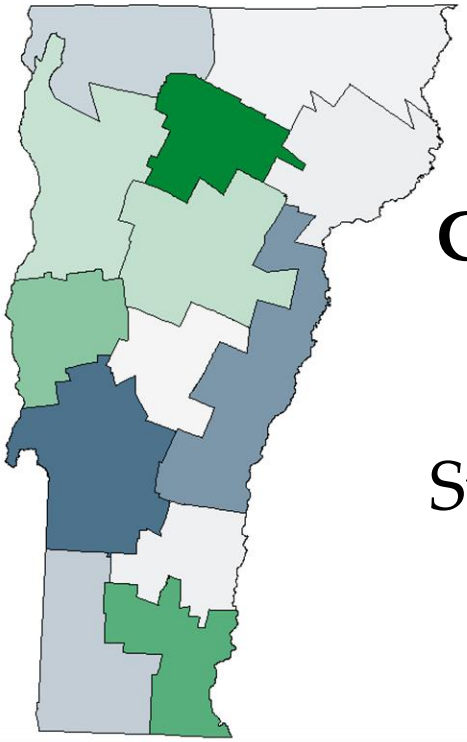

Green Mountain Care Board Overview

Kevin Mullin, GMCB Chair
Susan Barrett, GMCB Executive Director

January 16, 2019

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GREEN MOUNTAIN CARE BOARD

GMCB Members & Leadership

Kevin Mullin
GMCB Chair

Jessica Holmes, Ph.D.
GMCB Member

Robin Lunge, J.D., MHCDS
GMCB Member

Maureen Usifer
GMCB Member

Tom Pelham
GMCB Member

Susan Barrett, J.D.
GMCB Executive Director

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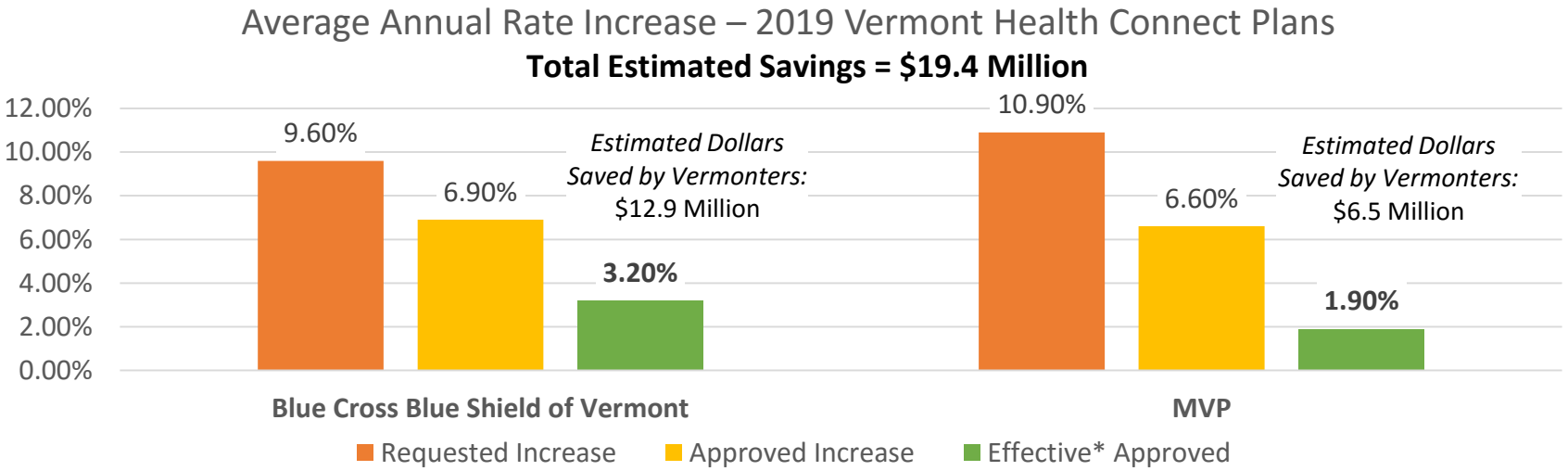
What is the Green Mountain Care Board?

- **Duties include:**
  - Review and approve health insurance rate increases annually
  - Review and approve hospital budgets annually
  - Review applications for Certificate of Need (CON)
  - Implement the All-Payer ACO Model (APM)
  - Oversee Vermont Accountable Care Organizations (ACOs)
  - Review and approve Vermont Health Information Exchange Plan, and budget oversight for Vermont Information Technology Leaders
  - Manage various health care datasets
  - Evaluate Vermont's health care spending and utilization
- **Mission**: To improve the health of Vermonters through a high-quality, accessible, and sustainable health care system.

Health Insurance Rate Review (Individual and Small Group Plans)

Relevant Statute/ Authority: 8 V.S.A. § 4062; 18 V.S.A. § 9375

Overview: The Board is tasked with reviewing major medical health insurance premium rates in the large, small, and individual insurance markets. The Board must determine whether a proposed rate is affordable, promotes quality care and access to health care, and protects insurer solvency.



* The "*effective*" rate increases—the actual rate increases that will be experienced by Vermonters—take into account the availability of additional federal subsidy dollars resulting from changes made to Vermont law during the 2018 legislative session.

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Hospital Budgets

Relevant Statute/Authority: 18 V.S.A. § 9375(b)(7); 18 V.S.A. § 9456

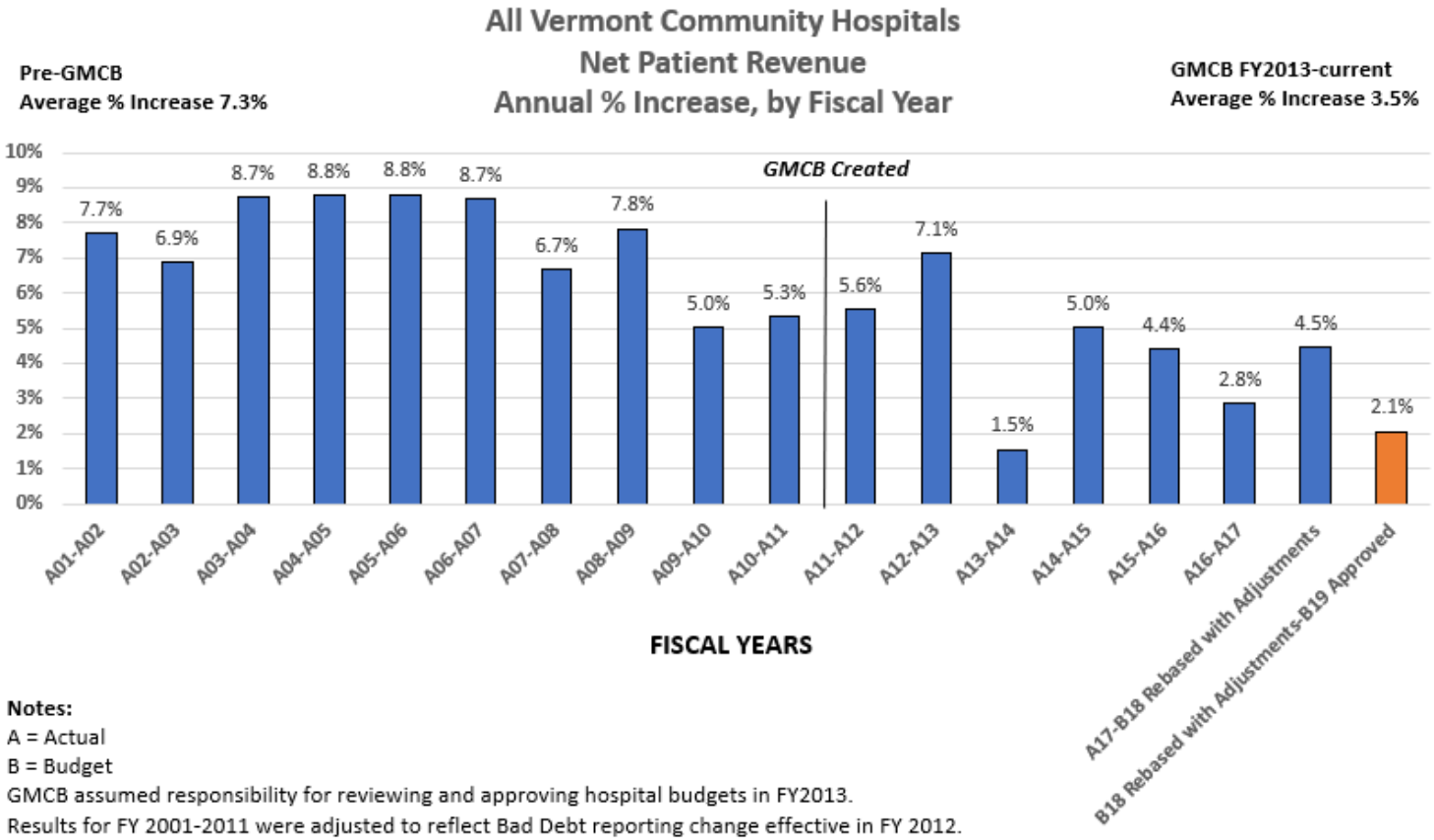
Overview: Annually by October 1, the Board has the responsibility to review and establish community hospital budgets.

- The Board is to promote the general good of the state by: improving the health of the population, reducing the rate of per capita health care cost growth while ensuring access to care and quality of care, enhancing the patient and provider experience of care, recruiting and retaining high quality health providers, and achieving administrative simplification.
- The Board may adjust a hospital's budget based on exceptional or unforeseen circumstances.

- FY2019 Hospital Budget Review: Hospitals initially requested a 2.9% increase in Net Patient Revenue (NPR) from the Board-approved Fiscal Year 2018 to the hospitals' submitted Fiscal Year 2019 budgets
- The Board approved a 2.1% NPR increase for Fiscal Year 2019 over the approved and adjusted Fiscal Year 2018 base ($52.8 million)

Hospital Budgets

Consistent with the Board's goal to reduce the rate of per capita health care cost growth, the average annual NPR increase since the responsibility for budget review was transferred to the Board (FY2012) is 3.5%, compared to an average annual NPR growth rate of 7.3% in FY2001-FY2011.



Notes:
A = Actual
B = Budget
GMCB assumed responsibility for reviewing and approving hospital budgets in FY2013.
Results for FY 2001-2011 were adjusted to reflect Bad Debt reporting change effective in FY 2012.

Certificate of Need (CON) 2018 Decisions

Relevant Statute/Authority: 18 V.S.A. § 9431- 9446.

Overview: Vermont law requires a hospital or health care facility to obtain a Certificate of Need before developing a new health care project as defined in 18 V.S.A. § 9434. This includes capital expenditures that meet statutory cost thresholds, purchase or lease of new equipment or technology that meet statutory cost thresholds, addition of new beds, any new home health services, health care facility ownership transfers (excluding nursing homes), and any new ambulatory surgical centers.

Each project must meet statutory criteria related to access, quality, cost, need and appropriate allocation of resources. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure equitable allocation of high-quality services/resources to all Vermonters.

- University of Vermont Medical Center (Replacement of Epic Health Information System)
- Rutland Regional Medical Center (Construction of New Medical Office Building)
- Kindred Healthcare (Corporate Restructure)
- University of Vermont Medical Center (Purchase of Real Estate in South Burlington)
- Gifford Health Care (Construction of an independent living facility)
- Northeastern Vermont Regional Hospital (Replacement of Mobile MRI with Fixed MRI)

For more information, see GMCB Certificate of Need webpage: http://gmcboard.vermont.gov/con/issued.

The Vermont All-Payer ACO Model:

Tackling Unsustainable Cost, Improving Quality and Outcomes

PROBLEM: The cost of health care in Vermont is increasing at an unsustainable rate and there is room to improve the health of Vermonters and the quality of care they receive.

STRATEGY:	**INTERVENTION:**
• *Care Delivery*: Facilitate integrated and coordinated delivery care across the continuum; focus more on primary care and prevention, deliver care lower cost settings, reduce duplication of services. • *Payment*: Move away from fee-for-service reimbursement, which rewards the delivery of more services, to population-based payments under which providers accept responsibility for the health of a group of patients in exchange for a set amount of money.	Implement a statewide ACO model under which the majority of Vermont providers participate in aligned programs across Medicare, Medicaid, and commercial payers. Agreement signed in 2016, enabling Medicare's participation.

All-Payer ACO Model: What Is It?

An ACO is a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high-quality care to patients

- 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.

All-Payer ACO Model Agreement

What is Vermont responsible for?

State Action on Financial Trends

- Moves from **volume-driven fee-for-service** payment… to a **value-based, pre-paid model for ACOs**
  - ✓ All-Payer Growth Target: Compounded annualized growth rate <3.5%
  - ✓ Medicare Growth Target: 0.1-0.2% below national projections
- Requires alignment across payers, which supports participation from providers and increases "Scale"
  - ✓ All-Payer Scale Target – Year 5: 70% of Vermonters
  - ✓ Medicare Scale Target – Year 5: 90% of Vermont Medicare Beneficiaries

State/Provider Action on Quality Measures

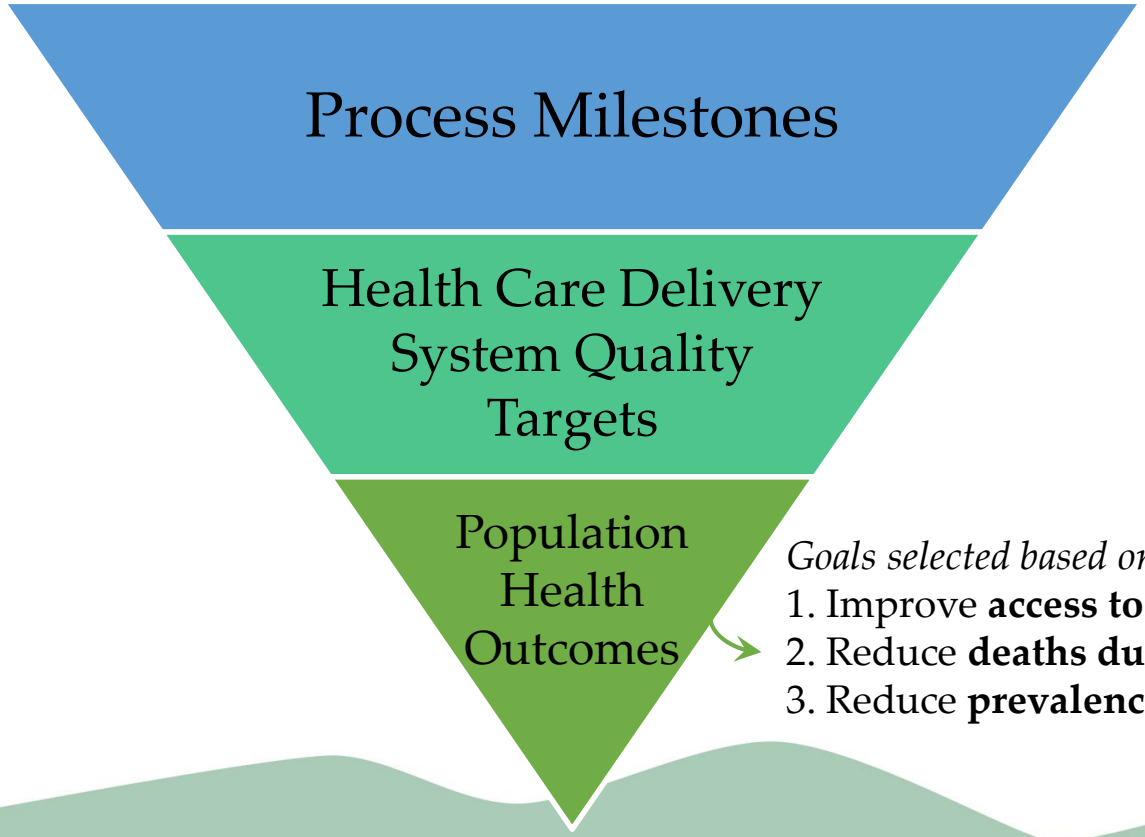
- State is responsible for performance on **20 quality measures** *(see next slide)*, including three population health goals for Vermont
  - ✓ Improve access to primary care
  - ✓ Reduce deaths due to suicide and drug overdose
  - ✓ Reduce prevalence and morbidity of chronic disease
- ACO/providers are responsible for meeting quality measures embedded in contracts with payers

Improving the Health of Vermonters

How will we measure success?

- Vermont is responsible for meeting targets on **20 measures** under the Model

Process Milestones and **Health Care Delivery System Quality Targets** support achievement of ambitious **Population Health Goals**



Goals selected based on Vermont's priorities:

1. Improve **access to primary care**
2. Reduce **deaths due to suicide and drug overdose**
3. Reduce **prevalence and morbidity of chronic disease**

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ACO Oversight: Certification & Budget Review

Relevant Statute/Authority: 18 V.S.A. § 9382; 18 V.S.A. § 9573 (Act 113 of 2016).

Overview: An ACO must be certified by GMCB to be eligible to receive payments from Medicaid or a commercial insurer through a payment reform initiative such as the APM. GMCB is also responsible for reviewing and approving ACO budgets. There is currently one ACO operating in Vermont: OneCare Vermont.

- Following an extensive review, the GMCB certified OneCare Vermont (OneCare) in March 2018. Reviewing continued eligibility for certification in January 2019.
- The GMCB reviewed OneCare's 2019 budget in late 2018. After careful analysis and an extended public comment period, the Board voted to approve OneCare's 2019 budget with conditions in December 2018.
- The approved budget is approximately $900 million with a vast majority of dollars flowing to providers, either through fixed payments from OneCare or fee-for-service payments from payers. This total reflects the inclusion of an estimated 196,000 Vermonters in ACO programs (up from 113,000 in 2018).

Health Information Technology

Relevant Statute/Authority: 18 V.S.A. § 9351; 18 V.S.A. § 9375

Overview: The Board has two major responsibilities related to health information technology:

- Review and approve the budget for Vermont Information Technology Leaders (VITL - Vermont's statutorily-designated clinical Health Information Exchange).
- Review and approve a state Health Information Technology Plan (now referred to as the state Health Information Exchange Plan, or HIE Plan) developed by DVHA.

- GMCB began receiving regular updates from VITL and DVHA in early 2018 in response to concerns about VITL's operations and performance. Act 187 of 2018 affirmed this course of action, and required DVHA and VITL to perform additional reporting.
- The Board reviewed and approved VITL's FY2019 budget in May 2018.
- DVHA proposed a Health Information Exchange Strategic Plan to the Board in Fall 2018. The Board voted to approve this plan in November 2018.

Data & Analytics

Relevant Statute/Authority: 18 V.S.A. § 9410.

Overview: The Board must maintain a unified health care database, reflecting health care utilization and costs for services provided in Vermont and to Vermont residents in another state. The Board maintains stewardship of two primary data sets:

- The Vermont Uniform Hospital Discharge Data Set (VUHDDS)
- The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

- Staff are developing visualizations of GMCB reports, including the annual Vermont Health Care Expenditure Analysis Report, to increase utility and accessibility.
- The GMCB reconvened its Data Governance Council with new, broader membership to ensure diverse viewpoints related to data stewardship.
- The GMCB is working to enhance Vermont's all-payer claims database, VHCURES, which comprises eligibility and claims data for most Vermont residents.
- Increasing capacity for in-house analysis to support regulatory decision-making, reducing GMCB reliance on contractors.

GMCB Priorities in 2019

1. **Year 2 All-Payer ACO Model (APM) Implementation:** Focused on meeting the goals of the APM Agreement while exercising robust ACO Oversight.
2. **Regulatory Integration:** Linking health insurance rate review, hospital budget review, Certificate of Need, and ACO certification and budget review to support the APM and overall goals.
3. **VHCURES 3.0:** New vendor to manage VHCURES system.
4. **HRAP 2020:** Act 167 of 2018 amended the requirements for the Health Resource Allocation Plan (HRAP). GMCB is working to re-imagine and assemble the HRAP as a series of dynamic reports, visualizations, or other user-friendly tools in 2019.
5. **Health Care Workforce:** Work with educators, health care providers, and state and community organizations to discuss opportunities to address Vermont's health care workforce challenges
6. **Transparent Regulation:** GMCB strives for transparency and public engagement in its regulatory activities.