Section by section summary of H.812, An act relating to implementing an all-payer model and oversight of accountable care organizations
Senate Health and Welfare Committee Amendment
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Sec. 1. All-payer model; Medicare agreement

- The Green Mountain Care Board (GMCB) and Agency of Administration can only enter into an agreement with CMS to waive Medicare provisions if the agreement:
  - is consistent with the Act 48 principles of health care reform
  - preserves Medicare consumer protections
  - allows providers to choose whether to participate in an ACO
  - allows Medicare patients to choose among providers
  - includes outcome measures for population health
  - continues to provide Medicare payments directly to providers or ACOs without State involvement

Sec. 2. All-payer model

- In order to implement an all-payer model, the GMCB and Agency of Administration must ensure that the model:
  - maintains consistency with the Act 48 principles
  - continues to provide Medicare payments directly to providers or ACOs without State involvement
  - maximizes alignment between Medicare, Medicaid, and commercial payers, including:
    - what is included in the calculation of total cost of care
    - attribution and payment mechanisms
    - patient protections
    - care management mechanisms
    - provider reimbursement processes
  - strengthens and invests in primary care
  - incorporates social determinants of health
  - follows federal and State laws on parity of mental health and substance abuse treatment and integrates them into the overall health system
  - includes a process for integrating community-based providers and their funding streams into a transformed, fully integrated health care system that may include transportation and housing
  - continues to prioritize local and regional health care provider collaboratives
  - pursues integrated approach to data collection, analysis, exchange, reporting
  - allows providers to choose whether to participate in ACOs
  - evaluates access to care, quality of care, patient outcomes, and social determinants of health
  - requires processes and shared protocols for shared decision making
  - supports coordination of care and care transitions through use of technology
  - ensures, with the Office of the Health Care Advocate (HCA), that robust patient grievance and appeals processes are available

Sec. 3. Definition of "accountable care organization" or "ACO"

- Adds a definition of "accountable care organization" or "ACO" to GMCB statutes

Sec. 4. Green Mountain Care Board duties

- Adds GMCB duty to promote seamless care, administration, and services delivery
- Adds GMCB duty to adopt by rule ACO standards, including reporting requirements, patient protections, solvency, and ability to assume financing risk

Sec. 5. Oversight of ACOs

- Requires all ACOs to obtain and maintain GMCB certification in order to be eligible to receive payments from Medicaid or commercial insurance through a payment reform program or initiative
- Requires the GMCB to adopt rules to establish standards for certifying ACOs
    - Board must ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation
- In order to certify an ACO, GMCB must ensure the following criteria are met:
    - the ACO's governance, leadership, and management structure is transparent, represents its providers and patients, includes a consumer advisory board and consumer input
    - the ACO has appropriate mechanisms to provide, manage, and coordinate high-quality health care services for its patients
    - the ACO has appropriate mechanisms to receive and distribute payments to its providers
    - the ACO has appropriate mechanisms and criteria for accepting providers to participate in the ACO
    - the ACO has appropriate mechanisms to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies
    - the ACO's participating providers have capacity for meaningful participation in health information exchanges
    - the ACO has performance standards and measures to evaluate quality and utilization of care
    - the ACO does not restrict information its providers can give to their patients
    - the ACO's providers engage patients in shared decision making
    - the ACO offers assistance to consumers, including a consumer phone line, complaint resolution, an accessible mechanism to explain how ACOs work, contact information for the HCA, sharing deidentified information with the HCA at least twice each year
    - the ACO collaborates with providers outside its financial model
    - the ACO does not interfere with patients' choice of their own providers under their health plan, does not reduce covered services, and does not increase patient cost-sharing
    - the ACO's governing body meetings include a public session
    - establishment and operation of the ACO does not diminish access or increase delays for the population and area served

    - the ACO has appropriate mechanisms to assess legal and financial vulnerabilities
    - the ACO has a financial guarantee sufficient to cover its potential losses
- The GMCB must adopt rules to establish standards and processes for reviewing, modifying, and approving budgets of ACOs with 10,000 or more attributed lives in Vermont, including reviewing and considering:
    - information about utilization of health care services delivered by the ACO's participating providers
    - goals and recommendations of the health resource allocation plan (HRAP)
    - expenditure analysis for the prior year and for the year under review
    - character, competence, fiscal responsibility, and soundness of the ACO and its principals
    - reports from professional review organizations
    - ACO's efforts to avoid duplicating high-quality services being provided by community-based providers; integration of efforts with Blueprint for Health
    - extent to which the ACO provides incentives for systemic investments to strengthen primary care
    - extent to which the ACO provides incentives for system investments in social determinants of health
    - extent to which the ACO provides incentives for preventing and address impacts of adverse childhood experiences (ACEs)
    - public comment on the ACO's costs and use and on its proposed budget
    - information from meetings with the ACO about its proposed budget
    - information on the ACO's administrative costs
    - Medicaid cost-shift
    - extent to which the ACO makes its costs transparent and easy to understand
- The HCA has the right to intervene in any ACO budget review
- Information filed by an ACO must be made available to the public upon request
- GMCB must supervise the parties as necessary to avoid federal antitrust violations

Sec. 6. GMCB rulemaking

- The GMCB must adopt rules by January 1, 2018 governing the oversight of ACOs
- By January 15, 2017, GMCB must provide an update on the rulemaking process and its vision for their implementation to the committees of jurisdiction

Sec. 7. DFR and DVHA rulemaking; denial of service

- The Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) must ensure their rules protect against wrongful denial of services for covered individuals attributed to an ACO
- DFR and DVHA may amend their rules to ensure that the Medicaid and insurance grievance and appeals processes are appropriate to an ACO structure

Sec. 8. Transition and implementation

- Prior to January 1, 2018, if the GMCB and Agency of Administration pursue an all-payer model, they must do so in a manner that works toward meeting the criteria in the bill for an all-payer model.

- By January 1, 2018, if the GMCB and Agency of Administration pursue an all-payer model, they must implement it in accordance with the criteria in the bill.
- Prior to January 1, 2018, the GMCB must oversee ACOs to encourage them to comply with the criteria in the bill and establish budgets that reflect the bill.
- By January 1, 2018, the GMCB must begin certifying ACOs that meet criteria in the bill and only approve budgets after review and consideration of criteria in the bill.

Secs. 9-10. Reducing administrative burden on providers

- Sec. 9 - to extent funds are available, GMCB may examine effectiveness of existing requirements for health care professionals and evaluate alternatives
- Sec. 10 - directs GMCB to establish a primary care professional advisory group to help the GMCB address the administrative burden on primary care professionals
    - GMCB will provide an update on the group in its annual report
    - Per diem and reimbursement of expenses up to $5,000 per year
    - Advisory group sunsets on July 1, 2018

Sec. 11. Agency of Human Services' contracts; report

- AHS, in consultation with stakeholders, must report by January 1, 2017 to committees of jurisdiction regarding:
    - amount and type of performance measures and other evaluations used in FY 2016 and 2017 AHS contracts with designated agencies, specialized service agencies, and preferred partners
    - how AHS funding of these service providers affects access and quality
    - how AHS funding for these service providers affects staff compensation in relation to public and private sector pay for the same services
- Report must include a plan developed with stakeholders to implement value-based payments for service providers that improve access and quality of care, including long-term financial sustainability
    - must describe interaction of value-based Medicaid payments to service providers from AHS with Medicaid payments to these providers from ACOs

Sec. 12. Medicaid pathway; report

- Requires AHS, in consultation with Director of Health Care Reform and affected providers, to create a process for payment and delivery reform for Medicaid providers and services, which must:
    - Address Medicaid payments to affected providers
    - Focus on services not in Medicaid equivalent of Medicare Parts A & B
    - Try to integrate providers into all-payer model, other payment and delivery system reform initiatives
- Annual report for the next five years on results of this process must address:
    - All Medicaid payments to affected providers
    - Changes to reimbursement methodology and services impacted
    - Efforts to integrate providers into all-payer model, other initiatives
    - Any changes to quality measure collection and identifying alignment efforts and analyses

- o The interrelationship of results-based accountability initiatives with the quality measures

Sec. 13. Medicaid advisory rate case for ACO services

- Requires GMCB to review by December 31, 2016 any all-inclusive population-based payment arrangement between DVHA and an ACO for calendar year 2017
- Specifies elements of GMCB's review; review is nonbinding on AHS

Sec. 14. Multi-year budgets for ACOs

- Directs GMCB to consider appropriate role, if any, of multi-year budgets for ACOS
- Report with findings and recommendations due January 15, 2017

Sec. 15. Multi-year budgets for Medicaid

- Directs JFO and Dept of Finance and Management to consider appropriate role, if any, of multi-year budgets for Medicaid
- Report with findings and recommendations due March 1, 2017

Sec. 16. All-payer model; alignment

- Requires GMCB to present information to legislative committees by January 15, 2017 on status of efforts to achieve alignment between the payers

Secs. 17-19. Nutrition procurement standards for State government

- Sec. 17 - findings about likely impacts of improving nutritional quality of food sold or provided by the State on public property
- Sec. 18 - Requires Dept of Health to establish and post nutrition procurement standards on its website; must review at least every five years and amend if needed
    - o Requires all food and beverages purchased, sold, or served by the State or on behalf of the State to meet the minimum nutrition procurement standards
    - o Requires all State-owned or -operated vending machines, food or beverage vendors, and cafeterias on State properties to display nutritional labeling
- Sec. 19 - requires existing contracts with food and beverage vendors to be modified to the extent possible to comply with the nutrition procurement standards

Sec. 20. Universal primary care and Dr. Dynasaur 2.0

- Expresses legislative intent to move forward with universal primary care or expansion of Dr. Dynasaur up to age 26, or both
- <u>Universal Primary Care</u> **-** Requires Secretary of Administration to:
    - o provide results of a literature review of savings in universal health care programs over time from having universal primary care
    - o determine insurance market impacts of universal primary care
    - o report on primary care models through all-payer model to provide guidance on appropriate reimbursement rates
- Secretary of Administration must provide summary of findings to JFO by November 15, 2016; JFO will do independent review, provide feedback by December 1, 2016; final report due to HROC, JFC, and standing committees by December 15, 2016

- Dr. Dynasaur 2.0 - Requires Secretary of Administration to analyze financing implications of expanding Dr. Dynasaur to all Vermonters up to age 26, including:
  - estimated program costs for 5-year period beginning January 1, 2019
  - increased provider reimbursement rates above Medicare rates
- Report due to standing committees by January 15, 2017 with analysis of costs and potential plans for financing

Sec. 21. Exchange sustainability analysis

- Requires JFO to contract out for analysis, with report due December 1, 2016, on current functionality and long-term sustainability of Vermont Health Benefit Exchange technology, including:
  - Recommendations for improvements
  - Evaluation of investment value of existing components and assessment of feasibility and cost-effectiveness of leveraging existing parts of Exchange for larger, integrated eligibility system
  - Comparison of investments to ensure sustainable State-based Exchange with investments to transition to fully or partially federally facilitated Exchange
- HROC and JFC to provide ongoing oversight and review of analysis and report

Secs. 22-24. Health Research Commission

- Sec. 22 - Establishes Health Research Commission to coordinate and provide oversight over legislative policy research, studies, and evaluations related to health care delivery, regulation, and reform
- Two members of the House, two members of the Senate, one Governor's appointee
- Commission will employ professional and secretarial staff and receive administrative, fiscal, and legal support from JFO and Legislative Council
- Commission will direct, supervise, and coordinate the work of its staff, including:
  - policy research and evaluation services related to health care for studies required by legislation enacted by the General Assembly
  - a continuing review of Vermont's health care reform initiatives
  - monitoring GMCB activities on behalf of the General Assembly
- Sec. 23 - transfers up to three positions from Agency of Administration to General Assembly by July 1, 2016 to provide staff for the Health Research Commission
- Sec. 24 - requires initial appointments to Commission by August 15, 2016

Secs. 25-27. Appropriations

- Sec. 25 - Appropriates $240,000 for universal primary care and Dr. Dynasaur 2.0 studies and $250,000 for the Health Research Commission
- Sec. 26 - reverts amounts from FY16 budget for Exchange sustainability analysis
- Sec. 27 - appropriates and allocates amounts for Exchange sustainability analysis based on House-passed FY17 budget
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Sec. 28. Repeal of Health Reform Oversight Committee

- Repeals Health Reform Oversight Committee on January 1, 2017

Sec. 29. Effective dates