

1 S.290

2 Introduced by Senators Lyons, Cummings, Kitchel and Westman

3 Referred to Committee on

4 Date:

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

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

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

3 An act relating to health care reform implementation

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

5 * * * Accountable Care Organizations * * *

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

7 § 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

8 (a) In order to be eligible to receive payments from Medicaid or
9 commercial insurance through any payment reform program or initiative,
10 including an all-payer model, each accountable care organization shall obtain
11 and maintain certification from the Green Mountain Care Board. The Board
12 shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and
13 processes for certifying accountable care organizations. To the extent
14 permitted under federal law, the Board shall ensure these rules anticipate and
15 accommodate a range of ACO models and sizes, balancing oversight with
16 support for innovation. In order to certify an ACO to operate in this State, the
17 Board shall ensure that the following criteria are met:

18 * * *

19 (2)(A) The ACO has established appropriate mechanisms and care
20 models to provide, manage, and coordinate high-quality health care services

1 for its patients, including incorporating the Blueprint for Health, coordinating
2 services for complex high-need patients, and providing access to health care
3 providers who are not participants in the ACO.

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

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

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

18 (4) The ACO has established appropriate mechanisms and criteria for
19 accepting health care providers to participate in the ACO that prevent
20 unreasonable discrimination and are related to the needs of the ACO and the
21 patient population served. The ACO fosters collaboration among its

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

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

11 * * *

12 (b)(1) The Green Mountain Care Board shall adopt rules pursuant to
13 3 V.S.A. chapter 25 to establish standards and processes for reviewing,
14 modifying, and approving the budgets of ACOs with 10,000 or more attributed
15 lives in Vermont. To the extent permitted under federal law, the Board shall
16 ensure the rules anticipate and accommodate a range of ACO models and sizes,
17 balancing oversight with support for innovation. In its review, the Board shall
18 review and consider:

19 * * *

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

1 achieved its savings and quality targets for the preceding ACO budget year.

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

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

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

10 * * *

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

14 * * *

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

16 § 9574. ANNUAL REPORTING

17 (a) Each accountable care organization certified pursuant to subsection
18 9382(a) of this title shall submit to the Green Mountain Care Board annually,
19 at the same time as the ACO submits its proposed budget to the Board in
20 accordance with subsection 9382(b) of this title, all of the following:

- 1 (1) a copy of the ACO's most recent audited financial statements,
2 prepared in accordance with generally accepted accounting principles;
- 3 (2) the evidence basis on which each of the ACO's programs and
4 initiatives was established and is being evaluated;
- 5 (3) benchmark data, including the numbers of attributed lives by type of
6 insurance or other coverage, quality metrics, and health outcomes;
- 7 (4) the ACO's outreach efforts to educate the public about the ACO's
8 mission, its initiatives, and its impacts to date on population health and other
9 outcome measures;
- 10 (5) the ACO's administrative costs, including salaries, by category, and
11 the source of funds that covers these costs; and
- 12 (6) the amount, if any, of shared savings achieved by the ACO during
13 the previous reporting year, how the savings were distributed, and the criteria
14 the ACO uses to determine distribution of shared savings.
- 15 (b) The quality metrics to be reported pursuant to subdivision (a)(3) of this
16 section shall include an assessment of the services patients receive across the
17 continuum of care, including primary care services, ongoing care management,
18 appropriate counseling services, trauma-informed support services provided in
19 the community, and other services that help patients to achieve positive clinical
20 outcomes.

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

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

13 * * * Hospital Rates * * *

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

15 § 9454. HOSPITALS; DUTIES

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

18 * * *

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

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

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

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

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

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

16 (1) a budget for the forthcoming fiscal year;

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

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

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

3 (4) utilization information;

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

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

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

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

11 (1) review utilization information;

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

16 (3) consider any reports from professional review organizations;

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

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

4 (e) The Board, in consultation with the Agency of Human Services and its
5 departments, shall establish a budget for each designated and specialized
6 service agency and preferred provider organization annually on or before June
7 15, followed by a written decision on or before July 1. Each designated and
8 specialized service agency and preferred provider organization shall operate
9 within the budget established under this section.

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

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

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

1 Sec. 6. 18 V.S.A. § 9374 is amended to read:

2 § 9374. BOARD MEMBERSHIP; AUTHORITY

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

9 (2) The Chair and the members of the Board shall be nominated by the
10 Green Mountain Care Board Nominating Committee established in
11 subchapter 2 of this chapter using the qualifications described in section 9392
12 of this chapter and shall be otherwise appointed and confirmed in the manner
13 of a Superior judge. The Governor shall not appoint a nominee who was
14 denied confirmation by the Senate within the past six years. At least one
15 member of the Board shall be an individual licensed to practice medicine under
16 26 V.S.A. chapter 23 or 33, an individual licensed as a naturopathic physician
17 pursuant to 26 V.S.A. chapter 81, an individual licensed as a physician
18 assistant under 26 V.S.A. chapter 31, or an individual licensed as a registered
19 nurse or an advanced practice registered nurse under 26 V.S.A. chapter 28.

20 * * *

1 (c)(1) No Board member shall, during his or her term or terms on the
2 Board, be an officer of, director of, organizer of, employee of, consultant to, or
3 attorney for any person subject to supervision or regulation by the Board;
4 provided that for a health care ~~practitioner~~ professional, the employment
5 restriction in this subdivision ~~shall apply only to administrative or managerial~~
6 ~~employment or affiliation with a hospital or other health care facility, as~~
7 ~~defined in section 9432 of this title, and~~ shall not be construed to limit
8 generally the ability of the health care ~~practitioner~~ professional to practice his
9 or her profession.

10 * * *

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

12 § 9375. DUTIES

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

15 (b) The Board shall have the following duties:

16 * * *

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

19 * * *

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

2 § 9376. PAYMENT AMOUNTS; METHODS

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

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

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

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

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

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

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

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

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

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

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

6 * * *

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

8 § 9384. HEALTH CARE CONTRACT REVIEW

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

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

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

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

3 * * *

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

5 § 9418c. FAIR CONTRACT STANDARDS

6 (a) Required information.

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

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

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

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

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

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

5 (iii) payment percentages for modifiers; and

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

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

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

18 * * *

19 (b) Summary disclosure form.

20 * * *

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

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

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

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

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

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

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

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

1 provided, however, that it shall not be construed to disqualify a non-health care
2 professional member serving on the Board on the date of passage of this act
3 from being reappointed after the date of passage to serve one or more
4 additional terms.

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

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

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

14 (g) Sec. 11 (18 V.S.A. § 9418c; fair contract standards) shall take effect on
15 passage and shall apply to all contract negotiations beginning on and after that
16 date, except that 18 V.S.A. § 9418c(c)(2) and (3) shall take effect on April 1,
17 2021.

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