GMCB's SUMMARY AND COMMENTS ON
S.63 AS PASSED BY SENATE

Sec. 1. 18 V.S.A. § 9351 – Health Information Technology Plan

- Eliminates GMCB's duty to approve the statewide Health Information Technology Plan and gives GMCB a voting seat on Health Information Exchange Steering Committee.
    - GMCB is currently in an oversight position and would prefer to have a more collaborative role in developing and updating the HIT Plan.

Sec. 2. 18 V.S.A. § 9352 – Vermont Information Technology Leaders (VITL)

- Eliminates GMCB's duty to approve VITL's budget.
    - VITL's financial position no longer merits review or oversight. The time and effort currently devoted to this work could be shifted elsewhere.

Sec. 3. 18 V.S.A. § 9374(h) – GMCB billback formula

- Modifies GMCB billback formula by eliminating the 8% allocation for ACOs and increasing the allocations for hospitals from 28.8% to 36% and for health insurers from 23.2% to 24%; the State's allocation remains at 40%.
    - OneCare Vermont, which pays the bulk of the 8% billback allocation to ACOs, will cease operating after 2025. If the billback formula is not changed, the amounts owed by Medicare-only ACOs, which currently have a very small footprint in Vermont, will increase dramatically. If these ACOs leave the state because of the increased billback assessments, it would be detrimental to providers, which can benefit from ACO participation (e.g., through a MIPS reporting exclusion and additional revenue).
    - Section 5 will impose new fees on ACOs operating in Vermont and these fees will reduce the total amount GMCB bills back to hospitals and insurers.

Sec. 4. 18 V.S.A. § 9375 – GMCB duties

- Eliminates GMCB duties the duty to:
    - Review and approve the Health Information Technology Plan;
        - See Sec. 1 above.
    - Review and approve criteria for providers' connectivity to the State's HIE network;
        - Connectivity criteria are VITL's purview; little value-add from GMCB.
    - Review and approve VITL's budget;
        - See Sec. 2 above.
    - Review mental health and substance abuse treatment data that used to be reported to DFR under a statutory provision that was repealed in 2015.
        - Technical correction – underlying statute was repealed in 2015.

Sec. 5. 18 V.S.A. § 9382 – Oversight of accountable care organizations (ACOs)

- Expands scope of ACOs that must be certified in order to operate in Vermont from just those that receive payments from Medicaid and/or commercial insurance through a payment reform program or initiative to any ACO.
    - Currently, Medicare-only ACOs do not need to be certified to operate in Vermont but do need to have their budgets approved by GMCB. Certification is a more effective tool for overseeing Medicare-only ACOs than budget review.
- PROPOSED MODIFICATION (see Appendix): Delay the requirement for an ACO to be certified to operate in Vermont to January 1, 2027. This will give GMCB time to amend its

ACO certification rules to reflect the modified criteria and establish a streamlined review process for Medicare-only ACOs (see below).

- Modifies and simplifies the criteria that must be met for GMCB to certify an ACO.
    - The ACO certification criteria were designed for a statewide, multi-payer ACO like OneCare Vermont. With the expiration of the Vermont All-Payer ACO Model, the criteria should be modified and simplified.
- Allows GMCB to adopt rules creating a streamlined certification process for Medicare-only ACOs.
    - Medicare-only ACOs are subject to significant vetting and oversight by CMS and a streamlined certification process for these ACOs could be appropriate.
- Eliminates existing ACO budget review provisions and establishes new budget review criteria for ACOs that accept Medicaid and/or commercial insurance (not Medicare) payments.
    - Medicare-only ACOs are often organized out of state and operate in multiple states, complicating budget review. As stated above, certification is a more appropriate tool to regulate Medicare-only ACOs.
- Establishes fees for ACOs: $10,000 for initial certification; $2,000 per year for continued certification; and $125,000 for budget review.
    - The proposed fees reflect the anticipated costs of the regulatory activities and will reduce the amount of the billback to hospitals and insurers.

Secs. 6 and 7. 18 V.S.A. §§ 9454 and 9456 – Hospital budget review

- Modifies the hospital budget review statutes to allow a psychiatric hospital that is not operated by the State to have a fiscal year that runs January 1 – December 31; all other hospitals will continue to have a fiscal year that runs October 1 – September 30.
    - Allows the Brattleboro Retreat to retain its calendar fiscal year and allows GMCB to continue reviewing the Brattleboro Retreat's budget after it establishes the budgets of the 14 acute care hospitals (no change to current practice).
- PROPOSED MODIFICATION TO SEC. 7 (See Appendix): Specify that 1) proceedings to review, establish, and enforce hospital budgets shall not be considered contested cases under the Vermont Administrative Procedure Act (VAPA) and 2) all final actions, orders, or determinations by GMCB under the hospital budget statute are appealable to the Supreme Court.
    - Background: GMCB ordered UVMMC and RRMC to lower their prices in FY25 to correct for budget overages in FY23. The hospitals appealed these "budget enforcement orders" to the superior court under 18 V.S.A. § 9456(h)(2)(B)(ii), asserting that GMCB was required to use the "contested case" procedures of the VAPA (e.g., to apply the Vermont Rules of Evidence and allow GMCB staff to be cross examined).
    - No impact on appeals: UVMMC's appeal will be dismissed under the settlement agreement, but RRMC's appeal will proceed. GMCB is not asking the Legislature to weigh in on the appeal; the courts will decide what existing law requires. However, it is not good policy to require GMCB to use contested case procedures to enforce hospital budget orders and the law should be clear that this is not required.
    - Consistency: Proceedings to establish hospital budgets are not contested cases (no hearing is required) and it would be illogical to require GMCB to follow more stringent procedures to enforce budgets than to establish them in the first place.

- Efficiency, cost, and burden: Requiring GMCB to use contested case procedures to enforce its budget orders will increase costs and burdens that will negatively impact Vermonters. First, more time and effort will be required of GMCB staff (e.g., to prepare for cross examination by hospital attorneys and to deal with evidentiary matters), which will reduce the amount of time they can devote to other important work or require more staff. Second, hospitals may feel the need to hire outside counsel for these matters (as insurers currently do in rate review proceedings, which are contested cases). The process will be slowed, and GMCB's ability to manage hospital costs and reduce commercial premiums will be weakened.
- Transparency: If hospital budget enforcement proceedings are contested cases, GMCB will be allowed to decide these matters in private because deliberations in contested cases are specifically excluded from Vermont's Open Meeting Law. *See* 1 V.S.A. §§ 310(8) (defining "quasi-judicial proceeding" to include "a contested case under the Vermont Administrative Procedure Act"), 312(e) (stating "[n]othing in this section or in section 313 of this title shall be construed as extending . . . to the deliberations of any public body in connection with a quasi-judicial proceeding.")
- Flexibility: Requiring GMCB to use contested case procedures to enforce its budget orders will make it more difficult for GMCB to consider information not presented by hospitals (e.g., information like RAND pricing studies). In contrast to insurance rate review proceedings (which are contested cases that the HCA participates in as a party), there is no party in hospital budget proceedings besides the hospitals. Given the varied factors GMCB must consider in reviewing a CON application, the Legislature has exempted CON proceedings from the VAPA's contested case requirements to give GMCB (and BISHCA before it) flexibility to develop a record. 18 V.S.A. § 9440(a). The same should be done for hospital budget proceedings.
- More adversarial: Requiring the use of trial-like contested case procedures will make the process more adversarial and encourage more litigation and conflict at a time when stakeholders need to come together. It will increase the number and types of issues that hospitals can appeal and appeals add uncertainty and confusion about health insurance premium growth and budget growth. Health insurers like Blue Cross also might legitimately want to obtain party status in these proceedings.
- Appeals: Hospitals have a right to appeal final actions by the Board but all appeals of should go directly to the Supreme Court.

Sec. 8. 18 V.S.A. § 9572 – Meetings of an ACO's governing body

- Updates statute on meetings of an ACO's governing to apply only to an ACO that contracts with Vermont Medicaid.
  - This statute was developed for OneCare Vermont, a statewide ACO that was central to the State's health care reform efforts. It is not appropriate to Medicare-only ACOs.

Sec. 9. Repeal

- Repeals a statute requiring GMCB to conduct an advisory annual review of any all-inclusive population-based payment arrangement between DVHA and an ACO for the following calendar year.
  - With the winding down of OneCare Vermont at the end of 2025 and the expiration of the All-Payer ACO Model, this statute is unnecessary.

Sec. 10. Effective dates

- Secs. 6 and 7 and this section take effect on passage.
- Remaining sections take effect on July 1, 2025.
- PROPOSED MODIFICATION (See Appendix): Make Sec. 5 effective January 1, 2026.
    - GMCB has approved budgets for several ACOs in 2025 and has certified OneCare Vermont to operate in the state for 2025. Delaying the effective date of Sec. 5 to January 1, 2026, will make it clear that ACO budget compliance and/or certification compliance for 2025 are not affected.

APPENDIX

GREEN MOUNTAIN CARE BOARD PROPOSED MODIFICAITONS TO S.63 AS PASSED BY THE SENATE

ACO Regulation: Delay requirement for ACOs to be certified and delay effective date.

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

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a)(1) Starting January 1, 2027, 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.

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Sec. 10. EFFECTIVE DATES

(a) Sec. 5 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.

Hospital Budget Regulation: Specify that hospital budget establishment and enforcement are not contested cases and that appeal lies in the Supreme Court.

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.

* * *

(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.~~