Green Mountain Care Board

ANNUAL REPORT FOR 2019

The Green Mountain Care Board seeks to improve the health of Vermonters through a high-quality, accessible, and sustainable health care system.

Submitted January 15, 2020

In accordance with 18 V.S.A. § 9375(d)

VERMONT

Green Mountain Care Board
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To: Sen. Anne Cummings, Chair, Senate Committee on Finance
Sen. Ginny Lyons, Chair, Senate Committee on Health and Welfare
Sen. Jane Kitchel, Chair, Senate Committee on Appropriations
Rep. Janet Ancel, Chair, House Committee on Ways and Means
Rep. Kitty Toll, Chair, House Committee on Appropriations
Rep. William J. Lippert, Chair, House Committee on Health Care

From: Green Mountain Care Board
Date: January 15, 2020
Title: 2019 Annual Report

Dear Sen. Cummings, Sen. Lyons, Sen. Kitchel, Rep. Ancel, Rep. Toll, and Rep. Lippert:

Please accept the annual report of the Green Mountain Care Board (hereafter GMCB or Board), as required by 18 V.S.A. § 9375(d).

The Board is guided by its statutory charge "to promote the general good of the state by: (1) improving the health of the population; (2) reducing the per capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised; (3) enhancing the patient and health care professional experience of care; (4) recruiting and retaining high quality health care professionals; and (5) achieving administrative simplification in health care financing and delivery."

2019 was a busy year for the GMCB. I am encouraged daily by the hard-working State employees at the GMCB, who, with Board Members, are committed to the difficult work of controlling health insurance premium growth, analyzing hospital and accountable care organization (ACO) budgets and new health care projects and expenditures, pursuing health care payment and delivery reforms, and developing a new statewide Health Resource Allocation Plan. And as we complete Year Two of the All-Payer ACO Model Agreement, the Board continues to work closely with our State and federal partners to move Vermont's health care system away from fee-for-service and towards one that encourages prevention, wellness, and better coordination of care.

We look forward to working with you during the upcoming Legislative Session.

Sincerely,

Kevin J. Mullin
Chair, Green Mountain Care Board

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EXECUTIVE DIRECTOR'S REPORT

Throughout 2019, the Board worked to improve the health of Vermonters by supporting the development of a high-quality, accessible, and sustainable health care system. The Board recognizes that for many Vermonters, health care remains unaffordable. Through its regulatory, innovative, and evaluative roles, the Board strives every day to bend the cost curve.

Green Mountain Care Board Themes from 2019

Major themes of the Board's work in 2019 were All-Payer ACO Model (APM) implementation, rural health system sustainability, and regulation and oversight.

All-Payer ACO Model Implementation

The Board and its staff continued to focus on the implementation of the APM Agreement between the State of Vermont and the Center for Medicare and Medicaid Innovation (CMMI). This agreement, which enters Year 3 in 2020, provides the opportunity to improve health care delivery to Vermonters by rewarding efforts to keep people well. This is consistent with the federal shift toward alternative payment models that reward value over volume.

This past year saw an expansion of payer and provider participation in health reform efforts under the APM. Based on 2020 hospital and ACO budget submissions, we anticipate 14 hospitals, 9 Federally Qualified Health Centers, and 10 Designated Agencies will participate through OneCare Vermont in alternative payment programs with Medicare, Medicaid, MVP Health Care, and Blue Cross Blue Shield of Vermont. We are pleased to see an expansion of the "coalition of the willing" but recognize more work must be done to achieve model scale, as required by the APM Agreement.

Although the APM is still young, there are some promising signs of delivery system reform: hospitals are increasing their investments in primary prevention and the social determinants of health; traditionally siloed providers are finding new ways to coordinate care and reduce duplication of services across the care continuum, and advances in data analytics are helping to identify high risk patients who would benefit most from early intervention and complex care coordination. While delivery system reform is by no means complete, we recognize that major transformation requires patience and time, and this reallocation of resources towards population health is reassuring. In 2019, the APM brought additional flexibility to Vermont providers through Medicare waivers. For example:

- Through a telehealth waiver included in the APM Agreement, the Support and Services at Home (SASH) program was able to provide Medicare recipients with access to primary care visits through an on-site telehealth facility, reducing transportation challenges for elderly residents.
- At its budget hearing this August, Porter Hospital in Middlebury described using the "three-day stay SNF waiver" to allow Medicare beneficiaries to access rehabilitation services at skilled nursing facilities without a previous three-day hospital stay. From May 2018 to May 2019 this waiver alone enabled 48 patient transfers, resulting in $907,299 of savings to the system.

Rural Health System Sustainability

Across the country, rural health care providers are struggling financially. From 2010-2019, 119 rural hospitals have closed, according to the University of North Carolina's Cecil G. Sheps Center for Health Services Research.[1] Vermont is not immune to the national trends affecting rural hospitals; workforce

[1] See https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

shortages, skyrocketing drug costs, growth in bad debt and free care, and an aging and declining population are increasing the financial pressure on many community hospitals. In 2019, Vermont saw the impact of the challenges to providing health care in a rural state firsthand as Springfield Hospital was forced to file for Chapter 11 bankruptcy. Other Vermont hospitals are struggling to stay in the black as well; six out of Vermont's 14 hospitals concluded 2018 with a negative operating margin.

After the announcement of Springfield's predicament, the goal of the State of Vermont and the Board was to ensure access to health care for all Vermonters served by this hospital service area. The Board has increased its monitoring of vulnerable hospitals and is working with them to develop financial sustainability plans. The Board also provided a re-assessment of financial health of the Vermont Critical Access Hospitals at the Governor's request.[2] Consistent with the above, the Board asked six hospitals with the greatest financial pressures to submit sustainability plans outlining their strategy to tackle cost, quality, and access. National experts, including Eric Shell of Stroudwater Associates, who presented to the GMCB in April 2019,[3] recommend rural health care providers seek out and participate in value-based models and coordinate and collaborate on patient care within available networks in order to survive and thrive in a rural setting. The Board and its staff are working with Vermont hospitals to create a roadmap at both the state and hospital levels to ensure financial viability and success in the future, which will require addressing workforce shortages.

In addition, the Legislature passed Act 26 of 2019, which created the Rural Health Care Task Force. This task force, chaired by Board Member Robin Lunge, is charged with evaluating "the current state of health care in Vermont and identify ways to ensure the system and to make sure it provides access to affordable, high-quality health care services." The task force will present its findings to the Legislature in early 2020.

Regulation and Oversight

Hospital Budget Review (see pg. 14): In 2019, the Board approved an estimated weighted average increase in hospital charges of 3.1% and reduced the system-wide increase in net patient revenue from a requested 4.6% to 4.3%, totaling $7.3 million in savings. The Board's decision came after several weeks of hospital narratives describing an environment over which they have little control: an aging population of higher acuity, rising costs of pharmaceuticals, workforce shortages forcing an overreliance on high cost temporary workers, a growing number of underinsured Vermonters leading to growth in bad debt and free care, and a changing payer mix caused by an increase in the number of patients who rely on Medicare and Medicaid for health insurance.

Health Insurance Premium Rate Review (see pg. 13): Many of the forces affecting hospitals have also affected insurance premiums. Vermont's aging population means a higher rate of chronic disease, greater health care utilization and increased medical expenditures. Higher prices, particularly for prescription drugs, as well as changes in federal taxes and fees, have placed additional pressure on health care premiums, deductibles, and copays this year. Through the health insurance rate review process, the Board reduced the rates requested by insurers by approximately $12.3 million, including

[2] GMCB Report on Financial Health of Vermont's Critical Access Hospitals at: https://gmcboard.vermont.gov/sites/gmcb/files/Merged%20letter%20and%20CAH%20report%201.9.2019.pdf
[3] See materials from April 3 Board meeting, available at: https://gmcboard.vermont.gov/board/meeting/minutes/2019.

$11.2 million for plans sold to individuals, families, and small businesses through Vermont Health Connect. Nonetheless, many Vermonters will experience significant premium increases this year.

Certificate of Need (CON) (see pg. 16): In 2019 the Board reviewed six CON applications, while determining that another 10 proposed projects fell outside of statutory jurisdictional parameters and were not subject to Board oversight.

ACO Oversight (see pg. 21): Beginning in the fall of 2019 and until year end, the Board rigorously examined the budget and operations of OneCare Vermont, which resulted in the Board approving a $1.4 billion OneCare budget on December 18, 2019. The Board's approval included 23 conditions which will support robust oversight, transparency, and accountability for the ACO in 2020. The 2020 budget reflects the inclusion of an estimated 250,000 Vermonters in ACO programs (an increase of 90,000 from 2019). We remain optimistic that the increased emphasis on primary prevention and complex care coordination, greater investment in the social determinants of health, and the move to more predictable, value-based payment has potential to improve health outcomes, reduce costs, and make health care more affordable for Vermonters.

Priorities for 2020

1. APM Implementation and ACO Oversight

As we enter Year 3 of implementation of the All-Payer ACO Model (APM), the Board continues to focus on meeting the goals of the APM Agreement while continuing to exercise robust oversight over Vermont's only ACO, OneCare Vermont. The Board plans to continue to develop and refine ACO reporting requirements in 2020 as part of its statutory monitoring and oversight responsibilities, including the design and implementation of an ACO performance dashboard.

2. Regulatory Integration

Under the APM Agreement, integration of the Board's regulatory processes – including health insurance rate review, hospital budget review, Certificate of Need, and ACO certification and budget review – has become increasingly important. Board members and staff will continue to work in 2020 to link these processes to help control rising costs and promote administrative and operational efficiencies. A white paper on options for regulatory alignment will be released in 2020, including results from a survey and focus group conducted in 2019 with key stakeholders (see pg. 10).

3. Sustainability of Vermont's Rural Health Care System

As described above, rural health care system sustainability was a major focus of the Board's work in 2019. This is expected to continue in 2020, as the Rural Health Services Task Force (RHSTF) submits its report and recommendations to the Legislature. The Board will also continue to work to support rural health care providers through its existing authorities, especially the hospital budget review process.

4. HRAP 2020

In 2018, the Legislature in Act 167 amended the requirements for the Health Resource Allocation Plan (HRAP). Board members and staff will continue to work throughout 2020 with other State of Vermont agencies and departments, as well as external partners, to re-imagine and assemble the HRAP as a series of dynamic reports, visualizations, or other user-friendly tools. Per statute, the HRAP will "inform the Board's regulatory processes, cost containment and statewide quality of care efforts, health care payment and delivery system reform initiatives, and any allocation of health resources within the State." 18 V.S.A. § 9405(b). The Board expects to release Phase 1 of HRAP in early 2020 (see pg. 23).

5. Health Care Workforce

The Board is charged with ensuring access to high quality health care while reducing the cost of that care, and health care workforce is a critical piece of this work. Workforce has been a major focus of the Board's work under Chair Mullin's active leadership: in 2019, the Board held several panel discussion and forums to highlight the health care workforce crisis, with topics ranging from review of Vermont's nursing shortage to provider burden, and this work will continue in 2020. The Board's Primary Care Advisory Group (PCAG) identified potential solutions to alleviate the serious shortage and looming crisis of primary care providers in Vermont. PCAG plans to present their proposal at a scheduled primary care workforce panel at the GMCB on January 15.

LEGISLATIVE REPORTS

Figure 1: Legislative Reports Submitted by GMCB, January 2019-January 2020

Report	Due Date	Corresponding Statute and 2019 Legislation
Billback Report	September 15, 2019	Act 79 of 2013, An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board, Sec. 37c (H.107)
Informed Health Care Financial Decision Making	November 15, 2019	Act 53 of 2019, An act relating to informed health care financial decision making and the consent policy for the Vermont Health Information Exchange, Sec. 2-3 (S.31)
Social Service Integration	December 1, 2019	Act 52 of 2019, An act relating to social service integration with Vermont's health care system, Sec. 2 (S.7)
Impact of Prescription Drug Costs on Health Insurance Premiums	January 1, 2020	18 V.S.A. § 4636 (b) Act 193 of 2018, An act relating to prescription drug price transparency and cost containment, Sec. 8 (S.92)
Primary Care Spend	January 15, 2020	Act 17 of 2019, An act relating to determining the proportion of health care spending allocated to primary care (S.53)
Cost Shift Impact *See Appendix A*	January 15, 2020	18 V.S.A. § 9375 (d) Act 63 of 2019, An act relating to health insurance and the individual mandate, Sec. 10 (H.524)
Rural Health Services Task Force	January 15, 2020	Act 26 of 2019, An act relating to the Rural Health Services Task Force, (H.528)
GMCB Annual Report	January 15, 2020	18 V.S.A. § 9375(d)
Expenditure Analysis	January 15, 2020	18 V.S.A. § 9375a (b) (repealed) 18 V.S.A. § 9383(a) (added in Act 167 of 2018, H. 912) Act 167 of 2018, An act relating to the health care regulatory duties of the Green Mountain Care Board (H.912)

Figure 2: Additional Legislative Reports Assigned during 2019 Legislative Session

Report	Due Date	Corresponding Statute and 2018 Legislation
Licensure of Ambulatory Surgical Centers	January 15, 2021	18 V.S.A. § 9375 (b)(14) Act 55 of 2019, An act relating to licensure of ambulatory surgical centers, (S.73) *Note: To be repealed on January 16, 2026.*
Chiropractic and Physical Therapy Copays	November 15, 2021	Act 15 of 2019, An act relating to miscellaneous provisions affecting navigators, Medicaid records, and the Department of Vermont Health Access, Sec. 3 (H.204)

STAKEHOLDER ENGAGEMENT IN 2019

The Green Mountain Care Board believes that all Vermonters are stakeholders in Vermont's health care system, and that public engagement and transparency are foundational to its work. The GMCB seeks stakeholder participation through a variety of forums, groups, and public comment opportunities, including:

- Green Mountain Care Board Meetings;
- The GMCB General Advisory Committee;
- The Primary Care Advisory Group;
- The Data Governance Council; and
- Ongoing and focused public comment opportunities.

GMCB Board Meetings

The Green Mountain Care Board generally meets weekly in open public meetings. GMCB meetings operate in accordance with Vermont's Open Meeting Law: they are noticed in advance, open to the public, audio-recorded, include an opportunity for public comment, and following the meeting, minutes are posted to the GMCB website. In addition, most meetings are videotaped by Onion River Community Access Media (ORCA). In 2019, the Board held 46 open meetings, including regular Board meetings, public hearings on proposed health insurance rate increases, Certificate of Need (CON) hearings, and public hearings on proposed hospital and ACO budgets, each of which included time for public comment. In addition, every year the Board travels to communities outside of Montpelier; in 2019, the Board hosted public meetings in Randolph, St. Albans, Castleton, and Middlebury.

GMCB General Advisory Committee

The GMCB General Advisory Committee[4] was formed in 2012 to provide input and recommendations to the Board, as required by 18 V.S.A. § 9374(e)(1). In 2018, the Board launched a redesign of the committee to better utilize members' time and expertise to support the Board's work. The Board reconvened the Advisory Committee in early 2019 with the new membership and worked with the committee to develop a charter outlining the group's purpose and its future work. The committee's current membership includes 21 representatives of Vermont businesses, consumers, health care providers and educators, patient advocates, and insurers.

Since the redesign, the Board has held three of the four annually scheduled General Advisory Committee meetings. The meetings featured presentations and small group discussions with the goal of utilizing the varied backgrounds and experiences of the Advisory Committee members. Meeting topics include the APM; OneCare Vermont ACO; the Health Resource Allocation Plan (HRAP); GMCB legislative priorities; health care workforce; and the make-up and work of the GMCB General Advisory Committee going forward. The General Advisory Committee is staffed by a GMCB staff member and chaired by the GMCB Executive Director, and all Board members attend each meeting.

[4] More information on the GMCB General Advisory Committee is available at: http://gmcboard.vermont.gov/board/advisory-committee

Primary Care Advisory Group

The Primary Care Advisory Group (PCAG)[5] was established in Act 113 of 2016 to provide input to the Board and address issues related to the administrative burden facing Vermont primary care professionals. In accordance with Act 113, the PCAG sunsetted on July 1, 2018. Recognizing the importance of this group, the Board used the authority granted in 18 V.S.A. § 9374(e)(2), which allows the Board to create advisory groups to carry out its duties, to continue to convene the PCAG. The current PCAG includes twelve primary care providers (a mix of physicians, nurse practitioners, and advanced practice registered nurses). It is staffed by a GMCB staff member and the GMCB Executive Director, and one rotating Board member attends each meeting. The PCAG met eight times in 2019 and presented once at the Board's regularly scheduled public meeting. In 2019, the group identified health care workforce as its main priority; this was the subject of a March 2019 presentation by some PCAG members to the Board, which included PCAG's concerns about physician burnout and recommendations for strengthening primary care in Vermont. The PCAG has also been assisting in the development of the HRAP and will continue to provide important clinical expertise for this project.

The group will continue to highlight opportunities for improving access to primary care and respond to specific Board questions and requests through presentations at public Board meetings. Potential areas for future discussion include hospital budget review, oversight of ACOs, payment and delivery system reform, health information technology, data collection and databases, and health care workforce planning.

Data Governance Council

The Data Governance Council[6] is a committee of the Board that supports the Board's data governance and stewardship and has the authority to make and execute decisions and assign resources to priority areas. The Data Governance Council, which meets bimonthly in open public meetings, consists seven voting members and currently includes one Board Member. In 2019, the Data Governance Council adopted revised Data Stewardship Principles and Policies;[7] addressed policy guidance around data linkage concerns and opportunities, as well as structures for allowable data release based on intended use; and considered specific data release applications and data linkage requests. Please see the Data and Analytics section on pg. 22 for more information.

Surveys and Focus Groups

Regulatory Alignment

During summer 2019, the GMCB engaged interested stakeholders through a survey and focus group to provide insight and other considerations for regulatory timeline design and policy alignment across four key regulatory areas: financial measurement, quality measurement, delivery system roles and responsibilities, and risk and reserves. Stakeholders engaged in this process included representatives from hospitals, primary care, specialty providers, mental health, home- and community-based services, or other non-hospital providers, payers, ACO, associations, consumers, and executive branch agencies.

[5] More information about the GMCB Primary Care Advisory Group is available at: http://gmcboard.vermont.gov/content/primary-care-advisory-group

[6] For more information on the GMCB Data Governance Council, see: https://gmcboard.vermont.gov/health-data-resources/data-governance/meetings.

[7] Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB_Data_Stewardship_Principles%26Policies-V2.0_April2019-ADOPTED.pdf.

Possible regulatory alignment proposed for consideration included:

- Streamlining and increasing stakeholder understanding of GMCB regulatory processes, ensuring that regulatory processes inform one another, and working toward alignment on key policy issues addressed by GMCB;
- Developing metrics to allow for comparison across GMCB regulatory processes (e.g., a per-person measure of spending for use across GMCB regulatory processes); and
- Envisioning future GMCB regulatory structures as Vermont continues to shift from fee-for-service to population-based payment models.

Data collected from stakeholder participants helped inform a white paper produced by the GMCB, expected in 2020.

Provider Participation in the All-Payer ACO Model

The GMCB and State of Vermont partner agencies conducted a survey in summer 2019 regarding provider participation in the All-Payer ACO Model. Vermont hospitals and federally qualified health centers (FQHCs) identified barriers to participation and Model scale and suggested potential strategies that State, federal, and ACO partners could use to eliminate these barriers. Examples of strategies to increase provider participation include:[8]

- Design an option for primary care to join without a hospital partner;
- Offer multiple ACO risk models based on hospital size and readiness;
- Improve clarity of contracts between the ACO and FQHCs;
- Offer or facilitate networked-based telehealth opportunities to smaller providers; and
- Continue to improve ACO-facilitated health information technology resources.

Rural Health Services Task Force

The Rural Health Services Task Force (RHSTF) was established in Act 26 of 2019 to evaluate the current state of rural health care in Vermont and identify ways to sustain the system while ensuring access to affordable, high-quality health care services. The Task Force, convened in June 2019, was chaired by GMCB Member Robin Lunge. Membership included state agency representatives, the Health Care Advocate's Office, health care providers and institutions. The Task Force submitted a final report[9] on January 10, 2020 which includes recommendations on four critical areas: workforce, financial resources, telehealth, and care management.

Opportunities for Public Comment

Members of the public are invited to provide comment to the GMCB at any time. The Board works with the Health Care Advocate, State agencies and departments, health care organizations, and members of the public to solicit and receive a broad spectrum of information to better assist the Board in its regulatory decision-making processes. In addition to the specific opportunities outlined above, the GMCB accepts public comment submissions via a standardized form available on the GMCB website, by telephone and U.S. mail to the GMCB offices, and by email.[10]

[8] Insights from Hospitals/FQHC Scale Survey: Results and Reactions Memo, *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf
[9] Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/Rural%20Health%20Services%20Task%20Force-%20Act%2026%20of%202019%20-%20Report%20%26%20Recommendations.pdf.
[10] The Board's Public Comment webpage can be found at: https://gmcboard.vermont.gov/board/comment.

PROGRESS IN 2019

HEALTH INSURANCE REGULATION

Health Insurance Rate Review

Project Area: Health Insurance Regulation

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. Within 90 days of submission, the Board must determine whether a proposed rate is affordable, promotes quality care and access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law.

Progress in 2019

- Rate Filings: The Board reviewed 8 rate filings in 2019,[11] representing approximately $589.0 million in health insurance premiums for approximately 92,000 Vermonters, with over 74,000 on the Exchange. Insurers requested approximately $82.0 million in premium increases. The Board reduced this amount by an estimated $12.3 million, including $11.2 million for plans sold on the Exchange.[12] Approved average rate increases for Exchange plans were 10.1% for MVP and 12.4% for Blue Cross and Blue Shield of Vermont.
- Rate Drivers: The cost of pharmaceuticals, particularly specialty pharmaceuticals, contributed significantly to the rate increases. Increases in the use of professional services (i.e., primary care, mental health, substance use, and laboratory and radiology services) and the return of the federal Health Insurance Providers Fee[13] also contributed to the increases. Reduced unit cost trends linked to the Board's hospital budget review helped offset increases.
- Impact of Federal Changes and the ACO: The Board's review of filings was impacted by changes in the availability of association health plans for 2020. Also, Blue Cross and Blue Shield of Vermont's rates for plans that will be sold on the Exchange in 2020 were reduced by its risk-sharing arrangement with OneCare Vermont.

Looking Ahead to 2021

- Federal Issues: In its Notice of Benefits and Payment Parameters for 2020, CMS expressed discomfort with the practice of "silver loading" and requested comments on ways in which it might address the practice in future rulemaking. As part of the "Further Consolidated Appropriations Act, 2020," Congress prohibited the federal government from taking any action to restrict the practice of silver loading for 2021.[14] Congress also repealed the Health Insurer Providers Fee effective in calendar year 2021.[15]
- State Issues: Section 12 of Act 63 (2019) requires the Agency of Human Services to evaluate Vermont's health insurance markets to determine the potential advantages and disadvantages of changing or maintaining Vermont's current health insurance market structure. We anticipate that this will be a subject of discussion during the upcoming session.

[11] The filings were reviewed in 2019 for renewals in 2019 and 2020.
[12] For a summary of 2019 filings and approved rates, see: https://ratereview.vermont.gov/. Filings for Review Year 2019, see: https://gmcboard.vermont.gov/sites/gmcb/files/documents/Health_Insurance_Rate_Review_2019.pdf.
[13] In January 2018, Congress imposed a moratorium on collection of the Health Insurance Providers Fee for plan year 2019 as part of a short-term government funding bill. See Pub. L. No. 115-120 (2018).
[14] Pub. L. No. 116-94, Division N, Title I, Subtitle E, Sec. 502.
[15] *Id.* at Subtitle F, Sec. 609.

REGULATING HEALTH CARE AND EVALUATING SPENDING

Hospital Budget Review

Project Area: Regulating Health Care and Evaluating Spending

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

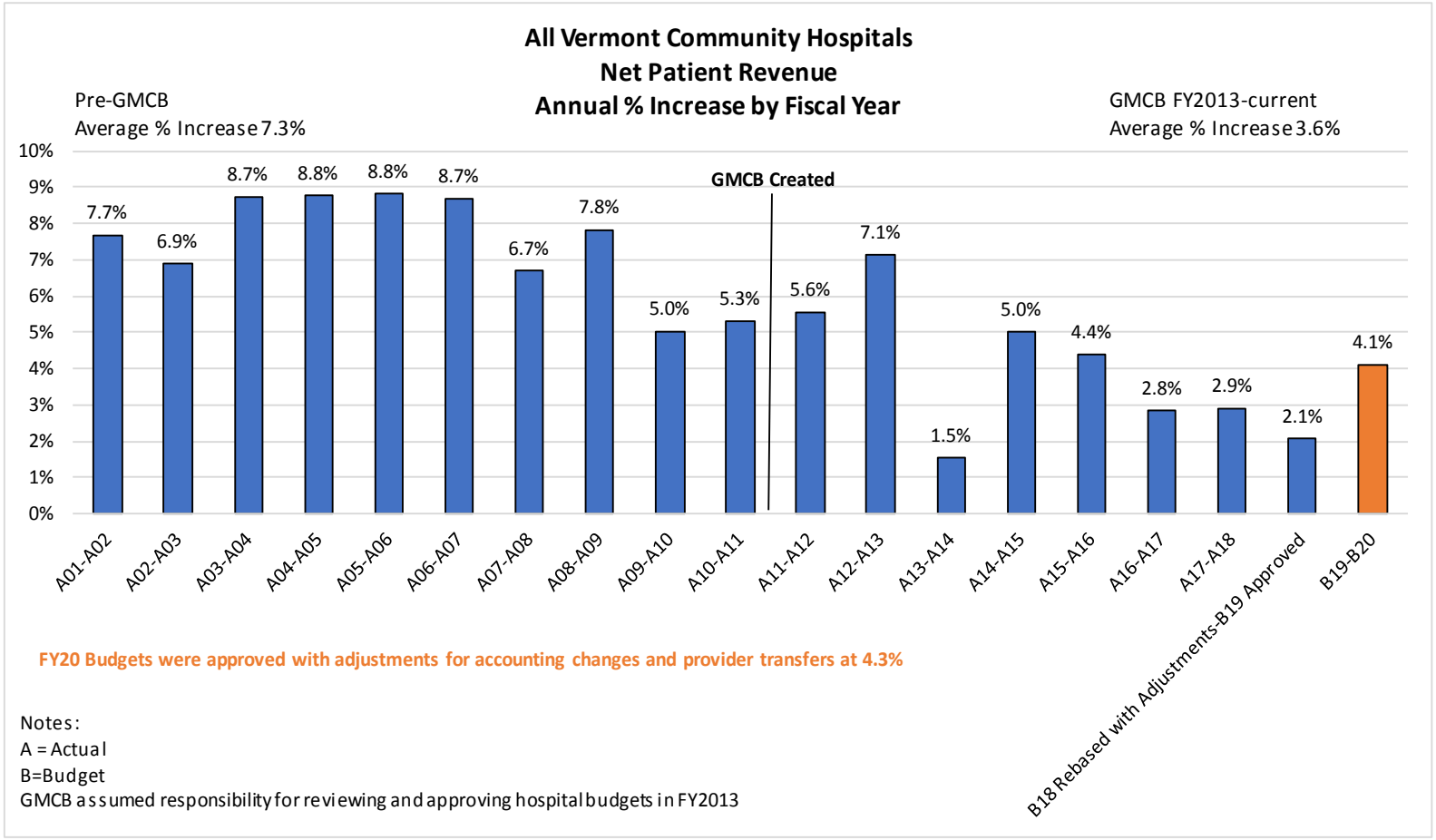
Progress in 2019

- FY2020 Hospital Budget Review Process: On July 1, 2019, Vermont's 14 regulated hospitals filed their proposed budgets for FY2020. The aggregated system-wide requested net patient revenue (NPR) increase was 4.5% over FY2019 system-wide budgets. Common themes that emerged from hospital budget submissions were issues of financial performance and solvency, continued focus on expense reductions, health care reform investments (e.g., telehealth), additional hospitals joining the ACO to participate in the All-Payer ACO Model, and workforce recruitment challenges. The Board reviewed and considered the aforementioned themes, as well as detailed staff analysis of hospital information (e.g., budgeted finances, payer mix, utilization), patient access, quality of care, budget compliance, NPR growth, and potential commercial charge increases. The Board also considered accounting changes and provider transfers in setting FY2020 NPR for some hospitals. The Board considered comments from the Office of the Health Care Advocate and the public.
- FY2020 Hospital Budget Decisions: The Board's FY2020 hospital budget orders resulted in a system-wide FY2020 NPR of $2.717 billion, a 4.3% NPR increase over FY2019 approved budgets. This represents a reduction of $7.33 million from hospitals' FY2020 budgets as submitted. The Board also reviewed each hospital's proposed increase in charges ("rate increase"); the system-wide increase in charges, as proposed, was 3.2%; the charge increases approved by the Board resulted in a system-wide average of 3.1%. In making their decision, the Board considered the demographic impact of an aging population, including increased patient acuity and shifting payer mix, as well as hospitals' financial solvency and potential impacts on access.
- Containment of Health Care Costs: FY2020 budgeted system-wide NPR was approved at 4.3% over FY2019 budgets, above the FY2020 targeted growth set forth in the budget guidance of 3.5%. However, average annual system-wide growth since 2013 is 3.6%, well below the annual growth of 7.3% cited during the decade prior to the creation of the GMCB (see Figure 3, pg. 15).

Looking Ahead

- Hospital Reporting: GMCB will seek to enhance periodic reporting while minimizing burden.
- Utilization and Cost: GMCB will seek insight into utilization trends across hospitals, correlations between utilization and cost, and development of per-person cost measures.
- Sustainability: GMCB will continue in 2020 to engage with hospitals and other integral partners to address sustainability in health care with a focus on rural hospitals.

Figure 3: Vermont Community Hospitals – System-Wide Net Patient Revenue Increases Over Time[16]



[16] This graph includes Vermont's 14 community hospitals; it excludes the Vermont Psychiatric Care Hospital, Brattleboro Retreat, and the VA (U.S. Department of Veterans Affairs) Medical Center in White River Junction. Net Patient Revenue (NPR) is monies hospitals will receive for services after accounting for contractual allowances, commercial discounts, and free care. NOTE: For the FY2019 budget process, the Board adjusted the FY2018 NPR budget NPR base for two hospitals to reflect FY2017 Actual NPR, adjusted for accounting changes and provider transfers.

Certificate of Need

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. §§ 9375(b)(8), 9433.

Overview: Vermont law requires hospitals and other health care facilities 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, changes in the number of licensed beds, offering 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 resources to all Vermonters.

Progress in 2019

- Issued Six CONs: The Board approved six applications with a total value of $19,710,061[17]:
  - University of Vermont Medical Center, for the routine replacement of an MRI system.
  - Rutland Regional Medical Center, for the remediation of ligature risks in the inpatient psychiatric unit.
  - University of Vermont Medical Center, for construction of a building to house Essex Adult Primary Care.
  - University of Vermont Medical Center, for the routine replacement of an interventional radiology suite.
  - Rutland Regional Medical Center, to replace a CT scanner and perform related renovations.
  - Valley Vista, for the conversion of licensed beds.
- Declined to Review 10 Projects: The Board determined that 10 proposed projects did not meet jurisdictional thresholds for CON review.

Looking Ahead to 2020

- New Applications: The following entities have either filed, or notified the Board that they intend to file, applications that will be reviewed in 2020:
  - Vermont Open MRI, to replace its MRI system.
  - Southwestern Vermont Health Care, to develop a family medicine residency program.
  - Southwestern Vermont Health Care, to renovate the emergency department and front entrance, renovate its cancer center, and transition to a new health information system (3 applications)
  - Northwestern Medical Center, to renovate its emergency department.
  - Vernon Homes, to construct a new skilled nursing facility using the Greenhouse Model.
  - Springfield Medical Care Systems, to replace its electronic medical records system.
  - University of Vermont Medical Center, to expand its health information system to two network hospitals in New York.
  - Silver Pines Partners, LLC, for development of a medically supervised withdrawal treatment center for individuals with substance use disorder.
  - Pine Heights at Brattleboro Center for Nursing and Rehabilitation, renovation project.
  - Northern Lights Recovery Center, for development of a SUD treatment facility.

[17] CONs and Statements of Decision for approved projects available at: https://gmcboard.vermont.gov/con/issued.

Vermont Health Care Expenditure Analysis

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. § 9383

Overview: The Board is tasked to develop an annual expenditure analysis and estimates of future health care spending.

- The analysis quantifies total spending for all health care services provided in Vermont (residents/non-residents), and for services provided to Vermonters regardless of site of service.
- The report analyzes broad sectors including hospitals, physician services, mental health, home health, and pharmacy. It also analyzes payers including Medicare, Medicaid, commercial plans, self-insured employers, and health maintenance organizations.

Progress in 2019

The most recent Health Care Expenditure Analysis (CY 2017) was completed in March 2019.[18,19]

- Vermont Resident Analysis, 2017: Total spending for Vermont residents receiving health care services both in- and out-of-state increased 1.7% from 2016 to 2017, to a total of $6.0 billion. Medicare spending increased 0.8% as a result of increases in hospital utilization, other professionals, and administration. A 0.2% increase in Medicaid spending stemmed primarily from growth in spending for mental health and other government activities (e.g., home- and community-based services), while expenditures decreased for drugs and supplies due to reduced spending and higher rebates for specialty drugs. Commercial insurance spending increased 2.5%, mainly due to growth in administration, other non-claims costs, and other professionals. Estimated growth from 2017 to 2018 is expected to be 1.7% and from 2018 to 2019 is 2.1%.
- Vermont Resident Analysis Compared to U.S., 2017: U.S. Health Consumption Spending increased by 3.8% in 2017, compared to a 5.0% increase in 2016. This was higher than Vermont's 1.7% total spending growth rate in 2017. Per person spending in Vermont increased by 1.8% from 2016 to 2017, and the $9,667 per person spending was below the national average of $10,229.
- Vermont Provider Analysis, 2017: Total revenues received by Vermont providers for health care services provided to in- and out-of-state patients increased 3.3% in 2017, to a total of $6.2 billion. This was slightly higher than the 3.2% increase in 2016 and lower than the average annual increase of 3.8% for 2012-2017. Estimated growth from 2017 to 2018 is expected to be 2.3% and from 2018 to 2019 is 2.7%.

Looking Ahead to 2020

- Preparing 2018 Health Care Expenditure Analysis: In 2020, staff will finalize the FY2018 Expenditure Analysis and two-year estimates, incorporating more data from VHCURES, VUHDDS, the Vermont Household Health Insurance Survey, Annual Statement Supplement Report, Accountable Care Organization reports and the best available data from other state and national resources. The analysis will be used as a tool to monitor the implementation of the APM Agreement's cost growth and other key financial metrics.

[18] The 2017 Health Care Expenditure Analysis is available at: https://gmcboard.vermont.gov/sites/gmcb/files/2017_Expenditure_Analysis_with_projections_March_27_2019.pdf.

[19] An interactive visualization tool for the 2017 Expenditure Analysis is available at: https://public.tableau.com/profile/state.of.vermont#!/vizhome/2017_ea_public/2017ResidentExp_Analysis.

Prescription Drug Monitoring

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. § 4635(b)

Overview: The Department of Vermont Health Access (DVHA), is required to create a list of 10 prescription drugs on which Vermont spends significant health care dollars and for which 1) costs have significantly increased either by 50% or more over 5 years, or by 15% or more during the previous calendar year and 2) the cost to DVHA, net of rebates and other price concessions, has increased by 50% or more over the past 5 years or by 15% or more during the previous calendar year.

Progress in 2019

Prescription Drug Cost Analysis – State Spending: DVHA submitted the prescription drug list for CY2018 in September. This list included drugs on which the State spends significant health care dollars or on which health insurance plans spend significant amounts of their premium dollars.[20]

- *DVHA Gross Drug Cost Analysis*: Gross spending on the ten drugs identified was over $2.6 million. Gross drug price increases ranged from 19.9% to 250% over the last calendar year, and 51.7% to 250.4% over a five-year period. None of the drugs identified were on the previous year's list.
- *DVHA Net Drug Cost Analysis*: Net drug price increases ranged from 17% to 201% over the last calendar year, and 52% to 730% over a five-year period. Two of the ten drugs identified were also on the previous year's list of drugs and none appeared on this year's gross cost list.
- *BCBSVT & MVP Drug Lists with Largest Net Price Increase*:[21] Drug price increases ranged from 57.7% to 119.5% in the past 5 years for BCBSVT and from 20% to 473% over the last calendar year for MVP.

Impact of Prescription Price Increases on Commercial Insurance Rates: The GMCB worked with commercial payers with more than 1,000 lives in Vermont to gather data on: a) the flow of funds related to prescription drugs between manufacturers, insurers, and plan members, including discounts and rebates; and b) on the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year price increases.[22] The report found that prescription drug costs account for approximately 17.32% of the commercial premiums under review. The three drugs with the greatest impact on premium are Humira Pen, Humira (CF Pen), and Enbrel Sureclick.

Looking Ahead to 2020

- Continued Prescription Drug Monitoring: The Board will continue to track drug costs through the health insurance rate review process and work with hospitals and insurers to reduce the impact of drugs on insurance rates.

[20] The DVHA drug cost analyses and methodology for CY2018 (submitted September 2019) are available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/DVHA_Methodology_2018_DrugPricingLists.pdf
[21] The BCBSVT & MVP drug cost analyses for CY2018 (updated November 2019) are available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/BCBSVT%26MVP_Submissions_2018.pdf
[22] The Act 193 Report is available at: https://gmcboard.vermont.gov/sites/gmcb/files/Act%20193%20Report-%20Impact%20of%20Prescription%20Drug%20Costs%20on%20Health%20Insurance%20Premiums.pdf.

Health Information Technology

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. §§ 9351, 9375(b)(2)

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. DVHA is required to comprehensively update to the plan every 5 years and to revise it annually.

The Board is also tasked with approving Connectivity Criteria for the Vermont Health Information Exchange (VHIE, operated by VITL).

Progress in 2019

- FY2019 VITL Budget Review: VITL submitted its proposed FY2020 budget on April 29, 2019, with anticipated total revenue $6,055,389 (an increase of just under $50,000 from FY2019), including $4,674,723 in state contracts, plus $1,380,667 from other sources, and anticipated total expenses of $6,241,877. This submission was presented to the GMCB at its May 15, 2019, public Board meeting,[23] and approved on June 5, 2019.[24]
- 2019-2020 HIE Plan and 2020 Connectivity Criteria Review and Approval: DVHA and the HIE Steering Committee developed an update to the 2018-2019 HIE Plan, which was submitted to the Board on November 2, 2019. DVHA and VITL presented the Plan, along with 2020 Connectivity Criteria, to the Board on November 13, 2019. The Board voted to approve the HIE Plan and Connectivity on November 20, 2019, with one condition (see below).[25]
- HIE Consent: Act 53 of 2019 required the HIE Plan to reflect an opt-out or presumed consent model to be implemented by March 1, 2020. The Board heard updates on consent policy development and implementation throughout 2019, and the decision approving the 2019-2020 HIE Plan requires DVHA to propose an addendum to the HIE Plan reflecting Act 53 prior to the March 1 implementation date.
- Ongoing Updates from DVHA and VITL: DVHA and VITL provided updates on HIE activities throughout 2019.

Looking Ahead to 2020

- Future HIE Plans: DVHA will continue to submit annual updates to the HIE Plan, developed in collaboration with the HIE Steering Committee.
- FY2020 VITL Budget Adjustment and FY2021 VITL Budget Review: At its November 13, 2019, quarterly update, VITL notified the Board that it would require an adjustment to its FY2020 budget. The Board will review the adjusted budget in early 2020. The Board expects to review VITL's FY2021 budget in late spring 2020.

[23] *See* FY2020 Budget Review Presentation (May 15, 2019): https://gmcboard.vermont.gov/sites/gmcb/files/VITL%20FY20%20Budget%20Presentation.pdf.
[24] *See* Order Approving Vermont Information Technology Leaders' FY2020 Budget (July 16, 2019): https://gmcboard.vermont.gov/sites/gmcb/files/VITL%20FY2020%20Order%20FINAL%207%2016%202019.pdf.
[25] The final 2019-2020 Health Information Exchange Strategic Plan, 2020 Connectivity Criteria, and GMCB order approving both are available at: https://gmcboard.vermont.gov/hit/plan.

ACCOUNTABLE CARE ORGANIZATIONS AND THE ALL-PAYER ACO MODEL

All-Payer Accountable Care Organization (ACO) Model (APM)

Project Area: ACOs and the All-Payer ACO Model

Relevant Statute/Authority: 18 V.S.A. § 9551; 42 U.S.C. § 1315a; All-Payer ACO Model Agreement

Overview: GMCB has four major responsibilities related to the All-Payer ACO Model:

- Set financial targets for Vermont Medicare ACOs and limit cost growth for certain health care services.
- Ensure reasonable alignment across Vermont ACO programs.
- Work with other signatories to achieve targets for the number of aligned Vermonters.
- Work with other signatories to achieve targets on twenty quality measures tied to three population health goals.

For additional information on the APM, please see materials here.

Progress in 2019

In 2019, Performance Year 2 of the APM, the GMCB focused its work on a number of major tasks:

- Evaluating Performance Year 1 (PY1) results:
  - *Scale*: PY1 results reflect significant growth in attributed lives since 2017; 22% of all-payer beneficiaries and 35% of Medicare beneficiaries are now included in the model. A gradual ramp up from PY1 through PY5 of the Model is expected.
  - *Quality*: Based on interim reports, in aggregate, Vermont showed improvement on all comparable quality metrics as compared to baseline. Performance differs when broken out by payer.
  - *Cost*: While the results for PY1 are not yet final, the total cost of care (TCOC) is expected to surpass the All-Payer TCOC target (3.5%) set over the life of the Model. It is expected that Vermont will slow its growth in later Model years as investments in preventative care and population health begin producing a return on investment.
- Addressing the Rural Health Challenges: The GMCB, AHS, and the Administration hosted federal All-Payer ACO Model partners from the Center for Medicare and Medicaid Innovation (CMMI) this summer and facilitated a two-day working meeting to discuss APM progress and challenges, including rural health care. It was apparent from these conversations that CMMI and Vermont hospitals are committed to working together to support rural Vermont hospitals in participating in value-based payment models.
- Setting the 2020 Medicare Benchmark: The APM Agreement authorizes the GMCB to prospectively develop benchmarks (financial targets) for ACOs participating in the 2020 Vermont Medicare ACO Initiative, subject to CMS approval. In December 2019, the GMCB approved a Non-End Stage Renal Disease (Non-ESRD) trend rate of 3.5%, an ESRD trend rate of 2.9%, and to include $8.4 million dollars in Advanced Shared Savings for continued investments in Blueprint for Health and the SASH program, consistent with the State's obligations under the Agreement.

Looking Ahead to 2020

- Rural Health: The GMCB is working to ensure the APM supports a robust rural health system.
- APM 2.0: GMCB will begin engaging stakeholders and experts as planning for a potential second All-Payer Model Agreement ("APM 2.0") ramps up. The GMCB, in consultation with AHS, is responsible for making a formal proposal to CMMI for a second model by December 31, 2021.

ACO Oversight: Budget Review and Certification

Progress in 2019

- 2019 ACO Oversight: On January 23, 2019, the GMCB approved OneCare's continued certification.[26] Through the ACO's now standard quarterly reporting, submitted in April, July, October, and January, the GMCB monitored OneCare's compliance with the conditions of its 2019 budget order.
- 2020 ACO Oversight: Beginning September 1, 2019, GMCB staff reviewed and verified OneCare's continued eligibility for certification, as documented in a memo to the Board expected by the end of January 2020. The Board also received OneCare's proposed 2020 budget on October 1, 2019 and after careful analysis and an extended public comment period, the Board voted on December 18, 2019 to approve the budget with 23 conditions, including a requirement that OneCare come back before the Board once their contracts and the population for which OneCare is accountable are final. The budget is approximately $1.4 billion, with more than 95% of dollars flowing to providers, either through fixed payments or fee-for-service payments for direct care of patients. This total reflects the inclusion of an estimated 250,000 Vermonters in ACO programs (up from 196,000 in 2019).[27] OneCare's budget also points to its substantial investments in population health, expected to total upwards of $43 million in 2020.
- Medicaid Advisory Rate Case: Per 18 V.S.A. § 9573, the GMCB is responsible for advising DVHA on the per beneficiary payment rates negotiated between DVHA and the ACO. The GMCB is working to finalize its review in January 2020 due to delays in receiving necessary data.[28]

Project Area: Accountable Care Organizations and the All-Payer ACO Model

Relevant Statute/Authority: 18 V.S.A. §§ 9382 9573.

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.

For additional information on ACO oversight, please see materials here.

Looking Ahead to 2020

- Integrating Regulatory Processes: The GMCB will continue to integrate ACO budget review and oversight with its other its regulatory processes in service of the goals of containing cost growth and improving access, quality, and health. In this vein, the GMCB will be exploring a number of regulatory intersections, including developing a policy on system-level risk, and the risk and reserve structures of the ACO and Vermont hospitals.

[26] 2020 ACO budget submissions, 2019 quarterly monitoring and reporting submissions, and certification validation materials are available at: https://gmcboard.vermont.gov/content/2020-aco-oversight.
[27] OneCare 2020 Budget Order not yet final as of January 15, 2020; final order will be posted to the GMCB website at: https://gmcboard.vermont.gov/content/2020-aco-oversight.
[28] Medicaid Advisory Rate Case of ACO Services not yet final as of January 15, 2020; final report will be posted to the GMCB website at: https://gmcboard.vermont.gov/content/2020-aco-oversight.

DATA, ANALYTICS, AND EVALUATION

Project Area: Data, Analytics, and Evaluation

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)

Data and Analytics

Progress in 2019

- Data Stewardship**:** As steward of VHCURES and VUHDDS, the GMCB is responsible for a broad set of data management concerns, including: risk management (implementing and enforcing the most appropriate data privacy and security standards and practice); data quality (establishing data stewardship to promote the highest possible quality of GMCB's data resources); program sustainability (evaluating opportunities to optimize sustainability and revenue for GMCB's data stewardship program); and data release (supporting clear processes for the evaluation of data requests and the release of data).
- Standard Reporting: Additional interactive reports were created to reflect the All-Payer ACO Model's Total Cost of Care by Hospital Service Area.[29]
- VHCURES procurement: After a robust Request for Proposals, the GMCB elected to retain the services of its current vendor, Onpoint Health Data. The new contract includes several enhancements to provide more detail to analysts, as well as summary information for wider audiences. The contract will also migrate all State users to the same analytical environment, ensuring better, more timely access coupled with more thorough auditing capabilities.
- All-Payer Model Support: The GMCB Analytical Team built greater capacity and readiness to fulfill the GMCB's obligations as envisioned in the All-Payer ACO Model Agreement, including data analysis to support the Board's proposal for the ACO's Medicare performance targets (i.e. the Medicare Benchmark) for Performance Year 2020.

Looking Ahead to 2020

- Expanded Reporting: The Board will continue to expand its standard reporting. Part of the new VHCURES procurement includes a set of ten reports that will be produced in conjunction with each update of the database.
- Improved Access to Data Assets: The GMCB will work on a suite of analytical files designed based on a set of common domains of questions (e.g., clinical, fiscal, population health). The files will promote use of the GMCB's data resources for a wider variety of analysts.
- Advanced Analyses: With its expanded resources, the Board will be in a position to provide more sophisticated, inferential analyses, such as determining drivers of the increases in the cost of health care, which will provide deeper insights for the Board's regulatory tools.

[29] Current analytic reports are available at: https://gmcboard.vermont.gov/data-and-analytics/analytics-rpts.

Health Resource Allocation Plan (HRAP)

The HRAP will be a series of dynamic reports, visualizations, and other user-friendly tools designed to convey relevant information. The Board expects to release Phase I of HRAP in early 2020.

Project Area: Data, Analytics, and Evaluation

Relevant Statute/Authority: 18 V.S.A. § 9405

Overview: In 2018, the Legislature amended the requirements for the Health Resource Allocation Plan. The new HRAP will:
- Report on Vermont's health care services and resources;
- Inform GMCB regulatory processes, cost containment and statewide quality of care efforts, health care payment and delivery system reform initiatives, and allocation of health resources within the state;
- Identify priorities using existing assessments, data, and public input;
- Consider the principles for health care reform in 18 V.S.A. § 9371;
- Identify and analyze gaps between needs and resources;
- Identify utilization trends;
- Consider cost impacts of filling gaps; and
- Be more dynamic and up-to-date.

Progress in 2019

- Project Specifications: The HRAP project team has developed project specifications and data templates, and worked with a vendor on a digital interactive prototype.
- Data Governance and Management: The Analytics team worked with the Agency of Digital Services to assess current data governance structure and future requirements for data integration and sustainability.
- Data Collection: The project team worked with different community health profiles to understand specific health needs and compiled resources and services information from varied data sources.[30]
- Stakeholder Engagement: The stakeholder engagement process has involved work with the GMCB PCAG and General Advisory Committee, as well as external organizations and provider interviews. Staff have partnered with other State agencies to coordinate related work around the state as part of the HRAP. In addition to public presentations, GMCB will solicit public comment at the completion of each phase of HRAP.
- GMCB Advisory Committee Presentation: GMCB staff presented to the Board and the GMCB General Advisory Committee on September 9, 2019.[31] The presentation included a project overview and progress to date.

Looking Ahead 2020

- Data Collection: GMCB will complete data collection to produce resource inventories of health needs for priority areas (mental health, substance use disorder, hospital services, oral health services, and home health and hospice).
- Data Analysis: Data analysis, including completion of a series of utilization and cost studies related to chronic diseases and hospital services, will continue throughout 2020.

[30] *See* Green Mountain Care Board Health Resource Allocation Plan webpage for detailed information: https://gmcboard.vermont.gov/gmcb-health-resource-allocation-plan

[31] *See* Green Mountain Care Board Health Resource Allocation Plan Update Presentation (Sept. 9, 2019): https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20HRAP%20Update%20to%20the%20GMCB%20General%20Advisory%20Committee%209.9.19.pdf.

APPENDICES

Appendix A: Cost Shift

Project Area: Health Insurance Regulation

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

Overview: 18 V.S.A. § 9375 requires the Board to report annually on the cost shift. The Board is tasked annually with recommending mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged. The APM holds Vermont harmless for Medicaid price increases in calculating APM total cost of care, a potential mechanism for decreasing the cost shift.

Progress in 2019

The cost shift may occur when hospitals receive higher revenues for services paid by commercial insurance payers to make up for lower revenues from Medicare and Medicaid, and to cover the cost of health care services that are provided but not paid for (uncompensated care) based on the hospital budget process, approved hospital budgets and actual results.

- Annual Estimated Cost Shift Impact: For the purposes of this report, the cost shift is an estimate calculated based on data submitted in the hospital budget process and assumes that each patient, regardless of the payer that they are insured by, should contribute equally to that budget, accounting for their proportional share of expenses and margin. Unlike academic research studies about the cost shift, this estimate does not assume negotiations impact the price, but is directly connected with approved net patient revenue increases and charge increases, which are part of the budget process. Figures 4 and 5 below depict the estimated cost shift by payer and by year from FY2008 to FY2020.
- Rate of Growth: From FY2008 to FY2019, the cost shift appears to have grown every year except one, with estimated growth of 7.7% from FY2018 Actual to FY2019 Budget. Hospitals are projecting an increase in the overall cost shift to Commercial payers (including self-insured) from FY2019 Budget to FY2020 Budget.
- Cost Shift Discussion at GMCB and Legislature: The cost shift was a recurring topic of discussion at GMCB meetings, health insurance rate review hearings, and the Legislature in 2019.

Looking Ahead to 2020

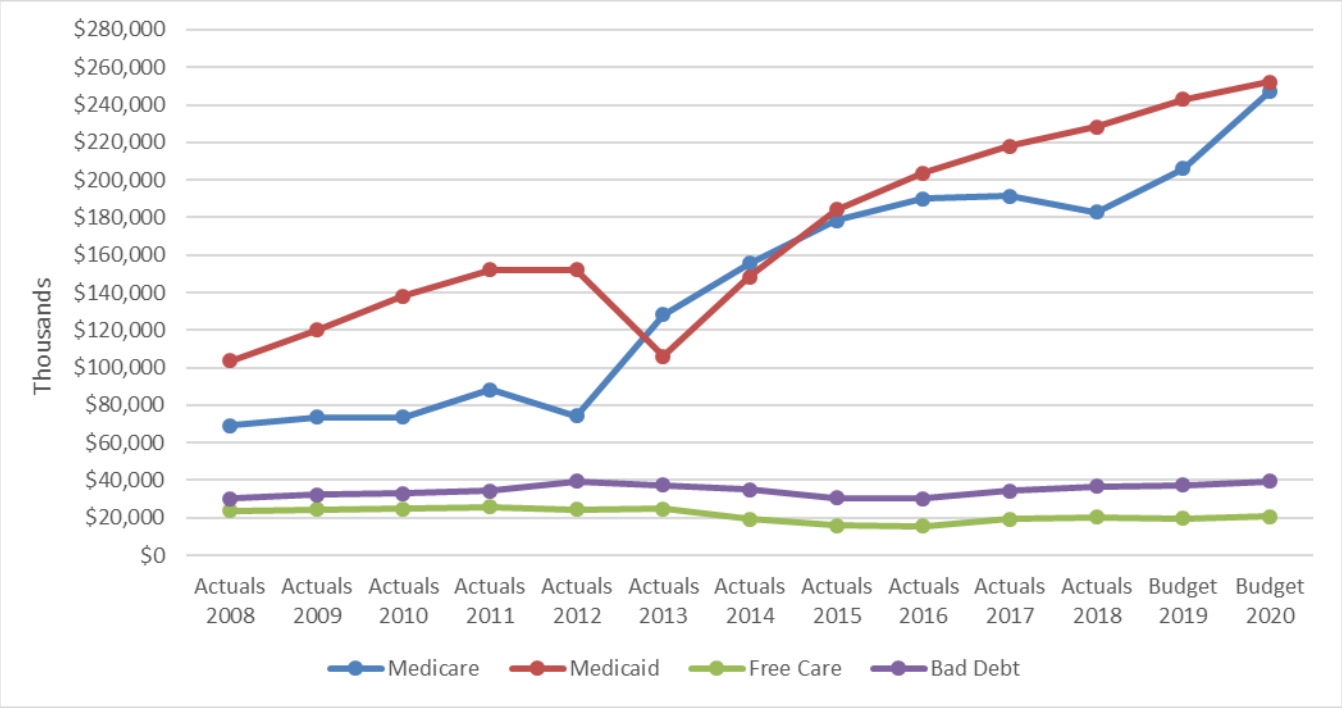
- Reporting and Analysis: GMCB staff will continue to refine the reporting of Vermont and non-Vermont payer revenue and the effect of the APM and any other payment reform initiatives on the cost shift.

Figure 4: Estimated Cost Shift by Payer (FY2008-FY2019), Vermont Community Hospitals

Fiscal Year	Estimated Medicare Cost of Services Shifted to Other Payers	Estimated Medicaid Cost of Services Shifted to Other Payers	Estimated Free Care Shifted to Other Payers	Estimated Bad Debt Shifted to Other Payers	Estimated Costs Shifted to Commercial and Other Payers	Estimated % Change from Prior Year in Shift to Commercial and Other Payers
Actuals 2008	$(69,003,712)	$(103,569,366)	$(23,623,972)	$(30,252,980)	$226,450,033	
Actuals 2009	$(73,627,496)	$(119,979,398)	$(24,292,187)	$(32,391,214)	$250,290,295	10.5%
Actuals 2010	$(73,515,988)	$(138,016,619)	$(24,806,398)	$(33,076,863)	$269,415,868	7.6%
Actuals 2011	$(88,399,861)	$(152,256,740)	$(25,784,124)	$(34,331,093)	$300,771,818	11.6%
Actuals 2012	$(74,383,192)	$(151,931,648)	$(24,347,367)	$(39,264,676)	$289,926,884	-3.6%
Actuals 2013	$(128,108,641)	$(105,982,171)	$(24,684,304)	$(37,383,822)	$296,158,938	2.1%
Actuals 2014	$(155,622,607)	$(148,344,481)	$(19,370,131)	$(34,885,055)	$358,222,274	21.0%
Actuals 2015	$(178,243,251)	$(184,115,357)	$(16,032,485)	$(30,469,896)	$408,860,990	14.1%
Actuals 2016	$(190,018,540)	$(203,622,426)	$(15,683,900)	$(30,318,995)	$439,643,861	7.5%
Actuals 2017	$(191,515,256)	$(217,814,796)	$(19,337,891)	$(34,451,540)	$463,119,483	5.3%
Actuals 2018	$(182,780,851)	$(228,177,679)	$(20,380,418)	$(36,600,429)	$467,939,377	1.0%
Budget 2019	$(206,077,135)	$(242,814,934)	$(19,673,922)	$(37,515,336)	$506,081,328	8.2%
Budget 2020	$(247,162,884)	$(252,018,779)	$(20,601,215)	$(39,279,171)	$559,062,050	10.5%

NOTE: 2017 and 2018 Actuals data updated to reflect allocation of provider tax across additional categories of payer revenues and Fixed Prospective Payments from ACO to hospitals.

Figure 5: Trends – Estimated Cost of Services Shifted to Other Payers (FY2008-FY2019)



Impact of Medicaid and Medicare Cost Shifts and Uncompensated Care on Health Insurance Premium Rates

Statutory Charge: Effective June 17, 2019, 18 V.S.A. § 9375(d)(F) requires the Board to report annually on "the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates . . . ."[32] This year's Annual Report is the first to include such an analysis.

Scope: Each year, the Board reports on the costs that Vermont community hospitals and their affiliated providers and facilities are expected to shift onto commercial insurers and other payers (e.g., self-insured employers and self-pay patients) to make up for lower reimbursements from Medicare and Medicaid and to cover the cost of uncompensated care. This information is found in the Cost Shift section of this report. This year, in accordance with 18 V.S.A. § 9375(d)(F), the Board calculated the impact of this cost shift on premiums for the products regulated by the Board, namely, comprehensive major medical health insurance plans in the large group and individual and small group markets.

Findings: With respect to the filings the Board reviewed in 2019, the costs projected to be shifted to commercial and other payers by facilities and providers impacted by the Board's hospital budget review increased rates an average of 14.5% across all filings; 14.7% for individual and small group filings; and 13.7% for large group filings.

Analysis: The Board determined what percentage of hospitals' budgeted commercial revenues are due to the cost shift. This is represented by figure (C) in the equation below. Next, the Board determined what percentage of projected premiums are due to projected FY20 hospital spending. This is represented by figure (D) in the equation below. The Board then multiplied figure (C) by figure (D) to determine that the average impact of the cost shift across all filings was 14.5%, as shown in Figure 6

Figure 6: Impact of Medicaid and Medicare Cost Shifts and Uncompensated Care on Health Insurance Premium Rates

	(A)	(B)	(C) = (A)/(B)	(D)	(E) = (C)*(D)
Budget 2020	Estimated Costs Shifted to Commercial and Other Payers	GMCB Regulated Hospitals' Budget for Commercial Payers	Percentage Impact on Hospital Budgets for Commercial Payers	FY20 Estimated GMCB Hospital as Percentage of Premium	Impact of Cost Shift on Rate Filings
	$559,062,050	$1,491,287,268	37.5%	38.7%	14.5%

The Board also calculated the average impact of the cost shift by market (i.e., individual and small group filings and large group filings). Figure (D) varies by filing and, on average, is larger for the individual and small group filings (39.2%) than for large group filings (36.4%), resulting in a larger impact on the individual and small group filings (14.7%) compared to large group filings (13.7%).[33]

[32] 2019 Vermont Laws No. 63 (H. 524), §§ 10, 13(d).
[33] Individual and Small Group (37.5% * 39.2%= 14.7%). Large Group (37.5% * 36.4% = 13.7%).

Appendix B: Green Mountain Care Board Meetings in 2019

Figure 7: Green Mountain Care Board Meetings, 2019

January 9, 2019	• Vermont Health Information Exchange (VHIE) Consent Policy Report • Household Insurance Survey Presentation • Accountable Care Organization Certification Eligibility Verification & New Criteria
January 16, 2019	• Strategies to Reduce Costs and Improve Quality in Healthcare
January 23, 2019	• Accountable Care Organization Eligibility Verification & New Criteria – Potential Vote
January 30, 2019	• Health Care Workforce Presentation
February 6, 2019	• Pharmacy Pricing and Pharmacy Benefit Managers (PBM) Overview • New Pharmaceutical Purchasing Approaches • Vermont Rate Review Program Evaluation Results
February 20, 2019	• FY2020 Hospital Budget Guidance • Department of Vermont Health Access (DVHA) Qualified Health Plan (QHP) 2020 Standard Plan Design • UVM Investments Towards Increasing Mental Health Capacity Update
February 27, 2019	• All-Payer Model Updates from the Field • QHP 2020 Standard Plan Design – Potential Vote • OneCare Vermont 2018 Budget Order and Grievance & Appeals Summary
March 13, 2019	• Gifford Hospital Budget Amendment Request – Potential Vote • FY2018 Hospital Budget Actuals • FY2020 Hospital Budget Guidance – Potential Vote • Vermont Information Technology Leaders (VITL) Quarterly Update • Department of Vermont Health Access (DVHA) Health Information Exchange (HIE) Quarterly Update • OneCare Vermont 2018 Budget Order Amendment Request – Potential Vote
March 20, 2019	• Proposed Rule 7.000 • Combatting the Effects of Toxic Stress and ACEs • Primary Care Advisory Group Update to the Board
March 27, 2019	• FY2019 Amended Budget Request – Springfield Hospital • FY2020 Hospital Budget Guidance – Potential Vote • FY2018 Hospital Budget Enforcement • 2017 Health Care Expenditure Analysis
April 3, 2019	• Rural Hospital Panel: Opportunities and Challenges Facing Rural Hospitals in Vermont and Around the Country
April 8, 2019	• FY2018 Gifford Medical Center – Hospital Budget Enforcement Hearing • FY2018 Northwestern Medical Center – Hospital Budget Enforcement Hearing • Porter Hospital 2018 Actuals Discussion – Potential Vote
April 10, 2019	• All-Payer Model Implementation and Accountable Care Organization Regulation Update • Total Cost of Care Presentation • FY2018 Mt. Ascutney Hospital and Health Center – Hospital Budget Enforcement Hearing • FY2018 North Country Hospital – Hospital Budget Enforcement Hearing
April 12, 2019	• FY2018 Copley Hospital – Hospital Budget Enforcement Hearing
April 17, 2019	• Green Mountain Surgery Center Certificate of Need Hearing
April 19, 2019	• FY2018 Hospital Enforcement Deliberation – Potential Vote(s)

April 24, 2019	• FY2018 Springfield Hospital Enforcement Deliberation – Potential Vote
May 15, 2019	• Vermont Information Technology Leaders FY2020 Budget Presentation and Quarterly Update • Department of Vermont Health Access Health Information Exchange Program Quarterly Update
May 29, 2019	• Traveling Board Meeting to Gifford Medical Center – Accountable Communities for Health Presentation
June 3, 2019	• OneCare Vermont 2019 Program Update • Legislative Update and Budget Overview
June 5, 2019	• Vermont Information Technology Leaders FY2020 Budget – Potential Vote • Support and Services at Home Presentation • Update to 2019 Legislative Overview • Accountable Care Organization Guidance Presentation
June 12, 2019	• University of Vermont Milestone Report and Investments towards Increasing Mental Health Capacity • FY2020 Non-Financial Reporting Update • Rate Review 101 Presentation
June 19, 2019	• University of Vermont Medical Center Update
June 26, 2019	• Accountable Care Organization Guidance – Potential Vote
July 10, 2019	• Risk-Based Capital Report and Vermont Department of Financial Regulation Order Presentation
July 22, 2019	• Rate Review Hearing
July 23, 2019	• Rate Review Hearing • Rate Review Public Comment Forum
July 31, 2019	• FY2020 Hospital Budget Submissions – Preliminary Review
August 7, 2019	• Vermont Information Technology Leaders Quarterly Update • Department of Vermont Health Access (DVHA) Health Information Exchange (HIE) Consent Policy Update • All-Payer Model Update – Q3 Total Cost of Care, Scale, Preliminary 2019
August 19, 2019	• Hospital Budget Hearing – Castleton
August 21, 2019	• Hospital Budget Hearing – Montpelier
August 23, 2019	• Hospital Budget Hearing – Montpelier
August 26, 2019	• Hospital Budget Hearing – Middlebury
August 28, 2019	• Hospital Budget Hearing – Montpelier
September 4, 2019	• GMCB General Advisory Committee Charter • FY2020 Hospital Budgets – Potential Vote(s)
September 9, 2019	• GMCB General Advisory Committee Charter – Potential Vote • University of Vermont Health Network: Central Vermont Medical Center – Restated FY2020 Budget • FY2020 Hospital Budgets – Potential Vote(s)
September 11, 2019	• FY2020 Hospital Budgets – Potential Vote(s)
September 18, 2019	• UVM Milestone Report on Investments Towards Increasing Mental Health Capacity • OneCare Vermont Q2 Update
September 25, 2019	• The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) in Action: Examples of how Vermont's claims data are used to understand and improve care

October 2, 2019	• Panel: An Update on Health Care Workforce Solutions
October 16, 2019	• Traveling Board Meeting to Northwestern Medical Center – Accountable Communities for Health Presentation
October 30, 2019	• GMCB Introduction to the ACO Regulatory Process • OneCare Vermont 2020 Budget and 2018 Results Hearing
November 13, 2019	• HIE Plan Presentation and Update on Op-Out Consent Implementation • VITL Quarterly Update
November 20, 2019	• HIE Plan – Potential Vote • APM Update/Benchmark Recommendation • Discussion on ACO 2018 Results
December 11, 2019	• ACO Medicare Benchmark Proposal – Potential Vote • GMCB Staff Recommendations on OneCare Vermont's 2020 Budget Submission
December 18, 2019	• ACO Medicare Benchmark Proposal – Potential Vote • GMCB ACO Budget – Potential Vote • GMCB Analytic Team's Proposed Research and Reporting Requirements for 2020-2022

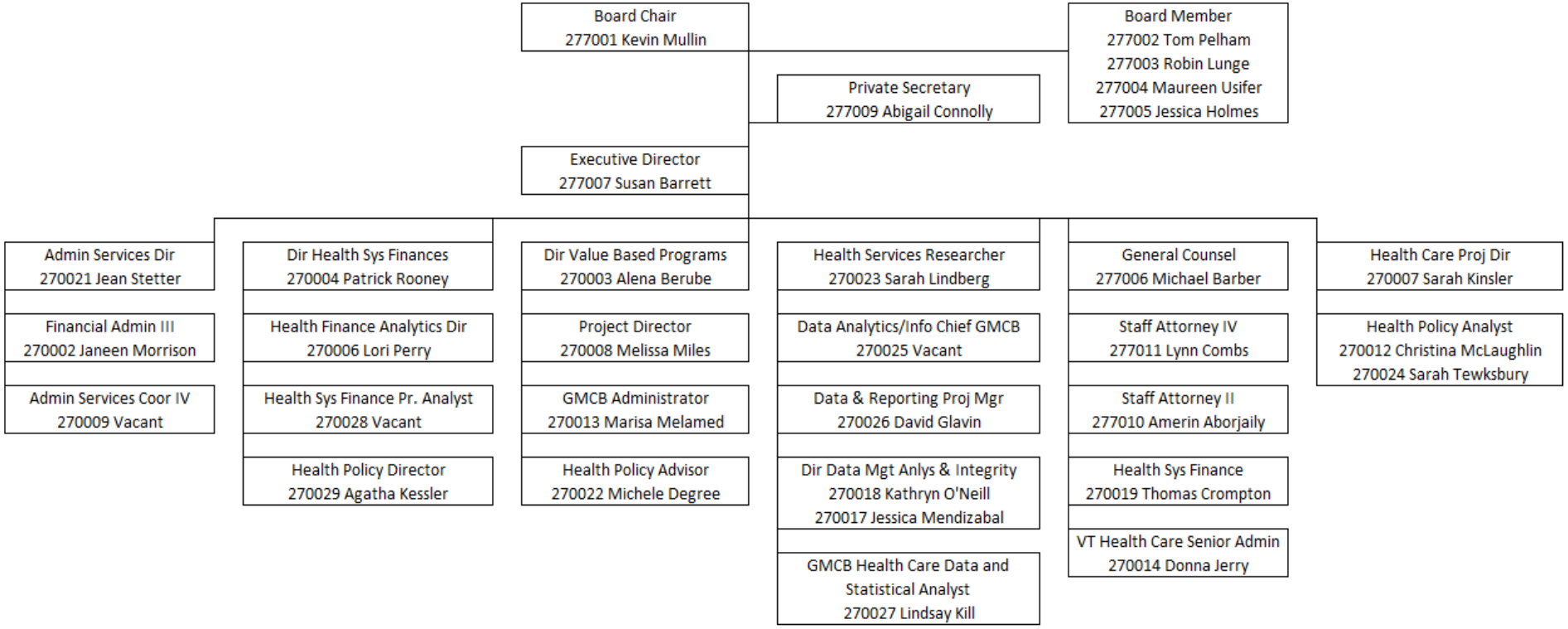
Appendix C: GMCB Budget and Staffing

Figure 8: GMCB Budget, 2019-2020

	FY2019 Budget	FY2019 Expenditures	FY2020 Budget
Total Budget	$9,335,997	$6,563,728	$9,325,076
Expenses by Fund			
General Fund	$2,609,930	$1,630,751	$4,050,536
GMCB Regulatory & Administration Fund	$3,951,345	$2,738,269	$5,274,540
Other Special Funds	$60,000	-	-
Global Commitment	$2,496,120	$2,067,161	-
Interdepartmental Transfer	$87,307	$61	-
Federal Fund	$131,295	$127,486	-

The Green Mountain Care Board's actual FY2019 spending came in under budget due to the VHCURES upgrade moving slower than projected during the Fall of 2017, lower than anticipated need for Certificate of Need contractors, and vacancy savings.

Appendix D: GMCB Organizational Chart



Appendix E: Board Member Biographies

The GMCB was created by the Vermont Legislature in 2011. It is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health care system improve quality while stabilizing costs. Nominated by a broad-based committee and appointed by the Governor, the Board includes:

Kevin Mullin, Chair

The Chair of the Green Mountain Care board is tasked with directing the board's charge of curbing health care cost growth and reforming the way health care is provided to Vermonters.

Kevin Mullin spent the majority of his career as a small business owner. He is a graduate of Castleton University with a degree in Finance, and has taught at the Community College of Vermont and served on numerous community and professional boards. He is a nineteen-year veteran of the Vermont Legislature including four years in the House and fifteen years in the Senate, where he has served on committees including as Chair of the Senate Education and Senate Economic Development, Housing, and General Affairs Committees. As a member of the Senate Health and Welfare Committee, he helped to write both Catamount Health and Green Mountain Care legislation. He has a deep commitment to controlling health care spending. Appointed by Governor Phil Scott on May 24, 2017, and reappointed on August 17, 2018 to a term ending on February 29, 2024.

Jessica Holmes, Ph.D.

Jessica Holmes is a Professor of Economics at Middlebury College. Her teaching portfolio includes courses in microeconomics, health economics, the economics of social issues and the economics of sin. She has published several articles in areas such as philanthropy, economic development, health economics, labor economics and pedagogy. Prior to joining the Middlebury faculty, she worked as a litigation consultant for National Economic Research Associates, conducting economic analyses for companies facing lawsuits involving securities fraud, product liability, and intellectual property. Jessica received her undergraduate degree from Colgate University and her PhD in Economics from Yale University. She is a past Trustee of Porter Medical Center, having served as Board Secretary and Co-chair of the Strategy Committee. Jessica lives in Cornwall. Appointed by Governor Peter Shumlin for a term beginning on October 8, 2014, and ending on September 30, 2020.

Robin Lunge, J.D., MHCDS

Robin J. Lunge, JD, MHCDS, was appointed to the Board in November 2016. Prior to joining the Board, Robin served for almost six years as the State's Director of Health Care Reform for Governor Peter Shumlin's administration. Her past experience includes working as a nonpartisan staff attorney at Vermont Legislative Council, where she drafted legislation and provided support to members of the Vermont Legislature relating to health and human services matters, and at the Center on Budget and Policy Priorities in Washington D.C. as a senior policy analyst on public benefits issues. Robin's areas of expertise are federal and state public benefit programs, health care, and health care reform. Robin holds a B.A. from the University of California Santa Cruz, a J.D. from Cornell Law School, and a Masters of Health Care Delivery Science from Dartmouth College. Appointed by Governor Peter Shumlin for a term beginning on November 28, 2016, and ending on November 27, 2022.

Tom Pelham

Tom Pelham served as Deputy Secretary of Administration and Tax Commissioner under Governor Jim Douglas, and as Commissioner and Deputy Commissioner of Finance and Management under Governor Howard Dean. As Finance Commissioner during the creation and enactment of the Vermont Health Access Plan (VHAP), Pelham was responsible for creating the fiscal capacity to expand health insurance to Vermonters while ensuring overall statewide budgetary sustainability. He also served as Commissioner and Deputy Commissioner of Housing and Community Affairs under Governors Madeleine Kunin and Richard Snelling. In 2002, Pelham was elected as an Independent to serve Vermont's Washington 6 District in the House of Representatives. While serving on the House Appropriations Committee, he helped restructure Vermont's Medicaid health care premium and co-pay system to better align with recipients' incomes and ability to pay. Pelham is a native Vermonter from Arlington and now resides in Berlin. He earned his B.A. from Tufts University and his M.A. from Harvard University. Appointed by Governor Phil Scott for a term commencing November 3, 2017 and ending-September 30, 2023.

Maureen Usifer

Maureen Usifer is a finance professional with over thirty years of corporate public and private CFO and board experience. Maureen currently serves on several public and non-profit boards including as Director and Audit Chair for BlackRock Capital Investment Corporation, Trustee and Audit Chair for Liberty All-Star Funds, Trustee for St. Michael's College and as a Green Mountain Consortium Board Member. Maureen was the CFO for Vermont-based Seventh Generation with oversight for Finance, Accounting, IT, and legal. Maureen was also a senior finance director with Church & Dwight Co., Inc., where her responsibilities included budget oversight, cost optimization, investor relations and mergers and acquisitions. Maureen lives in Colchester. She has an undergraduate degree from St. Michael's College and an M.B.A. from Clarkson University. Appointed by Governor Phil Scott for a term beginning May 24, 2017 and ending on September 30, 2021.

Leadership

Susan J. Barrett, J.D., Executive Director

Susan J. Barrett, an attorney, was formerly Director of Public Policy in Vermont for the Bi-State Primary Care Association. She joined Bi-State in 2011 after nearly 20 years in the pharmaceutical industry with Novartis, Merck, and Wyeth. Susan's health care experience also includes pro bono legal work and an internship with Health Law Advocates, a non-profit public interest law firm in Massachusetts. She is a graduate of New England Law Boston and Regis College. She lives in Norwich.

Appendix F: Glossary

ACO	Accountable Care Organization
ACH	Accountable Community for Health
APM	All-Payer ACO Model
CMMI	Center for Medicare and Medicaid Innovation
CON	Certificate of Need
DVHA	Department of Vermont Health Access
ESRD	End-Stage Renal Disease
FQHC	Federally Qualified Health Center
GMCB	Green Mountain Care Board
HRAP	Health Resource Allocation Plan
NPR	Net Patient Revenue
ORCA	Onion River Community Access
PCAG	Primary Care Advisory Group
QHP	Qualified Health Plan
RHSTF	Rural Health Services Task Force
SASH	Support and Services at Home
TCOC	Total Cost of Care
VHIE	Vermont Health Information Exchange
VITL	Vermont Information Technology Leaders
VHCURES	Vermont Health Care Uniform Reporting and Evaluation System
VUHDDS	Vermont Uniform Hospital Discharge Data Set

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