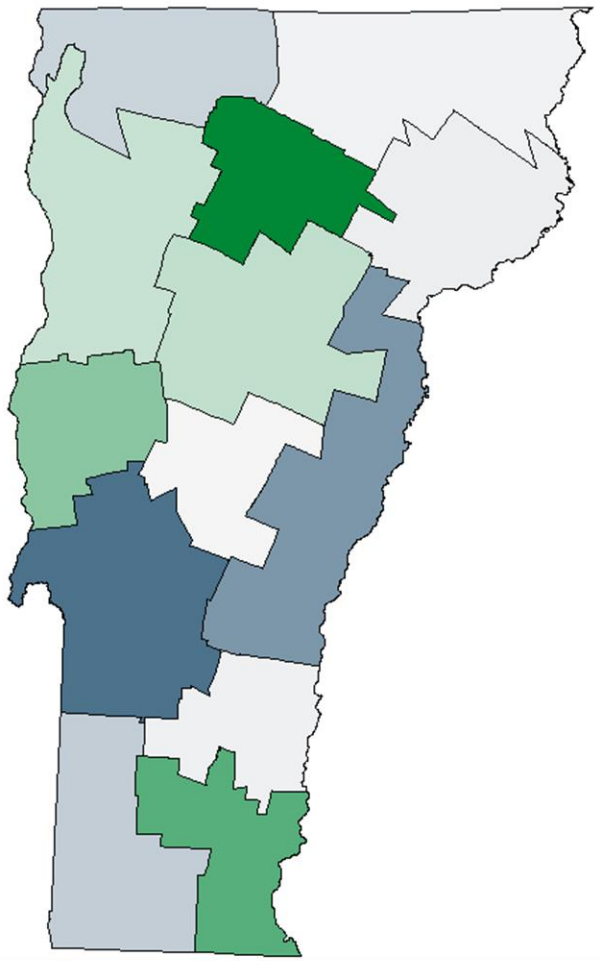


Green Mountain Care Board Overview

Susan Barrett, J.D., Executive Director

House Health Care Committee

January 11, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

What do I want you to come away with from this presentation?

1. An understanding of who the Green Mountain Care Board is and what we do.
2. An overview of the GMCB's role, as prescribed in Act 48 of 2011.
3. An overview of the GMCB's role and duties as prescribed in Act 113 of 2016, and the Vermont All-Payer Accountable Care Organization Model Agreement.

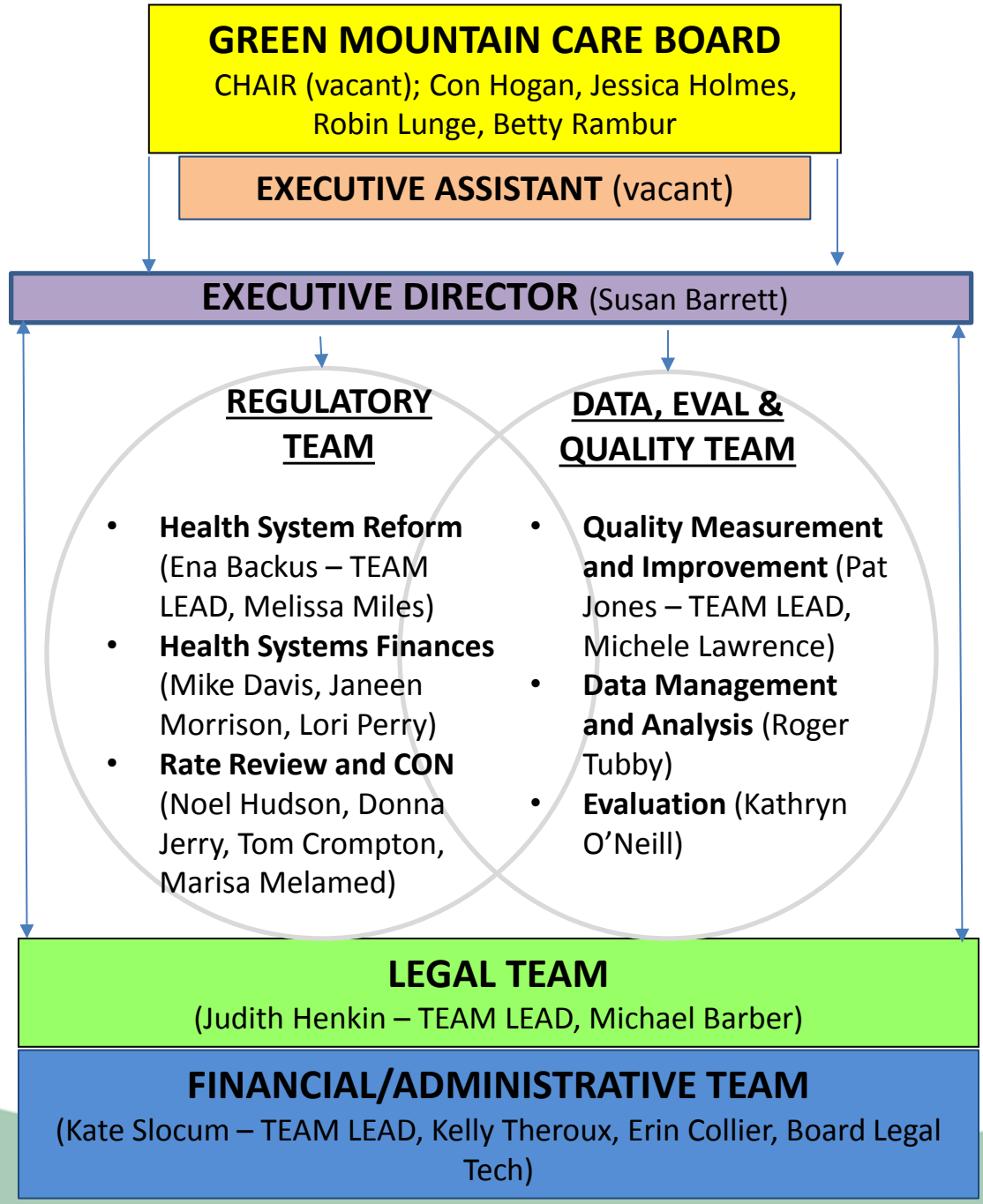
****For more information on the Green Mountain Care Board, please click here for the GMCB webpage.*

Who is the Green Mountain Care Board and what do we do?

The GMCB was created by the Vermont Legislature in 2011 through passage of Act 48.

It is an independent group of five Vermonters and 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.

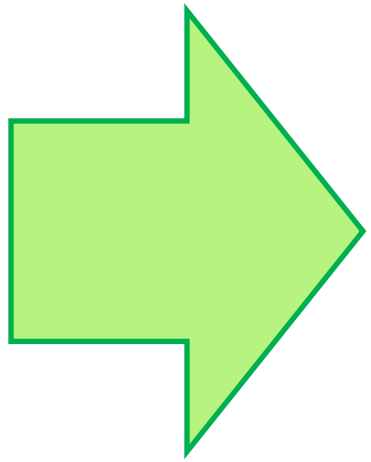
Members are nominated by a broad-based committee and appointed by the Governor with the advice and consent of the Senate. Appointed Members then serve a six year term.

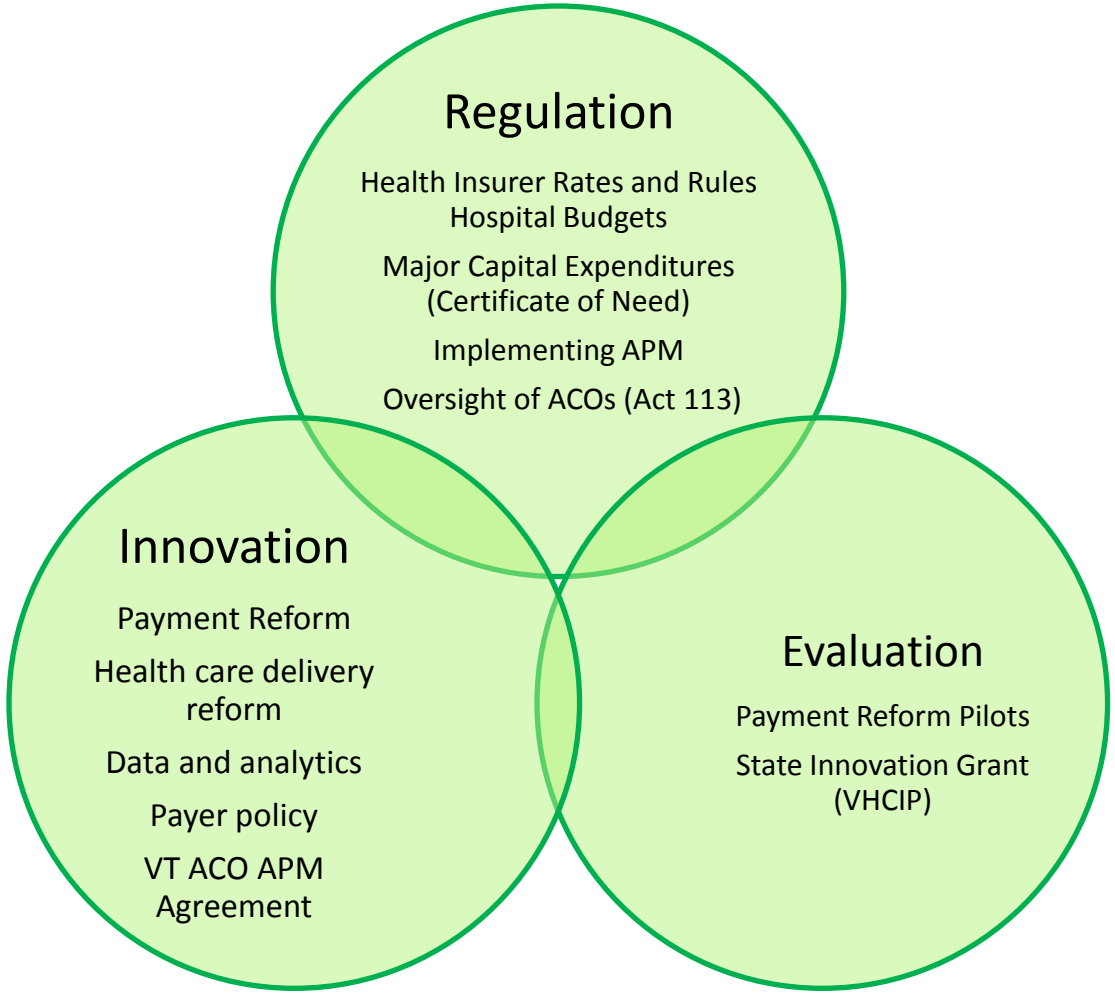

GREEN MOUNTAIN CARE BOARD
CHAIR (vacant); Con Hogan, Jessica Holmes, Robin Lunge, Betty Rambur
EXECUTIVE ASSISTANT (vacant)
EXECUTIVE DIRECTOR (Susan Barrett)
REGULATORY TEAM
Health System Reform (Ena Backus – TEAM LEAD, Melissa Miles)
Health Systems Finances (Mike Davis, Janeen Morrison, Lori Perry)
Rate Review and CON (Noel Hudson, Donna Jerry, Tom Crompton, Marisa Melamed)
DATA, EVAL & QUALITY TEAM
Quality Measurement and Improvement (Pat Jones – TEAM LEAD, Michele Lawrence)
Data Management and Analysis (Roger Tubby)
Evaluation (Kathryn O'Neill)
LEGAL TEAM
(Judith Henkin – TEAM LEAD, Michael Barber)
FINANCIAL/ADMINISTRATIVE TEAM
(Kate Slocum – TEAM LEAD, Kelly Theroux, Erin Collier, Board Legal Tech)

4

What do we do?

The **Green Mountain Care Board** is 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

Regulation

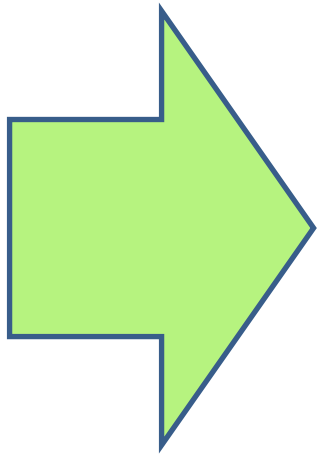
Health Insurer Rate and Rules
Hospital Budgets

Major Capital Expenditures

(Certificate of Need)

Implementation of APM &
Oversight of ACOs (Act 113)

VT ACO Agreement



Factors that
influence decisions:

Affordability
Accessibility
Quality

Insurance Rate Review Process

Background

The Rate Review process is governed by Title 8, Chapter 107 of the Vermont Statutes, and the GMCB's Rule 2.00 (Health Insurance Rate Review). The insurance rate review process begins when an insurance carrier submits a filing to the GMCB.

The GMCB must issue a decision approving, modifying, or disapproving a rate request through a process that must be completed within 90 days.

What determines the GMCB decision?

- ✓ Is the rate affordable?
- ✓ Does the rate promote quality care?
- ✓ Does the rate promote access to care?
- ✓ Is the rate adequate to cover the insurer's costs?
- ✓ Is the rate unjust, unfair, inequitable, misleading, or contrary to law?
- ✓ Is the rate excessive, inadequate or unfairly discriminatory?

Results:

The Board reviewed eleven rate filings in 2016, including two Vermont Health Connect Exchange filings.

The weighted average of all proposed rate increases in 2016 was 7.0%, and the weighted average of all approved increases was 5.7%, saving Vermonter consumers approximately $6.3 million.

Over three years of exchange filings (2014 – 2015, 2015 – 2016, and 2016 – 2017), GMCB Rate Review Process has saved Vermont consumers an estimated $21.8 M ($21,774,047)

****For more information about GMCB Insurance Rate Review, please click here for the Rate Review webpage.*

Certificate of Need (CON) Review Process

Background

The law that governs the Certificate of Need process can be found in Chapter 221 of Title 18 of the Vermont Statutes and in GMCB Rule 4.000.

Process

Vermont law requires that a health care facility must obtain a Certificate of Need (CON) before developing a health care project. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure the provision and equitable allocation of high quality health care services and resources to all Vermonters. The Board has jurisdiction over the CON process for all CON applications filed on or after January 1, 2013.

Results

In 2016, the Board approved ten CON applications, including an emergency CON for the purchase of Burlington Labs, a diagnostic testing facility in Burlington. The Board issued 14 jurisdictional determinations based upon proposals submitted through letters of intent, asserting jurisdiction for seven of the projects. (Applications have since been filed for two of the seven.)

***For more information, please click here for the GMCB, CON webpage.*

Hospital Budget Review Process

Background

Vermont's hospital budgets have been subject to state review since 1983 and have been regulated by the Green Mountain Care Board (GMCB) since hospital fiscal year 2013 (began in October, 2012).

Process

The GMCB's review process is guided by Hospital Budget Rule 3.000 and by the Board's policies on net patient revenue (NPR), community needs assessments, physician transfers, and enforcement found in Hospital Budget Reporting Requirements.

Results

In 2016 for FY 17:

Hospitals initially requested a 5% Net Patient Revenue (NPR) increase.

Once adjustments were made, the Board approved a 3.9% NPR increase.

The Board established commercial rate (price) increases at 1.8% (See Vermont Hospital System Approved Rate Increases chart for more results).

****NPR = Net Patient Revenue is Patient services including tests, procedures, prescription medications and time with providers minus the discounts on payments from payers, minus bad debt and free care.*

****for more information on GMCB Hospital Budget Review Process, please click here for the GMCB hospital budget webpage*

Budgeted Net Patient Revenue for Vermont Hospitals FY 2016-2017

	Unadjusted Net Patient Revenue change				Net Patient Revenue change - adjusted to reflect real growth	
	2016	2017	2017	2016 to 2017	2017	2016 to 2017
	Approved	Submitted	Approved	% Change	* Approved & adj for phys transfers	% Change
Brattleboro Memorial Hospital	$73,896,151	$76,408,611	$76,408,611	3.4%	$76,408,611	3.4%
Central Vermont Medical Center	$173,996,286	$193,220,803	$191,831,143	10.3%	$189,027,073	8.6%
Copley Hospital	$60,987,719	$65,509,894	$65,509,894	7.4%	$65,509,894	7.4%
Gifford Medical Center	$56,201,733	$57,762,429	$57,762,429	2.8%	$57,762,429	2.8%
Grace Cottage Hospital	$18,375,041	$19,205,503	$19,205,503	4.5%	$19,205,503	4.5%
Mt. Ascutney Hospital & Health Ctr	$48,060,871	$47,744,700	$47,744,700	-0.7%	$47,744,700	-0.7%
North Country Hospital	$76,604,320	$81,189,662	$81,189,662	6.0%	$81,189,662	6.0%
Northeastern VT Regional Hospital	$68,095,300	$71,339,400	$71,339,400	4.8%	$71,339,400	4.8%
Northwestern Medical Center	$95,697,390	$102,867,018	$101,935,937	6.5%	$98,855,612	3.3%
Porter Medical Center	$75,581,083	$76,094,922	$76,094,922	0.7%	$76,094,922	0.7%
Rutland Regional Medical Center	$233,248,162	$243,415,448	$243,415,448	4.4%	$241,042,465	3.3%
Southwestern VT Medical Center	$144,025,568	$152,792,211	$152,362,260	5.8%	$150,641,798	4.6%
Springfield Hospital	$55,936,500	$59,147,241	$59,147,241	5.7%	$59,147,241	5.7%
The University of Vermont Medical Center	$1,126,774,924	$1,175,237,274	$1,172,785,845	4.1%	$1,164,016,984	3.3%
Totals for All Hospitals	**$2,307,481,048**	**$2,421,935,116**	**$2,416,732,994**	4.7%	**$2,397,986,293**	3.92%

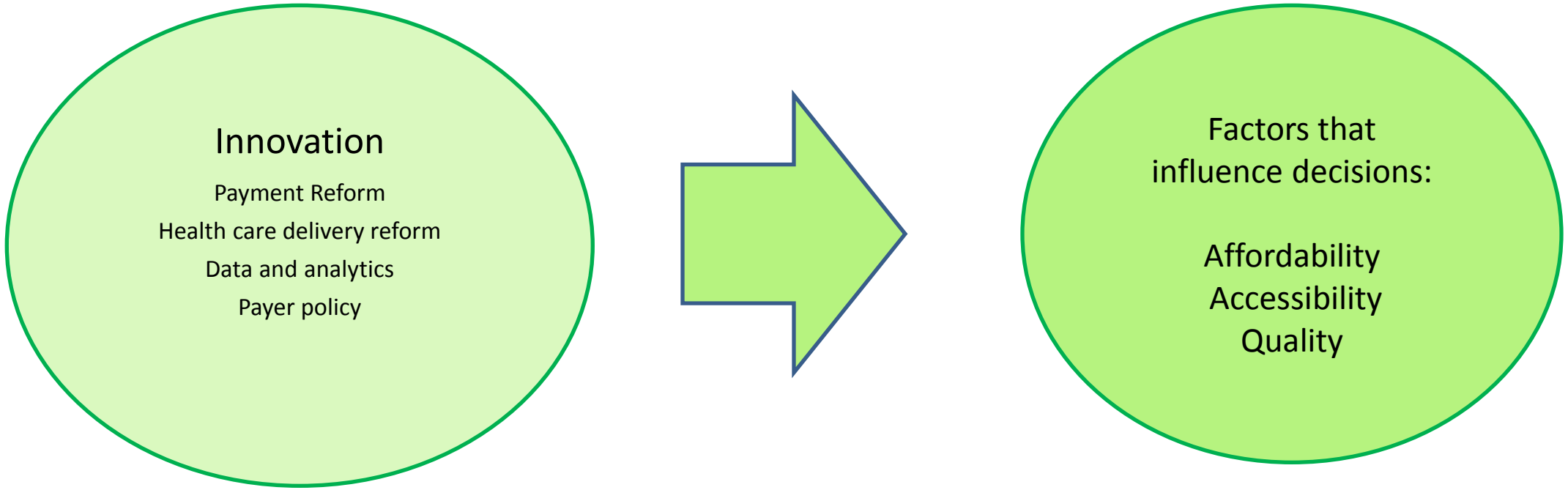
* "Real growth" was calculated by adjusting for physician transfers, which four of the hospitals experienced as follows:
CVMC $(2,804,070), NMC $(3,080,325), RRMC ($2,372,983), SVMC $(1,720,462) and UVMMC $(8,768,861)

National Hospital Snapshot Versus Vermont Hospitals

Hospital Benchmarks
U.S data from Becker's Hospital Review

	U.S Not-for-Profit Hospital 2015 medians	Vermont Community Hospitals	Description
	2015	2015	
Operating surplus %	3.4%	2.8%	Surplus as % of revenues. Industry ranges tend to be between 2% - 4%.
Three-year operating revenue CAGR	5.8%	4.5%	Compounded annual growth rate - revenues.
Three-year operating expense CAGR	5.5%	4.5%	Compounded annual growth rate - expenses.
Annual operating revenue growth rate	7.5%	4.7%	Increase (decrease) over the prior year - revenues.
Annual operating expense growth rate	6.6%	5.0%	Increase (decrease) over the prior year - expenses.
Total debt-to-capitalization	33.7%	27.6%	Lower values are favorable; less reliance on debt.
Current ratio	2.0	2.9	Ability to pay short term obligations; higher values favorable.
Annual debt service coverage	5.2	4.4	Ability to pay debt obligations; higher values favorable.
Capital spending ratio	1.1	1.0	Capital investment measure; cap spending vs. depreciation.
Cash on hand	211.8	137	Measure of liquidity; days of cash available to pay bills w/o collecting more revenue.
Days receivable	48.4	39.4	The average # of days before revenue is collected; measures change in liquidity.
Average payment period	64.3	65.0	Counterpart of Days receivable.
Average age of plant	11	10.6	Measures the age of fixed assets in years; lower values reflect newer investments.

Note: Medians from analysis of 2015 audited financials of 340 free standing hospitals, single-state health systems and multi-state health systems.
www.beckerhospitalreview.com; October 2016


Innovation
Payment Reform
Health care delivery reform
Data and analytics
Payer policy
Factors that
influence decisions:
Affordability
Accessibility
Quality

Payment and Delivery System Reform: The Journey Away from Fee for Service

ACOs and SSPs

- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to work together and be accountable for the cost and quality of care for a defined population

- Shared Savings Programs (SSPs) are payment reform initiatives developed by health care payers. SSPs are offered to providers (e.g., ACOs) who agree to participate with the payers to:
  - Promote accountability for a defined population
  - Coordinate care
  - Encourage investment in infrastructure and care processes
  - Share a percentage of savings realized as a result of their efforts

- Participation in ACOs and SSPs is voluntary

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
  - All payers pay providers using the same payment methodology

- 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.

What does health care look like with Fee-for-Service Payment vs. Value-Based Capitation-Style Payment?

Fee-for-Service

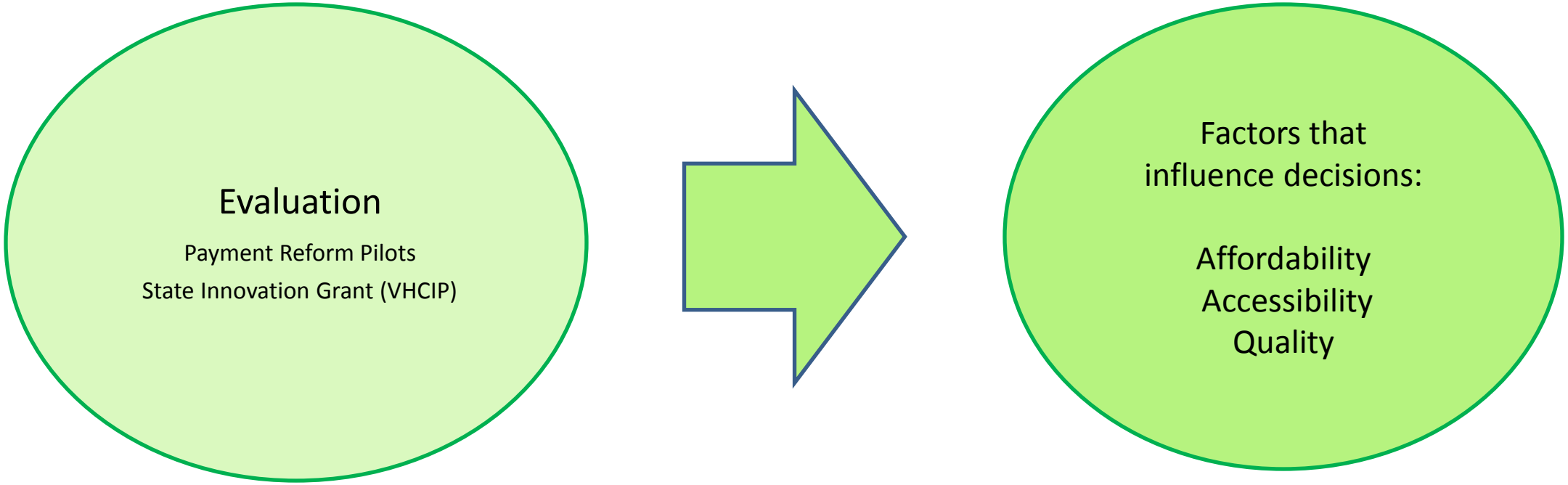
- Each medical service generates a fee
  - Unnecessary services may be provided
- Services that promote health may not be covered
  - phone consultations, time spent making referrals

Value-Based Capitation-Style Payment

- Providers receive a monthly amount to cover the health care services for their patients
- Providing services that promote health increases system efficiency

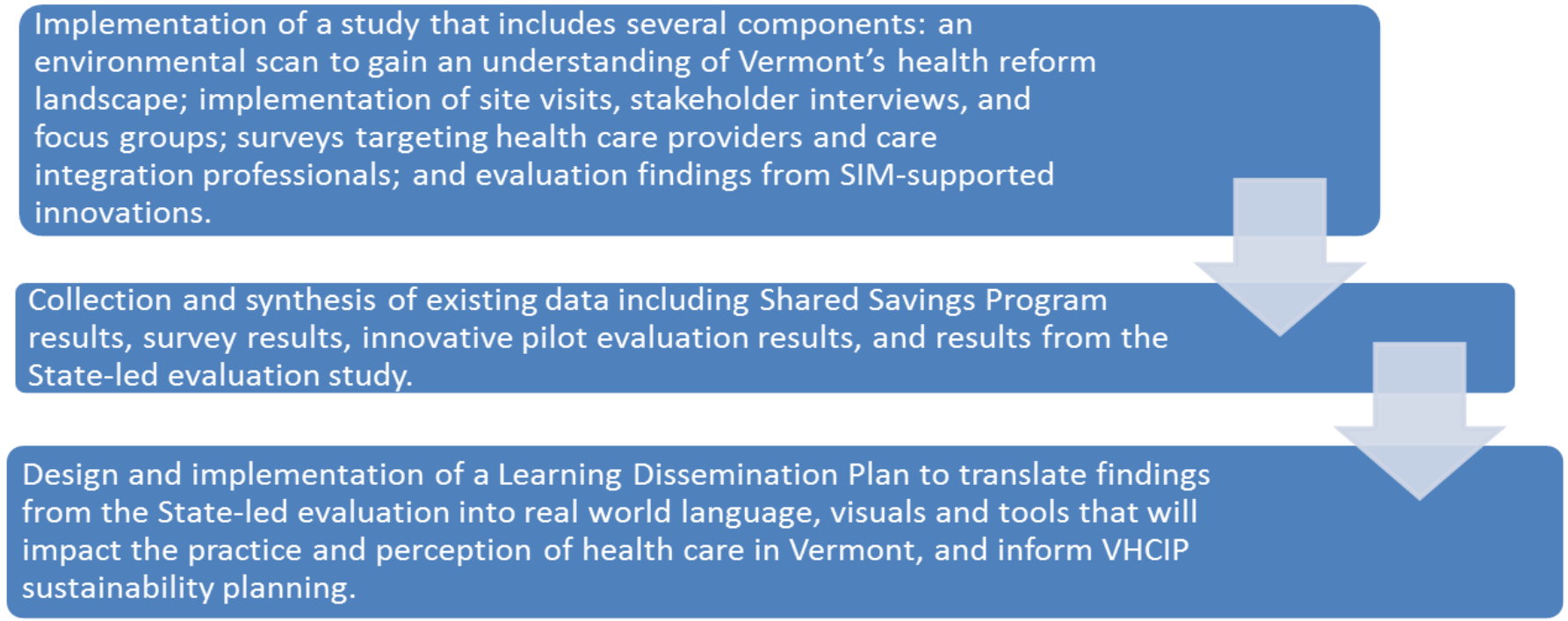
Act 113 of 2016
All-Payer Model; Medicare Agreement Criteria

1. Consistent with the principles of health care reform established in Act 48 of 2011
2. Preserves consumer protections, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes
3. Allows providers to choose whether to participate in ACOs
4. Allows Medicare patients to choose any Medicare-participating provider
5. Includes outcomes measures for population health
6. Continues to provide payments from Medicare directly to providers or ACOs


Evaluation
Payment Reform Pilots
State Innovation Grant (VHCIP)
Factors that
influence decisions:
Affordability
Accessibility
Quality

State Innovation Model Grant Evaluation

In 2016, the Green Mountain Care Board contracted with John Snow, Inc. (JSI) to conduct the independent State-led VHCIP evaluation. The three major evaluation activities conducted by JSI are:



References

Green Mountain Care Board Website:
http://gmcboard.vermont.gov

Link to GMCB Decision to APM:
http://gmcboard.vermont.gov/content/vermont-all-payer-accountable-care-organization-model-agreement