VERMONT

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

From: Green Mountain Care Board

Date: January 16, 2018

Title: Green Mountain Care Board Annual Report for 2017

Statute: 18 V.S.A. § 9375(d)

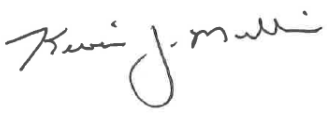
Dear Senator Cummings, Senator Ayer, Senator Kitchel, Representative Ancel, Representative Toll, and Representative Lippert:

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

It has been an exhilarating experience for me, personally, in my new role. I am encouraged daily by the hard-working state employees at GMCB. We are continuously working to add value to the citizens of Vermont through our work on health insurance rate review, hospital and ACO budget analysis, issuance or denial of certificate of needs, and working with our federal partners to move Vermont payment reform away from fee-for-service towards a model that encourages prevention, wellness, and better coordination of care.

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

Sincerely,



Kevin J. Mullin

Green Mountain Care Board

ANNUAL REPORT FOR 2017

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.

Submitted January 16, 2018

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INTRODUCTION

In the six years since its inception, the Green Mountain Care Board has been instrumental in working to guide the State, through a transparent process, on the path to ensuring that all Vermonters have access to high quality, affordable health care. Since the passage of Act 113 (2016) and the signing of the All-Payer Accountable Care Organization Model Agreement (APM Agreement) late in 2016, the Board has focused much of its work on planning for and implementing new regulatory processes, while aligning its new work with existing ones, to support the goals outlined in the legislation and in the Agreement. Throughout 2017, the Board continued to refine its regulatory oversight of hospital budgets, health facility planning through the certificate of need program, health insurance rates and qualified health plans, and in 2017 implemented a rigorous process for overseeing Accountable Care Organization (ACO) budgets as the State approached Performance Year One of the Agreement. However, health care is still unaffordable for many Vermonters, and the Board recognizes that more must be done.

Through the health insurance rate review process, the Board sought to minimize rate increases for Vermonters buying health insurance on Vermont Health Connect (VHC) for the 2018 plan year through a transparent, public process. Insurance plans purchased through VHC, with coverage beginning January 1, 2018, increased by an average of 8.0% over 2017 plans. As measured by the insurers' requested rates, compared to those approved by the Board after a full review, Vermonters saved an estimated $16.2 million.

For fiscal year (FY) 2018 hospital budgets, the Board approved an average annual increase in hospital rates of 2.1%, well below recent estimates of medical inflation. After adjusting for physician transfers, the Board held hospital net patient revenue (NPR) growth to 3.01% (or a weighted average increase of 2.08%), below the overall 3.6% growth rate requested by the hospitals.

The Board's work on payment and delivery reform in 2017 continued to focus on building a system to contain health care costs and reward high quality care. As required by Act 113, the GMCB drafted and promulgated Administrative Rule 5.000, governing ACO budget review and certification, in preparation for the January 1, 2018 start of Performance Year One of the APM Agreement. The APM Agreement, starting in 2018 and running through December 2022 (Performance Year 5), directs attention and resources to achieving three important population health goals: improving access to primary care, reducing deaths from suicide and drug overdose, and reducing the prevalence and morbidity of chronic disease. In addition, the APM Agreement constrains health care spending by establishing an annualized 3.5% maximum, measured at the end of the Agreement, on per capita health care expenditure growth for all major payers (Medicaid, Medicare, and commercial).

STRATEGIC PRIORITIES FOR 2018

It is the mission of the Green Mountain Care Board (GMCB) to regulate, innovate, and evaluate Vermont's changing health care system to improve the health of the population, provide access to high quality health services for all residents of the state, and ensure the affordability of health care by reducing the rate of growth in health care costs. GMCB is dedicated to providing value to Vermonters by ensuring access, controlling cost growth, and improving quality of care.

- **Implementation and Year One Launch of APM.** With the passage of Act 113 and the signing of the All-Payer ACO Model Agreement (APM) in 2016, planning and implementing new regulatory processes and aligning these with existing processes were key goals for GMCB in 2017. In 2018 (Performance Year One of the APM), priorities for its successful implementation include:
    - Working with the APM analytics vendor to develop and initiate reporting and oversight;
    - Setting Commercial and Medicare rates for ACOs;
    - Conducting ACO Budget Review and Certification that complies with antitrust laws and ensures any Vermont all-payer, ACO-based payment reform model is implemented in a manner consistent with the requirements of Vermont law and the APM Agreement; and
    - Monitoring and evaluating the success of the APM to ensure access to high-quality care for Vermonters, as well as reporting financial benchmarks, scale targets, and quality measures to CMS.

- **Alignment of GMCB Regulatory processes.** The GMCB is responsible for certifying ACOs; reviewing their budgets; reviewing and advising the Department of Vermont Health Access (DVHA) on Medicaid ACO rates; setting commercial and Medicare rates for ACOs; reporting on progress to the Centers for Medicare & Medicaid Services (CMS); tracking financial benchmarks, scale targets and quality targets, and implementing changes to other Board processes (*e.g.*, hospital budgets; health insurance rate review; certificate of need). The Board and its staff have been developing an integrated regulatory approach to these processes to ensure that they are performed in tandem, rather than in isolation, and that information garnered from one can inform the others. Work begun in 2017 will continue into 2018 to align these regulatory processes for improved reporting, monitoring, and evaluation.

- **Updating Certificate of Need Statute and procedures.** In 2017, GMCB began a review of the Certificate of Need (CON) statute, the accompanying rule, and the Board's procedures. Staff met with a stakeholder group to discuss proposed changes to the law, many of which are technical rather than substantive, and the Board submitted a draft of proposed changes to Legislative Council. The bill has been introduced in the Senate (S.277). This work will continue in 2018 with the goal of streamlining the process for CON applicants and for the Board and its staff.

- **VHCURES Procurement**. In 2018, GMCB will issue a Request for Proposal (RFP) seeking a new multi-year vendor to expand and enhance the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's All-Payer Claims Database (APCD).

LEGISLATIVE REPORTS

Exhibit 1: Legislative Reports, 2017

Report	Due Date	Corresponding Legislation
GMCB Program Performance Measures	January 15, 2017	Act 85: An act relating to making appropriations for the support of government
2016 Annual Report	January 15, 2017	Act 48: An act relating to a universal and unified health system
Multi-year Budget for ACOs	January 15, 2017	Act 113: An act relating to implementing an all-payer model and oversight of accountable care organizations
GMCB effort to achieve alignment between Medicare, Medicaid and Commercial Payers in APM	January 15, 2017	Act 112: An act relating to cataloguing and aligning health care performance measures
Provider Reimbursement Report	February 1, 2017	Act 143: An act relating to notice to patients of new health care provider affiliations
GMCB All-Payer ACO Model Update Benchmarks	June 15, 2017; September 15, 2017; December 15, 2017	Act 25: An act relating to Next Generation Medicaid ACO pilot project reporting requirements
Pharmacy Cost Transparency	August 2017	Act 165: An act relating to prescription drugs
Bill Back Report	September 15, 2017	Act 79: An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board
Fair Reimbursement Report	October 1, 2017	Act 85: An act relating to making appropriations for the support of government
Integration of Payments; Accountable Care Organizations	December 15, 2017; January 15, 2018	Act 82: An act relating to examining mental health care and care coordination
Rule 5.000: Oversight of Accountable Care Organizations	In effect January 1, 2018	Act 113: An act relating to implementing an all-payer model and oversight of accountable care organizations

STAKEHOLDER ENGAGEMENT IN 2017

The Green Mountain Care Board considers public engagement and transparency a foundation of its work. GMCB seeks stakeholder participation through a variety of forums, groups, and public comment opportunities including:

- GMCB Board Meetings;
- The GMCB Advisory Committee;
- The Primary Care Advisory Group;
- Clinician Surveys and Focus Groups; and
- Public comment opportunities.

GMCB Board Meetings

The Green Mountain Care Board meets weekly in open public meetings. GMCB meetings operate in accordance with Vermont's Open Meeting Law: they are warned in advance, open to the public, audio-recorded, include an opportunity for public comment, and following the meeting, minutes are posted to the GMCB website. In addition, most meetings are videotaped by Onion River Community Access Media (ORCA).

The GMCB Advisory Committee

The GMCB Advisory Committee was formed in 2012 to provide input and recommendations to the Board. The committee's fifty-two members represent consumers, businesses and health care professionals.

In 2017, the Advisory Committee convened once for a series of roundtable discussions with Board members and staff on five topics: Payment and Delivery System Reform, Health Care Workforce, Hospital Budgets, Insurance Rate Review, and Outreach and Education.

In 2018, the GMCB is committed to quarterly meetings of the advisory group. For more information, see http://gmcboard.vermont.gov/board/advisory-committee.

The Primary Care Advisory Group (PCAG)

In accordance with Act 113 of 2016, the GMCB established a Primary Care Advisory Group (PCAG). PCAG membership includes twenty-two primary care providers (a mix of physicians, nurse practitioners, and advanced practice registered nurses), a staff liaison from the Board, and one Board member. PCAG met thirteen times in 2017 and presented once at the Board's regularly scheduled public meeting.

PCAG members are developing suggestions on reducing administrative burdens facing primary care providers based on three areas outlined in Act 113: (1) meaningful measure selection, (2) reduction of prior authorization requirements, and (3) development of a uniform discharge summary. These are not areas over which the Board has jurisdiction, so many of the recommendations will take the form of suggested legislation or collaborative work with insurers or hospitals to change their internal processes. Members have begun to outline priorities, goals and responsibilities in each of the three areas. In 2017, PCAG members provided input to the Board's legislative report concerning cataloging and alignment of performance measures required of primary care providers, conducted ongoing discussions with Vermont payers regarding streamlining prior authorization, and created an initial draft of a uniform discharge summary.

The Board and PCAG are proposing an expansion of their role to the General Assembly to allow this group to provide advice to the Board on its regulatory duties as outlined in statute.

For more information, see http://gmcboard.vermont.gov/content/primary-care-advisory-group.

Clinician Surveys and Focus Groups

In addition to the two formally convened groups described above, GMCB works to understand the perspectives of Vermont's health care providers through surveys and focus groups. In 2017, GMCB held three focus groups in three locations identified based on stakeholder interest (Montpelier, Middlebury and Burlington), and fielded a survey that received responses from 400 clinicians from all hospital service areas. The results of these activities are described in further detail in the Data, Analytics, and Evaluation section of this report, beginning on Page 41.

Additional Public Comment Opportunities

Members of the public have a variety of opportunities to provide comment to the GMCB. The GMCB website lists options for members of the public to provide comment including submitting an online public comment form, calling the GMCB office, or emailing the GMCB.

PROGRESS IN 2017

HEALTH INSURANCE REGULATION

Insurance Rate Review

Overview

As the entity charged with regulating major medical insurance rates under state and federal law, the Green Mountain Care Board reviews proposed health insurance rate filings, identifies the drivers of rate increases, and approves, disapproves or modifies the filings with the goal of ensuring that Vermonters will have better access to quality, affordable health insurance coverage.

Under Vermont law, the Board must review and issue its decision on a proposed rate filing within 90 days, during which time the Board and its staff work with Lewis & Ellis (L&E), the Board's contract actuary, to ensure that resulting rates will have the minimum impact on Vermonters while still meeting actuarial standards. With L&E's technical support and assistance, the Board determines: whether a proposed rate will cover the insurer's cost of providing health care services to plan enrollees without allowing for excessive profit or surplus; whether the rate change is affordable for Vermonters; and, taking into consideration the opinion of the Vermont Department of Financial Regulation, whether modification of the proposed rate will jeopardize the insurer's solvency.

Progress During 2017

2017 RATE FILINGS

The Board reviewed twelve rate filings in 2017, as illustrated in Exhibit 2, below. Most significant are the filings for the Vermont Health Connect (VHC) plans offered by Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Care, which cover approximately 80,000 Vermonters. Over two days in July, the Board held hearings open to the public concerning the insurers' proposed rate increases in which the Vermont Office of the Health Care Advocate (HCA) participated. Members of the public were invited to observe the proceedings and submit in-person comment. In all, the GMCB received over 500 public comments about the VHC filings—through its website, by mail, by phone, and in-person— each of which urged the Board to trim the proposed rate increases. On August 10, 2017, the Board reduced BCBSVT's proposed 12.7% average annual rate increase to 9.2%, and MVP's proposed 6.7% average annual rate increase to 3.5%. When measured against the proposed rate increases, these two rate decisions produced an estimated $16.2 million in savings to Vermonters. When all twelve of the Board's 2017 rate decisions are accounted for, the savings rise to approximately $16.4 million.

FEDERAL CHANGES

After months of threatening to end cost-sharing reduction (CSR) payments to insurers, the Trump Administration confirmed on October 12, 2017, that the CSR payments would no longer be made, even though insurers were still required to offer the plans with reduced cost sharing to low-income consumers. With the possibility of discontinuation in mind, the Board requested that BCBSVT and MVP include in their VHC rate filings the effect on premiums if the CSR payments ceased. BCBSVT calculated that discontinuation of CSR payments would require it to raise premiums by approximately 1.9% across all metal levels (Bronze, Silver, Gold, and Platinum plans offered through Vermont Health Connect); MVP concluded that if the increase fell solely on silver

plans, those premiums would increase by approximately 7.8%; if spread across all metal levels, premiums would increase by approximately 2.8%.

Unlike many other state regulators, the Board did not require the insurers to provide two sets of rate filings, reflective of both scenarios should CSR payments cease, but instead requested that they file as if the CSR payments would continue. The Board's rate decisions became final thirty days following their issuance (on September 9, 2017) and were not appealed by either carrier. When it was confirmed in October that the CSR payments would end, the rates were final, and had been provided to the Department of Vermont Health Access (DVHA), which was in the midst of preparing for their release to the public.

The Board based its decision not to revisit the 2018 rates to account for the change in federal policy on two primary considerations; first, if the rate impact was directed solely at silver plans, small businesses in Vermont's merged market, which are ineligible for premium subsidies, would be unfairly singled out for large rate increases; and second, reopening the rate filings at such a late juncture would be chaotic for the State, which was already working on technology updates that would facilitate consumer access to online information and choice. The Board's decision left the impact of the CSR defunding on the insurers, who retain reserves for unexpected financial shortfalls, rather than on Vermont consumers.

Exhibit 2: 2017 Rate Filings

Decision Date	Docket No.	Company Name	Filing Name	Proposed Rate Change	Approved Rate Change	Change in Proposed Rate vs. Approved Rate
3/28/17	001-17rr	Cigna Health & Life Insurance Company	2017 Large Group Manual Rate	-3.7%	-5.1%	-1.4%
5/8/17	002-17rr	MVPHIC	3Q17/4Q17 Grandfathered Small Group EPO/PPO	3Q17 1.8% 4Q17 2.4%	3Q17 1.8% 4Q17 2.4%	0.0%
5/8/17	003-17rr	MVPHIC	3Q17/4Q17 Large Group EPO/PPO	3Q17 3.6% 4Q17 2.7%	3Q17 3.6% 4Q17 2.7%	0.0%
5/24/17	004-17rr	BCBSVT	3Q17 Large Group Rating Program - Annual	N/A (Factor Filing[1])	N/A	N/A
5/24/17	005-17rr	TVHP	3Q17 Large Group Rating Program - Annual	N/A (Factor Filing)	N/A	N/A
6/26/17	006-17rr	MVPHP	3Q17/4Q17 Large Group HMO	3Q17 -0.2% 4Q17 1.1%	3Q17 -0.2% 4Q17 1.1%	0.0%
8/10/17	007-17rr	MVPHP	2018 Exchange Filing	6.7%	3.5%	-3.2%
8/10/17	008-17rr	BCBSVT	2018 Exchange Filing	12.7%	9.2%	-3.5%
8/31/17	009-17rr	4 Ever Life Insurance Co.	Rate filing for new expatriate health plan	N/A	N/A	N/A
11/5/17	010-17rr	MVPHIC	1Q18/2Q18 Grandfathered Small Group EPO/PPO	4.2%	4.2%	0.0%
11/7/17	011-17rr	MVPHIC	1Q18/2Q18 Large Group EPO/PPO	5.8%	5.8%	0.0%
12/20/17	012-17rr	MVPHP	1Q18/2Q18 Large Group HMO	-6.1%	-6.1%	0.0%

[1] Rate factor filings are filings that include only one pricing component ("rate factor") for review.

Looking Ahead: 2018 Activities

Late in 2017, the Board began a series of meetings with members of its staff, the Departments of Financial Regulation and Vermont Health Access, the state's two major insurers, VAHHS, and the Office of the Health Care Advocate to discuss the impact of the federal government's decision to stop CSR payments on the insurers and Vermont consumers, and how to minimize any negative impacts in the future. A public board meeting in January 2018 focused on this topic, with the Board expressing support and interest in the development of a solution with the stakeholders.

This meeting also fostered discussion on whether the State should mandate that all Vermonters purchase health insurance. The discussion was in response to the recently passed federal tax reform bill of 2017 repealing the Affordable Care Act's individual health insurance mandate (individual mandate) which required nearly all Americans to purchase health insurance or incur a penalty. Beginning in 2019, the elimination of the individual mandate is expected to increase premiums nationwide as fewer Americans, particularly those in good health, choose to purchase health insurance. As part of a broad effort to address changes in federal health care policy, the GMCB will assess the impact of the repeal on enrollment and premiums in Vermont, and the potential for implementing an individual mandate at the state level.

The Board will also review 2019 Qualified Health Plans in the early part of the year as required by statute.

Cost Shift

Overview

The Green Mountain Care Board reports annually to the Legislature on the "cost shift" that occurs when hospitals and other health care providers charge higher prices for services paid for by commercial insurance to make up for lower reimbursements from Medicare and Medicaid, and to cover charity care and bad debt.[2]

Progress During 2017

The GMCB hospital budget staff each year estimates the impact of reimbursement variations between public and commercial payers, and produces a projection of monies "shifted" to commercial insurance and individuals who pay for their own care out-of-pocket (self pay), from Medicaid, Medicare, charity care, and bad debt.

Exhibit 3: Estimated Vermont Hospitals' Cost Shift by Payer

Fiscal Year	Medicare	Medicaid	Free Care	Bad Debt		*Commercial Insurance & Other	Annual Change %
Actuals 2008	$(69,003,712)	$(103,569,366)	$(23,623,972)	$(30,252,980)	------->	$ 226,450,033	
Actuals 2009	$(73,627,496)	$(119,979,398)	$(24,292,187)	$(32,391,214)	------->	$ 250,290,295	10.5%
Actuals 2010	$(73,515,988)	$(138,016,619)	$(24,806,398)	$(33,076,863)	------->	$ 269,415,868	7.6%
Actuals 2011	$(88,399,861)	$(152,256,740)	$(25,784,124)	$(34,331,093)	------->	$ 300,771,818	11.6%
Actuals 2012	$(74,383,192)	$(151,931,648)	$(24,347,367)	$(39,264,676)	------->	$ 289,926,884	-3.6%
Actuals 2013	$(128,108,641)	$(105,982,171)	$(24,684,304)	$(37,383,822)	------->	$ 296,158,938	2.1%
Actuals 2014	$(155,622,607)	$(148,344,481)	$(19,370,131)	$(34,885,055)	------->	$ 358,222,274	21.0%
Actuals 2015	$(178,243,251)	$(184,115,357)	$(16,032,485)	$(30,469,896)	------->	$ 408,860,990	14.1%
Actuals 2016	$(190,018,540)	$(203,622,426)	$(15,683,900)	$(30,318,995)	------->	$ 439,643,861	7.5%
Budget 2017	$(191,983,612)	$(224,300,822)	$(15,191,794)	$(31,866,696)	------->	$ 463,342,923	5.4%
Budget 2018	$(206,574,288)	$(236,503,974)	$(18,599,606)	$(29,207,786)	------->	$ 490,885,653	5.9%

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

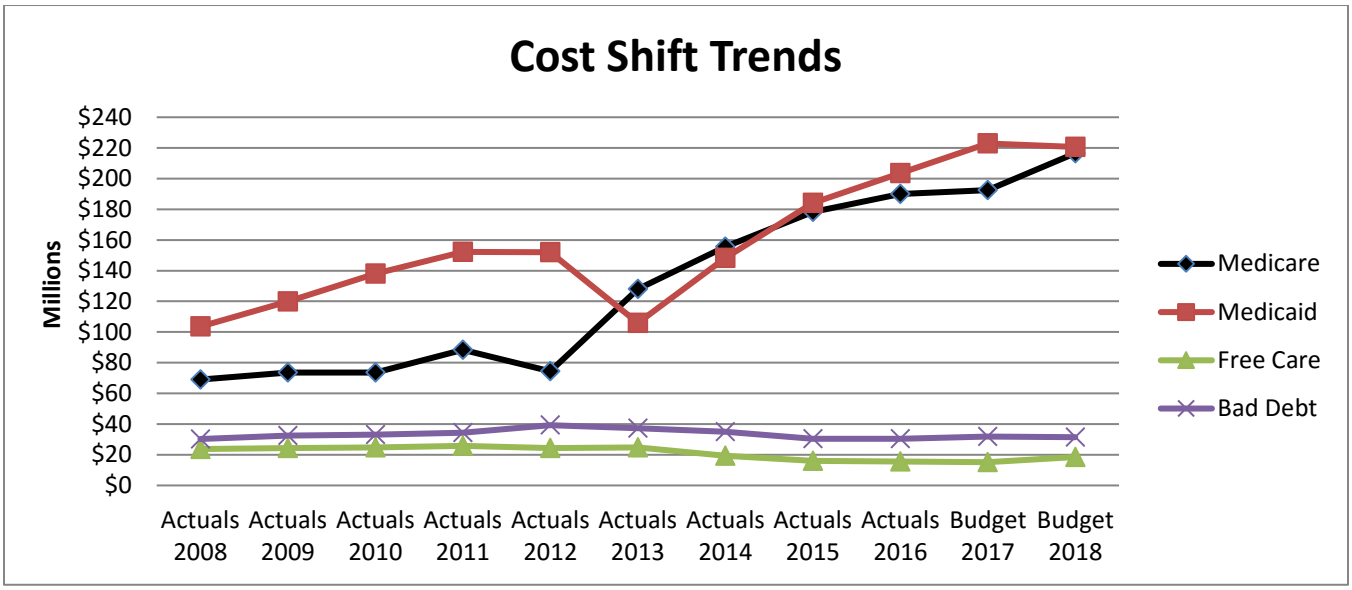
Although the rate of growth of the cost shift has slowed in recent years due in part to a decrease in bad debt (uncollectable amounts billed for patient services), Board staff anticipates that the Medicare cost shift will continue to grow at a faster pace into 2018 because of increased utilization of health care services and expected changes to Medicare reimbursement at the federal level. Staff projects that the Medicaid cost shift will also increase because provider reimbursements remain stagnant, and hospital Disproportionate Share Payments

[2] Act 79 of 2013, the Legislature required that the Board include in its annual report "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).

have decreased by $10 million. Shifts in insurance enrollment and federal changes affecting the Affordable Care Act may result in additional charity care.

Exhibit 4 illustrates the trends in Vermont hospitals' cost shift.

Exhibit 4: Vermont Hospitals – Cost Shift Trends



Looking Ahead: 2018 Activities

To better analyze and understand the cost shift, GMCB staff will work in 2018 to improve physician payer data, distinguish between Vermont and non-Vermont payer revenue, increase transparency around the Medicaid Disproportionate Share payments to hospitals that serve higher Medicaid populations, and track the effect of ACOs and payment reform initiatives on the cost shift.

REGULATING HEALTH CARE AND EVALUATING SPENDING

Hospital Budget Review

Overview

Hospital budget review is one of the GMCB's core regulatory responsibilities (18 V.S.A. §§ 9375(b)(7), 9456). In March 2017, the Board issued updated guidelines that established parameters for how the 14 Vermont hospitals should construct their Fiscal Year (FY) 2018 budgets. The Board set an overall system Net Patient Revenue (NPR)[3] growth cap of 3.0% over the hospitals' approved FY 2017 budget bases. The Board narrowed the health care reform criteria, but allowed up to an additional 0.4% in NPR for new health care reform activities, investments and initiatives related to four specific areas:

a. Support for Accountable Care Organization (ACO) infrastructure or ACO programs;
b. Support of community infrastructure related to ACO programs;
c. Building capacity for, or implementation of, population health improvement activities identified in the Community Health Needs Assessment (CHNA), [4] with a preference for those activities connected with the population health measures outlined in the All-Payer ACO Model Agreement; and
d. Support for programs designed to achieve the population health measures outlined in the All-Payer ACO Model Agreement.

Hospitals bear the burden to show that expenditures within the 0.4% allowance are truly new investments in a reformed delivery system.

Progress During 2017

FY 2018 REVIEW PROCESS

The Board and its staff analyzed each hospital's FY 2018 budget submission including: utilization information; net patient revenue and expenses; prior budget performance; financial and other key performance indicators and how they compare with state, regional, and national peers; staffing needs; capital expenditure needs; and the amount of in- and out-of-state patient migration, as well as comments from the Office of the Health Care Advocate (HCA) and from members of the public. The Board considered each hospital's unique circumstances, including its health care reform efforts and its work to address issues identified in its CHNA, as well as in- and out-of-state patient migration. Overall, the hospitals worked hard to meet policy guidelines and financial targets adopted by the Board in 2017, and submitted budgets with a system-wide NPR request of 3.6% over approved FY 2017 budgets. After adjusting for acquisitions and transfers of existing physician practices, and for changes in disproportionate share payments, the budget submissions reflected a system-wide NPR growth rate of 3.46%. After several days of public budget hearings, the Board ordered four hospitals to reduce their increase to rates,

[3] Net Patient Revenue (NPR), in hospitals, is gross inpatient revenue plus gross outpatient revenue minus related deductions and allowances from revenue (e.g., bad debt).
[4] Under the Affordable Care Act, tax-exempt hospitals are required to conduct a Community Health Needs Assessment every three years with input from public health experts and community members, and develop and adopt an implementation strategy.

and accepted one hospital's request to rebase its FY 2017 budget. As a result of these adjustments the system-wide increase in NPR was reduced to 3.01%.

Exhibit 5 below, illustrates the change in net patient revenue from 2017 to 2018. Exhibit 6, below, shows the average annual price increases for each Vermont hospital from FY 2014 to FY 2018. For FY 2018, the Board reduced the overall system weighted average price increase from the submitted 2.4% to 2.1%.

Exhibit 5: Vermont Hospitals – Net Patient Revenue Change, FY2018 Budgets

	Net Patient Revenue Change					Net Patient Revenue Change *Adjusted to Reflect Real Growth*	
				Approved 2017 to Approved 2018		Approved 2017 to Approved 2018	
	2017 Approved	2018 Submitted	2018 Approved	$ Change	% Change	**Approved *Adjusted for Physician Transfers*	% Change
Brattleboro Memorial Hospital	$76,408,611	$80,202,627	$78,879,432	$2,470,821	3.23%	$77,703,332	1.69%
Central Vermont Medical Center	$191,831,143	$198,726,498	$198,695,454	$6,864,311	3.58%	$198,327,393	3.39%
Copley Hospital	$64,819,405	$69,663,508	$68,024,531	$3,205,126	4.94%	$68,455,745	5.61%
Gifford Medical Center	$57,762,429	$59,497,391	$59,514,010	$1,751,581	3.03%	$59,514,010	3.03%
Grace Cottage Hospital	$19,205,503	$18,649,074	$18,649,074	-$556,429	-2.90%	$18,649,074	-2.90%
Mt. Ascutney Hospital & Health Center	$47,744,700	$48,395,281	$48,682,309	$937,609	1.96%	$48,682,309	1.96%
North Country Hospital	$81,189,662	$79,670,761	$79,074,579	-$2,115,083	-2.61%	$79,074,579	-2.61%
Northeastern Vermont Regional Hospital*	$77,069,500	$79,385,200	$78,818,099	$1,748,599	2.27%	$78,818,099	2.27%
Northwestern Medical Center	$101,935,936	$105,776,757	$104,401,050	$2,465,114	2.42%	$104,026,050	2.05%
Porter Medical Center	$76,094,922	$78,682,778	$79,146,442	$3,051,520	4.01%	$79,146,442	4.01%
Rutland Regional Medical Center	$243,415,448	$251,547,278	$250,963,330	$7,547,882	3.10%	$250,756,174	3.02%
Southwestern Vermont Medical Center	$152,362,260	$159,497,504	$159,497,504	$7,135,244	4.68%	$159,497,504	4.68%
Springfield Hospital	$59,147,241	$59,375,198	$59,375,198	$227,957	0.39%	$59,375,198	0.39%
The University of Vermont Medical Center	$1,172,785,845	$1,213,835,692	$1,212,580,571	$39,794,726	3.39%	$1,212,580,571	3.39%
Total Net Patient Revenue	**$2,421,772,605**	**$2,502,905,547**	**$2,496,301,583**	**$74,528,979**	**3.08%**	**$2,494,606,480**	**3.01%**

** Northeastern VT Regional Hospital – Rebased Approved Budget 2017 (from $71,339,400 to $77,069,500)*

*** "Real growth" was calculated by adjusting for physician transfers, which 5 hospitals experienced as follows:*

Brattleboro Memorial Hospital: $1,176,100
Central Vermont Medical Center: $368,061
Copley Hospital: $431,214
Northwestern Medical Center: $375,000
Rutland Regional Medical Center: $207,156

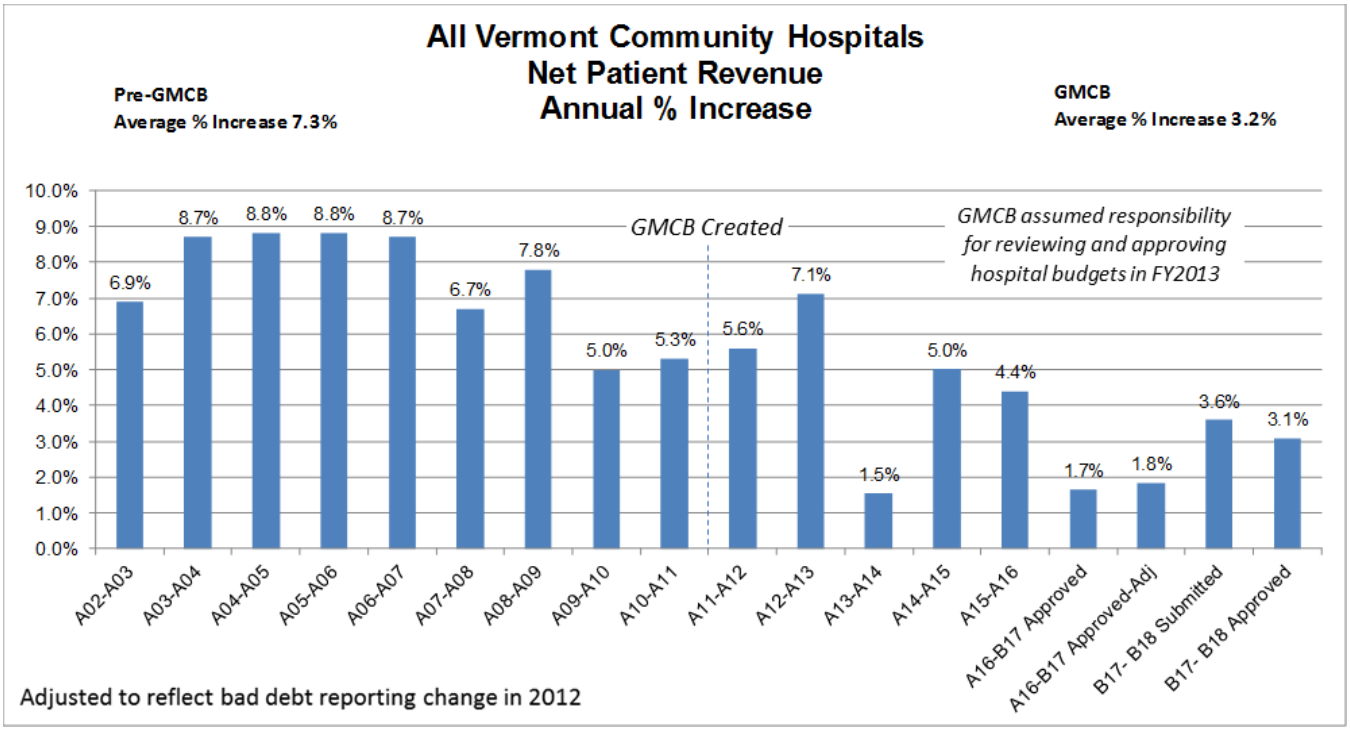
Exhibit 6: Vermont Hospitals – Annual Price Increase, FY 2014-2018

	2014		2015		2016		2017		2018	
	Submitted	*Approved*	*Submitted*	*Approved*	*Submitted*	*Approved*	*Submitted*	*Approved*	*Submitted*	*Approved*
Brattleboro Memorial Hospital	6.2%	5.8%	2.7%	2.7%	-1.2%	-1.4%	3.5%	3.5%	8.9%	5.7%
Central Vermont Medical Center	7.9%	6.9%	5.9%	5.9%	4.7%	4.7%	3.0%	2.5%	0.7%	0.7%
Copley Hospital	6.0%	6.0%	0.0%	0.0%	-3.0%	-4.0%	0.0%	-3.7%	0.0%	-3.4%
Gifford Medical Center	7.6%	7.6%	5.6%	5.6%	5.8%	5.8%	3.9%	3.9%	4.0%	4.0%
Grace Cottage Hospital	6.0%	6.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Mt. Ascutney Hospital & Health Center	5.0%	5.0%	3.2%	3.2%	5.7%	5.7%	4.9%	4.9%	4.9%	4.9%
North Country Hospital	8.0%	8.0%	8.3%	8.3%	4.8%	4.8%	3.5%	3.5%	5.0%	5.0%
Northeastern Vermont Regional Hospital	5.8%	5.6%	5.0%	5.0%	5.2%	5.2%	3.8%	3.8%	4.3%	3.2%
Northwestern Medical Center	4.6%	3.9%	6.4%	6.4%	-8.0%	-8.0%	2.9%	0.0%	6.0%	3.5%
Porter Medical Center	6.0%	6.0%	5.0%	5.0%	5.3%	5.3%	3.7%	3.7%	3.0%	3.0%
Rutland Regional Medical Center	4.8%	4.8%	8.4%	8.4%	3.7%	3.7%	-5.1%	-5.1%	4.9%	4.9%
Southwestern Vermont Medical Center	9.0%	7.2%	4.5%	4.5%	3.8%	3.8%	3.9%	3.4%	2.9%	2.9%
Springfield Hospital	6.0%	4.6%	5.5%	5.5%	2.8%	2.8%	0.0%	0.0%	6.5%	6.5%
The University of Vermont Medical Center	4.5%	4.4%	0.0%	0.0%	6.0%	6.0%	3.0%	2.5%	0.7%	0.7%
Weighted Average All Hospitals	**5.5%**	**5.2%**	**6.8%**	**6.8%**	**4.4%**	**4.4%**	**2.2%**	**1.7%**	**2.4%**	**2.1%**

Notes: UVMMC reported an overall 0% rate increase in fiscal years 2015, 2016, 2017, and 2018. CVMC reported an overall 0% rate increase in FY 2017 and 0.2% in FY 2018. Porter's overall approved rate for FY 2017 is 3.7% and negotiated commercial rate for FY 2017 is 5.3%, in FY 2018 they submitted 0% overall rate increase and 3.0% negotiated commercial rate. The weighted average has been estimated to reflect the UVMMC, CVMC and Porter negotiated commercial rates in fiscal years 2015, 2016, 2017, and 2018.

Consistent with its goal to constrain the costs of health care, the average annual NPR increase has fallen to 3.2% since the Board assumed jurisdiction over the hospital budget process in 2012, compared with an average of 7.3% in prior years. Exhibit 7, below, shows the increase in NPR over time:

Exhibit 7: Vermont Community Hospitals[5] – Net Patient Revenue Annual Percent Increase



Looking Ahead: 2018 Activities

The Board will continue to refine how it conducts its budget review and to better understand and align its regulatory work, consistent with the overarching reform goals expressed in Act 48 of 2011. As we move into Year 1 of the All-Payer Accountable Care Organization Model Agreement, the Board will continue to monitor and work with the hospitals as the State moves away from a fragmented, fee-for-service system toward an integrated delivery system and value-based provider reimbursement.

[5] This chart includes Vermont's 14 community hospitals, and excludes the Vermont State Psychiatric Hospital, Brattleboro Retreat, and White River Junction VA Medical Center.

Certificate of Need

Overview

Vermont law requires a health care facility to obtain a Certificate of Need (CON) before developing a new health care project. Each project is required to meet eight statutory criteria related to access, quality, cost, need, and appropriate allocation of resources. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure the provision and equitable allocation of high quality health care services and resources to all Vermonters. The Legislature transferred jurisdiction over the CON program to the Board in 2012, for CON applications filed on or after January 1, 2013.

Progress During 2017

Over the past year, the Board considered and approved eleven CON applications, including two emergency CON applications for facilities serving patients suffering from opiate and other substance use disorders. The Board issued CONs for the following projects:

- The University of Vermont Medical Center: replacement of electronic health records and related health information technology systems at four University of Vermont Health Network Hospitals (issued 1/5/18);
- Brattleboro Memorial Hospital: renovation and construction of a medical office building;
- Rutland Regional Medical Center: replacement of its nuclear medicine camera;
- Southwestern Vermont Medical Center: creation of a dental home;
- Green Mountain Surgery Center: development of a multi-specialty ambulatory surgical center;
- BAART Behavioral Health Services, Inc.: development of an outpatient opiate addiction treatment clinic (Emergency CON);
- The Pines at Rutland Center for Nursing and Rehabilitation: renovation and construction of the 125-bed skilled nursing facility;
- VNA & Hospice of the Southwest Region: expansion of its service area by merging with Manchester Health Services;
- OAS, LLC d/b/a Valley Vista: development of a 19-bed therapeutic community residence for women with alcohol and chemical dependencies (Emergency CON);
- Wake Robin: renovation of its 33-bed skilled nursing rooms; and
- Purchase of Rowan Court Health and Rehabilitation Center by Barre Gardens Holdings, LLC and Barre Gardens Nursing and Rehab, LLC.

Applications were filed, and decisions are pending, for the following projects:

- Northeastern Vermont Regional Hospital: replacement of existing mobile MRI with a fixed MRI unit and related new construction and renovations;
- Rutland Regional Medical Center: construction of new medical office building and renovations to existing buildings; and
- Birchwood Terrace: nursing home transfer of ownership.

As of the close of 2017, the Board has asserted jurisdiction, but has not received applications for the following proposed projects:

- Gifford Retirement Community: construction of 49 independent living units; and
- Gifford Retirement Community: construction of assisted living facility.

The Board declined review of six proposed projects that fall outside jurisdictional parameters set forth in statute.

Other Activities

PATH at Stone Summit

In 2017, the Vermont Supreme Court reviewed the Board's 2016 determination that it did not have jurisdiction over the proposed development of a therapeutic community residence, PATH at Stone Summit, (PATH), in rural Danby. *See In re PATH at Stone Summit, Inc.*, 2017 VT 56. After the Board issued a jurisdictional determination that the project would not trigger CON review, neighboring landowners ("Concerned Neighbors") attempted to intervene in the matter, which the Board denied. On appeal to the Supreme Court, the neighbors argued that the Board failed to adequately review PATH's projected operating expenses—which they believed had been understated and should have triggered CON review—and challenged the delegation of decision-making to GMCB staff.

In June 2017, the Court rejected the Concerned Neighbors' appeal. The Court concluded that because they had failed to timely file their request for intervention with the Board, the Board correctly denied the request, and the neighbors therefore lacked standing to challenge the Board's decision. The Court further concluded that even if they had been granted interested party status by the Board, their appeal to the Court had also been untimely.

Legislation has been introduced (S.263) to clarify the Board's ability to delegate work to staff.

Approval of the Application of Green Mountain Surgery Center

Besides being the first multi-specialty ambulatory surgery center in Vermont, thus generating significant public interest, the Green Mountain Surgery Center CON was unusual because it was heard by a three-member Board, prior to the appointments of Chair Kevin Mullin and Member Maureen Usifer. Although the three members constituted a quorum, and could therefore render a decision, it could only do so if the decision was unanimous. It was not, and the decision was not issued until the Board's two new members had the opportunity to fully review the record and participate in the decision-making process. Ultimately, the Board decided that the applicant met its burden of proof and issued a CON, with Member Hogan dissenting from the majority opinion.

Looking Ahead: 2018 Activities

In 2017, the Board convened a stakeholder group, led by members Lunge and Holmes, to develop a draft legislative proposal to address technical issues within the statute, streamline the CON process, and better align CON laws with Vermont health care priorities. The stakeholder group met four times from September through November. In November, the Board reviewed and discussed the draft proposal at its public board meeting and

endorsed the changes proposed in the document. S.277, a revision to CON statutes, was introduced in January 2018. The proposed changes to CON statute fall into five general areas:

1. Increasing monetary thresholds of review for hospitals;
2. Excluding certain capital expenditures;
3. Aligning criteria with statewide health care reform goals and principles; and
4. Revising enforcement authority.

The Board will follow the bill through the legislative process in 2018.

Vermont Health Care Expenditure Analysis

Overview

Since 1991, Vermont law has required a unified health care budget and an expenditure analysis to promote the policies set forth in sections 9371 and 9372 of Title 18. In Act 171 of 2011 (Adj. Sess.), the Legislature transferred this responsibility from the Department of Financial Regulation (formerly the Department of Banking, Insurance, Securities, and Health Care Administration) to the Board for final projection reports filed on or after January 15, 2013. 18 V.S.A. § 9375a.

To meet this obligation, the Board's finance team annually produces a report that compares Vermont data with federal data reflected in the National Health Accounts published by the Centers for Medicare & Medicaid Services (CMS). The report provides spending information from two different perspectives: spending on behalf of Vermont residents, regardless of where they receive care; and spending by Vermont providers for both residents and non-residents receiving care in Vermont. GMCB staff continue to improve this report as technology and resources have provided enhanced data.

Progress During 2017

The purpose of the annual Expenditure Analysis report is to inform policy makers and the public about health care spending in Vermont. The report serves as a guideline within which health care costs are controlled, resources directed, and quality and access assured. The report is a consistent model that:

- establishes a base of health care spending and funding;
- examines spending and sources of funds over time; and
- allows comparisons of Vermont spending to national health care spending.

HEALTH CARE SPENDING FOR VERMONT

Health care spending for residents receiving services both in and out-of-state increased 2.9% in 2015. This was lower than the 4.7% increase in 2014 and below the average annual increase of 4.1% for the period 2006 through 2015.

VERMONT COMPARED TO UNITED STATES

Health care spending in Vermont, per person, increased 3.0% from 2014 to 2015 to $9,112, below the national per person amount of $9,504, or 5.0%.

VERMONT PROVIDER HEALTH CARE REVENUE

In 2015, health care revenue, as measured by services delivered by Vermont providers, regardless of whether the patient resides in Vermont, increased 5.5%. This was higher than the 1.9% increase in 2014 and higher than the average annual increase of 4.7% for the period 2006 through 2015.

The full Vermont Health Care Expenditure Analysis report is available at:
http://gmcboard.vermont.gov/publications/expenditure

Looking Ahead: 2018 Activities

In 2018, staff will finalize the FY 2016 Expenditure Analysis, incorporating information and data from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont Hospital Discharge Dataset, Vermont Household Health Insurance Survey, Annual Statement Supplemental Report (ASSR), and the best available data from other national and state resources. The Board and its staff plan to use the Analysis as a key resource for monitoring cost growth to meet financial targets in the All Payer ACO Model Agreement as it begins its first year of implementation. The FY 2016 Health Care Expenditure Analysis will be released in early 2018.

In addition, legislation has been introduced (S.264) to revise the Board's duty to develop an expenditure analysis and to replace its duty to create a unified health care budget with a requirement that it develop an estimate of future health care spending.

Prescription Drug Monitoring

Overview

Act 165 of 2016 requires the Green Mountain Care Board, in collaboration with the Department of Vermont Health Access (DVHA), to: "Identify annually up to 15 prescription drugs on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing." 18 V.S.A. § 4635(b). Once identified, the Board must provide a list of the drugs, including the percentage of wholesale acquisition cost increase for each, to the Office of the Attorney General, and make the information available to the public on the GMCB website.

Progress During 2017

In order to identify prescription drugs whose pricing practices create a substantial public interest, the Board worked with DVHA and the DVHA Pharmacy Benefit Manager using the following criteria:

1. Drugs for which the wholesale acquisition cost (WAC) increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months. This was measured by comparing the Wholesale Acquisition Cost of each drug at the end of each fiscal year evaluated.
2. The five-year query compared the WAC on the last day of FY 2013 to the WAC on June 20, 2017 (almost the end of FY 2017). Drugs that had an increase in WAC of at least 50% were used.
3. The one-year query compared the WAC on the last day of FY 2016 to the WAC on June 20, 2017. Drugs that had an increase in WAC of at least 15% were used.

Ten drugs were identified through this process, four of which were also identified on the 2016 drug list. The final list of drugs for 2017, posted publicly on the GMCB website and provided to the Vermont Attorney General's office for further investigation, is available here: http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/Perscription%20Drug%20List%20Act%20165%208.10.2017.pdf. The accompanying press release is available here: http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/Press%20Release%20-%202017%20GMCB%20Prescription%20Drug%20List.pdf.

Looking Ahead: 2018 Activities

The Board will continue to work with DVHA and the Attorney General's office to develop an annual list of drugs that meet the pricing criteria described above, and to submit an annual report on pharmaceutical cost transparency.

ACCOUNTABLE CARE ORGANIZATIONS AND THE ALL-PAYER ACO MODEL

All-Payer Accountable Care Organization (ACO) Model

Overview

Health spending growth results from a combination of changes in population health, payments for services and the number and mix of services used. Distilled to its basic components, spending growth can be expressed as an equation: price multiplied by utilization equals health care spending. Experts make strong cases that high prices are primarily at fault for the nation's high cost of health care. Equally compelling is the case that overutilization of low-value health care services contributes to unsustainable cost growth and poor healthcare outcomes. The Vermont "All-Payer Accountable Care Organization (ACO) Model Agreement" (All-Payer Model) creates an explicit limit on health care cost growth for participating providers, both in terms of utilization and price.

The "Vermont All-Payer ACO Model Agreement" (All-Payer Model) is an agreement between the Centers for Medicare and Medicaid Services (CMS) and Vermont's Governor, Secretary of the Agency of Human Services, and Chair of the Green Mountain Care Board (GMCB). The Agreement builds on previous all-payer payment alternatives to promote a more integrated, high quality system of care and a sustainable rate of overall health care cost growth. Instead of fee-for-service reimbursement, the model employs value-based payments that shift some risk to health care providers in an Accountable Care Organization (ACO), allowing more flexibility to focus on wellness and prevention services that keep people well, and encouraging collaboration across the care continuum.

Spending, or prices in aggregate, can increase for the ACO only within the confines of the All-Payer and Medicare Growth Targets. Quality and performance measures are in place at the ACO level to ensure that Vermonters' care remains the same or improves in quality. Beyond the ACO, cost containment requirements in the Agreement apply to spending on behalf of all Vermont residents. The Agreement includes an All-Payer Growth Target of 3.5%, a Medicare Growth Target of 0.2% below national projections, and three statewide population health improvement goals: Improve access to primary care; Reduce deaths due to suicide and drug overdose; and Reduce prevalence and morbidity of chronic disease.

Progress in 2017

2017 marked "Year 0" of the All-Payer Model and was spent in preparation for Performance Year 1 (PY1). Staff members from the Board in collaboration with staff at the Department of Vermont Health Access (DVHA) have worked together to prepare for PY1 reporting on the All-Payer Model's progress in the areas of health care cost growth and quality; this means, developing detailed specifications for the All-Payer Total Cost of Care measure in consultation with Blue Cross and Blue Shield of Vermont and refining the specifications and the targets for the 21 quality measures that are outlined in the Agreement.

The APM Agreement authorizes the Board to prospectively develop the benchmark for the 2018 Vermont Modified Medicare Next Generation ACO program, subject to the approval of CMS. The Board's authority to modify the benchmark applies to any ACO in Vermont that is participating in the Next Generation ACO Program

and attests that it will work towards the goals stated in the Agreement. OneCare Vermont is the only ACO participating in the Medicare Next Generation ACO program. The State negotiated a "floor" to protect itself from low projected national Medicare growth in PY1. Because the floor was triggered, the Board was able to set the 2018 Medicare benchmark at 3.5%, citing the rate of growth as being important for OneCare to make investments in PY1 of the APM Agreement that may be essential to achieving savings in later years. While 3.5% is higher than the projected national Medicare growth rate for 2018 (2.7%), it is lower than preliminary data suggests may be the true rate of growth for OneCare-aligned beneficiaries in 2018 and represents an aggressive spending target for OneCare.

The Vermont Modified Medicare Next Generation ACO program is entirely voluntary for OneCare Vermont and the providers participating in the Accountable Care Organization Model; individual Vermonters may also opt out of the system by selecting providers who are not affiliated with the ACO. While the State/Federal agreement gives the Board authority to recommend a Medicare rate of growth for participating ACOs, the Board's ACO Oversight role, per Act 113 of the 2016 Vermont Legislative session, provides the Board's authority to examine ACO rates across all three major payer groups, and to ensure that the ACO is operating both in compliance with Vermont law, as well as being consistent with requirements of the All-Payer Model Agreement.

Looking Ahead: 2018 Activities

The Green Mountain Care Board, along with our partners at the Agency of Human Services (AHS) and the Center for Medicare and Medicaid Innovation (CMMI), will work together in 2018 to monitor the impact of the Vermont All-Payer Accountable Care Organization Model on health care cost growth and quality, and to integrate this new model with our existing regulatory functions, including insurance rate review and hospital budget review. The Board will identify a measure of ACO Primary Care Spend to determine whether investments in primary care are increasing under the new payment model. The Board will continue to take opportunities to tailor the All-Payer Model to meet the needs of Vermont's aging population, to be a part of a solution to the Opioid dependency crisis, and to continue our status as the one of the healthiest states in the nation.

ACO Oversight: Budget Review and Certification

Overview

In Act 113 (2016), the Legislature charged the Green Mountain Care Board with the oversight and regulation of Vermont's Accountable Care Organizations (ACOs). Early in 2017, the Board convened a stakeholder group to provide input on the ACO Oversight Rule, GMCB Rule 5.000, which was promulgated and became effective in late fall. The Rule sets forth standards for the Board to follow and criteria by which the ACOs would be evaluated as of January 1, 2018; 2017 served as a "test year" and the Board and staff worked to develop and refine guidance and processes for ACO budget review and certification. On December 21, 2017, the Board voted to approve, with conditions, the OneCare Vermont ACO Budget. On January 5, 2018, the Board voted to provisionally certify OneCare Vermont based on the information received to date through the Budget submission. In early 2018, the Board will require OneCare Vermont to develop and submit additional materials to complete their certification.

Progress During 2017

RULE 5.000

The Board developed the ACO Oversight Rule, GMCB Rule 5.000, by convening a group of stakeholders representing Accountable Care Organizations, health care payers, hospitals, health care providers, and the Office of the Health Care Advocate. Based on feedback from these stakeholders, a draft rule proposal was written and revised. The Board voted to proceed to the statutory rulemaking process with this draft. The Board received both oral and written comments from the public on its initial proposal for the ACO Oversight Rule. After reviewing and considering those comments and engaging in further discussion with stakeholders, a number of amendments were made to the initial proposal. The Board approved a final proposal in late summer 2017, which was filed with the Legislative Committee on Administrative Rules (LCAR). During LCAR's first hearing of the rule, public comment was provided by the Health Care Advocate and the Vermont Developmental Disabilities Council. In response, the Board modified the rule to address some of the concerns that these organizations raised. LCAR approved the rule at its second hearing. The adopted rule was filed with LCAR and with the Secretary of State's Office on November 2, 2017, and took effect fifteen days thereafter, on November 17, 2017.

ACO BUDGET REVIEW

As 2017 was a "test year" for ACO Budget Review, OneCare Vermont (OneCare) and Community Health Accountable Care (CHAC) were asked in the spring of 2017 to submit preliminary information on governance structure, payer contracts, provider participants, model of care, previous expenditure analysis and 2018 budgets. CHAC withdrew its submission on October 19, 2017, citing the decision of its Board to suspend operations and terminate its Medicare Shared Savings Program (SSP) contract as of December 31, 2017.

OneCare's final budget proposal, valued at $607 million, anticipated that over 120,000 Vermonters would be a part of the model through participation by health care payers (Medicare, Medicaid, BCBSVT) and primary care providers. Nine hospitals will participate in the risk-based model. Six will have contracts for Medicare, Medicaid, and Commercial services. Three hospitals chose to participate in the payment change only for Medicaid beneficiaries. Board staff made recommendations regarding the approval of OneCare's budget on December 12,

2017. Public comments on OneCare's proposed budget were accepted through December 19, 2017. On December 21, 2017, the Board voted to Approve OneCare's Budget. In its decision, the GMCB established some of the following conditions:

- A combined all-payer rate increase of less than 3%, after exclusion of Medicaid pricing changes;
- Ability to review OneCare's contracts with participating payers;
- Robust risk assumption, delegation, and mitigation strategy must be in place;
- Guaranteed funding for Medicare portion of SASH, Blueprint for Health, and Community Health Team payments;
- Investment of no less than 3.1% of overall budget in population health and primary care strengthening initiatives;
- OneCare must submit a payment differential report describing how the Comprehensive Primary Care Payment Reform pilot's payment methodology compares to the reimbursement that hospitals provide to employed primary care. The report must also assess quality outcomes in the pilot compared to outside the pilot, and address the degree to which the pilot is or is not reducing administrative burden;
- Administrative Expenses must be appropriately allocated between Vermont and New York and may not exceed the amount budgeted by more than 1%;
- OneCare must consult with the Office of the Health Care Advocate to identify a grievance and appeals policy that applies to all enrollees, across payers; and
- OneCare must work in consultation with the GMCB to identify a pathway by which potential savings from this model will be returned to commercial rate payers.

The Green Mountain Care Board has approved OneCare's budget conditional on its administrative expenses not increasing beyond their current ratio, which is considered to be in an acceptable range, compared with other ACOs. The Board has also conditioned the budget's approval on the demonstration that administrative expenses in this model do not outweigh savings under the model.

MEDICAID ADVISORY RATE CASE FOR ACO SERVICES

In 2017, the Legislature extended the Board's authority to review and provide advisory input on Medicaid rates and the per-member-per-month (PMPM) amount that is negotiated between the Department of Vermont Health Access (DVHA) and the ACO. This review was completed and provided to DVHA and was also taken into consideration as the Board reviewed the ACO's budget submission.

ACO CERTIFICATION

Effective January 1, 2018, the Board has authority to certify ACOs. An ACO must be certified by the Board to receive payments from Medicaid or a commercial insurer through any payment reform program or initiative. Act 113 allows the Board to begin the certification process prior to January 1, 2018. In the rule approved on November 17, 2017, the Board identified the information and documentation an ACO must submit to complete its application to become certified. Now that the rule is final, the Board has begun analyzing the information submitted through the ACO Annual Reporting and Budget Guidance. Based on this review, the Board voted to provide a provisional certification to OneCare Vermont on January 5, 2018, The Board will complete the certification in the first quarter of 2018.

Looking Ahead: 2018 Activities

In 2018, the Board will develop and establish an ACO Budget monitoring plan, and report regularly on the ACO's progress and compliance with the conditions of its Budget approval. Through a transparent public process, we will refine and improve the ACO budget review process and strengthen its link to Insurance Premium Rate Review and Hospital Budget Review.

ACO Model of Care and Integration with Community Providers

Overview

In Act 82, the Legislature required the Green Mountain Care Board to provide a summary of information relating to integration with community providers as part of its review of the ACO model of care and integration with community providers, including designated and specialized service agencies.

In its budget submissions to the Green Mountain Care Board (dated June 23, September 7, and October 20, 2017), OneCare Vermont provided the following information about efforts to integrate with community providers:

- Governance:
  - Community providers are represented within OneCare's governance structure, including on the Board of Managers as well as on issue-specific committees, where they help to direct the organization's strategy, identify clinical priorities, and more.
- Care Models:
  - OneCare's Care Model relies on interdisciplinary, cross-organization, community-based care coordination to support health and wellness for attributed beneficiaries, particularly those with chronic illnesses. The Care Model is designed to provide different interventions depending on the patient's level of risk. The Care Model specifically identifies community providers, including Designated and Specialized Service Agencies, Home Health Agencies, Area Agencies on Aging, the SASH Program, the Agency of Human Services, and social services providers as key partners and potential members of patients' complex care teams.
- Payment Models:
  - Complex Care Coordination Program: Designated and Specialized Service Agencies, Home Health Agencies, and Area Agencies on Aging receive $15 per-member per-month payments for each OneCare-attributed complex care patient if they are members of the patient's complex care team.
  - Patient Activation and Lead Care Coordinator Payment: Additional $10 per-member per-month payments and $150 one-time activation payment to whichever organization on the complex care team is selected by the patient to be the Lead Care Coordinator.
  - Value-Based Incentive Fund: Community providers are also eligible for bonus payments through the ACO's Value-Based Incentive Fund, awarded based on health service area-level performance on quality indicators.

In its review of OneCare's budget submission, the Green Mountain Care Board deemed these efforts to be a strong strategy to engage and compensate community-based providers; the success of this strategy will be assessed in subsequent budget reviews and, if not successful, the Board will require changes to OneCare's approach.

ACO Shared Savings Program

Overview

Shared Savings Programs (SSPs) are formal arrangements between insurers and providers that allow groups of providers, such as ACOs, to share in financial savings. The amount of savings that providers earn is determined by how well they perform on specified quality measures.

Since 2014, Vermont has designed and implemented Commercial and Medicaid SSPs to test the theory that sharing savings with providers will motivate continuous improvements in care and reductions in cost. These SSPs were designed to align as much as possible with the SSP offered by Medicare, in which Vermont's ACOs have participated. This multi-payer approach creates a strong foundation for the All-Payer Model, giving providers experience with an alternative payment model. Blue Cross and Blue Shield of Vermont (BCBSVT) and Vermont Medicaid joined Medicare in offering SSPs. Three ACOs — OneCare Vermont, Community Health Accountable Care (CHAC), and Vermont Collaborative Physicians (VCP)[6] — participated in at least one of Vermont's SSPs during each year from 2014-2016.

Progress During 2017

SHARED SAVINGS PROGRAM PARTICIPATION

Vermont's SSPs were initially designed as a three-year pilot, to run from January 2014 through December 2016. The Department of Vermont Health Access (DVHA) elected to move to a more advanced payment model in 2017, implementing the Vermont Medicaid Next Generation ACO Pilot in conjunction with OneCare Vermont (see All-Payer Model section). BCBSVT continued to offer a Commercial SSP in 2017, with participation from OneCare Vermont and CHAC. As of December 2016, more than 167,000 Vermonters (or about 27% of the State's population) were attributed to Commercial, Medicaid, or Medicare SSP-participating providers.

SHARED SAVINGS PROGRAM RESULTS, 2014-2016

- *Medicaid SSP Financial Results:* In 2014 (SSP Year 1), the two participating ACOs in the Medicaid SSP (OneCare Vermont and CHAC) achieved shared savings. CHAC also achieved savings in the Medicaid SSP in 2015 and 2016, though 2016 savings did not meet the 2% minimum savings rate that would have resulted in payment of savings to the ACO.
- *Commercial SSP Financial Results:* None of the ACOs participating in the Commercial SSP achieved savings in 2014 or 2015, at least partly because the financial targets were based on health insurance premiums rather than on historical claims experience. In 2016, the first year that targets could be based on some historical claims experience, CHAC achieved savings in the Commercial SSP. CHAC, OneCare, and VCP all showed movement toward Commercial financial targets from 2015 to 2016.
- *Quality Results:* There have been progressive improvements in overall Commercial and Medicaid SSP quality scores from 2014-2016 for CHAC and OneCare, and continued high quality performance for VCP

[6] OneCare Vermont and Community Health Accountable Care participated in Vermont's Commercial Shared Savings Program in 2017, as well as the Medicare Shared Savings Program; OneCare Vermont is also participating in DVHA's Vermont Medicaid Next Generation ACO Pilot.

for the Commercial SSP. Had the ACOs achieved savings in the Medicaid or Commercial SSPs in 2016, all would have been eligible for at least 90% of savings based on their quality results.

The 2014-2016 results for the Commercial and Medicaid SSPs are summarized in Exhibits 8-10; more detailed results are available on GMCB's website: http://www.gmcboard.vermont.gov/PaymentReform. Results for the 2017 Commercial Shared SSP are expected in fall 2018.

Vermont's SSP was part of a national movement toward advanced alternative payment models. Vermont's SSP performance fits within a national context of payment reform and innovation, and was a critical step in preparing Vermont (providers, ACOs, and the State) for the All-Payer Model.

The All-Payer Model builds on the infrastructure and provider and payer readiness foundation developed through the SSPs, while addressing some challenges of that model. Compared to the SSPs, the All-Payer Model has stronger financial incentives to encourage high-quality, coordinated, efficient care for ACO members. Incentives continue to be aligned across payers due to the multi-payer approach.

OTHER ACTIVITIES

GMCB Reform activities have also served as an impetus for improved coordination of activities across organizations. There has been impressive collaboration among the three ACOs in clinical data collection and quality improvement. There has also been strong collaboration between the ACOs and the state-led Blueprint for Health initiative. The Blueprint is considered the foundation for Vermont's payment and delivery system reforms. It serves the majority of Vermont residents by supporting primary care practices in achieving recognition as Patient Centered Medical Homes (PCMHs), providing multi-disciplinary support services through regional Community Health Teams (CHTs), and creating a network of self-management support programs. All major insurers in Vermont participate in the Blueprint's payment reforms.

The efforts of the Blueprint, the three ACOs and multiple health and community service providers in each of the state's regions are now coordinated through "Community Collaboratives" that are characterized by a shared governance structure with local leadership, a focus on improving the results of quality measures, support for the introduction and extension of promising care transformation models, and guidance for PCMH and CHT operations. Insurer, Blueprint and ACO leaders also co-produce performance reports showing results for quality, cost and utilization measures.

Looking Ahead: 2018 Activities

GMCB's 2018 activities related to SSPs include compiling and publishing summaries of ACO financial and quality performance from the 2017 Commercial SSP program.

In 2018, the Department of Vermont Health Access intends to continue to offer the Vermont Medicaid Next Generation Program, and Blue Cross and Blue Shield of Vermont intends to continue to offer an SSP.

Exhibit 8: Summary of Medicaid SSP Financial Results: 2014-2016

	Medicaid								
	Actual PMPM			PMPM Savings (Loss)			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$189.83	$182.06	$180.53	$24.85	$7.03	$0.75	46%	57%	70%
OneCare	$165.66	$171.55	$168.88	$14.93	$(2.18)	$(3.41)	63%	73%	77%
VCP									

Exhibit 9: Summary of Commercial SSP Financial Results: 2014-2016

	Commercial								
	Actual PMPM			PMPM Savings (Loss)			Quality Score		
	2014	2015	2016*	2014	2015	2016	2014	2015	2016
CHAC	$350.03	$369.68	$496.01	$(25.94)	$(14.02)	$2.38	56%	61%	74%
OneCare	$349.01	$348.81	$496.74	$(23.38)	$(13.57)	$(6.50)	67%	69%	88%
VCP	$286.08	$303.95	$430.01	$(19.36)	$(34.62)	$(17.91)	89%	87%	88%

* Commercial SSP PMPMs for 2016 are not directly comparable to 2014-2015 PMPMs. In 2016, allowed amounts were used to calculate expected and actual PMPMs for the Commercial SSP (vs. paid amounts in prior years), which led to a large increase in both expected and actual PMPMs. Expected and actual PMPMs for 2016 also incorporate a 12% trend adjustment.

Exhibit 10: Summary of Medicare SSP Financial Results: 2014-2016

	Medicare								
	Actual Aggregated Total			Savings as % of Expected			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$45,957,103	$56,658,198	$142,925,956	2.36%	-7.83%	-16.92%	Reporting	97%	90%
OneCare	$470,417,853	$511,835,661	$419,636,813	-0.89%	-5.56%	-4.64%	89%	96%	97%
VCP	$59,486,632			-4.87%			92%		

** Variation in Medicare financial results over time are due in part to variation in population size (number of attributed beneficiaries).

STATE INNOVATION MODEL (SIM) GRANT

Vermont Health Care Innovation Project (VHCIP)

Overview

In 2013, Vermont was awarded a $45 million State Innovation Model (SIM) grant, also known as the Vermont Health Care Innovation Project (VHCIP). The SIM opportunity was created by the Patient Protection and Affordable Care Act and is administered by the Center for Medicare & Medicaid Innovation (CMMI). Vermont's SIM grant ended in June 2017.

The Green Mountain Care Board, Agency of Administration (AOA), and Department of Vermont Health Access (DVHA) shared responsibility for implementing VHCIP grant. The Board's Chair was closely involved with VHCIP governance, as a co-chair of the SIM Steering Committee and a member of the Core Team, the project's decision-making body.

The overall goal of VHCIP effort was the Triple Aim: Better care, better health, and lower costs. To this end, Vermont organized its SIM activities and programmatic milestones into five focus areas:

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

Progress During 2017

SUSTAINABILITY PLANNING

As required by the terms of the SIM grant, a Sustainability Plan was developed and submitted prior to the end of the grant period. The creation of this document was supported by a group of private sector stakeholders, including co-chairs from each of the VHCIP work groups as well as representatives from payers, ACOs, the Vermont Medical Society, business, a hospital, consumer, and a consumer advocate. The Sustainability Plan received multiple rounds of public comment prior to submission to CMMI in June 2017. The Plan is available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Final%20Vermont%20SIM%20Sustainability%20Plan%206.30.17.pdf.

POPULATION HEALTH PLAN

As required by the terms of the SIM grant, project staff developed a Population Health Plan, which was vetted through a months-long stakeholder engagement process prior to its approval by the Core Team and submission

to CMMI in June 2017. The Population Health Plan is available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/SIM-PopulationHealthPlan-Final-Web.pdf.

PAYMENT MODEL DESIGN AND IMPLEMENTATION

In 2017, activities in the Payment Model Design and Implementation Focus Area included:

- Continuing Vermont's existing Medicaid and commercial Shared Savings Programs and transitioning them to new programs under the All-Payer ACO Model;
- Launch of an Accountable Communities for Health peer learning opportunity for regions around the state that sought to bridge efforts to improve clinical care and expand community supports with public health initiatives; and
- Efforts to advance Medicaid value-based payment for mental health services, substance use disorder treatment, developmental disability services, and long-term services and supports in alignment with the All-Payer ACO Model (also known as the Medicaid Pathway initiative).

PRACTICE TRANSFORMATION

In 2017, activities in the Practice Transformation Focus Area included:

- Continuing and expanding existing Learning Collaborative activities to strengthen care coordination;
- Concluding the VHCIP Sub-Grant Program, which provided grant funding to 14 competitively selected projects to implement and test provider-led innovations;
- Support to expand and develop Community Collaboratives to align Blueprint for Health and ACO governance and quality improvement activities; and
- Workforce activities, including continued analyses of workforce supply data and completion of a micro-simulation workforce demand modeling effort.

HEALTH DATA INFRASTRCTURE

In 2017, activities in the Health Data Infrastructure Focus Area included:

- Continued efforts with ACOs and Designated Agencies/Specialized Service Agencies to connect additional providers to the statewide Vermont Health Information Exchange (VHIE);
- Continued work to improve data quality within the VHIE;
- Completion of two pilot projects to implement telehealth technology in line with Vermont's health reform goals;
- Continued development and strategic planning related to data storage and analytics; and
- Continued efforts to design and implement electronic care management tools to support broader care management improvement efforts.

EVALUATION

John Snow, Inc. (JSI) entered into a contract to work with the Green Mountain Care Board (GMCB) to conduct the State-led evaluation of VHCIP within three focus areas: care integration, payment reform and financial incentive structures, and use of clinical and economic data to promote value-based care. The federal evaluation,

conducted by Research Triangle Institute (RTI), includes both state-specific and cross-state analyses and consists of and examination of state progress on project initiatives, quantitative impact analysis using claims data for Medicaid, Medicare and commercially insured populations within Vermont, and cross-state studies including states' progress, challenges, and lessons learned. CMMI's federal evaluation is on-going and GMCB staff continue to support that effort. RTI released their SIM third annual report in September 2017. *Available at* https://downloads.cms.gov/files/cmmi/sim-rd1mt-thirdannrpt.pdf) (RTI International, 2017)

The State-led evaluation of VHCIP concluded in June 2017 with the conclusion of the grant itself. The full State-led evaluation report, as well as other VHCIP materials and resources, are available on the VHCIP website at http://healthcareinnovation.vermont.gov/areas/evaluation/state/projects . In addition to the State-led evaluation, throughout 2017 GMCB staff supported the federal SIM evaluation effort. The federal evaluation is a quantitative study, looking at the overall impact of this investment using claims data for Medicaid, Medicare and commercially insured populations within Vermont, as well as a cross-state study of all SIM-funded states around payment reform, data infrastructure, workforce development, and population health integration. The following sub-sections highlight State-led evaluation findings.

Payment Reform

Substantial work was conducted by stakeholders through VHCIP to better align quality measures across payers to facilitate collection and reporting. The quality measures used in VHCIP informed the list of quality measures agreed upon for the All-Payer ACO Model. Through participation in Shared Savings Programs, providers developed a better understanding of financial risk and costs of care, what it takes to shift organizational culture toward value-based payments from volume-based payments, how to track and use quality metrics, and best practices to optimize quality. VHCIP served as a foundation for developing and moving to agreement on the All-Payer ACO Model (APM) designed to encourage delivery of well-coordinated, high quality person-level care within a defined all-inclusive population-based payment. Additional work is still needed, however, to engage providers in connecting payment reform to practice operations to achieve desired reductions in costs of care and quality improvement.

Data and Data Infrastructure

VHCIP has created a data and data infrastructure environment which enables practices to more effectively participate in health care reform and has fostered an environment of innovation which resulted in the creation of data and data infrastructure demand that continues to raise the bar on practice effectiveness in the use of data. However, health care organizations were hesitant to build or maintain capacity without a clear understanding of how it would be sustained. This is specifically true for organizations participating in SSPs where organizations consider investing resources for data infrastructure and data support up front without guarantee of obtaining shared savings.

Care Coordination

Regional Community Collaboratives (RCCs) in each HSA had a history of inter-organizational collaboration, particularly around care coordination. Membership in the RCCs continued to expand under VHCIP, with more community-based providers joining in. The RCCs are becoming increasingly sophisticated in the use of data to identify high need and high-risk patients in need of services and to monitor these patients over time. Vermont's

State-led efforts at health reform have historically emphasized local buy-in and transparency, and these core implementation strategies carried over to VHCIP, especially with regard to care integration. The sub-grants that focused on care coordination created or expanded innovative approaches to care integration. However, coordination still primarily occurs by fax and phone rather than electronically, which creates barriers to data sharing. Alternative payment models will facilitate financial support of care management, but there is still substantial work to do before such models are fully implemented. While the RCCs have had good success in engaging multi-disciplinary and cross-agency groups, primary care physicians (PCPs) tend to be less involved. PCPs have a powerful voice and can be strong advocates for care management with higher engagement leading to stronger advocacy.

Looking Ahead: 2018 Activities

The Vermont Health Care Innovation Project ceased with the end of Vermont's SIM grant in June 2017. The Vermont SIM Sustainability Plan identifies work areas for continuation, either by the State of Vermont or by private sector partners. The Vermont SIM Sustainability Plan is available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Final%20Vermont%20SIM%20Sustainability%20Plan%206.30.17.pdf.

DATA, ANALYTICS, AND EVALUATION

Data and Analytics

Overview

The Green Mountain Care Board has been tasked by 18 V.S.A. § 9410 with maintaining an All-Payer Claims Database (APCD) named the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). In addition, the Board is responsible for oversight of the Vermont Uniform Hospital Discharge Data Set (VUHDDS) that is managed by the Vermont Department of Health.

For these data sets, the Board oversees data collection, consolidation, and distribution, and also manages access to the data. Requests for data and reporting come from other state agencies and non-state organizations. Since the healthcare datasets contain protected health information, the Board has instituted processes to ensure that any information released falls within state and federal guidelines.

The Board uses the data, in addition to managing the data. Areas of inquiry include: determining the capacity and distribution of existing health care resources; identifying health care needs and informing health care policy; evaluating the effectiveness of intervention programs on improving patient outcomes; comparing costs between various treatment settings and approaches; providing information to consumers and purchasers of health care; and improving the quality and affordability of patient health care and health care coverage.

Progress During 2017

INCREASED CAPABILITIES

Over the past year, the Board has improved its capacity to manage and use these rich data sources. Staffing increases and technological advances allowed the Board to increase its responsiveness to requests. One of the most significant enhancements was the development and testing of a secure data enclave for VHCURES. The data enclave delivers VHCURES data to staff in a more timely and efficient manner. Data reports that took several hours in the previous database can now be completed in minutes.

In preparation for the data enclave and to refine methods for access to the VHCURES data sets, the Board is refining its data access policies and procedures. These new processes will allow the Board to improve turnaround time in responding to requests for information and datasets, while still ensuring data security.

This enhanced capacity and performance came at an ideal time, as the Board successfully obtained approval to use Medicare data from the Centers for Medicare & Medicaid Services (CMS). The addition of Medicare data to VHCURES provides a more complete picture of health care spending and utilization in Vermont. The timing also coincides with an agreement between the State and CMS to implement the Vermont All-Payer ACO Model (ACO APM) (see pg. 24). To support the initiative, GMCB analytical staff have worked to ensure that data can be collected to help inform measure development and to assess the performance of the ACO APM. Staff also provided state and federal policy makers with baseline information needed to set targets for the measures in the ACO APM.

Looking Ahead: 2018 Activities

EXPANDING ACCESS TO DATA

The Board will continue to strive to expand the audience able to use data from VHCURES, directly and indirectly. The data enclave should allow more agile access for a broader base of users, especially State agencies. For users without the need for full datasets, GMCB analytical staff will explore ways to respond to analytic requests.

In addition to data access, the Board is exploring the design and production of new public use files with deidentified information based on VHCURES; this will make VHCURES increasingly friendly to more potential users, including State agencies, researchers, and others. If the Board determines that these files can in fact be produced, they will be developed with the input of stakeholders and experts in the hope of addressing a wide base of existing need.

The Board will also begin publishing reports to summarize coverage and utilization for use by providers, state officials, the media, and the public. These recurring reports will eventually be expanded to include information related to the Board's other activities (e.g. reporting from VUHDDS, hospital and ACO budgets, and insurance rate review).

Health Information Technology

Overview

Act 54 of 2015 charged the Green Mountain Care Board with oversight of the budget and core activities of Vermont Information Technology Leaders (VITL). Specifically, Act 54 tasked the Board to "[a]nnually review the budget and all activities of VITL and approve the budget, consistent with available funds, and the core activities associated with public funding." Act 54 (2015) § 7 (adding 18 V.S.A. § 9375(b)(2)(C)). Each year, the Secretary of Administration or its designee, the Department of Vermont Health Access (DVHA), funds this work by "enter[ing] into procurement grant agreements with VITL" after the Board "approves VITL's core activities and budget." This division of regulatory tasks recognizes the interdependent roles of the Board and the Administration in managing the state's relationship with VITL. The Board's oversight is intended to provide strategic guidance and policy parameters within which the Administration, through DVHA, operationalizes that relationship.

Progress During 2017

FY 2018 VITL BUDGET REVIEW PROCESS

The Board adopted the following principles to guide its review of VITL's FY 2018 budget:

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

VITL leadership presented a $6,033,000 FY 2018 budget to the GMCB on March 30, 2017: http://gmcboard.vermont.gov/sites/gmcb/files/files/meetings/presentations/GMCB%20Budget%20Presentation%20-%2003-30-2017%20Final.pdf. On April 13, VITL and DVHA informed the GMCB that public funding for VITL was $5,445,000. The GMCB approved this revised budget on April 13, 2017. The Decision discussing the GMCB's rationale was released on May 12, 2017, and is available on the GMCB website: http://gmcboard.vermont.gov/sites/gmcb/files/files/healthit/VITL%20FY2018%20Budget%20Order.pdf.

ONGOING OVERSIGHT

VITL presents to the Board quarterly and additionally as requested to discuss key areas of work, provide updates on projects of interest, and provide financial updates.

On December 14, DVHA and a contractor (HealthTech Solutions) presented the results of the Evaluation of Vermont Health Information Technology Activities to the Board: http://gmcboard.vermont.gov/sites/gmcb/files/FINAL%20VITL%20Oversight%20Slides%20for%20Board%20Compiled%2012%2014%202107.pdf.

Looking Ahead: 2018 Activities

VITL BUDGET AND OVERSIGHT

The Board will work with DVHA and VITL to support proper oversight and broader HIE planning as VITL transitions to a new CEO in Spring 2018. The Board will receive bimonthly updates from DVHA on the VITL transition through June 2018, regular updates from VITL, and ad hoc presentations as requested. The Board expects to review VITL's FY 2019 budget in late spring 2018.

HEALTH INFORMATION EXCHANGE PLANNING

The Board will collaborate with DVHA to plan for Health Information Exchange capabilities to meet Vermont's needs, and will review an updated HIT/HIE Plan if and when it is presented to the Board.

Payment Differential and Provider Reimbursement Report

Overview

In a series of mandates since 2014, the Legislature has highlighted the payment differential between hospital-acquired practices and independent practices as a target for policy intervention. The primary concern has been that the payment differential between hospital-owned practices (specifically, the academic medical center) and their independent counterparts has led to the decline of independent providers in the state and to increased consolidation of the state's health care system.

In 2017, the Board took substantial action to achieve site-neutral, fair reimbursements for medical services. The Board ordered that UVMMC, Vermont's academic medical center, reallocate $11.3 million in rate reductions to address the differential, cutting fees for Evaluation and Management services (i.e.: office visits) and reducing out-of-pocket costs for consumers[7]. The rate reduction narrows the gap in payment differentials between provider types for these services. The Board formed a workgroup of stakeholders to focus on the issue of pay parity, and generate possible solutions that could be implemented. The Board conducted a survey and garnered useful information from a significant segment of clinicians in independent practices (see below). Although the Board continues to focus on the transition from a fee-for-service reimbursement model to population-based payments, the Board's recent orders and recommendations, including those relating to transparency, will narrow the gap between providers, and move the State closer to a site-neutral reimbursement structure.

The full Payment Differential and Provider Reimbursement Report can be found at: http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/GMCB_Fair%20Reimbursement%20Report_Oct_1_2017_FINAL.pdf.

Clinician Landscape Study

To support this effort, in August-September 2017 the Green Mountain Care Board administered an anonymous survey of active clinicians and conducted focus groups of active physicians in order to better understand the medical care climate in Vermont. Specifically, we were interested in learning what clinicians find most rewarding, the stressors they face in their practices, the factors that drive their employment choices, and their outlook on the profession in Vermont. Over 400 survey respondents included independent clinicians, clinicians employed by an academic medical center or its networks, and clinicians employed by FQHCs or other small rural clinics across all hospital service areas in Vermont. Through this survey, we learned the following key takeaways:

- Independently practicing clinicians cite strong patient relationships, the opportunity to run their own practice as well as flexibility and choice over work schedules as the factors most satisfying about their work.
- Independent clinicians are most frustrated by billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice and accessing costly technology.

[7] http://gmcboard.vermont.gov/sites/gmcb/files/files/hospital-budget/FY18%20UVMMC%20Order.pdf

- Employed clinicians are most satisfied about not having to run their own business, not being responsible for high practice costs, the opportunities to work with colleagues, and the certainty of their income in an employed setting.
- Like independent clinicians, employed clinicians find administrative burdens frustrating. They also identify the limited control they have over practice management, lack of control over their work schedule, and level of their income as frustrations.
- The top three most commonly cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement. The same top three threats apply to employed clinicians.
- Despite frustrations, the majority of clinicians, whether practicing independently or employed through a hospital, academic medical center, Federally Qualified Health Center (FQHC) or health clinic, are generally optimistic about their current employment and anticipate continuing to practice as they are today.

In focus group sessions, participating clinicians discussed survey findings in more detail. Specifically, they discussed factors related to employment choice, how healthcare and payment reform efforts impact clinical practices, perceptions about the future of healthcare in Vermont, and what Vermont's health policy makers need to know about conditions in the healthcare marketplace. In all, it became evident that the issues facing clinicians in Vermont are varied and speak to the complexity of the healthcare landscape. There is not a single story of the "clinician experience" but a few key takeaways emerged:

- Independent physicians who have been practicing for many years expressed concern about the negative impact of regulatory and compliance burdens, federal and state payment reform efforts, and increasing administrative demands on their ability to remain independent and provide timely patient care.
- Clinicians who switched from independent to employed status overwhelmingly identify the increasing costs of running independent practices (e.g. malpractice insurance, electronic health record systems, and increasing administrative workforce demands) as a primary driver of their decision to leave private practice.
- Clinicians who have been employed by a hospital system or health clinic during their entire career suggested that practice start-up costs, student debt burdens, and lack of business acumen served as barriers to seeking self-employment as a physician.

The full Vermont Clinician Landscape Study Report can be found at:
http://gmcboard.vermont.gov/publications/general-reports

APPENDICES

Appendix A: GMCB Budget and Staffing

Green Mountain Care Board	FY 2017 Budget	FY 2017 Expenditures	FY 2018 Budget Post Rescission
Total Budget	$ 9,572,404	$ 6,126,093	$ 8,609,341
Expenses by Fund			
General Fund	$ 1,243,276	$ 756,272	$ 2,076,352
GMCB Regulatory & Administration Fund	$ 2,045,927	$ 1,115,360	$ 3,460,827
Other Special Funds	$ 60,000	$ 38	$ 60,000
Global Commitment	$ 4,281,832	$ 2,793,460	$ 2,567,518
Interdepartmental Transfer	$ 1,492,561	$ 1,440,369	$ 218,070
Federal Fund	$ 448,808	$ 20,594	$ 226,574
Expenses by Category			
Personal Services: Personnel Salary & Fringe	$ 3,468,390	$ 2,748,195	$ 3,614,154
Personal Services: Third Party Contracts	$ 5,268,019	$ 3,001,352	$ 4,330,149
Operating Expenses	$ 835,995	$ 376,546	$ 665,038

Note: FY17 expenditures lower than planned due to All-Payer Model Agreement being signed later than originally planned during FY17 budget development process.

Appendix B: Board Member Biographies

The Green Mountain Care Board was created by the Vermont Legislature in 2011. Its current members were nominated by a broad-based committee and appointed by Governor Peter Shumlin. GMCB began 2017 with two board vacancies; Chair Al Gobeille stepped down on January 4, 2017, and Betty Rambur stepped down on January 15, 2017.

KEVIN MULLIN, CHAIR

The Chairman of the Green Mountain Care board is tasked with directing the board's charge of curbing health care cost growth and reforming the way health care is provided to Vermonters.
Kevin Mullin spent the majority of his career as a small business owner. He has taught at CCV and served on numerous community and professional boards. He is a graduate of Castleton University with a degree in Finance. He has served on numerous community and professional boards. He is a nineteen-year veteran of the Legislature including four years in the House and fifteen years in the Senate, where he has served on numerous committees including chairing Education and Economic Development, General & Housing. As a member of the Health & Welfare committee, he helped to write both Catamount Health and Green Mountain Care. He has a deep commitment to contain health care costs. Appointed: May 24, 2017 - September 30, 2018.

JESSICA HOLMES, PH.D.

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

ROBIN LUNGE, J.D., MHCDS

Robin J. Lunge, JD, was appointed to the Board in November 2016. Prior to joining the Board, Robin served for almost six years as the State's Director of Health Care Reform for Governor Peter Shumlin's administration. Her past experience includes working as a nonpartisan staff attorney at Vermont Legislative Council, where she drafted legislation and provided support to members of the Vermont Legislature relating to health and human services matters, and at the Center on Budget and Policy Priorities in Washington D.C. as a senior policy analyst on public benefits issues. Robin's areas of expertise are federal and state public benefit programs, health care, and health care reform. Robin holds a B.A. from the University of California Santa Cruz, a J.D. from Cornell Law School, and a Masters of Health Care Delivery Science from Dartmouth College. Appointed: November 2016 - September 30, 2022.

TOM PELHAM

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

MAUREEN USIFER

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

CORNELIUS HOGAN

Con Hogan served as Secretary of the Vermont Agency of Human Services under both the Snelling and Dean administrations. Prior to serving as Secretary, Con was President of International Coins and Currency based in Montpelier. Con has served in leadership positions at the Vermont Department of Corrections and previously worked for the New Jersey Department of Corrections. 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. Con holds a Master's 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. **Con completed his term in September 2017.**

Leadership

SUSAN J. BARRETT, J.D., EXECUTIVE DIRECTOR

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

Tribute to Con Hogan

From its inception, Con Hogan, who fulfilled a six-year term on September 30, 2017, has helped navigate the Green Mountain Care Board through changes in state and national health care policy, moving towards the goal of ensuring that all Vermonters have access to affordable, quality healthcare.

Con exemplifies dedication to public service. After 15 years working for the Vermont Department of Corrections, ultimately as its Commissioner, Con served for eight years as the Vermont Secretary of Human Services. Con's tireless drive to learn, understand, and improve the wellbeing of fellow Vermonters, and the state as a whole, highlighted his successful tenure. Following completion of his appointed term, Con has continued to be an ardent and vocal advocate on public health issues, with advocacy for early childhood intervention a top priority. Con has served as a Senior Fellow with the Center for the Study of Social Policy, a Senior Consultant for the Annie E. Casey Foundation, a Director of Fletcher Allen Health Care, Chair of the National Advisory Committee for the Robert Wood Johnson Initiative for Strengthening Families through health care access, a member of the Advisory Committee for the National Center for Children in Poverty, and as a consultant to the Children's Defense Fund. In his honor, the Vermont Community Foundation annually awards the Con Hogan Creative, Entrepreneurial, Community Leadership Award to one individual who exemplifies Con's vision for a better Vermont, and matches that vision by demonstrating his or her responsibility to bring the vision to fruition.

Con's talents and passions extend beyond his government service. Con has authored or co-authored six books, and plays banjo in the Plainfield-based Cold Country Bluegrass Band. Con, his wife Jeanette (who plays bass in the band), and their two children share a passion for horses and dressage, and host events and trainings at Con's home at East Hill Farm, founded in 1976. Con has a lifelong passion for sailing, which has taken him across the globe to distant places such as the Falkland Islands and the Arctic Circle.

Con completed his full six-year term this past fall without ever losing sight of the incremental tasks before the Board, and the State's larger health care reform goals. We will miss Con's presence in the office and his exceptional institutional knowledge, kind hearted spirit, good humor, and willingness to take the time to work through complex policy matters with other Board members, staff, and stakeholders. We have no doubt that Con will continue to advocate for a brighter health care future for Vermonters as he begins, for the second time, his formal retirement from State government.

On behalf of all Vermonters, we wish to extend our gratitude to Con for his many years of dedication to Vermont, and to the well-being and health of all of its citizens.

Green Mountain Care Board
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802-828-2177

***New Address as of January 26, 2018**:*
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