Annual Report of the Green Mountain Care Board to the Vermont General Assembly January 15, 2013

The Green Mountain Care Board is committed to the Institute for Healthcare Improvement's "Triple Aim, " which has been adopted by the federal Centers for Medicare and Medicaid Services. We aim to:

- ***Improve Vermonters' experience of care (including quality and satisfaction);***
- ***Improve the health of Vermonters; and***
- ***Reduce Vermont's per capita costs of health care.***

Cover photo courtesy of the Cabot Creamery Cooperative.
Photo by Skye Chalmers from the book *Sending Milk: The Northeast Farms and Farmers of the Cabot Creamery Cooperative*.
Our thanks to Alison Redlich for additional photography
and to Rick J. Blount for his assistance on this report.

Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

[phone] 802-828-2177
www.gmcboard.vermont.gov

Anya Rader Wallack, Ph.D., Chair
Alfred Gobeille
Karen Hein, MD
Con Hogan
Allan Ramsay, MD
Georgia Maheras, Executive Director

Claire Ayer, Chair, Senate Health and Welfare Committee
Mike Fisher, Chair, House Health Care Committee
State House
Montpelier, VT 05062

Dear Senator Ayer and Representative Fisher:

Enclosed is the annual report to the legislature of the Green Mountain Care Board (GMCB), as required by 18 VSA, § 9375.

The GMCB's job, according to our enabling statute, is to:

- improve the health of Vermonters;
- reduce the per-capita rate of growth in expenditures for health services in Vermont;
- enhance patient and health care professional experience of care; and
- achieve administrative simplification in health care financing and delivery.

This report describes important work toward carrying out our statutory obligations. In 2012, we:

- continued development of payment and delivery system reform that will underpin Vermont's future cost containment efforts;
- developed our role as decision-maker in health-insurance rate cases, completing 39 reviews;
- reviewed and approved 14 hospital budgets;
- approved benefit requirements for insurance plans on Vermont's Health Benefits Exchange;
- enhanced the availability and analysis of health care data to support decision making;
- explored ways in which a Unified Health Care Budget could be used as a meaningful tool for health care planning on cost containment;
- launched the "GMCB Health System Dashboard";
- increased transparency around health care regulatory processes and encouraged public engagement in our work;
- authorized changes to Vermont's Health Information Technology Plan; and
- approved a Workforce Strategic Plan.

The report also outlines our priorities for 2013.

Thank you for helping the GMCB to achieve our shared goals in 2012. We look forward to continued collaboration in 2013.

Sincerely,

Anya Rader Wallack

Anya Rader Wallack, PhD
Chair, Green Mountain Care Board

The members of the Green Mountain Care Board wish to express our gratitude to our amazing staff, who have demonstrated flexibility, dedication, passion, and a shared sense of good humor in our first year serving the people of Vermont.

Green Mountain Care Board Members and Staff

Board Members
Anya Rader Wallack, Ph.D., Chair
Al Gobeille
Karen Hein, M.D.
Cornelius Hogan
Allan Ramsay, M.D.

Staff
Georgia Maheras, Esq., Executive Director
Ena Backus, Health Care Administrator
Monica Buzzell, Financial Administrator
Doreen Chambers, Health Care Administrator
Mike Davis, Director of Health System Finances
Mike Donofrio, Esq., General Counsel
Judy Henkin, Esq., Health Policy Director
Donna Jerry, Health Care Administrator
Sam Lacy, Administrative Assistant
Kelly Macnee, Health Policy Analyst
Janeen Morrison, Financial Administrator
Stacey Murdock, Data and Information Project Manager
Lori Perry, Senior Financial Policy Analyst
Janet Richard, Administrative Services Coordinator
Richard Slusky, Director of Payment Reform
Spenser Weppler, Health Care Administrator

TABLE OF CONTENTS

Vermont's health system and the role of the GMCB…………………………………….....page 1
Vermont's Challenges…………………………………………………………………………………page 4
GMCB Progress in 2012………………………………………………………………………………page 7
GMCB Priorities for 2013…………………………………………………………………………page 23

Appendices

- **Appendix A**
    - Specific statutory requirements for this report
    - Alignment with the principles of 18 VSA § 9371
- **Appendix B**
    - List of 2012 GMCB meeting topics and presentations
- **Appendix C**
    - GMCB budget and staffing
- **Appendix D**
    - 2012 health insurance rate review decisions and hospital budget decisions
- **Appendix E**
    - Full listing of the powers and duties of the Green Mountain Care Board

From left to right: Board Member Al Gobeille, Board Chair Anya Rader Wallack, Executive Director Georgia Maheras, and Board Members Karen Hein, Con Hogan and Allan Ramsay

Vermont's Health System and the Role of the Green Mountain Care Board

State government has taken a more-activist role in overseeing health care delivery and spending in Vermont than in many other states. Ours has been a fairly oligopolistic health care market – one characterized by little competition -- for many years, and the state's policy has been to provide for significant regulatory oversight.

Vermont has had a system of hospital budget oversight in place since 1983, has required state approval of major capital expenditures by health care providers (under a "certificate of need" program) and has long required review and approval of health insurer rate increases. We also have developed an expenditure analysis since 1991 that details health care spending and cost growth from year-to-year. More recently, the state has developed an all-payer claims dataset (APCD). This is a repository of data from nearly all health insurers doing business in the

Some Features of Vermont's Health System

- 14 community hospitals, including 8 critical access hospitals (fewer than 25 beds).
- 1 in-state academic medical center, plus Dartmouth-Hitchcock, provide most tertiary care.
- 8 FQHCs serving more than 120,000 Vermonters.
- Fewer than 2000 physicians, more than half of whom are employed.
- 3 insurance carriers, only 2 in small group market.
- 6.8% uninsured.

state that allows us to examine patterns of health care use, price and overall cost in a way that is not possible in most states.

The Legislature created the Green Mountain Care Board (GMCB) in 2011. The GMCB was given broad authority over health policy-making, and was expected to provide for better cohesion of policy across previously separate elements and a higher level of accountability for outcomes, and foster improved transparency in regulatory processes. According to the GMCB's enabling statute (18 VSA § 9372):

> "It is the intent of the general assembly to create an independent board to promote the general good of the state by:
> 1. improving the health of the population;
> 2. reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
> 3. enhancing the patient and health care professional experience of care;
> 4. recruiting and retaining high-quality health care professionals; and
> 5. achieving administrative simplification in health care financing and delivery."

Vermont law (18 VSA, § 9375) requires that annually, on or before January 15, the GMCB submit a report of its activities for the preceding state fiscal year to the House Committee on Health Care and the Senate Committee on Health and Welfare. The law requires that the report include:

- Any changes to the payment rates for health care professionals established by the GMCB;
- Any new developments with respect to health information technology;
- Any health system evaluation criteria adopted by the GMCB;
- Any results of the system-wide performance and quality evaluations required of the GMCB;
- Any recommendations for modifications to Vermont statutes; and
- Any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs.

The law also requires that the report identify how the work of the GMCB aligns with the principles expressed in section 9371 of title 18. (See Appendix A for a full discussion of the statutory requirements for this report.)

This report is intended to meet the statutory requirements for GMCB reporting to the Legislature for 2013. While the statute technically requires a report on the previous state *fiscal year* (July 1 - June 30), we are reporting here on activities during calendar year 2012, as the board has yet to exist for a full fiscal year and calendar year reporting is more up-to-date.

The GMCB's role

The Legislature gave the GMCB a number of powers and duties to use in carrying out its charge. These include:

- **Payment and delivery system reform:** Develop, implement and evaluate the effectiveness of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont.
- **Health insurer rate approval:** Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board.
- **Hospital budget approval:** Review and establish hospital budgets annually.
- **Approval of major health care capital expenditures** (began January 1, 2013): Review and approve, approve with conditions, or deny applications for certificates of need.

Mark Larson, Commissioner of the Department of Vermont Health Access, testifies at a Green Mountain Care Board meeting.

- **Exchange benefits approval:** Review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans to be offered in Vermont's Health Benefit Exchange (in accordance with the federal Affordable Care Act).
- **Vermont health system Dashboard:** Develop and maintain a method for evaluating Vermont health system performance and quality.
- **Unified health care budget:** Develop a unified health care budget to guide the overall growth and allocation of health care spending in Vermont.
- **Health information technology:** Review and approve Vermont's statewide health information technology plan to ensure that the necessary infrastructure is in place to enable the state to achieve its health reform goals.
- **Health care workforce policy:** Review and approve the state's health care

workforce development strategic plan.
- **Health planning:** Review the state's health resource allocation plan.
- **Provider rate-setting:** Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

In addition, the GMCB has some specific duties related to development of Green Mountain Care, a program of publicly-financed, universal coverage under development for Vermont. These include:

- Prior to implementing Green Mountain Care, the GMCB shall consider recommendations from the Agency of Human Services, and define the Green Mountain Care covered benefits package.
- Prior to implementing Green Mountain Care and annually after implementation, the GMCB shall recommend to the general assembly and the governor a three-year Green Mountain Care budget, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

Vermont's Challenges

The Legislature created the GMCB to address pressing needs in Vermont: the need to reduce health care cost growth to a sustainable rate and the need to improve health and health care quality. Vermont has a high-quality health care system by many measures, but the overall rate of health care cost growth is not sustainable, and we do not get optimum return on our health care investments, for a number of reasons:

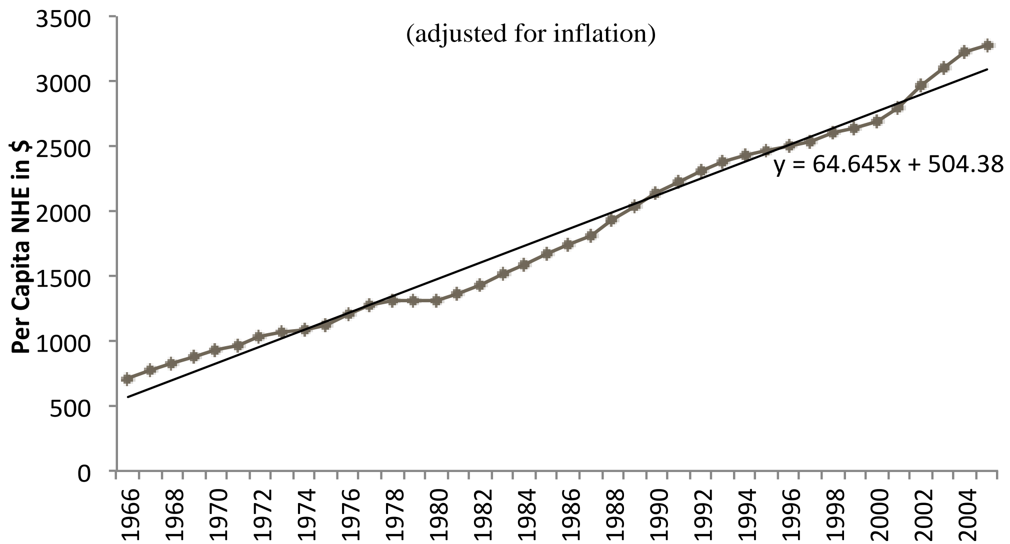
- Patient care is poorly integrated;
- Technology does not allow for adequate communication between providers;
- The payment system promotes the use of more health care services, rather than better health;
- The system is geared toward treating illness rather than preventing it;
- Vermonters do not do all they can to be healthy;
- We have a small population over which to spread fixed costs of health care facilities and services; and
- New innovations that improve the treatment of or cure disease often are very expensive.

Health care cost growth during the period 1997-2009 greatly outstripped economic

growth, in Vermont and nationally. In 2010 and 2011, health care cost increases were closer to (but still exceeded) economic growth, but experts predict that the gap between economic growth and health care cost growth will widen again in 2014 and continue for the years beyond. As shown in figure 1, United States health care cost growth consistently has exceeded inflation by about two percentage points, in good economic times and bad, resulting in higher per capita costs over time, even after adjusting for inflation.

Figure 1. Health Care Cost Growth Relative to Inflation, 1966-2006

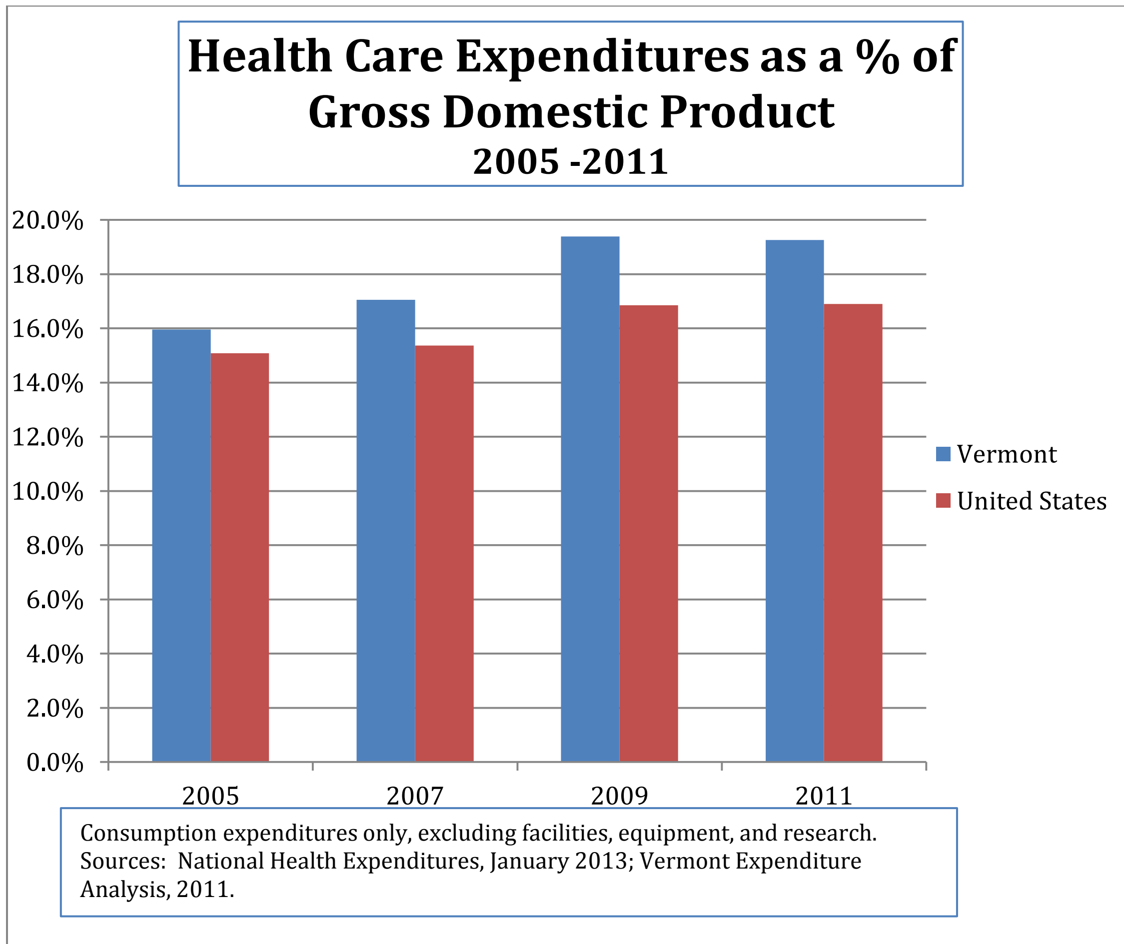
Per Capita Growth In Health Expenditures Has Been Growing at 2% Above Inflation For 40 Years



Source: Stuart Altman, Ph.D.

This mismatch might not sound significant, but it has resulted in fairly steady growth in the percentage of each dollar we earn that pays for health care. In 2011, Vermont spent an estimated 19.3 percent of gross domestic product on health care, significantly more than the national average of 16.9 percent (as shown in figure 2). Vermont health spending as a percentage of GDP was 16 percent in 2005. The percentage of GDP dedicated to health care did not grow in Vermont or nationally from 2009-2011, as a result of the recession and reduced government health care spending, but current predictions show health care growth continuing its historical trajectory in 2014 and beyond.

Figure 2



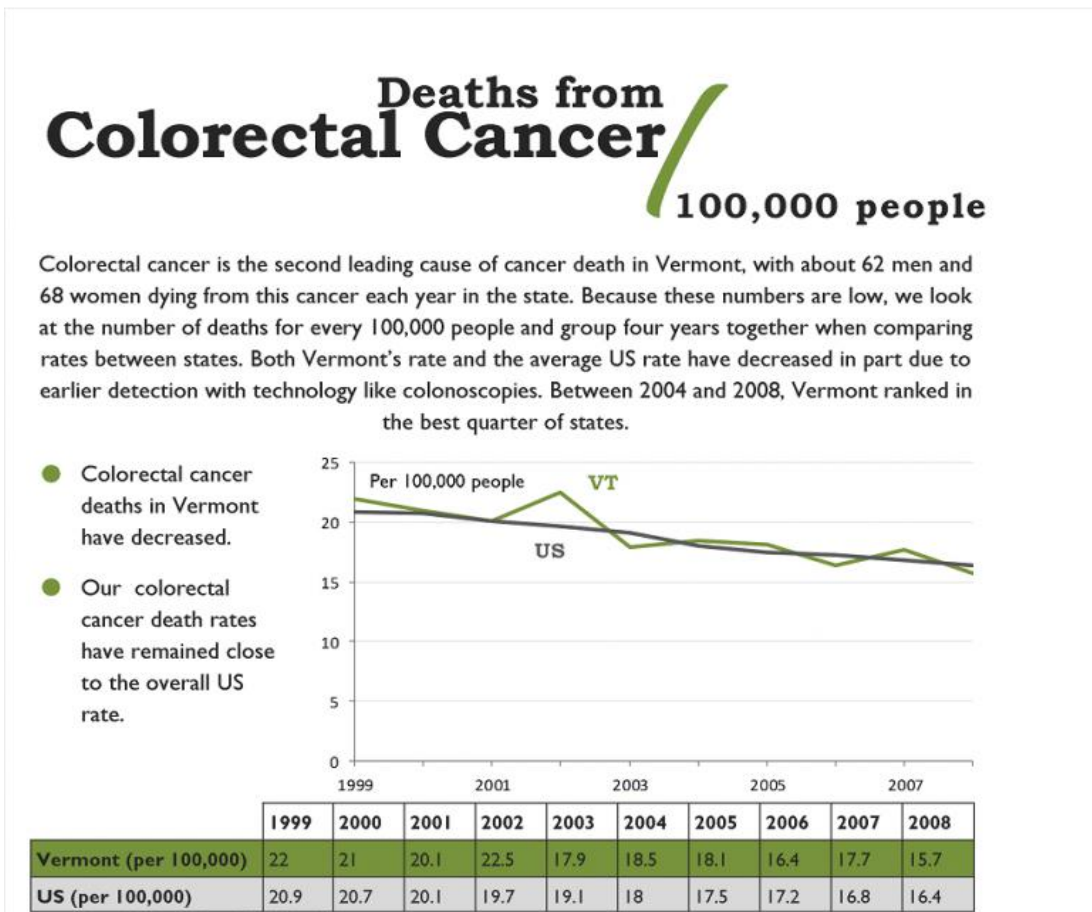
Creation of a new state regulatory body, like the GMCB, does not magically change the cost or outcomes of Vermont's health care system, but it allows us a new opportunity to share state policies that foster and support change among Vermonters, their health care providers, health care payers and government to reduce cost growth and improve outcomes. While Vermont generally gets high marks for the quality of its health system, there are areas such as deaths from colorectal cancer (see figure 3) and obesity (one in every four Vermonters is obese and that number is growing), in which we can improve. More than 40,000 Vermonters remain uninsured[1] and more than 160,000 Vermonters were underinsured meaning that their deductibles exceeded 5 percent of household income or health care expenses exceeded 10 percent of household income or both[2].

---

[1] 2012 Vermont Household Health Insurance Survey

[2] Vermont Office of Health Access Planning for Vermont's Health Benefits ExchangeTask 7: Study of the Uninsured and Underinsured

Figure 3



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Vermont (per 100,000)	22	21	20.1	22.5	17.9	18.5	18.1	16.4	17.7	15.7
US (per 100,000)	20.9	20.7	20.1	19.7	19.1	18	17.5	17.2	16.8	16.4

Source: Centers for Disease Control (CDC Wonder Online Database)

GMCB Progress in 2012

The GMCB made good progress during 2012 on addressing its responsibilities. We have increased transparency in Vermont health care regulation, increased public participation in shaping Vermont health care reform and had a positive effect on reducing costs and improving quality. Most crucially, we have taken important steps to encourage development of a true health ***system*** in Vermont. We have articulated a long-term vision and strategies and some shorter-term policies that will support:

- Alignment of provider payment and delivery system changes with state and federal health policy goals;
- Better integration and coordination across individual health care providers and provider groups; and

- Availability of good data and analysis to allow for evaluation of system changes over time.

The Commonwealth Fund in 2006 completed a study of "high performance health systems" around the globe that are successful in supporting their citizens to achieve long, healthy and productive lives. According to the Fund's 2006 report, "A Framework for a High Performance Health System in the United States,"[3] countries that achieve this mission have three core attributes:

- A commitment to a clear national strategy for achieving the mission and an established process to implement and refine their strategy for achieving it;
- Delivery of health care services through models that emphasize coordination and integration; and,
- Establishing and tracking metrics for health outcomes, quality of care, access to care, population-based disparities and efficiency.

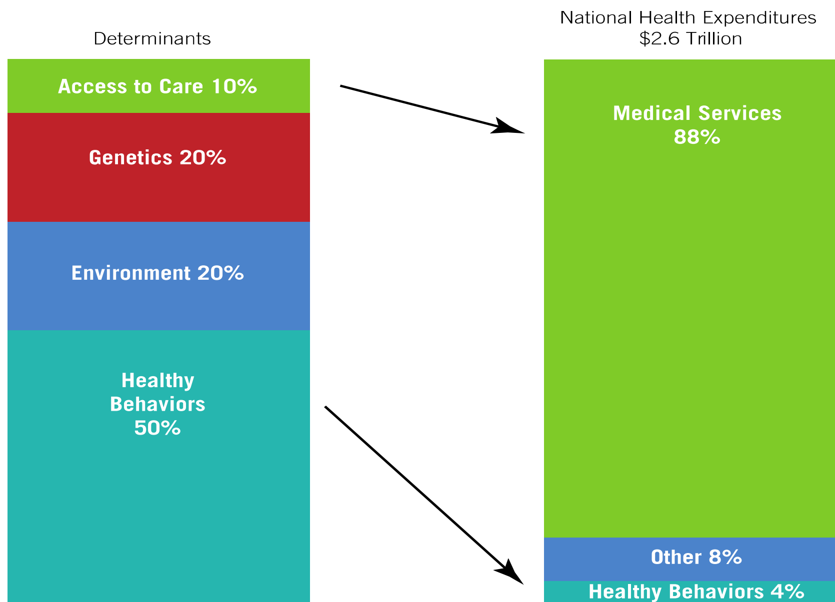
We believe we have made progress toward developing these attributes in the Vermont health care system in 2012, and we are convinced that, with more work, Vermont can serve as a proving ground for development of a high-performance health system at the state level. Vermont's strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance.

As part of our long-term strategy to develop a high-performance health system, we also began a process this year of examining ways in which factors outside the health care system influence health care costs and the health of Vermonters. Figure 4 below illustrates the strong influence that the environment and healthy behaviors exert on health.

---

[3] The Commonwealth Fund Commission on a High Performance Health System, Framework for a High Performance Health System for the United States, The Commonwealth Fund, August 2006 http://www.commonwealthfund.org/Publications/Fund-Reports/2006/Aug/Framework-for-a-High-Performance-Health-System-for-the-United-States.aspx

Figure 4



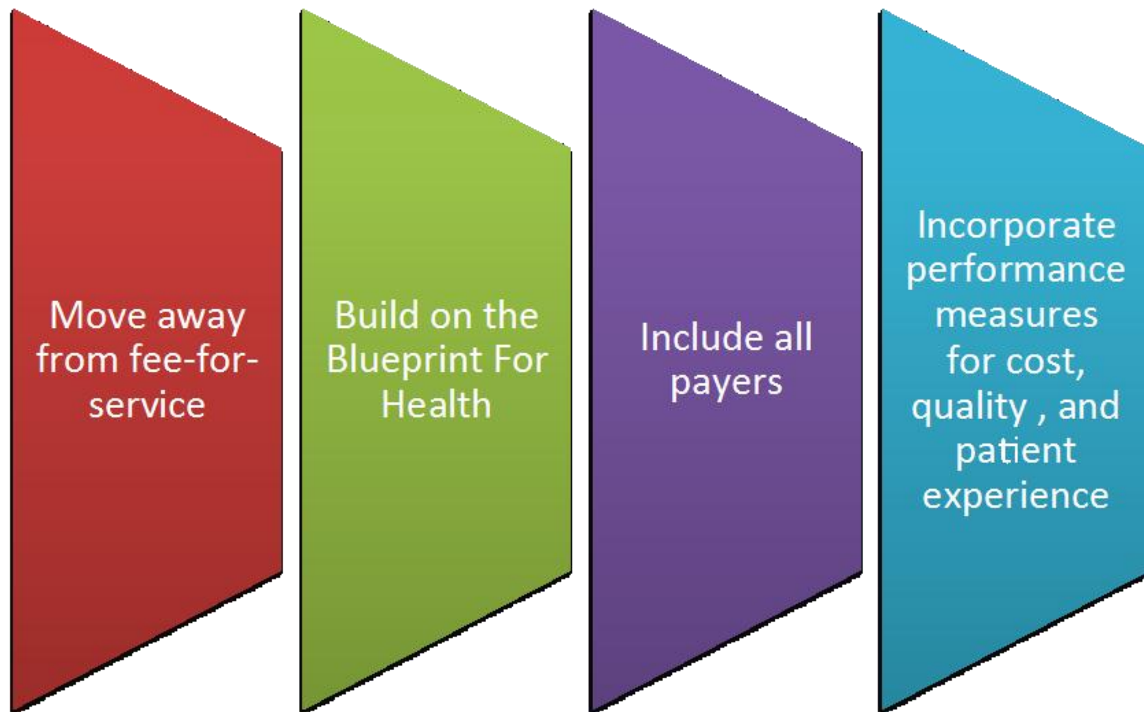
Throughout 2012, the Board focused its efforts on creating connections between its regulatory work and the goal of developing this High Performance Health System. The following pages will describe the specific progress made by the Board in our regulatory and program areas: payment and delivery system reforms, insurance carrier rate review decisions, hospital budgeting, Exchange benefits, expenditure analysis and data infrastructure, unified health care budgeting, system measurement through the Dashboard, transparency and public engagement, health information technology and workforce.

Payment and delivery system reform

During 2012 the GMCB continued development of payment and delivery system reform that will underpin Vermont's future cost containment efforts. Act 48's mandate is for payment reform in Vermont to move away from fee-for-service provider payments and toward payment methods that reinforce our efforts to improve the health of Vermonters, improve the quality of care, and contain the rate of growth in health care costs. In 2012, the GMCB began implementing new payment systems on a pilot basis with willing providers across all payers, including Medicaid and Medicare. The pilots include a strong element of "delivery system reform," meaning an effort to define the best care processes for a particular type of care while changing the payment stream to support adherence to that process. We are evaluating the pilots to judge their applicability to broader populations of providers and patients. Figure 5 shows the goals

of our delivery system and payment reform efforts.

Figure 5 Goals of GMCB Delivery System and Payment Reform Efforts



Our payment reform work has been aided by grant support from the Robert Wood Johnson Foundation to staff our management of payment reform pilots.

In September, the GMCB and the Agency of Human Services (AHS) jointly submitted an application to the federal Center for Medicare & Medicaid Innovation (CMMI) under the State's Innovation Models (SIM) initiative:
http://www.gmcboard.vermont.gov/sites/gmcboard/files/Project%20Narrative.pdf
If awarded, the grant will strengthen Vermont's capacity to implement and evaluate health care payment and delivery system reforms. To apply for the grant, we worked with numerous agencies and departments of state government and external stakeholders to develop a State Health Care Innovation Plan, which can be viewed at: http://gmcboard.vermont.gov/sites/gmcboard/files/B%20Vermont_Health_Care_Innovation_Plan%20FINAL.pdf. The plan and the grant narrative describe how we intend to develop a high performance health system in Vermont with federal support.

Under the SIM grant, Vermont proposed to test three payment models:

- Shared Savings Accountable Care Organizations (ACOs);
- Bundled Payments; and
- Pay for Performance (P4P).

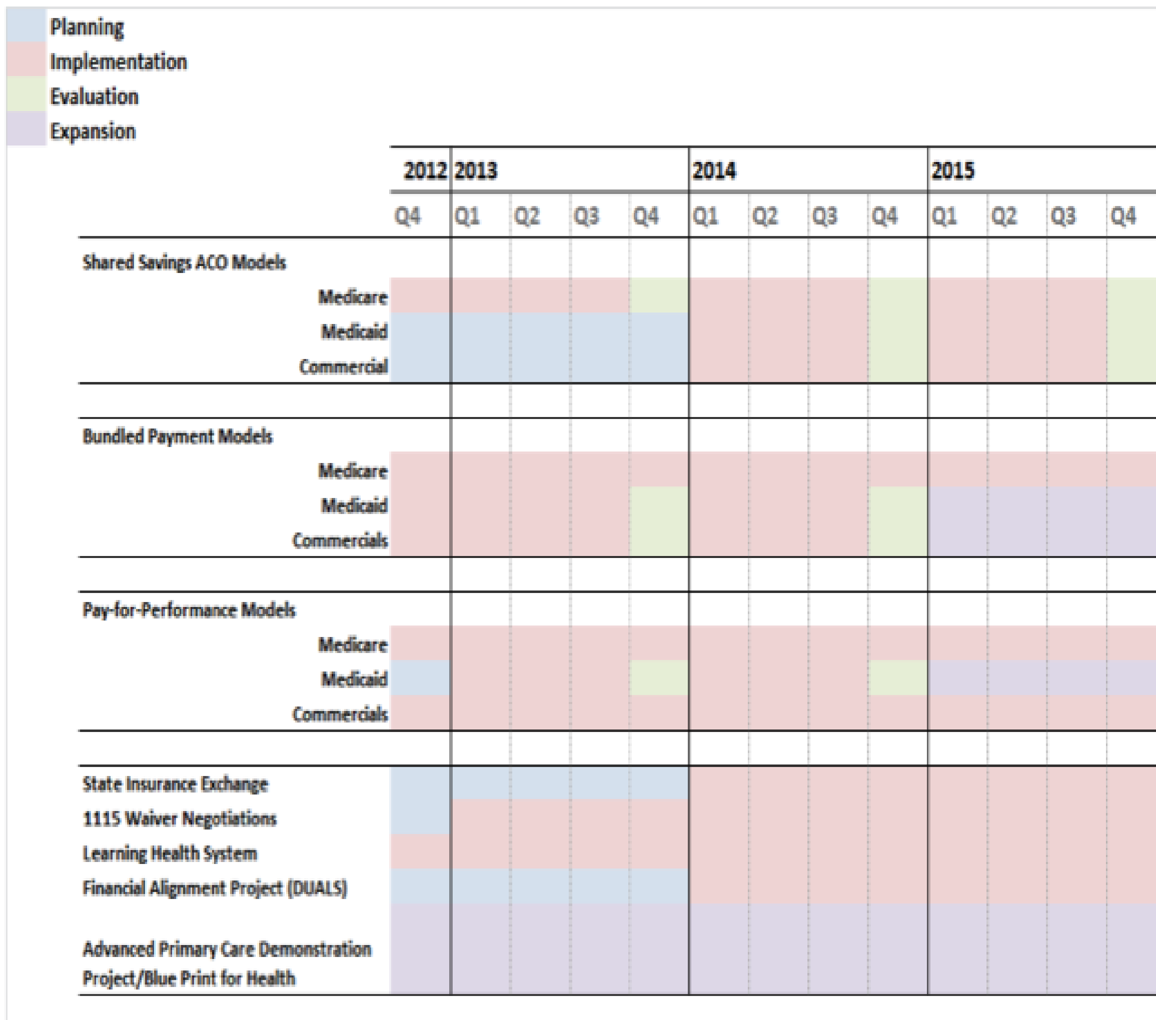
Table 1 summarizes the unique purpose of each model.

Table 1. Testing Models

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
To support an integrated delivery and financing system for Vermonters through an organized network of participating providers who have agreed to align their clinical and financial goals and incentives to improve patient experience and quality of care and reduce cost.	To remove FFS incentives and replace with those which reward collaboration and evidence-based practices across specialties and primary care providers for targeted episodes or types of care which represent opportunities for high return on investment	To enable all payers, particularly Medicaid, to use P4P approaches to improve performance and quality of its health systems

The SIM grant also would support broader efforts to assure that Vermont's health care data collection and analysis supports health system improvement and good health policy. The grant also would provide funds to coordinate payment and delivery system reforms across primary care, specialty care, mental health and long-term services and supports. Figure 6 provides a proposed timeline for implementation of the SIM models and the timing of related reform efforts.

Figure 6 Timeline for State Innovation Model Components and Related State Health Reform Efforts



To complement the work we have proposed under the SIM grant, the GMCB and AHS have proposed a state innovation oversight structure that includes representation from inside and outside state government. Overall SIM project management and decision-making will be provided by a Core Team comprised of the Chair of the GMCB, the Director of Health Care Reform, the Secretary of Human Services and the Commissioner of the Department of Vermont Health Access (DVHA). The Core Team will be advised by a SIM Steering Committee. This group will include internal and external stakeholders. Three working groups will report to the Steering Committee in specific subject areas: an ACO Standards Working Group, a Quality and Performance Measures Working Group and an HIT/Data Working Group.

The ACO Standards Working Group will focus on the development of standards to govern the operation of ACOs or other integrated care networks (ICNs) that could

operate in the commercially-insured market and Medicaid. The Quality and Performance Working Group will identify measures to reflect the performance of Accountable Care Organizations (ACOs) and other delivery system and payment reform models that could operate in the commercially-insured market and Medicaid. The working group also will identify ways to connect quality measures with payment mechanisms such as shared savings and communicate performance to consumers through public reporting. The HIT/Data Working Group will develop recommendations around the expansion of health information technology and health data analysis within Vermont to support implementation of the State's Health Care Innovation Plan.

As we await word from CMMI on the SIM grant, payment reform pilots progress on numerous fronts:

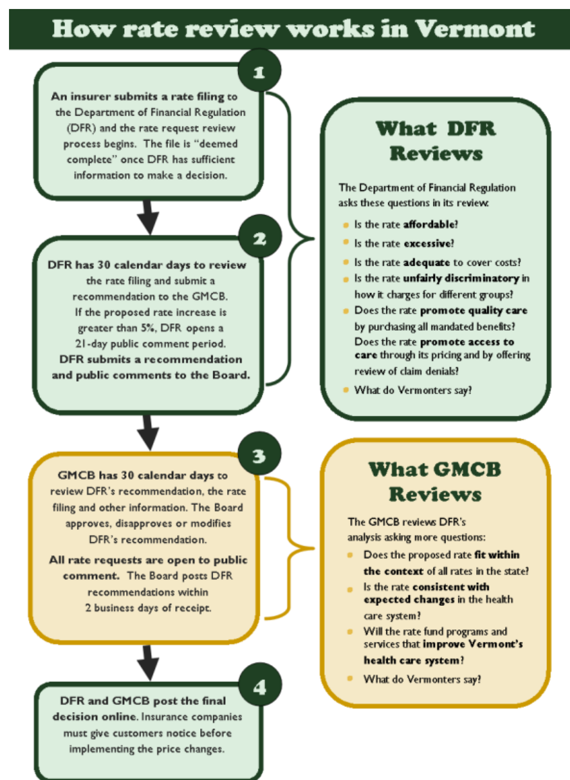
- **In St. Johnsbury**, payments have begun for providers involved in the Northeastern Vermont Oncology Pilot, which the GMCB approved in June. The pilot seeks to improve the quality of care for cancer patients in the area. It provides incentives to primary care providers, oncologists, and other providers to coordinate cancer care. GMCB staff and consultants are working with the operational and clinical team in St. Johnsbury to implement this pilot and evaluate its effectiveness. Work is currently underway with Dartmouth-Hitchcock Medical Center to develop the metrics and performance measures for the pilot. For more detail on this pilot: http://gmcboard.vermont.gov/sites/gmcboard/files/Oncology_Pilot.pdf
- **In Brattleboro**, we continue work with the Brattleboro Retreat to develop a Bundled Payment Initiative focusing on opiate detoxification. Our goal is to begin the pilot early in 2013.
- **In St. Albans, Northwestern Medical Center** has developed a project to reduce emergency room use, with a shared savings agreement with Medicaid and private payers. This project will come to the GMCB for approval in 2013.
- **In Burlington**, we are in the preliminary stages of evaluating data for hip and knee replacements with the intent of developing a bundled payment pilot.
- **In Rutland,** community providers and Rutland Regional Medical Center have developed a bundled payment initiative designed to improve care for patients with Congestive Heart Failure. The project was approved for Medicare participation this month.
- **Also in Rutland**, the local hospital and FQHC have been working with GMCB staff to develop a physician/hospital global budget model.
- **In addition, Vermont's eight federally-qualified health centers (FQHCs) are developing a joint proposal** for a shared savings payment reform pilot that would include Medicaid and commercial insurers. We expect to receive that proposal early in 2013.

In addition, we have worked closely with leaders of Vermont's emerging ACOs to shape their development. These are groups of physicians, hospitals and other health care

providers who form an organization to coordinate the services of the Medicare patients they serve. Two organizations in Vermont have applied to be Medicare ACOs: Accountable Care Coalition of the Green Mountains and OneCare Vermont. Accountable Care Coalition of the Green Mountains was approved by CMS on July 1, 2012 and includes approximately 100 physician members of Health First, a state-wide Independent Practice Association (IPA). OneCare Vermont was approved on January 10, 2013 as an LLC jointly formed by Fletcher Allen Health Care and Dartmouth Hitchcock Medical Center, which also includes 12 of the 13 community hospitals in Vermont and their employed physicians, two Federally Qualified Health Centers (FQHCs), five rural health centers, the Brattleboro Retreat and 58 community physician practices.

Health insurer rate approval

During 2012, the GMCB developed its role as decision-maker in health insurance rate cases. The law requires the GMCB to approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board. This has been one of our most challenging tasks to date. Since accepting responsibility for reviewing health insurance rate increases in January 2012, and receiving our first filing in April, the Board has completed 39 rate reviews and has held hearings in 12 of those reviews. Appendix D provides a full listing of proposed and approved rate increases considered by the GMCB during 2012.



The rate review process is two-fold: The Department of Financial Regulation (DFR) first reviews the carrier's request and the Commissioner of DFR makes a recommendation to the Board; the Board then reviews the filing with special attention to the effect of the proposed rate on cost containment, improving the quality of care, and improving the health of the population.

Of all the Board's duties, our actions on rate review tend to have the greatest immediate impact on Vermonters. For this reason, we devote special attention to

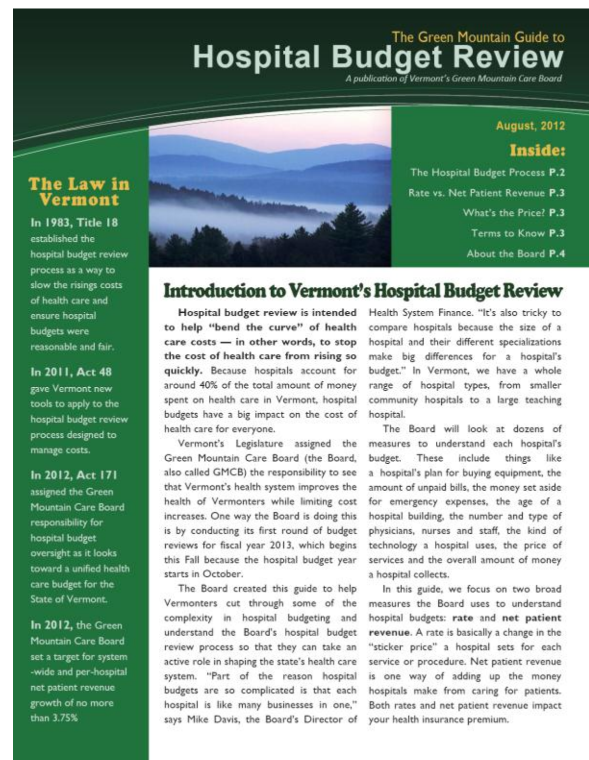
public outreach on rate review. In 2012, we published a *Green Mountain Guide* on the topic, began a series of public forums with a well-attended business forum co-hosted by the Lake Champlain Regional Chamber of Commerce, and working with the Department of Financial Regulation to make it easier for Vermonters to navigate the rate review website. We continue to work toward improving the rate review process, making it more understandable to Vermonters and ensuring value for businesses and individuals.

In 2013, we will seek ways to more explicitly connect rate review with cost containment targets and other policy goals, such as support for primary care.

Hospital budget approval

During 2012, the GMCB reviewed and approved 14 hospital budgets. The GMCB must review and establish hospital budgets annually. The hospital budget review process limits the amount of revenue that can be raised by Vermont's 14 community hospitals. Hospital budgets include more than 60 percent of health care spending in Vermont, excluding long-term care.

Our review process included a statewide public hearing held via Vermont Interactive Television and additional public input through the website's comment portal and through ongoing public meetings, which were actively encouraged through the publication of the *Green Mountain Guide to Hospital Rate Review*. In addition, six hospital CEOs were asked to come before the Board to respond to questions about their budgeted increases.



The Green Mountain Guide to

Hospital Budget Review

A publication of Vermont's Green Mountain Care Board

August, 2012

Inside:

The Hospital Budget Process **P.2**
Rate vs. Net Patient Revenue **P.3**
What's the Price? **P.3**
Terms to Know **P.3**
About the Board **P.4**

The Law in Vermont

In 1983, Title 18 established the hospital budget review process as a way to slow the risings costs of health care and ensure hospital budgets were reasonable and fair.

In 2011, Act 48 gave Vermont new tools to apply to the hospital budget review process designed to manage costs.

In 2012, Act 171 assigned the Green Mountain Care Board responsibility for hospital budget oversight as it looks toward a unified health care budget for the State of Vermont.

In 2012, the Green Mountain Care Board set a target for system -wide and per-hospital net patient revenue growth of no more than 3.75%

Introduction to Vermont's Hospital Budget Review

Hospital budget review is intended to help "bend the curve" of health care costs — in other words, to stop the cost of health care from rising so quickly. Because hospitals account for around 40% of the total amount of money spent on health care in Vermont, hospital budgets have a big impact on the cost of health care for everyone.

Vermont's Legislature assigned the Green Mountain Care Board (the Board, also called GMCB) the responsibility to see that Vermont's health system improves the health of Vermonters while limiting cost increases. One way the Board is doing this is by conducting its first round of budget reviews for fiscal year 2013, which begins this Fall because the hospital budget year starts in October.

The Board created this guide to help Vermonters cut through some of the complexity in hospital budgeting and understand the Board's hospital budget review process so that they can take an active role in shaping the state's health care system. "Part of the reason hospital budgets are so complicated is that each hospital is like many businesses in one," says Mike Davis, the Board's Director of Health System Finance. "It's also tricky to compare hospitals because the size of a hospital and their different specializations make big differences for a hospital's budget." In Vermont, we have a whole range of hospital types, from smaller community hospitals to a large teaching hospital.

The Board will look at dozens of measures to understand each hospital's budget. These include things like a hospital's plan for buying equipment, the amount of unpaid bills, the money set aside for emergency expenses, the age of a hospital building, the number and type of physicians, nurses and staff, the kind of technology a hospital uses, the price of services and the overall amount of money a hospital collects.

In this guide, we focus on two broad measures the Board uses to understand hospital budgets: **rate** and **net patient revenue**. A rate is basically a change in the "sticker price" a hospital sets for each service or procedure. Net patient revenue is one way of adding up the money hospitals make from caring for patients. Both rates and net patient revenue impact your health insurance premium.

With no legislatively mandated budget cap this year, the GMCB set a target for increases in net patient revenue of 3.75 percent for FY 2013, which began October 1, 2012. This compares with legislative caps of 4.5 percent and 4 percent in the previous two years. The budgets hospitals submitted to the GMCB proposed a net patient revenue increase of 7.2 percent.

In September, the GMCB approved budgets that will result in a total increase in hospital net patient revenue of $141.6 million over the prior fiscal-year level of $1.98 billion. The approved budgets include a 5.84 percent increase in "new" net patient revenue to the hospitals. This includes more than $37 in investments in health care reform (such as

health information technology and payment reform infrastructure) that the GMCB determined were likely to produce a greater return-on-investment over time. The new net patient revenue figure is exclusive of the transfer of numerous physician practices already within the Vermont health care system whose financial information is captured in the hospital budgets. These transfers amounted to $30.8 million of the total hospital revenue increase and included transfer or start-up funding of $10.8 million for primary care practices.

Two hospitals required follow up to the September rulings. The Board reviewed Copley's updated 2013 budget along with a clarification of their plans around orthopedic services. We approved the updated budget along with plans for an orthopedic hiring. We also reviewed and approved an updated budget for Porter Medical Center. While Grace Cottage's budget exceeded the 3.75 percent limit by $45,000, the Board allowed this due to concerns for Grace Cottage's unique circumstances.

The approved budgets assume a significant additional "cost shift" from public payers (Medicare and Medicaid) to private payers. Of the $141.6 million in new spending, it is anticipated that 80 percent will be borne by private payers -- including private insurers and Vermonters who are uninsured if Medicaid and Medicare do not increase expenditures beyond expected levels. The GMCB has been working with DVHA and the Secretary of Administration to develop a plan for addressing the cost shift through state budgeting. Further developments on this front will be announced as part of the Governor's FY2014 budget proposal. More information on specific hospitals is available here: http://gmcboard.vermont.gov/hospitalbudgets as well as in Appendix D.

We continue to monitor hospital budgets, including analyzing both FY2012 year-end results and FY 2013 year-to-date reports to ensure compliance with budget orders. We also continue to improve the hospital budgeting process -- including proposing new regulations governing the hospital budget process, which were approved by the Legislative Committee on Administrative Rules (LCAR) in November. In addition, the Board is hiring a vendor to provide budget performance software that is expected to enhance reporting, analysis, and presentation of hospital budgets and the Expenditure Analysis. A contract is expected to be approved in the first quarter of calendar 2013 and implementation should occur before the next hospital budgeting process.

Exchange Benefits

During 2012, the GMCB approved benefit requirements for health insurance plans to be offered on Vermont's Health Benefits Exchange. Under Act 48, the GMCB's responsibilities regarding benefits include accepting, rejecting, or modifying recommendations made by the administration regarding benefits to be offered in

Vermont's Health Benefits Exchange as well as those to be incorporated into the universal health system.

After discussion over numerous meetings – including a statewide Vermont Interactive Television forum yielding more than 90 comments – and review of more than 1,600 public comments, in September the Board approved the administration's recommendation of a Blue Cross Blue Shield of Vermont plan as the benchmark for plans within the Exchange, which takes effect January 1, 2014. More information on the Board's ruling is available here:
http://gmcboard.vermont.gov/sites/gmcboard/files/PlanDesignRec_090612.pdf.

The Administration recommended use of a Blue Cross Blue Shield of Vermont benchmark plan and has recommended a "hybrid" approach to benefit design, employing both state-specified plans that contain mandated benefits and "choice" plans that add innovations for health promotion and for engaging individuals in prevention..

Considerable Board discussion – and most of the public comment – concerned the potential addition of dental benefits. The Board voted against including dental in the plan, the cost of which would have been borne entirely by state government. The GMCB directed its Executive Director to commission a professional analysis of current access to dental care, organization of dental delivery, and financing of dental care in Vermont. The Board will release an RFP in early 2013 for this work.

Expenditure analysis, data sources & analytics

During 2012, the GMCB enhanced availability and analysis of health care data to support its decision making. A crucial component of Act 48's mandate is development and maintenance of a system to evaluate system-wide performance and quality. The *Vermont Health Care Expenditure Analysis* provides information on health care spending for services delivered in Vermont and for services provided to Vermont residents anywhere in the U.S. The analysis is prepared annually and is the foundation for the Unified Health Care Budget and the Three-Year Forecast. The GMCB published the 2010 Expenditure Analysis in March, 2012 in conjunction with the Department of Financial Regulation. The report provides basic information about the sources of financing for Vermont's health care system, what is being purchased, and estimates of future spending levels and trends. Data is summarized in two forms: the Resident analysis, which includes expenditures on behalf of Vermont residents, regardless of where the health care was provided; and the Provider analysis, which includes all revenue received for services by Vermont providers, regardless of where the patient lives.

We are now finalizing the 2011 Health Care Expenditure Analysis, which will include select data from the Vermont Healthcare Claims Uniform Reporting and Evaluation

System (VHCURES). It is expected in February 2013. The 2010 Expenditure Analysis can be found here: http://gmcboard.vermont.gov/sites/gmcboard/files/2010EA040212.pdf.

To anticipate future needs and guide our planning, the GMCB has hired the actuarial firm of Wakely Consulting to develop the three year forecast of health care expenditures. Wakely Consulting is developing a model that will enable the GMCB to input health care expenses from VHCURES, add in assumed growth trends and savings and predict future health care costs. The GMCB reviewed a draft of this model in mid-December, 2012 and we expect the full model to be operation in late winter. The GMCB is committed to working with other state agencies, including the Joint Financial Office (JFO), DVHA and the Blueprint for Health, to validate and test this model.

Unified Health Care Budget

During 2012, the GMCB explored ways in which a Unified Health Care Budget could be used as a meaningful tool for health care planning on cost containment. The Unified Health Care Budget (UHCB) has been part of Vermont law since 1991. The UHCB originally was intended to be a form of global budget for health care expenditures in Vermont. Global budgets are used in other countries to plan for, allocate and constrain total health care expenditures. The UHCB statute has been modified over time to more closely reflect its actual use – as a "guideline" for spending and not a real constraint. The UHCB has not functioned to control the rate of growth in health care spending in the state – nor has it been tied to, in any explicit manner, various regulatory processes and authorities in place at DFR and/or the GMCB.

The UHCB has to be more than a "guide." As with a personal or business budget, a state health care budget must have two attributes to be meaningful:

1. It is prospective, providing a plan for future spending based on anticipated available resources; and
2. It functions as a constraint on spending, establishing a maximum expenditure level at which some action is triggered – spending stops, or consumption is lowered, or the prices we are willing to pay are lowered (through negotiation with suppliers or by substituting less expensive goods).

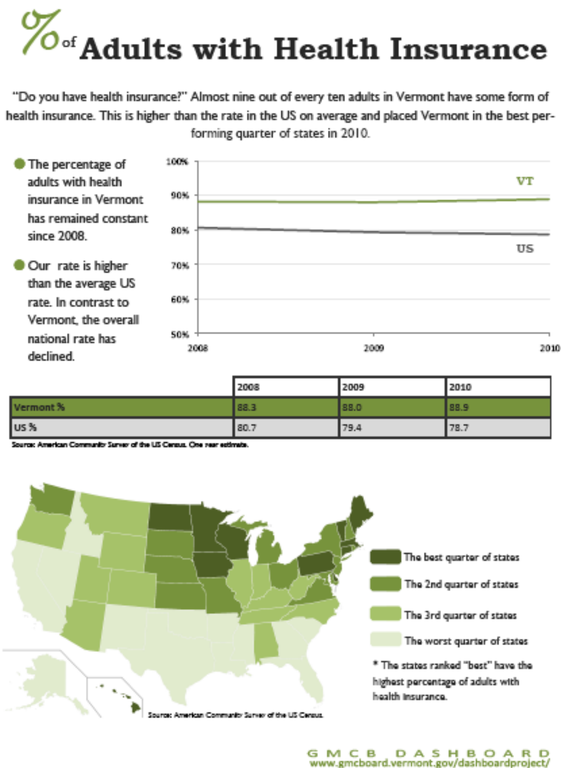
Working with a contractor who examined budgeting methodologies and appropriate benchmarks of health care growth in other states, the GMCB has been developing recommendations for a target rate of growth for hospital budgets, and a target rate of growth in total health care spending, for the federal fiscal year that begins October 2013. The GMCB solicited public comment on its initial proposal to limit growth of hospital budgets to 3.1 percent. The GMCB is in the process of evaluating the comments received and will develop a revised proposal in the near future.

Dashboard

During 2012, the GMCB launched "GMCB Health System Dashboard 1.0, in keeping with the Act 48 requirement to evaluate the performance of Vermont's health system. This first draft presents easy-to-understand analysis of data on 26 key indicators in four critical areas: cost, access to care, healthy lives, and prevention and treatment.

Presented in simple charts with plain language intended to demystify the statistics, the Dashboard attempts to present the best available data from numerous sources and to place the trends in context. For example, the discussion of "Adults with a usual source of care" notes that almost nine out of ten Vermonters report having one person they think of as their personal doctor or health care provider – a rate that is higher in Vermont than in the rest of the nation.

The Dashboard is accessible on GMCB's website at: http://www.gmcboard.vermont.gov/dashboardproject



	2008	2009	2010
Vermont %	88.3	88.0	88.9
US %	80.7	79.4	78.7

Transparency and public engagement

During 2012, the GMCB increased transparency around health care regulatory processes and encouraged public engagement in our work. As required by Act 48, the GMCB in February created an Advisory Committee with 41 members representing consumers, businesses and health care providers. The group met four times in 2012. Through meetings and via e-mails, the GMCB solicited the Advisory Committee seeking their input on policy issues related to our major areas of responsibility: hospital budgets and health system finances, insurance carrier rate review, Certificates of Need, benefit design, payment reform, quality, public engagement, and system oversight.

We also convened three technical advisory groups, with clear directives to provide input not on policy, but rather on how to implement policy.

In May, we created the Health Care Professional Technical Advisory Group to discuss and advise the Board on technical issues such as data analysis, development of provider payment models and development of a unified health care budget. The 64 members met twice in 2012, and for 2013 will conduct most of its work in small groups addressing four specific technical areas: affordability of care; appropriateness of care; quality assessment; and workforce.

Members of an advisory group meet in Montpelier.

In June, we created the Mental Health and Substance Abuse Technical Advisory Group, which will serve as a resource on technical issues related to the GMCB's work, including the development of provider payment models that support the integration of mental and physical health care. The group of 24 met once in 2012 and meets a second time as this report goes to press.

A third technical advisory group with expertise in Payment Reform, was moved to the GMCB from DFR. The group met twice in 2012.

Act 48 requires that the state "ensure public participation in the design, implementation, evaluation, and accountability mechanism of the health care system." From our first days on the job, GMCB Board and staff have made public engagement a major part of our work. Face-to-face discussions remain a priority: Board members recorded more than 100 events in all corners of Vermont -- speaking with, and listening to, an estimated 4600 Vermonters, including more than 2000 health professionals and nearly 400 business people. In one key event – a rate review forum for businesses co-hosted by the Lake Champlain Regional Chamber of Commerce – a follow-up evaluation (see figure 7) showed unanimous agreement that the Board had provided ample opportunity for attendees to make comments and have questions answered.

Figure 7: Survey responses from business forum participants

2. Please give your opinion of how well the event accomplished its goals. Create Chart Download

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Response Count
The forum helped me better understand insurance rate review.	20.0% (3)	**60.0% (9)**	13.3% (2)	6.7% (1)	0.0% (0)	15
The forum helped me see how I can play a role in rate review.	13.3% (2)	**53.3% (8)**	26.7% (4)	6.7% (1)	0.0% (0)	15
The forum provided an opportunity for my comments to be heard.	40.0% (6)	**60.0% (9)**	0.0% (0)	0.0% (0)	0.0% (0)	15
The forum provided an opportunity for me to ask questions.	**60.0% (9)**	40.0% (6)	0.0% (0)	0.0% (0)	0.0% (0)	15
The presenters answered audience questions well.	**50.0% (8)**	43.8% (7)	6.3% (1)	0.0% (0)	0.0% (0)	16
					Comments Show Responses	4
					answered question	**16**
					skipped question	**0**

Work on the formal Public Outreach & Engagement plan began in October, 2011 and culminated in Board approval in November, 2012. Created with help of a Vermont consultant to the Board and a team provided by the Robert Wood Johnson Foundation, the plan received input from key stakeholders during a public comment period. The plan's goal is "to educate, engage and listen to Vermonters regarding health system reform so that they understand what reform means for them and can take an active role in shaping the board's work to improve health care and moderate cost." The plan ensures transparency in all the GMCB does and puts the Board on track to reach out to Vermonters in numerous ways:

- Additional speaking events that ensure full geographic coverage of Vermont, with special attention to "core audiences" who can help encourage broad, informed discussion of health system reform in Vermont. A top priority is a new slate of public meetings for 2013. We are working on plans for a "listening tour" that will occasionally have the board conducting its regular meeting in locations around the state – providing more Vermonters a chance to sit in on meetings and giving the Board greater insight into local issues.

- Publications and digital media (especially an increasingly robust web site) that continue to explain the board's work and encourage public input in plain, compelling language.

- Continued presentation of the GMCB Dashboard and other health system data in a way that is accessible and puts information in context.

- Consistent, sustained evaluation of efforts, including careful attention to Vermonters' feedback on the effectiveness, transparency and responsiveness of engagement. This feedback will be gathered through public comment, face-to-face discussion, and evaluation tools.

The GMCB Public Outreach and Engagement Plan is available at:
http://gmcboard.vermont.gov/sites/gmcboard/files/PublicOutreachEngage110112.pdf

A specific issue that emerged in the development of the plan is the need for better methods to track the progress of insurance rate review filings as they move through a two-tiered process involving both the Department of Financial Regulation and GMCB. This is being addressed with the help of the Rate Review team and staff in the Department of Financial Regulation: We are posting an RFP for a contractor to build a joint website that will provide seamless access. (For more on rate review, read our newest Green Mountain Guide here:
http://gmcboard.vermont.gov/sites/gmcboard/files/RRGuide.pdf.)

Health Information Technology Plan

During 2012, the GMCB authorized changes to Vermont's Health Information Technology Plan that will improve patient care by enabling safe sharing of medical records among health care providers. In late August 2012, the Administration submitted a proposed HIT plan for the Board's review and approval, as required by Act 48. After stakeholders raised questions regarding patient consent and certain other aspects of the plan, the Administration withdrew the plan and worked with stakeholders to address those questions. On October 25, 2012, the Board approved the Administration's revised policy, which addressed the concerns raised in August.

Workforce Plan

During 2012, the GMCB approved a Workforce Strategic Plan that calls for better data gathering on the need for, and supply of, health care providers in Vermont and outlines specific strategies for strengthening provider supply as evidence of unmet need or anticipated shortages are identified. The Administration continues to develop a Workforce Strategic Plan for the GMCB's review and approval, as required by Act 48. Based on discussion at the August 2nd GMCB meeting, the Administration is expected to highlight the need for more-robust data collection of all health professions to ensure the workforce meets the needs of Vermonters. The GMCB received the Administration's Workforce plan on January 3rd and approved it with changes on January 9th.

GMCB Priorities for 2013

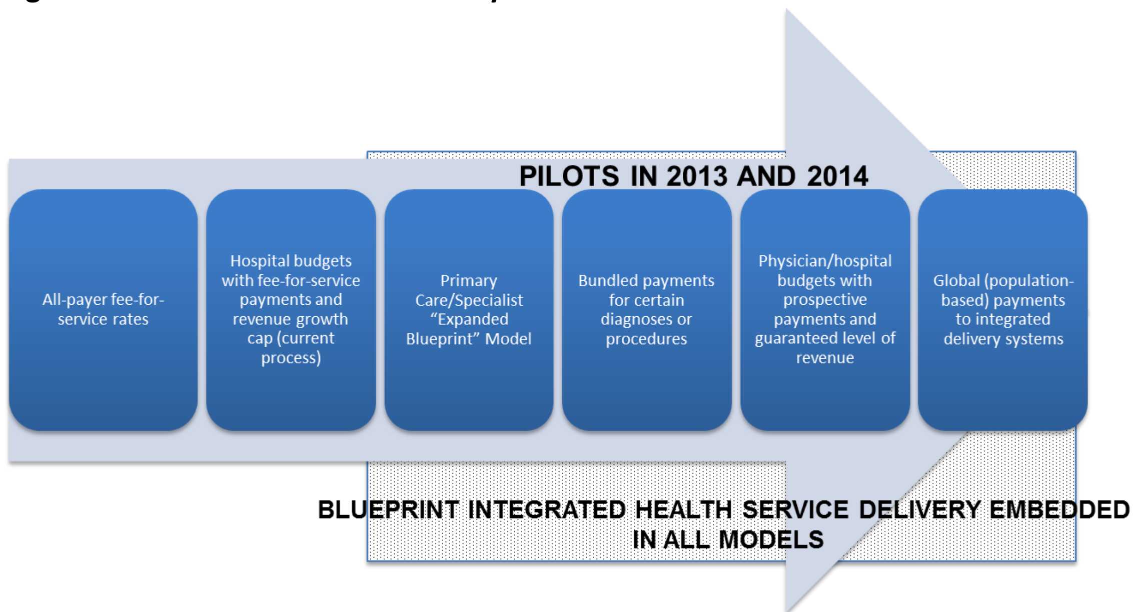
After a year of getting our feet on the ground, organizing ourselves and interacting with Vermonters, the members of the Green Mountain Care Board are eager to move forward with more effective and better informed efforts to implement our charge.

The GMCB's priorities for advancing our charge in 2013 include:

1. **Continue to develop meaningful health care cost containment through payment and delivery system reform and improved regulatory oversight.**

The GMCB will work in 2013 to implement the full range of payment reform pilots we have been designing, and to expand some of the pilots in scope. Further development of providers' health information technology – both continued installation of electronic health records in individual practices, and development of the state's health information exchange (HIE), which will serve to make EHRs capable of "interoperability" (talking to each other) – is essential to this effort, and we therefore will remain focused on tracking those efforts. Figure 8 below depicts this continued development.

Figure 8 Evolution of Health Care Payment Models



We plan to release the State Health Care Expenditure Analysis in February, examining sources of health care cost growth in 2011 with valid system-wide data and targeting priorities for reduced growth. In addition, we have contracted with an actuarial firm to develop a more advanced model of health care cost forecasting, and the model will be made available during the first quarter of 2013. The model

will allow us, among other things, to estimate the impact of targeted reforms (such as a concerted effort to reduce emergency department use) on health care costs.

Improving the consistency, transparency and effectiveness of the health insurer rate and hospital budget review processes will be among our highest priorities for the year, as will our efforts to assure that cost-shifting between public and private payers is not exacerbated, and that overall growth is moderated.

2. Begin a broad discussion and more effective state oversight of health planning.

The GMCB assumed responsibility for approval of major capital expenditures through the state's certificate of need (CON) process on January 1. We also are seeking legislative approval this year to assume responsibility for the Health Resource Allocation Plan (HRAP), the major planning document that guides CON review. Looking forward, we will be examining opportunities for multi-year and system-wide CON review and opportunities to incorporate a broader view of health (beyond health care providers and facilities) in health planning.

In addition, we will continue to seek ways to address emerging challenges in health planning, such as:

- How do we ensure that concerns about quality and access, not just efficiency, drive appropriate access to community services as well as factors such as the division of services between local and regional hospitals? This question becomes increasingly important as policies designed to curb cost growth drive greater efficiency, collaboration and development of economies of scale.
- How do we use quality measures to adequately gauge the impact of system changes on Vermonters, particularly those who are most vulnerable and need greatest assurance of the availability of the care they need?
- How do we begin to measure population health, and the factors that affect it, to inform policy decisions?

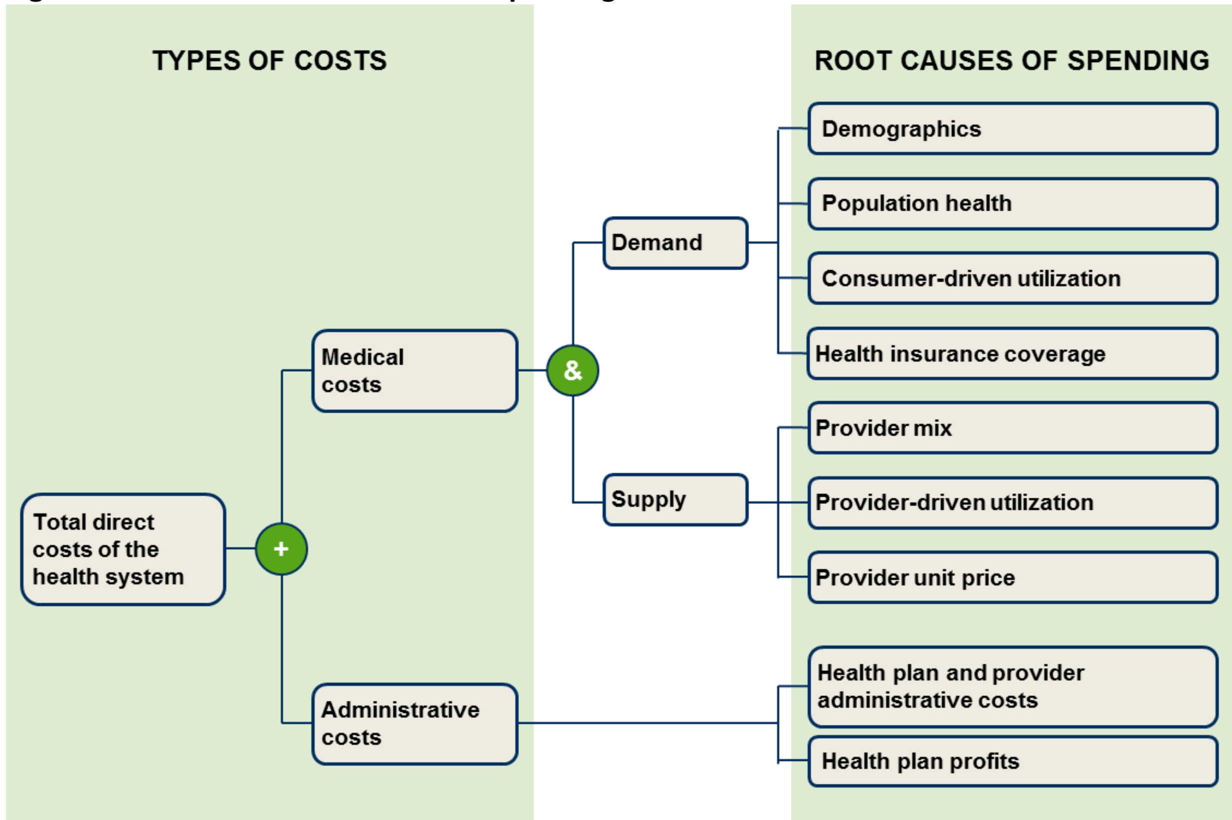
We look forward to a robust discussion with Vermonters about these issues.

3. Continue to improve our ability to objectively monitor and evaluate Vermont health reform efforts.

Evaluation of Vermont health reforms is essential to inform diffusion of specific interventions and development of a more integrated health care system. We are excited by the opportunity presented by the completion of Vermont's All-Payer Claims Dataset, known as VHCURES. Earlier this year Medicaid and Medicare data were added to the dataset, which previously included only private insurance claims data. Use of the Medicare portion of the dataset is still limited by the federal government, but we nonetheless have a greatly enhanced ability to analyze health care expenditures, cost drivers and health care service use in Vermont.

The VHCURES dataset is the foundation for the forecasting model described above. It also will be the focus of work by a new analytic contractor hired by the state to develop analyses of "cost drivers" and health care use in Vermont. In an attempt to identify specific opportunities for cost reduction, either statewide or regionally, the contractor will analyze and adjust for a number of the cost factors illustrated in Figure 9 below.

Figure 9 Root Causes of Health Care Spending



Appendix A
Specific statutory requirements for this report

As outlined in the introduction to this report, Vermont law requires that the GMCB report annually to the legislature on the following subjects:

- Any changes to the payment rates for health care professionals established by the GMCB;
- Any new developments with respect to health information technology;
- Any health system evaluation criteria adopted by the GMCB;
- Any results of the system-wide performance and quality evaluations required of the GMCB;
- Any recommendations for modifications to Vermont statutes; and
- Any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs.

Changes to payment rates for health care professionals established by the GMCB

The GMCB did not make any broad changes to payment rates for health care professionals during 2012. We have been involved in developing several payment reform pilot projects that would change provider payment for specific types of care – for example, providing new payments to both primary care physicians and specialists for improved management of cancer care – but these are limited in either geographic or clinical scope, and, in some cases, are limited to a specific payer (e.g., Medicare or Medicaid).

New developments with respect to health information technology

The GMCB approved a patient consent policy for Vermont's health information exchange in November after considerable stakeholder comment on an earlier draft. In addition, due to the importance of the state's Health Information Exchange to the success of delivery system and payment reform efforts, the chair of the GMCB assumed a seat on the VITL board beginning in December. During 2013 the GMCB will seek to assure that development of the HIE is progressing with necessary speed, and that continued investments by hospitals and other health care providers in electronic health records are well-informed and well-targeted. In the state's application for a federal State Innovation Model grant, the GMCB and the Agency of Human Services proposed a stepped-up state effort to expand the scope and depth of electronic health records, and a stronger system for oversight and coordination of health information technology in Vermont. As noted below, the GMCB is seeking statutory changes that would enable it to review and consider Health Information Exchange connectivity as a factor in the hospital budget review process.

Health system evaluation criteria adopted by the GMCB
In keeping with the Act 48 requirement to evaluate the performance of Vermont's health system, the GMCB in August launched "GMCB Health System Dashboard 1.0." This first iteration presents easy-to-understand analysis of data on 26 key indicators in four critical areas: cost, access to care, healthy lives, and prevention and treatment. It can be found at: http://www.gmcboard.vermont.gov/dashboardproject.

In addition, as part of the development of payment reform pilot projects, the board has identified specific measures of quality, patient experience, and cost that will be used to evaluate the pilots. The GMCB also has formed a broadly-representative Accountable Care Organization (ACO) quality measures working group that will be developing recommendations during 2013 for quality measures to be used in evaluating ACOs. The federal Centers for Medicare and Medicaid Services require reporting on 33 measures of Medicare ACO performance. The GMCB's work group will recommend appropriate modifications to these measures as the ACO model is expanded to Medicaid and private insurance.

Results of the system-wide performance and quality evaluations required of the GMCB

See the description of the Dashboard above.

Recommendations for modifications to Vermont statutes

The GMCB is requesting several modifications to Vermont statutes during the 2013 legislative session. These include proposed legislative changes that would:

- Transfer management of the state's all-payer claims dataset (VHCURES) and the Unified Hospital Discharge Data Set (UHDDS) from the Department of Financial Regulation (DFR) to the GMCB.
- Transfer responsibility for the Health Resource Allocation Plan (HRAP), the state's primary health planning document, from DFR to the GMCB.
- Authorize the GMCB to review and consider Health Information Exchange connectivity as a factor in the hospital budget review process. Create a GMCB billback fund so that the funds the GMCB collects through the its billback authority can be managed.
- Measure the cost shift from one payer to another in the health care system. This is a component of the hospital budget process that should reside with GMCB rather than DFR. The GMCB will be required to submit this information, in conjunction with DVHA, to the Joint Fiscal Office.

Actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs

The most likely impact of federal policy on the work of the GMCB during 2013 will result from Medicare payment policy. Any cuts in Medicare payments to Vermont health care providers, as are anticipated, will create pressure for providers to cut costs and for the GMCB to allow further shifting of costs to private payers. The cost shift borne by private payers in Vermont already is untenable.

On the other hand, CMS is attempting to support payment innovations, some of which are very consistent with Vermont's payment reform efforts. These innovations, including value-based purchasing, bundled payments, accountable care organizations, and the dual-eligible demonstration, could complement and accelerate Vermont's efforts to change provider payment.

In making decisions about the benefits to be offered in Vermont's Health Benefit Exchange, the GMCB was constrained by federal law and regulations. Any changes in or further definition of the federal regulations that govern Essential Health Benefits could impact our work in that arena.

Alignment with the principles of Act 48

Act 48 Principle	GMCB Work Aligned with this Principle
(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.	Much of our work during 2012 was aligned with this principle, including payment reform, hospitals budgeting, benefits standards for the Exchange and health insurer rate reviews.
(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.	Much of our work during 2012 was aligned with this principle, including payment reform, hospitals budgeting and health insurer rate reviews.
(3) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.	The body of this report describes much work to improve transparency and accountability through the GMCB. This includes appointment of numerous advisory committees, open weekly meetings, a new website, explanatory publications for consumers, and more than 100 public events at which GMCB members and their staff explained the Board's work.
(4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities. Other aspects of Vermont's health care infrastructure, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.	Enhancement of primary care has been a specific focus of the GMCB's payment reform policy and investments in strengthening primary care were considered a legitimate exemption from hospital budget constraints.
(5) Every Vermonter should be able to choose his or her health care providers.	All of the GMCB's payment reform efforts preserve patient freedom-of-choice of provider.
(6) Vermonters should be aware of the costs of the health services they receive. Costs	The GMCB has made a major effort this year to educate the public about health care costs.

should be transparent and easy to understand.	
(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.	The GMCB has commissioned consulting work this year to understand how health determinants such as the environment, personal behavior and socio-economic status affect health care costs and outcomes. We will continue to look for ways to incorporate this knowledge in our policy and regulatory decisions.
(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.	Our payment reform pilots aim to incorporate both best practices identified by health care practitioners and shared patient/provider decision-making.
(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.	Development of data systems and analytic capacity to support evaluation of health reform has been a major focus for the GMCB in 2012.
(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.	Identifying drivers of health care cost growth, and areas in which our system can be more efficient, are central to our payment reform and cost control efforts.
(11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.	The balance between provider solvency and sustainable cost control and the equitable sharing of costs across Vermonters have been at the heart of the GMCB's efforts to establish reasonable hospital budgets and insurer rates.
(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.	The balance between provider solvency, patient access, and sustainable cost control has been at the heart of the GMCB's efforts to establish reasonable hospital budgets and insurer rates.
(13) Vermont's health care system must operate as a partnership between	The GMCB has brought numerous constituencies into our decision-making

consumers, employers, health care professionals, hospitals, and the state and federal government.	processes through public meetings, targeted outreach and general public education. In addition, working across state agencies to achieve alignment of our policies has been a major focus.

Appendix B
GMCB 2012 Meeting Topics and Presenters

Meeting Date	Topics
1/3/12	Briefing on the Rochester, New York hospital experience with payment reform by Al Charbonneau (former director of the Rochester Health Commission)
1/10/12	Presentation on work plan by Anya Rader Wallack
1/17/12	Presentation on rate review process by Al Gobeille, GMCB, and Cliff Peterson, Special Assistant Attorney General as Legal Advisor to the Board and General Counsel at Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA); and Engagement plan presented by Karen Hein, GMCB
1/19/12	Briefing on health insurance solvency by Susan Donegan, Deputy Commissioner of Insurance at Vermont Department of Banking, Insurance, Securities & Health Care Administration and Kaj Samsom, CPA CFE, Director of Insurance at Vermont Department of Banking, Insurance, Securities & Health Care Administration; Briefing on Rate Review by Clifford Peterson, Special Assistant Attorney General as Legal Advisor to the Board and General Counsel, Vermont Department of Banking, Insurance, Securities, and Health Care Administration
1/24/12	Update on Vermont Department of Health Initiatives by Dr. Harry Chen, Commissioner, VDH; Briefing on Payment Reform Policy, Richard Slusky, Director of Payment Reform, GMCB
1/26/12	Discussion on Expenditure Analysis with Mike Davis and Lori Perry, GMCB
1/31/12	Briefing on Home Health Care, Peter Cobb, Executive Director for Vermont Assembly of Home Health Agencies
2/2/12	Briefing on HIT Plan by Hunt Blair, Deputy Commissioner, Health Care Reform for the Department of Vermont Health Access
2/7/12	Presentation on rate review regulation and regulatory oversight by Nancy Turnbull, Senior Lecturer on Health Policy and Associate Dean for Educational Programs at Harvard School of Public Health
2/9/12	Introduction to MVP Healthcare by Bill Little on behalf of MVP Healthcare; Briefing on Revised Proposed Payment Reform Policies Regarding Pilots by Richard Slusky, Director of Payment Reform, GMCB; Briefing on Rate Review Regulation, Al Gobeille, GMCB, and Georgia Maheras, Executive Director, GMCB
2/14/12	Introduction to Blue Cross Blue Shield of Vermont (BCBSVT) by Kevin Goddard, VP of External Affairs, Don George, President & CEO , and Catherine Hamilton, PhD, VP of Planning on behalf of BCBSVT
2/16/12	Briefing on Public Engagement by Karen Hein, GMCB member and Robin Lunge, Director of Health Care Reform; Briefing on Payment Reform Initiatives by contractors Michael Bailit from Bailit Health Purchasing, Mark Podrazik from Burns & Associates, and Robert Murray from Global Health Payment
3/1/12	Briefing on Rate Review Regulations by Al Gobeille, GMCB; Benefits discussion by Robin Lunge, Director of Health Care Reform and Kate Bazinsky, Bailit Health Purchasing, LLC

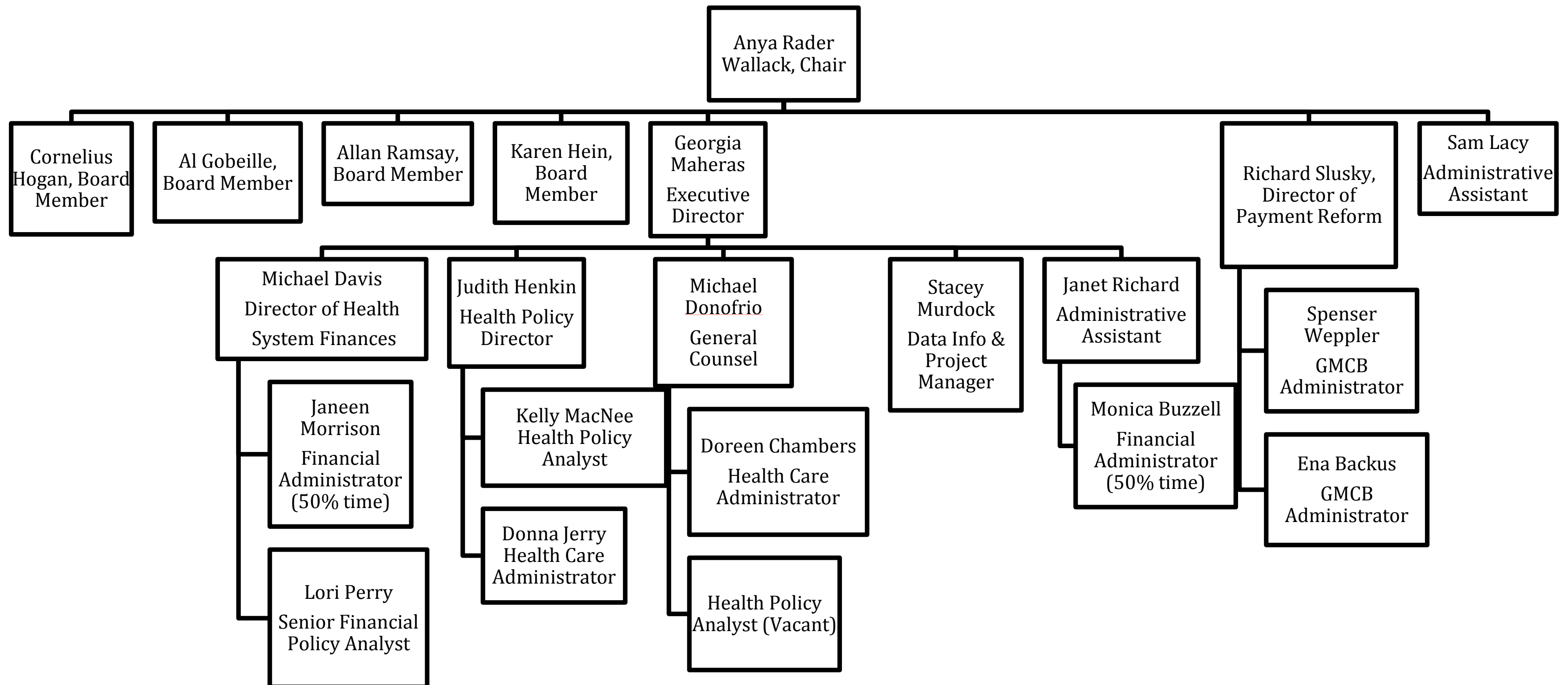
Meeting Date	Topics
3/8/12	Payment Reform Pilot Evaluation Measures by Anya Rader Wallack and Richard Slusky, GMCB; Briefing on the Hospital Budget Process by Con Hogan, GMCB; Discussion on Draft Rate Review
3/13/12	Update on the dual eligible project by Mark Larson, Commission of DVHA; Discussion of the dual eligible project and SASH by Nancy Eldridge, Executive Director, Cathedral Square Corporation; Updated on the HIT plan, Hunt Blair, Deputy Commissioner, Health Reform & State HIT Coordinator
3/15/12	Briefing on the Blueprint Annual Report, Craig Jones, Director of Blueprint, DVHA
3/20/12	Briefing on Substance Abuse Programs, Barbara Cimaglio, Deputy Commissioner of Alcohol and Drug Abuse Programs at the Department of Health; Briefing on IBM's integrated health services, Kyu Rhee, MD, MPP, Vice President, Integrated Health Services, IBM Corporation
3/27/12	Discussion regarding Vermont's Health Insurance Exchange by Lindsey Tucker, Deputy Commissioner, DVHA; Update by Anya Rader Wallack, GMCB, on the Board's Strategic Public and Stakeholder Engagement Plan
3/29/12	Briefing on benefits by Karen Hein, GMCB
4/3/12	Briefing on Mental Health Integration by Dr. Andrew Pomerantz, Director of VA Mental Health Integration; Briefing on 2010 Vermont Health Care Expenditure Analysis by Mike Davis, GMCB
4/5/12	Briefing on Rate Review in Rhode Island by Chris Koller, Rhode Island Health Commissioner; Discussion with Georgia Maheras, Executive Director, GMCB, on contracts
4/12/12	Discussion of the Public Service Board by Michael Dworkin, Former PSB Chair; Discussion on RFPs with Georgia Maheras, Executive Director, GMCB; Briefing on Rate Review rule by Michael Donofrio, General Counsel, GMCB
4/17/12	Briefing on the Public Service Board by Jim Volz, Chair of the Public Service Board and George Young, Director of Policy at the Public Service Board
4/19/12	Introduction of the Vermont Campaign for Health Care Security by Peter Sterling, Executive Director and Donna Sutton Fay of the Vermont Campaign for Health Care Security; Discussion of Workforce Strategic Plan by Davis Reynolds from the Department of Financial Regulation and Craig Stevens from JSI
5/1/12	Discussion with the Community Health Team from Bennington about the Blueprint for Health
5/3/12	Discussion of Mental Health with Patrick Flood, Commissioner DMH
5/8/12	Discussion about public participation in GMCB regulatory processes by: John Beling, Department of Public Service, Public Advocacy Division; and Trinka Kerr and Lila Richardson, Health Care Ombudsman's Office
5/10/12	Discussion about primary care with: Denis Barton, Director, Office of Primary Care and Area Health Education Centers (AHEC) Program; Dr. Charlie MacLean, Associate Dean for Primary Care, UVM College of Medicine; Steve Trombley, CEO and Rep. Jill Krowinski, Public Affairs Director of PPNNE; and Dr. Hannah Rabin, Richmond Family Medicine; Discussion on memorandums and contracts

Meeting Date	Topics
5/15/12	Discussion on Mental Health integration with Alice Silverman, MD, Board President and Sue Deppe, MD, Co-chair, Health Care Reform at the Vermont Psychiatric Association; and Rick Barnett, Psy. D., President of the Vermont Psychological Association; and Rilla Murray, National Association of Social Workers, Vermont Chapter
5/17/12	Discussion on health care quality measurement and reporting by Catherine Fulton, Executive Director, VPQHC and Deb Wilcox, Director of Planning and Health Care Quality, Vermont Department of Health
5/22/12	Discussion about Duals Integration with Julie Tessler, Vermont Council of Development and Mental Health Services; Peter Cobb Executive Director VAHHA, Ralph Provenza, Executive Director of the United Counseling Services
5/29/12	Discussion about hospital financing by Bob Murray, Global Health Payments; Hospital discussion with CEOs Dr. John Brumsted from Fletcher Allen Health Care, Tom Huebner from Rutland Regional Medical Center, and Kevin Donovan from Mt. Ascutney Hospital; Discussion and vote on draft Rate Review rule
6/5/12	Overview of H. 559 by Georgia Maheras, Executive Dir. and Michael Donofrio, General Counsel, from GMCB; Discussion on RFP and a contract
6/14/12	Briefing on the GMCB Analytic Plan Report by Steve Kappel of Policy Integrity and Cindy Thomas of Brandeis; A discussion of Massachusetts cost containment and data analysis by Anna Gosline, Director of Policy and Research Blue Cross Blue Shield of Massachusetts Foundation; Briefing on of St. Johnsbury payment reform pilot by Richard Slusky, Director of Payment Reform, GMCB; Discussion on a contract
6/21/12	Briefing on Certificates of Need and Insurance Carrier Rate Review, by Judy Henkin, GMCB; Updates on Payment Reform by Richard Slusky, Director of Payment Reform, GMCB, and Robert Murray, Global Health Payment; Briefing on Hospital Budgets by Mike Davis, GMCB; Discussion on Rulemaking by Michael Donofrio, General Counsel, GMCB
7/12/12	Discussion on Certificates of Need and Insurance Carrier Rate Review by Judy Henkin, GMCB; Update on Rulemaking by Michael Donofrio, General Counsel, GMCB
7/26/12	Briefing on Hospital budget submission by Mike Davis, GMCB, and Lori Perry, GMCB;
8/2/12	Update on Workforce Strategic Plan by David Reynolds, DFR, and Craig Stevens, JSI; GMCB Dashboard of Key Indicators by Cy Jordan, Georgia Maheras and Con Hogan, GMCB; Discussions on Rate Review by Judy Henkin and Ena Backus, GMCB; Briefing on applying for CMMI grant by Anya Rader Wallack, GMCB
8/9/12	Discussion of Exchange Benefits with Robin Lunge, Dir. of Health Care Reform, Agency of Administration and Julie Peper, Wakely Consulting, and Mark Larson, Commissioner, DVHA; Discussion of the VHCURES Business Intelligence Tool by Tom Crompton, DFR and Andrew Bourret, Onpoint
8/14/12	Presentation on Hospital budget by Mike Davis, GMCB

Meeting Date	Topics
8/21/12	Update on Hospital Budget Decision Tree by Anya Rader Wallack, GMCB; Update by Judy Henkin, GMCB, on Certificate of Need Regulation
8/30/12	Discussions on hospital budgets with some Hospitals; HIT discussions with Hunt Blair, DVHA, and Paul Harrington, VT Medical Society; SIM Update by Anya Rader Wallack, GMCB
9/6/12	Discussion of hospital budgets with John Brumsted, FAHC; Exchange Benefits Discussion with Robin Lunge, Dir. Of Health Care Reform, Agency of Administration, Mark Larson, Commissioner, Department of Vermont Health Access, and Julie Peper, Wakely Consulting; Briefing on Rulemaking by Michael Donofrio, General Counsel, GMCB
9/11/12	Discussion on Hospital Budgets
9/13/12	Discussion and vote on Hospital Budgets; Discussion on contracts
9/20/12	Discussions on Benefits with Susan Gretkowski from MVP, and Ellen Yakubik, Director of Marketing, and Kelly Sullivan, Product Development from Blue Cross Blue Shield of Vermont; and Robin Lunge, Director of Health Care Reform; and Lindsey Tucker, Deputy Commissioner for the Health Benefit Exchange, Department of Vermont Health Access
9/27/12	Update on Public engagement plan by Rich Blount; Discussion on Hospital Budget Orders and update on rulemaking with Michael Donofrio, General Counsel, GMCB; Discussion on a grant and contracts
10/4/12	Discussion and vote on Benefits plans with Robin Lunge, Director of Health Care Reform; Mark Larson, Commissioner of the Department of Vermont Health Access; Updates on contract
10/18/12	Presentation on Health Insurance Coverage and Cost Report by Lisa Ventriss, President, Vermont Business Roundtable, Don George, CEO, Blue Cross Blue Shield of Vermont, and Jack Hoffman from Public Assets Institute
10/25/12	Update on Health Information Exchange by Robin Lunge, Director of Health Care Reform and Mark Larson, Commissioner, DVHA; Presentations and discussions regarding Pharmacy by Robin Lunge, Director of Health Care Reform and Mark Larson, Commissioner, DVHA, Nancy Hogue, DVHA; David Dederichs and Adam Kautzner, Express Scripts, Charles Storrow, KSE Partners; Brian Murphy and Dr. Robert Wheeler, Blue Cross Blue Shield of Vermont; and Theo Kennedy, Otis & Kennedy, LLC and Jeff Hochberg, Rutland Pharmacy
11/1/12	Presentation and discussion on updated Public engagement plan with Rick Blount; Discussion with Michael Donofrio, General Counsel, GMCB, on rulemaking
11/8/12	Presentation on Shared Decision Making by Dr. James Weinstein, CEO & President, Dartmouth Hitchcock Medical Center; Discussion of Copley Hospital Budget with Mel Patashnick, President, Copley Hospital; Discussion on rulemaking with Michael Donofrio, General Counsel, GMCB
11/15/12	Discussion of Copley Hospital's Budget with Mel, Patashnick, Copley Hospital; Update on CIGNA's participation in payment reform pilots by Richard Slusky, Director of Payment Reform, GMCB; Discussion with Michael Donofrio, General Counsel, GMCB, on rulemaking; Discussion on RFPs and contracts

Meeting Date	Topics
11/29/12	Discussion with Jim Daily, Jean Cotner, Marilyn Olejnik from Porter Hospital regarding FY13 budget; Update on Payment Reform from Richard Slusky, Director of Payment Reform, GMCB; and Rulemaking update by Michael Donofrio, General Counsel, GMCB
12/6/12	Briefing on 2012 Massachusetts Health Care Reform by Brian Rosman, Research Director, Health Care For All ; Update on work related to Unified Health Care Budget with Val Bassett, Consultant; Discussion on contracts
12/13/12	Presentation on Volume-Driven Hospital Model and Payment Reform by Steve Rauh, independent health policy consultant and member of GMCB Advisory Committee; Discussion with Robert Murray, Global Health Payments on Unified Health Care Budget; Briefing by Lindsey Tucker, Deputy Commissioner, Health Benefit Exchange, DVHA on Exchange Benefits: Habilitative Services and Pediatric Vision; Update on Rulemaking by Michael Donofrio, General Counsel, GMCB
12/20/12	Presentation on Exchange Benefits: Habilitative Services by Mark Larson, Commission, DVHA; Payment Reform update done by Richard Slusky, GMCB; discussion on Unified Health Care Budget with Robert Murray, Global Health Payments; Update on CON and its transfer from DFR to GMCB by Michael Donofrio and Judy Henkin, GMCB

Appendix C
GMCB organizational chart and budget



GMCB FY 13 and Proposed FY 14 Budgets

Note: a significant increase in the GMCB's budget is proposed for FY 14, but the increase is accounted for entirely by a combination of time-limited grant funds and transfers of functions (and their associated funds) from the Department of Financial Regulation to the GMCB. The general fund allotment to the GMCB is proposed to be virtually flat from FY 13 to FY 14.

Department	Positions	FY13 Estimated Expenditures	FY14 Proposed Expenditures
Green Mountain Care Board	21	2,476,015	6,897,471
General Fund		467,038	473,118
Special Fund		392,352	1,010,428
Global Commitment		1,477,740	3,053,463
Interdepartmental Transfer (from DFR and DVHA MOUs)		138,885	3,053,463
Expenses by category			
Personal Services: Personnel Salary and Fringe		1,672,742	2,333,288
Personal Services: Third Party Contracts		526,475	4,275,007
Operating Expenses		276,798	289,176

Appendix D
GMCB Health Insurance Rate Review and Hospital Budget Decisions, 2012

Company Name	Type of Coverage	Approved Effective Date	Rate Requested	Rate Approved	# of Members Affected by Filing
Blue Cross Blue Shield of VT	Small Group	3Q12	-2.97%	-5.70%	3
Blue Cross Blue Shield of VT	Safety Net Rate	3Q12	-5.20%	-6.50%	1,189
The Vermont Health Plan	Large Group Rate	3Q12	4.30%	2.30%	2,710
The Vermont Health Plan	Small Group Rate	3Q12	5.50%	3.40%	1,227
MVP Health Insurance Company	Nongroup Indemnity Rate	3Q12	-4.10%	-6.50%	660
MVP Health Insurance Company	PPO/EPO Manual Rate	3Q12	9.10%	9.10%	1,102
MVP Health Insurance Company	Small Group PPO/EPO	3Q12	10%	9.97%	1,872
Blue Cross Blue Shield of VT	Combined Trend	3Q12	4.00%	3.67%	14,664
Blue Cross Blue Shield of VT	Administrative Trend	3Q12	2.90%	2.90%	14,664
MVP Health Plan	Small Group HMO	3Q12	8%	8%	48
MVP Health Plan	Large Group HMO	*N/A*	-4.70%	*Disapprove*	24
MVP Health Insurance Company	Catamount Rate	*N/A*	12.80%	*Disapprove*	600
Blue Cross Blue Shield of VT	Catamount Rate	3Q12	0%	0%	14,098
Blue Cross Blue Shield of VT	Combined Trend	4Q12	3.40%	3.10%	14,664
Blue Cross Blue Shield of VT	Administrative Trend	4Q12	2.90%	2.90%	5,669
Blue Cross Blue Shield of VT	Merit Rating Formula	2013	(Formula Change)	N/A	N/A
Blue Cross Blue Shield of VT	Safety Net Rate Rate *Adjustment*	4Q12-2Q13	1.3%-2.2%	1.3%-2.2%	N/A
MVP Health Insurance Company	Nongroup Indemnity Rate	4Q12	0.80%	0.80%	439
MVP Health Insurance Company	Small Group PPO/EPO	4Q12	14.40%	13.40%	2,302
MVP Health Insurance Company	Large Group PPO/EPO	4Q12	13.70%	13.70%	1,195
MVP Health Plan	Large Group HMO	4Q12	0%	0%	0
MVP Health Plan	Small Group HMO	4Q12	8.80%	8.80%	47
Blue Cross Blue Shield of VT	Vermont Auto Dealers Association	4Q12	4.62%	4.60%	2,330
Blue Cross Blue Shield of VT	Small Group Rate	4Q12	0.00%	0%	0
Blue Cross Blue Shield of VT	Grandfathered & New Business Nongroup	4Q12	-0.40%	0.03%	265
The Vermont Health Plan	Large Group Merit Manual	4Q12	7.40%	7%	849
Blue Cross Blue Shield of VT	Vermont Dental Society	2013	3.30%	3%	218
The Vermont Health Plan	Small Group Rate	4Q12	7.70%	6.90%	934
Blue Cross Blue Shield of VT	Vermont Association of Chamber Executives	2013	11.70%	11%	18,012
Blue Cross Blue Shield of VT	Combined Trend	1Q13 & 2Q13	6.00%	5.20%	39,659
Blue Cross Blue Shield of VT	Administrative Trend and Contribition to Reserve	1Q13	2.9% admin, 2% CTR	2.9% admin, 2% CTR	34,993
Blue Cross Blue Shield of VT	Vermont Health Services Group	2013	13.04%	16.20%	1,093
MVP Health Insurance Company	Small Group PPO/EPO	1Q13	14.50%	12.20%	10,473
	Small Group PPO/EPO	2Q13	14.40%	11.80%	1,270
MVP Health Insurance Company	Large Group PPO/EPO	1Q13	12%	9.80%	7,009
	Large Group PPO/EPO	2Q13	12%	9.50%	592
MVP Health Insurance Company	Small Group HMO	1Q13	9.20%	8.80%	53
	Small Group HMO	2Q13	8.30%	7.60%	8
MVP Health Insurance Company	Large Group HMO	1Q13	4.90%	4.60%	269
	Large Group HMO	2Q13	6.60%	5.80%	2
MVP Health Insurance Company	Nongroup Indemnity Rate	1Q13 & 2Q13	GF 14.7%, NGF 15.5%	GF 10.4%, NGF 11.1%	1,070
MVP Health Insurance Company	New Product Rate Filing	1Q13/2Q13	*No rate change*	*N/A*	0
MVP Health Insurance Company	Healthy Lifestyles Rider	1Q13/2Q13	*No rate change*	*N/A*	0

2012 Approved Hospital Budgets

FY 2013 Vermont Hospital Budgets

Hospital	FY 2013 Approved Total Net Patient Revenue	% Excluding Budget Neutral Exemptions
Brattleboro Memorial Hospital	$65,889,614	0.75%
Central Vermont Medical Center	$155,378,089	3.44%
Copley Hospital	$56,335,433	9.21%
Fletcher Allen Health Care	$1,014,716,512	7.22%
Gifford Medical Center	$62,965,572	3.17%
Grace Cottage Hospital	$18,722,593	6.89%
Mount Ascutney Hospital	$46,919,923	3.35%
North Country Hospital	$75,876,293	-0.22%
Northeastern VT Regional Hospital	$61,601,200	2.89%
Northwestern Medical Center	$83,550,542	9.57%
Porter Medical Center	$68,848,517	10.01%
Rutland Regional Medical Center	$211,476,550	4.50%
Southwestern VT Medical Center	$149,179,382	5.90%
Springfield Hospital	$51,874,106	2.30%
SYSTEM TOTAL	**$2,123,334,326**	5.84%

Appendix E
Full listing of the powers and duties of the Green Mountain Care Board

§ 9372. Purpose

It is the intent of the general assembly to create an independent board to promote the general good of the state by:

(1) improving the health of the population;

(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;

(3) enhancing the patient and health care professional experience of care;

(4) recruiting and retaining high-quality health care professionals; and

(5) achieving administrative simplification in health care financing and delivery.

§ 9374. Board membership; authority

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair and all of the members shall be state employees and shall be exempt from the state classified system. The chair shall receive compensation equal to that of a superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the chair.

(2) The chair and the members of the board shall be nominated by the Green Mountain Care board nominating committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a superior judge. The governor shall not appoint a nominee who was denied confirmation by the senate within the past six years.

(b)(1) The initial term of the chair shall be seven years, and the term of the chair shall be six years thereafter.

(2) The term of each member other than the chair shall be six years, except that of the members first appointed, one each shall serve a term of three years, four years, five years, and six years.

(3) Subject to the nomination and appointment process, a member may serve more than one term.

(4) Members of the board may be removed only for cause. The board shall adopt rules pursuant to 3 V.S.A. chapter 25 to define the basis and process for removal.

(c)(1) No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.

(2) No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member, individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.

(3) The prohibitions contained in subdivisions (1) and (2) of this subsection shall not be construed to prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

(A) being an insurance policyholder or from receiving health services on the same terms as are available to the public generally;

(B) owning a stock, bond, or other security in an entity subject to supervision or regulation by the board that is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the board member chooses the stock, bond, or security; or

(C) receiving retirement benefits through a defined benefit plan from an entity subject to supervision or regulation by the board.

(4) No board member shall, during his or her term or terms on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board.

(5) No board member may appear before the board or any other state agency on behalf of a person subject to supervision or regulation by the board for a period of one year following his or her last day as a member of the Green Mountain Care board.

(d) The chair shall have general charge of the offices and employees of the board but may hire a director to oversee the administration and operation.

(e)(1) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. Members of such advisory group who are not state employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

(f) In carrying out its duties pursuant to this chapter, the board shall seek the advice of the state health care ombudsman established in 8 V.S.A. § 4089w. The state health care ombudsman shall advise the board regarding the policies, procedures, and rules established pursuant to this chapter. The ombudsman shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the board in order to protect patients' and consumers' interests.

(g) The chair of the board or designee may apply for grant funding, if available, to advance or support any responsibility within the board's jurisdiction.

(h)(1) Expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the board shall be borne as follows:

(A) 40 percent by the state from state monies;

(B) 15 percent by the hospitals;

(C) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125;

(D) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101; and

(E) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

(2) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and

comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the board to perform its duties, the chair of the board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however,
any person subject to the board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the chair upon properly being ordered to do so may be assessed an administrative penalty by the chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

§ 9375. Duties

(a) The board shall execute its duties consistent with the principles expressed in 18 V.S.A. § 9371.

(b) The board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the board's proposed methodologies to the house committee on health care and the senate committee on health and welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of state government to engage in additional cost-containment activities to the extent permitted by state and federal law.

(2) Review and approve Vermont's statewide health information technology plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the state to achieve the principles expressed in section 9371 of this title.

(3) Review and approve the health care workforce development strategic plan created

in chapter 222 of this title.

(4) Review the health resource allocation plan created in chapter 221 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board;

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012.

(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning January 1, 2013.

(9) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

(C) in consultation with the department of health and the director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(D) for cost-containment and limiting the growth in health care expenditures;

(E) for determining the adequacy of the supply and distribution of health care resources in this state;

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the board.

(11) Develop the unified health care budget pursuant to section 9375a of this title.

(12) Review data regarding mental health and substance abuse treatment reported to the department of financial regulation pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the mental health technical advisory group established pursuant to subdivision 9374(e)(2) of this title.

(c) The board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the agency of human services, and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the agency of human services shall present a report on the benefit package proposal to the house committee on health care and the senate committee on health and welfare. The report shall describe the covered services to be included in the Green

Mountain Care benefit package and any cost-sharing requirements. If the general assembly is not in session at the time that the agency makes its recommendations, the agency shall send its report electronically or by first class mail to each member of the house committee on health care and the senate committee on health and welfare.
(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

§ 9377. Payment reform; pilots

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for payment and delivery system reform, including the pilot projects established in this section.

(2) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:

(A) payment reform pilot projects should align with the Blueprint for Health strategic plan and the statewide health information technology plan;

(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(C) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(E) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(3) In addition to the objectives identified in subdivision (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

(A) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(B) with input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(c) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

(d) The board or designee shall apply for grant funding, if available, for the evaluation of the pilot projects described in this section.

(e) The board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments, to advise the board in developing and implementing the pilot projects and to advise the Green Mountain Care board in setting overall policy goals.

(f) The first pilot project shall become operational no later than July 1, 2012, and two or more additional pilot projects shall become operational no later than October 1, 2012.

(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the department of financial regulation to the same extent as the requirement to participate in the Blueprint for Health pursuant to 8 V.S.A. § 4088h.

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of financial regulation. Health insurers shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(3) In the event that the secretary of human services is denied permission from the Centers for Medicare and Medicaid Services to include financial participation by Medicare in the pilot projects, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.

(4) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.