Senate proposal of amendment

H. 912

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

The Senate proposes to the House to amend the bill as follows:

First: In Sec. 4, 18 V.S.A. § 9405(b), by striking out subdivision (1) in its entirety and inserting in lieu thereof a new subdivision (1) to read as follows:

(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.

Second: By striking out Sec. 11, 32 V.S.A. § 307(d), in its entirety and inserting in lieu thereof the following:

Sec. 11. [Deleted.]

Third: By inserting a reader assistance heading and a new section to be Sec. 13a to read as follows:

* * * 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.

* * *

Fourth: By striking out Sec. 15 in its entirety and adding six new sections to read as follows:

* * * 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;

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* * * 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.

* * * Composition of Green Mountain Care Board and Advisory Group * * *

Sec. 18. 18 V.S.A. § 9374 is amended to read:

§ 9374. BOARD MEMBERSHIP; AUTHORITY

(a)(1) On July 1, 2011, the Green Mountain Care Board is created and shall consist of a chair and four members. The Chair and all of the members shall be State employees and shall be exempt from the State classified system. The Chair shall receive compensation equal to that of a Superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the Chair.

(2) The Chair and the members of the Board shall be nominated by the Green Mountain Care Board Nominating Committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a Superior judge. The Governor shall not appoint a nominee who was denied confirmation by the Senate within the past six years. At least one member of the Board shall be an individual licensed to practice medicine under 26 V.S.A. chapter 23 or 33, an individual licensed as a physician assistant under 26 V.S.A. chapter 31, or an individual licensed as a registered nurse or an advanced practice registered nurse under 26 V.S.A. chapter 28.

* * *

(c)(1) No Board member shall, during his or her term or terms on the Board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the Board; provided that ~~for a health care practitioner, the employment restriction in this subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession~~ these restrictions shall not preclude a Board member who is a health care professional from participating in an accountable care organization as long as the Board member is not otherwise affiliated in any way with a person subject to supervision or regulation by the Board.

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* * * 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) Sec. 18 shall take effect on passage and shall apply beginning with the first vacancy occurring on the Green Mountain Care Board on or after that date; provided, however, that it shall not be construed to disqualify a non-health care professional member serving on the Board on the date of passage of this act from being reappointed after the date of passage to serve one or more additional terms.

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