Green Mountain Care Board

2023 ANNUAL REPORT

The Green Mountain Care Board drives system-wide improvements in access, affordability, and quality of health care to improve the health of Vermonters.

Submitted January 16, 2024
In accordance with 18 V.S.A. § 9375(d)

Contents

REPORT SUMMARY

By: Green Mountain Care Board; **Date:** January 16, 2024
Prepared for: House Committee on Health Care; Senate Committee on Health and Welfare
Frequency: Annual Report; **Statute:** 18 V.S.A. § 9375(d)

Background:

- The GMCB is required to annually submit a report on or before January 15 to the House Committee on Health Care and Senate Committee on Health and Welfare.
- The report must include updates on each area of the GMCB's regulatory work, a report on the impact of the cost shift and uncompensated care, recommendations for modifications to Vermont statutes, and summaries of key findings from GMCB reports such as the expenditure analysis.
- The Annual Report is a resource to inform legislators and the public about the state of Vermont's health care system and has an overview of the GMCB's work and regulatory decisions from the prior year.

Key Terms
Green Mountain Care Board (GMCB): The GMCB is an independent Board composed of 5 board members who are appointed by the Governor for staggered six-year terms. The GMCB was created by the legislature in 2011.

Report Methods:

- Generally, each topic covered in this report is summarized in one page, or a second page for graphs and tables as needed. The table of contents allows readers to jump to each section.

Report Highlights:

- **Board Composition:** The Board consists of 5 members: Owen Foster, J.D., who serves as the Board Chair, and the following members: Robin Lunge, J.D., MHCDS; Jessica Holmes, Ph.D.; Thom Walsh, Ph.D., MS, MSPT; and David Murman, M.D.
- **Public Engagement:** In 2023, the GMCB held 53 public board meetings and continued to engage with the public through receipt of written public comment, oral public comment provided during Board hearings, community outreach, Board hearings featuring community members and local and national experts, and the return of traveling Board meetings. The Board additionally continued to regularly convene public meetings of three committees: the General Advisory Committee, Primary Care Advisory Group, and the Data Governance Council.
- **Hospital Sustainability:** In 2023, the GMCB continued focus on the hospital sustainability work outlined in Act 167. A contract was signed with OliverWyman Healthcare & Life Sciences. Community engagement began in the fall of 2023 with legislators, hospital leadership teams and boards, community health providers, and Vermonters. Work also continued on GMCB's regulatory process refinement and the All-Payer Model.
- **Regulatory Work:** The GMCB reviewed 15 hospital budgets, 8 rate filings, and 3 Accountable Care Organization budgets, and issued 7 Certificates of Need.

EXECUTIVE SUMMARY

As we look forward to 2024, Vermont patients, and the healthcare system that serves them, remain in a challenging environment. While Vermonter's healthcare costs continue to rise considerably faster than the rest of the nation, they encounter a system that is challenged to serve them and is itself under financial strain. Over the two-year period FY23-FY24 Vermont hospitals requested commercial rate increases of 21.1%, more than triple medical inflation over the same period. Despite this explosion of hospital spending, many remain in financial disarray. On average, qualified health plan insurance rates rose 26.6% - 32.9% over this period, due in large part to significantly increased hospital and pharmaceutical costs. A major impediment to hospital sustainability—and to access and affordability—is the lack of sufficient primary care, mental health care, and long-term care. Those critical community providers are under immense stress in Vermont, with inadequate reimbursements, widespread burnout, and significant administrative burden. Until we address those challenges, we will not have a well-functioning system.

GMCB took significant strides in 2023 to address these challenges.

First, GMCB held the state-wide accountable care organization, OneCare Vermont, accountable and required it to demonstrate how its efforts are meaningfully benefiting Vermonters. GMCB reduced OneCare's administrative spending by over 10% and required that funding be devoted to sorely needed additional financial support for providers. GMCB additionally required OneCare to provide budgetarily required primary care support payments after OneCare failed to make the requisite payments. GMCB will continue to closely scrutinize OneCare's performance and expects, and will require, performance to improve.

Second, GMCB reduced insurer rate requests across all filings by 24.8%, or approximately $26.2 million. Perhaps more importantly, GMCB required insurers to award rate increases to the entirety of their contract network based on consideration of access, affordability, and quality. Historically, Vermont hospitals demanded (and received) far larger rate increases than community providers. GMCB's new mandate will ensure all providers are treated equitably and those providing more affordable, accessible, and higher quality care will be rewarded with more favorable rate increases.

Third, GMCB employed a more granular and data-driven hospital budget review process. Hospitals were benchmarked against relevant peers, such as other academic medical centers, critical access hospitals (CAHs), and small rural hospitals. This improved process ensured that hospitals with effective expense control, tight administrative budgets, and good access were rewarded while others were required to improve their operations and were not subsidized by Vermont rate payers. Four hospitals were placed on performance improvement plans so that the GMCB could monitor and assist in their corrective efforts. GMCB approved hospital rate increases of 4.1% across the system. This increase, while lower than the 10.6% systemwide increase that hospitals requested (on top of the 10.5% FY23 requests), is a significant increase and a difficult financial burden to add to Vermonters' already exorbitant commercial insurance costs but was necessary to ensure sustainability of our hospital system. GMCB's reduction in hospital rate increases saved the Vermont commercial insured population $145 million in rate increases and freed up monies that could be utilized for preventative care and community providers to start the long and difficult process rebuilding and sustaining those aspects of our system.

Fourth, GMCB has worked in collaboration with AHS in connection with negotiating a potential new all-payer model with CMS. GMCB has taken the lead on evaluating and designing global payments. The State anticipates submitting a response to CMS's request for applications by mid-March 2024 and then will engage in an intensive negotiation and evaluation process to determine whether the State is in a position to benefit from CMS's AHEAD model.

Lastly, GMCB began its Act 167 community engagement work, which will result in a report and recommendations to Vermont hospitals on steps needed to increase access to critical services and to ensure sustainability of our health system. The community engagement work was broad and deep and resulted in 119 meetings with 1,800

participants. This qualitative and quantitative process will continue in the coming months with in-person meetings in local communities to discuss options for transforming our hospital system so that it has a sustainable future.

We thank the Legislature for its dedication to improve Vermont's health system and its continued support of the GMCB. While 2024 will present policy makers and decision makers with tough choices, the State is poised to take advantage of the significant opportunities available to revamp our healthcare system for the long-term sustainability of our providers and betterment of Vermonters.

LEGISLATIVE REPORTS

Figure 1: GMCB Legislative Reports Summary (* indicates reports submitted annually)

GMCB Legislative Reports Submitted in 2023		
Report	**Due Date**	**Corresponding Statute or Legislation**
Impact of Prescription Drug Costs on Health Insurance Premiums	January 1, 2023*	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)
GMCB 2023 Annual Report	January 15, 2023*	18 V.S.A. § 9375 (d)
2022 Vermont Health Care Expenditure Analysis	January 15, 2023* *NOTE: The VHCEA is delayed yearly due to data availability and staff resources. This report is typically published in May.*	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 GMCB (H.912)
Update on Act 167 of 2022, Sections 1 and 2	January 15, 2023	Act 167 of 2022, An act relating to health care reform initiatives, data collection, and access to home- and community-based services, Sec. 1 and 2 (S.285)
Cost Shift Impact (**page 17 of the 2023 Annual Report**)	January 15, 2023*	18 V.S.A. § 9375 (d) Act 63 of 2019, An act relating to health insurance and the individual mandate, Sec. 10 (H.524)
Billback Report	September 13, 2023*	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)

HEALTH CARE REGULATION

HEALTH CARE REGULATION

Health Insurance Rate Review

Project Area: Health Care 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 group, small group, 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 2023

- Rate Filings: The Board reviewed 8 rate filings in 2023[1] (see Figure 2, following page), representing approximately $699 million in health insurance premiums for approximately 80,550 Vermonters, with over 71,644 on the Exchange. Insurers requested approximately $106 million in premium increases overall. The Board reduced this amount by an estimated $26.2 million, including $24.8 million for plans sold on the Exchange. Approved average rate increases for individual Exchange plans were 11.4% (reduced from 15.0%) for MVP Health Plan, Inc. (MVP) and 14.0% (reduced from 18.0%) for Blue Cross Blue Shield of Vermont (BCBSVT). Approved average rate changes in the small group market were 11.5% (reduced from 15.4%) for MVP and 13.3% (reduced from 17.5%) for BCBSVT.[2]

- Provider Contracting/Rates: In its individual and small group decisions, the Board required MVP and BCBSVT to consider affordability, access, and quality in the provider contracting.

- Rate Drivers: Increases in the cost of medical services and pharmaceuticals were the primary drivers of rate increases for all filings.

Looking Ahead to 2024

- 2022 Inflation Reduction Act (IRA): In August of 2022, Congress passed the Inflation Reduction Act (IRA), which will continue ARPA's enhanced subsidies to lower the cost of purchasing a plan in the individual market through 2025. These subsidies come in the form of premium tax credits for eligible consumers who purchase their plans through Vermont Health Connect.

- Unmerged Individual and Small Group Markets: The individual and small group markets, which were unmerged in 2022, will continue to be separate for plan year 2025 pursuant to Act 7 (2023), after which point the markets will need to be remerged absent further action from the Legislature.

[1] The filings were reviewed in 2023 for renewals in 2023 and 2024. While plans sold on the Exchange operate on a January 1-December 31 plan year, large group plans do not have a standard plan year and rates for these plans are reviewed and approved on a rolling basis.
[2] *See* GMCB Rate Review website for a summary of filings and approved rates.

Figure 2: Insurance Rate Filings for the 2023 Review Year

Company Name	Filing Name	Proposed Rate Change	Approved Rate Change	Difference	*Estimated Premium Reduction
Blue Cross Blue Shield of Vermont (Q3, first file)	Large Group	10.8%	9.8%	1.0%	$449,976
Blue Cross Blue Shield of Vermont (Q4, second file)	Large Group	-2.8%	-3.4%	0.6%	$299,602
MVP Large Group HMO	Large Group	7.5%	2.7%	4.8%	$650,414
Blue Cross Blue Shield of Vermont	Association Health Plan	7.2%	7.1%	0.1%	$9,124
MVP Health Plan Inc.	Individual	15.0%	11.4%	3.6%	$4,288,921
MVP Health Plan Inc.	Small Group	15.4%	11.5%	3.9%	$5,105,338
Blue Cross Blue Shield of Vermont	Individual	18.0%	14.0%	4.0%	$7,390,594
Blue Cross Blue Shield of Vermont	Small Group	17.5%	13.3%	4.2%	$8,002,674
				3.7%	$26,196,642

* Estimated Premium Reduction - Insureds may not stay with the same plan or insurer from year to year. Large Group filings are based on the manual rate and may not be reflective of the actual rate increase. Groups with better experience will see lower rates, and groups with worse experience will see higher rates.

Certificate of Need (CON)

Project Area: Health Care Regulation

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 hospitals and 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 2023

- Issued seven CONs: The GMCB approved seven applications with a total value of over $105,770,574.
    - University of Vermont Medical Center Relocation of Outpatient Dermatology and Ophthalmology Practices to 350 Tilley Drive. ($35,246,100)
    - University of Vermont Medical Center Purchase of a da Vinci Robotic Surgical System. ($2,460,000)
    - University of Vermont Medical Center Replacement CT Scanner located in McClure Level 1, Room 1079 (CT Room 2) with Associated Renovations and Construction of a Mobile Pad Addition to the Essex Primary Care Facility. ($3,456,928)
    - Integrative Life Network, LLC Purchase of 100% Ownership Interest in Silver Pines Partners, LLC. ($CONFIDENTIAL)
    - Northeastern Vermont Regional Hospital West Wing Expansion Project ($14,464,831)
    - Grace Cottage Family Health & Hospital, New Primary Care Practice Building ($19,152,993)
    - Vernon Green Nursing Home Replacement ($30,989,722)
- One Material Change: The Board approved one material change to a CON project to increase the total project cost by more than 10%.
- Five non-material changes to CON projects: The Board approved five non-material changes to CON projects for changes in projects that either changed the original scope of the project or that total cost was less than the 10% threshold that would trigger a material change.
- Eight projects not reviewable: The Board determined that eight proposed projects did not meet jurisdictional thresholds for CON review.
- Applications under review:
    - University of Vermont Medical Center Outpatient Surgery Center.

Looking Ahead to 2024

- New applications: The following entities have either filed, or notified the Board that they intend to file, applications that will be reviewed in 2024:
    - BAART Behavioral Health Services Inc. Development of an opioid treatment program in Bennington County.
    - Southwestern Vermont Medical Center, development of adolescent inpatient mental health unit.

Hospital Budget Review

Project Area: Health Care Regulation

Relevant Statute/Authority: 18 V.S.A. §§ 9375(b)(7), 9456, 9371

Overview: Annually by October 1, the Board has the responsibility to review and establish community hospital budgets. In its review, the Board considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public.
The Board may adjust a hospital's budget based on exceptional or unforeseen circumstances.

In accordance with the state's stated principles of health care reform, "overall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care."

Progress in 2023

Almost half of health care spending in Vermont is for hospital-based services and as a percentage of resident health care spending, forty-percent is for hospital care.[3] Vermont has one of the highest levels of per capita hospital spending and growth over the last two decades, compared to other states.[4] The hospital budget review process has been in place in Vermont since 1983, and has been administered by the GMCB since 2012. The purpose of the GMCB is 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. Increasing pressure on commercial rate payers who are disproportionately absorbing costs associated with increased hospital care spending, requires the Board to carefully scrutinize the long-term viability of that approach as a mechanism to sustain hospitals, as well as the impact disproportionately large increases in hospital spending have on the broader healthcare system, including a strained mental health, primary care, and long term care system. Moreover, the Board must consider any collateral negative impacts on access and health care affordability in evaluating hospital budget requests that far outpace medical inflation and rates obtained by non-GMCB regulated entities and non-Vermont hospitals. The State's long-standing and legislatively enacted principle that "overall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care" has never been more challenging than in our current healthcare environment.

- FY2024 Hospital Budget Review Process: In this year's hospital budget guidance the Board established a two-year Net Patient Revenue (NPR) target of **8.6%,** based on targets put forth in the state's All Payer Model agreement which aims to bring health care spending in line with economic growth. Vermont's 14 community hospitals filed their proposed budgets for FY2024 on July 1, 2023, with a fiscal year start of October 1, 2023. The aggregated two-year system-wide requested net patient revenue (NPR) increase was **19.3%** over FY2022 system-wide actuals. Requests for increased charges were **10.6% system-wide** over prior year, which is more than double inflation estimates over the same period as measured by Vermont Median household income growth and Medicare Market Basket, at 3.9% and 3.0% respectively. Common themes that emerged from hospital budget submissions, continuing from prior years, are challenges navigating workforce shortages, staff burnout, and inflationary pressures, as well as challenges maximizing patient flows attributed to limited capacity in primary care, mental health, and long-term services and supports. Hospitals continue to work on cost reduction and creative ways to attract and retain high-quality staff and to compensate for a system that does not provide them with adequate

[3] 2020 Vermont Health Care Expenditure Analysis; This is the latest available expenditure analysis; GMCB is currently updating this report and its methodologies.
[4] Health Care Expenditures per Caita by State of Residence 1991-2020

opportunities to move patients to more appropriate care settings. The GMCB considered comments from the Office of the Health Care Advocate and the public in connection with evaluating FY2024 hospital budget requests.

- FY2024 Hospital Budget Decisions:[5] The GMCB's FY2024 hospital budget orders resulted in a system-wide NPR of $3.58 billion, an **18.2%** NPR increase over FY2022 approved budgets. The Board approved seven hospital budgets as submitted, and made adjustments to seven hospitals' budgets to limit the rate increase that impacts commercially insured patients, representing a **7.8% reduction** ($145 million) from submitted budgets. In reaching its decision, the GMCB considered the environmental and sustainability challenges hospitals were facing, as well as issues with access to care. Striking the balance between health care affordability and hospital solvency is increasingly difficult, as hospital fixed costs continue to grow, and the commercially insured population are disproportionally shouldering the burden, despite already unaffordable plans.

- Regulatory Evolution: The GMCB continued work to evolve the hospital budget process to move toward a more predictable and less administratively burdensome process, relying more heavily on data and evidence to inform its decision-making.

Looking Ahead to 2024

- While the Board does not approve the FY2025 hospital budget guidance until March 2024, staff are already building on progress made in FY2024. This includes continued improvement efforts as it relates to the Board's a priori setting of hospital budget targets, as well as its use and consideration of evidence and data in its regulatory process and streamlining data collection and analytic processes. Given continued challenges associated with health care affordability, in addition to a target for net patient revenue, staff will be proposing the inclusion of targets for commercial price and operating efficiency, among others.

- The connection between the hospital budget review process and Act 167 community engagement to support hospital transformation will also begin in the FY2025 process. Though the recommendations from community engagement will have only just been released, staff will recommend soliciting hospitals' preliminary thoughts on the recommendations and lessons learned through the community engagement process. Tackling our health care affordability and access challenges will require the State and healthcare system to take advantage of opportunities for system-wide efficiencies, address deficiencies in our system that are negatively impacting our population's health and hospitals' finances, as well as improve hospital productivity.

[5] *See* GMCB FY23 Hospital Budgets webpage.

ACO Oversight: Budget Review and Certification

Project Area: Health Care Regulation

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. GMCB is also responsible for reviewing and approving ACO budgets. For additional information on ACO oversight, please see materials here.

Progress in 2023

- 2023 Revised Budget and Monitoring – OneCare Vermont (OCV): In February, GMCB informed OCV that it was out of compliance with its budget order for failing to fund primary care support payments at the level approved by GMCB. GMCB required OCV to comply with those provisions of its budget order and mandated OCV continue to support primary care at the higher GMCB-approved levels. In May and June 2023, GMCB reviewed OCV's revised budget and added additional conditions: requirements that OCV obtain attestations to ensure that funds intended to support hospital-based primary care practices are directed to those practices; and to cap OCV executive compensation. The GMCB continues to work on increasing transparency into OCV's executive compensation, and OCV has appealed the GMCB's order that OCV be accountable for ensuring primary care support payments are utilized for that purpose, as well as the GMCB's order on OCV's executive compensation. Throughout 2023, GMCB monitored OCV's compliance with conditions of its FY23 budget order throughout the year, as outlined in the FY23 Reporting Manual.

- 2024 OCV ACO Certification and Budget Review: GMCB received OCV's certification eligibility submission on August 29, 2023, is reviewing OCV's continued eligibility for certification, and will document its review in a memo. GMCB received OCV's proposed FY24 budget on October 2, 2023. After careful analysis of OCV's budget and numerous public comments, GMCB voted on December 20, 2023, to modify OCV's budget to increase its Medicare risk corridor from 3% to 4% and require OCV to retain the downside of the additional 1% (approximately $5.7M) at the entity level and not pass this risk on to their network, and GMCB required OCV to cut its operating expenses by 6.7% (approximately $957,000) and redirect those funds to population health or primary care programs. GMCB approved OCV's budget with approximately 20 conditions, including requirements for continued reporting, transparency, verification that program funds intended to support primary care flow to primary care practices, and improved performance benchmarking.

- FY24 OCV Budget Summary: After giving effect to GMCB's required changes, OCV's total population health and operational budget is $40 million ($26.7M in population health investments, $13.3M in operational expenses). OCV's entity-level budget reported in line with U.S. Generally Accepted Accounting Principles was $22.4 million, representing the organization's operational expenses ($13.3 M) and the portion of population health management program funding handled directly by OneCare ($9.1M). The full accountability budget of $1.0 billion includes the projected cost of care for which OCV is accountable, including funds that pass directly to providers, contract revenues, and organizational revenues and expenses.

- 2024 Medicare-Only ACO Budget Review: GMCB reviewed the FY24 budgets of two Medicare-only ACOs this year: Lore Health ACO LLC (formerly Gather Health) and Vytalize Health 9 ACO (a new entrant in this budget cycle). Lore Health submitted its FY24 budget on October 2, 2023, and Vytalize Health 9 submitted its FY24 budget on November 1, 2023. After analysis, GMCB voted on December 6, 2023, to approve both Medicare-Only ACOs' budgets with six conditions focused on monitoring the ACO's care model, financials, quality reporting, beneficiary complaints and collaboration with the Blueprint for Health.

- Review of 2024 Medicaid Advisory Opinion: Per 18 V.S.A. § 9573, GMCB is responsible for advising DVHA on the population-based payment arrangement negotiated between DVHA and OCV. GMCB received information from DVHA in October and December and issued an advisory opinion on December 20, 2023.

Looking Ahead to 2024

- Aligning ACO Oversight with Other Regulatory Processes: GMCB continues to work to align ACO oversight with other regulatory processes in service of containing cost growth and improving access, quality, and health. This will include alignment with a potential future federal-state model.

- Evolving Medicare-Only ACO Oversight: GMCB is seeking to evolve its oversight of Medicare-only ACOs to ensure appropriate monitoring and transparency while recognizing the State's limited levers for requiring programmatic changes.

Regulating Cost Shifting to Commercial Payers

Project Area: Health Care Regulation

Relevant Statute/Authority: 18 V.S.A. § 9375 & § 9371

Overview: 18 V.S.A. § 9375(d)(1)(F) requires the Board to report annually on the impact of the "cost shift" on health insurance premium rates. The statute also allows the Board to recommend mechanisms to ensure that appropriations made to address the Medicaid "cost shift" reduce commercial insurance premiums.

18 V.S.A. § 9371 describes the principles of health care reform, one of which is that "overall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care."

Vermont law requires the GMCB to both control cost growth and assess cost shifts to commercial payers. The "cost shift" is the theory that public payer reimbursements to health care providers are insufficient to cover providers' costs and, to stay financially viable, providers must charge higher prices to private payers; in other words, private payers subsidize the cost of caring for patients who are insured by public payers. However, the "cost shift" theory has been increasingly challenged by leading academics who posit that some systems may have higher relative negotiating leverage due to greater market power and may be able to demand higher prices beyond what the market would otherwise determine to be an efficient price.[6]

Further, even if the price can be determined to be "efficient" relative to the market for similar services, the "cost shift" assumes that a hospital's operating costs are fixed, necessary, and appropriate. However, hospitals experience significant variation in their productivity and efficiency due to a range of internal and external factors.[7] As Vermonters have experienced extreme increases in their health insurance costs, performance benchmarking and operating cost assessments have become increasingly important and an additional mechanism in the Board's hospital budget review process.

Additionally, how services are configured across hospitals and communities has implications for system-wide operating costs (e.g., how much duplication is there in services/infrastructure across communities). While hospitals consider a variety of factors in deciding services to provide (e.g., community need, services offered by competitors, profitability of services, etc., the services that end up being delivered may not necessarily be the most efficient on a system level and may not maximize affordability or quality of care. The Board's Act 167 community engagement and related work explores opportunities to better balance system-wide efficiencies and community needs.

While the GMCB is submitting this year's cost shift report consistent with existing statue, the Board recognizes the malleability of hospital and health system costs, considering both costs at the system- as well as hospital-levels, and continues to use its regulatory levers to facilitate improvement. We have also included in our summary related insights from the National Academy for State Health Policy's (NASHP) commercial breakeven analysis, as well as RAND's Relative Price Analysis. The NASHP break even analysis quantifies "the reimbursement rate a hospital needs to receive from commercial payers to cover all of its expenses for hospital inpatient and outpatient services, without profit,"[8] while the RAND relative price analysis compares prices paid to hospitals by commercial plans as a proportion of those paid by Medicare for similar services.[9] Highlights from this year's "cost shift" analysis, and related analyses and discussions below:

- Annual Estimated "Cost Shift" Impact: Given extant hospital and health system costs, Figures 1-3 in the analysis following represent the estimated cost shift by payer and by year from FY2010 actuals to

[6] Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality
[7] Productivity Variation and Input Misallocation: Evidence from Hospitals
[8] NASHP Commercial Breakeven Analysis
[9] RAND Relative Price Analysis

FY2024 budget, as historically measured by the GMCB. The cost shift is an estimate based on data submitted in the hospital budget process and assumes that each payer should contribute equally to these budgets, accounting for their proportional share of expenses and margins. Though substantively this only represents a "price shift" since costs are not measured directly.

- "Cost Shift" Rate of Growth: From FY2010 to FY2019, the cost shift appears to have grown at a compound rate of 7.9%, with an estimated growth of -9.8% from FY2019 Actual to FY2020 Actual and 9.2% from FY2020 Actual to FY2024 Budget. The estimated growth of the cost shift for FY2020, FY2021, and FY2022 are affected by the COVID-19 pandemic in that patients were not seeking hospital services at historically comparable rates.

- NASHP Breakeven & RAND Relative Price Analyses[10]: In the latest available data (2022), while Vermont's commercial price for hospital care (inpatient and outpatient) is approximately 215% of Medicare, the NASHP breakeven price is 109% of Medicare; this compares to a national average 260% of Medicare, and 127% of Medicare, respectively. Across Vermont hospitals, commercial prices range from 106% to 321% of Medicare, whereas the breakeven price ranges from 45% to 282%.

- Regulating Cost Shifting to Commercial Payers: In the FY2024 hospital budget process, the Board capped commercial rate growth by payer for the first time. In previous years the cap was applied to average charges, which hospitals may have used to allow variable growth rates across payers as long as the average charge growth across payers and services remained below the Board's ordered rate. The revised regulatory approach ensures that there is a cap on commercial rate growth and that no payer population is disproportionately or inequitably burdened by increases in hospital prices.

- Cost Shift Discussion at the GMCB and in Legislature: The role of the cost shift versus other explanatory factors (i.e. consolidation and market power) in driving increases in hospital prices has been an ongoing topic of discussion in GMCB meetings, including hospital budget review hearings, as well as health insurance rate review hearings, and in the Legislature. In 2022 the Health Care Advocate issued a white paper on this topic. In 2023, the GMCB devoted a series of board meetings to further understand this topic. Below is a list of participating speakers and links to their slides and recordings of their public presentations.

    - Jeff Stensland, PhD, Medicare Payment Advisory Commission (slides/recording)
    - Zack Cooper PhD, Yale University & The Healthcare Pricing Project (slides/recording)
    - Christopher Whaley PhD, RAND Corporation (slides/recording)

Looking Ahead to 2024

As part of the GMCB's mission to balance affordability, quality and access, it is imperative to understand, measure, and control the drivers and impacts of price discrimination and variation. In this vein, the Board will continue honing its regulatory processes and evaluating their implementation to ensure that the intent of its authority and decisions are properly implemented. As part of this effort, the Board is exploring the implementation of its existing authorities, refining of ongoing regulatory processes and metrics, and whether additional resources may be necessary to improve its regulation.

[10] Sage Transparency Dashboard – Employer Hospital Price Transparency Project & NASHP Hospital Cost Tool

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

Premium Rates Statutory Charge: 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…"

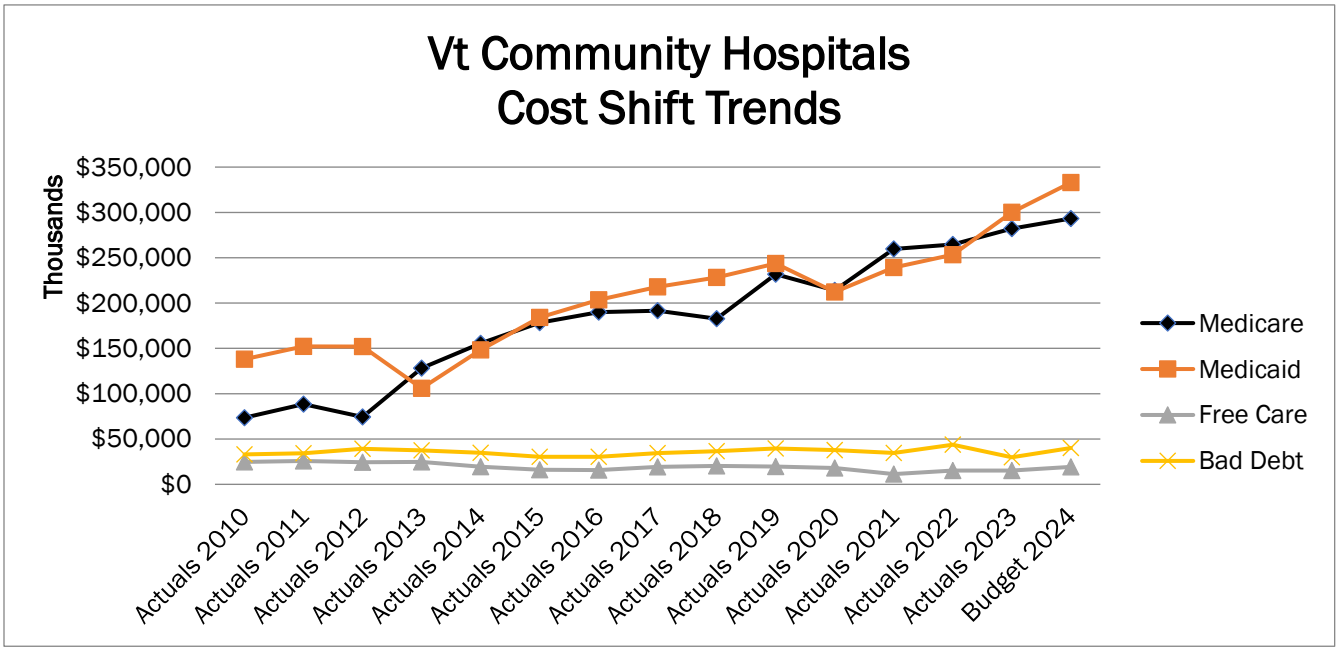
Scope: Each year, the Board reports on the costs that Vermont community hospitals and their affiliated providers and facilities are expected to shift onto commercial insurers and other payers (e.g., self-insured employers and self-pay patients) to make up for lower reimbursements from Medicare and Medicaid and to cover the cost of uncompensated care. This information is found in the Cost Shift section of this report. 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 2023, 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; 14.6% for individual and small group filings; and 14.1% for large group filings.

Figure 1: Estimated Cost Shift by Payer (FY2010-FY2024), 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	Annual Change	Estimated % Change from Prior Year in Shift to Commercial and Other Payers
Actuals 2010	$ (73,515,988)	$ (138,016,619)	$ (24,806,398)	$ (33,076,863)	$ 269,415,868	$ 19,125,573	7.64%
Actuals 2011	$ (88,399,861)	$ (152,256,740)	$ (25,784,124)	$ (34,331,093)	$ 300,771,818	$ 31,355,950	11.6%
Actuals 2012	$ (74,383,192)	$ (151,931,648)	$ (24,347,367)	$ (39,264,676)	$ 289,926,884	$ (10,844,935)	-3.6%
Actuals 2013	$ (128,108,641)	$ (105,982,171)	$ (24,684,304)	$ (37,383,822)	$ 296,158,938	$ 6,232,054	2.1%
Actuals 2014	$ (155,622,607)	$ (148,344,481)	$ (19,370,131)	$ (34,885,055)	$ 358,222,274	$ 62,063,336	21.0%
Actuals 2015	$ (178,243,251)	$ (184,115,357)	$ (16,032,485)	$ (30,469,896)	$ 408,860,990	$ 50,638,716	14.1%
Actuals 2016	$ (190,018,540)	$ (203,622,426)	$ (15,683,900)	$ (30,318,995)	$ 439,643,861	$ 30,782,871	7.5%
Actuals 2017	$ (191,515,256)	$ (217,814,796)	$ (19,337,891)	$ (34,451,540)	$ 463,119,483	$ 23,475,623	5.3%
Actuals 2018	$ (182,780,851)	$ (228,177,679)	$ (20,380,418)	$ (36,600,429)	$ 467,939,377	$ 4,819,894	1.0%
Actuals 2019	$ (231,725,743)	$ (243,616,824)	$ (19,635,798)	$ (39,595,820)	$ 534,573,257	$ 66,633,880	14.2%
Actuals 2020	$ (213,990,446)	$ (212,239,269)	$ (17,947,862)	$ (37,824,364)	$ 482,001,013	$ (52,572,244)	-9.8%
Actuals 2021	$ (259,644,195)	$ (239,187,977)	$ (11,311,885)	$ (34,678,866)	$ 544,822,923	$ 62,821,910	13.0%
Actuals 2022	$ (264,629,430)	$ (253,380,720)	$ (15,224,557)	$ (43,723,386)	$ 576,958,093	$ 32,135,170	5.9%
Actuals 2023	$ (282,081,537)	$ (300,057,115)	$ (15,124,524)	$ (29,851,130)	$ 627,114,305	$ 50,156,213	8.7%
Budget 2024	$ (293,282,886)	$ (332,855,876)	$ (19,333,513)	$ (40,093,912)	$ 685,566,187	$ 58,451,882	9.3%

Figure 2: Trends – Estimated Cost of Services Shifted to Other Payers (FY2010-FY2024)



Analysis: The Board determined what percentage of hospitals' budgeted commercial revenues are due to the cost shift. This is represented by column (C) in the equation below. Next, the Board determined what percentage of projected premiums are due to projected FY24 hospital spending. This is represented by column (D) in the equation below. The Board then multiplied column (C) by column (D) to determine that the average impact of the cost shift across all filings was 21%, as shown in Figure 3.

Figure 3: Estimated Impact of Vermont Hospital Budgets on Insurance Premiums Observed through Rate Review 2010 Actuals to 2024 Budget

	(A)	(B)	(C) = (A)/(B)	(D)	(E) = (C)(D)
	Estimated Costs Shifted to Commercial and Other Payers	GMCB Regulated Hospitals' Budget for Commercial Payers	Percentage Impact on Hospital Budgets for Commercial Payers	Estimated GMCB Hospital Percentage of Premium	Estimated GMCB Hospital as Percentage of Premium Impact of Cost Shift on Rate Filings
Budget 2024	685,566,187	1,767,406,507	38.8%	37.5%	14.5%
Budget 2023	729,724,617	1,954,311,795	37.3%	38.3%	14.3%
Budget 2022	610,843,154	1,729,759,911	35.3%	38.4%	13.6%

The Board also calculated the average impact of the cost shift by market (i.e., individual, and small group filings and large group filings). Column (D) varies by filing and, on average, is larger for the individual and small group filings (37.6%) than for large group filings (36.3%), resulting in a larger impact on the individual and small group filings (14.6%) compared to large group filings (14.1%).[11]

[11] Individual and Small Group (38.8% * 37.6% = 14.6%). Large Group (38.8% * 36.25% = 14.1%).

DATA AND ANALYTICS

DATA AND ANALYTICS

Progress in 2023

- Data Stewardship: The GMCB's Data Governance Council approved changes in VHCURES data submission by payers, adding fields to collect data on race and ethnicity, monthly premium amounts, and an indicator for mail-order pharmacy claims, as well as now requiring payers to securely submit data without required one-way encryption.
- Data Linkage and Integration: The GMCB Analytical Team continued to work on new and meaningful opportunities to integrate data for enhanced health care research and analytics.
- Standard Reporting:[12] Interactive reports available for public use from the GMCB website were updated and expanded. These reports include Reimbursement Variation, All-Payer Total Cost of Care reports, Patient Migration, and Market Share Reports.[13]

Looking Ahead to 2024

- Data and Analyses: Throughout 2024 GMCB will continue its work, with vendor support, on a number of specialized projects, including: Assessment of outpatient capacity and technical assistance to support the GMCB's Certificate of Need Program, comparative healthcare spending and analysis of potentially avoidable utilization and/or low-value care, hospital profiles and analytics to support the Act 167 provider and community engagement process.
- Expanded Support Across the GMCB: The Analytical Team is continuing to embed analysts in projects that span the organization to better fulfill the GMCB's desire to use data to inform its decision making.

[12] *See* GMCB Data Analysis and Reporting webpage for current analytic reports.
[13] This supports the Health Resource Allocation Plan (HRAP).

Health Resource Allocation Plan (HRAP)

GMCB hosts the Health Resource Allocation Plan (HRAP), which is intended to capture what is happening in the State in terms of health care services, accessibility, quality, and cost.

HRAP includes dashboards, reports, needs assessments, and inventories from GMCB, Agency of Human Services, Vermont Department of Health, and other partners. By packaging available data and reports from across state government, HRAP supports the GMCB in its regulatory work (e.g., the Certificate of Need program) and serves as a resource for health care projects and decision-making across state government. Importantly, HRAP is not a single document or published at a single time; it includes inventories, reports, assessments, etc. that may have been a onetime project or may be a recurring report. The GMCB's website has a page[3] where one can go to view the interactive reports and available data.

Project Area: Data and Analytics

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 2023

- HRAP Process Improvement Road Map: Developed priorities for targeted reports and/or dashboards. The road map includes HRAP plans for updating existing reports and changes to regulatory process compared to health care resource and community assessments.
- HRAP Framework: Designed an HRAP framework to enhance HRAP use. The framework includes four processes: requirement gathering for GMCB regulatory processes, stakeholder engagement, data collection and analysis, and visualization and packaging of information. Utilization, access, and payer mix will be key data indicators for analysis, when applicable.
- Data Analysis: Gender affirming care and reproductive care services were added to the HRAP list of health care topics. Other reports include avoidable use analysis, hospital service inventory, market share report, and patient migration.
- Stakeholder Engagement: The stakeholder engagement process is ongoing and involves state agencies, legislative representatives as well as regulated entities. Public feedback is solicited through public board meetings and the GMCB's established public comment process.

Looking Ahead to 2024

- Data Collection and Management: Essential data sets that reflect health care needs and resources by sector and geographic region will continue to be maintained over the next year. Relevant updates will be highlighted on the GMCB website.
- Data Analysis: Act 167 community engagement results will be added to the HRAP. End stage renal disease (ESRD) study will be conducted.
- Strategic Planning: Further assessments will be conducted to package reports and analysis in an effective way for HRAP.
- Data Visualization: Hospital Profiles dashboard will be developed to showcase metrics/indicators for a number of topic areas stratified by hospital. The goal of the Hospital Profiles will be to be a one-stop-shop for information around hospital data regarding topics like quality, utilization, access, etc.

Vermont Health Care Expenditure Analysis

Project Area: Data and Analytics

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

Overview: The Board is tasked with developing an annual expenditure analysis and estimates of future health care spending. The Expenditure Analysis is a rich, detailed data source specific to Vermont, and has been published annually since 1991. • 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, and compares Vermont spending to national data published annually by CMS.

Progress in 2023

Vermont's Health Care Expenditure Analysis is modeled after the CMS-generated National Health Expenditures (NHE), and work is underway to update the analysis to include 2021 and 2022. The analysis uses the best available data to answer the following 4 questions:

(1) What is the total healthcare spend in Vermont?

(2) What is Vermont's total predicted healthcare spend in the future (2024, 2025, 2026, and 2027)?

(3) What is the health spend by health insurance types (Medicare, Medicaid, and private insurance) and by health services types (personal health care, hospital care, physician and clinical services, dental services, home health care, prescription drugs, durable medical products, nursing home care, and other important categories)?

(4) How does Vermont's healthcare spend per capita compare to other states and the U.S.?

Vermont's Expenditure Analysis answers these questions for two important groups, Vermont residents (which includes health care dollars spent inside and outside Vermont) and Vermont healthcare organizations/providers (which includes healthcare dollars spent inside Vermont regardless of where people seeking health care live).

Due to data lag and staff vacancies, answers to questions 1, 2, and 3 will be available for the years 2021 and 2022 in early 2024. A summary of the most recent year (2020) that CMS produced state by state comparisons is in Attachment A (note that the state-by-state comparison is completed every 5 years, and national benchmarks are available annually).

Looking Ahead to 2024

- Finalizing 2021 and 2022 Health Care Expenditure Analysis: In 2024, staff will finalize the 2021 and 2022 Expenditure Analysis along with four-year estimates.

Health Information Technology

Project Area: Data and Analytics

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 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 2023

- FY2023 VITL Budget Amendment: On February 10, 2023, VITL submitted a budget amendment for the remainder of their FY2023 budget. VITL's updated budget anticipated an increase of $543k in revenue and an increase of $541k in expenses. Per the budget guidance, VITL submitted a formal budget amendment to the Board as variances were over 5% of the total original budget for revenue and expenses. VITL presented the amended budget to the Board on February 22, 2023 and the Board voted unanimously to approve the amendment.

- FY2024 VITL Budget Review: VITL submitted its proposed budget for FY2024 (July 1, 2023 – June 30, 2024) on May 10, 2023, with anticipated total revenue of $11,270,664, including $10,788,782 in state contracts. The FY2024 budget includes an anticipated total expense of $11,172,927. This submission was presented to the GMCB at its May 17, 2023 public Board meeting,[14] and approved on May 31, 2023.[15] VITL provided quarterly updates on their operations and budget throughout 2023 as required by its FY2023 and FY2024 budget orders, on topics including governance and operations, finances, technology, and stakeholder engagement around HIE consent, including patient education.

- 2023 Health Information Exchange (HIE) Strategic Plan and 2024 Connectivity Criteria Review and Approval: 18 V.S.A. § 9351(a)(1) requires a comprehensive five-year HIE Plan update to be submitted every five years and an annual update. On November 15, 2023, AHS and VITL presented the annual update to the HIE Plan, including the 2024 Health Information Exchange Connectivity Criteria, to the GMCB. Following Board discussion and requests for changes, AHS resubmitted the HIE Plan on November 30, 2023. The GMCB voted at its December 13, 2023 meeting to approve the HIE Plan 2023 update and Connectivity Criteria for 2024.[16]

Looking Ahead to 2024

- FY2025 VITL Budget Review: The Board expects to review VITL's FY2025 budget in late spring 2024.

- Future HIE Plan Updates: In recent years, the task of HIE Plan annual update submissions has been completed by AHS central office (rather than DVHA staff) in collaboration with the HIE Steering Committee. This practice will continue and the annual update to the 2023-2027 Plan submission is expected on November 1, 2024.

[14] *See* FY2024 Budget Review Presentation (May 17, 2023).
[15] *See* Order Approving Vermont Information Technology Leaders' FY2024 Budget (June 30, 2023).
[16] See GMCB's Health Information Exchange (HIE) Plan webpage for more information.

Ambulatory Surgical Center Reporting

Progress in 2023

Project Area: Data and Analytics

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

Overview: 18 V.S.A. § 9375 requires the Board to collect and review annualized data from ambulatory surgical centers (ASCs), which shall include net patient revenues, and which may include data on a center's scope of services, volume, payer mix, and coordination with other aspects of the health care system. The Board's processes shall be appropriate to ASC scale, their role in Vermont's health care system, and their administrative capacity. The Board shall also consider ways in which ASCs can be integrated into systemwide payment and delivery system reform.

Most surgeries in Vermont happen in outpatient settings, either at hospitals or at distinct entities called Ambulatory Surgical Centers (ASCs). ASCs provide surgical services to patients where the expected duration of services does not exceed 24 hours. Evidence on ASCs nationally points to better safety at lower costs than in hospital settings,[17][18][19] and ASCs can sometimes help mitigate the impacts of decreased competition from increasingly concentrated outpatient surgery markets on consumers and payers.[20][21]. At the same time, if the ASCs create duplicative services in a small healthcare system like Vermont, this could be costly to taxpayers, and evidence shows that such excess surgical capacity could lead to unnecessary procedures, negatively impacting patient care.[22] Legislatively-mandated reporting requires GMCB to assess the following:

1) What surgical services are provided?
2) What is the payer mix (Medicaid, Medicare and Private Insurance)?
3) What are the costs for these services?
4) What other settings are providing the same surgeries in Vermont? And how do the costs compare in ASC vs. non-ASC settings?

<u>Data Sources that will be Used to Answer the Above Questions, with Important Limitations:</u>

- Vermont Health Care Uniform Reporting and Evaluation System - VHCURES
  - Limitations: 1) VHCURES does not include the uninsured, federal employees, small insurers (<200 people), and self-insured employees (a significant part of the VT insurance market); 2) Privacy requires suppression of procedures <11 people so the full scope of services are not included; 3) Due to limited mapping of providers to organizations (such as in a provider index), it is not possible to highly accurately track which providers work for which organizations, and as such, setting cannot always be accurately determined; 4) ASCs can rent their surgical suites to other providers, which

[17] Munnich EL, Parente ST. Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up. Health Affairs. 2014; 33(5) 764-769.
[18] Weber E. Measuring welfare from ambulatory surgery centers: a spatial analysis of demand for healthcare facilities. J Ind Econ. 2014;62(4):591-631.
[19] Munnich EL, Parente ST. Returns to specialization: evidence from the outpatient surgery market. J Ind Econ. 2014; 62(4) 591-631.
[20] Carey K, Burgess JF Jr, Young GJ. Hospital competition and financial performance: the effects of ambulatory surgery centers. Health Econ. 2010;29(5):765-773.
[21] Baker LC, Bundorf MK, Kessler DP. Competition in outpatient procedure markers. Med Care. 2019;57(1):36-41.
[22] "Reducing Waste in Health Care, " Health Affairs Health Policy Brief, December 13, 2012.

represents revenue and additional use of the facilities, but would not appear in the claims.

- Vermont Uniform Hospital Discharge Dataset – VUHDDS
  - Limitations: 1) VUHDDS includes Green Mountain Surgery Center only (not Vermont Eye Surgery and Laser Center) and reporting began in mid-2021; 2) While VUHDDS does include many of the populations excluded from VHCURES, VUHDDS does not include any financial information usable to inform patient costs.

The full report will be published in early 2024 on the GMCB website on the Reports and Analyses page.[23]

Looking Ahead to 2024

- Through the CON process, GMCB will continue current work to assess outpatient surgical need and capacity at the University of Vermont Medical Center related to UVMMC's application for the development of an outpatient surgery center. The GMCB will engage medical claim billing and coding experts to learn about the variations across facilities to ensure monitoring efforts are comparable, effective, and accurate. As required by statute, ASCs will begin reporting discharge records as part of the Vermont Uniform Hospital Discharge Data Set (VUHDDS), which will provide a census of all care delivered by ASCs and provide ready comparisons with Vermont's hospitals.

[23] *See* GMCB Data Analysis and Reporting webpage for current analytic reports.

Prescription Drug Monitoring

Project Area: Data and Analytics

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

Overview: The Department of Vermont Health Access (DVHA) and health insurers are required to identify prescription drugs that they spend significant health care dollars on and that have seen a significant cost increases.

Progress in 2023

- Prescription Drug Cost Analysis – State Spending: Vermont law 18 V.S.A. § 4635 requires that the Department of Vermont Health Access (DVHA) collect data on prescription drugs that have significantly increased in price, either in wholesale acquisition cost (WAC) or in net cost to the State (the wholesale acquisition cost minus rebates). The law requires that the DVHA report such data to the GMCB on or before June 1 of each year, to better inform the GMCB's regulatory work and to educate the public on the issue of drug price increases.
- In adherence to the statute, DVHA gave the GMCB two sets of analysis to disclose to the public:
    - *DVHA Analysis on WAC Increases:* This dataset contains ten drugs that experienced the highest increase in WAC over CY2022 (and that met other criteria specified by the statute). The increases in WAC ranged from 19% for Emflaza to 112% for Temazepam. Only one of the ten drugs in the dataset, Prednisolone Sodium Phosphate, appeared in the dataset for last year. Altogether, a substantial amount of gross State spending was incurred for the drugs: approximately $380,992 in CY2022 (largely attributable to $230,224 in spending for "Emflaza").
    - *DVHA Analysis on Net Cost Increases:* This list contains ten drugs that experienced the highest increase in net cost to the State (and that met other criteria specified by the statute). The increases in net cost ranged from 19% to 127%. None of the ten drugs in the dataset appeared in the dataset for last year. Altogether, a substantial amount of gross State spending was incurred for the drugs: approximately $8,789,738 in CY2022 (largely attributable to $5,824,224 in spending for "Stelara").
- Impact of Prescription Price Increases on Commercial Insurance Rates: The GMCB works with commercial payers with more than 1,000 lives in Vermont to gather data on 1) the flow of funds related to prescription drugs between manufacturers, insurers, and plan members, including discounts and rebates; and 2) the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year price increases. The data suggest that the increase in prescription drug payments is a significant driver in the increase in insurance premiums. The top three drugs with the greatest impact on premiums were Humira Pen, Stelara, and Enbrel Sureclick – all specialty drugs.
- For more detailed information on the effects of drug price increases, please refer to the reports on the GMCB webpage titled "Prescription Drug Price Transparency": **https://gmcboard.vermont.gov/publications/legislative-reports/Act165**

Looking Ahead to 2024

- Continued Prescription Drug Monitoring: The GMCB will continue to track drug costs through the health insurance rate review process and work with hospitals and insurers to measure the impact of drugs on insurance rates. The GMCB is currently debating how to better consolidate its drug data and contextualize it within the national landscape.

MONITORING HEALTH SYSTEM TRANSFORMATION

MONITORING HEALTH SYSTEM TRANSFORMATION

Act 167 of 2022, Sections 1 and 2

The financial health and sustainability of Vermont's hospitals has been top of mind for the GMCB for years. Given the national trends of rural hospital closures, the GMCB has been studying opportunities to ensure hospitals' financial health.

In 2022, the Vermont Legislature passed Act 167, "An act relating to health care reform initiatives, data collection, and access to home- and community-based services," which included funding for the GMCB to deepen its work on these issues in partnership with hospitals, other health care providers, insurers, Vermonters, and other State of Vermont partner agencies. Act 167 tasks the GMCB with 1) engaging in data analysis and community engagement to support hospital transformation; and 2) developing new payment models for hospitals, including global payment models. The Agency of Human Services (AHS) is a critical collaborator in this work. An additional workstream – planning for the evolution of the GMCB's hospital budget review process – is discussed in the Hospital Budget Review section of this report (pg. 10).

Project Area: Monitoring Health System Transformation

Relevant Statute/Authority: 18 V.S.A. §§ 9375(b)(7), 9456, Act 159 of 2020, Section 4, Act 167 of 2022

Overview: Since 2005, 104 rural hospitals have closed nationally, with 2020 closure rates higher than any previous year. Recent financial struggles at many Vermont hospitals caused the Board to consider hospital sustainability within its hospital budget process. In 2022, the Vermont Legislature passed Act 167, which requires the GMCB to continue its work on hospital sustainability.

Community Engagement to Support Hospital Transformation

Progress in 2023

- Community Engagement: Throughout summer and early fall 2023, GMCB sought feedback from close collaborators within AHS and other State of Vermont and external partners on the approach and materials for this work. In October and November 2023, the facilitation contractor, Oliver Wyman (OW) Healthcare and Life Sciences Group, led 32 virtual, public community meetings throughout each of Vermont's 14 Hospital Service Areas to gather feedback on community needs and resources and patient and provider experiences of care, and to discuss attendees' vision for the future of their local health care system. The GMCB website includes community and provider meeting materials. OW also held 13 interviews, focus groups, and listening sessions to better understand the experiences and needs of diverse populations and populations more likely to be impacted by health inequities, including BIPOC Vermonters, immigrant and refugee communities, LGBTQIA+ individuals, Vermonters with disabilities, and those with substance use disorder and mental health conditions. Over 1800 participants and 100 organizations engaged in first round meetings. The full engagement plan is posted to GMCB's website.
- Data Analysis to Support Hospital Transformation: GMCB staff and contractors are working to provide the OW team with data to inform the community engagement process and development of subsequent recommendations.

Looking Ahead to 2024

- Recommendations and Second Round Engagement: Based on the data and input received during the 2023 listening tour, OW will develop recommendations for Vermont hospitals and the State in spring 2024. These recommendations will be brought back to hospital leaders and communities for further discussion and refinement. In person, public meetings will be held in each of Vermont's Hospital Service Areas. Details will be posted to the GMCB website as they become available.

Payment Model Development – Global Payments for Hospitals

Progress in 2023

- Global Budget Technical Advisory Group: In January 2023, GMCB and AHS co-convened a Global Budget Technical Advisory Group (GBTAG) to engage in detailed payment model development. The GBTAG included hospital representatives (finance and equity), payers, advocates, a union representative, an ACO representative, a member of GMCB's general advisory committee, and state agencies. TAG members worked through technical topics related to model goals, model scope, methodology for calculating global payments (baseline and adjustments), and topics related to supporting and ensuring hospital transformation, program administration, and evaluation and monitoring. The group also reviewed federal requirements for a global payment methodology for traditional Medicare through their AHEAD model.

Looking Ahead to 2024

- Finalize Traditional Medicare Payment Model Development: In early 2024, the GB TAG will complete its work; its final product will be a technical document describing the model. GMCB and AHS will work with federal partners to negotiate acceptability of this model for the AHEAD model, if the State is accepted and chooses to participate. GMCB is working to develop hospital-specific financial modeling to assist hospitals in understanding the model and potential impacts on their institutions.
- Develop Commercial Global Payment Methodology: GMCB, in partnership with AHS, will work with payers and hospitals to understand special concerns related to commercial plan participation and to develop and finalize a commercial specification.

Vermont's All-Payer Model (APM)

Progress in 2023

- Short-Term APM Extension; Bridge to Potential Future Model: Led by AHS, the Vermont APM signatories worked with the Centers for Medicare and Medicaid Innovation (CMMI) throughout 2022 to negotiate the terms of a short-term extension of the APM Agreement (summary; full Agreement text). 2023 was the first extension year (Performance Year/PY6), and in March CMMI offered Vermont an additional PY7 in 2024, which Vermont accepted. In Summer 2023, CMMI informed Vermont that its planned multi-state model, known as AHEAD, would not start until 2026. As a result, CMMI and Vermont will enter negotiations for a "bridge year" in 2025, with the goal of providing a smooth transition to a potential new Medicare/multi-payer model in 2026 if Vermont chooses to participate in the AHEAD model.
- Performance to Date on APM Agreement Targets: Scale target performance is available through PY5 (2022), while results for quality and cost targets are available through PY4 (2021). Submitted APM Reports and a summary dashboard are posted to GMCB's website.
    - *Scale*: In PY5, all-payer scale stayed flat (49% in PY4 to 50% in PY5), while Medicare scale grew from 54% in PY4 to 62% in PY5. While results were still below APM Agreement targets, CMMI has waived scale enforcement (October 2021 letter).
    - *Quality*: PY4 shows Vermont on track to meet four of six population-level health outcomes targets; five of eight health care delivery system quality targets; and four of four process milestones; four measures did not have available comparisons to targets or are monitoring-only. The impacts of COVID-19 on care patterns and utilization in PY3 and beyond make it challenging to draw generalizable conclusions about quality of care and to consider trends. PY5 data is expected in June 2024.
    - *Cost*: PY4 results show a 14.4% increase in All-Payer Total Cost of Care compared to PY3; this result was largely due to the impact of the COVID-19 pandemic on PY3 costs. Compound average growth over the life of the model is 3.8%, within the target range (3.5% - 4.3%).
- Setting the Annual Medicare Benchmark (Financial Target): On December 20, 2023, the GMCB voted to approve a trend rate of 6.7% for End Stage Renal Disease (ESRD) and 4.3% for Non-ESRD Benchmark and include an advance of approximately $9.96 million for Blueprint for Health and the SASH program.

Looking Ahead to 2024

- Third Federal APM Evaluation Report: Vermont received the Third Federal APM Evaluation Report (at-a-glance summary; full report) by the independent federal evaluation contractor, NORC, in July 2023. The report showed reduced Medicare spending in Vermont compared to other states with similar reform activities and positive effects for the full Vermont population.
- Future Federal-State Model: Through fall 2023, AHS and GMCB continued to engage with CMMI regarding CMMI's planned States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model, a multi-state model which features global payments for hospitals, enhanced primary care payments, and targets for cost containment, primary care spending, quality, and health equity. The model Notice of Funding Opportunity (NOFO) was released in November 2023. AHS is working with GMCB and stakeholders to develop a response.

APPENDICES

Appendix A: Green Mountain Care Board Meetings in 2023

January 11, 2023	• Health Resource Allocation Plan Update • Hospital Budget Reboot • Consideration of changing hospital finance reporting to bi-annual schedule
January 18, 2023	• Rural Hospitals' Financial Health; A National Perspective • Act 167 Update
February 1, 2023	• 2024 Standard Qualified Health Plan Designs
February 8, 2023	• 2024 Standard Qualified Health Plan Designs – Potential Vote
February 22, 2023	• Update: FY2017 UVMMC Enforcement Action regarding Self Restricted Funds for Mental Health Capacity • VITL Budget Amendment – Potential Vote
March 2, 2023	• Update and Deliberation: OneCare Vermont FY2023 Budget Resubmission – Primary Care Payments
March 8, 2023	• Springfield Hospital Update on FY2023 Q1 Financial Performance • Update: FY2017 Enforcement Action regarding UVMMC Self Restricting Funds for Mental Health Capacity – Potential Vote • Cost Share Reduction Draft Policy
March 15, 2023	• Draft Cost Share Reduction Policy – Potential Vote • FY2024 Hospital Budget Guidance
March 22, 2023	• Modification of UVMMC FY2017 Enforcement Action – Potential Vote
March 29, 2023	• FY2022 Hospital Budget Actuals • FY2024 Hospital Budget Guidance – Potential Vote
April 5, 2023	• MVP Non-Standard QHP Plan Review and Approval - Potential Vote • Roundtable Discussion: *Hospital Prices in the US: Why Are They High, Why Do They Vary, and Why Do They Grow?* • Potential Revisions to CON Monetary Thresholds
April 12, 2023	• Potential Revisions to CON Monetary Thresholds – Potential Vote • Roundtable Discussion: *Policy Approaches to Address Healthcare Market Concentration*
April 19, 2023	• Roundtable Discussion: *Sustainability of Primary Care in Vermont* • AHS Presentation: *Health Care Workforce Development Strategic Plan Update*
May 3, 2023	• Roundtable Discussion: *Referenced Based Pricing* • OneCare Vermont Revised FY23 Budget – GMCB Staff Presentation
May 5, 2023	• OneCare Vermont Revised FY23 Budget Presentation
May 17, 2023	• VITL FY2024 Budget • VAHHS Request for Reconsideration of FY24 Hospital Budget Guidance – Potential Vote • OneCare Vermont Revised FY23 Budget - GMCB Staff Presentation - Potential Vote
May 31, 2023	• VAHHS Request for Reconsideration of FY24 Hospital Budget Guidance – Potential Vote • VITL Budget and modification to HIE Plan, GMCB Staff Presentation - Potential Vote
June 7, 2023	• Community Health Care Panel Discussion: *Creative Solutions that are Improving Health Care Access* and *Cost Containment and Coordination of Care*

June 14, 2023	• OneCare Vermont Revised FY2023 Budget – Potential Vote • Medicare-Only Budget Guidance Presentation
June 21, 2023	• Palliative Care Assessment in Vermont • Medicare-Only Budget Guidance - Potential Vote • Staff Presentation on OCV Budget Guidance
June 28, 2023	• Update on Evolution of GMCB's Hospital Budget Review Process • All-Payer Model Update from Agency of Human Services • Update on Hospital Sustainability and Global Payment Model Development • Medicare-Only Budget Guidance - Potential Vote • ACO Budget Guidance – Potential Vote
July 14, 2023	• OneCare Vermont FY24 Budget Guidance - Potential Vote
July 17, 19, 24, 2023	• Individual and Small Group Hearings and Public Comment Forum
August 2, 2023	• Agency of Human Services Update on All-Payer Model • GMCB Update on Act 167

August 9, 2023	• Hospital Budget Hearing
	  ○ Southwestern Vermont Medical Center
	  ○ Brattleboro Memorial Hospital
	• ACO Budget Condition Modification – Potential Vote

August 14, 2023	• Hospital Budget Hearing
	  ○ Grace Cottage
	  ○ Northwestern Medical Center
	  ○ Rutland Regional Medical Center

August 18, 2023	• Hospital Budget Hearing
	  ○ Gifford Medical Center
	  ○ Mt Ascutney Hospital & Health Center
	  ○ Northeastern Vermont Regional Hospital

August 21, 2023	• Hospital Budget Heating ○ Copley Hospital

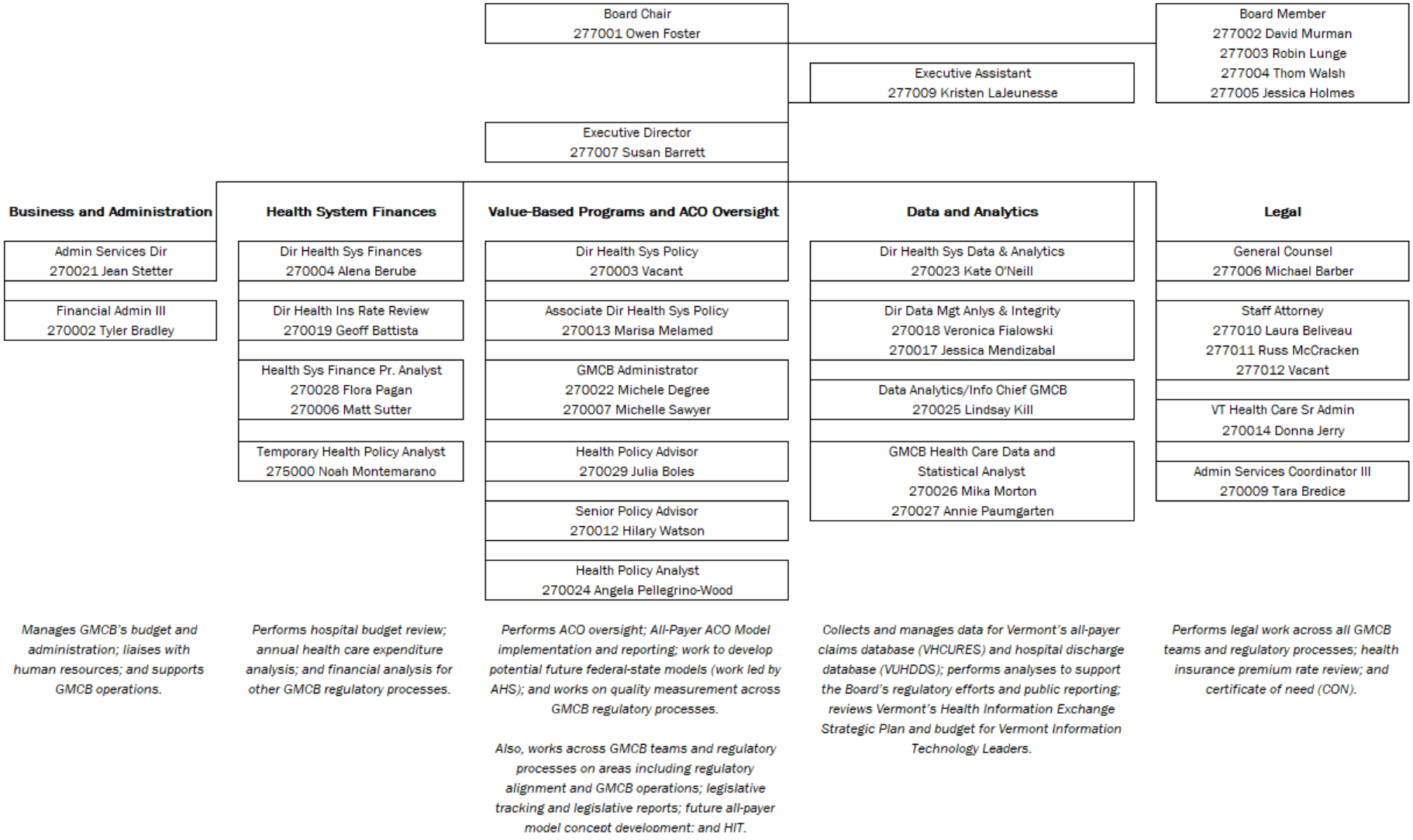
August 23, 2023	• Hospital Budget Hearing
	  ○ University Of Vermont Medical Center
	  ○ Porter Medical Center
	  ○ Central Vermont Medical Center

August 25, 2023	• Hospital Budget Hearing
	  ○ Springfield Hospital
	  ○ North Country Hospital

August 30, 2023	• Staff Presentation: *Outline of Deliberative Process* • Standard Conditions Overview and Discussion • Hospital Budget – Potential Vote
August 31, 2023	• Vermont Federation of Nurses & Health Professionals: *The State of Nursing in Vermont: A Nurse's Perspective*
September 6, 2023	• Standard Budget Order Conditions – Potential Vote • Hospital Budget Deliberations – Potential Votes
September 11, 2023	• Hospital Budget Deliberations
September 13, 2023	• Hospital Budget Deliberations • Standard Budget Order Conditions – Potential Vote
September 15, 2023	• Hospital Budget Deliberations • Standard Budget Order Conditions

October 11, 2023	• AHEAD Model Update • Global Budget Technical Advisory Group Update • Act 167 Community Engagement Contract Overview and Project Plan
October 27, 2023	• NVRH FY24 Hospital Budget Order Modification - Potential Vote • Review of Budget Order Cap on Change in Charge
November 1, 2023	• Lore Health ACO FY24 Budget Hearing
November 8, 2023	• OneCare Vermont FY24 Budget Hearing
November 15, 2023	• 2023-2027 Health Information Exchange Strategic Plan – 2023 Update • Vytalize Health 9 ACO Budget Hearing
November 20, 2023	• FY2024 Medicare-Only ACO Budget Review (Lore Health and Vytalize Health 9) - Staff Analysis and Recommendations
November 29, 2023	• ACO Results Payer Panel
December 6, 2023	• GMCB Staff Analysis of OneCare Vermont's FY24 Budget • Medicare Only ACO FY24 Budget – Potential Vote
December 13, 2023	• Medicare Benchmark Proposal • OneCare Vermont's FY24 Budget Deliberations – Potential Vote • Monthly All-Payer Model & Global Payments Update • HIE Strategic Plan & Connectivity Criteria – Potential Vote
December 20, 2023	• Brattleboro Retreat FY24 Budget – Potential Vote • Medicare Benchmark Proposal – Potential Vote • OneCare Vermont FY24 Budget – GMCB Staff Recommendations & Potential Vote

Appendix B: GMCB Organizational Chart



Appendix C: GMCB Budget

Green Mountain Care Board Appropriations	FY2022 Base Budget 2021 Act 74 B.345	FY2023 Base Budget 2022 Act 185 B.345	FY2024 Base Budget 2022 Act 78 B.345	FY2024 One-Time 2022 Act 78 B.1100 (k)
Total Budget	7,737,643	8,211,730	8,539,233	790,500
General Fund	3,094,435	3,261,362	3,392,339	790,500
GMCB Regulatory & Admin Fund	4,643,208	4,950,368	5,146,894	
Other Special Funds				
Global Commitment				
Interdepartmental Transfer				
Coronavirus Relief Fund				
Federal Fund				

2022 Act 78 Sec. B.1100 (k) Misc. FY24 One-time Appropriations for (1) $620,000 for costs associated with the implementation of the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) database; (2) $120,500 for the implementation of a new financial database solution; and (3) $50,000 for the development of the statutorily required Health Resources Allocation Plan Tool.

2022 Act 83 appropriated $500,000.00 one-time funds to GMCB "for a consultant to perform per capita benchmarking analyses with comparisons to national, peers, and better performers. This shall include an analysis of avoidable utilization and low value care." GMCB selected a bid for $419,557.00, so the remaining balance was reverted in the FY23 BAA. GMCB carried $19,557.00 forward from FY23 to FY24 as this project was finalized in FY24.

The financial health and sustainability of Vermont's hospitals has been top of mind for the GMCB for years. Given the national trends of rural hospital closures, the GMCB has been studying opportunities to ensure hospitals' financial health. In 2022, the Vermont Legislature passed Act 167, which included funding for the GMCB to deepen its work on these issues in partnership with hospitals, other health care providers, insurers, Vermonters and other SoV partner agencies. GMCB carried $2,986,070.26 forward.
Learn more at: https://gmcboard.vermont.gov/hospitalsustainability.

Appendix D: Board Member Biographies

The GMCB was created by the Vermont Legislature in 2011. It is an independent group of five Vermonters who 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 GMCB includes:

Owen Foster, J.D.

Owen Foster served as an Assistant United States Attorney in the United States Attorney's Office for the District of Vermont for eight years, where he was the health care fraud coordinator and ethics officer. Prior to joining the United States Attorney's Office, he was a securities litigation associate for seven years at Dechert, LLP. Owen was born and raised in Middlebury, Vermont and graduated from the University of Vermont in 2001, and from Columbia Law School in 2007. Appointed by Governor Phil Scott for a term beginning October 1, 2022, and ending September2024.

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, Vermont. Appointed by Governor Peter Shumlin for a term beginning on October 8, 2014, and ending on September 30, 2020. Reappointed by Governor Phil Scott for a second term ending in 2026.

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. Ms. Lunge's term ends in September 2023.

Thom Walsh, Ph.D., MS, MSPT

Dr. Thomas Walsh is a professor of health policy who holds academic appointments at the Dartmouth Institute for Health Policy and Clinical Practice and Boise State University's College of Health Science. He is also a physical therapist and orthopedic clinical specialist who has practiced across the country, including at Dartmouth Hitchcock in New Hampshire. Dr. Walsh is an expert in health care systems, policy, and patient care. He is currently a senior expert on health system transformation at the Joint Commission - Center for Transforming Healthcare. In previous roles, he served as a high reliability organization expert for the Veterans Health Administration with Safe & Reliable Healthcare and as founder and Chief Strategy Officer for Cardinal Point Healthcare Solutions, whose clients included U.S. Navy Medicine, One Health Nebraska, the Connecticut Institute for Primary Care Innovation, Maine Medical Center among others. Dr. Walsh was appointed by Governor Phil Scott in December 2021. Dr. Walsh's term will expire in 2027. He currently resides in Barre, Vermont.

David Murman, M.D.

David Murman currently works as an emergency medical clinician at Central Vermont Medical Center (CVMC). Prior to his current position, he was an emergency physician and co-director of emergency ultrasound at the University of Vermont Medical Center, an emergency physician at Baystate Medical Center, and completed emergency residency at Boston Medical Center. At CVMC, Murman has been active on finance and operations committees, medical student and resident education, and was a founding member of the diversity, equity, and inclusion committee. He received a B.S. in psychology and his Doctor of Medicine from Tufts University. Before attending medical school, Murman worked in non-profit education/intervention programs for underserved youth, cardiac surgery clinical research, and public health research in Botswana. Murman's appointment begins October 1, 2022, for a term expiring September 2028.

Leadership

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

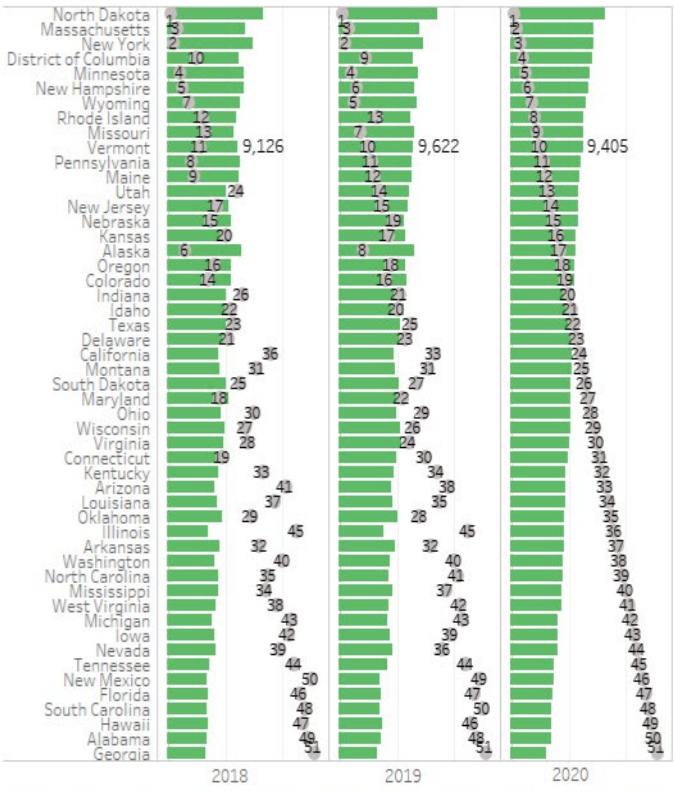
Susan J. Barrett, an attorney, was formerly Director of Public Policy in Vermont for the Bi-State Primary Care Association. She joined Bi-State in 2011 after nearly 20 years in the pharmaceutical and vaccine industry with Novartis, Merck, and Wyeth. Susan's health care experience also includes pro bono 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, Vermont.

Appendix E: Glossary

ACO	Accountable Care Organization
AHS	Agency of Human Services
APCD	All -Payer Claims Database
APM	All-Payer Model
CMMI	Center for Medicare and Medicaid Innovation
CON	Certificate of Need
DVHA	Department of Vermont Health Access
ESRD	End Stage Renal Disease
FY	Fiscal Year
GMCB	Green Mountain Care Board
GMSC	Green Mountain Surgery Center
HRAP	Health Resource Allocation Plan
MARC	Medicaid Advisory Rate Case
MRI	Magnetic Resonance Imaging
NPR	Net Patient Revenue
ORCA	Onion River Community Access
PCAG	Primary Care Advisory Group
QHP	Qualified Health Plan
RFP	Request for Proposals
RHSTF	Rural Health Services Task Force
SASH	Support and Services at Home
TCOC	Total Cost of Care
VELSC	Vermont Eye Surgery and Laser Center
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

ATTACHMENTS

Attachment A: CMS State Health Expenditures



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
United States	5,669	5,698	5,807	6,080	6,277	6,219	6,602	6,729	6,803	6,777	6,646	6,682	6,867	6,694	6,777	6,853	6,977	7,245	7,649	7,727
Mideast	9,035	9,058	9,277	9,348	9,397	9,452	9,772	9,844	9,718	9,491	9,518	9,158	9,069	9,138	8,635	8,922	9,391	9,822	9,958	9,702
New England	9,021	9,043	9,634	10,273	10,632	10,297	10,653	10,292	10,616	9,888	9,146	9,183	9,156	8,611	8,886	8,868	8,824	9,197	9,309	9,390
Plains	6,267	6,709	6,825	7,280	7,630	7,761	8,147	8,419	8,515	8,301	8,079	8,337	8,489	8,276	7,889	7,665	7,960	8,546	9,148	8,930
Rocky Mountains	6,265	6,190	6,066	6,308	6,522	6,574	6,981	7,332	7,219	7,303	6,807	7,304	7,691	7,080	6,962	6,658	6,997	7,966	8,645	8,401
Far West	3,803	3,742	3,922	4,126	4,368	4,338	4,598	4,866	4,898	5,021	5,160	5,580	5,993	5,412	6,398	6,902	6,566	6,620	7,206	7,701
Southwest	4,850	4,816	4,713	4,935	5,344	5,451	5,805	6,051	6,259	6,443	6,315	5,954	6,195	6,629	6,678	6,625	6,531	6,948	7,363	7,503
Great Lakes	6,079	6,004	5,922	5,930	6,124	5,724	6,178	6,070	6,380	6,214	5,812	6,029	6,379	6,163	6,120	6,035	6,282	6,324	6,903	7,245
Southeast	4,676	4,757	4,908	5,367	5,388	5,323	5,824	5,939	5,922	6,010	5,806	5,778	5,833	5,837	5,576	5,415	5,672	5,915	6,227	6,130

CMS State Health Expenditures 'Personal Health Care' Medicaid: VT Residents

In the most recent year available (2020), personal health care expenditures were $9405 annually for

	2016		2017		2018		2019		2020	
	%	Per-Enrollee	%	Per-Enrollee	%	Per-Enrollee	%	Per-Enrollee	%	Per-Enrollee
Medicaid/Other Health, Residential, and Personal Care ($)	31%	2,531	31%	2,640	31%	2,858	31%	3,002	31%	2,917
Medicaid/Hospital Care ($)	30%	2,414	30%	2,517	30%	2,727	30%	2,856	30%	2,800
Medicaid/Physician & Clinical Services ($)	15%	1,253	15%	1,304	16%	1,416	15%	1,480	15%	1,439
Medicaid/Nursing Home Care ($)	6%	457	6%	496	6%	541	7%	654	7%	650
Medicaid/Prescription Drugs and Other Non-durable Medical Products ($)	7%	555	7%	556	6%	581	6%	582	6%	569
Medicaid/Home Health Care ($)	4%	327	4%	341	4%	369	4%	386	4%	381
Medicaid/Other Professional Services ($)	3%	261	3%	266	3%	291	3%	305	3%	295
Medicaid/Dental Services ($)	3%	227	3%	237	3%	256	3%	267	3%	265
Medicaid/Durable Medical Products ($)	1%	76	1%	79	1%	86	1%	90	1%	88

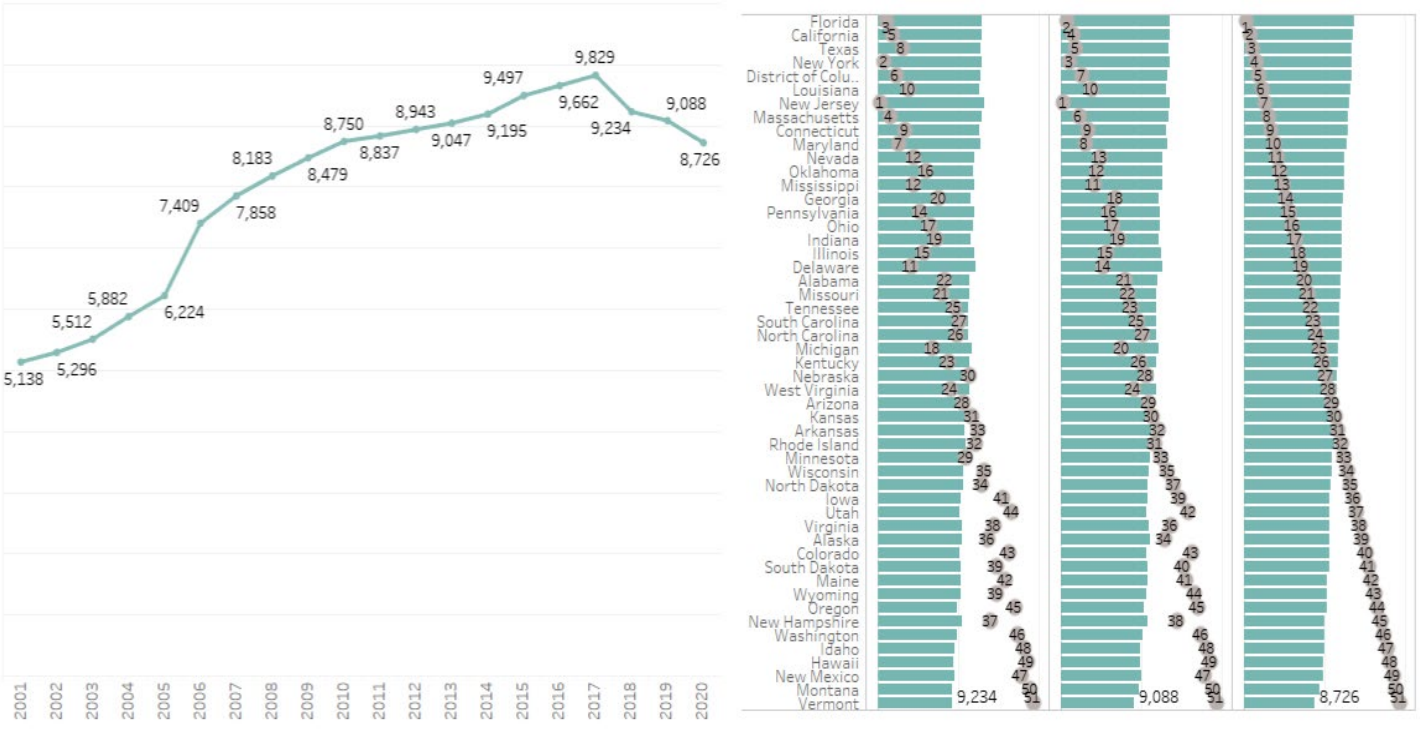
Medicaid recipients, with Vermont ranking 10th across all the U.S. states. This was more than the national average of $7272, and close to the New England average of $9390.

Among the components of personal health care expenditures, the Vermont's highest % is in the category of 'Other Health, Residential, and Personal Care' which includes care provided in residential care facilities (private residential facilities for the intellectually disabled and residential mental health and substance abuse facilities), ambulance services, and services provided in non-traditional settings (worksite healthcare, school health, and other types of miscellaneous care funded by federal or state programs. The largest component of spending in this category is home and community-based waivers under the Medicaid program.).

	2018				2019				2020			
	New England		United States		New England		United States		New England		United States	
	% of Total	Per-Enrollee	% of Total	Per-Enrollee	% of Total	Per-Enrollee	% of Total	Per-Enrollee	% of Total	Per-Enrollee	% of Total	Per-Enrollee
Medicaid/Other Health, Residential, and Personal Care ($)	25%	2,277	21%	1,501	25%	2,296	20%	1,547	24%	2,283	21%	1,604
Medicaid/Hospital Care ($)	34%	3,157	37%	2,697	33%	3,095	37%	2,864	35%	3,293	38%	2,907
Medicaid/Physician & Clinical Services ($)	11%	1,049	15%	1,067	11%	1,061	15%	1,154	11%	1,028	15%	1,142
Medicaid/Nursing Home Care ($)	11%	993	10%	702	11%	1,016	9%	722	11%	997	9%	701
Medicaid/Prescription Drugs and Other Non-durable Medical Products ($)	4%	411	6%	415	5%	472	6%	439	5%	490	6%	455
Medicaid/Home Health Care ($)	9%	838	7%	478	10%	885	7%	514	9%	846	7%	529
Medicaid/Other Professional Services ($)	1%	132	1%	104	2%	141	1%	112	2%	148	1%	109
Medicaid/Dental Services ($)	3%	241	2%	172	3%	241	2%	183	2%	205	2%	166
Medicaid/Durable Medical Products ($)	1%	98	2%	110	1%	102	2%	115	1%	101	1%	112

In 2020, Medicaid 'other health residential, and personal care' expenditures for Vermont residents was higher than New England and the US (VT ranked 5th nationally); VT spent $2917 compared to New England $2283 and nationally $1604. Medicaid hospital care spending per-enrollee of $2800 is close to national per-enrollee spending $2907 and lower than New England $3293. For 2020 per-enrollee Medicaid spending for VT residents, Vermont ranked 7th nationally for dental spending, 10th for physicians and clinical services, 12th for prescription drugs and other non-durables, 34th for durable medical products, 23rd for home health, and 31st for nursing home care.

CMS State Health Expenditures 'Personal Health Care' Medicare: VT Residents



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
United States	6,110	6,481	6,823	7,358	7,855	9,026	9,448	9,959	10,339	10,493	10,721	10,741	10,796	10,965	11,168	11,279	11,529	11,871	12,372	12,271
Mideast	6,922	7,284	7,527	7,989	8,569	9,812	10,377	10,913	11,271	11,403	11,692	11,625	11,694	11,910	12,100	12,177	12,377	12,691	13,138	12,876
Southwest	6,036	6,496	6,959	7,617	8,179	9,416	9,839	10,267	10,681	10,872	11,047	11,030	11,025	11,188	11,388	11,492	11,762	12,146	12,711	12,716
Far West	6,122	6,537	6,827	7,210	7,669	8,761	9,072	9,792	10,197	10,338	10,595	10,701	10,828	10,948	11,272	11,457	11,648	12,000	12,532	12,536
Southeast	6,019	6,390	6,766	7,364	7,833	9,035	9,448	9,932	10,333	10,495	10,695	10,719	10,717	10,837	11,031	11,128	11,392	11,760	12,344	12,334
New England	6,340	6,647	6,997	7,568	7,959	9,154	9,628	10,048	10,439	10,558	10,779	10,799	10,884	11,167	11,398	11,521	11,699	11,991	12,419	12,011
Great Lakes	5,916	6,268	6,647	7,236	7,762	8,897	9,324	9,847	10,234	10,384	10,629	10,614	10,704	10,869	10,972	11,076	11,339	11,646	12,087	11,886
Plains	5,264	5,580	5,893	6,389	6,860	7,985	8,360	8,741	9,017	9,206	9,433	9,553	9,680	9,946	10,174	10,269	10,664	11,018	11,363	11,291
Rocky Mountains	4,949	5,264	5,604	6,107	6,489	7,402	7,672	7,960	8,272	8,432	8,589	8,697	8,709	8,991	9,179	9,315	9,693	9,992	10,412	10,330

In 2020 and the two years prior, Medicare spending per-enrollee for Vermont residents ranked lowest in the nation for 2020 at $8726, compared to $12,271 U.S. spending and $12,011 for New England.

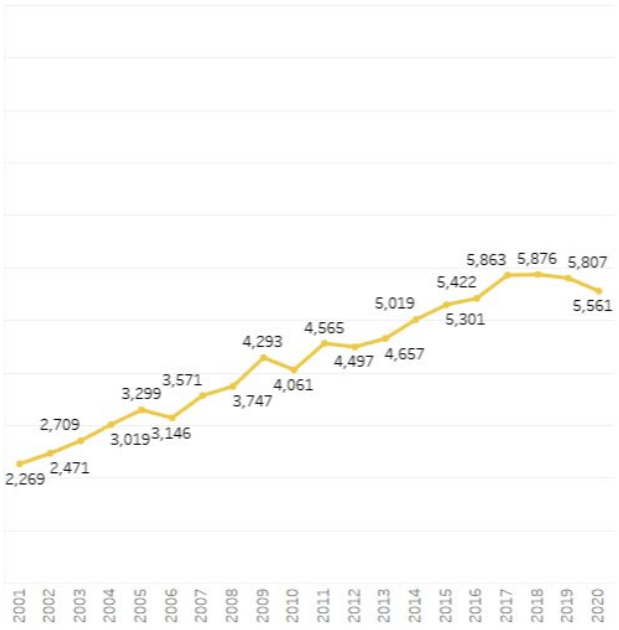
	2016		2017		2018		2019		2020	
	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee
Medicare/Hospital Care ($)	56%	5,379	56%	5,464	51%	4,753	49%	4,420	48%	4,180
Medicare/Prescription Drugs and Other Non-durable Medical Products ($)	15%	1,438	15%	1,455	16%	1,471	17%	1,548	18%	1,588
Medicare/Physician & Clinical Services ($)	13%	1,260	13%	1,273	14%	1,329	15%	1,407	15%	1,337
Medicare/Home Health Care ($)	6%	567	6%	608	7%	635	7%	656	7%	618
Medicare/Nursing Home Care ($)	6%	547	6%	551	6%	540	6%	530	6%	480
Medicare/Other Professional Services ($)	3%	279	3%	296	3%	313	4%	325	4%	322
Medicare/Other Health, Residential, and Personal Care ($)	1%	110	1%	110	1%	111	1%	108	1%	95
Medicare/Durable Medical Products ($)	1%	80	1%	70	1%	77	1%	88	1%	95
Medicare/Dental Services ($)	0%	1	0%	2	0%	3	0%	6	0%	12

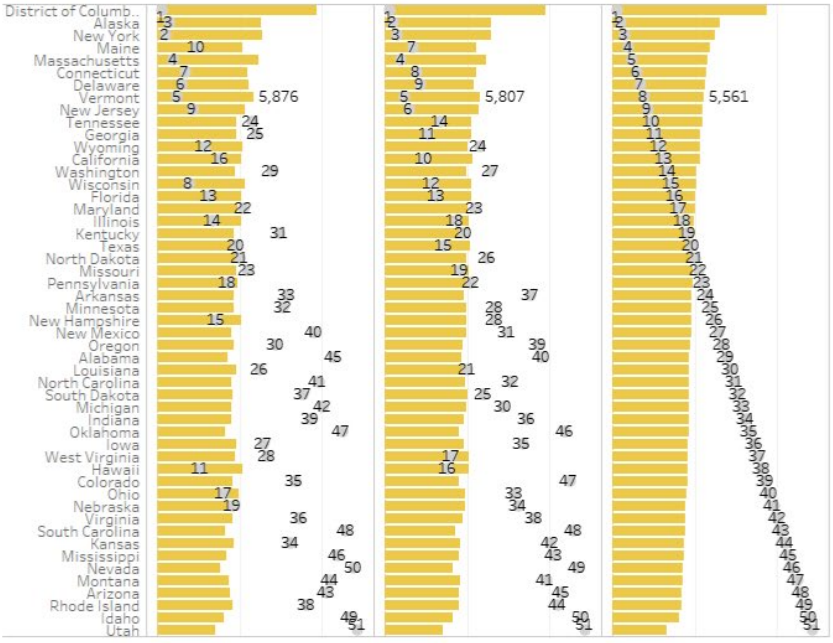
The highest % of VT Medicare expenditures for personal health care were for hospital care at $4,180, followed by prescription drugs and other non-durable medical products at $1,588.

	2018				2019				2020			
	New England		United States		New England		United States		New England		United States	
	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee	% of Total $	amount Per-Enrollee
Medicare/Hospital Care ($)	47%	5,627	43%	5,121	46%	5,768	43%	5,282	45%	5,447	42%	5,192
Medicare/Prescription Drugs and Other Non-durable Medical Products ($)	15%	1,739	14%	1,693	15%	1,838	14%	1,773	16%	1,899	15%	1,824
Medicare/Physician & Clinical Services ($)	21%	2,479	26%	3,034	21%	2,627	26%	3,219	21%	2,539	26%	3,167
Medicare/Home Health Care ($)	6%	758	6%	690	6%	783	6%	715	6%	704	6%	676
Medicare/Nursing Home Care ($)	6%	724	5%	641	6%	698	5%	632	6%	715	5%	644
Medicare/Other Professional Services ($)	4%	425	4%	436	4%	457	4%	475	4%	452	4%	471
Medicare/Other Health, Residential, and Personal Care ($)	1%	120	1%	84	1%	111	1%	80	1%	95	1%	72
Medicare/Durable Medical Products ($)	1%	108	1%	151	1%	116	1%	163	1%	129	1%	182
Medicare/Dental Services ($)	0%	11	0%	20	0%	22	0%	32	0%	32	0%	42

Medicare per-enrollee expenditures for Vermont residents were lower than New England and the US across all components of personal health care except for other health residential, and personal care which accounts for 1% of total expenditures (VT ranked 8th across all states). Other rankings include 17th for home health, 30th for hospital care, 32nd for prescription drugs and other non-durables, 34th for nursing home care and >40th for all other categories.

CMS State Health Expenditures 'Personal Health Care' Private Health Insurance: VT Residents





	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
United States	2,176	2,371	2,594	2,779	2,981	3,125	3,312	3,457	3,713	3,850	4,006	4,078	4,081	4,183	4,339	4,549	4,735	4,941	5,129	4,994
Mideast	2,378	2,512	2,746	2,914	3,108	3,352	3,585	3,702	4,038	4,183	4,448	4,483	4,572	4,602	4,852	4,993	5,281	5,601	5,775	5,626
New England	2,518	2,677	2,845	3,153	3,319	3,456	3,674	4,003	4,317	4,550	4,751	4,833	4,753	4,810	4,981	5,134	5,557	5,679	5,708	5,554
Far West	2,047	2,219	2,501	2,678	2,894	3,031	3,228	3,390	3,643	3,827	4,097	4,097	4,048	4,201	4,425	4,748	4,812	4,940	5,154	5,168
Southeast	2,094	2,281	2,463	2,679	2,840	2,929	3,111	3,282	3,489	3,617	3,720	3,821	3,833	3,958	4,128	4,285	4,444	4,705	4,996	4,872
Southwest	2,019	2,272	2,518	2,626	2,976	2,992	3,142	3,212	3,581	3,762	3,781	3,966	3,973	4,079	4,116	4,398	4,470	4,713	4,960	4,763
Great Lakes	2,282	2,546	2,789	2,927	3,156	3,310	3,533	3,657	3,867	3,995	4,010	4,035	4,050	4,164	4,275	4,520	4,727	4,875	4,982	4,748
Plains	2,053	2,263	2,447	2,756	2,784	3,089	3,184	3,343	3,558	3,587	3,858	3,999	3,905	3,987	4,120	4,199	4,523	4,742	4,904	4,698
Rocky Mountains	1,996	2,180	2,358	2,478	2,808	2,885	2,995	3,057	3,207	3,178	3,400	3,500	3,589	3,726	3,745	4,076	4,227	4,216	4,159	4,102

Vermont ranks 8th in 2020 for private health insurance per-enrollee healthcare expenditure. Breakdowns by component are not provided for private health insurance at the individual state level by CMS. Efforts are underway to try and mimic the methods of CMS at the state level in order to better understand private health insurance expenditures and update Medicare and Medicaid estimates for more recent years.

More information on methods for generating CMS state health expenditure estimates are located at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence