S.211

Introduced by Senators Lyons, Clarkson and Kitchel

Referred to Committee on

Date:

Subject: Health; health care reform; Director of Health Care Reform; Green Mountain Care Board; hospitals

Statement of purpose of bill as introduced: This bill proposes to transfer certain duties from the Green Mountain Care Board to the Director of Health Care Reform in the Agency of Human Services and to modify or eliminate other Board duties. It bill would specify that the Board's review, consideration, and approval of hospital budgets and of certification and budgets of accountable care organizations (ACOs) are the deliberations of a public body in connection with a quasi-judicial proceeding. The bill would direct the Board to adopt rules to establish processes for certifying Medicare-only ACOs and would direct the Board of Nursing to adopt rules establishing a student nurse apprenticeship program. The bill would require insurers to participate in multipayer alternative payment models and would require nonbinding mediation conducted by the Green Mountain Care Board prior to the termination of a contract between a health care provider and a health plan. The bill would require alignment of certain health insurer credentialing practices, quality measures, and data collection. It would revise aspects of the

Green Mountain Care Board's hospital budget review processes and require the Secretary of State to provide training for the Board's members and staff. The bill also would require reports on population-based hospital budgeting; on realignment of the timing of the Green Mountain Care Board's regulatory processes; on review and approval of mergers, affiliations, and divestments involving Vermont-based health care providers; and on designating a single State agency for coordination of clinical health care data.

An act relating to health care reform and to the regulatory duties of the Green Mountain Care Board

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

Sec. 1. 3 V.S.A. § 3027 is amended to read:

§ 3027. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY AND AFFORDABILITY

(a) The Director of Health Care Reform in the Agency of Human Services shall be responsible for the coordination of health care system reform efforts among Executive Branch agencies, departments, and offices, and for coordinating with the Green Mountain Care Board established in 18 V.S.A. chapter 220, including engaging in payment and delivery system reform to the extent so directed by the General Assembly.

(b) The Director of Health Care Reform, in consultation with the Green Mountain Care Board and the Department of Health, shall develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(1) for determining public and health care professional satisfaction with the health system;

(2) for utilization of health services;

(3) also in consultation with the Director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(4) for cost-containment and limiting the growth in health care expenditures;

(5) for determining the adequacy of the supply and distribution of health care resources in this State;

(6) to address access to and quality of mental health and substance use disorder treatment services;

(7) for including population-level clinical data to measure population health improvements and for providing the information to the Green Mountain Care Board to inform the Board's decisions regarding health insurance rates, hospital budgets, and accountable care organization certification and budgets;

(8) for improving access to care through care coordination between providers and services, such as between hospitals and residential or long-term care services, between primary care and specialty care, between primary care and access to mental health or substance use disorder treatment and recovery services; and

(9) for other measures as determined by the Director.

Sec. 2. 18 V.S.A. chapter 13, subchapter 2 is added to read:

Subchapter 2. Payment Reform

§ 721. INSURER PARTICIPATION IN MULTIPAYER ALTERNATIVE PAYMENT MODELS

It is the intent of the General Assembly first to provide commercial health insurers in the State with the opportunity to participate in Vermont's multipayer alternative payment model or models established pursuant to the State's agreement with the Center for Medicare and Medicaid Innovation. In the event that no insurers elect to participate in Vermont's multipayer alternative payment model or models, the Department of Financial Regulation shall require health insurers to participate in Vermont's multipayer alternative payment models as a condition of doing business in this State.

Sec. 3. 18 V.S.A. § 9372 is amended to read:

§ 9372. PURPOSE

It is the intent of the General Assembly to create an independent board to promote the general good of the State by:

(1) ~~improving the health of the population~~ making decisions that improve population health;

(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers through regulation of health insurance rates pursuant to 8 V.S.A. § 4062; establishment of hospital budgets, including global hospital budgets, pursuant to chapter 221, subchapter 7 of this title; and certification of accountable care organizations and regulation of accountable care organization budgets pursuant to section 9382 of this title while ensuring that access to care and quality of care are not compromised; and

(3) ~~enhancing the patient and health care professional experience of care;~~

~~(4) recruiting and retaining high-quality health care professionals; and~~

~~(5) achieving administrative simplification in health care financing and delivery~~ aligning payer policies, administrative obligations, and clinical services to reduce administrative burdens, establish and improve equitable reimbursements, and ensure clinically appropriate care coordination and continuity of and access to high-quality care.

Sec. 4. 18 V.S.A. § 9374(d) and (e) are amended to read:

(d)(1) The Chair shall have general charge of the offices and employees of the Board but may hire a director to oversee the administration and operation.

(2)~~(A) Except for final decisions in regulatory matters over which the Board has jurisdiction, a member of the Board, Board officer, or Board employee may perform any service that is within the Board's jurisdiction and that the Board delegates to the member, officer, or employee.~~

~~(B)~~ The Board shall establish procedures to ensure that Board employees have appropriate supervision in their performance of delegated activities and that the Board remains informed regarding these activities.

(e)(1) The Board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the Board. Members of such advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The Board may establish additional advisory groups and subcommittees as needed to carry out its duties. The Board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

~~(3) To the extent funds are available, the Board may examine, on its own or through collaboration or contracts with third parties, the effectiveness of existing requirements for health care professionals, such as quality measures and prior authorization, and evaluate alternatives that improve quality, reduce costs, and reduce administrative burden.~~

Sec. 5. 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, in collaboration with the Director of Health Care Reform in the Agency of Human Services:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont~~, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms~~.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs that may include the participation of Medicare ~~and~~, Medicaid, and commercial insurance, which may include the creation of health care professional cost-

containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(i) The Board shall work in collaboration with the Director of Health Care Reform in the Agency of Human Services and health care providers to develop payment models that preserve access to care and quality in each community and that provide for equitable reimbursements to providers.

(ii) The rule shall take into consideration current Medicare designations and payment methodologies, including critical access hospitals, prospective payment system hospitals, graduate medical education payments, Medicare dependent hospitals, and federally qualified health centers.

(iii) The payment reform methodologies developed by the Board shall encourage coordination and planning on a regional basis, taking into account existing local relationships between providers and human services organizations.

(B) Prior to the ~~initial~~ adoption of the rules described in subdivision (A) of this subdivision (1), report the Board's proposed methodologies to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of State government to engage in additional cost-containment activities to the extent permitted by State and federal law.

(2)(A) Review and approve Vermont's statewide Health Information Technology Plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the State to achieve the principles expressed in section 9371 of this title.

(B) Review and approve the criteria required for health care providers and health care facilities to create or maintain connectivity to the State's health information exchange as set forth in section 9352 of this title. Within 90 days following this approval, the Board shall issue an order explaining its decision.

(C) Annually review and approve the budget, consistent with available funds, of the Vermont Information Technology Leaders, Inc. (VITL). This review shall take into account VITL's responsibilities pursuant to

section 9352 of this title and the availability of funds needed to support those responsibilities.

(3) ~~Review and approve the Health Care Workforce Development Strategic Plan created in chapter 222 of this title.~~ [Repealed.]

(4) Publish on its website the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources in accordance with section 9405 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, protecting insurer solvency, and other issues at the discretion of the Board.

(7) Review and establish hospital budgets, including global budgets, pursuant to chapter 221, subchapter 7 of this title.

(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title.

(9) Review and approve, with recommendations from the Commissioner of Vermont Health Access, the benefit package or packages for qualified

health benefit plans and reflective health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1. The Board shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare within 15 days following its approval of any substantive changes to the benefit packages.

(10) ~~Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:~~

~~(A) for determining public and health care professional satisfaction with the health system;~~

~~(B) for utilization of health services;~~

~~(C) in consultation with the Department of Health and the Director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;~~

~~(D) for cost-containment and limiting the growth in health care expenditures;~~

~~(E) for determining the adequacy of the supply and distribution of health care resources in this State;~~

~~(F) to address access to and quality of mental health and substance abuse services; and~~

~~(G) for other measures as determined by the Board.~~

Engage in payment and delivery system reform to the extent so directed by the General Assembly or in collaboration with the Agency of Human Services.

* * *

Sec. 6. 18 V.S.A. § 9376 is amended to read:

§ 9376. PAYMENT AMOUNTS; METHODS

(a) It is the intent of the General Assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest. It is also the intent of the General Assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

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

professionals over time and need not set rates for all types of health care professionals.

(B) The Board may utilize reference-based pricing, site-neutral payments, and other strategies that promote equitable reimbursement and the quality of, access to, and affordability of health care services in this State, provided such strategies are not inconsistent with the State's health care reform initiatives.

(C) In establishing rates, the Board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the State, and the need for health care professionals in particular areas of the State, particularly in underserved geographic or practice shortage areas.

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

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

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

* * *

Sec. 7. 18 V.S.A. § 9377 is amended to read:

§ 9377. PAYMENT REFORM~~; PILOTS~~

~~(a) It is the intent of the General Assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the General Assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the General Assembly to ensure sufficient State involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and State antitrust provisions by replacing competition between payers and others with State-supervised cooperation and regulation.~~

~~(b)(1)~~ The Board shall ~~be responsible for payment and delivery system reform, including the pilot projects established in this section~~ engage in payment and delivery system reform only to the extent directed by the General Assembly or in collaboration with the Director of Health Care Reform in the Agency of Human Services.

~~(2) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:~~

~~(A) payment reform pilot projects should align with the Blueprint for Health strategic plan and the Statewide Health Information Technology Plan;~~

~~(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure that results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;~~

~~(C) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets, which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;~~

~~(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and~~

~~(E) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.~~

~~(3) In addition to the objectives identified in subdivision (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:~~

~~(A) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and~~

~~(B) with input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.~~

~~(c) To the extent required to avoid federal antitrust violations, the Board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The Board shall ensure that the process and implementation include sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, violate State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to~~

~~health care, increasing efficiency, or reducing costs by modifying payment methods.~~

~~(d) The Board or designee shall apply for grant funding, if available, for the evaluation of the pilot projects described in this section.~~

~~(e) The Board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the Office of the Health Care Advocate, and State and local governments, to advise the Board in developing and implementing the pilot projects and to advise the Green Mountain Care Board in setting overall policy goals.~~

~~(f) The first pilot project shall become operational not later than July 1, 2012, and two or more additional pilot projects shall become operational not later than October 1, 2012.~~

~~(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the Department of Financial Regulation to the same extent as the requirement to participate in the Blueprint for Health pursuant to 8 V.S.A. § 4088h.~~

~~(2) The Board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the Board, in consultation with the Commissioner of Financial Regulation. Health insurers shall be exempt from participation if the insurer offers only benefit plans that are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.~~

~~(3) In the event that the Secretary of Human Services is denied permission from the Centers for Medicare and Medicaid Services to include financial participation by Medicare in the pilot projects, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.~~

~~(4) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.~~

Sec. 8. 18 V.S.A. § 9382 is amended to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

* * *

(d) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public upon request, provided that individual patients or health care providers shall not be directly or indirectly identifiable. The Board's review, consideration, and approval of an application for certification or a budget of an ACO under this section shall be considered the deliberations of a public body in connection with a quasi-judicial proceeding in accordance with 1 V.S.A. § 312.

* * *

(f) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying ACOs that receive payments only from Medicare. In determining whether to certify an Medicare-only ACO to operate in this State, the Board may consider as many of the criteria described in subsection (a) of this section as the Board deems appropriate to a specific ACO's size and scope.

Sec. 9. 18 V.S.A. § 9406 is added to read:

§ 9406. GREEN MOUNTAIN CARE BOARD; MEDIATION PRIOR TO TERMINATION OR NONRENEWAL

At least 60 days prior to the termination of a contract between a health care provider, including a health care facility, and a health plan issued or offered by a health insurer, the parties shall utilize the mediation services of the Green

Mountain Care Board to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on the parties.

Sec. 10. 18 V.S.A. § 9407 is added to read:

§ 9407. ALIGNMENT OF CREDENTIALING, QUALITY MEASURES, AND DATA COLLECTION

(a) Each health insurer and Vermont Medicaid shall credential and enroll any health care provider who is credentialed and enrolled in Medicare.

(b) A health insurer shall not require a health care provider to engage in or report on quality measures other than those used by the Centers for Medicare and Medicaid Services.

(c) A health insurer shall not require health care providers to collect data other than that collected by the Centers for Medicare and Medicaid Services.

Sec. 11. 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, as well as aggregate data on provider productivity;

(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) salary information for the hospital's executive and clinical leadership and the hospital's salary spread; and

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

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

Sec. 12. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

(a) The Board shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter and in accordance with a schedule established by the Board. The Board's review, consideration, and establishment of hospital budgets under this section shall be considered the deliberations of a public body in connection with a quasi-judicial proceeding in accordance with 1 V.S.A. § 312.

(b) In conjunction with budget reviews, the Board shall:

(1) review utilization information and aggregate data on provider productivity;

(2) consider the quality of, access to, and affordability of the services provided by each hospital;

(3) consider the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources developed pursuant to section 9405 of this title;

~~(3)~~(4) consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review as well as evaluating and considering spending across sectors of the health care industry, including primary care, mental health care, long-term care, hospitals, independent specialists, and substance use disorder treatment;

~~(4)~~(5) consider any reports from professional review organizations;

~~(5)~~(6) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

~~(6)~~(7) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

~~(7)~~(8) give public notice of the meetings with hospitals~~,~~ and invite the public to attend and to comment on the proposed budgets;

~~(8)~~(9) consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;

~~(9)~~(10) require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals;

~~(10)~~(11) require each hospital to provide information on administrative costs, as defined by the Board, including specific information on the amounts spent on marketing and advertising costs;

~~(11)~~(12) require each hospital to create or maintain connectivity to the State's Health Information Exchange Network in accordance with the criteria established by the Vermont Information Technology Leaders, Inc., pursuant to subsection 9352(i) of this title, provided that the Board shall not require a hospital to create a level of connectivity that the State's Exchange is unable to support;

~~(12)~~(13) review the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors; ~~and~~

~~(13)~~(14) consider the salaries for the hospital's executive and clinical leadership and the hospital's salary spread, including a comparison of median salaries to the medians of northern New England states; and

(15) if the hospital is part of a hospital system, as defined in subsection 9420(b) of this chapter, consider the role of the hospital in the hospital system when evaluating performance, financial stability, and internal allocation of resources.

(c) Individual hospital budgets established under this section shall:

(1) be consistent with the Health Resource Allocation Plan;

(2) take into consideration national, regional, or in-state peer group norms, according to indicators, ratios, and statistics established by the Board;

(3) promote efficient and economic operation of the hospital;

(4) reflect budget performances for prior years;

(5) include a finding that the analysis provided in subdivision ~~(b)(9)~~ (b)(10) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers; and

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

(d)(1) Annually, the Board shall establish a budget for each hospital on or before ~~September~~ June 15, followed by a written decision by ~~October~~ July 1. Each hospital shall operate within the budget established under this section.

(2) Any hospital revenue connected to a fixed prospective payment arrangement shall not be considered as part of a hospital's budget for purposes of Board review under this subchapter.

(3)(A) It is the General Assembly's intent that hospital cost containment conduct is afforded state action immunity under applicable federal and State antitrust laws, if:

(i) the Board requires or authorizes the conduct in any hospital budget established by the Board under this section;

(ii) the conduct is in accordance with standards and procedures prescribed by the Board; and

(iii) the conduct is actively supervised by the Board.

(B) A hospital's violation of the Board's standards and procedures shall be subject to enforcement pursuant to subsection (h) of this section.

~~(3)~~(4)(A) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to the hospital budget review and may:

(i) ask questions of employees of the Green Mountain Care Board related to the Board's hospital budget review;

(ii) submit written questions to the Board that the Board will ask of hospitals in advance of any hearing held in conjunction with the Board's hospital review:

(iii) submit written comments for the Board's consideration; and

(iv) ask questions and provide testimony in any hearing held in conjunction with the Board's hospital budget review.

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

(e)(1) The Board may establish a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks. Any such criteria or benchmarks shall be set at the hospital level or across the health care system, and not at an individual cost center or service level. The Board shall consult with stakeholders prior to establishing any such criteria or benchmarks; any criteria or benchmarks shall be established not later than March 31 annually and shall not be adjusted or amended during the budget process except by mutual agreement of the affected parties.

(2) The Board may waive one or more of the review processes listed in subsection (b) of this section.

(f) The Board may, upon application, adjust a budget established under this section upon a showing of need based upon exceptional or unforeseen

circumstances in accordance with the criteria and processes established under section 9405 of this title.

* * *

Sec. 13. 26 V.S.A. § 1574 is amended to read:

§ 1574. POWERS AND DUTIES

(a) In addition to the powers granted by 3 V.S.A. § 129, the Board shall:

* * *

(11) Adopt rules establishing a student nurse apprenticeship program, including determining eligibility for the program, defining the scope of practice for student nurse apprentices, and providing for Board issuance of student nurse apprentice permits to eligible nursing students.

* * *

Sec. 14. GREEN MOUNTAIN CARE BOARD TRAINING

The Secretary of State shall provide or arrange for the provision of training for members and staff of the Green Mountain Care on Vermont's Open Meeting Law; conduct of a contested case, including appropriate decorum during hearings and other public meetings; and such other topics as the Secretary deems appropriate for the proper operation of a governmental board. The training shall be provided to newly appointed members of the Board and at such other times as the Chair of the Board may request.

Sec. 15. POPULATION-BASED HOSPITAL BUDGETING; REPORT

(a) The Agency of Human Services, Department of Financial Regulation, and Green Mountain Care Board shall collaborate to develop a joint plan to implement population-based hospital budgeting that is based on an actuarily determined rate of growth designed to ensure hospital solvency and stability and that may serve as a model for future payment reform initiatives. The plan may include one or more of the following:

(1) creation of a unified, comprehensive data source that supports both attribution and measurement of per capita costs in various populations;

(2) use of geography-based attribution, enhanced by person-level information;

(3) selection of a geographic unit for attribution;

(4) separate attribution of populations by type of care;

(5) development of one or more mechanisms to attribute the portion of the population in each geographic unit whose use of hospital care is at other than the dominant hospital;

(6) establishment of an initial budget; and

(7) establishment of methods to project expected cost growth and the setting of an allowed growth rate.

(b)(1) On or before September 30, 2024, the Agency, Department, and Board shall provide a progress report on their plan development to the Health Reform Oversight Committee.

(2) On or before January 15, 2025, the Agency, Department, and Board shall submit their joint plan for implementing population-based hospital budgeting to the House Committee on Health Care and the Senate Committee on Health and Welfare.

Sec. 16. GREEN MOUNTAIN CARE BOARD REGULATORY REVIEW; REALIGNMENT REPORT

The Green Mountain Care Board, in consultation with the Director of Health Care Reform in the Agency of Human Services, shall evaluate realignment of the timing of the Green Mountain Care Board's regulatory processes. The evaluation shall build and expand upon the Board's regulatory alignment efforts and may include considering alternative models such as multi-year budget reviews, multi-year financial stability audits, and other regulatory processes that achieve the State's goals of improving the health of the population and reducing the per capita rate of cost growth while ensuring access to and quality of health care. The Board shall report its findings and recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on or before January 15, 2025.

Sec. 17. REVIEW AND APPROVAL OF MERGERS, AFFILIATIONS, DIVESTMENTS; REPORT

The Office of the Attorney General, in collaboration with the Green Mountain Care Board, shall develop joint legislative proposals for appropriate review and approval of mergers, affiliations, and divestments involving hospitals, clinics, independent practices, long-term care facilities, and other health care providers located in Vermont by the Office of the Attorney General or the Green Mountain Care Board, or both. On or before December 15, 2024, the Office of the Attorney General and the Green Mountain Care Board shall provide their legislative proposals to the House Committees on Health Care and on Human Services, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee.

Sec. 18. SINGLE STATE AGENCY FOR CLINICAL HEALTH CARE DATA COORDINATION; REPORT

The Director of Health Care Reform in the Agency of Human Services, in consultation with interested stakeholders, shall develop a proposal for a single entity in Executive Branch, such as the Department of Health, to be responsible for establishing and maintaining a system for collecting and integrating clinical health care data. The system, which shall be designed and implemented in collaboration with the Director of the Health Care Reform, the Green Mountain Care Board, the Blueprint for Health, the Vermont Program

for Quality in Health Care, Inc. (VPQHC), Vermont Information Technology Leaders, Inc. (VITL), and other entities collecting clinical and claims data, shall collect and integrate the data from sources including the Vermont Health Information Exchange, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), accountable care organizations, and VPQHC in a manner that allows the data to be made accessible for analysis by provider type and to be used for bundled payments, for clinical improvement as determined to be appropriated by health care providers, and for other purposes in keeping with monitoring and improving population health and health outcomes.

Sec. 19. EFFECTIVE DATES

This act shall take effect on July 1, 2024, except that Sec. 11 (18 V.S.A. § 9454) and, in Sec. 12 (18 V.S.A. § 9454), subsections (b)–(d) shall take effect on January 1, 2025 and apply to hospital budget reviews occurring on or after that date.