Green Mountain Care Board

ANNUAL REPORT FOR 2020

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

Submitted January 15, 2021
Resubmitted June 25, 2021
In accordance with 18 V.S.A. § 9375(d)

VERMONT
GREEN MOUNTAIN CARE BOARD

144 State Street
Montpelier, VT 05602
802-828-2177

To: Sen. Anne Cummings, Chair, Senate Committee on Finance
Sen. Ginny Lyons, Chair, Senate Committee on Health and Welfare
Sen. Jane Kitchel, Chair, Senate Committee on Appropriations
Rep. Janet Ancel, Chair, House Committee on Ways and Means
Rep. Mary S. Hooper, Chair, House Committee on Appropriations
Rep. William J. Lippert, Chair, House Committee on Health Care

From: Green Mountain Care Board
Date: January 15, 2021
Title: 2020 Annual Report

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

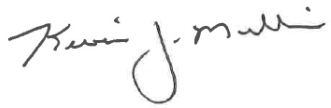
Please accept the annual report of the Green Mountain Care Board (hereafter GMCB or Board), as required by 18 V.S.A. § 9375(d).

The Board is guided by its statutory principles "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."

2020 was a year of incredible unpredictability for the entities that we regulate and thus required great nimbleness from the GMCB. The pandemic required us to make changes to almost every process. Despite having to work remotely, I am amazed by the productivity of the hard-working State employees at the GMCB. The staff and Board Members are committed to the difficult and challenging work of controlling health insurance premium growth, analyzing hospital and accountable care organization (ACO) budgets and new health care projects and expenditures, pursuing health care payment and delivery reforms, and developing a new statewide Health Resource Allocation Plan. And as we complete Year Three of the All-Payer Model Agreement, the Board continues to work closely with our State and federal partners to move Vermont's health care system away from fee-for-service and towards one that encourages prevention, wellness, and better coordination of care.

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

Sincerely,



Kevin J. Mullin
Chair, Green Mountain Care Board

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Executive Director's Report

Throughout 2020, the Board worked to improve the health of Vermonters by supporting the development of a high-quality, accessible, and sustainable health care system. As for most agencies, and likely most Vermonters, COVID-19 was the major theme of 2020. While COVID-19 required temporary changes to the Board's regulatory processes and other projects, the Board continued to meet statutory requirements while making progress on projects like the Health Resource Allocation Plan (HRAP), hospital sustainability planning, and implementing the All-Payer Model (APM).

The GMCB's 2019 Annual Report, submitted in January 2020, could not have anticipated the major focus of our work in 2020: the COVID-19 pandemic and public health emergency. This year brought immense challenges to the health care system, as health care providers and organizations in Vermont came together to fight the COVID-19 pandemic. We saw all parts of our health care system and the state collaborate to address the challenges of the pandemic and innovate in the pandemic world.

COVID-19 also caused major instability in many health care organizations' finances. On March 20, 2020, Governor Scott suspended all non-essential adult elective procedures and medical surgical procedures. This change preceded a dramatic decrease in health care utilization in April and May, including procedures and office visits, at Vermont's provider practices and hospitals. With this decrease, providers' fee-for-service (FFS) revenue also sharply decreased. Fortunately, many providers and 13 of Vermont's 14 hospitals were participants in Vermont's APM and received some proportion of their revenue as fixed prospective payments. These fixed payments helped providers maintain some financial stability during the shutdown, in conjunction with federal and state relief funds. In addition to highlighting the benefits of innovative payment models, COVID-19 also highlighted technical and clinical innovation by Vermont's health care system, which embraced expanded use of telemedicine at the height of the first wave of the pandemic. With the support of the Legislature and swift action of payers, providers delivered needed services to patients through video and phone visits. While telemedicine visits have decreased slightly since spring 2020, we expect to see continued increases in the use of this technology. Unfortunately, recent upticks in COVID-19 at the end of 2020 may require telehealth to replace some in-person visits once again.

Green Mountain Care Board Themes from 2020

Regulatory Response to COVID-19

The primary focus of the Board throughout the pandemic was to balance appropriate regulation of Vermont's private sector health care entities as required by statute with doing what we could to reduce administrative burden and allow flexibility for the Board's regulated entities, especially Vermont's hospitals, so they could focus on care for their patients. As we write this report, COVID-19 is again surging in Vermont and throughout the country. The regulatory work of the Board is immensely important in containing health care costs while maintaining access to high quality care for all Vermonters and our processes must be tailored to accommodate the needs of provider organizations working on the front lines during the pandemic. In 2020 the Board was successful in complying with all of its statutory duties and roles despite the pandemic.

Early on in the pandemic, Vermont's Legislature responded to the state of emergency and passed Act 91 of 2020 which offered the GMCB and GMCB-regulated entities temporary flexibility in response to the pandemic. The Board's response has included:

- Providing new guidance for emergency certificate of need (CON) applications related to the COVID-19 response (allowable under existing authority) and, after passage of Act 91, waiving the need for CON review of certain projects;

- Continuing to monitor hospital solvency and issuing new hospital budget process guidance intended to reduce the regulatory burden on hospitals, including delaying hospital budget submission due dates (note that hospital budgets were approved on time despite the flexibility afforded to hospitals);
- Working with federal partners at the Center for Medicare & Medicaid Innovation (CMMI) to request monitoring flexibility and additional funding for providers participating in Vermont's All-Payer Model (see pg. 24 for more information);
- Amending OneCare Vermont's 2020 Budget Order to allow the redirection of resources toward front-line providers, and to extend the reporting timeline to allow for revisions in light of COVID-19 and accounting for delays in the availability of information;
- Delaying GMCB's insurance rate review decisions by one week (allowable under existing authority); and
- Data analysis to support the State's response.

Each section of this report will also describe the impact of COVID-19 and/or changes to the Board's work in response, as appropriate.

In addition to working with health care providers and other regulated entities to provide appropriate flexibility, the Board made major internal changes in response to the pandemic, including quickly transitioning to remote work for our staff, and to all-remote Board meetings and hearings. As with other agencies that host a large number of public meetings, this was a major effort and required our staff to adapt rapidly. Members of the GMCB staff provided one-on-one trainings and support to members of the public, stakeholders, and parties to ensure that all-remote Board meetings and hearings remained truly accessible to the public. Despite occasional hiccups, holding Board meetings and hearings remotely has been successful; the Board has not only been able to continue its normal business, but has been able to welcome Vermonters who might not otherwise be able to travel to Montpelier at our Board meetings. The Board is exploring how it could continue to provide this expanded access once the state of emergency ends.

We recognize that COVID-19 will continue to be a major focus for Vermont's health care system in 2021 and anticipate that we will continue to work with the Scott Administration, legislators, and regulated entities to provide appropriate flexibility within the Board's regulatory authority.

Implementing Vermont's All-Payer Model

The Board and its staff continued to focus on the implementation of the APM Agreement between the State of Vermont and CMMI. This agreement, which enters Year 4 in 2021, provides the opportunity to improve health care delivery to Vermonters by rewarding efforts to keep people well. This is consistent with the federal shift toward alternative payment models that reward value over volume.

As mentioned above, fixed payments offered to providers under the APM proved immensely valuable this year as health care utilization dropped in the early months of the COVID-19 pandemic. Fixed payments provided a financial lifeline for providers who elected to receive them, highlighting the pitfalls of traditional fee-for-service payment models and the need for expanded access to predictable fixed payments.

In response to the pandemic, the Board also requested federal flexibility related to performance against the targets laid out in the APM Agreement and in the contract between Medicare and Vermont's ACO. This is because the impact of COVID-19 on 2020 performance against these targets is not predictable and is likely to be outside of providers' control. The Board worked with federal

partners to limit providers' potential risk for shared losses for 2020; to waive financial penalties related to quality to allow providers to focus on the COVID-19 response; and to extend the deadline for providers to decide whether to participate in the Medicare ACO program in 2021. In addition, the State is likely to request and receive flexibility related to performance on overall health care cost growth (known as Total Cost of Care under the APM Agreement) and potentially other model targets. We continue to measure providers' performance and will continue reporting to our federal partners as outlined in the APM Agreement.

Also, in 2020, Vermont received a warning notice from CMMI due to expected underperformance on the model's scale targets. The Vermont APM signatories' response to this warning notice describes Vermont's strategy for improving scale performance, including a reduced risk corridor for 2021 and beyond in the Medicare ACO program. This strategy allowed greater participation by rural providers, adding 7,500 Medicare beneficiaries in the Rutland region to Vermont's Medicare and all-payer scale performance. Board staff also provided input to the AHS Director of Health Care Reform as AHS developed its APM Implementation Improvement Plan, released in late November 2020. While the feedback from Board staff incorporated into the Implementation Improvement Plan generally mirrors views expressed historically by the Board and some of its recommendations were considered as part of the Board's ACO oversight processes (see pg. 7 and 25), some of the regulatory strategies specifically included in the report have not yet been discussed by the Board in a public meeting. The GMCB, in its role as an independent board, will consider whether and how some recommendations from AHS's APM Implementation Improvement Plan might strengthen its work.

In December, the GMCB published an All-Payer Model Performance Summary dashboard summarizing performance to-date on the APM Agreement targets. The dashboard will continue to be updated as more results are finalized.

Regulation, Oversight, and Data

Regulatory Alignment: Under the APM Agreement, integration of the Board's regulatory processes – including health insurance rate review, hospital budget review, Certificate of Need, and ACO certification and budget review – has become increasingly important. In 2019, the GMCB announced its intention to develop a white paper series focused on opportunities for improving alignment across regulatory processes. This white paper series aims to improve the Board's ability to make decisions consistently across regulatory processes and ensure appropriate assessment of regulated entities in a reformed payment and delivery system environment. In summer 2020, the GMCB released discussion drafts of the first two white papers, focused on exploring the GMCB's regulatory processes and the connections between them in their current state, and on potential changes to the annual regulatory timeline to improve alignment. Key findings from the first two white papers include:

- Differences in population, included services/costs, and payers make it challenging to compare regulatory processes directly; when considering the impact of each process on the system as a whole, the focus should be on the size and scope of the impacts (e.g., the population, providers, and proportion of spending impacted).
- Data availability drives current regulatory timelines.
- There are important connections between the GMCB's regulatory work and other State agencies and the federal government; any changes will need to be attentive to these intersections.

The first two white papers were presented to the Board and the public at the September 30, 2020 board meeting, and a special public comment period was open through October 30. Final versions of both white papers are expected to be released in early 2021, incorporating public comment.

Hospital Budget Review (pg. 17-18): In 2020, following budget hearings and lengthy Board discussions, the Board approved a system-wide increase in net patient revenue of 2.7% (compared to a requested 3.3%, a total of approximately $17.1 million in savings) and an estimated weighted average increase in hospital charges of 5.6%. The COVID-19 pandemic was at the center of many hospitals' narratives, including the direct costs of responding to the pandemic, sharply reduced health care utilization and lost revenue in spring 2020, and the impact of Federal and State efforts to stabilize hospitals' finances. Despite early indications that workforce shortages were eased in 2020, by late 2020 hospitals indicated that this was again a critical concern. In addition, payer mix was a continued theme for hospitals that serve higher proportions of Medicare and Medicaid enrollees. A number of hospitals also shared with the Board that fixed payments under the APM provided predictable, stable funding even as fee-for-service revenue dropped sharply in spring 2020.

In its FY2021 hospital budget decisions (issued in September 2020), the GMCB required all Vermont hospitals to engage in a sustainability planning process led by Board staff (pg. 19), a requirement echoed by the Legislature through Act 159 (Sec. 4) of 2020. Sustainability planning flows from the concerns raised by the bankruptcy filing of Springfield Medical Care Systems and Springfield Hospital in June 2019 and by the recommendations of the Rural Health Services Task Force in early 2020. To reduce administrative burden, the Board's staff is providing data and analysis on hospital finances, utilization, and quality to hospitals in an effort to identify opportunities to improve sustainability and better prepare for value-based care models. In response to a resurgence of COVID-19 in November, the Board issued a letter to notify hospitals that it would delay the timeline for engaging hospitals until after this wave of the pandemic subsides.

Health Insurance Premium Rate Review (pg. 15-16): Many of the forces affecting hospitals have also affected health insurance premiums. Vermont's aging population means a higher rate of chronic disease, greater health care utilization and increased medical expenditures. Higher costs of specialty prescription drugs and medical services have placed additional pressure on health care premiums, deductibles, and copays this year. Through the health insurance rate review process, the Board reduced the rates requested by insurers by approximately $20 million, including $18.8 million for plans sold to individuals, families, and small businesses through Vermont Health Connect. For all requested rate filings in 2020, the Board denied additional increases for administrative costs and COVID-19 impacts. Nonetheless, many Vermonters will experience a premium increase in the 2021 plan year.

Certificate of Need (CON) (pg. 20): In 2020 the Board reviewed five CON applications, while determining that another five proposed projects fell outside of statutory jurisdictional parameters and were not subject to Board oversight.

ACO Oversight (pg. 25): Beginning in the fall of 2020, the Board rigorously examined the budget and operations of OneCare Vermont, which resulted in the Board approving OneCare's FY2021 budget on December 23, 2020, with 17 conditions. These conditions will support robust oversight, transparency, and accountability for the ACO in 2021. The Board also expressed its intent to incorporate a new requirement in its ACO oversight rule (Rule 5.000) that executive compensation be tied to ACO quality and financial performance. The 2021 budget reflects the inclusion of an estimated 238,000 Vermonters in ACO programs (up from 223,000 in 2020). The Board continues to evolve its ACO oversight efforts as the ACO program matures and as we acquire more data to evaluate ACO performance and the efficacy of ACO programs and investments. As described above, the Board is considering whether and how some recommendations from AHS's APM Implementation Improvement Plan might strengthen its work, and the 2021 ACO Budget decision reflects some of the report's suggestions. For example, it requires the ACO to work with payers to develop a timeline

for increasing fixed prospective payments, with clear goals, milestones, and targets. We remain optimistic that the increased emphasis on primary prevention and complex care coordination, greater investment in the social determinants of health, and the move to more predictable, value-based payment has potential to improve health outcomes, reduce costs, and make health care more affordable for Vermonters.

Data (pg. 26-27): GMCB supported increased access to the VHCURES all-payer claims database and VUHDDS hospital discharge database through improved application processes, standard reports, and analysis-ready files, and published the first phase of the Health Resource Allocation Plan.

Priorities for 2021

1. ACO Oversight, APM Implementation, and APM 2.0 Planning and Engagement

As we enter Year 4 of implementation of the APM, the Board continues to focus on meeting the goals of the APM Agreement while continuing to exercise robust oversight over Vermont's only ACO, OneCare Vermont. The Board plans to continue to develop and refine ACO reporting requirements in 2021 as part of its statutory monitoring and oversight responsibilities, and to work with the Scott Administration and other model partners to improve performance on APM targets, including on scale as described in our response to the 2020 CMMI scale warning notice. The GMCB will also be working with the Scott Administration, providers, payers, advocates, and other stakeholders to plan for a potential subsequent APM Agreement; under Vermont's current Agreement, a proposal for a subsequent model is due to our federal partners at the Center for Medicare and Medicaid Innovation (CMMI) on December 31, 2021.

2. Hospital Sustainability

Ensuring hospital sustainability will be a major focus of the Board's work in 2021. The Board will continue to work with hospitals to complete the sustainability planning process, focusing on price, cost, capacity, quality, and access. The goal is to optimize our delivery system and ensure that hospitals are sustainable and prepared for a shift from fee-for-service to value-based payment models. Per Act 159 of 2020, the Board will report to the Legislature on findings from this work by September 1 (or November 15 if the process continues to be delayed by COVID-19).

3. Regulatory Alignment

GMCB continues work on a third white paper on potential areas for policy alignment across regulatory processes. A discussion draft is expected in early 2021, accompanied by a public presentation and comment period to collect feedback and input. A final white paper on policy alignment, incorporating this feedback and input from other State agencies, will be published later in 2021. The Board will consider recommendations from the white papers and identify next steps to ensure more streamlined and consistent regulatory processes.

4. Health Care Workforce

Health care workforce issues impact the Board's ability in its regulatory processes to focus on ensuring access to high quality health care while reducing the cost of that care. Workforce has been a major focus of the Board's work under Chair Mullin's active leadership: in 2020, the Board submitted the Rural Health Services Task Force report, which included major workforce recommendations; the Board held a panel discussion to highlight the primary care health care workforce crisis; and members of the Board's Primary Care Advisory Group (PCAG) testified to the health care committees, identifying potential solutions to alleviate the serious shortage and looming crisis of primary care providers in Vermont. Per Act 155, the Board is expected to review and approve the health care workforce strategic plan, which will be developed by the Director of Health Care Reform at the Agency of Human Services, on or before July 1, 2021.

5. VHCURES 3.0, Transparency, & Data

After completing initial implementation of VHCURES 3.0 in 2020, the Board will continue to work in 2021 to expand the capabilities of VHCURES, including health care Business Intelligence and analytic tools, other data enhancements and improved training (see pg. 26), such as through working to improve data validation and increase price transparency per Act 159 of 2020:

- Building on the GMCB's analytic plan, the Legislature passed Act 159 which outlines the steps the Board will take to validate its data sources and increase price transparency for Vermont consumers. The Board staff will work with its data sources – Vermont's all-payer claims data base (VHCURES) and hospital discharge data set (VUHHDS) – and gain input from stakeholders on this project.
- Board staff continue to collaborate with other agencies to pursue opportunities to integrate VHCURES data with other data sources, including the birth and death registries (Vermont Vital Statistics).

The Board's 2021 Annual Report (due January 15, 2022) will also include information regarding high-volume outpatient surgeries and procedures performed in ambulatory surgical centers and hospital settings in Vermont, any changes in utilization over time, and a comparison of the commercial insurance rates paid for the same surgeries and procedures performed in ambulatory surgical centers and in hospitals in Vermont, as required by § 9375(b)(14)(B).

6. New Prescription Drug Technical Advisory Group

The high cost of prescription drugs is discussed as an issue in nearly all of the Board's regulatory processes. Seeking to address this issue, both within our regulatory authorities and in recommendations to other areas of government or external stakeholders, the Board created the Prescription Drug Affordability Work Group which will meet throughout 2021 to make recommendations. The group consist of pharmacists, payers, providers, and state experts.

Legislative Reports

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

Legislative Reports Submitted by GMCB in 2020		
Report	**Due Date**	**Corresponding Statute or Legislation**
Impact of Prescription Drug Costs on Health Insurance Premiums	January 1, 2020*	18 V.S.A. § 4636 (b) Act 193 of 2018, An act relating to prescription drug price transparency and cost containment, Sec. 8 (S.92)
Rural Health Services Task Force Report	January 15, 2020	Act 26 of 2019, An act relating to the Rural Health Services Task Force, Sec. 1 (H.528)
Primary Care Spend Report	January 15, 2020	Act 17 of 2019 (Sec. 2), An act relating to determining the proportion of health care spending allocated to primary care
Cost Shift Impact **(See GMCB 2019 Annual Report, Appendix A)**	January 15, 2020* *(See Appendix A)*	18 V.S.A. § 9375 (d) Act 63 of 2019, An act relating to health insurance and the individual mandate, Sec. 10 (H.524)
GMCB 2019 Annual Report	January 15, 2020*	18 V.S.A. § 9375 (d)
2018 Vermont Health Care Expenditure Analysis	January 15, 2020* *NOTE: The VHCEA is delayed yearly due to data availability and staff resources. Published annually in summer.*	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)
Billback Report	September 15, 2020*	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)
GMCB Legislative Reports Due in 2021		
Report	**Due Date**	**Corresponding Statute or Legislation**
Impact of Prescription Drug Costs on Health Insurance Premiums	January 1, 2021* *NOTE: The 2020 report was published June 2021 due to delay in data availability.*	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)
Cost Shift Impact (See GMCB 2020 Annual Report, Appendix A)	January 15, 2021* *NOTE: The 2020 report was published June 2021 due to delay in data availability.*	18 V.S.A. § 9375 (d) Act 63 of 2019, An act relating to health insurance and the individual mandate, Sec. 10 (H.524)
GMCB 2020 Annual Report	January 15, 2021* Note: Resubmitted June 25, 2021 with updates.	18 V.S.A. § 9375 (d)
2019 Vermont Health Care Expenditure Analysis	January 15, 2021* *NOTE: The VHCEA is delayed yearly due to data availability and staff resources. This report was published May 2021.*	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)

Hospital Price Transparency Dashboard	February 1, 2021 (Update) *Final report due February 1, 2022.*	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 1-3 (H.795)
Provider Sustainability & Reimbursements	March 15, 2021	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 5 (H.795) *Update provided to HROC November 1, 2020*
Hospital Sustainability Planning	April 1, 2021 (Update) Sept 1, 2021 (Final) *NOTE: In the event of a COVID-19 surge, update due Sept 1, 2021, and report due Nov 15, 2021.*	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 5 (H.795) *Update provided to HROC November 15, 2020*
Billback Report	September 15, 2021*	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)
Chiropractic and Physical Therapy Co-Pays	November 15, 2021	Act 15 of 2019, An act relating to miscellaneous provisions affecting navigators, Medicaid records, and the Department of Vermont Health Access (H.204)
Additional One-Time Legislative Reports Assigned during 2020 Legislative Session		
Report	**Due Date**	**Corresponding Statute or Legislation**
Ambulatory Surgical Center Reporting	January 15, 2022* *(1st year of reporting)*	18 V.S.A. § 9375 (b) Act 55 of 2019, An act relating to licensure of ambulatory surgical centers (S.73)
Prior Authorization and All-Payer ACO Model	January 15, 2022	Act 140 of 2020, An act relating to miscellaneous health care provisions, Sec. 10 (H.960)
Hospital Price Transparency Dashboard	February 1, 2022 (Final report)	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 1-3 (H.795)

Stakeholder Engagement in 2020

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

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

GMCB Board Meetings

The Green Mountain Care Board generally meets weekly in open public meetings. GMCB meetings operate in accordance with Vermont's Open Meeting Law: they are noticed in advance, open to the public, audio-recorded, include an opportunity for public comment, and following the meeting, minutes are posted to the GMCB website. In addition, most meetings are videotaped by Onion River Community Access Media (ORCA). In 2020, the Board held nine in-person meetings and starting mid-March, held 43 meetings via video conference with a call-in option due to COVID-19. The meetings include regular Board meetings, hearings on proposed health insurance rate changes, Certificate of Need (CON) hearings, and hearings on proposed hospital and ACO budgets, each of which included time for public comment.

GMCB General Advisory Committee

The GMCB General Advisory Committee[1] was formed in 2012 to provide input and recommendations to the Board, as required by 18 V.S.A. § 9374(e)(1). In 2018, the Board launched a redesign of the committee to better utilize members' time and expertise to support the Board's work. The Board reconvened the Advisory Committee in early 2019 with the new membership and worked with the committee to develop a charter outlining the group's purpose and its future work. The committee's current membership includes 20 representatives of Vermont businesses, consumers, health care providers and educators, patient advocates, and insurers.

In 2020, the Board held three General Advisory Committee meetings. The meetings featured presentations and small group discussions with the goal of utilizing the varied backgrounds and experiences of the Advisory Committee members to inform the Board. Meeting topics include the APM; OneCare Vermont ACO; prescription drug pricing; GMCB legislative priorities; COVID-19 impacts; and the make-up and work of the GMCB General Advisory Committee going forward. The General Advisory Committee is staffed by a GMCB staff member and chaired by the GMCB Executive Director, and all Board members attend each meeting.

Primary Care Advisory Group

The Primary Care Advisory Group (PCAG)[2] was established in Act 113 of 2016 to provide input to the Board and address issues related to the administrative burden facing Vermont primary care professionals. In accordance with Act 113, the PCAG sunsetted on July 1, 2018. Recognizing the importance of this group, the Board used the authority granted in 18 V.S.A. § 9374(e)(2), which allows the Board to create advisory groups to carry out its duties, to continue to convene the PCAG. The current PCAG includes twelve primary care providers (a mix of physicians and advanced practice registered nurses). It is staffed by a GMCB staff member and the GMCB Executive Director, and one

[1] *See* GMCB General Advisory Committee webpage.
[2] *See* GMCB Primary Care Advisory Group webpage.

rotating Board member attends each meeting. The PCAG met eight times in 2020 and focused on primary care workforce. Group members testified to the Senate Health and Welfare and House Health Care committees on this issue, outlining the need for additional primary care providers in Vermont. The PCAG members also collaborated with legislators on Act 155 of 2020 (H.607) and continue to provide important clinical expertise for the HRAP.

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

Prescription Drug Technical Advisory Group

The GMCB Prescription Drug Technical Advisory Group[3] was established in 2020 in response to the Legislature's interest in controlling prescription drug costs at the state level. On December 2, 2020, the Board convened the first meeting with representatives from the Agency of Human Services, Department of Vermont Health Access, Department of Financial Regulation, the Attorney General's Office, Vermont Association of Hospitals and Health Systems, Vermont Medical Society, Bi-State Primary Care Association, BlueCross BlueShield of Vermont, MVP Health Care, as well as an independent pharmacist and chain pharmacist. The group meets bi-weekly and is staffed by a GMCB staffer and Board Member Robin Lunge.

Data Governance Council

The Data Governance Council[4] is a committee of the Board that supports the Board's data governance and stewardship and has the authority to make and execute decisions and assign resources to priority areas. The Data Governance Council, which meets bimonthly in open public meetings, consists of seven voting members, and currently includes one Board Member. In 2020, the Data Governance Council adopted a Data Linkage Policy[5] and considered specific data release applications and data linkage requests. Please see the Data and Analytics section on pg. 26 for more information.

Opportunities for Public Comment

Members of the public are invited to provide comment to the GMCB at any time. The Board works with the Health Care Advocate, State agencies and departments, health care organizations, and members of the public to solicit and receive a broad spectrum of information to better assist the Board in its regulatory decision-making processes. In addition to the specific opportunities outlined above, the GMCB accepts public comment submissions via a standardized form available on the GMCB website, by telephone and U.S. mail to the GMCB offices, and by email.[6]

[3] *See* GMCB Prescription Drug Technical Advisory Group information.
[4] *See* GMCB Data Governance Council information.
[5] *See* GMCB Data Governance Council Data Linkage Policy.
[6] *See* GMCB Public Comment webpage.

PROGRESS IN 2020

HEALTH INSURANCE REGULATION

Project Area: Health Insurance Regulation

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

Overview: The Board is tasked with reviewing major medical health insurance premium rates in the large 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.

Health Insurance Rate Review

Progress in 2020

- Rate Filings: The Board reviewed 7 rate filings in 2020[7] (see Figure 2, following page), representing approximately $634.0 million in health insurance premiums for approximately 87,272 Vermonters, with over 75,401 on the Exchange. Insurers requested approximately $40.0 million in premium increases. The Board reduced this amount by an estimated $20 million, including $18.8 million for plans sold on the Exchange.[8] Approved average rate increases for Exchange plans were 2.7% (reduced from 7.3% as submitted) for MVP and 4.2% (reduced from 6.3% as submitted) for Blue Cross and Blue Shield of Vermont.
- Rate Drivers: The cost of pharmaceuticals, particularly specialty pharmaceuticals, contributed significantly to the rate increases, as did increases in the utilization and cost of medical services. The repeal of the federal Health Insurer Providers Fee offset some of these increases. The Board also reduced overall rate requests to reflect the expectation the insurers do not increase administrative costs.
- COVID-19: The COVID-19 pandemic was a factor in some rate filings reviewed by the Board in 2020. In general, either carriers did not ask to increase their rates specifically because of the pandemic, or the Board disallowed requested increases given the uncertainty of Vermont's and the nation's pandemic response in 2021.

Looking Ahead to 2021

- Federal Issues: The U.S. Supreme Court heard oral arguments in November 2020 in *California v. Texas*, a case brought by a group of 20 states to strike down the Affordable Care Act (ACA). If all or most of the ACA is struck down, it will have complex and far-reaching consequences for the nation's health care system. While Vermont has codified some of the ACA's protections into state law with Act 63 of 2019 (minimum essential coverage, protection of pre-existing conditions, an individual mandate, coverage of young adults up to age 26, cost-sharing limits, etc.), losses in federal subsidies and changes to Medicaid eligibility could significantly affect Vermonters' coverage options and premium costs.
- COVID-19: Rates filed in 2021 for the coming plan year could be impacted by COVID-19, depending on a number of factors, such as the availability and timing of a vaccine, the availability of federal funds to pay for the cost of the vaccine and vaccinations, continued delayed treatment if COVID surges and/or possible pent-up demand if the pandemic subsides.

[7] The filings were reviewed in 2020 for renewals in 2020 and 2021. 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.
[8] *See* GMCB Rate Review website for a summary of 2020 filings and approved rates, including filings for Review Year 2020.

Figure 2: Insurance Rate Filings for the 2020 Review Year

Company Name	Filing Name	Proposed Rate Change	Approved Rate Change	Difference	Estimated Premium Reduction *
Cigna Health and Life Insurance Company	Large Group	15.00%	9.00%	-6.00%	$380,693
Blue Cross Blue Shield of Vermont and TVHP (2 Filings)	Large Group	1.90%	0.70%	-1.20%	$882,059
Blue Cross Blue Shield of Vermont	Association Health Plan	**N/A	**N/A	**N/A	**N/A
MVP Health Plan Inc.	Qualified Health Plan/Exchange	7.30%	2.70%	-4.60%	$11,450,995
Blue Cross Blue Shield of Vermont	Qualified Health Plan/Exchange	6.70%	4.20%	-2.50%	$7,318,164
MVP Health Plan Inc.	Large Group	-1.20%	-4.60%	-3.40%	$426,065
				Total	$20,457,976

* 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.

** N/A – First year, no rate change

REGULATING HEALTH CARE AND EVALUATING SPENDING

Hospital Budget Review

Project Area: Regulating Health Care and Evaluating Spending

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

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

Progress in 2020

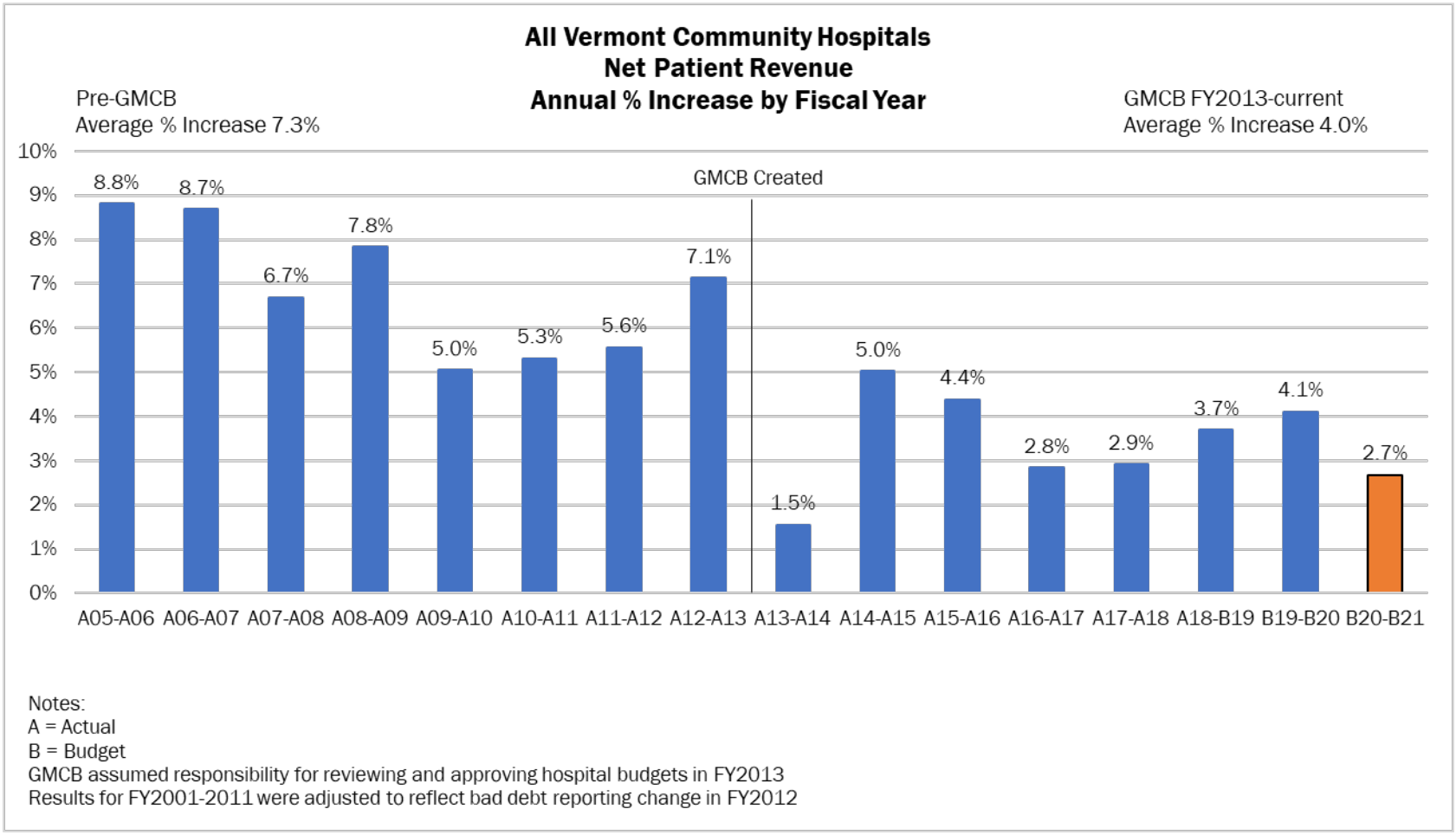
- FY2021 Hospital Budget Review Process: Vermont's 14 regulated hospitals filed their proposed budgets for FY2021 (October 1, 2020-September 30, 2021) on July 31, 2020, an extension from the original deadline of July 1 due to COVID-19. The aggregated system-wide requested net patient revenue (NPR) increase was 3.3% over FY2020 system-wide budgets. Common themes that emerged from hospital budget submissions were the impact of COVID-19 on financial performance and solvency, federal and state stabilization grants and loans, and pandemic-related expense increases and cost reduction efforts, as well as health care reform investments (e.g., telehealth), All-Payer Model participation, and workforce recruitment challenges. In the Board's review of hospitals' budgets, the Board considered these themes, as well as detailed staff analysis of hospitals' finances, payer mix, utilization, patient access, quality of care, budget compliance, NPR growth, potential commercial charge increases, and accounting changes and provider transfers where applicable. The Board considered comments from the Office of the Health Care Advocate and the public.
- FY2021 Hospital Budget Decisions:[9] The Board's FY2021 hospital budget orders resulted in a system-wide FY2021 NPR of $2.79 billion, a 2.67% NPR increase over FY2020 approved budgets. This represents a reduction of $17.1 million from hospitals' FY2021 budgets as submitted. The Board also reduced the system-wide average increase in charges from 7.0% to 5.6%. In making their decision, the Board considered medical inflation (including the rising costs of recruitment and retention of health care providers), the demographic impact of an aging population, including increased patient acuity and shifting payer mix, as well as hospitals' financial solvency and potential impacts on access.
- Health Care Cost Containment: FY2021 budgeted system-wide NPR was approved at 2.67% over FY2020 budgets, below the FY2021 targeted growth set forth in the budget guidance of 3.5%. Average annual system-wide growth since 2013 is 4.0%, well below the annual growth of 7.3% seen during the decade prior to the creation of the GMCB (see Figure 3, pg. 18).

Looking Ahead to 2021

- Hospital Reporting: GMCB will seek to enhance periodic reporting while minimizing burden.
- Utilization and Cost: GMCB will seek insight into utilization trends across hospitals, correlations between utilization, price and cost, and development of per-person cost measures, building on the patient migration/origin studies conducted in 2020 (see pg. 26).
- Sustainability: Hospital sustainability was a major theme of the FY2021 budget hearings and will be a focus of GMCB's work in 2021. See Hospital Sustainability section, pg. 19.

[9] *See* GMCB FY21 Hospital Budgets webpage.

Figure 3: Vermont Community Hospitals – System-Wide Net Patient Revenue Increases Over Time[10]



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

Hospital Sustainability Planning

Project Area: Regulating Health Care and Evaluating Spending

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

Overview: Since 2005, 170 rural hospitals have closed nationally, with 2019 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, requiring 6 of 14 hospitals to develop sustainability plans in its FY2020 hospital budget orders, and later mandating that all Vermont hospitals do the same in the FY2021 hospital budget process.

Progress in 2020

- Hospital Sustainability Framework: In its FY2021 hospital budget decisions (issued in September 2020), the GMCB required all Vermont hospitals to engage in a GMCB-led sustainability planning process. A draft sustainability planning framework was approved by the Board in August of 2020. After discussions with leadership from most Vermont hospitals,[11] project goals were refined, allowing for a robust revision of the framework while retaining the spirit of the original exercise:
  (1) Engage in a robust conversation on maintaining access to essential services in our communities while improving cost and quality, preparing for a shift to value-based care, and understanding the threats to sustainability of our rural health care system;
  (2) Encourage hospital leadership, boards, and communities to work together to address sustainability challenges and the shift to value-based care;
  (3) Identify hospital-led strategies for sustainability, including efforts to "right-size" hospital operations, particularly in the face of Vermont's demographic challenges and making the shift to value-based care; and
  (4) Identify external barriers to sustainability and making a successful shift to value-based care that are more aptly addressed by other stakeholders, policymakers, or regulatory bodies, and generate insights to inform the state's approach to planning for and designing a proposal for a subsequent APM Agreement (APM 2.0).

  The Board will be asked to review the revised framework again in early 2021. This process was codified by the Legislature through Act 159 (Section 4) of 2020, which requires the Board to make recommendations on hospital sustainability by fall 2021.
- Stakeholder Engagement: Board members and staff met with leadership from 13 Vermont hospitals, the HCA, and VAHHS in October and November 2020 to gather feedback on the framework. In response, the GMCB (1) refined the framework to make tighter connections between insights and their intended use and (2) significantly streamlined the framework to reduce the burden on providers. The revised framework relies on GMCB-gathered data when possible and explores the preparedness of hospitals in the shift to value-based care.
- Delays Due to COVID-19: In November 2019, Vermont's hospitals requested that GMCB delay this process due to a surge in COVID-19 cases. Board staff plan to move forward with the sustainability process by conducting an internal analysis of price, cost, quality, and capacity of our hospital system. Once the COVID surge passes, GMCB will reengage hospitals.

Looking Ahead to 2021

- Data Analysis, Hospital Feedback, and Recommendations: The Board will issue later stages of the framework in 2021 and analyze hospital responses. Per Act 159, GMCB will deliver recommendations to the Legislature by Sept. 1 (Nov. 15 in the event of a COVID-19 surge).

[11] A discussion with UVM Health Network planned for late fall was delayed by the October cyberattack.

Certificate of Need (CON)

Project Area: Regulating Health Care and Evaluating Spending

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

Overview: Vermont law requires hospitals and other health care facilities to obtain a Certificate of Need before developing a new health care project as defined in 18 V.S.A. § 9434. This includes capital expenditures that meet statutory cost thresholds, purchase or lease of new equipment or technology that meet statutory cost thresholds, changes in the number of licensed beds, offering any new home health services, health care facility ownership transfers (excluding nursing homes), and any new ambulatory surgical centers. Each project must meet statutory criteria related to access, quality, cost, need, and appropriate allocation of resources. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure equitable allocation of resources to all Vermonters.

Progress in 2020

- Issued Five CONs: The Board approved five applications with a total value of $60,717,600:[12]
    - Vermont Open MRI, to replace its outdated MRI system.
    - Northwestern Medical Center, to renovate its emergency department.
    - University of Vermont Medical Center, to expand its health information system to two network hospitals in New York.
    - Silver Pines Partners, LLC, for development of a medically supervised withdrawal treatment center for individuals with substance use disorder.
    - Southwestern Vermont Health Care, to modernize the emergency department and front entrance.
- Five Projects Not Reviewable: The Board determined that five proposed projects did not meet jurisdictional thresholds for CON review.
- Green Mountain Surgery Center Vermont Supreme Court Decision: The Vermont Supreme Court upheld the Board's interpretation of the scope of the CON issued to the Green Mountain Surgery Center in 2017.

Looking Ahead to 2021

- New Applications: The following entities have either filed, or notified the Board that they intend to file, applications that will be reviewed in 2021:
    - Pine Heights at Brattleboro Center for Nursing and Rehabilitation, renovation project.
    - Northern Lights Recovery Center, for development of a SUD treatment facility.
    - Rutland Regional Medical Center, replacement of MRI Unit.
    - Vernon Homes, to construct a new skilled nursing facility using the Greenhouse Model.
    - The Divided Sky Foundation and Ascension Recovery Services, for development of a SUD treatment facility.

[12] *See* CONs and Statements of Decision for approved projects.

Vermont Health Care Expenditure Analysis

The most recent Health Care Expenditure Analysis (CY 2018) was completed in July 2020.[13]

- Vermont Resident Analysis, 2018: Total spending for Vermont residents receiving health care services both in- and out-of-state increased 1.9% from 2017 to 2018, to a total of $6.3 billion. This was lower than the 3.7% increase in 2017 and the average annual increase of 3.4% for the period 2013 through 2018. Medicare spending increased 5.1% as a result of increases in hospital utilization, and spending on nursing homes, physicians, and drugs and supplies. A 1.1% increase in Medicaid spending stemmed primarily from growth in spending for mental health and other government activities (e.g., home- and community-based services), while expenditures decreased for hospital utilization and drugs and supplies due to reduced spending and higher rebates for specialty drugs. Commercial insurance spending increased 1.7%, mainly due to growth in hospital utilization, drugs and supplies, and other non-claims costs. Estimated growth is expected to be 3.2% from 2018 to 2019 and 3.0% from 2019 to 2020.
- Vermont Resident Analysis Compared to U.S., 2018: From 2017 to 2018, U.S. health consumption spending increased 4.8% (compared to 1.9% for Vermont). The U.S. spending increase was higher than the 4.0% increase from 2016 to 2017, while Vermont's spending increase was lower than the 3.7% increase from 2016 to 2017. National per-person spending was $10,640, higher than Vermont's per-person spend of $9,995.
- Vermont Provider Analysis, 2018: Total revenues received by Vermont providers for health care services provided to in- and out-of-state patients increased 3.2% in 2018, to a total of $6.4 billion. This was slightly lower than the 3.3% increase in 2017 and lower than the average annual increase of 3.4% for 2013-2018. Estimated growth is expected to be 3.2% from 2018 to 2019 and 3.3% from 2019 to 2020.

Project Area: Regulating Health Care and Evaluating Spending

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

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

Looking Ahead to 2021

- Preparing 2019 Health Care Expenditure Analysis: In 2021, staff will finalize the 2019 Expenditure Analysis and two-year estimates. The analysis will be used as a tool to monitor the implementation of the APM Agreement's cost growth and other key financial metrics.[14]

[13] *See* 2018 Health Care Expenditure Analysis (PDF) or interactive 2018 Expenditure Analysis visualization. The VHCEA relies on a variety of Vermont-specific data sources, incorporating data from VHCURES, VUHDDS, the Vermont Household Health Insurance Survey, Annual Statement Supplement Report, ACO reports, and the best available data from other state and national resources. Most other analyses of health expenditures (e.g., Kaiser State Health Facts) use resident and provider data produced every 5 years based on US Census data; because of Vermont's small size, the VHCEA's more granular data sources allow for a richer, detailed analysis.
[14] The 2019 Expenditure Analysis was published on May 12, 2021 and is available on the GMCB website.

Prescription Drug Monitoring

Project Area: Regulating Health Care and Evaluating Spending

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

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

Progress in 2020

- Prescription Drug Cost Analysis – State Spending: DVHA submitted the prescription drug lists for CY2019 in July. This list included drugs on which the State spends significant health care dollars or on which health insurance plans spend significant amounts of their premium dollars.[15] DVHA developed the list based on the one-year increase in wholesale acquisition cost (WAC) and net cost.
    - *DVHA Gross Drug Cost Analysis*: This list contains the drugs for which the WAC increased by 15% or more in the CY2019. Gross spending on the ten drugs identified was $327,206 and gross drug price increases ranged from 18.65% to 666.67%. None of the drugs identified were on the previous year's list.
    - *DVHA Net Drug Cost Analysis*: This list contains drugs for which the net cost to DVHA increased by 15% or more in CY2019. Net drug price increases ranged from 15.15% to 744.14% over the last calendar year and two of the ten drugs identified were also on the previous year's list of drugs. None appeared on this year's gross cost list.
    - *BCBSVT & MVP Drug Lists with Largest Net Price Increase*:[16] For the previous calendar year, drug price increases ranged from 43.6% to 347.7% for BCBSVT and from 17.7% to 385.9% for MVP.
- 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: a) the flow of funds related to prescription drugs between manufacturers, insurers, and plan members, including discounts and rebates; and b) on the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year price increases.[17] The 2020 report found that prescription drug costs account for approximately 11% of the commercial premiums under review. The three drugs with the greatest impact on premium are Humira (CF) Pen, Humira Pen, and Stelara.

Looking Ahead to 2021

- Continued Prescription Drug Monitoring: The Board will continue to track drug costs through the health insurance rate review process and work with hospitals and insurers to measure the impact of drugs on insurance rates.
- Prescription Drug Technical Advisory Group: The Board will continue to work with stakeholders to address the rising costs of prescription drugs by examining potential state solutions.

[15] *See* DVHA drug cost analyses and methodology for CY2019.
[16] *See* BCBSVT & MVP drug cost analyses for CY2019.
[17] *See* GMCB Prescription Drug Transparency webpage for Act 193 Report. The 2020 report was published June 11, 2021 due to a delay in data availability.

Health Information Technology

Project Area: Regulating Health Care and Evaluating Spending

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

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

- Review and approve the budget for Vermont Information Technology Leaders (VITL - Vermont's statutorily designated clinical health information exchange).
- Review and approve a state Health Information Technology Plan (now referred to as the state Health Information Exchange Plan, or HIE Plan) developed by DVHA. DVHA is required to comprehensively update to the plan every 5 years and to revise it annually.

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

Progress in 2020

- FY2021 VITL Budget Review: VITL submitted its proposed budget for FY2021 (July 1, 2020-June 30, 2021) on May 18-19, 2020, with anticipated total revenue of $8.1 million, including $7.6 million in state contracts, plus $1.0 million from other sources and a negative revenue line of $517,000 to cover contingencies related to COVID-19 or other unplanned circumstances. The FY2021 budget included anticipated total expenses of $7.8 million. This submission was presented to the GMCB at its June 3, 2020, public Board meeting,[18] and approved on June 17, 2020.[19] VITL provided quarterly updates on their operations and budget throughout 2020 as required by their FY2020 and FY2021 budget orders, on topics including governance and operations, finances, technology, and stakeholder engagement around HIE consent.
- 2020 Update to Health Information Exchange (HIE) Strategic Plan and 2021 Connectivity Criteria Review and Approval: DVHA and the HIE Steering Committee submitted an annual update to the HIE Plan on November 2, 2020. DVHA and VITL presented the Plan, along with 2021 Connectivity Criteria, to the Board on November 18, 2020. Following Board discussion, DVHA resubmitted the HIE Plan with minor changes. The Board voted unanimously to approve the HIE Plan and Connectivity on December 2.[20]
- HIE Consent: Act 53 of 2019 required the HIE Plan to reflect an opt-out or presumed consent model to be implemented by March 1, 2020. The Board heard updates on consent policy development and implementation throughout 2019, and the new policy was implemented on March 1, 2020. An evaluation of implementation of this change was included in the 2020 Update to the HIE Plan as Appendix G.

Looking Ahead to 2021

- Future HIE Plan Updates: DVHA will continue to submit annual updates to the HIE Plan, developed in collaboration with the HIE Steering Committee.
- FY2022 VITL Budget Review: The Board expects to review VITL's FY2022 budget in late spring 2021.

[18] *See* FY2021 Budget Review Presentation (June 3, 2020).
[19] *See* Order Approving Vermont Information Technology Leaders' FY2021 Budget (July 24, 2020).
[20] *See* 2020 Update to the HIE Strategic Plan as approved by GMCB (December 1, 2020) and Order Approving 2020 Update to the HIE Plan and 2021 VHIE Connectivity Criteria (January 7, 2021). See GMCB's Health Information Exchange (HIE) Plan webpage for more information.

ACOs AND THE ALL-PAYER MODEL

Project Area: ACOs and the APM

Relevant Statute/Authority: 18 V.S.A. § 9551; 42 U.S.C. § 1315a; APM Agreement

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

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

For additional information see GMCB APM Website.

Vermont's All-Payer Model (APM)

Progress in 2020

COVID-19 presented many challenges in the third year of the APM (2020) but also confirmed the need to move away from fee for service to predictable and flexible (fixed) payments.

- Responding to COVID-19: APM-participating providers electing to receive a fixed payment were able to stabilize their finances despite significant decreases in utilization due to COVID-19. GMCB is working to identify ways to increase fixed payments across our health care system. In addition, the Board requested federal flexibility related to financial penalties related to quality to allow providers to focus on the COVID-19 response; we continue to measure performance.
- Evaluating Performance Year 2 (PY2) results:[21]
  - *Scale*: PY2 results reflected growth in all-payer scale, from 21% in PY1 (2018) to 30% in PY2 (2019), and Medicare scale of 35% in PY1 to 47% in PY2. However, results were still below APM Agreement targets (50% for all-payer scale, 75% for Medicare scale in PY2), resulting in a warning notice from CMMI. The Vermont APM signatories responded, describing Vermont's strategy for improving scale performance, including a reduced risk corridor for the 2021+ in the Medicare ACO program, which added 7,500 Medicare beneficiaries to the program in the Rutland region.[22]
  - *Quality*: Where interim results are available, Vermont is showing marked improvement over prior year results. PY2 reporting is expected in February 2021 (delay due to COVID-19).
  - *Cost*: While the results for PY2 are not yet final, the total cost of care (TCOC) in 2019 was on track to surpass the All-Payer TCOC target (3.5%) set over the life of the model. This trend is likely to be offset in PY3 (2020) due to decreased utilization associated with COVID-19 and is below the level to trigger action by the federal government.
- Other Reporting: GMCB submitted required Payer Differential Assessment and Options reports.
- Setting the Annual Medicare Benchmark (Financial Target): In response to COVID-19, the GMCB proposed revising the methodology used to develop the 2020 Medicare benchmark to more accurately reflect utilization. On December 23, 2020, the GMCB also voted to propose the use of this new methodology in developing the 2021 Medicare benchmark, and to include approximately $8.7 million to the benchmark to continue investments in Blueprint for Health and the SASH program in 2021.

Looking Ahead to 2021

- APM 2.0: GMCB will begin engaging stakeholders and experts as planning for a potential second APM Agreement (APM 2.0) ramps up. The GMCB, in consultation with AHS, is responsible for making a formal proposal to CMMI for a second model by December 31, 2021.

[21] All submitted reports are available on GMCB's APM Reports webpage.
[22] See CMMI scale targets warning letter (September 14, 2020) and Vermont's response (December 10, 2020).

ACO Oversight: Budget Review and Certification

Project Area: ACOs and the APM

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

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

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

Progress in 2020

- 2020 ACO Oversight: The Board monitored OneCare's compliance with conditions of its 2020 budget order throughout the year, through the ACO's quarterly reporting. In March, OneCare submitted a letter to the GMCB requesting operational relief adjustments to the FY20 order in light of the COVID-19 public health emergency. The GMCB issued a budget order amendment in April and considered OneCare's revised budget in July.[23] The revised budget is approximately $1.2 billion, with 96% of dollars flowing to providers, either through fixed payments or fee-for-service payments for direct care of patients. 3% of revenue flowing through the ACO goes back out to providers and community organizations as population health program investments; 1% is ACO operating expenses, funding personnel and analytics to support providers and population health programs.
- 2021 ACO Certification and Budget Review: Beginning September 1, GMCB staff reviewed and verified OneCare's continued eligibility for certification. Certification eligibility was reviewed during the GMCB staff analysis presentation and is documented in a memo. The Board received OneCare's proposed 2021 budget on October 1 and after careful analysis and an extended public comment period, the Board voted on December 23, 2020 to modify and approve the budget with 17 conditions, including a cap on administrative expenses, submission of a revised budget in spring once contracts and funding sources are final, applying an inflationary trend to Blueprint and SASH funding, additional reporting on the revised risk model, and compliance with the reporting manual developed by the Board. The Board also expressed its intent to incorporate a new requirement in its ACO oversight rule (Rule 5.000) that executive compensation be tied to ACO quality and financial performance. The preliminary revenue budget is approximately $1.46 billion, with 97% of dollars flowing to providers, either through fixed payments or fee-for-service payments for direct care of an estimated 238,000 Vermonters (up from 223,000 in 2020).[24] OneCare's FY2021 budget includes an expected $30.5 million of investments in population health, or approximately 2% of total revenues. Operating expenses remain around 1% of total revenues.
- Review of 2021 Medicaid Advisory Rate Case: Per 18 V.S.A. § 9573, the GMCB is responsible for advising DVHA on the per beneficiary payment rates negotiated between DVHA and the ACO. The GMCB issued the Medicaid Advisory Rate Case on December 30, 2020.

Looking Ahead to 2021

- Aligning ACO Oversight with Other Regulatory Processes: Through its regulatory alignment efforts (see pg. 6), the GMCB will continue work to align ACO oversight with its other regulatory processes in service of containing cost growth and improving access, quality, and health. The third Regulatory Alignment White Paper will explore topics central to ACO oversight, including risk and reserves, delivery system transformation, quality oversight, and financial measures.
- Standardizing ACO Reporting: To improve tracking ACO performance and accountability over time, the GMCB will continue to work toward collecting data quarterly and year-over-year in standard reporting formats, including development of an ACO reporting manual in 2021.

[23] *See* 2020 ACO Oversight materials and OneCare Vermont's FY20 Revised Budget: GMCB Staff Analysis.
[24] *See* FY20 Accountable Care Organization Budget Order (January 31, 2020).

DATA AND ANALYTICS

Data and Analytics

Project Area: Data and Analytics

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

Overview: The Board must maintain a unified health care database, reflecting health care utilization and costs for services provided in Vermont and to Vermont residents in another state. The Board maintains stewardship of two primary data sets:
- The Vermont Uniform Hospital Discharge Data Set (VUHDDS)
- The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

Progress in 2020

- Data Stewardship: The GMCB Data Governance Council supported improved access to its data assets by developing a simplified data application procedure for VHCURES and standing up a broad use Data Use Agreement structure for state analysts using VUHDDS. The Council also voted to approve a dedicated policy for linking the GMCB's data assets to other data sets to help make them more useful to approved data users.
- Standard Reporting: Expanded interactive reports to include geographic reports related to patients spending and utilization patterns.[25] This includes a report detailing where Vermonters have sought care over time (Patient Migration Report) and another detailing the patterns in where patients have come from when seeking care at Vermont hospitals over time (Patient Origin Report).[26]
- Analysis-Ready Files: The final phase of this project will provide the GMCB with a recommendation of files most likely to inspire greater use and utility of the GMCB's data assets.
- Enhanced Data Validation: The GMCB Analytical Team is working with representatives from the provider community and insurers to complete a thorough validation of its data assets. The project is a key component in the GMCB's 2-year Research and Reporting Priorities.[27]

Looking Ahead to 2021

- Data Enhancements: The Board will pursue opportunities to enhance the usefulness of the claims data by combining it with other data sets, such as birth and death certificates.
- Next Steps on Price Variation: As required by Act 159 of 2020, the GMCB Analytical Team will develop an interactive report highlighting price variation, expected to be released in early 2022, and updated annually. This dashboard will provide consumers, policymakers, and providers with greater understanding of variation in the reimbursements paid by Vermont residents for a specific set of services.
- Improved Training: The GMCB Analytical Team will explore a potential new model for training "super users" of VHCURES. The dedicated program will be designed to provide more intensive and exhaustive training to a collaborative group, including practical components developed by participants.
- Expanded Support Across the GMCB: The Analytical Team is working to embed analysts in projects that span the organization to better fulfill the Board's desire to use data to inform its decision making.

[25] *See* GMCB Data Analysis and Reporting webpage for current analytic reports.
[26] *See* Patient Migration Report and Patient Origin Report.
[27] *See* GMCB Analytic Team's Proposed Research and Reporting Priorities for 2020-2021.

Health Resource Allocation Plan (HRAP)

The HRAP is a series of dynamic reports, visualizations, and other user-friendly tools designed to convey relevant information. These tools are available on the Board's website in addition to detailed information on health care services by geographic region.[28]

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 2020

- Project Specifications: The HRAP project team has developed web-based interactive reports that demonstrate health care needs, resources, and utilization patterns across hospital service areas.
- Data Governance and Management: The HRAP team continues to work with the Health Department to coordinate statewide data efforts to support health care priorities areas.
- Data Collection: GMCB completed service and bed-level resource inventories in the following priority areas: mental health, substance use disorder, hospital services, and home health and hospice.
- Stakeholder Engagement: The stakeholder engagement process has involved work with multiple State agencies, legislative representatives as well as external organizations to help ensure data is accurate and presented effectively. Staff continue to partner with State agencies to coordinate related work that supports resource planning. Public feedback is an ongoing component in project development.

Looking Ahead to 2021

- Data Collection and Management: Maintenance of essential data sets that reflect health care needs and resources by sector and geographic region. Organization of related resources curated on the GMCB website.
- Data Analysis: Data analysis, including a series of utilization and cost studies related to chronic diseases, COVID-19, and hospital services has begun and will continue throughout 2021. These efforts will support larger GMCB initiatives such as hospital sustainability and the All-Payer Model.
- Strategic planning: Develop and restructure processes for data requests to support Certificate of Need and Hospital Budget Programs.

[28] *See* Green Mountain Care Board Health Resource Allocation Plan webpage.

APPENDICES

Appendix A: Cost Shift

Project Area: Health Insurance Regulation

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

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

Progress in 2020[29]

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

- Annual Estimated Cost Shift Impact: For the purposes of this report, unlike academic research studies about the cost shift, this estimate does not assume negotiations impact the price, but is directly connected with approved net patient revenue increases and charge increases, which are part of the budget process. Figures 4 and 5 below represent the estimated cost shift by payer and by year from FY2008 to FY2021. 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.
- Rate of Growth: From FY2008 to FY2020, the cost shift appears to have grown every year, with estimated growth of 4.6% from FY2019 Actual to FY2020 Budget and 4.1% from FY2020 Budget to FY2021 Budget.
- Cost Shift Discussion at GMCB and Legislature: The cost shift has been a recurring topic of discussion at GMCB meetings, health insurance rate review hearings, and the Legislature in 2020.

Looking Ahead to 2021

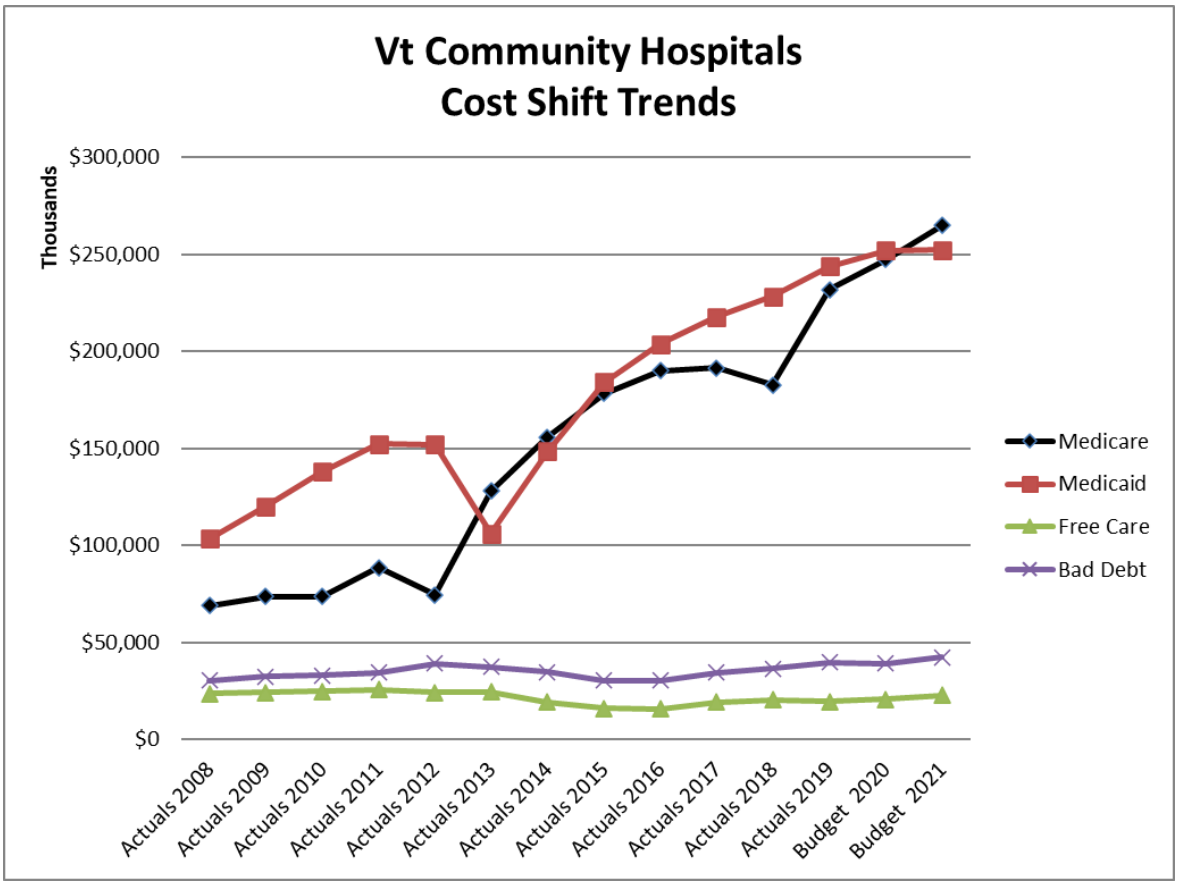
- Reporting and Analysis: GMCB staff will continue to refine the reporting of Vermont and non-Vermont payer revenue and the effect of the APM and any other payment reform initiatives on the cost shift.

[29] In 2020, GMCB's regular annual reporting about the Cost Shift (and the related report, Impact of Medicaid and Medicare Cost Shifts and Uncompensated Care on Health Insurance Premium Rates, required by 18 V.S.A. § 9375(d)(F)) was delayed. These reports rely on hospital financial reporting which was delayed as hospitals grappled with the COVID-19 public health emergency and the financial reporting requirements related to stabilization grants and loans.

Figure 4: Estimated Cost Shift by Payer (FY2008-FY2021), Vermont Community Hospitals

Fiscal Year	Estimated Medicare Cost of Services Shifted to Other Payers	Estimated Medicaid Cost of Services Shifted to Other Payers	Estimated Free Care Shifted to Other Payers	Estimated Bad Debt Shifted to Other Payers	Estimated Costs Shifted to Commercial and Other Payers	Estimated % Change from Prior Year in Shift to Commercial and Other Payers
Actuals 2008	$(69,003,712)	$(103,569,366)	$(23,623,972)	$(30,252,980)	$226,450,033	
Actuals 2009	$(73,627,496)	$(119,979,398)	$(24,292,187)	$(32,391,214)	$250,290,295	10.5%
Actuals 2010	$(73,515,988)	$(138,016,69)	$(24,806,398)	$(33,076,863)	$269,415,868	7.6%
Actuals 2011	$(88,399,861)	$(152,256,740)	$(25,784,124)	$(34,331,093)	$300,771,818	11.6%
Actuals 2012	$(74,383,192)	$(151,931,648)	$(24,347,367)	$(39,264,676)	$289,926,884	-3.6%
Actuals 2013	$(128,108,641)	$(105,982,171)	$(24,684,304)	$(37,383,822)	$296,158,938	2.1%
Actuals 2014	$(155,622,607)	$(148,344,481)	$(19,370,131)	$(34,885,055)	$358,222,274	21.0%
Actuals 2015	$(178,243,251)	$(184,115,357)	$(16,032,485)	$(30,469,896)	$408,860,990	14.1%
Actuals 2016	$(190,018,540)	$(203,622,426)	$(15,683,900)	$(30,318,995)	$439,643,861	7.5%
Actuals 2017	$(191,515,256)	$(217,814,796)	$(19,337,891)	$(34,451,540)	$463,119,483	5.3%
Actuals 2018	$(182,780,851)	$(228,177,679)	$(20,380,418)	$(36,600,429)	$467,939,377	1.0%
Actuals 2019	$(231,725,743)	$(243,616,824)	$(19,635,798)	$(39,595,820)	$534,573,257	14.2%
Budget 2020	$(247,163,929)	$(252,019,881)	$(20,601,238)	$(39,279,236)	$559,063,357	4.6%
Budget 2021	$(264,647,895)	$(252,180,150)	$(22,757,902)	$(42,240,612)	$581,826,559	4.1%

Figure 5: Trends – Estimated Cost of Services Shifted to Other Payers (FY2008-FY2021)



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

Statutory Charge: Effective June 17, 2019, 18 V.S.A. § 9375(d)(F) requires the Board to report annually on "the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates . . . ."[30] This year's Annual Report is the first to include such an analysis.

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

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

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

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

	(A)	(B)	(C) = (A)/(B)	(D)	(E) = (C)*(D)
Budget 2021	Estimated Costs Shifted to Commercial and Other Payers	GMCB Regulated Hospitals' Budget for Commercial Payers	Percentage Impact on Hospital Budgets for Commercial Payers	FY20 Estimated GMCB Hospital as Percentage of Premium	Impact of Cost Shift on Rate Filings
	$581,826,559	$1,491,287,268	37.5%	38.7%	14.5%

The Board also calculated the average impact of the cost shift by market (i.e., individual, and small group filings and large group filings). Figure (D) varies by filing and, on average, is larger for the individual and small group filings (39.2%) than for large group filings (36.4%), resulting in a larger impact on the individual and small group filings (14.7%) compared to large group filings (13.7%).[31]

[30] 2019 Vermont Laws No. 63 (H. 524), §§ 10, 13(d).
[31] Individual and Small Group (37.5% * 39.2%= 14.7%). Large Group (37.5% * 36.4% = 13.7%).

Appendix B: Green Mountain Care Board Meetings in 2020

January 8, 2020	• Rural Health Services Task Force (RHSTF) Presentation
January 15, 2020	• Primary Care Workforce Panel
January 22, 2020	• DVHA Act 53 HIE Consent Implementation Report • VITL FY 2020 Budget Adjustment and Quarterly Review • Preliminary Staff Recommendations: HIE Plan Addendum on Consent and VITL FY2020 Budget Adjustment
January 29, 2020	• Non-Standard QHP Design Approval Process and 2021 Evaluation Criteria
February 5, 2020	• Act 53 HIE Consent Implementation; VITL FY2020 Budget Adjustment– Potential Votes • Non-Standard QHP Design Approval Process and 2021 Evaluation Criteria – Potential Vote • OneCare Vermont's Lead Primary Prevention Program: An Overview of RiseVT Expansion and Outcomes Measurement
February 12, 2020	• Proposed 2021 Standard Qualified Health Plan (QHP) Designs
February 19, 2020	• UVM Milestone Report on Investments Towards Increasing Mental Health Capacity • Standard QHP Designs Discussion – Potential Vote
February 26, 2020	• Hospital Operating Performance FY19 Year-End Report • All-Payer Model Updates: 2018 Annual Total Cost of Care Report and APM Agreement Technical Changes • Overview of Sustainability Plans
March 11, 2020	• FY 2021 Hospital Budget Guidance
March 18, 2020	• FY 2021 Hospital Budget Guidance – Follow-up • FY 2021 NPR/FPP Growth Limit – Potential Vote • Enforcement Discussion • Hospital Sustainability Plan Discussion
March 25, 2020	• Certificate of Need Hearing: Silver Pines, LLC, Proposed Development of Medically Supervised Withdrawal Treatment Center for Substance Use Disorder in Stowe • Draft Emergency Certificate of Need Procedure
April 1, 2020	• FY 2020 Accountable Care Organization (ACO) Budget – Potential Vote
April 8, 2020	• Letter from State of Vermont to CMMI – Potential Vote • 2018 Statewide Health Outcomes and Quality of Care Results • Waiver of CON Review for Certain COVID-19 Related Projects – Potential Vote
April 22, 2020	• OneCare Vermont 2020 Update • BCBSVT Non-Standard Plan Design Presentation – Potential Vote
April 29, 2020	• Northwestern Medical Center 2020 Budget Amendment Request – Potential Vote • COVID-19 Response Updates from Health Insurers
May 4, 2020	• Northwestern Medical Center 2020 Budget Amendment Request – Potential Vote
May 13, 2020	• National Trends in State Affordability and Sustainability Strategies • Updated Hospital Budget Guidance • Discussion on whether the GMCB shall establish a Prescription Drug Technical Advisory Group pursuant to 18 V.S.A. § 9374(e)(2)
May 20, 2020	• Updated Hospital Budget Guidance
May 27, 2020	• COVID-19 Response and Updates from the Agency of Human Services • Updated Hospital Budget Guidance – Potential Vote
June 3, 2020	• VITL FY21 Budget Presentation and Quarterly Update • FY21 ACO Budget Guidance Presentation
June 17, 2020	• VITL FY21 Budget Presentation and Quarterly Update – Potential Vote • FY21 ACO Budget Guidance Presentation – Potential Vote
June 24, 2020	• OneCare Vermont FY20 ACO Budget Presentation
July 8, 2020	• 2018 Vermont Health Care Expenditure Analysis

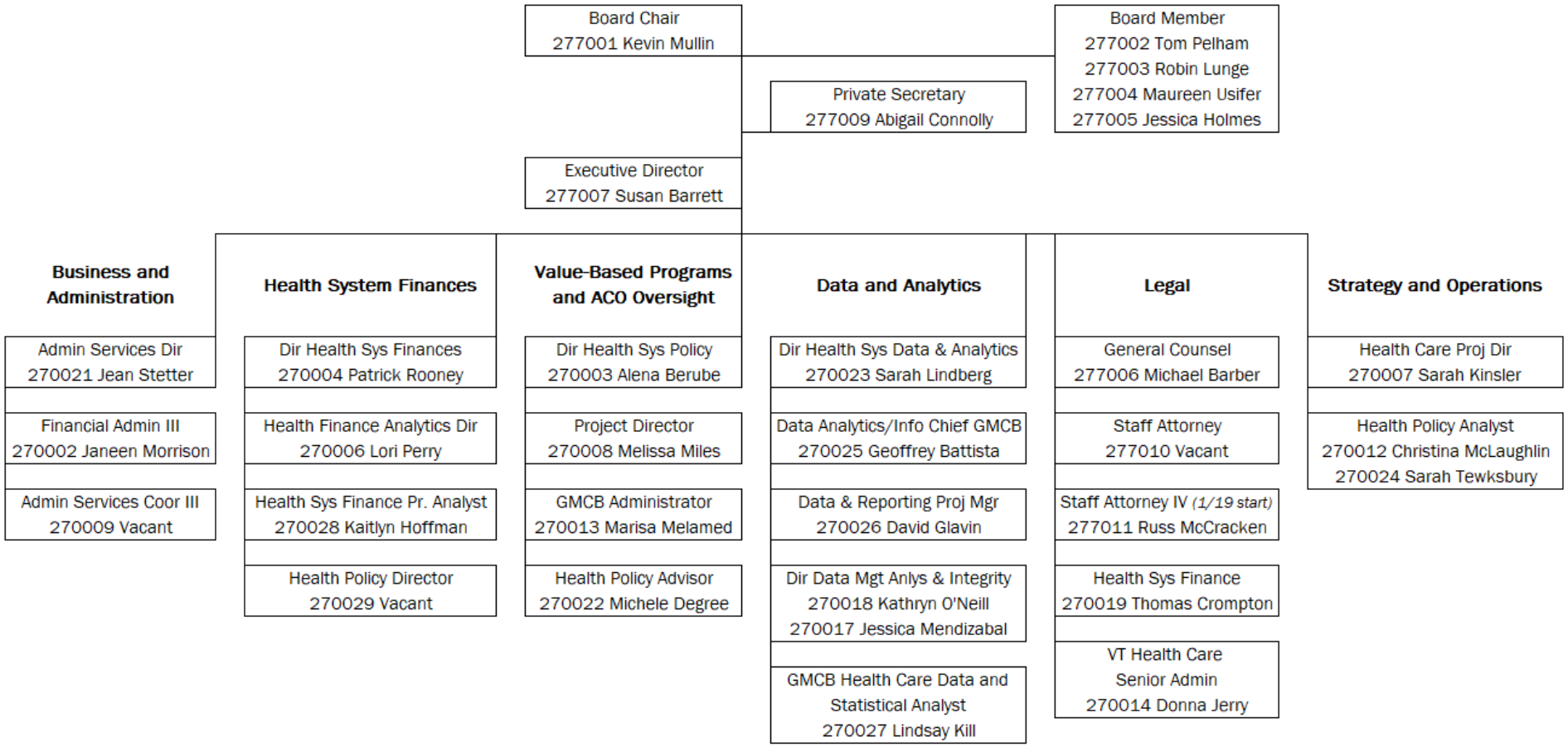
July 15, 2020	• Agency of Human Services COVID-19 Relief Funding Update • Reboot of Sustainability Plans and Update on Financial Health of Hospitals • Legislative Update
July 20, 2020	• Rate Review Hearing
July 21, 2020	• Rate Review Hearing • Rate Review Public Comment Forum
July 29, 2020	• Staff Analysis on FY20 Accountable Care Organization (ACO) Revised Budget
August 5, 2020	• GMCB Geographic Reporting: The Use and Cost of Health Care Services for Vermonters and Access Patterns for Vermont Hospitals • Hospital Sustainability Plans – Potential Vote
August 18, 2020	• Hospital Budget Hearing
August 20, 2020	• Hospital Budget Hearing
August 24, 2020	• Hospital Budget Hearing
August 26, 2020	• Hospital Budget Hearing
August 28, 2020	• Hospital Budget Hearing
September 2, 2020	• FY 2021 Hospital Budget Deliberations
September 9, 2020	• FY 2021 Hospital Budget Deliberations – Potential Vote • Discussion Regarding Changes to Primary Care Program for 2021
September 15, 2020	• COVID Relief Funds Update • FY 2021 Hospital Budget Deliberations – Potential Vote
September 16, 2020	• FY 2021 Hospital Budget Deliberations – Potential Vote
September 29, 2020	• Hearing on Request for FY21 Budget Reconsideration – Potential Vote
September 30, 2020	• VITL Quarterly Update • Staff Presentation on GMCB Regulatory Alignment
October 7, 2020	• Accountable Care Organization (ACO) Payer-Quality Results 2019
October 14, 2020	• Revised 2020 Medicare Benchmark Proposal
October 21, 2020	• New Tools to Help States Address Hospital Costs • FY 2021 Hospital Budget Debrief • Revised 2020 Medicare Benchmark Proposal – Potential Vote
October 28, 2020	• GMCB Introduction to the ACO Regulatory Process • OneCare Vermont FY 2021 Budget Hearing
November 4, 2020	• FY 2021 Hospital Budget Debrief
November 18, 2020	• 2020 Update to 2018-2022 Health Information Exchange (HIE) Strategic Plan
November 25, 2020	• All-Payer ACO Model Agreement Implementation Improvement Plan • Scale Target Letter Response - Staff Presentation
December 2, 2020	• Continue FY21 Hospital Budget Debrief • 2020 Update to the HIE Strategic Plan and 2021 Connectivity Criteria – Potential Vote • 2019 ACO Financial Results Panel • All-Payer Model Update
December 9, 2020	• ACO Oversight: FY2021 Staff Analysis and Preliminary Recommendations
December 16, 2020	• 2021 Medicare Benchmark Proposal • New England States' All-Payer Report on Primary Care Payments • Panel Discussion: Provider Reimbursement in Vermont
December 18, 2020	• FY2021 ACO Budget Discussion
December 23, 2020	• 2021 Medicare Benchmark Proposal – Potential Vote • ACO Oversight: FY2021 ACO Budget – Potential Vote
December 30, 2020	• Delegation of All-Payer Model Negotiating Authority – Potential Vote

Appendix C: GMCB Budget, FY2020-FY2021 and Staffing

	FY2020 Budget	FY2020 Expenditures	FY2021 Budget
Total Budget	**$9,325,076**	**$7,004,998**	**$9,129,267**
General Fund	$4,050,536	$2,825,011	$4,015,799
GMCB Regulatory & Administration Fund	$5,274,540	$4,150,682	$5,113,468
Coronavirus Relief Fund	-	$29,305	-

The Green Mountain Care Board's actual FY2020 spending came in under budget due to the Board's and contractors deferred work while pivoting to work on issues related to the COVID-19 pandemic. It was also due to lower than budgeted need for Data Set Files contract, Certificate of Need contracts and personnel costs.

Appendix D: GMCB Organizational Chart



Appendix E: Board Member Biographies

The GMCB was created by the Vermont Legislature in 2011. It is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health care system improve quality while stabilizing costs.

Nominated by a broad-based committee and appointed by the Governor, the Board includes:

Kevin Mullin, Chair

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

Kevin Mullin spent the majority of his career as a small business owner. He is a graduate of Castleton University with a degree in Finance and has taught at the Community College of Vermont and served on numerous community and professional boards. He served nineteen years in the Vermont Legislature including four years in the House and fifteen years in the Senate, where he served on committees including as Chair of the Senate Education and Senate Economic Development, Housing, and General Affairs Committees. As a member of the Senate Health and Welfare Committee, he helped to write both Catamount Health and Green Mountain Care legislation. He has a deep commitment to improving the lives of Vermonters by improving health care quality and controlling health care spending.

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.

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.

Tom Pelham

Tom Pelham served as Deputy Secretary of Administration and Tax Commissioner under Governor Jim Douglas, and as Commissioner and Deputy Commissioner of Finance and Management under Governor Howard Dean. As Finance Commissioner during the creation and enactment of the Vermont Health Access Plan (VHAP), Pelham was responsible for creating the fiscal capacity to expand health insurance to Vermonters while ensuring overall statewide budgetary sustainability. He

also served as Commissioner and Deputy Commissioner of Housing and Community Affairs under Governors Madeleine Kunin and Richard Snelling. In 2002, Pelham was elected as an Independent to serve Vermont's Washington 6 District in the House of Representatives. While serving on the House Appropriations Committee, he helped restructure Vermont's Medicaid health care premium and co-pay system to better align with recipients' incomes and ability to pay. Pelham is a native Vermonter from Arlington and now resides in Berlin. He earned his B.A. from Tufts University and his M.A. from Harvard University.

Maureen Usifer

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

Leadership

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

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

Appendix F: Glossary

ACO	Accountable Care Organization
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
GMCB	Green Mountain Care Board
HRAP	Health Resource Allocation Plan
NPR	Net Patient Revenue
ORCA	Onion River Community Access
PCAG	Primary Care Advisory Group
QHP	Qualified Health Plan
RHSTF	Rural Health Services Task Force
SASH	Support and Services at Home
TCOC	Total Cost of Care
VHIE	Vermont Health Information Exchange
VITL	Vermont Information Technology Leaders
VHCURES	Vermont Health Care Uniform Reporting and Evaluation System
VUHDDS	Vermont Uniform Hospital Discharge Data Set

Green Mountain Care Board
144 State Street
Montpelier, Vermont 05620-3601
802-828-2177

www.gmcboard.vermont.gov