Green Mountain Care Board

ANNUAL REPORT FOR 2021

The Green Mountain Care Board seeks to improve the health of Vermonters through a high-quality, accessible, affordable, and sustainable health care system.

Submitted January 14, 2022
In accordance with 18 V.S.A. § 9375(d)

VERMONT
GREEN MOUNTAIN CARE BOARD

144 State Street
Montpelier, VT 05602
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To: Sen. Anne Cummings, Chair, Senate Committee on Finance
Sen. Ginny Lyons, 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. Mary S. Hooper, Chair, House Committee on Appropriations
Rep. William J. Lippert, Chair, House Committee on Health Care

From: Green Mountain Care Board
Date: January 14, 2022
Title: 2021 Annual Report

Dear Sen. Cummings, Sen. Lyons, Sen. Kitchel, Rep. Ancel, Rep. Hooper, and Rep. Lippert:

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

The Board is guided by its statutory principles "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."

2021 was another year of incredible unpredictability for the entities that we regulate and thus required great nimbleness from the GMCB. The pandemic required us to continue to modify most processes. Despite having to work mostly remote, I continue to be amazed by the productivity of the hard-working State employees at the GMCB. The staff and Board Members are committed to the difficult and challenging work of controlling health insurance premium growth, analyzing hospital and accountable care organization (ACO) budgets and new health care projects and expenditures, and pursuing health care payment and delivery reforms. As we complete Year Four of the All-Payer Model Agreement, the Board continues to work closely with our State and federal partners to move Vermont's health care system away from fee-for-service and towards one that encourages prevention, wellness, and better coordination of care. We continue to make progress on sustainability, but it has been frustratingly slow due to stakeholders rightfully placing their focus on the pandemic.

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

Sincerely,

Kevin J. Mullin
Chair, Green Mountain Care Board

Contents

Executive Director's Report

While writing this report, Vermont hospitals are experiencing record cases and hospitalizations related to COVID-19. Health care workers are currently battling the fourth wave of the pandemic. They are tired, worn down, and exhausted. The COVID-19 surge, sicker patients due to deferred care, and the lack of health care workers in Vermont and throughout the nation have created a perfect storm.

The Board is immensely grateful for Vermont's nurses, doctors, respiratory therapists, environmental services staff, and all other providers throughout the system of care. The commitment and dedication health care workers have shown over the last two years is immense, and the Board will continue to focus on improving the supply of health care workers serving Vermonters well into the future.

Further, the pandemic has reinforced concerns such as the unpredictability of the fee-for-service reimbursement system, the pricing of prescription drug costs, and access to care inequities. While the GMCB has utilized its regulatory levers, where possible, to address these issues, the pandemic has informed the Board that more effort is needed, especially in support of fixed, population-based payment models across the broad spectrum of Vermont's payers and health care providers.

The Vermont Legislature mandated in 2020 that the Director of Health Care Reform update the State's Health Care Workforce Strategic Plan for review and approval by the Board. When the Legislature passed this mandate, it was clear the state's health care workforce needed more focused attention. However, Vermont was unaware the pandemic would prove how fragile and essential our health care workforce was and continues to be. Simultaneously, the Legislature was working on how to address the rising cost of prescription drugs at the state level. The Board offered to convene a stakeholder group under our technical advisory group authority to address the cost of prescription drugs and held the first meeting in December of 2020. The group will share its ideas to address prescription drug out-of-pocket costs with the Legislature this upcoming session.

Even before the pandemic, rural hospitals struggled to survive in Vermont and throughout the country. Nationally, 180 rural hospitals have closed their doors since 2005. As reimbursement for health care continues to change from a per procedure model to a population fixed payment model, our regulatory system and hospitals must prepare for this shift. Further, as more of our population shifts to government payers, Vermonters paying commercial premiums will pay more to cover the gap if the growing cost shift is not addressed. Per Act 159 of 2020, the Board is hoping to finalize recommendations for sustainability planning for Vermont's hospitals early in the new year, contingent on the ability of hospitals to provide input. Among other recommendations, the Board will identify ways hospitals can be supported and resourced to transition to fixed population payments and sustain operations. The pandemic highlights the benefits of fixed, predictable payments to our health care providers to care for Vermonters. We will continue to work with Vermont's hospitals and state leaders to ensure access to high-quality health care in all communities throughout the state.

The Board is also strongly committed to improving health equity in Vermont. Last year, the Board requested to update Vermont's All-Payer Claims Database (APCD) Regulation H-2008-01 to improve Vermont's data related to health equity. The legislature approved the change to allow race and ethnicity data to be securely reported to Vermont's APCD. This legislative change will improve analysis regarding equity and access to health care. In addition, it will provide a more robust and longitudinal understanding of COVID-19 and its costs. We will continue to identify areas in the Board's regulatory duties and data systems to assist in addressing the inequities, such as access to care and costs for patients, in our health care system.

Green Mountain Care Board Themes from 2021

Regulatory Response to COVID-19

The primary focus of the Board throughout the pandemic has been to balance appropriate regulation of Vermont's private sector and non-profit health care entities as required by statute while reducing administrative burden and allowing flexibility for the Board's regulated entities, especially Vermont's hospitals, to focus on care for patients. The regulatory work of the Board is immensely important in containing health care costs while maintaining access to high quality care for all Vermonters and yet our processes must be tailored to accommodate the needs of front-line provider organizations during the pandemic. In 2021, the Board was successful in complying with all its statutory duties and roles despite the ongoing pandemic.

When Vermont's State of Emergency ended in June 2021, the Board quickly returned to offering a physical location for Board meetings and hearings to comply with Vermont's Open Meeting Law, while maintaining remote access. Members of the GMCB staff continued to work with members of the public, stakeholders, and parties to ensure all meetings were truly accessible. To promote transparency and accountability, the Board will continue to provide both in-person and remote access to all meetings and hearings. We will continue to work with the Scott Administration, legislators, and regulated entities to provide appropriate flexibility within the Board's regulatory authority.

Hospital Sustainability

In 2021, the GMCB continued to evolve the hospital sustainability framework based on feedback from stakeholders and national and state-level experts on rural hospital sustainability. The framework focuses on the link between hospital financial health and equitable access to high quality, affordable health care for all Vermonters. Given the demands of COVID-19 on hospitals in addition to the fear of more hospital bankruptcies, the Board took on most of the hospital sustainability work to allow hospitals to focus on patient care. Even with ongoing challenges, the hospitals participated in a series of meetings and were invited to join conversations last summer with Eric Shell, MBA, CPA of Stroudwater Associates, a rural hospital finance expert. Due to the pandemic response, limited feedback from hospitals was provided to the Board. Therefore, further work will be necessary to refine the data and analysis based on provider feedback.

Implementing Vermont's All-Payer Model

The APM Agreement between the State of Vermont and CMMI enters Year 5 in 2022, providing the continued opportunity to improve health care delivery to Vermonters by rewarding providers to keep people well. The APM Agreement is consistent with the federal shift toward alternative payment models that reward value over volume.

Fixed payments offered to providers under the APM proved immensely valuable again this year as health care utilization remained low for a while due to the COVID-19 pandemic. Fixed payments provided a financial lifeline for the many providers who elected to receive them while highlighting the pitfalls of traditional fee-for-service payment models. Due to the pandemic, the Board also requested and received federal flexibility regarding financial penalties related to quality measures.

COVID-19 also caused challenges in evaluating APM performance in 2020 (PY3) and beyond. While PY3 results were below APM Agreement targets, results showed growth in all-payer scale. CMMI recognized in an October 2021 letter that the targets are not achievable and therefore waived enforcement through PY5 of the Agreement. However, in August, the federal government released its first evaluation report of Vermont's APM, focusing on Medicare's participation and Medicare beneficiaries. The report examines the first two years of the Model (2018-2019) and found Medicare

spending in Vermont declined compared to other states with similar reform activities. In addition, the report found positive effects for the full Vermont population since many of the Model's population health initiatives serve Vermonters regardless of insurance or ACO participation and the Board's regulatory structure has statewide impacts on cost containment. The report also notes the APM is supporting collaboration across the health care system and identifies areas for improvement, many of which echo AHS's APM Implementation Improvement Plan.

In September, the GMCB updated its All-Payer Model Performance Summary dashboard profiling performance to-date on the APM Agreement targets. The dashboard will continue to be updated as more results are finalized.

In December, the state submitted a request to CMMI for a one-year extension of the Agreement, noting that the pandemic response has limited the ability of the administration to develop a concept for a new or renewed Agreement, due at the end of 2021. After negotiations on the extension are complete, the final proposal will come back before the Board for a vote.

Regulation, Oversight, and Data

Regulatory Alignment: Under the APM Agreement, integration of the Board's regulatory processes – including health insurance rate review, hospital budget review, Certificate of Need, and ACO certification and budget review – has become increasingly important. In 2019, the GMCB announced its intention to develop a white paper series focused on opportunities for improving alignment across regulatory processes. This white paper series aims to improve the Board's ability to make decisions consistently across regulatory processes and ensure appropriate assessment of regulated entities in a reformed payment and delivery system environment. In summer 2021, the GMCB released final versions of two white papers focused on exploring the GMCB's regulatory processes and the connections between them in their current state, and on potential changes to the annual regulatory timeline to improve alignment.

Hospital Budget Review (pg. 16-17): In 2021, following budget hearings and lengthy Board discussions, the Board approved a system-wide increase in net patient revenue (NPR) of 6.20% (compared to a requested 6.4%, a total reduction of approximately $6.3 million) and lowered the system-wide average increase in charges from 5.98% to 5.21%. The ongoing impacts of the COVID-19 pandemic was at the center of many hospitals' narratives, as well as the impact of Federal and State efforts to stabilize hospitals' finances. Factors such as health care workforce shortages, cost of travelers, prescription drug costs, inflationary pressures, health care reform investments, and access to care challenges were common themes that emerged from hospital budget submissions. In addition, payer mix and the cost shift were continued themes for hospitals that serve higher proportions of Medicare and Medicaid enrollees versus higher reimbursed commercial enrollees. In making their decision, the Board considered COVID-19's ongoing impact, rising inflation factors, workforce challenges, the demographic impact of an aging population, including increased patient acuity and patient demand, and shifting payer mix, as well as hospitals' financial solvency and the growing impact on access to care. All of these considerations led the Board to approve historically higher NPR and charge growth for the 14 community hospitals.

Health Insurance Premium Rate Review (pg. 14-15): Many of the forces affecting hospitals have also affected health insurance premiums. Price is the major driver of increases in health care premiums, which is in part due to the uncertainty of utilization and out-of-state health care utilization. Higher costs of specialty prescription drugs and medical services have continued to place additional pressure on health care premiums, deductibles, and copays this year. Through the health insurance rate review process, the Board reduced the rates requested by insurers by approximately $14.5 million, including $13.6 million for plans sold to individuals, families, and small businesses through

Vermont Health Connect. In addition, the 2021 American Rescue Plan Act expanded subsidies for plan year 2022 in the individual market. In response, Vermont unmerged the individual and small group markets for plan year 2022, resulting in small group premiums decreasing relative to individual premiums with enhanced subsidies offsetting the individual market increase.

Certificate of Need (CON) (pg. 19): In 2021, because of delayed capital improvement projects in 2020, the Board received more CON applications. The Board reviewed six CON applications, while determining that another eight proposed projects fell outside of statutory jurisdictional parameters and were not subject to Board oversight. The increase of CON requests is expected to continue into 2022.

ACO Oversight (pg. 24): Beginning in the fall of 2021, the Board rigorously examined the budget and operations of OneCare Vermont, which resulted in the Board approving OneCare's FY2022 budget on December 22, 2021, with 19 conditions. The conditions include implementing an ACO benchmarking system to compare key quality, cost, and utilization metrics to national benchmarks; maintaining funding for timely rewards for providers who meet clinical quality goals ($2.24 million); working with Medicare Advantage plans to develop scale target qualifying programs for FY23; and continued emphasis on increasing fixed payments, tying payments to performance on clinical quality measures, and increasing commercial insurer participation. These conditions will support robust oversight, transparency, and accountability for the ACO in 2022.

Data (pg. 25-26): GMCB supported increased quality of and access to the VHCURES all-payer claims database and VUHDDS hospital discharge database through improved data linkage and integration, standard reports, and analysis-ready files, and continues to update interactive reports related to the Health Resource Allocation Plan.

Priorities for 2022

Health Care Workforce and Access to Care

Health care workforce issues impact the Board's ability in its regulatory processes to focus on ensuring access to high quality health care while reducing the cost of that care. Workforce has been a major focus of the Board's work under Chair Mullin's active leadership and a priority of the Board's Primary Care Advisory Group. Act 155 of 2020 established that the Director of Health Care Reform in the Agency of Human Services will maintain a current health care workforce development strategic plan to ensure that Vermont has the workforce necessary to provide care to all Vermonters. In 2021, the Board reviewed, modified, and approved the Health Care Workforce Strategic Plan submitted by the Director of Health Care Reform, which identified potential solutions to alleviate the serious shortage and looming crisis of health care workers in Vermont. The Board plans to receive periodic updates on the Health Care Workforce Strategic Plan to ensure accountability and will continue to work with educators, health care providers, and state and community organizations to discuss opportunities to address Vermont's health care workforce challenges, including developing sustainable in-state educational pathways to train Vermont health care providers and staff. The Board will also continue to work in partnership with AHS and DFR to identify challenges to access to care with the goal of improving quality and access for Vermonters while also reducing cost.

In partnership with health providers, advocates, independent experts, and community members, the Board is also working with the Agency of Human Services and Department of Financial Regulation to study excessive health service wait times. The interagency investigation team has been meeting since October 2021 and held two public listening sessions in the fall in partnership with the Health Care Advocate to hear from the public. The team will report its findings and recommendations to the Vermont Legislature in early 2022.

Data Integration, Transparency, and Quality

The Board will continue to work in 2022 to produce more timely, focused information to directly inform regulatory activities and expand the capabilities of VHCURES, including requiring data related to race, ethnicity, and preferred languages. Per Act 159 of 2020, the Board will develop an interactive report highlighting reimbursement variation, which will be released in early 2022 and updated annually. This Annual Report also includes information regarding high-volume outpatient surgeries and procedures performed in ambulatory surgical centers and hospital settings in Vermont, any changes in utilization over time, and a comparison of the commercial insurance rates paid for the same surgeries and procedures performed in ambulatory surgical centers and in hospitals in Vermont, as required by § 9375(b)(14)(B).

Hospital Sustainability

Ensuring hospital sustainability will be a major focus of the Board's work in 2022. The Board will continue to work with hospitals to complete the sustainability planning process, focusing on price, cost, capacity, quality, and access. The goal is to optimize our delivery system and ensure that hospitals are sustainable and prepared for a shift from fee-for-service to value-based payment models. Per Act 159 of 2020, the Board updated the Legislature on the findings from this work in April and September 2021 and will submit the final report by February 1, 2022. The Board expects the work will be ongoing, given the limited availability of hospitals to engage in the process due to the pandemic.

ACO Oversight

As we enter Year 5 of implementation of the APM, the Board continues to focus on meeting the goals of the APM Agreement while continuing to exercise robust oversight over OneCare Vermont. In addition, the Board will be reviewing the budget of a second ACO, Clover Health LLC, which is based out-of-state and participates in the Centers for Medicare & Medicaid Services' (CMS) Direct Contracting Model. The Board plans to continue to develop and refine ACO reporting requirements in 2022 as part of its statutory monitoring and oversight responsibilities, and to work with the Scott Administration and the Centers for Medicare and Medicaid Services' (CMS) to achieve Vermont's goal to pay for value in the form of fixed payments.

All-Payer (APM) Implementation

On December 15, 2021, the Board voted to approve the submission of a proposal for a one-year extension of the current APM Agreement. The proposed Year 6 (2023) allows for additional time to develop a proposal for a 5-year subsequent agreement, which has been delayed by COVID-19. Given the proposed extension, the State has proposed to delay the deadline for making a formal proposal to the Center for Medicare and Medicaid Innovation (CMMI) for a subsequent model for one year, to December 31, 2022. AHS and the Scott Administration are taking the lead in proposing a potential subsequent APM Agreement (APM 2.0), and the GMCB will continue working with providers, payers, advocates, and other stakeholders to implement the Agreement.

Regulatory Alignment and Integration

GMCB will continue to work on regulatory alignment, incorporating feedback and input from other State agencies and the legislature. As we continue to move to population-based payments away from fee-for-service, the Board's regulatory structures will evolve to align with these changes.

Recommendations to Modify Statutes

Per 18 V.S.A § 9375, the Board's annual report shall include any recommendations for modifications to Vermont statutes. For the 2022 legislative session, the Board is requesting technical changes related to the following areas:

- Act 193 of 2018: Impact of Prescription Drug Costs on Health Insurance Premiums Report
- GMCB Nomination and Appointment
- GMCB Billback
- Expenditure Analysis
- Health Care Database
- Conditional Approval of Hospital Budgets

Board Member Updates

Maureen Usifer concluded her term in September of 2021. In her tenure at the Board, Maureen provided valuable expertise on financial and budgetary issues, especially for hospital budgets. She was eager to roll up her sleeves and assist the staff in analyzing budget submissions and many of her recommendations live on in the Board's budgetary review processes. Maureen will be missed, and we thank her for her work at the Green Mountain Care Board and for serving Vermonters.

In December of 2021, Thom Walsh, PhD, MS, MSPT was appointed to the Board. Thom is a professor of health policy at Dartmouth Institute for Health Policy and Clinical Practice and Boise State University's College of Health Science. Thom is also a physical therapist and orthopedic clinical specialist who has practiced across the country, including at Dartmouth Hitchcock in New Hampshire. See page 33 for Thom's full bio.

The Board is excited to welcome Thom to the GMCB.

Legislative Reports

Figure 1: GMCB Legislative Reports Summary (indicates reports submitted annually)*

Legislative Reports Submitted by GMCB in 2021		
Report	**Due Date**	**Corresponding Statute or Legislation**
Impact of Prescription Drug Costs on Health Insurance Premiums	January 1, 2021* *(NOTE: This report was posted in June 2021 due to a delay in data.)*	18 V.S.A. § 4636 (b) Act 193 of 2018, An act relating to prescription drug price transparency and cost containment, Sec. 8 (S.92)
Cost Shift Impact (See GMCB 2019 Annual Report, Appendix A)	January 15, 2021* *(See Appendix A)*	18 V.S.A. § 9375 (d) Act 63 of 2019, An act relating to health insurance and the individual mandate, Sec. 10 (H.524)
GMCB 2020 Annual Report	January 15, 2021* *(NOTE: This report was resubmitted June 2021 with updates.)*	18 V.S.A. § 9375 (d)
Hospital Price Transparency Dashboard	February 1, 2021 (Update) *Final report due February 1, 2022.*	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 1-3 (H.795)
2019 Vermont Health Care Expenditure Analysis	January 15, 2021* *NOTE: The VHCEA is delayed yearly due to data availability and staff resources. This report was published May 2021.*	18 V.S.A. § 9375a (b) (repealed) 18 V.S.A. § 9383 (a) (added in Act 167 of 2018, H. 912) Act 167 of 2018, An act relating to the health care regulatory duties of the GMCB (H.912)
Provider Sustainability &	March 15, 2021	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability

Reimbursements Report		planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 5 (H.795)
Hospital Sustainability Planning (April 1 Update & September 1 Update)	April 1, 2021 (Update) Sept 1, 2021 (Update) *NOTE: Due to COVID-19, the final report will be submitted on or before February 1, 2022.*	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 5 (H.795)
Billback Report	September 15, 2021*	Act 79 of 2013, An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board, Sec. 37c (H.107)
Chiropractic and Physical Therapy Co-Pays	November 15, 2021	Act 15 of 2019, An act relating to miscellaneous provisions affecting navigators, Medicaid records, and the Department of Vermont Health Access (H.204)
GMCB Legislative Reports Due in 2022		
Report	**Due Date**	**Corresponding Statute or Legislation**
Impact of Prescription Drug Costs on Health Insurance Premiums	January 1, 2022* *NOTE: This report is delayed due to data availability.*	18 V.S.A. § 4636 (b) Act 193 of 2018, An act relating to prescription drug price transparency and cost containment, Sec. 8 (S.92)
Cost Shift Impact (See Attachment A)	January 15, 2022* *NOTE: The 2021 is delayed due to data availability.*	18 V.S.A. § 9375 (d) Act 63 of 2019, An act relating to health insurance and the individual mandate, Sec. 10 (H.524)
GMCB 2021 Annual Report	January 15, 2022*	18 V.S.A. § 9375 (d)
2020 Vermont Health Care Expenditure Analysis	January 15, 2022* *NOTE: The VHCEA is delayed yearly due to data availability and staff resources.*	18 V.S.A. § 9375a (b) (repealed) 18 V.S.A. § 9383 (a) (added in Act 167 of 2018, H. 912) Act 167 of 2018, An act relating to the health care regulatory duties of the GMCB (H.912)
Ambulatory Surgical Center Reporting (See Attachment B)	January 15, 2022	18 V.S.A. § 9375 (b) Act 55 of 2019, An act relating to licensure of ambulatory surgical centers (S.73)
Prior Authorization and All-Payer ACO Model Report	January 15, 2022	Act 140 of 2020, An act relating to miscellaneous health care provisions, Sec. 10 (H.960)
Hospital Price Transparency Dashboard Update	February 1, 2022	Act 159 of 2020, An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information, Sec. 1-3 (H.795)
Billback Report	September 15, 2022*	Act 79 of 2013, An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board, Sec. 37c (H.107)

Stakeholder Engagement in 2021

The Green Mountain Care Board believes that all Vermonters are stakeholders in Vermont's health care system, and that public engagement and transparency are foundational to our work. The GMCB seeks stakeholder participation through a variety of forums, groups, and public comment opportunities, including:

- Green Mountain Care Board Meetings;
- The GMCB General Advisory Committee;
- The Primary Care Advisory Group;
- The Data Governance Council; and
- Ongoing and focused public comment opportunities.

GMCB Board Meetings

The Green Mountain Care Board generally meets weekly in open public meetings. GMCB meetings operate in accordance with Vermont's Open Meeting Law: they are noticed 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). In 2021, the Board held 20 fully remote meetings and, starting mid-June, held 33 meetings with a physical location option while maintaining remote access after the Vermont's State of Emergency ended. The meetings include regular Board meetings, hearings on proposed health insurance rate changes, Certificate of Need (CON) hearings, and hearings on proposed hospital and ACO budgets, each of which included time for public comment.

GMCB General Advisory Committee

The GMCB General Advisory Committee[1] was formed in 2012 to provide input and recommendations to the Board, as required by 18 V.S.A. § 9374(e)(1). In 2018, the Board launched a redesign of the committee to better utilize members' time and expertise to support the Board's work. The Board reconvened the Advisory Committee in early 2019 with the new membership and worked with the committee to develop a charter outlining the group's purpose and its future work. The committee's current membership includes 20 representatives of Vermont businesses, consumers, health care providers and educators, patient advocates, and insurers.

In 2021, the Board held three General Advisory Committee meetings. The meetings featured presentations and small group discussions with the goal of utilizing the varied backgrounds and experiences of the Advisory Committee members to inform the Board. Meeting topics include the APM; OneCare Vermont ACO; prescription drug pricing; GMCB legislative priorities; COVID-19 impacts; the Health Care Workforce Strategic Plan; and the make-up and work of the GMCB General Advisory Committee going forward. The General Advisory Committee is staffed by a GMCB staff member and chaired by the GMCB Executive Director, and all Board members attend each meeting.

Primary Care Advisory Group

The Primary Care Advisory Group (PCAG)[2] was established in Act 113 of 2016 to provide input to the Board and address issues related to the administrative burden facing Vermont primary care professionals. In accordance with Act 113, the PCAG sunsetted on July 1, 2018. Recognizing the importance of this group, the Board used the authority granted in 18 V.S.A. § 9374(e)(2), which allows the Board to create advisory groups to carry out its duties, to continue to convene the PCAG. The current PCAG includes 13 primary care providers (a mix of physicians and advanced practice registered nurses). It is staffed by a GMCB staff member and the GMCB Executive Director, and one

[1] *See* GMCB General Advisory Committee webpage.
[2] *See* GMCB Primary Care Advisory Group webpage.

rotating Board member attends each meeting. The PCAG met nine times in 2021 and focused on primary care workforce. Group members provided feedback on the draft Health Care Workforce Strategic Plan, outlining the need for additional primary care clinicians in Vermont. The PCAG members also provided feedback on the HIT/HIE Strategic Plan and GMCB-led legislative reports.

The group will continue to highlight opportunities for improving access to primary care and respond to specific Board questions and requests. Potential areas for future discussion include hospital budget review, oversight of ACOs, payment and delivery system reform, health information technology, data collection and databases, and health care workforce planning.

Prescription Drug Technical Advisory Group

The GMCB Prescription Drug Technical Advisory Group[3] was established in 2020 in response to the Legislature's interest in controlling prescription drug costs at the state level. The group members include representatives from the Agency of Human Services, Department of Vermont Health Access, Department of Financial Regulation, the Attorney General's Office, Vermont Association of Hospitals and Health Systems, Vermont Medical Society, Bi-State Primary Care Association, BlueCross BlueShield of Vermont, MVP Health Care, the Health Care Advocate, as well as an independent pharmacist and chain pharmacist. In 2021, the group held eight public meetings and met more often in subgroups bi-weekly. The group is staffed by a GMCB staffer and Board Member Robin Lunge.

Data Governance Council

The Data Governance Council[4] is a committee of the Board that supports the Board's data governance and stewardship and has the authority to make and execute decisions and assign resources to priority areas. The Data Governance Council, which meets bimonthly in open public meetings, consists of seven voting members, and currently includes one Board Member. In 2021, the Data Governance Council recommended the revision of administrative Rules for Data Submission and Data Release[5] and considered specific data release applications and data linkage requests. Please see the Data and Analytics section on pg. 25 for more information.

Opportunities for Public Comment

Members of the public are invited to provide comment to the GMCB at any time. The Board works with the Health Care Advocate, State agencies and departments, health care organizations, and members of the public to solicit and receive a broad spectrum of information to better assist the Board in its regulatory decision-making processes. In addition to the specific opportunities outlined above, the GMCB accepts public comment submissions via a standardized form available on the GMCB website, by telephone and U.S. mail to the GMCB offices, and by email.[6]

[3] *See* GMCB Prescription Drug Technical Advisory Group information.
[4] *See* GMCB Data Governance Council information.
[5] *See* Vermont Proposed Rules Postings.
[6] *See* GMCB Public Comment webpage.

PROGRESS IN 2021

HEALTH INSURANCE REGULATION

Project Area: Health Insurance Regulation

Relevant Statute/Authority: 8 V.S.A. § 4062; 18 V.S.A. § 9375

Overview: The Board is tasked with reviewing major medical health insurance premium rates in the large group, small group, and individual insurance markets. Within 90 days of submission, the Board must determine whether a proposed rate is affordable, promotes quality care and access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law.

Health Insurance Rate Review

Progress in 2021

- Rate Filings: The Board reviewed 10 rate filings in 2021[7] (see Figure 2, following page), representing approximately $614 million* in health insurance premiums for approximately 80,830 Vermonters, with over 71,860 on the Exchange. Insurers requested approximately $25 million in premium increases overall. The Board reduced this amount by an estimated $14.5 million, including $13.6 million for plans sold on the Exchange.[8] Approved average rate increases for individual Exchange plans were 12.7% (reduced from 17.0% as submitted) for MVP Health Plan, Inc. (MVP) and 4.7% (reduced from 7.9% as submitted) for Blue Cross and Blue Shield of Vermont (BCBSVT). Approved average rate changes in the small group market were 0.8% (reduced from 5%) for MVP and -6.7% (adjusted from -7.8% as submitted) for BCBSVT.[9]
- Rate Drivers: The cost of pharmaceuticals, particularly specialty pharmaceuticals, contributed significantly to the rate requests, as did increases in the cost of medical services.
- COVID-19: The Vermont Department of Financial Regulation released a report in July 2021 that examined the financial impacts of COVID-19 on various segments of the commercial health insurance markets (excluding ERISA-governed plans) and concluded that premium relief is warranted in two market segments at this time. The GMCB approved a premium credit in one of these markets (Cigna large group). The other market segment (BCBSVT Medicare Supplement) is regulated by DFR.

Looking Ahead to 2022

- 2021 American Rescue Plan Act (ARPA): ARPA expanded the subsidies available from the federal government in 2022 to lower the cost of purchasing a plan in the individual market. In response to ARPA's expanded subsidies, Vermont unmerged the individual and small group markets for plan year 2022. This unmerging resulted in small group premiums decreasing relative to individual premiums, with the enhanced subsidies offsetting the individual-market increase. An important issue in the coming plan year will be whether the ARPA subsidies are renewed and whether the markets will be unmerged for plan year 2023.

[7] The filings were reviewed in 2021 for renewals in 2021 and 2022. While plans sold on the Exchange operate on a January 1-December 31 plan year, large group plans do not have a standard plan year and rates for these plans are reviewed and approved on a rolling basis.
[8] See GMCB Rate Review website for a summary of filings and approved rates.
[9] BCBSVT has appealed the Board's individual and small group rate decision.

Figure 2: Insurance Rate Filings for the 2021 Review Year

Company Name	Filing Name	Proposed Rate Change	Approved Rate Change	Difference	*Estimated Premium Reduction
Cigna Health and Life Insurance Company	Large Group	-0.83%	-0.83%	0.00%	$0
Blue Cross Blue Shield of Vermont and TVHP (2 Filings)	Large Group	-0.60%	-1.70%	-1.10%	$639,927
MVP Large Group (Rider)	Large Group	-3.40%	-3.40%	0.00%	$0
Blue Cross Blue Shield of Vermont	Association Health Plan	-0.30%	-1.30%	-1.00%	$130,561
MVP Health Plan Inc.	Individual	17.03%	12.65%	4.38%	$4,749,325
MVP Health Plan Inc.	Small Group	4.97%	0.83%	4.14%	$6,192,670
Blue Cross Blue Shield of Vermont	Individual	7.88%	4.68%	3.20%	$4,003,390
Blue Cross Blue Shield of Vermont	Small Group	-7.78%	-6.87%	-0.92%	-$1,343,403
MVP Health Plan Inc.	Large Group	8.46%	6.81%	-1.65%	$218,822
				Total	**$14,591,292**

* Estimated Premium Reduction - Insureds may not stay with the same plan or insurer from year to year.
Large Group filings are based on the manual rate and may not be reflective of the actual rate increase.
Groups with better experience will see lower rates, and groups with worse experience will see higher rates.

REGULATING HEALTH CARE AND EVALUATING SPENDING

Hospital Budget Review

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. §§ 9375(b)(7), 9456

Overview: Annually by October 1, the Board has the responsibility to review and establish community hospital budgets. In its review, the Board considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public. The Board may adjust a hospital's budget based on exceptional or unforeseen circumstances.

Progress in 2021

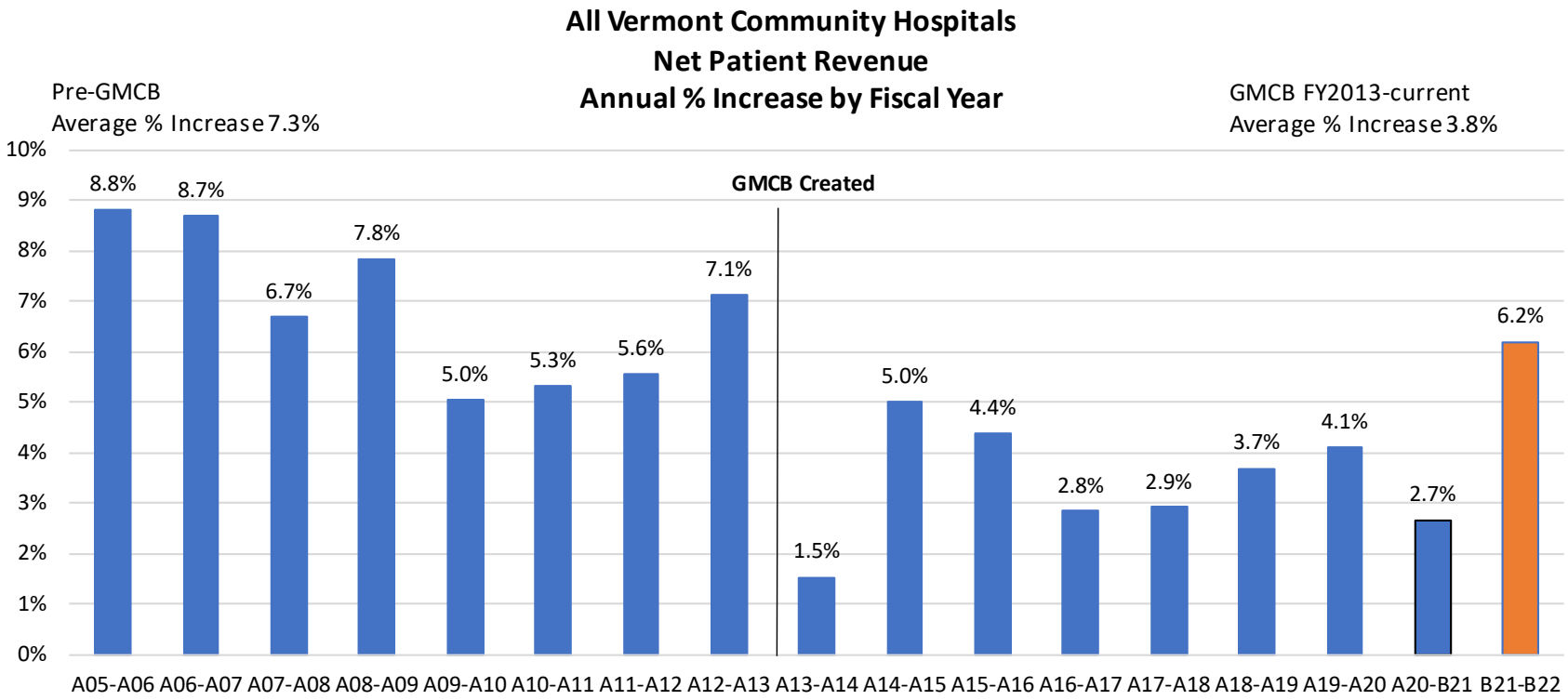
- FY2022 Hospital Budget Review Process: Vermont's 14 community hospitals filed their proposed budgets for FY2022 (October 1, 2021-September 30, 2022) on July 1, 2021. Springfield Hospital submitted a revised budget on November 3, 2021, as ordered by the Board. The aggregated system-wide requested net patient revenue (NPR) increase was 6.4% over FY2021 system-wide budgets. Due to the ongoing challenges of the pandemic, the Board allowed hospitals to forgo a public budget hearing if the FY2022 budget met specific criteria, thus qualifying them for pre-approval of the FY2022 budget. Two of Vermont's 14 community hospitals were able to meet those criteria and have their budget pre-approved. Common themes that emerged from hospital budget submissions were the ongoing impact of COVID-19, federal and state stabilization funding, hospital-based vaccination clinics and testing, pandemic-related expense increases, inflationary pressures, and cost reduction efforts, as well as the impact of the cost shift on commercial rate requests, health care reform investments (e.g., telehealth), All-Payer Model participation, workforce recruitment and access to care challenges. In the Board's review of hospitals' budgets, the Board considered these themes, as well as detailed staff analysis of hospitals' finances, payer mix, utilization, patient access, quality of care, budget compliance, NPR growth, potential commercial charge increases, and accounting changes and provider transfers where applicable. The Board considered comments from the Office of the Health Care Advocate and the public.
- FY2022 Hospital Budget Decisions:[10] The Board's FY2022 hospital budget orders resulted in a system-wide FY2022 NPR of $2.96 billion, a 6.20% NPR increase over FY2021 approved budgets. This represents a reduction of $6.3 million from hospitals' FY2022 budgets as submitted. The Board also reduced the system-wide average increase in charges from 5.98% to 5.21%. In making its decision, the Board considered COVID-19's ongoing impact, rising inflation factors (including the rising costs of recruitment and retention of health care providers), workforce challenges, the demographic impact of an aging population, including increased patient acuity and patient demand, and shifting payer mix, as well as hospitals' financial solvency and the growing impact on access to care. All of these considerations led the Board to approve historically higher NPR and charge growth for the 14 community hospitals.
- Health Care Cost Containment: FY2022 budgeted system-wide NPR was approved at 6.20% over FY2021 budgets, and over the FY2022 targeted growth set forth in the budget guidance of 3.5%. Average annual system-wide growth since 2013 is 3.8%, well below the annual growth of 7.3% seen during the decade prior to the creation of the GMCB (see Figure 3, pg. 18).

Looking Ahead to 2022

- Continued improvements in reporting/monitoring and impact of sustainability planning on hospital processes. Additionally, the GMCB is looking to finalize an RFP to bring on an outside consultant to assess the current process and recommend options to improve the hospital budget process.

[10] *See* GMCB FY22 Hospital Budgets webpage.

Figure 3: Vermont Community Hospitals – System-Wide Net Patient Revenue Increases Over Time[11]



Notes:
A = Actual
B=Budget
GMCB assumed responsibility for reviewing and approving hospital budgets in FY2013

[11] This graph includes Vermont's 14 community hospitals; it excludes the Vermont Psychiatric Care Hospital, Brattleboro Retreat, and the VA (U.S. Department of Veterans Affairs) Medical Center in White River Junction. Net Patient Revenue (NPR) is monies hospitals will receive for services after accounting for contractual allowances, commercial discounts, and free care.

Hospital Sustainability Planning

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. §§ 9375(b)(7), 9456, Act 159 of 2020, Section 4

Overview: Since 2005, 180 rural hospitals have closed nationally, with 2020 closure rates higher than any previous year. Recent financial struggles at many Vermont hospitals caused the Board to consider hospital sustainability within its hospital budget process, requiring 6 of 14 hospitals to develop sustainability plans in its FY2020 hospital budget orders, and later mandating that all Vermont hospitals do the same in the FY2021 hospital budget process.

Progress in 2021

- Hospital Sustainability Framework: In 2021, GMCB staff continued to evolve the hospital sustainability framework based on feedback from stakeholders and experts at the national and state levels on rural hospital sustainability. The resulting framework centers around the link between hospital financial health and Vermonters' equitable access to high-quality, affordable care, i.e., value-based care.
- Data Analysis: Given hospitals' limited bandwidth due to the ongoing pandemic, GMCB staff worked with outside consultants to evaluate Vermont hospital price and cost variation, as well as quality and capacity. The analysis was presented to the Board on October 27th, 2021, along with recommendations to support hospital sustainability in a value-based world.
- Stakeholder Engagement: Initially, the Board envisioned sustainability planning as a series of hospital-led analyses and discussions about reimagining a value-based delivery system. However, the demands of the pandemic on hospitals paired with the fear of additional hospital bankruptcies, led the Board to take on much of this work to ensure its continuation. Despite these challenges, Board staff are thankful for hospitals continued engagement to date. Among other feats, hospitals participated in a series of focused meetings, including the validation of the data underlying the analyses performed by the contractors mentioned above. Hospitals were also invited to participate in conversations over the summer with rural hospital finance expert, Eric Shell of Stroudwater, in which Eric outlined recommendations to continue to evolve hospital payment structures so that a greater share of hospital budgets are made up of fixed population-based payments, among others. Despite hospital engagement, limited feedback was provided to the Board by hospitals on the analyses presented in October. Further analytic work may be necessary before specific recommendations can be made for delivery system and payment transformation.
- COVID-19 related delays: Board staff would also like to thank the Legislature for granting an extension for the submission of this report given the challenges associated with the delta and omicron variants of COVID-19 and the very important work hospitals are doing to guard the health of Vermonters during this pandemic. The participation of hospitals in strengthening Vermont's health system in preparation for future pandemics or public health emergencies is of the upmost importance.

Looking Ahead to 2022

- Final Report and Next Steps: The Board expects to submit its final report to the Legislature by February 1st, 2022, which will outline key findings and potential paths forward for rebalancing Vermont's hospital system toward a more sustainable future, one that may support higher quality and more equitable and affordable health care for Vermonters. The Board expects the work will be ongoing, given the limited availability of hospitals to engage in the work due to the pandemic.

Certificate of Need (CON)

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. § 9375(b)(8), § 9433.

Overview: Vermont law requires hospitals and other health care facilities to obtain a Certificate of Need before developing a new health care project as defined in 18 V.S.A. § 9434. This includes capital expenditures that meet statutory cost thresholds, purchase or lease of new equipment or technology that meet statutory cost thresholds, changes in the number of licensed beds, offering any new home health services, health care facility ownership transfers (excluding nursing homes), and any new ambulatory surgical centers. Each project must meet 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 equitable allocation of resources to all Vermonters.

Progress in 2021

- Issued six CONs: The Board approved six applications with a total value of $41,976,490.
    - WLRC Medical, Inc., to purchase AmCare Ambulance Service. ($2,543,378)
    - Visiting Nurse and Hospital for Vermont and New Hampshire (VNH), to replace outdated HIT systems with a single-platform, unified EHR system from Epic Systems. ($5,869,024)
    - Department of Mental Health, for the construction of a secure residential treatment program in Essex. ($21,900,521)
    - Vermont Veterans' Home, for the implementation of a comprehensive electronic security and access system. ($2,623,375)
    - University of Vermont Medical Center, to purchase an MRI system and construct an addition to house the MRI at 192 Tilley Drive in South Burlington. ($4,080,192)
    - University of Vermont Medical Center Conceptual CON, for planning, design, and permitting activities for the eventual development of an outpatient surgery center. ($4,960,000)
- Eight Projects Not Reviewable: The Board determined that eight proposed projects did not meet jurisdictional thresholds for CON review.
- Applications Under Review:
    - Divided Sky Foundation, to develop a 40-bed residential SUD treatment facility in Ludlow.
    - Pine Heights at Brattleboro Center for Nursing and Rehabilitation, renovation project.
    - The Collaborative Surgery Center, to develop an ambulatory surgery center in Colchester.
    - The Kahm Clinic, to develop an intensive outpatient and partial hospitalization treatment program for eating disorders.
    - Rutland Regional Medical Center, replacement of fixed MRI.
    - University of Vermont Medical Center, outpatient pharmacy expansion.

Looking Ahead to 2022

- New Applications: The following entities have either filed, or notified the Board that they intend to file, applications that will be reviewed in 2022:
    - Vermont Veteran's Home, for the demolition and rebuild of the A-Wing.
    - PATH at Stone Summit, to expand its therapeutic community residential treatment program.
    - North Country Hospital, to construct a new two-story addition and renovations.
    - Benchmark Senior Living, change in the number of licensed beds.
    - Mt. Ascutney Hospital and Health Center, implementation of health information technology project.
    - Grace Cottage Family Health & Hospital, new primary care practice building.

Vermont Health Care Expenditure Analysis

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority:
18 V.S.A. § 9383

Overview: The Board is tasked to develop an annual expenditure analysis and estimates of future health care spending. The Expenditure Analysis is a rich, detailed data source specific to Vermont, and has been published annually since 1991.

- The analysis quantifies total spending for all health care services provided in Vermont (residents/non-residents), and for services provided to Vermonters regardless of site of service.
- The report analyzes broad sectors including hospitals, physician services, mental health, home health, and pharmacy. It also analyzes payers including Medicare, Medicaid, commercial plans, self-insured employers, and health maintenance organizations, and compares Vermont spending to national data published annually by CMS.

The most recent Health Care Expenditure Analysis (CY 2019) was completed in May 2021.[12]

- Vermont Resident Analysis, 2019: Total spending for Vermont residents receiving health care services both in- and out-of-state increased 4.1% from 2018 to 2019, to a total of $6.5 billion. This was higher than the 1.9% increase in 2018 and the average annual increase of 3.3% for the period 2014 through 2019. Medicare spending increased 6.3% due to increases in drugs and supplies, home health, other unclassified and physicians, with decreases in nursing homes and hospitals. A 2.9% increase in Medicaid spending stemmed primarily from growth in spending for mental health and other government activities (e.g., home- and community-based services), hospitals and nursing homes, while expenditures decreased for physicians, admin. & net cost of health insurance, home health and drugs and supplies due to reduced spending and higher rebates for specialty drugs. Commercial insurance spending increased 3.7%, mainly due to growth in hospital utilization, drugs and supplies, and physicians, but decreases in other non-claims costs and other licensed professionals. Estimated growth[13] is expected to be 1.2% from 2019 to 2020 and 2.7% from 2020 to 2021.
- Vermont Resident Analysis Compared to U.S., 2019: From 2018 to 2019, U.S. health consumption spending increased 4.5% (compared to 4.1% for Vermont). The U.S. spending increase was lower than the 4.7% increase from 2017 to 2018, while Vermont's spending increase was higher than the 1.9% increase from 2017 to 2018. National per-person spending was $10,967, higher than Vermont's per-person spend of $10,442.
- Vermont Provider Analysis, 2019: Total revenues received by Vermont providers for health care services provided to in- and out-of-state patients increased 5.6% in 2019, to a total of $6.8 billion. This was higher than the 3.2% increase in 2018 and higher than the average annual increase of 4.2% for 2014 to 2019. Estimated growth is expected to be 2.0% from 2019 to 2010 and 3.8% from 2020 to 2021[14].

Looking Ahead to 2022

- Preparing 2020 Health Care Expenditure Analysis: In 2022, staff will finalize the 2020 Expenditure Analysis and two-year estimates. The analysis will be used as a tool to monitor the implementation of the APM Agreement's cost growth and other key financial metrics. The 2020 Health Care Expenditure Analysis will be affected by the COVID-19 pandemic and some data may have to be revised due to estimates being used in the place of delayed or unknown data at the time of the publication.

[12] *See* 2019 Health Care Expenditure Analysis (PDF) or interactive 2019 Expenditure Analysis visualization. The VHCEA relies on a variety of Vermont-specific data sources, incorporating data from VHCURES, VUHDDS, the Vermont Household Health Insurance Survey, Annual Statement Supplement Report, ACO reports, and the best available data from other state and national resources. Most other analyses of health expenditures (e.g., Kaiser State Health Facts) use resident and provider data produced every 5 years based on US Census data; because of Vermont's small size, the VHCEA's more granular data sources allow for a richer, detailed analysis.
[13] Estimated Vermont Resident growth was predicted at the start of the COVID-19 pandemic these estimates are expected to vary significantly.
[14] Estimated Vermont Provider growth was predicted at the start of the COVID-19 pandemic these estimates are expected to vary significantly.

Prescription Drug Monitoring

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/Authority: 18 V.S.A. § 4635(b)

Overview: The Department of Vermont Health Access (DVHA), is required to create a list of 10 prescription drugs on which Vermont spends significant health care dollars and for which 1) costs have significantly increased either by 50% or more over 5 years, or by 15% or more during the previous calendar year and 2) the cost to DVHA, net of rebates and other price concessions, has increased by 50% or more over the past 5 years or by 15% or more during the previous calendar year.

Progress in 2021

- Prescription Drug Cost Analysis – State Spending: DVHA submitted the prescription drug lists for CY 2020 in June. This list included drugs on which the State spends significant health care dollars or on which health insurance plans spend significant amounts of their premium dollars.[15] DVHA developed the list based on the one-year increase in wholesale acquisition cost (WAC) and net cost.
    - *DVHA Gross Drug Cost Analysis*: This list contains the drugs for which the WAC increased by 15% or more in CY 2020. Gross spending on the ten drugs identified was $271,637 and gross drug price increases ranged from 17.72% to 100.00%. None of the drugs identified were on the previous year's list.
    - *DVHA Net Drug Cost Analysis*: This list contains drugs for which the net cost to DVHA increased by 15% or more in CY 2020. Net drug price increases ranged from 16.3% to 62.6% over the last calendar year and three of the ten drugs identified appeared on the previous year's list of drugs. None appeared on this year's gross cost list.
    - *BCBSVT & MVP Drug Lists with Largest Net Price Increase*:[16] For the previous calendar year, drug price increases ranged from 546.5% to 2700.0% for BCBSVT and from 19.62% to 431.99% for MVP.
- Impact of Prescription Price Increases on Commercial Insurance Rates: The GMCB works with commercial payers with more than 1,000 lives in Vermont to gather data on: a) the flow of funds related to prescription drugs between manufacturers, insurers, and plan members, including discounts and rebates; and b) on the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year price increases.[17] Due to a delay in data, the CY 2020 report will be finalized and posted after the GMCB 2021 Annual Report is submitted.

Looking Ahead to 2022

- Continued Prescription Drug Monitoring: The Board will continue to track drug costs through the health insurance rate review process and work with hospitals and insurers to measure the impact of drugs on insurance rates.
- Prescription Drug Technical Advisory Group: The Board will continue to work with stakeholders to address the rising costs of prescription drugs by examining potential state solutions.

[15] *See* DVHA drug cost analyses and methodology for CY2020.
[16] *See* BCBSVT & MVP drug cost analyses for CY2020.
[17] *See* GMCB Prescription Drug Transparency webpage for Act 193 Report.

Health Information Technology

Project Area: Regulating Health Care and Evaluating Spending

Relevant Statute/ Authority: 18 V.S.A. §§ 9351, 9375(b)(2)

Overview: The Board has two major responsibilities related to health information technology:

- Review and approve the budget for Vermont Information Technology Leaders (VITL - Vermont's statutorily designated clinical health information exchange).
- Review and approve a state Health Information Technology Plan (now referred to as the state Health Information Exchange Plan, or HIE Plan) developed by DVHA. DVHA is required to comprehensively update to the plan every 5 years and to revise it annually.

The Board is also tasked with approving Connectivity Criteria for the Vermont Health Information Exchange (VHIE, operated by VITL).

Progress in 2021

- FY2021 VITL Budget Review: VITL submitted its proposed budget for FY2021 (July 1, 2021-June 30, 2022) on June 9, 2021, with anticipated total revenue of $11.6 million, including $10.6 million in state contracts, plus $1.2 million from other sources and a negative revenue line of $212,000 to cover contingencies related to COVID-19 or other unplanned circumstances. The FY2022 budget included anticipated total expenses of $11.1 million. This submission was presented to the GMCB at its June 9, 2021, public Board meeting,[18] and approved on June 23, 2021.[19] VITL provided quarterly updates on their operations and budget throughout 2021 as required by their FY2021 and FY2022 budget orders, on topics including governance and operations, finances, technology, and stakeholder engagement around HIE consent.
- 2021 Update to Health Information Exchange (HIE) Strategic Plan and 2022 Connectivity Criteria Review and Approval: DVHA and the HIE Steering Committee submitted an annual update to the HIE Plan on November 1, 2021. DVHA and VITL presented the Plan, along with 2021 Connectivity Criteria, to the Board on November 17, 2021. Following Board discussion, DVHA resubmitted the HIE Plan with additional focus on data planning and a vision for future funding. The Board voted unanimously to approve the HIE Plan and Connectivity Criteria on December 1.[20]

Looking Ahead to 2022

- Future HIE Plan Updates: DVHA will continue to submit annual updates to the HIE Plan, developed in collaboration with the HIE Steering Committee.
- FY2023 VITL Budget Review: The Board expects to review VITL's FY2023 budget in late spring 2022.

[18] *See* FY2021 Budget Review Presentation (June 3, 2020).
[19] *See* Order Approving Vermont Information Technology Leaders' FY2021 Budget (July 24, 2020).
[20] *See* 2020 Update to the HIE Strategic Plan as approved by GMCB (December 1, 2020) and Order Approving 2020 Update to the HIE Plan and 2021 VHIE Connectivity Criteria (January 7, 2021). See GMCB's Health Information Exchange (HIE) Plan webpage for more information.

ACOs AND THE ALL-PAYER MODEL

Project Area: ACOs and the APM

Relevant Statute/Authority: 18 V.S.A. § 9551; 42 U.S.C. § 1315a; APM Agreement

Overview: GMCB has four major responsibilities related to the All-Payer Model:

- Set financial targets for Vermont Medicare ACOs and limit cost growth for certain health care services.
- Ensure reasonable alignment across Vermont ACO programs.
- Work with other signatories to achieve targets for the number of aligned Vermonters.
- Work with other signatories to achieve targets on twenty-two quality measures tied to three population health goals.

For additional information see GMCB APM Website.

Vermont's All-Payer Model (APM)

Progress in 2021

- Request for One-Year APM Extension: On December 15, 2021, the Board voted to approve proposing a one-year extension of the current APM Agreement. The proposed Year 6 (2023) will allow additional time to develop a proposal for a longer-term subsequent Agreement, planning for which has been delayed by COVID-19.
- Performance Year 3 (PY3) results: The COVID-19 public health emergency has caused challenges in evaluating performance in 2020 (PY3) and is expected to continue to be an issue for the remainder of the Agreement. Submitted APM Reports are posted to GMCB's website.
  - *Scale*: PY3 results reflected growth in all-payer scale, from 30% in PY2 to 45% in PY3, while Medicare scale remained flat at 47%. While PY3 results were still below APM Agreement targets, CMMI recognized in an October 2021 letter that the targets are not achievable and has waived enforcement through PY5.
  - *Quality*: GMCB staff are currently awaiting preliminary data on PY3 quality, which is expected to be finalized and reported to CMMI in March 2022. Nonetheless, the impacts of COVID-19 on care patterns and utilization in 2020 and beyond will make it very challenging to draw generalizable conclusions about quality of care, and to consider trends in quality over time.
  - *Cost*: While the results for PY3 are not yet final, the total cost of care (TCOC) in 2019 surpassed the All-Payer TCOC target range (3.5% - 4.3%) set over the life of the model. Preliminary data indicate that this trend is likely to be offset in PY3 (2020) due to decreased utilization associated with COVID-19.
- First Federal All-Payer Model Evaluation Report: The federal government's evaluation of Vermont's APM, focused on Medicare's participation and Medicare beneficiaries, released its first report in August 2021. The report examines the first two years of the Model (2018-2019). Findings included reduced Medicare spending in Vermont compared to other states with similar reform activities, as well as positive effects for the full Vermont population because many of the Model's population health initiatives serve Vermonters regardless of insurance or ACO participation and the Board's regulatory structure has statewide impacts on cost containment, highlighting Vermont's long history of investment in primary care and population health, culture of reform, and strong hospital and ACO regulation. The report also notes that the APM is supporting collaboration across the health care system around shared goals and identifies areas for improvement.
- Setting the Annual Medicare Benchmark (Financial Target): In response to COVID-19, the GMCB proposed revising the methodology used to develop the 2020 Medicare benchmark to more accurately reflect utilization; this methodology was used again in 2021. On December 22, 2021, the GMCB also voted to approve a trend rate of 7.3% for End Stage Renal Disease (ESRD) and Non-ESRD Benchmark and include an advance of approximately $9 million for Blueprint for Health and the SASH program.

Looking Ahead to 2022

- Subsequent APM Agreement: AHS and the GMCB began engaging stakeholders and experts as planning for a potential second APM Agreement (APM 2.0) ramps up. Given the proposed extension year discussed above, the State has proposed to delay the deadline for making a formal proposal to CMMI for a subsequent model for one year, to December 31, 2022.

ACO Oversight: Budget Review and Certification

Project Area: ACOs and the APM

Relevant Statute/Authority: 18 V.S.A. §§ 9382 9573

Overview: An ACO must be certified by GMCB to be eligible to receive payments from Medicaid or a commercial insurer through a payment reform initiative such as the APM. GMCB is also responsible for reviewing and approving ACO budgets.

For additional information on ACO oversight, please see materials here.

Progress in 2021

- 2021 ACO Oversight – OneCare Vermont: The Board monitored OneCare's compliance with conditions of its FY21 budget order throughout the year, through the ACO's quarterly reporting.
- 2022 ACO Certification and Budget Review: Beginning September 1, GMCB staff reviewed and verified OneCare's continued eligibility for certification. Certification eligibility was reviewed during the GMCB staff analysis presentation and will be documented in a memo. The Board received OneCare's proposed FY22 budget on October 1. After careful analysis and a public comment period, the Board voted on December 22, 2021 to approve the budget with 19 conditions, including implementing an ACO benchmarking system to compare key quality, cost, and utilization metrics to national benchmarks; maintaining funding for timely rewards for providers who meet clinical quality goals ($2.24 million); working with Medicare Advantage plans to develop scale target qualifying programs for FY23; and continued emphasis on increasing fixed payments, tying payments to performance on clinical quality measures, and increasing commercial insurer participation.
- FY22 OneCare Budget Figures: OneCare's entity-level (GAAP) budget of $27.3 million represents the organization's operational expenses and the portion of population health management program funding handled directly by OneCare in line with U.S. Generally Accepted Accounting Principles. The full accountability budget of $1.37 billion includes the projected cost of care for which OneCare is accountable, including funds that pass directly to providers, contract revenues, and organizational revenues and expenses.
- Review of 2021 Medicaid Advisory Rate Case: Per 18 V.S.A. § 9573, the GMCB is responsible for advising DVHA on the per beneficiary payment rates negotiated between DVHA and OneCare Vermont. The GMCB received the Medicaid Advisory Rate Case on December 29, 2021 and will consider it early in 2022.
- Development of Medicare-only ACO Budget Review Guidance: On October 20, 2021, the Board approved budget guidance for ACOs that contract with Vermont providers who have payer arrangements with Medicare only. One new market entrant, Clover Health, began operating in Vermont in 2021. Clover Health submitted its budget on December 31, 2021, and the GMCB will review it in early 2022.

Looking Ahead to 2022

- Aligning ACO Oversight with Other Regulatory Processes: Through its regulatory alignment efforts (see pg. 6), the GMCB will continue work to align ACO oversight with its other regulatory processes in service of containing cost growth and improving access, quality, and health. This will include alignment with any proposal for a longer-term subsequent All-Payer Model agreement.
- Standardizing ACO Reporting and Benchmarking: To improve tracking ACO performance and accountability over time, the GMCB will continue to work toward collecting data quarterly and year-over-year in standard reporting formats, including a revised ACO reporting manual in 2022. The GMCB will work with OneCare to implement the results-based ACO benchmark dashboard described in their FY22 budget conditions.

DATA AND ANALYTICS

Data and Analytics

Project Area: Data and Analytics

Relevant Statute/ Authority: 18 V.S.A. § 9410

Overview: The Board must maintain a unified health care database, reflecting health care utilization and costs for services provided in Vermont and to Vermont residents in another state. The Board maintains stewardship of two primary data sets:

- The Vermont Uniform Hospital Discharge Data Set (VUHDDS)
- The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

Progress in 2021

- Data Stewardship**:** Having completed all the steps in the Administrative Rulemaking process, the Board adopted two revised administrative rules for data submission and data release. The Council also prioritized recommended actions to improve data quality and accessibility of the GMCB's data resources.
- Data Linkage and Integration: The GMCB Analytical Team explored ways to make data and information more meaningful to broader audiences through integration of data including VHCURES, electronic health records and vital statistics data.
- Standard Reporting: Interactive reports were expanded to include OneCare Vermont ACO Network Provider Participation and All-Payer Total Cost of Care reports.[21]
- Analysis-Ready Files: The final phase of this project provided the GMCB with a set of recommended actions necessary to create analysis-ready data files designed to inspire greater use and utility of the GMCB's data assets.
- Enhanced Data Validation: The GMCB Analytical Team is working with representatives from the provider community and insurers to complete a thorough validation of its data assets. The project is a key component in the GMCB's 2-year Research and Reporting Priorities.[22]

Looking Ahead to 2022

- Reimbursement Variation: As required by Act 159 of 2020, the GMCB Analytical Team will develop an interactive report highlighting reimbursement variation, expected to be released in early 2022, and updated annually. This interactive report will expand understanding of variation in the reimbursements paid by Vermont residents for a specific set of services.
- Expanded Support Across the GMCB: The Analytical Team is continuing to embed analysts in projects that span the organization to better fulfill the Board's desire to use data to inform its decision making.

[21] *See* GMCB Data Analysis and Reporting webpage for current analytic reports.
[22] *See* GMCB Analytic Team's Proposed Research and Reporting Priorities for 2020-2021.

Health Resource Allocation Plan (HRAP)

Project Area: Data and Analytics

Relevant Statute/Authority: 18 V.S.A. § 9405

Overview: In 2018, the Legislature amended the requirements for the Health Resource Allocation Plan. The new HRAP will:
- Report on Vermont's health care services and resources;
- Inform GMCB regulatory processes, cost containment and statewide quality of care efforts, health care payment and delivery system reform initiatives, and allocation of health resources within the state;
- Identify priorities using existing assessments, data, and public input;
- Consider the principles for health care reform in 18 V.S.A. § 9371;
- Identify and analyze gaps between needs and resources;
- Identify utilization trends;
- Consider cost impacts of filling gaps; and
- Be more dynamic and up to date.

The HRAP is a series of dynamic reports, visualizations, and other user-friendly tools designed to convey relevant information. These tools are available on the Board's website in addition to detailed information on health care services by geographic region.[23]

Progress in 2021

- Project Specifications: GMCB continues to analyze health care needs, resources, and utilization patterns across hospital service areas as a way to support regulatory decisions. Interactive reports were updated to reflect current data and consider additional concepts such as costs, insurance coverage and travel patterns. Work performed this year also supported several integrated efforts at GMCB including hospital sustainability planning and the Certificate of Need Program.
- Data Governance and Management: The HRAP team continues to work with several state agencies and health care partners to coordinate statewide data efforts to support health care priority areas.
- Data Collection: GMCB expanded upon information collected in resource inventories and contracted with Berkely Research Group to conduct hospital capacity and quality assessments (see section on Hospital Sustainability Planning for details).
- Stakeholder Engagement: The stakeholder engagement process is ongoing and involves state agencies, legislative representatives as well as regulated entities. Public feedback is solicited through public board meetings and the Board's established public comment process.

Looking Ahead to 2022

- Data Collection and Management: Maintenance of essential data sets that reflect health care needs and resources by sector and geographic region will continue over the next year. Relevant updates will be highlighted on the GMCB website.
- Data Analysis: Further analysis exploring the gaps between available healthcare resources and the needs of the Vermonters.
- Strategic planning: Further assessment to streamline data requests to support Certificate of Need and Hospital Budget Programs.

[23] *See* Green Mountain Care Board Health Resource Allocation Plan webpage.

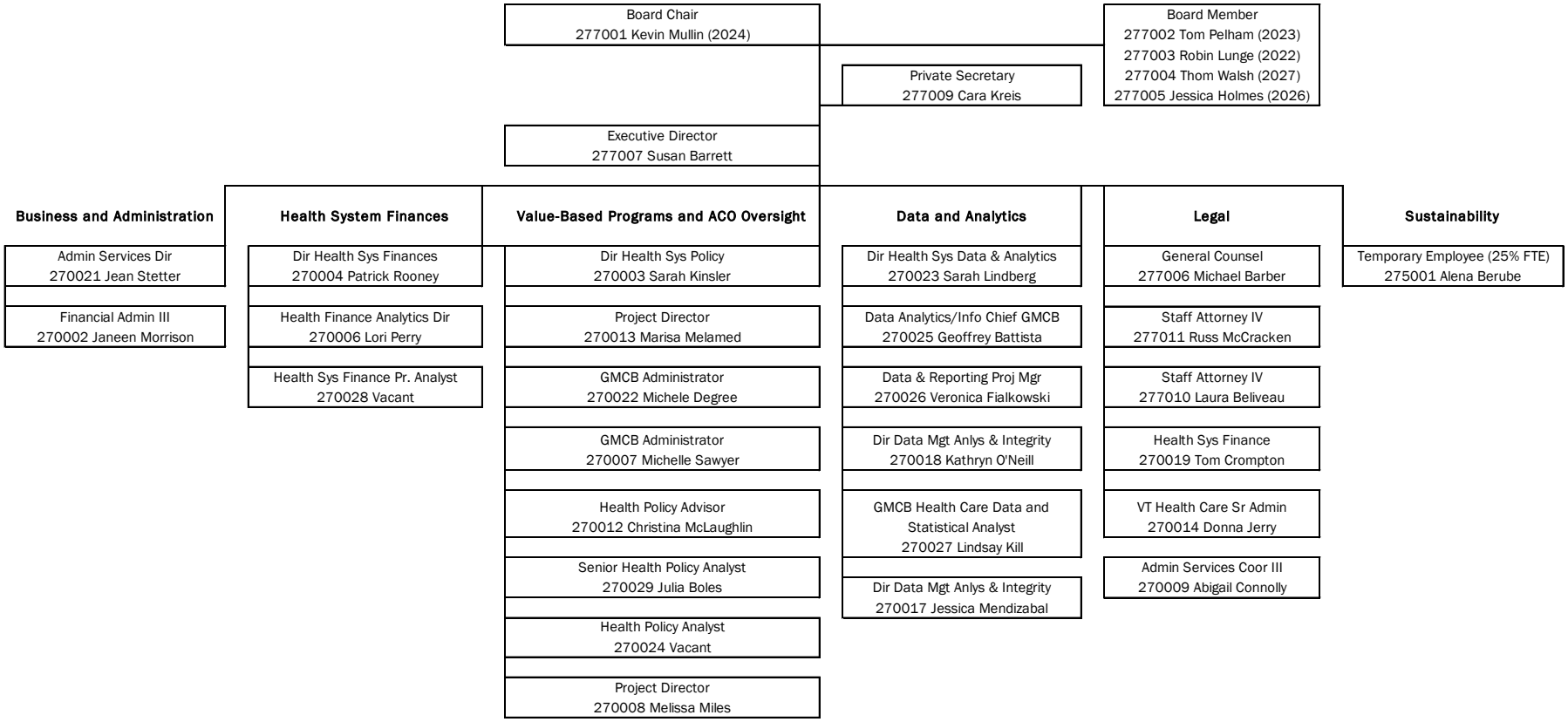
APPENDICES

Appendix A: Green Mountain Care Board Meetings in 2021

January 20, 2021	• Federal Price Transparency Update
January 27, 2021	• Update from the GMCB Data Team • All-Payer Model Payer Differential Reports
February 3, 2021	• 2022 Standard Qualified Health Plan Designs
February 10, 2021	• 2022 Standard Qualified Health Plan Designs – Potential Vote • VITL Quarterly Update and Mid-Year Budget Forecast • Update on Potential ACO Rule Revision
February 17, 2021	• Vermont Program for Quality in Health Care (VPQHC): Quality Systems Overview
February 24, 2021	• GMCB Annual Report for 2020
March 3, 2021	• Hospital Operating Performance FY20 Year-End Report
March 10, 2021	• FY22 Hospital Budget Guidance
March 17, 2021	• FY22 Hospital Budget Guidance – Potential Vote
March 24, 2021	• FY22 Hospital Budget Guidance – Potential Vote
March 31, 2021	• VITL Budget Guidance • 2019 All-Payer Model Update: Quality and TCOC
April 7, 2021	• Act 159 of 2020 Section 5 – Provider Sustainability and Reimbursement Equity
April 14, 2021	• VITL Budget Guidance – Potential Vote • Act 159 of 2020 Section 4 – Update on Hospital Sustainability Planning • Update on All-Payer ACO Model Agreement Implementation Improvement Plan from the Agency of Human Services
April 21, 2021	• Introduction of the Data Governance Council • Proposed Data Submission and Release Draft Rules – Potential Vote
May 5, 2021	• Proposed Data Submission and Release Draft Rules – Potential Vote • Value-Based Payment: Role of a Capitated FQHC APM • Guidance Regarding Accountable Care Organization (ACO) Executive Compensation under GMCB Rule 5.000
May 12, 2021	• Guidance Regarding Accountable Care Organization (ACO) Executive Compensation under GMCB Rule 5.000 – Potential Vote • Core Competencies of High Performing ACOs • FY 2022 ACO Guidance Kick-Off & 2021 Debrief • 2019 Expenditure Analysis
May 19, 2021	• Support and Services at Home (SASH) Presentation • FY 2021 Vermont Hospital Budgets Provider Transfers – Potential Vote
May 26, 2021	• OneCare Vermont FY21 Revised Budget Presentation
June 2, 2021	• An Update on Federal Issues Related to Vermont Health Insurance
June 9, 2021	• VITL Budget Presentation and Quarterly Update • FY 2022 ACO Budget Guidance Presentation
June 23, 2021	• Future of Rural Healthcare: Vermont Vision 2030 • VITL Quarterly Budget – Potential Vote • FY 2022 ACO Budget Guidance – Potential Vote • Clover Health Partners, LLC Waiver Request
June 30, 2021	• 2020 Annual Scale Report • Agency of Human Services APM Update • Clover Health Partners, LLC Waiver Request – Potential Vote
July 14, 2021	• Hospital Report Update

July 19, 2021	• MVP Rate Review Hearing
July 21, 2021	• BCBSVT Rate Review Hearing
July 22, 2021	• Rate Review Public Comment Forum
July 28, 2021	• Preliminary Review of FY22 Hospital Budget Submissions and Public Hearing Exemptions – Potential Vote
August 4, 2021	• CON Hearing: Vermont Department of Mental Health, A Secure Residential Treatment Program in Essex
August 11, 2021	• Avoidable Utilization in Rural Hospitals
August 17, 2021	• FY22 Hospital Budget Hearings
August 19, 2021	• FY22 Hospital Budget Hearings
August 23, 2021	• FY22 Hospital Budget Hearings
August 25, 2021	• FY22 Hospital Budget Hearings
August 27, 2021	• FY22 Hospital Budget Hearings
September 1, 2021	• FY22 Hospital Budget Deliberations – Potential Vote
September 3, 2021	• FY22 Hospital Budget Deliberations – Potential Vote
September 13, 2021	• FY22 Hospital Budget Deliberations – Potential Vote
September 15, 2021	• Request to Reconsider Brattleboro Memorial Hospital FY22 Budget – Potential Vote
October 13, 2021	• GMCB Data and Analytical Team's Research and Reporting Priorities for 2022-2023 • 2022 Budget Guidance and Reporting Requirements for Medicare-Only Non-Certified Accountable Care Organizations
October 20, 2021	• Draft Vermont Health Care Workforce Development Strategic Plan • 2022 Budget Guidance and Reporting Requirements for Medicare-Only Non-Certified Accountable Care Organizations – Potential Vote
October 27, 2021	• Hospital Payment and Cost Coverage Variation • VT Hospital Quality Review and Capacity Planning in Preparation for Value-Based Care
November 3, 2021	• Draft Vermont Health Care Workforce Strategic Plan – Board Discussion and Vote
November 5, 2021	• Federal Evaluation of the Vermont All-Payer Mode: First Two Years (2018-2019)
November 10, 2021	• Updated Vermont Health Care Workforce Development Strategic Plan – Potential Vote • FY 2022 OneCare Vermont Budget Hearing
November 12, 2021	• Updated Vermont Health Care Workforce Development Strategic Plan – Potential Vote
November 17, 2021	• 2021 Update to 2018-2022 Health Information Exchange (HIE) Strategic Plan and 2022 Connectivity Criteria
November 22, 2021	• 2020 ACO Financial Settlement and Quality Performance
December 1, 2021	• 2021 Update to 2018-2022 Health Information Exchange (HIE) Strategic Plan and 2022 Connectivity Criteria GMCB Staff Recommendation – Potential Vote • All-Payer Model Agreement – Proposal to Request 1-Year Extension of Current Agreement
December 8, 2021	• FY 2022 OneCare Vermont ACO Budget and Certification – GMCB Staff Analysis and Preliminary Recommendations
December 15, 2021	• 2022 Medicare Benchmark Proposal • 2021 Update to 2018-2022 Health Information Exchange (HIE) Strategic Plan and 2022 Connectivity Criteria GMCB Staff Presentation – Potential Vote • All-Payer Model Agreement – Proposal to Request 1-Year Extension of Current Agreement • FY 2022 OneCare Vermont ACO Budget and Certification – Additional GMCB Staff Analysis
December 22, 2021	• 2022 Medicare Benchmark Proposal – Potential Vote • FY 2022 OneCare Vermont ACO Budget and Certification – Potential Vote

Appendix B: GMCB Organizational Chart



Appendix C: GMCB Budget

	FY2021 Budget	FY2021 Expenditures	FY2022 Budget
Total Budget	**$9,129,267**	**$7,344,208**	**$10,259,959**
General Fund	$4,015,799	$2,932,366	$4,324,990
GMCB Regulatory & Administration Fund	$5,113,468	$4,271,204	$5,118,507
Interdepartmental Transfer	-	$140,638	$816,462

As with the latter portion of FY20, the pandemic and unexpected long-term medical leave of a key staff member continued to impact the Board's ability fully spend its budget and FY20 to FY21 carry-forward. The Interdepartmental Transfer funds are DVHA's Blueprint expenses under the GMCB's contract with Onpoint.

Appendix D: Board Member Biographies

The GMCB was created by the Vermont Legislature in 2011. It is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health care system improve quality while stabilizing costs.

Nominated by a broad-based committee and appointed by the Governor, the Board includes:

Kevin Mullin, Chair

The Chair 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 is a graduate of Castleton University with a degree in Finance and has taught at the Community College of Vermont and served on numerous community and professional boards. He served nineteen years in the Vermont Legislature including four years in the House and fifteen years in the Senate, where he served on committees including as Chair of the Senate Education and Senate Economic Development, Housing, and General Affairs Committees. As a member of the Senate Health and Welfare Committee, he helped to write both Catamount Health and Green Mountain Care legislation. He has a deep commitment to improving the lives of Vermonters by improving health care quality and controlling health care spending.

Jessica Holmes, Ph.D.

Jessica Holmes was appointed to the Board in October 2014. In addition to serving on the Board. Jessica is a Professor of Economics at Middlebury College. Her teaching portfolio includes courses in health economics and policy, health law, economics and regulation, microeconomics, the economics of social issues and the economics of sin. For six years, Jessica also directed Middlebury's award-winning leadership and innovation program, MiddCORE. 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.

Robin Lunge, J.D., MHCDS

Robin J. Lunge, JD, MHCDS, 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.

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 with recipients' incomes and 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.

Thom Walsh, Ph.D., MS, MSPT

Dr. Thomas Walsh is a professor of health policy who holds academic appointments at the Dartmouth Institute for Health Policy and Clinical Practice and Boise State University's College of Health Science. He is also a physical therapist and orthopedic clinical specialist who has practiced across the country, including at Dartmouth Hitchcock in New Hampshire. Dr. Walsh is an expert in health care systems, policy, and patient care. He is currently a senior expert on health system transformation at the Joint Commission - Center for Transforming Healthcare. In previous roles, he served as a high reliability organization expert for the Veterans Health Administration with Safe & Reliable Healthcare and as founder and Chief Strategy Officer for Cardinal Point Healthcare Solutions, whose clients included U.S. Navy Medicine, One Health Nebraska, the Connecticut Institute for Primary Care Innovation, Maine Medical Center among others. Dr. Walsh was appointed by Governor Phil Scott December 2021 and will serve a six-year term. He currently resides in Colchester, Vermont.

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, 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.

Appendix E: Glossary

ACO	Accountable Care Organization
APM	All-Payer Model
CMMI	Center for Medicare and Medicaid Innovation
CON	Certificate of Need
DVHA	Department of Vermont Health Access
ESRD	End Stage Renal Disease
GMCB	Green Mountain Care Board
GMSC	Green Mountain Surgery Center
HRAP	Health Resource Allocation Plan
NPR	Net Patient Revenue
ORCA	Onion River Community Access
PCAG	Primary Care Advisory Group
QHP	Qualified Health Plan
RHSTF	Rural Health Services Task Force
SASH	Support and Services at Home
TCOC	Total Cost of Care
VELSC	Vermont Eye Surgery and Laser Center
VHIE	Vermont Health Information Exchange
VITL	Vermont Information Technology Leaders
VHCURES	Vermont Health Care Uniform Reporting and Evaluation System
VUHDDS	Vermont Uniform Hospital Discharge Data Set

ATTACHMENTS

Attachment A: Cost Shift

Project Area: Health Insurance Regulation

Relevant Statute/Authority: 18 V.S.A. § 9375

Overview: 18 V.S.A. § 9375 requires the Board to report annually on the cost shift. The Board is tasked annually with recommending mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing commercial insurance premiums below the amount they otherwise would have been. The APM holds Vermont harmless for Medicaid price increases in calculating APM total cost of care, a potential mechanism for decreasing the cost shift.

Progress in 2021

The cost shift may occur when hospitals receive higher revenues for services paid by commercial insurance payers to make up for lower revenues from government payers such as Medicare and Medicaid, and to cover the cost of health care services that are provided but not paid for (uncompensated care) based on the hospital budget process, approved hospital budgets and actual results.

- Annual Estimated Cost Shift Impact: For the purposes of this report, unlike academic research studies about the cost shift, this estimate does not assume negotiations impact the price, but is directly connected with approved net patient revenue increases and charge increases, which are part of the budget process. Figures 4 and 5 below represent the estimated cost shift by payer and by year from FY2010 to FY2022. The cost shift is an estimate based on data submitted in the hospital budget process and assumes that each payer should contribute equally to these budgets, accounting for their proportional share of expenses and margins.
- Rate of Growth: From FY2012 to FY2019, the cost shift appears to have grown at the annual average rate of 9.1% every year, with an estimated growth of -11.1% from FY2019 Actual to FY2020 Actual and 6.0% from FY2021 Budget to FY2022 Budget. Hospitals reporting a slightly smaller reimbursement ratio for commercial compared to 2019 and the COVID-19 relief funds contributed to the estimated growth of -11.1%. The estimated growth of the cost shift for FY2020, FY2021, and FY2022 are affected by the COVID-19 pandemic in that patients were not seeking hospital services and the budgets were hard to estimate in these under certain times.
- Cost Shift Discussion at GMCB and Legislature: The cost shift has been a recurring topic of discussion at GMCB meetings, health insurance rate review hearings, and the Legislature in 2020 and 2021.

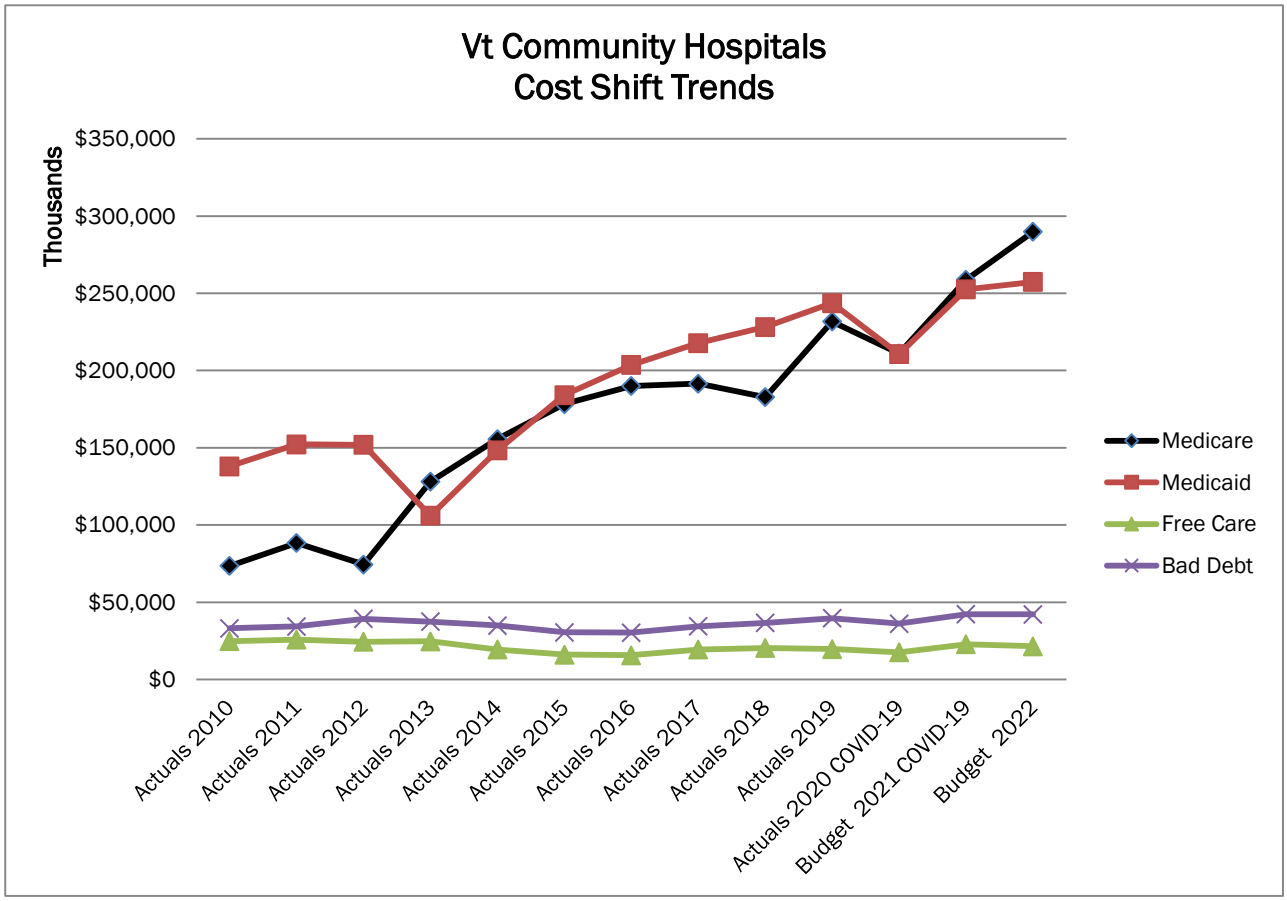
Looking Ahead to 2022

- Reporting and Analysis: GMCB staff will continue to refine the reporting of Vermont and non-Vermont payer revenue and the effect of the APM and any other payment reform initiatives on the cost shift.

Figure 4: Estimated Cost Shift by Payer (FY2010-FY2022), Vermont Community Hospitals

Fiscal Year	Estimated Medicare Cost of Services Shifted to Other Payers	Estimated Medicaid Cost of Services Shifted to Other Payers	Estimated Free Care Shifted to Other Payers	Estimated Bad Debt Shifted to Other Payers	Estimated Costs Shifted to Commercial and Other Payers	Estimated % Change from Prior Year in Shift to Commercial and Other Payers
Actuals 2010	$(73,515,988)	$(138,016,69)	$(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%
Actuals 2017	$(191,515,256)	$(217,814,796)	$(19,337,891)	$(34,451,540)	$463,119,483	5.3%
Actuals 2018	$(182,780,851)	$(228,177,679)	$(20,380,418)	$(36,600,429)	$467,939,377	1.0%
Actuals 2019	$(231,725,743)	$(243,616,824)	$(19,635,798)	$(39,595,820)	$534,573,257	14.2%
Actuals 2020 COVID-19	$(211,057,470)	$(210,626,826)	$(17,589,600)	$(36,102,974)	$475,375,942	-11.1%
Budget 2021 COVID-19	$(258,817,866)	$(252,526,371)	$(22,758,192)	$(42,241,903)	$576,344,332	21.2%
Budget 2022	$(289,854,726)	$(257,405,004)	$(21,491,725)	$(42,091,700)	$610,843,154	6.0%

Figure 5: Trends – Estimated Cost of Services Shifted to Other Payers (FY2010-FY2022)



Impact of Medicaid and Medicare Cost Shifts and Uncompensated Care on Health Insurance Premium Rates

Statutory Charge: 18 V.S.A. § 9375(d)(F) requires the Board to report annually on "the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates…"

Scope: Each year, the Board reports on the costs that Vermont community hospitals and their affiliated providers and facilities are expected to shift onto commercial insurers and other payers (e.g., self-insured employers and self-pay patients) to make up for lower reimbursements from Medicare and Medicaid and to cover the cost of uncompensated care. This information is found in the Cost Shift section of this report. In accordance with 18 V.S.A. § 9375(d)(F), the Board calculated the impact of this cost shift on premiums for the products regulated by the Board, namely, comprehensive major medical health insurance plans in the large group and individual and small group markets.

Findings: With respect to the filings the Board reviewed in 2021, the costs projected to be shifted to commercial and other payers by facilities and providers impacted by the Board's hospital budget review increased rates an average of 13.6% across all filings; 13.7% for individual and small group filings; and 12.0% for large group filings.

Analysis: The Board determined what percentage of hospitals' budgeted commercial revenues are due to the cost shift. This is represented by column (C) in the equation below. Next, the Board determined what percentage of projected premiums are due to projected FY22 hospital spending. This is represented by column (D) in the equation below. The Board then multiplied column (C) by column (D) to determine that the average impact of the cost shift across all filings was 13.6%, as shown in Figure 6.

Figure 6: Impact of Medicaid and Medicare Cost Shifts and Uncompensated Care on Health Insurance Premium Rates

	(A)	(B)	(C) = (A)/(B)	(D)	(E) = (C)*(D)
Budget 2022	Estimated Costs Shifted to Commercial and Other Payers	GMCB Regulated Hospitals' Budget for Commercial Payers	Percentage Impact on Hospital Budgets for Commercial Payers	FY22 Estimated GMCB Hospital as Percentage of Premium	Impact of Cost Shift on Rate Filings
	$610,843,154	$1,729,759,911	35.3%	38.4%	13.6%

The Board also calculated the average impact of the cost shift by market (i.e., individual, and small group filings and large group filings). Column (D) varies by filing and, on average, is larger for the individual and small group filings (38.9%) than for large group filings (34.0%), resulting in a larger impact on the individual and small group filings (13.7%) compared to large group filings (12.0%).[24]

[24] Individual and Small Group (35.3% * 38.9%= 13.7%). Large Group (35.3% * 34.0% = 12.0%).

Attachment B: Ambulatory Surgical Center Reporting

Project Area: Ambulatory Surgical Center Reporting

Relevant Statute/Authority: 18 V.S.A. § 9375

Overview: 18 V.S.A. § 9375 requires the Board to collect and review annualized data from ambulatory surgical centers (ASCs), which shall include net patient revenues, and which may include data on a center's scope of services, volume, payer mix, and coordination with other aspects of the health care system. The Board's processes shall be appropriate to ASC scale, their role in Vermont's health care system, and their administrative capacity. The Board shall also consider ways in which ASCs can be integrated into systemwide payment and delivery system reform.

Progress in 2021

Ambulatory surgical centers (ASCs) are distinct entities whose sole purpose is to provide surgical services to patients not requiring hospitalization where expected duration of services does not exceed 24 hours following an admission. As technology advances, more procedures are expected to be eligible to be performed in outpatient settings, including ASCs, over the coming years. GMCB currently reviews information from two ASCs, Green Mountain Surgery Center (GMSC) and Vermont Eye Surgery and Laser Center (VESLC). GMCB monitors many aspects of these ASCs, including case type, case volume, and reimbursement levels.

- Data Collection & Reporting: The GMCB's main source of reimbursement information comes from its all-payer claims database, VHCURES. VHCURES has detailed information from medical claims for most Vermont residents. For the purposes of comparing reimbursement for ambulatory surgical services, the GMCB leveraged reporting by its vendor, Onpoint Health Data. They have developed a set of services most appropriate for comparison in claims-based reimbursement. In this set of services, there were 5 services with enough volume to be analyzed for GMSC and 1 service for VESLC.
- Considerations: Part of the reason for such a low number of services observed for the GMSC is due to the disruption of service in 2020 due to COVID-19. Future reporting is likely to yield more services for comparison. Another caveat is that the data available currently excludes Southwestern Vermont Medical Center and Central Vermont Medical Center, as their data were mapped incorrectly. The error has been remedied for the next iteration. These facilities, as well as the ASCs, will be included in the GMCB's reimbursement variation dashboard, which will be completed in February of 2022.

Looking Ahead to 2022

- The GMCB will enlist contractual support to enhance its assessment of outpatient need and capacity, including developing mechanisms for more timely, standardized data collection that minimizes burden on providers. The analysis will further be integrated with broader GMCB efforts to conceptualize and incentivize a more sustainable health care delivery system in Vermont.
- The GMCB will expand its assessment of ASC performance, as more data become available. These facilities will also be included in the GMCB's reimbursement variation report, which will be released in February of 2022.

- As required by statute, ASCs will begin reporting discharge records as part of the Vermont Hospital Discharge Data Set (VUHDDS), which will provide a census of all care delivered by ASCs and provide ready comparisons with Vermont's hospitals.
- The Collaborative Surgery Center (CSC) certificate of need application is currently in progress at the Board.

GMSC and VESLC

Overall, the GMSC and VESLC demonstrated lower median reimbursements per episode of care than most hospitals, though some hospitals' reimbursements were similar (i.e., Copley, Northwestern, and Springfield). It is important to note that these observed reimbursements were not adjusted for the complexity of patients. Since ASCs would be expected to provide care for less complex cases, part of the larger reimbursements observed among hospitals may be due to more complex care.

It appears that the GMSC had the lowest proportion of patients with Medicaid coverage and highest proportion of patients with commercial coverage for the selected procedures. These statistics hold even after excluding Cataract Removal with Impact of Lens—a predominantly Medicare-paid procedure not performed at GMSC—from all facilities' market share calculations. VESLC has the highest proportion of patients with Medicare coverage, which is expected given the higher rate of cataracts among those eligible for Medicare.

Figure 7: Median Commercial Price Paid for Common Outpatient Surgeries, CY 2019

Facility	Carpal Tunnel Surgery	Cataract Removal with Implant of Lens	Colonoscopy and Biopsy	Colonoscopy with Lesion Removal	Diagnostic Colonoscopy	Endoscopy of Esophagus, Stomach and Duodenum
Brattleboro Memorial Hospital (BMH)	$5,795	$8,675	$3,835	$4,070	$2,938	$4,074
*Copley (COP)	$2,481	$5,802	$3,286	$3,055	$1,939	$2,858
Gifford Medical Center (GMC)	$8,284	$6,243	$5,251	$6,363	$3,025	$4,500
*GMSC (ASC)	$2,987		$2,233	$2,313	$1,580	$2,078
Mt. Ascutney Hospital & Health Center (MAHHC)		$9,789	$3,484	$4,314		$4,464
North Country Hospital (NCH)	$7,177	$6,618	$5,916	$5,933	$5,094	$5,797
*Northwestern Medical Center (NMC)	$3,209	$5,782	$2,135	$2,233	$1,906	$2,630
Northeastern Vermont Regional Hospital (NVRH)		$10,527	$6,018	$6,718	$5,177	$5,211
Porter Medical Center (PMC)	$4,992	$4,688	$3,525	$4,207	$2,600	$3,768
Rutland Regional Medical Center (RRMC)	$5,004	$5,931	$5,354	$5,276	$4,054	$5,515
*Springfield (SPR)	$2,398		$3,291	$3,266	$2,595	$2,991
UVM Medical Center (UVMMC)	$4,708	$5,810	$4,830	$4,981	$3,892	$3,794
*VELSC (ASC)		$3,751				

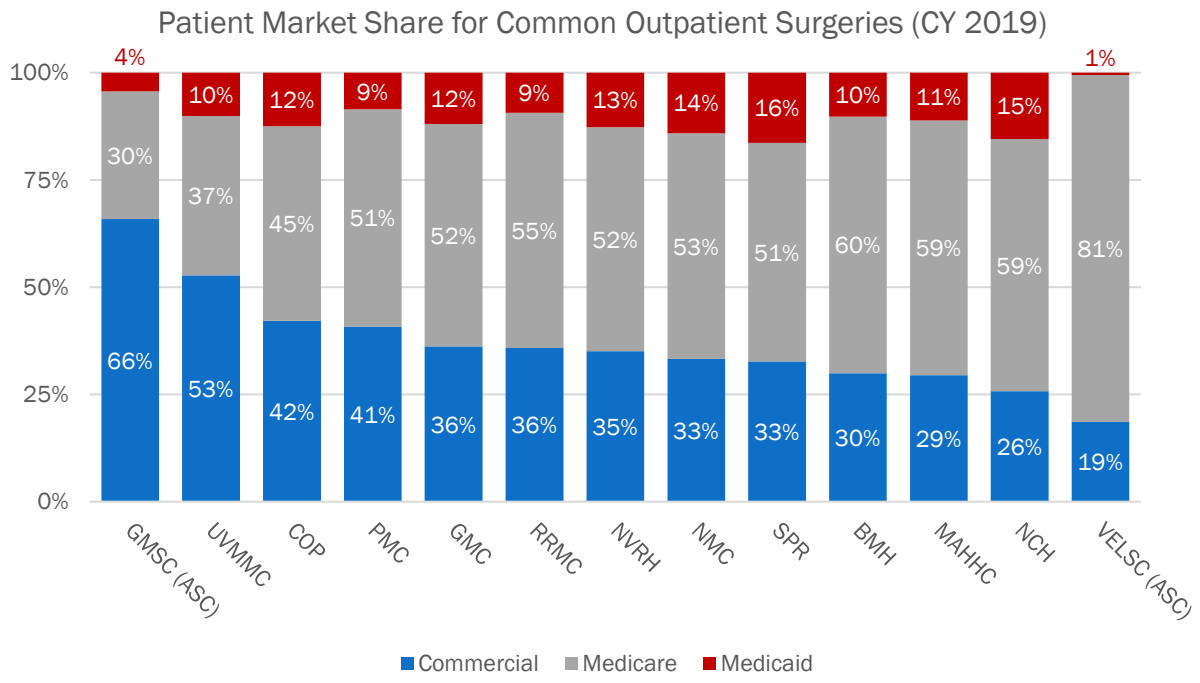
Source: VHCURES. Facilities are arranged by alphabetical order. SVMC and CVMC are excluded due to data quality issues.

Figure 8: Facilities Ranked by Affordability for Common Outpatient Surgeries, CY 2019

Facility	Carpal Tunnel Surgery	Cataract Removal with Implant of Lens	Colonoscopy and Biopsy	Colonoscopy with Lesion Removal	Diagnostic Colonoscopy	Endoscopy of Esophagus, Stomach and Duodenum
BMH	8	9	7	5	6	7
*COP	2	4	3	3	3	3
GMC	10	7	9	11	7	9
*GMSC (ASC)	3		2	2	1	1
MAHHC		10	5	7		8
NCH	9	8	11	10	10	12
*NMC	4	3	1	1	2	2
NVRH		11	12	12	11	10
PMC	6	2	6	6	5	5
RRMC	7	6	10	9	9	11
*SPR	1		4	4	4	4
UVMMC	5	5	8	8	8	6
*VESLC (ASC)		1				

Source: VHCURES. Facilities are arranged by alphabetical order. "*" indicates Top 5 rank for all available surgeries. SVMC and CVMC are excluded due to data quality issues.

Figure 9: Patient Market Share for Common Outpatient Surgeries, CY 2019



Source: VHCURES. Facilities are arranged by commercial market share. Surgeries included are the same as the previous figure: carpel tunnel surgery, cataract removal with implant of lens, colonoscopy and biopsy, colonoscopy with lesion removal, diagnostic colonoscopy, and endoscopy of esophagus, stomach, and duodenum. Market share depends in part on the average age of patients for certain procedures, e.g., cataract surgery. SVMC and CVMC are excluded due to data quality issues.

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