

1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred Senate Bill No. 285
3 entitled “An act relating to health care reform initiatives, data collection, and
4 access to home- and community-based services” respectfully reports that it has
5 considered the same and recommends that the House propose to the Senate that
6 the bill be amended by striking out all after the enacting clause and inserting in
7 lieu thereof the following:

8 * * * Payment and Delivery System Reform; Appropriations * * *

9 Sec. 1. DEVELOPMENT OF PROPOSAL FOR SUBSEQUENT

10 ALL-PAYER MODEL AGREEMENT

11 (a)(1) The Director of Health Care Reform in the Agency of Human
12 Services, in collaboration with the Green Mountain Care Board, shall develop
13 a proposal for a subsequent agreement with the Center for Medicare and
14 Medicaid Innovation to secure Medicare’s sustained participation in multi-
15 payer alternative payment models in Vermont. In developing the proposal, the
16 Director shall consider:

17 (A) total cost of care targets;

18 (B) global payment models;

19 (C) **strategies and investments to strengthen access to:**

20 (i) primary care;

21 (ii) **investments in** home- and community-based services;

1 (iii) investments in subacute services;

2 (iv) investments in long-term care services;

3 (v) strategies to address social determinants of health; **and**

4 (vi) strategies to improve access to mental health and substance
5 use disorder treatment services; and

6 (D) strategies **and investments** to address health inequities.

7 (2)(A) The development of the proposal shall include consideration of
8 alternative payment and delivery system approaches for hospital services and
9 community-based providers such as primary care providers, mental health
10 providers, substance use disorder treatment providers, skilled nursing facilities,
11 home health agencies, and providers of long-term services and supports.

12 (B) The alternative payment models to be explored shall include, at a
13 minimum:

14 (i) value-based payments for hospitals, including global payments,
15 that take into consideration the sustainability of Vermont's hospitals **and the**
16 **State's rural nature**, as set forth in subdivision (b)(1) of this section;

17 (ii) geographically or regionally based global budgets for health
18 care services;

19 (iii) existing federal value-based payment models; and

20 (iv) broader total cost of care and risk-sharing models to address
21 patient migration patterns across systems of care.

1 (C) The proposal shall:

2 (i) include appropriate mechanisms to convert fee-for-service
3 reimbursements to predictable payments for multiple provider types, including
4 those described in subdivision (A) of this subdivision (2);

5 (ii) include a process to ensure reasonable and adequate rates of
6 payment and a reasonable and predictable schedule for rate updates;

7 (iii) meaningfully impact health equity and address inequities in
8 terms of access, quality, and health outcomes; and

9 (iv) support equal access to appropriate mental health care that
10 meets standards of quality, access, and affordability equivalent to other
11 components of health care as part of an integrated, holistic system of care.

12 (3)(A) The Director of Health Care Reform, in collaboration with the
13 Green Mountain Care Board, shall ensure that the process for developing the
14 proposal includes opportunities for meaningful participation by the full
15 continuum of health care and social service providers, payers, and other
16 interested stakeholders in all stages of the proposal’s development.

17 (B) The Director shall seek to minimize the administrative burden of
18 and duplicative processes for stakeholder input.

19 (C) To promote engagement with diverse stakeholders and ensure the
20 prioritization of health equity, the process may utilize existing local and
21 regional forums, including those supported by the Agency of Human Services.

1 (b) As set forth in subdivision (a)(2)(B)(i) of this section and
2 notwithstanding any provision of 18 V.S.A. § 9375(b)(1) to the contrary, the
3 Green Mountain Care Board shall:

4 (1) in collaboration with the Agency of Human Services and using the
5 stakeholder process described in subsection (a) of this section, build on
6 successful health care delivery system reform efforts by developing value-
7 based payments, including global payments, from all payers to Vermont
8 hospitals or accountable care organizations, or both, that will:

9 (A) help move the hospitals away from a fee-for-service model;

10 (B) provide hospitals with predictable, sustainable funding that is
11 aligned across multiple payers, consistent with the principles set forth in
12 18 V.S.A. § 9371, and sufficient to enable the hospitals to deliver high-quality,
13 affordable health care services to patients; **and**

14 (C) take into consideration the necessary costs and operating
15 expenses of providing services and not be based solely on historical charges;

16 **and**

17 **(D) take into consideration Vermont’s rural nature, including**
18 **that many areas of the State are remote and sparsely populated;**

19 (2) determine how best to incorporate value-based payments, including
20 global payments to hospitals or accountable care organizations, or both, into
21 the Board’s hospital budget review, accountable care organization certification

1 and budget review, and other regulatory processes, including assessing the
2 impacts of regulatory processes on the financial sustainability of Vermont
3 hospitals and identifying potential opportunities to use regulatory processes to
4 improve hospitals' financial health; and

5 (3) recommend a methodology for determining the allowable rate of
6 growth in Vermont hospital budgets, which may include the use of national
7 and regional indicators of growth in the health care economy and other
8 appropriate benchmarks, such as the Hospital Producer Price Index, Medical
9 Consumer Price Index, bond-rating metrics, and labor cost indicators, as well
10 as other metrics that incorporate differentials as appropriate to reflect the
11 unique needs of hospitals in highly rural and sparsely populated areas of
12 the State.

13 (c) On or before January 15, 2023, the Director of Health Care Reform and
14 the Green Mountain Care Board shall each report on their activities pursuant to
15 this section to the House Committees on Health Care and on Human Services
16 and the Senate Committees on Health and Welfare and on Finance.

17 Sec. 2. HOSPITAL SYSTEM TRANSFORMATION; PLAN FOR
18 ENGAGEMENT PROCESS; REPORT

19 (a) The Green Mountain Care Board shall develop a plan for a data-
20 informed, patient-focused, community-inclusive engagement process for
21 Vermont's hospitals to reduce inefficiencies, lower costs, improve population

1 health outcomes, reduce health inequities, and increase access to essential
2 services **while maintaining sufficient capacity for emergency management.**

3 (b) The plan for the engagement process shall include:

4 (A) which organization or agency will lead the engagement process;

5 (B) a timeline that shows the engagement process occurring after the
6 development of the all-payer model proposal as set forth in Sec. 1 of this act;

7 (C) how to hear from and share data, information, trends, and insights
8 with communities about the current and future states of the hospital delivery
9 system, unmet health care as identified through the community health needs
10 assessment, and opportunities and resources necessary to address those needs;
11 and

12 (D) a description of the opportunities to be provided for meaningful
13 participation in all stages of the process by employers; consumers; health care
14 professionals and health care providers, including those providing primary care
15 services; Vermonters who have direct experience with all aspects of Vermont's
16 health care system; and Vermonters who are diverse with respect to race,
17 income, age, and disability status;

18 (E) a description of the data, information, and analysis necessary to
19 support the process, including information and trends relating to the current
20 and future states of the health care delivery system in each hospital service
21 area, **the effects of the hospitals in neighboring states on the health care**

1 services delivered in Vermont, the potential impacts of hospital system
2 transformation on Vermont's community-based nonhospital health care and
3 social service providers, the workforce challenges in the health care and human
4 services systems, and the impacts of the pandemic;

5 (F) how to assess the impact of any changes to hospital services on
6 nonhospital providers, including on workforce recruitment and retention; and

7 (G) the amount of the additional appropriations needed to support the
8 engagement process; and

9 (H) a process for determining the amount of resources that will
10 be needed to support hospitals in implementing the transformation
11 initiatives to developed as a result of the engagement process.

12 (c) On or before January 15, 2023, the Green Mountain Care Board shall
13 report on its activities pursuant to this section to the House Committees on
14 Health Care and on Human Services and the Senate Committees on Health and
15 Welfare and on Finance.

16 Sec. 3. PAYMENT AND DELIVERY SYSTEM REFORM;

17 APPROPRIATIONS

18 (a) The sum of \$1,400,000.00 is appropriated from the General Fund to the
19 Agency of Human Services in fiscal year 2023 to support the work of the
20 Director of Health Care Reform as set forth in Sec. 1 of this act.

1 (C) evaluating the effectiveness of intervention programs on
2 improving patient outcomes;

3 (D) comparing costs between various treatment settings and
4 approaches;

5 (E) providing information to consumers and purchasers of health
6 care; and

7 (F) improving the quality and affordability of patient health care and
8 health care coverage.

9 (2) [Repealed.]

10 (b) The database shall contain unique patient and provider identifiers and a
11 uniform coding system; and shall reflect all health care utilization, costs, and
12 resources in this State; and health care utilization and costs for services
13 provided to Vermont residents in another state.

14 * * *

15 ~~(e) Records or information protected by the provisions of the physician-~~
16 ~~patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be~~
17 ~~held confidential, shall be filed in a manner that does not disclose the identity~~
18 ~~of the protected person. [Repealed.]~~

19 (f) The Board shall adopt a confidentiality code to ensure that information
20 obtained under this section is handled in an ethical manner.

21 * * *

1 (h)(1) All health insurers shall electronically provide to the Board in
2 accordance with standards and procedures adopted by the Board by rule:

3 (A) their health insurance claims data, provided that the Board may
4 exempt from all or a portion of the filing requirements of this subsection data
5 reflecting utilization and costs for services provided in this State to residents of
6 other states;

7 (B) cross-matched claims data on requested members, subscribers, or
8 policyholders; and

9 (C) member, subscriber, or policyholder information necessary to
10 determine ~~third party~~ third-party liability for benefits provided.

11 (2) The collection, storage, and release of health care data and statistical
12 information that are subject to the federal requirements of the Health Insurance
13 Portability and Accountability Act (HIPAA) shall be governed exclusively by
14 the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

15 * * *

16 (3)(A) The Board shall collaborate with the Agency of Human Services
17 and participants in the Agency's initiatives in the development of a
18 comprehensive health care information system. The collaboration is intended
19 to address the formulation of a description of the data sets that will be included
20 in the comprehensive health care information system, the criteria and
21 procedures for the development of limited-use data sets, the criteria and

1 procedures to ensure that HIPAA compliant limited-use data sets are
2 accessible, and a proposed time frame for the creation of a comprehensive
3 health care information system.

4 (B) To the extent allowed by HIPAA, the data shall be available as a
5 resource for insurers, employers, providers, purchasers of health care, and
6 State agencies to continuously review health care utilization, expenditures, and
7 performance in Vermont. In presenting data for public access, comparative
8 considerations shall be made regarding geography, demographics, general
9 economic factors, and institutional size.

10 (C) Consistent with the dictates of HIPAA, and subject to such terms
11 and conditions as the Board may prescribe by rule, the Vermont Program for
12 Quality in Health Care shall have access to the unified health care database for
13 use in improving the quality of health care services in Vermont. In using the
14 database, the Vermont Program for Quality in Health Care shall agree to abide
15 by the rules and procedures established by the Board for access to the data.
16 The Board’s rules may limit access to the database to limited-use sets of data
17 as necessary to carry out the purposes of this section.

18 (D) Notwithstanding HIPAA or any other provision of law, the
19 comprehensive health care information system shall not publicly disclose any
20 data that contain direct personal identifiers. For the purposes of this section,
21 “direct personal identifiers” include information relating to an individual that

1 contains primary or obvious identifiers, such as the individual’s name, street
2 address, e-mail address, telephone number, and Social Security number.

3 * * *

4 * * * Blueprint for Health * * *

5 Sec. 6. 18 V.S.A. § 702(d) is amended to read:

6 (d) The Blueprint for Health shall include the following initiatives:

7 * * *

8 (8) The use of quality improvement facilitation and other means to
9 support quality improvement activities, including using integrated clinical and
10 claims data, where available, to evaluate patient outcomes and promoting best
11 practices regarding patient referrals and care distribution between primary and
12 specialty care.

13 Sec. 7. BLUEPRINT FOR HEALTH; COMMUNITY HEALTH TEAMS;

14 QUALITY IMPROVEMENT FACILITATION; REPORT

15 On or before January 15, 2023, the Director of Health Care Reform in the
16 Agency of Human Services shall recommend to the House Committees on
17 Health Care and on Appropriations and the Senate Committees on Health and
18 Welfare, on Appropriations, and on Finance the amounts by which health
19 insurers and Vermont Medicaid should increase the amount of the per-person,
20 per month payments they make toward the shared costs of operating the
21 Blueprint for Health community health teams and providing quality

1 improvement facilitation, in furtherance of the goal of providing additional
2 resources necessary for delivery of comprehensive primary care services to
3 Vermonters and to sustain access to primary care services in Vermont. **The**
4 **Agency shall also provide an estimate of the State funding that would be**
5 **needed to support the increase for Medicaid, both with and without**
6 **federal financial participation.**

7 * * * Options for Extending Moderate Needs Supports * * *

8 Sec. 8. OPTIONS FOR EXTENDING MODERATE NEEDS SUPPORTS;
9 WORKING GROUP; GLOBAL COMMITMENT WAIVER; REPORT

10 (a) **The As part of developing the Vermont Action Plan for Aging Well**
11 **as required by 2020 Acts and Resolves No. 156, Sec. 3, the** Department of
12 Disabilities, Aging, and Independent Living shall convene a working group
13 comprising representatives of older Vermonters, home- and community-based
14 service providers, the Office of the Long-Term Care Ombudsman, the Agency
15 of Human Services, and other interested stakeholders to consider extending
16 access to long-term home- and community-based services and supports to a
17 broader cohort of Vermonters who would benefit from them, and their family
18 caregivers, including:

19 (1) the types of services, such as those addressing activities of daily
20 living, falls prevention, social isolation, medication management, and case
21 management that many older Vermonters need but for which many older

1 Vermonters may not be financially eligible or that are not covered under many
2 standard health insurance plans;

3 (2) the most promising opportunities to extend supports to additional
4 Vermonters, such as expanding the use of flexible funding options that enable
5 beneficiaries and their families to manage their own services and caregivers
6 within a defined budget and allowing case management to be provided to
7 beneficiaries who do not require other services;

8 (3) how to set clinical and financial eligibility criteria for the extended
9 supports, including ways to avoid requiring applicants to spend down their
10 assets in order to qualify;

11 (4) how to fund the extended supports, including identifying the options
12 with the greatest potential for federal financial participation;

13 (5) how to proactively identify Vermonters across all payers who have
14 the greatest need for extended supports;

15 (6) how best to support family caregivers, such as through training,
16 respite, home modifications, payments for services, and other methods; and

17 (7) the feasibility of extending access to long-term home- and
18 community-based services and supports and the impact on existing services.

19 (b) The working group shall also make recommendations regarding
20 changes to service delivery for persons who are dually eligible for Medicaid

1 and Medicare in order to improve care, expand options, and reduce
2 unnecessary cost shifting and duplication.

3 (e c) On or before January 15, **2023 2024**, the Department shall report to
4 the House Committees on Human Services, on Health Care, and on
5 Appropriations and the Senate Committees on Health and Welfare and on
6 Appropriations regarding the working group’s findings and recommendations,
7 including its recommendations regarding service delivery for dually eligible
8 individuals, and an estimate of any funding that would be needed to implement
9 the working group’s recommendations.

10 (e d) The Department shall collaborate with others in the Agency of
11 Human Services as needed in order to incorporate the working group’s
12 recommendations on extending access to long-term home- and community-
13 based services and supports **as an amendment to the Global Commitment to**
14 **Health Section 1115 demonstration in effect in 2024 or** into the Agency’s
15 proposals to and negotiations with the Centers for Medicare and Medicaid
16 Services for the iteration of Vermont’s Global Commitment to Health Section
17 1115 demonstration that will take effect following the expiration of the
18 demonstration currently under negotiation.

19 * * * Summaries of Green Mountain Care Board Reports * * *

20 Sec. 9. 18 V.S.A. § 9375 is amended to read:

21 § 9375. DUTIES

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(e)(1) The Board shall summarize and synthesize the key findings and recommendations from reports prepared by and for the Board, including its expenditure analyses and focused studies. The Board shall develop, in consultation with the Office of the Health Care Advocate, a standard for creating plain language summaries that the public can easily use and understand.

(2) All reports and summaries prepared by the Board shall be available to the public and shall be posted on the Board’s website.

*** * * Prior Authorizations * * ***

Sec. **10**. DEPARTMENT OF FINANCIAL REGULATION; GREEN
MOUNTAIN CARE BOARD; PRIOR AUTHORIZATIONS;
ADMINISTRATIVE COST REDUCTION; REPORT **(NEW)**

(a) The Department of Financial Regulation shall explore the feasibility of requiring health insurers and their prior authorization vendors to access clinical data from the Vermont Health Information Exchange whenever possible to support prior authorization requests in situations in which a request cannot be automatically approved.

(b) The Department of Financial Regulation shall direct health insurers to provide prior authorization information to the Department in a format required by the Department in order to enable the Department to analyze opportunities

1 to align and streamline prior authorization request processes. The Department
2 shall share its findings and recommendations with the Green Mountain Care
3 Board, and the Department and the Board shall collaborate to provide
4 recommendations to the House Committee on Health Care and the Senate
5 Committees on Health and Welfare and on Finance on or before January 15,
6 2023 regarding the statutory changes necessary to align and streamline prior
7 authorization processes and requirements across health insurers.

8 * * * Effective Dates * * *

9 Sec. 11. EFFECTIVE DATES

10 (a) Sec. 3 (payment and delivery system reform; appropriations) shall take
11 effect on July 1, 2022.

12 (b) The remainder of this act shall take effect on passage.

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18 (Committee vote: _____)

19 _____
20 Representative _____

21 FOR THE COMMITTEE