S.290

Introduced by Senators Lyons, Cummings, Kitchel and Westman

Referred to Committee on

Date:

Subject: Health; health insurance; Green Mountain Care Board; accountable care organizations; hospitals; health care providers

Statement of purpose of bill as introduced: This bill proposes to create additional reporting, certification, and budget requirements for accountable care organizations; direct hospitals to report certain rate increases to the Green Mountain Care Board; and impose new requirements on contracting between health plans and health care providers. It would require the Green Mountain Care Board to review annually the budgets of designated and specialized service agencies and preferred provider organizations. The bill would specify that the Green Mountain Care Board's membership must include a health care professional, require the Board to begin exercising its rate-setting authority and to establish site-neutral reimbursement amounts, and direct the Board to review and approve contracts between health plans and health care providers. The bill would also impose limits on health insurance rate increases attributable to administrative expenses and require the Agency of Human Services to report on two-year accountable care organization budget and reporting cycles and on

the likely effects of attributing or not attributing State employees and public school employees to an accountable care organization.

An act relating to health care reform implementation

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

* * * Accountable Care Organizations * * *

Sec. 1. 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:

* * *

(2)(A) The ACO has established appropriate mechanisms and care models 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.

(B) The ACO consults with the Agency of Human Services and its departments regarding public health and population health issues and coordinates its services and initiatives in these areas with Agency and departmental programming.

(C) The ACO ensures equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care.

(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.

(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. The ACO fosters collaboration among its

participating providers, including hospitals and community providers and has established appropriate mechanisms for evaluating the extent to which these providers collaborate effectively.

(5) The ACO has established mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care, where feasible. The ACO engages in ongoing and multiyear relationships with its participating providers and encourages the development of sustainable programs and initiatives.

* * *

(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:

* * *

(3)(A) The Green Mountain Care Board shall only approve an ACO's budget containing salary increases for ACO employees if the ACO has

achieved its savings and quality targets for the preceding ACO budget year. The Board shall not approve an ACO's budget containing salary increases if the ACO has failed to achieve its savings or quality targets, or both, for the preceding ACO budget year.

(B) The Green Mountain Care Board shall not approve an ACO budget if the total proposed administrative expenses, as defined by the Board, comprise more than 15 percent of the ACO's overall proposed budget.

(4)(A) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to any ACO budget review and may:

* * *

(B) The Office of the Health Care Advocate shall not disclose further any confidential or proprietary information provided to the Office pursuant to this subdivision ~~(3)~~(4).

* * *

Sec. 2. 18 V.S.A. § 9574 is added to read:

§ 9574. ANNUAL REPORTING

(a) Each accountable care organization certified pursuant to subsection 9382(a) of this title shall submit to the Green Mountain Care Board annually, at the same time as the ACO submits its proposed budget to the Board in accordance with subsection 9382(b) of this title, all of the following:

(1) a copy of the ACO's most recent audited financial statements, prepared in accordance with generally accepted accounting principles;

(2) the evidence basis on which each of the ACO's programs and initiatives was established and is being evaluated;

(3) benchmark data, including the numbers of attributed lives by type of insurance or other coverage, quality metrics, and health outcomes;

(4) the ACO's outreach efforts to educate the public about the ACO's mission, its initiatives, and its impacts to date on population health and other outcome measures;

(5) the ACO's administrative costs, including salaries, by category, and the source of funds that covers these costs; and

(6) the amount, if any, of shared savings achieved by the ACO during the previous reporting year, how the savings were distributed, and the criteria the ACO uses to determine distribution of shared savings.

(b) The quality metrics to be reported pursuant to subdivision (a)(3) of this section shall include an assessment of the services patients receive across the continuum of care, including primary care services, ongoing care management, appropriate counseling services, trauma-informed support services provided in the community, and other services that help patients to achieve positive clinical outcomes.

Sec. 3. ACCOUNTABLE CARE ORGANIZATIONS; TWO-YEAR BUDGET AND REPORTING CYCLE; REPORT

The Agency of Human Services, in consultation with the Green Mountain Care Board and each accountable care organization (ACO) certified pursuant to 18 V.S.A. § 9382(a), shall evaluate the advantages and disadvantages of shifting the ACO budget review process set forth in 18 V.S.A. § 9382(b) and the ACO reporting requirements set forth in 18 V.S.A. § 9574 from a one-year to a two-year cycle. On or before December 1, 2020, the Agency of Human Services shall report its findings and recommendations with respect to moving ACO budgets and reporting to a two-year cycle to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee.

* * * Hospital Rates * * *

Sec. 4. 18 V.S.A. § 9454 is amended to read:

§ 9454. HOSPITALS; DUTIES

(a) Hospitals shall file the following information at the time and place and in the manner established by the Board:

* * *

(6) known depreciation schedules on existing buildings, a four-year capital expenditure projection, and a one-year capital expenditure plan; ~~and~~

(7) the three specific health care services that were subject to the largest increase in commercial rates, and the three services that experienced the largest decrease in commercial rates, during the previous fiscal year; and

(8) such other information as the Board may require.

* * *

(c) A hospital shall report to the Green Mountain Care Board within 30 days following an increase of 0.5 percent or more to the commercial rate for any health care service offered by the hospital.

* * * Green Mountain Care Board * * *

Sec. 5. 18 V.S.A. § 8915 is added to read:

§ 8915. DESIGNATED AND SPECIALIZED SERVICE AGENCY AND PREFERRED PROVIDER ORGANIZATION BUDGET REVIEW

(a) As used in this section:

(1) "Designated and specialized service agencies" means the community mental health and developmental disability agencies designated by the Commissioner of Mental Health or of Disabilities, Aging, and Independent Living, or both, pursuant to this chapter.

(2) "Preferred provider organization" means a preferred provider organization certified by the Department of Health to provide substance use disorder treatment in the community.

(b) The Green Mountain Care Board, in consultation with the Agency of Human Services and its departments, shall review annually the budget of each designated and specialized service agency and preferred provider organization as set forth in this section. The Board shall:

(1) adopt uniform formats that each designated and specialized service agency and preferred provider organization shall use to report its financial, scope-of-services, and utilization data and information;

(2) designate a data organization with which each designated and specialized service agency and preferred provider organization shall file its financial, scope-of-services, and utilization data and information; and

(3) designate one or more data organizations to process, analyze, store, or retrieve data or information.

(c) Each designated and specialized service agency and preferred provider organization shall file the following information at the time and place and in the manner established by the Board:

(1) a budget for the forthcoming fiscal year;

(2) financial information, including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of services, and wage and salary data;

(3) scope-of-service and volume-of-service information, including, as applicable, adult outpatient, community rehabilitation and treatment, substance

use disorder treatment, developmental disabilities, children and family, emergency, and advocacy and peer services;

(4) utilization information;

(5) any new services or programs proposed for the forthcoming fiscal year;

(6) known depreciation schedules on existing buildings and any other facilities and equipment; and

(7) such other information as the Board may require.

(d) In conjunction with designated and specialized service agency and preferred provider organization budget reviews, the Board shall:

(1) review utilization information;

(2) consider the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources developed pursuant to section 9405 of this title as it pertains to the services provided by designated and specialized service agencies and preferred provider organizations;

(3) consider any reports from professional review organizations;

(4) solicit public comment on all aspects of designated and specialized service agency and preferred provider organization costs and use and on the budgets proposed by individual agencies and organizations; and

(5) meet with designated and specialized service agencies and preferred provider organizations to review and discuss their budgets for the forthcoming fiscal year.

(e) The Board, in consultation with the Agency of Human Services and its departments, shall establish a budget for each designated and specialized service agency and preferred provider organization annually on or before June 15, followed by a written decision on or before July 1. Each designated and specialized service agency and preferred provider organization shall operate within the budget established under this section.

(f) The Board may, upon application, adjust a budget established under this section upon a showing of need based on exceptional or unforeseen circumstances.

(g) The Board may request, and a designated or specialized service agency or preferred provider organization shall provide, information determined by the Board to be necessary to determine whether the agency or organization is operating within a budget established under this section.

(h) The Board may adopt rules in accordance with 3 V.S.A. chapter 25 to carry out the purposes of this section.

Sec. 6. 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 naturopathic physician pursuant to 26 V.S.A. chapter 81, 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~~ professional, 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~~ professional to practice his or her profession.

* * *

Sec. 7. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

(a) The Board shall execute its duties consistent with the principles expressed in section 9371 of this title.

(b) The Board shall have the following duties:

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(16) Review and approve proposed health care contracts between a health plan or other contracting entity and a health care provider.

* * *

Sec. 8. 18 V.S.A. § 9376 is amended to read:

§ 9376. PAYMENT AMOUNTS; METHODS

(a) It is the intent of the General Assembly:

(1) to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest~~. It is also the intent of the General Assembly~~;

(2) to ensure equitable reimbursement amounts to providers, regardless of setting or hospital affiliation, while also allowing for facility fees, if appropriate; and

(3) to eliminate the shift of costs between the payers of health services ~~to ensure~~ so that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

(b)(1) The Board shall set reasonable, site-neutral rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons, regardless of setting or hospital affiliation. In its discretion, the Board may implement rate-

setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the Board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the State~~,~~ and the need for health care professionals in particular areas of the State, particularly in underserved geographic or practice shortage areas, but the Board shall not create reimbursement disparities for the same services based on the health care setting in which services are delivered or on a health care professional's affiliation with a hospital.

(2) Nothing in this subsection shall be construed to:

(A) limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection (b) from a patient without health insurance or other coverage for the service or services received; or

(B) reduce or limit the covered services offered by Medicare or Medicaid.

(c) The Board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy

lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, shall apply to the reimbursement amounts provided to health care professionals through the All-Payer ACO Model, and may include fee-for-service payments ~~if~~ to the extent the Board determines such payments to be appropriate.

* * *

Sec. 9. 18 V.S.A. § 9384 is added to read:

§ 9384. HEALTH CARE CONTRACT REVIEW

(a) As used in this section, "contracting entity," "health care contract," "health care provider," and "health plan" have the same meanings as in chapter 221, subchapter 2 of this title.

(b) A health care contract between a health plan or other contracting entity and a health care provider shall not be effective until it has been reviewed and approved by the Green Mountain Care Board for fairness, adherence to the rate parameters set by the Board pursuant to section 9376 of this title, and consistency with the provisions of chapter 221, subchapter 2 of this title and other applicable laws.

(c) The Board shall adopt rules in accordance with 3 V.S.A. chapter 25 establishing the health care contract review process.

* * * Health Insurers * * *

Sec. 10. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, a health maintenance organization, or a managed care organization and not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this State, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form and of the rules for the classification of risks has been filed with the Department of Financial Regulation and a copy of the premium rates has been filed with the Green Mountain Care Board; and the Green Mountain Care Board has issued a decision approving, modifying, or disapproving the proposed rate.

* * *

(3) The Board shall determine whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. In making this determination, the Board shall consider the analysis and opinion provided by the Department of Financial Regulation pursuant to subdivision (2)(B) of this subsection. A proposed rate increase shall be considered unjust

if the proportion of the rate attributable to administrative expenses exceeds the cumulative Consumer Price Index rate of inflation for the applicable period.

* * *

Sec. 11. 18 V.S.A. § 9418c is amended to read:

§ 9418c. FAIR CONTRACT STANDARDS

(a) Required information.

(1) Each contracting entity shall provide and each health care contract shall obligate the contracting entity to provide participating health care providers information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following:

(A) The manner of payment, such as fee-for-service, capitation, case rate, or risk.

(B) ~~On~~ Upon request, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a provider in the same specialty typically uses or that the requesting provider actually bills. Fee schedule information may be provided by CD-ROM or electronically, at the election of the contracting entity, but a provider may elect to receive a hard copy of the fee schedule information instead of the CD-ROM or electronic version.

(C) A clearly understandable, readily available mechanism, such as a specific website address, that includes the following information:

(i) the name of the commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer uses;

(ii) the standard or standards from subsection 9418a(c) of this title that the entity uses for claim edits;

(iii) payment percentages for modifiers; and

(iv) any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product, which are made at the request of the health plan, contracting entity, covered entity, or payer, and which have been approved by the Commissioner pursuant to subsection 9418a(b) or (c) of this title.

(2) Contracting entities shall provide the information described in subdivisions (1)(A) and (B) of this subsection to health care providers who are actively engaged in the process of determining whether to become a participating provider in the contracting entity's network.

(3) ~~Contracting entities may require health care providers to execute written confidentiality agreements with respect to fee schedule and claim edit information received from contracting entities.~~ [Repealed.]

* * *

(b) Summary disclosure form.

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(5) Upon request, contracting entities shall provide the summary disclosure form to a participating provider or a provider who is actively engaged in the process of determining whether to become a participating provider within 60 days of the request.

(c)(1) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in subdivisions (a)(1)(A) and (B) of this section. A contracting entity shall provide at least 120 days for a provider's consideration of a proposed contract and for negotiation of contract terms, including reimbursement amounts.

(2) Health care contracts shall be for a minimum of two years and shall include reimbursement amounts that are consistent with the rate parameters set by the Green Mountain Care Board pursuant to section 9376 of this title.

(3) Prior to a health care contract taking effect, it shall be reviewed and approved by the Green Mountain Care Board in accordance with section 9384 of this title for fairness, adherence to the rate parameters set by the Board, and consistency with the provisions of this subchapter and other applicable laws.

* * *

(e) ~~The requirements of subdivision (b)(5) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement~~

~~between the provider and the contracting entity regarding the terms of the proposed health care contract.~~ [Repealed.]

* * * Public Employees; Attributed Lives; Report * * *

Sec. 12. PUBLIC EMPLOYEE ATTRIBUTION TO ACCOUNTABLE CARE ORGANIZATIONS; ALL-PAYER ACO MODEL; REPORT

(a) The Agency of Human Services, in consultation with the Green Mountain Care Board, the Department of Human Resources, and the unions representing State employees and public school employees, shall determine the likely effects of attributing and not attributing State and public school employees who receive employer-sponsored health insurance, and their dependents, to an accountable care organization. The Agency shall consider the expected impacts of attribution and non-attribution on:

(1) State employees' and public school employees' access to health care;

(2) State employees' and public school employees' health outcomes;

(3) State employees' and public school employees' experience of the health care system;

(4) the relative value of State employees' and public school employees' employer-sponsored health benefits if their lives are and are not attributed to an accountable care organization; and

(5) the State's likelihood of meeting the scale targets contemplated by the All-Payer ACO Model and the related effects on health care reform efforts in Vermont.

(b) On or before October 15, 2020, the Agency of Human Services shall report its findings and recommendations regarding attribution of State and public school employees to an accountable care organization to the House Committees on Health Care, on Education, and on Government Operations, the Senate Committees on Health and Welfare, on Education, and on Government Operations, and the Health Reform Oversight Committee.

* * * Effective Dates * * *

Sec. 13. EFFECTIVE DATES

(a) Secs. 1 (18 V.S.A. § 9382; ACO certification and budgets) and 2 (18 V.S.A. § 9574; ACO annual reporting) shall take effect on passage and shall apply beginning with the ACO certification and budget review for ACO fiscal year 2022.

(b) Secs. 4 (18 V.S.A. § 9454; hospital budgets; rate increases) and 5 (18 V.S.A. § 8915; designated and specialized service agency and preferred provider organization budget review) shall take effect on July 1, 2020.

(c) Sec. 6 (18 V.S.A. § 9374; health care provider on Green Mountain Care Board) 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.

(d) Secs. 7 and 9 (18 V.S.A. §§ 9375 and 9384; Green Mountain Care Board; health care contract review) shall take effect on April 1, 2021, with the Board reviewing all proposed health care contracts between contracting entities and providers under negotiation on and after that date.

(e) Sec. 8 (18 V.S.A. § 9376; Green Mountain Care Board; provider rate-setting) shall take effect on July 1, 2020, with the Board setting site-neutral provider rates that shall be in effect starting on January 1, 2021.

(f) Sec. 10 (8 V.S.A. § 4062; health insurance rates) shall take effect on passage and shall apply beginning with rates filed for the 2021 plan year.

(g) Sec. 11 (18 V.S.A. § 9418c; fair contract standards) shall take effect on passage and shall apply to all contract negotiations beginning on and after that date, except that 18 V.S.A. § 9418c(c)(2) and (3) shall take effect on April 1, 2021.

(h) Secs. 3 (two-year ACO budgets; report) and 12 (State and public school employee attribution to ACO) and this section shall take effect on passage.