Annual Report of the Green Mountain Care Board to the Vermont General Assembly January 15, 2013

The Green Mountain Care Board is committed to the Institute for Healthcare Improvement's "Triple Aim, " which has been adopted by the federal Centers for Medicare and Medicaid Services. We aim to:

- ***Improve Vermonters' experience of care (including quality and satisfaction);***
- ***Improve the health of Vermonters; and***
- ***Reduce Vermont's per capita costs of health care.***

VERMONT

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Claire Ayer, Chair, Senate Health and Welfare Committee
Mike Fisher, Chair, House Health Care Committee
State House
Montpelier, VT 05062

Dear Senator Ayer and Representative Fisher:

Enclosed is the annual report to the legislature of the Green Mountain Care Board (GMCB), as required by 18 VSA, § 9375.

The GMCB's job, according to our enabling statute, is to:

- improve the health of Vermonters;
- reduce the per-capita rate of growth in expenditures for health services in Vermont;
- enhance patient and health care professional experience of care; and
- achieve administrative simplification in health care financing and delivery.

This report describes important work toward carrying out our statutory obligations. In 2012, we:

- continued development of payment and delivery system reform that will underpin Vermont's future cost containment efforts;
- developed our role as decision-maker in health-insurance rate cases, completing 39 reviews;
- reviewed and approved 14 hospital budgets;
- approved benefit requirements for insurance plans on Vermont's Health Benefits Exchange;
- enhanced the availability and analysis of health care data to support decision making;
- explored ways in which a Unified Health Care Budget could be used as a meaningful tool for health care planning on cost containment;
- launched the "GMCB Health System Dashboard";
- increased transparency around health care regulatory processes and encouraged public engagement in our work;
- authorized changes to Vermont's Health Information Technology Plan; and
- approved a Workforce Strategic Plan.

The report also outlines our priorities for 2013.

Thank you for helping the GMCB to achieve our shared goals in 2012. We look forward to continued collaboration in 2013.

Sincerely,

Anya Rader Wallack

Anya Rader Wallack, PhD
Chair, Green Mountain Care Board

Cover photo courtesy of the Cabot Creamery Cooperative.
Photo by Skye Chalmers from the book *Sending Milk: The Northeast Farms and Farmers of the Cabot Creamery Cooperative*.
Our thanks to Alison Redlich for additional photography
and to Rick J. Blount for his assistance on this report.

The members of the Green Mountain Care Board wish to express our gratitude to our amazing staff, who have demonstrated flexibility, dedication, passion, and a shared sense of good humor in our first year serving the people of Vermont.

Green Mountain Care Board Members and Staff

Board Members
Anya Rader Wallack, Ph.D., Chair
Al Gobeille
Karen Hein, M.D.
Cornelius Hogan
Allan Ramsay, M.D.

Staff
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Janet Richard, Administrative Services Coordinator
Richard Slusky, Director of Payment Reform
Spenser Weppler, GMCB Health Care Administrator

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From left to right: Board Member Al Gobeille, Board Chair Anya Rader Wallack, Executive Director Georgia Maheras, and Board Members Karen Hein, Con Hogan and Allan Ramsay

Vermont's Health System and the Role of the Green Mountain Care Board

State government has taken a more-activist role in overseeing health care delivery and spending in Vermont than in many other states. Ours has been a fairly oligopolistic health care market – one characterized by little competition -- for many years, and the state's policy has been to provide for significant regulatory oversight.

Vermont has had a system of hospital budget oversight in place since 1983, has required state approval of major capital expenditures by health care providers (under a "certificate of need" program) and has long required review and approval of health insurer rate increases. We also have developed an expenditure analysis since 1991 that details health care spending and cost growth from year-to-year. More recently, the state has developed an all-payer claims dataset (APCD). This is a repository of data from nearly all health insurers doing business in the

Some Features of Vermont's Health System

- 14 community hospitals, including 8 critical access hospitals (fewer than 25 beds).
- 1 in-state academic medical center, plus Dartmouth-Hitchcock, provide most tertiary care.
- 8 FQHCs serving more than 120,000 Vermonters.
- Fewer than 2000 physicians, more than half of whom are employed.
- 3 insurance carriers, only 2 in small group market.
- 6.8% uninsured.

state that allows us to examine patterns of health care use, price and overall cost in a way that is not possible in most states.

The Legislature created the Green Mountain Care Board (GMCB) in 2011. The GMCB was given broad authority over health policy-making, and was expected to provide for better cohesion of policy across previously separate elements and a higher level of accountability for outcomes, and foster improved transparency in regulatory processes. According to the GMCB's enabling statute (18 VSA § 9372):

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

Vermont law (18 VSA, § 9375) requires that annually, on or before January 15, the GMCB submit a report of its activities for the preceding state fiscal year to the House Committee on Health Care and the Senate Committee on Health and Welfare. The law requires that the report include:

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

The law also requires that the report identify how the work of the GMCB aligns with the principles expressed in section 9371 of title 18. (See Appendix A for a full discussion of the statutory requirements for this report.)

This report is intended to meet the statutory requirements for GMCB reporting to the Legislature for 2013. While the statute technically requires a report on the previous state *fiscal year* (July 1 - June 30), we are reporting here on activities during calendar year 2012, as the board has yet to exist for a full fiscal year and calendar year reporting is more up-to-date.

The GMCB's role

The Legislature gave the GMCB a number of powers and duties to use in carrying out its charge. These include:

- **Payment and delivery system reform:** Develop, implement and evaluate the effectiveness of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont.
- **Health insurer rate approval:** Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board.
- **Hospital budget approval:** Review and establish hospital budgets annually.
- **Approval of major health care capital expenditures** (began January 1, 2013): Review and approve, approve with conditions, or deny applications for certificates of need.

Mark Larson, Commissioner of the Department of Vermont Health Access, testifies at a Green Mountain Care Board meeting.

- **Exchange benefits approval:** Review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans to be offered in Vermont's Health Benefit Exchange (in accordance with the federal Affordable Care Act).
- **Vermont health system Dashboard:** Develop and maintain a method for evaluating Vermont health system performance and quality.
- **Unified health care budget:** Develop a unified health care budget to guide the overall growth and allocation of health care spending in Vermont.
- **Health information technology:** Review and approve Vermont's statewide health information technology plan to ensure that the necessary infrastructure is in place to enable the state to achieve its health reform goals.
- **Health care workforce policy:** Review and approve the state's health care

workforce development strategic plan.
- **Health planning:** Review the state's health resource allocation plan.
- **Provider rate-setting:** Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

In addition, the GMCB has some specific duties related to development of Green Mountain Care, a program of publicly-financed, universal coverage under development for Vermont. These include:

- Prior to implementing Green Mountain Care, the GMCB shall consider recommendations from the Agency of Human Services, and define the Green Mountain Care covered benefits package.
- Prior to implementing Green Mountain Care and annually after implementation, the GMCB shall recommend to the general assembly and the governor a three-year Green Mountain Care budget, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

Vermont's Challenges

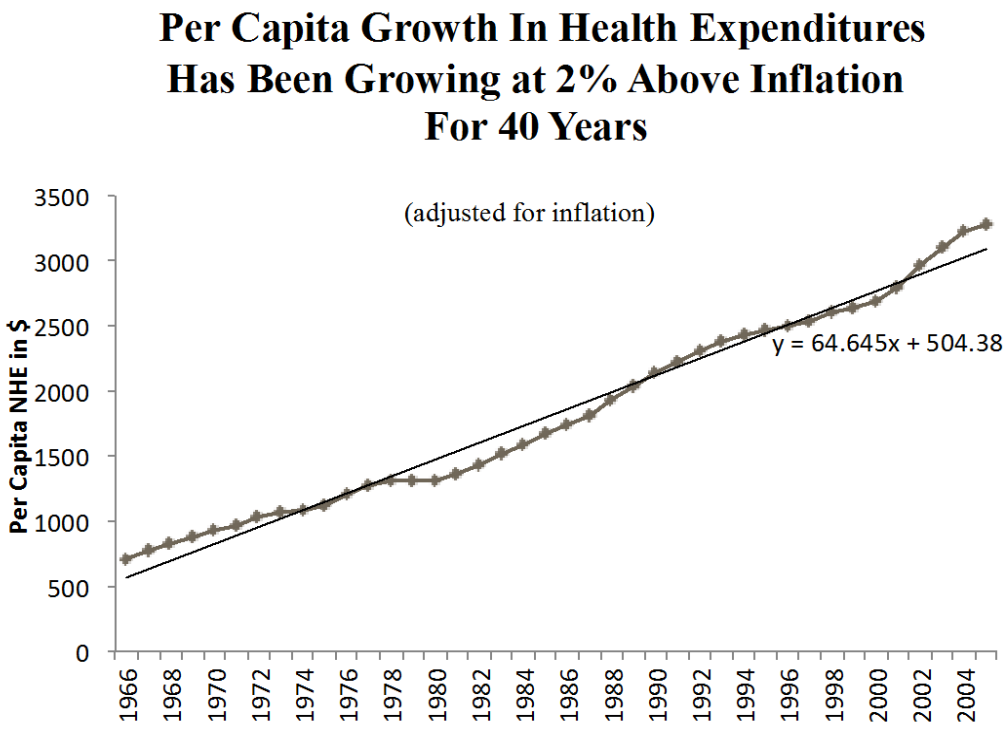
The Legislature created the GMCB to address pressing needs in Vermont: the need to reduce health care cost growth to a sustainable rate and the need to improve health and health care quality. Vermont has a high-quality health care system by many measures, but the overall rate of health care cost growth is not sustainable, and we do not get optimum return on our health care investments, for a number of reasons:

- Patient care is poorly integrated;
- Technology does not allow for adequate communication between providers;
- The payment system promotes the use of more health care services, rather than better health;
- The system is geared toward treating illness rather than preventing it;
- Vermonters do not do all they can to be healthy;
- We have a small population over which to spread fixed costs of health care facilities and services; and
- New innovations that improve the treatment of or cure disease often are very expensive.

Health care cost growth during the period 1997-2009 greatly outstripped economic

growth, in Vermont and nationally. In 2010 and 2011, health care cost increases were closer to (but still exceeded) economic growth, but experts predict that the gap between economic growth and health care cost growth will widen again in 2014 and continue for the years beyond. As shown in figure 1, United States health care cost growth consistently has exceeded inflation by about two percentage points, in good economic times and bad, resulting in higher per capita costs over time, even after adjusting for inflation.

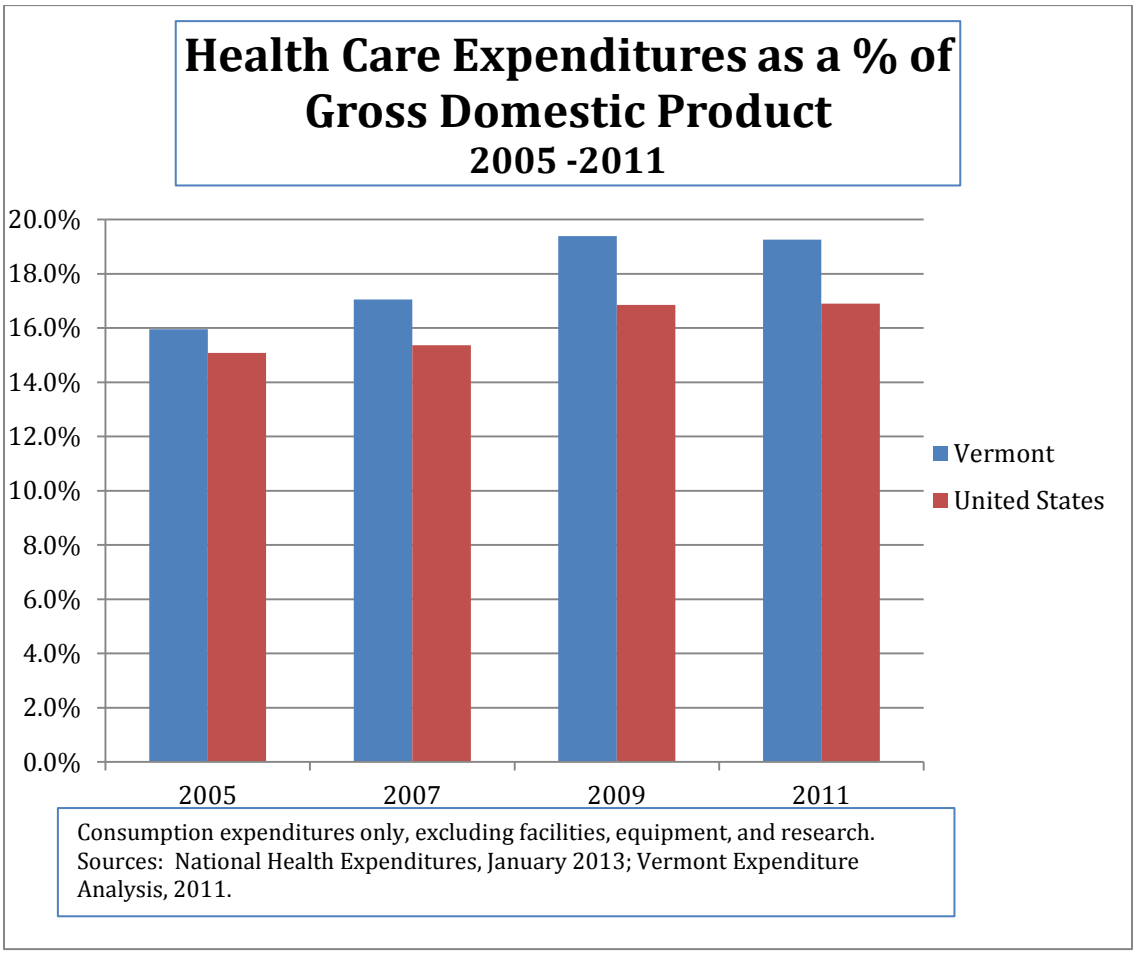
Figure 1. Health Care Cost Growth Relative to Inflation, 1966-2006



Source: Stuart Altman, Ph.D.

This mismatch might not sound significant, but it has resulted in fairly steady growth in the percentage of each dollar we earn that pays for health care. In 2011, Vermont spent an estimated 19.3 percent of gross domestic product on health care, significantly more than the national average of 16.9 percent (as shown in figure 2). Vermont health spending as a percentage of GDP was 16 percent in 2005. The percentage of GDP dedicated to health care did not grow in Vermont or nationally from 2009-2011, as a result of the recession and reduced government health care spending, but current predictions show health care growth continuing its historical trajectory in 2014 and beyond.

Figure 2

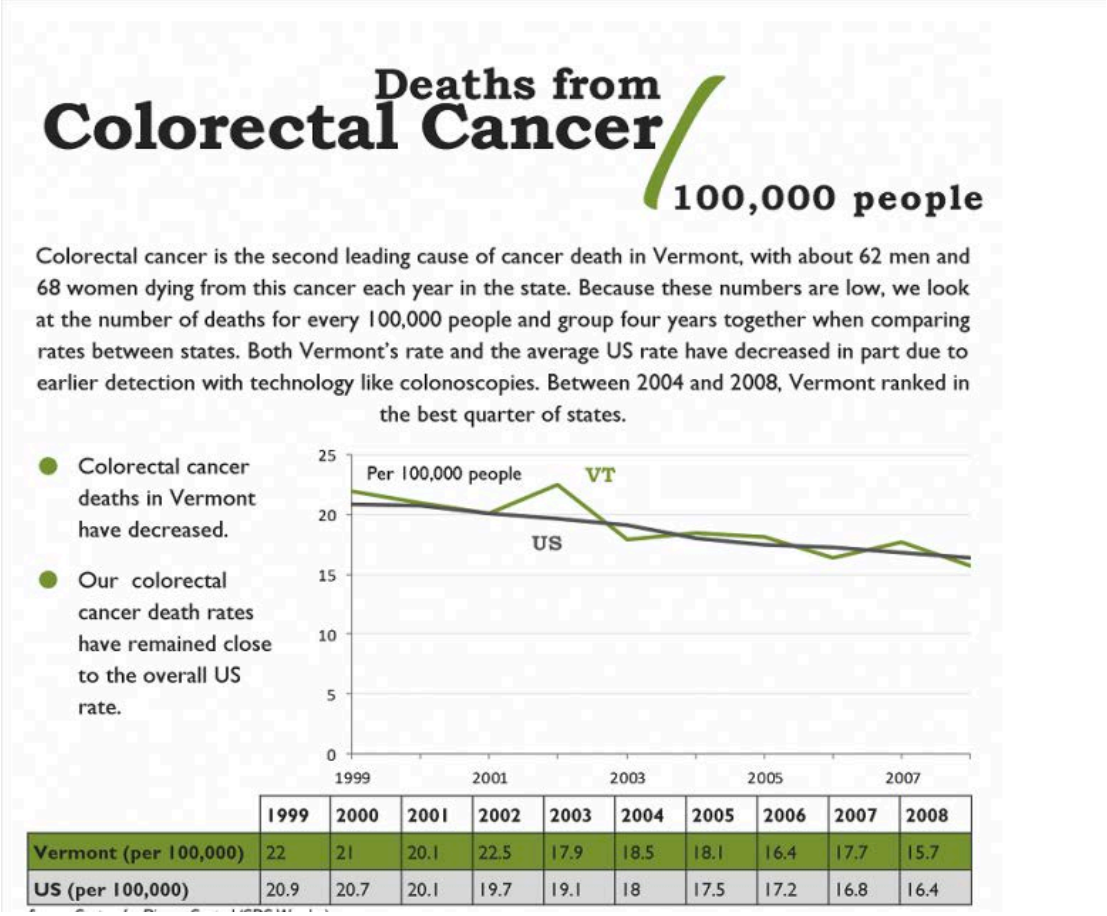


Creation of a new state regulatory body, like the GMCB, does not magically change the cost or outcomes of Vermont's health care system, but it allows us a new opportunity to share state policies that foster and support change among Vermonters, their health care providers, health care payers and government to reduce cost growth and improve outcomes. While Vermont generally gets high marks for the quality of its health system, there are areas such as deaths from colorectal cancer (see figure 3) and obesity (one in every four Vermonters is obese and that number is growing), in which we can improve. More than 40,000 Vermonters remain uninsured[1] and more than 160,000 Vermonters were underinsured meaning that their deductibles exceeded 5 percent of household income or health care expenses exceeded 10 percent of household income or both[2].

[1] 2012 Vermont Household Health Insurance Survey

[2] Vermont Office of Health Access Planning for Vermont's Health Benefits ExchangeTask 7: Study of the Uninsured and Underinsured

Figure 3



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Vermont (per 100,000)	22	21	20.1	22.5	17.9	18.5	18.1	16.4	17.7	15.7
US (per 100,000)	20.9	20.7	20.1	19.7	19.1	18	17.5	17.2	16.8	16.4

Source: Centers for Disease Control (CDC Wonder Online Database)

GMCB Progress in 2012

The GMCB made good progress during 2012 on addressing its responsibilities. We have increased transparency in Vermont health care regulation, increased public participation in shaping Vermont health care reform and had a positive effect on reducing costs and improving quality. Most crucially, we have taken important steps to encourage development of a true health ***system*** in Vermont. We have articulated a long-term vision and strategies and some shorter-term policies that will support:

- Alignment of provider payment and delivery system changes with state and federal health policy goals;
- Better integration and coordination across individual health care providers and provider groups; and

- Availability of good data and analysis to allow for evaluation of system changes over time.

The Commonwealth Fund in 2006 completed a study of "high performance health systems" around the globe that are successful in supporting their citizens to achieve long, healthy and productive lives. According to the Fund's 2006 report, "A Framework for a High Performance Health System in the United States,"[3] countries that achieve this mission have three core attributes:

- A commitment to a clear national strategy for achieving the mission and an established process to implement and refine their strategy for achieving it;
- Delivery of health care services through models that emphasize coordination and integration; and,
- Establishing and tracking metrics for health outcomes, quality of care, access to care, population-based disparities and efficiency.

We believe we have made progress toward developing these attributes in the Vermont health care system in 2012, and we are convinced that, with more work, Vermont can serve as a proving ground for development of a high-performance health system at the state level. Vermont's strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance.

As part of our long-term strategy to develop a high-performance health system, we also began a process this year of examining ways in which factors outside the health care system influence health care costs and the health of Vermonters. Figure 4 below illustrates the strong influence that the environment and healthy behaviors exert on health.

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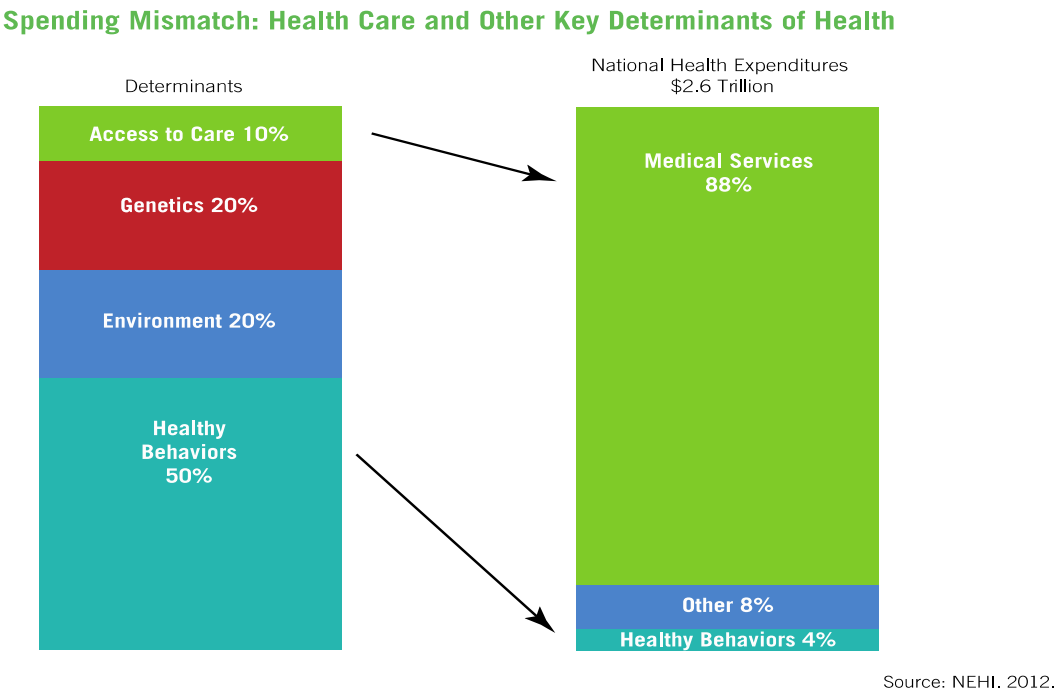
[3] The Commonwealth Fund Commission on a High Performance Health System, Framework for a High Performance Health System for the United States, The Commonwealth Fund, August 2006 http://www.commonwealthfund.org/Publications/Fund-Reports/2006/Aug/Framework-for-a-High-Performance-Health-System-for-the-United-States.aspx

Figure 4



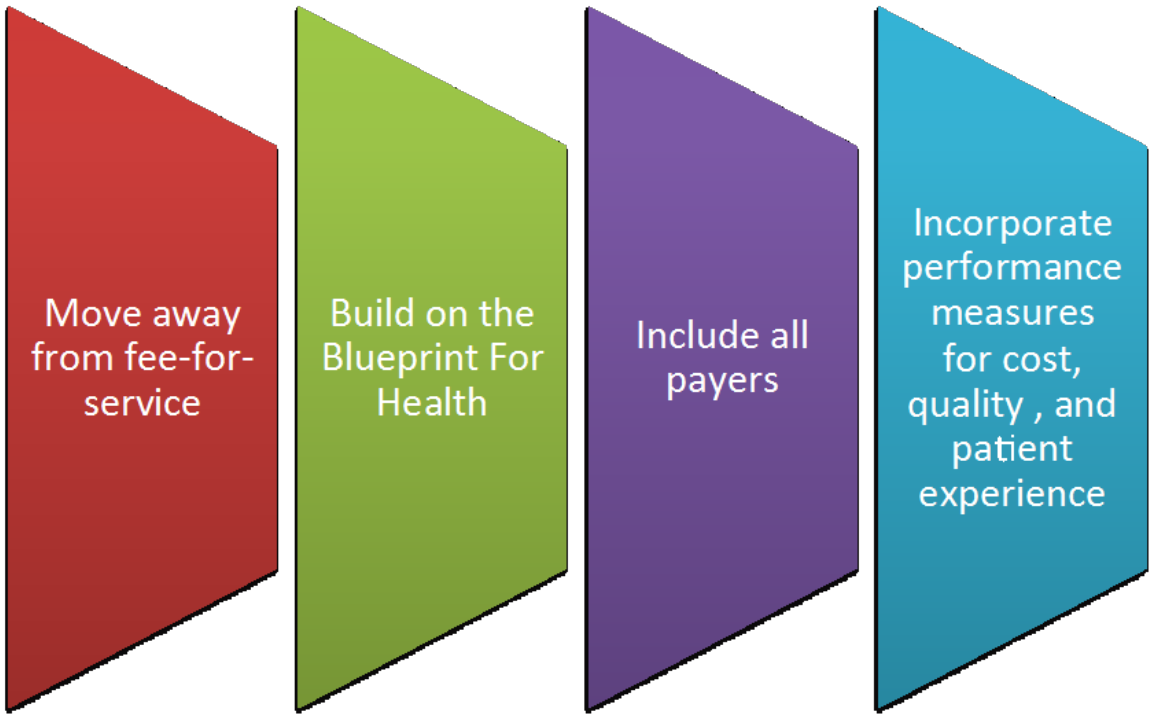
Throughout 2012, the Board focused its efforts on creating connections between its regulatory work and the goal of developing this High Performance Health System. The following pages will describe the specific progress made by the Board in our regulatory and program areas: payment and delivery system reforms, insurance carrier rate review decisions, hospital budgeting, Exchange benefits, expenditure analysis and data infrastructure, unified health care budgeting, system measurement through the Dashboard, transparency and public engagement, health information technology and workforce.

Payment and delivery system reform

During 2012 the GMCB continued development of payment and delivery system reform that will underpin Vermont's future cost containment efforts. Act 48's mandate is for payment reform in Vermont to move away from fee-for-service provider payments and toward payment methods that reinforce our efforts to improve the health of Vermonters, improve the quality of care, and contain the rate of growth in health care costs. In 2012, the GMCB began implementing new payment systems on a pilot basis with willing providers across all payers, including Medicaid and Medicare. The pilots include a strong element of "delivery system reform," meaning an effort to define the best care processes for a particular type of care while changing the payment stream to support adherence to that process. We are evaluating the pilots to judge their applicability to broader populations of providers and patients. Figure 5 shows the goals

of our delivery system and payment reform efforts.

Figure 5 Goals of GMCB Delivery System and Payment Reform Efforts



Our payment reform work has been aided by grant support from the Robert Wood Johnson Foundation to staff our management of payment reform pilots.

In September, the GMCB and the Agency of Human Services (AHS) jointly submitted an application to the federal Center for Medicare & Medicaid Innovation (CMMI) under the State's Innovation Models (SIM) initiative: http://www.gmcboard.vermont.gov/sites/gmcboard/files/Project%20Narrative.pdf If awarded, the grant will strengthen Vermont's capacity to implement and evaluate health care payment and delivery system reforms. To apply for the grant, we worked with numerous agencies and departments of state government and external stakeholders to develop a State Health Care Innovation Plan, which can be viewed at: http://gmcboard.vermont.gov/sites/gmcboard/files/B%20Vermont_Health_Care_Innovation_Plan%20FINAL.pdf. The plan and the grant narrative describe how we intend to develop a high performance health system in Vermont with federal support.

Under the SIM grant, Vermont proposed to test three payment models:

- Shared Savings Accountable Care Organizations (ACOs);
- Bundled Payments; and
- Pay for Performance (P4P).

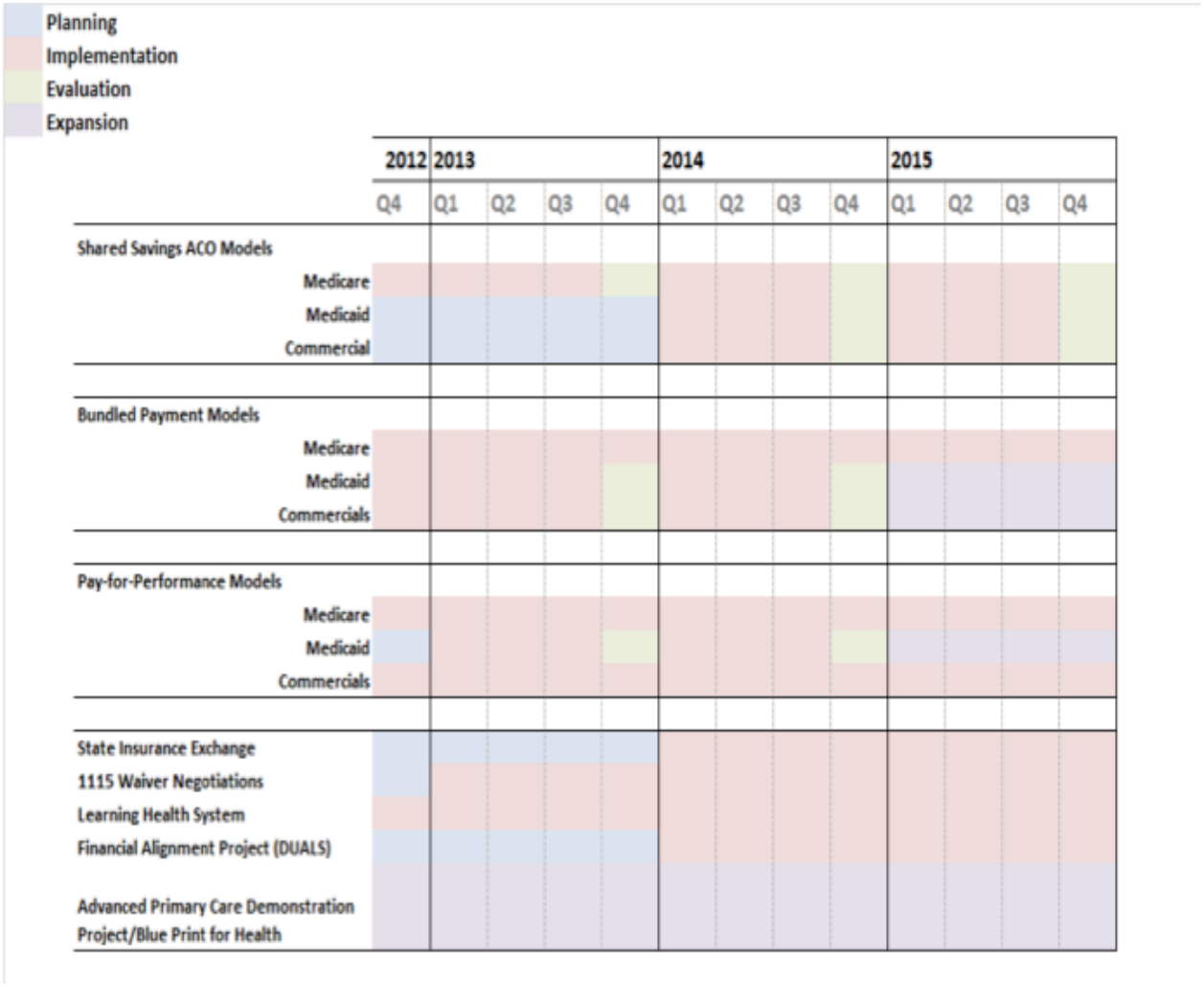
Table 1 summarizes the unique purpose of each model.

Table 1. Testing Models

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
To support an integrated delivery and financing system for Vermonters through an organized network of participating providers who have agreed to align their clinical and financial goals and incentives to improve patient experience and quality of care and reduce cost.	To remove FFS incentives and replace with those which reward collaboration and evidence-based practices across specialties and primary care providers for targeted episodes or types of care which represent opportunities for high return on investment	To enable all payers, particularly Medicaid, to use P4P approaches to improve performance and quality of its health systems

The SIM grant also would support broader efforts to assure that Vermont's health care data collection and analysis supports health system improvement and good health policy. The grant also would provide funds to coordinate payment and delivery system reforms across primary care, specialty care, mental health and long-term services and supports. Figure 6 provides a proposed timeline for implementation of the SIM models and the timing of related reform efforts.

Figure 6. Timeline for State Innovation Model Components and Related State Health Reform Efforts



To complement the work we have proposed under the SIM grant, the GMCB and AHS have proposed a state innovation oversight structure that includes representation from inside and outside state government. Overall SIM project management and decision-making will be provided by a Core Team comprised of the Chair of the GMCB, the Director of Health Care Reform, the Secretary of Human Services and the Commissioner of the Department of Vermont Health Access (DVHA). The Core Team will be advised by a SIM Steering Committee. This group will include internal and external stakeholders. Three working groups will report to the Steering Committee in specific subject areas: an ACO Standards Working Group, a Quality and Performance Measures Working Group and an HIT/Data Working Group.

The ACO Standards Working group will focus on the development of standards to govern the operation of ACOs or other integrated care networks (ICNs) that could

operate in the commercially-insured market and Medicaid. The Quality and Performance Working group will identify measures to reflect the performance of Accountable Care Organizations (ACOs) and other delivery system and payment reform models that could operate in the commercially-insured market and Medicaid. The working group also will identify ways to connect quality measures with payment mechanisms such as shared savings and communicate performance to consumers through public reporting. The HIT/Data Work group will develop recommendations around the expansion of health information technology and health data analysis within Vermont to support implementation of the State's Health Care Innovation Plan.

As we await word from CMMI on the SIM grant, payment reform pilots progress on numerous fronts:

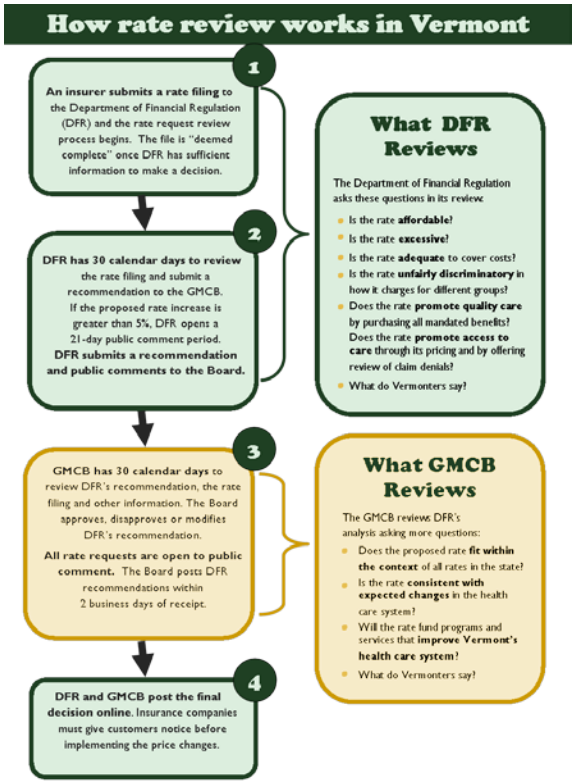
- **In St. Johnsbury**, payments have begun for providers involved in the Northeastern Vermont Oncology Pilot, which the GMCB approved in June. The pilot seeks to improve the quality of care for cancer patients in the area. It provides incentives to primary care providers, oncologists, and other providers to coordinate cancer care. GMCB staff and consultants are working with the operational and clinical team in St. Johnsbury to implement this pilot and evaluate its effectiveness. Work is currently underway with Dartmouth-Hitchcock Medical Center to develop the metrics and performance measures for the pilot. For more detail on this pilot: http://gmcboard.vermont.gov/sites/gmcboard/files/Oncology_Pilot.pdf
- **In Brattleboro**, we continue work with the Brattleboro Retreat to develop a Bundled Payment Initiative focusing on opiate detoxification. Our goal is to begin the pilot early in 2013.
- **In St. Albans, Northwestern Medical Center** has developed a project to reduce emergency room use, with a shared savings agreement with Medicaid and private payers. This project will come to the GMCB for approval in 2013.
- **In Burlington**, we are in the preliminary stages of evaluating data for hip and knee replacements with the intent of developing a bundled payment pilot.
- **In Rutland,** community providers and Rutland Regional Medical Center have developed a bundled payment initiative designed to improve care for patients with Congestive Heart Failure. The project was approved for Medicare participation this month.
- **Also in Rutland**, the local hospital and FQHC have been working with GMCB staff to develop a physician/hospital global budget model.
- **In addition, Vermont's eight federally-qualified health centers (FQHCs) are developing a joint proposal** for a shared savings payment reform pilot that would include Medicaid and commercial insurers. We expect to receive that proposal early in 2013.

In addition, we have worked closely with leaders of Vermont's emerging ACOs to shape their development. These are groups of physicians, hospitals and other health care

providers who form an organization to coordinate the services of the Medicare patients they serve. Two organizations in Vermont have applied to be Medicare ACOs: Accountable Care Coalition of the Green Mountains and OneCare Vermont. Accountable Care Coalition of the Green Mountains was approved by CMS on July 1, 2012 and includes approximately 100 physician members of Health First, a state-wide Independent Practice Association (IPA). OneCare Vermont was approved on January 10, 2013 as an LLC jointly formed by Fletcher Allen Health Care and Dartmouth Hitchcock Medical Center, which also includes 12 of the 13 community hospitals in Vermont and their employed physicians, two Federally Qualified Health Centers (FQHCs), five rural health centers, the Brattleboro Retreat and 58 community physician practices.

Health insurer rate approval

During 2012, the GMCB developed its role as decision-maker in health insurance rate cases. The law requires the GMCB to approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board. This has been one of our most challenging tasks to date. Since accepting responsibility for reviewing health insurance rate increases in January 2012, and receiving our first filing in April, the Board has completed 39 rate reviews and has held hearings in 12 of those reviews. Appendix D provides a full listing of proposed and approved rate increases considered by the GMCB during 2012.



The rate review process is two-fold: The Department of Financial Regulation (DFR) first reviews the carrier's request and the Commissioner of DFR makes a recommendation to the Board; the Board then reviews the filing with special attention to the effect of the proposed rate on cost containment, improving the quality of care, and improving the health of the population.

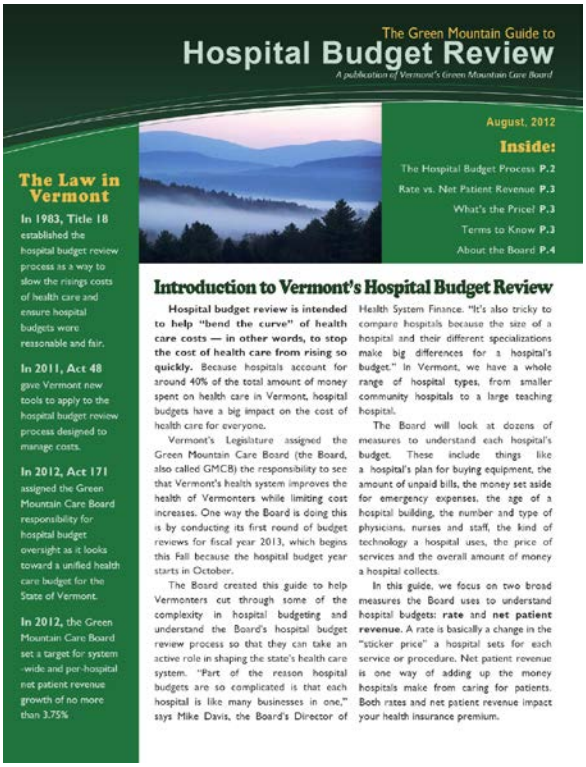
Of all the Board's duties, our actions on rate review tend to have the greatest immediate impact on Vermonters. For this reason, we devote special attention to

public outreach on rate review. In 2012, we published a *Green Mountain Guide* on the topic, began a series of public forums with a well-attended business forum co-hosted by the Lake Champlain Regional Chamber of Commerce, and working with the Department of Financial Regulation to make it easier for Vermonters to navigate the rate review website. We continue to work toward improving the rate review process, making it more understandable to Vermonters and ensuring value for businesses and individuals.

In 2013, we will seek ways to more explicitly connect rate review with cost containment targets and other policy goals, such as support for primary care.

Hospital budget approval

During 2012, the GMCB reviewed and approved 14 hospital budgets. The GMCB must review and establish hospital budgets annually. The hospital budget review process limits the amount of revenue that can be raised by Vermont's 14 community hospitals. Hospital budgets include more than 60 percent of health care spending in Vermont, excluding long-term care.


The Green Mountain Guide to
Hospital Budget Review
A publication of Vermont's Green Mountain Care Board
August, 2012
Inside:
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Rate vs. Net Patient Revenue P.3
What's the Price? P.3
Terms to Know P.3
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The Law in Vermont
In 1983, Title 18 established the hospital budget review process as a way to slow the risings costs of health care and ensure hospital budgets were reasonable and fair.
In 2011, Act 48 gave Vermont new tools to apply to the hospital budget review process designed to manage costs.
In 2012, Act 171 assigned the Green Mountain Care Board responsibility for hospital budget oversight as it looks toward a unified health care budget for the State of Vermont.
In 2012, the Green Mountain Care Board set a target for system-wide and per-hospital net patient revenue growth of no more than 3.75%
Introduction to Vermont's Hospital Budget Review
Hospital budget review is intended to help "bend the curve" of health care costs — in other words, to stop the cost of health care from rising so quickly. Because hospitals account for around 40% of the total amount of money spent on health care in Vermont, hospital budgets have a big impact on the cost of health care for everyone.
Vermont's Legislature assigned the Green Mountain Care Board (the Board, also called GMCB) the responsibility to see that Vermont's health system improves the health of Vermonters while limiting cost increases. One way the Board is doing this is by conducting its first round of budget reviews for fiscal year 2013, which begins this Fall because the hospital budget year starts in October.
The Board created this guide to help Vermonters cut through some of the complexity in hospital budgeting and understand the Board's hospital budget review process so that they can take an active role in shaping the state's health care system. "Part of the reason hospital budgets are so complicated is that each hospital is like many businesses in one," says Mike Davis, the Board's Director of Health System Finance. "It's also tricky to compare hospitals because the size of a hospital and their different specializations make big differences for a hospital's budget." In Vermont, we have a whole range of hospital types, from smaller community hospitals to a large teaching hospital.
The Board will look at dozens of measures to understand each hospital's budget. These include things like a hospital's plan for buying equipment, the amount of unpaid bills, the money set aside for emergency expenses, the age of a hospital building, the number and type of physicians, nurses and staff, the kind of technology a hospital uses, the price of services and the overall amount of money a hospital collects.
In this guide, we focus on two broad measures the Board uses to understand hospital budgets: **rate** and **net patient revenue**. A rate is basically a change in the "sticker price" a hospital sets for each service or procedure. Net patient revenue is one way of adding up the money hospitals make from caring for patients. Both rates and net patient revenue impact your health insurance premium.

Our review process included a statewide public hearing held via Vermont Interactive Television and additional public input through the website's comment portal and through ongoing public meetings, which were actively encouraged through the publication of the *Green Mountain Guide to Hospital Rate Review*. In addition, six hospital CEOs were asked to come before the Board to respond to questions about their budgeted increases.

With no legislatively mandated budget cap this year, the GMCB set a target for increases in net patient revenue of 3.75 percent for FY 2013, which began October 1, 2012. This compares with legislative caps of 4.5 percent and 4 percent in the previous two years. The budgets hospitals submitted to the GMCB proposed a net patient revenue increase of 7.2 percent.

In September, the GMCB approved budgets that will result in a total increase in hospital net patient revenue of $141.6 million over the prior fiscal-year level of $1.98 billion. The approved budgets include a 5.84 percent increase in "new" net patient revenue to the hospitals. This includes more than $37 in investments in health care reform (such as

health information technology and payment reform infrastructure) that the GMCB determined were likely to produce a greater return-on-investment over time. The new net patient revenue figure is exclusive of the transfer of numerous physician practices already within the Vermont health care system whose financial information is captured in the hospital budgets. These transfers amounted to $30.8 million of the total hospital revenue increase and included transfer or start-up funding of $10.8 million for primary care practices.

Two hospitals required follow up to the September rulings. The Board reviewed Copley's updated 2013 budget along with a clarification of their plans around orthopedic services. We approved the updated budget along with plans for an orthopedic hiring. We also reviewed and approved an updated budget for Porter Medical Center. While Grace Cottage's budget exceeded the 3.75 percent limit by $45,000, the Board allowed this due to concerns for Grace Cottage's unique circumstances.

The approved budgets assume a significant additional "cost shift" from public payers (Medicare and Medicaid) to private payers. Of the $141.6 million in new spending, it is anticipated that 80 percent will be borne by private payers -- including private insurers and Vermonters who are uninsured if Medicaid and Medicare do not increase expenditures beyond expected levels. The GMCB has been working with DVHA and the Secretary of Administration to develop a plan for addressing the cost shift through state budgeting. Further developments on this front will be announced as part of the Governor's FY2014 budget proposal. More information on specific hospitals is available here: http://gmcboard.vermont.gov/hospitalbudgets as well as in Appendix D.

We continue to monitor hospital budgets, including analyzing both FY2012 year-end results and FY 2013 year-to-date reports to ensure compliance with budget orders. We also continue to improve the hospital budgeting process -- including proposing new regulations governing the hospital budget process, which were approved by the Legislative Committee on Administrative Rules (LCAR) in November. In addition, the Board is hiring a vendor to provide budget performance software that is expected to enhance reporting, analysis, and presentation of hospital budgets and the Expenditure Analysis. A contract is expected to be approved in the first quarter of calendar 2013 and implementation should occur before the next hospital budgeting process.

Exchange Benefits

During 2012, the GMCB approved benefit requirements for health insurance plans to be offered on Vermont's Health Benefits Exchange. Under Act 48, the GMCB's responsibilities regarding benefits include accepting, rejecting, or modifying recommendations made by the administration regarding benefits to be offered in

Vermont's Health Benefits Exchange as well as those to be incorporated into the universal health system.

After discussion over numerous meetings --including a statewide Vermont Interactive Television forum yielding more than 90 comments -- and review of more than 1,600 public comments, in September the Board approved the administration's recommendation of a Blue Cross Blue Shield of Vermont plan as the benchmark for plans within the Exchange, which takes effect January 1, 2014. More information on the Board's ruling is available here: http://gmcboard.vermont.gov/sites/gmcboard/files/PlanDesignRec_090612.pdf.

The Administration recommended use of a Blue Cross Blue Shield of Vermont benchmark plan and has recommended a "hybrid" approach to benefit design, employing both state-specified plans that contain mandated benefits and "choice" plans that add innovations for health promotion and for engaging individuals in prevention..

Considerable Board discussion – and most of the public comment – concerned the potential addition of dental benefits. The Board voted against including dental in the plan, the cost of which would have been borne entirely by state government. The GMCB directed their Executive Director to commission a professional analysis of current access to dental care, organization of dental delivery, and financing of dental care in Vermont. The Board will release an RFP in early 2013 for this work.

Expenditure analysis, data sources & analytics

During 2012, the GMCB enhanced availability and analysis of health care data to support its decision making. A crucial component of Act 48's mandate is development and maintenance of a system to evaluate system-wide performance and quality. The *Vermont Health Care Expenditure Analysis* provides information on health care spending for services delivered in Vermont and for services provided to Vermont residents anywhere in the U.S. The analysis is prepared annually and is the foundation for the Unified Health Care Budget and the Three-Year Forecast. The GMCB published the 2010 Expenditure Analysis in March, 2012 in conjunction with the Department of Financial Regulation. The report provides basic information about the sources of financing for Vermont's health care system, what is being purchased, and estimates of future spending levels and trends. Data is summarized in two forms: the Resident analysis, which includes expenditures on behalf of Vermont residents, regardless of where the health care was provided; and the Provider analysis, which includes all revenue received for services by Vermont providers, regardless of where the patient lives.

We are now finalizing the 2011 Health Care Expenditure Analysis, which will include select data from the Vermont Healthcare Claims Uniform Reporting and Evaluation

System (VHCURES). It is expected in February 2013.The 2010 Expenditure Analysis can be found here: http://gmcboard.vermont.gov/sites/gmcboard/files/2010EA040212.pdf.

To anticipate future needs and guide our planning, the GMCB has hired the actuarial firm of Wakely Consulting to develop the three year forecast of health care expenditures. Wakely Consulting is developing a model that will enable the GMCB to input health care expenses from VHCURES, add in assumed growth trends and savings and predict future health care costs. The GMCB reviewed a draft of this model in mid-December, 2012 and we expect the full model to be operation in late winter. The GMCB is committed to working with other state agencies, including the Joint Financial Office (JFO), DVHA and the Blueprint for Health, to validate and test this model.

Unified Health Care Budget

During 2012, the GMCB explored ways in which a Unified Health Care Budget could be used as a meaningful tool for health care planning on cost containment. The Unified Health Care Budget (UHCB) has been part of Vermont law since 1991. The UHCB originally was intended to be a form of global budget for health care expenditures in Vermont. Global budgets are used in other countries to plan for, allocate and constrain total health care expenditures. The UHCB statute has been modified over time to more closely reflect its actual use – as a "guideline" for spending and not a real constraint. The UHCB has not functioned to control the rate of growth in health care spending in the state, nor has it been tied to in any explicit manner various regulatory processes and authorities in place at DFR and/or the GMCB.

The UHCB has to be more than a "guide." As with a personal or business budget, a state health care budget must have two attributes to be meaningful:

1. It is prospective, providing a plan for future spending based on anticipated available resources; and
2. It functions as a constraint on spending, establishing a maximum expenditure level at which some action is triggered – spending stops, or consumption is lowered, or the prices we are willing to pay are lowered (through negotiation with suppliers or by substituting less expensive goods).

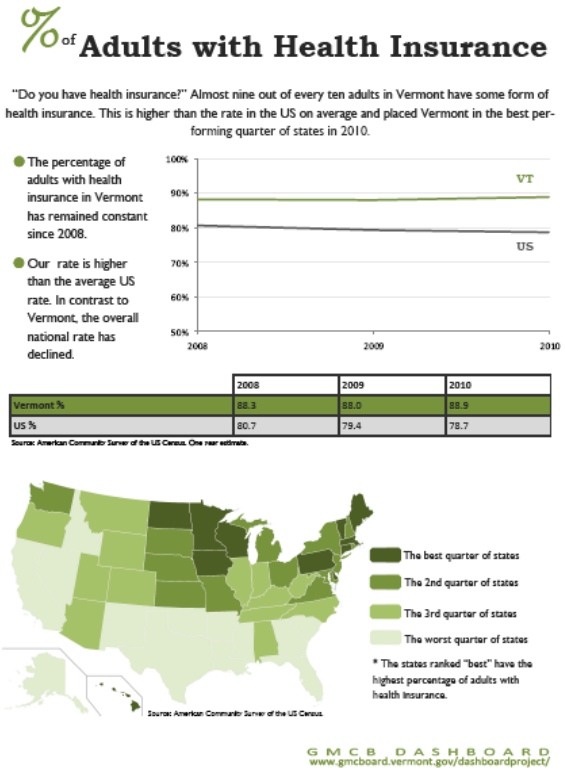
Working with a contractor who examined budgeting methodologies and appropriate benchmarks of health care growth in other states, the GMCB has been developing recommendations for a target rate of growth for hospital budgets, and a target rate of growth in total health care spending, for the federal fiscal year that begins October 2013. The GMCB solicited public comment on its initial proposal to limit growth of hospital budgets to 3.1 percent. The GMCB is in the process of evaluating the comments received and will develop a revised proposal in the near future.

Dashboard

During 2012, the GMCB launched "GMCB Health System Dashboard 1.0, in keeping with the Act 48 requirement to evaluate the performance of Vermont's health system. This first draft presents easy-to-understand analysis of data on 26 key indicators in four critical areas: cost, access to care, healthy lives, and prevention and treatment.

Presented in simple charts with plain language intended to demystify the statistics, the Dashboard attempts to present the best available data from numerous sources and to place the trends in context. For example, the discussion of "Adults with a usual source of care" notes that almost nine out of ten Vermonters report having one person they think of as their personal doctor or health care provider – a rate that is higher in Vermont than in the rest of the nation.

The Dashboard is accessible on GMCB's website at: http://www.gmcboard.vermont.gov/dashboardproject



Transparency and public engagement

During 2012, the GMCB increased transparency around health care regulatory processes and encouraged public engagement in our work. As required by Act 48, the GMCB in February created an Advisory Committee with 41 members representing consumers, businesses and health care providers. The group met four times in 2012. Through meetings and via e-mails, the GMCB solicited the Advisory Committee seeking their input on policy issues related to our major areas of responsibility: hospital budgets and health system finances, insurance carrier rate review, Certificates of Need, benefit design, payment reform, quality, public engagement, and system oversight.

We also convened three technical advisory groups, with clear directives to provide input not on policy, but rather on how to implement policy.

In May, we created the Health Care Professional Technical Advisory Group to discuss and advise the Board on technical issues such as data analysis, development of provider payment models and development of a unified health care budget. The 64 members met twice in 2012, and for 2013 will conduct most of its work in small groups addressing four specific technical areas: affordability of care; appropriateness of care; quality assessment; and workforce.

Members of an advisory group meet in Montpelier.

In June, we created the Mental Health and Substance Abuse Technical Advisory Group, which will serve as a resource on technical issues related to the GMCB's work, including the development of provider payment models that support the integration of mental and physical health care. The group of 24 met once in 2012 and meets a second time as this report goes to press.

A third technical advisory group with expertise in Payment Reform, was moved to the GMCB from DFR. The group met twice in 2012.

Act 48 requires that the state "ensure public participation in the design, implementation, evaluation, and accountability mechanism of the health care system." From our first days on the job, GMCB Board and staff have made public engagement a major part of our work. Face-to-face discussions remain a priority: Board members recorded more than 100 events in all corners of Vermont -- speaking with, and listening to, an estimated 4600 Vermonters, including more than 2000 health professionals and nearly 400 business people. In one key event – a rate review forum for businesses co-hosted by the Lake Champlain Regional Chamber of Commerce – a follow-up evaluation (see figure 7) showed unanimous agreement that the Board had provided ample opportunity for attendees to make comments and have questions answered.

Figure 7: Survey responses from business forum participants

2. Please give your opinion of how well the event accomplished its goals. Create Chart Download

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Response Count
The forum helped me better understand insurance rate review.	20.0% (3)	**60.0% (9)**	13.3% (2)	6.7% (1)	0.0% (0)	15
The forum helped me see how I can play a role in rate review.	13.3% (2)	**53.3% (8)**	26.7% (4)	6.7% (1)	0.0% (0)	15
The forum provided an opportunity for my comments to be heard.	40.0% (6)	**60.0% (9)**	0.0% (0)	0.0% (0)	0.0% (0)	15
The forum provided an opportunity for me to ask questions.	**60.0% (9)**	40.0% (6)	0.0% (0)	0.0% (0)	0.0% (0)	15
The presenters answered audience questions well.	**50.0% (8)**	43.8% (7)	6.3% (1)	0.0% (0)	0.0% (0)	16
					Comments Show Responses	4
					answered question	**16**
					skipped question	**0**

Work on the formal Public Outreach & Engagement plan began in October, 2011 and culminated in Board approval in November, 2012. Created with help of a Vermont consultant to the Board and a team provided by the Robert Wood Johnson Foundation, the plan received input from key stakeholders during a public comment period. The plan's goal is "to educate, engage and listen to Vermonters regarding health system reform so that they understand what reform means for them and can take an active role in shaping the board's work to improve health care and moderate cost." The plan ensures transparency in all the GMCB does and puts the Board on track to reach out to Vermonters in numerous ways:

- Additional speaking events that ensure full geographic coverage of Vermont, with special attention to "core audiences" who can help encourage broad, informed discussion of health system reform in Vermont. A top priority is a new slate of public meetings for 2013. We are working on plans for a "listening tour" that will occasionally have the board conducting its regular meeting in locations around the state – providing more Vermonters a chance to sit in on meetings and giving the Board greater insight into local issues.

- Publications and digital media (especially an increasingly robust web site) that continue to explain the board's work and encourage public input in plain, compelling language.

- Continued presentation of the GMCB Dashboard and other health system data in a way that is accessible and puts information in context.

- Consistent, sustained evaluation of efforts, including careful attention to Vermonters' feedback on the effectiveness, transparency and responsiveness of engagement. This feedback will be gathered through public comment, face-to-face discussion, and evaluation tools.

The GMCB Public Outreach and Engagement Plan is available at:
http://gmcboard.vermont.gov/sites/gmcboard/files/PublicOutreachEngage110112.pdf

A specific issue that emerged in the development of the plan is the need for better methods to track the progress of insurance rate review filings as they move through a two-tiered process involving both the Department of Financial Regulation and GMCB. This is being addressed with the help of the Rate Review team and staff in the Department of Financial Regulation: We are posting an RFP for a contractor to build a joint website that will provide seamless access. (For more on rate review, read our newest Green Mountain Guide here:
http://gmcboard.vermont.gov/sites/gmcboard/files/RRGuide.pdf.)

Health information technology plan

During 2012, the GMCB authorized changes to Vermont's Health Information Technology Plan that will improve patient care by enabling safe sharing of medical records among health care providers. In late August 2012, the Administration submitted a proposed HIT plan for the Board's review and approval, as required by Act 48. After stakeholders raised questions regarding patient consent and certain other aspects of the plan, the Administration withdrew the plan and worked with stakeholders to address those questions. On October 25, 2012, the Board approved the Administration's revised policy, which addressed the concerns raised in August.

Workforce Plan

During 2012, the GMCB approved a Workforce Strategic Plan that calls for better data gathering on the need for, and supply of, health care providers in Vermont and outlines specific strategies for strengthening provider supply as evidence of unmet need or anticipated shortages are identified. The Administration continues to develop a Workforce Strategic Plan for the GMCB's review and approval, as required by Act 48. Based on discussion at the August 2nd GMCB meeting, the Administration is expected to highlight the need for more-robust data collection of all health professions to ensure the workforce meets the needs of Vermonters. The GMCB received the Administration's Workforce plan on January 3rd and approved it with changes on January 9th.

GMCB Priorities for 2013

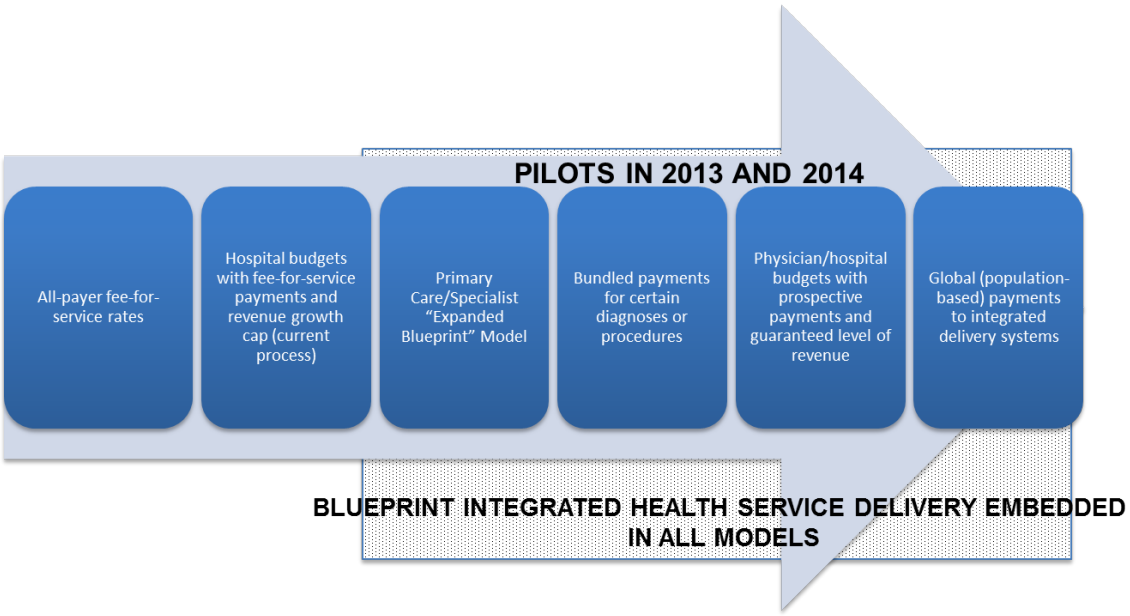
After a year of getting our feet on the ground, organizing ourselves and interacting with Vermonters, the members of the Green Mountain Care Board are eager to move forward with more effective and better informed efforts to implement our charge.

The GMCB's priorities for advancing our charge in 2013 include:

1. **Continue to develop meaningful health care cost containment through payment and delivery system reform and improved regulatory oversight.**

The GMCB will work in 2013 to implement the full range of payment reform pilots we have been designing, and to expand some of the pilots in scope. Further development of providers' health information technology – both continued installation of electronic health records in individual practices, and development of the state's health information exchange (HIE), which will serve to make EHRs capable of "interoperability" (talking to each other) – is essential to this effort, and we therefore will remain focused on tracking those efforts. **Figure 8 below depicts this continued development.**

Figure 8: Evolution of Health Care Payment Models



We plan to release the State Health Care Expenditure Analysis in February, examining sources of health care cost growth in 2011 with valid system-wide data and targeting priorities for reduced growth. In addition, we have contracted with an actuarial firm to develop a more advanced model of health care cost forecasting, and the model will be made available during the first quarter of 2013. The model

will allow us, among other things, to estimate the impact of targeted reforms (such as a concerted effort to reduce emergency department use) on health care costs.

Improving the consistency, transparency and effectiveness of the health insurer rate and hospital budget review processes will be among our highest priorities for the year, as will our efforts to assure that cost-shifting between public and private payers is not exacerbated, and that overall growth is moderated.

2. Begin a broad discussion and more effective state oversight of health planning.

The GMCB assumed responsibility for approval of major capital expenditures through the state's certificate of need (CON) process on January 1. We also are seeking legislative approval this year to assume responsibility for the Health Resource Allocation Plan (HRAP), the major planning document that guides CON review. Looking forward, we will be examining opportunities for multi-year and system-wide CON review and opportunities to incorporate a broader view of health (beyond health care providers and facilities) in health planning.

In addition, we will continue to seek ways to address emerging challenges in health planning, such as:

- As policies design to curb cost growth drive greater efficiency, collaboration and development of economies of scale, how do we assure appropriate access to community services and that the division of service delivery between local and regional hospitals, for example, is driven by concerns of quality and access and not solely efficiency?
- How do we measure quality to adequately gauge the impact of system changes on Vermonters, particularly those who are most vulnerable and need greatest assurance of the availability of the care they need?
- How do we begin to measure population health, and the factors that effect it, to inform policy decisions?

We look forward to a robust discussion with Vermonters about these issues.

3. Continue to improve our ability to objectively monitor and evaluate Vermont health reform efforts.

Evaluation of Vermont health reforms is essential to inform diffusion of specific interventions and development of a more integrated health care system. We are excited by the opportunity presented by the completion of Vermont's All-Payer Claims Dataset, known as VHCURES. Earlier this year Medicaid and Medicare data were added to the dataset, which previously included only private insurance claims data. Use of the Medicare portion of the dataset is still limited by the federal government, but we nonetheless have a greatly enhanced ability to analyze health care expenditures, cost drivers and health care service use in Vermont.

The VHCURES dataset is the foundation for the forecasting model described above. It also will be the focus of work by a new analytic contractor hired by the state to develop analyses of "cost drivers" and health care use in Vermont. The contractor will analyze and adjust for a number of the cost factors illustrated in Figure 9 below, in an attempt to identify specific opportunities for cost reduction, either statewide or regionally.

Figure 9. Root Causes of Health Care Spending