UNEDITED DRAFT FOR DISCUSSION PURPOSES

TO THE HONORABLE SENATE:

The Committee on Health and Welfare to which was referred Senate Bill No. 290 entitled "An act relating to health care reform implementation" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Accountable Care Organizations * * *

Sec. 1. 18 V.S.A. § 9382 is amended to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

* * *

(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:

* * *

(M) information on the ACO's administrative costs, as defined by the Board, including the annual salaries and benefits by position for all of the ACO's management-level employees;

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

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

(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations;

(Q) the ACO's efforts to education providers on best practices and protocols for patient management; and

(R) the ACO's outreach efforts to educate providers and the public about the ACO's mission, its initiatives, and its impacts to date on population health.

* * *

Sec. 2. AGENCY OF HUMAN SERVICES; ACCOUNTABLE CARE ORGANIZATIONS; PUBLIC AND POPULATION HEALTH

In its contracts with a certified accountable care organization (ACO), the Department of Vermont Health Access shall require the ACO to consult with the Agency of Human Services and its departments regarding public health and population health issues and to coordinate its services and initiatives in these areas with Agency and departmental programming.

Sec. 3. REGULATION OF ACCOUNTABLE CARE ORGANIZATIONS; ALL-PAYER ACO MODEL FUTURE PLANNING; REPORT

(a) The Joint Fiscal Office shall contract with a qualified, independent, external organization to recommend to the General Assembly the most appropriate manner in which to regulate accountable care organizations (ACOs) and to recommend modifications for future iterations of the All-Payer ACO Model.

(b) On or before January 15, 2021, the Joint Fiscal Office shall provide to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare, on Finance, and on Appropriations the external organization's report, which shall include recommendations regarding:

(1) a model for regulation of ACOs that is feasible for Vermont;

(2) methods for increasing an ACO's transparency and accountability, including whether to require an ACO to establish a policy linking the compensation for management-level employees to the ACO's financial and quality outcomes;

(3) ways to ensure that an 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;

(4) ways to encourage the ACO to engage in ongoing and multiyear relationships with its participating providers and to promote the development of sustainable programs and initiatives;

(5) whether and to what extent provider solvency should be considered in the distribution plan for shared savings realized by an ACO;

(6) whether ACO budgets should be set on a multi-year basis;

(7) more to come…

* * * Hospitals * * *

Sec. 4. HIGH-COST HEALTH CARE SERVICES; HOSPITALS; REPORT

(a) As part of their budget submissions for hospital fiscal year 2021, each hospital shall report to the Green Mountain Care Board the services that the provide at the highest cost.

(b) On or before December 1, 2020, the Green Mountain Care Board shall compile the information provided to it pursuant to subsection (a) of this section and provide a comprehensive summary to the House Committee on Health Care and the Senate Committee on Health and Welfare.

Sec. 5. 18 V.S.A. § 9453(a) is amended to read:

(a) The Board shall:

(1) adopt uniform formats that hospitals shall use to report financial, reimbursement, scope-of-services, and utilization data and information;

* * *

Sec. 6. 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:

(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 inpatient services, outpatient services, and ancillary services by type of service provided;

(4) utilization information;

(5) new hospital services and programs proposed for the forthcoming fiscal year;

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

(7) reimbursement information, including commercial rates, charges, fee schedules, reimbursement methodologies, proposed reimbursement increases or decreases, and rates as a percentage of Medicare or another benchmark determined by the Board; and

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

(b) Hospitals shall adopt a fiscal year ~~which~~ that shall begin on October 1.

Sec. 7. 18 V.S.A. § 9457 is amended to read:

§ 9457. INFORMATION AVAILABLE TO THE PUBLIC

(a)(1) All information required to be filed under this subchapter shall be made available to the public upon request~~, provided that~~ in accordance with 1 V.S.A. chapter 5, subchapter 3 (Public Records Act), except that the following information shall be exempt from public inspection and copying under the Public Records Act and shall be kept confidential:

(A) information that directly or indirectly identifies individual patients or health care practitioners ~~shall not be directly or indirectly identifiable~~;

(B) reimbursement information submitted by a hospital pursuant to section 9454 of this subchapter, except that the Board may disclose or release information publicly in summary or aggregate form if doing so would not disclose trade secrets, as defined in 1 V.S.A. § 317(c)(9); and

(C) financial information the Board collects to address financial solvency issues.

(2) Notwithstanding 1 V.S.A. § 317(e), the Public Records Act exemptions created in this subsection shall continue in effect and shall not be repealed through operation of 1 V.S.A. § 317(e).

(b) Notwithstanding 1 V.S.A. chapter 5, subchapter 2 (Vermont Open Meeting Law) or any provision of this subchapter to the contrary, the Board may examine and discuss confidential information outside a public hearing or meeting.

* * * Green Mountain Care Board * * *

Sec. 8. 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. 9. 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:

* * *

(16) Collect and review data from each community mental health and developmental disability agency designated by the Commissioner of Mental Health or of Disabilities, Aging, and Independent Living pursuant to chapter 207 of this title, which may include data regarding a designated or specialized service agency's scope of services, volume, utilization, payer mix, quality, coordination with other aspects of the health care system, and financial condition, including solvency. The Board's processes shall be appropriate to the designated and specialized service agencies' scale and their role in Vermont's health care system, and the Board shall consider ways in which the designated and specialized service agencies can be integrated fully into systemwide payment and delivery system reform.

* * *

Sec. 10. GREEN MOUNTAIN CARE BOARD; RATE-SETTING; PAYMENT REFORM; REPORT

(a) On or before January 15, 2021, the Green Mountain Care Board shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) the estimated personnel and other resources that would be necessary for the Board to exercise its authority under 18 V.S.A. § 9376 to set provider rates, both for fee-for-service payments and under various fixed-payment models, including global budgets for individual hospitals and global budgets for the hospital system as a whole;

(2) the projected impact of rate setting on the total cost of care under the All-Payer ACO Model and on the sustainability of rural health care facilities;

(3) the manner in which specialty care shall be incorporated appropriately into the All-Payer ACO model;

(4) an analysis of the increases in health insurers' administrative expenses over the most recent five-year period for which information is available and a comparison of those increases with increases in the Consumer Price Index; and

(5) a recommendation regarding whether the Board should conduct limited budget reviews for preferred provider organizations.

(b) The Department of Vermont Health Access and health insurers shall provide to the Board upon request data on their reimbursement amounts as needed for the Board to comply with the requirements of subsection (a) of this section, which data shall be exempt from public inspection and copying under the Public Records Act and shall be kept confidential.

Sec. 11. ROLE OF GREEN MOUNTAIN CARE BOARD ROLE IN HEALTH CARE REGULATION AND HEALTH CARE REFORM; REPORT

(a) The Joint Fiscal Office shall contract with a qualified, independent, external organization to evaluate the structures and processes by which Vermont currently regulates and oversees the health care system and by which it fosters innovation in health care reform and to recommend redistribution of responsibility and authority as appropriate among the Green Mountain Care Board, the Agency of Human Services and its departments, the Department of Financial Regulation, the Office of the Attorney General, and other public and private stakeholders.

(b) On or before January 15, 2021, the Joint Fiscal Office shall provide to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare, on Finance, and on Appropriations the external organization's report, which shall include recommendations regarding:

(1) which entity or entities should be responsible for:

(A) developing and implementing health care reform initiatives;

(B) conducting health insurance rate review;

(C) regulating health insurers, including ensuring insurer solvency;

(D) reviewing the budgets of hospitals and other health care facilities and entities;

(E) certifying and overseeing accountable care organizations;

(F) issuing certificates of need;

(G) providing health insurance consumer protection;

(H) containing health care costs;

(I) monitoring and regulating health care safety, quality, and access;

(J) licensing and regulating health care providers and health care facilities; and

(K) setting equitable health care provider reimbursement rates, both in and outside the All-Payer ACO Model;

(2) whether it would be useful for purposes of health care cost containment for hospitals to report when they increase the commercial rates for certain health care services;

(3) more to come….

* * * 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.

* * *

(language to be added about providing reimbursement rates and the confidentiality of that information)

Sec. 12. 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.

* * *

(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.

* * *

(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.]

* * * Provider Rates and Contracts * * *

Sec. 13 to be added re AHS work group with DFR, GMCB, stakeholders on regulation and oversight of provider rates and contracts

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

Sec. 14. 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. 15. EFFECTIVE DATES

(to be revised)

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE