S.129

An act relating to containing health care costs

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

* * * Variation in Health Care Utilization * * *

Sec. 1. STUDY OF HEALTH CARE UTILIZATION

(a)(1) The commissioner of banking, insurance, securities, and health care administration shall analyze variations in the use of health care provided both by hospitals and by physicians treating Vermont residents as measured across the appropriate geographic unit or units. The commissioner shall contract with the Vermont program for quality in health care (VPQHC) pursuant to 18 V.S.A. § 9416 and may contract or consult with other qualified professionals or entities as needed to assist in the analysis and recommendations. To the extent possible, the analysis shall include information already available in medical literature and the Vermont quality report.

(2) The purpose of the analysis is to identify treatments or procedures for which the utilization rate varies significantly among geographic regions within Vermont, where the utilization rates are changing faster in one geographic region than another, to determine the reasons for the variations and changes in utilization, and to recommend solutions to contain health care costs by appropriately reducing variation, including by promoting the use of equally

or more effective, lower-cost treatments and therapies provided by all health care professionals licensed in the state. The commissioner may examine the utilization rates of comparable, out-of-state hospitals or entities and regions if necessary to complete this analysis.

(3) The secretary of human services shall collaborate with the commissioner of banking, insurance, securities, and health care administration in the analysis required by this section. To the extent that the agency has data to contribute to the analysis that may not be shared directly, the agency shall provide the analysis to the commissioner of banking, insurance, securities, and health care administration.

(4) The commissioner and the secretary may begin the analysis with the following services:

(A) whose utilization is governed largely by patient preference, including:

(i) cataract surgery;

(ii) joint replacement;

(iii) back surgery; and

(iv) elective cardiac and vascular procedures.

(B) whose utilization appears to be governed largely by the available supply of the service, including:

(i) total physician visits, including to specialists and primary care physicians;

(ii) medical admissions to hospitals, including number of inpatient days and outpatient visits, including emergency room visits;

(iii) ambulatory-sensitive conditions;

(iv) advanced imaging;

(v) diagnostic tests; and

(vi) minor procedures.

(b)(1) In fiscal year 2010, the commissioner of banking, insurance, securities, and health care administration shall collect the same amount under subsection 9416(c) of Title 18 as was collected in state fiscal year 2009 for the expenses incurred under that section.

(2) In fiscal year 2010, the commissioner of banking, insurance, securities, and health care administration may redistribute up to $150,000.00 of the amount collected under subsection 9416(c) of Title 18 in order to ensure that the analyses and report required by this section are completed.

(c) No later than January 15, 2010, the secretary of human services and the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare containing a summary of their analysis of health care utilization, including explanations for variations or increases in

spending and recommendations for containing health care costs by reducing variation, including promoting the use of equally or more effective lower cost treatment alternatives, prevention, or other methods of appropriately changing utilization.

Sec. 2. UTILIZATION REVIEW AND REMEDIATION PLAN

No later than January 15, 2010, using the analysis required in Sec. 1 of this act as the primary source of analysis, the commissioner of banking, insurance, securities, and health care administration shall consult with the Vermont Association of Hospitals and Health Systems, Inc., the Vermont Medical Society, insurers, and others to recommend:

(1) A process to ensure appropriate utilization in treatments or procedures across Vermont, including:

(A) identifying inappropriately low or high utilization in a geographic region for which there is a method of changing utilization;

(B) prioritizing variation identified in a geographic region by considering the impact a change in inappropriately low or high variations could have on cost or quality and the potential to develop strategies to rectify inappropriate variations;

(C) determining the causes of inappropriately low or high utilization identified pursuant to the process developed under this subdivision in a particular geographic region;

(D) providing the information gathered pursuant to the process developed under this subdivision to the health care professionals and facilities in the geographic region and in a publicly available format; and

(E) monitoring the health care professionals and facilities in the geographic region's progress.

(2) Modifications, if any, to existing regulatory processes, including the certificate of need process or the annual hospital budget process.

(3) Solutions to reduce inappropriate low or high utilization, including initiatives to improve public health and change reimbursement methodologies.

(4) Incentives for hospitals and health care professionals to change inappropriately low or high utilization.

* * * Administrative Cost * * *

Sec. 3. HEALTH PLAN ADMINISTRATIVE COST REPORT

(a) No later than December 15, 2009, the commissioner of banking, insurance, securities, and health care administration, in collaboration with the secretary of human services and the commissioner of human resources, shall provide a health plan administrative cost report to the health care reform commission, the house committee on health care, and the senate committee on health and welfare.

(b) The report shall:

(1) identify a common methodology based on the current rules for insurer reports to the department of banking, insurance, securities, and health care administration for calculating costs of administering a health plan in order to provide useful comparisons between the administrative costs of:

(A) private insurers;

(B) entities administering self-insured health plans, including the state employees' and retirees' health benefit plans; and

(C) offices or departments in the agency of human services; and

(2) compare administrative costs across the entities in Vermont providing health benefit plans.

* * * Shared Decision-making * * *

Sec. 4. SHARED DECISION-MAKING DEMONSTRATION PROJECT

(a) No later than January 15, 2010, the secretary of administration or designee shall present a plan to the house committees on health care and on human services and the senate committee on health and welfare for a shared decision-making demonstration project to be integrated with the Blueprint for Health. The purpose of shared decision-making shall be to improve communication between patients and health care professionals about equally or more effective treatment options where the determining factor in choosing a treatment is the patient's preference. The secretary shall consider existing

resources and systems in Vermont as well as other shared decision-making models. The plan shall analyze potential barriers to health care professionals participating in shared decision-making, including existing law on informed consent, and recommend solutions or incentives to encourage participation by health care professionals in the demonstration project.

(b) "Shared decision-making" means a process in which the health care professional and patient or patient's representative discuss the patient's health condition or disease, the treatment options available for that condition or disease, the benefits and harms of each treatment option, information on the limits of scientific knowledge on patient outcomes from the treatment options, and the patient's values and preferences for treatment with the use of a patient decision aid.

* * * Health Care Quality * * *

Sec. 5. BISHCA; REVIEW OF HEALTH QUALITY INITIATIVES

(a) The commissioner of banking, insurance, securities, and health care administration, in collaboration with the Vermont program for quality in health care, shall conduct a review of health care quality organizations in other states and countries to identify and evaluate quality improvement strategies, initiatives, and best practices. The review shall determine how other jurisdictions conduct health care quality reviews, including what types of organizations are providing health care quality analysis, the content of the

analysis, the methods used by the organization to do the analysis, and other relevant information.

(b) No later than January 15, 2010, the commissioner shall provide a report to the house committee on health care and the senate committee on health and welfare, including his or her findings, a comparison of Vermont's program with other jurisdictions, and any recommendations for modifying the program.

* * * Accountable Care Organization Pilot Project * * *

Sec. 6. ACCOUNTABLE CARE ORGANIZATION WORK GROUP

(a) It is the intent of the general assembly that all Vermonters receive affordable and appropriate health care at the appropriate time, and that health care costs be contained over time. In order to achieve this goal and to ensure the success of health care reform, it is essential to pursue innovative approaches to a system of health care delivery that integrates health care at a community level and contains costs through community-based payment reform, such as developing an accountable care organization. It is also the intent of the general assembly to ensure sufficient state involvement and action in designing and implementing an accountable care organization in order to comply with federal anti-trust provisions by replacing competition between payers and others with state regulation and supervision.

(b)(1)(A) The commission on health care reform shall convene a work group to support the development of an application by at least one Vermont

network of community health care providers for participation in a national accountable care organization (ACO) state learning collaborative sponsored by the Dartmouth Institute for Health Policy and Clinical Practice and the Brookings Institution with the intent that at least one ACO pilot project be implemented in Vermont no later than July 1, 2010. The network of community health care providers shall include primary care professionals, specialists, hospitals, and other health care providers and entities.

(B) An accountable care organization is an entity that enables networks of community health care providers to become accountable for the overall costs and quality of care for the population they jointly serve and to share in the savings created by improving quality and slowing spending growth as described in Fostering Accountable Health Care: Moving Forward in Medicare by Fisher et al, Health Affairs w219, 2009.

(2) The commission shall research other opportunities to create proposals to establish an ACO pilot project or another similar payment reform pilot project, which may become available through participation in a demonstration waiver in Medicare, payment reform in Medicare, national health care reform, or other federal changes that support the development of accountable care organizations.

(c)(1) The commission shall solicit participation in the work group from a broad group of interested stakeholders, including the secretary of

administration or designee, the commissioner of banking, insurance, securities, and health care administration or designee, the director of the office of Vermont health access or designee, representatives of private insurers, employers, consumers, and representatives of health care professionals and facilities interested in participating in the ACO pilot project.

(2) To the extent required to avoid federal anti-trust violations, the commissioner of banking, insurance, securities, and health care administration shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of an accountable care organization. The department shall ensure that the application includes sufficient state supervision over these entities to comply with federal anti-trust provisions. The department shall propose to the commission any legislation necessary for implementation of the ACO pilot project.

(3) The director of the office of Vermont health access shall propose to the commission a plan for including Medicaid, VHAP, and Dr. Dynasaur in the accountable care organization, including a model for recapturing a portion of anticipated savings from participation in an ACO which would be reinvested with health care professionals and facilities. Notwithstanding section 1901 of Title 33, the commission, with consultation from the health access oversight committee may approve the director of Vermont health access' plan for

including Medicaid, VHAP, and Dr. Dynasaur in the ACO pilot project if it is necessary for the director to apply for the waiver amendment outside of the legislative session to ensure implementation of the ACO pilot project no later than July 1, 2010.

(d) The work group shall:

(1) identify local community health care professional and facility networks interested in participating in the ACO pilot project and assist them in qualifying as a site;

(2) develop a financial model for the community provider network involved in the accountable care organization to estimate the fiscal impact of the ACO pilot project on payers, the local community health care professional and facility network, and the state, including a model for recapturing a portion of anticipated savings from participation in an ACO which would be reinvested with health care professionals and facilities; and

(3) ensure that the ACO pilot project proposal is coordinated with the Blueprint for Health, existing medical home projects, and shared decision-making pilot projects.

(e) No later than January 15, 2010, the commission on health care reform shall report to the house committees on health care and human services and the senate committee on health and welfare on the ACO state learning collaborative application, the status of the development of an application by a

Vermont network of health care providers, and any proposed legislation necessary for the implementation of the ACO pilot project.

(f) The work group shall cease to exist on January 1, 2011.

Sec. 7. ACCOUNTABLE CARE ORGANIZATION PILOT; MEDICAID WAIVER

If the plan provided for under Sec. 6(c)(3) of this act is approved by the commission on health care reform, the director of Vermont health access shall apply to the Centers on Medicare and Medicaid Services (CMS) for an amendment to the Global Commitment for Health Medicaid Section 1115 waiver to allow for participation in a national accountable care organization state learning collaborative sponsored by the Dartmouth Institute for Health Policy and Clinical Practice and the Brookings Institution.

* * * Health Care Administration * * *

Sec. 8. 18 V.S.A. § 9401 is amended to read:

§ 9401. POLICY

(a) It is the policy of the state of Vermont to ~~insure~~ ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

(b) It is further the policy of the state of Vermont that the health care system should:

(1) Maintain and improve the quality of health care services offered to Vermonters.

(2) ~~Promote market or other~~ Utilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Vermonters' incomes or the moneys available for other services required to insure the health, safety, and welfare of Vermonters.

(3) Encourage regional and local participation in decisions about health care delivery, financing, and provider supply.

(4) ~~Promote market or other~~ Utilize planning, market, and other mechanisms that will achieve rational allocation of health care resources in the state.

(5) Facilitate universal access to preventive and medically necessary health care.

(6) Support efforts to integrate mental health and substance abuse services with overall medical care.

Sec. 9. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

* * *

(6) "Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision ~~9432(7)~~ 9432(10) of this title, except health maintenance organizations.

* * *

(10) "Health resource allocation plan" means the plan ~~developed~~ adopted by the commissioner ~~and adopted by the governor~~ of banking, insurance, securities, and health care administration under section 9405 of this title.

(11) "Home health agency" means a for-profit or ~~not-for-profit~~ nonprofit health care facility providing part-time or intermittent skilled nursing services and at least one of the following other therapeutic services made available on a visiting basis, in a place of residence used as a patient's home: physical, speech, or occupational therapy; medical social services; home health aide services; or other non-nursing therapeutic services, including the services of nutritionists, dieticians, psychologists, and licensed mental health counselors.

* * *

(13) "Hospital" means an acute care hospital licensed under chapter 43 of this title ~~and falling within one of the following four distinct categories, as defined by the commissioner by rule:~~

~~(A) Category A1: tertiary teaching hospitals.~~

~~(B) Category A2: regional medical centers.~~

~~(C) Category A3: community hospital systems.~~

~~(D) Category A4: critical access hospitals~~.

* * *

* * * Certificate of Need * * *

Sec. 10. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the commissioner. For purposes of this subsection, a "new health care project" includes the following:

* * *

(5) The offering of a health care service or technology having an annual operating expense which exceeds $500,000.00 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed, either on a fixed or a mobile basis, by the health care facility within the previous three fiscal years.

(6) The construction, development, purchase, lease, or other establishment of an ambulatory surgical center.

* * *

Sec. 10a. 18 V.S.A. § 9434(b)(3) is amended to read:

(3) The offering of a health care service or technology having an annual operating expense which exceeds $500,000.00 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed, either on a fixed or a mobile basis, by the hospital within the previous three fiscal years.

Sec. 11. 18 V.S.A. § 9440(c)(2) is amended to read:

(c) The application process shall be as follows:

* * *

(2)(A) Prior to filing an application for a certificate of need, an applicant shall file an adequate letter of intent with the commissioner no less than 30 days or, in the case of review cycle applications under section 9439 of this title, no less than 45 days prior to the date on which the application is to be filed. The letter of intent shall form the basis for determining the applicability of this subchapter to the proposed expenditure or action. A letter of intent shall become invalid if an application is not filed within six months of the date that the letter of intent is received or, in the case of review cycle applications under section 9439 of this title, within such time limits as the commissioner shall

establish by rule. Except for requests for expedited review under subdivision (5) of this subsection, public notice of such letters of intent shall be provided in newspapers having general circulation in the region of the state affected by the letter of intent. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application or petition to intervene must be filed. In addition, a copy of the public notice shall be sent to the clerk of the municipality in which the health care facility is located. Upon receipt, the clerk shall post the notice in or near the clerk's office and in at least two other public places in the municipality.

(B) Applicants who agree that their proposals are subject to jurisdiction pursuant to section 9434 of this title shall not be required to file a letter of intent pursuant to subdivision (A) of this subdivision (2) and may file an application without further process. Public notice of the application shall be provided upon filing as provided for in subdivision (A) of this subdivision (2) for letters of intent.

Sec. 12. 18 V.S.A. § 9443 is amended to read:

§ 9443. EXPIRATION OF CERTIFICATES OF NEED

~~The commissioner shall adopt rules providing for the expiration of certificates of need.~~

(a) Unless otherwise specified in the certificate of need, a project shall be implemented within five years or the certificate shall be invalid.

(b) No later than 180 days before the expiration date of a certificate of need, an applicant that has not yet implemented the project approved in the certificate of need may petition the commissioner for an extension of the implementation period. The commissioner may grant an extension in his or her discretion.

(c) Certificates of need shall expire on the date the commissioner accepts the final implementation report filed in connection with the project implemented pursuant to the certificate.

(d) An action or expenditure that is related to a service or expenditure that was the subject of a certificate of need shall not be considered a material or nonmaterial change to that project if the original certificate of need expired, as provided in this section, at least two years before the action is proposed. The proposed action shall require a certificate of need only if the change itself would be considered a new health care project under section 9434 of this title.

Sec. 13. 18 V.S.A. § 9432 is amended to read:

§ 9432. DEFINITIONS

As used in this subchapter:

* * *

(2) "Annual operating expense" means that expense which, by generally accepted accounting principles, is incurred by a new health care service during

the first fiscal year in which the service is in full operation after completion of the project.

~~(2)~~(3) "Applicant" means a person who has submitted an application or proposal requesting issuance of a certificate of need.

~~(3)~~(4) "Bed capacity" means the number of licensed beds operated by the facility under its most current license under chapter 43 of this title and of facilities under chapter 71 of Title 33.

~~(4)~~(5) "Capital expenditure" means an expenditure for the plant or equipment which is not properly chargeable as an expense of operation and maintenance and includes acquisition by purchase, donation, leasehold expenditure, or lease which is treated as capital expense in accordance to the accounting standards established for lease expenditures by the Financial Accounting Standards Board, calculated over the length of the lease for plant or equipment, and includes assets having an expected life of at least three years. A capital expenditure includes the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment.

~~(5)~~(6) "Construction" means actual commencement of any construction or fabrication of any new building, or addition to any existing facility, or any expenditure relating to the alteration, remodeling, renovation, modernization,

improvement, relocation, repair, or replacement of a health care facility, including expenditures necessary for compliance with life and health safety codes.

~~(6)~~(7) "To develop," when used in connection with health services, means to undertake activities which on their completion will result in the offer of a new health care project, or the incurring of a financial obligation in relation to the offering of a service.

~~(7)~~(8) "Health care facility" means all persons or institutions, including mobile facilities, whether public or private, proprietary or not for profit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any institution operated by religious groups relying solely on spiritual means through prayer for healing, but shall include but is not limited to:

* * *

~~(8)~~(9) "Health care provider" means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment, or confinement.

~~(9)~~(10) "Health services" mean activities and functions of a health care facility that are directly related to care, treatment, or diagnosis of patients.

(11) "Material change" means a change to a health care project for which a certificate of need has been issued which:

(A) constitutes a new health care project as defined in section 9434 of this title; or

(B) increases the total costs of the project by more than 10 percent of the approved amount.

(12) "Nonmaterial change" means a modification that does not meet the cost threshold of a material change as defined in subdivision (11) of this section, but otherwise modifies the kind, scope, or capacity of a project for which a certificate of need has been granted under this subchapter.

~~(10)~~(13) "Obligation" means an obligation for a capital expenditure which is deemed to have been incurred by or on behalf of a health care facility or health maintenance organization.

~~(11)~~(14) "To offer," when used in connection with health services, means that a health care provider holds itself out as capable of providing, or as having the means for the provision of, specified health services.

~~(12) "Annual operating expense" means that expense which, by generally accepted accounting principles, is incurred by a new health care service during the first fiscal year in which the service is in full operation after completion of the project.~~

Sec. 14. 18 V.S.A. § 9444 is amended to read:

§ 9444. REVOCATION OF CERTIFICATES; MATERIAL CHANGE

(a) The commissioner may revoke a certificate of need for substantial noncompliance with the scope of the project as designated in the application, or for failure to comply with the conditions set forth in the certificate of need granted by the commissioner.

(b)(1) In the event that after a project has been approved, its proponent wishes to materially change ~~the scope or cost of~~ the approved project, all such changes are subject to review under this subchapter. ~~If a change itself would be considered a new health care project as defined in section 9434 of this title, it shall be considered as material. If the change itself would not be considered a new health care project as defined in section 9434 of this title, the commissioner may decide not to review the change and shall notify the applicant and all parties of such decision. Where the commissioner decides not to review a change, such change will be deemed to have been granted a certificate of need.~~

(2) Applicants shall notify the commissioner of a nonmaterial change to the approved project. If the commissioner decides to review a nonmaterial change, he or she may provide for any necessary process, including a public hearing, before approval. Where the commissioner decides not to review a change, such change will be deemed to have been granted a certificate of need.

* * *CONSUMER INFORMATION* * *

Sec. 15. CONSUMER HEALTH CARE PRICE AND QUALITY INFORMATION; WEBSITE

On the front page of Vermont's state government website, the secretary of administration or designee shall prominently post a link, worded in a clear and understandable manner, to the price and quality information for consumers. The price and quality information shall be available in an easy-to-use format that is understandable to the average consumer.

Sec. 16. IMPLEMENTATION

Sec. 12 of this act, amending section 9443 of Title 18, shall apply to certificates of need issued on or after July 1, 2009.