H.627

Introduced by Representative Maier of Middlebury

Referred to Committee on

Date:

Subject: Health; insurance; hospitals; health care professionals; technology; primary care; workforce

Statement of purpose: This bill proposes to require participation by insurers in the Blueprint for Health, to make receipt of Medicaid information technology funds to hospitals and many health care professionals conditioned on participation in the Blueprint for Health, to create a task force to provide recommendations on how to ensure necessary resources in primary care, to prohibit the inclusion of advertising and marketing expenses in the hospital budgets, to include under the certificate of need program and hospital budget review program the parent or affiliate of a hospital which exercises control over the hospital, and to authorize the commissioner of banking, insurance, securities, and health care administration to issue emergency orders with respect to a hospital whose financial circumstances threaten immediate harm to the public.

An act relating to health care cost containment

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

Sec. 1. 18 V.S.A. § 701 is amended to read:

§ 701. DEFINITIONS

For the purposes of this chapter:

(1) "Blueprint for Health" means the state's plan for chronic care infrastructure, prevention of chronic conditions, and chronic care management program, and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives.

(2) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, hyperlipidemia, and chronic pain.

(3) "Chronic care information system" means the electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.

(4) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(5) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(6) "Health insurer" shall have the same meaning as in section 9402 of this title.

(7) "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

Sec. 2. 18 V.S.A. § 702 is amended to read:

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

(a) ~~As used in this section, "health insurer" shall have the same meaning as in section 9402 of this title.~~

~~(b)~~ The director of the Blueprint, in collaboration with the commissioner of health, shall oversee the development and implementation of the Blueprint for Health, including the five-year strategic plan. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration.

~~(c)~~(b)(1) The secretary shall establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall consist of no fewer than 10 individuals, including the commissioner of health; a representative from the department of banking, insurance, securities, and health care administration; a representative from the office of Vermont health access; a representative from the Vermont medical society; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine profession; a primary care professional serving low income or uninsured Vermonters; and a representative of the state employees' health plan, who shall be designated by the director of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan. In addition, the director

of the commission on health care reform shall be a nonvoting member of the executive committee.

(2) The executive committee shall engage a broad range of health care professionals who provide services as defined under section 4080f of Title 18, health ~~insurance plans~~ insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local government in developing and implementing a five-year strategic plan.

~~(d)~~(c) The Blueprint shall be developed and implemented to further the following principles:

(1) the primary care provider should serve a central role in the coordination of care and shall be compensated appropriately for this effort;

(2) use of information technology should be maximized;

(3) local service providers should be used and supported, whenever possible;

(4) transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to the Blueprint model of health care delivery and payment;

(5) implementation of the Blueprint in communities across the state should be accompanied by payment to providers sufficient to support care management activities consistent with the Blueprint, recognizing that interim

or temporary payment measures may be necessary during early and transitional phases of implementation; and

(6) interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior, the physical and social environment, and health care policies and systems.

~~(e)~~(d)(1) The strategic plan shall include:

(A) a description of the Vermont Blueprint for Health model, which includes general, standard elements established in section 1903a of Title 33, patient self-management, community initiatives, and health system and information technology reform, to be used uniformly statewide by ~~private~~ health insurers, third party administrators, and public health benefit programs;

(B) a description of prevention programs and how these programs are integrated into communities, with chronic care management, and the Blueprint for Health model;

(C) a plan to develop and implement reimbursement systems aligned with the goal of managing the care for individuals with or at risk for conditions in order to improve outcomes and the quality of care;

(D) the involvement of public and private groups, health care professionals, health insurers, third party administrators, associations, and firms to facilitate and assure the sustainability of a new system of care;

(E) the involvement of community and consumer groups to facilitate and assure the sustainability of health services supporting healthy behaviors and good patient self-management for the prevention and management of chronic conditions;

(F) alignment of any information technology needs with other health care information technology initiatives;

(G) the use and development of outcome measures and reporting requirements, aligned with existing outcome measures within the agency of human services, to assess and evaluate the system of chronic care;

(H) target timelines for inclusion of specific chronic conditions in the chronic care infrastructure and for statewide implementation of the Blueprint for Health;

(I) identification of resource needs for implementing and sustaining the Blueprint for Health and strategies to meet the needs; and

(J) a strategy for ensuring statewide participation no later than January 1, 2011 by health insurers, third-party administrators, health care professionals, hospitals and other professionals, and consumers in the chronic care management plan, including common outcome measures, best practices

and protocols, data reporting requirements, payment methodologies, and other standards. In addition, the strategy should ensure that all communities statewide will have implemented at least one component of the Blueprint by January 1, 2009.

(2) The strategic plan shall be reviewed biennially and amended as necessary to reflect changes in priorities. Amendments to the plan shall be included in the report established under subsection (i) of this section.

~~(f)~~(e) The director of the Blueprint shall facilitate timely progress in adoption and implementation of clinical quality and performance measures as indicated by the following benchmarks:

(1) ~~by July 1, 2007, clinical~~ Clinical quality and performance measures are adopted and maintained for each of the chronic conditions included in the Medicaid Chronic Care Management Program. These conditions include, but are not limited to, asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.

(2) ~~at~~ At least one set of clinical quality and performance measures will be added each year and a uniform set of clinical quality and performance measures for all chronic conditions to be addressed by the Blueprint will be available for use by health insurers and health care providers ~~by January 1, 2010~~.

(3) ~~in~~ In accordance with a schedule established by the Blueprint executive committee, all clinical quality and performance measures shall be reviewed for consistency with those used by the Medicare program and updated, if appropriate.

~~(g)~~(f) The director of the Blueprint shall facilitate timely progress in coordination of chronic care management as indicated by the following benchmarks:

(1) ~~by October 1, 2007, risk stratification strategies shall be used~~ A system for health maintenance, prevention, and chronic disease management shall be used by health care professionals to identify individuals with or at risk for chronic disease and to assist in the determination of the severity of the chronic disease or risk thereof, as well as the appropriate type and level of care management services needed to manage those chronic conditions.

(2) ~~by January 1, 2009, guidelines~~ Guidelines for promoting greater commonality, consistency, and coordination across health insurers in care management programs and systems shall be developed and maintained in consultation with employers, consumers, health insurers, and health care providers.

~~(3) beginning July 1, 2009, and each year thereafter, health insurers, in collaboration with health care providers, shall report to the secretary on evaluation of their disease management programs and the progress made~~

~~toward aligning their care management program initiatives with the Blueprint guidelines.~~

~~(h)~~(g)~~(1) No later than January 1, 2009, the director shall, in consultation with employers, consumers, health insurers, and health care providers, complete a comprehensive analysis of sustainable payment mechanisms. No later than January 1, 2009, the director shall report to the health care reform commission and other stakeholders his or her recommendations for sustainable payment mechanisms and related changes needed to support achievement of Blueprint goals for health care improvement, including the essential elements of high quality chronic care, such as care coordination, effective use of health care information by physicians and other health care providers and patients, and patient self-management education and skill development.~~

~~(2)~~ By January 1, 2009, and each year thereafter, health insurers will participate in a coordinated effort to determine satisfaction levels of physicians and other health care providers participating in the Blueprint care management initiatives, and will report on these satisfaction levels to the director and in the report established under subsection ~~(i)~~(h) this section.

~~(i)~~(h) The director shall report annually, no later than January 1, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year, and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight

committee, and the commission on health care reform. The report shall include the number of participating insurers, health care professionals and patients; the progress for achieving statewide participation in the chronic care management plan, including the measures established under ~~subsection (e) of~~ this section; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in ~~subsections (g) and (h) of~~ this section; and other information as requested by the committees. The surveys shall be developed in collaboration with the executive committee established under subsection ~~(c)~~(b) of this section.

~~(j)~~(i) ~~It is the intent of the general assembly that health~~ Health insurers shall participate in the Blueprint for Health and create or maintain connectivity to the state's health information exchange as a condition of doing business in this state no later than January 1, ~~2009 and shall engage health care providers in the transition to full participation in the Blueprint~~ 2011. In order to be eligible for incentive payments to Medicaid providers for adopting, implementing, or upgrading certified electronic health record technology or for meaningful use of that technology as provided for under sections 1903 and 4201 of the American Reinvestment and Recovery Act of 2009 and upon approval by the Centers for Medicare and Medicaid Services, health care providers and

professionals shall participate in the Blueprint for Health and create or maintain connectivity to the state's health information exchange.

Sec. 3. RULES

By emergency rule as provided for in chapter 25 of Title 3, the secretary of administration or designee shall specify the requirements and timeframe that an insurer, health care provider, or health care professional must met to be considered participating in the Blueprint for Health and creating or maintaining connectivity to the state's health information exchange as required by sections 702 of Title 18 and section 4062 of Title 8.

Sec. 4. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a) No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any ~~such~~ policy be used, until:

(1) a copy of the form, premium rates, and rules for the classification of risks ~~pertaining thereto have~~ has been filed with the commissioner of banking, insurance, securities, and health care administration; and

(2) the company offering the policy or certificate has certified that it agrees to participate in the Blueprint for Health as required under chapter 13 of

Title 18, to create or maintain connectivity to the state's health information exchange.

(b) ~~nor shall any such~~ No form, premium rate, or rule shall be ~~so~~ used until the expiration of 30 days after having been filed, unless the commissioner ~~shall sooner give his or her~~ gives written approval ~~thereto~~ sooner. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state, or if the company has failed to provide the certification required in subdivision (a)(2) of this section. In ~~such~~ the notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. In all other cases, the commissioner shall give his or her approval.

(c) After the expiration of such 30 days from the filing of any such form, premium rate, or rule and the certification, or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 days written notice has been given to the insurer ~~using such form, premium rate or rule~~, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

Sec. 5. HEALTH INFORMATION TECHNOLOGY; MEDICAID

(a) No later than September 1, 2010, the commissioner of human services or designee shall request approval from the Centers for Medicare and Medicaid Services (CMS) to provide for incentive payments to Medicaid providers for adopting, implementing, or upgrading certified electronic health record technology or for meaningful use of that technology as provided for under sections 1903 and 4201 of the American Reinvestment and Recovery Act of 2009. The agency shall include in its request that the criteria for meaningful use of certified electronic health records include a requirement that a health care professional or provider:

(1) participate in the Blueprint for Health; and

(2) create or maintain connectivity to the state's health information exchange.

(b) If the commissioner receives approval from CMS, the commissioner or designee shall establish by rule provisions for implementing the incentive payments, including criteria for meaningful use of certified health information technology.

Sec. 6. INTERIM STUDY OF VERMONT'S PRIMARY CARE DELIVERY SYSTEM

(a) Creation of committee. There is created a primary care delivery system committee to determine the additional capacity needed in the primary care

delivery system if Vermont achieves the health care reform principles and purposes established in Secs. 1 and 2 of No. 191 of the Acts of the 2005 Adj. Sess. (2006) and to create a strategic plan for ensuring that the necessary capacity is achieved in the primary care delivery system. The primary care delivery system shall include physicians, advanced practice nurses, and other health care professionals providing primary care as defined in section 4080f of Title 8.

(b) Membership. The primary care delivery system committee shall be composed of 14 members as follows:

(1) the secretary of administration or designee;

(2) the deputy commissioner of the division of health care administration or designee;

(3) the director of the Blueprint for Health;

(4) the commissioner of health or designee;

(5) a representative of the University of Vermont College of Medicine's Area Health Education Centers (AHEC) program;

(6) a representative of the University of Vermont College of Medicine's Office of Primary Care, a representative of the University of Vermont College of Nursing and Health Sciences, a representative of nursing programs at the Vermont State Colleges, and a representative from Norwich University's nursing programs appointed by the governor or their designees;

(7) a representative of the Vermont Association of Naturopathic Physicians;

(8) a representative of Bi-State Primary Care Association;

(9) a representative of Vermont Nurse Practitioners Association;

(10) a representative of Physician Assistant Academy of Vermont; and

(11) a representative of the Vermont Medical Society.

(c) Powers and duties.

(1) The committee shall study the primary care workforce and delivery system in Vermont, including the following issues:

(A) the current capacity and capacity issues of the primary care workforce and delivery system in Vermont, including the number of primary care professionals, issues with geographic access to services, and unmet needs of patients;

(B) the resources needed to ensure that the primary care workforce and the delivery system are able to provide sufficient access to services should all or most of Vermonters become insured, to provide sufficient access to services given demographic factors in the population and in the workforce, to fully participate in health care reform initiatives, including participation in the Blueprint for Health and transition to electronic medical records; and

(C) how state government, universities and colleges, and others may develop the resources in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes.

(2) The committee shall create a detailed and targeted five-year strategic plan with specific action steps for attaining sufficient capacity in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes. By November 15, 2010, the committee shall report to the joint legislative commission on health care reform, the house committee on health care, and the senate committee on health and welfare its findings, the strategic plan, and any recommendations for legislative action.

(3) For purposes of its study of these issues, the committee shall have administrative support from the office of Vermont health access and the department of health. The secretary of administration or designee shall call the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership.

(d) Term of committee. The committee shall cease to exist on January 31, 2011.

Sec. 7. 18 V.S.A. § 9451 is amended to read:

§ 9451. DEFINITIONS

As used in this subchapter:

(1) "Hospital" means a general hospital licensed under chapter 43 of this title.

(2) "Marketing and advertising" means promotion, or any activity that is intended to be used or is used to influence individuals seeking health care services to use a specific hospital to attain those services.

(3) "Volume" means the number of inpatient days of care or admissions and the number of all inpatient and outpatient ancillary services rendered to patients by a hospital.

Sec. 8. 18 V.S.A. § 9456(c) is amended to read:

(c) Individual hospital budgets established under this section shall:

(1) be consistent with the health resource allocation plan;

(2) take into consideration national, regional, or instate peer group norms, according to indicators, ratios, and statistics established by the commissioner;

(3) promote efficient and economic operation of the hospital;

(4) reflect budget performances for prior years; ~~and~~

(5) include a finding that the analysis provided in subdivision (b)(9) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers; and

(6) not include spending on marketing and advertising.

Sec. 9. MARKETING AND ADVERTISING INFORMATION

For hospital fiscal year 2011, the commissioner of banking, insurance, securities, and health care administration may require a hospital to provide information on marketing and advertising costs pursuant to section 9454 of Title 18 if the commissioner determines the information is necessary to ensure compliance with Secs. 7 and 8 of this act.

Sec. 10. 18 V.S.A. § 9402(13) is amended to read:

(13) "Hospital" means an acute care hospital licensed under chapter 43 of this title. The term hospital shall also include all corporate or other entities affiliated with the licensed hospital which the commissioner determines are necessary to carry out the purposes of subchapters 5 and 7 of this chapter.

Sec. 11. 18 V.S.A. § 9456(h)(2) is amended to read:

(2)(A) After notice and an opportunity for hearing, the commissioner may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of no more than ~~$40,000~~ $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than ~~$100,000~~ $100,000.00

or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

(B) The commissioner may order a hospital to cease violating this subchapter, or a regulation or order issued pursuant to this subchapter, or to cease operating contrary to the budget established for the hospital under this section, and to make such further orders as are necessary to carry out the purposes of this subchapter. Such orders shall be issued after notice and an opportunity to be heard, except that where the commissioner finds that a hospital's financial or other emergency circumstances pose an immediate threat of harm to the public or to the financial condition of the hospital, the commissioner may issue such orders without written or oral notice to the hospital. Where such an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. Such hearing shall be held within 30 days of receipt of the hospital's request for a hearing, and a decision shall be issued within 30 days after the conclusion of the hearing. The commissioner may extend the time to hold the hearing or render the decision for good cause shown.

Sec. 12. EFFECTIVE DATES

(a) Secs. 1, 3, 5, 6, and this section shall take effect upon passage.

(b) Secs. 10 and 11 of this act shall take effect on July 1, 2010.

(c) Secs. 7, 8, and 9 of this act shall apply to the hospital fiscal year beginning on October 1, 2010.

(d) Secs. 2 and 4 of this act shall apply to all health insurers on and after October 1, 2010, and to existing contracts or network agreements between health insurers and health care providers on the date that the contract or agreement is renewed or amended, but in no event later than October 1, 2011.