Introduced by Committee on Health and Welfare

Date:

Subject: Health; health care reform; Green Mountain Care Board; Agency of Human Services; Statewide Health Care Delivery Plan; health information technology; hospitals

Statement of purpose of bill as introduced: This bill proposes to <to be completed after bill text has been finalized>

An act relating to health care payment and delivery system reform

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

* * * Hospital Budgets and Payment Reform * * *

Sec. 1. 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:

(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, which may include the creation of health care professional cost-containment targets, reference-based pricing, 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.

* * *

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time beginning with reference-based pricing in 2025, 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, including implementation of reference-based pricing; protecting insurer solvency~~,~~; and other issues at the discretion of the Board.

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, including establishing standards for global hospital budgets that reflect the implementation of reference-based pricing and the total cost of care targets set by the Statewide Health Care Delivery Plan developed pursuant to section 9403 of this title. Beginning in hospital fiscal year 2028, the Board shall establish global hospital budgets for not fewer than five Vermont hospitals that are not critical access hospitals. By hospital fiscal year 2030, the Board shall establish global hospital budgets for all Vermont hospitals.

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Sec. 2. 18 V.S.A. § 9376 is amended to read:

§ 9376. PAYMENT AMOUNTS; METHODS

(a) Intent. 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) Rate-setting.

(1) 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. 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.

(c) Methodologies. The Board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the Board determines such payments to be appropriate.

(d) Supervision. To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the Board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.

(e) Reference-based pricing.

(1) The Board shall establish reference-based prices that represent the amounts that payers in this State shall pay to health care professionals for services delivered to Vermont residents. The purposes of reference-based pricing are to contain costs and to move health care professionals toward a site-neutral pricing structure while also allowing the Board to differentiate prices among health care professionals based on factors such as demographics, population health in a given hospital service area, and a specific provider’s role in Vermont’s health care system. The Board shall consult with payers,

including health insurers and the Agency of Human Services, on ways to approach reference-based pricing in an effort to achieve all-payer alignment on design and implementation of the program.

(2) Reference-based prices established pursuant to this subsection shall be based on a percentage of the Medicare reimbursement rate for the same service, provided that after the Board establishes initial prices that are referenced to Medicare, the Board may opt to update the prices in the future based on a reasonable rate of growth that is separate from Medicare rates in order to provide predictability and consistency for health care professionals and payers and to protect against federal funding pressures that may impact Medicare rates in an unpredictable manner.

(3) The Board shall begin implementing reference-based pricing by establishing the amounts that health insurers in this State shall pay to Vermont hospitals during hospital fiscal year 2026 for services delivered to individuals covered by the health insurer’s health insurance plans.

(4) The Board, in consultation with the Blueprint for Health and with other State agencies as appropriate, shall implement reference-based pricing for nonhospital services and may increase or decrease the percentage of Medicare or another benchmark as appropriate, first to enhance access to primary care and later for alignment with the Statewide Health Care Delivery Plan established pursuant to section 9403 of this title.

(5) The Board may enter into contracts as needed for initial implementation of reference-based pricing pursuant to this subsection.

Sec. 3. 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:

* * *

(6) known depreciation schedules on existing buildings, a four-year capital expenditure projection, and a one-year capital expenditure plan; ~~and~~

(7) the number of employees of the hospital whose duties are primarily administrative in nature, as defined by the Board, and the number of employees whose duties primarily involve delivering health care services directly to hospital patients;

(8) information regarding base salaries and total compensation for the hospital’s executive and clinical leadership and for its employees who deliver health care services directly to hospital patients; and

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

(b) All hospitals shall use a uniform system of accounts identified by the Board to allow the Board to directly compare hospital expenses across the health care system.

(c) Hospitals shall adopt a fiscal year that shall begin on October 1.

Sec. 4. 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. <u>The Board shall require hospitals to use a uniform system of accounts identified by the Board to allow the Board to directly compare hospital expenses across the health care system.</u>

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

(1) review utilization information;

(2) <u>consider the Statewide Health Care Delivery Plan developed pursuant to section 9403 of this title, including the total cost of care targets, and consult with the Agency of Human Services to ensure compliance with federal requirements regarding Medicare and Medicaid;</u>

<u>(3)</u> 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)~~<u>(4)</u> consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

~~(4)~~<u>(5)</u> consider any reports from professional review organizations;

(6) for a hospital that operates within a hospital network, review the hospital network's financial operations as they relate to the budget of the individual hospital;

(7) develop incentives for hospitals to support community-based, independent, and nonhospital providers, including mental health and substance use disorder treatment providers, primary care providers, long-term care providers, and physical therapists; services provided through the Blueprint for Health, Choices for Care, and Support and Services at Home (SASH); investments in the health care workforce; and other nonhospital aspects of Vermont's health and human services systems that affect population health outcomes, including the social drivers of health;

~~(5)~~(8) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

~~(6)~~(9) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

~~(7)~~(10) give public notice of the meetings with hospitals, and invite the public to attend and to comment on the proposed budgets;

~~(8)~~(11) 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)~~(12) 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)~~(13) 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)~~(14) 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)~~(15) 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)~~(16) 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 a comparison of the base salaries and total compensation for the hospital's executive and clinic leadership with those of the hospital's lowest-paid employees who deliver health care services directly to hospital patients; and

(17) consider the number of employees of the hospital whose duties are primarily administrative in nature, as defined by the Board, compared with the number of employees whose duties primarily involve delivering health care services directly to hospital patients, as well as national average staffing ratios for hospitals of a similar size and with a similar number of locations and industry best practices for such hospital staffing ratios.

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

(1) be consistent with the Statewide Health Care Delivery Plan, including the total cost of care targets, and the Health Resource Allocation Plan;

(2) reflect the reference-based prices established by the Board pursuant to section 9376 of this title;

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

~~(3)~~(4) promote efficient and economic operation of the hospital;

~~(4)~~(5) reflect budget performances for prior years;

~~(5)~~(6) include a finding that the analysis provided in subdivision ~~(b)(9)~~ (b)(12) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers; and

~~(6)~~(7) 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)(A) Annually, the Board shall establish a budget for each hospital on or before September 15, followed by a written decision by October 1. Each hospital shall operate within the budget established under this section.

(B) Beginning in hospital fiscal year 2028, the Board shall establish global hospital budgets for not fewer than five Vermont hospitals that are not critical access hospitals. Not later than hospital fiscal year 2030, the Board shall establish global hospital budgets for all Vermont hospitals.

* * *

(e)(1) The Board shall establish outcome measurements to ensure that hospital costs are appropriate, that quality and access are maintained or improved, and that hospitals implement their budget orders in a manner that is consistent with the Statewide Health Care Delivery Plan.

(2) A hospital that proposes to reduce or eliminate any service in order to comply with a budget established under this section shall provide a notice of intent to the Board, the Agency of Human Services, the Office of the Health Care Advocate, and the members of the General Assembly who represent the hospital service area not less than 90 days prior to the proposed reduction or

elimination. The Board shall evaluate the proposed reduction or elimination for consistency with the hospital transformation efforts pursuant to 2022 Acts and Resolves No. 167, Secs. 1 and 2; the Statewide Health Care Delivery Plan, once established; and the needs of the community served by the hospital and may modify the hospital's budget or take such additional actions as the Board deems appropriate to preserve access to necessary services.

(3) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of any authorized decrease in hospital services to ensure that it results in either a commensurate decrease in health insurance premiums or in investments that support primary care and population health, which may include social drivers of health.

(4) The Board may establish a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks.

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

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Sec. 5. 18 V.S.A. § 9458 is added to read:

§ 9458. HOSPITAL NETWORK FINANCIAL OPERATIONS

In order to protect the public interest, the Board may, on its own initiative, investigate the financial operations of any hospital network that derives 50 percent or more of its operating revenue from Vermont hospitals. The Board may take appropriate action as necessary to correct a hospital network's operations that are inconsistent with the principles for health care reform expressed in section 9371 of this title.

* * * Statewide Health Care Delivery Plan; Health Care Delivery Advisory Committee * * *

Sec. 6. 18 V.S.A. § 9403 is added to read:

§ 9403. STATEWIDE HEALTH CARE DELIVERY PLAN

(a) The Green Mountain Care Board and the Agency of Human Services, in collaboration with the Department of Financial Regulation, the Vermont Program for Quality in Health Care, the Health Care Delivery Advisory Committee established in section 9403a of this title, and other interested stakeholders, shall jointly lead development of an integrated Statewide Health Care Delivery Plan as set forth in this section.

(b) The Plan shall:

(1) Align with the principles for health care reform set forth in section 9371 of this title.

(2) Ensure access to high-quality, cost-effective acute care, primary care, chronic care, long-term care, and hospital-based, independent, and community-based services across Vermont.

(3) Ensure that mental health services, substance use disorder treatment services, emergency medical services, nonemergency medical services, and nonmedical services and supports are available in each region of Vermont.

(4) Provide annual targets for the total cost of care across Vermont's health care system and include reasonable annual cost growth rates that will bring hospital and total health care spending in Vermont to at or below national growth rates of gross domestic product and that will bring Vermont's total health care spending into alignment with or better than U.S. average, adjusting as necessary to address Vermont's demographics and rural nature. Using these total cost of care targets, the Plan shall identify appropriate allocations of health care resources and services across the State that balance quality, access, and cost containment. The Plan shall also establish targets for the percentages of overall health care spending that should reflect spending on primary care services, including mental health services, and preventive care services, which targets shall be aligned with the total cost of care targets.

(5) Build on data and information from:

(A) the transformation planning resulting from 2022 Acts and Resolves No. 167, Secs. 1 and 2;

(B) the expenditure analysis and health care spending estimate developed pursuant to section 9383 of this title;

(C) the State Health Improvement Plan adopted pursuant to subsection 9405(a) of this title;

(D) the Health Resource Allocation Plan published by the Green Mountain Care Board in accordance with subsection 9405(b) of this title;

(E) hospitals' community health needs assessments and strategic planning conducted in accordance with section 9405a of this title;

(F) hospital and ambulatory surgical center quality information published by the Department of Health pursuant to section 9405b of this title;

(G) the statewide quality assurance program maintained by the Vermont Program for Quality in Health Care pursuant to section 9416 of this title; and

(H) such additional sources of data and information as the Board, Agency, and Department deem appropriate.

(6) Identify:

(A) gaps in access to care, as well as circumstances in which service closures or consolidations could result in improvements in quality, access, and affordability;

(B) opportunities to reduce administrative burdens, such as complexities in contracting and payment terms and duplicative quality reporting requirements; and

(C) federal, State, and other barriers to achieving the Plan's goals and, to the extent feasible, how those barriers can be removed or mitigated.

(c) The Green Mountain Care Board shall contribute data and expertise related to its regulatory duties and its efforts pursuant to 2022 Acts and Resolves No. 167. The Agency of Human Services shall contribute data and expertise related to its role as the State Medicaid agency, its work with community-based providers, and its efforts pursuant to 2022 Acts and Resolves No. 167.

(d) The Green Mountain Care Board shall provide administrative, technical, and legal assistance for the development of the Plan.

(e)(1) From 2025 through 2027, the Green Mountain Care Board and the Agency of Human Services shall engage with stakeholders; collect and analyze data; gather information obtained through the processes established in 2022 Acts and Resolves No. 167, Secs. 1 and 2; and solicit input from the public.

(2) In 2028, the Board and the Agency shall prepare the Plan.

(3) On or before January 15, 2029, the Board and the Agency shall present the Plan to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare.

(4) The Board and Agency shall prepare an updated Plan every three years and shall present it to the General Assembly on or before January 15 every third year after 2029.

Sec. 7. 18 V.S.A. § 9403a is added to read:

§ 9403a. HEALTH CARE DELIVERY ADVISORY COMMITTEE

(a) There is created the Health Care Delivery Advisory Committee to:

(1) evaluate and monitor the performance of Vermont's health care system and its impacts on population health outcomes;

(2) collaborate with the Green Mountain Care Board, the Agency of Human Services, the Department of Financial Regulation, and other interested stakeholders in the development and maintenance of the Statewide Health Care Delivery Plan developed pursuant to section 9403 of this title; and

(3) advise the Green Mountain Care Board on the design and implementation of an ongoing evaluation process to continuously monitor current performance in the health care delivery system.

(4) provide coordinated and consensus recommendations to the General Assembly on issues related to health care delivery and population health.

(b)(1) The Advisory Committee shall be composed of 11 members as follows:

(A) the Chair of the Green Mountain Care Board or designee;

(B) the Director of Health Care Reform in the Agency of Human Services;

(C) three members representing [health care providers, including primary care providers and community-based providers; health care facilities, health insurers, and patients and consumers], appointed by the Speaker of the House;

(D) three members representing [health care providers, including primary care providers and community-based providers; health care facilities, health insurers, and patients and consumers], appointed by the Senate Committee on Committees; and

(E) three members representing [health care providers, including primary care providers and community-based providers; health care facilities, health insurers, and patients and consumers], appointed by the Governor.

(2) The Chair of the Green Mountain Care Board or designee and the Director of Health Care Reform shall co-chair the Advisory Committee.

(3) The Green Mountain Care Board shall provide administrative, technical, and legal assistance to the Advisory Committee.

* * * Data Integration * * *

Sec. 8. 18 V.S.A. § 9353 is added to read:

§ 9353. INTEGRATION OF HEALTH CARE DATA

(a) The Agency of Human Services shall collaborate with health care providers, payers, and the Vermont Program for Quality in Health Care in the development of an integrated system of clinical and claims data in order to improve patient, provider, and payer access to relevant information and reduce administrative burdens on providers.

(b) The Agency's process shall:

(1) align with the statewide Health Information Technology Plan established pursuant to section 9351 of this title;

(2) build on the Agency's experience in developing and implementing the Unified Health Data Space to include additional payers;

(3) utilize the expertise of the Health Information Exchange Steering Committee;

(4) incorporate best practices for privacy and security standards;

(5) determine how best to incorporate data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) and data regarding social drivers of health and health-related social needs;

(6) establish the steps necessary to enable interoperability of electronic health records systems between providers;

(7) identify the resources necessary to complete data linkages for clinical and research usage;

(8) establish a timeline for setup and access to the integrated system;

(9) develop and implement a system that ensures rapid access for patients, providers, and payers; and

(10) identify additional opportunities for future development, including interoperability for emergency medical services providers and linkages between State agencies and federal nutrition programs, such as the USDA's

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

(c) The Agency shall provide access to data to State agencies and health care providers as needed to support the goals of the Statewide Health Care Delivery Plan established pursuant to section 9403 of this title.

* * * Retaining Accountable Care Organization Capabilities * * *

Sec. 9. RETAINING ACCOUNTABLE CARE ORGANIZATION CAPABILITIES; GREEN MOUNTAIN CARE BOARD; BLUEPRINT FOR HEALTH; REPORT

The Green Mountain Care Board and the Blueprint for Health shall jointly explore opportunities to retain capabilities developed by or on behalf of a certified accountable care organization that were funded in whole or in part using State or federal monies, or both, and that have the potential to make beneficial contributions to Vermont's health care system, such as capabilities related to comprehensive payment reform and electronic health records. On or before November 1, 2025, the Board and the Blueprint shall report to the Health Reform Oversight Committee with their findings and recommendations.

* * * Positions; Appropriations * * *

Sec. 10. GREEN MOUNTAIN CARE BOARD; POSITIONS

(a) The establishment of five new permanent [exempt/classified] positions, [Title(s)], is authorized at the Green Mountain Care Board in fiscal year 2026.

<u>These positions shall be transferred and converted from existing vacant positions in the Executive Branch.</u>

<u>(b) It is the intent of the General Assembly to authorize the establishment of an additional five new permanent positions at the Green Mountain Care Board in fiscal year 2027 and another five new permanent positions in fiscal year 2028.</u>

Sec. 11. APPROPRIATIONS

<u>(a) The sum of $500,000.00 is appropriated from the General Fund to the Agency of Human Services in fiscal year 2026 for use as follows:</u>

<u>(1) $250,000.00 for grants to hospitals as needed for transformation efforts initiated pursuant to 2022 Acts and Resolves No. 167 and to transition their systems to implement reference-based pricing;</u>

(2) $50,000.00 for expenses associated with development of the Statewide Health Care Delivery Plan; and

(2) $200,000.00 for contracts for consultants and other expenses associated with implementation of this act.

(b) The sum of $250,000.00 is appropriated from the Health IT-Fund to the Agency of Human Services in fiscal year 2026 for grants to health care providers for data integration in accordance with Sec. 8 of this act.

(c) The sum of $1,300,000.00 is appropriated from the General Fund to the Green Mountain Care in fiscal year 2026 for use as follows:

(1) $750,000.00 for the positions authorized in Sec. 10 of this act;

(2) $500,000.00 for contracts, including contracts for assistance with implementing reference-based pricing in accordance with this act; and

(3) $50,000.00 for expenses associated with development of the Statewide Health Care Delivery Plan.

* * * Effective Dates * * *

Sec. 12. EFFECTIVE DATES

(a) Secs. 10 (positions) and 11 (appropriations) shall take effect on July 1, 2025.

(b) The remaining sections shall take effect on passage.