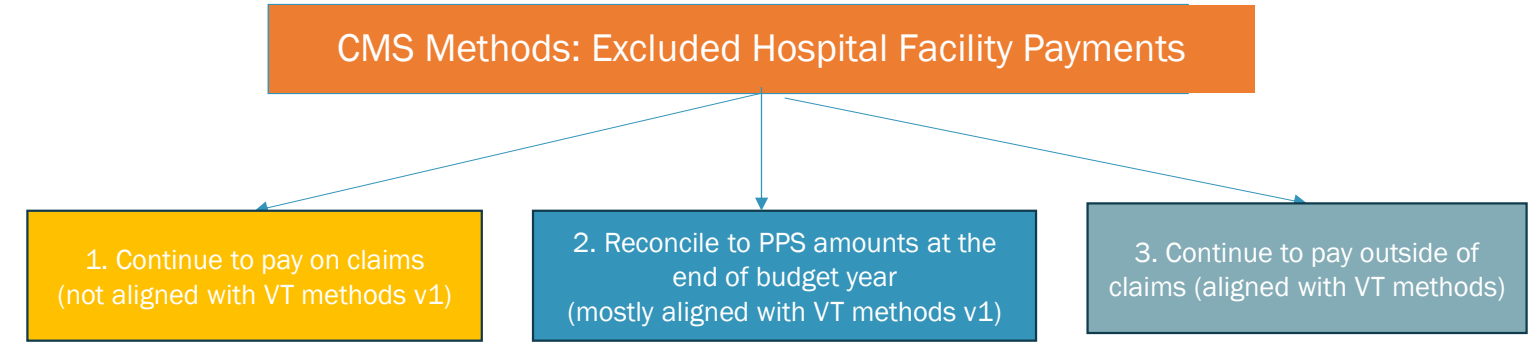
TAG input: include as much revenue as possible under global payment to maximize the incentives. Concerns are also raised that hospitals may stop providing high-cost services that there should be special adjustments or exclusions for tertiary care.



- Medicare secondary payer and patient portion (aligned with VT draft Medicare Methods)
- **Distinct part units (psych beds, rehab units etc.)***
- **CAH Method II billing for professional services***
- **New technology adjustment payments (NTAP)***
- **OP carve-outs: Outpatient claims with reasonable cost payments (drugs, biologicals, blood products, brachytherapy, etc.)***

- **Outlier payments***
- Low volume payments
- **BY 3 as floors***
  - Indirect medical education (IME)
  - Disproportionate share (DSH)
  - Uncompensated Care (UCC)
  - CAH total revenue

- Bad Debt
- Direct Graduate Medical Education
- Nurse and Allied Health Education
- Organ acquisition cost

***not aligned with VT methods**

Overall Summary – FY* 2023

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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

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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	339,679,706	7.0%	19,739,259	7%	60,179,455	8%	4,057,837	12%
Critical Access Hospital	125,378,321	-1.5%	-	na	-	na	4,004,242	-18%
Vermont Total	**465,058,028**	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.

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BASELINE ADJUSTMENTS (DISCUSSED PREVIOUSLY)

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Vermont Medicare Hospital Global Payment Components

Baseline Adjustment	Description (Draft methods)	Purpose
Historical baseline	Weighted average historical payment amounts to set the starting revenue.	Provide a reasonable starting point based on historical payments.
Transformation incentive	1% additional funding for joining the program in the first two years.	Participation incentive to join the program early.
Vermont delivery reform funding	Additional funding if available based on state's negotiation with CMS.	Targeted investment opportunity to support delivery transformation.

*Required in state designed methodology per NOFO

Baseline Historical Revenue

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CMS Method: Average three years of historical revenue with *Yr1=10%, Yr2=30%, Yr3=60% weights*

- *CMS will monitor CY2022 hospital data for impacts due to the COVID-19 public health emergency (PHE) and will revisit baseline hospital global budget calculations if necessary.*

Potential Vermont Proposal: Use the highest of weighted historical average or most recent year

- Rationale: If most recent year revenue is higher than the weighted average, incentive to join the program will diminish.

CY 2026 Start Date Example	FY2022	FY2023	FY2024
CMS Method	10%	30%	60%
VT Proposal	10%	30%	60%
	OR (whichever is higher)		
			100%

Baseline Incentives

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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.

Potential additional adjustments for Vermont delivery reform to support State goals and improve access.

Statewide Medicare FFS savings targets negotiated with CMS will impact additional funding potentially available for Vermont delivery system reform funding.

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	2021	VT difference	18 to 21 Growth rate
Actual payments			
National	$11,637.26	-16.1%	8.8%
Rural counties	$10,684.68	-8.6%	8.8%
Vermont	$9,760.91		7.6%
Adjusted for beneficiary health status and standard prices			
National list	$11,165.67	-10.5%	5.5%
Rural counties	$11,082.77	-9.8%	4.7%
Vermont*	$9,994.47		4.0%

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

*Vermont's difference from the national average equals to $132.8 mil.

Vermont has higher spending compared to nation for Medicaid, Private and overall.

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	Medicare Part A and/or Part B Program Payments Per Traditional Medicare Enrollee, 2021	Variance from National	All Full-Benefit Medicaid Enrollees, 2019	Variance from National	Per Enrollee Private Health Insurance Spending*, 2020	Variance from National	Total Health Care Spending, 2020	Variance from National
United States	$11,080		$7,106		$4,994		$10,191	
Vermont	$9,206	**-17%**	$9,712	**37%**	$5,561	**11%**	$12,756	**25%**
Maine	$9,159	-17%	$8,206	15%	$5,911	18%	$12,077	19%
New Hampshire	$9,369	-15%	$7,664	8%	$4,806	-4%	$11,793	16%

Source: https://www.kff.org/statedata/custom-state-report/?i=142248%7Cdb8fc213~251870%7Ced7659b0~251873%7Ced7659b0~32646%7C456145be~32625%7C1bdc7765~32626%7C1bdc7765&g=us~vt~nh~me&view=3

*includes spending for all privately funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.)

Vermont Health Care Spending by Service Line, 2019

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Health Care Expenditures per Capita, 2020	Vermont	United States	Vermont's difference from U.S.	Maine	Massachusetts	New Hampshire	Rhode Island
Health Spending per Capita	$12,756	$10,191	25%	$12,077	$13,319	$11,793	$11,694
Health Care Expenditures per Capita by Service, 2019							
Health Spending per Capita	$12,159	$9,672	26%	$11,489	$12,727	$11,310	$10,987
Hospital Care*	$5,378	$3,636	48%	$4,551	$4,772	$4,534	$4,013
Physician and Clinical Services	$2,214	$2,339	-5%	$2,306	$2,811	$2,469	$2,351
Other Professional Services	$442	$339	30%	$384	$376	$388	$379
Prescription Drugs and Other Medical Nondurables	$987	$1,277	-23%	$1,387	$1,413	$1,257	$1,697
Nursing Home Care	$668	$531	26%	$557	$731	$676	$923
Dental Services	$555	$436	27%	$458	$592	$652	$383
Home Health Care	$376	$344	9%	$317	$727	$361	$350
Medical Durables	$153	$174	-12%	$159	$211	$212	$153
Other Health, Residential, and Personal Care	$1,386	$596	133%	$1,370	$1,094	$761	$738

Source: https://www.kff.org/statedata/custom-state-report/?i=142248%7Cdb8fc213~251870%7Ced7659b0~251873%7Ced7659b0~32646%7C456145be~32625%7C1bdc7765~32626%7C1bdc7765&g=us~vt~nh~me~ma~ri&view=3

*Hospital Care (NAICS 622) reflects spending for all services that are provided to patients and that are billed by the hospital. Expenditures include revenues received to cover room and board, ancillary services such as operating room fees, services of hospital residents and interns, inpatient pharmacy, hospital-based nursing home care, care delivered by hospital-based home health agencies, and fees for any other services billed by the hospital.

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ANNUAL UPDATES (NEW MATERIAL)

Vermont Medicare Hospital Global Payment Components: Annual Updates

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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.

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Annual Updates: *Inflation & Medicare Policy*

Adjustment type	Vermont GPP	Compared to current payment methods (FFS, Cost-based CAH reimbursement)
Inflation and Policy	PPS Market Basket* (without productivity adjustment)	FFS includes productivity adjustment (0.3 to 0.7 percent reduction on market basket)
	Wage index, low volume, etc.	Similar
	IME, DSH, UCC**	Similar/More revenue
	Floors for CAHs	TBD (Under development)
Quality	All CMS quality programs	Similar
Other	Sequestration	Similar

*CMS Hospital Global Budget (HGB) Method includes productivity adjustment. Draft methods proposes to include an all-payer efficiency, effectiveness and productivity adjustment for VT model. See later slide.
**These are additional payments made by CMS for Indirect medical education (IME), Disproportionate share (DSH), Uncompensated Care (UCC)

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

Annual Updates: Inflation Adjustment

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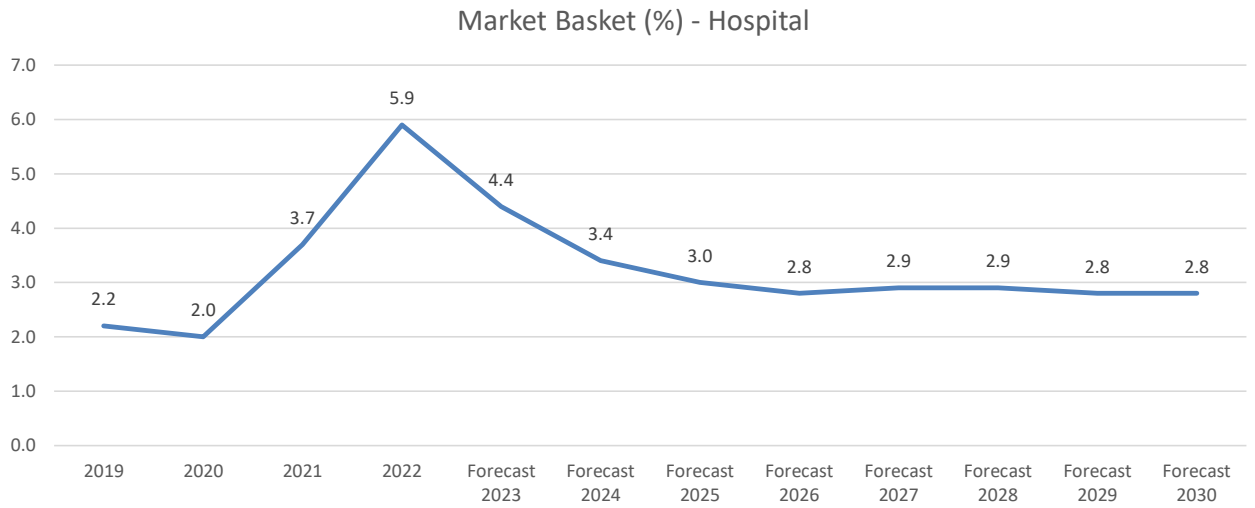
Purpose: Provide annual updates similar to Medicare's general trend and cover inflationary cost increases.



Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata. Latest update: reflects the 2023Q4 forecast with historical data through 2022Q4

Annual Updates: *Utilization*

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1. Beneficiary changes (Demographic adjustment)

Purpose: Adjust the payment for utilization changes which would go up and down based on how many people are enrolled in the insurance plan.

2. Service line changes

Purpose: *Prevent "stinting" of care, maintain funding for fixed cost, improve access to care.*

Adjustment types (CMS methodology)

1. Planned service line changes: Pre-approval process and reconciliation to FFS utilization for the first two-years of service line change.
2. Market shifts: Shifts to/from other hospitals/providers: Done at the end of the period looking for shifts between hospitals for specific service lines
3. Unplanned Volume Change Adjustment: If the variation in volume exceeds +/- 5%, additional adjustment made to the budget

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

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Annual Updates: Beneficiary Change Adjustment

Adjustment type	VT GPP Draft Methods	CMS HGB
Membership/ demographic changes	Medicare beneficiary change adjusted for age, gender, ESRD Accounts for migration of patients from hospital service areas to other hospitals.	Prospective: Population growth 65+ adjusted for age Correction: Medicare FFS beneficiary growth adjusted for HCC Limits the adjustment to overall statewide growth and distributes the trend to hospitals based on their share.

Due to decline in traditional Medicare enrollment, this adjustment is likely to be negative or small after age, gender and ESRD adjustment. However, early data trend below shows the decline in membership slowed down.

Calendar Year	Traditional Medicare Membership Count	Annual Rate of Growth	Medicare Advantage Membership Count	Annual Rate of Growth	Medicare Advantage Market Size
2018	121,314	2.1%	10,330	15.0%	8.5%
2019	122,585	1.0%	12,428	20.3%	10.1%
2020	123,532	0.8%	15,077	21.3%	12.2%
2021	117,691	-4.7%	17,483	16.0%	14.9%
2022	108,641	-7.7%	19,721	12.8%	18.2%
2023*	**106,615**	**-1.9%**	**22,462**	**13.9%**	**21.1%**

Source: GMCB APM Monitoring Reports.
*Based on Q1 estimates.

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Annual Updates: Service Line Change Adjustments

Utilization Adjustments	Purpose	Details of CMS Methods Adjustment
Market Shift Adjustment (MSA)	Maintain competition, while controlling the cost). Budget is adjusted only if there is a corresponding change at other hospitals.	Algorithm is used by MD and PA. Track changes in volume by service lines and make proportional allocations. Pay 50% of average "cost".
Service Line Adjustment (SLA)	Provide additional funding for new service lines/expansions. Reduce budget for closures while funding the fixed costs.	• New services: 2-year reconciliation to claim-based payment amounts. Mid-year reconciliations to account for data lags. • Contraction/elimination: PPS hospital retains up to 50% of historical payment, CAH may retain 100% of payment. • Must be pre-planned and approved by State and CMS. Must align with State Health Equity plan.
Unplanned Volume Change Adjustment (UVA)	Overall control lever for adjusting budget for any change greater than +/-5% if it is not a market shift or planned.	• Additional adjustment for volume changes +/- 5 percent volume change after all other adjustments. • Declines: remove full amount for PPS, retain 50% for CAHs. • Increases: receive 50% of the revenue provided hospital if achieved total cost benchmark.

Annual Updates: Service Line Change

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Service line adjustment	Market shifts/transfers	Unplanned volume change

• **Hospital-initiated prospective adjustment for pre-defined list of service lines that meet a $ or % threshold**
• Addition/expansion: forecasted then actual growth
• Contraction/elimination:
  • PPS: 50% reduction
  • CAH/MDH: 0% reduction
	• **Due to small cell sizes and limited shifts, VT will conduct market shift review every 3-5 years to assess whether rebasing is needed**
	• VT will review transfer rates or volumes from participating and non-participating hospitals and adjust the global payments if there is a disproportionate increase in transfers
		• **Service line additions, expansions, eliminations, or contractions greater than 5% volume change that are not disclosed and pre-approved or accounted for in the transfer or demographic adjustments**
		• Volume increase >5%: 50% above threshold added to global payments
		• Volume decrease >5%:
		  • PPS: additional revenue removed from HGB
		  • CAH/MDH: 50% of the revenue beyond the 5 percent threshold would be removed

Note: MedPAC used a conservative approach to estimate hospitals' fixed costs and found that about 20 percent of hospital costs are fixed (excluding managerial or clinical labor costs). Among smaller hospitals, about 50 percent of costs are fixed over a one-year period due to low occupancy rates and difficulty reducing staff and equipment costs when volume decrease.

https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-3-online-only-appendixes-hospital-inpatient-and-outpatient-services-march-2015-report-.pdf

VT Global Budget Payment Potential Alignment with CMS Methods

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Service line adjustment considerations:

- Set thresholds for prospective service line adjustments (e.g., $100K or 0.5% of Total GB)
- Consider different variable cost factors based on hospital type. (CMS uses 50%)
- Use changes in transfers instead of CMS algorithm-based market shift adjustments
- If volume change is +- 5 % review service lines and make additional adjustments.
- Review major market shifts by service lines every 2-3 years and make adjustments accordingly.

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

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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.

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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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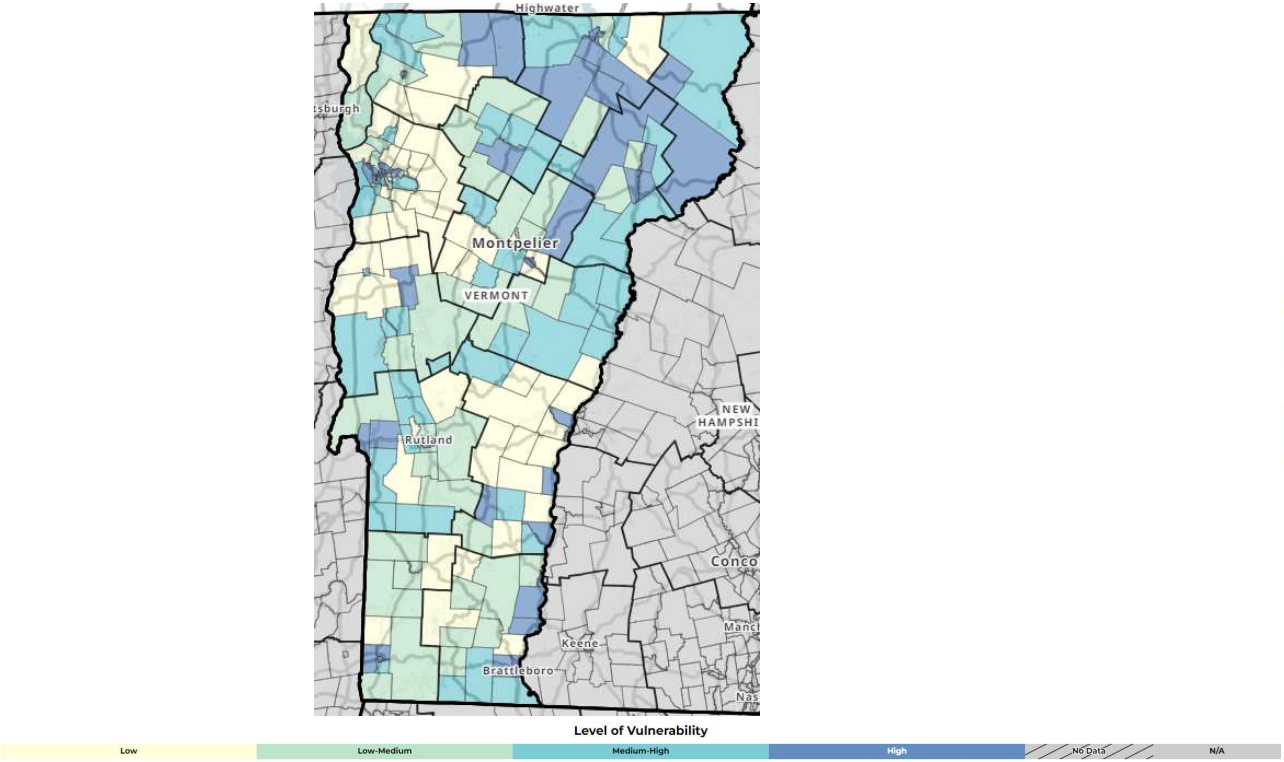
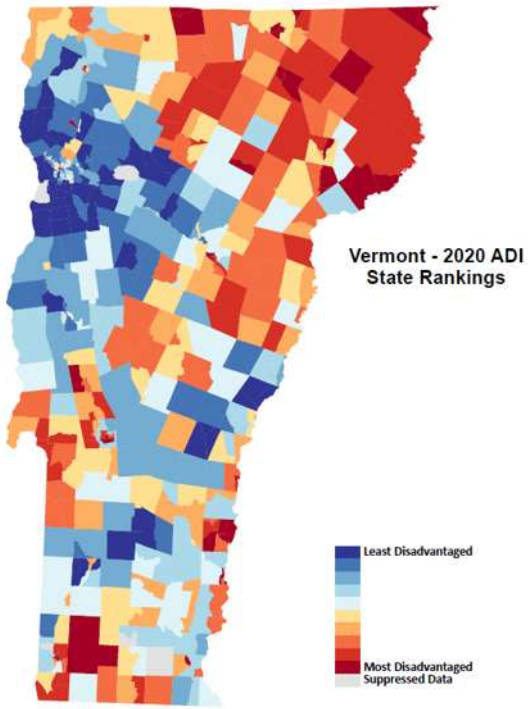
SVI by Census Tract, 2020



ADI by Census block group, 2020



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PERFORMANCE ADJUSTMENTS (NEW MATERIAL)

Vermont Medicare Hospital Global Payment Components: Performance Adjustments

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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.

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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.

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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.

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Performance Adjustments: Total Cost of Care (TCOC)

	VT GPP prior discussions / considerations	CMS HGB
Attribution	Hospital service area (HSA), except small hospitals use sub-level HSA assignment (methods for sub-level to come next year) Considerations: Market share of hospitals is small in some HSAs (See next slide)	Hospital lists a zip code as Primary Service Area Any unclaimed zip code is attributed based on hospital's share and/or 30-minute travel time.
Benchmark	**Two options for benchmark:** **Option 1: tie to VT negotiated Medicare TCOC savings target** Considerations: in this option, working towards a common statewide accountability target; benchmark is reflective of VT **Option 2: Align with AHEAD** Considerations: VT counties may not be as comparable to national counties; if CMS selects benchmark counties, it may be difficult to foresee the implications.	Matching algorithm to select comparable national counties.
Excluded payments	The baseline incentives and Vermont passthrough payments that are excluded from the all-payer total cost of care statewide expenditure performance calculations for savings requirements will also be excluded from the hospital TCOC adjustment. **Additional exclusions:** Social Risk Adjustment (SRA), Transformation Incentive Adjustment (TIA), Enhanced Primary Care Payments (EPCP)	Per NOFO, "CMS will exclude the enhanced primary care Enhanced Primary Care Payments (EPCP) from the Medicare FFS and all-payer TCOC expenditure performance calculations; the EPCP will be part of the all-payer TCOC expenditure performance calculations beginning in PY4… will also exclude the Transformation Incentive Adjustment in the hospital global budget from the Medicare FFS and all-payer TCOC expenditure performance calculation" (pg. 119)
Performance	Part A and Part B spending only. Consider use of corridors: For example, if the benchmark is 5%, an adjustment would only occur If TCOC growth was +/- 1% + 5%.	Part A and B spending, risk adjusted by HCC. Determine a growth target based on comparison benchmarks.
Financial Impact	Align?	Maximum +/- 2 percent.
Timing of Implementation	First performance year is PY2 (CY 2027). Align ?	**PPS:** PY4 adjustment based on PY2 performance (upwards only) PY5 adjustment based on PY3 performance (upwards and downwards) and so on for all other PYs **CAH and SNH:** PY4 adjustment based on PY2 performance (upwards only) PY5 adjustment based on PY3 performance (upwards only) Upwards and downwards for all other PYs (beginning in PY6 based on PY4 performance)

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

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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
NH Upper Valley Region	Central Vermont Medical Center	23%	17%	$ 634,384
NY Capital District	Rutland Regional Medical Center	16%	12%	$ 649,821
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

**Grace Cottage Hospital does not have significant market share in any of HSAs.*

Data Source: VHCURES, FY 2022. No exclusions are applied. Total Medicare Payments for VT hospitals include other providers associated with hospital.

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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 -.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

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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

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- 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 Medicare FFS Payments (w/o AIPBP)	Estimated total Medicare FFS Payment for VT residents (w/ AIPBP)	Estimated total Medicare FFS Payment (w/ AIPBP)
PAU Total Payments to VT Hospitals	$36 mil.	$52 mil.	$60 mil.
Readmission to the same hospital	$15 mil.	$21 mil.	$24 mil.
Prevention quality indicators (PQI)	$17.5 mil.	$25 mil.	$29 mil.
Avoidable ED	$3 mil.	$11 mil.	$12 mil.
Selected over-use measures*	$1.5 mil.		

	Proportion of Hospital Payments for PAU	Proportion of Hospital Payments for PAU (w/ AIPBP)
VT Hospital Median Rate	11%	14%
National Hospital Average	12%	11%
Lowest VT Hospital Rate	8%	8%
Highest VT Hospital Rate	24%	19%

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

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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	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)

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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. 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)

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Concerns raised	Potential solutions under Vermont Global Payment Program
Under fixed-revenue model, hospital may stop offering high-cost services. FFS incentivizes closures of services if they are not profitable and open new services if they provide high-margins. Under fixed-revenue model, hospitals are incentivized to close high-cost services. Expanding services would require policy decisions on determining financing mechanism.	High intensity and high-cost services are excluded from the global payment program. Payments will be adjusted for changes in services offered (+/-) based on agreed upon methodologies. 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)

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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

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

Next Steps

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- ❑ Any other Board feedback on what you heard today & any thoughts on our 5/1 topics (CAH-specific adjustments + Delivery System Reform/Hospital Transformation Funding) by 5/3.
- ❑ Full draft of Vermont Medicare Hospital Global Payment Methods Paper expected 5/15.
- ❑ 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?

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

You'll have another bite at the apple when…

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

VERMONT
GREEN MOUNTAIN CARE BOARD

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.*