TO THE HONORABLE SENATE:

The Committee on Health & Welfare to which was referred House Bill No. 812 entitled "An act relating to implementing an all-payer model and oversight of accountable care organizations" respectfully reports that it has considered the same and recommends that the Senate propose to the House that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * All-Payer Model * * *

Sec. 1. ALL-PAYER MODEL; MEDICARE AGREEMENT

The Green Mountain Care Board and the Agency of Administration shall only enter into an agreement with the Centers for Medicare and Medicaid Services to waive provisions under Title XVIII (Medicare) of the Social Security Act if the agreement:

(1) is consistent with the principles of health care reform expressed in 18 V.S.A. § 9371, to the extent permitted under Section 1115A of the Social Security Act and approved by the federal government;

(2) preserves the consumer protections set forth in Title XVIII of the Social Security Act, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes;

(3) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(4) allows Medicare patients to choose their providers;

(5) includes outcome measures for population health; and

(6) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont.

Sec. 2. 18 V.S.A. chapter 227 is added to read:

CHAPTER 227. ALL-PAYER MODEL

§ 9551. ALL-PAYER MODEL

In order to implement a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, **other State-funded health care programs, (Richter)** and commercial insurance using a common methodology that may include population-based payments, the Green Mountain Care Board and Agency of Administration shall ensure that the model:

(1) maintains consistency with the principles established in section 9371 of this title;

(2) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont;

(3) maximizes alignment between Medicare, Medicaid, **other State-funded health care programs, (Richter)** and commercial payers to the extent permitted under federal law and waivers from federal law, including:

(A) what is included in the calculation of the total cost of care;

(B) attribution and payment mechanisms;

(C) patient protections;

(D) care management mechanisms; and

(E) provider reimbursement processes;

(4) strengthens and invests in primary care;

(5) incorporates social determinants of health;

(6) adheres to federal and State laws on parity of mental health and substance abuse treatment, integrates mental health and substance abuse treatment systems into the overall health care system, and does not manage mental health or substance abuse care separately from other health care;

(7) includes a process for integration of community-based providers, including home health agencies, mental health agencies, development disability service providers, emergency medical service providers, and area agencies on aging, and their funding streams, into a transformed, fully integrated health care system;

(8) continues to prioritize the use, where appropriate, of existing local and regional collaboratives of community health providers that develop

integrated health care initiatives to address regional needs and evaluate best practices for replication and return on investment;

(9) pursues an integrated approach to data collection, analysis, exchange, and reporting to simplify communication across providers and drive quality improvement and access to care;

(10) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(11) evaluates access to care, quality of care, patient outcomes, and social determinants of health;

(12) requires processes and protocols for shared decision making between the patient and his or her health care providers that take into account a patient's unique needs, preferences, values, and priorities, including use of decision support tools and shared decision-making methods with which the patient may assess the merits of various treatment options in the context of his or her values and convictions, and by providing patients access to their medical records and to clinical knowledge so that they may make informed choices about their care;

(13) supports coordination of patients' care and care transitions through the use of technology, with patient consent, such as sharing electronic summary records across providers and using telemedicine, home telemonitoring, and other enabling technologies; and

(14) ensures, in consultation with the Office of the Health Care Advocate, that robust patient grievance and appeal protections are available.

* * * Oversight of Accountable Care Organizations * * *

Sec. 3. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

* * *

(16) "Accountable care organization" and "ACO" means an organization of health care providers that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it.

Sec. 4. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

* * *

(13) Adopt by rule pursuant to 3 V.S.A. chapter 25 standards for accountable care organizations, including reporting requirements, patient protections, solvency and ability to assume financial risk, and other matters the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter.

Sec. 5. 18 V.S.A. § 9382 is added to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a) In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization with 10,000 or more attributed lives in Vermont shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations, which may include consideration of acceptance of accreditation by the National Committee for Quality Assurance or another national accreditation organization for any of the criteria set forth in this section. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

(1) the ACO's governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input;

(2) the ACO has established appropriate mechanisms to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO;

(3) the ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers;

(4) the ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination and are related to the needs of the ACO and the patient population served;

(5) the ACO has established mechanisms to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, and effective health care services;

(6) the ACO has the capacity for meaningful participation in health information exchanges;

(7) the ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers;

(8) the ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health;

(9) the ACO's participating health care providers engage their patients in shared decision making to ensure their awareness and understanding of their treatment options and the related risks and benefits of each;

(10) the ACO has an accessible mechanism for explaining how ACOs work; provides contact information for the Office of the Health Care Advocate; maintains a consumer telephone line for complaints and grievances from attributed patients; responds and makes best efforts to resolve complaints and grievance from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan; and share deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually;

(11) the ACO collaborates with providers not included in its financial model, including home- and community-based providers and dental health providers;

(12) the ACO does not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the ACO; does not reduce covered services; and does not increase patient cost sharing;

(13) meetings of the ACO's governing body include a public session at which all business that is not confidential or proprietary is conducted and members of the public are provided an opportunity to comment;

(14) the impact of the ACO's establishment and operation does not diminish access to any health care service for the population and area it serves; and

(15) the ACO has in place a financial guarantee sufficient to cover its potential losses.

(b)(1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving ACO budgets. In its review, the Board shall review and consider:

(A) information regarding utilization of the health care services delivered by health care providers participating in with the ACO;

(B) the goals and recommendations of the health resource allocation plan created in chapter 221 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

(E) any reports from professional review organizations;

(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area;

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand

capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

(H) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

(I) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(J) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(K) information on the ACO's administrative costs, as defined by the Board;

(L) the effect, if any, of Medicaid reimbursement rates on the rates for other payers; and

(M) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive.

(2) The Office of the Health Care Advocate shall have the right to intervene in any ACO budget review under this subsection. As an intervenor, the Office of the Health Care Advocate shall receive copies of all materials in the record and may:

(A) ask questions of any participant in the Board's ACO budget review;

(B) submit written comments for the Board's consideration; and

(C) provide testimony in any hearing held in connection with the Board's ACO budget review.

(c) The Board's rules shall include requirements for submission of information and data by ACOs and their participating providers as needed to evaluate an ACO's success. They may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

(d) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public upon request, provided that individual patients or health care providers shall not be directly or indirectly identifiable.

(e) To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

* * * Rulemaking * * *

Sec. 6. GREEN MOUNTAIN CARE BOARD; RULEMAKING

On or before January 1, 2018, the Green Mountain Care Board shall adopt rules governing the oversight of accountable care organizations pursuant to 18 V.S.A. § 9382. On or before January 15, 2017, the Board shall provide an update on its rulemaking process and its vision for implementing the rules to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 7. DENIAL OF SERVICE; RULEMAKING

The Department of Financial Regulation and the Department of Vermont Health Access shall ensure that their rules protect against wrongful denial of services under an insured's or Medicaid beneficiary's health benefit plan for an insured or Medicaid beneficiary attributed to an accountable care organization. The Departments may amend their rules as necessary to ensure that the grievance and appeals processes in Medicaid and commercial health benefit plans are appropriate to an accountable care organization structure.

* * * Implementation Provisions * * *

Sec. 8. TRANSITION; IMPLEMENTATION

(a) Prior to January 1, 2018, if the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, they shall develop and implement the model in a manner that works toward meeting the criteria established in 18 V.S.A. § 9551. Through its authority over payment reform pilot projects under 18 V.S.A. § 9377, the Board shall also oversee the development and operation of accountable care organizations in order to encourage them to achieve compliance with the criteria established in 18 V.S.A. § 9382(a) and to establish budgets that reflect the criteria set forth in 18 V.S.A. § 9382(b).

(b) On or before January 1, 2018, the Board shall begin certifying accountable care organizations that meet the criteria established in 18 V.S.A. § 9382(a) and shall only approve accountable care organization budgets after

review and consideration of the criteria set forth in 18 V.S.A. § 9382(b). If the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, then on and after January 1, 2018 they shall implement the all-payer model in accordance with 18 V.S.A. § 9551.

* * * **Primary Care Professional Advisory Group (VMS)** * * *

Sec. 9. 18 V.S.A. § 9374(e) is amended to read:

(e)(1)**(A)** The Board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the Board. Members of ~~such~~ **the** advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(B) The Board shall establish a primary care professional advisory group to provide input and recommendations to the Board. The Board may seek assistance for the advisory group from organizations representing primary care professionals. Members of the advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A.

§ 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year. The Board shall seek the input from the primary care professional advisory group to address issues related to the administrative burden facing primary care professionals, including:

(i) identifying circumstances in which existing reporting requirements for primary care professionals may be replaced with more meaningful measures that require minimal data entry;

(ii) creating opportunities to reduce requirements for primary care professionals to provide prior authorization for their patients to receive radiology, medication, and specialty services; and

(iii) developing a uniform hospital discharge summary for use across the State.

(2) The Board may establish additional advisory groups and subcommittees as needed to carry out its duties. The Board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

(3) To the extent funds are available, the Board shall support research that examines the effectiveness of existing requirements for health care professionals, such as quality measures and prior authorization, and evaluates alternatives that improve quality, reduce costs, and reduce administrative burden.

* * * Universal Primary Care and Dr. Dynasaur 2.0 * * *

Sec. 10. UNIVERSAL PRIMARY CARE; DR. DYNASAUR 2.0 (Agency of Administration no-cost language)

(a) It is the intent of the General Assembly to move forward with implementation of universal primary care for all Vermonters or expansion of Dr. Dynasaur to all Vermont residents up to 26 years of age, or both.

(b) In order to determine a path forward toward implementing universal primary care in Vermont, the Agency of Administration shall:

(1) create a menu of tax options available to fund universal primary care, based on the cost estimates included in the report entitled Cost Estimates of Universal Primary Care submitted to the General Assembly by the Agency of Administration on December 16, 2015;

(2) provide the results of a literature review of any savings realized by universal health care programs over time that are attributable to the availability of universal access to primary care; and

(3) report on primary care payment models created through the development of the all-payer model in order to enable legislators to estimate appropriate reimbursement amounts for health care providers delivering primary care services.

(c) In order to determine a path forward toward expanding Dr. Dynasaur to all Vermont residents up to 26 years of age, the Agency of Administration shall study:

(1) the incremental and administrative costs of expanding Dr. Dynasaur;

(2) the menu of tax options available to fund the Dr. Dynasaur expansion; and

(3) the results of a literature review of the savings over time, if any, attributable to expanded health care coverage.

(d) On or before December 15, 2016, the Agency of Administration shall report the results of the universal primary care and Dr. Dynasaur 2.0 studies required by this section to the House Committees on Appropriations, on Health Care, and on Ways and Means and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

* * * Exchange Sustainability Analysis * * *

Sec. 11. VERMONT HEALTH BENEFIT EXCHANGE TECHNOLOGY; SUSTAINABILITY ANALYSIS; REPORT;

(a)(1) The Joint Fiscal Office, in collaboration with one or more independent third parties pursuant to contracts negotiated for that purpose, shall conduct an analysis and provide a report to the General Assembly on or before December 1, 2016 on the current functionality and

long-term sustainability of the technology for Vermont's Health Benefit Exchange, including a review of the deficiencies in Vermont Health Connect functionality and the integration, connectivity, and business logic of each as they pertain to both the back-end systems and the user interface of Vermont Health Connect.

(2) The analysis shall provide recommendations for improving the function, efficiency, reliability, operations, and customer experience of the technology going forward.

(3) The report shall include an evaluation of the investment value of existing components of the Exchange technology and the contractor's assessment of the feasibility and cost-effectiveness of leveraging existing components of the Vermont Health Benefit Exchange as part of the technology for a larger, integrated eligibility system, including reviewing changes other states have made to the Exchange components of their technology infrastructure.

(4) The analysis and report shall provide a comparison of the investments required to ensure a sustainable State-based Exchange through further investment in Vermont Health Connect's current technology, including any opportunities to build on other states' Exchange technology, with the estimated investments that would be required to transition to a fully or partially federally facilitated Exchange.

(b) In conducting the analysis and report pursuant to this section, and in preparing any requests for proposals from independent third parties, the Joint Fiscal Office shall consult with health insurers offering qualified health plans on Vermont Health Connect.

(c) The General Assembly shall provide ongoing oversight and review of the analysis and report.

* * * Effective Dates * * *

Sec. **12**. EFFECTIVE DATES

(a) Secs. 1 (Medicare waiver), 6–7 (rulemaking), 8 (transition; implementation)**, 9 (primary care professional advisory group), 10 (universal primary care and Dr. Dynasaur 2.0 studies), 11 (Exchange sustainability analysis),** and this section shall take effect on passage.

(b) Secs. 2 (all-payer model) and 3–5 (ACOs) shall take effect on January 1, 2018.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE