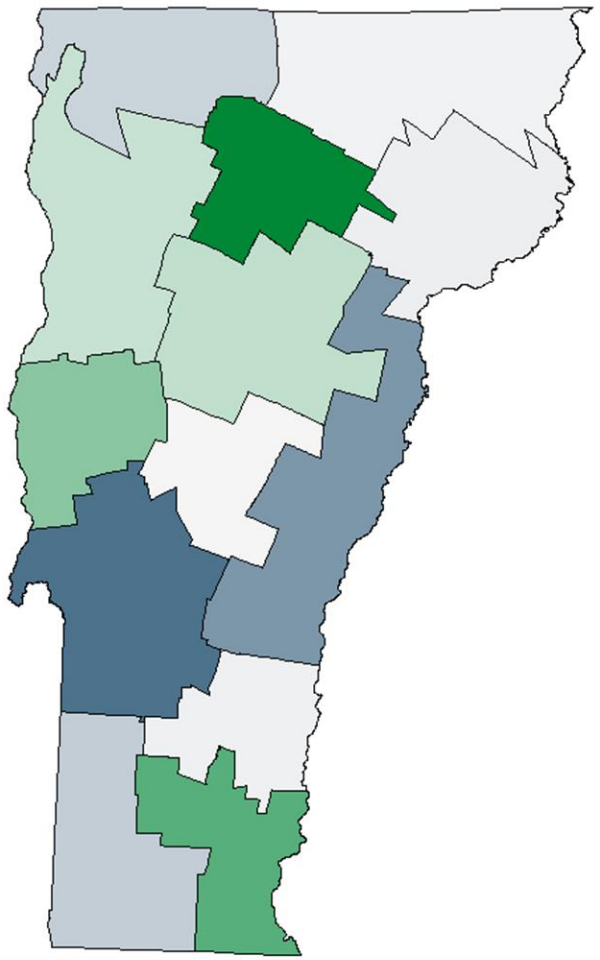


Green Mountain Care Board (GMCB)

Advisory Committee Meeting

Thursday, November 10, 2016

VERMONT
GREEN MOUNTAIN CARE BOARD

Exchange Rate Review

- Blue Cross Blue Shield of Vermont (BCBSVT) requested an 8.2% average annual rate increase, later amended to an 8.6%
    - The Board approved a 7.3% average annual rate increase
    - Estimated dollars saved = $3,505,618

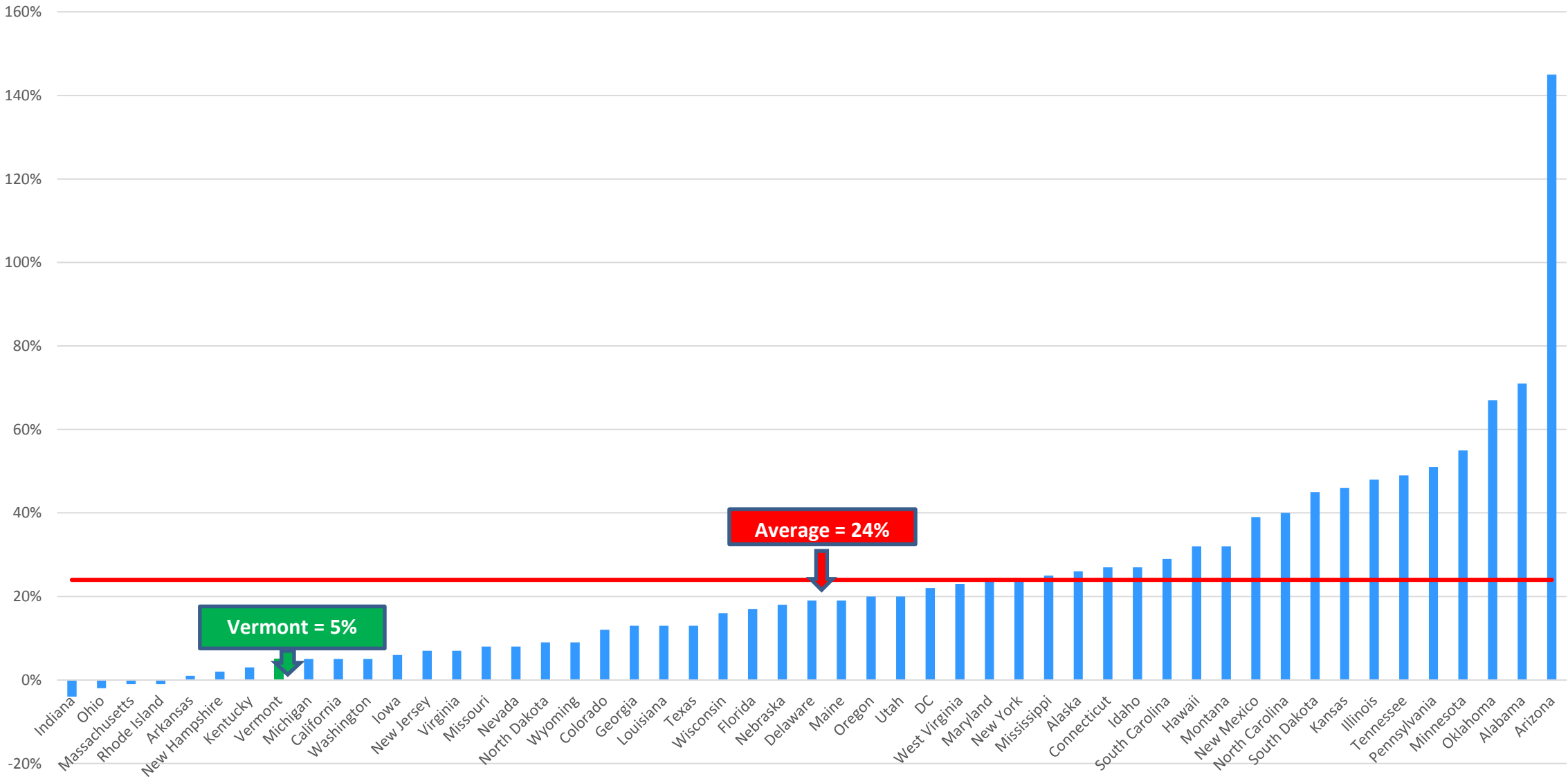
- MVP requested an 8.8% average annual rate increase
    - The Board approved a 3.7 % average annual rate increase
    - Estimated dollars saved = $1,208,608

- Total estimated dollars saved = $5.2 Million

Hospital Budget Update

- Hospitals initially requested a 5% Net Patient Revenue (NPR) increase, or roughly a $114 million-dollar increase
- The Board approved a 3.9% NPR increase, or roughly a $90.5 million-dollar increase
- Approved commercial rate (price) increases were established at 1.8% for FY 2017

2016 to 2017 2nd Lowest Cost Silver Plan Rate Increase by State



Adapted from: http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

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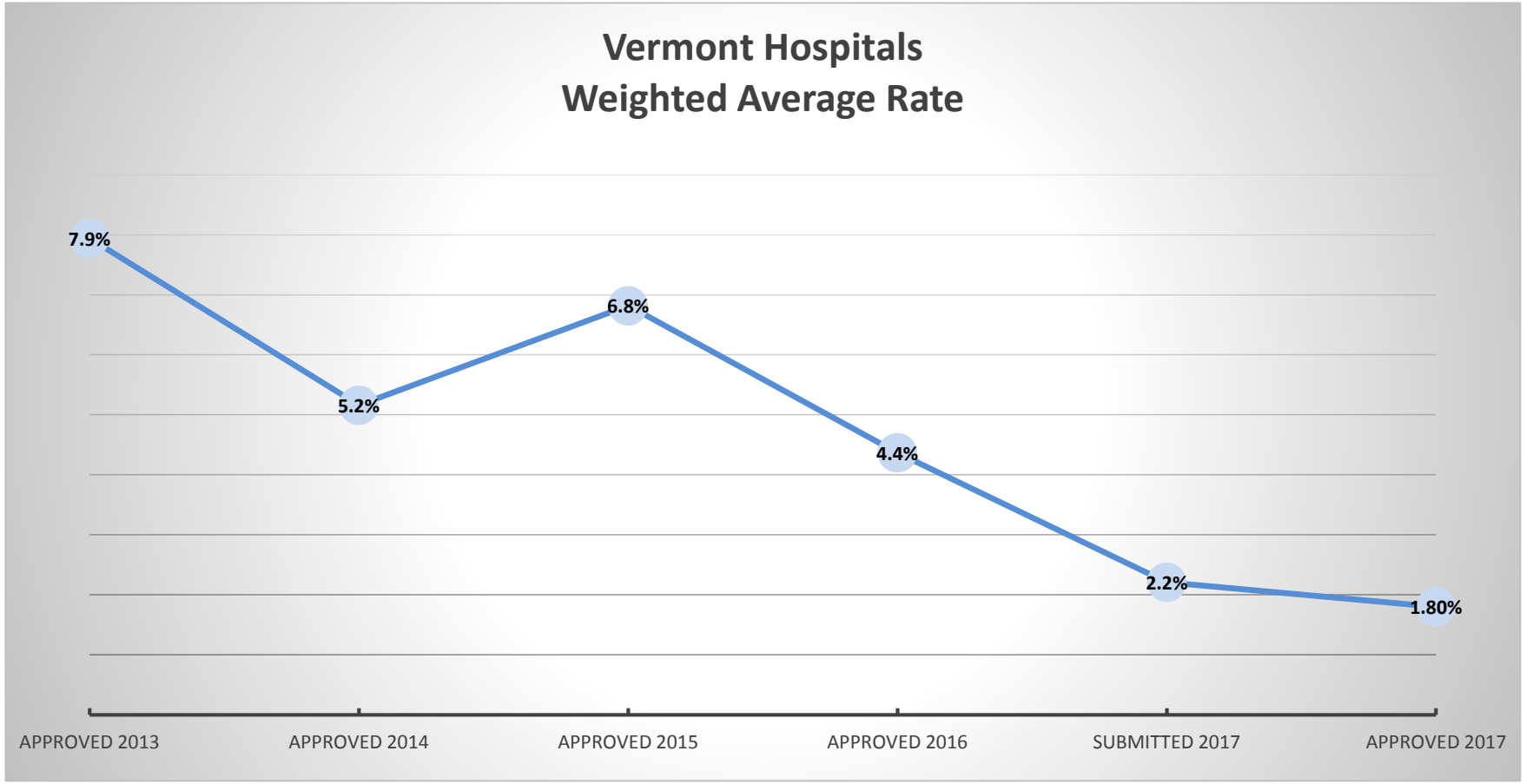
Vermont Hospital System Approved Rate Increases

The hospital commercial rate increases have declined over the time period 2014 - 2017.

These rates have a direct effect on insurance rate increases.



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GREEN MOUNTAIN CARE BOARD

GMCB Update

Certificate of Need (CON) 2016 Decisions

- Visiting Nurse & Hospice for Vermont and New Hampshire: Purchase of Office Condominium to House Parent Administrative Offices, Docket No. GMCB-019-15con
- Copley: Construction of new surgical suite, renovation to ambulatory care unit & backfil of existing surgical suite, Docket No. GMCB015-13con
- Rutland Regional Medical Center: Replacement of Air Handling System, Docket No. GMCB-023-15con
- Norris Cotton Cancer Center: Purchase and installation of a new Varian TrueBeam linear accelerator, Docket No. GMCB-005-15con
- Genesis Healthcare, Inc.: Purchase of five Vermont skilled nursing facilities located in Bennington, Berlin, Burlington, Springfield and St. Johnsbury, Docket No. GMCB-014-15con
- Burlington Labs: Acquistion of Burlington Labs, a diagnostic testing facility headquarterted in Burlington, by Burlington Labs Acquistion, LLC, Docket No. GMCB-014-16con.
- Vermont Veterans' Home: Renovation of the main kitchen and creation of four country kitchens, Docket No. GMCB-008-15con.
- UVMMC Replacement of PET/CT System: Docket No. GMCB-011-16con.
- UVMMC Replacement of da Vinci Robotic Surgical System: Docket No. GMCB-010-16con.

(Please click here for CON webpage)

Act 113 of 2016

All-Payer Model; Medicare Agreement Criteria

- Consistent with the principles of health care reform established in Act 48 of 2011
- Preserves consumer protections, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes
- Allows providers to choose whether to participate in ACOs
- Allows Medicare patients to choose any Medicare-participating provider
- Includes outcomes measures for population health
- Continues to provide payments from Medicare directly to providers or ACOs

Act 113 of 2016

All-Payer Model Criteria

- Maximizes alignment between Medicare, Medicaid, and Commercial payers
    - Total Cost of Care (TCOC)
    - Attribution and payment mechanisms
    - Patient protections
    - Provider reimbursement strategies
- Strengthens and invests in primary care
- Incorporates social determinants of health
- Adheres to federal and state laws on parity of Mental Health (MH) and Substance Use (SA) treatment and integration of MH/SU into overall system
- Includes process for integration of community-based providers
- Prioritizes the use of existing local and regional collaboratives of community health providers
- Pursues integrated approach to data collection, analysis, and exchange
- Evaluates access to care, quality of care, patient outcomes, and social determinants of health
- Requires process and protocols for shared decision making
- Supports coordination of patients' care and care transitions through use of technology
- Ensures consultation with Office of Health Care Advocate

10 Key Features of the Model Agreement

(1-5)

1. The All-Payer Model is the first step in a multi-step process; it creates an opportunity for provider-led reform.

2. The All-Payer Model would move away from fee-for-service reimbursement on a statewide level and establish an annualized limit of 3.5% on per capita healthcare expenditure growth for all major payers.

3. Medicare beneficiaries would keep all of their current benefits, covered services, and choice of providers, as would persons with Commercial or Medicaid coverage.

4. Vermont is not taking over the health care payment system; all payers continue to directly pay health care providers or organizations.

5. Joining the All-Payer Model would be voluntary for health care providers.

10 Key Features of the Model Agreement

(6-10)

6. The proposed Agreement establishes a phased-in approach for implementation.
    - 2017 is a preparatory “Year 0”.
    - Incremental scale targets set goal for 70% of all-payer beneficiaries to be attributed to an ACO by 2022.

7. Agreement contains 3 high level health improvement goals:
    - Improving access to primary care
    - Reducing deaths from suicide and drug overdose
    - Reducing prevalence and morbidity of chronic disease (COPD, Diabetes, Hypertension)

8. The State could terminate the Agreement at any time for any reason with at least 180 calendar days’ notice.

9. There would be no financial penalty to the State if financial and quality targets were not met.

10. The Agreement would preserve Medicare funding for the nationally-recognized Blueprint for Health program and the Support and Services at Home (SASH) program providing care coordination and preventive services to Medicare beneficiaries.

Act 113: ACO Oversight

Certification Criteria

GMCB certifies that the ACO meets criteria in the following categories:

- Governance
- Care management and coordination
- Provider participation, payment, and collaboration
- Participation in health information exchanges
- Quality and performance measures
- Patient engagement and information sharing
- Consumer assistance, access, and freedom of provider choice
- Appropriate financial protections against potential losses

Act 113: ACO Oversight

Review, Modification, Approval of Budgets

GMCB shall review and consider the following categories of information with respect to budgets for ACOs with 10,000 or more attributed lives:

- Health care services utilization
- Health Resource Allocation Plan
- Fiscal responsibility
- Reports from professional review organizations
- Avoidance of duplicative service provision
- Extent of investment in primary care
- Extent of investment in social determinants of health
- Extent of investment in prevention of Adverse Childhood Experiences
- Administrative costs
- Medicaid cost-shift
- Extent to which ACO costs are made transparent to consumers

Questions and Discussion