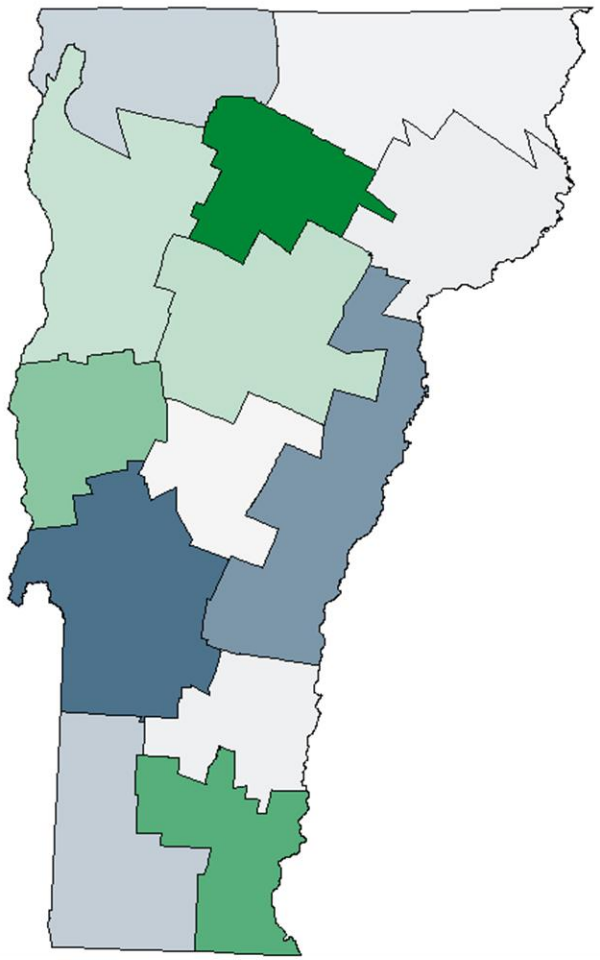


Green Mountain Care Board
Results and Updates

Advisory Committee Meeting

Wednesday, October 10, 2018

VERMONT
GREEN MOUNTAIN CARE BOARD

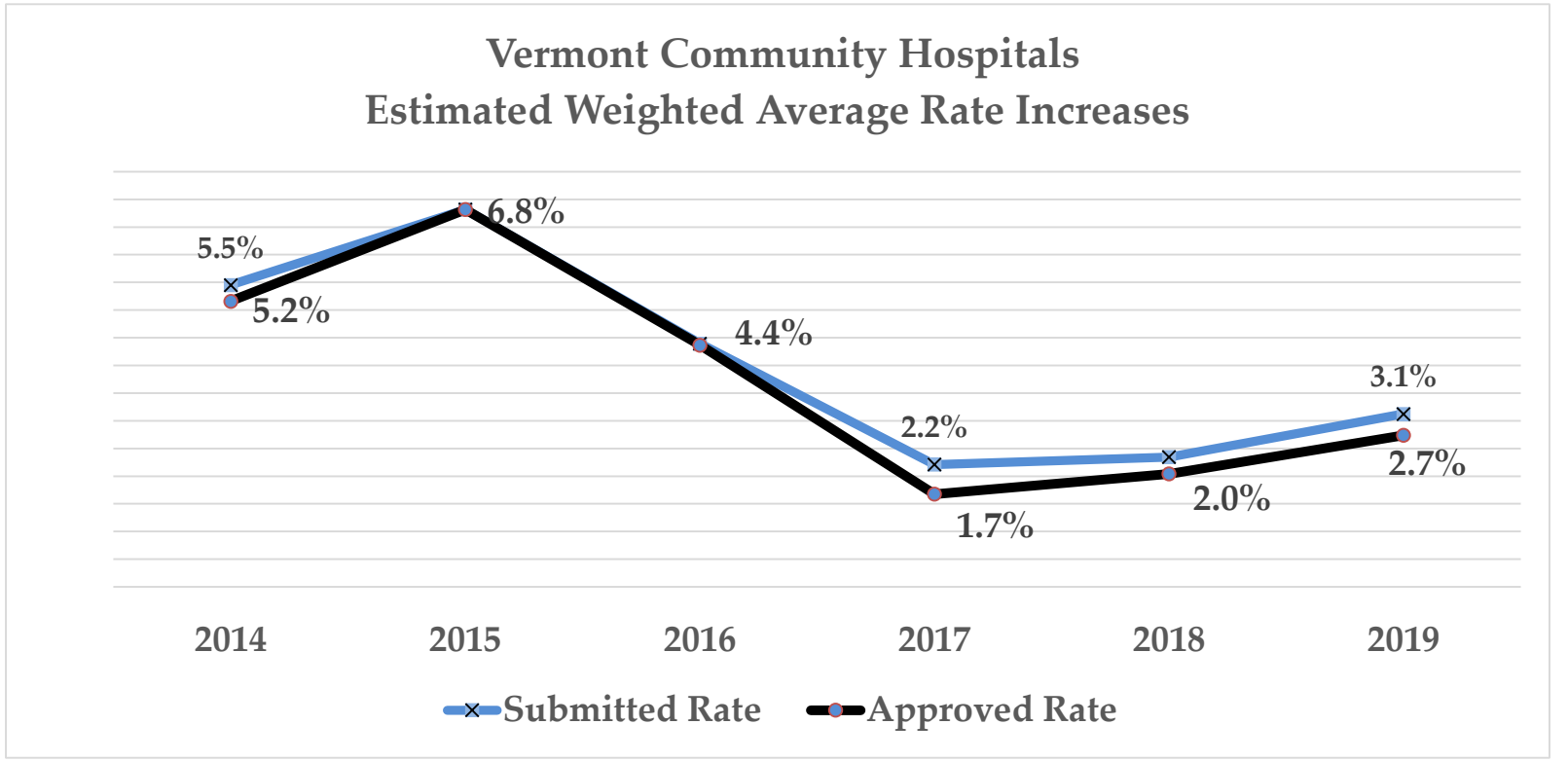
SUMMER-FALL 2018
GMCB ACTIVITIES

Hospital Budgets

- Hospitals initially requested a 2.9% increase in Net Patient Revenue (NPR) from the Board-approved Fiscal Year 2018 base to the hospitals' submitted Fiscal Year 2019 budgets
- After the Board approved adjustments for several hospitals (e.g., adjustments for accounting changes, provider transfers and acquisitions), the submissions reflected a 2.2% increase (approximately $56.5 million) in NPR
- The Board approved a 2.1% NPR increase for Fiscal Year 2019 over the approved and adjusted Fiscal Year 2018 base ($52.8 million)
- Hospitals requested an estimated weighted average 3.1% increase in commercial rates, from approved Fiscal Year 2018 to Fiscal Year 2019 budgets. The Board approved a 2.7% estimated weighted average rate increase

Vermont Community Hospital System
Approved Rate Increases

The Board's approved estimated weighted average hospital rate increases for the last three years have been the lowest increases in 18 years. Hospital rates have an effect on commercial health insurance rates.



Health Insurance Rate Review
(2019 Individual and Small Group Plans)

Blue Cross Blue Shield of Vermont (BCBSVT) requested a 9.6% average annual rate increase, with an *effective average increase* of 5.8%*

- **Approved Average Annual Rate Increase**: 6.9%, with an *effective average increase of 3.2%*
- **Estimated Dollars Saved by Vermonters**: $12.9 million

MVP requested a 10.9% average annual rate increase, with an *effective average increase of 6.6%*

- **Approved Average Annual Rate Increase:** 6.4%, with an *effective average increase of 1.9%*
- **Estimated Dollars Saved by Vermonters**: $6.5 million

Total Estimated Savings = $19.4 Million

* The "*effective*" rate increases—the actual rate increases that will be experienced by Vermonters—take into account the availability of additional federal subsidy dollars resulting from changes made to Vermont law during the 2018 legislative session.

Certificate of Need (CON) 2018 Decisions

- University of Vermont Medical Center (Replacement of Epic Health Information System), Docket No. GMCB-001-17con
- Rutland Regional Medical Center (Construction of New Medical Office Building), Docket No. GMCB-012-17con
- Kindred Healthcare (Corporate Restructure), Docket No. GMCB-002-18con
- University of Vermont Medical Center (Purchase of Real Estate in South Burlington), Docket No. GMCB-004-18con
- Morgan Orchards (Independent Living Facility), Docket No. GMCB-015-17con
- Northeastern Vermont Regional Hospital (Replacement of Mobile with Fixed MRI), Docket No. GMCB-005-17con

For more information, see GMCB Certificate of Need webpage: http://gmcboard.vermont.gov/con/issued.

What is the All-Payer ACO Model?

The All-Payer ACO Model Agreement is an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care, with Medicare's participation.

Past/Current State: Fee-For-Service

Each medical service generates a fee; this can encourage unnecessary services. Services that promote health – like phone consults, referrals, and coordination of care between providers – may not be covered.

Current/Future State: Value-Based Care

All-Payer ACO Model enables Medicaid, Medicare, and participating commercial insurers to work together with providers to be accountable for the quality and cost of care for the people they serve. Encourages services that support disease prevention and coordination of care.

Provider-Driven Reform

What are Accountable Care Organizations?

Five-year Agreement signed in October 2016 was the first step to create an All-Payer Model:

- **Step 1:** Agreement between CMS and VT provided an opportunity for private-sector, provider-led reform in Vermont
- **Step 2:** ACOs and payers (Medicaid, Medicare, Commercial) work together to develop ACO-level agreements
- **Step 3:** ACOs and providers that want to participate work together to develop provider-level agreements

Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population. These providers share governance and work together to provide coordinated, comprehensive care for their patients.

- Under the All-Payer ACO Model, ACOs are the organizations that can accept alternatives to fee-for-service payment. Vermont has one ACO certified by the Green Mountain Care Board: OneCare Vermont

All-Payer ACO Model Agreement

What is Vermont responsible for?

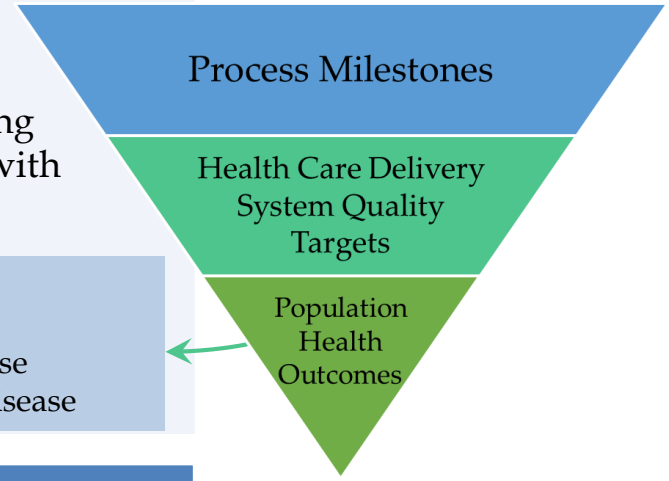
State Action on Financial Trends

- Moves from **volume-driven fee-for-service** payment… to a **value-based, pre-paid model for ACOs**
  - ✓ All-Payer Growth Target: Compounded annualized growth rate <3.5%
  - ✓ Medicare Growth Target: 0.1-0.2% below national projections
- Requires alignment across payers, which supports participation from providers and increases "Scale"
  - ✓ All-Payer Scale Target – Year 5: 70% of Vermonters
  - ✓ Medicare Scale Target – Year 5: 90% of Vermont Medicare Beneficiaries

State/Provider Action on Quality Measures

- State is responsible for performance on **20 quality measures** *(see next slide)*, including three population health goals for Vermont
  - ✓ Improve access to primary care
  - ✓ Reduce deaths due to suicide and drug overdose
  - ✓ Reduce prevalence and morbidity of chronic disease
- ACO/providers are responsible for meeting quality measures embedded in contracts with payers

Goals selected based on Vermont's priorities:
1. Improve access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Reduce prevalence and morbidity of chronic disease



APM Activities in Summer-Fall 2018

ACO Regulation:

- Continued monitoring of OneCare Vermont's 2018 budget and ACO certification
- 2019 ACO Budget review:
  - Guidance issued July 24, 2018
  - Budget submission received October 1, 2018

All-Payer ACO Model Program Development and Implementation:

- Preparing to set financial targets for ACOs participating in the 2019 VT Medicare ACO Initiative
- Finalize specifications for total cost of care and other measures described in the All-Payer ACO Model Agreement, in order to support reporting to federal partners
- Work with federal partners on potential agreement changes, including consensus changes to quality measure sets, a plan to tie Medicare financial targets to quality performance, and several operational changes

For more information, see GMCB Report to the Legislature (September 15), available at https://legislature.vermont.gov/reports-and-research

APM Activities Planned for October-December 2018

ACO Regulation:

- Continued monitoring of OneCare Vermont's 2018 budget and ACO certification
- 2019 ACO Budget review
  - Staff and Board review of OneCare's 2018 budget currently underway. Budget review will ensure compliance with Act 113 of 2016 and Rule 5.000
  - Budget and staff analysis will be presented to GMCB in November; decision expected in late November or December

All-Payer ACO Model Program Development and Implementation:

- Board to set financial targets for ACOs participating in the Vermont Medicare ACO Initiative in 2019
- Develop and submit first reports due to federal partners under the APM Agreement (Q1 2018 Total Cost of Care Report)
- Prepare for future reporting required under the APM agreement

GMCB ADVISORY COMMITTEE
FUTURE OPTIONS

GMCB Advisory Committee

- Current State: GMCB leadership has received continued feedback from Advisory Committee members that this group lacks direction; that members feel their time and expertise aren't optimally utilized; and that you feel your concerns are not heard by the Board

- Today: GMCB is seeking your help to re-envision this group, with **three goals**:

    1. Advisory Committee members provide valuable and diverse input to the Board to support policymaking and strategic planning, based on their expertise
    2. Advisory Committee members feel their time and expertise are respected and valued
    3. Advisory Committee does not duplicate existing Vermont stakeholder groups (e.g., MEAB) or existing opportunities to provide input to GMCB (e.g., public comment process)

Vision for 2019 Advisory Committee

- Membership: Representing diverse stakeholder groups and geography. To include…
  - Health care consumers
  - Consumer advocates
  - Payer representatives
  - Provider representatives, including at least primary care, hospital, mental health, substance use disorder, long-term services and supports, and at-large provider representative
  - Business representative
  - At-large members (may or may not represent categories above)
- Meeting Frequency: Quarterly
- Meeting Structure: Meetings will be used to gather input on specific Board decisions (e.g., HIE Plan), to gather member input on major challenges facing Vermont's health care system, and to develop relationships between stakeholders to support further collaboration
- Process for Joining: To be developed based on October 2018 feedback; will include an application

Discussion Groups – Led by Board Members

- Discussion Questions:
  - Why did you join the GMCB Advisory Committee?
  - From your perspective, what about the Advisory Committee currently works well?
  - From your perspective, what about the Advisory Committee currently does not work well?
  - How could GMCB use the Advisory Committee's time and expertise most effectively?
  - How can the Advisory Committee ensure that GMCB receives feedback that's representative of stakeholders, including providers, health care consumers, and others?
  - When you consider the Advisory Committee meetings you've attended during the past year, which have been the most interesting and productive? (Meeting formats have included presentations, small group discussions, and speaker panels)
  - What topics are you most interested in hearing about and discussing as part of the GMCB Advisory Group?