S.255

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

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

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.]

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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.

~~(c)~~(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, 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.