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Vermont Hospital Global Budget Design

An Ongoing Discussion…

April 17th, 2024

Agenda

1. Background for Today's Discussion
2. Board Questions to Date: AHEAD/Hospital Global Payments
3. Health Care Reform Big Picture
4. Digging into AHEAD & Hospital Global Payment Design
5. Public Comment
6. *Executive Session (if necessary)*

What is Medicare's AHEAD model?

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AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

Components

Strategies

In lieu of "Behavioral Health", VT uses the term "Mental Health and Substance Use Disorder Treatment"

Source: CMS Presentation from September 18 AHEAD Model Overview Webinar

Controlling Health Care Cost Growth: Hospital Global Budgets vs. Payments

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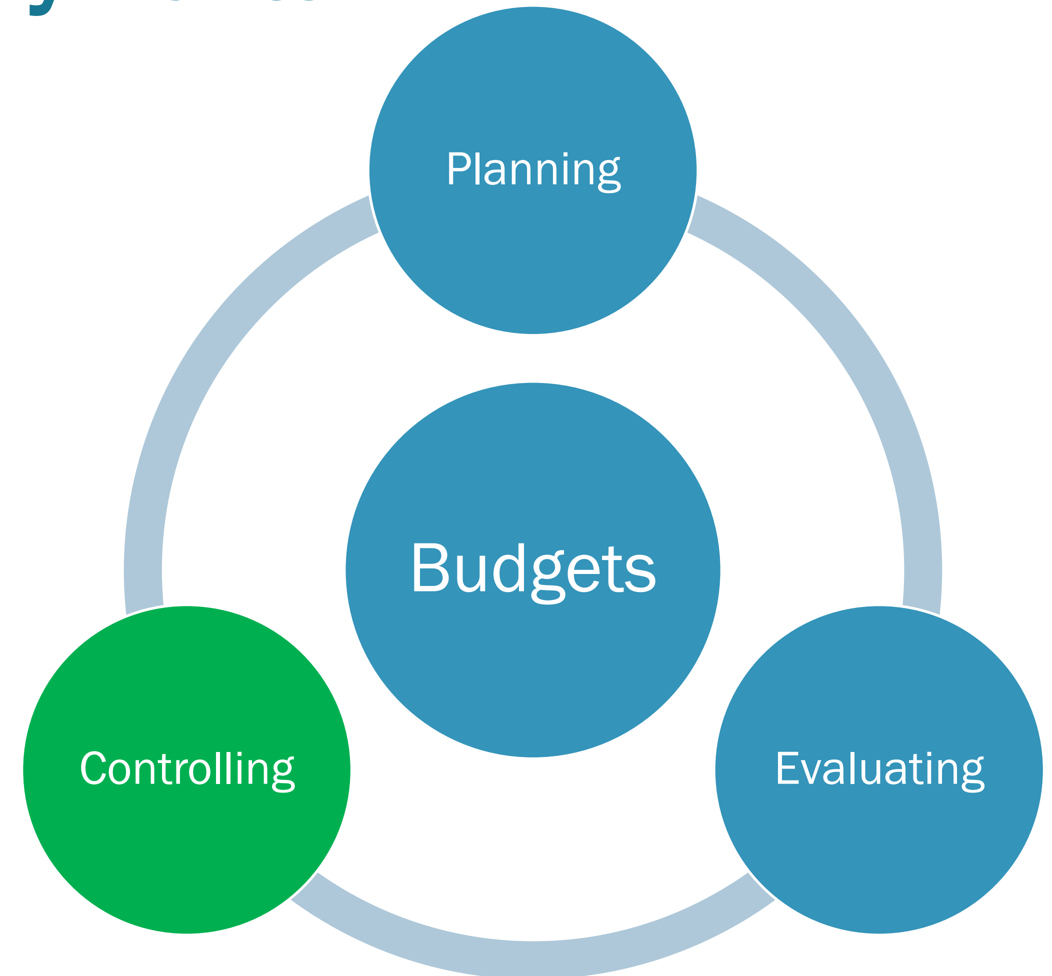
Controlling Hospital Spending (in aggregate) can happen two key ways:

1. Setting a growth target or adjusting a future year's **budget**
2. Controlling **payment** directly

Hospital Global Budgets are already implemented in VT by establishing a **cap** on Net Patient Revenue (NPR) growth through GMCB's hospital budget review.

Hospital Global Payments can be designed a variety of ways. Under the AHEAD model they are insurer-specific payments to a particular hospital, in advance, for a set of services.



(Some) Board Questions to Date: AHEAD & Hospital Global Payments

- Will AHEAD/HGP reduce Vermont's reliance on Commercial insurance to sustain the hospital financial health?
- What are the mitigation strategies for the incentive under a fixed budget to ration care and avoid delivery of high-cost services, particularly in a state where we already have access challenges and low utilization?
- What are the implications of AHEAD/HGP on wait-times for hospital care?
- How does this model incentivize hospital system transformation? What kind of transformation?
- What are the implications of this model for Primary care & Mental Health access?
- What are the implications of this model for the challenges associated with hospital borders & other capacity pressures due to challenges outside the hospital?
- How do the risks and opportunities of AHEAD/HGP differ on a voluntary or mandatory basis? How are we defining mandatory or voluntary participation? What does all-payer participation mean (Vermont Act 167 vs. CMMI)?
- What is our "Best Alternative To a Negotiated Agreement" (BATNA)? And how does AHEAD/HGB compare?
- What are the lessons learned from our current reform models? Do we have a Vermont-centered evaluation?
- What does this model mean for the financial strain/fragility of our hospital system, given that 8/14 hospitals have negative margins?
- Some are concerned that implementing hospital global payments before transformation means locking in current inefficiencies. What are the mechanisms for identifying and removing inefficiencies under the AHEAD model?
- What will Medicaid and Commercial Hospital Global Payments look like and how will they all work together?

More Board Questions included in the Appendix.

Considerations when evaluating Vermont's participation in AHEAD

Considerations*	AHEAD/Hospital GB (Better, Neutral, Worse, N/A)	Mitigation Strategy?
Cost Containment & Health Care Affordability	?	?
Hospital Sustainability	?	?
Hospital System Transformation	?	?
Access	?	?
Quality	?	?
Health Equity	?	?
Health System Preparedness	?	?
Administrative Burden	?	?
Healthcare Workforce	?	?
and more… *more detail in appendix		

Question for Board Members

What is missing from these lists of questions & considerations?

Which questions/considerations do you think are most important for improving Vermonters' access to high quality affordable care?

What work needs to be done before you would be confident in implementing AHEAD/Hospital Global Payments?

Goals of Health Care Reform

Health Care Reform seeks to address challenges in our health care system. Goals include:

- Reducing cost growth to ensure that health insurance and health care are affordable
- Improving access to care by making sure that Vermonters can get care when and where it is needed
- Improving quality and experience of care for Vermonters
- Improving the health of the entire population
- Ensuring health equity so that all Vermonters are healthy and well
- Supporting providers in caring for Vermonters

Payment reform is one component of health care reform. Goal is for payment changes to support changes in how care is delivered, leading to **better health outcomes and population health.**

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Recent History of Vermont Health Care Reform

- **2005:** VT first approved for federal 1115 Global Commitment Waiver for Medicaid, providing flexibility to expand insurance coverage, implement innovative care models, accelerate payment models, and strengthen care coordination and population health management to encompass the full spectrum of health-related services and supports
- **2007:** VT expanded insurance coverage through Catamount Health, affordable individual health insurance for qualified Vermonters without access to employer insurance
- **2008:** Medicaid pilots VT Blueprint for Health care delivery reform model establishing integrated health and human services and advanced primary care; commercial insurers joined in 2010; Medicare in 2011
- **2013:** Vermont Health Connect launched in response to the federal Affordable Care Act to provide eligible Vermonters with health insurance and premium assistance
- **2016:** Current Vermont All-Payer Model Agreement signed between state leaders and the federal Centers for Medicare & Medicaid Services

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Multiple Strategies for Health Care Reform

- No single initiative can address all goals; multiple strategies needed to change how care is delivered for Vermonters across entire health system.
- Requires stable system with new ways to fund care, including preventive care and community-based services; transparent data collection and reporting; policies to support changes.
- State of Vermont, with federal and community partners, has been working intentionally on multiple fronts for many years to address underlying challenges.

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Examples of Investments in Continuum of Care

Medicare models don't always include specific broader system investments but do often:

- Encourage cross-organization partnerships
- Highlight potential for eventual redirection of funding
- Offer waivers of certain Medicare regulations that could support care delivery transformation

Vermont Medicaid focus on broader system:

- Over $164 million in base rate increases across health system over last two fiscal years
- Financial relief
- Additional targeted investments in critical areas from 2022-2025
- Workforce initiatives
- Grants for providers of home and community-based services

Rate Increases, Financial Relief

- Over $164 million in base rate increases in state fiscal years 2023 and 2024:
  - Mental health and substance use disorder treatment providers
  - Primary care providers
  - Federally qualified health centers and rural health clinics
  - Hospitals
  - Dentists
  - Home health agencies
  - Adult day providers
  - Other home and community-based service providers

- Financial relief on case-by-case basis

Targeted Investments

- Augmenting mental health crisis system of care (e.g., adding 988 suicide prevention lifeline, mobile crisis services, alternatives to ED)
- Expanding youth mental health hospital beds (expected 2025) and residential treatment capacity (proposed)
- Supporting certified community-based clinics through Vermont's designated mental health agencies to provide comprehensive and coordinated treatment for people with mental health and substance use disorder conditions
- Providing Medicaid funding through Blueprint to pilot embedding mental health services and screening for health-related social needs (e.g., housing, food security, transportation) in primary care
- Seeking specialized skilled nursing beds for people with complex needs (expected late 2024)
- Provider tax relief for home health agencies

Workforce Initiatives; HCBS Provider Grants

- **Health care workforce initiatives include:**
  - Partnering with health employers on retention and recruitment
  - New programs to grow the state’s nursing workforce
  - Creating health care workforce data center to better understand and find solutions to Vermont’s health workforce challenges
- **Initiatives related to Home and Community-based Services (HCBS) include:**
  - More than $17 million in grants supporting home and community-based services made to providers and local organizations to:
    - Address critical investments in infrastructure
    - Enhance workforce capabilities
    - Drive care model innovation
    - Strengthen provider processes

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AHEAD Model in Context of Broader Health Care Reform

- AHEAD would be **one component of** Vermont's health care reform portfolio; as part of a multi-faceted approach, could offer opportunity to address some challenges.
- AHEAD (like Vermont's current All-Payer Model) allows **Medicare** to join Medicaid and commercial insurers in **paying for health care differently** than fee-for-service.
- Emphasis on **hospital and primary care** payments and **care transformation**.
- **Health equity** central to the model.
- **Continues Medicare support** for Vermont's Blueprint for Health and Support and Services at Home (SASH).
- Offers waivers of Medicare regulations that provide **flexibility** in how services are delivered to Medicare beneficiaries.
- States accountable for meeting targets related to **total cost of care, primary care investment, and equity and population health outcomes.**

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Medicare Options if Vermont Does Not Participate in AHEAD

- Fee-for-Service; providers subject to Medicare's Merit-based Incentive Payment System (MIPS) quality payment program
- Existing National Models:
  - ACO REACH (with out-of-state ACO)
  - Medicare Shared Savings Program (ACO model)
- Potential impacts

AHEAD Timeline: Key Components

	Deadline Type	Board Vote Required	Due Date
Vermont-specific Medicare Global Payment Specification	**CMMI**	**Yes**	**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)

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 Questions from April 1st meeting & Negotiation Strategy: (3) Step Back Big Picture – AHEAD & Hospital GB	**April 17th**
Review Board Questions from April 17th meeting & Negotiation Strategy: (4) VT Medicare GB Specification: Annual/Performance Adj.	April 29th
Review Board Questions from April 17th meeting & Negotiation Strategy: (5) CAH-specific considerations & Utilization	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

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

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))

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***.

You'll have another bite at the apple when…

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

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DIGGING INTO AHEAD & MEDICARE HOSPITAL GLOBAL PAYMENT DESIGN

Hospital Global Payment Business Model

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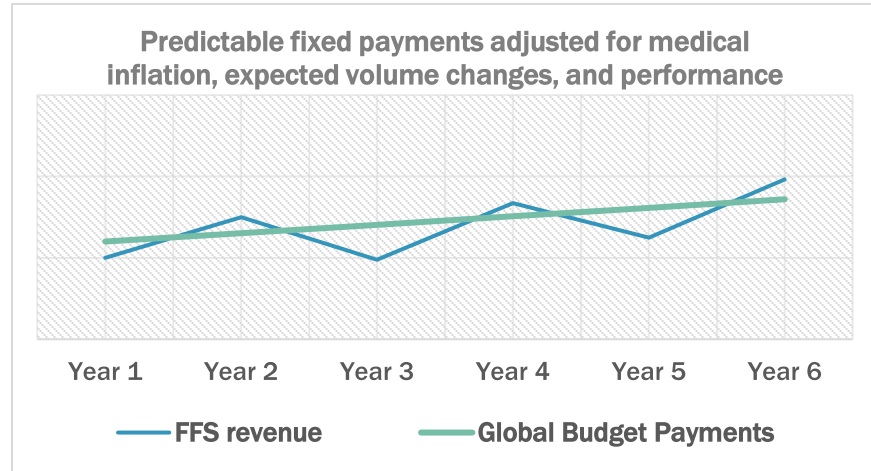
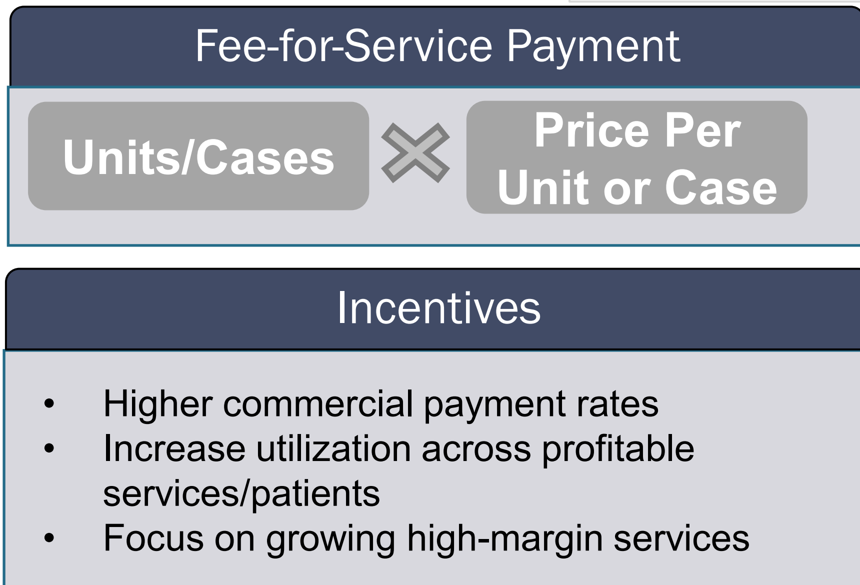
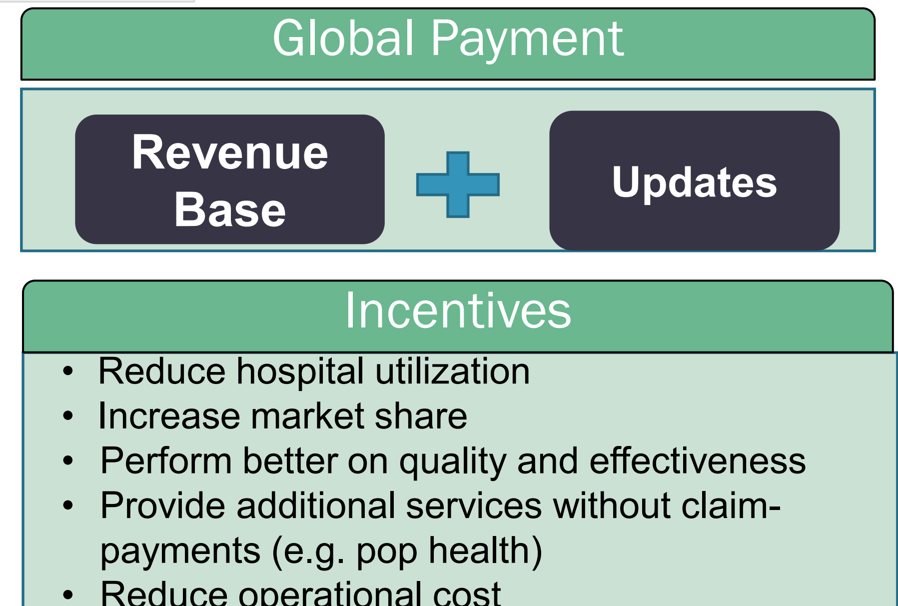




- Higher commercial payment rates
- Increase utilization across profitable services/patients
- Focus on growing high-margin services



- 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
- Methodologies will be aligned as much as possible across different payers
- GMCB's hospital budget review will continue to include ALL hospital revenue

CMS Global Budget Payment
DVHA/Medicaid Global Budget Payment
Commercial payer I Global Budget Payment
Commercial payer II Global Budget Payment
Excluded hospital revenue
GMCB Hospital Budget Review

All Medicare FFS revenue (VT and Non-VT residents)
Vermont residents
ASO
Fully insured
Medicare Advantage
ASO
Fully insured
Medicare advantage

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

Global Payment

*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
- 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

Mathematica
Progress Together

Concerns with Hospital Global Payments

Global payment is a method to change the way hospitals receive their revenue. It removed 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 needs to be couple with delivery reform strategies with infrastructure support, technical assistance and additional policy levers to achieve the goals.

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 control 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 and performance. New measures would be needed to define efficiency if hospital is incentivized to improve population health, improve access and reduce avoidable utilization

Concerns with Hospital Global Payments

Concerns raised	Potential solutions under Vermont Global Payment Program
Under fixed-revenue model, hospital may stop offering high-cost services.	Payments will be adjusted for changes in services offered (+/-) based on agreed upon methodologies.
FFS incentivizes closures of services if they are not profitable and open new services if they provider high-margins. Expanding services require additional revenue source to cover the initial costs and increased utilization in the short-run to become profitable.	Payments will be adjusted prospectively for new service lines that are aligned with the community needs. Monitoring metrics will include transfers, wait times and other metrics to monitor the performance and unintended consequences.
Under fixed-revenue model, hospitals are incentivized to close high-cost services. Expanding services would require policy decisions on determining financing mechamism.	Oversight could be added to monitor changes in services offered (reductions, closures, expansions, additions).

Concerns with Hospital Global Payments

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

Statewide Medicare FFS savings targets negotiated with CMS will impact additional funding benchmarks for the Vermont Medicare Global Payment Program.

	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%

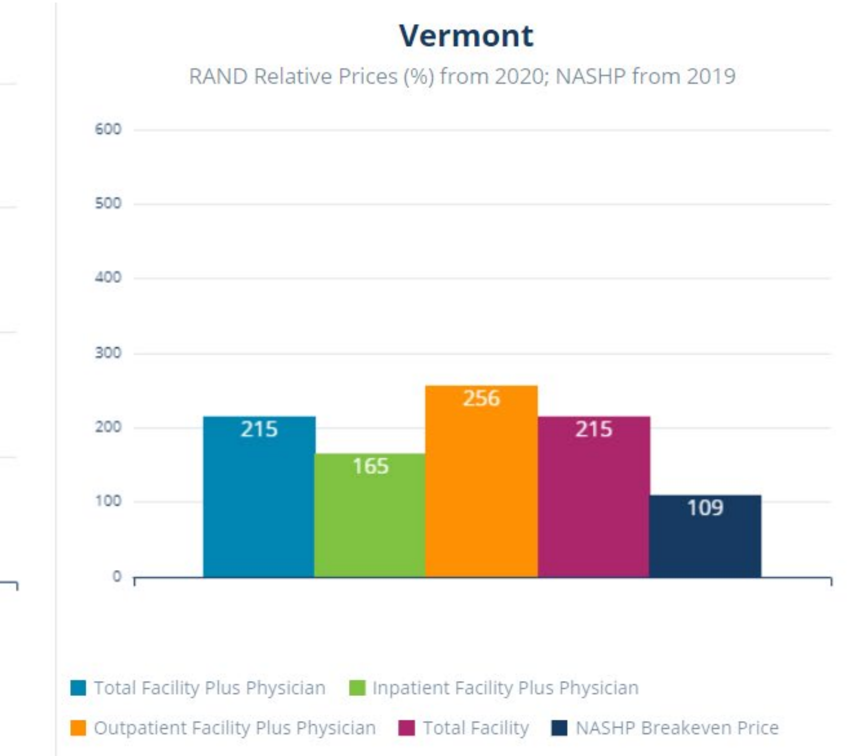
Source: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county

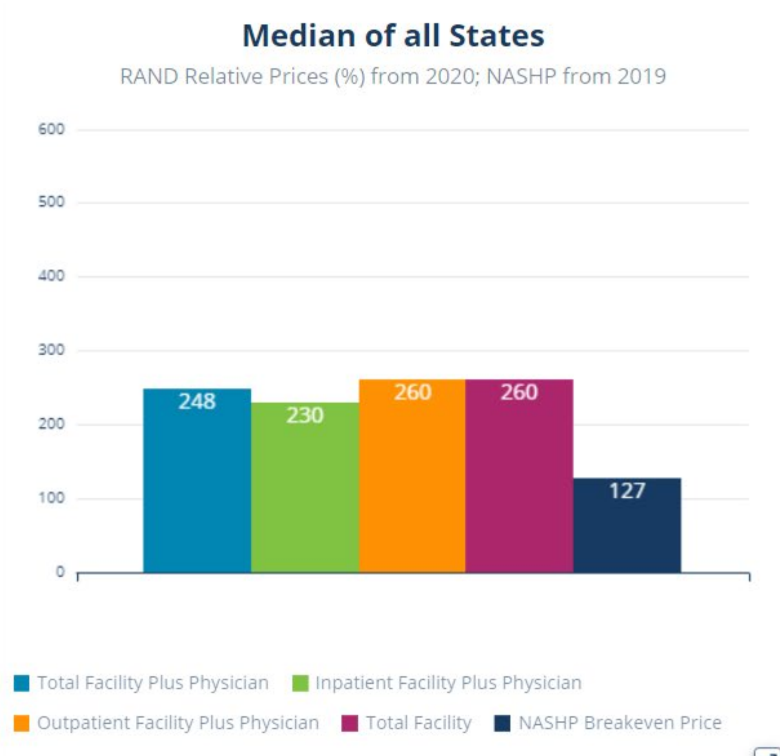
Vermont has higher spending compared to nation for Medicaid, Private and overall.

	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

VT state level commercial mark-up and break-even price points are lower than national state medians).





Source: Sage Transparency Tool

Delivery Transformation Goals

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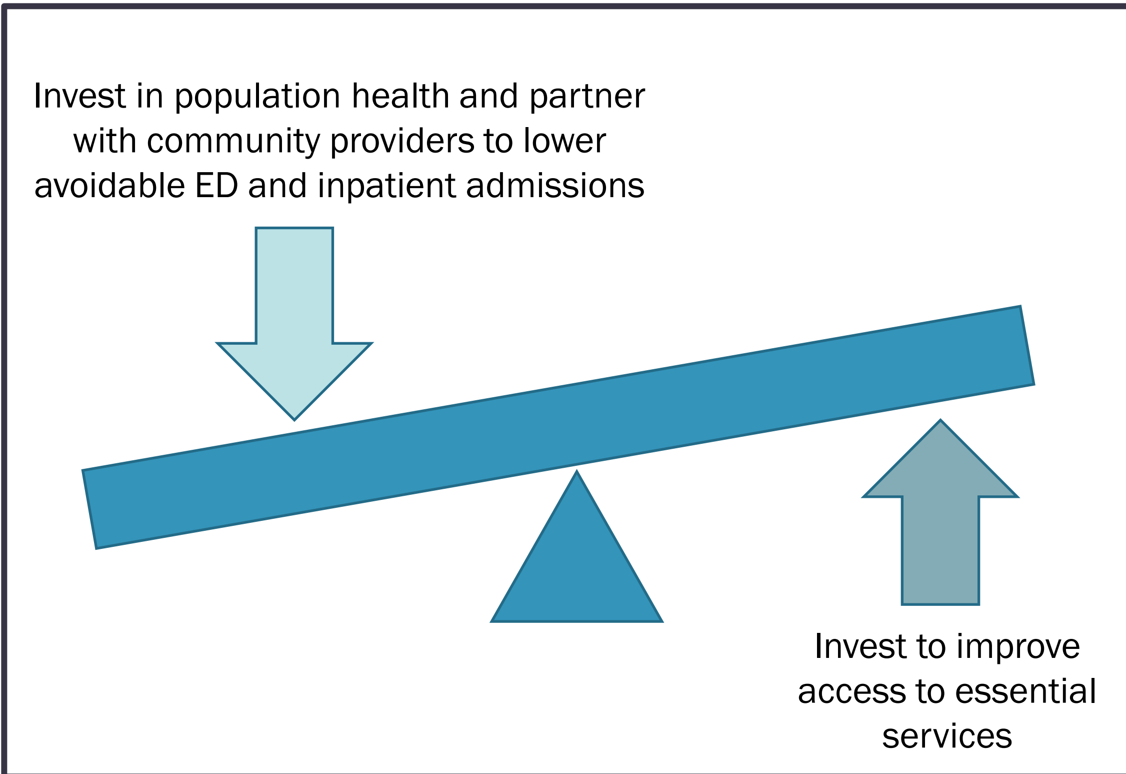

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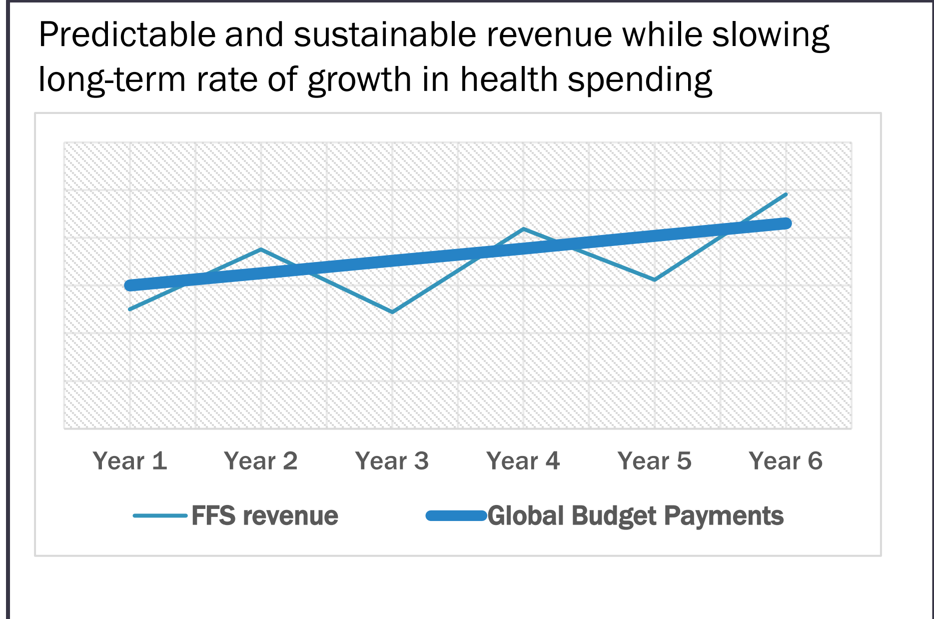

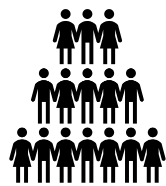

Transformation Support

- Operational flexibilities
- Data systems and infrastructure
- Performance measures

Vermont has better health status, lower utilization rates, except for ED, Hospital Outpatient and Rural Health Clinics

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

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

Avoidable Utilization and 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

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

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

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

	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%

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

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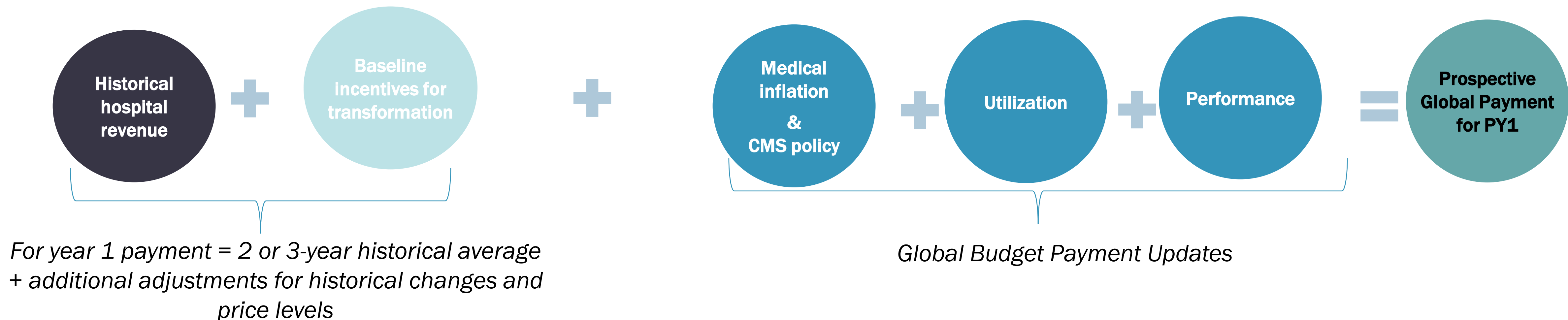
Calculating Global Budget Payments – Baseline Payments

- 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)



Vermont Medicare Hospital Global Payment Components

Base/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

Vermont Medicare Hospital Global Payment Components

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.

*Required in state designed methodology per CMS.

Vermont Medicare Hospital Global Payment Components

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).
Health equity improvement bonus*	Up to +2% funding for improvement in high-adversity populations.	Rewards hospitals for improving care for the most disadvantaged populations.
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.

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

Framework for Evaluation and Measurement

Federal-State Accountability Targets	Hospital-Level Payment Model Measures	Primary Care Measures	Broader Monitoring and Evaluation
• 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	• 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	• 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	• 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.

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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***.

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

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.*

APPENDIX – CONSIDERATIONS FOR AHEAD/HOSPITAL GLOBAL PAYMENTS

Considerations when evaluating Vermont's participation in AHEAD: Cost

Considerations for COST	AHEAD/Hospital GB (Better, Neutral, Worse, NA)	Mitigation Strategy (As necessary)
Commercial Insurance Affordability	?	?
Controlling health care spending growth	?	?
Regulatory Cost	?	?
Hospital operating cost growth	?	?
Hospital financial sustainability	?	?
Independent provider sustainability	?	?
Flexible & Predictable Funding	?	?
Amount of potentially avoidable utilization and associated savings	?	?
Uptick of Medicare Advantage	?	?
Administrative Burden	?	?
Administrative vs. Clinical Investments	?	?
Provider recruitment & retention	?	?
Shrinking commercial population	?	?
Pharmaceutical drug prices	?	?
Aging health system infrastructure	?	?
High statewide infrastructure costs	?	?
Payer & Provider Equity	?	?

Considerations when evaluating Vermont's participation in AHEAD: Access/Quality

Considerations for ACCESS/QUALITY	AHEAD/Hospital GB (Better, Neutral, Worse, NA)	Mitigation Strategy (As necessary)
Feasibility of reducing avoidable utilization to achieve savings	?	?
Hospital Borders due to lack of post-discharge care (SNF, Long term care)	?	?
Hospital Mental Health Borders	?	?
Wait times	?	?
Cultural change (hospital business model from treating illness to wellness)	?	?
Inequities in Access/Quality of care	?	?
System Preparedness (incl. provider burnout)	?	?
Access to Primary Care & Prevention	?	?
Federal/statewide waivers	?	?
Warranted/unwarranted utilization	?	?
Health disparities	?	?
Low volume procedures	?	?
Access to Mental Health Care	?	?

Considerations when evaluating Vermont's participation in AHEAD: Community Needs

Considerations for COMMUNITY NEEDS	AHEAD/Hospital GB (Better, Neutral, Worse, NA)	Mitigation Strategy (As necessary)
Rurality	?	?
Aging Population	?	?
Deaths due to Suicide	?	?
Deaths due to Drug Overdose	?	?
Housing	?	?
Transportation	?	?
Social Disparities	?	?
Economic Disparities	?	?

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APPENDIX – BOARD QUESTIONS ON AHEAD/HOSPITAL GLOBAL PAYMENTS

Questions: Planning Process

- How and what are the alternatives, or counterfactuals to the AHEAD model being considered?
- Staffing and planning for Hospital Budget review – will the GMCB regulate hospitals under a global payment differently? If voluntary, will GMCB have staff necessary to run two parallel processes? What are the implications of having two regulatory systems?
- Does the planning process consider all the relevant voices who would be affected by health care reform, and how does the structure of the planning process give us confidence that we will arrive at the best option for Vermonters?
- Does the state have a clear and collective understanding of the problem that health care reform is seeking to solve in our state? And are those problems front and center in the health care reform planning process? Which of these issues are addressed by AHEAD? And of those issues address/not addressed by AHEAD, how do we know we are allocating Vermont's resources efficiently?
- Does the state have a clear position on the conditions under which it makes sense to "walk-away"?

Questions: Elements of Model Design & Implementation

- ❑ Does, or can, this model address key delivery system challenges that exist in Vermont? One of the main objectives of global hospital payments is to curb health care utilization – how do we know the appropriate threshold where access is already limited?
- ❑ What measurements are in place to monitor utilization and access?
- ❑ Is Medicare paying their fair share? And how do we measure and know this is improving over time?
- ❑ What are the Medicare specific benefits/risks to this model?
- ❑ VT has some of the lowest Medicare spending in the country while commercial spend is among the highest. What is the potential impact?
- ❑ How can we ensure sustainable funding for evidence-based programs (i.e. Medicare investment in Blueprint & SASH)?
- ❑ How can we ensure that reducing regulation is not used as a negotiating tool?
- ❑ Are the dollars included in the Medicare global payment for transformation sufficient for the changes we need to see?
- ❑ Given that the hospital global payments are based on historical data, how can we be sure that inefficiencies are not baked in in perpetuity?
- ❑ What are the plans for future evaluation of this model? How do we know "it's working"? What are the tangible benefits to Vermonters?

Questions: Operations

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- ❑ Does this state have (or is willing to invest in) the resources necessary to appropriately monitor and evaluate the state's implementation of this model – to include staffing and contractor dollars?
- ❑ What are the intersections between payment and the Board's existing regulatory processes (hospital budget review, rate review, ACO regulation, CON, etc.)? What is required to evolve the Board's existing regulatory processes to recognize these intersections?
- ❑ What are the administrative costs for the State and the participating hospitals?
- ❑ What is the role of ACOs should the state adopt AHEAD?
- ❑ Under a voluntary model, what are the operational changes for hospitals who do not join the Medicare global payment in PY1? What does moving back to traditional FFS reimbursement look like?