TO THE HONORABLE SENATE:

The Committee on Health and Welfare to which was referred Senate Bill No. 285 entitled "An act relating to expanding the Blueprint for Health and access to home- and community-based services" 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:

* * * Payment and Delivery System Reform * * *

Sec. 1. HOSPITAL VALUE-BASED PAYMENT DESIGN; DATA COLLECTION AND ANALYSIS; APPROPRIATIONS; REPORT

(a) The sum of $1,400,000.00 is appropriated from the General Fund to the Green Mountain Care Board in fiscal year 2023 to engage one or more consultants to assist the Board to:

(1) develop a process, consistent with 18 V.S.A. § 9375(b)(1) and including the meaningful participation of health care providers, payers, and other stakeholders in all stages of the development, for establishing and distributing value-based payments, including global payments, from all payers to Vermont hospitals that will:

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

(B) provide hospitals with predictable, sustainable funding that is aligned across multiple payers, consistent with the principles set forth in 18

V.S.A. § 9371, and sufficient to enable the hospitals to deliver high-quality, affordable health care services to patients; and

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

(2) determine how best to incorporate value-based payments, including hospital global payments, into the Board's hospital budget review, accountable care organization certification and budget review, and other regulatory processes, including assessing the impacts of regulatory processes on the financial sustainability of Vermont hospitals and identifying potential opportunities to use regulatory processes to improve hospitals' financial health; and

(3) recommend a methodology for determining the allowable rate of growth in Vermont hospital budgets, which may include the use of national and regional indicators of growth in the health care economy and other appropriate benchmarks, such as the Hospital Producer Price Index, Medical Consumer Price Index, bond-rating metrics, and labor cost indicators.

(b) As used in this section, "value-based payments" means payments made pursuant to a health care payment model in which health care providers, including hospitals and physicians, are paid based on patient health outcomes and in which health care providers are rewarded with

incentive payments based on the quality of the health care services they deliver.

(c)(1) On or before November 1, 2022, the Green Mountain Care Board shall provide an update on its use of the funds appropriated in this section to the Health Reform Oversight Committee.

(2) On or before January 15, 2023, the Green Mountain Care Board shall report on its use of the funds appropriated in this section to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 2. HEALTH CARE DELIVERY SYSTEM TRANSFORMATION; COMMUNITY ENGAGEMENT; APPROPRIATIONS; REPORT

(a) The sum of $2,500,000.00 is appropriated from the General Fund to the Green Mountain Care Board in fiscal year 2023 to engage one or more consultants with expertise in community engagement, preferably with experience in working with a diverse, rural population, and one or more consultants with expertise in health system design to assist the Board, in consultation with the Director of Health Care Reform in the Agency of Human Services, to build on successful health care delivery system reform efforts by:

(1) facilitating a patient-focused, community-inclusive plan for Vermont's health care delivery system to reduce inefficiencies, lower costs, improve population health outcomes, and increase access to essential services,

including both providing the analytics to support delivery system transformation and leading the broad-based community engagement process; and

(2) providing support and technical assistance to hospitals and communities to facilitate planning for delivery system reform and transformation initiatives.

(b) The community engagement process shall:

(1) include hearing from and sharing information, trends, and insights with communities about the current state of the health care providers in their hospital service area, unmet health care needs in their community, and opportunities to address those needs; and

(2) provide opportunities at all stages of the process for meaningful participation by employers; consumers; health care professionals and health care providers, including those providing primary care services; Vermonters who have direct experience with all aspects of Vermont's health care system; and Vermonters who are diverse with respect to race, income, age, and disability status.

(c) The Green Mountain Care Board shall use a portion of the funds appropriated in subsection (a) of this section to contract with a current or recently retired primary care provider to assist the Board in assessing and strengthening the role of primary care in its regulatory processes and to inform

the Board's efforts in payment reform and delivery system transformation from a primary care perspective.

(d)(1) In developing a plan for delivery system transformation pursuant to this section, the Green Mountain Care Board and the Director of Health Care Reform in the Agency of Human Services shall consider the capacity of Vermont's community-based health care and social service providers to effectively implement the plan as it relates to community providers while providing the appropriate level of services to consumers.

(2) For purposes of this section, "community-based health care and social service providers" includes federally qualified health centers, designated and specialized service agencies, home health agencies, area agencies on aging, adult day providers, residential care homes, nursing homes, providers of services addressing homelessness, and community action agencies.

(e)(1) On or before November 1, 2022, the Green Mountain Care Board shall provide an update on its use of the funds appropriated in this section to the Health Reform Oversight Committee.

(2) On or before January 15, 2023, the Green Mountain Care Board shall report on its use of the funds appropriated in this section to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 3. DEVELOPMENT OF PROPOSAL FOR SUBSEQUENT ALL-PAYER MODEL AGREEMENT; APPROPRIATION

(a)(1) The Director of Health Care Reform in the Agency of Human Services, in collaboration with the Green Mountain Care Board, shall design and develop a proposal for a subsequent agreement with the Centers for Medicare and Medicaid Innovation to secure Medicare's continued participation in multi-payer alternative payment models in Vermont. The proposal shall be informed by the community- and provider-inclusive process set forth in Sec. 2 of this act and designed to reduce inefficiencies, lower costs, improve population health outcomes, and increase access to essential services.

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

(3)(A) The alternative payment models to be explored shall include, at a minimum:

(i) global payments for hospitals;

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

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

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

(B) The alternative payment models shall:

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

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

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

(b) To support the design and development of a proposed agreement with the Centers for Medicare and Medicaid Innovation for Medicare's participation in multi-payer initiatives, which may include engaging consulting and analytic support, the following sums are appropriated from the General Fund in fiscal year 2023:

(1) $550,000.00 to the Agency of Human Services; and

(2) $550,000.00 to the Green Mountain Care Board.

Sec. 4. HEALTH INFORMATION EXCHANGE STEERING COMMITTEE; DATA STRATEGY

The Health Information Exchange (HIE) Steering Committee shall continue its work to create one health record for each person that integrates data types to include health care claims data; clinical, mental health, and substance use disorder services data; and social determinants of health data. In furtherance of these goals, the HIE Steering Committee shall include a data integration strategy in its 2023 HIE Strategic Plan to merge and consolidate claims data in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) with the clinical data in the HIE.

Sec. 5. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE DATABASE

(a)(1) The Board shall establish and maintain a unified health care database to enable the Board to carry out its duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

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

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

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

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

(2) [Repealed.]

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

* * *

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

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

* * *

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

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

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

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

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

* * *

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and

performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

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

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contain direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

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* * * Blueprint for Health * * *

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

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

* * *

(8) The use of quality improvement facilitators and other means to support quality improvement activities, including using clinical and claims data to evaluate patient outcomes and promoting best practices regarding patient referrals and care distribution between primary and specialty care.

Sec. 7. BLUEPRINT FOR HEALTH; COMMUNITY HEALTH TEAMS; QUALITY IMPROVEMENT FACILITATORS; REPORT

On or before September 1, 2022, the Director of Health Care Reform in the Agency of Human Services shall recommend to the Health Reform Oversight Committee the amounts by which health insurers and Vermont Medicaid should increase the amount of the per-person, per month payments they make toward the shared costs of operating the Blueprint for Health community health teams and quality improvement facilitators ~~to contribute to~~ **in furtherance of** the goal of ~~increasing each plan's or payer's spending on primary care~~ **providing additional resources necessary for delivery of** comprehensive primary care services to Vermonters and to sustain access to primary care services in Vermont. Such increases shall be reflected in health insurers' plan year 2024 rate filings if the increases cannot be implemented in a rate-neutral manner. The Agency shall also provide an estimate of the State funding that would be needed to support the increase for Medicaid, both with and without federal financial participation.

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

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

(a) The Department of Disabilities, Aging, and Independent Living shall convene a working group comprising representatives of older Vermonters, home- and community-based service providers, the Office of the Long-Term Care Ombudsman, the Agency of Human Services, and other interested stakeholders to consider extending access to long-term home- and community-based services and supports to a broader cohort of Vermonters who would benefit from them, and their family caregivers, including:

(1) the types of services, such as those addressing activities of daily living, falls prevention, social isolation, medication management, and case management that many older Vermonters need but for which many older Vermonters may not be financially eligible or that are not covered under many standard health insurance plans;

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

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

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

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

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

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

(b) The working group shall also make recommendations regarding changes to service delivery for persons who are dually eligible for Medicaid and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication.

(c) The Department shall collaborate with others in the Agency of Human Services as needed in order to incorporate the working group's recommendations on extending access to long-term home- and community-based services and supports into the Agency's proposals to and negotiations with the Centers for Medicare and Medicaid Services for the iteration of Vermont's Global Commitment to Health Section 1115 demonstration that will

take effect following the expiration of the demonstration currently under negotiation.

(d) On or before January 15, 2023, the Department shall report to the House Committees on Human Services, on Health Care, and on Appropriations and the Senate Committees on Health and Welfare and on Appropriations regarding the working group's findings and recommendations, including its recommendations regarding service delivery for dually eligible individuals, and an estimate of any funding that would be needed to implement the working group's recommendations.

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

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

§ 9375. DUTIES

* * *

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

* * * Effective Date * * *

Sec. 10. EFFECTIVE DATE

This act shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to health care reform initiatives, data collection, and access to home- and community-based services"

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE