- **Section 1 – 18 VSA § 9382. Oversight of Accountable Care Organizations**
  - General feedback
    - Move from certification to ACO budget section of statute
  - (a)(2)(B) – ACO should consult with AHS/VDH
    - Strike
    - Alternative: Require DVHA to include language in their contract with the ACO (which funds these activities at least in part). DVHA could talk with VDH & fund activities they agree to.
  - (a)(4)&(5) – ACO to foster collaboration among providers and engage in multi-year relationship
    - Strike. Rationale:
      - We are concerned about being able to implement these requirements as they would be a challenge to measure and document.
      - There is also the concern that forcing multi-year relationships may lock providers into contracts that would benefit from continued evolution to respond to model innovations; consider multi-year language once the model is at scale.
  - (b)(3)(A) – GMCB to approve salary increases for ACO employees only upon achieving savings and quality targets
    - Amend to require transparency of annual salaries and benefits by position for ACO management (all director level positions and above)
      - Alternative if the committee pursues: Require the ACO to produce a policy that ties management compensation to financial and quality outcomes.
    - Rationale: timing lag of at least 12 months (e.g. claims run-out and data validation, through ACO oversight processes); implementation of salary changes based on events that happened two years prior.
  - (b)(3)(B) – ACO administrative expenses <15% of overall proposed budget
    - Strike:
      - Rationale: Already in the Budget order. Admin expenses are only 1.4% of the ACO's proposed 2020 overall value-based budget[1], this includes salaries and benefits of case management staff;
      - Alternative if the committee pursues: tie expenses to an industry benchmark (DVHA or private insurance carrier)
- **Section 2 – 18 VSA § 9574. Annual Reporting**
  - Strike (a).
    - Rationale: A separate report does not make sense & we already collect the following:
      - (1) most recent audited financial statements – see condition 21 (page 26) of OCV's 2020 budget order
      - (2) evidence basis for establishing ACO programs, and their evaluation – see condition 18 (page 25) of OCV's 2020 budget order

[1] see slide 77 in December 11th GMCB staff presentation of preliminary recommendations on ACO Oversight 2020

            - (3) benchmark data – see condition 19 (page 25) of OCV's 2020 budget order
                - While we agree that quality should be tracked and evaluated, this does not make sense in an annual report as outlined here
            - (5) ACO's administrative costs – see Part 4 Question 4 a and b and Appendix 4.2 of the ACO's 2020 budget submission
            - (6) the amount of shared savings achieved, how distributed and the criteria for distribution – see Rule 5.209 Provider payment (page 16); the ACO submits its policy on shared savings distribution under certification and then reports on actual and projected settlement via the budget process (Appendix 4.4 of 2020 budget submission), and once final provides settlement details by hospital
        - Alternative: We do not (formally) collect (4) ACO's public outreach efforts, but could easily incorporate into the budget review process.
    - Strike (b) – quality metrics. Rationale:
        - This does not align with existing All Payer Model quality framework, and does not reflect what is traditionally captured in quality measurement
        - Adds administrative burden of additional quality measurement on Vermont providers and the ACO.
- **Section 3 – Accountable Care Organizations; Two-Year Budget and Reporting Cycle; Report**
    - Strike & revisit when the ACO is at scale. Rationale:
        - GMCB-DVHA conducted a study on multi-year budgets in response to Act 113, which was submitted to HHC, HHS, SH&W, and SF;
        - Because we are not yet at scale, it may be premature to move to multi-year budgets; furthermore, the state has obligations to report to CMS on APM progress on an annual basis, and is required to set the Medicare benchmark annually.
- **Section 4 – 18 VSA § 9454. Hospitals; Duties**
    - (a)(7): Replace with more general language allowing for consideration of reimbursement rates in the budgets & the ability to discuss currently confidential material for sustainability planning & commercial charge approvals. (see below)
    - (c) - (0.5%) Include in the study suggested for Secs 7-10. Rationale:
        - need to understand the cost to the state as well as the administrative burden to providers; some Vermont hospitals have 80+ payers and depending on fluctuation of rates, this could be a substantial lift in terms of reporting volume
- **Section 5 – 18 VSA § 8915. Designated and Specialized Service Agency and Preferred Provider Organization Budget Review**
    - Amend to use Brattleboro Retreat oversight language from last year.
        - Rationale: Given the board's lack of regulatory levers over designated agencies, or their primary funding source (Medicaid), we recommend a review for solvency and transparency. Also provides the board insight into the DA's role in sustainability of rural health care (regulatory integration).
    - Preliminary Funding Request: limited oversight would require an additional 1 FTE

        - We are neutral on funding source – possibilities are bill back or GF. If bill back, then bill back statute would need to be changed.

- **Section 6 – 18 VSA § 9374. Board Membership; Authority**
    - We are neutral on this language, however it may be useful to consider what happens if no qualified provider applies for the position (which has happened before).
- **Sections 7 through 10 – 18 VSA § 9375. Duties; 18 VSA § 9376. Payment Amounts; Methods; 18 VSA § 9384. Health Care Contract Review; 18 VSA § 4062. Filing and Approval of Policy Forms and Premiums;**
    - Replace with a study:
        - We recommend a study to understand what it would take to implement FFS rate setting, but also to consider additional methodologies as we transition away from FFS and toward fixed payments, for example global budgets. Among other topics, study could explore the number of legal FTEs required to review and approve contracts under a FFS model, the volume of insurers and the number of their programs and rates that they set, and the extent of impact that this could have on the total cost of care under the All payer model as well as sustainability of rural health care institutions. Commercial insurance rate-setting only impacts 92,000 Vermonters.
        - Require insurers and DVHA to provide data necessary to determine current reimbursements & allow for confidentiality of this data.
        - Funding: contractual support for consultants would be beneficial, including the potential for actuarial support & ERISA analysis. Working on cost estimate.
        - Due: January 15, 2021
    - For section 10: we can provide an analysis of increases of admin exp over 5 years, compared to CPI (to be delivered by end of March 2020) or add to study for January.
- **Section 11 – 18 VSA § 9418c. Fair Contract Standards**
    - Neutral
- **Section 12 – Public Employee Attribution to Accountable Care Organizations; All-Payer ACO Model; Report**
    - GMCB will provide scale target performance and ACO scale strategy submitted via ACO oversight processes; GMCB recommends delivering this report as soon as possible to continue scale momentum.

Replacement language for Section 4:

18 V.S.A. § 9453 (Amend subdivision (1) of subsection (a)).

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

18 V.S.A. § 9454 (Amend subdivisions (2) and (7) of subsection (a) and make conforming changes).

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

…

(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 other benchmark; and

§ 9457 (Add subsections (a), (b), and (c)).

(a) All information required to be filed under this subchapter shall be made available to the public upon request in accordance with the Vermont Public Records Act, except the following information shall be treated as confidential and exempt from public inspection and copying:

(1) Information that directly or indirectly identifies~~, provided that~~ individual patients or health care practitioners~~ shall not be directly or indirectly identifiable~~;

(2) Reimbursement information submitted by a hospital pursuant to 18 V.S.A. § 9454 or by an insurer pursuant to 8 V.S.A. § 4062; and

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

(b) Notwithstanding anything to the contrary in this subchapter or the Vermont Open Meeting Law, the Board may examine and discuss confidential information outside of a public hearing or meeting.

(c) Notwithstanding anything to the contrary in subsection (a), subdivision (2) of this section, the Board may publicly disclose or release reimbursement information in summary or aggregate form if doing so does not raise competitive concerns.

8 V.S.A. § 4062 (Add subdivision (3) to subsection (b)).

(3) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall disclose to the Board provider reimbursement information, including fee schedules, payment methodologies, and other information as requested. The Board may use this information in conducting its duties under this section and under 18 V.S.A. § 9456, subject to confidentiality protections provided for by 18 V.S.A. § 9457.