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S.63

An act relating to modifying the regulatory duties of the Green Mountain
Care Board

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 [Repealed.]~~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

1 information among health care facilities, health care professionals, public and
2 private payers, and patients. The Plan shall provide for each patient's
3 electronic health information that is contained in the Vermont Health
4 Information Exchange to be accessible to health care facilities, health care
5 professionals, and public and private payers to the extent permitted under
6 federal law unless the patient has affirmatively elected not to have the patient's
7 electronic health information shared in that manner.

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

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

15 * * *

16 (c) The Department of Vermont Health Access, in consultation with the
17 Steering Committee ~~and subject to Green Mountain Care Board approval~~, may
18 propose updates to the Plan in addition to the annual updates as needed to
19 reflect emerging technologies, the State's changing needs, and such other areas
20 as the Department deems appropriate. The Department shall solicit
21 recommendations from interested stakeholders in order to propose updates to

1 the Health Information Technology Plan pursuant to subsection (a) of this
2 section and to this subsection, including applicable standards, protocols, and
3 pilot programs, and ~~following approval of the proposed updates by the Green~~
4 ~~Mountain Care Board~~, may enter into a contract or grant agreement with
5 appropriate entities to update some or all of the Plan. ~~Upon approval of the~~
6 ~~updated Plan by the Green Mountain Care Board, the~~ The Department of
7 Vermont Health Access shall distribute the updated Plan to the Secretary of
8 Administration; the Secretary of Digital Services; the Commissioner of
9 Financial Regulation; the Green Mountain Care Board; the Secretary of
10 Human Services; the Commissioner of Health; the Commissioner of Mental
11 Health; the Commissioner of Disabilities, Aging, and Independent Living; the
12 Senate Committee on Health and Welfare; the House Committee on Health
13 Care; affected parties; and interested stakeholders. Unless major modifications
14 are required, the Department may present updated information about the Plan
15 to the legislative committees of jurisdiction in lieu of creating a written report.

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

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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.

1 The report shall include an assessment of progress in implementing health
2 information technology in Vermont and recommendations for additional
3 funding and legislation required. In addition, VITL shall publish minutes of
4 VITL meetings and any other relevant information on a public website. The
5 provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply
6 to the report to be made under this subsection.

7 * * *

8 (i) Certification of meaningful use and connectivity.

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

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

18 * * *

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

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

- 1 (i) ~~40.0~~ 40 percent by the State from State monies;
- 2 (ii) ~~28.8~~ 36 percent by the hospitals; and
- 3 (iii) ~~23.2~~ 24 percent by nonprofit hospital and medical service
- 4 corporations licensed under 8 V.S.A. chapter 123 or 125, health insurance
- 5 companies licensed under 8 V.S.A. chapter 101, and health maintenance
- 6 organizations licensed under 8 V.S.A. chapter 139; ~~and~~
- 7 (iv) ~~8.0 percent by accountable care organizations.~~

8 (B) Expenses under subdivision (A)(iii) of this subdivision (1) shall

9 be allocated to persons licensed under Title 8 based on premiums paid for

10 health care coverage, which for the purposes of this subdivision (1) shall

11 include major medical, comprehensive medical, hospital or surgical coverage,

12 and comprehensive health care services plans, but shall not include long-term

13 care, limited benefits, disability, credit or stop loss, or excess loss insurance

14 coverage.

15 (C) ~~Expenses~~ Amounts assessed pursuant to the provisions of ~~section~~

16 sections 9382 and 9441 of this title shall not be assessed in accordance with the

17 formula set forth in subdivision (A) of this subdivision (1).

18 (2) The Board may determine the scope of the incurred expenses to be

19 allocated pursuant to the formula set forth in subdivision (1) of this subsection

20 if, in the Board's discretion, the expenses to be allocated are in the best

21 interests of the regulated entities and of the State.

1 ~~Within 90 days following this approval, the Board shall issue an order~~
2 ~~explaining its decision.~~

3 ~~(C) Annually review and approve the budget, consistent with~~
4 ~~available funds, of the Vermont Information Technology Leaders, Inc. (VITL).~~
5 ~~This review shall take into account VITL's responsibilities pursuant to section~~
6 ~~9352 of this title and the availability of funds needed to support those~~
7 ~~responsibilities. [Repealed.]~~

8 * * *

9 ~~(12) Review data regarding mental health and substance abuse treatment~~
10 ~~reported to the Department of Financial Regulation pursuant to 8 V.S.A. §~~
11 ~~4089b(g)(1)(G) and discuss such information, as appropriate, with the Mental~~
12 ~~Health Technical Advisory Group established pursuant to subdivision~~
13 ~~9374(e)(2) of this title. [Repealed.]~~

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

19 * * *

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

2 § 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

3 (a)(1) In order to be eligible to ~~receive payments from Medicaid or~~
4 ~~commercial insurance through any payment reform program or initiative,~~
5 ~~including an all-payer model~~ operate in Vermont, each accountable care
6 organization shall obtain and maintain certification from the Green Mountain
7 Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to
8 establish standards and processes for certifying accountable care organizations.
9 To the extent permitted under federal law, the Board shall ensure these rules
10 anticipate and accommodate a range of ACO models and sizes, balancing
11 oversight with support for innovation. In order to certify an ACO to operate in
12 this State, the Board shall ensure that the following criteria are met:

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

17 ~~(2) The ACO has established appropriate mechanisms and care models~~
18 ~~to provide, manage, and coordinate high-quality health care services for its~~
19 ~~patients, including incorporating the Blueprint for Health, coordinating~~
20 ~~services for complex high-need patients, and providing access to health care~~
21 ~~providers who are not participants in the ACO. The ACO ensures equal access~~

1 ~~to appropriate mental health care that meets standards of quality, access, and~~
2 ~~affordability equivalent to other components of health care as part of an~~
3 ~~integrated, holistic system of care , taken as a whole, support and do not hinder~~
4 ~~the State’s principles for health care reform as set forth in section 9371 of this~~
5 ~~title.~~

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

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

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

20 ~~(5) The ACO has established mechanisms and care models to promote~~
21 ~~evidence based health care, patient engagement, coordination of care, use of~~

1 ~~electronic health records, and other enabling technologies to promote~~
2 ~~integrated, efficient, seamless, and effective health care services across the~~
3 ~~continuum of care, where feasible.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (2) Notwithstanding subdivision (1) of this subsection, the Green
10 Mountain Care Board may adopt rules in accordance with 3 V.S.A. chapter 25
11 to establish a streamlined process for certification as a Medicare-only ACO for
12 an entity authorized by the Centers for Medicare and Medicaid Services to act
13 as an accountable care organization under the Medicare program. The
14 streamlined process may require a Medicare-only ACO to meet one or more of
15 the criteria set forth in subdivision (1) of this subsection. Certification
16 obtained pursuant to the streamlined process shall apply to the Medicare-only
17 ACO's actions only as they relate to Medicare beneficiaries and only to the
18 extent that the federal authorization allows.

19 (b)~~(1)~~ The Green Mountain Care Board shall adopt rules pursuant to in
20 accordance with 3 V.S.A. chapter 25 to establish standards and processes for
21 reviewing, modifying, and approving the budgets of ACOs ~~with 10,000 or~~

1 ~~more~~ that receive payments from Medicaid or commercial insurers, or both, on
2 behalf of attributed lives in Vermont. To the extent permitted under federal
3 law, the Board shall ensure the rules anticipate and accommodate a range of
4 ACO models and sizes, balancing oversight with support for innovation. In its
5 review, the Board shall review and consider:

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

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

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

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

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

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

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

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

12 ~~(I) the extent to which the ACO provides incentives for systemic~~
13 ~~health care investments in social determinants of health, such as developing~~
14 ~~support capacities that prevent hospital admissions and readmissions, reduce~~
15 ~~length of hospital stays, improve population health outcomes, reward healthy~~
16 ~~lifestyle choices, and improve the solvency of and address the financial risk to~~
17 ~~community-based providers that are participating providers of an accountable~~
18 ~~care organization;~~

19 ~~(J) the extent to which the ACO provides incentives for preventing~~
20 ~~and addressing the impacts of adverse childhood experiences (ACEs) and other~~
21 ~~traumas, such as developing quality outcome measures for use by primary care~~

1 ~~providers working with children and families, developing partnerships between~~
2 ~~nurses and families, providing opportunities for home visits, and including~~
3 ~~parent-child centers and designated agencies as participating providers in the~~
4 ~~ACO;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 ~~(d)(e)~~ All information required to be filed by an ACO pursuant to this
21 section or to rules adopted pursuant to this section shall be made available to

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

4 ~~(e)~~(f) To the extent required to avoid federal antitrust violations, the Board
5 shall supervise the participation of health care professionals, health care
6 facilities, and other persons operating or participating in an accountable care
7 organization. The Board shall ensure that its certification and oversight
8 processes constitute sufficient State supervision over these entities to comply
9 with federal antitrust provisions and shall refer to the Attorney General for
10 appropriate action the activities of any individual or entity that the Board
11 determines, after notice and an opportunity to be heard, may be in violation of
12 State or federal antitrust laws without a countervailing benefit of improving
13 patient care, improving access to health care, increasing efficiency, or reducing
14 costs by modifying payment methods.

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

17 (1) \$10,000.00 for initial certification in accordance with subsection (a)
18 of this section;

19 (2) \$2,000.00 annually following initial certification to maintain
20 certification; and

1 Sec. 10. EFFECTIVE DATES

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

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