No. 62. An act relating to modifying the regulatory duties of the Green Mountain Care Board.

(S.63)

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

Sec. 1. 18 V.S.A. § 9351 is amended to read:

§ 9351. HEALTH INFORMATION TECHNOLOGY PLAN

(a)(1) The Department of Vermont Health Access, in consultation with the Department's Health Information Exchange Steering Committee, shall be responsible for the overall coordination of Vermont's statewide Health Information Technology Plan. The Plan shall be revised annually and updated comprehensively every five years to provide a strategic vision for clinical health information technology.

(2) ~~The Department shall submit the proposed Plan to the Green Mountain Care Board annually on or before November 1. The Green Mountain Care Board shall approve, reject, or request modifications to the Plan within 45 days following its submission; if the Board has taken no action after 45 days, the Plan shall be deemed to have been approved.~~ [Repealed.]

(3)(A) The Department, in consultation with the Steering Committee, shall administer the Plan.

(B) The Plan shall include the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. The Plan shall provide for each patient's

electronic health information that is contained in the Vermont Health Information Exchange to be accessible to health care facilities, health care professionals, and public and private payers to the extent permitted under federal law unless the patient has affirmatively elected not to have the patient's electronic health information shared in that manner.

(C) The Plan shall include standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, access to advance care planning documents, and, overall, a more efficient and less costly means of delivering quality health care in Vermont.

(D) A representative of the Green Mountain Care Board shall be a voting member of the Steering Committee.

* * *

(c) The Department of Vermont Health Access, in consultation with the Steering Committee ~~and subject to Green Mountain Care Board approval~~, may propose updates to the Plan in addition to the annual updates as needed to reflect emerging technologies, the State's changing needs, and such other areas as the Department deems appropriate. The Department shall solicit recommendations from interested stakeholders in order to propose updates to the Health Information Technology Plan pursuant to subsection (a) of this section and to this subsection, including applicable standards, protocols, and pilot programs, and ~~following approval of the proposed updates by the Green~~

~~Mountain Care Board,~~ may enter into a contract or grant agreement with appropriate entities to update some or all of the Plan. ~~Upon approval of the updated Plan by the Green Mountain Care Board, the~~ The Department of Vermont Health Access shall distribute the updated Plan to the Secretary of Administration; the Secretary of Digital Services; the Commissioner of Financial Regulation; the Green Mountain Care Board; the Secretary of Human Services; the Commissioner of Health; the Commissioner of Mental Health; the Commissioner of Disabilities, Aging, and Independent Living; the Senate Committee on Health and Welfare; the House Committee on Health Care; affected parties; and interested stakeholders. Unless major modifications are required, the Department may present updated information about the Plan to the legislative committees of jurisdiction in lieu of creating a written report.

(d) The Health Information Technology Plan shall serve as the framework within which the Green Mountain Care Board reviews certificate of need applications for information technology under section 9440b of this title. In addition, the ~~Commissioner of Information and Innovation~~ Secretary of Digital Services shall use the Health Information Technology Plan as the basis for independent review of State information technology procurements.

* * *

Sec. 2. 18 V.S.A. § 9352 is amended to read:

§ 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

* * *

(c) Health information exchange operation.

(1) VITL shall be designated in the Health Information Technology Plan ~~approved by the Green Mountain Care Board pursuant to section 9351 of this title~~ to operate the exclusive statewide health information exchange network for this State. The Plan shall determine the manner in which Vermont's health information exchange network shall be managed. ~~The Green Mountain Care Board shall have the authority to approve VITL's budget pursuant to chapter 220 of this title.~~ Nothing in this chapter shall impede local community providers from the exchange of electronic medical data.

* * *

(e) Report. On or before January 15 of each year, VITL shall file a report with the Green Mountain Care Board; the Secretary of Administration; the Secretary of Digital Services; the Commissioner of Financial Regulation; the Commissioner of Vermont Health Access; the Secretary of Human Services; the Commissioner of Health; the Commissioner of Mental Health; the Commissioner of Disabilities, Aging, and Independent Living; the Senate Committee on Health and Welfare; and the House Committee on Health Care. The report shall include an assessment of progress in implementing health information technology in Vermont and recommendations for additional funding and legislation required. In addition, VITL shall publish minutes of VITL meetings and any other relevant information on a public website. The

provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subsection.

* * *

(i) Certification of meaningful use and connectivity.

(1) To the extent necessary to support Vermont's health care reform goals or as required by federal law, VITL shall be authorized to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont.

(2) VITL, in consultation with health care providers and health care facilities, shall establish criteria for creating or maintaining connectivity to the State's health information exchange network. ~~VITL shall provide the criteria annually on or before March 1 to the Green Mountain Care Board established pursuant to chapter 220 of this title.~~

* * *

Sec. 3. 18 V.S.A. § 9374(h) is amended to read:

(h)(1)(A) Except as otherwise provided in subdivisions (1)(C) and (2) of this subsection (h), the expenses of the Board shall be borne as follows:

(i) ~~40.0~~ 40 percent by the State from State monies;

(ii) ~~28.8~~ 36 percent by the hospitals; and

(iii) ~~23.2~~ 24 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125, health insurance

companies licensed under 8 V.S.A. chapter 101, and health maintenance organizations licensed under 8 V.S.A. chapter 139~~; and~~

~~(iv) 8.0 percent by accountable care organizations~~.

(B) Expenses under subdivision (A)(iii) of this subdivision (1) shall be allocated to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this subdivision (1) shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care, limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(C) ~~Expenses~~ Amounts assessed pursuant to the provisions of ~~section~~ sections 9382 and 9441 of this title shall not be assessed in accordance with the formula set forth in subdivision (A) of this subdivision (1).

(2) The Board may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subdivision (1) of this subsection if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

(3) If the amount of the proportional assessment to any entity calculated in accordance with the formula set forth in subdivision (1)(A) of this subsection would be less than $150.00, the Board shall assess the entity a minimum fee of $150.00. The Board shall apply the amounts collected based on the difference between each applicable entity's proportional assessment

amount and $150.00 to reduce the total amount assessed to the regulated entities pursuant to subdivisions ~~(1)(A)(ii) (iv)~~ (1)(A)(ii) and (iii) of this subsection.

* * *

Sec. 4. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

* * *

(b) The Board shall have the following duties:

* * *

(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.~~ [Repealed.]

* * *

(12) ~~Review data regarding mental health and substance abuse treatment reported to the Department of Financial Regulation pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the Mental Health Technical Advisory Group established pursuant to subdivision 9374(e)(2) of this title.~~ [Repealed.]

(13) Adopt by rule pursuant to 3 V.S.A. chapter 25 such standards as the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter, including reporting requirements, patient protections, and solvency and ability to assume financial risk.

* * *

Sec. 5. 18 V.S.A. § 9382 is amended to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a)(1) In order to be eligible to ~~receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model~~ operate in Vermont, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations.

To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

~~(1)~~(A) The ACO's ~~governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input.~~

~~(2) The ACO has established appropriate~~ mechanisms and care models ~~to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO. The ACO ensures 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~~, taken as a whole, support and do not hinder the State's principles for health care reform as set forth in section 9371 of this title.

(B) The ACO's financial incentives for providers and patients are reasonably calculated to improve, or at a minimum, maintain, the quality of, access to, and affordability of care.

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

~~(4)~~(D) The ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination ~~and are related to the needs of the ACO and the patient population served~~.

~~(5) The ACO has established mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care, where feasible.~~

~~(6) The ACO's participating providers have the capacity for meaningful participation in health information exchanges.~~

~~(7)~~(E) The ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers.

~~(8)~~(F) The ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health.

~~(9) The ACO's participating health care providers engage their patients in shared decision making to inform them of their treatment options and the related risks and benefits of each.~~

~~(10)~~(G) The ACO offers assistance to health care consumers, including:

~~(A)~~(i) maintaining a consumer telephone line for questions, complaints, and grievances from attributed patients;

~~(B)~~(ii) responding and making best efforts to resolve complaints and grievances from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan;

~~(C)~~(iii) providing an accessible mechanism for explaining how ACOs work;

~~(D)~~(iv) providing contact information for the Office of the Health Care Advocate; and

~~(E)~~(v) sharing deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually.

~~(11) The ACO collaborates with providers not included in its financial model, including home- and community-based providers and dental health providers.~~

~~(12) The ACO does not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the ACO; does not reduce covered services; and does not increase patient cost sharing.~~

~~(13) The meetings of the ACO's governing body comply with the provisions of section 9572 of this title.~~

~~(14) The impact of the ACO's establishment and operation does not diminish access to any health care or community-based service or increase delays in access to care for the population and area it serves.~~

~~(15) The ACO has in place appropriate mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities.~~

~~(16)~~(H) The ACO has in place a financial guarantee sufficient to cover its potential losses.

~~(17) The ACO provides connections and incentives to existing community services for preventing and addressing the impact of childhood adversity. The ACO collaborates on the development of quality-outcome measurements for use by primary care providers who work with children and families and fosters collaboration among care coordinators, community service providers, and families.~~

(2) Notwithstanding subdivision (1) of this subsection, the Green Mountain Care Board may adopt rules in accordance with 3 V.S.A. chapter 25 to establish a streamlined process for certification as a Medicare-only ACO for

an entity authorized by the Centers for Medicare and Medicaid Services to act as an accountable care organization under the Medicare program. The streamlined process may require a Medicare-only ACO to meet one or more of the criteria set forth in subdivision (1) of this subsection. Certification obtained pursuant to the streamlined process shall apply to the Medicare-only ACO's actions only as they relate to Medicare beneficiaries and only to the extent that the federal authorization allows.

(b)~~(1)~~ The Green Mountain Care Board shall adopt rules ~~pursuant to~~ in accordance with 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs ~~with 10,000 or more~~ that receive payments from Medicaid or commercial insurers, or both, on behalf of attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

~~(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;~~

~~(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;~~

~~(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;~~

~~(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;~~

~~(E) any reports from professional review organizations;~~

~~(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;~~

~~(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;~~

~~(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;~~

~~(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing~~

~~support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;~~

~~(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;~~

~~(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;~~

~~(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;~~

~~(M) information on the ACO's administrative costs, as defined by the Board;~~

~~(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;~~

~~(O) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and~~

~~(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.~~

~~(2) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with fewer than 10,000 attributed lives in Vermont. In its review, the Board may consider as many of the factors described in subdivision (1) of this subsection as the Board deems appropriate to a specific ACO's size and scope~~

(1) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(2) the efficacy with which the ACO uses funds from Medicaid and commercial insurers, as applicable, to enhance and expedite the State's health care system transformation efforts;

(3) the ACO's reasonable use of State and commercial insurance funds for its own administrative costs, as defined by the Board;

(4) the ACO's collaboration with a range of provider types, such as home- and community-based providers, dental health providers, and mental health and substance use disorder treatment providers;

(5) the ACO's use of a consumer advisory board and other mechanisms for inviting and considering consumer input; and

(6) public comment on all aspects of the ACO's costs, operations, and proposed budget.

~~(3)(A)~~(c)(1) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to any ACO certification or budget review and may:

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

~~(ii)~~(B) submit written questions to the Board that the Board will ask of the ACO in advance of any hearing held in conjunction with the Board's ACO review;

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

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

~~(B)~~(2) The Office of the Health Care Advocate shall not disclose further any confidential or proprietary information provided to the Office pursuant to this ~~subdivision (3)~~ subsection.

~~(c)~~(d) The Board's rules shall include requirements for submission of information and data by ACOs and their participating providers as needed to evaluate an ACO's success. ~~They~~ The rules may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

~~(d)~~(e) 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~~ in accordance with 1 V.S.A. chapter 5, subchapter 3 (Public Records Act), provided that individual patients or health care providers shall not be directly or indirectly identifiable.

~~(e)~~(f) To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute 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, may be in violation of 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.

(g) The Board shall collect the following amounts from an accountable care organization:

(1) $10,000.00 for initial certification in accordance with subsection (a) of this section;

(2) $2,000.00 annually following initial certification to maintain certification; and

(3) $125,000.00 for each review of the accountable care organization's budget in accordance with subsection (b) of this section.

Sec. 6. 18 V.S.A. § 9454 is amended to read:

§ 9454. HOSPITALS; DUTIES

* * *

(b)(1) ~~Hospitals~~ General hospitals, as defined in section 1902 of this title, shall adopt a fiscal year that shall begin on October 1.

(2) Psychiatric hospitals, as defined in section 1902 of this title but excluding those conducted, maintained, or operated by the State of Vermont, shall adopt a fiscal year that shall begin on January 1.

Sec. 7. 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. Notwithstanding any provision of 3 V.S.A. chapter 25 to the contrary, the Board's review,

establishment, and enforcement of hospital budgets under this section shall not be construed to be a contested case. Any person aggrieved by a final Board action, order, or determination under this section may appeal as set forth in section 9381 of this title.

* * *

(d)(1)(A) Annually, the Board shall establish a budget for each general hospital, as defined in section 1902 of this title, on or before September 15, followed by a written decision ~~by~~ on or before October 1.

(B) Annually, the Board shall establish a budget for each psychiatric hospital, as defined in section 1902 of this title but excluding those conducted, maintained, or operated by the State of Vermont, on or before December 15, followed by a written decision on or before December 31.

(C) Each hospital shall operate within the budget established under this section.

* * *

(h)(1) If a hospital violates a provision of this section, the Board may maintain an action in the Superior Court of the county in which the hospital is located to enjoin, restrain, or prevent such violation.

(2)(A) After notice and an opportunity for hearing, the Board may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of ~~no~~ not more than $40,000.00, or in the case of a continuing violation, a civil

administrative penalty of ~~no~~ not more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

(B)(i) The Board may order a hospital to:

* * *

(ii) Orders issued under this subdivision (2)(B) shall be issued after notice and an opportunity to be heard, except where the Board finds that a hospital's financial or other emergency circumstances pose an immediate threat of harm to the public or to the financial condition of the hospital. Where there is an immediate threat, the Board may issue orders under this subdivision (2)(B) without written or oral notice to the hospital. Where an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. The hearing shall be held within 30 days after receipt of the hospital's request for a hearing, and a decision shall be issued within 30 days after conclusion of the hearing. The Board may increase the time to hold the hearing or to render the decision for good cause shown. ~~Hospitals may appeal any decision in this subsection to Superior Court. Appeal shall be on the record as developed by the Board in the administrative proceeding and the standard of review shall be as provided in 8 V.S.A. § 16.~~

Sec. 8. 18 V.S.A. § 9572 is amended to read:

§ 9572. MEETINGS OF AN ACCOUNTABLE CARE ORGANIZATION'S GOVERNING BODY

(a) Application. This section shall apply to all regular, special, and emergency meetings of the governing board of an accountable care ~~organization's governing body~~ organization that contracts with the Vermont Medicaid program, whether the meeting is held in person or by electronic means, as well as to any other assemblage of members of the ACO's governing body at which binding action is taken on behalf of the ACO. For purposes of this section, the term "ACO's governing body" shall also include the governing body of any organization acting as a coordinating entity for two or more ACOs that contract with Vermont Medicaid.

* * *

Sec. 9. REPEAL

18 V.S.A. § 9573 (Medicaid advisory rate case) is repealed.

Sec. 10. EFFECTIVE DATES

(a) In Sec. 5, (18 V.S.A. § 9382), subsection (a) shall take effect on January 1, 2027 and subsections (b)–(g) shall take effect on January 1, 2026.

(b) Secs. 6 (18 V.S.A. § 9454) and 7 (18 V.S.A. § 9456) and this section shall take effect on passage.

(c) The remaining sections shall take effect on July 1, 2025.

Date Governor signed bill: June 12, 2025