Annual report of the Green Mountain Care Board to the Vermont General Assembly January 17, 2012

The members of the Green Mountain Care Board wish to express our gratitude to our staff, who have shown a remarkable degree of flexibility and positive attitude during our start-up phase. We appreciate your hard work, dedication to our charge and tolerance for change.

Photo credit: front cover photograph of Williamstown, Vermont by Doreen Chambers, Green Mountain Care Board staff

Table of Contents

Introduction

This is the first annual report to the legislature from the Green Mountain Care Board. The Board was created by Act 48 of the 2011 legislative session. Act 48 states:

> *It is the intent of the general assembly to create an independent board to promote the general good of the state by:*
>
> *(1) improving the health of the population;*
>
> *(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;*
>
> *(3) enhancing the patient and health care professional experience of care;*
>
> *(4) recruiting and retaining high-quality health care professionals; and*
>
> *(5) achieving administrative simplification in health care financing and delivery.*

The members of the Green Mountain Care Board take this charge seriously, and have been working diligently for the past 3½ months to lay a solid foundation for fulfilling the intent and the promise of Act 48.

Act 48 requires the Board to report annually to the legislature on its activities and on any statutory changes recommended to support the board's work and health care reform generally. The law also requires the Board, in its first year of operation, to submit a work plan to the legislature:

> *The Green Mountain Care board established in 18 V.S.A. chapter 220, in collaboration with the director of health care reform in the agency of administration, shall develop a work plan for the board, which may include any necessary processes for implementation of the board's duties, a time line for implementation of the board's duties, and a plan for ensuring sufficient staff to implement the board's duties. The work plan shall be provided to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.*

Our work plan is summarized in this report and a detailed work plan is provided in the appendices to this report. In accordance with the law, the work plan was developed in cooperation with the Director of Health Care Reform in the Agency of Administration.

Under Act 48, the Green Mountain Care Board (hereafter GMCB) has a broad array of powers and duties related to restructuring and regulating Vermont's health care payment and delivery systems. The full list of our responsibilities is provided in the appendices to this report, but we summarize them as follows:

- Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality
- Implement methodologies for achieving payment reform and containing costs
- Engage Vermonters in seeking ways to equitably distribute health services
- Review and approve Vermont's statewide health information technology plan
- Review and approve the health care workforce development strategic plan
- Review the health resource allocation plan
- Set rates for health care professionals
- Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration (BISHCA) on:
    - any health and long term care insurance rate increases, beginning January 1, 2012;
    - hospital budgets, beginning July 1, 2012; and
    - certificates of need, beginning July 1, 2012
- Develop and maintain a method for evaluating system-wide performance and quality
- Review and approve the benefit package or packages for qualified health benefit plans to be offered in Vermont's health benefit exchange
- Define the Green Mountain Care benefit package

The Board and its focus to date

The GMCB includes five members: Chair Anya Rader Wallack, Ph.D. and members Albert Gobeille, Karen Hein, M.D., Cornelius Hogan and Allan Ramsay, M.D. The members come from a variety of backgrounds and together bring to the board experience in direct health care delivery, health care management, business, public sector management, U.S. health policy and international health policy. All are committed to the principles underlying Act 48. Board members were appointed for terms ranging in length from three to seven years, and can be removed from office only for cause.

The members of the GMCB were appointed by Governor Peter Shumlin in September 2011 and began work on October 1. In the short period since then, the members of the GMCB and our staff have focused on:

1. Understanding our powers and duties, relevant health policy at the state and federal levels and related initiatives in the public and private sectors;
2. Advancing plans for payment reform and cost containment;
3. Assuring that we will have data and analytic capabilities to meet our future needs;
4. Preparing to assume a role in the state's health care regulatory processes;
5. Assuring adequate staffing within our available resources;
6. Assuring transparency and public engagement in our work; and

7. Developing a work plan for the full scope of our responsibilities.

Work in each of these areas is described in more detail below, along with our plans and priorities for 2012.

Work to date

Much of the GMCB's work to date has involved getting organized, staffed and housed to effectively tackle our ambitious agenda. In addition, we have undertaken specific work to meet our statutory charge, as follows:

1. ***Understanding our powers and duties, relevant health policy at the state and federal levels and related initiatives in the public and private sectors***

The GMCB has had 16 meetings since October 1. At most of these meetings, we have received briefings from experts who have helped educate us about key issues on which we should be informed and current. Below is a list of our meeting dates, subjects and presenters.

Table 1

Subjects of GMCB meetings to date

10/24/2011	Description of state data sources and use of these data by Steve Kappel (consultant to BISHCA) Description of the Blueprint for Health by Craig Jones (Director of the Blueprint)
11/1/2011	Federal framework for health care reform by Robin Lunge (Director of Health Reform)
11/3/2011	An explanation of the Expenditure Analysis by Mike Davis and Lori Perry (GMCB Staff)
11/8/2011	An explanation of VHCURES, the multi-payer claims database by Dian Kahn (BISHCA)
11/15/2011	An explanation of informatics and a proposed informatics platform by Neil Sarkar (University of Vermont)
11/22/2011	Payment reform pilots status report by Richard Slusky (DVHA)
11/29/2011	Primary care supply and workforce development by David Adams and Charles MacLean (University of Vermont)
11/30/2011	Meeting with Centers for Medicare and Medicaid Services Region 1 Director Rich McGreal (CMS)
12/1/2011	An explanation of and status report on Health Information Technology in Vermont by Hunt Blair (DVHA) and David Cochran (VITL)
12/6/2011	An explanation of Federally Qualified Health Centers by David Reynolds (Office of Senator Sanders) and Susan Barrett (BiState Primary Care)
12/8/2011	An explanation of the BISHCA rate review process by Phil Keller (BISHCA) and Tammy Tomczyk (Oliver Wyman)
12/9/2011	Discussion of federal payment reform opportunities by Jim Hester of the Centers for Medicare and Medicaid Innovation (CMMI)

12/20/2011	A briefing on Vermont hospitals by Bea Grause (VAHHS)
12/22/2011	An explanation of Medicaid by Mark Larson (DVHA) and Robin Lunge (Director of Health Reform)
1/3/2012	Briefing on the Rochester, New York hospital experience with payment reform by Al Charbonneau (former director of the Rochester Health Commission)
1/10/2012	A discussion of the GMCB Workplan

These meetings have been open to the public and, thanks to the work of volunteer Thomas Hall, many of them have been broadcast on local cable access television. The upshot of these briefings has been an understanding on the part of GMCB members that there is much work underway at both the state and federal levels to implement important health care reform elements, and that coordination with these efforts is imperative to our success.

2. Advancing our plans for payment reform and cost containment

The GMCB has been focused squarely on advancing payment reform and other methods of health care cost containment during its first months of operation. Act 48 provided a clear legislative directive to move the state away from fee-for-service provider payment, toward payment systems that reward value. Act 48 also made clear that these efforts should, to the greatest extent possible, include all payers (both public and private), reduce cost-shifting between the public and private sectors, and assure fair payment to health care providers. The GMCB understands that change in how providers are compensated will require a fundamental change in business models and behavior. We believe the models of payment reform we are pursuing (described below) will help providers implement fair and cost-effective improvements in health care delivery in Vermont.

During the next three years, we intend to model and test a range of payment reform options, including population-based payments to integrated health care delivery systems, global physician/hospital budgets, and bundled payments for specific diagnoses and procedures. Testing these models will move us toward a system in which we can control the rate of growth in health care costs while providing strong incentives to improve health care quality and the health of Vermont's population.

We see the models we are proposing as building blocks to achieve the ultimate goal of a population-based budget covering a broad array of health care services for most Vermonters. Each model offers specific advantages:

- Bundled payments provide patients, physicians, hospitals and, in some cases, post-acute providers such as rehabilitation facilities and nursing homes, the opportunity to share in the savings associated with improvements in the total care of people with specific diagnoses or surgical procedures.

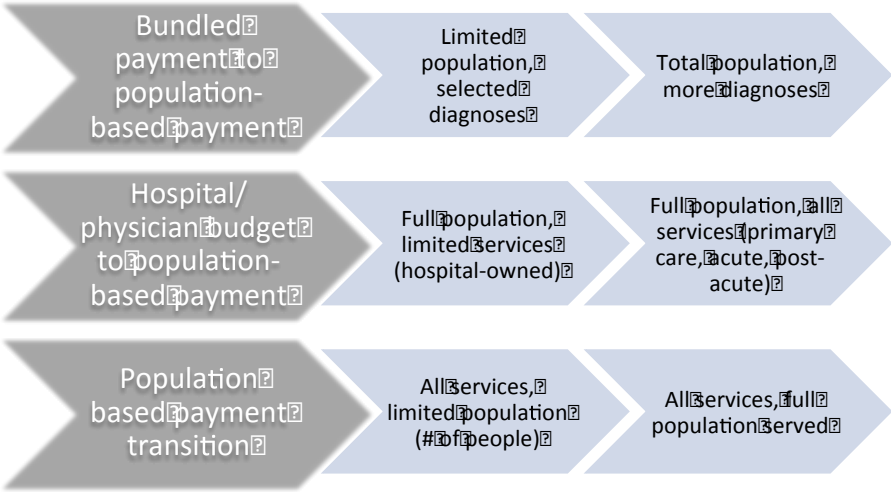
- Hospital/physician budgets provide a fixed amount of revenue for a given hospital and affiliated physicians based on historical utilization and expenditure patterns. A global budget contains strong financial incentives to reduce hospital utilization, and to better manage costs.
- Population-based global payments provide revenue to integrated delivery systems on a per capita payment basis and are designed to cover the broadest possible array of inpatient, outpatient and physician services to a defined population in a specific geographic area.

It is critical, in implementing these models, to include rigorous quality and performance measurement, including measures of patient experience, to assure that incentives for cost containment do not result in diminished quality of care or limited access to needed services.

The figure below depicts how each of the three proposed payment models can transition, over time, to population-based payments for a full array of services, including inpatient, outpatient, physician, and community based post-acute services, for both physical and mental health, provided throughout Vermont.

Figure 1

Transition of pilot payment reform models to broader scope over time



The three basic payment models provide clear steps toward development of a mixed model of payment that balances incentives for reduced utilization, high quality care and improved access to care and satisfaction, while supporting adherence to an overall state health care budget. In addition, we are exploring expansion of the Blueprint for Health payment model beyond primary care to provide additional financial incentives to primary care providers and specialists who agree to improve their coordination of care and follow clinical guidelines in the treatment of patients with certain chronic conditions. We will be working to implement each of these models on an all-payer basis and intend to use the models, where possible, to advance the goal of better integrating physical and mental health care.

In accordance with Act 48, the GMCB is committed to aligning future payment reforms with the Blueprint for Health's Integrated Health Services model. We also intend to employ, to the greatest extent possible, the evaluation infrastructure (data collection, performance measures and overall impact modeling) developed for the Blueprint to support evaluation of broader payment reforms.

Our work to articulate the next phase of payment reform was incorporated into a grant application that was submitted to the Robert Wood Johnson Foundation on January 12. Vermont was one of 15 sites invited to submit a proposal under this solicitation, chosen from 120 initial applicants. We will learn in May if we have been awarded the grant, which would augment state resources already committed to payment reform.

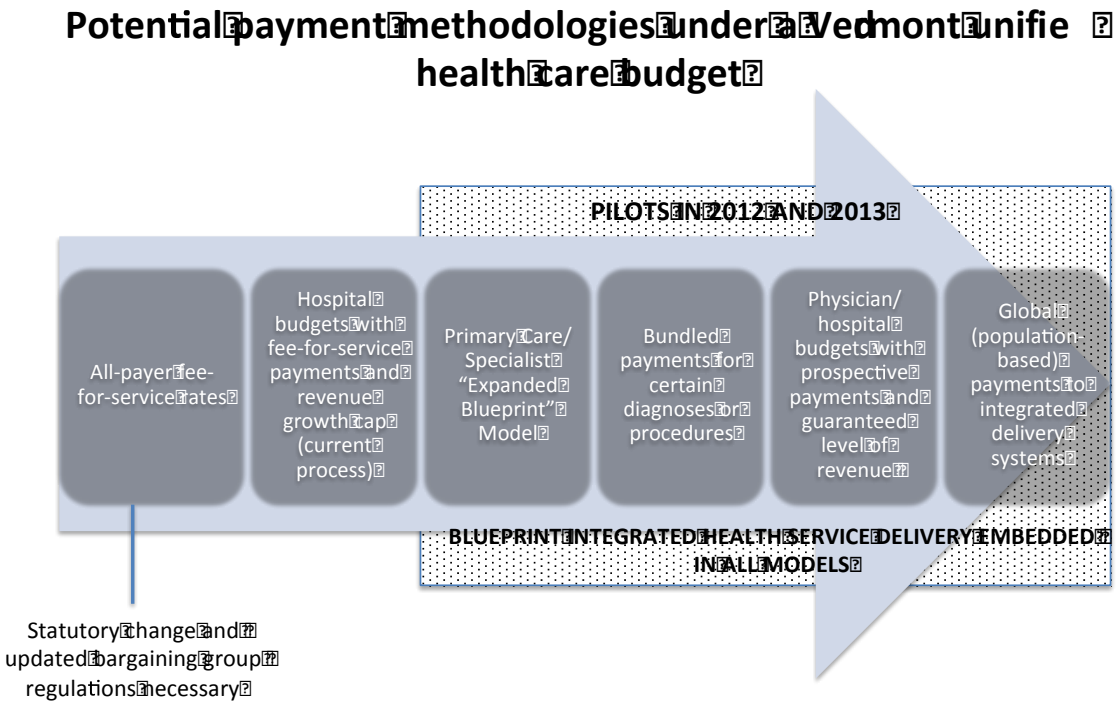
We currently are engaged in discussions with several provider groups about launching the next round of payment reform pilots, and five hospitals have agreed to explore at

least one of the options outlined in the RWJ grant application (Fletcher Allen Health Care, Rutland Regional Medical Center, Porter Medical Center, Northeastern Vermont Regional Hospital and Springfield Hospital). Vermont's major public and private payers have agreed to participate in our analysis as well, and we will be asking CMS for Medicare participation once we have established our pilot design and participants within the state.

In addition, in November we submitted a joint letter of intent to the Centers for Medicare and Medicaid Services (CMS) with the Vermont Association of Hospital and Health Systems (VAHHS) to act as a "convenor" for the CMS bundled payment demonstration model. This demonstration provides an avenue for hospitals to apply for bundled payments from Medicare for certain diagnoses and procedures. The GMCB and VAHHS will receive data from CMS that allows for modeling of the impact of bundled payments in Vermont, and hospitals will declare by May whether they want to participate in the demonstration and to select the payment bundles they wish to pursue.

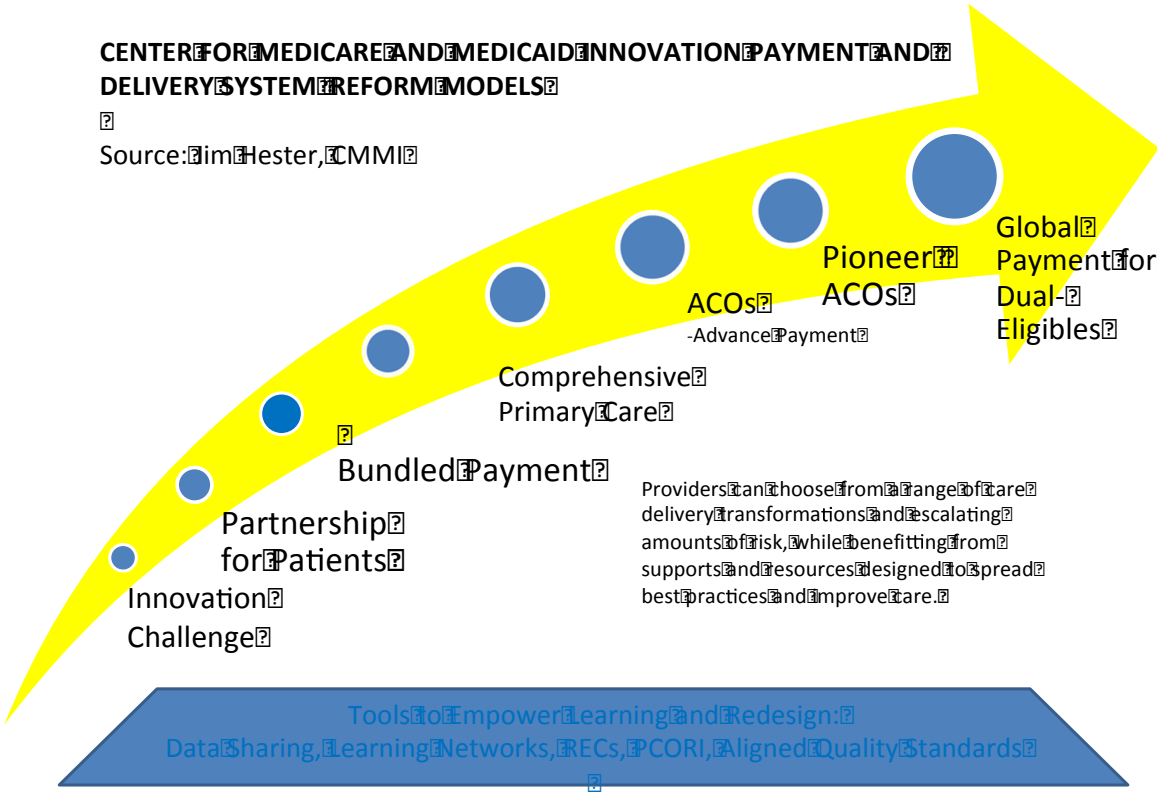
The ultimate goal of our health reform efforts is to assure that Vermont has a means of establishing and enforcing a health care budget that meets the needs of our population. Vermont law has included a "unified health care budget" since the 1990s but it has had little effect on influencing health care cost growth. Figure 2 depicts how, in the short run, the full range of payment models will figure into the Vermont unified health care budget. In the long run, as we test and hopefully prove the success of new payment models, the range of options for provider payment likely will narrow to those with proven success.

Figure 2



Vermont's movement away from fee-for-service provider payments, and our intent to test a range of models for payment reform, is consistent with policies being pursued at the federal level and in other states. In December the GMCB received a presentation from Jim Hester, a senior official at the CMS Centers for Medicare and Medicaid Innovation (CMMI) on the payment reform initiatives supported by federal policy. Like Vermont, CMMI is pursuing a range of options for payment reform, with the goal of evaluating the models to identify those that work best in containing costs and improving quality. Figure 3 below was provided by Dr. Hester, and depicts the range of options supported by current CMMI initiatives. Vermont currently is pursuing payment reforms that are consistent with the federal array through the Blueprint for Health, the expanded Blueprint/Specialist model, bundled payments, physician/hospital global budgets and population-based payments. In this sense, we believe we are well-positioned to attract federal participation in our payment reforms through Medicare.

Figure 3



3. *Assuring that we will have data and analytic capabilities to meet our future needs*

Our efforts to implement payment reform, cost control and performance measurement have brought to the forefront the limitations of Vermont's current health care data sets and analytic capability. To perform our job, the GMCB will need more complete, timely and accurate data on health care use, expenditures and outcomes than has ever been available to policy-makers. We also will need the capacity and skills to analyze available data sets to support decision-making and evaluation.

Vermont has in place a strong platform for an all-payer claims dataset, called VHCURES, but completion of that dataset did not occur in prior years. The dataset, which is maintained by BISHCA, currently contains only commercial claims data. Good progress was made during 2011 to begin the process of Medicaid data integration into VHCURES, but that process is not expected to be complete until March 2012.

Integration of Medicare data into VHCURES also remains a challenge, as barriers to federal data-sharing are an impediment to our efforts. Inclusion of data from Medicare in VHCURES is central to developing a full picture of health care costs and use in Vermont.

During 2011 the state received permission to use Medicare data for evaluation of our Blueprint demonstration project. We expect that data for that purpose will be integrated into our data warehouse (currently maintained by a vendor, OnPoint) by March. However, we have not yet received permission from CMS to use the data for broader purposes, and are exploring several options for obtaining that permission. In December, BISHCA Commissioner Steve Kimbell and GMCB Chair Anya Rader Wallack submitted a joint letter to CMS asking for broader data use authority. That request is under review at CMS. In addition, the GMCB intends to file with CMS, before the end of January, a more limited request to use Medicare data for our research purposes.

The state made progress during 2011 to assure that data use agreements are in place to allow sharing of VHCURES data across departments, once the data set is complete. In addition, the GMCB hired a consultant to develop a data analysis plan that prioritizes data analysis tasks to support the board's work. Finally, we engaged in discussions with the University of Vermont regarding their potential ability to support the state's data analysis needs and continue to evaluate that as an option for the future.

4. Preparing to assume a role in the state's health care regulatory processes

The GMCB is required under Act 48 to become a participant during 2012 in health insurer rate review, hospital budget-setting and certificate of need processes, all of which were previously administered by BISHCA. Act 48 sets up a two-step process for regulatory decisions – BISHCA, starting in 2012, will make a recommendation on insurer rate increases, hospital budget increases and certificate of need approvals or disapprovals, and the GMCB will accept or reject that recommendation. The GMCB is expected to introduce to those processes considerations related to the goals of Act 48 – namely, are rate increases, budget increases or CONs consistent with the goals of containing costs, improving quality of care, and improving the health of the population?

Implementing this component of Act 48 is critical to achieving the goals of the law. If regulatory processes are disconnected from overall state health policy goals, Vermont's health care system is unlikely to change in meaningful ways. Our success depends on a structured partnership between regulator and regulated in which we provide clear signals and consistent incentive structures to guide insurer and provider business decisions.

On the other hand, implementing these regulatory provisions is one of the most complicated tasks contemplated by Act 48. We have begun drafting regulations that will govern administration of our responsibilities under the law. Insurer rate regulation

regulations are most immediate, as we must have in place a process for considering rate increase requests for which we already have responsibility under the law. Hospital budget and CON regulations will be forthcoming soon as well. Our approach to each of these processes is described below.

Insurer rate review

We have requested authority through the Budget Adjustment Act to implement emergency regulations for the insurer rate review process. This request would allow the GMCB to implement a regulation for 120 days on an emergency basis. The 120-day period would begin after a ten business day public comment period and after the GMCB's formal response to public comments. This would not replace the normal regulatory review process, but would allow us to get a regulation in place and provide some formal framework for our review of insurer rates while the normal process proceeds. This process is necessary because, as noted above, the GMCB already has responsibility for this review under Act 48 since the timeframes did not reflect the start date of the Board, which was finalized as October 1st in the Act 48 conference committee.

The GMCB will consider draft regulations for the rate review process in a public meeting during the week of January 15. We have scheduled a meeting for late January with stakeholders and affected entities to ensure that the regulations are informed by their input.

Hospital budgets

In the case of the hospital budget process, we do not believe (and are in agreement with BISHCA on this point) that a two-step process of approval of hospital budgets makes sense in practice. The process of reviewing hospital budgets is staffed by one senior staff person with two support staff, and their task is very technical. These staff have been transferred to the GMCB, as they handle other tasks central to our agenda (such as the expenditure analysis) and it does not make sense to recreate this capacity in another place. We therefore are requesting in H. 559 that the legislature assign responsibility for the hospital budget solely to the GMCB in the future (see description of recommended statutory changes below).

We also have requested in H. 559 the authority to implement emergency regulations for the hospital budget process. As with the insurer rate review process, this request would allow the GMCB to implement regulations for 120 days on an emergency basis, after a 10-day public comment period with GMCB response to comments, and would not replace the normal regulatory review process. The emergency regulations would provide a formal framework and regulatory predictability for our review of hospital budgets while the normal process proceeds.

In the meantime, we have been participating in preparations for the fiscal year 2013 hospital budget process with BISHCA on equal terms. Vermont hospitals operate on a federal fiscal year, meaning the next budget year will begin October 1, 2012. To have in place approved budgets by that deadline, hospitals need guidance from their regulators by February and budgets must be filed with the state by July.

For fiscal years 2011 and 2012 hospitals were subject to legislatively-mandated net patient revenue caps of 4.5 percent and 4 percent respectively. The caps were adhered to in both years. No such legislatively-mandated cap applies in FY 2013, but we are currently engaged in discussions with hospitals to identify a reasonable limit on the rate of increase in their net patient revenues, consistent with the state's goal of continued health care cost growth reduction. Our discussions with the hospitals also have addressed how payment reform initiatives will relate to the hospital budget process, and the extent to which hospitals might be "held harmless" in the budget process for investments in health care reform efforts or changes in state policy that are outside their control. We aim to have recommendations from this process presented to the full GMCB within the next month.

Certificates of need

The GMCB will promulgate regulations on the normal schedule for the CON process, and will become involved in CON considerations after July 1.

5. Assuring adequate staffing within our resources

Act 48 provided ten positions to the GMCB, in addition to the five board members and an administrative assistant. Five and a half of these positions were occupied by incumbents at the Division of Health Care Administration within the Department of Banking, Insurance, Securities and Health care Administration (BISHCA). The remaining four and a half positions were vacant. Of those, four were reclassified to more appropriately meet the needs of the GMCB. Reclassifications are subject to processes provided for in current law that applies to all state positions.

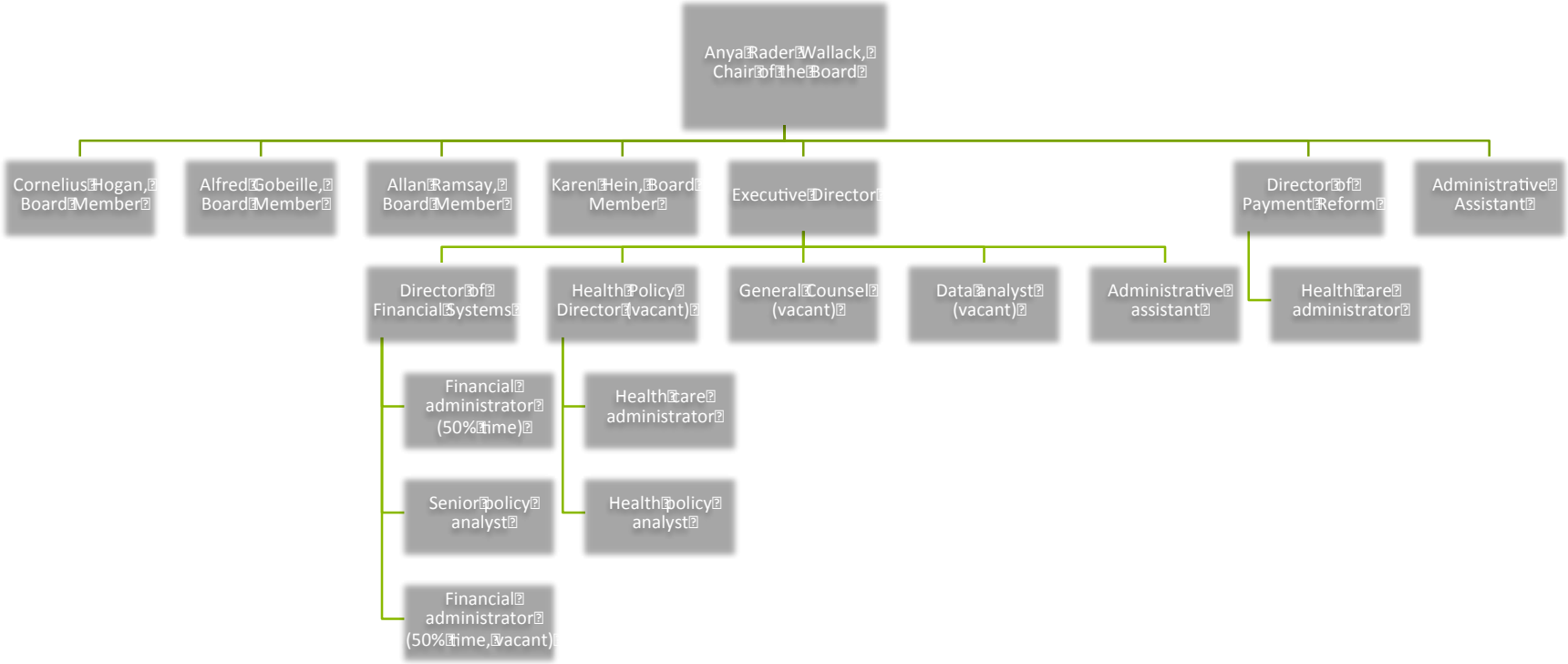
Since passage of Act 48, the State has received two federal grants, each of which funds an additional staff person for the board on a limited service basis. One of those is reflected in our organizational chart and our budget; the other awaits Joint Fiscal Committee approval. At present, three and a half of our positions remain vacant, with two of those currently posted for recruiting.

We hired Georgia Maheras, former Policy Manager for Health Care for All in Massachusetts, as our Executive Director in October. Georgia has assumed responsibility for supervision of most staff and oversight of our budget and administrative operations, and for hiring.

In addition, in November we hired a Director of Payment Reform, Richard Slusky. Richard is a former Vermont hospital CEO and had served as the Director of Payment Reform within the Department of Vermont Health Access since 2010. In his new position, he will have an expanded scope of responsibility related to all-payer payment reform and overall state payment reform policy. DVHA currently is recruiting to replace Richard with someone who can focus on developing Medicaid's capacity to understand Medicaid requirements for payments, understand flexibility in payment methods provided for in the Global Commitment to Health waiver, and participate in the state's payment reform efforts.

An organizational chart for the GMCB is provided below. The GMCB's fiscal year 2012 estimated budget and fiscal year 2013 proposed budget are provided in the appendices to this report.

Green Mountain Care Board Organizational Chart



6. Assuring transparency and public engagement in our work

Consistent with our statutory charge, the GMCB is working to deliberately include Vermonters in our work and assure that our decision-making process is as transparent and open as possible. The GMCB has held more than 15 public meetings since October. In addition, board members have appeared at public events and explained our statutory charge and our approach to implementing that charge in every corner of the state, to audiences too numerous to list. We have drafted a public engagement plan, which we will consider at an upcoming public meeting, and we intend to refine and implement that plan during 2012. The plan will identify methods for reaching out to all areas of the state, through a variety of means, to inform Vermonters of our responsibilities and key points for public input.

In addition, we have solicited applications for our Advisory Board, and will make appointments to that board early this year. We intend to establish additional technical advisory groups related to specific technical tasks throughout the year.

Finally, we have established a working relationship with the Health Care Ombudsman and are developing protocols for how she can participate in all formal aspects of our decision-making, consistent with the law.

7. Developing a work plan/identification of priorities for 2012

The GMCB approved a work plan at our meeting on January 10. The work plan identifies our major tasks according to the categories of responsibility assigned by Act 48, identifies legislatively-imposed or self-imposed deadlines, and identifies lead staff for each task. Many of our tasks are interdependent, and therefore require deliberate sequencing. For example, the VHCURES dataset must be completed before we can perform full-blown analysis of potential payment reform models. A delay in one area could result in a delay in one or more other areas.

Within our work plan, we have identified the following priorities for 2012:

- **Completion of VHCURES** – the addition of Medicaid and Medicare data to the all-payer dataset and development of analytic files is paramount

- **Development of analysis plan** – we have hired a contractor who will assist us in developing an analysis plan to guide prioritization of data analysis. This is a critical step in assuring that we use our analytic resources wisely and efficiently to have in place analysis to guide critical decisions this year and beyond.

- **Completion of reformed regulatory structure and relationship to BISHCA** – it is important to finalize the transfer of responsibilities from BISHCA, and to have our respective roles in insurer rate review, hospital budgeting and CON review sorted out. This will make it possible for regulated entities and the public to understand those processes and use them to further the goals of Act 48, including further reductions in cost growth and implementation of payment reform.

- **Expansion of payment reform** – 2012 will be an important year in establishing the framework (as described above) for the next phase of payment reform. Our work this year will include full development of the models for the next phase of pilots, including the cost and quality metrics to be used to gauge their success.

- **Development of a system performance "dashboard"** – Act 48 requires the GMCB to have a system for measuring key aspects of health care costs and quality. We will adopt the initial version of this dashboard this year, allowing for ongoing measurement of the impact of reforms relative to our baseline.

- **Benefits consideration** – The GMCB, during 2012, will receive recommendations from the Department of Vermont Health Access regarding proposed benefits for both the Health Benefit Exchange and Green Mountain Care. The board will monitor the development of these recommendations and conduct independent research to inform our consideration of benefits.

- **Continued transparency and public engagement** – the GMCB has worked during 2011 to establish regular open meetings, a website and other avenues through which the public can participate in, understand and inform our work (see below). These efforts will be stepped up in 2012, as we seek to broaden the scope of people who engage in our work and the range of communications methods we use to inform and engage the public.

Requested statutory changes

The GMCB is requesting the following statutory changes in 2012:

1. expanded authority to apply for grant funding beyond initial authorization to get grants for payment reform pilots
2. billback authority (identical to BISHCA's) so that we can fund the staff previously being funded by this
3. subpoena power, authority to examine persons, administer oaths, and require production of papers and records, consistent with the need to enforce our existing statutory authority
4. conforming amendments to the Unified Health Care Budget and Expenditure Analysis provisions to move them from BISHCA to the GMCB

5. conforming amendments to the Certificate of Need statute
6. amendments to the hospital budget statute to move the process entirely to the GMCB
7. an allowance for provider bargaining groups to negotiate with the GMCB
8. conforming amendments to the insurer rate review process to allow adequate time for review of rate increase requests
9. conforming amendments related to payment reform pilots to reflect the GMCB's role in broader payment reform policy and the expected timeline for development of additional payment reform pilots
10. conforming amendments to the Blueprint for Health statute to recognize the role of the GMCB
11. technical changes to the GMCB nominating process to ensure confidentiality of applicant information
12. emergency rulemaking authority (as described above)

Conclusions

The GMCB has had a productive start. We are up-to-date on activities that relate to our charge and have established clear priorities, a work plan and a staffing structure to support our immediate responsibilities. We have in place plans for advancing payment reform and cost containment efforts. In the coming year, we expect to make continued progress toward our goals of: reducing the per-capita rate of growth in expenditures in Vermont; ensuring that access to care and quality of care are not compromised; and enhancing the patient and health care professional experience of care. We also intend to develop approaches to the remainder of our charge: improving the health of the population; recruiting and retaining high-quality health care professionals; and achieving administrative simplification in health care financing and delivery. Our agenda is full, and we will be challenged to meet the high expectations set for us. However, we are well-positioned to advance on our highest priorities, and remain excited and hopeful about what we can accomplish, in collaboration with Vermonters.

Appendix A
Detailed work plan of the Green Mountain Care Board

GREEN MOUNTAIN CARE BOARD WORK PLAN (Note: this is not an exhaustive list of our responsibilities, but emphasizes high priorities based on Act 48)				
TASK/RESPONSIBILITY	**STATUTORY DEADLINE**	**INTERNAL DEADLINE**	**STATUS**	**STAFF LEAD**
Develop analytic tools and capacity; maintain a method for evaluating systemwide performance and quality	Ongoing			
Assure completion of VHCURES to support GMCB analysis	None	March, 2012	Medicaid data integration into VHCURES in progress; Medicare data integration in progresss; letter submitted to CMS to authorize use of Medicare data; data use agreement in place with BISHCA; data use agreement with DVHA in progress	Georgia Maheras/Richard Slusky
Use VHCURES and other data sources to perform analyses that support GMCB decision-making	None	Analysis plan due first quarter 2012	Contractor hired to develop analysis plan; Data analysis RFP to follow completion of plan	Georgia Maheras/Richard Slusky
Engage contractor to develop data analysis plan	None	January, 2012	RFP released, contractor chosen, contract in process	Georgia Maheras
Engage contractor to perform data analysis based on analysis plan	None	February, 2012	RFP to be written after analysis plan is complete	Georgia Maheras
Develop dashboard version 1.0	None	February, 2012	Draft developed, redraft in progress	Doreen Chambers
Engage contractor to implement website version	None	March, 2012	RFP to be written after dashboard approved by GMCB	Doreen Chambers
Identify necessary data and measure development to refine the dashboard	None	ongoing	TBD	Doreen Chambers
Oversee development and implementation of payment and delivery system reforms and ensure payment reform pilots are consistent with overall policy	Ongoing -- deadline for next pilot is January, 2012			
Approve policy regarding acceptance of payment reform pilots	None	February, 2012	Policy ready for board consideration January, 2012	Richard Slusky
Identify PCP-specalist pilot sites and develop pilot agreements	One pilot due by January, 2012	First quarter 2012	Efforts to develop PCP/Specialist and Oncology pilot agreements underway in St. Johnsbury	Richard Slusky
Identify population-based payment pilot site	One pilot due by January, 2012	First quarter 2012	Proposal from Fletcher Allen/Vermont Managed Care in development	Richard Slusky
Enable hospitals to participate in CMS "bundled payment" initiative	None	April, 2012 for hospitals to express intent to participatein initiative	leter of intent submitted to CMS; awaiting CMS data release for modeling	Richard Slusky/Mike Davis

GREEN MOUNTAIN CARE BOARD WORK PLAN (Note: this is not an exhaustive list of our responsibilities, but emphasizes high priorities based on Act 48)				
TASK/RESPONSIBILITY	**STATUTORY DEADLINE**	**INTERNAL DEADLINE**	**STATUS**	**STAFF LEAD**
Refine additional pilot models and sites; seek funding for modeling	None	January, 2012 for grant submission; May, 2012 for grant award	Invited to apply to RWJ to support development of three models: bundled pmts; global hospital budgets ; population-based pmts. Application submitted January 12; grant awards to be announced in May; at least four hospitals intend to explore implementation of models in their service area	Richard Slusky
Request Medicaid and private payer participation in pilots	None	First quarter 2012	Will follow negoatiation of pilot agreements (see above)	Richard Slusky
Request Medicare partricipation in pilots	None	July, 2012	Awaits development of pilot agreements and Medicaid/private payer agreement to participate; plan to meet with CMS staff in January or February to bengin discussions	Richard Slusky
Redesign hospital budget process to encourage pilot participation by hospitals	None	February, 2012	Discussion with hospitals underway	Mike Davis/Richard Slusky
Set rates for health care professionals	Not specified			
Engage contractor to analyze and model all-payer rates	None	December, 2011	Contractor engagement in negotiation, should be completed by 1/15	Richard Slusky
Update provider bargaining group regulations	None	July, 2012	Rewrite of regs in process with BISHCA attorneys	Georgia Maheras/General Counsel
Engage in discussions with provider bargaining groups, private payers and Medicaid regarding all-payer rates	None	December, 2012	Informal discussions launched; Medicaid analysis underway	Georgia Maheras/General Counsel
Develop proposed all-payer rate methodology	None	3rd quarter 2012	TBD	Richard Slusky
Present methodology to the legislature	Prior to implementatio	January, 2013	TBD	Richard Slusky
Request Medicare participation in all-payer rate system	None	January, 2013	plan to meet with CMS staff to discuss in January/February	Richard Slusky
Write and seek legislative approval for regulations governing all-payer ratesetting process	None	Q1 2013	TBD	General counsel

GREEN MOUNTAIN CARE BOARD WORK PLAN (Note: this is not an exhaustive list of our responsibilities, but emphasizes high priorities based on Act 48)				
TASK/RESPONSIBILITY	**STATUTORY DEADLINE**	**INTERNAL DEADLINE**	**STATUS**	**STAFF LEAD**
Review decisions of BISHCA Commissioner on health insurer rates (begins 1/1/12)	January, 2012			
Work with BISHCA to assure consistency and clarity in criteria and respective roles in rate review	None	January, 2012	Discussions underway with BISHCA	Georgia Maheras/Rate review director
Write and seek legislative approval for regulations governing GMCB review of insurer rates	January, 2012	January, 2012	Regs drafted by our general counsel, rewriting, will come to GMCB for approval in January; stakeholder meeting scheduled	Georgia Maheras/General Counsel
Review decisions of BISHCA Commissioner on hospital budgets	July, 2012			
Propose to legislature conforming amendments to hospital budget statute -- sole responsibility to GMCB	None	April, 2012	Amendments drafted, to be introduced in January	Mike Davis
Develop recommendations for changes to hospital budget process	None	January, 2012	Discussions with hospitals underway	Mike Davis
Write and seek legislative approval for regulations governing GMCB review of hospital budgets	None	First quarter 2012	Regs to follow discussions with hospitals and GMCB deliberations	Mike Davis/General Counsel
Review decisions of BISHCA Commissioner on certificates of need	July, 2012			
Develop criteria for GMCB CON review; coordinate with hospital budget process and criteria		January, 2012	in progress	Georgia Maheras/General Counsel
Work with BISHCA to assure consistency and clarity in criteria and respective roles in CON review		January, 2012	in progress	Georgia Maheras/General Counsel
Write and seek legislative approval for regulations governing GMCB review of certificates of need		February, 2012	in progress	Georgia Maheras/General Counsel
Expenditure analysis and forecast	Ongoing			
Report 2011 analysis to legislature	February, 2012	February, 2012	Report near completion	Mike Davis
Develop recommendations for modifications to analysis/reporting for future	None	April, 2012	underway	Mike Davis
Implement recommendations for modification	None	July, 2012	TBD	Mike Davis
Unified health care budget	February, 2012			
Submit budget using old methodology	February, 2012	February, 2012	Underway	Mike Davis
Engage contractor to develop methodology for prospective all-system budgeting and enforcement	None	mid-2012	RFP to be developed	Mike Davis/Richard Slusky

GREEN MOUNTAIN CARE BOARD WORK PLAN (Note: this is not an exhaustive list of our responsibilities, but emphasizes high priorities based on Act 48)				
TASK/RESPONSIBILITY	**STATUTORY DEADLINE**	**INTERNAL DEADLINE**	**STATUS**	**STAFF LEAD**
Engage Vermonters/public input process	Ongoing			
Develop draft communications plan	None	December, 2011	Draft in progress, board to consider in January, 2012	Doreen Chambers
Engage contractor to refine and support implementation of communications plan	None	January, 2012	RFP released	Doreen Chambers
Appoint Advisory Committee	None	January, 2012	Applications received, under review by GMCB	Doreen Chambers
Hold AC meetings at least 3X/year	None	Begin January, 2012	First meeting planned for February, 2012	Doreen Chambers
Identify necessary technical advisory groups	None	February, 2012	GMCB members to submit proposals to chair	TBD
Appoint TAGs	None	March, 2012	TBD	TBD
Hold TAG meetings as necessary	None	Ongoing	TBD	TBD
Review proposed benefits for Green Mountain Care	Not specified, but necessary for modeling by 3rd quarter			
Monitor development of benefits by DVHA	None	First quarter 2012	Process underway, GMCB monitoring	TBD
Assess "best practices" in benefit design	None	First quarter 2012	Both Al Golbeille and Karen Hein conducting research	TBD
Develop criteria for review of benefit recommendations	None	July, 2012	TBD	TBD
Review proposed benefits for the Health Benefit Exchange	Not specified, but necessary by October			
Monitor development of benefits by DVHA	None	First quarter 2012	Process underway, GMCB monitoring	TBD
Assess "best practices" in benefit design	None	First quarter 2012	Both Al Golbeille and Karen Hein conducting research	TBD
Develop criteria for review of benefit recommendations	None	July, 2012	TBD	TBD

Appendix B
Description of Appropriations, Divisions, & Programs for the Green Mountain Care Board, Fiscal Year 2012 and Fiscal Year 2013

The GMCB receives funds from four sources: the General Fund, the Medicaid Global Commitment, bill-backs for specific regulatory functions, and grants from outside sources. These funds support the Board's operations and staffing, including staffing for the hospital budget review process and review of health insurer rate increase requests that have been approved by the Commissioner of Banking, Insurance, Securities and Health Care Administration. The funds also support consulting contracts that the board has or will enter into to analyze health care data, model changes in health care payment and delivery and support the Board's decision-making.

Department	Positions	FY 12 Estimated Expenditures	FY13 Proposed Expenditures
Green Mountain Care Board	18	2,135,952	2,476,015
Fund Type			
General Fund		467,038	467,038
Special Fund		0	392,351
Global Commitment		557,886	1,577,740
Interdepartmental Transfer (from BISHCA)		1,111,028	138,886
Expenses by category			
Personal Services: Personnel Salary and Fringe (partial year for FY12)		1,081,850	1,654,256
Personal Services: Third Party Contracts		899,952	544,961
Operating Expenses		154,150	276,798

Appendix C
Full Powers and Duties of the Green Mountain Care Board (from Act 48)

§ 9375. DUTIES

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

(b) The board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in chapter 13, subchapter 2 of this title are consistent with such reforms.

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

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

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

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

(2) Review and approve Vermont's statewide health information technology plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the state to achieve the principles expressed in section 9371 of this title.

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

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

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

(6) Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business days of receipt of such recommendations and taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board, on:

(A) any insurance rate increases pursuant to 8 V.S.A. chapter 107, beginning January 1, 2012;

(B) hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012; and

(C) certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning July 1, 2012.

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

(8) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

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

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

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

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

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

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

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

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

(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the

benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the board comports with the principles expressed in section 9371 of this title.

(e) All reports prepared by the board shall be available to the public and shall be posted on the board's website.