H.912

An act relating to the health care regulatory duties of the Green Mountain Care Board

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

* * * State Health Improvement Plan; Health Resource Allocation Plan * * *

Sec. 1. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

* * *

(4) ~~Review~~ Publish on its website the Health Resource Allocation Plan ~~created in chapter 221 of this title~~ identifying Vermont's critical health needs, goods, services, and resources in accordance with section 9405 of this title.

* * *

Sec. 2. 18 V.S.A. § 9382(b)(1) is amended to read:

(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 the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

* * *

(B) ~~the goals and recommendations of~~ the Health Resource Allocation Plan ~~created in chapter 221 of this title~~ identifying Vermont's

critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;

* * *

Sec. 3. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

(10) "Health Resource Allocation Plan" means the plan ~~adopted~~ published by the Green Mountain Care Board ~~under section~~ in accordance with subsection 9405(b) of this title.

* * *

(16) "State Health Improvement Plan" means the plan developed under section 9405 of this title.

* * *

Sec. 4. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH IMPROVEMENT PLAN; HEALTH RESOURCE ALLOCATION PLAN

(a) ~~No later than January 1, 2005, the~~ The Secretary of Human Services or designee, in consultation with the Chair of the Green Mountain Care Board and health care professionals and after receipt of public comment, shall adopt a State Health Improvement Plan that sets forth the health goals and values for the State. The Secretary may amend the Plan as the Secretary deems necessary

and appropriate. The Plan shall include health promotion, health protection, nutrition, and disease prevention priorities for the State~~,~~; identify available human resources as well as human resources needed for achieving the State's health goals and the planning required to meet those needs~~,~~; and identify geographic parts of the State needing investments of additional resources in order to improve the health of the population. ~~The Plan shall contain sufficient detail to guide development of the State Health Resource Allocation Plan.~~ Copies of the Plan shall be submitted to members of the Senate ~~and House Committees~~ Committee on Health and Welfare ~~no later than January 15, 2005~~ and the House Committee on Health Care.

(b) ~~On or before July 1, 2005, the~~ The Green Mountain Care Board, in consultation with the Secretary of Human Services or designee, shall ~~submit to the Governor a four-year Health Resource Allocation Plan~~ publish on its website the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources, which shall be used to inform the Board's regulatory processes, cost containment and statewide quality of care efforts, health care payment and delivery system reform initiatives, and any allocation of health resources within the State. The Plan shall identify Vermont residents' needs ~~in~~ for health care services, programs, and facilities; the resources available and the additional resources that would be required to realistically meet those needs and to make access to those services, programs, and facilities affordable for consumers; and the priorities for addressing those

needs on a statewide basis. The Board may expand the Plan to include resources, needs, and priorities related to the social determinants of health. The Plan shall be revised periodically, but not less frequently than once every four years.

(1) ~~The Plan shall include~~ In developing the Plan, the Board shall:

(A) ~~A statement of principles reflecting the policies~~ consider the principles in section 9371 of this title, as well as the purposes enumerated in sections 9401 and 9431 of this ~~chapter to be used in allocating resources and in establishing priorities for health services.~~ title;

~~(B) Identification of the current supply and distribution of hospital, nursing home, and other inpatient services; home health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services, including primary care resources, federally qualified health centers, and free clinics; major medical equipment; and health screening and early intervention services.~~

~~(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the Green Mountain Care Board shall consider at least the following factors:~~

~~(i) the values and goals reflected in the State Health Plan;~~

~~(ii) the needs of the population on a statewide basis;~~

~~(iii) the needs of particular geographic areas of the State, as identified in the State Health Plan;~~

~~(iv) the needs of uninsured and underinsured populations;~~

~~(v) the use of Vermont facilities by out-of-state residents;~~

~~(vi) the use of out-of-state facilities by Vermont residents;~~

~~(vii) the needs of populations with special health care needs;~~

~~(viii) the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners;~~

~~(ix) the cost impact of these resource requirements on health care expenditures;~~

~~(x) the overall quality and use of health care services as reported by the Vermont Program for Quality in Health Care and the Vermont Ethics Network;~~

~~(xi) the overall quality and cost of services as reported in the annual hospital community reports;~~

~~(xii) individual hospital four-year capital budget projections; and~~

~~(xiii) the four-year projection of health care expenditures prepared by the Board~~

(B) identify priorities using information from:

(i) the State Health Improvement Plan;

(ii) the community health needs assessments required by section 9405a of this title;

(iii) available health care workforce information;

(iv) materials provided to the Board through its other regulatory processes, including hospital budget review, oversight of accountable care organizations, issuance and denial of certificates of need, and health insurance rate review; and

(v) the public input process set forth in this section;

(C) use existing data sources to identify and analyze the gaps between the supply of health resources and the health needs of Vermont residents and to identify utilization trends to determine areas of underutilization and overutilization; and

(D) consider the cost impacts of fulfilling any gaps between the supply of health resources and the health needs of Vermont residents.

(2) ~~In the preparation of the Plan, the~~ The Green Mountain Care Board shall convene the Green Mountain Care Board General Advisory Committee established pursuant to subdivision 9374(e)(1) of this title~~. The Green Mountain Care Board General Advisory Committee shall review drafts and~~ to provide recommendations to the Board during the Board's development of the Plan.

(3) The Board~~, with the Green Mountain Care Board General Advisory Committee, shall conduct at least five public hearings, in different regions of the State, on the Plan as proposed~~ shall receive and consider public input on the Plan at a minimum of one Board meeting and one meeting of the Advisory Committee and shall give interested persons an opportunity to submit their views orally and in writing. ~~To the extent possible, the Board shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the Board shall publish in the manner prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place and period during which to direct written comments to the Board. In addition, the Board may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.~~

(4) ~~The Board shall develop a mechanism for receiving ongoing public comment regarding the Plan and for revising it every four years or as needed~~ As used in this section:

(A) "Health resources" means investments into the State's health care system, including investments in personnel, equipment, and infrastructure necessary to deliver:

(i) hospital, nursing home, and other inpatient services;

(ii) ambulatory care, including primary care services, mental health services, health screening and early intervention services, and services for the prevention and treatment of substance use disorders;

(iii) home health services; and

(iv) emergency care, including ambulance services.

(B) "Health resources" may also include investments in personnel, equipment, and infrastructure necessary to address the social determinants of health.

~~(5) The Board in consultation with appropriate health care organizations and State entities shall inventory and assess existing State health care data and expertise, and shall seek grants to assist with the preparation of any revisions to the Health Resource Allocation Plan.~~

~~(6) The Plan or any revised plan proposed by the Board shall be the Health Resource Allocation Plan for the State after it is approved by the Governor or upon passage of three months from the date the Governor receives the proposed Plan, whichever occurs first, unless the Governor disapproves the proposed Plan, in whole or in part. If the Governor disapproves, he or she shall specify the sections of the proposed Plan which are objectionable and the changes necessary to meet the objections. The sections of the proposed Plan not disapproved shall become part of the Health Resource Allocation Plan.~~

Sec. 5. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

* * *

(b) In conjunction with budget reviews, the Board shall:

(1) review utilization information;

(2) consider ~~the goals and recommendations of~~ the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources developed pursuant to section 9405 of this title;

* * *

* * * Certificate of Need * * *

Sec. 6. 18 V.S.A. chapter 221, subchapter 5 is amended to read:

Subchapter 5. Health Facility Planning

§ 9431. POLICY AND PURPOSE

(a) It is declared to be the public policy of this State that the general welfare and protection of the lives, health, and property of the people of this State require that all new health care projects be offered or developed in a manner that avoids unnecessary duplication and contains or reduces increases in the cost of delivering services, while at the same time maintaining and improving the quality of and access to health care services, and promoting rational allocation of health care resources in the State; and that the need, cost, type, level, quality, and feasibility of providing any new health care project be subject to review and assessment prior to any offering or development.

(b) ~~In order to carry out the policy goals of this subchapter, the board shall adopt by rule by January 1, 2013, certificate of need procedural guidelines to assist in its decision making. The guidelines shall be consistent with the state health plan and the health resource allocation plan.~~ [Repealed.]

* * *

§ 9433. ADMINISTRATION

(a) The Green Mountain Care Board shall exercise such duties and powers as ~~shall be~~ necessary for the implementation of the certificate of need program as provided by and consistent with this subchapter. The Board shall issue or deny certificates of need and administer the program.

(b) The Board ~~may~~ shall adopt rules governing the review of certificate of need applications consistent with and necessary to the proper administration of this subchapter. All rules shall be adopted pursuant to 3 V.S.A. chapter 25.

(c) The Board shall consult with hospitals~~, nursing homes,~~ and other health care facilities, professional associations and societies, the Secretary of Human Services, the Office of the Health Care Advocate, and other interested parties in matters of policy affecting the administration of this subchapter.

(d) ~~The board shall administer the certificate of need program.~~ [Repealed.]

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

* * *

(b) 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 Board. For purposes of this subsection, a "new health care project" includes the following:

(1) The construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a hospital, for which the capital cost exceeds $3,000,000.00.

(2) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of ~~$1,000,000.00~~ $1,500,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment that are necessarily interdependent in the performance of their ordinary functions or that would constitute any health care facility included under subdivision 9432(8)(B) of this title, as determined by the Board, shall be considered together in calculating the amount of an expenditure. The Board's determination of functional interdependence of items of equipment under this subdivision shall have the effect of a final decision and is subject to appeal under section 9381 of this title.

(3) The offering of a health care service or technology having an annual operating expense that exceeds ~~$500,000.00~~ $1,000,000.00 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.

(4) The offering of any home health service.

* * *

(e) ~~Beginning January 1, 2013, and biannually thereafter, the~~ The Board may ~~by rule~~ periodically adjust the monetary jurisdictional thresholds contained in this section. In doing so, the Board shall reflect the same categories of health care facilities, services, and programs recognized in this

section. Any adjustment by the Board shall not exceed an amount calculated using the cumulative Consumer Price Index rate of inflation.

§ 9435. EXCLUSIONS

* * *

(f) Excluded from this subchapter are routine replacements of nonmedical equipment and fixtures, including furnaces, boilers, refrigeration units, kitchen equipment, heating and cooling units, and similar items. These replacements purchased by a hospital shall be included in the hospital's budget and may be reviewed in the budget process set forth in subchapter 7 of this chapter.

§ 9437. CRITERIA

A certificate of need shall be granted if the applicant demonstrates that the project serves the public good and the Board finds ~~that~~:

(1) ~~the application is consistent with the Health Resource Allocation Plan~~ The proposed project aligns with statewide health care reform goals and principles because the project:

(A) takes into consideration health care payment and delivery system reform initiatives;

(B) addresses current and future community needs in a manner that balances statewide needs, if applicable; and

(C) is consistent with appropriate allocation of health care resources, including appropriate utilization of services, as identified in the Health Resource Allocation Plan developed pursuant to section 9405 of this title.

(2) ~~the~~ The cost of the project is reasonable, because each of the following conditions is met:

(A) ~~the~~ The applicant's financial condition will sustain any financial burden likely to result from completion of the project~~;~~.

(B) ~~the~~ The project will not result in an undue increase in the costs of medical care or an undue impact on the affordability of medical care for consumers. In making a finding under this subdivision, the Board shall consider and weigh relevant factors, including:

(i) the financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures, and charges; and

(ii) whether the impact on services, expenditures, and charges is outweighed by the benefit of the project to the public~~; and~~.

(C) ~~less~~ Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate~~;~~.

(D) If applicable, the applicant has incorporated appropriate energy efficiency measures.

(3) ~~there~~ There is an identifiable, existing, or reasonably anticipated need for the proposed project ~~which~~ that is appropriate for the applicant to provide~~;~~.

(4) ~~the~~ The project will improve the quality of health care in the State or provide greater access to health care for Vermont's residents, or both~~;~~.

(5) ~~the~~ The project will not have an undue adverse impact on any other existing services provided by the applicant~~;~~.

(6) ~~the project will serve the public good;~~ [Repealed.]

(7) ~~the~~ The applicant has adequately considered the availability of affordable, accessible ~~patient~~ transportation services to the facility~~; and~~, if applicable.

(8) ~~if~~ If the application is for the purchase or lease of new Health Care Information Technology, it conforms with the ~~health information technology plan~~ Health Information Technology Plan established under section 9351 of this title.

§ 9439. COMPETING APPLICATIONS

* * *

(b) When a letter of intent to compete has been filed, the review process is suspended and the time within which a decision must be made as provided in subdivision 9440(d)(4) of this title is stayed until the competing application has been ruled complete or for a period of 55 days from the date of notification under subdivision 9440(c)(8) as to the original application, whichever is shorter.

* * *

(d) ~~The Board may, by rule, establish regular review cycles for the addition of beds for skilled nursing or intermediate care.~~ [Repealed.]

(e) ~~In the case of proposals for the addition of beds for skilled nursing or intermediate care, the Board shall identify in advance of the review the number of additional beds to be considered in that cycle or the maximum additional financial obligation to be incurred by the agencies of the State responsible for financing long-term care. The number of beds shall be consistent with the number of beds determined to be necessary by the Health Resource Management Plan or State Health Plan, whichever applies, and shall take into account the number of beds needed to develop a new, efficient facility.~~ [Repealed.]

(f) Unless an application meets the requirements of subsection 9440(e) of this title, the Board shall consider disapproving a certificate of need application for a hospital if a project was not identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan required under subdivision 9454(a)(6) of this title. The Board shall review all hospital four-year capital plans as part of the review under subdivision 9437(2)(B) of this title.

§ 9440. PROCEDURES

* * *

(c) The application process shall be as follows:

(1) ~~Applications shall be accepted only at such times as the Board shall establish by rule.~~ [Repealed.]

(2)(A) Prior to filing an application for a certificate of need, an applicant shall file an adequate letter of intent with the Board ~~no~~ not 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~~ after 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 Board shall establish by rule~~. The Board shall post public notice of such letters of intent on its website electronically within five business days ~~of~~ after receipt. The public 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.

* * *

(5)(A) An applicant seeking expedited review of a certificate of need application may simultaneously file with the Board a request for expedited review and an application. After receiving the request and an application, the Board shall issue public notice of the request and application in the manner set forth in subdivision (2) of this subsection.

(B)(i) At least 20 days after the public notice was issued, if no competing application has been filed and no party has sought and been granted,

nor is likely to be granted, interested party status, the Board~~, upon making a determination that~~ may issue a certificate of need in accordance with such expedited process as the Board deems appropriate, if the Board determines that:

(I) the proposed project ~~may be uncontested~~ appears likely not to be contested and does not substantially alter services~~, as defined by rule, or upon making a determination that~~; or

(II) the application relates to a health care facility affected by bankruptcy proceedings~~, may formally declare the application uncontested and may issue a certificate of need without further process, or with such abbreviated process as the Board deems appropriate~~.

(ii) Any order granting expedited review shall include the procedures and timelines that the Board shall follow for the expedited review process. If practicable, the expedited review process shall include acceptance of public comment until at least 10 days after the expedited application is complete.

(C) If a competing application is filed or a person ~~opposing the application~~ is granted interested party status, the applicant shall follow the certificate of need standards and procedures in this section, except that:

(i) a competing applicant or interested party may waive, in writing, the requirement for a public hearing; and

(ii) in the case of a health care facility affected by bankruptcy proceedings, the Board may, after notice and an opportunity to be heard ~~may,~~ issue a certificate of need with such abbreviated process as the Board deems appropriate, notwithstanding the contested nature of the application.

(D) The Board shall review applications for the following projects on an expedited basis, unless a request for intervention as a competing applicant or interested party is granted:

(i) the repair, renovation, or replacement of facility infrastructure, or a combination thereof that does not involve new construction; and

(ii) the routine replacement of medical equipment if the technology and capability of the new equipment is comparable to that of the replaced equipment.

(6) If an applicant fails to respond to an information request under subdivision (4) of this subsection within ~~six months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the Board shall establish by rule~~ 90 days, the application ~~will~~ shall be deemed inactive unless the applicant, within six months after the expiration of the 90-day period, requests in writing and shows good cause that the application should be reactivated, and the Board grants the request. If an applicant fails to respond to an information request within ~~12 months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the Board shall establish by rule~~ six months, the application ~~will~~

shall become invalid unless the applicant requests, and the Board grants, an extension.

(7) For purposes of this section, "interested party" status shall be granted to persons or organizations representing the interests of persons who demonstrate that they will be substantially and directly affected by the new health care project under review. Persons able to render material assistance to the Board by providing nonduplicative evidence relevant to the determination may be admitted in an amicus curiae capacity but shall not be considered parties. A petition seeking party or amicus curiae status ~~must~~ shall be filed ~~within 20 days following public notice of the letter of intent, or within 20 days following public notice that the petition is complete~~ not later than five business days after the application is complete. The Board shall grant or deny a petition to intervene under this subdivision within 15 days after the petition is filed. The Board shall grant or deny the petition within an additional 30 days upon finding that good cause exists for the extension. Once interested party status is granted, the Board shall provide the information necessary to enable the party to participate in the review process, including information about procedures, copies of all written correspondence, and copies of all entries in the application record.

(8) Once an application has been deemed to be complete, public notice of the application shall be provided ~~in newspapers having general circulation in the region of the State affected by the application~~ electronically on the Board's

website. The notice shall identify the applicant, the proposed new health care project, and the date ~~by which a competing application under section 9439 of this title or a petition to intervene must be filed~~, time, and location of any public hearing.

(9) The Office of the Health Care Advocate established under chapter 229 of this title or, in the case of nursing homes, the Long-Term Care Ombudsman's Office established under 33 V.S.A. § 7502, is authorized but not required to participate in any administrative or judicial review of an application under this subchapter and shall be considered an interested party in such proceedings upon filing a notice of intervention with the Board. Once either office files a notice of intervention pursuant to this subchapter, the Board shall provide that office with the information necessary to participate in the review process, including information about procedures, copies of all written correspondence, and copies of all entries in the application record for all certificate of need proceedings, regardless of whether expedited status has been granted.

(d) The review process shall be as follows:

(1) The Board shall review:

(A) the application materials provided by the applicant; and

(B) any information, evidence, or arguments raised by interested parties or amicus curiae, and any other public input.

(2) Except as otherwise provided in subdivision (c)(5) and subsection (e) of this section, the Board shall hold a public hearing during the course of a review.

(3) The Board shall make a final decision within 120 days after the date of notification under subdivision (c)(4) of this section. Whenever it is not practicable to complete a review within 120 days, the Board may extend the review period up to an additional 30 days. ~~Any review period may be extended with the written consent of the applicant and all other applicants in the case of a review cycle process.~~

* * *

(h) As used in this section, an application or proposed project is "contested" if one or more interested parties have intervened in the proceeding. If an interested party withdraws from the application or signifies its support of the application in writing before the Board renders a final decision, the application shall not be considered contested and the Board shall not be required to hold a public hearing on the application pursuant to subdivision (d)(2) of this section or issue a proposed decision pursuant to subdivision (d)(5) of this section.

* * *

§ 9440b. INFORMATION TECHNOLOGY; REVIEW PROCEDURES

Notwithstanding the procedures in section 9440 of this title, ~~upon approval by the General Assembly of the Health Information Technology Plan~~

~~developed under section 9351 of this title,~~ the Board shall establish by rule standards and expedited procedures for reviewing applications for the purchase or lease of health care information technology that otherwise would be subject to review under this subchapter. Such applications ~~may~~ shall not be granted or approved unless they are consistent with the Health Information Technology Plan developed under section 9351 of this title and the Health Resource Allocation Plan. ~~The Board's rules may include a provision requiring that applications be reviewed by the health information advisory group authorized under section 9352 of this title. The advisory group shall make written findings and a recommendation to the board in favor of or against each application.~~

§ 9441. FEES

* * *

(d) All fees collected pursuant to this section shall be deposited into the Green Mountain Care Board Regulatory and Administrative Fund established by subsection 9404(d) of this title and may be used by the Board to administer its obligations, responsibilities, and duties as required by law.

* * *

§ 9445. ENFORCEMENT

(a) Any person who offers or develops any new health care project within the meaning of this subchapter without first obtaining a certificate of need as required ~~herein~~ by this subchapter, or who otherwise violates any of the

provisions of this subchapter or any rule adopted or order issued pursuant to this subchapter, may be subject to one or both of the following administrative sanctions by the Board, after notice and an opportunity to be heard:

* * *

(b) In addition to all other sanctions, if any person offers or develops any new health care project without first having been issued a certificate of need or certificate of exemption for the project, or violates any other provision of this subchapter or any ~~lawful~~ rule adopted or order issued pursuant to this subchapter, the Board, the Office of the Health Care Advocate, the State Long-Term Care Ombudsman, and health care providers and consumers located in the State shall have standing to maintain a civil action in the Superior Court of the county in which such alleged violation has occurred, or in which such person may be found, to enjoin, restrain, or prevent such violation. Upon written request by the Board, it shall be the duty of the Vermont Attorney General to furnish appropriate legal services and to prosecute an action for injunctive relief to an appropriate conclusion, which shall not be reimbursed under subdivision (a)(2) of this section.

(c)(1) After notice and an opportunity for hearing, the Board may impose on a person who ~~knowingly~~ violates a provision of this subchapter~~,~~ or a rule adopted or order ~~adopted~~ issued pursuant to this subchapter ~~or 8 V.S.A. § 15~~, one or more of the following:

(A) a civil administrative penalty of ~~no~~ not more than ~~$40,000.00~~ $75,000.00, or in the case of a continuing violation, a civil administrative penalty of ~~no~~ not more than ~~$100,000.00~~ $200,000.00 or one-tenth of one percent of the gross annual revenues of the health care facility, whichever is greater, which shall not be reimbursed under subdivision (a)(2) of this section~~,~~ ~~and the Board may~~;

(B) an order that the ~~entity to~~ person cease and desist from further violations~~,~~; and ~~to take~~

(C) any such other actions necessary to remediate a violation.

(2) A person aggrieved by a decision of the Board under this ~~subsection~~ subchapter may appeal under section 9381 of this title.

(d) The Board shall adopt by rule criteria for assessing the circumstances in which a violation of a provision of this subchapter, a rule adopted pursuant to this subchapter, or the terms or conditions of a certificate of need require that a penalty under this section shall be imposed, and criteria for assessing the circumstances in which a penalty under this section may be imposed.

§ 9446. HOME HEALTH AGENCIES; GEOGRAPHIC SERVICE AREAS

The terms of a certificate of need relating to the boundaries of the geographic service area of a home health agency may be modified by the Board, in consultation with the Commissioner of Disabilities, Aging, and Independent Living, after notice and opportunity for hearing, or upon written application to the Board by the affected home health agencies or consumers,

demonstrating a substantial need ~~therefor~~ for the modification. Service area boundaries may be modified by the Board to take account of natural or physical barriers that may make the provision of existing services uneconomical or impractical, to prevent or minimize unnecessary duplication of services or facilities, or otherwise to promote the public interest. The Board shall issue an order granting such application only upon a finding that the granting of such application is consistent with the purposes of 33 V.S.A. chapter 63, subchapter 1A and the Health Resource Allocation Plan established under section 9405 of this title and after notice and an opportunity to participate on the record by all interested persons, including affected local governments~~, pursuant to rules adopted by the Board~~.

* * * Expenditure Analysis; Health Care Spending Estimate * * *

Sec. 7. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

* * *

(14) ~~"Unified health care budget" means the budget established in accordance with section 9375a of this title.~~ [Repealed.]

* * *

(17) "Health care spending estimate" means the estimate established in accordance with section 9383 of this title.

Sec. 8. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

* * *

(11) Develop the ~~unified~~ health care ~~budget~~ spending estimate pursuant to section ~~9375a~~ 9383 of this title.

* * *

Sec. 9. 18 V.S.A. § 9383 is added to read:

§ 9383. EXPENDITURE ANALYSIS; HEALTH CARE SPENDING ESTIMATE

(a) The Board shall develop annually an expenditure analysis and an estimate of future health care spending covering a period of at least two years. These analyses shall contain data and information as set forth in this section that the Board shall consider and incorporate into its work in furtherance of its statutory duties, including using them as tools in the Board's review of health insurance rates and the budgets of hospitals and accountable care organizations. The analyses shall:

(1) inform the Board's regulatory processes in order to promote improved health outcomes, health care cost containment, quality of care, access to care, and appropriate resource allocation; and

(2) quantify the total amount of money that has been and is estimated to be expended for all health care services provided by health care facilities and

providers in Vermont and for health care services provided to residents of this State regardless of the site of service, to the extent data are available.

(b) The expenditure analysis and the estimate of future health care spending shall include breakdowns for broad sectors such as hospital, physician, mental health, home health, and pharmacy and may include estimates for disease prevention and health promotion activities and other social determinants of health. The analyses shall include:

(1) expenditures by commercial health plans, hospital and medical service corporations, and health maintenance organizations regulated by this State; and

(2) expenditures for Medicare, Medicaid, self-insured employers, and other forms of health coverage, to the extent data are available.

(c) Annually on or before January 15, the Board shall submit the expenditure analysis and the estimate of future health care spending to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

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

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

(5) "Expenditure analysis" means the expenditure analysis developed pursuant to section ~~9375a~~ 9383 of this title.

* * *

(15) "~~Unified health care budget~~ Health care spending estimate" means the ~~budget~~ spending estimate established in accordance with section ~~9375a~~ 9383 of this title.

* * *

Sec. 11. [Deleted.]

Sec. 12. REPEAL

18 V.S.A. § 9375a (expenditure analysis; unified health care budget) is repealed.

* * * Delegation of Services by the Green Mountain Care Board * * *

Sec. 13. 18 V.S.A. § 9374(d) is amended to read:

(d)(1) The Chair shall have general charge of the offices and employees of the Board but may hire a director to oversee the administration and operation.

(2)(A) Except for final decisions in regulatory matters over which the Board has jurisdiction, a member of the Board, Board officer, or Board employee may perform any service that is within the Board's jurisdiction and that the Board delegates to the member, officer, or employee.

(B) The Board shall establish procedures to ensure that Board employees have appropriate supervision in their performance of delegated activities and that the Board remains informed regarding these activities.

* * * Accountable Care Organizations; Fair and Equitable Payment Amounts * * *

Sec. 13a. 18 V.S.A. § 9382 is amended 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 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. To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

* * *

(3) The ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers in a fair and equitable manner. To the extent that the ACO has the authority and ability to establish provider reimbursement rates, the ACO shall minimize differentials in payment methodology and amounts among comparable participating providers across all practice settings, as long as doing so is not inconsistent with the ACO's overall payment reform objectives.

* * *

* * * Medicaid Advisory Rate Case * * *

Sec. 14. 18 V.S.A. § 9573 is added to read:

§ 9573. MEDICAID ADVISORY RATE CASE

(a) On or before December 31 of each year, the Green Mountain Care Board shall review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access and an accountable care organization for the following calendar year. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per member, per month payment, and any other nonclaims payments. The Board's review may include deliberative sessions to the same extent permitted for insurance rate review under 8 V.S.A. § 4062.

(b) The review shall be nonbinding on the Agency of Human Services, and nothing in this section shall be construed to abrogate the designation of the Agency of Human Services as the single State agency as required by 42 C.F.R. § 431.10.

(c) The Board shall review the payment arrangement prior to the finalization of a contract between the Department and the accountable care organization and shall maintain the confidentiality of information as needed to preserve the parties' contract negotiations. The Board shall release its advisory opinion within 30 days following the finalization of the contract between the parties.

(d) The Department of Vermont Health Access shall provide the Board and its contractors with all data and information that the Board requests for its review within the time frame set forth by the Board.

* * * Medicaid Budget Estimates * * *

Sec. 15. 32 V.S.A. § 305a(c) is amended to read:

(c)(1)(A) The January estimates shall include estimated caseloads and estimated per-member per-month expenditures for the current and next succeeding fiscal years for each Medicaid enrollment group as defined by the Agency and the Joint Fiscal Office for State Health Care Assistance Programs or premium assistance programs supported by the State Health Care Resources and Global Commitment Funds, and for the Programs under any Medicaid Section 1115 waiver.

(B) For Board consideration, there shall be provided ~~two~~ three versions of the next succeeding fiscal year's estimated per-member per-month expenditures:

(i) one version shall include ~~an increase in Medicaid provider reimbursements in order to ensure that the expenditure estimates reflect amounts attributable to health care inflation as required by subdivisions 307(d)(5) and (d)(6) of this title and~~ inflation trends as set forth in subdivision 307(d)(5) of this title;

(ii) one version shall be without the inflationary adjustment; and

(iii) one version shall reflect any additional increase or decrease to Medicaid provider reimbursements that would be necessary to attain Medicare levels as set forth in subdivision 307(d)(6) of this title.

(C) For VPharm, the January estimates shall include estimated caseloads and estimated per-member per-month expenditures for the current and next succeeding fiscal years by income category.

(D) The January estimates shall include the expenditures for the current and next succeeding fiscal years for the Medicare Part D phased-down State contribution payment and for the disproportionate share hospital payments.

(2) In July, the Administration and the Joint Fiscal Office shall make a report to the Emergency Board on the most recently ended fiscal year for all Medicaid and Medicaid-related programs, including caseload and expenditure information for each Medicaid eligibility group. Based on this report, the Emergency Board may adopt revised estimates for the current fiscal year and estimates for the next succeeding fiscal year.

Sec. 16. 32 V.S.A. § 307(d) is amended to read:

(d) The Governor's budget shall include his or her recommendations for an annual budget for Medicaid and all other health care assistance programs administered by the Agency of Human Services. The Governor's proposed Medicaid budget shall include a proposed annual financial plan, and a proposed five-year financial plan, with the following information and analysis:

* * *

(5) health care inflation trends ~~consistent with~~ that reflect consideration of provider reimbursements approved under 18 V.S.A. § 9376 and expenditure trends reported under 18 V.S.A. § ~~9375a~~ 9383;

* * *

* * * Green Mountain Care Board Billback Formula * * *

Sec. 17. 18 V.S.A. § 9374(h) is amended to read:

(h)(1) The Board may assess and collect from each regulated entity the actual costs incurred by the Board, including staff time and contracts for professional services, in carrying out its regulatory duties for health insurance rate review under 8 V.S.A. § 4062; hospital budget review under chapter 221, subchapter 7 of this title; and accountable care organization certification and budget review under section 9382 of this title.

(2)(A) ~~Except~~ In addition to the assessment and collection of actual costs pursuant to subdivision (1) of this subsection and except as otherwise provided in ~~subdivision (2)~~ subdivisions (2)(C) and (3) of this subsection, all other expenses ~~incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by~~ of the Board shall be borne as follows:

~~(A)~~(i) 40 percent by the State from State monies;

~~(B)~~(ii) ~~15~~ 30 percent by the hospitals;

~~(C)~~(iii) ~~15~~ 24 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125~~;~~

~~(D) 15 percent by,~~ health insurance companies licensed under 8 V.S.A. chapter 101~~; and~~

~~(E) 15 percent by~~, and health maintenance organizations licensed under 8 V.S.A. chapter 139; and

(iv) six percent by accountable care organizations certified under section 9382 of this title.

(B) Expenses under subdivision (A)(iii) of this subdivision (2) shall be allocated to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this subdivision (2) shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care, limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(C) Expenses incurred by the Board for regulatory duties associated with certificates of need shall be assessed pursuant to the provisions of section 9441 of this title and not in accordance with the formula set forth in subdivision (A) of this subdivision (2).

~~(2)~~(3) The Board may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subdivision ~~(1)~~(2) of this

subsection if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

~~(3) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.~~

(4) If the amount of the proportional assessment to any entity calculated in accordance with the formula set forth in subdivision (2)(A) of this subsection would be less than $150.00, the Board shall assess the entity a minimum fee of $150.00. The Board shall apply the amounts collected based on the difference between each applicable entity's proportional assessment amount and $150.00 to reduce the total amount assessed to the regulated entities pursuant to subdivisions (2)(A)(ii)–(iv) of this subsection.

Sec. 18. [Deleted.]

* * * Regulation of Freestanding Health Care Facilities * * *

Sec. 19. REGULATION OF FREESTANDING HEALTH CARE FACILITIES; WORKING GROUP; REPORT

(a) The Secretary of Human Services or designee shall convene a working group to develop recommendations for the regulation of freestanding health

care facilities and their role in a coordinated and cohesive health care delivery system. The recommendations shall include:

(1) whether and how the State should license and regulate ambulatory surgical centers, freestanding birth centers, urgent care clinics, retail health clinics, and other freestanding health care facilities; and

(2) whether and to what extent these facilities should participate in Vermont's health care reform initiatives.

(b) The working group shall comprise representatives of ambulatory surgical centers, urgent care clinics, hospitals, the Green Mountain Care Board, the Department of Vermont Health Access, the Department of Health, the Office of the Health Care Advocate, the Vermont Program for Quality in Health Care, Inc., and other interested stakeholders.

(c) On or before February 1, 2019, the working group shall provide its recommendations to the House Committees on Health Care and on Ways and Means, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee.

* * * Effective Dates * * *

Sec. 20. EFFECTIVE DATES

(a) Secs. 6 (certificate of need) and 17 (billback formula) shall take effect on July 1, 2018, provided that for applications for a certificate of need that are already in process on that date, the rules and procedures in place at the time the

application was filed shall continue to apply until a final decision is made on the application.

(b) The remaining sections of this act shall take effect on passage.