

1 TO THE HONORABLE SENATE:

2 The Committee on Health and Welfare to which was referred House Bill  
3 No. 812 entitled “An act relating to implementing an all-payer model and  
4 oversight of accountable care organizations” respectfully reports that it has  
5 considered the same and recommends that the Senate propose to the House that  
6 the bill be amended by striking out all after the enacting clause and inserting in  
7 lieu thereof the following:

8 \* \* \* All-Payer Model \* \* \*

9 Sec. 1. ALL-PAYER MODEL; MEDICARE AGREEMENT

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

14 (1) is consistent with the principles of health care reform expressed in  
15 18 V.S.A. § 9371, to the extent permitted under Section 1115A of the Social  
16 Security Act and approved by the federal government;

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

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

3           (4) allows Medicare patients to choose among providers;

4           (5) includes outcome measures for population health; and

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

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

9                                   CHAPTER 227. ALL-PAYER MODEL

10           § 9551. ALL-PAYER MODEL

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

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

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

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

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

5                   (B) attribution and payment mechanisms;

6                   (C) patient protections;

7                   (D) care management mechanisms; and

8                   (E) provider reimbursement processes;

9           (4) strengthens and invests in primary care;

10           (5) incorporates social determinants of health;

11           (6) adheres to federal and State laws on parity of mental health and  
12           substance abuse treatment and integrates mental health and substance abuse  
13           treatment systems into the overall health care system;

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

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

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

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

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

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

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

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

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

3                     \*\*\* Oversight of Accountable Care Organizations \*\*\*

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

5       § 9373. DEFINITIONS

6           As used in this chapter:

7   \*\*\*

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

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

13           (b) The Board shall have the following duties:

14                 (1) Oversee the development and implementation, and evaluate the  
15                 effectiveness, of health care payment and delivery system reforms designed to  
16                 control the rate of growth in health care costs; promote seamless care,  
17                 administration, and service delivery; and maintain health care quality in  
18                 Vermont, including ensuring that the payment reform pilot projects set forth in  
19                 this chapter are consistent with such reforms.

20   \*\*\*

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

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

7           § 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

8           (a) In order to be eligible to receive payments from Medicaid or  
9           commercial insurance through any payment reform program or initiative,  
10           including an all-payer model, each accountable care organization shall obtain  
11           and maintain certification from the Green Mountain Care Board. The Board  
12           shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and  
13           processes for certifying accountable care organizations. To the extent  
14           permitted under federal law, the Board shall ensure these rules anticipate and  
15           accommodate a range of ACO models and sizes, balancing oversight with  
16           support for innovation. In order to certify an ACO to operate in this State, the  
17           Board shall ensure that the following criteria are met:

18           (1) the ACO's governance, leadership, and management structure is  
19           transparent, reasonably and equitably represents the ACO's participating  
20           providers and its patients, and includes a consumer advisory board and other  
21           processes for inviting and considering consumer input;

1           (2) the ACO has established appropriate mechanisms and care models to  
2           provide, manage, and coordinate high-quality health care services for its  
3           patients, including incorporating the Blueprint for Health, coordinating  
4           services for complex high-need patients, and providing access to health care  
5           providers who are not participants in the ACO;

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

8           (4) the ACO has established appropriate mechanisms and criteria for  
9           accepting health care providers to participate in the ACO that prevent  
10           unreasonable discrimination and are related to the needs of the ACO and the  
11           patient population served;

12           (5) the ACO has established mechanisms and care models to promote  
13           evidence-based health care, patient engagement, coordination of care, use of  
14           electronic health records, and other enabling technologies to promote  
15           integrated, efficient, seamless, and effective health care services across the  
16           continuum of care, where feasible;

17           (6) the ACO's participating providers have the capacity for meaningful  
18           participation in health information exchanges;

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

1           (8) the ACO does not place any restrictions on the information its  
2           participating health care providers may provide to patients about their health or  
3           decisions regarding their health;

4           (9) the ACO’s participating health care providers engage their patients  
5           in shared decision making to inform them of their treatment options and the  
6           related risks and benefits of each;

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

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

10                   (B) responding and making best efforts to resolve complaints and  
11                   grievances from attributed patients, including providing assistance in  
12                   identifying appropriate rights under a patient’s health plan;

13                   (C) providing an accessible mechanism for explaining how  
14                   ACOs work;

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

17                   (E) sharing deidentified complaint and grievance information with  
18                   the Office of the Health Care Advocate at least twice annually;

19           (11) the ACO collaborates with providers not included in its financial  
20           model, including home- and community-based providers and dental health  
21           providers;



1           (12) the ACO does not interfere with patients' choice of their own  
2           health care providers under their health plan, regardless of whether a provider  
3           is participating in the ACO; does not reduce covered services; and does not  
4           increase patient cost sharing;

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

8           (14) the impact of the ACO's establishment and operation does not  
9           diminish access to any health care service or increase delays in access to care  
10           for the population and area it serves;

11           (15) the ACO has in place appropriate mechanisms to conduct ongoing  
12           assessments of its legal and financial vulnerabilities; and

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

15           (b)(1) The Green Mountain Care Board shall adopt rules pursuant to  
16           3 V.S.A. chapter 25 to establish standards and processes for reviewing,  
17           modifying, and approving the budgets of ACOs with 10,000 or more attributed  
18           lives in Vermont. To the extent permitted under federal law, the Board shall  
19           ensure the rules anticipate and accommodate a range of ACO models and sizes,  
20           balancing oversight with support for innovation. In its review, the Board shall  
21           review and consider:

- 1           (A) information regarding utilization of the health care services  
2           delivered by health care providers participating in the ACO and the effects of  
3           care models on appropriate utilization, including the provision of innovative  
4           services;
- 5           (B) the goals and recommendations of the health resource allocation  
6           plan created in chapter 221 of this title;
- 7           (C) the expenditure analysis for the previous year and the proposed  
8           expenditure analysis for the year under review by payer;
- 9           (D) the character, competence, fiscal responsibility, and soundness of  
10          the ACO and its principals;
- 11          (E) any reports from professional review organizations;
- 12          (F) the ACO’s efforts to prevent duplication of high-quality services  
13          being provided efficiently and effectively by existing community-based  
14          providers in the same geographic area, as well as its integration of efforts with  
15          the Blueprint for Health and its regional care collaboratives;
- 16          (G) the extent to which the ACO provides incentives for systemic  
17          health care investments to strengthen primary care, including strategies for  
18          recruiting additional primary care providers, providing resources to expand  
19          capacity in existing primary care practices, and reducing the administrative  
20          burden of reporting requirements for providers while balancing the need to

1 have sufficient measures to evaluate adequately the quality of and access  
2 to care;

3 (H) the extent to which the ACO provides incentives for systemic  
4 integration of community-based providers in its care model or investments to  
5 expand capacity in existing community-based providers, in order to promote  
6 seamless coordination of care across the care continuum;

7 (I) the extent to which the ACO provides incentives for systemic  
8 health care investments in social determinants of health, such as developing  
9 support capacities that prevent hospital admissions and readmissions, reduce  
10 length of hospital stays, improve population health outcomes, reward healthy  
11 lifestyle choices, and improve the solvency of and address the financial risk to  
12 community-based providers that are participating providers of an accountable  
13 care organization;

14 (J) the extent to which the ACO provides incentives for preventing  
15 and addressing the impacts of adverse childhood experiences (ACEs), such as  
16 developing quality outcome measures for use by primary care providers  
17 working with children and families, developing partnerships between nurses  
18 and families, providing opportunities for home visits, and including  
19 parent-child centers and designated agencies as participating providers in the  
20 ACO;

1           (K) public comment on all aspects of the ACO’s costs and use and on  
2           the ACO’s proposed budget;

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

5           (M) information on the ACO’s administrative costs, as defined by the  
6           Board;

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

9           (O) the extent to which the ACO makes its costs transparent and easy  
10          to understand so that patients are aware of the costs of the health care services  
11          they receive.

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

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

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

19               (C) provide testimony in any hearing held in connection with the  
20               Board’s ACO budget review.

1       (c) The Board’s rules shall include requirements for submission of  
2       information and data by ACOs and their participating providers as needed to  
3       evaluate an ACO’s success. They may also establish standards as appropriate  
4       to promote an ACO’s ability to participate in applicable federal programs  
5       for ACOs.

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

10       (e) To the extent required to avoid federal antitrust violations, the Board  
11       shall supervise the participation of health care professionals, health care  
12       facilities, and other persons operating or participating in an accountable care  
13       organization. The Board shall ensure that its certification and oversight  
14       processes constitute sufficient State supervision over these entities to comply  
15       with federal antitrust provisions and shall refer to the Attorney General for  
16       appropriate action the activities of any individual or entity that the Board  
17       determines, after notice and an opportunity to be heard, may be in violation of  
18       State or federal antitrust laws without a countervailing benefit of improving  
19       patient care, improving access to health care, increasing efficiency, or reducing  
20       costs by modifying payment methods.



1 works toward meeting the criteria established in 18 V.S.A. § 9551. Through  
2 its authority over payment reform pilot projects under 18 V.S.A. § 9377, the  
3 Board shall also oversee the development and operation of accountable care  
4 organizations in order to encourage them to achieve compliance with the  
5 criteria established in 18 V.S.A. § 9382(a) and to establish budgets that reflect  
6 the criteria set forth in 18 V.S.A. § 9382(b).

7 (b) On or before January 1, 2018, the Board shall begin certifying  
8 accountable care organizations that meet the criteria established in 18 V.S.A.  
9 § 9382(a) and shall only approve accountable care organization budgets after  
10 review and consideration of the criteria set forth in 18 V.S.A. § 9382(b). If the  
11 Green Mountain Care Board and the Agency of Administration pursue  
12 development and implementation of an all-payer model, then on and after  
13 January 1, 2018 they shall implement the all-payer model in accordance with  
14 18 V.S.A. § 9551.

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

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

17 (e)(1) The Board shall establish a consumer, patient, business, and health  
18 care professional advisory group to provide input and recommendations to the  
19 Board. Members of such advisory group who are not State employees or  
20 whose participation is not supported through their employment or association  
21 shall receive per diem compensation and reimbursement of expenses pursuant

1 to 32 V.S.A. § 1010, provided that the total amount expended for such  
2 compensation shall not exceed \$5,000.00 per year.

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

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

12 Sec. 10. PRIMARY CARE PROFESSIONAL ADVISORY GROUP

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

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



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

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

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

9           (c) The Board may seek assistance from organizations representing primary  
10          care professionals. Members of the advisory group who are not State  
11          employees or whose participation is not supported through their employment  
12          or association shall receive per diem compensation and reimbursement of  
13          expenses pursuant to 32 V.S.A. § 1010, provided that the total amount  
14          expended for such compensation shall not exceed \$5,000.00 per year. The  
15          advisory group shall cease to exist on July 1, 2018.

16                                   \* \* \* Additional Reports \* \* \*

17          Sec. 11. AGENCY OF HUMAN SERVICES’ CONTRACTS; REPORT

18          (a) On or before January 1, 2017, the Agency of Human Services, in  
19          consultation with Vermont Care Partners, the Green Mountain Care Board, and  
20          representatives from preferred providers, shall submit a report to the Senate

1 Committee on Health and Welfare and to the House Committees on Health  
2 Care and on Human Services. The report shall address the following:

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

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

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

12 (b) The report shall contain a plan developed in conjunction with the  
13 Vermont Health Care Innovation Project and in consultation with the Vermont  
14 Care Network and the Vermont Council of Developmental and Mental Health  
15 Services to implement a value-based payment methodology for designated  
16 agencies, specialized service agencies, and preferred providers that shall  
17 improve access to and quality of care, including long-term financial  
18 sustainability. The plan shall describe the interaction of the value-based  
19 payment methodology for Medicaid payments made to designated agencies,  
20 specialized service agencies, and preferred providers by the Agency with any

1 Medicaid payments made to designated agencies, specialized service agencies,  
2 and preferred providers by the accountable care organizations.

3 (c) As used in this section:

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

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

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

14 Sec. 12. MEDICAID PATHWAY; REPORT

15 (a) The Secretary of Human Services, in consultation with the Director of  
16 Health Care Reform, the Green Mountain Care Board, and affected providers,  
17 shall create a process for payment and delivery system reform for Medicaid  
18 providers and services. This process shall address all Medicaid payments to  
19 affected providers, focus on services not included in the Medicaid equivalent  
20 of Medicare Part A and Part B services, and integrate the providers to the

1 extent practicable into the all-payer model and other existing payment and  
2 delivery system reform initiatives.

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

7 (1) all Medicaid payments to affected providers, including progress  
8 toward integration of services not included in the Medicaid equivalent of  
9 Medicare Part A and Part B services in the previous year;

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

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

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

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

17 Sec. 13. MEDICAID ADVISORY RATE CASE FOR ACO SERVICES

18 On or before December 31, 2016, the Green Mountain Care Board shall  
19 review any all-inclusive population-based payment arrangement between the  
20 Department of Vermont Health Access and an accountable care organization  
21 for calendar year 2017. The Board's review shall include the number of

1 attributed lives, eligibility groups, covered services, elements of the  
2 per-member, per-month payment, and any other nonclaims payments. The  
3 review shall be nonbinding on the Agency of Human Services, and nothing in  
4 this section shall be construed to abrogate the designation of the Agency of  
5 Human Services as the single State agency as required by 42 C.F.R. § 431.10.

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

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

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

15 The Joint Fiscal Office and the Department of Finance and Management, in  
16 collaboration with the Agency of Human Services Central Office and the  
17 Department of Vermont Health Access, shall consider the appropriate role, if  
18 any, of using multi-year budgets for Medicaid and other State-funded health  
19 care programs to reduce administrative burden, improve care quality, and  
20 ensure sustainable access to care. On or before March 1, 2017, the Joint Fiscal  
21 Office and the Department of Finance and Management shall provide their

1 findings and any recommendations for statutory change to the House  
2 Committees on Appropriations, on Health Care, and on Human Services and  
3 the Senate Committees on Appropriations, on Health and Welfare, and on  
4 Finance.

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

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

11 \* \* \* Nutrition Procurement Standards for State Government \* \* \*

12 Sec. 17. FINDINGS

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

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

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

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

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

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

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

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

12       § 160c. NUTRITION PROCUREMENT STANDARDS

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

15                (A) consider relevant guidance documents, including those published  
16       by the U.S. General Services Administration, the American Heart Association,  
17       and the National Alliance for Nutrition and Activity and, upon request, the  
18       Department shall provide a rationale for any divergence from these guidance  
19       documents;

20                (B) consider both positive and negative contributions of nutrients,  
21       ingredients, and food groups to diets, including calories, portion size, saturated

1 fat, trans fat, sodium, sugar, and the presence of fruits, vegetables, whole  
2 grains, and other nutrients of concern in Americans' diets; and

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

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

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

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

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



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

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

8        Sec. 19. EXISTING PROCUREMENT CONTRACTS

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

12                \* \* \* Universal Primary Care and Dr. Dynasaur 2.0 \* \* \*

13        Sec. 20. UNIVERSAL PRIMARY CARE; DR. DYNASAUR 2.0

14        (a) Regardless of any future developments in payment and delivery system  
15        reform, Vermont is likely to continue to have uninsured or underinsured  
16        residents. Expanding access to primary care services is a proven method for  
17        improving population health. It is the intent of the General Assembly to move  
18        forward with implementation of universal primary care for all Vermonters or  
19        expansion of Dr. Dynasaur to all Vermont residents up to 26 years of age, or  
20        both.

1       (b)(1) In order to determine a path forward toward implementing universal  
2       primary care in Vermont, the Secretary of Administration shall:

3               (A) provide the results of a literature review of any savings realized  
4       by universal health care programs over time that are attributable to the  
5       availability of universal access to primary care;

6               (B) determine the impacts on the individual, small group, and large  
7       group health insurance markets of providing primary care through a universal,  
8       publicly funded program; and

9               (C) report on primary care payment models created through the  
10       development of the all-payer model in order to enable legislators to estimate  
11       appropriate reimbursement amounts for health care providers delivering  
12       primary care services.

13       (2) On or before November 15, 2016, the Secretary of Administration  
14       shall provide to the Joint Fiscal Office a summary of its findings on the topics  
15       described in subdivision (1) of this subsection. The Joint Fiscal Office shall  
16       conduct an independent review of the methods and assumptions underlying the  
17       Secretary's findings and shall provide its comments and feedback to the  
18       Secretary on or before December 1, 2016. On or before December 15, 2016,  
19       the Secretary shall provide to the Health Reform Oversight Committee, the  
20       Joint Fiscal Committee, the House Committees on Health Care, on  
21       Appropriations, and on Ways and Means, and the Senate Committees on

1 Health and Welfare, on Appropriations, and on Finance a final report on the  
2 literature review, market impacts, and primary care models required by  
3 subdivision (1) of this subsection.

4 (c)(1) In order to determine a path forward toward expanding Dr. Dynasaur  
5 to all Vermont residents up to 26 years of age, the Secretary of Administration  
6 shall analyze the financial implications of expanding Dr. Dynasaur, the State's  
7 children's Medicaid and Children's Health Insurance Program, to all Vermont  
8 residents up to 26 years of age.

9 (2)(A) Estimated program costs shall include the cost of coverage,  
10 one-time and ongoing operating costs, administrative costs, and reserves or  
11 reinsurance to the extent they are deemed advisable.

12 (B) The cost estimates shall be for a period of five years beginning  
13 on January 1, 2019, and shall assume a reasonable rate of health care spending  
14 growth.

15 (C) Estimated costs shall be offset by any cost reductions to State  
16 government spending and by any avoided State or federal tax liability that the  
17 State of Vermont would otherwise incur as an employer.

18 (D) The cost estimates shall include an analysis of any cost increases  
19 or reductions anticipated for municipalities and school districts, including  
20 impacts on projected education spending.

1           (E) The cost estimates shall project increasing provider  
2           reimbursement rates at regular intervals from 100 percent of Medicare rates up  
3           to commercial rates. Medicare and commercial rates shall be determined  
4           based on claims data from the Vermont’s all-payer claims database.

5           (3)(A) On or before January 15, 2017, the Secretary shall submit a  
6           report to the House Committees on Health Care, on Appropriations, and on  
7           Ways and Means and the Senate Committees on Health and Welfare, on  
8           Appropriations, and on Finance comprising its analysis of the costs of  
9           expanding Dr. Dynasaur to all Vermont residents up to 26 years of age and  
10           potential plans for financing the expansion. The financing plans shall be  
11           consistent with the principles of equity expressed in 18 V.S.A. § 9371(11),  
12           which states that financing of health care in Vermont must be sufficient, fair,  
13           predictable, transparent, sustainable, and shared equitably. In developing the  
14           financing plans, the Secretary shall consider the following:

15                   (i) all current sources of funding for State government, including  
16                   taxes, fees, and assessments;

17                   (ii) existing health care revenue sources, including the claims tax  
18                   levied pursuant to 32 V.S.A. chapter 243, the provider assessments imposed  
19                   pursuant to 33 V.S.A. chapter 19, subchapter 2, and the employer assessment  
20                   required pursuant to 21 V.S.A. chapter 25, to determine whether they are  
21                   suitable for preservation or expansion to fund the program expansion;

1                    (iii) new revenue sources such as a payroll tax, gross receipts tax,  
2                    or business enterprise tax, or a combination of these;

3                    (iv) expansion or reform of existing taxes;

4                    (v) opportunities and challenges presented by federal law,  
5                    including the Internal Revenue Code; Section 1332 of the Patient Protection  
6                    and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care  
7                    and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and Titles  
8                    XIX (Medicaid) and XXI (SCHIP) of the Social Security Act, and by State  
9                    tax law; and

10                   (vi) anticipated federal funds that may be used for health care  
11                   services, including consideration of methods to maximize receipt of federal  
12                   funds available for this purpose.

13                   (B) The Secretary's report shall also include information on the  
14                   impacts of the coverage and proposed tax changes on individuals, households,  
15                   businesses, public sector entities, and the nonprofit community, including  
16                   migration of coverage, insurance market impacts, financial impacts, federal tax  
17                   implications, and other economic effects. The impact assessment shall cover  
18                   the same five-year period as the cost estimates.

19                   (4) Agencies, departments, boards, and similar units of State  
20                   government, including the Agency of Human Services, Department of  
21                   Financial Regulation, Department of Labor, Director of Health Care Reform,

1 and Green Mountain Care Board, shall provide information and assistance  
2 requested by the Secretary and the Secretary's contractors to enable them to  
3 conduct the analysis required by this act.

4 (5) The Secretary shall provide periodic updates to the Joint Fiscal  
5 Office on the estimates and analysis required by this subsection and his or her  
6 underlying fiscal assumptions.

7 (d)(1) The Secretary may contract with other individuals and entities as  
8 needed to provide actuarial services, economic modeling, and any other  
9 assistance the Secretary requires in carrying out the analyses described in  
10 subsections (b) and (c) of this section.

11 (2) To the extent necessary to conduct the analyses required by  
12 subsections (b) and (c) of this section and consistent with the requirements of  
13 the Health Insurance Portability and Accountability Act of 1996, a health  
14 insurer licensed to do business in Vermont shall provide information requested  
15 by the Secretary or the Secretary's contractors within 30 days of the request, to  
16 the extent feasible and upon receipt by the health insurer of a nondisclosure  
17 agreement from the State and its contractors. The Secretary may enter into a  
18 confidentiality agreement with an insurer if the data requested includes  
19 proprietary or other confidential material. No health insurer shall be required  
20 to provide protected health information.

1                                   \* \* \* Exchange Sustainability Analysis \* \* \*

2           Sec. 21. VERMONT HEALTH BENEFIT EXCHANGE

3                                   TECHNOLOGY; SUSTAINABILITY ANALYSIS; REPORT

4           (a)(1) The Joint Fiscal Office, in collaboration with one or more  
5           independent third parties pursuant to contracts negotiated for that purpose,  
6           shall conduct an analysis and provide a report to the General Assembly on or  
7           before December 1, 2016 on the current functionality and long-term  
8           sustainability of the technology for Vermont’s Health Benefit Exchange,  
9           including a review of the deficiencies in Vermont Health Connect functionality  
10           and the integration, connectivity, and business logic of each as they pertain to  
11           both the back-end systems and the user interface of Vermont Health Connect.

12                               (2) The analysis shall provide recommendations for improving the  
13           functionality, efficiency, reliability, operations, and customer experience of the  
14           technology going forward.

15                               (3) The report shall include an evaluation of the investment value of  
16           existing components of the Exchange technology and the contractor’s  
17           assessment of the feasibility and cost-effectiveness of leveraging existing  
18           components of the Vermont Health Benefit Exchange as part of the technology  
19           for a larger, integrated eligibility system, including reviewing changes other  
20           states have made to the Exchange components of their technology  
21           infrastructure.

1           (4) The analysis and report shall provide a comparison of the  
2           investments required to ensure a sustainable State-based Exchange through  
3           further investment in Vermont Health Connect’s current technology, including  
4           any opportunities to build on other states’ Exchange technology and  
5           opportunities to join with other states in a regional Exchange, with the  
6           estimated investments that would be required to transition to a fully or partially  
7           federally facilitated Exchange.

8           (b) In conducting the analysis and report pursuant to this section, and in  
9           preparing any requests for proposals from independent third parties, the Joint  
10           Fiscal Office shall consult with health insurers offering qualified health plans  
11           on Vermont Health Connect.

12           (c) The Health Reform Oversight Committee and the Joint Fiscal  
13           Committee shall provide ongoing oversight and review of the analysis and  
14           report.

15                                   \* \* \* Health Research Commission \* \* \*

16           Sec. 22. 2 V.S.A. chapter 27 is added to read:

17                                   CHAPTER 27. HEALTH RESEARCH COMMISSION

18           § 961. CREATION OF COMMISSION

19           (a) There is established the Health Research Commission to coordinate and  
20           provide oversight over legislative policy research, studies, and evaluations  
21           related to health care delivery, regulation, and reform.



1       (b) Members of the Commission shall include two members of the House  
2       of Representatives appointed by the Speaker of the House, two members of the  
3       Senate appointed by the Senate Committee on Committees, and one member  
4       appointed by the Governor.

5       (c) The Commission may meet as needed. For attendance at meetings  
6       during adjournment of the General Assembly, legislative members of the  
7       Commission shall be entitled to per diem compensation and reimbursement of  
8       expenses pursuant to section 406 of this title. The member appointed by the  
9       Governor shall be entitled to per diem compensation and reimbursement of  
10       expenses pursuant to 32 V.S.A. § 1010 if he or she is not a full-time State  
11       employee.

12       § 962. EMPLOYEES; BUDGET

13       (a) The Commission shall meet promptly following the appointment of its  
14       members in order to organize and begin conducting its business. The  
15       Commission may adopt its own rules for the operation of its personnel.

16       (b)(1) The Commission shall employ professional and secretarial staff as  
17       needed to carry out its functions and shall determine their compensation  
18       subject to legislative appropriation.

19       (2)(A) All requests for assistance, information, and advice from the  
20       Commission and all information the Commission receives in connection with  
21       research or related studies is exempt from public inspection and copying under

1 the Public Records Act and shall be kept confidential unless the party  
2 requesting assistance or providing information specifies otherwise. All  
3 Commission reports, documents, and transcripts or minutes of Commission  
4 meetings, including written testimony submitted to the Commission, are not  
5 confidential under this subdivision.

6 (B) The staff of the Commission may sign data use agreements and  
7 confidentiality agreements on the Commission’s behalf in order to collect the  
8 data, including health care claims and tax information, needed to carry out the  
9 duties of the Commission. Data collected by Commission staff may be used  
10 only for the purposes of studies and evaluation. Appropriate data standards  
11 shall be maintained to ensure confidentiality.

12 (c) The Commission shall prepare a budget as part of the Joint Fiscal  
13 Committee’s budget.

14 (d) The Commission shall receive administrative, fiscal, and legal support  
15 from the Joint Fiscal Office and the Legislative Council. In addition, the  
16 Commission may retain the services of one or more consultants or experts  
17 knowledgeable in health care systems, financing, or delivery to assist in its  
18 work within the amounts appropriated in its budget.

19 § 963. FUNCTIONS

20 The Commission shall direct, supervise, and coordinate the work of its staff,  
21 which shall include:

1           (1) furnishing policy research and evaluation services, including  
2           coordinating contracts with consultants, related to health care for studies  
3           required by legislation enacted by the General Assembly;

4           (2) engaging in a continuing review of the State's health care reform  
5           initiatives;

6           (3) monitoring the activities of the Green Mountain Care Board on  
7           behalf of the General Assembly; and

8           (4) keeping and maintaining minutes of its meetings.

9           Sec. 23. POSITIONS

10           On or before July 1, 2016, up to three positions and appropriate amounts for  
11           personal services and operating expenses shall be transferred from the Agency  
12           of Administration to the General Assembly to provide staff for the Health  
13           Research Commission established in Sec. 22 of this act.

14           Sec. 24. APPOINTMENTS TO THE HEALTH RESEARCH COMMISSION

15           The Speaker of the House of Representatives, the Senate Committee on  
16           Committees, and the Governor shall appoint the first members of the Health  
17           Research Commission established pursuant to 2 V.S.A. chapter 27 on or before  
18           August 15, 2016.

\*\*\* Appropriations \*\*\*

Sec. 25. APPROPRIATIONS

(a) The sum of \$240,000.00 is appropriated from the General Fund to the Secretary of Administration in fiscal year 2017 to support the universal primary care and Dr. Dynasaur expansion studies and reports pursuant to Sec. 20 of this act.

(b) The sum of \$250,000.00 is appropriated from the General Fund to the General Assembly in fiscal year 2017 for purposes of the Health Research Commission established pursuant to 2 V.S.A. chapter 27.

Sec. 26. FISCAL YEAR 2016; REVERSIONS; APPROPRIATIONS

(a) Notwithstanding any provision of law to the contrary, and in addition to any other reversions in fiscal year 2016, the following amounts appropriated in fiscal year 2016 to the following sources shall revert to the General Fund:

(1) from the Office of the State Treasurer, the amount of \$115,000.00;

(2) from the Green Mountain Care Board, the amount of \$109,320.00.

(b) The amount of \$224,320.00 is appropriated in fiscal year 2016 from the General Fund to the Joint Fiscal Office for the purpose of implementing Sec. 21 of this act.

Sec. 27. FISCAL YEAR 2017; APPROPRIATION; ALLOCATION

(a) Of the amounts appropriated in fiscal year 2017 from the General Fund to the Agency of Agriculture, Food and Markets, the amount of \$175,680.00 is

1 appropriated from the Agency to the Joint Fiscal Office for the purpose of  
2 implementing Sec. 21 of this act.

3 (b) The Commissioner of Finance and Management shall exercise his or  
4 her authority pursuant to 32 V.S.A. § 511 (allocation of excess receipts) to  
5 allocate \$175,680.00 to the Agency of Agriculture, Food and Markets.

6 \* \* \* Repeal \* \* \*

7 Sec. 28. REPEAL

8 2 V.S.A. chapter 20 (Health Reform Oversight Committee) is repealed on  
9 January 1, 2017.

10 \* \* \* Effective Dates \* \* \*

11 Sec. 29. EFFECTIVE DATES

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

14 (b) Secs. 17–19 (nutrition procurement standards), 25 (FY17  
15 appropriations) and 27 (FY17 appropriation and allocation) shall take effect on  
16 July 1, 2016.

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

18 (Committee vote: \_\_\_\_\_)

19 \_\_\_\_\_

20 Senator \_\_\_\_\_

21 FOR THE COMMITTEE