

1 S.255

2 Introduced by Senators Ayer and Lyons

3 Referred to Committee on Health and Welfare

4 Date: January 5, 2016

5 Subject: Health; health insurance; Department of Financial Regulation

6 Statement of purpose of bill as introduced: This bill proposes to require
7 hospitals to provide information to the public about their community health
8 needs and to allow public participation in the community health needs
9 assessment process. It would establish a statewide comparative hospital
10 quality report and modify the regulation of managed care organizations. The
11 bill would also expand the information health insurers must report annually to
12 include detailed information regarding claims processing, denials, grievances,
13 and provider satisfaction, and it would require insurers to post all of the
14 information on their websites.

15 An act relating to regulation of hospitals, health insurers, and managed care
16 organizations

1 It is hereby enacted by the General Assembly of the State of Vermont:

2 ~~Sec. 1. 18 V.S.A. § 9405a is amended to read:~~

3 § 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

4 (a) ~~Each hospital shall have a protocol for meaningful public participation~~
5 ~~in its strategic planning process for identifying and addressing health care~~
6 ~~needs that the hospital provides or could provide in its service area. Needs~~
7 ~~identified through the process shall be integrated with the hospital's long-term~~
8 ~~planning. The process shall be updated as necessary to continue to be~~
9 ~~consistent with such planning and capital expenditure projections, and~~
10 ~~identified needs shall be summarized in the hospital's community report. Each~~
11 ~~hospital shall post on its website a description of its identified needs, strategic~~
12 ~~initiatives developed to address the identified needs, annual progress on~~
13 ~~implementation of the proposed initiatives, and opportunities for public~~
14 ~~participation. Hospitals may meet the community health needs assessment and~~
15 ~~implementation plan requirement through compliance with the relevant~~
16 ~~Internal Revenue Service community health needs assessment requirements for~~
17 ~~nonprofit hospitals.~~

18 (b) ~~When a hospital is working on a new community health needs~~
19 ~~assessment, the hospital shall post on its website information about the process~~
20 ~~for developing the community needs assessment and opportunities for public~~
21 ~~participation in the process.~~

1 ~~Sec. 2. 18 V.S.A. § 9405b is amended to read:~~

2 § 9405b. HOSPITAL COMMUNITY REPORTS

3 (a) The Commissioner of Health, in consultation with representatives from
4 hospitals, other groups of health care professionals, and members of the public
5 representing patient interests, shall adopt rules establishing a ~~standard format~~
6 ~~for community reports, as well as the contents, which~~ statewide comparative
7 hospital quality report. Hospitals located outside this State which serve a
8 significant number of Vermont residents, as determined by the Commissioner
9 of Health, shall be invited to participate in the community report process
10 established by this section. The report shall include:

11 (1) Measures of quality, including process and performance measures,
12 that are valid, reliable, and useful, including comparisons to appropriate
13 national benchmarks for high quality and successful results.

14 (2) Measures of patient safety that are valid, reliable, and useful,
15 including comparisons to appropriate industry benchmarks for safety;

16 (3) Measures of hospital-acquired infections that are valid, reliable, and
17 useful, including comparisons to appropriate industry benchmarks.

18 (4) Valid, reliable, and useful information on nurse staffing, including
19 comparisons to appropriate industry benchmarks for safety. This information
20 may include system-centered measures such as skill mix, nursing care hours

1 ~~per patient day, and other system centered measures for which reliable industry~~
2 benchmarks become available.

3 (5) Measures of the hospital's financial health, including comparisons to
4 appropriate national benchmarks for efficient operation and fiscal health.

5 ~~(5)(6)~~ A summary of the hospital's budget, including revenue by source,
6 the one-year and four-year capital expenditure plans, the depreciation schedule
7 for existing facilities, and quantification of cost shifting to private payers.

8 ~~(6)(7)~~ Data that provides valid, reliable, useful, and efficient information
9 for payers and the public for the comparison of charges for higher volume
10 health care services.

11 (b) Each hospital shall publish on its website:

12 ~~(7)(1)~~ The the hospital's process for achieving openness, inclusiveness,
13 and meaningful public participation in its strategic planning and
14 decision-making; decisionmaking;

15 ~~(8)(2)~~ The the hospital's consumer complaint resolution process,
16 including identification of the hospital officer or employee responsible for its
17 implementation;

18 ~~(9)~~ Information concerning recently completed or ongoing quality
19 improvement and patient safety projects.

1 ~~(10) A description of strategic initiatives discussed with or derived from~~
2 ~~the identification of health care needs; the one-year and four-year capital~~
3 ~~expenditure plans; and the depreciation schedule for existing facilities.~~

4 ~~(11)(3) Information information on membership and governing body~~
5 ~~qualifications, a listing of the current governing body members, and means of~~
6 ~~obtaining a schedule of meetings of the hospital's governing body, including~~
7 ~~times scheduled for public participation; and~~

8 ~~(4) a link to the comparative statewide hospital quality report.~~

9 ~~(12) Valid, reliable, and useful information on nurse staffing, including~~
10 ~~comparisons to appropriate industry benchmarks for safety. This information~~
11 ~~may include system-centered performance measures, such as skill mix, nursing~~
12 ~~care hours per patient day, and other such system-centered performance~~
13 ~~measures as reliable industry benchmarks become available in the future.~~

14 ~~(b) On or before January 1, 2005, and annually thereafter beginning on~~
15 ~~June 1, 2006, the board of directors or other governing body of each hospital~~
16 ~~licensed under chapter 43 of this title shall publish on its website, making~~
17 ~~paper copies available upon request, its community report in a uniform format~~
18 ~~approved by the Commissioner of Health and in accordance with the standards~~
19 ~~and procedures adopted by rule under this section. Hospitals located outside~~
20 ~~this State which serve a significant number of Vermont residents, as~~

1 ~~determined by the Commissioner of Health, shall be invited to participate in~~
2 ~~the community report process established by this subsection.~~

3 (c) ~~The community reports shall be provided to the Commissioner of~~
4 ~~Health. The Commissioner of Health shall publish the reports statewide~~
5 ~~comparative hospital quality report on a public website and shall develop and~~
6 ~~include a format for comparisons of hospitals within the same categories of~~
7 ~~quality and financial measures update the report at least annually beginning on~~
8 ~~June 1, 2017.~~

9 Sec. 3. 18 V.S.A. § 9408a is amended to read:

10 § 9408a. UNIFORM PROVIDER CREDENTIALING

11 * * *

12 (e) ~~The commissioner may enforce compliance with the provisions of this~~
13 ~~section as to insurers and as to hospitals as if the hospital were an insurer under~~
14 ~~8 V.S.A. § 3661. [Repealed.]~~

15 * * *

16 Sec. 4. 18 V.S.A. § 9414 is amended to read:

17 § 9414. QUALITY ASSURANCE FOR MANAGED CARE

18 (a) The Commissioner shall have the power and responsibility to ensure
19 that each managed care organization provides quality health care to its
20 members, in accordance with the provisions of this section.

1 ~~(1) In determining whether a managed care organization meets the~~
2 requirements of this section, the Commissioner ~~shall~~ may review and examine,
3 in accordance with subsection (e) of this section, the organization's
4 administrative policies and procedures, quality management and improvement
5 procedures, utilization management, credentialing practices, members' rights
6 and responsibilities, preventive health services, medical records practices,
7 grievance and appeal procedures, member services, financial incentives or
8 disincentives, disenrollment, provider contracting, and systems and data
9 reporting capacities. The Commissioner ~~may~~ shall establish, by rule, specific
10 criteria to be considered under this section.

11 * * *

12 (4) The Commissioner or designee may resolve any consumer complaint
13 arising out of this subsection as though the managed care organization were an
14 insurer licensed pursuant to Title 8. As used in this section, "complaint"
15 means a report of a violation or suspected violation of the standards set forth in
16 this section or adopted by rule pursuant to this section and made by or on
17 behalf of a consumer or provider.

18 (b)(1) A managed care organization shall assure that the health care
19 services provided to members are consistent with prevailing professionally
20 recognized standards of medical practice.

1 ~~(2) A managed care organization shall participate in establish a chronic~~
2 ~~care program as needed to implement the Blueprint for Health established in~~
3 ~~chapter 13 of this title. The program If needed to implement the Blueprint, a~~
4 ~~managed care organization shall establish a chronic care program, which shall~~
5 ~~include:~~

6 (A) appropriate benefit plan design;

7 (B) informational materials, training, and follow-up necessary to
8 support members and providers; and

9 (C) payment reform methodologies.

10 (3) Each managed care organization shall have procedures to assure
11 availability, accessibility, and continuity of care, and ongoing procedures for
12 the identification, evaluation, resolution, and follow-up of potential and actual
13 problems in its health care administration and delivery.

14 (4) Each managed care organization shall be accredited by a national
15 independent accreditation organization approved by the Commissioner.

16 (c) The Consistent with participation in the Blueprint for Health pursuant to
17 subdivision (b)(2) of this section and the accreditation required by subdivision
18 (b)(4) of this section, the managed care organization shall have an internal
19 quality assurance program to monitor and evaluate its health care services,
20 including primary and specialist physician services, and ancillary and
21 preventive health care services, across all institutional and noninstitutional

1 ~~settings. The internal quality assurance program shall be fully described in~~

2 written form, provided to all managers, providers, and staff and made available

3 to members of the organization. The components of the internal quality

4 assurance program shall include, ~~but not be limited to,~~ the following:

5 (1) a peer review committee or comparable designated committee
6 responsible for quality assurance activities;

7 (2) accountability of the committee to the Board of Directors or other
8 governing authority of the organization;

9 (3) participation by an appropriate base of providers and support staff;

10 (4) supervision by the medical director of the organization;

11 (5) regularly scheduled meetings; and

12 (6) minutes or records of the meetings which describe in detail the
13 actions of the committee, including problems discussed, charts reviewed,
14 recommendations made, and any other pertinent information.

15 ~~(d)(1) In addition to its internal quality assurance program, each managed
16 care organization shall evaluate the quality of health and medical care provided
17 to members. The organization shall use and maintain a patient record system
18 which will facilitate documentation and retrieval of statistically meaningful
19 clinical information.~~

1 ~~(2) A managed care organization may evaluate the quality of health and~~
2 ~~medical care provided to members through an independent accreditation~~
3 ~~organization. [Repealed.]~~

4 * * *

5 Sec. 5. 18 V.S.A. § 9414a is amended to read:

6 § 9414a. ANNUAL REPORTING BY HEALTH INSURERS

7 (a) As used in this section:

8 (1) “Adverse benefit determination” means a denial, reduction,
9 modification, or termination of, or a failure to provide or make payment in
10 whole or in part for, a benefit, including:

11 (A) a denial, reduction, modification, termination, or failure to
12 provide or make payment that is based on a determination of the member’s
13 eligibility to participate in a health benefit plan;

14 (B) a denial, reduction, modification, or termination of, or failure to
15 make payment in whole or in part for, a benefit resulting from the application
16 of any utilization review; and

17 (C) a failure to provide coverage for an item or service for which
18 benefits are otherwise provided because the item or service is determined to be
19 experimental, investigational, or not medically necessary or appropriate.

1 ~~(2) "Claim" means a request for payment for a covered service that a~~
2 ~~member or the member's health care provider submits to the insurer at or after~~
3 ~~the time that health care services have been provided.~~

4 (3) "Concurrent review" means utilization review conducted during a
5 member's stay in a hospital or other facility, or during another ongoing course
6 of treatment.

7 (4) "Grievance" means a complaint submitted by or on behalf of a
8 member regarding:

9 (A) an adverse benefit determination;

10 (B) the availability, delivery, or quality of health care services;

11 (C) claims payment, handling, or reimbursement for health care
12 services; or

13 (D) matters relating to the contractual relationship between a member
14 and the managed care organization or health insurer offering the health benefit
15 plan.

16 (5) "Independent external review" means a review of a health care
17 decision by an independent review organization pursuant to 8 V.S.A. § 4089f.

18 (6) "Post-service review" means the review of any claim for a benefit
19 that is not a pre-service or concurrent review.

1 ~~(7) "Pre service review" means the review of any claim for a benefit~~
2 ~~with respect to which the terms of coverage condition receipt of the benefit in~~
3 ~~whole or in part on approval of the benefit in advance of obtaining health care.~~

4 (8) "Utilization review" means a set of formal techniques designed to
5 monitor the use, or evaluate the clinical necessity, appropriateness, efficacy, or
6 efficiency, of health care services, procedures, or settings, including
7 prescription drugs.

8 (b) Health insurers with a minimum of 2,000 Vermont lives covered at the
9 end of the preceding year or who offer insurance through the Vermont Health
10 Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall
11 annually report the following information to the Commissioner of Financial
12 Regulation, in plain language, as an addendum to the health insurer's annual
13 statement:

14 (1) the health insurer's state of domicile and the total number of states in
15 which the insurer operates;

16 (2) the total number of Vermont lives covered by the health insurer;

17 (3) the total number of claims submitted to the health insurer;

18 (4) the total number of claims denied by the health insurer, including the
19 total number of denied claims for mental health services, treatment for
20 substance use disorder, and prescription drugs;

1 ~~(5) data regarding the number and percentage of denials of service by~~
2 ~~the health insurer at the preauthorization level, based on utilization review,~~
3 ~~including utilization review at the pre-service review, concurrent review, and~~
4 ~~post-service review levels and including denials of mental health services,~~
5 ~~services for substance use disorder, and prescription drugs broken out~~
6 ~~separately, including:~~

7 ~~(A) the total number of denials of service by the health insurer at the~~
8 ~~preauthorization level;~~

9 ~~(B) the total number of denials of service at the preauthorization level~~
10 ~~appealed to the health insurer at the first-level grievance and, of those, the total~~
11 ~~number overturned;~~

12 ~~(C) the total number of denials of service at the preauthorization level~~
13 ~~appealed to the health insurer at any second-level grievance and, of those, the~~
14 ~~total number overturned;~~

15 ~~(D) the total number of denials of service at the preauthorization~~
16 ~~pre-service level for which external review was sought and, of those, the total~~
17 ~~number overturned;~~

18 (6) the total number of adverse benefit determinations made by the
19 health insurer, including:

1 ~~(A) the total number of adverse benefit determinations appealed to~~
2 the health insurer at the first-level grievance and, of those, the total number
3 overturned;

4 ~~(B) the total number of adverse benefit determinations appealed to~~
5 the health insurer at any second-level grievance and, of those, the total number
6 overturned;

7 ~~(C) the total number of adverse benefit determinations for which~~
8 external review was sought and, of those, the total number overturned;

9 ~~(7) the total number of claims denied by the health insurer because the~~
10 ~~service was experimental, investigational, or an off-label use of a drug, was not~~
11 ~~medically necessary, involved access to a provider that is inconsistent with the~~
12 ~~limitations imposed by the plan, or was subject to a preexisting condition~~
13 ~~exclusion; [Repealed.]~~

14 ~~(8) the total number of claims denied by the health insurer as duplicate~~
15 ~~claims, as coding errors, or for services or providers not covered;~~

16 ~~(9) the percentage of claims processed in a timely manner;~~

17 ~~(10) the percentage of claims processed correctly;~~

18 ~~(11) the composite percentage of claims processed in a timely manner~~
19 ~~and correctly;~~

20 ~~(12) the number and percentage of utilization review decisions meeting~~
21 ~~the timelines described in subdivisions (A)–(D) of this subdivision (12),~~

1 ~~including timeliness data for all utilization review decisions and timeliness~~
2 data for physical health, mental health, substance use disorder, and prescription
3 drug utilization review decisions broken out separately:
4 (A) concurrent reviews within 24 hours;
5 (B) urgent pre-service reviews within 48 hours of receipt of the
6 request;
7 (C) non-urgent pre-service reviews within two business days of
8 receipt of request; and
9 (D) post-service reviews within 30 days of receipt of request;
10 (13) data regarding the number of grievances related to availability,
11 delivery, or quality of health care services or matters relating to the contractual
12 relationship between a member and the health insurer, including:
13 (A) health care provider performance and office management issues;
14 (B) plan administration;
15 (C) access to health care providers and services;
16 (D) access to mental health providers and services; and
17 (E) access to substance use disorder providers and services;
18 (14) the total number of claims, including separate numbers for claims
19 related to mental health services, services for substance use disorder, and
20 prescription drugs, denied by the health insurer on the grounds that the service
21 was experimental, investigations, or an off-label use of a drug; was not

1 ~~medically necessary; or involved access to a provider that is inconsistent with~~

2 the limitations imposed by the plan;

3 (15) results of surveys evaluating health care provider satisfaction with
4 the health insurer;

5 (16) the health insurer's actions taken in response to the prior year's
6 health care provider survey results;

7 (17)(A) the titles and salaries of all corporate officers and board
8 members during the preceding year;

9 (B) the bonuses and compensatory benefits of all corporate officers
10 and board members during the preceding year;

11 ~~(10)~~(18) the health insurer's marketing and advertising expenses during
12 the preceding year;

13 ~~(11)~~(19) the health insurer's federal and Vermont-specific lobbying
14 expenses during the preceding year;

15 ~~(12)~~(20) the amount and recipient of each political contribution made by
16 the health insurer during the preceding year;

17 ~~(13)~~(21) the amount and recipient of dues paid during the preceding year
18 by the health insurer to trade groups that engage in lobbying efforts or that
19 make political contributions;

20 ~~(14)~~(22) the health insurer's legal expenses related to claims or service
21 denials during the preceding year; and

1 ~~(15)(23) the amount and recipient of charitable contributions made by~~
2 the health insurer during the preceding year.

3 ~~(b)(c)~~ Health insurers may indicate the extent of overlap or duplication in
4 reporting the information described in subsection ~~(a)(b)~~ of this section.

5 ~~(e)(d)~~ The Department of Financial Regulation shall create a standardized
6 form using terms with uniform, industry-standard meanings for the purpose of
7 collecting the information described in subsection ~~(a)(b)~~ of this section, and
8 each health insurer shall use the standardized form for reporting the required
9 information as an addendum to its annual statement. To the extent possible,
10 health insurers shall report information specific to Vermont on the
11 standardized form and shall indicate on the form where the reported
12 information is not specific to Vermont.

13 ~~(d)(e)(1)~~ The Department of Financial Regulation and the Office of the
14 Health Care Advocate shall post on ~~its website~~ their websites links to the
15 standardized form completed by each health insurer pursuant to this section.
16 Each health insurer shall post its form on its own website.

17 (2) The Department of Vermont Health Access shall post on the
18 Vermont Health Benefit Exchange established pursuant to 33 V.S.A.
19 chapter 18, subchapter 1 an electronic link to the standardized form posted by
20 the Department of Financial Regulation pursuant to subdivision (1) of this
21 subsection.

1 ~~(e)(f) The Commissioner of Financial Regulation may adopt rules pursuant~~
2 to 3 V.S.A. chapter 25 to carry out the purposes of this section.

3 Sec. 6. 18 V.S.A. § 1854(a) is amended to read:

4 (a) A hospital shall make public the maximum patient census and the
5 number of registered nurses, licensed practical nurses, and licensed nursing
6 assistants providing direct patient care in each unit during each shift. Each
7 unit's information shall be reported in full-time equivalents, with either every
8 eight hours or 12 hours worked by a registered nurse, licensed practical nurse,
9 or licensed nursing assistant during the shift as one full-time equivalent. The
10 reporting of this information shall be in a manner consistent with the
11 requirements for public reporting for measures of nurse staffing selected by the
12 ~~commissioner of financial regulation~~ Commissioner of Health under
13 subdivision ~~9405b(a)(12)~~ 9405b(a)(4) of this title, but shall not in any way
14 change what is required to be posted as set forth in this subsection. Each unit's
15 information shall be posted in a prominent place that is readily accessible to
16 patients and visitors in that unit at least once each day. The posting shall
17 include the information for the preceding seven days.

18 Sec. 7. EFFECTIVE DATES

19 (a) Secs. 1 (hospital needs assessment) and 2 (hospital community reports)
20 and this section shall take effect on passage.

21 (b) The remaining sections shall take effect on July 1, 2016.

Sec. 1. 18 V.S.A. § 9405a is amended to read:

§ 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

(a) Each hospital shall have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Needs identified through the process shall be integrated with the hospital's long-term planning. ~~The process shall be updated as necessary to continue to be consistent with such planning and capital expenditure projections, and identified needs shall be summarized in the hospital's community report.~~ Each hospital shall post on its website a description of its identified needs, strategic initiatives developed to address the identified needs, annual progress on implementation of the proposed initiatives, and opportunities for public participation. Hospitals may meet the community health needs assessment and implementation plan requirement through compliance with the relevant Internal Revenue Service community health needs assessment requirements for nonprofit hospitals.

(b) When a hospital is working on a new community health needs assessment, the hospital shall post on its website information about the process for developing the community needs assessment and opportunities for public participation in the process.

Sec. 2. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The Commissioner of Health, in consultation with representatives from hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules establishing a ~~standard format for community reports, as well as the contents, which~~ statewide comparative hospital quality report. Hospitals located outside this State which serve a significant number of Vermont residents, as determined by the Commissioner of Health, shall be invited to participate in the community report process established by this section. The report shall include:

(1) Measures of quality, including process and performance measures, that are valid, reliable, and useful, including comparisons to appropriate national benchmarks for high quality and successful results.

(2) Measures of patient safety that are valid, reliable, and useful, including comparisons to appropriate industry benchmarks for safety;

(3) Measures of hospital-acquired infections that are valid, reliable, and useful, including comparisons to appropriate industry benchmarks.

(4) Valid, reliable, and useful information on nurse staffing, including comparisons to appropriate industry benchmarks for safety. This information may include system-centered measures such as skill mix, nursing care hours per patient day, and other system-centered measures for which reliable industry benchmarks become available.

(5) Measures of the hospital's financial health, including comparisons to appropriate national benchmarks for efficient operation and fiscal health.

(5)(6) A summary of the hospital's budget, including revenue by source, the one-year and four-year capital expenditure plans, the depreciation schedule for existing facilities, and quantification of cost shifting to private payers.

(6)(7) Data that provides valid, reliable, useful, and efficient information for payers and the public for the comparison of charges for higher volume health care services.

(b) Each hospital shall publish on its website:

(7)(1) The the hospital's process for achieving openness, inclusiveness, and meaningful public participation in its strategic planning and decision-making; decisionmaking;

(8)(2) The the hospital's consumer complaint resolution process, including identification of the hospital officer or employee responsible for its implementation-;

(9) Information concerning recently completed or ongoing quality improvement and patient safety projects.

(10) A description of strategic initiatives discussed with or derived from the identification of health care needs; the one year and four year capital expenditure plans; and the depreciation schedule for existing facilities.

(11)(3) Information information on membership and governing body qualifications, a listing of the current governing body members, and means of obtaining a schedule of meetings of the hospital's governing body, including times scheduled for public participation; and

(4) a link to the comparative statewide hospital quality report.

(12) Valid, reliable, and useful information on nurse staffing, including comparisons to appropriate industry benchmarks for safety. This information may include system-centered performance measures, such as skill mix, nursing care hours per patient day, and other such system centered performance measures as reliable industry benchmarks become available in the future.

~~(b) On or before January 1, 2005, and annually thereafter beginning on June 1, 2006, the board of directors or other governing body of each hospital licensed under chapter 43 of this title shall publish on its website, making paper copies available upon request, its community report in a uniform format approved by the Commissioner of Health and in accordance with the standards and procedures adopted by rule under this section. Hospitals located outside this State which serve a significant number of Vermont residents, as determined by the Commissioner of Health, shall be invited to participate in the community report process established by this subsection.~~

~~(c) The community reports shall be provided to the Commissioner of Health. The Commissioner of Health shall publish the reports statewide comparative hospital quality report on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial measures update the report at least annually beginning on June 1, 2017.~~

Sec. 3. 18 V.S.A. § 9408a is amended to read:

§ 9408a. UNIFORM PROVIDER CREDENTIALING

* * *

~~(e) The commissioner may enforce compliance with the provisions of this section as to insurers and as to hospitals as if the hospital were an insurer under 8 V.S.A. § 3661. [Repealed.]~~

* * *

Sec. 4. 18 V.S.A. § 1905 is amended to read:

§ 1905. LICENSE REQUIREMENTS

Upon receipt of an application for license and the license fee, the licensing agency shall issue a license when it determines that the applicant and hospital facilities meet the following minimum standards:

* * *

~~(5) All patients admitted to the hospital shall be under the care of a state State registered and licensed practicing physician as defined by the laws of the State of Vermont. All hospitals shall use the uniform credentialing application form described in subsection 9408a(b) of this title.~~

* * *

Sec. 5. 18 V.S.A. § 9409 is amended to read:

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

(a) ~~The commissioner~~ Green Mountain Care Board may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. A bargaining group is authorized to negotiate on behalf of all participating providers with the ~~commissioner, the secretary of administration, the secretary of human services, the Green Mountain Care board, or the commissioner of labor~~ Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the Commissioner of Labor with respect to any matter in this chapter; chapter 13, 219, 220, or 222 of this title; 21 V.S.A. chapter 9; and 33 V.S.A. chapters 18 and 19 with respect to provider regulation, provider reimbursement, administrative simplification, information technology, workforce planning, or quality of health care.

(b) ~~The commissioner~~ Green Mountain Care Board shall adopt by rule criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section.

(c) The rules relating to negotiations shall include a nonbinding arbitration process to assist in the resolution of disputes. Nothing in this section shall be construed to limit the authority of the ~~commissioner, the commissioner of labor, the secretary of administration, the Green Mountain Care board, or the secretary of human services~~ Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the Commissioner of Labor to reject the recommendation or decision of the arbiter.

**Sec. 6. HEALTH CARE PROVIDER BARGAINING GROUP;
RULEMAKING**

For the purposes of regulating health care provider bargaining groups pursuant to 18 V.S.A. § 9409, the Green Mountain Care Board shall apply Rule 6.00 of the Department of Financial Regulation, as that rule exists on the effective date of this section, until the Board's adoption of a permanent rule on provider bargaining groups pursuant to Sec. 5 of this act. The Board's rule shall be at least as protective of health care providers as Rule 6.00.

Sec. 7. 18 V.S.A. § 9414 is amended to read:

§ 9414. QUALITY ASSURANCE FOR MANAGED CARE

(a) The Commissioner shall have the power and responsibility to ensure that each managed care organization provides quality health care to its members, in accordance with the provisions of this section.

(1) In determining whether a managed care organization meets the requirements of this section, the Commissioner ~~shall~~ may review and examine, in accordance with subsection (e) of this section, the organization's administrative policies and procedures, quality management and improvement

procedures, utilization management, credentialing practices, members' rights and responsibilities, preventive health services, medical records practices, grievance and appeal procedures, member services, financial incentives or disincentives, disenrollment, provider contracting, and systems and data reporting capacities. The Commissioner ~~may~~ shall establish, by rule, specific criteria to be considered under this section.

* * *

(4) The Commissioner or designee may resolve any consumer or provider complaint arising out of this subsection as though the managed care organization were an insurer licensed pursuant to Title 8. As used in this section, "complaint" means a report of a violation or suspected violation of the standards set forth in this section or adopted by rule pursuant to this section and made by or on behalf of a consumer or provider.

(5) The Commissioner shall prepare an annual report on or before July 1 of each year providing the number of complaints received during the previous calendar year regarding violations or suspected violations of the standards set forth in this section or adopted by rule pursuant to this section. The report shall specify the aggregate number of complaints related to each standard and shall be posted on the Department's website.

(b)(1) A managed care organization shall assure that the health care services provided to members are consistent with prevailing professionally recognized standards of medical practice.

(2) A managed care organization shall participate in ~~establish a chronic care program as needed to implement~~ the Blueprint for Health established in chapter 13 of this title. The program ~~If needed to implement the Blueprint, a managed care organization shall establish a chronic care program, which shall include:~~

(A) appropriate benefit plan design;

(B) informational materials, training, and follow-up necessary to support members and providers; and

(C) payment reform methodologies.

(3) Each managed care organization shall have procedures to assure availability, accessibility, and continuity of care, and ongoing procedures for the identification, evaluation, resolution, and follow-up of potential and actual problems in its health care administration and delivery.

(4) Each managed care organization shall be accredited by a national independent accreditation organization approved by the Commissioner.

~~(c) The Consistent with participation in the Blueprint for Health pursuant to subdivision (b)(2) of this section and the accreditation required by subdivision (b)(4) of this section, the managed care organization shall have an internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The internal quality assurance program shall be fully described in written form, provided to all managers, providers, and staff and made available to members of the organization. The components of the internal quality assurance program shall include, but not be limited to, the following:~~

- ~~(1) a peer review committee or comparable designated committee responsible for quality assurance activities;~~
- ~~(2) accountability of the committee to the Board of Directors or other governing authority of the organization;~~
- ~~(3) participation by an appropriate base of providers and support staff;~~
- ~~(4) supervision by the medical director of the organization;~~
- ~~(5) regularly scheduled meetings; and~~
- ~~(6) minutes or records of the meetings which describe in detail the actions of the committee, including problems discussed, charts reviewed, recommendations made, and any other pertinent information.~~

~~(d)(1) In addition to its internal quality assurance program, each managed care organization shall evaluate the quality of health and medical care provided to members. The organization shall use and maintain a patient record system which will facilitate documentation and retrieval of statistically meaningful clinical information.~~

~~(2) A managed care organization may evaluate the quality of health and medical care provided to members through an independent accreditation organization. [Repealed.]~~

* * *

Sec. 8. 18 V.S.A. § 9414a is amended to read:

§ 9414a. ANNUAL REPORTING BY HEALTH INSURERS

(a) As used in this section:

(1) “Adverse benefit determination” means a denial, reduction, modification, or termination of, or a failure to provide or make payment in whole or in part for, a benefit, including:

(A) a denial, reduction, modification, termination, or failure to provide or make payment that is based on a determination of the member's eligibility to participate in a health benefit plan;

(B) a denial, reduction, modification, or termination of, or failure to make payment in whole or in part for, a benefit resulting from the application of any utilization review; and

(C) a failure to provide coverage for an item or service for which benefits are otherwise provided because the item or service is determined to be experimental, investigational, or not medically necessary or appropriate.

(2) "Claim" means a pre-service review or a request for payment for a covered service that a member or the member's health care provider submits to the insurer at or after the time that health care services have been provided.

(3) "Concurrent review" means utilization review conducted during a member's stay in a hospital or other facility, or during another ongoing course of treatment.

(4) "Grievance" means a complaint submitted by or on behalf of a member regarding:

(A) an adverse benefit determination;

(B) the availability, delivery, or quality of health care services;

(C) claims payment, handling, or reimbursement for health care services; or

(D) matters relating to the contractual relationship between a member and the managed care organization or health insurer offering the health benefit plan.

(5) "Independent external review" means a review of a health care decision by an independent review organization pursuant to 8 V.S.A. § 4089f.

(6) "Post-service review" means the review of any claim for a benefit that is not a pre-service or concurrent review.

(7) "Pre-service review" means the review of any claim for a benefit with respect to which the terms of coverage condition receipt of the benefit in whole or in part on approval of the benefit in advance of obtaining health care.

(8) "Utilization review" means a set of formal techniques designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of health care services, procedures, or settings, including prescription drugs.

(b) Health insurers with a minimum of 2,000 Vermont lives covered at the end of the preceding year or who offer insurance through the Vermont Health Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall annually report the following information to the Commissioner of Financial Regulation, in plain language, as an addendum to the health insurer's annual statement:

(1) the health insurer's state of domicile and the total number of states in which the insurer operates;

(2) the total number of Vermont lives covered by the health insurer;

(3) the total number of claims submitted to the health insurer;

(4) the total number of claims denied by the health insurer, including the total number of denied claims for mental health services, treatment for substance use disorder, and prescription drugs;

(5) data regarding the number and percentage of denials of service by the health insurer ~~at the preauthorization level,~~ based on utilization review, including utilization review at the pre-service review, concurrent review, and post-service review levels and including denials of mental health services, services for substance use disorder, and prescription drugs broken out separately, including:

(A) ~~the total number of~~ denials of service by the health insurer ~~at the preauthorization level;~~

(B) ~~the total number of~~ denials of service ~~at the preauthorization level~~ appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

(C) ~~the total number of~~ denials of service ~~at the preauthorization level~~ appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

(D) ~~the total number of~~ denials of service at the ~~preauthorization pre-service~~ level for which external review was sought and, of those, the total number overturned;

(6) the total number of adverse benefit determinations made by the health insurer, including:

(A) the total number of adverse benefit determinations appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

(B) the total number of adverse benefit determinations appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

(C) the total number of adverse benefit determinations for which external review was sought and, of those, the total number overturned;

~~(7) the total number of claims denied by the health insurer because the service was experimental, investigational, or an off-label use of a drug, was not medically necessary, involved access to a provider that is inconsistent with the limitations imposed by the plan, or was subject to a preexisting condition exclusion; [Repealed.]~~

(8) the total number of claims denied by the health insurer as duplicate claims, as coding errors, or for services or providers not covered;

(9) the percentage of claims processed in a timely manner;

(10) the percentage of claims processed accurately, both financially and administratively;

(11) the number and percentage of utilization review decisions meeting the timelines described in subdivisions (A)–(D) of this subdivision (11), including timeliness data for all utilization review decisions and timeliness data for physical health, mental health, substance use disorder, and prescription drug utilization review decisions broken out separately;

(A) concurrent reviews within 24 hours;

(B) urgent pre-service reviews within 48 hours of receipt of the request;

(C) non-urgent pre-service reviews within two business days of receipt of request; and

(D) post-service reviews within 30 days of receipt of request;

(12) data regarding the number of grievances related to availability, delivery, or quality of health care services or matters relating to the contractual relationship between a member and the health insurer, including:

(A) health care provider performance and office management issues;

(B) plan administration;

(C) access to health care providers and services;

(D) access to mental health providers and services; and

(E) access to substance use disorder providers and services;

(13) the total number of claims, including separate numbers for claims related to mental health services, services for substance use disorder, and prescription drugs, denied by the health insurer on the grounds that the service was experimental, investigations, or an off-label use of a drug; was not medically necessary; or involved access to a provider that is inconsistent with the limitations imposed by the plan;

(14) results of surveys evaluating health care provider satisfaction with the health insurer;

(15) the health insurer's actions taken in response to the prior year's health care provider survey results;

(16)(A) the titles and salaries of all corporate officers and board members during the preceding year; and

(B) the bonuses and compensatory benefits of all corporate officers and board members during the preceding year;

(10)(17) the health insurer's marketing and advertising expenses during the preceding year;

(11)(18) the health insurer's federal and Vermont-specific lobbying expenses during the preceding year;

(12)(19) the amount and recipient of each political contribution made by the health insurer during the preceding year;

(13)(20) the amount and recipient of dues paid during the preceding year by the health insurer to trade groups that engage in lobbying efforts or that make political contributions;

(14)(21) the health insurer's legal expenses related to claims or service denials during the preceding year; and

(15)(22) the amount and recipient of charitable contributions made by the health insurer during the preceding year.

(b)(c) Health insurers may indicate the extent of overlap or duplication in reporting the information described in subsection (a)(b) of this section.

(e)(d) The Department of Financial Regulation shall create a standardized form using terms with uniform, industry-standard meanings for the purpose of collecting the information described in subsection (a)(b) of this section, and each health insurer shall use the standardized form for reporting the required information as an addendum to its annual statement. To the extent possible, health insurers shall report information specific to Vermont on the standardized form and shall indicate on the form where the reported information is not specific to Vermont.

~~(d)(e)(1) The Department of Financial Regulation and the Office of the Health Care Advocate shall post on its website their websites links to the standardized form completed by each health insurer pursuant to this section. Each health insurer shall post its form on its own website.~~

~~(2) The Department of Vermont Health Access shall post on the Vermont Health Benefit Exchange established pursuant to 33 V.S.A. chapter 18, subchapter 1 an electronic link to the standardized forms posted by the Department of Financial Regulation pursuant to subdivision (1) of this subsection.~~

~~(e)(f) The Commissioner of Financial Regulation may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this section.~~

~~Sec. 9. 18 V.S.A. § 1854(a) is amended to read:~~

~~(a) A hospital shall make public the maximum patient census and the number of registered nurses, licensed practical nurses, and licensed nursing assistants providing direct patient care in each unit during each shift. Each unit's information shall be reported in full-time equivalents, with either every eight hours or 12 hours worked by a registered nurse, licensed practical nurse, or licensed nursing assistant during the shift as one full-time equivalent. The reporting of this information shall be in a manner consistent with the requirements for public reporting for measures of nurse staffing selected by the commissioner of financial regulation Commissioner of Health under subdivision 9405b(a)(12) 9405b(a)(4) of this title, but shall not in any way change what is required to be posted as set forth in this subsection. Each unit's information shall be posted in a prominent place that is readily accessible to patients and visitors in that unit at least once each day. The posting shall include the information for the preceding seven days.~~

~~Sec. 10. RECOMMENDATIONS FOR POTENTIAL ALIGNMENT~~

~~The Director of Health Care Reform in the Agency of Administration, in collaboration with the Green Mountain Care Board and the Department of Financial Regulation, shall compare the requirements in federal law applicable to Vermont's accountable care organizations and to the Department of Vermont Health Access in its role as a public managed care organization with the provisions of 18 V.S.A. § 9414(a)(1) as they apply to managed care organizations to identify opportunities for alignment. The Director of Health Care Reform shall consult with interested stakeholders, including accountable care organizations; health insurance and managed care organizations, as defined in 18 V.S.A. § 9402; health care providers; and the Office of the Health Care Advocate, shall take into consideration the financial and operational implications of alignment, and shall make recommendations on or before December 15, 2017 to the House Committee on Health Care and~~

~~the Senate Committees on Health and Welfare and on Finance on appropriate ways to improve alignment.~~

Sec. 10. RECOMMENDATIONS FOR POTENTIAL ALIGNMENT

The Director of Health Care Reform in the Agency of Administration, in collaboration with the Green Mountain Care Board and the Department of Financial Regulation, shall compare the requirements in federal law applicable to Vermont's accountable care organizations and to the Department of Vermont Health Access in its role as a public managed care organization with the provisions of 18 V.S.A. § 9414(a)(1) as they apply to managed care organizations to identify opportunities for alignment, including alignment of mental health standards. The Director of Health Care Reform shall make recommendations on or before December 15, 2017 to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on appropriate ways to improve alignment. In preparing his or her recommendations, the Director shall take into consideration the financial and operational implications of alignment and shall consult with interested stakeholders, including health care providers, accountable care organizations, the Office of the Health Care Advocate, and health insurance and managed care organizations, as defined in 18 V.S.A. § 9402.

Sec. 11. EFFECTIVE DATES

(a) Secs. 1 (hospital needs assessment) and 2 (hospital community reports) and this section shall take effect on passage.

(b) The remaining sections shall take effect on July 1, 2016.