GREEN MOUNTAIN CARE BOARD
FY17 Budget Adjustment Presentation
to House Healthcare

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VERMONT
GREEN MOUNTAIN CARE BOARD

Modification of Titles for APM Positions Created in Act 172 of 2016:

Sec. 69. 2016 Acts and Resolves No.172, Sec. E.100(a)(1) is amended to read:
Sec. E. 100 EXECUTIVE BRANCH POSITION AUTHORIZATIONS
(1) In the Green Mountain Care Board – one (1~~) Health Care Statistical Information Administrator~~ Health Policy Analyst, one (1) ~~Health Facility Senior Auditor & Rate Specialist, and~~ Financial Manager II, ~~two (2) Reimbursement Analyst,~~ one (1) Financial Systems Analyst, and one (1) Health Policy Advisor.
EXPLANATION: Change in position titles created in 2016 Act 172 due the evolution of the Board's position requirements to implement the All Payer Model.

Health Policy Analyst – Assistance with coordination, analysis and development of payment and delivery system reform and other health policy initiatives (including the All-Payer ACO Model), and to help with implementation of those initiatives. Operations, reporting, regulatory activity and outreach for the APM and ACO Oversight as outlines in Act 113 of 2016. Identifying and analyzing potential federal policy changes that would support attainment of All-Payer ACO Model financial and quality targets. Designing standardized reports and monitoring strategies to assess impacts of the model on health care access, quality, cost, scale, and financial performance.

Financial Manager II - Work at the direction of the Health Care Systems Finance Director, and to focus on the intersection of hospital budget analysis and analysis of ACO budgets, prescribed for review by Act 113 of 2016. Duties shall include assisting the Director of Health Care Systems Finance in assessing necessary information relevant to both ACO and hospital budget review. Creating standard reporting templates to gather ACO budget information for the Board's review and approval of the all VT Hospitals and ACOs.

Financial Systems Analyst - Work at the direction of the Health Care Systems Finance Director with a focus on methodology development and implementation for All-Payer Rate Review. Assist regulatory team with developing methodology, in collaboration with the Center for Medicare and Medicaid Innovation (CMMI), for Medicare benchmarking for ACOs, as well as commercial and Medicaid Per Member Per Month (PMPM) rate setting. Assist in developing methodology for tracking percentage of hospital budget revenue derived from ACO contracts. Assist in developing methodology for tracking scale of ACO participation and influence on health care cost trends in the State of Vermont. Create standard reports and public facing materials to communicate progress against financial targets.

Health Policy Advisor – Shall the Chief of Health Policy and to perform a variety of duties related to the regulation of ACOs, Hospital Budgets, and Insurance Premium Rate Review, while considering the impact of additional policy proposals and or policy changes at the State and Federal levels. Lead on identifying and analyzing potential state and federal policy changes that could impact on regulation of ACOs, Hospital Budgets, or Insurance Premiums for Vermonters. Assist with ACO certification and budget review required by Act 113, specifically through management of stakeholder participation in the process. Liaison with the Office of the Health Care Advocate regarding its role in ACO Budget Review, Hospital Budget Review, and Insurance Premium Rate Review.

Conversion of 3 positions from Limited Service to Classified Permanent:

Sec. 70. 2016 Acts and Resolves No.172, Sec. E.100(a) is added to read:
(2) The conversion of classified limited service positions to classified permanent status in fiscal year 2017 as follows:
(i) In the Green Mountain Care Board – one (1) Health Policy Director, one (1) Health Policy Analyst, and one (1) Board Legal Technician.

EXPLANATION: Base funding was allocated for these positions in FY 2017 budget; language authorizing permanent status was not included in the final bill. These positions were originally transferred to the Board from DFR in 2013 along with the Federal grant which created the positions. The positions make up 2/3rds of the insurance rate review team at the board and with out them, the Board will have no way to properly carry out is regulatory roles of the review and approval of insurance rates for the state. These positions are set to expire 6/30/2017.

Health Policy Director– Reviews and analyzes insurer rate review recommendations preparing reports for use by the GMC Board in making rate review decisions. Consults on rate filings, prepares reports for use the GMC Board, DFR the Legislature, and other parties. Analyzes and prepares reports on insurer and economic activities. Supports the role the GMC Board as an expert witness at Department and Legislative Hearings through the provision and interpretation of reports. Serves as a source of technical advice on insurer rate review activities. Supervises other staff as assigned. Performs related duties as required.

Health Policy Analyst- Duties include consultation and support on insurance rate review and certificate of need policy issues. Assist in the development of policy initiatives by performing independent policy research, policy evaluation and other programmatic activities to further the organization's goals and objectives. Extensive interaction is required with people and organizations responsible for gathering and reporting data. Work is performed under the general direction of an administrative supervisor.

Board Legal Technician – Duties include providing administrative support for the legal and regulatory functions of a Board. This position involves advanced administrative, technical and coordinating work for a board. Acts as the Boards Public Records liaison and Records Retention Technician. Perform and manage a variety of activities relating to the Boards records management program, including the receipt, storage, retrieval, and disposition of official records in accordance with legal requirements and state records management policies and procedures. Ensures that necessary documents are included in all files before submitting them to the Vermont State Archives & Records Administration. Coordinates in Administrative Rulemaking process for regulations involving the Board.

Medicaid Advisory Rate Case for ACO Services

Sec. 77. 2016 Acts and Resolves No. 113, Sec. 13 is amended to read:

Sec. 13. MEDICAID ADVISORY RATE CASE FOR ACO SERVICES

(a) On or before December 31, 2016 2017, the Green Mountain Care Board shall review any all inclusive population-based payment arrangement between the Department of Vermont Health Access and an accountable care organization for calendar year years 2017 and 2018. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per-member, per-month payment, and any other nonclaims payments. The Board's review may include deliberative sessions to the same extent as allowable under insurance rate review in 8 V.S.A. §4062.

(b) The review shall be nonbinding on the Agency of Human Services, and nothing in this section shall be construed to abrogate the designation of the Agency of Human Services as the single State agency as required by 42 C.F.R. §431.10.

(c) The Board shall review the payment arrangement prior to the finalization of a contract between the Department and the accountable care organization and shall maintain the confidentiality of information necessary to preserve contract negotiations of the parties. The Board shall release its advisory opinion within 30 days of the finalization of the contract between the parties.

(d) The Department of Vermont Health Access shall provide the Board and its contractors such data and information requested by the Board for its review on the timeframe set forth by the Board.

EXPLANATION: The Green Mountain Care Board was provided one year of authority to review Medicaid's ACO payment arrangement in Act 113. With the finalization of the All Payer ACO Model, an extension of this authority is necessary for one year while the Board works to implement new regulatory authority. The Board expects to request statutory changes in 2018.

Last legislative session, the general assembly charged the Green Mountain Care Board (GMCB) with reviewing the Department of Vermont Health Access' (DVHA) per member per month payment arrangement with an accountable care organization (ACO) in support of the All-Payer Model. This was one-time authority in 2017 to test the concept of the review.

The GMCB would like to extend this authority for 2018 and has included language in the Budget Adjustment Act (BAA) proposal to do so (see reverse side). The language includes clarifications to address issues that were raised during the review in 2017, such as clarifying the timing of the review and the GMCB's authority to maintain confidentiality pending contact finalization. The language extends the one-time authority through 2018, in lieu of proposing statutory changes, because the GMCB is in process of developing rules under Act 113 of 2016 for ACO budget review, and intends to propose statutory changes next year once the processes have been finalized. This language has been shared with the new Commissioner and staff at the Department of Vermont Health Access, but has not yet had feedback from the new staff. We will work with DVHA to address any concerns or issues.

The GMCB requested the language as part of BAA because the GMCB anticipates beginning the Medicaid review in March 2018. This timing ensures that the GMCB will have the necessary information to understand the interplay of the DVHA payment to the ACO, payments from other payers, and the ACO's budget. The GMCB will also use this information in the future in its total cost of care analysis and payer differential required under the All-Payer Model.

BAA Funding Request:
Sec. 78. REPEAL
(a) 2016 Acts and Resolves No.172, Sec. E.345.1 is repealed on upon passage of this Act.
EXPLANATION: All Payer Model language currently under the E-Board authority repealed in favor of adding funding through the FY 2017 Budget Adjustment.

Green Mountain Care Board FY17 Budget Adjustment Request

		FY16	FY17
Personnel	GMCB	3,046,113.00	2,766,267.00
	APM 1	319,004.00	356,069.00
	APM 2	-	314,251.00
Operating	Base	574,910.00	711,469.82
	APM 1	63,879.00	78,780.18
	APM 2	-	45,745.00
Contractual	Base	5,187,406.00	5,299,822.00
	APM 1	300,000.00	300,000.00
	APM 2	-	395,000.00
Big Bill Appropriatior		9,491,312.01	9,572,404.00
	Potential FY17 Vacancy Savings		(300,000.00)
Total Need		9,491,312.01	9,967,404.00
Budget Adjustment Request			395,000.00

<u>$300k in APM1 FY17:</u>
consultant to assist with APM negotiations

<u>$395K in APM2 FY17:</u>
~$100k to work with an actuary on the Medicaid rate case for rate validation;
~$75k for data analysis as required by CMMI and ACO Oversight authority for quality and financial reporting as well as monitoring;
~$20k for an analytic assessment to look at data sources and provide a plan to what can be monitored and reported; and
~$300k for APM Modeling to validate Medicare rates

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