H.812

Introduced by Representatives Lippert of Hinesburg and Pearson of Burlington

Referred to Committee on

Date:

Subject: Health; accountable care organizations; consumer protection

Statement of purpose of bill as introduced: This bill proposes to establish consumer protection guidelines and principles in the context of accountable care organizations.

~~An act relating to consumer protections for accountable care organizations~~
An act relating to implementing an all-payer model and oversight of accountable care organizations

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

~~Sec. 1. 18 V.S.A. chapter 221, subchapter 3 is added to read:~~

Subchapter 3. Accountable Care Organizations

§ 9425. ACCOUNTABLE CARE ORGANIZATIONS; CONSUMER PROTECTIONS

As Vermont moves toward new models of health care, it is essential to ensure that the rights and interests of consumers and patients are considered and protected. In the context of accountable care organizations, the General Assembly adopts the following guidelines and principles to safeguard the health and wellbeing of Vermont residents:

(1) Consumer representation.

(A) An accountable care organization's governing body should include at least three consumer members, including one Medicaid beneficiary, one Medicare beneficiary, and one beneficiary of a commercial health insurance plan.

(B) An accountable organization's governing body should include at least one consumer advocate with training or professional experience in advocating for the rights of consumers.

(C) Each entity developed or administered through an accountable care organization or the Blueprint for Health for the purpose of collaboration and sharing information among providers regarding best practices should include at least two consumer representatives residing in the region the entity serves.

(2) Consumer advisory board. An accountable care organization should have a regularly scheduled process for inviting and considering consumer input regarding the accountable care organization's policy, including a consumer advisory board with membership drawn from the community the accountable care organization serves. The consumer advisory board should include patients, their families, and caregivers, as well as beneficiaries of Medicaid, Medicare, and commercial insurance plans.

(3) Governance; transparency. The accountable care organization's governing body should have a transparent governing process and open meetings.

(4) Accountability for access, quality, and health outcomes.

(A) An accountable care organization should measure progress toward improving access to care, quality of care, and health outcomes. The accountable care organization should be responsible for reporting its measures at least quarterly to the Department of Vermont Health Access, the Green Mountain Care Board, and participating commercial payers. Medicaid and participating commercial payers should incorporate these measures into their contracts with an accountable care organization to hold the organization responsible for quality of care, access to care, and health outcomes, as well as a positive patient experience.

(i) In order to ensure that Vermonters' access to health care is improved by the accountable care organization and that the accountable care organization does not underserve its patients, measurement should include metrics of access to and use of primary care, specialty care, inpatient care, substance use disorder treatment, and mental health treatment services.

(ii) In order to ensure that the quality of care provided to Vermont residents is improved by the accountable care organization, measurement should evaluate the patient experience and include metrics of the quality of

~~primary care, specialty care, inpatient care, substance use disorder treatment,~~ and mental health treatment services.

(iii) In order to ensure that the health of Vermonters is improved by the accountable care organization, measurement should include metrics of outcomes related to primary care, specialty care, inpatient care, substance use disorder treatment, and mental health treatment services.

(B) An accountable care organization should be required to meet specific quality, access, and outcome thresholds in order to participate in alternative payment methodologies such as capitated payments, shared savings, and global budgets. The Green Mountain Care Board should enforce these thresholds.

(5) Grievances and appeals. The Green Mountain Care Board should adopt rules to protect against wrongful denial of services and to address grievances of patient attributed to an accountable care organization. The rules should provide for internal and external review processes.

(6) Provider choice. Patients should be allowed to identify their own primary care provider through an attestation process as the primary method of attribution. An accountable care organization should not interfere in any way with the ability of a patient to receive services from any provider of his or her choice.

(7) Consumer protection.

(A) An accountable care organization should provide each patient attributed to the organization with written notice explaining that his or her provider is participating with an accountable care organization and that he or she has been attributed to that organization. The notice should include information about the accountable care organization and explain the patient's rights, including the right to choose and change providers regardless of their affiliation with the accountable care organization and an explanation of the grievance and appeal process.

(B) Attribution of a patient to an accountable care organization should not result in increased patient costs, including cost-sharing increases or penalties, regardless of the patient's patterns of care and choice of providers.

(8) Integrated care. An accountable care organization should collaborate with providers of services not included in the accountable care organization's financial model, if any, which may include providers of mental health and substance use disorder services, long-term services and supports, and dental care.

Sec. 2. EFFECTIVE DATE

This act shall take effect on passage.

** * * All-Payer Model * * **

Sec. 1. ALL-PAYER MODEL; MEDICARE AGREEMENT

~~The Green Mountain Care Board and the Agency of Administration shall~~ only enter into an agreement with the Centers for Medicare and Medicaid Services to waive provisions under Title XVIII (Medicare) of the Social Security Act if the agreement:

(1) is consistent with the principles of health care reform expressed in 18 V.S.A. § 9371, to the extent permitted under Section 1115A of the Social Security Act and approved by the federal government;

(2) preserves the consumer protections set forth in Title XVIII of the Social Security Act, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes;

(3) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(4) allows Medicare patients to choose their providers;

(5) includes outcome measures for population health; and

(6) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont.

Sec. 2. 18 V.S.A. chapter 227 is added to read:

CHAPTER 227. ALL-PAYER MODEL

§ 9551. ALL-PAYER MODEL

~~*In order to implement a value based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments, the Green Mountain Care Board and Agency of Administration shall ensure that the model:*~~

(1) maintains consistency with the principles established in section 9371 of this title;

(2) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont;

(3) maximizes alignment between Medicare, Medicaid, and commercial payers to the extent permitted under federal law and waivers from federal law, including:

(A) what is included in the calculation of the total cost of care;

(B) attribution and payment mechanisms;

(C) patient protections;

(D) care management mechanisms; and

(E) provider reimbursement processes;

(4) strengthens and invests in primary care;

(5) incorporates social determinants of health;

(6) adheres to federal and State laws on parity of mental health and substance abuse treatment, integrates mental health and substance abuse treatment systems into the overall health care system, and does not manage mental health or substance abuse care separately from other health care;

(7) includes a process for integration of community-based providers, including home health agencies, mental health agencies, development disability service providers, emergency medical service providers, and area agencies on aging, and their funding streams, into a transformed, fully integrated health care system;

(8) continues to prioritize the use, where appropriate, of existing local and regional collaboratives of community health providers that develop integrated health care initiatives to address regional needs and evaluate best practices for replication and return on investment;

(9) pursues an integrated approach to data collection, analysis, exchange, and reporting to simplify communication across providers and drive quality improvement and access to care;

(10) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(11) evaluates access to care, quality of care, patient outcomes, and social determinants of health;

(12) requires processes and protocols for shared decision making between the patient and his or her health care providers that take into account a patient's unique needs, preferences, values, and priorities, including use of decision support tools and shared decision-making methods with which the patient may assess the merits of various treatment options in the context of his or her values and convictions, and by providing patients access to their medical records and to clinical knowledge so that they may make informed choices about their care;

(13) supports coordination of patients' care and care transitions through the use of technology, with patient consent, such as sharing electronic summary records across providers and using telemedicine, home telemonitoring, and other enabling technologies; and

(14) ensures, in consultation with the Office of the Health Care Advocate, that robust patient grievance and appeal protections are available.

** * * Oversight of Accountable Care Organizations * * **

Sec. 3. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

** * **

(16) "Accountable care organization" and "ACO" means an organization of health care providers that has a formal legal structure, is

~~*identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it.*~~

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

(b) The Board shall have the following duties:

* * *

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

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

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a) 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, each accountable care organization with 10,000 or more attributed lives in Vermont 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, which may include consideration of acceptance of accreditation by the National Committee for Quality Assurance or another national accreditation organization for any of the criteria set forth

~~*in this section. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:*~~

(1) 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 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;

(3) the ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers;

(4) 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 to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, and effective health care services;

~~(6) the ACO has the capacity for meaningful participation in health information exchanges;~~

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

(8) 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 ensure their awareness and understanding of their treatment options and the related risks and benefits of each;

(10) the ACO has an accessible mechanism for explaining how ACOs work; provides contact information for the Office of the Health Care Advocate; maintains a consumer telephone line for complaints and grievances from attributed patients; responds and makes best efforts to resolve complaints and grievance from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan; and share 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) meetings of the ACO's governing body include a public session at which all business that is not confidential or proprietary is conducted and members of the public are provided an opportunity to comment; ~~and~~

(14) the impact of the ACO's establishment and operation does not diminish access to any health care service for the population and area it serves; and

(15) the ACO has in place a financial guarantee sufficient to cover its potential losses.

(b)(1) 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 ACO budgets. 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 with the ACO;

(B) the goals and recommendations of the health resource allocation plan created in chapter 221 of this title;

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

(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;

(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 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;*

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

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

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

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

(M) 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.

(2) The Office of the Health Care Advocate shall have the right to intervene in any ACO budget review under this subsection. As an intervenor, the Office of the Health Care Advocate shall receive copies of all materials in the record and may:

(A) ask questions of any participant in the Board's ACO budget review;

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

~~*(C) provide testimony in any hearing held in connection with the Board's ACO budget review.*~~

(c) 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 may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

(d) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public upon request, provided that individual patients or health care providers shall not be directly or indirectly identifiable.

(e) 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.*~~

** * * Rulemaking * * **

Sec. 6. GREEN MOUNTAIN CARE BOARD; RULEMAKING

On or before January 1, 2018, the Green Mountain Care Board shall adopt rules governing the oversight of accountable care organizations pursuant to 18 V.S.A. § 9382. On or before January 15, 2017, the Board shall provide an update on its rulemaking process and its vision for implementing the rules to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 7. DENIAL OF SERVICE; RULEMAKING

The Department of Financial Regulation and the Department of Vermont Health Access shall ensure that their rules protect against wrongful denial of services under an insured's or Medicaid beneficiary's health benefit plan for an insured or Medicaid beneficiary attributed to an accountable care organization. The Departments may amend their rules as necessary to ensure that the grievance and appeals processes in Medicaid and commercial health benefit plans are appropriate to an accountable care organization structure.

** * * Implementation Provisions * * **

Sec. 8. TRANSITION; IMPLEMENTATION

~~*(a) Prior to January 1, 2018, if the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, they shall develop and implement the model in a manner that works toward meeting the criteria established in 18 V.S.A. § 9551. Through its authority over payment reform pilot projects under 18 V.S.A. § 9377, the Board shall also oversee the development and operation of accountable care organizations in order to encourage them to achieve compliance with the criteria established in 18 V.S.A. § 9382(a) and to establish budgets that reflect the criteria set forth in 18 V.S.A. § 9382(b).*~~

~~*(b) On or before January 1, 2018, the Board shall begin certifying accountable care organizations that meet the criteria established in 18 V.S.A. § 9382(a) and shall only approve accountable care organization budgets after review and consideration of the criteria set forth in 18 V.S.A. § 9382(b). If the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, then on and after January 1, 2018 they shall implement the all-payer model in accordance with 18 V.S.A. § 9551.*~~

** * * Effective Dates * * **

Sec. 9. EFFECTIVE DATES

(a) Secs. 1 (Medicare waiver), 6–7 (rulemaking), and 8 (transition; implementation) and this section shall take effect on passage.

~~*(b) Secs. 2 (all payer model) and 3–5 (ACOs) shall take effect on January 1, 2018.*~~

** * * All-Payer Model * * **

Sec. 1. ALL-PAYER MODEL; MEDICARE AGREEMENT

The Green Mountain Care Board and the Agency of Administration shall only enter into an agreement with the Centers for Medicare and Medicaid Services to waive provisions under Title XVIII (Medicare) of the Social Security Act if the agreement:

(1) is consistent with the principles of health care reform expressed in 18 V.S.A. § 9371, to the extent permitted under Section 1115A of the Social Security Act and approved by the federal government;

(2) preserves the consumer protections set forth in Title XVIII of the Social Security Act, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes;

(3) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(4) allows Medicare patients to choose any Medicare-participating provider;

(5) includes outcome measures for population health; and

(6) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont.

Sec. 2. 18 V.S.A. chapter 227 is added to read:

CHAPTER 227. ALL-PAYER MODEL

§ 9551. ALL-PAYER MODEL

In order to implement a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments and increased financial predictability for providers, the Green Mountain Care Board and Agency of Administration shall ensure that the model:

(1) maintains consistency with the principles established in section 9371 of this title;

(2) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont;

(3) maximizes alignment between Medicare, Medicaid, and commercial payers to the extent permitted under federal law and waivers from federal law, including:

(A) what is included in the calculation of the total cost of care;

(B) attribution and payment mechanisms;

(C) patient protections;

(D) care management mechanisms; and

(E) provider reimbursement processes;

(4) strengthens and invests in primary care;

(5) incorporates social determinants of health;

(6) adheres to federal and State laws on parity of mental health and substance abuse treatment, integrates mental health and substance abuse treatment systems into the overall health care system, and does not manage mental health or substance abuse care through a separate entity; provided, however, that nothing in this subdivision (6) shall be construed to alter the statutory responsibilities of the Departments of Health and of Mental Health;

(7) includes a process for integration of community-based providers, including home health agencies, mental health agencies, developmental disability service providers, emergency medical service providers, adult day service providers, and area agencies on aging, and their funding streams to the extent permitted under federal law, into a transformed, fully integrated health care system that may include transportation and housing;

(8) continues to prioritize the use, where appropriate, of existing local and regional collaboratives of community health providers that develop

integrated health care initiatives to address regional needs and evaluate best practices for replication and return on investment;

(9) pursues an integrated approach to data collection, analysis, exchange, and reporting to simplify communication across providers and drive quality improvement and access to care;

(10) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(11) evaluates access to care, quality of care, patient outcomes, and social determinants of health;

(12) requires processes and protocols for shared decision making between the patient and his or her health care providers that take into account a patient's unique needs, preferences, values, and priorities, including use of decision support tools and shared decision-making methods with which the patient may assess the merits of various treatment options in the context of his or her values and convictions, and by providing patients access to their medical records and to clinical knowledge so that they may make informed choices about their care;

(13) supports coordination of patients' care and care transitions through the use of technology, with patient consent, such as sharing electronic summary records across providers and using telemedicine, home telemonitoring, and other enabling technologies; and

(14) ensures, in consultation with the Office of the Health Care Advocate, that robust patient grievance and appeal protections are available.

** * * Oversight of Accountable Care Organizations * * **

Sec. 3. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

** * **

(16) "Accountable care organization" and "ACO" means an organization of health care providers that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it.

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

(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.

** * **

(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 added to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a) 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, 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) 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;

(3) the ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers;

(4) 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) the ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers;

(8) 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) the ACO offers assistance to health care consumers, including:

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

(B) 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) providing an accessible mechanism for explaining how ACOs work;

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

(E) 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) meetings of the ACO's governing body include a public session at which all business that is not confidential or proprietary is conducted and members of the public are provided an opportunity to comment;

(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; and

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

(b)(1) 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 10,000 or more 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 goals and recommendations of the health resource allocation plan created in chapter 221 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; and

(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.

(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.

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

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

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

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

(B) 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).

(c) 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 may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

(d) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public upon request, provided that individual patients or health care providers shall not be directly or indirectly identifiable.

(e) 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.

** * * Rulemaking * * **

Sec. 6. GREEN MOUNTAIN CARE BOARD; RULEMAKING

On or before January 1, 2018, the Green Mountain Care Board shall adopt rules governing the oversight of accountable care organizations pursuant to 18 V.S.A. § 9382. On or before January 15, 2017, the Board shall provide an update on its rulemaking process and its vision for implementing the rules to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 7. DENIAL OF SERVICE; RULEMAKING

The Department of Financial Regulation and the Department of Vermont Health Access shall ensure that their rules protect against wrongful denial of services under an insured's or Medicaid beneficiary's health benefit plan for an insured or Medicaid beneficiary attributed to an accountable care

organization. The Departments may amend their rules as necessary to ensure that the grievance and appeals processes in Medicaid and commercial health benefit plans are appropriate to an accountable care organization structure.

** * * Implementation Provisions * * **

Sec. 8. TRANSITION; IMPLEMENTATION

(a) Prior to January 1, 2018, if the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, they shall develop and implement the model in a manner that works toward meeting the criteria established in 18 V.S.A. § 9551. Through its authority over payment reform pilot projects under 18 V.S.A. § 9377, the Board shall also oversee the development and operation of accountable care organizations in order to encourage them to achieve compliance with the criteria established in 18 V.S.A. § 9382(a) and to establish budgets that reflect the criteria set forth in 18 V.S.A. § 9382(b).

(b) On or before January 1, 2018, the Board shall begin certifying accountable care organizations that meet the criteria established in 18 V.S.A. § 9382(a) and shall only approve accountable care organization budgets after review and consideration of the criteria set forth in 18 V.S.A. § 9382(b). If the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, then on and after

January 1, 2018 they shall implement the all-payer model in accordance with 18 V.S.A. § 9551.

** * * Reducing Administrative Burden on Health Care Professionals * * **

Sec. 9. 18 V.S.A. § 9374(e) is amended to read:

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

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

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

Sec. 10. PRIMARY CARE PROFESSIONAL ADVISORY GROUP

(a) The Green Mountain Care Board shall establish a primary care professional advisory group to provide input and recommendations to the Board. The Board shall seek input from the primary care professional advisory group to address issues related to the administrative burden facing primary care professionals, including:

(1) identifying circumstances in which existing reporting requirements for primary care professionals may be replaced with more meaningful measures that require minimal data entry;

(2) creating opportunities to reduce requirements for primary care professionals to provide prior authorization for their patients to receive radiology, medication, and specialty services; and

(3) developing a uniform hospital discharge summary for use across the State.

(b) The Green Mountain Care Board shall provide an update on the advisory group's work in the annual report the Board submits to the General Assembly in accordance with 18 V.S.A. § 9375(d).

(c) The Board may seek assistance from organizations representing primary care professionals. Members of the advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount

expended for such compensation shall not exceed $5,000.00 per year. The advisory group shall cease to exist on July 1, 2018.

** * * Additional Reports * * **

Sec. 11. AGENCY OF HUMAN SERVICES' CONTRACTS; REPORT

(a) On or before January 1, 2017, the Agency of Human Services, in consultation with Vermont Care Partners, the Green Mountain Care Board, and representatives from preferred providers, shall submit a report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services. The report shall address the following:

(1) the amount and type of performance measures and other evaluations used in fiscal year 2016 and 2017 Agency contracts with designated agencies, specialized service agencies, and preferred providers;

(2) how the Agency's funding levels of designated agencies, specialized service agencies, and preferred providers affect access to and quality of care; and

(3) how the Agency's funding levels for designated agencies, specialized service agencies, and preferred providers affect compensation levels for staff relative to private and public sector pay for the same services.

(b) The report shall contain a plan developed in conjunction with the Vermont Health Care Innovation Project and in consultation with the Vermont Care Network and the Vermont Council of Developmental and Mental Health

Services to implement a value-based payment methodology for designated agencies, specialized service agencies, and preferred providers that shall improve access to and quality of care, including long-term financial sustainability. The plan shall describe the interaction of the value-based payment methodology for Medicaid payments made to designated agencies, specialized service agencies, and preferred providers by the Agency with any Medicaid payments made to designated agencies, specialized service agencies, and preferred providers by the accountable care organizations.

(c) As used in this section:

(1) "Designated agency" means the same as in 18 V.S.A. § 7252.

(2) "Preferred provider" means any substance abuse organization that has attained a certificate of operation from the Department of Health's Division of Alcohol and Drug Abuse Programs and has an existing contract or grant from the Division to provide substance abuse treatment.

(3) "Specialized service agency" means any community mental health and developmental disability agency or any public or private agency providing specialized services to persons with a mental condition or psychiatric disability or with developmental disabilities or children and adolescents with a severe emotional disturbance pursuant to 18 V.S.A. § 8912.

Sec. 12. MEDICAID PATHWAY; REPORT

(a) The Secretary of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all Medicaid payments to affected providers and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives.

(b) On or before January 15, 2017 and annually for five years thereafter, the Secretary of Human Services shall report on the results of this process to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services. The Secretary's report shall address:

(1) all Medicaid payments to affected providers;

(2) changes to reimbursement methodology and the services impacted;

(3) efforts to integrate affected providers into the all-payer model and with other payment and delivery system reform initiatives;

(4) changes to quality measure collection and identifying alignment efforts and analyses, if any; and

(5) the interrelationship of results-based accountability initiatives with the quality measures in subdivision (4) of this subsection.

Sec. 13. MEDICAID ADVISORY RATE CASE FOR ACO SERVICES

On or before December 31, 2016, the Green Mountain Care Board shall review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access and an accountable care organization for calendar year 2017. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per-member, per-month payment, and any other nonclaims payments. The review shall be nonbinding on the Agency of Human Services, and nothing in this section shall be construed to abrogate the designation of the Agency of Human Services as the single State agency as required by 42 C.F.R. § 431.10.

Sec. 14. MULTI-YEAR BUDGETS; ACOS; REPORT

The Green Mountain Care Board shall consider the appropriate role, if any, of using multi-year budgets for ACOs to reduce administrative burden, improve care quality, and ensure sustainable access to care. On or before January 15, 2017, the Green Mountain Care Board and the Department of Vermont Health Access shall provide their findings and recommendations to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance.

Sec. 15. MULTI-YEAR BUDGETS; MEDICAID; REPORT

The Joint Fiscal Office and the Department of Finance and Management, in collaboration with the Agency of Human Services Central Office and the Department of Vermont Health Access, shall consider the appropriate role, if

any, of using multi-year budgets for Medicaid and other State-funded health care programs to reduce administrative burden, improve care quality, and ensure sustainable access to care. On or before March 1, 2017, the Joint Fiscal Office and the Department of Finance and Management shall provide their findings and any recommendations for statutory change to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

Sec. 16. ALL-PAYER MODEL; ALIGNMENT; REPORT

On or before January 15, 2017, the Green Mountain Care Board shall present information to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on the status of its efforts to achieve alignment between Medicare, Medicaid, and commercial payers in the all-payer model as required by 18 V.S.A. § 9551(a)(3).

** * * Nutrition Procurement Standards for State Government * * **

Sec. 17. FINDINGS

(a) Approximately 13,000 Vermont residents are employed by the State or employed by a person contracting with the State. Reducing the impact of diet-related diseases will support a more productive and healthy workforce that will pay dividends to Vermont's economy and cultivate national competitiveness for State residents and employees.

(b) Improving the nutritional quality of food sold or provided by the State on public property will support people in making healthy eating choices.

(c) State properties are visited by Vermont residents and out-of-state visitors, and also provide care to dependent adults and children.

(d) Approximately 25 percent of Vermont residents are overweight or obese.

(e) Obesity costs Vermont $291 million each year in health care costs, contributing to debilitating yet preventable diseases, such as heart disease, cancer, stroke, and diabetes.

(f) Improving the types of foods and beverages served and sold in workplaces positively affects employees' eating behaviors and can result in weight loss.

(g) Maintaining a healthy workforce can positively affect indirect costs by reducing absenteeism and increasing worker productivity.

Sec. 18. 29 V.S.A. § 160c is added to read:

§ 160c. NUTRITION PROCUREMENT STANDARDS

(a)(1) The Commissioner of Health shall establish and post on the Department's website nutrition procurement standards that:

(A) consider relevant guidance documents, including those published by the U.S. General Services Administration, the American Heart Association, and the National Alliance for Nutrition and Activity and, upon request, the

Department shall provide a rationale for any divergence from these guidance documents;

(B) consider both positive and negative contributions of nutrients, ingredients, and food groups to diets, including calories, portion size, saturated fat, trans fat, sodium, sugar, and the presence of fruits, vegetables, whole grains, and other nutrients of concern in Americans' diets; and

(C) contain exceptions for circumstances in which State-procured foods or beverages are intended for individuals with specific dietary needs.

(2) The Commissioner shall review and, if necessary, amend the nutrition procurement standards at least every five years to reflect advances in nutrition science, dietary data, new product availability, and updates to federal Dietary Guidelines for Americans.

(b)(1) All foods and beverages purchased, sold, served, or otherwise provided by the State or any entity, subdivision, or employee on behalf of the State shall meet the minimum nutrition procurement standards established by the Commissioner of Health.

(2) All bids and contracts between the State and food and beverage vendors shall comply with the nutrition procurement standards. The Commissioner, in conjunction with the Commissioner of Buildings and General Services, may periodically review or audit a contracting food or beverage vendor's financial reports to ensure compliance with this section.

(c) The Governor's Health in All Policies Task Force may disseminate information to State employees on the Commissioner's nutrition procurement standards.

(d) All State-owned or -operated vending machines, food or beverage vendors contracting with the State, or cafeterias located on property owned or operated by the State shall display nutritional labeling to the extent permitted under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ch. 9 § 301 et seq.

(e) The Commissioner of Buildings and General Services shall incorporate the nutrition procurement standards established by the Commissioner into the appropriate procurement document.

Sec. 19. EXISTING PROCUREMENT CONTRACTS

To the extent possible, the State's existing contracts and agreements with food and beverage vendors shall be modified to comply with the nutrition procurement standards established by the Commissioner of Health.

** * * Effective Dates * * **

Sec. 20. EFFECTIVE DATES

(a) Secs. 2 (all-payer model) and 3–5 (ACOs) shall take effect on January 1, 2018.

(b) Secs. 17–19 (nutrition procurement standards) shall take effect on July 1, 2016.

(c) This section and the remaining sections shall take effect on passage.