

STATE OF VERMONT
HEALTH CARE AUTHORITY

Rule 6.000

6.000 PROVIDER BARGAINING GROUPS

6.100 Authority

This rule is promulgated by the Health Care Authority under the authority of 18 V.S.A. §§ 9404(d)(2) and 9409(b).

6.200 Scope and Purpose

Section 9406 of Title 18 requires the Health Care Authority to establish a unified health care budget on an annual basis. In preparing the budget each year, the Authority will engage in discussions with representatives of many sectors of Vermont's health care system, including but not limited to health care providers, so that the budgeting process is based on as much information as possible. Individual health care providers who wish to negotiate with the Authority may feel constrained, however, from full participation for fear that their activities will be deemed anticompetitive behavior subject to sanctions under applicable antitrust laws. This rule allows health care providers to benefit from the "state action immunity doctrine" under which a state may allow certain anticompetitive behavior, so long as the behavior is clearly articulated and actively supervised. To that end, this rule is designed to implement 18 V.S.A. § 9409(a) by governing the creation of provider bargaining groups, clearly articulating the scope of the matters that groups can negotiate with the Authority and the health care purchasing pool, and providing for active supervision of all approved activities by the state. Once approved under this rule, a provider bargaining group will be able to engage in the types of negotiations authorized herein without the threat of a challenge under the antitrust laws.

6.201 Applicability

This rule shall apply to health care providers negotiating, or desiring to negotiate, with the Health Care Authority or the health care purchasing pool any matters authorized under 18 V.S.A. § 9409(a).

6.202 Purpose

Section 9409 of Title 18 permits the Health Care Authority Board to approve the creation of one or more provider bargaining groups, consisting of health care providers who choose to participate in such groups. This rule defines the criteria governing the formation and approval of provider bargaining groups and the activities authorized by § 9409(a).

Rule adopted: May 31, 1994
Effective date: June 15, 1994

6.203 Definitions

- (A) "Authority" means the Health Care Authority established under 18 V.S.A. § 9403(a).
- (B) "Board" means the board of the Authority established under 18 V.S.A. § 9403(b).
- (C) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all facilities and institutions included in 18 V.S.A. § 9432(10).
- (D) "Health care provider" or "provider" means a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service in Vermont to an individual during that individual's medical care, treatment or confinement.
- (E) "Health care purchasing pool" or "purchasing pool" means the purchasing pool established by the secretary of administration pursuant to 18 V.S.A. § 9413(a).
- (F) "Provider bargaining group" means a group of health care providers authorized under this rule to engage in negotiations with the Authority and the purchasing pool.
- (G) "Sector" means a part of the unified health care budget as defined by the Authority.
- (H) "Unified health care budget" means the annual budget adopted by the Board pursuant to 18 V.S.A. § 9406(b).

6.300 Formation and Approval of Provider Bargaining Groups

6.301 Criteria Governing Approval as Provider Bargaining Group

A group of health care providers may be approved by the Authority as a provider bargaining group if the group seeking approval has shown:

- (A) Status as health care providers: that all members of the proposed bargaining group are licensed, certified or authorized by law to provide professional health care services in the state of Vermont;

Rule adopted: May 31, 1994
Effective date: June 15, 1994

- (B) Common interest: that all members of the group are linked by a specified common interest such that negotiations with them as a group, rather than as individual providers, will be effective and efficient; for purposes of this rule, a "common interest" could include, but is not limited to, being licensed in the same profession, practicing in the same health care entity or facility, or belonging to the same professional practice group;
- (C) Nondiscrimination: that the proposed bargaining group will not exclude from its membership health care providers who share the common interest linking the group under subsection (B) of this section;
- (D) Authority to represent members: that the group is represented by one or more individuals with express authority to represent group members' interests before the Authority or the purchasing pool;
- (E) Unified health care budget: that the group has, or will have, a significant effect on the costs of one or more sectors of the unified health care budget and on resource allocation consistent with the health resource management plan adopted under 18 V.S.A. § 9405; and
- (F) Public interest: that the group is of sufficient size and represents a sufficient sector or portion of health care providers such that it will be in the public interest for the Authority or the purchasing pool to engage in negotiations with it under 18 V.S.A. § 9409.

6.302 Application Procedure for Approval as Provider Bargaining Group

- (A) A group of health care providers seeking approval as a provider bargaining group shall file a written application (original and five copies) with the Authority. The application shall set forth in detail how the proposed bargaining group meets the criteria set forth in § 6.301, above.
- (B) The Authority shall review the application and, within fifteen working days, notify the applicant either that the application is complete or that additional information is required.
 - (1) Applicants shall respond to requests for additional information within fifteen working days. Failure of an applicant to do so may, in the discretion of the Board, be considered a withdrawal of the application. An applicant's response time may be extended by the Authority for good cause shown.
 - (2) The Authority shall review additional information filed in response to its request and, within fifteen working days, notify the applicant either that the application is complete or that additional information is still

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required. Further requests for information under this section shall be subject to the same review and response guidelines as the original request for additional information.

- (3) If the Authority fails to notify the applicant in a timely manner that an application is either complete or incomplete under this subsection, the application shall be deemed to be complete on the sixteenth working day after the date the application was filed or the last information was received, whichever is later.
- (C) When an application has been deemed complete, the Authority shall fully review the application under the criteria established in § 6.301 of this rule.
- (1) The Authority may in its discretion schedule a hearing on the completed application, at which time the applicant, and other parties, at the discretion of the Board, will be given the opportunity to present support for the application and the Board will have the opportunity to inquire into the merits of the application.
 - (2) The applicant may request such a hearing before the Board at the time it files its application or at any time before the application is deemed complete.
 - (3) A hearing under this subsection is an informal process designed to give the applicant and the Board the opportunity to discuss the merits of the application. It is not a "contested case" as that term is used in the Vermont Administrative Procedure Act and is not subject to the provisions of that act.
- (D) The Authority shall complete its review and the Board shall make a decision either to approve or to deny the application within forty-five days of the date the application was deemed complete, or within sixty days if a hearing was requested by the applicant or scheduled by the Authority. For purposes of this rule, the completion date is either the date that notification is sent to the applicant that the application is complete, or the date established under § 6.302(B)(3), above.
- (E) The Authority may, in its discretion, issue a conditional approval to a provider bargaining group, including limitations on the matters that a group will be authorized to negotiate under 18 V.S.A. § 9409 and this rule.

Rule adopted: May 31, 1994
Effective date: June 15, 1994

6.303 Effect of Approval as Provider Bargaining Group

Once approved, a provider bargaining group may, subject to any limitations imposed under § 6.302(E) of this rule, participate in the activities set forth in § 6.400 of this rule for three years or until its approval is revoked, whichever is earlier.

6.304 Review and Extension or Revocation of Approval as Provider Bargaining Group

- (A) The Authority shall review each provider bargaining group's qualifications under the criteria established in § 6.301 of this rule at least three months before a group's approval expires. If the Authority is satisfied that the group continues to meet the criteria, it may extend the bargaining group's approval for another three years; otherwise, it will allow the group's approval to expire.
- (B) The Authority may, upon notice, review a provider bargaining group's qualifications under this rule at any time before its approval expires if it has reason to believe that the group may no longer meet the criteria in § 6.301. If the Authority is satisfied that the group continues to meet the criteria, it may either extend the bargaining group's approval for another three years from the time of the review, or allow the original three-year period to continue to elapse, in which case the group will be subject to an additional review in accordance with § 6.304(A), above. If the Authority finds, after a review conducted under this section, that a group no longer satisfies the criteria for recognition as a provider bargaining group, it shall revoke the group's approval effective immediately.

6.400 Scope of Authorized Activities

6.401 Once approved in accordance with § 6.300 of this rule, a provider bargaining group is authorized:

- (A) to negotiate with the Authority
 - (1) the establishment or definition of the sectors of the health care system separately identified in the unified health care budget;
 - (2) the methods or processes used by the Board in allocating resources among the sectors;
 - (3) the economic indicators used by the Board to define the parameters of the rate of growth in the cost of the health care system and its sectors;

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- (4) processes and criteria for responding to exceptional and unforeseen circumstances affecting the system and its sectors;
 - (5) the establishment of the total amounts to be paid for services provided by the system and its sectors; and
 - (6) any matter related to the reimbursement of health care providers under the unified health care budget; and
- (B) to negotiate with the purchasing pool
- (1) contracts for the delivery of health care services, including agreements securing discounts for regular, bulk payments to providers and agreements establishing uniform provider reimbursement; and
 - (2) any matter related to the reimbursement of health care providers by the purchasing pool.

6.402 Nothing in this section shall be construed to authorize a provider bargaining group to engage in any activities other than those specified in 18 V.S.A. § 9409(a) and in § 6.401 of this rule.

6.500 Procedures for Authorized Activities

6.501 Negotiations with the Authority Related to Sectors of the Unified Health Care Budget

- (A) On or before October 1 of each year, the Authority shall notify all provider bargaining groups that negotiations will begin for the adoption of the next fiscal year's unified health care budget. The Authority may, in its discretion, furnish copies of its proposed unified health care budget, including the sectors to be included in the budget, if any, to the groups at that time.
- (B) On or before November 1, if the Authority has furnished provider bargaining groups with copies of a proposed budget, each group shall file with the Authority, in writing, its response to the proposed budget, and shall furnish copies of its response to all other provider bargaining groups approved under this rule. The Authority shall conduct at least one public hearing on the responses filed by provider bargaining groups.
- (C) Between November 2 and March 1, the Authority shall meet with provider bargaining groups to negotiate any matter authorized by 18 V.S.A. § 9409(a) and Section 6.401 of this rule relating to the unified health care budget, including the reimbursement of sectors once defined. If in the course of

Rule adopted: May 31, 1994
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these negotiations the Authority and a provider bargaining group reach agreement as to the reimbursement of the health care providers represented by the bargaining group, on or before July 1 the Authority may enter into a nonbinding reimbursement contract with the group.

- (D) If the provider bargaining groups and the Authority do not agree on resolution of the matters being negotiated, including the designation and establishment of appropriate sectors within the unified health care budget, any such issue shall be referred to an arbitration panel no later than March 1.
 - (1) The arbitration panel shall consist of one member chosen by the Health Care Authority, one member chosen by the provider bargaining groups involved in the dispute, and one member to be chosen by the first two panel members.
 - (2) The arbitration panel shall review the matters in dispute and make a recommendation as to resolution of those matters to the Board within thirty days, but in no event later than April 1.
 - (3) Nothing in these rules shall be construed to limit the Board's authority to reject the recommendation or decision of the arbitration panel or to limit the Board's authority under 18 V.S.A. § 9406 to establish the unified health care budget.
- (E) The Authority may elect to hold one or more public hearings between March 1 and April 30 relating to the results of its negotiations with provider bargaining groups on the proposed unified health care budget.

6.502 General Negotiations with the Authority as to Provider Reimbursement

The Authority shall meet with a provider bargaining group, from time to time, at its discretion or at the request of the group, to negotiate any matter related to the reimbursement, under the unified health care budget, of the health care providers represented by the group, and may enter into a nonbinding contract with the group as to reimbursement.

6.503 Purchasing Pool

The purchasing pool shall meet with a provider bargaining group from time to time, at its discretion or at the request of the group, to negotiate any matter related to contracts with the pool for the delivery of health care services by the health care providers represented by the group and the reimbursement of such health care

Rule adopted: May 31, 1994
Effective date: June 15, 1994

providers by the purchasing pool, and may enter into a contract with the group as to reimbursement.

6.504 Timelines

The timelines established in Section 6.501 of this rule may be changed by the Authority as necessary to accommodate the activities of the Authority in establishing a unified health care budget from year to year. Any such change shall be effective thirty days after notice by the Authority to all approved provider bargaining groups. Notice shall be sent by first-class mail and is deemed given on the date mailed. A copy of such change shall be filed at the same time with the Secretary of State's office.

6.600 Active Oversight of Authorized Activities

The Authority shall actively monitor and oversee the activities engaged in by provider bargaining groups. Such active monitoring and oversight shall consist of at least the following:

- (A) No provider bargaining group shall engage in negotiations with the Authority or the purchasing pool until the group has applied for status as, and been approved as, a provider bargaining group pursuant to § 6.300 of this rule.
- (B) The Authority, as set forth in § 6.304 of this rule, shall periodically review each provider bargaining group to ensure that the group continues to meet the criteria required for the establishment and approval of a provider bargaining group.
- (C) The Authority shall actively participate in all negotiations with provider bargaining groups, either singly or jointly, to ensure that any anticompetitive activities are in conformity with and within the scope of the legislative mandate of 18 V.S.A. § 9409 authorizing the creation and activities of provider bargaining groups.
- (D) This rule shall not be construed as requiring the Authority to accept the position of any provider bargaining group. In addition, as stated in § 6.501(D)(3) of this rule, the Board has the discretion to reject any recommendation or decision of an arbitration panel called upon to assist the Board and provider bargaining groups to resolve disputes among them.
- (E) If a contract for provider reimbursement is negotiated between the Authority and a provider bargaining group or between the purchasing pool and a provider bargaining group, the contract shall not take effect unless approved by the Board upon a finding that it is consistent with the unified health care budget and the health resource management plan adopted under 18 V.S.A. § 9405 and that the contract is consistent with the public good of the state of Vermont.

Rule adopted: May 31, 1994
Effective date: June 15, 1994