GREEN MOUNTAIN CARE BOARD

Annual Report

January 15, 2016

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Introduction

In 2011, the State of Vermont took the bold step of creating an independent board to oversee regulation, innovation, and evaluation of the health care system. Four years later, when it is clear that a publicly financed health care system will not be achieved in the near term, it is appropriate to ask if this progressive step towards the goal of providing affordable, accessible, quality health care to Vermonters, has delivered on its part of the legislative intent. Simply stated:

Does the regulatory framework, payment reform empowerment, and delegation of health care evaluation to an independent Board yield results that were before unattainable?

Plainly, the answer is yes. The convergence of traditional regulatory tools and the authority to evaluate and reform how we deliver and pay for Vermonters' care in a transparent, deliberative body has created meaningful checks and balances on a shifting health care system. In concert with other sectors of state government, the citizens of Vermont, and with the valued input and cooperation of the respected healthcare professionals who deliver and manage our health care resources, the Green Mountain Care Board has succeeded in slowing what has been an unsustainable rate of growth of health care costs, while working to improve and monitor quality and access to health care services.

The Board's work over the last four years has fostered these key indicators of progress:

- An independent evaluation concludes that Vermont's insurance premium rate review process has saved consumers approximately $66 million since 2012, equal to three percent of total proposed premiums.
- By holding premium increases in check, the Board has contributed to the reduction of our uninsured rate from 6.7 percent to 3.75 percent, and the child uninsured rate to below 1 percent.
- Since establishing hospital growth rate targets in 2013, the average rate of growth for hospitals has been 2.4 percent. In the prior six years, hospitals grew at an average rate of 6.3 percent. One percentage point is equal to approximately $20 million of health system costs.
- Through collaboration with stakeholders, the Board has created standards for and evaluated commercial and Medicaid Shared Savings Programs (SSPs) for Accountable Care Organizations (ACOs). These SSPs create incentives for providers to improve efficiency and quality in the delivery system across all payers.
- Federally Qualified Health Centers (FQHCs), hospitals and independent physicians have invested in population health improvement, working to build integrated systems of care across all payers.

By making healthcare more affordable and accessible, creating systems to measure quality across payers, and working closely with the administration to reduce the uninsured rate to historic lows, the Board has demonstrated that it can and is delivering on the charge it was given by the legislature in Act 48. Most importantly, the Board is fulfilling that charge and reaching its goals in a collaborative and transparent manner, notwithstanding the broad powers conferred to it in statute.

Finally, we look ahead knowing that health care is a personal matter and that the success or failure of the health care system will always be measured one patient, one provider, and one better outcome at a time. General discussions of affordability and access have little to no meaning for those that still cannot afford care. High deductible plans, unaffordable prices, and a lack of access to local care is still a reality for some people in our state. It is in these interactions that we see how far we still have to go, and how important our work is to Vermonters.

Progress in 2015

Regulation

Hospital Budgets

The Green Mountain Care Board's 2015 hospital budget review marks the completion of a three-year budget review process. In 2013, the Board implemented a set of principles to govern the hospital budget review process for federal fiscal years 2014 through 2016. The Board set a target rate for increases in hospital net patient revenue (NPR)[1] of three percent for FY 2014 through FY 2016, with an allowance for investments in health care reform. In April of 2015, the Board issued written guidance for hospitals that addressed key elements for their FY 2016 budgets:

- For FY 2016, no more than 0.6 percent of additional growth in NPR would be considered for credible health care reform proposals intended to save money and improve care over the long term.
- Net patient revenue increases from hiring physicians already practicing in the community would not be counted against the target if a hospital demonstrated that the change would be revenue neutral; dollars already being spent on health care in the community would simply move into the hospital budget.

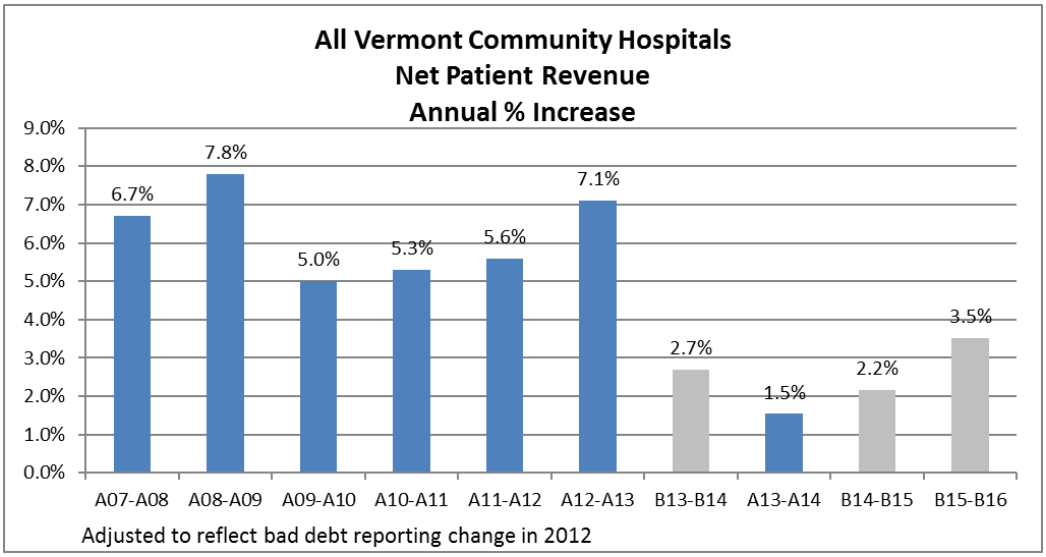
For the third straight year the Board enforced its NPR target rate, resulting in restrained hospital budget growth. The lower budgets were the result of a review process that has been improved by experience, collaboration, and the efforts of each Vermont hospital. Along with lower budgets, hospitals also chose to make investments in health care reform that were approved by the Board.

The 2016 budget submissions from Vermont's hospitals were adjusted by the Board and established a system-wide growth rate in NPR of 3.5 percent. Because individual hospital budgets can vary from year to year due to patient utilization changes, unique needs related to capital projects and the need to meet financial obligations, and program reductions or changes, individual hospitals' budgets ranged from a NPR decrease of 2.7 percent to an increase of 5.4 percent.

The following chart on the next page illustrates the increase in NPR over time:

[1] Net patient revenue includes payments from patients, government, and insurers for patient care, but does not include revenues from sources such as cafeterias, parking, and philanthropy.

Figure 1: Vermont Hospital System Net Patient Revenues Annual Percent Increase



A=Actual
B-Budgeted

Figure 2, below, illustrates the submitted and approved budgets. As part of the budget review process, the Board also examined underlying organizational changes that moved certain services into or out of a hospital's budget. Accounting for these changes, the Board determined an actual overall increase of 3.2 percent, slightly lower than the approved 3.5 percent level.

Figure 2: Budgeted Net Patient Revenue for Vermont Hospitals FY 2015-2016

Hospital	Approved 2015B	Submitted 2016B	Submitted NPR % change	Approved 2016B	Approved NPR % Change
Brattleboro Memorial Hospital	$71,284,571	$73,993,163	3.8%	$73,896,151	3.7%
Central Vermont Medical Center	$166,221,844	$173,996,286	4.7%	$173,996,286	4.7%
Copley Hospital	$59,600,484	$61,469,771	3.1%	$60,987,719	2.3%
Gifford Medical Center	$57,753,248	$56,201,733	-2.7%	$56,201,733	-2.7%
Grace Cottage Hospital	$17,980,282	$18,375,041	2.2%	$18,375,041	2.2%
Mt. Ascutney Hospital & Health Center	$48,508,891	$48,060,871	-0.9%	$48,060,871	-0.9%
North Country Hospital	$73,586,147	$76,604,320	4.1%	$76,604,320	4.1%
Northeastern Vermont Regional Hospital	$65,324,117	$68,487,300	4.8%	$68,095,300	4.2%
Northwestern Medical Center	$90,795,885	$96,172,890	5.9%	$95,697,390	5.4%
Porter Medical Center	$72,696,905	$75,581,083	4.0%	$75,581,083	4.0%
Rutland Regional Medical Center	$224,138,940	$233,248,162	4.1%	$233,248,162	4.1%
Southwestern Vermont Medical Center	$139,041,542	$144,025,568	3.6%	$144,025,568	3.6%
Springfield Hospital	$54,360,014	$55,936,500	2.9%	$55,936,500	2.9%
University of Vermont Medical Ctr	$1,087,767,762	$1,126,774,924	3.6%	$1,126,774,924	3.6%
Totals	$2,229,060,632	$2,308,927,612	3.6%	$2,307,481,048	3.5%

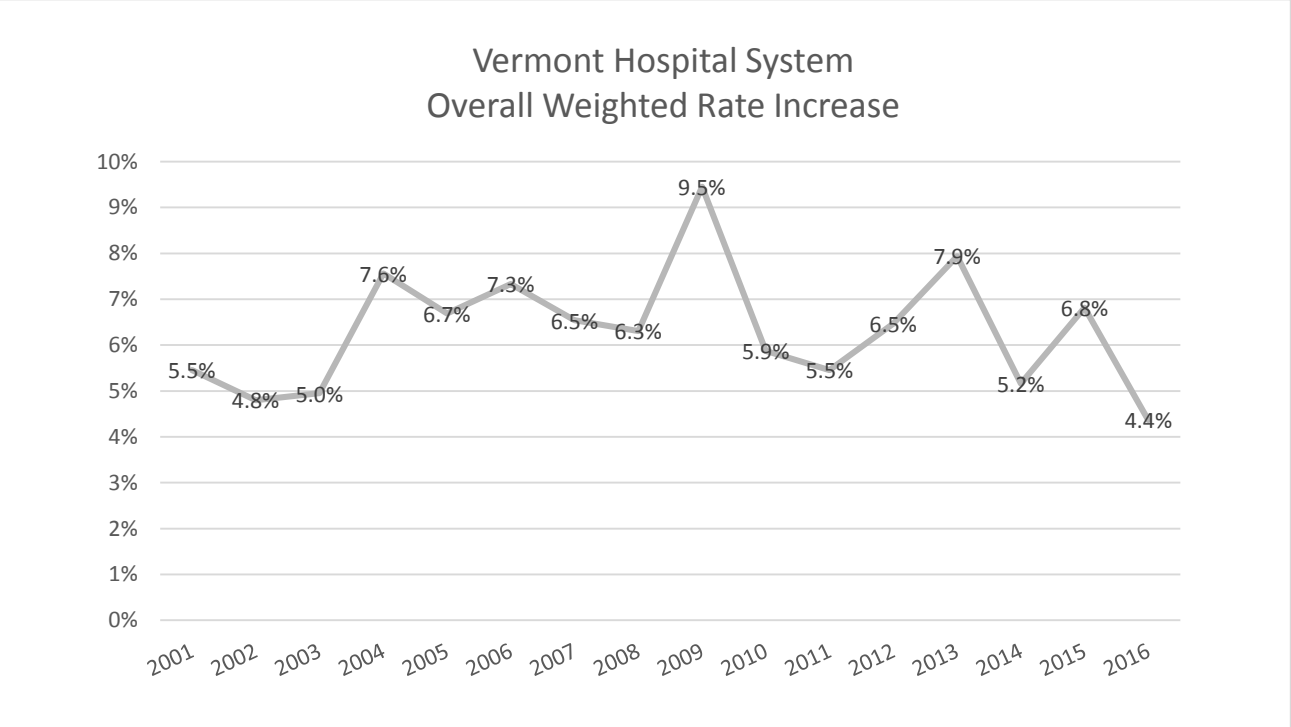
Along with curbing budget growth, Vermont's hospitals limited increases in their FY 2016 overall rates comparable to previous years. Rate changes ranged from a reduction of 8.0 percent to an increase of 6.0 percent, resulting in a weighted average increase of 4.4 percent. This compares favorably to the 5.2 percent and 6.8 percent weighted averages in FY 2014 and FY 2015, respectively. The table below shows the details of hospital rate changes:

Figure 3: Annual Overall Rate Increases for Vermont Hospitals FY 2014-2016

	Approved Rate 2014	Approved Rate 2015	Submitted Rate 2016	**Approved Rate 2016**
Brattleboro Memorial Hospital	5.8%	2.7%	-1.2%	**-1.4%**
Central Vermont Medical Center	6.9%	5.9%	4.7%	**4.7%**
Copley Hospital	6.0%	0.0%	-3.0%	**-4.0%**
Gifford Medical Center	7.6%	5.6%	5.8%	**5.8%**
Grace Cottage Hospital	6.0%	5.0%	5.0%	**5.0%**
Mt. Ascutney Hospital & Health Ctr	5.0%	3.2%	5.7%	**5.7%**
North Country Hospital	8.0%	8.3%	4.8%	**4.8%**
Northeastern VT Regional Hospital	5.6%	5.0%	5.2%	**5.2%**
Northwestern Medical Center	3.9%	6.4%	-8.0%	**-8.0%**
Porter Medical Center	6.0%	5.0%	5.3%	**5.3%**
Rutland Regional Medical Center	4.8%	8.4%	3.7%	**3.7%**
Southwestern VT Medical Center	7.2%	4.5%	3.8%	**3.8%**
Springfield Hospital	4.6%	5.5%	2.8%	**2.8%**
University of Vermont Medical Center	4.4%	7.8% *	6.0% *	**6.0% ***

The FY 2015 and 2016 approved rate for the University of Vermont Medical Center (UVMMC) refers to its "commercial ask," as explained in its budget narrative. The actual overall rate change for UVMMC was 0.0 percent for each of those years. UVMMC changed rates for certain services but the overall budget effect on prices was considered neutral (since some prices were lowered). The reimbursement effect on commercial payers, however, is estimated to increase by 7.8 percent in 2015 and 6.0 percent in 2016.

Figure 4: Vermont Hospital System Overall Weighted Rate Increase



The Board continues to prioritize its analysis and evaluation of changes to NPR by payer. In 2015, the Board made improvements to its online budgeting tool to allow in-depth "apples-to-apples" analysis across the 14 hospital budgets; previously individual hospitals did not report budget information in the same standardized format, hindering system-wide assessment. In addition, for the second year hospitals were directed to submit their Community Health Needs Assessment (CHNA) reports. The CHNA reports contain a rich amount of information about each hospital's community. While, Vermont's budget review process does not align with federal filing requirements for these reports, the Board expects that in time the information they contain will be more fully integrated and utilized in the budget process.

Early in 2016, the Board will begin to construct the next set of written hospital budget guidance for Vermont hospitals, building on lessons learned from three successful years applying a target rate of NPR growth and taking value-based payment and delivery system reform into consideration. Also in 2016, the Board will analyze initial hospital budget submissions with the express purpose of informing insurance premium rate review.

Cost Shift

In 2006, the legislature in Act 191 created the Cost Shift Task Force. The cost shift occurs when hospitals and other health care providers charge higher prices to patients who have private insurance or are uninsured to make up for lower reimbursement from Medicare, Medicaid, charity care, or bad debt. The Board is responsible for creating an annual report for the legislature that describes the cost shift, quantifies its impact, and presents reporting recommendations that include:

- A standard reporting instrument;
- Improvements to physician payer data;
- Distinctions between the amount of Vermont Medicaid and non-Vermont Medicaid payments;
- Increased transparency in reporting on "disproportionate share"—the Medicaid payments to hospitals that serve populations with especially high coverage by Medicaid.

In Act 79 of 2013, the legislature added a requirement that the annual report include "any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged." 18 V.S.A. § 9375(d)(1)(F).

In 2015, the Board found that there were no Medicaid appropriations to address the cost shift in 2016. The Board's evaluation included a review of the revenue estimates for each payer, including Medicaid. The chart on the following page shows the cost shift by payer:

Figure 5: Estimated Vermont Hospitals' Cost Shift by Payer

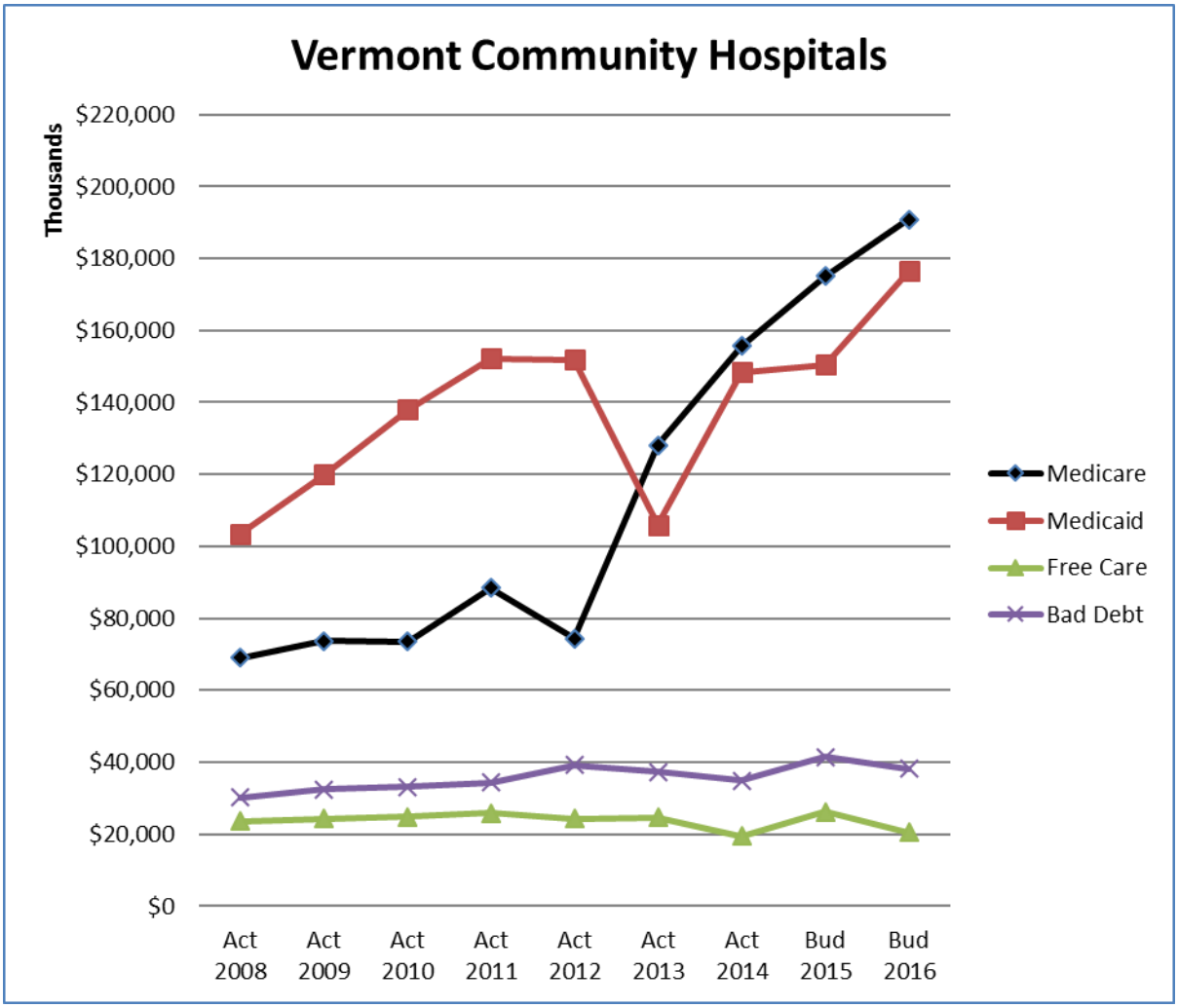
Fiscal Year	Medicare	Medicaid	Free Care	Bad Debt		*Commercial Insurance & Other
Act 2008	($69,003,712)	($103,569,366)	($23,623,972)	($30,252,980)	→	$226,450,033
Act 2009	($73,627,496)	($119,979,398)	($24,292,187)	($32,391,214)	→	$250,290,295
Act 2010	($73,515,988)	($138,016,619)	($24,806,398)	($33,076,863)	→	$269,415,868
Act 2011	($88,399,861)	($152,256,740)	($25,784,124)	($34,331,093)	→	$300,771,818
Act 2012	($74,383,192)	($151,931,648)	($24,347,367)	($39,264,676)	→	$289,926,884
Act 2013	($128,108,641)	($105,982,171)	($24,684,304)	($37,383,822)	→	$296,158,938
Act 2014	($155,622,607)	($148,344,481)	($19,370,131)	($34,885,055)	→	$358,222,274
Bud 2015	($175,004,081)	($150,468,588)	($26,141,210)	($41,473,636)	→	$393,087,516
Bud 2016	($190,902,198)	($176,505,430)	($20,475,712)	($38,158,176)	→	$426,041,516

Payer values include all hospital and employed physician services
Numbers in parentheses reflect the estimated cost of services that each payer shifted to other payers
Medicaid values include non-Vermont Medicaid of approximately 5%.
* The amount providers shifted to commercial insurance and self pays.

The Board projects that the Medicare cost shift will continue to increase in 2015 and 2016, largely the result of Medicare reimbursement changes anticipated at the federal level. The Medicaid cost shift for hospitals is also expected to increase in 2016, in part because Medicaid provider rates have not increased. Bad debt declined from 2013 to 2014 by approximately $2.5 million and after a rise is expected to stabilize. Charity care (shown on Figure 4 as Free Care) is expected to decrease from $24.6 million in 2013 to $20.5 million in 2016. In sum, while the overall cost shift continues to increase, the pace of its increase has slowed compared to past years. Slower growth in the cost shift is reflective of the reduced need to provide free care as well as the restraint in Vermont hospitals' budget submissions; on the whole, hospitals' lower rate of growth eases the pressure on commercial rates.

The following graph illustrates Vermont cost shift trends:

Figure 6: Vermont Hospitals' Cost Shift Trends



Designated Agency Budget Review

Section 28 of Act 54 of 2015 requires the Green Mountain Care Board to analyze the budget and Medicaid rates for a Designated Agency (DA) using similar criteria to those used for the Board's review of hospital budgets. This work also requires the Board to consider whether to include DAs in a potential all-payer model. A report is due to the legislature on January 31, 2016.

The Board chose Howard Center in Burlington for its trial DA budget analysis. Howard Center has shared its annual outcomes report, internal budget schedules and presentations, and its latest audit with the Board and its staff to help it assess the agency's program structure, understand its current budgeting process and chart of accounts, and determine whether its budget information can be evaluated and standardized in the same manner as hospital budget information.

With this information, staff is currently preparing a budget summary for the Board to review prior to submission of its findings to the legislature at the end of January. Howard Center is scheduled to present its current budget to the Board on January 13, 2016.

Provider Parity
Act 54 directs the Board to "require any health insurer, as defined in 18 V.S.A. § 9402, with more than 5,000 covered lives for major medical insurance to develop and submit to the Board, on or before July 1, 2016, an implementation plan for providing fair and equitable reimbursement amounts for professional services provided by academic medical centers and other professionals." The Board may approve, modify, or reject each insurer's plan and "shall require any Vermont academic medical center to accept the reimbursements included in the plan, through the hospital budget process and other appropriate enforcement mechanisms." In 2016, the Board will provide guidance to the qualifying insurers on process and content for submitting the required plans on or before July 1. The Board has discussed the provider parity study at several public Board meetings. Further, Board staff has held preliminary discussions on the report requirements with insurers.

Certificate of Need

Vermont law requires that a health care facility must obtain a Certificate of Need (CON) from the Board, which has jurisdiction over all CON applications filed on or after January 1, 2013, prior to developing a new health care project in the state. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure the provision and equitable allocation of high quality health care services and resources to all Vermonters.

In 2015, the Board saw increased activity over the first two years of its CON jurisdiction. At hearings open to the public, the Board approved and issued eight CON applications.

The Board approved:

- CCK Holdings, LLC and Redstone Villa, LLC's purchase of Redstone Villa Nursing Home in St. Albans (projected cost of $555,000)
- The Visiting Nurse Association of Chittenden and Grand Isle Counties' request to construct a new 21-bed Vermont Respite House in Colchester (projected cost of $7,920,054)
- Green Mountain Realty LLC and Green Mountain Nursing and Rehabilitation LLC's request to purchase the real estate and operations of Green Mountain Nursing Home, a 73-bed facility in Colchester (projected cost of $4,035,514), in conjunction with White River Property LLC and Brookside Nursing and Rehabilitation Center LLC's request to purchase the real estate and operations of Brookside Nursing Home, a 67-bed facility located in White River Junction (projected cost of $3,958,764)
- The University of Vermont Medical Center's (formerly Fletcher Allen Health Care) request to construct a seven-story inpatient building above the existing emergency department parking lot (projected cost of $187,297,729). The Board issued a CON with special conditions. Board member Ramsay concurred with the decision issuing the CON but disagreed with the imposition of the conditions; Board member Hogan filed a separate dissenting opinion
- Vermont Open MRI, LLC's request to continue offering MRI imaging services with a Philips Panorama 0.6T Open MRI machine (operating expenses exceed $500,000). The Board deferred a decision on the applicant's proposed purchase and installation of a Hitachi Oasis 1.2T MRI machine in 2017
- Southwestern Vermont Medical Center's request to purchase and install a replacement linear accelerator (projected cost of $3,949,294)
- Northwest Medical Center's request to construct an attached two-story medical office building (projected cost of $2,595,250)
- Northwest Medical Center's request to construct new space and renovate existing space to combine its medical/surgical and intensive care units and to convert all rooms to single occupancy; the hospital will

additionally redesign its lobby to create a centralized entrance and registration area and an area for specialty clinics (projected cost of $20,632,359)

The Board denied one CON application:

- Attuned Living and Eating Center, LLC's (d/b/a Green Mountain at Fox Run) request to operate an outpatient eating disorder treatment program for women with binge eating disorder (BED) in Ludlow

CON applications have been filed and are under review for the following CONs:[2]

- Genesis Healthcare, Inc.'s proposed purchase of five Vermont nursing homes located in Bennington, Berlin, Burlington, Springfield and St. Johnsbury (proposed project cost of $39,137,496)
- ACTD LLC's request to own and operate Green Mountain Surgery Center, an ambulatory surgical center in Colchester (projected cost of $7,423,283)
- Visiting Nurse Association and Hospice for Vermont and New Hampshire, Inc.'s request to purchase an office building in White River Junction to house its administrative offices (projected cost of $4,244,000)
- Southwestern Vermont Medical Center's request to replace the boiler plant on its Bennington Campus (projected cost of $3,275,000)

In addition, the Board is considering Copley Hospital's request to construct a new surgical suite, to renovate its ambulatory care unit and to make modifications to its operating rooms (projected cost of $12,500,000). A hearing was held on the application on December 1, 2015; the Board must issue a decision within 120 days from the close of the application (October 16, 2015).

The Board has asserted jurisdiction over, but has not yet received CON applications for, the following projects:

- North Country Oncology Center's proposed construction of a new vault for a second linear accelerator;
- Vermont Veterans' Home's request to renovate its kitchen;
- Northwestern Vermont Regional Hospital's request to replace an MRI;
- The proposed transfer of a 99% interest in the Franklin County Rehabilitation Center; and
- Barre Gardens Holding, LLC and Barre Gardens Nursing and Rehab, LLC's proposed purchase of Rowan Court Nursing Home.

The Board in 2015 also declined review of ten proposed projects that fall outside jurisdictional parameters set forth in statute. The Board retains ongoing jurisdiction over the implementation of 16 previously approved CON projects.

[2] One CON application is pending but currently inactive at the request of the applicant: the University of Vermont Medical Center's request to acquire commercial buildings and open land in South Burlington, filed in 2014 (projected cost of $51 million).

Insurance Rates

Since January 1, 2014, the Green Mountain Care Board has exercised primary responsibility over major medical health insurance rate review. In its role as regulator, the Board must approve, modify, or disapprove a proposed rate filing within 90 days of its submission. The Board contracts with Lewis & Ellis Actuaries and Consultants (L&E) to provide technical support and assist the Board in determining whether proposed rates are affordable, promote quality care, are fair and equitable, and do not jeopardize insurer solvency. In addition to actuarial assistance, the Board takes into consideration the analysis and opinion of Department of Financial Regulation regarding insurer solvency.

The Board has seen a steady decline in the number of filings since 2014. The decline is largely attributable to changes spurred by the Affordable Care Act—Vermont consolidated the individual and small group markets into one merged market— and implementation of Vermont Health Connect (VHC), the state's online health insurance marketplace, which made coverage more readily available to Vermonters. The Board reviewed 41 filings in 2012 and 31 in 2013; in 2014, the number fell to 18; in 2015, the Board reviewed only 12 filings.

As in the past two years, the most significant rate filings reviewed by the Board, based on the number of Vermonters affected, were for the Vermont Health Connect plans. After public hearings on two consecutive days in July, the Board reduced an 8.6 percent rate increase proposed by Blue Cross and Blue Shield of Vermont to 5.9 percent, and a 3.0 percent increase proposed by MVP Health Plan, Inc. to 2.4 percent.

Also in 2015, the work funded by the federal Cycle II Rate Review Grant, transferred to the Board by the Center for Consumer Information & Insurance Oversight (CCIIO) at the start of 2014, came to an end. An independent evaluation of Vermont's use of the grant funds and its impact on the rate review process concludes that Vermont's review process has saved consumers approximately $66 million since 2012, or three percent of total proposed premiums. In addition, the evaluation concludes that Vermont's review process is efficient, fair and thorough, and that the Board's rate review website, which captures rate information and activity in a reader-friendly format, is meeting the needs of Vermont consumers.

The following chart on the next page outlines the Board's rate review decisions during 2015:

Figure 7: Rate Review Decision During 2015

2015 Rate Filings						
Decision Date	**Docket No.**	**Company Name**	**Filing Name**	**Proposed Rate Change**	**Approved Rate Change**	**Change in Proposed Rate vs. Approved Rate**
4/30/2015	001-15rr	MVPHIC	3Q15/4Q15 Large Group EPO/PPO	3Q15 HDHP 3.1%, NHDHP 17.5%, 4Q15 HDHP 3.5%, NHDPD 18%	3Q15 HDHP 2.0%, NHDHP 16.4%, 4Q15 HDHP 2.4%, NHDPD 16.9%	-1.1%
	002-15rr	MVPHIC	3Q15/4Q15 Grandfathered Small Group EPO/PPO	3Q15 4.8%, 4Q15 5.30%	3Q15 3.5%, 4Q15 4.0%	-1.3%
5/1/2015	003-15rr	BCBSVT	3Q15 Large Group Rating Program-Annual	N/A (Factor Filing)	N/A	N/A
5/5/2015	004-15rr	TVHP	3Q15 Large Group Rating Program-Annual	N/A (Factor Filing)	N/A	N/A
5/6/2015	005-15rr	MVPHP	3Q15/4Q15 Large Group HMO	3Q15 5.50%, 4Q15 6.10%	3Q15 4.40%, 4Q15 5.0%	-1.1%
7/27/2015	006-15rr	Cigna Health & Life Insurance Company	2015 Large Group Manual Rate	0.50%	-2.00%	-2.50%
8/13/2015	007-15rr	MVPHIC	2016 Exchange Filing	3.00%	2.40%	-0.60%
8/13/2015	008-15rr	BCBSVT	2016 Exchange Filing	8.60%	5.90%	-2.70%
8/31/2015	009-15rr	4 Ever Life Insurance Company	New Product: Global Health Guard Ex-Patriot Rate Filing	N/A (New Product)	N/A (New Product)	N/A (New Product)
11/16/2015	010-15rr	MVPHIC	1Q/2Q16 Large Group EPO/PPO	1Q16 9.2%, 2Q16 9.1%	1Q16 8.8%, 2Q16 8.5%	1Q16 -0.4%, 2Q16 -0.6%
11/16/2015	011-15rr	MVPHIC	1Q16/2Q16 Grandfathered Small Group	1Q16 2.7%, 2Q16 2.3%	1Q16 2.4%, 2Q16 1.9%	1Q16 -0.3%, 2Q16 -0.4%
12/24/2015	012-15rr	MVPHIC	2015 Agriservices	27.4%	0.00%	-27.40%

Lastly, Act 54 requires that the Board, in consultation with the Department of Financial Regulation, "analyze the projected impact on rates in the large group health insurance market if large employers are permitted to purchase qualified health plans through the Vermont Health Benefit Exchange beginning in 2018." Act 54 of 2015, § 15. The analysis must include the expected impact on employee premiums if the market were to transition from experience to community rating. Board staff is presently working with its actuaries to collect and analyze insurer data for this report, and anticipates issuing its analysis and findings in early 2016.

Health Information Technology

Act 54 refined the Board's existing authority concerning Vermont's health information technology plan (HIT Plan) and health information exchange connectivity criteria, and charged the Board with overseeing the budget and core activities of Vermont Information Technology Leaders (VITL). As explained below, the Board in 2015 began a transparent regulatory process for the interrelated tasks of VITL oversight and review of the upcoming revisions to the HIT Plan in 2016.

Act 54 directs the Board to "[a]nnually review the budget and all activities of VITL and approve the budget, consistent with available funds, and the core activities associated with public funding." 18 V.S.A. § 9375(b)(2)(C). These core activities must include "establishing the interconnectivity of electronic medical records held by health care professionals and the storage, management, and exchange of data received from such health care professionals, for the purpose of improving the quality of and efficiently providing health care to Vermonters." *Id.* The Board's review must take into account VITL's responsibilities under Section 9352 of Title 18, as well as the availability of funds required to support those functions. *Id.*

Act 54 also clarifies that the Secretary of Administration (or the Department of Vermont Health Access (DVHA) as its designee) shall exercise its existing and ongoing authority to "enter into procurement grant agreements with VITL" after the Board "approves VITL's core activities and budget." Act 54, § 9 (amending 18 V.S.A. § 9352(c)). This change recognizes the interdependent roles of the Board and the Administration in shaping the state's relationship with VITL: The Board's oversight is intended to provide strategic guidance and policy parameters within which the Administration, through DVHA, can operationalize that relationship via annual procurement grant agreements with VITL.

Finally, Act 54 clarified two other Board tasks related to HIT. First, it makes clear that the Board must consult with and consider recommendations from VITL in the course of reviewing and approving Vermont's HIT Plan. Second, it charges the Board with reviewing and approving the criteria developed by VITL for providing connectivity to the health information exchange and with issuing a written order within 90 days of any decision. *Id.* See 18 V.S.A. § 9375(b)(2)(A), (B). In 2015, VITL recommended leaving unchanged the connectivity criteria it developed and the Board accepted in 2014.[3]

[3] The connectivity criteria are available at:
http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB_guidance_connectivity_criteria%20withJ_App_A%282%29.pdf

GMCB review of VITL and the Vermont HIT Plan

Basic principles

- The Board's processes will be transparent and will incorporate public input.
- The Board will review VITL's budget and core activities in order to determine whether they reflect a strategy and priorities consistent with the state's health care reform goals and the HIT Plan. The Board will not direct the technical details of VITL's work or the details of VITL's contractual relationship with the state.
- The Board's review process must be structured and timed in order to assist DVHA and VITL in negotiating timely, effective grant agreements each year.
- The process must result in Board decisions that are sufficiently clear to enable VITL to do its work and DVHA to support that work without requiring repeated clarification or intervention by the Board.

Review of VITL's budget and activities

The Board will review VITL's budget and activities through a series of open board meetings, soliciting public and stakeholder input at each step consistent with the Board's standard practice and culminating in a written decision. VITL and DVHA, as the entities who must operationalize any decisions by the Board, will be present for and actively involved in all public meetings on this topic. As with all of the Board's open meetings, other stakeholders and individual Vermonters are welcome and encouraged to attend, participate, and offer input. The Board has two key goals for this process:

- Provide guidance that is sufficiently clear and timely to enable VITL and DVHA to conclude their annual contracting process by July 1 each year; and
- Ensure that VITL's budget and activities align with the state's health care policy goals, within the funding made available by the Legislature.

The Board will aim to issue its decision no later than April 1, 2016. Based on input from DVHA and VITL, this deadline should synchronize with their contractual negotiations, and issuing a decision beyond that date would jeopardize their ability to finalize the grant agreements by July 1, 2016.

In order to meet the April 1 deadline, especially in this initial year of review, the Board devoted public meeting time in October, November, and December 2015 to educate itself and the public about the review process, the parties, and the issues. At its December 17, 2015 meeting, DVHA and VITL presented information to the Board reflecting their progress to date on VITL's budget for state fiscal year (SFY) 2017. The parties will present to the Board again in early February 2016, once they have begun more concrete negotiations on the SFY 2017 agreements, affording the Board adequate time to gather public input, re-engage with DVHA and VITL on open questions, and issue a decision by April 1.

HIT Plan review process

In addition to its new regulatory role with respect to VITL, the Board must "[r]eview and approve Vermont's statewide Health Information Technology Plan . . . to ensure that the necessary infrastructure is in place to enable the State to achieve the principles expressed in section 9371 of this title." 18 V.S.A. § 9375(b)(2)(A). DVHA, the entity charged with developing the HIT Plan, has convened a steering committee, including a

member of the Board's staff, that has been working over the past year to create the next iteration of the HIT Plan.[4]

Because the HIT Plan governs the state's efforts to implement and improve "integrated electronic health information infrastructure," 18 V.S.A. § 9351(a), the Plan is a resource to inform the Board's decision-making around VITL's budget and activities. Therefore, the Board has worked with the HIT Plan steering committee and VITL to synchronize its review of the HIT Plan with its review of VITL's budget and activities.

To that end, the steering committee made an initial presentation to the Board outlining the key elements and initiatives of the revised HIT Plan on December 17, 2015. The committee intends to release a draft of the plan for public review and comment on January 15, 2016, and will provide an update at the Board's January 21, 2016 public meeting. The committee will present another draft of the Plan at the Board's February 4 meeting and will return submit its final version to the Board at its February 25 meeting. This timeline will enable the Board to use the information developed by the steering committee both to make a timely decision regarding the HIT Plan and to inform its decision-making regarding VITL.

[4] The current HIT Plan, which predates the Board's existence, is available here: http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf

Innovation

Payment & Delivery System Reform

The Green Mountain Care Board's Payment and Delivery System Reform program is designed to move from volume-based payments (e.g., paying fee-for-service) to value-based payments that reinforce and encourage innovative delivery system reforms. The overarching goals are to improve the health of Vermonters, improve quality of care, and moderate the rate of growth in health care costs.

Continued Oversight of Accountable Care Organizations and Development of Shared Savings Programs
Shared Savings Programs (SSPs) are formal arrangements between insurers and providers that require the sharing of savings resulting from improvements in cost, quality, and access for people who are served by participating providers and covered by participating insurance products (known as "attributed" people). Vermont is testing the theory that sharing savings between insurers and providers will motivate continuous improvements in care and reductions in cost. Throughout 2015, the second year of Vermont's Medicaid and Commercial Shared Savings Programs, focus shifted from program design to monitoring, refinement, evaluation, and care delivery transformation.

Blue Cross and Blue Shield of Vermont (BCBSVT), Medicaid, and Vermont's three Accountable Care Organizations (ACOs)[5]—OneCare Vermont, Community Health Accountable Care (CHAC), and Vermont Collaborative Physicians (VCP)[6]— participate and share savings in Vermont's SSPs[7]. Consistent with numbers seen in 2014, in 2015 more than 150,000 Vermonters were attributed to Commercial, Medicaid, or Medicare SSP-participating providers.

The identification of quality and financial measures is key to SSP implementation—how ACOs perform helps to determine the amount of shared savings they receive from the insurers. In 2015, a multi-stakeholder work group identified and recommended that the Board approve updated SSP measures of quality, patient experience, cost, and utilization for the Commercial SSP for 2015 and 2016. After discussion and public comment, the Board approved the recommended 2015 updates and will review the 2016 recommendations in early 2016.

In October 2015, the Board received reports on ACO SSP financial and quality measures for Year 1 (2014). Combined, the two participating ACOs in the Medicaid SSP (OneCare Vermont and CHAC) saved approximately $14 million against their projected expenditure target for an aggregated attributed population of 64,500 lives; the maximum savings that could be earned by the two ACOs combined was approximately $7 million, prior to the application of the quality requirements. When quality results were considered, OneCare Vermont earned 100 percent of the maximum savings, while CHAC earned 85 percent. As a result, each of the two ACOs earned an estimated $3.3 million in Year 1 of the Medicaid SSP, reflecting quality results and the number of attributed lives in each ACO.

[5] ACOs are groups of providers that agree to work together to improve care and reduce costs for the people that they serve.
[6] OneCare Vermont and Community Health Accountable Care participate in Vermont's Medicaid and Commercial Shared Savings Programs, as well as the Medicare Shared Savings Program. Vermont Collaborative Physicians participates in Vermont's Commercial Program and the Medicare Program.
[7] MVP Health Care has been an active participant in developing the commercial program, and plans to participate when a sufficient volume of its members are included in the program.

By contrast, none of the three ACOs participating in the Commercial SSP, with an aggregated total of 40,139 attributed lives, achieved savings in Year 1. The use of expenditure targets based on health insurance premiums established before the attributed population could be identified resulted in an underestimation of costs for the population ultimately attributed to one of the three ACOs. Had the ACOs achieved Commercial SSP savings, all would have been eligible for a percentage of the savings based on their quality results.

Vermont's ACOs performed above the national median for most of the measures with national benchmarks. For a number of the measures, the ACOs performed above the 75th percentile. Results varied across ACOs; rates for some of the measures could be improved even though the ACOs performed better than the national benchmarks.

At this early stage of the program, Year 1 results should be interpreted with caution, and limitations acknowledged. The ACOs have different populations and started at different times. Because there was no historical data for Commercial SSP members prior to their enrollment dates, some measures with look-back periods did not have adequate denominators, which made establishing accurate financial targets difficult. Data collection and analysis was challenging, despite an impressive collaboration among the three ACOs in clinical data collection. There also remains substantial potential for improvement in the patient experience measures.

The 2014 results for the Commercial and Medicaid SSPs are available on the Board's website: http://www.gmcboard.vermont.gov/PaymentReform.

The Interface Between the Vermont Blueprint for Health and ACOs

Launched in 2003 as a Governor's Initiative and considered the foundation for Vermont's payment and delivery system reforms, the Blueprint for Health serves the majority of Vermont residents by providing them with advanced primary care in the form of Patient Centered Medical Homes (PCMHs), multi-disciplinary support services through Community Health Teams (CHTs), and a network of self-management support programs. All major insurers in Vermont participate in Blueprint payment reforms designed to support the PCMHs and CHTs in their efforts to achieve delivery system reform through the transformation of care processes.

A key question is how the Blueprint, Vermont's ACOs, and the newly-established SSPs will be optimally integrated. As described in the October 1, 2014 report to the Vermont Legislature entitled *Blueprint for Health Report: Medical Homes, Teams and Community Health Systems*, significant efforts are underway to coordinate the activities of the Blueprint and the three ACOs in each of the state's regions.

Unified Community Health Systems to Support Care Transformation

In 2015, Blueprint and ACO leadership worked together in each regional Health Service Area to establish a single unified health system initiative called the "Regional Community Collaborative." These regional systems include medical and non-medical providers, a shared governance structure with local leadership, a focus on improving the results of ACO quality measures, support for the introduction and extension of promising care transformation models, and guidance for PCMH and CHT operations. The community collaboratives adopted governance structures, developed charters, prioritized improvement opportunities based on unified performance reports, and agreed on quality improvement initiatives.

Unified Performance Reporting and Data Infrastructure

Insurers and Blueprint and ACO leaders continue to co-produce performance reports that show results for quality, cost and utilization measures, as well as developing reporting standards that support care transformation and other priorities of the Unified Community Health Systems. The goal is to develop a

collaborative, advanced data infrastructure that can support a wide range of data needs for Vermont's health system.

Payment Modifications

During 2015, targeted modifications to current Blueprint primary care practice PCMH and CHT payments were adopted. From July 2015 to January 2016 implemented changes included increasing CHT payments to provide Vermonters with greater access to multi-disciplinary preventive services; increasing PCMH payments to maintain practice participation and encourage the highest level of medical home recognition; and adding outcomes-based payments tethered to performance on ACO quality measures and improvements in avoidable utilization.

Exploration of an All-Payer Model and Medicare Waivers

Act 54 directs the Board and the Agency of Administration (AOA) to jointly explore an all-payer model. With the Shared Savings Program and the Blueprint for Health as a foundation, the Board and the AOA are investigating how a model of two-sided risk and capitation-style payments to ACOs could better facilitate delivery system reform in the state and lead to an enhanced, more accessible primary care system in Vermont. The state is in discussions with the Center for Medicare and Medicaid Innovation (CMMI) about a possible agreement for waivers to allow Medicare, along with commercial payers and Vermont Medicaid, to participate in the Vermont value-based payment system described above. Medicare waivers cannot and will not reduce health care coverage or the benefits for Medicare recipients.

As the Board has demonstrated, its work to transform the health care system will be shaped by collaboration and guidance from Vermont's health care providers, payers, and citizens. In spring of 2015, Board staff convened a group of stakeholders which included the state's three ACOs, the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, Bi-State Primary Care Association, Blue Cross Blue Shield of Vermont, MVP Health Care, and DVHA; the group was thereafter expanded to include representatives from Vermont Legal Aid's Office of Health Care Advocate, Home Health Agencies, and Designated Mental Health Agencies. The purpose of convening this group was to discuss and outline the governance structure, provider payment policies and related parameters for an all-payer ACO model in Vermont. The group developed and drafted a framework document that is intended to be presented to the Board for potential use: first, as the basis for the design and operations of an integrated accountable organization operating within an all-payer ACO model; and second, to inform the Board and the state's CMMI waiver negotiating team regarding how an all-payer model might be implemented in Vermont. The framework was completed in December 2015 and will be presented to the Board, AOA, legislature and other stakeholders in early 2016.

Other Payment and Delivery System Reform Initiatives

In addition to the programs described above, the Board supports the following initiatives:

- Rutland Regional Medical Center and other Rutland providers have implemented a project coordinating care for congestive heart failure (CHF) patients, and combining payment for that care. The Episodes of Care (EOC) project currently includes approximately 80 Medicare beneficiaries. Project results show that all-cause 30-day readmission rates for participants were held to 12.5 percent in 2014, approximately half of historical readmission rates of 24 to 25 percent. Rutland has expanded the project to include people with chronic obstructive pulmonary disease (COPD), and engaged additional providers and organizations in its efforts to improve care and health outcomes.
- In St. Johnsbury, primary care providers and specialists from Dartmouth-Hitchcock Medical Center's Norris Cotton Cancer Center participated in the Vermont Oncology Project (VOP), the first payment reform pilot supervised by the Board, to test promising interventions to improve provider

communications, collaboration, and coordination of care for patients diagnosed with cancer. A qualitative evaluation of the VOP was completed in 2015; its findings document the evolution of VOP goals from a focus on improving care quality and reducing costs for individuals in relatively advanced stages of cancer to a focus on community-based coordination of care for all cancer patients using a chronic care model. The evaluation reflects changes in the definition of the target population, shifts in the roles of key stakeholders, and an increased dependence on non-electronic information sharing methods. Results from a quantitative evaluation are expected in the spring of 2016.

- The Board helped facilitate discussions between surgeons and hospitals to encourage statewide participation in the American College of Surgeons National Surgical Quality Improvement Program, a nationally validated program that supports hospitals and surgeons in measuring and improving the quality of surgical care. Led by the surgeons, the Vermont Program for Quality in Health Care, and the Vermont Association of Hospitals and Health Systems, the initiative is financially supported by the Vermont Health Care Innovation Project (VHCIP).
- Act 79 of 2013 requires the Board to establish a Prior Authorization Pilot Program to determine the impact on primary care of eliminating insurer prior authorization requirements for certain procedures and services. Three of the state's major insurers have worked with Board Member Allan Ramsay, M.D. and Board staff to implement a pilot program that could determine the effect of reducing the burden of prior authorization on health care costs and provider satisfaction. Pilot programs were developed for two types of services—advanced imaging and drugs—and began on May 1, 2015. The Prior Authorization Study Group meets every three months to evaluate technical issues, cost implications, and overall results of the pilot. The pilot will be conducted for one year.

Claims Edits

The Board is tasked under Vermont law with "develop[ing] a complete set of standardized edits and payment rules based on Medicare or on another set of standardized edits and payment rules appropriate for use in Vermont." 2013 Acts and Resolves No. 79, Sec. 5b. An edit, often referred to as a "claims edit," is an adjustment made by a payer to the procedure codes providers use to describe and bill for services and is used by the payer to correct errors or inconsistencies in the bills processed by payers and are used to reject some claims. As a very simple example, a payer might impose a claims edit that precludes payment if a provider bills for services related to pregnancy for a male patient. Each payer's system of claims edits is, in fact, extensive and complex, and often comprises proprietary intellectual property developed and customized by a software vendor on behalf of a payer.

The Board has been working with the private payers, Medicaid, the Vermont Association of Hospitals & Health Systems, the Vermont Medical Society, Bi-State Primary Care, the Health Care Advocate, McKesson, Medicare, the American Medical Association, and others since receiving this task during the 2013 legislative session. The task of creating a complete set of standardized edits has proven difficult, due to the proprietary nature of each payer's system, the differences between the edits used by public and private payers, and other factors. Nonetheless, the stakeholders have worked diligently with the Board to find ways to eliminate unnecessary variation among edits across payers.

During the 2015 session, the Board, on behalf of the stakeholder group, proposed legislation that would have replaced the charge to develop a complete, standardized set of edits with a process aimed at harmonizing those specific edits identified as causing significant administrative burden. While that legislation did not move forward, the Board and stakeholder group spent the balance of 2015 implementing such a process. The group began with a document from a 2012 legislatively mandated workgroup report that listed 10-15 "problem edits." Over the course of several meetings, the group analyzed each "problem edit" and

determined which of the predominant private insurers (MVP, BCBSVT, and Cigna) and Medicaid was out of alignment with the others for each edit. The group determined that for eight of the "problem edits," all four insurers were in alignment; the other seven were identified as action items that the group will continue working on in 2016.

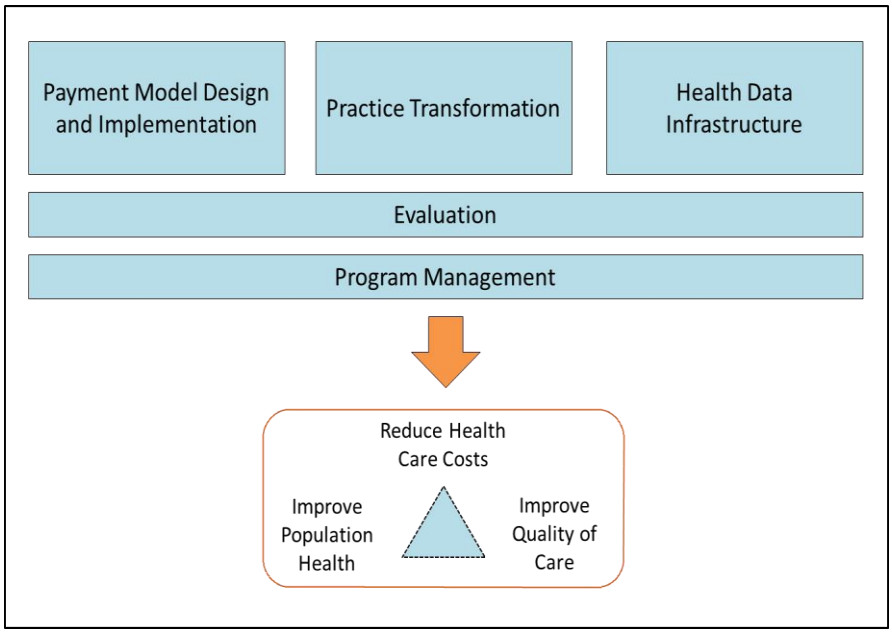
Vermont Health Care Innovation Project (VHCIP)

The Green Mountain Care Board continues to play a central role in Vermont's three-year, $45 million State Innovation Model (SIM) grant, also known as The Vermont Health Care Innovation Project (VHCIP). The SIM Initiative was created by the Patient Protection and Affordable Care Act and is administered by the Center for Medicare & Medicaid Innovation. The Board, AOA and DVHA share responsibility for implementing Vermont's SIM grant, which launched in 2013. The Board's Chair serves as a co-chair for the VHCIP Steering Committee and is a voting member of the Core Team, the project's decision-making body.

Vermont is using SIM funds to increase provider-level accountability, monitoring and assessment for cost and quality; sharing of health information across settings; and management of population health. To achieve these outcomes, VHCIP is supporting the design, implementation, and evaluation of a myriad of activities that build upon the State's health insurance reforms and experiences gained as an early adopter of innovative delivery and payment models.

Overall, VHCIP seeks to use SIM funds to strive towards better care, better health, and lower costs. VHCIP is working to advance the Triple Aim through a series of tasks that fall under five major focus areas:

Figure 8: VHCIP Focus Areas



- **Payment Model Design and Implementation**: Supporting creation and implementation of value-based payments for providers in Vermont across all payers.
- **Practice Transformation**: Enabling provider readiness and encouraging practice transformation to support creation of a more integrated system of care management for Vermonters.
- **Health Data Infrastructure**: Supporting provider, payer, and state readiness to participate in alternative payment models by building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.
- **Evaluation:** Assessing whether program goals are being met.
- **Program Management and Reporting:** Ensuring an organized project.

VHCIP **payment model design** initiatives include:

- Medicaid and Commercial ACO Shared Savings Programs
- Medicaid episode-based payment program
- Alignment with expanded pay-for-performance in the Blueprint for Health advanced primary care initiative
- Medicaid Value-Based Purchasing (current Hub & Spoke program to improve care for people with opioid dependence, planned Home Health Prospective Payment System, and planned value-based purchasing for Mental Health and Substance Use services)

VHCIP **practice transformation** initiatives include:

- Accountable Communities for Health
- Integrated Communities Care Management Learning Collaborative to support integration of health and community services for people with complex needs
- Provider sub-grant program piloting innovative practice models throughout the state
- Regional collaboratives that bring together local leadership from the Blueprint, ACOs, and health and community organizations to improve care
- Health workforce planning, monitoring, and modeling activities

VHCIP **health data infrastructure** initiatives include:

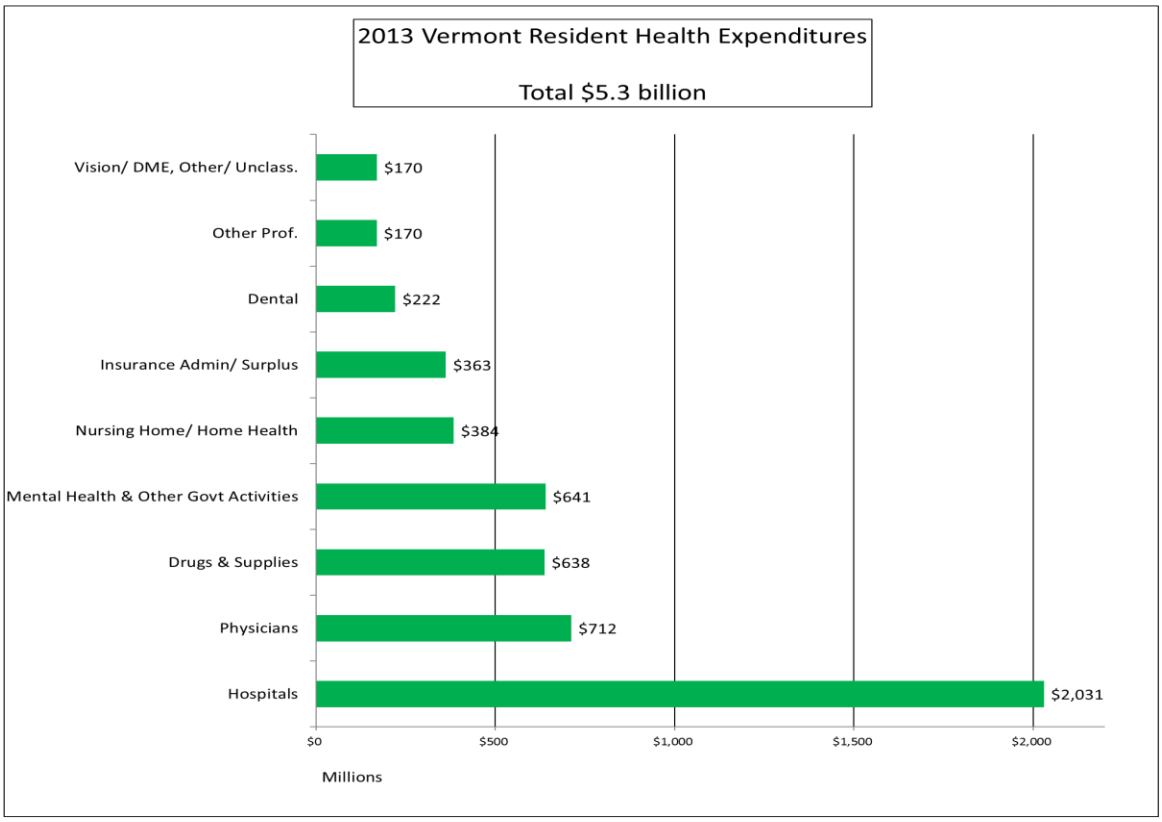
- Expanding connectivity to the Vermont Health Information Exchange (VHIE), including gap analysis and remediation for performance measurement, and availability of data extracts
- Improving quality of data flowing into the VHIE
- Development of a statewide telehealth strategy, and investment in telehealth pilots
- Expanding Electronic Medical Record usage
- Developing and populating a data warehouse to support the work of Designated Mental Health and Specialized Service Agencies
- Developing and implementing electronic tools to support care management (shared care plans, uniform transfer protocols, event notification)
- Developing a statewide, publically available health data inventory
- Ongoing planning to support health information exchange

Evaluation

Vermont Health Care Expenditure Analysis

Since 1993, Vermont has created an annual Health Care Expenditure Analysis that summarizes health spending two ways: by resident, which includes expenditures made on behalf of Vermont residents regardless of where the health care was provided; and by provider, which includes all revenue received for services by Vermont providers regardless of where the patient lives. The FY 2013 Health Care Expenditure Analysis provides the most recent official data; the FY 2014 Analysis is under development and expected to be released in early 2016.

The chart below illustrates health care spending on behalf of Vermont residents for 2013, including care they may have received outside Vermont:



A significant enhancement for the FY 2014 Expenditure Analysis will be to integrate claims data from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) to produce a more accurate and detailed analysis of Vermont resident spending on health care. With the current ability to examine over 65 percent of spending for Medicare, Medicaid, and Medicare by member demographics, geographic regions, and age profiles, it is expected that inclusion of the VHCURES data will enable Board staff to better monitor and forecast Vermont health care spending.

Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

Many states, particularly in New England, have statutes that either provide for or mandate the development of a database, commonly known as an all-payer claims database, that collects health care data from public and private sources. In Vermont, 18 V.S.A. § 9410 requires that the Green Mountain Care Board establish and maintain a database to support health care regulation and reform efforts. Known as the Vermont Health Care

Uniform Reporting and Evaluation System, or VHCURES, Vermont's database comprises approximately 90 percent of commercially insured residents and 100 percent of Medicare and Medicaid beneficiaries. VHCURES is the state's primary means to conduct population-based analyses of the health care system, which in turn support a broad spectrum of regulatory and reform efforts. In close collaboration with the Vermont Department of Health (VDH), the Board also oversees the Vermont Uniform Hospital Discharge Data Set, which compiles information from fourteen of Vermont's general acute care hospitals.

Over the past year, the Board has made substantial operational improvements to VHCURES, including the implementation of new systems for data request processing, data release tracking and reporting, and has further refined the forms and documentation used to manage the distribution of data collected. Board staff has made progress drafting an amended VHCURES rule in preparation for its formal promulgation.

During 2015, the Board utilized VHCURES in a number of analytic activities:

- Annual health expenditure analysis
- Evaluation of existing payment reform and innovation models that includes an assessment of ACO performance against cost and quality measures
- Modeling of payment reforms
- Several special studies involving both Board staff and analytic contractors

The Vermont Blueprint for Health continues its contract with the analytic division of Onpoint Health Data to utilize VHCURES to develop a variety of reports, including practice-level clinical quality summaries. This analytic work, which is integral to advancing and evaluating primary care reform and to furthering payment reform initiatives, depends on VHCURES. The Blueprint also continues its work with RTI International to evaluate the multi-payer advanced primary care practice (MAPCP) demonstration. Vermont is one of five states that participate with the Centers for Medicare & Medicaid (CMS) in this type of demonstration effort that focuses on disease management and prevention.

Also in 2015, the Agency of Administration contracted with Wakely Consulting Group to utilize VHCURES data to begin a study on universal primary care that will extend into 2016. In addition to the AOA, nine other Vermont state agencies have entered into agreements with the Board to use VHCURES data.

The Data Governance Council is a committee of the Board working to develop strategies to increase the utility of health data resources to state and health care industry stakeholders, while ensuring that appropriate protections of sensitive information are in place. The Council meets monthly in public and at its 2015 meetings addressed topics relating to data quality, privacy, security, and financial sustainability. Meeting materials and Council agendas can be viewed on the Board's website:
http://www.gmcboard.vermont.gov/VHCURES/Data_Governance_Program/meetings

Health Care System Analysis & Reporting

In 2015, the Board applied its data and analytical resources to measuring and analyzing trends in health care spending and other health care system metrics. Working with Truven Health Analytics, the Board updated its annual Health Care Expenditure Analysis by incorporating information from VHCURES. This information allowed for tracking of spending, utilization, and enrollment trends at a level of detail that was not previously available. The 2014 Expenditure Analysis will be the first to include health care spending and utilization trends informed by VHCURES.

Truven Health Analytics, with sub-contractor Brandeis University, also produced studies on defining health care service areas, market areas, and decomposition of prices. These special studies were commissioned by the Board in order to implement its Analytic Plan created in 2012.[8] The Analytic Plan recommends that the Board undertake measures to enhance current information sources, starting with VHCURES.

The special studies were designed to:

- Explain in greater detail the high level trends identified in the Truven health accounts work
- Provide building blocks to support population-based health system and payment reform
- Develop recommendations for further use of VHCURES in support of the all-payer model and other reforms.

The studies revisit and analyze the usefulness of regional markets to implement reforms (e.g., ACO); measure growth and variation of price, service mix, and utilization with standardized metrics across payers, markets, and providers; identify drivers of health spending and the information necessary for any cost containment efforts; and develop an interactive tool for simulating "what-if" scenarios to identify potential savings and potential impacts of payment reform. Together, these studies provide a baseline for Vermont's current population and health system and demonstrate a VHCURES-based analytics program for monitoring and evaluating the impact of Vermont's health reform activities in future years. The studies documented both health care utilization and spending levels and trends for the years 2008-2012, and compared these trends, where possible, to those of other states and to national trends.

Transparency Study

Act 54 required that the Green Mountain Care Board "evaluate potential models for allowing consumers to compare information about the cost and quality of health care services available across the State, including a consideration of the models used in Maine, Massachusetts, and New Hampshire, as well as the platforms developed or under development by health insurers pursuant to 18 V.S.A. § 9413."

To fulfill this mandate, the Board contracted with the Human Services Research Institute (HSRI) to examine the state's options and overall best practices for delivering health care cost and quality information to consumers via the web. HSRI and its partner, NORC at the University of Chicago, conducted a comprehensive review of existing consumer transparency sites and platforms; compared existing websites to best practices in public reporting; and studied the feasibility of implementing models and tools examined for use in Vermont. To complement the website review, the HSRI-NORC Team also conducted expert interviews with directors of thirteen of these transparency websites, including Vermont's three predominant insurance carriers and public and private entities considered national leaders in public reporting.

Based on its findings, HSRI provided the following Vermont-specific considerations:

- Perhaps the **most important consideration in Vermont is resources**. Best-practice transparency websites (as opposed to limited-functionality sites) are expensive to create and costly to maintain. For example, one state model implemented by an outside vendor had startup costs ranging from $400,000 to $500,000 and ongoing maintenance and support costs of about $200,000 annually. Ongoing support is carried out by three to four FTEs, including one full-time person dedicated to proactively managing and resolving all data errors and performing any additional data quality investigations. In addition, two respondents representing insurance plan websites estimated that startup costs ranged from $200,000

[8]The Green Mountain Care Board's analytic plan is entitled, *Analysis in support of health reform. Recommendations to the Green Mountain Care Board for an analytic plan, June 2012*. (http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB060512.pdf).

to $300,000 and annual maintenance totaled about $200,000.

- VHCURES—primarily a tool to analyze broader trends in utilization and spending—inherently limits the GMCB's ability to adapt the data for a consumer-facing site that compares costs for specific procedures. Limits include:

    1. No process yet exists whereby payers can validate VHCURES data
    2. Correlating each payment to a specific provider
    3. Tracking and sorting secondary payments (payments made by a second payer when the patient has coverage from multiple sources)
    4. Identifying and evaluating particular payment models, e.g., DRG payments, episode payments, or global fees, on a basis other than line by line
- Insurers have real-time access to their subscriber's benefits and claims; they can therefore provide consumers with tailored cost estimates based on each subscriber's co-pays, co-insurance, remaining deductibles and network of providers. Moreover, this personalized cost data is often provided alongside quality and practice information. These are the only websites that examined for the study that are able to provide timely information on individuals' Out-Of-Pocket (OOP) costs for specific providers and procedures. VHCURES cannot provide this information.

Gobeille vs. Liberty Mutual

On December 2, 2015, Vermont's Solicitor General—representing the Petitioner Board Chairman Gobeille in his official capacity—argued the case of *Gobeille v. Liberty Mutual Insurance Company* before the United States Supreme Court. The core issue in this appeal is whether the Employee Retirement Income Security Act of 1974 (ERISA) preempts states from collecting claims data from self-insured entities for use in all-payer claims databases such as VHCURES. Vermont, joined by the federal government, argues that collection of the detailed data helps it more fully understand and manage the state's health care needs and expenditures. Liberty Mutual, prevailing party in the two-to-one decision of the Second Circuit Court of Appeals, contends that ERISA's preemption provision is broad and prohibits individual states—which could impose divergent reporting requirements— from mandating the collection of claims data relating to ERISA plans.

A decision is expected by late Spring 2016.

Vermont Health Care Innovation Project (VHCIP) Evaluation

The terms of the federal State Innovation Model (SIM) grant require two evaluations: an independent federally-led evaluation conducted by the Research Triangle Institute (RTI) and a Vermont-led evaluation. The federal evaluation includes longitudinal, summative and comparative analyses within Vermont and across states. RTI is tracking the following metrics in order to gauge SIM's success:

- Number of visits to a primary care physician
- Number of visits to a specialist
- Rates of hospitalization for composite AHRQ Prevention Quality Indicator (PQI) conditions
- All-cause acute inpatient admissions
- All-cause emergency room visits
- Emergency room visits not leading to a hospitalization
- Re-admissions to the hospital
- Well-child visits
- Average per member per month (PMPM) payments
- % of inpatient discharges with a follow-up visit within 14 days

VHCIP's Vermont-led evaluation includes a wide range of continuous improvement activities and evaluation of Vermont-specific pilots and innovations. The evaluation has two primary goals: 1) to provide timely feedback to inform corrections in the implementation and operation of VHCIP-sponsored initiatives, and 2) to generate actionable recommendations to guide Vermont state leadership's decisions to scale-up and diffuse VHCIP-supported initiatives. The GMCB is engaged in three major evaluation activities designed to help achieve these goals:

1. Implementing a mixed-methods, cross-sectional study on three topical areas deemed by Stakeholders as key to understanding the *how* and *why* of VHCIP pilot successes and challenges: care integration, use of clinical and economic data for performance improvement, and payment reform incentives.
2. Collection and synthesis of existing data including Shared Savings Program metric results, survey results, innovative pilot evaluation results, and results from the state-led evaluation study. These data will be analyzed/integrated into clear, cogent, and cohesive reporting that provides actionable recommendations on whether and what VCHIP-supported initiatives, and/or best practices within initiatives, should be scaled-up and diffused.
3. Implementing a Learning Dissemination Plan that includes sharing evaluation findings from across VHCIP to maximize project effectiveness and contribute to sustainability efforts.

Priorities for 2016

To continue to make quality health care more affordable and accessible to Vermonters, the Board's work will include the following priorities in 2016:

Continue to integrate the complementary functions of regulation, innovation, and evaluation

- Issue updated hospital budget guidance building on previous target growth rate construct
- Adjust hospital budget guidance to reflect potential all-payer model
- Develop system for utilizing information from hospital budget reporting to inform insurance premium rate review
- Assess potential terms and conditions for an all-payer model agreement with CMMI
- Assess framework document for potential all-payer model, with attention to improving access to primary care in all regions of the state
- Through exercises such as Designated Agency budget review, evaluate work necessary to more seamlessly integrate Mental Health and Substance Abuse services within the traditional medical care continuum
- Update Green Mountain Care Board Analytic Plan
- Utilize VHCURES for policy and decision making while engaging in continuous improvement through data governance
- Apply preliminary findings from VHCIP evaluation to future innovation efforts

Maximize the transparent process for policy and decision making

- Continue to utilize Board meetings and Advisory Committee Meetings for vetting and evaluating regulatory initiatives, payment and delivery system reform plans, and results and outcomes of health care system transformation
- Ensure appropriate stakeholder and consumer input and participation in each aspect of the Board's work
- Continue to monitor, share, and discuss the impacts of policy change and reform on Vermont's health care workforce

Appendix

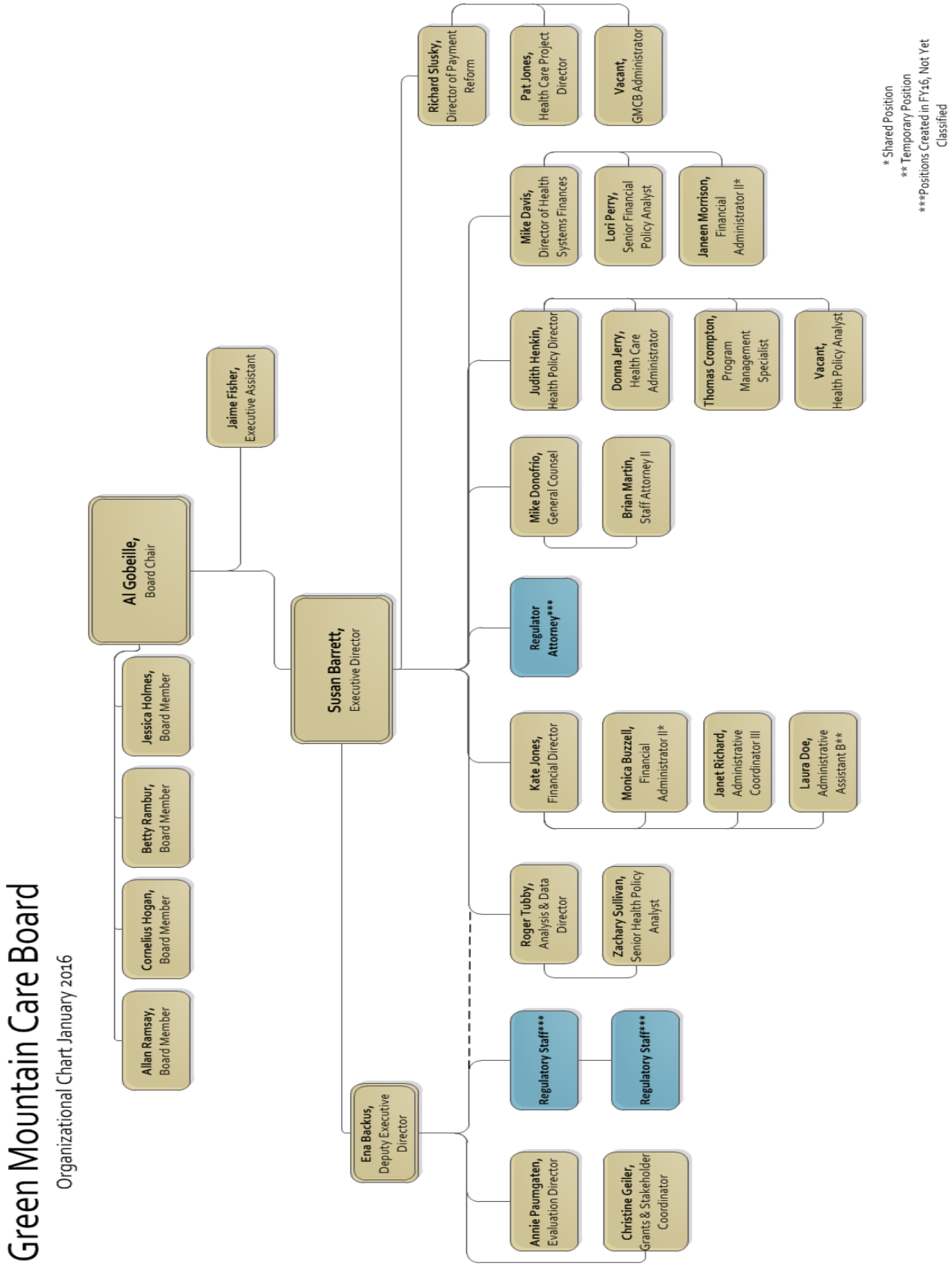
Appendix A: List of 2014 GMCB Meetings

Meeting Date	Topics
1/8/2015	• Data Governance Council Data Stewardship procedures and policies.
1/15/2015	• RFP for evaluation services related to the Cycle II Rate Review Grant • VHCURES 2.0
1/22/2015	• Development of Standardized Edits and Payment Rules • Discussion of Issues Raised by Budget Address • GMCB FY 2016 Budget
1/29/2015	• Text Messaging and Patient Engagement • Specialty Drugs that increase Vermonter's Drug Costs • Administration's legislative proposal.
2/5/2015	• 2016 Qualified Health Plans on Vermont Health Connect • Sole source contract for financial and real estate analysis of UVM Medical Center's proposed replacement of • In patient bed facility and proposed South Burlington property acquisition. • Simplified bid and contract for court reporter and transcription services • Administration's legislative proposal
2/12/2015	• 2016 Qualified Health Plans on Vermont Health Connect • All Payer Model Procurement • Vote on contracted technical assistance for All Payer Model.
2/19/2015	• MVP Health Care's feedback on Vermont Health Connect's recommended changes to 2016 Qualified Health Plans. • BCBSVT's feedback on Vermont Health Connect's recommended changes to 2016 Qualified Health Plans.
2/26/2015	• Certificate of Need Hearing: Green Mountain at Fox Run-Attuned Eating and Living Centers, LLC • Board discussion of topics brought up by Senate Health and Welfare including price transparency, alignment of surveys, and a health resource allocation plan at the service level. • Discussion of Data Governance Council Charter • Vote on No Cost Extension for contract with PRS Consulting LLC.
3/5/2015	• 2014 Hospital Budget Actuals • Discussion/vote of proposed changes to 2016 Qualified Health Plans on Vermont Health Connect • 2013 Expenditure Analysis • Vote on Data Governance Council Charter New Business
3/12/2015	• Vermont Health Care Innovation Project • Quality and Performance Measures for Vermont's ACO Shared Savings Programs • Proposed changes to 2016 Qualified Health Plans on Vermont Health Connect
3/19/2015	• Vermont Health Information Technology Plan • Creating a Sustainable Primary Care Infrastructure within Vermont: A Qualitative Study of Vermont's Front-Line Providers

Meeting Date	Topics
	• 2016 Qualified Health Plans on Vermont Health Connect • Quality and Performance Measures for Vermont's ACO Shared Savings Programs.
3/25/2015	• Fiscal Year 2014 Hospital Budgets • The Cost Shift
3/26/2015	• Continued Certificate of Need Hearing: Green Mountain at Fox Run- Attuned Eating and Living Centers
4/02/2015	• Approval of contract for technical assistance for All Payer Model
4/09/2015	• ACO Care Management Standards
4/16/2015	• Data Analysis of Vermont Health Spending Growth Drivers Commercial and Medicaid • Certificate of Need Contracts Approval • ACO Care Management Standards • Vote on vendor selection for the Cycle II Rate Review Grant Evaluation Request for Proposal • Vote to release a Request for Proposal for a Medical Price Transparency Study under the Cycle IV Rate Review Grant
4/23/2015	• Discussion of release a Request for Proposal for a Survey of the General Surgery Practice Landscape in Vermont • Contract amendment
5/14/2015	• Contract matters
5/18/2015	• Certificate of Need Hearing: The University of Vermont Medical Center, Inpatient Bed Replacement Project
5/19/2015	• Certificate of Need Hearing: The University of Vermont Medical Center, Inpatient Bed Replacement Project
5/28/2015	• Coordinated Care Management, Champlain Valley Area on Aging
6/04/2015	• Legislative Wrap Up – Bill S.139 • GMCB Budget for FY 2016
6/11/2015	• Vermont Health Care Innovation Project Evaluation • Vendor selection for a Medical Price Transparency Study under the Cycle IV Rate Review Grant • Certificate of Need Contract Approvals
6/18/2015	• Rate Review Forum • Blueprint for Health Funding • VHCIP Evaluation Plan
6/25/2015	• Changes to VHCIP Quality and Performance Measures – ACO Shared Savings Program Measures • ACO Commercial SSP standards • Creating a Sustainable Primary Care Infrastructure within Vermont • 2017 Qualified Health Plan Benchmark Plan.
7/23/2015	• Hospital Budget Preliminary Look • Payment and Health Care Delivery - Commercial Accountable Care Organizations (ACO's) and Shared Savings Programs (SSPs) • Pilot Standard • Vermont Open MRI, Certificate of Need
7/30/2015	• Truven and Brandeis Presentation - results from analytic services contract

Meeting Date	Topics
	• UVMMC Certificate of Need-modification of order
8/13/15	• Payment and Health Care Delivery System
8/20/2015	• Certificate of Need - Green Mountain Nursing Home in Colchester and Brookside Nursing Home
9/2/2015	• Contract Renewal • Clarification of UVMMC Hospital Budget as relates to CON Application • FY16 Hospital Budget Submissions
10/8/159/3/2015	• FY16 Hospital Budget Submissions
9/9/15	• University of Vermont Health Network's Clinical and Physician Integration • FY16 Hospital Budget Submissions • Contract Approvals
9/24/15	• Northeastern Vermont Regional Hospital – FY16 Budget
10/8/15	• Northwestern Medical Center – Reconsideration of Budget • Certificate of Need - UVMMC
10/22/15	• Certificate of Need Hearing – Northwestern Medical Center
10/29/15	• Board Priorities and Responsibilities
11/5/15	• Year 3 ACO Standards with Proposed Revision • Vermont Technology Information Leaders (VITL) Overview
11/9/15	• Executive Session
11/17/15	• University of Vermont College of Medicine • Howard Center • Federally Qualified Health Centers: Little Rivers Health Care, Inc., Northern Tier Center for Health, Northwestern Counseling and Support Services.
12/3/15	• Rate Review Forum
12/10/15	• Mental Health Integration
12/17/15	• Health Information Technology (HIT) Plan Progress

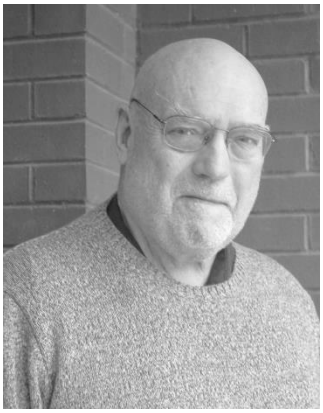
Appendix B: GMCB Organizational Chart



Appendix C: Board Biographies

Alfred Gobeille, Chair. As Chairman of the Green Mountain Care Board, Al Gobeille is tasked with directing the Board's charge of curbing health care cost growth and reforming the way health care is provided to Vermonters. In addition, he owns Gobeille Hospitality, a Burlington based restaurant and hospitality business that includes four popular restaurants and catering businesses: Shanty on the Shore, Burlington Bay Market and Café, Breakwater Café and Grill, and Northern Lights Cruises. Gobeille Hospitality employs 230 people. Al served on the Town of Shelburne Select Board and has negotiated with the Town's union employees on health insurance benefits. He was a board member of the Visiting Nurses Association of Chittenden and Grand Isle Counties, and served on the State of Vermont's Payment Reform Advisory Committee. Al is a graduate of Norwich University and has served as an officer in the United States Army. He lives in Shelburne.

Betty Rambur, Ph.D., R.N. is Professor of Nursing and Health Policy at the University of Vermont (UVM). From 2000-2009 she served as an academic dean at UVM, where she led the merger of the School of Nursing and School of Health Sciences to establish the College of Nursing and Health Sciences. From 1991-1995 Betty led the statewide health financing reform effort in North Dakota. She maintains an active research program focused on health services, quality, workforce, and ethics. She has led or participated in research, education, and public service grants exceeding $2 million and is the author of approximately 40 published articles and numerous invited presentations on her research, health care economics and policy, and leadership development. In 2007, her research was honored by Sigma Theta Tau International. In 2013, Betty received the UVM Graduate Student Senate Excellence in Teaching Award and the Sloan Consortium Excellence in Online Teaching and Learning Award. Her teaching expertise includes the organization, finance and policy of health care and evidence-based practice. Betty is currently writing a textbook designed to explain health care finance, economics, and policy in an easy-to-understand, reader-friendly manner. A registered nurse, Betty received her Ph.D. in nursing from Rush University in Chicago, IL. She lives in South Burlington.



Cornelius Hogan served as Secretary of the Agency of Human Services (AHS) for the State of Vermont under both the Snelling and Dean administrations. Since his retirement from state service in 1999, Con has consulted internationally with governments on human services and health care management. He has co- authored several books on Vermont's health policy. Prior to serving as AHS Secretary, Con was for more than 10 years President of International Coins and Currency based in Montpelier. Con served in leadership positions at the Vermont Department of Corrections and previously worked for the New Jersey Department of Corrections. Con holds a Masters of Governmental Administration from the Wharton School of Business at the University of Pennsylvania, and an Honorary Doctorate of Laws from the University of Vermont. He lives in Plainfield.

Allan Ramsay, M.D. is a Colchester-based primary care physician who has practiced in Vermont for 30 years. Allan's signature work is in the area of palliative care, where he has been a leader in developing models for assuring that patients' wishes are followed at the end of their lives. He is past Medical Director of Fletcher Allen Health Care's Palliative Care Service and the founder of the Rural Palliative Care Network. In his long career in academic medicine, Allan served as Residency Director and Vice Chair in the Department of Family Medicine at UVM, where he is now Professor Emeritus. Allan is a past member of the board of the Visiting Nurse Association of Chittenden and Grand Isle Counties and the Board of the Community Health Center of Burlington. Prior to moving to Vermont, Allan served in the National Health Service Corps in rural Colorado. He was also President of an HMO Professional Service Corporation in the San Luis Valley of southern Colorado. Allan holds a medical degree from Emory University and is board certified in internal medicine, geriatrics, hospice and palliative medicine. He lives in Essex Junction.

Jessica Holmes, Ph.D. is a Professor of Economics and the Director of MiddCORE, an award-winning leadership and innovation program 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 Ph.D. 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.

Susan J. Barrett, J.D., Executive Director, 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 (HLA), 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.

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