Green Mountain Care Board

2015

Annual Report to the

Vermont General Assembly

The members of the Green Mountain Care Board wish to express our gratitude to our staff, who bring dedication, creativity, intelligence, shared purpose, and humor to the work of improving Vermont's health care system.

The Green Mountain Care Board

Alfred Gobeille, Chair; Cornelius Hogan; Betty Rambur, Ph.D., R.N.; Allan Ramsay, M.D., Jessica A. Holmes, Ph.D.

The Green Mountain Care Board Staff

Ena Backus, Deputy Executive Director
Susan Barrett, Esq., Executive Director
Anna Bassford, Executive Assistant
Monica Buzzell, Financial Administrator II
Thomas Crompton, Program Management Specialist
Mike Davis, Director of Health System Finances
Sharon Degreenia, Administrative Assistant B
Michael Donofrio, Esq., General Counsel
Christine Geiler, Grants & Stakeholder Coordinator
Judith Henkin, Esq., Health Policy Director
Donna Jerry, Senior Health Policy Analyst
Kate Jones, Financial Director
Pat Jones, Health Care Director
Dian Kahn, Analysis & Data Director
Kelly Macnee, Health Policy Analyst
Brian E. J. Martin, Associate General Counsel
Janeen Morrison, Financial Administrator II
Stacey Murdock, Data & Information Project Director
Annie Paumgarten, Evaluation Director
Lori Perry, Senior Financial Policy Analyst
Janet Richard, Administrative Services Coordinator III
Richard Slusky, Director of Payment Reform
Zachary Sullivan, Health Policy Analyst
Spenser Weppler, Health Reform Specialist

Table of Contents

Executive Summary 1

Introduction 2

Progress in 2014 3

- **Regulation** 3
  - Hospital Budgets 3
  - Cost Shift 5
  - Certificate of Need 6
  - Insurance Rates 7
  - Health Information Technology 10
- **Innovation** 11
  - Payment and Deliver System Reform 11
  - Vermont Health Care Innovation Project (VHCIP) 14
  - Workforce 15
- **Evaluation** 16
  - Vermont Health Care Expenditure Analysis 16
  - Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) 16
  - Health Care System Analysis & Reporting 17
  - Dashboard 2.0 17
  - Vermont Health Care Innovation Project (VHCIP) Evaluation 17

Priorities for 2015 19

Appendix 20

- Appendix A: Statutory Requirements of this Report 20
- Appendix B: Alignment with Principles of Act 48 22
- Appendix C: List of 2014 GMCB Meetings 25
- Appendix D: Full List of GMCB Powers and Authorities 31
- Appendix E: GMCB Budget 40
- Appendix F: GMCB Organizational Chart 41
- Appendix G: Board Biographies 42

Executive Summary

The Green Mountain Care Board (the GMCB, or the Board) is charged with reducing the rate of health care cost growth in Vermont while ensuring that the State of Vermont maintains a high quality, accessible health care system. The GMCB is a five-member independent board, supported by a staff of 24 employees. In this fourth annual report to the Legislature, the Board explains its statutory responsibilities across the areas of regulation, innovation, and evaluation of the health care system and reform efforts.

Regulation

The Board's regulatory activities include reviewing hospital budgets and health insurer rates, evaluating Certificate of Need (CON) applications for new health care services and facilities, and assessing Health Information Technology (HIT) planning for the state.

Innovation

The Board facilitates a range of payment and delivery system reforms from small pilots to Shared Savings Programs (SSPs) that cover a substantial portion of the population. The Board has contracted for formal studies of payment and price variation to inform its work.

Evaluation

The Board evaluates the payment and delivery system reforms on Vermont's health care system, as well as the Vermont Health Care Innovation Project (VHCIP). Ongoing, the Board evaluates spending in Vermont's health care system and produces the Vermont Health Care Expenditure Analysis.

In 2014, the GMCB reached the following milestones:

- Original Board member, Dr. Karen Hein, concluded her three-year term.
- Jessica A. Holmes, Ph.D. was appointed to a three-year term.
- Hospital budgets stayed below the target growth rate.
- Successful rate review processes limited health insurance rate increases.
- Medicaid and commercial insurance Shared Savings Programs were negotiated, finalized, launched, and implemented.
- The Rate Review Cycle II Grant awarded by the Center for Consumer Information & Insurance Oversight (CCIIO) was transitioned from the Department of Financial Regulation (DFR) to the GMCB.
- CCIIO awarded the Board a $1,179,000 Cycle IV Grant to States to Support Health Insurance Rate Review and Increase Transparency in the Pricing of Medical Services.
- For the first time, Medicare data was incorporated into the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), making it a true all-payer claims database.
- The VHCURES Data Governance Council was formed to provide oversight for the VHCURES program.

In 2015, the Board will:

1. Maintain an open, transparent, stakeholder-driven process of health care reform.
2. Further reduce the rate of growth in health care costs and create a more unified health care system through all-payer payment and delivery reforms, price transparency, and enhanced regulation.
3. Improve the health of the population by strengthening the primary care foundation and better integrating mental health and substance abuse treatment into the health care system as a whole.

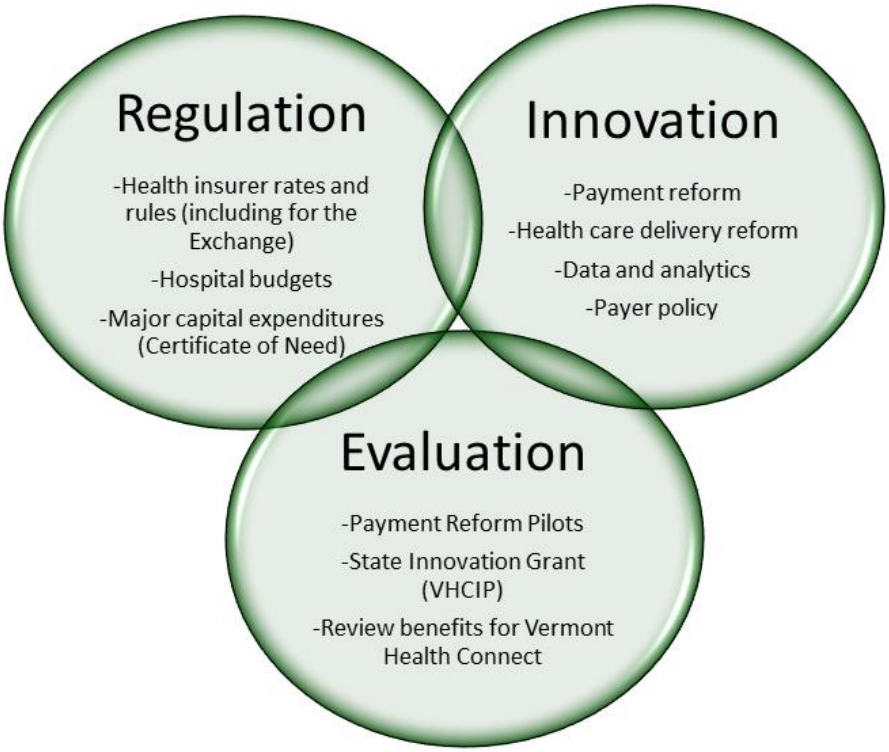
Introduction

Act 48 of 2011 created the Green Mountain Care Board to reduce health care cost growth to a sustainable rate and to ensure a high-quality health care system that promotes the well-being of Vermonters. The Board has the ability to address health care costs, quality, and access through its role as regulator, innovator, and evaluator of Vermont's health care system.

During its third full year of operation, the Board continued to work with hospitals to meet budget targets, to scrutinize health insurance rate increases, to evaluate Certificate of Need (CON) applications, and to assess Health Information Technology (HIT) planning. In tandem with these regulatory activities, the Board facilitated payment and delivery system reforms both as a part of its role in the Vermont Health Care Innovation Project (VHCIP) and through its own study of payment and price variation. Keeping the experience of Vermonters and health care providers central to its analysis, the Board, ongoing, will evaluate the impact of payment and delivery reforms on health care quality and cost.

Across all areas of responsibility, the Board's work was shaped by input from stakeholders and members of the public who participated in weekly public meetings, advisory committees, and work groups. The GMCB held traveling Board meetings in Springfield, Burlington, and Middlebury. The Board heard from health care providers, legislators, and members of the public on the challenges they experience, as well as the innovative solutions they have implemented to meet the needs of their communities. Individually, Board members participated in over 60 speaking engagements allowing them to explain the work of the Board and gather feedback from a variety of participants.

This report provides an overview of major milestones for the GMCB in 2014, updates on progress in the Board's three major areas of work – regulation, innovation, and evaluation – and outlines its priorities for 2015.



Progress in 2014

Regulation

Hospital Budgets

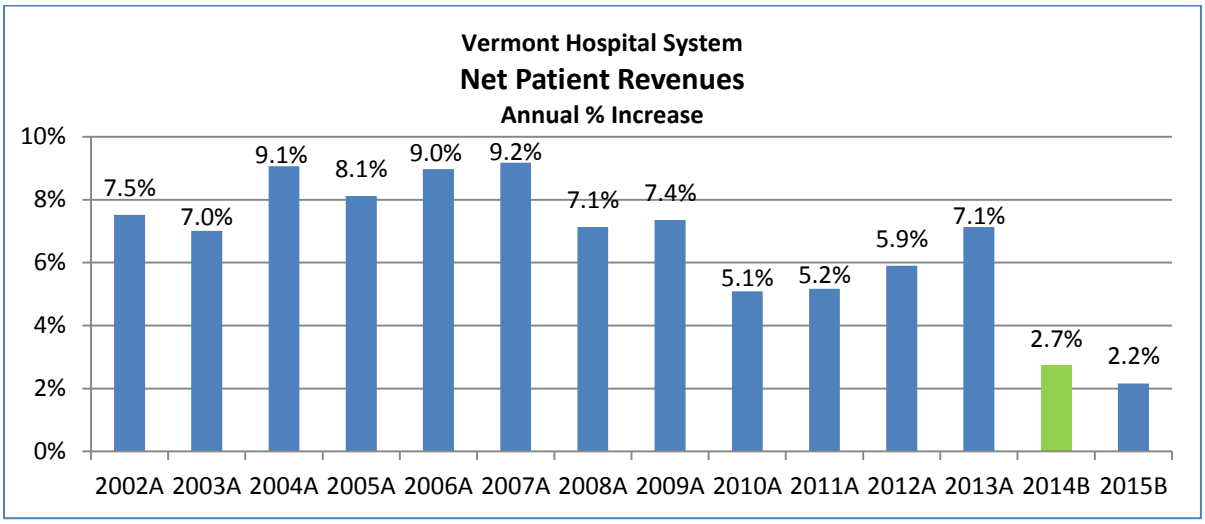
In 2013, the Green Mountain Care Board implemented a set of principles to govern the hospital budget review process for federal fiscal years 2014 through 2016. The Board set a target rate for increases in hospital net patient revenue (NPR)[1] of three percent for FY 2014 through FY 2016, with an allowance for investments in health reform. In March of 2014, the Board's expectations were spelled out for hospitals through written guidance addressing key elements of the budget for FY 2015:

- For FY 2015, no more than 0.8 percent of additional growth in NPR would be considered for credible health reform proposals 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 targets if a hospital demonstrated that the change would be revenue neutral. This means that dollars already being spent on health care in the community would simply move into the hospital budget.

With this guidance in place, the budget submissions from Vermont's hospitals were virtually approved as submitted, with only one adjustment necessary. The system-wide growth in NPR was established at 2.2 percent, with individual hospitals' budgets ranging from a decrease of 9.6 percent to an increase of 8.6 percent.

In 2014, for the second straight year, the Board enforced its NPR rate target for 2015, resulting in restrained hospital budget growth in Vermont. The lower budgets were the result of a review process that has been improved by experience, collaboration, and the efforts of each Vermont hospital. The following chart illustrates this accomplishment:

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



A=Actual B=Budgeted

[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.

The table below shows the submitted and approved budgets. As part of the review, the Board examined underlying organizational changes, as some hospitals have moved services out of the budget. Accounting for those changes, the Board found that the overall increase was 3.1 percent, which still falls within the total targeted system increase of 3.8 percent.

Figure 2: Net Patient Revenue for Vermont Hospitals FY 2014-2015

Hospital	Approved Budget 2014	Submitted Budget 2015	Submitted % Change	Approved Budget 2015	Approved % Change
Brattleboro Memorial Hospital	$ 69,793,065	$ 71,284,571	2.1%	$ 71,284,571	2.1%
Central Vermont Medical Center	$ 160,372,377	$ 166,221,844	3.6%	$ 166,221,844	3.6%
Copley Hospital	$ 57,795,625	$ 59,600,484	3.1%	$ 59,600,484	3.1%
Fletcher Allen Health Care	$ 1,059,369,725	$ 1,087,767,762	2.7%	$ 1,087,767,762	2.7%
Gifford Medical Center	$ 64,106,475	$ 57,753,248	-9.9%	$ 57,753,248	-9.9%
Grace Cottage Hospital	$ 16,560,535	$ 17,980,282	8.6%	$ 17,980,282	8.6%
Mt. Ascutney Hospital & Health Center	$ 46,900,851	$ 48,508,891	3.4%	$ 48,508,891	3.4%
North Country Hospital	$ 75,375,299	$ 73,586,147	-2.4%	$ 73,586,147	-2.4%
Northeastern Vermont Regional Hospital	$ 64,687,170	$ 65,324,117	1.0%	$ 65,324,117	1.0%
Northwestern Medical Center	$ 87,759,305	$ 90,795,885	3.5%	$ 90,795,885	3.5%
Porter Medical Center	$ 69,809,475	$ 72,696,905	4.1%	$ 72,696,905	4.1%
Rutland Regional Medical Center	$ 217,820,712	$ 224,138,940	2.9%	$ 224,138,940	2.9%
Southwestern Vermont Medical Center	$ 139,576,168	$ 139,041,542	-0.4%	$ 139,041,542	-0.4%
Springfield Hospital	$ 51,978,213	$ 54,652,014	5.1%	$ 54,360,014	4.6%
Totals	$ 2,181,904,996	$ 2,229,352,632	2.2%	$ 2,229,060,632	2.2%

Along with curbing budget growth, Vermont's hospitals limited increases in their FY 2015 overall rates comparable to previous years. Price increases ranged from 0 percent to 8.4 percent, with the median rate at 5.25 percent. This compares favorably to the 5.9 percent median for FY 2014 approved rates. The table below shows the details of hospital rate changes:

Figure 3: Annual Overall Rate Increase for Vermont FY 2013-2015

	Approved Rate 2013	Approved Rate 2014	Submitted Rate 2015	**Approved Rate 2015**
Brattleboro Memorial Hospital	5.2%	5.8%	2.7%	**2.7%**
Central Vermont Medical Center	5.0%	6.9%	5.9%	**5.9%**
Copley Hospital	3.0%	6.0%	0.0%	**0.0%**
Fletcher Allen Health Care	9.4%	4.4%	7.8% *	**7.8% ***
Gifford Medical Center	6.1%	7.6%	5.6%	**5.6%**
Grace Cottage Hospital	6.5%	6.0%	5.0%	**5.0%**
Mt. Ascutney Hospital & Health Ctr	7.0%	5.0%	3.2%	**3.2%**
North Country Hospital	4.6%	8.0%	8.3%	**8.3%**
Northeastern VT Regional Hospital	6.5%	5.6%	5.0%	**5.0%**
Northwestern Medical Center	2.9%	3.9%	6.4%	**6.4%**
Porter Medical Center	5.0%	6.0%	5.0%	**5.0%**
Rutland Regional Medical Center	10.3%	4.8%	8.4%	**8.4%**
Southwestern VT Medical Center	6.8%	7.2%	4.5%	**4.5%**
Springfield Hospital	6.0%	4.6%	5.5%	**5.5%**

** The actual rate change for FAHC was 0.0% in 2015. While rates were changed for certain services, the overall budget effect from prices was considered neutral because some prices were lowered. The reimbursement increase effect to commercial payers is estimated to increase payers' obligation by 7.8%.*

Reports to analyze and evaluate changes to NPR by payer continue to be a priority. This year featured the continued improvement of the Board's online budgeting tool to allow in-depth "apples-to-apples" analysis across the 14 hospital budgets. In addition, this was the second year that hospitals were directed to submit their Community Health Needs Assessment (CHNA) reports, which are attached to each hospital's federal tax filing as part of hospital budget filing. The CHNA reports contain a rich amount of information about the each hospital's community. The GMCB will continue to evaluate how these reports can best be used as part of the overall budget 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 no insurance to make up for lower reimbursement from Medicare, Medicaid, charity care, or bad debt. The GMCB 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.

Act 79 of 2013 added a requirement that the GMCB's 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 2014, the Board found that there were no appropriations of Medicaid to address the cost shift in 2015. The Board's evaluation included a review of the revenue estimates for each payer, including Medicaid. The following chart (Figure 4) shows the cost shift by payer.

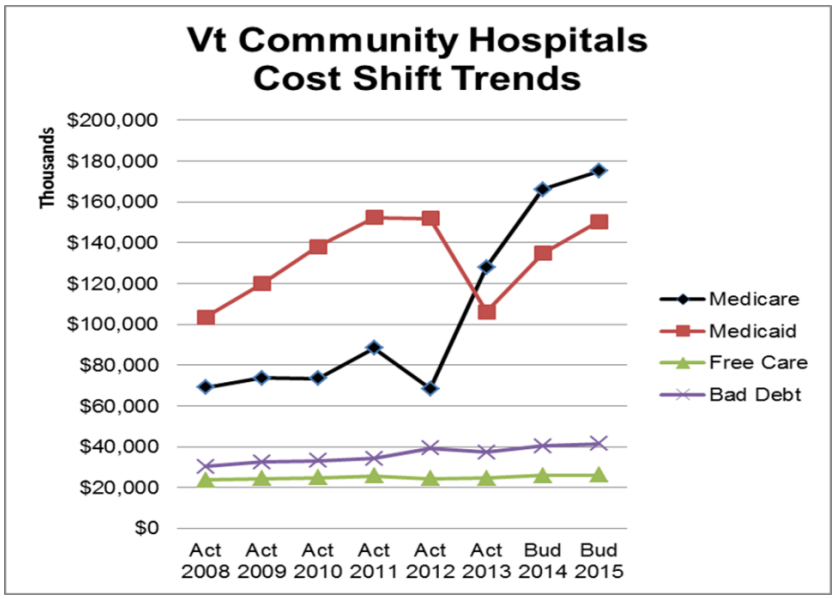
Figure 4: Estimated Vermont Community Hospitals Cost Shift by Payer

Fiscal Year	Medicare	Medicaid	Free Care	Bad Debt		*Commercial Insurance & Other
Actual 2008	$ 69,003,712	$ 103,569,366	$ 23,623,972	$ 30,252,980	→	$ 226,450,033
Actual 2009	$ 73,627,496	$ 119,979,398	$ 24,292,187	$ 32,391,214	→	$ 250,290,295
Actual 2010	$ 73,515,988	$ 138,016,619	$ 24,806,398	$ 33,076,863	→	$ 269,415,868
Actual 2011	$ 88,399,861	$ 152,256,740	$ 25,784,124	$ 34,331,093	→	$ 300,771,818
Actual 2012	$ 68,334,861	$ 151,931,648	$ 24,347,367	$ 39,264,676	→	$ 283,878,552
Actual 2013	$ 128,033,776	$ 105,998,937	$ 24,685,204	$ 37,386,222	→	$ 296,104,139
Budget 2014	$ 166,065,165	$ 134,778,449	$ 25,982,503	$ 40,263,981	→	$ 367,090,098
Budget 2015	$ 175,171,362	$ 150,394,735	$ 26,137,170	$ 41,464,624	→	$ 393,167,892

Payer values include all hospital and employed physician services.
Medicaid values include non-Vermont Medicaid of approximately 5%.
* The amount shifted to commercial insurance and self-pays.

The Medicaid cost shift for hospitals, while slowing in 2013 and 2014, is estimated to increase to $150,000,000 in 2015. GMCB staff calculations show a significant increase in the Medicare cost shift for 2014 and 2015, largely the result of Medicare reimbursement changes anticipated at the federal level. The Medicare cost shift will total $175,000,000 in FY 2015. Bad debt and "free care" also contribute to the cost shift, increasing from a total of $60,000,000 in 2011 to $68,000,000 in 2015. As seen on the following graph, this portion of the cost shift remained remarkably consistent over the last several years.

Figure 5: Vermont Community Hospitals Cost Shift Trends



Certificate of Need

Beginning in 2013, the Vermont Legislature transferred jurisdiction over the Certificate of Need (CON) process from the Department of Financial Regulation to the Green Mountain Care Board. The CON process seeks to restrain health care costs by allowing for coordinated planning of new health care services and facility construction, and ensuring the provision and equitable allocation of high quality health care services and resources to all Vermonters.

In 2014, the Board approved five CON applications and declined review over an additional twelve proposed projects that fall outside jurisdictional parameters set forth in statute. *See* 18 V.S.A. § 9434 (Certificate of need; general rules).

The Board approved:

- Pathways Vermont's request to create Soteria Vermont, a five-bed residence in Burlington for adults experiencing a first episode of psychosis (proposed operating budget of $1,000,000, plus $292,644 in expenses);
- Rutland Area Visiting Nurse Association and Hospice's purchase of the Bennington Home Health and Hospice Agency (total project cost of $1,314,809);
- Fletcher Allen Health Care's request to replace equipment and upgrade two cardiac catheterization laboratories (total project cost of $6,054,397);

- Mt. Ascutney Hospital and Health Center's requests to renovate and repurpose hospital, nursing home, and professional office building space, to convert existing acute care space to private rooms, and to make infrastructure upgrades and purchase additional equipment (total project cost of $6,001,906);
- Rutland Regional Medical Center's renovation of its emergency department and the construction of a one-story addition to house offices and support staff (total project cost of $4,714, 861).

Applications are pending for the following CONs:

- Copley Hospital's request to construct a new surgical suite, to renovate its ambulatory care unit's infusion suite, and to make modifications to its operating rooms (projected project cost of $12,500,000);
- Vermont Open MRI, LLC in South Burlington (operating expenses that exceed $500,000);
- Green Mountain at Fox Run's proposal to create an outpatient eating disorder treatment program in Ludlow (operating expenses that exceed $500,000);
- The University of Vermont Medical Center's (formerly Fletcher Allen Health Care) request to construct an inpatient building of approximately 180,000 square feet and replace inpatient beds (projected project cost of $187,297,729);
- Northwestern Medical Center's proposal for construction and renovation to create single occupancy rooms for its medical/surgical intensive care patient units, to establish centralized registration for non-emergent services within the hospital, and to renovate space to accommodate cardiology, pulmonary, OB/GYN and medical specialty clinics within the hospital (projected project cost of $20,632,359);
- The proposed purchase by Brookside Property, LLC, a Delaware limited liability company, of the Green Mountain Nursing Home in Colchester and Brookside Health and Rehabilitation in White River Junction.

In addition, The University of Vermont Medical Center has filed an application requesting authorization to acquire commercial buildings and open land in South Burlington at a capital cost not to exceed $51,000,000. At the request of the applicant, the Board suspended review of the project until it completes review of the applicant's inpatient bed replacement project.

The Board has asserted jurisdiction over the following projects, but the applicants have not yet filed CON applications:

- The Visiting Nurse Association of Chittenden and Grand Isle Counties' proposed replacement and expansion of Vermont Respite House;
- Franklin County Rehabilitation Center's proposed purchase of Redstone Villa in St. Albans;
- Northwestern Medical Center's proposal for construction of a medical office building that will be attached to the hospital.

The GMCB currently retains ongoing jurisdiction over the implementation of 14 previously approved CON projects.

Insurance Rates

Until the start of 2014, the Green Mountain Care Board shared responsibility for health insurance rate review with the Department of Financial Regulation (DFR). Under the bifurcated process, the DFR received and reviewed rate filings and recommended that the Board approve, modify, or disapprove a proposed rate change within 30 days of receipt of the recommendation. With the passage of Act 79 (2013), the Legislature expanded

the Board's authority over health insurance rate increases and on January 1, 2014, the Board became the primary reviewer of rates, while the DFR's role was limited to providing the GMCB with an analysis and opinion regarding insurer solvency. To assist in its work, the Board has contracted with Lewis & Ellis Actuaries and Consultants (L&E) to provide technical support to GMCB staff in the review of insurance rate changes affecting Vermont consumers.

Since the enactment of the Affordable Care Act and the introduction of Vermont Health Connect (VHC), the state's online health insurance marketplace, the GMCB has seen a decrease in the annual number of rate filings. In 2014, the Board reviewed 18 rate filings, compared to 31 filings in 2013 and 41 filings in 2012. Of the 18 filings in 2014, the Board modified rates downward in twelve prior to their approval; the remaining six were approved without modification.

As in 2013, the most significant rate decisions made by the Board concerned rates for Vermont Health Connect plans, offered by Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Plan, Inc. (MVP). After public hearings held over two days in August at the Vermont State House, the Board in early September announced its decisions to reduce BCBSVT's proposed VHC rate increase from 9.8 percent to 7.7 percent, and MVP's proposed VHC rate increase from 15.4 percent to 10.9 percent, resulting in approximately $6.9 million in savings to Vermont consumers.

Also beginning in 2014, the Board launched a new rate review website, providing heightened consumer access to health insurance rate information.[2] The website explains the rate review process and key technical terms in plain language, allows consumers to track the status of rate filings and receive notifications of new filings, and provides a gateway for Vermonters to comment about specific rate filings or the rate review process in general. In April 2014, Families USA, a national non-profit organization that advocates for health care consumers, commended Vermont's website for presenting "user-friendly information on health insurance rate filings."

In 2014, the Center for Consumer Information & Insurance Oversight (CCIIO), the federal office charged with overseeing implementation of the Affordable Care Act provisions related to private health insurance, approved the transition of the Cycle II Rate Review Grant from the DFR to the Board, and thereafter awarded the Board a no-cost extension allowing for grant-funded work to continue for an additional year (until September 30, 2015). In addition, the Board was awarded a $1,179,000 "Grant to States to Support Health Insurance Rate Review and Increase Transparency in the Pricing of Medical Services, Cycle IV" on September 19, 2014. The Cycle IV grant will allow the GMCB to expand its scope of rate review work to explore ways to use available data as a means to better understand health insurance rates and medical trends, increase medical pricing transparency, and to develop rate enforcement mechanisms and insurer reporting standards.

The following chart outlines the Board's rate review decisions during 2014.

[2] The website is available at: http://ratereview.vermont.gov/

Figure 6: 2014 Rate Review Filings

2014 Rate Review Filings					
Docket No.	**Company**	**Type of Rate Filing**	**Decision**	**Proposed Rate Change**	**Approved Rate Change**
GMCB-001	The Vermont Health Plan	2014 Benefit Relativity Factor Filing	Approved as Filed	NA	NA
GMCB-002	BCBSVT	2014 Benefit Relativity Factor Filing	Approved as Filed	NA	NA
GMCB-003	The Vermont Health Plan	2014 Risk and Admin Charges for Experience Refund Eligible Product	Approved as Filed	NA	NA
GMCB-004	BCBSVT	2014 Charge Factors for Aggregate Stoploss, Risk and Admin Charges	Approved as Filed	NA	NA
GMCB-005	The Vermont Health Plan	2014 Provision for Large Claims	Approved as Filed	NA	NA
GMCB-006	BCBSVT	2015 Provision for Large Claims	Approved as Filed	NA	NA
GMCB-007	Cigna Health & Life Ins.Co.	2014 Large Group Manual Rate Filing	Approved with Modification	3.80%	-6.60%
GMCB-008	Conn. General Life Ins.Co.	2014 Large Group Manual Rate Filing	Approved with Modification	3.80%	-6.60%
GMCB-009	MVP Health Ins. Company	3Q/4Q14 Small Group Grandfathered Rate Filing	Approved with Modification	4.9%, 3.5%	4.9%, 3.5%
GMCB-010	MVP Health Ins. Company	3Q/4Q14 Large Group Experience Rated Addendum (Manual Rate)	Approved as Filed	0.80%	0.80%
GMCB-011	MVP Health Plan	3Q/4Q14 Large Group HMO Experience Rated Addendum	Approved as Filed	5%, 4.8%	5%, 4.8%
GMCB-012	BCBSVT	3Q/4Q14 Trend Factor Filing	Approved as Filed	(combined) 5.2%	(combined) 5.2%
GMCB-013	The Vermont Health Plan	3Q/4Q14 Trend Factor Filing	Approved as Filed	(combined) 5.2%	(combined) 5.2%
GMCB-014	MVP Health Ins. Company	3Q/4Q14 Grandfathered Individual Indemnity	Approved with Modification	9.40%	8.30%
GMCB-015	The Vermont Health Plan	4Q14-3Q15 Admin and CTR	Approved with Modification	1.2%, 2%	0%, 1%
GMCB-016	BCBSVT	4Q14-3Q15 Admin and CTR	Approved with Modification	1.2%, 2%	0%, 1%
GMCB-017	MVP Health Plan	2015 Vermont Health Connect Rate Filing	Approved with Modification	15.30%	10.90%
GMCB-018	BCBSVT	2015 Vermont Health Connect Rate Filing	Approved with Modification	9.80%	7.70%
GMCB-019	MVP Health Ins. Company	2015 Agriservices Rate Filing	Approved with Modification	16%	14.6%
GMCB-020	MVP Health Ins. Company	1Q/1Q15 Grandfathered Small Group Rate Filing	Approved with Modification	10.1%, 10.2%	7.4%, 7.5%
GMCB-021	MVP Health Ins. Company	1Q/2Q15 Large Group EPO/PPO Manaul Rate Filing (1Q15 HDHP, Non-HDHP) (2Q15 HDHP, Non-HDHP)	Approved with Modification	(-6.8%, 6.3%) (-6.7%, 6.5%)	(-7.9%, 5.2%) (-7.7%, 5.5%)
GMCB-022	MVP Health Ins. Company	1Q/2Q15 New Product Rate Filing	Approved with Modification	NA	NA
GMCB-023	MVP Health Plan	1Q/2Q15 Large Group HMO	Approved with Modification	5.50%	4.40%
GMCB-024	MVP Health Ins. Company	1Q/2Q15 Small Group Grandfathered New Product	Approved with Modification	NA	NA

Health Information Technology

Consent Policy for Vermont Health Information Exchange
The Green Mountain Care Board is responsible for reviewing and approving Vermont's Health Information Technology (HIT) plan to ensure that the necessary infrastructure is in place to enable the state to achieve its health reform goals. In 2014, the Board reviewed and approved proposed revisions to the Policy on Patient Consent for Provider Access to Protected Health Information on the Vermont Health Information Exchange or through the Blueprint (the "Consent Policy"). The Consent Policy is an important part of achieving the goals of Vermont's HIT plan because it governs provider access to patient information through the Vermont Health Information Exchange (VHIE).

Using its regular, open public meetings as a vehicle, the Board facilitated a thorough and transparent process for stakeholders and the public to provide feedback to the Vermont Information Technology Leaders (VITL), the Secretary of the Administration, and the Board on the proposed changes to the Consent Policy. This public process resulted in the Board's approval of the changes, but with conditions to specifically address concerns raised through the collaborative vetting of the proposal. In contrast to the former Consent Policy, where Vermonters would have to provide consent each time they wanted a new health care provider to access their medical records, the updated Consent Policy offers Vermonters the choice of providing one-time, global consent to their medical records information being accessed through the VHIE by all of their treating providers.[3]

Connectivity Criteria for the Vermont Health Information Exchange
Act 79 of 2013 gave the Board the authority to review and consider Health Information Exchange (HIE) connectivity as a factor in the hospital budget review process, using criteria set by VITL. In consultation with a broad cross-section of Vermont providers, VITL developed connectivity criteria, which the Board voted to accept on February 6, 2014. The criteria comprise four incremental stages designed to achieve interoperability among providers via the VHIE:

- Stage 1 (Pre-condition): Basic interaction with the VHIE;
- Stage 2 (Baseline): Minimal connectivity, sufficient to support identity matching;
- Stage 3 (Transitional): Information exchange with inbound and outbound interfaces, contributing and receiving clinical data;
- Stage 4 (Interoperable): Full integration of providers with the VHIE.

The connectivity criteria are a critical tool in achieving Vermont's health care reform goals. According to the U.S. Department of Health and Human Services, "all patients, their families, and providers should expect to have consistent and timely access to standardized health information that can be securely shared" across the full spectrum of providers and others involved in health care delivery and decision-making. Interoperability is reflected in the core values embodied in Vermont's HIT Plan, which recognizes that "[s]hared health care data that provides a direct value to the patient, provider or payer is a key component of an improved health care system. Data interoperability is vital to successful sharing of data." Currently, however, Vermont providers use more than 70 different electronic health record systems (EHRs), and the state's provider community will continue to acquire EHRs and update or replace existing ones. The Board believes that provider support and compliance with the connectivity criteria in the selection and implementation of EHRs is critical to achieving interoperability, as it will accelerate connectivity to the VHIE and reduce the cost and complexity of developing interfaces for the many different EHRs in use in Vermont.

[3] The current Consent Policy is available on the GMCB's website:
http://www.gmcboard.vermont.gov/sites/gmcboard/files/Consent_Policy022714.pdf

Innovation

Payment & Delivery System Reform

The goal of the Green Mountain Care Board's Payment and Delivery System Reform Program is to move away from volume-based payments (e.g., paying fee-for-service) toward 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 contain the rate of growth in health care costs.

Establishing Accountable Care Organizations (ACOs) and Shared Savings Programs
During 2014, an important milestone was achieved when Medicaid and commercial insurance Shared Savings Programs were negotiated, finalized, launched, and implemented. Shared Savings Programs 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). The theory being tested is that sharing savings between insurers and providers will motivate continuous improvements in care and reductions in cost.

Blue Cross and Blue Shield of Vermont and Medicaid[4] are the participating insurers in the Vermont Shared Savings Programs. These participating insurers share savings with Vermont's three Accountable Care Organizations (ACOs): OneCare Vermont, Community Health Accountable Care, and Vermont Collaborative Physicians.[5] ACOs are groups of providers that agree to work together to improve care and reduce costs for the people that they serve. More than 150,000 Vermonters were attributed to Commercial, Medicaid, or Medicare Shared Savings Program participating providers in 2014.

As part of the implementation process, Vermont's ACO Shared Savings Program Standards were finalized in January 2014. These standards establish program requirements on topics such as how savings will be calculated and shared between insurers and ACOs, how performance on quality measures will impact the amount of shared savings that ACOs receive, how ACOs should be governed, and data sharing between insurers and ACOs. This led to the launch of Vermont's Medicaid and Commercial Shared Savings Programs in March 2014 (retroactive to January 1, 2014), which is very similar to the Medicare ACO Shared Savings Program, launched previously. In fact, the Medicare Program's standards and performance measures served as a basis for the Vermont programs.

The identification of quality and financial measures is another key aspect of Shared Savings Program implementation—how ACOs perform on such measures helps to determine the amount of shared savings they receive from the insurers. In Vermont, a multi-stakeholder Quality and Performance Measures Work Group identifies and recommends standardized Shared Savings Program measures to evaluate ACO performance. The GMCB approved measures of quality, patient experience, cost, and utilization for 2014 in December 2013. During 2014, the Work Group developed recommendations for 2015 measures, and after obtaining extensive public comment, the GMCB approved the 2015 measures in October 2014.

---

[4] 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.
[5] 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.

In 2015, as data on the 2014 quality and financial measures become available, there will be a shift in focus from program implementation to monitoring, evaluation, and care delivery transformation. Preliminary data is already being exchanged between the insurers, ACOs, GMCB staff, and an analytics contractor for the Board. Final 2014 results will be available during the third quarter of 2015. In addition to assessing ACO performance, this data will be essential in informing future health care payment and delivery system reforms in Vermont.

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 Shared Savings Programs 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. The GMCB supports these efforts to unify operations and work towards common goals. As further described in the 2014 report, these efforts include establishing:

Unified Community Health Systems to Support Care Transformation: In each regional Health Service Area, payers, Blueprint and ACO leadership are working together to form a single unified health system initiative. 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.

Unified Performance Reporting and Data Infrastructure: Insurers and Blueprint and ACO leaders are co-producing performance reports that show results for quality, cost and utilization measures, as well as developing reporting that supports 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: Targeted modifications to current Blueprint PCMH and CHT payments could help optimize the effectiveness of the Unified Community Health Systems. Options include 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.

Studying Variation in Health Care Payments

During 2013 and 2014, the Green Mountain Care Board commissioned and reviewed two formal studies regarding health care payment variation in Vermont. *Vermont Health Systems Payment Variation Report,* completed in June 2013 by the Vermont Association of Hospitals and Health Systems Network Services Organization, confirmed the existence and extent of variation in provider payments among commercial payers.[6] *Price Variation Analysis* was completed in August 2014 by the University Of Vermont College Of

[6] The report is available at: http://gmcboard.vermont.gov/sites/gmcboard/files/Variation_Jun03.pdf.

Medicine, the University of Massachusetts Medical School, and Wakely Consulting Group.[7] This second study attempted to explain why health care providers are paid differently for essentially the same services and provided principles and policy recommendations for reducing variation in payments over time. With these reports as a basis, the GMCB aims to design an all-payer rate setting process to bring transparency to variations in payments and create a more rational payment system. In order to implement an all-payer rate setting process, the state must obtain a waiver from the federal government to allow Medicare to participate in an all-payer system.

Exploration of an All-Payer Model and Waiver with Medicare

The implementation of Shared Savings Programs, the collaboration between the Blueprint and the ACOs, and the findings of the price variation studies all set the stage for an all-payer system of payments to providers. The Board and the state will pursue a federal "all-payer waiver" which, in combination with the statutory authority vested in the Board, would allow for implementation of a reformed payment system across all payers, including Medicare and Medicaid. The Board and the state will request a waiver to allow for greater flexibility in the use of Medicare funds, with no reductions in the coverage of Medicare beneficiaries.

The waiver would exempt Vermont from certain national Medicare payment methods and would allow the state's providers to be paid by Medicare and all other payers in a way that would support promising delivery system reforms and movement away from the volume-based, fee-for-service payment system. An agreement between the state, the federal government, and providers on a total growth cap, across all payers and on health care costs and changes in provider payment methods, will help the state to achieve its goals of improving the health of Vermonters, improving quality of care, and containing the rate of growth in health care costs.

The all-payer model and waiver proposal will be developed through a partnership between the GMCB, the Agency of Human Services, and the Agency of Administration. In an all-payer system, the Board would exercise its statutory authority to determine payment rules for ACOs and non-ACO providers. As mentioned above, the majority of Vermont's health care providers and many of its long-term services and supports providers are ACO participants. For those providers that do not participate in ACOs, the Board will need to establish rules to govern fee-for-service payments and ensure a transparent fee schedule. All payment rules will reflect the Board's priorities for a strong and well-integrated primary care foundation. 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.

Other Payment and Delivery System Reform Initiatives

In addition to the programs described above, the GMCB supports several current and proposed payment and delivery system reform initiatives throughout Vermont, including:

- Board and DVHA staff are working through the Vermont Health Care Innovation Project (VHCIP) to explore how Episodes of Care (EOC) programs might complement Shared Savings Programs and the Blueprint. EOC programs establish quality goals and payment mechanisms that encourage regional collaboration and care transformation between hospitals, specialists, post-acute care, and specialized service providers for particular clinical conditions or procedures (for example, congestive heart failure or hip and knee replacements). Combining an EOC program with the payment incentives in Vermont's Shared Savings Programs could create strong disincentives for unnecessary utilization, variations in care practices, and uncoordinated care among settings and providers, resulting in improved quality and patient experiences of care.

[7] The report is available at:
http://gmcboard.vermont.gov/sites/gmcboard/files/Meetings/Presentations/Price_Variation_Analysis_GMCB100214.pdf

- As part of a national Bundled Payment Initiative of the Centers for Medicare and Medicaid Services (CMS), Rutland Regional Medical Center and other Rutland providers have implemented a project coordinating all care for congestive heart failure (CHF) patients across several organizations and combining payment for that care. The project, which is an example of an EOC program that predated the VHCIP work, currently includes approximately 80 Medicare beneficiaries. CHF all-cause 30-day readmission rates were held to 12.5 percent in 2014 for these patients, well below their historical rates of 24 to 25 percent. Rutland has expanded the focus of this work to include people with chronic obstructive pulmonary disease (COPD), engaging 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 are participating in the Vermont Oncology Project to test promising interventions to improve provider communications, collaboration, and coordination of care for patients diagnosed with cancer. An evaluation plan for this pilot has been developed and will be implemented in the coming year.

- The GMCB 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 VHCIP and will be implemented during 2015.

- Act 79 of 2013 requires the Board to establish a Prior Authorization Pilot Program to determine the impact on primary care costs of eliminating insurer prior authorization requirements for certain procedures and services. Pilot programs are being planned for two types of services: advanced imaging and drugs. The imaging pilot will take place in Middlebury and Rutland. The drug pilot will be implemented statewide; three of the state's major insurers came together with Board Member Allan Ramsay, M.D., and GMCB staff to decide on two classes of drugs for which prior authorization requirements could be removed. These pilots are expected to start in the spring of 2015.

Vermont Health Care Innovation Project (VHCIP)

The Green Mountain Care Board plays a central role in the $45 million dollar State Innovation Model grant, also known as The Vermont Health Care Innovation Project (VHCIP). The Chair of the Board serves as a co-chair for the VHCIP Steering Committee and also as a voting member of the core team responsible for managing the grant. The GMCB and DVHA share responsibility for the grant, along with the Agency of Administration.

The VHCIP aims to increase the level of accountability for cost and quality outcomes among provider organizations; to create a health information network that supports and informs the best possible care management and assessment of cost and quality outcomes; to ensure accountability for outcomes from both the public and private sectors; and to create commitment to change and synergy between public and private cultures, policies, and behaviors. Year one of the VHCIP began in October 2013.

Along with extensive payment and delivery system reform efforts, year two of the VHCIP will be devoted to creating a unified system of care management across the state and a unified approach to provider performance reporting and data analyses. Specifically, the VHCIP will build on year one investments in Health Information Technology (HIT), Health Information Exchange (HIE) capacity, and monitor the progress of our contractors and sub-grantees to ensure that year one undertakings are proceeding apace. These initiatives include:

- Build-out of HIE interfaces;
- Expansion of HIT and HIE interfaces to mental health and long-term services and supports providers;
- Construction of gateways for ACO and other analytics.

The VHCIP will also continue to support strategic planning around health information data collection, storage, and interoperability. Key implementation activities in year two include:

- Development of a unified system of care management;
- Development of unified performance reporting and data analyses;
- Designing population-based payments for ACOs;
- Designing alternative payment models for non-ACO providers;
- Planning and implementation of HIT/HIE data integration.

Workforce

The Green Mountain Care Board is responsible for reviewing and approving the Administration's Health Care Workforce Strategic Plan. In 2013, the Board approved the strategic plan, which created the Health Care Workforce Work Group. In addition to the activities laid out in the strategic plan, the Workforce Work Group administered a Statewide Workforce Symposium in November of 2014. The focus of the symposium was planning for a future workforce within a reformed health care system. Board member Betty Rambur, Ph.D., R.N., participated in the planning of this event, which featured national health care workforce experts. The symposium was attended by a broad audience of health care providers, educators, and state agency representatives.

During 2014 the Board worked closely with John Matulis, D.O., General Internist at Dartmouth-Hitchcock Medical Center and Masters in Public Health student at the Dartmouth Institute for Health Policy and Clinical Practice, whose research is focused on primary care workforce retention. The Board recognizes that the primary care workforce is the foundation for healthcare reform and is essential to any high functioning system but that many factors contribute to low rates of recruitment and retention of primary care providers across the country. Dr. Matulis is undertaking qualitative work looking at the primary care landscape within Vermont, exploring how the nature of the work may contribute to the sense of burnout and physician turnover, and trying to identify common challenges and ideas for improvement in working conditions which can be packaged into actionable recommendations for the Board.

Evaluation

Vermont Health Care Expenditure Analysis

Since 1993, Vermont has created an annual Health Care Expenditure Analysis. The Expenditure Analysis summarizes health spending in two forms: the Resident Analysis, which includes expenditures on behalf of Vermont residents regardless of where the health care was provided; and the Provider Analysis, which includes all revenue received for services by Vermont providers regardless of where the patient lives. At this time, the FY 2012 Health Care Expenditure Analysis provides the most current official data; the FY 2013 Analysis is under development and expected to be released in early 2015. A significant enhancement for the FY 2013 Expenditure Analysis will be to integrate claims data from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). GMCB staff is now reviewing work to this end performed by Truven Health Analytics and Brandeis University which will provide a closer alignment of commercial and government spending data with member demographics, utilization, and geographic regions.

Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

On July 1, 2013, the GMCB assumed responsibility for VHCURES, Vermont's all-payer claims database. VHCURES data allows for a population-based analyses of health care system performance. In 2014, the GMCB, with the input of stakeholders and analysts, continued to work on both improving the quality of the information contained in the database and on ensuring that there is appropriate access to the information by authorized users of the database. Also in 2014, the Board incorporated Medicare data into VHCURES, making it a true all-payer claims database containing medical and pharmacy claims and demographic information for 90 percent of commercially insured Vermonters and 100 percent of Medicaid and Medicare enrollees.

Through data use agreements, VHCURES data is being utilized by state agencies, state contractors and academic researchers to support analysis of health care access, spending, utilization, and quality. Examples include: the evaluation of the Blueprint for Health primary care medical home program, which relies heavily on metrics and reports generated from VHCURES; the Health Care Cost Institute (HCCI)'s *2007-2011 Vermont Health Care Cost and Utilization Report*, which compares national and Vermont health care trends for the privately insured; and The *Dartmouth Atlas of Children's Health Care in Northern New Englan*d, produced by The Dartmouth Institute for Health Policy & Clinical Practice, which examines small area variations in children's health care. In addition, the Centers for Disease Control and Prevention has sponsored specialized training, through an epidemiologist assigned to the Vermont Department of Health, that concentrates on working with the claims data to support research on maternal child health.

During 2014, the Board approved the implementation of a Data Governance Council to oversee data stewardship in areas of data quality, risk pertaining to data privacy and security, financial sustainability of the VHCURES program, and data release to support research. This five-member council made up of GMCB staff and Board members meets at least once per month in an open, public meeting. Meeting materials for the Data Governance Council can be found at the GMCB website, under the heading, "Data Governance Program."

Also in 2014, the Board, drawing on stakeholder input and based on use cases for the data, began drafting an amended rule for VHCURES that will support the aims and mission of the Board. The Board anticipates making a draft available for comment early in 2015, prior to formal filing of the rule.

Health Care System Analysis & Reporting

In 2014, the Board applied its data and analytical resources to measuring and analyzing trends in health care spending and other health care system metrics. The Board worked with Truven Health Analytics (Truven), its analytical vendor, to build improvements into the annual Health Care Expenditure Analysis for tracking spending and utilization rates and trends. Truven has also produced preliminary reports on defining health care service areas, market areas, and decomposition of prices, which are scheduled for release in final form by May 2015. This foundational work informs the strategic approaches that the state will use for implementing cohesive system innovation, regulation, and for evaluation and measuring the impacts of innovations.

In addition, the GMCB was awarded a Cycle IV Rate Review grant from the U.S. Department of Health and Human Services that will support improvements to the Board's data resources and analytics related to the development of price transparency information for consumers and other stakeholders in health care financing, purchasing and service provision. The GMCB continues to believe that timely and accessible information on prices for health care services can help consumers understand more about cost and related issues of quality and effectiveness of care that define value and improve health.

Dashboard 2.0

In 2012, the GMCB developed Dashboard 1.0 to broadly reflect Vermont's health care system in four key areas: (1) cost, (2) access to care, (3) healthy lives, and (4) prevention and treatment. Recognizing that where Vermonters live, learn, work, and play also have a profound impact on our health, the GMCB and the Vermont Program for Quality in Health Care facilitated a stakeholder process for assessing the gaps in Dashboard 1.0 and planning for Dashboard 2.0.

Dashboard 2.0 measures 51 non-medical and medical health indicators, grouped in twelve categories, throughout the developmental lifespan. While some of these indicators reflect directly on our health care system, "community" indicators (such as early Adverse Childhood Experiences [ACEs], adult mentoring programs for youth, access to healthy and nutritious food, support for persons with disabilities, and unemployment rates) are included because of their impact on Vermonters' health.

The innovative approach to Dashboard 2.0 is based on a series of reports produced by the Agency of Human Services (AHS) in the 1990s, guided by the then-AHS Secretary and now-Board member Cornelius Hogan. AHS has recently re-adopted this "Vermont Well-Being" framework for its Results Scorecards. Similar to Dashboard 2.0, the Results Scorecards are intended as a tool for assessing the state of well-being in Vermont, and for understanding the impact of current programs and initiatives on the health care system and the health of Vermonters. Moving forward, the Board will partner with AHS to ensure that health and well-being indicators are as aligned as possible, and that they continue to be available and useful to the public.

Vermont Health Care Innovation Project (VHCIP) Evaluation

GMCB staff are developing a VHCIP self-evaluation plan with the support of a contractor, IMPAQ International, and its subcontractor Brandeis University. The self-evaluation plan, expected to be completed in early 2015, will include a complementary array of qualitative and quantitative analyses with the goals of:

- Determining whether VHCIP is on track to achieve its intended outcomes;
- Informing in a timely and in-depth manner the development and targeting of continuous quality improvement activities;
- Understanding downstream impacts of VHCIP;

- Making recommendations regarding the future diffusion of VHCIP initiatives.

The current draft evaluation plan calls for the completion of six complementary sets of activities, including:

- Assessment of state-led implementation planning and stakeholder engagement activities;
- Development of metrics to monitor implementation effectiveness;
- Collection and analysis of qualitative data documenting the experiences and perceptions of frontline providers involved in VHCIP implementation and operation;
- Collection and analysis of primary survey data documenting provider perceptions of VHCIP impacts and unintended consequences;
- Use of secondary administrative (VHCURES) and survey data (e.g., the Behavioral Risk Factor Surveillance System) to monitor trends in health care expenditures, care processes and population health on a state-wide basis and for subgroups based on demographic and clinical characteristics;
- Time series analysis informing the impact of VHCIP on health care expenditures, care processes, and population health.

These activities will facilitate regular reporting to the Center for Medicare and Medicaid Innovation (CMMI), inform the need to adjust implementation activities as needed to maximize project impact, and provide a rigorous, empirical basis for recommendations to scale-up and broadly diffuse VHCIP initiatives.

Priorities for 2015

1. Maintain an open, transparent process of stakeholder driven health care reform.

During its first three full years of operation, the Board relied on a transparent process of decision-making that incorporates the input of stakeholders and the public. Through weekly open meetings, advisory committee meetings, traveling board meetings, rate review forums, VHCIP workgroups, and a consistent public comment process, many Vermonters have contributed their point of view and have collaborated on reform. As the Board continues to advance health care reform in Vermont, the willing participation of stakeholders and the public will remain a fundamental component of sound policymaking.

2. Reduce the Rate of Growth in Health Care Costs by Creating a More Unified System.

In 2015, the Board will continue to advance payment and delivery system reform. In cooperation with the Agency of Human Services, the Department of Vermont Health Access, and the Agency of Administration the Board will pursue an all-payer payment model and a waiver from the federal government to allow Medicare to participate. An all-payer model would lead to more consistency, predictability, and transparency in health care system planning and governance. By facilitating more transparency in the reporting of prices for health care services, a more uniform set of information about health care costs will be available to Vermonters.

3. Pursue Population Health Improvement.

The Board will continue to prioritize primary care improvement in collaboration with the Blueprint for Health. A strong primary care foundation, including Mental Health and Substance Abuse Services, is imperative to improving the health of Vermonters.

Appendix

Appendix A: Statutory Requirements of This Report

Vermont law requires that the GMCB report annually to the Legislature on the following subjects:

- Any changes to the payment rates for health care professionals established by the GMCB.
- Any new developments with respect to health information technology.
- Any health system evaluation criteria adopted by the GMCB.
- Any results of the system-wide performance and quality evaluations required of the GMCB.
- 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.
- Any recommendations for modifications to Vermont statutes.
- Any actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs.

Changes to payment rates for health care professionals established by the GMCB
The GMCB did not make any changes to payment rates for health care professionals during 2014.

New developments with respect to health information technology
The GMCB is responsible for reviewing and approving Vermont's Health Information Technology (HIT) plan to ensure that the necessary infrastructure is in place to enable the state to achieve its health reform goals. In 2014, the Board reviewed and approved proposed revisions to the Policy on Patient Consent for Provider Access to Protected Health Information on the Vermont Health Information Exchange or through the Blueprint (the "Consent Policy"). The Consent Policy is an important part of achieving the goals of Vermont's HIT plan because it governs provider access to patient information through the Vermont Health Information Exchange (VHIE).

Act 79 of 2013 gave the Board the authority to review and consider Health Information Exchange (HIE) connectivity as a factor in the hospital budget review process, using criteria set by VITL. In consultation with a broad cross-section of Vermont providers, VITL developed connectivity criteria, which the Board voted to accept on February 6, 2014.

Health system evaluation criteria adopted by the GMCB
In keeping with the Act 48 requirement to evaluate the performance of Vermont's health system, the Board launched GMCB Dashboard 2.0 in 2014 with input and guidance from the GMCB, Dashboard Stakeholder Group, and Vermont Program for Quality in Health Care. Dashboard 2.0 is intended to accomplish the following:

- Identify dashboard indicators that are accessible to health care consumers.
- Align with measures reported elsewhere and/or use existing data streams.
- Include the most currently available data.
- Align with the goals for the GMCB Dashboard.

The identification of quality and financial measures is a key aspect of the Shared Savings Program implementation described in this report. Specifically, how ACOs perform on such measures helps to determine the amount of shared savings they receive from the insurers. In Vermont, a multi-stakeholder Quality and Performance Measures Work Group, identifies and recommends standardized Shared Savings Program measures to evaluate ACO performance. The GMCB approved measures of quality, patient experience, cost, and utilization for 2014 in December 2013. During 2014, the Work Group developed recommendations for 2015 measures, and after obtaining extensive public comment, the GMCB approved the 2015 measures in October 2014.

Results of the system-wide performance and quality evaluations required of the GMCB
See the description of the Dashboard above.

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
The GMCB found no appropriations in 2014 to address the Medicaid cost shift in 2015. As detailed in the body of this report, the GMCB will continue to monitor the cost shift and the specific impact of any new Medicaid appropriations. Board and staff members are available to present further details and updates on the cost shift as needed.

Recommendations for modifications to Vermont statutes
The GMCB does not anticipate requesting any modifications to Vermont statutes during the 2014 legislative session.

Actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs
The Board, in partnership with the Agency of Human Services and the Agency of Administration, will pursue a waiver proposal to the federal government to allow for Medicare to participate in an all-payer model in Vermont.

Appendix B: Alignment with Principles of Act 48

Act 48 Principle	GMCB Work Aligned with this Principle
(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.	The Board's work on payment and delivery reform, hospital budgeting, health insurer rate reviews, CON review, and HIT planning align with this principle.
(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.	The Board's work on payment and delivery reform, hospital budgeting, health insurer rate reviews, CON review, and HIT planning align with this principle.
(3) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.	The body of this report describes much work to improve transparency and accountability through the GMCB. This includes open weekly Board meetings (including traveling meetings in Springfield, Burlington, and Middlebury), a new rate review web site, meetings with the advisory committee, explanatory publications for consumers, and more than 60 public speaking events at which GMCB members and their staff explained the Board's work.
(4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities. Other aspects of Vermont's health care infrastructure, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.	Enhancement of primary care has been a specific focus of the GMCB's payment and delivery reform policy. Investments in strengthening primary care were considered a legitimate exemption from hospital budget constraints. As discussed in the body of this report, it is central to the GMCB's role to consider the full scope of needs in Vermonter's health care infrastructure. This includes the unique needs of the state's rural areas and the role of the state's academic medical center.

Act 48 Principle	GMCB Work Aligned with this Principle
(5) Every Vermonter should be able to choose his or her health care providers.	The GMCB's regulatory and innovation efforts preserve Vermonters' freedom to choose their health care providers.
(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.	Cost is a major focus of virtually all of the GMCB's regulatory and innovation activities. For example, the Board publishes the annual Expenditure Analysis, a key source of information for government, consumers, and regulated entities regarding health care costs.
(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.	By launching Dashboard 2.0, the GMCB intends for Vermonters to have an accessible source of information about key indicators of health and well-being.
(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.	Where appropriate, the Board's policy decisions around payment and delivery reform aim to incorporate both best practices identified by health care practitioners and shared patient/provider decision-making.
(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.	The identification of quality and financial measures is a key aspect of the Shared Savings Program for ACOs and allows the Board a framework for regularly evaluating the effects of health care payment and delivery system reforms on access, quality, and cost containment. In addition the VHCIP evaluation takes into account the entire landscape of health care reform activities in the state in order to assess overall access, quality, and cost containment.
(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high- quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.	Identifying drivers of health care cost growth, and areas in which our system can be more efficient, are central to the Board's payment reform and cost control efforts.

Act 48 Principle	GMCB Work Aligned with this Principle
(11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.	An all-payer model of payments for health care services can create a more predictable, transparent, and sustainable system. The GMCB will pursue development of an all-payer model in 2015.
(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.	The GMCB will rely on input and collaboration from individuals, health care professionals, and suppliers as it develops a proposal for an all-payer model in Vermont. In particular, the Board will look to stakeholders to ensure that system changes will continue to support solvency for providers and efficient health services in the interest of the public.
(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.	The GMCB has brought numerous constituencies into our decision-making processes through public meetings, targeted outreach and general public education. In addition, working across state agencies to achieve alignment of our policies has been a major focus. This cross- and inter-disciplinary approach is part of the fabric of our work and is again a priority in 2015.
(14) State government must ensure that the health care system satisfies the principles expressed in this section.	As described above and throughout this report, the Board brings these principles to bear on its work. Indeed, these principles are woven into the Board's specific statutory duties and authorities, and they guide our regulatory and policy decision- making.

Appendix C: List of 2014 GMCB Meetings

Meeting Date	Meeting Agenda
1/09/2014	VHCIP Analytics Contractor RFP by Richard Slusky, GMCB Director of Payment Reform. Clinician Leaders Whitepapers by Cy Jordan, MD, MPH, VMS Director of the Foundation for Education and Research. Expenditure Analysis and FY15 Hospital Budget Guidance by Mike Davis, GMCB Director of Health System Finances. Use of Mid-Level Dentals Providers in Vermont by S. Beth Nolan, Voices for Vermont's Children, Outreach & Project Coordinator; and J. Steve Arthur, DDS, MPH, Vermont Department of Health, Director Office of Oral Health. Medical Records Study Update by Michael Donofrio, Esq., GMCB General Counsel.
1/16/2014	Rate Review and CON Briefing by Judy Henkin, Esq., GMCB Health Policy Director. Prior Authorization Project Update by Allan Ramsay, GMCB Board Member. Proposed changes to the cost sharing structures of qualified health plans by Lindsey Tucker, DVHA Deputy Commissioner Vermont Health Connect; and Erick Carrera, DVHA Health Benefit Exchange Policy Analyst. Vote on VHCIP Analytics Contractor RFP.
1/23/2014	Lewis and Ellis Actuaries by David M. Dillon, FSA, MAAA, Vice President & Principal; and Jackie Lee, FSA, MAAA, Vice President and Consulting Actuary. Act 48 Criteria Discussion. Vote on Proposed changes to the cost sharing structures of qualified health plans.
1/30/2014	GMCB Budget Overview by Susan Barrett, JD, GMCB Executive Director; and Mike Davis, GMCB Director of Health System Finances. VT Hospitals FY14 Year to Date Operating Results by Mike Davis, GMCB, Director of Health System Finances. Update re H.596: Conversion of Hospital Assets by Michael Donofrio, Esq., GMCB Legal Counsel. Update and Vote on Proposed changes to the cost sharing structures of qualified health plans presented by Devon Green, Agency of Administration, Health Care Policy Analyst. Vote on the description of GMCB's oversight role in relation to the ACO Program Agreement by Richard Slusky, GMCB Director of Payment Reform.
2/06/2014	Discussion of Criteria for Creating or Maintaining Connectivity to the State's Health Information Exchange Network by John Evans, MHA, FACHE, President/CEO of VITL; and Liora Alschuler, CEO of Lantana Consulting Group. Vote to accept the Connectivity Criteria as established by VITL. Update on GMCB's Advisory Groups by Susan Barrett, GMCB, Executive Director; and Rick Blount, GMCB Contractor.
2/13/2014	HIT/HIE Consent Policy by Robin Lunge, AOA Director of Health Care Reform; John K. Evans, VITL President/CEO; Anne E. Cramer, Esq., of Primmer, Piper, Eggleston & Cramer; Rob Gibson, VITL, VP Marketing and Business Development; Kate McIntosh, MD, VITL, Medical Director; Paul Harrington, Vermont Medical Society, Executive Vice President; and Allen Gilbert, American Civil Liberties Union Executive Director. Future of Dental Care in Vermont by Vaughn Collins, Vermont State Dental Society Executive Director, and Gary Davis, DDS, Timber Lane Dental Group Pediatric Dentist.
2/20/2014	Rethink Eye Care by Karena Shippee, OD, Vermont Optometric Association, Legislative Chair; and Frank Pinard, OD, Vermont Optometric Association President. Expenditure Analysis Discussion by Mike Davis, GMCB, Director of Health System Finances. Update on Health Analysis by Ena Backus, GMCB, Deputy Director of Policy and Evaluation; and Dian Kahn, GMCB, Director of Analysis and Data Management.

Meeting Date	Meeting Agenda
2/27/2014	HIT/HIE Discussion. VHCURES Background and Update on Procurement Process by Stacey Murdock, GMCB, Data and Information Project Manager; Charlie Leadbetter, PMP, Berry, Dunn, McNeil and Parker, LLC. Principle; and David Regan, PMP, Berry, Dunn, McNeil and Parker, LLC, Senior Consultant.
3/13/2014	Blueprint Annual Report by Craig Jones, MD, Blueprint for Health Executive Director. Soteria- Certificate of Need presented by Donna Jerry, GMCB Health Care Administrator. Vote on HIT/HIE Consent Policy.
3/20/2014	Payment Reform Pilot Update by Richard Slusky, GMCB Director of Payment Reform. Hub and Spoke Discussion by Beth Tanzman, MSW, Vermont Blueprint for Health Assistant Director; and Barbara Cimaglio. Vermont Department of Health, Deputy Commissioner for Alcohol and Drug Abuse Programs.
3/27/2014	Rate Review Update by Judy Henkin, Esq., GMCB Health Policy Director. FY 2013 Hospital Financial Operating Results by Mike Davis, GMCB Director of Health System Finances. FY 2015 Budget Plans and Instructions by Mike Davis, GMCB Director of Health System Finances. Board Discussion of Global Budgets by Richard Slusky, GMCB Director of Health Care Reform.
4/03/2014	Core Community Practices by Cy Jordan, MD, MPH, Director, Vermont Medical Society Education and Research Foundation; Josh Plavin, M.D., MPH – Medical Director of Gifford Health Care; and Fay Homan, M.D., Family Medicine & Obstetrics, Little Rivers Health Care, Wells River. BCBSVT Administrative Costs by Don George, CEO BCBSVT; and Ruth Greene, CFO, BCBSVT. Vote on Statewide Analytics Contractor related to the State Innovation Model Grant.
4/17/2014	Public Announcement of Rate Review Decisions. Vote on No-Cost Contract Extension for John Snow Inc. Vote on Contract Amendment for Policy Integrity, LLC. GMCB Budget Update by Mike Davis, GMCB Director of Health System Finances. Update/Vote on ACO Shared Savings Program Measure Review and Modification by Pat Jones, GMCB, Health Care Project Director; Dian Kahn, GMCB, Director of Analysis and Data Management; and Stacey Murdock, GMCB, Data and Information Project Manager.
4/24/2014	GMCB Round Table Discussion.
5/01/2014	**Traveling Board Meeting, Springfield Vermont:** Timothy Ford, CEO, Springfield Medical Care Systems; George Karabakakis, CEO, Emeritus Health Care & Rehabilitation Services ; Judith Hayward, CEO, Emeritus Health Care & Rehabilitation Services; and Jeanne McLaughlin, CEO, Visiting Nurse & Hospice of Vermont/New Hampshire.
5/08/2014	Vote on Contract Amendment for Berry, Dunn, McNeil & Parker, LLC. Truven Health Analytics.
5/15/2014	Vote on New England Medical Design, Inc., Contract period extension. Vote on Hyman Hayes, LLC contract period extension. Vote on sole source contract for VAHHS-NSO. Certificate of Need Discussion and Vote: Replacement of Two Cardiac Catheterization Laboratories at Fletcher Allen Health Care. VHCIP Update by Georgia Maheras, VHCIP, Project Director. Legislative Update by Michael Donofrio, Esq., GMCB, General Counsel; and Ena Backus, GMCB, Deputy Director of Policy and Evaluation.
5/22/2014	Vermont Colocation of Mental Health and Primary Care Survey Results: Allan Ramsay, MD, GMCB, Board Member; and Bud Vana. OneCare Update: Todd B. Moore, MBA, OneCare Vermont, CEO; Barbara Walters, DO. OneCare Vermont, Chief Medical Officer;

Meeting Date	Meeting Agenda
	Norm Ward, M.D. OneCare Vermont, Executive Medical Director; and J. Churchill Hindes, PhD, OneCare Vermont, Chief Operating Officer. Changes to the Open Meeting by Michael Donofrio, Esq., GMCB General Counsel. Possible Vote on VHCURES RFP.
5/29/2014	**Traveling Board Meeting and Rate Review Forum, Burlington Vermont:** John Brumsted, MD, President & CEO, Fletcher Allen Health Care; Frederick Morin, MD, Dean, UVM College of Medicine; Patty Prelock, Ph.D., Dean, College of Nursing and Health Sciences. Jack Donnelly, MBA, CEO, Community Health Centers of Burlington. Todd Centybear, MS, Executive Director, Howard Center. Judy Peterson, RN, CEO, Visiting Nurse Association of Chittenden & Grand Isle Counties.
6/05/2014	Request for approval of a subcontract to the existing Truven Health Analytics contract. Vote on subcontract to Truven Health Analytics Contract. ACO Analytics Contract. Vote on ACO Analytics Contract RFP.
6/12/2014	Certificate of Need Hearing: Proposed Purchase of Visiting Nurse Association and Hospice of Southwestern Vermont Medical Center, Inc. by Rutland Area Visiting Nurse Association and Hospice RAVNAH, Bayada Home 6/19/2014.
6/19/2014	Act 79 Energy Plans by Richard Morley, VP of Support Services, Central Vermont Medical Center; and Tim Perrin, Senior Account Manager, Efficiency Vermont.
6/26/2014	Internal Budget Update by Mike Davis, GMCB, Director of Health System Finances. Health Insurance Rate Review Grant Program. VHCURES RFP Update. Update and Vote on Kelly Services.
7/10/2014	Health Services Enterprise, Secretary Douglas Racine, Agency of Human Services; and Stephanie Beck, Program Director of the Health Services Enterprise. Update and Vote on the Certificate of Need for the Proposed Purchase of the Visiting Nurse Association and Hospice of Southwestern Vermont Medical Center, Inc. by Rutland Area Visiting Nurse Association & Hospice presented by Judy Henkin, Esq., GMCB, Director of Health Policy; and Donna Jerry, GMCB, Health Care Administrator. Board Discussion, Vote.
7/17/2014	Vermont Information Technology Leaders by John K Evans, MHA, FACHE, President/CEO, VITL. New Business. Changes to Rate Review Confidentiality Order by Michael Donofrio, GMCB, General Counsel Esq.
7/24/2014	Update on the Vermont Blueprint for Health by Craig Jones, MD, Director, Vermont Blueprint for Health. VHCIP Self Evaluation Contract by Annie Paumgarten, GMCB, Evaluation Director; and Georgia Maheras, Esq., Project Director, Vermont Health Care Innovation Grant.
7/31/2014	Preliminary look at Fiscal Year 2015 Hospital Budgets by Mike Davis, GMCB, Director of Health System Finances. VHCIP Self Evaluation Contract. Annie Paumgarten, GMCB, Evaluation Director; and Georgia Maheras, Esq., Project Director, Vermont Health Care Innovation Grant. Vote on VHCIP Self -Evaluation Contract.
8/07/2014	Substantive and Technical changes to Accountable Care Organization Standards by Richard Slusky, GMCB Director of Payment Reform. Reviewing Work Products for GMCB by Ena Backus, GMCB, Deputy Director of Policy and Evaluation.
8/12/2014	BCBSVT Exchange Insurance Rate Review Hearing
8/13/2014	MVP Exchange Insurance Rate Review Hearing
8/21/2014	Health Care Reform Presentation by VT Hospitals by Jill Berry Bowen, CEO, Northwestern Medical Center; Tom Dee, CEO, Southwestern VT Health Care; and Paul Bengtson, CEO, Northeastern VT Regional Hospital. Vote on Technical and Substantive changes for ACO

Meeting Date	Meeting Agenda
	Pilot Standards. VHCURES Governance by Stacey Murdock, GMCB, Data and Information Project Manager.
8/26/2014	FY 2015 Hospital Budget Hearings
8/27/2014	FY 2015 Hospital Budget Hearings
8/28/2014	FY 2015 Hospital Budget Hearings
9/04/2014	Vote on Claims Edit Sole Source Contract. Hospital Budget Discussions & Votes.
9/11/2014	Vote on Claims Edit Sole Source Contract. Hospital Budget Discussion & Votes.
9/23/2014	VHCURES Process Update. Vote on Sole Source Contract.
10/02/2014	Evaluation of Support and Services at Home (SASH) by RTI, presented by Nancy Eldridge, CEO, Cathedral Square/SASH; Molly Dugan, Director SASH, Cathedral Square; Allyn Webert, RN, Health Coordinator, Community Health Team, Berlin Family Medicine; and Abigail M. Crocker, Research Assistant Professor, UVM Department of Mathematics and Statistics. Payment Variation Report by Steve Kappel, University of Vermont College of Medicine, Global Health Economics Unit, Vermont Center for Clinical and Translational Science; Katherine London, University of Massachusetts Medical School, Center for Health Law and Economics; Michael Grenier, University of Massachusetts Medical School, Center for Health Law and Economics; and Richard Slusky, GMCB, Director of Payment Reform.
10/09/2014	Certificate of Need: Mt. Ascutney Renovation of Existing Space for Single Occupancy Rooms and Other Renovations by Donna Jerry, GMCB, Health Care Administrator. Vote on Mt. Ascutney Certificate of Need. Discussion of the proposed Quality and Performance Measure Changes for Year 2 of Vermont's ACO shared savings programs by Pat Jones, GMCB, Health Care Project.
10/16/2014	Certificate of Need: Rutland Regional Medical Center- Renovation of Emergency Department by Donna Jerry, GMCB Health Care Administrator. Vote on Rutland Regional Medical Center's Certificate of Need.
10/23/2014	Proposed changes to the Quality and Performance Measure Changes for Year 2 of Vermont's ACO shared savings programs. Vote on the proposed Quality and Performance Measure Changes for Year 2 of Vermont's ACO shared savings programs. Discussion of RFP for services related to development of an all-payer waiver. Vote on VHCURES 2.0 Vendor Selection.
10/30/2014	**Traveling Board Meeting- Middlebury:** Green Mountain Care Board Introduction. Vote to release an RFP for professional services to support development of an All-payer Waiver. Funding of Designated Agencies Overview by Vermont Care Partners Addison County and The Counseling Service of Addison County. Discussion of Health Care in Addison County: From Current to Future Presentations/Discussion by Community Stakeholders.
11/06/2014	Vote to make changes to change order for VAHHS NSO contract. Vermont Health Care Innovation Plan Update by Richard Slusky, GMCB Director of Payment Reform; Georgia Maheras, Esq., VHCIP, Project Director; and Kara Suter, Director, Payment Reform and Reimbursement, Department of Vermont Health Access.
11/13/2014	Socioeconomic Determinants of Health and Wellbeing by Sam Liss, Vice President, Board of Directors, Vermont Center of Independent Living (VCIL); Barbara Donovan, Public Transit Administrator, Agency of Transportation; Nancy Eldridge, CEO, Cathedral

Meeting Date	Meeting Agenda
	Square/Support and Services at Home; and Ed Paquin, Executive Director, Disability Rights Vermont, Inc.
11/20/2014	Independent Physician Report by Robin Lunge, Agency of Administration, Director of Health Care Reform; Kara Suter, Director, Payment Reform and Reimbursement, Department of Vermont Health Access; and Steve Kappel, Policy Integrity.
12/02/2014	**GMCB Rate Review Forum:** Introduction to GMCB Insurance Rate Review by Judith Henkin, Esq., GMCB, Health Policy Director. Comments from the Audience.
12/04/2014	Lewis and Ellis, Inc., Change Order. Background on Green Mountain Care Benefits by Robin Lunge, Agency of Administration, Director of Health Care Reform; and Devon Green, Agency of Administration, Health Care Policy Analyst.
12/11/2014	Green Mountain Care Benefits by Robin Lunge, Agency of Administration, Director of Health Care Reform; Devon Green, Agency of Administration, Special Counsel for Health Care Reform; and Ellen Meara, Ph.D., Associate Professor, The Dartmouth Institute of Health Policy Clinical Practice, Dartmouth College.
12/18/2014	Open Public Comment Period. Update on GMCB Data Governance Council by Susan Barrett, GMCB, Executive Director. New Business.

Appendix D: Full List of GMCB Powers and Authorities

The Vermont Legislature established the Green Mountain Care Board and delegated powers and duties to it in Act 48 of 2011. Most of the statutes defining the Board and its roles appear at sections 9371-9381 of Title 18 of Vermont Statutes Annotated. The specific sections containing the Board's powers and duties are reproduced in full below. Section 1822 of Title 33, which sets out the determinations the Board must make before Green Mountain Care can be implemented, is also reproduced in full below.

As set forth in 18 V.S.A. § 9375(b) (6)-(8) (see below), the Board has jurisdiction over health insurance rate review, hospital budget review, and certificate of need review. The specific statutes governing those review processes are not reproduced in this Appendix, and can be found in Vermont Statutes Annotated as follows:
Health insurance rate review: 8 V.S.A. § 4062
Hospital budget review: 18 V.S.A. §§ 9453-9457
Certificate of need review: 18 V.S.A. §§ 9431-9446

18 V.S.A. § 9372. Purpose

It is the intent of the general assembly to create an independent board 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.

18 V.S.A. § 9374. Board membership; authority

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair and all of the members shall be state employees and shall be exempt from the state classified system. The chair shall receive compensation equal to that of a superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the chair.

(2) The chair and the members of the board shall be nominated by the Green Mountain Care board nominating committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a superior judge. The governor shall not appoint a nominee who was denied confirmation by the senate within the past six years.

(b)(1) The initial term of the chair shall be seven years, and the term of the chair shall be six years thereafter.

(2) The term of each member other than the chair shall be six years, except that of the members first appointed, one each shall serve a term of three years, four years, five years, and six years.

(3) Subject to the nomination and appointment process, a member may serve more than one term.

(4) Members of the board may be removed only for cause. The board shall adopt rules pursuant to 3 V.S.A. chapter 25 to define the basis and process for removal.

(c)(1) No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this

subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.

(2) No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member, individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.

(3) The prohibitions contained in subdivisions (1) and (2) of this subsection shall not be construed to prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

(A) being an insurance policyholder or from receiving health services on the same terms as are available to the public generally;

(B) owning a stock, bond, or other security in an entity subject to supervision or regulation by the board that is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the board member chooses the stock, bond, or security; or

(C) receiving retirement benefits through a defined benefit plan from an entity subject to supervision or regulation by the board.

(4) No board member shall, during his or her term or terms on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board.

(5) No board member may appear before the board or any other state agency on behalf of a person subject to supervision or regulation by the board for a period of one year following his or her last day as a member of the Green Mountain Care board.

(d) The chair shall have general charge of the offices and employees of the board but may hire a director to oversee the administration and operation.

(e)(1) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. Members of such advisory group who are not state employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

(f) In carrying out its duties pursuant to this chapter, the board shall seek the advice of the state health care ombudsman established in 8 V.S.A. § 4089w. The state health care ombudsman shall advise the board regarding the policies, procedures, and rules established pursuant to this chapter. The ombudsman shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the board in order to protect patients' and consumers' interests.

(g) The chair of the board or designee may apply for grant funding, if available, to advance or support any responsibility within the board's jurisdiction.

(h)(1) Expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the board shall be borne as follows:

(A) 40 percent by the state from state monies; (B)

15 percent by the hospitals;

(C) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125;

(D) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101; and

(E) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

(2) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the board to perform its duties, the chair of the board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however, any person subject to the board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the chair upon properly being ordered to do so may be assessed an administrative penalty by the chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

18 V.S.A. § 9375. Duties

(a) The board shall execute its duties consistent with the principles expressed in 18 V.S.A. § 9371. (b) The board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost- containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the board's proposed methodologies to the house committee on health care and the senate committee on health and welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of state government to engage in additional cost-containment activities to the extent permitted by state and federal law.

(2) Review and approve Vermont's statewide health information technology plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the state to

achieve the principles expressed in section 9371 of this title.

(3) Review and approve the health care workforce development strategic plan created in chapter 222 of this title.

(4) Review the health resource allocation plan created in chapter 221 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board;

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012.

(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning January 1, 2013.

(9) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

(10) Develop and maintain a method for evaluating system-wide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system; (B) for utilization of health services;

(C) in consultation with the department of health and the director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(D) for cost-containment and limiting the growth in health care expenditures;

(E) for determining the adequacy of the supply and distribution of health care resources in this state;

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the board.

(11) Develop the unified health care budget pursuant to section 9375a of this title.

(12) Review data regarding mental health and substance abuse treatment reported to the department of financial regulation pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the mental health technical advisory group established pursuant to subdivision 9374(e)(2) of this title.

(c) The board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the agency of human services, and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the agency of human services shall present a report on the benefit package proposal to the house committee on health care and the senate committee on health and welfare. The report shall describe the covered services to be included in the Green Mountain Care benefit package and any cost- sharing requirements. If the general assembly is not in session at the time that the agency makes its recommendations, the agency shall send its report electronically or by first class mail to each member of

the house committee on health care and the senate committee on health and welfare.
(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

18 V.S.A. § 9375a. Expenditure analysis; unified health care budget

(a) Annually, the board shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in sections 9371 and 9372 of this title.

(1) The budget shall:

(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.

(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont and for all health care services provided to residents of this state.

(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.

(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

(2) The board shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.

(b)(1) Annually the board shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the board under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:

(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organization, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and

(B) expenditures for Medicare, all self-insured employers, and all other health insurance.

(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the board's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year and an evaluation of the efficacy of any cost containment efforts the plan has made.

(3) The board's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department of financial regulation, and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.

(4) The board shall prepare a report of the final projections made under this subsection and file the report with the general assembly on or before January 15 of each year.

18 V.S.A. § 9376. Payment amounts; methods

(a) It is the intent of the general assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent

basis, effective and efficient health services that are in the public interest. It is also the intent of the general assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

(b)(1) The board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the state, and the need for health care professionals in particular areas of the state, particularly in underserved geographic or practice shortage areas.

(2) Nothing in this subsection shall be construed to limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection from a patient without health insurance or other coverage for the service or services received.

(c) The board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the board determines such payments to be appropriate.

(d) To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.

18 V.S.A. § 9377. Payment reform; pilots

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects
described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for payment and delivery system reform, including the pilot projects established in this section.

(2) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:

(A) payment reform pilot projects should align with the Blueprint for Health strategic plan and the statewide health information technology plan;

(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(C) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(E) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(3) In addition to the objectives identified in subdivision (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

(A) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(B) with input from long-term care providers, the inclusion of home health services and long- term care services as part of capitated payments.

(c) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

(d) The board or designee shall apply for grant funding, if available, for the evaluation of the pilot projects described in this section.

(e) The board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments, to advise the board in developing and implementing the pilot projects and to advise the Green Mountain Care board in setting overall policy goals.

(f) The first pilot project shall become operational no later than July 1, 2012, and two or more additional pilot projects shall become operational no later than October 1, 2012.

(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the department of financial regulation to the same extent as the requirement to participate in the Blueprint for Health pursuant to 8 V.S.A. § 4088h.

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of financial regulation. Health insurers shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(3) In the event that the secretary of human services is denied permission from the Centers for Medicare and Medicaid Services to include financial participation by Medicare in the pilot projects, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.

(4) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.

18 V.S.A. § 9377a. Prior authorization pilot program

(a) The Green Mountain Care Board shall develop and implement a pilot program or programs for the purpose of measuring the change in system costs within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The program shall be designed to measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. In developing the pilot program proposal, the board shall collaborate with health care professionals and health insurers throughout the State or regionally.

(b) The board shall submit an update regarding implementation of prior authorization pilot programs as part of its annual report under subsection 9375(d) of this title.

33 V.S.A. § 1822. Implementation; waiver

(a) Green Mountain Care shall be implemented 90 days following the last to occur of:

(1) Receipt of a waiver under Section 1332 of the Affordable Care Act pursuant to subsection (b) of this section.

(2) Enactment of a law establishing the financing for Green Mountain Care.

(3) Approval by the Green Mountain Care Board of the initial Green Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

(4) Enactment of the appropriations for the initial Green Mountain Care benefit package proposed by the Green Mountain Care Board pursuant to 18 V.S.A. § 9375.

(5) A determination by the Green Mountain Care Board, as the result of a detailed and transparent analysis, that each of the following conditions will be met:

(A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy. This determination shall include an analysis of the impact of implementation on economic growth.

(C) The financing for Green Mountain Care is sustainable. In this analysis, the Board shall consider at least a five-year revenue forecast using the consensus process established in 32 V.S.A. § 305a, projections of federal and other funds available to support Green Mountain Care, and estimated expenses for Green Mountain Care for an equivalent time period.

(D) Administrative expenses in Vermont's health care system for which data are available will be reduced below 2011 levels, adjusted for inflation and other factors as necessary to reflect the present value of 2011 dollars at the time of the analysis.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending without reducing access to necessary care or resulting in excessive wait times for services.

(F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

(b) As soon as allowed under federal law, the Secretary of Administration shall seek a waiver to allow the State to suspend operation of the Vermont Health Benefit Exchange and to enable Vermont to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing

subsidies, and small business tax credits provided in the Affordable Care Act. The Secretary may seek a waiver from other provisions of the Affordable Care Act as necessary to ensure the operation of Green Mountain Care.

(c) The Green Mountain Care Board's analysis prepared pursuant to subdivision (a)(5) of this section shall be made available to the General Assembly and the public and shall include:

(1) a complete fiscal projection of revenues and expenses, as described in subdivision (a)(5) of this section, including reserves, if recommended, and other costs in addition to the cost of services, over at least a five-year period for a public-private universal health care system providing benefits with an actuarial value of 80 percent or greater;

(2) the financing plans provided to the General Assembly in January 2013 pursuant to Sec. 9 of No. 48 of the Acts of 2011;

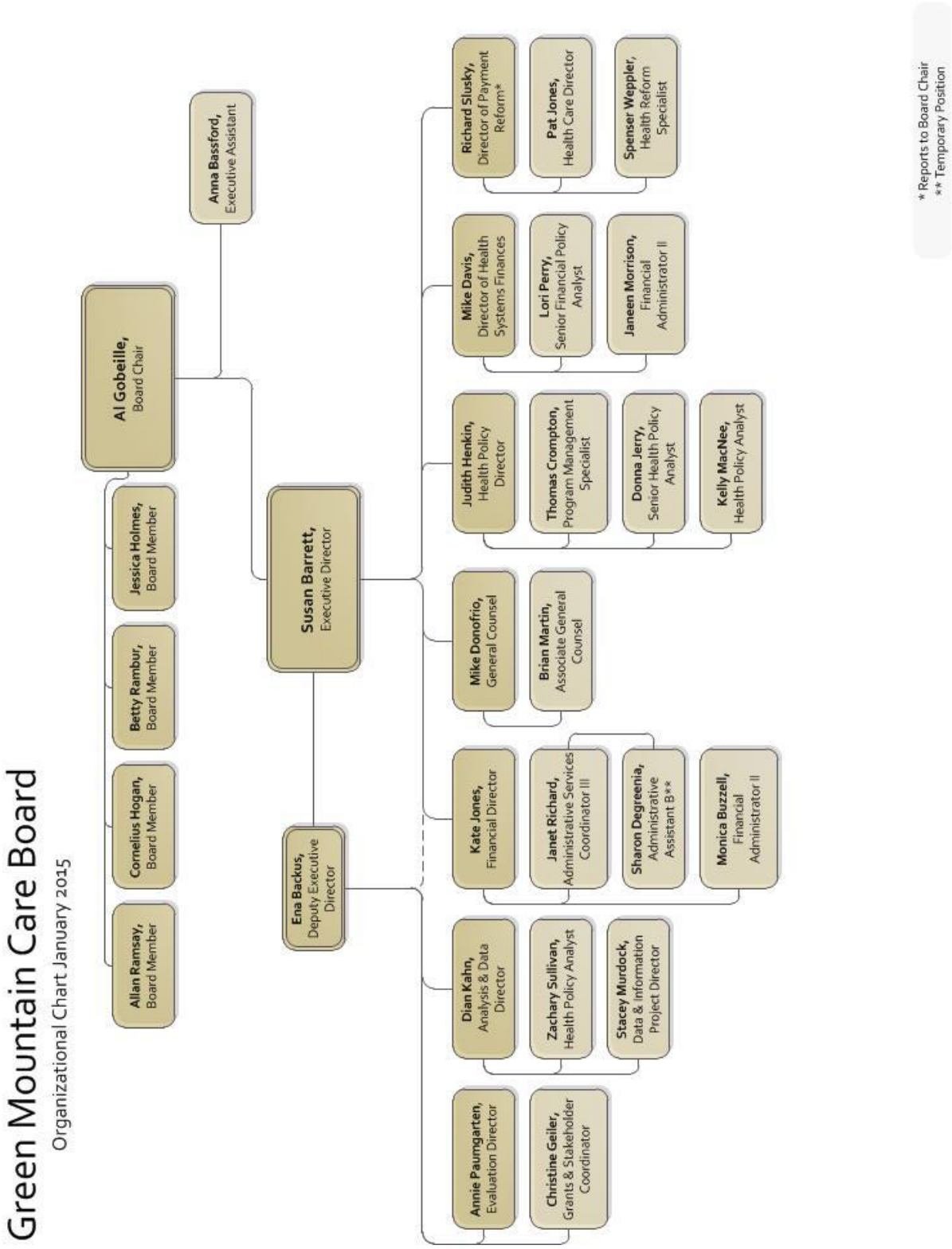
(3) an analysis of how implementing Green Mountain Care will further the principles of health care reform expressed in 18 V.S.A. § 9371 beyond the reforms established through the Blueprint for Health; and

(4) a comparison of best practices for reducing health care costs in self-funded plans, if available.

Appendix E: GMCB Budget

Department	Positions	FY15 Estimated Expenditures	FY16 Proposed Expenditures
Green Mountain Care Board	Currently 28, 37 Requested in FY16	9,308,933	11,918,573
General Fund		792,263	1,777,656
Special Fund		1,496,200	2,504,552
Global Commitment		2,699,237	3,811,359
Interdepartmental Transfer (from DFR and DVHA MOUs)		2,502,142	2,755,540
Federal Fund		1,891,546	1,069,466
Expenses by Category			
Personal Services: Personnel Salary and Fringe		3,134,441	3,765,190
Personal Services: Third Party Contracts		5,800,550	7,514,594
Operating Expenses		373,942	638,789

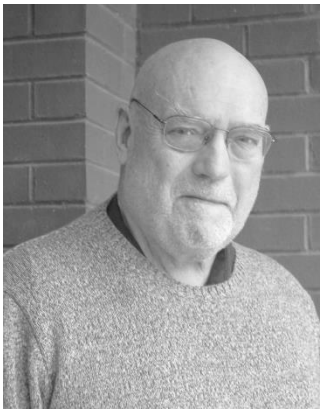
Appendix F: GMCB Organizational Chart



Appendix G: 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. Mr. Gobeille 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. Mr. Gobeille 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 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 life. 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.

With this year's annual report, we remember our friend and colleague, Andrea Grishman, who spent 21 years working on health care issues and reform for the State of Vermont, and who passed away in 2014 from breast cancer. We thank Andrea for sharing her keen intellect, precise editorial pen and good humor with our office.

VERMONT

GREEN MOUNTAIN CARE BOARD

www.gmcboard.vermont.gov