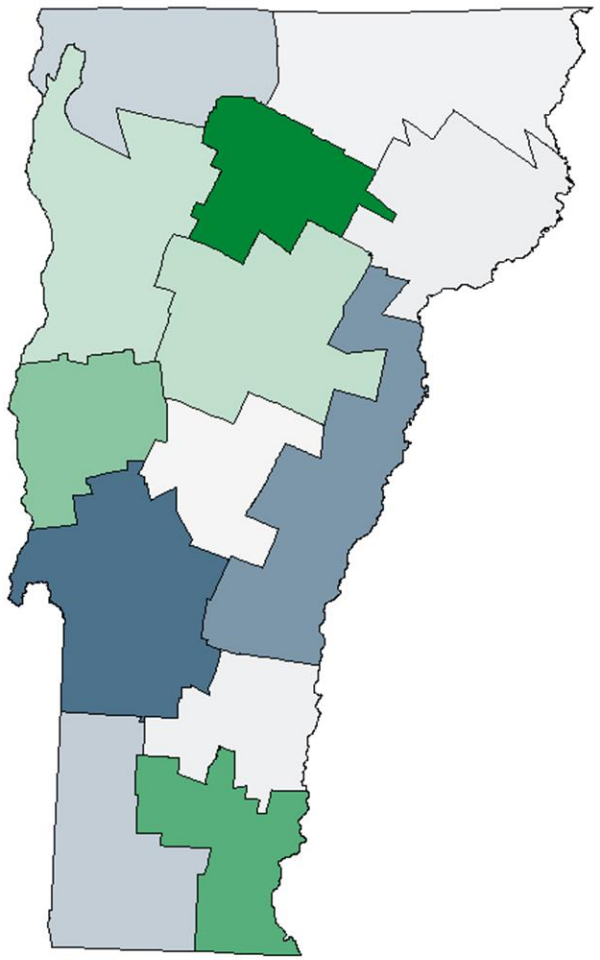


Green Mountain Care Board

House Health Care Committee

January 23, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Items For Review

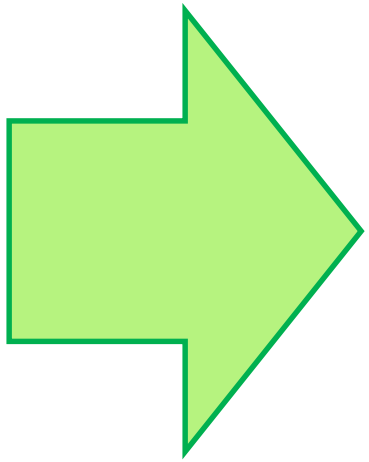
- Overview of the Board's work
- Overview of Annual Report
- Update on the All-Payer implementation and ACO regulation (budget and certification monitoring)
- Update on billback

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.

The Role of GMCB

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.



Health insurer rate review (including the Exchange)

Hospital Budgets

ACO Budgets

VITL Budget

Major capital expenditures (Certificate of Need)

Health Resource Allocation Plan (HRAP)

Implementation of APM

ACO Oversight, Certification, Rule 5.0 (Act 113)

Review/modify/approve plan designs for Vermont Health Connect

Data and Analytics (VHCURES, VUHHDS and APM Analytics)

Primary Care Advisory Group

Billback Fund Management

Expenditure Analysis

Cost Shift Report

Outreach and Education/ OML

Approve State HIT and Health Care Workforce Plan

Prescription Drug List Per Act 165

A Year In Review

In the six years since its inception, the Green Mountain Care Board has been instrumental in working to guide the State, through a transparent process, on the path to ensuring that all Vermonters have access to high quality, affordable health care. Since the passage of Act 113 (2016) and the signing of the All-Payer Accountable Care Organization Model Agreement (APM Agreement) late in 2016, the Board has focused much of its work on planning for and implementing new regulatory processes, while aligning its new work with existing ones, to support the goals outlined in the legislation and in the Agreement. Throughout 2017, the Board continued to refine its regulatory oversight of hospital budgets, health facility planning through the certificate of need program, health insurance rates and qualified health plans, and in 2017 implemented a rigorous process for overseeing Accountable Care Organization (ACO) budgets as the State approached Performance Year One of the Agreement. However, health care is still unaffordable for many Vermonters, and the Board recognizes that more must be done.

Through the health insurance rate review process, the Board sought to minimize rate increases for Vermonters buying health insurance on Vermont Health Connect (VHC) for the 2018 plan year through a transparent, public process. Insurance plans purchased through VHC, with coverage beginning January 1, 2018, increased by an average of 8.0% over 2017 plans. As measured by the insurers' requested rates, compared to those approved by the Board after a full review, Vermonters saved an estimated $16.2 million.

For fiscal year (FY) 2018 hospital budgets, the Board approved an average annual increase in hospital rates of 2.1%, well below recent estimates of medical inflation. After adjusting for physician transfers, the Board held hospital net patient revenue (NPR) growth to 3.01% (or a weighted average increase of 2.08%), below the overall 3.6% growth rate requested by the hospitals.

The Board's work on payment and delivery reform in 2017 continued to focus on building a system to contain health care costs and reward high quality care. As required by Act 113, the GMCB drafted and promulgated Administrative Rule 5.000, governing ACO budget review and certification, in preparation for the January 1, 2018 start of Performance Year One of the APM Agreement. The APM Agreement, starting in 2018 and running through December 2022 (Performance Year 5), directs attention and resources to achieving three important population health goals: improving access to primary care, reducing deaths from suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. In addition, the APM Agreement constrains health care spending by establishing an annualized 3.5% maximum, measured at the end of the Agreement, on per capita health care expenditure growth for all major payers (Medicaid, Medicare, and commercial).

GMCB Goals and Regulatory Levers

Goal #1:
Vermont will reduce the rate of growth in health care expenditures

GMCB Regulatory Levers:

Hospital Budget Review

ACO Budget Review

ACO Certification

Medicare ACO Program Rate-Setting and Alignment

Health Insurance Rate Review

Certificate of Need

Goal #2:
Vermont will ensure and improve quality of and access to care

GMCB Regulatory Levers:

All-Payer Model Criteria

ACO Budget Review

ACO Certification

Quality Measurement and Reporting

INTEGRATION OF REGULATORY PROCESSES

Strategic Priorities for 2018

Implementation and Year One Launch of All-Payer ACO Model	All-Payer ACO Model Analytics; setting commercial and Medicare rates; ACO budget review and certification; monitoring and evaluating the success of the APM.
Alignment of GMCB Regulatory processes	Tracking financial benchmarks, scale targets and quality targets, and implementing changes to other Board processes (e.g., hospital budgets; health insurance rate review; certificate of need).
Updating Certificate of Need Statute and procedures	S.277 Goal of streamlining the process for CON applicants and for the Board and its staff.
VHCURES Procurement	Request for Proposal (RFP) seeking a new multi-year vendor to expand and enhance the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES).

Vermont All-Payer Accountable Care Organization Agreement and Regulation of Accountable Care Organizations in Vermont

All-Payer Model Agreement: Review

Green Mountain Care Board Accountability for All-Payer Model and Regulation of Vermont Accountable Care Organizations

1. State/Federal Agreement
2. Act 113 of 2016

Major Milestones in 2017

All-Payer Model and ACO Regulation Follow-Up: Potential Topics

1. Quality and Performance Measures
2. Consumer Protections
3. Financial Regulation and Investments in Delivery System Reform

All-Payer ACO Model: Review

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.

- Sets an aggregate price for services, based on historical expenditures, and rate of growth for the ACO
- Encourages payment based on quality rather than quantity
- Creates a more predictable revenue stream to support providers in initiating delivery system reforms that improve quality and reduce costs

Facilitated by state law and an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Medicare to participate in a custom Vermont model that recognizes:

- Vermont's unique Medicare trends
- Vermont's aging population
- Statewide accountability for population health level outcomes

GMCB Accountability For All-Payer Model: State/Federal Agreement

State action on financial trends & quality measures

- All-Payer Growth Target: 3.5%
- Medicare Growth Target: 0.1-0.2% below national projections
- Medicare ACO Benchmark must be tied to ACO level quality measures included in participation agreement
- Quality improvement targets for three major payer groups
- Requires quality and payment model alignment across Medicare, Medicaid, and participating Commercial payers

Goals for improving the health of Vermonters (20 indicators, including statewide and ACO level)

- Improve access to primary care
- Reduce deaths due to suicide and drug overdose
- Reduce prevalence and morbidity of chronic disease

GMCB Accountability Per Act 113 of 2016: All-Payer Model and Accountable Care Organization (ACO) Oversight

- Establishes Criteria for Implementing All-Payer Value-Based Payment Model and Medicare Agreement Criteria
- **Requires Review, Modification, and Approval of ACO Budgets**
- **Requires Certification of ACOs**
- Required Medicaid advisory rate case for ACO Services (one time per 113, reinstated in Act 3 of 2017 Sec. 80)

2017 Major Milestones for All-Payer Model and ACO Oversight:

We can have a follow-up slide highlighting Accomplishments in Each Activity Area? I will give an Example Using ACO Budget

1. Finalization of Rule 5.000 governing ACO Oversight
2. Completion of ACO Budget Review and Approval of Budget
3. Analysis, Vote, and CMMI Approval of Medicare rate of growth for ACO
4. Provisional ACO Certification

ACO Budget Review and Approval: Example Conditions

- A combined all-payer rate increase of less than 3%, after exclusion of Medicaid pricing changes;
- Ability to review OneCare's contracts with participating payers;
- Robust risk assumption, delegation, and mitigation strategy must be in place;
- Guaranteed funding for Medicare portion of SASH, Blueprint for Health, and Community Health Team
- payments;
- Investment of no less than 3.1% of overall budget in population health and primary care strengthening initiatives;
- OneCare must submit a payment differential report describing how the Comprehensive Primary Care

ACO Budget Review and Approval: Example Conditions

- Payment Reform pilot's payment methodology compares to the reimbursement that hospitals provide to employed primary care. The report must also assess quality outcomes in the pilot compared to outside the pilot, and address the degree to which the pilot is or is not reducing administrative burden;
- Administrative Expenses must be appropriately allocated between Vermont and New York and may not exceed the amount budgeted by more than 1%;
- OneCare must consult with the Office of the Health Care Advocate to identify a grievance and appeals policy that applies to all enrollees, across payers; and
- OneCare must work in consultation with the GMCB to identify a pathway by which potential savings from this model will be returned to commercial rate payers
- Administrative expenses must not increasing beyond ratio in budget submission

ACO Oversight and All-Payer Model
Potential Topics for Follow-Up

1. Investments in Primary Care
2. Quality and Performance Measures
3. Consumer Protections
4. Financial Regulation through Hospital Budget and Insurance Premium Rate Review
5. Suggestions from the Committee?

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

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

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

Act 113 of 2016 ACO Budget Review 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

Accountable Care Organization Oversight

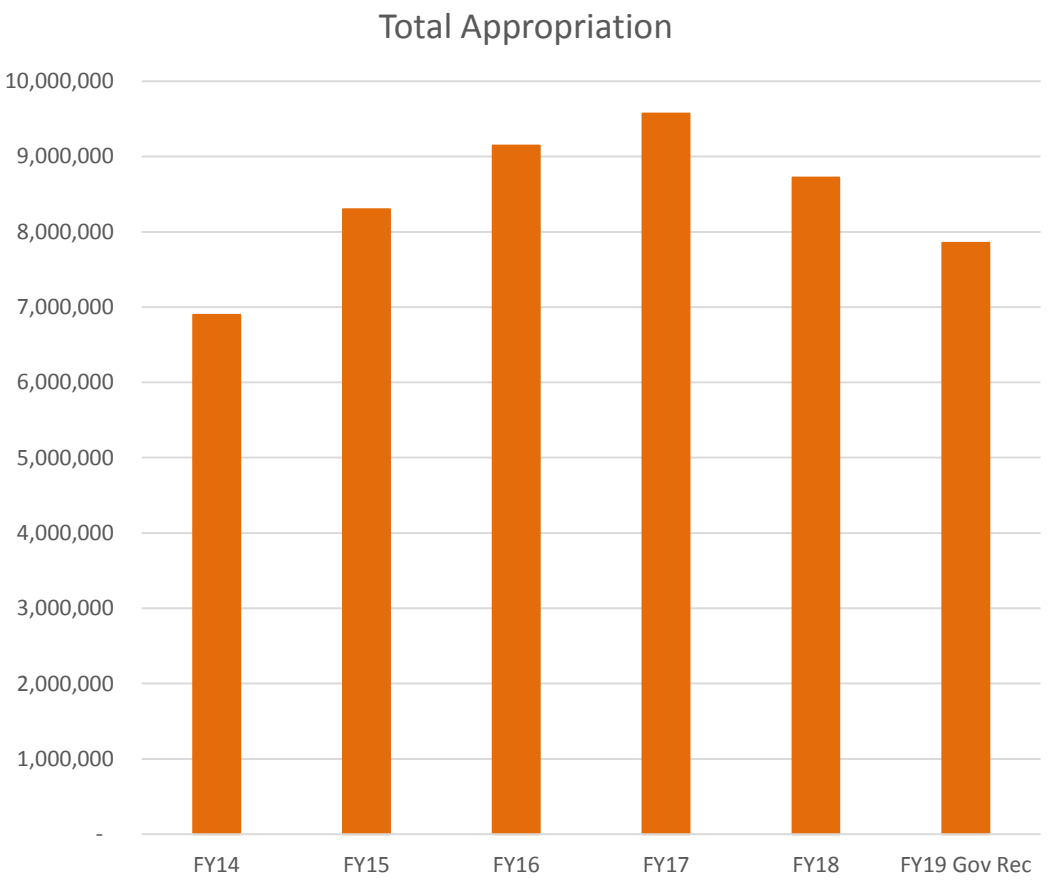
Certification Criteria

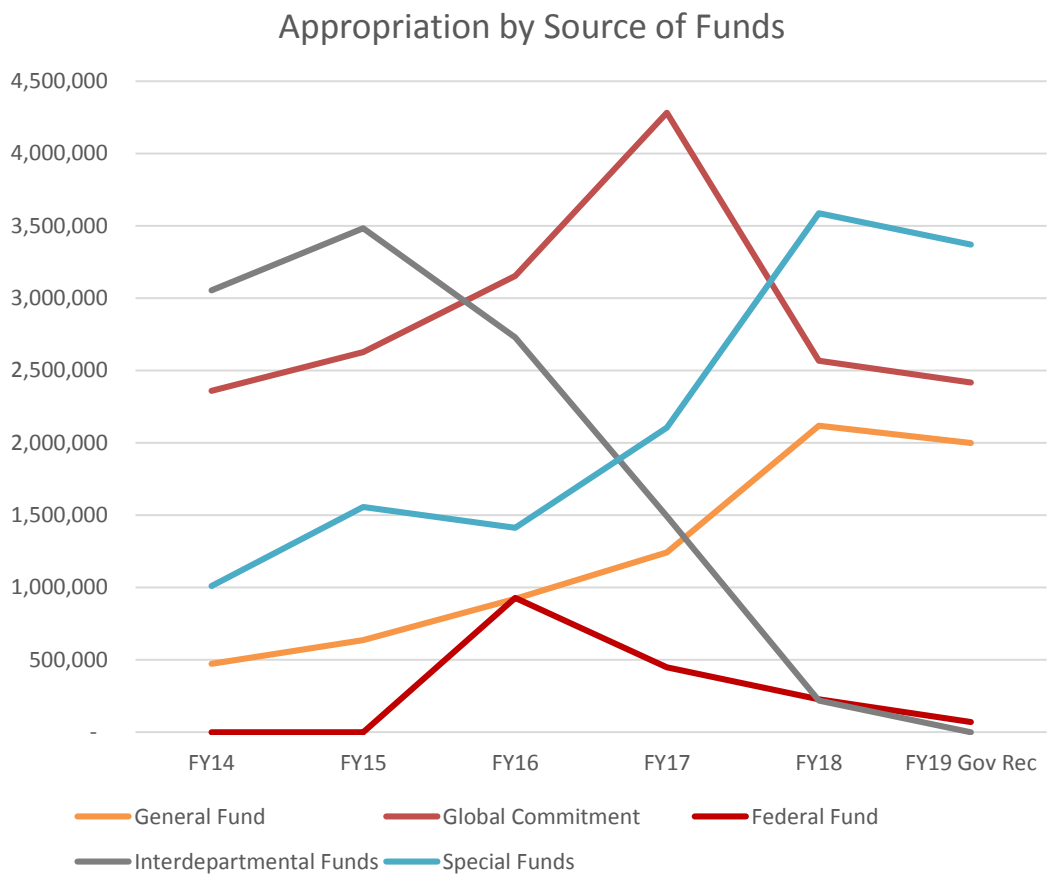
The GMCB must ensure that the ACO meets criteria in the following categories:

- Governance
- Care management and coordination
- Provider participation, payment, and collaboration
- Participation in health information exchanges
- Quality and performance measures
- Patient engagement and information sharing
- Consumer assistance, access, and freedom of provider choice
- Appropriate financial protections against potential losses

Context for Bill back

GMCB Appropriation 2014 - 2019 Gov. Rec





VERMONT
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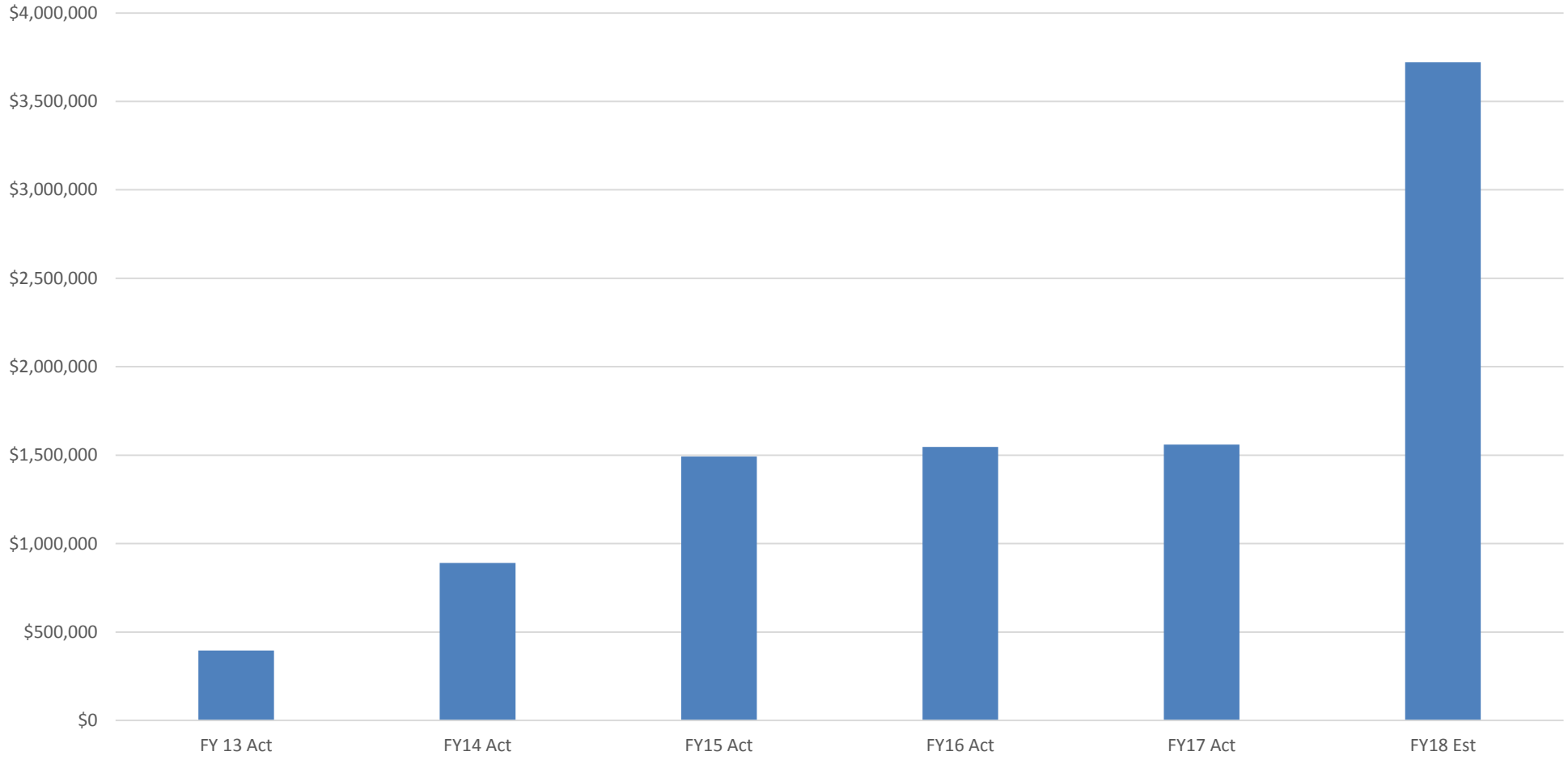
Total Amount Billed Back to Regulatory Entities

per Annual Report to Legislature



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Bill Back 2016-2018

	SFY16 Act	SFY17 Act	SFY18 Bud
State	40%	40%	40%
HMS (BCBS)	15%	15%	45%
HMO	15%	15%	
Insurer	15%	15%	
Hospitals	15%	15%	15%
ACO	0%	0%	0%

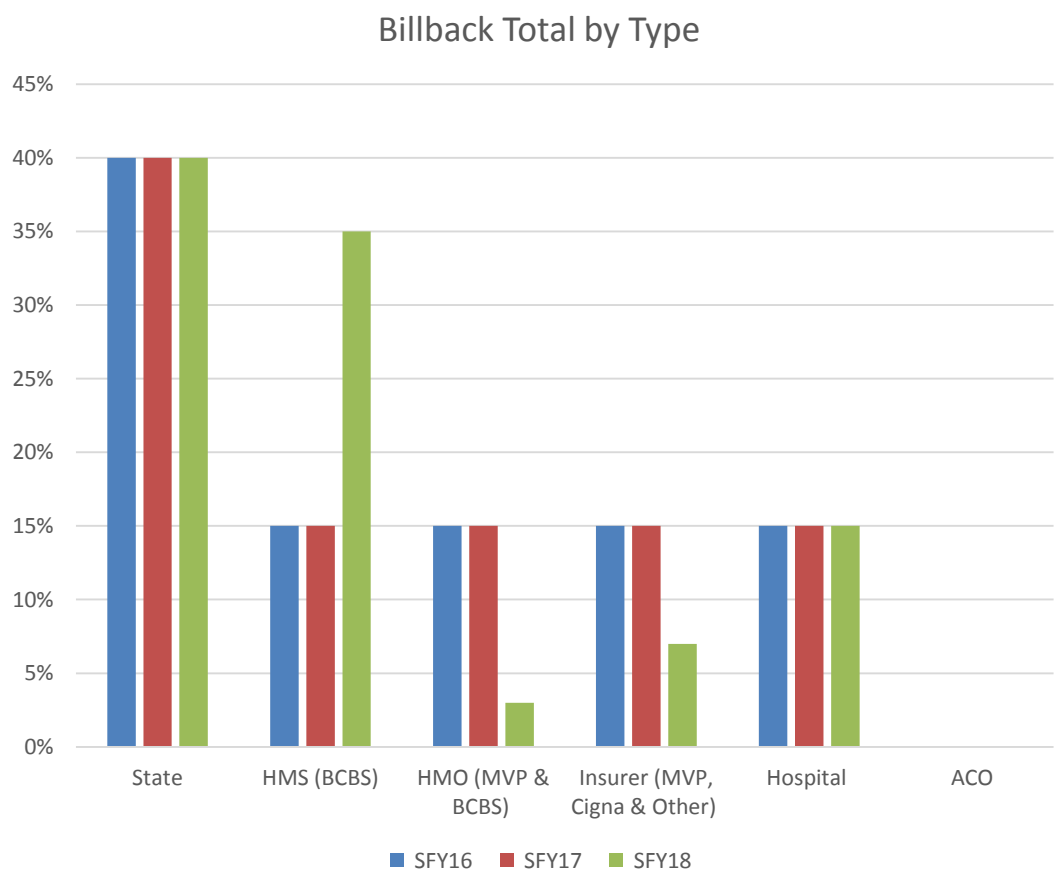
Key: HMS means: Health Medical Service Organizations (currently only BCBSVT)

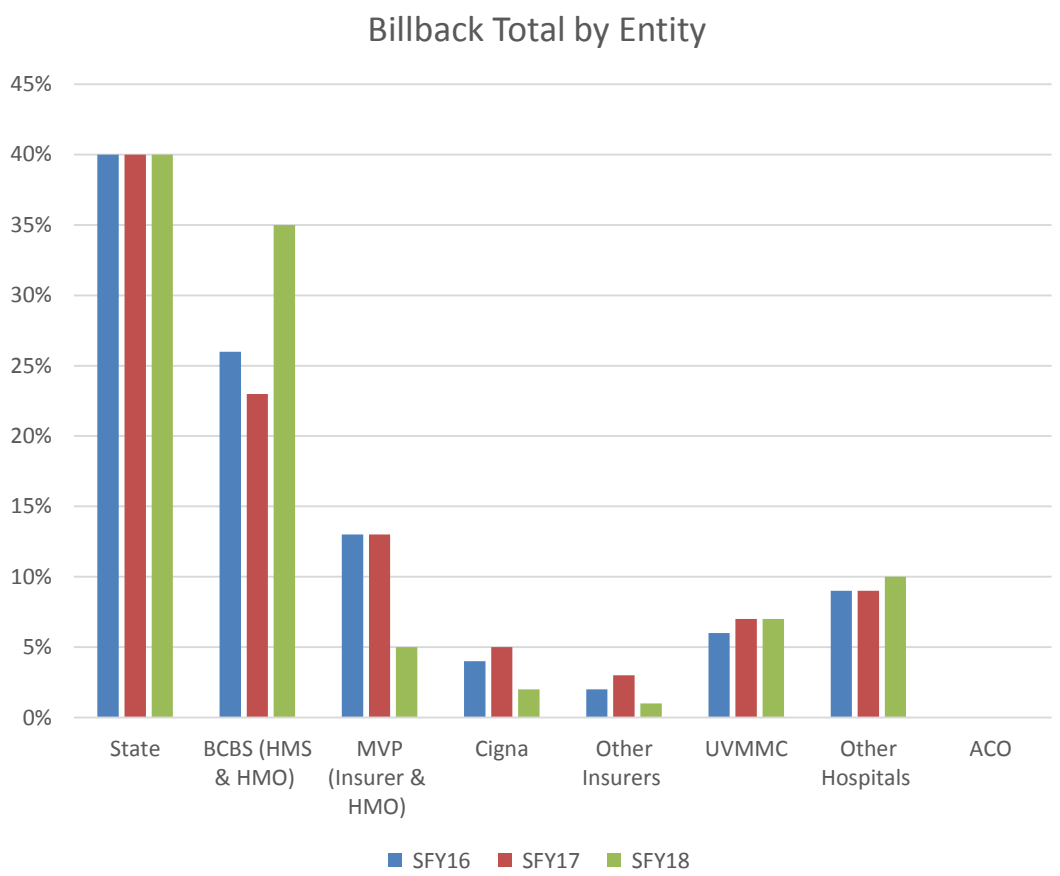
SFY16 Basis for Billback = HMS HMO Insurer based on 2014 premium dollars earned. Hospitals based on current year actual acute admissions.

SFY17 Basis for Billback = Total Billback less 2016 Act v Bud Reconciliation (reduced FY17 by $665k). HMS HMO Insurer based on 2015 premium dollars earned. Hospitals based on current year actual acute admissions.

SFY18 Methodology = Will be based on HMS HMO Insurer 2016 premium dollars earned. Hospitals based on current year actual acute admissions. Total Billback less 2017 Act v Bud Reconciliation TBD.

Bill Back 2016-2018





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All Payer Model Implementation Reports

Report of the GMCB Progress in Meeting All-Payer Model ACO Implementation Benchmarks (June 15, 2017)

Report of GMCB Progress in Meeting All-Payer Model ACO Model Implementation Benchmarks (September 15, 2017)

Report of GMCB Progress in Meeting All-Payer Model ACO Model Implementation Benchmarks (December 15, 2017)

Resource Slides

Annual Report

Legislative Reports

Insurance Rate Review

All-Payer Model Information