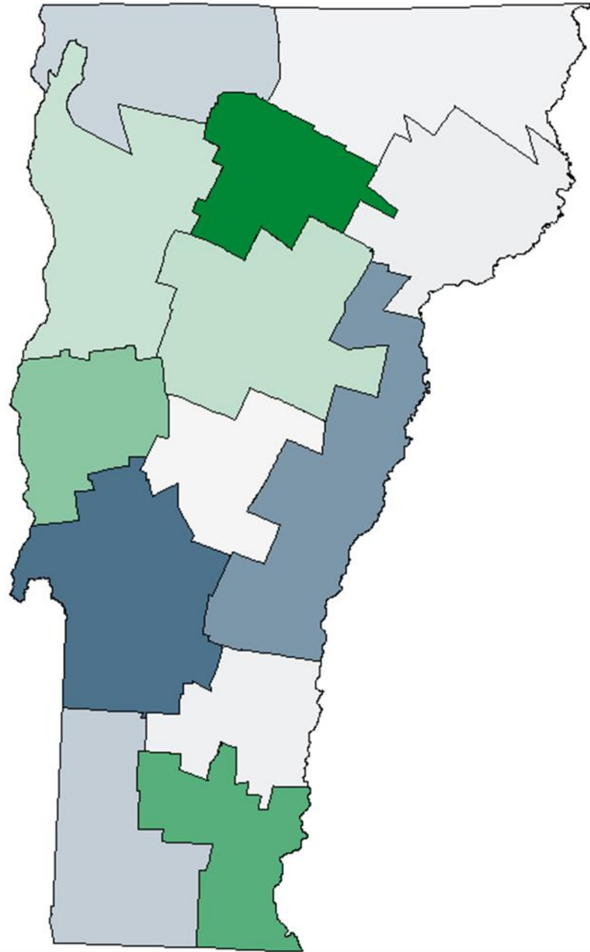


Green Mountain Care Board

House Health Care Committee

Thursday, December 14, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Who is the Green Mountain Care Board?

It is an independent group of five Vermonters who, with their staff, are charged with reducing the rate of health care cost growth in Vermont while ensuring that the State of Vermont maintains a high quality, accessible health care system.

VERMONT
GREEN MOUNTAIN CARE BOARD

Hospital Budget & Exchange Rate Review

Hospital Budget

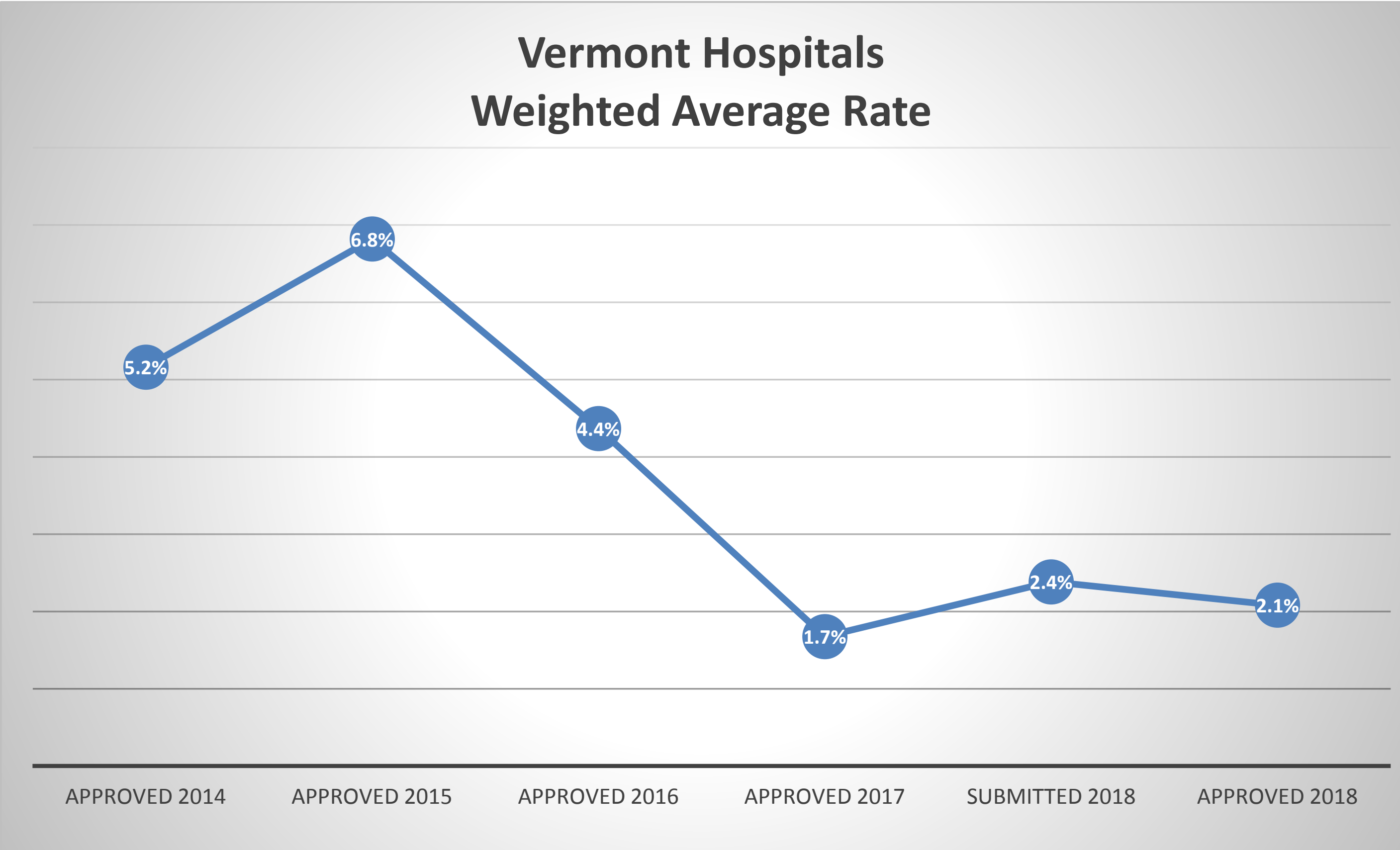
- Hospitals initially requested 3.6% increase, or roughly $86.9 million-dollar increase
- The Board approved a 3.08% NPR increase, or 3.01% after adjusting for physician transfers and/or acquisitions.

Exchange Rate Review

- Blue Cross Blue Shield of Vermont (BCBSVT) requested a 12.7% average annual rate increase.
  - The Board approved a 9.2% average annual rate increase
  - Estimated Dollars Saved = $14,393,199
- MVP requested an 6.7% average annual rate increase
  - The Board approved a 3.4 % Average annual rate increase
  - Estimated Dollars Saved = $1,826,687
- Total Exchange Estimated Dollars Saved = $16.2 Million

Vermont Hospital System
Approved Rate Increases

The hospital rate (price) increases for the last two years have been the lowest increases in 17 years. These rates have a direct effect on commercial insurance rate increases.



VERMONT
GREEN MOUNTAIN CARE BOARD

Certificate of Need (CON) 2017 Decisions

(Please click here for CON webpage)

- Brattleboro Memorial Hospital (Construction of Four-Story Medical Office Building and Replacement Boilers), Docket No. GMCB-001-16con
- Rutland Regional Medical Center (Replacement of Nuclear Medicine Camera), Docket No. GMCB-012-16con
- Southwestern Vermont Medical Center (SVMC Dental Home), Docket No. GMCB-015-16con
- Green Mountain Surgery Center, Docket No. GMCB-010-15con
- BAART Behavioral Health Services, Inc., Docket No. GMCB-011-17con
- The Pines at Rutland Center for Nursing and Rehabilitation, Docket No. GMCB-013-16con.
- VNA & Hospice of the Southwest Region, Docket No. GMCB-008-17con.
- OAS, LLC d/b/a Valley Vista, Docket No. GMCB-004-17con.
- Wake Robin, Docket No. GMCB-024-15con.
- Rowan Court Nursing and Rehab Center, Docket No. GMCB-020-15con.

All-Payer ACO Model: What Is It?

- The All-Payer Model enables the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to pay an Accountable Care Organization (ACO) differently than through fee-for-service reimbursement.
  - Facilitated by state law and an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Medicare's participation

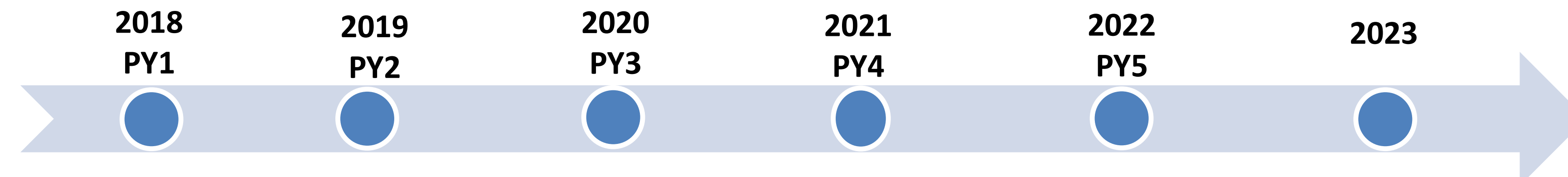
- Provides the opportunity to improve health care delivery to Vermonters, changing the emphasis from seeing patients more routinely for episodic illness to providing longitudinal and preventive care. A more predictable revenue stream supports providers in initiating additional delivery system reforms that improve quality and reduce costs.

Improved Health, Improved Care, Controlled Costs: the "All-Payer Model"

- State action on financial trends & quality measures
  - Moves from volume-driven fee-for-service payment to a value-based, pre-paid model for ACOs
    - ✓ All-Payer Growth Target: 3.5%
    - ✓ Medicare Growth Target: 0.1-0.2% below national projections
  - Requires alignment across Medicare, Medicaid, and participating Commercial payers
  - Statewide quality framework

- Goals for improving the health of Vermonters
  - Improve access to primary care
  - Reduce deaths due to suicide and drug overdose
  - Reduce prevalence and morbidity of chronic disease

VT All-Payer ACO Model Agreement Reporting Timeline



Quarterly, starting in September 2018:
VT reports performance on All-Payer Total Cost of Care per Beneficiary Growth Target (TCOC) to CMS

2018 (PY1)

June 30– Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30– Annual Quality Report

Dec. 31– Assessment of Payer Differential

2019 (PY2)

June 30– Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Public Health Accountability Framework

Sept. 30– Annual Quality Report

Dec. 31– Financing & delivery of Medicaid MH/SA and HCBS

Options to narrow Payer Differential

2020 (PY3)

June 30– Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30– Annual Quality Report

Dec. 31– Optional proposal for subsequent 5-year Model (2023-2027)

2021 (PY4)

June 30– Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30– Annual Quality Report

2022 (PY5)

June 30– Annual TCOC Report

Annual ACO Scale Targets & Alignment Report

Sept. 30– Annual Quality Report

Annual Reports are for prior year

Burgundy font = One-time report

Act 113 of 2016
ACO Budget Criteria Statutory Requirements

(b) (1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives….In its review, the Board shall review and consider:

- Character, competence, fiscal responsibility, and soundness of the ACO and its principals, including reports from professional review organizations
- Arrangements with ACO's participating providers
- How resources are allocated in the system
- Expenditure analysis of previous, current, and future years
- Integration of efforts with Blueprint for Health, community collaboratives and providers
- Systemic investments to:
  - Strengthen primary care
  - Address social determinants of health
  - Address impacts of adverse childhood experiences (ACEs)
- Solvency
- Transparency

Act 113 of 2016
All-Payer Model Criteria for Implementing a Value-Based Payment Model

- Alignment of payers
- Strengthens and invests in primary care
- Incorporates social determinants of health
- Includes process for integration of community-based providers
- Prioritizes use of existing local and regional clinical collaboratives
- Pursues an integrated approach to data collection, analysis, exchange
- Requires process and protocols for shared decision making
- Supports coordination of patient care and care transitions through use of technology
- Ensures consultation with the Health Care Advocate

2018 ACO Budget Review: Timeline

June 23, 2017 – OneCare Vermont and CHAC first submission

July 13, 2017 – OneCare Vermont and CHAC presentations

October 19, 2017 – CHAC submits budget withdrawal

October 20, 2017 – OneCare Vermont second submission

November 2, 2017 – OneCare Vermont second presentation

December 12, 2017 – Staff recommendations

December 21, 2017 – ACO budget (potential vote)

Proposed areas of Legislation 2018

- Certificate of Need Statute
- Health Resource Allocation Plan
- Primary Care Advisory Group (PCAG)
- Billback

Draft legislative proposal for CON

- Why?
  - Updates needed to thresholds, review categories, and enforcement (last update 2003)
  - Streamline CON process and align CON laws with VT health care priorities

- What?
  - Clarify Board delegation to staff
  - Increase monetary thresholds (hospital only)
  - Exclude vs. expedite review of certain capital expenditures
  - Align criteria with statewide health care reform goals and principles
  - Revise enforcement authority

HRAP Proposal(s)

- Current HRAP statute describes a static inventory of a specified set of health care goods and services, with focus on supply; is not a driver of solutions; does not measure gaps or underlying need.

- Suggest more general language that would:
    - Assist GMCB members with analysis and decision-making around Certificate of Need applications, hospital budgets, and ACO budgets in context of larger system.
    - Utilize existing data and data sources.
    - Be more dynamic and up-to-date.