VERMONT
GREEN MOUNTAIN CARE BOARD

GMCB Authorities

January 21, 2022

General Principles

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- A public agency has only such powers as are **expressly granted** by the Legislature, together with those **implied as necessary** for the full exercise of those granted.
- To determine the scope of authority vested in an agency by a statutory grant of power, courts looks to the agency's enabling legislation and seek to give effect to the Legislature's intent.
  - Where the meaning of a statute is plain on its face, courts will enforce the statute according to its terms.
  - Where there is ambiguity in a statute, courts will look to the general context of the statutory language.
- Depending on its enabling statute, an agency may exercise **judicial** or **legislative** authorities, or both.

General Principles

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- The Board must execute its duties consistent with the principles for health care reform. 18 V.S.A. § 9375(a). These principles include the:
  - need to ensure universal access to high-quality, affordable, health services and eliminate systemic barriers such as cost;
  - need for cost containment, efficiency, and elimination of unnecessary expenditures, including reducing administrative costs;
  - need to identify sources of excess growth and potential improvements in access and quality;
  - need for transparency and public participation;
  - need to preserve and enhance primary care within patient's communities and ensure access to appropriate mental health care as part of a holistic system;
  - need to support the educational and research missions of State's academic medical center, the nonprofit missions of community hospitals, and the critical access designation of rural hospitals so that all Vermonters have access to necessary health services that are sustainable;
  - importance of transparency and understandability of costs for health services;
  - need for financing of health care to be sufficient, fair, predictable, transparent, sustainable, and equitable;
  - need to consider the effects of payment reform on individuals and providers;
  - need for partnership between consumers, employers, health care professionals, hospitals, and state and federal government. 18 V.S.A. § 9371.

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Implied Authorities

Examples: Authority Found

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- *In re Prof'l Nurses Serv., Inc.*, 164 Vt. 529 (1996); *In re ACTD LLC*, 2020 VT 89 (2020).
  - The power to clarify a certificate of need is one of the implied powers necessary to carry out the Board's express authority to review and approve changes to an approved project.

Examples: Authority Not Found

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- *New Hampshire-Vermont Physician Serv. v. Comm'r, Dep't of Banking & Ins.*, 132 Vt. 592 (1974); *New Hampshire-Vermont Hospitalization Serv. v. Comm'r, Dep't of Banking & Ins.*, 133 Vt. 333 (1975).
  - The Court held that the Commissioner of Banking and Insurance did not, in connection with rate review decisions, have the authority to issue supplemental orders that required the insurers to, for example, 1) eliminate certain coverage clauses that unfairly discriminated against women; 2) increase the maximum major medical lifetime benefit; 3) reconstitute their Boards of Directors; 4) file a report on prospective reimbursement, 5) review and seek improvements in hospital budgets; 6) file a report on waivers of pre-existing condition exclusions; and 7) reject provider cost increases until they are adjusted to the lowest reasonable level of payment.
  - The Court reasoned that the Commissioner's authority was narrow; the statute forbade a hospital service corporation doing business in Vermont from contracting with a subscriber until it had obtained a permit from the Commissioner and allowed the Commissioner to refuse a permit if the rates submitted were "excessive, inadequate, or unfairly discriminatory." The Court explained: "We have found nothing either in the statutes or our case law which can reasonably be construed as expanding the passive power of approval and disapproval defined above into the active authority indicated by the challenged supplemental orders."

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Express Authorities

Express Authorities Hospital Budgets

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- The Board shall **establish a budget for each hospital**. 18 V.S.A. § 9456(d)(1); Rule 3.307.
  - The statute previously applied only to "general hospitals."
  - Effective July 6, 2020, the definition of a "hospital" was changed to mean any hospital licensed under Title 18, Chapter 43, except a hospital that is conducted, maintained, or operated by the State of Vermont. Act 140 of 2020, §§ 2, 18.
    - Includes the Brattleboro Retreat.
    - Excludes the Vermont Psychiatric Care Hospital and the VA Hospital.
  - The Board must conduct a full review of the Retreat's budget not later than the budget for fiscal year 2024. Act 140 of 2020, § 3.
- Statute does not limit the Board to net patient revenue or charges.

Express Authorities Hospital Budgets

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- Hospital budgets must
  - be consistent with the HRAP;
  - consider national, regional, or in-state peer group norms, according to indicators, ratios, and statistics established by the Board;
  - promote efficient and economic hospital operation;
  - reflect prior budget performances;
  - include a finding that the hospital presented a reasonable analysis reflecting a reduction in net revenue needs for non-Medicaid payers due to any anticipated increase in Medicaid, Medicare, or other public health care program reimbursements or any reduction in bad debt or charity care due to a decrease in the uninsured rate; and
  - support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care. 18 V.S.A. § 9456(c).
- Hospitals must justify their budgets. Rule 3.306(a).

Express Authorities Hospital Budgets

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- The Board may **define, on an annual basis, criteria for hospitals to meet**, such as utilization and inflation benchmarks. 18 V.S.A. § 9456(e).
- The Board will, on an annual basis, **establish benchmarks** for any indicators for use in developing and preparing the upcoming fiscal year's hospital budgets. Rule 3.202(a). Benchmarks may include
  - growth indicators;
  - prior budget performance;
  - efficiency or productivity indicators;
  - capital investment indicators;
  - profitability indicators;
  - cost and price indicators;
  - liquidity and debt structure indicators;
  - other financial measure recognized or used in evaluating budgets and/or financial plans;
  - disease, population health, access, and quality indicators. Rule 3.202(c).
- The Board may adjust proposed budgets of hospitals that do not meet the established benchmarks. Rule 3.305.

Express Authorities Hospital Budgets

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- The Board may **adopt rules** to effectuate the purposes of the hospital budget statutes. 18 V.S.A. § 9453(b); *see also* 18 V.S.A. § 9380.
- The Board shall **adopt uniform formats** for hospitals to report financial, scope-of-services, and utilization data and information. 18 V.S.A. § 9453(a)(1).
- The Board also has **enforcement authorities** to ensure compliance with orders and deal with noncompliance. 18 V.S.A. § 9456(h), Rule 3.401.

Express Authorities ACO Budgets

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- The Board shall **adopt rules** that
  - **establish standards and processes for reviewing, modifying, and approving the budgets of ACOs**. 18 V.S.A. § 9382.
  - **establish standards the Board deems necessary and appropriate to the operation and evaluation of ACOs**, including solvency and ability to assume financial risk. 18 V.S.A. § 9375(b)(13).
- An ACO is "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."
- The Board's rules specify that it may **establish benchmarks** for any indicators to be used by ACOs in preparing their budgets and that it will **establish budgets** for ACOs by written order. Rule 5.402, 5.406.

Express Authorities ACO Budgets

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- Considerations
  - For ACOs with 10,000 or more attributed lives, the Board must consider 16 factors in its review. For ACOs with less than 10,000 attributed lives, the Board may consider as many of the factors as it deems appropriate to the ACO's size/scope. 18 V.S.A. § 9382(b).
  - In addition to the statutory factors, the Board will consider any benchmarks it has established; the ACO's payer programs and any applicable requirements of 18 V.S.A. § 9551 (principles for all-payer model) or the Vermont All-Payer ACO Model Agreement; and any other issues at its discretion. Rule 5.405(b)-(c).
- ACOs must justify their proposed budgets. Rule 5.405(a).

Express Authorities ACO Budgets

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- The Board's rules specify that, as part of a risk-bearing ACO's budget, the Board will **approve a maximum amount of risk** that an ACO can assume. Rule 5.403(b).
- The Board's rules also outline **enforcement authorities**. For example, the Board may
  - **review an ACO's performance under an established budget** at any time. Rule 5.407(a).
    - Such reviews need not be limited to reviews of financial performance and may cover any matter approved by the Board as part of the ACO's budget.
  - **take remedial action against an** ACO that is failing to meet requirements of an order of the Board. Rule 5.504(b).
    - Remedial actions may include placing the ACO on a monitoring or auditing plan or requiring the ACO to implement a corrective action plan.

Express Authorities Insurance Rates

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- The Board shall review rate requests for major medical health insurance policies and shall **approve, modify, or disapprove** a rate request within 90 calendar days. 8 V.S.A. § 4062(a)(2)(A); 18 V.S.A. § 9375(b)(6).
- In deciding whether to approve, modify, or disapprove a rate request, the Board shall determine whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of Vermont, and is not excessive, inadequate, or unfairly discriminatory, taking into consideration the requirements of the underlying statute; changes in health care delivery; changes in payment methods and amounts; DFR's analysis and opinion regarding the impact of the proposed rate on the insurer's solvency and reserves; and other issues at the discretion of the Board. 18 V.S.A. § 4062(a)(3); 18 V.S.A. § 9375(b)(6); Rule 2.401.

Express Authorities Rate Review Conditions

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- In response to the Court's decisions in *New Hampshire-Vermont Physician Serv. v. Comm'r, Dep't of Banking & Ins.* and *New Hampshire-Vermont Hospitalization Serv. v. Comm'r, Dep't of Banking & Ins.* (see slide 6) the Legislature enacted statutes that now authorize the Board 1) to **issue reasonable supplemental orders** to non-profit hospital and medical service corporations and health maintenance organizations in connection with rate decisions and 2) **to attach reasonable conditions and limitations to such orders** if 3) the Board finds, on the basis of competent and substantial evidence, that they are **necessary to ensure benefits and services are provided at minimum cost under efficient and economical management**, provided that 4) the Board does not set the rate of payment or reimbursement made to any physician, hospital, or other provider (except as otherwise provided by 18 V.S.A. §§ 9375 and 9376). 8 V.S.A. §§ 4513, 4584, 5104.
    - 18 V.S.A. § 9375(b)(1) gives the Board the duty to oversee the development and implementation of payment and delivery system reforms, including the authority to authority to implement by rule methodologies for achieving payment reform and containing costs (e.g., global budgets or risk-adjusted capitated payments).
    - 18 V.S.A. § 9376 gives the Board authority to set reasonable reimbursement rates for health care professionals, provider bargaining groups, manufacturers of prescribed products, medical supply companies, and other companies providing health care services or supplies based on methodologies pursuant to 18 V.S.A. § 9375 in order to have a consistent reimbursement amount accepted by these persons.

Express Authorities Rate Review Conditions

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- *In re Vermont Health Serv. Corp.*, 144 Vt. 617 (1984).
  - The Commissioner of Banking and Insurance denied BCBSVT's request for 30% rate increase and issued supplemental orders. One of the orders required BCBSVT to 1) reform or cancel its contracts with all participating hospitals by a specific date; 2) incorporate modifications requested by the Commissioner into BCBSVT's hospital contracts or provide substantiated reasons why the modifications could not be made; 3) assign sufficient staff to conduct comparison budget reviews of participating hospitals reasonable costs; 4) develop proposals for economic risks and incentives to encourage efficiency and cost savings; and 5) incorporate into the reformed contracts a system of utilization review to ensure BCBSVT was only reimbursing for necessary and actual services.
  - The Court upheld the Commissioner's authority to issue this supplemental order, noting that the statute had been changed to give the Commissioner authority over Blue Cross's contracting process that the Court had previously held was not available to him.
  - The Court explained that a contrary holding would place the Commissioner in an untenable position; he would be required to ensure that subscriber rates were not excessive, inadequate, or unfairly discriminatory, and that benefits and services were being provided at minimum cost, and yet not have the means to actively bring this about.
  - The Court noted that costs for hospital care consume a much higher percentage of the health care dollar than any other service and that BCBSVT was the primary purchaser of hospital services.

Express Authorities Rate Review Conditions

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- *In re Vermont Health Serv. Corp.,* 155 Vt. 457 (1990).
  - BCBSVT filed a request with the Commissioner of Banking and Insurance for permission to increase its rates for Medicomp hospital and medical benefits coverage. The Commissioner issued a decision and five supplemental orders. BCBSVT appealed three of those supplemental orders, one requiring BCBSVT to conduct a study of administrative expense reduction and to report to the Commissioner, one requiring VHSC to obtain the Commissioner's prior approval for capital expenditures in excess of $250,000, and one requiring BCBSVT to properly credit subscribers for investment income in future rate filings. BCBSVT argued, among other things, that the first two orders improperly stepped on management prerogatives. The Court upheld the Commissioner's authority to issue the orders.

Express Authorities Health Care Reform

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- The Board has the duty to **oversee the development and implementation of health care payment and delivery system reforms and evaluate the effectiveness of such reforms.**
- In connection with this duty, the Board has a duty to **implement by rule methodologies for achieving payment reform and containing costs** that may include the participation of Medicare and Medicaid and that may include the creation of **health care professional cost-containment targets, 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**. 18 V.S.A. § 9375(b)(1).

Express Authorities Health Care Reform

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- The Board must work with providers to develop payment models that preserve access to care and quality in each community and must engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.
- The rule must take into consideration current Medicare designations and payment methodologies (critical access hospitals, prospective payment system hospitals, graduate medical education payments, Medicare dependent hospitals, and federally qualified health centers).
- The payment reform methodologies developed by the Board must encourage coordination and planning on a regional basis.
- Prior to the initial adoption of the rules, the Board must report its proposed methodologies to the House Committee on Health Care and the Senate Committee on Health and Welfare.

Express Authorities Provider Rate Setting

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- The Legislature directed the Board to **set reasonable rates** for health care health care professionals, health care provider bargaining groups, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to 18 V.S.A. § 9375, in order to have a consistent reimbursement amount accepted by these persons. 18 V.S.A. § 9376(b)(1).
- The Legislature specified that its intent was to
  - ensure that payments to health care professionals 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; and
  - eliminate the shift of costs between payers 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.

Express Authorities Provider Rate Setting

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- 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.
- 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.
- In establishing rates, the Board may consider legitimate differences in costs and the need for health care professionals in particular areas, particularly in underserved geographic or practice shortage areas.

Legal Constraints on Rate Setting or Payment Reform

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- All-Payer reform/cost containment methodologies or rate setting would require federal waiver(s).

Express Authorities HRAP

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- The Board shall, in consultation with Secretary of AHS, publish a Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources, which shall be used to inform the Board's regulatory processes, cost containment and statewide quality of care efforts, health care payment and delivery system reform initiatives, and any allocation of health resources within the State.
- The Plan shall identify Vermonters' needs for health care services, programs, and facilities; the resources available and additional resources required to realistically meet those needs and to make access to those services, programs, and facilities affordable; and the priorities for addressing those needs.