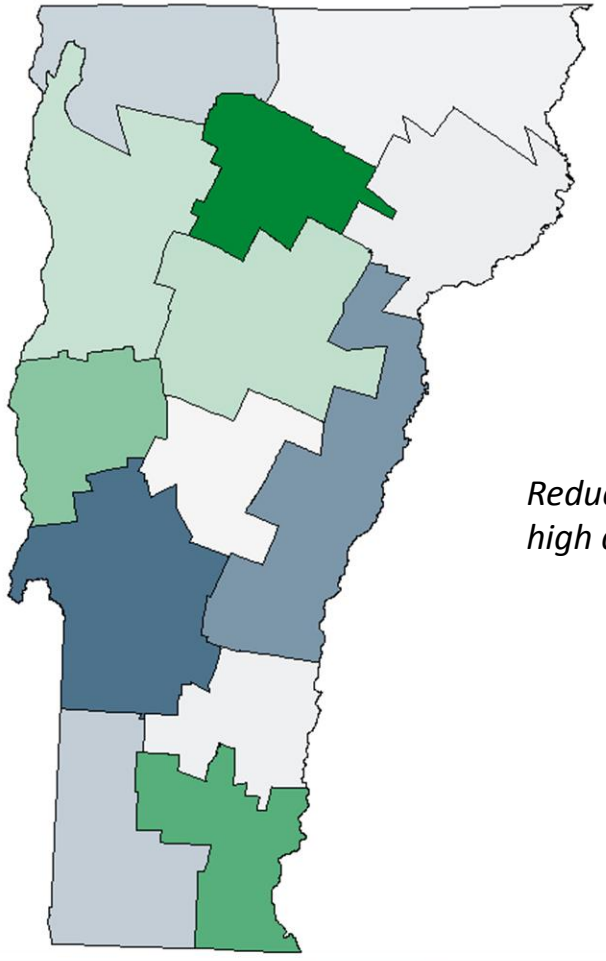

Green Mountain Care Board

ANNUAL REPORT FOR 2017

Slide Deck Companion

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.

Submitted January 16, 2018

Scroll, swipe or click here to view the contents of this slide deck.

Click here for more information about the Green Mountain Care Board (external site).

VERMONT
GREEN MOUNTAIN CARE BOARD

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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).

Legislative Reports

Report	Due Date	Corresponding Legislation
GMCB Program Performance Measures	January 15, 2017	Act 85: An act relating to making appropriations for the support of government
2016 Annual Report	January 15, 2017	Act 48: An act relating to a universal and unified health system
Multi-year Budget for ACOs	January 15, 2017	Act 113: An act relating to implementing an all-payer model and oversight of accountable care organizations
GMCB effort to achieve alignment between Medicare, Medicaid and Commercial Payers in APM	January 15, 2017	Act 112: An act relating to cataloguing and aligning health care performance measures
Provider Reimbursement Report	February 1, 2017	Act 143: An act relating to notice to patients of new health care provider affiliations
GMCB All-Payer ACO Model Update Benchmarks	June 15, 2017; September 15, 2017; December 15, 2017	Act 25: An act relating to Next Generation Medicaid ACO pilot project reporting requirements
Pharmacy Cost Transparency	August 2017	Act 165: An act relating to prescription drugs
Bill Back Report	September 15, 2017	Act 79: An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board
Fair Reimbursement Report	October 1, 2017	Act 85: An act relating to making appropriations for the support of government
Integration of Payments; Accountable Care Organizations	December 15, 2017; January 15, 2018	Act 82: An act relating to examining mental health care and care coordination
Rule 5.000: Oversight Of Accountable Care Organizations	In effect January 1, 2018	Act 113: An act relating to implementing an all-payer model and oversight of accountable care organizations

Stakeholder Engagement in 2017

GMCB Board Meetings

The Green Mountain Care Board meets weekly in open public meetings.

GMCB Advisory Committee

The GMCB Advisory Committee formed in 2012 to provide input and recommendation to the Board. The committee's fifty-two members represent consumers, businesses, and health care professionals.

Primary Care Advisory Group

In accordance with Act 113 of 2016, the GMCB established a Primary Care Advisory Group (PCAG). PCAG membership includes twenty-two primary care providers (a mix of physicians, nurse practitioners, and advanced practice registered nurses), a staff liaison from the Board, and one Board member. PCAG met thirteen times in 2017 and presented once at the Board's regularly scheduled public meeting.

Clinician Surveys and Focus Groups

To better understand the perspectives of Vermont's health care providers, in 2017, GMCB held three focus groups in three locations identified based on stakeholder interest (Montpelier, Middlebury and Burlington), and fielded a survey that received responses from 400 clinicians from all hospital service areas.

Additional Public Comment Opportunities

Members of the public have a variety of opportunities to provide comment to the GMCB. The GMCB website lists options for members of the public to provide comment including submitting an online public comment form, calling the GMCB office, or emailing the GMCB.

Insurance Rate Review

The Board reviewed twelve rate filings in 2017. Most significant are the filings for the Vermont Health Connect (VHC) plans offered by Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Care, which cover approximately 80,000 Vermonters.

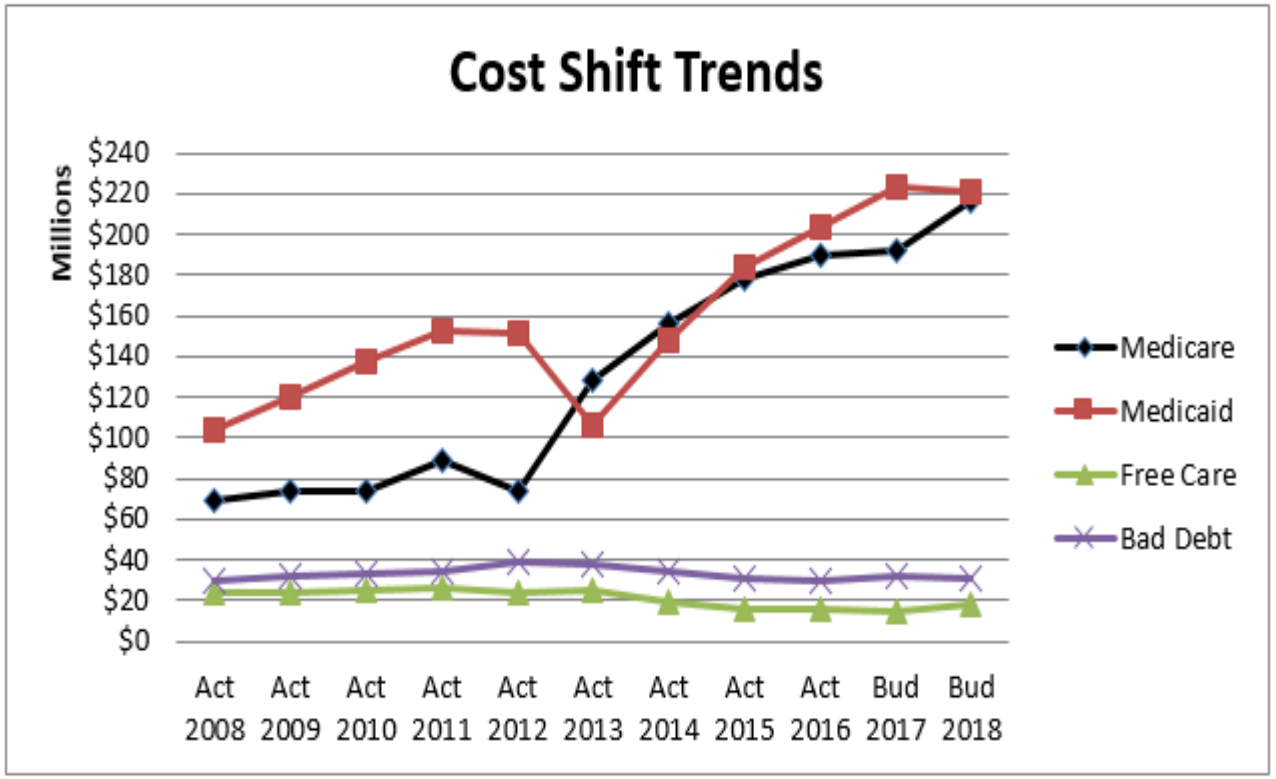
The Board reduced BCBSVT's proposed 12.7% average annual rate increase to 9.2%, and MVP's proposed 6.7% average annual rate increase to 3.5%, producing an estimated $16.2 million in savings to Vermonters. When all twelve of the Board's 2017 rate decisions are accounted for, the savings rise to approximately $16.4 million.

Decision Date	Docket No.	Company Name	Filing Name	Proposed Rate Change	Approved Rate Change	Change in Proposed Rate vs. Approved Rate
3/28/17	001-17rr	Cigna Health & Life Insurance Company	2017 Large Group Manual Rate	-3.7%	-5.1%	-1.4%
5/8/17	002-17rr	MVPHIC	3Q17/4Q17 Grandfathered Small Group EPO/PPO	3Q17 1.8% 4Q17 2.4%	3Q17 1.8% 4Q17 2.4%	0.0%
5/8/17	003-17rr	MVPHIC	3Q17/4Q17 Large Group EPO/PPO	3Q17 3.6% 4Q17 2.7%	3Q17 3.6% 4Q17 2.7%	0.0%
5/24/17	004-17rr	BCBSVT	3Q17 Large Group Rating Program - Annual	N/A (Factor Filing[1])	N/A	N/A
5/24/17	005-17rr	TVHP	3Q17 Large Group Rating Program - Annual	N/A (Factor Filing)	N/A	N/A
6/26/17	006-17rr	MVPHP	3Q17/4Q17 Large Group HMO	3Q17 -0.2% 4Q17 1.1%	3Q17 -0.2% 4Q17 1.1%	0.0%
8/10/17	007-17rr	MVPHP	2018 Exchange Filing	6.7%	3.5%	-3.2%
8/10/17	008-17rr	BCBSVT	2018 Exchange Filing	12.7%	9.2%	-3.5%
8/31/17	009-17rr	4 Ever Life Insurance Co.	Rate filing for new expatriate health plan	N/A	N/A	N/A
11/5/17	010-17rr	MVPHIC	1Q18/2Q18 Grandfathered Small Group EPO/PPO	4.2%	4.2%	0.0%
11/7/17	011-17rr	MVPHIC	1Q18/2Q18 Large Group EPO/PPO	5.8%	5.8%	0.0%
12/20/17	012-17rr	MVPHP	1Q18/2Q18 Large Group HMO	-6.1%	-6.1%	0.0%

Cost Shift

"Cost shift" occurs when hospitals and other health care providers charge higher prices for services paid for by commercial insurance to make up for lower reimbursements from Medicare and Medicaid, and to cover charity care and bad debt.

Medicare cost shift is anticipated to grow at a faster pace into 2018 because of increased utilization of health care services and expected changes to Medicare reimbursement at the federal level. Medicaid cost shift will likely also increase because provider reimbursements remain stagnant, and hospital Disproportionate Share Payments have decreased by $10 million.



Hospital Budget Review

As one of the GMCB's core regulatory responsibilities, the Board set an overall system Net Patient Revenue (NPR) growth cap of 3.0% over the hospitals' approved FY 2017 budget bases, and narrowed the health care reform criteria, but allowed up to an additional 0.4% in NPR for new health care reform activities investments and initiatives.

From analysis of each hospital's FY 2018 budget submission including: utilization information; net patient revenue and expenses; prior budget performance; financial and other key performance indicators and how they compare with state, regional, and national peers; staffing needs; capital expenditure needs; and the amount of in- and out-of-state patient migration, as well as comments from the Office of the Health Care Advocate (HCA) and from members of the public, and considered each hospital's unique circumstances, including its health care reform efforts and its work to address issues identified in its Community Health Needs Assessment (CHNA), as well as in- and out-of-state patient migration.

The Board approved a system-wide increase in NPR of 3.01%.

Vermont Hospitals
Net Patient Revenue change
FY2018 Budgets

	Net Patient Revenue change					Net Patient Revenue change-adjusted to reflect real growth	
	2017	2018	2018	Approved 2017 to Approved 2018		Approved 2017 to Approved 2018	
	Approved	Submitted	Approved	$ Change	% Change	**Approved & adjusted for Physician Transfers	% Change
Brattleboro Memorial Hospital	$76,408,611	$80,202,627	$78,879,432	$2,470,821	3.23%	$77,703,332	1.69%
Central Vermont Medical Center	$191,831,143	$198,726,498	$198,695,454	$6,864,311	3.58%	$198,327,393	3.39%
Copley Hospital	$64,819,405	$69,663,508	$68,024,531	$3,205,126	4.94%	$68,455,745	5.61%
Gifford Medical Center	$57,762,429	$59,497,391	$59,514,010	$1,751,581	3.03%	$59,514,010	3.03%
Grace Cottage Hospital	$19,205,503	$18,649,074	$18,649,074	-$556,429	-2.90%	$18,649,074	-2.90%
Mt. Ascutney Hospital & Health Ctr	$47,744,700	$48,395,281	$48,682,309	$937,609	1.96%	$48,682,309	1.96%
North Country Hospital	$81,189,662	$79,670,761	$79,074,579	-$2,115,083	-2.61%	$79,074,579	-2.61%
Northeastern VT Regional Hospital*	$77,069,500	$79,385,200	$78,818,099	$1,748,599	2.27%	$78,818,099	2.27%
Northwestern Medical Center	$101,935,936	$105,776,757	$104,401,050	$2,465,114	2.42%	$104,026,050	2.05%
Porter Medical Center	$76,094,922	$78,682,778	$79,146,442	$3,051,520	4.01%	$79,146,442	4.01%
Rutland Regional Medical Center	$243,415,448	$251,547,278	$250,963,330	$7,547,882	3.10%	$250,756,174	3.02%
Southwestern VT Medical Center	$152,362,260	$159,497,504	$159,497,504	$7,135,244	4.68%	$159,497,504	4.68%
Springfield Hospital	$59,147,241	$59,375,198	$59,375,198	$227,957	0.39%	$59,375,198	0.39%
The University of Vermont Medical Center	$1,172,785,845	$1,213,835,692	$1,212,580,571	$39,794,726	3.39%	$1,212,580,571	3.39%
Total Net Patient Revenue	**$2,421,772,605**	**$2,502,905,547**	**$2,496,301,583**	**$74,528,979**	**3.08%**	**$2,494,606,480**	**3.01%**

*Note: Northeastern VT Regional Hospital -- Rebased Approved Budget 2017 (from $71,339,400 to $77,069,500)

"Real growth" was calculated by adjusting for physician transfers, which 5 hospitals experienced as follows: BMH $1,176,100, CVMC $368,061, Copely -$431,214, NMC $375,000, RRMC $207,156.

Certificate of Need
2017 Activities

Approved:

•The University of Vermont Medical Center: replacement of electronic health records and related health information technology systems at four University of Vermont Health Network Hospitals (issued 1/5/18)
•Brattleboro Memorial Hospital: renovation and construction of a medical office building;
•Rutland Regional Medical Center: replacement of its nuclear medicine camera
•Southwestern Vermont Medical Center: creation of a dental home
•Green Mountain Surgery Center: development of a multi-specialty ambulatory surgical center
•BAART Behavioral Health Services, Inc.: development of an outpatient opiate addiction treatment clinic (Emergency CON)
•The Pines at Rutland Center for Nursing and Rehabilitation: renovation and construction of the 125-bed skilled nursing facility
•VNA & Hospice of the Southwest Region: expansion of its service area by merging with Manchester Health Services
•OAS, LLC d/b/a Valley Vista: development of a 19-bed therapeutic community residence for women with alcohol and chemical dependencies (Emergency CON)
•Wake Robin: renovation of its 33-bed skilled nursing rooms
•Purchase of Rowan Court Health and Rehabilitation Center by Barre Gardens Holdings, LLC and Barre Gardens Nursing and Rehab, LLC.

Pending:

•Northeastern Vermont Regional Hospital: replacement of existing mobile MRI with a fixed MRI unit and related new construction and renovations
•Rutland Regional Medical Center: construction of new medical office building and renovations to existing buildings
•Birchwood Terrace: nursing home transfer of ownership.
•Gifford Retirement Community: construction of 49 independent living units
•Gifford Retirement Community: construction of assisted living facility.

Other Activities:

PATH at Stone Summit: After the Board issued a jurisdictional determination that the proposed development of a therapeutic community residence, PATH at Stone Summit, would not trigger CON review, the Vermont Supreme Court reviewed the Board's 2016 determination that it did not have jurisdiction over the project. In June 2017, the Court rejected the Concerned Neighbors' appeal. Legislation has been introduced (S.263) to clarify the Board's ability to delegate work to staff.

Green Mountain Surgery Center: the Board decided that the applicant met its burden of proof and issued the surgery center a CON, with Member Hogan dissenting from the majority opinion.

Vermont Health Care Expenditure Analysis

The annual Health Care Expenditure Analysis Report provides spending information from two different perspectives: spending on behalf of Vermont residents, regardless of where they receive care; and spending by Vermont providers for both residents and non-residents receiving care in Vermont. The purpose of this report is to inform policy makers and the public about health care spending in Vermont, and serves as a guideline within which health care costs are controlled, resources directed, and quality and access assured.

Health Care Spending For Vermont

Health care spending for residents receiving services both in and out-of-state increased 2.9% in 2015. This was lower than the 4.7% increase in 2014 and below the average annual increase of 4.1% for the period 2006 through 2015.

Vermont Compared To United States

Health care spending in Vermont, per person, increased 3.0% from 2014 to 2015 to $9,112, below the national per person amount of $9,504, or 5.0%.

Vermont Provider Health Care Revenue

In 2015, health care revenue, as measured by services delivered by Vermont providers, regardless of whether the patient resides in Vermont, increased 5.5% in 2015. This was higher than the 1.9% increase in 2014 and higher than the average annual increase of 4.7% for the period 2006 through 2015.

Prescription Drug Monitoring

Act 165 of 2016 requires the Green Mountain Care Board, in collaboration with the Department of Vermont Health Access (DVHA), to: "Identify annually up to 15 prescription drugs on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing."

Ten drugs were identified through this process, four of which were also identified on the 2016 drug list.

Ranking	PRODUCT_NAME	LABELER_NAME	BG_IND	AVG_PERCENT_INCREASE	TOTAL_QUANTITY	TOTAL_AMOUNT_PAID	List appeared on:
1	VYVANSE	SHIRE US, INC.	B	58.60%	639,728	$5,473,510.83	5
2	METHYLPHENIDATE HCL ER	WATSON PHARMA, INC.	G	50.14%	615,342	$4,466,606.97	5
				18.50%			1
3	HUMIRA PEN	ABBVIE INC	B	102.80%	2,806	$4,978,270.95	5
4	LYRICA	PFIZER, INC	B	105.79%	724,390	$3,541,871.94	5
				19.77%			1
5	FOCALIN XR	NOVARTIS	B	80.32%	252,509	$2,846,464.99	5
				15.40%			1
6	ENBREL SURECLICK	AMGEN/IMMUNEX	B	87.95%	2,916	$2,417,969.47	5
				19.13%			1
7	NOVOLOG FLEXPEN	NOVO NORDISK, INC.	B	94.50%	95,305	$2,409,488.27	5
				16.43%			1
8	LATUDA	SUNOVION PHARMACEUTICALS, INC	B	95.30%	57,035	$1,754,771.27	5
				20.76%			1
9	EPIPEN 2-PAK	MYLAN SPECIALTY L.P.	B	152.89%	4,171	$1,193,858.28	5
10	NOVOLOG	NOVO NORDISK, INC.	B	94.52%	69,900	$1,583,541.29	5
				16.43%			1

All-Payer Accountable Care Organization (ACO) Model

The “Vermont All-Payer ACO Model Agreement”(All-Payer Model) is an agreement between the Centers for Medicare and Medicaid Services (CMS) and Vermont’s Governor, Secretary of the Agency of Human Services, and Chair of the Green Mountain Care Board (GMCB). The Agreement builds on previous all-payer payment alternatives to promote a more integrated, high quality system of care and a sustainable rate of overall health care cost growth. Instead of fee-for-service reimbursement, the model employs value-based payments that shift some risk to health care providers in an Accountable Care Organization (ACO), allowing more flexibility to focus on wellness and prevention services that keep people well, and encouraging collaboration across the care continuum.

2017 APM “Performance Year 0”

- Prepared for PY1 reporting on the All-Payer Model’s progress in the areas of health care cost growth, scale, and quality.
- Negotiated a “floor” to protect the State from low projected national Medicare growth in PY1. The Board set the 2018 Medicare benchmark at 3.5%, citing the rate of growth as being important for OneCare to make investments in PY1 of the APM Agreement that may be essential to achieving savings in later years.

Medicare Benchmark

- APM Agreement authorizes the Board to prospectively develop the benchmark for the 2018 Vermont Modified Medicare Next Generation ACO program, subject to the approval of CMS.
- Set the 2018 Medicare benchmark at 3.5%, citing the rate of growth as being important for OneCare to make investments in PY1 of the APM Agreement that may be essential to achieving savings in later years.

ACO Monitoring

- Initiated monitoring of the impact of the Vermont All-Payer Accountable Care Organization Model on health care cost growth, scale, and quality.
- Integrating this new model with our existing regulatory functions, including insurance rate review and hospital budget review.
- Monitoring ACO Primary Care Spend to determine whether investments in primary care are increasing under the new payment model.

ACO Oversight: Budget Review and Certification

In Act 113 (2016), the Legislature charged the Green Mountain Care Board with the oversight and regulation of Vermont's Accountable Care Organizations (ACOs).

GMCB Rule 5.000

- The ACO Oversight Rule, GMCB Rule 5.000, which was promulgated and became effective in late fall, sets forth standards for the Board to follow and criteria by which the ACOs would be evaluated as of January 1, 2018.
- The adopted rule was filed with LCAR and with the Secretary of State's Office on November 2, 2017, and took effect fifteen days thereafter, on November 17, 2017.

ACO Budget Review

- OneCare's final budget proposal, valued at $607 million, anticipated that over 120,000 Vermonters would be a part of the model through participation by health care payers (Medicare, Medicaid, BCBSVT) and primary care providers. Nine hospitals will participate in the risk-based model. Six will have contracts for Medicare, Medicaid, and Commercial services. Three hospitals chose to participate in the payment change only for Medicaid beneficiaries.
- On December 21, 2017, the Board voted to Approve OneCare's Budget with conditions.

ACO Certification

- Effective January 1, 2018, the Board has authority to certify ACOs. An ACO must be certified by the Board to receive payments from Medicaid or a commercial insurer through any payment reform program or initiative.
- In the rule approved on November 17, 2017, the Board identified the information and documentation an ACO must submit to complete its application to become certified.
- The Board voted to provide a provisional certification to OneCare Vermont on January 5, 2018. The Board will complete the certification in the first quarter of 2018.

Medicaid Advisory Rate Case For ACO Services

- In 2017, the Legislature extended the Board's authority to review and provide advisory input on Medicaid rates and the per-member-per-month (PMPM) amount that is negotiated between the Department of Vermont Health Access (DVHA) and the ACO.
- This review was completed and provided to DVHA and was also taken into consideration as the Board reviewed the ACO's budget submission.

ACO Model of Care and Integration with Community Providers

In Act 82, the Legislature required the Green Mountain Care Board to provide a summary of information relating to integration with community providers as part of its review of the ACO model of care and integration with community providers, including designated and specialized service agencies. In its budget submissions to the Green Mountain Care Board (dated June 23, September 7, and October 20, 2017), OneCare Vermont provided the following information about efforts to integrate with community providers.

Governance

- Community providers are represented within OneCare's governance structure, including on the Board of Managers as well as on issue-specific committees, where they help to direct the organization's strategy, identify clinical priorities, and more.

Care Models

- OneCare's Care Model relies on interdisciplinary, cross-organization, community-based care coordination to support health and wellness for attributed beneficiaries, particularly those with chronic illnesses. The Care Model is designed to provide different interventions depending on the patient's level of risk. The Care Model specifically identifies community providers, including Designated and Specialized Service Agencies, Home Health Agencies, Area Agencies on Aging, the SASH Program, the Agency of Human Services, and social services providers as key partners and potential members of patients' complex care teams.

Payment Models

- **Complex Care Coordination Program**: Designated and Specialized Service Agencies, Home Health Agencies, and Area Agencies on Aging receive $15 per-member per-month payments for each OneCare-attributed complex care patient if they are members of the patient's complex care team.
- **Patient Activation and Lead Care Coordinator Payment**: Additional $10 per-member per-month payments and $150 one-time activation payment to whichever organization on the complex care team is selected by the patient to be the Lead Care Coordinator.
- **Value-Based Incentive Fund**: Community providers are also eligible for bonus payments through the ACO's Value-Based Incentive Fund, awarded based on health service area-level performance on quality indicators.

ACO Shared Savings Program

Shared Savings Programs (SSPs) are formal arrangements between insurers and providers that allow groups of providers, such as ACOs, to share in financial savings. The amount of savings that providers earn is determined by how well they perform on specified quality measures. From 2014-2016, Vermont designed and implemented Commercial and Medicaid SSPs to test the theory that sharing savings with providers will motivate continuous improvements in care and reductions in cost. These SSPs were designed to align as much as possible with the SSP offered by Medicare, in which Vermont's ACOs have participated.

Participation

- Vermont's SSPs were initially designed as a three-year pilot, to run from January 2014 through December 2016.
- As of December 2016, more than 167,000 Vermonters (or about 27% of the State's population) were attributed to Commercial, Medicaid, or Medicare SSP-participating providers.
- The Department of Vermont Health Access (DVHA) elected to move to a more advanced payment model in 2017, implementing the Vermont Medicaid Next Generation ACO Pilot in conjunction with OneCare Vermont (see All-Payer Model section). BCBSVT continued to offer a Commercial SSP in 2017, with participation from OneCare Vermont and Community Health Accountable Care (CHAC).

Results

- **Medicaid SSP Financial Results**: In 2014, the two participating ACOs in the Medicaid SSP (OneCare Vermont and CHAC) achieved shared savings. CHAC also achieved savings in the Medicaid SSP in 2015 and 2016, though 2016 savings did not meet the 2% minimum savings rate that would have resulted in payment of savings to the ACO.
- **Commercial SSP Financial Results**: None of the ACOs participating in the Commercial SSP achieved savings in 2014 or 2015, at least partly because the financial targets were based on health insurance premiums rather than on historical claims experience. In 2016, the first year that targets could be based on some historical claims experience, CHAC achieved savings in the Commercial SSP.
- **Quality Results**: There have been progressive improvements in overall Commercial and Medicaid SSP quality scores from 2014-2016 for CHAC and OneCare, and continued high quality performance for VCP for the Commercial SSP. Had the ACOs achieved savings in the Medicaid or Commercial SSPs in 2016, all would have been eligible for at least 90% of savings based on their quality results.

Other Activities

- Vermont's SSP was part of a national movement toward advanced alternative payment models. Vermont's SSP performance fits within a national context of payment reform and innovation, and was a critical step in preparing Vermont (providers, ACOs, and the State) for the All-Payer Model.
- The All-Payer Model builds on the infrastructure and provider and payer readiness foundation developed through the SSPs, while addressing some challenges of that model. Compared to the SSPs, the All-Payer Model has stronger financial incentives to encourage high-quality, coordinated, efficient care for ACO members. Incentives continue to be aligned across payers due to the multi-payer approach.
- GMCB Reform activities have also served as an impetus for improved coordination of activities across organizations. There has been impressive collaboration among the three ACOs in clinical data collection and quality improvement.

Vermont Health Care Innovation Project (VHCIP)

In 2013, Vermont was awarded a $45 million State Innovation Model (SIM) grant, also known as the Vermont Health Care Innovation Project (VHCIP). The SIM opportunity was created by the Patient Protection and Affordable Care Act and is administered by the Center for Medicare & Medicaid Innovation (CMMI). Vermont's SIM grant ended in June 2017. The overall goal of VHCIP effort was the Triple Aim: Better care, better health, and lower costs.

Payment Model Design and Implementation

In 2017, activities in the Payment Model Design and Implementation Focus Area included:

- Continuing Vermont's existing Medicaid and commercial Shared Savings Programs and transitioning them to new programs under the All-Payer ACO Model.
- Launch of an Accountable Communities for Health peer learning opportunity for regions around the state that sought to bridge efforts to improve clinical care and expand community supports with public health initiatives.
- Efforts to advance Medicaid value-based payment for mental health services, substance use disorder treatment, developmental disability services, and long-term services and supports in alignment with the All-Payer ACO Model (also known as the Medicaid Pathway initiative).

Practice Transformation

In 2017, activities in the Practice Transformation Focus Area included:

- Continuing and expanding existing Learning Collaborative activities to strengthen care coordination.
- Concluding the VHCIP Sub-Grant Program, which provided grant funding to 14 competitively selected projects to implement and test provider-led innovations.
- Support to expand and develop Community Collaboratives to align Blueprint for Health and ACO governance and quality improvement activities.
- Workforce activities, including continued analyses of workforce supply data and completion of a micro-simulation workforce demand modeling effort.

Health Data Infrastructure

In 2017, activities in the Health Data Infrastructure Focus Area included:

- Continued efforts with ACOs and Designated Agencies/Specialized Service Agencies to connect additional providers to the statewide Vermont Health Information Exchange (VHIE).
- Continued work to improve data quality within the VHIE.
- Completion of two pilot projects to implement telehealth technology in line with Vermont's health reform goals.
- Continued development and strategic planning related to data storage and analytics.
- Continued efforts to design and implement electronic care management tools to support broader care management improvement efforts.

Vermont Health Care Innovation Project (VHCIP) Evaluation

The State-led evaluation of VHCIP, which concluded in June 2017, focused on three areas: care integration, payment reform and financial incentive structures, and use of clinical and economic data to promote value-based care. The federal evaluation includes both state-specific and cross-state analyses and consists of and examination of state progress on project initiatives, quantitative impact analysis using claims data for Medicaid, Medicare and commercially insured populations within Vermont, and cross-state studies including states' progress, challenges, and lessons learned. CMMI's federal evaluation is on-going and GMCB staff continue to support that effort.

Payment Reform

Substantial work was conducted by stakeholders through VHCIP to better align quality measures across payers to facilitate collection and reporting. The quality measures used in VHCIP informed the list of quality measures agreed upon for the All-Payer ACO Model. Through participation in Shared Savings Programs, providers developed a better understanding of financial risk and costs of care, what it takes to shift organizational culture toward value-based payments from volume-based payments, how to track and use quality metrics, and best practices to optimize quality. VHCIP served as a foundation for developing and moving to agreement on the All-Payer ACO Model (APM) designed to encourage delivery of well-coordinated, high quality person-level care within a defined all inclusive population-based payment. Additional work is still needed, however, to engage providers in connecting payment reform to practice operations to achieve desired reductions in costs of care and quality improvement.

Data and Data Infrastructure

VHCIP has created a data and data infrastructure environment which enables practices to more effectively participate in health care reform and has fostered an environment of innovation which resulted in the creation of data and data infrastructure demand that continues to raise the bar on practice effectiveness in the use of data. However, health care organizations were hesitant to build or maintain capacity without a clear understanding of how it would be sustained. This is specifically true for organizations participating in SSPs where organizations consider investing resources for data infrastructure and data support up front without guarantee of obtaining shared savings.

Care Coordination

Regional Community Collaboratives (RCCs) in each HSA had a history of inter-organizational collaboration, particularly around care coordination. Membership in the RCCs continued to expand under VHCIP, with more community based providers joining in. The RCCs are becoming increasingly sophisticated in the use of data to identify high need and high-risk patients in need of services and to monitor these patients over time. Vermont's State-led efforts at health reform have historically emphasized local buy-in and transparency, and these core implementation strategies carried over to VHCIP, especially with regard to care integration. However, coordination still primarily occurs by fax and phone rather than electronically, which creates barriers to data sharing. Alternative payment models will facilitate financial support of care management, but there is still substantial work to do before such models are fully implemented.

Data and Analytics

Overview

18 V.S.A. § 9410 assigns the Board the duty of maintaining an All-Payer Claims Database (APCD) named the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). In addition, the Board is responsible for oversight of the Vermont Uniform Hospital Discharge Data Set (VUHDDS) that is managed by the Vermont Department of Health. For these data sets, the Board oversees data collection, consolidation, and distribution, and manages access to the data.

The Board uses the data as well. Areas of inquiry include:

- determining the capacity and distribution of existing health care resources
- identifying health care needs and informing health care policy
- evaluating the effectiveness of intervention programs on improving patient outcomes
- comparing costs between various treatment settings and approaches
- providing information to consumers and purchasers of health care
- improving the quality and affordability of patient health care and health care coverage

Increased Capabilities

The Board has improved its capacity to manage and use these rich data sources; one of the most significant enhancements was the development and testing of a secure data enclave for VHCURES.

The data enclave delivers VHCURES data to staff in a more timely and efficient manner. Data reports that took several hours in the previous database can now be completed in minutes.

Supporting the All-Payer ACO Model

The Board successfully obtained approval to use Medicare data from the Centers for Medicare & Medicaid Services (CMS). The addition of Medicare data to VHCURES provides a more complete picture of health care spending and utilization in Vermont. To support the initiative, GMCB analytical staff have worked to ensure that data can be collected to help inform measure development and to assess the performance of the APM. Staff also provided state and federal policy makers with baseline information needed to set targets for the measures in the APM.

Health Information Technology

Overview

Act 54 of 2015 charged the Green Mountain Care Board with oversight of the budget and core activities of Vermont Information Technology Leaders (VITL). Specifically, Act 54 tasked the Board to "[a]nnually review the budget and all activities of VITL and approve the budget, consistent with available funds, and the core activities associated with public funding." Act 54 (2015) § 7 (adding 18 V.S.A. § 9375(b)(2)(C)).

Each year, the Secretary of Administration or its designee, the Department of Vermont Health Access (DVHA), funds this work by "enter[ing] into procurement grant agreements with VITL" after the Board "approves VITL's core activities and budget." This division of regulatory tasks recognizes the interdependent roles of the Board and the Administration in managing the state's relationship with VITL.

The Board's oversight is intended to provide strategic guidance and policy parameters within which the Administration, through DVHA, operationalizes that relationship.

FY 2018 VITL Budget Review Process

The Board adopted the following principles to guide its review of VITL's FY 2018 budget:

1. The review process will be transparent and will incorporate public input.

2. The Board will review VITL's budget and core activities in order to determine whether they reflect a strategy and priorities consistent with the State's health care reform goals and the Health Information Technology (HIT) Plan. The Board will not direct the technical details of VITL's work or the details of VITL's contractual relationship with the State.

3. The Board's review process must be structured and timed in order to assist the Department of Vermont Health Access (DVHA) and VITL in negotiating timely, effective grant agreements each year.

4. The process must result in Board decisions that are sufficiently clear to enable VITL to do its work and DVHA to support that work without requiring repeated clarification or intervention by the Board.

On-Going Oversight

VITL leadership presented a $6,033,000 FY 2018 budget to the GMCB on March 30, 2017. On April 13, VITL and DVHA informed the GMCB that public funding for VITL was $5,445,000. The GMCB approved this revised budget on April 13, 2017. VITL presents to the Board quarterly and additionally as requested to discuss key areas of work, provide updates on projects of interest, and provide financial updates. The Board will work with DVHA and VITL to support proper oversight and broader HIE planning as VITL transitions to a new CEO in Spring 2018.

Payment Differential and Provider Reimbursement Report

In 2017, the Board took substantial action to achieve site-neutral, fair reimbursements for medical services. The Board ordered that UVMMC, Vermont's academic medical center, reallocate $11.3 million in rate reductions to address the differential, cutting fees for Evaluation and Management services (i.e.: office visits) and reducing out-of-pocket costs for consumers . The rate reduction narrows the gap in payment differentials between provider types for these services. The Board formed a workgroup of stakeholders to focus on the issue of pay parity, and generate possible solutions that could be implemented. The Board conducted a survey and garnered useful information from a significant segment of clinicians in independent practices

Clinician Landscape Survey

The Board administered an anonymous survey of active clinicians to better understand the medical care climate in Vermont, including what clinicians find most rewarding, the stressors they face in their practices, the factors that drive their employment choices, and their outlook on the profession in Vermont. We learned the following key takeaways:

• Independently practicing clinicians cite strong patient relationships, the opportunity to run their own practice as well as flexibility and choice over work schedules as the factors most satisfying about their work.

• Independent clinicians are most frustrated by billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice and accessing costly technology.

•Employed clinicians are most satisfied about not having to run their own business, not being responsible for high practice costs, the opportunities to work with colleagues, and the certainty of their income in an employed setting.

• Like independent clinicians, employed clinicians find administrative burdens frustrating. They also identify the limited control they have over practice management, lack of control over their work schedule, and level of their income as frustrations.

• The top three most commonly cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement. The same top three threats apply to employed clinicians.

• Despite frustrations, the majority of clinicians, whether practicing independently or employed through a hospital, academic medical center, Federally Qualified Health Center (FQHC) or health clinic, are generally optimistic about their current employment and anticipate continuing to practice as they are today.

Clinician Focus Groups

In focus group sessions, participating clinicians discussed survey findings in more detail. Specifically, they discussed factors related to employment choice, how healthcare and payment reform efforts impact clinical practices, perceptions about the future of healthcare in Vermont, and what Vermont's health policy makers need to know about conditions in the healthcare marketplace.

•There is not a single story of the "clinician experience" but a few key takeaways emerged:

• Independent physicians who have been practicing for many years expressed concern about the negative impact of regulatory and compliance burdens, federal and state payment reform efforts, and increasing administrative demands on their ability to remain independent and provide timely patient care.

•Clinicians who switched from independent to employed status overwhelmingly identify the increasing costs of running independent practices (e.g. malpractice insurance, electronic health record systems, and increasing administrative workforce demands) as a primary driver of their decision to leave private practice.

•Clinicians who have been employed by a hospital system or health clinic during their entire career suggested that practice start-up costs, student debt burdens, and lack of business acumen served as barriers to seeking self-employment as a physician.

Green Mountain Care Board Budget

Green Mountain Care Board	FY 2017 Budget	FY 2017 Expenditures	FY 2018 Budget Post Rescission
Total Budget	$ 9,572,404	$ 6,126,093	$ 8,609,341
Expenses by Fund			
General Fund	$ 1,243,276	$ 756,272	$ 2,076,352
GMCB Regulatory & Administration Fund	$ 2,045,927	$ 1,115,360	$ 3,460,827
Other Special Funds	$ 60,000	$ 38	$ 60,000
Global Commitment	$ 4,281,832	$ 2,793,460	$ 2,567,518
Interdepartmental Transfer	$ 1,492,561	$ 1,440,369	$ 218,070
Federal Fund	$ 448,808	$ 20,594	$ 226,574
Expenses by Category			
Personal Services: Personnel Salary & Fringe	$ 3,468,390	$ 2,748,195	$ 3,614,154
Personal Services: Third Party Contracts	$ 5,268,019	$ 3,001,352	$ 4,330,149
Operating Expenses	$ 835,995	$ 376,546	$ 665,038

Board Members in 2017

GMCB began 2017 with two board vacancies:
Chair Al Gobeille stepped down on January 4, 2017, and Betty Rambur stepped down on January 15, 2017.

In September 2017, Con Hogan completed his term.


Kevin Mullin, Chair


Maureen Usifer

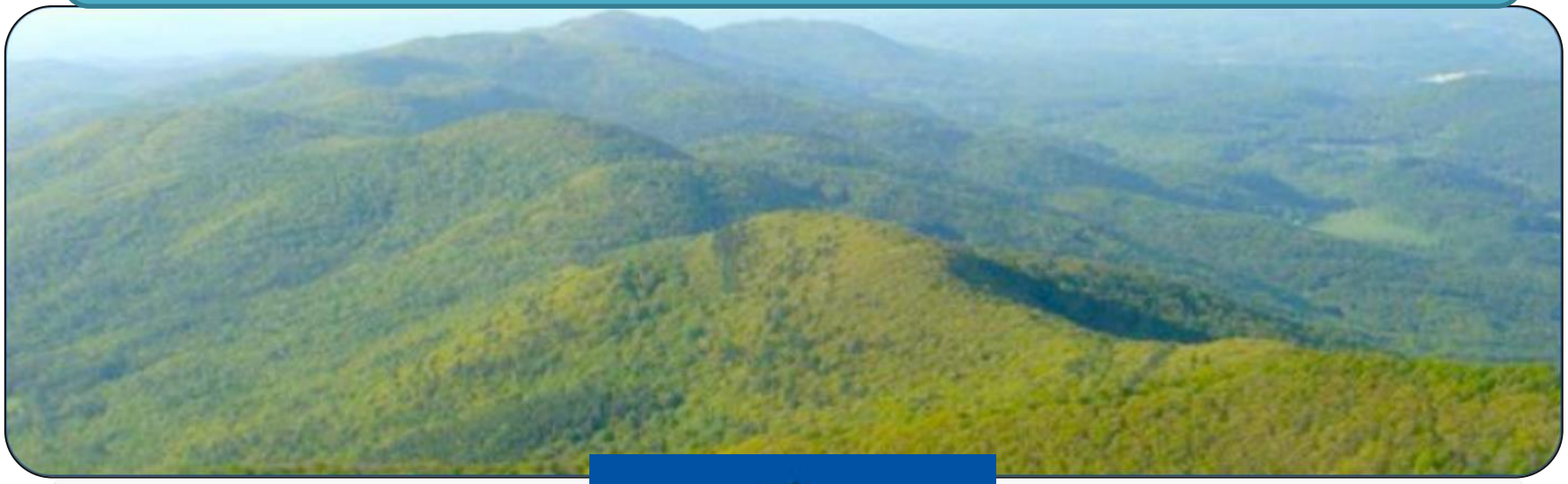

Jessica Holmes, Ph.D.


Robin Lunge, J.D., MHCDS


Tom Pelham

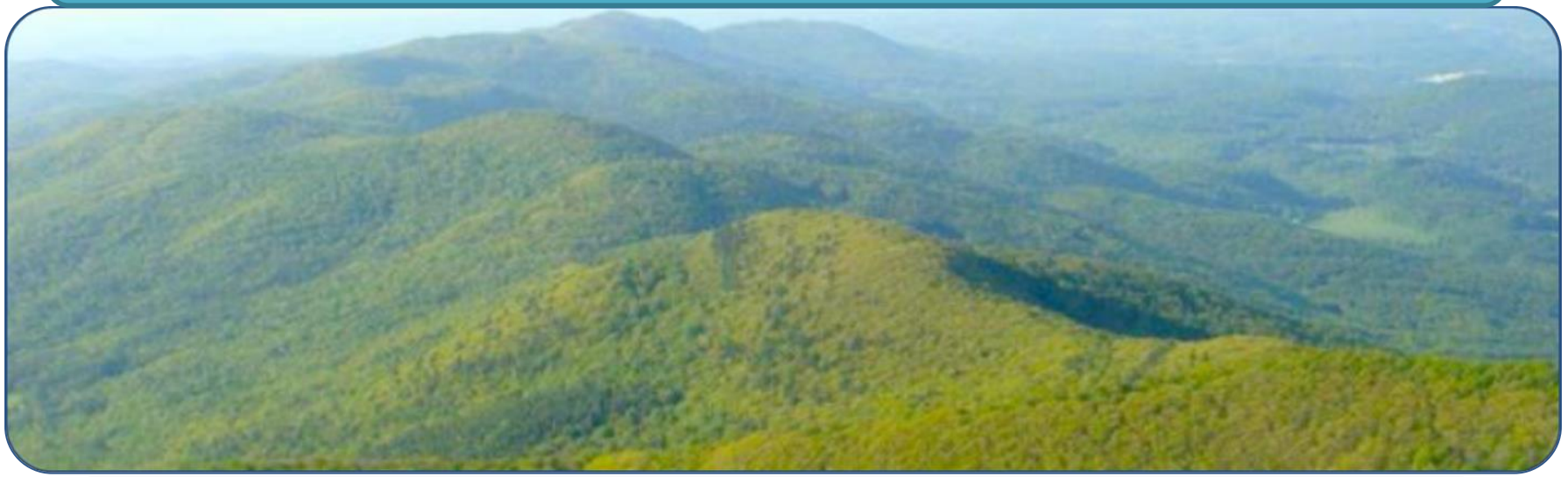
Click here for Board Member biographies

Legislation Establishing the Green Mountain Care Board



Act 48 of 2012

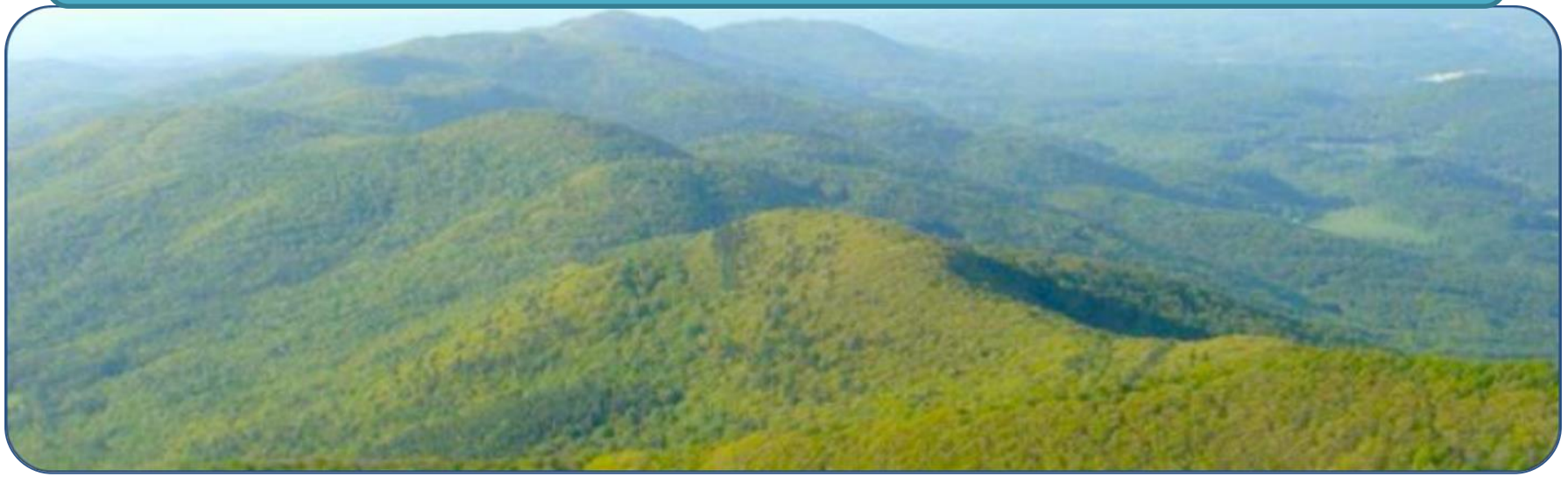
Requirements of this Report



18 V.S.A. § 9375. DUTIES

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the board comports with the principles expressed in section 9371 of this title.

Green Mountain Care Board



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