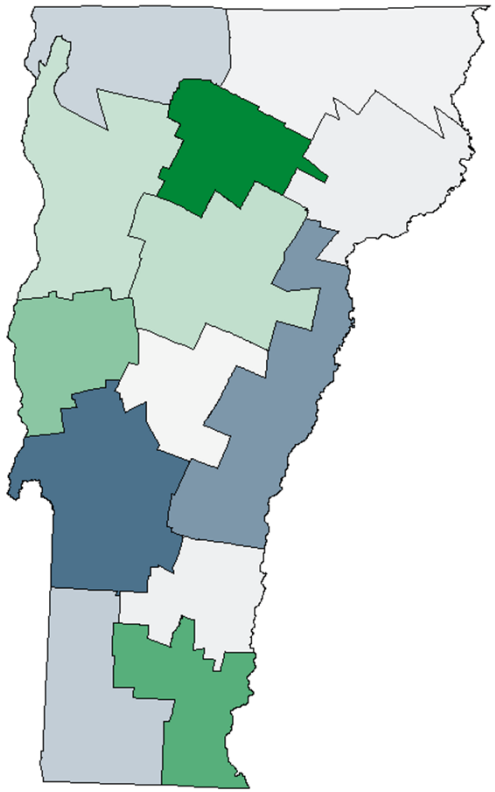


Green Mountain Care Board Value

Susan Barrett, J.D., Executive Director
Kate Slocum, Financial Director

House Appropriations Committee

April 13, 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.
4. Understanding of GMCB's unique importance to Vermonters and Health Care regulation.

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

Key Points – GMCB

- The GMCB was created by Act 48 of 2011 to focus on containing health care costs through regulation, innovation, and evaluation.
- Despite common misperception, the GMCB was not created to establish a single-payer health care system. In fact, the GMCB was charged with providing a check and balance to the executive branch by evaluating the executive's plan through an evaluation of triggers prior to implementation.
- The GMCB has a key role in regulating accountable care organizations and implementing the All Payer Model Agreement with the Centers for Medicare and Medicaid Services (CMS).
- Members are nominated by a broad-based committee and appointed by the Governor with the consent of the Senate. Appointed Members then serve a six year term.

What is distinct about the way the GMCB does business?

The GMCB is governed by the Open Meeting law, unlike an executive branch agency. This creates:

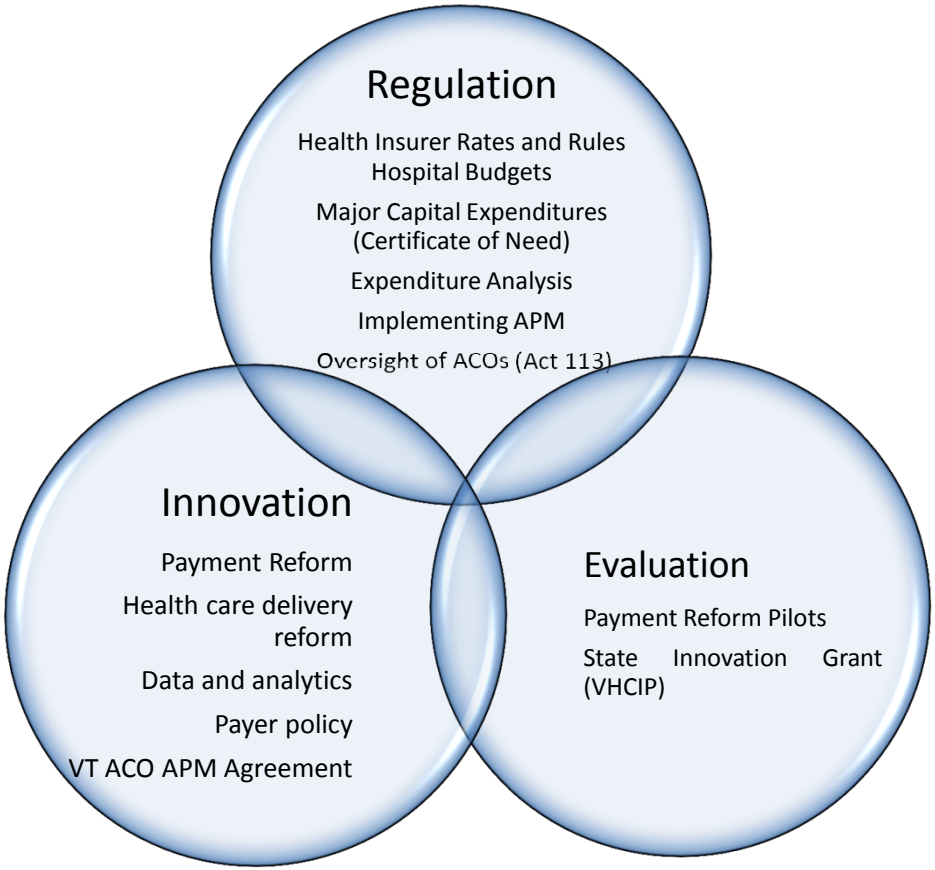
- Transparency in Process – adds rigor and shines a light on the issues; and
- Public Accountability – creates robust public input in decisions

The Board's structure, with 5 members and 6 year staggered terms, allows for:

- Discussion and Debate – ensures multiple viewpoints contribute to decisions;
- Independence – buffers decisions from gubernatorial changes and electoral politics through longer terms and multiple members; and
- Innovation – balances new thinking from new members being added annually through staggered terms and long-term vision from 6 year terms

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.



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Regulation: 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:

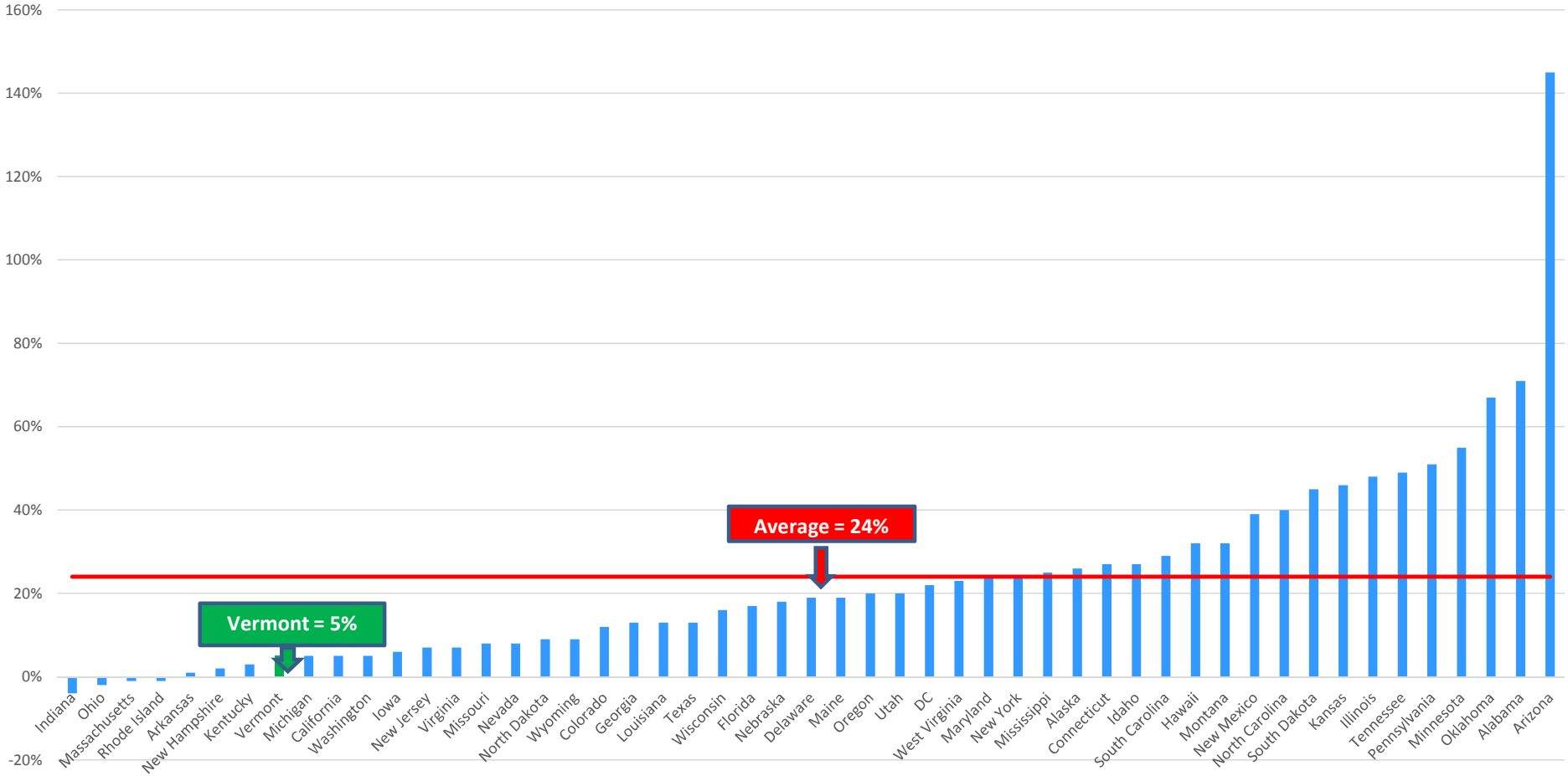
The Board reviewed eleven rate filings in 2016, including two Vermont Health Connect Exchange filings.

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.*

2016 to 2017 2nd Lowest Cost Silver Plan Rate Increase by State



Adapted from: http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

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Regulation: 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.*

Regulation: 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:

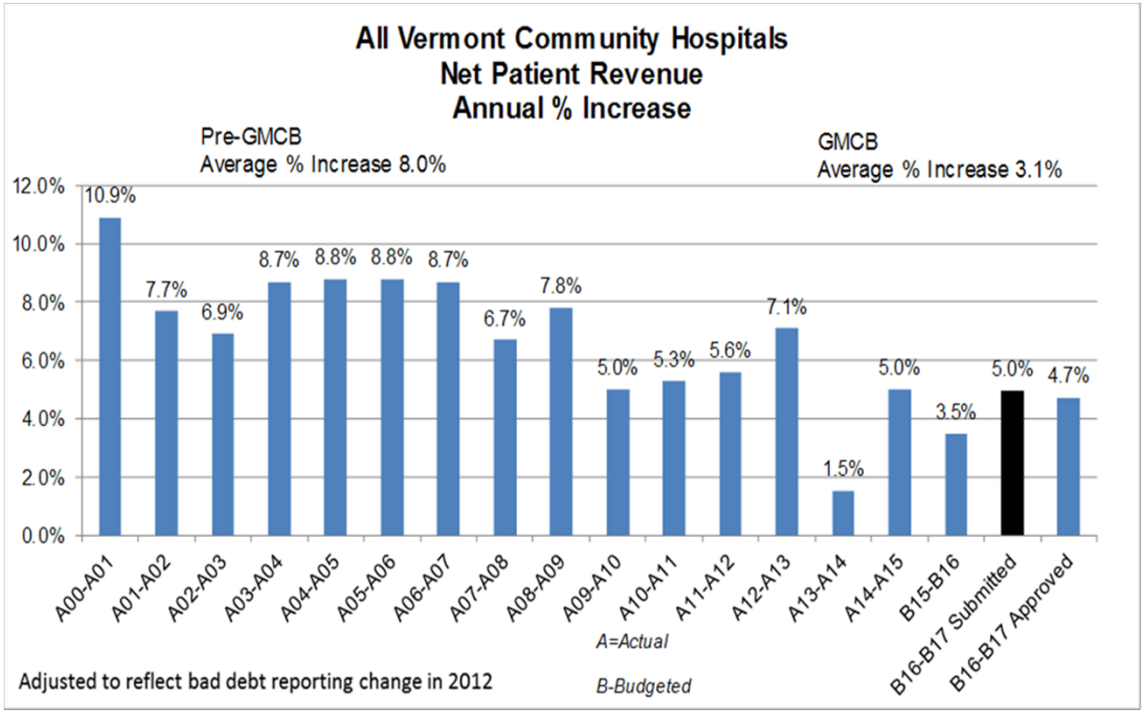
Hospitals initially requested a 5% Net Patient Revenue (NPR) increase.

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*

Hospital Budget Results pre and post GMCB



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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: Act 113 of 2016

- All-Payer Model Implementation
- ACO Certification
- ACO Budget Approval and Annual Reporting
- Primary Care Advisory Group
- Advisory Medicaid ACO rate case
- Report on multi-year ACO budgets
- Consultation on AHS Medicaid Pathway Report
- Develop Rule for ACO Oversight

GMCB APM and Act 113 Implementation Activities Completed (as of April 13, 2017)

- Established communication mechanisms with CMMI
- Established communication mechanisms with State government partners
- Established communication mechanisms with private sector partners
- Conduct regular reporting to GMCB and public
- Received one-time funding for Blueprint, SASH and ACO *(Agreement)*
- Conducted advisory Medicaid ACO rate case *(Act 113)*
- Established Primary Care Advisory Group *(Act 113)*
- Issued report on multi-year ACO budgets *(Act 113)*
- Provided consultation on AHS Medicaid Pathway Report *(Act 113)*
- Developed ACO Budget Guidance for FY 2018 *(Act 113)*
- Developed Draft Rule for ACO Oversight *(Act 113)*
- Developed Analytics RFP

How would the All Payer Model Agreement be impacted by changes to the GMCB?

- The federal government has established agreements with three States: Maryland, Vermont, and Pennsylvania. Maryland and Vermont's models are built around independent regulatory Boards operating to look at the total cost of care. Pennsylvania's model is much more limited – focusing only on establishing global budgets for rural hospitals who choose to participate and is led by their Governor and the PA Department of Health. The Vermont All Payer Model is much broader and is built on GMCB's current public structure and broad oversight of the health care system.

- At minimum, changes which substantially restructure the Board or its roles would require re-negotiation of the All Payer Model Agreement.

Evaluation: 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: